Issue Brief
September 2025

Milbank Memorial Fund
Using evidence to improve population health

Rhode Island's Health Care Affordability Standards: Lessons for Other States Seeking to Control Health Care Spending

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Policy Points

- States interested in controlling health care spending can learn from Rhode Island, which has lowered hospital prices relative to other states by capping the growth of insurer reimbursement rates for hospitals.
- Affordability standards like those in Rhode Island should be paired with robust commercial health insurance rate review processes that require prior approval of proposed premiums and allow for the modification of insurer proposals.
- Caps on the growth of reimbursement rates should be recalibrated regularly to ensure that they do not unduly constrain hospital operating margins.

ABSTRACT

In 2010, Rhode Island established affordability standards to cap annual increases in commercial insurers' reimbursement rates for hospitals. A recent study from the Brown University Center for Advancing Health Policy through Research finds that these standards, which apply only to the fully insured market, have led to a 9% relative reduction in hospital prices across the entire commercial market. By 2022, the standards also reduced premiums in the fully insured market by $1,000 per member relative to other states, although they failed to reduce premium equivalents in the self-insured market. The standards have reduced hospital revenues by over $150 million annually, contributing to hospital operating margins in Rhode Island falling well below the national average. The experience of Rhode Island provides some important policy lessons for other states that are interested in reducing health care costs in the commercial market.

INTRODUCTION

The United States spends more on health care than any other country, and this spending is increasing at rates that outpace those in other countries.[1,2] Over the past two decades, the growth in hospital prices for commercially insured patients has been a key driver of health care spending.[3,4,5,6] There is a notable and growing gap between the amount that commercial insurers pay for hospital services and the amount that Medicare pays for the same services. On average, commercial prices are more than two and a half times higher than what Medicare pays.[7,8,9,10] High hospital prices have increased insurance premiums, decreased the generosity of employment benefits, and caused wage growth to stagnate.[11] In the absence of federal action to combat the hospital consolidation that is driving price increases, states have begun experimenting with strategies to curb hospital prices.[12]

One way that states have tried to limit the effect of spending increases on individuals is through the insurance rate review process. In 2010, the Affordable Care Act (ACA) required that premium rate reviews take place in every state. States are able to meet the ACA requirements either by establishing their own "effective" rate review processes (meaning that the state has the resources and authority to review excessive rate increases) or by deferring to the federal government to review excessive rate increases.[13] Even among states that have ACA-compliant effective rate review programs, there is significant variation in the strength of regulatory authority.[14] In addition, the rate review processes tend to focus solely on the appropriateness of rate increases in the fully insured market, given that these processes lack tools to address the causes of spending increases for insurers, such as hospital price increases. One state that has taken a particularly innovative approach to its rate review process in an effort to address cost drivers is Rhode Island.

Overview of Rhode Island's Affordability Standards

Beginning in 2010, Rhode Island's Office of the Health Insurance Commissioner (OHIC) issued a regulatory package of affordability standards to cap the amount by which insurers could increase their reimbursement rates for hospitals.[15,16] Specifically, OHIC mandated that the commissioner review and provide prior approval to fully insured health plans that propose average reimbursement rate increases in excess of inflation (which was initially calculated as the rate of Medicare hospital payment increases, but is now calculated as the Consumer Price Index) plus 1%.[17,18] OHIC promulgated these regulations partially on the basis of statutory authority directing the commissioner to "[p]rotect the interests of consumers."[19]

The cap on reimbursement rates was one of multiple conditions for contracts between hospitals and insurers that were established by the standards. The standards also required such contracts to pay for inpatient and outpatient services using units of service that encourage efficient resource use; provide quality incentive payments to hospitals; attribute a portion of any proposed rate increase to said quality incentive payments; and improve care coordination.[20] Notably, the standards also mandated increased investment in primary care services. Between 2010 and 2014, insurers were required to increase the share of total medical payments paid for primary care services by 1% annually from 2010 to 2014, without passing the related cost from this on to consumers via higher premiums.[21]

Summary of Findings

Earlier evaluations of Rhode Island's affordability standards have shown promising results. A 2019 evaluation found that the affordability standards reduced commercial prices and spending growth for hospitals relative to comparison states in the early years of implementation.[22] These results are in line with analyses of cost-control policies in other states. For example, Montana and Oregon have instituted caps (set as a percentage of Medicare rates) on the amount that their state employee health plans can reimburse hospitals for medical services received by their members. Evaluations of hospital price caps in both states have shown that they reduced state expenditures and out-of-pocket spending.[23,24,25] This is consistent with modeling studies that highlight the potential for large reductions in health care expenditures through commercial price caps.[26,27]

