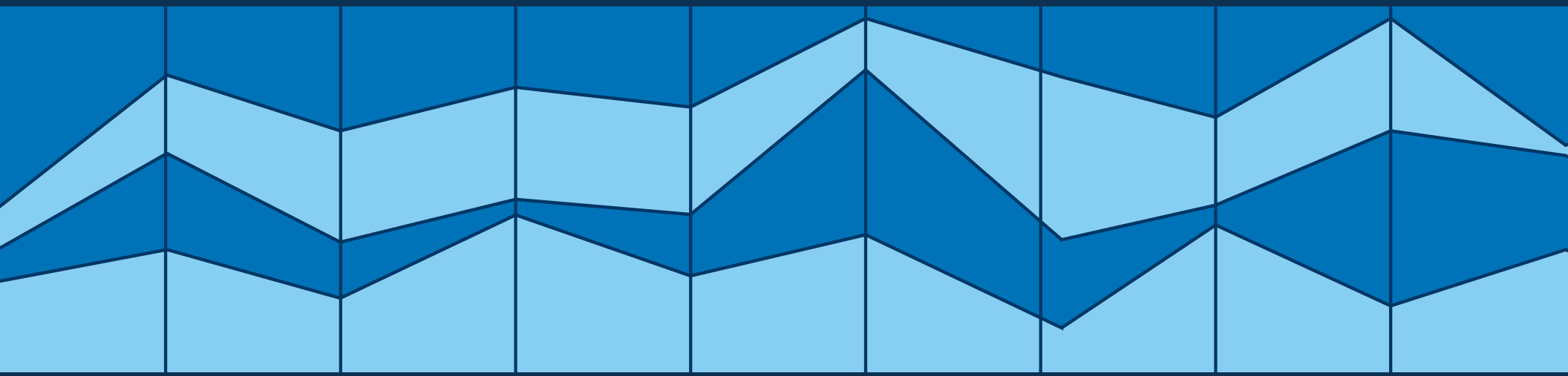
STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

CHARTBOOK

Rhode Island OHIC

2024



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CHAPTER 1

Commercial Spending Trends

Introduction

- This chapter provides readers with an overview of commercial market spending and spending trends, using the most recent data available.
- Most of the analyses in this chapter utilize data from Rhode Island's All-Payer Claims Database (ACPD), HealthFacts RI. The 'Composition of Non-Claims Spending in the Commercial Market' chart uses data from the cost growth target data collection, as those data are not reported in the APCD (more details follow below).
- Key terms used in this chapter:
  - PMPM = Per Member Per Month, equal to the total spend amount for the year divided by the number of member months.
  - PPU = Payment Per Unit, equal to the total spend amount divided by the number of service units.
  - UPK = Units per 1,000 members, calculated as the unit of care divided by the number of members multiplied by 1,000.

Important note: This chartbook contains analyses using data from both HealthFacts RI and the Rhode Island Health Care Cost Growth Target data collection. While these data sources have some shared features, there are also important differences between them that affect the comparability of analyses generated from their use. The table below details the similarities and distinctions between them.

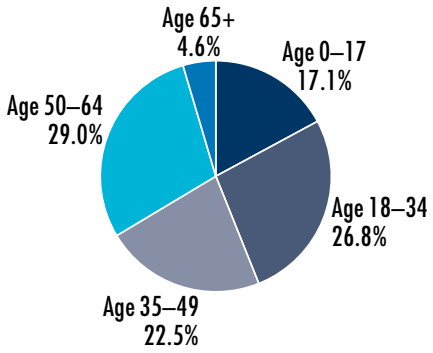
	Cost Growth Target Data Collection (Total Medical Expense ("TME") Data)	All-Payer Claims Database	Notes
Primary Purpose & Key Questions Answered	Used to calculate growth in total health care costs ("total medical expense") over a given period (assess performance against the cost growth target); represents all health care spending in the state. • How much did spending increase or decrease from one year to the next?	Used to identify cost drivers and cost growth drivers for the purpose of identifying opportunities for cost growth mitigation; does not include all state spending data. • What is driving overall cost and cost trends? Where are the opportunities to reduce cost growth?	None
Level of Detail in Data	Aggregate data; does not allow for claim-level analyses.	Granular data; allows for claim-level analyses.	Data from the cost growth target data collection are publicly reported on an annual basis at the state, market, payer, and provider levels.[1] Payer and provider-level analyses rely on data from the cost growth target data collection.
Populations Included or Excluded in Commercial Market Data	Includes data for all state residents of fully insured plans (individual, small, and large group plans) and self-insured plans.	Includes data for all state residents of fully insured plans (individual, small, and large group plans) and self-insured employers that elect to voluntarily submit data to the APCD.	RI's APCD (like other states' APCDs) does not fully contain spending associated with residents with commercial market coverage due to the State's inability to require claims submissions from self-insured employers (although some do opt in and submit data). Approximately 80 percent of total commercial spending, and 80 percent of commercially covered lives in the state are represented in the APCD.
Types of Data Included or Excluded			
Spending on Non-Claims	Included.	Excluded.	None
Pharmacy Claims Spending	Includes estimated pharmacy spending for members with carved-out benefits (e.g., pharmacy coverage that is not part of their medical health benefits plan).	Includes actual claims from pharmacy benefit managers that administer carve-out pharmacy benefits.	This key difference leads to higher pharmacy spending in the APCD relative to the cost growth target data collection.
Pharmacy Rebates[2]	Includes pharmaceutical rebates for both drugs administered by a health care provider (i.e., "medical pharmacy"), and for prescription medications obtained by consumers in a retail setting (e.g., drugstore) or via mail order.	Excludes all pharmacy rebates.	Analyses using cost growth target data collection are typically reported net of rebates and will be specified as such when relevant.

1 OHIC annually publishes the results from its analysis of performance against the cost growth target. For more information, see: Office of the Health Insurance Commissioner, *Health Spending Accountability and Transparency Program*, accessed April 27, 2024, https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program

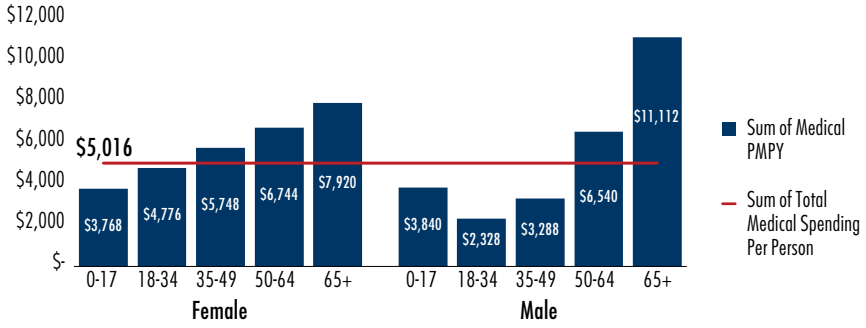
2 Drug rebates are discounts that drug manufacturers give to third-party entities such as health insurers on the cost of prescription drugs. In the cost growth target data collection, payers report pharmaceutical rebates in aggregate, and these rebates are "netted out" (i.e., removed) from pharmacy spending in analyses.

Commercial Health Care Spending by Age and Sex & Distribution by Age Group (2022)

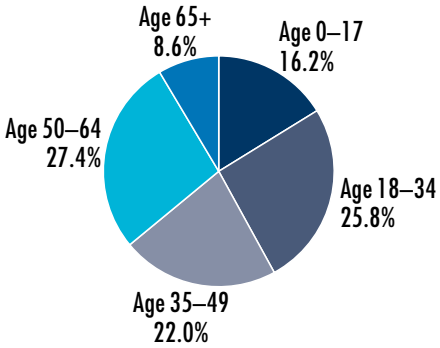
2022 Population Distribution for Medical Services by Age Band



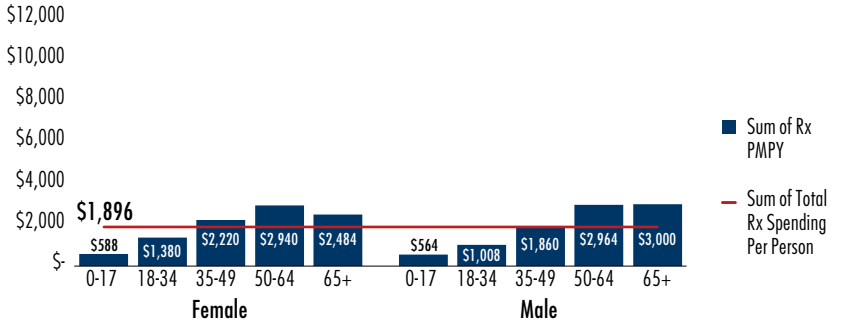
2022 Medical Services Spending Per Person by Age and Sex



2022 Population Distribution for Retail Pharmacy Services by Age Band



2022 Retail Pharmacy Spending Per Person by Age and Sex



Source: OHIC analysis of HealthFacts RI data. 'Medical services' includes Inpatient Hospital, Outpatient Hospital, Professional services, Long-Term Care, and Other claims (includes hospice, dialysis, care management, vision, hearing, and speech). Population and spending for Medical and Retail Pharmacy services are shown separately because of differences in the populations. Members included under 'Medical' had 1) both medical and pharmacy benefit coverage, and 2) just medical benefit coverage. Those members under 'Retail Pharmacy' had 1) both medical and pharmacy benefits, and 2) just pharmacy.

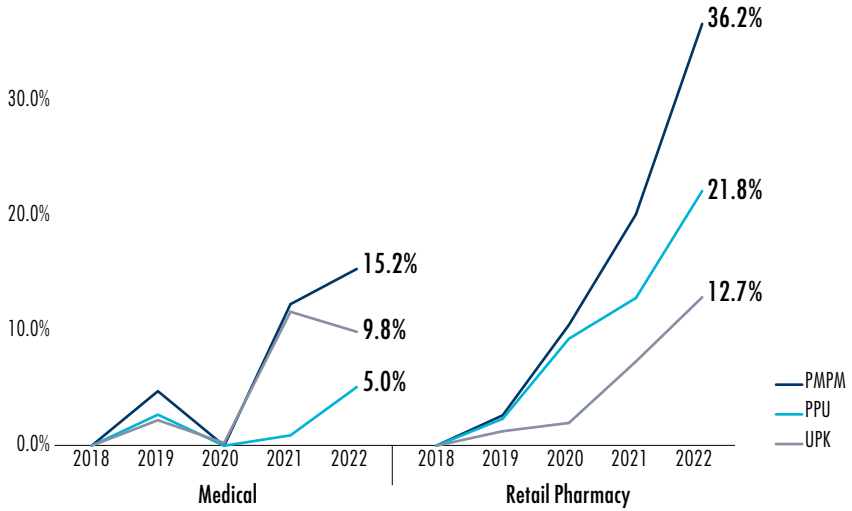
Note: OHIC's 2024 Annual Report on Health Care Spending and Quality in Rhode Island reported that, according to data reported by the four largest commercial insurers in the state (Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Plan (THP), and UnitedHealthcare (UHC)) as part of the Cost Growth Target data collection, per capita spending for all services (both Medical and Retail Pharmacy) in the commercial market was $6,378 in 2022. For more information, see Office of the Health Insurance Commissioner, Health Spending Accountability and Transparency Program, accessed April 27, 2024, https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program. The sum of the PMPY values for Medical and Retail Pharmacy services from the APCD is $6,912 (given the differences in the population for the two services, this should be understood as a rough estimate for illustrative purposes). The difference in these values can be attributed to the methodological differences between the two data sources outlined in the Introduction (e.g., the cost growth target data have pharmacy rebates removed, while the APCD data do not).

Summary Observations

- In 2022, the average per person spending for Medical services was $5,016. The average spend per person for prescription drugs was $1,896.
- More than half of the Rhode Island commercial enrollees represented in the APCD data are over 35 years old. Seniors (65+) make up a small portion of the commercially insured population.
- Medical spending for females steadily increased with age, with spending lowest for children and adolescent girls, and highest for elderly women. On the other hand, for males, spending per person for both young adult and middle-aged men were lower than spending per person for children and adolescent boys. Generally, health care spending was higher for females than males. Two exceptions to this were for the 0–17 age band, where spending between the sexes was similar, and the 65+ age band, where males' spending was nearly 50% higher than that of females.
- Retail Pharmacy spending for female and male children was comparable, but females had substantially higher spending in both young adulthood (18–34 years) and middle age (35–49 years).

Key takeaway: Unsurprisingly, health care spending increases with age.

Cumulative Percentage Change in PMPM, PPU, and UPK for Medical Services Overall and Retail Pharmacy (2018–2022)



Source: OHIC analysis of HealthFacts RI data. 'Medical services' includes Inpatient Hospital, Outpatient Hospital, Professional services, Long-Term care, and Other claims (includes hospice, dialysis, care management, vision, hearing, and speech). Metrics for Medical and Retail Pharmacy services are shown separately because of differences in their populations. Members under 'Medical' includes enrollees with 1) both medical and pharmacy benefits, and 2) just medical benefits. Those under 'Retail Pharmacy' are those with 1) both medical and pharmacy benefits, and 2) just pharmacy. The data labels correspond to cumulative growth over the five-year period. Pharmacy units are in 30-day equivalents.

PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

Medical

- Spending per person on Medical services grew 15 percent, at an average annual rate of 3.8 percent. This increase was driven by both growing utilization and average unit payments; utilization increased nearly two percent per year, while average payment per unit increased about one percent per year.
- Both 2020 and 2021 were dramatically impacted by COVID-19, particularly with respect to service utilization. In 2020, people decreased their use of health care services due to fear of spreading infection and quarantine orders. In 2021, utilization increased substantially (12 percent), largely due to people seeking care after having delayed, canceled, or avoided it in 2020.
- While utilization grew substantially in 2021, payment per unit increased only slightly (0.8 percent). This was likely because the rebound in utilization was for less costly services, especially high-volume and low-priced COVID-19 vaccines in 2021.

