Care New England, 10 Charles Street, Suite 250, Providence, RI 02904
carenewengland.org

To: Senate Committee on Finance
From: Care New England Health System
Date: March 31, 2026
Subject: CNE Opposition on Article 11, Section 12 - Health Spending Accountability and Transparency Program

Dear Chairman DiPalma and members of the Committee,

Care New England (CNE) strongly opposes the proposed Health Spending Accountability and Transparency Program set forth in Article 11, Section 12 of the Governor's FY 2027 budget. While CNE fully supports the shared objective of improving affordability, access, equity, and quality for Rhode Islanders, this legislation adopts a fundamentally flawed framework that will not achieve those goals and risks significant unintended consequences.

At its core, the proposal misdiagnoses the primary drivers of health care cost growth, concentrates extraordinary regulatory authority in a single office without sufficient checks and balances, relies on vague and punitive enforcement mechanisms, and selectively targets large, integrated health systems - particularly CNE and Brown University Health - without addressing broader systemic drivers such as federal payment policy, pharmaceutical pricing, labor market pressures, and fragmented care for the highest-need patients. **Rather than stabilizing Rhode Island's fragile health care ecosystem, the proposal risks exacerbating financial instability, discouraging investment, and undermining access to essential services for the state's most vulnerable populations.**

I. Fundamental Misinterpretation of Health Care Cost Drivers

The proposed legislation is rooted in an outdated and incomplete understanding of what drives health care spending growth.

The emphasis on "rebalancing spending toward primary care and prevention," while laudable as a long-term aspiration, fails to address the immediate and dominant cost driver in the system: a small, high-need population whose care is fragmented, poorly coordinated, and often inaccessible across the continuum. Roughly five percent of patients account for approximately fifty percent of total health care spending. For these individuals, costs are driven not by insufficient prevention alone, but by:

- Fragmented care delivery across settings and providers
- Poor integration between medical, behavioral health, and social services
- Inadequate access to timely outpatient, behavioral, and community-based care
- Structural health inequities and disparities

Absent a policy framework that explicitly prioritizes integration, continuity, and access for these high-risk and emerging-risk populations, the state will not meaningfully bend the cost curve. The proposed legislation instead risks diverting attention toward blunt spending targets that do not distinguish between productive investment and waste.

II. Over-Concentration of Authority in the Health Insurance Commissioner

Article 11, Section 12 grants sweeping new authority to the Office of the Health Insurance Commissioner (OHIC), with minimal guardrails, limited procedural protections, and no meaningful counterbalance from other branches of government or independent bodies.

Although the proposal establishes advisory committees, these bodies are explicitly advisory only. Ultimate authority (including target setting, determinations of compliance, approval or rejection of performance improvement plans, and imposition of financial penalties) rests solely with the Commissioner.

This structure creates significant risk of arbitrary or capricious decision-making and undermines confidence in regulatory fairness, particularly when applied to complex, mission-driven health systems operating under severe financial constraints.

III. Advisory Committee Structure Is Unworkable and Unbalanced

The proposed advisory structure is deeply flawed:

- The Affordability Advisory Committee requires members to have no direct financial interest in the health care system, yet demands sophisticated expertise in health care economics, delivery, and financing - a combination that will be extraordinarily difficult to achieve within RI's small market.
- The legislation is silent on conflicts of interest involving other organizations (e.g., the plaintiff bar and nationally funded advocacy organizations), which have material financial and political interests in health care regulation.
- There is no clear mechanism to ensure balanced representation or to prevent informal influence outside the advisory process.

As designed, the advisory committees are unlikely to meaningfully constrain or inform the Commissioner's decisions in a rigorous, balanced, and transparent manner.

IV. Punitive and Open-Ended Use of Performance Improvement Plans (PIPs)

The proposal relies heavily on performance improvement plans as a primary enforcement tool, modeled loosely on Massachusetts' experience. However, critical contextual differences are ignored:

- Massachusetts operates in a substantially better-funded reimbursement environment, with higher commercial and public payer rates than Rhode Island.
- There is no credible evidence that Massachusetts' Health Policy Commission has materially reduced overall health care cost growth at the state level.

Under the proposed legislation:

- The Commissioner has unilateral discretion to require PIPs.
- The affected organization bears the full cost of plan development, oversight, and monitoring.
- There is no independent appeals process.

This creates a perverse incentive to deploy PIPs frequently, regardless of whether cost growth is driven by factors outside a provider's control, such as labor shortages, drug pricing, or payer behavior.

V. Selective and Disproportionate Targeting of Large Health Systems

Although the legislation is framed as system-wide accountability, its practical impact will fall disproportionately (and intentionally) on a small number of large provider entities, most notably CNE and Brown University Health.

The definition of "large provider entity," combined with vague language regarding market attribution and spending responsibility, invites selective enforcement and regulatory overreach. The proposal does not meaningfully address:

- Dominant specialty providers with substantial market share
- Pharmaceutical manufacturers and pharmacy benefit managers as primary cost drivers

- Federal payment policy constraints in Medicare and Medicaid

This selective focus risks weakening the very organizations that anchor access to maternity care, behavioral health, safety-net services, and academic medicine in Rhode Island.

VI. Failure to Address All-Payer Reality and Structural Underfunding

The legislation inadequately accounts for the all-payer environment in which Rhode Island providers operate:

- Medicare and Medicaid rates remain structurally inadequate and are largely outside state control.
- Employer-sponsored, self-insured plans are treated inconsistently.
- State and municipal benefit structures are insufficiently addressed.

Without confronting these realities, imposing cost growth targets on providers is both inequitable and ineffective.

VII. Risk to Access, Stability, and Long-Term Sustainability

Rhode Island's health care system is already under extraordinary strain. Hospitals and health systems face:

- Chronic operating losses
- Workforce shortages and escalating labor costs
- Aging infrastructure
- Rising pharmaceutical and supply expenses

Layering an aggressive, punitive regulatory regime on top of this fragile environment risks accelerating service reductions, delaying investment, and ultimately diminishing access for patients.

Conclusion

CNE urges the Committee to not advance Article 11, Section 12 in its current form. The proposal reflects a punitive, centralized, and misdirected approach to health care affordability that fails to address the true drivers of cost growth and threatens the stability of Rhode Island's health care system.

CNE stands ready to work collaboratively with policymakers, regulators, employers, labor, and consumer advocates on a more balanced and constructive framework - one that prioritizes access, integration, equity, and sustainable investment rather than punitive oversight.

Respectfully submitted,

Michael Wagner, MD

Care New England Health System