Health Care Cost Growth Trends in Oregon, 2018-2020

2022 Sustainable Health Care Cost Growth Target Annual Report

May 2, 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 between 2018 and 2020. Building on the *Health Care Cost Trends, 2013-2019* report, this report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2018 and 2020.

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.

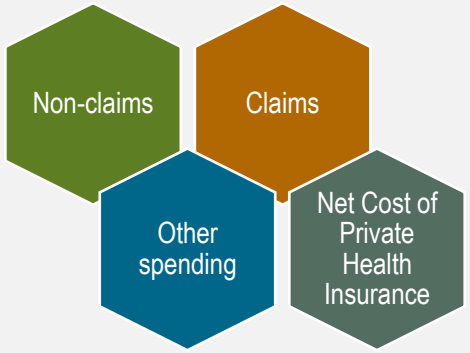
By identifying drivers of health care cost growth in Oregon, this report sets the stage for policymakers, health system partners, and other stakeholders to identify opportunities and strategies to slow cost growth and address growing affordability concerns across public and private markets.

HEALTH CARE COST GROWTH TARGET

Click the icon to explore the Cost Growth Target 2018-2020 Databook

This report uses **Total Health Care Expenditures (THCE)** to report on health care spending growth between 2018 and 2020 at the state and market level (Medicaid, Medicare, Commercial).

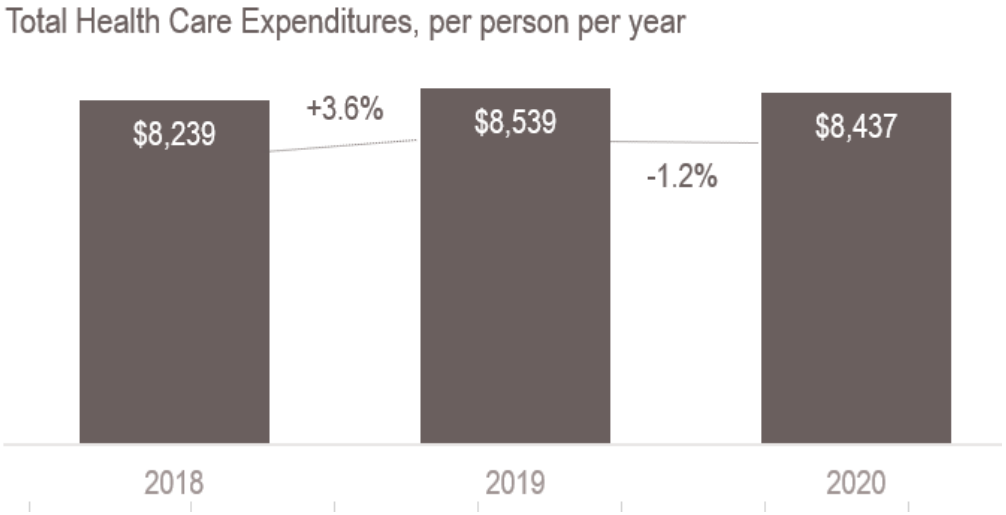
THCE includes claims and non-claims payments between payers and provider organizations, as well as other health care spending in public programs like Veterans Affairs and the Department of Corrections, and the Net Cost of Private Health Insurance (the costs associated with administering a health plan).



This report also looks at health care spending by category, e.g., hospital inpatient, retail pharmacy, value-based payments, etc.

Key Findings

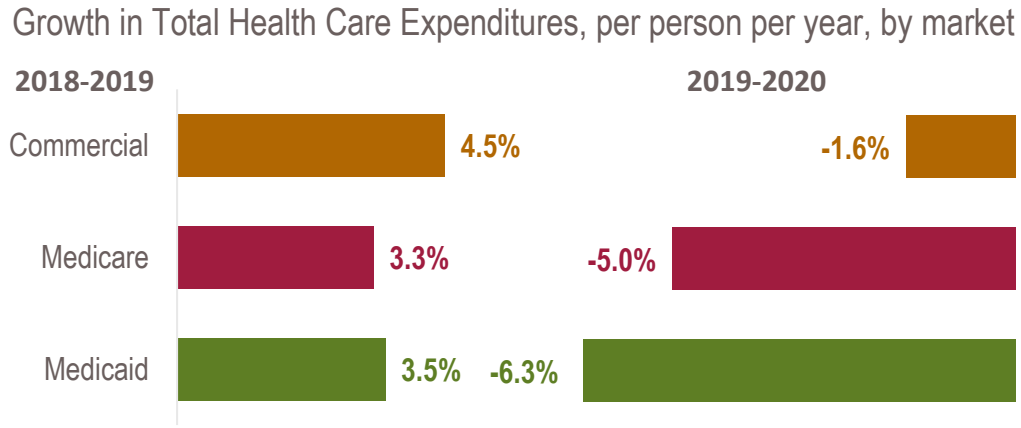
Total health care expenditures per person per year in Oregon increased between 2018-2019, then decreased slightly between 2019-2020



Between 2018 and 2019, total health care expenditures (THCE) per person per year grew 3.6%, from $8,239 to $8,549, slightly above the cost growth target of 3.4%.

Between 2019 and 2020, THCE per person per year decreased slightly (-1.2%) to $8,437.

All markets experienced growth in total health care expenditures between 2018-2019, then a decrease between 2019-2020, although the experience varied by market

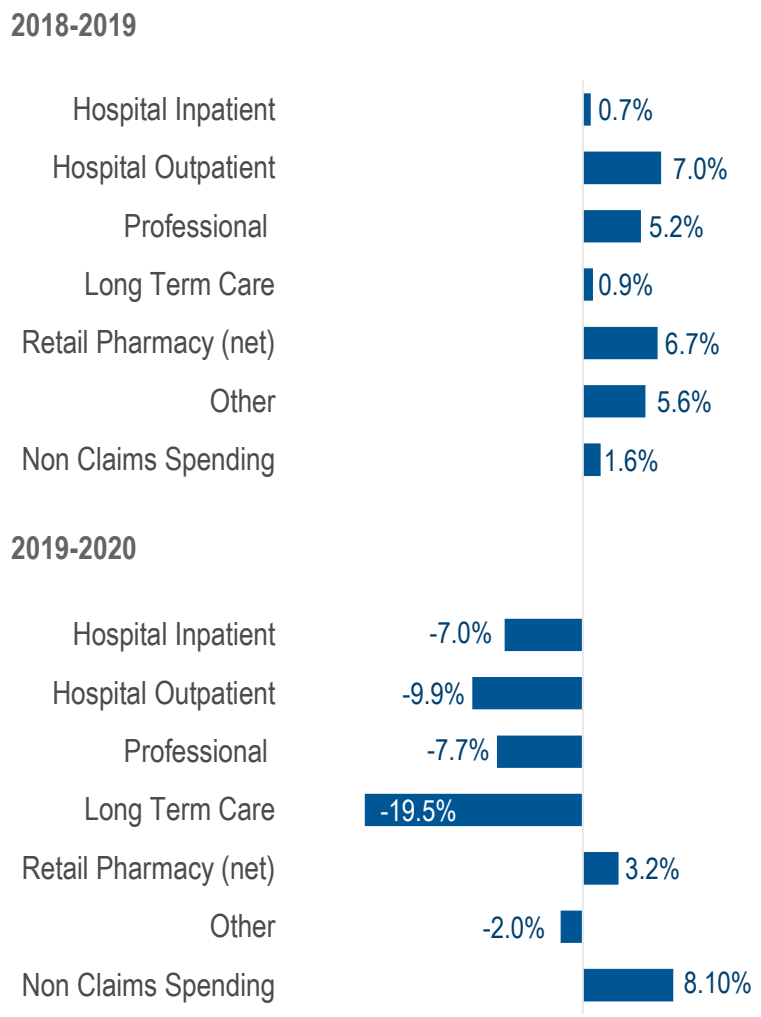


Commercial, Medicare, and Medicaid all experienced similar growth in health care spending between 2018-2019.

Total health care expenditures decreased the most for Medicaid between 2019-2020 (-6.3%) and the least for the commercial market (-1.6%).

Retail pharmacy spending continued to increase between 2018-2020, while spending declined in most other service categories between 2019-2020 due to the pandemic

Growth in Total Medical Expenditures, by category, statewide



Between 2018-2019, per person per year spending grew in all categories.

Hospital outpatient services and retail pharmacy (net of pharmacy rebates) experienced the most growth.

Between 2019-2020, the COVID-19 pandemic greatly shifted health care demand, which impacted spending as people delayed or cancelled care.

Per person per year spending declined in most categories, however, retail pharmacy continued to grow.

Table of Contents

Suggested Citation: Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2018-2020. Portland, OR. May 2023.

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 2018 and 2020. Building on the *Health Care Cost Trends, 2013-2019* report, which used claims data to understand health care spending, this report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2018 and 2020.

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. These data are used to measure statewide, market level, payer, and large provider organization performance relative to the cost growth target each year. See *Appendix 1: Methodology* for a summary of the different analyses and data sources used by the Cost Growth Target Program.

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.

In This Report

Chapter I explores health care cost growth trends between 2018 and 2020 statewide and by market (Commercial, Medicaid and Medicare).

Chapter II presents health care cost growth trends by category (e.g., hospital inpatient, pharmacy, value-based payments) statewide and by market (Commercial, Medicaid, and Medicare)

Chapter III provides an overview of health care cost growth trends for *de-identified* payer and provider organizations.

Note: Identified payer and provider organization health care cost growth will be included in the 2023 Annual Report (May 2023).

Chapter IV discusses external factors that have impacted Oregon's health care system and spending during 2018-2020 (e.g., COVID-19 pandemic).

HEALTH CARE COST GROWTH TARGET

Click the icon to explore the Cost Growth Target 2018-2020 Databook

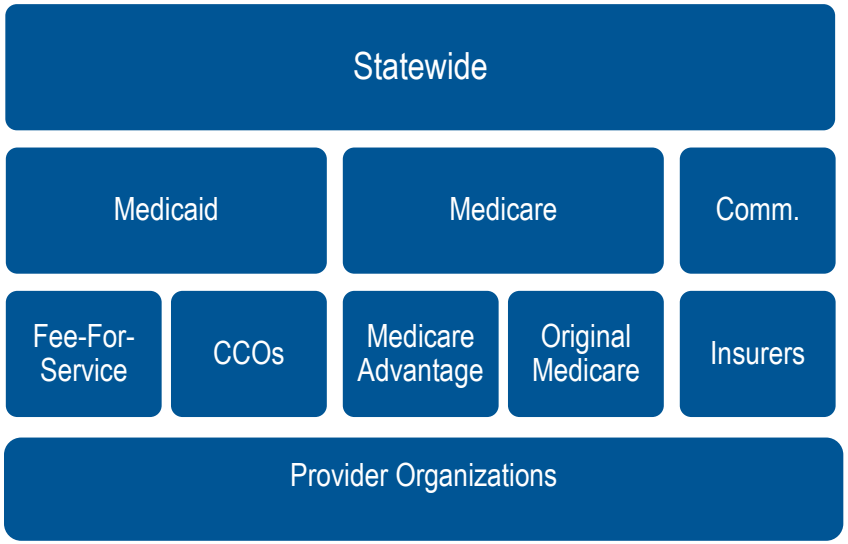
What is the health care cost growth target?

Oregon believes that cost containment is possible in the current health care system, where multiple payers negotiate with multiple provider organizations. To successfully address health care costs, all parts of the health care system must share a high-level goal for cost growth.

Therefore, the cost growth target applies and is measured at four different levels: statewide, by market, by payer, and by large provider organization.

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 person-centered view of health care spending includes all costs related to an individual's care, rather than focusing on a single factor like prices.

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



Oregon's health care cost growth target sets an aspirational annual rate of growth for health care spending in the state.

An important distinction must be made between cost growth targets and spending caps. Cost growth targets do not limit or cap health care spending; instead, they aim 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 (2021-2025), and 3.0% for the second five years (2026-2030).

2021-2025 **3.4%**	**2026-2030** **3.0%**
Informed by historical GDP and historical median wage.	Advisory Committee will re-assess cost growth target value in 2025 and adjust if needed.

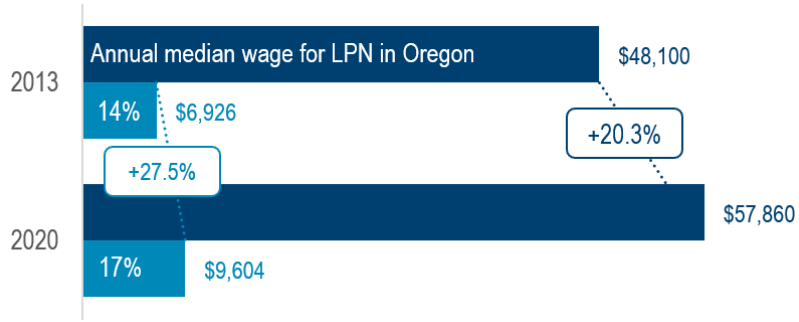
Health care costs continue to grow in Oregon, taking up a greater share of income, leading people to delay health care.

In 2020, health care and health insurance spending represented 23% of all household spending in Oregon.[1] Personal consumption expenditures (PCE) on health care in Oregon increased to $7,629 per person between 2018-2019, growing faster than the national rate. PCE on health care declined at similar rates between 2019-2020.[2]

Growth in personal consumption expenditures on health care

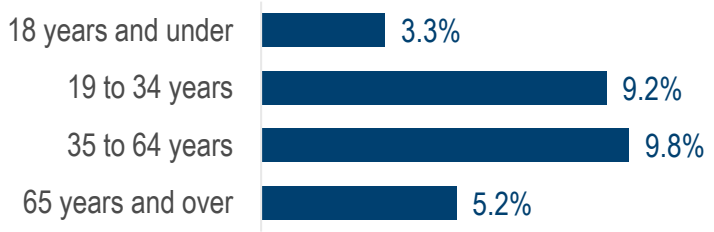
Health care costs take up a growing share of income. For example, in 2013, the employee share of health insurance premiums and out of pocket spending on deductibles and co-payments was 14% of the annual median wage for a Licensed Practical Nurse in Oregon. By 2020, that increased to 17%.[3]

In 2020, **the employee share of health insurance premiums and out of pocket spending** was 17% of the **median wage for an LPN** in Oregon



High costs cause people in Oregon to delay health care – especially working age adults. A national poll found that 38% of adults reported delaying care due to costs in 2022.[4]

Percent of people in Oregon reporting they delayed health care due to costs, 2021



[1] Bureau of Economic Analysis Personal Consumption Expenditures by Function (SAPCE4), 2020
[2] Bureau of Economic Analysis Personal Consumption Expenditures by major type of product (SAPCE1), 2018-2020.
[3] Bureau of Labor Statistics Annual Median Wage by Occupation. AHRQ MEPS Insurance Component
[4] Oregon Health Insurance Survey, 2021. Gallup Health and Healthcare Poll, January 2023.

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 – 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 the most rigorous in the nation.

Transparency: This 2022 report includes health care cost growth trends at the state and market level; public reporting of cost growth trends at the payer and provider organization level begins in the 2023 report.

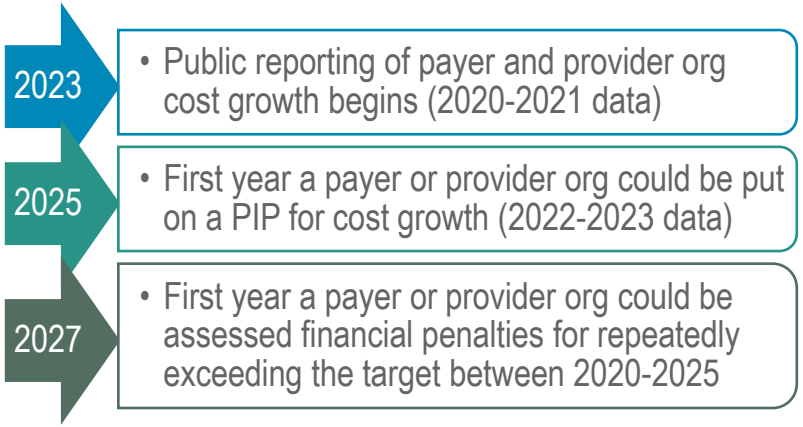
Performance Improvement Plans: PIPs may be applied to payers and provider organizations who exceed the target with statistical certainty AND without a good reason.[5] In January 2023, after consideration of inflation and labor costs, the Advisory Committee agreed to delay implementation of PIPs by one year from the original timeline.

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.

Justifiable reasons for a payer or provider organization to exceed the cost growth target

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

Accountability Implementation Timeline[6]



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

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

Measuring Health Care Cost Growth

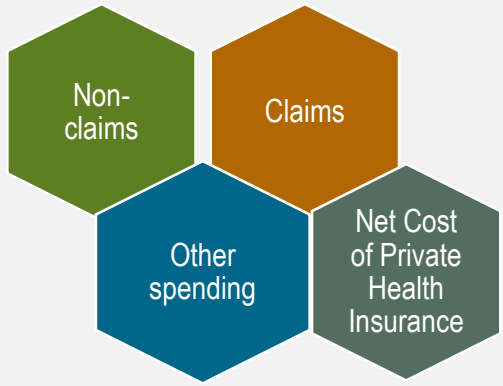
Oregon reports on health care cost growth using two different metrics: Total Health Care Expenditures and Total Medical Expenses. See sidebar.

What's included in each type of health care spending:

- **Claims spending** is composed of 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.
- **Non-claims spending** includes all payments that payers make to providers other than providers' claims; these can include incentive payments, prospective payments (e.g., capitation), payments to support care transformation (e.g., patient-centered primary care home payments), etc.
- **Net Cost of Private Health Insurance** captures the cost associated with the administration of private health insurance. It is the difference between collected health plan premiums and claims paid by payers.
- **Other spending** includes state and federal payments for health care for military veterans, people in state correctional facilities, direct contracts for behavioral health services, and more.

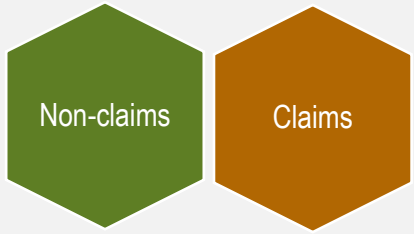
Total Health Care Expenditures

For reporting statewide and market level cost growth:



Total Medical Expenses

For reporting service category, and payer and provider organization cost growth:



See Appendix 1 and 2 for additional details.

Glossary

Cost growth: "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.

Market: "market" in this report refers to Commercial, Medicaid, and Medicare – also known as "line of business".

Net Cost of Private Health Insurance (NCPHI): this captures the cost to Oregon residents associated with the administration of private health insurance. It is the difference between health premiums collected 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. NCPHI is calculated for commercial health plans, Medicare Advantage plans, and Medicaid Coordinated Care Organizations.

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

Provider organization: this report uses "provider organization" to refer to an entity with primary care providers that directs the care of its patients, thereby assuming responsibility for a total cost of care for that person.

Total Medical Expense (TME): sum of the allowed amount of total claims and total non-claims spending paid to providers for all health care services delivered to Oregon residents.

Total Health Care Expenditure (THCE): the sum of TME plus insurers' NCPHI and other spending.

Chapter I. Health Care Cost Growth Trends, 2018-2020 Statewide and by Market

This first section of the report explores health care cost growth trends between 2018 and 2020 statewide and by market (commercial, Medicaid, Medicare).

Cost growth trends are presented in both total dollars spent in Oregon and on a per person per year basis.

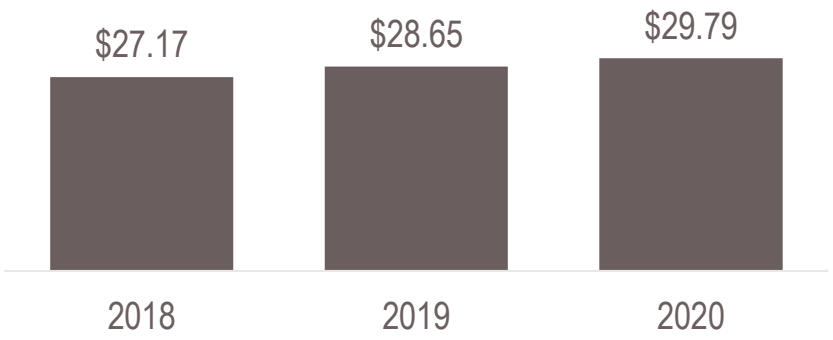
List of Figures

Total Health Care Spending in Oregon

Total Health Care Spending, Statewide

In 2020, health care spending in Oregon totaled $29.79 billion, increasing from $27.17 billion in 2018 and $28.65 billion in 2019. This represents a 5.4% increase between 2018-2019 and a 4.0% increase between 2019-2020.

Fig 1.1 Total health care spending in Oregon, in billions



Total health care spending as portion of state gross domestic product increased from 11.5% in 2018 to 12.2% in 2020.

This growth in spending aligns with CMS National Health Expenditures (NHE) data which captures a broader scope of health spending for states. Using NHE data, Oregon's health spending as a share of state gross domestic product increased from 16.2% in 2018 to 17.6% in 2020.

Total Health Care Spending, by Market

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 $10.64 billion in 2020 and represented almost 36% of health care spending in Oregon in 2020.

Commercial health insurance is the second largest market in Oregon by total dollars spent. Commercial spending in 2020 was about $8.98 billion, representing 30% of health care spending that year.

Medicaid provides health insurance for families and people with low incomes. Total Medicaid spending in Oregon was $5.85 billion in 2020, almost 20% of health care spending.

Net Cost of Private Health Insurance represents the costs of administering a health insurance plan. NCPHI totaled $2.28 billion, or almost 8% of spending in 2020.

