November 6, 2025

I, Jennifer Duck, Vice President of Public Affairs of Novo Nordisk, Inc, hereby attest that:

1. I am legally authorized and empowered to represent Novo Nordisk, Inc. for the purposes of this testimony.
2. The testimony submitted and all statements made by me in connection with this matter are true and correct to the best of my knowledge, information, and belief.

Signed under the pains and penalties of perjury this November 6, 2025, in Washington, DC.

Jennifer Duck
Vice President, Public Affairs
Novo Nordisk, Inc.

MASSACHUSETTS
HEALTH POLICY COMMISSION

2025 Pre-Filed Testimony

As part of the *Annual Health Care Cost Trends Hearing*

Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

INSTRUCTIONS FOR WRITTEN TESTIMONY

If you are receiving this, you are hereby required under M.G.L. c. 6D, § 8 to submit written pre-filed testimony for the 2025 Annual Health Care Cost Trends Hearing.

On or before the close of business on **Friday, October 31, 2025**, please electronically submit testimony as a Word document to: HPC-Testimony@mass.gov. Please complete relevant responses to the questions posed in the provided template. If necessary, you may include additional supporting testimony or documentation in an appendix. Please submit any data tables included in your response in Microsoft Excel or Access format.

Your submission must contain a statement from a signatory that is legally authorized and empowered to represent the named organization for the purposes of this testimony. The statement must note that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission. All submissions are public record and will be posted to the HPC's website.

If you have any difficulty with the template or have any other questions regarding the pre-filed testimony process or the questions, please contact HPC General Counsel Lois Johnson at HPC-Testimony@mass.gov or Lois.Johnson@mass.gov.

THE 2025 HEALTH CARE COST TRENDS HEARING: PRE-FILED TESTIMONY

The Massachusetts Health Policy Commission (HPC), along with the Office of the Attorney General (AGO), holds the Health Care Cost Trends Hearing each year to examine the drivers of health care costs and consider the challenges and opportunities for improving the Massachusetts health care system.

The 2025 Health Care Cost Trends Hearing offers a critical opportunity to discuss the pressing issues challenging the stability and sustainability of the Commonwealth's health care system. These include mounting affordability issues, workforce constraints, financial volatility, increasing prescription drug costs, and threats to health care access and coverage – and the ongoing efforts to address them.

Recent federal action has created uncertainties about the health care landscape in Massachusetts. It will require a renewed commitment among stakeholders and policymakers to work together towards a health care system that is more affordable, accessible, and equitable for all residents. The 2025 Health Care Cost Trends Hearing will convene industry leaders, clinicians, and community members to reflect on recent policy actions and invite further collaborative action in Massachusetts, advancing the Commonwealth's health care goals and values.

Amid the federal activity, Massachusetts is still contending with existing affordability hardships facing the Commonwealth's residents. Massachusetts now has the highest family health insurance premiums in the country. In 2024, the average annual cost of health care for a family exceeded $31,000 (including out-of-pocket spending). As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. These rates become particularly dire when health care premiums and out-of-pocket spending reach 25% of total income – a reality that 41% of Hispanic families and 26% of black families in Massachusetts faced in 2023 compared to 9% of white families. Furthermore, the average annual cost sharing per person grew from $849 in 2019 to $1,049 in 2023 (a 29% increase), and residents paying $5,000 or more annually in cost sharing doubled from 2019 (1.5%) to 2023 (3.1%).

This is the first hearing since the enactment of two significant health care laws earlier this year (Chapters 342 and 343 of the Acts of 2024), which strengthen the health care market, address rising prescription drug costs, and enhance the public transparency and accountability of the Commonwealth's health care system – including requiring additional health care market participants to provide public testimony. As the HPC, the AGO, and other state agency partners continue implementation of these new laws, the 2025 Health Care Cost Trends Hearing will focus on working together to safeguard the Commonwealth's commitment to health care affordability, access, and equity.

The pre-filed written testimony affords the HPC and the AGO, on behalf of the public, an opportunity to engage with a broad range of Massachusetts health care market participants. In addition to pre-filed written testimony, the public hearing features in-person testimony from leading health care industry executives, stakeholders, and consumers, with questions posed by the HPC's Board of Commissioners about the state's performance under the Health Care Cost Growth Benchmark and the status of public and industry-led health care policy reform efforts.

QUESTIONS FROM THE HEALTH POLICY COMMISSION

1. In recent years, prescription drugs have been a key driver of spending growth in the Commonwealth, consistently growing at a faster rate than the state's health care cost growth benchmark, and contributing to challenges related to health care affordability, medication access, and health disparities among Massachusetts residents.

    a. What policies or strategies should policymakers and/or other market participants consider to (1) provide greater transparency and (2) address the growing cost of prescription drugs in Massachusetts, balancing patient access to needed medications and therapies with the imperative to offer affordable coverage for employers and residents?

