To: Corey King, Director, Office of Health Insurance Commissioner

Cc. RI Attorney General, Peter Neronha

From: J. Mark Ryan, MD, FACP

Date: August 21, 2024

Re: Payer Requested Premium Increases

Thank you for the work your office has done on this complex issue. I am writing to oppose the increased premiums being requested by private health insurance corporations doing business in Rhode Island.

Their requests are not justified by "increases in utilization, provider prices, and pharmaceuticals."

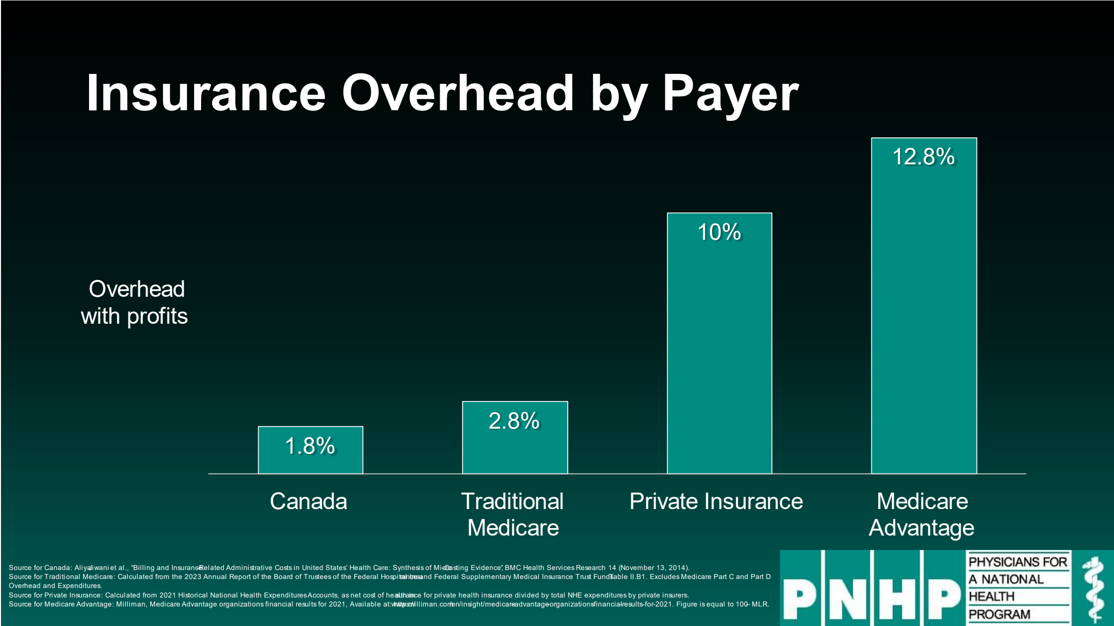
"Utilization" means patients seeking goods and services. "Provider prices" means what healthcare providers (mainly doctors and hospitals) are charging. "Pharmaceuticals" means what manufacturers are charging for prescription drugs. Even though these costs are increasing, one group responsible for skyrocketing healthcare costs is entirely left out of analyses: the group before OHIC asking for higher premiums, i.e., the commercial health insurance corporations.

According to a recent Commonwealth Fund study, at least 30 cents of every health care dollar is spent on costs related to administrative costs imposed by insurers:

"higher administrative costs associated with health insurance — for example, those related to eligibility, coding, submission, and rework — represent approximately 15 percent of excess U.S. health spending. Higher administrative burden on providers — for example, general administration, human resources, and quality reporting and accreditation — represents an additional 15 percent of the excess. This makes administrative complexity the single biggest component of excess U.S. spending estimated in this study. The large impact of administrative costs is consistent with previous research that found 39 percent of the difference between U.S. and Canadian spending on hospital and physician care was administration.[i]

