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The Honorable Marvin L. Abney, Chairman
Of the House Finance Committee
State House
Providence, RI 02903

RE: AHIP Comments on H-7255, An Act Relating to Insurance – Accident and Sickness Insurance Policies [OPPOSE]

To Chairman Abney and Members of the House Committee on Finance,

America's Health Insurance Plans (AHIP) appreciates the opportunity to comment on H-7255, legislation that would require coverage of specified FDA-approved contraceptive drugs, devices, and other products, voluntary sterilization procedures, patient education, and counseling on contraception, and follow-up services without cost-sharing or medical management restrictions.

We share the Rhode Island's commitment to expand access to contraceptive drugs and devices. However, we are concerned that that provisions restricting cost-sharing and utilization management for these services will have the unintended consequences of 1) increasing health care costs for all Rhode Islanders by prohibiting cost sharing; and 2) adversely affecting patient safety. Further, we are concerned that the bill as currently drafted removes the ability of the use of prescription drug formulary by requiring a plan to cover *all* contraceptive methods without cost-sharing.

Prior authorization and step therapy are critical to ensuring safe, effective, and cost-efficient health care for patients.

Health plans are focused on ensuring that patients get the right care, at the right time, in the right setting, and covered at a cost that patients can afford. Plans are uniquely positioned to have a holistic view of a patient's health care status and thus use effective medical management procedures, such as prior authorization (PA) and step therapy, to help lower a patient's out-of-pocket costs, to protect patients from overuse, misuse or unnecessary (or potentially harmful) care, and to ensure care is consistent with evidence-based practices before care is delivered.

When providers and plans work together, the patient benefits with better outcomes and less financial burden. Health plans continue to innovate and collaborate with providers and other stakeholders to implement solutions to promote evidence-based care and improve the prior authorization process. Examples include:

- Streamlining prior authorization for complete courses of treatment for musculoskeletal and other conditions.
- Promoting electronic prior authorization requests and decisions.
- Providing feedback to health care providers on their performance relative to their peers and professional society guidelines.
- Waiving prior authorization for providers with a demonstrated track record in practicing evidence-based care.

PA and step therapy also promote the appropriate use of medications and services by helping to confirm that they do not interfere with other types of medications or potentially worsen existing conditions. This includes verifying that medications are not co-prescribed that could have dangerous, even potentially fatal, interactions. Additionally, these utilization management tools help to ensure that medications and treatments are safe, effective, and appropriate. Furthermore, they provide guardrails to help ensure that drugs and devices are not used for clinical indications other than those approved by the Food and Drug Administration or those that are supported by medical evidence. And finally, they help ensure that patients with a newly prescribed medication or course of treatment will receive accompanying services such as counseling, peer support, or community-based support, as appropriate.

The use of PA and step therapy are based on evidence-based medical criteria developed by nationally recognized entities. One study shows that the amount of medical knowledge ***doubles every 73 days***.[2] And according to another study from the Journal of Internal Medicine, primary care providers would have to practice medicine for nearly 27 hours per day to keep up with the latest guidelines.[3] Thus, these medical management tools help providers ensure they are adhering to the most up-to-date evidence-based standards.

Even with these fast-paced innovations, health plans use PA sparingly, with the percentage of covered services, procedures, and treatments requiring PA around less than 15%.[4] Of that, health plans report that up to 30% of PA requests they receive from clinicians are for unnecessary care that is not supported by medical evidence.

Health plans are committed to working with providers to streamline the prior authorization process.

It is important to note that PA programs are collaborative – health plans use provider input to help ensure treatment plans are protecting patient safety, improving outcomes, and controlling costs. In this spirit, in January 2018, AHIP, together with providers and hospitals, issued a joint consensus statement [5]

Recent surveys show that health plans are waiving or reducing PA requirements, - between 2019 to 2022, the percentage of plans waiving or reducing PA based on participation in risk-based contracts increased from 25% to 46% for medical services, from 25% to 46% and from 5% to 8% for prescription medications[6].

Similarly, step therapy encourages physicians and patients to undertake a more evidence-based, measured approach to treatment that is tailored to the individual by gauging a patient's response to less harmful medications before graduating to more potent and high-risk drugs.

The use of step therapy not only assists in the quality of patient care but also allows for overall cost savings to patients. Prescription drugs account for 22.2% of health care premiums.[10] Without adequate cost containment measures, prescription drug costs drastically increase, especially for treatments still under patent ("brand" medications). Generic alternatives provide a wider scope of potentially just as effective medications for a lesser cost.

Mandating coverage for these contraceptive drugs and devices without cost sharing will increase health care costs for Rhode Island businesses and consumers.

Eliminating cost-sharing shifts those costs to the entire risk pool, thereby raising costs for all consumers. Thus, though some consumers may be shielded from the immediate impact of high drug prices, the elimination of cost-sharing laboratory testing will result in higher costs for other services and higher premiums for all consumers.

Actuarial value (AV) requirements for individual and small group markets require a set percentage of all enrollees' medical expenses to be covered by the health plan. Any time cost-sharing is reduced for one service, it must be increased for another type of service to maintain the actuarial value for that plan. This is called a "balloon squeeze" effect, causing cost-sharing for other services to rise. Thus, if a plan covers

more of the overall cost of a benefit (by eliminating consumers' cost share), they must cover less of the costs for other benefits included in the health plan to meet the AV. Simply put, enrollees will pay more for doctor visits and other benefits to offset no cost-sharing for lab tests to monitor those taking HIV prevention medication.

For these reasons, we oppose H-7255 and urge the Committee not to pass this bill.

Thank you for your consideration of our comments. AHIP and its members stand ready for further discussions on this important topic.

Sincerely,
America's Health Insurance Plans

By:_____
Terrance S. Martiesian

AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public private partnerships that make health care better and coverage more affordable and accessible for everyone. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.