Utah Healthcare Spending Growth Trends, 2021-2024

Utah Healthcare Spending Growth Measurement Annual Report

January 2026

One Utah Health Collaborative

Overview

As the steward of the Utah Model of Care, the One Utah Health Collaborative is committed to helping all healthcare stakeholders, patients, employers, and policymakers understand and monitor the growth of healthcare spending. This allows us—as a community —to take deliberate actions to ensure a sustainable course of action and measure the impact of those actions. Healthcare affordability, transparency, and accountability are central to ensuring Utah's healthcare system is sustainable for patients and employers. The Utah Healthcare Spending Growth Measurement Report, examines healthcare spending growth trends in Utah, and reflects our commitment to provide critical insights that will guide collaborative efforts. This work will address emerging challenges and prevent further escalation resulting in financial burdens for Utahns.

With support from payers across Medicaid, Medicare, and commercial markets, this initiative identifies areas of concentrated spending growth and pinpoints partnership opportunities with stakeholders to create impactful, data-driven solutions toward the shared vision of the Utah Model of Care. This collective effort entails a commitment to accountability and strives to build a healthier, more sustainable future for the state.

Key Takeaways

The findings highlight several important trends at both the state and market levels:

- From 2021 to 2024, Utah's healthcare expenditures rose, with an increase of 6.2% from 2021 to 2022, 9.4% from 2022 to 2023, and 8.3% from 2023 to 2024. Healthcare spending per capita grew modestly by 1.7% in 2021–2022, lagging behind a 4.2% rise in per capita income, likely due to the impact of the pandemic, cost management by payers, increased average membership, and reduced inpatient spending. In 2022 to 2023, per capita healthcare spending accelerated to 5.2% but was still slightly below a 6.2% per capita income growth. However, from 2023 to 2024, per capita healthcare spending grew 9.2%, driven by higher professional service spending, drastically outpacing a 4.3% increase in per capita income growth.

- **Commercial** insurance, being the largest healthcare market in Utah by total dollars spent with a 49.5% spending share, experienced a 4.5% increase in total healthcare expenditures from 2021 to 2022, followed by a 13.7% increase from 2022 to 2023, and an 11.5% increase from 2023 to 2024. Cumulative commercial per capita healthcare spending growth was 13.9% ($5,691 to $6,484 per member per year). From 2021 to 2024, spending on **outpatient**, **professional behavioral health services**, and **retail pharmacy** (net of rebates) grew much faster than **inpatient** spending.

- **Medicare,** being the second-largest market by total dollars spent with 34.8% spending share, grew 6.2% from 2021 to 2022, 7.0% from 2022 to 2023, and 6.2% from 2023 to 2024. Cumulative Medicare per capita healthcare spending growth from 2021 to 2024 was 13.5% ($14,019 to $15,915). **Retail pharmacy** (net of rebates), **outpatien**t, professional services, and **non-claims** spending grew substantially. Medicare Advantage **professional behavioral health spending** grew at a significant rate but had only a moderate impact because of relatively low baseline behavioral health spending relative to other service categories.

- **Medicaid** witnessed a 10.6% increase from 2021 and 2022 followed by a 3.0% increase from 2022 to 2023 and 3.5% increase from 2023 to 2024 for total healthcare spending. Per capita total healthcare spending grew cumulatively by 45.4% from 2021 and 2024, from $6,698 to $9,699 per member per year. More than 80% of this increase occurred from 2023 to 2024 due to the end of Medicaid Unwinding in 2024, which

resulted in many low-utilizing Medicaid members being disenrolled and a much higher average per capita healthcare spending among the remaining Medicaid population. From 2021 to 2022, average member enrollment saw a substantial increase of 10.2%, which was followed by a moderate decline of 4.8% in 2022 to 2023, and a drastic decline of 22.7% in 2023 to 2024. During this time, expenditures on **retail pharmacy** (after rebates) and **professional behavioral health services** saw significant growth.

- The shifting of spending from **inpatient** to **outpatient** services may likely be due to increased utilization of **outpatient** services, the need for additional ancillary services, higher administrative costs of complex billing methods, and investments in additional equipment and infrastructure.

- The rise in **professional behavioral health services** can be attributed to several factors, including a growing demand driven by increased member needs, a higher number of individuals accessing these services, a shift toward managing more complex cases requiring extended care and specialized treatments, advancements in standardizing data collection, improvements in care delivery, and escalating treatment costs.

- **Retail pharmacy** spending remains a significant driver of overall spending growth. The rising cost may be attributed to increasing market share of specialty drugs, increasing drug prices, and increasing utilization.

- Performance incentive payments declined by 39.9%, while prospective payments increased by 36.5% from 2021 to 2024. Payments to support population health tripled but were still quite modest in 2024 (less than $1 million).

- Total healthcare spending on **professional primary care services** experienced growth, increasing from $658 million in 2021 to $839 million in 2024 (not including Medicare FFS for which professional primary care service spending was not reported separately). Despite this growth, **professional primary care** spending continues to represent about one sixth of expenditures on overall professional services.

These statistics underscore areas of rapid growth and illuminate potential opportunities for collaboration and innovation among healthcare stakeholders to focus interventions and control spending.

Influencing Factors and Limitations

While this report provides a comprehensive look at healthcare spending trends, certain limitations and external factors may influence its findings:

- **Data limitations**: The data used for this report is not inflation-adjusted. Contracts between payers and providers often include inflation adjustments, with some tied to government rates or influenced by chargemaster rate changes, while medical inflation effects may not be immediately apparent or may vary depending on economic conditions. Furthermore, variability in data sources and detailed methodology from payers could also have an impact on the results of the report.

- **Economic and demographic shifts**: Workforce shortages contribute to delays in healthcare delivery and may have resulted in acute treatments delivered later that ultimately drove up costs. Rising administrative and labor expenses, including compliance and billing complexities along with competitive wages, further strain budgets. Additionally, the increasing cost of living may have caused patients to delay

treatment due to affordability concerns. The aging population adds to the challenge, requiring more frequent and complex care, as well as increased chronic disease management and long-term care needs.

- **Environmental and policy changes**: Public health emergencies may have led to shifts in utilization of medical care and emergency services. This can have a long-term impact on costs, while regulatory changes can require significant investments. Policy shifts such as expansion or reduction in coverage have an impact on healthcare utilization and spending.

- **Medical and technological advances**: The emergence of new treatments, the development of pharmaceuticals, and other healthcare innovations, while transformative and aimed at improving outcomes, may also contribute to rising costs.

We trust this second annual Utah healthcare spending growth report will serve as a foundation for transparent discussions and actionable strategies as we continue to align with stakeholders to ensure Utah's healthcare system remains affordable, high-quality, and trusted. Some values for 2021 through 2023 in this report may differ slightly from the values in the first annual report due to the following: 1) updates to 2023 data payers submitted including due to changes in claims runout period, 2) implementing a more comprehensive methodology for estimating pharmacy expenses and pharmacy rebates for partial claims commercial plans from which pharmacy expenses are carved out, 3) adjusting the methodology for distributing Medicaid statutory pharmacy rebates between the Medicaid FFS and Medicaid ACO submarkets, and 4) correcting one Medicare Advantage pharmacy rebate value for 2021 and 2022 (less than $1 million difference)

We extend our heartfelt thanks to the committed payers who contributed data for this crucial, ongoing project. Their efforts exemplify alignment and collaboration, which enables our community and stakeholders to effectively monitor and address the trajectory of health spending growth. A special thank you to our generous donors who support the One Utah Health Collaborative. Their support is instrumental in driving meaningful progress toward a sustainable system.

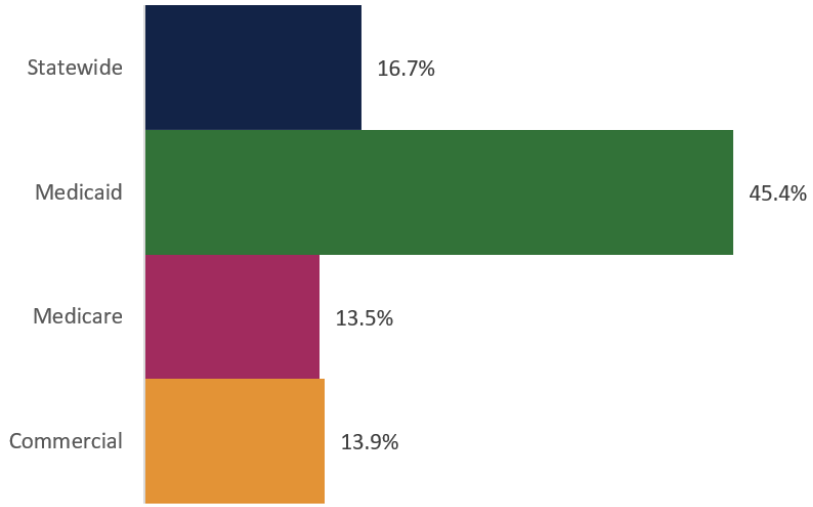
Executive Summary

This report describes healthcare spending growth in Utah from 2021 and 2024 statewide, by market (Medicare, Medicaid, and commercial) and by service category. The expenditures collected from payers and other sources together represent the total cost of healthcare in Utah and are referred to as "Total Health Care Expenditures" (THCE) throughout this report. This assessment of healthcare spending in Utah was developed to inform policymakers and other stakeholders of the current state of healthcare spending growth, illustrate potential cost drivers, and identify focused opportunities to slow healthcare spending.

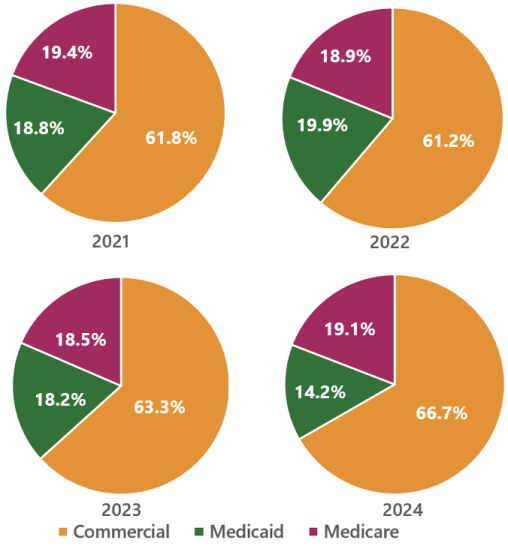
Summary Findings: THCE Per Member Per Year and Enrollment Share

Statewide THCE in Utah in 2021 was $15.66 billion and grew to $19.69 billion in 2024, a 25.7% increase. On a per member per year (PMPY) basis, the statewide THCE PMPY grew by 16.7%, from $7,490 in 2021 to $8,744 in 2024, driven by a sharp 9.2% increase from 2023 and 2024. Medicaid had the highest cumulative growth rate for THCE PMPY from 2021 and 2024 at 45.4%, much higher than the Medicare and commercial markets that grew 13.5% and 13.9%, respectively. The end of Medicaid Unwinding in 2024 resulted in many low-utilizing Medicaid members being disenrolled and a higher average per capita healthcare spending among the remaining Medicaid population. Statewide enrollment decreased by 0.8% from 2023 to 2024 while the state population grew by about 1.8% according to the US Census Bureau, suggesting that a notable portion of low-utilizing members who disenrolled in Medicaid in 2024 did not enroll in commercial insurance or Medicare. Low-utilizing Medicaid members becoming uninsured in 2024 would put upward pressure on statewide THCE PMPY growth. From 2021 to 2024, the proportion of statewide health insurance member years decreased notably for Medicaid from 18.8% to 14.2%, decreased slightly for Medicare from 19.4% to 19.1%, and increased notably for commercial from 61.8% to 66.7%. The shift toward a higher commercial enrollment share put downward pressure on statewide THCE PMPY growth because the commercial market has the lowest THCE PMPY.

Cumulative Percentage Change in THCE PMPY by Market, 2021-2024



Enrollment Share by Market, Statewide

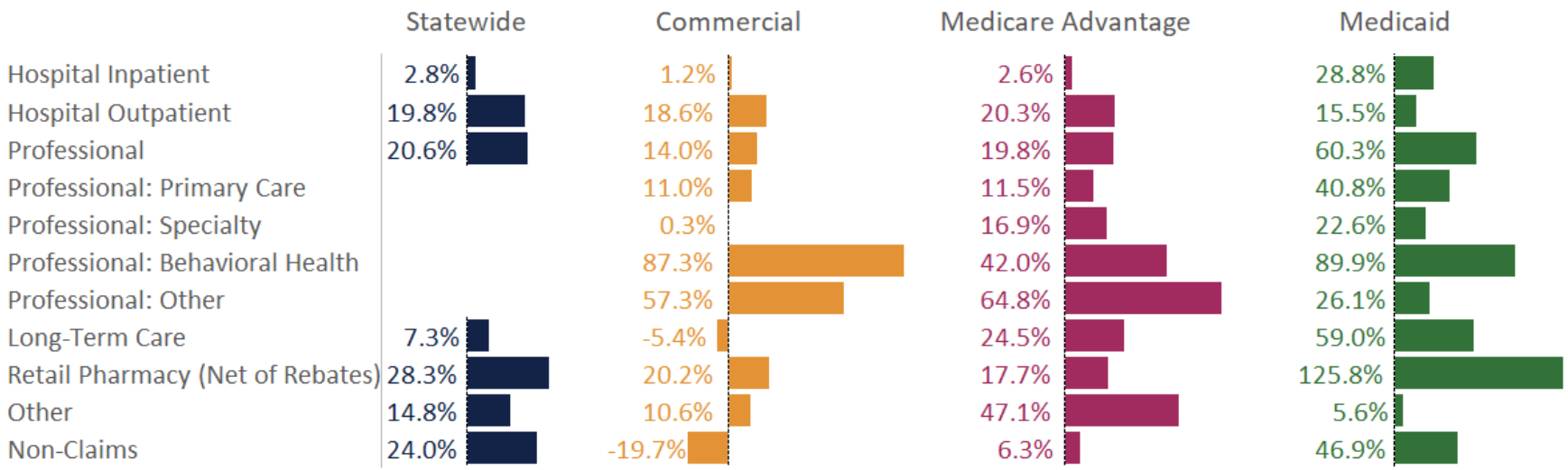


Summary Findings: Total Medical Expenses

Total Medical Expenses (TME) are comprised of claims and non-claims expenditures and were submitted by participating payers at the year, line of business, and service category level. From 2021 to 2024, statewide TME increased 26.3% and statewide TME PMPY grew 17.2%.

Analyzing TME PMPY spending for each service category shows that retail pharmacy, professional services, and outpatient spending drove much of the statewide spending growth from 2021 and 2024. Statewide hospital inpatient PMPY spending increased by only 2.8%. Professional behavioral health service spending increased steadily for commercial, Medicare Advantage, and Medicaid (+87.3%, +42.0%, and +89.9%, respectively). The Medicaid market, which includes Medicaid fee-for-service and Medicaid Accountable Care Organization payment arrangements, saw a large increase in retail pharmacy (net of pharmacy rebates from drug manufacturers) of 125.8%.

Cumulative Change in TME PMPY from 2021 to 2024 by Market and Category



Note: Statewide professional spending by subcategory is not available because Medicare FFS data included only a professional spending category without any subcategories.

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Background

In 2022, Utah Governor Spencer J. Cox launched the One Utah Health Collaborative (the Collaborative), an independent 501(c)(3) organization. The organization is committed to addressing the growth of healthcare spending in Utah, through public and private funding, a community-centric approach, and an emphasis on supporting innovation, the Collaborative aligns the community on a long-term roadmap to a better healthcare system.