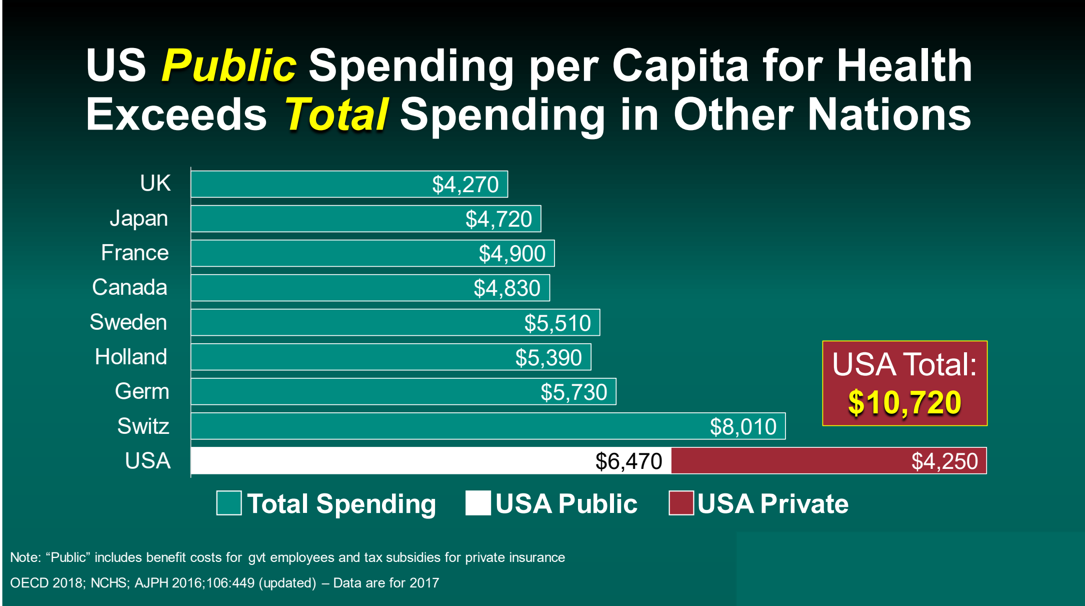
As a specific example of an unjustified administrative expense, in 2020, BCBSRI made $1.75 billion and gave its CEO a bonus of $ 1.2 million for a total compensation package of $2.2 million, and their CFO bonus was $447,250, pushing his total pay for the year above $1 million.[ii]

Commercial insurers should not be given premium increases until OHIC analyzes their excessive internal administrative costs and considers evidence that such expenses are not necessary, including what is illustrated below.

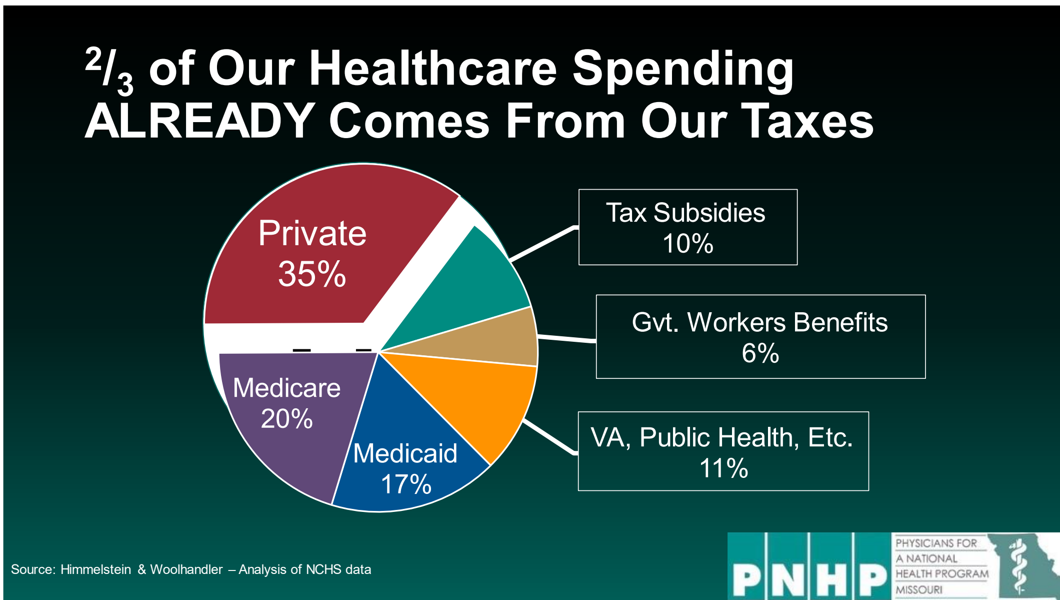


Premium increases are also not necessary because commercial insurers are already reaping enormous revenues – including from their pharmacy benefit managers (PBMs). "Big Insurance revenues and profits have increased by 300% and 287% respectively since 2012 due to explosive growth in the companies' pharmacy benefit management (PBM) businesses and the Medicare replacement plans they call Medicare Advantage."[iii] OHIC should not grant premium increases and add to the enormous revenue insurers and their PBMs are already getting; too much is already being taken unnecessarily from providers and patients.[iv]

