Health Care Cost Growth Trends in Oregon, 2023-2024

2026 Sustainable Health Care Cost Growth Target Annual Report

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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.

About This Report

This report presents data on health care spending and health care cost growth in Oregon from 2023 to 2024. This report uses a total cost of care approach for a comprehensive look at health care spending across the state between 2023 and 2024.

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.

This report is accompanied by the Cost Growth Target 2023-2024 Databook.

Key Findings

Total Spending

Health care spending in Oregon in 2024 totaled $42.99 billion dollars, 6.7% more than spending in 2023.

On a per person per year basis, Total Health Care Expenditures (THCE) increased 6.7% between 2023-2024, above the cost growth target of 3.4%.

Growth in THCE per person per year was above the target in every market: 8.0% for Commercial, 3.8% for Medicare, and 10.1% for Medicaid.

Percent change in THCE PPPY, by market, 2023-2024

*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.

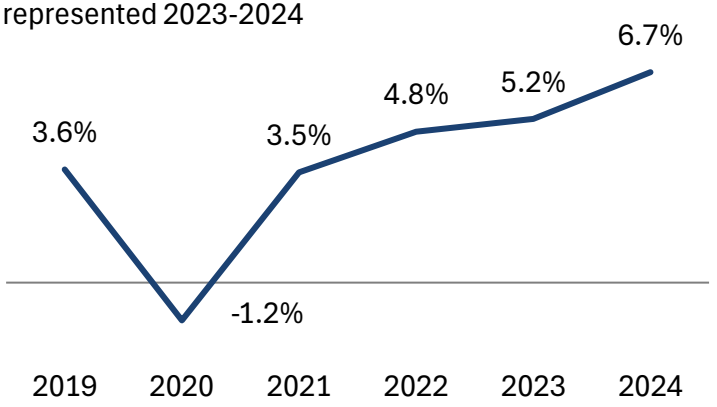
Statewide Cost Growth

Between 2023-2024, cost growth was the highest that it has been in Oregon across all measurement periods for which cost growth target data are available. **Statewide total health care expenditure (THCE) growth was 6.7% on a per person per year basis,** compared to 5.2% from 2022-2023 and 4.8% from 2021-2022.

- **Cost growth was high across all service categories except non-claims:** Spending increased across most service categories, with the exception of non-claims spending, which decreased by 9.1% on a per person basis.
- **Hospital Outpatient and Medical Pharmacy cost growth was driven by price increases:** Cost growth in Hospital Outpatient and Medical Pharmacy services was mainly driven by increases in unit cost (the average cost of a visit for outpatient and the average cost of a procedure for medical pharmacy) as opposed to utilization.
- **Cost growth in most other service categories was driven by increases in both price *and* utilization.** To supplement analysis of the cost growth target data collected from payers for the 2023-2024 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. The analysis suggests that the 2023-2024 cost growth was driven by both price and utilization in Hospital Inpatient, Emergency Department, and Professional services, while growth in Claims Other and Long-Term Care was driven solely by utilization.

Growth in Statewide Total Health Care Expenditures, Per Person Per Year, 2018-2024

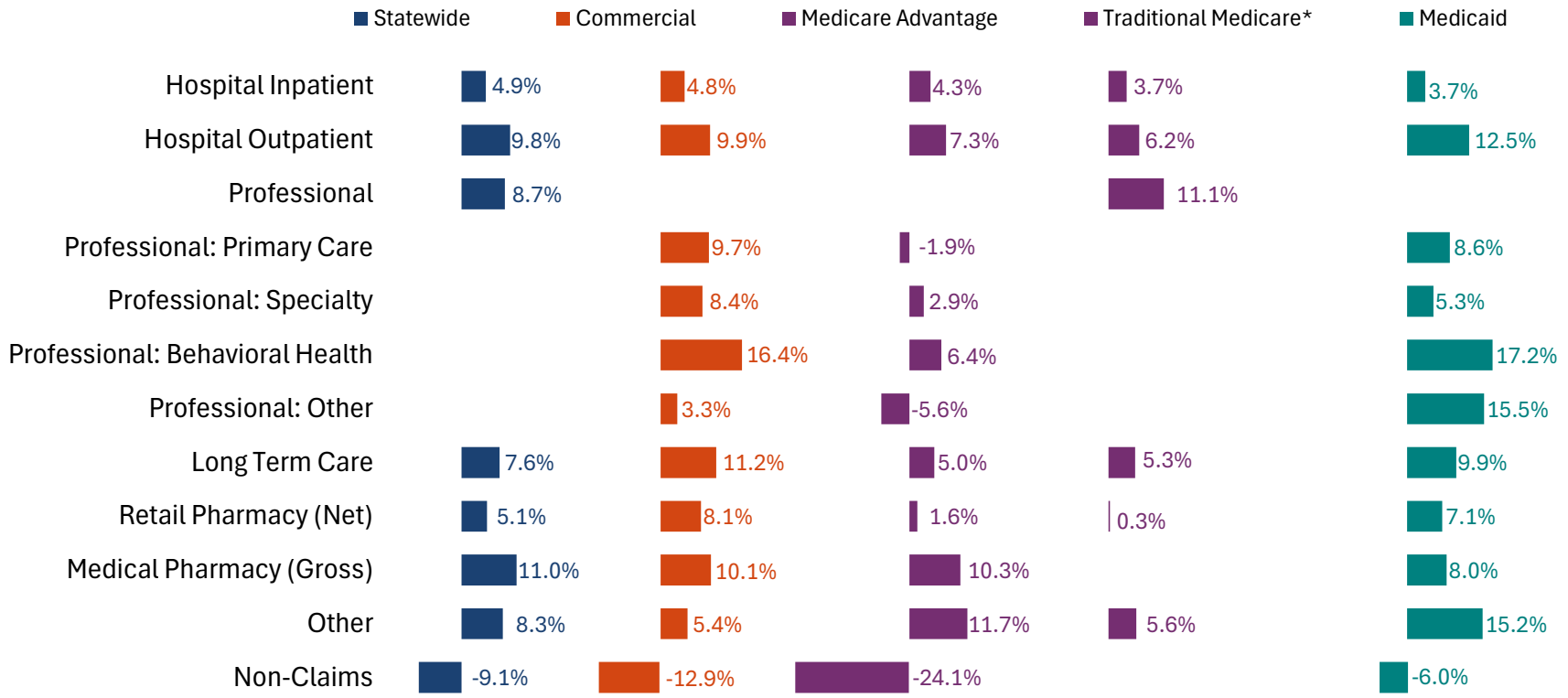
Years are year 2 of a 2-year period, e.g. "2024" represented 2023-2024



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 the Medicare Advantage market, to increases in Behavioral Health spending in the Commercial and Medicaid markets. Categories where spending increases across all markets exceeded Oregon's cost growth target of 3.4% include Hospital Inpatient, Outpatient, Behavioral Health, Long-Term Care, Medical Pharmacy, and Other.

Percent Change in PPPY Spending by Service Category, Statewide and Across Markets, 2023-2024



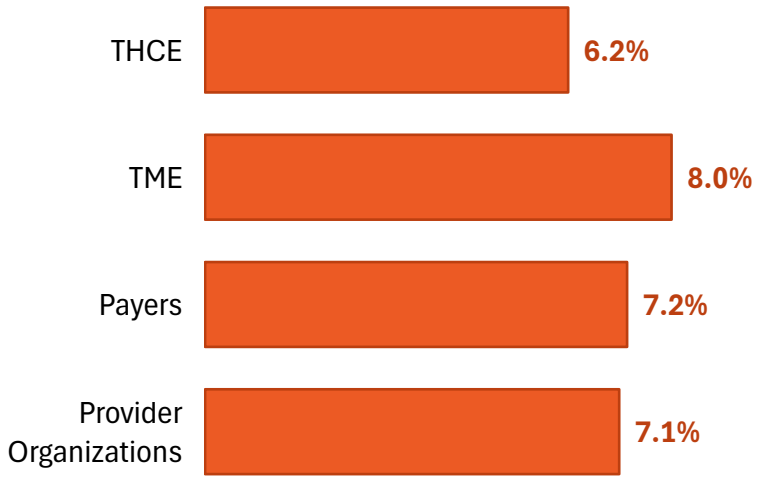
*Traditional Medicare data is submitted to OHA by the Centers for Medicare and Medicaid Services (CMS) with different service category breakouts that are not completely comparable to other Cost Growth Target data submissions.

Commercial Cost Growth

From 2023 to 2024, Total Health Care Expenditures (THCE) per person, inclusive of the net cost of private health insurance (NCPHI), grew 6.2% in the Commercial market, while Total Medical Expenses (TME) per person grew 8.0% (unadjusted). After adjusting for age and sex demographics, TME per person grew 7.2% for Commercial payers and 7.1% for provider organizations and independent provider associations.

- Commercial cost growth was highest for Hospital Outpatient (9.0%, or $176 per person per year) services, while Professional services contributed the most to spending growth (7.8% or $219 per person per year). Professional services include a 16.4% growth in per person per year spending for Behavioral Health services.
- Commercial cost growth for Hospital Outpatient and Medical Pharmacy services was driven by price increases. Commercial cost growth for Hospital Inpatient, Emergency Department, and Professional services was driven by both price and utilization, while growth in Other services, was driven only by utilization.
- NCPHI – the amount available to health plans for the administration, marketing, and profit – declined 9.8%. The percent of premiums collected by payers that went to cover medical claims increased from 84.9% in 2023 to 88.5% in 2024.

Commercial Cost Growth, 2023-2024



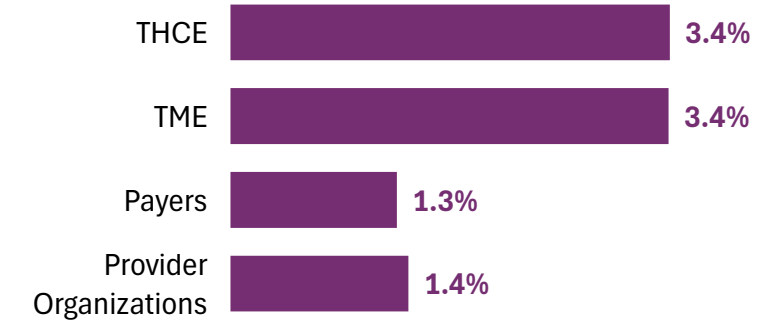
THCE and TME growth are changes in PPPY spending across Full and Partial Claims, net of rebates and unadjusted for demographics. Payer and provider organization cost growth are changes in PMPM using Full Claims and adjusted for sex/age. Payer growth is measured net of rebates, while provider organization growth is measured gross of rebates.

Medicare Cost Growth

From 2023 to 2024, Total Health Care Expenditures (THCE) per person, inclusive of the net cost of private health insurance (NCPHI), grew 2.3% in the Medicare market, while Total Medical Expenses (TME) per person also grew 3.4% (unadjusted). THCE and TME spending includes Traditional (Fee-For-Service) Medicare, Medicare Advantage, and Dual Eligibles (duals).

After adjusting for age and sex demographics and excluding duals, TME per person grew 1.3% for Medicare Advantage payers and 1.4% for provider organizations and independent provider associations.

Medicare Cost Growth, 2023-2024



THCE and TME growth are changes in per person per year spending across Medicare FFS and Medicare Advantage including duals, net of pharmacy rebates and unadjusted for demographics. Payer and provider organization cost growth are changes in per member per month for Medicare Advantage excluding duals, and adjusted for sex/age. Payer growth is measured net of rebates, while provider organization growth is measured gross of rebates.

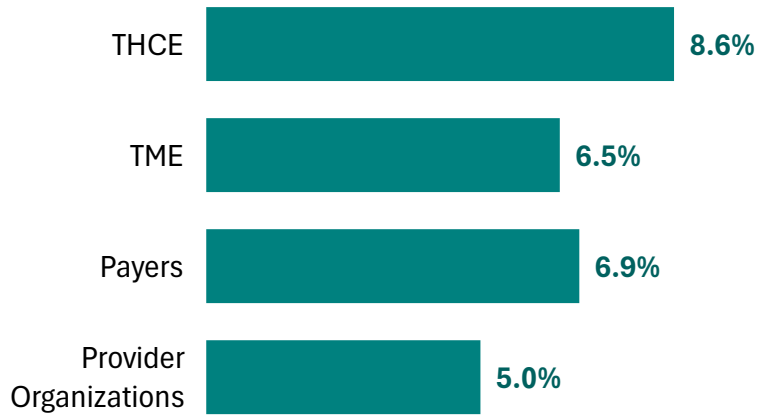
- For Medicare Advantage, Hospital Outpatient was the largest contributor to per person cost growth, rising 7.3% ($192) from 2023 to 2024. In Traditional Medicare, Professional services contributed the most, increasing 11.1% ($301). Both price increases and higher utilization were key drivers of the cost growth in these two service categories.
- Medical Pharmacy was another major cost driver. In Medicare Advantage, Medical Pharmacy (gross of rebates) grew 7.3% ($192) per person. Nearly half of the spending was for chemotherapeutic agents, which grew 17.2% over the period and was driven by increases in both price and utilization.
- Durable Medical Equipment (DME) had the highest per person spending growth (80.4%). The growth occurred primarily in Traditional Medicare and was driven by price increases.
- While per person claims spending growth in Medicare increased by 4.5% during this period, the cost growth was tempered by a significant decline in Non-Claims spending, which fell 24.1% (-$265) on a per person basis.
- Medicare Advantage NCPHI declined from $1,616 per person per year in 2023 to $1,510 in 2024 (-6.6%). The percent of premiums collected by payers going to cover medical claims increased from to 88.5% in 2023, to 89.2% in 2024.

Medicaid Cost Growth

From 2023 to 2024, Total Health Care Expenditures (THCE) grew 8.6% in the Medicaid market (inclusive of the net cost of private health insurance - NCPHI). Total Medical Expenses (TME) grew 6.5% (unadjusted). THCE and TME include spending for both Medicaid Open Card (Fee-For-Service) and Coordinated Care Organizations (CCO).

After adjusting for age and sex demographics, TME per person grew 6.9% for Medicaid payers and 5.0% for provider organizations and independent provider associations.

Medicaid Cost Growth, 2023-2024



THCE and TME growth are changes in PPPY spending , net of rebates and unadjusted for demographics. Payer and provider organization cost growth are changes in PMPM for Medicaid excluding duals, and adjusted for sex/age. Payer growth is measured net of rebates, while provider organization growth is measured gross of rebates·

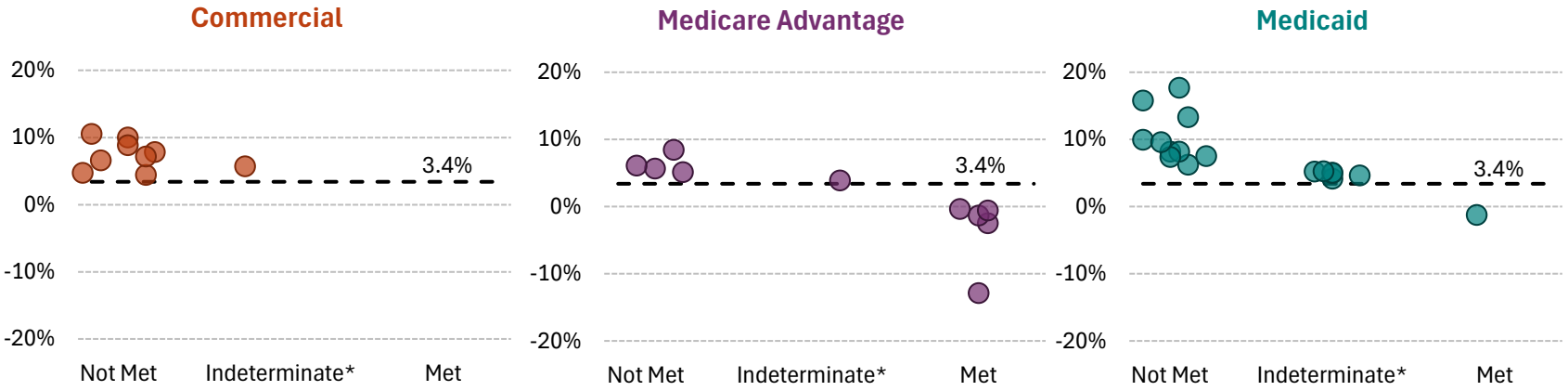
- More than a quarter of Medicaid cost growth resulted from increased spending on Professional Behavioral Health services (+17.2%, or $91 per person per year). Oregon House Bill 5202 (2022) increased behavioral health provider rates by an average of 30% beginning in mid-2022 for Medicaid FFS and 2023 for Medicaid CCOs. This rate increase drove both price and utilization of behavioral health services which continued through this measurement period.
- Hospital Outpatient was another major driver of cost growth in Medicaid with per person spending increased by 12.5% ($98). The increased spending was driven by price increases in Lab and Pathology services, and by both price and utilization across all other Outpatient procedure categories.
- Among Medicaid CCOs, NCPHI shrank -5.4% from 2023 to 2024, which was much less than the decrease of 38.2% from 2022 to 2023. In 2024, Medicaid redeterminations ended and membership levels returned to pre-COVID trends. The modest 5.4% decrease in NCPHI from 2023 to 2024 indicates increasing stability among most CCOs.

Cost Growth by Payer

Thirty-one payers are included in cost growth target reporting for 2023-2024. Payers are included in cost growth target reporting if they have at least 10,000 covered lives in a given market. Payers can be included in multiple markets. Of the 31:

- 9 are included for the Commercial market – none of them met the target.
  Commercial cost growth across all payers was 7.2%
- 10 are included for the Medicare Advantage market – five met the target.
  Medicare Advantage cost growth across all payers was 1.3%
- 17 are included for the Medicaid market – only one met the target.
  Medicaid cost growth across all payers was 6.9%

Distribution of Payer Performance Relative to the Cost Growth Target for **Commercial**, **Medicare Advantage**, and **Medicaid** Markets, 2023-2024



*Indeterminate means OHA could not determine with statistical certainty whether the payer had met the target.

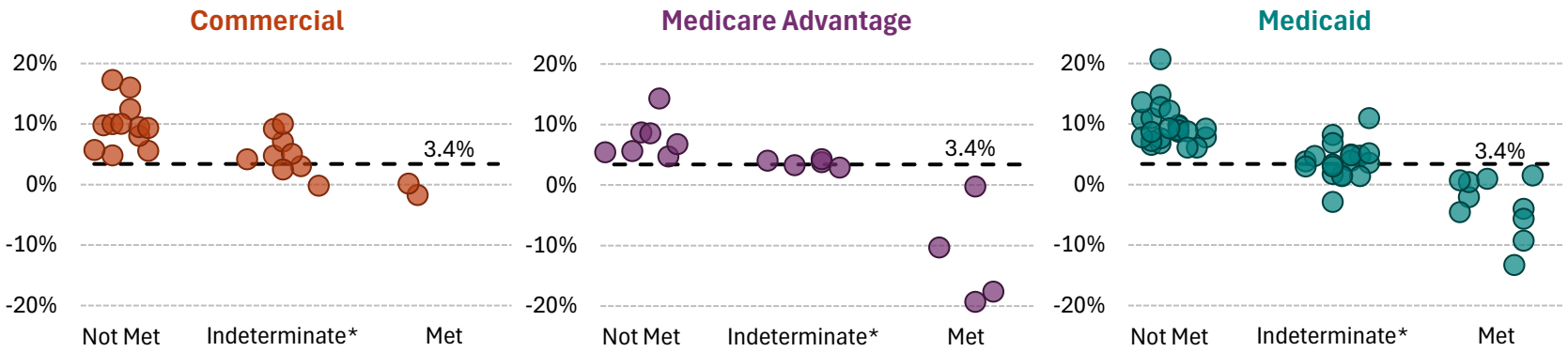
Market	# of Payers	# of Payers Met Target	2023-2024 Cost Growth at Payer Level
Commercial	9	0	7.2%
Medicare Advantage	10	5	1.3%
Medicaid	17	1	6.9%

Cost Growth by Provider Organization and IPA

Fifty-eight provider organizations and three Independent Provider Associations (IPAs) are included in cost growth target reporting for 2023-2024. Provider organizations can be included in multiple markets. Of those:

- 23 are included for the Commercial market – two met the target.
  Commercial cost growth across all provider organizations and IPAs was 7.1%
- 16 are included for the Medicare Advantage market – four met the target.
  Medicare Advantage cost growth across all provider organizations and IPAs was 1.4%
- 53 are included for the Medicaid market – eight met the target.
  Medicaid cost growth across all provider organizations and IPAs was 5.0%

Distribution of Provider Organization and IPA Performance Relative to the Cost Growth Target for **Commercial**, **Medicare Advantage**, and **Medicaid** Markets, 2023-2024



* Indeterminate means OHA could not determine with statistical certainty whether the provider organization had met the target.

Market	# of Provider Orgs	# of Provider Orgs Met Target	2023-2024 Cost Growth at Provider Org Level
Commercial	23	2	7.1%
Medicare Advantage	16	4	1.4%
Medicaid	53	10	5.0%

Table of Contents

Introduction

This report presents data on health care spending and health care cost growth in Oregon between 2023 and 2024. Building on the previous annual reports (covering spending from 2018 onward), this report presents information on total statewide health care spending, spending by market, 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 2023-2024 Databook.

In This Report

The Introduction provides background information on Oregon's cost growth target.

Chapter I explores health care cost growth trends between 2023 and 2024 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.

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.

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.*

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.

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

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 3.75% for the second five years (2026-2030).

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

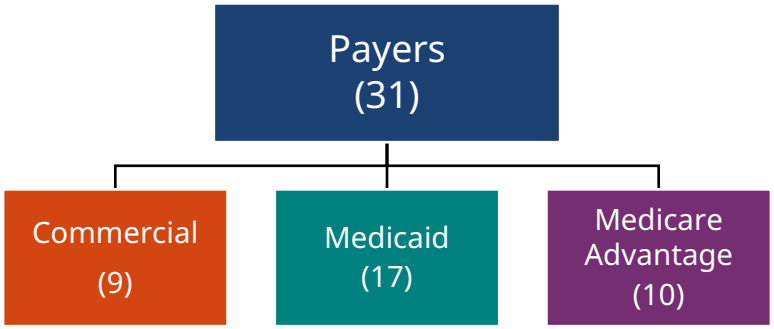
Reasons for health care cost growth are studied and publicized, informing policy recommendations.

Who is included?

In 2019, the Oregon Legislature passed Senate Bill 889, establishing the Sustainable Health Care Cost Growth Target Program, and convening an Implementation Committee under the direction of the Oregon Health Policy Board. The establishing legislation directs that all payers and health care providers be subject to the Cost Growth Program, but the Implementation Committee developed a specific set of inclusion criteria for reliable reporting.

Payers

All payers and third-party administrators (TPAs) with at least 1,000 members in Oregon must submit cost growth target data to the Oregon Health Authority. OHA identifies mandatory data submitters each year, using enrollment data from Medicaid enrollment reports and the Department of Consumer and Business Services.



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

Provider Organizations and Independent Physician Associations (IPAs)

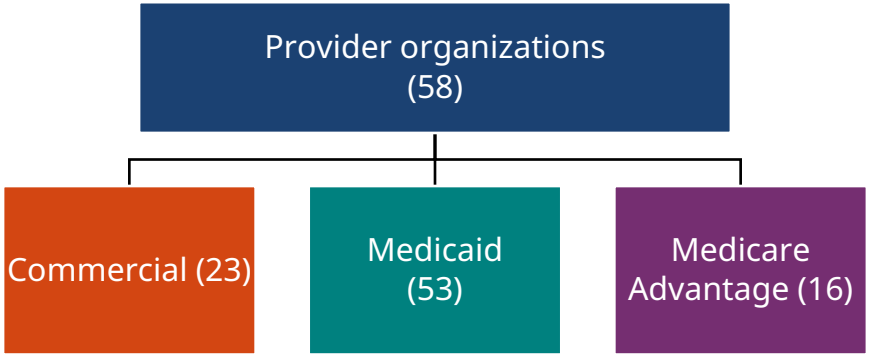
Provider organizations are included in the Cost Growth Target Program if they are primary care providers who direct a patient's care (and can influence where a patient receives care) and/or have sufficient patient volume to calculate accurate and reliable cost growth, defined as at least 10,000 attributed patients across all markets or at least 5,000 attributed patients in any one market.

To measure provider cost growth, the Implementation Committee recommended removal of the net cost of private health insurance and pharmacy rebates to look at Total Medical Expenditures (TME). Not all provider organizations can be held accountable for Total Medical Expenditures, as TME accountability typically applies to provider organizations that could in theory take on contracts where they are responsible for the total cost of care because they:

- Include primary care providers who direct a patient's care and/or
- Can influence where a patient receives care to promote high value providers and care.

Note provider organizations do not have to be in total cost of care contracts to be included in the Cost Growth Target Program. Total cost of care contracts are agreements between payers and provider organizations wherein a provider organization accepts clinical and financial responsibility for a population of patients, regardless of where the patients receive their care.

While Independent Physician Associations (IPAs) have always been included in this definition, they have not been included in previous annual reports and have been included this year to better understand their impact. This 2026 report, covering the 2023-2024 reporting period, includes three IPAs among the provider organizations.



See Appendix for full list of provider organizations and IPAs.

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)

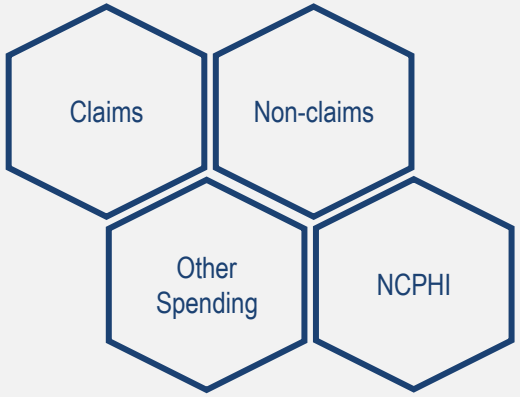
TME is used to measure health care cost growth for payers and provider organizations and IPAs. It is a subset of THCE and includes claims and non-claims spending reported by payers.

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.

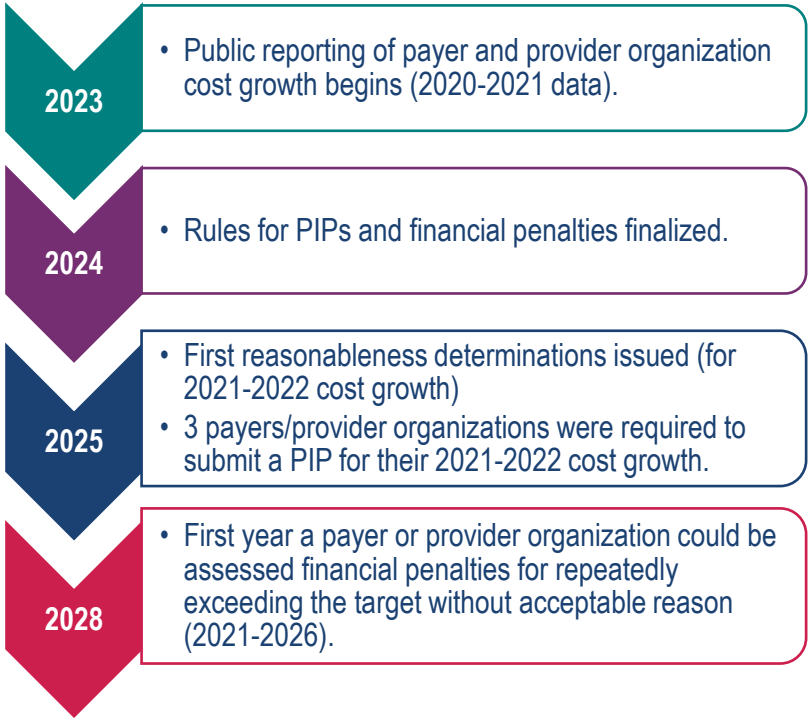
Performance Improvement Plans: Payers and provider organizations who exceed the target with statistical confidence AND without an acceptable reason may be subject to performance improvement plans.

