CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

To:	Peter F. Neronha, Rhode Island Attorney General
From:	Erin C. Fuse Brown & Hayden Rooke-Ley, Center for Advancing Health Policy through Research (CAHPR), Brown University School of Public Health[1]
Date:	May 27, 2025
Re.:	Policy Brief on the Menu of Policy Options for State-Based Universal Health System Reform

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Introduction

This memorandum responds to a request from Rhode Island Attorney General Peter F. Neronha for a menu of policy options to improve the state's health care system. Like many states, Rhode Island faces mounting challenges related to access, affordability, and long-term sustainability. Hospitals report significant financial distress, driven by workforce shortages and reimbursement rates that lag behind peer states. Primary care is also under strain, as patients face growing access challenges.[2] Nearly 12 percent of residents report that they do not have a regular place to receive medical care.[3] Most recently, Anchor Medical—a multi-site primary care clinic serving more than 25,000 patients—announced its closure, citing the increasing administrative burden and the state's difficulty attracting primary care clinicians.[4]

In addition to access and capacity challenges, many Rhode Islanders struggle to afford care. Although average premiums in the private insurance market compare favorably to those in other states,[5] families are still feeling the squeeze. Out-of-pocket spending per capita reached $3,706 in 2024, significantly exceeding national averages and increasing over 30% since 2022.[6] Despite the state's low uninsurance rate, 28.4% of Rhode Islanders are considered underinsured, compared to 23% nationally.[7]

Below we outline structural reform options to place Rhode Island's health care system on a more sustainable trajectory. Each proposal is evaluated in light of key policy goals: achieving universal coverage and access, maintaining affordability, and creating sustainability and administrative simplicity. Subsequent analysis would be required to estimate budgetary and health care fiscal impacts of select policy options. The proposals vary in scope, legal complexity, and political feasibility, but each offers a potential pathway for meaningful reform.

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[2] Christine Haran & Mary Louise Gilburg, *Rhode Island and Massachusetts Step Up to Support Primary Care*, Milbank Memorial Fund (May 14, 2025), https://www.milbank.org/news/rhode-island-and-massachusetts-step-up-to-support-primary-care/.

[3] The Commonwealth Fund, *Adults age 18 and older with a usual source of care (%)*, The Commonwealth Fund (2023), https://www.commonwealthfund.org/datacenter/adults-usual-source-care.

[4] Lynn Arditi, *As Anchor Medical Shuts Down, 25,000 Rhode Islanders Scramble for Primary Care*, Rhode Island PBS (April 29, 2025), https://www.ripbs.org/news-culture/health/as-anchor-medical-shuts-down-25-000-rhode-islanders-scramble-for-primary-care.

[5] Andrew M. Ryan, et al., *Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums* 597-605, Health Affairs 44:5 (May 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01146.

[6] HealthSource RI, *Rhode Island Health Information Survey (HIS): 2024 Executive Summary Report* (2024), https://healthsourceri.com/wp-content/uploads/HIS-2024_Executive-Summary-FINAL-9.30.24.pdf.

[7] Sara R. Collins & Avni Gupta, *The State of Health Insurance Coverage in the U.S.: Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey*, Commonwealth Fund (Nov. 21, 2024), https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey.; HealthSource RI, *Rhode Island Health Information Survey (HIS): 2024 Executive Summary Report* (2024), https://healthsourceri.com/wp-content/uploads/HIS-2024_Executive-Summary-FINAL-9.30.24.pdf.

1. **State-Based Single-Payer Plan**: Provides universal coverage through a publicly financed plan, requiring federal waivers and a payroll tax to replace employer-based insurance contributions. Though legally and politically complex, this proposal would most directly advance all of the aforementioned state policy goals by standardizing coverage and unifying the payment system.
2. **Comprehensive Public Option**: Creates a state-administered public option plan on Rhode Island's individual marketplace, and makes it available to individuals receiving employer-based insurance. While still requiring a waiver, this proposal would expand coverage and affordability with fewer political and legal barriers than single-payer.
3. **Pricing Parity:** Substantially increases Medicaid reimbursements with the option of controlling commercial prices. This proposal would maintain net spending on health care in the state while increasing the federal contribution. While it would require minimal or no waivers, this proposal relies heavily on federal contributions to Medicaid, which may be subject to impending cuts.
4. **State Prescription Drug Purchasing Pool:** Expands the state's drug purchasing pool beyond the state employee plan to include other purchases, such as other government entities and employers.

Each section of the memo describes the key design features of the proposal, analyzes legal risks, and considers overall benefits and tradeoffs of each proposal.

State-Based Single-Payer Plan

I. Overview

A state-based single-payer plan, if properly implemented, would provide universal and affordable insurance coverage for all Rhode Island residents, administrative simplification, and payment equity.[8] The primary policy and legal challenge is consolidating existing state and federal funding streams into the single state-based plan.[9] Several states have explored single-payer systems in recent years, though none has yet succeeded. Vermont passed the nation's first single-payer law in 2011 but ultimately abandoned the effort before securing federal waivers or implementing the necessary state-level financing.[10] More recently, California, Oregon, and Washington have established task forces to examine single-payer models.[11, 12] Between 2010 and 2019, there were 66 single-payer bills introduced across 21 states.[13] In Rhode Island, single-payer legislation has been introduced and referred to the Senate Committee on Health and Human Services, signaling potential for continued policy development.[14]

II. Key Design Features and Legal Risks

A. Coverage and Costs

A single-payer plan would provide universal health coverage to all residents by combining financing for all health care services into a single, state-administered payer. Typical characteristics of state-based single payer plans include: universal eligibility for state residents, reliance on statutory waivers from Medicare, Medicaid and the Affordable Care Act (ACA) to combine these sources of funding and populations into the state plan, expansive provider

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[8] Lindsay F. Wiley, *State-Level Single-Payer Health Care From a Public Health Perspective,* American Journal of Public Health (Nov. 2019), https://pmc.ncbi.nlm.nih.gov/articles/PMC6775895/; Oregon Legislative Policy and Research Office, *Joint Task Force on Universal Health Care* (2022), https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20September%202022.pdf.