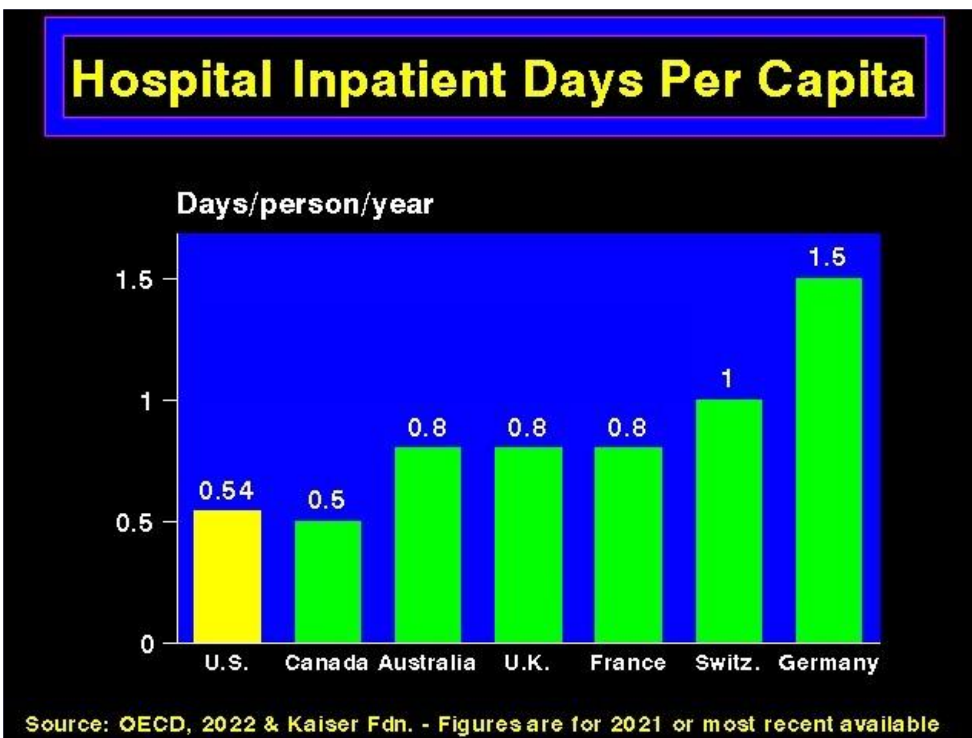
Giving them a premium increase will only exacerbate the problem in America that we pay about double per capita what those in other industrialized nations pay for healthcare.

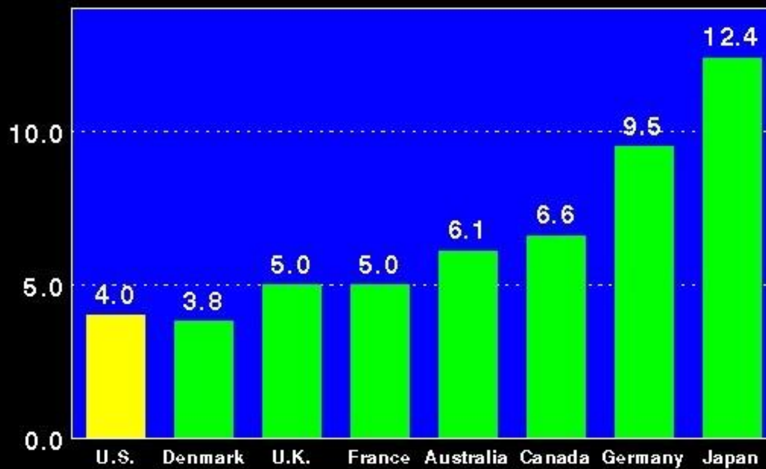


PUBLIC spending or what we pay using tax dollars already exceed TOTAL spending in all but one other nation. So, Americans already pay for universal comprehensive healthcare – we just don't get it.

