

AG Exhibit 1

Consumer and Economic Report: Neighborhood Health Plan of Rhode Island

Researched and authored by Christopher Whaley, Ph.D.

Thank you for the opportunity to provide comments in this proceeding. My name is Christopher Whaley. I am trained as a health economist and am an Associate Professor of Health Services and Policy Analysis at the Brown University School of Public Health. I received my PhD in Health Services and Policy analysis from the University of California, Berkeley. My comments are delivered in my personal capacity as an expert on US health care markets and financing. My research focuses on US health care markets and the impacts of health care spending on patient access to care and finances. I have published over 125 peer-reviewed publications and testified before state and Congressional bodies on these topics.

I have been asked by the Rhode Island Attorney General's Office to provide comments on Neighborhood Health Plan of Rhode Island's (NHPRI) proposed premium increases as a part of Rhode Island Office of the Health Insurance Commissioner's Rate Review process. The Attorney General's Office has the responsibility to "represent, protect, and advocate the rights of the consumers" in the rate review process.¹ NHPRI has requested a weighted average premium increase of 24.9%. This requested premium increase is substantially higher than historical premium growth and medical inflation trends, and also follows a 20% increase in Neighborhood premiums in 2026. Reasons for the requested increase include expiration of the Affordable Care Act's (ACA's) premium tax credits, increased utilization trends, and increased inflationary trends.

¹ Source: R.I. Gen. Laws § 27-36-1

However, as I discuss in my report, the requested rate will put undue burden on Rhode Islanders and will cause direct harm to Rhode Island consumers. The requested rate will likely also destabilize the Rhode Island individual health insurance market. It also rests on several sources of misunderstanding. My report identifies several areas, including provider reimbursement and newly-enacted Rhode Island subsidies, that can decrease the requested rate. I also highlight several places where the assumptions that underlie the requested rate rely on faulty assumptions or incomplete data. As I also highlight, the requested rate is indicative of the need for potential broader reforms to the Rhode Island health care marketplace. If such rates are to be approved, the stability of the health insurance market in Rhode Island will be harmed. The magnitude of the proposed rate increase will cause harm to Rhode Island consumers and their ability to purchase affordable health insurance coverage.

I. Health Expenses Have a Growing Economic Impact on Consumers

In Rhode Island, the average cost of an average benchmark plan on the Marketplace Exchange is over \$6,000.² With the requested premium increase, the benchmark premium paid by Rhode Island families will increase to \$7,584. These costs equate to over 10 percent of median income among Rhode Island workers, assuming full labor force participation.³ These costs are acute for both households above 400% of Federal Poverty Line limits, due to a lack of premium or cost-sharing subsidies, and for lower-income families, who have fewer resources to afford coverage (even after taking

² Source: <https://www.kff.org/affordable-care-act/state-indicator/average-marketplace-premiums-by-metal-tier/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

³ Source: <https://www2.census.gov/library/publications/2024/demo/p60-282.pdf>, Figure 4 inflated to 2025 dollars using the growth rates in weekly earnings: Assuming 2,080 annual work hours.

account of subsidies). These costs also do not account for household expenses for deductible or out-of-pocket cost-sharing payments. Because NHPRI is currently the lowest-cost health insurance option in Rhode Island, the cumulative premium increase will disproportionately impact lower-income Rhode Islanders.

Critically for Rhode Island families, the requested premium increase is not just a single-year increase in household expenses. Rather, it is compounded by the 20% increase in Neighborhood premiums last year. For a Rhode Islander with continuous enrollment in a Neighborhood insurance product, the cumulative impact of these rate increases is approximately 50%. These costs further strain household expenses and create an acute health care affordability crisis in Rhode Island.

NHPRI's requested rate increases far exceed medical inflation. Medical inflation data is collected and reported by the Bureau of Labor Statistics (BLS) to measure the costs of health care, including insurance premiums, prescription drugs, medical care services, and professional services.⁴ Medical inflation provides an insight into the overall changes in health care goods and services, and is specific to the health care sector, unlike general inflation measures.

The BLS estimates that recent, 2025, medical inflation was 3.2%.⁵ Over the 2020-2026 period, medical inflation has increased by 15%.⁶ Yet, Neighborhood premiums have increased by 52% over this period (**Figure 1**).⁷ Particularly over the most recent two years, Neighborhood rates have sharply diverged from medical inflation. With the

⁴ Source and more details: <https://www.bls.gov/cpi/factsheets/medical-care.htm>

⁵ Source: Bureau of Labor Statistics. <https://www.bls.gov/opub/ted/2026/consumer-price-index-2025-in-review.htm>

⁶ Medical inflation data pulled from Federal Reserve Bank of St. Louis FRED data, Consumer Price Index for All Urban Consumers: Medical Care in U.S. City Average: <https://fred.stlouisfed.org/series/CPIMEDSL>.

