



Making Insulin Affordable for People with Diabetes: A Primer for Health Care Professionals

The American Diabetes Association (ADA) is the nation's leading voluntary health organization fighting to bend the curve on the diabetes epidemic and help people living with diabetes thrive. For 83 years, the ADA has driven discovery and research to treat, manage, and prevent diabetes while working relentlessly for a cure. Through advocacy, program development, and education we aim to improve the quality of life for the over 136 million Americans living with diabetes or prediabetes. Diabetes has brought us together. What we do next will make us Connected for Life®. To learn more or to get involved, visit us at diabetes.org or call 1-800-DIABETES (1-800-342-2383).

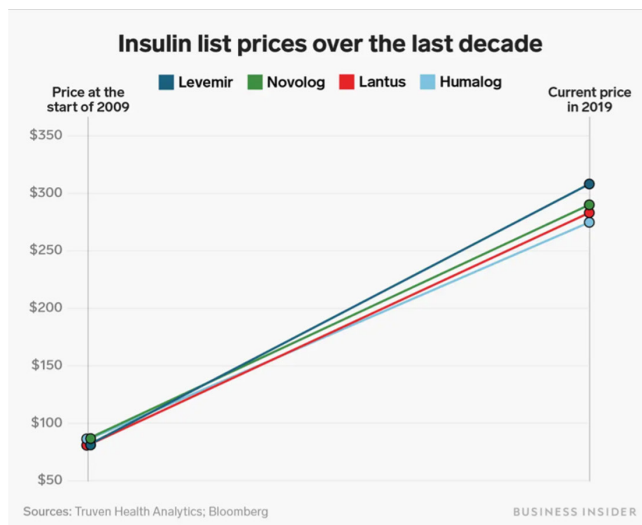
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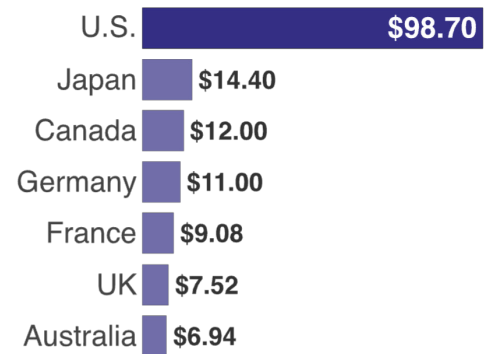
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Introduction

Approximately 11% of the United States population has diabetes, making it the nation’s costliest chronic health condition.¹ All people with type 1 diabetes and 30% of people with type 2 diabetes—an estimated 7.4 million Americans—require insulin.^{2,3} Unfortunately, the cost of insulin has nearly tripled in the past 15 years³ and this cost has become a burden to people living with diabetes.⁴ In 2017–2018, 14% of people with diabetes spent more than 40% of their post-subsistence family income on insulin alone, a level of spending considered catastrophic.⁵ As a result of the high cost of insulin, nearly 26% of U.S. residents with diabetes report having rationed insulin at least once in the previous year, compared to 6% in other high-income countries.⁶ This is alarming, given that diabetes is a leading cause of death in the U.S., and insulin is a crucial tool for managing the condition and maintaining overall health of people with diabetes.⁷



Average price per vial across all types of insulin in 2018:



[Graphic: Increase in insulin costs over time, disproportionate costs borne by U.S. residents]

The U.S. is currently facing a pressing crisis in insulin affordability due to several interconnected factors. These include the widespread prevalence of diabetes, the life-long necessity of insulin therapy for many individuals, and the alarming reality that access to this vital medication often stands as a matter of life and death.⁸ In 2020, inspired by its Health Equity Bill of Rights, the American Diabetes Association® (ADA) initiated the Health Equity Now® campaign which advocates for universal access to essential resources and care for everyone with diabetes. This report focuses on two of the 10 rights in this bill, **the right to access insulin and other drugs affordably and the right to the latest medical advances**, such as continuous glucose monitoring (CGM) as a support tool to those on insulin therapy.⁹

Health care professionals (HCPs) who witness the daily repercussions of the insulin affordability crisis may often find themselves grappling with a sense of overwhelm and helplessness in the face of the current situation. However, it is crucial to recognize that HCPs wield significant influence when it comes to catalyzing change

for people with diabetes, both on an individual and policy level. This report has been crafted to equip HCPs with the knowledge and tools necessary to enhance insulin access for individuals living with diabetes.

