OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND

March 19, 2024

The Honorable Joshua Miller
Chairperson, Senate Committee on Health and Human Services
Rhode Island State House
82 Smith Street
Providence, RI 02903

RE: S2722 – AN ACT RELATING TO STATE AFFAIRS AND GOVERNMENT -- THE RHODE ISLAND HEALTH CARE REFORM ACT OF 2004 -- HEALTH INSURANCE OVERSIGHT – Letter of Concern

Dear Chairperson Miller:

I write on behalf of the Rhode Island Office of the Health Insurance Commissioner (OHIC) to express concerns regarding S2722 as presently written. Rhode Island's health care system, like the health care systems of other states, regionally and nationally, is facing many challenges. The organizing objectives of the Senate HEALTH initiative are consumer protection, provider availability and care quality, cost containment, and health system financial stability. These are objectives that I embrace, and they are consistent with OHIC's mission. I applaud the Senate for elevating these issues and working to move Rhode Island's health care system forward.

S2722 amends OHIC's enabling statute to create a new framework governing the reimbursement rates, or prices, that commercial health insurers pay hospitals, physicians, and advanced practice providers. The legislation would mandate an increase in reimbursement rates sufficient to equal the average of reimbursement rates in the states of Connecticut and Massachusetts, phased in over a three-year period beginning in 2025, as well as mandating additional annual rate increases tied to "healthcare inflation." Beginning in 2028, Rhode Island reimbursement rates would be adjusted biennially to meet a reimbursement rate floor defined as the average of reimbursement rates in Connecticut and Massachusetts. To make way for this new framework, S2722 repeals several components of OHIC's Affordability Standards regulations.

According to publicly available data sources, such as the RAND employer hospital price transparency project, average hospital reimbursement is higher in Connecticut and Massachusetts. Providers have also stated that average physician reimbursement is higher in neighboring states as well, but there is less publicly available data on physician reimbursement from commercial health insurers. The reasons for differences in provider reimbursement rates between states are complex. They include differences in

state economies, health care market structure, and public policy. Rhode Island also generally has lower health insurance premiums compared to Connecticut and Massachusetts (see Attachment 1).

As presently written, the regional rate parity framework will increase the health insurance premiums paid by individuals and small businesses in Rhode Island. It will also increase the cost of health care paid by self-funded employers for their employees' health care benefits, including Rhode Island's cities and towns and state government. Given the significant role of employers in the provision of health insurance in our society, it may be tempting to draw the inference that employers will simply absorb these additional costs. However, the economics literature consistently finds that individuals and families ultimately bear the costs of higher health care prices and higher premiums. I find a quote from economist Martin Gaynor, an expert on health care markets and competition, to be a compelling summary of the literature. Professor Gaynor stated:

> "[T]he burden of higher provider prices falls on individuals, not insurers or employers .... Insurers facing higher provider prices increase their premiums to employers. Employers then pass those increased premiums on to their workers, either in the form of lower wages (or smaller wage increases) or reduced benefits (greater premium sharing, greater cost sharing, or less extensive coverage) .... Employers may also respond to these increases in their costs of employing workers by reducing workers' hours or the number of workers."[1]

Rhode Islanders rely on their wages to pay for housing, utilities, food, childcare, transportation, and to build their personal wealth.[2] The burden of increasing costs will fall more heavily on lower wage workers, small businesses, and individuals and families with significant health care needs. Considering the findings from the economics literature I will observe that median household income in Rhode Island is lower than median household income in Connecticut and Massachusetts by approximately 14% (see Attachment 2).[3] Through the regional rate parity framework, Rhode Islanders would have to pay health care prices locally that reflect prices in the Connecticut and Massachusetts markets for a broad set of services, but with lower incomes to meet these higher expenses. This begs the question: What do we know about the burden of health care costs in neighboring states?

