Health Care Cost Growth Trends in Oregon, 2020-2021

2023 Sustainable Health Care Cost Growth Target Annual Report

May 9, 2023

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET

Oregon's Sustainable Health Care Cost Growth Target Program

In 2019, the Oregon Legislature established the Sustainable Health Care Cost Growth Target Program, which sets a statewide target for the annual per person growth rate of total health care spending in the state. The cost growth target helps ensure that health care costs are not growing faster than wages, inflation, and other economic indicators so that people continue to have access to high quality, affordable care. This program is the culmination of years of collaboration with multiple health system partners and legislators to address the rising cost of health care.

Cost Growth Target Program Annual Cycle

Each year, the program will measure, analyze, and publicly report on total health care spending and spending growth statewide.

These reports, along with public hearings, engage a variety of policymakers, health system partners, and others in efforts to control rising health care costs.

Visit the Cost Growth Target website for more information.

Executive Summary

This report presents data on health care spending and health care cost growth in Oregon from 2020 to 2021. This report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2020 and 2021.

This is the first cost growth report that includes cost growth for individual payers and provider organizations.

Every year, Oregon's Sustainable Health Care Cost Growth Target Program collects data from payers and other sources to provide this comprehensive view into health care spending and spending growth.

By identifying drivers of health care cost growth in Oregon, this report sets the stage for policymakers, health system partners, and other stakeholders to identify opportunities and strategies to slow cost growth and address growing affordability concerns across public and private markets.

HEALTH CARE COST GROWTH TARGET

Click the icon to explore the Cost Growth Target 2020-2021 Databook

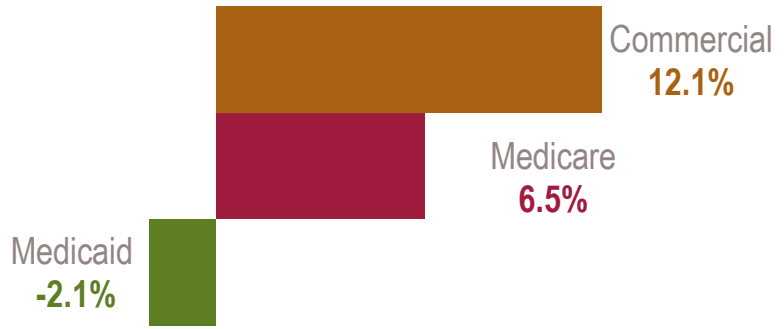
Key Findings

In 2021, total health care spending in Oregon totaled $31.07 billion dollars.

On a per person per year basis, Total Health Care Expenditures increased 3.5% between 2020-2021, just above the cost growth target of 3.4%.

Cost growth for the commercial market was 12.1%, compared to 6.5% for Medicare and -2.1% for Medicaid.

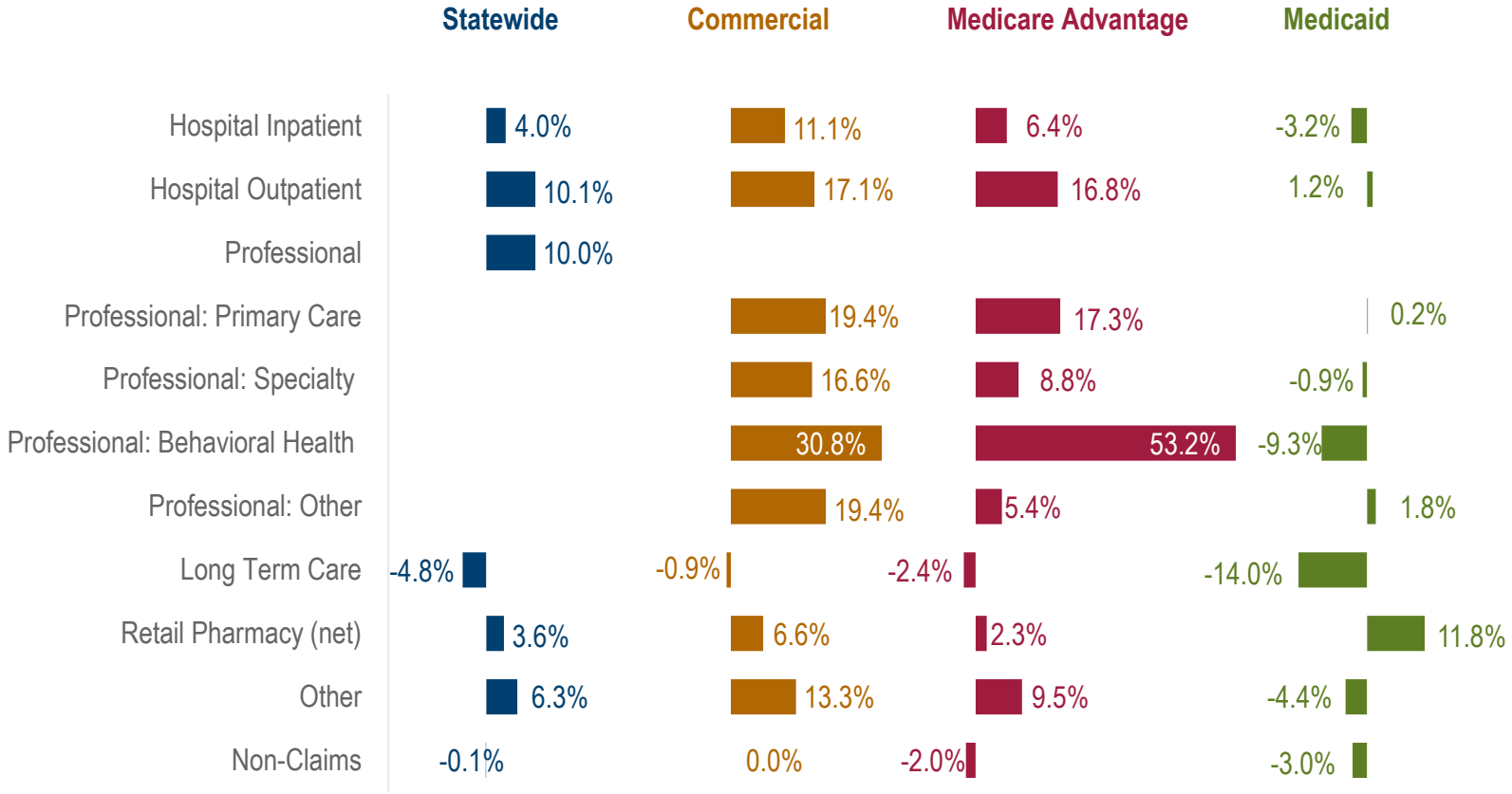
Percent change in total health care expenditures, by market, 2020-2021



Key Findings

Total Medical Expenses increased by 5.6% on a per person per year basis. Primary cost drivers include increase in hospital outpatient and professional services utilization, as people resumed care they may have delayed in the first part of the COVID-19 pandemic. Retail pharmacy also continued to grow in all markets, even after pharmacy rebates were taken into account.

Total Medical Expenses Spending by Service Category, Statewide and by Market (unadjusted)



29 payers were included in cost growth target reporting for 2020-21.

Overall cost growth for payers was 4.7%.

Cost growth for commercial payers was 11.5%, compared to 6.0% for Medicare Advantage payers. Medicaid payers had the lowest overall cost growth at -3.0%.

Of the 29 payers, 11 met the target for at least one market. Seven commercial payers and eight Medicare Advantage payers exceeded the target with statistical certainty.

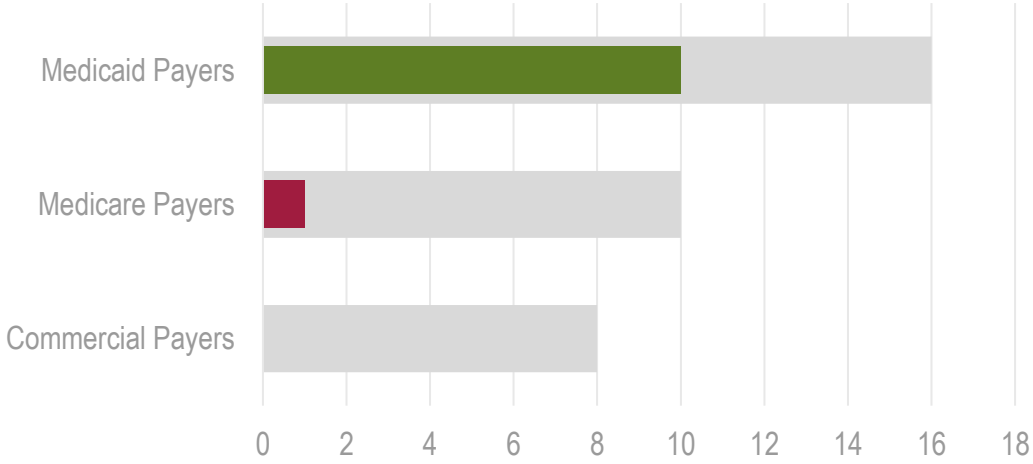
51 provider organizations were included; 26 met the target.

Overall cost growth for provider organizations was 4.9%.

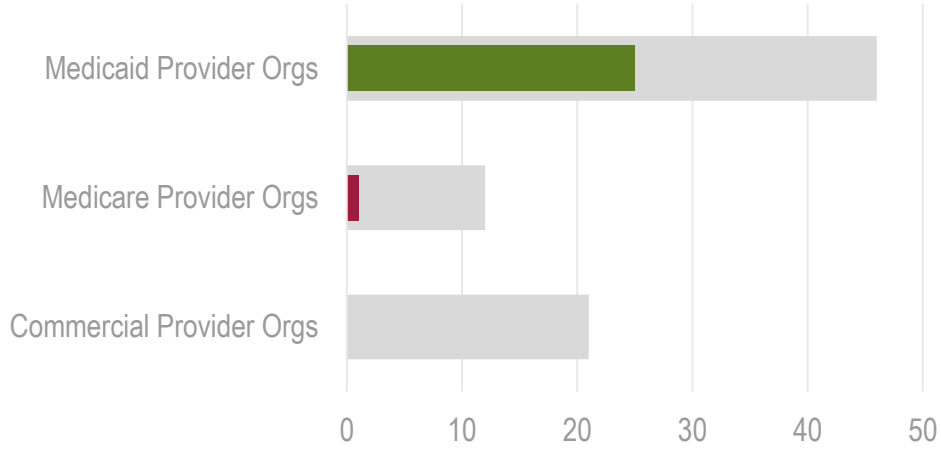
Provider organization cost growth for the commercial market was 11.8%, compared to 6.3% for Medicare Advantage and -3.0% for Medicaid.

Of the 51 provider organizations, 26 met the target for at least one market. Sixteen commercial provider organizations and 10 Medicare provider organizations exceeded the target with statistical certainty.

Number of **commercial**, **Medicare Advantage**, and **Medicaid** payers in each market who met the cost growth target.



Number of **commercial**, **Medicare Advantage**, and **Medicaid** provider organizations in each market who met the cost growth target.



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For questions about this report, please contact: HealthCare.CostTarget@oha.oregon.gov.

Introduction

This report presents data on health care spending and health care cost growth in Oregon between 2020 and 2021. Building on the 2022 Annual Report (spending between 2018-2020), this report presents information on total statewide health care spending and, for the first time, includes cost growth at the payer and provider organization level.

Every year, Oregon's Sustainable Health Care Cost Growth Target Program collects data from payers and other sources to provide this comprehensive view into health care spending and health care cost growth.

By identifying drivers of health care cost growth in Oregon, this report allows policymakers, health system partners, and others to identify opportunities to slow cost growth and address growing health care affordability concerns.

In This Report

Chapter I explores health care cost growth trends between 2020 and 2021 statewide and by market (Commercial, Medicaid and Medicare).

Chapter II provides an overview of health care cost growth trends for payers by market.

Chapter III provides an overview of health care cost growth trends for provider organizations by market.

All data are included in the Cost Growth Target 2020-2021 Databook (click the icon to access).

What is the health care cost growth target?

To successfully contain health care costs, all parts of the health care system must share a high-level goal for cost growth and an understanding of cost drivers.

In Oregon, payers, providers, industry experts, consumer/patient advocates, legislators, and other stakeholders came together to establish the Cost Growth Target Program.

To ensure that payers and provider organizations have flexibility in their contracting and in their operations, the cost growth target is calculated at a high-level, using a total cost of care approach. This view of health care spending includes all costs related to an individual's care, rather than focusing on a single factor like prices.

A statewide health care cost growth target provides:

Sustainability
The target ensures health care costs do not outpace other economic growth.

A Common Goal
Payers and provider organizations are publicly responsible for reducing health care cost growth.

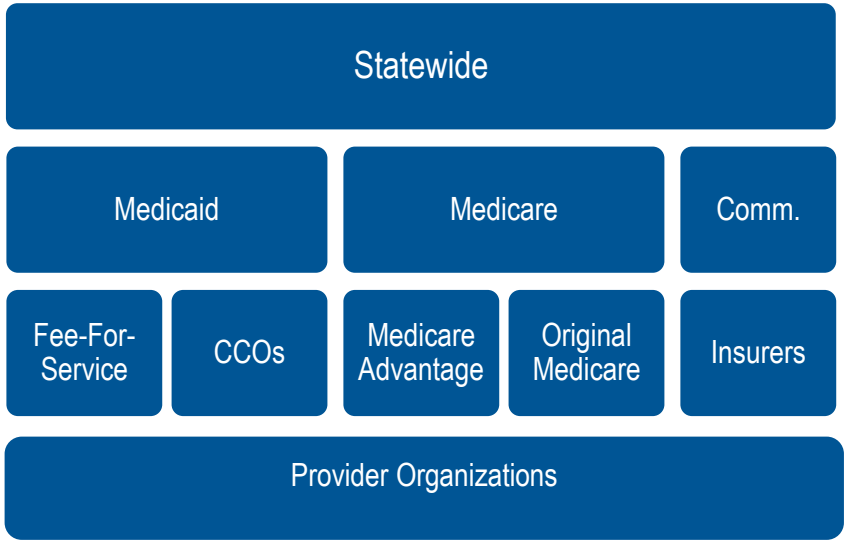
Transparency
Reasons for health care cost growth are studied and publicized, informing policy recommendations

Oregon's health care cost growth target sets an aspirational annual rate of growth for health care spending in the state. The cost growth target is *not* a spending cap and does not limit health care spending. Instead, the target aims to achieve a *sustainable rate of growth*.

The cost growth target is set using economic data, such as historic and projected gross state product, wages, and income.

Oregon's cost growth target is 3.4% for the first five years of the program (2021-2025), and 3.0% for the second five years (2026-2030).

