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

RE: AHIP Comments on H.6047, An Act Relating to Insurance – Accident and Sickness Insurance Policies -- OPPOSE

To Chairman Abney and Members of the House Finance Committee,

On behalf of AHIP, we respectfully offer the following comments in opposition to H.6047, which requires health plans to cover FDA-approved contraceptives, sterilization, contraception counseling, and follow-up services without cost-sharing and without any utilization control that would limit the supply of the FDA-approved contraception to an amount that is less than a twelve-month supply.

Unfortunately, H.6047 would undermine patient safety and affordability. As a result, AHIP respectfully opposes this legislation, and we are committed to continued collaboration with the Committee on solutions that promote health care quality, access, and affordability for Rhode Islanders.

Within H.6067, there are amendments to Sections 27-18-57, 27-19-48, 27-20-43, 27-41-59, and 40-8-33, new Subsections (b) that propose to prohibit group or blanket policies from "imposing utilization or other forms of medical management limiting the supply of FDA-approved contraception that may be dispensed or furnished … in an amount that is less than a twelve (12) month supply." This would include prohibiting prior authorization (PA).

Prior Authorization Protects Patient Safety

PA is a proven tool to ensure patients receive safe, effective, and evidence-based care. It serves as a critical safeguard to prevent unnecessary or inappropriate treatments that could result in harm. For example:

- ***Preventing low-value or inappropriate services.*** PA ensures patients do not receive services that do not improve outcomes and can lead to more unnecessary care, potential harm, and avoidable costs. Prior authorization can ensure that appropriate alternatives are used, consistent with evidence-based guidelines and providers' own recommendations.[1]
- ***Preventing dangerous drug interactions.*** PA helps prevent dangerous drug interactions and ensures medications and treatments are safe, effective, and appropriate for a patient's specific condition.
- ***Ensuring drugs are used as clinically indicated.*** PA acts as a guardrail to ensure that medications are not used for clinical indications other than those approved by the Food and Drug Administration.

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[1] *Prior Authorization Promotes Evidence-Based Care That Is Safe and Affordable for Patients*. AHIP. November 2023.

Medical knowledge doubles every 73 days[2] and, to keep up with these changes, studies show that primary care providers would need to practice medicine nearly 27 hours per day.[3] This is why it is so important that health plans, providers, and hospitals work together to ensure treatments delivered to patients align with nationally recognized, evidence-based clinical criteria, protecting patients from unnecessary, potentially harmful drugs and services.

Prior Authorization Helps Reduce Patients' Health Care Costs

In addition to promoting safe, evidence-based care, PA helps ensure coverage is as affordable as possible. At a time when experts agree that roughly a quarter of all medical spending is wasteful or low-value, PA is instrumental in combating rising costs by addressing overuse and low-value care that cost the U.S. $340 billion annually.[4] Eighty-seven percent of doctors have reported negative impacts from low-value care[5] and an AHIP clinical appropriateness project with John Hopkins found that about 10% of physicians provided care inconsistent with consensus and evidence-based standards.[6]

By guiding patients to the right care, at the right time, in the right setting, PA reduces wasteful spending and helps ensure health care dollars are used efficiently, while protecting patients from low-value care.

It is important for policymakers consider how prohibitions or limitations on PA like those contained in H.6047 could result in higher costs for Rhode Island patients and purchasers of health care. Two recent studies quantify these costs for policymakers:

- A Milliman study found that removing prior authorization could raise premiums by $20.10 to $29.52 PMPM nationwide, totaling $43–$63 billion annually in the commercial market, threatening affordability in an already costly system.[7]
- In Massachusetts, a separate study added an examination of the "sentinel effect" of eliminating prior authorization to quantify the costs related to requests for authorizations that were previously unsubmitted when prior authorization was in place because providers did not expect an approval. In that study, the estimated premium increases jumped to $51.19 to $130.28 PMPM if prior authorization were eliminated entirely.[8]

Cost-Sharing Prohibition

AHIP is aligned with Rhode Island's commitment to increased access to high-quality, affordable health care. Everyone should be able to get the medications they need at a cost they can afford. More than 24 cents[9] of every dollar spent on health insurance premiums goes to pay for prescription drugs – more than

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[2] Densen, Peter. *Challenges and Opportunities Facing Medical Education*. Transactions of the American Clinical and Climatological Association 2011.

