

Total Cost of Insulin Work Group

Final Report

Substitute House Bill 1728; Section 1(4); Chapter 205; Laws of 2022

July 1, 2023

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Executive Summary

The Washington State Health Care Authority (HCA) convened the Total Cost of Insulin Work Group (Work Group) as directed by [Substitute House Bill \(SHB\) 1728 \(2022\)](#), and is submitting this report as required in RCW 70.14.160(4):

“The work group must submit a final report by July 1, 2023, to the governor and the legislature. The final report must include any statutory changes necessary to implement the strategies.”

This final legislative report details the work HCA and the Work Group have performed in reviewing and designing strategies to:

- Reduce the cost of and total expenditures of insulin in this state; and
- Provide a once yearly 30-day supply of insulin to individuals on an emergency basis.

To support the Work Group, HCA contracted with the [Center for Evidence-based Policy \(Center\)](#) at [Oregon Health & Science University \(OHSU\)](#) to provide assistance with policy review, facilitate Work Group meetings, and develop strategies related to improving insulin access and affordability. HCA convened five meetings for the Work Group and received input from Work Group members about how these strategies could improve insulin accessibility and affordability. Data analyses from prior efforts around [Engrossed Substitute Senate Bill \(ESSB\) 5203 \(2021\)](#), which directed HCA to establish partnerships to produce, distribute, or purchase insulin and generic prescription drugs, were also presented to the Work Group to demonstrate insulin costs in Washington.

This final report lays out policy frameworks for the governor and the legislature to consider for reducing the cost and total expenditures on insulin and for providing a once yearly 30-day supply of insulin to individuals on an emergency basis. The key aspects of these frameworks are:

- Contracting with manufacturers to sell discounted insulin to all Washingtonians.
 - This will reduce the total cost of insulin by providing greater access to rebates or contracting with manufacturers with low net costs to ensure access in the state.
 - This aligns with work from ESSB 5203 (2021).
- Requiring manufacturers to cover the cost of a 30-day supply of insulin for emergencies.
 - This policy has been effective in Maine and Minnesota since the cost of insulin is often the greatest barrier that patients face when needing an emergency supply.

Background

Many Washingtonians living with diabetes depend on daily use of prescribed insulin to survive. Insulin is used to control blood glucose levels within a standard range which helps prevent complications when their blood sugars become too high. Without the proper amount of insulin, patients may suffer permanent damage to organs or fall into a diabetic coma due to dehydration from elevated blood glucose levels. Without emergency care, diabetic comas can be fatal. Insulin is an integral medication to the health and well-being of Washingtonians living with diabetes. However, many find insulin inaccessible or unaffordable due to its high list price or high cost-shares from their health insurance. As a result, some Washingtonians ration their insulin or skip doses, which jeopardizes their health.

The Washington State Legislature addressed insulin affordability by passing Engrossed Second Substitute House Bill 2662 and Engrossed Second Substitute Senate Bill 6087 in 2020 and Substitute Senate Bill 5546 in 2022. Both 2020 bills addressed patient out-of-pocket costs by capping the copay for a 30-day supply of insulin to a maximum of \$100 effective in 2021. In 2022, Senate Bill 5546 lowered this maximum copay to \$35 for those with qualifying insurance, effective in 2023. This legislation is effective for those covered by commercial insurance because capping the cost-share reduces the likelihood that patients with high cost-shares may not fill their prescriptions or use their insulin as directed. Legislation was introduced in 2023 with Senate Bill 5729 to remove the expiration date for the copay cap. The bill was signed by Governor Inslee on March 30, 2023, and will be effective July 23, 2023.

Additionally, the legislature intended to review, consider, and pursue several strategies with the goal of reducing the total cost of insulin beyond just what patients pay for insulin at their pharmacies. To address this issue, the 67th Washington State Legislature passed Substitute House Bill (SHB) 1728. This bill directed HCA to accomplish several tasks with a focus on addressing insulin access and affordability in the state. The first step was for HCA to create a Total Cost of Insulin Work Group (Work Group) as described in statute. HCA is to receive input from the Work Group about strategies to reduce the cost of, and total expenditure on, insulin and how to provide a 30-day supply of insulin to individuals on an emergency basis.

HCA contracted with the Center for Evidence-based Policy (Center) at Oregon Health & Science University (OHSU) to support HCA with research assistance, facilitating surveys for Work Group members, and helping prepare materials for meetings. HCA previously worked with the Center on Engrossed Substitute Senate Bill (ESSB) 5203 (2021) for exploring options around establishing partnerships to produce, distribute, or purchase insulin. Some of the strategies researched and data analyses conducted during that work were brought forward as considerations for the Work Group, in the form of survey questions or topics discussed at Work Group meetings.

HCA worked closely with the Governor's office to identify and recruit stakeholders from agencies, organizations, and the public to participate in this Work Group in accordance with the legislative directive. A list of Work Group members can be found in Appendix A.

Process Overview

HCA planned five Work Group meetings from July 2022 to March 2023 to present proposed strategies, facilitate discussions, solicit feedback, gather recommendations, and draft a final legislative report. Table 1 outlines the meeting schedule and topics covered for each Work Group meeting. The Work Group's process was flexible and iterative, being based on feedback from members and the policy research conducted. Following Table 1 is a detailed description of the Work Group's process used to develop the 2 recommended policies assigned to the Work Group.

Table 1. Total Cost of Insulin Work Group Meetings and Topics

Meeting	Date	Topics Covered
Total Cost of Insulin Work Group #1	July 8, 2022	<ul style="list-style-type: none"> Review legislation and workplan Review insulin cost analyses developed under SB 5203 (2021) Solicit feedback from Work Group about topics to cover Overview and discussion of Survey #1
Total Cost of Insulin Work Group #2	August 25, 2022	<ul style="list-style-type: none"> Review existing Washington capacities including, but not limited to, the ArrayRx discount card program Review research relating to distribution or purchase of insulin developed under SB 5203 (2021) Polled members on the pros and cons of state approaches including ArrayRx and collaboration with other states or non-profit insulin programs Overview and discussion of Survey #2
Total Cost of Insulin Work Group #3	October 27, 2022	<ul style="list-style-type: none"> Presentation on patient perspectives for an emergency supply program Review emergency supply program options and discuss considerations for: <ul style="list-style-type: none"> Eligibility criteria Patient access Program monitoring Pharmacy reimbursement Overview and discussion of Survey #3
Total Cost of Insulin Work Group #4	December 6, 2022	<ul style="list-style-type: none"> Q&A session with Utah Insulin Savings Program Continue review of emergency supply policy option including: <ul style="list-style-type: none"> Comparisons of other state policies Draft Washington policy Work Group poll on proposed policy elements Updated insulin cost analysis report Review of long-term cost containment policy option including: <ul style="list-style-type: none"> Comparisons of other state policies Draft Washington policy Work Group poll on proposed policy elements
Total Cost of Insulin Work Group #5	March 16, 2023	<ul style="list-style-type: none"> Review and finalize recommendations Work Group input and public testimony

HCA and the Center planned to accomplish the requirements of SB 1728 by completing six tasks to research, develop, and present strategies for insulin access and affordability. These tasks were:

1. Review cost analysis for insulin
2. Review relevant prior work by HCA
3. Conduct survey of nationwide policy options
4. Create policy comparison grids and solicit feedback from other states
5. Review policy grids with Work Group and document areas of agreement and disagreement
6. Compile policy recommendations into final report and review report with Work Group

Task 1: Review cost analysis for insulin

HCA and the Center began preparing a cost analysis review for the first Work Group meeting by reevaluating work from 2021 Senate Bill 5203 which directed HCA to establish partnerships to produce, distribute, or purchase generic prescription drugs and insulin. As part of that work, the Center conducted an analysis of insulin claims from the Washington State All Payers Claim Database (APCD). This information would be useful for the Work Group because it analyzed insulin cost trends for the state of Washington as part of understanding the total cost of insulin.

During the first meeting, the Center presented findings from this research and solicited feedback from the Work Group. The Work Group feedback prompted additional research on the incidence of diabetes in Washington, an estimation of uninsured diabetics, and recent national trends in insulin pricing. Key findings from this research are presented in Appendix B.

Task 2: Review relevant prior work by HCA

Through the work of 2021 SB 5203, the Center and HCA completed a comprehensive analysis of potential policies aimed at reducing the cost of insulin. The analysis included:

- Policy review of best practices for bulk purchasing and distribution of insulin including:
 - California’s Affordable Drug Manufacturing Act
 - ArrayRx Solutions
 - CivicaRx
 - Utah Insulin Savings Program
- Washington-specific insulin policy recommendation, including:
 - State-run manufacturing
 - White-label program
 - Public health distributor
- Other tools and considerations for bulk purchasing and distribution including state-run manufacturing, state-run white-labeling, and a public health distributor

During the second Work Group meeting, HCA and the Center presented an overview of its research and how these options may address insulin access and affordability in the state. This meeting included presentations on a comprehensive overview of ArrayRx’s current operations and how two of its current offerings, the discount card and voucher program, could potentially be used as part of the legislative requirements. Work Group members discussed these options. The full presentation from the August 25, 2022 meeting can be found [online](#).

Task 3: Conduct survey of nationwide policy options

After evaluating the different options, Work Group members strongly supported discussing Minnesota's Alec Smith Insulin Affordability Act as a potential policy for both legislative requirements. According to the second survey submitted by Work Group members, on a scale of 1-5 (with 5 being strongly support) the average score from Work Group members was 4.2 in favor of discussing Minnesota's legislation, which was the highest of the options considered. As a next step in developing an emergency supply policy option, HCA and the Center conducted a survey of state legislation for emergency supply insulin programs.

Through that research, HCA and the Center found four examples of emergency supply insulin programs. The four examples were:

- Maine Insulin Safety Net Program
- Minnesota Insulin Safety Net program
- Utah's Insulin Savings Program
- Ohio House Bill 37 (2022)

These programs and their corresponding legislation range in scope, eligibility, and operations including application process, amount of drug dispensed, reimbursement policies, eligibility criteria, patient access, drugs, and program monitoring. For example, Maine and Minnesota both require manufacturers to reimburse pharmacies directly for dispensed amounts of insulin. Utah requires residents to enroll in a health benefit plan that includes a single benefit, which is low-cost insulin. Ohio's bill targets all noncontrolled medications, not just insulin and only applies to the commercially-insured. The full presentation of these policies from the October 27, 2022 meeting can be found [online](#).

During this step in the process, Work Group members strongly suggested creating policy grids to compare legislation options and program elements to better evaluate how these programs differed. This suggestion guided future work and served as a road map for future Work Group meetings which would begin to focus on potential policy recommendations.

Task 4: Create policy comparison grids and solicit feedback from other states

Following Work Group meeting 3, HCA and the Center began focusing on refining the policy grids on both short-term emergency supplies options and long-term policies on reducing the total costs of insulin in the state. This process included analyzing state legislation from each program and compiling that information into separate grids for the Work Group to clearly compare and contrast the policy options. The final policy grids are included in the Strategies section of the report following the Process Overview section.

As part of the research completed while drafting the grids, the Center reached out to other states including Maine, Minnesota, and Utah in hopes of inviting the states to share lessons learned with the Work Group and any recommendations. A representative from Utah met with members during Work Group meeting 4 to discuss the Utah Insulin Savings Program. Utah's program has had lower participation rates than expected as it launched during the COVID-19 pandemic, and the program did not receive any funding or resources for public awareness efforts.

Task 5: Review policy grids with Work Group and document areas of agreement and disagreement

The fourth meeting allowed Work Group members to evaluate both the emergency supply policy grid and the long-term cost reduction policy grid. HCA and the Center solicited feedback from Work Group members about the different aspects of the policies and programs. Members were able to document their support for each program element for both the short-term and long-term policy options. Each program element was presented, and members were able to rank their support on a scale of 1-5. Full results of these polls from the December 6, 2022 meeting can be found [online](#).

Task 6: Compile policy recommendations into final report and review report with Work Group

In the fifth meeting, HCA and Center staff presented the comprehensive, final policy recommendations developed from Work Group input. The meeting included an update on insulin-related bills introduced during the Washington State legislature during the 2023 legislative session. Additionally, there was a detailed overview of two of ArrayRx's programs: the discount card program and voucher program.

The presentation of the final policy recommendations included reviewing the draft final report, newly-developed policy resources, such as visual depictions of the policy, and previous survey results from the Work Group showing areas of support or disagreement. The meeting ended with an open discussion of the final report and policy recommendations where Work Group members were encouraged to share any feedback and requests for the final report.

Long-term Strategy: Design strategy to reduce the cost of and total expenditures on insulin in Washington State

Summary of Policy

The potential long-term policy option for Washington State includes a three-pronged approach to offer comprehensive access to affordable insulin. The three strategies represent a spectrum of options that target different individual needs, incomes, and are at varying levels of implementation (see Table 2).

Table 2. Implementation Status and Income Eligibility Criteria for Long-term Strategies

Strategy	Implementation Status	Income Eligibility
ArrayRx Discount Card	Implemented as of 2005	None
ArrayRx Insulin Voucher Program	ArrayRx has a voucher program but not an insulin-specific program.	HCA has authority to determine any eligibility criteria for insulin-specific voucher program or any legislation could include criteria. Work Group members' proposal: Provide address in state but do not require ID or proof of residency (same as Discount Card).
Manufacturer Assistance Program	Currently does not exist. This would need to be created.	Would need to be designed by legislature. Programs in other states limit to at or below 400% FPL.

The three strategies are:

- 1) **ArrayRx discount card:** This program has existed since 2005 and is available to all Washingtonians. All FDA approved drugs are eligible for a discount, there is no formulary and no preferred drugs. The discount card is used at a network pharmacy at the point of sale to allow any state resident to pay the ArrayRx contracted discounted rate. There are 1,177 network pharmacies in Washington State and 52,775 network pharmacies across the country. This means that Washingtonians can always access a discounted rate on all prescription drugs, including insulin and diabetes supplies.

This strategy would reduce the cost of insulin in the state for some Washingtonians. Washingtonians can compare the cost of insulin through their existing insurance, if they have it, to the price contracted through the discount card. People with diabetes can enroll in the program online and receive a digital card, or physical card if requested, to present at a participating pharmacy to receive insulin at the discounted price. This strategy can be leveraged to provide

discounted insulin while the other strategies are implemented. Patients would also have access to all other FDA approved drugs at discounted prices, which may lower their total health care expenditure beyond just insulin.

The ArrayRx network pharmacies and discounted prices can be found on the [ArrayRx Card look up tool](#).

- 2) **ArrayRx voucher program:** An ArrayRx voucher program specific for insulin could be created to provide greater discounts than the current ArrayRx discount card. ArrayRx voucher programs are currently used by facilities and public sector entities to provide medication to patients at a predetermined co-pay or at no cost to the recipient. This insulin voucher strategy could provide a greater discount because a lower price would be negotiated directly with the manufacturer, similar to Utah's Insulin Savings Program.

To create an insulin voucher program, the legislature would direct HCA to issue a Request for Proposals (RFP) to manufacturers for a discounted price on insulins and any related products (e.g., syringes, pen needles, etc.). Manufacturers would bid on the RFP, and the awarded manufacturer(s) insulins and related products would be available through the voucher program. Pharmacies would be paid the full price of the insulin. The payment would be paid in two parts: a predetermined price by the patient and the remaining balance by the state agency. The state agency would then be reimbursed by the manufacturer in the form of a rebate.

To access this voucher program, patients could register through an online process as long as they have a Washington address. There would be no income or age restrictions to qualify for this program. The patient would present the voucher card at a network pharmacy and pay the discounted, post-rebate price for insulin.

- 3) **Manufacturer patient assistance programs:** In the first two options, patients would have access to discounted prices but not free insulin. The manufacturer patient assistance program would be a no-cost option for patients with a family income under a specific income threshold. For example, programs in other states have set patient assistance thresholds at a family income less than 400% of the Federal Poverty Level (FPL).

