Dear Chair Murray and Honorable Members of the Senate Health & Human Services Committee,

I am writing to express my strong support for S2877, legislation that would cap out-of-pocket costs for insulin administration and glucose monitoring supplies at $25, exclude these items from deductible requirements, and ensure predictable access to the tools necessary for safe diabetes self-management. I offer this perspective as a licensed clinical pharmacist practicing in Rhode Island with a collaborative practice agreement, where I routinely manage patients with diabetes through comprehensive disease-state and medication management.

In my clinical practice, I regularly assess and manage patients with both insulin-treated and non-insulin-treated diabetes. My role includes prescribing and titrating medications, ordering and interpreting laboratory tests, providing extensive education on disease management and lifestyle modification, and helping patients navigate the financial barriers embedded in insurance benefit design. Few chronic diseases demonstrate the connection between affordability and outcomes as clearly as diabetes.

I frequently encounter patients, particularly those with high-deductible health plans, who face out-of-pocket insulin costs of $300 to $400 or more per month until their deductible is met. These costs are not theoretical; they are presented to patients at the pharmacy counter, often without warning. When confronted with these prices, many patients either delay filling their prescriptions or insist that something “cheaper” be prescribed.

Importantly, this phenomenon is not limited to low-income patients. Even financially stable or wealthy individuals often push back against insulin costs at this level, requesting lower-cost alternatives regardless of clinical appropriateness. As a clinician, I frequently see patients pressured by cost to accept inferior or suboptimal treatment regimens, not because they are clinically indicated, but because they are all the patient can reasonably afford.

Diabetes care should be driven by evidence and individual patient needs, not by whether a patient can absorb a sudden four-hundred-dollar copay. When patients compromise on insulin type, dosing strategies, or monitoring due to cost, the results are predictable: poorer glycemic control, increased hypoglycemia or hyperglycemia, avoidable acute events, and long-term complications that drive substantial healthcare spending.

Access to insulin alone is insufficient. Safe diabetes management also depends on consistent access to glucose monitoring supplies and insulin administration equipment. I routinely see patients ration test strips, delay replacing sensors, reuse supplies longer than recommended, or reduce monitoring frequency, not due to lack of education, but because these items are subject to high deductibles or unpredictable cost-sharing. These decisions are rational responses to financial pressure, but they place patients at real clinical risk.

S2877 meaningfully addresses this problem by ensuring that diabetes supplies are affordable, predictable, and immediately accessible, rather than theoretically covered but financially unattainable. By capping costs and removing deductibles for these essential items, the bill supports adherence to prescribed treatment plans and allows clinicians and patients to make decisions based on clinical need rather than price alone.

From a value-based care and payer perspective, this legislation promotes cost avoidance by preventing downstream complications. Poorly controlled diabetes is a major driver of emergency department visits, hospitalizations, diabetic ketoacidosis, severe hypoglycemia, and long-term microvascular and macrovascular complications. The cost of a single acute hospitalization vastly exceeds the cost of ensuring affordable access to insulin supplies and monitoring tools.

S2877 does not expand unnecessary utilization. It ensures that patients can actually use the therapies and devices already deemed medically necessary. By reducing cost-driven nonadherence and suboptimal treatment decisions, this bill helps stabilize disease control, reduce high-cost utilization, and improve patient outcomes.

As a clinician responsible for helping patients manage a complex and relentless chronic disease, I view S2877 as a practical, patient-centered policy that aligns insurance benefit design with real-world diabetes care. It ensures that coverage is meaningful, supports appropriate clinical decision-making, and protects patients from avoidable harm driven by cost rather than care.

I respectfully urge the Committee to support S2877 and advance legislation that strengthens diabetes care in Rhode Island through sensible benefit design, improved adherence, and reduced avoidable healthcare spending.

Thank you for your time, leadership, and commitment to improving health outcomes for Rhode Islanders. I would welcome the opportunity to serve as a clinical resource or answer any questions as you consider this legislation.

Sincerely,
Christopher Durigan, PharmD
Thundermist Health Center, Woonsocket, RI
christopherdu@thundermisthealth.org