By delving into the ways in which broadening insulin accessibility can yield improved health outcomes and foster equity among people with diabetes, this report illuminates the recent strides made in the nationwide endeavor to make affordable insulin a tangible reality. It culminates by presenting practical measures that HCPs can proactively undertake to ensure their patients can reap the benefits of the Health Equity Now movement.

Lack of Access to Insulin and Related Treatments Drive Health Disparities

Historically marginalized groups, including racial and ethnic minorities, shoulder a disproportionate burden of diabetes.¹⁰ While the prevalence of diabetes among white individuals stands at 7%, this figure significantly rises to 15% among American Indian/Alaska Native populations, and 12% among both Black and Hispanic/Latino communities.¹¹ Individuals with diabetes who are members of racial and ethnic minority groups face a significantly heightened risk of developing serious diabetes-related complications, including blindness, amputations, chronic kidney disease, and mortality.¹⁰ To illustrate this, even after accounting for sociodemographic and clinical factors, individuals of American Indian, Hispanic/Latino, and Black heritage with diabetes exhibit a higher likelihood of undergoing lower extremity amputations during hospital admissions related to diabetes.¹²

Research has demonstrated a direct correlation between an individual's socioeconomic status and their susceptibility to type 2 diabetes.¹³ For instance, the data reveals that while a mere 6% of adults with an income at or exceeding 500% of the federal poverty level are affected by diabetes, this figure escalates to 14% among adults with an income falling below 100% of the federal poverty level.¹¹ Moreover, after being diagnosed with type 2 diabetes, individuals from lower socioeconomic backgrounds tend to encounter a greater prevalence of complications and experience a shorter life expectancy compared to their counterparts with higher socioeconomic status.¹³

Social determinants of health shape the relationship between race and ethnicity, socioeconomic status, and health disparities in diabetes outcomes.¹⁴ These determinants encompass a range of crucial factors, including access to education, nutritional resources, income, transportation, stable housing, quality health care, and social support systems. These elements collectively play a pivotal role in determining an individual's capacity to advocate for oneself to achieve health goals. The seemingly routine tasks of scheduling a health care appointment, physically reaching the health care facility, and obtaining prescribed treatments can pose formidable barriers for individuals grappling with limited income, transportation options, and insurance coverage. For some individuals living with diabetes, the financial strain of acquiring essential medications like insulin may force them into the agonizing choice between sacrificing meals or essential utilities.

It follows logically that as the cost of insulin increases, the likelihood of individuals to achieve optimal medication-taking behavior decreases.¹⁵ For example, people with an average out-of-pocket expense exceeding \$50 per month for insulin are more prone to experiencing gaps in their insulin supply compared to those with out-of-pocket costs ranging from \$0 to \$20, irrespective of whether they have type 1 or type 2 diabetes.¹⁶ Growing insulin costs have predictably led to rationing of this critical medicine. In a recent nationwide survey, it was found that one in five adults with diabetes under the age of 65 (i.e., not yet eligible for Medicare) reported rationing insulin due to cost-related factors.¹⁷ Furthermore, certain demographic groups face even higher rates of rationing, with research revealing that Black and Hispanic/Latino individuals are more likely than their white counterparts to resort to insulin rationing.¹⁷ Additionally, a study conducted at an urban diabetes center discovered that one in four patients admitted to rationing their insulin.¹⁸ Alarming statistics also indicate that among individuals with diabetes earning an annual income of less than \$35,000, one in three report having to ration their medications.¹⁹ Predictably, those who engage in insulin rationing are more prone to experiencing poor glycemic management.¹⁸

CGM offers real-time blood glucose tracking, aiding individuals with diabetes in effective condition management and insulin dosage adjustments. However, affordability remains a concern for newer diabetes management technologies like CGM. A research body, including randomized controlled trials and prospective studies, consistently demonstrates that CGM leads to improved glycemic outcomes and reduces diabetes-related hospitalizations and emergency room visits, particularly for individuals employing intensive insulin regimens.²⁰ Emerging evidence supports similar benefits for individuals with type 2 diabetes receiving less intensive insulin treatments. As a result, CGM has become the **standard of care** for all adults with diabetes requiring multiple daily insulin injections, continuous subcutaneous insulin delivery, or basal insulin.²¹