Other includes health care spending in programs like the Department of Corrections and Veterans Affairs. Other spending totaled $2.05 billion in 2020, or about 7%

See Fig 1.4 on the next page for the growth rate in total dollars spent in each market and Fig 1.5 for a more detailed discussion of other spending.

Fig 1.2
Total health care spending in Oregon, by market, in billions

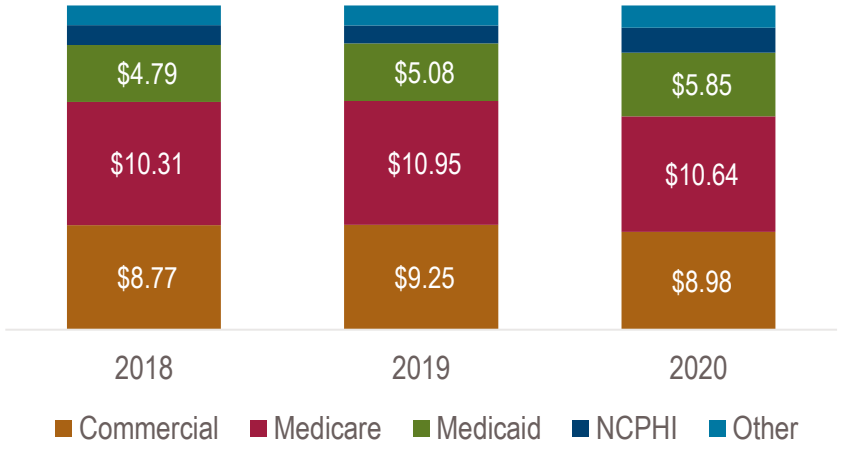


Fig 1.3
Total health care spending, by market, as percentage of total

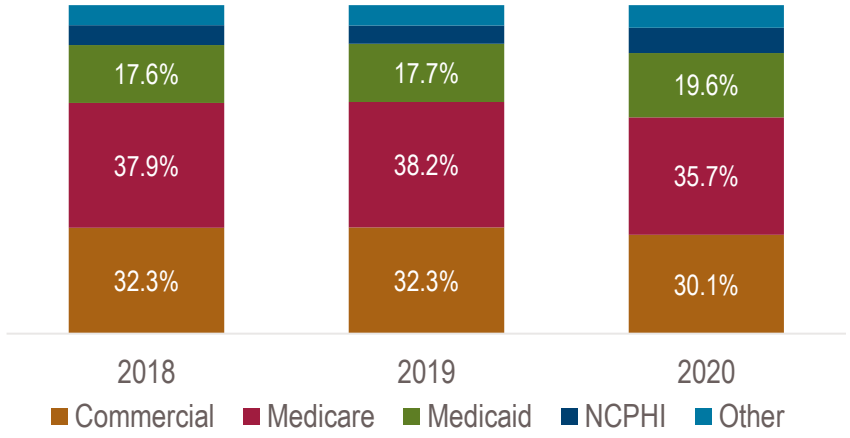
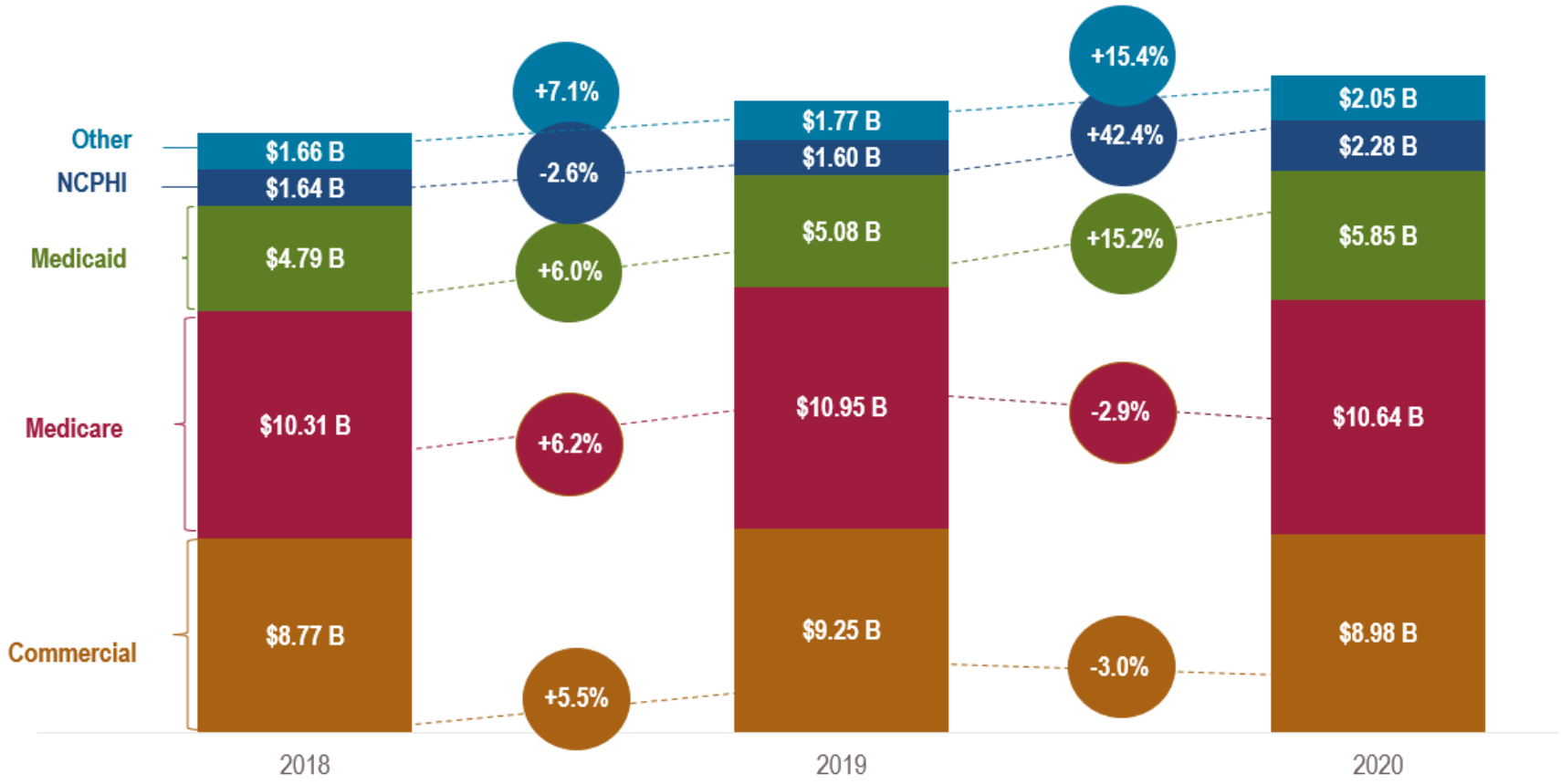


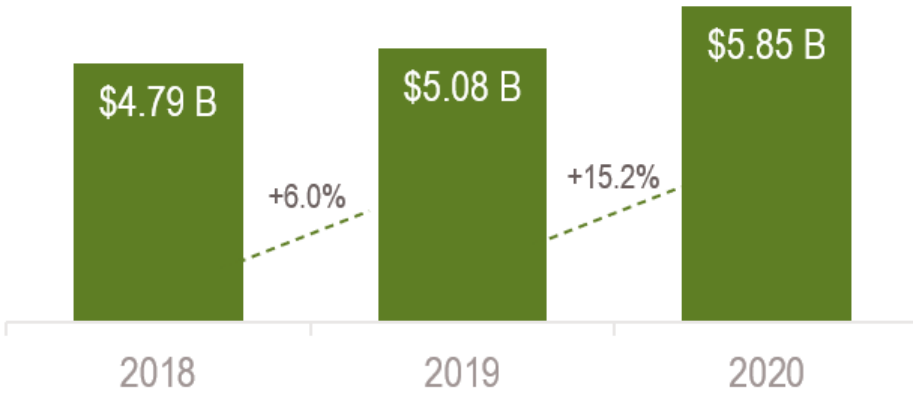
Fig 1.4 Growth rate in total health care spending, by market

Total health care spending grew across all markets between 2018-2019 followed by declines in 2020 in the commercial and Medicare markets, likely due to the COVID-19-related drop in health care utilization. This can also be seen in the increase in the Net Cost of Private Health Insurance (NCPHI) in 2020 – as health plans had fewer claims to pay, their NCPHI grew. See pages 23-24.



Medicaid Spending and the Public Health Emergency

Fig 1.5 Growth rate in total health care spending, Medicaid

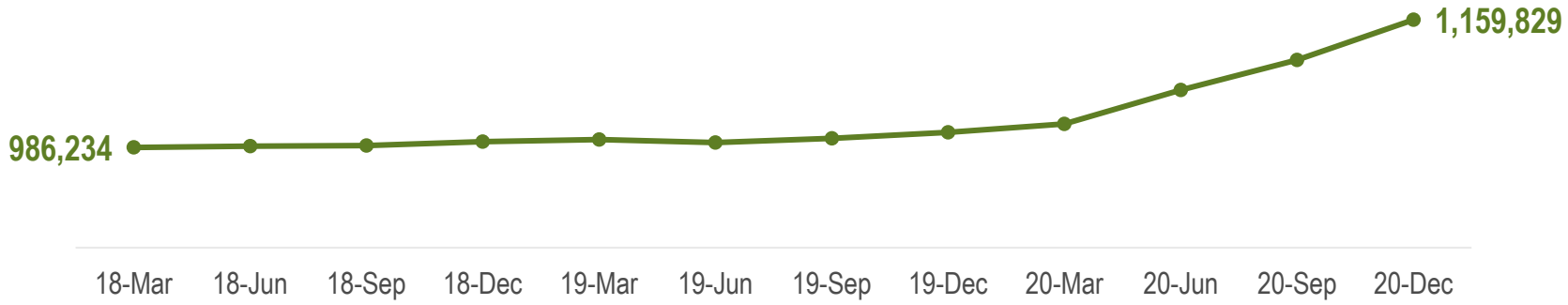


Between 2018 and 2019, total health care spending in the Medicaid market increased 6%, to $4.79 billion.

Between 2019 and 2020, total Medicaid spending increased 15.1%, most likely due to the increased enrollment resulting from the Public Health Emergency (see Figure 1.6). Medicaid eligibility increased 17.6% between 2018 and 2020.

See the table on the next page for additional factors affecting Medicaid spending.

Fig 1.6 Medicaid eligibility by quarter[7]



[7] Medicaid enrollment reflects eligibility totals on the 15th of the month for physical health mental health and dental health, Oregon Health Plan, Cover All Kids (CAK) and the Healthier Oregon Program (HOP) https://www.oregon.gov/oha/hsd/ohp/pages/reports.aspx

Other Factors Affecting Medicaid Spending

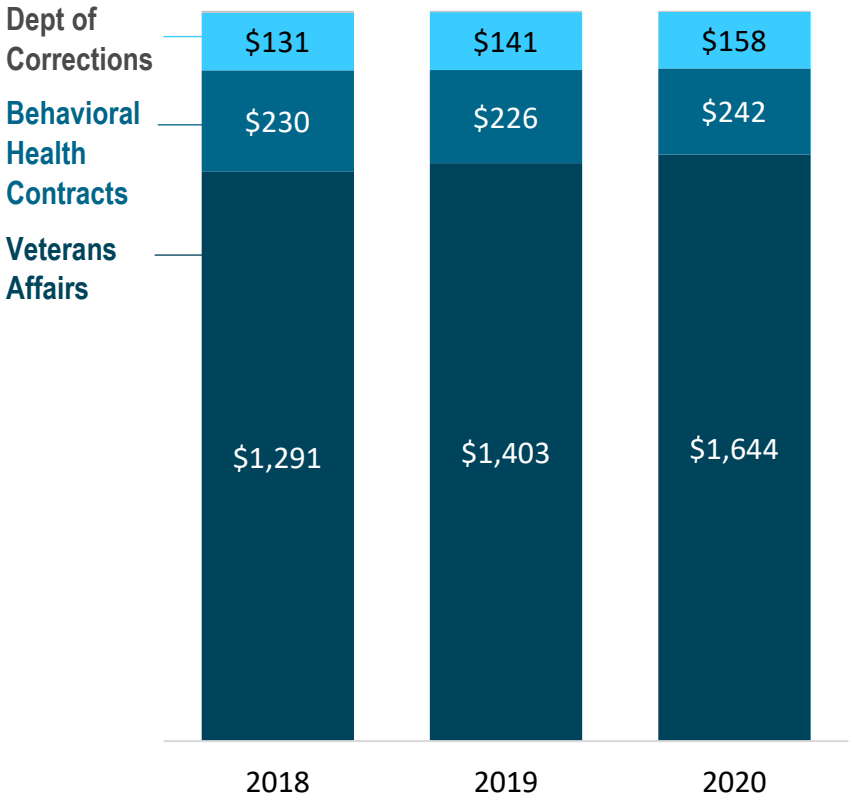
	2018-2019	2019-2020
Changes	No significant benefit changes	CCO procurement resulted in three new CCOs and changes in membership across CCOs
CCO Rate Increase	5%	8%
CCO Rate Adjustments	Redetermination adjustments due to Cover Oregon failure resulted in lower cost members being removed[8]	COVID-19 adjustments for the public health emergency:[9] • Acuity adjustment for disenrollment freeze • Quality payment withhold suspended
Other		CCOs were encouraged to make Provider Stabilization Payments[10]
Fee For Service Payments[11]	Updated to align with 2019 Medicare rates Rate increases for behavioral health and substance use disorder services (SB 5525, 2019)	Updated to align with 2020 Medicare rates

[8] CCO Rate Certification 2019
[9] CCO Rate Certification 2020
[10] Provider Financial Support Strategies, 2020
[11] Oregon Health Plan Fee Schedule

Total Health Care Spending - Other Spending

In addition to health care cost data submitted by payers, the Cost Growth Target Program also compiles costs for other health care programs administered by state and federal agencies, and for other spending outside of health plan payments to providers, where possible. This other spending represents between 6% and 7% of total health care spending in Oregon each year.

Fig 1.7 Total health care spending in other programs, in millions



Most of the other spending comes from the U.S. Department of Veterans Affairs. Spending for eligible veterans in Oregon increased by 8.7% from 2018 to 2019 and 17.2% from 2019 to 2020. Total spending in 2020 reached $1.64 billion.

The next largest category includes state funding for behavioral health – this includes contracts for treatment and recovery supports for mental health, substance use disorder, and problem gambling. Spending decreased by -1.7% from 2018 to 2019 and grew 7.1% 2019 to 2020.

Health care costs for people in state correctional facilities are covered by the Oregon Department of Corrections (DOC). This spending increased 7.4% from 2018 to 2019 and 12.2% from 2019 to 2020.

Also included is consumer spending on prescription drugs through the state's prescription drug discount card program – ArrayRx (not shown in Fig 1.7). This represents card holder spending on prescriptions that is not otherwise captured in claims spending. In 2020, this spending totaled $3.2 million.

Note health care spending at the Oregon State Hospital is not included in this report.

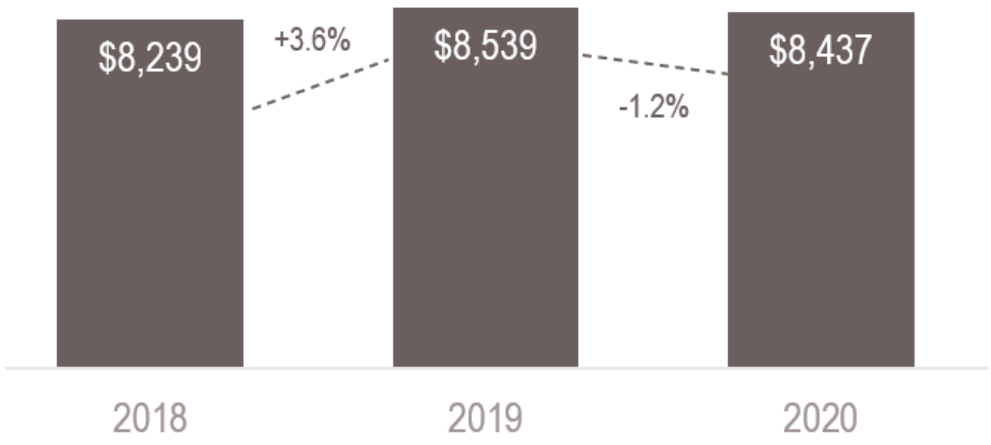
Total Health Care Expenditures

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 spending on other public programs and the Net Cost of Private Health Insurance. THCE is reported on a *per person per year* basis.

The previous section reported on 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. Total Health Care Expenditures 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

Fig 1.8 Total Health Care Expenditures per person per year and growth rate between years



Between 2018 and 2019, THCE spending per person per year grew 3.6%, from $8,239 to $8,539

Between 2019 and 2020, THCE spending per person per year decreased slightly (-1.2%) to $8,437.

If the cost growth target was in effect during this measurement period, statewide, across all markets, Oregon would have exceeded the target between 2018-2019, and met the target in 2019-2020.

Total Health Care Expenditures by Market

Measuring Total Health Care Expenditures statewide can mask differences between markets. In general, Medicare THCE on a per person per year basis are more than twice commercial or Medicaid THCE (as Medicare members are older and utilize more health care). Changes in THCE by market can also be calculated. 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.

Fig 1.9 Total Health Care Expenditures in Oregon, per person per year, by market

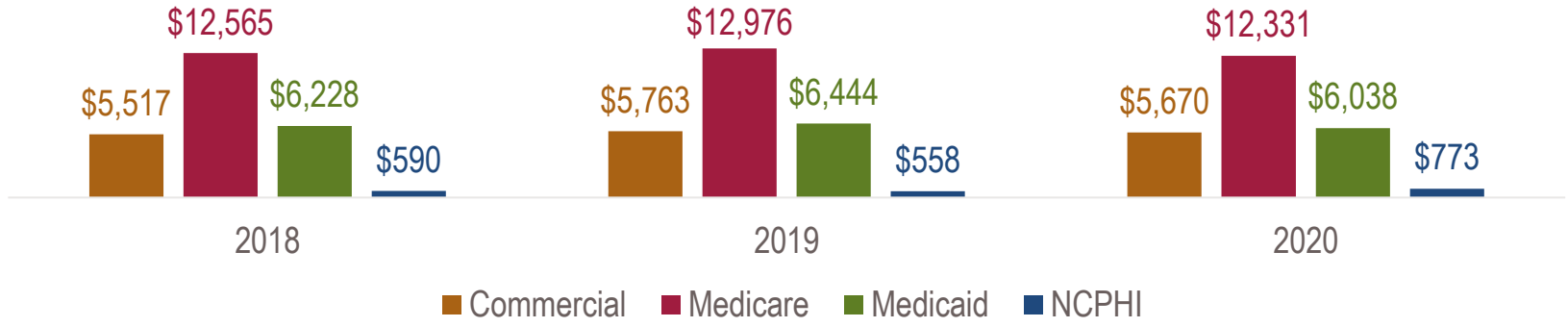
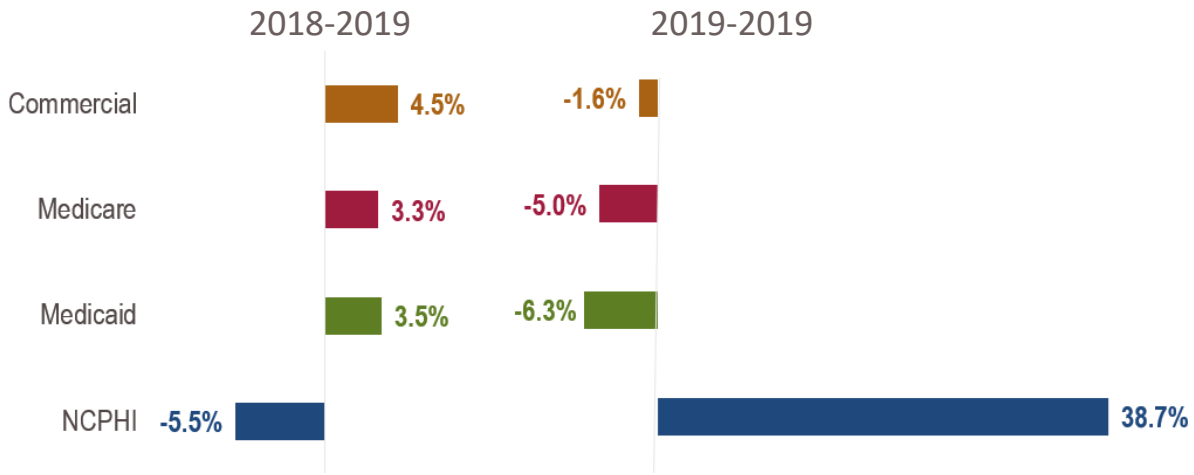


Fig 1.10 THCE in Oregon, per person per year, growth rate by market,



THCE for Oregon's commercial market increased 4.5% between 2018-2019, then decreased by -1.6% between 2019-2020. Medicare increased 3.3% and Medicaid increased 3.5% between 2018-2019, followed by decreases of -5.0% and -6.3% respectively. If the cost growth target had applied in these years, the commercial and Medicaid markets would have exceeded the target between 2018-2019.

Net Cost of Private Health Insurance, by Market

NCPHI applies to commercial insurers, Medicare Advantage insurers, and Medicaid Coordinated Care Organizations.[12] 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 approximately 6-8% of total health care spending in Oregon.

In Oregon, NCPHI on a per person per year basis, declined -5.5% between 2018-2019, then grew 38.7% between 2019-2020. The increase in NCPHI between 2019-2020 was likely due in large part to overall low claims expenses during the COVID-19 pandemic as people put off elective procedures and non-emergency health services while still paying monthly insurance premiums.[13]

Figure 1.9 and 1.10 presented the Net Cost of Private Health Insurance statewide. NCPHI can also be applied at the market level for commercial health plans, Medicare Advantage plans, and Medicaid Coordinated Care Organizations (CCOs).