Looking to Massachusetts, just last week (March 14th), the Massachusetts Center for Health Information and Analysis (CHIA) issued its Annual Report on the Performance of the Massachusetts Health Care System.[4] In a new chapter on affordability, the CHIA wrote: "Massachusetts residents face growing health care affordability concerns due to rising health care costs, increased demand for health care

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[1] Professor Gaynor's quote is provided as reproduced in Attorney General Neronha's Decision Denying the Merger Application of Lifespan and Care New England, p.45. The source document is testimony provided before the United States Senate Committee on the Judiciary, Subcommittee on Competition Policy, Antitrust, and Consumer Rights. See Statement before the Committee on the Judiciary Subcommittee on Competition Policy, Antitrust, and Consumer Rights U.S. Senate, May 2021, p. 6, which includes citations to the literature.

[2] In recent months OHIC has issued short briefs on the economics literature. See Attachment 3 and Attachment 4.

[3] This is based on a 5-year average of the difference in Rhode Island median household income to the average of median household income in Connecticut and Massachusetts. Data are from the U.S. Census Bureau and compiled by the Federal Reserve Bank of St. Louis.

[4] Annual Report on the Performance of the Massachusetts Health Care System, March 2024.

services, and growing enrollment in high deductible health plans (HDHPs)."[5] A key finding in this year's report reads:

> "In 2021, over four in 10 Massachusetts residents reported experiencing health care affordability issues in the past 12 months, and more than half of Black and Hispanic residents reported affordability issues (e.g., problems paying medical bills or forgoing needed health care due to cost)."[6]

The Health Policy Commission, the health regulator established to keep health care costs in Massachusetts in check, issued a press release on March 14th with the headline: *State Leaders Grapple with Rising Health Care Costs and Affordability Challenges*.[7] In reference to the report, the press release read: the "findings confirm the concerning trends that the [Health Policy Commission] has identified in recent reports – health care costs are rising at a pace inconsistent with wage growth and are increasingly unaffordable for Massachusetts residents."

In Connecticut, a 2022 survey by Altarum found that 55% of respondents reported at least one health care affordability burden in the past year, and nearly 4 in 5 worried about affording health care in the future.[8]

OHIC suggests a far more targeted approach that also accounts for recent state and federal payment changes that have and will continue to provide financial support to Rhode Island's provider systems. These include Governor McKee's new Medicaid State Directed Payment Program for hospitals, which was authorized by the General Assembly in the FY 2024 budget, and materially increases Medicaid funding for hospitals, the reinstatement of the Medicare imputed rural floor by Congress in 2021, the OHIC-mandated inpatient rate adjustment for lower reimbursed hospitals in 2020, and the expected implementation of the Medicaid rate increases proposed in Governor McKee's FY 2025 budget following the OHIC rate review.

In addition to the concerns raised above, I would like to comment on the amendments to § 42-14.5-2., OHIC's statutory purposes. Under existing law, "the health insurance commissioner shall discharge the powers and duties of office to: … protect the interests of consumers." Current law supports a broad interpretation of "the interests of consumers" to conform to the complexity of the health care environment.

As presently written, S2722 explicitly defines "interests" to mean "high quality, accessible, safe and contemporary health systems situated with substantially similar providers, facilities and digital systems of coordination." OHIC understands the term "health systems" to mean corporate entities comprising brick and mortar facilities (hospitals, ambulatory care centers, physician practices, etc.), networks of

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[5] Annual Report on the Performance of the Massachusetts Health Care System, March 2024, p. 47.
[6] Annual Report on the Performance of the Massachusetts Health Care System, March 2024, p. 46.
[7] https://www.mass.gov/news/state-leaders-grapple-with-rising-health-care-costs-and-affordability-challenges
[8] https://www.healthcarevaluehub.org/application/files/1816/6610/6517/Hub-Altarum_Data_Brief_No._133_-_Connecticut_Healthcare_Affordability.pdf

clinicians, and health information technology infrastructure. Excluded from this conception of interests are affordable health care, access to covered benefits, protection from deceptive marketing practices, etc. As presently written, S2722 limits the construction of the "interests of consumers" relative to the broad construction that OHIC employs to support regulatory decisions, set regulatory standards for commercial health insurers, and perform ongoing oversight of insurer market conduct today.

