Guiding Greater Health

601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, D.C. 20004

T 202.778.3200
F 202.331.7487
ahip.org

March 18, 2025

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

RE: AHIP Comments on H.5432, An Act Relating to Insurance – Insurance Coverage for Mental Illness and Substance Use Disorders – OPPOSE

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

AHIP appreciates the opportunity to provide comments on H.5432, legislation that would prohibit health plans from requiring prior authorization for in-network mental health or substance use disorder (MH/SUD) services. Unfortunately, this bill would undermine patient safety and affordability, and therefore AHIP respectfully opposes this legislation.

AHIP is committed[1] to advocating for policies to expand access to mental health and substance use disorder (MH/SUD) care, improve quality and value, promote parity and advance equity. We also share your commitment to ensuring patients have access to high-quality, affordable health care. Mental health is an essential part of a person's overall health and well-being, and coverage of MH/SUD care must be on par with medical and surgical care.

Health Plans' Efforts to Improve Behavioral Health. Health plans are facilitating and paying for more MH/SUD care than ever before. A recent AHIP analysis of employer-sponsored plans estimated that plan expenditures for MH/SUD care nearly doubled (from $33.9 billion to $60.8 billion) from 2013-2021.[2] Among commercial health plans, the number of in-network mental health providers has also grown by an average of 48% in 3 years.[3]

- ***Integrating MH/SUD Care into Other Care Settings, including Primary Care.*** Health plans are uniquely positioned to help their members access whole-person health, including integrating MH/SUD care with other health care services[4].

- ***Expanding the Use of Telehealth for Behavioral Health Care and Supporting Workforce Expansion.*** As we have seen, telehealth platforms can create new opportunities for consumers to access therapists or other mental health care practitioners, particularly if they reside in rural

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[1] *Statement of Commitment: Improving Access to and Quality of Mental Health and Addiction Support*. AHIP Board of Directors. August 23, 2022.

A Vision for Improved Mental Health Care Access for Every American. AHIP. August 23, 2022.

[2] *AHIP Analysis of Group Health Plan Claims for Mental Health and Substance Use Disorder Treatment, 2013-2021*. This 2023 AHIP analysis estimated the total expenditure on behavioral health, including mental health and substance use disorder treatments, in the employer-sponsored market in 2018-2021 using the Merative® Commercial Claims Dataset. The study identified behavioral health enrollees using behavioral health diagnostic codes and behavioral health related procedure codes. Both inpatient and outpatient costs were included. The national expenditure was then estimated using the US Census national enrollment in the employer-sponsored market. All prices were adjusted for inflation.

[3] *July 2022 Mental Health Survey*. AHIP. August 4, 2022.

New Survey Shows Strong Action by Health Insurance Providers to Growing Mental Health Care Demands. AHIP. August 4, 2022.

[4] *Integrating Behavioral Health and Primary Care*. AHIP. February 2022.

and underserved communities.[5] There is currently an insufficient supply of mental health care providers and, while telehealth does not increase the overall number of providers, it can make it more efficient for patients and providers to connect for care.

- ***Focusing on the Mental Health Needs of Children and Adolescents.*** Health insurance providers are addressing the mental health needs of children and adolescents through a range of innovative and collaborative approaches. For example, health insurance providers are working with pediatricians and other primary care providers to implement integrated care models focused on children and adolescents, such as using an inter-generational approach to assess family and guardian issues, and then coordinating care between multiple systems, schools, therapy providers, and community resources.

Medical management tools help to ensure that patients receive the most effective, affordable, and necessary care. H.5432 prohibits health plans from requiring prior authorization (PA) for in-network MH/SUD services.

Health plans need these tools to help advocate for the people they serve by ensuring that the right care is delivered at the right time in the most appropriate setting – and covered at a cost that patients can afford. These are quality, affordability, and waste-prevention tools. Furthermore, with a comprehensive view of the health care system and each patient's medical claims history, health plans work to ensure treatments and/or medications prescribed are safe, effective, and affordable to meet each patient's health care needs. This results in better health care outcomes and lower costs for patients.