In the commercial market, NCPHI declined slightly (-3.2%) between 2018-2019, then increased by 30% between 2019-2020, totaling $840 per person per year in 2020. In the Medicare Advantage market, NCPHI increased 13.7% between 2018-2019, then increased again by 64.4%, totaling $1,360 per person per year in 2020. A national analysis of insurer profitability found that gross margins per member for Medicare Advantage plans increased from $1,727 in 2019 to $2,257 in 2020, well above gross margin per member of $958 for commercial: group insurance plans.[14] For Medicaid CCOs, NCPHI decreased -25% between 2018-2019 and grew 49.5% between 2019-2020 (totaling $424 per person per year in 2020).

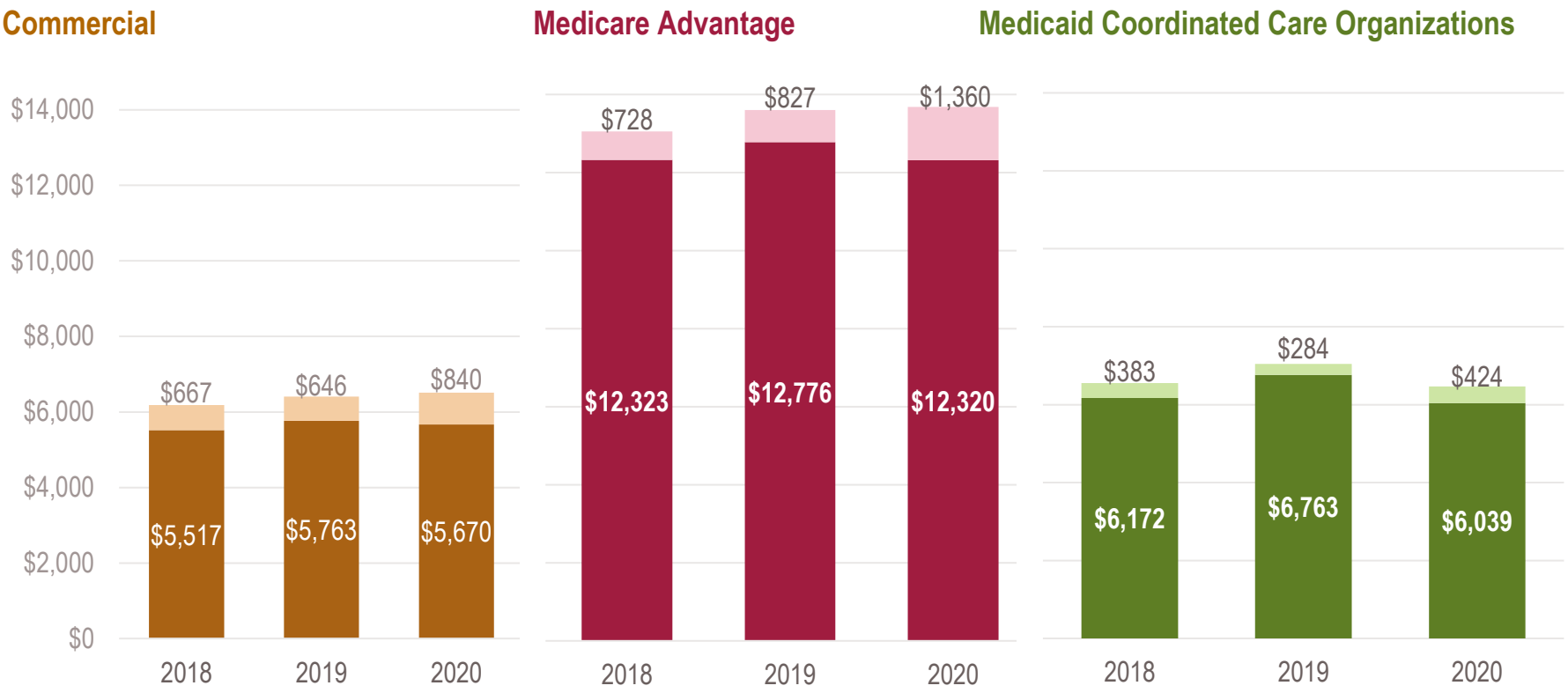
---

[12] Not all SHCE reports were collected in time to be included in this report. NCPHI data does not include Health Net Life Insurance Company (measurement years 2018, 2019, 2020) and Health Plan Of CareOregon, Inc. (measurement year 2020).

[13] Abelson, Reed. "Major U.S. Health Insurers Report Big Profits, Benefiting From the Pandemic." *The New York Times*, August 5, 2020.

[14] Health insurer financial performance in 2021. Kaiser Family Foundation.

Fig 1.11 Total Health Care Expenditures, by market, with Net Cost of Private Health Insurance (lighter bars) per person per year



Medicare Advantage includes spending for dual eligible members.

Other Medicaid Coordinated Care Organization Spending

In addition to the claims and non-claims payments Medicaid Coordinated Care Organizations make to provider organizations that are described in more detail in chapter II, Medicaid CCOs also make several other types of payments that can be included in Total Health Care Expenditures for the Medicaid market. These data are taken from CCOs' Exhibit L financial reporting.

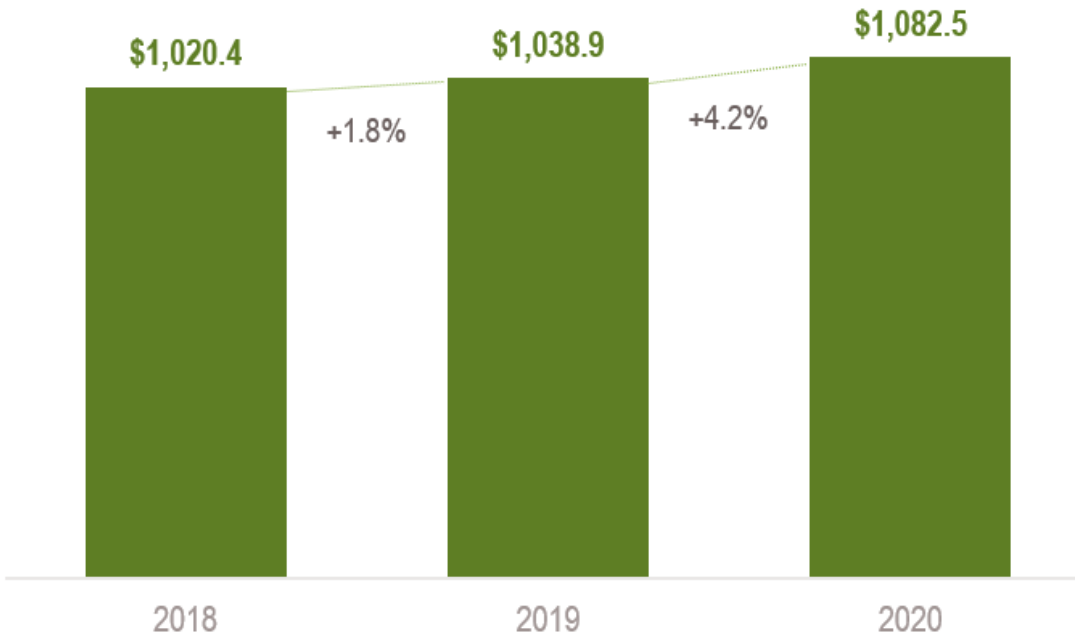
Qualified Directed Payments and Hospital Reimbursement Adjustments

Qualified Directed Payments (QDPs) and Hospital Reimbursement Adjustments (HRAs) are CMS-approved incentive payments designed to improve quality and access to health care services for Medicaid members.

OHA makes these payments to CCOs and they are required to distribute them to certain providers for certain services for certain members. For example, OHA makes payments to CCOs for each hospital inpatient and outpatient encounter at specified hospitals (Type A and B, Public Academic Health Centers, and DRG hospitals).

CCOs are required to distribute these funds to the appropriate hospital.[15]

Fig 1.12 Medicaid CCO spending on Qualified Directed Payments and Hospital Reimbursement Adjustments, in millions



[15] See Oregon Administrative Rule 410-125-0230.

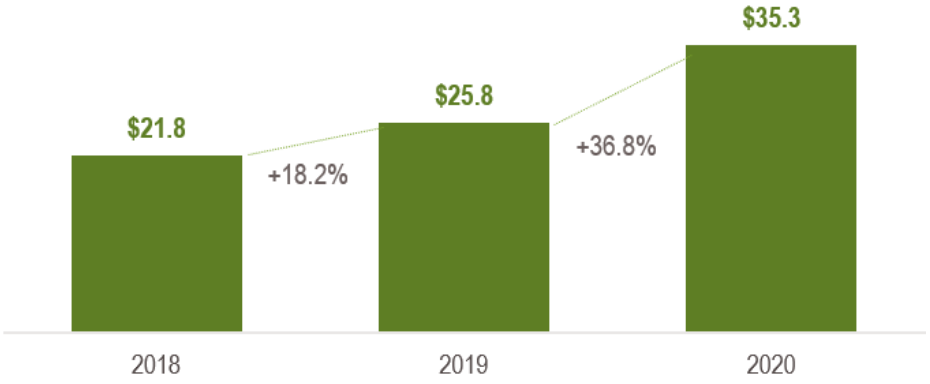
Health Related Services

Health-related services (HRS) are non-covered services that are offered as a supplement to covered benefits under Oregon's Medicaid State Plan to improve care delivery and overall member and community health and well-being. CCOs are required to report on their HRS-spending to OHA each year.[16]

HRS include flexible services, which are cost-effective services offered to an individual member to supplement covered benefits, and community benefit initiatives, which are community-level interventions focused on improving population health and health care quality. Examples include spending on health information technology, housing, and food access.

2020 spending also included addressing community and member needs exacerbated by COVID-19 and emergency needs related to wildfire relief. In 2020, CCOs spent 62% of HRS dollars on community benefit initiatives, 15% on flexible services, and 22% on health information technology services.[17]

Fig 1.13 Medicaid CCO spending on Health-Related Services, in millions



This graph represents the total amount of HRS spending as reported by CCOs in their annual Exhibit L submission. OHA's HRS team further reviews the spending detail to ensure it meets HRS criteria and makes a final determination, which is what is reported in the HRS Spending Report. In 2020, 87% of the CCO reported HRS spending met criteria. Totals reported here are higher than those in the HRS Spending Report.

[16] Health-Related Services, Oregon Health Authority Transformation Center
[17] 2020 CCO Health-Related Services Spending Report

Chapter II. Health Care Cost Growth Trends, 2018-2020 by Service Category

Chapter II includes total medical expenses (TME) broken out into mutually exclusive health care service categories that fall into either claims or non-claims spending. That is, dollars are only reported in one category.[18]

List of Figures

Pharmacy Rebate Figures

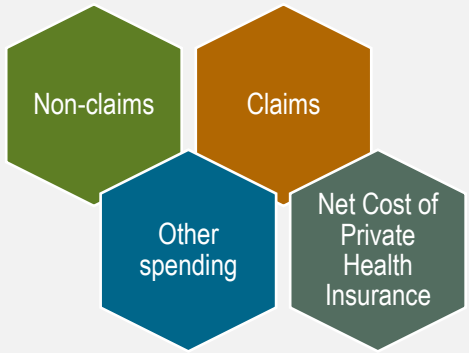
[18] The service categories in this Cost Growth Trends Report are similar to those reported in Health Care Cost Trends, 2013-2019 but have fundamental differences due to data collection methodology and should not be directly compared. While payers report data to both the Cost Growth Target and the All Payer All Claims Programs, Cost Growth Target data is collected on a total cost of care basis for insured Oregon residents and directly allocated to service categories, while APAC collects claims-level data which can be used to assign spending to service categories based on place of service and how the service was billed. See Appendix 1 Methodology for additional differences.

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. Claims data for TME are reported net of pharmacy rebates.

Total Health Care Expenditures

For reporting statewide and market level cost growth



Total Medical Expenses

For reporting service category and payer and provider organization cost growth.

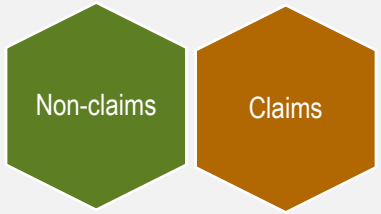


Fig 2.1 Total Health Care Expenditures, statewide per person per year

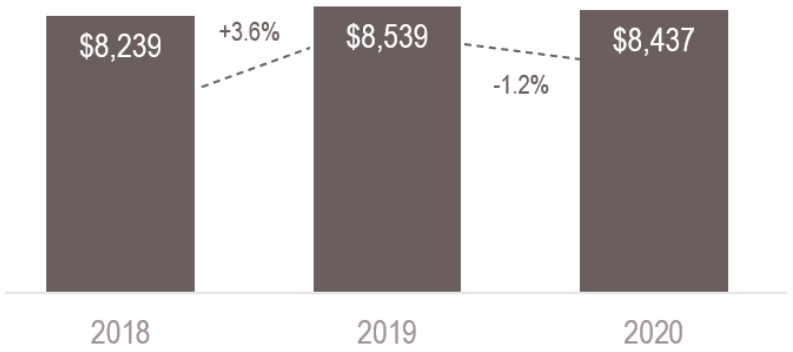
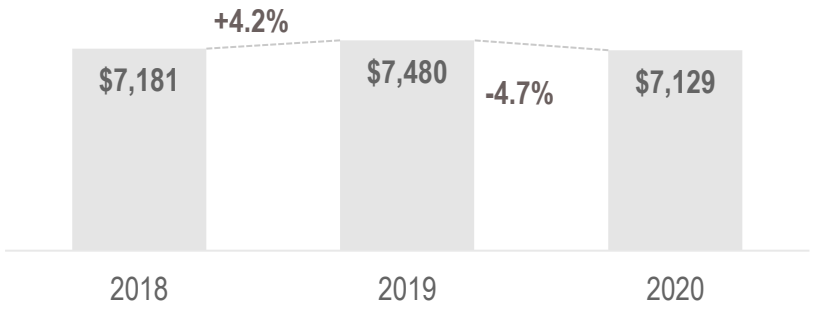


Fig 2.2 Total Medical Expenses, statewide per person per year



What's Included in Claims and Non-Claims Spending Categories?

Claims Spending Categories
Hospital inpatient
Hospital outpatient
Professional
Retail pharmacy
Other

Non-Claims Spending Categories
Prospective payments
Incentive payments
Population health payments
Provider salaries
Recovery
Other

Claims spending includes the allowed amount from payers to provider organizations and any member cost sharing such as co-payments, deductibles, and co-insurance.

Professional services can be broken out into several sub-categories, including primary care, behavioral health, specialty, and other. See pages 46-48 for this detail at the market level.

Claims spending in this section is reported both gross (before) and net (after) of pharmacy rebates. That is, when claims spending is reported net of rebates, any rebates from pharmaceutical manufacturers that payers received have been taken into account (resulting in lowered retail pharmacy costs overall). Figure 2.3 shows the impact of pharmacy rebates on claims spending overall, and page 49 has additional information about pharmacy rebates.

Non-claims spending includes all payments made from payers to provider organizations outside of claims.

See Appendix 1 for details about each spending category.[19]

[19] Additional information about TME spending categories is also available in the Cost Growth Target Data Specifications Manual.

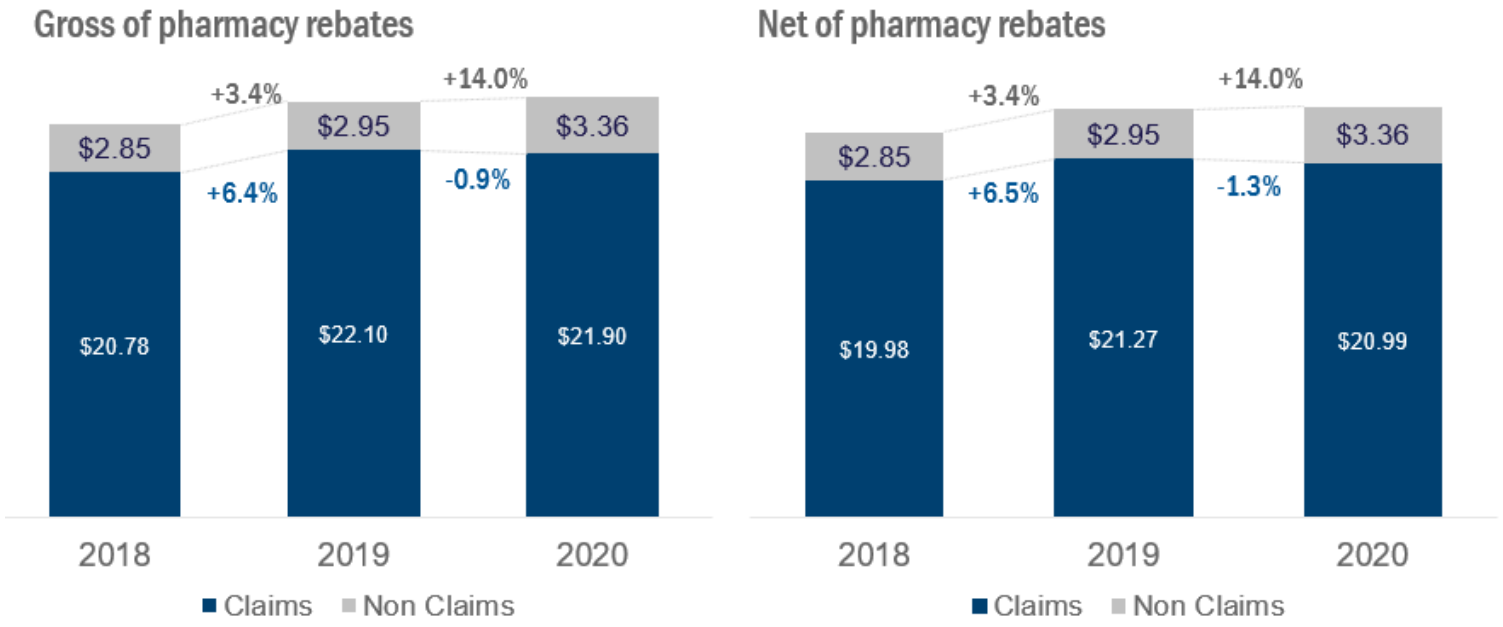
Total Medical Expenses – Total Spending, Statewide

The majority of health care spending in Oregon is through claims. In 2020, more than 86% of dollars were paid out in claims, rather than in other payment arrangements. Claims spending increased by more than 6% between 2018-2019, then decreased slightly between 2019-2020, most likely due to reduced utilization.

Non-claims-based spending increased by 14% between 2019-2020. Many payers increased non-claims payments or pushed out more dollars through these payment arrangements to help stabilize provider organizations through decreased utilization in the first part of the COVID-19 pandemic.

Pharmacy rebates account for just under $1 billion per year. With pharmacy rebates taken into account, claims spending in 2020 drops from $22 billion to $21 billion, statewide. See page 47 for a closer look at pharmacy spending.

Fig 2.3 Total Medical Expenses – total dollars spent, in billions, and growth rate, statewide



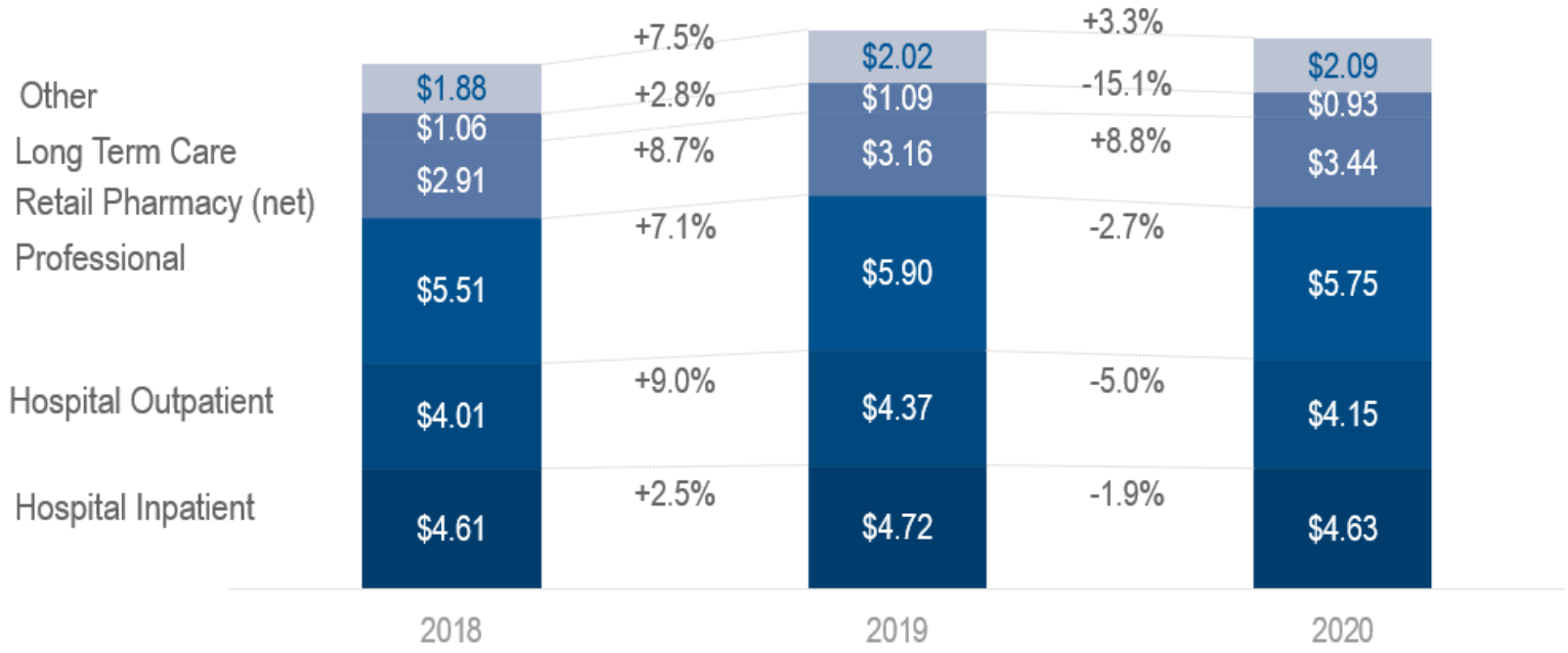
Total Medical Expenses – Claims and Non-Claims Spending, Statewide

The largest share of claims spending in Oregon is for hospital inpatient and outpatient services, totaling $8.7 billion in 2020. Professional services are the next largest spending category, at $5.75 billion in 2020, then retail pharmacy at $3.44 billion.