Finally, 2722 sets forth a host of reasonable objectives, including guarding the solvency of provider systems and advancing health equity. However, the legislation does not assign powers to OHIC sufficient to validate that these objectives are being achieved.

Thank you for your continued leadership and hard work on all matters related to the health of Rhode Islanders.

Sincerely,

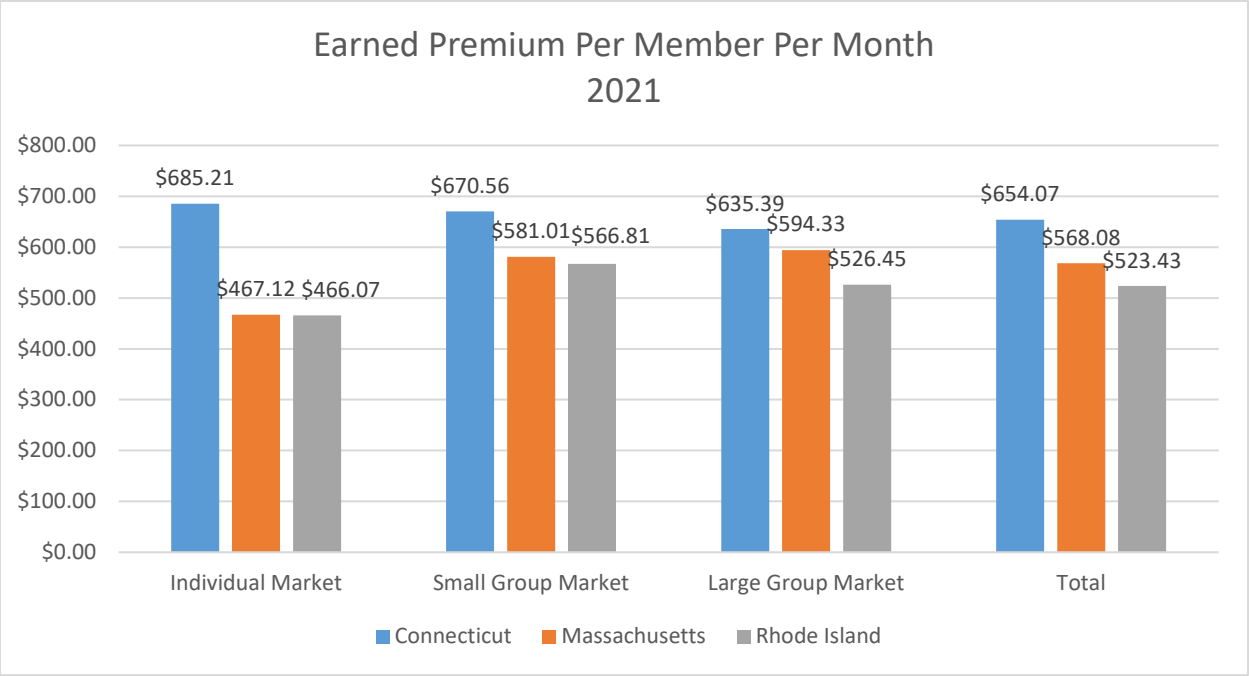
Cory B. King
Acting Health Insurance Commissioner