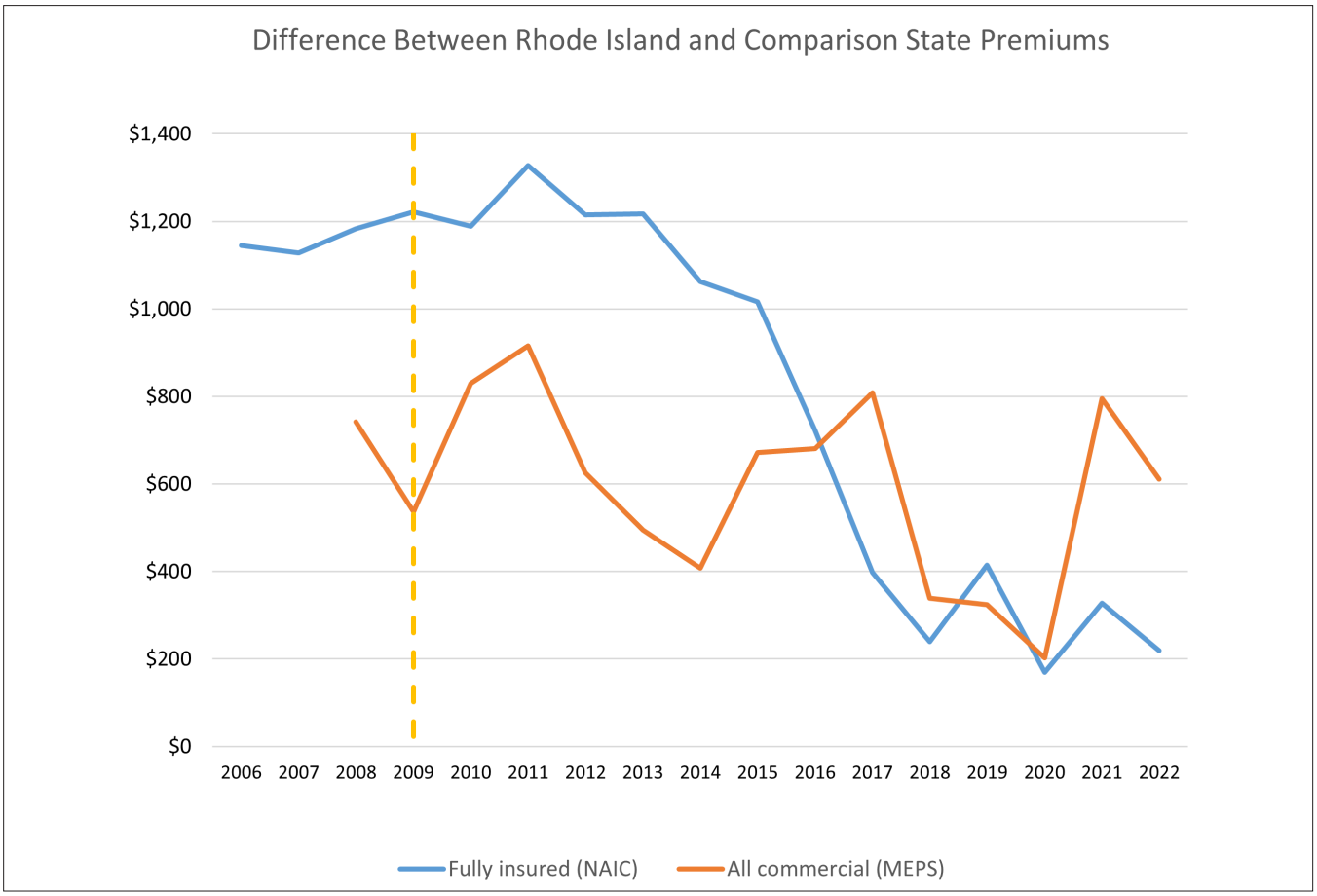
In a recent *Health Affairs* study[28] by researchers at the Brown University Center for Advancing Health Policy through Research (CAHPR), the authors find that Rhode Island's affordability standards were associated with large relative reductions in hospital prices, averaging 9% over the study period. To bring this into the national context: In 2012, commercial hospital prices in Rhode Island were 106% of the national average, but they had declined to 84% of the national average in 2022. These price reductions were similar for both the fully insured and self-insured segments of the commercial market. (See Figure 1.) This is notable since the affordability standards applied only to the fully insured market. One potential explanation for the standards' effect on the self-insured market is that insurance companies negotiate provider rate schedules jointly for both their fully insured and self-insured segments. Regardless, this finding suggests that caps on reimbursement rates in the fully insured market could spill over to the self-insured market, even if the caps do not expressly apply to the self-insured market.

