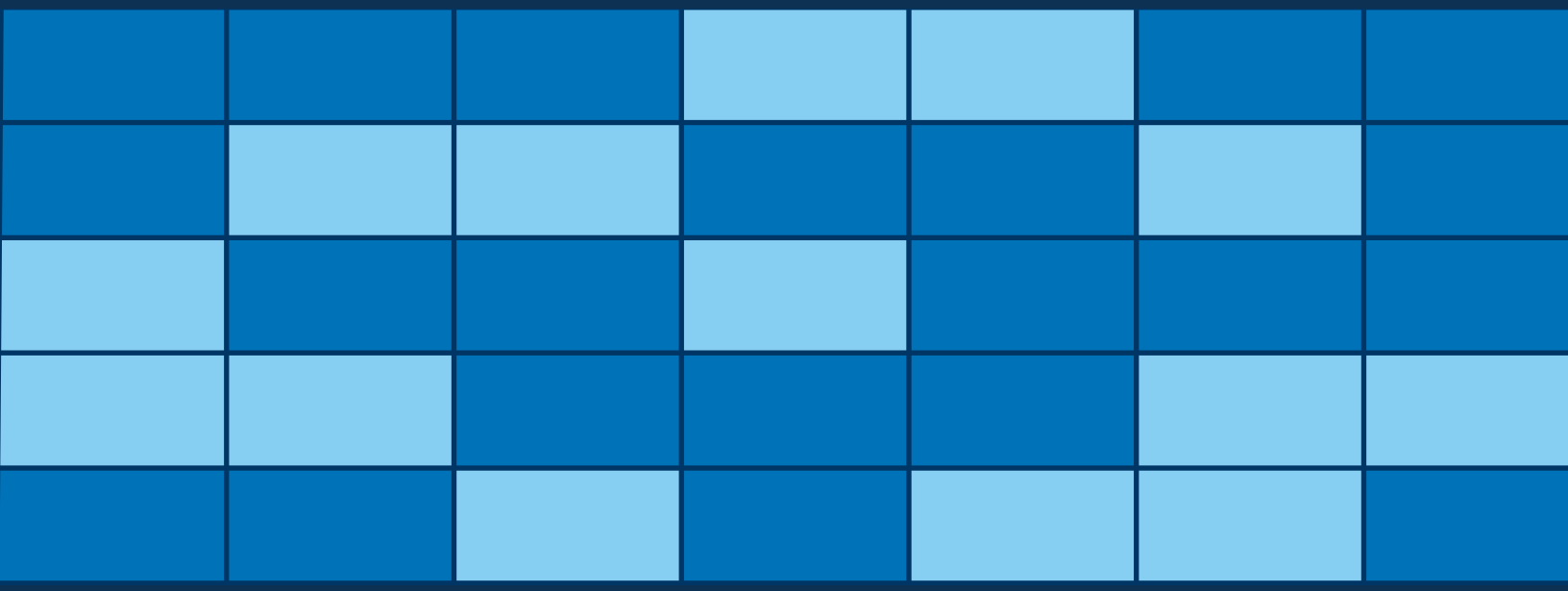
ANNUAL REPORT

Health Care Spending and Quality in Rhode Island

2026



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

Index of Acronyms

ACO	Accountable Care Organization
AE	Accountable Entity
APCD	All-Payer Claims Database
BCBSRI	Blue Cross Blue Shield of Rhode Island
BVCHC	Blackstone Valley Community Health Care
CCBHC	Certified Community Behavioral Health Clinic
CMS	Centers for Medicare & Medicaid Services
EOHHS	Executive Office of Health and Human Services
FQHC	Federally Qualified Health Center
IHP	Integrated Healthcare Partners
GLP-1	Glucagon-like peptide-1
HPHC	Harvard Pilgrim Health Care
LPE	Large Provider Entity
MMP	Medicare-Medicaid Plan
NA	Not Available
NCPHI	Net Cost of Private Health Insurance
NHPRI	Neighborhood Health Plan of Rhode Island
NR	Not Reported
OHIC	Office of the Health Insurance Commissioner
PBM	Pharmacy Benefit Manager
PCHC	Providence Community Health Centers
PCTL	Percentile
PGSP	Potential Gross State Product
PMPM	Per Member Per Month
PMPY	Per Member Per Year
RI	Rhode Island
RIPCPC	Rhode Island Primary Care Physicians Corporation
SDP	State-Directed Payment
THCE	Total Health Care Expenditures
THP	Tufts Health Plan
THPP	Tufts Health Public Plans
TME	Total Medical Expense
UHC	UnitedHealthcare
UHCCP	UnitedHealthcare Community Plan

Annual Report: Health Care Spending and Quality in Rhode Island (2026)

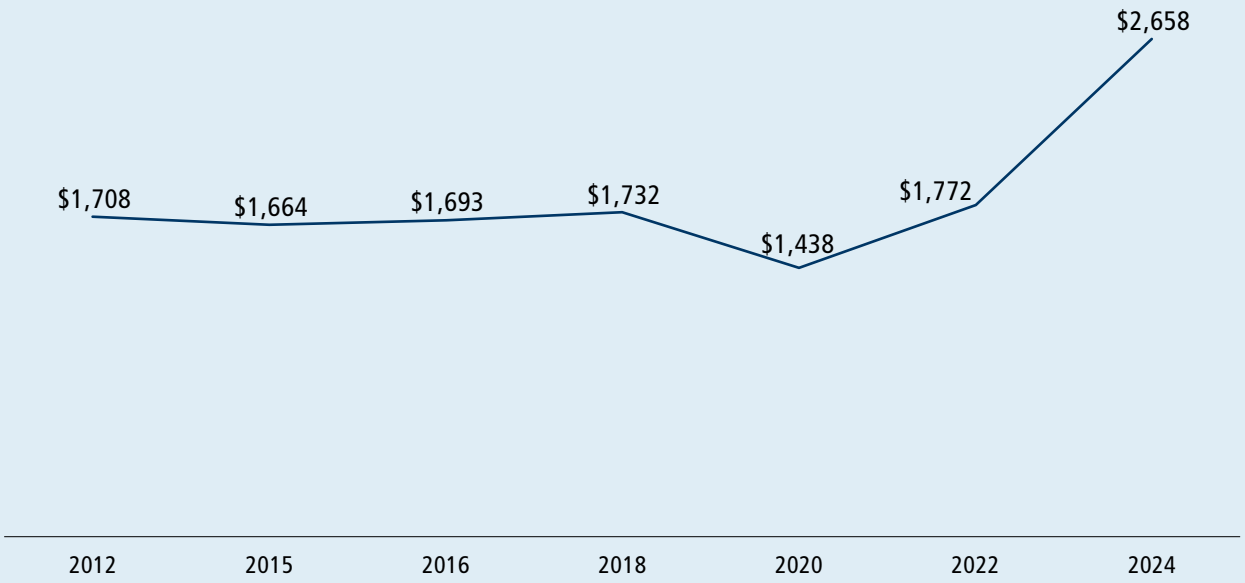
The Rhode Island Office of the Health Insurance Commissioner (OHIC) was established through legislation in 2004 to broaden the accountability of health insurers operating in Rhode Island. The Office is dedicated to: protecting consumers, encouraging fair treatment of medical service providers, ensuring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

Contents

Introduction

High health care costs are putting a significant strain on Rhode Island residents. In 2024, the annual health insurance premium for family coverage in Rhode Island was over $25,000.[1] This is equivalent to 28 percent of the state's median household income,[2] which is the most financial experts say should be spent on a home mortgage.[3] Premiums do not include the costs that residents have to pay out of pocket: from 2012 to 2020, the average out-of-pocket spending reported by a family was between $1,400 and $1,800. In 2024, the average rose to more than $2,500.[4] It is no wonder that, according to one estimate, approximately 40,000 Rhode Islanders are in debt due to medical expenses.[5]

Exhibit A. Average Out-Of-Pocket Spending on All Services for Rhode Island Residents (2012–2024)



Source: HealthSource RI.
Note: 'All Other Medical' expenses does not distinguish between patient cost sharing obligations (e.g., deductibles and coinsurance) and non-covered services expenses.[6]

Anxiety about health care affordability is widespread across the state. One survey found that 8 in 10 residents reported being worried about affording some aspect of their health care in the future. This concern was reported across all income levels. Furthermore, nearly 7 in 10 experienced at least one health care affordability burden in the last year.[7]

The evidence is clear: something needs to change. Health care costs are crowding out family budgets and leaving little room for necessities, like housing, food, and clothing. **The Rhode Island Office of the Health Insurance Commissioner (OHIC) has taken on the challenge of slowing health care spending growth and improving the health care system.**

1 Average Annual Family Premium per Enrolled Employee for Employer-Based Health Insurance. KFF. https://www.kff.org/private-insurance/state-indicator/family-coverage
In this analysis, "family coverage" is defined as any coverage other than single and employee-plus-one. It refers to health insurance plans that cover the enrollee and members of the enrollee's immediate family (spouse and/or children). Source: MEPS-IC Glossary Health Insurance Terms. Accessed March 4, 2026.
https://datatools.ahrq.gov/meps-ic/glossary-health-insurance-terms/#FamilyCoverage

2 Real Median Household Income in Rhode Island. FRED. https://fred.stlouisfed.org/series/MEHOINUSRIA672N

3 Elkins, Kathleen. "Here's how much of your income you should be spending on housing." CNBC. 2018.
https://www.cnbc.com/2018/06/06/how-much-of-your-income-you-should-be-spending-on-housing.html

4 HealthSource RI. 2024 Rhode Island Health Insurance Survey. Accessed March 2, 2026. https://healthsourceri.com/surveys-and-reports

5 Rakshit S, Rae M, Claxton G, Amin K, and Cox C. "The burden of medical debt in the United States." KFF.
2024. https://www.kff.org/health-costs/the-burden-of-medical-debt-in-the-united-states

6 The corresponding question from HSRI was: "Over the last 12 months, about how much has your family had to pay out of pocket for: your family's prescription medications, dental and vision care, mental health care, and all other medical expenses, including for doctors, hospitals, and tests. This would include common medical expenses such as over-the-counter medications, first aid materials, and so on." OHIC removed dental and vision costs from its analysis so that the pool of services better aligned with what is included in medical premiums.

7 Consumer Healthcare Experience State Survey: Rhode Island. Altarum Health Care Value Hub. 2024.
https://healthcarevaluehub.org/consumer-healthcare-experience-state-survey/rhode-island

Specifically, through its Health Spending Accountability and Transparency Program, OHIC has established three goals to curb health care spending growth:

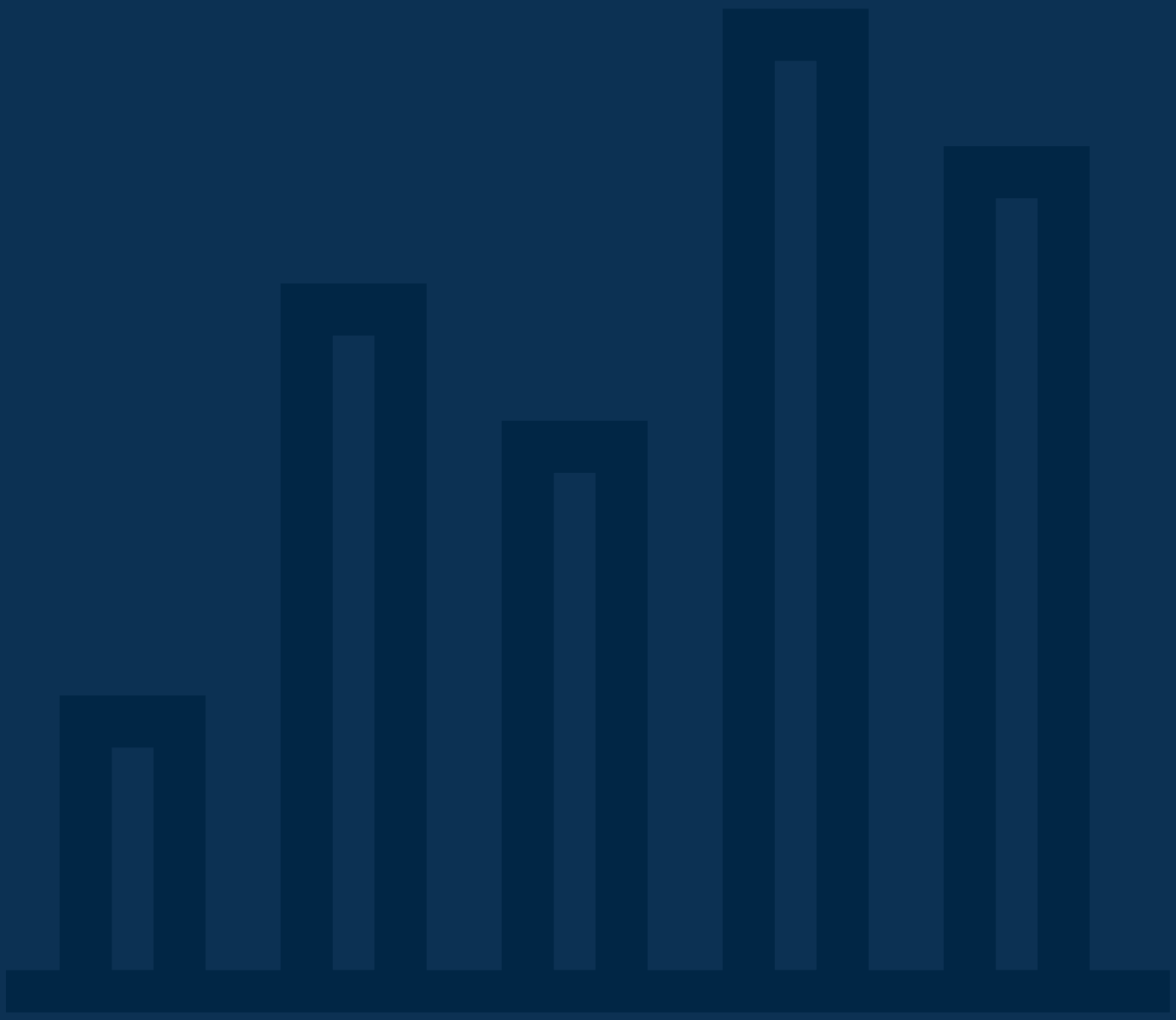
1. Understand and create transparency around health care costs and the drivers of cost growth.
2. Create shared accountability for health care costs and cost growth among health insurers, providers, and government by measuring performance against a cost growth target tied to economic indicators.
3. Lessen the negative impact of rising health care costs on Rhode Island residents, businesses, and government.

Data collected and analyzed as part of this program highlight areas of problematic spending growth and opportunities for strategic investment in the health care delivery system.

This report presents the findings from analyses performed by OHIC to examine the array of factors driving health care spending growth in Rhode Island in 2024. Chapter 1 presents state and market-level performance against the cost growth target. Chapter 2 reports on insurer performance against the cost growth target for each market and describes market-specific cost drivers. Chapter 3 showcases provider performance against the cost growth target by market. Chapter 4 provides a deep-dive into spending on retail prescription drugs using data from HealthFacts RI, the state's All-Payer Claims Database (APCD). Chapter 5 summarizes the Rhode Island health care system's performance on standard quality metrics. Chapter 6 describes the state's performance on public health and health equity measures. The report concludes with OHIC's recommendations on necessary steps to keep annual spending growth in Rhode Island below the target, while maintaining high standards for quality health care.