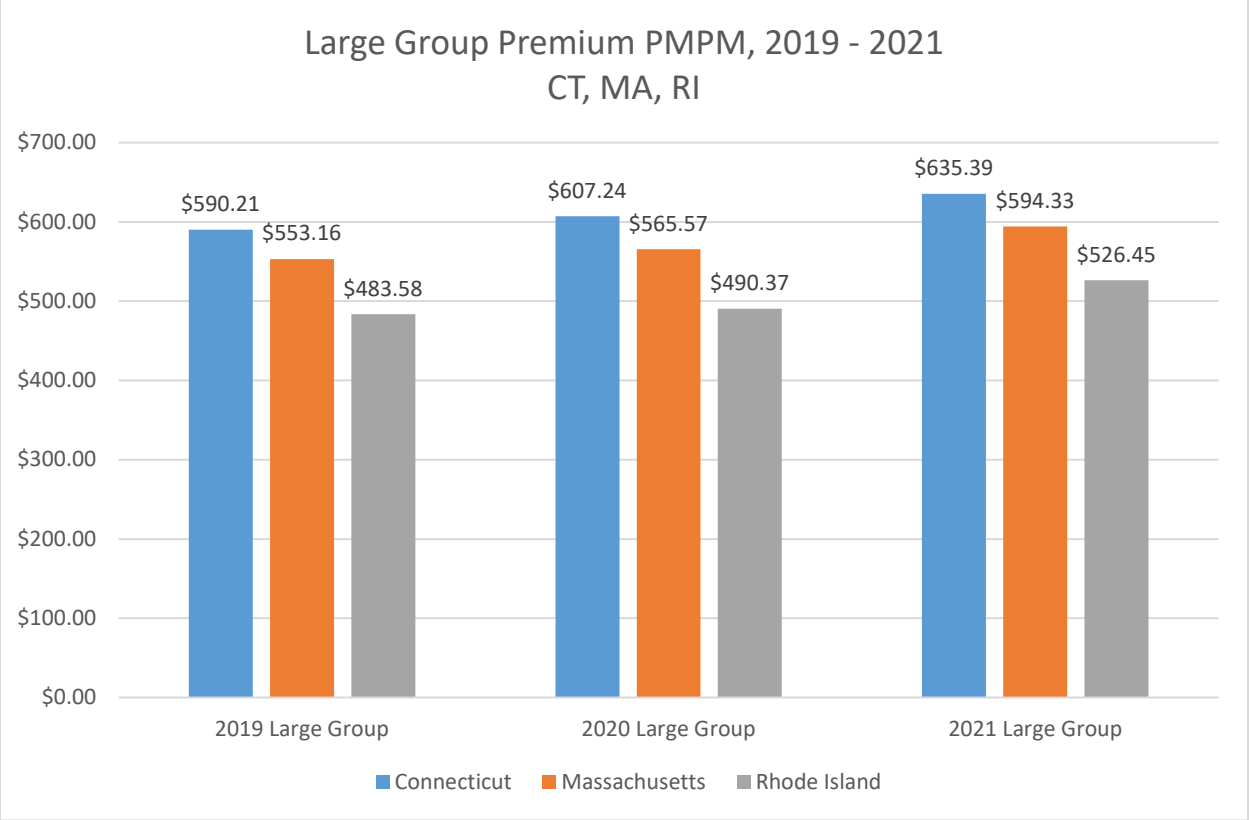
CC: The Honorable Members of the Senate Committee on Health and Human Services
Honorable V. Susan Sosnowski
Kristen Silvia, Director of Legislation and Deputy Chief of Staff

Attachments:

Attachment 1: Earned Premium Per Member Per Month for CT, MA, RI.
Attachment 2: Median Household Income for CT, MA, RI.
Attachment 3: Data Story: As Health Care Costs Rise, Employee Wage Growth Declines.
Attachment 4: New Research: More Evidence That Rising Health Care Costs Crowd Out Wage Growth.