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 previous measurement period (2022-2023) was the first time that payers and provider organizations that exceed the cost growth target without an acceptable reason could have been subject to a PIP. See the 2022-2023 Accountability Report for additional information.

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 performance improvement plan 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 process, OHA issues a reasonableness determination that dictates whether a PIP or financial penalty will apply for the measurement period.

Acceptable Reasons for Cost Growth

- Change in mandated benefits , to the extent that the mandated benefits are not defrayed under applicable law
- New pharmaceuticals and new uses of existing pharmaceuticals or new treatments, procedures, or devices entering the market
- Changes in taxes or other administrative factors
- "Acts of God" – natural disasters, pandemics, other
- Changes in federal or state law
- Investments to improve population health and/or address health equity
- Macroeconomic factors
- Total compensation for frontline workers
- High-cost outliers

Determinations for each measurement period are posted online once completed.

How to read charts in this report

This report presents information about payer and provider organization cost growth in relation to the 3.4% cost growth target.

In the example chart, the y-axis lists provider organizations that are accountable for meeting the cost growth target. Dots represent 2023-2024 cost growth for the provider organizations listed. Bars represent confidence intervals. Positive percentages show how much health care spending increased, while negative percentages mean that health care spending went down.

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

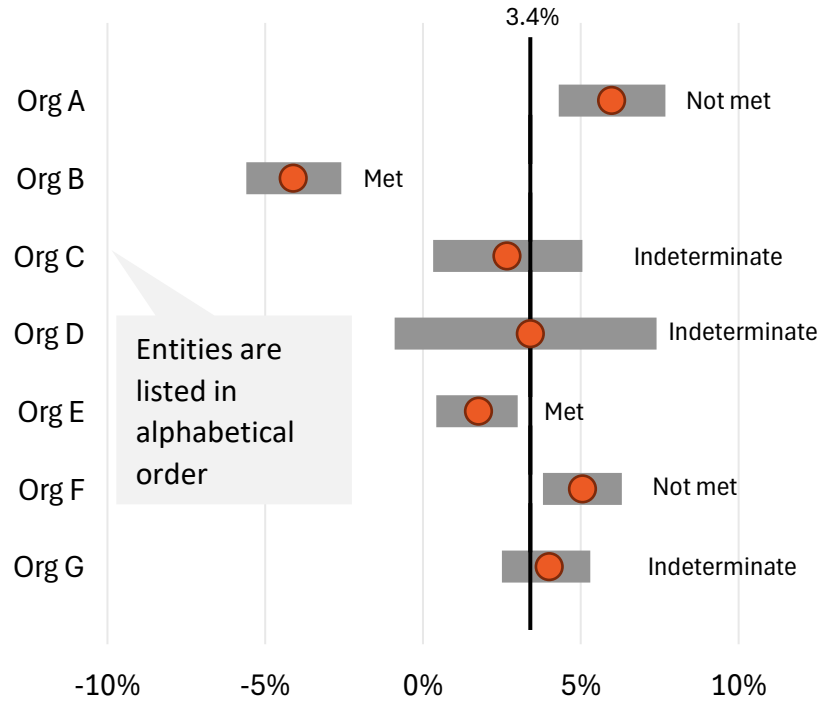
How to interpret confidence intervals

Confidence intervals help ensure that data are accurate and reliable by giving a range of plausible values. In calculating cost growth, OHA uses a 95% confidence interval, which means that we are 95% confident that an organization's cost growth value falls within that range.

The gray bars in the chart show the confidence interval range, with longer bars indicating a greater range and smaller bars indicating a smaller range. Generally, organizations with a larger number of members or patients will have a shorter confidence interval bar, while a company with a smaller number of members or patients will have a longer bar.

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

Example: cost growth for provider organizations



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.

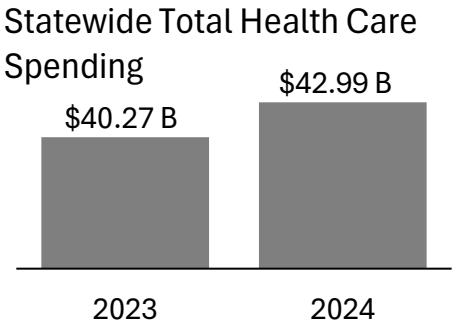
TME = Nonclaims + Claims

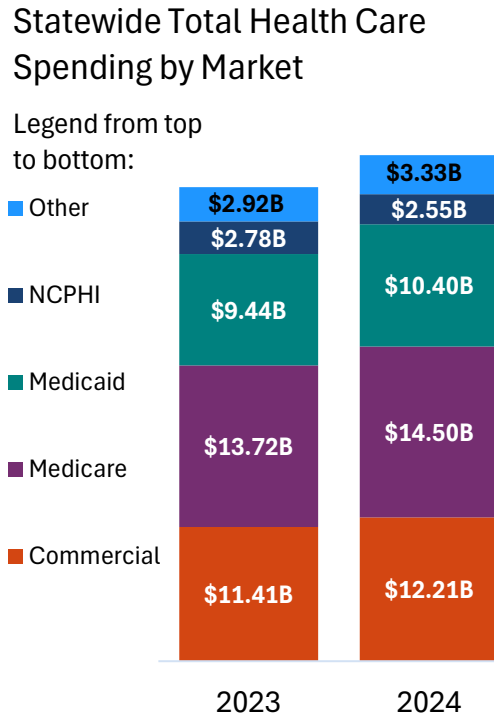
Total Health Care Expenditure (THCE): the sum of TME (the allowed amount of total claims spending plus total non-claims spending paid to providers), payers' NCPHI amounts, and other program spending for people in Oregon. This report uses THCE to measure statewide cost growth.

THCE = Nonclaims + Claims + NCPHI + Other spending

Chapter I. Health Care Cost Growth Trends Statewide, 2023-2024

Total Health Care Spending in Oregon





Statewide, total dollars spent on health care in Oregon increased 6.7% between 2023 and 2024, climbing from $40.27 billion in 2023 to $42.99 billion in 2024.

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 $14.50 billion in 2024 and represented 33.7% of health care spending in Oregon. Total Medicare spending grew 5.7% between 2023-2024.*

Commercial health insurance is the second largest market in Oregon by total dollars spent. Commercial spending in 2024 was about $12.21 billion, representing 28.4% of health care spending in the state. Total Commercial spending grew 7.0% between 2023-2024.

Medicaid provides health insurance for families and people with low incomes. Total Medicaid spending in Oregon was $10.40 billion in 2024, about 24.2% of health care spending in the state. Total Medicaid spending grew 10.1% between 2023-2024.

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 $2.55 billion, or 5.9% of statewide spending in 2024. NCPHI spending grew 4.0% between 2023-2024.

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 $3.33 billion in 2024, 7.7% of all health care spending. Other spending grew 13.8% between 2023-2024.

*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.

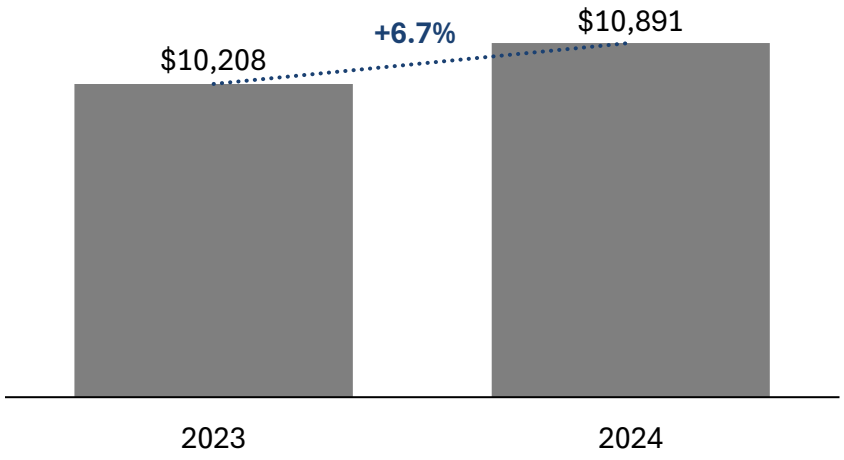
The previous page reported *total* dollars spent on health care in Oregon, which can be affected by the number of people in Oregon overall and the number of people with health insurance coverage. THCE provides a standardized comparison of how much is spent on health care per person each year that accounts 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 state and market level.

Total Health Care Expenditures, Statewide

Between 2023 and 2024, THCE spending per person per year grew 6.7%, above the cost growth target of 3.4%. Per person per year spending increased to $10, 891.

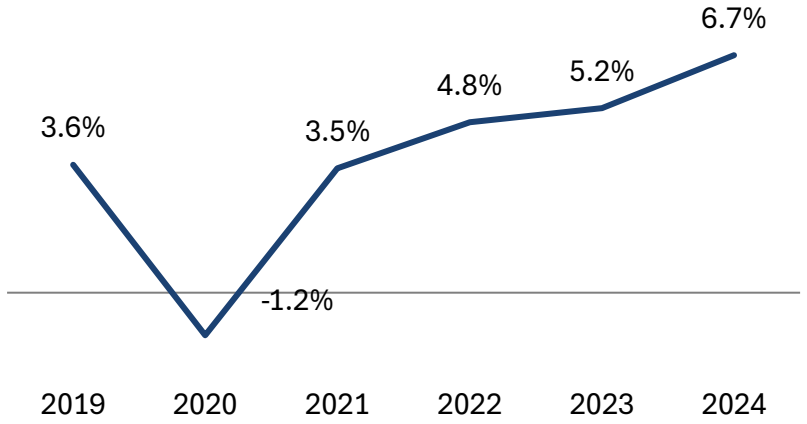
THCE spending growth between 2023 and 2024 was higher than other recent periods, and higher than before the pandemic. Average annual growth from 2018-2024 was 3.8%.

Statewide THCE PPPY grew 6.7% between 2023-2024



Growth in Statewide Total Health Care Expenditures, Per Person Per Year, 2018-2024

Years are year 2 of a 2-year period, e.g. “2024” represented 2023-2024



Total Health Care Expenditures Per Person Per Year, By Market

Percent change in THCE PPPY, by market, 2023-2024

*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.

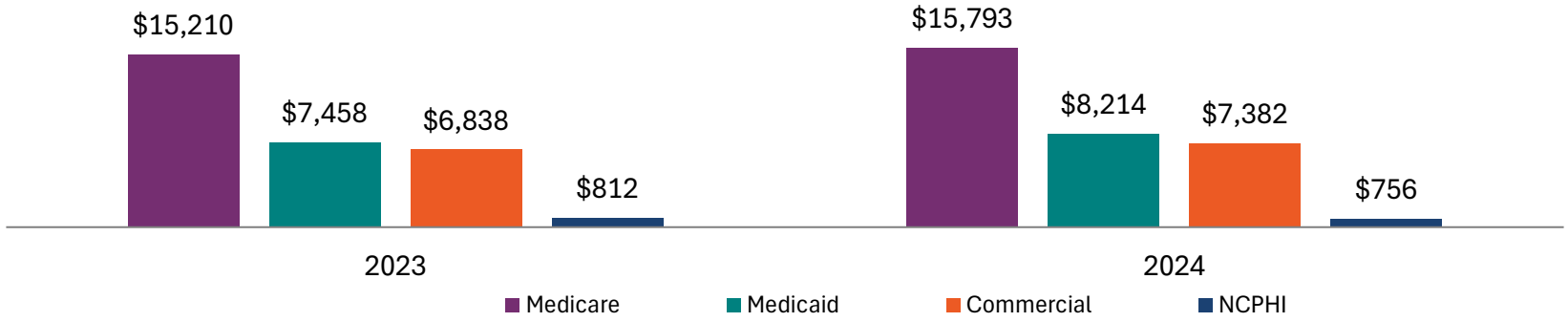
Total Health Care Expenditures per person per year (PPPY) grew well above the target across all markets in Oregon from 2023-2024.

Medicaid growth was the highest at 10.1%, followed by Commercial (8.0%) and Medicare (3.8%). The Net Cost of Private Health Insurance (NCPHI) decreased by 6.9%.

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 2024, Medicaid THCE on a per person per year basis saw the highest growth at 10.1%. 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 10.1% increase in Medicaid spending per year represented an absolute dollar increase of $756 in costs per person, while Medicare costs grew $583 per person and Commercial costs grew $544 per person.

Absolute change THCE PPPY, by market, 2023-2024



Total Health Care Expenditures, By Market, Over Time

The COVID-19 pandemic had a significant impact on cost growth between 2020 and 2022, but by 2023 the impact had started to wane. Since 2022:

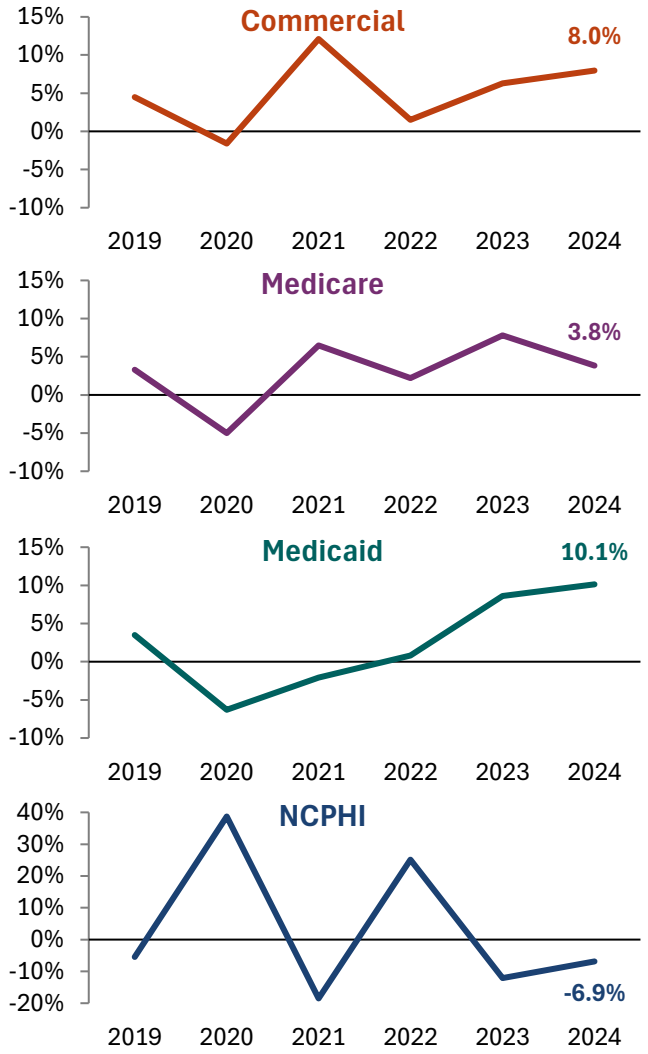
- the **Commercial** market grew 6.3% in 2022-23 and 8.0% in 2023-24.
- the **Medicare** market grew 7.8% in 2022-23 and 3.8% in 2023-24.
- the **Medicaid** market grew 8.6% in 2022-23 and 10.1% in 2023-24.
- **NCPHI** has been the most volatile, increasing in years when claims spending was lower in relation to premiums collected and decreasing in years with higher claims spending. NCPHI decreased by 12.1% from 2022 to 2023, and continued to decrease by 6.9% from 2023 to 2024.

Across all years for which Cost Growth Target data have been collected (2018-2024), cumulative percent growth was highest in the Commercial.

- THCE per person in the **Commercial** market grew cumulatively 33.8% from 2018 to 2024, from $5,517 to $7,382 per person.
- THCE per person in the **Medicare** market grew 25.7% in this period, rising from $12,565 to $15,793 per person.
- Cumulative cost growth in the **Medicaid** market from 2018-2024 should not be calculated due to methodological changes in 2023.

Growth in THCE PPPY by Market

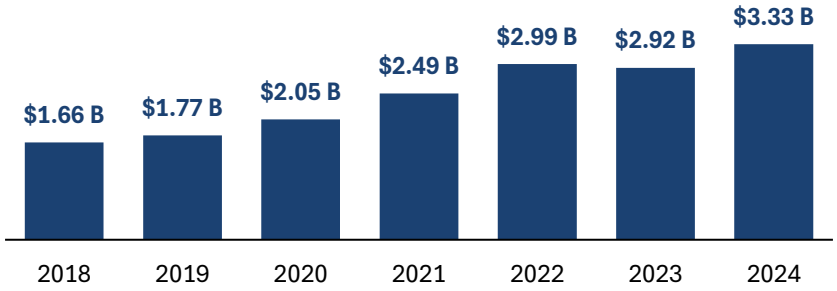
Years on x-axis represent year 2 of a 2-year growth period, e.g. “2024” for 2023-2024



Other Spending

Other spending includes health care expenditures in programs such as the Department of Corrections, Veterans Affairs, and behavioral health contracts funded by the state. Beginning in 2021, spending on the Oregon State Hospital was also included. Total other spending reached $3.33 billion in 2024, with cumulative growth of 33.8% from 2021 to 2024.

Statewide Other Spending, 2018-2024

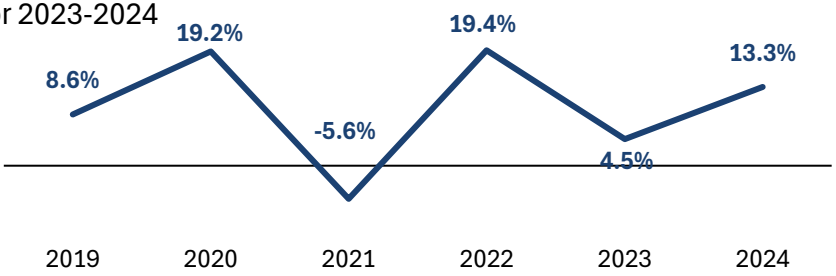


Veterans Affairs Spending

Health care spending in Veterans Affairs was the largest category within Other spending, accounting for 62.6% in 2024. The per person per year spending growth between 2023 and 2024 was 13.3%. The cumulative per person growth between 2018 to 2024 was 72.8%, increasing from $12,473 to $21,559.

Per Person Per Year Veterans Affairs Spending in Oregon

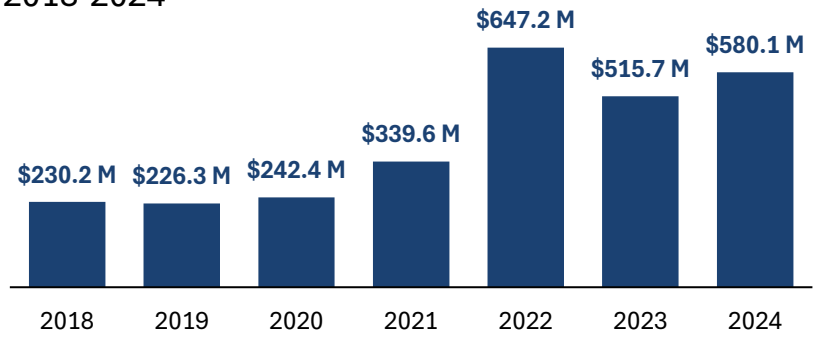
Years on x-axis represent year 2 of a 2-year growth period, e.g. “2024” for 2023-2024



State Spending on Behavioral Health

The Cost Growth Target Program also tracks Oregon’s investments in additional behavioral health contracts. In 2024, spending on these contracts accounted for 17.4% of Other spending. Between 2023 and 2024, the spending increased from $515.7 million in 2023 to $580.1 million in 2024, following a decline between 2022 and 2023.

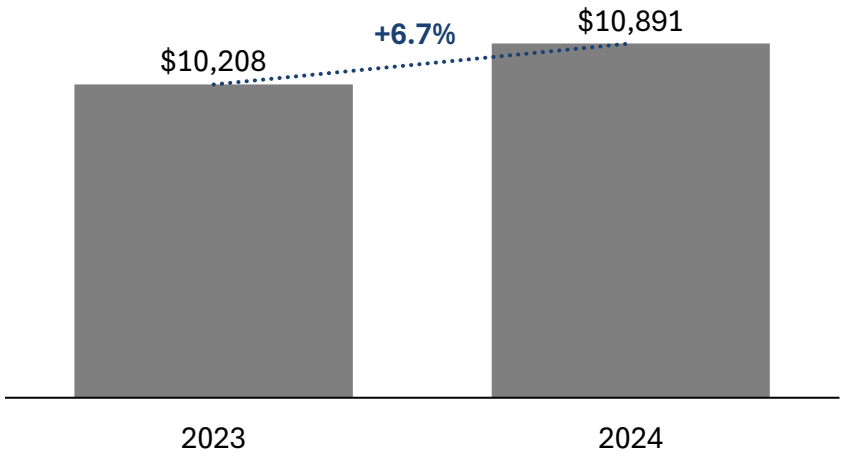
Total Spending in State Behavioral Health Contracts, 2018-2024



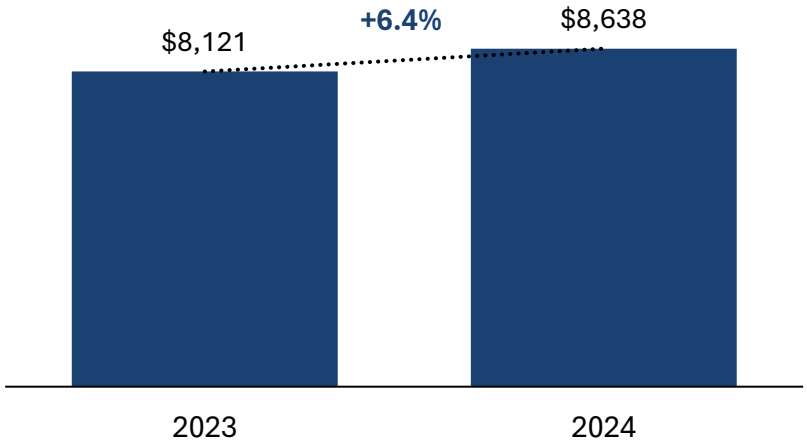
Total Medical Expenses

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.

Statewide THCE PPPY grew 6.7% between 2023-2024



Statewide TME PPPY (Unadjusted) grew 6.4% between



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.

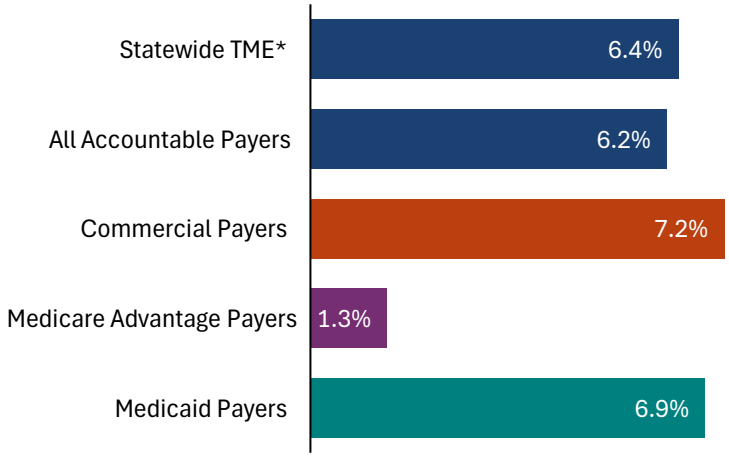
Calculated without Medicare FFS, statewide TME spending adjusted, grew 6.4% between 2023-2024, from $7,199 to $7,657 per person per year.

Total Medical Expenses – Payer Cost Growth

On average, 2023-2024 cost growth in demographically adjusted TME was 6.4% at the statewide level and 6.2% across payers. Average cost growth was highest among Commercial payers (7.2%), followed by Medicaid (6.9%) and Medicare Advantage payers (1.3%).

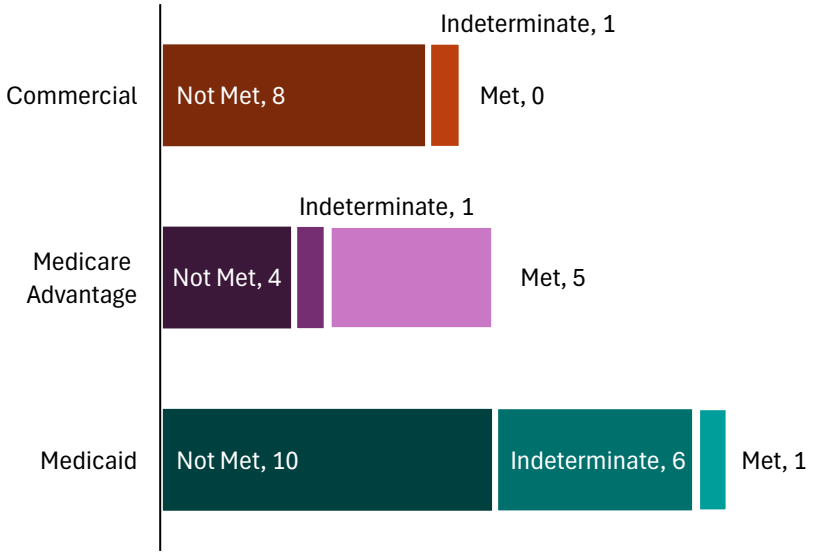
For this measurement period, no Commercial payers met the cost growth target. Five Medicare Advantage payers met the target, and in the Medicaid market, one Coordinated Care Organization (CCOs) met the target.

Average TME Spending Growth, 2023-2024, Statewide and for payers by market



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

Number of Payers Who Didn't Met the Cost Growth Target, Indeterminate, and Met the Target

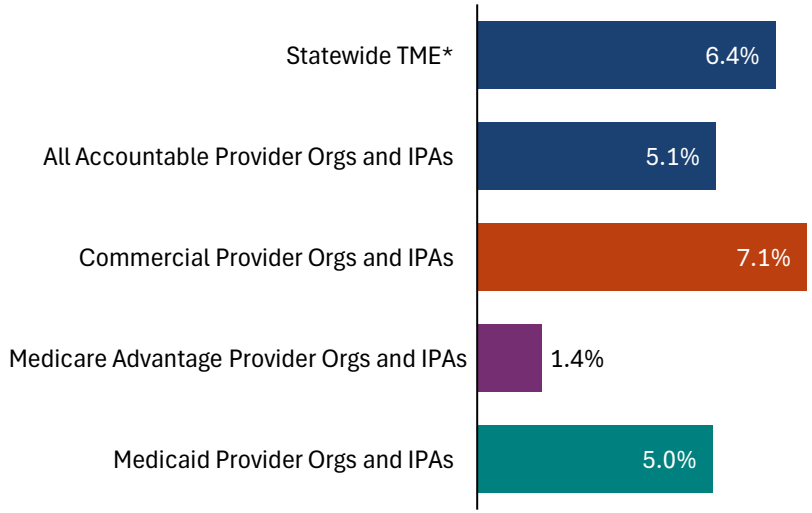


Total Medical Expenses – Provider Organization and IPA Cost Growth

Fifty-eight provider organizations and Independent Physician Associations (IPAs) were included in cost growth target reporting for 2023-2024. Overall cost growth for provider organizations and IPAs was 5.1%. Average cost growth was highest among Commercial provider organizations (7.1%), followed by Medicaid (5.0%) and Medicare Advantage (1.4%).