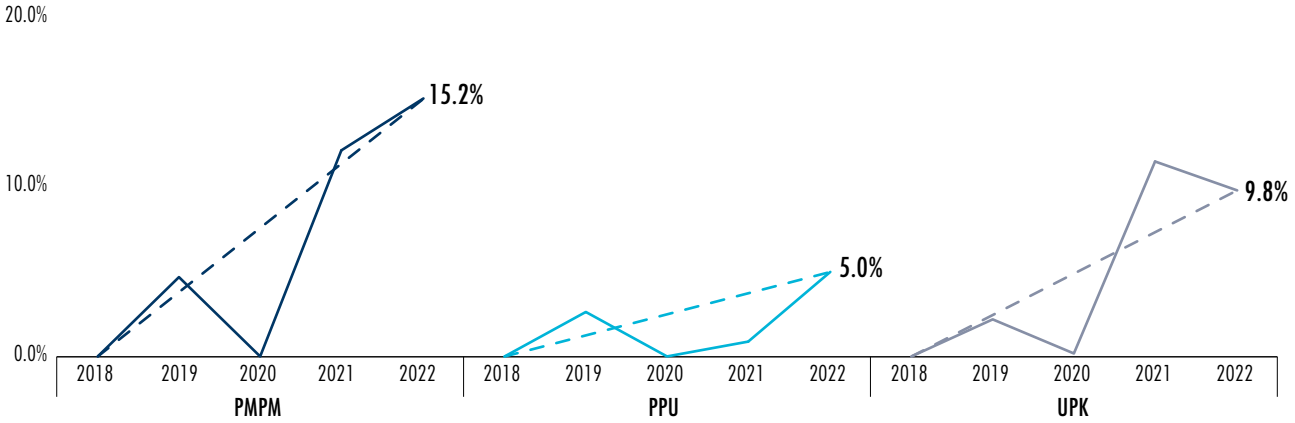
Retail Pharmacy

- Between 2018 and 2022, spending per person increased over 36 percent; this growth in spending was primarily due to an increase in unit payments.
- In this five-year period, prescription drug unit payments increased most dramatically in 2020 (6.7 percent) and 2022 (8.2 percent). In both years, unit payments for Humira, an immunological agent that treats different auto-immune conditions that has repeatedly topped the list of highest spend drugs in the commercial market in the state, increased substantially (9.3 percent and 8.4 percent, respectively).
  - Unit payments for prescription drugs overall grew more modestly in 2021 at 3.2 percent; this is due to the introduction of COVID-19 vaccines that were subsidized and made available at very low unit prices.
- Utilization, on the other hand, increased slightly through 2020, but then increased more substantially in 2021 and 2022. The sharper increases in utilization can partially be owed to 1) the shift in prescribing practices, where pharmacists dispensed 90-day supplies of prescriptions during the height of the coronavirus pandemic, and 2) the administration of high volumes of COVID-19 vaccines, especially in 2021.

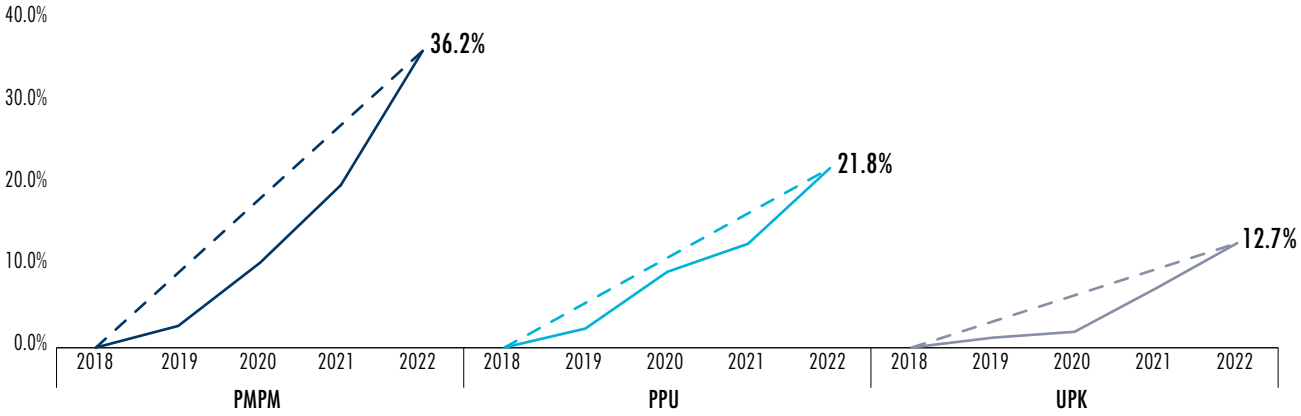
Key takeaway: Between 2018 and 2022, growth in spending, utilization, and service unit payments for medical services overall was modest in Rhode Island. As for prescription drugs, a large increase in spending was driven by an increase in unit payments and utilization.

Cumulative Percentage Change and Trend Line of Constant Growth in PMPM, PPU, and UPK for Medical Services and Retail Pharmacy (2018–2022)

Medical Services



Retail Pharmacy



Source: OHIC analysis of HealthFacts RI data. 'Medical services' includes Inpatient Hospital, Outpatient Hospital, Professional services, Long-Term Care, and Other claims (includes hospice, dialysis, care management, vision, hearing, and speech). Metrics for Medical and Retail Pharmacy services are shown separately because of differences in their populations. Members under 'Medical' includes enrollees with 1) both medical and pharmacy benefits, and 2) just medical benefits. Those under 'Retail Pharmacy' are those with 1) both medical and pharmacy benefits, and 2) just pharmacy. The data labels correspond to cumulative growth over the five-year period. Pharmacy units are in 30-day equivalents.

Note: The Medical and Retail Pharmacy charts have different scales on their y-axes so that the detail for these metrics for Medical can be seen more easily.

PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

Medical

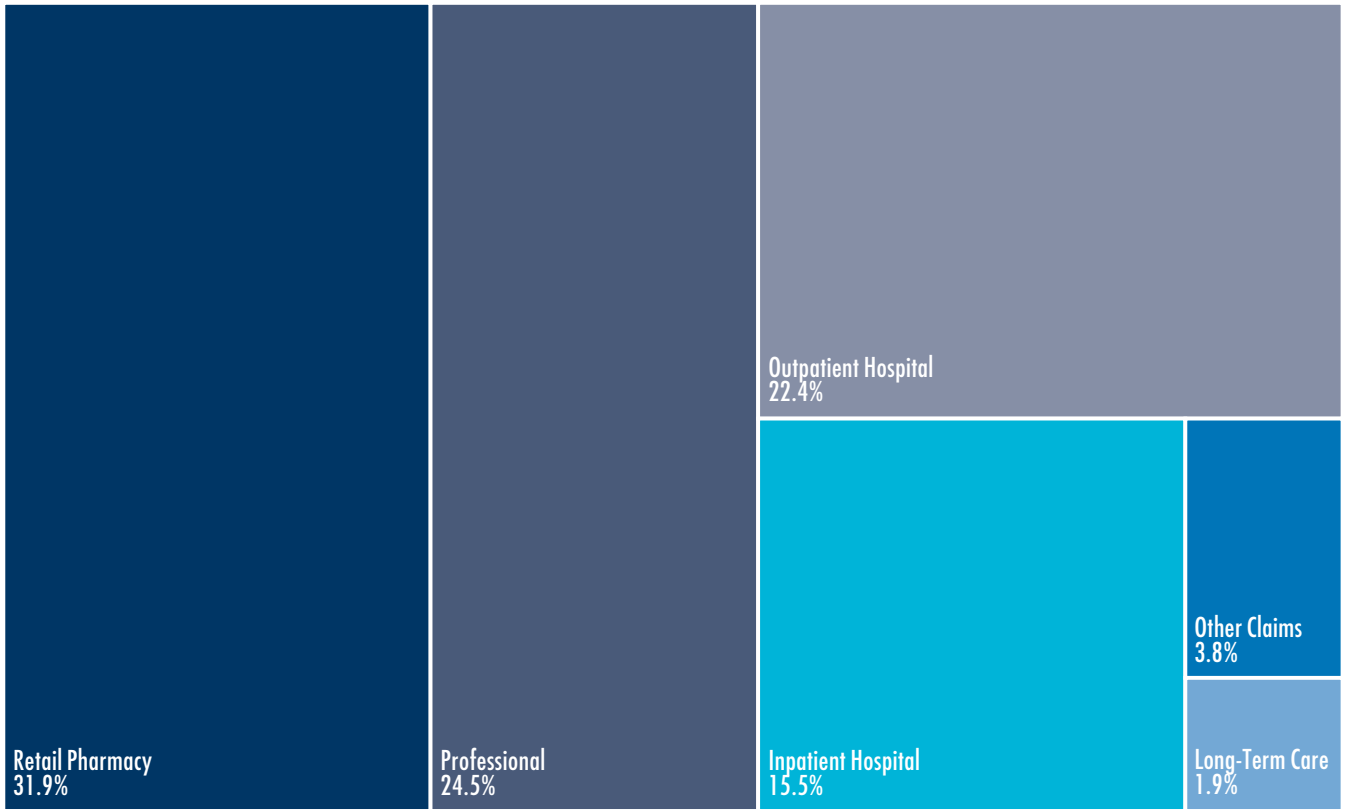
- The rebound in 2021 in per person spending on overall Medical services offset the significant drop in 2020, and the trajectory of PMPM spending growth in 2021 and 2022 mirrored its growth in 2019 and 2020.
- Average PPU also experienced a substantial drop in 2020, but growth was slow in 2021. The deviation in PPU from its five-year trend from 2018 through 2021 was balanced out by the 4.2 percent increase in 2022.

Retail Pharmacy

- Spending, average payment per unit, and utilization of prescription drugs continued to increase through the pandemic.

Key takeaway: Spending, utilization, and average payments of medical services were significantly affected by the COVID-19 pandemic. On the other hand, notably, prescription drug unit payment growth remained fairly constant while utilization was less affected by the COVID-19 pandemic.

Share of Aggregate Commercial Spending by Service Category (2022)



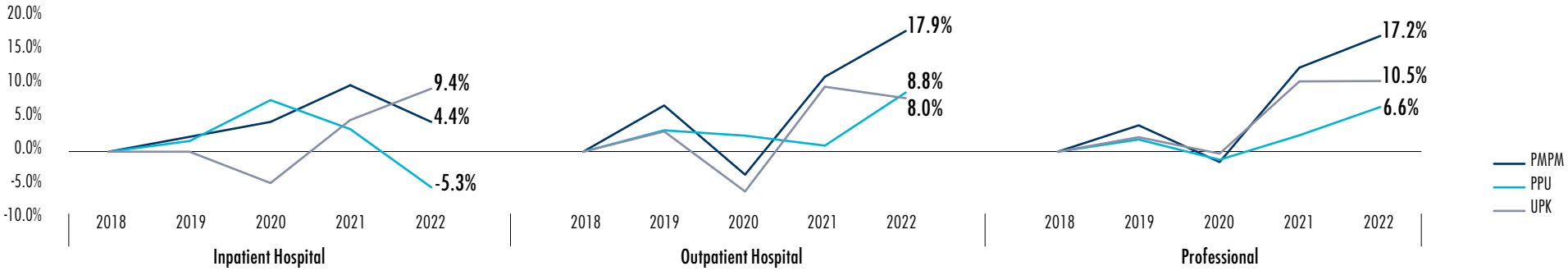
Source: OHIC analysis of HealthFacts RI data. These data include pharmacy rebates. "Other" includes hospice, dialysis, care management, vision, hearing, and speech.

Note: OHIC's 2024 Annual Report on Health Care Spending and Quality in Rhode Island reported that, according to data for performance 2022 submitted by the four largest commercial insurers in the state (BCBSRI, NHPRI, THP, and UHC) as part of the Cost Growth Target data collection, the service category with the highest spending per person was Outpatient Hospital. Additionally, in the cost growth target data collection, spending on 'Professional' services is broken up into 'Professional Physician' and 'Professional Other'. If the per capita values for these categories from the cost growth target data were summed, the resulting total 'Professional' category would be the service category with the highest spending.
For more information, see: Office of the Health Insurance Commissioner, Health Spending Accountability and Transparency Program, accessed April 27, 2024, https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program

Summary Observations

Spending on Retail Pharmacy and Professional services combined represented over half of all spending for the commercial market in 2022. As expected, Long-Term Care and Other Claims represented a small portion of spending.

Cumulative Percentage Change in PMPM, PPU, and UPK for Inpatient Hospital, Outpatient Hospital, and Professional Services (2018–2022)



Summary Observations

- **Inpatient Hospital:** Spending increased over four percent over this five-year period, at an average rate of one percent per year. Spending levels peaked in 2021, when utilization rebounded following the height of the coronavirus pandemic. However, at the same time, average payment per unit for Inpatient Hospital services steadily declined in 2021 and 2022 (-4.0 percent and -8.4 percent, respectively). These decreases likely resulted from, among other factors, the transition of joint replacements being performed in an inpatient setting to an outpatient setting (for more information, see Explanations for Decrease in Inpatient Hospital PPU (2021 and 2022).
- **Outpatient Hospital:** Per person spending on Outpatient Hospital services grew 17.9 percent between 2018 and 2022, averaging 4.5 percent per year. The increase in spending in 2021 reflected more than just a rebound from the COVID-19 pandemic. Some of this is likely attributed to the consequences of delaying care in 2020; for those with chronic conditions, delaying necessary medical care means disease progression and increased health care costs down the line. These increases in spending coincided with large increases in utilization.
  - Average payment per unit for Outpatient Hospital services declined slightly in 2020, more dramatically so in 2021, and then increased by 7.8 percent in 2022. The PPU decrease in 2021 is due to the inclusion of COVID vaccines in the data. As reported by OHIC in its 2024 Annual Report, the increase in PPU in 2022 was influenced by the movement of joint replacement surgeries from inpatient to outpatient settings.[1] Additionally, it is possible that deferred care in 2020 was for expensive services (certain elective procedures) that were then performed in 2022.
- **Professional:** Per person spending on Professional services grew at an average of 4.3 percent annually. As was the case with Outpatient Hospital services, there was also a dramatic drop in per person spending on Professional services in 2020, and spending more than rebounded in 2021. The large jump in utilization in 2021 appears to be driven, at least in part, by the increased use of mental health counseling services.[2] In 2022, spending continued to increase while utilization generally remained at its heightened level.