The growing need for further reform of Pharmacy Benefit Managers (PBMs), is underscored by their persistently opaque business practices, which often disadvantage patients. PBMs have become increasingly powerful intermediaries in the pharmaceutical supply chain, with the three largest PBMs controlling over 80 percent of the prescription drug market in Massachusetts. This market dominance is further entrenched by their ownership by leading health insurance companies, concentrating influence over drug pricing and access. A central issue lies in the non-transparent financial mechanisms PBMs employ, such as vertical integration, the use of offshore Group Purchasing Organizations (GPOs) as rebate aggregators, and the imposition of various nonclinical fees. These strategies enable PBMs to amass significant profits, which are rarely passed on to patients. Instead, such practices create conflicts of interest and obscure the true cost of medicines, undermining the affordability and accessibility of essential treatments. Despite PBMs negotiating substantial rebates from drug manufacturers, these savings are not typically used to defray patient costs at the point of sale or in their coinsurance. For instance, Novo Nordisk returns a significant proportion of our revenue—up to 75 percent—through rebates, discounts, and fees, this has not translated into reduced out-of-pocket costs for patients. The gap between the list and net prices of medicines has continued to widen, even for newer therapies

such as GLP-1 medicines like Ozempic®. Although the net price of Ozempic® has dropped by around 40 percent since its introduction, patients have not experienced corresponding savings. A major contributor to this problem is the cumulative effect of various PBM-imposed charges, including rebates, administration fees, data portal fees, and service fees—often calculated as a percentage of the drug's list price. While most manufacturer rebates are passed to plan sponsors, PBMs typically retain these additional fees, which have become their fastest-growing sources of profit. The requirement to pay such fees for formulary inclusion further entrenches their position. To remedy these issues, meaningful reform must address the lack of transparency in PBM revenue streams and redirect savings towards patient affordability. One solution is the adoption of delinking policies, which separate the cost of medicines from the fees PBMs charge manufacturers. By tying PBM compensation to fixed service fees or performance-based outcomes, rather than drug prices, these reforms would eliminate incentives to favor high-priced medicines and promote fairer negotiations. Colorado's recent adoption of such a policy, effective from 1 January 2027, demonstrates a practical step towards greater transparency and value for patients. In addition, policies requiring PBMs to pass rebates directly to consumers at the point of sale, reduce enrollee premiums, or enhance benefits would ensure that negotiated savings are more equitably distributed. By mandating that rebates benefit patients, these reforms could lower out-of-pocket expenses and make medicines more accessible. Nevertheless, PBMs have shown agility in circumventing reform by reclassifying or redirecting revenue streams to maintain profit margins and system inefficiencies. For example, they may introduce new administrative fees or utilize complex financial arrangements to obscure the flow of funds, diluting the intended impact of rebate pass-through policies and keeping the pharmaceutical supply chain unnecessarily inflated. To counter these evasive tactics, rebate pass-through requirements should be paired with robust transparency mandates. This includes comprehensive reporting standards for all PBM revenue sources, stringent auditing, and clear disclosure of how rebates and other financial incentives are allocated. Enforceable limits on nonclinical fees and mandatory justifications for administrative charges would further prevent the proliferation of new, opaque revenue streams. Ultimately any serious attempt to reduce patients' prescription costs must confront the roles and incentives of PBMs in the supply chain. Reforms to benefit design are needed to eliminate the current incentive for health plans to prioritize higher rebates over lower-priced medicines. 340B REFORM: Congress created the 340B program to benefit safety-net providers serving low-income and uninsured patients. The manufacturer discounts provided to the statutorily designated safety-net hospitals and clinics allows them to free up resources to provide discounted health care

services and medications to their most vulnerable patients. However, since HRSA's release of the 2010 program guidance, for-profit intermediaries, including retail chain pharmacies, pharmacy benefit managers, and third-party administrators, have capitalized on the contract pharmacy model to generate billions of dollars in profits that are not reducing the cost of medicines or health care for low-income and underserved patients. Congress never intended for-profit intermediaries to benefit from this program; pharmacies and PBMs are not among the statutory list of 340B eligible entities. Nonetheless, it has become extremely profitable for pharmacies (and vertically integrated health plans and PBMs) to make outsized profits from the 340B discount provided by manufacturers to covered entities and their contract pharmacies, which sell the drugs to patients at the non-discounted price. In fact, one study found that the "average profit margin on 340B medicines commonly dispensed through contract pharmacies is an estimated 72% compared with just 22% for non-340B medicines dispensed through independent pharmacies." Contract pharmacies have become a significant revenue stream for these for-profit intermediaries that have no obligation to ensure that the underserved receive the benefit of the 340B discount; there are 5,215 arrangements in Massachusetts between for-profit contract pharmacies and 340B covered entities. Abuse of the 340B program is negatively impacting employers and state and local governments in Massachusetts. Employers pay an estimated $241M more in health care costs due to foregone rebates (which reduce the price of medicine) as a result of the 340B program; this leads to a $12.1M reduction in state and local tax revenue. The Massachusetts legislature is considering legislation that would prohibit manufacturer limits on contract pharmacies, which is estimated to increase health care costs for employers and state and local governments by $118.2M due to additional foregone rebates. Rather than expanding the 340B program in the state, Massachusetts should enact policies that ensure that the program benefits the patients that it was designed to serve.