CHAPTER 1

Health Care Spending and Spending Growth in Rhode Island



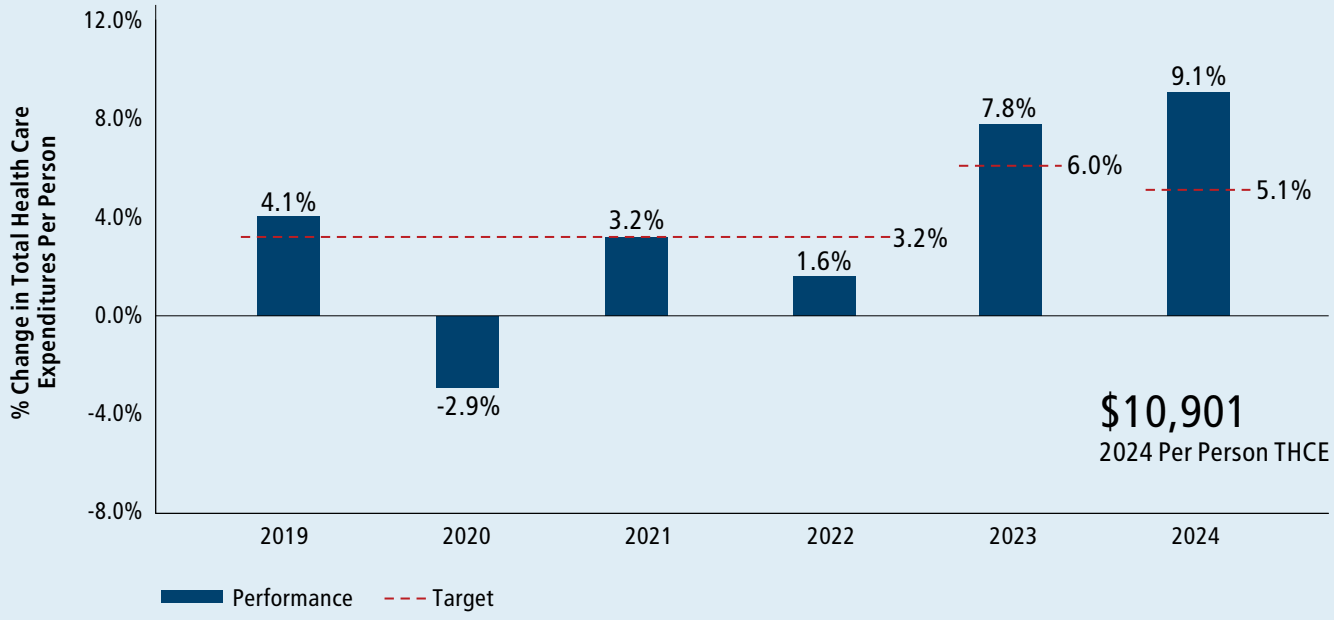
This is the sixth year for which OHIC has collected, analyzed, and publicly reported on health care spending data in the state. In 2024, the cost growth target was 5.1 percent, a value that reflects a blend of projected state economic growth and forecasted median household income growth in the state. The target accounts for the anticipated lagged impact of the sharp rise in general inflation that occurred during the height of the coronavirus pandemic.[1] This chapter summarizes 2024 statewide and insurance market performance against the cost growth target, and health care spending patterns based on OHIC's annual Cost Trends data collection.[2]

2024 was the second year in a row the state did not meet the cost growth target. Spending grew over 9 percent, the highest rate of growth the state has experienced since the establishment of its target.

Statewide Spending and Spending Growth

OHIC assesses statewide performance against the health care cost growth target by calculating the annual change in Total Health Care Expenditures (THCE). This measure includes all claims and non-claims payments to providers for covered services[3] (also referred to as Total Medical Expense, or TME) delivered to Rhode Island residents who receive coverage through commercial insurance, Medicare, and Medicaid. It also factors in the cost of administering private health insurance (also known as the Net Cost of Private Health Insurance, or NCPHI). To measure THCE, OHIC uses aggregate data from licensed health insurers in the state, as well as state and federal government data.

Exhibit 1.1: Statewide Performance Against the Cost Growth Target (2019–2024)



Source: OHIC analysis of TME data from insurers, the Centers for Medicare & Medicaid Services (CMS), Rhode Island Executive Office of Health and Human Services (EOHHS), and publicly available insurer regulatory findings.

1 The measure of state economic growth used for calculation of the target is potential gross state product (PGSP). One of the inputs for this measure is 'expected national inflation'; this component was adjusted to account for the two-year lag of general inflation on health care costs for performance years 2023 and 2024. For more information on the State's cost growth targets set using this blended calculation, see: RI Health Care Cost Trends Steering Committee, *Compact to Reduce the Growth in Health Care Costs while Improving Health Care Access, Equity, Patient Experience, and Quality in Rhode Island.* Accessed February 10, 2026.

2 For details on the data collection and analysis methodology, see: OHIC, *Rhode Island Health Care Cost Growth Target and Primary Care Expenditure Obligation Data Submission Guide* (PDF), August 14, 2025.

3 Some non-claims payments are not for covered services but are for incentives or infrastructure payments needed to support care delivery, e.g., electronic health record infrastructure payments.

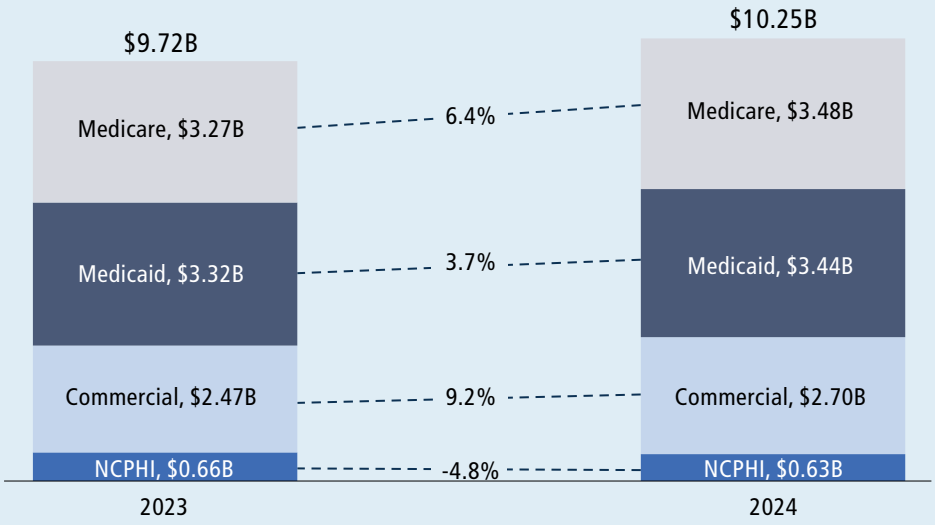
OHIC had previously elevated the cost growth target value for 2024 to 5.1 percent as a conscious effort to account for high 2022 inflation having a lagged impact on prices in 2024,[4] and to account for anticipated elevated rates in insurers' provider contracts.

Statewide per capita health care spending grew by 9.1 percent in 2024, surpassing the cost growth target by 4.0 percentage points and reaching its highest level since the target was established in 2019. This is the second year in a row in which the state has exceeded its target by a large margin, after four years of modest growth. In 2024, other states also far exceeded their targets.[5] Insurers reported to OHIC that state-level spending per person growth was driven by increased utilization and prices for medical and surgical services and specialty retail prescription drugs (including glucagon-like peptide-1 drugs [GLP-1s]).[6]

Spending by THCE Component

Statewide spending on health care amounted to $10.25 billion in 2024 (see Exhibit 1.2). The commercial market represented 26.4 percent of spending at $2.70 billion. Of total spending, Medicaid represented 33.6 percent at $3.44 billion, and Medicare represented 33.9 percent of total spending at $3.48 billion. Lastly, private insurance administrative spending and margin represented 6.1 percent of total health care spending at $628 million.

Exhibit 1.2: Aggregate Statewide Spending Growth by THCE Component (2023–2024)



Source: OHIC analysis of TME data from insurers, CMS, RI EOHHS, and publicly available insurer regulatory findings.

4 Research has shown that the broader economy impacts health care prices on a gradual and lagged basis. For more information, see: Kaiser Family Foundation, *Assessing the Effects of the Economy on the Recent Slowdown in Health Spending*, April 22, 2013. Accessed February 4, 2026.

5 Connecticut's statewide spending grew 7.9 percent, nearly double its 4.0 percent target. For more information, see: Connecticut Health Strategy. Healthcare Benchmark Initiative Cost Growth Benchmark and Primary Care Spending Target: 2023–2024 Performance. Delaware's statewide spending grew 12.2 percent, more than four times its 3.0 percent target. For more information, see: Delaware Department of Health and Social Services. Calendar Year 2024 Results. Benchmark Trend Report. Massachusetts' statewide spending grew at 5.7 percent, more than two percentage points above its 3.6 percent target. For more information, see: Massachusetts Center for Health Information and Analysis. 2026 Annual Report on the Performance of the Massachusetts Health Care System.

6 OHIC is unable to verify insurer statements using cost growth target data, as health plans report spending in aggregate, and not broken down by unit payments and utilization. OHIC can, however, do so with APCD data. Analysis of data from the APCD corroborates most of these spending patterns, with the exception of utilization of inpatient hospital services.

On a per capita basis, 2024 commercial market spending was $7,181, which represents a 7.1 percent increase over 2023 (see Exhibit 1.3). Per capita spending on Medicare increased 5.1 percent to $14,951, while per capita Medicaid spending increased 16.3 percent to $9,442.

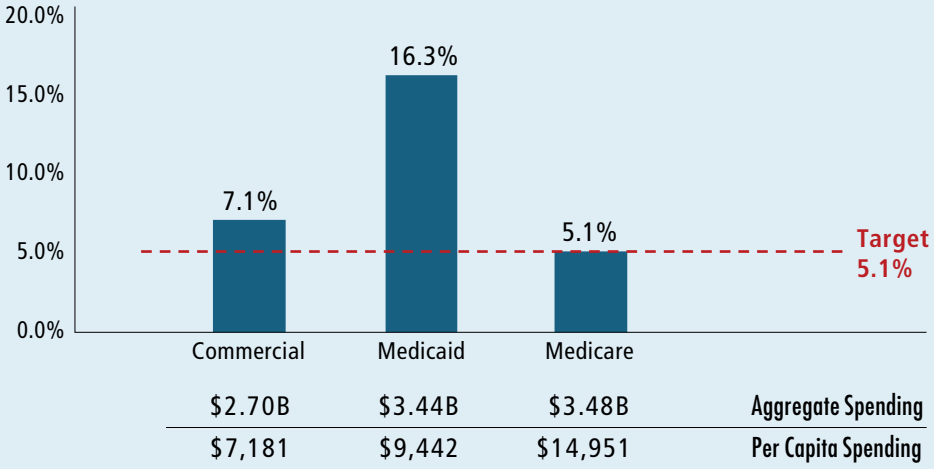
2024 was an unusual year for Medicaid in Rhode Island. Historically, Medicaid per person spending growth has been modest; in 2020 and 2021, spending decreased or remained flat, and in 2022, spending grew just 3.1 percent. In 2023, spending grew nearly 7 percent, owing in part to the April 2023 expiration of the federal requirement to maintain continuous coverage. The Medicaid unwinding process concluded in 2024 and the Medicaid population dropped 10 percent between CY2023 and CY2024. NHPRI reported to OHIC that those who were no longer eligible for Medicaid were typically healthier with lower spending and OHIC risk score analysis confirmed a drop in population health risk. This change resulted in substantially elevated per-person spending growth. By way of comparison, aggregate Medicaid spending increased 3.7 percent, which was the lowest aggregate spending growth among the three market segments.

Aside from the large reduction in the Medicaid population, another factor that largely impacted spending growth was the disbursement of hundreds of millions of dollars of state-directed payments (SDPs) from the Medicaid Managed Care Organizations (MCOs) to hospitals for inpatient and outpatient services. In accordance with the hospital SDP model that was approved by CMS, this payment was based on utilization of these services for Medicaid enrollees covered under the relevant contract. The MCOs reported disbursing an aggregate $417M in SDPs across both 2023 and 2024. When removing these costs, per capita Medicaid spending growth remains high at 12.1 percent.

Two other known factors that contributed to Medicaid's high per capita spending growth were OHIC's recommended rate increases for publicly funded social and human service providers resulting in $160M in new annualized spending, and the launch of the Certified Community Behavioral Health Clinics (CCBHCs). Both changes went into effect during State Fiscal Year 2025. OHIC was unable to quantify the impact of these two factors on Medicaid spending growth in time for this report; individually the impact is likely less significant than that of the hospital SDPs.

2024 per person Medicaid spending growth was inflated due to the conclusion of the Medicaid unwinding process, the disbursement of state-directed payments to hospitals by MCOs, the implementation of OHIC's recommended rate increases for publicly funded social and human service providers, and the launch of the Certified Community Behavioral Health Clinics.

Exhibit 1.3: Growth in Per Capita TME, by Market (2023–2024)



Source: OHIC analysis of TME data from insurers, CMS, and RI EOHHS.

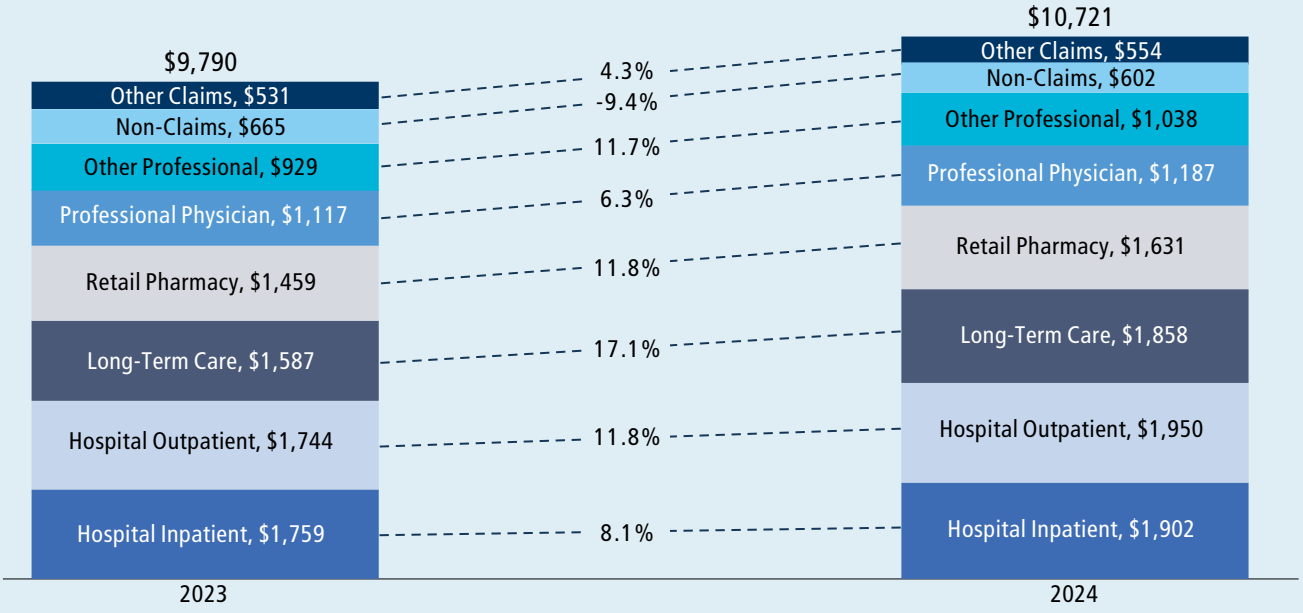
Statewide Spending Trends by Service Category

An examination of spending by service category shows that all claims categories saw increases between 4 and 17 percent between 2023 and 2024, with four categories seeing double-digit increases (see Exhibit 1.4). Long-Term Care saw the largest increase in per person spending at 17.1 percent, followed by an 11.8 percent increase in spending for both Hospital Outpatient services and Retail Pharmacy, and an 11.7 percent increase in per person spending for Other Professional.

Insurers reported that the increase in Hospital Outpatient services was influenced by increased utilization, notably for emergency services.[7] Spending on Hospital Inpatient services increased 8.1 percent, less than the increase in spending on Hospital Outpatient services. Per person spending on Hospital Outpatient services also surpassed that of Hospital Inpatient services in 2024 ($1,950 and $1,902 respectively). Hospital services continued to make up the largest portion of health care spending in the state, making up more than a third of overall TME per person spending in 2024.[8]

The substantial increase in Professional Other, which includes behavioral health services delivered by non-physician professionals, may have been influenced, in part, by fee schedule increases for pediatric and adolescent behavioral health services in the commercial market. The increase in Retail Pharmacy spending was largely attributed to increased spending on GLP-1s.[9] Professional Physician spending increased 6.3 percent, while spending on the Other Claims category increased 4.3 percent. Non-Claims spending decreased nearly 10 percent, reflecting fewer incentive payments to providers.

Exhibit 1.4: Per Capita TME by Service Category (2023–2024)



Source: OHIC analysis of TME data from insurers, CMS, and RI EOHHS.