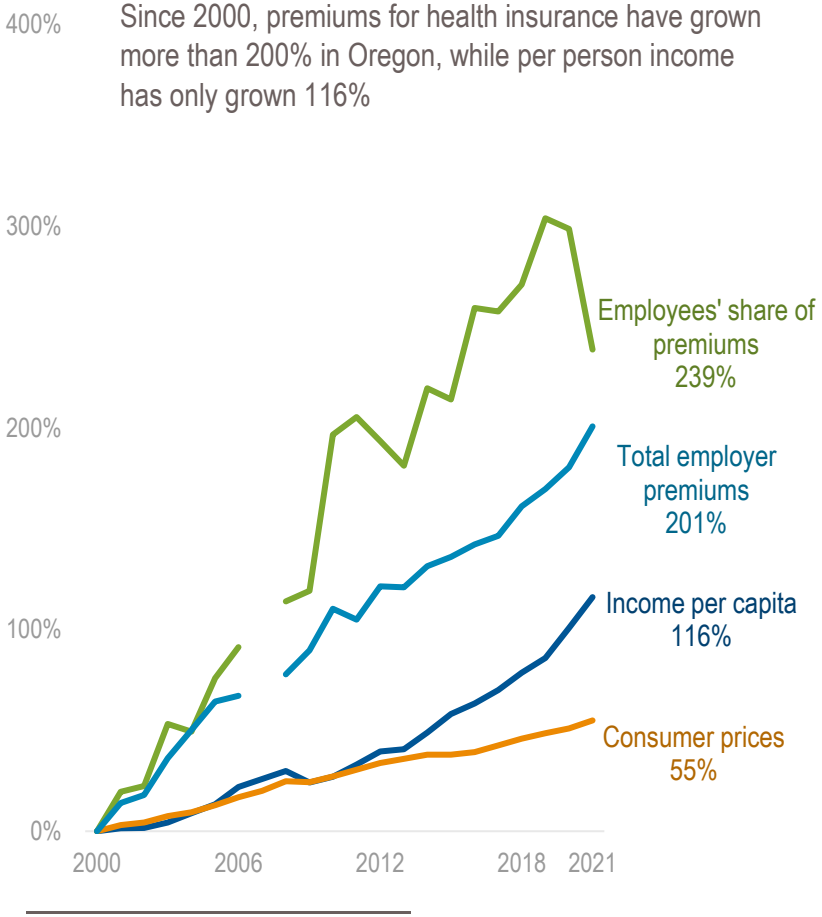
Oregon's cost growth target is measured at four levels:



Why do we need a cost growth target?

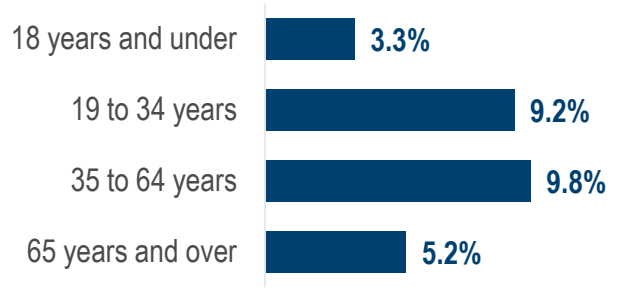
Health care costs continue to grow faster than wages and the economy in Oregon.[1] This forces people to spend a greater share of their income on health care.

Since 2000, premiums for health insurance have grown more than 200% in Oregon, while per person income has only grown 116%

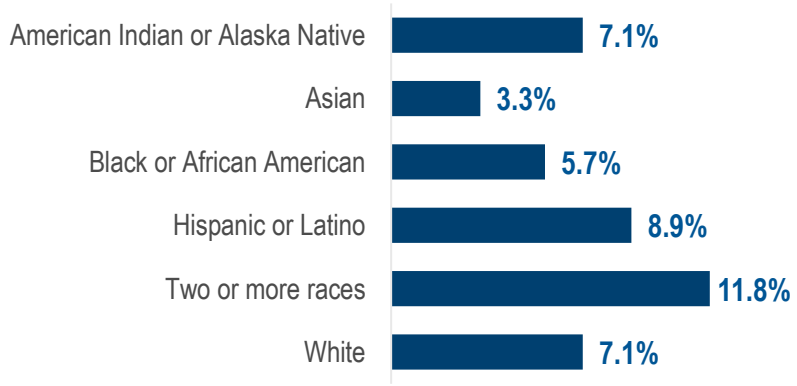


High costs cause people in Oregon to delay health care – and the problem is getting worse. A national poll found that 38% of adults reported delaying care due to costs in 2022.[2]

Percent of people in Oregon reporting they delayed health care due to costs, by age, 2021[3]



Percent of people in Oregon reporting they delayed health care due to costs, by race/ethnicity, 2021



[1] Premiums from AHRQ Medical Expenditures Panel Survey; Income from March 2023 Economic Forecast; Prices from Consumer Price Index.

[2] Gallup Poll, Jan 2023

[3] Oregon Health Insurance Survey, 2021.

How is cost growth measured?

This report includes two key measures of cost growth: Total Health Care Expenditures and Total Medical Expenses. See Appendix for more information about how these measures are calculated.

Total Health Care Expenditures (THCE)

THCE measures statewide health care cost growth in Oregon. It is an aggregate measure of health care spending, including all claims and non-claims spending reported by payers as well as the Net Cost of Private Health Insurance (NCPHI) (i.e., administrative costs of health insurance) and other spending such as health care for military veterans and people incarcerated in state facilities.

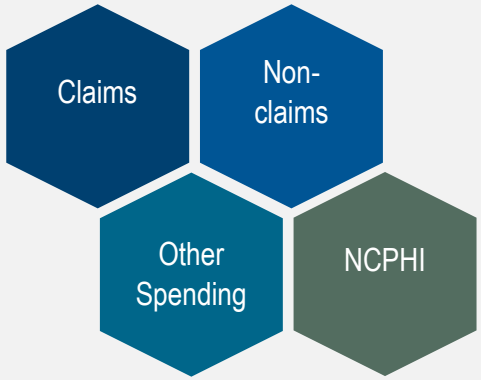
Total Medical Expenses (TME)

TME is used to measure health care cost growth for payers and provider organizations. It is a subset of THCE and includes claims and non-claims spending reported by payers.

TME is reported unadjusted and demographically-adjusted, to account for changes in payer and provider organization patients and members that might affect spending trends.

Total Health Care Expenditures

Statewide and market level cost growth is reported using THCE



Total Medical Expenses

Payer and provider organization cost growth is measured using TME

How are payers and provider organizations held accountable for health care cost growth?

Oregon's Cost Growth Target Program has three different accountability mechanisms:

1) Transparency through public reporting
2) Performance Improvement Plans (PIPs)
3) Financial Penalties

These accountability mechanisms are established by state laws ORS 442.385 and ORS 442.386 and make the Oregon Cost Growth Target Program one of the most rigorous in the nation.

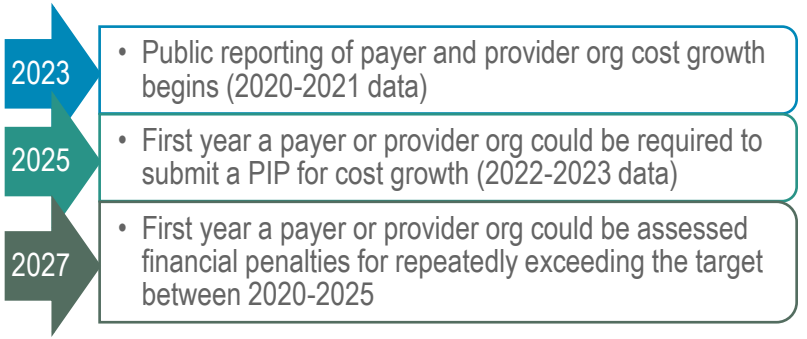
Transparency: Cost growth for payers and provider organizations is publicly reported. This report is the first to include public reporting of cost growth trends at the payer and provider organization level. Cost growth trends and cost drivers will also be shared at public hearings.

Performance Improvement Plans: PIPs may be applied to payers and provider organizations who exceed the target with statistical certainty AND without a good reason.[4]

Financial Penalties: Financial penalties may be applied to payers and provider organizations who repeatedly exceed the target with statistical certainty and without a good reason.

Cost growth target accountability is phased in over several years. In January 2023, after consideration of inflation and labor costs, the Advisory Committee agreed to delay implementation of PIPs by one year from the original timeline.

Accountability Implementation Timeline[5]



No payers or provider organizations are subject to Performance Improvement Plans or financial penalties for the 2020-2021 measurement period.

[4] Draft potential acceptable reasons for exceeding the cost growth target. This will be further developed in administrative rulemaking in fall 2023.

[5] More detailed timeline for implementing accountability mechanisms, updated March 2023

Not all cost growth is bad.

The Cost Growth Target Program aims for *sustainable* cost growth and acknowledges that some cost growth is necessary to achieve high quality care and effectively meet the health needs of people in Oregon.

As such, the program has identified acceptable reasons for a payer or provider organization to exceed the cost growth target.

- "Acts of God" (e.g. pandemics, natural disasters)
- Changes in mandated benefits
- Changes in taxes or administrative factors
- Changes in federal or state policy/law
- Investments to improve population health & health equity
- Macro-economic factors
- New drugs or treatments

OHA meets with payers and provider organizations to discuss performance results and understand key factors driving costs.

"Acts of God": Factors wholly outside of an entity's control that could not have been prevented. Examples include pandemics, public health emergencies, extreme weather, and natural disasters.

Changes in mandated benefits: New changes to coverage mandated by state or federal requirements. May include coverage requirements for specific types of care or populations.

Changes in taxes or administrative factors: New state, local, or federal taxes, administrative, or operational drivers. For example, a new behavioral health tax where dollars are not passed back to entities.

Changes in policy or law: Federal, state, or local regulatory changes that increase costs. This could include new workforce, labor, or compliance requirements.

Investments in to improve population health & equity: Short- or long-term investments that address social needs, fund communities, improve access, and/or strengthen networks.

Macro-economic factors: Economic factors that are outside of an entities control, such as inflation or labor market challenges.

New drugs or treatments: New drugs, treatments, or procedures that are costly enough to drive cost growth. For example, if artificial organ transplants became widely available.

Glossary

Claims spending refers to payments made for a claim, including amounts paid by insurers and any cost-sharing by patients. A health care claim is a request for payment that a provider sends to a health insurer. This report uses allowed amounts to report claims spending, which is the negotiated amount an insurer has agreed to pay for services.

Cost growth: refers to the change of the average per person cost of health care. For example, if the average cost of something is $100 one year and $115 the next year, the cost has increased by 15 percent.

Cost sharing: refers to the amounts that members of an insurance plan pay for health care services. Cost sharing includes copayments, deductibles, and co-insurance. Premium payments are not included in cost-sharing amounts.

Market: refers to Commercial, Medicaid, and Medicare coverage – also known as "line of business".

Net Cost of Private Health Insurance (NCPHI): captures the cost to Oregon residents associated with the administration of private health insurance. It is the difference between the amount payers collect in premiums and the amount they pay through claims. It includes costs related to paying bills, advertising, sales commissions, other administrative costs, premium taxes, and other fees. It also includes payers' profits or losses.

Non-claims spending includes payments from payers to providers outside of claims. This may include incentive payments, prospective payments (e.g. capitation), payments to support care transformation (e.g. patient-centered primary care home payments), and other value-based payments.

Other spending: includes state and federal payments for health care for military veterans, people in state prisons and jails, direct contracts for behavioral health, and more.

Partial claims: sometimes, services such as behavioral health or pharmacy may be "carved out" or provided separately by other benefit providers that contract with the health insurer and the insurer does not have full details about these payments. Payers report this data to the OHA separately as "partial claims" with adjustments made to estimate what expenses may be on a per member basis.

Payer: refers to an entity that pays for an individual's health care, such as a health insurance company.

Provider organization: refers to a health care entity with primary care providers that directs the care of its patients and thereby assumes responsibility for a total cost of care for that person.

Total Medical Expense (TME) is the sum of the allowed amount of total claims and total non-claims spending paid to providers for all health care services delivered to people in Oregon. This report uses TME to measure the cost growth of individual payers and provider organizations.

$$TME = Nonclaims + Claims$$

Total Health Care Expenditure (THCE) is the sum of TME (the allowed amount of total claims spending plus total non-claims spending paid to providers), payers' NCPHI amounts, and other program spending for people in Oregon. This report uses THCE to measures statewide cost growth.

$$THCE = Nonclaims + Claims + NCPHI + Other\ spending$$

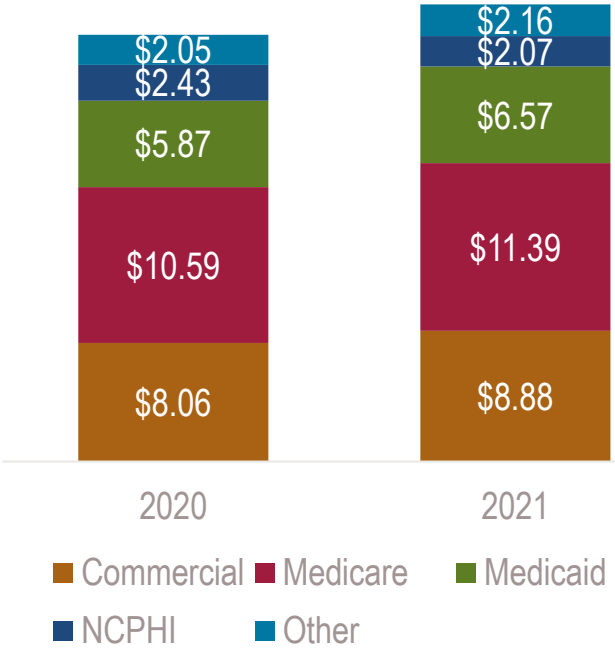
Chapter I. Health Care Cost Growth Trends, 2020-2021 Statewide and by Market

Total Health Care Spending in Oregon

Statewide

By Market

in billions



Statewide, total health care spending in Oregon increased 7.2% between 2020 and 2021, totaling $31.07 billion in 2021.

The largest health care market in Oregon by total dollars spent is **Medicare**, which serves adults aged 65 or older and some younger people with disabilities. Medicare spending totaled $11.39 billion in 2021 and represented 37% of health care spending in Oregon. Medicare spending grew 7.6% between 2020-2021.

Commercial health insurance is the second largest market in Oregon by total dollars spent. Commercial spending in 2021 was about $8.88 billion, representing 29% of health care spending. Commercial spending grew 10.2%.

Medicaid provides health insurance for families and people with low incomes. Total Medicaid spending in Oregon was $6.57 billion in 2021, about 21% of health care spending. Medicaid spending grew 12.0%.

Net Cost of Private Health Insurance represents the costs of administering a health insurance plan. NCPHI totaled $2.07 billion, or almost 7% of spending in 2021. Total dollars for NCPHI declined -14.8%.

Other includes health care spending in programs like the Department of Corrections and Veterans Affairs. Other spending totaled $2.16 billion in 2021, or about 7%. Other spending grew 7.2%.

At the state level, all spending for people dually enrolled in Medicare and Medicaid is reported in the Medicare market. OHA is unable to estimate a unique count of individual members between all dual market data sources.

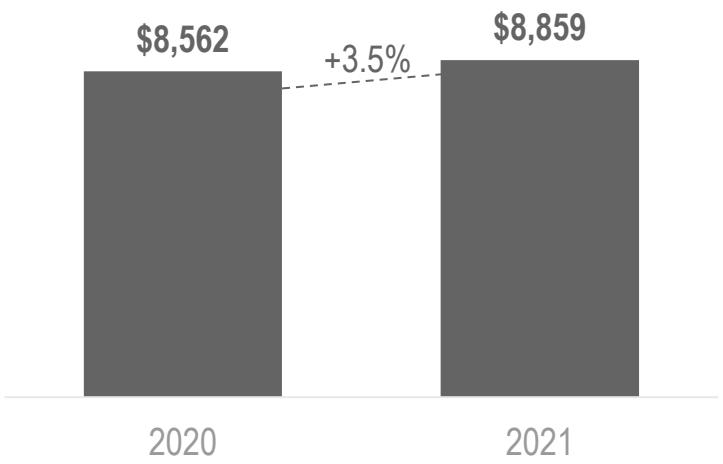
Total Health Care Expenditures

To compare health care cost growth to the cost growth target at the state and market level, Oregon uses a measure called Total Health Care Expenditures. THCE includes all claims and non-claims-based spending, as well as the Net Cost of Private Health Insurance and spending in other programs. THCE is reported on a *per person per year* basis.

The previous page reported total dollars spent on health care in Oregon, which can be affected by the number of people in Oregon overall and the number of people with health insurance coverage. THCE provides a standardized comparison of how much is spent on health care per person each year that accounts for any underlying changes in the number of people. THCE is the measure Oregon uses to compare health care cost growth to the target at the state and market level.