Key takeaway: Spending, utilization, and average unit payments each grew over this five-year period for Outpatient Hospital and Professional services. The decrease in PPU for Inpatient Hospital services is unusual and unexpected, as insurers are highly unlikely to have done anything but increased their contracted rates; for more explanation on this pattern, see Explanations for Decrease in Inpatient Hospital PPU (2020–2022).

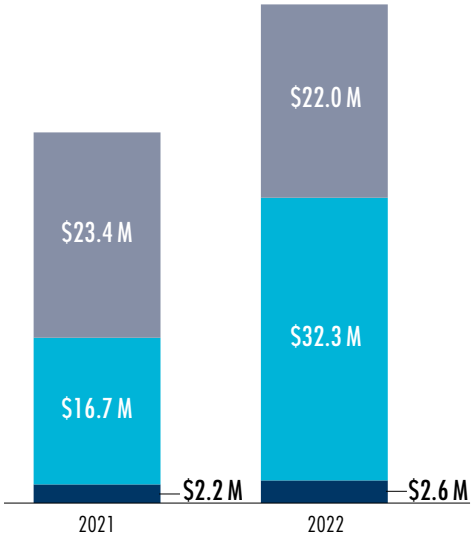
1 For more information, see: Office of the Health Insurance Commissioner, *Health Spending Accountability and Transparency Program*, accessed April 27, 2024, https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program.
2 An OHIC analysis of professional spending related to mental health services found that utilization rates for mental health services increased substantially for children, adolescents, and young adults spanning the years leading up to and during the COVID-19 pandemic. For more information, see: Office of the Health Insurance Commissioner, *Mental Health Service Utilization on the Rise in Rhode Island*. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-03/RI%20OHIC%20March%20Data%20Story%20Mental%20Health.pdf

Source: OHIC analysis of HealthFacts RI data. The data labels correspond to cumulative growth over the five-year period.

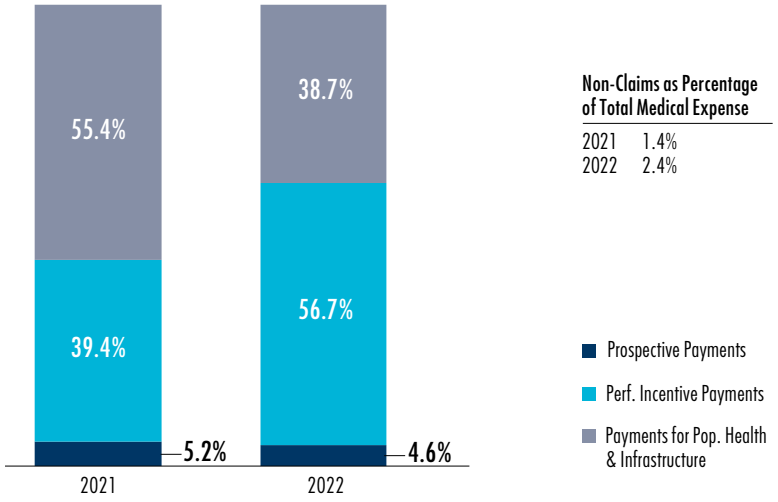
PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Composition of Non-Claims Spending in the Commercial Market (2021–2022)

Spending by Category



Spending by Category as Percentage



'Non-Claims spending' includes payments under alternative payment methods (APMs) and others (e.g., Payments for Population Health and Infrastructure). APMs are payment arrangements that incentivize providers to provide high-quality and cost-effective health care and reward them when they do.

'Prospective Payments' include: capitated, global budget, case rate, and episode-based payments. 'Performance incentive payments' includes pay-for-performance and pay-for-reporting. 'Payments for Population Health and Infrastructure' includes payments that support care management, care coordination, and population health (e.g., infrastructure payments for health information technology or management of electronic health records systems.

Source: OHIC analysis of TME data submitted by the four largest commercial insurers in the state (Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Plan (THP), and UnitedHealthcare (UHC)) as part of the Cost Growth Target data collection. There are three other commercial insurers in the state: Harvard Pilgrim Health Care, Aetna, and Cigna, each of which has limited presence in the RI commercial insurance market. Note that the source for these data differs from the source for the data for the preceding graphs in this chapter. HealthFacts RI does not include data on non-claims spending.

Summary Observations

- Most Non-Claims spending in 2021 was for Population Health and Infrastructure Support; in 2022, most Non-Claims spending was for Performance Incentive Payments. Capitated payments were low in both years.
- Overall, Non-Claims payments make up a small portion of total spending in the commercial market. In 2022, only 2.4 percent of total health care spending was for Non-Claims payments, which represented a one percentage point increase from 2021.

CHAPTER 2

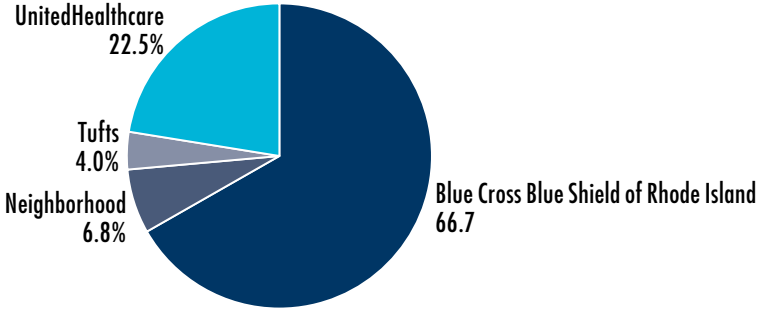
Commercial Payer & ACO Spending

Introduction

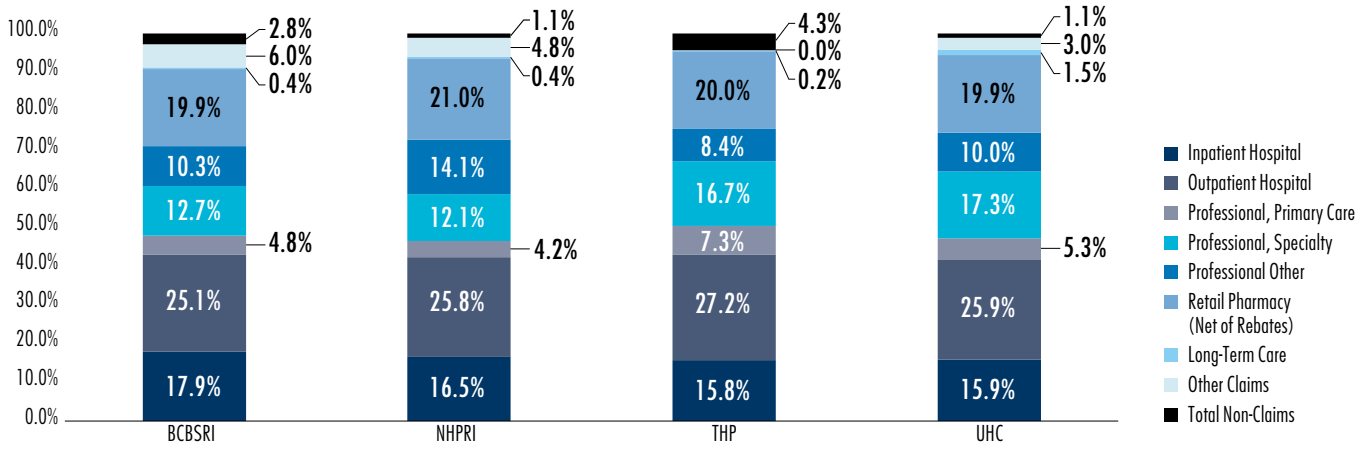
- The analyses in this chapter rely on data reported for the cost growth target data collection. The analyses shown here are not directly comparable, nor are they entirely consistent with those in Chapter 1 due to key data source differences:
  - Cost growth target data are for all state residents of fully insured and self-insured plans, while APCD data are for state residents of fully insured plans and self-insured employers that opt to submit data, and
  - pharmacy spending from the cost growth target data includes pharmacy rebates while that spending in the APCD does not.

Attributed Lives & Service Category Contribution to Commercial TME by Payer (2022)

2022 Commercial Attributed Lives by Payer



2022 Service Category Contribution to Commercial TME by Payer



Source: OHIC analysis of TME data submitted by the four largest commercial insurers in Rhode Island (Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Plan (THP), and UnitedHealthcare (UHC)) as part of the Cost Growth Target data collection. There are three other commercial insurers in the state: Harvard Pilgrim Health Care, Aetna, and Cigna, each of which has limited presence in the RI commercial insurance market. Retail pharmacy spending is net of total pharmacy rebates.

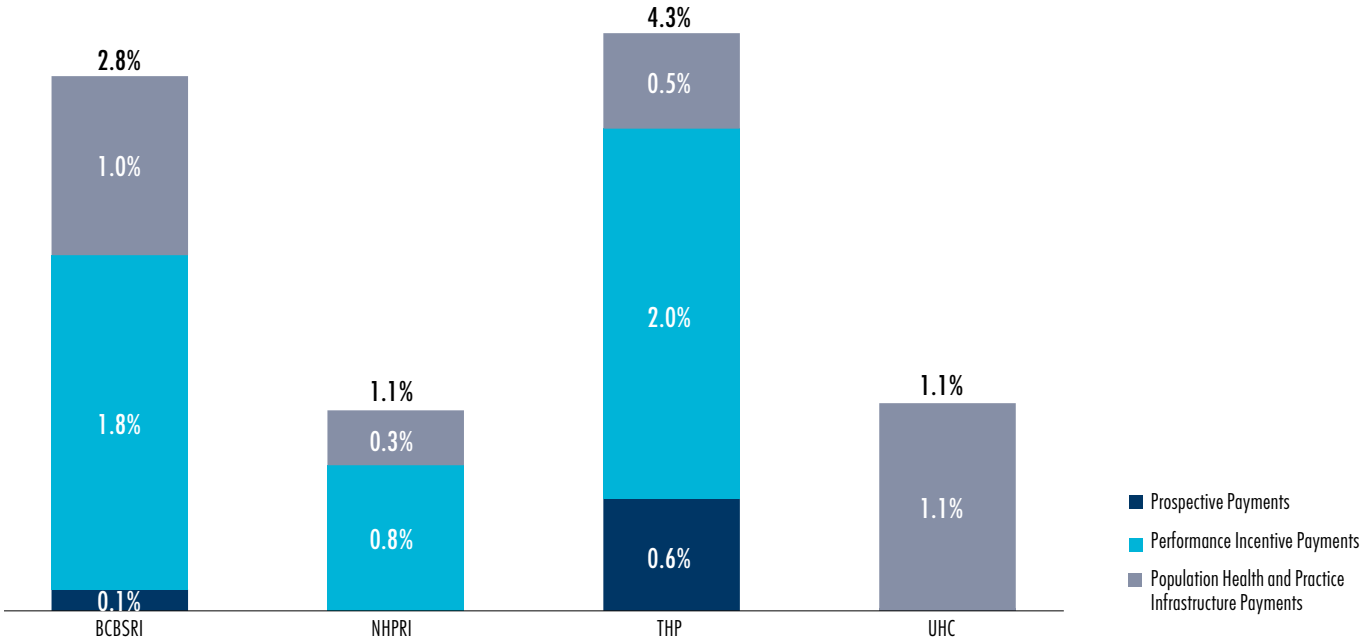
Important Note: The data in the bar graph are not the same as the data that are used to assess payers against OHIC's Primary Care Spend Obligation, which is a regulatory requirement included in OHIC's Affordability Standards.[1] The data shown in this graph reflect the entirety of the fully insured and self-insured segments of the commercial market, while the Primary Care Spend Obligation is relevant only for the fully insured segment and for payments to Rhode Island providers. Additionally, the Primary Care Spend Obligation excludes Long-Term Care in its definition of total medical expense, while the cost growth target data collection includes it. Therefore, commercial insurers' levels of investment in primary care in 2022 under the Primary Care Spend Obligation will differ from what is shown here.

1 OHIC's Affordability Standards, per RICR-20-30-4, direct commercial insurers to annually spend at least 10.7 percent of their annual medical expenses for all fully insured lines of business on primary care. For more information, see the Rhode Island Cost Growth Target and Primary Care Spend Obligation Implementation Manual: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/RI%20TME%20%26%20PC%20Spend%20Implementation%20Manual_CY21-22%202023%2008-01_v1.pdf

Summary Observations:

- The largest service spending categories for each payer are Outpatient Hospital and Retail Pharmacy claims, the latter even after accounting for pharmacy rebates. As expected, the smallest expenses are for total Non-Claims and Long-Term Care services.

Share of Commercial Non-Claims by Payer (2022)



Source: OHIC analysis of TME data submitted by the four largest commercial insurers (Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Plan (THP), and UnitedHealthcare (UHC)) in Rhode Island as part of the Cost Growth Target data collection. There are three other commercial insurers in the state: Harvard Pilgrim Health Care, Aetna, and Cigna, who each have limited presence in the RI commercial insurance market. The percentages in each category represent its proportion of total medical expense (claims and non-claims) for each payer.