[9] Cris M. Currie, *ERISA and State Single-Payer Healthcare: A Primer,* Health Care for All - WA (May 08, 2023), https://www.hcfawa.org/erisa_and_state_single_payer_healthcare_a_primer.

[10] Jane Norman, *Vermont Lays Out a Plan for Single-Payer, But It's a Long Journey,* Commonwealth Fund (May 06, 2011), https://www.commonwealthfund.org/publications/newsletter-article/vermont-lays-out-path-single-payer-its-long-journey.

[11] Mark Ghaly, et al., *Key Design Considerations for a Unified Healthcare Financing System in California* (2022), https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf.

[12] Oregon Legislative Policy and Research Office, *Joint Task Force on Universal Health Care* (2022), https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20September%202022.pdf.

[13] Erin C. Fuse Brown and Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care* 403-422, 168 U. PENN. L. REV. 389 (2020), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9687&context=penn_law_review;

[14] *An Act Relating to Health and Safety – The Rhode Island Comprehensive Health Insurance Program,* State of Rhode Island General Assembly (2025), (introduced by Senators Bell, Ujifusa, Murray, Valverde, Lawson, DiMario, Mack, Euer, Quezada, and Kallman), https://webserver.rilegislature.gov/BillText/BillText25/SenateText25/S0346.pdf.

eligibility, administered payment rates, low or no cost-sharing, comprehensive covered services, and mechanisms for care coordination.[15] To capture private health care spending, funding could come from a payroll or income tax, or both. By eliminating private insurance companies and consolidating the system under one payer, the plan could offer comprehensive coverage, streamline administrative burdens on providers, and standardize provider payment rates.

State-level analyses have found that a well-designed single-payer system could achieve these objectives. For example, a 2022 actuarial review commissioned by Oregon's Universal Health Care Task Force projected that a Universal Health Plan offering benefits far more generous than Medicare—including coverage for medical, dental, vision, hearing, mental health, and complementary care with no premiums or cost-sharing—would save the state nearly $1 billion annually. These savings would stem from streamlined administration and would not reduce aggregate provider payments. The analysis concluded that most households and employers would contribute less than under the current system, while receiving more comprehensive and equitable coverage.[16]

B. Consolidation of Federal Funds

A critical component of implementing a state-based single-payer plan is consolidating funding from Medicaid, Medicare, and the Affordable Care Act (ACA), which requires multiple federal waivers.[17] For Medicaid, a Section 1115 waiver would be necessary to pool funds into a unified state plan, because federal Medicaid funding cannot otherwise be used to cover populations not eligible for Medicaid.[18] While Section 1115 does not allow fundamental changes to Medicaid's structure or direct diversion of funds, it can likely permit the state to channel funding through a single Medicaid Managed Care Organization (MCO) and to use excess savings for non-Medicaid health programs.[19] Vermont, for example, has operated under a similar waiver since 2005, allowing Medicaid funds to flow through a single MCO and allocating savings beyond cost-growth targets to broader health initiatives.[20]

The most viable waiver to integrate Medicare funding would be a Section 1115A waiver, established by the ACA through the Center for Medicare and Medicaid Innovation (CMMI).[21] The ACA, in establishing CMMI, gave broad authority to waive requirements under the Social

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[15] Erin C. Fuse Brown and Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care* 403-422, 168 U. PENN. L. REV. 389, 399 (2020), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9687&context=penn_law_review

[16] Oregon Legislative Policy and Research Office, *Joint Task Force on Universal Health Care* (2022), https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20September%202022.pdf.

[17] Lindsay Wiley, *Medicaid for All?: State-Level Single-Payer Health Care*, 79 OHIO STATE LAW JOURNAL (2018). Available at: https://digitalcommons.wcl.american.edu/facsch_lawrev/1169.

[18] Mark Ghaly, et al., *Key Design Considerations for a Unified Healthcare Financing System in California* 95-98, (2022), https://www.chhs.ca.gov/wp-content/uploads/2022/04/Key-Design-Considerations_April-2022_Final-Report-for-Distribution.pdf.

[19] Id.

[20] Id.

[21] Id.

Security Act to test payment and delivery system innovations that reduce costs and improve quality.[22] Under this waiver, the state could create a unified Medicare Advantage plan or a statewide Accountable Care Organization. It is plausible that, under a broad interpretation of the statute, Rhode Island could directly receive Medicare funds and incorporate them into a single-payer model. While this remains legally plausible, it would depend heavily on federal executive branch discretion and political support.

A Section 1332 waiver would also be necessary to redirect federal funding currently used for ACA exchange subsidies into the state plan and to waive the ACA's employer mandate, allowing employers to participate. If implemented effectively, a state-based single-payer plan would likely meet the waiver's core requirements: providing coverage that is as comprehensive and affordable as current ACA plans, maintaining protections against excessive out-of-pocket costs, covering a comparable number of residents, and avoiding any increase to the federal deficit.[23] If the plan proves more financially efficient than existing federally subsidized coverage, the resulting federal savings could be passed through to the state. These funds—equivalent to the tax credits and cost-sharing subsidies already allocated under the ACA—could then help finance the single-payer system.

