

Mister Chairperson and members of the Appropriations committee, my name is Angela Kritzberger and I am from Hillsboro. I am a mother to Nina, who, at the age of 7, was diagnosed with Type 1 Diabetes. I have been working closely and tirelessly with Danelle Johnson and Carlye Gast of Fargo to address the issue of insulin affordability in North Dakota since our childrens' diagnoses. As parents, caregivers and advocates for someone living with a chronic life-threatening disease, we may grow weary from telling our story, but we will never give up the fight and always welcome honest conversations to shed light on this complex disease and its cost to thousands in North Dakota. We are also here to continue the fight for those who no longer have a voice to the issue.

When it comes to Type 1 Diabetes, it seems that we are continually faced with educating the people we meet as to what caring for a person who is insulin dependent is like. Why? It is simply a matter of life or death. We educate our families, friends, neighbors, teachers, caregivers, you as legislators and often times even our local medical support team. It is our responsibility as their caregivers to take the same oath as a physician: to do no harm.

I would like to take a moment of your time to illustrate what our physician has recommended for a care plan for our daughter, which includes rapid acting insulin with the use of a continuous glucose monitor and insulin pump.

A typical blood glucose for a person without diabetes and a working pancreas is under 100. At diagnosis, our daughter's was 598. It is our goal to keep our daughter within a range of 80-150. For her current insulin needs, she requires a slow drip of 3 units of insulin each hour over a 24-hour period. Within that 24-hour period, if she eats 3 grams of carbs, her ratio to carbs is 1 unit of insulin to treat her food. An average meal that might consists of 30 grams would require 10 units of insulin administered 15 minutes prior to eating. The duration of the insulin working in her body is factored for 3 hours but the net effect of the food on her blood glucose peaks around 1 – 1 ½ hours depending on the protein to fat ratio. Another calculation we have set is her sensitivity to insulin based on her current blood glucose called a correction factor or insulin sensitivity. She has five different settings that are programmed over a 24-hour period. The data that I can produce from her continuous glucose monitor helps me to closely monitor and readjust her multiple settings on a bi-monthly to monthly basis as needed so she can maintain a healthy blood glucose. An A1C is a measurement that providers use to determine the long-term effect of controlled or uncontrolled blood glucose. At diagnosis, our daughter's was 12; a non-diabetic would be under 5.7. Our providers goal is 7.5 and most recently I am extremely proud of the work we have done to shift her A1C to 6.3 in the last year. While a blood glucose gives you a snapshot of the current picture at any given second, the A1C provides a truer picture of the overall management of blood glucose levels.

Why do we use this approach? The answer is quite simple – while we want her to live a long and healthy life free from complications, we also hope to lessen the burden on the healthcare system as well as the continued financial burden that life with diabetes can bring. A hypoglycemic event, or low blood sugar, can cost over \$2,000 for an emergency room visit; while a 3-day event for Diabetic Ketoacidosis, or high blood sugar, can cost over \$20,000. Both of these events are serious and life threatening. With the aid of this technology and our continued focus on our daughter's health I am happy to say we have not yet had an ER visit or

hospital stay. Unfortunately, this could quickly take a turn for the worse even with near perfect control if she were to become sick from the flu or other illness because it puts added stress on the body which can affect blood glucose levels and raise the chance of serious health complications for people living with diabetes.

We are a farm family who, because we are self-employed, must provide for ourselves an individual health insurance plan. It is a high deductible plan with a maximum out of pocket at \$7,000 and co-insurance of 10% Our monthly premium this year is \$2,600. I would like to give a breakdown of our year thus far:

- **\$3,000** = cash price before \$7,000 out of pocket family maximum is met for insulin pump supplies and continuous glucose monitor supplies which last up to 3 months. It also includes \$500 for basic supplies of glucagon pen, test strips, ketone strips, lancets, needles and syringes which are used as needed.
- **\$150** = for purchasing snacks to treat hypoglycemic events, low or no carb snacks, glucose tabs, auxiliary skin prep wipes, allergy sprays, and bandages.
- **\$100** = No vision insurance from being self-employed. Health insurance plan will not cover even though she's diabetic.
- **\$25** = co-pay for insulin. My carrier implemented a cap starting in 2021 that was not communicated during plan renewal and was previously \$1,200 with a rebate that was set to expire at the end of the year.
- **Cost unknown.** Quarterly diabetic health exam with pediatric endocrinologist to review bloodwork, health trends and address any changes to care plan.

**\$3,275.00 TOTAL spent on supplies from 6 different vendors on 6 different days to date. [What you see in this suitcase shows on top the very basic supplies-the bottom is what we use in one month's time. The life of a diabetic is tethered to this.]**

Managing this chronic life-threatening disease is like no other. Decisions are made independently and with little hesitation because treating this disease comes every second of every minute of every hour of every day of every week of every month of every year until a cure is found. It is not done with medical staff at our side. Too much or too little insulin can cause death. Without insulin death is imminent in days. The emotional and physical burden is heavy. We need to lift the financial burden for North Dakotans because it has been placed on them without their doing. If we cannot be the ones to find a cure, then we must be the ones to seek the funding from those who profit from their lives. Insulin has been around for over 100 years. Modern insulin has been around for close to 40 years and there still is not a generic option on the market.

Our SB 2183 was created and drafted with bipartisan support to help address the grave differences that we continue to hear on insulin and diabetes supplies affordability. We have worked not only on this current piece of legislation, but also introduced Senate Concurrent Resolution 4002 in the 66<sup>th</sup> ND legislative session and have met with Sen. Kevin Cramer to address these issues while being engaged in and supporting the work that is being done on the

federal level. While some may feel that this issue cannot be addressed through a state mandate, this often seems to be a knee-jerk response when we see other states that are passing similar legislation, and advocates that support us in the medical field that see these devastating issues firsthand. We strongly feel it starts right here.

What we have learned in our work is this: 1) If a person has access to health insurance, they offer significantly different levels of coverage for insulin, making it often times unaffordable. We also continue to hear discrepancies amongst carriers and plans. 2) Basic diabetes supplies are often not qualified to be processed through insurance plans but are easily accessible through a local pharmacy. 3) There are many other supportive supplies and costs associated with this disease that are not taken into account. This bill was created to cast a conservative net around the most basic needs of a person who is insulin dependent and basic supplies.

In conclusion, we feel there is no better time than now to come back to the table for meaningful discussion and to make the lives of North Dakotans and SB2183 whole again.

Thank you for your time.