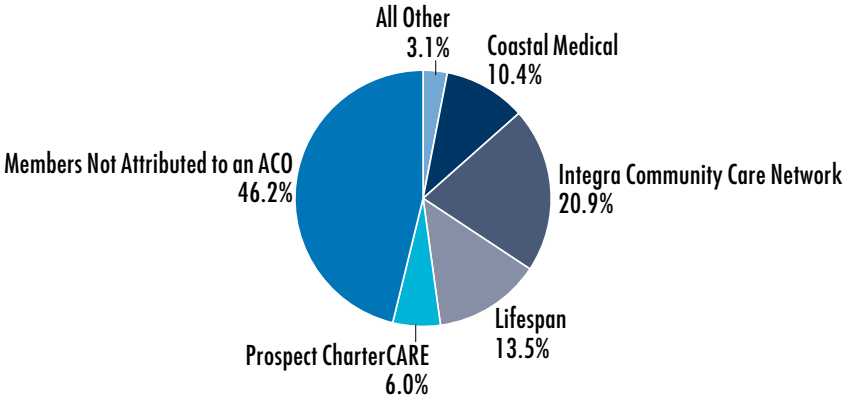
Summary Observations

- 'Population Health and Infrastructure Payments' was the only non-claims category for which all payers made payments in 2022.
- 'Performance Incentive Payments'[1] made up most of the non-claims payments made by BCBSRI, NHPRI, and THP in 2022. These payments can include shared savings distributions.

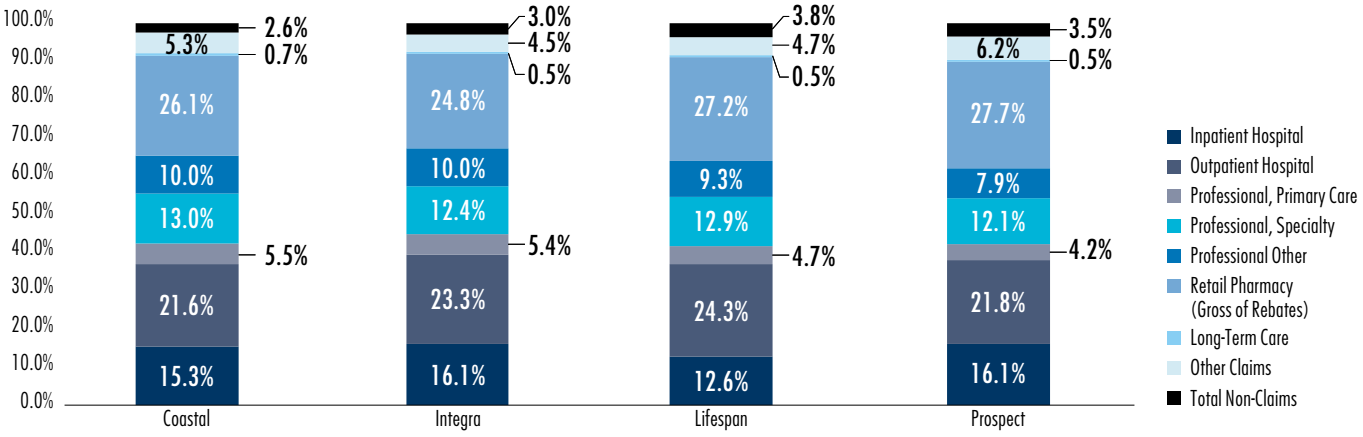
1 UnitedHealthcare made some 'Performance Incentive Payments' to providers in 2022. This amounted to less than a percentage point of their total commercial TME.

ACO Attributed Lives & Service Category Contribution to Commercial TME by ACO (2022)

2022 Share of Commercial Attributed Lives by ACO



2022 Service Category Contribution to Commercial TME by ACO



Source: OHIC analysis of TME data submitted by the four largest commercial insurers in Rhode Island (Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Plan (THP), and UnitedHealthcare (UHC)) as part of the Cost Growth Target data collection. The four ACOs shown here are those that meet the minimum attributed[1] lives for the commercial market requirement for public reporting of 5,000 members (60,000 member months). The remaining four (Blackstone Valley Community Health Center, Integrated Healthcare Partners, Providence Community Health Centers, and Thundermist Health Center) do not. The total membership across these organizations is contained within the "All Other" category. Retail pharmacy spending data are reported gross of rebates, as payers are unable to attribute pharmacy rebates to specific provider entities.

1 Attribution refers to the practice of insurers assigning patients to provider organizations, primarily through evidence of patient relationships with primary care clinicians affiliated with the organization. Attribution is performed to inform insurer/provider organization contractual terms and for other purposes.

Summary Observations

- Nearly half of commercially insured members are not attributed to an ACO. There are three reasons for this: the member:
  1. was not enrolled in a health insurance plan that required member designation of a primary care clinician,
  2. did not access primary care services during the measurement year or a prior year(s), or
  3. received primary cares, but the rendering primary care clinician was not attributed to an ACO during 2022.
- As was the case for the commercial insurers, the largest service spending categories for ACOs were Outpatient Hospital and Retail Pharmacy.

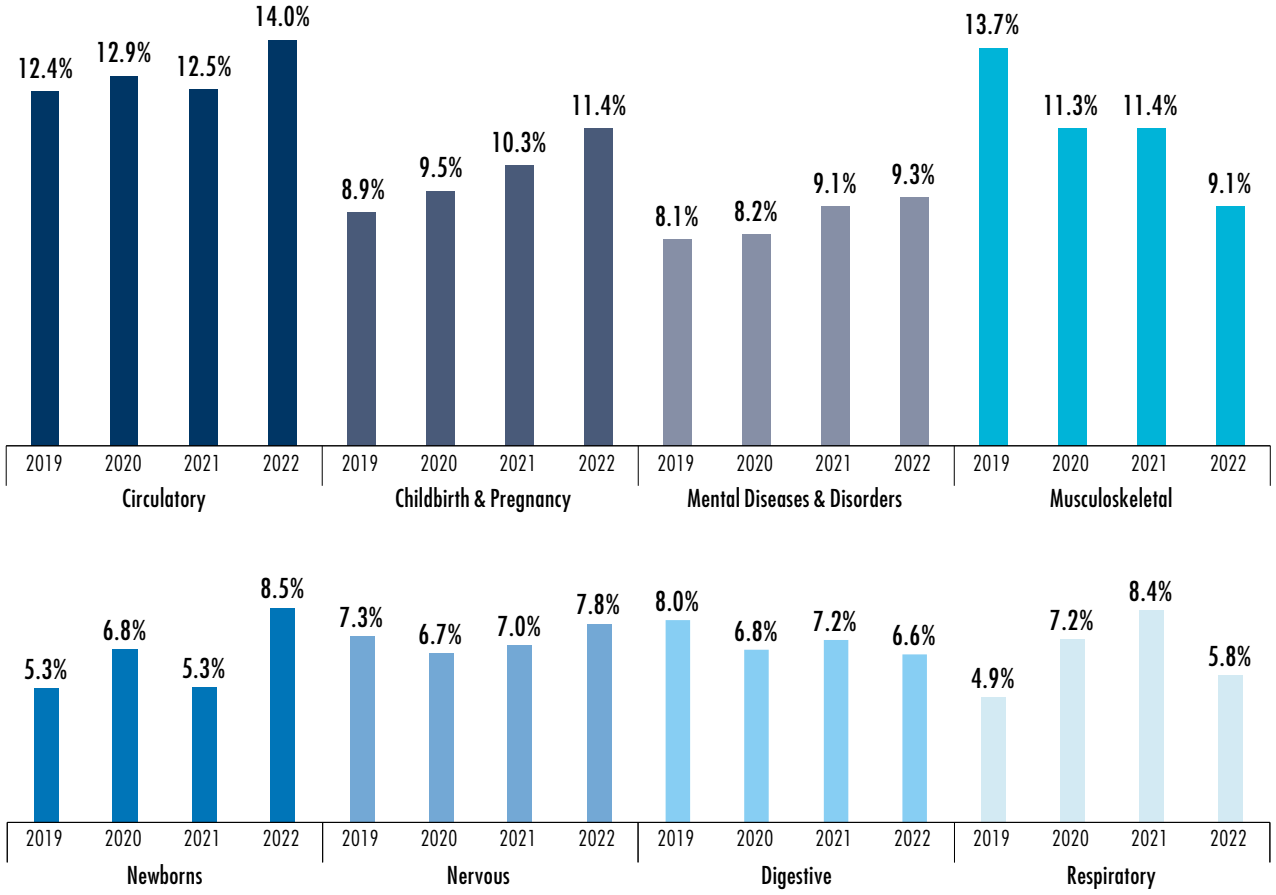
CHAPTER 3

Inpatient Hospital Spending Trends in the Commercial Market

Introduction

- The analyses in this chapter rely on data from HealthFacts RI. These analyses use claims-level data to provide insight into Inpatient Hospital spending per person, unit payments, and utilization, as well as more detail on the kinds of services included under the broader Inpatient Hospital category. Data collected as part of the cost growth target performance measurement are aggregated and do not allow for these kinds of detailed analyses.
- Key terms used in this chapter:
  - PMPM = Per Member Per Month, equal to the total spend amount for the year divided by the number of member months.
  - PPU = Payment Per Unit, equal to the total spend amount divided by the number of service units.
  - UPK = Units per 1,000 members, calculated as the unit of care divided by the number of members multiplied by 1,000.

Share of Inpatient Facility Spending for Select Diagnostic Categories (2019–2022)



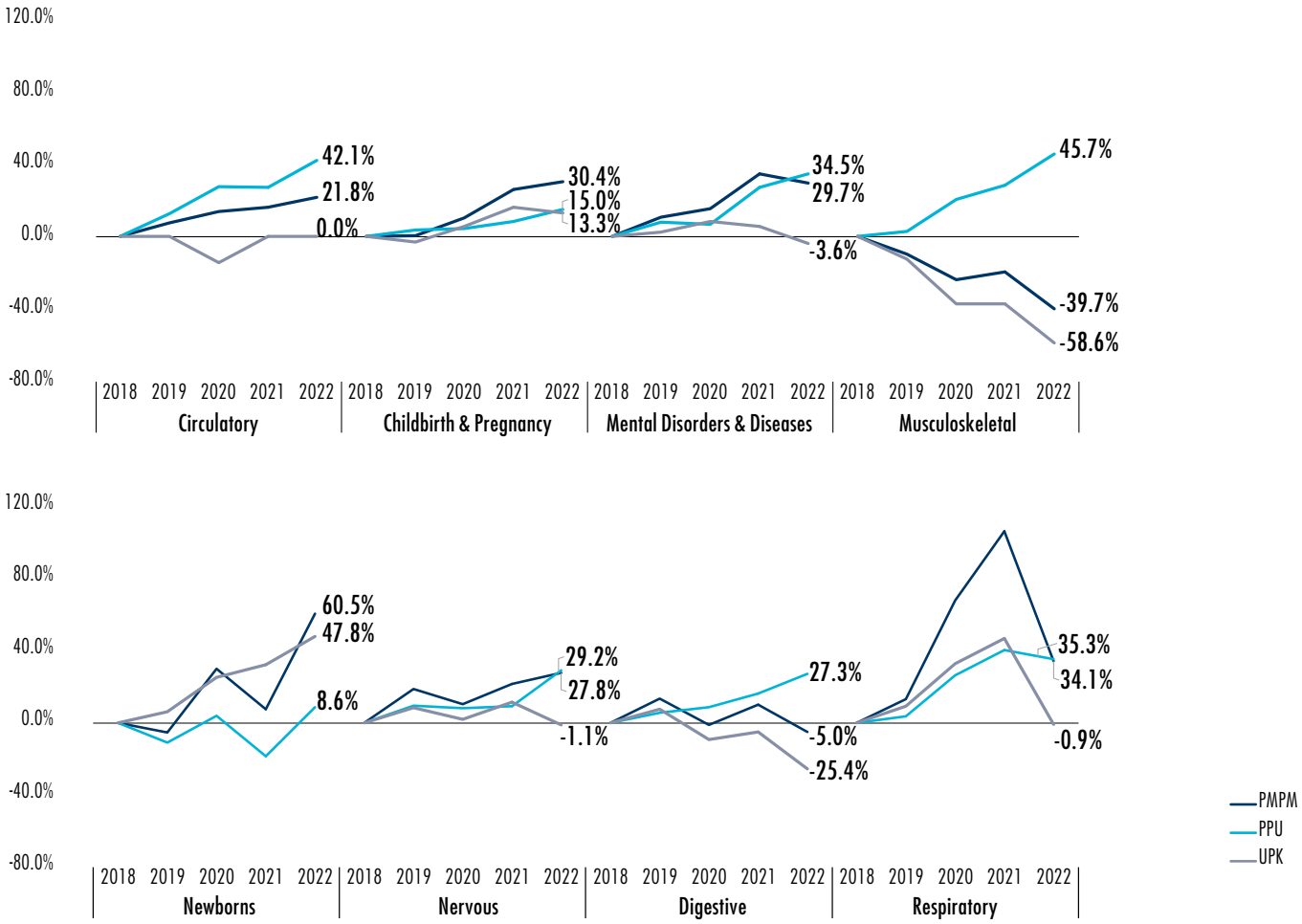
Source: OHIC analysis of HealthFacts RI data.

Note: Inpatient Hospital facility spending captures payments to facilities for services delivered during an inpatient admission. These eight diagnostic categories were those that had the highest spending in 2022 (there are a total of 27 inpatient Major Diagnostic Categories associated with the calculation of total Inpatient Hospital spending) and are ordered from highest to lowest spending in 2022.

Summary Observations

- The eight Major Diagnostic Categories shown here collectively made up more than 70 percent of total inpatient facility spending in 2022.
- Over time, musculoskeletal procedures' share of inpatient facility spending has gradually declined (13.7 percent in 2019; 9.1 percent in 2022).
- At the same time, the share of spending for procedures of the circulatory system has slowly increased (12.4 percent in 2019; 14.0 percent in 2022). The same occurred for childbirth-related procedures (8.9 percent in 2019 to 11.4 percent in 2022).