C. Consolidation of State Funds

Rhode Island would need to capture existing employer-based health spending—likely through a payroll tax—from employer and employee contributions currently directed toward employer-sponsored insurance.[24] For example, the Rhode Island single-payer bill proposes a 10% payroll tax, with at least 80% of the burden falling on employers and the remainder paid by employees in lieu of existing premiums, deductibles, and out-of-pocket costs.[25] The exact tax rate would depend on the total cost of the single-payer plan, which in turn would be shaped by administrative savings, provider reimbursement levels, covered benefits, and cost-sharing design.

The primary legal challenge in capturing employer-based health spending is navigating the federal Employee Retirement Income Security Act (ERISA), which limits state authority to regulate employer health plans (ERISA plans), particularly those that are self-insured. ERISA's broad preemption provision prohibits states from directly mandating or dictating the choices of ERISA plans.[26] Rhode Island could not, for example, ban employers from offering health

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[22] 42 U.S.C. 1315a.

[23] Centers for Medicare & Medicaid Services, *Section 1132: State Innovation Waivers*, https://www.cms.gov/marketplace/states/section-1332-state-innovation-waivers.

[24] Erin C. Fuse Brown and Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care* 403-422, 168 UNIVERSITY OF PENNSYLVANIA LAW REVIEW 389 (2020), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9687&context=penn_law_review.

[25] *An Act Relating to Health and Safety – The Rhode Island Comprehensive Health Insurance Program,* State of Rhode Island General Assembly (2025), (introduced by Senators Bell, Ujifusa, Murray, Valverde, Lawson, DiMario, Mack, Euer, Quezada, and Kallman), https://webserver.rilegislature.gov/BillText/BillText25/SenateText25/S0346.pdf.

[26] Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Could States Do Single-Payer Health Care?*, HEALTH AFFAIRS FOREFRONT (Jul. 22, 2019), http://www.healthaffairs.org/do/10.1377/forefront.20190717.466249/full/ (last visited May 9, 2025).

coverage or compel them to redirect existing spending into the single-payer system. Moreover, unlike other federal statutes, ERISA lacks a waiver mechanism for states.[27] However, several ERISA-compliant design strategies could support a state-based single-payer framework.[28] First, any payroll and income taxes introduced to capture employment-based contributions could be structured to fund the program and indirectly discourage employers from offering duplicative coverage. Second, the state could require participating providers to participate only in the single-payer plan for covered services, thereby reducing the utility of alternative plans. Third, the state could adopt pay-and-recoup provisions that allow the single-payer program to pay providers for services and seek reimbursement from patient's other sources of coverage, including employer-sponsored plans. These strategies can be used individually or in combination; the single-payer legislation currently pending in the Rhode Island General Assembly, for example, includes both a payroll tax and provider participation restrictions as part of its proposed model.

III. Policy Tradeoffs

A state-based single-payer plan in Rhode Island has the potential to expand access, coverage, equity, and affordability, and reduce administrative burdens without increasing overall system costs or reducing provider payments. However, while there is a viable legal path to consolidating federal and state funds under one plan, it is unprecedented and legal uncertainties remain. The primary challenges are likely to be political. Although the state would not require increased contributions to health care from individuals or employers, those contributions would be redirected to the state through taxes. Rhode Island would also need federal political support to secure the necessary waivers.

Comprehensive Public Option

I. Overview

The comprehensive public insurance option would offer a state-regulated plan on Rhode Island's existing health insurance marketplace, HealthSource RI. Focusing on affordable, comprehensive coverage, the plan would compete with private options on the individual market and be available to the employer-based insurance market, where healthcare costs are highest. Funding would come from a combination of state tax revenues, premiums, employer contributions, and federal subsidies, with Rhode Island seeking a Section 1332 federal waiver to maximize savings and increase flexibility. Like a single-payer plan, a comprehensive public option is a state-sponsored health plan that is available to a broad scope of privately insured residents in the state, including those in the individual, small group, or large-group markets. The

[27] Erin C. Fuse Brown and Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care* 403-422, 168 UNIVERSITY OF PENNSYLVANIA LAW REVIEW 389, 445 (2020), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=9687&context=penn_law_review.

[28] Id. at 401-414; Erin C. Fuse Brown and Elizabeth Y. McCuskey, *Could States Do Single-Payer Health Care?*, Health Affairs Forefront (July 22, 2019), https://www.healthaffairs.org/content/forefront/could-states-do-single-payer-health-care.

policy goals of a comprehensive public option include: universal coverage untethered from employment, improving affordability by applying rate limits to the commercial insurance market, and simplifying administrative burdens by combining the risk pools of large, small, and individual markets into one state-regulated plan.[29]

While Medicaid populations could be included, comprehensive public option plans typically do not extend to Medicare-covered residents.[30] A comprehensive public option plan could create a glide-path toward a single-payer system, while acknowledging that a multi-payer system will persist for some time, if not indefinitely. A prior study identified 15 bills proposing a comprehensive public option across 5 states between 2010 and 2021.[31]

II. Key Design Features and Legal Considerations

In contrast to states like Washington and Colorado, which have implemented public options solely for the individual insurance market, a comprehensive approach would extend the plan to employer-based insurance.[32] In addition to expansion to the employer market, the public option could expand eligibility to undocumented immigrants and those over income thresholds for premium subsidies. The plan could be state-administered or contracted to a private entity to operate.[33]

The state would set payment rates, regulate plan benefits, and oversee provider networks. Premiums and cost-sharing would be set competitively to ensure affordability while maintaining actuarial soundness. The state could also cap out-of-pocket expenses and deductibles at lower levels than private plans to encourage participation. To achieve this affordability, the plan would contract with existing healthcare providers at state-determined reimbursement rates, potentially pegged to Medicare rates or a percentage above Medicaid reimbursement levels.[34]

There are three main sources of financing for Comprehensive public option plans: (1) premiums and cost-sharing; (2) federal funds, including Marketplace premium tax credits and Medicaid matching funds; and (3) state revenues from payroll and other taxes.[35] To fund the plan, the state could pursue a "premium-only" proposal, similar to the model used in Massachusetts, where the public option would be financed solely by the premiums paid by individuals who enroll. However, this approach would significantly limit the scope of the public option because, under ERISA, employers could not be required to participate or contribute to the

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[29] Jaime S. King, Katherine L. Gudiksen, and Erin C. Fuse Brown, *Are State Public Option Health Plans Worth It?* 59 HARVARD JOURNAL ON LEGISLATION 145, 188 (2022),https://journals.law.harvard.edu/jol/wp-content/uploads/sites/86/2022/03/104_King-et-al.pdf.