Payers Who Submitted Data by Market

Payer	Market				
	Commercial	Medicaid ACO	Medicaid Fee-for-Service	Medicare Advantage	Medicare Fee-for-Service
Aetna	X			X	
Cigna Health and Life Insurance Co.	X				
Centers for Medicare & Medicaid Services					X
Health Choice Utah		X		X	
Molina Healthcare of Utah	X	X		X	
Public Employee Health Plan	X				
Regence BlueCross BlueShield of Utah	X			X	
Select Health	X	X		X	
UnitedHealthcare	X			X	
University of Utah Health Plans	X	X		X	
Utah Medicaid		X	X		

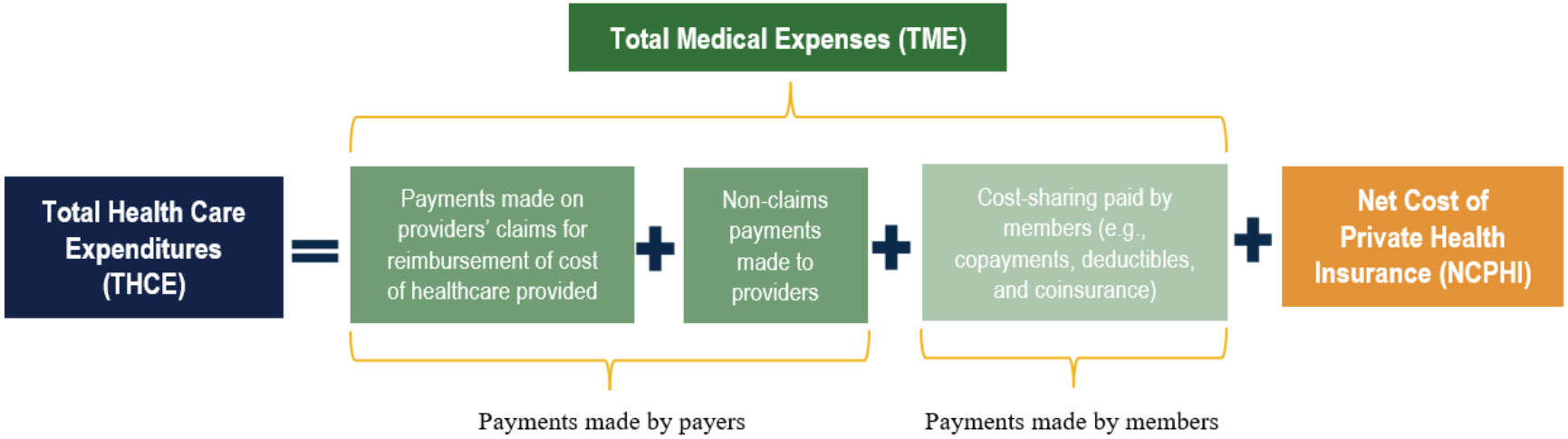
To address the growth of healthcare spending in Utah, the Collaborative implemented the Utah Healthcare Spending Growth Measurement Initiative with support from consultant Mathematica.

As part of this initiative, the Collaborative is reporting on annual healthcare spending at two levels: for the state overall and for each insurance market (Medicaid, Medicare, and commercial) using annual data submitted from payers and other sources. The Medicare market is composed of Medicare Fee-for-Service (FFS), Medicare/Medicaid Dual Eligibles, and Medicare Advantage. The Medicaid market is composed of Medicaid FFS and Medicaid Accountable Care Organization (ACO). Individual, self-insured, small and large group, and student health insurance plans are collectively referred to as the commercial market. Eleven payers submitted data for this initiative.

Total Health Care Expenditures

The Collaborative uses Total Health Care Expenditures (THCE) as the measure of overall healthcare spending in Utah statewide and by market. THCE is the Total Medical Expenses (TME) incurred by Utah residents for all healthcare services for all payers reporting data, plus the payers' Net Cost of Private Health Insurance (NCPHI) (i.e., cost to Utah residents associated with the administration of private health insurance). TME includes claims and non-claims spending reported by payers, net of pharmacy rebates. Non-claims payments include incentive payments, prospective payments for healthcare services, payments that support care transformation and infrastructure, and other payments that support provider services. The Collaborative reports THCE on a per member per year (PMPY) basis.

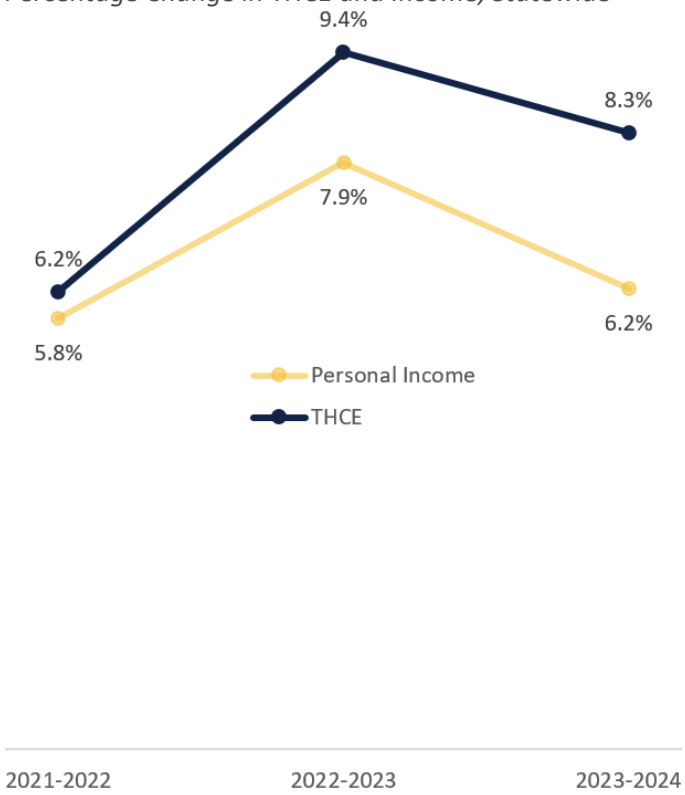
Components of THCE



Statewide THCE

To understand growth in healthcare spending in the broader Utah context, the Collaborative compares growth in THCE with growth in Utah personal income across years. Compared with statewide personal income, statewide THCE grew slightly faster from 2021 to 2022 (6.2% vs. 5.8%) and significantly faster from 2022 to 2023 (9.4% vs. 7.9%) and 2023 to 2024 (8.3% vs. 6.2%).

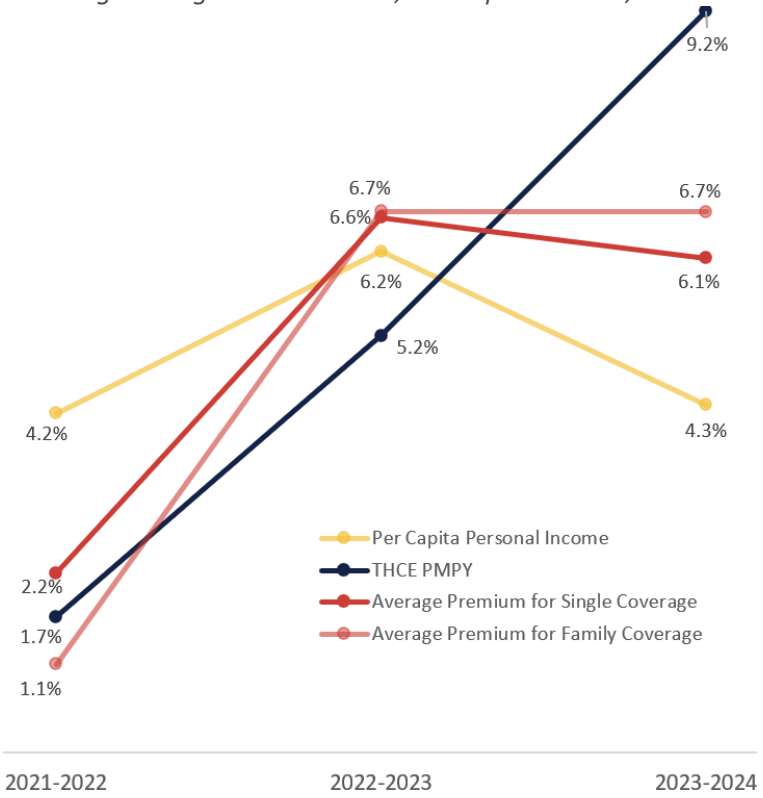
Percentage Change in THCE and Income, Statewide



Statewide THCE PMPY

The Collaborative compares growth in THCE PMPY with growth in Utah per capita personal income and health insurance premiums – as a proxy of the degree to which Utah residents can afford increases in healthcare expenses. From 2021 to 2022, growth in personal income (+4.2%) outpaced growth in statewide THCE PMPY (+1.7%) and average health insurance premiums (+2.2% for individual, +1.1% for family). From 2022 to 2023, the growth in per capita personal income (+6.2%) was similar to growth in THCE PMPY (+5.2%) and average health insurance premiums (+6.6% for individual and +6.7% for family). However, from 2023 to 2024, growth in THCE PMPY (+9.2%) and health insurance premiums (+6.1% for individual, +6.7% for family) outpaced growth in personal income (+4.3%). THCE PMPY growth is higher than THCE growth from 2023 to 2024 due to a 0.8% decrease in the number of Utah residents enrolled in health insurance.

Percentage Change in THCE PMPY, Per Capita Income, and Premiums



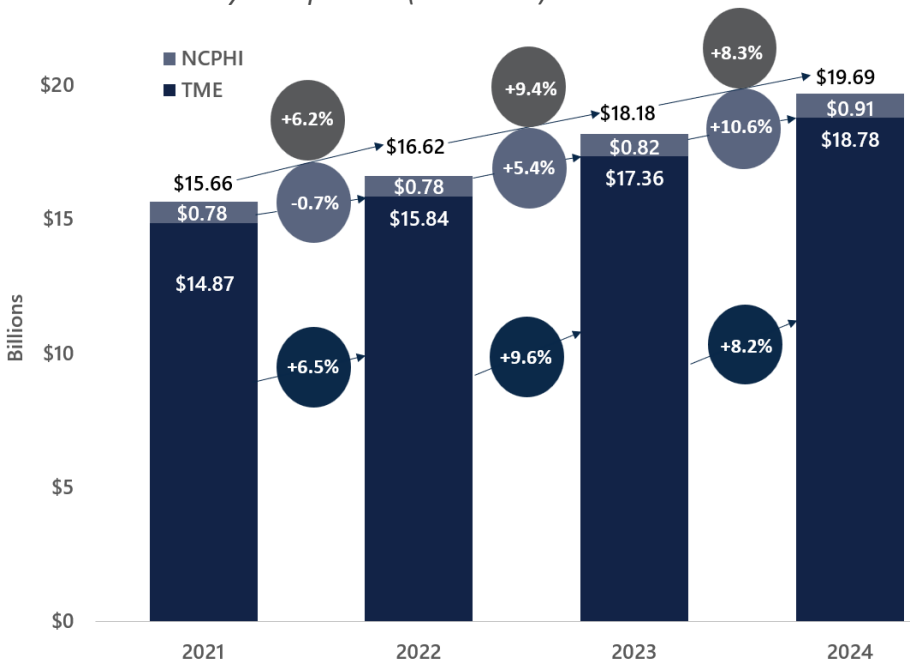
Statewide THCE by Component and Enrollment

NCPHI is used for payer costs related to healthcare claims processing, paying bills, advertising, sales commissions, other administrative costs, premium taxes, and fees. It also includes a payer's profits (contribution to margin) or losses. NCPHI can fluctuate year to year depending on how accurately premium projections are able to forecast actual services rendered.

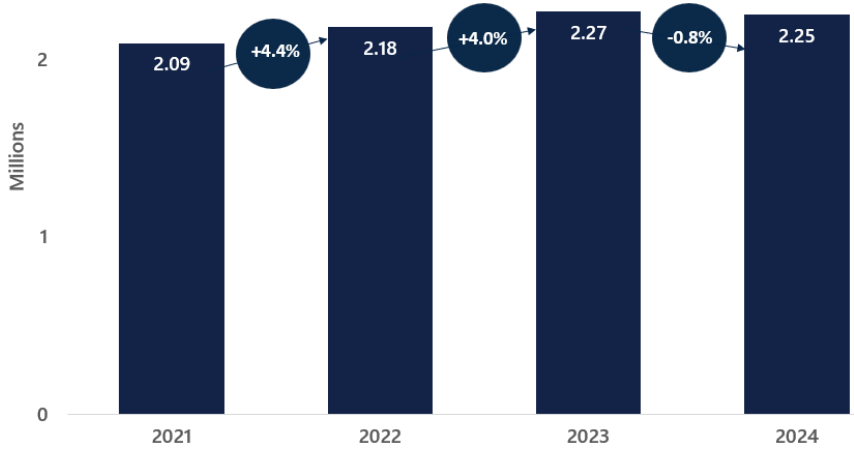
THCE in Utah grew from $15.66 billion in 2021 to $19.69 billion in 2024. TME accounted for about 95% of THCE and grew at a similar pace from 2021 to 2024 as THCE. NCPHI totaled around $906 million in 2024 and changed less than TME from 2021 to 2024, resulting in an overall minor impact of NCPHI on the growth in statewide THCE.

Statewide enrollment in health insurance grew from 2.09 million member years in 2021 to 2.27 million in 2023 (about +4% increase per year) but decreased slightly by 0.8% to 2.25 million in 2024.

Statewide THCE by Component (in billions)



Statewide Member Years (in millions)

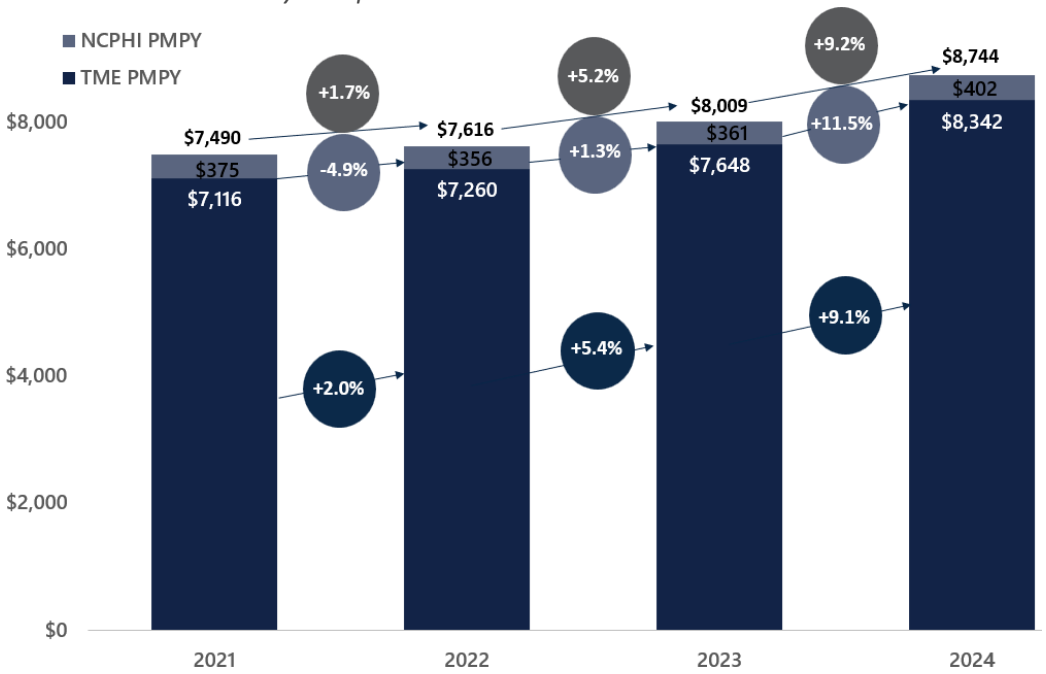


Statewide THCE PMPY by Component and Enrollment

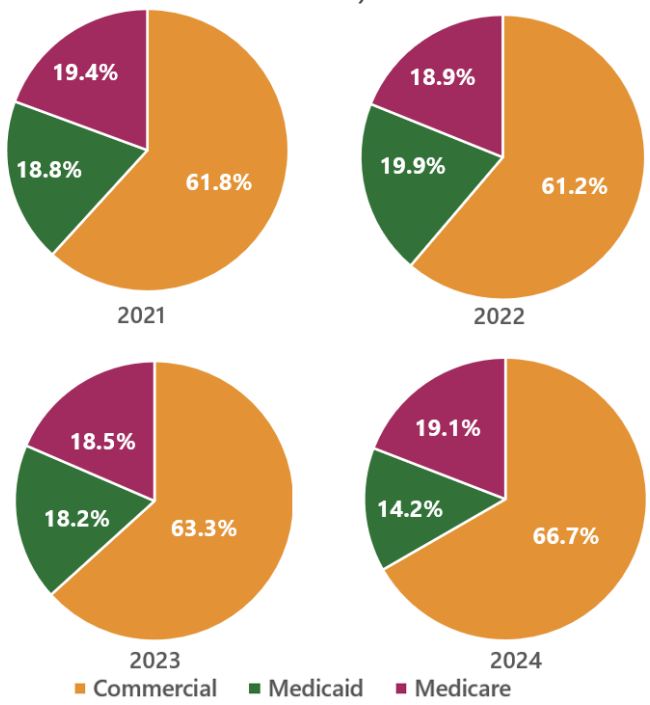
Statewide THCE PMPY increased slightly from 2021 to 2022 (+1.7%), moderately from 2022 to 2023 (+5.2%), and steeply from 2023 to 2024 (+9.2%). Growth in TME PMPY, which accounts for about 95% of THCE PMPY, drove the trends in THCE PMPY growth. Decreases in NCPHI from 2021 to 2023 slightly moderated growth in THCE PMPY; however, growth of 11.5% in NCPHI from 2023 to 2024 outpaced growth in TME of 9.1%. Growth in statewide TME PMPY was 0.5% higher than growth in statewide THCE PMPY. NCPHI PMPY increased by 7.4% from 2021 to 2024 but had a small impact on growth in THCE PMPY because NCPHI PMPY is only about 5 percent of THCE.

