HB 1114

NovaRest
ACTUARIAL CONSULTING

December 31, 2024

Analysis of 25.0118.01000 Relating to Insulin Drugs and Supplies

Prepared for the North Dakota Legislative Council
Pursuant to North Dakota Century Code 54-03-28

Amanda Rocha
Richard Cadwell, ASA, MAAA
Donna Novak, FCA, ASA, MAAA

156 West Calle Guija, Suite 200, Sahuarita, AZ 85629 - 520-908-7246 - NovaRest.com

NovaRest
ACTUARIAL CONSULTING

Table of Contents

I. Evaluation of Proposed Mandated Health Insurance Services

The North Dakota Legislative Council (NDLC) was asked to perform a cost-benefit analysis of Draft Bill No. 25.0118.01000[1] for the 69th Legislative Assembly pursuant to the North Dakota Century Code (NDCC) 54-03-28. Draft Bill No. 25.0118.01000 creates and enacts a new section to chapters 26.1-36 and amends and reenacts sections 54-52.1-04.18 of the North Dakota Century Code. This Draft Bill proposes coverage for cost-sharing for a 30-day supply of:

A. Covered insulin drugs which may not exceed twenty-five ($25) dollars per pharmacy or distributor, regardless of the quantity or type of insulin drug used to fill the covered individual's prescription needs, where insulin includes the following categories:
    a. Rapid-acting insulin
    b. Short-acting insulin
    c. Intermediate-acting insulin
    d. Long-acting insulin
    e. Premixed insulin product
    f. Premixed insulin/GLP-1 RA product
    g. Concentrated human regular insulin

B. Covered medical supplies for insulin dosing and administration, which may not exceed twenty-five ($25) dollars per pharmacy or distributor, regardless of the quantity or manufacturer of supplies used to fill the covered individual's prescription needs.
    a. Blood glucose meters
    b. Blood glucose test strips
    c. Lancing devices and lancets
    d. Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone strips
    e. Glocagon, injectable or nasal forms
    f. Insulin pen needles
    g. Insulin syringes

NovaRest, Inc. has been contracted as the NDLC's consulting actuary and has prepared the following evaluation of diabetes drugs and supply coverage.

This report includes information from several sources to provide more than one perspective on the proposed mandate and provide an unbiased report. As a result, there may be some conflicting information within the contents. Although we only used sources that we consider credible, we do not offer any opinions regarding whether one source is more credible than another.

NovaRest was asked to provide estimates for the North Dakota Public Employee Retirement System (NDPERS), as well as the impact if the Draft Bill was expanded to the commercial market. We were provided information on four plans administered by NDPERS, 1. Grandfathered PPO/Basic Plan, 2. Non-Grandfathered PPO/Basic Plan, 3. High Deductible Health Plan (HDHP), and 4. Dakota Retiree Plan. For the commercial market we used information from the National Association of Insurance Commissioners Supplemental Health Care Exhibit for individual, small group, and large group. Generally, when considering benefits for the individual and small group we considered the Affordable Care Act (ACA) single-risk pool plans, and for large group we considered a sample of plans from the largest three insurers in the North Dakota market.

We understand that individual market, small group market, and NDPERS non-Medicare plans (including the Dakota Plan for non-Medicare retirees) already have cost sharing for covered insulin drugs and covered medical supplies limited to $25 for a 30-day supply. Therefore, the impact is 0% of premium, or $0.00 PMPM.

The bill does not apply to the Medicare Part D prescription drug coverage plan.

Therefore, the only market where we anticipate an increase in premiums is in the large group commercial market. NovaRest estimates a premium increase 0.05% to 0.20% and $0.30 to $1.00 on a per-member-per-month (PMPM) basis for large group plans. The variation reflects variation in the large group plan cost sharing, in addition to the variation in the cost of insulin drugs and insulin medical supplies that are commonly used.

II. Process

NovaRest was asked to address the following analyses regarding this proposed mandate:

- The extent to which the proposed mandate would increase or decrease the cost of the service;
- The extent to which the proposed mandate would increase the appropriate use of the service;
- The extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
- The impact of the proposed mandate on the total cost of health care.

NovaRest reviewed literature and developed an independent estimate of the proposed mandate's impact on premiums.