The manufacturer assistance program would have stricter eligibility criteria than the ArrayRx options, which would be open to all Washingtonians. Legislative action would need to require manufacturers to participate in the patient assistance program and assume responsibility for daily operation of the program. Through the manufacturer patient assistance program, Washington residents would apply to the program directly with the manufacturer. If deemed eligible, the patient would then present the manufacturer-provided proof of eligibility to the pharmacy to receive insulin at no cost. The pharmacy would then work directly with the manufacturer to be reimbursed either with replaced supply or monetarily via electronic claims submission. The state would establish an eligibility appeal process in case of denials or other complaints.

[Minnesota's Insulin Safety Net Program](#) is an example of a similar program.

Each strategy targets a different population and would have varying eligibility requirements. Each strategy is also in different stages of implementation. For example, the ArrayRx discount card is currently available and patients are receiving discounted insulin today. An insulin voucher program through ArrayRx would be a new adaptation of the existing voucher program and the eligibility criteria, including income qualifications, would need to be designed. The manufacturer patient assistance program does not currently exist in the state and legislation creating it would require setting eligibility requirements.

Table 3 below outlines the different long-term policy recommendations in more detail.

Table 3: Long-Term Policy Recommendation Grid

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
Summary of Policy	<p>Provide discounted insulin to Washingtonians through:</p> <ul style="list-style-type: none"> • ArrayRx discount card • ArrayRx voucher program • Manufacturer patient assistance programs 	<ul style="list-style-type: none"> • Discount card: No • Voucher program: No • Manufacturer patient assistance program: Yes 	<p>Yes; appropriation would be needed for the voucher program to function because there would be a cash flow gap between the time HCA (or a state entity) pays pharmacies in full for the dispensed insulin and the rebate amount to be received.</p>	<p>A Participating Program Agreement would be needed to create an insulin voucher program with ArrayRx. ArrayRx would collect the manufacturer rebates and deliver them to HCA.</p>
Eligibility Criteria	<p>ArrayRx:</p> <ul style="list-style-type: none"> • Discount card current eligibility: All state residents qualify, no age or income restrictions. Does require ID or documentation of residence; all that is required is Washington address. And for people who are houseless, they can put down shelter or leave it blank. • Voucher program: All state residents qualify, no age or income restrictions. Does 	<p>Yes; statute changes for manufacturer patient assistance program¹</p>	<p>If eligibility verification is required for the voucher program, HCA would potentially need resources to manage that process.</p> <p>Depending on the volume of eligibility appeals from the manufacturer assistance program, HCA might need resources to manage the number of appeals.</p>	<p>None</p>

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	<p>require ID or documentation of residence; all that is required is Washington address. And for people who are houseless, they could put down shelter or leave it blank.</p> <p>Manufacturer assistance program:</p> <ul style="list-style-type: none"> • Additional requirement for patient assistance program: family income less than 400% FPL 			
Application Process	<p>All patients would sign up online or at health care sites and receive either a digital card delivered to their phone or paper card mailed to them. (Through ArrayRx or through a manufacturer patient assistance program.)</p>	None	If eligibility verification is required for voucher program HCA may need an FTE to manage applications.	Depending on eligibility verification needs and the number of appeals from the manufacturer assistance program, HCA may need additional resources.
Manufacturer Responsibilities	<p>ArrayRx:</p> <ul style="list-style-type: none"> • Discounted insulin: Washington Legislature could require manufacturers to offer insulin at discounted price, such as requiring insulin be evaluated annually by the Prescription Drug Affordability Board. • Voucher program: manufacturers would bid on HCA's RFP and the winner's 	<p>Yes; WA legislature need to direct manufacturers to offer insulin at discounted price</p> <p>Yes; would need legislation for manufacturer program assistance program. Other state legislation included things like:²</p> <ul style="list-style-type: none"> • Criteria for participation (e.g., any manufacturer selling 	For ArrayRx to conduct an RFP, there would be a work order with designated funds.	HCA would need to execute a work order with ArrayRx to create the insulin voucher program.

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	<p>brand(s) would be used for voucher program.</p> <p>Manufacturer assistance program:</p> <ul style="list-style-type: none"> • Manufacturer assistance program: manufacturer would be responsible for eligibility determination, providing insulin to pharmacies or patients via direct mail service, and reimbursing pharmacies for dispensed insulin. 	<p>more than 1,000,000 units of insulin in the state each year).</p> <ul style="list-style-type: none"> • Definition of manufacturer (e.g., RCW 18.64.011(22)). • Reporting requirements (manufacturer must send annual reports of how many people accessed program, how many units of insulin were dispensed, value of dispensed insulin, etc. • Eligibility process: MN and ME both require manufacturer to determine eligibility but state has oversight of appeals. 		
Patient Responsibilities	<p>ArrayRx voucher program or discount card:</p> <ul style="list-style-type: none"> • Patients would be responsible for enrolling in programs online and presenting ArrayRx card at pharmacy. • Patients would be able to check online for participating pharmacies (1,177 in WA). 	Yes; would be required for manufacturer assistance program. ³	None; the patient would be responsible for covering the administrative fees ArrayRx charges (as is current process with discount card).	Voucher program: State entity would need to cover cash flow gap in order to pay pharmacy in whole and wait to receive rebates from ArrayRx.

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	<p>Manufacturer assistance program:</p> <ul style="list-style-type: none"> Patients would need to apply through manufacturer and present proof of eligibility (provided by manufacturer) to pharmacy. 			
Pharmacy Responsibilities	<p>ArrayRx:</p> <ul style="list-style-type: none"> Discount card and voucher program: Pharmacy would collect money from patient. <p>Manufacturer assistance program:</p> <ul style="list-style-type: none"> Pharmacy would work out with manufacturer payment or product replacement. 	Yes; would be required for manufacturer assistance program. ⁴	None	For the insulin voucher program, pharmacies would invoice ArrayRx and then ArrayRx would invoice HCA.
Reimbursement Process	<p>ArrayRx:</p> <ul style="list-style-type: none"> Discount card: Patient pays discounted price at pharmacy. Voucher program: covered medications are paid to pharmacy by state agency sponsoring program plus the patient cost share for prescription. <ul style="list-style-type: none"> Assume that the pharmacy would still 	<p>No; HCA would not need statutory changes to create an insulin voucher program, only an initial appropriation.</p> <p>Yes; for manufacturer assistance program process for reimbursement (through claim or reimbursed supply) must be outlined.⁵</p>	HCA would need an appropriation to cover the cash flow gap that exists between paying the pharmacy the full drug cost and receiving the rebate from ArrayRx.	For the insulin voucher program, pharmacies would invoice ArrayRx and then ArrayRx would invoice HCA.

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	<p>be paid the contracted amount and that the patient would pay the contracted amount less the negotiated rebate. HCA would have to backfill the cash flow gap to the pharmacy with state funds until rebate is received by HCA from the drug manufacturer.</p> <p>Manufacturer assistance program:</p> <ul style="list-style-type: none"> Manufacturers would be responsible for reimbursing pharmacies directly. 			
Educational Assistance	<p>Work Group suggestion: Create an educational program for pharmacists and patients to help identify patients that need help overcoming barriers.</p>	<p>Yes; this would be required for all aspects of program.</p> <p>Other states include specifics for what must be included such as: contact information for peer navigator services, information on applying for state-sponsored health plan, information on providers that participate</p>	<p>If this was part of a larger public awareness campaign, an appropriation would likely be needed. For example, Minnesota received a one-time appropriation of \$250,000 to cover that work.</p>	<p>Administrative resources would be needed if HCA was responsible for creating educational assistance information.</p>

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
		in prescription drug discount programs, etc. ⁶		
State Entity Responsibilities	<p>Work Group members prioritized access to state-negotiated insulin prices through ArrayRx Solutions as a top policy strategy for a long-term affordable insulin program.</p> <p>ArrayRx Solutions has interagency participation from Washington, Oregon, and Nevada state agencies.</p> <p>At the request of HCA, ArrayRx would go out for bid, get preferred price of insulin and work with state’s existing drug discount card or voucher program to pass through discounted insulin to consumers.</p> <p>Individuals on government-purchased health plans would continue with their existing benefit process.</p> <p>HCA would have to backfill the cash flow gap to the pharmacy with state funds until rebate is received by HCA from the drug manufacturer.</p> <p>HCA would manage the eligibility appeals process under the assistance program.</p>	<p>No; HCA would not need statutory changes to create an insulin voucher program, only an initial appropriation.</p> <p>Yes; for manufacturer assistance program legislation would be needed to outline reimbursement responsibilities of state as well as how the eligibility appeal system would work.⁷</p>	HCA would need an appropriation to cover the cash flow gap that exists between paying the pharmacy the full drug cost and receiving the rebate from ArrayRx.	HCA would issue an RFP and contract with the winning bidder(s).

Table 4: Legislative Language Examples for Manufacturer Patient Assistance Program

Element	Example Legislative Language
¹ Eligibility Criteria	<p>Per Subdivision 4 of Minnesota’s Legislation</p> <p>To be eligible to participate in a manufacturer's patient assistance program, the individual must:</p> <p>(1) be a Minnesota resident with a valid Minnesota identification card that indicates Minnesota residency in the form of a Minnesota identification card, driver's license or permit, or tribal identification card as defined in section 171.072, paragraph (b). If the individual is under the age of 18, the individual's parent or legal guardian must provide proof of residency;</p> <p>(2) have a family income that is equal to or less than 400 percent of the federal poverty guidelines;</p> <p>(3) not be enrolled in medical assistance or MinnesotaCare;</p> <p>(4) not be eligible to receive health care through a federally funded program or receive prescription drug benefits through the Department of Veterans Affairs; and</p> <p>(5) not be enrolled in prescription drug coverage through an individual or group health plan that limits the total amount of cost-sharing that an enrollee is required to pay for a 30-day supply of insulin, including co-payments, deductibles, or coinsurance to \$75 or less, regardless of the type or amount of insulin needed.</p> <p>(c) Notwithstanding the requirement in paragraph (b), clause (4), an individual who is enrolled in Medicare Part D is eligible for a manufacturer's patient assistance program if the individual has spent \$1,000 on prescription drugs in the current calendar year and meets the eligibility requirements in paragraph (b), clauses (1) to (3).</p> <p>(d) An individual who is interested in participating in a manufacturer's patient assistance program may apply directly to the manufacturer; apply through the individual's health care practitioner, if the practitioner participates; or contact a trained navigator for assistance in finding a long-term insulin supply solution, including assistance in applying to a manufacturer's patient assistance program.</p>
² Manufacturer Responsibilities	<p>Per Subdivision 1 of Minnesota’s Legislation</p> <p>Manufacturer Eligibility:</p>

Element	Example Legislative Language
	<p>(c) Any manufacturer with an annual gross revenue of \$2,000,000 or less from insulin sales in Minnesota is exempt from this section. To request a waiver under this paragraph, the manufacturer must submit a request to the Board of Pharmacy that includes documentation indicating that the manufacturer is eligible for an exemption.</p> <p>(d) An insulin product is exempt from this section if the wholesale acquisition cost of the insulin is \$8 or less per milliliter or applicable National Council for Prescription Drug Plan billing unit, for the entire assessment time period, adjusted annually based on the Consumer Price Index.</p> <p>Per Subdivision 5 of Minnesota’s Legislation</p> <p>Application Responsibilities:</p> <p>(b) If the individual is determined to be eligible, the manufacturer shall provide the individual with an eligibility statement or other indication that the individual has been determined eligible for the manufacturer's patient assistance program. An individual's eligibility is valid for 12 months and is renewable upon a redetermination of eligibility.</p> <p>(c) If the eligible individual has prescription drug coverage through an individual or group health plan, the manufacturer may determine that the individual's insulin needs are better addressed through the use of the manufacturer's co-payment assistance program, in which case, the manufacturer shall inform the individual and provide the individual with the necessary coupons to submit to a pharmacy. In no instance shall an eligible individual be required to pay more than the co-payment amount specified under subdivision 6, paragraph (e).</p> <p>Per Subdivision 13 of Minnesota’s Legislation</p> <p>Reporting Requirements</p> <p>(a) By February 15 of each year, beginning February 15, 2021, each manufacturer shall report to the Board of Pharmacy the following:</p> <p>(1) the number of Minnesota residents who accessed and received insulin on an urgent-need basis under this section in the preceding calendar year;</p>

Element	Example Legislative Language
	<p>(2) the number of Minnesota residents participating in the manufacturer's patient assistance program in the preceding calendar year, including the number of Minnesota residents who the manufacturer determined were ineligible for their patient assistance program; and</p> <p>(3) the value of the insulin provided by the manufacturer under clauses (1) and (2).</p> <p>For purposes of this paragraph, "value" means the wholesale acquisition cost of the insulin provided.</p> <p>(b) By March 15 of each year, beginning March 15, 2021, the Board of Pharmacy shall submit the information reported in paragraph (a) to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The board shall also include in the report any administrative penalties assessed under subdivision 10, including the name of the manufacturer and amount of the penalty assessed.</p>
³ Patient Responsibilities	<p>Per Subdivision 6 of Minnesota's Legislation</p> <p>(a) The individual shall submit to a pharmacy the statement of eligibility provided by the manufacturer under subdivision 5, paragraph (b). Upon receipt of an individual's eligibility status, the pharmacy shall submit an order containing the name of the insulin product and the daily dosage amount as contained in a valid prescription to the product's manufacturer.</p>
⁴ Pharmacy Responsibilities	<p>Per Subdivision 6 of Minnesota's Legislation</p> <p>(b) The pharmacy must include with the order to the manufacturer the following information:</p> <p>(1) the pharmacy's name and shipping address;</p> <p>(2) the pharmacy's office telephone number, fax number, email address, and contact name; and</p> <p>(3) any specific days or times when deliveries are not accepted by the pharmacy.</p> <p>(c) Upon receipt of an order from a pharmacy and the information described in paragraph (b), the manufacturer shall send to the pharmacy a 90-day supply of insulin as ordered, unless a lesser amount is requested in the order, at no charge to the individual or pharmacy.</p>

Element	Example Legislative Language
	<p>(d) Except as authorized under paragraph (e), the pharmacy shall provide the insulin to the individual at no charge to the individual. The pharmacy shall not provide insulin received from the manufacturer to any individual other than the individual associated with the specific order. The pharmacy shall not seek reimbursement for the insulin received from the manufacturer or from any third-party payer.</p> <p>(e) The pharmacy may collect a co-payment from the individual to cover the pharmacy's costs for processing and dispensing in an amount not to exceed \$50 for each 90-day supply if the insulin is sent to the pharmacy.</p> <p>(f) The pharmacy may submit to a manufacturer a reorder for an individual if the individual's eligibility statement has not expired. Upon receipt of a reorder from a pharmacy, the manufacturer must send to the pharmacy an additional 90-day supply of the product, unless a lesser amount is requested, at no charge to the individual or pharmacy if the individual's eligibility statement has not expired.</p>
⁵ Reimbursement Process	<p>Per Subdivision 6 of Minnesota's Legislation</p> <p>(d) Except as authorized under paragraph (e), the pharmacy shall provide the insulin to the individual at no charge to the individual. The pharmacy shall not provide insulin received from the manufacturer to any individual other than the individual associated with the specific order. The pharmacy shall not seek reimbursement for the insulin received from the manufacturer or from any third-party payer.</p> <p>(e) The pharmacy may collect a co-payment from the individual to cover the pharmacy's costs for processing and dispensing in an amount not to exceed \$50 for each 90-day supply if the insulin is sent to the pharmacy.</p> <p>(f) The pharmacy may submit to a manufacturer a reorder for an individual if the individual's eligibility statement has not expired. Upon receipt of a reorder from a pharmacy, the manufacturer must send to the pharmacy an additional 90-day supply of the product, unless a lesser amount is requested, at no charge to the individual or pharmacy if the individual's eligibility statement has not expired.</p>
⁶ Educational Assistance	<p>Per Subdivision 7 of Minnesota's Legislation</p> <p>(a) The Board of Pharmacy shall develop an information sheet to post on its website and provide a link to the information sheet on the board's website for pharmacies, health care practitioners, hospital</p>

Element	Example Legislative Language
	<p>emergency departments, urgent care clinics, and community health clinics. The information sheet must contain:</p> <ul style="list-style-type: none"> (1) a description of the urgent-need insulin safety net program, including how to access the program; (2) a description of each insulin manufacturer's patient assistance program and cost-sharing assistance program, including contact information on accessing the assistance programs for each manufacturer; (3) information on how to contact a trained navigator for assistance in applying for medical assistance, MinnesotaCare, a qualified health plan, or an insulin manufacturer's patient assistance programs; (4) information on how to contact the Board of Pharmacy if a manufacturer determines that an individual is not eligible for the manufacturer's patient assistance program; and (5) notification that an individual in need of assistance may contact their local county social service department for more information or assistance in accessing ongoing affordable insulin options.
<p>⁷State Entity Responsibilities</p>	<p>Per Subdivision 8 of Minnesota's Legislation</p> <p>(a) If an individual disagrees with a manufacturer's determination of eligibility under subdivision 5, the individual may contact the Board of Pharmacy to request the use of a three-person panel to review eligibility. The panel shall be composed of three members of the board. The individual requesting the review shall submit to the board, with the request, all documents submitted by the individual to the manufacturer. The board shall provide the panel with the documents submitted by the individual. The panel shall render a decision within ten business days of receipt of all the necessary documents from the individual. The decision of the panel is final.</p> <p>(b) If the panel determines that the individual is eligible, the manufacturer shall provide the individual with an eligibility statement in accordance with subdivision 5.</p>

Summary of Work Group Contributions for Long-term Options

In addition to the policy elements in the above grid, the Work Group had additional recommendations for a long-term affordable insulin program. This section outlines major contributions from the Work Group that are important to share given the discussions at Work Group meetings. Additional comments and feedback can be found in the survey responses, including in Appendix C.