[3] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care*. Journal of General Internal Medicine. January 2023.

[4] *Low-Value Care*. University of Michigan V-BID Center. February 2022.

[5] Ganguli, Ishani. *Characteristics of Low-Value Services Identified in US Choosing Wisely Recommendations*. JAMA Internal Medicine. February 1, 2022.

[6] *Clinical Appropriateness Measures Collaborative Project*. AHIP. December 2021.

[7] Busch, Fritz S., and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*. Milliman. March 30, 2023.

[8] Busch, Fritz S. and Peter Fielek. *Potential Impacts on Costs and Premiums Related to the Elimination of Prior Authorization Requirements in Massachusetts*. Milliman. November 29, 2023.

[9] *Where Does Your Health Care Dollar Go?* AHIP. October 24, 2024.

any other individual category. The problem with prescription drug affordability is the list price, which pharmaceutical manufacturers alone set and control without parameters or oversight.

While capping or prohibiting cost-sharing (copays, coinsurance, deductibles) may seem like a consumer-friendly approach to hold costs down, these approaches can have the following negative consequences:

- By not addressing the underlying price of prescription drugs, equipment, or supplies, these bills will likely allow the underlying prices to increase with even less transparency.
- Allows drug makers to avoid accountability, oversight, and transparency in pricing.
- Shifts costs to the entire risk pool, raising costs for all consumers.

H.6047 will not reduce the unaffordable prescription drug prices set by drugmakers. It is critical that legislative proposals actively address problems they are trying to solve. By overlooking manufacturers' role in setting exorbitantly high drug prices and not pursuing an approach that can effectively lower drug costs, employers and patients will be left paying more under this proposal.

As stated above, amendments to H.6047 prohibits group or blanket policies from imposing "a deductible, coinsurance, copayment or any other cost-sharing requirement on the coverage provided". As such, the bill does not address or impact the underlying cost drivers associated with the prices for healthcare services, equipment, and drugs. Cost-sharing limitations will instead only exacerbate those cost drivers because they reduce health insurance providers' ability to negotiate with drug manufacturers and providers. Without any sort of public pressure or accountability at the pharmacy counter, drug makers will be allowed – and even encouraged – to continue to increase their already high prices. This approach hides the true price of prescription drugs and instead spreads the cost to other services & consumers.

Cost-sharing limitations allow drug makers to avoid accountability, oversight, and transparency of drug prices. On the surface, they seem like a straightforward solution to address consumers' struggle to afford their prescription medications. However, these policies allow drug companies to continue to raise their prices without scrutiny, hiding and shifting drug costs. Consumers may see savings at the counter, but those savings must be offset through higher, actuarially sound, Insurance Department-approved premium rates.

When cost-sharing prohibitions are in place, pharmaceutical manufacturers are given a blank check to charge whatever they want because consumers do not see the increases reflected in their share of cost. Blinding the public and policymakers to drug price increases makes it harder for health insurance providers to control drug costs because public knowledge of and responses to skyrocketing price increases is mitigated. When premiums rise, the pressure is placed on insurers to lower costs, but without an economic incentive to for drug manufacturers to negotiate, it is nearly impossible for payers to lower costs on their own.

For example, in the last decade, the list prices of common types of insulin have roughly tripled, even though they're the exact same products offered 10 years ago.[10] A bipartisan investigation from the US Senate Finance Committee found that insulin manufacturers aggressively raised the list price absent significant advances in the efficacy of the drugs thanks to a lack of transparency and misaligned incentives.[11]

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[10] Gillett, Rachel and Shayanne Gal. *One chart reveals how the cost of insulin has skyrocketed in the US, even though nothing about it has changed*. Business Insider. September 18, 2019. Available at https://www.businessinsider.com/insulin-price-increased-last-decade-chart-2019-9.

[11] *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*. US Senate Finance Committee. Available at https://www.finance.senate.gov/imo/media/doc/Grassley-Wyden%20Insulin%20Report%20(FINAL).pdf.