From 2021 to 2023, the Medicare proportion of statewide health insurance member years decreased by about 0.9%, which put some downward pressure on statewide THCE PMPY growth given that Medicare THCE PMPY is more than twice as large as THCE PMPY for commercial and Medicaid. However, Medicare proportion of statewide enrollment increased back to 19.1% from 2023 to 2024, which put upward pressure on THCE PMPY growth during that period. From 2023 to 2024, Medicaid proportion of statewide enrollment decreased dramatically from 18.2% to 14.2%, driven by the end of Medicaid Unwinding in 2024. As a result of Medicaid Unwinding, many low-utilizing Medicaid members were disenrolled and average per capita healthcare spending is higher among the remaining Medicaid population, putting upward pressure on statewide THCE PMPY.

Statewide THCE PMPY by Component



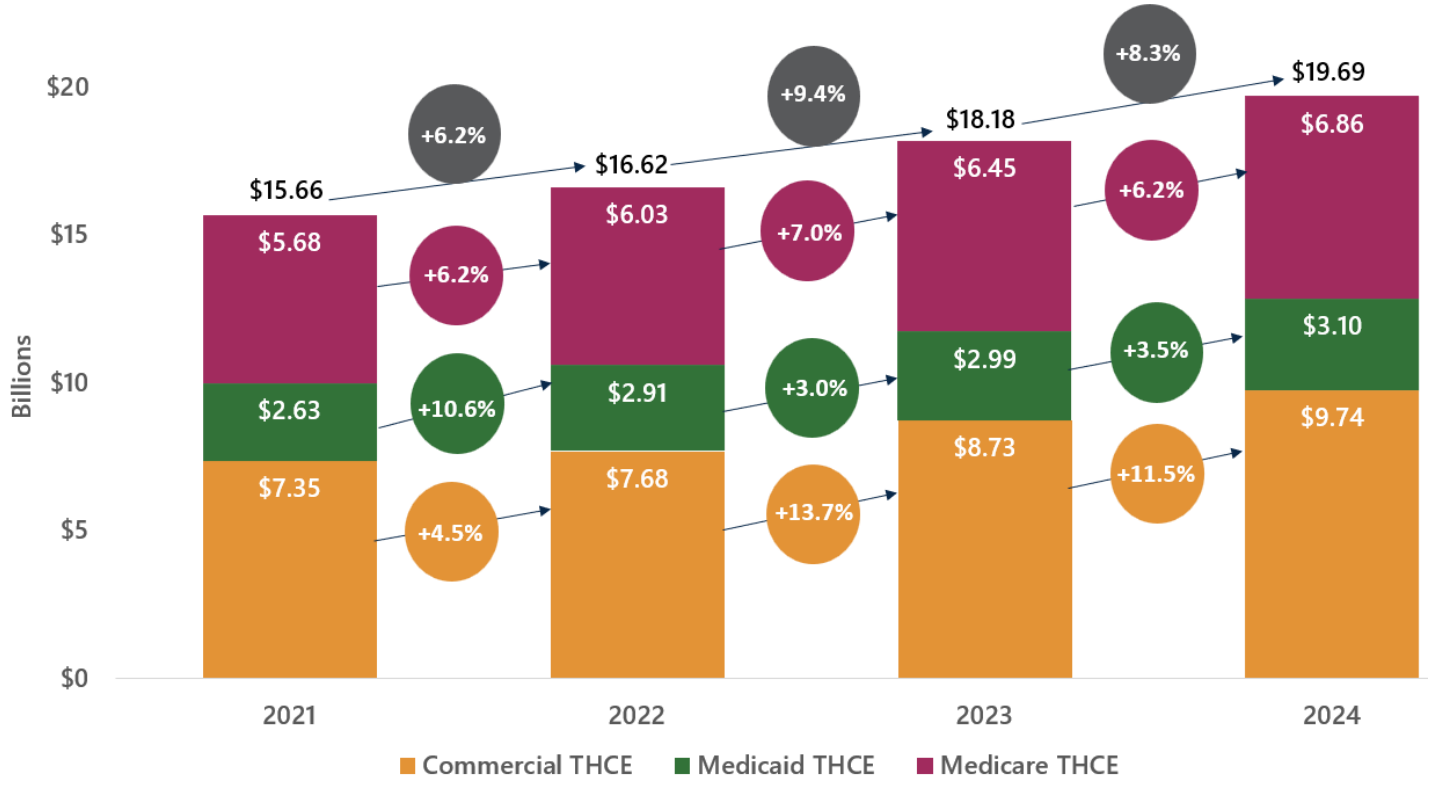
Statewide Enrollment Share by Market



THCE by Market

Commercial is the largest healthcare market in Utah by total dollars spent, with a THCE of $9.74 billion in 2024, representing 49.5% of Utah healthcare spending. Commercial THCE grew slower than statewide THCE from 2021 to 2022 (+4.5% vs. +6.2%) but grew faster than statewide THCE from 2022 to 2023 (+13.7% vs. +9.4%) and 2023 to 2024 (+11.5% vs. +8.3%). Medicare is the second largest market in Utah by total dollars spent, with $6.86 billion in 2024, and represented 34.8% of healthcare spending. Medicare THCE grew at 6% to 7% per year from 2021 to 2024, similar to statewide THCE from 2021 to 2022 but about 2% slower than statewide THCE growth from 2022 to 2023 and 2023 to 2024. Total Medicaid spending in Utah was $3.10 billion in 2024, 15.7% of healthcare spending. From 2021 to 2022, the growth in THCE for Medicaid was 10.6%, which was greater than the statewide THCE growth of 6.2%. However, Medicaid THCE grew much more slowly than statewide THCE from 2022 to 2023 (+3.0% vs. +9.4%) and 2023 to 2024 (+3.5% vs +8.3%), driven by reductions in Medicaid enrollment in 2023 and 2024.

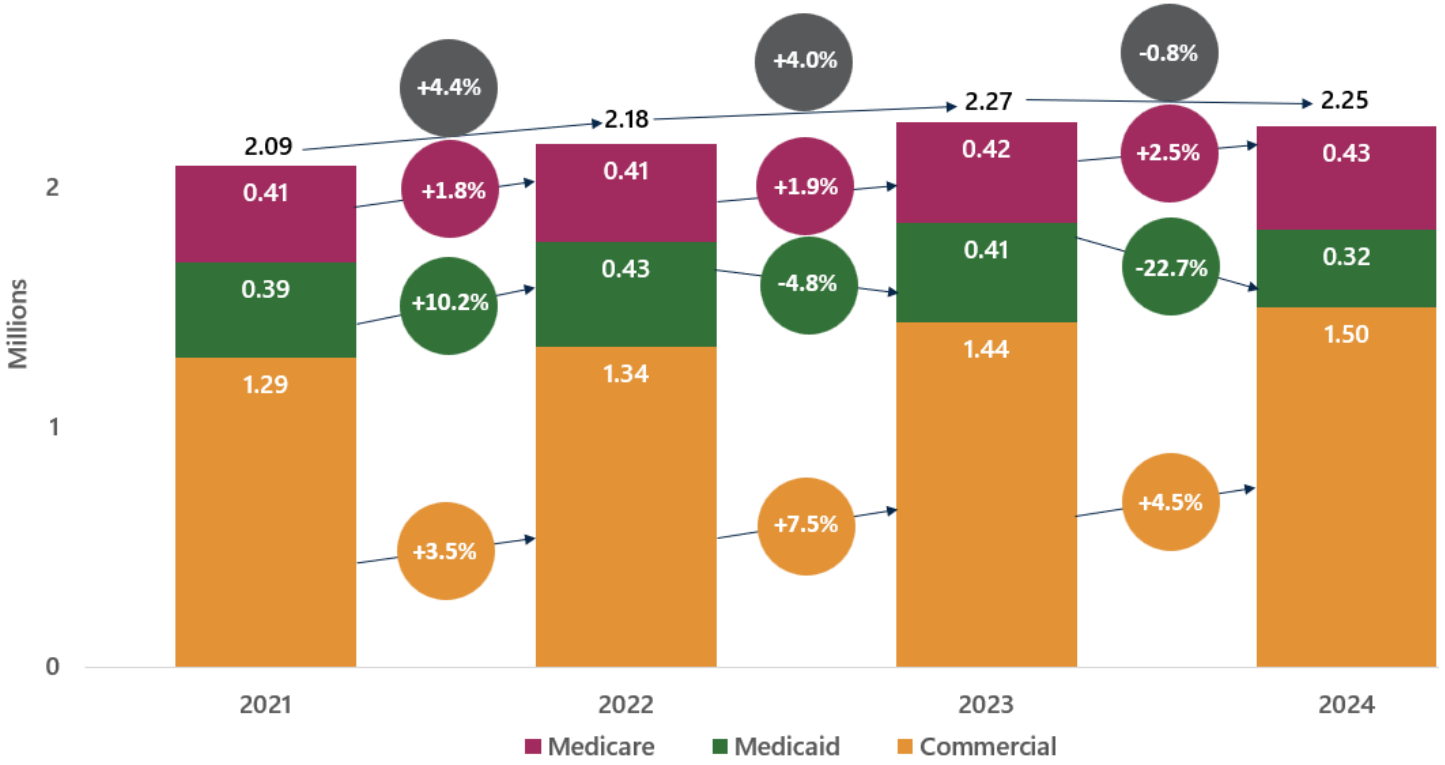
THCE by Market, Statewide (in billions)



Enrollment by Market

From 2021 to 2022, health insurance enrollment increased 4.4%, driven by a 10.2% increase in Medicaid member years. From 2022 to 2023, 7.5% growth in commercial enrollment counteracted a 4.8% decline in Medicaid enrollment, resulting in a 4.0% growth in statewide enrollment. From 2023 to 2024, statewide enrollment decreased by 0.8%, which was driven by a 22.7% reduction in Medicaid enrollment due to the end of Medicaid Unwinding in 2024.

Member Years by Market, Statewide (in millions)



THCE PMPY and Enrollment by Submarket

From 2021 to 2022, slow commercial growth in THCE PMPY (+1.0%) and a decrease in Medicaid ACO THCE PMPY (-4.8%) kept statewide THCE PMPY growth low at 1.7%. From 2022 to 2023, Medicare Advantage experienced a relatively slow growth in THCE PMPY (+2.9%), but all other submarkets experienced relatively fast growth, resulting in a 5.2% growth in statewide THCE PMPY. From 2023 to 2024, the 9.2% increase in statewide THCE PMPY was driven by very large increases in THCE PMPY for Medicaid ACO (+30.9%) and Medicaid FFS (+44.6%).

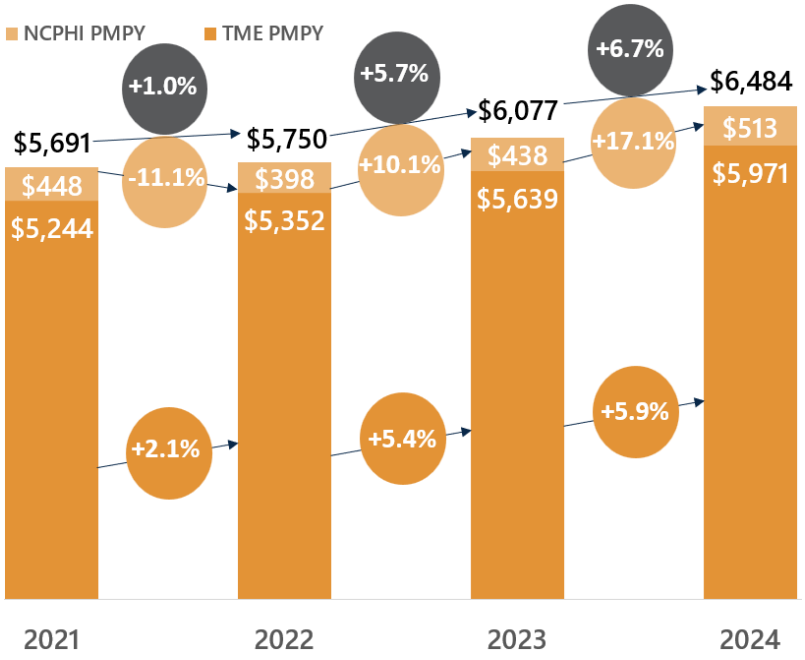
From 2021 to 2024, an inverse relationship existed between Medicaid enrollment and Medicaid THCE PMPY changes, suggesting members who enrolled in Medicaid in 2022 and disenrolled in Medicaid in 2023 and 2024 were relatively low utilizers of healthcare. From 2021 to 2022, large increases in Medicaid ACO and Medicaid FFS enrollment (+10.8% and +7.8%) coincided with a 4.8% decrease in Medicaid ACO THCE PMPY and relatively slow growth of 2.3% in Medicaid FFS THCE PMPY. From 2022 to 2023 and 2023 to 2024, decreases in Medicaid enrollment coincided with large increases in Medicaid THCE PMPY.

Commercial THCE PMPY by Component and Enrollment

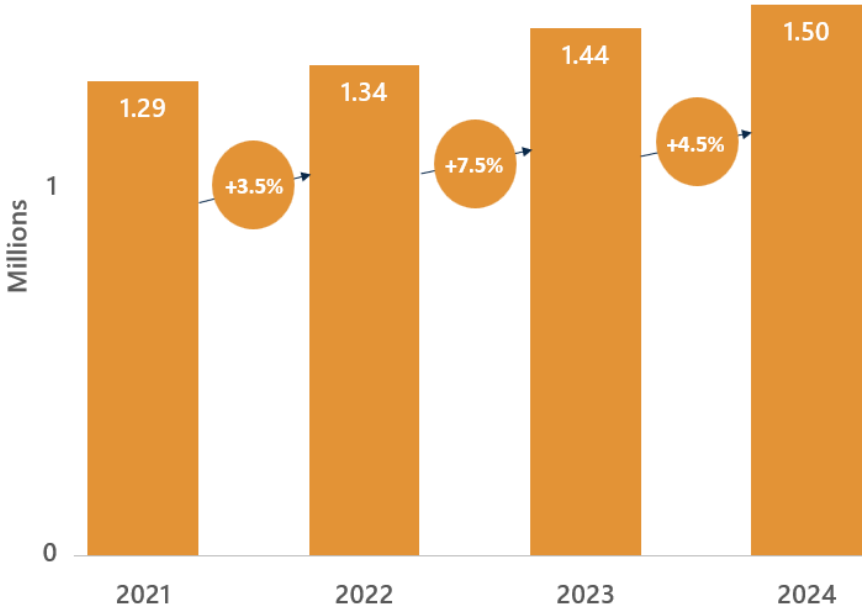
From 2021 to 2024, NCPHI accounts for 7 to 8 percent of THCE. From 2021 to 2022, commercial THCE PMPY growth of 1.0% was slower than TME PMPY growth of 2.1% because NCPHI PMPY decreased by 11.1%. From 2022 to 2023 and 2023 to 2024, commercial NCPHI PMPY grew much faster than commercial TME PMPY, putting upward pressure on commercial THCE PMPY.

Commercial enrollment increased from 1.29 million member years in 2021 to 1.50 million member years in 2024, growing an average of about 5 percent a year.