- **Drug Price and Financial Transparency:** Work Group members supported exploring drug price and financial transparency disclosures related to the prices of insulin from manufacturers, PBMs, and plans regarding what the plan paid, member paid, rebates, and acquisition costs through required disclosures to the current Washington State Drug Price Transparency (DPT) program.
 - This would require legislative changes to require transparent financial disclosures to be reported by manufacturers to HCA and in the manner dictated by HCA.
 - Since the Washington State DPT Program is not able to share information about individual businesses, drugs, or drug classes, the DPT program is not able to meet the desires of the Work Group recommendation.
 - A change in [RCW 43.71C.100](#) would be required to share this information publicly.
 - This may require a change to current DPT program rules.
 - This change may require staff resources to compile information and draft reports.
 - This may potentially require stakeholder engagement process related to the exemption of Washington's DPT program and whether manufacturers have appeal rights.
- **Integrated Data:** Work Group members advocated for integrated data to publish total diabetes impact and improved outcomes.
- **Insulin price changes in 2023:** Work Group members were aware of news of manufacturers lowering the prices of insulin. Work Group members recommended to continue pursuing these options to ensure Washingtonians would be protected in case of future insulin price uncertainty.

Emergency Supplies Strategy: Design a strategy to provide a once yearly 30-day supply of insulin to individuals on an emergency basis

Summary of Policy

Work Group members immediately recommended an emergency supply policy similar to the program created by Minnesota's Alec Smith Emergency Insulin Act. Maine has a policy and program very similar to Minnesota's program, as both provide emergency supplies of insulin to residents of their states. After extensive research and discussion, the Work Group supported using those two pieces of legislation to serve as examples for a potential Washington State policy.

To meet the legislative intent assigned to the Work Group, this report details a policy to provide a once-yearly 30-day supply of emergency insulin. There was significant feedback from the Work Group recommending other options, including a 90-day supply, multiple 30-day supplies, and also unlimited access to emergency insulin in various forms. Providing a variety of types and brands of insulin from various manufacturers would mitigate any non-medical switching of prescriptions. Those recommendations are outlined below in the summary of Work Group contributions section.

In following the designs of Maine's and Minnesota's emergency supply programs, the Work Group recommended requiring manufacturers to reimburse pharmacies for the cost of the dispensed insulin. Pharmacies would need to be reimbursed for both the *acquisition* cost of the drug as well as the cost of *dispensing* the drug. In Maine and Minnesota, the manufacturer is required to reimburse the pharmacy, monetarily or through replaced supply, for the *acquisition* cost of the dispensed insulin. To cover the *dispensing* fee, pharmacies are allowed to charge the patient up to \$35 in these two states.

Statutory changes will be needed to direct manufacturers to reimburse pharmacies for dispensing the emergency supply insulin. Additional necessary statutory changes can be found in Table 5 below. These statutory changes will need to be addressed by the legislature, including eligibility, reimbursement processes, program monitoring, patient access, and educational materials provided.

Table 5: Emergency Supply Policy Grid

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
Summary of Policy	A policy to make a once-yearly 30-day emergency supply of insulin available.	Yes; would be necessary to require manufacturers to reimburse pharmacies for dispensed emergency supply of insulin. ¹	<p>If the manufacturers are responsible for covering the cost of the dispensed insulin, no additional appropriation is needed.</p> <p>If the state is directed to provide the emergency supply, an appropriation would be needed.</p>	A Participating Program Agreement would need to be created with program specific needs if ArrayRx is designated to reimburse pharmacies for dispensed insulin.
Emergency Prescription Authority (specific to insulin)	Upon receipt of completed and signed application, pharmacist may dispense emergency refills of insulin and associated insulin-related devices and supplies.	Yes; this is different than existing general emergency prescribing abilities for 72-hour supply. ²	No	Administrative consideration should be made regarding how pharmacy communicates with reimbursing entity about which kind of insulin was dispensed.
Amount Supplied	To meet legislative intent of the Work Group, a once-yearly 30-day supply of insulin should be provided.	Yes ³	<p>No additional appropriation is needed if manufacturers are directed to reimburse pharmacy via electronic claim or replaced supply.</p> <p>If the state is responsible for reimbursing, then an appropriation is needed.</p>	None

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
Funding Source	Manufacturers would reimburse pharmacies in an amount that covers the pharmacy's acquisition cost for insulin as well as the Business and Occupation tax (gross receipts tax).	Yes; would be necessary to require manufacturers to reimburse for dispensed supply (including tax amounts). ⁴ Might need to define manufacturer (e.g., RCW 18.64.011(22)).	If the state is directed to administer program, an additional FTE may be needed.	If state is directed to reimburse pharmacies and administer program, the timeline would need to include hiring considerations.
Copayment Instructions	Pharmacy should be made whole including <i>dispensing</i> fee through a copayment of \$15.	Yes; reimbursement amount would need to be in legislation. Another consideration would be to include a time frame in legislation for manufacturer reimbursement (e.g., 10 days). ⁵	The \$15 copay is for the dispensing of the drug – the rest of reimbursement would need to come from manufacturer.	None
Eligibility Criteria	The recommendation is to require state residency (in the form of providing Washington address on application form). The Work Group recommends against requiring state ID as this would limit access of	Yes; eligibility criteria would need to be outlined in legislation. ⁶	None	None

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	people who are undocumented, homeless, or staying in Washington temporarily.			
Application Process	<p>Individuals could apply at pharmacy, health care clinics, or online. They would present completed application to pharmacy who would review form and dispense emergency supply.</p> <p>Pharmacies should not be required to maintain copies of patient applications as this is just an additional administrative burden.</p> <p>Registration system should be standard and easy to use.</p>	Yes; legislation needed to outline application process and responsibilities. ⁷	No	No
Reimbursement Process	Pharmacies would be supported by the manufacturer through replacement stock or reimbursement from the manufacturer.	Yes; legislature would need to direct manufacturers to reimburse pharmacies for dispensed supply and	None	None

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	<p>Majority of Work Group members supported requiring manufacturers to reimburse supply but some people thought pharmacies should be able to choose preferred reimbursement process.</p> <p>If manufacturers are reimbursing, policy should make sure reimbursement is timely (e.g., 10 days).</p>	outline process for reimbursement. ⁸		
Educational Materials Provided	Educational material should be provided to all patients accessing emergency supply and should include information on wraparound services and other health insurance options or state programs.	Yes; required educational materials given to patients would need to be included in legislation. ⁹	Minnesota was appropriated \$250,000 for a larger public awareness campaign.	Depending on the requirements of the educational materials, there may need to be additional state resources either through FTE or contracts.
Prescriber Reporting Requirements	We will not mandate prescriber reporting requirements due to burden to pharmacies and unclear value. Other states require attestation on the application form that the patient has not received a	Yes; would need to be included in legislation.	None	None

Element	Potential Washington Policy (based on Work Group feedback)	Statute Change Required?	Appropriation Required?	Administrative Considerations
	30-day emergency supply within the last 12-months.			

Table 6: Legislative Language Examples of Minnesota Emergency Supply Legislation

Element	Example Legislative Language
<p>¹Summary of Policy</p>	<p>Per Subdivision 1 of Minnesota’s Legislation</p> <p>(a) By July 1, 2020, each manufacturer must establish procedures to make insulin available in accordance with this section to eligible individuals who are in urgent need of insulin or who are in need of access to an affordable insulin supply.</p> <p>(c) Any manufacturer with an annual gross revenue of \$2,000,000 or less from insulin sales in Minnesota is exempt from this section. To request a waiver under this paragraph, the manufacturer must submit a request to the Board of Pharmacy that includes documentation indicating that the manufacturer is eligible for an exemption.</p> <p>(d) An insulin product is exempt from this section if the wholesale acquisition cost of the insulin is \$8 or less per milliliter or applicable National Council for Prescription Drug Plan billing unit, for the entire assessment time period, adjusted annually based on the Consumer Price Index.</p>
<p>²Emergency Prescription Authority</p>	<p>Per Subdivision 3 of Minnesota’s Legislation</p> <p>(c) Upon receipt of a completed and signed application, the pharmacist shall dispense the prescribed insulin in an amount that will provide the individual with a 30-day supply.</p> <p>(b) If the individual is in urgent need of insulin, the individual may present a completed, signed, and dated application form to a pharmacy. The individual must also:</p> <ul style="list-style-type: none"> (1) have a valid insulin prescription; and (2) present the pharmacist with identification indicating Minnesota residency in the form of a valid Minnesota identification card, driver's license or permit, or tribal identification card as defined in section 171.072, paragraph (b). If the individual in urgent need of insulin is under the age of 18, the individual's parent or legal guardian must provide the pharmacist with proof of residency.

Element	Example Legislative Language
³ Amount Supplied	<p>Per Subdivision 3 of Minnesota’s Legislation</p> <p>(c) Upon receipt of a completed and signed application, the pharmacist shall dispense the prescribed insulin in an amount that will provide the individual with a 30-day supply.</p> <p>Per Section 1 of Ohio’s Legislation</p> <p>(b) If one thirty-day supply or one standard unit that exceeds a thirty-day supply is dispensed, then for a second or third dispensing of the drug under this section during the same twelve-month period, the amount shall not exceed a seven-day supply or, if the drug is packaged in a manner that provides more than a seven-day supply, the lowest available supply.</p>
⁴ Funding Source	<p>Per Subdivision 3 of Minnesota’s Legislation</p> <p>(d) The pharmacy may submit to the manufacturer of the dispensed insulin product or to the manufacturer's vendor a claim for payment that is in accordance with the National Council for Prescription Drug Program standards for electronic claims processing, unless the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the manufacturer or the manufacturer's vendor, the manufacturer or vendor shall reimburse the pharmacy in an amount that covers the pharmacy's acquisition cost.</p>
⁵ Copayment Instructions	<p>Per Subdivision 3 of Minnesota’s Legislation</p> <p>(e) The pharmacy may collect an insulin co-payment from the individual to cover the pharmacy's costs of processing and dispensing in an amount not to exceed \$35 for the 30-day supply of insulin dispensed.</p>
⁶ Eligibility Criteria	<p>Per Subdivision 2 of Minnesota’s Legislation</p> <p>(a) To be eligible to receive an urgent-need supply of insulin under this section, an individual must attest to:</p>

Element	Example Legislative Language
	<p>(1) being a resident of Minnesota;</p> <p>(2) not being enrolled in medical assistance or MinnesotaCare;</p> <p>(3) not being enrolled in prescription drug coverage that limits the total amount of cost-sharing that the enrollee is required to pay for a 30-day supply of insulin, including co-payments, deductibles, or coinsurance, to \$75 or less, regardless of the type or amount of insulin prescribed;</p> <p>(4) not having received an urgent-need supply of insulin through this program within the previous 12 months, unless authorized under subdivision 9; and</p> <p>(5) being in urgent need of insulin.</p> <p>(b) For purposes of this subdivision, "urgent need of insulin" means having readily available for use less than a seven-day supply of insulin and in need of insulin in order to avoid the likelihood of suffering significant health consequences.</p>
<p>⁷Application Process</p>	<p>Per Subdivision 3 of Minnesota's Legislation</p> <p>(a) MNSure shall develop an application form to be used by an individual who is in urgent need of insulin. The application must ask the individual to attest to the eligibility requirements described in subdivision 2. The form shall be accessible through MNSure's website. MNSure shall also make the form available to pharmacies and health care providers who prescribe or dispense insulin, hospital emergency departments, urgent care clinics, and community health clinics. By submitting a completed, signed, and dated application to a pharmacy, the individual attests that the information contained in the application is correct</p>
<p>⁸ Reimbursement Process</p>	<p>Per Subdivision 3 of Minnesota's Legislation</p> <p>(d) The pharmacy may submit to the manufacturer of the dispensed insulin product or to the manufacturer's vendor a claim for payment that is in accordance with the National Council for Prescription Drug Program standards for electronic claims processing, unless the manufacturer agrees to send to the pharmacy a replacement supply of the same insulin as dispensed in the amount dispensed. If the pharmacy submits an electronic claim to the manufacturer or the manufacturer's</p>

Element	Example Legislative Language
	<p>vendor, the manufacturer or vendor shall reimburse the pharmacy in an amount that covers the pharmacy's acquisition cost.</p>
<p>⁹Educational Materials Provided</p>	<p>Per Subdivision 3 of Minnesota's Legislation</p> <p>(f) The pharmacy shall also provide each eligible individual with the information sheet described in subdivision 7 and a list of trained navigators provided by the Board of Pharmacy for the individual to contact if the individual is in need of accessing ongoing insulin coverage options, including assistance in:</p> <p>(1) applying for medical assistance or MinnesotaCare;</p> <p>(2) applying for a qualified health plan offered through MNsure, subject to open and special enrollment periods;</p> <p>(3) accessing information on providers who participate in prescription drug discount programs, including providers who are authorized to participate in the 340B program under section 340b of the federal Public Health Services Act, United States Code, title 42, section 256b; and</p> <p>(4) accessing insulin manufacturers' patient assistance programs, co-payment assistance programs, and other foundation-based programs.</p>

Summary of Work Group Contributions

The Work Group had several discussions about the details of this short-term policy. Among the major themes:

- **Expand policy beyond once-yearly 30-day supply:** Work Group members requested expanding the emergency supply beyond the once-yearly 30-day supply. There was consistent and substantial feedback that a once-yearly 30-day supply of insulin was not enough. The Work Group understood that the 30-day supply was the legislative directive as written in statute, but they strongly advocated for the legislature to weigh the following policy elements when designing legislation for emergency supplies of insulin:
 - The once-yearly amount supplied should be 90 days instead of 30 days; or
 - There should be multiple 30-days allowed within a year; or
 - There should be no limit to the amount of times an individual can access the emergency supply within an annual period.
- **Effectiveness Review:** Work Group members requested that any program include a legislative review piece to evaluate the effectiveness of the program after an established implementation period (e.g., 2 years after implementation).
- **Alternative Approaches:** In an alternative approach to the recommended policy, the Washington State Legislature could direct health plans or the state to fund the emergency insulin program.
 - We did not find any examples where states were expected to cover the cost of providing discounted insulin to residents.
 - If the legislature does direct HCA to provide the emergency supply insulin, the state would require additional resources to work with ArrayRx on creating the emergency supply program.
 - The state would need an appropriation to cover the cost of emergency insulin. Instead of billing manufacturers directly, pharmacies would go through ArrayRx, to reimburse for the dispensed insulin.
- **Insulin price changes in 2023:** Work Group members were aware of news of manufacturers lowering the prices of insulin. Work Group members recommended to continue pursuing the emergency supply options as Washingtonians may still face emergency situations where they cannot afford the cost of insulin.

