Health Care Cost Growth Trends in Oregon, 2022-2023

2025 Sustainable Health Care Cost Growth Target Annual Report

June 2025

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 measures, analyzes, and publicly reports on total health care spending and spending growth statewide.

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

Visit the Cost Growth Target website for more information.

Executive Summary

This report presents data on health care spending and health care cost growth in Oregon from 2022 to 2023. This report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2022 and 2023.

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.

Note: this report does not include cost growth trend data for provider organizations subject to the cost growth target; OHA will publish provider organization level cost growth, which is derived from payer cost growth data, when data validation is completed later in 2025.

HEALTH CARE COST GROWTH TARGET

Click the icon to explore the Cost Growth Target 2022-2023 Databook

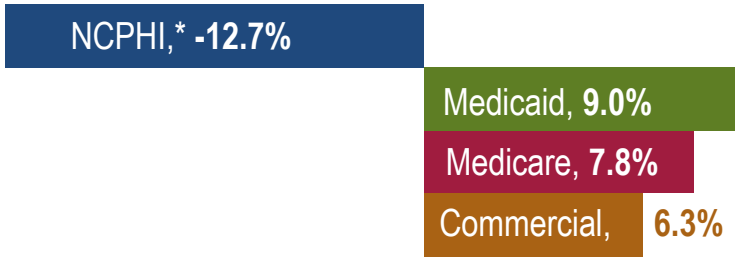
Key Findings: Total Spending

Health care spending in Oregon in 2023 totaled almost $38.75 billion dollars, 8.0% more than 2022 spending.

On a per person per year basis, Total Health Care Expenditures (THCE) increased 5.2% between 2022-2023, above the cost growth target of 3.4%.

Growth in THCE per person per year (PPPY) was above the target in every market: 9.0% for Medicaid, 7.8% for Medicare, and 6.3% for the Commercial market.

Percent change in total health care expenditures, by market, 2022-2023



*NCPHI is the Net Cost of Private Health Insurance, which is the difference between premiums collected and claims paid for medical services. NCPHI covers the cost of health plan administration, marketing, and profits.

Key Findings: Statewide Growth

Statewide from 2022-2023, cost growth was the highest that it has been across all measurement periods for which cost growth target data are available.

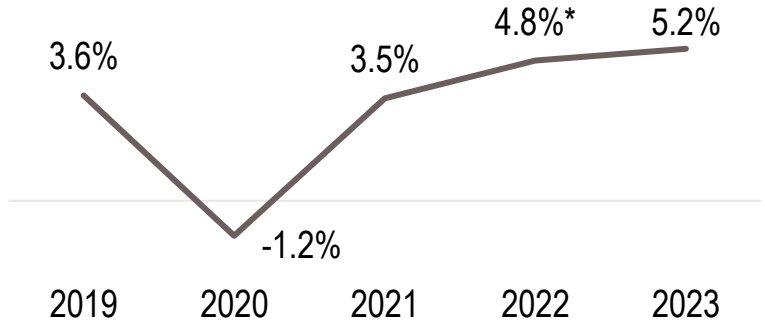
Statewide cost growth was 5.2% on a per person per year basis, compared to 4.8% from 2021-2022 and 3.5% from 2020-2021. Key cost dynamics included:

- **High medical expenses:** Growth was driven by spending on medical services, while the net cost of private health insurance – the amount available to health plans for administration, marketing and profit – shrank by 12.7%.
- **High growth across service categories:** Spending was high across most service categories, with the exception of Hospital Inpatient spending, where growth was more modest.
- **Growth driven by price:** Growth during the period was mainly driven by increases in unit cost (the average cost of a claim, hospital discharge or 30-day prescription) as opposed to utilization.

Five payers met the 3.4% cost growth target, while five had indeterminant growth and the rest exceeded the target with statistical confidence.

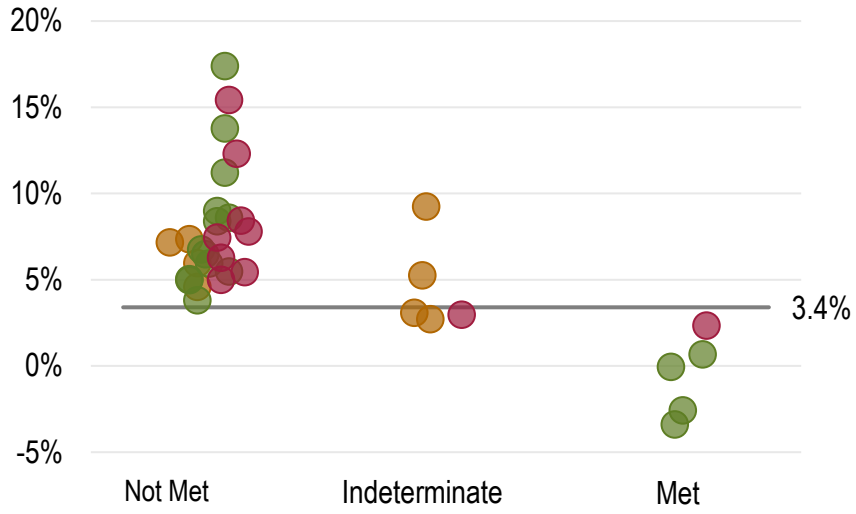
Growth in Total Health Care Expenditures, 2018-2023

Years are year 2 of a 2-year period, e.g. "2023" represents 2022-2023



*2021-2022 growth updated to include additional NCPHI sources not available at the time of the publication of the Health Care Cost Trends report in 2024.

Payer performance relative to the cost growth target for **Commercial**, **Medicare Advantage**, and **Medicaid**, 2022-2023



Key Findings: Commercial Growth

From 2022-2023, THCE inclusive of the net cost of private health insurance (NCPHI) grew 6.4% in the Commercial market, while Total Medical Expenses (TME) grew 6.3% (unadjusted). Adjusted for age/sex demographics, per person per month TME for commercial payers grew 5.7%.

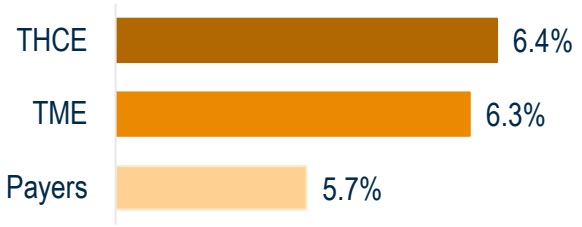
No Commercial payers met the cost growth target, and five out of eight payers exceeded it with statistical confidence.

- Commercial cost growth was highest for **Professional Services** (9%, or $215 per person per year)**,** including 20.3% growth in per person per year spending for behavioral health services. **Hospital Outpatient** spending grew $111 (7%) per person per year, driven by the increased cost of facility claims.

- Commercial Hospital Outpatient and Retail Pharmacy cost growth was driven by **price**; Hospital Inpatient and Emergency Department cost growth was driven by **utilization.**

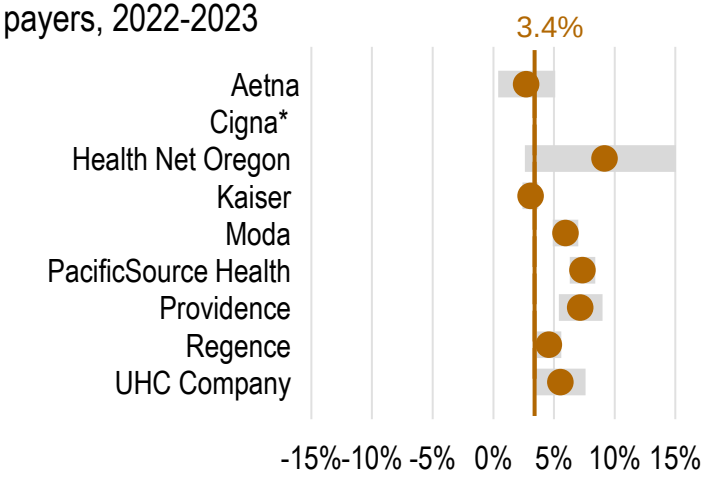
- NCPHI – the amount available to health plans for administration, marketing and profit – grew 7.0%, and the percent of premiums collected by payers that went to cover medical claims decreased modestly on average.

Per Person Per Year Cost Growth, Commercial Market, 2022-2023



THCE and TME growth is growth in PPPY spending across Full and Partial Claims, net of pharmacy rebates, unadjusted for demographics. THCE includes payer NCPHI. Payer cost growth is growth in PMPM, net of rebates for Full Claims, adjusted for age/sex demographics.

Per Member Per Month Cost Growth, Commercial payers, 2022-2023



*Cigna did not complete data validation in time to be included in this report.

Grey bars indicate confidence intervals.

Key Findings: Medicare Growth

From 2022-2023, THCE inclusive of NCPHI grew 7.5% in the Medicare market, while TME grew 6.9% (unadjusted). THCE and TME spending includes both Traditional (Fee-For-Service) Medicare and Medicare Advantage. Per person per month TME (adjusted) for Medicare Advantage payers grew 7.3%.

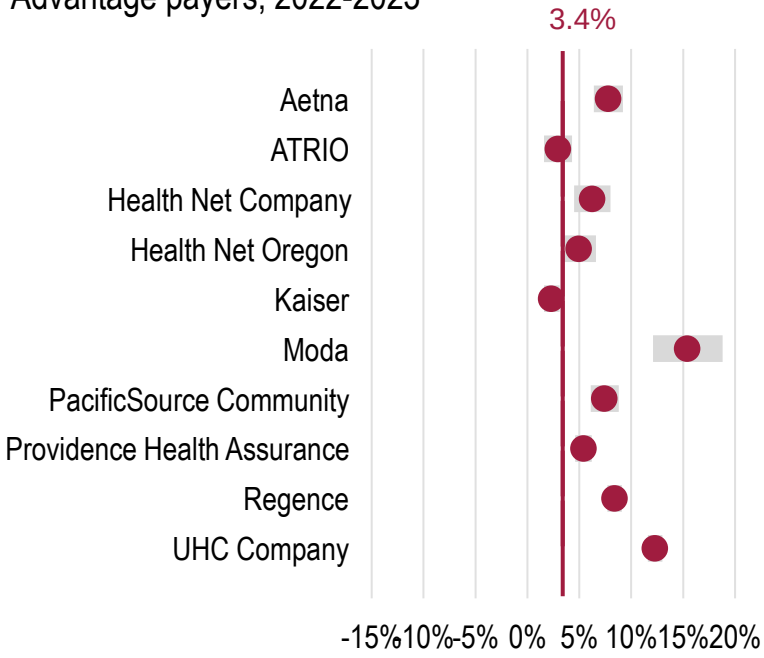
One Medicare Advantage payer met the cost growth target; seven of 10 exceeded it with statistical confidence.

- **Professional Services** and **Retail Pharmacy** were responsible for about 40% of Medicare spending growth. Spending on drugs administered in a doctor's office (**Medical Pharmacy**) grew 14.3% per person per year, with most growth concentrated on a short list of high-cost drugs.
- Statewide, Hospital Inpatient cost growth was driven more by **utilization** than price.
- In **Medicare Advantage, Non-Claims growth** was a significant factor, with spending per person per year increasing by 42.9% ($279). Non-claims spending includes things like global budgets, risk sharing contracts, and incentive payments made to providers.

*THCE and TME growth is growth in PPPY spending across Medicare FFS and Medicare Advantage, net of Medicare Advantage rebates, unadjusted for sex/age, including Medicare/Medicaid Duals. THCE includes payer NCPHI. Payer cost growth is PMPM, net of rebates, adjusted for sex/age, for Medicare Advantage excluding Duals.

Per Person Per Year Cost Growth, Medicare, 2022-2023*

Per Member Per Month Cost Growth, Medicare Advantage payers, 2022-2023



Grey bars indicate confidence intervals.

Key Findings: Medicaid Growth

From 2022-2023, THCE grew 4.1% in the Medicaid market (inclusive of NCPHI), while TME grew 7.0% (unadjusted). THCE includes spending for both Medicaid Open Card (Fee-For-Service) and Coordinated Care Organization (CCO). Per person per month TME (adjusted) for Medicaid payers grew 6.0%. Four CCOs met the target.

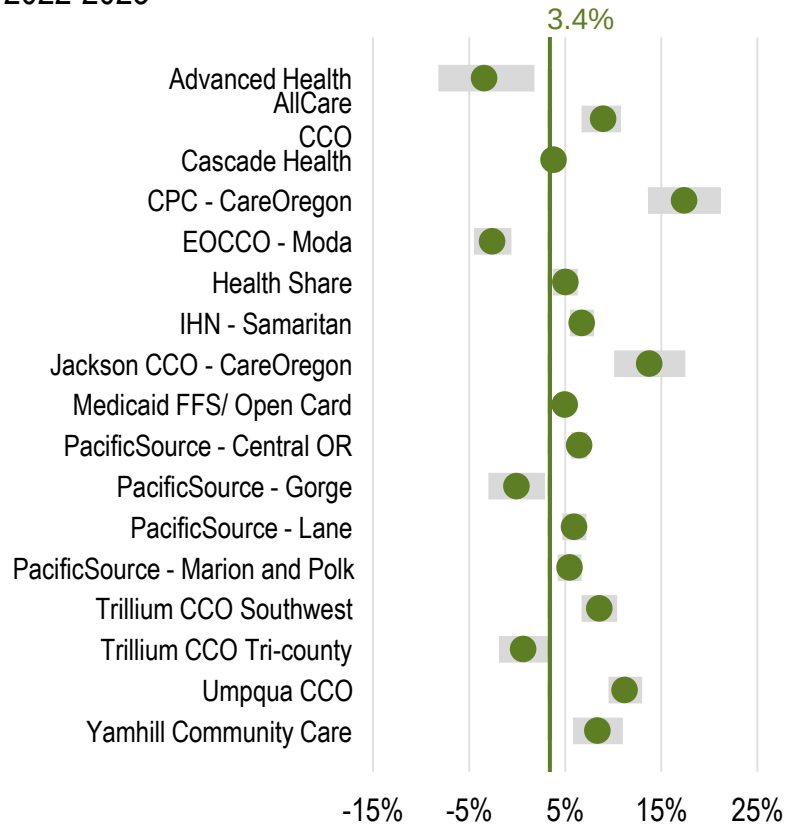
- Almost a third of Medicaid cost growth resulted from increased spending on **Professional Behavioral Health services** (+23.4%, or $97 per person per year). In 2023, Oregon implemented a behavioral health directed payment policy which increased reimbursement for behavioral health services. This policy drove both increased price and utilization of behavioral health services.

- **Hospital Inpatient** spending grew 4.6% and **Hospital Outpatient** spending grew 10%, almost entirely due to **price** increases. During this period, Oregon increased Medicaid rates paid to hospitals by 5% due to pressures from the COVID-19 pandemic.

*THCE growth is growth in PPPY spending including Medicaid CCO and Medicaid Open Card claims and non-claims spending, as well as Medicaid CCO-F and Medicaid FFS carve-out spending, CCO Other spending, and CCO NCPHI. TME growth is growth in Medicaid CCO and Open Card claims and non-claims, net of pharmacy rebates and unadjusted. Payer cost growth is PMPM, net of rebates, adjusted for sex/age.

Per Person Per Year Cost Growth, Medicaid, 2022-2023*

Per Member Per Month Cost Growth, Medicaid payers, 2022-2023

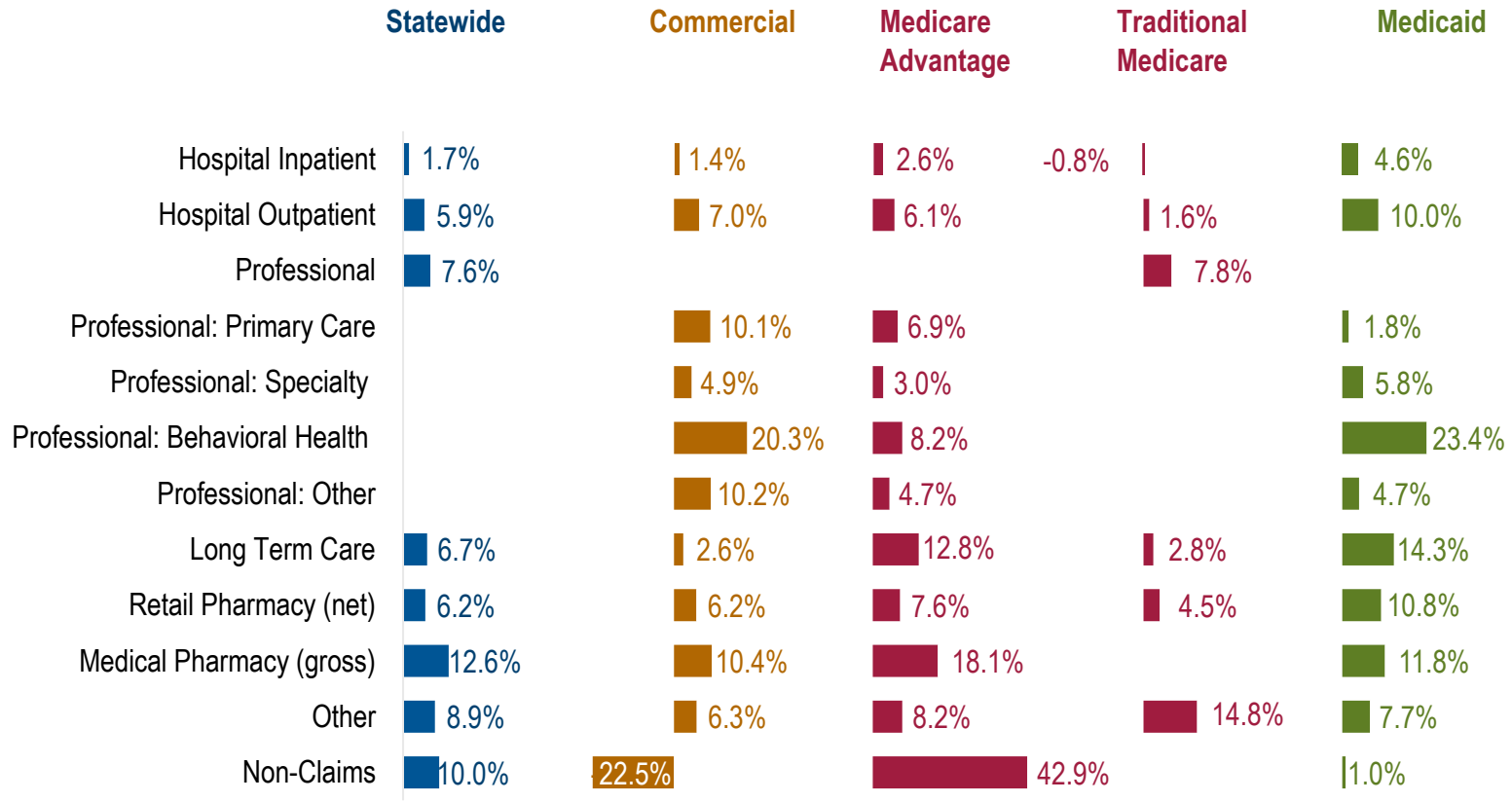


Grey bars indicate confidence intervals.

Key Findings: Cost Growth by Service Category

The graph below shows the percent change in per person per year (PPPY) spending by service category, statewide and across markets. Cost drivers vary by market, from increased Non-Claims spending in Medicare Advantage, to increases in Behavioral Health spending in the Commercial and Medicaid markets.

Total Medical Expenses Spending by Service Category, Statewide and by Market (unadjusted), 2022-2023



*Traditional Medicare data is submitted to OHA by the Centers for Medicare and Medicaid Services (CMS) with different service category breakouts that are not completely comparable to other Cost Growth Target data submissions.

Table of Contents

Suggested Citation: Oregon Health Authority. Health Care Cost Growth Trends in Oregon, 2022-2023. Portland, OR. June 2025.

Version 2 Updated June 18, 2025 to correct payer cost growth on page 66 (AllCare CCO, Trillium CCO SW, Trillium CCO Tri-County)

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 2022 and 2023. Building on the previous annual reports (covering spending from 2018 onward), this report presents information on total statewide health care spending, spending by market, by service category, and cost growth for payers.

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

By identifying drivers of health care cost growth in Oregon, the Cost Growth Target Program and this report allow policymakers, health system partners, and others to identify opportunities to slow cost growth and address growing health care affordability concerns.

All data are included in the Cost Growth Target 2022-2023 Databook (click the icon to access).

In This Report

Chapter I explores health care cost growth trends between 2022 and 2023 statewide and reviews trends across three markets (Commercial, Medicare, Medicaid).

Chapter II explores health care cost drivers and payer cost growth in the Commercial market.

Chapter III explores health care cost drivers and payer cost growth in the Medicare market.

Chapter IV explores health care cost drivers and payer cost growth in the Medicaid market.

Note: this report does not include cost growth trend data for provider organizations subject to the cost growth target; OHA will publish provider organization level cost growth when data validation is completed later in 2025. More information on page 15.

What is the health care cost growth target?

To successfully contain health care costs, all parts of the health care system must share a high-level goal for cost growth and understand what is driving health care costs.

In Oregon, payers, provider organizations, industry experts, patient advocates, legislators, and other partners came together to establish the Cost Growth Target Program.

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

A statewide health care cost growth target provides:

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

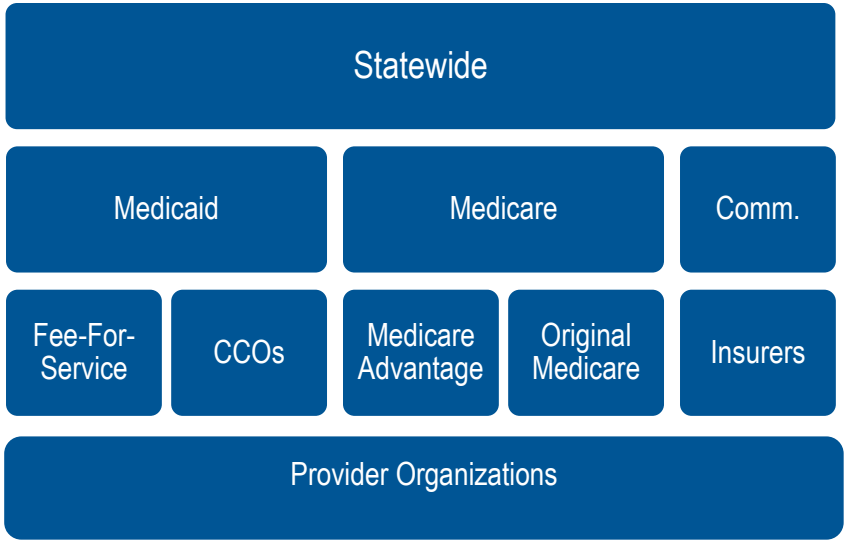
A Common Goal
Payers and provider organizations are publicly responsible for meeting the cost growth target each year.

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

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

The cost growth target is set using economic data, such as historic and projected gross state product, wages, and income. Oregon's cost growth target is 3.4% for the first five years of the program (2021-2025), and 3.0% for the second five years (2026-2030).

Oregon's cost growth target is measured at four levels: statewide, by market, for payers, and for provider organizations.



How is cost growth measured?

This report includes two key measures of cost growth: Total Health Care Expenditures and Total Medical Expenses.

Total Health Care Expenditures (THCE)

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

Total Medical Expenses (TME)

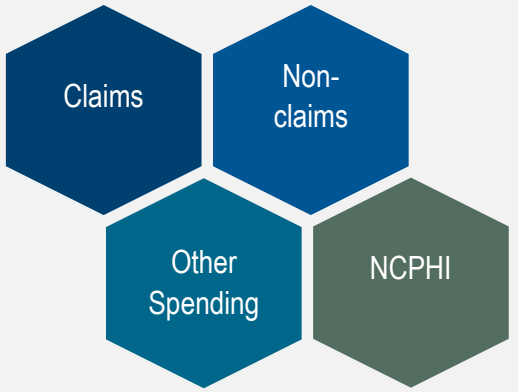
TME is used to measure health care cost growth for payers and provider organizations. It is a subset of THCE and includes claims and non-claims spending reported by payers.

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

See Appendix A for more information about how these measures are calculated.

Total Health Care Expenditures

Statewide and market level cost growth is reported using THCE.



Total Medical Expenses

Payer and provider organization cost growth is measured using TME.

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

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

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

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

Transparency: Cost growth for payers and provider organizations is publicly reported. Cost growth trends and cost drivers will also be shared at annual public hearings.

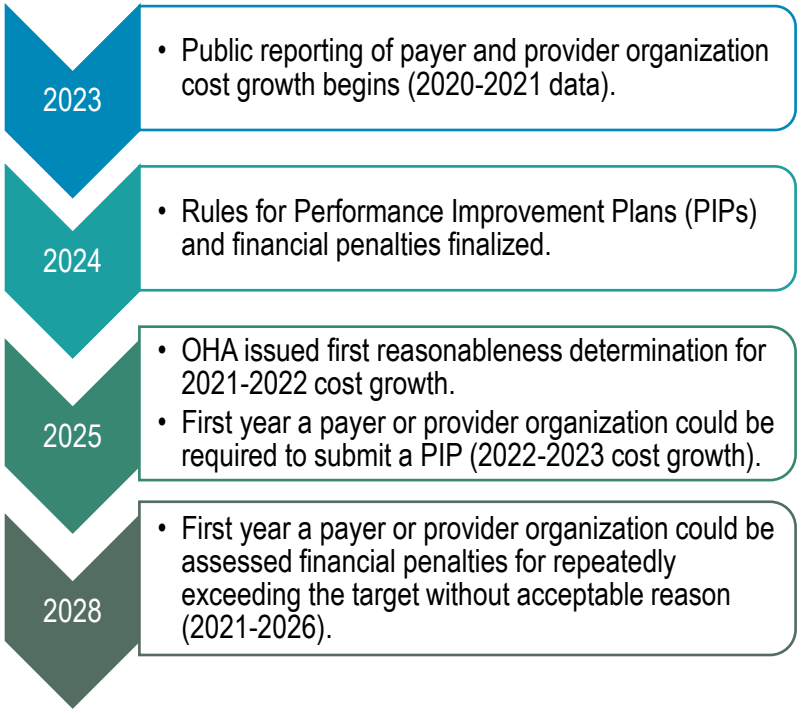
Performance Improvement Plans: Payers and provider organizations who exceed the target with statistical confidence AND without an acceptable reason may be subject to performance improvement plans.

Financial Penalties: Payers and provider organizations who repeatedly exceed the target with statistical confidence and without an acceptable reason in 3 out of 5 consecutive measurement periods may be subject to financial penalties.

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

Cost growth target accountability has been phased in over several years. The current measurement period (2022-2023) is the first time that payers and provider organizations that exceed the cost growth target without an acceptable reason may be put on a PIP.

Accountability Implementation Timeline



Determining cost growth reasonableness

The Cost Growth Target Program aims for *sustainable* cost growth and acknowledges that some cost growth is necessary to achieve high quality care and effectively meet the health needs of people in Oregon. Because of this, before any payers or provider organizations can be held accountable to the target through a PIP or financial penalty, OHA reviews reasons for cost growth to determine if they were reasonable.

A (non-exhaustive) list of acceptable reasons for growth is specified in Oregon Administrative Rule 409-065-0035, with additional details in OHA's sub-regulatory guidance.

Through the "determining reasonableness" process, payers and provider organizations that have exceeded the cost growth target with statistical confidence meet with OHA to discuss the reasons for their cost growth. Through this process OHA and accountable entities exchange additional data and documentation about cost growth drivers during the period. Following this meeting, OHA issues a reasonableness determination that dictates whether a PIP or financial penalty will apply for the measurement period.