Cumulative Percentage Change in Inpatient Hospital Facility PMPM, PPU, and UPK for Select Diagnostic Categories (2018–2022)



Source: OHIC analysis of HealthFacts RI data. Inpatient Hospital facility spending captures payments to facilities for services delivered during an inpatient admission. These eight diagnostic categories were those that had the highest spending in 2022 (there are a total of 27 inpatient services included in the calculation of total Inpatient Hospital spending) and are ordered from highest to lowest spending in 2022.

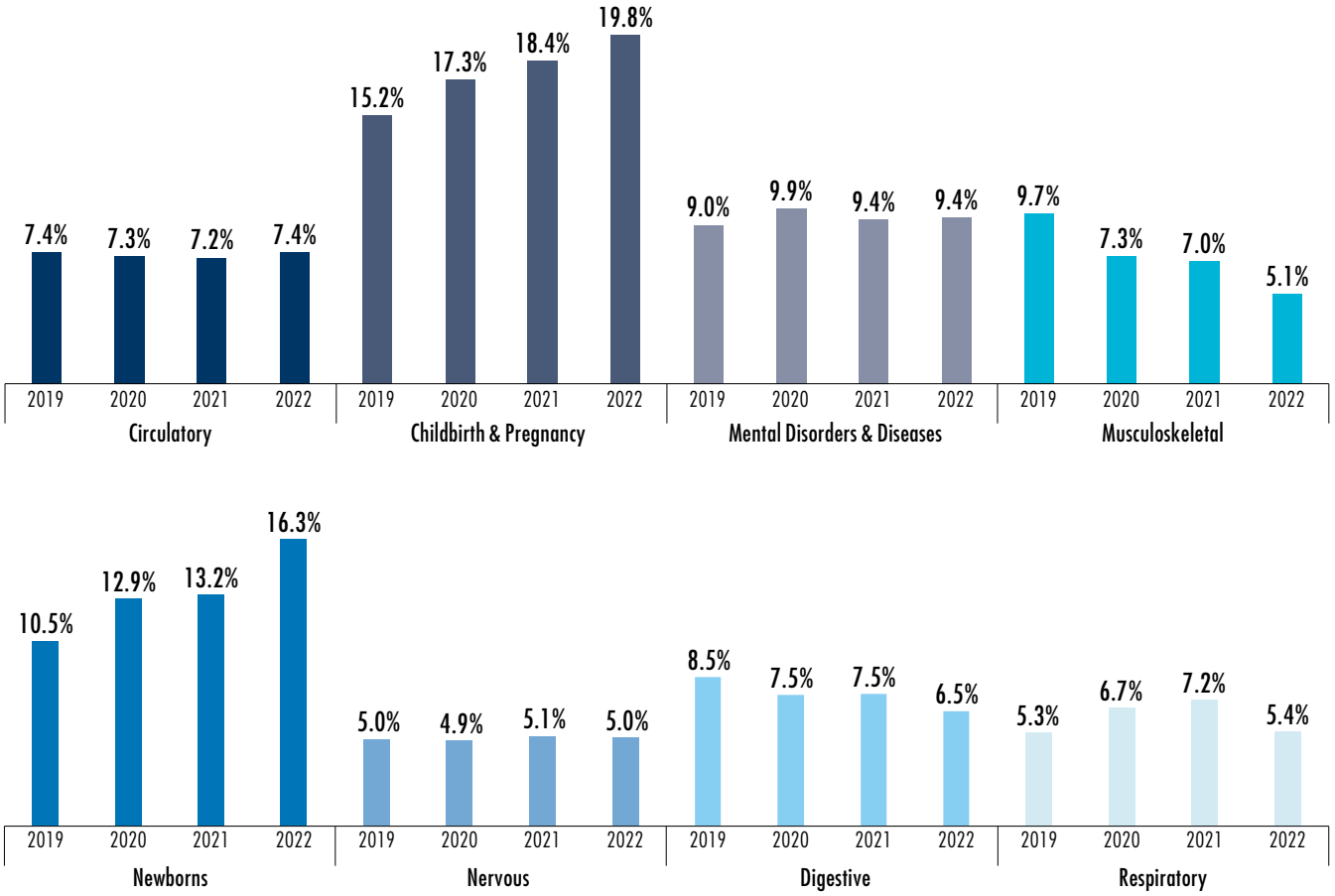
PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

- Spending on these select Inpatient Hospital diagnostic categories, except for musculoskeletal procedures and digestive procedures, increased over this five-year period.
  - The decrease in spending on musculoskeletal procedures was driven by plummeting utilization, owed to the fact that many of these procedures moved to outpatient settings. Average payments for these procedures increased substantially, at an average of about nine percent per year.
  - For digestive procedures, utilization steadily decreased while average payments increased.
- For procedures on the circulatory system, utilization remained flat or decreased, while unit payments increased dramatically.

Key takeaway: For most of these eight diagnostic categories, cumulative growth in PPU surpassed cumulative growth in UPK between 2018 and 2022; in most cases, dramatically so.

Share of Inpatient Admissions for Select Diagnostic Categories (2019–2022)



Source: OHIC analysis of HealthFacts RI data. These eight diagnostic categories were those that had the highest spending in 2022 (there are a total of 27 inpatient diagnostic categories included in the calculation of total Inpatient Hospital spending) and are ordered from highest to lowest spending in 2022. The percentages in this graph are calculated based on absolute counts (i.e., not UPK) of inpatient admissions for these diagnostic categories.

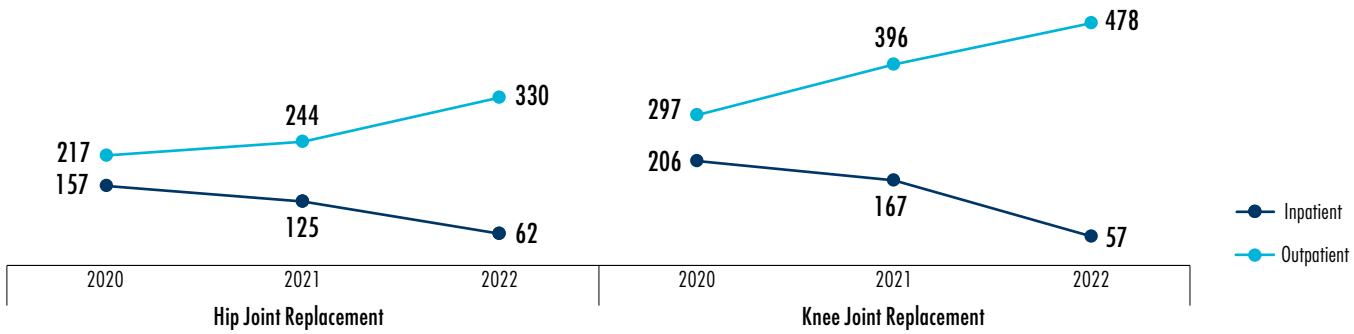
Summary Observations

- Between 2019 and 2022, musculoskeletal procedures' share of total admissions steadily decreased (these services made up nearly ten percent of total services in 2019, but only five percent of total services in 2022).
- At the same time, the share of total admissions for childbirth steadily increased (15 percent in 2019 to almost 20 percent in 2022). The share of units for diagnoses related to newborns and other neonates increased (more than ten percent in 2019 to over 16 percent in 2022).
- Collectively, childbirth and newborn related care made up more than a third of total inpatient admissions in 2022.

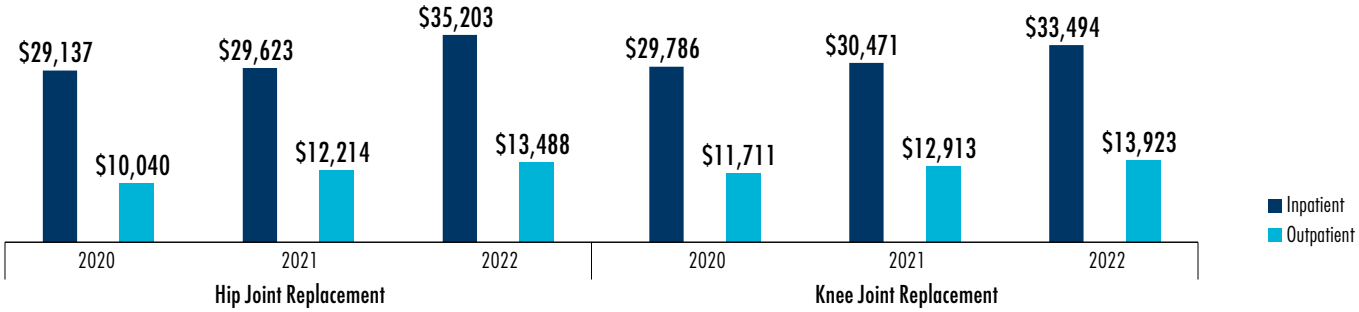
Explanation of Decrease in Inpatient Hospital PPU (2021 and 2022)

As reported in the **Cumulative Percentage Change in PMPM, PPU, and UPK for Inpatient Hospital, Outpatient Hospital, and Professional Services** graph in Chapter 1, Inpatient Hospital PPU decreased by 4.0 percent in 2021, and by 8.4 percent in 2022. There are a few contributing factors to these decreases. This section explores three main drivers of this decrease: a) the movement of joint replacement surgeries being performed from an inpatient to outpatient setting, b) decrease in utilization of tracheostomies and transplants, and c) decreases in cases of major respiratory infections and inflammations.

Shift in Joint Replacements from Hospital Inpatient to Outpatient Settings (2020–2022)



Unit Payments for Hip and Knee Replacements in Outpatient and Inpatient Settings (2020–2022)

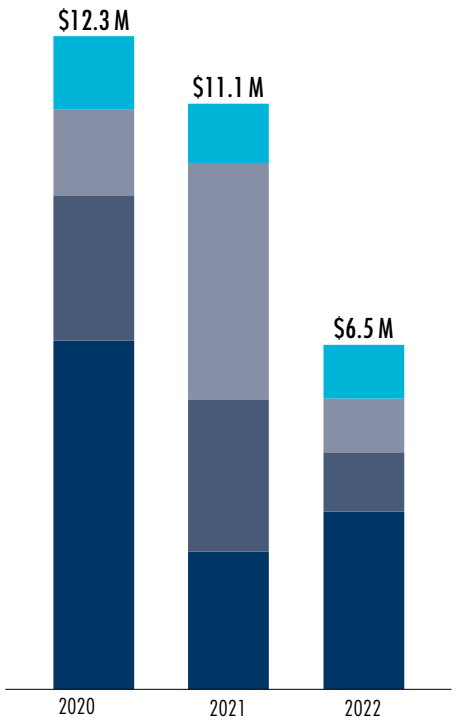


Source: OHIC analysis of HealthFacts RI data.

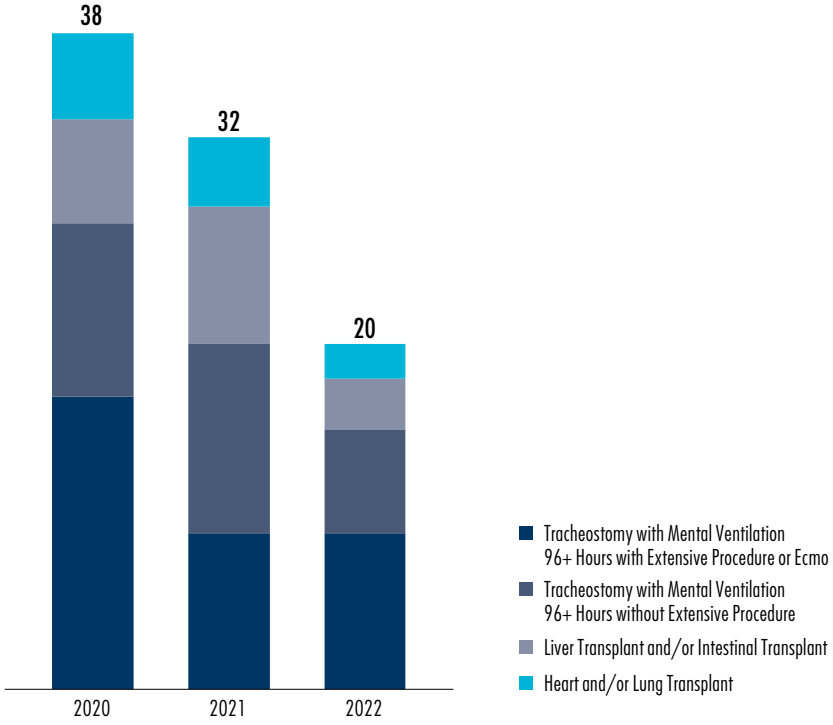
Shift in Performing Joint Replacement Surgeries from Inpatient to Outpatient Settings

The average unit payment for performing joint replacement surgeries in an outpatient hospital setting is significantly less than their inpatient counterparts; from 2020 to 2022, for both knee and hip replacements, the unit payments for these procedures in an outpatient setting were 40 percent of the unit payment in an inpatient setting.

Total Spending for Transplants and Tracheostomies (2020–2022)



Total Units for Transplants and Tracheostomies (2020–2022)

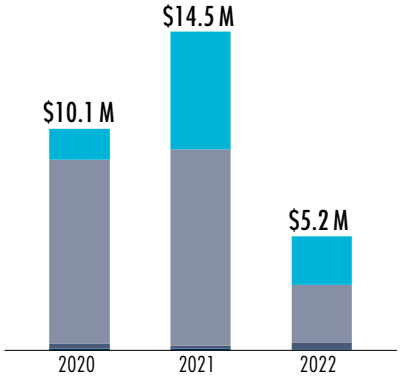


Source: OHIC analysis of HealthFacts RI data.

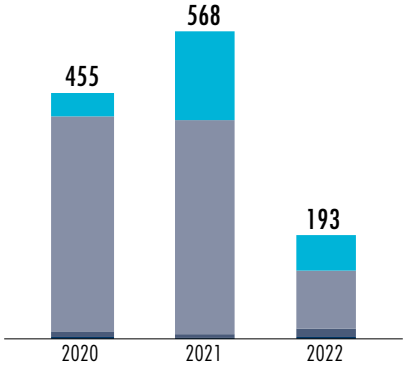
Decrease in Utilization of High-Cost Services: Transplants and Tracheostomies

Another contributing factor was the decrease in utilization of high-cost services, like transplants and tracheostomies. Both types of services are very high-cost services in Rhode Island, with unit payments exceeding $200,000. Spending and units decreased from 2020 to 2021, then more dramatically from 2021 to 2022, which supports the possibility that the decline in tracheostomies may be associated with the decline in COVID-19 admissions.