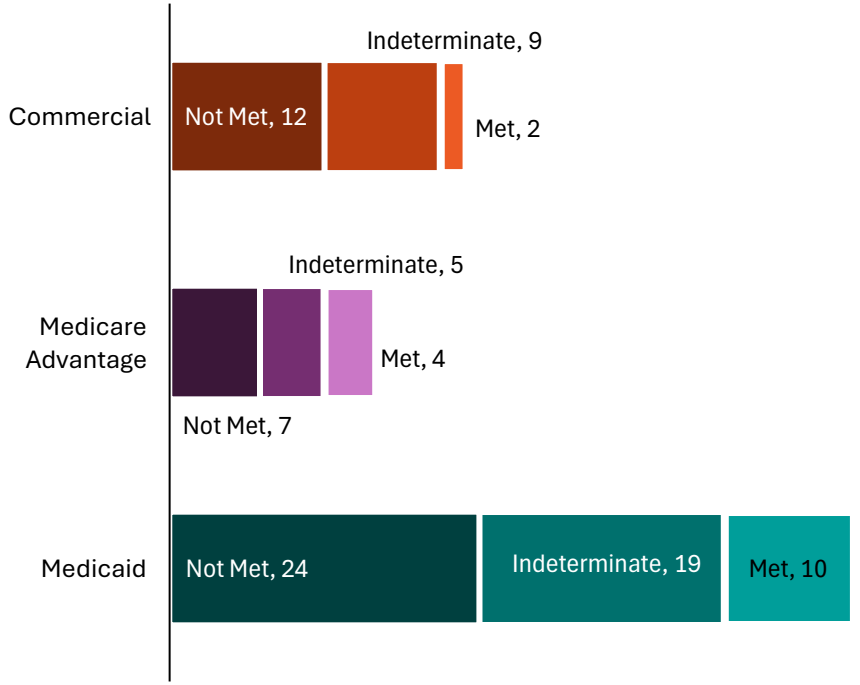
For this measurement period, two Commercial provider organizations and IPAs met the cost growth target. Four Medicare Advantage provider organizations and IPAs met the target, and in the Medicaid market, ten met the target.

Average TME Spending Growth, 2023-2024, Statewide and for Provider Organizations and IPAs by Market



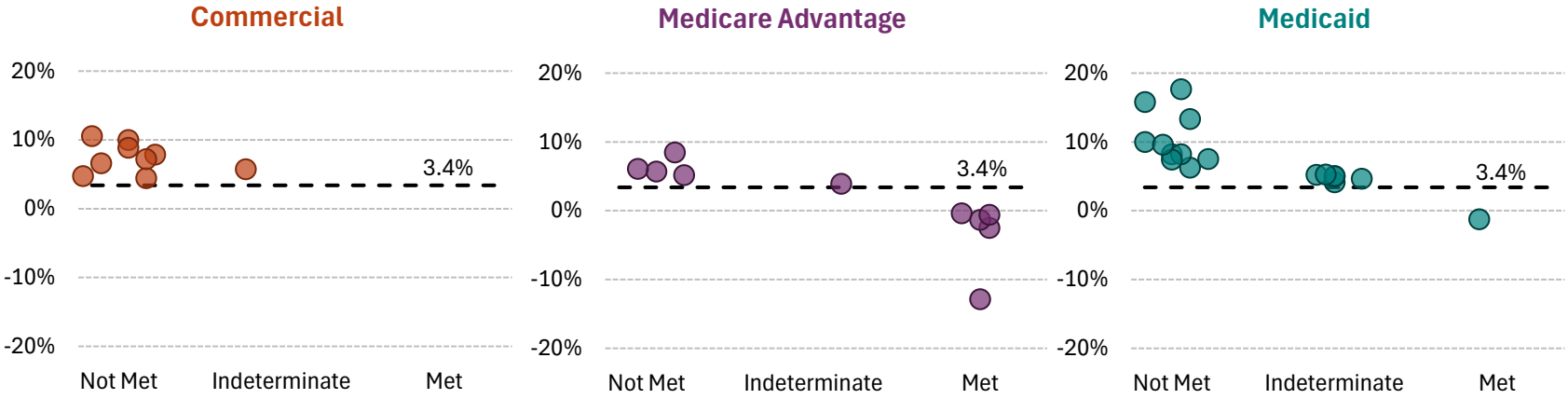
* Statewide TME excluding Medicare FFS, with a demographic adjustment. All accountable provider organization and IPA TME growth is demographically adjusted

Number of Provider Organizations and IPAs Who Didn't Meet the Cost Growth Target, Indeterminate, and Met the Target

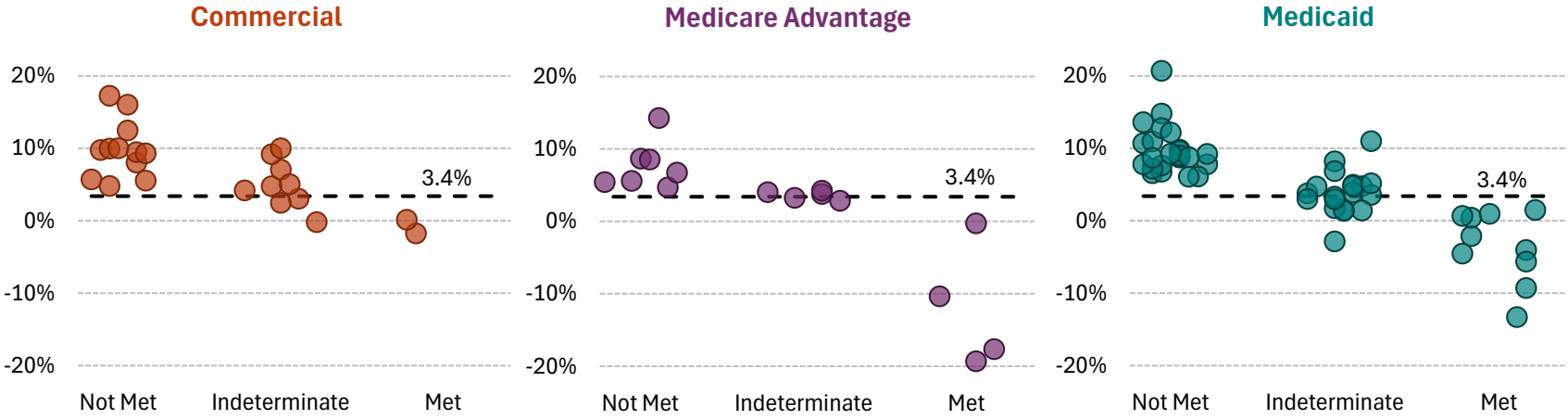


Total Medical Expenses – Distribution of Payer, Provider Organization, and IPA Performance

Distribution of Payer Performance Relative to the Cost Growth Target for **Commercial**, **Medicare Advantage**, and **Medicaid** Markets, 2023-2024



Distribution of Provider Organization and IPA Performance Relative to the Cost Growth Target for **Commercial**, **Medicare Advantage**, and **Medicaid** Markets, 2023-2024



Total Medical Expenses – Total Spending by Service Category, Statewide

Hospital Outpatient, Professional, and Claims Other service categories were top drivers of statewide health care spending growth between 2023-2024.

Claims for Hospital Outpatient services comprised 20.6% of overall spending in 2024 and grew by $611 million (9.8%).

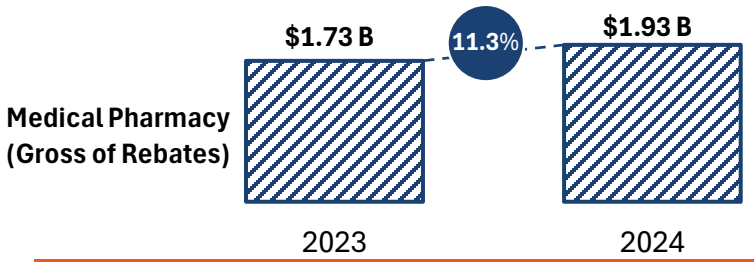
Spending on Professional services comprised 30.0% of overall TME in 2024, and this service category grew by $803 million (8.8%) from 2023 to 2024.

Growth in Claims Other spending was also significant between 2023-2024. This spending grew 8.3%, an increase of $267 million. This category includes spending on things like durable medical equipment, hospice services, and transportation.

Non-Claims spending saw a decrease (-9.0%) in 2024, with TME spending dropping by $198 million from 2023 to 2024.

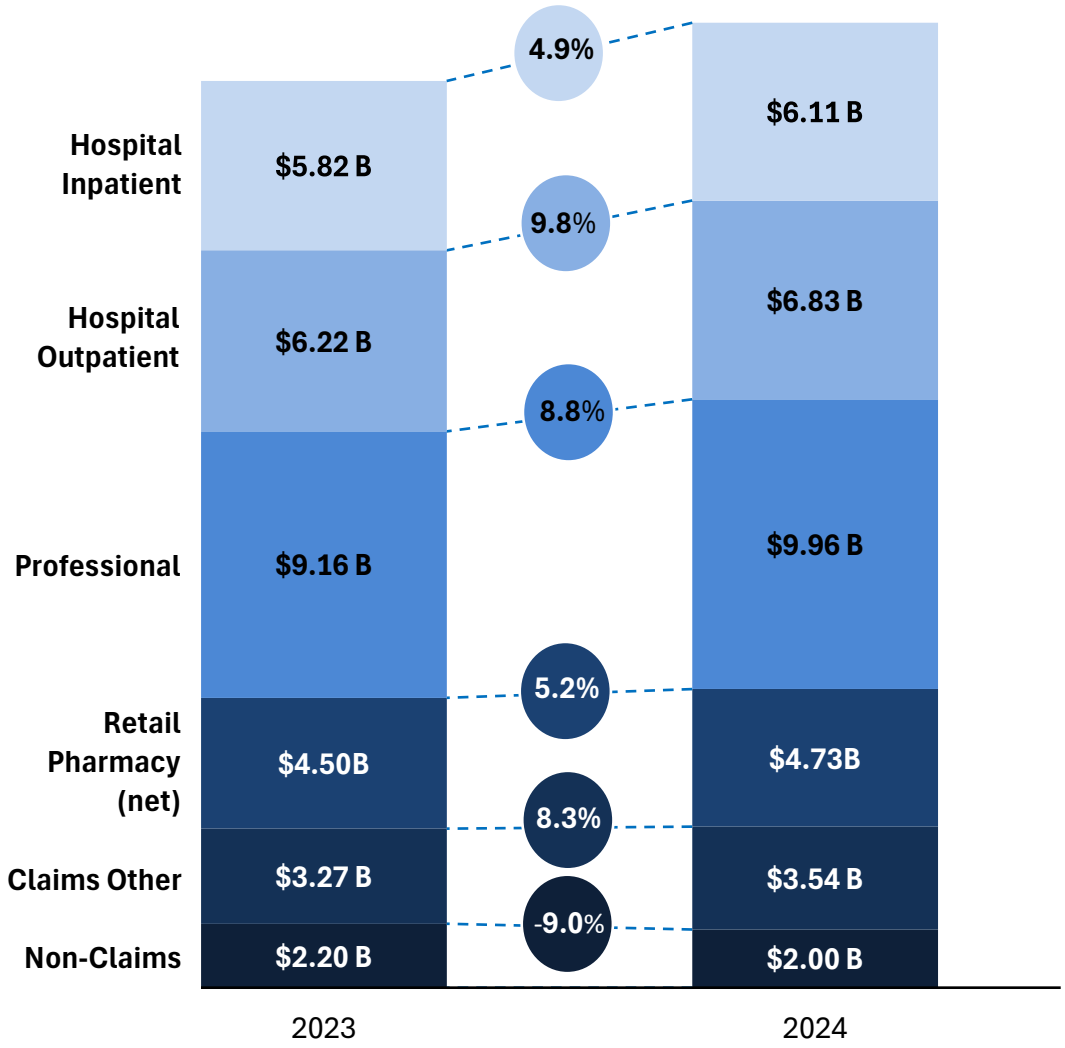
Statewide Total Medical Pharmacy Spending and Growth Rate, 2023-2024

Medical pharmacy spending was included in Hospital Inpatient, Hospital Outpatient, Professional, and Claims Other in the right chart.



Statewide Total Medical Expenses – Total Claims spending and Growth Rate, 2023-2024

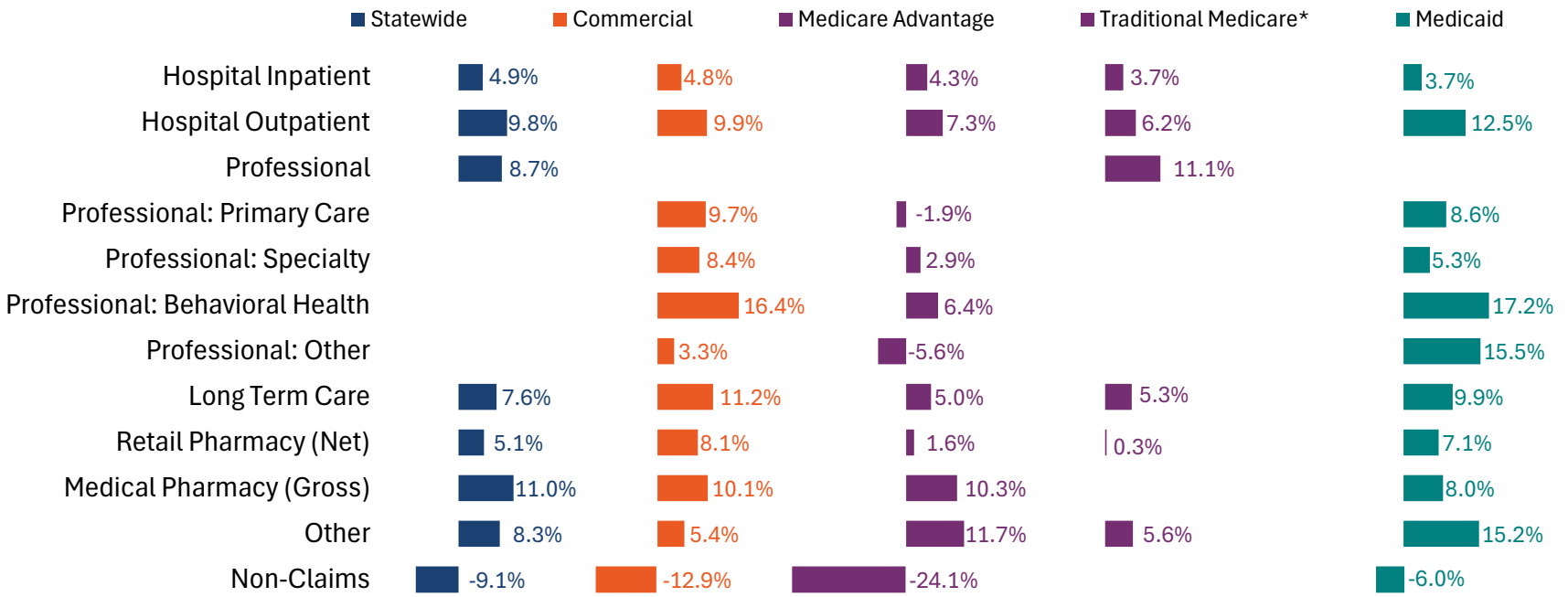
Spending is reported net of pharmacy rebates



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 (11.0%) and Hospital Outpatient (9.8%). **Service category growth differed widely by market**. Primary Care spending grew by almost 10% in the Commercial market and by almost 9% in the Medicaid market, but saw negative growth of -1.9% in the Medicare Advantage market. Spending on Professional: Behavioral Health increased more than 16% in the Commercial and Medicaid markets but only increased by 6.4% in the Medicare Advantage market. Spending on Hospital Outpatient services grew more in Medicaid (12.5%) than Commercial (9.9%) or Medicare Advantage (7.3%).

Percent Change in PPPY Spending by Service Category, Statewide and Across Markets, 2023-2024



*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, 2023-2024

On a per person per year basis, the **biggest contributor to absolute change in statewide health care spending between 2023-2024 came from the Professional service category, which saw an increase of $208.16 per person**. Across Professional Service subcategories, increases were concentrated in Specialty services for both the Commercial and Medicare Advantage markets, whereas in Medicaid most of the increase occurred in Behavioral Health.

Increases in Hospital Outpatient are also a big contributor. Hospital Outpatient per person spending increased by $158.30, with the largest increase occurring in Medicare Advantage ($191.82), followed by Commercial ($175.66) and Medicaid ($97.96). For Medicare Advantage, Medical Pharmacy is another major contributor, with an increase of $130.50. However, Medicare Advantage also experienced a substantial decrease in Non-Claims (–$265.38).

	Statewide	Commercial	Medicare Advantage	Traditional Medicare	Medicaid
Hospital Inpatient	$74.15	$54.44	$125.27	$114.15	$32.11
Hospital Outpatient	$158.30	$175.66	$191.82	$134.94	$97.96
Professional: Primary Care		$62.00	-$15.91		$20.63
Professional: Specialty		$90.60	$65.73		$21.73
Professional: Behavioral Health		$49.77	$4.26		$90.81
Professional: Other		$16.28	-$30.65		$45.03
Long Term Care	$16.74	$5.14	$30.21	$37.54	$9.75
Retail Pharmacy (Net)	$59.62	$81.85	$41.25	$5.10	$27.86
Medical Pharmacy (Gross)	$56.17	$48.78	$130.50		$18.89
Other	$52.39	$17.18	$89.72	$140.52	$47.84
Non-Claims	-$51.90	-$8.71	-$265.38		-$66.39

*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.

Statewide Cost Drivers – Price vs. Utilization

To supplement analysis of the cost growth target data collected from payers for the 2023-2024 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 increases are driven by the unit price of a service or by the number of services being provided.

Cumulative Growth, 2018-2024

Since 2018, the cumulative growth in price has outpaced utilization in every service category. For example, Retail Pharmacy prices in 2024 are 26.9% higher than 2018, while utilization in this service category has only grown by 10.6% since 2018. *See price and utilization graphs by service category on the next page.*

Year Over Year Growth, 2023-2024

If you isolate changes to just those occurring between 2023 and 2024, Inpatient, Professional, Long-Term Care, and Other service categories saw growth driven primarily by increases in utilization. *See page 41.*

National Perspective

In 2024, national health care expenditures grew 6.1%; approximately 41% of this growth was due to increases in price, and 59% was due to changes in utilization of health care services and intensity of services (that is, the kinds of services people receive). Use and intensity for hospital care, physician and clinical services, and retail pharmacy all contributed more to overall cost growth in 2024.[1]

Definitions

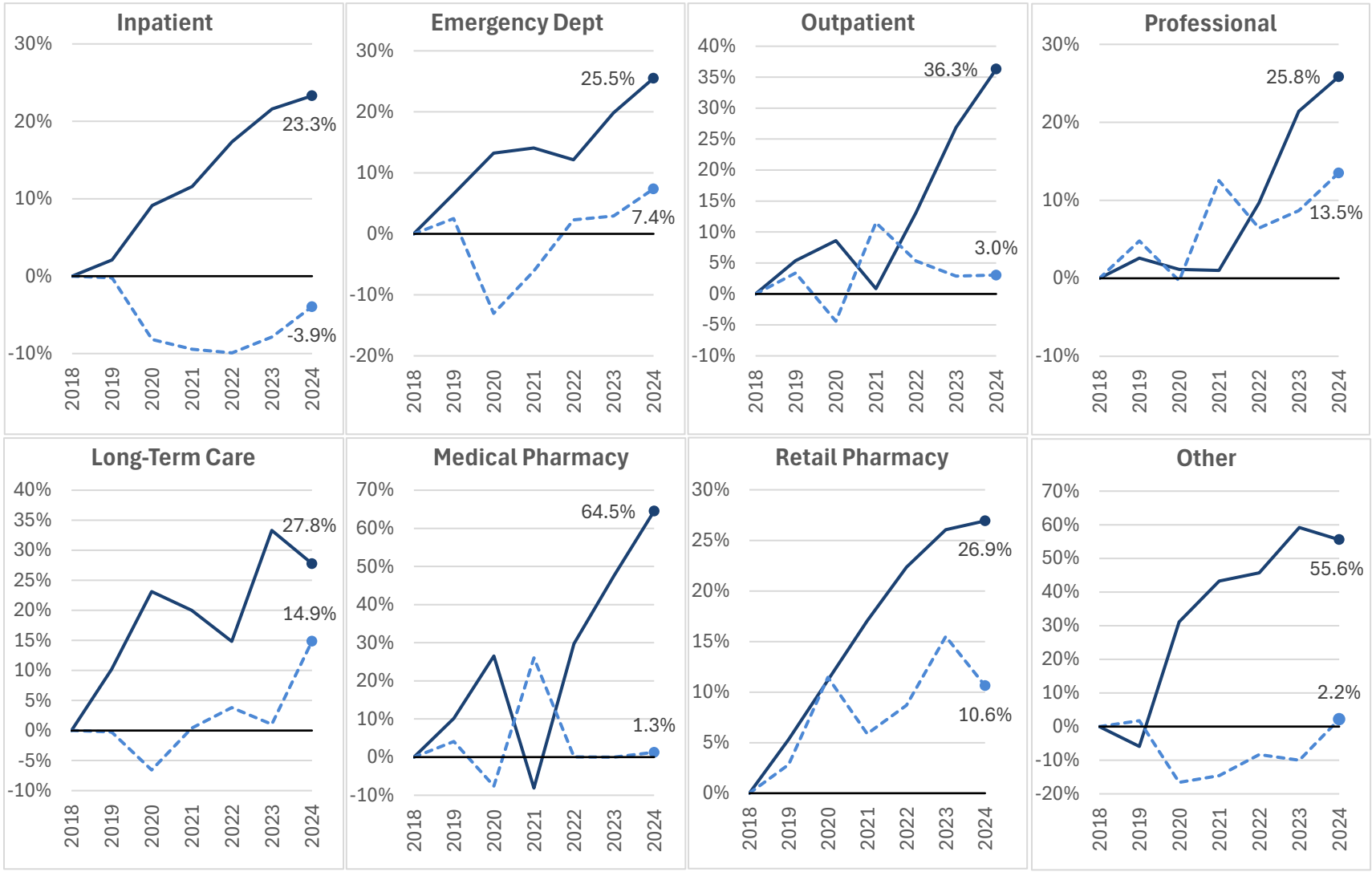
For this report, **price** is measured as the cost per discharge for Hospital Inpatient services, the cost per 30-day prescription for Retail Pharmacy (gross of rebates), and the cost per claim for all other services categories.

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

[1] Hartman et al. (February 2026). National Health Care Spending Increased 7.2 Percent In 2024 As Utilization Remained Elevated

Statewide price and utilization growth (cumulative), by service category, 2018-2024

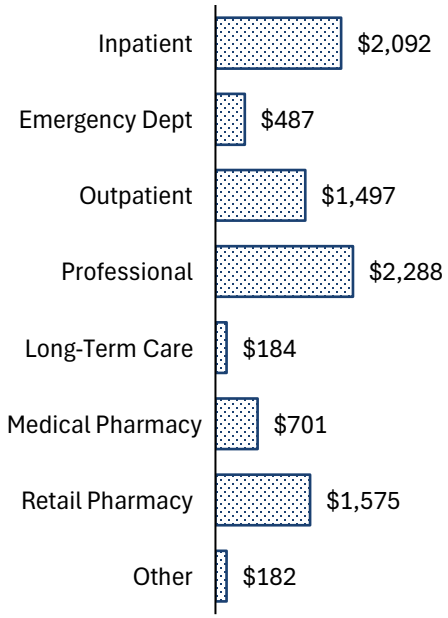
APAC claims analysis. Overall price is shown in the darker solid line, and utilization is shown in the lighter dotted line.



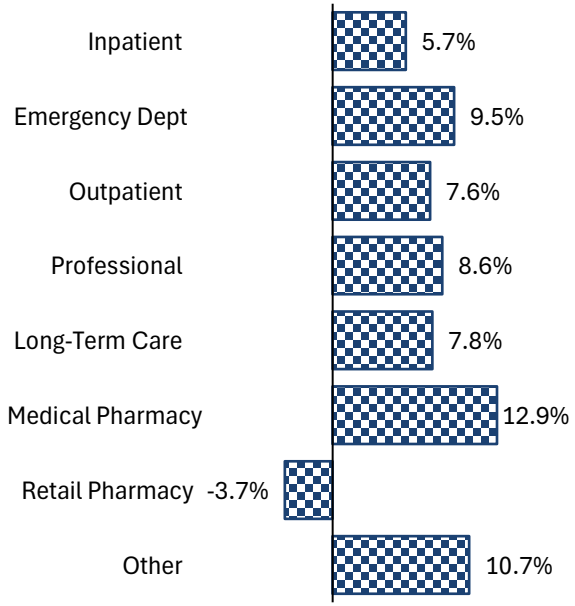
Between 2023-2024, the service category with the highest cost per person growth was Medical Pharmacy at 12.9%, with the majority of that growth driven by cost per unit (price). The service category with the next highest cost per person growth (Other) was driven by utilization.

Other service categories with high cost per person growth, such as Emergency Department and Professional, were driven by a more balanced mix of cost and utilization.

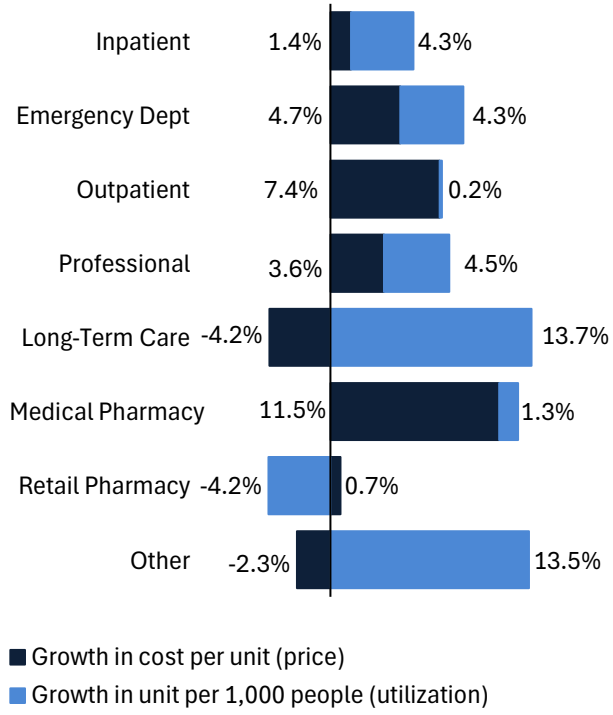
Statewide Cost Per Person by Service Category, 2024



Statewide Cost per Person Growth by Service Category, 2023-2024



Statewide Growth in Price vs. Utilization by Service Category, 2023-2024



Chapter II. Health Care Cost Growth Trends in the Commercial Market, 2023-2024

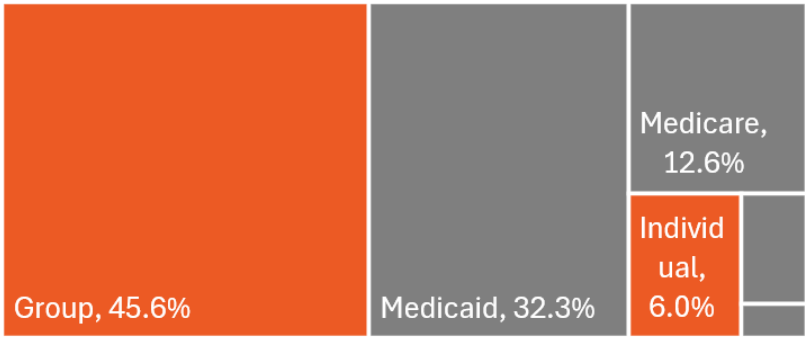
Introduction: Commercial Cost Growth

In 2024, more than half of Oregonians (~52%) had commercial health insurance.[2] 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.