III. Coverage for Insulin Drugs and Supplies

There are approximately 57,805 people in North Dakota with diagnosed diabetes[2] and approximately 31% of those with diabetes use insulin.[3]

North Dakota Public Employees Retirement System (NDPERS)

NDPERS currently includes a limit of $25 for a 30-day supply of the insulin drugs and medical supplies identified by Draft Bill 25.0118.01000 for three of the four plans administered by NDPERS. We note that the fourth plan administered is a Medicare plan, and Draft Bill 25.0118.01000 is not applied to Medicare Prescription Drug Coverage.

Commercial Market

Coverage for the individual and small group markets is primarily dictated through the Essential Health Benefits Benchmark Plan (EHB-BP) coverage document. The current EHB Benchmark Plan (EHB-BP), which covers the individual and small group markets, currently includes the coverage of diabetes medication and supplies. It states that "Copayment Amount shall not exceed $25.00 for a 30-day supply of insulin that is lawfully dispensed according to federal laws upon receipt of a Prescription Order and is approved by the U.S. Food and Drug Administration for treating diabetes. Insulin includes but is not limited to the following categories: rapid-acting insulin, short-acting insulin, intermediate-acting insulin, long-acting insulin, premixed insulin product, premixed insulin/GLP-1 RA product, and concentrated human regular insulin." The Benchmark Plan also provides coverage for the use of GLP1 and GIP drugs (specifically semaglutide and tirzepatide) for the prevention of diabetes and treatment of insulin resistance, metabolic syndrome, and/or morbid obesity.

Through our discussions with other states and CMS, it is unclear if insurers must use the cost-sharing prescribed in the EHB-BP. We reviewed recent forms filings available on the North Dakota public filing search site[4] for Blue Cross Blue Shield of North Dakota, Sanford Health Plan, and Medica Insurance Company, and it appears all are following the EHB-BP cost-sharing limitation for individuals and small groups. A carrier survey would likely be required to verify.

While coverage in the large group market may vary between insurers and plans, we reviewed recent forms filings available on the North Dakota public filing search site[5] for Blue Cross Blue Shield of North Dakota, Sanford Health Plan, and Medica Insurance Company, which make up a majority of North Dakota's large group market,[6] and determined the insulin drugs and medical supplies identified in Draft Bill 25.0118.01000 appear to be covered, however, are not subject to the member cost-sharing limitation of $25.

Analyses Concerning Mandated Coverage

The extent to which the coverage will increase or decrease the cost of the service.

Mandating a service or product or decreasing the cost sharing amount often increases the demand for that service or product, which typically increases the cost of the service, where allowed. Insurers can offset this upward pressure on price by contracting with providers and/or using managed care protocols.

Our understanding is that insulin drugs and supplies are currently covered by non-Medicare NDPERS plans, capped at $25 member cost sharing for a 30-day supply. Therefore, we estimate no change in the cost of the service. We note the limit does not apply to the Medicare part D prescription drug coverage plan.

If the Draft Bill language was extended to include the commercial market, we estimate there would be no impact in the individual and small group markets which already cap insulin drugs and supplies at $25 member cost sharing for a 30-day supply.

Insulin drugs and medical supplies appear to also be covered in the large group market; however, they are not be capped at $25 for a 30-day supply. We estimate approximately 300-400 more large group members will increase insulin usage (as opposed to rationing insulin) due to lower member cost-sharing in the commercial market; however, we do not believe this additional demand would be sufficient to impact the cost of insulin or prescribed medical supplies for insulin.

The extent to which the coverage will increase the appropriate use of the service.

Our understanding is that insulin drugs and supplies are currently covered by non-Medicare NDPERS plans, capped at $25 member cost sharing for a 30-day supply. Therefore, we estimate no change in the appropriate use of the service. We note the limit does not apply to the Medicare part D prescription drug coverage plan.

If the Draft Bill language was extended to include the commercial market, we estimate there would be no impact in the appropriate use of the service in the individual and small group markets which we believe already cap insulin drugs and supplies at $25 member cost sharing for a 30-day supply.

In the large group market, we would expect an increase in the appropriate use of insulin drugs and supplies. Approximately 14% of adequately insured members ration insulin due to cost.[7] If the Draft Bill language was extended to the large group commercial market, we estimate approximately 300-400 will increase appropriate insulin usage (as opposed to rationing insulin) due to lower member cost-sharing. Please see Appendix B for more information on our assumptions and methodology.