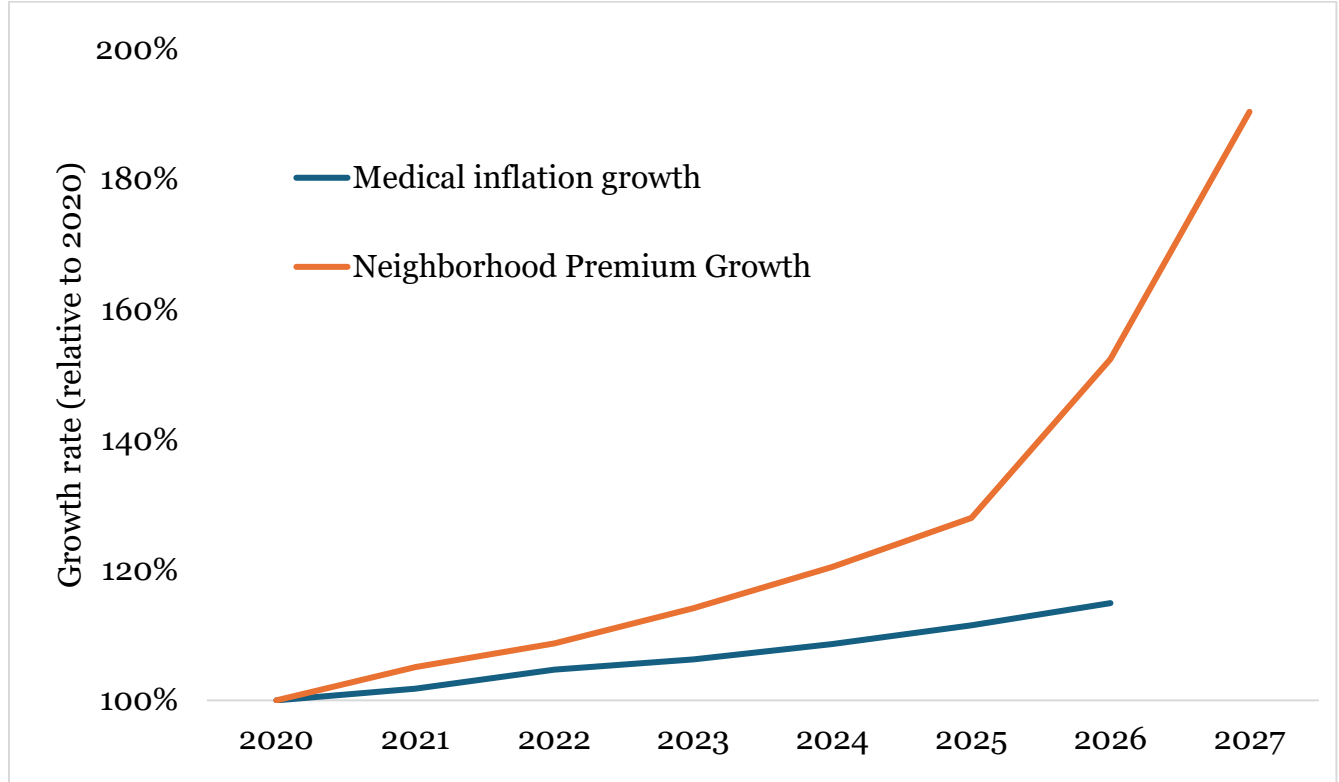
⁷ For Neighborhood consumer premiums, I use the Rhode Island Benchmark premium.

requested rate, Neighborhood's premiums will have increased by nearly 50% over the 2026-2027 period. In comparison, over the entire 2020-2025 period, premiums increased by 22%. This premium growth over just the 2026-2027 period exceeds premium growth over the entire 2020-2025 period by over 120%. Particularly in the last two years, these rates are increasingly disconnected from changes in the underlying costs of providing and covering the costs of care. Relative to 2024, medical inflation increased by 5.8%, compared to a 26.5% increase in Neighborhood's consumer premiums. Thus, over just this two-year period, Neighborhood's premium growth exceeded national medical inflation growth by 359%. When using medical claims expenses, Neighborhood's incurred claim expenses increased by 22% over the 2023-2025 period, while 2026-2027 premiums have increased by 51%, a 230% difference.⁸ Thus, regardless of the measure, Neighborhood's recent premium increases are increasingly disconnected from the underlying costs of medical care.

If Neighborhood premiums kept pace with medical inflation, they would be 25% (\$124 per month) lower in 2026. Using a projected medical inflation rate of 2.9% in 2027, the requested 2027 premium would be 38% (\$241) lower. As discussed below, innovative policies, such as the Colorado Public Option limit Exchange product insurance growth to medical inflation rates.

⁸ Source: June 29, 2026 communication. Page 4.

Figure 1: Growth in Neighborhood Health Insurance Premiums Compared to Medical Inflation Trends



Source: Medical inflation data from the BLS and Rhode Island benchmark premium rates.

This doubling of insurance premium costs in just two years is economically harmful for Rhode Islanders, who are legally required to have insurance coverage. Rhode Islanders without insurance are required to pay a tax penalty of the maximum of approximately \$700 or 2.5% of net income above the Rhode Island tax threshold.⁹ This large increase in costs will force many Rhode Island families to weigh insurance coverage and affording household expenses. Given the order-of-magnitude difference between the tax penalty and premiums, it is likely that many Rhode Island families will elect to forgo insurance coverage.

⁹ Source: <https://healthsourceri.com/mandate/#>

This dynamic further threatens the stability of health insurance markets in Rhode Island. The Rhode Islanders who elect to forgo insurance coverage are likely those with lower expected health spending. Those who maintain coverage will likely have higher expected health spending needs. These enrollee selection challenges risk a “death spiral” that threatens the sustainability of the Rhode Island insurance market.¹⁰ Rather than further financially burden Rhode Islanders and potentially undermine the viability of the individual market in Rhode Island, it is critical for the Rhode Island policy and insurance systems to address structural issues that threaten health care affordability.

II. Contributors to Requested Rate Requests

NHPRI’s filing notes several sources that drive the 25% requested rate increase. The stated reasons for the requested rate are assessed below. I estimate that due to recent Rhode Island funding sources, Neighborhood’s requested premium can be reduced, although the magnitude of this impact is reliant on several sources of data collected by HealthSource RI. Additionally, the assumed increases in provider prices are due to a misunderstanding of the Rhode Island Affordability Standards. Additionally, the underlying trends in health care utilization are not sufficient to justify the projected 13.1% increase in inpatient utilization.

Increases in Provider Prices

Neighborhood references increased provider payment rates as a reason for its requested increase. NHPRI appears to rely on claimed increases in hospital costs, which

¹⁰ Cutler, David M., and Sarah J. Reber. 1998. “Paying for Health Insurance: The Trade-Off between Competition and Adverse Selection.” *The Quarterly Journal of Economics* 113 (2): 433–66. <https://doi.org/10.1162/003355398555649>. Cutler, David M., and Richard J. Zeckhauser. 2000. “Chapter 11 The Anatomy of Health Insurance.” In *Handbook of Health Economics*, edited by Anthony J. Culyer and Joseph P. Newhouse, 1, Part A:563–643. Elsevier. <http://www.sciencedirect.com/science/article/pii/S1574006400801705>.