For the 2021-2022 cost growth measurement period, OHA collaborated with 28 payers and provider organizations to review their reasons for growth. Of these entities, three had cost growth that was determined to be unreasonable. The remaining organizations had growth that was acceptable, for reasons that are summarized in the table to the right. More information provided in the 2024 accountability report.

Acceptable Reasons for 2021-2022 Cost Growth Among Payers and Provider Organizations

	Medicare	Medicaid	Commercial
High-cost outlier patients or members	✓	✓	✓
Hospital discharge issues led to increased length of stay	✓		✓
Frontline workforce costs	✓		✓
Increased performance incentives, including COVID-19 payments to stabilize providers	✓	✓	
Post-COVID utilization rebound	✓		
Medical and retail pharmacy costs	✓		
Investment in new facilities to increase access to care			✓
Service expansion to meet community needs, particularly related to behavioral health		✓	
Increased reimbursement rates for behavioral health and primary care		✓	

Cost Growth Target Data Validation

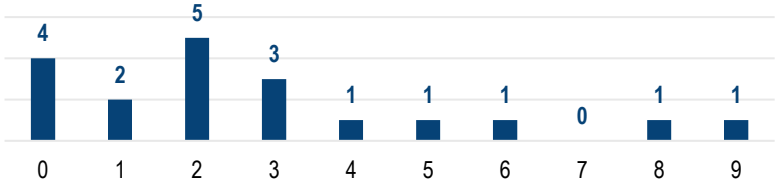
OHA conducts comprehensive validation on the cost growth target data submissions from payers each year. A data submission is considered validated when OHA and the payer have had a chance to review, correct if needed, and discuss any questions and provide any clarifications for completeness and quality. See Appendix A for additional details on data validation.

Payer Validation, 2022-2023 data

Cost growth target data submissions are typically due in early September. While payer data validation has historically taken several months, the data validation process for the 2022-2023 measurement period introduced significant delays.

While more than half of payers were able to complete their data submission and any needed corrections within one or two resubmissions, some payers required extensive resubmission, and for the first time, OHA issued notices of intent to impose civil penalties to payers for failure to comply with data submission requirements.

Count of Payers, by Number of Resubmissions Needed for 2022-2023 Cost Growth Target Data



Implications for Data Reporting

OHA must complete the data validation process with payers before compiling provider organization level cost growth and reviewing cost growth performance with each provider organization.

As a result of the delays validating 2022-2023 data with payers, OHA has not yet been able to validate cost growth data with provider organizations and has not included provider organization level data in this report.

OHA opted to include all payer level data that has completed validation checks in this report, in the interest of transparency, and because payers have requested having payer level trend data available prior to their determining reasonableness conversations.

Next Steps

OHA hopes to resolve outstanding compliance issues with payer data validation and finalize data validation with provider organizations in June 2025.

After provider organizations have reviewed their data, OHA will conduct reasonableness conversations with payers and provider organizations who exceeded the cost growth target with statistical confidence.

OHA will publish provider organization cost data and payer and provider organization reasonableness determinations when the process is complete later this year.

Glossary

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

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

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

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

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

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

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

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

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

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

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

$$TME = Nonclaims + Claims$$

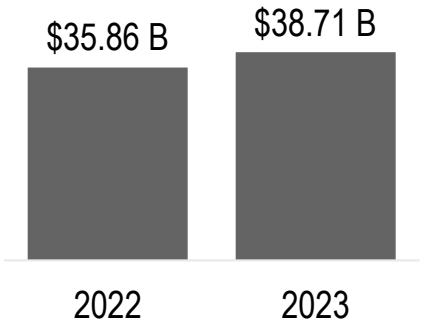
Total Health Care Expenditure (THCE): the sum of TME (the allowed amount of total claims spending plus total non-claims spending paid to providers), payers' NCPHI amounts, and other program spending for people in Oregon. This report uses THCE to measures statewide cost growth.

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

Chapter I. Health Care Cost Growth Trends Statewide, 2022-2023

Total Health Care Spending in Oregon

Statewide

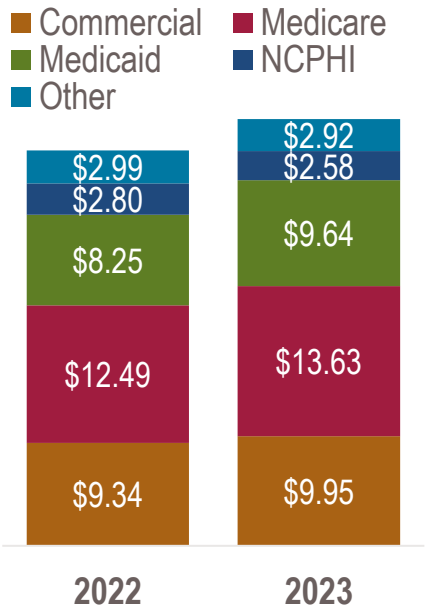


Statewide, total dollars spent on health care in Oregon increased 7.9% between 2022 and 2023, climbing from $35.86 billion in 2022 to $38.71 billion in 2023.

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 $13.63 billion in 2023 and represented 35.2% of health care spending in Oregon. Total Medicare spending grew 9.1% between 2022-2023.

Commercial health insurance is the second largest market in Oregon by total dollars spent. Commercial spending in 2023 was about $9.95 billion, representing 25.7% of health care spending in the state. Commercial spending grew 6.5% between 2022-2023.

By Market *in billions*



Medicaid provides health insurance for families and people with low incomes. Total Medicaid spending in Oregon was $9.64 billion in 2023, about 24.9% of health care spending in the state. Medicaid spending grew 16.9% between 2022-2023.

Net Cost of Private Health Insurance (NCPHI) represents the costs of administering a health insurance plan (including a payer's profits or losses). NCPHI totaled $2.58 billion, or 6.7% of statewide spending in 2023. Total dollars for NCPHI shrank 7.9% between 2022-2023.

Other includes health care spending in programs like the Department of Corrections, Veterans Affairs, behavioral health contracts paid by the State, and the Oregon State Hospital. Other spending totaled $2.92 billion in 2023, 7.5% of all health care spending. Other spending fell 2.4% between 2022-2023, mainly due to reductions in spending on Other Behavioral Health.

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

Total Health Care Expenditures

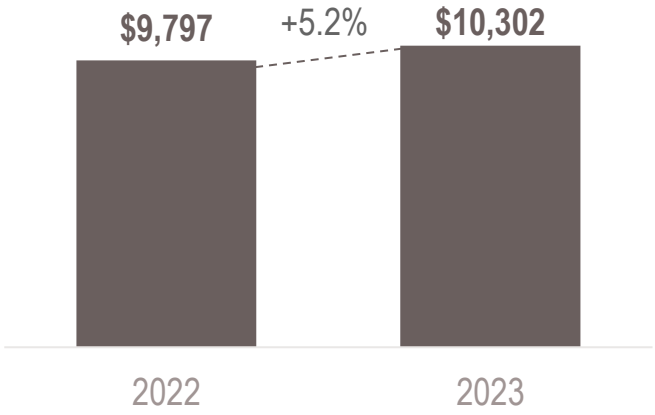
To compare health care cost growth to the cost growth target at the state and market level, Oregon tracks Total Health Care Expenditures (THCE). THCE includes all claims and non-claims-based spending, as well as the Net Cost of Private Health Insurance (NCPHI) and spending in other programs. THCE is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

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

Total Health Care Expenditures, Statewide

Between 2022 and 2023, THCE spending per person per year grew 5.2%, above the cost growth target of 3.4%. Per person per year spending increased to $10,302. Growth came primarily from increased spending on medical services by Medicare, Medicaid, and Commercial payers.

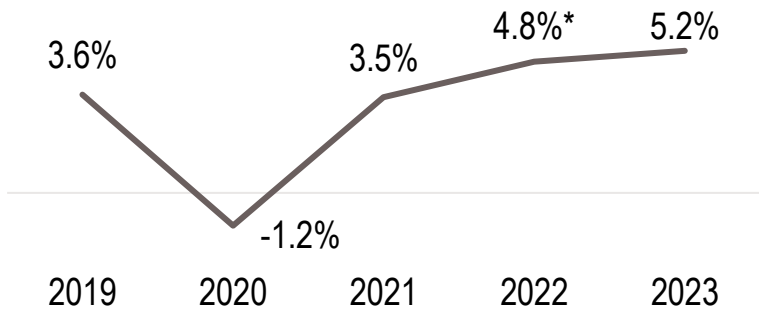
Total Health Care Expenditures, per person per year, statewide, 2022-2023



Growth in 2023 was higher relative to other recent periods, and higher than before the pandemic. Average annual growth from 2018 to 2023 was 3.2%. Cumulative growth cannot be calculated for 2023 relative to 2018 given methodological changes in the 2023 Medicaid data.

Growth in Total Health Care Expenditures, 2018-2023

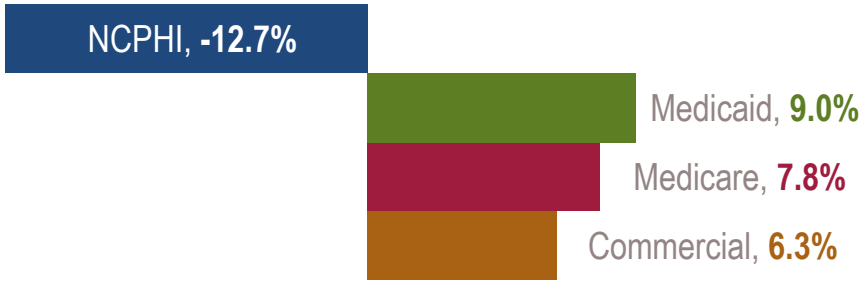
Years are year 2 of a 2-year period, e.g. “2023” represents 2022-2023



*2021-2022 growth updated to include additional NCPHI sources not available at the time of the publication of the Health Care Cost Trends report in 2024.

Total Health Care Expenditures Per Person Per Year, By Market

Percent change in THCE PPPY, by market, 2022-2023

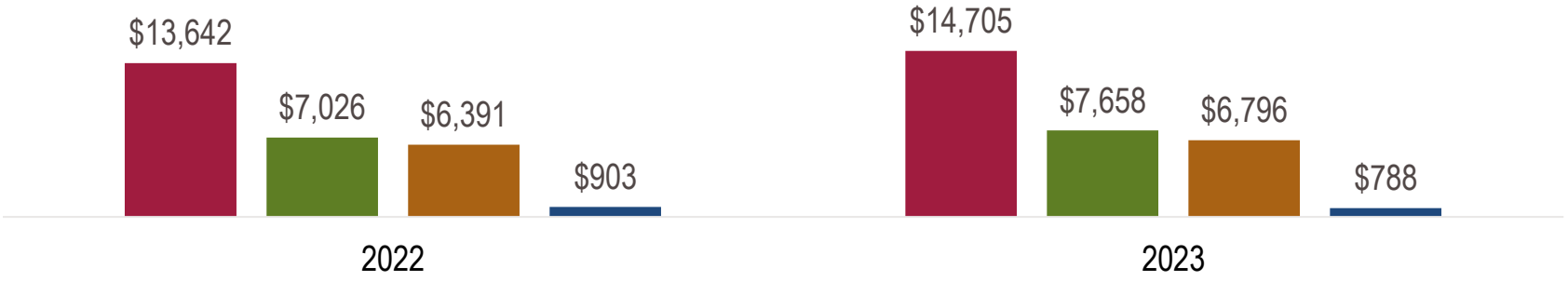


Total Health Care Expenditures per person per year (PPPY) grew well above the target across all markets in Oregon from 2022-2023.

Medicaid growth was the highest at 9.0%, followed by Medicare (7.8%) and Commercial (6.3%).

Spending by market also includes the Net Cost of Private Health Insurance (NCPHI). After increasing by 25.1% from 2021-2022*, NCPHI decreased by 12.7% from 2022-2023. Trends in NCPHI varied by market and are discussed in market-specific chapters. NCPHI only applies to portions of the Medicare and Medicaid markets, so is broken out separately here. NCPHI varies from year to year based on several factors, including how accurately payers are able to project the medical costs to be covered by premiums.

Total Health Care Expenditures vary considerably by market. In general, Medicare THCE on a per person per year basis is almost twice Commercial or Medicaid THCE. Since large changes in trend can occur for small dollar amounts (and vice versa), it is important to consider both dollars spent and percent change. The 7.8% increase in Medicare spending per year represented an absolute dollar increase of $1,063 in costs per person, while Medicaid costs grew $632 per person and Commercial costs grew $405 per person.

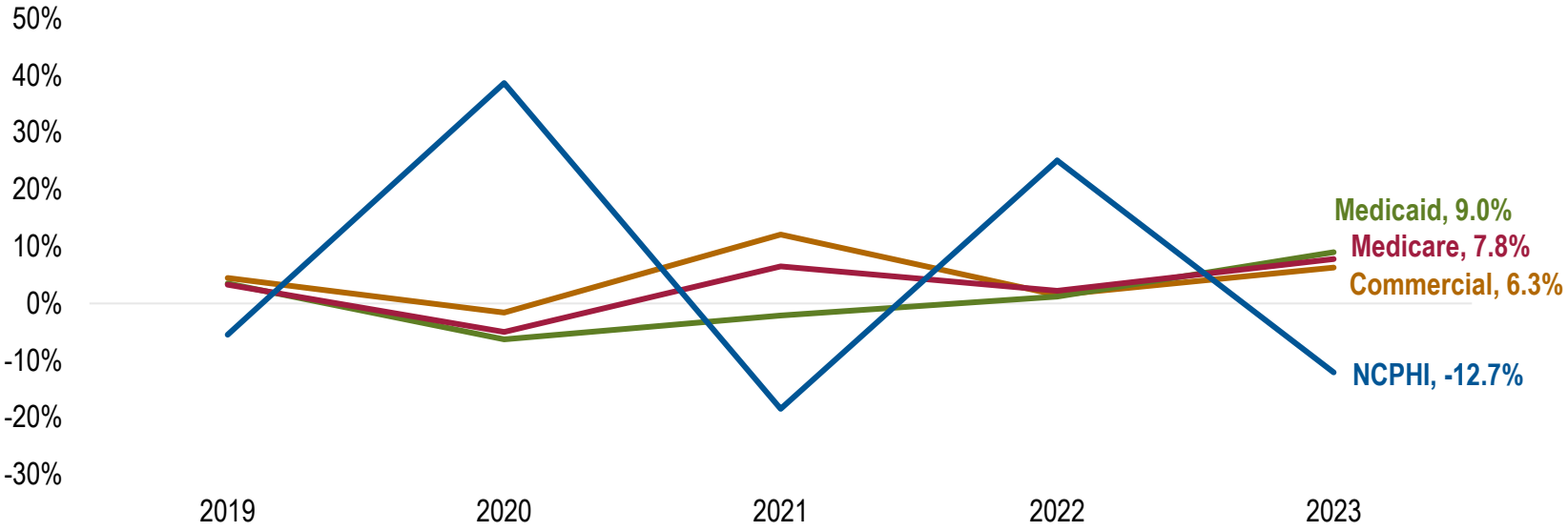


*2021-2022 NCPHI growth has been updated to include sources not available at the time of the publication of the Health Care Cost Trends report in 2024.

Total Health Care Expenditures, By Market, Over Time

Annual percent change in THCE, by market, 2018-2023

Years on x-axis represent year 2 of a 2-year growth period, e.g. “2023” for 2022-2023.



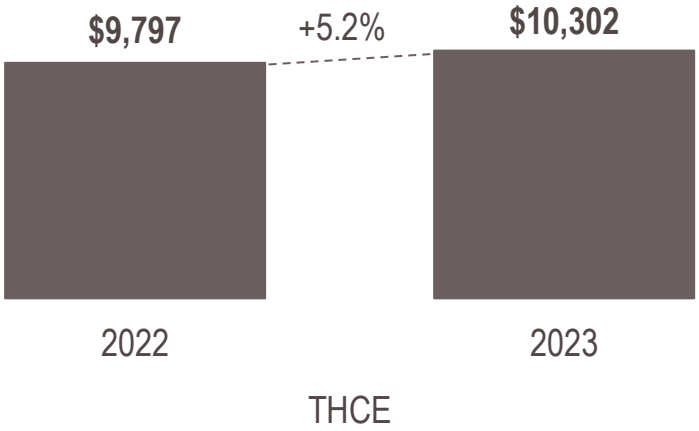
Growth in THCE per person per year fluctuated widely over the course of the COVID-19 pandemic, with negative cost growth in all three markets in the 2019-2020 period. In the **Commercial** and **Medicare** markets, cost growth rebounded from 2020-2021 then moderated from 2021-2022 before speeding up again in the 2022-2023 period. In the **Medicaid** market, cost growth was negative from 2019-2021, due primarily to increasing enrollment by lower-cost individuals as access was expanded during the pandemic. Cost growth began to rise from 2021-2022 and increased even more in the 2022-2023 period, due to a combination of stabilization in Medicaid enrollment and implementation of state policies that increased behavioral health spending and hospital reimbursement. **NCPHI** increased in years when claims spending was lower in relation to premiums collected and decreased in years with higher claims spending.

Across all years for which Cost Growth Target data have been collected (2018-2023), cumulative percent growth was highest in the Commercial market. Commercial THCE per person grew cumulatively 23.2% from 2018-2023, from $5,517 to $6,796 per person. Absolute dollar growth in spending was highest in the Medicare market, where spending was $1,579 (17.0%) higher in 2023 than in 2018, going from $12,565 to $14,705. Cumulative cost growth for Medicaid from 2018-2023 should not be calculated due to methodological changes in 2023 data.

Total Medical Expenses

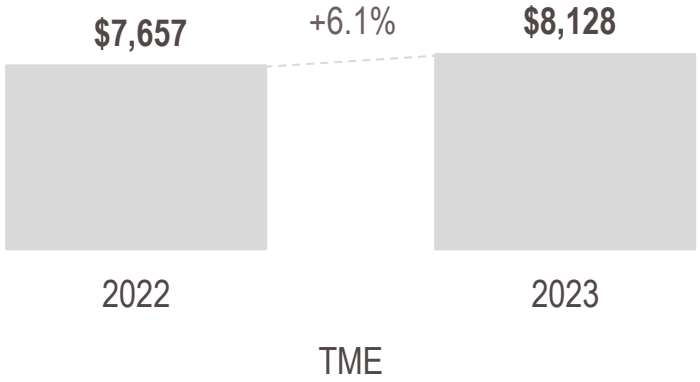
When reporting on health care cost growth relative to the target for payers, provider organizations, and by service categories, Oregon uses a measure called Total Medical Expenses (TME). TME is a subset of Total Health Care Expenditures and includes claims and non-claims payments only. It does not include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

THCE spending grew 5.2% between 2022-2023



THCE

TME spending (unadjusted) grew 6.1% between 2022-2023



TME

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

The TME spending reported above includes Medicare Fee-For-Service (FFS). OHA does not have Medicare FFS spending data that can be attributed to provider organizations. TME spending without Medicare FFS is used to track payer and provider cost growth and detailed service category breakouts.

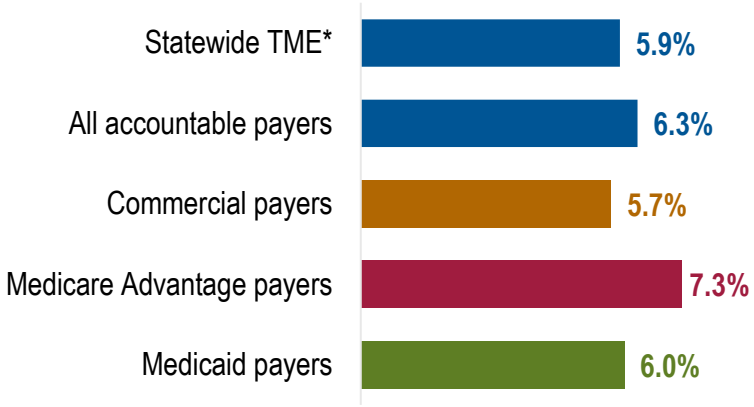
Calculated without Medicare FFS, TME spending statewide, demographically adjusted, grew 5.9% between 2022-2023, to $7,208 per person per year.

Total Medical Expenses – Payer Cost Growth

On average, 2022-2023 cost growth in demographically adjusted TME was 5.9% at the statewide level and 6.3% across payers. Average cost growth was highest among Medicare Advantage payers (7.3%), followed by Medicaid (6.0%) and Commercial payers (5.7%).

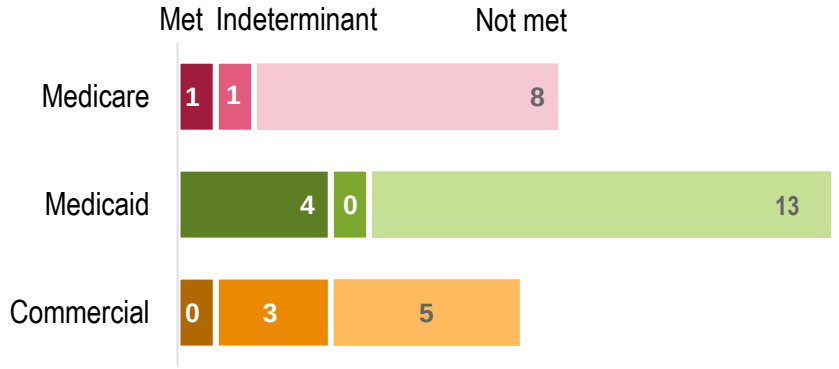
For this measurement period, five payers met the cost growth target in one of their accountable markets. In the Medicaid market, four Coordinated Care Organizations (CCOs) met the target. One Medicare Advantage payer met the cost growth target, and no Commercial payers met it.

Average TME Spending Growth, 2022-2023, Statewide and for payers by market

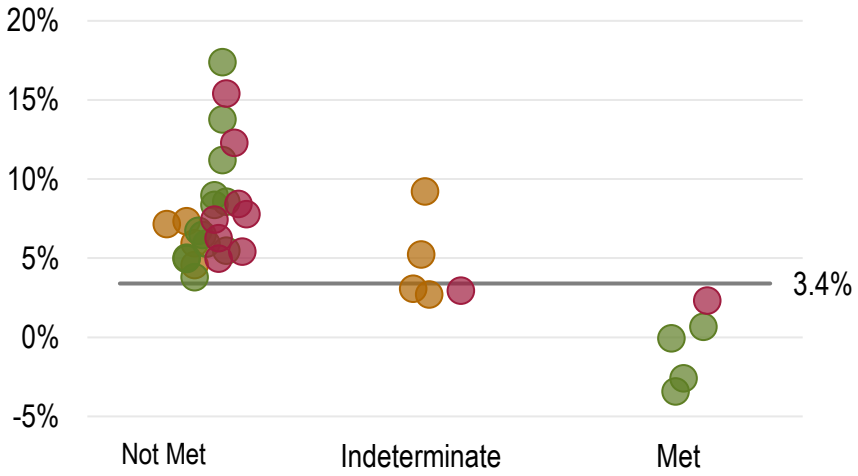


* Statewide TME excluding Medicare FFS, with a demographic adjustment. All accountable payer TME growth is demographic adjusted.

Number of payers who met the cost growth target, had indeterminant growth, and didn't meet the target, 2022-2023



Payer performance relative to the cost growth target for **Commercial**, **Medicare Advantage**, and **Medicaid** markets, 2022-2023



Total Medical Expenses – Total Spending by Service Category, Statewide

Professional and Hospital Outpatient service categories were top drivers of statewide health care spending growth between 2022-2023.

Spending on Professional services comprised 29.7% of overall TME in 2023, and this service category grew by $842.8 million (10.6%) from 2022 to 2023.

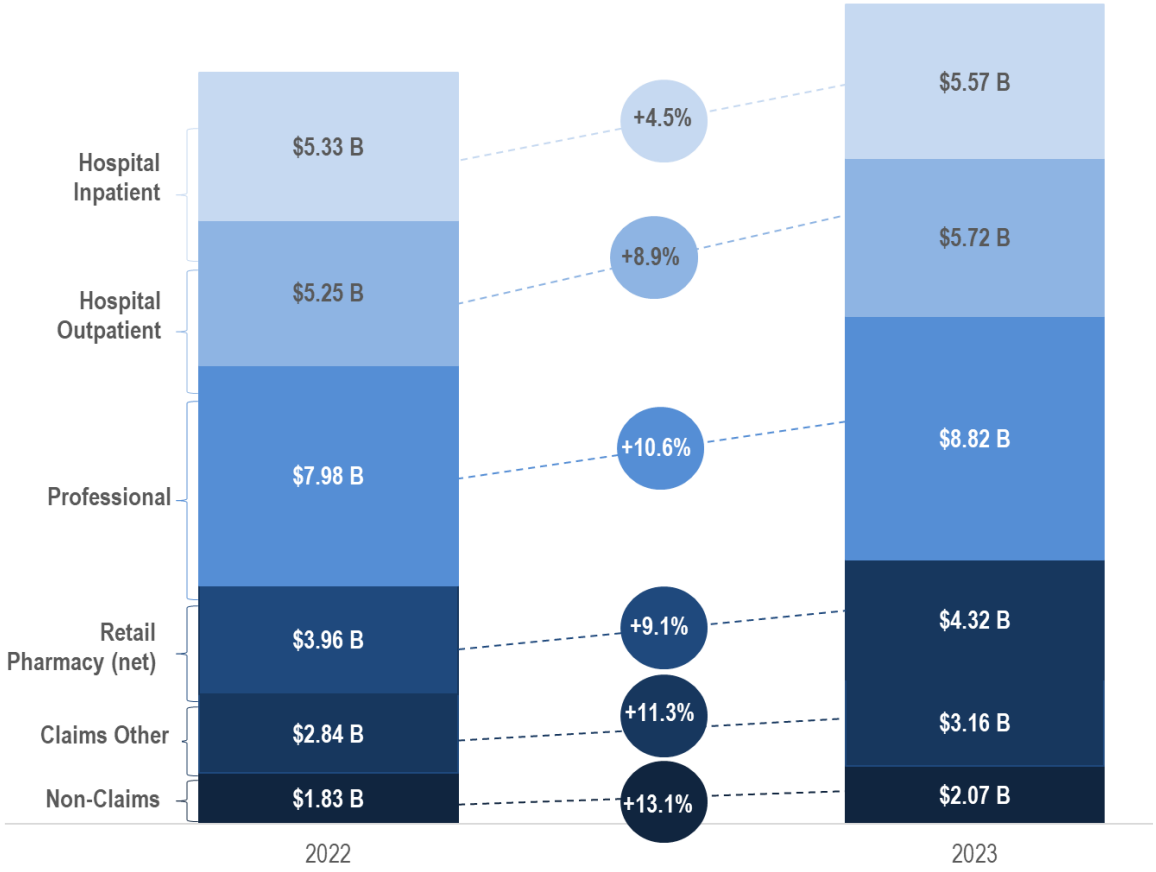
Claims for Hospital Outpatient services comprised 19.3% of overall spending in 2023 and grew by $466.0 million (8.9%).

Growth in retail pharmacy spending (net of pharmacy rebates) was also significant between 2022-2023. Retail pharmacy grew 9.1%, an increase of $360.5 million.

This is the first year the Cost Growth Target program collected data on medical pharmacy costs, or the cost of drugs administered in a physician's office. Statewide, medical pharmacy accounted for at least $237.0 million of the overall increase across service categories (data not shown).