[30] Id. at 189.

[31] Id. An additional 21 bills across 10 states proposed a Marketplace-based public option, limited to the individual market, and an additional 22 bills across 16 states proposed a Medicaid buy-in. Due to legal difficulties and limited scope, these models of state-based public options are not discussed here. For more discussion of these other public option models, *see* Id.

[32] Erin C. Fuse Brown, Katherine L. Gudiksen & Jaime S. King, *State Public Option Plans — Too Modest to Improve Affordability?*, 385 N ENGL J MED 1057 (2021), http://www.nejm.org/doi/10.1056/NEJMp2111356.

[33] Id. at 196-97 (describing administration of comprehensive public option proposals).

[34] Id. at 200 (describing provider payments).

[35] Id. at 198 (describing financing sources).

financing of the public option.[36] Nor can employers be prohibited from offering alternative coverage. Another approach—to capture more employer spending—would be to fund the program through a combination of three funding sources: premiums, premium tax credits, and a payroll tax similar to, though more limited than, the single-payer proposal.[37] ERISA preemption can be avoided by structuring the payroll tax to provide a meaningful choice to employers between maintaining their own health plan or using the public option.[38]

To capture premium subsidies for the individual market, a comprehensive public option would require Rhode Island to secure an ACA Section 1332 waiver. This would allow Rhode Island to waive provisions such as the employer mandate (allowing employers to satisfy the mandate if they pay for employees to purchase public option coverage), apply federal subsidies beyond the Marketplace, and consolidate coverage and funding into a unified public plan.[39] Though administratively complex, the waiver would enable federal pass-through funding, which could subsidize coverage for individuals otherwise ineligible for Marketplace subsidies or Medicaid coverage.[40] Section 1332 waiver proposals are required by law to ensure deficit neutrality and maintain the comprehensiveness and affordability of coverage in line with ACA benchmarks.[41]

Finally, a key challenge lies in structuring financing to preserve employers' tax benefits on health spending, including deciding which party would bear the burden of a potential payroll tax: employers or employees.[42] If the state levies a payroll tax on employees or an income tax on individuals to pay for the public option, the existing tax advantage for employees' health spending would be lost. Currently, employees' share of their health plan premiums are excluded from their taxable income and federal payroll taxes. Employee-facing payroll or income taxes would be subject to the current $10,000 cap on state and local tax (SALT) deductions at the federal level,[43] potentially raising tax liabilities for middle and high-income earners with already-high tax liabilities at the state or local level. (The Republican tax bill passed by the U.S. House of Representatives in May 2025 would increase the SALT tax limit to $40,000.[44]) Under current limits, residents could be double-taxed for amounts over the cap (once at the state level and once at the federal level) under a new employee-facing payroll or income tax, but not if the employee

[36] Id. at 192.
[37] Id. at 194-196.
[38] Id. at 192-93.
[39] Id. at 170 - 172.
[40] Id. at 198.
[41] Id. at 170-172.
[42] Id. at 194-195.
[43] Note, the current SALT cap, which was established in the Tax Cuts and Jobs Act of 2017, is set to expire on December 31, 2025 if Congress does not extend it. Lawmakers are debating whether to raise the SALT cap income limits. https://www.wsj.com/politics/policy/the-salt-deduction-fight-is-coming-backwhoever-wins-the-election-956d0513?
[44] Kate Dore, *House Republican tax bill passes 'SALT' deduction cap of $40,000. Here's who benefits*, CNBC (May 22, 2025), https://www.cnbc.com/2025/05/22/salt-deduction-trump-tax-bill.html.

contribution were structured as a premium.[45] However, if the payroll tax were to be levied on the employer, rather than the employee, the existing tax benefits for employers would be essentially preserved and the SALT cap would not apply. This is because employer-side payroll taxes, like employer spending on employee health benefits, are excluded from employees' taxable income as business expenses to the employer.[46]

III. Benefits and Tradeoffs

A comprehensive public option offers states the opportunity to expand coverage across all markets, simplify administration, control costs, and lay the groundwork for single-payer. By including the large-group employer market, these plans go beyond existing marketplace-only public options (implemented in Washington and Colorado), but face greater political and administrative complexity. While such plans promise affordable alternatives to private insurance and potential administrative savings if they eventually replace much of the private market, early implementation would add another insurer to a fragmented system. Thus, near-term savings would mainly stem from regulated provider payments, though aggressive rate caps may deter provider participation and jeopardize network adequacy.

Financing remains a key challenge. Employer payroll taxes can effectively capture existing health spending and preserve tax advantages, but may raise ERISA concerns if not carefully structured. Conversely, premium-only models minimize legal risk and preserve employer flexibility, but they would miss employer contributions and could inadequately fund coverage for low-income or high-cost individuals. States aiming to serve undocumented immigrants or those above ACA subsidy thresholds would need to fund these efforts with state dollars or the pass-through of ACA marketplace subsidies through a broad Section 1332 waiver.