The extent to which the coverage will increase or decrease the administrative expenses of carriers, including health maintenance organizations, or other organizations authorized to provide health benefit plans in the State, and the premium and administrative expenses of policyholders and contract holders.

Our understanding is that insulin drugs and supplies are currently covered by non-Medicare NDPERS plans, capped at $25 member cost sharing for a 30-day supply. Therefore, we estimate no change administrative expenses or premiums. We note the limit does not apply to the Medicare part D prescription drug coverage plan.

If the Draft Bill language was extended to include the commercial market, we estimate there would be no impact in the administrative expenses or premiums in the individual and small group markets which we believe already cap insulin drugs and supplies at $25 member cost sharing for a 30-day supply.

For the large group market, while the insulin drugs and medical supplies included in Draft Bill 25.0118.01000 are already covered, Therefore we do not believe the impact on administrative cost will be significant.

NovaRest estimates a premium increase 0.05% to 0.20% and $0.30 to $1.00 on a per-member-per-month (PMPM) basis for large group plans. The variation reflects variation in the large group plan cost sharing, in addition to the variation in the cost of insulin drugs and insulin medical supplies that are commonly used. Please see Appendix B for more information on our assumptions and methodology.

The impact of this coverage on the total cost of health care.

Our understanding is that insulin drugs and supplies are currently covered by non-Medicare NDPERS plans, capped at $25 member cost sharing for a 30-day supply. Therefore, we estimate no change in the total cost of health care. We note the limit does not apply to the Medicare part D prescription drug coverage plan.

If the Draft Bill language was extended to include the commercial market, we estimate there would be no change total cost of health care in the individual and small group markets which we believe already cap insulin drugs and supplies at $25 member cost sharing for a 30-day supply.

For the large group market, while most of the premium impact reflects cost shifting from the member to the insurer paying the cost-sharing, there may be an increase in the total cost of health care due to members increasing their usage of insulin, as opposed to rationing insulin. We anticipate an additional $20,000 to $190,000 to the total cost of health care annually for this additional utilization.

We also note that savings from preventing more serious diseases may offset this cost. If left untreated or not treated properly, diabetes can lead to life-threatening diseases such as cardiovascular disease, nerve damage (neuropathy), kidney damage (nephropathy), and eye damage (retinopathy).[8]

IV. Other State Diabetes Drugs and Supplies Laws[9]

There are approximately 25 states and Washington, D.C. that have passed legislation addressing the issue of capping copays for diabetes drugs and supplies. Below is a summary of that legislation.

State	Legislation
Alabama[10]	$35 cap for a 30-day supply of insulin
Colorado	$100 cap for a 30-day supply of insulin
Connecticut	$25 cap for 30-day supply of insulin or other diabetes medications, $100 cap for 30-days' worth of devices and supplies
Delaware	$100 collective cap for 30-day supply, $0 for insulin pumps, and collective $35 cap per month for other specified diabetes equipment and supplies
Illinois	$100 cap for a 30-day supply of insulin; effective 7/1/25, the collective cap will be $35 for a 30-day supply
Kentucky	$30 cap for a 30-day supply of insulin
Louisiana	$75 cap for 30-day supply
Maine	$35 cap for a 30-day supply of insulin
Maryland	$30 cap for a 30-day supply of insulin
Minnesota	As of 1/1/25, $25 monthly cap for diabetes medications and $50 monthly cap for supplies State-required manufacturer assistance program has a $35 cap for emergency 30-day supply, $50 cap for a 90-day supply of insulin
Montana	$35 for 30-day supply of insulin
Nebraska	$35 cap for 30-day supply of insulin
New Hampshire	$30 cap for a 30-day supply of insulin
New Jersey	$35 cap for 30-day supply of insulin, effective 1/1/25
New Mexico	$25 cap for a 30-day supply of insulin
New York	$100 cap for a 30-day supply of insulin; effective 1/1/25 the cost will be $0
Oklahoma	$30 cap for a 30-day supply of insulin, $90 cap for 90-day supply of insulin
Oregon	$85 cap for a 30-day supply of insulin Effective 1/1/25 it will be $35 cap for a 30-day supply, $105 cap for a 90-day supply
Rhode Island	$40 cap for a 30-day supply of insulin
Texas	$25 cap for each insulin prescription per month
Utah	$30 cap for a 30-day supply of insulin
Vermont	$100 cap for a 30-day supply of insulin
Virginia	$50 cap for a 30-day supply of insulin
Washington	$35 cap for a 30-day supply of insulin
Washington, D.C.	$30 cap for a 30-day supply of insulin and $100 cap for 30-day supply of covered diabetes devices
West Virginia	$35 collective cap for 35-day supply; $100 collective cap on a 30-day supply of specified diabetes equipment and supplies

