Dear Chair Murray and Honorable Members of the Senate Health & Human Services Committee,

I am writing to express my strong support for S2876, legislation that would cap patient out-of-pocket costs for prescription inhalers, inhalation devices, and related equipment at $25 per 30-day supply and exclude these medications from deductible requirements. I offer this perspective as a licensed clinical pharmacist practicing in Rhode Island, with direct experience managing chronic respiratory disease and helping patients navigate insurance-driven barriers to essential medications.

In my daily practice, I am frequently tasked with finding more affordable alternatives for patients facing inhaler copays in the range of $200–$400 per month, often due to high deductibles or benefit design. These conversations occur routinely; not only with low-income patients, but with individuals across the socioeconomic spectrum. I often find myself questioning whether even a wealthy patient would reasonably choose to pick up a medication with a copay that high.

The reality I see is that many patients simply go without treatment or are forced to settle for suboptimal therapy based solely on what they can afford, not what is clinically appropriate. Even so-called “generic” inhalers frequently remain prohibitively expensive, leaving patients with few realistic options. As a result, adherence suffers, disease control worsens, and preventable exacerbations become more common.

S2876 directly addresses this access barrier by ensuring predictable, affordable cost-sharing for life-sustaining respiratory medications. Inhalers are not optional therapies; they are foundational to the management of asthma and other chronic respiratory conditions. When patients cannot afford these medications, the consequences are immediate and dangerous.

From a value-based care and payer perspective, this legislation promotes cost avoidance by shifting care away from high-cost settings. Poorly controlled asthma and chronic lung disease frequently result in emergency department visits, hospitalizations, missed work or school, and long-term complications—all of which carry substantial costs that far exceed the price of covering inhalers affordably at the pharmacy counter.

Capping out-of-pocket costs for inhalers does not create new utilization; it enables patients to access medications that have already been prescribed and deemed medically necessary. By removing deductible barriers and excessive copays, S2876 improves adherence, stabilizes disease control, and reduces reliance on emergency and inpatient care. This represents smarter spending, not increased spending, by prioritizing prevention and maintenance therapy over crisis intervention.

Importantly, S2876 also includes appropriate guardrails by limiting prior authorization to confirmation of diagnosis and medical necessity, reducing administrative burden without eliminating oversight. The bill strikes a thoughtful balance between patient access, clinical appropriateness, and insurer accountability.

As a clinician, I routinely witness the ethical and clinical tension created when cost, not evidence, dictates therapy. S2876 is a pragmatic and patient-centered solution that aligns insurance benefit design with the realities of chronic disease management and the broader goals of value-based healthcare.

I respectfully urge the Committee to support S2876 and advance legislation that ensures Rhode Islanders can access the respiratory medications they need when they need them, without facing financially punitive barriers. This bill will improve patient outcomes, reduce avoidable high-cost utilization, and strengthen the overall efficiency of our healthcare system.

Thank you for your time, leadership, and commitment to improving healthcare access in Rhode Island. I would be glad to serve as a clinical resource or to answer any questions as you consider this legislation.

Sincerely,
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