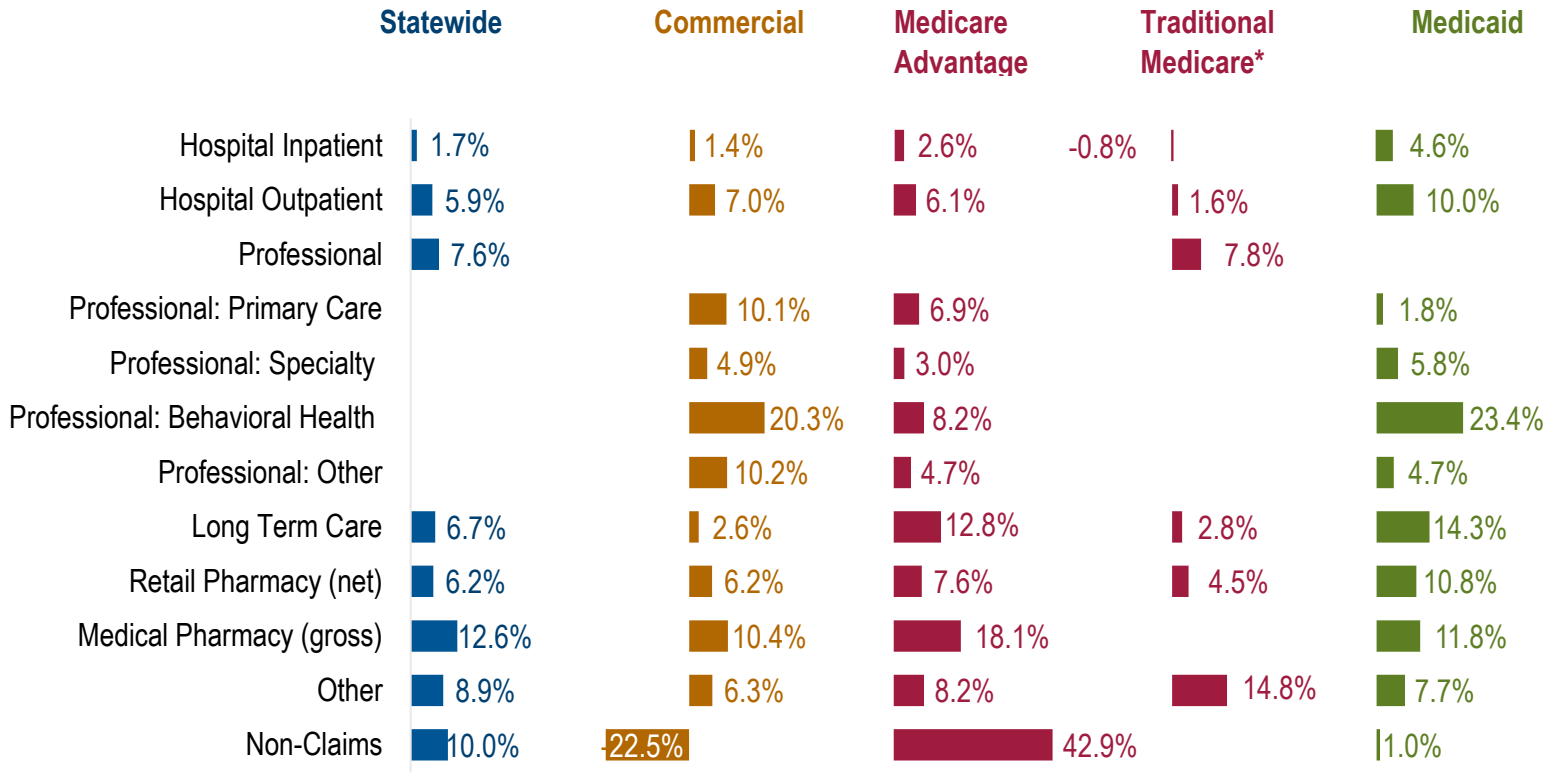
Total Medical Expenses – total claims spending, in billions, and growth rate, statewide, 2022-2023

Spending is reported net of pharmacy rebates



Total Medical Expenses – Percent Change in Per Person Per Year Spending by Service Category, Statewide and Across Markets

Statewide, on a per person, per year basis, the service categories with the most growth were Medical Pharmacy (12.6%) and Non-Claims (10.0%). **Service category growth differed widely by market**. Non-Claims spending grew almost 43% in the Medicare Advantage market, but only 1.0% in Medicaid and had negative growth in the Commercial market. Spending on Hospital Outpatient services grew more in Medicaid (10.0%) than Commercial (7.0%) or Medicare Advantage (6.1%). See Appendix for more detail on what is included in Non-Claims spending. Spending on Behavioral Health Professional Services increased more than 20% in the Commercial and Medicaid markets and was 8.2% in the Medicare Advantage market.



*Traditional Medicare data is submitted to OHA by the Centers for Medicare and Medicaid Services (CMS) with different service category breakouts that are not completely comparable to other Cost Growth Target data submissions.

Total Medical Expenses – Absolute Dollar Change in Per Person Per Year Spending by Service Category, Statewide and Across Markets

On a per person per year (PPPY) basis**, the biggest contributor to absolute change in statewide health care spending between 2022-2023 came from the Professional service category, which saw an increase of $170.33 per person**. The increase across Professional service subcategories was more evenly distributed in the Commercial market, while for Medicare Advantage it was concentrated in Primary Care and Specialty services and most of the increase in Medicaid was for Behavioral Health. **Increases in pharmaceutical spending were also a big contributor**, as the total increase in spending on Retail Pharmacy and drugs administered in the doctor's office (Medical Pharmacy) was $119.76 combined, or about 25.5% of the total $470.47 PPPY increase.

	Statewide	Commercial	Medicare Advantage	Traditional Medicare	Medicaid
Hospital Inpatient	$25.57	$15.68	$94.92	$37.93	$39.33
Hospital Outpatient	$87.79	$110.60	$137.91	$74.62	$72.88
Professional	$170.33	$216.02	$129.64	$185.41	$136.87
Professional: Primary Care		$60.33	$53.63		$4.66
Professional: Specialty		$49.29	$56.36		$21.87
Professional: Behavioral Health		$51.49	$2.81		$96.97
Professional: Other		$54.90	$16.84		$13.36
Long Term Care	$14.05	$0.86	$68.41	$20.27	$12.07
Retail Pharmacy (net)	$68.72	$57.96	$117.77	$145.04	$41.68
Medical Pharmacy (gross)	$51.04	$49.42	$207.02		$23.51
Other	$75.71	$18.20	$55.03	$307.00	$22.40
Non-Claims	-$5.77	-$14.35	$270.48		$10.81

Statewide Cost Drivers – Price vs. Utilization, 2018-2023

To supplement analysis of the cost growth target data collected from payers for the 2022-2023 measurement period, OHA analyzed data on price and utilization from the state's All Payer All Claims (APAC) database. This analysis helps identify whether health care spending increase are driven by the unit price of a service or by the number of services being provided.

Cost growth trends over the last few years were greatly impacted by fluctuations in utilization due to the COVID-19 pandemic. Analysis of APAC data confirms that utilization of health care services dropped steeply in Oregon from 2019-2020, across insurance markets, and in most service categories except for Retail Pharmacy.

By the beginning of the current measurement period, utilization per person had exceeded or was close to pre-pandemic levels in the Commercial market in all service categories except Hospital Inpatient.

In the Medicaid and Medicare markets, utilization per person had recovered to pre-pandemic levels for Hospital Outpatient services but remained somewhat lower than pre-pandemic levels for Professional services.

Between 2018-2023, the cost per unit (price) of health care services increased almost continually across service categories in all markets. Price was the major driver of health care spending across markets and service categories in Oregon during this period.

See price and utilization graphs by service category on the next page.

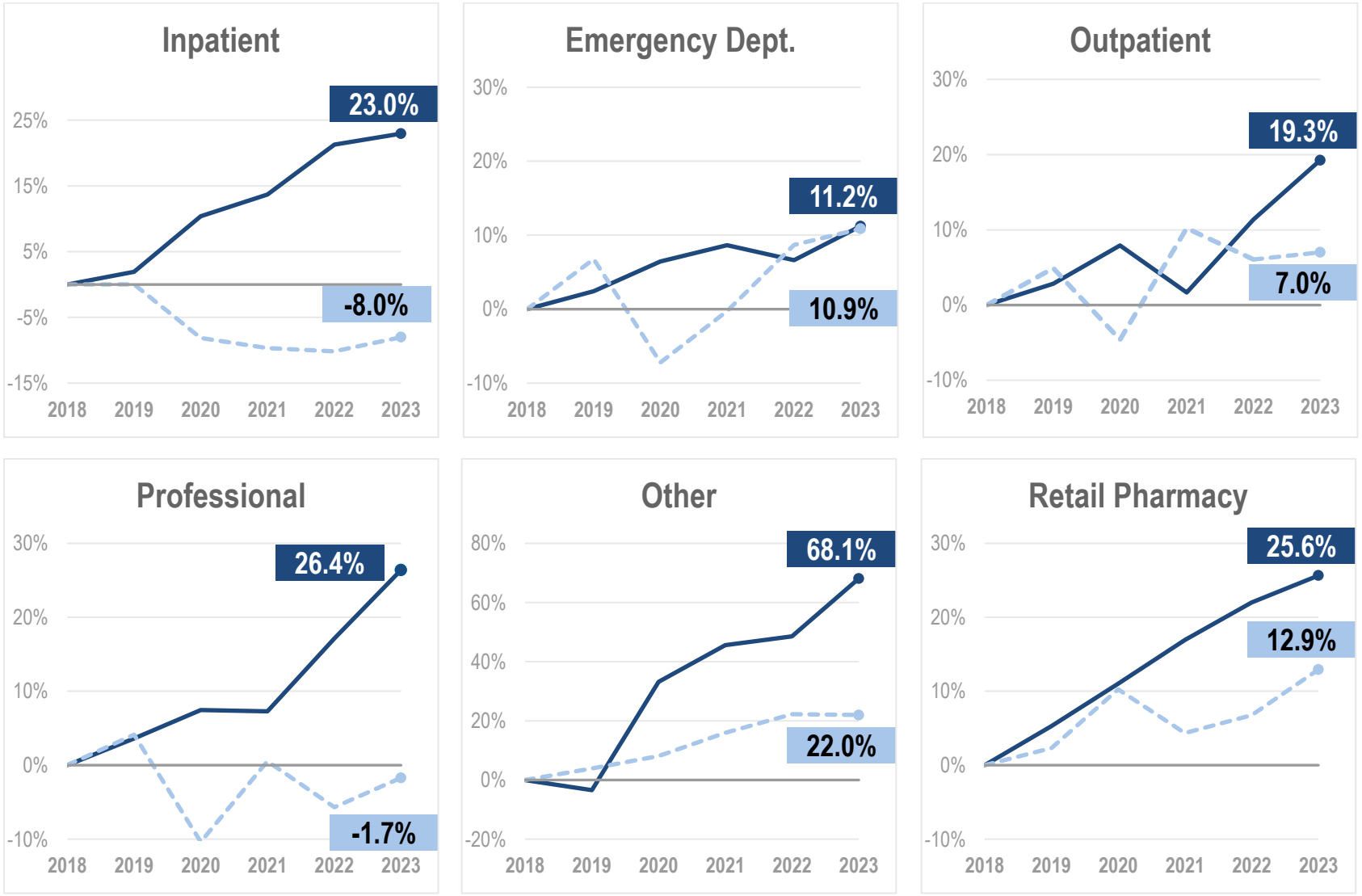
For this report, **price** is measured as the cost per discharge for Hospital Inpatient services, the cost per 30-day prescription for Retail Pharmacy (gross of rebates), and the cost per claim for all other services categories.

Utilization is measured as the number of discharges for Hospital Inpatient services, the number of 30-day prescriptions for Retail Pharmacy, and the number of claims for all other service categories.

This report also looks at utilization as the number of units per 1,000 people to control for shifts in the size of enrolled populations.

Statewide price and utilization growth (cumulative), by service category, 2018-2023

APAC claims analysis. Overall price in darker color (solid line), utilization in lighter color (dotted line).



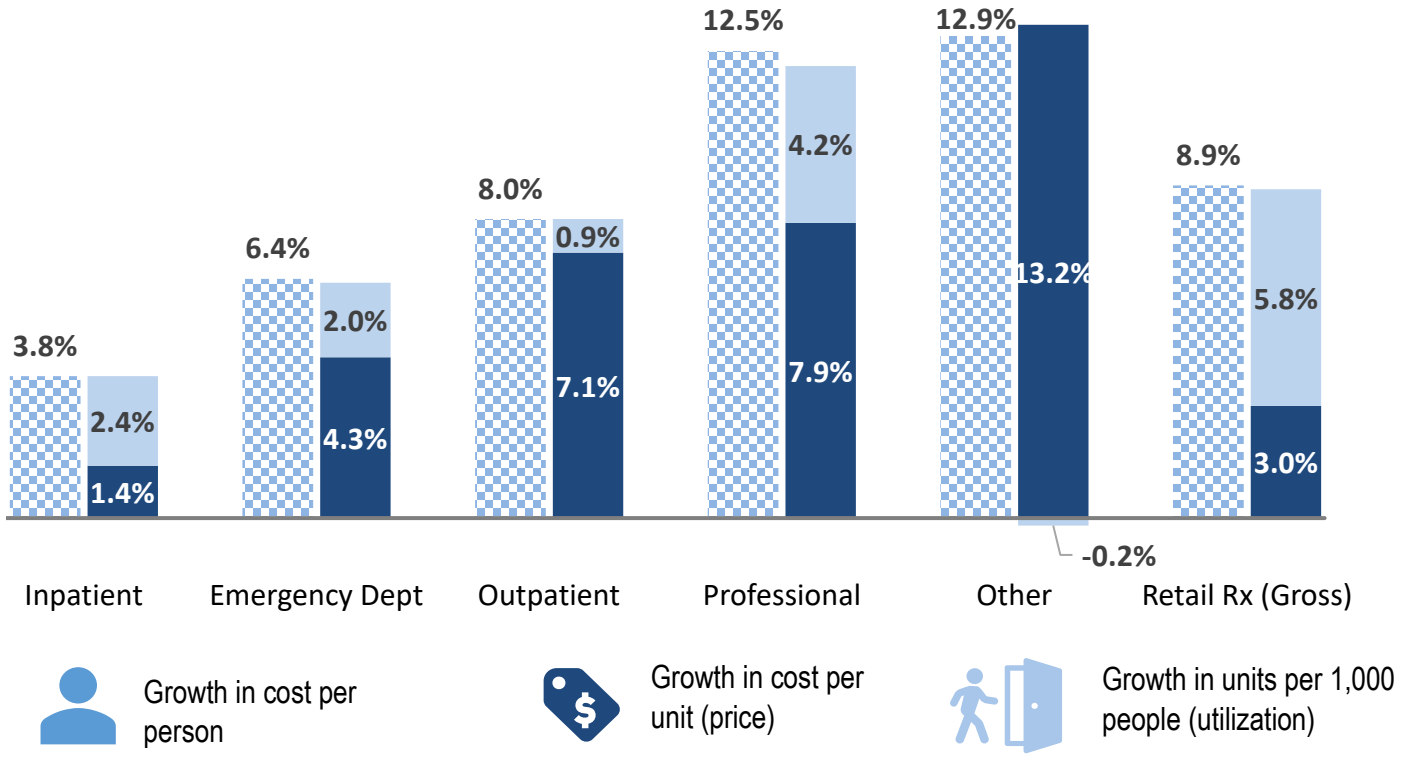
Statewide Cost Growth Drivers – Price vs. Utilization, 2022-2023

Between 2022-2023, the primary driver of cost growth statewide was cost per unit (price), which increased by 7.9% in the Professional Services category and 7.1% in the Hospital Outpatient category, the service categories with the most cost growth during the period.

Utilization also contributed to Professional Services cost growth, though the 4.2% increase in the number of Professional claims per person was lower than the 7.9% price increase. In the Retail Pharmacy category, growth was driven by a combination of price and utilization.

Statewide per person cost growth, by service category, by price and utilization, 2022-2023

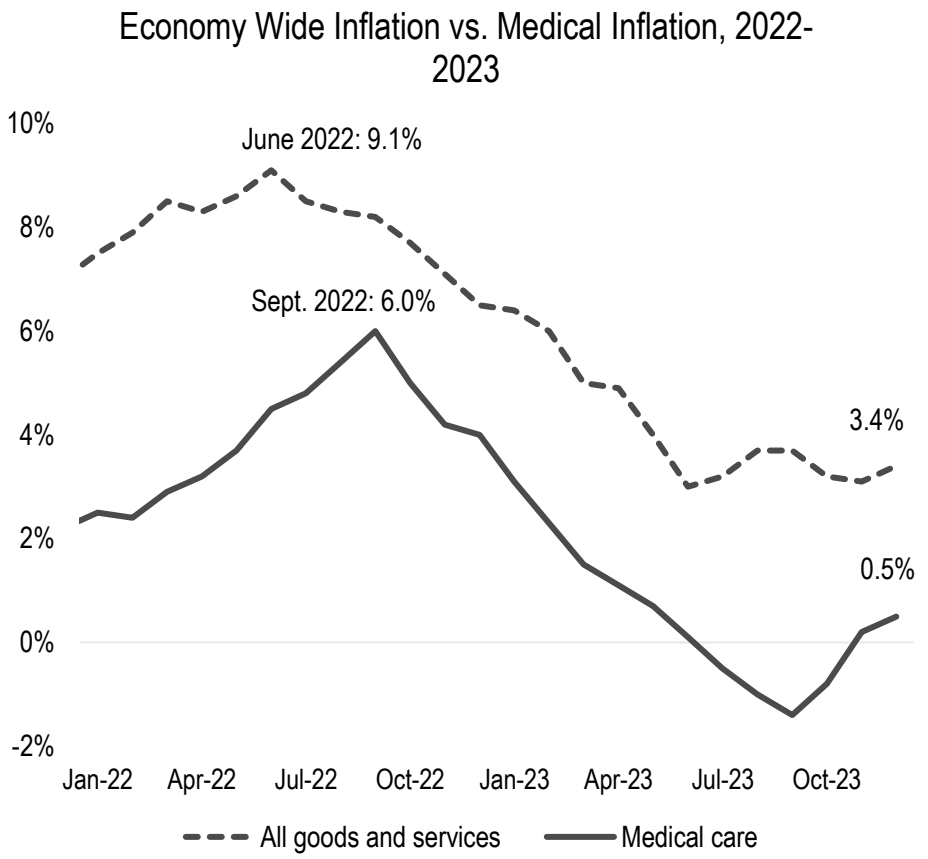
APAC claims analysis. Overall spending growth shown in checks, price in darker color, utilization in lighter.



Price has been the primary contributor to cost growth in the Commercial market in Oregon for many years.[1] During the 2022-2023 measurement period, price growth was also high in Medicare and Medicaid, with some variation across service categories.

In the Medicaid market, price growth was primarily the result of policies implemented by the state in 2022 and 2023 to boost spending on behavioral health and support hospitals dealing with upward cost pressures coming out of the COVID-19 pandemic.[2] See Chapter IV for more information.

Prices were higher coming out of the pandemic than during previous periods. At the national level, health care prices as measured by the National Health Care Expenditure deflator grew 3.1% in 2022 and 3.0% in 2022, compared to a yearly average of 2.5% from 2020-2022 and 1.4% from 2016-2019.[3] Medical inflation peaked at 6.0% in September of 2022.[4]



[1] OHA (November 2022). Health Care Cost Trends: Price and Utilization, State and Market Level Data in Oregon, 2013-2019.
[2] Mercer (October 2022). Rate Year 2023 Coordinated Care Organization Program Capitation Rate Development and Certification, State of Oregon.
[3] Martin et al. (December 2024). National Health Expenditures in 2023: Faster Growth as Insurance Coverage and Utilization Increased. Health Affairs 44(1)
[4] Rakshit et al. (August 2024). How does medical inflation compare to inflation in the rest of the economy? Peterson-KFF Health System Tracker.

Chapter II. Health Care Cost Growth Trends in the Commercial Market, 2022-2023

Introduction: Commercial Cost Growth

In 2023, more than half of Oregonians (~52%) had commercial health insurance.[5] Most people with commercial health insurance purchase it through their employer (group), but some buy individual plans, such as those available on the Oregon Health Insurance Marketplace.

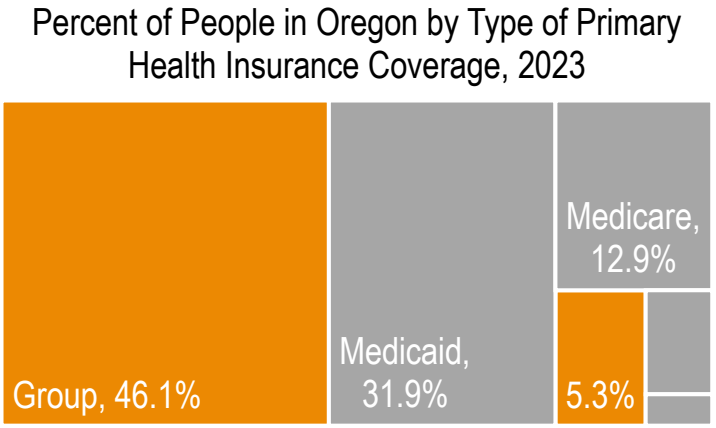
Increasing costs in the Commercial market have led to affordability challenges for Oregonians. As costs go up, so do premiums. From 2018-2023, average employer-paid premiums increased 20.1% for employer-sponsored family plans and 23.6% for individual plans, putting a strain on both employers and employees and limiting wage growth.[6]

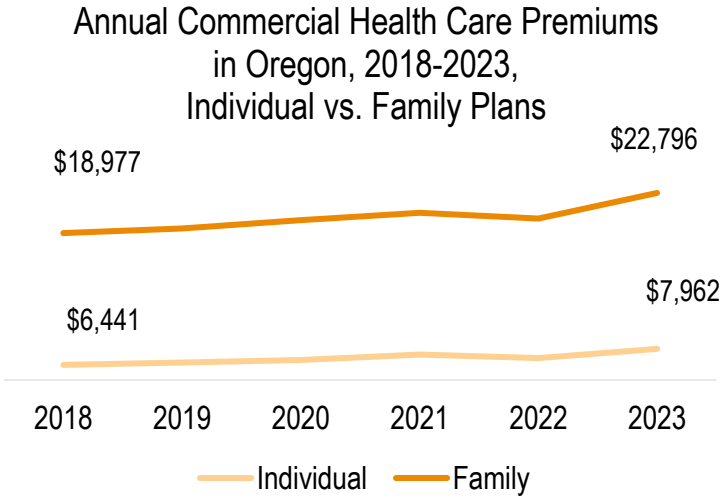
From 2018-2022, average Commercial patient cost sharing increased by 9.8%, with co-insurance rising by 28.1% and the amount paid in deductibles increasing by 12.3%.[7]

This chapter delves more deeply into these trends in the Commercial market in 2023, reviewing cost growth within different service categories and supplementing these data with an analysis of the role of price and utilization in driving cost growth.

Topline findings for the 2022-2023 measurement period include:

- In 2023, the annual growth in statewide Commercial Total Medical Expenditures (TME) (net of pharmacy rebates,





[5] OHIS data: https://www.oregon.gov/oha/HPA/ANALYTICS/pages/ohis-coverage.aspx
[6] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. "Medical Expenditure Panel Survey (MEPS) Insurance Component (IC): Private Sector - State." 2023.
[7] Data from OHA's Patient Cost Sharing: 2015-2022 dashboard.

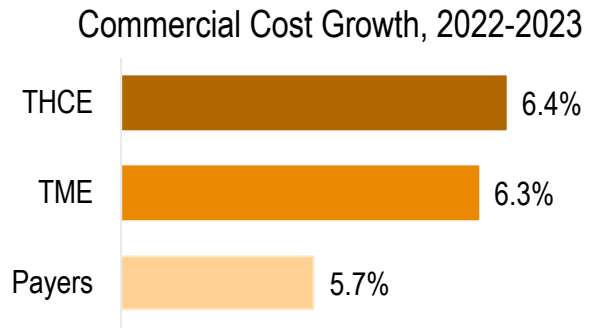
unadjusted) was 6.3%. Due to the COVID-19 pandemic, cost growth has fluctuated widely over the first five measurement periods of Cost Growth Data. However, on average, annual growth in TME per person per year from 2018 to 2023 was 4.6%, over the target of 3.4%

- At the statewide level, Commercial cost growth was highest in the Professional service category, with particularly high growth (20.3%) in per person per year spending on behavioral health services. Hospital Outpatient costs were the next most influential category, growing by $111 (7%) per person per year, and were driven by the increased cost of hospital facility claims.

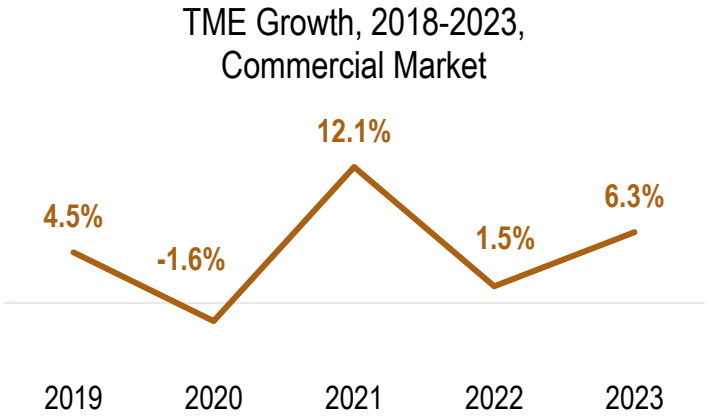
- Price vs Utilization: Commercial market spending growth was driven more by price than utilization for Hospital Outpatient and Retail Pharmacy costs, while utilization was more important for Hospital Inpatient and Emergency Department costs. Growth in Professional Services was driven by both price and utilization.

- The Net Cost of Private Health Insurance (NCPHI) grew slightly more rapidly than TME from 2022-2023 (+7.0%), and the percent of premiums collected by payers that were used to cover medical claims decreased modestly on average.

- Of the eight Commercial payers included in Cost Growth Target reporting for 2022-2023, none met the cost growth target, and five exceeded the target.



THCE and TME growth is growth in PPPY spending across Full and Partial Claims, net of pharmacy rebates, unadjusted for demographics. Payer cost growth is growth in PMPM, net of rebates for Full Claims, adjusted for sex/age demographics.



TME growth is growth in PPPY spending across Full and Partial Claims, net of pharmacy rebates, unadjusted for demographics.

Commercial Cost Growth - Service Categories, 2022-2023

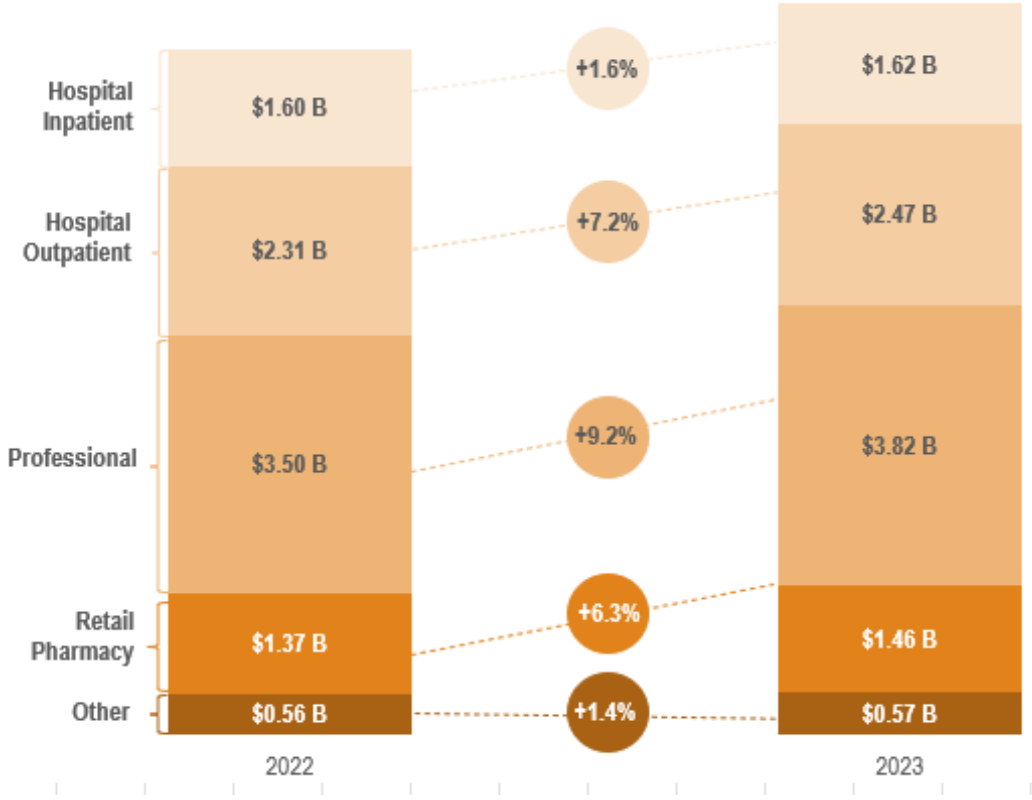
Between 2022-2023, Total Medical Expenses (TME) for people in Oregon with Commercial health insurance grew by $606.7 million, or 6.5%.