Regrettably, the utilization of CGM technology remains relatively low. A 2018 survey conducted among 22,697 participants in the T1D Exchange (a comprehensive diabetes study aimed at advancing our understanding of type 1 diabetes) revealed that only 38% of respondents reported using CGM, with even lower adoption rates among racial and ethnic minorities.²² Further studies have highlighted lower initiation rates and higher discontinuation rates for CGM among Black and Hispanic/Latino children compared to their white counterparts.²³ Similarly, an analysis of Medicare beneficiaries who acquired CGM devices between July and December 2020 found that 91% were white, while only 0.5% were Black, and a mere 3% were Hispanic/Latino.²⁰ This disparity in CGM adoption persists across various age groups, health insurance coverage types, and geographical locations, with Black individuals consistently exhibiting the lowest rates of CGM utilization, underscoring the stark inequality in access to this essential diabetes management tool.⁷

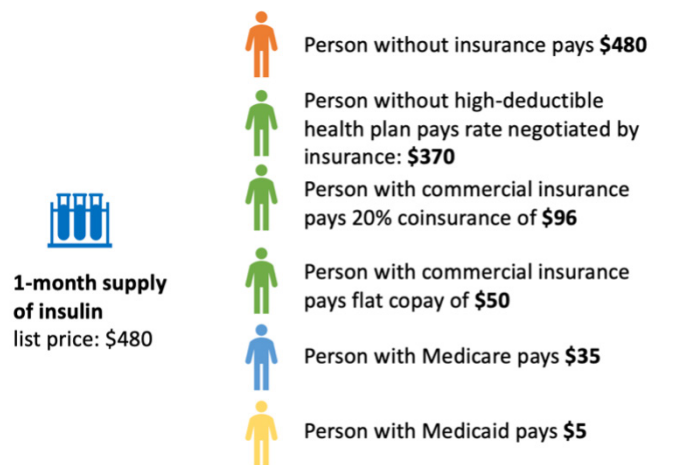
Takeaways:

- Rationing insulin due to cost is common among people with diabetes.

- A lack of affordable Insulin helps drive racial/ethnic and socioeconomic health disparities among people with diabetes.
- Use of CGM is also lower in racial and ethnic minorities, further contributing to health disparities among people with diabetes.

A Deep Dive Into the Cost of Insulin and CGM for People with Diabetes

The price of insulin can fluctuate significantly based on an individual's insurance plan and the location of purchase. Given the complex and often non-transparent factors influencing the out-of-pocket expenses for those with diabetes, understanding the extent of these cost disparities can be challenging. In this discussion, we delve into the diverse cost implications of insulin for individuals consulting the same HCP, highlighting how varied the financial burden can be.



[Graphic: Different people pay very different prices for the same insulin product]

Health care practices cater to patients with a range of insurance coverage options. These include individuals with commercial insurance, encompassing both traditional policies and high deductible health plans (HDHPs), as well as those covered by Medicare and Medicaid. Additionally, they also serve patients who are uninsured. It's not unexpected that insulin rationing is predominantly observed among people with diabetes who are either underinsured or without insurance.¹⁷ It is important for HCPs to understand the costs associated with HDHPs, as in 2021 over 55% of U.S. private-sector workers were enrolled in these types of health plans.²⁴ People with HDHPs must typically pay for medications out-of-pocket until they reach their annual deductible, which averaged \$2,925 for an individual in 2022.²⁵ One study found people with HDHPs had out-of-pocket costs nearly three times that of people with traditional commercial insurance plans for a 30-day supply of insulin.²⁶ It is not unexpected that individuals enrolled in HDHPs are more inclined to ration insulin compared to those with traditional commercial insurance plans.¹⁹

The financial burden of health care is often most acute for individuals without insurance. Those with HDHPs might have the advantage of reduced costs due to their insurer's negotiated prices, but this benefit eludes those without any insurance who are typically required to pay the full list-price for medications. A study underscored this disparity, revealing the annual out-of-pocket expenses for uninsured people with diabetes are significantly higher, amounting to \$2,456, in contrast to \$1,274 for those with commercial insurance.²⁷ Consequently, while only 10% of people with diabetes with commercial insurance struggle to afford prescription medications, this issue affects 38% of uninsured individuals with diabetes. It's not surprising, then, that possessing health insurance is the most significant factor determining whether adults with diabetes can meet individual quality measures for diabetes care.¹³ From a clinical perspective, the absence of insurance in people with diabetes leads to a staggering 168% increase in emergency department visits when compared to those who are insured.²⁸

CGM systems also vary in cost, depending on the brand and model. The cost of a CGM system can vary with additional costs for supplies, such as sensors and inserter devices. Some insurance plans may cover the cost of CGM systems, but coverage varies widely and may require prior authorization. Self-paying patients may be able to find discounts through manufacturer programs or through third-party online sellers.