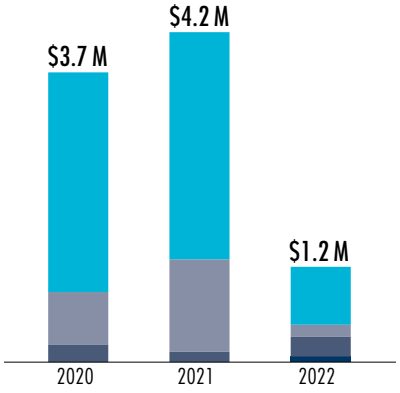
Total Spend for Major Respiratory Infections and Inflammations by Level of Severity



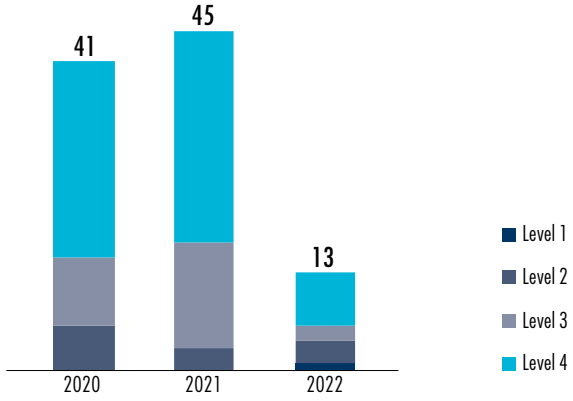
Total Units for Major Respiratory Infections and Inflammations by Level of Severity



Total Spend for Respiratory Support with Ventilator



Total Units for Respiratory Support with Ventilator



Source: OHIC analysis of HealthFacts RI data.

Decrease in Cases of Major Respiratory Infections and Inflammations

Last, and unsurprisingly, the decrease in respiratory-related admissions influenced the decrease in Inpatient Hospital PPU. Two types of respiratory conditions that likely impacted overall PPU were for major respiratory infections and inflammations, which includes COVID-19 cases, and respiratory support with use of a ventilator. Unlike the previous two services, from 2020 to 2021, spending and units increased, and cases were more severe, but then utilization, spending, and severity plummeted in 2022. This reflects lower prevalence of severe illness from COVID-19, as the population increasingly became vaccinated in 2022 or developed some measure of immunity from prior infection.

The increase in spending and units for these procedures partially moderated the decrease in Inpatient Hospital PPU from 2020 to 2021; if units and spending for major respiratory infections and inflammations decreased instead, Inpatient Hospital PPU would have decreased by more than four percent in 2021. Conversely, in 2022, the decrease in utilization and spending of these services helped to magnify the drop in Inpatient Hospital PPU.

Key takeaway: The decrease in Inpatient Hospital PPU was influenced by at least three factors: a) the movement of joint replacement surgeries being performed from an inpatient to outpatient setting, b) the decrease in utilization and spending for high-cost transplants and tracheostomies, and c) the decrease in respiratory-related admissions associated with COVID-19 infection.

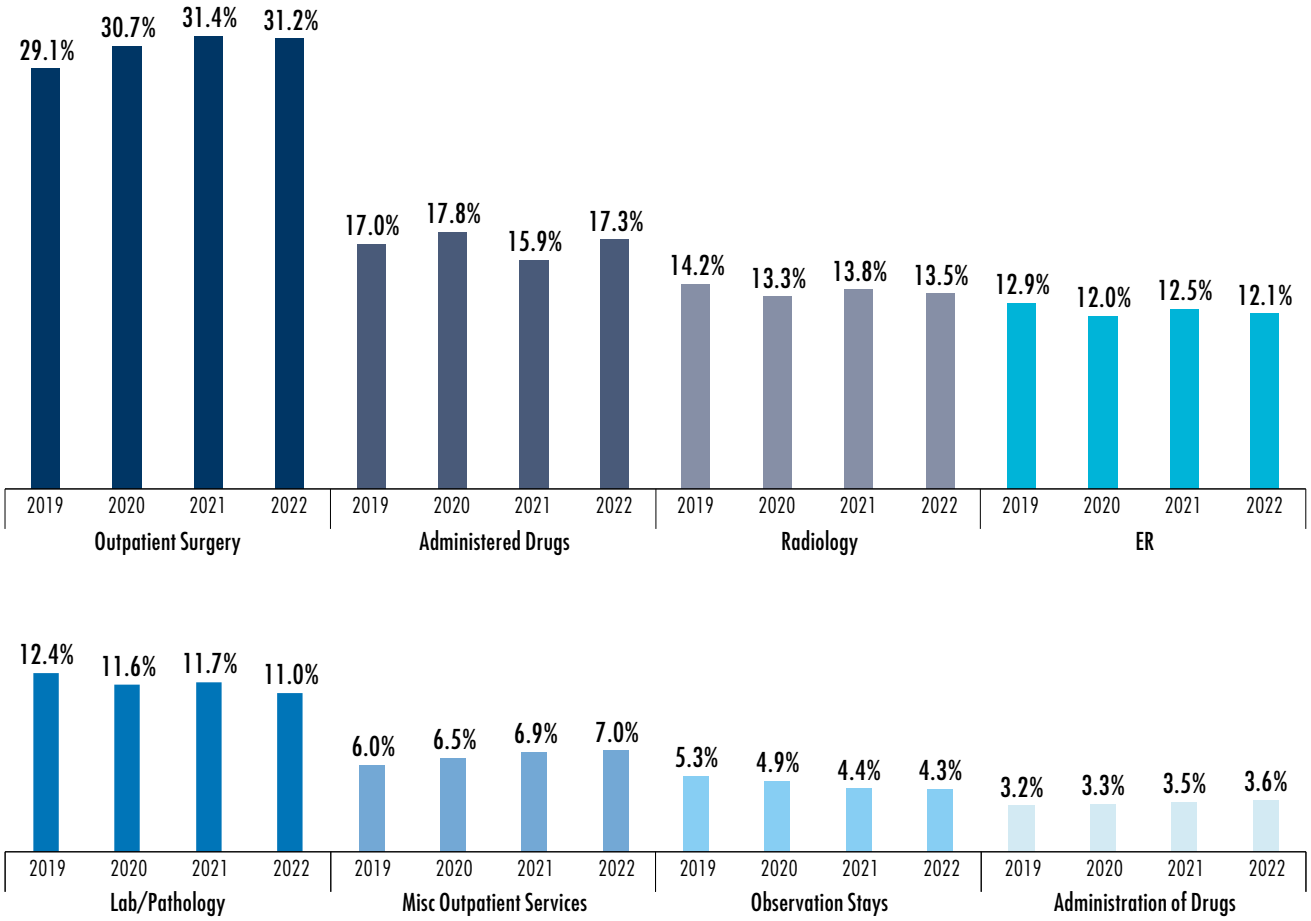
CHAPTER 4

Outpatient Hospital Spending Trends in the Commercial Market

Introduction

- The analyses in this chapter rely on data from HealthFacts RI. These analyses use claims-level data to provide insight into Outpatient Hospital spending per person, unit payments, and utilization, as well as more detail on the kinds of services included under the broader Outpatient Hospital category. Data collected as part of the cost growth target performance measurement are aggregated and do not allow for these kinds of detailed analyses.
- Key terms used in this chapter:
  - PMPM = Per Member Per Month, equal to the total spend amount for the year divided by the number of member months.
  - PPU = Payment Per Unit, equal to the total spend amount divided by the number of service units.
  - UPK = Units per 1,000 members, calculated as the unit of care divided by the number of members multiplied by 1,000.

Share of Total Outpatient Hospital Facility Spending by Service (2019–2022)



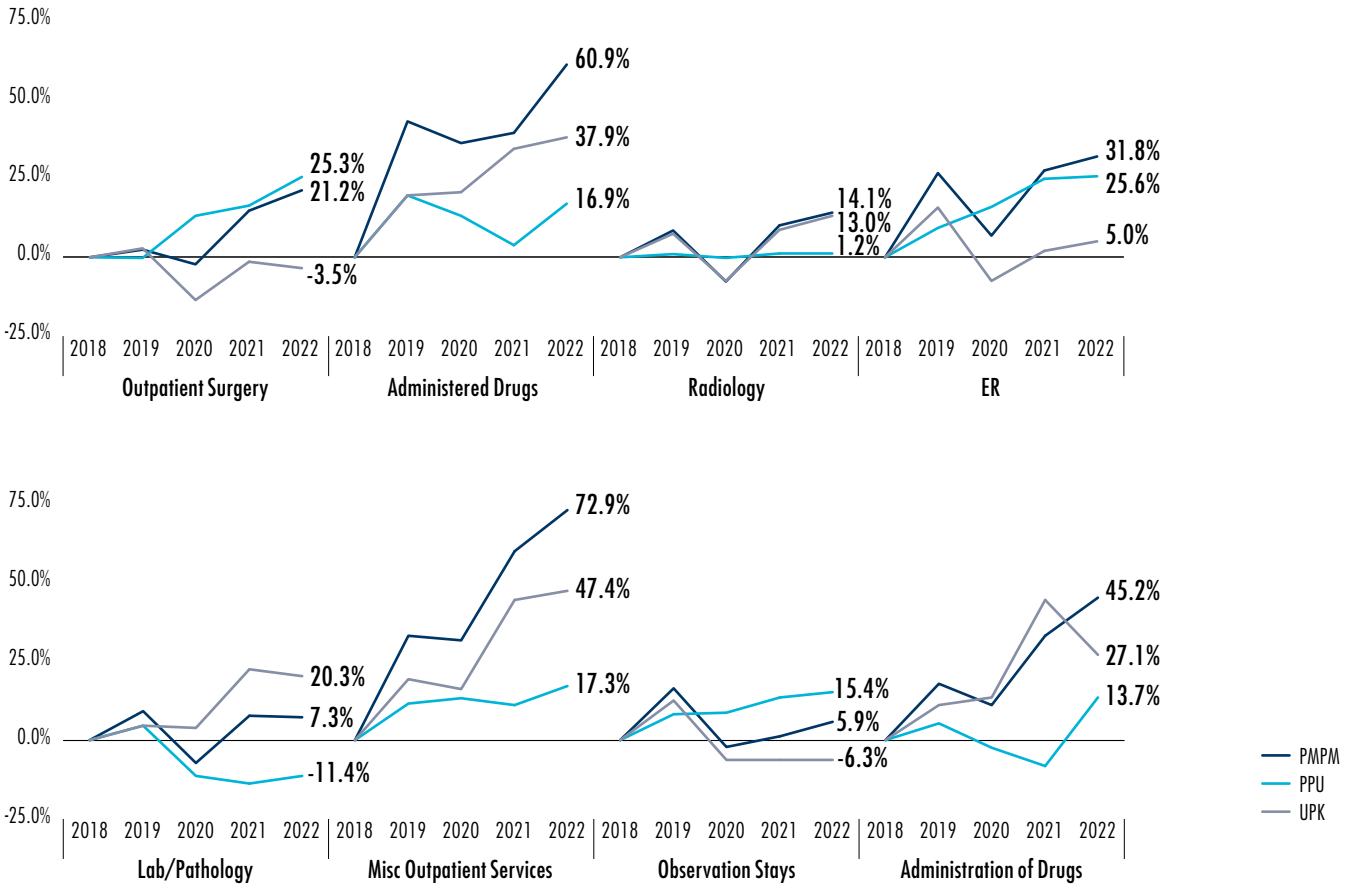
Source: OHIC analysis of HealthFacts RI data. These eight services make up all spending on Outpatient Hospital services. 'Misc Outpatient Services' includes anesthesia, vision and hearing services, dialysis, and physical, occupational, and speech therapy services.

Note: The number of procedure codes contained within each Outpatient Hospital subcategory is as follows: Outpatient Surgery (>6,000); Administered Drugs (>1,000); Radiology (>1,000); ER (15); Lab/Pathology (>2,000); Misc Outpatient Services (>1,000); Observation Stays (12); and Administration of Drugs (80).

Summary Observations

- Each year, Outpatient Surgery and Administered Drugs collectively made up nearly 50 percent of total spending on Outpatient Hospital services.
- Drugs and their administration made up about 20 percent of total spending.
- Each category's share of Outpatient Hospital facility spending was generally stable year-over-year.

Cumulative Percentage Change in Outpatient Hospital Facility PMPM, PPU, and UPK for All Services (2018–2022)



Source: OHIC analysis of HealthFacts RI data. These eight services make up all spending on Outpatient Hospital services. 'Misc Outpatient Services' includes anesthesia, vision and hearing services, dialysis, and physical, occupational, and speech therapy services.

Note: UPK for Outpatient Surgery overall decreased, despite the move of joint replacement surgeries to the outpatient setting. Even though many units shifted to the outpatient setting, utilization of musculoskeletal procedures decreased overall. Additionally, procedures of the cardiovascular and digestive systems overall decreased substantially (for more information, see **Cumulative Percentage Change in PMPM, PPU, & UPK for Outpatient Surgery Categories**).