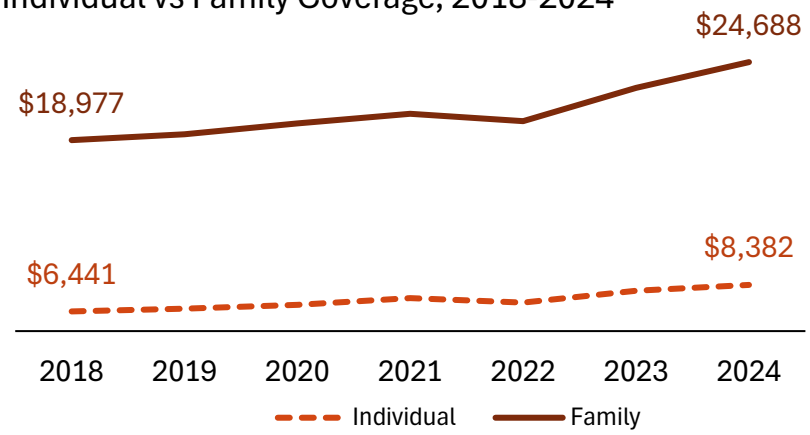
Increasing costs in the Commercial market have led to affordability challenges for Oregonians. As costs go up, so do premiums. From 2018-2024, average employer-paid premiums increased 30.1% for both employer-sponsored family plans and individual plans, putting a strain on both employers and employees and limiting wage growth.[3]

This chapter delves more deeply into these trends in the Commercial market in 2024, 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.

Percent of People in Oregon by Type of Primary Health Care Insurance Coverage, 2024



Annual Commercial Health Care Premiums in Oregon, Individual vs Family Coverage, 2018-2024



[2] Oregon Health Insurance Survey (OHIS), 2025. https://www.oregon.gov/oha/HPA/ANALYTICS/pages/ohis-coverage.aspx

[3] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. "Medical Expenditure Panel Survey (MEPS) Insurance Component (IC): Private Sector - State".

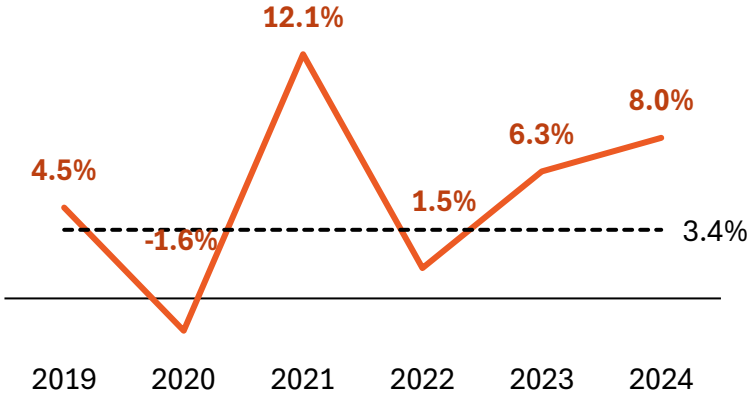
Topline findings for the 2023-2024 measurement period include:

- From 2023 to 2024, Commercial Total Medical Expenses (TME) (net of pharmacy rebates, unadjusted) was 8.0%. The annual growth in TME per person per year from 2018 to 2024 was 5.1%, over the target of 3.4%.
- Commercial cost growth was highest for **Hospital Outpatient** (9.0%, or $176 per person per year). **Professional service category contributed the most in terms of per person** spending grew $219 (7.8%) per person per year, including 16.4% growth in per person per year spending for behavioral health services.
- **Commercial Hospital Outpatient cost growth was driven by price**, while the utilization for the services decreased during this period. Prices mainly increased for Surgical, Radiology, Chemotherapy, and Laboratory and Pathology services.
- **Commercial Medical Pharmacy cost growth was also driven by price**, while utilization decreased. Chemotherapeutic Agents represented the largest spending drug family in Medical Pharmacy, with per person cost growth of 12.0% between 2023 and 2024, and price growth (8.1%) outpacing utilization growth (4.4%).
- Of nine Commercial payers, none met the cost growth target, and eight exceeded the target with statistical significance.
- Of twenty three Commercial provider organizations and IPAs, only two met the cost growth target, and twelve exceeded the target with statistical significance.

Commercial Cost Growth, 2023-2024

THCE and TME growth are changes in PPPY spending across Full and Partial Claims, net of rebates and unadjusted for demographics. Payer and provider organization cost growth are changes in PMPM using Full Claims and adjusted for sex/age. Payer growth is measured net of rebates, while provider organization growth is measured gross of rebates.

Commercial TME Growth, 2018-2024



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

Commercial Cost Growth - Service Categories, 2023-2024

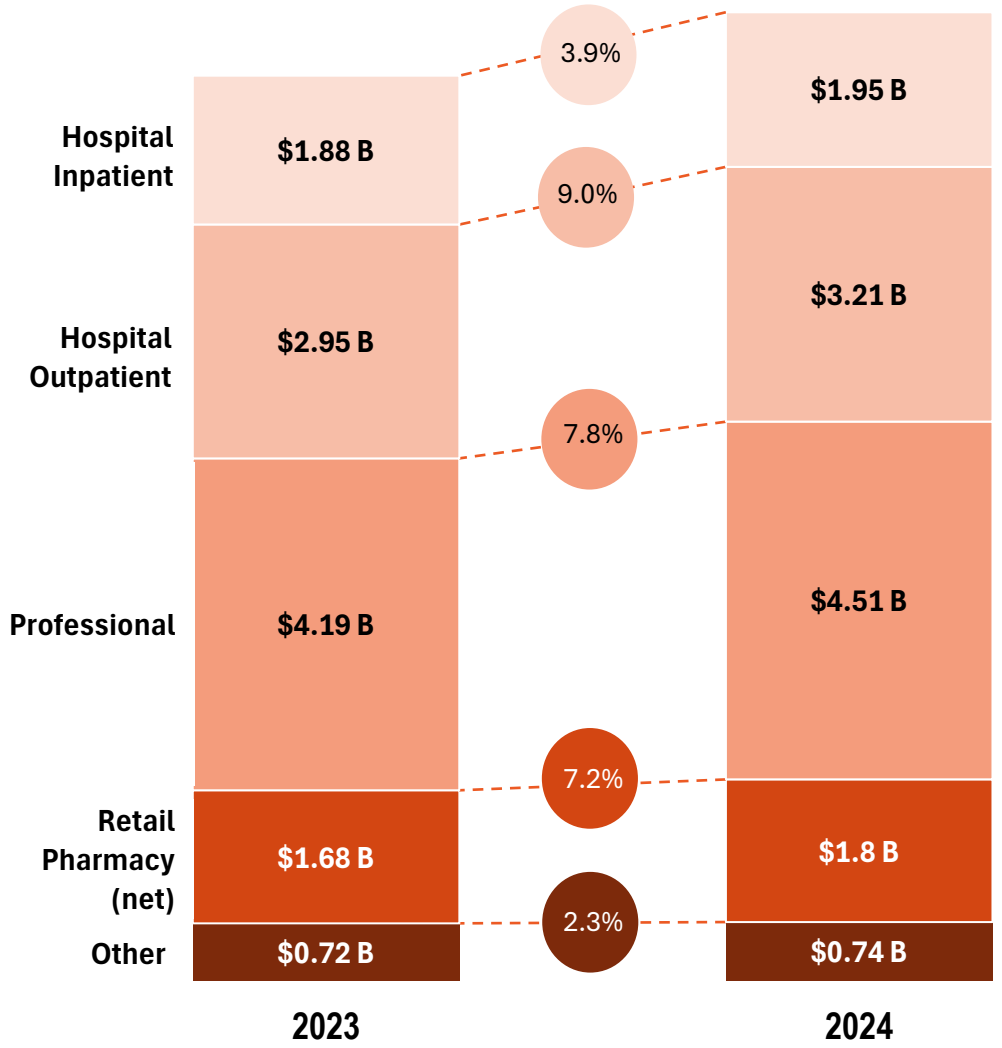
Between 2023-2024, Total Medical Expenses (TME) for people in Oregon with Commercial health insurance grew by $801 million, or 6.5%.

During the measurement period, Commercial health plan enrollment (member months) remained essentially flat, decreasing by 0.9%. This suggests that increases in total spending were not due to growth in enrollment, but to increased price and utilization of services. The Commercial population demographics also remained similar, with only 0.3% change in age/sex demographic scores.

Total spending increased across all service categories from 2023-2024. The categories with the highest growth in spending in the Commercial market were Hospital Outpatient (+9.0%, or $264.9 million), Professional (+7.8%, or $325.3 million) and Retail Pharmacy (+7.2%, or $120.8 million).

Total Spending and Growth Rate, Commercial Market, 2023-2024

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



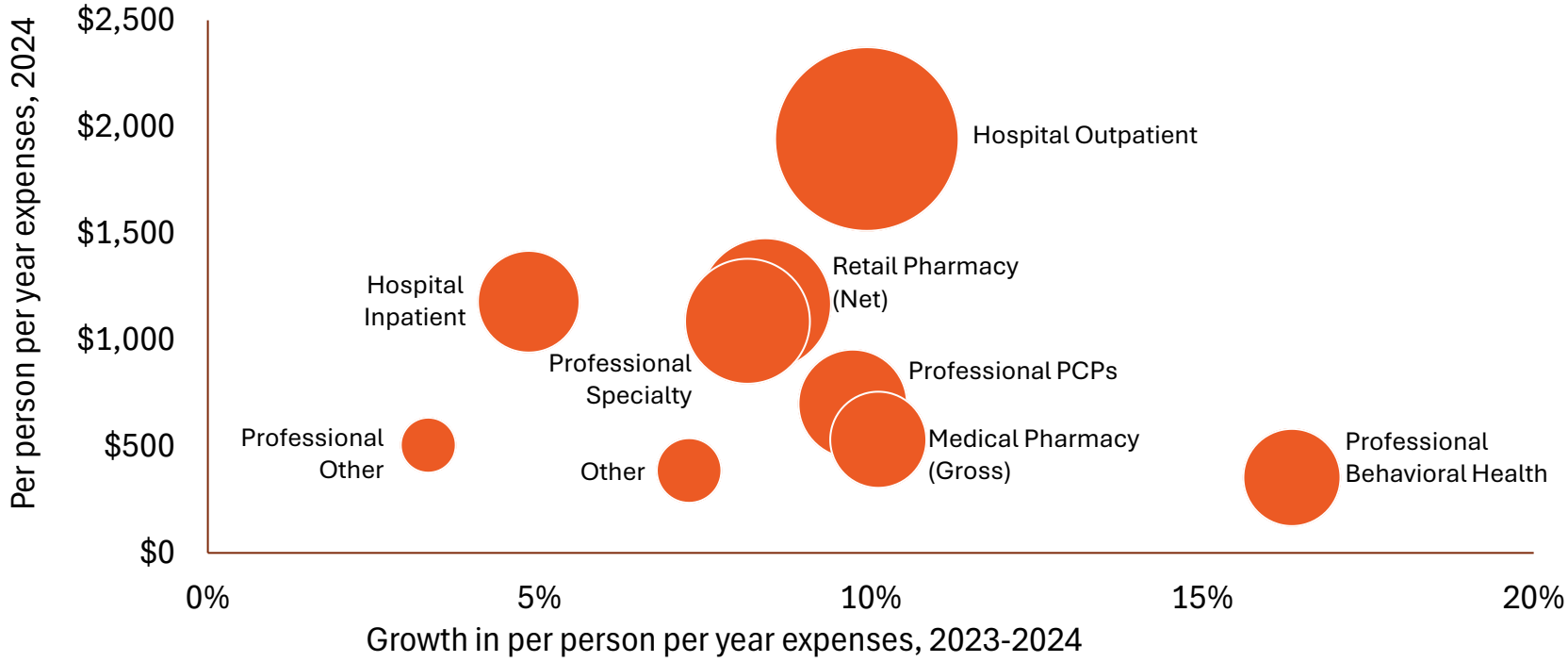
Growth in TME Per Person Per Year by Service Category, Commercial Market

In the Commercial market, the single largest service category driving per person per year spending growth from 2023-2024 was Professional services, which saw a $219 (+7.8%) increase. In the chart below, the Professional services category is broken into four subcategories. Professional Behavioral Health spending per person per year grew 16.4% ($50) and was an outsized contributor to the high growth in the Professional services category during the period.

Hospital Outpatient and Retail Pharmacy services were additional categories contributing to cost growth in Commercial spending. Spending per person per year increased by $176 (+9.0%) in Hospital Outpatient services and by $82 (+8.1%) in Retail Pharmacy services.

Commercial Total Medical Expenses – Growth in Per Person Per Year spending by Service Category, 2023-2024

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



Commercial Cost Growth Drivers – Price vs. Utilization, 2023-2024

Between 2023-2024, the primary drivers of cost growth in the Commercial market varied by service category.

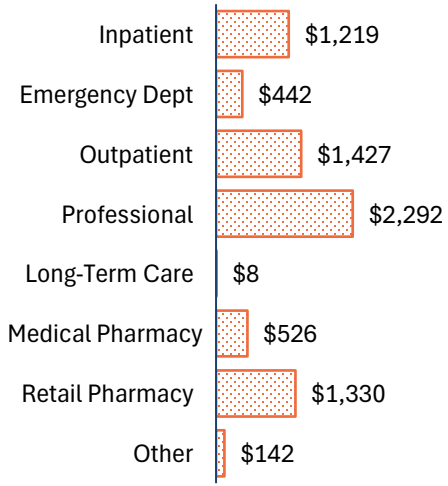
The Professional service category accounted for the highest cost per person ($2,292), with a mix of utilization (+4.6%) and price (+3.2%) driving the growth.

The next service category accounting for the highest cost per person in 2024 was Hospital Outpatient ($1,427), which saw 7.6% growth between 2023-2024; growth in this service category was entirely driven by price (+13.0%) with utilization decreasing (-4.8%).

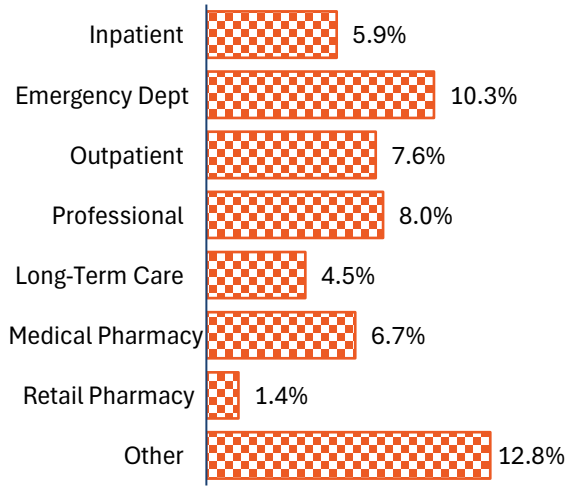
Similarly, the cost per person growth between 2023-2024 in the Medical Pharmacy service category (6.7%) was also driven by price (+17.9%) with utilization decreasing (-7.6%).

The service category with the highest cost per person growth between 2023-2024 was Other (12.8%), driven by a significant increase in utilization (+21.4%), but the overall impact was minor due to the relatively low overall cost per person ($142).

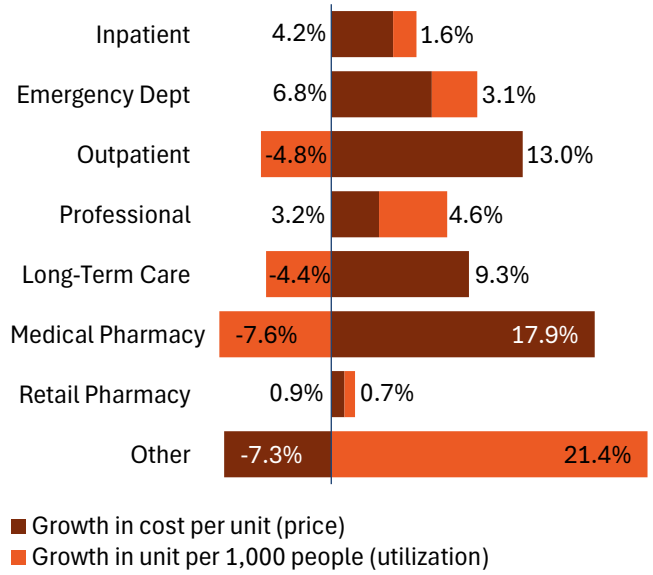
Cost Per Person by Service Category in Commercial, 2024



Cost per Person Growth by Service Category in Commercial, 2023-2024



Growth in Price vs. Utilization by Service Category in Commercial, 2023-2024

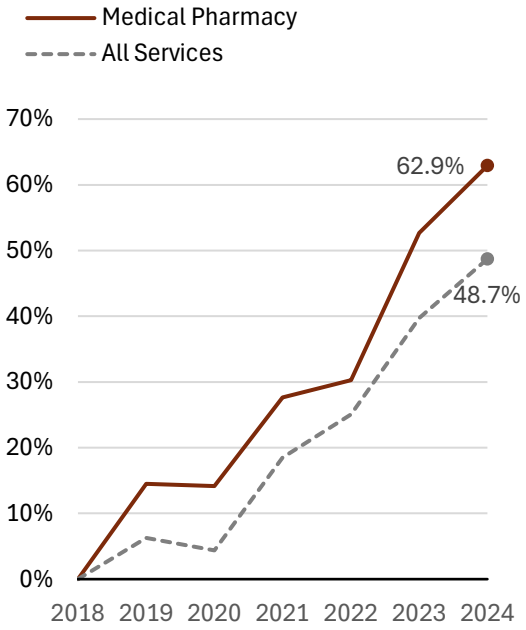


Commercial Spotlight: Medical Pharmacy Price Growth

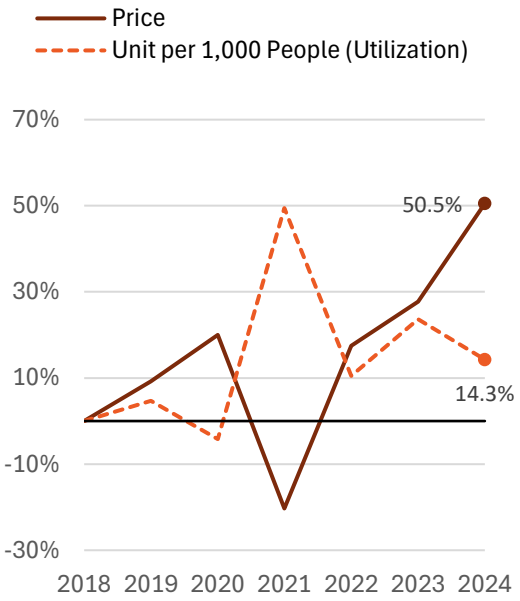
Price has been a major driver of spending in the Commercial market in Oregon since at least 2013. A good example of this can be found by looking at the Medical Pharmacy service category in the Commercial market. Since 2018, the cumulative per person cost growth across all Commercial service categories was 48.7% but growth in Medical Pharmacy was 62.9%. Price has been the major driver of growth in this service category. Between 2023-2024, Medical Pharmacy price grew by 17.9% (50.5% cumulative growth since 2018), while utilization decreased by 7.6% between 2023-2024 (14.3% cumulative growth since 2018).

The drug family category accounting for the most Medical Pharmacy spending in 2024 is Chemotherapeutic Agents, at 12.0% growth between 2023-2024, with price outpacing utilization growth 8.1% to 4.4%. Of the nine drug family categories that grew between 2023-2024, six were driven primarily by price.

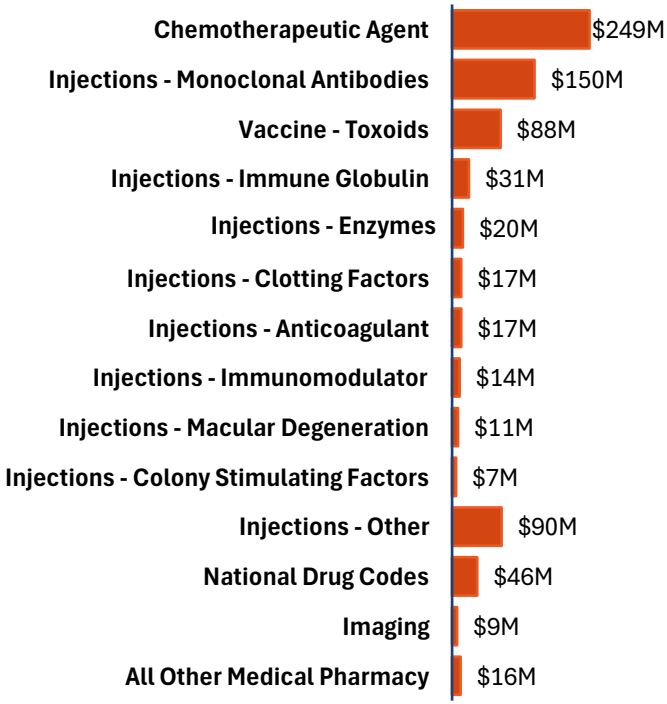
Cumulative Cost Per Person Growth in Medical Pharmacy vs. All Services, Commercial, 2018-2024



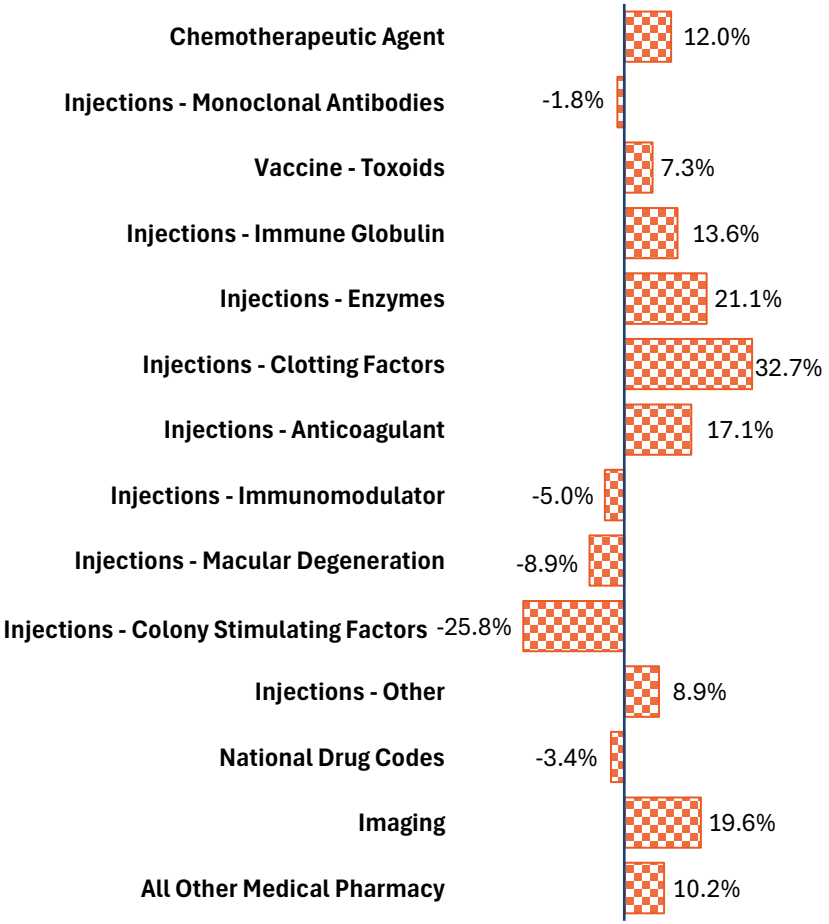
Cumulative Price and Utilization Growth in Medical Pharmacy, Commercial, 2018-2024



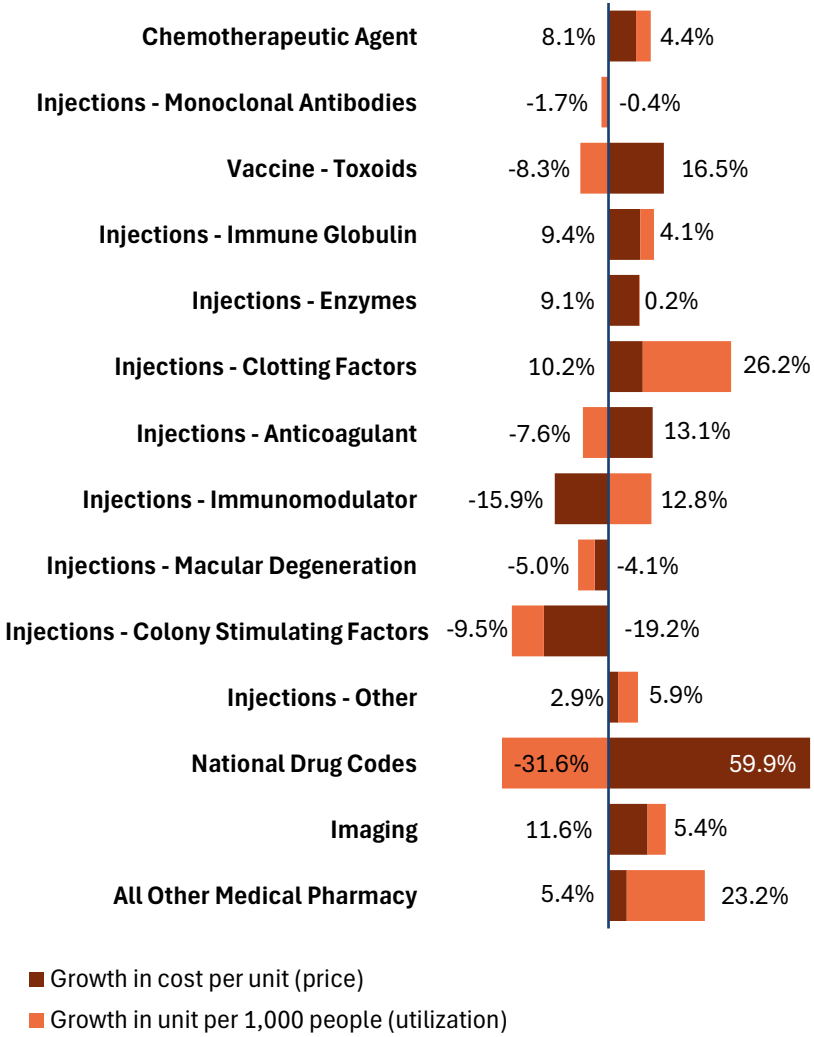
Commercial Medical Pharmacy Spending by Drug Family, 2024



Per Person Commerical Cost Growth in Medical Pharmacy by Drug Family, 2023-2024



Growth in Commerical Price vs. Utilization in Medical Pharmacy by Drug Family, 2023-2024



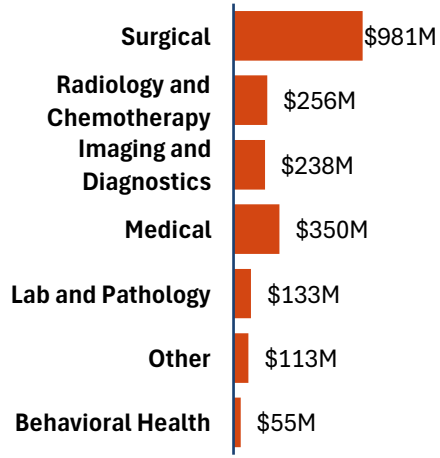
Commercial Spotlight: Hospital Outpatient Price Growth

Another service category in the Commercial Market that saw growth driven primarily by price was Hospital Outpatient. Between 2023-2024, the average cost per claim (price) for Hospital Outpatient services grew 13.0% across all procedure categories, while the number of claims per person (utilization) decreased 4.8%.