Practical Benefits of Affordable Insulin and CGM

The importance of ensuring affordability and accessibility of insulin and CGM for those with diabetes who need them is crucial given the current challenging landscape. Achieving glycemic goals are paramount to preventing complications, but data from 2005 to 2012 shows only 31% of U.S. adults with diabetes managed to keep their A1C levels below 7%, and just 62% had A1C levels under 8%.²⁹

More concerning is the deterioration in many clinical outcomes for people with diabetes in recent years. Between 2009 and 2015, there was an increase in the incidence of hyperglycemic crises (a serious medical condition where there is an extremely high blood glucose level, often leading to severe symptoms and complications that require immediate medical attention) among U.S. adults with diabetes, noted in both emergency and inpatient settings.³⁰ This trend was observed across all age groups, genders, and regions nationwide. Notably, about 40% of these acute events occurred in individuals living in low-income ZIP Codes, leading to the hypothesis that the escalating cost of insulin may be a significant factor in the rise of diabetes complications.³⁰

Healthy People 2030 is dedicated to promoting a healthier nation through establishing data-driven objectives for the next decade, with several goals such as lowering the percentage of individuals with diabetes having A1C values above 9% and reducing diabetes-related deaths and amputations, which are heavily dependent on enhancing glycemic outcomes.³¹ Equipping individuals with diabetes with the necessary tools and education for self-management is essential to help them reach and maintain their glycemic goals.³² Eliminating financial barriers to accessing insulin and other diabetes medications is shown to enhance

medication-taking behavior and improve clinical outcomes. This includes critical HEDIS (Healthcare Effectiveness Data and Information Set) measures for diabetes management such as A1C levels and blood pressure.^{33,34} HEDIS measures are important as they are used to assess the quality of care and services provided by health plans. At the individual level, effective management of blood glucose can decrease the risk of complications involving the eyes, kidneys, and nerves by 40%.¹ On a broader societal scale, improving diabetes medication-taking behavior, including insulin, has the potential to prevent nearly 700,000 emergency department visits and over 340,000 hospitalizations annually, resulting in savings of about \$4.7 billion.³⁵

Recent Progress Toward Affordable Insulin and CGM

Recent years have witnessed significant initiatives at both state and federal levels to address the affordability crisis of insulin.² Medicare has played a pivotal role in making insulin and CGM more affordable. Effective from January 1, 2023, Medicare drug plans are limited to charging no more than \$35 for a one-month supply of a Part D–covered insulin product, and annual deductibles are no longer applicable to insulin. This new price cap of \$35 is anticipated to aid nearly half of Medicare’s enrollees.⁴ Additionally, in April 2023, Medicare expanded CGM coverage to include type 2 diabetes enrollees who use any type of insulin, and also those who do not use insulin but have a history of problematic hypoglycemia.³⁶ This expansion is expected to set a precedent for most private insurers, with several major insurance companies already implementing similar policies.³⁷

A recent study found Medicare’s new \$35 monthly cap for insulin prescriptions is already improving access for enrollees.³⁸ Normally, when a new calendar year begins, insulin refills by Medicare enrollees decline, as annual deductibles reset and people with diabetes must pay for prescriptions out of pocket. In early 2023, after the out-of-pocket cap was put in place, this decline in insulin refills did not occur for the first time.³⁸ It was still present, however, among people aged 60–64 years who were slightly too young to qualify for Medicare and thus did not benefit from the out-of-pocket cap.