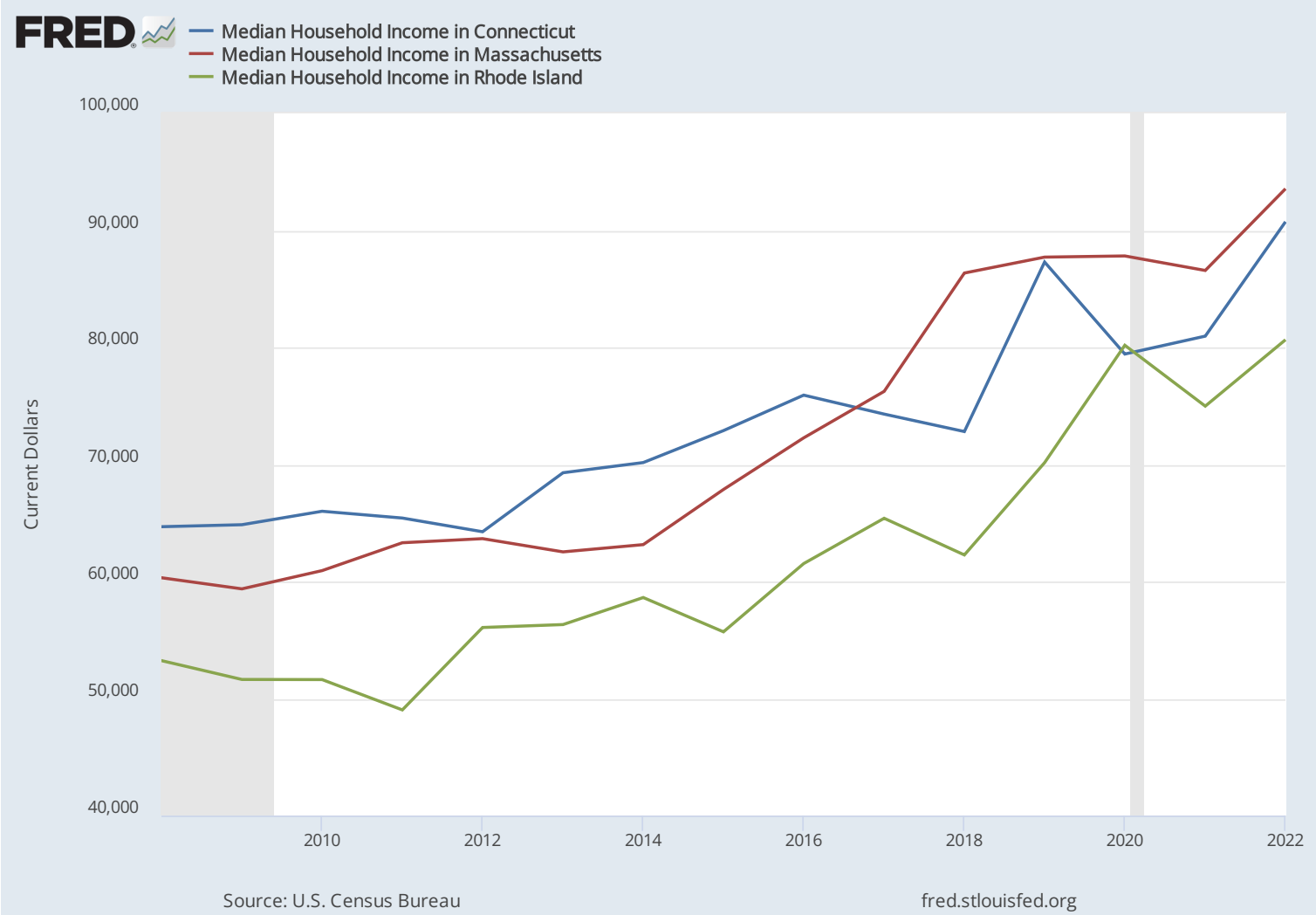
Earned Premium Per Member Per Month (PMPM): CT, MA, RI





Source: Federal Medical Loss Ratio Filings. Data summarized by Oliver Wyman at the request of OHIC.

Notes: Massachusetts merges its individual and small group markets for rating.


FRED
Median Household Income in Connecticut
Median Household Income in Massachusetts
Median Household Income in Rhode Island
100,000
90,000
80,000
70,000
60,000
50,000
40,000
Current Dollars
2010
2012
2014
2016
2018
2020
2022
Source: U.S. Census Bureau
fred.stlouisfed.org

STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

As Health Care Costs Rise, Employee Wage Growth Declines

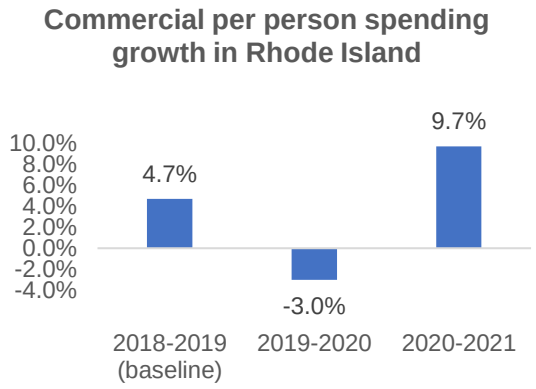
The Problem

Consumers and employers face growing health care costs in Rhode Island.