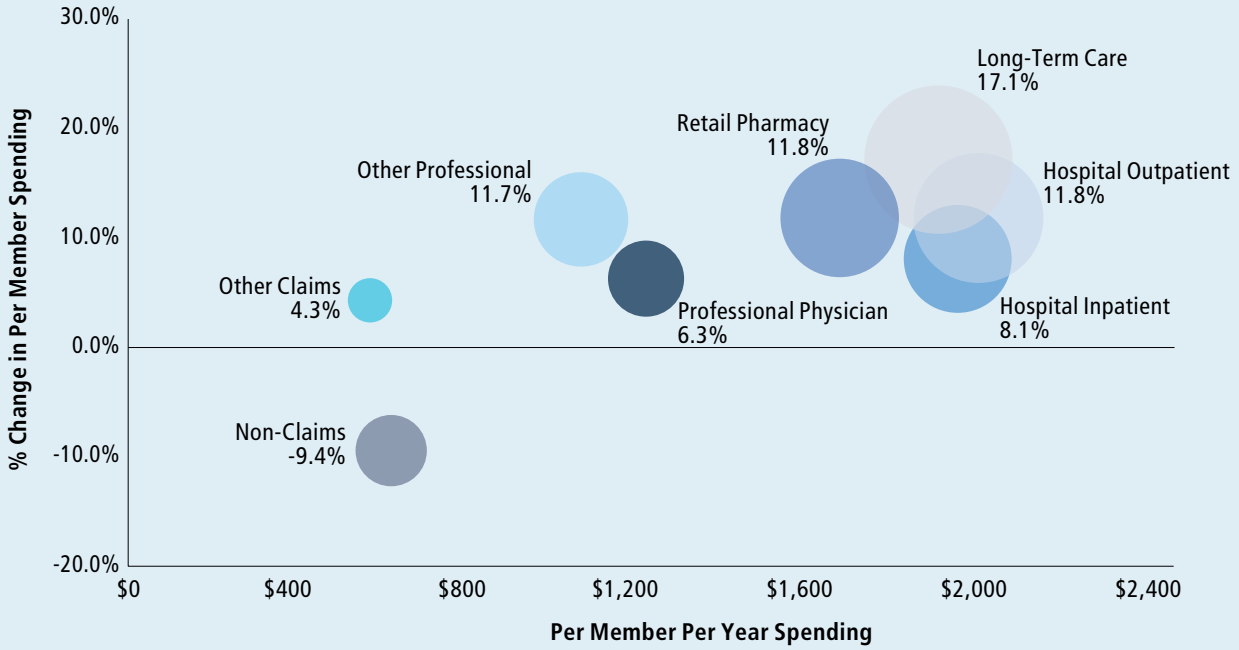
7 According to the APCD, utilization of emergency services increased over 6 percent in 2024.
8 If spending associated with hospital and health system-employed professionals was included in this calculation, the percentage would likely be much higher.
9 OHIC's analysis of RI APCD data revealed that spending on GLP-1s (Mounjaro, Ozempic, Rybelsus, Saxenda, semaglutide, Trulicity, Victoza, and Zepbound) increased over 60 percent in 2024.

Drivers of Statewide Spending Growth

Two factors determine a particular service category's contribution to overall spending growth – the level of per person spending for the service category, and its annual rate of growth.[10] At the state level, Long-Term Care and Hospital Outpatient spending drove overall change in spending in 2024, contributing 25.6 percent and 19.5 percent to overall spending growth, respectively (see Exhibit 1.5). All service categories contributed a positive amount to overall spending growth, with Other Claims contributing the smallest amount at 2.2 percent.

The large contributions of Long-Term Care, Hospital Outpatient, and Retail Pharmacy spending to overall spending growth are not unique to 2024; these service categories were primary contributors to spending growth in 2023. Nearly all Long-Term Care spending is from Medicaid.[11] Hospital Inpatient and Other Professional continued to play substantial roles in driving statewide spending growth in 2024, as they did in 2023.

Exhibit 1.5: State Level Service Category Contribution to Growth (2023–2024)



Source: OHIC analysis of TME data from insurers, CMS, and RI EOHHS. Data are not risk-adjusted. Retail and medical pharmacy rebates are accounted for in the reporting of Retail Pharmacy spending. Data do not include NCPHI. The width of the bubbles represents relative contribution to spending growth.

10 Contribution to overall spending growth was calculated by taking the absolute difference in per capita spending between 2023 and 2024 for each service category and dividing it by the sum of the absolute differences in per capita spending between 2023 and 2024 for all service categories.

11 Spending on long-term care by beneficiaries enrolled in the Medicaid-Medicare Plan (i.e., the Integrity product from the Neighborhood Health Plan of RI) is included in Medicaid. Additionally, OHIC's mandated rate increases apply to services captured under long-term care.

CHAPTER 2

Health Care Spending Growth by Insurer & Market and Market-Specific Cost Drivers

OHIC publicly reports on insurers' performance against the cost growth target in the pursuit of shared accountability for health care spending across the state. This chapter outlines 2024 performance against the cost growth target for each insurer by market, and cost drivers for each market.

Insurers' Spending Growth by Market

OHIC publicly reports performance against the target for insurers in three markets (commercial, Medicare Advantage, and Medicaid Managed Care) with at least 5,000 enrolled members in the respective market. OHIC determines insurers' performance by analyzing annual growth in per person spending on health care and employing statistical significance testing using a 95 percent confidence interval. If an insurer's spending growth and confidence interval fall below the target, OHIC considers the insurer to have met the target. Alternatively, if an insurer's spending growth and confidence interval are above the target, OHIC considers the insurer to have exceeded the target. If the confidence interval intersects with the target, OHIC cannot determine whether the insurer has met or exceeded the cost growth target with statistical certainty. Insurers' spending data in this chapter are adjusted for annual changes in age and sex, and truncated to remove high-cost outliers.[1,2]

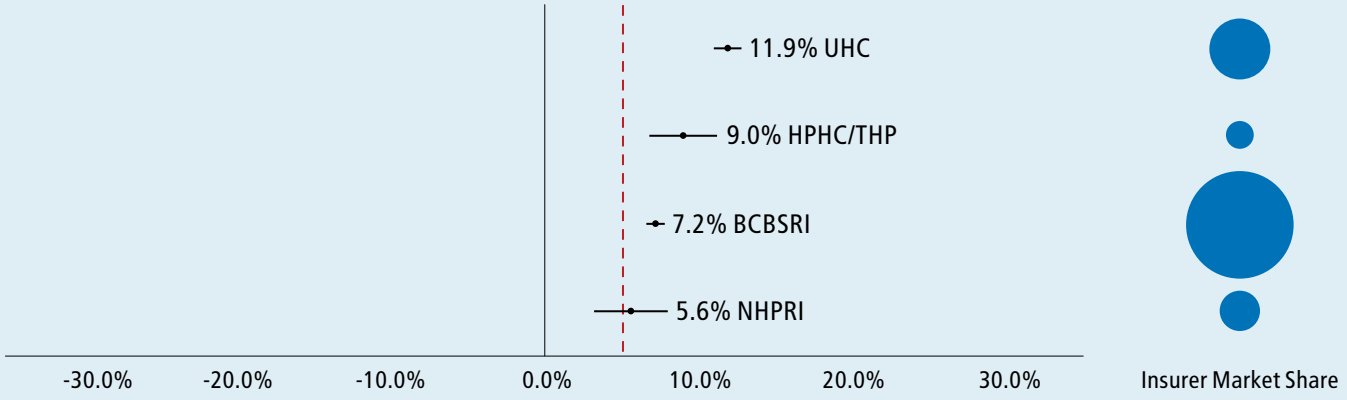
Commercial Insurers' Performance Against the Cost Growth Target

OHIC collected data from the state's four largest commercial insurers: Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Harvard Pilgrim Health Care and Tufts Health Plan combined (HPHC/THP),[3] and UnitedHealthcare (UHC).[4]

Insurers in the commercial market saw spending growth in 2024 ranging from 5.6 to 12.0 percent (See Exhibit 2.1). Three commercial insurers exceeded the target – UHC (11.9 percent), HPHC/THP (9.0 percent), and BCBSRI (7.2 percent). Performance for NHPRI could not be assessed based on statistical testing because its confidence interval intersected with the cost growth target. The state's commercial insured population remained relatively stable from 2023 to 2024.

1 This differs from the data shown in Chapter 1, where OHIC presents data that are not age/sex-adjusted. For more information on the methodology, see: OHIC, *Rhode Island Health Care Cost Growth Target and Primary Care Expenditure Obligation Data Submission Guide* (PDF), August 14, 2025.
2 In 2024, the percentages of claims truncated by market were: 7.6 percent (commercial), 8.9 percent (Medicare), and 3.7 percent (Medicaid).
3 Tufts Health Plan and Harvard Pilgrim Health Care merged to create Point32Health in 2021. Tufts Health Plan commercial members began migrating to Harvard Pilgrim commercial products in 2023; for the purposes of this analysis, their membership and spending information are combined.
4 Two other insurers, Aetna and Cigna, each had fewer than 5,000 members in Rhode Island's commercial insurance market, and so did not report health care spending for the cost growth target data collection.

Exhibit 2.1: Commercial Insurers' 2024 Performance Against the Cost Growth Target

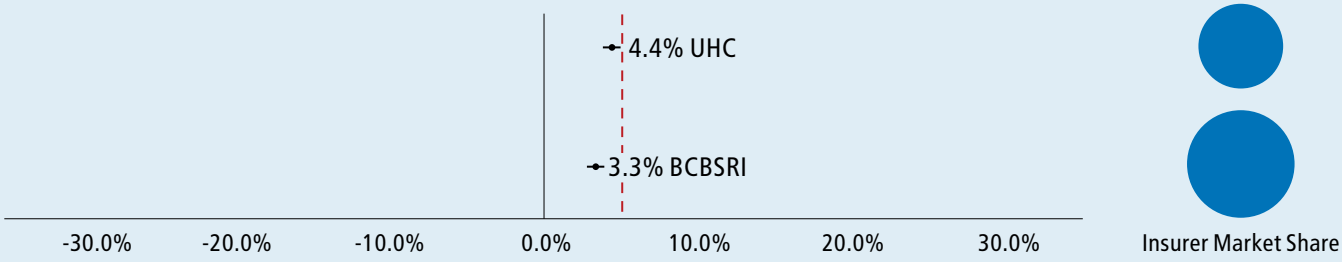


Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex adjustment. Data represent spending on fully insured and self-insured products, including the Federal Employee Health Benefits Program. The width of the bubbles represents the payers' market share. There is no x-axis of the bubble graph, as each data point represents each individual payer.

Medicare Advantage Insurers' Performance Against the Cost Growth Target

BCBSRI and UHC are the Medicare Advantage insurers in Rhode Island that meet the minimum covered lives threshold for public reporting.[5] Both insurers met the cost growth target with growth rates of 3.3 and 4.4 percent, respectively (see Exhibit 2.2). Both insurers saw lower health care spending growth in the Medicare Advantage market than in the commercial market. BCBSRI's Medicare Advantage population saw significant growth (6.8 percent) while UHC's population growth was more modest (3.7 percent).

Exhibit 2.2: Medicare Advantage Insurers' 2024 Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex adjustment. The width of the bubbles represents the payers' market share. There is no x-axis of the bubble graph, as each data point represents each individual payer.

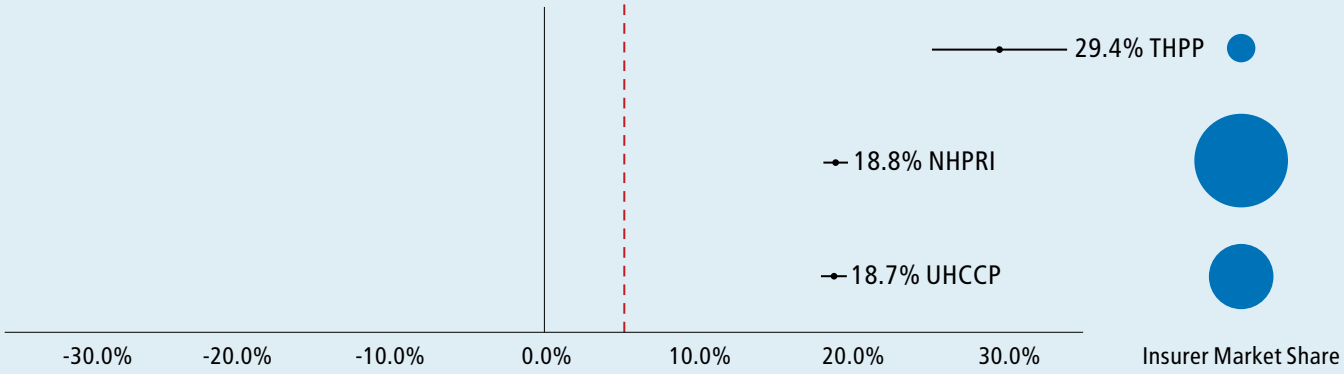
5 There are other Medicare Advantage insurers with Rhode Island enrollment less than 5,000 members. For more information, see: Centers for Medicare & Medicaid Services. MA Enrollment by SCC 2025 12. Accessed February 9, 2026.

Medicaid Insurers' Performance Against the Cost Growth Target

The three Medicaid insurers in Rhode Island are NHPRI, Tufts Health Public Plan (THPP), and UnitedHealthcare Community Plan (UHCCP).

All three insurers exceeded the cost growth target (see Exhibit 2.3). Each MCO saw significant declines in their populations in 2024, when the State completed its Medicaid redeterminations during the "unwinding" period related to the end of the COVID-19 Public Health Emergency. Additionally, these growth rates include the hospital state-directed payments (SDPs) disbursed by the MCOs. When removing these payments from MCOs' spending, the MCOs still exceeded the target with high growth rates: THPP (19.9 percent), NHPRI (11.1 percent), and UHC (10.0 percent).

Exhibit 2.3: Medicaid Managed Care Organizations' 2024 Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex adjustment. The width of the bubbles represents the payers' market share. There is no x-axis of the bubble graph, as each data point represents each individual payer.

Medicare-Medicaid Plans' Performance Against the Cost Growth Target

Through CMS' Financial Alignment Initiative, Rhode Island has provided coverage to individuals who are dually eligible for Medicare and Medicaid through a combined Medicare-Medicaid Plan (MMP).[6] NHPRI was the only insurer to offer such a product in 2024. Target performance is calculated using TME data, after applying truncation. MMP spending is not adjusted for changes in population age and sex composition, as adjustment is not performed at the market level and NHPRI's population represents the entire population of individuals enrolled in this market. For the 2024 performance period, NHPRI's exceeded the cost growth target with spending growth of 8.2 percent.

6 For more information on Integrity, see: Neighborhood Health Plan of Rhode Island, Neighborhood INTEGRITY (Medicare-Medicaid Plan), accessed February 12, 2026.

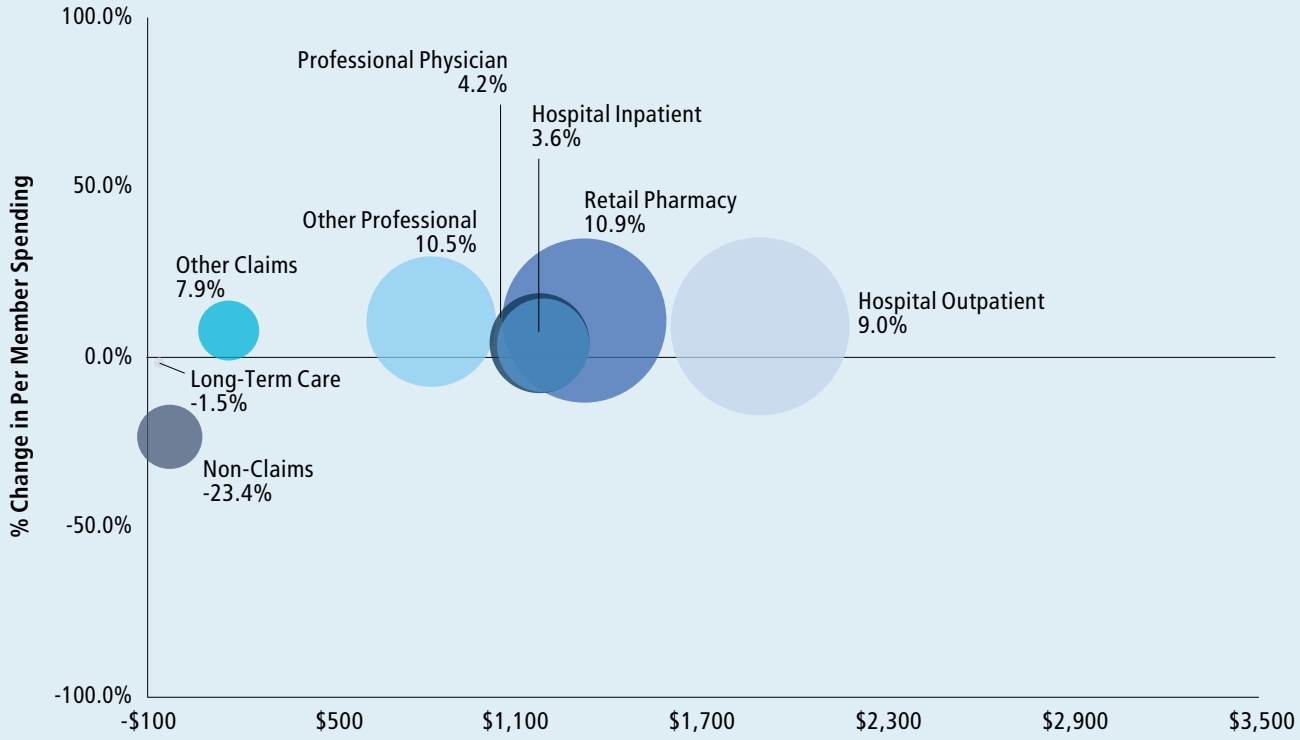
Market-Specific Cost Drivers

Commercial Service Category Cost Drivers

In 2024, per person spending growth in the commercial market was most influenced by growth in Hospital Outpatient and Retail Pharmacy spending. Other Professional was also a major contributor to spending growth.