Neighborhood attributes to the Rhode Island Affordability Standards. NHPRI's Consumer Narrative states that "[t]he key drivers of this rate change ... are an increase in medical services costs driven by required hospital rate increases tied to inflation."¹¹ Neighborhood further clarified that its hospital contracts include an inflation adjustment of CPI-U +1%. [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

¹¹ Source: Neighborhood Health Plan of Rhode Island. Individual Market Products Part II, Consumer Narrative Justification. Page 1

[REDACTED]

These statements and contracting behavior appear to be a fundamental misunderstanding of the Rhode Island Affordability Standards, which requires Office of the Health Insurance Commissioner approval if a rate increase is *greater than* CPI-U (less food and energy) plus 1%.¹² It does not require the insurer to automatically increase payment rates at CPI-U + 1 on an annual basis. [REDACTED]

[REDACTED]

[REDACTED] In the face of a nearly 25% premium rate increase, applying common managed care cost-containment strategies, such as negotiating favorable rates or selectively contracting to obtain reimbursement discounts, may be warranted as a cost-control strategy. Such strategies are a core component of common insurer administrative expenses.

Neighborhood also states that provider price increases are driven by provider consolidation (e.g., merger and acquisition activity).¹³ Many economic studies document increases in prices following consolidation as a result of increased provider negotiation leverage with commercial insurers (Richards and Whaley 2026). Neighborhood notes that 78% of covered inpatient discharges are from consolidated health systems, which “command higher negotiated rates, and recent merger activity has further reduced

¹² Source: 230-RICR-20-30-4. TITLE 230 – DEPARTMENT OF BUSINESS REGULATION. PART 4 – Powers and Duties of the Office of the Health Insurance Commissioner.

¹³ Source: June 9, 2026 Response Document. Page 17.

NHPRI's bargaining leverage." [REDACTED]

[REDACTED]

[REDACTED] it is unclear how merger-induced changes in bargaining leverage will change negotiation outcomes. Further, the Rhode Island Affordability Standards limit any rate increases to an exogenous benchmark (CPI-U +1%), which further limits the payment impacts of increased negotiation leverage obtained through consolidation activity.

Additionally, price increases require new contracts with increased rates. In documents provided by Neighborhood, nearly all of their major provider contracts were negotiated in March 2026 and are set past 2027. Additionally, the Rhode Island Affordability Standards by nature limit the amount that consolidation activity can increase prices.

Changes in Enrollment and Composition

Following the removal of federal subsidies, Exchange enrollment decreased in Rhode Island and other states. A second impact is an increase of enrollees purchasing lower-cost Bronze insurance plans. At the same time, approximately 870 enrollees switched from BCBS Rhode Island to Neighborhood health plans.

A key component of enrollment changes are enrollee risk profiles. Neighborhood is unable to obtain consistent risk scores of enrollees and acknowledges that "its coding practices do not keep pace with the rest of the market."¹⁴ Due to NHPRI's reported under-coding of patient illness burden, Neighborhood's requested premiums are impacted through two different channels. First, Neighborhood is a reinsurance payee to the other

¹⁴ June 23, 2026, Neighborhood response document, Page 4.

Rhode Island Exchange insurance plan. Second, Neighborhood's utilization and intensity trend is disproportionately increased, resulting in higher projected future utilization. While Neighborhood may face difficulties ensuring its contracted providers appropriately code enrollee illness burden, it is not appropriate to place the resulting financial burdens on Rhode Island consumers in the forms of consecutive premium increases excessive of 20%.

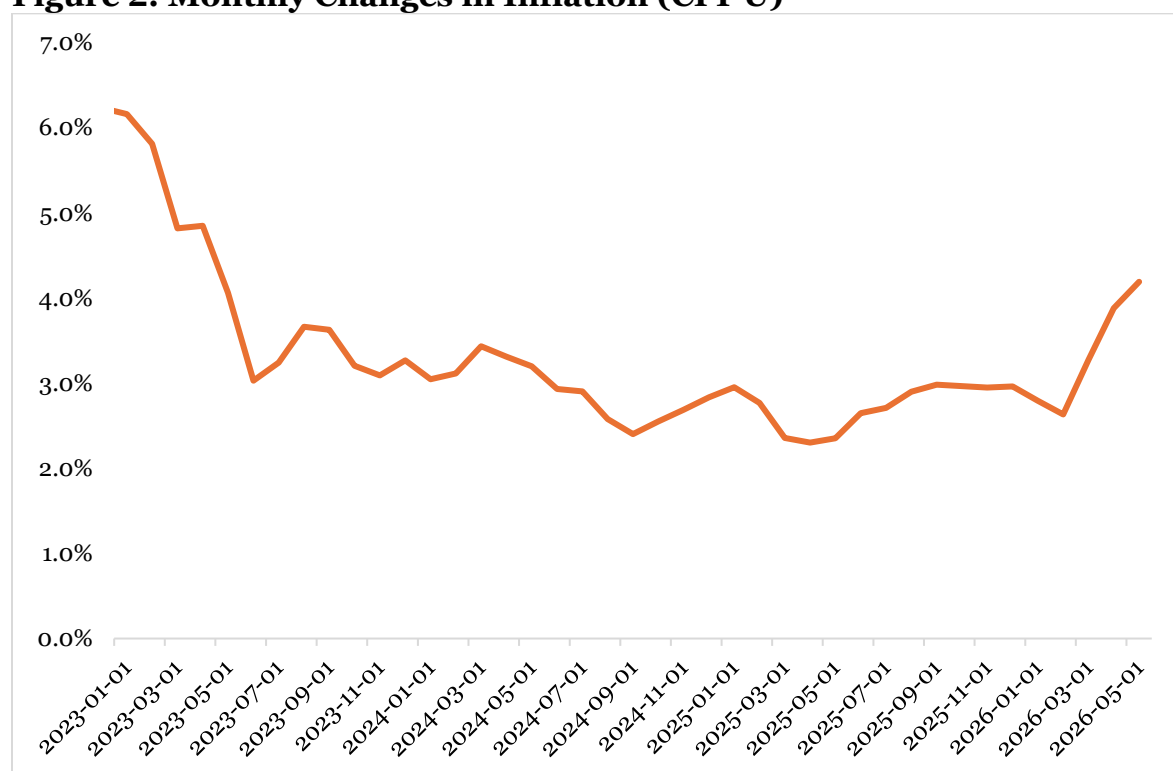
General Inflation

Neighborhood notes that the requested rate increase is influenced by inflation.¹⁵ While noted as a core reason for the request rate increase, inflation has been stable over the last few years and has receded from pandemic-era levels (Figure 2). General inflation is relevant for both overall operating costs and the Rhode Island hospital price cap policy, which limits non-ERISA commercial insurance prices for hospital care to an annual increase of CPI-U + 1%. Core CPI-U was 4.2% over the 12-month period ending in May 2026.¹⁶ Overall inflation was driven by energy-sector inflation. CPI-U excluding energy and food items was lower, 2.9%, over this period. The health care sector is less impacted by energy inflation, and so should expect less of a general inflationary impact.