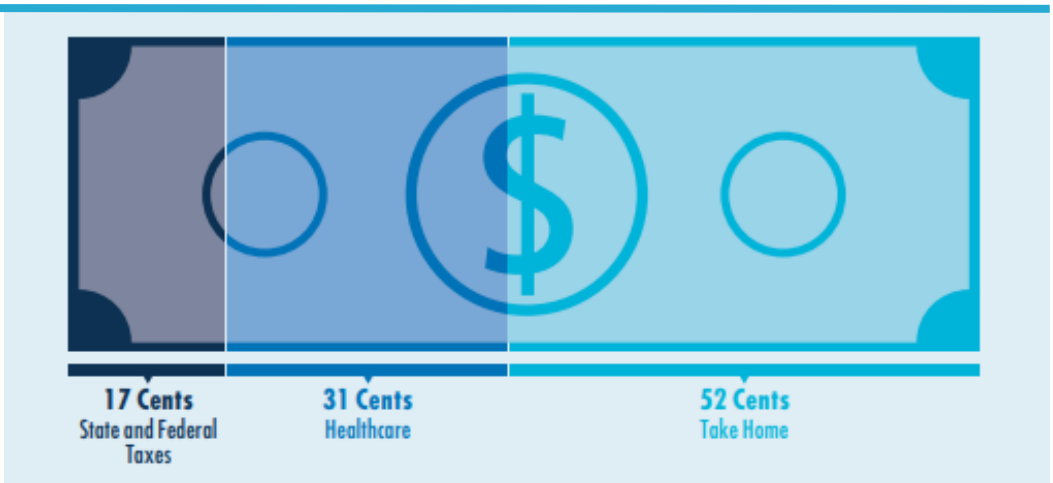
- In 2019, the state established its annual cost growth target of 3.2%.
- Commercial health care spending growth has exceeded the target two out of three years since it was established.
- Commercial spending per person grew nearly 10% from 2020 to 2021.[1]
- When Rhode Island met its target for commercial spending growth in 2020, it was only because of reduced health care utilization and spending due to the pandemic.[2]

Health care in Rhode Island is very expensive.

- In 2022, the average health insurance premium for a family plan was $22,955 in Rhode Island[3] – nearly the average cost of a new compact car ($23,839).[4]



According to a household survey from 2022, too many Rhode Island families reported problems paying their medical bills, being unable to pay for necessities like food or rent and using up savings to pay for medical bills.[5]



An estimated 31 cents of each additional dollar earned by Rhode Island families between 2017 and 2019 went to health care.

This includes the employer's share of the premium, the employee's share of the premium, and estimates of out of pocket payments for deductibles, copays, and coinsurance.

Why This Matters

High and rising commercial health care costs reduce employee wage growth.

- Employers and employees split the cost of health insurance.
- Employers have a finite pool of money to fund both health insurance and wages.
- As health care spending goes up, there is less money available for cash compensation increases.[6]

High and rising health care costs reduce available income for household use.

- As a result of rising premiums and cost sharing, an estimated 31 cents of each additional dollar earned by RI families between 2017 and 2019 went to health care costs.[7]
- The average family deductible has quadrupled in the last 20 years.[8]
- Rising health care costs take money out of Rhode Islander's paychecks and pocketbooks.