During the measurement period, Commercial health plan enrollment (member months) remained essentially flat, growing only 0.2%. This suggests that increases in total spending were not due to growth in Commercial insurance enrollment, but to increased price and utilization of services. The Commercial population demographics also remained similar, with only 0.3% growth in age/sex demographic scores.

Spending increased across all service categories from 2022-2023. The categories with the highest growth in spending in the Commercial market were Professional Services (+9.2%, or $321.4 million), Hospital Outpatient (+7.2%, or $165.3 million) and Retail Pharmacy (+6.3%, or $86.9 million).

Total Medical Expenses – total spending, in billions, and growth rate, Commercial Market, 2022-2023

Spending is reported net of pharmacy rebates. Other includes non-claims spending.



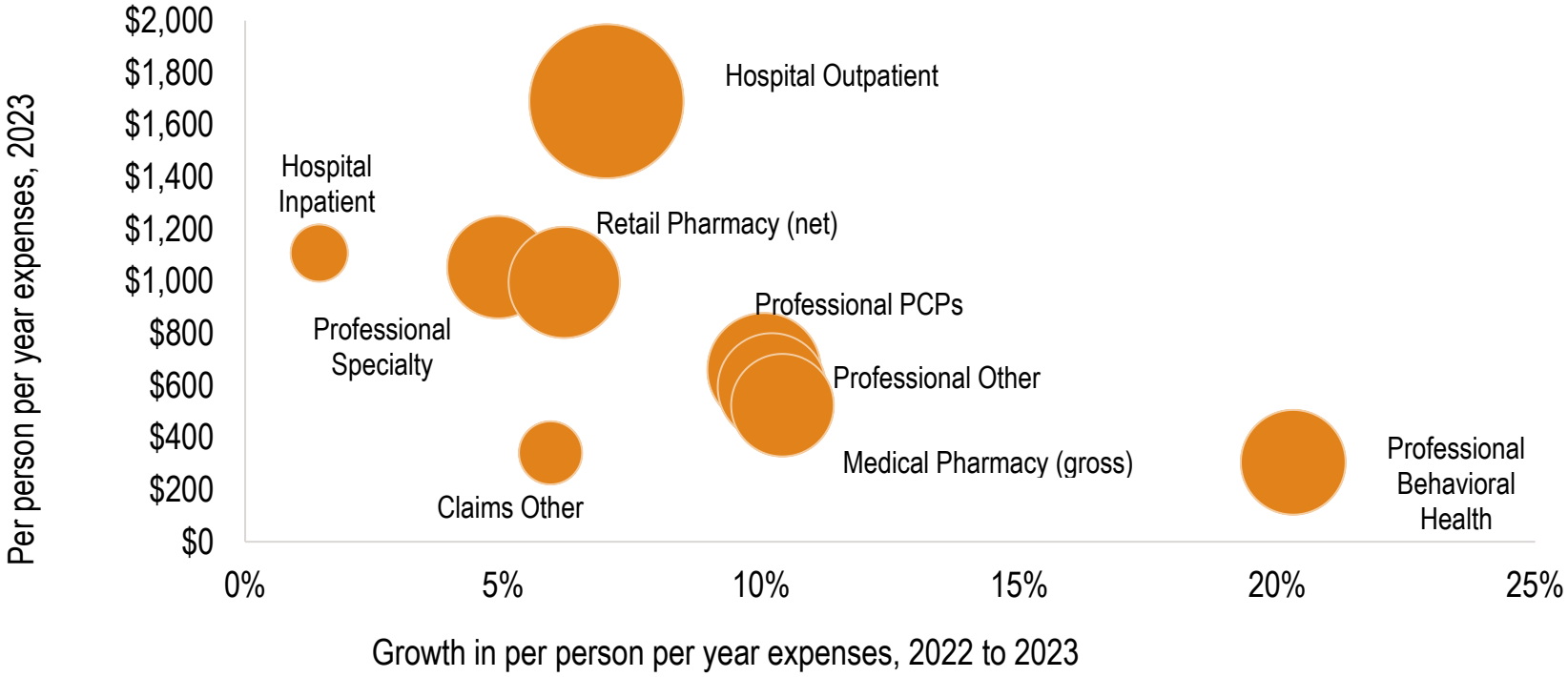
Growth in TME Per Person Per Year by Service Category, Commercial Market

The same service categories that drove growth in total Commercial spending from 2022-2023 also drove per person per year (PPPY) spending: Professional Services, Hospital Outpatient, and Retail Pharmacy.

This bubble chart breaks the Professional Services category into four subcategories, but overall, this category grew the most, 9.0%, or $216 per person per year. Professional Behavioral Health spending PPPY grew 20.3% ($51) and was an outsized contributor to the high growth in the Professional Services category during the period. Spending on Hospital Outpatient services grew $111 PPPY, or 7.1%. Retail pharmacy (net of pharmacy rebates) was the next biggest contributor to spending growth, increasing $58 PPPY (6.2%).

Total Medical Expenses – Growth in per person per year spending by service category, Commercial market, 2022-2023

Spending is reported net of retail pharmacy rebates. Bubble size represents absolute dollar change in per person per year spending. PPPY spending on non-claims was much lower than other categories and is not included in this figure.



Commercial Cost Growth Drivers – Price vs. Utilization, 2022-2023

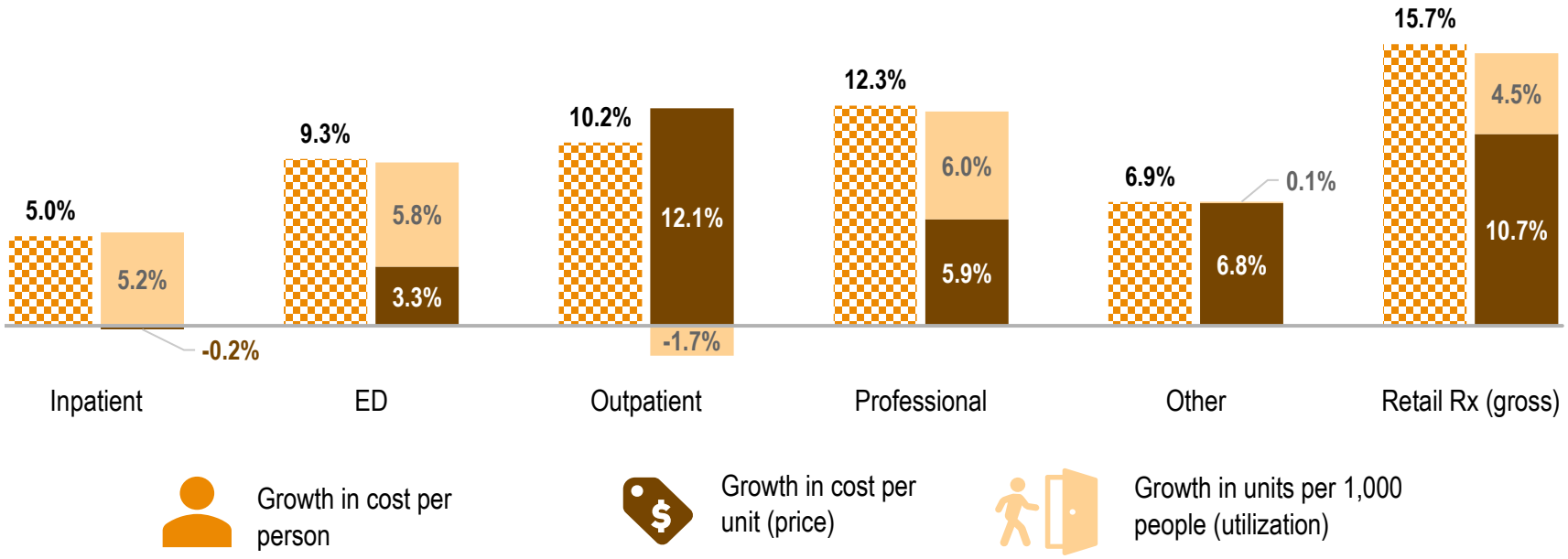
Between 2022-2023, the primary drivers of cost growth in the Commercial market varied by service category.

In the Professional Services category, the 12.3% increase in per-person spending was the result of a 6.0% increase in the cost per claim (price) and a 5.9% increase in the number of claims per 1,000 people (utilization). The relative growth in price or utilization differed depending on the type of professional service; for example, a large increase in spending on surgical procedures was due to a 23.3% increase in utilization, while growth in spending on radiology and chemotherapy services was due to an 18% price increase.

In the Hospital Outpatient category, spending growth was driven entirely by a 12.1% increase in the average cost per claim, while the number of claims decreased by 1.7%. However, Emergency Department spending growth was driven more by a 5.8% increase in utilization.

Commercial per person cost growth, by service category, by price and utilization, 2022-2023

APAC claims analysis. Overall spending growth shown in checks, price in darker color, utilization in lighter.



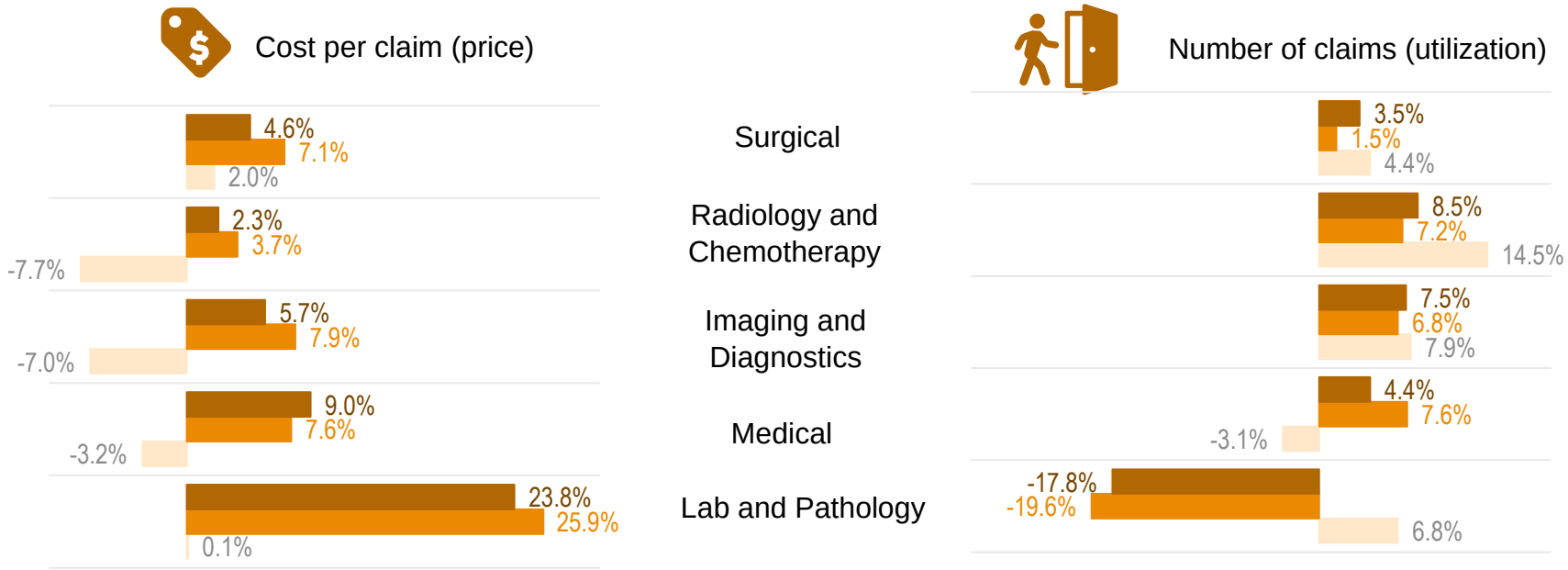
Commercial Spotlight: Hospital Outpatient Price Growth

Price has been a major driver of spending in the Commercial market in Oregon since at least 2013. Between 2022-2023, the average cost per claim (price) for Hospital Outpatient services grew by 12.1% across all types of services, while the number of claims per person (utilization) decreased 1.7%.

Hospital Outpatient services are typically billed through two different types of claims: **Professional** claims cover the cost of the doctors, nurses and other medical professionals contributing their expertise to care. **Facility** claims cover the cost of support services, materials, and hospital overhead. Between 2022-2023, price increases across Hospital Outpatient services were primarily driven by the increasing cost of facility claims, while the average cost per professional claim decreased. Utilization increases were driven by increases in the number of both professional and facility claims, though the number of professional claims per person grew faster for most types of outpatient services.

Growth in Price vs. Utilization of Hospital Outpatient Claims by Subcategory, 2022-2023

All Claims, **Facility Claims**, and **Professional Claims**



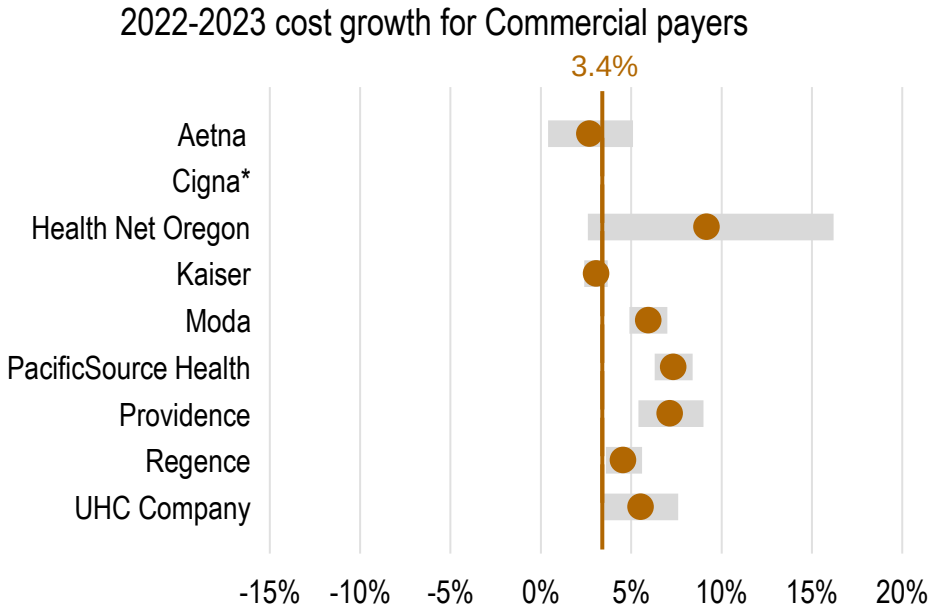
Other and Surgical Anesthesiology sub-categories are excluded, as there is no facility vs. professional breakdown for these types of claims.

Commercial Cost Growth – By Payer, 2022-2023

Of the eight Commercial payers included in Cost Growth Target reporting for 2022-2023, none met the cost growth target, and five exceeded the target. Cost growth ranged from 2.7% to 9.2%.

Three payers had indeterminant cost growth, meaning the bounds of their 95% confidence intervals included the cost growth target of 3.4%.

Since OHA only uses full claims to calculate cost growth in the Commercial market, some Commercial payers do not have all their members or spending captured. Members with partial claims have Commercial insurance plans that "carve out" certain services like retail pharmacy. Since costs for these carve-outs must be estimated, they are not included in payer cost growth as measured against the target.



Commercial Payer	Partial claims, as a percentage of member months	
	2022	2023
Aetna	60.0%	58.2%
Moda	18.5%	24.0%
Regence	33.7%	35.5%
UHC Company	1.9%	4.4%

**Cigna's data has been excluded from this report due to ongoing data validation concerns which OHA is continuing to work with Cigna to resolve.*

Commercial Payer	Target Performance	2022-2023 Cost Growth
Aetna	Indeterminant	2.7%
Cigna*	--	--
Health Net Oregon	Indeterminant	9.2%
Kaiser	Indeterminant	3.1%
Moda	Not met	5.9%
PacificSource Health	Not met	7.3%
Providence	Not met	7.1%
Regence	Not met	4.6%
UHC Company	Not met	5.5%

Commercial Cost Growth Drivers – by Payer and by Service Category, 2022-2023

During the 2022-2023 cost growth period, the most consistent service category contributing to Commercial payer per member per month growth was Hospital Outpatient, which grew at rates above 5% for all payers except one, and also saw higher absolute dollar growth. However, some Hospital Outpatient growth was offset by reduced Hospital Inpatient costs for some payers. Medical Pharmacy cost trends were high across most payers.

During the measurement period, several Commercial payers saw increased primary care and behavioral health services spending for their populations. Increased spending on Professional Primary Care Provider services was a significant contributor to growth for Aetna and Kaiser. Growth in Professional Behavioral Health spending was above 18% for Moda, Regence, PacificSource, Kaiser, and Providence, though the influence of absolute dollar growth from this spending on overall PMPM change was variable, as indicated by the lighter coloration in some of the heat map cells below.

Heat map showing which service categories had the most influence on total growth in per member per month spending for each Commercial payer, 2022-2023

*The percentages in the table below reflect the percent increase in per member per month spending (unadjusted) by service category, while the cells are colored based on the total absolute dollar PMPM change. The **darker** the cell color, the higher the absolute dollar change. Categories with darker cells had more influence on the payer's overall spending growth. Columns in **grey** are payers whose Commercial cost growth was indeterminant. Payers with orange columns exceeded the target with statistical confidence.*

	Aetna	Health Net Oregon	Kaiser	Moda	PacificSource Health	Providence	Regence	UHC Company
Inpatient	6.1%	58.4%	-5.3%	4.6%	-4.2%	7.2%	-6.7%	3.0%
Outpatient	5.1%	10.3%	2.3%	5.4%	10.2%	6.1%	9.0%	7.5%
Professional PCP	7.2%	8.1%	15.0%	6.8%	6.4%	9.6%	7.8%	9.2%
Professional Specialty	3.7%	-3.5%	7.0%	2.4%	6.8%	2.5%	5.5%	2.1%
Professional BH	8.4%	-43.7%	20.0%	27.8%	20.1%	18.1%	26.7%	-
Professional Other	17.5%	-14.5%	3.5%	15.7%	12.0%	14.6%	18.3%	24.2%
Long Term Care	-52.1%	-64.6%	-5.4%	-22.9%	2.4%	-2.5%	16.4%	9.9%
Medical Pharmacy	-4.5%	-11.2%	19.6%	6.0%	11.7%	7.4%	7.1%	33.3%
Retail Pharmacy (net)	1.0%	-17.7%	1.0%	1.3%	12.0%	9.8%	4.0%	6.2%
Claims Other	-5.0%	11.9%	-1.2%	5.6%	8.0%	5.3%	4.0%	0.2%
Non-Claims	-75.7%	-	-46.4%	-4.3%	-96.5%	-14.7%	-19.2%	19219.2%

Commercial Market - Growth in Net Cost of Private Health Insurance (NCPHI), 2022-2023

The Net Cost of Private Health Insurance (NCPHI) is the difference between premiums collected by health insurance plans and the money paid out to cover the cost of medical care for their enrolled members. NCPHI covers the cost of administering the health plan, marketing and quality improvement efforts, and includes any profits.

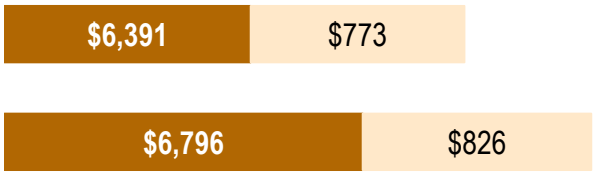
Between 2022-2023, NCPHI grew 7.0% per person per year for Commercial payers in Oregon, compared to 6.3% growth in medical expenses. NCPHI growth has fluctuated since 2018, largely because of the reduction and resurgence in health care utilization that occurred during the COVID-19 pandemic.

NCPHI can be analyzed by calculating a simple medical loss ratio (MLR), that is, the percentage of premium dollars that go to cover medical claims for the insurer's covered population. Across Commercial payers in 2023, the weighted average simple MLR was 84.6% for small group plans, 84.9% for large group plans, and 85.4% for individual plans.

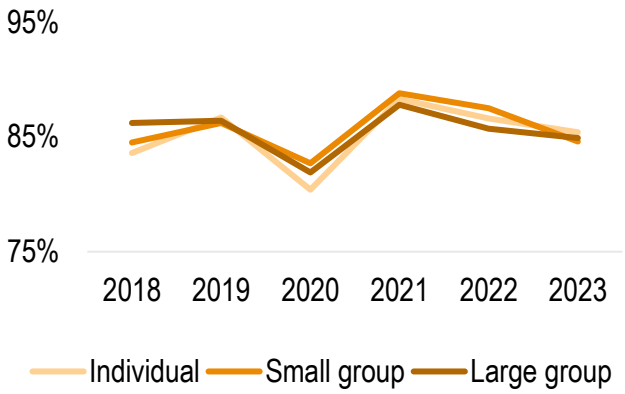
Loss ratios in 2023 were lower than 2022 and 2021 and closer to typical loss ratios pre-pandemic. Falling loss ratios in recent periods may reflect a stabilization in the amount of money being collected through premiums relative to claims spending as utilization returns to normal after the COVID-19 pandemic. Loss ratios in 2023 were also higher than federally mandated minimum MLR levels: 80% for individual and small group plans and 85% for large group plans. [8]

Per person per year expenditures, 2022-2023, Commercial Payers

Total Health Care Expenditures (dark) | NCPHI (light)



Average Simple Medical Loss Ratio, 2018-2023, Commercial Payers, By Plan Type



[8] The Federal MLR calculation allows payers to include the cost of quality improvement in the numerator of the MLR calculation. Average MLRs in Oregon would have been higher than the average simple MLRs reported here if quality dollars were included. Background here.

Chapter III. Health Care Cost Growth Trends in the Medicare Market, 2022-2023

Introduction: Medicare Cost Growth

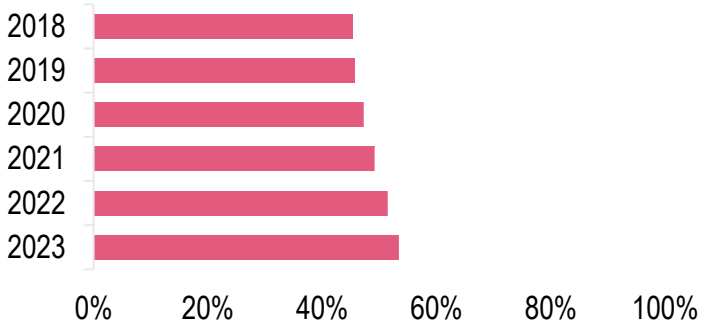
In Oregon, the Medicare market serves a relatively small proportion of the total population, but it accounts for a large share of medical spending and cost growth in the state. Approximately 13% of people in Oregon have Medicare coverage.[9]

The Medicare market includes both Traditional Medicare and Medicare Advantage. Medical costs for Traditional Medicare enrollees are paid by the federal government on a fee-for-service basis with few constraints on utilization. Medicare Advantage plans are managed by private insurance companies. These companies receive a set amount of money from the federal government for the care of their members and use tools like provider networks and prior approvals to manage the cost of care.

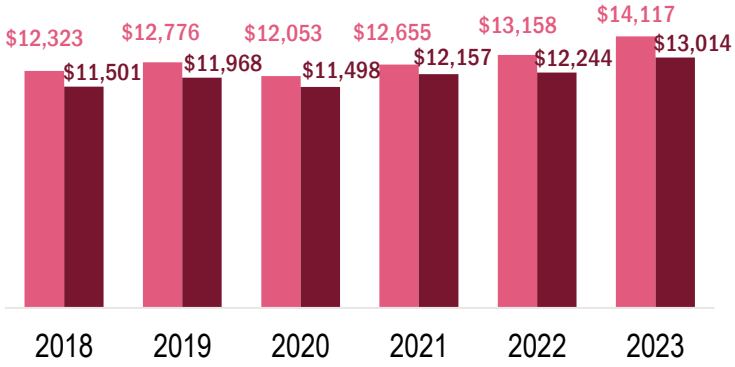
In recent years, enrollment in Medicare Advantage relative to Traditional Medicare has grown. Between 2018 and 2023, the percent of the Medicare-eligible population in Oregon covered by Medicare Advantage increased from 45.4% to 53.4%.[10]

The cost of care for Medicare Advantage enrollees is consistently higher than that of Traditional Medicare.[11] In 2023, the average Total Medical Expenses (TME) per person per year in Medicare Advantage in Oregon was $14,117, which was 8.5% higher than the $13,014 paid for Traditional Medicare enrollees. The higher cost of care for Medicare Advantage enrollees is impacted by the additional benefits offered by Medicare Advantage plans, elevated diagnostic coding intensity, and the extra quality payments that these plans receive.[12]

Percent of Oregon Medicare-Eligible Population **Enrolled in Medicare Advantage**, 2018-2023



Total Medical Expenses PMPY, **Medicare Advantage** vs. **Traditional Medicare**



[9] OHIS data: https://www.oregon.gov/oha/HPA/ANALYTICS/pages/ohis-coverage.aspx
[10] Enrollment data for June of 2018 and 2023 from CMS monthly enrollment files.
[11] The Commonwealth Fund (January 2024). Medicare Advantage: A Policy Primer.
[12] MedPAC (2025). March 2025 report to Congress: Medicare Payment Policy.

Between 2022-2023, total Medicare spending grew by $1.14 billion and made up about 40% of total growth in statewide Total Health Care Expenditures (THCE). On a per person per year basis, THCE across Traditional Medicare and Medicare Advantage increased 7.5%, from $13,211 in 2022 to $14,207 in 2023.

Between 2020-2021, Total Medical Expenditure (TME) growth was higher in Medicare Advantage than in Traditional Medicare. Between 2021-2022 and 2022-2023, TME growth was higher in Traditional Medicare, although trends are similar. Between 2022-2023, TME per person grew 7.3% in Medicare Advantage and 6.3% in traditional Medicare.

This chapter reviews trends in cost growth for the Medicare market overall and broken out for Traditional Medicare and Medicare Advantage. Topline findings include:

- Growth in total medical expenses spending in Medicare was high across all service categories, except Hospital Inpatient, which only grew by 3.2%. The most significant service categories contributing to Medicare cost growth in 2022-2023 were Professional Services and Retail Pharmacy.