¹⁵ Source: Actuarial Memorandum, page 17

¹⁶ Source: Bureau of Labor Statistics <https://www.bls.gov/cpi/>

Figure 2: Monthly Changes in Inflation (CPI-U)

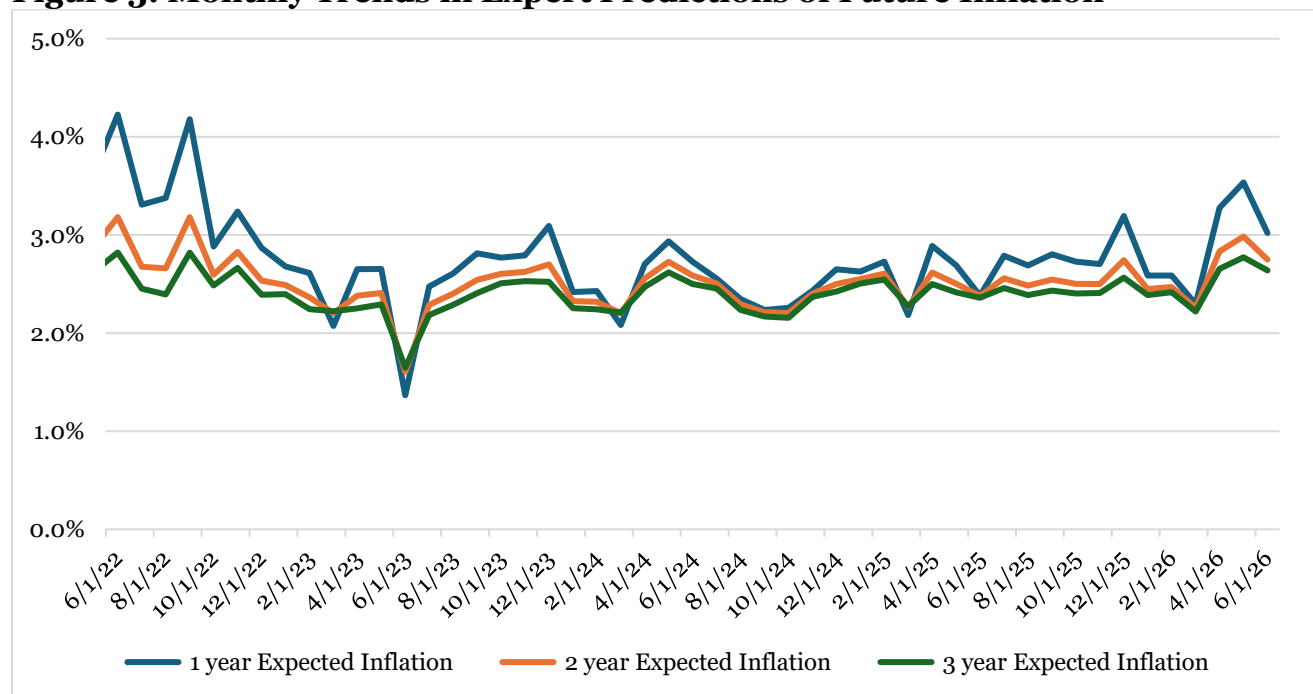


Note: Figure shows 12-month lagging inflation rates. October 2025 inflation numbers not reported due to the federal government shutdown.

These stable inflation trends are expected to continue. As highlighted in Figure 3, expert predictions of 1-, 2-, and 3-year expected inflation collected and reported by the Cleveland Federal Reserve Bank range from 3.1% to 2.7%.¹⁷ As additionally reported by the Federal Reserve Bank, the historical expectations have been similar to realized inflation and have also been stable over the last few years.

¹⁷ Source: <https://www.clevelandfed.org/indicators-and-data/inflation-expectations>

Figure 3: Monthly Trends in Expert Predictions of Future Inflation



Note: Figure shows trends in expert predictions of inflation obtained from the Cleveland Federal Reserve Bank's survey of inflation expectations.

Neighborhood's rate filing request notes that inflation is directly relevant to requested premiums due to its impacts on provider reimbursement. Neighborhood's consumer narrative states that rate increases are partially due to "increases in unit costs of medical services due to inflation."¹⁸ Yet, payer-provider rates are most commonly established contractually and apply over a longer time period and do not commonly directly apply inflation adjustments. Neighborhood also states that hospital reimbursement rates are statutorily indexed to inflation. Yet, as discussed above, this appears to mis-apply the Rhode Island hospital Affordability Standards, which use inflation rates as a payment *limit* rather than as a payment *floor*.

¹⁸ Source: Individual market Consumer Narrative. Page 1.

The economic data do not support the levels of increased inflation that would contribute to a 25% increase in insurance premiums. Additionally, core inflation is not a direct component of a large portion of Neighborhood’s claim expenses. Where inflation is directly relevant, hospital prices, as discussed above, Neighborhood applies the statutory rate maximum, rather than negotiate favorable rates. NHPRI overestimates inflation, but even existing inflation estimates do not support the requested rate increase.