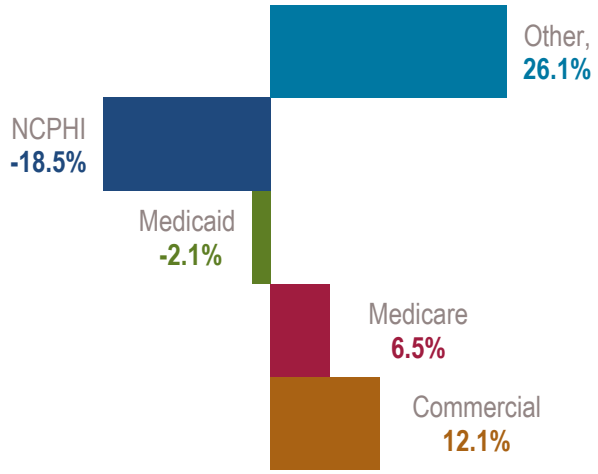
Total Health Care Expenditures, Statewide

Between 2020 and 2021, THCE spending per person per year grew 3.5%, just above the cost growth target of 3.4%. Per person per year spending increased to $8,859.



Total Health Care Expenditures, By Market

Percent change in THCE, by market, 2020-2021



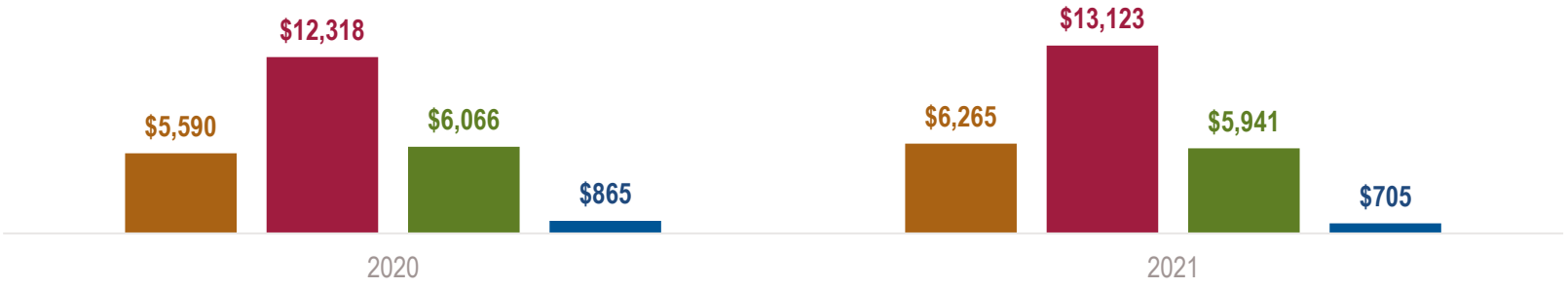
THCE for Oregon's commercial market increased 12.1% between 2020-2021, compared to 6.5% for Medicare and -2.1% for Medicaid. The only market to meet the cost growth target for 2021 is Medicaid.

Other spending grew 26.1% primarily driven by an increase in health care spending at the Department of Corrections.

The Net Cost of Private Health Insurance decreased -18.5% between 2020-2021; as people accessed care they may have delayed in the first part of the COVID-19 pandemic, payers paid out more in claims, leaving less for their administrative costs (including profit margins).[6] See next page for NCPHI by market.

Total health care expenditures vary considerably by market. In general, Medicare THCE on a per person per year basis are more than twice commercial or Medicaid THCE. Since large changes in trend can occur for small dollar amounts (and vice versa), it is important to consider both dollars spent and percent change.

Total Health Care Expenditures, per person per year, by market



[6] This aligns with national trends: The Peterson-KFF Health System Tracker found that administrative costs fell $38 billion nationally between 2020-2021.

Net Cost of Private Health Insurance, by Market

NCPHI applies to commercial insurers, Medicare Advantage insurers, and Medicaid Coordinated Care Organizations.[7]

NCPHI is used to pay payer costs related to health care claims, 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. NCPHI represents 7% of total health care spending in Oregon.

In Oregon, NCPHI declined -18.5% between 2020-2021, likely impacted by increased utilization as people sought health care they may have delayed in the first part of the pandemic.

In the commercial market, NCPHI declined by -29.4%.

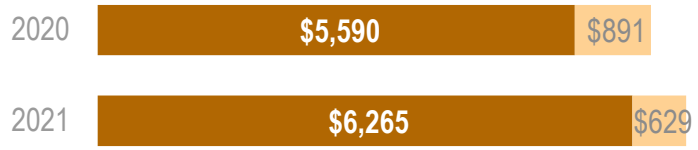
In the Medicare Advantage market, NCPHI declined by -23.7%. Medicare Advantage includes spending for dual eligible members.

As Medicaid enrollment increased throughout 2021 (see below), Medicaid's total health care expenditures per person dropped, including for Medicaid CCOs, leading to an increase in NCPHI for this period.

Total Health Care Expenditures, by market, with Net Cost of Private Health Insurance (lighter bars) per person per year

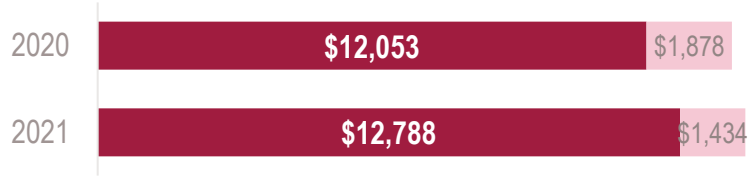
Commercial

NCPHI declined by -29.4%.



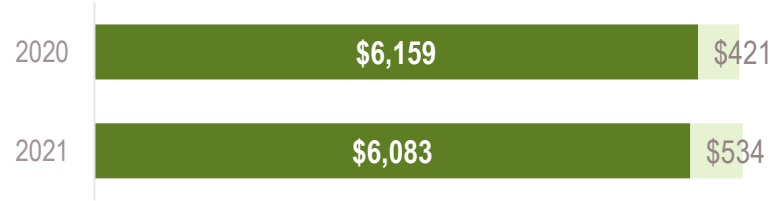
Medicare Advantage

NCPHI declined by -23.7%



Medicaid CCOs

NCPHI increased by 26.8%

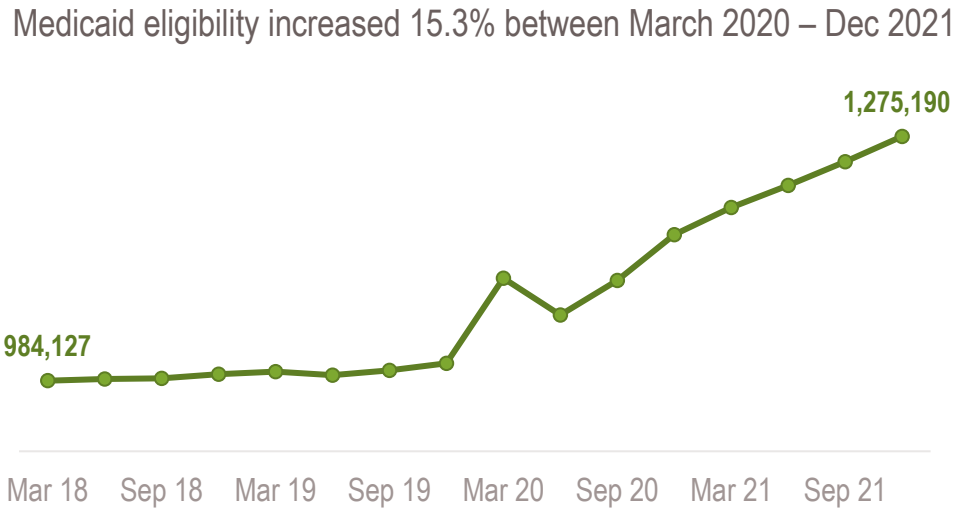


[7] Not all SHCE reports were collected in time to be included in this report. NCPHI data does not include Health Net Life Insurance Company (2020), Health Net Health Plan Of Oregon, Inc. (2020-2021), and United Healthcare Insurance Company Of America (2021)

Medicaid spending

Between 2020 and 2021, total health care spending in the Medicaid market increased 12%, to $6.57 billion, most likely due to the continued increase in enrollment resulting from the Public Health Emergency while redeterminations were paused and no members lost Medicaid coverage.[8]

On a per person per year basis, Medicaid spending declined -0.2% from $6,489 to $6,475. The decline in spending was greater for Medicaid Fee For Service / Open Card than for Medicaid CCOs (see Chapter II). Other factors affecting Medicaid spending include[9]:



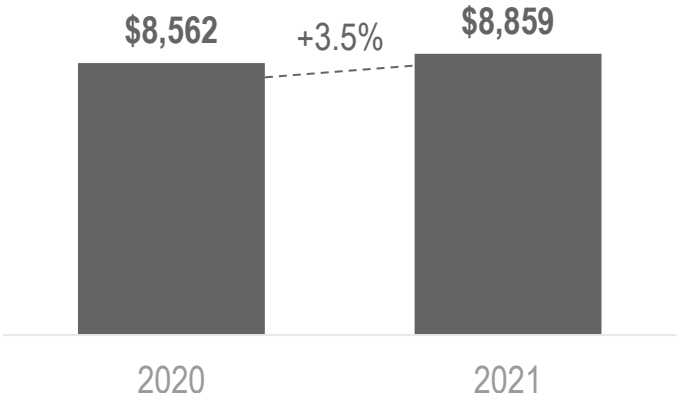
	2020-2021
Changes	The Quality Pool Incentive program moved back to an incentive payment, rather than a withhold from CCO capitation rates. Benefit change for intensive in-home behavioral health treatment for age 17 and under.
CCO Rate Increase	3.4%.
CCO Rate Adjustments	Maternity non-delivery adjustment (+0.2%); -0.4% reduction due to reporting change to reinsurance Hospital Reimbursement Adjustment removed, resulting in 1.7% increase to rates for DRG facility repricing.
Fee For Service Payments[10]	Update to align with 2021 Medicare rates

[8] Medicaid eligibility total on the 15th of the month for physical health, Oregon Health Plan, Cover All Kids/Healthier Oregon Program. OHA Monthly Medicaid Population Report.
[9] CCO Rate Certification 2021
[10] Oregon Health Plan Fee Schedule

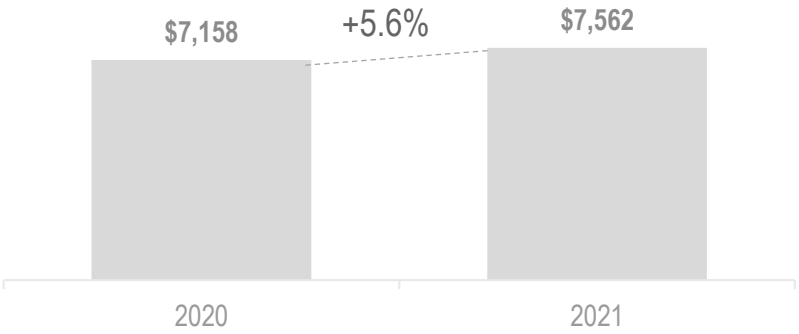
Total Medical Expenses

When reporting on health care cost growth relative to the target for payers, provider organizations, and by service categories, Oregon uses a measure called Total Medical Expenses. TME is a subset of Total Health Care Expenditures and includes claims and non-claims payments only. It does not include other spending and the costs of administering health plans. Claims data for TME are reported net of pharmacy rebates.

THCE spending grew 3.5% between 2020-2021



TME spending grew 5.6% between 2020-2021



	THCE	TME
Claims	●	●
Non-claims	●	●
NCPHI	●	
Other spending	●	

The TME spending above includes Medicare Fee For Service. OHA does not have Medicare FFS spending data that can be attributed to payers and provider organizations.

Calculated without Medicare FFS, TME spending statewide, demographically adjusted, grew 4.5% between 2020-2021, to $6,717 per person per year. TME spending without Medicare FFS is used for comparisons in Chapters II and III.

Demographic Adjustment

The TME spending data above is unadjusted for any changes in the state's population. However, some changes will have an impact on spending growth, for example, an older population would be expected to have higher spending than the previous year. OHA is applying a demographic adjustment to TME spending data at the payer and provider organization level (see Appendix).

This adjustment is unnecessary at the state and market level because populations are large enough to be stable over time. However, an adjusted TME at the market level can be calculated to provide a more accurate comparison with the payer and provider organization level data presented in Chapters II and III. The table below shows the adjusted and unadjusted TME for each market.

In the commercial market, demographic adjustment lowered cost growth from 12.1% to 10.4%, while it slightly increased cost growth in the Medicare Advantage market (6.1% to 6.4%). The demographic adjustment for Medicaid also lowered cost growth from -1.4% to -2.0%, again, likely due to the continued enrollment for member due to the Public Health Emergency (i.e., because members remained enrolled in Medicaid when they wouldn't have otherwise, changes in demographics had less of an impact on costs than we might have expected).

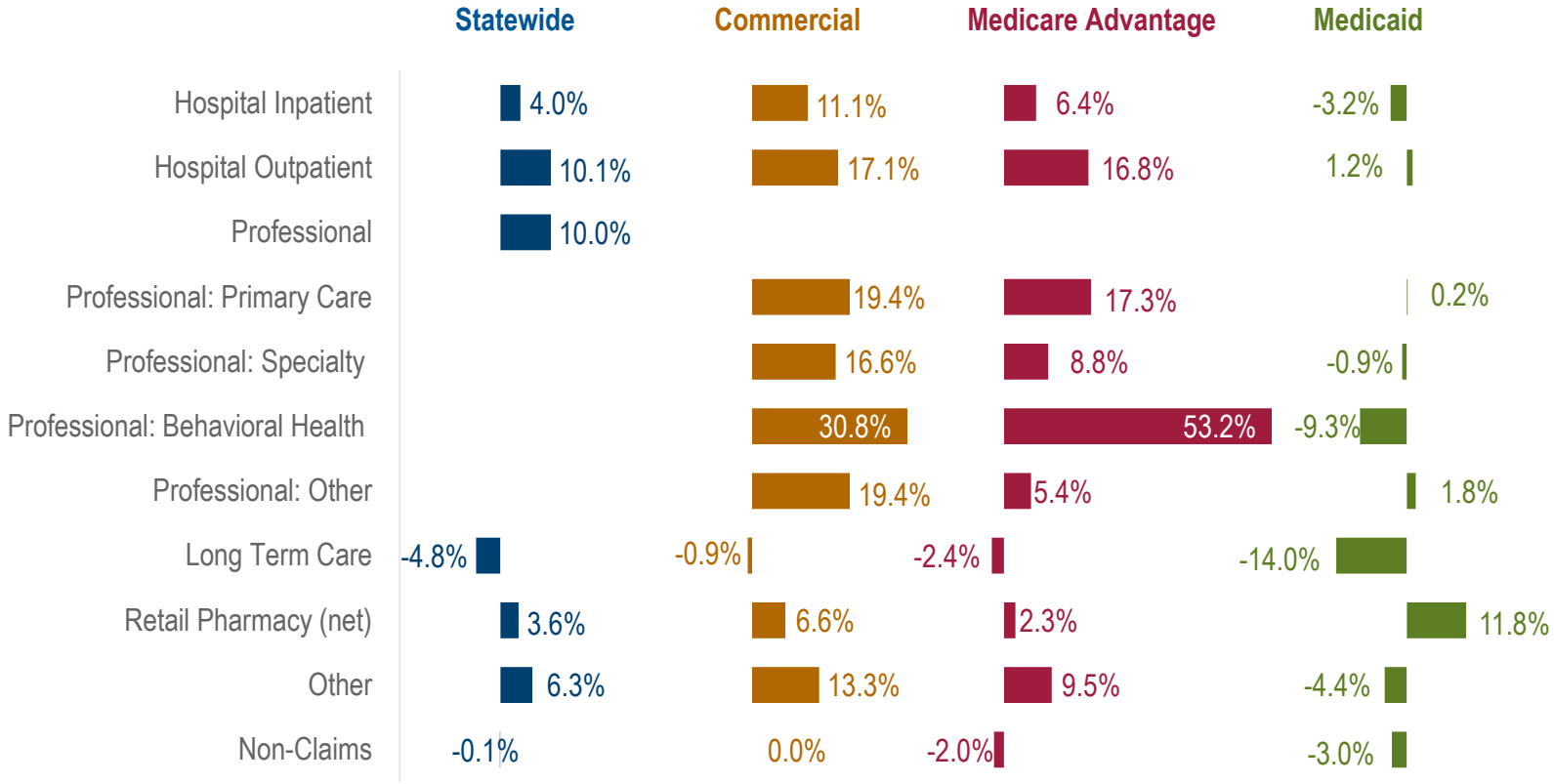
Total Medical Expenses by market, with and without demographic adjustment

Commercial[11]	**2020**	**2021**	**Growth Rate**
TME Unadjusted	$5,590	$6,265	12.1%
TME Adjusted	$5,569	$6,150	10.4%
Medicare Advantage[12]			
TME Unadjusted	$12,053	$12,788	6.1%
TME Adjusted	$12,159	$12,938	6.4%
Medicaid			
TME Unadjusted	$4,862	$4,765	-2.0%
TME Adjusted	$4,697	$4,565	-2.8%

[11] Includes full and partial claims spending.
[12] Includes spending for dual eligible members.