Per capita spending on Retail Pharmacy and Other Professional increased by double digit percentages – from $1,265 to $1,403 (10.9 percent) and $825 to $911 (10.5 percent) respectively. Growth in per capita Hospital Outpatient and Other Claims spending was also high, at 9.0 percent and 7.9 percent respectively. The growth in spending on Hospital Outpatient and Retail Pharmacy alone accounted for more than half of spending growth in the commercial market. Notably, non-claims spending decreased by nearly 25 percent, due to providers earning fewer performance incentive payments in 2024 than in 2023, likely a result of the high growth in claims spending disqualifying provider groups in value-based payment contracts from earning shared savings payments. This is a continuation of a trend observed in 2023 performance data.

Exhibit 2.4: Commercial Service Category Contribution to Growth (2023–2024)



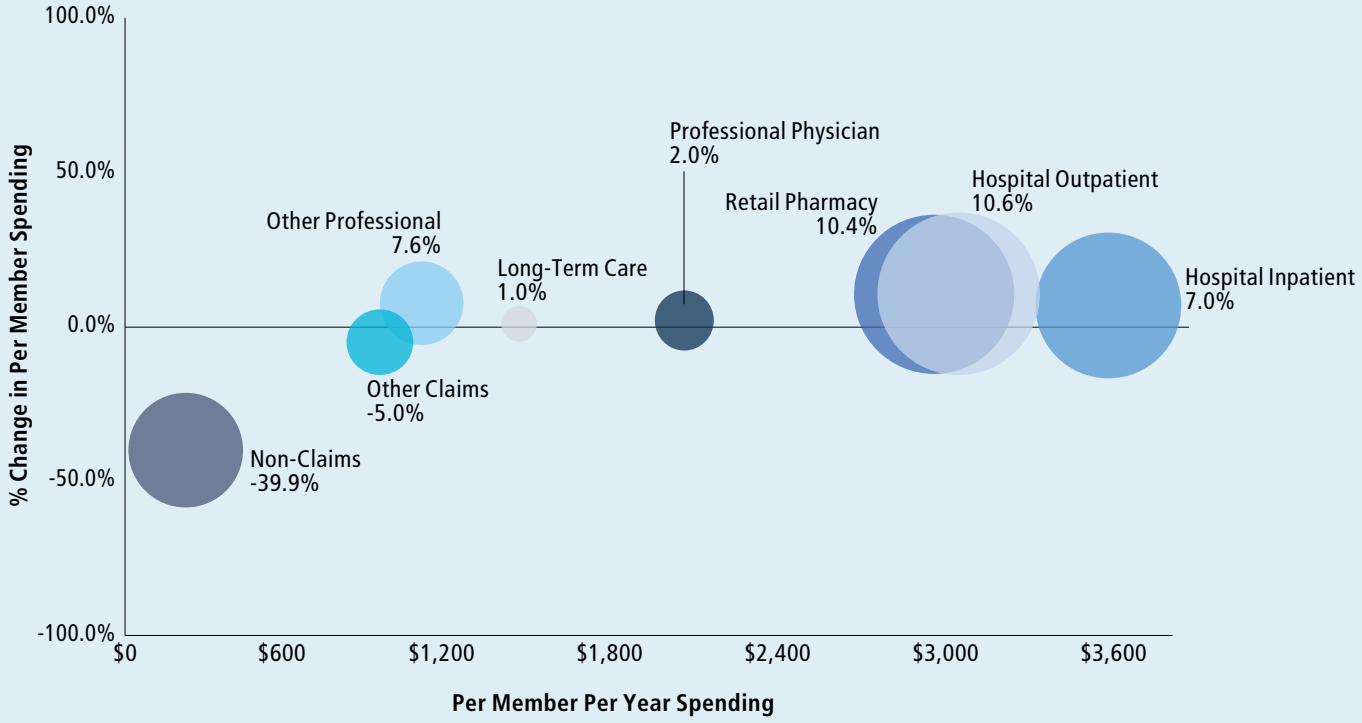
Source: OHIC analysis of TME data from insurers. Data are not age/sex adjusted and are reported net of pharmacy rebates. The width of the bubbles represents relative contribution to spending growth.

Note: The bubble for Professional Physician is hidden beneath Hospital Inpatient.

Medicare Service Category Cost Drivers

In the Medicare market, Hospital Outpatient, Retail Pharmacy, and Hospital Inpatient were all key drivers of spending growth (see Exhibit 2.5). Hospital Outpatient spending increased from $2,690 to $2,976 per person (10.6 percent), Retail Pharmacy spending increased from $2,615 to $2,888 (10.4 percent), and Hospital Inpatient spending grew from $3,281 to $3,509 (7.0 percent). These three categories accounted for over 70 percent of spending growth in the Medicare market in 2024. Non-Claims spending decreased by 39.9 percent, or from $355 to $213 per capita. As with the commercial market, this appears to reflect a decline in shared savings payments.

Exhibit 2.5: Medicare Service Category Contribution to Growth (2023–2024)

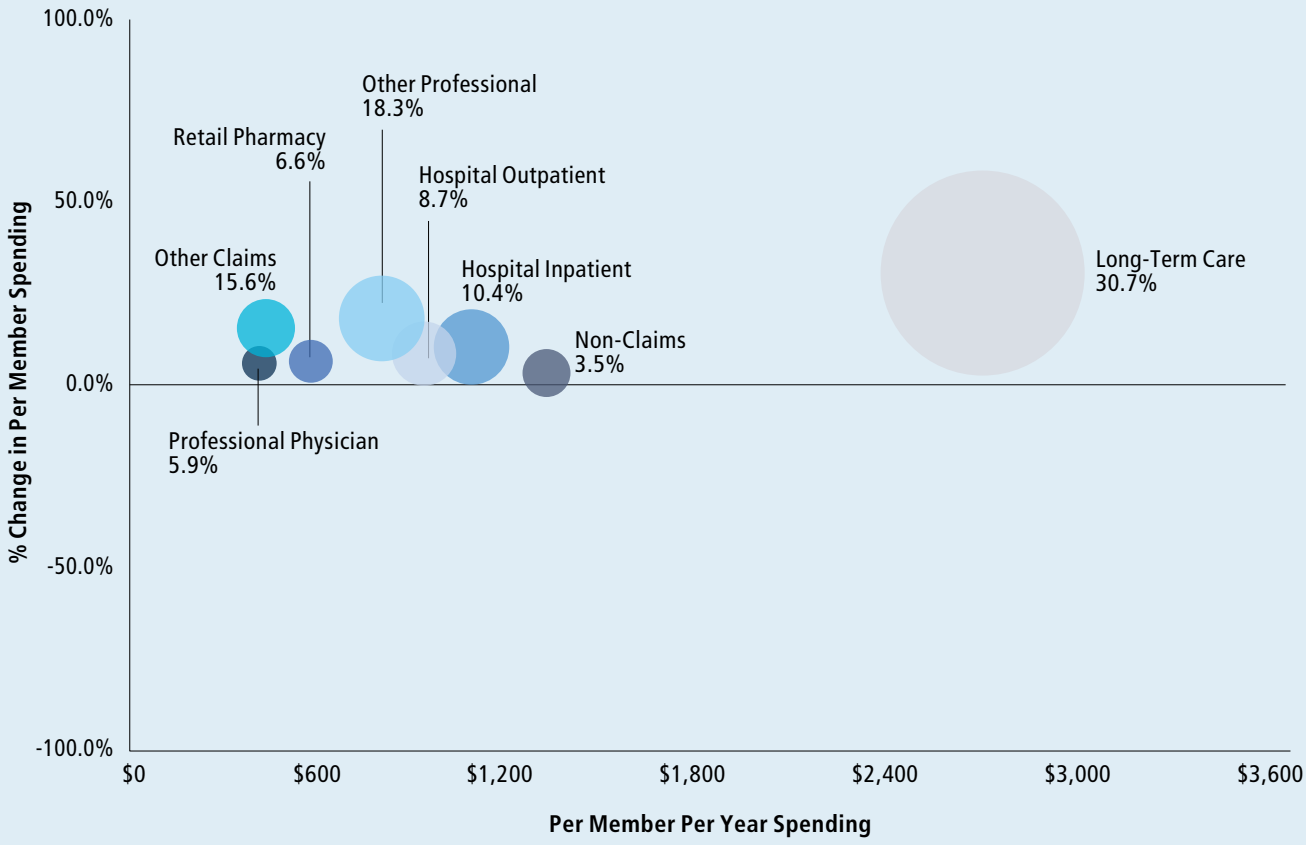


Source: OHIC analysis of TME data from insurers. Data are not age/sex adjusted and are reported net of pharmacy rebates. The width of the bubbles represents relative contribution to spending growth.

Medicaid Service Category Cost Drivers

Long-Term Care spending was the primary driver of Medicaid spending growth in 2024. Unusually large increases in Other Professional[7] and Hospital Inpatient spending also contributed to growth, but to a much lesser extent. Long-Term Care spending increased by 30.7 percent, growing from $2,656 to $3,471, while spending on Other Professional, Other Claims, and Hospital Inpatient grew by 18.3 percent, 15.6 percent, and 10.4 percent respectively (see Exhibit 2.6). Long-Term Care spending has grown at accelerating rates over three years, having increased by 15.1 percent in 2023 and by 6.7 percent in 2022. Per person spending growth for Long-Term Care in 2024 was driven by increased nursing and home care. Spending associated with the hospital SDPs was not a factor in growth for any of the claims categories; OHIC placed this spending under Non-Claims for the purposes of this analysis.

Exhibit 2.6. Medicaid Service Category Contribution to Growth (2023–2024)



Source: OHIC analysis of TME data from insurers. Data are not age/sex adjusted and are reported net of pharmacy rebates. The width of the bubbles represents relative contribution to spending growth.

7 This category of spending includes the provision of behavioral health services by non-physician professionals (e.g., therapists, nurse practitioners, and psychologists).

CHAPTER 3

Health Care Spending Growth by Provider & Market

Providers' Spending Growth by Market

Large Provider Entities, or LPEs, are provider organizations contracted with one or more insurers that, at a minimum, include primary care providers, and that collectively, during any given calendar year, have enough attributed lives to participate in total cost of care contracts, even if they are not engaged in a total cost of care contract as an Accountable Care Organization (ACO) or Accountable Entity (AE).[1] ACOs are provider organizations contracted with one or more insurers and are held accountable for the health care quality, outcomes, and total cost of care of an attributed commercial or Medicare population. In Rhode Island's Medicaid market, these provider organizations are called AEs and are certified by EOHHS.

OHIC assesses performance against the cost growth target for LPEs that have at least 5,000 attributed members.[2] As is the case with insurers, OHIC applies statistical significance testing using a 95 percent confidence interval to determine whether the state's provider organizations have met the target. Providers' spending data in this chapter are adjusted for annual change in attributed population age and sex, and truncated to remove high-cost outliers. This chapter presents 2024 performance against the cost growth target for each LPE by market.

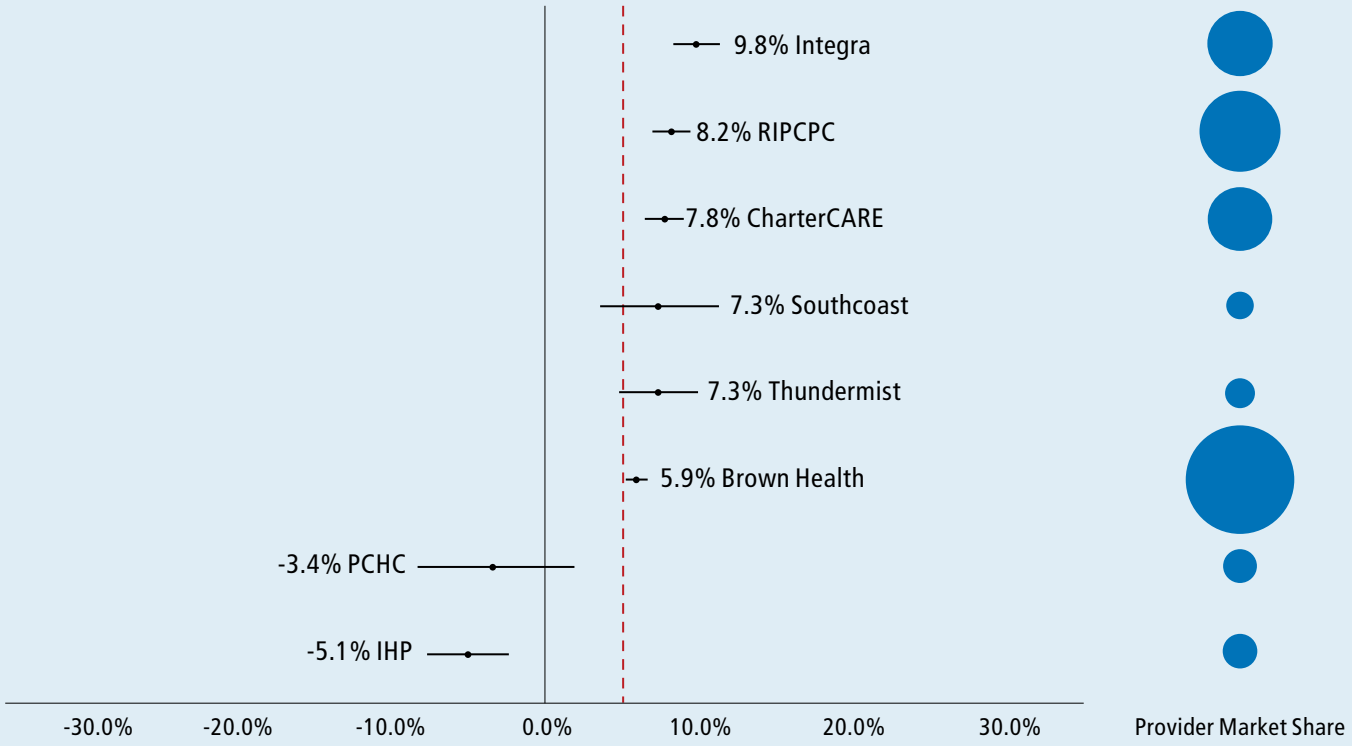
LPE Commercial Performance Against the Cost Growth Target

There were nine commercial LPEs in Rhode Island in 2024. Commercial spending growth is not published for Blackstone Valley Community Health Care (BVCHC), because it did not have the minimum number of commercial attributed lives required for public reporting. Of the eight LPEs that had sufficient attributed lives for performance to be publicly reported, four LPEs (Integra, Rhode Island Primary Care Physicians Corporation (RIPCPC), CharterCARE, and Brown University Health (Brown Health)) exceeded the cost growth target for the 2024 performance period (see Exhibit 3.1). Two LPEs, Integrated Healthcare Partners (IHP) and Providence Community Health Centers (PCHC) met the target; they each saw decreases in per person spending in 2024. IHP and PCHC each experienced a 30 percent increase in attributed commercial members. Most of the increase in membership for both entities was due to NHPRI attributing more commercial members to them. It is likely that the influx of membership came from those who lost their Medicaid coverage and then purchased coverage in the individual market. Performance for Southcoast Health (Southcoast) and Thundermist Health Center (THC) could not be assessed based on statistical testing because their confidence intervals intersected with the target.

1 Beginning with the 2023-2024 data collection cycle, OHIC broadened its definition of provider organizations to include non-ACO/AE "large provider entities" (LPEs). OHIC did so in recognition that some organizations no longer hold ACO contracts with insurers; absent a revised definition, the provider groups spending would no longer be included in entity reporting. Additionally, there are some provider organizations with significant attributed lives for which payers have not reported because they do not hold ACO and/or AE contracts with the entities. These members have historically been captured in the group, "Members Not Attributed to an ACO/AE." All ACOs are considered LPEs; however, not all LPEs are ACOs or AEs (e.g., Brown University Health is not an AE, but it is identified as an LPE per OHIC's reporting requirements). Because LPE is the more inclusive term, OHIC opted to use this term for each of the markets in this analysis.

2 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.