Other Legislative Considerations

This section outlines potential legislative policies that are beyond the scope of the Work Group but are additional avenues for pursuing affordable insulin. These policy examples emerged from Work Group discussions and are important to note given how they relate to the main objectives of this Work Group. States have used several strategies other than emergency supply or patient assistance programs to improve access and affordability of insulin and diabetic supplies including:¹

- Copayment limits on insulin products
- Evaluating Medicaid and commercial insurance coverage for diabetes-related equipment and supplies

In 2021-22 Washington State passed SB 5546 and capped the total amount that an enrollee is required to pay for a 30-day supply of a covered insulin at \$35. The copay cap was set to expire January 1, 2024, but, Senate Bill 5729, was signed by Governor Inslee on March 30, 2023, meaning this copay limit will be effective in 2024 and beyond.²

Copay Caps

19 states and the District of Columbia have enacted legislation that caps copayments on insulin. Almost all of the passed legislation only applies to the commercially insured population. Utah and Minnesota are exemptions where the copay cap also applies to uninsured population. It's important to note that the copay cap legislations do not apply to every health care plan in a state.^{3,4} The legislation typically apply to state-regulated plans and do not include plans for the self-insured or employee-sponsored plans which are regulated at the federal level.^{3,4}

Table 7. State Policies for Affordable Insulin

State	Copay Cap	Notes
Alabama	\$100 per 30-day supply	Applies to commercially-insured population
Colorado	\$100 per 30-day supply	Applies to commercially-insured population
Connecticut	\$25 per 25-day supply for insulin \$100 cap per month for insulin-related supplies	Supplies include test strips, BGMs, CGMs
Delaware	\$100 per 30-day supply	Applies to commercially-insured population
Illinois	\$100 per 30-day supply	Applies to commercially-insured population
Maine	\$100 per 30-day supply	Applies to commercially-insured population
Minnesota	\$50 per 90-day supply	Applies to uninsured and low-income underinsured population

State	Copay Cap	Notes
New Hampshire	\$30 per 30-day supply	Applies to commercially-insured population
New Mexico	\$25 for 30-day supply	Applies to commercially-insured population
New York	\$100 for 30-day supply	Applies to commercially-insured population
Texas	\$25 for monthly prescription	Applies to commercially-insured population
Utah	\$30 for 30-day supply	Applies to people with commercial insurance and uninsured
Vermont	\$100 for 30-day supply	Applies to commercially-insured population
Virginia	\$50 for 30-day supply	Applies to commercially-insured population
Washington	\$35 for 30-day supply	Applies to commercially-insured population
West Virginia	\$100 per 30-day supply	Applies to commercially-insured population

Source: diaTribe Change³

An insulin cap for Medicare beneficiaries was passed as part of the Inflation Recovery Act in 2022. The copayment cap is \$35 per month for Medicare patients and was implemented January 1, 2023.

Some states also cap copayments on insulin-related supplies. In 2020, Connecticut passed HB 6003 which limited the cost of diabetes devices and supplies to \$100 per a 30-day supply.⁵

Coverage of Equipment and Supplies

Another policy approach to making insulin more accessible and affordable would be to study coverage of supplies and equipment used to manage diabetes by Medicaid and commercial insurers. Most state Medicaid programs, including Washington, provide coverage for continuous glucose monitors (CGM) to people with diabetes. As another potential action, the state could conduct research to better understand current insurance coverage gaps regarding supplies and equipment. State examples include:

- **Delaware:** Mandates coverage of insulin pumps at no cost to the consumer.⁶
- **New York:** Requires state insurance plans, excluding ERISA plans, to include coverage for blood glucose monitors, data management systems, test strips, injection aids, insulin pumps, infusion devices, oral agents, and other supplies.⁷

- **West Virginia:** Requires coverage for supplies including blood glucose monitors, injection aids, infusion devices, syringes, and other types of monitoring supplies.⁸

Changes in Insulin Pricing in 2023

The policy landscape for affordable insulin is currently evolving. At the time of writing this report, several insulin manufacturers announced they would be lowering prices and capping out-of-pocket costs on their products.

- On March 1, 2023, Eli Lilly announced it would immediately cap monthly out-of-pocket cost of some of its insulin products at \$35 and would cap Lispro® prices later this year to \$25 a vial.⁹
- On March 15, 2023 Novo Nordisk also announced it plans to reduce U.S. list prices for several insulin products by up to 75%.¹⁰
- Sanofi announced at March 16, 2023 that it would cut the cost of Lantus® by 78% and cap out-of-pocket costs for commercially insured patients to \$35.¹¹
- Together, these 3 manufacturers supply 90% of the insulin sales in the U.S.⁹
- All 3 manufacturers were already offering discounted insulin (\$25 - \$35 a vial) to patients that meet certain eligibility criteria including: residency, prescriber, insurance coverage, and income.¹²⁻

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Additionally, CivicaRx has announced its plan to produce 3 insulin biosimilars, available in vials and pens, to sell at significantly lower prices than other insulins in the market.¹⁵ CivicaRx and the State of California announced a partnership on March 18, 2023 to manufacture insulins for the State of California's CalRx Biosimilar Insulin Initiative.¹⁶ CivicaRx will produce 3 insulins for the state which are expected to have a manufacturer suggested retail price of no more than \$30 per 10mL vial and no more than \$55 for a box of five 3mL pre-filled pens.¹⁶ National pressure on insulin prices is rapidly affecting policies and any major events that occurred during the wrap-up of the Total Cost of Insulin Work Group should be considered in future discussions.

Conclusion

This final report outlines the Work Group’s process for researching, evaluating, discussing, developing, and finalizing strategies that address the total cost of insulin and emergency supplies for patients in Washington. As described, the report covered key themes of Work Group member surveys and meetings to demonstrate the focus of the Work Group and how they recommend strategies on insulin access and affordability in Washington. By reviewing legislation and policies that were effective in other states, the Work Group highlighted these as viable options for Washington to consider in addressing the total cost of insulin and improving access to those in need of insulin for emergency situations.

The key aspects of these frameworks are to create new legislation that requires the Washington Prescription Drug Program to solicit bids for reduced cost insulin to be available through a voucher program and to require manufacturers to reimburse pharmacies for dispensing 30-day supplies of insulin in emergency situations. The legislature can use the examples from Minnesota, as provided in this report, as a start for designing these policies and programs for Washingtonians.

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Appendix A – Work Group Members

Membership Type	Name	Participation Dates Red = Unable to attend
<i>An association representing health carriers</i>	Chris Bandoli Jennifer Seely	7/8/22, 8/25/22 12/6/22, 3/16/2023
<i>A state agency that purchases health care services and drugs for a selected population</i>	William Hayes	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023
<i>Health Care Authority</i>	Mary Fliss	7/8/22, 8/25/22, 10/27/22, 12/6/22
<i>Health Care Authority (temp.)</i>	Ryan Pistorosi	3/16/2023 (previously attended as staff member)
<i>The prescription drug purchasing consortium</i>	Donna Sullivan	7/8/22, 8/25/22, 10/27/22, 12/6/2022 3/16/2023
<i>A drug distributor or wholesaler that distributes or sells insulin in the state</i>	Leah Lindahl Matthew DiLoreto Kelly Memphis	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023 12/6/22 12/6/22
<i>Attorney general's office with expertise in prescription drug purchasing</i>	Lumi Nodit	7/8/22, 8/25/22, 10/27/22, 12/6/22 , 3/16/2023
<i>Office of the Insurance Commissioner</i>	Barbara Hewitt Jones Shari Maier Jane Beyer	7/8/22, 8/25/22, 10/27/22 , 12/6/22 12/6/22, 3/16/2023
<i>An association representing pharmacy benefit managers</i>	LuGina Mendez-Harper	7/8/22, 8/2/22, 10/27/22, 12/6/22, 3/16/2023
<i>Pharmacy Quality Assurance Commission</i>	Kat Kahachatourian Tim Lynch	7/8/22, 8/25/22 10/27/22, 12/6/22 , 3/16/2023
<i>Public Member</i>	Lori Evans	7/8/22, 8/25/22, 10/27/22 , 12/6/22. 3/16/2023
<i>Public Member</i>	Laura Keller	7/8/22, 8/25/22, 10/27/22 , 12/6/22 , 3/16/2023
<i>Public Member</i>	Amber Markland	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023
<i>Public Member</i>	Jennifer Perkins	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023
<i>Public employees' benefits board or the school employees' benefits board</i>	Dan Gossett	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023

<i>An organization representing diabetes patients who is living with diabetes</i>	Kevin Wren	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023
<i>An association representing independent pharmacies</i>	Jenny Arnold	7/8/22, 8/25/22, 10/27/22, 12/6/22, 3/16/2023

Appendix B – Insulin Expenditure Data Analysis Report



Washington Insulin Workgroup Summary of Insulin Claims Data Research

January 2023

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Oregon Health & Science University
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Background

In 2021, the Washington State Legislature passed Engrossed Substitute Senate Bill 5203, authorizing HCA to establish partnerships to produce, distribute or purchase generic prescription drugs and insulin. During its regular 2022 session, the Legislature passed House Bill 1728, directing the Washington Health Care Authority (HCA) to convene a Total Cost of Insulin Work Group (Work Group) to review and design strategies (1) to reduce the cost of and total expenditures on insulin and (2) to provide a once yearly 30-day supply of insulin to individuals on an emergency basis. These two bills share a common goal in helping provide access to more affordable insulin to Washingtonians.

In 2021, HCA contracted with the Center for Evidence-based Policy (Center) at Oregon Health & Science University (OHSU) to perform research and develop policy options to consider for the production, distribution, or purchase of insulins. The assignment included the aggregation and analysis of all payer claims data related to insulin prescriptions to better understand the current landscape of costs and utilization of insulin in Washington.

In July 2022, the Center presented findings of its research into paid insulin claims from the All Payer Claims Database to the Total Cost of Insulin Workgroup. The Workgroup identified a number of limitations in use of aggregated claims data and requested additional research to better describe insulin utilization and costs. In addition, the Workgroup requested data from the 2019 Diabetes Epidemic Action Report to supplement information and findings from the All Payer Claims Database. The following report highlights some key data findings from the original research into paid insulin claims, along with updated analyses based on feedback from the Work Group.

Methods

The Center worked with staff of HCA to conduct the data research and analysis described in this report. Primary research involved the collection and aggregation of paid claims for insulin products. The research team produced separate sets of aggregations for calendar years 2018, 2019, and 2020. The Center provided a data template to guide the data collection and aggregation process. HCA staff used the template to identify specific data elements for aggregation, and developed the coding required to extract and compile tables of aggregated claims data from the APCD. HCA conducted an internal, independent review of the coding used to compile the aggregated tables. In addition, APCD staff reviewed all completed tables to ensure compliance with data use agreements and restrictions. Once these quality control checks were completed, APCD staff transferred the aggregated tables to a secure workspace used by the Center to complete its analysis.

For each of these sets of aggregated and compound tables, HCA staff produced aggregated values for each of the following data elements:

- Year
- Paid Claims
- Members
- 30-Day Equivalent Prescriptions
- Units Dispensed
- Days Supply
- Charges and Average Charge
- Paid Amount and Average Paid (Insurer Payments)

- Copayments and Average Copayment
- Coinsurance Payment and Average Coinsurance Payment
- Deductible Payment and Average Deductible

In addition to the aggregated tables, HCA staff produced an annual count of paid claims, including separate sub-totals for claims with copayments, coinsurance payments, deductible payments.

The tables provided the principal source of aggregated data used to analyze drug utilization and cost, accumulating individual paid claims into aggregations for each unique combination of payer type, drug formulation, and product type. When referencing average payments, this report is referring to the average of utilization measures and payments based on the discrete combinations of payer type, drug formulation and product type.

The Center supplemented claims data with utilization and cost data from the following federal, state, and independent sources:

- National Average Drug Acquisition Cost (NADAC) data for 2020, published by the Centers for Medicare & Medicaid Services.
- Washington state drug utilization data for 2020 reported by HCA to by the Centers for Medicare & Medicaid Services.
- Insulin cost sharing trends by private market segment in 2018, compiled by The Peterson-KFF Health System Tracker in a report entitled "Out-of-pocket spending on insulin among people with private insurance". <https://www.healthsystemtracker.org/brief/out-of-pocket-spending-on-insulin-among-people-with-private-insurance/>.

The Center further supplemented its research with findings and data from the 2019 Diabetes Epidemic Action Report (D.E.A.R.), and the data supplement on the prevalence of diabetes in Washington. While this report and data supplement did not include significant new information on the utilization and cost of insulin, both sources provided meaningful insights into the size of the diabetes epidemic in the state. Coupled with information from the Washington Commissioner of Insurance, the Center used the D.E.A.R. report to estimate the number of uninsured persons with diabetes, a population of particular interest to the Work Group.

Limitations

The Washington All Payer Claims Database is an invaluable resource for the kind of research requested by the HCA for this project. The depth and breadth of information contained in health care claims provides significant insight into health care, but it is not without its limitations. The tens of millions of data points across the population and over time holds out great promise for evidence-based research, analyses, and decision-making. However, the very size of the database, coupled with the complexity of health care transactions, present serious challenges to effective data aggregation. As a result, the findings of this report are circumscribed by the following limitations:

1. Claims data are limited by the number and types of organizations that report transactions to the APCD. This means that the analysis includes about 70% of Washington's total population. As a result, the Center's research excluded self-insured transactions, primarily from large employers that offer self-contained, self-financed health care benefits to their employees. Analysis and findings described in this report cannot be generalized or applied to these populations.

2. The quality of claims data is dependent on the consistent and accurate reporting of billing information, particularly information describing the demographic characteristics of the beneficiary of a transaction such as age, race/ethnicity, and geographic location. In most cases, aggregations based on these characteristics resulted in disproportionately large shares of beneficiaries characterized as “other”, “unknown” or “out-of-state”. As a result, this report excludes any findings of drug utilization and costs by demographic characteristics.
3. The very nature of aggregating data into sub-totals and averages has the effect of smoothing over variations in utilization and cost trends across the patient population. Averaging tends to hide the broad range of utilization measures and payments that exist at a granular, transaction-specific, level in the APCD. In order to help expose the deviations from average results, this report includes median payment values alongside averages of payments.
4. Any analysis of utilization and costs of insulin is confounded by variations in treatment regimens, dosage and other characteristics of insulin products, as well as the treatment needs and histories of diabetes patients. Comparing utilization and cost across insulin products is extremely problematic regardless of whether averaging is calculated per paid claim, 30-day equivalent prescription, day’s supply or unit dispensed. Recognizing this challenge, this report includes a commentary based on the potential treatment experiences of three representative diabetes patients.

Findings

The overall takeaway from this research is not surprising to anyone familiar with pharmaceutical products and pricing, and the complexities of pharmaceutical insurance coverage, especially diabetic patients who are dependent on access to effective and affordable insulin products and the accompanying supplies and equipment to manage their treatment. High-level takeaways include:

- The cost, price and value of an insulin product vary greatly by product type, manufacturer, insurance plan, and patient treatment regimen.
- Aggregated insulin claims data mask the complexity and dynamic nature of insulin utilization and cost and the ways in which manufacturers and insurers manage pricing and product formulation to optimize their book of business.
- Average payment data give a false impression that insulin is more affordable than generally reported or publicly perceived. Median payment data help expose the fact that payments per claim for the same insulin product vary widely by insurer and insurance plan. For example, the average patient payment per commercial claim for a specific insulin product ranged from a minimum average of \$24 and a maximum average of \$1,018 in 2020.
- An estimated 33,000 patients (13% of total patients) had paid claims in 2020 that averaged greater than \$35 per claim. Their average payments ranged from \$36 to \$1018 per claim and had an overall average of \$121 per claim.