Instead of adopting policies that investigate drug makers' pricing tactics or correct the market imbalance that allows this behavior to occur, many states chose policy measures that allow that behavior to continue and get worse through copay cap legislation. These bills partially shield patients from costs for insulin supplies/equipment at the pharmacy counter, but they encourage drug manufacturers to continue their bad pricing behavior.

Prohibiting cost-sharing for benefits shifts these costs to the entire risk pool, raising costs for all consumers. Though some consumers may be shielded from the immediate impact of high drug prices, cost-sharing limitations will result in higher costs for other services and higher premiums for all consumers. It is important for policymakers to understand the larger market consequences before pursuing copay caps.

- **Cost-sharing prohibitions for some services will have a "balloon squeeze" effect, causing copays for other services to rise.** 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 a copay is reduced for one service, it must be increased for another type of service to maintain the actuarial value for that plan. Thus, if an insurer covers more of the overall cost of prescription drugs, supplies, or equipment (by lowering 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 these bills' capped copays.

  Bronze plans will have an especially difficult time complying with AV standards if copay caps are adopted:

  - A Milliman analysis confirms that certain caps on bronze plans would cause them to fall out of compliance with AV rules and force the plans to be redesigned, which would entail significant increases in cost-sharing for other services, such as a 35% increase in specialty copayments, 40% increase in primary care co-pays, and/or 60% increase in generic drug copayments.[12]
  - When adopting its standard benefit designs, Covered California determined that a prescription drug copay cap for bronze plans had to be $250 higher than the cap for other metal levels to meet AV requirements.[13]

- **Cost-sharing prohibitions shift costs from patients taking prescription drugs to the entire risk pool.** Passing on some costs to the entire risk pool requires health insurance providers to increase premiums to compensate for higher costs. Eventually, all members bear these higher costs through higher premium rates. Studies have repeatedly found that copay caps raise the cost of insurance for all consumers:

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[12] *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*. Milliman, Inc., NY, commissioned by The Leukemia & Lymphoma Society. March 5, 2015. Available at https://www.lls.org/sites/default/files/National/USA/Pdf/Milliman%20Report%20on%20Prescription%20Cost%20Sharing%20Limits%20for%20Exchange%20Plans.pdf.

[13] *Covered California Policy and Action Items*. May 21, 2015. Available at http://board.coveredca.com/meetings/2015/5-21/PPT%20-Covered%20California%20Policy%20and%20Action%20Items_May%2021,%202015.pdf

- The Kentucky Department of Insurance found that copay caps would add approximately $10-13 million to private market insurance premiums annually. These price controls could cost each enrollee almost $50 a year in increased premiums.[14]
- In the state of Washington, an Oliver Wyman analysis found that a $250 copay cap per 30-day script would shift costs to health plans and consumers by $900 million over five years.[15]
- A Milliman analysis found that imposing copay caps would increase the cost of bronze coverage by nearly 5 percent[16] – a large amount for price-sensitive consumers in search of affordable coverage.

For all these reasons, ***AHIP urges you not to pass H.6047.*** We encourage policymakers to collaborate with health plans, providers, and hospitals on solutions that balance patient safety and affordability. We also remain supportive of efforts to reduce high drug prices, but the aspects of the bill discussed above will not do so. AHIP stands ready to work together with Rhode Island policymakers to help ensure every patient has access to the high quality, affordable drugs that they need.

Sincerely,

Sarah Lynn Geiger, MPA
Regional Director, State Affairs
America's Health Insurance Plans

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.

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[14] *SB 31, Fiscal Impact Statement*. Kentucky Department of Insurance. 2015. Available at https://apps.legislature.ky.gov/record/15RS/sb31/HM.pdf.

[15] *Cost-sharing Caps Don't Solve the Problem of High Drug Prices*. PCMA. Available at https://www.pcmanet.org/wp-content/uploads/2017/04/CoPay-Cap_infographic_FINAL-1.pdf

[16] *Pharmacy Cost Sharing Limits for Individual Exchange Benefit Plans: Actuarial Considerations*. Milliman, Inc.