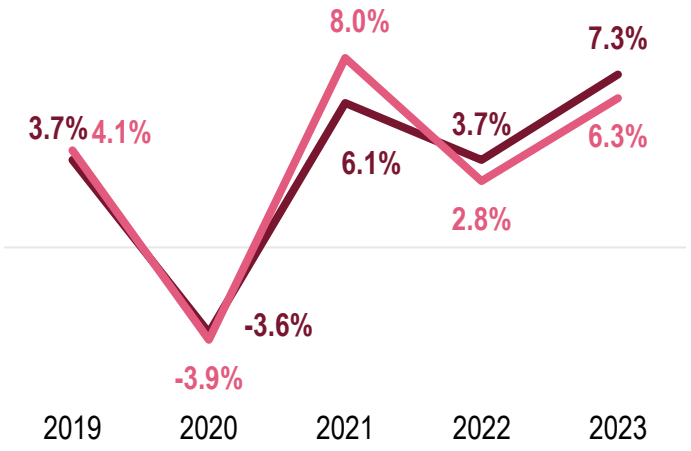
- Medicare Advantage spending per person per year was driven by a 42.9% ($279) increase in non-claims spending, most of which was in the prospective payments category, which grew 115.7%. Traditional Medicare cost growth was driven by spending on medical equipment (42.9%, or $113).

- Price was a more prominent factor than utilization in increased spending for both Medicare Advantage and Traditional Medicare in most service categories, except for Hospital Inpatient cost

Per Person Per Year Cost Growth, Medicare, 2022-2023

THCE and TME growth is growth in PPPY spending across Medicare FFS and Medicare Advantage, net of Medicare Advantage rebates, unadjusted for sex/age, including Medicare/Medicaid Duals. Payer cost growth is growth in PMPM, net of rebates, adjusted for sex/age, for Medicare Advantage excluding Duals.

Growth in TME PMPY –
Medicare Advantage vs. Traditional Medicare



growth, which was driven by utilization.

- Almost 40% of per person per year growth in Medicare Advantage total medical expenses between 2022-2023 stemmed from increased spending in Retail Pharmacy (net of rebates) and Medical Pharmacy. Across both types of Medicare, Medical Pharmacy spending (using APAC data) grew 14.3% per person per year, with most of the increase coming from spending on drugs for cancer, ophthalmic conditions, and immunizations.

- Average growth rates among Medicare Advantage payers (adjusted for age/sex) were 7.3%. Out of ten Medicare Advantage payers, seven exceeded the cost growth target with statistical confidence, two had indeterminant cost growth, and one met the target.

Medicare Cost Growth – Service Categories, 2022-2023

From 2022-2023, total medical expenses (TME) for people in Oregon with Medicare health insurance grew by $960.7 million, or 8.3%.

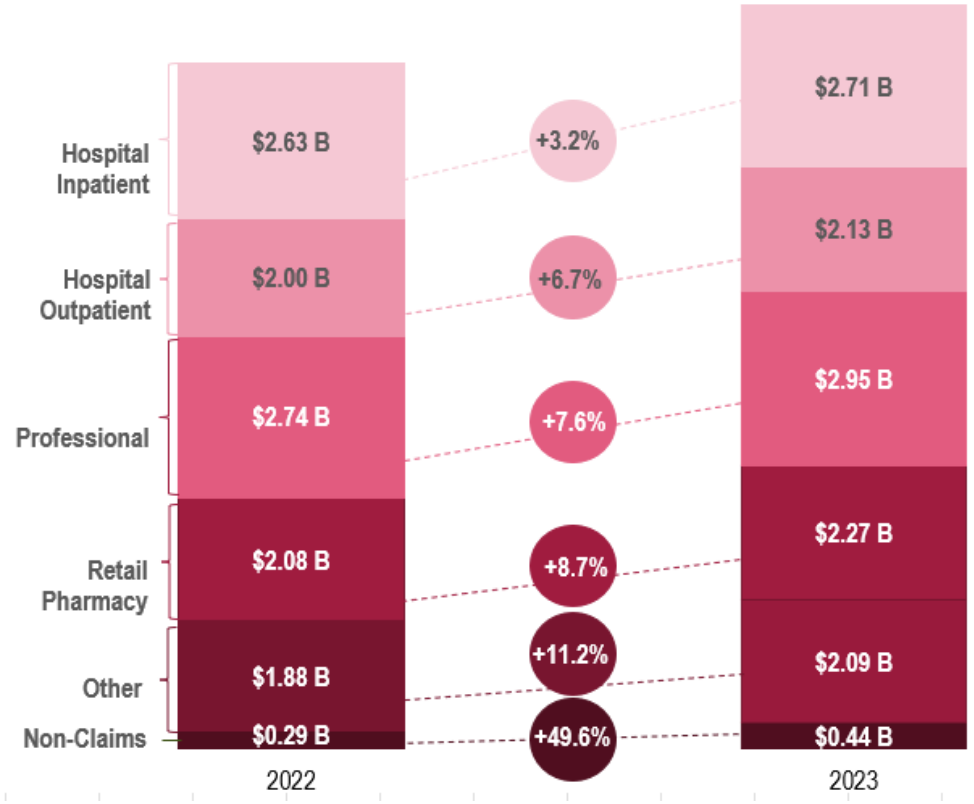
The biggest service category driving growth in total Medicare spending in was Professional Services, where total costs grew by $209.2 million. This was followed by increased spending on Retail Pharmacy (net of rebates), which grew by $180.5 million.

The next two biggest service categories in terms of cost growth, Non-Claims and Other, grew the most in Medicare Advantage and Traditional Medicare respectively and are discussed on the following pages.

Total members enrolled in Medicare as tracked by the Cost Growth Target program grew around 1.2% between 2022-2023. As a result, Total Medical Expenditure growth per person was lower than growth in total spending. About 1.4% of growth in total spending was explained by the increase in enrolled members.

Total Medical Expenses – total spending, in billions, and growth rate, Medicare Market, 2022-2023

Spending is reported net of pharmacy rebates and includes Medicare/Medicaid Duals



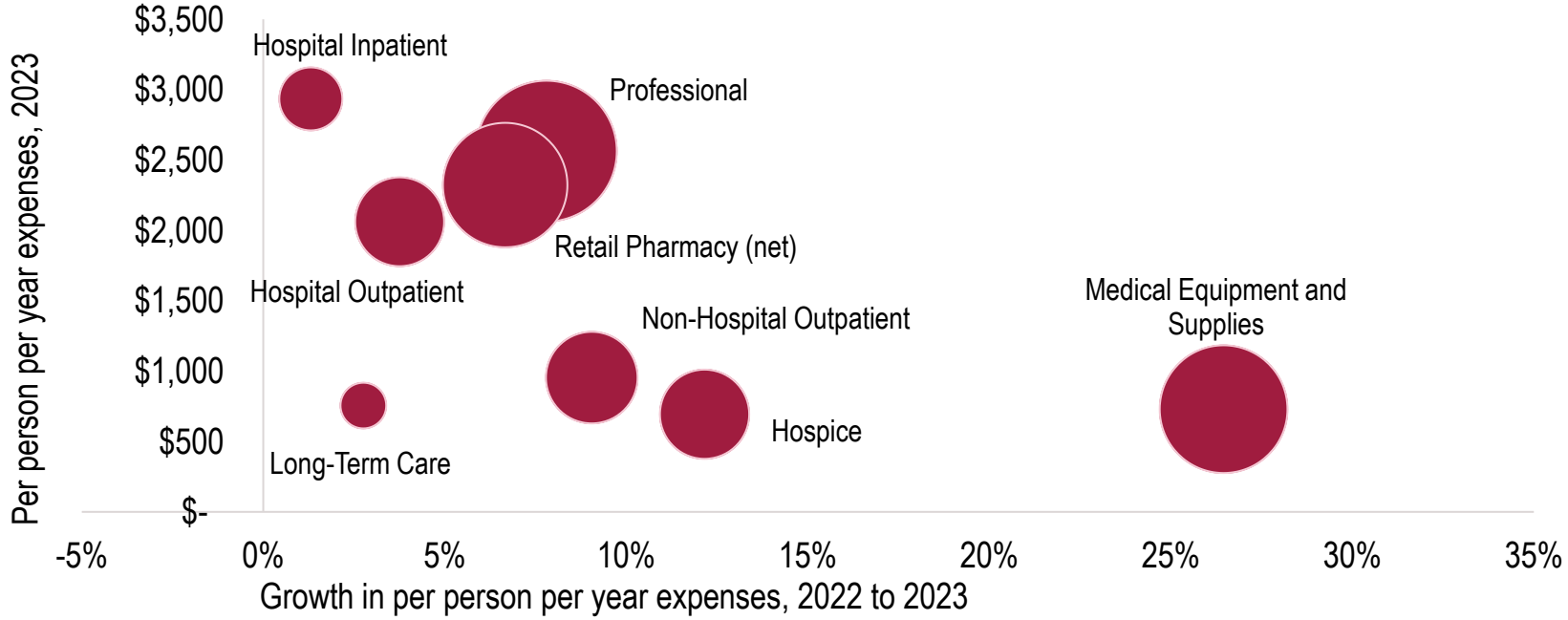
Growth in TME Per Person Per Year Spending by Service Category, Traditional Medicare

In Traditional Medicare, the single largest subcategory driving growth from 2022-2023 was the medical equipment and supplies category, which saw a 42.9% ($113) increase in spending per person per year. This category includes the cost of surgical supplies, orthotic devices, hospital beds, oxygen, wheelchairs and other materials supporting medical treatment. It also includes the cost of certain drugs administered in concert with durable medical equipment (DME).

Analysis of claims data revealed that the price and utilization of DME products increased dramatically from 2022-2023 under Traditional Medicare. Notably, there was a substantial increase in spending for wound care products for diabetes, radiopharmaceuticals for treating prostate cancer, and treatment for urinary incontinence.

Total Medical Expenses – Growth in per person per year spending by service category, Traditional Medicare, 2022-2023

Spending is reported net of retail pharmacy rebates and includes Medicare/Medicaid Duals. Bubble size represents absolute dollar change in per person per year spending. PPPY spending on non-claims was much lower than other categories and is not included in this figure.



Note that subcategories available for traditional Medicare (data from the Centers for Medicare and Medicaid Services) differ from Medicare Advantage.

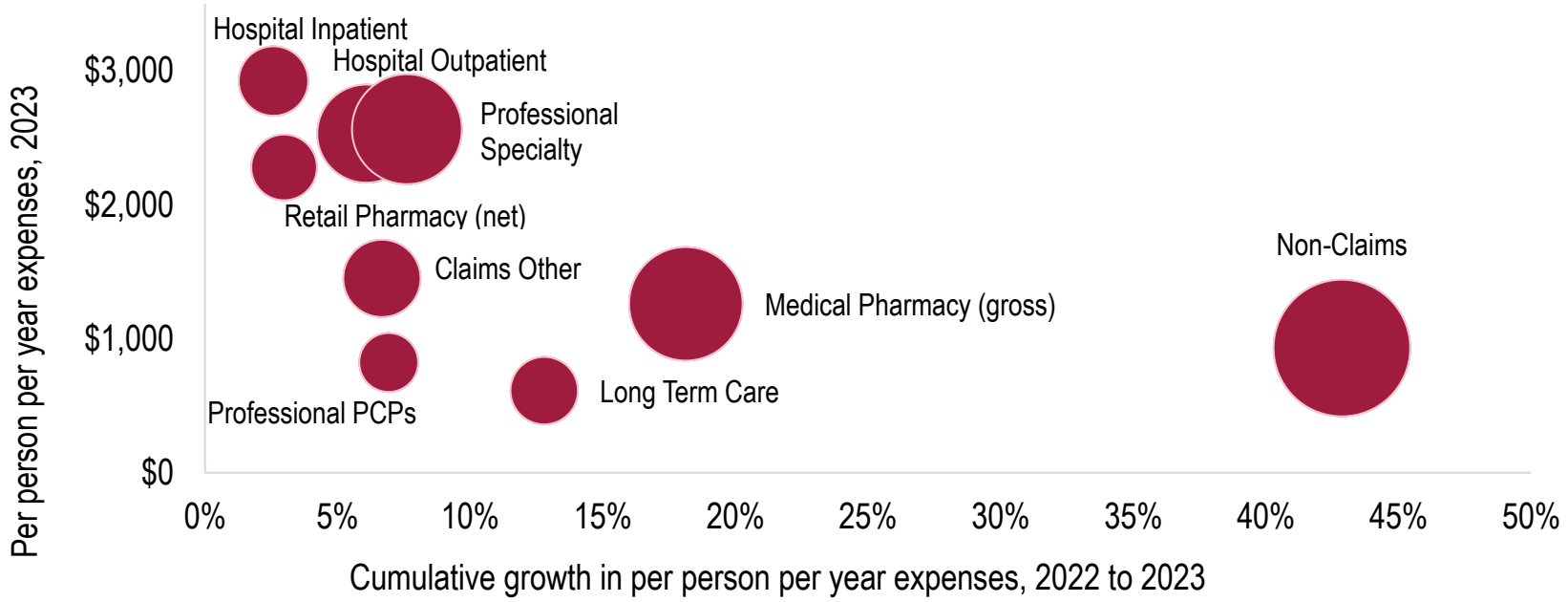
Growth in TME Per Person Per Year Spending by Service Category, Medicare Advantage

In Medicare Advantage, the service category driving cost growth from 2022-2023 was non-claims, which grew 42.9% ($279) on a per person per year (PPPY) basis, driven by a 115.7% increase in prospective payments. Most of this increase was due to growth in non-claims spending by UnitedHealthcare, which has shifted a large portion of its Medicare claims payments to non-claims.

Medicare Advantage cost growth was also due to increased drug spending. Net of rebates, Retail Pharmacy spending grew $181 PPPY from 2022-2023 (7.6%). This year, OHA began collecting data on medical pharmacy spending, or drugs administered in the physician's office. In 2023, Medicare Advantage payers spent an additional $193 PPPY on medical pharmacy costs for their members compared to 2022, a growth of 18.1%. Together, these two drug categories accounted for 39.1% of per person per year cost growth in Medicare Advantage for this measurement period.

Total Medical Expenses – Growth in per person per year spending by service category, Medicare Advantage, 2022-2023

Spending is reported net of retail pharmacy rebates, and includes Medicare/Medicaid Duals. Bubble size represents absolute dollar change in per person per year spending.



Medicare Cost Growth Drivers - Price vs Utilization, 2022-2023

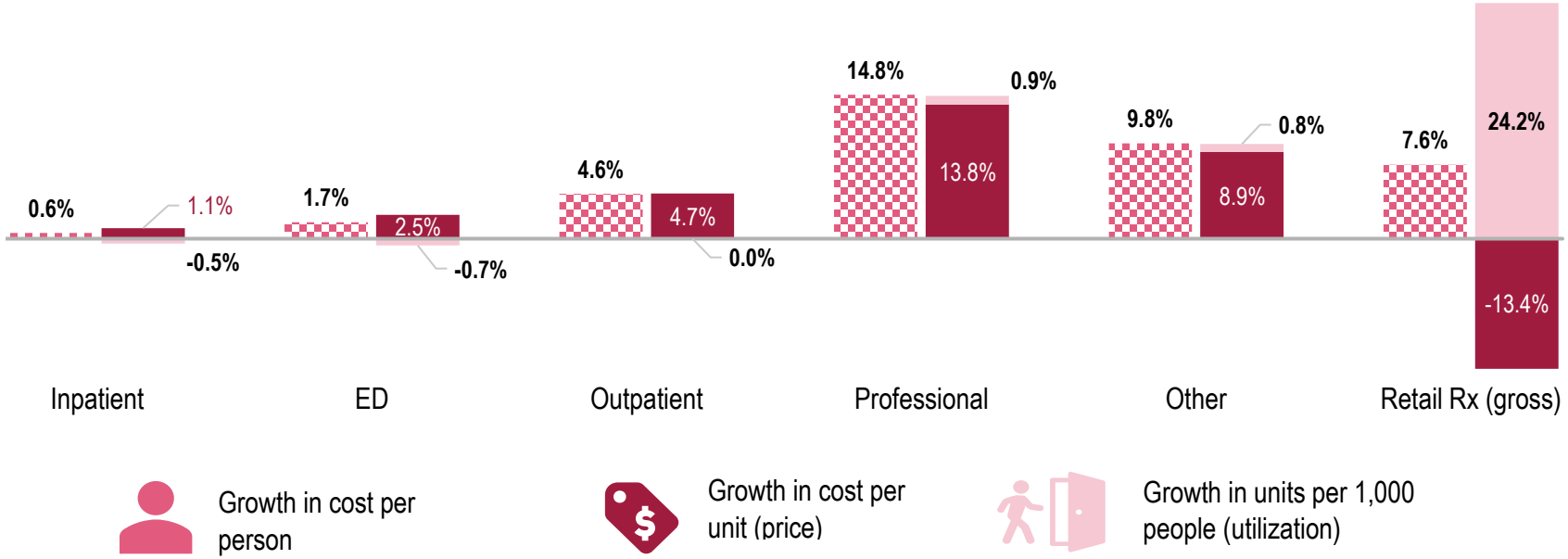
Traditional Medicare

Increased Professional service category spending played a major role in Traditional Medicare cost growth between 2022-2023 and price was the primary drive of the increase. The average cost per Professional claim increased by 14.8%, from $203.76 to $231.84, and total spending in this service category increased by $90.8 million, even as utilization remained flat.

Professional services price increases were highest in the Professional Non-Hospital Surgical and Professional Other subcategories, where prices grew an average of 17.2% and 60.7% respectively. Within the Professional Non-Hospital Surgical subcategory, the cost of treatment for individuals with hypertension and diabetes-related ulcers, and with age or diabetes-related ophthalmic issues grew particularly rapidly.

Traditional Medicare per person cost growth, by service category, for non-Duals, by price and utilization, 2022-2023

APAC claims analysis. Overall spending growth shown in checks, price in darker color, utilization in lighter color. Excludes Medicare/Medicaid duals.



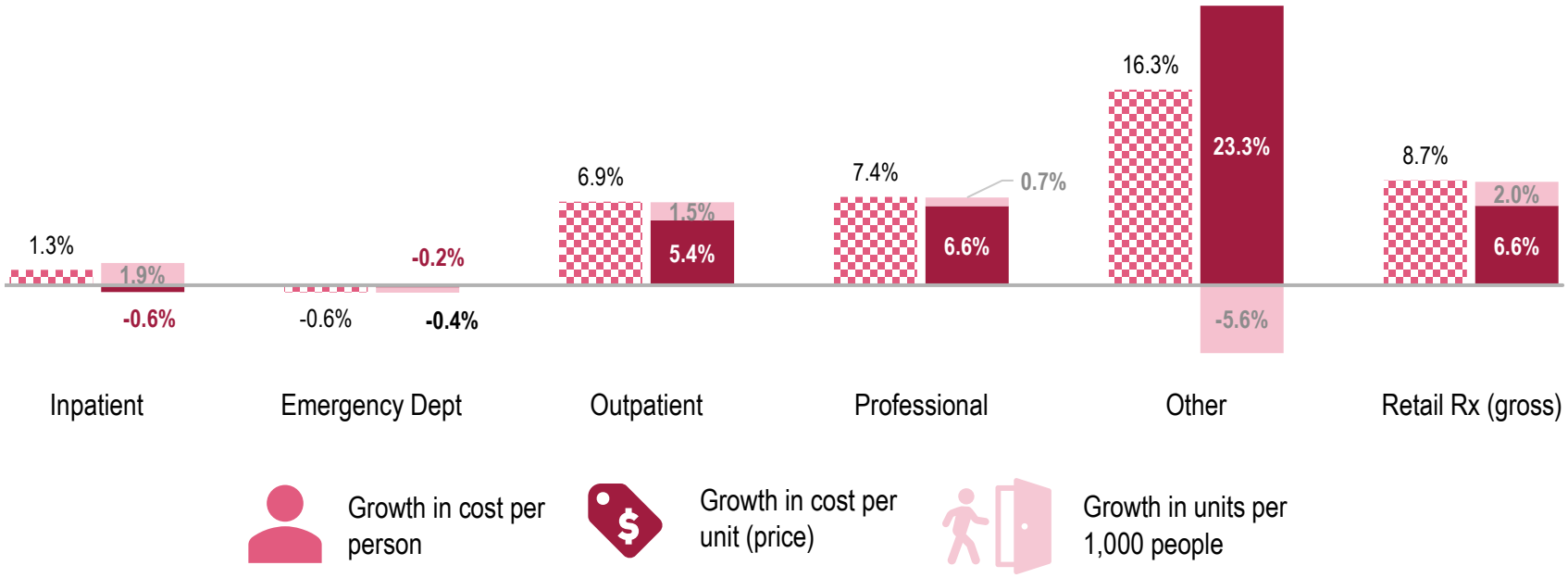
Medicare Advantage

Total Medicare Advantage spending in the Professional Services category grew by $134.6 million from 2022-2023, with the increase largely spread across the surgical, medical, and radiology/chemotherapy subcategories. Utilization increased by 9.9% in the Professional Non-Hospital Surgery subcategory, compared to a 1.3% increase in price. Many of these claims were for general consultations for common ailments such as arthritis and cataracts. Price increases were a key factor in rising radiology, chemotherapy and general medical expenses. In the radiology and chemotherapy subcategory, price increases averaged 26.2%.

The price for a 30-day supply of many drugs in the Retail Pharmacy category increased significantly. The highest increase was in the Hormones and Synthetic Substitutes subcategory, where average prices grew by 14.2%, or $12.89 per unit. Utilization grew 3.9%. Total expenditures in this drug class grew $47.0 million, more than a third of the overall $124.1 million increase in Retail Pharmacy spending.

Medicare Advantage per person cost growth, by service category, for non-Duals, by price and utilization, 2022-2023

APAC claims analysis. Overall spending growth shown in checks, price in darker color, utilization in lighter color. Excludes Medicare/Medicaid duals.



Medicare Spotlight: Medical Pharmacy Spending

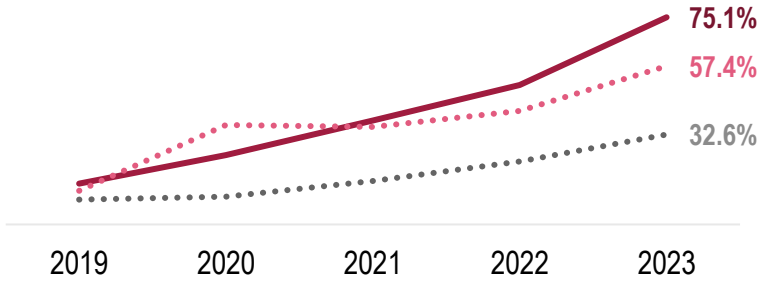
Cost Growth Target data submitted by Medicare payers showed that Medical Pharmacy – drugs administered in a doctor's office – was a significant contributor to 2022-2023 cost growth. Analysis of Medicare claims data in APAC confirms that the total cost of medical pharmacy products has been growing rapidly.

Since 2018, cumulative spending on Medical Pharmacy has grown faster than overall Medicare spending in Oregon, and since 2021, Medical Pharmacy has grown faster than Retail Pharmacy. In 2023, Medicare spending on Medical Pharmacy in Oregon reached at least $935.4 million.[13]

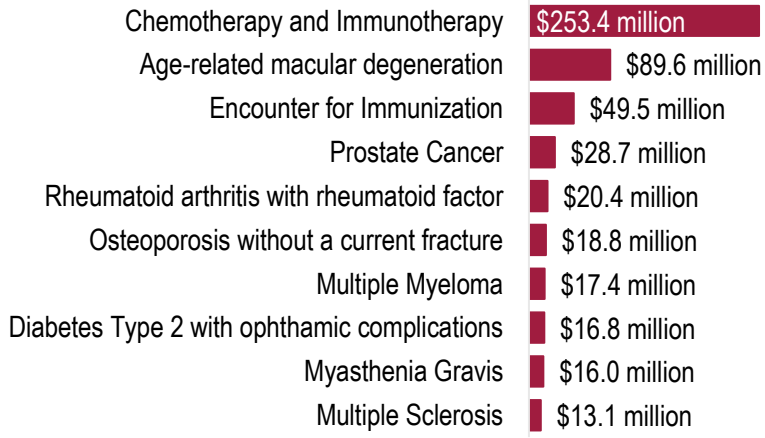
Between 2022-2023, the total medical pharmacy cost per person per year for non-Dual Medicare members grew 14.3%, from $1,104 per person in 2022 to $1,262 in 2023. A large proportion of the medical pharmacy spending in this population – around 27.1%, or $253.4 million – was for chemotherapy and immunotherapy.

Other diagnoses with significant Medical Pharmacy spending included ophthalmological diagnoses like age-related macular degeneration and diabetes type 2 with ophthalmic complications; encounters for immunization; rheumatoid arthritis; osteoporosis; and different types of autoimmune disorders and cancer.

Cumulative change in total **Medical Pharmacy**, **Retail Pharmacy**, and **Overall** spend, Medicare non-Duals, 2018-2023



Top ten diagnoses by total Medical Pharmacy spend, Medicare non-Duals, 2023



[13] The total medical pharmacy spend detailed in this section is the claim line level amount spent on medical pharmacy products as defined by the list assembled by OHA for use by Cost Growth Target data submitters. Some drugs have a line-level amount of $0 because their cost is bundled with other lines in the claim.

[14] Park, Andrea (May 2024). "Roche's soaring Vabysmo sales raise the stakes in ophthalmology face-off with Regeneron's Eylea." Fierce Pharma.

The table on the next page lists the top 10 Medical Pharmacy drugs by increase in total Medicare spend in 2023. These 10 drugs include newer cancer treatments and contributed $93.1 million to the total $130.5 million net increase in spending on all medical pharmacy for Medicare non-Duals from 2022-2023.

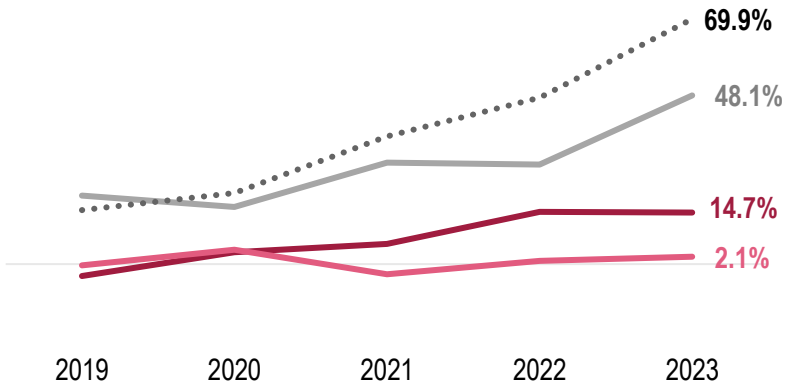
Some of the drugs on the top 10 list were newer drugs replacing older competitors. For example, Vabysmo entered the market in 2022 as a more effective alternative to competitor Eylea.[14] Other drugs are older drugs that were approved for new uses or for use in combination with other drugs, as is the case with Keytruda.[15]

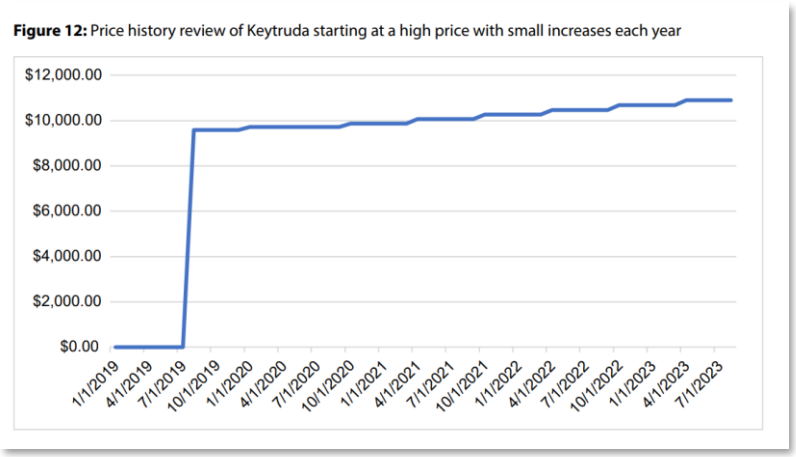
Across all separately billable Medical Pharmacy drugs in Medicare, the primary driver of the spending increase between 2018 and 2023 was an increase in utilization (the number of units, or amount of drugs administered) per person.