Total Medical Expenses Spending by Service Category, Statewide and by Market (unadjusted)

Between 2020 and 2021, total medical expenses increased 5.6% on a per person per year basis, with claims spending increasing 6.7% and non-claims spending declining by -0.1% statewide. This was primarily driven by increases in hospital outpatient and professional services utilization. The commercial and Medicare Advantage markets saw strong increases in professional: behavioral health services. Medicaid experienced a large increase in retail pharmacy spending (even after rebates were applied).



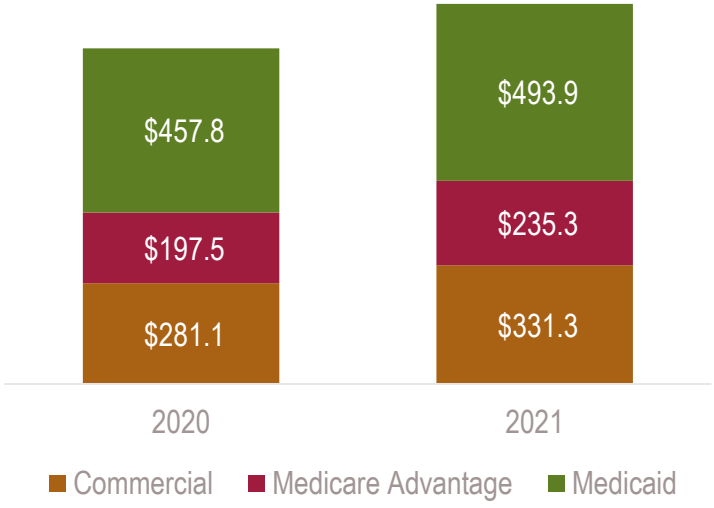
Note statewide data includes Medicare Advantage and Original Medicare. Original Medicare only reports spending for an aggregate professional service category and those dollars are not reflected here; Oregon collects more detailed subcategories for professional spending in other markets

Pharmacy Rebates

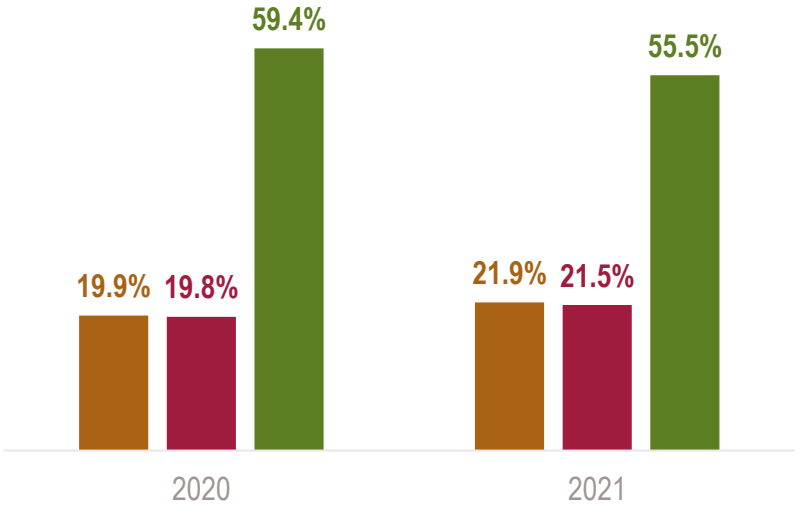
Pharmacy rebates account for around $1 billion per year in Oregon. The total amount of pharmacy rebates increased 13.3% statewide between 2020-2021 (increasing 18% for commercial, 19% for Medicare Advantage, and 8% for Medicaid).

Statewide, about 23% of spending for retail pharmacy was returned to payers and pharmacy benefit managers (PBMs) through rebates, although this was driven by Medicaid. Medicaid continues to recoup more than 50% of prescription drug costs through rebates, due to federal and state policies that ensure that Medicaid gets the lowest available price for pharmaceuticals.

Amount saved in pharmacy rebates each year, by market
in millions



Rebates as a percent of gross retail pharmacy spending, by market



Chapter II. Health Care Cost Growth Trends, 2020-2021 by Payers and Market

Key Findings

Twenty-nine payers were included in cost growth target reporting for the 2020-2021 measurement period. Overall cost growth for payers was 4.7%, compared to statewide TME growth of 4.5%.

Cost growth for commercial payers was 11.5%, while Medicare Advantage cost growth was 6.0%. Medicaid payers had the lowest overall cost growth at -3.0%. Of the 29 payers, 11 met the target for at least one market.

Payer perspectives on cost growth

Effects of the COVI-19 pandemic were key drivers of cost growth trends for 2020-2021.

Increased utilization

Payers saw delayed care in 2020 due to the pandemic. 2021 brought a large increase in demand for services. Some payers noted increased need for behavioral health services.

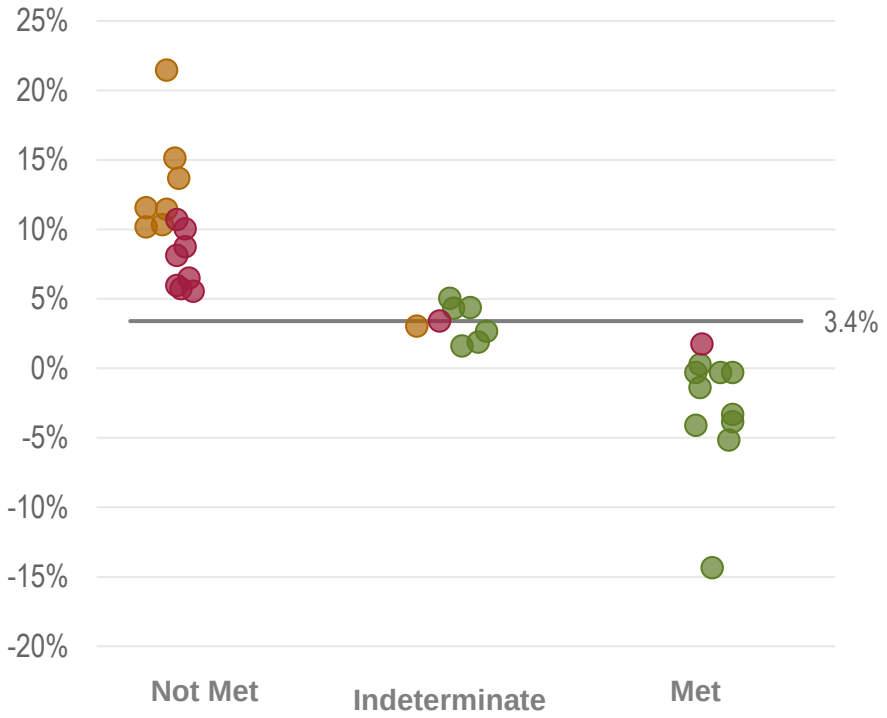
Higher acuity

The pandemic caused people to delay care in 2020 and many of those that sought care in 2021 had more acute and chronic care needs. This led to increases in hospital stays and higher costs.

Shifting care sites

Due to capacity issues, patients received care in higher cost locations. For example, limited primary care availability meant that more patients sought care in urgent care settings. Patients have longer inpatient stays when skilled nursing facility beds were not available.

Payer performance in relation to the cost growth target for **commercial**, **Medicare Advantage**, and **Medicaid** markets, 2020-2021.



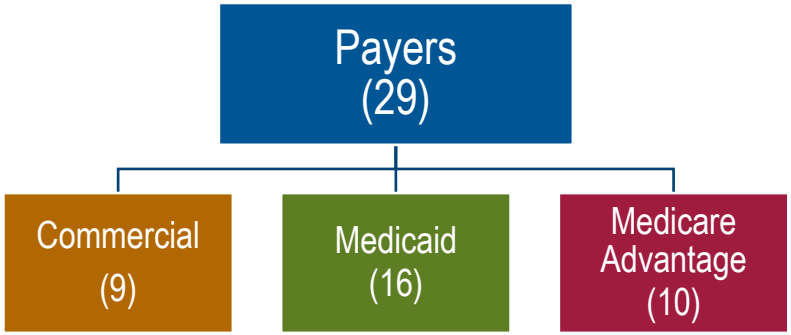
Market	Group Count	Met Target Count	Cost Growth 2020-21
Commercial	8	0	11.5%
Medicare Advantage	10	1	6.0%
Medicaid	16	10	-3.0%

Which payers are included?

Data Submission: All payers and third-party administrators (TPAs) with at least 1,000 members in Oregon must submit cost growth target data to the Oregon Health Authority. OHA identifies mandatory data submitters each year, using enrollment data from Medicaid enrollment reports and the Department of Consumer and Business Services. ERISA self-insured plans may voluntarily submit data. The mandatory data submitter notification letter and list of payers for 2020-2021 is available online, as is the list of voluntary data submitters.

Public Reporting: Payers and TPAs with at least 5,000 lives in a given market (Medicaid, Medicare, Commercial) are included in public reporting. All other payer level data is included in aggregate in the state and market level totals.

Number of payers meeting the reporting threshold for 2020-2021, by market

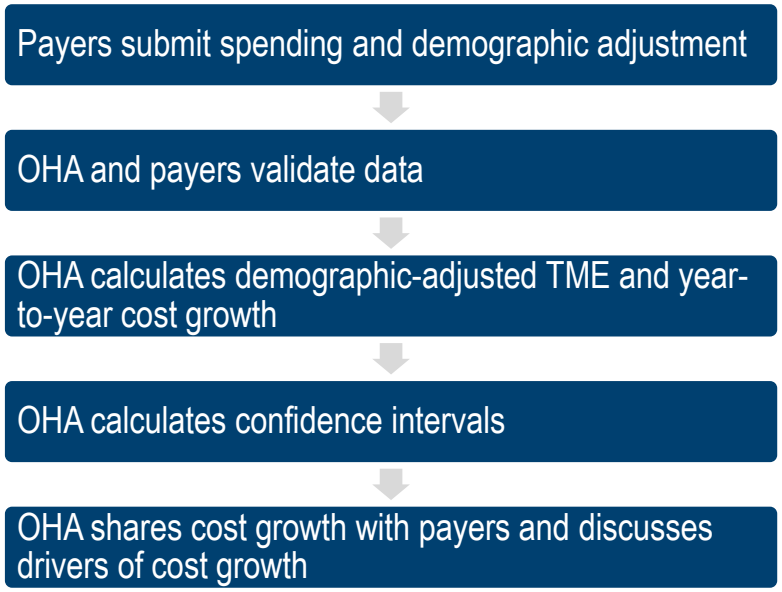


Payer	Comm.	MA	Medicaid
Advanced Health			●
Aetna	●		
AllCare CCO			●
ATRIO		●	
Cascade Health			●
Cigna	●		
CPC - CareOregon			●
EOCCO - Mode			●
Health Net Company		●	
Health Net Oregon	●	●	
Health Share			●
IHN - Samaritan			●
Jackson CCO -CareOregon			●
Kaiser	●	●	
Medicaid FFS/ Open Card			●
Moda	●	●	
PacificSource - Central OR			●
PacificSource - Gorge			●
PacificSource - Lane			●
PacificSource - Marion and Polk			●
PacificSource Community		●	
PacificSource Health	●		
Providence	●	●	
Regence	●	●	
Trillium CCO			●
UHC Company	●	●	
UHC Oregon		●	
Umpqua CCO			●
Yamhill Community Care			●

How is cost growth measured for payers?

When reporting on health care cost growth relative to the target for payers and provider organizations, OHA uses a measure called Total Medical Expenses (TME). TME includes claims and non-claims payments paid to providers for all health care services delivered to Oregon members. Claims data for TME are reported net of pharmacy rebates (i.e., after rebates have been applied). Payer cost growth is presented as the percent increase in per person spending from 2020 to 2021; dollar amounts for payers are not included.

Cost growth is calculated for payers using data that is submitted by payers each year.



Demographic adjustment

States with cost growth target programs adjust spending data in various ways to account for changes in populations that may impact spending growth. For example, a population with more health needs can be expected to have higher spending.

Oregon uses a demographic adjustment to account for underlying factors that may differ across populations and contribute to health care spending and variation between years.

Beginning with the 2022 data submissions, payers implemented an age and sex adjustment, using the approach defined by OHA. See Appendix for more information about demographic adjustment.

Full claims and partial claims

Oregon collects both full and partial claims spending from payers. Full claims data are reported when a payer has information about all direct claims and any claims paid by a delegated entity. Partial claims are those where a payer only has limited data because benefits are carved out or provided by others. Some payers carve out benefits (e.g., prescription drugs or behavioral health care services) by contracting with another entity that takes on the responsibility of paying for those carved out services. Payers estimate these costs.

OHA uses only full claims to calculate Total Medical Expenditures for commercial payers because partial claims cannot be fully allocated on a per member basis.

How to read the charts in this chapter

Chapters II and III present information about individual payer and provider organization cost growth in relation to the 3.4% target.

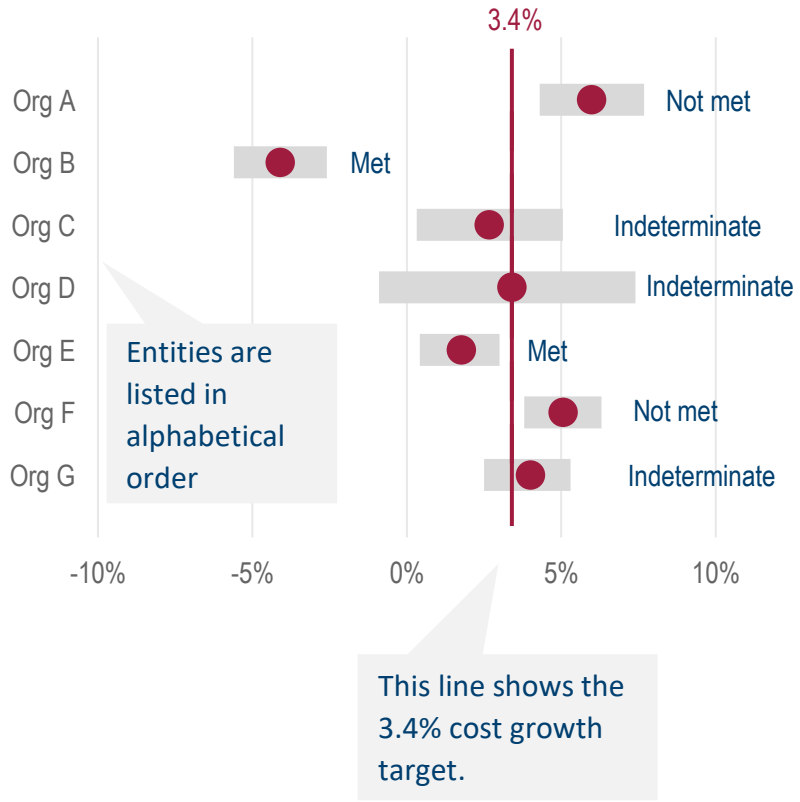
In the example chart, the y-axis lists payers that are accountable for meeting the cost growth target. Dots represent 2020-2021 cost growth for the payers listed. Bars represent confidence intervals. Positive percentages show how much health care spending increased, while negative cost growth percentages mean that health care spending went down.