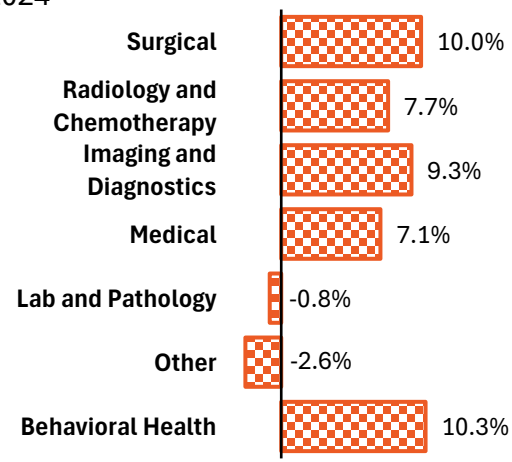
The Hospital Outpatient procedure category responsible for the most spending, Surgical at $981 million in 2024, saw 10.0% growth between 2023-2024 with price growth outpacing utilization growth 7.8% to 2.0%. Growth in other high-spend procedure categories like Medical and Radiology/ Chemotherapy were also driven by increases in price.

One more thing to note - some hospitals in 2024 are starting to carve out some Lab and Pathology services to 3rd party vendors which could explain some of the significant utilization decreases in that procedure category. Since these services are no longer counted under Hospital Outpatient, they are now reported in the Other service category on page 42, which may be why we see a 21.4% increase in utilization there.

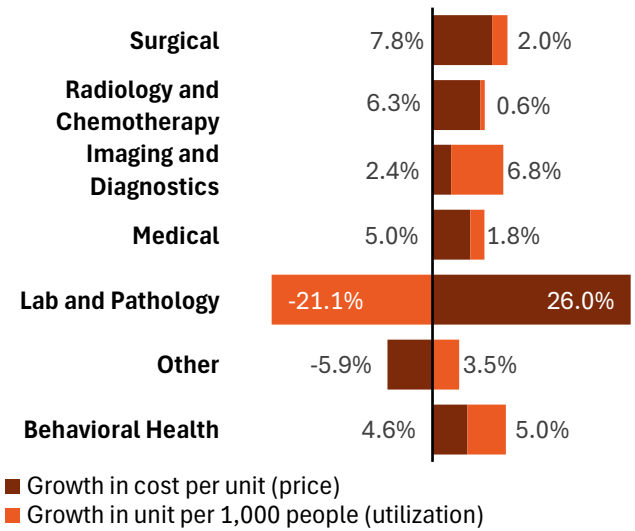
Commercial Outpatient Spending by Procedure Category, 2024



Commercial Per Person Cost Growth in Outpatient by Procedure Category, 2023-2024



Growth in Commerical Price vs Utilization in Outpatient by Procedure Category, 2023-2024

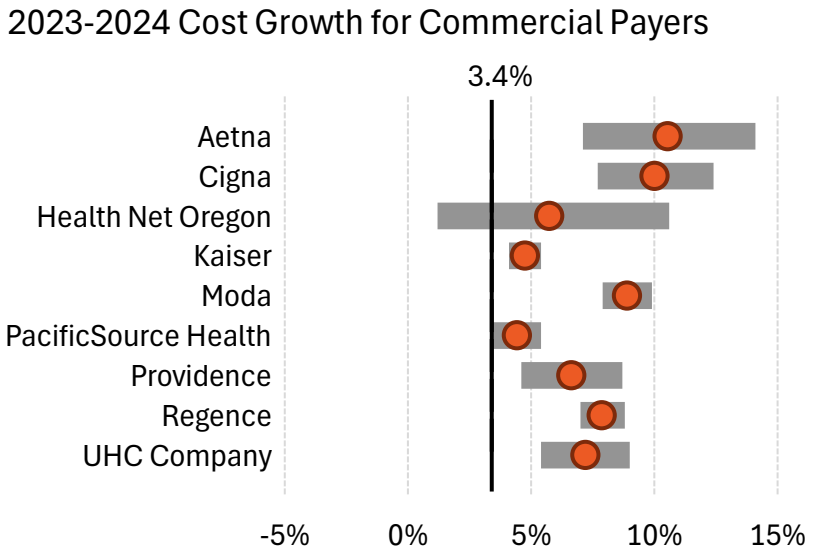


Commercial Cost Growth – By Payer, 2023-2024

Of the nine Commercial payers included in Cost Growth Target reporting for 2023-2024, none met the cost growth target, and seven exceeded the target. Cost growth ranged from 4.4% to 10.5%.

Two 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	Percent of Member Months in Partial Claims, 2023	Percent of Member Months in Partial Claims, 2024
Aetna	58.4%	56.1%
Cigna	23.4%	20.7%
Moda	84.9%	86.1%
Regence	23.2%	23.3%
UHC Company	27.5%	22.4%

Commercial Payer	Target Performance	2023-2024 Cost Growth
Aetna	Not Met	10.5%
Cigna	Not Met	10.0%
Health Net Oregon	Indeterminate	5.7%
Kaiser	Not Met	4.8%
Moda	Not Met	8.9%
PacificSource Health	Indeterminate	4.4%
Providence	Not Met	6.6%
Regence	Not Met	7.9%
UHC Company	Not Met	7.2%

Commercial Cost Growth Drivers – by Payer and by Service Category, 2023-2024

The table below shows how much each service category contributes to the total per person per year spending difference from 2023 to 2024, by Commercial payer, with each column summing to 100%. Each cell in the table shows how much the service category contributed to overall cost growth – for example, Professional Specialty was responsible for 15.3% of the Commercial cost growth between 2023-2024. Darker cells indicate larger absolute spending changes. Grey columns represent payers with indeterminate cost growth, and orange columns indicate payers that exceeded the target with statistical confidence.

Hospital Outpatient is the primary cost driver on a per person per year spending difference basis across the Commercial market; it was the largest contributor to the spending difference between 2023-2024 for five payers (Aetna, Health Net Oregon, Moda, PacificSource Health, and Regence) and the second largest contributor for the other four Commercial payers (Cigna, Kaiser, Providence, and UHC Company).

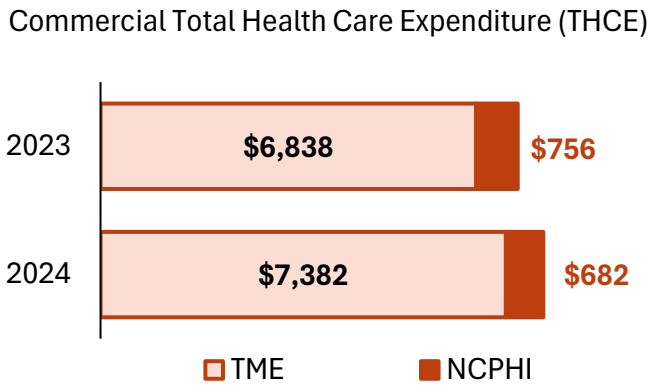
Retail Pharmacy (Net) is the top contributor of the per person per year spending difference for Cigna and Providence. Professional Specialty leads for Kaiser. Hospital Inpatient is the largest contributor for UHC Company. For Regence, Retail Pharmacy (Net) and Hospital Inpatient are the second and third largest contributors.

	Commercial	Aetna	Cigna	Health Net Oregon	Kaiser	Moda	PacificSource Health	Providence	Regence	UHC Company
Inpatient	9.2%	11.7%	12.1%	-59.1%	0.7%	13.1%	0.2%	6.3%	19.8%	28.9%
Outpatient	29.6%	22.7%	26.4%	62.4%	22.0%	34.5%	50.3%	23.6%	21.9%	28.3%
Professional PCP	10.5%	9.1%	9.0%	9.5%	8.0%	8.2%	12.0%	12.4%	13.4%	10.9%
Professional Specialty	15.3%	11.6%	9.8%	27.5%	45.8%	9.3%	17.8%	13.9%	5.9%	0.2%
Professional BH	8.4%	3.4%	2.8%	7.7%	16.1%	10.2%	8.0%	8.5%	6.9%	10.5%
Professional Other	2.7%	9.5%	-1.7%	5.2%	-18.1%	10.7%	11.1%	3.2%	5.4%	3.6%
Long-Term Care	0.9%	0.1%	3.6%	3.3%	-0.2%	0.2%	0.6%	1.7%	0.2%	5.6%
Medical Pharmacy	13.8%	13.5%	0.4%	30.5%	17.3%	4.8%	14.7%	3.4%	5.5%	10.2%
Retail Pharmacy (Net)	8.2%	14.9%	27.5%	4.9%	13.3%	5.4%	-5.2%	27.0%	21.7%	0.5%
Claims Other	2.9%	4.6%	5.9%	8.1%	-2.6%	4.8%	0.2%	2.9%	0.7%	2.0%
Non-Claims	-1.5%	-1.1%	4.2%	0.1%	-2.4%	-1.3%	-9.8%	-2.9%	-1.4%	-0.7%

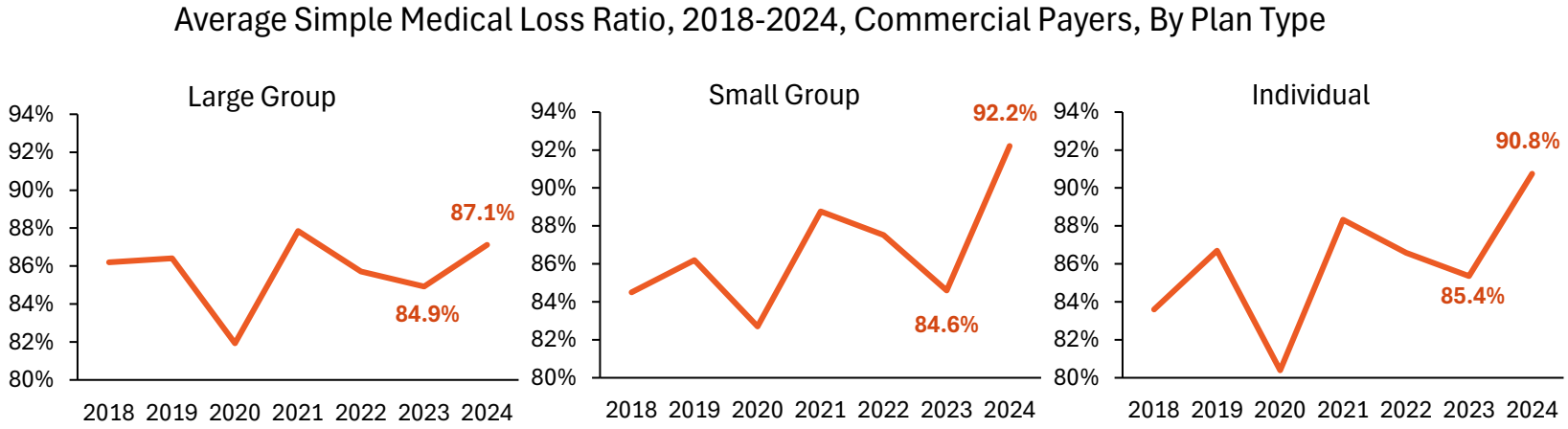
Commercial Market - Growth in Net Cost of Private Health Insurance (NCPHI), 2023-2024

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 2023-2024, NCPHI decreased 9.8% per person per year for Commercial payers in Oregon, compared to 8.0% 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 2024, the weighted average simple MLR was 87.1% for large group plans, 92.2% for small group plans, and 90.8% for individual plans, reaching the highest levels since 2018.



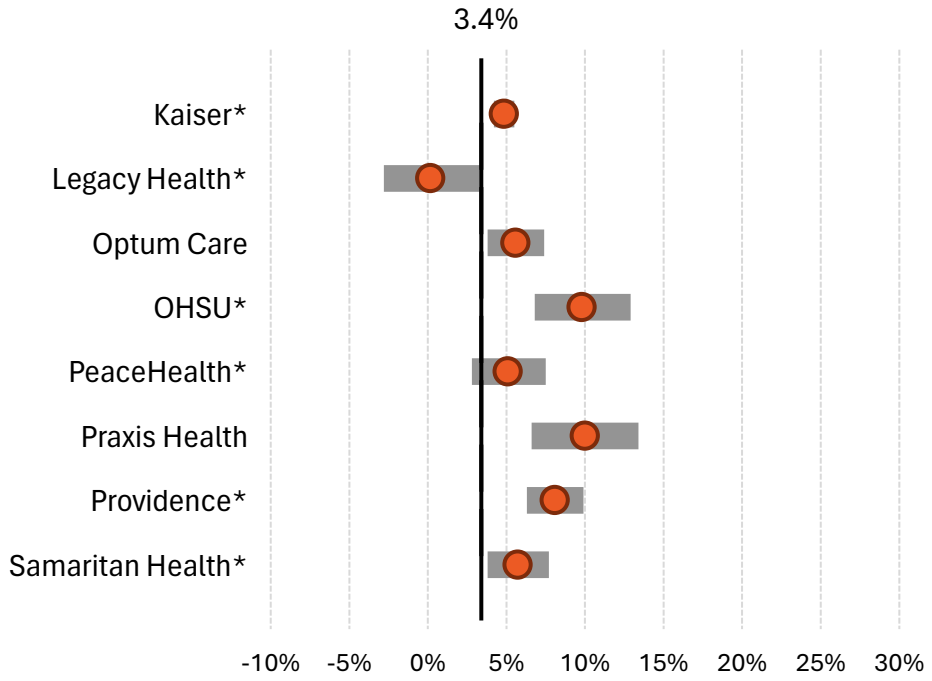
Commercial Cost Growth – By Provider Organization and IPA, 2023-2024

Large Provider Organizations and IPAs

This group includes eight provider organizations, each with more than 20,000 attributed patients in 2024 with Commercial health insurance coverage. Cost growth for this group ranged from 0.2% to 10.0%. One provider organization met the target with statistical confidence.

Commercial Cost Growth for Large Provider Organizations, 2023-2024

More than 20,000 Attributed Patients in 2024



Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Kaiser*	Not Met	4.8%
Legacy Health*	Met	0.2%
Optum Care	Not Met	5.6%
OHSU*	Not Met	9.8%
PeaceHealth*	Indeterminate	5.1%
Praxis Health	Not Met	10.0%
Providence*	Not Met	8.1%
Samaritan Health*	Not Met	5.7%

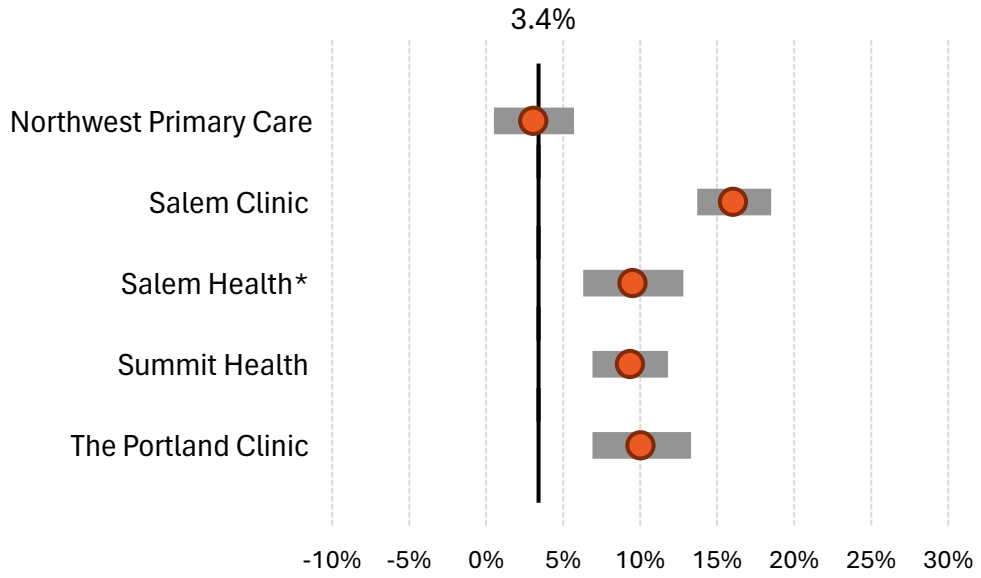
* Provider organizations that include hospitals.

Mid-Sized Provider Organizations and IPAs

This group includes five provider organizations, each had between 10,000 and 20,000 attributed patients in 2024 with Commercial coverage. Cost growth for this group ranged from 3.1% to 16.0%. No provider organizations met the target with statistical confidence.

Commercial Cost Growth for Mid-Sized Provider Organizations, 2023-2024

10,000 to 20,000 Attributed Patients in 2024



Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Northwest Primary Care	Indeterminate	3.1%
Salem Clinic	Not Met	16.0%
Salem Health*	Not Met	9.5%
Summit Health	Not Met	9.4%
The Portland Clinic	Not Met	10.0%

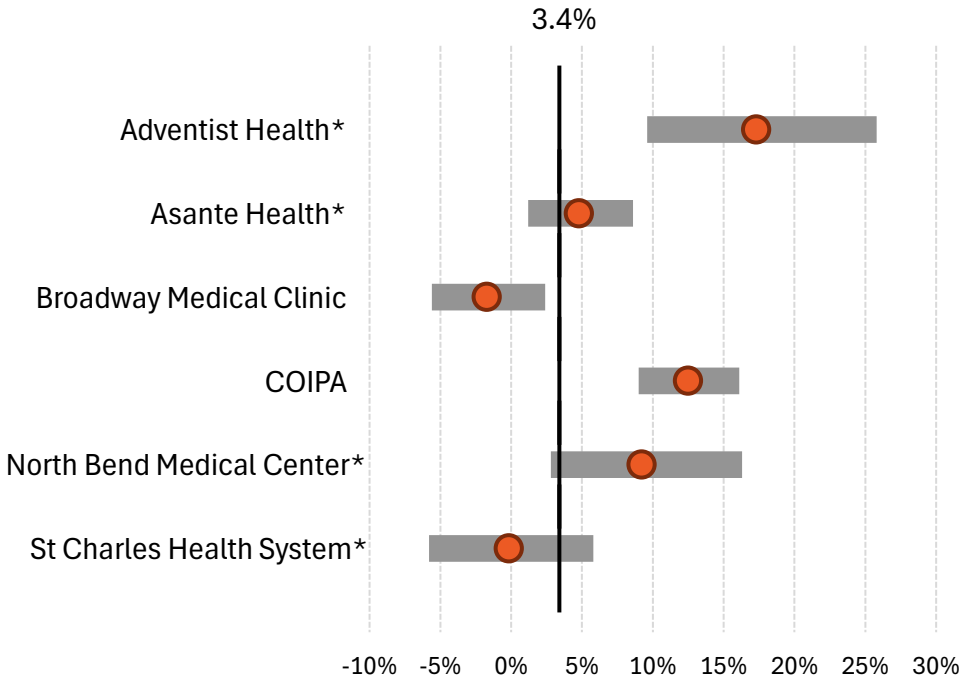
* Provider organizations that include hospitals.

Smaller Provider Organizations and IPAs

This group includes five provider organizations and one IPA, each with fewer than 10,000 attributed patients in 2024 with Commercial coverage. Cost growth for this group ranged from -1.7% to 17.3%. One provider organization met the target with statistical confidence.

Commercial Cost Growth for Small Provider Organizations, 2023-2024

Fewer than 10,000 Attributed Patients in 2024



Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Adventist Health*	Not Met	17.3%
Asante Health*	Indeterminate	4.8%
Broadway Medical Clinic	Met	-1.7%
COIPA	Not Met	12.5%
North Bend Medical Center*	Indeterminate	9.2%
St Charles Health System*	Indeterminate	-0.2%

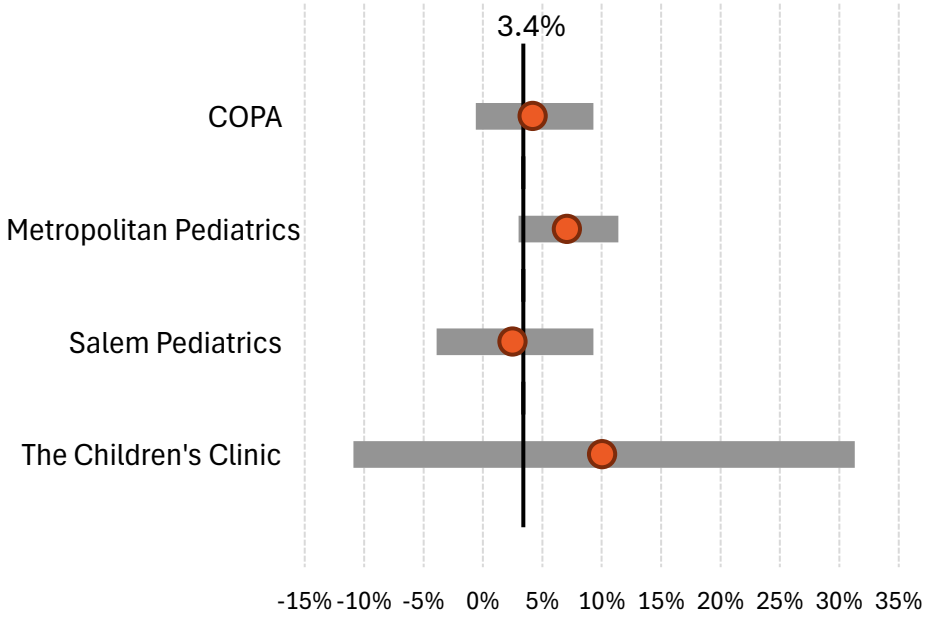
* Provider organizations that include hospitals.

Pediatric Provider Organizations

This group includes four pediatric practices. Cost growth for this group ranged from 2.5% to 10.1%. No pediatric provider organizations met the target with statistical confidence.

OHA understands that pediatric providers play a critical role in managing health care costs by focusing on preventative care and early intervention. By addressing health issues in children before they escalate, pediatric providers help mitigate the need for costly treatments later in life. The emphasis on family-centered care may ultimately reduce health care expenditures.

Commercial Cost Growth for Pediatric Provider Organizations, 2023-2024



Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
COPA	Indeterminate	4.2%
Metropolitan Pediatrics	Indeterminate	7.1%
Salem Pediatrics	Indeterminate	2.5%
The Children's Clinic	Indeterminate	10.1%

Chapter III. Health Care Cost Growth Trends in the Medicare Market, 2023-2024

Introduction: Medicare Cost Growth

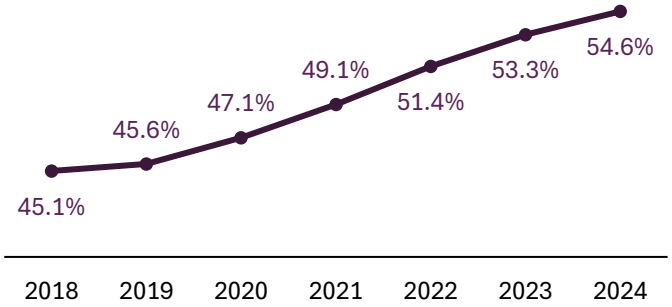
In Oregon, the Medicare market serves a relatively small proportion of the total population, but it accounts for a large share of medical spending and cost growth in the state. Approximately 13% of people in Oregon have Medicare coverage.[4]

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

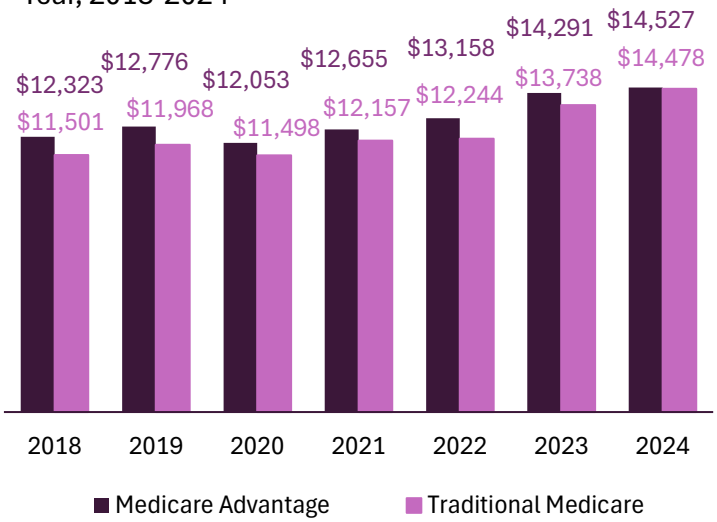
In recent years, enrollment in MA relative to Traditional Medicare has grown, in Oregon and nationally. Between 2018 and 2024, the percent of the Medicare-eligible population in Oregon enrolled in MA plans increased from 45.1% to 54.6%. The cost of care for MA enrollees has consistently been higher than that of Traditional Medicare, but the gap narrowed in 2023 and 2024. In 2024, the average Total Medical Expenses (TME) per person per year in MA in Oregon was $14,527, compared with $14,478 in Traditional Medicare. The difference between the two was less than 1%.

Between 2023-2024, Medicare spending totaled $14.50 billion in 2024 and made up 33.8% of total growth in statewide Total Health Care Expenditures (THCE). On a per person per year basis, THCE across Traditional Medicare and MA including duals increased 3.4%, from $16,047 in 2023 to $16,598 in 2024. MA TME growth was 3.4%.

Percent of Oregon Medicare-Eligible Population Enrolled in **Medicare Advantage**, 2018-2024



Medicare Total Medical Expenses Per Person Per Year, 2018-2024

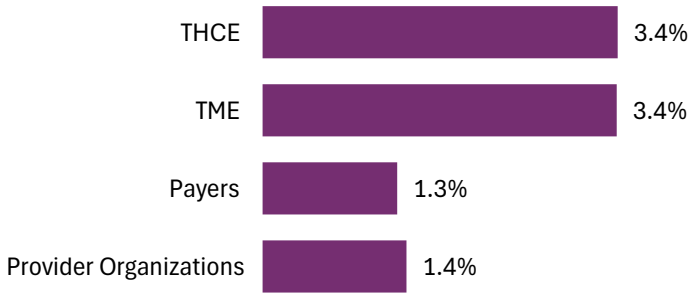


[4] Oregon Health Insurance Survey (OHIS), 2024. https://www.oregon.gov/oha/HPA/ANALYTICS/pages/ohis-coverage.aspx

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

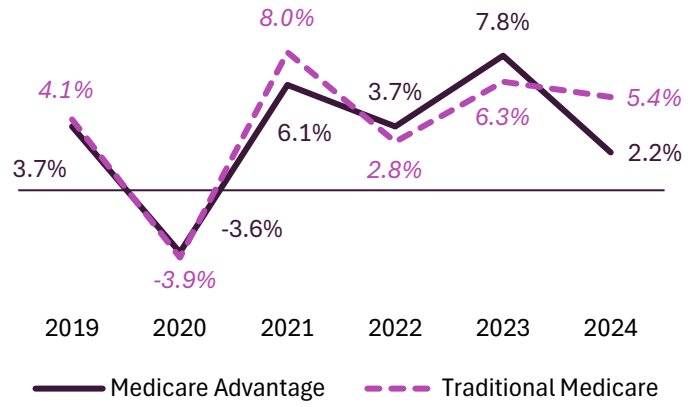
- In MA, the **Hospital Outpatient** service category was the largest contributor to per person cost growth, rising 7.3% ($192) from 2023 to 2024. In Traditional Medicare, **Professional** services contributed the most, increasing11.1% ($301). Both price increases and higher utilization contributed to cost growth in these two service categories.
- **Medical Pharmacy** was another major cost driver during the period. In MA, Medical Pharmacy (gross of rebates) grew 7.3% ($192) per person. **Nearly half of the spending was for chemotherapeutic agents**, which grew 17.2% over the period and was driven by both price and utilization.
- **Durable Medical Equipment (DME)** had the highest per person spending growth (80.4%). The growth occurred primarily in Traditaional Medicare and was driven by price increases.
- Of ten MA payers, five met the cost growth target, and four exceeded the target with statistical significance.
- Of sixteen MA provider organizations and IPAs, four met the cost growth target, and seven exceeded the target with statistical significance.