Oregon's **Prescription Drug Price Transparency Program** analyzes information from drug manufacturers, health insurers, and consumers to increase understanding of the factors that influence prescription prices, and how drug prices affect Oregonians. The Annual Report looks in detail at specific drugs and price increase – see example of Keytruda price increases from the 2023 Report.

https://dfr.oregon.gov/drugtransparency/

Cumulative change in **average price**, **utilization**, **user population size**, and **spending per person**, separately billable medical pharmacy in Medicare, 2018-2023





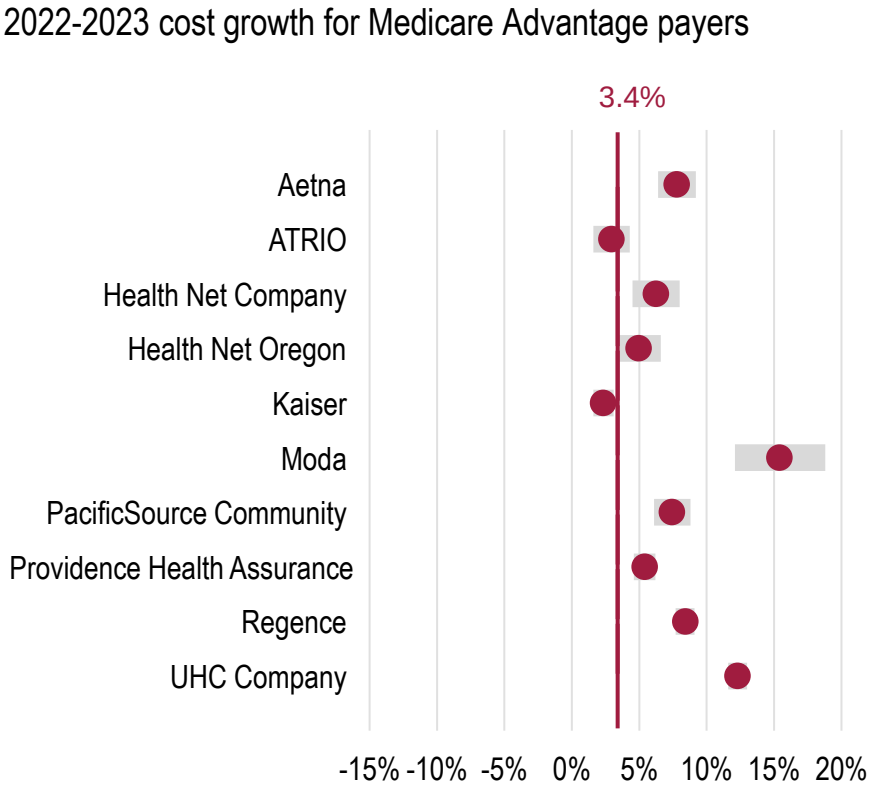
Top 10 physician-administered drugs by increase in total spend, Medicare, 2022-2023

Product	Use	Total Medicare Spend, 2022	Total Medicare Spend, 2023	Cost Per Person, 2023	% change in price	% change in units PPPY	% change in # users
Vabysmo (0.1 mg)	Age-related macular degeneration and diabetic edema	$3.5 million	$30.7 million	$13,936	2.8%	189.9%	192.8%
Keytruda (1 mg)	Cancer	$85.9 million	$100.7 million	$78,571	6.3%	-2.2%	12.9%
Darzalex Faspro (10 mg)	Cancer	$32.1 million	$42.6 million	$99,192	4.9%	0.1%	26.2%
Pluvicto (1 millicurie)	Prostate Cancer	$2.4 million	$12.0 million	$124,917	3.2%	62.4%	200.0%
Prevnar 20	Pneumococcal vaccine	$5.2 million	$14.6 million	$313	9.4%	0.1%	154.3%
Opdualag	Cancer (melanoma)	$0.8 million	$5.5 million	$157,042	1.2%	136.5%	191.7%
Opdivo (1 mg)	Cancer	$31.6 million	$36.2 million	$76,397	5.7%	-1.1%	9.7%
Enhertu (1 mg)	Breast Cancer	$4.2 million	$8.5 million	$71,299	0.7%	14.9%	75.0%
Reblozyl (0.25 mg)	Anemia	$5.3 million	$9.6 million	$121,861	7.6%	14.7%	46.3%
Vyvgart (2 mg)	Myasthenia gravis	$8.4 million	$12.2 million	$62,669	8.8%	11.6%	19.0%

[15] Grand View Research (2025). Keytruda Market Analysis Report.

Medicare Advantage Cost Growth – By Payer, 2022-2023

Of the ten Medicare Advantage payers included in Cost Growth Target reporting for 2022-2023, seven exceeded the target with statistical confidence, two had indeterminant cost growth, and one payer met the cost growth target. The average cost growth across payers was 7.3%, and cost growth ranged from 2.3% to 15.4%.



Medicare Advantage Payer	Target Performance	2022-2023 Cost Growth
Aetna	Not Met	7.8%
ATRIO	Indeterminant	3.0%
Health Net Company	Not Met	5.0%
Health Net Oregon	Indeterminant	6.3%
Kaiser	Met	2.3%
Moda	Not Met	15.4%
PacificSource Community	Not Met	7.4%
Providence Health Assurance	Not Met	5.4%
Regence	Not Met	8.4%
UHC Company*	Not Met	12.3%

*UHC Company includes all UHC Medicare entities (Care Improvement Plus South Central Insurance Company and UnitedHealthcare Benefits of Texas, Inc.)

Medicare Advantage Cost Growth Drivers – by Payer and by Service Category, 2022-2023

Among Medicare Advantage payers that exceeded the cost growth target between 2022-2023 with statistical confidence, a common driver was increased Hospital Inpatient spending. Hospital Inpatient spending for non-Dual Medicare Advantage members increased 3.8% per person per year statewide, while per person per year costs declined by 4.1% among Duals. Duals are not included in payer cost growth calculations. Claims data show that Medicare Advantage Hospital Inpatient costs increased primarily due to increased utilization, as opposed to price (see page 49).

Other service categories that impacted Medicare Advantage payer cost growth included Hospital Outpatient and Retail and Medical Pharmacy costs. UHC Company was an outlier, with most of its Medicare Advantage growth appearing in the Non-Claims category.

Heat map showing which service categories had the most influence on total growth in per member per month spending for each Medicare Advantage payer, 2022-2023

*The percentages in the table below reflect the percent increase in per member per month spending (unadjusted) by service category, while the cells are colored based on the total absolute dollar PMPM change. The **darker** the cell color, the higher the absolute dollar change. Categories with darker cells had more influence on the payer's overall spending growth. Columns in **grey** are payers whose Medicare Advantage cost growth was indeterminant or below the target. Payers with maroon columns exceeded the target with statistical confidence.*

	Aetna	ATRIO	Health Net Company	Health Net Oregon	Kaiser	Moda	PacificSource Community	Providence Health Assurance	Regence	UHC Company
Inpatient	1.3%	4.1%	14.8%	5.4%	-3.1%	28.0%	21.1%	10.2%	9.2%	-4.8%
Outpatient	10.2%	7.0%	2.2%	18.0%	5.3%	15.7%	14.7%	6.7%	8.0%	-0.6%
Professional PCP	2.9%	4.7%	3.2%	0.9%	21.8%	14.2%	4.4%	9.0%	7.0%	-4.1%
Professional Specialty	7.2%	4.0%	3.9%	3.4%	7.4%	2.4%	6.0%	8.5%	4.7%	-5.3%
Professional BH	-1.1%	13.3%	-13.0%	-25.6%	10.8%	-3.9%	9.6%	14.0%	2.7%	-14.0%
Professional Other	13.8%	-0.6%	1.6%	6.4%	1.0%	2.8%	-1.4%	25.1%	13.4%	-2.4%
Long Term Care	-25.9%	10.6%	38.5%	20.9%	9.3%	45.7%	9.0%	23.7%	17.3%	9.0%
Medical Pharmacy	23.2%	12.0%	3.1%	18.9%	41.9%	34.6%	16.1%	23.2%	22.0%	6.4%
Retail Pharmacy (net)	19.1%	3.3%	7.0%	-0.2%	-5.2%	11.7%	0.4%	9.1%	11.4%	9.8%
Claims Other	6.8%	9.6%	12.2%	7.5%	-4.7%	16.2%	0.7%	12.0%	9.4%	3.4%
Non-Claims	10.8%	1502.8%	-11.1%	-61.0%	-33.3%	279.4%	-80.1%	-37.9%	-10.6%	106.1%

Medicare Advantage - Growth in Net Cost of Private Health Insurance (NCPHI)

In Medicare Advantage, the Net Cost of Private Health Insurance (NCPHI), represents the difference between the amount a payer receives in premiums and federal capitation payments and the cost of claims paid out.

Federal capitation payments are determined based on several factors. Each year, the Centers for Medicare and Medicaid Services (CMS) establishes a benchmark capitation rate – determined by a percentage of traditional Medicare spending in a given county – and payers estimate how much they need to manage the care of the population in that area (the plan "bid"). Most plans bid lower than the benchmark and receive a "rebate" from the federal government that can be used to offer more benefits or lower premiums or patient cost sharing.[21] Medicare Advantage plans can earn more money for member care if they have a higher quality rating (up to 5 stars), or for members with higher risk scores.

During this period, the CMS regional benchmark for Oregon increased by 4.5%, while average star ratings decreased following the phase out of a pandemic-era policy that had bumped up ratings in 2022 to increase plan revenue.

Factors impacting Medicare Advantage Plan Revenue

	2022	2023
CMS Regional Benchmark[16]	$1,066	$1,020
Average Quality Star Ratings (Oregon): Local PPO[17]	3.8	3.2
Average Quality Star Ratings (Oregon) HMO[18]	4.2	3.8
Plan bids as a percentage of benchmark (national)[19]	85%	83%

Among Medicare Advantage payers included in the Cost Growth Target Program, the average amount of revenue collected to cover the cost of member care increased by 5.2%, from $1,064 in 2022 to $1,119 in 2023. Nationally, Medicare Advantage payer profit margins were slightly lower in 2023 when compared to previous periods.

Plans' administrative expenses held steady during the period.[20]

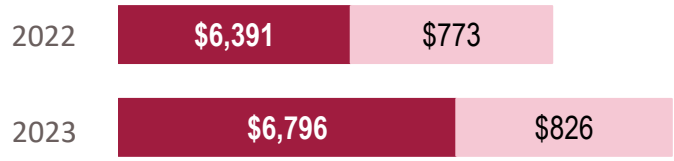
[16] See CMS website for 2022 and 2023.
[17] Star ratings data for 2022 and 2023 available from CMS at this link.
[18] Ibid
[19] MedPac (March 2023). Report to Congress: Medicare Payment Policy.
[20] Ellenberg et al. (December 2024). Medicare Advantage Organizations financial results for 2023. Milliman.
[21] It cannot be determined from these data whether the revenue from these rebates resulted in more Medicare Advantage members utilizing benefits.

Between 2022-2023, the Medicare Advantage NCPHI shrank slightly, going from $1,585 per person per year in 2022 to $1,561 in 2023 (-1.5%).

The proportion of Medicare Advantage plan income going towards claims (the simple Medical Loss Ratio) among Medicare Advantage payers in Oregon increased modestly to 88.5% in 2023, compared to 87.6% in 2022, edging back towards its pre-pandemic level.

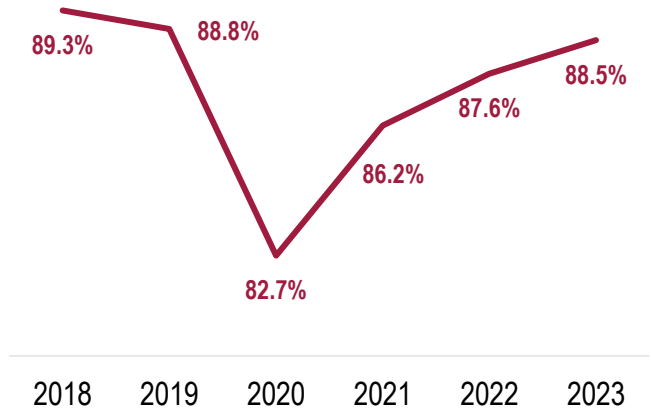
Per person per year expenditures, 2022-2023, Medicare Advantage

Total Health Care Expenditures (darker) | NCPHI (lighter)*



*THCE excludes Medicaid Duals dollars.

Average Simple Medical Loss Ratio, 2018-2023, Medicare Advantage Plans



Chapter IV. Health Care Cost Growth Trends in the Medicaid Market, 2022-2023

Introduction: Medicaid Cost Growth

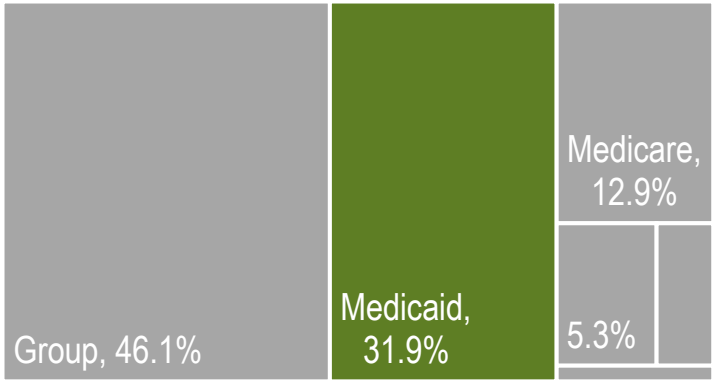
The Oregon Health Plan (OHP), the state's Medicaid program, provides comprehensive medical, dental, and behavioral health coverage to a significant portion of the population. As of December of 2023, approximately 1,460,889 Oregonians were enrolled in Medicaid, representing about 34% of the state's total population.[22]

Most Medicaid enrollees in Oregon receive services through Coordinated Care Organizations (CCOs), which are regional networks of healthcare providers that deliver integrated care. CCOs are central to Oregon's strategy for managing Medicaid expenditures while aiming to improve health outcomes.

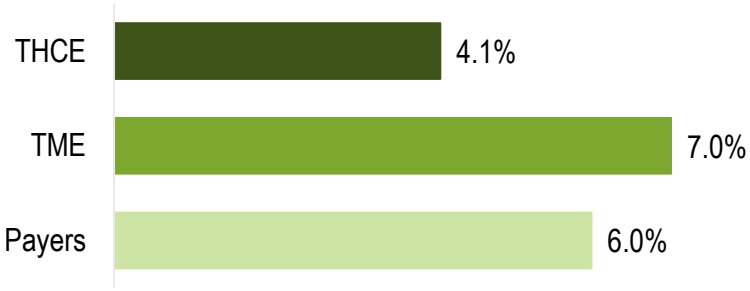
In 2023, Oregon initiated the redetermination process following the expiration of federal continuous coverage requirements established during the COVID-19 Public Health Emergency. Despite the challenges associated with redetermining eligibility for all Medicaid members, Oregon successfully maintained coverage for over 80% of its Medicaid population. See enrollment graph on page 60.

Between 2022 and 2023, total Medicaid Total Health Care Expenditures (THCE) increased by $1.07 billion, or 11.6%; however, the number of member months covered under Medicaid also increased by 7.2%, resulting in per person per year THCE growth of 4.1%. Total Medical Expenses (TME) per person per year grew 7.0%. Four CCOs met the cost growth target.

Percent of People in Oregon by Type of Primary Health Insurance Coverage, 2023



Per Person Per Year Medicaid Cost Growth, 2022-2023



[22] Enrollment data from OHA's Office of Health Analytics. The total Oregon population in 2023 was 4,253,653.

Growth in TME was higher from 2022-2023 than it has been in any period since the Cost Growth Target Program began collecting data, including the 2018-2019 pre-pandemic period. Growth was negative or low throughout the pandemic largely because of increased enrollment due to pandemic-era policies that made Medicaid coverage more accessible. In the current period, higher levels of reimbursement due to state policies drove growth.

Key context for 2023 Medicaid cost growth includes:

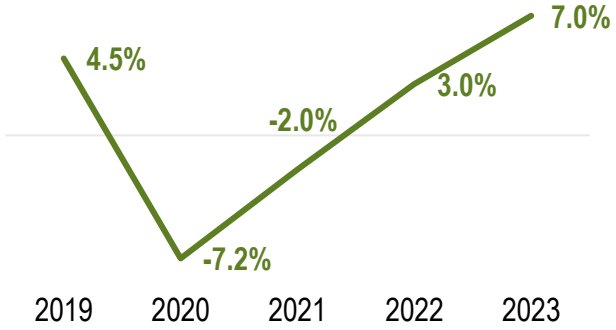
- Capitation rates for CCOs increased by 3.6%, reflecting updated actuarial trend assumptions and policy investments, including behavioral health service expansions and temporary enhanced DRG hospital reimbursement.
- OHA directed CCOs to make significant unit cost increases across a broad array of behavioral health services. These increased reimbursement levels also impacted utilization rates of behavioral health services. On a per person per year basis, Medicaid behavioral health claims increased 23.4%. See page 65.
- Federal continuous coverage requirements in effect during the Public Health Emergency led to historically high Medicaid enrollment. As of Q3 2023, Medicaid enrollment in Oregon peaked at over 1.47 million members, an increase of 48% compared to pre-pandemic levels.

  While redeterminations began mid-2023, membership during the measurement year remained elevated and finally saw a small decline in Q4 2024. This is important to consider when understanding that the cost growth target is a measurement relative to member months – so as low-utilizing members are redetermined, cost per member will increase.

PPPY TME growth, 2018-2023, Medicaid Market

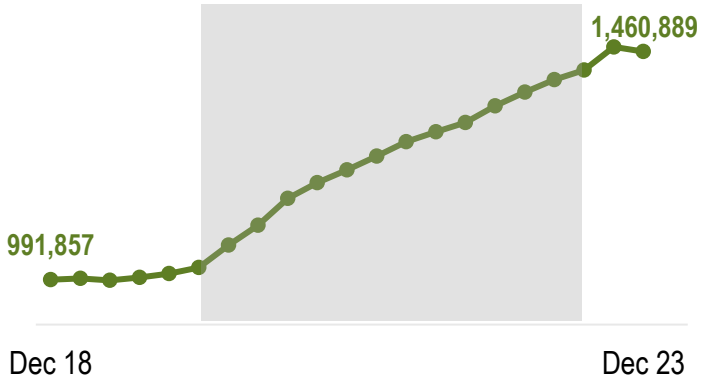
Net of rebates, unadjusted

Years are year 2 of a 2-year period, eg "2023" for 2022-2023



Quarterly Oregon Medicaid Enrollment, December 2018- December 2023

The COVID-19 public health emergency in grey.



Medicaid Cost Growth - Service Categories, 2022-2023

Total medical expenses (TME) for Medicaid in Oregon grew by $903.3 million in 2023, a 14.5% increase, from 2022-2023.

Spending increased in all service categories.

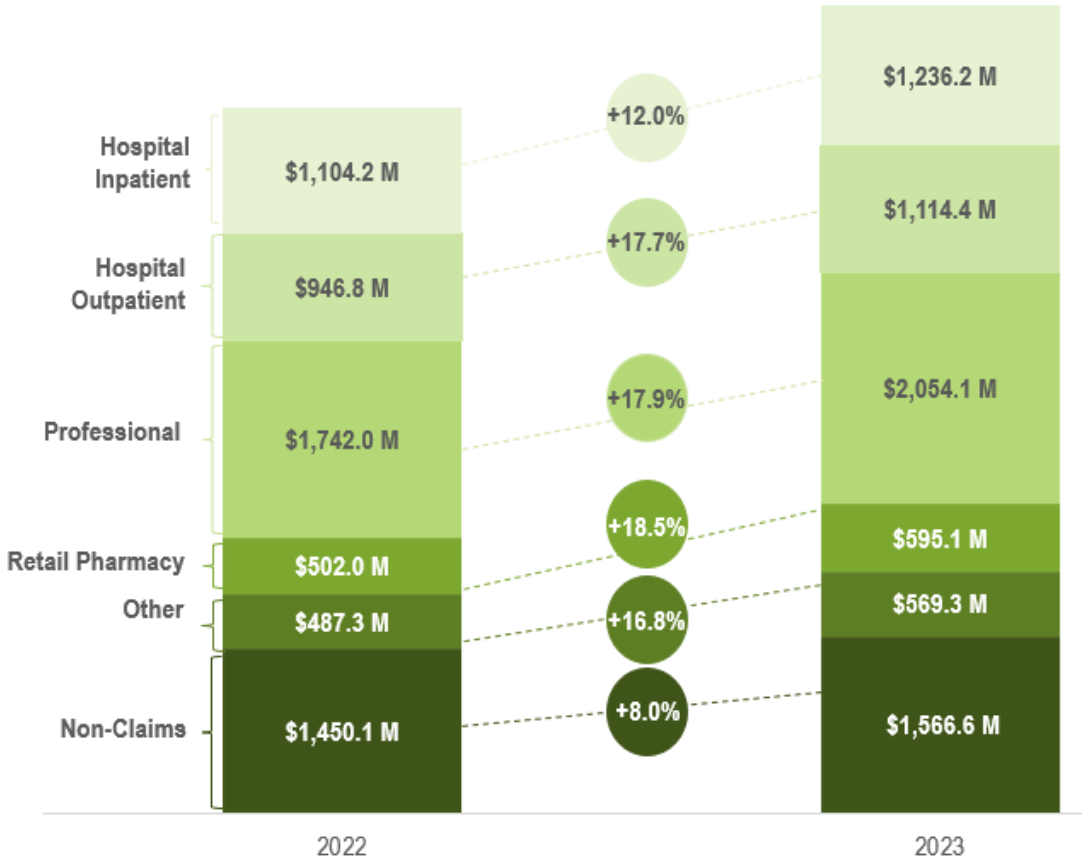
The service category with the most growth (in total dollars spent) was Professional Services, specifically due to a $172.5 million increase in behavioral health spending.

Hospital Inpatient and Outpatient spending also grew by $299.5 million.

See page 65 for more information on factors driving behavioral health and hospital spending.

Total Medical Expenses – total spending, in millions, and growth rate, Medicaid Market, 2022-2023

Spending is reported net of pharmacy rebates

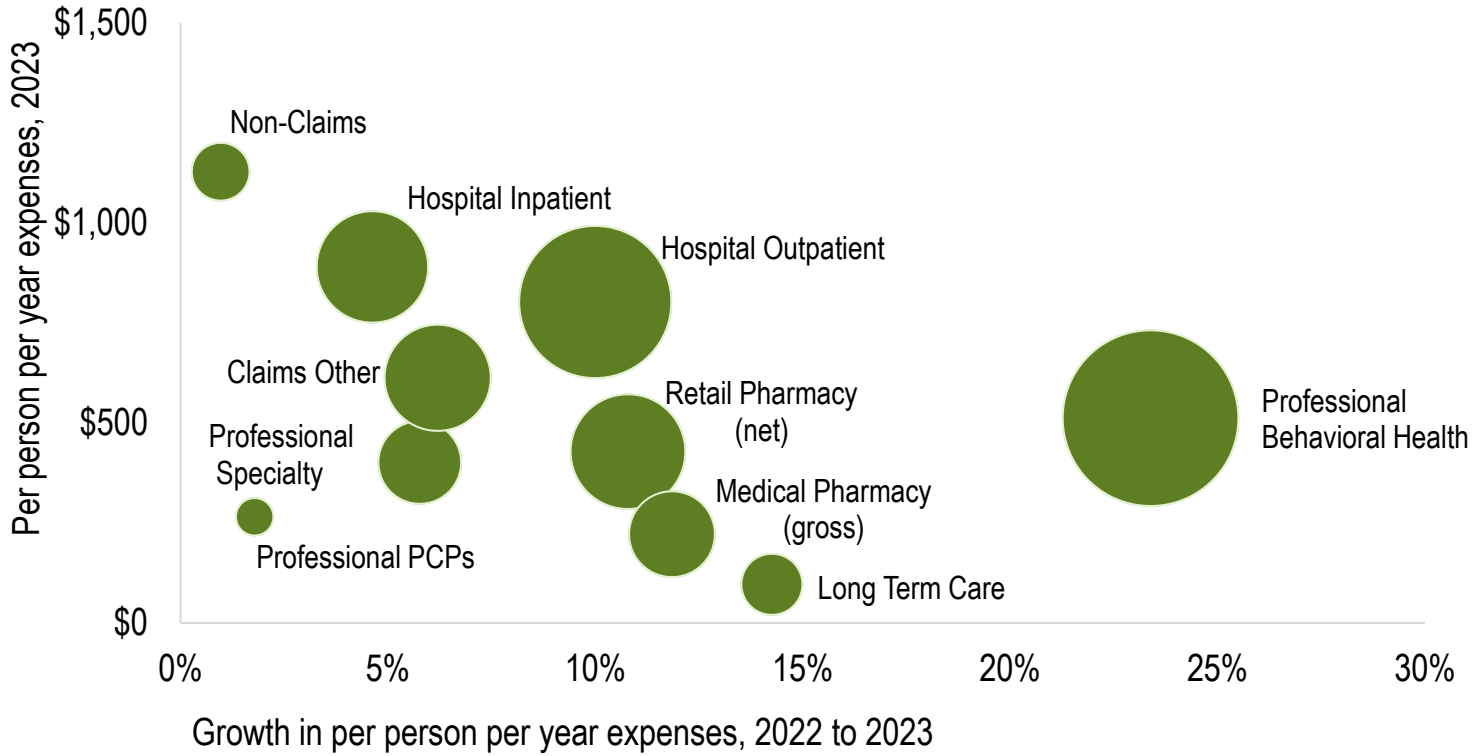


Growth in TME Per Person Per Year Spending by Service Category, Medicaid

From 2022-2023, growth in Medicaid on a PPPY basis exceeded the cost growth target in every category except Professional Primary Care and Non-Claims. Professional Behavioral Health spending saw tremendous growth of $97 in response to state Directed Payments (see page 65). Hospital Outpatient (+10%, or $73) and Retail Pharmacy (+11.6%, or $42) were the next most influential categories, along with Hospital Inpatient (+4.6%, or $39).

