Res. A-11-19

TITLE: **Insulin Price Inflation**

Introduced by: Dr. Veronica Jordan and the North Bay Chapter of CAFP

Endorsed by:

WHEREAS, 1 in 12 adult Californians has diabetes [1]; and

WHEREAS, insulin is an essential (life or death) medication, and 30% of diabetics use insulin [2]; and

Whereas, the percent of adults in Californians with diabetes is almost two times higher in those with family incomes below 200% of the federal poverty level (FPL) compared to those whose income is 300% above the FPL[3]; and

WHEREAS, Medi-Cal is the state's largest insurance agency, covering one-third of the state's population – over 13.5 million Californians and the majority of our state's diabetics [4]; and.

WHEREAS, the original patent for insulin was sold by the Nobel prize winning physician in 1923 for $1 to ensure that every human who needed insulin could have access to it.

WHEREAS, adjusted for inflation, the price of insulin has increased by 700% in the last 20 years[5]; and

WHEREAS, the State of Minnesota and Minnesota Attorney General Keith Ellison are suing the three drug manufacturers of insulin (Sanofi-Aventis, Novo Nordisk and Eli Lilly) for inflating the list price of insulin, and then offering misleading discounts to insurance companies via pharmacy benefit managers (PBM)[6]; and

WHEREAS, inflated sticker prices increase not only our state's spending on insulin but also put vulnerable patients at risk for being unable to afford insulin (particularly those uninsured and people with high deductible plans); and

WHEREAS, we must be part of the solution of controlling drug costs and ensuring access to life-saving medications, now, therefore be it

RESOLVED, That California Academy of Family Physicians lobby our California State Attorney General, Xavier Becerra to join Minnesota's lawsuit against the pharmaceutical companies to ensure proper pricing of insulin and access to our most vulnerable patients; and be it further

RESOLVED, That CAFP work with Medi-Cal's Pharmacy benefits Manager (PBM) to investigate alternative sources for insulin, including allowing for alternate manufacturers.

Speaker's Note:

Existing CAFP and AAFP policy supports efforts to explore policy and legislation that will reduce drug prices, including policies that control drug prices directly, or the introduction of generic equivalents or alternatives.

Drug pricing is not a component of CAFP's 2019-2021 Strategic Plan. The resolveds could result in significant additional staff workload and development or bringing in additional expertise that could take resources, including staff time away from activities outlined in the CAFP strategic plan.

CAFP policy

Prescription Drug Cost Containment and Price Transparency Policy

CAFP urges the elimination of the Medicare prohibition on drug price negotiation and encourages federal legislation to give the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.

CAFP supports an appropriate balance between incentives for innovation and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

CAFP opposes anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

CAFP encourages the mitigation of restrictions that limit patient access to, and market competition for, prescription medication.

CAFP encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

CAFP supports increased manufacturer rebates if the price of a generic drug rises faster than inflation.

CAFP supports shortening exclusivity time periods for biologics.

CAFP supports the freedom of family physicians to use the most effective pharmaceuticals when prescribing drugs for their patients and encourages family physicians to supplement medical judgment with cost considerations in making these choices;

CAFP encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

CAFP encourages family physicians to consider prescribing the least expensive FDA A-rated generic products, unless it is not available; and

CAFP encourages family physicians to become familiar with the prices in their communities of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

CAFP supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs incentivize research and development of clinically needed prescription drugs, while ensuring patients can reasonably afford their medications as long as clinically indicated. BoD 7.16.16

AAFP policy
Generic Drug Pricing – AAFP Legislative Stance (https://www.aafp.org/about/policies/all/drug-pricing.html)

"The American Academy of Family Physicians supports legislation insuring the availability of effective, safe and affordable medications." (2002) (2014 BOD) Drugs, Generic (https://www.aafp.org/about/policies/all/generic-drugs.html)