With the general takeaways in mind, the remainder of this report presents more detailed findings beginning with findings from the 2019 Diabetes Data Supplement¹, and a set of general population statistics. Following these contextual sections, the report provides 4 research-specific sections, including:

- Average and Median Payments by Patients
- National Cost Data Comparison
- Impacts of Insurance Plans on Affordability
- Representative Patient Profiles and Commentary

Appendix B.1 of this report contains a set of tables of aggregated claims data from the APCD.

- Table 1 presents statistics describing the entire Washington health insurance market.
- Table 2 reports summary data of insulin claims, comparing activity and payments for 2018 and 2020.
- Table 3 summarizes insulin claims data for 2020 by type of insurer, including commercial payers, Medicaid and Medicare.
- Table 4 summarizes insulin utilization by insurer group, including patients served, paid claims, and units dispensed.
- Table 5 reports average payments per claim made by insurers and patients, differentiated by insurer group.

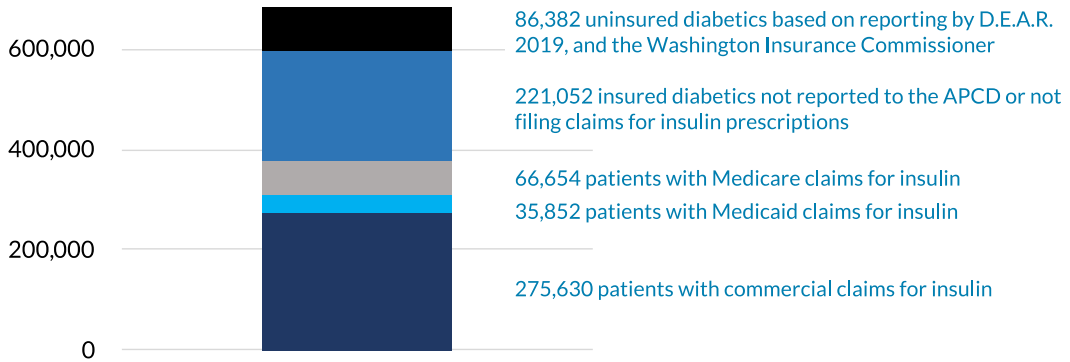
2019 Diabetes Data Supplement

In order to gain a more complete understanding of the dynamics of insulin claims, the Total Cost of Insulin Workgroup requested information on the incidence of diabetes as reported in the 2019 Diabetes Data Supplement, a companion resource of the 2019 Diabetes Epidemic Action Report. Key findings include the following:

- About 682,600 adults (or 1 in 8) had diabetes in 2017.
- After nearly doubling from 1990 to 2010, the growth in diagnosed diabetes among adults began to slow as of 2011.
- About 2,970 youth under 18 years of age (1 in 550) had diabetes in 2017.
- Onset of type 1 and type 2 diabetes in youth is increasingly common in recent decades.
- About 142,000 out of 2 million Medicaid enrollees had diabetes in 2017. The percent with diabetes has remained stable at around 7% from 2012 to 2017 and greatly varies across Medicaid coverage groups.
- In 2017, 30,510 out of about 400,000 state public employees (or 7.6%) had diabetes.
- Members enrolled in Medicare due to disability were 3.3 times more likely to have diabetes than non-Medicare members.
- In addition to those who already have diabetes, an estimated 2 million adults statewide (or 1 in 3) had prediabetes in 2017. Three of four adults with prediabetes were not aware of their condition.
- At the request of the Workgroup, the Center estimated the uninsured diabetes population based on combined data from the 2019 Diabetes Data Supplement with data reported by the Washington Insurance Commissionerⁱⁱ. Figure 1 presents an estimate of the number of uninsured Washingtonians with diabetes in 2019, based on data from the 2019 Diabetes Data Supplement

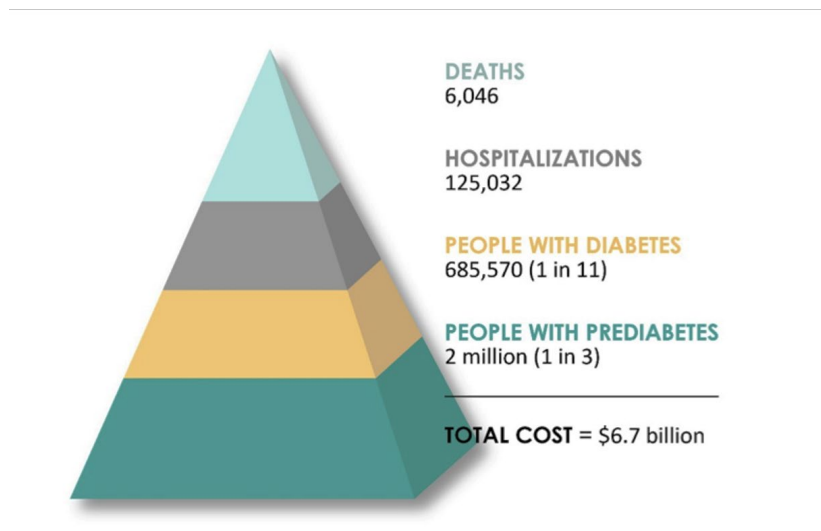
and the Washington Insurance Commissioner’s 2021 “Report on the number of uninsured people in Washington state”.

Figure 1
Estimated Population of Uninsured Persons with Diabetes in Washington
Total Estimated Diabetes Population = 685,570
Calendar 2019



The 2019 Diabetes Data Supplement included the following infographic (Figure 2); a summary of the Washington diabetic population, diabetic hospitalizations and deaths, and an estimate of the total financial burden associated with diabetes.

Figure 2
Burden and Financial Impact of Diabetes
Calendar 2017



General Population Statistics from the All Payer Claims Database

In addition to contextual data from the Washington Department of Health, the Center analyzed paid insulin claims compiled and aggregated from the Washington All Payer Claims Database (APCD). The following statistics summarize paid insulin claims for Calendar Year 2020.

- Nearly 5.4 million Washingtonians had insurance coverage in 2020. Of this total, nearly 1.5 million had coverage from multiple private and public sources.
 - Commercial and private plans covered nearly 3.5 million people, representing nearly 65% of all insured persons.
 - Medicaid provided coverage to more than 2 million people representing 37% of the total insured population.
 - Medicare covered nearly 1.4 million people or 26% of the insured population.
- Paid claims for insulin products were processed for more than 378,000 patients in 2020.
 - More than 275,000 (72.9%) of these patients filed claims with commercial insurers. Roughly 8% of commercially insured patients received insulin in 2020.
 - Nearly 36,000 (9.5%) filed claims with Medicaid., representing less than 2% of patients covered by Medicaid.
 - Nearly 67,000 (17.6%) patients filed claims with Medicare, representing nearly 5% of patients covered by Medicaid.
- 33.4 million units of insulin were dispensed in 2020.
 - Commercial plans accounted for nearly 24 million units, nearly 86 units per patient served.
 - Medicaid accounted for 3.2 million units, more than 89 units per patient served.
 - Medicare accounted for 6.5 million units, more than 97 units per patient served.

Figures 3 and 4 illustrate the distribution and change in claims activity between 2018 and 2020.

Figure 3
Distribution of Paid Claims, Patients and Units Dispensed by Payer Type
Calendar 2020

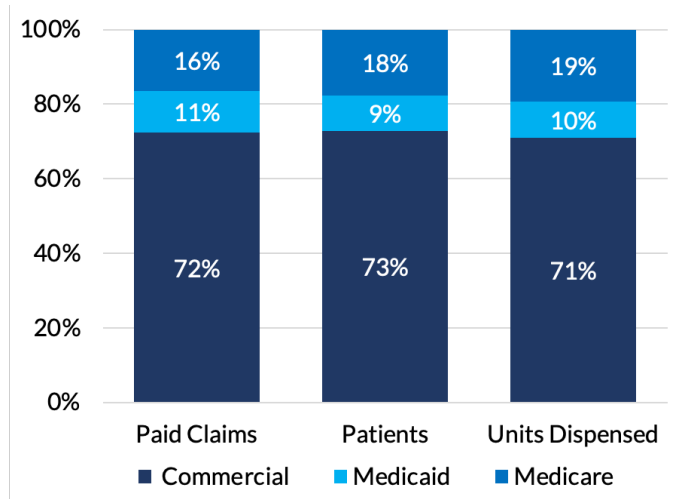
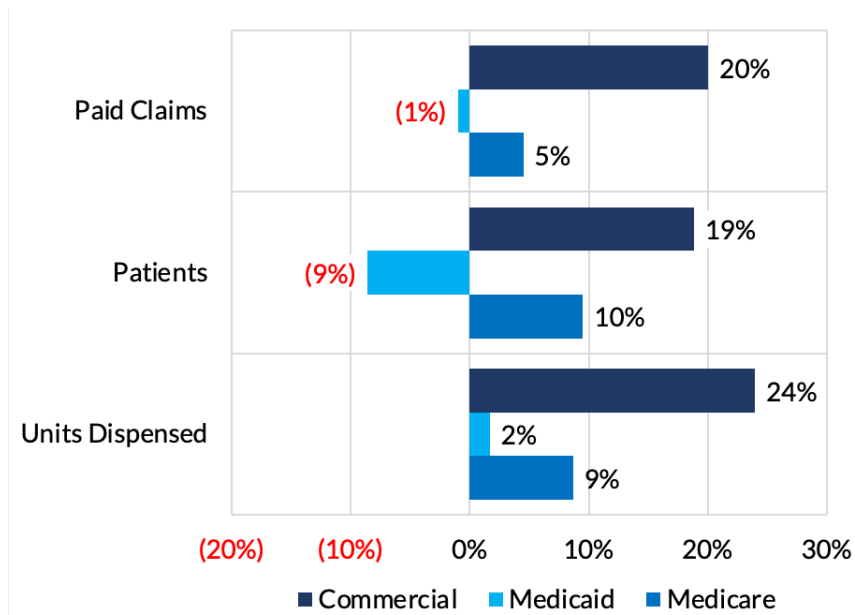


Figure 4
Change in Paid Claims, Patients and Units Dispensed by Payer Type
Calendar 2018 to 2020



Note that the term “units” referred to in the claims data does not correspond with units of insulin used by patients based on their treatment regimen. Depending on the product, a unit of insulin dispensed and recorded on an insurance claim may consist of multiple units used by a patient.

Appendix B1 of this report contains a set of tables of aggregated claims data from the APCD.

- Table 1 presents statistics describing the entire Washington health insurance market.
- Table 2 reports summary data of insulin claims, comparing activity and payments for 2018 and 2020.
- Table 3 summarizes insulin claims data for 2020 by type of insurer, including commercial payers, Medicaid, and Medicare.
- Table 4 summarizes insulin utilization by insurer group, including patients served, paid claims, and units dispensed.
- Table 5 reports average payments per claim made by insurers and patients, differentiated by insurer group.

Average and Median Payments by Insurers and Patients

Finding No. 1 – Overall Average and Median Payments per commercial insulin claim

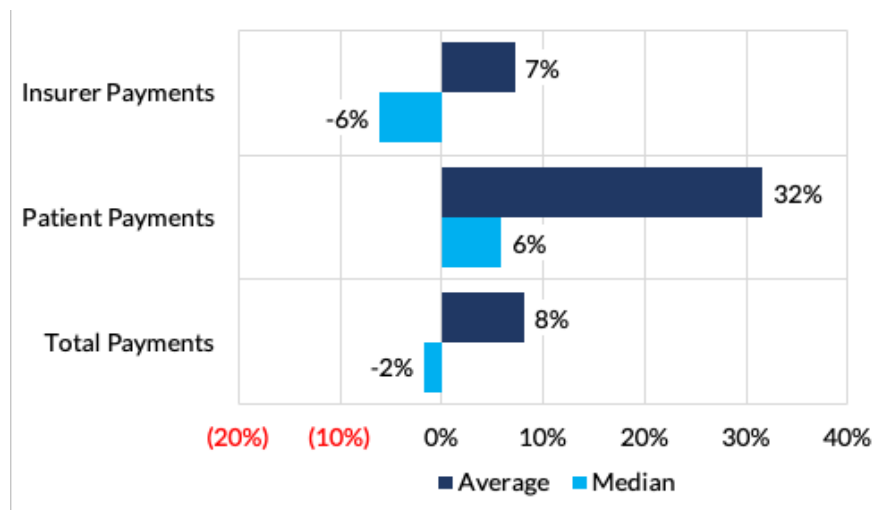
The average payment per commercial insulin claim was more than \$581 in 2020, an 8% increase over 2018. Average insurer and patient component payments were \$555.14 and \$26.57, respectively. By comparison median payments by insurers and patients were \$408.78 and \$70.31, respectively. Table 1 provides a comparison of average and median payments for 2018 and 2020.

Table 1
Average and Median Payments per Paid Commercial Claim
Calendar 2018 and 2020

	Average Payments		Median Payment	
	2018	2020	2018	2020
Insurer Payments	\$517.85	\$555.14	\$435.21	\$408.78
Patient Payments	\$20.18	\$26.57	\$66.38	\$70.31
Total Payments	\$538.01	\$581.71	\$422.30	\$415.03

Median patient payments in 2018 and 2020 were significantly higher than average patient payments during the same years, based on commercial insulin claims. The higher median values indicate that a disproportionate number of claims involved patient payments that were greater than the overall average patient payment per claim. This trend increased for patient payments from 2018 to 2020. By contrast, the opposite was true for insurer payments per commercial claim. The median insurer payment per claim fell from 2018 to 2020, indicating that an increased number of insurer payments fell below the overall average insurer payment per claim during this 2-year period. Figure 5 illustrates changes in average and median payments from 2018 to 2020.

Figure 5
Change in Average and Median Payments per Commercial Claim
Calendar 2018 to 2020



Finding No. 2 – Average and Median Patient Payments by Insulin Formulation

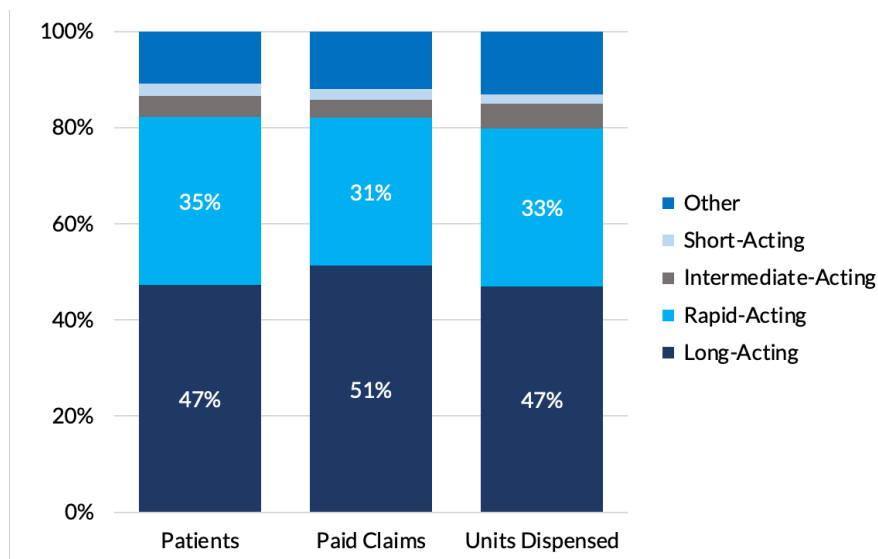
There are many different types of insulin based on their duration of action, their concentration (strength), and method of administration. Table 2 reports the paid commercial claims activity by type of insulin formulation in 2020. Figure 6 illustrates the distribution of 2020 paid commercial claims activity, highlighting the significant shares represented by long-acting and rapid-acting insulin products.

Table 2
Paid Claims Activity by Insulin Formulation
Commercial Claims in Calendar 2020

Formulation	Patients Served	Paid Claims	Units Dispensed
Long-Acting	130,284	600,307	11,144,868
Rapid-Acting	96,600	361,921	7,777,484
Intermediate-Acting	11,669	43,592	1,233,171
Short-Acting	7,215	25,490	466,049
Other	29,862	139,711	3,081,338
All Claims	275,630	1,171,021	23,702,909

Note: "All Claims" represents total paid claim activity, not the sum of activity by product formulation. For example, the sum of patients served exceeds the "All Claims" count of patients, reflecting that patients frequently are prescribed multiple types of insulin based on their individual treatment regimen.