Until now, the impact of the Rhode Island affordability standards on premiums and out-of-pocket spending

has been unknown. But the CAHPR study finds that the hospital price reductions translated into substantial reductions in fully insured premiums relative to comparison states, amounting to $1,000 per member by 2022. Across the entire fully insured market in Rhode Island, the standards reduced aggregate premium and out-of-pocket expenses for members by an average of $87.7 million annually. Most of these savings were realized through employer premiums ($64.1 million annually), followed by member premiums ($20.8 million annually) and member out-of-pocket spending ($2.9 million annually). (See Figure 2.) The CAHPR study estimates that *all* of the reductions in hospital spending associated with the standards were passed through to fully insured members in the form of reduced cost-sharing. Rhode Island's robust premium rate review process has likely contributed to the effectiveness of this policy in passing along cost savings to members.

When looking at the broader commercial market, the study finds that the standards had a modest impact on overall commercial premiums in the state. In the entire commercial market, the standards were associated with an $87 relative decline in premiums, which is much less than the $1,000 reduction in premiums in the fully insured market. Among large employers (which are much more likely to be self-insured), there was a $206 relative *increase* in premiums. These findings imply that the cost savings for self-insured plans were not passed along to members in the form of lower premium equivalents.

Figure 1. Difference in Commercial Health Insurance Premiums Between Rhode Island and Comparison States, by Insurance Market Segment, 2006–2022



Data: Analysis of data from the Medical Expenditure Panel Survey—Insurance Component (MEPS) and the National Association of Insurance Commissioners, 2006—2022, accessed through the Mark Farrah Associates Health Coverage Portal. Notes: Comparison states consist of all other states and Washington, D.C. MEPS data were not available in 2007; the data point at 2007 for "all commercial" is the average of the values for 2006 and 2008. Source: Ryan AM, Whaley CM, Fuse Brown EC et al. Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums. Health Aff (Millwood). 2025 May;44(5):184–189. Available from: https://doi.org/10.1377/hlthaff.2024.01146

Figure 2. Impact of Affordability Standards on Rhode Island Hospitals and Commercially Insured Members

Impacted group	Aggregate impact per year, million $
Fully-insured segment	
Employer premiums	-64.1
Member Premiums	-20.8
Out-of-pocket spending	-2.9
Total	-87.7
Self-insured segment	
Employer premiums	27.2
Member premiums	8.8
Out-of-pocket spending	-5.3
Total	30.7
Statewide hospital commercial revenue	-158.3

Data: Analysis of data from the Health Care Cost Institute, 2012—2022; Healthcare Cost and Utilization Project, 2010—2022 (accessible from the Agency for Healthcare Research and Quality's HCUPNet online data tool); National Association of Insurance Commissioners, 2010—2022 (accessed from the Mark Farrah Associates Health Coverage Portal); and the Medical Expenditure Panel Survey—Insurance Component, 2010—2022. Notes: The impact statistics presented here are calculated from values of various parameters derived from the sources listed above. Source: Ryan AM, Whaley CM, Fuse Brown EC et al. Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums. Health Aff (Millwood). 2025 May;44(5):184–189. Available from: https://doi.org/10.1377/hlthaff.2024.01146

There are three main reasons why this could be the case.

- First, self-insured plans are frequently offered by large employers with employees in multiple states. Therefore, it is possible that the spending reductions associated with these plans' Rhode Island-based members were modest compared with health expenditures in other states, and therefore did not affect premium equivalents.
- Second, premium equivalents in self-insured plans—which are not technically premiums—are not determined prospectively. Instead, they depend on the health expenditures of the plan's members, as well as on the fees charged by third-party administrators (TPAs) or administrative services only (ASOs) providers.[29] With employers lacking transparency into these fees, TPAs and ASOs may have been able to increase fees to offset savings in hospital prices. There was some evidence that this happened in Rhode Island, although the data were not conclusive.
- Third, the Employee Retirement Income Security Act of 1974 (ERISA) restrains the ability of states to regulate the affordability of self-insured plans. Consequently, Rhode Island's insurance commissioner does not have the authority to approve, reject, or modify premium equivalents in the self-insured market in the same way that the commissioner does with the fully insured market.