Dots and bars that fall left of the target line have met the target. Dots and bars to the right of the line have not met the target. If bars cross the target line, performance is indeterminate (i.e., the payer did not meet or exceed the target with statistical certainty).

How to interpret confidence intervals

Confidence intervals help ensure that data are accurate and reliable by giving a range of plausible values. In calculating cost growth, OHA uses a 95% confidence interval, which means that we are 95% certain that an organization's cost growth value falls within that range. The gray bars in the chart show the confidence interval range, with longer bars indicating a greater range and smaller bars indicating a smaller range. Generally, organizations with a larger number of members or patients will have a shorter confidence interval bar, while a company with a smaller number of members or patients will have a longer bar.

Example: cost growth for payers



Payers and provider organizations must exceed the cost growth target with statistical confidence before they could potentially be held accountable in future years.

For any entities where cost growth is "indeterminate" – no accountability would apply.

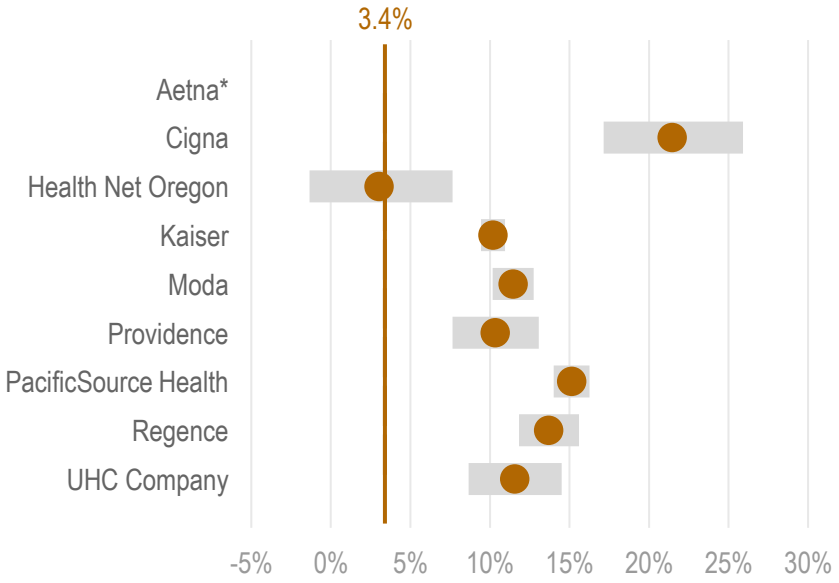
Commercial Payers

Eight commercial payers were included in the Cost Growth Target program in 2020-2021.

Cost growth for commercial payers ranged from 3.0% to 21.5%, with average cost growth of 11.5%. No commercial payers met the cost growth target: one payer was indeterminate, and seven payers exceeded the target with statistical certainty.

Since OHA only uses full claims to calculate cost growth, some payers do not have all their members and/or spending data captured. The table below shows the portion of commercial payer's members were reported in partial claims (and therefore not reflected in the cost growth trends presented on this page).

2020-2021 cost growth for commercial payers



*Data for Aetna are not included because the files they submitted did not pass validation in time to be included in the report.

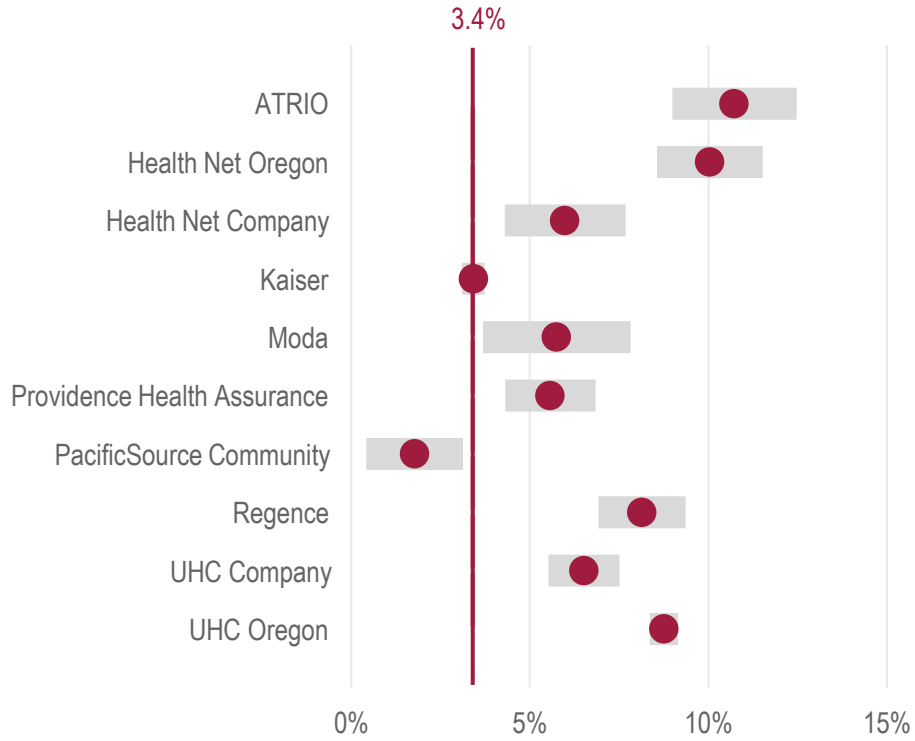
Commercial Payer	Partial claims, as a percentage of member months	
	2020	2021
Cigna	33%	37%
Moda	18%	19%
Regence	39%	38%

Commercial Payer	Target performance	20-21 cost growth
Aetna*	--	--
Cigna	Not Met	21.5%
Health Net Oregon	Indeterminate	3.0%
Kaiser	Not Met	10.2%
Moda	Not Met	11.5%
Providence	Not Met	10.3%
PacificSource Health	Not Met	15.1%
Regence	Not Met	13.7%
UHC Company	Not Met	11.6%

Medicare Advantage Payers

Ten Medicare Advantage payers were included in the Cost Growth Target program for the 2020-2021 performance period. Cost growth for Medicare Advantage payers ranged from 1.8% to 10.7%. One payer met the target, one payer was indeterminate, and eight payers exceeded the target with statistical certainty.

2020-2021 cost growth for Medicare Advantage payers

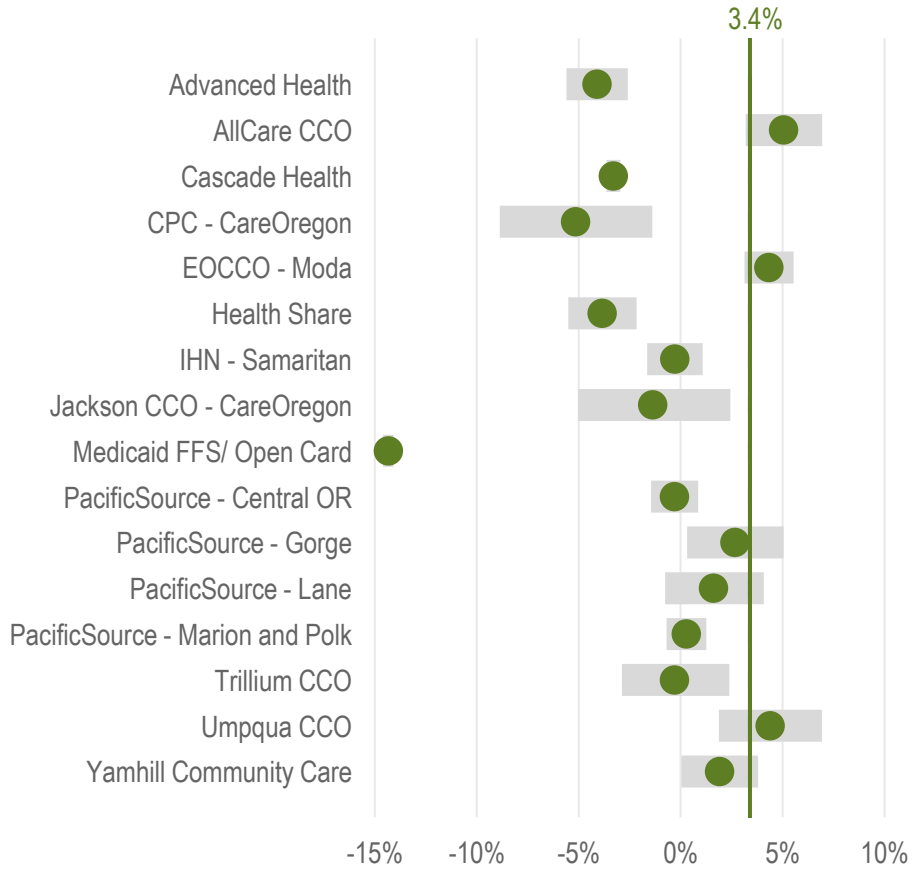


Medicare Advantage Payer	Target performance	20-21 cost growth
ATRIO	Not Met	10.7%
Health Net Company	Not Met	6.0%
Health Net Oregon	Not Met	10.0%
Kaiser	Indeterminate	3.4%
Moda	Not Met	5.7%
PacificSource Community	Met	1.8%
Providence Health Assurance	Not Met	5.6%
Regence	Not Met	8.1%
UHC Company	Not Met	6.5%
UHC Oregon	Not Met	8.8%

Medicaid Payers

Sixteen Medicaid payers were included in the Cost Growth Target program for the 2020-2021 performance period, including all Coordinated Care Organizations (CCOs) and Medicaid Fee For Service (FFS)/Open Card. Cost growth for Medicaid payers ranged from -14.3% to 5.1%. Ten Medicaid payers met the target and six were indeterminate.[13]

2020-2021 cost growth for Medicaid payers



Medicaid Payer	Target Performance	20-21 Cost Growth
Advanced Health	Met	-4.1%
AllCare CCO	Indeterminate	5.1%
Cascade Health	Met	-3.3%
CPC - CareOregon	Met	-5.2%
EOCCO - Moda	Indeterminate	4.3%
Health Share	Met	-3.8%
IHN - Samaritan	Met	-0.3%
Jackson CCO - CareOregon	Met	-1.4%
Medicaid FFS/ Open Card	Met	-14.3%
PacificSource - Central OR	Met	-0.3%
PacificSource - Gorge	Indeterminate	2.7%
PacificSource - Lane	Indeterminate	1.6%
PacificSource - Marion Polk	Met	0.3%
Trillium CCO	Met	-0.3%
Umpqua CCO	Indeterminate	4.4%
Yamhill Community Care	Indeterminate	1.9%

[13] The majority of Medicaid pharmacy rebates are collected at the state level and applied to the Medicaid market in aggregate. Any pharmacy rebates reported by CCOs are included in CCO-level total medical expense calculation, but the majority of Medicaid pharmacy rebates are not applied to the results on this page.

Chapter III. Health Care Cost Growth Trends, 2020-2021 by Provider Organization and Market

Key Findings

Fifty-one provider organizations were included in cost growth target reporting for the 2020-2021 measurement period. Overall cost growth for provider organizations was 4.9%, compared to statewide TME of 4.5%.

Commercial cost growth for provider organizations was 11.8%, while Medicare Advantage cost growth was 6.3%. Provider organizations had the lowest cost growth for Medicaid, at -3.0%. Of the 51 provider organizations, 26 met the target for at least one market.

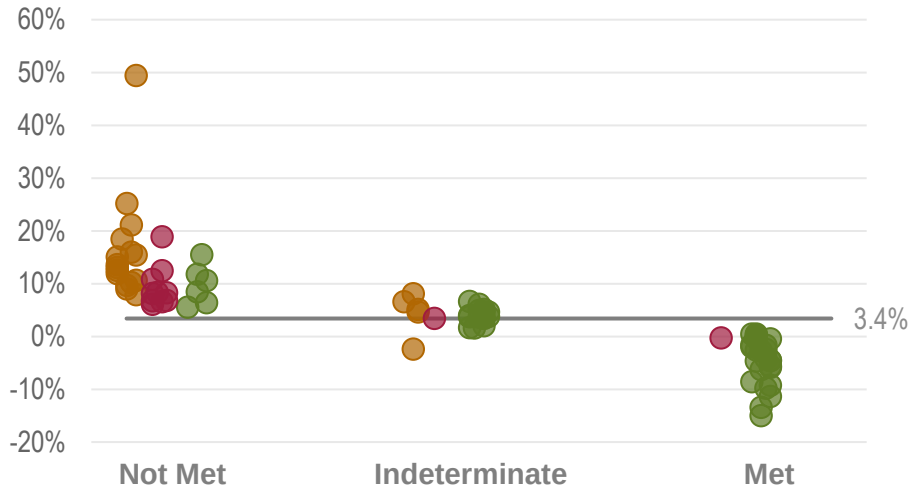
Provider perspectives on cost growth

As part of the 2020-2021 data validation process, OHA shared detailed data summaries to all provider organizations and met with some organizations to discuss cost growth drivers. Some key themes emerged from those conversations, including that the effects of COVID-19 were key drivers of cost growth. Provider organizations noted that they expect to see the effects of the COVID-19 pandemic for years to come.

Utilization increases

COVID-19 profoundly disrupted the health care system, resulting in many non-essential services being paused and patients delaying care during 2020. In 2021, utilization increased as patients returned to seek services for health care needs.

Provider organization performance in relation to the cost growth target for **commercial**, **Medicare Advantage**, and **Medicaid** markets, 2020-2021



Market	Group Count	Met Target Count	Cost growth
Commercial	21	0	11.8%
Medicare Advantage	12	1	6.3%
Medicaid	46	25	-3.0%

Increased acuity of patients

Many provider organizations cited increased acuity as a driver of cost. Due to pandemic uncertainty, many patients were not able to receive care 2020. Because of this delayed care, many patients who sought care in 2021 had more serious health needs or chronic conditions, requiring more complex and higher cost care.

Capacity issues

Many providers, including hospitals, struggled with maintaining capacity to care for patients. The increase in patients combined with workforce challenges meant that patients were not always able to receive care in the best, most cost-effective setting.

Workforce and staffing challenges

Several provider organizations highlighted workforce issues. Organizations struggled to recruit and retain staff and staffing costs increased. Organizations expect staffing issues will lead to higher cost growth in future years.

Behavioral health needs

Some providers highlighted increased need for behavioral health services and investments they made in those areas. Providers highlighted a need for inpatient behavioral health and psychiatric crisis units.

Context matters

Several provider organizations voiced the need for their cost growth to be contextualized and for reporting to account for factors like outliers, complexity of patient populations, and regional variations in provider and payer networks.