States should finance comprehensive public options through a mix of employer payroll taxes and individual premiums (rather than individual income or payroll taxes). This approach supports broader coverage, preserves current tax benefits, and helps avoid ERISA preemption—particularly if employer participation remains voluntary and contributions are structured as general payroll taxes.

Ambitious models may seek to consolidate the entire privately insured market—marketplace and off-marketplace populations, small and large groups, public and private employees—into a single system through a broad Section 1332 waiver. Though legally complex, such a waiver—if secured—could allow for unified administration, expanded subsidies via federal pass-through funding, and more comprehensive risk pooling.

[45] Jaime S. King, Katherine L. Gudiksen, and Erin C. Fuse Brown, *Are State Public Option Health Plans Worth It?* 59 HARVARD JOURNAL ON LEGISLATION 145, 194-196 (2022).
[46] Id. at 194.

Pricing Parity: Increasing Medicaid and Controlling Commercial Prices

I. Overview

Short of adopting a single-payer plan or a comprehensive public option, Rhode Island could move toward standardizing health care prices across payers by significantly increasing Medicaid reimbursements and controlling prices in the commercial market. Despite the state's existing Affordability Standards,[47] commercial rates in the state remain substantially higher than Medicaid. Currently, Medicaid reimburses providers at approximately 37% of Medicare rates (according to 2019 statistics),[48] while commercial insurers pay nearly 197% of Medicare (according to 2022 statistics).[49] Increasing Medicaid rates would directly channel resources to Rhode Island's most distressed providers, and it would reduce incentives for providers to cherry pick privately insured patients in a way that limits Medicaid patients' access. This strategy would increase health care investment by leveraging the Medicaid matching contribution from the federal government. In addition to expanding access and reimbursement in Medicaid, this proposal could be coupled with controls on commercial price growth that could address affordability in the state for commercially insured patients.[50] This would promote equity by compressing discrepancies between Medicaid and commercial rates, thereby reducing incentives for providers to serve commercially insured patients over Medicaid patients. Finally, by increasing the federal government's contribution to the state via Medicaid, the overall contribution from the state, employers, and employees would decline.

II. Key Design Features and Legal Risks

A. Increasing Medicaid Reimbursement

The first step toward achieving price parity is increasing Medicaid reimbursement rates, which currently lag well behind commercial rates. On average, Medicaid pays significantly less than both Medicare and commercial insurers—a disparity that discourages access and investments in lower-income and underserved areas. By increasing Medicaid's share of total health spending, the state can enhance its federal funding through the Medicaid match system.

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[47] Andrew M. Ryan, et al., *Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums* 597-605, Health Affairs 44:5 (May 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01146.

[48] Kaiser Family Foundation, *Medicaid-to-Medicare Fee Index* (2019), https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&sortModel=%7B%22colId%22:%22All%20Services%22,%22sort%22:%22asc%22%7D.

[49] RAND, *Nationwide Evaluation of Health Care Prices Paid by Private Health Plans* (2020), https://www.rand.org/pubs/research_reports/RR4394.html.

[50] Andrew M. Ryan, et al., *Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums* 597-605, Health Affairs 44:5 (May 2025), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2024.01146.

There are three main approaches to increasing Medicaid payments, which could be used in combination. First, the state could directly increase base rates for fee-for-service Medicaid, which are not subject to a federal cap and could be set above Medicare levels. Second, the state could use supplemental payments, a common mechanism—including in Rhode Island—to enhance targeted provider reimbursement. However, these are federally capped: institutional payments cannot exceed Medicare rates, and payments to physicians and other non-institutional providers are limited to average commercial rates.[51] Therefore, any increase above Medicare for hospitals must occur through base rates, not supplemental payments.

Third, to address the vast majority of Medicaid enrollees who are in managed care, the state could expand the use of state-directed payments (SDPs). Federal rules prohibit states from directly dictating how managed care organizations (MCOs) pay providers, but SDPs allow states to require rate increases for broad categories of services. Rhode Island already uses SDPs for hospitals and behavioral health.[52] Recent federal guidance clarifies that SDPs can raise provider rates up to average commercial levels and introduces streamlined processes for states to peg payments to Medicare without prior federal approval.[53] This would be a key lever for Rhode Island to increase Medicaid rates across lines of service.

B. Financing Medicaid Increases

To fund the proposed increase in Medicaid spending, Rhode Island can draw on a mix of federal support, provider taxes, and state general revenue. The key fiscal advantage of this approach is that the federal government covers more than half of all Medicaid spending in the state, with a federal matching rate of 56.31%.[54] As a result, any increase in Medicaid reimbursement rates to offset reductions in commercial payments would be largely financed by federal dollars. Additionally, Rhode Island—like many states—uses provider taxes to help fund its share of Medicaid costs.[55] These taxes—applied to hospitals, nursing homes, and managed

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[51] Medicaid and CHIP Payment and Access Commission, *Upper Payment Limit Supplemental Payments* (2021), https://www.macpac.gov/wp-content/uploads/2021/11/Upper-Payment-Limit-Supplemental-Payments.pdf.

[52] Rhode Island Executive Office of Health and Human Services, *Adult Behavioral Health Workforce*, https://eohhs.ri.gov/initiatives/hcbs-workforce-recruitment-and-retention/adult-behavioral-health-workforce; Rhode Island Governor Dan McKee, *Governor McKee, EOHHS Announce State-Directed Payments to Local Hospitals* (January 18, 2024), https://governor.ri.gov/press-releases/governor-mckee-eohhs-announce-state-directed-payments-local-hospitals.