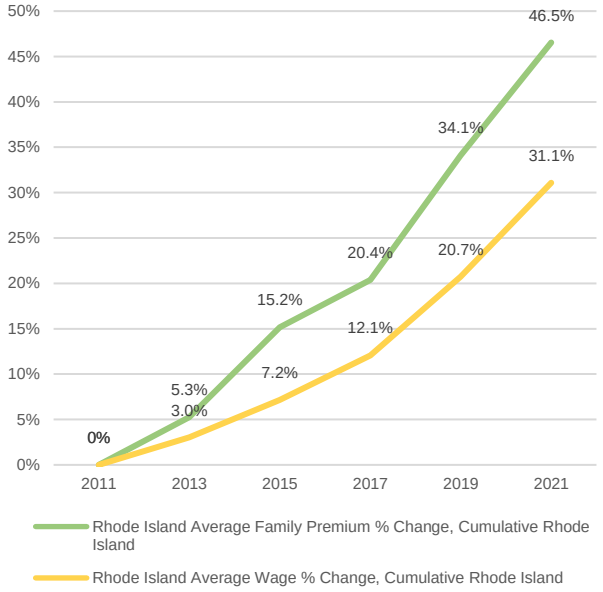
Rhode Islanders are unable to access necessary care.

- Many state residents cannot afford large out-of-pocket medical expenses, so they defer, or worse, avoid necessary care.

OHIC Tracks Spending Growth

We cannot improve what we cannot measure. In 2022, the Rhode Island Office of the Health Insurance Commissioner established the Health Spending Accountability and Transparency Program to improve affordability and facilitate access to high-quality care for all Rhode Islanders. OHIC measures health care spending against the state's cost growth target and is currently analyzing data for the 2021-2022 reporting cycle. OHIC will report its findings and policy recommendations in the spring of 2024.

Cumulative Average Family Premium and Wage Growth[9] in Rhode Island, 2011 - 2021



Health insurance premiums have outpaced wage growth over the last decade.

Rhode Islanders rely on wages to fund housing, food, utilities, childcare, transportation, and build their personal wealth.

Recent research shows that rising health care costs reduce employee wage growth and push greater cost sharing onto workers.[10]

References

1. Annual Report: Health Care Spending and Quality in Rhode Island. Office of the Health Insurance Commissioner (2023).
2. Rhode Island Health Care Cost Trends Steering Committee. March 29, 2022.
3. https://datatools.ahrq.gov/meps-ic/?tab=private-sector-state&dash=26
4. https://www.iseecars.com/affordable/affordable-small-cars#:~:text=The%20average%20starting%20price%20for,the%20ranking%20of%20each%20vehicle
5. https://healthsourceri.com/surveys-and-reports/
6. Congressional Budget Office (2022), p.9 and https://www.rand.org/pubs/working_papers/WRA621-2.html
7. Allocation of the increase in monthly compensation between 2017 and 2019 for a median income Rhode Island family with employer-sponsored insurance. See Exhibit 1.2, p. 6 of the Annual Report: Health Care Spending and Quality in Rhode Island.
8. https://datatools.ahrq.gov/meps-ic?tab=private-sector-state&dash=27
9. Average Annual Wages (All Occupations) by State. Data from Occupational Employment and Wage Statistics (OEWS) Survey Data, State XLSX Files
10. See footnote 6.

Learn More about OHIC at www.ohic.ri.gov

STATE OF RHODE ISLAND
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Department of Business Regulation

The Rhode Island Office of the Health Insurance Commissioner (OHIC) was established through legislation in 2004 to broaden the accountability of health insurers operating in Rhode Island. The Office is dedicated to: protecting consumers, encouraging fair treatment of medical service providers, ensuring solvency of health insurers, and improving the health care system's quality, accessibility, and affordability.

STATE OF RHODE ISLAND
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New Research: More Evidence That Rising Health Care Costs Crowd Out Wage Growth

The Research

A recent study published in JAMA Network Open examined the association of increasing health care premium costs with earnings inequality and wage stagnation among US families with employer sponsored health insurance (ESI).