All claims spending categories increase between 2018-2019, with hospital outpatient services growing by 9% and retail pharmacy growing by 8.7%, then most claims spending categories experience a drop between 2019-2020 due to reduced utilization in the first part of the pandemic. However, total retail pharmacy spending (net of rebates) continued to increase between 2019- 2020.

Fig 2.4 Total Medical Expenses – total claims spending, in billions, and growth rate, statewide

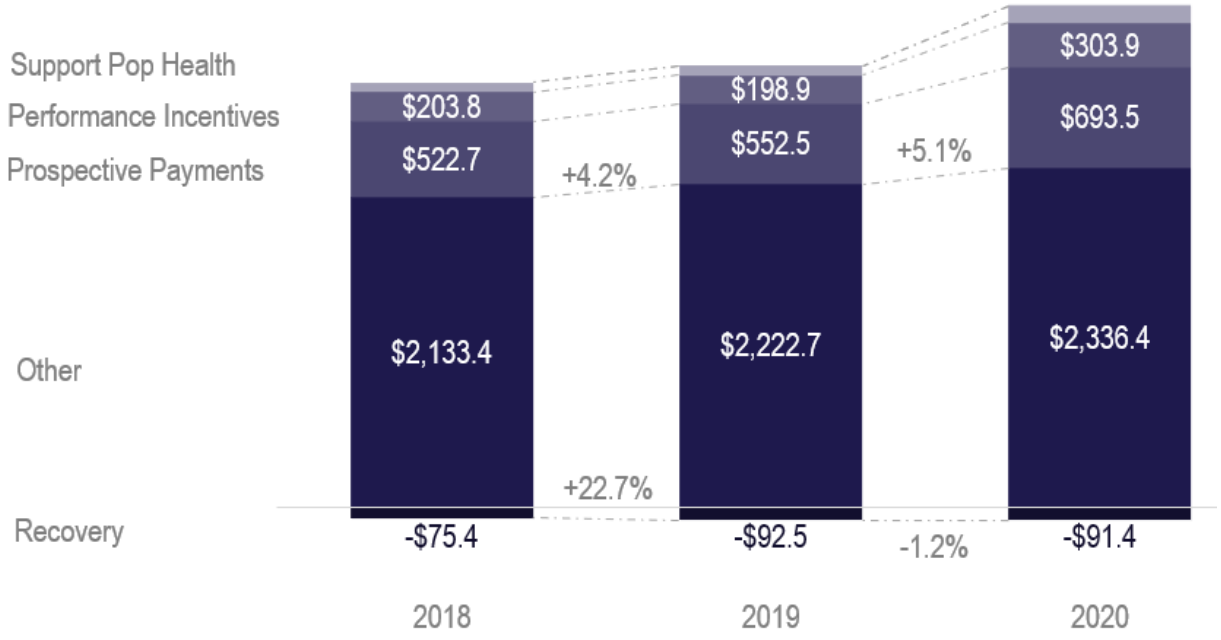
Spending is reported net of pharmacy rebates.



Non-claims payments are payments that health plans make to provider organizations outside of claims, such as quality incentive program payments or global budgets. Non-claims payments totaled $3.36 billion statewide in 2020 (or approximately 13% of all health care spending).

Non-claims payments grew 3.4% between 2018-2019 and 14% between 2019-2020. Non-claims cost growth was primarily driven by the 5.1% increase in the other payment category, which includes payments made to providers to support clinical and business operations during the COVID-19 pandemic, and the 52.8% increase in the performance incentive category, as many payers used these programs to help sustain provider organizations. Changes between 2018-2019 and 2019-2020 varied considerably by market – see Fig 2.13, 2.15, and 2.17.

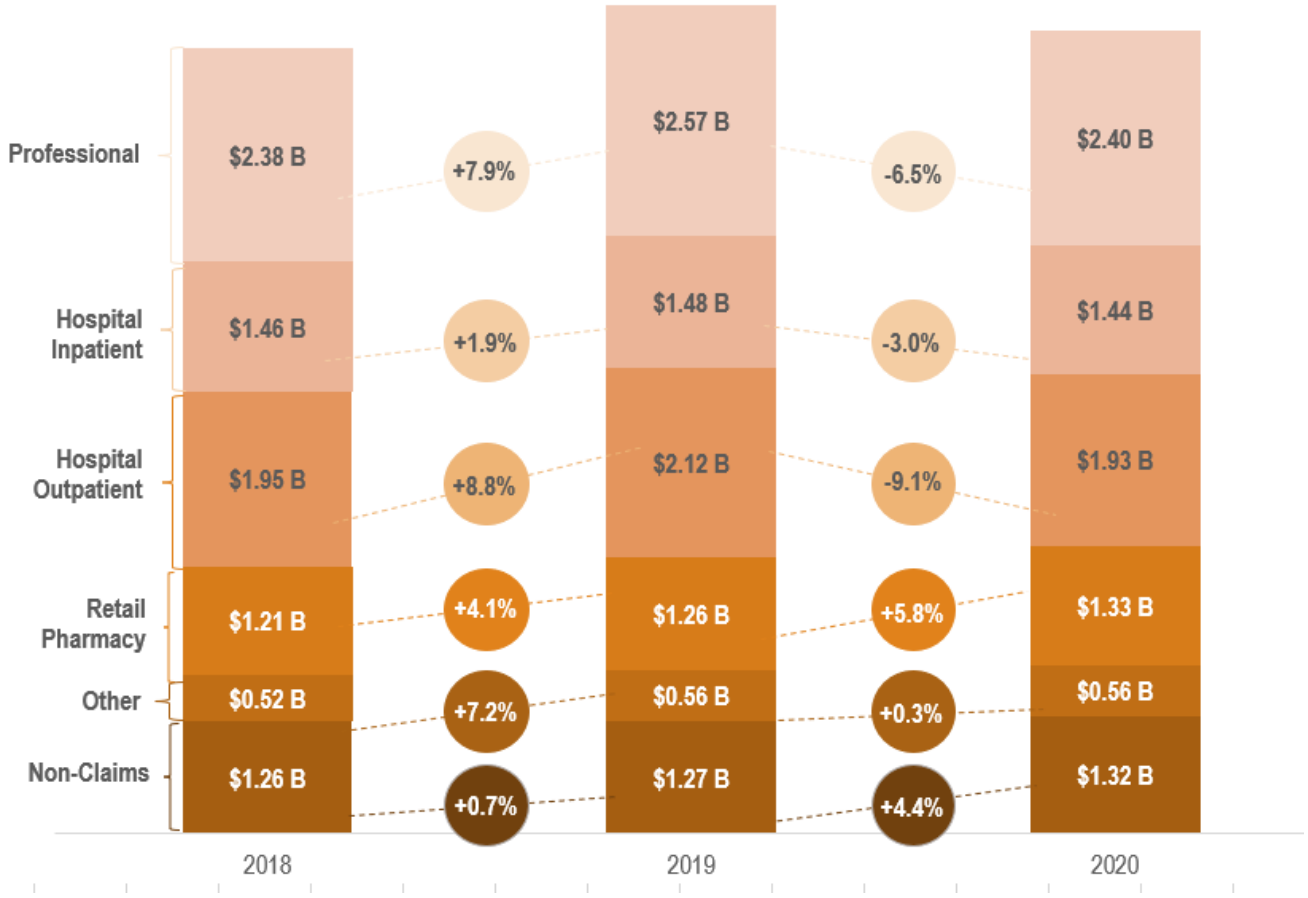
Fig 2.5 Total Medical Expenses - non-claims spending categories, in millions, and growth rate, statewide



Total Medical Expenses – Total Spending and Spending Growth by Category and by Market

Fig 2.6 Total Medical Expenses – total spending and spending growth by category, commercial

Spending is reported net of pharmacy rebates. Spending in billions.



The largest service category of commercial spending was professional services followed by hospital outpatient and inpatient services.

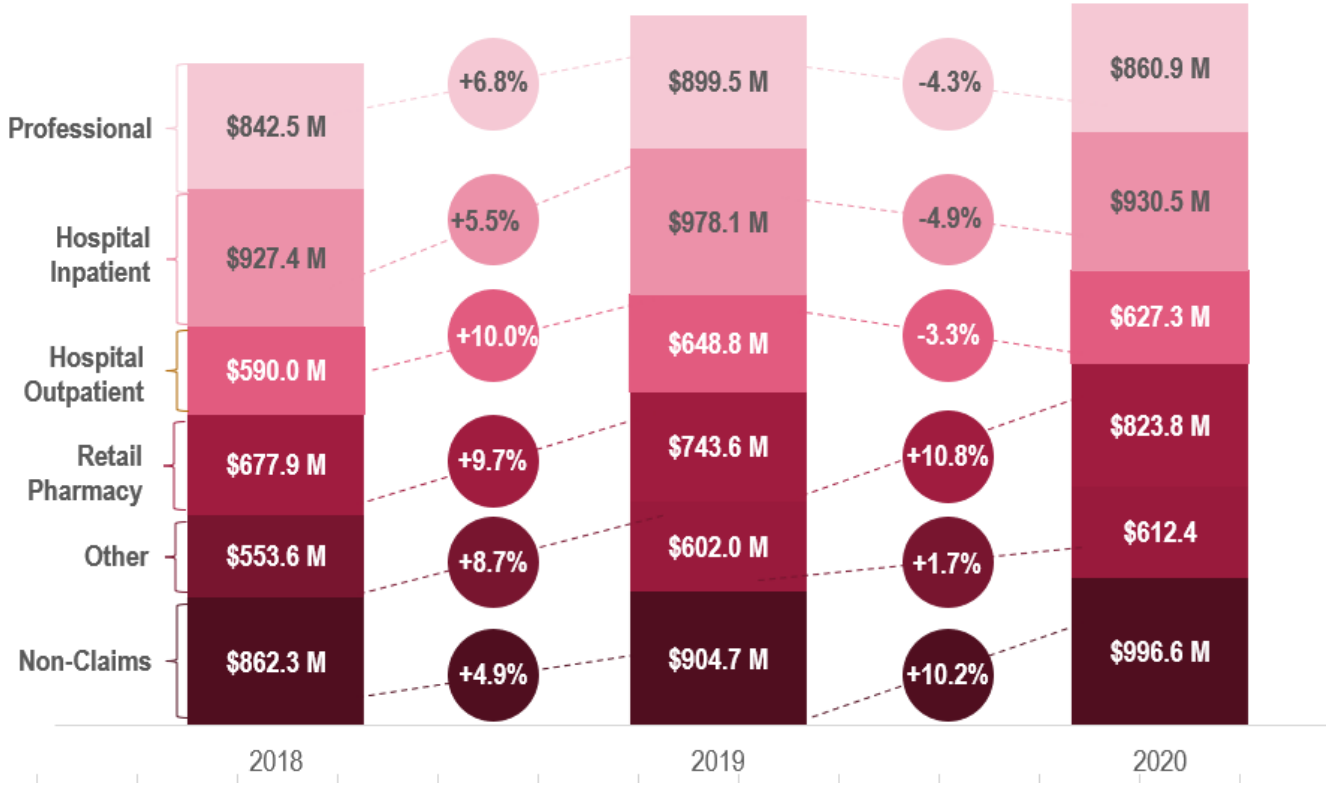
From 2018 to 2019, total commercial spending increased across all service categories. Hospital outpatient services grew the fastest at 8.8% followed by professional services at 7.9%.

From 2019 to 2020, total commercial spending decreased for most categories. Retail pharmacy and non-claims spending continued to grow during this period.

Note Other in this figure includes Long Term Care.

Fig 2.7 Total Medical Expenses – total spending and spending growth by category, Medicare Advantage

Spending is reported net of pharmacy rebates. Spending in millions.



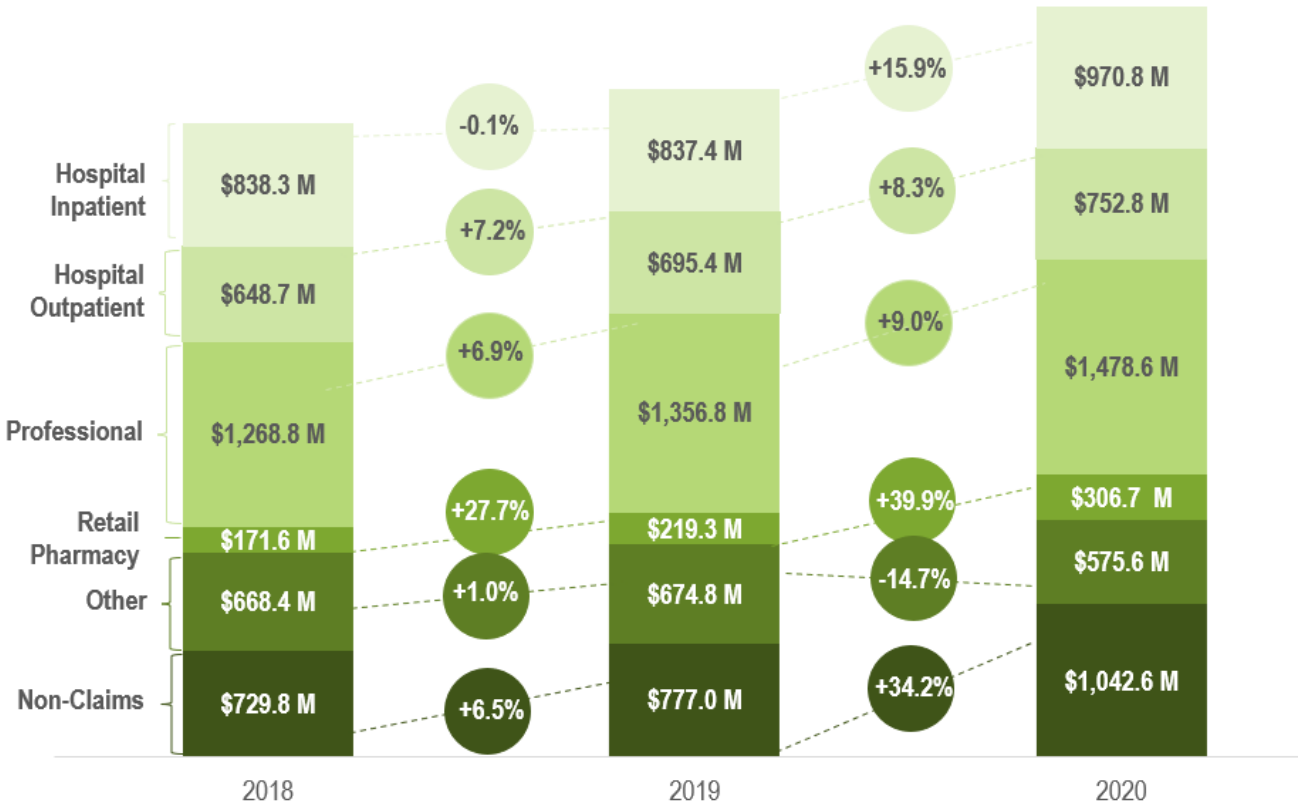
From 2018 to 2019, total Medicare Advantage spending increased in all categories. Hospital outpatient services grew the fastest at 10% followed by retail pharmacy at 9.7%.

From 2019 to 2020, total Medicare Advantage spending decreased slightly for professional and hospital inpatient and outpatient services. However, retail pharmacy continued to grow (10.8%) as did non-claims spending (10.2%).

Note Other in this figure includes Long Term Care.

Fig 2.8 Total Medical Expenses – total spending and spending growth by category, Medicaid

Spending is reported net of pharmacy rebates. Spending in millions.



From 2018 to 2019, total Medicaid spending increased in all categories except hospital inpatient. Retail pharmacy grew the most, at 27.7%.

From 2019-2020, total Medicaid spending continued to increase in most categories, particularly non-claims (34.2%), pharmacy (39.9%) and hospital inpatient (15.9%).

Hospital inpatient and outpatient services combined are the largest category, followed by professional services.

Note Other in this figure includes Long-Term Care.

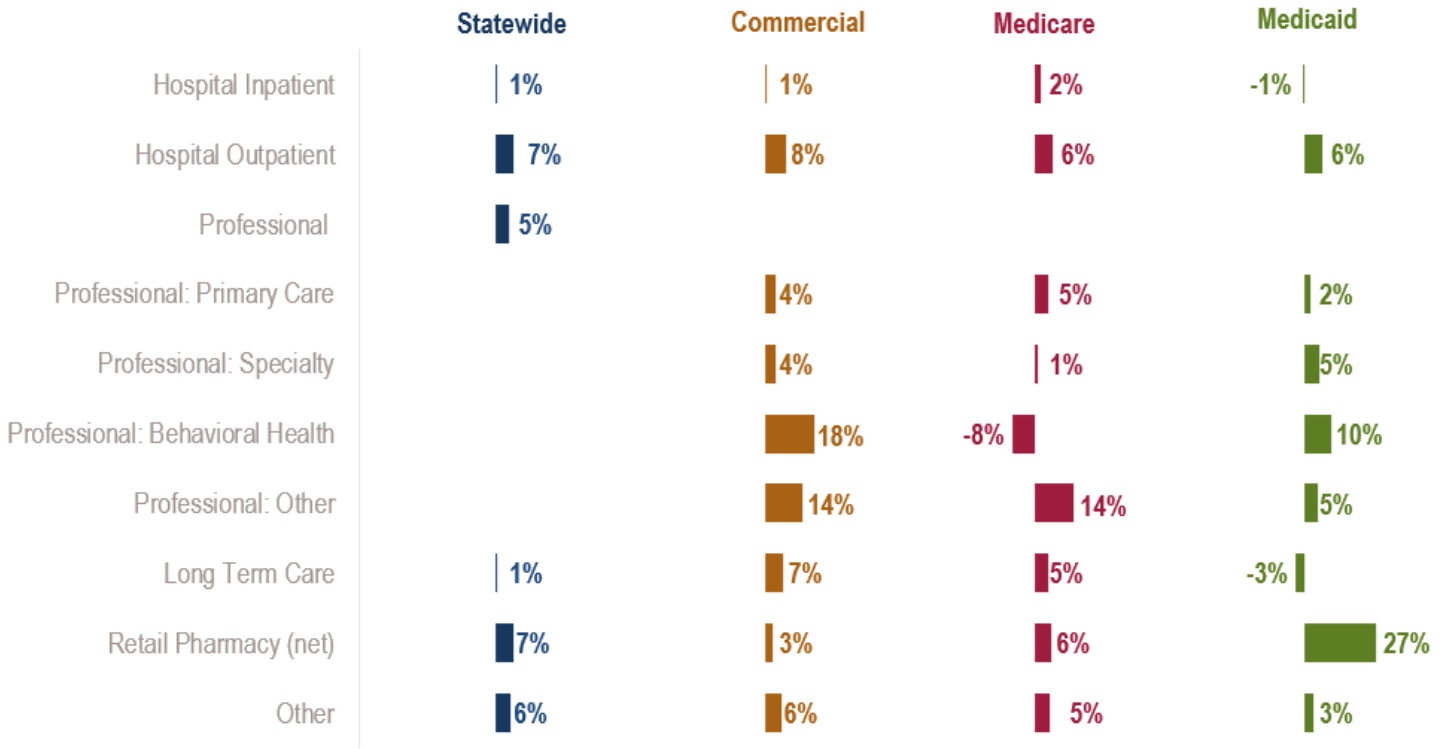
See pages 18-19 for more details on the overall increase in Medicaid spending between 2019-2020.

Total Medical Expenses – Growth in Per Person Per Year Spending, by Category and by Market

The previous figures reported on total dollars spent on health care in Oregon by service category and by market, which can be affected by the number of people in Oregon overall and the number of people with health insurance coverage in a market. Total Medical Expenses can also be reported on a *per person per year* basis to provide a standardized comparison across markets and service categories. The next figures summarize the growth rate for per person per year spending, by market.

Per person per year spending increased between 2018-2019 in almost all service categories in all markets – commercial, Medicare Advantage, and Medicaid. Hospital outpatient services and retail pharmacy experienced some of the largest growth. The commercial and Medicaid markets also saw large growth in spending on professional: behavioral health services.