Exhibit 3.1: LPEs' 2024 Commercial Market Performance Against the Cost Growth Target

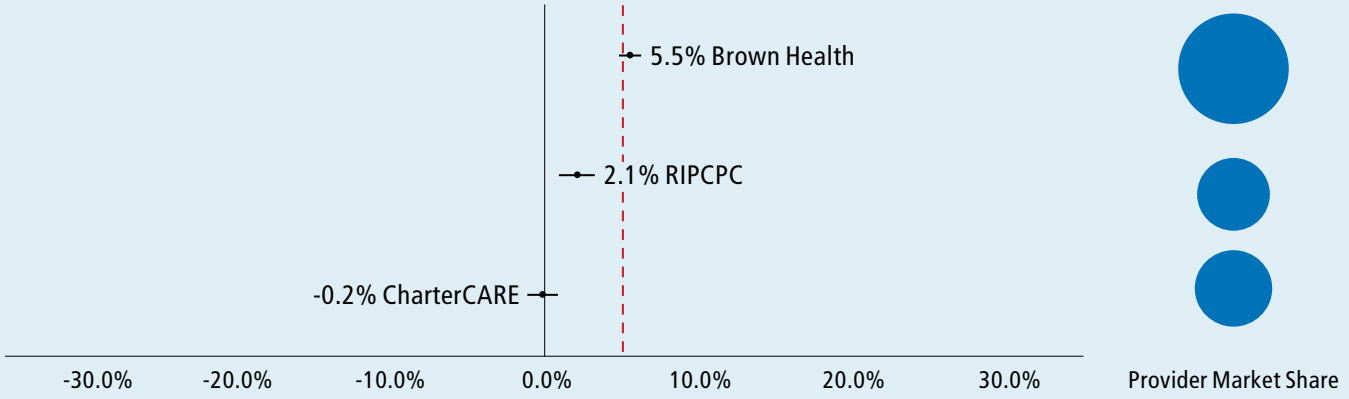


Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex adjusted spending. The width of the bubbles represents the LPEs' market share; it does not represent relative contribution to commercial market LPE spending growth. LPE-level spending is both age/sex adjusted and truncated; neither of these adjustments is applied to market-level spending. There is no x-axis of the bubble graph, as each data point represents each individual LPE.

LPE Medicare Advantage Performance Against the Cost Growth Target

There were nine LPEs in Rhode Island contracted with Medicare insurers in 2024. Medicare Advantage spending growth is not published for BVCHC, Integra, IHP, PCHC, Southcoast or Thundermist because they did not have the minimum number of Medicare Advantage attributed lives required for public reporting. Of the three LPEs that met the minimum for reporting, two (CharterCARE and RIPCPC) met the cost growth target for the 2024 performance period (see Exhibit 3.2). Brown Health's performance could not be assessed based on statistical testing because the confidence interval intersected with the target. Cost growth for both CharterCARE and RIPCPC was much lower in the Medicare market than their respective growth in the commercial market.

Exhibit 3.2: LPEs' 2024 Medicare Advantage Market Performance Against the Cost Growth Target

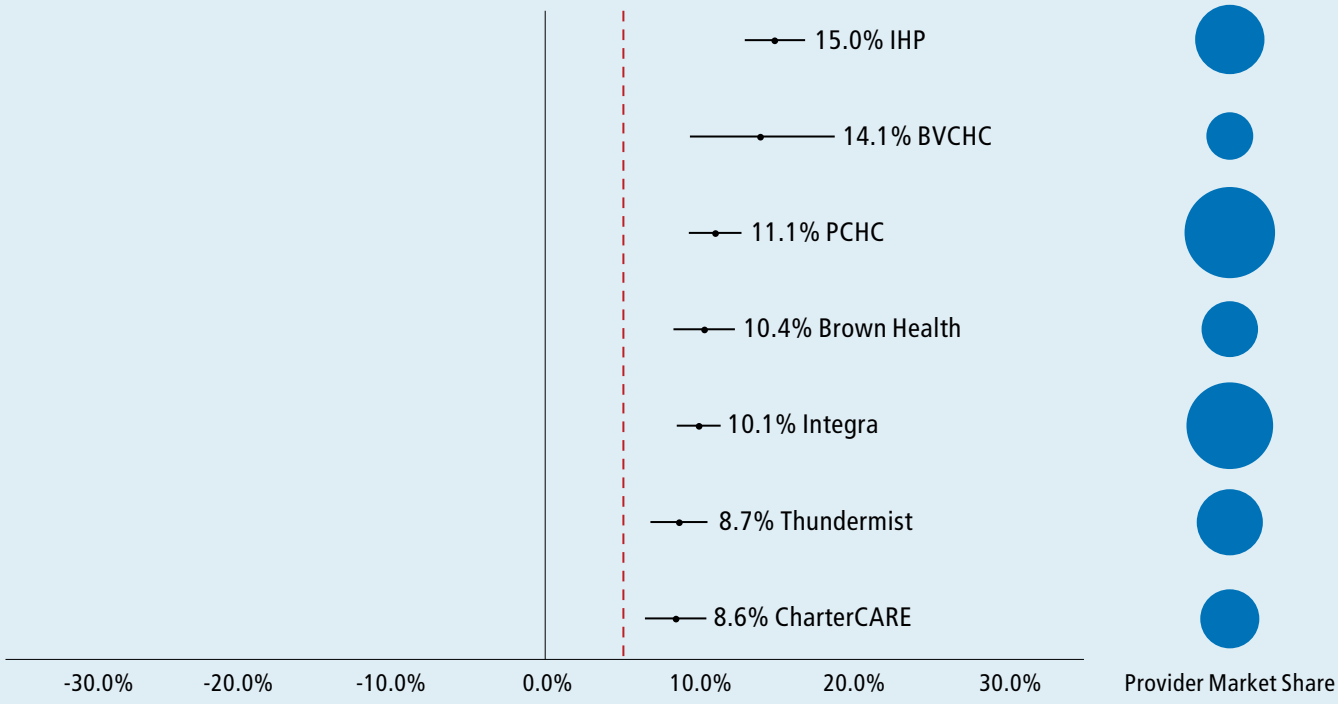


Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex adjusted spending. The width of the bubbles represents the LPEs' market share; it does not represent relative contribution to Medicare Advantage market LPE spending growth. LPE-level spending is both age/sex adjusted and truncated; neither of these adjustments is applied to market-level spending. There is no x-axis of the bubble graph, as each data point represents each individual LPE.

LPE Medicaid Performance Against the Cost Growth Target

There were seven Medicaid LPEs in Rhode Island in 2024.[3] All seven LPEs exceeded the cost growth target (see Exhibit 3.3). These growth rates do not include hospital SDPs.

Exhibit 3.3: LPEs' 2024 Medicaid Market Performance Against the Cost Growth Target

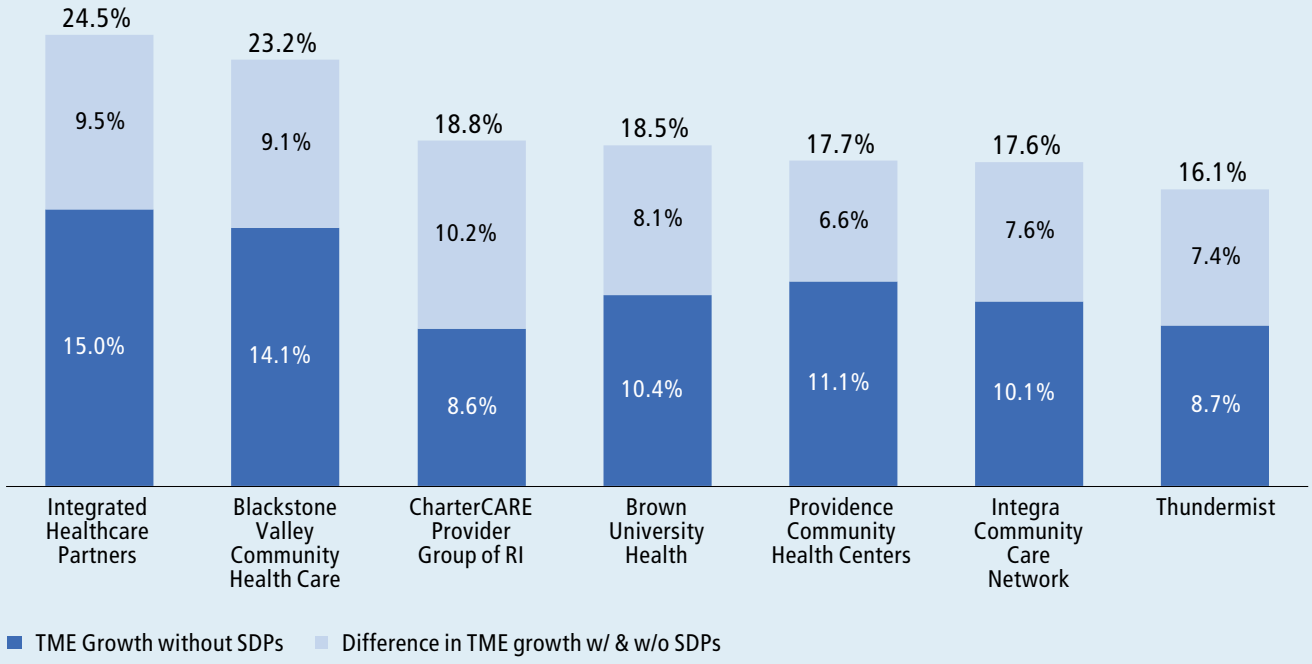


Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex adjusted spending. The width of the bubbles represents the LPEs' market share; it does not represent relative contribution to Medicaid market LPE spending growth. LPE-level spending is both age/sex adjusted and truncated; neither of these adjustments is applied to market-level spending. There is no x-axis of the bubble graph, as each data point represents each individual LPE.

3 RIPCPC participated in the AE program as part of Integra in 2023 and 2024. For this reason, RIPCPC is not identified as a separate provider for the purposes of this analysis. RIPCPC separated from Integra in 2025 and became a Medicaid AE.

OHIC allocated the SDPs reported by the MCOs to each of the LPEs for the purposes of this analysis.[4] Doing so resulted in an extra 6.6 to 10.2 percentage points in spending growth across the LPEs.

Exhibit 3.4: LPEs' 2024 Medicaid Market Growth with Hospital SDPs



Source: OHIC analysis of TME data submitted by insurers.

4 To allocate SDPs to the Medicaid LPEs, OHIC totaled SDPs across the MCOs, and allocated spending to each LPE based on their contribution to total Medicaid hospital TME, as reported by the MCOs. OHIC determined that this method, while imperfect, is acceptable for this year's reporting, and more suitable than other approaches that would demand time and resources of the insurers.

CHAPTER 4

Factors Driving Retail Pharmacy Cost Growth in the Commercial Market

Spending on retail prescription drugs has consistently grown at high rates in Rhode Island.[1] During the height of the coronavirus pandemic, in 2020, it was the only service category where spending increased. In 2024, spending growth in this category was high in all three markets – spending grew 6.6 percent for Medicaid and over 10 percent each for the Medicare and commercial markets. In the commercial market, per person pre-rebate spending for this category rose to over $1,400, surpassing spending for inpatient hospital services. Given its ongoing role in driving cost growth, OHIC examined spending, average unit payment, and utilization trends in the commercial market using data from HealthFacts RI, the state's All-Payer Claims Database (APCD), to comprehensively assess retail pharmacy spending patterns.

Spending, Unit Payment, and Utilization for Prescription Drugs for Rhode Island Residents with Commercial Coverage

Between 2020 and 2024, spending on prescription drugs grew an average of 8.9 percent annually, from $128 to $179 per person. Each year, spending growth was fueled primarily by increases in average unit payment. Utilization, on the other hand, stayed relatively flat in this five-year period.

Table 4.1. Spending, Average Unit Payment, and Utilization of All Retail Prescription Drugs in the Commercial Market (2020–2024)

Year	Total Spend	PMPM	PMPM $ Change	PPU	UPK	PMPM % Change	PPU % Change	UPK % Change
2020	$558.3 M	$130	–	$95	16,372	–	–	–
2021	$604.8 M	$139	$9	$101	16,570	7.0%	5.7%	1.2%
2022	$680.4 M	$155	$16	$107	17,360	11.3%	6.3%	4.8%
2023	$727.6 M	$173	$18	$117	17,645	11.8%	10.0%	1.6%
2024	$786.5 M	$184	$10	$132	16,392	6.0%	12.6%	-7.1%
Average Annual % Change	–	–	–	–	–	9.0%	8.7%	0.1%

Source: OHIC analysis of HealthFacts RI data.
Excludes COVID-related medications. Data are gross of rebates.
PMPM = Per Person Per Month; PPU = Payment Per Unit (also known as average unit payment), and UPK = Units per 1,000 members. Units are defined as 30-day equivalents.

Examining Spending Growth Drivers

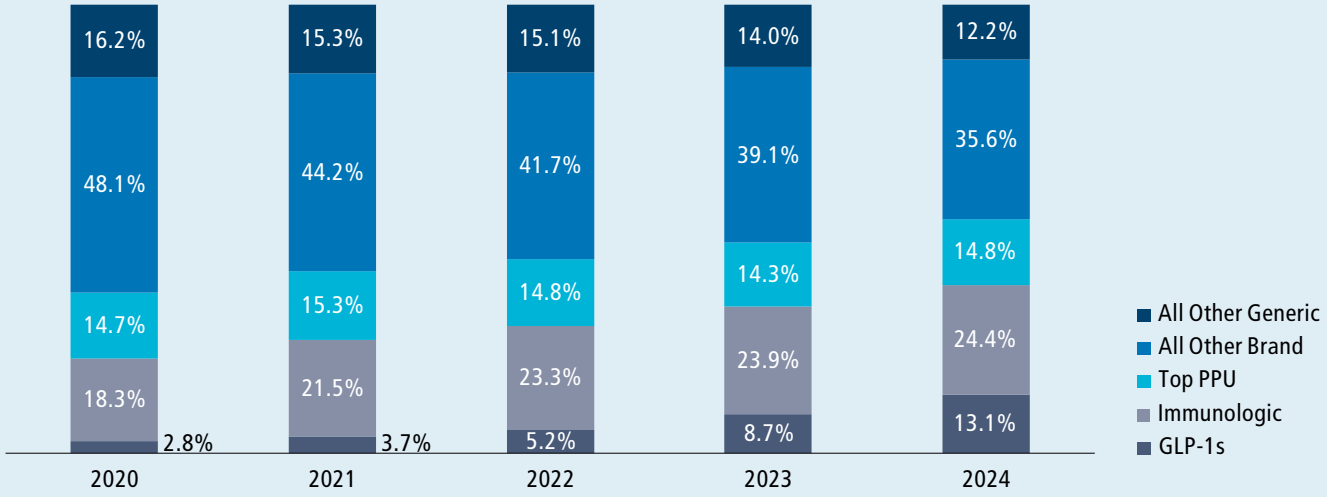
Historically, OHIC has conducted detailed analyses on high-profile medications like Humira and other leading immunological agents[2] and glucagon-like peptide-1 (GLP-1) therapies.[3] These analyses revealed that these medications have been major contributors to the growth in pharmacy costs due to their high unit payments and a surge in utilization. Collectively, these two groups of medications made up just over 20 percent of total spending on prescription drugs in 2020; in 2024, their share of spending increased to nearly 40 percent (see Figure 4.1).[4] When examining unit

1 Rates for the commercial market: 9.9 percent in 2020; 2.8 percent in 2021; 6.3 percent in 2022; 7.4 percent in 2023. These values are net of rebates. In 2021, spending growth was depressed due to significant rebates from manufacturers. These high growth rates align with experience in other cost growth target states: in Connecticut, per person spending on prescription drugs increased 9.0 percent in 2022, and 8.6 percent in 2023. In Massachusetts, spending increased 10.5 percent in 2022 and 9.0 percent in 2023. OHIC accessed these data in publicly available reports. For more information, see: Connecticut Office of Health Strategy. Reports and Updates. Accessed March 11, 2026. Massachusetts Center for Health Information and Analysis. Annual Report on the Performance of the Massachusetts Health Care System. Accessed March 11, 2026.
2 Rhode Island Office of the Health Insurance Commissioner. 2025 Annual Report: Health Care Spending and Quality in Rhode Island.
3 Rhode Island Office of the Health Insurance Commissioner. 2025 Chartbook.
4 The spending on GLP-1s in the APCD does not include spending not captured in claims data; for example, it does not include residents' spending on these medications that they purchase online. Therefore, total spending for GLP-1s is understated in this analysis.

payments across the market from 2020 to 2024, OHIC found that medications with unit payments of greater than $10,000 made up less than 4 percent of total drugs in the APCD, yet represented approximately 15 percent of total spending each year.

To isolate these drugs' contribution to spending growth, OHIC assessed how prescription drug spending trends changed when these groups of medications (leading immunological agents, GLP-1s, and medications with the highest average unit payments) were removed from the analysis. For the purposes of this analysis, OHIC grouped the remainder of prescription drugs into two categories: brand or generic.