Medicare Advantage Cost Growth, 2023-2024



THCE and TME growth are changes in PPPY spending across Medicare FFS and Medicare Advantage including duals, net of rebates and unadjusted for demographics. Payer and provider organization cost growth are changes in PMPM for Medicare Advantage excluding duals, and adjusted for sex/age. Payer growth is measured net of rebates, while provider organization growth is measured gross of rebates.

TME PPPY Growth in Traditional Medicare vs Medicare Advantage Including Duals, 2018-2024



Medicare Cost Growth – Service Categories, 2023-2024

From 2023-2024, Total spending for people in Oregon with Medicare health insurance grew by $667.6 million, or 5.3%.

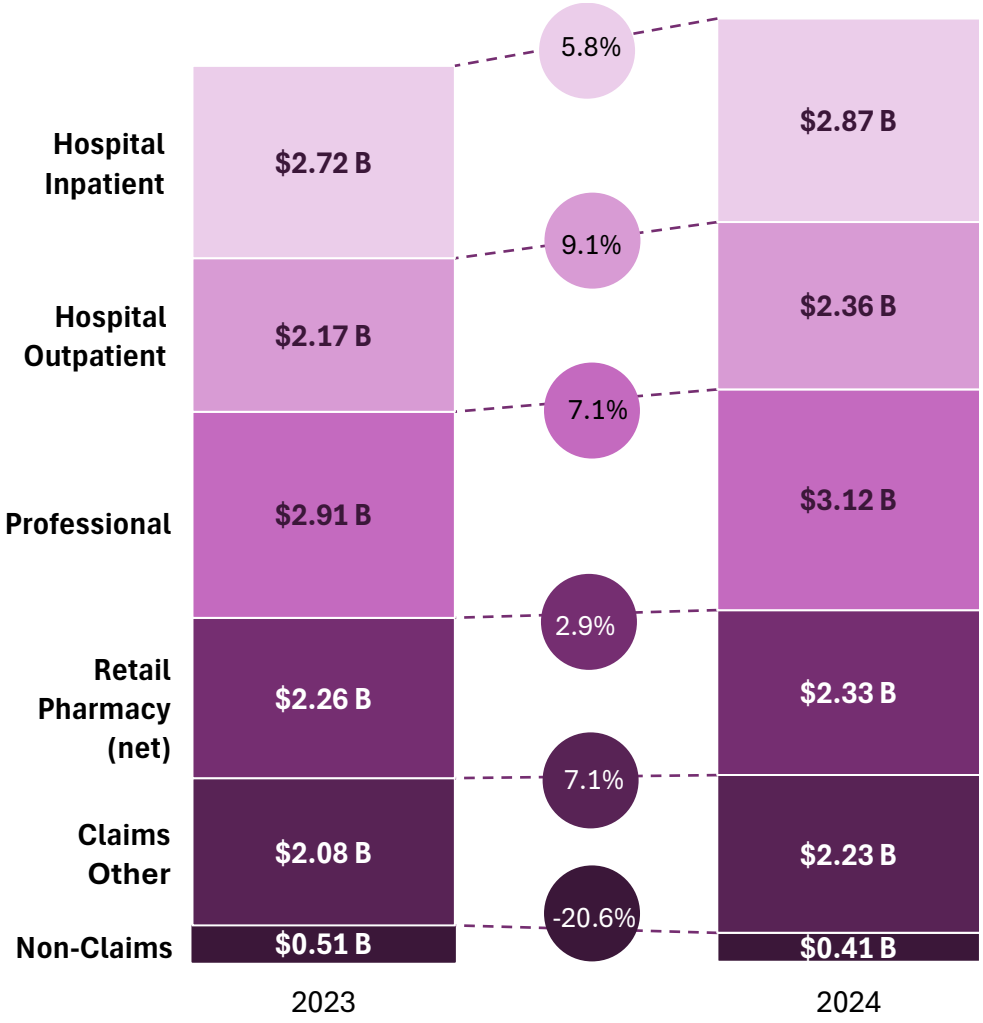
The biggest service category driving total Medicare spending was Hospital Outpatient, which grew 9.1% ($196.5 million). This was followed by increased spending on Professional services where costs grew by $206.3 million, and Claims Other, which grew by $148.2 million. This category includes spending on things like durable medical equipment, hospice services, and transportation.

Total members enrolled in Medicare including people who are dually eligible for Medicare and Medicaid ("duals") as tracked by the Cost Growth Target program grew around 1.8% between 2023-2024.

As a result of the increased enrollment, Total Medical Expenditure growth per person was 3.4%, lower than growth in total spending. About 1.9% of growth in total spending was explained by the increase in enrolled members.

Total Spending and Growth Rate, Medicare Market, 2023-2024

Spending is reported net of pharmacy rebates.



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

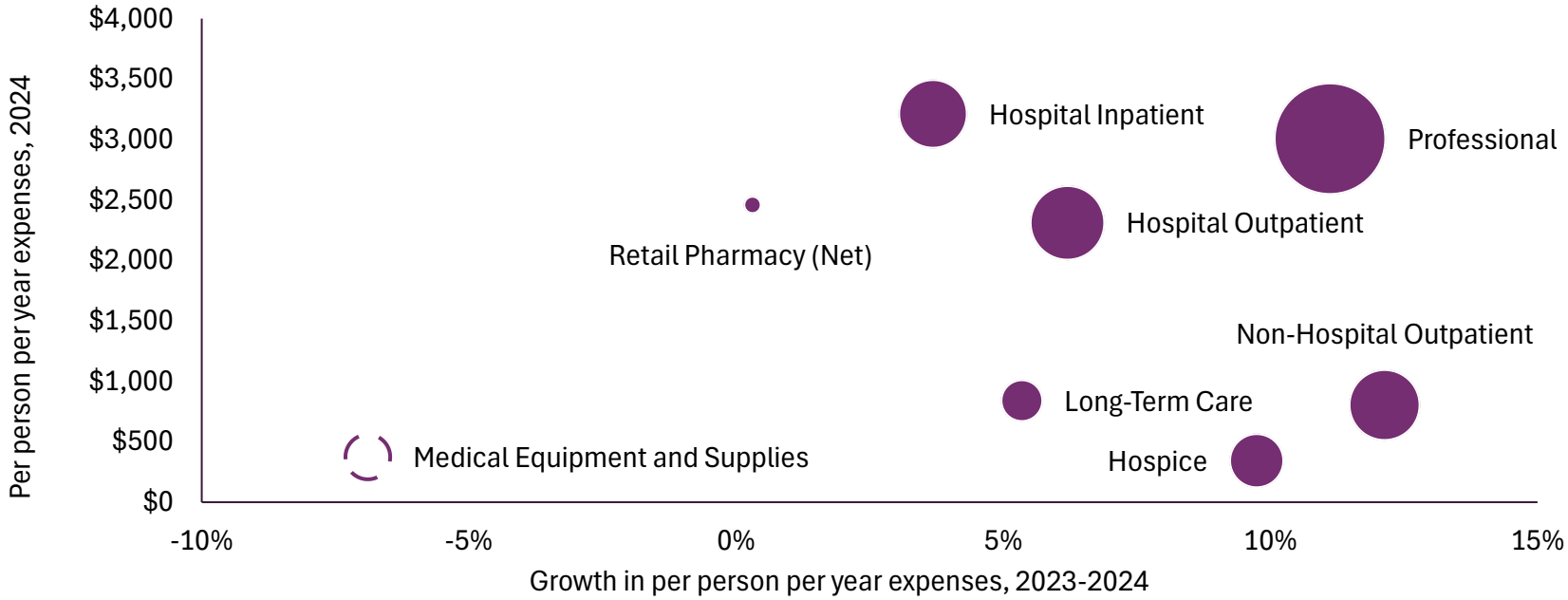
In Traditional Medicare, the single largest service category driving per person per year spending growth from 2023-2024 was Professional services, which saw a $301 (+11.1%) increase. This category includes the cost of professional services delivered by physicians and other providers.

Non-Hospital and Hospital Outpatient services were additional categories contributing to Traditional Medicare cost growth. Spending per person per year increased by $135 (+6.2%) in Hospital Outpatient services and by $122 (+12.1%) in Non-Hospital Outpatient services.

The analysis of claims data indicates that cost growth in Outpatient and Professional services is driven by price, see page 61 for details.

Traditional Medicare Total Medical Expenses – Growth in per Person per Year spending by Service Category, 2023-2024

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



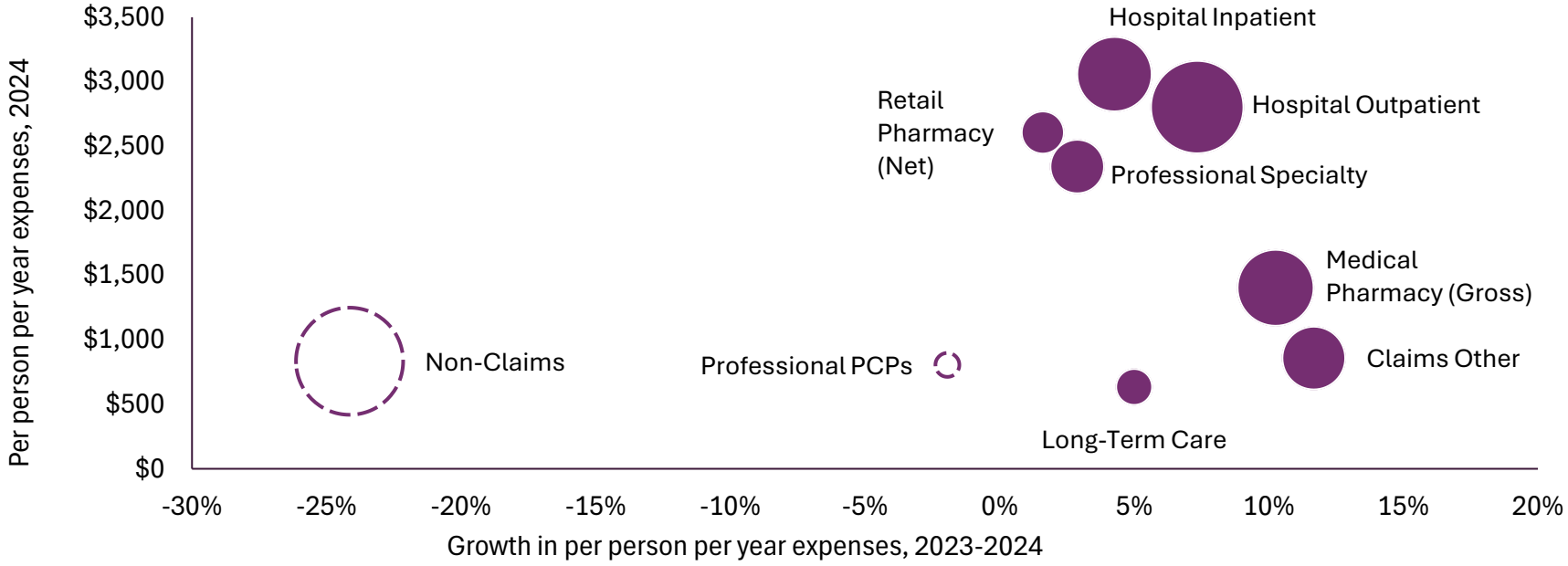
Growth in TME Per Person Per Year Spending by Service Category, Medicare Advantage

In Medicare Advantage, the service category driving cost growth from 2023-2024 was Hospital Outpatient, which grew 7.3% ($192) per person per year. This was followed by growth in Medical Pharmacy (Gross of Rebates), which grew 10.3% ($131) per person per year. While Medical Pharmacy (Gross) had a higher percent change, the higher per person per year spending for Hospital Outpatient made that the bigger driver.

While most Medicare Advantage service categories saw a spending increase in 2024, overall spending growth in the Medicare Advanatge market was tempered by a significant decrease in Non-Claims spending. Non-Claims spending decreased by 24.1% (-$265) per person per year.

Medicare Advantage Total Medical Expenses – Growth in Per Person per Year spending by Service Category, 2023-2024

Spending is reported net of retail pharmacy rebates. Bubble size represents absolute dollar change in per person per year spending. Negative growth (spending decrease) are shown in dotted lines.

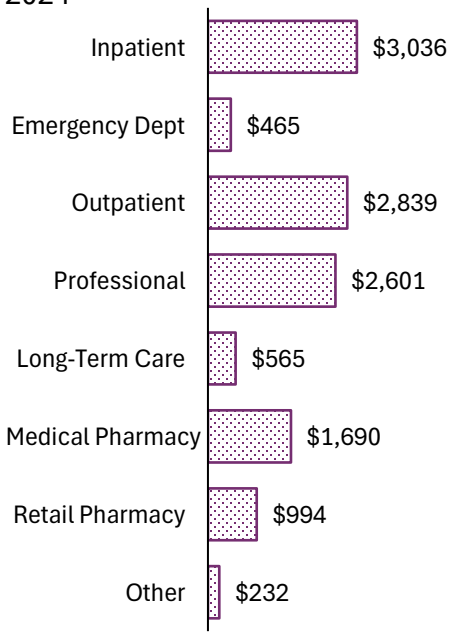


Medicare Cost Growth Drivers – Price vs Utilization, 2023-2024

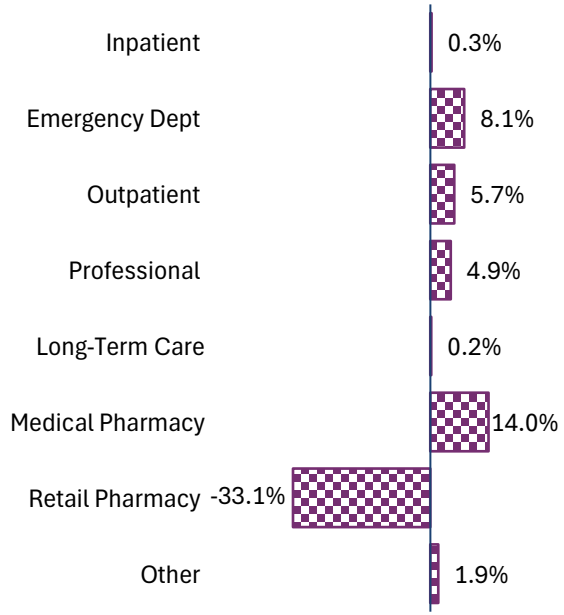
Traditional Medicare

For Traditional Medicare, nearly every service category saw increases in price and decreases in utilization. This was especially true in the service categories that accounted for the most spend in 2024, such as Inpatient, Outpatient, Professional, and Medical Pharmacy. In some service categories, such as Inpatient, the decrease in utilization (-2.8%) nearly matched the growth in price (+2.9%) to result in very little overall cost growth (+0.3%). But in the majority of service categories, growth in price outpaced decreases in utilization resulting in positive cost growth between 2023-2024.

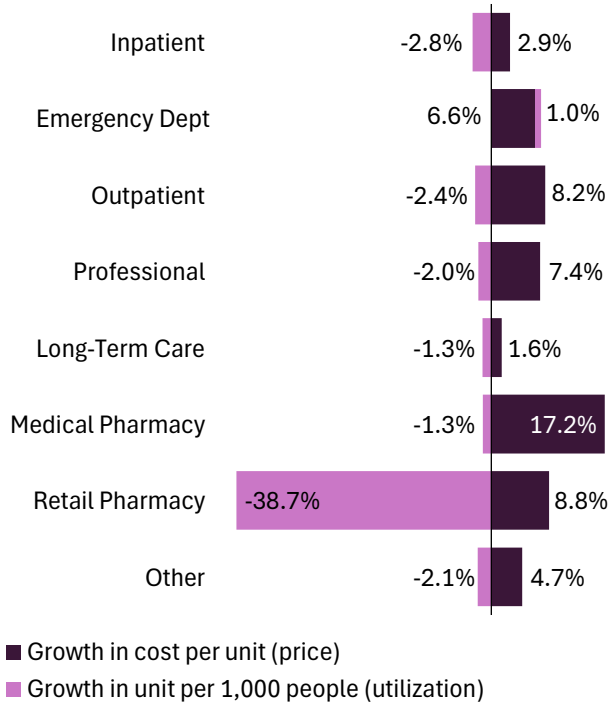
Cost Per Person by Service Category in Traditional Medicare, 2024



Cost Per Person Growth by Service Category in Traditional Medicare, 2023-2024



Growth in Price vs. Utilization by Service Category in Traditional Medicare, 2023-2024



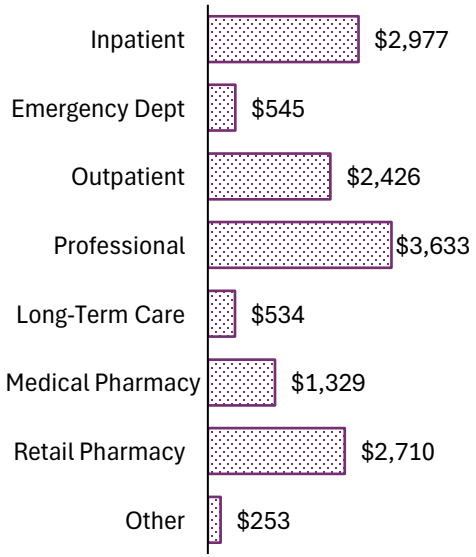
Medicare Advantage

For Medicare Advantage, every service category saw positive cost growth between 2023-2024, with utilization playing a more significant role in most service categories. For example, the two service categories accounting for the most Medicare Advantage spend in 2024, Inpatient and Professional, both saw cost growth driven primarily by increases in utilization.

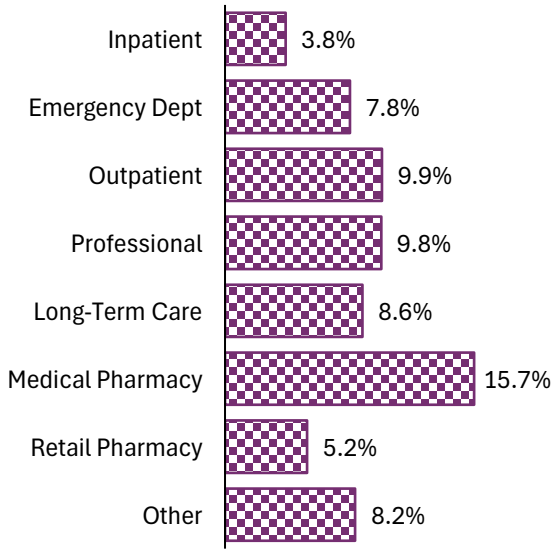
The next two service categories accounting for the most Medicare Advantage spend in 2024, Outpatient and Retail Pharmacy, also saw increases in utilization between 2023-2024 but the cost growth in those two categories was driven more by increases in price.

The service category that saw the highest cost growth by percentage, Medical Pharmacy (+15.7%), was driven entirely by increases in price and. Please see the Medicare Spotlight on the following page for more information Medical Pharmacy spending in 2024.

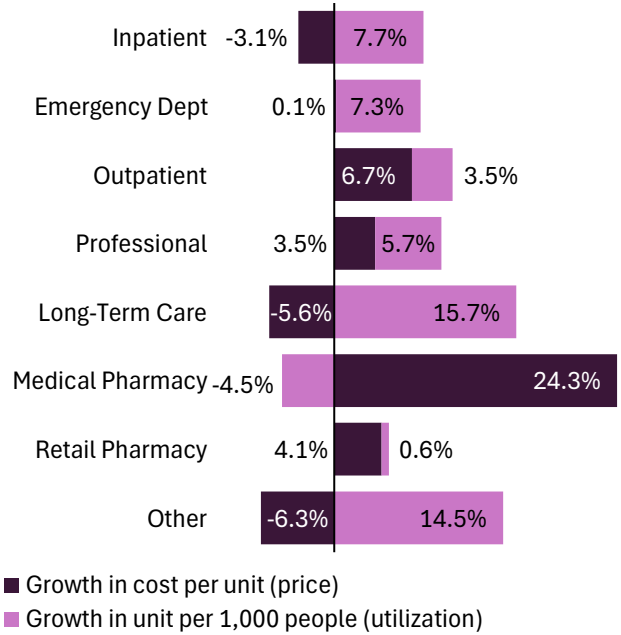
Cost Per Person by Service Category in Medicare Advantage, 2024



Cost per Person Growth by Service Category in Medicare Advantage, 2023-2024



Growth in Price vs. Utilization by Service Category in Medicare Advantage, 2023-2024

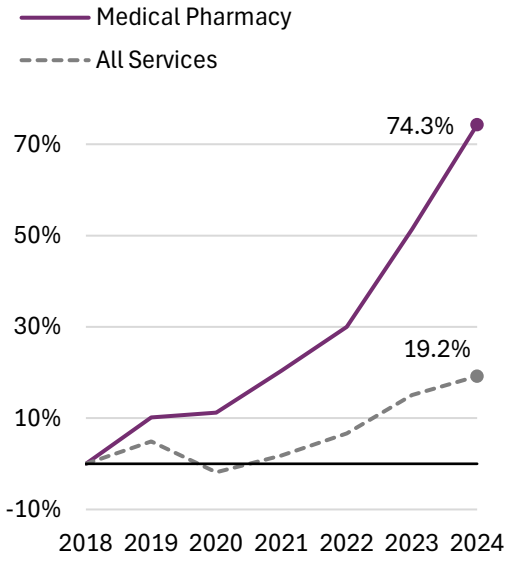


Medicare Spotlight: Medical Pharmacy Spending

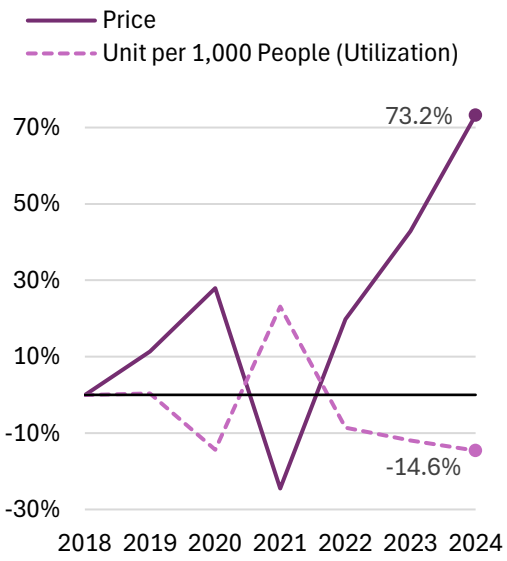
Cost Growth Target data submitted by Medicare payers showed that Medical Pharmacy – drugs administered in a doctor's office – was a significant contributor to 2023-2024 cost growth. Analysis of Medicare claims data confirms that the cost of medical pharmacy products has been growing rapidly. From 2018 to 2024, cumulative per-person spending on Medical Pharmacy increased at a significantly faster rate than overall per-person Medicare spending in Oregon (74.3% compared with 19.2%). When examining the overall Medical Pharmacy cost growth from 2018 to 2024 for non-dual Medicare members, prices emerged as the main driver. Over this period, cumulative prices rose 73.2%, while cumulative utilization declined 14.6%. In 2024, non-dual Medicare spending on Medical Pharmacy in Oregon exceeded $1 billion.

Nearly half of the medical pharmacy spending (44.0%) in non-dual Medicare in 2024 was for Chemotherapeutic Agents (drugs used to treat cancer). From 2023 to 2024, per person spending on these drugs rose 17.2%, driven by a 5.4% increase in price and a 9.2% increase in utilization. Based on total spending in 2024, Injections – Monoclonal Antibodies was the second-largest drug family in 2024. Per person spending increased 5.8%, driven by an 8.1% rise in utilization from 2023 to 2024.