Figure 6
Distribution of Patients, Paid Claims and Units Dispensed by Insulin Formulation
Calendar 2020



An analysis of aggregated claims by insulin formulation identified a wide variation of patient payments in 2020. Table 3 reports average and median patient payments based on 2020 commercial claims. Average payments ranged from \$11.39 per paid commercial claim for short-acting formulations to \$26.65 for long-acting formulations. The two most dispensed formulations based on number of patients served – long-acting and rapid-acting – experienced significant increases in median payments per claim from 2018 to 2020. This change suggests significant increases in the number of patients making above-average payments per claim for these insulin formulations in 2020. Short-acting formulations also experienced a near doubling of median payments per claim in 2020.

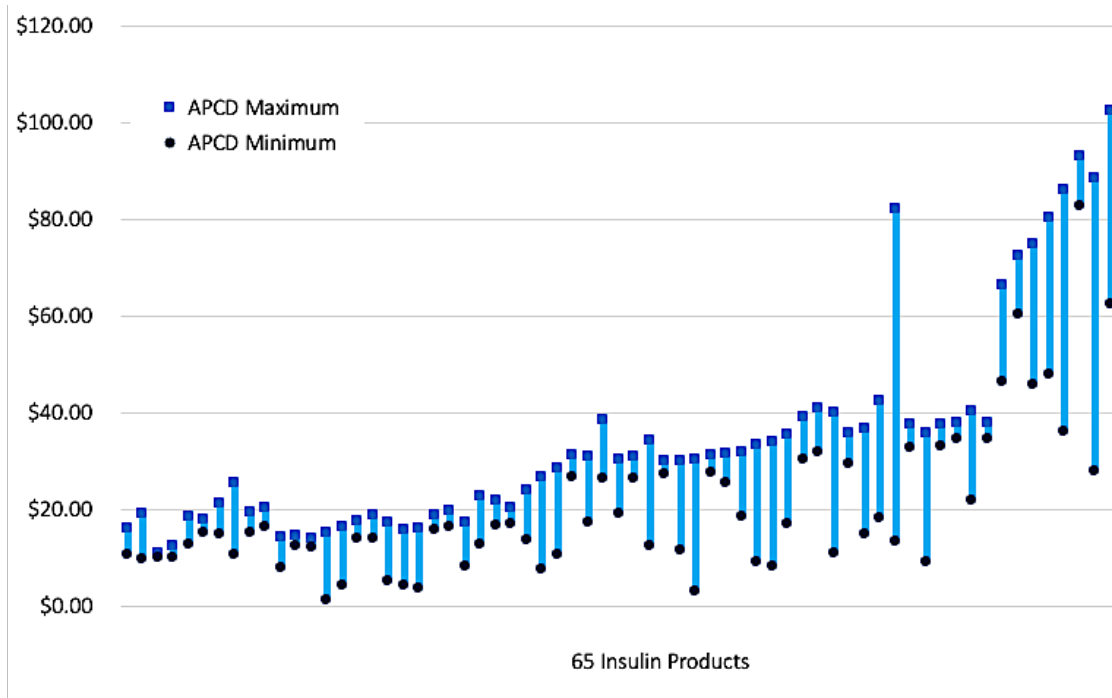
Table 3
Average and Median Patient Payments per Paid Commercial Claim
by Major Insulin Formulation
Calendar 2020

	Average Payments		Median Payment	
	2018	2020	2018	2020
Long-Acting	\$27.15	\$26.65	\$22.97	\$48.19
Rapid-Acting	\$21.86	\$24.67	\$19.21	\$40.52
Intermediate-Acting	\$18.45	\$22.63	\$20.09	\$23.67
Short-Acting	\$11.56	\$11.39	\$11.69	\$20.89

Finding No. 3 – Minimum and Maximum Payments for 65 selected insulin products in 2020

An analysis of paid commercial claims for 65 insulin products revealed that more than a third of the products had a variation between the lowest and highest payment that was more than double the minimum payment (Figure 7). The average and median percentage of variation were 125% and 60%, respectively. These variations reflect the impact of insurance plans, insulin products and prescription patterns on the pricing and payment of insulin.

Figure 7
Minimum and Maximum Payments per unit dispensed
Calendar 2020

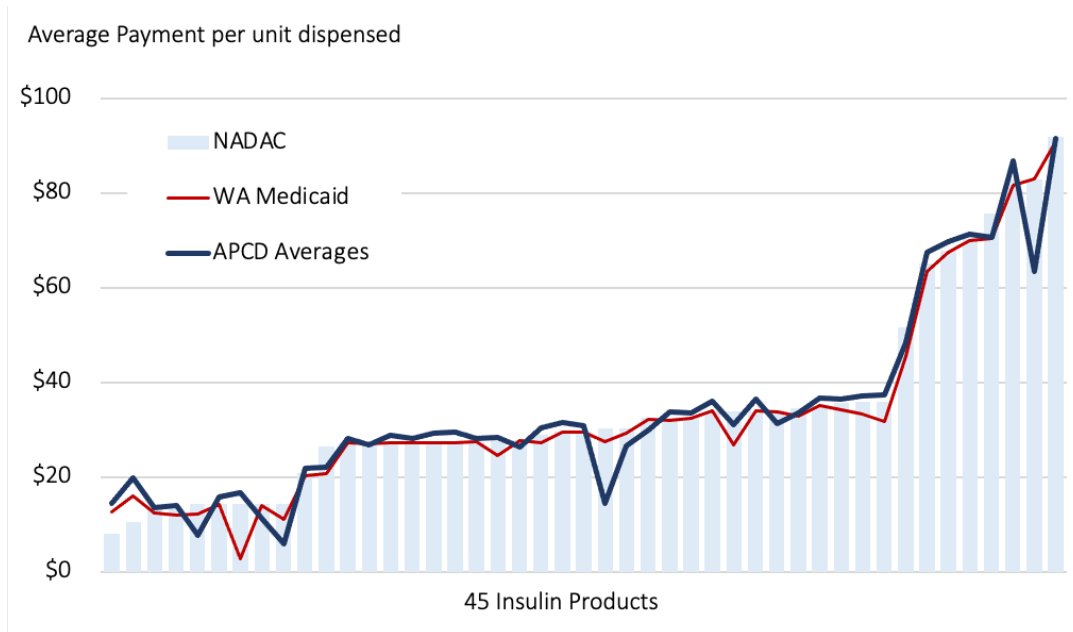


National Cost Data Comparison

Finding No. 4 – Close Correlation to National Average Drug Acquisition Costs (NADAC)ⁱⁱⁱ and Washington State Medicaid Drug Utilization Data.^{iv}

The Center’s research project included a comparison of insulin claims data from the All Payer Claims Database (APCD) to NADAC reporting by CMS, and Medicaid Drug Utilization data reported by the Washington Health Care Authority in 2020. Figure 8 shows very close correlations between WA-APCD average payments per unit dispensed, NADAC unit cost data and Washington Medicaid Reimbursement data, based on 45 insulin products for which data were available.

Figure 8
Comparison of WA-APCD, NADAC and WA-Medicaid Drug Utilization Data
Calendar 2020



Impact of Insurance Plans on Affordability

Finding No. 5 – National study confirms impacts of insurance plans on affordability

In March 2022, the Peterson-KFF Health System Tracker^v published a national study of claims data from private health plans. The study identified individual and small group market plans that are offered under the Affordable Care Act (ACA). The following excerpt from the study provides a helpful description of the cost-sharing differences between the various tiers of coverage.

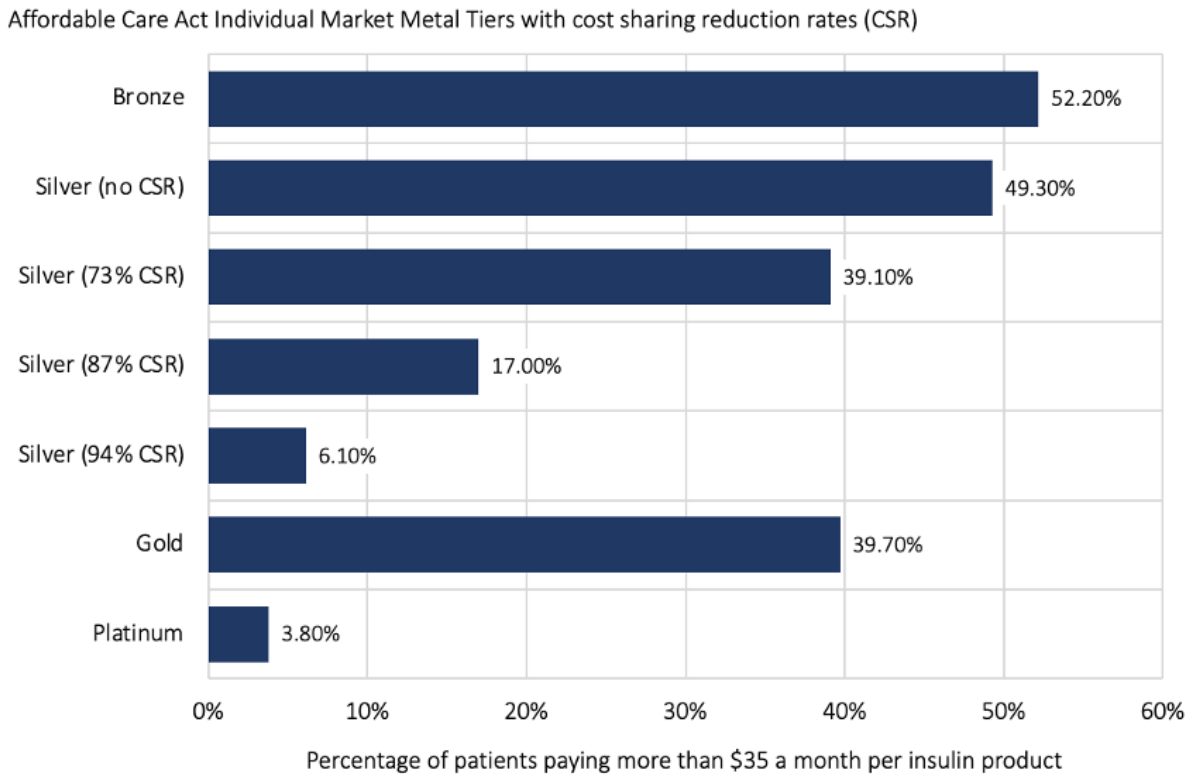
“Under the Affordable Care Act (ACA), individual and small group market plans are offered in four “metal” level categories based on plan actuarial value (the average share of costs the plan will cover for covered benefits). Bronze plans tend to have the lowest share of covered costs (60% actuarial value on average) and highest deductibles and other cost sharing, followed by silver (70%), gold (80%), and platinum (90%). Platinum plans have very low out-of-pocket costs.

Low-income enrollees with incomes below 250% of poverty who enroll in silver Marketplaces plans also get help with cost sharing. Cost-sharing reductions (CSRs) help reduce out-of-pocket costs for enrollees on a sliding scale. People with incomes up to 150% of poverty (for a single individual just over \$18,000 in 2018 and just over \$19,000 in 2022) enrolled in a silver Marketplace plan get cost sharing reduced and the insurance plan will cover 94% of the costs of covered benefits on average. People with incomes

between 150% and 200% of poverty get cost sharing reduced to 87%. Those with incomes between 200% and 250% get some cost-sharing reduction help to 73% (from 70% of typical silver plan benefits).”

Figure 9 reports the percentage of patients paying more than \$35 a month per insulin product by metal level.

Figure 9
Percentage of patients paying more than \$35 a month per insulin product



Finding No. 6 – Insulin pricing patterns reflect changes in evolving mix of insulin products

In January 2022, GoodRx Health^{vi} published an investigation comparing the retail pricing of generic and brand insulin products. The study relied on “usual and customary” prices reported by pharmacies, insurers and other sources, and excluded transactions involving GoodRx. Pricing information excluded insurance copays or coinsurance. For each insulin product, GoodRx reported an average price per unit and an average price per dispenser or package. The investigation produced the following findings:

- The average retail price for insulin rose 54% from 2014 to 2019.
- During COVID-19, prices decreased by 5% from January 2020 to October 2021.

- FDA approvals of generics and biosimilars are largely responsible for the downward trend in overall cash prices.
- Traditional insulins are cheaper than modern insulins.
- Vials are cheaper than newer dispensers.
- Consumers should be discriminating about the cost and effectiveness of new product features and formulations.

Table 4 provides average and median (in parentheses) prices by type of insulin product and active agents based on the detailed reporting from the investigation.

Table 4
Average (and Median) Prices per Unit by Insulin Product Type and Active Agent
based on a pricing investigation by GoodRx Health, January 26, 2022

Active Agents	Mixed	Short Intermediate	Rapid	Long
Insulin lispro/Insulin lispro protamine	\$0.38 (\$0.39)			
Insulin isophane/insulin human	\$0.17 (\$0.18)			
Insulin aspart/insulin aspart protamine	\$0.26 (\$0.23)			
Insulin isophane		\$0.18 (\$0.19)		
Insulin human		\$0.16 (\$0.19)	\$1.30 (\$1.31)	
Insulin lispro			\$0.35 (\$0.34)	
Insulin glulisine			\$0.44 (\$0.44)	
Insulin aspart			\$0.30 (\$0.35)	
Insulin glargine				\$0.32 (\$0.34)
Insulin detemir				\$0.39 (\$0.39)
Insulin degludec				\$0.54 (\$0.42)

Concluding Remarks

Research into paid insulin claims confirmed much of the conventional wisdom about the complex interplay between pharmaceutical companies, insurers, pharmaceutical intermediaries, medical practitioners and patients. A patient's out-of-pocket expense for insulin depends on their illness and treatment regimen, the products prescribed, pricing strategies used by the product producers, and structure of their insurance plan. Two patients with the same diagnosis and treatment regimen may have wildly different out-of-pocket expenses depending on whether they have insurance, and the extent of their insurance coverage, including levels of deductibles, copayments and coinsurance. It is equally true that the same insulin product may be priced and discounted differently depending on the producer's relationships with pharmacies, health systems and insurers.

The complexity of the insulin supply chain and finances—from producer to patient—may be well beyond the ability of most patients to comprehend, navigate and manage. That said, the research into insulin utilization and payment data reveal a number of trends that may prove useful for patients and policymakers alike.

- The number of diabetes patients with paid claims increased by more than 46,000 (13.9%) from 2018 to 2020. In 2020, nearly 10% of these patients incurred no costs for their prescriptions, and another two-thirds paid on average less than \$2.00 per billable unit of insulin dispensed. [Patients with no payments: 35,882. Patients with payments of \$2 or less: 254,940. Patients paying more than \$2: 87,324. Total patients with insulin claims: 378,146.]
- The number of patients with low cost and no cost insulin claims fell markedly from 2018 to 2020. The number of patients paying \$2 or less per unit dispensed fell by more than 30,000 (10.7%), while the number of patients with no payments fell by 3,380 (8.6%). During this period, there was a 10-fold increase in patients paying more than \$2 per unit dispensed. 58% of this increase came from new patients added to the claims data, while 42% migrated from the lower cost and no cost categories of patients.
- The average payment per unit dispensed increased by 5.5% between 2018 and 2020, from \$26.82 to \$28.31. The average patient share during the same period increased by more than 17%, from \$1.26 to \$1.51. For commercially insured patients, the average patient share increased by 27.5% between 2018 and 2020, from \$1.03 to \$1.31. Looking deeper into the commercial claims, the average patient share for low-cost claims increased by more than 48%, from \$0.75 per unit dispensed in 2018 to \$1.11 in 2020.
- An investigation by GoodRx Health reports that average insulin prices declined by 5% between January 2020 and October 2021 due in large part to the introduction of generic and biosimilar products. At the same time the report suggested that new drug products and drug delivery systems are more expensive than their traditional counterparts. These trends suggest that patients pay close attention to the changing mix of products and pricing to better manage their insurance coverage and out-of-pocket expenses.