Some highlighted the difficulty in calculating cost growth rates across different types of providers. *To address this concern, OHA created groups for presenting provider organization cost growth in this report, based on patient volume and type of organization (see next page).*

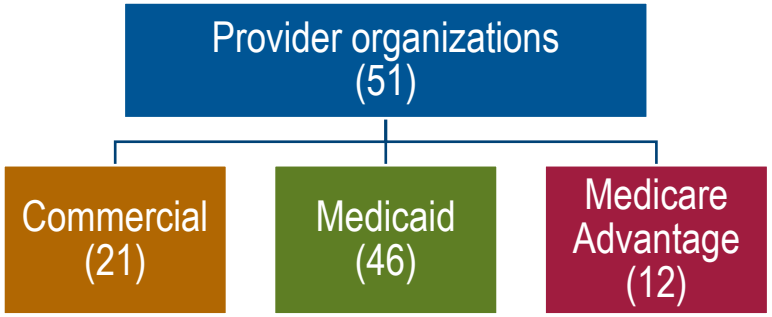
Which provider organizations are included in reporting?

Provider organizations are included in the Cost Growth Target Program if they meet the following criteria:

1. Include primary care providers who direct a patient's care (and can influence where a patient receives care)

2. Have sufficient patient volume to calculate accurate and reliable cost, defined as at least 10,000 attributed patients across all markets or at least 5,000 attributed patients in any one market.

Number of provider organizations meeting the threshold for 2020-2021, by market



This report includes cost growth information for 51 provider organizations. Some provider organizations are included in multiple markets (commercial, Medicaid, and Medicare), while others may only be included in reporting for one market.

Grouping similar provider organizations

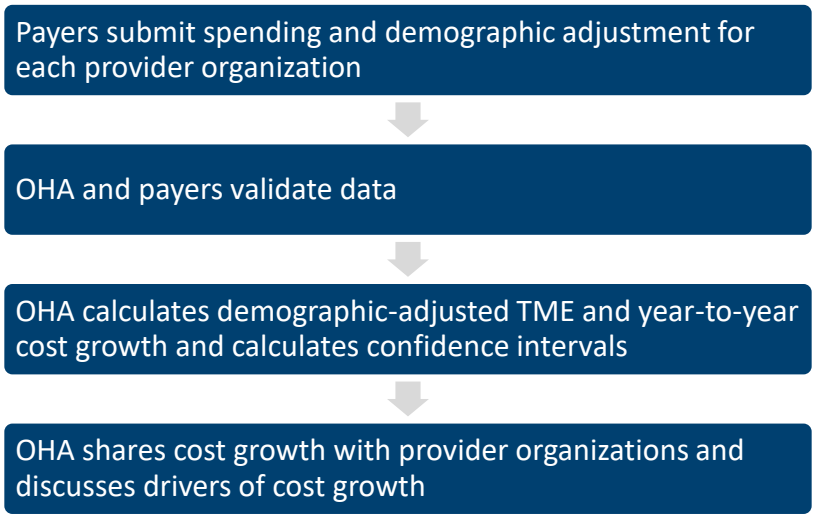
To avoid inaccurate comparisons, OHA created groups for presenting provider organization cost growth, based on patient volume and type of organization.

Market	Provider Organization Group	Count
Commercial	Large health systems and group practices (more than 20,000 attributed patients)	**7**
	Mid-sized health systems and group practices (10,000 to 20,000 attributed patients)	**4**
	Smaller health systems and group practices (fewer than 10,000 attributed patients)	**6**
	Pediatric practices	**4**
Medicare Advantage	All	12
Medicaid	Federally qualified health centers (FQHCs)	15
	Large health systems and group practices (more than 20,000 attributed patients)	5
	Mid-sized health systems and group practices (10,000 to 20,000 attributed patients)	7
	Smaller health systems and group practices (fewer than 10,000 attributed patients)	12
	Pediatric practices	7

How is cost growth measured for provider organizations?

When reporting on health care cost growth relative to the target for payers and provider organizations, OHA uses a measure called Total Medical Expenses (TME). TME includes claims and non-claims payments only. Claims data at the provider level are reported gross of rebates. TME has been demographically adjusted (see Appendix). Provider organization cost growth is presented as the percent increase in per person spending from 2020 to 2021; dollar amounts are not included.

Cost growth is calculated for provider organizations using data submitted by payers. Once OHA has calculated cost growth, OHA staff meet with provider organizations to validate findings and discuss factors that drove cost growth.



Attribution to provider organizations

When payers submit data to the cost growth target program, they attribute their members to provider organizations based on where those members receive primary care.

Payers use one of these three approaches to attribute members, listed in hierarchical order:

1. **Member selection:** Members who were required to select a primary care provider or a primary care home by plan design should be assigned to that primary care provider's organization.

2. **Contract arrangement:** Members not included in #1 who were attributed to a primary care provider or a primary care home during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care provider's organization. For example, if a provider is engaged in a total cost of care arrangement, then the payer may use its attribution model for that contract to attribute members.

3. **Utilization:** Members not included in #1 or #2 who can be attributed to a primary care provider or a primary care home based on the member's utilization, using the payer's own attribution methodology.

Not all members are attributed to provider organizations. In 2020, 61% of all individuals were attributed to provider organizations; 62% in 2021.

Demographic adjustment

States with cost growth target programs adjust spending data in various ways to account for changes in populations that may impact spending growth. For example, a population with more health needs can be expected to have higher spending.

Oregon uses a demographic adjustment to account for underlying factors that may differ across populations and contribute to health care spending and variation between years.

Beginning with the 2022 data submissions, payers implemented an age and sex adjustment, using the approach defined by OHA. See Appendix for more information about demographic adjustment.

The demographic adjustment is also applied to provider organization level cost growth.

Full claims and partial claims

Oregon collects both full and partial claims spending from payers.

- Full claims data are reported when a payer has information about all direct claims and any claims paid by a delegated entity.
- Partial claims are those where a payer only has limited data because benefits are carved out or provided by others. Some payers carve out benefits (e.g., prescription drugs or behavioral health care services) by contracting with another entity that takes on the responsibility of paying for those carved out services. Payers estimate these costs.

OHA uses only full claims to calculate Total Medical Expenditures for commercial provider organizations because partial claims cannot be fully allocated to attributed patients.

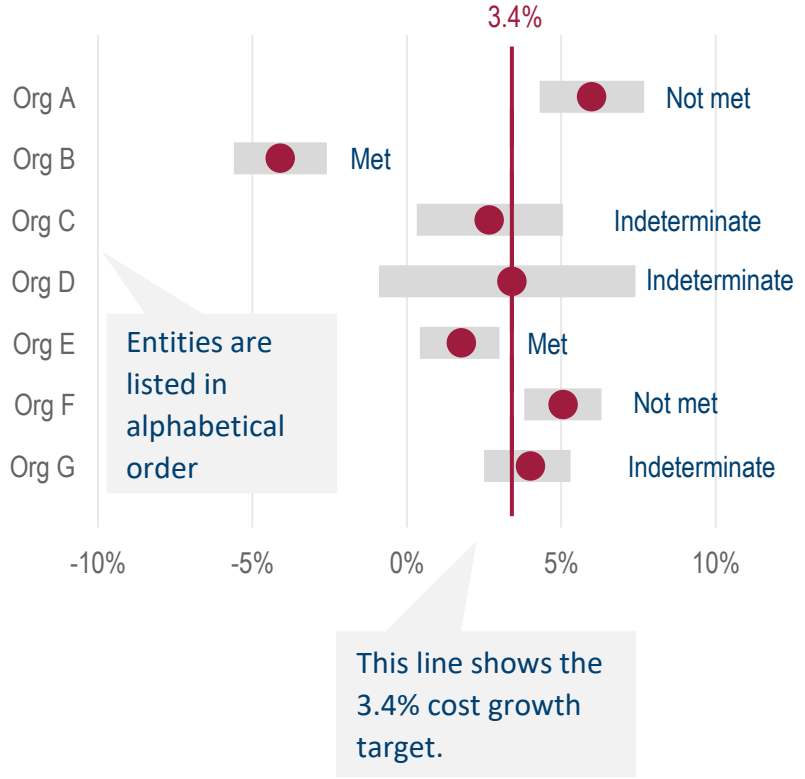
How to read the charts in this chapter

Chapters II and III present information about individual payer and provider organization cost growth in relation to the 3.4% target.

In the example chart, the y-axis lists provider organizations that are accountable for meeting the cost growth target. Dots represent 2020-2021 cost growth for the provider organizations listed. Bars represent confidence intervals. Positive percentages show how much health care spending increased, while negative cost growth percentages mean that health care spending went down.

Dots and bars that fall left of the target line have met the target. Dots and bars to the right of the line have not met the target. If bars cross the target line, performance is indeterminate (i.e., the provider organization did not meet or exceed the target with statistical certainty).

Example: cost growth for provider organizations



How to interpret confidence intervals

Confidence intervals help ensure that data are accurate and reliable by giving a range of plausible values. In calculating cost growth, OHA uses a 95% confidence interval, which means that we are 95% certain that an organization's cost growth value falls within that range. The gray bars in the chart show the confidence interval range, with longer bars indicating a greater range and smaller bars indicating a smaller range. Generally, organizations with a larger number of members or patients will have a shorter confidence interval bar, while a company with a smaller number of members or patients will have a longer bar.

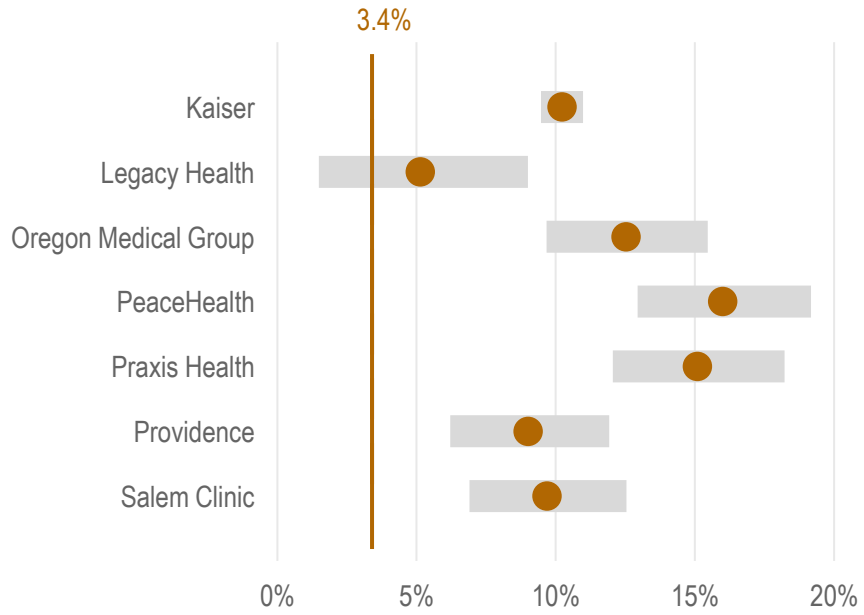
Payers and provider organizations must exceed the cost growth target with statistical confidence before they could potentially be held accountable in future years. For any entities where cost growth is "indeterminate" – no accountability would apply.

Commercial: Large Provider Organizations

This group includes seven provider organizations. Organizations in this group had more than 20,000 attributed patients with commercial insurance coverage. Cost growth for this group ranged from 5.1% to 16.0% and cost growth for the group overall was 9.9%. None of the organizations in this group met the target; six exceeded the target with statistical certainty and one was indeterminate.

Provider organizations cited several key factors that drove cost growth, including staffing and workforce challenges and increasing complexity of patient health care needs.

2020-2021 commercial cost growth for large provider organizations (more than 20,000 attributed patients)



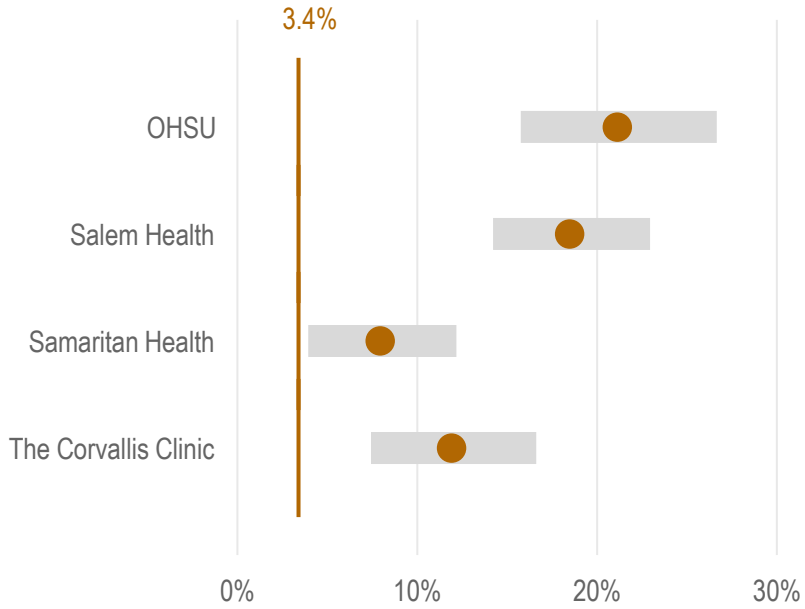
Provider Organization	Target performance	20-21 commercial cost growth
Kaiser	Not Met	10.2%
Legacy Health	Indeterminate	5.1%
Oregon Medical Group	Not Met	12.5%
PeaceHealth	Not Met	16.0%
Praxis Health	Not Met	15.1%
Providence	Not Met	9.0%
Salem Clinic	Not Met	9.7%

Commercial: Mid-Sized Provider Organizations

This group includes four provider organizations. Organizations in this group had between 10,000 and 20,000 attributed patients with commercial insurance coverage. Cost growth for this group ranged from 7.9% to 21.1%. All the organizations in this group exceeded the target.

In meetings with OHA, provider organizations in this group cited increased utilization as a key driver of growth, rather than price increases. They also pointed to outliers and increased patient acuity, particularly for patients seeking orthopedic, cancer, and vascular services.

2020-2021 commercial cost growth for mid-sized provider organizations (10,000 to 20,000 attributed patients)



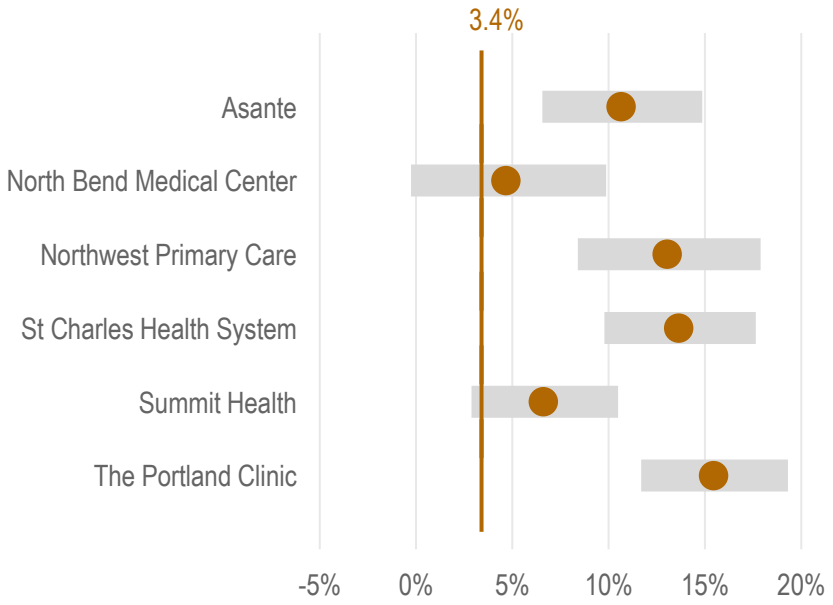
Provider Organization	Target performance	20-21 commercial cost growth
OHSU	Not Met	21.1%
Salem Health	Not Met	18.5%
Samaritan Health	Not Met	7.9%
The Corvallis Clinic	Not Met	11.9%

Commercial: Smaller Provider Organizations

This group includes six provider organizations. Organizations in this group had fewer than 10,000 attributed patients with commercial insurance coverage. Cost growth for this group ranged from 4.7% to 15.4%. None of the provider organizations in this group met the target; four exceeded the target and two were indeterminate.