Utilization Trends

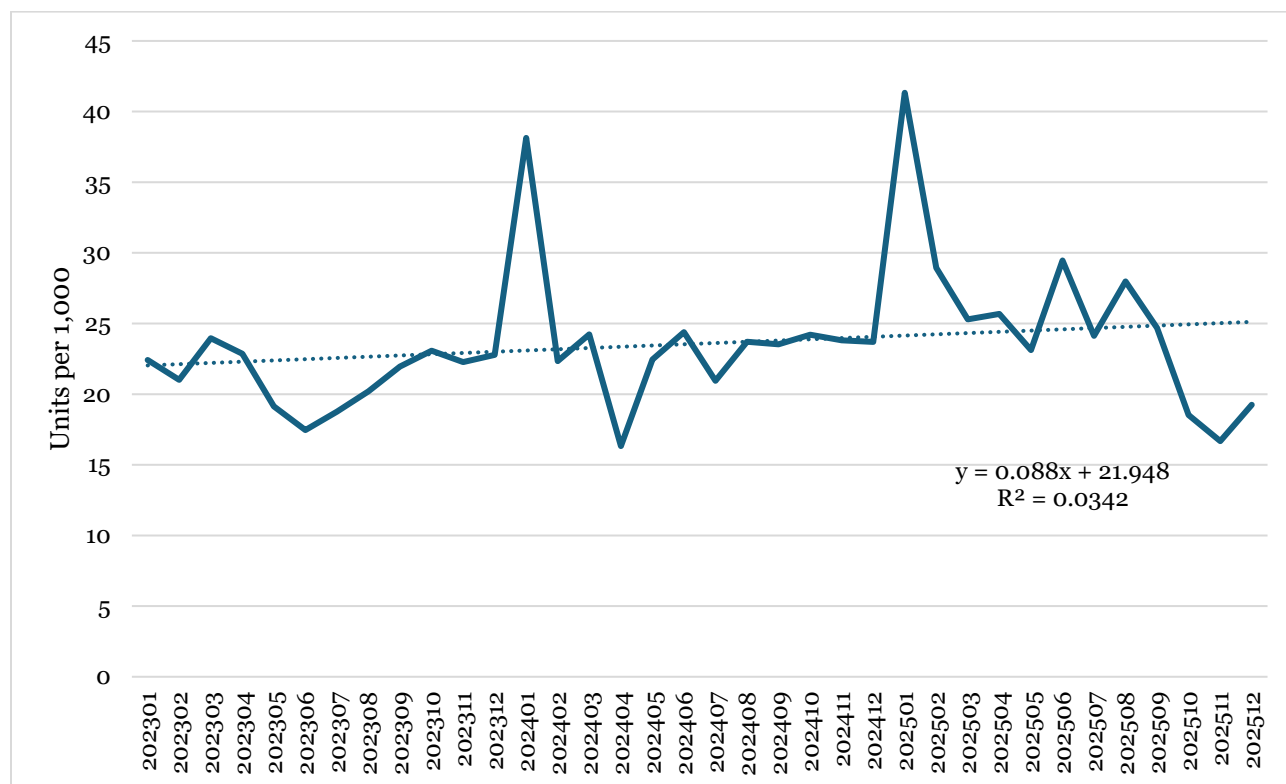
A related contributor to the requested rate increase is observed trends in utilization, particularly among inpatient services. Future inpatient trends are forecasted to be 13.1% on each subsequent year.¹⁹ These trends are based off of the claims and utilization experience over the 2023 to 2025 period. Yet, data during this period may reflect the residual impacts of delayed care during the COVID pandemic, which “rebounded” during this period. How the post-pandemic increase in claims volume is accounted for in regression modeling is not discussed.

Additionally, the underlying trends in inpatient utilization are less suggestive of a 13.1% annual increase in utilization. While the 13.1% projection is derived from a rolling average of monthly inpatient utilization trends over the 2024-2025 period, examining the underlying utilization trends over the supplied 2023-2025 period (the first few months of 2026 were provided but excluded to ensure claims run out) are less stark. Over this period, a linear regression (Figure 1) points to 0.088-per 1,000 increase in inpatient utilization. When applied to the 2023 mean of 21.3 and annualized over a 12-month period, this increase translates to an annual 5.0% increase in inpatient utilization per

¹⁹ Source: Actuarial Memorandum, Table 4.3.1

1,000 enrollees. The R-squared of this regression is 0.03, which further suggests poor model fit and limited predictive validity. Thus, the underlying trends in inpatient utilization are unstable and unlikely to increase by 13.1%, as projected.

Figure 4: Monthly Trends in Inpatient Utilization per 1,000 Enrollees



Additionally, when discussing utilization trends, Neighborhood again appears to mis-attribute the Rhode Island Affordability Standards. For both trends in inpatient and outpatient utilization, Neighborhood states, "We expect the actual cost trend to exceed the hospital cap and thus expect the hospital cap to apply." Yet, the Affordability Standards apply to reimbursement prices, and not utilization. Thus, the impact of the Affordability standards on utilization trends is not clear.

Primary Care Spending

Rhode Island individual and small-group insurers are required to spend 9% of total medical expenses on primary care provider (PCP) services, with a goal of reaching 10% by 2028. To help meet this goal, NHPRI waives cost-sharing for the first two PCP visits.²⁰ Neighborhood also plans additional marketing to increase PCP use. Yet, mechanisms, such as advertising, have much smaller impact on patient demand.²¹

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

Neighborhood attributes growing costs of specialty drugs as a contributor to future expense growth. Yet, Neighborhood also reports that use of lower-cost biosimilar drugs is approximately 95% for common treatments with an available biosimilar.²³ [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED] In contrast, adoption of biosimilars among other insurers is far lower

²⁰ Source: Actuarial Memorandum, Page 3

²¹ Alpert, Abby E., Atul Gupta, Michael R. Richards, Sarah D. Schutz, and Christopher M. Whaley. 2026. “Does Advertising Expand the Market for Hospital Services? Evidence from Medicare.” Working Paper No. 34657. Working Paper Series. National Bureau of Economic Research, January.

²² Source: $0.109 / 0.2 = 0.545$

²³ Source: June 23, 2026 response letter, page 4.

These factors help lower Neighborhood's exposure to rising specialty and administered drug costs.