Appendix B.1: Data Tables

Table 1
Washington State All Payers Claims Data
Covered Lives and Claims by Market Segment
Calendar Years 2019 and 2020

WA-APCD Membership Counts – Medical and Pharmacy Eligibility		
Market Segment	CY 2019	CY 2020
Commercial	2,076,611	2,081,398
Self-Insured	409,098	505,660
Public Employees Benefits Board (PEBB)	380,035	377,263
School Employees Benefits Board (SEBB)	0	263,820
Exchange	246,445	245,147
Medicaid	2,021,340	2,011,673
Medicare Advantage	413,284	490,617
Medicare FFS ¹	898,733	888,912
Total Lives with Medical Coverage (including Medicare FFS estimate) ²	5,298,177	5,364,925
Total WA Population ³	7,546,400	7,656,200
% of Total Population Captured (including Medicare FFS)	70%	70%
Other Insurance Markets		
Dental	4,399,468	4,732,586
Worker’s Compensation	144,318	120,984
Out-of-State Lives	2,194,717	3,044,680

¹ FFS estimated based on CMS statistics: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>.

² Total Lives with Medical Coverage include lives represented by Pharmacy claims and are less than the sum of the different plan types because some members may have had two types of coverage during the year. The totals reflect each member with *any* coverage during the year.”

³ Total WA population estimate based on OFM reporting: <https://www.ofm.wa.gov/washington-data-research/statewide-data/washington-trends/population-changes/total-population-and-percent-change>.

Source: Table 3 WA-APCD covered lives and claims during calendar years 2019 and 2020, by market segment
 Washington State Health Care Authority | Report to the Legislature
 Washington State All-Payer Claims Database and Lead Organization biennial report
 Cost, performance, and effectiveness of the database and performance of the Lead Organization
 Engrossed Substitute Senate Bill 5741, Section 8(1); Chapter 319; Laws of 2019 March 31, 2022
<https://www.hca.wa.gov/assets/program/wa-apcd-performance-report-2022-03-02.pdf>

Table 2
Washington State All Payers Claims Data
Paid Claims for Insulin
Calendar Years 2018 and 2020

	Aggregate Claims Data		Change 2018-2020	
	2018	2020	Absolute	Percent
Claims Activity				
Patients	332,081	378,146	46,065	13.9%
Paid Claims	1,410,688	1,615,977	205,289	14.6%
30-day equivalent prescription	1,939,805	2,404,774	464,969	24.0%
Units Dispensed	28,240,830	33,394,192	5,153,362	18.2%
Aggregate Charges and Payments				
Charges	\$941,372,371	\$1,195,495,223	\$254,122,853	27.0%
Total Payments	\$757,545,406	\$945,413,126	\$187,867,721	24.8%
Insurer Payments	\$721,171,020	\$894,951,114	\$173,780,093	24.1%
Patient Payments	\$36,374,385	\$50,462,013	\$14,087,627	38.7%
Average Payments per Claim				
Insurer Payment	\$511.22	\$553.81	\$42.59	8.3%
Patient Payment	\$25.78	\$31.23	\$5.44	21.1%
Total Payment	\$537.00	\$585.04	\$48.04	8.9%
Average Payments per Unit Dispensed				
Insurer Payment	\$25.54	\$26.80	\$1.26	4.9%
Patient Payment	\$1.29	\$1.51	\$0.22	17.3%
Total Payment	\$26.82	\$28.31	\$1.49	5.5%

Table 3
Washington State All Payers Claims Data
Paid Claims for Insulin by Payer Type
Calendar Year 2020

	All Paid Claims	Commercial	Medicaid	Medicare
Aggregated Paid Claim Activity				
Patients	378,146	275,630	35,852	66,654
Paid Claims	1,615,977	1,171,021	180,140	264,796
30-Day Equivalent Prescriptions	2,404,774	1,728,527	217,279	458,946
Units Dispensed	33,394,192	23,702,909	3,208,044	6,482,946
Days Supply	65,382,381	46,698,860	5,858,298	12,824,673
Aggregated Financial Summary				
Total Claims	\$1,195,495,223	\$883,207,443	\$111,067,787	\$201,202,580
Total Payments – All Sources	\$945,413,126	\$681,191,622	\$101,332,746	\$162,877,168
Total Insurer Payments	\$894,951,114	\$650,076,979	\$101,332,746	\$143,536,429
Copayments	\$20,950,559	\$16,109,682	\$0	\$4,840,862
Coinsurance	\$14,778,126	\$4,500,826	\$0	\$10,275,599
Deductibles	\$14,733,328	\$10,504,135	\$0	\$4,224,278
Total Patient Payments	\$50,462,013	\$31,114,643	\$0	\$19,340,740
Average Payments per Unit Dispensed				
Insurer Payment	\$26.80	\$27.43	\$31.59	\$22.14
Patient Payment	\$1.51	\$1.31	\$0.00	\$2.98
Total Payment	\$28.31	\$28.74	\$31.59	\$25.12

Table 4
Washington State All Payers Claims Data
Insulin Utilization by Insurer Group
Calendar Year 2020

Code	Payer Type	Insulin Products Dispensed	Patients Served	Paid Claims	Units Dispensed
PS	COMMERCIAL	96	226,641	969,827	18,430,562
HN	MEDICARE	91	45,310	181,296	4,622,461
MC	MEDICAID	83	35,852	180,140	3,208,044
PR	COMMERCIAL	91	35,297	148,679	3,569,583
MD	MEDICARE	83	21,341	83,496	1,860,409
HM	COMMERCIAL	61	13,122	50,330	1,637,935
EP	COMMERCIAL	39	517	1,979	60,804
ST	COMMERCIAL	14	48	183	3,680
-1	NOT SPECIFIED	7	10	20	292
WC	COMMERCIAL	4	4	19	226
SP	MEDICARE	3	3	4	76
IN	COMMERCIAL	1	1	4	120
All Claims		230	378,146	1,615,977	33,394,192

Table 5
Washington State All Payers Claims Data
Average Insulin Payments per Claim by Insurer Group
Calendar Year 2020

Code	Payer Type	Patients Served	Insurer Payment	Patient Payment	Total Payment
PS	COMMERCIAL	226,641	\$566	\$22	\$587
HN	MEDICARE	45,310	\$519	\$59	\$578
MC	MEDICAID	35,852	\$563	\$0	\$563
PR	COMMERCIAL	35,297	\$555	\$48	\$603
MD	MEDICARE	21,341	\$593	\$103	\$696
HM	COMMERCIAL	13,122	\$357	\$51	\$408
EP	COMMERCIAL	517	\$478	\$159	\$637
ST	COMMERCIAL	48	\$447	\$34	\$481
-1	NOT SPECIFIED	10	\$248	\$332	\$580
WC	COMMERCIAL	4	\$318	\$0	\$318
SP	MEDICARE	3	\$0	\$409	\$409
IN	COMMERCIAL	1	\$392	\$14	\$406
All Claims		378,146	\$554	\$31	\$585

Appendix B Endnotes

ⁱ Washington Department of Health. 2019 Diabetes Data Supplement. December 2019.

<https://doh.wa.gov/sites/default/files/legacy/Documents/Pubs//140-222-DiabetesDataSupplement2019.pdf>. Accessed July 29, 2022.

ⁱⁱ Washington State Office of the Insurance Commissioner. Report on the number of uninsured people in Washington state 2014-2020. December 30, 2021.

<https://www.insurance.wa.gov/sites/default/files/documents/2021-uninsured-report.pdf> Accessed August 3, 2022.

ⁱⁱⁱ Centers for Medicare & Medicaid Services. NADAC (National Average Drug Acquisition Cost) 2020; Updated August 23, 2021. <https://data.medicaid.gov/dataset/c933dc16-7de9-52b6-8971-4b75992673e0>. Accessed July 17, 2022.

^{iv} Data.Medicaid.Gov. Open Data. Washington State Drug Utilization Data for 2020.

[https://data.medicaid.gov/dataset/cc318bfb-a9b2-55f3-a924-d47376b32ea3/data?conditions\[0\]\[resource\]=t&conditions\[0\]\[property\]=state&conditions\[0\]\[value\]=WA&conditions\[0\]\[operator\]=%3D](https://data.medicaid.gov/dataset/cc318bfb-a9b2-55f3-a924-d47376b32ea3/data?conditions[0][resource]=t&conditions[0][property]=state&conditions[0][value]=WA&conditions[0][operator]=%3D). Accessed July 17, 2022.

^v Amin K, Claxton G, Rae M, Cox C. Out-of-pocket spending on insulin among people with private insurance. Peterson-KFF Health System Tracker; March 24, 2022.

<https://www.healthsystemtracker.org/brief/out-of-pocket-spending-on-insulin-among-people-with-private-insurance/>. Accessed September 27, 2022.

^{vi} Lee, B. How Much Does Insulin Cost? Here's How 28 Brands and Generics Compare. GoodRx Health; Updated on January 26, 2022. Accessed October 5, 2022. <https://www.goodrx.com/healthcare-access/research/how-much-does-insulin-cost-compare-brands>

Appendix C – Work Group Surveys

Washington Insulin Group (WAIG) Stakeholder Survey #1

In its 2022 session, the Washington Legislature passed HB 1728 which directs the Health Care Authority (HCA) to create a total cost of insulin work group and secure input from this Work Group about strategies to reduce the cost of, and total expenditure on, insulin and provide a 30-day supply of insulin to individuals on an emergency basis.

This survey is intended to collect initial thoughts from Work Group members regarding the barriers and opportunities for new purchasing and distribution approaches to control cost and ensure access to insulin.

Q0: Please select your identified stakeholder group: [\[Drop down\]](#)

- Insurance commissioner or designee
- Prescription drug purchasing consortium
- Pharmacy quality assurance commission
- Association representing independent pharmacies
- Association representing health carriers
- Public employees' benefits board or the school employees' benefits board
- Health care authority
- Association representing pharmacy benefit managers
- Drug distributor or wholesaler that distributes or sells insulin in the state
- State agency that purchases health care services and drugs for a selected population
- Attorney general's office with expertise in prescription drug purchasing
- Organization representing diabetes patients who is living with diabetes
- Member of the public living with diabetes

Q1: What do you think are the primary reasons patients do not have access to affordable insulin? [\[Check box\]](#)

Q2: Using a scale of 1 – 10 with 1 being the most important and 10 being the least how would you rank the following as an issue to affordable insulin?

- Supply shortages
- Patient out-of-pocket costs (i.e., co-pay, deductible)
- High list prices set by drug manufacturers
- Lack of transparency throughout the insulin supply chain
- Challenges working with health plan (e.g., pharmacy benefit manager, group purchasing organization, distributor)

Q3: What strategies should HCA consider to reduce the cost of insulin and total expenditures for patients? [\[Open-ended\]](#)

Q4: How would you rank the following strategies to reduce the cost of insulin and total expenditure for patients? Please drag and drop to rank in order of priority from highest favorability (1) to least favorability (3). Note: if you'd like to keep this list in its current order, please click at least one of the options and move it in place to activate the question and ensure your response is recorded. [\[Rank order\]](#)

- A state agency buys drugs for resale and distribution (e.g., a licensed drug wholesaler)

- A state agency manages prescription drug benefits on behalf of health insurers, large employers, and other payers (e.g., a registered pharmacy benefit manager)
- A state agency purchases prescription drugs on behalf of the state directly from other states or in coordination with other states

Q5: What do you see as the biggest barriers to the HCA entering into partnership with other entities (e.g., insulin manufacturer, pharmacy benefit manager) to distribute or purchase insulin?

[\[Open-ended\]](#)

Q6: What are your recommendations to overcome the barriers that you've identified above?

[\[Open-ended\]](#)

Q7: What do you see as the biggest barriers to the HCA providing a once yearly 30-day supply of insulin to individuals on an emergency basis?

[\[Open-ended\]](#)

Q8: What are your recommendations to overcome the barriers that you've identified above?

[\[Open-ended\]](#)

You have reached the end of the survey. Please submit your results by clicking the arrow below. Results of this survey will be presented at the first Insulin Work Group meeting scheduled for Friday, July 8 from 10 am - 1 pm.

Washington Insulin Group (WAIG) Stakeholder Survey #2

(1) Intro/Background

In the 2022 session, the Washington Legislature passed HB 1728, which directs the Health Care Authority (HCA) to create a total cost of insulin work group and secure input from this Work Group about strategies to reduce the cost of, and total expenditure on, insulin and provide a 30-day supply of insulin to individuals on an emergency basis.

[HB 1728 Legislation Link](#)

(1.1): Please select your identified stakeholder group: [\[Drop down\]](#)

- Insurance commissioner or designee
- Prescription drug purchasing consortium
- Pharmacy quality assurance commission
- Association representing independent pharmacies
- Association representing health carriers
- Public Employees' Benefits Board or the School Employees' Benefits Board
- Health Care Authority
- Association representing pharmacy benefit managers
- Drug distributor or wholesaler that distributes or sells insulin in the state

- State agency that purchases health care services and drugs for a selected population
- Attorney general's office with expertise in prescription drug purchasing
- Organization representing patients living with diabetes
- Member of the public living with diabetes

(2) Feedback on Priority Issues

This section of the survey is intended to gauge support and interest for prioritizing key issues raised during Work Group meeting 1 on July 8, 2022. This Work Group's scope is defined in state statute RCW 70.14.160. The Work Group is directed to do the following:

- Review and design strategies to:
 - "Reduce the cost of and total expenditures on insulin in this state"
 - "Provide a once yearly 30-day supply of insulin to individuals on an emergency basis"

Population Prioritization

(2.1) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support focusing on the uninsured population first: [\[1, 2, 3, 4, 5\]](#)

(2.2) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support focusing on those with commercial insurance first: [\[1, 2, 3, 4, 5\]](#)

(2.3) How would you rank the two populations in order of priority? Please drag and drop to rank in order of priority from highest priority (1) to lowest priority (2):

- Uninsured
- Commercially Insured

(2.4) What, if any, feedback do you have for the Work Group to consider around focus areas on different patient populations? [\[Open Question\]](#)

Emergency Supplies

(2.5) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support continuing to discuss a recommendation for Washington to consider legislation replicating [Minnesota's Alec Smith Insulin Affordability Act](#) (*eligible individuals in urgent need of insulin can go to their pharmacy once in a 12-month period and receive a one-time, 30-day supply of insulin for a \$35 co-pay*): [\[1, 2, 3, 4, 5\]](#)

(2.6) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support continuing to discuss a recommendation for the state to consider a policy providing emergency supply of insulin beyond 30 days (i.e., 90 days): [\[1, 2, 3, 4, 5\]](#)

(2.7) How would you rank these two policy options in order of priority? Please drag and drop to rank in order of priority from highest priority (1) to lowest priority (2):

- Minnesota's Alec Smith Insulin Affordability Act
- Providing emergency supply of insulin beyond 30 days

(2.8) What, if any, feedback do you have for the Work Group to consider around emergency supply access? [\[Open Question\]](#)

Access to state-negotiated price

(2.9) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support the Work Group exploring options to provide access to state-negotiated insulin prices through the ArrayRx Solutions for all Washington residents (e.g., uninsured, underinsured, privately-insured): [\[1, 2, 3, 4, 5\]](#)

(2.10) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support further evaluating a recommendation for Washington to collaborate with other state or non-profit insulin programs (i.e., Utah, California, and non-profit manufacturers): [\[1, 2, 3, 4, 5\]](#)

(2.11) How would you rank these two policy options in order of priority? Please drag and drop to rank in order of priority from highest priority (1) to lowest priority (2):

- Access to state-negotiated insulin prices through the ArrayRx Solutions for all Washington residents
- Collaborate with other state or non-profit insulin programs

(2.12) What, if any, feedback do you have for the Work Group to consider around potentially expanding access to state-negotiated insulin prices or state partnerships?