"The AAFP supports affordable generic medications and believes such medications should be readily available for family physicians to prescribe. The AAFP's policy, Generic Drug Pricing – AAFP Legislative Stance, supports this position. […] The AAFP recommends that further efforts be supported to enhance post-market medication surveillance for all generic and brand name pharmaceuticals." (1989) (2017 COD)
Drugs – Therapeutic Substitution (https://www.aafp.org/about/policies/all/drugs-therapeutic.html)

"The AAFP strongly opposes any legislative or regulatory effort at the state or federal level to permit therapeutic substitution, that is the substitution of a therapeutic alternate, a drug product containing a different pharmaceutical moiety but which is of the same therapeutic or pharmacologic class." (1988) (2018 COD)

Fiscal Note:
The costs should be considered relative to each of the directives included in this resolution:

"CAFP lobby our California State Attorney General, Anthony Becerra to join Minnesota's lawsuit against the pharmaceutical companies to ensure proper pricing of insulin and access to our most vulnerable patients."
Up to $5,000 in staff time. At a minimum, this requires conducting preliminary research on the price of insulin in California, then writing to California State Attorney General Becerra to encourage California to join the state of Minnesota's lawsuit against pharmaceutical companies to ensure proper pricing of insulin.

This would constitute a minor operational effort for staff. Additional lobbying efforts would result in additional staff cost and potential outside lobbyist cost.

"CAFP work with Medi-Cal's PBM to investigate alternative sources for insulin, including allowing for alternate manufacturers."
Between $5000 to $75,000 in staff time for activities that may include but not be limited to:

- Conducting preliminary research on the price of insulin in California and the range of manufacturers operating or capable of operating in the state.
- Engaging with Medi-Cal's Pharmacy Benefit Manager (PBM) regarding sources of insulin and obstacles to identifying and/or allowing for alternate manufactures.
- Potentially hiring a consultant with expertise in PBM policies and regulations to craft strategy and work with Medi-Cal's PBM to remove those obstacles or lobby for policy changes to facilitate the removal of those obstacles.

This has the potential to constitute anywhere from a minor operational effort for staff to a major organizational strategic priority.

Citations and Additional References Provided by Author:

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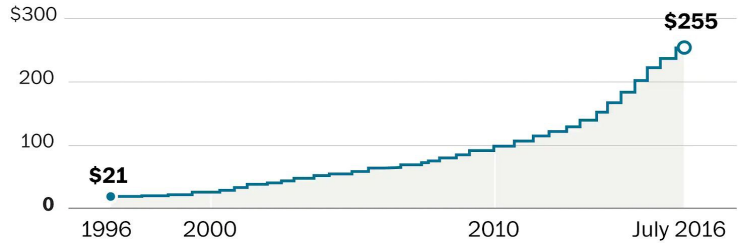
3. https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/CDCB/CDPH%20Document%20Library/N on-ADA%20Compliant%20Docs%20-%206%20Month%20Extension/FINAL%20Rpt%20(1877)
4. %20DM%20burden%202014_9-04-14MNR3.pdf

5. (https://www.chcf.org/publication/2017-edition-medi-cal-facts-and-figures/)
6. https://www.washingtonpost.com/news/wonk/wp/2016/10/31/why-insulin-prices-have-kept-rising-for-95-years/?noredirect=on&utm_term=.f7e7c8c801de
7. Minnesota v. Sanofi-Aventis U.S. LLC, et al, U.S. District Court, District of New Jersey, No. 18-cv-1499

https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7700.pdf Articles on insulin pricing: http://care.diabetesjournals.org/content/41/6/1299 https://www.washingtonpost.com/news/wonk/wp/2016/10/31/why-insulin-prices-have-kept-rising-for-95-years/?noredirect=on&utm_term=.c4efdc55f871 https://www.businessinsider.com/insulin-prices-could-be-much-lower-and-drug-makers-would-still-make-healthy-profits-2018-9 (estimating cost of insulin and profit margins)

The list price of Humalog insulin keeps going up

Since 1996, there have been more than two dozen price increases on a vial of Humalog insulin. Adjusted for inflation, the current price is 700% higher than it was 20 years ago.



Note: List price is in unadjusted dollars and does not reflect rebates or discounts

Source: Truven Health Analytics THE WASHINGTON POST