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March 6, 2025

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.5429, An Act Relating to Insurance – Third Party Health Insurance Administrators – Prescription Drug Cost Control and Transparency

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

On behalf of AHIP, we offer the following comments in opposition to H.5429, which restricts health plans' contracting options and broadly prohibits pharmacy benefit managers (PBM) from employing utilization management processes, including prior authorization. While we are aligned with Rhode Island's commitment to increased access to high-quality, affordable health care, we are concerned this bill would undermine patient safety and affordability while doing nothing to control the soaring prices of prescription drugs.

Health plans partner with PBMs to obtain affordable and accessible medications for patients. Health plans are on the side of patients, tasked with lowering prices to ensure access to medications for employers and individuals they serve. Many health plans choose to partner with pharmacy benefit managers (PBMs) to negotiate with drug manufacturers who often hold monopoly power over medicines and who have little to no incentive to negotiate with health plans.

By partnering with PBMs, health plans can use PBMs' technology-based tools and programs to drive value, efficiency, and effectiveness that ensure patient access. PBMs are able to represent the covered lives of all their plan sponsors and health plan clients, enabling patients to obtain the medications they need at the lowest possible cost. PBMs also help plan efforts to ensure patients receive safe, evidence-based care, and prior authorization provides a critical layer of support and oversight in such efforts.

Delinking:
Limiting compensation arrangements for PBMs to an administrative fee structure:

- **does nothing to reduce drugmakers' inflated prescription drug prices,**
- **limits contracting options for employers, and**
- **increases costs for consumers.**

The proposed amendment to 27-29.1-7, Section 3(b)(2), requires PBMs to retain "only a pre-determined administrative fee."

This provision would tie health plans' hands in developing the most appropriate compensation package for their contracted PBM. Moreover, the bill fails to address the true cause of high drug prices, and as a result, may have the unintended consequence of undermining market competition and driving prescription drug prices even higher.

Everyone should be able to get the medications they need at a cost they can afford. More than 24 cents[1] of every dollar spent on health insurance premiums goes to pay for prescription drugs – more than 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.

Consumers benefit when health plans and employers have the option to compensate PBMs for the services performed through various methodologies and the ability to choose the option that best fits the needs of their plan and enrollees. Some of these methodologies allow PBMs to derive some or all of the payment for their services from the rebates that they negotiate with drug manufacturers. These contracting models can help PBMs negotiate the lowest prices for the health plans and employers that they serve.

Mandating a flat-fee reimbursement arrangement by limiting compensation to an administrative fee removes existing options for plans and employers to promote prescription drug affordability, undermining private market competition, failing to address high drug prices, and potentially resulting in increased administrative costs to plans and patients.

It is critical that legislative proposals actively address problems they are trying to solve. By ignoring manufacturers' role in setting exorbitantly high drug prices and not pursuing an approach that can effectively lower drug costs, the proposal will leave employers and patients paying more.

We have seen repeatedly that misdirected attempts to address drug costs lead to the unintended consequences of undermining market competition and increasing costs:

- The Centers for Medicare and Medicaid Services estimated the federal Rebate Rule, which required rebates to be more direct shared with consumers, would have increased Medicare premiums for seniors by 25%, increased Medicare drug spending by $196 billion and given drug makers a $100 billion windfall in new revenue.[2]
- This type of proposal would have similar consequences: a working paper published by the National Bureau of Economic Research estimates the potential cost of "delinking" PBM compensation from rebates in commercial health insurance to be $8.4 to $26.6 billion nationally.[3]

H.5429's limitations on PBM compensation represent an overly broad, market-undermining approach that would unnecessarily limit contracting options and competition, leading to higher costs. Pharmaceutical manufacturers deliberately advocate for a focus on rebates, rather than list prices, to avoid legislation addressing the more serious issues surrounding the lack of competition, transparency, and accountability in their pricing of prescription drugs. We remain supportive of efforts to reduce high drug prices, but the aspects of the bill discussed above will not do so and will instead impose new mandates that take away important tools for health plans and employers to improve prescription drug affordability.

Prior Authorization

The proposed amendment to 27-29.1-7, Section 3(b)(4), requires PBMs to "Cease utilization management processes, including prior authorization," and other important tools. If all monitoring tools, such as prior authorization (PA), are removed, Rhode Island patients will face increased risk of receiving inappropriate or low-value services that are not consistent with evidence-based standards, leading to potential harm and higher costs.

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

[2] *Rebate Rule Would Increase Drug Prices, Premiums, and Costs to Taxpayers*. AHIP. March 2019.

[3] Mulligan, Casey B. *Ending Pay for PBM Performance: Consequences for Prescription Drug Prices, Utilization, and Government Spending*. National Bureau of Economic Research. September 2023.

PA protects patient safety. PA is a proven tool to ensure that 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 protects patients from receiving services that do not improve outcomes and can lead to more unnecessary care, potential harm, and avoidable costs. PA can ensure that appropriate alternatives are used, consistent with evidence-based guidelines and providers' own recommendations.[4]

- ***Preventing dangerous drug interactions.*** PA helps prevent dangerous drug interactions and help ensure 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[5] and, to keep up with these changes, studies show that primary care providers would need to practice medicine nearly 27 hours per day.[6] 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.

PA helps reduce patients' health care costs. In addition to promoting safe, evidence-based care, PA helps keep coverage 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.[7] Eighty-seven percent of doctors have reported negative impacts from low-value care,[8] and an AHIP clinical appropriateness project with John Hopkins found that about 10% of physicians provided care inconsistent with consensus and evidence-based standards.[9]

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 to consider how prohibitions and limitations on PA like those contained in H.5429 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 PMPM nationwide, totaling $43–$63 billion annually in the commercial market, threatening affordability in an already costly system.[10]

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

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

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

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

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

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

[10] 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.

- 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.[11]

AHIP Recommendation. For all these reasons, **AHIP urges you not to pass H.5429.** AHIP stands ready to work together with Rhode Island policy makers to ensure every patient has access to the high quality, affordable drugs that they need while also balancing patient safety.

Sincerely,

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

[11] 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.