States are also stepping up to control the out-of-pocket costs of insulin. By September 2022, 23 states had established insulin price caps ranging between \$25 and \$100.³⁹ (Note: As of April 2024, this has expanded to 25 states and District of Columbia.) In addition, several state marketplaces have completely removed cost sharing for some or all insulin products. There’s a growing trend in state-level expansion of coverage for CGM as well. For instance, by 2024, all commercial insurance plans in Illinois are required to cover the cost of medically necessary CGM for individuals with type 1 or type 2 diabetes who require insulin.⁴⁰ However, it’s crucial to acknowledge that states do not have jurisdiction over self-insured plans, which account for 64% of all employer-based insurance plans.³⁹

Finally, the three major insulin manufacturers, which make up approximately 90% of the U.S. insulin market, are taking steps to limit insulin costs for people with diabetes around the nation.¹⁷ In 2023, Eli Lilly and Sanofi capped out-of-pocket costs for insulin refills at \$35 a month and Novo Nordisk reduced the list price of its most prescribed insulins by up to 75%.

Takeaways:

- Medicare has instituted a \$35 cap on insulin prescriptions and now covers CGM for people with both type 1 and type 2 diabetes.
- Major insurance companies and some manufacturers have also introduced a \$35 cap for insulin prescriptions that benefits people with commercial insurance.
- Many states are instituting their own caps on insulin prescriptions, and some are also introducing commercial insurance coverage requirements for CGM.

Continued Challenges in the Fight for Affordable Insulin and CGM

Recent changes have improved insulin and CGM affordability and access for people with diabetes. Work must still be done to ensure Medicare enrollees are aware of the coverage they are entitled to. Research shows that Black and Hispanic/Latino Medicare enrollees with diabetes are less likely to be familiar with Medicare policies around paying for diabetes testing supplies and self-management education than white enrollees with diabetes.⁴¹ In addition, 71% of adults who reported rationing insulin in a recent nationwide study were younger than 65 years of age and thus ineligible for Medicare and its prescription price cap.¹⁷ People with diabetes who are underinsured or who lack insurance continue to struggle to access critical tools for managing their diabetes. Indeed, the most common barriers to CGM use remain cost and lack of insurance coverage.⁴² Efforts are being made to address barriers and a comprehensive consideration of state-based restrictions is important.

It is crucial to understand that copay amounts alone don't fully represent the affordability of insulin. For instance, while copays for Medicaid recipients are generally low, ranging from \$1 to \$5 for a 30-day insulin supply, even these relatively small amounts can be a financial burden for many enrollees. One study found that people eligible for both Medicaid and Medicare were actually more likely to ration medication than people only eligible for Medicare.⁴³ Financial burdens for Medicaid enrollees may arise due to prescriptions for multiple comorbidities, causing aggregate costs. CGM coverage under Medicaid varies by state and is often less inclusive than Medicare's. Some states limit Medicaid CGM coverage to people with type 1 diabetes, others include both type 1 and type 2 diabetes, while a few restrict it to pediatric cases only.⁴⁴ CGM policies around prescribers, prior authorizations, and medical documentation vary by state, adding complexity to access. These challenges in affordability and access lead to a scenario where people with Medicaid often face suboptimal diabetes management, poorer glycemic outcomes, increased care barriers, and more diabetes-related complications compared to those with commercial insurance.^{20,44}

Expectations within the diabetes community regarding biosimilars lowering insulin prices, similar to the cost reductions seen with generics for various expensive medications, have been unmet. Although the U.S. approved the first biosimilar insulin product in 2015, the adoption of biosimilars among U.S. residents with diabetes remained disappointingly low, with only 8% using them by 2020.⁴⁵ Presently, the U.S. theoretically offers two interchangeable biosimilar insulins, both manufactured by major pharmaceutical companies. The term “interchangeable” implies that in most states, pharmacists can seamlessly replace the original insulin prescription with these more affordable alternatives, akin to the process for generic medication substitutions. However, the reality is that biosimilar insulins are seldom accessible. In a 2019 survey conducted across nearly 400 pharmacies nationwide, it was discovered that one biosimilar from a prominent manufacturer was unavailable at 83% of pharmacies and could not even be ordered at 69% of them.³⁹ In 14 states, none of the surveyed pharmacies had the biosimilar insulin in stock, and in 17 states, it was only accessible at one of the surveyed pharmacies. Surprisingly, for many individuals, the out-of-pocket expenses for biosimilars are higher compared to the original insulin products. This is due to the fact that the original products provide more options such as coupons, vouchers, and discounts through patient assistance programs.⁴⁶

Takeaways:

- 80% of U.S. residents do not benefit from the \$35 Medicare cap on insulin prescriptions.
- Even people with low copays may not be able to afford insulin.
- The most common barriers to the use of CGM remain cost and lack of insurance coverage.
- Interchangeable insulin biosimilars have done little to improve insulin affordability.