PA 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 prevents patients from receiving services that do not improve outcomes and can lead to more unnecessary care, potential harm, and avoidable costs. PA can ensure appropriate alternatives are used, consistent with evidence-based guidelines and providers' own recommendations.[6]
- ***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 medications are not used for clinical indications other than those approved by the Food and Drug Administration.

Medical knowledge doubles every 73 days[7] and, to keep up with these changes, studies show that primary care providers would need to practice medicine nearly 27 hours per day.[8] 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 and evidence-based clinical criteria - protecting patients from unnecessary and potentially harmful drugs and services.

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[5] *Supporting Mental Health Through Telehealth*. AHIP. October 2022.

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

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

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

Broad exemptions for care jeopardize patient safety. Monitoring provider quality performance is essential to ensuring patients receive safe, evidence-based care, and PA provides a critical layer of support and oversight. If this monitoring is removed, as it is H.5432, 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.

Wholly exempting in-network MH/SUD services from PA undermines critical patient safeguards and increases the risk of low-value care and inappropriate treatments being delivered to patients.

PA 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.[9] Eighty-seven percent of doctors have reported negative impacts from low-value care[10] and an AHIP clinical appropriateness project with John Hopkins found that about 10% of physicians provided care inconsistent with consensus and evidence-based standards.[11]

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 on prior authorization like those contained in S54 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.[12]
- 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 prior authorization were eliminated entirely.[13]

Health plans are leading the way to further simplify and improve prior authorization for patients and providers. As part of this ongoing commitment[14], health insurance plans have been taking significant steps, including:

- ***Making significant investments to promote and support provider electronic prior authorization (ePA) adoption.*** Despite health plans offering the capability for ePA, 60% of prior authorization requests for medical services are still submitted manually (via phone, fax, or mail).[15] ePA has shown that it can streamline requests, shorten decision times and lower administrative

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

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

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

[12] 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.

[13] 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.

[14] *How Health Insurance Provider Are Delivering on Their Commitments*. AHIP. July 2022.

[15] *AHIP 2022 Survey on Prior Authorization Practices and Gold Carding Experiences*. AHIP. November 14, 2022.

burdens on providers and plans alike. Its adoption remains a major opportunity for improving prior authorization.

- ***Streamlining PA for full treatment courses***. Health plans have streamlined PA for common conditions like musculoskeletal disorders.
- ***Waiving PA for high-performing providers***. Health plans are implementing voluntary programs to waive PA requirements for providers with a demonstrated track record of practicing evidence-based care and for providers participating in risk-based payment contracts.

Industry Innovations and Upcoming Technology Requirements. Health plans are committed to improving PA through technology and innovation. The recent CMS final rule on Advancing Interoperability and Improving Prior Authorization Processes highlights this progress.[16] This rule requires plans in federal programs to build and maintain four new application programming interfaces (APIs):

1. To enable faster ePA decisions.
2. To share large-scale population health data files with providers for value-based care.
3. To allow patients to access their claims and clinical data more easily.
4. To support care coordination when a patient transitions between payers.

These APIs are designed to reduce administrative burdens, enhance efficiency, and promote greater transparency in health care delivery. Industry stakeholders are actively analyzing and implementing these changes to ensure compliance and maximize their positive impact. By aligning with these federal efforts, health insurance providers are proactively addressing challenges in utilization management while continuing to ensure timely, evidence-based care for patients.

AHIP Recommendation. For these reasons, ***AHIP urges the Committee not to pass H.5432***. Instead, we encourage policymakers to collaborate with health plans, providers, and hospitals on solutions that promote MH/SUD care quality, access, and affordability for Rhode Islanders. AHIP and its members stand ready to work with you on this important issue.

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

[16] *Advancing Interoperability and Improving Prior Authorization Processes*. Centers for Medicare & Medicaid Services. 89 FR 8758. February 8, 2024.