Commercial THCE PMPY by Component

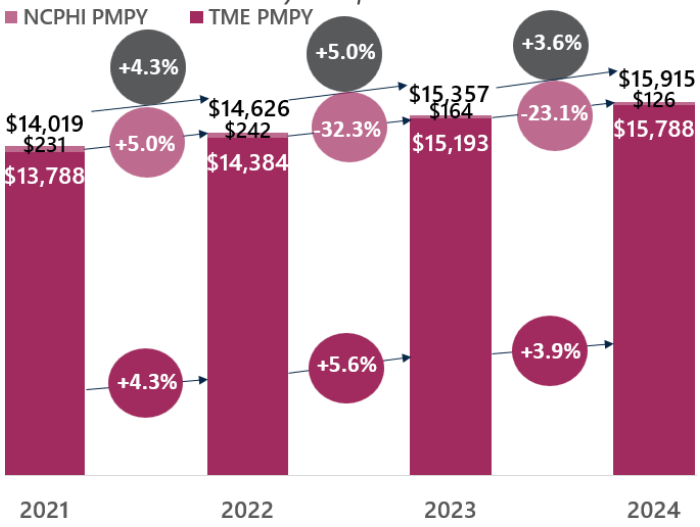


Commercial Member Years

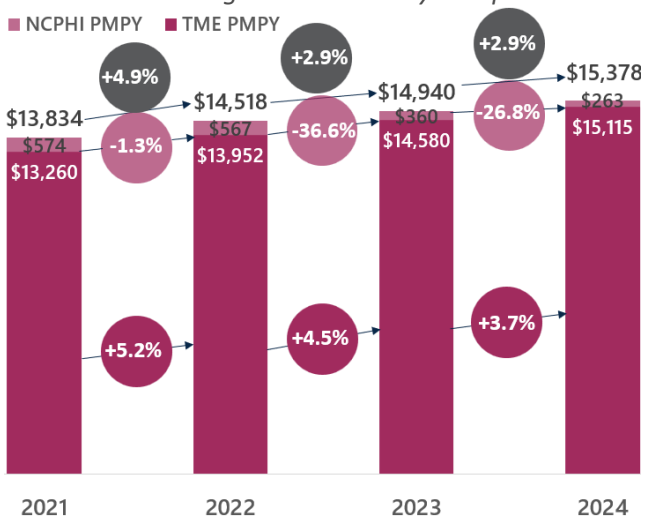


Medicare THCE PMPY by Component and Enrollment

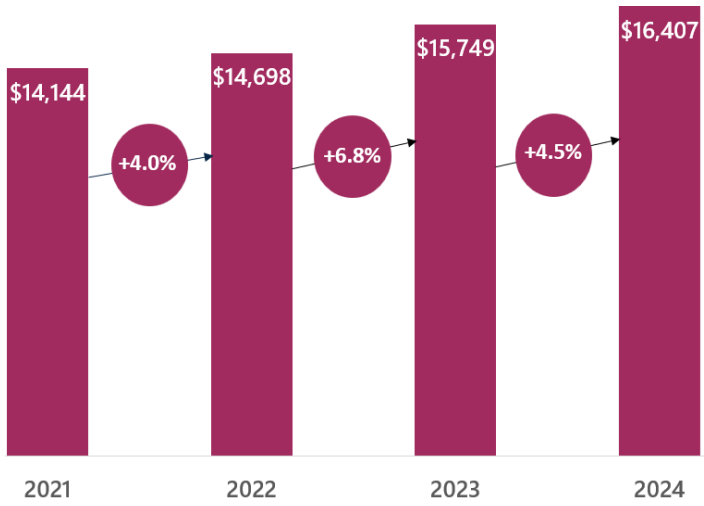
Medicare THCE PMPY by Component



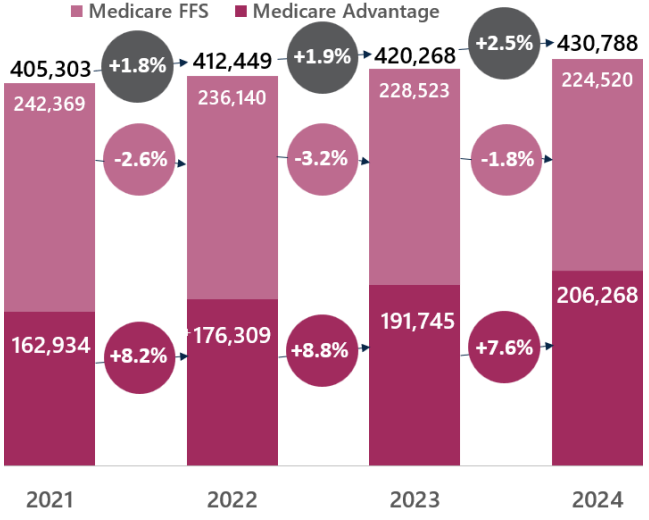
Medicare Advantage THCE PMPY by Component



Medicare FFS THCE PMPY



Medicare Member Years by Submarket

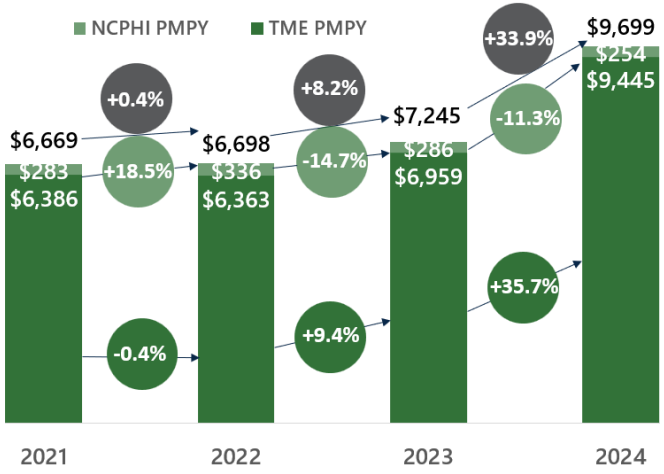


From 2021 to 2024, Medicare Advantage proportion of Medicare member years increased from 40.2% to 47.9%, putting a slight downward pressure on Medicare THCE PMPY growth given Medicare Advantage THCE PMPY is slightly lower than Medicare FFS THCE PMPY.

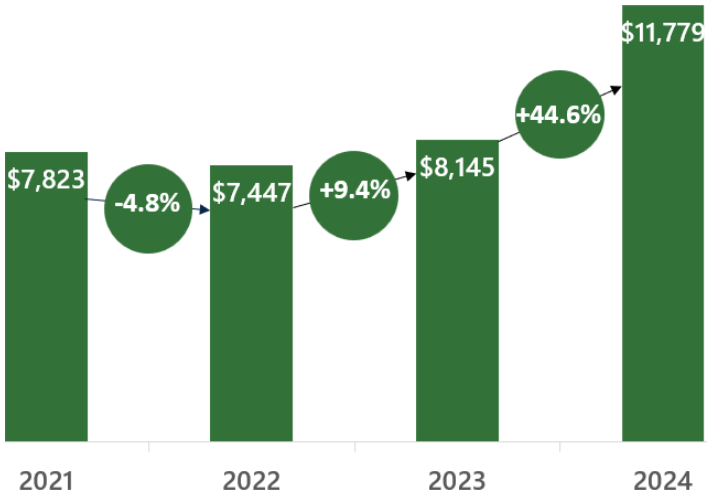
From 2021 to 2022, Medicare Advantage THCE PMPY grew slightly faster than Medicare FFS THCE PMPY (4.9% vs. 4.0%). Medicare Advantage THCE PMPY grew slower than Medicare FFS THCE PMPY from 2022 to 2023 (2.9% vs. 6.8%) and 2023 to 2024 (2.9% vs. 4.5%).

Medicaid THCE PMPY by Component and Enrollment

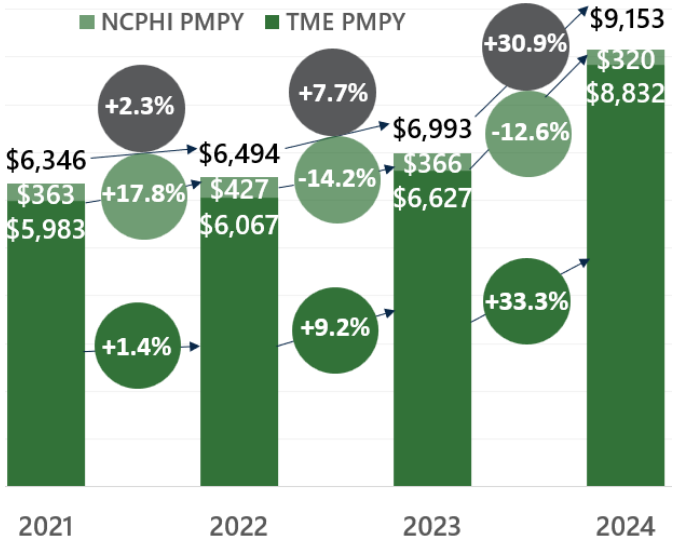
Medicaid THCE PMPY by Component



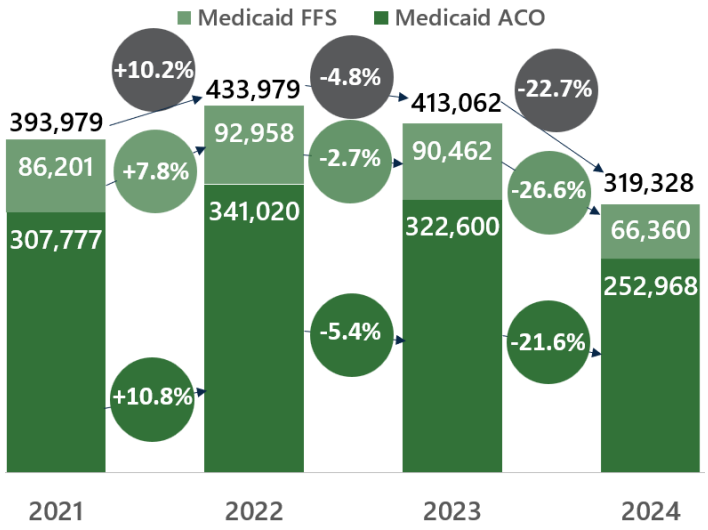
Medicaid FFS THCE PMPY



Medicaid ACO THCE PMPY



Medicaid Member Years by Submarket



Medicaid ACO THCE PMPY drove Medicaid THCE PMPY because Medicaid ACOs accounted for 78 to 79% of Medicaid enrollees across years.

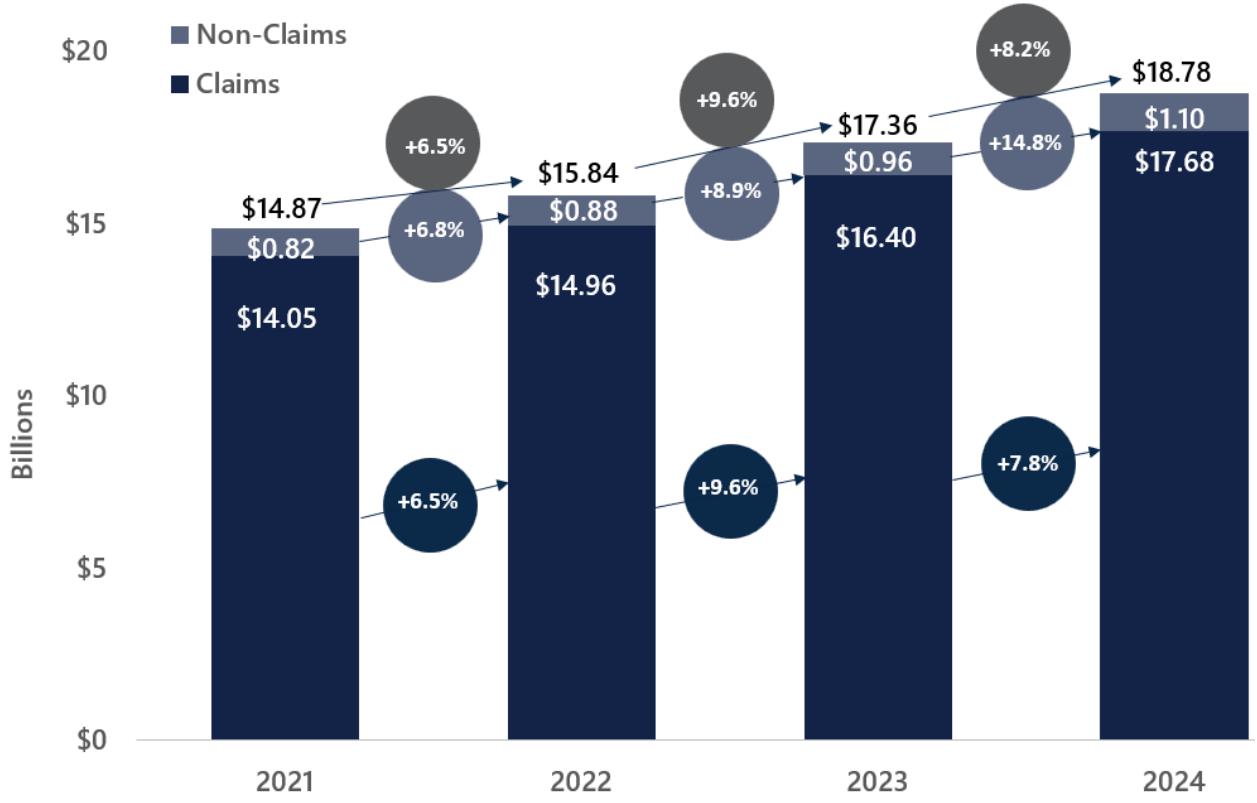
From 2021 to 2022, Medicaid THCE PMPY remained essentially flat (+0.4%) due to modest increases in Medicaid ACO THCE PMPY (+2.3%) being cancelled out by a 4.8% decrease in Medicaid FFS THCE PMPY. From 2022 to 2023 and 2023 to 2024, decreases in Medicaid enrollment coincided with sharp increases in THCE PMPY for both Medicaid FFS and Medicaid ACOs.

Statewide TME by Component: Claims and Non-Claims Spending

Service categories can be organized into two major buckets: claims and non-claims.

- Claims spending includes the allowed amount reimbursed from payers to provider organizations for specific services rendered (e.g., for a doctor's visit).
- Non-claims spending includes payments made through alternative kinds of arrangements. Providers may receive incentive dollars from a payer for meeting certain quality metrics or a monthly flat rate to manage a panel of patients.

Claims Spending and Non-Claims Spending, Statewide (in billions)



From 2021 to 2024, non-claims spending accounted for about 6 percent of TME.

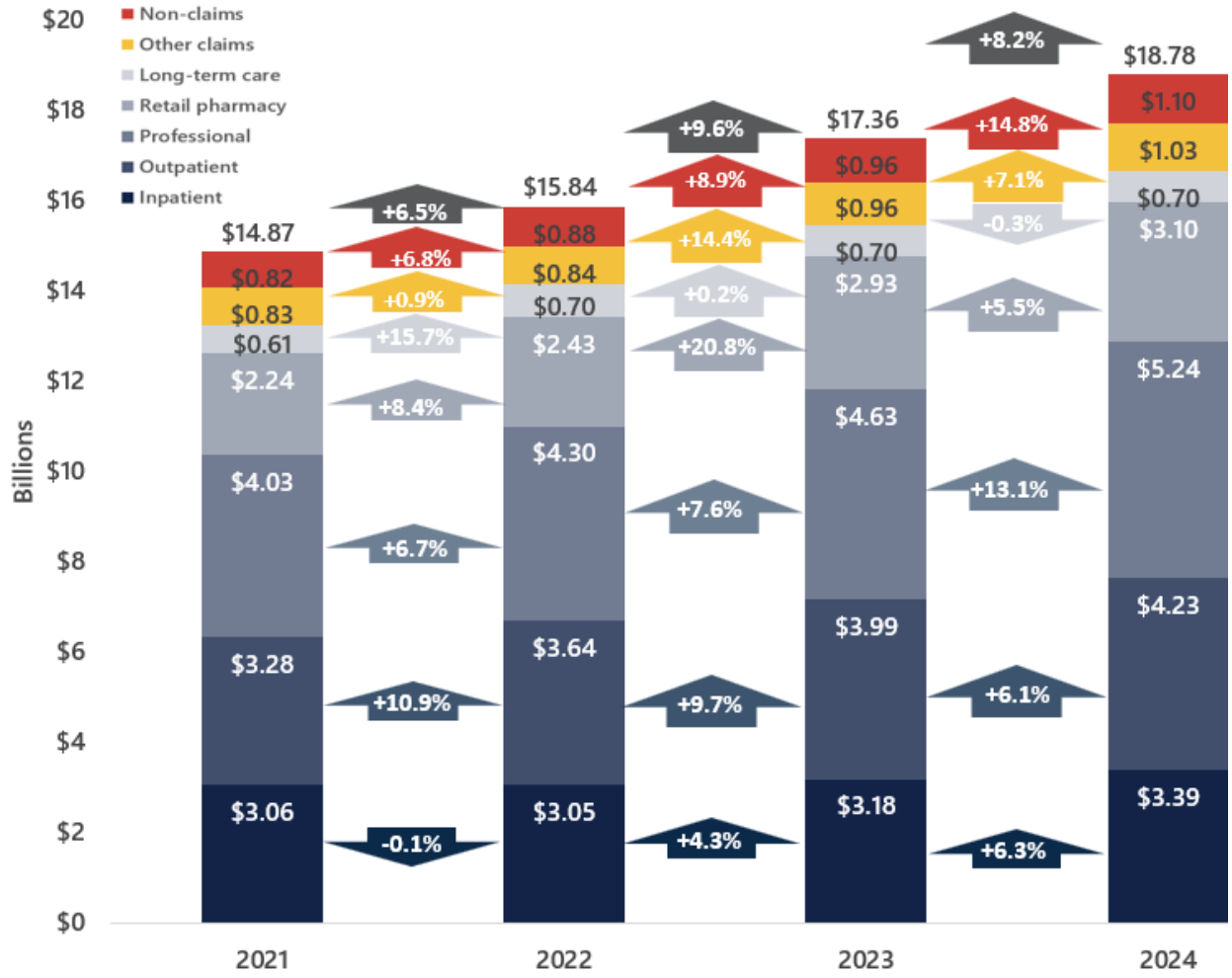
From 2021 to 2022 and 2022 to 2023, non-claims and claims spending grew at similar rates.

From 2023 to 2024, non-claims spending grew almost twice as fast as claims spending, leading TME growth to be somewhat higher than claims spending growth (8.2% vs. 7.8%).

Statewide TME by Category

Inpatient, outpatient, professional services, and retail pharmacy are the four largest service categories statewide, together accounting for about 85 percent of overall claims and non-claims spending. Long-term care, other claims (including but not limited to durable medical equipment, hospice, hearing aids, optical services, transportation, and diagnostic services at freestanding facilities), and non-claims have much smaller contributions to overall spending.