2. Direct-to-consumer ("DTC") sales of prescription drugs is a growing trend in the United States, enabling pharmaceutical companies to sell their drug products to patients directly or through a third party or government platform, often at discounted prices. If your company currently offers or has publicly announced plans to offer any DTC programs, either directly or through a third-party, for the sale and distribution of any of your prescription drug products, please respond to the following questions:

    a. How do you select the drug products offered in your DTC programs? Which drug products do you offer through your DTC programs and which do you plan to offer?

DTC programs are developed where we see gaps in affordability. Our insulin program was initiated in response to patients being exposed to high out-of-pocket costs through high-deductible health plans and co-insurance when list prices were higher. We then launched Wegovy because so many payers fail to recognize obesity as a disease and thereby do not provide coverage as a standard benefit. We currently offer Wegovy® and Ozempic® as the primary products in the DTC programs we support. We consistently assess new offerings that support patient access including when new products are launched.

    b. For each drug product that you currently sell through your DTC programs, indicate the DTC price for a one-month supply, and the DTC price's percentage discount off list price (if prices differ by dosage, please respond separately for each).

For Self-Pay: Wegovy®: 63% ($1349.02 WAC and $499 Self-Pay Price); Ozempic® 50% ($997.58 WAC and $499 Self-Pay Price) MyIsulinRx allow patients to receive three insulin vials or two packs of pens for $35; For insured patients: the prices patients pay vary based on insurance coverage

    c. Please describe any eligibility requirements that consumers must meet to purchase drug products through your DTC programs, and which payment methods your programs accept or will accept, including cash pay, insurance, FSA/HSA accounts, and other payment methods.

Eligibility requirements vary by program and product. Terms and conditions can be found at NovoCare® Pharmacy Terms and Conditions of Use | NovoCare®, Wegovy® (semaglutide) injection 2.4 mg Text Savings | NovoCare®,Diabetes Savings Card Program | NovoCare® | Insulin savings eligibility | NovoCare®

d. Please describe any prescriber consultations that you facilitate, either directly or through a partnership with a provider organization, for consumers seeking to purchase a drug product through your DTC programs.

Novo Nordisk is not involved in any prescriber consultation with regard to patients seeking our products through a DTC program.

3. Massachusetts now has the highest family health insurance premiums in the United States. In 2024, the average annual cost of health care for a family exceeded $31,000 (including out of pocket spending). This reflects the growth in underlying health care costs. As health care spending grows as a portion of household income, more and more families incur medical debt and avoid using needed care. Collaborative, urgent action across market participants is needed to reverse these trends. How can your organization contribute to this effort?

Novo Nordisk is dedicated to ensuring broad access to all of our products in order to support patients living with chronic conditions. We are firmly committed to providing affordable access to our medications for residents of Massachusetts. To address diverse patient needs, we have established several targeted affordability initiatives support individuals who are underinsured or uninsured. For example, our Patient Assistance Program offers medications at no cost to eligible patients who are U.S. citizens or legal residents and whose household income does not exceed 400% of the federal poverty level. Additionally, our patient co-pay cards can reduce out-of-pocket expenses for select insulins to as low as $35 for a 30-day supply, and for Ozempic®, the cost can be reduced to as little as $25 per month. These offers are designed specifically for cash-paying patients without insurance or those with commercial insurance lacking coverage for these medications, and do not apply to government-insured patients. Furthermore, in response to evolving healthcare needs, we have introduced a direct-to-patient program, enabling self-paying individuals to access their necessary medicines securely. This initiative provides a reliable alternative for those without access to obesity medications. We have implemented, and remain committed to implementing, measures that ensure patients have continued access to our medications.

Despite these efforts, patients still face high out-of-pocket costs due to insurance design and the role of the PBMs in driving up list prices. As we outlined in question #1, the existing system creates incentives that benefit PBMs financially while contributing to inefficiency and higher health care costs for Massachusetts residents.