Exhibit 4.1 Share of Spending by Drug Segment (2020–2024)



Source: OHIC analysis of HealthFacts RI data

Notes: "Leading Immunological Agents" includes eight medications: Dupixent, Enbrel, Humira, Otezla, Rinvoq, Skyrizi, Stelara, and Tremfya.[5,6]
There are nine GLP-1s included in this analysis: Mounjaro, Ozempic, Rybelsus, Saxenda, Semaglutide, Trulicity, Victoza, Wegovy, and Zepbound.
There are over 5,000 drugs included under "All Other Brand" (examples include: Biktarvy and Januvia) across all years – in some years, many drugs do not have spending data associated with them.

When these drugs are removed from the analysis, absolute per person spending and unit payments drop dramatically. Both measures fell between 35 and 50 percent each year, as did their growth, especially in 2023 and 2024 (see Table 4.2). Because removing these high-cost drugs shrinks spending significantly, OHIC deduced that overall spending growth for prescription drugs is driven by this small set[7] of high-cost drugs. OHIC's analysis confirms this. The rest of the retail prescription drug market shows low growth or decreases in spending, modest price increases, and flat or declining utilization.

5 Stelara and Skyrizi are high-spend immunological agents that also had average unit payments greater than $10,000 in some years For this analysis, OHIC categorized them as immunologics to be consistent with their therapeutic class.
6 According to the APCD, these eight drugs were among the highest spend immunological agents each year.
7 The prescription medications captured across these three categories made up between 2 and 3 percent of all drugs in the APCD – in 2024, these drugs made up just 2.6 percent of available drugs in the APCD (241 out of 10,500).

Table 4.2. Spending, PMPM, PPU, and UPK for Prescription Drugs (Less GLP-1s, Top-Spend Immunologics, and Drugs with Unit Payments >$10,000)

Year	Total Spend	PMPM	PPU	UPK	PMPM % Change	PPU % Change	UPK % Change
2020	$358.7 M	$83	$62	16,256	–	–	–
2021	$360.0 M	$82	$60	16,422	-1.0%	-1.9%	1.0%
2022	$386.4 M	$87	$61	17,164	6.0%	1.6%	4.5%
2023	$386.2 M	$91	$63	17,357	4.1%	3.3%	1.1%
2024	$375.8 M	$86	$65	15,990	-5.7%	2.2%	-7.9%
Average Annual % Change	–	–	–	–	0.9%	1.3%	-0.3%

Source: OHIC analysis of HealthFacts RI data.
Excludes COVID-related medications. Data are gross of rebates.
PMPM = Per Person Per Month; PPU = Payment Per Unit (also known as average unit payment), and UPK = Units per 1,000 members. Units are defined as 30-day equivalents.

Calculating Drug Segments' Contribution to Change

OHIC sought to further understand each segment's contribution to overall spending growth.

OHIC's analysis found that the three drug segments of focus accounted for nearly all of spending growth across the market. In the early years, spending growth was overwhelmingly driven by spending on immunologic drugs. The market then shifted in 2023 such that both immunologic agents and GLP-1s played large roles in driving spending growth; in 2024, GLP-1s dominated as the driver of commercial prescription drug spending growth. In 2021 and 2024, decreased spending on "all other" brand and generic drugs acted as meaningful offsets to the high growth experienced by the three categories (see Tables 4.3 and 4.4).

Table 4.3. PMPM ($) Change Attributable to Each Segment (2020–2024)

Drug Category	2021	2022	2023	2024
GLP-1s	$1.62	$2.82	$7.23	$9.24
Immunologics	$6.21	$6.26	$5.58	$3.84
Top PPU	$2.13	$1.69	$1.83	$2.54
All Other Brand	-$1.06	$2.95	$2.92	-$2.64
All Other Generic	$0.25	$1.96	$0.68	-$2.54

Source: OHIC analysis of HealthFacts RI data.

Table 4.4. % Change Attributable to Each Segment (2020–2024)

Drug Category	2021	2022	2023	2024
GLP-1s	17.7%	18.0%	39.7%	88.5%
Immunologics	67.8%	39.9%	30.6%	36.8%
Top PPU	23.2%	10.8%	10.0%	24.3%
All Other Brand	-11.5%	18.8%	16.0%	-25.3%
All Other Generic	2.8%	12.5%	3.7%	-24.3%

Source: OHIC analysis of HealthFacts RI data.

Additionally, OHIC investigated the drugs within the "All Other Brand" category. OHIC's analysis revealed that increases in unit payment for the top spend[8] remaining brand-name drugs were a stable and predictable driver of spending growth across the market, while utilization was highly volatile (see Table 4.5). Most prices increased between 3 percent and 6 percent each year. Utilization, on the other hand, played an inconsistent role; for some of the identified medications, growth was strongly positive in both years, while for others, it may have grown significantly in 2023, and then dropped in 2024. Utilization can reflect clinical changes, which can manifest as large increases in utilization, as seen with Jardiance,[9] or with flat or declining utilization, as seen with Eliquis.[10]

Table 4.5. Change in Average Unit Payment (PPU) and Utilization (UPK) for 12 Spend Other Brand Drugs (2022–2023 and 2023–2024)

Drug Name	Share of Total Spending on Other Brand Drugs (2024)	2022–23		2023–24	
		PPU	UPK	PPU	UPK
Jardiance	6.4%	4.6%	28.7%	2.4%	14.0%
Eliquis	3.7%	6.7%	0.2%	4.8%	-13.6%
Biktarvy	4.2%	6.0%	1.6%	3.2%	4.5%
Vyvanse	1.9%	5.1%	8.2%	3.9%	-35.3%
Xarelto	1.8%	6.4%	0.6%	3.8%	-23.5%
Descovy	1.9%	5.6%	-5.2%	1.0%	2.0%
Cosentyx Pen (2 Pens)	2.2%	5.4%	16.8%	2.4%	-1.1%
Taltz Autoinjector	2.0%	2.8%	11.3%	3.1%	7.1%
Nurtec Odt	2.8%	10.7%	36.8%	6.7%	18.2%
Cimzia	1.2%	12.6%	-7.8%	-0.4%	-5.1%
Trelegy Ellipta	1.6%	3.2%	27.6%	0.6%	8.0%
Gonal-F Rff Redi-Ject	1.1%	15.9%	-5.7%	2.7%	-7.4%

Source: OHIC analysis of HealthFacts RI data.
Shading identifies the dominant spending growth driver. No shading indicates split roles of PPU and UPK in driving spending growth.
PPU = Average Payment Per Unit; UPK = Units per 1,000 Members

8 These 12 drugs made up about 30 percent of All Other Drug spending each year.
9 Jardiance is a medication that has been available since 2014. OHIC asked a Rhode Island clinician for context on these utilization increases. The provider provided a few hypotheses: 1) the American Diabetes Association recommends the use of a sodium-glucose cotransporter 2 inhibitor, like Jardiance, or a GLP-1 receptor agonist, like Ozempic, the next step after metformin, 2) Jardiance has been recommended for preventive kidney care, and 3) Jardiance is now recommended as standard of care that for patients with congestive heart failure.
10 A reduced dose of Eliquis (apixaban) was associated with a lower risk of bleeding without compromising efficacy or increasing mortality.

Drug Prices: A Persistent Challenge for Rhode Islanders

In recent years, spending growth has been concentrated within a small number of high-cost therapies. Effective drug cost mitigation strategies should prioritize this narrow set of drugs, as they offer the greatest opportunity for meaningful savings. OHIC's analyses have also revealed that those drugs that are most fueling spending growth change over even a few years, making it prudent to continuously monitor the market to ensure policy focus areas remain relevant and potentially impactful. Additionally, it is important to monitor the drug development pipeline to anticipate when new, expensive drugs will come onto the market. These ever-changing dynamics of the market underscore the importance of conducting comprehensive, multi-year assessments of the prescription drug price and utilization patterns.

Recent trends in Rhode Island underscore these dynamics. Through 2022, Humira and other expensive immunologics were in the spotlight for their high prices and associated ever-growing spending. For 2023 and 2024, attention has shifted to GLP-1s as their use expanded dramatically, and immunologics' cost began to drop with Humira losing its patent and many biosimilar drugs entering the market. Despite these shifts, the takeaway remains the same: these specialty medications consistently exert upward pressure on spending.

Time and again, the market has shown that pharmacy costs pose a major challenge for health care affordability for consumers, employers, and businesses. More than half of RI residents reported in 2024 being somewhat or very worried about affording the cost of prescription drugs, a concern shared across all income levels.[11] Addressing the costs of prescription drugs remains essential, as the cost of medications continue to consume a larger share of household budgets.

11 Consumer Healthcare Experience State Survey: Rhode Island. Altarum Health Care Value Hub. 2024. https://healthcarevaluehub.org/chess-state-survey/rhode-island/2024/rhode-island-survey-respondents-worried-about-high-drug-costs-support-a-range-of-government-solutions

CHAPTER 5

Health Care Quality

OHIC reports health care quality data in conjunction with spending data to offer a balanced perspective on health system performance. Since 2017, OHIC has required commercial insurers to use "core measures" from OHIC's Aligned Measure Sets in any provider contract with a financial incentive tied to quality.[1,2] In addition, Rhode Island Medicaid's Accountable Entities (AE) program requires measurement and reporting of AE quality performance using the Medicaid AE Common Measure Slate, which EOHHS voluntarily aligns with the OHIC ACO Core Measure Set, to inform the distribution of any shared savings earned under total cost of care contracts. For these reasons, and because OHIC assesses large provider entities against the spending growth target, the Cost Trends Steering Committee recommended using OHIC's existing ACO Core Measure Set to monitor quality alongside spending growth.[3]

This chapter presents 2024 commercial and Medicaid quality performance data for the core measures in OHIC's ACO Aligned Measure Set.

What Are OHIC's Aligned Measure Sets?

Since 2015, OHIC has maintained a common set of quality measures for use in contracts between insurers and providers. OHIC requires commercial plans to adhere to these aligned measure sets for use in primary care, ACO, acute care hospital, and behavioral health hospital contracts. Each of the measure sets includes *core measures* that insurers must use in applicable provider contracts; *menu measures* that are for optional use; and *developmental measures* that need further refinement and/or testing before measure set adoption.

Aligned Measure Set Performance

2024 ACO Core Measure Set

The 2024 ACO Core Measure Set contained the following ten measures addressing four domains: chronic disease management, behavioral health, prevention and screening, and pediatric care:

- Breast Cancer Screening
- Child and Adolescent Well-Care Visits (Total)
- Chlamydia Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Eye Exam for Patients with Diabetes
- Follow-Up After Hospitalization for Mental Illness (7-Day)
- Glycemic Status Assessment for Patients with Diabetes (<8%)
- Immunizations for Adolescents (Combo 2)[4]
- Lead Screening in Children

OHIC obtains commercial performance on the ACO Core Measure Set measures directly from insurers as part of the cost growth target data collection.[5] The Rhode Island Executive Office of Health and Human Services provides the data to calculate Medicaid performance on the ACO Core Measure Set measures.[6]

1 Rhode Island Code of Regulations, ***230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner***.
2 For OHIC's guidance for insurers related to the implementation of its Aligned Measure Sets required under 230-RICR-20-30-4.10(D)(5), see: Office of the Health Insurance Commissioner, ***Updated Guidance on Use of Aligned Measure Set***, September 19, 2025.
3 For details on the data collection and analysis methodology, see: OHIC, ***Rhode Island Quality Reporting Data Submission Guide***, August 14, 2025.
4 NCQA Immunizations for Adolescents Combo 2 measure includes one dose of the meningococcal vaccine, one Tdap vaccine, and a completed human papillomavirus (HPV) vaccine series by the 13th birthday.
5 For details on the data collection and analysis methodology, see: OHIC, ***Rhode Island Quality Reporting Data Submission Guide***, August 14, 2025.
6 For more information on the AE Common Measure Slate data reporting requirements, see: ***Rhode Island Executive Office of Health and Human Services, Rhode Island Accountable Entity Program: Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual***, February 2, 2024.

Statewide Commercial Performance on the ACO Core Measure Set

Rhode Island scored above the national 75th percentile for the commercial market on all measures for which national benchmarks were available, except one – *Glycemic Status Assessment for Patients with Diabetes* – for which performance was below that benchmark. Rhode Island exceeded the national 90th percentile on all but three of the measures, *Controlling High Blood Pressure, Glycemic Status Assessment*, and *Follow-Up After Hospitalization for Mental Illness (7-Day)* (see Table 5.1).[7] Commercial performance on *Controlling High Blood Pressure* has been stagnant at 74% for the past three years (2022–2024), while performance on *Glycemic Status Assessment* and *Follow-Up After Hospitalization for Mental Illness (7-Day)* has improved (from 63 percent to 67 percent and from 58 percent to 59 percent, respectively), with the latter measure's improvement likely not statistically significant.

Table 5.1: 2024 Statewide Commercial Performance on the ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PERCENTILE	90TH PERCENTILE	ABOVE 75TH PERCENTILE?	ABOVE 90TH PERCENTILE?
Breast Cancer Screening	77%	80%	Yes 86%	Yes 86%
Child and Adolescent Well-Care Visits (Total)	66%	74%	Yes 79%	Yes 79%
Chlamydia Screening	49%	57%	Yes 66%	Yes 66%
Colorectal Cancer Screening	63%	68%	Yes 76%	Yes 76%
Controlling High Blood Pressure	71%	75%	Yes 74%	No 74%
Eye Exam for Patients with Diabetes	55%	61%	Yes 68%	Yes 68%
Follow-Up After Hospitalization for Mental Illness (7-Day)	56%	64%	Yes 59%	No 59%
Glycemic Status <8.0%	69%	73%	No 67%	No 67%
Immunizations for Adolescents (Combo 2)	36%	41%	Yes 60%	Yes 60%
Lead Screening in Children	NA	NA	87%	87%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island. Statewide commercial performance is based on a weighted average of insurer performance using membership from the insurers' cost growth target data submissions, rather than performance for the full population, because multiple insurers submitted measurement data using population samples.

Statewide Medicaid Performance on the ACO Core Measure Set

In 2024, Rhode Island exceeded the national 75th percentile for the Medicaid market on all but three measures – *Chlamydia Screening in Women, Controlling High Blood Pressure*, and *Glycemic Status Assessment for Patients with Diabetes*. Rhode Island did not exceed the national 90th percentile on any of the measures, despite seeing slightly higher performance rates for almost all measures compared to the prior year. This is a dramatic departure from 2023, when Rhode Island exceeded the national 90th percentile on all but four measures in the ACO Core Measure Set. In general, Medicaid managed care quality performance across the U.S. has improved at a greater rate than in Rhode Island.

7 National benchmarks were not available for the commercial market for *Lead Screening in Children*.

Table 5.2. 2024 Statewide Medicaid Performance on the ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PERCENTILE	90TH PERCENTILE	ABOVE 75TH PERCENTILE?	ABOVE 90TH PERCENTILE?
Breast Cancer Screening	61%	66%	Yes 64%	No 64%
Child and Adolescent Well-Care Visits (Total)	61%	68%	Yes 64%	No 64%
Chlamydia Screening	65%	71%	No 64%	No 64%
Colorectal Cancer Screening	48%	53%	Yes 51%	No 51%
Controlling High Blood Pressure	71%	75%	No 71.2%	No 71%
Eye Exam for Patients with Diabetes	63%	69%	Yes 67%	No 67%
Follow-Up After Hospitalization for Mental Illness (7-Day)	49%	58%	Yes 53%	No 53%
Glycemic Status <8.0%	65%	67%	No 59%	No 59%
Immunizations for Adolescents (Combo 2)	44%	52%	Yes 46%	No 46%
Lead Screening in Children	76%	83%	Yes 79%	No 79%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from EOHHS. Medicaid performance represents the full population for the measure because EOHHS requires that insurers submit performance data for their full population.

Tables 5.1 and 5.2 demonstrate significant inequities in quality between commercial and Medicaid populations for some measures, with much smaller gaps for others. Notable opportunities for improved health equity for Medicaid members exist for Breast Cancer Screening (22 percentage-point difference), Child and Adolescent Well-Care Visits and Colorectal Cancer Screening (15 percentage-point difference each) and Immunizations for Adolescents (Combo 2) (14 percentage-point difference).

Longitudinal Quality Performance in the Commercial Market

In addition to assessing 2024 commercial performance on the ACO Core Measure Set, OHIC analyzed longitudinal performance for measures that are in the ACO Measure Set from 2011 to 2024. Of the six measures that are in the ACO Measure Set, two saw improved performance and four saw a decline in performance between 2011 and 2024 (see Table 5.3). This lack of meaningful performance improvement is troubling. Similar patterns of lack of performance improvement for these measures are seen for neighboring states of Connecticut and Massachusetts. Only one of the six measures saw a decline in performance nationally during this time period.