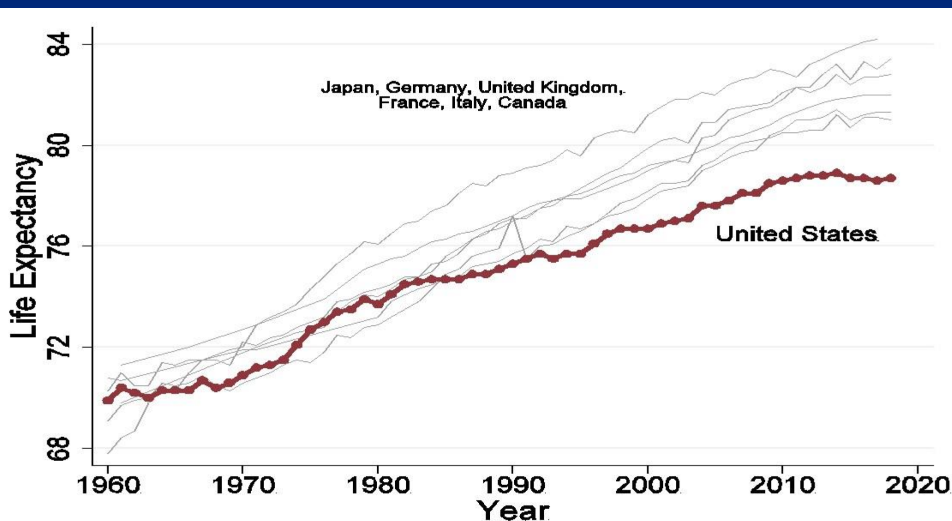


What is driving our costs is NOT higher utilization. Americans generally spend less days in the hospital and visit the doctor less often per capita.





Americans also do NOT spend more because we get better health outcomes. Our mortality and morbidity rates show worse outcomes.



A.G. Neronha is correct when he wrote, "Unfortunately, keeping these premiums low will also not solve the fundamental problems of soaring healthcare costs and lack of healthcare providers."

Rhode Island must take a more comprehensive approach to fix our broken healthcare financing system – and that approach would be to rein in private health insurance corporations, not provide them premium increases and blame providers and patients for soaring costs. We must stop ignoring middlemen insurers and allowing them to "manage" our health care. There is no evidence that payers have lowered costs of health care and improved health outcomes (morbidity and mortality). None.[v]

While we wait for a national single payer improved Medicare-For-All program to pass, we must ensure at the state level that middlemen are not permitted to raise premiums and collect enormous revenues from their PBM affiliates. We should follow the lead of states like Connecticut[vi] and Ohio[vii] that are de-privatizing health care. Rhode Island policymakers studying the issue concluded over two decades ago that we could afford universal healthcare.[viii]

Please contact me if you would like further information. Thank you for considering this submission.

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[i] https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going#footnote3, cited in https://www.commonwealthfund.org/publications/issue-briefs/2023/oct/high-us-health-care-spending-where-is-it-all-going#:~:text=We%20estimate%20that%20higher%20administrative,spending%20estimated%20in%20this%20study, see also Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? *JAMA.* 2021;326(17):1679–1680. doi:10.1001/jama.2021.17318, https://jamanetwork.com/journals/jama/fullarticle/2785479

[ii] https://www.wpri.com/business-news/blue-cross-ri-paid-1-2-million-bonus-to-ceo-last-year/

[iii] https://www.congress.gov/118/meeting/house/116373/documents/HHRG-118-GO00-20230919-SD008.pdf

[iv] See, e.g., https://phrma.org/Blog/FTC-report-confirms-PBMs-profit-at-the-expense-of-patients#:~:text=Pharmacy%20Benefit%20Managers%20(PBMs)%20are,Federal%20Trade%20Commission%20(FTC).&text=FTC%20report%20confirms%20PBMs%20profit%20at%20the%20expense%20of%20patients.

[v] Gondi S, Joynt Maddox K, Wadhera RK. Looking AHEAD to State Global Budgets for Health Care. N Engl J Med. 2024 Jan 18;390(3):197-199. doi: 10.1056/NEJMp2313194. Epub 2024 Jan 13. PMID: 38226845, https://www.nejm.org/doi/10.1056/NEJMp2313194?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubme . See also, 252-page analysis of the Maryland all-payer model, on which AHEAD is based, that concluded: "The All-Payer Model was not associated with population health improvement," https://downloads.cms.gov/files/md-allpayer-finalevalrpt.pdf

[vi] https://portal.ct.gov/-/media/departments-and-agencies/dss/medicaid-hospital-reimbursement/precis_of_ct_medicaid_program.pdf

[vii] https://medicaid.ohio.gov/about-us/budget/sustainability-quality-access/next-generation-of-ohio-medicaid-managed-care#:~:text=Single%20PBM:%20The%20single%20PBM,$184.4M%20in%20SFY%202023&text=Unified%20PDL:%20This%20initiative%20is,savings%20of%20$60M%20annually.

[viii] https://www.bu.edu/sph/files/2015/05/SPRI-RI-UHC-report-25-Nov-02-final-with-summary-1.pdf