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March 12, 2026

The Honorable Susan R. Donovan, Chairwoman
Of the House Health and Human Services Committee
Rhode Island State House Providence,
RI 02903

RE: AHIP Comments on:

- **H.7943, An Act Relating to Insurance – Insurance Coverage for Mental Illness and Substance Use Disorders**
- **H.7945, An Act Relating to Insurance – Insurance Coverage for Mental Illness and Substance Use Disorders**

To Chairwoman Donovan and Members of the House Health and Human Services Committee,

AHIP appreciates the opportunity to provide comments on:

- H.7943, legislation that would prohibit prior authorization (PA) for in-network mental health or substance use disorder (MH/SUD) services; and
- H.7945, legislation that would require health plans to use "generally accepted standards of care" in conducting utilization review relating to service intensity or level of care placement for MH/SUD services.

We appreciate the Committee's work to advance solutions that promote health care quality, access, and affordability for Rhode Islanders. We are, however, concerned that these bills would undermine these tenets and undermine industry efforts currently underway. We respectfully oppose H.7943 and H.7945 and urge the Committee not to move these bills forward.

Prior Authorization Protects Patient Safety. Prior authorization is an important safeguard used by both public and private payers to help ensure patients receive care that is safe, evidence-based, and affordable – ultimately ensuring Americas' health care dollars are spent wisely. For example, PA protects patients by:

- ***Preventing low-value or inappropriate services.*** PA ensures patients do not receive services that do not improve outcomes and can lead to more unnecessary treatments or services, potential harms, and avoidable costs. PA 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.

Medical knowledge doubles every 73 days[1] and, to keep up with these changes, studies show primary care providers would need to practice medicine nearly 27 hours per day.[2] 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 treatments that cost the U.S. $340 billion annually.[3] Eighty-seven percent of doctors have reported negative impacts from low-value services or treatments[4] and an AHIP clinical appropriateness project with John Hopkins found that about 10% of physicians provided services or treatments inconsistent with consensus and evidence-based standards.[5]

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 or inappropriate services.

It is important for policymakers to consider how prohibitions on PA like those contained in H.7943 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 PA could raise premiums by **$20.10 to $29.52** per member per month (PMPM) nationwide, totaling $43–$63 billion annually in the commercial market, threatening affordability in an already costly system.[6]
- In Massachusetts, a separate study added an examination of the "sentinel effect" of eliminating PA to quantify the costs related to requests for authorizations that were previously unsubmitted when PA 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 PA were eliminated entirely.[7]

While PA is utilized very selectively, the experience often reflects fragmentation and outdated processes that hold back the performance of the health care system. This experience can be frustrating for everyone involved – particularly for patients.

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

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

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

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

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

[6] 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.

[7] 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.

Health Plans Voluntarily Commit to Streamline and Simplify Prior Authorization. In June 2025, health plans announced a series of multi-year voluntary commitments to streamline and simplify the PA process for patients and providers.[1] Simplifying PA means that patients will have faster, more direct access to appropriate treatments and medical services. When providers transition away from antiquated approaches, such as fax machines, these commitments will also enable a more efficient, transparent and modernized experience.

These commitments are being implemented across insurance markets, including those with commercial coverage, Medicare Advantage, and Medicaid managed care, consistent with state and federal regulations. Health plans serving nearly 270 million Americans are participating in this initiative. Through these actions, health plans will deliver a faster, more seamless patient experience and enable providers to focus on patient care, while also helping to modernize the system. Commitments in health plans' initiative include:

- Reducing the Scope of Claims Subject to Prior Authorization
- Ensuring Continuity of Care When Patients Change Plans
- Enhancing Communication and Transparency on Determinations
- Ensuring Medical Review of Non-Approved Requests
- Expanding Real-Time Responses
- Standardizing Electronic Prior Authorization

Health plans' progress will be tracked, and aggregated information will be publicly reported starting later this year. More details on these voluntary commitments, as well as a 2024 PA survey of AHIP's members, can be found here.

For these reasons, AHIP respectfully opposes H.7943 and asks the Committee to allow the industry's voluntary commitments to move forward without this bill that could impede health plans' progress to ensure successful progress on simplifying PA for patients and providers.

Utilization Management Programs are Founded on Evidence-Based Criteria. Section 27-38.2-1 (i) of H.7945 requires health plans to use "generally accepted standards of care", defined in Section 27-38.22(2), when developing MH/SUD coverage and clinical criteria, including utilization review. This includes an inexhaustive list of standards established by various nonprofit professional provider associations. Health plans employ doctors, nurses, and other clinicians to develop and regularly utilization management (UM) programs using evidence-based criteria. UM programs are examined by health plan Pharmacy and Therapeutics (P&T) Committees, required by federal programs, and which must include clinicians that are independent and free of conflicts of interest.

A health plan's utilization management processes, such as prior authorization, must meet stringent standards established by national health care accreditation agencies, such as the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC). These accreditation standards address the clinical criteria used for decisions, regular review and availability of the criteria, practitioner involvement, qualifications of health professionals making prior authorization decisions, and timeframes for decisions.

[1] *Health plans are making voluntary commitments to support patients and providers*. AHIP.

As drafted, AHIP is concerned with H.7945 would create overlapping requirements for health plans' UM programs. In particular, the bills' broad definition for "generally accepted standards of care" could conflict with – or introduce variability relative to – existing national UM standards that health plans already follow. Because the bill does not specify when emerging clinical guidance becomes "generally accepted," there will be uncertainty about which standards apply and when. Given the rapid advancements in medical knowledge, plans need UM programs that can ensure patient safety while also protecting patient access to health care.

AHIP Recommendation. Due to the concerns outlined above regarding patient protection and affordability, ***AHIP urges the Committee to vote no on H.7943 and H.7945***. We encourage policymakers to collaborate with health plans, providers, and hospitals on solutions that focus on patient safety and affordability. AHIP and its members stand ready to work with you on this important issue.

Sincerely,

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cc: Members, House Health and Human Services Committee

ABOUT AHIP

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**.