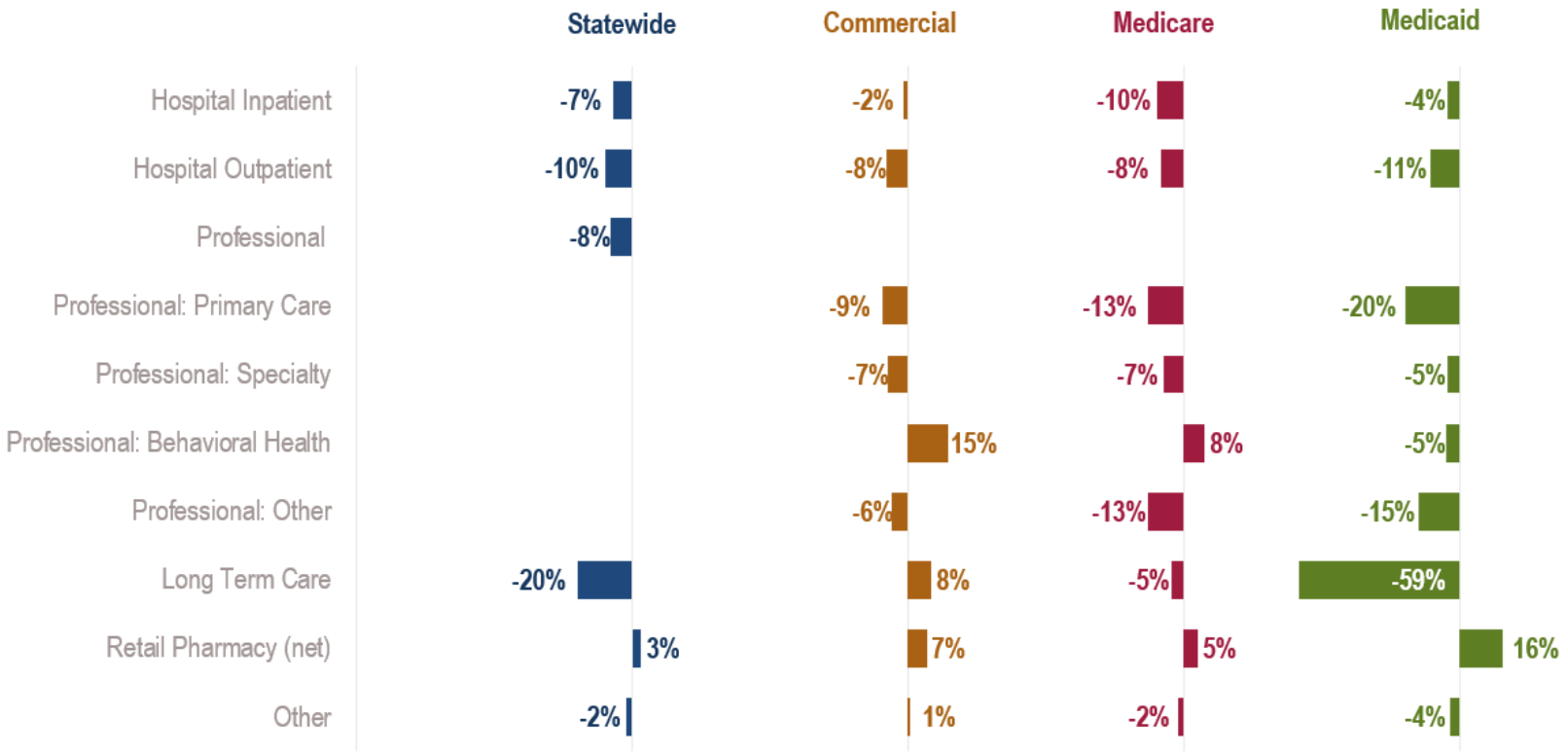
Fig 2.9 Total Medical Expenses - growth between 2018-2019, claims spending categories, by market
Per person per year



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.

Between 2019-2020, per person per year spending in most claims-based categories in most markets decreased. The largest decreases in spending were for hospital outpatient services and professional: primary care services in all three markets and hospital inpatient services for Medicare Advantage. Exceptions include an increase in professional: behavioral health spending for the commercial and Medicare Advantage markets, and an increase in retail pharmacy (net of rebates) in all three markets.

Fig 2.10 Total Medical Expenses – growth between 2019-2020, claims spending categories, by market
Per person per year



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.

Total Medical Expenses – Spending Growth and Per Person Amounts

Between 2018-2019, per person per year spending grew in each category, statewide. Between 2019-2020, per person per year spending declined in most categories, although retail pharmacy (net of rebates) grew 3.2% and non-claims spending grew by 8.1%. Hospital outpatient, professional services, and other services (including long-term care) experienced the sharpest decline.

Fig 2.11 Total Medical Expenses – per person per year and spending growth by service category, statewide

Spending is reported net of pharmacy rebates

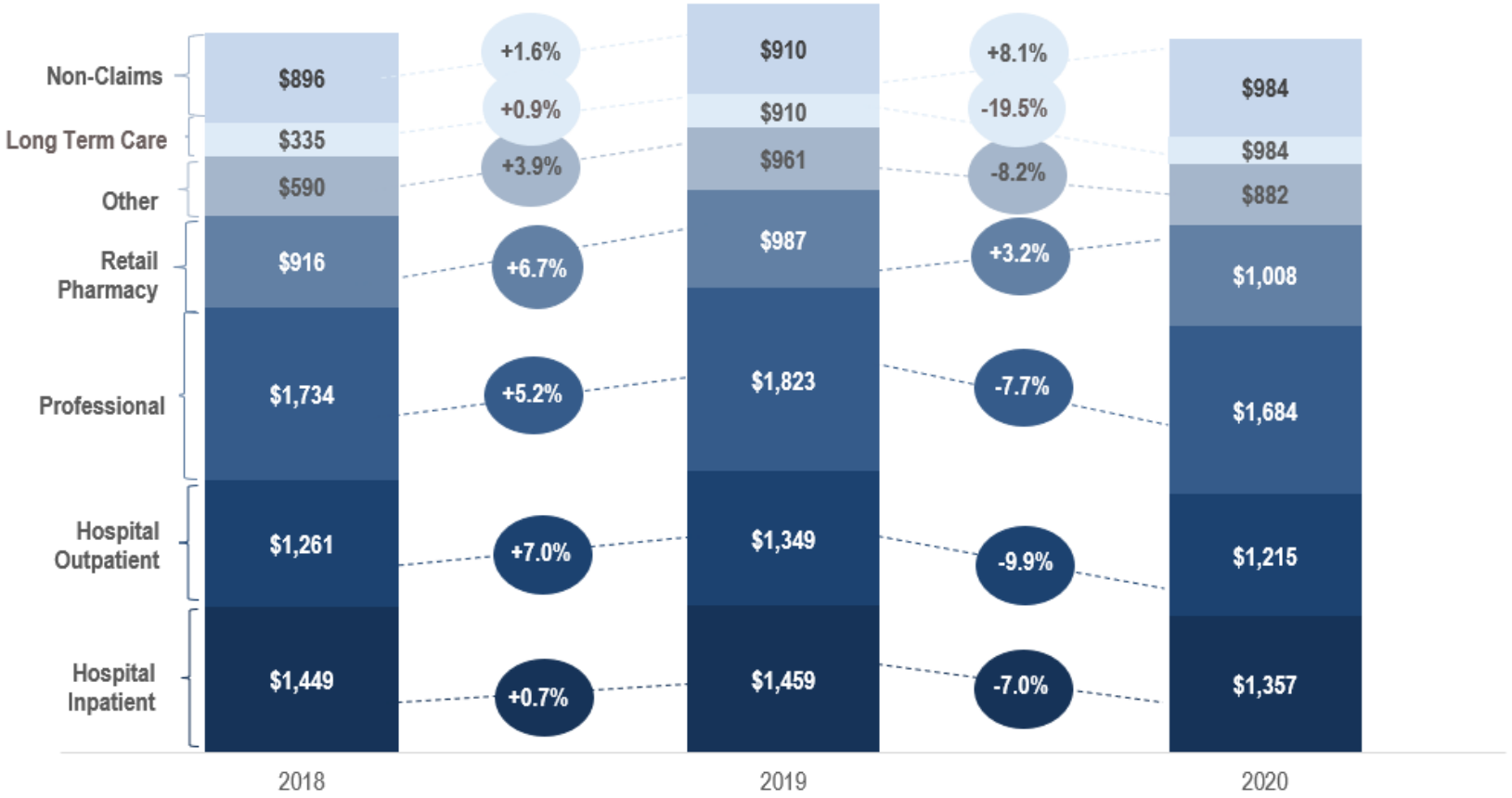
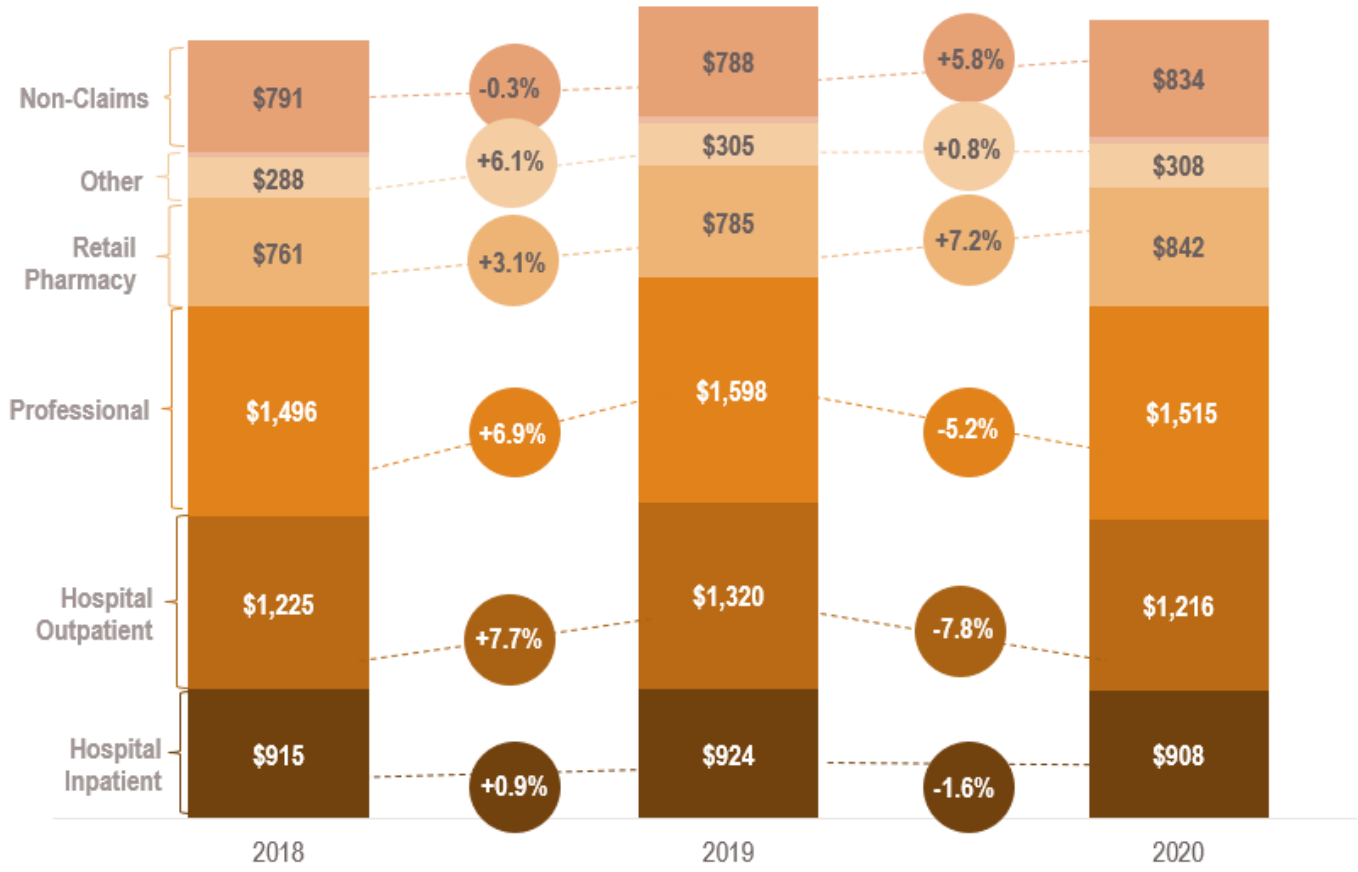


Fig 2.12 Total Medical Expenses – per person per year and spending growth by service category, commercial

Spending is reported net of pharmacy rebates

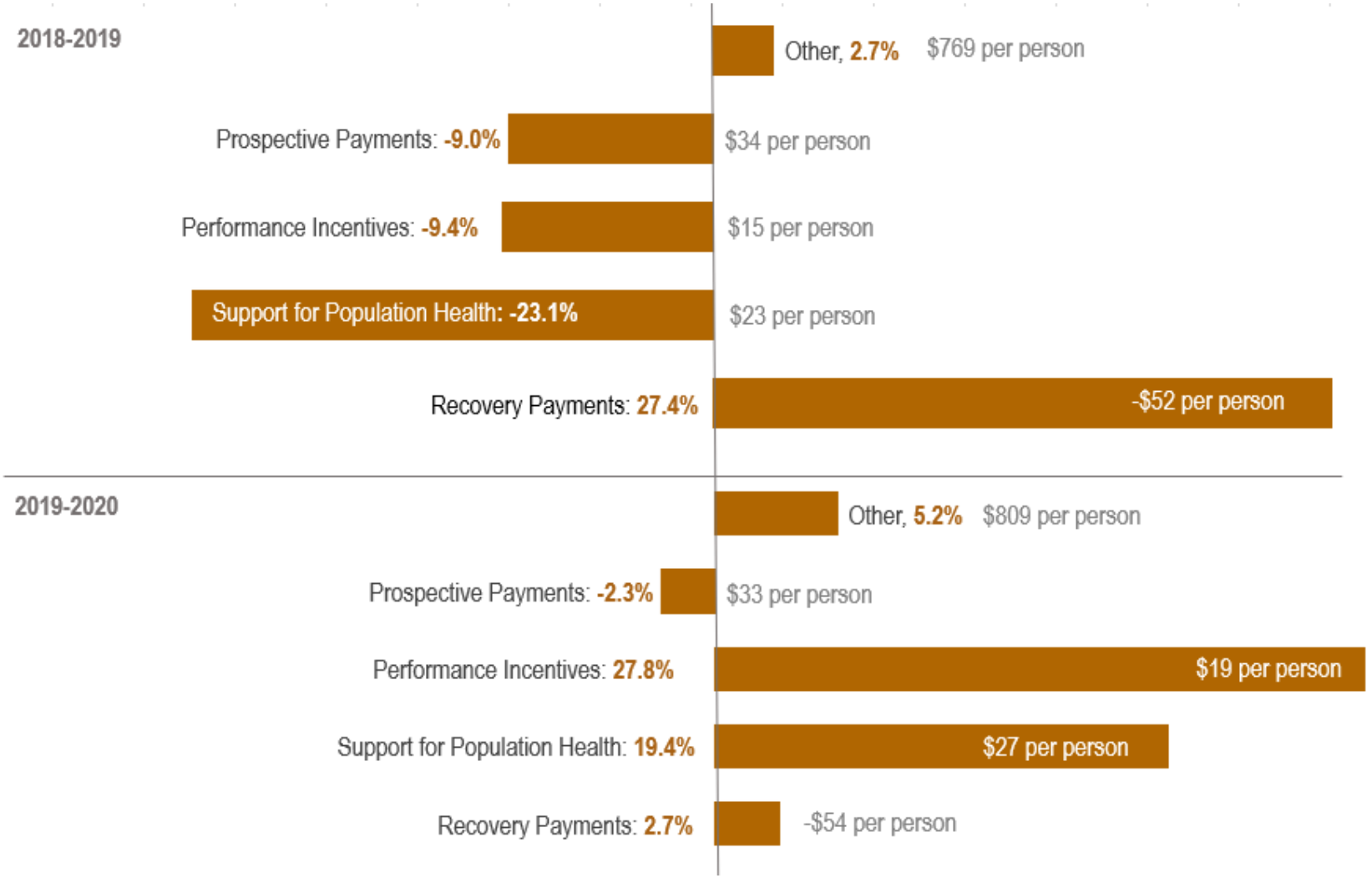


From 2018 to 2019, hospital outpatient spending per person grew the fastest at 7.7%, followed by professional services at 6.9%. Non-claims spending overall experienced a slight spending decrease.

From 2019 to 2020, retail pharmacy experienced the most growth in per person spending, 7.2%, followed by a 5.8% increase in non-claims spending. Most service categories experienced a decrease in per person spending between 2019-2020.

Overall, non-claims spending in the commercial market decreased slightly between 2018-2019 (-0.3%) and increased by 5.8% between 2019-2020. However, there was considerable variation in the types of non-claims payments made – see Fig 2.13.

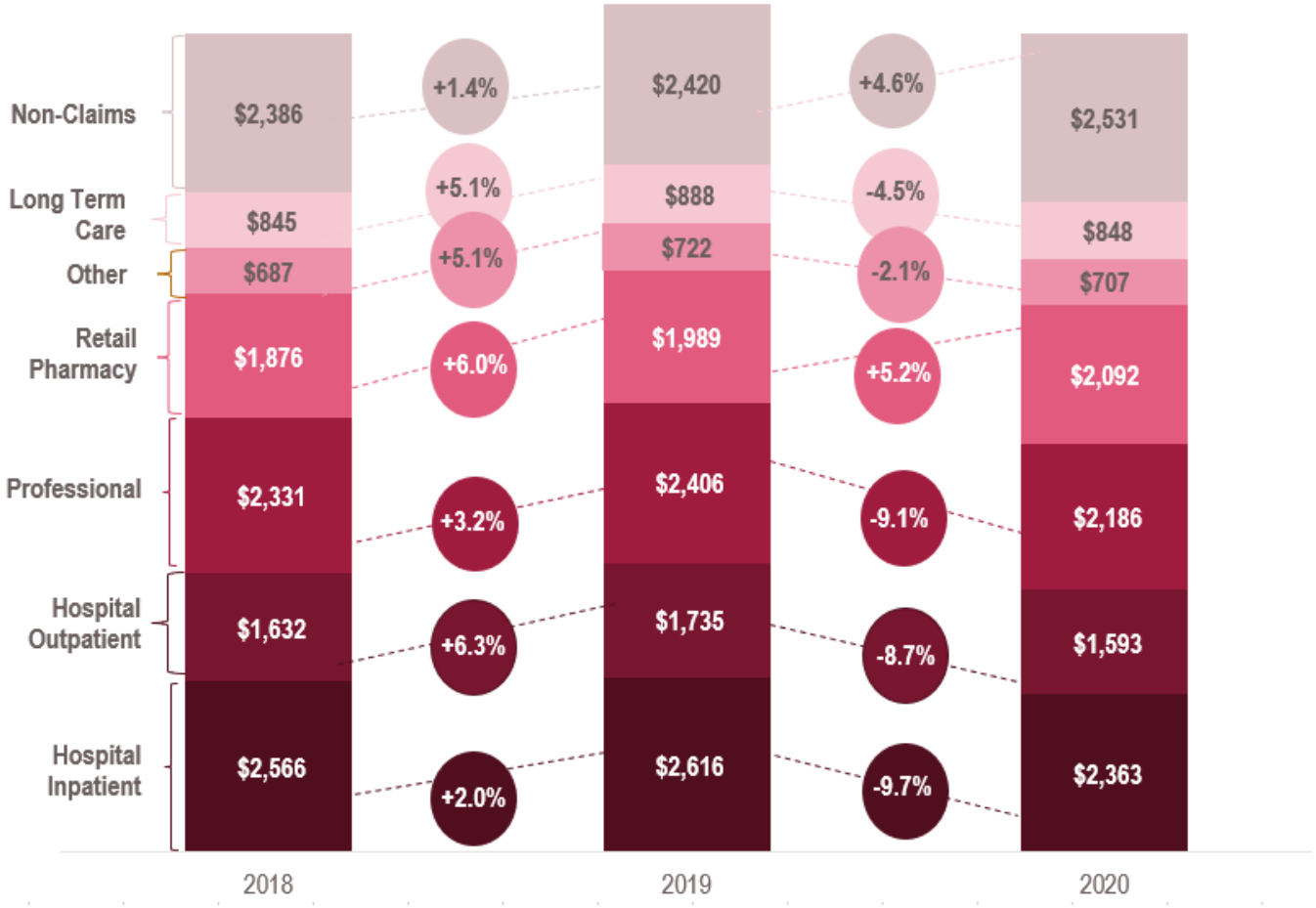
Fig 2.13 Total Medical Expenses – non-claims spending, commercial.
Percent growth and per person per year cost



The graph shows positive growth for recovery payments, yet they are reported as a negative number because they represent all payments received from a provider, member or other payer, which were later recouped due to a review, audit or investigation.