In meetings with OHA, provider organizations in this group cited increased utilization as a key driver of growth. They also pointed to hospital capacity issues, investments in behavioral health, hospital, and pharmacy costs, and shifting costs to the commercial sector as drivers of cost growth.

2020-2021 commerical cost growth for smaller provider organizations (fewer than 10,000 attributed patients)

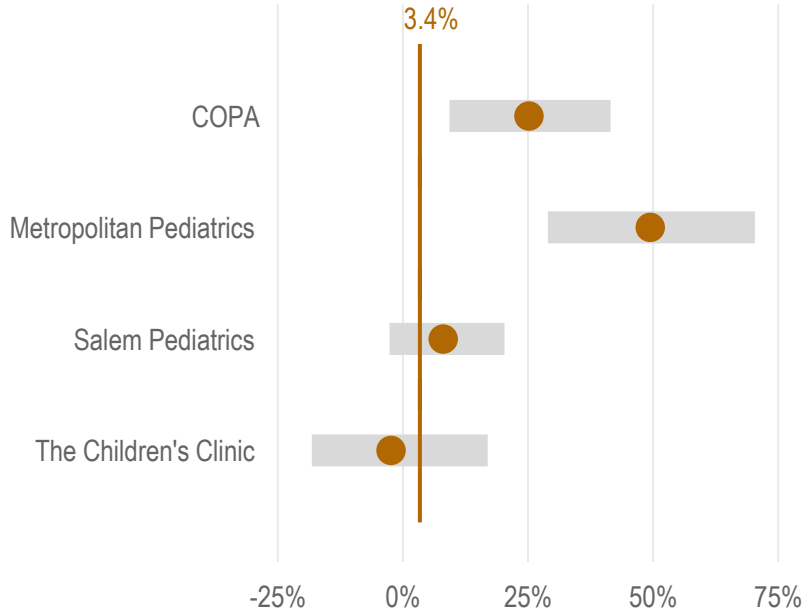


Provider Organization	Target performance	20-21 commercial cost growth
Asante	Not Met	10.6%
North Bend Medical Center	Indeterminate	4.7%
Northwest Primary Care	Not Met	13.0%
St Charles Health System	Not Met	13.6%
Summit Health	Indeterminate	6.6%
The Portland Clinic	Not Met	15.4%

Commercial: Pediatric Provider Organizations

This group includes four pediatric practices. Cost growth for patients with commercial insurance coverage varied widely, ranging from -2.4% to 49.5%. None of the pediatric practices met the target: two exceeded and two were indeterminate.

2020-2021 commercial cost growth for pediatric provider organizations

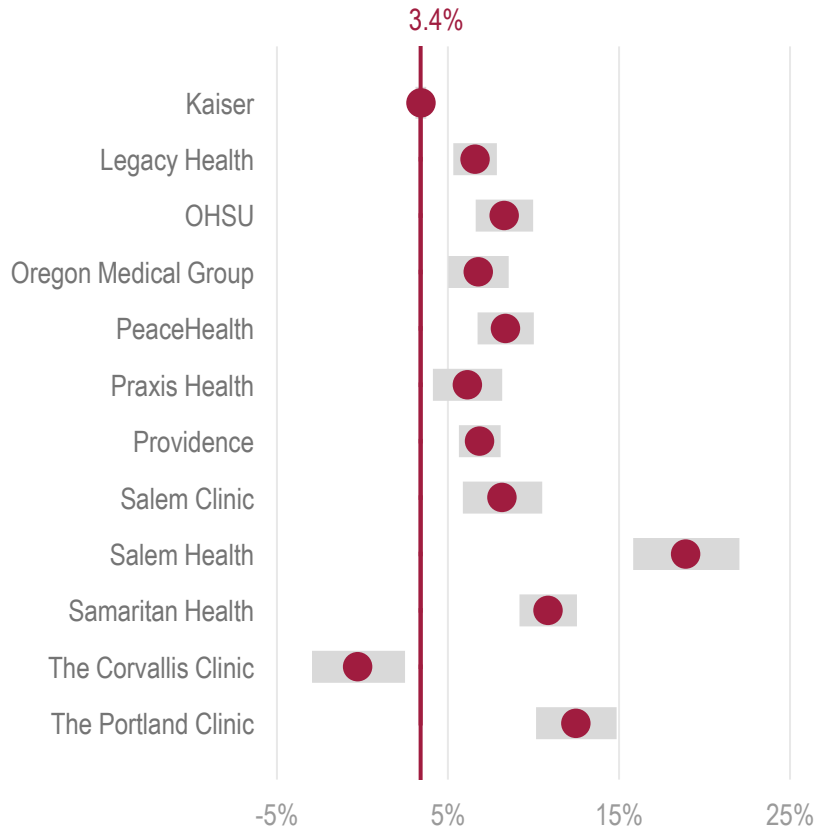


Provider Organization	Target performance	20-21 commercial cost growth
COPA	Not Met	25.2%
Metropolitan Pediatrics	Not Met	49.5%
Salem Pediatrics	Indeterminate	8.1%
The Children's Clinic	Indeterminate	-2.4%

Medicare Advantage

This group includes all 12 provider organizations that had attributed patients with Medicare Advantage insurance coverage. Cost growth for this group ranged from -0.3% to 18.9%. One organization met the target, one was indeterminate, and ten exceeded the target with statistical certainty.

2020-2021 Medicare Advantage cost growth for provider organizations



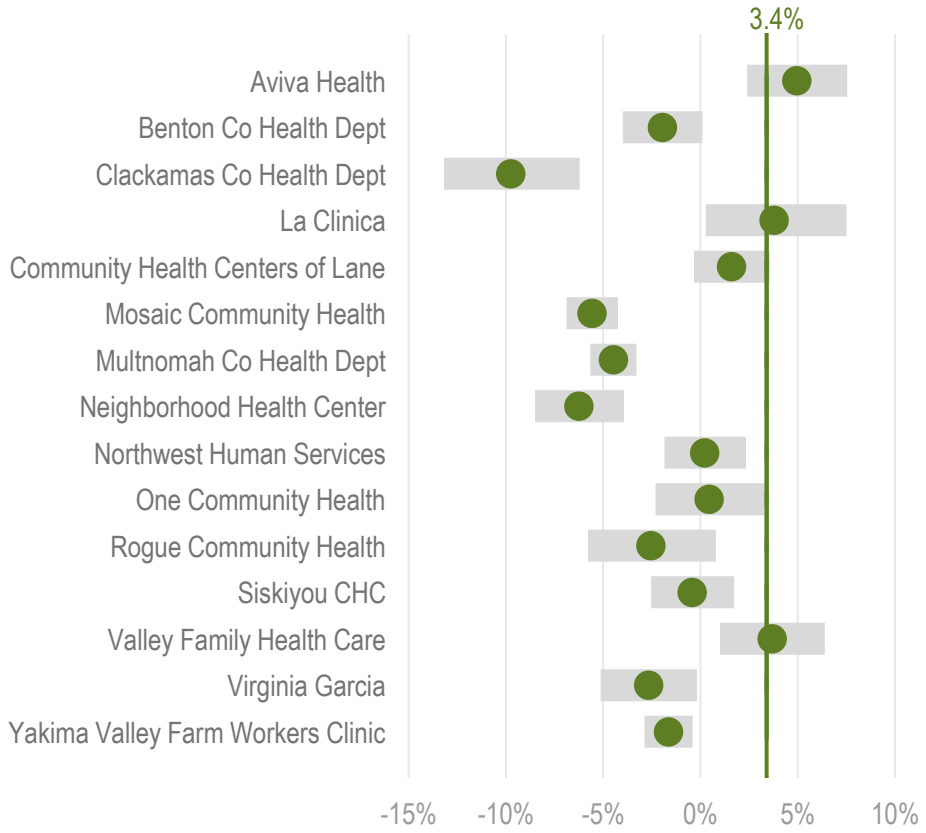
Provider Organization	Target performance	20-21 Medicare Advantage cost growth
Kaiser	Indeterminate	3.4%
Legacy Health	Not Met	6.6%
OHSU	Not Met	8.3%
Oregon Medical Group	Not Met	6.8%
PeaceHealth	Not Met	8.4%
Praxis Health	Not Met	6.1%
Providence	Not Met	6.8%
Salem Clinic	Not Met	8.2%
Salem Health	Not Met	18.9%
Samaritan Health	Not Met	10.8%
The Corvallis Clinic	Met	-0.3%
The Portland Clinic	Not Met	12.5%

Medicaid: Federally Qualified Health Centers

A Federally Qualified Health Center (FQHC), also known as a Community Health Center, is a primary care center that is community-based and patient directed. By mission and design, FQHCs exist to serve those who have limited access to healthcare and welcome low-income individuals, the uninsured, and the underinsured.

This group includes 15 provider organizations with attributed patients with Medicaid coverage. Cost growth for this group ranged from -9.8% to 4.9%. Eleven FQHCs met the cost growth target and four were indeterminate.

2020-2021 Medicaid cost growth for FQHCs

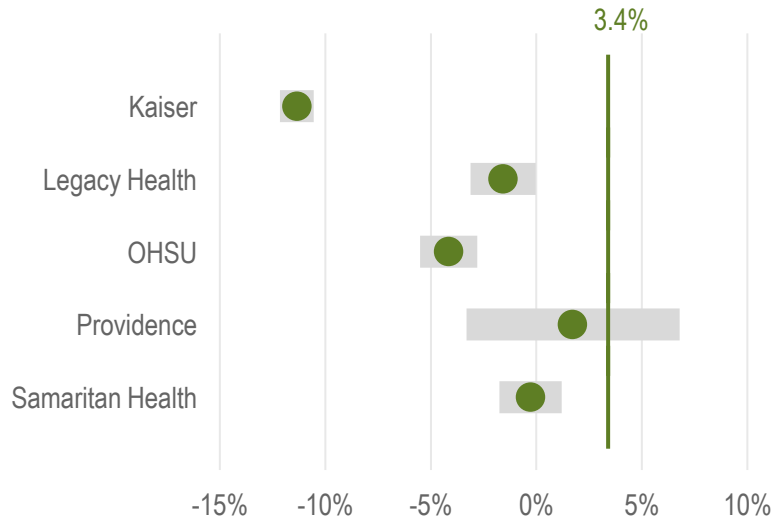


Provider Organization	Target performance	20-21 Medicaid cost growth
Aviva Health	Indeterminate	4.9%
Benton Co Health Dept	Met	-2.0%
Clackamas Co Health Dept	Met	-9.8%
La Clinica	Indeterminate	3.8%
Community Health Centers of Lane County	Indeterminate	1.6%
Mosaic Community Health	Met	-5.6%
Multnomah Co Health Dept	Met	-4.5%
Neighborhood Health Center	Met	-6.2%
Northwest Human Services	Met	0.2%
One Community Health	Met	0.4%
Rogue Community Health	Met	-2.5%
Siskiyou CHC	Met	-0.4%
Valley Family Health Care	Indeterminate	3.7%
Virginia Garcia	Met	-2.7%
Yakima Valley Farm Workers Clinic	Met	-1.6%

Medicaid: Large Provider Organizations

This group includes five provider organizations, each with more than 20,000 attributed patients with Medicaid coverage. Cost growth for this group ranged from -11.4% to 1.7%. Four of the organizations met the cost growth target and one organization was indeterminate.

2020-2021 Medicaid cost growth for large provider organizations

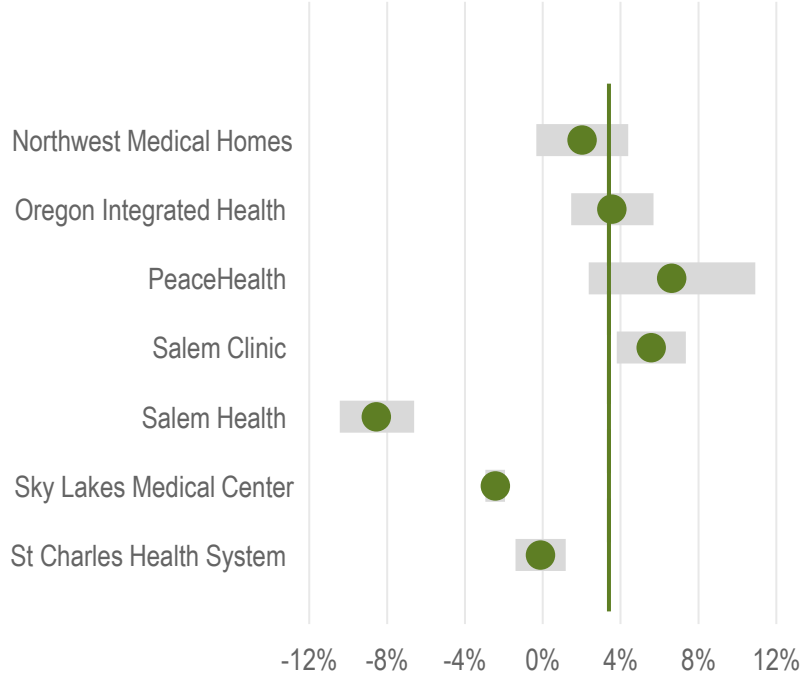


Provider Organization	Target performance	20-21 Medicaid cost growth
Kaiser	Met	-11.4%
Legacy Health	Met	-1.6%
OHSU	Met	-4.2%
Providence	Indeterminate	1.7%
Samaritan Health	Met	-0.3%

Medicaid: Mid-sized Provider Organizations

This group includes eight provider organizations, each with 10,000 to 20,000 attributed patients with Medicaid coverage. Cost growth for this group ranged from -8.5% to 6.6%. Three organizations met the cost growth target, four were indeterminate, and one organization exceeded the cost growth target with statistical certainty.

2020-2021 Medicaid cost growth for mid-sized provider organizations

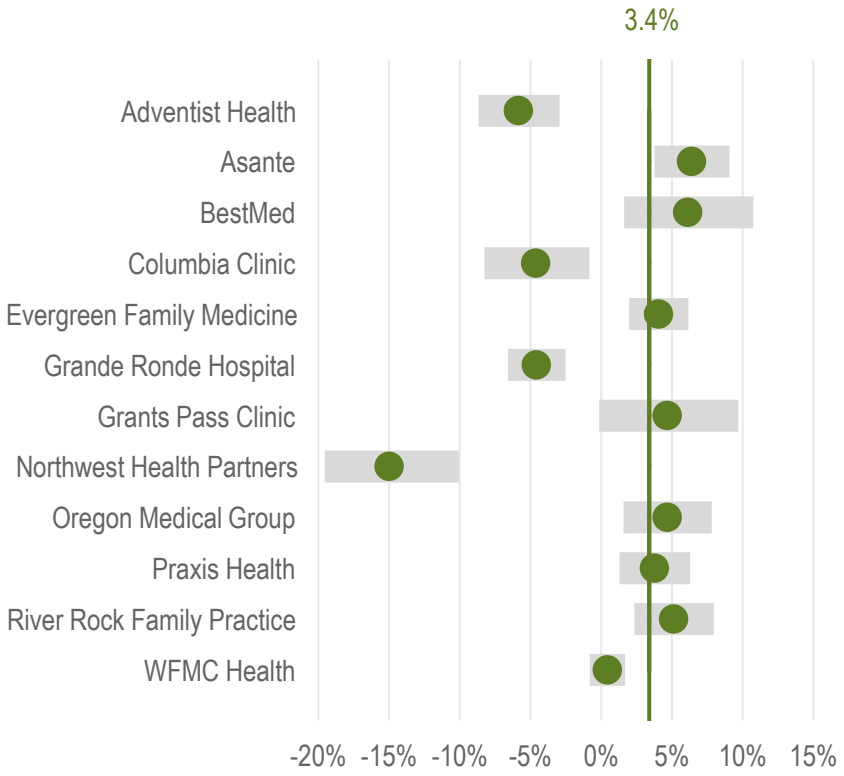


Provider Organization	Target performance	20-21 Medicaid cost growth
Northwest Medical Homes	Indeterminate	2.0%
Oregon Integrated Health	Indeterminate	3.6%
PeaceHealth	Indeterminate	6.6%
Salem Clinic	Not Met	5.6%
Salem Health	Met	-8.5%
Sky Lakes Medical Center	Met	-2.4%
St Charles Health System	Met	-0.1%

Medicaid: Smaller Provider Organizations

This group includes 12 provider organizations, each with fewer than 10, 000 attributed patients with Medicaid coverage. Cost growth for this group ranged from -15.0% to 6.4%. Six organizations met the cost growth target, five were indeterminate, and one organization exceeded the cost growth target with statistical certainty.