V. Limitations

NovaRest has prepared this report in conformity with its intended use by persons technically competent to evaluate our estimate regarding Draft Bill 25.0118.01000. Any judgments as to the data contained in the report or conclusions about the ramifications of that data should be made only after reviewing the report in its entirety, as the conclusions reached by review of a section or sections on an isolated basis may be incorrect. Appropriate staff is available to explain and/or clarify any matter presented herein. It is assumed that any user of this report will seek such explanations as to any matter in question.

NovaRest did not have access to actual insurer claims data by service type or reimbursement rates. NovaRest also did not perform an insurer data request for the commercial market, or have access to the most recent rate filings in North Dakota. NovaRest has developed projections in conformity with what we believe to be the current and proposed operating environments and are based on best estimates of future experience within such environments. It should be recognized that actual future results may vary from those projected in this report. Factors that may cause the actual results to vary from the projected include new insurance regulations, differences in implementation of the required coverage by NDPERS, changes in medical treatments and practices, accounting practices, changes in federal and/or local taxation, external economic factors such as inflation rates, investment yields and ratings, and inherent potential for normal random fluctuations in experience.

VI. Reliance and Qualifications

We are providing this report to you solely to communicate our findings and analysis of Draft Bill 25.0118.01000. The reliance of parties other than the North Dakota Legislative Council (NDLC) on any aspect of our work is not authorized by us and is done at their own risk.

To arrive at our estimate, we made use of information provided by Sanford Health Plan for NDPERS, carrier rate filings and other public sources including census data and National Association of Insurance Commissioners financial data. We did not perform an independent investigation or verification. If this information was in any way inaccurate, incomplete, or out of date, the findings and conclusions in this report may require revision.

This memorandum has been prepared in conformity with the applicable Actuarial Standards of Practice.

We have no conflicts of interest in performing this review and providing this report. We are members of the American Academy of Actuaries and meet that body's Qualification Standards to render this opinion. We meet the Qualification Standards promulgated by these professional organizations to perform the analyses and opine upon the results presented in this Actuarial Report.

Appendix A: Definitions

a) "Insulin drug" means prescription drug that contains insulin and is used to treat a form of diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes insulin in the following categories:

   1) Rapid-acting insulin
   2) Short-acting insulin
   3) Intermediate-acting insulin
   4) Long-acting insulin
   5) Premixed insulin product
   6) Premixed insulin/GLP-1 RA product
   7) Concentrated human regular insulin

b) "Medical supplies for insulin dosing and administration" means supplies needed for proper insulin dosing, as well as supplies needed to detect or address medical emergencies in an individual using insulin to manage diabetes mellitus. The term does not include an insulin pump, an electronic insulin-administering smart pen, or a continuous glucose monitor, or supplies needed specifically for the use of such electronic devices. The term includes:

   1) Blood glucose meters
   2) Blood glucose strips
   3) Lancing devices and lancets
   4) Ketone testing supplies, such as urine strips, blood ketone meters, and blood ketone test strips
   5) Glucagon, injectable or nasal forms
   6) Insulin pen needles
   7) Insulin syringes

c) "Pharmacy or distributor" means a pharmacy or medical supply company, or other medication or medical supply distributor filling a covered individual's prescriptions.

d) "Policy" means accident and health insurance policy, contract, or evidence of coverage on a group, individual, blanket, franchise, or association basis.