We cannot say with certainty what contributed to this performance deterioration. OHIC analysis found that it cannot be explained by a decline in access to well-care visits, but the lack of *increased* well-care utilization may have been a barrier to improvement. Substantial declines in performance for *Controlling High Blood Pressure, Follow-Up After Hospitalization for Mental Illness (7-Day)*, and *Glycemic Status (<8%)* warrant attention. Lack of control of blood pressure and blood sugar are each associated with higher morbidity and mortality.

Table 5.3: Cumulative Change in Commercial Performance (2011–2024)

Measure	Rhode Island	Connecticut	Massachusetts	National
Breast Cancer Screening	+1.2%	+5.3%	+/- 0%	+6.3%
Chlamydia Screening	+14.0%	-3.2%	+2.9%	+3.3%
Colorectal Cancer Screening	-2.1%	+/- 0%	-7.9%	+0.7%
Controlling High Blood Pressure	-5.9%	+3.1%	-2.3%	+1.9%
Follow-up After Hospitalization for Mental Illness (7-Day)	-16.0%	-7.8%	-18.4%	-6.1%
Glycemic Status <8.0%	-8.6%	+1.7%	-3.1%	+5.1%

Source: NCQA Quality Compass.

Insurers' Performance on the ACO Core Measure Set

Commercial Insurers' Performance on the ACO Core Measure Set

OHIC collects performance for four commercial insurers (BCBSRI, NHPRI, THP, and UHC). This report presents performance for all the insurers except for THP because THP did not have denominators large enough to report for the preponderance of measures. Overall, the insurers performed well on adult prevention and screening and pediatric care measures, including *Breast Cancer Screening*, *Chlamydia Screening*, *Colorectal Cancer Screening, Immunizations for Adolescents (Combo 2)*, *Eye Exam for Patients with Diabetes*, and *Child and Adolescent Well-Care Visits (Total)*, with more mixed results on chronic disease management and behavioral health measures.

- BCBSRI exceeded the national 75th percentile for nearly all reported measures and frequently achieved performance at or above the 90th percentile, except for *Controlling High Blood Pressure*, *Follow-Up After Hospitalization for Mental Illness (7-Day)*, and *Glycemic Status <8.0%*.
- UHC met or exceeded the 75th percentile on several preventive measures, including *Breast Cancer Screening*, *Chlamydia Screening, Immunizations for Adolescents (Combo 2)*, and *Eye Exam for Patients with Diabetes*, but did not consistently reach top-percentile benchmarks for *Child and Adolescent Well-Care Visits (Total)*, *Colorectal Cancer Screening, Controlling High Blood Pressure*, or *Glycemic Status <8.0%*.
- NHPRI exceeded the 75th percentile on select screening and immunization measures but did not achieve this benchmark on several chronic disease and follow-up measures, including *Follow-Up After Hospitalization for Mental Illness (7-Day)* and *Glycemic Status <8.0%*. Across insurers, performance was strongest for cancer screening, immunizations, and diabetes eye exams, and weakest for glycemic control and follow-up after hospitalization for mental illness.

BCBSRI's performance compared favorably to the other insurers across most measures, while NHPRI's overall performance compared unfavorably to that of BCBSRI and UHC. (see Table 5.4).

Table 5.4: 2024 Commercial Insurers' Performance on the ACO Core Measure Set

Measure Name	National Benchmarks		Above 75th Percentile?			Above 90th Percentile?		
	75TH PCTL	90TH PCTL	BCBSRI	NHPRI	UHC	BCBSRI	NHPRI	UHC
% of Measures Above Nat'l Benchmark			100%	44%	89%	67%	44%	56%
Breast Cancer Screening	77%	80%	Yes 88%	No 76.9%	Yes 80%	Yes 88%	No 77%	Yes 80.2%
Child and Adolescent Well-Care Visits (Total)	66%	74%	Yes 83%	No 59%	Yes 74%	Yes 83%	No 59%	No 73.8%
Chlamydia Screening	49%	57%	Yes 67%	Yes 60%	Yes 65%	Yes 67%	Yes 60%	Yes 65%
Colorectal Cancer Screening	63%	68%	Yes 81%	No 60%	Yes 66%	Yes 81%	No 60%	No 66%
Controlling High Blood Pressure	71%	75%	Yes 75%	Yes 78%	Yes 71.3%	No 74.8%	Yes 78%	No 71%
Eye Exam for Patients with Diabetes	55%	61%	Yes 71%	Yes 70%	Yes 62%	Yes 71%	Yes 70%	Yes 62%
Follow-Up After Hospitalization for Mental Illness (7-Day)	56%	64%	Yes 58%	No 51%	Yes 66%	No 58%	No 51%	Yes 66%
Glycemic Status <8.0%	69%	73%	Yes 70%	No 23%	No 68%	No 70%	No 23%	No 68%
Immunizations for Adolescents (Combo 2)	36%	41%	Yes 60%	Yes 46%	Yes 54%	Yes 60%	Yes 46%	Yes 54%
Lead Screening in Children	NA	NA	86%	NA	NA	86%	NA	NA

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.
Notes:
NA = Not Available. Insurer did not submit performance on this measure.
NR = Not Reported. The insurer did not meet the minimum denominator size required for public reporting.

Medicaid Insurers' Performance on the ACO Core Measure Set

OHIC reports performance for two Medicaid plans (NHPRI and UHCCP).[8] Overall, plan performance was mixed and generally below national top-percentile benchmarks, with more limited attainment of the 75th and 90th percentiles than observed in the commercial market. Both plans exceeded the national 75th percentile for several measures, including *Breast Cancer Screening*, *Child and Adolescent Well-Care Visits (Total)*, *Colorectal Cancer Screening*, *Immunizations for Adolescents (Combo 2)*, *Lead Screening in Children*, and *Follow-Up After Hospitalization for Mental Illness (7-Day)*, though neither plan consistently achieved 90th percentile performance.

NHPRI and UHC performance was comparable for nearly all measures. NHPRI exceeded the 75th percentile for *Eye Exam for Patients with Diabetes*, while UHCCP exceeded this benchmark for *Controlling High Blood Pressure* and F*ollow-Up After Hospitalization for Mental Illness (7-Day)*. Both plans performed below 75th percentile national benchmarks for *Chlamydia Screening* and *Glycemic Status <8.0%*.

Across measures, performance was strongest for pediatric and preventive services and weakest for chronic disease management, particularly glycemic control (see Table 5.5).

8 EOHHS does not collect quality data from THP due to its small enrolled population.

Table 5.5: 2024 Medicaid Insurers' Performance on ACO Core Measure Set

Measure	National Benchmarks		Above 75th Percentile?		Above 90th Percentile?	
	75TH PCTL	90TH PCTL	NHPRI	UHCCP	NHPRI	UHCCP
% of Measures Above Nat'l Benchmark			70%	70%	10%	10%
Breast Cancer Screening	61%	66%	Yes 65%	Yes 62%	No 65%	No 62%
Child and Adolescent Well-Care Visits (Total)	61%	68%	Yes 64%	Yes 65%	No 64%	No 65%
Chlamydia Screening	65%	71%	No 64%	No 64%	No 64%	No 64%
Colorectal Cancer Screening	48%	53%	Yes 52%	Yes 50%	No 52%	No 50%
Controlling High Blood Pressure	71%	75%	No 70%	Yes 73%	No 70%	No 73%
Eye Exam for Patients with Diabetes	63%	69%	Yes 70%	No 61%	Yes 70%	No 61%
Follow-Up After Hospitalization for Mental Illness (7-Day)	49%	58%	Yes 51%	Yes 58%	No 51%	Yes 57.9%
Glycemic Status <8.0%	65%	67%	No 59%	No 60%	No 59%	No 60%
Immunizations for Adolescents (Combo 2)	44%	52%	Yes 45%	Yes 49%	No 45%	No 49%
Lead Screening in Children	76%	83%	Yes 80%	Yes 77%	No 80%	No 77%

Source: OHIC analysis of quality performance data submitted by Rhode Island managed care plans to EOHHS and provided to OHIC by EOHHS.

Providers' Performance on the ACO Core Measure Set

OHIC reports on quality performance of the state's ACOs and AEs. This is different from the large provider entity reporting for cost growth. OHIC maintains the ACO and AE construct for quality reporting to align with payers' contractual arrangements with these organizations.

ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

There was notable variation in 2024 ACO commercial performance on the ACO Core Measure Set relative to the national 75th percentile.

- Brown University Health, Integra, and Prospect (now Astrana Health) performed strongest overall, exceeding the 75th percentile on nearly all measures with sufficient denominator size, including *Breast Cancer Screening*, *Child and Adolescent Well-Care Visits (Total)*, *Colorectal Cancer Screening*, *Controlling High Blood Pressure*, *Eye Exam for Patients with Diabetes*, and *Glycemic Status <8.0%*.
- Thundermist and IHP exceeded the 75th percentile on a majority of measures but did not consistently achieve this benchmark across all chronic disease measures.
- PCHC and BVCHC exceeded the 75th percentile on few measures, with BVCHC not meeting that benchmark for any measure with sufficient denominator size.

Overall, non-Federally Qualified Health Center (FQHC)-based provider organizations demonstrated superior performance to that of FQHCs. FQHCs are federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. OHIC cannot determine if this difference reflects a) better care, b) better quality measurement or improvement processes, and/or c) differences in the social and health risks of patient populations.

Across ACOs, performance was strongest for preventive and screening measures, including *Chlamydia Screening* and *Immunizations for Adolescents (Combo 2)*, and more variable for *Controlling High Blood Pressure* and *Glycemic Status <8.0%*. Smaller denominator sizes limited reporting for *Follow-Up After Hospitalization for Mental Illness (7-Day)* and *Lead Screening in Children* for several ACOs (see Table 5.6).

Table 5.6: 2024 ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

Measure Name	Nat'l 75th Pctl	Above 75th Percentile?						
		BVCHC	BROWN	INTEGRA	IHP	PCHC	PROSPECT	THUNDER-MIST
% of Measures Above Nat'l Benchmark		0%	100%	100%	67%	38%	88%	63%
Breast Cancer Screening	77%	No 68%	Yes 91%	Yes 89%	No 76.6%	No 71%	Yes 86%	No 76%
Child and Adolescent Well-Care Visits (Total)	66%	No 56%	Yes 83%	Yes 85%	Yes 73%	No 65.8%	Yes 73%	Yes 75%
Chlamydia Screening	49%	NR	Yes 73%	Yes 66%	Yes 51%	Yes 66%	Yes 63%	Yes 57%
Colorectal Cancer Screening	63%	No 55%	Yes 85%	Yes 81%	Yes 69%	No 53%	Yes 81%	Yes 66%
Controlling High Blood Pressure	71%	No 54%	Yes 74%	Yes 79%	Yes 73%	No 67%	Yes 83%	No 67%
Eye Exam for Patients with Diabetes	55%	No 35%	Yes 75%	Yes 65%	Yes 62%	Yes 59%	Yes 74%	Yes 68%
Follow-Up After Hospitalization for Mental Illness (7-Day)	56%	NR	Yes 63%	Yes 56.1%	No 47%	NR	No 55%	NR
Glycemic Status <8.0%	69%	No 37%	Yes 74%	Yes 70%	No 44%	No 58%	Yes 72%	No 59%
Immunizations for Adolescents (Combo 2)	36%	NR	Yes 64%	Yes 63%	Yes 45%	Yes 41%	NR	Yes 63%
Lead Screening in Children	NA	NR	85%	84%	NR	NR	NR	NR

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.
Note:
NA = Not Available.
NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.

ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

There was greater variation in ACO performance relative to the national 90th percentile.

- Brown University Health and Integra performed strongest overall, each exceeding the 90th percentile for a majority of measures with sufficient denominator size. Prospect also exceeded the 90th percentile on several measures.
- IHP and Thundermist achieved 90th percentile performance on a more limited number of measures.
- PCHC exceeded the 90th percentile for select measures.
- BVCHC did not exceed the 90th percentile for any measures with sufficient denominator size.

No ACO exceeded the 90th percentile for *Follow-Up After Hospitalization for Mental Illness (7-Day)* and only Brown University Health did so for *Glycemic Status <8.0%* (see Table 5.7).

Table 5.7: ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

Measure Name	Nat'l 90th Pctl	Above 90th Percentile?						
		BVCHC	BROWN	INTEGRA	IHP	PCHC	PROSPECT	THUNDER-MIST
% of Measures Above Nat'l Benchmark		0%	78%	78%	33%	25%	63%	50%
Breast Cancer Screening	80%	No 68%	Yes 91%	Yes 89%	No 77%	No 71%	Yes 86%	No 76%
Child and Adolescent Well-Care Visits (Total)	74%	No 56%	Yes 83%	Yes 85%	No 73%	No 66%	No 73%	Yes 75%
Chlamydia Screening	57%	NR	Yes 73%	Yes 66%	No 51%	Yes 66%	Yes 63%	Yes 57%
Colorectal Cancer Screening	68%	No 55%	Yes 85%	Yes 81%	Yes 69%	No 53%	Yes 81%	No 66%
Controlling High Blood Pressure	75%	No 54%	No 74%	Yes 79%	No 73%	No 67%	Yes 83%	No 67%
Eye Exam for Patients with Diabetes	61%	No 35%	Yes 75%	Yes 65%	Yes 62%	No 59%	Yes 74%	Yes 68%
Follow-Up After Hospitalization for Mental Illness (7-Day)	64%	NR	No 63%	No 56%	No 47%	NR	No 55%	NR
Glycemic Status <8.0%	73%	No 37%	Yes 74%	No 70%	No 44%	No 58%	No 72%	No 59%
Immunizations for Adolescents (Combo 2)	41%	NR	Yes 64%	Yes 63%	Yes 45%	Yes 41%	NR	Yes 63%
Lead Screening in Children	NA	NR	85%	84%	NR	NR	NR	NR

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.
Note:
NA = Not Available.
NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.

AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

There was substantial variation in AE performance in the Medicaid market relative to the national 75th percentile.

- Brown University Health and Integra performed strongest overall, exceeding the 75th percentile for nearly all reported measures, while Prospect also exceeded the benchmark for a majority of measures.
- PCHC demonstrated moderate performance, exceeding the 75th percentile for several measures.
- BVCHC, IHP, and Thundermist exceeded the benchmark for relatively few measures.

As with the commercial population, non-FQHC-based provider organizations demonstrated superior performance to that of FQHCs. Here again, OHIC cannot determine if this difference reflects a) better care, b) better quality measurement or improvement processes, and/or c) differences in the social and health risks of patient populations.

Across AEs, performance most consistently exceeded the 75th percentile for *Eye Exam for Patients with Diabetes* and *Follow-Up After Hospitalization for Mental Illness (7-Day)*, while only Brown exceeded the benchmark for *Glycemic Status <8.0%* (see Table 5.8).

Table 5.8: AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

Measure Name	Nat'l 75th Pctl	Above 75th Percentile?						
		BVCHC	BROWN	INTEGRA	IHP	PCHC	PROSPECT	THUNDER-MIST
% of Measures Above Nat'l Benchmark		20%	100%	90%	10%	50%	70%	10%
Breast Cancer Screening	61%	No 57%	Yes 71%	Yes 67%	No 56%	Yes 70%	Yes 63%	No 56%
Child and Adolescent Well-Care Visits (Total)	61%	No 54%	Yes 69%	Yes 73%	No 57%	No 58%	Yes 62%	Yes 65%
Chlamydia Screening	65%	No 63%	Yes 66%	Yes 72%	No 50%	Yes 65%	No 63%	No 62%
Colorectal Cancer Screening	48%	Yes 49%	Yes 63%	Yes 53%	No 46%	Yes 51%	Yes 55%	No 46%
Controlling High Blood Pressure	71%	No 68%	Yes 77%	Yes 75%	No 69%	No 68%	Yes 74%	No 68%
Eye Exam for Patients with Diabetes	63%	Yes 67%	Yes 65%	Yes 67%	No 61%	Yes 72%	Yes 64%	Yes 68%
Follow-Up After Hospitalization for Mental Illness (7-Day)	49%	No 45%	Yes 68%	Yes 58%	Yes 55%	No 46%	Yes 50%	Yes 53%
Glycemic Status <8.0%	65%	No 51%	Yes 67%	No 58%	No 60%	No 60%	No 60%	No 59%
Immunizations for Adolescents (Combo 2)	44%	No 36%	Yes 45%	Yes 54%	No 35%	No 41%	Yes 56%	Yes 55%
Lead Screening in Children	76%	No 75.9%	Yes 91%	Yes 77%	No 70%	Yes 83%	No 69%	No 69%

Source: OHIC analysis of quality performance data of Rhode Island Accountable Entities submitted by Rhode Island managed care plans to EOHHS and provided to OHIC by EOHHS.

AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

- Brown University Health exceeded the 90th percentile for a majority of measures, including *Breast Cancer Screening, Child and Adolescent Well-Care Visits (Total)*, *Colorectal Cancer Screening*, *Controlling High Blood Pressure*, *Follow-Up After Hospitalization for Mental Illness (7-Day)*, and *Lead Screening in Children*.
- Integra also achieved 90th percentile performance on several measures, including *Breast Cancer Screening*, *Child and Adolescent Well-Care Visits (Total)*, *Chlamydia Screening*, and *Follow-Up After Hospitalization for Mental Illness (7-Day)*.
- Prospect and PCHC exceeded the 90th percentile for select measures, while Thundermist did so for one measure.
- BVCHC and IHP did not exceed the 90th percentile for any reported measure.

No AE exceeded the 90th percentile for Glycemic Status <8.0%. (see Table 5.9).

Table 5.9: AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

Measure Name	Nat'l 90th Pctl	Above 90th Percentile?						
		BVCHC	BROWN	INTEGRA	IHP	PCHC	PROSPECT	THUNDER-MIST
% of Measures Above Nat'l Benchmark		0%	60%	60%	0%	20%	20%	10%
Breast Cancer Screening	66%	No 57%	Yes 71%	Yes 67%	No 56%	Yes 70%	No 63%	No 56%
Child and Adolescent Well-Care Visits (Total)	68%	No 54%	Yes 69%	Yes 73%	No 57%	No 58%	No 62%	No 65%
Chlamydia Screening	71%	No 63%	No 66%	Yes 72%	No 50%	No 65%	No 63%	No 62%
Colorectal Cancer Screening	53%	No 49%	Yes 63%	No 52.6%	No 46%	No 51%	Yes 55%	No 46%
Controlling High Blood Pressure	75%	No 68%	Yes 77%	Yes 75%	No 69%	No 68%	No 74%	No 68%
Eye Exam for Patients with Diabetes	69%	No 67%	No 65%	No 67%	No 61%	Yes 72%	No 64%	No 68%
Follow-Up After Hospitalization for Mental Illness (7-Day)	58%	No 45%	Yes 68%	Yes 58%	No 55%	No 46%	No 50%	No 53%
Glycemic Status <8.0%	67%	No 51%	No 66.8%	No 58%	No 60%	No 60%	No 60%	No 59%
Immunizations for Adolescents (Combo 2)	52%	No 36%	No 45%	Yes 54%	No 35%	No 41%	Yes 56%	Yes 55%
Lead Screening in Children	83%	No 76%	Yes 91%	No 77%	No 70%	No 82.5%	No 69%	No 69%

Source: OHIC analysis of quality performance data of Rhode Island Accountable Entities submitted by Rhode Island managed care plans to EOHHS and provided to OHIC by EOHHS.

CHAPTER 6

Public Health and Health Equity

In addition to health care quality data, OHIC also reports public health and health equity data to complement annual public reporting of spending growth. With this reporting, OHIC establishes improved public health and health equity as an additional state objective along with improved affordability and high-quality care.

In 2023, the Rhode Island Cost Trends Steering Committee recommended that OHIC select a set of public health and health equity accountability measures with associated improvement goals to be reported publicly. OHIC convened a Public Health and Health Equity Target Measures Work Group in 2023, which recommended six measures for inclusion. The measures are related to behavioral health, childhood obesity, health care access and maternal and infant health. OHIC assesses state-level performance using data available from the Rhode Island Department of Health (RIDOH) and from other public sources. OHIC reports data annually against performance targets for 2027.

This chapter presents 2024 performance on the six Public Health and Health Equity Measures.

Public Health and Health Equity Measure Set Performance

Public Health and Health Equity Measure Set and Target Values

The Public Health and Health Equity Measure Set contains the following six measures addressing four domains: childhood obesity, behavioral health, health care access and maternal and infant health:

Table 6.1: Public Health and Health Equity Measure Set: Domains and Measures

Domain	Measure
Health Care Access	Adults without a Usual Source of Care
Childhood Obesity	Childhood Obesity Rate
Behavioral Health	Fatal Overdoses
Maternal and Infant Health	Inadequate Prenatal Care
	Infant Mortality Rate
	Severe Maternal Morbidity

Each measure has either a total population target or a target focused on reducing a significant inequity in performance.

2024 Performance on the Public Health and Health Equity Measure Set

Rhode Island's 2024 results on the Public Health and Health Equity Measure Set show a mix of meaningful progress and emerging areas of concern. The state continued to see improvements in several key indicators, including reductions in childhood obesity among both Black and Hispanic children, substantial progress in lowering the fatal overdose rate, and continued declines in the infant mortality rate for Black and Hispanic infants (see Table 6.2).

At the same time, two measures moved in the wrong direction in 2024.

- The percentage of Hispanic adults without a usual source of care rose for the second consecutive year, reaching 32%, the highest point since baseline and significantly above the 2024 statewide rate of 13%.
- Inadequate prenatal care among mothers under age 20 increased to 10.7%, markedly above the 4.0% target.

OHIC is not reporting 2024 performance on severe maternal morbidity because the CDC updated the definition such that 2024 performance is no longer comparable to the 2027 target. OHIC plans to bring an updated 2027 target value to the Steering Committee for its consideration for this measure.

Table 6.2: Statewide Performance on the Public Health and Health Equity Measure Set

Measure Name	Population	Baseline Performance[1]	2023 Performance	2024 Performance	2027 Target
Adults without a Usual Source of Care	Hispanic adults	24% *Compared to 11.4% statewide*	30%	32%	<17%
Childhood Obesity Rate	Separate targets for Black and Hispanic children	Black children: 29% Hispanic children: 33% *Compared to 23% statewide*	Black children: 28% Hispanic children: 32%	Black children: 26% Hispanic children: 30%	Black children: <23% Hispanic children: <27%
Fatal Overdoses	Total population	39.8 deaths per 100,000 persons *Compared to 35.0 nationally*	37.6 deaths per 100,000 persons	30.6 deaths per 100,000 persons	<35.0 deaths per 100,000 persons
Inadequate Prenatal Care	Ages < 20 years	8.1% *Compared to 3.3% statewide*	8.8%	10.7%	<4.0%
Infant Mortality Rate	Combined target for Black and Hispanic mortality rate	7.7 deaths per 1,000 live births *Compared to 5.5 statewide*	6.6 deaths per 1,000 live births	5.8 deaths per 1,000 live births	<5.5 deaths per 1,000 live births
Severe Maternal Morbidity	Total population	86.2 per 10,000 delivery hospitalizations[2]	86.7 per 10,000 delivery hospitalizations	NA[3]	<75.0 per 10,000 delivery hospitalizations

Source: *Childhood Obesity Rate* is sourced from the RI KIDS COUNT Factbook. *Fatal Overdoses* is sourced from the CDC State Unintentional Drug Overdoses Reporting System. *Adults without a Usual Source of Care* performance for Baseline Data and for 2023 is sourced from the RI Foundation Health in RI Dashboard which uses Behavioral Risk Factor Surveillance System (BRFSS) data. *Adults without a Usual Source of Care* performance for 2024 is based on the Commonwealth Fund's analysis of BRFSS data. *Inadequate Prenatal Care* and *Infant Mortality Rate* are calculated using Vital Records Birth Certificate data analyzed by the Center for Health Data and Analysis, RI Department of Health. *Severe Maternal Morbidity* is calculated using Hospital Discharge Data analyzed by the Center for Health Data and Analysis, RI Department of Health.

1 Baseline performance is for 2022 for *Adults without a Usual Source of Care* and *Fatal Overdoses*. Baseline performance is for 2021 for *Childhood Obesity Rate*. Baseline performance for *Inadequate Prenatal Care, Infant Mortality* and *Severe Maternal Morbidity* is measured using a five-year rate (2018–2022).

2 A comparable national figure for *Severe Maternal Morbidity* is not available for this time period.

3 The CDC made a significant change to the definition of severe maternal morbidity in 2024. The 2027 target was set using baseline data using the old definition, making 2024 performance not comparable to the target.

In 2023, the Rhode Island Cost Trends Steering Committee recognized that in order to make measurable improvements on the public health and health equity measures, the state would need an action plan to address performance on each measure. As such, the Steering Committee directed the formation of a new OHIC-convened work group in 2024 titled the Public Health and Health Equity Strategies Work Group. The Work Group recommended actions to support meaningful progress toward meeting the public health and health equity performance targets and finalized its recommendations in December 2024.

Since then, the Steering Committee has committed to supporting continued funding for MomsPRN, a free psychiatric telephone consultation service for health care providers treating pregnant and postpartum women. Although the original HRSA grant ended in 2024, the Rhode Island legislature approved state funding through the first half of CY2025, and legislation to continue the program was re-introduced in the Senate this year. The Steering Committee and OHIC continue to consider next steps for implementing additional recommended strategies.

Conclusion

Public opinion polling consistently points to health care affordability as the key domestic concern facing Americans in 2026. In March, Gallup found that 61 percent of Americans worried "a great deal" about the availability and affordability of health care.[1] Health care ranked higher than any other domestic economic or policy concern. Likewise, in January, KFF found "two-thirds of the public (66 percent) say they worry about being able to afford health care for them and their family, ranking higher than utilities, food and groceries, housing, and gas."[2]

What is true of Americans at large is true of Rhode Islanders. In 2024, a survey of Rhode Islanders found that 82 percent worried about affording health care in the future and 66 percent reported delaying or going without health care during the prior 12 months.[3] When the cost of health care exceeds Rhode Islanders' ability to pay, they experience hardships and feel the anxieties observed in the survey data. This is why OHIC has taken on the important work of understanding the drivers of increasing health care costs. Understanding the drivers helps us develop interventions to slow spending growth. What does the most recent data tell us?

Health care spending per capita in Rhode Island increased 9.1 percent in 2024, the highest annual growth since OHIC began tracking the state's health care spending. For the first time, spending exceeded $10,000 per person. Rhode Island has experienced two consecutive years of record statewide spending growth. Within the commercial market, per capita spending grew 7.1 percent, two percentage points above the target. This is the second highest annual increase, only exceeded by the post-pandemic rebound in 2021. The preceding chapters highlight hospital outpatient, other professional, and prescription drug spending as the primary drivers of commercial spending growth.

The trend line is increasing. And so are Rhode Islander's health insurance premiums and medical bills. Rising premiums strain working families' wages and paychecks. Medical bills burden household budgets and drive some families to forgo necessities, use up savings, or assume debt. What actions can we take to address this?

Affordability is the key issue facing Rhode Islanders in 2026. The McKee administration has taken concrete steps to address the affordability and accessibility of health care through investments in primary care, reducing administrative burdens due to prior authorizations, and the issuance of Executive Order 26-03: *Lowering Marketplace Premiums, Increasing Transparency, and Making Health Coverage More Affordable*.[4]

Executive Order 26-03 will leverage increased federal tax credits for Rhode Islanders who purchase coverage on HealthSourceRI, make prices for common health care procedures more transparent, and evaluate opportunities for cost savings through reviews of site neutral payment practices and state health insurance benefit mandates.

1 Saad L. **Healthcare Reclaims Top Spot Among U.S. Domestic Worries**. Gallup. Published online March 31, 2026. Accessed May 4, 2026.
2 Schumaker S, Kearney A, Mulugeta M, Valdes I, Kirzinger A, Hamel L. **KFF Health Tracking Poll: Health Care Costs, Expiring ACA Tax Credits, and 2026 Midterms**. KFF. Published online January 29, 2026. Accessed May 4. 2026.
3 Altarum Healthcare Value Hub. **Rhode Island Survey Respondents Struggle to Afford High Health Care Costs; Worry about Affording Health Care in the Future; Support Government Action Across Party Lines**. Published online July 15, 2024. Accessed May 4, 2026.
4 RI Executive Order 26-03. **Lower Marketplace Premiums, Increasing Transparency, and Making Health Coverage More Affordable**. March 12, 2026.

Governor McKee's Affordability for All agenda includes three initiatives focused on the improving the affordability of health care through greater accountability for health care costs by industry, greater transparency, and targeted state-based premium subsidies. These initiatives are included in Article 11 of the proposed Fiscal Year 2027 budget. They are as follows:

1. Enforceable Caps on Cost Growth

The first proposal seeks to make health care more affordable for Rhode Island's employers, labor unions, and working families. Article 11 Sections 12 and 13 would codify the **Health Spending Accountability and Transparency Program** and create new enforcement authorities for OHIC which will make the cost growth target more binding and effective. The proposal brings commercial health insurers and large provider entities within the same regulatory framework. Beyond an enforceable cost growth target, the proposal includes annual public hearings to address industry stakeholder contributions to cost growth, and an all-payer primary care investment target. The all-payer primary investment target centers the role of primary care to achieve more accessible and affordable health care. Figure 1 provides an overview of the five key elements of the regulatory framework.

Figure 1: Elements of the Proposed Health Spending Accountability & Transparency Program

Cost Growth Target	All-Payer Primary Care Investment Target	Public Reporting	Annual Public Hearing	New Enforcement Authority
• Ties health care cost growth to growth of the economy and household income. • Sets a key performance measure for our health care system. • Allows flexibility to adjust for changing economic and market conditions over time. • OHIC will also set quality targets and health equity targets.	• Ensures that all payers are investing in primary care while managing overall costs. • Rebalances Rhode Island's health care spending toward primary care and chronic disease management. • Builds on OHIC's existing regulatory requirement for commercial insurers.	• Comprehensive reporting on over $10 billion of health care spending for Rhode Island residents. • Reporting of trends at the state and market level. • Transparency into trends by insurer and large provider organization. • Annual policy recommendations.	• Public testimony by insurers, PBMs, large providers, drug manufacturers, and other entities that contribute to increased costs and premiums. • Review analysis from public reporting. • Take public comment from consumers, employers, and others.	• Authority will extend to commercial market spending. It will not include Medicare or Medicaid. • OHIC may require commercial insurers and large provider entities to implement performance improvement plans. • OHIC may levy financial penalties for excessive cost growth.

2. Pharmacy Benefit Manager Transparency and Reporting

The second proposal addresses the role of Pharmacy Benefit Managers in the structure and cost of health insurance. Article 11 Section 1 creates the Pharmacy Benefit Manager Transparency Reporting and Study Act. This proposal will provide a foundation for Pharmacy Benefit Manager (PBM) oversight in Rhode Island. PBMs occupy a significant place in the distribution and financing of prescription drugs in Rhode Island, and the nation. Prescription drug costs are a major driver of total health

care spending growth and contribute to rapidly rising health insurance premiums. There are also significant administrative costs associated with pharmacy claims processing, network development, formulary design, and utilization review which are managed by health insurers and PBMs. PBMs negotiate price concessions from drug manufacturers which total hundreds of millions of dollars per year in exchange for placement on health plan drug formularies. The proposal represents a first step in characterizing and quantifying the role of PBMs in Rhode Island's health care system. The transparency provisions seek to quantify and make transparent the flow of drug rebates and administrative fees through PBMs. The Act would require OHIC to produce a report with recommended next steps for PBM regulation.

3. The Rhode Island Marketplace Affordability Program Act of 2026

The third proposal lowers health insurance premiums for low-and-moderate income Rhode Islanders who purchase their own insurance through HealthSource RI. Article 11 Section 14 will create the Rhode Island Marketplace Affordability Program Act of 2026. Through this Act, Governor McKee has proposed creating the first state-based health insurance premium subsidy for Rhode Islanders with income below 200 percent of the federal poverty level. This proposal will backfill the loss of federal enhanced premium tax credits and support the integrity of the individual market by reversing coverage losses experienced through early 2026.

Rhode Island has positioned itself as a national leader for health system performance and policy initiatives to promote affordability. To maintain this standing in the face of rising costs, new approaches are needed. These three initiatives will advance the public's interest in more affordable health insurance.

Appendix

Differences between TME and APCD Data Sources

Below are the key differences between the data submitted by insurers as part of the cost growth target data collection, and data from HealthFacts RI, the state's All-Payer Claims Database.

Cost Growth Target Data Collection

- Used to calculate growth in health care costs over a given time period using aggregate data reported by insurers and public payers
- Data are aggregated and do not allow for claim-level analyses
- Includes data for both the commercial fully insured and self-insured lines of business
- Includes non-claims spending
- Includes estimated pharmacy spending for carve out groups
- Includes both medical and retail pharmacy rebates
- Includes insurer administration costs and profits

All-Payer Claims Database

- Used to study cost drivers and cost growth drivers to identify opportunities for cost growth mitigation
- Data are granular and allow for claim-level analyses
- Includes data for commercial fully insured, but only some of the self-insured (e.g., self-funded employers who opt in)
- Does not include non-claims spending
- Includes actual claims from pharmacy benefit managers
- Does not include any pharmacy rebates

Data for this presentation was obtained through an approved request to the Rhode Island All-Payer Claims Database as administered by the Rhode Island Department of Health (RIDOH). Data was obtained for 2020 through 2024. RIDOH is not responsible for the author's analysis, opinions and conclusions contained in this document.