Statewide TME by Category, Statewide



Compared to overall TME growth:

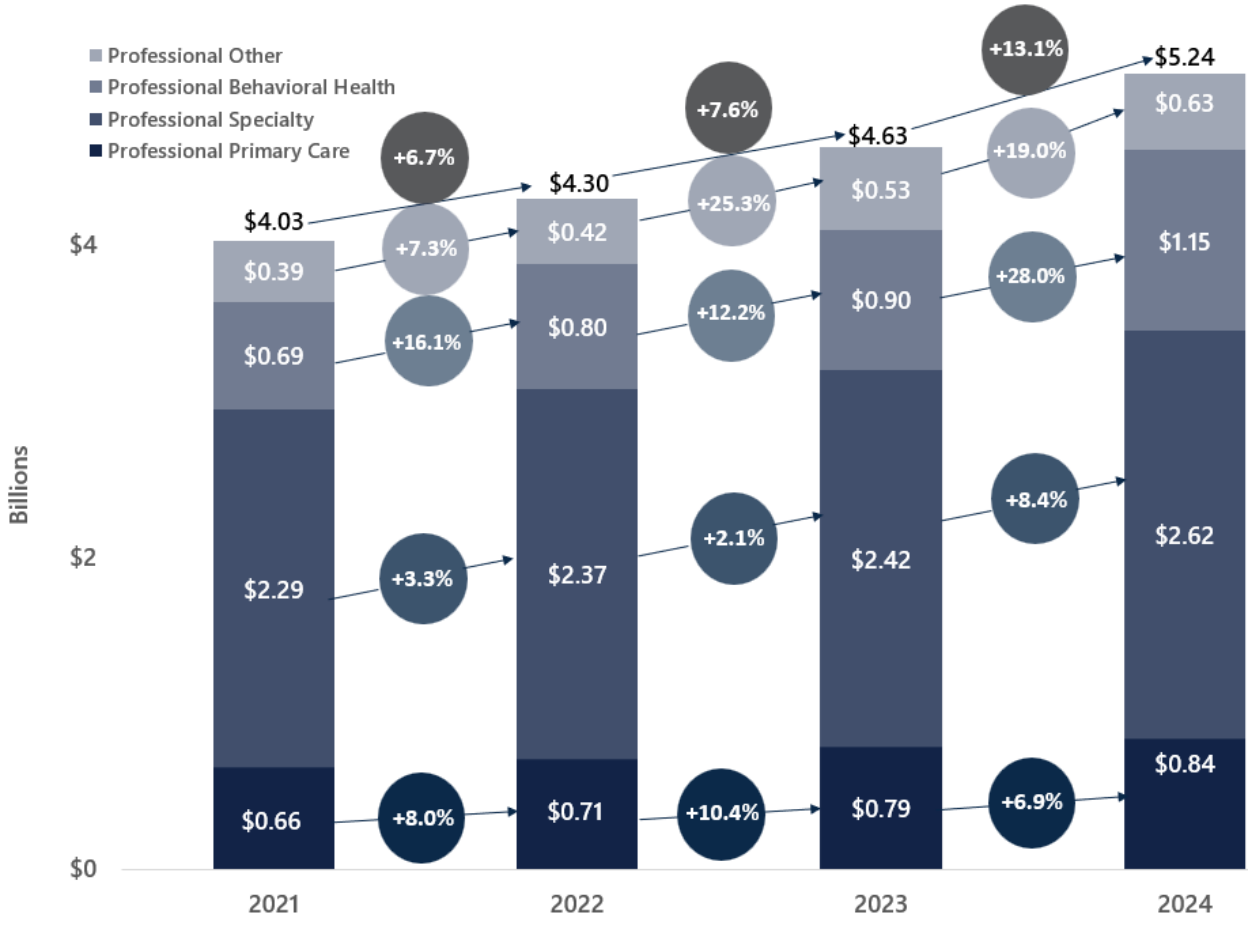
- Retail pharmacy spending and outpatient spending grew faster from 2021 to 2023 but slower from 2023 to 2024.
- Inpatient spending grew slower from 2021 to 2024
- Professional services spending grew faster from 2023 to 2024

Due to differential growth rates by category from 2021 to 2024:

- Inpatient spending decreased from 20.6% to 18.0% of TME
- Retail pharmacy spending increased from 15.1% to 16.5% of TME

Professional Spending by Category

Professional Spending by Category, Statewide



Compared to overall professional spending:

- Professional primary care spending grew faster from 2021 to 2023 but slower from 2023 to 2024
- Professional behavioral health spending grew substantially faster from 2021 to 2024

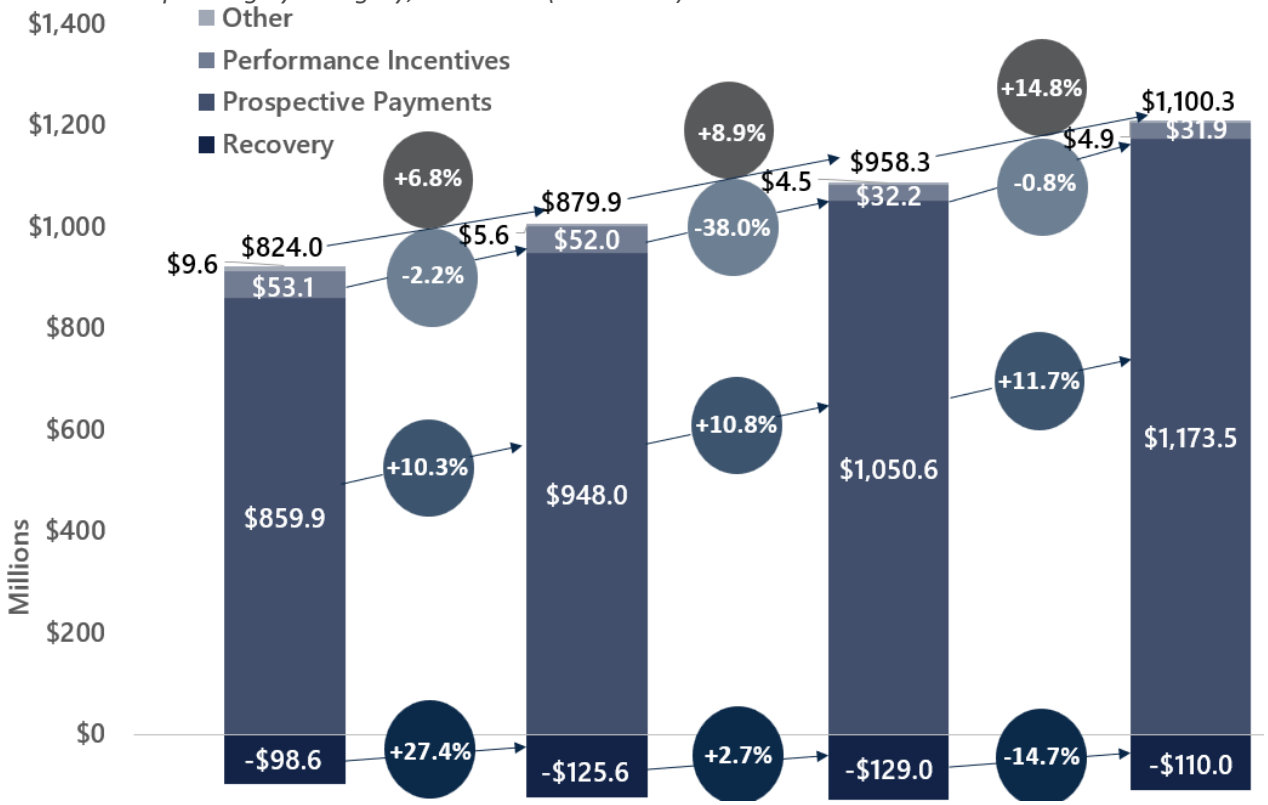
Due to differential growth rates by category from 2021 to 2024:

- Professional behavioral health spending increased from 17.1% to 22.0% of professional spending
- Professional specialty spending decreased from 56.8% to 50.0% of professional spending

Non-Claims Spending by Category

Non-claims payments are payments that payers make to providers outside of claims. Statewide, the largest category of non-claims spending by far was prospective payments (i.e., non-claims-based payments for services delivered under capitation payments, global budget payments, case rate payments, and prospective episode-based payments). These prospective payments grew from $859.9 million in 2021 to $1.17 billion in 2024, growing at 10 to 12 percent each year.

Non-Claims Spending by Category, Statewide (in millions)



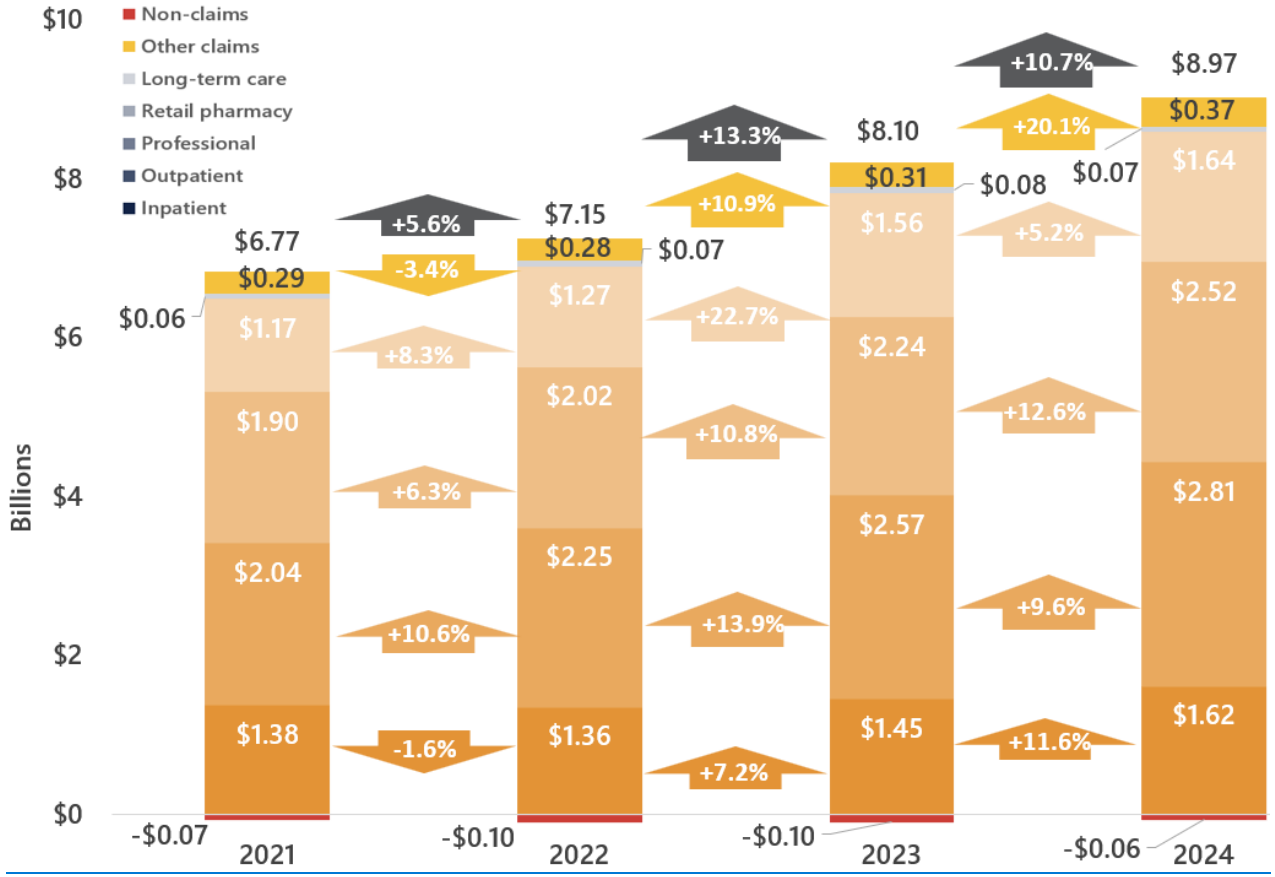
Recovery (i.e., payments recouped due to a review, audit, or investigation) was the second-largest category of non-claims spending, hovering around negative $100 to $130 million annually from 2021 to 2024.

The third-largest non-claims spending category – performance incentive payments – represents a small fraction of healthcare spending, with around $50 million in 2021 and 2022 and only about $32 million in 2023 and 2024.

Payments to support population health and practice infrastructure were only a few million dollars each year and were included in the Other non-claims category.

TME by Market by Category
Commercial TME by Category

Commercial TME by Category (in billions)



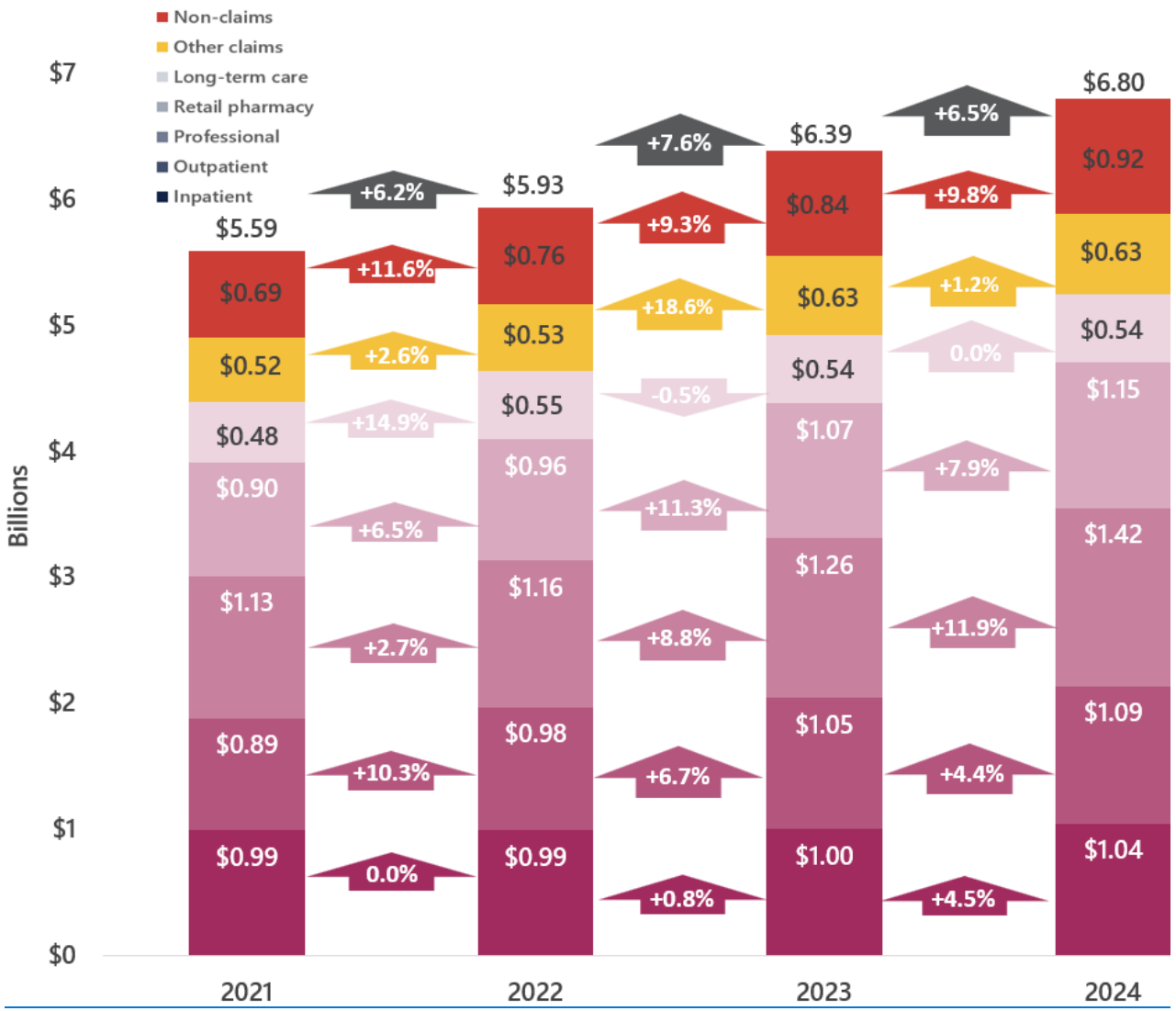
Compared to growth in overall commercial TME:

- Retail pharmacy and outpatient spending grew faster from 2021 to 2023 but slower from 2023 to 2024.
- Inpatient spending grew much slower from 2021 to 2023 but slightly faster from 2023 to 2024.
- Professional spending grew at a similar rate, comprising about 28.1% of commercial TME in both 2021 and 2024

As a result of differential growth rates by category, compared with 2021, inpatient spending accounted for about 2% less of Commercial TME in 2024 and outpatient spending and retail pharmacy spending each accounted for about 1% more of Commercial TME.