Fig 2.14 Total Medical Expenses – per person per year and spending growth by service category, Medicare Advantage

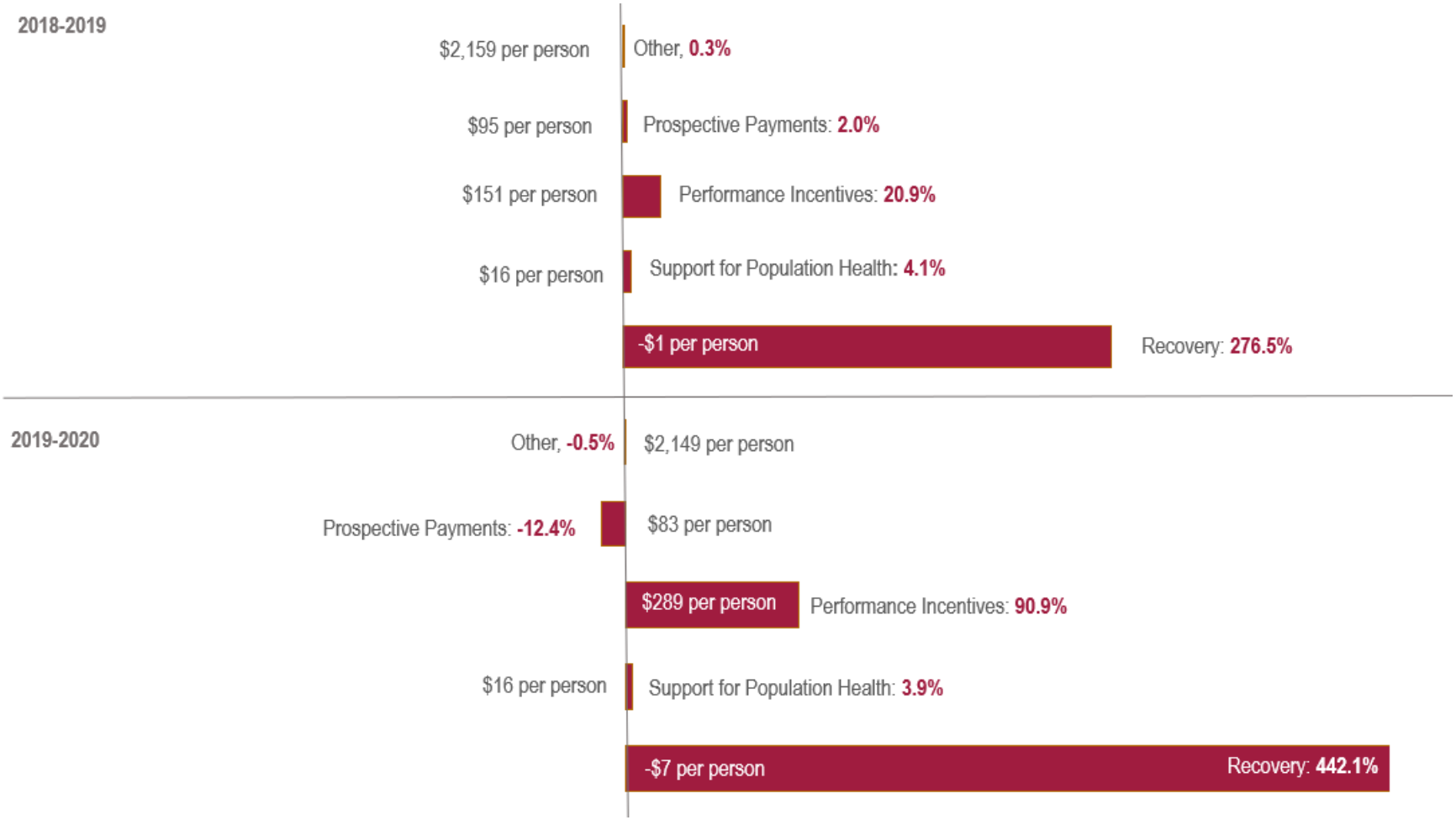
Spending is reported net of pharmacy rebates



From 2018 to 2019, per person spending increased in all categories; hospital outpatient spending grew the fastest at 6.3%.

From 2019 to 2020, retail pharmacy (net of rebates) continued to increase at 5.2%, and non-claims spending increased by 4.6%. All other spending categories experienced a decrease. Hospital inpatient spending decreased by 9.7%, followed by a 9.1% decrease in professional services.

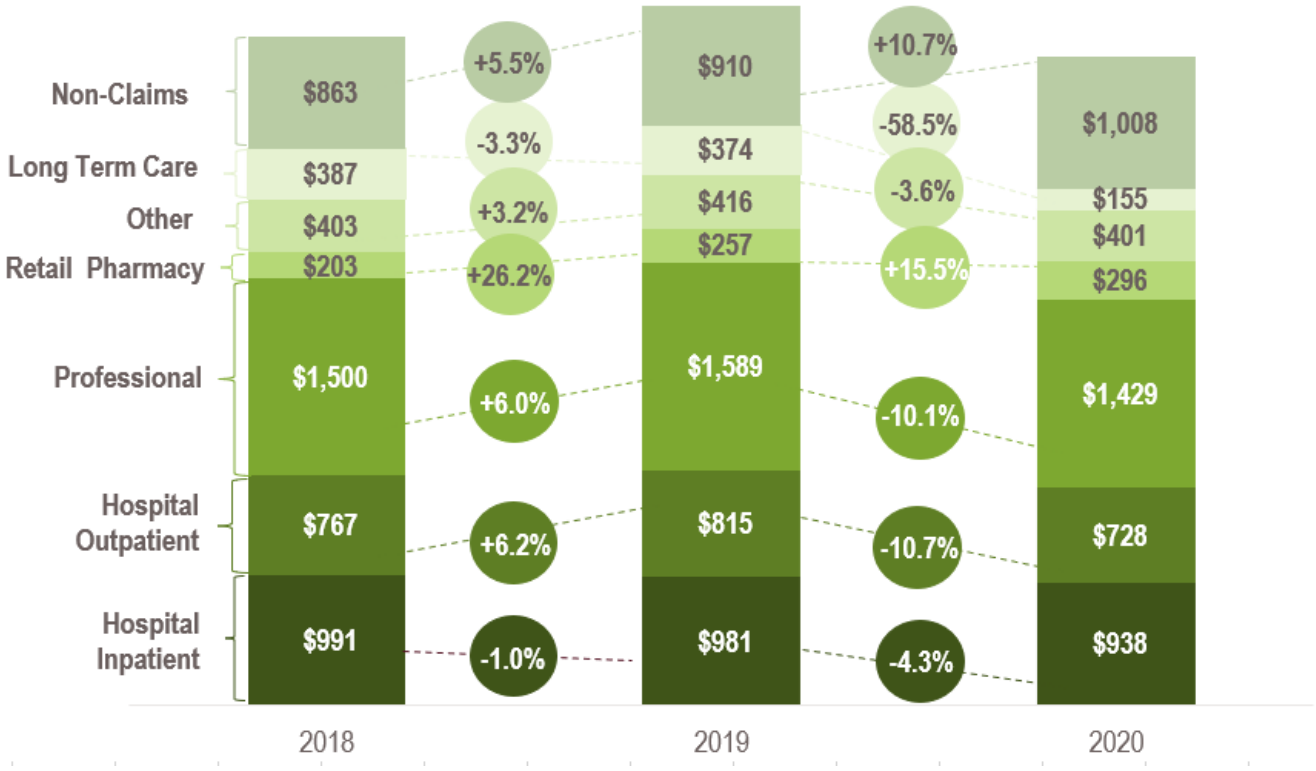
Fig 2.15 Total Medical Expenses – non-claims spending, Medicare Advantage
Percent growth and per person per year cost



The graph shows positive growth for recovery payments, yet they are reported as a negative number because they represent all payments received from a provider, member or other payer, which were later recouped due to a review, audit or investigation.

Fig 2.16 Total Medical Expenses – per person per year and spending growth by service category, Medicaid

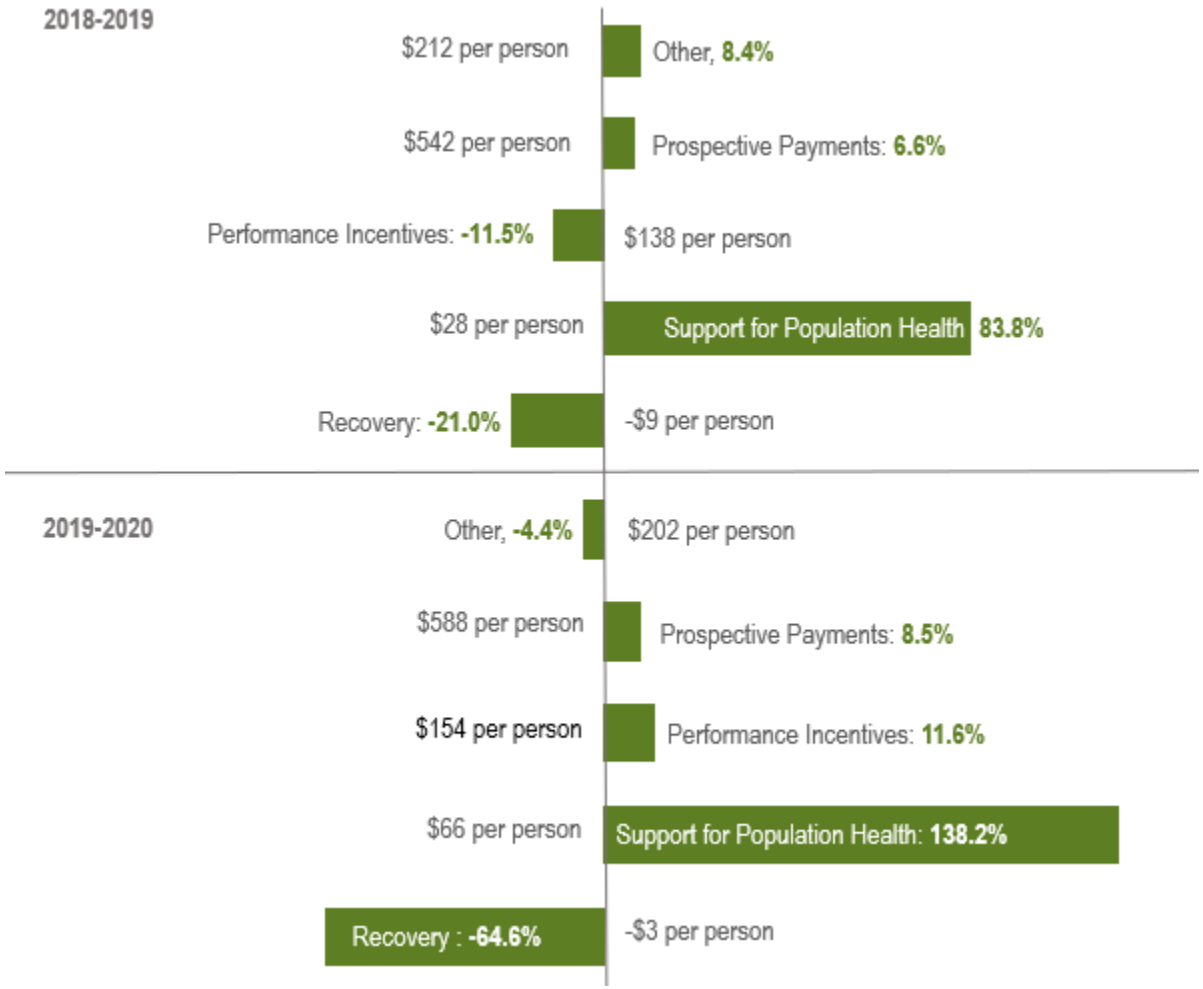
Spending is reported net of pharmacy rebates



From 2018 to 2019, Medicaid per person spending in retail pharmacy (net of rebates) grew the fastest at 26.2%. Professional services grew by 6.0% and hospital outpatient spending grew by 6.2%.

From 2019 to 2020, Medicaid continued to see retail pharmacy spending grow (15.5%), as well as non-claims spending (10.7%). All other categories declined, including a 4.3% decrease in hospital inpatient spending and a 10.7% decrease in hospital outpatient spending.

Fig 2.17 Total Medical Expenses – non-claims spending, Medicaid
Percent growth and per person per year cost

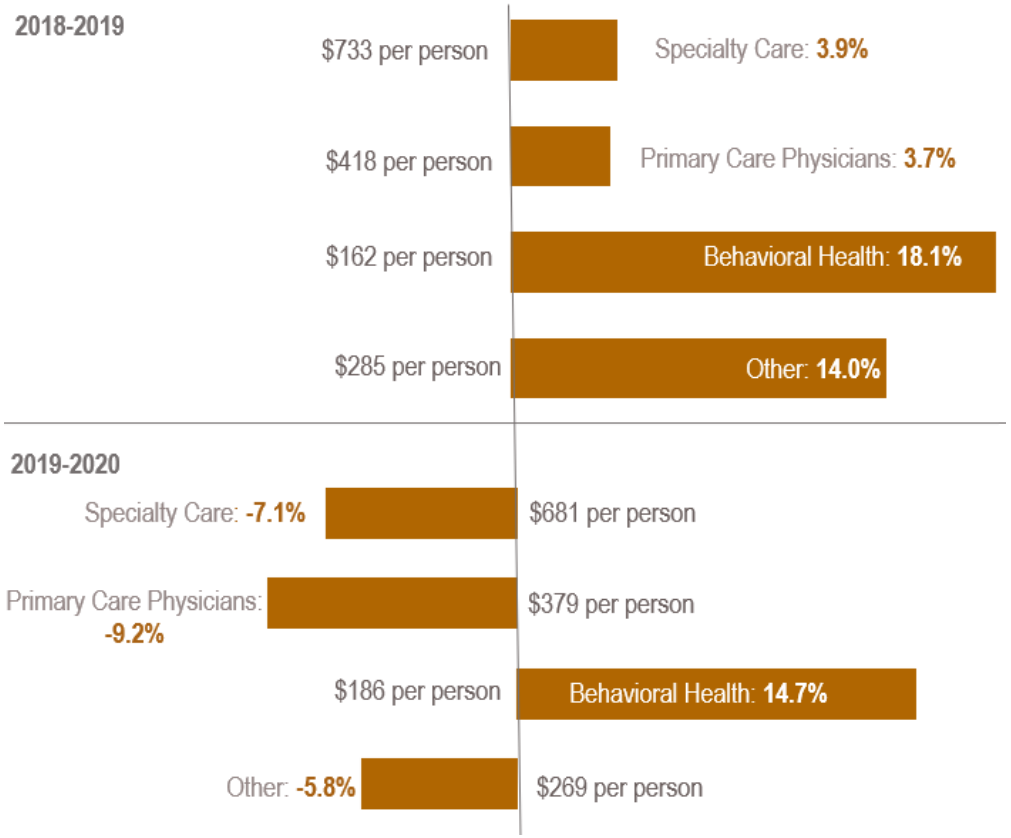


Recovery payments are reported as a negative number because they represent all payments received from a provider, member or other payer, which were later recouped due to a review, audit or investigation.

A Closer Look at Spending on Professional Services

Professional services spending represents payment for the services of providers, separate from facility or institutional charges. Oregon collects detailed subcategories for professional spending by market and can report on spending growth by these subcategories, as well as the per person spending in each subcategory, which varies by market.

Fig 2.18 Total Medical Expenses – claims: professional services spending by subcategory, commercial

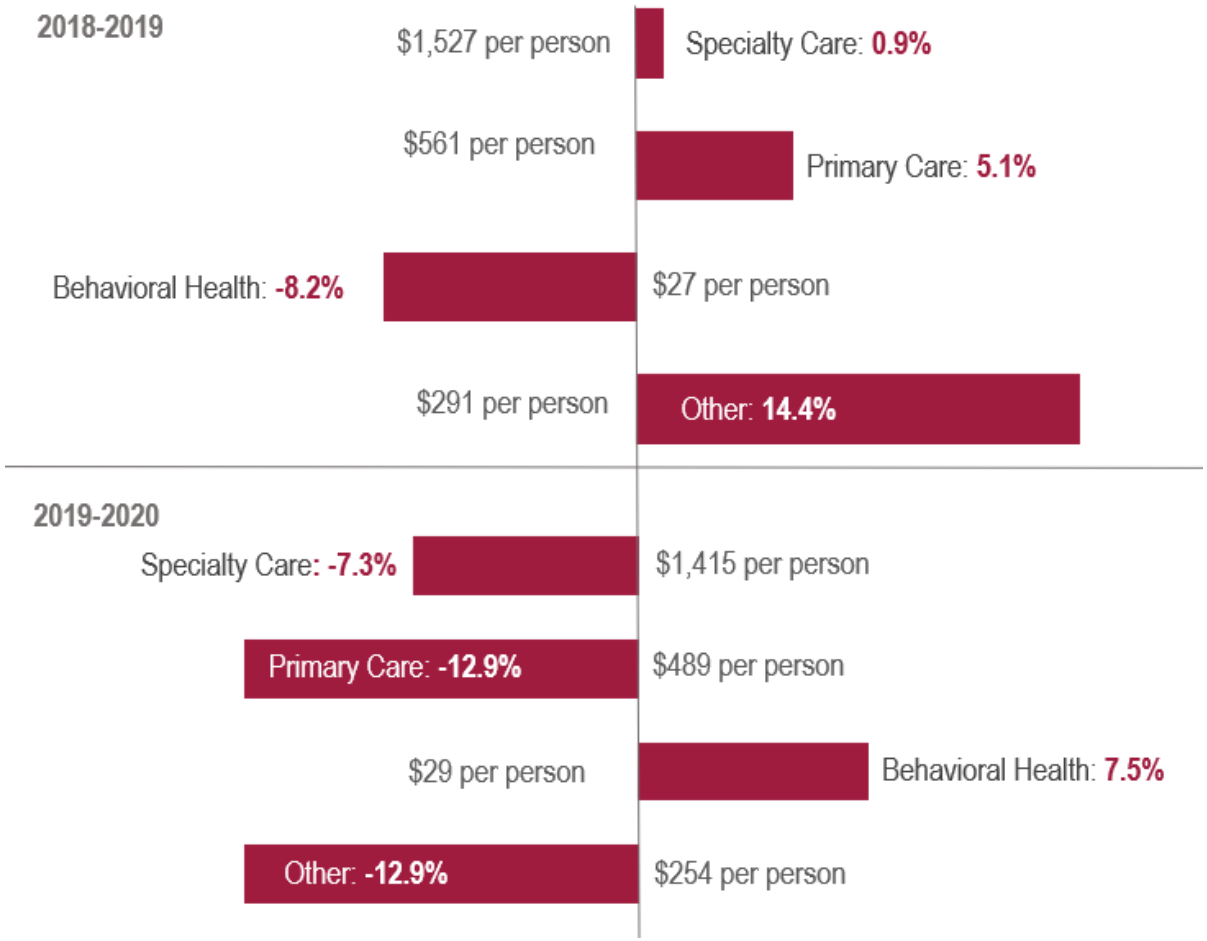


Between 2018-2019, spending for professional: behavioral health services increased by 18% in the commercial market.

Spending for behavioral health services continued to increase between 2019-2020, despite declines in all other professional services subcategories, which may reflect increased access to tele-behavioral health services during the first part of the pandemic, as well as the increased demand for behavioral health services.

Per person spending in the commercial market is highest for professional: specialty care services, averaging $681 in 2020, almost twice the per person spending on professional: primary care services ($379).

Fig 2.19 Total Medical Expenses – claims: professional services spending by subcategory, Medicare Advantage

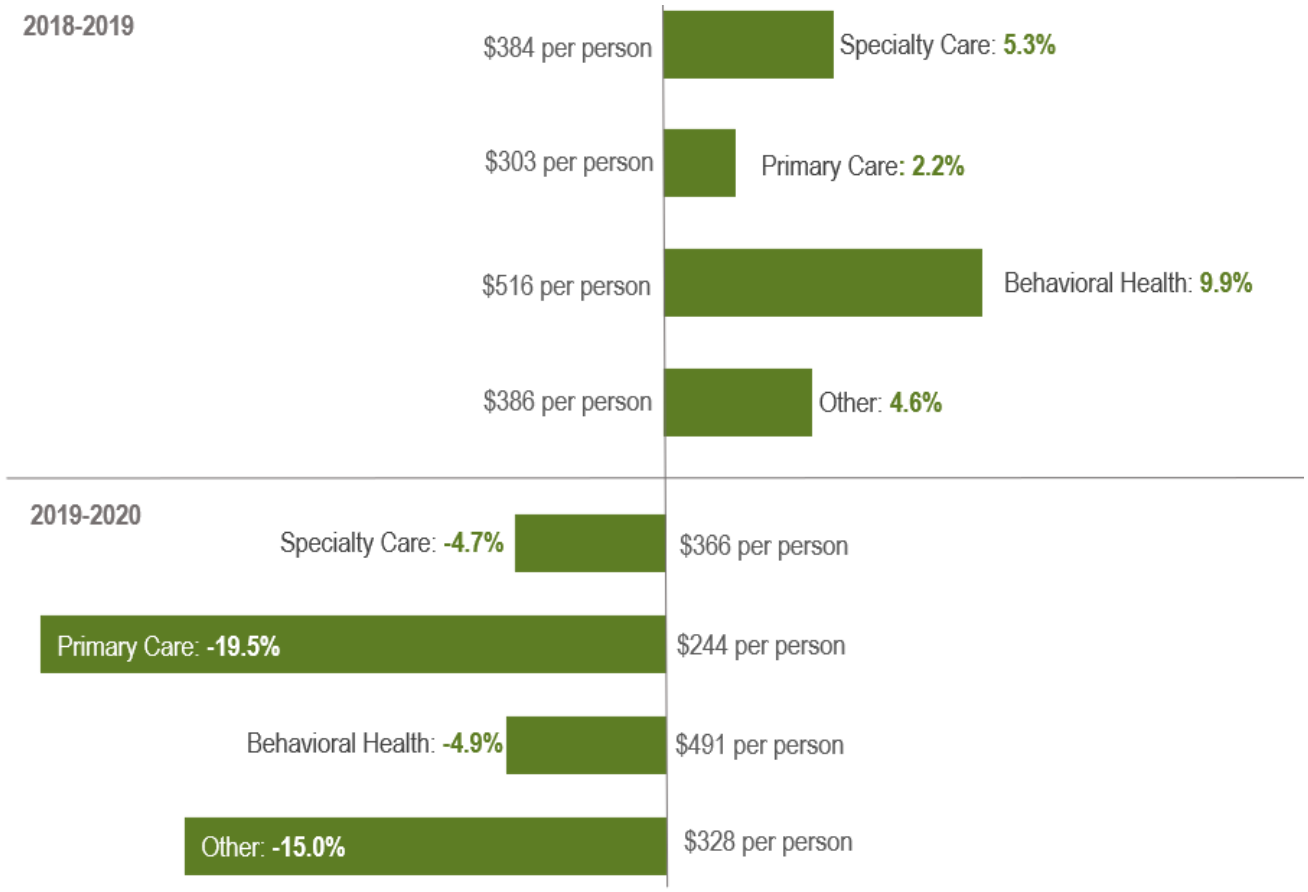


Between 2018-2019, the largest increase in professional services spending for Medicare Advantage was in the Other category. This includes but is not limited to services provided by licensed podiatrists, non-primary care nurse practitioners, non-primary care physician assistants, physical therapists, occupational therapists, speech therapists, dieticians, dentists, chiropractors, etc.