Key Findings[1]

- "Our analysis suggests that increasing health insurance premium costs were associated with decreased annual wages and increased earnings inequality by race and ethnicity and wage level and were likely associated with meaningful wage stagnation among US families receiving [employer-sponsored insurance] ESI."
- "Black and Hispanic families with ESI lost a higher percentage of their wages than White families with ESI to increasing health care premiums. By 2019, health care premiums as a percentage of compensation were 19.2% for Black families and 19.8% for Hispanic families, while they were only 13.8% for White families."
- "Our results depict the hidden costs of increasing health insurance premiums for the US worker: less opportunity for wage growth and a heavier burden of health insurance premiums on lower-paid workers and on Black and Hispanic workers."
- "Our analysis does not account for increasing personal deductibles and other out-of-pocket medical expenses; thus, our findings likely underestimate the full negative association of increasing health care costs with economic disparities by race and ethnicity and wage level."

Original Investigation | Health Policy

January 16, 2024

Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families

Kurt Hager, PhD, MS ; Ezekiel Emanuel, MD, PhD ; Dariush Mozaffarian, MD, DrPH

JAMA Netw Open. 2024;7(1):e2351644. doi:10.1001/jamanetworkopen.2023.51644

Why Do Premiums Increase?

The key driver of premium increases is the **cost of health care**: the **quantity** of health care goods and services provided and the **prices** of those goods and services.

Why This Research Matters

ESI is the predominant form of insurance coverage in Rhode Island.

- Over 50% of Rhode Islanders are insured through their employer.[2]
- Most Rhode Islanders with ESI are covered by a self-insured employer. These typically include large private firms and state and municipal government plans.[3]
- The balance of Rhode Islanders with ESI are covered through fully insured small employer and large employer plans.

High and rising health care costs reduce available income for household use.

- As a result of rising premiums and cost sharing Rhode Islanders have less income to spend on housing, education, and necessities.
- Rising health care costs may worsen inequities in society.

Key Takeaways from OHIC

Rising commercial health care costs, and rising premiums, pose significant tradeoffs for employers, families, and policymakers.

- Rhode Island must remain committed to strategies that control health care cost growth, while supporting needed investments in primary care and behavioral health care.
- Rhode Island has strengths that other states lack, including an all-payer cost growth target and robust policies to protect consumers from rapidly escalating prices in a *highly concentrated* market for inpatient general acute care services.[4]
- Transparency into the drivers of health care spending growth and accountability for spending growth are critical to ensure access to affordable health care.

What is the difference between self-insured employer coverage and fully insured employer coverage?

A self-insured employer bears the risk of paying the medical and pharmacy claims of their employees. This is different than a fully insured employer, who transfers this risk to a health insurance company in exchange for paying a premium. While self-insurance is commonly associated with large private employers, self-insured plans also cover most of Rhode Island's public servants, including teachers, firefighters, and other municipal and state government workers. Self-insured employer plans are not subject to state insurance regulation even though they cover the majority of Rhode Islanders with employer-sponsored health insurance coverage. This means that OHIC does not conduct rate review for self-insured plans and does not review their plan designs. Self-insured employers commonly utilize private health insurers to administer their plans, which includes processing claims, managing utilization review, contracting with provider networks, and negotiating reimbursement rates with providers on the employer's behalf. Reimbursement rates, or "prices," are key drivers of total health care expenditures. As prices increase, health care costs increase, and these increases affect self-insured employers and their employees as much as they affect fully insured employers and their employees.

References

1. Hager K, Emanuel E, Mozaffarian D. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association with Earnings Inequality Among US Families. JAMA Netw Open. 2024;7(1):e2351644. doi:10.1001/jamanetworkopen.2023.51644
2. https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
3. OHIC estimates that approximately 60% of Rhode Islanders with ESI are covered through self-insured employers. This is based on reporting from Rhode Islands four largest health insurers.
4. Plum, Kevin, Competitive Effects Analysis of Lifespan's Proposed Acquisition of Care New England. February 13, 2022., p. 57. Dr. Plum's structural analysis of the market for inpatient general acute care concluded that the Rhode Island market is highly concentrated.

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