Total Medical Expenses – Growth in per person per year spending by service category, Medicaid, 2022-2023

Spending is reported gross of retail pharmacy rebates. Bubble size represents absolute dollar change in per person per year spending



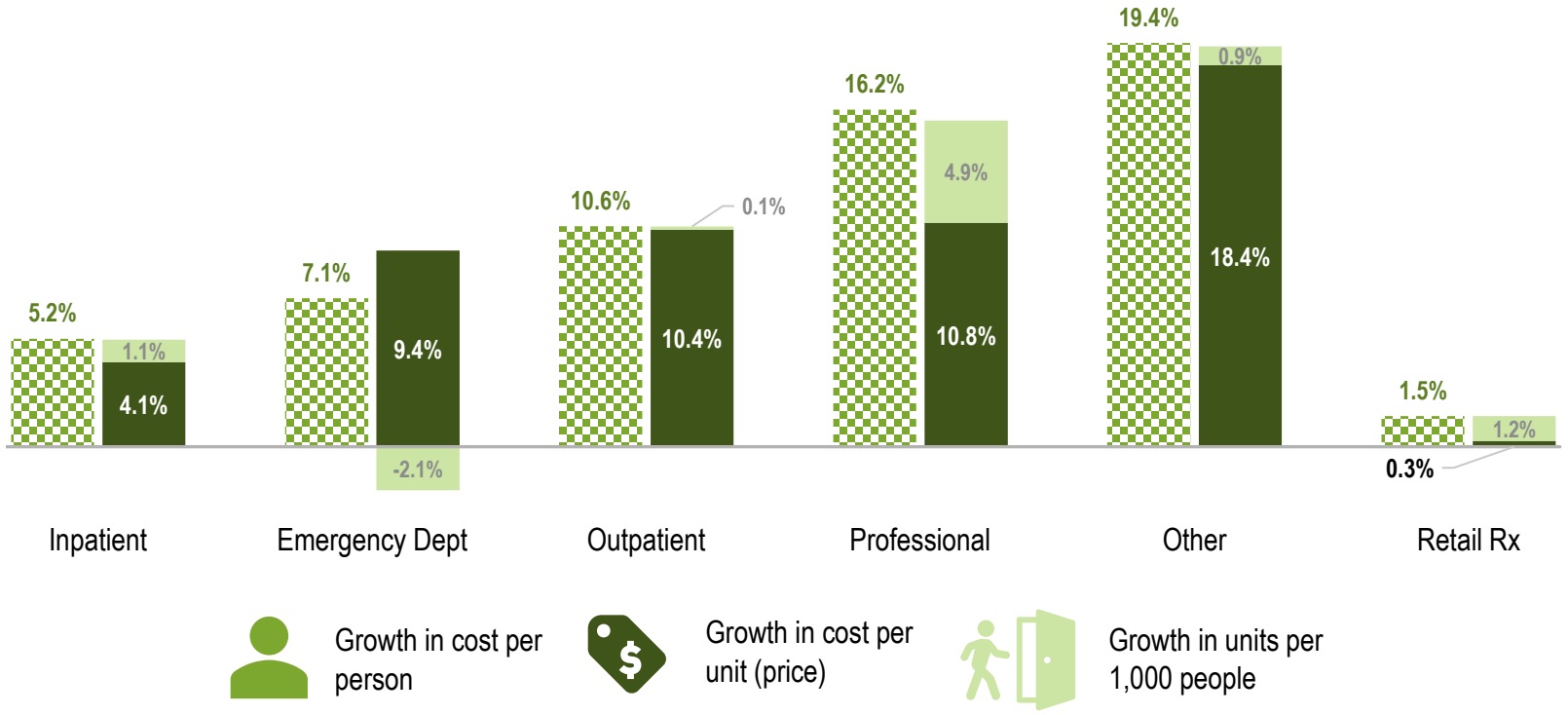
Medicaid Cost Growth Drivers – Price vs Utilization, 2022-2023

Most Medicaid cost growth was driven by a large increase in unit cost (price). Emergency Department, Hospital Outpatient, and Professional service categories all saw price increases around 10%. Meanwhile, only the Professional service category saw a meaningful increase in utilization (almost 5%). Medicaid utilization increased in most service categories in 2022, after the artificial depression during the pandemic in 2020 and 2021.

While the Other service category also saw outsized growth in Total Medical Expense, with unit cost making up 18.4% of the total 19.4% increase, the amount of money spent in this category is significantly less than that of any others.

Medicaid per person cost growth, by service category, by price and utilization, 2022-2023

APAC claims analysis. Overall spending growth shown in checks, price in darker color, utilization in lighter color



Medicaid Spotlight: State-Mandated Benefits

State policy had a major impact on Medicaid cost growth.

Behavioral Health Rate Increase

The Oregon Legislature appropriated funds to increase Medicaid behavioral health rates in the 2021 to 2023 biennium. Beginning in 2023, OHA directed CCOs to increase payments to behavioral health providers across a broad array of services. OHA separately implemented similar fee schedule increases for Medicaid Open Card.

These Behavioral Health Directed Payments (BHDPs) were intended to create significant and sustained increases in wages to help remedy existing disparities in reimbursement rates, as well as address the lack of behavioral health providers across the state.

Hospital Facility Rate Increase

The other major policy change that occurred during the 2022-2023 measurement period was an increase in Medicaid rates for services in hospital facilities. Due to cost pressures faced by hospitals related to workforce challenges and the COVID-19 pandemic, CCOs were expected to temporarily increase their payments to diagnosis-related group (DRG) hospitals to 85% of Medicare rates in 2023, higher than the 2022 expectation of 80% of Medicare rates.

	2022 - 2023
CCO Rate Increase[23]	CCO capitation rates increased 3.6% overall, varied by aid category.
CCO Rate Adjustments[24]	Primary drivers of the 2023 Medicaid rates include: • Behavioral Health Directed Payments, • DRG hospital temporary 5% reimbursement increase • Indian Health Care Provider increased reimbursement encounter rates
Healthier Oregon Program[25]	New coverage for Oregonians who were not previously eligible.

[23] CY23 Oregon Medicaid Rate Certification

[24] Ibid

[25] CY23 Oregon HOP Rate Certification

Impact of Medicaid Behavioral Health Directed Payments

The introduction of the Medicaid Behavioral Health Directed Payments (BHDPs) was responsible for nearly 30% of the Medicaid cost growth between 2022-2023.

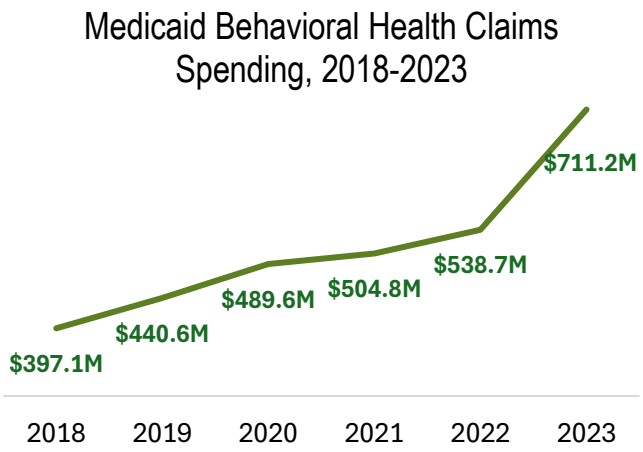
- If the Medicaid BHDPs were excluded from Medicaid spending calculations for 2022-2023, the per person per year growth rate would drop from 5.9% to 4.4%.

- A 22% growth in Behavioral Health claims drove almost 28% of all CCO spending in this measurement period. Medicaid Open Card saw a 35% increase in Behavioral Health claims.

The BHDPs were intended to address a major public health issue in the state. Oregonians have higher rates of anxiety, depression, and suicide than the United States as a whole. At the same time, in 2022 almost a third (32.3%) of Oregonians who needed counseling or therapy were unable to access it.[26]

A lack of behavioral health practitioners is at the root of this issue, as is a lack of adequate wages for these practitioners. Reimbursement rates are often lower in Medicaid than among other insurers, so raising rates was one step towards increasing access to providers.[27]

Based on cost growth target data and Medicaid claims data, the introduction of BHDPs met the goal of encouraging increased access to behavioral health services.



Key Findings

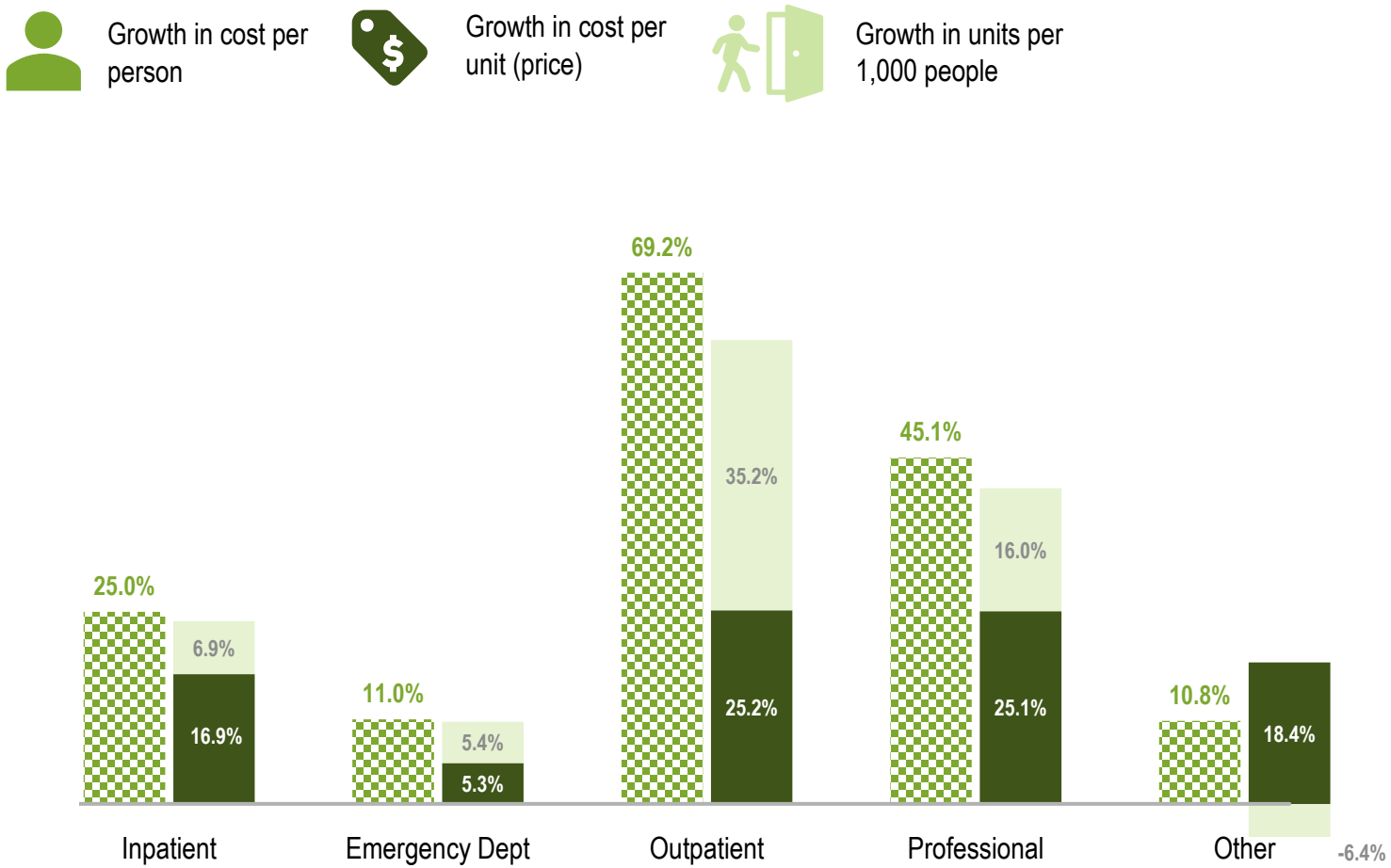
- Total Medicaid claims spending for behavioral health services increased $266.2 million across all service types, with about half of this increase - $131.9 million – coming from the Professional Services category.

- Even though a rate change was the origin of this increase, the growth was driven by both price and utilization, suggesting that the policy encouraged behavioral health providers to make their services more available to Medicaid members.

[26] See KFF Fact Sheet on Mental Health in Oregon.
[27] Zhu et al (February 2022). Behavioral Health Workforce Report to the Oregon Health Authority and State Legislature. Center for Health Systems Effectiveness.

Medicaid per person cost growth, behavioral health services, by price and utilization, 2022-2023

APAC claims analysis. Overall spending growth shown in checks, price in darker color, utilization in lighter color

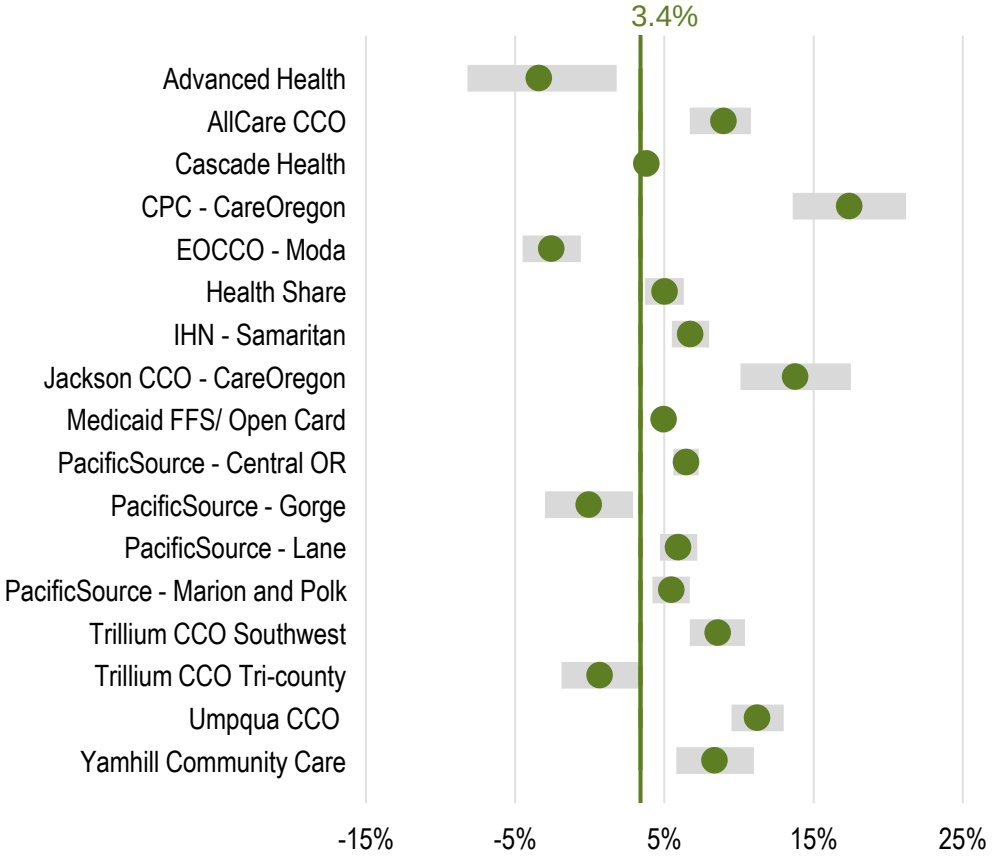


Growth in cost per unit and growth in units per 1,000 people are calculated using a different metric than growth in cost per person. i.e. growth in cost per person does not equal growth in cost per unit + growth in units per 1,000 people. See Appendix for details.

Medicaid Cost Growth – By Payer, 2022-2023

Of the 17 Medicaid payers (16 CCOs and Open Card) included for 2022-2023, four met the cost growth target. The average cost growth across Medicaid payers was 6.0% and cost growth ranged from -4.0% to 17.4%.

2022-2023 cost growth for Medicaid payers



Medicaid Payer	Target Performance	2022-2023 Cost Growth
Advanced Health	Met	-3.4%
AllCare CCO	Not Met	9.0%
Cascade Health	Not Met	3.8%
CPC - CareOregon	Not Met	17.4%
EOCCO - Moda	Met	-2.6%
Health Share	Not Met	5.0%
IHN - Samaritan	Not Met	6.5%
Jackson CCO - CareOregon	Not Met	13.8%
Medicaid FFS/ Open Card	Not Met	14.9%
PacificSource - Central OR	Not Met	6.5%
PacificSource - Gorge	Met	-0.1%
PacificSource - Lane	Not Met	5.9%
PacificSource - Marion Polk	Not Met	5.5%
Trillium CCO Southwest	Not Met	8.6%
Trillium CCO Tri-County	Met	0.7%
Umpqua CCO	Not Met	11.2%
Yamhill Community Care	Not Met	8.4%

Medicaid Cost Growth Drivers – by Payer and by Service Category, 2022-2023

Between 2022-2023, the most consistent service category that contributed to Medicaid cost growth was behavioral health, which saw double digit growth for most of the Medicaid payers who exceeded the cost growth target. Other high impact service categories were Hospital Inpatient, Outpatient, and Non-Claims. Inpatient cost increases may also be tied to the DRG hospital rate increase for 2023 (see page 64). Professional Primary Care spending decreased for 9 of the 17 Medicaid payers in the measurement period.

Heat map showing which service categories had the most influence on total growth in per member per month spending for each Medicaid payer, 2022-2023*

*The percentages in the table below reflect the percent increase in per member per month spending (unadjusted) by service category, while the cells are colored based on the total absolute dollar PMPM change. The **darker** the cell color, the higher the absolute dollar change. Categories with darker cells had more influence on the payer's overall spending growth. Columns in **grey** are payers whose Medicaid cost growth was indeterminant or under the target. Payers with green columns exceeded the target with statistical confidence.*

	Advanced Health	AllCare CCO	Cascade Health	CPC-CareOregon	EOCCO-Moda	Health Share	IHN-Samaritan	Jackson CCO-CareOregon	Medicaid FFS/ Open Card	Pacific Source-Central OR	Pacific Source-Gorge	Pacific Source-Lane	Pacific Source-Marion Polk	Trillium CCO Southwest	Trillium CCO Tri-County	Umpqua CCO	Yamhill Community Care
Inpatient	8.1%	15.0%	-7.5%	15.3%	7.7%	9.3%	9.2%	15.4%	-13.5%	24.3%	26.8%	7.4%	7.7%	11.3%	0.2%	5.7%	11.1%
Outpatient	33.6%	9.4%	-5.3%	15.5%	6.7%	11.6%	3.0%	4.9%	9.2%	16.1%	4.1%	9.8%	21.7%	8.7%	5.1%	9.5%	12.2%
Professional PCP	17.0%	-5.8%	-15.1%	11.0%	-6.2%	7.3%	-0.5%	13.2%	-4.9%	0.2%	-7.4%	-6.8%	-6.3%	-1.6%	11.7%	3.1%	-9.4%
Professional Specialty	4.7%	12.5%	7.5%	4.9%	8.4%	2.3%	14.6%	3.9%	10.7%	5.5%	6.0%	3.6%	5.7%	-2.1%	7.9%	14.3%	16.0%
Professional BH	9.6%	71.8%	62.8%	60.8%	61.6%	11.1%	23.1%	44.8%	35.0%	36.8%	27.6%	30.3%	20.9%	38.0%	19.3%	64.5%	22.4%
Professional Other	13.8%	35.7%	6.4%	15.0%	1.6%	1.9%	23.8%	6.5%	8.2%	18.8%	1.3%	2.4%	11.3%	-5.9%	7.5%	-	5.7%
Long Term Care	68.5%	11.8%	16.9%	26.0%	69.5%	22.1%	16.2%	-3.6%	27.0%	165.3%	98.1%	67.4%	68.1%	-35.7%	36.3%	23.2%	93.8%
Medical Pharmacy	5.9%	16.0%	-21.7%	20.2%	7.3%	14.4%	13.5%	15.6%	-4.4%	14.8%	-0.9%	15.8%	9.7%	7.7%	-10.1%	19.9%	17.1%
Retail Pharmacy (gross)*	5.8%	8.6%	14.4%	13.9%	9.2%	5.8%	-2.2%	7.6%	10.2%	4.1%	5.5%	0.2%	-0.0%	4.4%	12.1%	15.8%	8.0%
Claims Other	20.7%	-20.1%	55.6%	-0.3%	2.3%	9.7%	8.3%	5.1%	-7.5%	7.6%	8.4%	16.5%	3.1%	10.3%	18.9%	16.8%	13.5%
Non-Claims	-17.8%	1.3%	-6.9%	28.0%	-15.9%	0.1%	16.3%	20.5%	33.2%	0.2%	-19.9%	0.2%	5.7%	13.4%	-13.0%	5.0%	9.0%

**Note that retail pharmacy rebate data is incomplete at the payer level for Medicaid, as most pharmacy rebates are received at the state level and only a small proportion are processed by CCOs. Open Card retail pharmacy growth is gross of pharmacy rebates.*

Medicaid Market - Growth in Net Cost of Private Health Insurance (NCPHI), 2022-2023

The Net Cost of Private Health Insurance (NCPHI) I is the difference between premiums collected by insurers and the money they pay out to cover the cost of medical care. NCPHI covers the cost of plan administration, marketing and quality improvement efforts, and also includes insurer profits.

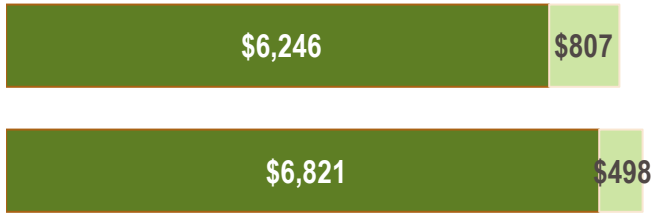
NCPHI for Medicaid Coordinated Care Organizations (CCOs) does not include payments made by OHA earmarked for hospitals in the form of Directed Payments, which are generally passed through and are not included in operating margin calculations. Furthermore, NCPHI includes dual-eligible members and their relevant Medicaid expenses and payment streams. Net operating margin for CCOs in 2023 was $173 million, down –47% from 2022.[28]

Among CCOs, NCPHI shrank -38.2% from 2022-2023, following growth of 49.5%, 26.8%, and 46.5% from 2020-22, respectively. The growth in prior years was likely due to changes in health care utilization during the COVID-19 pandemic.

As noted above, pandemic-era Medicaid policies paused regular determinations of member eligibility, resulting in a rapid increase in enrollment. During the same time, health care expenses remained low, resulting in increased NCPHI for CCOs. The decrease in NCPHI seen in 2023 likely reflects increased reimbursement rates with contracted providers and increased utilization.

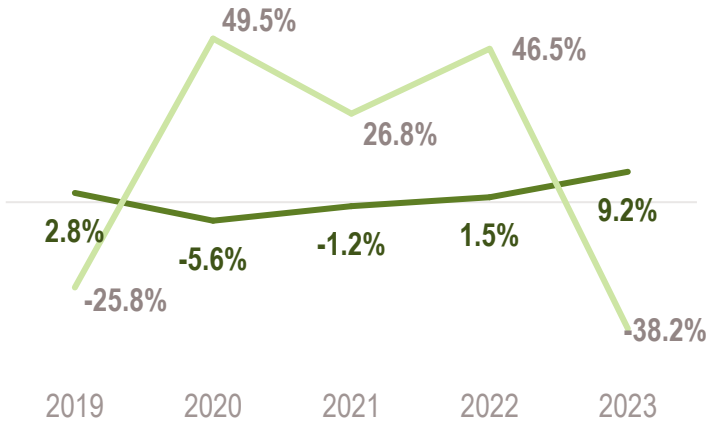
Per person per year expenditures, 2022-2023, Medicaid CCOs

Total Health Care Expenditures (darker) | NCPHI (lighter)



Percent change in **THCE** vs. **NCPHI**, 2018-2023

Years are year 2 of a 2-year period, e.g., “2023” for 2022-2023



[28] CCO Exhibit L submissions.

Appendix A: 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. It is measured at the state, payer, and provider level.	An analysis of what was driving health care cost growth in a measurement period, for example, growth in prices or growth in utilization.
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.

Cost Growth Target Performance

Data Sources

Cost Growth Target Data Submissions

Total health care expenditure data for calendar years 2022-2023 was collected in the 2024 CGT data submissions. These files were submitted by mandatory data reporters in September 2024.

Mandatory reporters include payers and third-party administrators (TPAs) with at least 1,000 covered Oregon lives across all lines of business. 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.

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

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

Other Data Sources

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

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

OHA also compiles data to calculate the Net Cost of Private Health Insurance from the CMS MLR resources website and National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) reports provided by DCBS or from payers.

Market Specific Notes

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).

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.

The methodology applied to Medicaid Open Card data for the 2022-2023 period differs from methods applied in previous years. In previous data cycles, only Open Card members with enrollment data during the year and at least one claim were included, and that claim did not have to have a matching enrollment record in the same month. This methodology helped filter out many Open Card members who have only a single month of enrollment prior to being moved to a CCO. In this report, Open Card members must have enrollment data in the month of any claims included in the total Open Card costs. OHA continues to work to improve methodologies for monitoring Medicaid Open Card cost growth.

This year's Medicaid data also includes funds for carve-outs, or services for CCO members that are covered by Medicaid fee-for-service. Carve out costs have been excluded from Open Card TME but included in Medicaid Total Health Care Expenditures.

Dual Eligible Members

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

When reporting Total Medical Expenditures, spending for dual eligible members are reported on a *paid amount* basis (unlike other cost growth target TME data, which is reported on an allowed amount basis). Spending for dual eligible members is reported for paid amounts because some duals spending would be excluded if only the allowed amounts were reported.

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

Exclusions

The Cost Growth Target program excludes the following:

- Health care spending for out-of-state residents who received care from Oregon providers and people without insurance.

- Certain benefit plans, including accident policy; disability policy; hospital indemnity policy; long-term care insurance; Medicare supplemental insurance (AKA Medigap); stand-alone prescription drug plans; specific disease policy; stop-loss plans; supplemental insurance that pays deductibles, copays, or coinsurance; vision-only insurance; workers compensation; and dental-only insurance.
- Certain payments, including CMS reconciliation payments (such as Medicare sweep or Part D) and ACA risk transfer payments.
- Premium payments made by people to their health plan.
- Payer reinsurance recoveries or reinsurance premiums.
- Discounts and other perks, such as gym memberships.
- COVID-related funds that are *not* paid to providers.

Data Validation

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

A data submission is considered validated when OHA and the payer have had a chance 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.

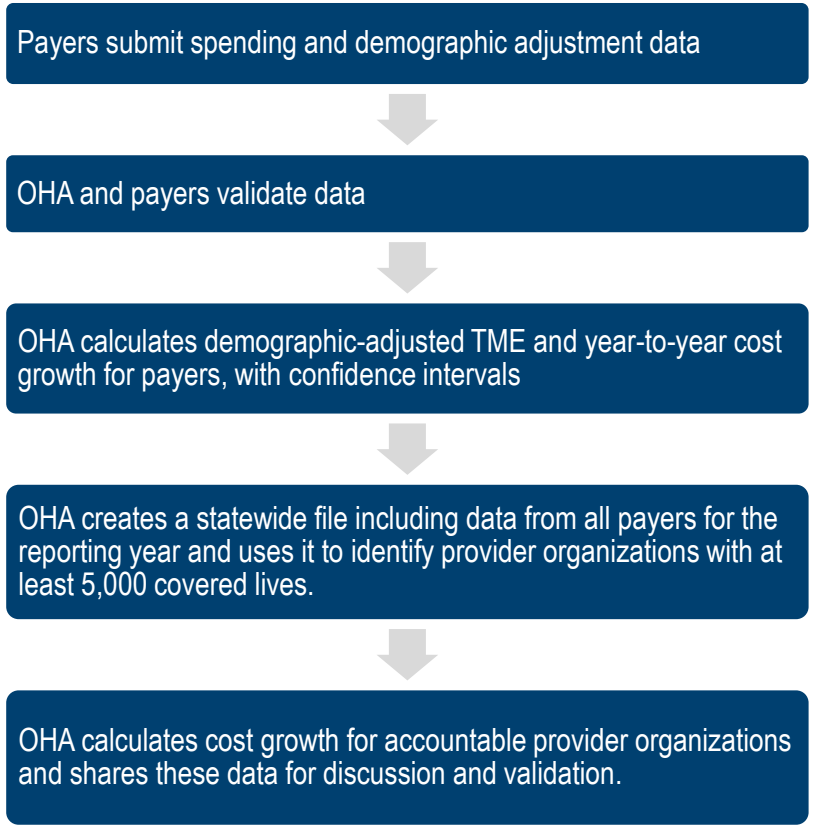
Stage 2: Detailed review for trends and outliers
OHA produces and reviews cost growth trends for each data submitter for each market in which they have sufficient members. If any potential issues are identified, OHA will communicate with the data submitter during Stage 3.

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.

The data validation process with provider organizations:



Adjustment

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

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 2022-2023, payers submitted unadjusted and adjusted spending data using demographic risk adjustment methodology provided by OHA.