Medicare Advantage spending for professional: behavioral health services totaled only $29 per person in 2020, a 7.5% increase from $27 per person in 2019.

Similar to the commercial market, Medicare Advantage professional service spending decreased in specialty, primary care, and other service subcategories between 2019-2020.

Fig 2.20 Total Medical Expenses – claims: professional services spending by subcategory, Medicaid



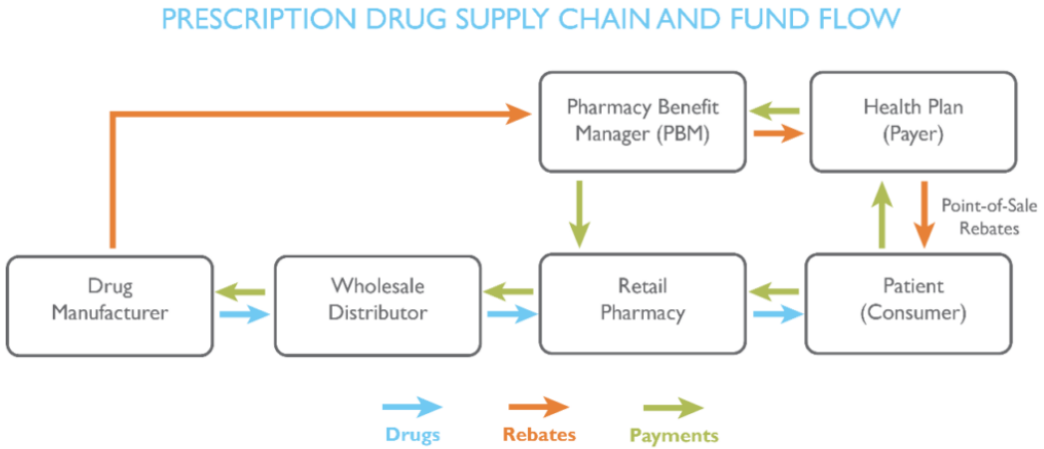
Between 2018-2019, Medicaid spending for professional services increased in all subcategories; professional: behavioral health spending increased almost 10%, to $516 per person in 2019.

Between 2019-2020, Medicaid spending for professional services decreased in all subcategories; the greatest decrease was for primary care services.

A Closer Look at Pharmacy Rebates

Retail pharmacy has been consistently identified as a primary driver of health care spending.[20] Before rebates, Oregon spent $4.4 billion on retail drugs in 2020, up 9% from 2019. Unlike other types of health care, pharmacy spending did not experience significant declines due to the COVID-19 pandemic. On a per person basis, Oregon's pharmacy cost growth has remained persistently high through 2020.

Pharmacy rebates are payments from drug manufacturers to health plans or pharmacy benefit managers (PBMs) that return some of the purchase price of a prescription drug, which can be in exchange for placing specific drugs on the health plan's preferred drug list or formulary or to help reduce the cost of certain drugs. The exchange of dollars in the drug supply chain is complex, and involves multiple parties including pharmaceutical manufacturers, health insurers, PBMs, pharmacies, wholesalers, and patients.



Source: Center for Improving Value in Health Care

The PBM typically shares rebates with health insurers to help reduce the cost of specific drugs. Payers and PBMs may pass some rebates on to employers or purchasers or use the rebates to help lower or constrain commercial health plan premiums. Manufacturers may also make some rebates directly available to patients.

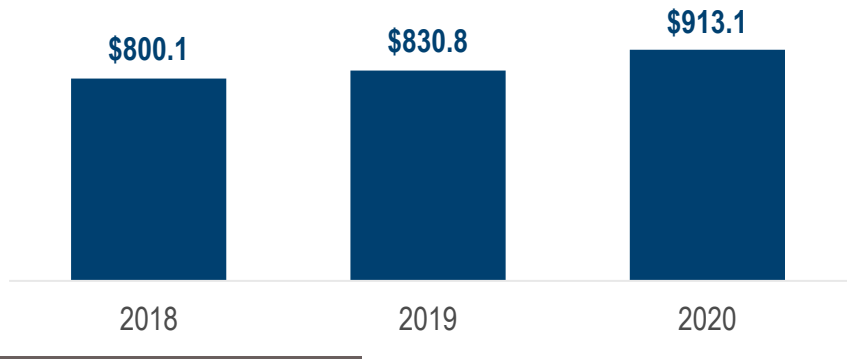
[20] Health Care Cost Institute. 2020 Health Care Cost And Utilization Report. May 2022.

Pharmacy rebates are not captured in the All Payer All Claims database so Oregon has not had much insight into how much pharmacy rebates may be offsetting costs for prescription drugs across the state. In their 2022 report, Oregon's Prescription Drug Price Transparency Program collected data on the total amount of pharmacy rebates collected by each commercial health plan as compared to dollars spent on prescription drugs and found that most reported rebates between 10% and 20% of total pharmacy spending.[21]

The Cost Growth Target Program is collecting both retail and medical pharmacy rebate information in aggregate for all data submitters, which means Oregon is able to see a more complete picture of the impact of pharmacy rebates on drug spending across markets. [22]

Pharmacy rebates in Oregon totaled $2.5 billion between 2018-2020

Fig 2.21 Total amount of pharmacy rebates, statewide
In millions



Total pharmacy rebates increased 3.8% between 2018-2019 and 9.9% between 2019-2020.

This is similar to increases in prescription drug rebates for these years in Colorado, one of the only states collecting detailed rebate data (3.8% and 11.8%, respectively).

[21] Prescription Drug Price Transparency Program, 2022 Annual Report

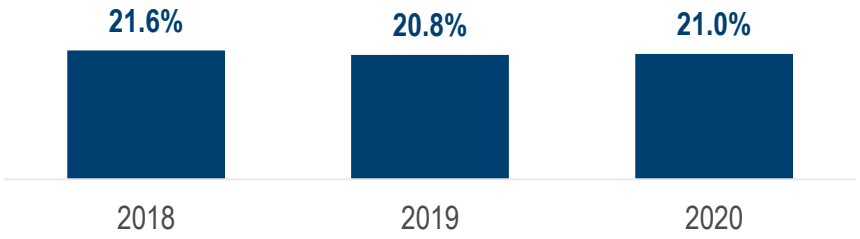
[22] Rebates are reported as the estimated value of rebates attributed to Oregon residents provided by pharmaceutical manufacturers for prescription drugs with specified fill dates corresponding with the reporting period, excluding manufacturer-provided fair market value bona fide service fees for retail prescription drugs or pharmaceuticals that are paid for under the member's medical benefit. See Cost Growth Target Data Submission Manual (CGT-2) for additional details on payer reported pharmacy rebates. This includes rebates for medical pharmacy, also known as physician-administered drugs (PAD). Most medical pharmacy costs are captured in the hospital inpatient, hospital outpatient, and professional spending categories. Because rebates are reported in aggregate for medical and retail pharmacy, rebates as a percent of *retail* pharmacy spending is slightly inflated.

Statewide, about 21% of spending for retail pharmacy was returned to payers and PBMs through rebates

Or, for every dollar that was spent in Oregon on prescription drugs in a retail setting, drug manufacturers returned about 21 cents in rebates to health plans and pharmacy benefit managers.

The percent of pharmacy rebates as a share of overall retail pharmacy spending remained consistent between 2018-2020.

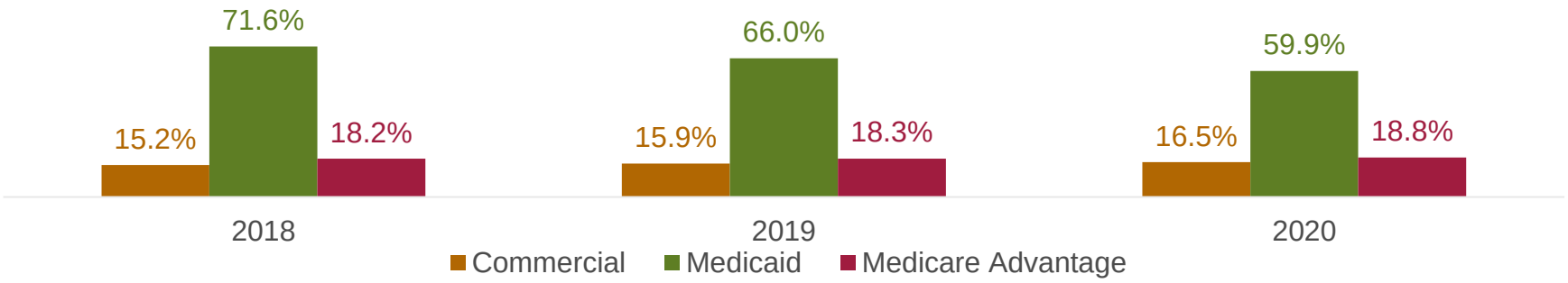
Fig 2.22 Rebates as a percent of gross retail pharmacy spending, statewide



Medicaid recoups a majority of prescription drug costs through rebates, due to federal and state policies

For every dollar that was spent in Oregon on prescription drugs for Medicaid in 2020 in a retail setting, drug manufacturers returned 60 cents in rebates. Since 1990, the federal Medicaid Prescription Drug Rebate Program (MDRP) requires manufacturers who want their drug covered by Medicaid to enter into rebate agreements. The program was later expanded in the Affordable Care Act. Rebate amounts are set in statute and ensure that Medicaid gets the "best price" –that is, the lowest available price to any wholesaler, retailer, or provider.[23]

Fig 2.23 Rebates as a percent of gross retail pharmacy spending, by market



[23] Understanding the Medicaid Prescription Drug Rebate Program, KFF, November 2019

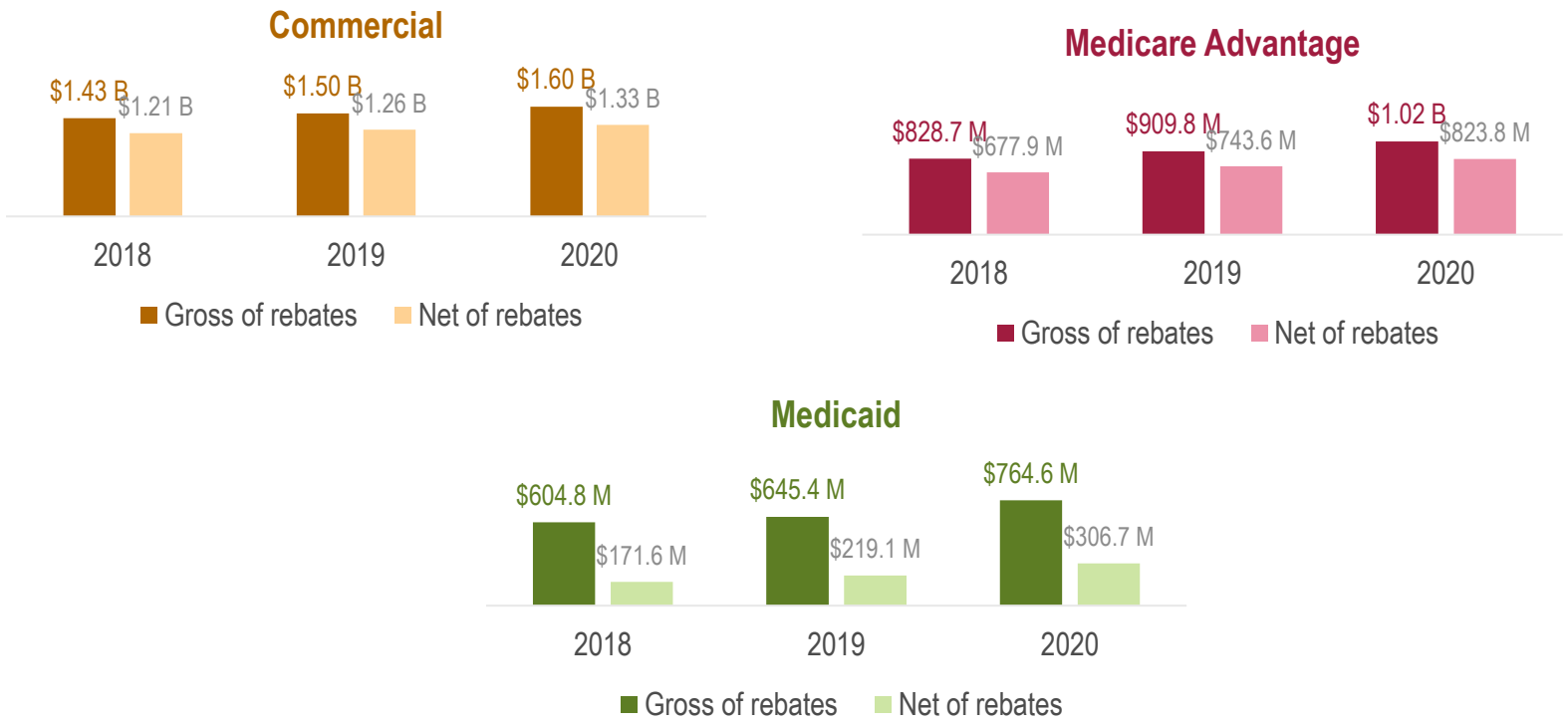
Even with pharmacy rebates taken into account, pharmacy spending continues to grow in each market

Without rebates taken into account, retail pharmacy spending in the commercial market grew 5.1% between 2018-2019 and 6.5% between 2019-2020. With rebates, commercial retail pharmacy spending grew 4.1% and 5.8%, respectively.

Without rebates, retail pharmacy spending for Medicare Advantage grew 9.8% between 2018-2019 and 11.6% between 2019-2020. With rebates, Medicare Advantage retail pharmacy spending grew 9.7% and 10.8% respectively.

Without rebates, retail pharmacy spending for Medicaid grew 6.7% between 2018-2019 and 18.5% between 2019-2020. With rebates, Medicaid retail pharmacy spending grew 27.7% and 39.9% respectively.

Fig. 2.24. Retail pharmacy spending gross (before) and net (after) pharmacy rebates, by market



Chapter III. Health Care Cost Growth Trends, 2018-2020 Payer and Provider Level (de-identified)

Chapter III presents de-identified health care cost growth trends between 2018 and 2020 for payer and provider organizations.

These de-identified trends are provided to give some context for the variation across the state and the differences by market, as well as differences across payer and provider organizations. Not all parts of the health system experienced the early part of the COVID-19 pandemic in the same way, such as increased labor costs and decreased utilization.

Cost Growth Target Year	0	1
Cost growth between	2018-2020	2020-2021
Data submitted in	2021	2022
Report published	May 2, 2023	May 9, 2023
Are payers and provider organizations identified?	NO	YES

Oregon is phasing in transparency measures and identified reporting of health care cost growth trends at the payer and provider organization level will begin in the next report.

Note OHA has not applied statistical testing to any of the de-identified payer and provider organizations reported on the following pages. A de-identified entity may appear to be over the cost growth target but may not have statistically significant growth and would not be held accountable if the cost growth target was in effect for this measurement period.

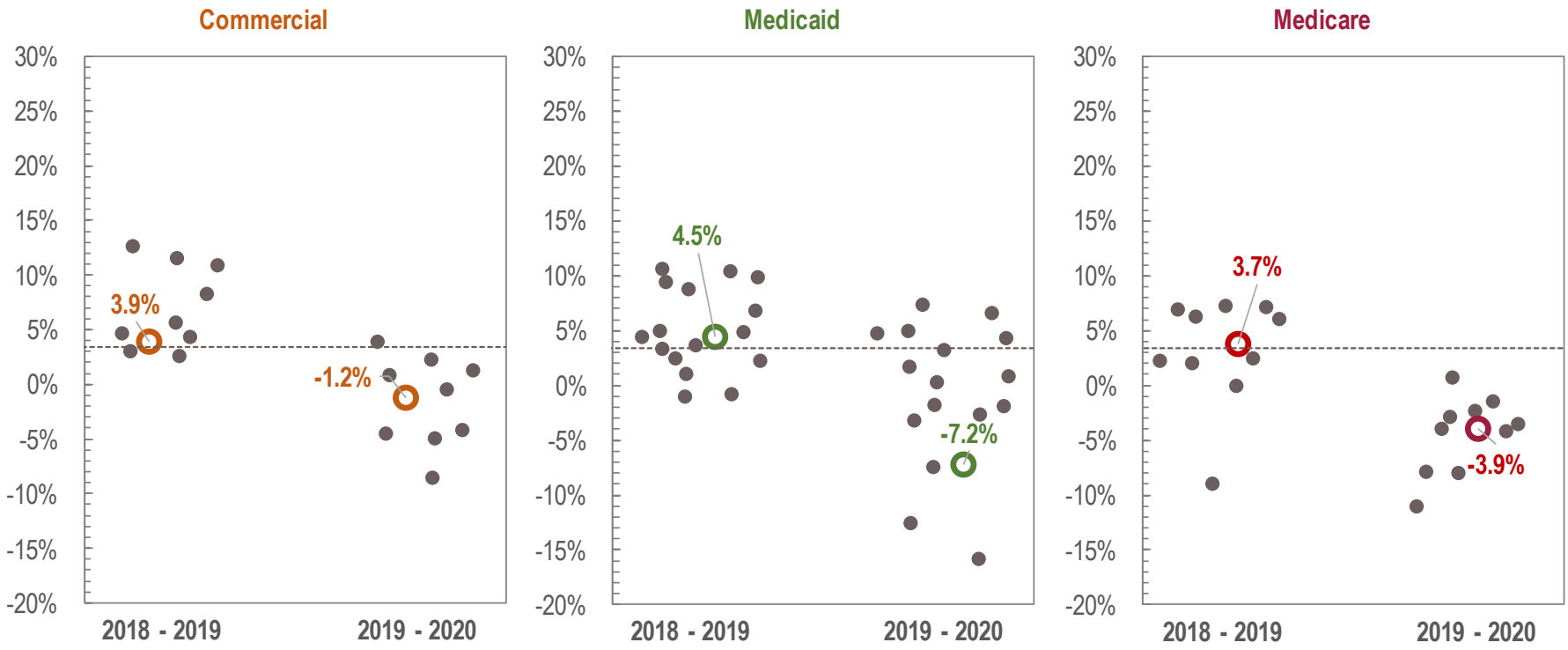
List of Figures

Total Medical Expenses – De-identified Payers by Market

From 2018 to 2019, the average payer cost growth trend was over the 3.4% target in all markets. Medicaid had the highest trend (4.5%) followed by Commercial (3.9%) and Medicare (3.7%). The statewide TME trend was 4.2%

From 2019 to 2020, cost trends declined due to the COVID-19 pandemic and most payers saw negative cost growth. Commercial payers saw the least impact with an average growth of -1.2% between 2019 and 2020. The Medicare average was -3.9% with all Medicare payers experiencing a negative trend. Medicaid had the lowest average trend of -7.2% and the widest range of cost trends across payers. The statewide TME trend was -4.7%.

Fig 3.1 TME cost growth for de-identified payers, compared to the statewide average for each market



Payer Perspectives

OHA met with each of the payers subject to the Cost Growth Target Program to review and validate their 2018-2020 data and discuss cost growth and cost growth drivers. Themes from payer conversations included:

COVID-19

Payers consistently reported on the impacts of the pandemic, including drops in utilization as members delayed care. Payers anticipate significant health care cost growth between 2020-2021 to address pent up demand and overall cost increases due to economic factors.

Hospital Costs

Several payers noted high payments to hospitals as a contributing factor to their cost growth, particularly for inpatient hospital services. Payers also noted shifts in where members are receiving care (impact of facility fees, more inpatient stays and surgeries).

Pharmacy Costs

Payers identified pharmacy costs as a key driver of cost growth in all markets, especially specialty drug costs.

Behavioral Health

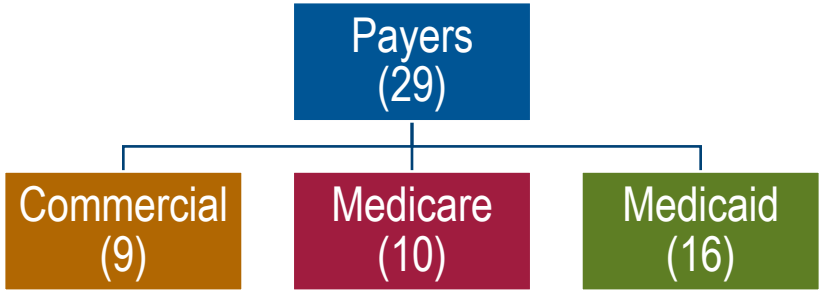
Efforts to expand and improve behavioral health access, including behavioral health integration, as well as a Medicare 2020 behavioral health rate increase all contributed to increased behavioral health spending.

Shift towards Alternate Payment Methods

Several payers noted the ongoing transition from fee-for-service / volume-based payment models to value-based payment models, and the increase in performance incentive payments, particularly for Medicaid. See Chapter II for more details on non-claims payments by market.

Payers by Market

To be included in cost growth target reporting, payers must have at least 5,000 covered lives in Oregon in a given market. The de-identified payer data above represents 29 payers.