Appendix B: NovaRest Methodology and Assumptions

Data

- Commercial market premiums, claims, and membership were from the 2023 National Association of Insurance Commissioners Supplemental Health Care Exhibit.
- The age and gender proportions of North Dakota's population are based on the 2023 Vintage population estimates.[11]
- Information on North Dakota households is based on 2021 American Community Survey (ACS) Data.[12]

Assumptions

- Individual, small group and NDPERS markets already provide coverage consistent with Draft Bill 25.0118.01000.[13]
- There is little information on the distribution, type(s) of insulin used, or the dosage(s), since these are prescribed individually. For insulin, we assumed 62 units per day.[14] The cost per unit is based on GoodRx prices.[15]
- Cost of insulin and supplies were based on a variety of sources.[16,17,18]
- Cost sharing varies by large group plan. Based on a review of policy forms, we used a range of 75% to 85% insurer cost sharing.
- We assume 57,805 people in North Dakota have diabetes.[19]
- We assume 5-10% of people with diabetes are Type 1,[20] and 100% of people with Type 1 diabetes use insulin.[21]
- We assume 90-95% of people with diabetes are Type 2,[22] and 25% of people with Type 2 diabetes use insulin.[23]
- Pregnancies in North Dakota were estimated using ACS data[24] to determine the number of live births and assuming 62% of pregnancies end in live births.[25]
- We assume 2% to 10% of pregnancies result in gestational diabetes,[26] and 20% of these cases will use insulin.[27]
    - Gestational diabetes can also occur in pregnancies that do not end in live birth, however, we tested the sensitivity of this assumption and found the impact is de minimis. No adjustment was made for pregnancies not ending in live birth.
- Number of people rationing insulin 34% for uninsured/underinsured, 14% for adequately insured.[28]
    - Assume adequately insured is 60% cost sharing, used linear interpolation to determine assumption at 75% and 85% cost sharing.
    - Assume rationing means one to two days of currently not using prescribed insulin.

Methodology

- Using the assumptions described above, we estimated the average current member cost sharing for people who use insulin for insulin and insulin supplies. We then estimated the member cost sharing under the proposed $25 limitation on insulin and insulin supplies. The difference would be the cost-sharing dollars shifted from the members to commercial large group plans.
- Using commercial and public sources, we estimated the number of large group members who use insulin as a portion of the total number of individuals that use insulin. We then applied this number to the cost-sharing dollars shifted to the commercial large group plans to determine the cost impact.

Sources:

[1] https://ndlegis.gov/assembly/68-2023/interim/25-0118-01000.pdf
[2] (N.d.). Retrieved from https://diabetes.org/sites/default/files/2023-09/ADV_2023_State_Fact_sheets_all_rev_North_Dakota.pdf. Accessed 20 Dec. 2024.
[3] Trief PM, Cibula D, Rodriguez E, Akel B, Weinstock RS. Incorrect Insulin Administration: A Problem That Warrants Attention. Clin Diabetes. 2016 Jan;34(1):25-33. doi: 10.2337/diaclin.34.1.25. PMID: 26807006; PMCID: PMC4714726.
[4] https://www.insurance.nd.gov/companies/policy-form-and-rate-filing
[5] Ibid.
[6] Per the 2023 National Association of Insurance Commissioners Supplemental Health Care Exhibit.
[7] Fang M, Selvin E. Cost-Related Insulin Rationing in US Adults Younger Than 65 Years With Diabetes. JAMA. 2023 May 16;329(19):1700-1702. doi: 10.1001/jama.2023.5747. PMID: 36988971; PMCID: PMC10061307.
[8] Diabetes. (2024). Retrieved from https://www.mayoclinic.org/diseases-conditions/diabetes/symptoms-causes/syc-20371444. Access 20 Dec. 2024.
[9] "State Insulin Copay Caps." *State Insulin Copay Caps | ADA*, diabetes.org/tools-resources/affordable-insulin/state-insulin-copay-caps. Accessed 22 Dec. 2024.
[10] ByStaff. "Sewell Votes to Cap Monthly Insulin Copay Costs at $35." *Alabama Political Reporter*, 1 Apr. 2022, www.alreporter.com/2022/04/01/congresswoman-sewell-votes-to-cap-monthly-insulin-costs-at-35/#:~:text=Beginning%20in%202023%2C%20the%20bill,of%20a%20plan's%20negotiated%20price. Accessed 21 Dec. 2024
[11] Bureau, US Census. "State Population by Characteristics: 2020-2024." *Census.Gov*, 25 Nov. 2024, www.census.gov/data/tables/time-series/demo/popest/2020s-state-detail.html. Accessed 20 Dec. 2024.
[12] Bureau, United States Census. "B13004 Women 15 – 50 Years Who Had a Birth in the Past 12 Months by Presence of Spouse or Unmarried Partner", *Explore Census Data*, data.census.gov/table/ACSDT5Y2023.B13002?q=ZCTA5+90746+Health. Accessed 20 Dec. 2024.
[13] Based on a review of policy forms for the commercial market published at https://www.insurance.nd.gov/companies/policy-form-and-rate-filing and for NDPERS information published on their website at https://www.ndpers.nd.gov/. Accessed 26 Dec. 2024.
[14] Hayes, Tara O'Neill, et al. "Insulin Cost and Pricing Trends." *AAF*, 2 Apr. 2020, www.americanactionforum.org/research/insulin-cost-and-pricing-trends/. Accessed 20 Dec. 2024.
[15] (N.d.). Retrieved from https://www.goodrx.com/healthcare-access/research/how-much-does-insulin-cost-compare-brands. Accessed 22 Dec. 2024.
[16] How Much Does a Glucose Meter Cost? (n.d.). Retrieved from https://health.costhelper.com/glucose-meter.html#:~:text=Typical%20costs%3A,on%20the%20meter's%20extra%20features. Accessed 22 Dec. 2024.
[17] www.goodrx.com/glucagon?dosage=amphastar-of-1mg&form=kit&label_override=glucagon&quantity=1&sort_type=popularity. Accessed 21 Dec. 2024.
[18] Person. "Insulin Pumps, Pens, Syringes, and More." *Healthline*, Healthline Media, 4 Mar. 2020, www.healthline.com/health/type-2-diabetes/insulin-prices-pumps-pens-syringes. Accessed 22 Dec. 2024
[19] American Diabetes Association. (2023). North Dakota State Fact Sheet. Retrieved from https://diabetes.org/sites/default/files/2023-09/ADV_2023_State_Fact_sheets_all_rev_North_Dakota.pdf on December 26, 2024.
[20] Trief, P. M., Cibula, D., Rodriguez, E., Akel, B., & Weinstock, R. S. (n.d.). Incorrect Insulin Administration: A Problem That Warrants Attention.
[21] About Type 1 Diabetes. (n.d.). Retrieved from https://www.cdc.gov/diabetes/about/about-type-1-diabetes.html?CDC_AAref_Val=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fbasics%2Fwhat-is-type-1-diabetes.html. Accessed 21 Dec. 2024
[22] "Type 2 Diabetes." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, www.cdc.gov/diabetes/about/about-type-2-

diabetes.html?CDC_AAref_Val=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fbasics%2Ftype2.html. Accessed 21 Dec. 2024.
[23] Trief, P. M., Cibula, D., Rodriguez, E., Akel, B., & Weinstock, R. S. (n.d.). Incorrect Insulin Administration: A Problem That Warrants Attention.
[24] Bureau, United States Census. "B13004 Women 15 – 50 Years Who Had a Birth in the Past 12 Months by Presence of Spouse or Unmarried Partner", *Explore Census Data*, data.census.gov/table/ACSDT5Y2023.B13002?q=ZCTA5+90746+Health. Accessed 20 Dec. 2024.
[25] "NCHS Pressroom - 1999 Fact Sheet - Trends in Pregnancies and Pregnancy Rates." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, 17 Nov. 2009, www.cdc.gov/nchs/pressroom/99facts/pregrate.htm#:~:text=This%20means%20that%2062%20percent,in%20a%20miscarriage%20or%20stillbirth. Accessed 21 Dec. 2024
[26] "About Gestational Diabetes." *Centers for Disease Control and Prevention*, Centers for Disease Control and Prevention, www.cdc.gov/diabetes/about/gestational-diabetes.html?CDC_AAref_Val=https%3A%2F%2Fwww.cdc.gov%2Fdiabetes%2Fbasics%2Fgestational.html. Accessed 21 Dec. 2024.
[27] Taking medication and insulin for gestational diabetes. (n.d.). Retrieved from https://www.tommys.org/pregnancy-information/pregnancy-complications/gestational-diabetes/taking-medication-and-insulin-gestational-diabetes. Accessed 21 Dec. 2024
[28] Fang M, Selvin E. Cost-Related Insulin Rationing in US Adults Younger Than 65 Years With Diabetes. JAMA. 2023 May 16;329(19):1700-1702. doi: 10.1001/jama.2023.5747. PMID: 36988971; PMCID: PMC10061307.