The Last Thing Insulin Markets Need Is More Government

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August 10th, 2022

Congressional Republicans defeated a proposal by congressional Democrats to mandate that private insurance companies cap out-of-pocket spending on insulin by their enrollees at $35 per month. This follows years of reporting on the high cost of insulin and nearly two dozen states that have imposed similar co-payment price caps for insulin. Yet this proposal neglects to address the way the government drives up the cost of insulin. Further intervention would make matters worse.

In January 1922, a Canadian boy hospitalized and dying from diabetes received the first insulin shot. One hundred years later, insulin gives diabetics around the world the ability to live full lives. Yet government makes it both unnecessarily difficult and expensive for diabetics to access this lifesaving drug. Rather than prices falling over time, insulin prices have more than doubled over the last 10 years. Many diabetics struggle with those rising prices, sometimes with deadly consequences.

Thanks to government, new insulin is expensive to bring to market. As my colleague Dr. Jeffrey Singer and I have written, "in 2019 dollars, the average estimated cost of each new drug approval has risen from $523 million in 1987 to $1.2–1.8 billion in 2000 to $3.2 billion in 2013. The cost grew at an average annual real rate of 9.4 percent in the 1970s, 7.4 percent in the 1980s, and 8.5 percent from 1990 through the early 2010s." The high cost of government regulation discourages the development of new insulin products, reduces the number of insulin manufacturers, and increases the prices of any products that do make it through that process, both by requiring manufacturers to recoup those regulatory-compliance costs and by enabling tacit price collusion.

Thanks to government, insulin is hard to get. Government increases the cost of insulin by requiring diabetics to get prescriptions before purchasing many insulin products. It makes little sense to require diabetics, who are highly knowledgeable repeat consumers of insulin, to obtain prescriptions each time they purchase it. Canada generally allows diabetics to purchase any insulin product without a prescription. If the FDA or Congress were to remove those requirements, both the price of insulin and the ancillary costs of obtaining it would fall.

Thanks to government, insurance companies *at best* only have an incentive to maximize the short-term health of diabetics. The government discourages private insurance companies from structuring insulin cost-sharing to maximize the long-term health of diabetics. If insurance companies had lifelong relationships with their enrollees, they would have incentives to structure cost-sharing for insulin and other preventive care in a way that keeps their enrollees alive and paying premiums while minimizing their enrollees' long-term medical spending.

Insurance companies do not have lifelong relationships with enrollees because Congress penalizes lifelong insurance. The U.S. tax code penalizes workers unless they obtain employer-sponsored health insurance, a type of health insurance that disappears when workers change jobs. Given that Americans change jobs on average a dozen times by age 52, insurance companies that invest in promoting cost-effective preventive care (e.g., insulin use) will not see the long-term benefits of that investment. Those benefits will likely go to one of their competitors, either another private insurance company or the government.

Thanks to government, most people end up with excessive insurance coverage and little awareness of how much things cost. As Cato scholars explain here, here, and here, excessive health insurance encourages providers to increase prices because heavily insured patients care less about price increases. The fact that government insulates consumers from the price of their health insurance guarantees that consumers will rebel against attempts by insurance companies to negotiate lower prices, such as by excluding high-price drugs or providers from coverage. When Congress capped cost-sharing for contraceptives at $0, prices for hormones and oral contraceptives skyrocketed.

Furthermore, as Cato adjunct scholars Charlie Silver and David Hyman write in *Overcharged: Why Americans Pay Too Much for Health Care*, government-encouraged excessive coverage enables tacit collusion among insulin manufacturers to raise prices. Insulin manufacturers have little incentive to cut prices — and every incentive to raise them — because government already so heavily insulates diabetics from the price of insulin that reducing prices does not gain manufacturers a larger market share.

Had government never intervened in the health sector, private insurance companies might already be offering more comprehensive cost-sharing for insulin than congressional Democrats propose, without driving insulin prices higher. Or perhaps insulin prices would be so low that no one would feel the need to purchase insurance that covers it. All we know for sure is that, like past government interventions, attempts by government to cap cost-sharing for insulin will have unintended consequences that make matters worse for diabetics and all consumers.

If Congress and/or federal bureaucrats really wanted to expand access to insulin, they could do so tomorrow. But it would require them to give up some of their power. The fact that congressional Democrats and the rest of the federal government will not give up *even a little bit* of their power to help diabetics tells you where their hearts really lie.

Biography Michael F. Cannon is the Cato Institute's ***director of health policy studies****. Previously, he served as a domestic policy analyst for the U.S. Senate Republican Policy*

Committee, where he advised the Senate leadership on health, education, labor, welfare, and the Second Amendment.