[\[Open Question\]](#)

Data Transparency

(2.13) On a scale of 1-5 (with 5 being Strongly Support), how strongly would you support the Work Group exploring data transparency efforts related to the price of prescription drugs (i.e., Medicare Advantage Direct Remediation Reporting (DIR) or Washington State Drug Price Transparency): [\[1, 2, 3, 4, 5\]](#)

(2.14) What, if any, feedback do you have for the Work Group to consider around drug pricing data transparency efforts [\[Open Question\]](#)

(3) Wrap-Up

Any additional feedback you wish to provide? [\[Open Question\]](#)

Washington Insulin Group (WAIG) Stakeholder Survey #3

(1) Intro/Background

In the 2022 session, the Washington Legislature passed HB 1728, which directs the Health Care Authority (HCA) to create a Total Cost of Insulin Work Group and secure input from this Work Group about strategies to reduce the cost of, and total expenditure on, insulin and to provide a 30-day supply of insulin to individuals on an emergency basis.

[HB 1728 Legislation Link](#)

(1.1): Please select your identified stakeholder group: [\[Drop down\]](#)

- Insurance commissioner or designee
- Prescription drug purchasing consortium
- Pharmacy quality assurance commission
- Association representing independent pharmacies
- Association representing health carriers
- Public Employees' Benefits Board or the School Employees' Benefits Board
- Health Care Authority
- Association representing pharmacy benefit managers
- Drug distributor or wholesaler that distributes or sells insulin in the state
- State agency that purchases health care services and drugs for a selected population

- Attorney general’s office with expertise in prescription drug purchasing
- Organization representing patients living with diabetes
- Member of the public living with diabetes

(2) Feedback on Short Term Policy Options

This section of the survey is intended to gauge support and interest for aspects of state legislation on emergency insulin supply programs. The main bills reviewed and referenced are [Maine’s Insulin Safety Net Program](#) and [Minnesota’s Insulin Safety Net Program](#). Both programs are for eligible state residents who have cost-shares greater than \$75 per 30-day supply, either with or without insurance, and require a valid insulin prescription. A comparison of the two bills is included in the table below.

Table 1: Comparison of Policy Elements in Emergency Supply of Insulin Programs

Item	Maine Only	Minnesota Only	Both
Eligibility			<ul style="list-style-type: none"> • State Resident • Not enrolled in plan that limits copayment for 30-day supply of insulin to \$75 or less • Have not received urgent supply in 12-month period • Urgent need of insulin
Manufacturer Fees	\$75,000 annually	None	
Pharmacy Copayment			Up to \$35 for 30-day supply to cover dispensing costs
Pharmacy Reimbursement from Manufacturer			Can be reimbursed by manufacturer sending replacement supply or reimbursing in amount equal to pharmacy’s acquisition cost
Reporting to health care practitioner	Pharmacy shall notify health care practitioner who issued prescription	N/A	

Item	Maine Only	Minnesota Only	Both
	of order no later than 72 hours after the insulin is dispensed		
Patient information	Upon dispensing insulin, pharmacy shall provide information sheet with info on: Contact info or the health insurance consumer assistance program	Upon dispensing insulin, pharmacy shall provide information sheet and a list of trained navigators provided by Board of Pharmacy to contact if individual needs to access ongoing insulin coverage options	

(2.1) Both programs allow pharmacies to collect a copayment up to \$35 from the patient to cover the pharmacy’s cost of processing and dispensing an emergency supply of insulin. What, if any, aspects of how pharmacies are paid for their services would you recommend including as part of the workgroup’s report to the legislature? [\[open ended\]](#)

(2.2) Both bills allow patient access to the emergency 30-day supply of insulin to once in a 12-month period based on a completed application. What, if any, aspects about this verification process would you recommended including as part of the workgroup’s report to the legislature? [\[open ended\]](#)

(2.3) Maine’s insulin safety net program requires manufacturers who sell or distribute 500,000 or more units of insulin per year to pay a \$75,000 annual registration fee to the Maine Board of Pharmacy which funds one full-time equivalent (FTE) position to manage Insulin Safety Net Program. What, if any, aspects of this funding would you recommend including as part of the workgroup’s report to the legislature? [\[open ended\]](#)

(2.4) Both bills require manufacturers to reimburse pharmacies with backfilled supply of the emergency insulin dispensed or reimburse monetarily for the dispensed insulin equal to the pharmacy’s acquisition cost. What, if any, aspects of this reimbursement or replenishment model would you recommend including as part of the workgroup’s report to the legislature? [\[open ended\]](#)

(2.5) What, if any, aspects of the Maine or Minnesota legislation or any other legislation related to insulin would you recommend **for** including as part of the workgroup’s report to the legislature? [\[open ended\]](#)

(2.6) What, if any, aspects of the Maine or Minnesota legislation or any other legislation related to insulin would you recommend **against** including as part of the workgroup’s report to the legislature? [\[open ended\]](#)

(3) Wrap-Up

Any additional feedback you wish to provide? [\[Open Question\]](#)

Washington Insulin Group (WAIG) Stakeholder Survey #4

(1.1): Please select your identified stakeholder group: [\[Drop down\]](#)

- Insurance commissioner or designee
 - Prescription drug purchasing consortium
 - Pharmacy quality assurance commission
 - Association representing independent pharmacies
 - Association representing health carriers
 - Public Employees’ Benefits Board or the School Employees’ Benefits Board
 - Health Care Authority
 - Association representing pharmacy benefit managers
 - Drug distributor or wholesaler that distributes or sells insulin in the state
 - State agency that purchases health care services and drugs for a selected population
 - Attorney general’s office with expertise in prescription drug purchasing
 - Organization representing patients living with diabetes
 - Member of the public living with diabetes
-
-

(2.1) Eligibility Criteria: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

For ArrayRx discount card and voucher program, utilize ArrayRx current eligibility: all state residents qualify, no age or income incomes. Would not require ID or documentation of residence; all that is required is Washington address. And for people who are houseless, they could put down shelter or leave blank.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.2) Eligibility Criteria: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

Require additional requirement for manufacturer patient assistance program that family income be less than 400% FPL.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.3) Application Process: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

All individuals would sign up online and receive either a digital card delivered to their phone or paper card mailed to them.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.4) Manufacturer Responsibilities: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

For discounted insulin: Washington Legislature would require manufacturers to offer insulin at discounted price – such as requiring insulin be evaluated annually by the Prescription Drug Affordability Board.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.5) Manufacturer Responsibilities: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

For voucher program: manufacturers would bid on ArrayRx's RFP and their brand would be used for voucher program.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.6) Manufacturer Responsibilities: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

For manufacturer assistance program: manufacturer would be responsible for eligibility determination, providing insulin to pharmacies or patients via direct mail service, and reimbursing pharmacies for dispensed insulin.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.7) Patient Responsibilities: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

Patients would be responsible for enrolling in program online and presenting an ArrayRx card or manufacturer's proof of eligibility at pharmacy. For ArrayRx programs, patients would also be able to check online for participating pharmacies (1,200 in WA).

[\[score 1-5 with 5 being strongly support\]](#)
[\[open response for comments\]](#)

(2.8) Pharmacy Responsibilities: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:
Individuals would show ArrayRx discount card or proof of eligibility for manufacturer assistance program at point of sale at pharmacy to receive discounted price.

[\[score 1-5 with 5 being strongly support\]](#)
[\[open response for comments\]](#)

(2.9) Reimbursement Process: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:
Voucher program: covered medications are paid to pharmacy by state agency sponsoring program plus the patient cost share for prescription.

[\[score 1-5 with 5 being strongly support\]](#)
[\[open response for comments\]](#)

(2.10) Reimbursement Process: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:
HCA would backfill the cash flow gap with state funds until rebate is received from the drug manufacturer.

[\[score 1-5 with 5 being strongly support\]](#)
[\[open response for comments\]](#)

(2.11) Reimbursement Process: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:
For patient assistance program, manufacturers would be responsible for reimbursing pharmacies directly.

[\[score 1-5 with 5 being strongly support\]](#)
[\[open response for comments\]](#)

(2.12) Educational Assistance: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:
Make educational program available for pharmacists and patients to help identify individuals that need assistance overcoming barriers.

[\[score 1-5 with 5 being strongly support\]](#)
[\[open response for comments\]](#)

(2.13) State Entity Responsibilities: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:
Prioritize access to state-negotiated insulin prices through ArrayRx solutions as a top policy strategy for long-term affordable insulin program.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.14) Reporting Requirements: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

Require transparent financial disclosures from manufacturers, PBMs, and plans regarding what the plan paid, member paid, rebates, and acquisition costs through quarterly disclosure. This would require an exemption to current Washington Drug Price Transparency (DPT) program rules.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.15) Other: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

ArrayRx could also be used for an emergency supply of insulin if Washington legislature enacted the same law directing all insulin manufacturers to provide a free or minimal copay for an emergency supply.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

(2.16) Other: On a scale of 1-5 (with 5 being strongly support), how strongly would you support the following:

We could consider providing patient navigators as part of a long-term assistance program like Minnesota has done.

[\[score 1-5 with 5 being strongly support\]](#)

[\[open response for comments\]](#)

Wrap-Up

(3.1) Do you have any additional comments you would like to share?

[\[open response for comments\]](#)

Appendix D - Work Group Survey Results

Findings from Work Group Survey #1

Thirteen of 16 Work Group members responded to Survey #1. Work Group members consistently cited high list prices and patient out of pocket costs (e.g., copays, deductibles, coinsurance) as well as lack of market competition as factors preventing patients from accessing affordable insulin. Lack of transparency in the supply chain was also noted as an important challenge.

Work Group members were interested in learning about and potentially adopting approaches taken in other states. These approaches include:

- Minnesota's Alec Smith Emergency Insulin Act, allowing the uninsured to access a 30-day emergency supply;
- Ohio's Kevin's Law, expanding emergency dispensing authorization in Ohio up to a 30-day supply for all noncontrolled medications;
- Connecticut's copayment caps, capping insulin at \$25 for a 30-day supply, and insulin-related supplies, such as test strips, Blood Glucose Meters (BGM), and Continuous Glucose Monitors (CGM), are capped at \$100 per month. Other glucose-lowering medications are capped at \$25 per month;
- Multi-state compacts on insulin affordability in California and Maine, allowing for multi-state compacts to address insulin affordability;
- Texas's legislation protecting community pharmacies and ensuring patient choice by prohibiting pharmacy benefits managers (PBM) from steering patients to pharmacies they own; and
- Utah's insulin savings program, allowing Utah residents to purchase insulin at the discounted rate available to members of the Public Employees Health Plan (PEHP).

Additional approaches included partnering with other purchasers, negotiating better manufacturer pricing, limiting options on formularies for manufacturers that increase wholesale acquisition cost (WAC) above a certain threshold, and promoting transparency in the supply chain. Work Group participants underscored the importance of keeping the patient group (e.g., uninsured, underinsured, and insured) at the center of policy development, while understanding that total cost of insulin includes more than patient out of pocket costs.

Findings from Work Group Survey #2

Thirteen of 16 Work Group members responded to Survey #2. Work Group members showed a high preference for prioritizing uninsured populations; however, all populations were ranked similarly in terms of importance. Participants noted that those who are uninsured are the most vulnerable and underscored the importance of mitigating patient costs to the fullest extent possible. Other participants noted that the commercially insured and the uninsured can represent the same people at different times in their lives.

Participants ranked the Minnesota Alec Smith Insulin Affordability Act and the 30-day emergency supply proposal highly in terms of importance. Many noted that a 30-day emergency supply does not constitute a long-term solution for Washingtonians with chronic access problems and that insulin supplies (e.g., syringes, pen needles) should be included in such a program.

Work Group participants prioritized collaborating with other states over exploring access to state-negotiated prices through ArrayRx, although they ranked the latter as a high priority proposal.

Participants noted that both proposals may be effective long-term solutions, but that more information is needed regarding the time and effort required to implement these proposals.

Findings from Work Group Survey #3

Thirteen of 15 Work Group members responded to Survey #3. Survey 3 was focused on gathering feedback on the policy for emergency supply insulin. Prior to the survey, members were briefed on policies in Maine and Minnesota that provide a 30-day emergency supply of insulin. This survey included open-ended questions only where members were asked to write down their support for various aspects of each policy.

Survey responses indicated strong feedback for keeping the copayment amount as minimal as possible. Both Maine and Minnesota set the copayment limit at \$35 for a 30-day supply. Members were clear that their main concerns were keeping the price as low as it could be while still covering the dispensing fee for the pharmacy.

In terms of eligibility, members expressed concern that Maine and Minnesota’s policies are limited to state residents with an ID only. This policy could exclude undocumented immigrants, people without IDs, or people who are experiencing houselessness.

The strongest feedback to the policies was in the area of amount of insulin supplied. Several members wrote in that Washington should allow for greater flexibility in providing emergency insulin more than once in a 12-month period and that the policy should be for a 90-day supply instead of 30.

Findings from Work Group Survey #4

Ten of 16 Work Group members responded to Survey #4. Members were surveyed on their support for all elements of the long-term strategy for affordable insulin by scoring each element of the proposal. In summary, the Work Group members were most supportive of the ArrayRx discount card element of the long-term strategy approach. The other 2 elements of the 3-pronged approach were less favorable to the members but still mostly supported with an average score of about 3.0 for both options. The table below outlines the average score for each of the elements of the long-term policy for affordable insulin.

Element	Potential Washington Policy (based on workgroup feedback)	Average Score (1-5 with 5 being strongly support)
Summary of Policy	Provide discounted insulin to Washingtonians through: <ol style="list-style-type: none"> 1. ArrayRx discount card 2. ArrayRx voucher program 3. Manufacturer patient assistance programs 	
Eligibility Criteria	ArrayRx current eligibility: all state residents qualify, no age or income restrictions. Would not require ID or documentation of residence; all that is required is Washington address. And for people who are houseless, they could put down shelter or leave it blank.	4.6

Element	Potential Washington Policy (based on workgroup feedback)	Average Score (1-5 with 5 being strongly support)
State Entity Responsibilities	<p>Workgroup members prioritized access to state-negotiated insulin prices through ArrayRx Solutions as a top policy strategy for a long-term affordable insulin program.</p> <p>ArrayRx Solutions has interagency participation from Washington, Oregon, and Nevada state agencies.</p> <p>At the request of HCA, ArrayRx would go out for bid, get preferred price of insulin and work with state’s existing drug discount card or voucher program to pass through discounted insulin to consumers.</p> <p>Individuals on government-purchased health plans would continue with their existing benefit process.</p> <p>HCA would have to backfill the cash flow gap to the pharmacy with state funds until rebate is received by HCA from the drug manufacturer.</p>	4.2
Reporting requirements	<p>Workgroup requests:</p> <p>Transparent financial disclosures from manufacturers, PBMs, and plans regarding what the plan paid, member paid, rebates, and acquisition costs through quarterly disclosure. Ability to integrate data and publish total diabetes impact and improved outcomes.</p> <p>Workgroup members supported exploring data transparency efforts related to the price of prescription – this would require exception to current Washington Drug Price Transparency (DPT) program rules.</p>	4.5
Other notes	<p>ArrayRx could also be used for an emergency supply of insulin if Washington Legislature enacted same law directing all insulin manufacturers to provide a free or minimal copay for an emergency supply.</p> <p>We could consider providing patient navigators as part of a long-term assistance program like Minnesota has done.</p>	4.0

Appendix E – Online Resources

Washington Total Cost of Insulin Work Group Materials (includes all meeting agendas, presentations, recorded webinars, and transcripts):

<https://www.hca.wa.gov/about-hca/programs-and-initiatives/clinical-collaboration-and-initiatives/total-cost-insulin-work-group>

Work Group Meeting #1 Slides:

<https://www.hca.wa.gov/assets/program/wa-insulin-work-group-meeting-slide-deck-2022-07-08.pdf>

Work Group Meeting #2 Slides:

<https://www.hca.wa.gov/assets/waig-slides-2022-08-25.pdf>

Work Group Meeting #3 Slides:

<https://www.hca.wa.gov/assets/washington-insulin-workgroup-meeting-october-27-2022.pdf>

Work Group Meeting #4 Slides:

<https://www.hca.wa.gov/assets/billers-and-providers/washington-insulin-work-group-meeting-4-slides.pdf>

Work Group Meeting #5 Slides:

<https://www.hca.wa.gov/assets/billers-and-providers/washington-insulin-work-group-meeting-5-slides.pdf>