Medicare TME by Category

Medicare TME by Category (in billions)



Compared to growth in Medicare TME from 2021 to 2024:

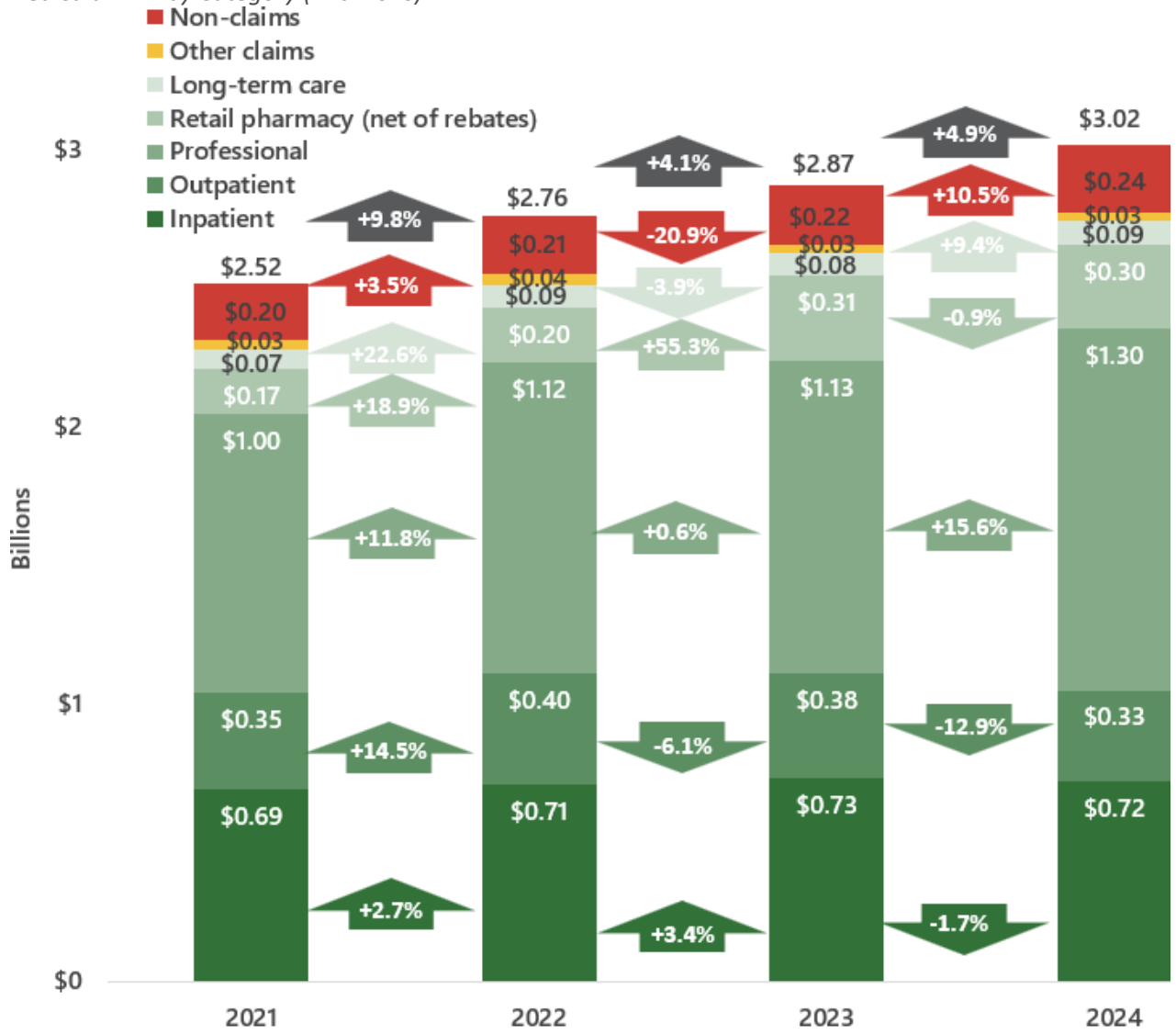
- non-claims spending grew much faster
- professional services and retail pharmacy spending grew faster from 2022 to 2024
- inpatient spending grew much more slowly, especially from 2021 to 2023.

Due to differential growth rates by category from 2021 to 2024:

- Inpatient spending decreased from 17.7% to 15.3% of Medicare TME
- Non-claims spending increased from 12.3% to 13.5% of Medicare TME
- Retail pharmacy spending increased from 16.1% to 17.0% of Medicaid TME

Medicaid TME by Category

Medicaid TME by Category (in billions)



Compared to growth in Medicaid TME from 2021 to 2024:

- Inpatient spending grew much more slowly
- Outpatient spending grew more rapidly from 2021 to 2022 but then decreased sharply from 2022 to 2024
- Professional services spending grew significantly faster from 2023 to 2024
- Retail pharmacy spending grew faster from 2021 to 2023 but then decreased slightly from 2023 to 2024

Due to differential growth rates by category from 2021 to 2024:

- Inpatient spending decreased from 27.4% to 23.9% of Medicaid TME
- Outpatient spending decreased from 14.0% to 10.9% of Medicaid TME
- Professional spending increased from 39.8% to 43.2% of Medicaid TME
- Retail pharmacy spending increased from 6.6% to 10.1% of Medicaid TME

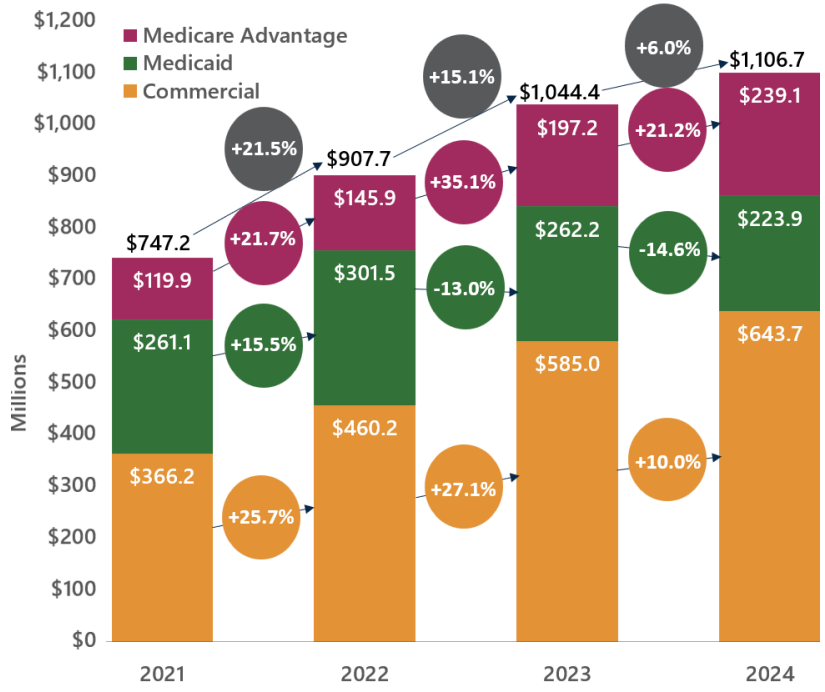
Pharmacy Rebates by Market

Pharmacy rebates grew rapidly from $747.2 million in 2021 to $1.04 billion in 2023 but grew less steeply to $1.11 billion in 2024. Commercial and Medicare Advantage pharmacy rebates grew more rapidly than Medicaid pharmacy rebates from 2021 to 2024. Medicaid pharmacy rebates grew 15.5% from 2021 to 2022 but decreased by a similar degree in the following two years, resulting in 2024 pharmacy rebates being about 15% lower than 2021 levels. Please note that Medicare FFS pharmacy rebates are omitted because they were not reported.

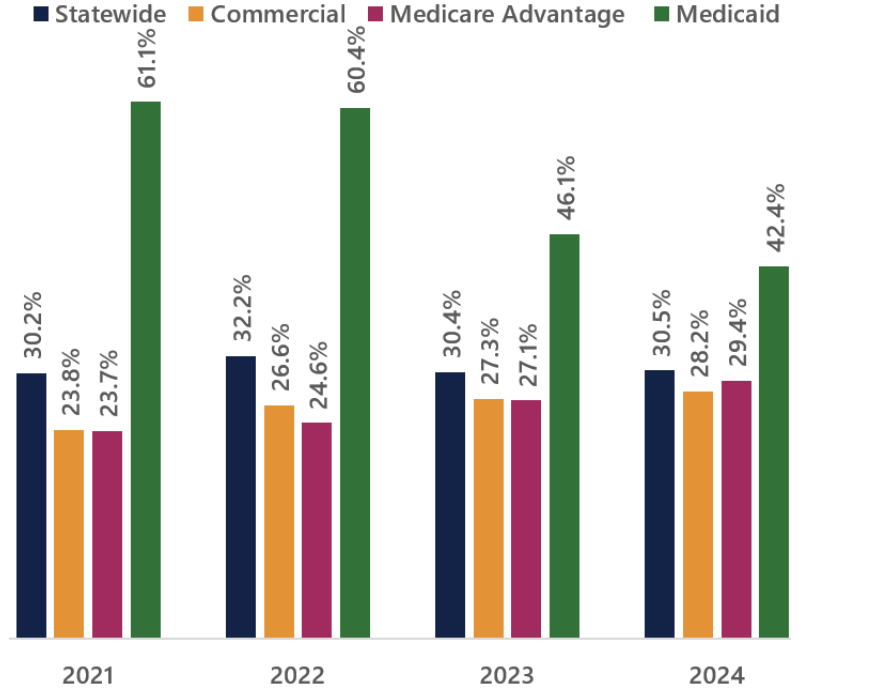
Statewide from 2021 to 2024 about 30 to 32 percent of spending for retail pharmacy was returned to payers and pharmacy benefit managers (PBMs) through rebates. Medicaid recouped a substantially higher percentage of prescription drug costs than commercial and Medicare Advantage due to federal and state policies that ensure that Medicaid gets the lowest available price for pharmaceuticals; however, the pharmacy rebate differential across markets decreased in 2023 and 2024.

Increases in gross pharmacy spending was a driver of increases in statewide pharmacy rebates. However, for Medicaid, decreases in rebate percentages largely explain the lower levels of pharmacy rebates in 2023 and 2024. For commercial and Medicare Advantage, increases in pharmacy rebate percentages (from 23.8% to 28.2% for commercial, from 23.7% to 29.4% for Medicaid Advantage) do partly explain increases in commercial and Medicare Advantage pharmacy rebates from 2021 to 2024.

Pharmacy Rebates by Market, Statewide (in billions)



Pharmacy Rebate Percent of Gross Retail Pharmacy Spending, by Market

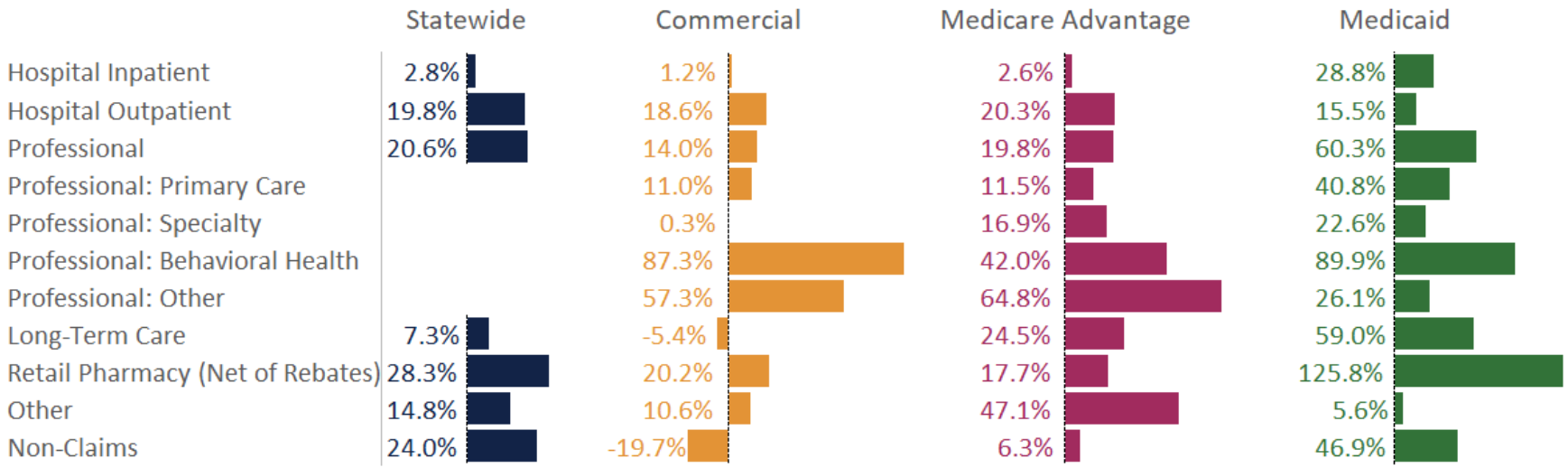


Percentage Change in TME by Category and by Market, 2021-2024

The previous pages included breakdowns of aggregate spending by category for each market. TME are reported below on a PMPY basis to provide a standardized comparison across markets and service categories.

TME PMPY increased by 17.2% from 2021 to 2024 statewide, driven by increases in spending on retail pharmacy after accounting for rebates, professional services spending, and hospital outpatient services across markets. Professional behavioral health spending grew particularly rapidly across markets (+87.3% for commercial, +42.0% for Medicare Advantage, +89.9% for Medicaid). Hospital inpatient PMPY spending only increased by 2.8% statewide, but did increase by 28.8% for Medicaid.

Cumulative Change in TME PMPY from 2021 to 2024 by Market and Category



Note: Statewide professional spending by subcategory is not available because Medicare FFS data included only a professional spending category without any subcategories.

From 2021 to 2024, statewide PMPY spending growth was concentrated in three of the four largest service categories: professional (+$396.69), hospital outpatient (+$310.75), and retail pharmacy (+$303.47). Hospital inpatient spending increased slightly statewide (+$40.79), but drastically for Medicaid (+$503.77). Retail pharmacy spending PMPY grew steadily across markets and particularly steeply for the Medicare Advantage market (+$419.08) and Medicaid (+$531.08). Statewide hospital outpatient PMPY spending growth was the only major spending category for which Medicaid PMPY growth (+$138.76) was slower than commercial (+$293.13) and Medicare Advantage (+369.95). Statewide professional PMPY spending growth (+$369.69) was heavily driven by the Medicaid (+1,534.15) and Medicare Advantage (+407.79) markets. Growth in Medicaid PMPY professional spending (+$1,534.15) was heavily driven by increases in behavioral health spending (+$1,207.70). Non-claims spending PMPY grew substantially for Medicare Advantage (+$263.02) and Medicaid (+$242.72) but minimally for commercial (+$9.95).

Change in TME PMPY by Market and Category, 2021 to 2024

	Statewide	Commercial	Medicare Advantage	Medicaid
Hospital Inpatient	$40.79	$13.21	$45.62	$503.77
Hospital Outpatient	$310.75	$293.13	$369.95	$138.76
Professional	$396.69	$206.60	$407.79	$1,534.15
Professional: Primary Care		$40.54	$46.79	$117.97
Professional: Specialty		$2.19	$246.28	$188.17
Professional: Behavioral Health		$94.22	$31.00	$1,207.70
Professional: Other		$69.65	$83.72	$20.31
Long-Term Care	$21.13	-$2.56	$186.79	$103.92
Retail Pharmacy (Net of Rebates)	$303.47	$183.39	$419.08	$531.08
Other	$58.89	$23.55	$162.65	$4.61
Non-Claims	$94.48	$9.95	$263.02	$242.72

From 2021 to 2022, statewide PMPY spending growth was concentrated in three of the four largest service categories: professional (+$41.76), hospital outpatient (+$97.59), and retail pharmacy (+$40.80). Hospital inpatient spending decreased statewide (-$63.16), minimally for Medicare Advantage (-$0.51) but drastically for Medicaid (-$119.24). Retail pharmacy spending PMPY grew steadily across markets and particularly steeply for the Medicare Advantage market (+$172.01). Growth in Medicaid TME PMPY professional spending (+$37.24) was driven by increases in behavioral health spending (+$48.10). Non-claims spending PMPY grew substantially for Medicare Advantage (+$140.23) but decreased slightly for commercial (-$21.44) and Medicaid (-$31.06).

Change in TME PMPY by Market and Category, 2021 to 2022

	Statewide	Commercial	Medicare Advantage	Medicaid
Hospital Inpatient	-$63.16	-$51.95	-$0.51	-$119.24
Hospital Outpatient	$97.59	$108.05	$180.20	$34.93
Professional	$41.76	$40.54	$33.32	$37.24
Professional: Primary Care		$5.31	$18.94	$18.34
Professional: Specialty		$9.42	$14.27	-$19.48
Professional: Behavioral Health		$22.29	-$1.48	$48.10
Professional: Other		$3.52	$1.59	-$9.73
Long-Term Care	$31.35	$4.92	$124.83	$19.94
Retail Pharmacy (Net of Rebates)	$40.80	$42.39	$172.01	$33.50
Other	-$13.43	-$14.79	$41.38	$1.66
Non-Claims	$9.02	-$21.44	$140.23	-$31.06

From 2022 to 2023, statewide PMPY spending growth was concentrated in three of the four largest service categories: professional (+$68.37), hospital outpatient (+$91.24), and retail pharmacy (+$179.96). Hospital inpatient spending increased slightly statewide (+$3.40), but substantially for Medicaid (+$141.33). Retail pharmacy spending PMPY grew steadily across markets and particularly steeply for the Medicare Advantage market (+$222.59) and Medicaid (+$287.62). Growth in Medicaid PMPY professional spending (+$147.05) was driven by increases in behavioral health spending (+$142.07).