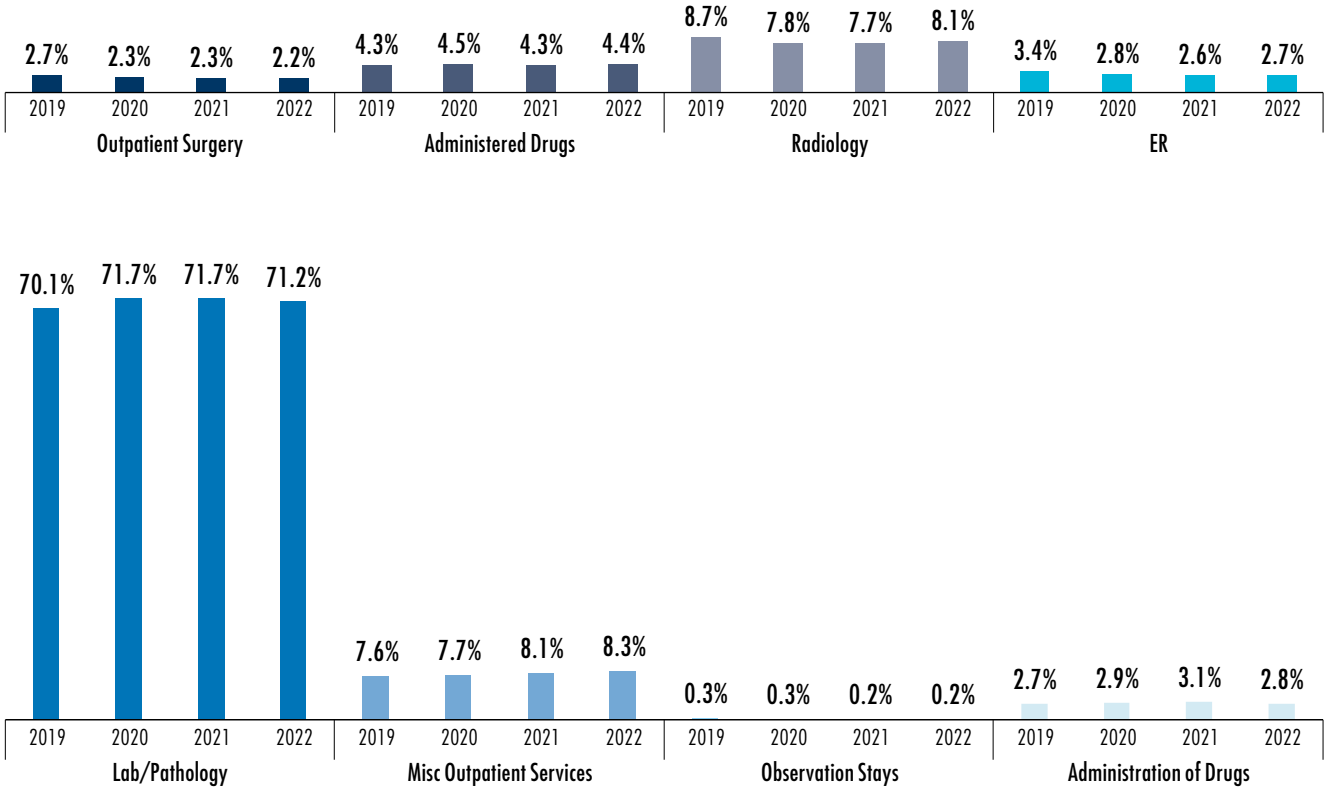
PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

- Spending growth on Outpatient Surgery services, the category with highest outpatient facility spending, was driven by growth in average payments. Utilization for Administered Drugs, which was the category with the second highest outpatient facility spending, drove spending growth.
- Outpatient Surgery and Observation Stays are the only two outpatient facility services where utilization decreased over the five-year period.
- Lab/Pathology was the only category where unit payments decreased.

Key takeaway: There is no clear pattern in the relationship between PMPM, PPU, and UPK for these outpatient services.

Share of Outpatient Hospital Utilization for All Services (2019–2022)



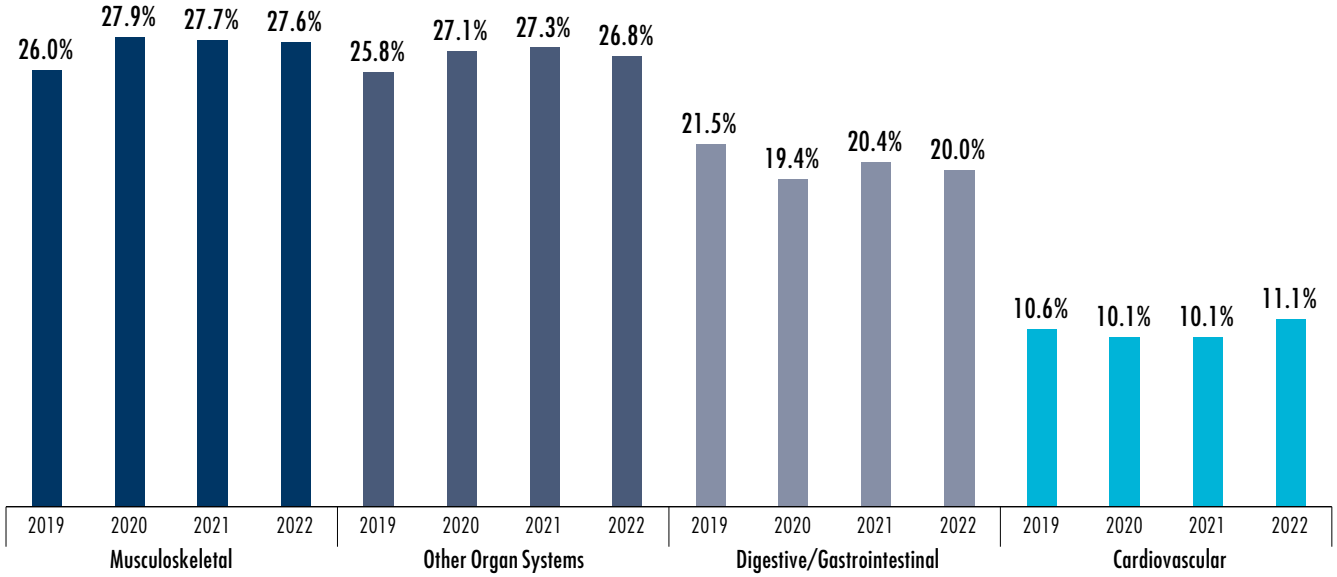
Source: OHIC analysis of HealthFacts RI data. These eight services make up all spending on Outpatient Hospital services. 'Misc Outpatient Services' includes anesthesia, vision and hearing services, dialysis, and physical, occupational, and speech therapy services.

PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

- Most Outpatient Hospital facility service units are for lab and pathology services.
- The next page examines spending on Outpatient Surgery services by procedure category.

Share of Outpatient Surgery Services Spending for Top 4 Spend Diagnostic Categories (2019–2022)

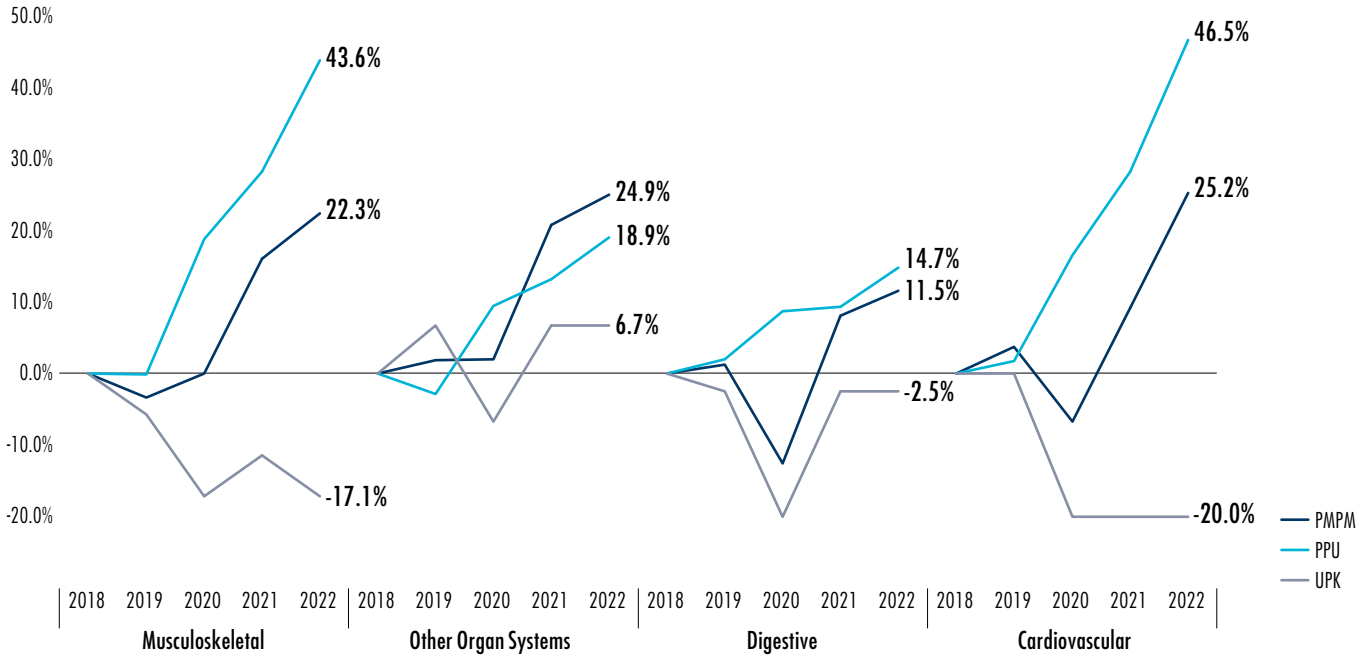


Source: OHIC analysis of HealthFacts RI data. 'Other Organ Systems' includes biopsies, otolaryngological procedures, and other procedures that do not fit into the other surgical categories. This category includes over 1,800 services, which is about 30 percent of all Outpatient Surgery services.

Summary Observations

- Each year, these four diagnostic categories comprised about 85 percent of total spending on Outpatient Surgery. The remaining 15 percent was spread over the following diagnostic categories: Breast, Skin, Vascular, Eye, and Hematology.

Cumulative Percentage Change in PMPM, PPU, and UPK for Outpatient Surgery Categories (2018–2022)



Source: OHIC analysis of HealthFacts RI data. 'Other Organ Systems' includes biopsies, otolaryngological procedures, and other procedures that do not fit into the other surgical categories.

Note: UPK for musculoskeletal procedures plummeted, despite the substantial growth in joint replacement surgery. The overall decrease in utilization from 2018 to 2022 is largely due to the significant decreases in utilization of arthroscopies of the lower and upper extremities; use of these services decreased by 49 percent and 67 percent, respectively. The large drop in volume of arthroscopies may be attributed to the following: 1) new high-resolution magnetic resonance imaging (MRI) scans can fully define the anatomy of the shoulder, knee, or hip, thus rendering arthroscopy unnecessary; 2) "palliative" arthroscopy has not been shown to offer the patient any benefit over non-invasive methods, such as significant weight loss (this is particularly relevant for knee and hip arthroscopy); 3) arthroscopy is often bundled with ICD codes with higher unit payments, and the bundle is often billed with the higher paying "bundled" code, and 4) joint injections are delaying the need for arthroscopic surgery by a few years, thereby slightly reducing the need for these procedures.

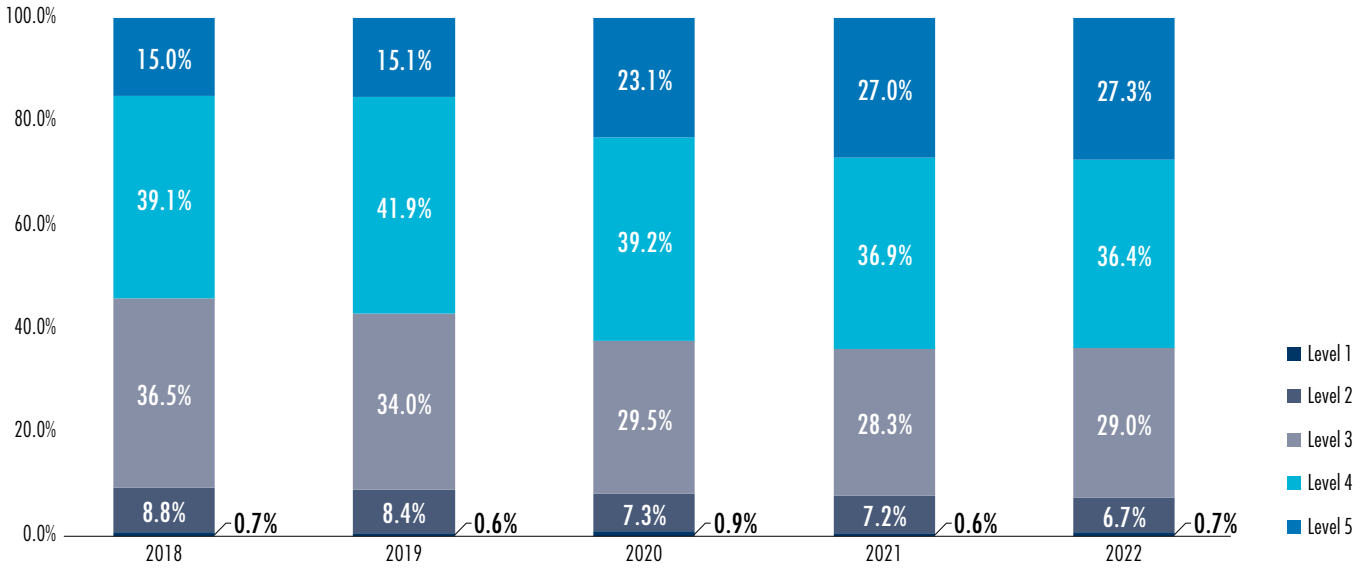
PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

- For each of these categories, growth in spending per person was driven by growth in average payments.
- 'Other Organ Systems' was the only Outpatient Surgery subcategory that experienced growth in per person spending in 2020. The other categories saw varying degrees of rebounds in spending in 2021 and 2022; utilization dropped but average payments grew significantly.
- 'Other Organ Systems' was also the only Outpatient Surgery subcategory to experience growth in utilization between 2018 and 2022.