Further, the CAHPR researchers find that the standards reduced commercial revenue for Rhode Island hospitals by over $150 million annually, which exceeded the reductions in premiums. The standards also contributed to operating margins in Rhode Island hospitals falling below

the national average. Depending on how hospital operating margins are defined, the average margins at Rhode Island hospitals were either –0.4% (compared with 4.8% nationally) or 14% (compared with 17.2% nationally) after the adoption of the standards.

Policy Implications

Reducing Prices and Premiums

The CAHPR study has a number of policy implications for state policymakers. First, it appears that the affordability standards established by Rhode Island have effectively reduced hospital prices across the commercial market and insurance premiums for fully insured members. As states are considering a range of different policies to improve health care affordability (including health care spending targets [30] and hospital price caps [31]), caps on rate increases are another tool that should be added to the toolkit of policy options available.

Key lesson(s): Caps on the increases of insurer reimbursement rates for hospitals are effective at reducing hospital price growth across the commercial market and premiums in the fully insured market.

Market Concentration and Statutory Authority

Second, the affordability standards were established in Rhode Island, a state that has a highly concentrated fully insured market and proactive regulatory authority. There are only five insurers operating in the fully insured market in the state, and 88% of the market is constrained to just two insurers.[32] It is unclear whether similar rate increase caps would be as successful in states with more diversified fully insured markets. In addition, not only does OHIC have the statutory authority to modify proposed premium rates, but the commissioner also routinely uses that authority to limit premium rate increases from insurers.[33, 34] States seeking to adopt this policy must first ensure that their insurance commissioner has the authority to modify premium rates, which many insurance commissioners do not currently have the ability to do. Some states currently have "file and use" processes for premium rate review, in which insurers are only required to inform states of the premiums they are setting. Other states have "prior approval" processes, in which the state must approve proposed premium rates before they go into effect.[35] However, even among "prior approval" states, not every state has the authority to modify proposed premium rates. Instead, some state insurance commissioners are simply allowed to give up-or-down approval or disapproval to proposed premium rates.[36] Rate modification authority is essential to the deployment of affordability standards like the ones established in Rhode Island.

Key lesson(s): Insurance commissioners must have the statutory authority, and the political will, to modify proposed premium rates in the fully insured market for this policy to be successful.

Uncertain Impacts on the Self-Insured Segment

Third, the premium reductions resulting from the affordability standards did not spill over to the self-insured market. As previously mentioned, this could be due to a variety of factors, including the national nature of self-insured plans; the ability of TPAs and ASOs to increase rates in a black box, without employer visibility; and federal restrictions on state regulation of ERISA plans. This issue is particularly salient given that over 60% of Americans covered by employer-sponsored insurance are in self-funded plans.[37]

Key lesson(s): Greater transparency in self-funded insurance arrangements is essential to ensure that provider rate reductions are passed through to employers and members.

Hospital Margins

Fourth, the affordability standards likely had direct impacts on hospital revenue. After the establishment of the standards, hospital operating margins fell below the margins of hospitals in other states. However, there could be other factors contributing to the relatively low operating margins in Rhode Island. For example, Rhode Island has a relatively low share of commercially insured patients and a relatively high rate of Medicaid enrollment, ranking 17th nationally in terms of the percentage of the population enrolled in Medicaid.[38] Regardless, it appears likely that the affordability standards have been a factor in reducing hospital revenues. CAHPR does not have enough financial information to understand whether hospital operating margins are too low after implementation of the standards. Yet evidence from other research suggests that the standards may have led Rhode Island hospitals to operate more efficiently. Researchers from the Massachusetts Health Policy Commission found that Massachusetts hospitals' administrative spending grew 39% between 2011 and 2019, compared with 20% in

Rhode Island.[39] These rates of administrative spending growth match hospital revenue growth almost exactly in both states. While this evidence does not rule out effects of the standards on clinical operations, it does suggest that hospitals can operate more efficiently when faced with revenue reductions. Nonetheless, policymakers considering hospital caps should consider periodic recalibrations of the cap, to monitor the effect of this policy on hospital finances.

Key lesson(s): Policymakers should periodically recalibrate caps on rate increases, to ensure they do not have an undue impact on hospital operating margins.

CONCLUSION

Rhode Island's affordability standards have led to relative reductions in hospital prices across the state's commercial market. These standards have yielded cost savings for consumers in the fully insured market, and they have reduced hospital revenues and contributed to hospital operating margins falling below the national average. The experience of Rhode Island provides some important policy lessons for other states that are interested in reducing health care costs. States interested in this policy should also ensure their insurance commissioners have the statutory authority to modify proposed premium rates through their insurance rate review processes. Finally, states pursuing this policy should periodically recalibrate caps on rate increases, to ensure that the policy does not have negative impacts on hospital operations.

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