Change in TME PMPY by Market and Category, 2022 to 2023

	Statewide	Commercial	Medicare Advantage	Medicaid
Hospital Inpatient	$3.40	-$3.01	$25.01	$141.33
Hospital Outpatient	$91.24	$99.11	$146.38	-$12.77
Professional	$68.37	$45.98	$148.47	$147.05
Professional: Primary Care		$15.62	$21.72	$24.76
Professional: Specialty		-$45.07	$72.42	-$24.10
Professional: Behavioral Health		$37.34	$5.43	$142.07
Professional: Other		$38.09	$48.90	$4.31
Long-Term Care	-$11.90	$1.18	$17.17	$1.87
Retail Pharmacy (Net of Rebates)	$179.96	$133.84	$222.59	$287.62
Other	$38.42	$6.40	$44.50	-$14.09
Non-Claims	$18.98	$3.91	$24.82	$45.38

From 2023 to 2024, increases in professional spending (+$286.56) was the largest driver of statewide PMPY spending growth. Increased spending on hospital outpatient (+$121.92), hospital inpatient (+$100.56), retail pharmacy (+$82.71), and non-claims (+$66.48) also had notable impacts on statewide TME PMPY growth. Growth in retail pharmacy spending PMPY was much more pronounced for Medicaid (+$209.96) than Medicare Advantage (+$24.49) or commercial (+$7.15). Growth in hospital inpatient spending was much more pronounced for Medicaid (+$481.68) than commercial (+$68.18) and Medicare Advantage (+$21.12). Growth in Medicaid PMPY professional spending (+$1,349.87) was driven by increases in behavioral health spending (+$1,017.53). Growth in Medicare Advantage professional spending (+$226.00) was driven by increases in professional specialty spending (+$159.59).

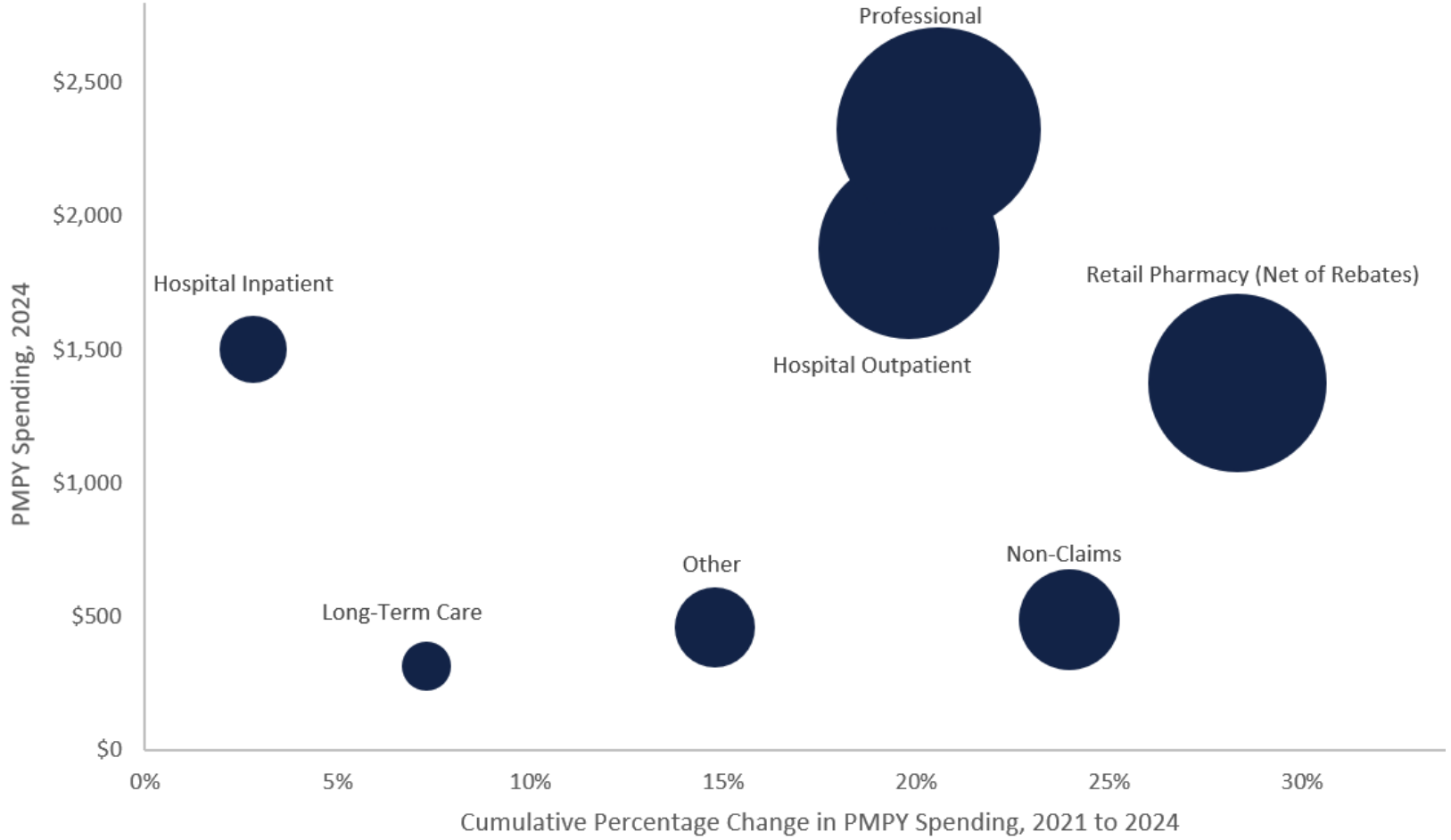
Change in TME PMPY by Market and Category, 2023 to 2024

	Statewide	Commercial	Medicare Advantage	Medicaid
Hospital Inpatient	$100.56	$68.18	$21.12	$481.68
Hospital Outpatient	$121.92	$85.97	$43.37	$116.61
Professional	$286.56	$120.08	$226.00	$1,349.87
Professional: Primary Care		$19.61	$6.13	$74.87
Professional: Specialty		$37.84	$159.59	$231.75
Professional: Behavioral Health		$34.59	$27.05	$1,017.53
Professional: Other		$28.05	$33.23	$25.72
Long-Term Care	$1.68	-$8.66	$44.80	$82.11
Retail Pharmacy (Net of Rebates)	$82.71	$7.15	$24.49	$209.96
Other	$33.91	$31.93	$76.77	$17.04
Non-Claims	$66.48	$27.48	$97.97	$228.40

TME – Cumulative Change in PMPY Spending by Category and by Market, 2021-2024

Statewide Cumulative Change in Spending PMPY from 2021 to 2024 by Category and 2024 PMPY Spending by Category

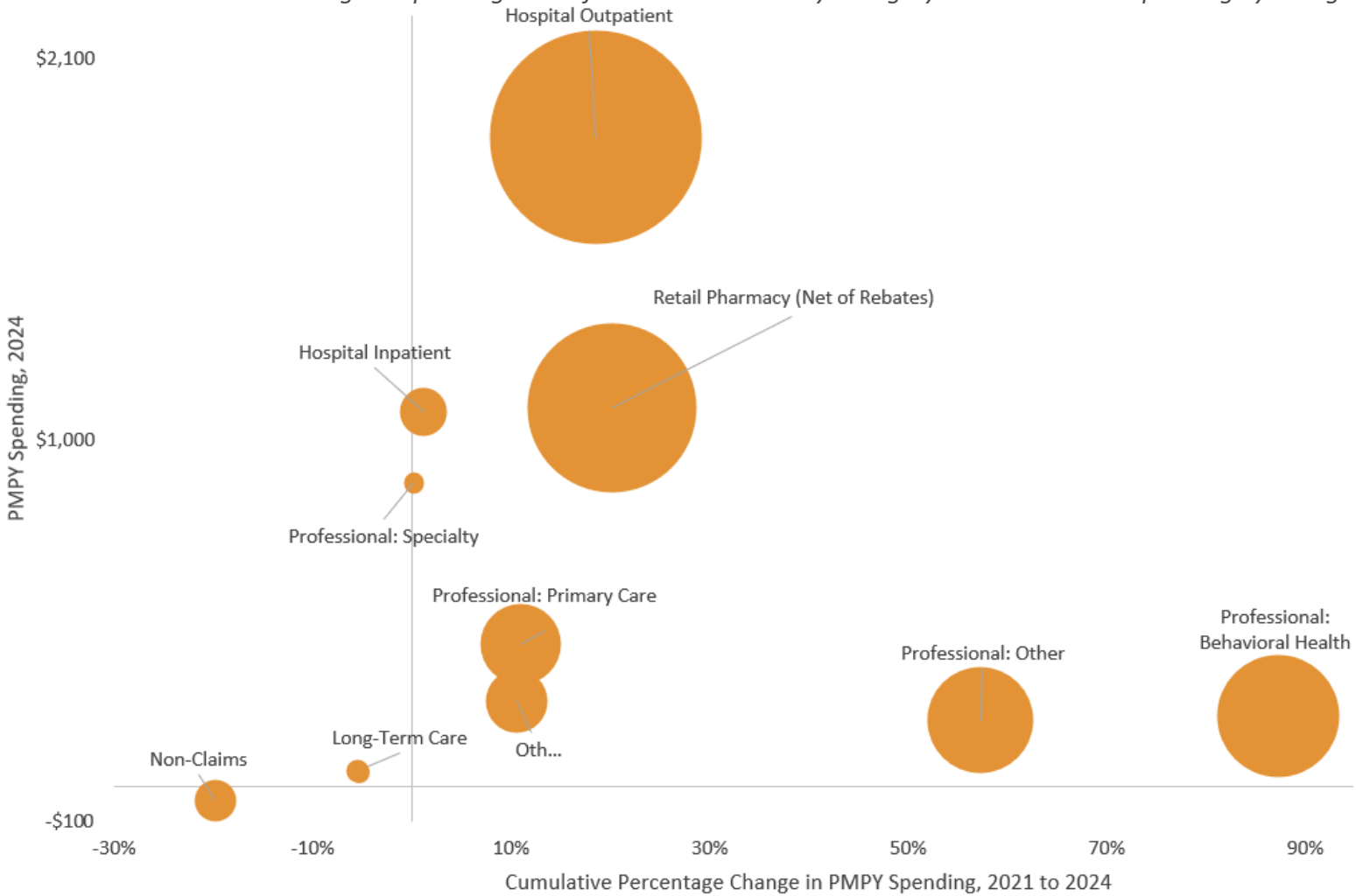
Relatively large PMPY increases in professional services spending (+20.6%, +$396.69 PMPY), hospital outpatient spending (+19.8%, $310.75), and retail pharmacy spending (+28.3%, $303.47) explain a large portion of the 17.2% growth in statewide TME PMPY from 2021 to 2024. Hospital inpatient spending statewide only increased by 2.8% (+$40.79 PMPY).



Note: Larger bubbles indicate larger absolute dollar change in PMPY spending for category.

From 2021 to 2024, large PMPY increases in hospital outpatient (18.6%, +$293.13 PMPY), retail pharmacy (+20.2%, +$183.39 PMPY), and behavioral health spending (+87.3%, +$94.22 PMPY) drove commercial TME PMPY growth of 13.9%. Commercial hospital inpatient spending PMPY increased by 1.2% from 2021 to 2024 (+$13.21 PMPY).

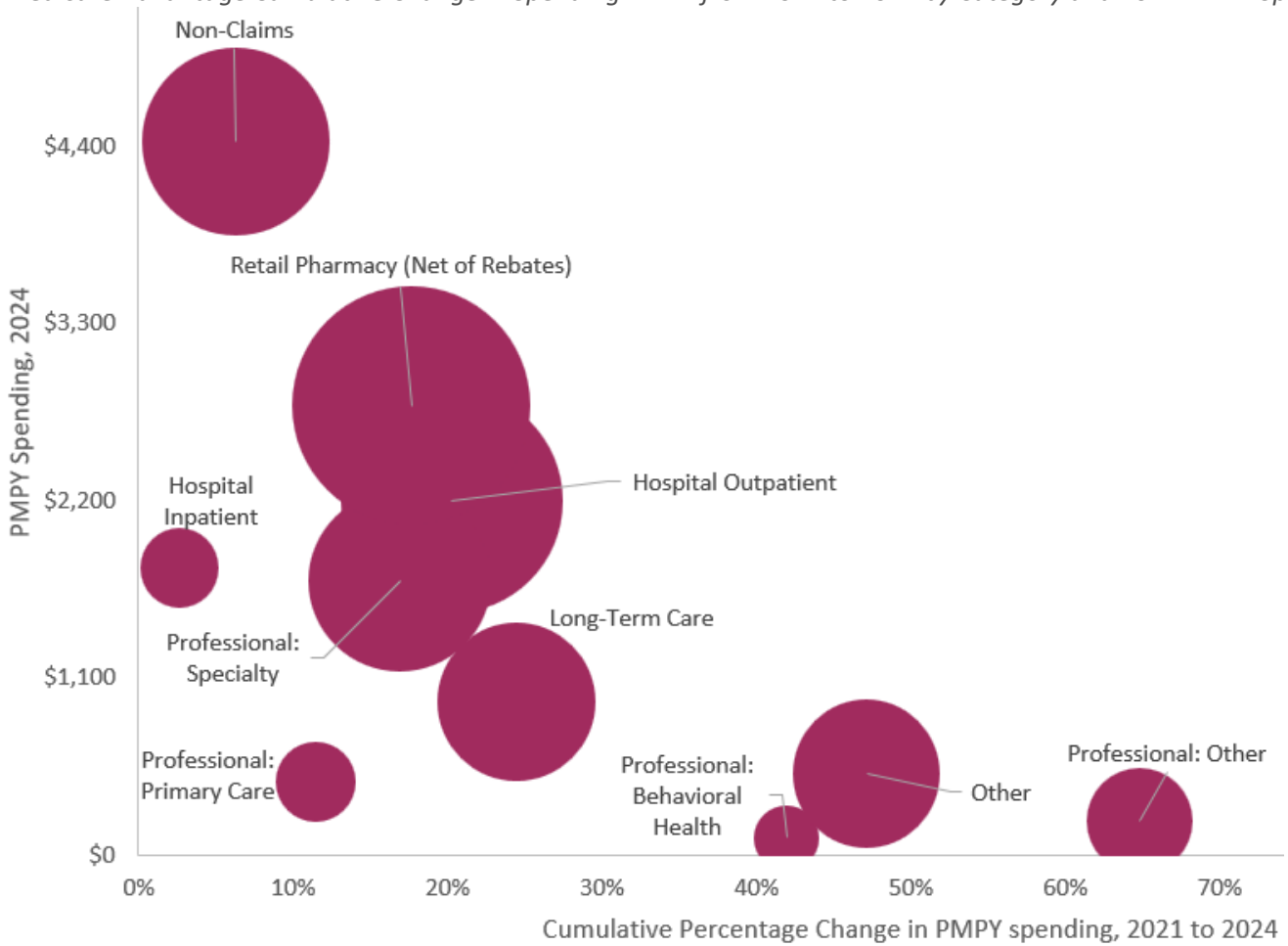
Commercial Cumulative Change in Spending PMPY from 2021 to 2024 by Category and 2024 PMPY Spending by Category



Note: Larger bubbles indicate larger absolute dollar change in PMPY spending for category.

Medicare Advantage TME PMPY growth of 14.0% from 2021 to 2024 was predominately driven by increases in retail pharmacy spending (+17.7%, +$419.08 PMPY), , outpatient spending (+20.3%, +$369.95 PMPY), professional specialty spending (+16.9%, +$246.28 PMPY), and long-term care spending (+24.5%, +$186.79). Non-claims spending grew substantially (+$263.02 PMPY) but grew slower (+6.3%) than other spending categories, putting downward pressure on Medicare Advantage TME PMPY growth. Medicare Advantage behavioral health spending PMPY grew 42.0% from 2021 to 2024 but had only a moderate impact on Medicare Advantage TME PMPY growth (+$31.00 PMPY) because of low baseline behavioral health spending in 2021 compared to other service categories.