Administrative Expenses

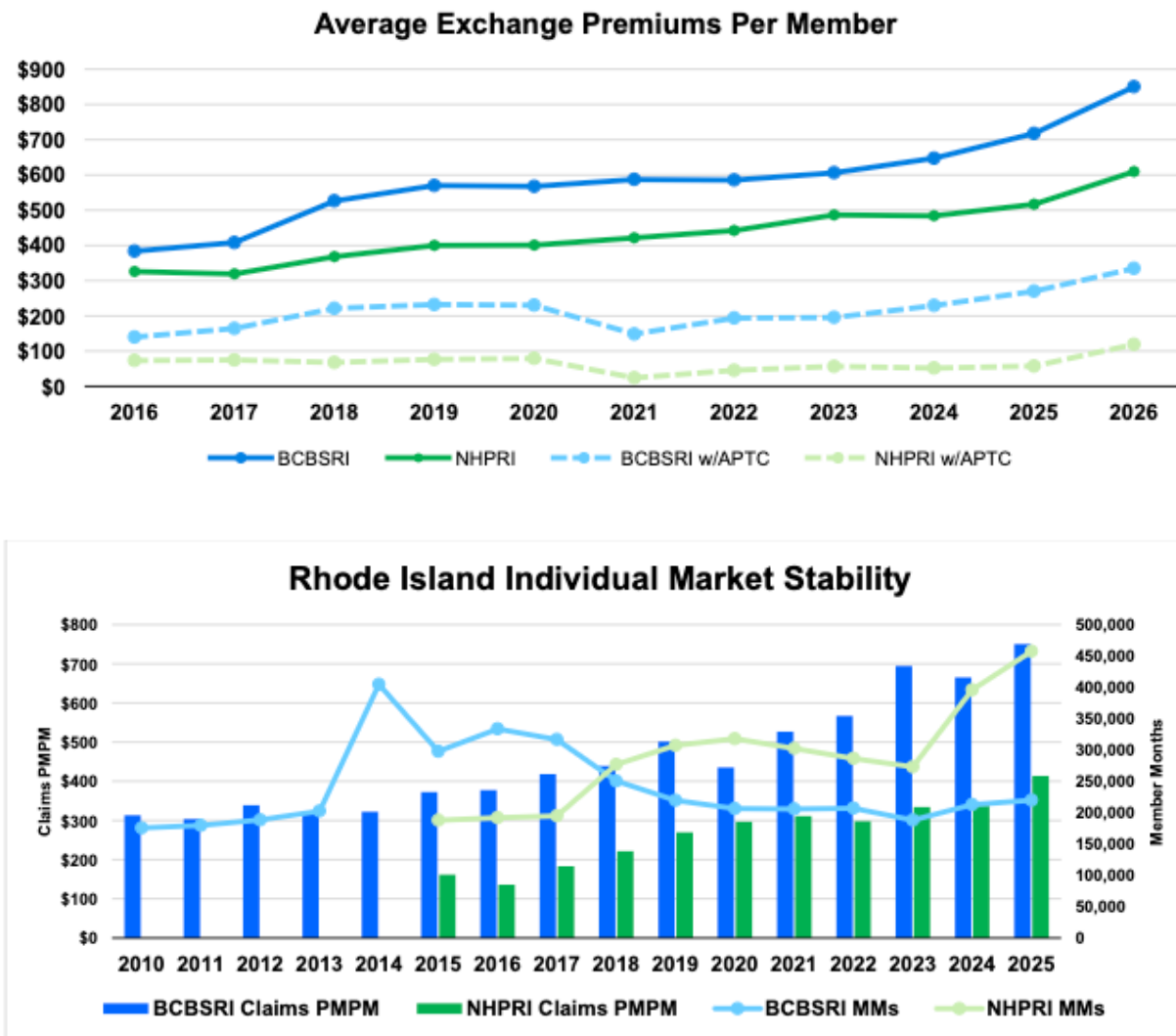
As with other insurers, administrative costs are passed along to insurance premiums. Neighborhood notes that small group premiums are expected to increase by nearly 26%.²⁵ Looking more broadly, it is clear that Neighborhood's premiums have outpaced claims expenses. Using data provided by Neighborhood, the 2025 average premiums per Exchange member was approximately \$500 per month, while the average claims PMPM was approximately \$415 (e.g., approximately \$85 absolute difference, 20% relative difference).

²⁴ Robinson, James C., Ari D. Kosorukov, and Christopher M. Whaley. 2026. "Hospital Adoption and Pricing for Oncology Biosimilars." *JAMA*.

Robinson, James C., Christopher Whaley, and Sanket S. Dhruva. 2024. "Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance." *New England Journal of Medicine* 390 (4): 338–45.

²⁵ Source: Actuarial Memorandum, Table 4.3.2

Table 5: Rhode Island Exchange Premiums and Claims Expense Trends



Note: Figures obtained from June 9, 2026, Milliman response letter.

While claim expenses are not the sole contributor to health insurance premiums, they are the largest factor. Particularly with multiple lines of insurance business (e.g., Exchange, Commercial, and Medicaid), it is important to ensure that Exchange plan expenses are not used to offset losses in other lines of business (e.g., Medicaid). Neighborhood reports lower than forecasted premium revenue from Medicaid

operations.²⁶ In the face of 25% premium increases among the individual market, it is unreasonable for Exchange consumers to offset losses on the Medicaid portion of Neighborhood's business. Doing so both harms Rhode Island consumers and threatens the stability of the individual insurance market in Rhode Island.

Changes in State and Federal Policies

A key change to Exchange plans nationwide is the expiration of the COVID-era enhanced Advanced Premium Tax Credits (APTCs), which reduced the costs of insurance for many exchange participants. Federal funding for APTCs expired at the end of 2025. Approximately 36,000 Rhode Island exchange enrollees received a APTC subsidy in 2025.²⁷ The increased costs of insurance can lead enrollees to forgo insurance coverage or select less generous plans.

Yet, the existing actuarial analysis of the impacts of subsidies is incomplete. In response to the decline in federal subsidies, Rhode Island intervened and partially restored APTC subsidies with a \$19 million fund allocated to provide premium assistance. To my knowledge, the impacts of this subsidy have not been accounted for in Neighborhood's rate request. Yet, the impacts of this additional source of funding are likely to reduce rates. The lower rates as a direct result are also likely to attract new insurance enrollees. If these additional enrollees are healthier, then premiums requirements will dynamically be lower.