What Health Care Professionals Can Do to Improve Insulin and CGM Affordability

Access to insulin and CGM, along with their affordability, undoubtedly represent societal challenges. Nevertheless, HCPs can be instrumental in driving the necessary transformations. In their daily practice, they can heighten their **awareness** and understanding of their patients’ situations, **tailor**/adjust their care to meet individual needs, and **assist** people with diabetes in surmounting barriers related to access and affordability.⁴⁷ On a larger scale, HCPs can **align** with like-minded partners and organizations to **advocate** for policies aimed at enhancing the accessibility and affordability of insulin and CGM.

Building Awareness of Patients' Barriers to Accessing Insulin and Helpful Resources

A key step HCPs can take to improve access to insulin and CGM is to inquire and counsel people with diabetes about financial concerns regarding their treatment plan. Many patients refrain from discussing financial issues during medical appointments, often because they feel ashamed due to the stigma associated with financial constraints or lack of insurance. Additionally, there may be a perception that financial matters are not appropriate topics for health care discussions. In a study involving individuals who reported rationing insulin, around 40% admitted to never having talked about insulin costs with their health care provider.¹⁸ HCPs have the capacity to transform this scenario by proactively addressing the issue of insulin and CGM affordability themselves. By broaching the subject with empathy and creating a welcoming environment for open dialogue, they can play a pivotal role in fostering discussions about affordability. Furthermore, being prepared to offer guidance and resources on navigating affordability challenges is essential to effectively support patients in managing their health care costs.

In fact, the ADA's *Standards of Care in Diabetes* recommends HCPs assess various social determinants of health, including food insecurity, housing insecurity or homelessness, financial barriers, and the presence of social capital and community support.²¹ This assessment should inform treatment decisions and involve referring people with diabetes to suitable local community resources. To integrate this assessment seamlessly into the typical office visit workflow and reduce any associated stigma, one effective approach is for HCPs to administer a social risk screener to all individuals with diabetes (refer to the Resource List for available tools). If conducting the entire social risk screener is not feasible due to resource constraints, HCPs can start by incorporating a single question into their existing health screening process, inquiring about insulin affordability. This approach can effectively identify individuals who may need assistance. Being prepared to address these social determinants of health can significantly enhance patient care and wellbeing.

To help patients address financial barriers and other social risks, HCPs can also improve their awareness of helpful resources. The results of social risk screenings or discussions about treatment affordability may require HCPs to connect people with diabetes to social services or community resources (see Resource List).⁴⁸ For HCPs practicing in large systems, it may be possible to refer people with diabetes to a patient navigator or social worker who can match them with local resources and help them apply for relevant programs.^{21,47,49} Practices may want to forge links with community health advisors, health coaches, or programs that help link people with financial assistance, groceries, meals, housing, and transportation.

Regarding insulin and CGM affordability specifically, HCPs can make sure they are up to date on the lowest cost options for patients who are underinsured or who lack insurance. As discussed, out-of-pocket costs can vary tremendously based on a person's insulin type, insurance status, and the pharmacy they use. In addition, the best options are continually changing, so helping patients identify an insulin

that is affordable for them is key to treatment success. To illustrate, in 2019 researchers called more than 250 pharmacies around the country asking the cash price for a five-pack of a specific type of insulin injector pen.⁵⁰ The prices cited ranged from \$96 to \$1,759, with a median price of \$445. *This means that over a single year, a patient paying the median cash price every month would spend \$4,000 more than a patient paying the lowest price, while a patient paying the highest price would spend nearly \$20,000 more.* HCPs can also become familiar with manufacturer-sponsored patient assistance programs and Medicaid requirements for various types of insulin and CGM devices, so they can help patients qualify for these types of support.