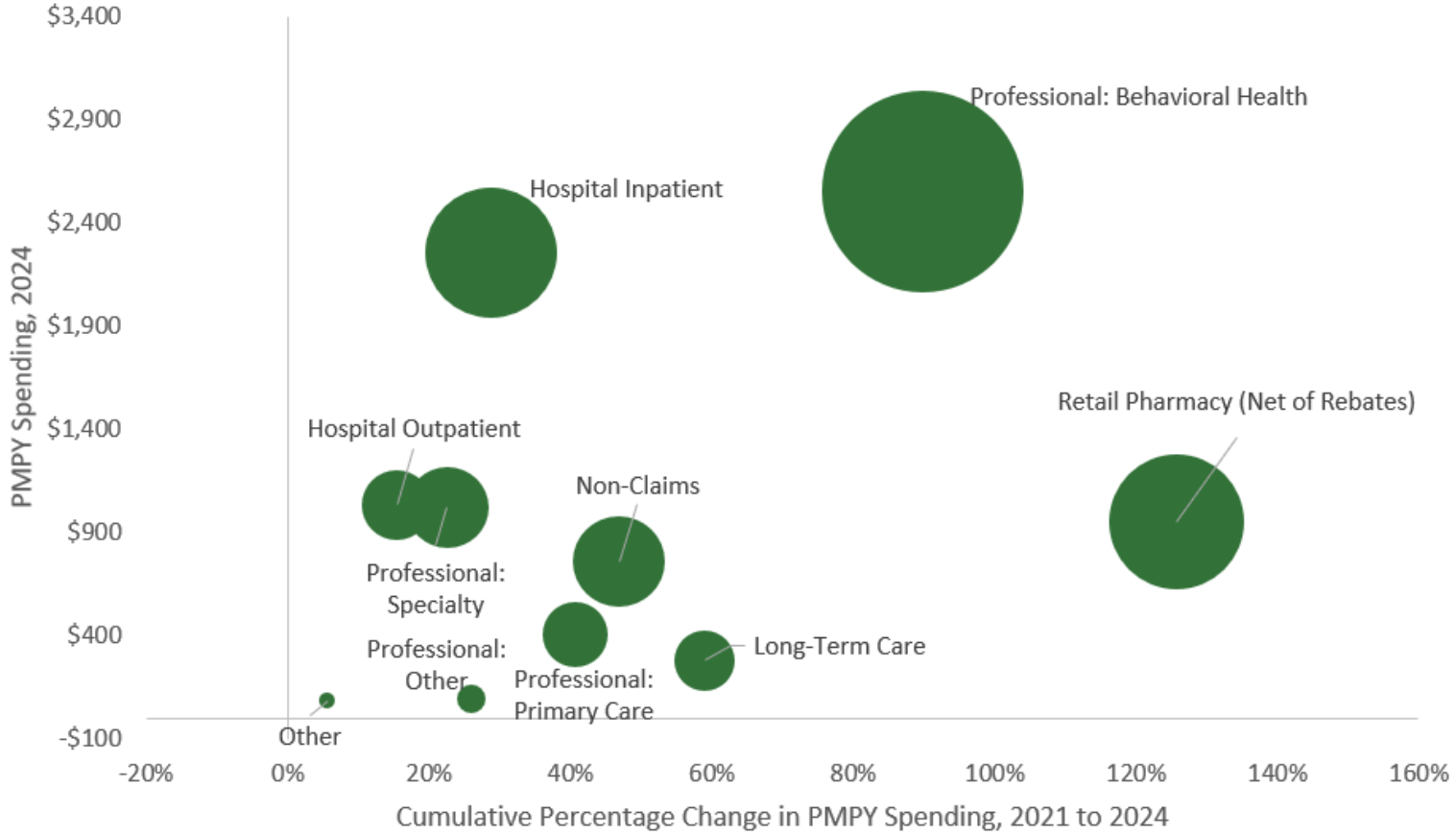
Medicare Advantage Cumulative Change in Spending PMPY from 2021 to 2024 by Category and 2024 PMPY Spending by Category



Note: Larger bubbles indicate larger absolute dollar change in PMPY spending for category.

From 2021 to 2024, large increases in behavioral health spending (+$1,207.70 PMPY), retail pharmacy (+125.8%, +$531.08), inpatient spending (+28.8%, +$503.77), and non-claims spending (+46.9%, $242.72 PMPY) drove Medicaid TME PMPY growth of 47.9%. Medicaid hospital outpatient increased less rapidly (+15.5%) than the other spending categories.

Medicaid Cumulative Change in Spending PMPY from 2021 to 2024 by Category and 2024 PMPY Spending by Category



Note: Larger bubbles indicate larger absolute dollar change in PMPY spending for category.

Appendix

Data Sources

Eleven payers participating in the Utah Healthcare Spending Growth Measurement Initiative submitted THCE data for calendar years 2021 to 2024 to the Collaborative in Fall of 2024 and Fall of 2025.

Payers Who Submitted Data by Market

	Market				
Payer	Commercial	Medicaid ACO	Medicaid FFS	Medicare Advantage	Medicare FFS
Aetna	X			X	
Cigna Health and Life Insurance Co.	X				
Centers for Medicare & Medicaid Services					X
Health Choice Utah		X		X	
Molina Healthcare of Utah	X	X		X	
Public Employee Health Plan	X				
Regence BlueCross BlueShield of Utah	X			X	
Select Health	X	X		X	
UnitedHealthcare	X			X	
University of Utah Health Plans	X	X		X	
Utah Medicaid		X	X		

The Collaborative compiled data to calculate the Net Cost of Private Health Insurance from the CMS MLR resources website and National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) reports.

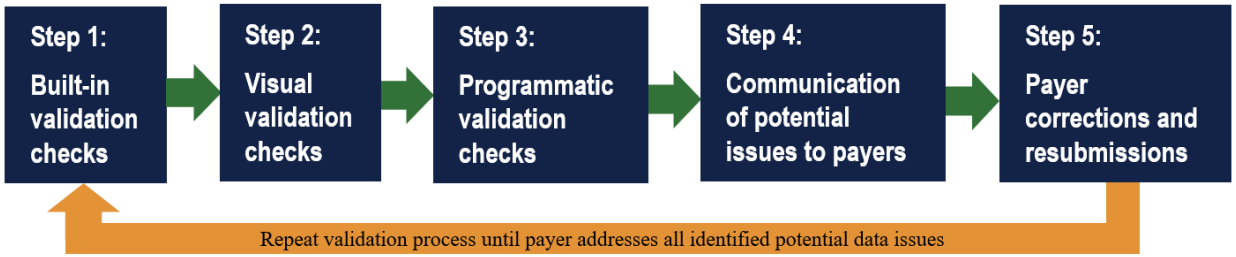
Components of THCE by Data Source

Component	Category	Data Source
TME	Payer claims payments, non-claims payments, and enrollment for commercial, Medicaid ACOs, and MA	Payer data submissions
	Payer pharmacy rebates	Payer data submissions
	Medicare FFS claims payments and enrollment, Part D spending	CMS
	Medicaid FFS claims payments and enrollment	Utah Medicaid
NCPHI	NCPHI for commercial fully insured market	Federal commercial MLR reports; SHCE for payers without MLR report
	NCPHI for MA and Medicaid ACOs	SHCE
	Income from fees of uninsured plans	Payer data submissions: SEC 10-k filings if omitted from payer data submission
	Enrollment for commercial, Medicaid ACOs, and MA	Payer data submissions

Data Validation

The Collaborative and consultant Mathematica conducted a rigorous data validation process to confirm that aggregate payer data conformed to expectations.

Data Validation Process



Step 1: Built-in validation checks. The Excel data collection template payers used for data submissions contained built-in validation checks that enabled payers to validate their data before submission. The built-in validation checks included highlighting cells with unexpected values (e.g., negative values that should be positive values) and identifying internal inconsistencies in TME, member months, and demographic scores across the various levels of data payers submit.

Step 2: Visual validation checks. Each payer data submission was visually inspected for potential issues. If visual inspection uncovered potential issues, the Collaborative communicated the potential issue(s) to the payer and asked the payer to address the issue(s) and resubmit a corrected file.

Step 3: Programmatic validation checks. After a payer data submission passed visual inspection, each payer's data submission was run through a Python validation program to programmatically identify any incompleteness or unreasonable values falling outside of anticipated ranges.

Step 4: Communication of potential issues to payers. The Collaborative and Mathematica met with payers to discuss a validation report outlining potential issues with data completeness and reasonableness identified during visual and programmatic validation. Payers resolved each potential issue by either providing an explanation (e.g., large demographic change in patient population explains large annual increase) or making a correction.

Step 5: Payer corrections and resubmissions. The Collaborative and Mathematica implemented the validation process for each corrected and resubmitted payer data file. A payer's data file was deemed acceptable after all potential issues were addressed.

Market-Specific Notes

Payers reported all claims and non-claims payments in three major markets: commercial, Medicare, and Medicaid.

Commercial: includes individual, large group, small group, self-insured, short-term, and student plans. The commercial data in this report includes fully-insured and for self-insured plans, but not all self-insured spending.

Medicare: includes both Medicare Advantage and traditional Medicare fee-for-service (FFS). The Medicare data at the statewide level include both commercial Medicare Advantage plans (Part C) and Medicare fee-for-service (A, B, D). Medicare FFS data included only a professional spending category without any subcategories.

Medicaid: includes Medicaid fee-for-service (FFS) and Medicaid Accountable Care Organization (ACO). Payers submitted Medicaid ACO expenses separately for integrated members and non-integrated members.

Dual-Eligible Members: At the statewide level, THCE data for people dually enrolled in Medicare and Medicaid are reported in the Medicare market. For TME data reporting, Medicare expenses and Medicaid expenses reported for Medicare/Medicaid dual-eligible beneficiaries are reported using Paid Amounts regardless of whether the payer is the primary or secondary payer.

Limitations and Considerations

The following are limitations to the reported measurements of healthcare spending in Utah and considerations to understand when examining the Utah healthcare spending results included in this report:

1) Statewide professional spending by subcategory is not available because Medicare FFS data included only a professional spending category without any subcategories.
2) Medicare FFS was excluded from pharmacy rebate findings because Medicare FFS pharmacy rebate data were not available.

Glossary of Definitions

Allowed Amounts: the maximum allowed charge for a covered benefit, which includes both the amount paid by the insurer to the provider and the patient liability owed directly to the provider, regardless of whether the patient actually paid the owed amount; this is also known as the negotiated rate or the contract rate. The full allowed amount is reported, regardless of whether stop loss/reinsurance policies are applied. The allowed amount is not necessarily the sum of what the provider organization is paid.

Claims Payments: all the allowed amounts on provider claims to payers, including the amount payers paid to providers and any member cost sharing, including copayments, deductibles, and co-insurance.

Cost Sharing: includes patient liability, such as copayments, deductibles, and coinsurance payments recorded by payers.

Market: the highest levels of categorization of the health insurance market. For example, traditional Medicare and Medicare Advantage are collectively referred to as the "Medicare market" and Medicaid Fee-for-Service and Medicaid ACO are collectively referred to as the "Medicaid market." Individual, self-insured, small and large group, and student health insurance plans are collectively referred to as the "commercial market."

Net Cost of Private Health Insurance (NCPHI): captures the cost to Utah residents associated with the administration of private health insurance. It is the difference between health premiums earned and claims paid. It consists of payers' costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes payers' profits (contribution to margin) or losses.

Non-Claims Payments: all payments that payers make to providers other than providers' claims. This includes incentive payments, prospective payments for healthcare services (e.g., capitation), payments that support care transformation and infrastructure (e.g., care manager payments, lump sum investments, patient-centered primary care home payments), and other payments that support provider services.

Paid Amounts: the actual dollar amount paid by the insurer to the provider.

Payer: a public or private organization or entity that offers one or more of the following: commercial insurance, benefit administration for self-insured employers, Medicaid, and/or Medicare.

Pharmacy Rebates: any rebates from pharmaceutical manufacturers to payers for prescription drugs, excluding manufacturer-provided fair market value bona fide service fees. TME is reported net of pharmacy rebates.

Total Healthcare Expenditures (THCE): the total medical expense incurred by Utah residents for all healthcare services for all payers reporting data, plus the payers' NCPHI.

Total Medical Expense (TME): the sum of the allowed amount of total claims and total non-claims spending paid to providers for all healthcare services delivered to Utah residents. TME is measured net of pharmacy rebates. Only allowed amounts from final, paid claims are included; TME excludes claims that have been denied or are in an adjudication process.

Claims Spending Categories

Hospital Services	
Inpatient Care	This service category includes: • all room and board and ancillary payments for all hospital types • both medical and behavioral hospitalizations • payments for emergency room services when the member is admitted to the hospital in accordance with the specific payer's payment rules This service category does not include: • payments made for observation services • payments made for physician services provided during an inpatient stay that have been billed directly by a physician group practice or an individual physician • inpatient services at non-hospital facilities (e.g., residential treatment facilities)
Outpatient Care	This service category includes: • all hospital types and payments made for hospital-licensed satellite clinics • emergency room services not resulting in admittance • observation services This service category does not include: • payments made for physician services provided on an outpatient basis that have been billed directly by a physician group practice or an individual physician
Professional Services	
Primary Care	This service category includes claims paid to healthcare providers that are defined as a primary care provider (including but not limited to: Doctor of Medicine or osteopathy in family medicine, internal medicine, general medicine, pediatric medicine, nurse practitioners, and physician assistants).
Specialty Care	This service category includes claims for services provided by Doctor of Medicine or osteopathy working in clinical areas other than family medicine, internal medicine, general medicine, or pediatric medicine, not defined as primary care (see above).
Behavioral Health	This service category includes claims for services provided by behavioral health providers, including, but not limited to: physician—addiction specialist, physician – psychiatrist, community mental health center, certified community behavioral health clinic, counselor (including LMHC and LADC), early intervention agency, licensed social worker, local education agency, marriage and family therapist, peer recovery specialist, nurse practitioner (psychiatric), psychiatric rehabilitation practitioners, psychologist, registered behavior technician, and single specialty group.
Other	This service category includes claims for services provided by licensed practitioners other than a physician but not identified as primary care, specialist, or behavioral health above. This includes but is not limited to: licensed podiatrists,

	non-primary care nurse practitioners, non-primary care physician assistants, physical therapists, occupational therapists, speech therapists, dieticians, dentists, chiropractors, and any other professional claims that do not fit other categories.
Retail Pharmacy	
This service category includes claims for prescription drugs, biological products, and vaccines as defined by the payer's prescription drug benefit. Pharmacy spending provided under the medical benefit should be attributed to the location in which it was delivered (e.g., pharmaceuticals delivered in a hospital inpatient setting should be included in the Hospital Inpatient service category).	
Other	
Long-Term Care	This service category includes claims for: • nursing homes and skilled nursing facilities (SNFs) • intermediate care facilities for individuals with intellectual disabilities (ICF/ID) and assisted living facilities • providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, eating), homemaker and chore services, home-delivered meal programs, home health services, adult day care, self-directed personal assistance services (e.g., assistance with grocery shopping), and programs designed to assist individuals with long-term care needs who receive care in their home and community, such as PACE This service category does not include: • payments made for professional services rendered during a facility stay that have been billed directly by a physician group practice or an individual practitioner
All Other	This service category includes claims for all other services not mentioned above, including but not limited to: • durable medical equipment (DME) • freestanding diagnostic facility services • hospice • hearing aid services • optical services • transportation • facility fees for community health center services • facility fees for non-hospital-owned ambulatory surgical center services

Non-Claims Spending Categories

Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments
All non-claims-based payments for services delivered under the following payment arrangements: • capitation payments, i.e., single payments to providers to provide healthcare services over a defined period of time • global budget payments, i.e., prospective payments made to providers for a comprehensive set of services for a broadly defined population or a defined set of services where certain benefits (e.g., behavioral health, pharmacy) are carved out • case rate payments, i.e., prospective payments made to providers in a given provider organization for a patient receiving a defined set of services for a specific period of time • prospective episode-based payments, i.e., payments received by providers (which can span multiple provider organizations) for a patient receiving a defined set of services for a specific condition across a continuum of care, or care for a specific condition over a specific time period.
Performance Incentive Payments
All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, i.e., payments to reward providers for achieving a set target, and pay-for-reporting, i.e., payments to providers for reporting on a set of metrics, usually to build capacity for pay-for-performance payments. Includes shared savings distributions, i.e., payments received by providers if costs of services are below a set target, and shared risk recoupments (i.e., payments providers must recoup if costs of services are above a set target).
Payments to Support Population Health and Practice Infrastructure
All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality, and control costs. This category includes but is not limited to payments that support care management, care coordination, and population; data analytics; EHR/HIT infrastructure payments; medication reconciliation; patient-centered medical home (PCMH) recognition payments; and primary care and behavioral health integration that are not reimbursable through claims.
Provider Salaries
All payments for salaries of providers who provide healthcare services not otherwise included in other claims and non-claims categories. This category is typically applicable only to closed delivery systems.
Recovery
All payments received from a provider, member/beneficiary, or other payer, which were distributed by a payer and then later recouped due to a review, audit, or investigation. This can also include infrastructure payments that are recouped under total cost of care arrangements if a provider does not generate savings.
Other
All other payments made pursuant to the insurer's contract with a provider not made based on a claim for healthcare benefits/services and cannot be properly classified elsewhere. This may include governmental payer shortfall payments, grants, or other surplus payments.