Key takeaway: Future analyses could dig into spending on 'Other Organ Systems' to better understand the changes in PMPM, PPU, and UPK over this period.

Distribution of Emergency Department Visits for Commercially Insured Patients by Complexity Level (2018–2022)



Source: OHIC analysis of HealthFacts RI data.

Level 1 = CPT Code 99281 (low intensity ED visit requiring straightforward medical decision making);
Level 2 = CPT code 99282 (moderate intensity ED visit requiring medical decision making of low complexity);
Level 3 = CPT code 99283 (moderate intensity ED visit requiring medical decision making of moderate complexity);
Level 4 = CPT code 99284 (moderate-to-high intensity ED visit requiring medical decision making of moderate complexity);
Level 5 = CPT code 99285 (high intensity ED visit requiring medical decision making of high complexity).

Summary Observations

- Every year, high intensity visits (Levels 4 and 5) make up more than half of all ED visits.
- The share of emergency department (ED) visits coded as a Level 5 has increased over time.
- The share of ED visits coded as Levels 1 and 2 has remained low and stable over time.
- The share of ED visits coded as Level 3 has gradually decreased over time – its share in 2022 was seven percentage points lower than its share in 2018. Conversely, those coded as Level 4 stayed relatively constant, only changing between two and three percentage points between 2018 and 2022.

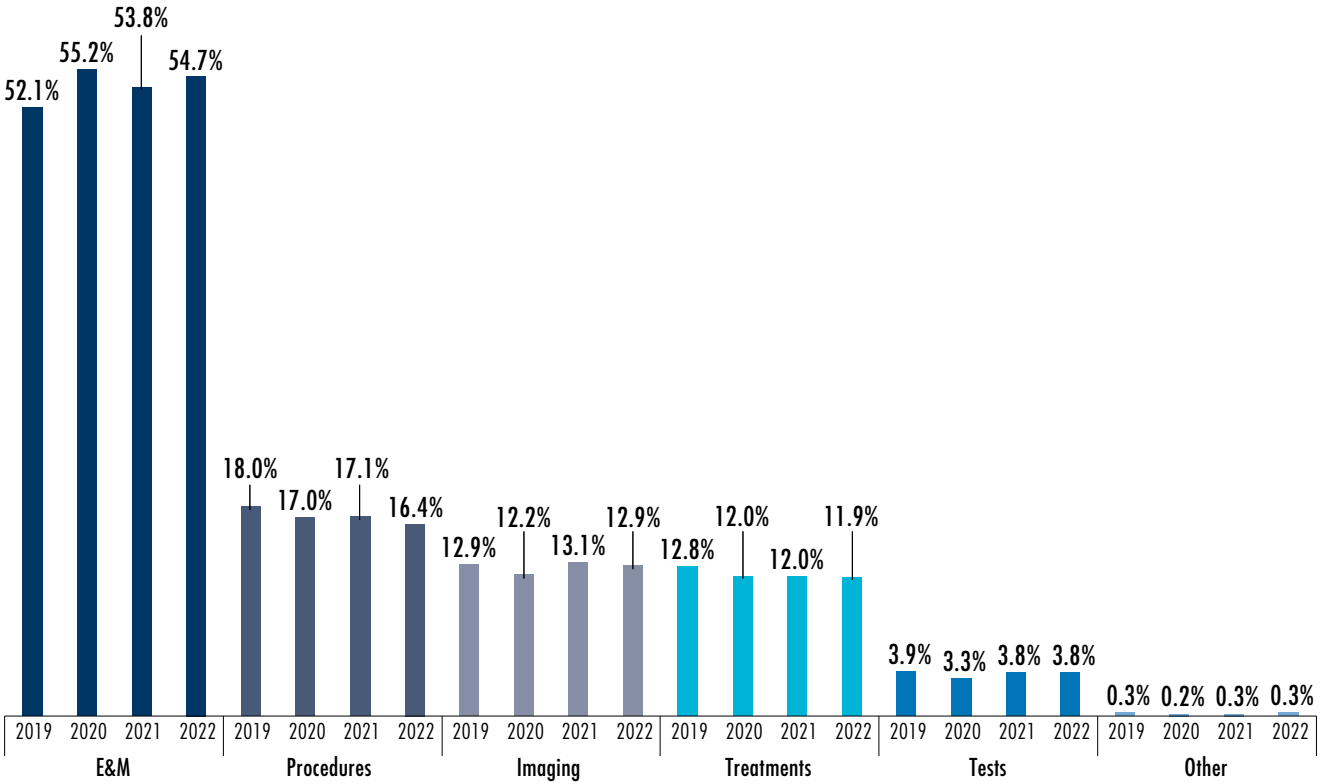
CHAPTER 5

Professional Services Spending Trends in the Commercial Market

Introduction

- The analyses in this chapter rely on data from HealthFacts RI. These analyses use claims-level data to provide insight into Professional services spending per person, unit payments, and utilization, as well as more detail on the kinds of services included under the broader Professional category. Data collected as part of the cost growth target performance measurement are aggregated and do not allow for these kinds of detailed analyses.
- In these analyses, "Professional" refers to the professional component of a claim that goes to the physician who provided the service.
- The service categories differ from the diagnostic categories used in the equivalent charts in the Outpatient Hospital Spending Trends chapter. OHIC and its analytics vendor intend to recategorize Professional services spending in the same way in future analyses.
- Key terms used in this chapter:
  - PMPM = Per Member Per Month, equal to the total spend amount for the year divided by the number of member months.
  - PPU = Payment Per Unit, equal to the total spend amount divided by the number of service units.
  - UPK = Units per 1,000 members, calculated as the unit of care divided by the number of members multiplied by 1,000.

Share of Total Professional Services Spending by Category (2019–2022)

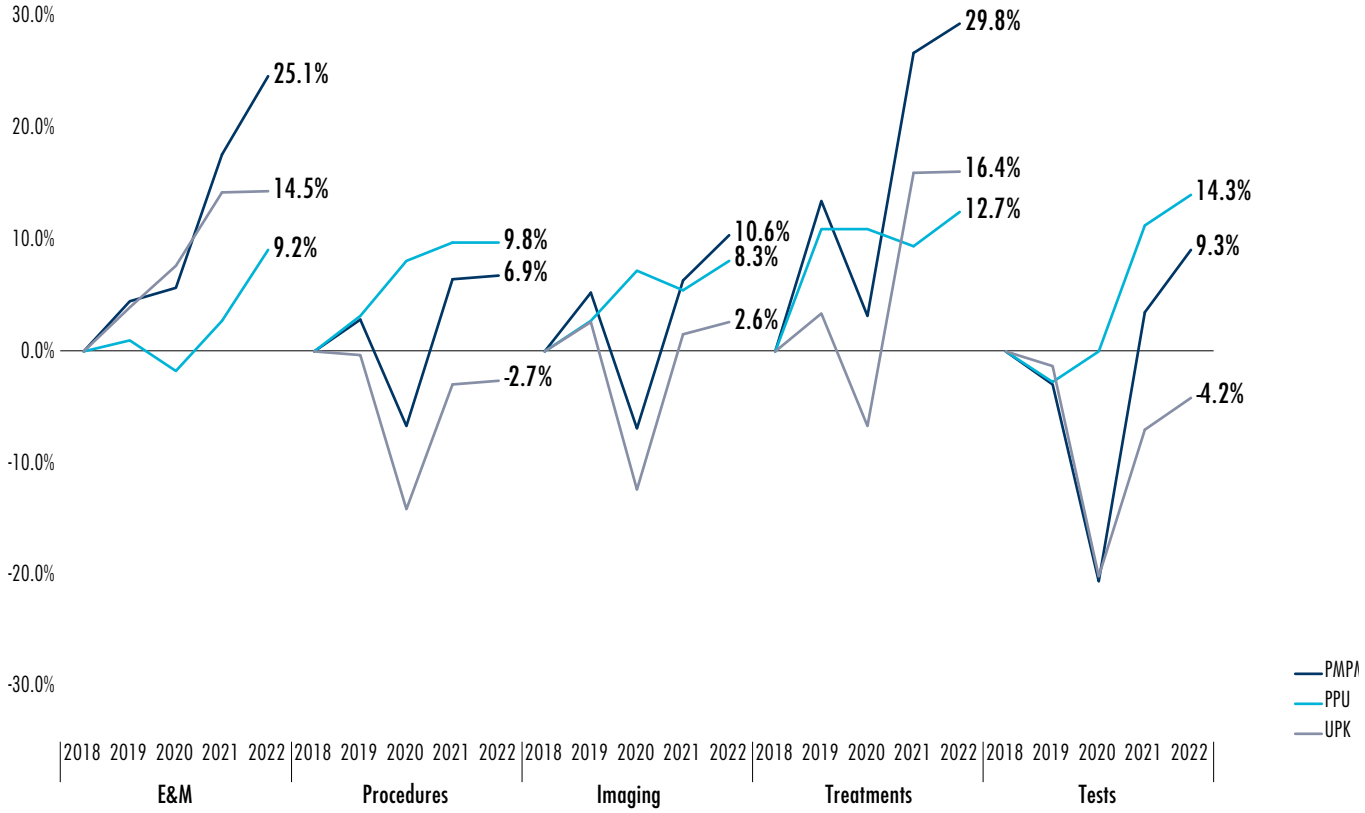


Source: OHIC analysis of HealthFacts RI data. 'Other' includes ambulance transportation and vision, hearing, and speech services. These six service categories make up the entirety of Professional spending.

Summary Observations

- Most professional spending is on evaluation and management (E&M) services, which are provided by a physician or other qualified health care professional.

Cumulative Percentage Change in PMPM, PPU, and UPK for Professional Services by Category (2018–2022)



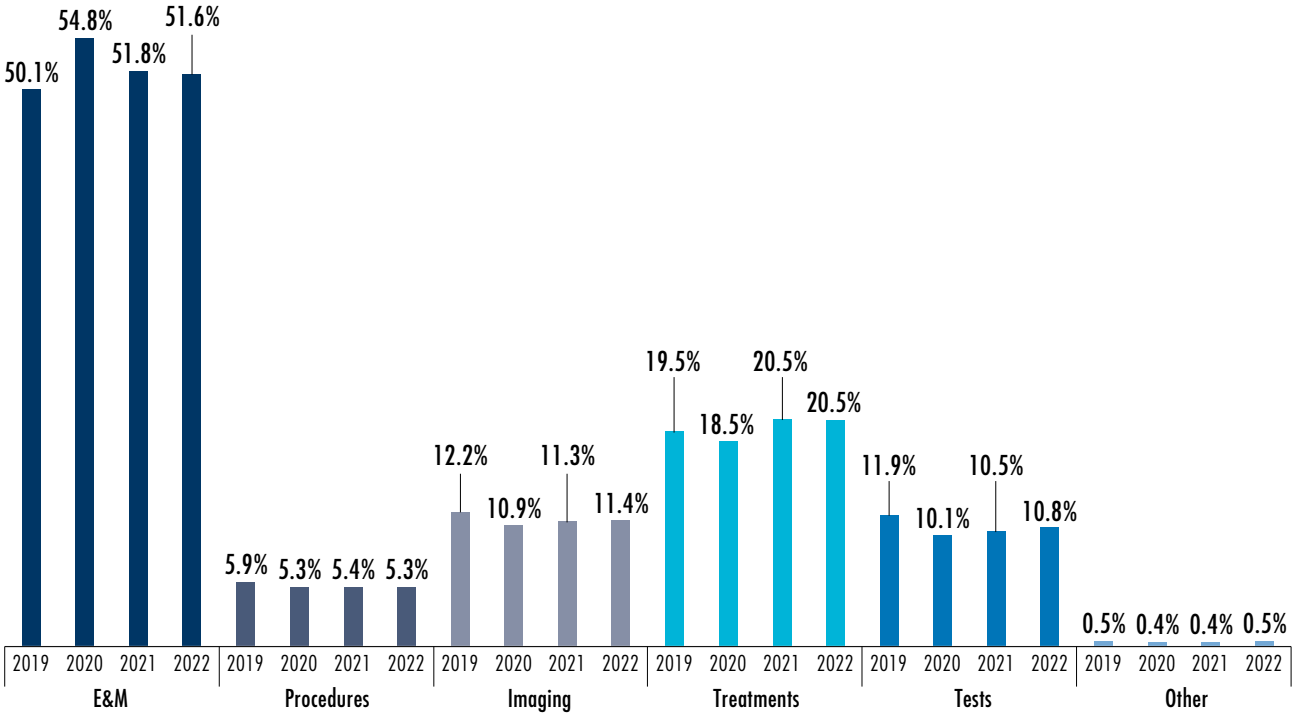
Source: OHIC analysis of HealthFacts RI data. 'Other' is omitted because of its low share of spending and utilization. These six service categories make up the entirety of Professional spending.
PMPM = Per Member Per Month; PPU = Payment Per Unit; UPK = Units per 1,000 members.

Summary Observations

- PMPM spending for each of these categories increased over this five-year period; however, E&M visits & Treatments were the only categories where spending increased in 2020.
- E&M visits was the only category to have experienced an increase in utilization in 2020, which could possibly be attributed to the increase in utilization of mental health services.
- Unit payments for each of these categories of Professional spending grew modestly over this five-year period, with average annual rates ranging from two percent to about four percent.

Key takeaway: Average unit payments increased modestly for each of these categories from 2018 to 2022, while changes in utilization followed the COVID-19-influenced pattern witnessed for other services, except for E&M visits.

Share of Professional Services Utilization (2019–2022)



Source: OHIC analysis of HealthFacts RI data. 'Other' includes ambulance transportation and vision, hearing, and speech services. These six service categories make up the entirety of Professional spending.

Summary Observations

- Unsurprisingly, E&M visits made up the largest share of services provided in office settings, while procedures made up a small share.

STATE OF RHODE ISLAND

Office of The Health Insurance Commissioner

Department of Business Regulation

Chartpack: Health Care Spending in Rhode Island (2024)

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