²⁶ Source: Neighborhood Health Plan of RI Statement of Profit and Loss_2026 Forecast Updated with May 2026 YTD Actual.

²⁷ Source: CMS <https://www.cms.gov/files/document/effectuated-enrollment-early-snapshot-2025-and-full-year-2024-average.pdf>

III. Structural Reforms Needed to Improve Rhode Island Health Care Affordability

High requested premium increases are indicative of broader Rhode Island health care market challenges and threats to health care affordability for consumers. If the Rhode Island individual insurance market is to be maintained, there are urgent structural changes that must be applied to ensure both the ability of insurers to operate and the ability of Rhode Island consumers to purchase affordable health insurance.

While requested rate increases may appear to be a one-time impact to consumers, there exists the potential that without structural reform to health care markets in Rhode Island, these rate increases may become commonplace. This year represents the third consecutive year of Rhode Island insurance rate review hearings, which are required when requested rates exceed 10%. Additionally, if the current rate request of nearly 25% is due to the dis-enrollment impacts of the prior year's nearly 20% rate increase, it is very likely that these challenges will be exacerbated and that next year's rate increase will be of similar, or even higher, magnitude. If rates increase another 25% next year, it will represent an almost doubling of rates in just a 3-year period. Such a rate increase is both unsustainable for Rhode Island consumers and for the stability of the Rhode Island insurance market. Additionally, these rising costs will likely lead many Rhode Islanders to forgo insurance coverage. As a result, the requested premium is likely to reduce access to care, increase uninsurance, and place further strains on the Rhode Island delivery system.

In response to rising underlying health care costs, innovative insurers and purchasers have addressed high underlying health care costs through a variety of solutions. For example, several purchasers have implemented reference-based pricing

incentives to incentivize the use of lower-priced providers, yielding savings of approximately 20% for common services.²⁸ Other purchasers have used narrow or tiered network approaches to reduce spending by approximately 5%.²⁹ More recently, a variety of purchasers have limited hospital payment to a multiple of Medicare, reducing hospital-based spending by over 50%.³⁰

Other states have addressed underlying structural challenges in their health care markets through innovative approaches. One particular example comes from Vermont, which faced high premium growth, largely due to provider prices.³¹ Vermont policymakers responded by implementing a policy that limits the prices hospitals can charge commercial insurers to 200 percent of Medicare rates.³² My estimates suggest that this policy itself can reduce Vermont health care spending by over \$400 million.³³ Given the similar size and market dynamics, it is likely that savings in Rhode Island could be similar. Given differing market environments, a potential payment cap policy would require implementing a Rhode Island-specific payment cap. Other states have

²⁸ Robinson, James C., Timothy T. Brown, and Christopher Whaley. 2017. “Reference Pricing Changes The ‘Choice Architecture’ Of Health Care For Consumers.” *Health Affairs* 36 (3): 524–30.

²⁹ Gruber, Jonathan, and Robin McKnight. 2016. “Controlling Health Care Costs through Limited Network Insurance Plans: Evidence from Massachusetts State Employees.” *American Economic Journal: Economic Policy* 8 (2): 219–50.

Sinaiko, Anna D., Mary Beth Landrum, and Michael E. Chernew. 2017. “Enrollment In A Health Plan With A Tiered Provider Network Decreased Medical Spending By 5 Percent.” *Health Affairs (Project Hope)* 36 (5): 870–75.

³⁰ Murray, Roslyn C., and Christopher M. Whaley. 2026. “Commercial Prices Relative to Medicare Were Lower Under An Employer-Based Reference Pricing Program.” *Health Affairs Scholar*, 2026, qxag156.

³¹ Fisher, Michael. 2026. “Vermont Could Become The National Leader In Reference-Based Pricing | Health Affairs Forefront.” *Health Affairs Forefront*, May 5, 2026. <https://www.healthaffairs.org/doi/10.1377/forefront.20260428.962900/full/>.

³² Source: <https://gmcboard.vermont.gov/hospital-reference-based-pricing>

³³ Source: Vermont House Committee on Health Care. April 2025. S.126 Payment Reforms Presentation: “Vermont Healthcare Affordability: Cost Drivers and Economic Impacts” <https://gmcboard.vermont.gov/legislative-testimony>

implemented varying payment caps, depending on their market environment, ranging from 200% of Medicare in Vermont to 265% of Medicare in Indiana.

High prices for specialty and administered drugs is a common driver of health care spending. Yet, administered drugs are commonly associated with high provider markups, often exceeding the underlying costs of the drug itself.³⁴ Vermont also experienced the nation's highest provider markups for clinician-administered specialty drugs (Whaley et al. 2024). Corresponding legislation in Vermont caps administered drug prices to 120 percent of Average Sales Price (ASP).

In large part due to these proactive approaches, Vermont insurers have requested premium increases of less than 5%.³⁵ Other states, including Indiana, Oregon, and Washington have adopted similar reference-based pricing programs. Oregon's reference-based pricing model reduced spending among public employees by over \$100 million in its first two years, with no changes to hospital quality, staffing, or access.³⁶ Washington's payment limits are attributed to lower-than-trend premium increases.³⁷ These policies address underlying structural drivers of health care cost growth, including how to limit the consequences of provider consolidation and how to pay for new and emerging

³⁴ Robinson, James C., Christopher Whaley, and Sanket S. Dhruva. 2024. "Hospital Prices for Physician-Administered Drugs for Patients with Private Insurance." *New England Journal of Medicine* 390 (4): 338–45.

³⁵ Source: <https://vermontbiz.com/news/2026/may/12/blue-cross-vt-requests-lowest-premium-increase-five-years>

³⁶ Murray, Roslyn C., Zach Y. Brown, Sarah Miller, Edward C. Norton, and Andrew M. Ryan. 2024. "Hospital Facility Prices Declined As A Result Of Oregon's Hospital Payment Cap." *Health Affairs* 43 (3): 424–32.