OHA used demographically adjusted data to calculate cost growth trends at the payer and provider level. OHA used unadjusted data to calculate the state and market level trends for this report, but also calculates the demographically adjusted state and market level trends to provide an appropriate comparison for payer and provider organization cost growth.

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

Cost Growth Target Analysis

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

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

THCE is reported as total dollars spent and on a per person per year (PPPY) basis. The year-over-year growth rate for both total dollars and PPPY is calculated between 2022-2023.

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

TME is reported as total dollars spent and on a per person per year (PPPY) basis at the state, market, payer, and provider organization level. The year-over-year growth rate for both total dollars and PPPY is calculated between 2022-2023.

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

Measuring cost growth against the target for payers and provider organizations

When reporting on health care cost growth relative to the target for payers and provider organizations, the cost growth target program uses TME.

- For payers, growth in TME is reported on a per person per year basis, demographically adjusted and net of pharmacy rebates.
- For provider organizations, growth in TME is reported on a per person per year basis, demographically adjusted and gross of pharmacy rebates. Pharmacy rebate data are not available at the provider organization level.

Payer and provider cost growth are presented as the percent increase in per person spending from 2022 to 2023; the dollar amount of per person per year spending in each measurement year is not reported at the payer and provider organization level.

Full claims and partial claims

Oregon collects both full and partial claims spending from payers. Full claims data are reported when a payer has information about all direct claims and any claims paid by a delegated entity.

Partial claims are those where a payer only has limited data because benefits are carved out or provided by others. Some payers carve out benefits (e.g., prescription drugs or behavioral health care services) by contracting with another entity that takes on the responsibility of

paying for those carved out services. Payers estimate these costs.

In the Commercial market, OHA only uses full claims to calculate TME for payers and provider organizations because partial claims cannot be fully allocated on a per person basis.

Dual Eligible members

When reporting cost growth for the Medicare and Medicaid markets at the payer and provider level, the costs of dual eligible members are excluded.

Attribution to provider organizations

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

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

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

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

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

Not all members are attributed to provider organizations. In 2021, 61% of all individuals were attributed to provider organizations; 62% in 2022.

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. Does not include physician-administered medications.	
Medical Pharmacy	
Physician-administered drugs, as identified in a list of CPT/HCPCS codes developed by OHA and shared with CGT data submitters. Medical pharmacy costs overlap with costs also reported in other claims categories, with the exception of Retail Pharmacy, which does not overlap with Medical Pharmacy.	

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

Price vs. Utilization Analysis

Data Sources – Oregon's All Payer All Claims database (APAC)

The data source for the cost driver/price vs. utilization analysis is Release 23 of the Oregon All Payer All Claims (APAC) database, which was refreshed in Q4 2024 and published on March 21, 2025. The APAC data used includes monthly eligibility files as well as medical and pharmacy claims.

APAC contains data representing roughly 92% of Oregon residents, though it lacks data on spending by some self-insured plans, as well as federal programs such as Tricare and Veteran Affairs. Data in APAC are received from insurance companies, third party administrators, pharmacy benefits managers and the State of Oregon (Medicaid). In 2018, APAC contained medical and pharmaceutical spending data for approximately 100% of the fully-insured commercial population, 36-61% of the self-insured commercial population, 96% of Medicaid members, and 100% of the Medicare population. These data represent 5,891,642 people total or 3.4 to 3.9 million people annually, compared with the current state population of approximately 4.3 million people. About 1 percent of the people in APAC do not reside in Oregon but are included because they were insured by the Oregon Public Employee or Educator Benefit Board (PEBB or OEBB).

For more information about Oregon's APAC program, visit https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/All-Payer-All-Claims.aspx.

Inclusion and Exclusion Criteria

This report includes data from medical and pharmaceutical claims for services rendered from 2018-2023 for Oregon residents with Commercial, Medicaid, Medicare Advantage, and Traditional Medicare insurance coverage. Medicare members with secondary coverage through Medicaid (the Oregon Health Plan), known as Medicare/Medicaid Duals, are included in the statewide analysis but excluded from the Medicare and Medicaid level analyses. Individuals with only medical coverage and no pharmaceutical coverage in APAC were excluded to avoid underestimating per-person pharmaceutical costs. Individuals with only pharmaceutical coverage and no medical coverage were also excluded.

For spending, this report only includes claims-based spending for people who utilized health care services during the measurement years. Individuals may be covered by more than one health plan, and their coordination of benefit claims are included in the report. The data used in this analysis do not include dental claims, administrative spending, profits, or non-claims spending such as value-based payments or alternative payment methodologies. The dollar amounts in this

report include both member-paid cost sharing such as patients' copays and deductible payments as well as plan-paid amounts.

Measures

Service Categories

To calculate price and utilization trends, OHA first categorized all services into service categories. The service categories in this report were defined by place of service, bill type and revenue codes. All spending was categorized as inpatient, emergency department, outpatient, professional services or retail pharmacy. Any remaining costs that were not included in these categories were assigned to the "other" category. As long as one claim line has been assigned with a service category, that category will be applied to all claim lines in that claim, so there's one service category per claim. The categories are mutually exclusive based on a hierarchical order in medical claims: inpatient, ED, outpatient professional, and other. Detailed definitions of the service categories are as follows. Note that definitions of service categories for cost driver analysis are different from those for cost growth target performance.

Service Category	Specifications
Inpatient Care	Claims with at least one claim line has one or more of the following codes. • Types of bill code start with 11, 12, 17, 82 • Revenue codes start with 010-017 • Place of service codes are 21, 51, 55, 56, 61
Emergency Dept.	Claims not categorized as inpatient care with at least one claim line has one or more of the following codes. • Revenue codes start with 045 or is 0981 • Place of service code is 23
Outpatient Care	Claims not categorized as inpatient care or ED with at least one claim line has one or more of the following codes. • Types of bill code start with 13, 14, 32-34, 71-77, 85 • Place of service codes are 19, 22
Professional	Claims not categorized as inpatient care, ED, or outpatient care with at least one claim line meets one of more the following conditions. • Place of service codes are 03, 11, 17, 20, 24, 49, 50, 53, 57, 60, 62, 65, 71, 72

Service Category	Specifications
	• Place of service code is 12 and no type of bill codes or types of bill codes do not start with 32-34.
Other	Medical claims that are not categorized as inpatient, ED, outpatient, or professional.
Retail pharmacy	All the pharmaceutical claims

Behavioral Health

Behavioral health (BH) services are identified based on the diagnosis codes in the combination of procedure codes, revenue codes. BH services and spending are flagged at the claim-line level. Below is the table of BH diagnosis codes.

Behavioral Health ICD-10-CM Diagnosis Codes

ICD-10 Code	Description	Exclusions
F01 – F09	Organic, including symptomatic, mental disorders	
F10 – F16.99	Mental and behavioral disorders due to psychoactive substance use	
F17	Nicotine Dependence	
F18 – F19.99	Inhalant Related Disorders	
F20 – F29	Schizophrenia and Delusional disorders	
F30 – F39	Mood disorders	Excluding F38 Other mood [affective] disorders
F40 – F48	Neurotic, stress-related, somatoform disorders	
F50 – F59	Behavioral syndromes	Excluding F54 (Psychological and behavioral factors associated with disorders or diseases classified elsewhere), F55 (Abuse of non-dependence-producing substances)
F60 – F69	Disorders of adult personality and behavior	Excluding F61 (Mixed and other personality disorders) and F62 (Enduring personality changes, not

		attributable to brain damage and disease)
F80 – F89	Disorders of psychological development	Excluding F83 (Mixed specific developmental disorders)
F90 – F98	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	Excluding F92 (Mixed disorders of conduct and emotions)
F99	Mental disorder, not otherwise specified	
T14.91	Suicide attempt	
T40	Death – poisoning by opium, heroin, other opioids, methadone, synthetic narcotics, unspecified narcotic	
R41.82	Altered mental status, unspecified	
R45	Symptoms and signs involving emotional state	

Inpatient BH claim lines are identified using the inpatient service category defined in the “Service Category” section and the presence of a principal BH diagnosis. BH claim lines in other care settings are flagged independently of the service categories. This analysis does not include BH prescription drugs.

Service Category	Specifications
Inpatient Care	Claim lines categorized as inpatient and with a BH principal diagnosis code.
Emergency Dept. **Outpatient Care** **Professional** **Other**	• Claim lines not categorized as inpatient and with – a revenue code starting with 045 or equal to 0981, or place of service equal to 23; **and** – a BH principal diagnosis code • Claim lines not categorized as inpatient and with – a revenue code starting with 051, 052, or equal to 0944, 0945, 0982, 0983, 1000, 1001, 1002; **and** – a BH principal diagnosis code • Claim lines not categorized as inpatient and with – a revenue code starting with 090 or 091; **and** – a BH diagnosis code in any position on a claim line

Service Category	Specifications
	• Claim lines not categorized as inpatient and with – a place of service code equal to 02, 03, 04 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72; **and** – a procedure code equal to 96372, 97530, 97535, 97110-97112, 97803, 98960-98962, 98966-98969, 99078, 99199, 99201-99205, 99211-99215, 99221-99223, 99231-99233, 99238-99239, 99241-99245, 99251- 99255, 99291, 99304, 99341-99350, 99354-99359, 99441-99444, 99483-99484, 99487, 99489-99491, 99510, 99534, 99381-99387, 99391-99397, 99510, 99401- 99404, 99406-99409, 99411-99412, G0463, G0480-G0483, G0506, G8427, G9004-G9012, T1006, T1012, T1015, T1023, or T1027; **and** – a BH principal diagnosis code • Claim lines not categorized as inpatient and with – a place of service code equal to 02, 03, 04 05, 07, 09, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 24, 33, 49, 50, 52, 53, 57, 71, 72; **and** – a procedure code equal to 90785; 90791- 90792, 90832-90840, 90845, 90846, 90847, 90849, 90853, 90863, 90865, 90867-90870, 90875, 90876, 90880, 90882, 90887, 96105, 96110, 96112, 96113, 96116, 96121, 96125, 96127, 96130-96133, 96136-96139, 96146, 99492-99494, G0396, G0397, G0155, G0176, G0177, G0409, G0410, G0411, G0442, G0443, G0451, G0468- G0469-G0470, G0512, G2067-G2080, H0001, H0002, H0004, H0007, H0010- H0020, H0022-H0023, H0031-H0040, H0047, H0049, H0050, H1005, H2000, H2001, H2010-H2020, H2027, H2035, H2036, J0571-J0575, J1230, J2315, J3490, S0109, S0201, S9475, S9480, S9484, S9485; **and** – a BH diagnosis code in any position on a claim line
Retail pharmacy	BH retail pharmacy claims are excluded from the analysis.

Cost per Person

The annual per-person spending amounts are calculated by dividing all spending in a health insurance market (e.g., Medicaid, Commercial, Medicare) by the total number of unduplicated individuals who had health insurance coverage in

that market. This means that the covered individuals with no health care utilization are also included in the denominator when calculating the annual cost per person. The spending amounts include both payer-paid amounts and members cost-share. The dollar amounts and trends presented in this report are not adjusted for inflation or risk-adjusted in any way.

Utilization

To measure the health care utilization, this report uses the utilization rates per 1,000 individuals to control for shifts in the size of enrolled population.

- Inpatient utilization was calculated by the number of discharges.
- Pharmacy utilization was calculated using 30-day equivalents. CMS determines the 30-day equivalent supply as follows: If the days' supply reported on a prescription drug event (PDE) is less than or equal to 34, the number of 30-day equivalent supplies equals one. If the days' supply reported on a PDE is greater than 34, the number of 30-day equivalent supplies is equal to the number of days' supply reported on each PDE divided by 30.
- The unit of analysis for ED, outpatient, professional services, and other services is the number of claims.
- The claims with paid amounts equal to or smaller than 0 are excluded from utilization counts.

Price

- This report calculated the price by summing all the paid amounts, including payer-paid amounts and members cost-share for a given year and dividing by the total number of units defined in utilization section. The results are the average mean paid amounts for that year. The claims with paid amounts equal to or smaller than 0 are excluded from the price analysis.

Medical Pharmacy Analysis – APAC

To measure medical pharmacy costs in Medicare, OHA pulled any medical claim that matched the specifications below:

- For total spending on medical pharmacy in 2023, included all claim lines that either had a non-null value for the National Drug Code (NDC) data field, or that had a HCPCS or CPT code matching any codes on the code list developed by OHA and shared with cost growth target mandatory data submitters for the 2024 data submission, available here. The codes in this document originate in the following sources:
    - All codes included in quarterly updates of the Medicare Part B Average Sales Price Files from October of 2017 through April of 2024.
    - All HCPCS/CPT codes with a status indicator of G, K or L in the Outpatient Prospective Payment System (OPPS)'s Addendum B, January updates, 2018-2024.
    - All HCPCS codes from PDAC's NDC/HCPCS crosswalk, January updates from 2017-2024.
    - BETOS list generated using BETOS code categories D1G (Drugs Administered through DME), O1C (Enteral and Parenteral), O2D (Chemotherapy), O1E (Other Drugs), and O1G (Influenza Immunization). The list only includes codes not in the lists above, and certain codes for drug administration or related supplies were individually removed.
- For per member per year costs across years on medical pharmacy, only claim lines matching the HCPCS/CPT code list were used. NDC codes were a new field in APAC for 2022-2023 data and this data field is more complete for 2023, so using this field to identify medical pharmacy claims across years would cause an over-estimate of the amount of cost growth between the two years.
- Per member per year costs and utilization at the individual drug level were calculated using claim lines that matched a list of HCPCS/CPT codes for drugs that are separately billable under the Outpatient Prospective Payment system (OPPS). Drugs with a status code of G, K or L in the January release of OPPS Addendum B anytime from 2017-2024 were included. In calculating growth in price and utilization of separately billable drugs:
    - Price was the total allowed amount (payer paid + patient responsibility) of any matching lines, divided by the number of service units billed for in the claim.
    - Utilization was the number of service units for all matching claim lines per person.

Appendix B: Historical Cost Growth Performance

Since implementing the Cost Growth Target Program, payers and provider organizations have encouraged OHA to consider cost growth in the context of a wider historical trend. OHA acknowledges the value of multi-year analysis; a payer or provider organization may have cost growth below the target in one measurement period and exceed the target in the next period. The relationship of annual growth from one period to another was especially clear during the COVID-19 pandemic, which saw steep drops in spending from 2019 to 2020 and rebounding growth from 2020 to 2021 and to a certain extent from 2021 to 2022.

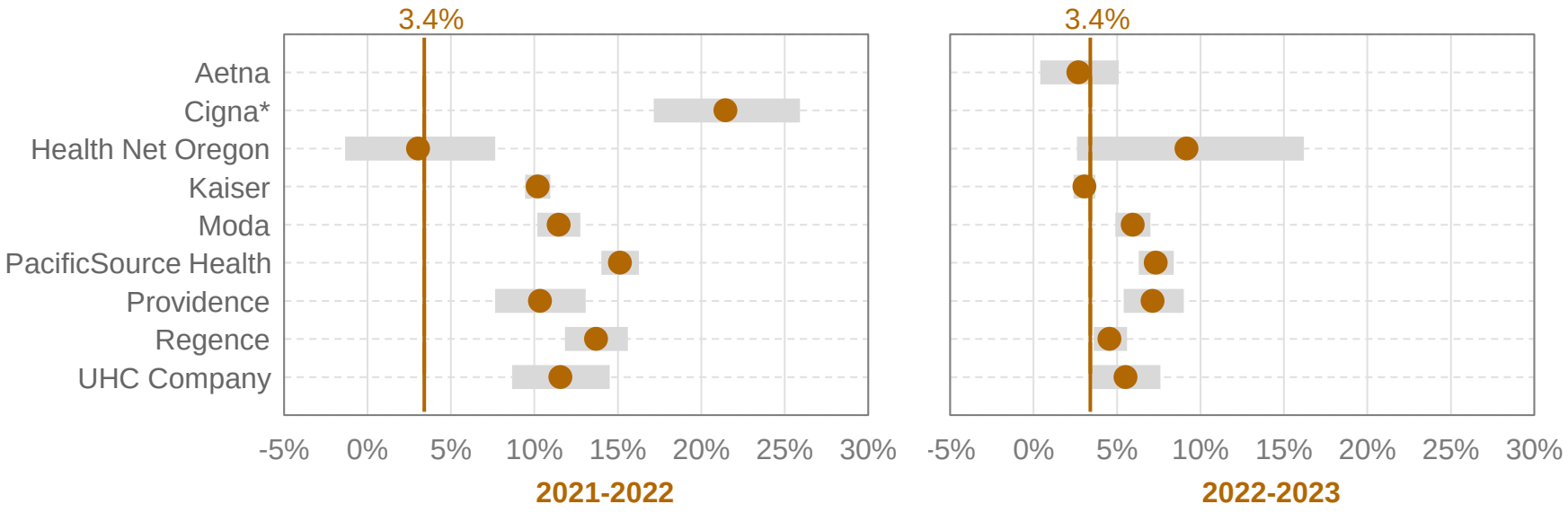
The Cost Growth Target Program has flexibility to consider multi-year trends when determining accountability. Before putting a payer or provider organization on a Performance Improvement Plan (PIP) when their cost growth exceeds the target, OHA and the entity discuss whether cost growth was due to an acceptable reason (see pages 13-14). If growth was low one year and above the target the next year for an acceptable reason, OHA will determine the cost growth reasonable, and the payer or provider organization would not be subject to a PIP. In designing the program, the Cost Growth Target Implementation Committee also recommended that financial penalties would only be applicable if a payer or provider organization exceeded the cost growth target in three out of five years without an acceptable reason, leaving room for some variation in growth from period to period.

Although cost growth during 2022-2023 is the focus of this report, OHA is committed to explaining and contextualizing payer and provider organization cost growth trends. The tables and graphs in this appendix provide an easy reference for each payer's cost growth over the most recent two years of reporting. Similar tables and graphs will be shared for providers when their data have been validated for the period.

Historical cost growth for payers by market, 2021-2023

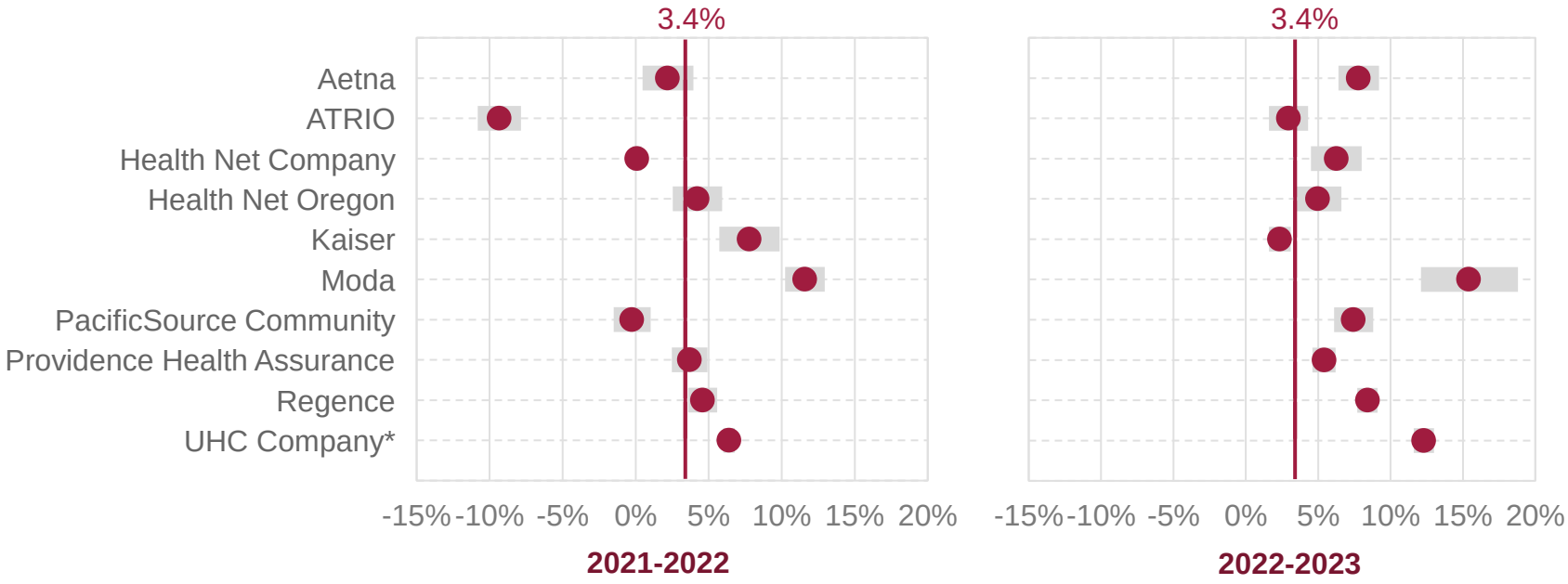
Entities marked with an asterisk (*) in charts were not included in public cost growth target reporting for either the 2021-2022 cycle or the 2022-2023 cycle.

Cost Growth for Commercial Payers



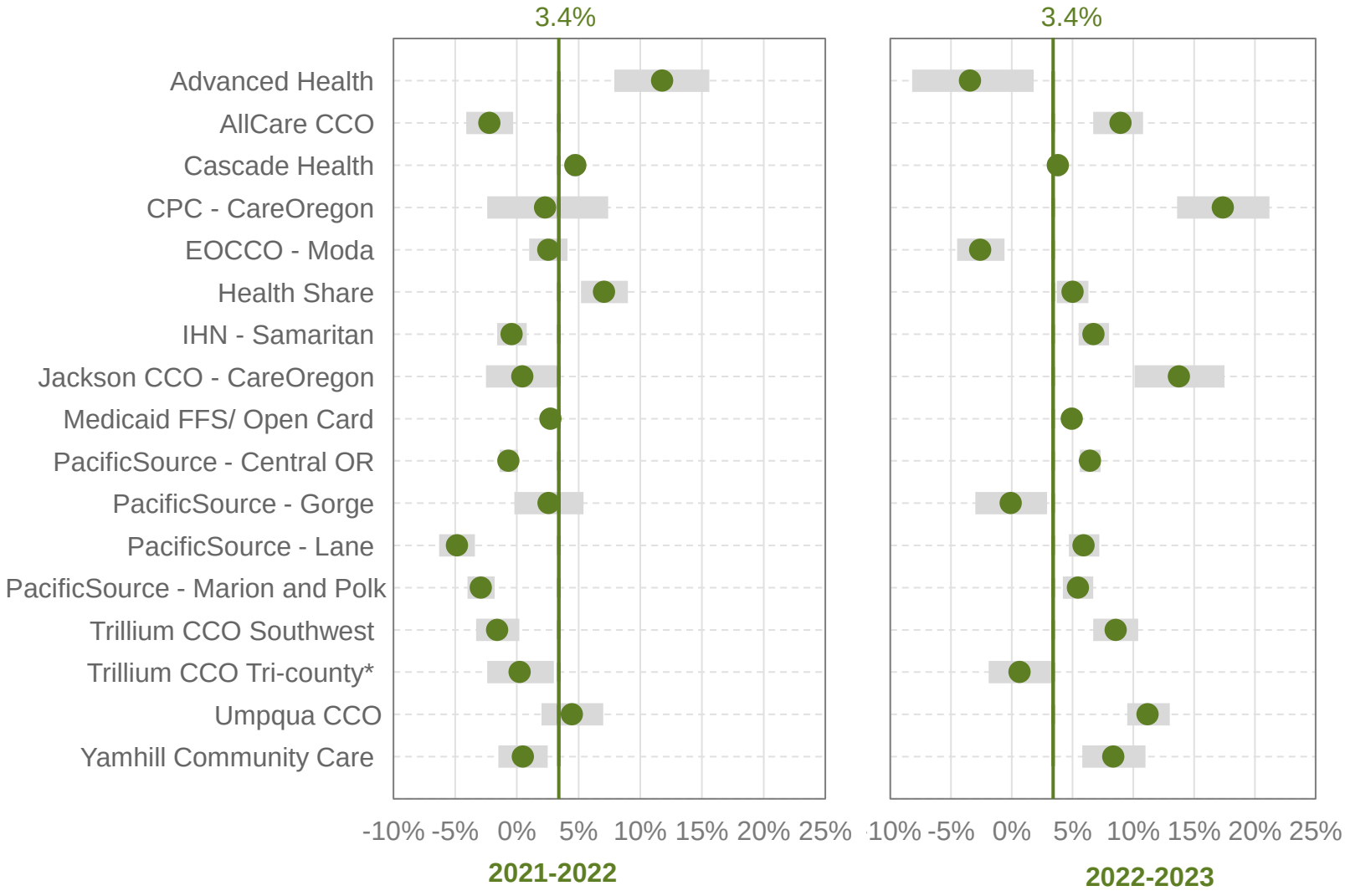
Commercial Payer	2021-22 Cost Growth	2021-22 Target Performance	2022-23 Cost Growth	2022-23 Target Performance
Aetna	-2.2%	Met	2.7%	Indeterminate
Cigna*	0.4%	Met	--	--
Health Net Oregon	-1.1%	Met	9.2%	Indeterminate
Kaiser	0.3%	Met	3.1%	Indeterminate
Moda	-0.1%	Met	5.9%	Not Met
PacificSource Health	2.8%	Indeterminate	7.3%	Not Met
Providence	1.0%	Met	7.1%	Not Met
Regence	3.5%	Indeterminate	4.6%	Not Met
UHC Company	-0.9%	Met	5.5%	Not Met

Cost Growth for Medicare Advantage Payers



Medicare Advantage Payer	2021-22 Cost Growth	2021-22 Target Performance	2022-23 Cost Growth	2022-23 Target Performance
Aetna	2.2%	Indeterminate	7.8%	Not Met
ATRIO	-9.3%	Met	3.0%	Indeterminate
Health Net Oregon	4.2%	Indeterminate	5.0%	Not Met
Health Net Company	0.1%	Met	6.3%	Not Met
Kaiser	7.8%	Not Met	2.3%	Met
Moda	11.6%	Not Met	15.4%	Not Met
PacificSource Community	-0.3%	Met	7.4%	Not Met
Providence Health Assurance	3.7%	Indeterminate	5.4%	Not Met
Regence	4.6%	Not Met	8.4%	Not Met
UHC Company	6.4%	Not Met	12.3%	Not Met

Cost Growth for Medicaid Payers



Medicaid Payer	2021-22 Cost Growth	2021-22 Target Performance	2022-23 Cost Growth	2022-23 Target Performance
Advanced Health	11.8%	Not Met	-3.4%	Met
AllCare CCO	-2.2%	Met	9.0%	Not Met
Cascade Health	4.7%	Not Met	3.8%	Not Met
CPC - CareOregon	2.3%	Indeterminate	17.4%	Not Met
EOCCO - Moda	2.6%	Indeterminate	-2.6%	Met
Health Share	7.1%	Not Met	5.0%	Not Met
IHN - Samaritan	-0.4%	Met	6.7%	Not Met
Jackson CCO - CareOregon	0.4%	Indeterminate	13.8%	Not Met
Medicaid FFS/ Open Card	2.7%	Met	5.0%	Not Met
PacificSource - Central OR	-0.7%	Met	6.5%	Not Met
PacificSource - Gorge	2.6%	Indeterminate	-0.1%	Met
PacificSource - Lane	-4.9%	Met	5.9%	Not Met
PacificSource - Marion Polk	-2.9%	Met	5.5%	Not Met
Trillium CCO Southwest	-1.6%	Met	0.7%	Met
Trillium CCO Tri-County	0.2%	Met	8.6%	Not Met
Umpqua CCO	4.5%	Indeterminate	11.2%	Not Met
Yamhill Community Care	0.5%	Met	8.4%	Not Met

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.

OREGON HEALTH AUTHORITY

HEALTH CARE COST GROWTH TARGET