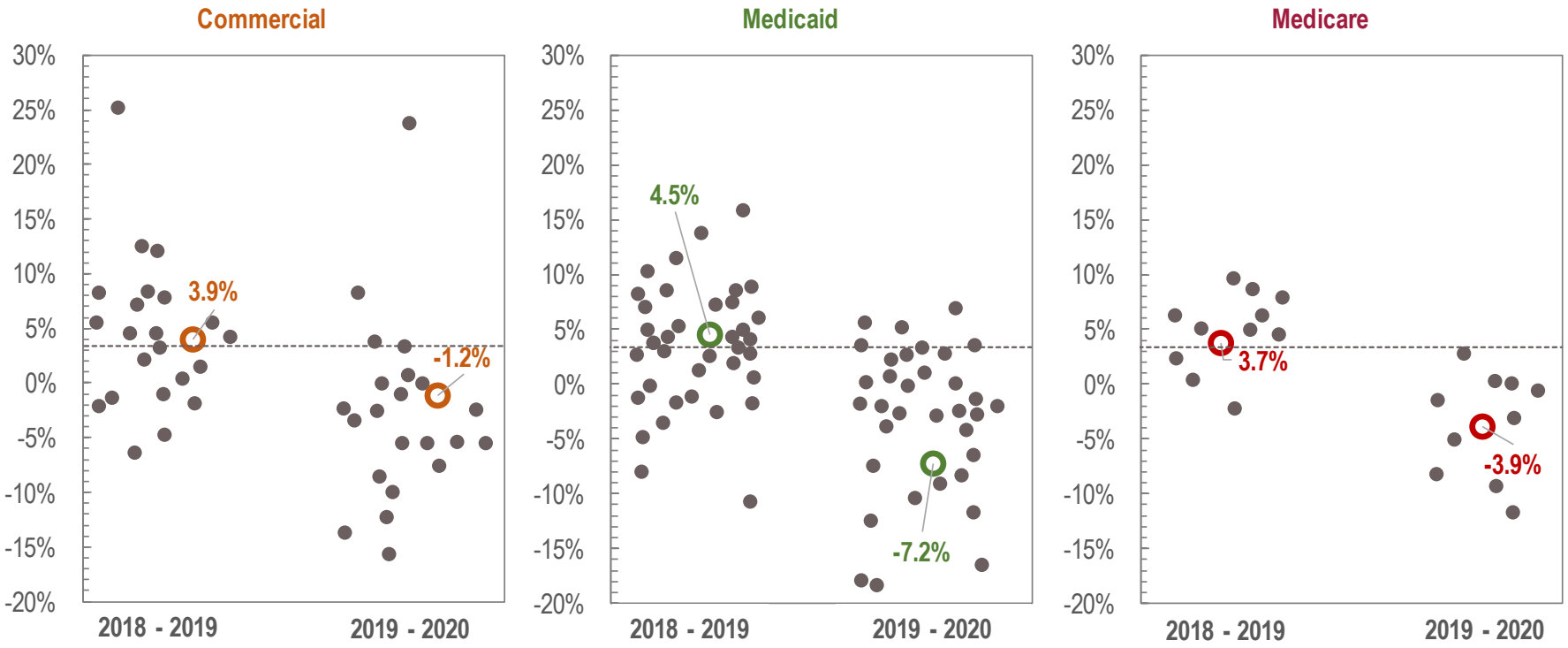


Total Medical Expenses – De-identified Provider Organizations by Market

From 2018 to 2019, the average provider organization cost growth trend exceeded the 3.4% target in all markets. Medicaid had the highest trend (4.5%) followed by Commercial (3.9%) and Medicare (3.7%). The statewide TME trend was 4.2%

From 2019 to 2020, most provider organization cost trends declined due to the COVID-19 pandemic. Commercial provider organizations saw the least impact with an average cost growth of -1.2%. The Medicare average cost growth was -3.9% with all provider organizations experiencing a negative trend in this market. Medicaid had the lowest average trend of -7.2% and the widest range of cost trends among provider organizations. The statewide TME trend was -4.7%.

Fig 3.2 TME cost growth for de-identified provider organizations, compared to the statewide average for each market



Provider Organization Perspectives

OHA met with most of the provider organizations subject to the Cost Growth Target Program to review and validate their 2018-2020 data and discuss cost growth and cost growth drivers. Themes from provider conversations included:

COVID-19 and Economic Factors

Provider organizations noted the decline in utilization and increase in patient acuity since the start of the pandemic. Provider organizations are concerned about the impact of inflation in upcoming years and many identified increased workforce costs.

Shift towards Alternate Payment Methods

Providers anticipate non-claims spending increasing in future years, due to new capitation arrangements and performance incentive programs.

Changes in Service Offerings

Several provider organizations noted changes in the services they offer, including opening new behavioral health facilities and oncology centers, or contracting out for services that were previously offered in-house.

Equity

Several provider organizations expressed concern about creating disincentives for providing care to higher-cost, but vulnerable populations. Some noted their patient populations may be higher risk than other provider organizations, which would affect their cost growth.

Provider organizations are looking for actionable data

Providers are interested in better understanding their cost growth and cost growth drivers, which may necessitate additional data sharing with payers. Providers were also particularly interested in how they compared to others.

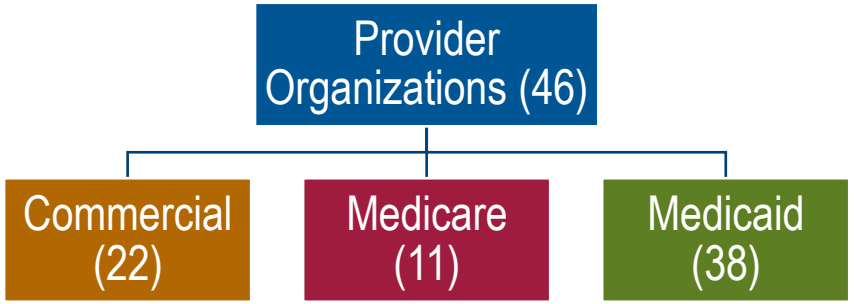
Provider organizations are not confident in their ability to control costs that occur outside of their offices

Several provider organizations noted that they operate in a limited market – there are few options for specialists or hospitals to refer patients to, which may result in higher costs.

Provider organizations are interested in strategies and tools that will help them address costs more broadly, and in clarifying what is and is not within their ability to control.

Provider Organizations by Market

Provider organizations must have at least 60,000 member months (~ 5,000 lives) in at least one market to be included in public reporting. The de-identified data above represents 46 provider organizations.



Chapter IV. External Factors Impacting Health Care Spending in Oregon

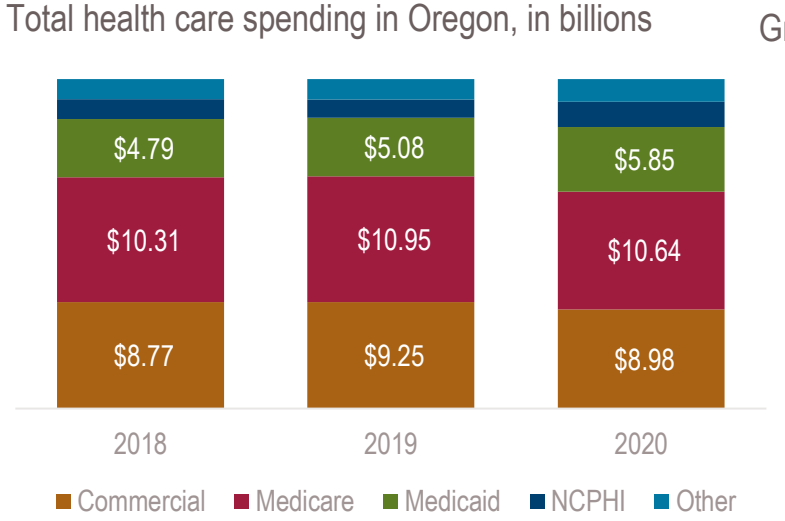
COVID-19 Pandemic

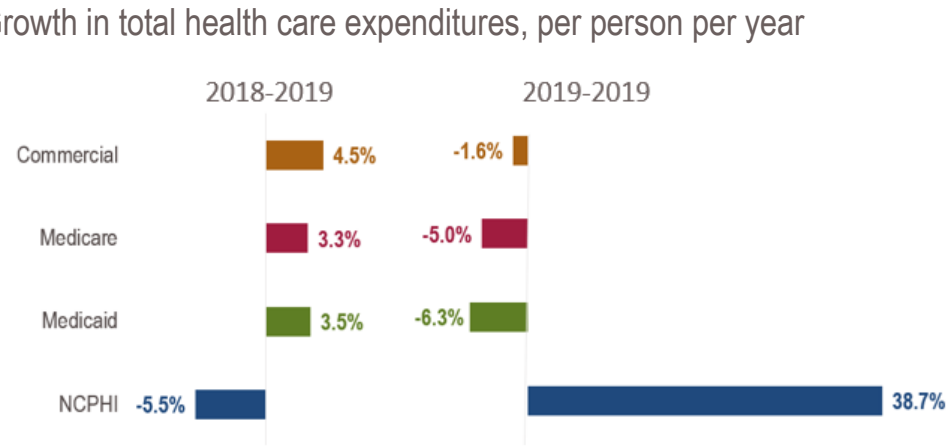
Collecting total cost of care data from 2018 to 2020 provides insight into where health spending was before the COVID-19 pandemic and a first look at the impacts of the pandemic on health care spending due to the social-distancing procedures that affected much of the state, and the pause on elective services that resulted in certain types of care being delayed or cancelled, especially in the early months of the pandemic.[24]

While this report and cost growth data are not built to comprehensively examine the complex nature and impacts of a global infectious disease outbreak, these health care cost growth trends shine a light on the initial impacts that the pandemic had on utilization and on payments between payers and provider organizations.

Impacts on spending differed by market

The impact of COVID-19 as observed in Oregon's cost growth target trend data shows up largely as declines in per person spending between 2019 and 2020, though the experience differed by market. Total Medicaid spending grew in 2020 due to increased enrollment, while total spending declined for the Medicare and commercial markets. However, on a per person per year basis, Total Health Care Expenditures declined for all markets, with the largest decline in Medicaid and Medicare.





[24] Peterson-KFF Health System Tracker. How have health spending and utilization changed during the coronavirus pandemic? March 2021.

Health care spending in 2020 was in part driven by financial supports for provider organizations

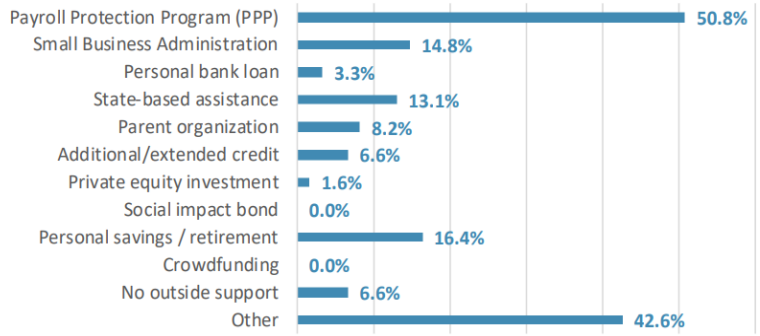
Health care providers, hospitals, and health systems across Oregon lost revenue due to COVID-19 and some provider organizations were at risk of closing.

A survey conducted with primary care practices in Oregon in June 2020 found that more than a third reported they were not likely to have enough cash on hand or enough billable services in the upcoming four weeks to be able to stay open.[25]

Multiple state and federal programs were launched to help make up for revenue shortfalls and ensure provider organizations could remain open.[26] Payers and provider organizations in Oregon may have also been eligible for other federal programs such as the Paycheck Protection Program and other small business relief. These programs all contributed to the increase in health spending in 2020. [27]

Oregon payers also arranged COVID-19-related support payments for provider organizations that were experiencing sharp declines in patient utilization. These payments are reflected in non-claims spending across various categories, including performance incentives and payments in support of population health. See Chapter II for details.

Percent of Oregon primary care practices who indicated their practice received financial support from… (May 2020)



Federal programs to support providers included multiple rounds of the CARES Act Provider Relief Fund distributions to hospitals and providers; Medicare Accelerated and Advance Payment loans; and direct reimbursement to providers for COVID-19 testing and treatment for uninsured individuals

State strategies included accelerated DHS payments to hospitals; stability payments to Medicaid FFS providers; "reserve service capacity" payments to behavioral health residential settings; enhanced rates and supplemental payments to Tribal and urban Indian Health Programs; increased rates for nursing facilities, assisted living facilities, residential care, and private duty nurses; and Rural Hospital Sustainability & Transformation Grants.

[25] Impacts of COVID-19 on Oregon's Primary Care Providers: Survey Highlights. July 2020.
[26] OHA provided a more detailed summary of state and federal supports and dollars flowing into Oregon as of Oct 2020.
[27] Centers for Medicare & Medicaid Services. National Health Spending in 2020 Increases due to Impact of COVID-19 Pandemic. Dec 2021.

Short and long-term impact of changes in the health care workforce

While the total medical expenses data included in this report do not directly reflect provider organization operating costs, changes in the health care workforce have both short- and longer-term effects on health care cost growth.

About 55% of health care spending is related to salaries and wages.

- Ezekiel Emanual M.D. and Bob Kocher M.D
Stat News 2020

2020

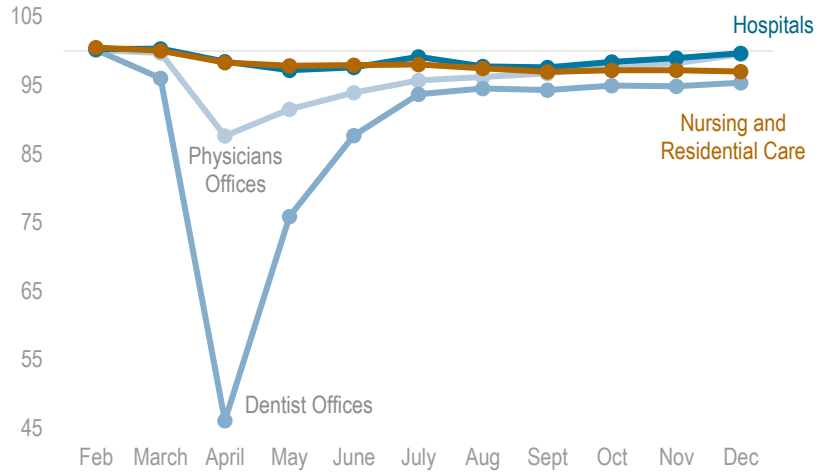
In addition to pre-pandemic workforce shortages, survey data from the early months of the pandemic indicate many health care workers were furloughed or had hours reduced as facilities closed and elective procedures were paused.[28]

In June 2020, 45% of Oregon primary care practices reported they had reduced staffing to remain financially solvent.[29] Hospitals also reported cutting labor costs through staff furloughs and reduced hours.[30]

However, not all parts of the health system experienced the same impacts and recovery to their workforce, and the health system has not had the same experience as other sectors (e.g. construction).[31]

The graph below shows some of the variation across Oregon's health care system of both the initial employment losses and the rebound later in 2020.

Private healthcare employment trends in 2020, by subsector
Relative to January 2020 employment, not seasonally adjusted



Oregon Employment Department, Employment and Wages by Sector, 2020

[28] Impact of the COVID-19 pandemic on the hospital and outpatient clinician workforce: challenges and policy responses (Issue Brief No. HP-2022-13). Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. May 2022.

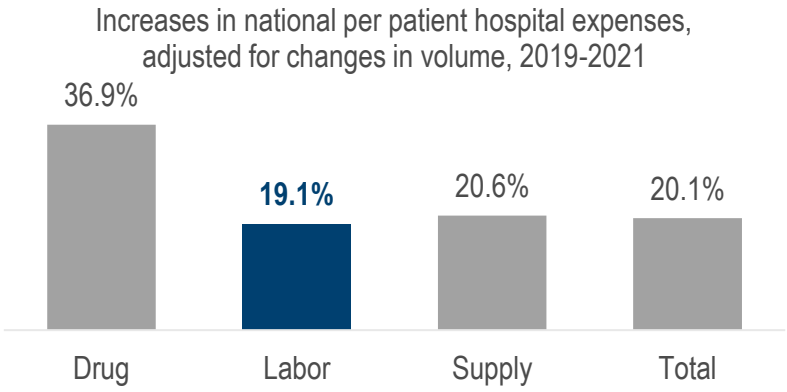
[29] Impacts of COVID-19 on Oregon's Primary Care Providers: Survey Highlights. July 2020.
[30] Oregon Association of Hospitals and Health Systems, April 2020
[31] Oregon Employment Department. The Re-Employment of Oregon. Aug 2022.

2021 and Beyond

As the pandemic continued, hospitals and other parts of the health system continued to report workforce challenges, including staff shortages, difficulty recruiting and retaining staff, and increased labor costs.

In 2021, the Oregon Association of Hospitals and Health Systems / Apprise Health Insights reported that Oregon hospital payroll costs had increased 20 percent over the last three years.[32]

A nationwide analysis found that by the end of 2021, total hospital expenses were up 11% overall compared to pre-pandemic levels in 2019 (20.1% adjusted for changes in volume).[33]



The long-term impacts of these increased health care workforce costs may show up in the future in the form of higher rates in payer-provider contracts. Because contracts are negotiated for specific periods of time, high labor costs may not be reflected in health care spending for several years.

Future reporting on Total Health Care Expenditures may capture these increased costs, and they may also be reflected in increased premiums for consumers.

In Summary

Total cost of care spending in Oregon is a high-level view of how health care dollars are flowing in the system.

Many factors influence Oregon's total cost of care, including insurance coverage across the state, health care prices set by contracts negotiated between health insurers and providers in the previous year, non-claims payment arrangements (e.g., value-based payments), insurance premium rates, and patient utilization.

The pandemic's impact on all these factors (and more) will likely continue to affect the system, total cost of care, and the state's collective ability to maintain cost growth near and below the target.

[32] Oregon Hospital Utilization and Financial Analysis, Q2 2021.

[33] American Hospital Association. 2021 Cost of Caring Report.

Appendix 1. Methodology

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. See Appendix 2 for additional details.

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 in either the Medicaid or Medicare market depending on whether the payer was the primary insurer for that member.

Dual Medicaid expenses are *under-reported* in this report due to limitations of the initial reporting methodology. This has been updated for future cost growth target data submissions and will be reflected in future reports.

The guidance for the initial cost growth target data submission for 2018-2020 directed payers to report *only* the primary payer allowed amount and not the secondary payer paid amount. However, in Oregon, it is not a correct assumption that the primary allowed amount will reflect the entire payment that the provider receives for a dual eligible member, and as written, the guidance likely resulted in not capturing the total cost of care for dual eligible members.

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-19-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.

Risk 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 2018-2020, payers submitted unadjusted and adjusted spending data using their own risk adjustment tools and methodologies. OHA used unadjusted data to calculate the state and market level trends for this report.

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.

Other Data Sources

The cost growth target program collects additional data on health care spending outside of the payer-submitted files to more comprehensive report on Total Health Care Expenditures. This includes:

- A data file from CMS with spending for Medicare Fee-For-Service members in Oregon
- Veterans Affairs spending in Oregon
- State funding for behavioral health (e.g. contracts for treatment and recovery supports for mental health, substance use disorder, and problem gambling)
- Spending for people in state correctional facilities covered by the Oregon Department of Corrections
- Spending by consumers on prescription drugs through the state's prescription drug discount card program – ArrayRx – not otherwise captured in claims spending

OHA also compiles data to calculate the Net Cost of Private Health Insurance (NCPHI) from the CMS MLR resources website and National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) reports provided by DCBS or directly 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 (2018-2020)
- HEALTH PLAN OF CAREOREGON, INC. (2020)

Additional data about Medicaid spending is taken from Coordinated Care Organization Exhibit L submissions.

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 (e.g. other public programs).

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 2018-2019 and 2019-2020.

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 and market level. The year-over-year growth rate for both total dollars and PPPY is calculated between 2018-2019 and 2019-2020.

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.

Appendix 2. Medicaid Cost Growth Measurements

Oregon's Medicaid program has many different types of cost growth measurements. Each focuses on slightly different areas of the Medicaid program and are therefore calculated using different methodologies, with certain benefits and segments of the Medicaid population included or excluded in the calculation.

1. Oregon Legislature requires that state funds used for the Medicaid program (prior to any expansions of benefits) can grow no more than 6.92 percent per biennium, which is equivalent to 3.4 percent per year after compounding. State funds support programs such as Cover All Kids and the state-share of payments to CCOs and for the Children's Health Insurance Program.

2. A 3.4 percent growth target is specified in the agreement between Oregon and the federal government in the form of the state's 1115 Medicaid waiver. This growth target is specific to most of the Medicaid program, but there are some components that are excluded such as mental health drugs, costs associated with individuals dually enrolled in Medicaid and Medicare, Certified Community Behavioral Health Clinics, and more.

3. The OHA has an internal benchmark of 3.4 percent growth for CCO capitation rates. This target includes only payments made to CCOs and excludes all costs associated with individuals who have Medicaid but are not enrolled in a CCO. This growth benchmark also excludes medical costs for individuals who are undocumented, direct payments to medical providers, and more. There have been years in which the CCO capitation rate exceeded 3.4 percent for justifiable reasons, including legislatively funded expansions of benefits. Going forward, OHA will also assess CCOs' risk adjusted rate of growth as per the Legislature's direction.[34]

4. The Oregon Sustainable Health Care Cost Growth Target is another cost growth measurement that applies to Medicaid. It will differ from the previous ways that the state has limited the cost growth of the Medicaid program.

The analysis presented in this report does not align with any of the abovementioned 3.4 percent growth measurements. See Appendix 1 for more details on specific CGT methodology

[34] Risk Adjusted Rate of Growth memo, 2020.

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