[53] Niraj Gowda & Anthony M. DiGiorgio, *Implications Of The 2024 CMS Rule Change To State-Directed Payment Financing,* Health Affairs Forefront (April 2025), https://www.healthaffairs.org/content/forefront/implications-2024-cms-rule-change-state-directed-payment-financing.

[54] Kaiser Family Foundation, *Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier*, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/?currentTimeframe=1&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D , https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/index.html

[55] Margot Sanger-Katz & Sarah Kliff, *G.O.P. Targets a Medicaid Loophole Used by 49 States to Grab Federal Money*, NEW YORK TIMES, May 6, 2025, https://www.nytimes.com/2025/05/06/upshot/medicaid-hospitals-republicans-cuts.html; .
Alison Mitchell, *Medicaid Provider Taxes*, Congressional Research Service (December 30, 2024) https://crsreports.congress.gov/product/pdf/RS/RS22843#:~:text=A%20vast%20majority%20of%20states,disabilities%20(ICF/ID);

care organizations (MCOs)—generate additional revenue and reduce the burden on the state's general fund. Currently, the state assesses a 5.5% provider tax on nursing facilities, just below the federal maximum of 6%, leaving room to increase within federal limits.[56] Rhode Island could raise existing provider taxes to the federal cap and explore expanding taxes to include other sectors of health care, such as managed care organizations, physicians, and pharmacies. More generally, the state could apply a payroll tax to recoup some of the savings that insurance plans will receive from price controls on providers. Since increasing Medicaid spending would also raise the state's required contribution (in addition to federal matching funds), expanding provider taxes could help offset the need for additional general revenue.

C. Regulate Commercial Prices

Depending on Rhode Island's interest in managing aggregate health care cost inflation, increases in Medicaid reimbursement could be coupled with controls of prices in the commercial insurance market. In this vein, states are increasingly taking action to curb excessive hospital prices. Oregon, for example, recently capped hospital prices for its state employee plan at 200% of Medicare,[57] and in 2025, Indiana and Vermont passed legislation to limit hospital prices across all lines of commercial insurance.[58, 59] Rhode Island currently limits price growth in the fully-insured, non-ERISA commercial market by capping annual increases in hospital and physician prices at the rate of inflation plus 1%.[60]

This option could build on Rhode Island's existing "Affordability Standards" in two key ways. First, it would regulate providers in addition to insurers, thereby extending price regulation to the self-insured ERISA market—the largest segment of commercial insurance in the state.[61] In doing so, Rhode Island could control hospital prices for self-insured ERISA plans without triggering federal preemption.[62] Second, provider-facing rate controls could also be targeted to the highest-priced providers and include a reimbursement "floor" for financially struggling hospitals, so as to support the sustainability of the overall health system. Finally, because

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[56] Rhode Island Executive Office of Health and Human Services, *Rhode Island Medicaid Nursing Facility Rate Development* (May 14, 2024) https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2024-05/Nursing%20Facility%20Rate%20Development%20-%20October%201%2C%202024.pdf

[57] Roslyn C. Murray et al., *Hospital Facility Prices Declined As A Result Of Oregon's Hospital Payment Cap* 424-432, Health Affairs 43:3 (March 2024), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2023.01021.

[58] H.B. 1004, 2025 Sess. (Ind. 2025), https://iga.in.gov/legislative/2025/bills/house/1004/details.

[59] S.126, 2025-2026 Sess. (Vt. 2025), https://legislature.vermont.gov/bill/status/2026/S.126.

[60] Andrew M. Ryan et al., Rhode Island's Affordability Standards Led To Hospital Price Reductions And Lower Insurance Premiums, 44 Health Affairs 597 (2025), http://www.healthaffairs.org/doi/10.1377/hlthaff.2024.01146; The Commonwealth Fund, *Profiles of Cost Containment Strategies* (February 2022), https://www.commonwealthfund.org/sites/default/files/2022-02/Hwang_health_care_cost_growth_strategy_03_rates.pdf.

[61] Agency for Healthcare Research and Quality, *2020 Medical Expenditure Panel Survey-Insurance Component* (2020), https://meps.ahrq.gov/data_stats/summ_tables/insr/state/series_6/2020/tvib2b1.htm.

[62] *See* New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 656 (1995) (holding that ERISA does not preempt state regulation of health care provider payment rates, despite indirect economic impact on self-insured ERISA plans); Rutledge v. Pharmaceutical Care Management Ass'n, 592 U.S. 80 (2020) (holding that ERISA does not preempt state health care cost regulation).

provider-facing rate controls would be paired with substantial Medicaid rate increases, commercial spending could be constrained while preserving or increasing overall provider revenue.

III. Benefits and Tradeoffs

The pricing parity proposal aims to improve access and equity by significantly increasing Medicaid reimbursement rates, with the option of controlling providers' commercial prices to contain overall cost growth. This strategy would allow Rhode Island to strengthen Medicaid, lower commercial insurance costs, and maintain or increase overall provider revenue. By increasing the federal share of health care spending, the approach could also reduce the state's total contribution, and it would likely avoid the need for a federal waiver, unlike other reform options. If Rhode Island were to pursue the dual path, a key challenge would be ensuring that the third-party administrators for self-funded employer-based plans pass along savings to consumers, rather than retaining them as profits or offsetting them through higher premiums. The policy could also have distributional effects: it would redistribute health care funding to even out resources between hospitals, which could garner resistance from hospitals with favorable proportions of privately insured patients. The approach could also be affected by shifting federal policy, particularly efforts to scale back Medicaid funding and the use of provider taxes.[63, 64]

Rhode Island will need to carefully weigh various elements of the proposal. If budget neutrality is paramount, Medicaid rate increases may need to be modest, limiting how far the state can push pricing parity across payers. Pursuing full parity, by contrast, would require more substantial Medicaid investments, potentially funded through insurer taxes. But such taxes could mute savings passed to employers, and the state cannot require self-insured plans to follow suit. If increasing provider reimbursement is the primary goal, then the state would want to minimize employer taxes and controls on commercial prices, but would need to find revenue elsewhere to fund the state portion of Medicaid increases.