2020-2021 Medicaid cost growth for smaller provider organizations

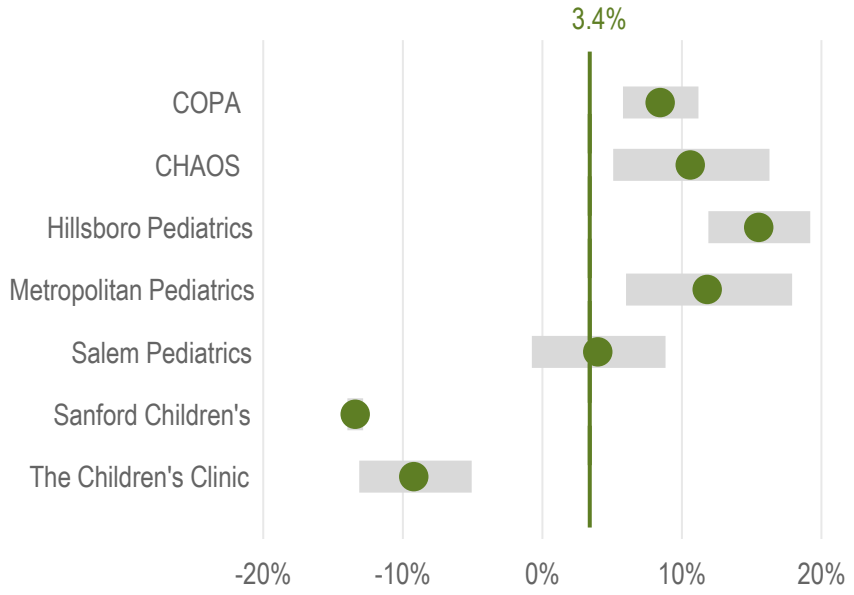


Provider Organization	Target performance	20-21 Medicaid cost growth
Adventist Health	Met	-5.9%
Asante	Not Met	6.4%
BestMed	Indeterminate	6.1%
Columbia Clinic	Met	-4.6%
Evergreen Family Medicine	Indeterminate	4.1%
Grande Ronde Hospital	Met	-4.6%
Grants Pass Clinic	Indeterminate	4.7%
Northwest Health Partners	Met	-15.0%
Oregon Medical Group	Indeterminate	4.7%
Praxis Health	Indeterminate	3.8%
River Rock Family Practice	Indeterminate	5.1%
WFMC Health	Met	0.4%

Medicaid: Pediatric Provider Organizations

Seven pediatric provider organizations had attributed Medicaid patients. Cost growth for this group ranged from -13.4% to 15.5%. Two organizations met the cost growth target, one was indeterminate, and four organizations exceeded the cost growth target with statistical certainty.

2020-2021 Medicaid cost growth for pediatric provider organizations



Provider Organization	Target performance	20-21 Medicaid cost growth
COPA	Not Met	8.4%
CHAOS	Not Met	10.6%
Hillsboro Pediatrics	Not Met	15.5%
Metropolitan Pediatrics	Not Met	11.8%
Salem Pediatrics	Indeterminate	4.0%
Sanford Children's	Met	-13.4%
The Children's Clinic	Met	-9.2%

Appendix: Methodology

Data Sources

Cost Growth Target Data Submissions

Total health care expenditure data for calendar years 2020-2021 is collected in the 2022 CGT data submissions. These files were submitted by mandatory data reporters (payers with at least 1,000 covered lives) in the Fall/Winter of 2022.

OHA conducted a comprehensive three-stage data validation process with all data reporters, focusing on data completeness and quality, understanding cost growth trends, and outliers in the data. OHA met individually with each data reporter about their data submission before finalizing the files used for analysis.

OHA obtained a data file from CMS with spending for Medicare Fee-For-Service members in Oregon.

Other Data Sources

Other health care spending was collected from a variety of sources, including:

- Veterans Affairs spending in Oregon from the US Department of Veteran's Affairs
- Spending for people in state correctional facilities from the Oregon Department of Corrections
- State funding for behavioral health (e.g., contracts for treatment and recovery supports for mental health, substance use disorder, and problem gambling) from OHA.
- Consumer spending on prescriptions through Oregon's regional bulk pharmacy discount program (ArrayRx) not otherwise captured in claims spending, from OHA.

OHA also compiles 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 provided by DCBS or from payers.

Some SHCE data were not available in time to be included in this report and are not reflected in the market level NCPHIs:

- HEALTH NET LIFE INSURANCE COMPANY (2020)
- HEALTH NET HEALTH PLAN OF OREGON, INC. (2020-2021)
- UNITED HEALTHCARE INSURANCE COMPANY OF AMERICA (2021)

Types of Cost Growth Target Program Analyses

	Cost Growth Target Performance	Cost Driver Analysis
What is this?	A calculation of health care cost growth over a given period, compared to the cost growth target.	An analysis of what was driving health care cost growth in a given period, for example, growth in prices or growth in services
What data are used?	Aggregate data on health care costs, submitted by payers specifically for the Cost Growth Target Program. Includes claims and non-claims spending, pharmacy rebates, and administrative costs.	Granular claims data from Oregon's All Payer All Claims (APAC) database, submitted by payers, third-party administrators, and pharmacy benefit managers.
When is the analysis conducted?	Annually. Payers submit data to the Cost Growth Target Program each fall, data is validated and analyzed and published several months later.	Ad hoc throughout the year, as needed to supplement the Cost Growth Target Performance analysis and to help identify and inform opportunities and strategies to reduce cost growth.

Payer Inclusion

All payers and third-party administrators (TPAs) with at least 1,000 covered Oregon lives across all lines of business must submit cost growth target data to the Oregon Health Authority.

OHA uses enrollment data from the Department of Consumer and Business Services and from OHA's Medicaid enrollment reports to identify mandatory data submitters each year. OHA also identifies ERISA self-insured plans and invites these payers to voluntarily submit cost growth data.

More detail on payer inclusion criteria can be found in Oregon Administrative Rule 409-065.

Cost Growth Target Data

Payers reported all claims and non-claims payments made to provider organizations in three major markets: Commercial, Medicare, and Medicaid.

Commercial includes individual, large group, small group, self-insured, short-term, and student plans.

Medicare includes both Medicare Advantage and traditional Medicare fee-for-service (FFS), also known as Original Medicare.

Medicaid includes both Coordinated Care Organizations and Open Card / Medicaid fee-for-service (FFS).

Market Specific Notes

Commercial

The Commercial data in this report includes fully-insured and PEBB/OEBB plans. Commercial data includes some spending for self-insured plans, but not all self-insured spending.

Medicare

The Medicare data at the statewide level include both commercial Medicare Advantage plans (Part C) and Medicare fee-for-service (A, B, D).

In Total Medical Expenditure (TME) reporting, Medicare market data is limited to Medicare Advantage only. Medicare FFS data is provided in aggregate by CMS and does not precisely match the service categories used.

Medicaid

Medicaid Coordinated Care Organizations report data that includes all Medicaid and CHIP expenditures across all CCO benefit categories (A, B, E and G) unless specifically excluded, see *Guidance for Medicaid Coordinated Care Organizations (CCOs)* in the Data Specification Manual.

The Medicaid trends identified in this report do not necessarily align with CCO global budgets trends or the state budget for the Medicaid program due to significant differences in methodology, inclusion and exclusion criteria, and data sources.

Dual Eligible Members

At the statewide level, Total Health Care Expenditures for people dually enrolled in Medicare and Medicaid is reported in the Medicare market. OHA is unable to estimate a unique count of individual members between all dual market data sources.

When reporting Total Medical Expenditures, spending for dual eligible members are reported on a *paid amount* basis (unlike other cost growth target TME data, which is reported on an allowed amount basis). Spending for dual eligible members is reported for paid amounts because some duals spending would be excluded if only the allowed amounts were reported. This is a change from how spending for dual eligible members was collected and reported on in the 2018-2020 report (which was a known undercount of spending for duals).

Payers report payments for dual eligible members whether they were the primary or secondary insurer for that member. Medicare-related expenses are reported under the Medicare Duals line of business and Medicaid-related expenses are reported under the Medicaid Duals line of business.

Exclusions

The cost growth target program excludes the following:

- Health care spending for out-of-state residents who received care from Oregon providers and people without insurance.
- Certain benefit plans, including accident policy; disability policy; hospital indemnity policy; long-term care insurance; Medicare supplemental insurance (AKA Medigap); stand-alone prescription drug plans; specific disease policy; stop-loss plans; supplemental insurance that pays deductibles, copays, or coinsurance; vision-only insurance; workers compensation; and dental-only insurance.
- Certain payments, including CMS reconciliation payments (such as Medicare sweep or Part D) and ACA risk transfer payments.
- Premium payments made by people to their health plan.
- Payer reinsurance recoveries or reinsurance premiums.
- Discounts and other perks, such as gym memberships.
- COVID-related funds that are *not* paid to providers.

Data Validation

OHA conducts comprehensive validation on the cost growth target data submissions each year.

A data submission is considered validated when OHA and the payer have had a change to review, correct if needed, and discuss any questions and provide any clarifications for completeness and quality.

The cost growth target data validation process includes:

1) Initial review for completeness
2) Detailed review for trends and outliers
3) Data review and finalization

Stage 1: Initial review for completeness

OHA reviews each data submission for completion of all relevant tabs in the workbook and for consistency of dollars, member months, provider organizations, and other information across the workbook.

A data submission must pass Stage 1 before moving forward; any failed validation checks prevents the data submission file from being used to produce year-to-year cost trends or merged into the statewide data file.

Stage 2: Detailed review for trends and outliers

OHA produces and reviews cost growth trends for each data submitter for each market in which they have sufficient members. If any potential issues are identified, OHA will communicate with the data submitter during Stage 3.

Stage 3: Data review and finalization

OHA shares the Stage 2 data output with the payer and holds a meeting to discuss any outstanding questions or concerns. Stage 3 meetings can result in a final data submission or a request for the payer to resubmit the data file with any needed corrections.

Regular communication occurs between OHA and data submitter staff throughout the data validation process. Once all potential issues have been addressed and approved by OHA, then the data file is considered finalized and ready for statewide, market, payer, and provider organization analysis.

More detail on the data validation process is available in the CGT Data Specification Manual.

Adjustment

The Cost Growth Target Implementation Committee recommended that performance relative to the cost growth target needs to be risk-adjusted for payers and provider organizations, but not at the market or statewide levels, since these populations are large enough to be stable over time.

For 2020-2021, payers submitted unadjusted and adjusted spending data using demographic risk adjustment methodology provided by OHA. OHA used demographically adjusted data to calculate cost growth trends at the payer and provider level. OHA used unadjusted data to calculate the state and market level trends for this report, but also calculates the demographically adjusted state and market level trends to provide an appropriate comparison for payer and provider organization cost growth.

This is a change from the previous reporting period – for 2018-2020, payers submitted unadjusted and adjusted spending data using their own risk adjustment tools and methodology.

Covered benefits and cost and utilization patterns differ across markets and across years. No adjustments were made in this report to account for those differences.

Cost Growth Target Analysis

The cost growth target program measures the total cost of care and spending trends in Oregon across multiple levels and using two key measures:

Total Health Care Expenditures (THCE)

THCE is an aggregate measure of health care spending that includes all claims and non-claims based spending, as reported in the cost growth target data submission. It also includes the Net Cost of Private Health Insurance, and other spending from supplemental data sources.

THCE is reported as total dollars spent and on a per person per year (PPPY) basis. The year-over-year growth rate for both total dollars and PPPY is calculated between 2020-2021.

Total Medical Expenses (TME)

TME is an aggregate measure of health care spending that includes all claims and non-claims based spending, as reported in the cost growth target data submission.

TME is reported as total dollars spent and on a per person per year (PPPY) basis at the state, market, payer, and provider organization level. The year-over-year growth rate for both total dollars and PPPY is calculated between 2020-2021.

OHA calculates both an unadjusted and demographically-adjusted TME at the state and market level, so that payer and provider organization cost growth can be compared to the adjusted statewide cost growth rate.

Claims Spending Categories

Hospital Services	
Inpatient care	Hospital-based care after being admitted. Examples include childbirth, complex surgeries, medical or behavioral hospitalizations. Includes drugs that are administered to patients admitted in a hospital.
Outpatient care	Services provided in hospital-licensed satellite clinic settings; specifically excludes services that are rendered to patients admitted in a hospital. Includes emergency room services not resulting in admittance and observation services.
Professional Services	
Primary care	Services provided by health care providers that are defined as a primary care provider including, but not limited to: doctors of medicine or osteopathy in family medicine, internal medicine, general medicine, pediatric medicine, nurse practitioners, and physician assistants.
Specialty care	Services provided by doctors 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	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, etc.
Other	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, nonprimary care physician assistants, physical therapists, etc.
Retail Pharmacy	
Retail prescription drugs, biological products, and vaccines as defined by the payer. This category does not include physician-administered medications.	
Other	
Long-Term care	Care provided in nursing homes and skilled nursing facilities (SNF), intermediate care facilities for individuals with intellectual disabilities (ICF/ID) and assisted living facilities. Also includes providers of home- and community-based services, including personal care (e.g., assistance with dressing, bathing, etc.), homemaker and chore services, home delivered meal programs, home health services, etc.
All other	All other services including ambulance rides, independent laboratories, hospice, and any service not otherwise categorized.

Non-Claims Spending Categories

Prospective Capitated, Prospective Global Budget, Prospective Case Rate, or Prospective Episode-Based Payments

All payments based under the following payment arrangements: *capitation payments*, *global budget payments, case rate payments* (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

Payments to reward providers for reaching quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. This category includes pay-for-performance, pay-for-reporting, shared savings distributions, and shared risk recoupments.

Payments to Support Population Health and Practice Infrastructure

Payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs. Includes payments that support care management, care coordination and population, data analytics, EHR/HIT infrastructure payments, medication reconciliation; patient-centered medical home 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 only applicable to closed delivery systems.

Recovery

All payments received by a payer 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.

Other

All other payments made in accordance with a contract between a payer and provider not made on the basis of a claim for health care benefits or services and cannot be classified elsewhere. This may include governmental payer shortfall payments, grants or other surplus payments. For calendar years 2020 and 2021, this may also include supportive funds made to providers to support clinical and business operations during the global COVID-19 pandemic.

You can get this document in other languages, large print, braille, or a format you prefer. Contact the Sustainable Health Care Cost Growth Target Program at 503-385-5948 or email HealthCare.CostTarget@oha.oregon.gov.

HEALTH CARE COST GROWTH TARGET

Oregon Health Authority