Finally, HCPs can consider prescribing human insulin and determining which patients it may be appropriate for.¹⁵ Human insulin is often the lowest commercially priced insulin available. Patients can purchase it from larger retailers, often without a prescription, for as little as \$25 a vial.⁵¹ Evidence supports the use of this type of insulin in patients with type 2 diabetes who are having trouble affording analog insulins.⁵¹

Adjusting Practices to Better Serve Patients with Diabetes

In addition to screening individuals with diabetes for financial and other social risks that could impact their ability to adhere to an optimal treatment plan, HCPs can implement changes in their practice to better serve their patients. For instance, HCPs can collaborate with their administrative staff to enhance proactive outreach to high-risk individuals. This high-risk group includes individuals transitioning from pediatric care, those lacking insurance or with inadequate coverage, Medicaid beneficiaries, and those who have recently turned 26 and might have lost parental insurance coverage.⁴⁷ Although it is essential to address financial barriers with all patients with diabetes, it holds particular significance for these individuals.

Administrative staff can also help HCPs proactively identify who may newly qualify for a CGM. Unfortunately, prescribing biases appear to play a significant role in racial and ethnic disparities in CGM use.³² This observation also points toward an opportunity to address inequities in CGM use. Often HCPs may avoid offering CGM devices to patients for whom they believe may have trouble accessing this technology. The ADA's *Standards of Care in Diabetes* recommends that CGM be offered to all adults with diabetes who are on multiple daily injections of insulin, continuous subcutaneous insulin, or basal insulin.²¹ Many people with diabetes may not be aware that CGM is an option or that it may be covered by their insurance or a patient assistance program. Moreover, the groups of patients who currently have the lowest rates of CGM use may stand to benefit the most from this technology.⁴²

Assisting Patients with Access to Insulin and CGMs

By being informed about resources for people with diabetes, HCPs can guide them towards government and community initiatives that enhance the affordability of insulin and CGMs. HCPs can directly aid in pinpointing budget-friendly insulin and CGM alternatives. HCPs should consider prescribing the most cost-effective insulin that can safely and effectively meet a person's treatment needs.¹⁵ This could involve prescribing human insulin to those who are underinsured or uninsured. It might also involve guiding people with diabetes to the most affordable pharmacy options or assisting them in enrolling in manufacturer-sponsored assistance programs. Thankfully, there are location-based resources to facilitate this process (refer to the Resource List). The ADA's *Standards of Care in Diabetes* emphasizes considering the costs of care and insurance stipulations when devising treatment strategies to diminish potential cost-related adherence barriers.²¹

Aligning with Partners and Advocating for Policies that Improve Insulin Affordability

Although considerable progress has been made recently toward capping out-of-pocket expenses for insulin, much remains to be done. In its policy work, the ADA's priority is to ensure all people with and at risk for diabetes are covered under public and private health insurance plans that provide adequate and affordable access to the medications, tools, education, and health care necessary to meet the organization's standards as outlined in the ADA's *Standards of Care in Diabetes*.⁵² In short, the ADA works to make insulin affordable and accessible for all who need it.

At the federal level, the ADA urges Congress to make diabetes research, prevention, and treatment a priority through the Congressional Diabetes Caucus and advocates for legislation that will limit insulin copays to \$35 for commercially insured people with diabetes.⁵³ The ADA also issues active alerts to keep members apprised of what is going on in their states, makes sure state officials hear the stories of constituents with diabetes, and promotes policy change at the state level.⁵⁴ Finally, at the grassroots level, the ADA helps people with diabetes and HCPs share their stories, both by directly contacting policymakers and raising awareness via social media.⁵⁵ HCPs can use their expertise and social capital to join the ADA in one or all of these lines of advocacy.

Conclusion

The issue of insulin affordability may appear overwhelming, but HCPs hold a formidable platform. Their decisions not only impact individuals with diabetes, but also resonate across the nation through advocacy. While recent strides have improved insulin and CGM affordability for some, the proactive engagement and voices of HCPs remain pivotal for sustained progress. This resource sheet serves as a resource for HCPs committed to staying informed about optimal diabetes care practices and championing universal insulin affordability for all those affected.

Helpful Resources

- The ADA's [Standards of Care in Diabetes](#)
- [Social Needs Screening Tool, Guide, and Neighborhood Resources Navigator](#)

Insulin Affordability Resources

- [Insulin Cost-Saving Resource Guide](#)
- [Insulin affordability help for people with diabetes](#)

CGM Affordability Resources and Suggestions

- [CGM Insurance Coverage Tool](#)
- [CGM cost-saving resource guide](#)
- [CGM affordability help for people with diabetes](#)

Advocacy for Affordable Insulin

- [Learn how to get involved](#)

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