State-based Purchasing Pool for Prescription Drugs

I. Overview

Rhode Island could establish a State purchasing pool for prescription drugs (Rx) to address rising drug costs. Following the National Academy for State Health Policy's (NASHP) model,[65] this policy would extend the purchasing power of the existing State Employee

[63] Alice Burns, et al., *5 Key Facts About Medicaid and Provider Taxes*, Kaiser Family Foundation (March 26, 2025), https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-and-provider-taxes/.
[64] Margot Sanger-Katz & Sarah Kliff, *G.O.P. Targets a Medicaid Loophole Used by 49 States to Grab Federal* Money, The New York Times (May 6, 2025), https://www.nytimes.com/2025/05/06/upshot/medicaid-hospitals-republicans-cuts.html.
[65] National Academy for State Health Policy, *A Model Act to Allow Buy-in into State Purchasing Pools for Prescription Drugs* (January 10, 2020), https://www.nashp.org/wp-content/uploads/2020/01/Model-Legis-Purchasing-Pool-convert-to-pdf-1-30-2020.pdf.

Prescription Drug Plan (SEPDP) to additional public and private entities.[66] The primary goal of a state prescription drug purchasing pool is to use public buying power to lower drug costs. Since states already buy prescriptions for their employees—often among the largest groups in the state—they can leverage that scale to negotiate better prices. Expanding these pools to include others increases bargaining power and savings for all participants. Though this public Rx purchasing pool would be legally distinct, it would coordinate with the existing SEPDP, leveraging the joint purchasing power.[67] As part of this plan, Rhode Island could also explore expanding its prescription drug discount card program to reduce costs for residents without prescription drug coverage.

II. Key Design Features

The state prescription drug purchasing pool would leverage the state's substantial bargaining power as a major employer to negotiate better prices with manufacturers, wholesalers, and PBMs. By opening the pool to non-state public employers (like counties, school districts, and universities), private employers, insurers, and individuals, this plan enhances price leverage for all participants and expands the negotiating base of the State Employee Prescription Drug Plan (SEPDP).

The state Rx purchasing pool streamlines administrative burdens through a unified formulary and PBM contract across participants, which can simplify benefit design and reduce complexity across employers and plans. Importantly, because prescription drug coverage does not involve risk pooling, expanding participation does not increase financial risk to the state. Discounts and rebates are based on the total number of covered lives, not health risk, so broader participation enhances savings without raising costs through adverse selection. The pool can also improve access to more favorable pricing and plan terms in parts of the private market that lack strong competition, such as small employers or individual purchasers.

The extent of cost savings depends on favorable terms in the state's PBM contract, for which NASHP's model PBM contract offers guidance.[68] Thus, ensuring a strong PBM contract through the state's procurement process is the first step toward leveraging additional savings through a state Rx purchasing pool. Favorable PBM contract terms include administrative-only fee structures (no spread-pricing), 100% pass-through of rebates and revenues, cost-trend and pricing guarantees, transparency, and member cost-sharing protections.[69]

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[66] Rhode Island Office of Employee Benefits, *Prescription Coverage*, https://employeebenefits.ri.gov/benefit-programs/active-employees/health-benefits/prescription.

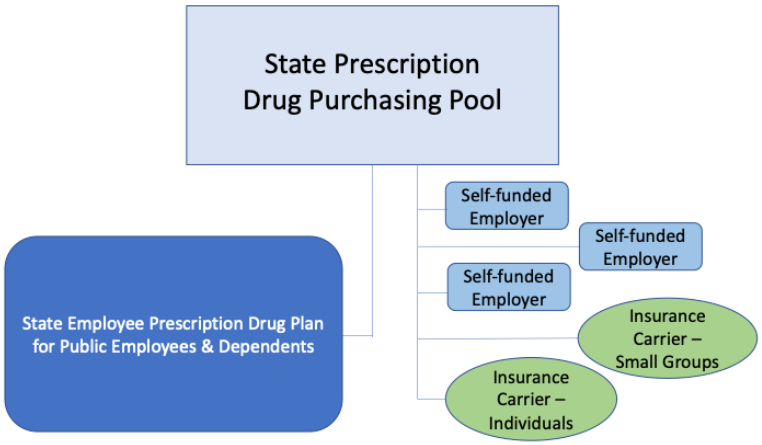
[67] Erin C. Fuse Brown & Mark D. Hunter, NASHP's Proposal for a State Purchasing Pool for Prescription Drugs, National Academy for State Health Policy (Oct. 28, 2019), https://nashp.org/nashps-proposal-for-a-state-purchasing-pool-for-prescription-drugs/ .

[68] Jennifer Reck, Model Pharmacy Benefit Manager Contract Terms Help States Achieve Prescription Drug Savings, National Academy for State Health Policy (Jan. 27, 2020), https://nashp.org/model-pharmacy-benefit-manager-contract-terms-help-states-achieve-prescription-drug-savings/.

[69] Erin C. Fuse Brown, NASHP Model Pharmacy Benefit Manager Contract Terms (Jan. 27, 2020), https://www.nashp.org/wp-content/uploads/2020/01/New-Model-PBM-Contract-final-convert-to-.pdf-1.27.20.pdf.