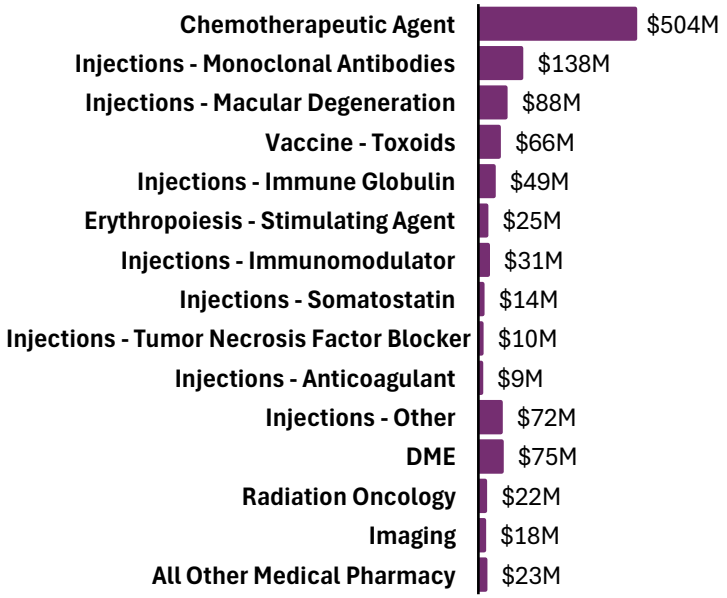
Cumulative Cost Per Person Growth in Medical Pharmacy vs. All Services, Non-Dual Medicare, 2018-2024



Cumulative Price and Utilization Growth in Medical Pharmacy, Non-Dual Medicare, 2018-2024

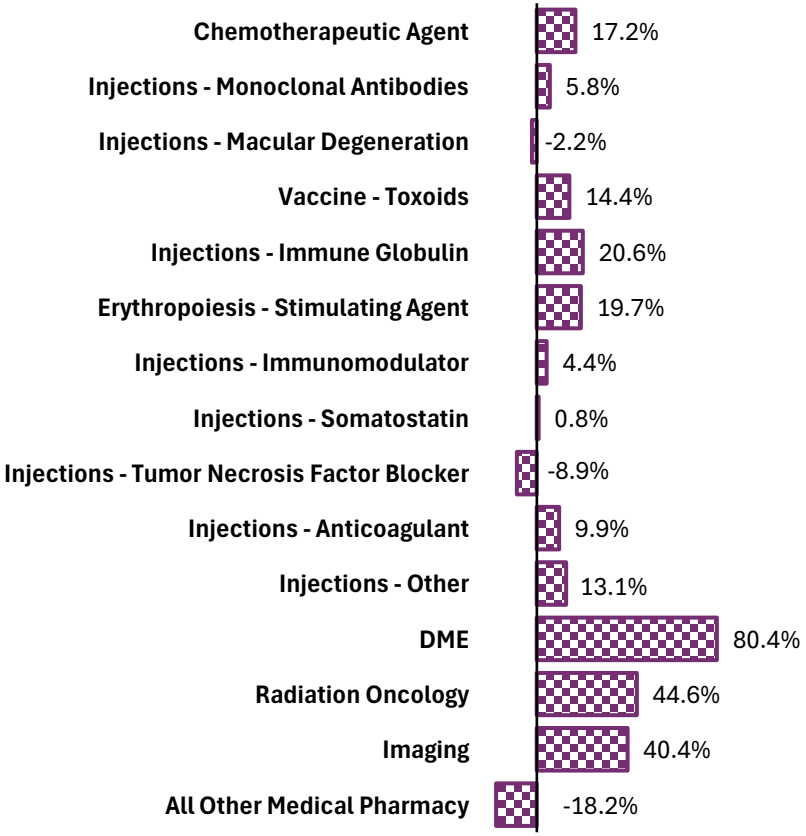


Medical Pharmacy Spending by Drug Family, Non-Dual Medicare, 2024

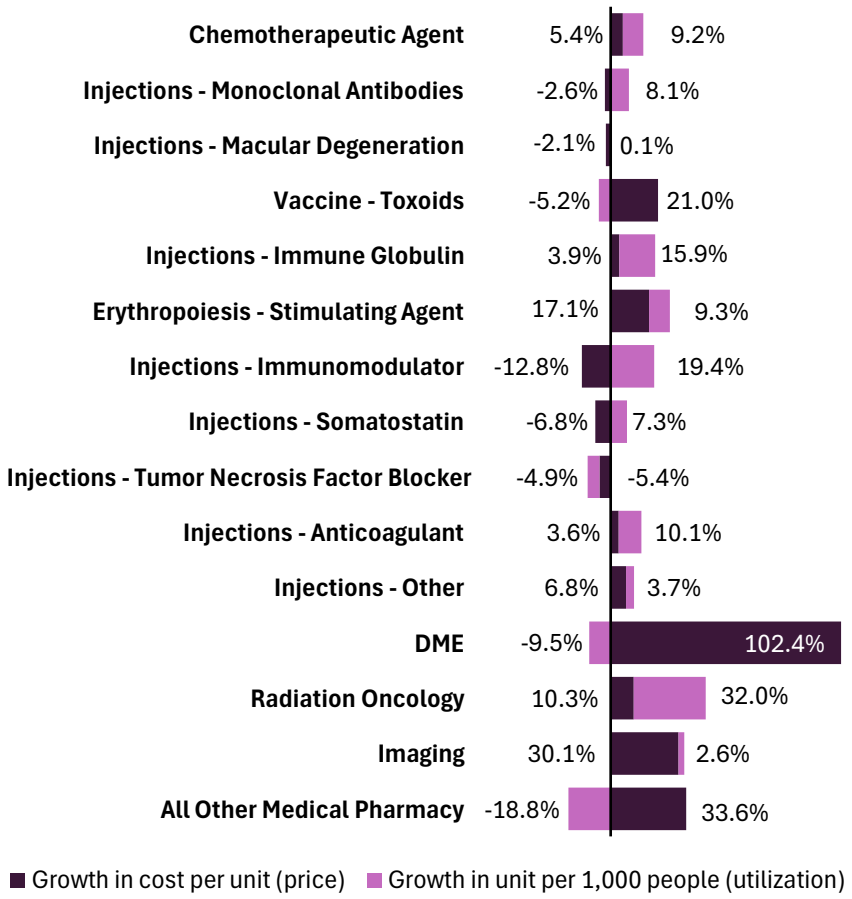


Between 2023 and 2024, Durable Medical Equipment (DME) had the highest per person spending growth in Non-Dual Medicare (80.4%). This growth occurred primarily within Traditional Medicare and was driven by a 102.4% increase in price. Radiation Oncology shows the second highest cost growth from 2023 to 2024 at 44.6%, driven by a 10.3% increase in price and a 32.0% increase in utilization. Imaging was the third highest cost growth at 40.4%, mainly driven by a 30.1% increase in price.

Cost Per Person Growth in Medical Pharmacy by Drug Family in Non-Dual Medicare, 2023-2024

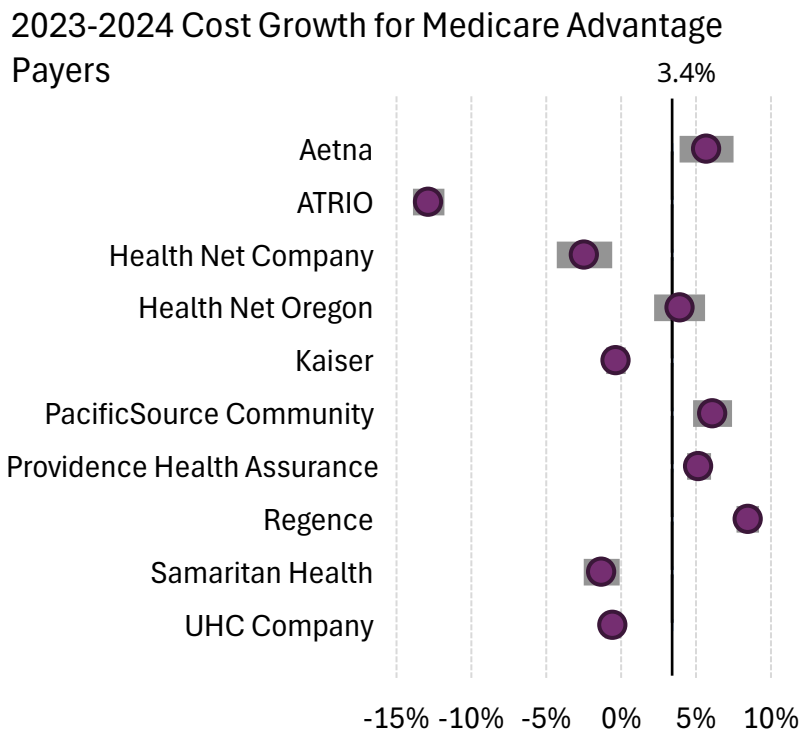


Growth in Price vs. Utilization in Medical Pharmacy by Drug Family in Non-Dual Medicare, 2023-2024



Medicare Advantage Cost Growth – By Payer, 2023-2024

Of the ten Medicare Advantage payers included in Cost Growth Target reporting for 2023-2024, four exceeded the target with statistical confidence, one had indeterminate cost growth, and four payers met the cost growth target. The average cost growth across Medicare Advantage payers was 1.3%, and cost growth ranged from -12.9% to 8.5%.



Medicare Advantage Payer	Target Performance	2023-2024 Cost Growth
Aetna	Not Met	5.7%
ATRIO	Met	-12.9%
Health Net Oregon	Indeterminate	3.9%
Health Net Company	Met	-2.5%
Kaiser	Met	-0.4%
PacificSource Community	Not Met	6.1%
Providence Health Assurance	Not Met	5.2%
Regence	Not Met	8.5%
Samaritan Health	Met	-1.3%
UHC Company*	Met	-0.6%

*UHC Company includes all UHC Medicare entities (Care Improvement Plus, South Central Insurance Company and United Healthcare Benefits of Texas

Medicare Advantage Cost Growth Drivers – by Payer and by Service Category, 2023-2024

The table below shows each service category contributes to the total per person per year spending difference from 2023 to 2024, by Medicare Advantage payer, with each column summing to 100%. Each cell in the table shows how much the service category contributed to overall cost growth – for example, Hospital Outpatient was responsible for 52.3% of Medicare Advantage cost growth. Darker cells indicate larger absolute spending changes. Grey columns represent payers with indeterminate or met the cost growth target, and purple columns indicate payers that exceeded the target with statistical confidence.

Among Medicare Advantage payers that exceeded the cost growth target between 2023-2024 with statistical confidence, a common driver was increased Hospital spending. Hospital Inpatient is the top contributor to spending growth for Aetna and Providence, and Hospital Outpatient is the leading factor for PacificSource and Regence. Retail Pharmacy (Net of Rebates) is another category where costs are rising in Medicare Advantage. Across all Medicare Advantage payers, Retail Pharmacy (Net) accounted for 35.6% of the per person per year spending growth. It is the top cost contributor for Providence and the second-largest contributor for PacificSource and Regence. Non-Claims per person per year spending decreased, primarily driven by UHC Company.

	Medicare Advantage	Aetna	ATRIO	Health Net Oregon	Health Net Company	Kaiser	PacificSource Community	Providence Health Assurance	Regence	Samaritan	UHC Company
Inpatient	34.2%	36.5%	4.3%	25.8%	15.6%	-22.8%	-8.2%	29.1%	13.2%	62.7%	-4.9%
Outpatient	52.3%	14.0%	-2.1%	45.0%	107.6%	13.0%	35.4%	13.7%	21.3%	-11.4%	53.1%
Professional PCP	-4.3%	8.9%	-2.0%	2.5%	10.3%	-82.3%	1.1%	6.7%	3.7%	-11.1%	-28.4%
Professional Specialty	17.9%	12.3%	-11.8%	22.6%	29.0%	103.2%	12.5%	16.4%	7.0%	11.3%	14.1%
Professional BH	1.2%	1.2%	2.0%	2.5%	1.7%	5.1%	-0.1%	1.1%	0.6%	-2.3%	-0.9%
Professional Other	-8.4%	-3.3%	-1.3%	-19.9%	-41.8%	-45.9%	4.1%	3.7%	-2.5%	-1.6%	-5.7%
Long-Term Care	8.2%	0.1%	-2.8%	11.1%	23.1%	-7.4%	6.4%	8.5%	-2.1%	-15.6%	11.4%
Medical Pharmacy	11.2%	18.1%	6.6%	58.6%	42.4%	51.7%	11.0%	15.6%	14.0%	3.2%	58.2%
Retail Pharmacy (Net)	35.6%	-0.4%	-11.5%	-44.8%	-62.2%	48.1%	31.7%	35.7%	25.7%	32.5%	55.5%
Claims Other	24.5%	4.2%	13.5%	-1.5%	-4.1%	36.6%	1.8%	2.4%	18.1%	2.3%	22.4%
Non-Claims	-72.3%	8.4%	105.1%	-1.9%	-21.6%	0.7%	4.3%	-32.9%	1.0%	30.0%	-74.9%

Medicare Advantage – Growth in Net Cost of Private Health Insurance

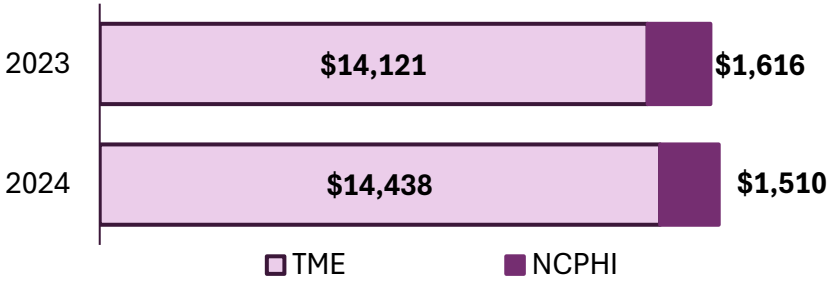
In Medicare Advantage, the Net Cost of Private Health Insurance (NCPHI), represents the difference between the amount a payer receives in premiums and federal capitation payments and the cost of claims paid out.

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.[5] 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.

Between 2023-2024, the Medicare Advantage NCPHI declined from $1,616 per person per year in 2023 to $1,510 in 2024 (-6.6%).

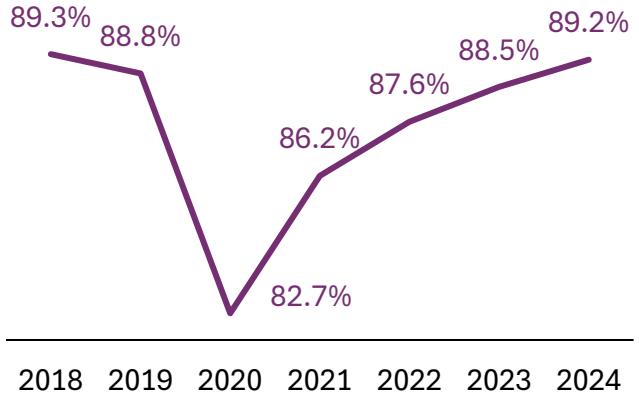
The proportion of Medicare Advantage plan income going towards claims (the simple Medical Loss Ratio) among Medicare Advantage payers in Oregon increased modestly to 89.2% in 2024, compared to 88.5% in 2023, edging back towards its pre-pandemic level.

Medicare Advantage Total Health Care Expenditure



THCE excludes Medicaid Duals dollars.

Medicare Advantage Average Simple Medical Loss Ratio, 2018-2024

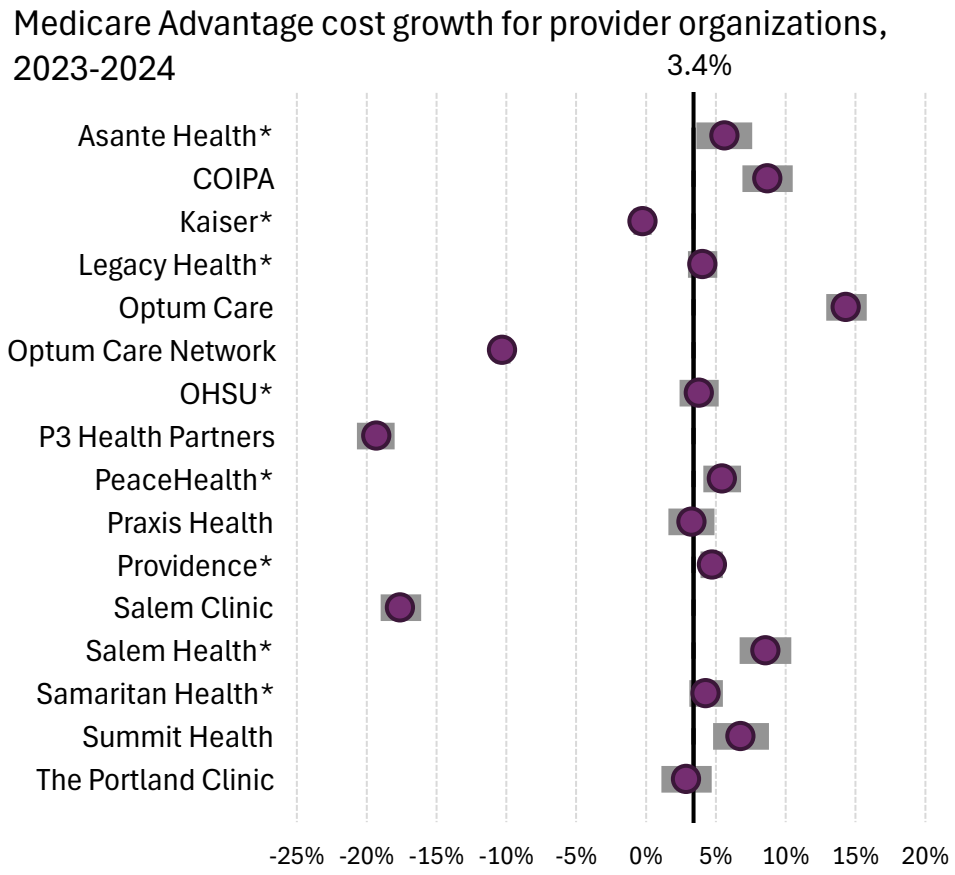


[5] It cannot be determined from these data whether the revenue from these rebates resulted in more Medicare Advantage members utilizing benefits.

Medicare Advantage Cost Growth – By Provider Organization and IPA, 2023-2024

All Provider Organizations and IPAs

This group includes all 13 provider organizations and 3 IPAs that had attributed patients with Medicare Advantage insurance coverage in the measurement period. Cost growth for this group ranged from -19.3% to 14.3%. Four provider organization met the target with statistical confidence.



* Provider organizations that inlcude hospitals.

Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Asante Health*	Not Met	5.6%
COIPA	Not Met	8.7%
Kaiser*	Met	-0.2%
Legacy Health*	Indeterminate	4.1%
Optum Care	Not Met	14.3%
Optum Care Network	Met	-10.3%
OHSU*	Indeterminate	3.8%
P3 Health Partners	Met	-19.3%
PeaceHealth*	Not Met	5.5%
Praxis Health	Indeterminate	3.3%
Providence*	Not Met	4.7%
Salem Clinic	Met	-17.6%
Salem Health*	Not Met	8.6%
Samaritan Health*	Indeterminate	4.3%
Summit Health	Not Met	6.8%
The Portland Clinic	Indeterminate	2.9%

Chapter IV. Health Care Cost Growth Trends in the Medicaid Market, 2023-2024

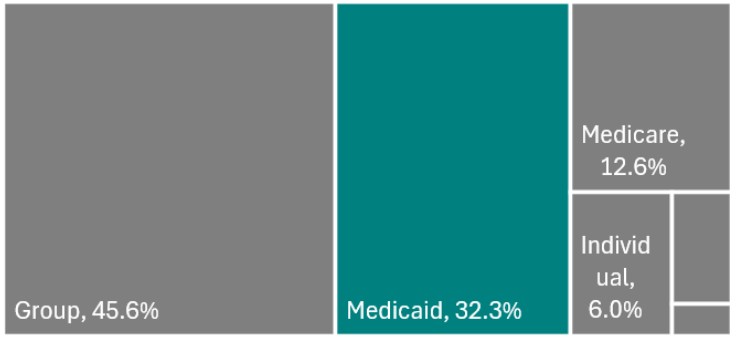
Introduction: Medicaid Cost Growth

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 January of 2025, approximately 1,457,828 Oregonians were enrolled in Medicaid, about one in three of the state's total population.[6]

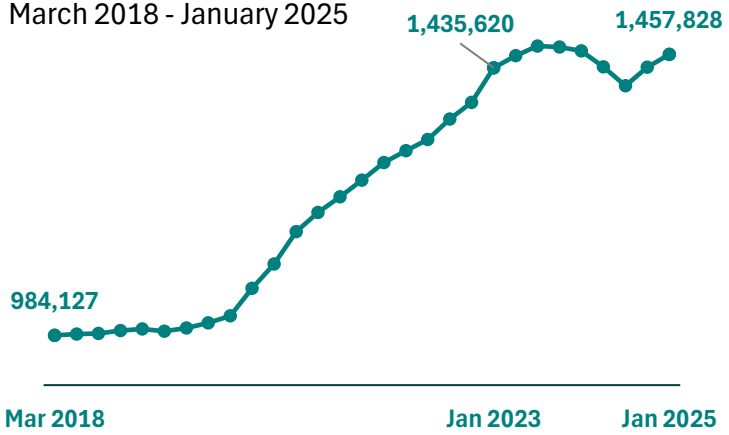
Most Medicaid enrollees in Oregon receive services through Coordinated Care Organizations (CCOs), which are regional networks of health care providers that deliver integrated care. CCOs are central to Oregon's strategy for managing Medicaid expenditures while aiming to improve health outcomes.

Between 2023 and 2024, total Medicaid Total Health Care Expenditures (THCE) increased by $1.10 billion, or 11.9%. The number of members covered under Medicaid remained stable over this period, resulting in per person THCE growth also being 11.9%.

Percent of People in Oregon by Type of Primary Health Care Insurance Coverage



Quarterly Oregon Medicaid Enrollment, March 2018 - January 2025

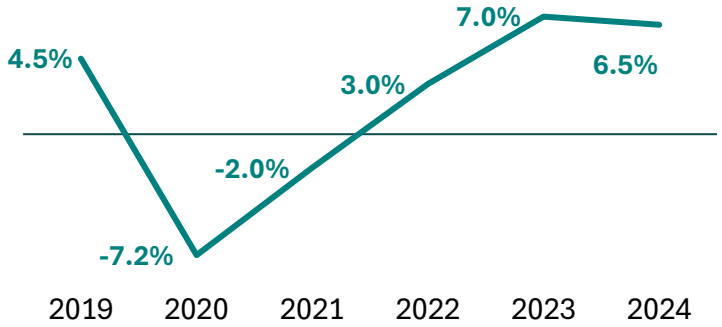


[6] Enrollment data from OHA's Office of Health Analytics. https://www.oregon.gov/oha/hpa/analytics/pages/medicaid-enrollment.aspx

Between 2023 and 2024, Medicaid Total Medical Expenses (TME) (net of pharmacy rebates, unadjusted) was 6.5%, which was slightly lower than the cost growth between 2022 and 2023. Key context for 2023-2024 Medicaid cost growth includes:

- More than a quarter of Medicaid cost growth resulted from increased spending on **Professional Behavioral Health services** (+17.2%, or $91 per person per year). 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.
- **Hospital Outpatient** was another major driver of cost growth in Medicaid with per person spending increased by $98 (+12.5%) during this period. The analysis suggests the increase was driven by price in Lab and Pathology, and by both price and utilization across all other Outpatient procedure categories.
- Claims Other grew at 15.2% ($48) was driven primarily by utilization during this period.
- Of sixteen Medicaid CCOs and Medicaid Open Card, only one met the cost growth target, and ten exceeded the target with statistical significance.
- Of fifty three Medicaid provider organizations and IPAs, ten met the cost growth target, and twenty four exceeded the target with statistical significance.

TME Growth, Medicaid Market, 2018-2024
2018-2024 Years are year 2 of a 2-year period, e.g., “2024” for 2023-2024



TME growth is growth in PPPY spending across Medicaid excluding CCOF and Medicaid Carve-Out, net of pharmacy rebates, unadjusted for demographics.

Medicaid Cost Growth, 2023-2024

THCE and TME growth are changes in PPPY spending , net of rebates and unadjusted for demographics. Payer and provider organization cost growth are changes in PMPM for Medicaid excluding duals, and adjusted for sex/age. Payer growth is measured net of rebates, while provider organization growth is measured gross of rebates.

Medicaid Cost Growth – Service Categories, 2023-2024

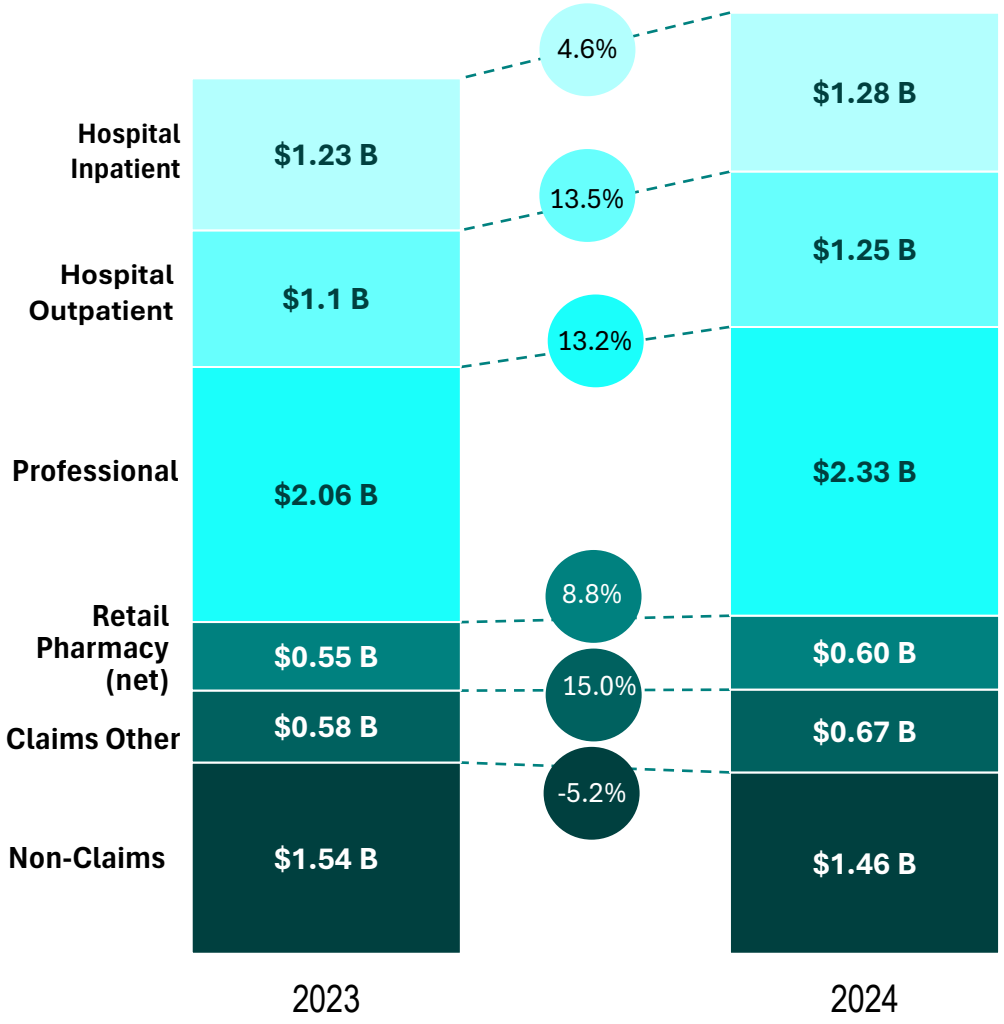
From 2023-2024, total medical expenses (TME) for Medicaid grew by $529.7 million, or 7.5%. Spending increased across all claims service categories, while non-claims spending declined.

The service category with the greatest growth in total dollar spent was Professional Services, where total costs increased by $271.8 million, or 13.2%. Behavioral Health accounted for the largest increase in Professional Services, with spending up by $135.6 million.

The next largest service category driving growth in total spending is Hospital Outpatient, where spending increased by $149.1 million, or 13.5%.

Total Spending and Growth Rate, Medicaid Market, 2023-2024

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



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

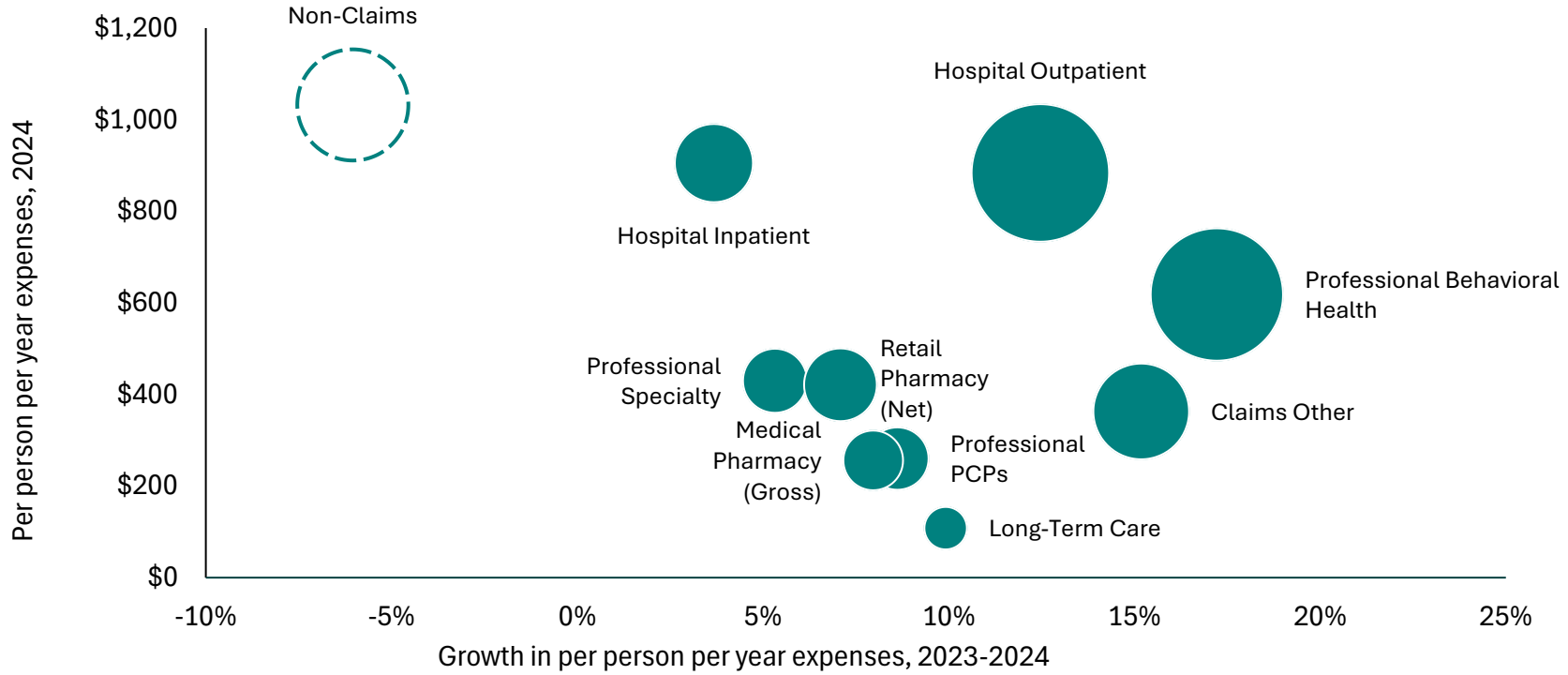
In the Medicaid market, the single largest service category driving per person per year spending growth from 2023-2024 was Professional Behavioral Health services, which saw a $91 (+17.2%) increase.

