

4/14/2026

Robin Dionne

Senate Health and Human Services

RE: SB2877

Dear Robin Dionne and members of the Senate:

My name is Cara Moeller and I was diagnosed with Type 1 Diabetes over 30 years ago on October 16th 1995. Much has changed with diabetes management over the last 30 years. I started with 6 plus finger sticks daily to check my glucose levels and 4 plus injections with needles to administer insulin. Using this regimen, I knew what my blood glucose was 6 times daily. A lot can happen in a day. There are 24 hours in a day and 1440 minutes in a day. I knew what my blood glucose was 6 times a day. A lot can affect a blood glucose levels including but not limited to carbohydrates, protein, fiber, hydration, insulin administered, exercise, illness, my menstrual cycle, caffeine, scar tissue, stress and poor sleep. Due to infrequent testing (although this was the maximum volume approved by my insurance) my blood glucose values were very erratic despite me and my families best efforts.

I later moved to insulin pens to administer insulin along with the 6 – 10 finger sticks daily to test my blood glucose levels. My insurance allowed me to test more often however working as a night nurse in a hospital with fluctuating sleeping patterns it was still very difficult to manage my glucose values. It was extremely frustrating to be very knowledgeable in this field of diabetes and take all the steps necessary to have exemplary blood glucose values and still have an A1c value above 7%. The American Diabetes Associations encourages most individuals with diabetes to have an A1c less than 7%, ideally less than 6.5% or in the “normal” range.

For the last 10 years I have been using a continuous glucose monitor (CGM) to continuously check my glucose level and alarm me if I become too hyperglycemic or

hypoglycemic. Hyperglycemic values are blood glucose values over target which can lead to nausea, vomiting and ketosis. Hypoglycemic values are blood glucose values below target that can lead to confusion, coma and death. For the first time since I was 10 years old I was not afraid of becoming hypoglycemic and dying while I was sleeping. A Dexcom CGM is truly an incredible device. Over the last 6 years insulin pumps have also come a long way. I am currently using an insulin pump that communicates with my CGM to help manage my diabetes as best as possible. I have had an A1c in the 5% range for years now which is incredible. My current A1c is lower than someone with pre-diabetes. Diabetes is still a lot of work but the devices on the market now are incredible and life changing if you can afford them.

My current deductible for myself alone is \$7,500. This means every January 1st my Commercial Blue Cross plan will not pay for anything until I pay \$7,500 out of pocket. Once I pay \$7,500 they will then cover products to help keep me alive at 80%. I still need to pay 20%. I am not a smoker, I exercise daily, I eat very healthy, I have my eyes and bloodwork checked annually. I have no other comorbidities. I did nothing to trigger my body to develop this horrible illness 30 years ago. I was only hospitalized in diabetic ketoacidosis at diagnosis. I have never been to the hospital since my diagnosis for any diabetes related issues. Again, my A1c has been in the 5% range for years and yet my out of pocket cost and deductibles consistently go up. The only cost my insurance company actually pays for is my diabetes supplies at 80% after I pay my \$7,500 deductible. My endocrinology appointment generally costs \$250 each time and I see her twice a year. My Tslim cartridges are \$40/month, TrueSteel Tslim sites are \$80/month, Dexcom G6 CGM sensors are \$350/month, Dexcom G6 CGM transmitters are \$250 every 3 months. Add that all up and it totals \$7140 out of pocket. Mind you I also need to pay for insulin to put into the pump, glucagon, a glucometer and strips. The insurance will pay nothing to assist in my health care.

Which leads me to think, why do I even have this insurance? Why have my employer pay for me on top of my \$7,500 deductible? What is the purpose of premiums? BCBS of RI is making substantial money off of me being a member on their policy. My incredibly high deductible is essentially having me pay for everything out of pocket anyways.

I am not trying to pay for fancy equipment. I am simply trying to purchase the necessary equipment to keep me out of the hospital and have an A1c recommended by the ADA. There should absolutely be a \$25 cap on each item for a 30 day supply. If a \$25 cap was in place I would be spending closer to \$1,700 for my 2 endocrinology appointments, CGM and pump

supplies rather than \$7140. These are lifesaving devices that unfortunately come at a very steep cost. Please help regulate this. The deductibles are only going to continue to climb. I fear for what I am going to be able to afford in another 30 years. If people can not afford their diabetes supplies their health is only going to revert back to the health we had 30 years ago. We are going to have to revert back to finger sticks and injections if people are unable to pay for CGMs and insulin pump supplies. A1cs are going to rise and more comorbidities will develop. It will cost our government more in the long run to continue to sit back and watch the cost of diabetes related equipment and insurance deductibles soar up without stepping in. Please help.

Sincerely,

Cara Moeller, FNP, CBCDE

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