To maintain compliance with federal regulations, the purchasing pool should be administratively separate from the SEPDP. Allowing non-state employees to buy directly into the SEPDP could jeopardize its ERISA-exempt status as a government plan and invite oversight as a multiple employer welfare arrangement (MEWA).[70] Instead, Rhode Island should establish a separate but coordinated State Rx Purchasing Pool that purchases prescription drugs according to a common PBM contract that the SEPDP and other purchasers can access.[71] Thus, the purchasing pool would be structured as a standalone entity while still leveraging state-negotiated PBM contract terms. Under this structure, customers would remain separate, meaning that each participating plan retains control over its benefits while benefiting from state-negotiated pricing.

Figure 1: State Prescription Drug Purchasing Pool**



** Allows SEPDP to retain ERISA government exemption; does not create a MEWA

For residents without prescription drug coverage, Rhode Island could explore coordinating the State Rx Purchasing Pool's formulary and pricing with its the state's prescription drug discount card program, which currently provides prescription drug discounts for uninsured or underinsured residents.[72] Uninsured individuals could use the drug discount card to access the discounted drug prices available to state employees and other members of the purchasing pool. Uninsured individuals using the discount card would pay for their own prescription drug costs, but they would benefit from the deep discounts the state was able to negotiate via the purchasing pool.

While similar in intent, state prescription drug discount card programs are more limited than a State Rx Purchasing Pool. Discount card programs rely on the state's Medicaid purchasing power to negotiate discounts, but they do not offer Medicaid prices. Instead, they leverage tools

[70] Id.
[71] NASHP, Q&A: A Model Act to Allow Buy-In into a State Purchasing Pool for Prescription Drugs, Jan. 3, 2020, https://nashp.org/qa-a-model-act-to-allow-buy-in-into-a-state-purchasing-pool-for-prescription-drugs/.
[72] Rhode Island Rx Card, *About Rhode Island Rx Card*, https://rirx.com/.

like prior authorization threats to encourage manufacturer discounts. However, because Medicaid must cover all FDA-approved drugs and cannot use closed formularies, the state's leverage in these programs is constrained.[73]

In contrast, the State Rx Purchasing Pool derives its bargaining power through the SEPDP and other non-Medicaid purchasers. The state has more flexibility in administration of these drug benefits—including formularies, tiering, and utilization management—allowing it to negotiate more effectively for discounts than is possible under Medicaid rules.

V. Legal Risks

To preserve the ERISA-exempt status of the State Employee Prescription Drug Plan (SEPDP) as a governmental plan, non-state employers cannot be permitted to buy into the SEPDP directly.[74] Doing so would trigger federal oversight and additional compliance burdens under ERISA. Establishing a standalone, administratively separate purchasing pool allows non-state employers and other entities to participate without compromising the SEPDP's exempt status or exposing the state to these risks.

In addition, allowing private, non-governmental employers to buy into the SEPDP directly would reclassify the plan as a Multiple Employer Welfare Arrangement (MEWA),[75] subject both to federal and state laws. In Rhode Island, MEWAs may not be self-insured and must obtain a license as an insurer.[76] These legal difficulties regarding creation of a MEWA can largely be avoided by separating the administration of the SEPDP and a State Rx Purchasing Pool, as described above.

The Affordable Care Act (ACA) requires health plans in the individual and small group markets to cover a set of Essential Health Benefits (EHB),[77] including prescription drugs. To remain compliant, the State Rx Purchasing Pool must not function to carve-out prescription drug benefits from insurers' existing products. Instead, insurers participating in the purchasing pool should be allowed to adopt the state's pharmacy benefit design and PBM contract terms, which could help control drug costs while maintaining full benefit coverage. Because Rhode Island operates its own ACA marketplace, HealthSource RI, it has the flexibility to certify qualifying health plans that participate in the State Rx Purchasing Pool to furnish its prescription drug benefit.

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[73] Erin C. Fuse Brown & Mark D. Hunter, NASHP's Proposal for a State Purchasing Pool for Prescription Drugs, National Academy for State Health Policy (Oct. 28, 2019), https://nashp.org/nashps-proposal-for-a-state-purchasing-pool-for-prescription-drugs/ .

[74] Id.

[75] U.S. Department of Labor, *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* (April 2022), https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/mewa-under-erisa-a-guide-to-federal-and-state-regulation.pdf.

[76] https://rules.sos.ri.gov/Regulations/part/230-20-30-11?reg_id=9773.

[77] Centers for Medicare & Medicaid Services, *Information on Essential Health Benefits (EHB) Benchmark Plans*, https://www.cms.gov/marketplace/resources/data/essential-health-benefits.

III. Benefits and Tradeoffs

A State Rx Purchasing Pool could help Rhode Island address rising prescription drug costs that continue to strain the state budget, employers, and consumers. By leveraging the SEPDP, the state could secure lower drug prices for a broader range of public and private entities. One clear advantage of this model is its potential to achieve significant cost savings through bulk purchasing and formulary management strategies.

The advantages of the State Rx Purchasing Pool derive from the strength of the state's contractual terms with and oversight over its PBM. To strengthen the state's oversight over its PBM, the state may need to renegotiate or re-procure its PBM contract to ensure the most favorable terms for the purchasing pool.

For those without prescription drug coverage, the Rhode Island discount card program could gain greater negotiating flexibility by coordinating with the State Rx Purchasing Pool's negotiated prices and formulary management, rather than relying on Medicaid's limited negotiating power.

A key challenge lies in preserving the SEPDP's ERISA-exempt status: allowing non-state employees to buy into the SEPDP directly could trigger additional federal and state oversight. To mitigate this risk, the purchasing pool must remain administratively separate from the SEPDP, ensuring regulatory compliance while enabling expanded participation. While this would avoid federal oversight, it adds a layer of administrative complexity for the state to navigate.