Murray, Roslyn C., Andrew M. Ryan, and Christopher M. Whaley. 2025. "Hospital Finances, Operations, And Patient Experience Remain Stable After Oregon's Hospital Payment Cap Was Implemented." *Health Affairs* 44 (12): 1482–89.

³⁷ Source: <https://www.hca.wa.gov/assets/pebb/peb-board-briefing-book-062526.pdf>

technologies. Rather than grant to pass double-digit premium growth to insurers, Rhode Island policymakers could look at these other state-led innovations.

Relatedly, several studies and policymakers have noted the wide range in prices between hospital and non-hospital facilities for the same services. These “site-of-care” payment differentials are a key driver of increased spending and prices, despite no difference observed in quality or patient outcomes.³⁸ In light of these differences, state and federal policymakers have considered a variety of site-neutral payment policies. Most notably, proposed legislation in New York seeks to adopt the site-neutral policy developed by the Medicare Payment Advisory Commission (MedPAC).³⁹ My research shows that if Rhode Island adopted similar policies, per-capita spending could be reduced by \$60.⁴⁰ Applying these estimates to Neighborhood’s requested 2027 individual market premium yields a 8.2% reduction in premiums.⁴¹

Other potential approaches include addressing the structure of Rhode Island insurance markets. Currently, only two firms offer Exchange plan insurance offerings. The limited scope of competition among a duopoly limits the incentives to innovate and improve health care affordability. Insurer concentration also limits the incentives to pass along savings to patients and plan purchasers.⁴² Other states, namely Colorado, have addressed limited insurer competition by implementing a public option plan. Colorado

³⁸ Robinson, James, Christopher Whaley, and Sanket Dhruva. 2024. *Prices and Complications in Hospital-Based and Freestanding Surgery Centers*. April 2024, vol. 30 (April 2024): 179–84.

³⁹ Source: <https://nashp.org/new-site-neutral-payment-model-legislation-for-states/>

⁴⁰ Murray, Roslyn C., Haroon Janjua, and Christopher M. Whaley. 2025. “Site-Neutral Payment for Routine Services Could Save Commercial Purchasers and Patients Billions.” *Health Affairs Scholar* 3 (12): qxaf241.

⁴¹ (\$736 - \$60) / \$736

⁴² Dafny, Leemore, Mark Duggan, and Subramaniam Ramanarayanan. 2012. “Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry.” *American Economic Review* 102 (2): 1161–85.

Exchange plans had several years of double-digit premium increases. In response, starting in 2023, public option plans were required to *reduce* premiums by 5 percent annually.

Starting in 2026, public option plan premiums are only allowed to increase at the medical inflation rate. My analysis finds that Colorado public option plan premiums are more than \$100 less expensive than comparable plans.⁴³ A Mathematica report finds 3.4 to 7.8 percent lower premiums, depending on selected metal tier, and 15 percent lower patient out-of-pocket spending.⁴⁴ To not exceed medical inflation premium growth, Colorado public option plans have a provision that allows the State to proactively reduce provider prices if plan premiums are forecasted to exceed medical inflation growth. My research finds that this provision placed downward pressure on provider price growth.⁴⁵ If a key underlying source of consistently rising health insurance premiums in Rhode Island is due to rising provider prices or unchecked service utilization, a public option could yield similar savings.⁴⁶

Rhode Island has recently taken other steps that I estimate will, albeit over a longer time period, improve health care affordability. These policies include removing Certificate of Need policies that create barriers to provider entry and competition. Rhode Island has also expanded the ability of advance-practice nursing professionals to perform primary

⁴³ Sources : <https://www.healthaffairs.org/content/forefront/can-public-option-plans-improve-affordability-insights-colorado> and [https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Brief %20Colorado%20Option%20Premiums%20\(1\).pdf](https://cahpr.sph.brown.edu/sites/default/files/documents/Policy%20Brief%20Colorado%20Option%20Premiums%20(1).pdf)

⁴⁴ Pohl, Vincent, Alli Steiner, Monica Davadi, Kara Nester, Leah Faunce, Monica Farid, and Becca Gordon. 2026. *Analysis of the Colorado Option*. Mathematica. <https://www.mathematica.org/publications/analysis-of-the-colorado-option>.

⁴⁵ Source: <https://repository.library.brown.edu/studio/item/bdr:gzp4t9ra/>

⁴⁶ Murray, Roslyn, and Christopher Whaley. 2026. “Can Public Option Plans Improve Affordability? Insights From Colorado | Health Affairs Forefront.” *Health Affairs Forefront*, January 15, 2026. <https://www.healthaffairs.org/doi/10.1377/forefront.20250113.844529/full/>.

care services independent of a physician. These expanded Scope of Practice policies are likely to improve primary care access and quality, with longer-run reductions in per-visit prices.⁴⁷ While these benefits will not likely impact 2027 costs, they will likely have longer-run benefits to Rhode Island health care affordability.

In conclusion, approving the requested rate increase from Neighborhood will mean that health insurance costs increase for many Rhode Island families by 50 percent in just two years. Rhode Islanders are required to purchase insurance. Premium increases of this magnitude are likely to be harmful to Rhode Island consumers and further strain household budgets. The large and immediate financial shock of the proposed rate could threaten to pose economic hardship and potentially threaten insurance market stability. The effects of an approximately 25% annual increase in insurance premium rates, on top of last year's nearly 20% rate increase, would place immediate and significant financial pressures on Rhode Island consumers and households. As a result of these increases, uninsurance rates in Rhode Island will likely increase. This potential increase in uninsurance will likely create access barriers to appropriate care and place additional financial strain on the Rhode Island health care system.

⁴⁷ Muench, Ulrike, Christopher Whaley, Janet Coffman, and Joanne Spetz. 2020. "Scope-of-Practice for Nurse Practitioners and Adherence to Medications for Chronic Illness in Primary Care." *Journal of General Internal Medicine*.

Xue, Ying, Zhiqiu Ye, Carol Brewer, and Joanne Spetz. 2016. "Impact of State Nurse Practitioner Scope-of-Practice Regulation on Health Care Delivery: Systematic Review." *Nursing Outlook* 64 (1): 71–85.