Hospital Outpatient and Claims Other services were additional categories contributing to cost growth in Medicaid spending. Spending per person per year increased by $98 (+12.5%) in Hospital Outpatient services and by $48 (+15.2%) in Claims Other services.

While those three service categories drove spending growth in the Medicaid market, every service category but Non-Claims saw growth that exceeded the cost growth target.

Total Spending and Growth Rate, Medicaid Market, 2023-2024

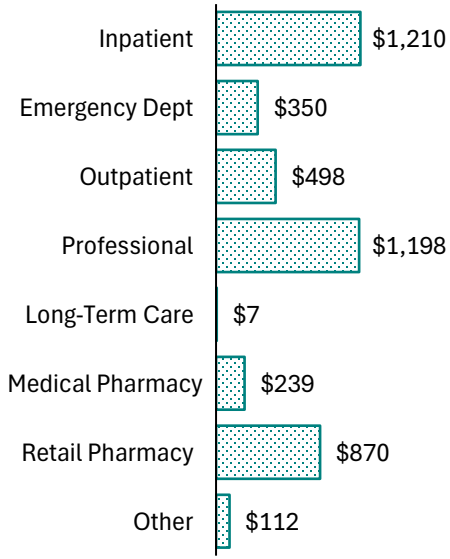
Spending is reported net of pharmacy rebates. Other includes non-claims spending.



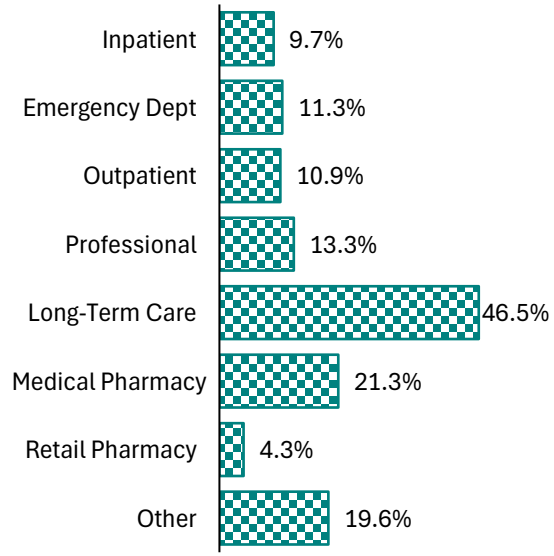
Medicaid Cost Growth Drivers – Price vs Utilization, 2023-2024

The Medicaid market saw growth in every service category between 2023-2024, with both price and utilization contributing to that growth. The service category with the highest percent growth between 2023-2024 was Long-Term Care (+46.5%), but due to the very low overall spend in this category ($7 per person) the overall impact of growth in this service category was minor. The service categories with the biggest impact on overall growth in the Medicaid market were Inpatient and Professional. Inpatient services accounted for the most Medicaid spend in 2024 ($1,210 per person) and saw 9.7% growth which was driven by nearly equal growth in price and utilization. Professional services accounted for $1,198 per person spend and saw 13.3% growth driven slightly more by price (+6.5%) than utilization (+5.1%).

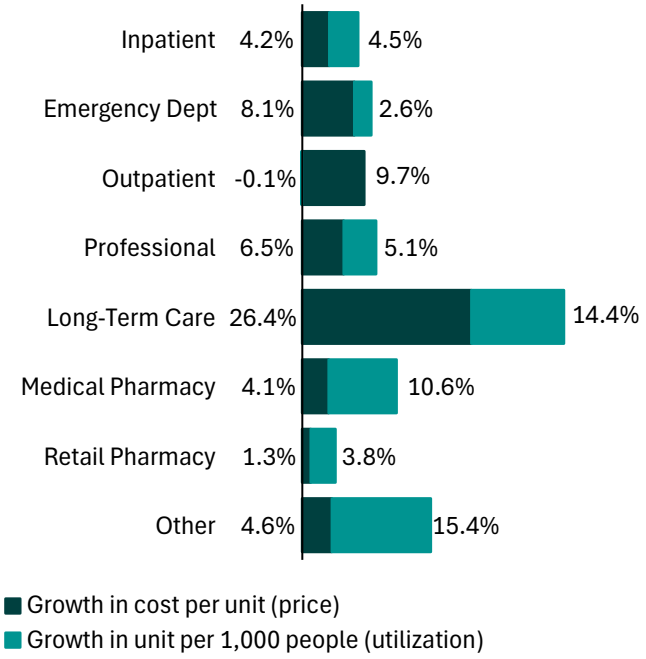
Cost Per Person by Service Category in Medicaid, 2024



Cost Per Person Growth by Service Category in Medicaid, 2023-2024



Growth in Price vs. Utilization by Service Category in Medicaid, 2023-2024



Medicaid Spotlight: State Medicaid Program and Policy Changes

Every year, state Medicaid program and policy changes are reflected in Cost Growth Target Program data and reporting. Below are some of the major program and policy changes impacting the 2023-2024 measurement period.

COVID-19 Vaccine Costs

Effective October 1, 2024, CCOs must fund COVID-19 vaccine costs through the capitation rates.

Behavioral Health Directed Payments / Mobile Crisis Payments

In CY23, Behavioral Health Directed Payments (BHDPs) were implemented 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. A lack of behavioral health practitioners is at the root of this issue, as is a lack of adequate wages for these practitioners. BHDPs continued in CY24 and, in an effort to expand the use of Mobile Crisis Intervention Services (MCIS) and Stabilization Services across the State, OHA directed CCOs to pay providers at or above the applicable fee-for-service (FFS) State Plan rate for mobile crisis services in CY24.

Diagnosis-Related Group (DRG) Hospital Payment Rates Every year changes

Due to transitory upward cost pressures faced by hospitals related to workforce challenges and the COVID-19 pandemic, OHA temporarily increased expectations from 80% to 85% of base Medicare. Consistent with the CY23 intent and messaging, CCO payment expectations for DRG hospitals is reverting back to 80% of Medicare for CY24.

Required Payments for Culturally and Linguistically Specific Services (CLSS)

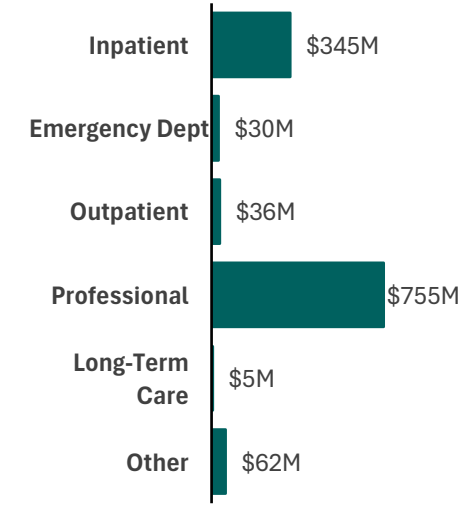
With the strategic goal to eliminate health inequities in Oregon, OHA has put high-priority on implementing program and policy changes targeted to address inequities. As part of this effort, OHA directed CCOs to implement a uniform dollar increase for payments for Culturally and Linguistically Specific Services delivered by applicable behavioral health providers.

Key Findings: Price vs Utilization Analysis for Behavioral Health in Medicaid, 2023-2024

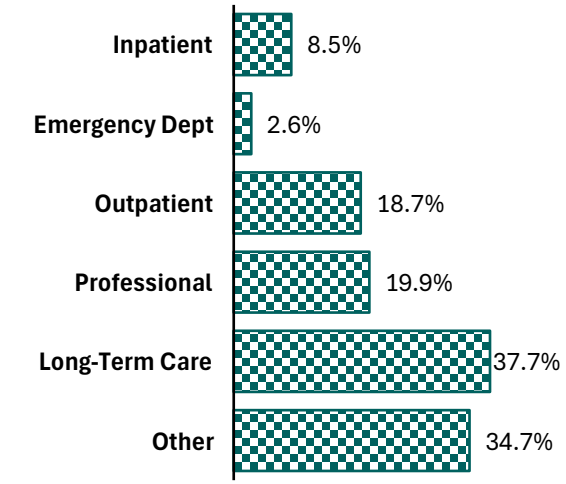
Price vs utilization analysis shows that total Medicaid claims spending for behavioral health services increased by $214 million across all service types from 2023 to 2024 (from $1.024 billion to $1.235 billion), with about half of this increase—$148 million—coming from the Professional Services category. Total spending for behavioral health in Professional in 2024 was $755 million.

The Professional: Behavioral Health per person cost growth from 2023 to 2024 was 19.9%, driven by price growth of 9.8% and utilization growth of 7.6%. 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.

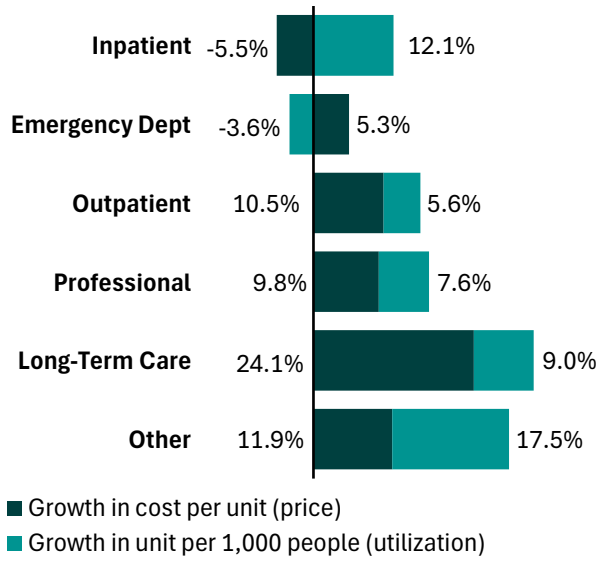
Behavioral Health Spending by Service Category in Medicaid, 2024



Cost Per Person Growth in Behavioral Health by Service Category in Medicaid, 2023-2024



Growth in Price vs Utilization in Behavioral Health by Service Category in Medicaid, 2023-2024

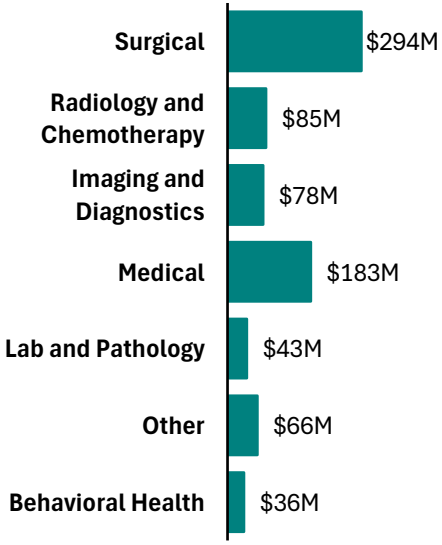


Medicaid Spotlight: Hospital Outpatient Cost Growth

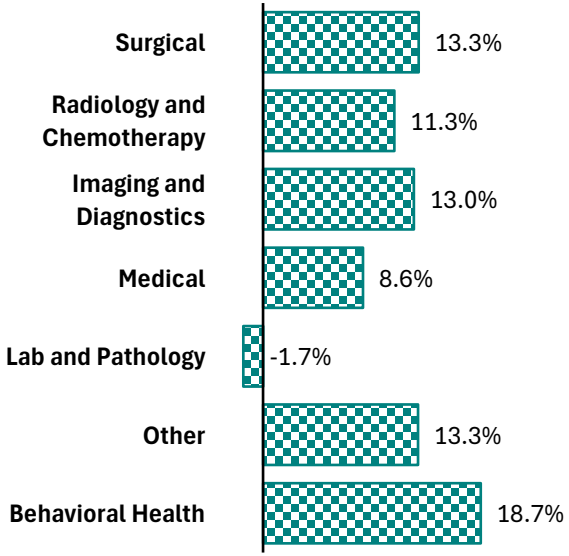
Medicaid Hospital Outpatient cost growth by procedure category is driven by both price and utilization for almost all of the categories, except in Lab and Pathology, where price increased and utilization decreased between 2023 and 2024.

Surgical and Medical are the largest Hospital Outpatient procedure categories in terms of total spending in 2024, and in both categories, growth in utilization outpaced growth in price. In Outpatient Behavioral Health, price growth exceeded utilization growth, reflecting the influence of the Behavioral Health Directed Payments (BHDPs) in Medicaid (see page 75-76).

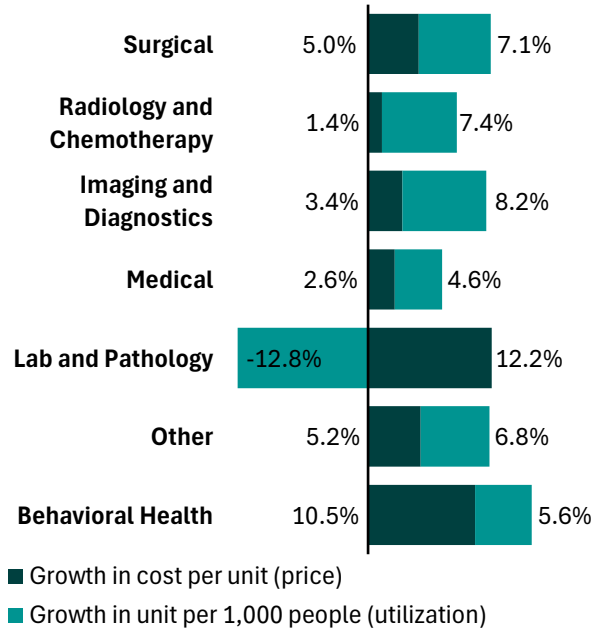
Hospital Outpatient Spending by Procedure Category in Medicaid, 2024



Cost Per Person Growth in Hospital Outpatient by Procedure Category in Medicaid, 2023-2024

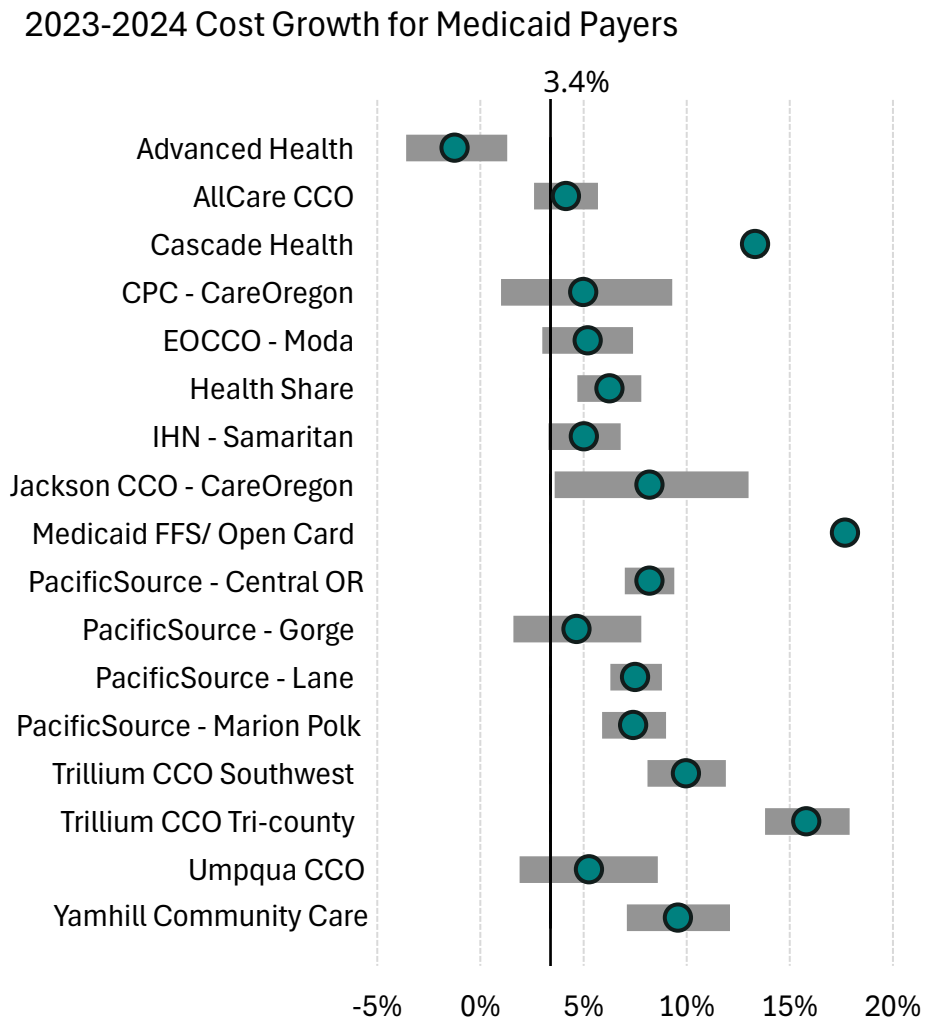


Growth in Price vs Utilization in Hospital Outpatient by Procedure Category in Medicaid, 2023-2024



Medicaid Cost Growth – By Payer, 2023-2024

Of the 17 Medicaid payers (16 CCOs and Open Card) included for 2023-2024, 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%.



Medicaid Payers	Target Performance	2023-2024 Cost Growth
Advanced Health	Met	-1.2%
AllCare CCO	Indeterminate	4.2%
Cascade Health	Not Met	13.3%
CPC - CareOregon	Indeterminate	5.0%
EOCCO - Moda	Indeterminate	5.2%
Health Share	Not Met	6.3%
IHN - Samaritan	Indeterminate	5.0%
Jackson CCO - CareOregon	Not Met	8.2%
Medicaid FFS/ Open Card	Not Met	17.7%
PacificSource - Central OR	Not Met	8.2%
PacificSource - Gorge	Indeterminate	4.7%
PacificSource - Lane	Not Met	7.5%
PacificSource - Marion Polk	Not Met	7.4%
Trillium CCO Tri-county	Not Met	15.8%
Trillium CCO Southwest	Not Met	10.0%
Umpqua CCO	Indeterminate	5.3%
Yamhill Community Care	Not Met	9.6%

Medicaid Cost Growth Drivers – by Payer and by Service Category, 2023-2024

The tables on the next page show each service category's percent contribution to the total per person per year (PPPY) spending difference from 2023 to 2024, by Medicaid payer, with each column summing to 100%. Darker cells indicate larger absolute spending changes. Grey columns represent payers that met the cost growth target or had indeterminante cost growth, and green columns indicate payers that exceeded the target with statistical confidence.

Hospital Outpatient is the largest contributor to per person per year spending differences in Medicaid, accounting for 28.0% of cost growth across all payers and showing double-digit contributions for most payers except Medicaid Open Card and Yamhill Community Care. It is also the top contributor to cost growth for PacificSource–Central OR, Lane, and Marion-Polk CCOs, as well as Trillium Southwest and Tri-County CCOs. Claims-based price vs. utilization analysis shows that Medicaid Hospital Outpatient costs rose due to increases in both price and utilization.

Behavioral Health remained a major cost driver in Medicaid between 2023 and 2024, accounting for 26.6% of the per person per year spending difference across all payers and showing double-digit growth for most Medicaid payers that exceeded the cost-growth target. It is also the the main cost driver for Cascade Health, Health Share of Oregon, and Medicaid Open Card.

Retail Pharmacy (Net of Rebates) is another significant contributor to per person per year spending differences in Medicaid. Among the ten Medicaid payers that exceeded the cost-growth target with statistical confidence, eight showed double-digit growth in Retail Pharmacy.

Overall, most Medicaid payers experienced a decrease in non-claims spending between 2023 and 2024.

	Medicaid	Advanced Health	AllCare CCO	Cascade Health	CPC – CareOregon	EOCCO – Moda	Health Share	IHN – Samaritan	Jackson CCO – CareOregon
Inpatient	9.2%	180.8%	-20.8%	12.5%	-12.9%	5.8%	3.8%	21.2%	14.0%
Outpatient	28.0%	406.0%	43.3%	20.6%	62.3%	47.2%	13.6%	33.0%	16.8%
Professional: PCP	5.9%	16.5%	4.5%	1.0%	7.2%	2.1%	7.2%	8.5%	4.1%
Professional: Specialty	6.2%	25.7%	47.4%	0.9%	-9.5%	4.4%	0.1%	0.6%	-11.5%
Professional: BH	26.0%	6.5%	11.2%	23.8%	3.6%	13.9%	30.4%	17.2%	22.7%
Professional: Other	12.9%	14.0%	5.8%	13.5%	11.8%	5.9%	20.8%	4.5%	25.7%
Long-Term Care	2.8%	-2.1%	0.4%	1.2%	0.9%	0.9%	3.1%	18.5%	0.1%
Medical Pharmacy	8.9%	69.2%	6.0%	-0.2%	31.8%	13.5%	7.8%	17.2%	8.5%
Retail Pharmacy (Net)	5.4%	194.1%	19.4%	16.4%	10.7%	5.3%	8.5%	-5.6%	12.6%
Claims Other	13.7%	83.1%	-6.6%	4.3%	16.2%	6.8%	14.4%	17.3%	14.8%
Non-Claims	-19.0%	-893.8%	-10.6%	6.0%	-22.2%	-5.9%	-9.6%	-32.4%	-7.7%

	Medicaid FFS/ Open Card*	PacificSource – Central OR	PacificSource – Gorge	PacificSource – Lane	PacificSource – Marion Polk	Trillium CCO Southwest	Trillium CCO Tri-county	Umpqua CCO	Yamhill Community Care
Inpatient	16.6%	11.3%	-23.8%	16.0%	31.5%	8.0%	11.6%	44.5%	3.9%
Outpatient	9.8%	29.3%	56.9%	34.1%	29.6%	24.4%	17.4%	36.0%	7.6%
Professional: PCP	4.0%	4.6%	2.8%	4.1%	3.4%	5.1%	4.9%	15.8%	1.4%
Professional: Specialty	0.3%	9.9%	6.1%	9.3%	12.5%	9.9%	10.9%	34.7%	24.3%
Professional: BH	26.6%	29.0%	9.9%	28.0%	8.9%	11.2%	11.3%	35.8%	10.0%
Professional: Other	17.9%	1.8%	2.6%	10.4%	3.6%	2.2%	1.6%	0.0%	3.8%
Long-Term Care	3.5%	1.6%	0.8%	1.0%	0.9%	2.4%	0.9%	3.6%	0.4%
Medical Pharmacy	-3.1%	0.8%	21.4%	1.6%	6.0%	5.8%	9.4%	9.6%	4.7%
Retail Pharmacy (Net)	17.9%	21.2%	31.4%	12.4%	19.6%	0.5%	10.3%	32.9%	29.9%
Claims Other	1.2%	5.1%	17.3%	8.2%	5.4%	5.3%	5.3%	8.1%	2.7%
Non-Claims	5.4%	-14.7%	-25.3%	-25.1%	-21.3%	25.1%	16.4%	-121.0%	11.3%

**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 reported gross of pharmacy rebates.*

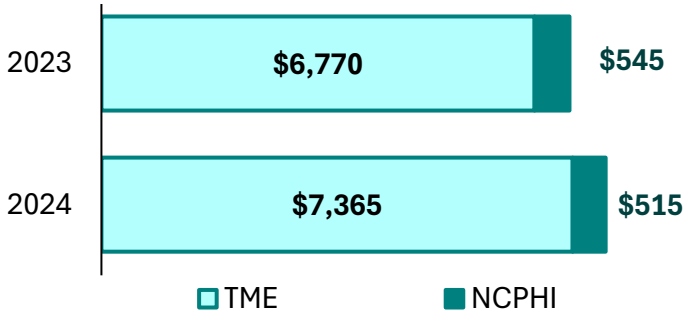
Medicaid Market – Growth in Net Cost of Private Health Insurance (NCPHI), 2023-2024

The Net Cost of Private Health Insurance (NCPHI) 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. The Net Operating Income for CCOs in 2024 was $129,000, down from $173M in 2023. The 2024 Operating Income includes $59.5M in losses from Premium Deficiency Reserves.[7]

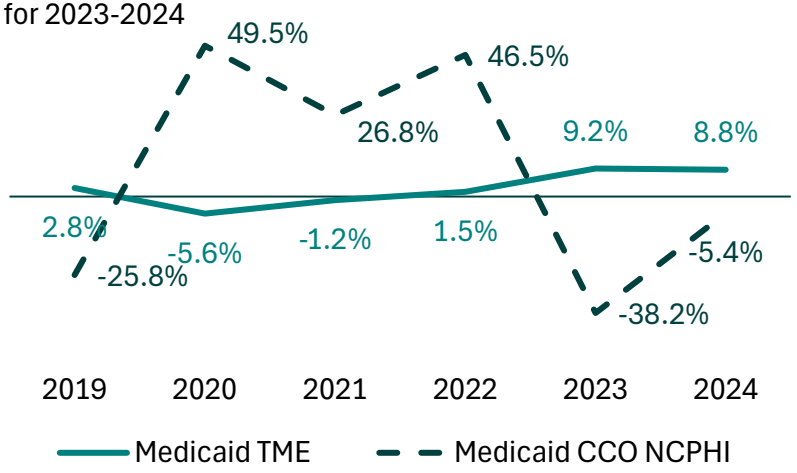
Among CCOs, NCPHI shrank 5.4% from 2023 to 2024, which was much less than the decrease of 38.2% in 2022-2023. Positive NCPHI in the 2020-2022 period was likely due to reduced health care utilization during the COVID-19 pandemic. As Medicaid members returned to care, medical expenditures increased and NCPHI decreased. In 2024, Medicaid redeterminations ended and membership levels returned to pre-COVID trends. The modest 5.4% decrease in NCPHI from 2023 to 2024 indicates increasing stability among most CCOs.

Medicaid Total Health Care Expenditure (THCE) per Person per Year: TME vs NCPHI, 2023-2024



Medicaid Percent Change in TME vs. NCPHI

2018-2024 Years are year 2 of a 2-year period, e.g., "2024" for 2023-2024



[7] OAFA CCO Financial Performance Memorandum, August 2025

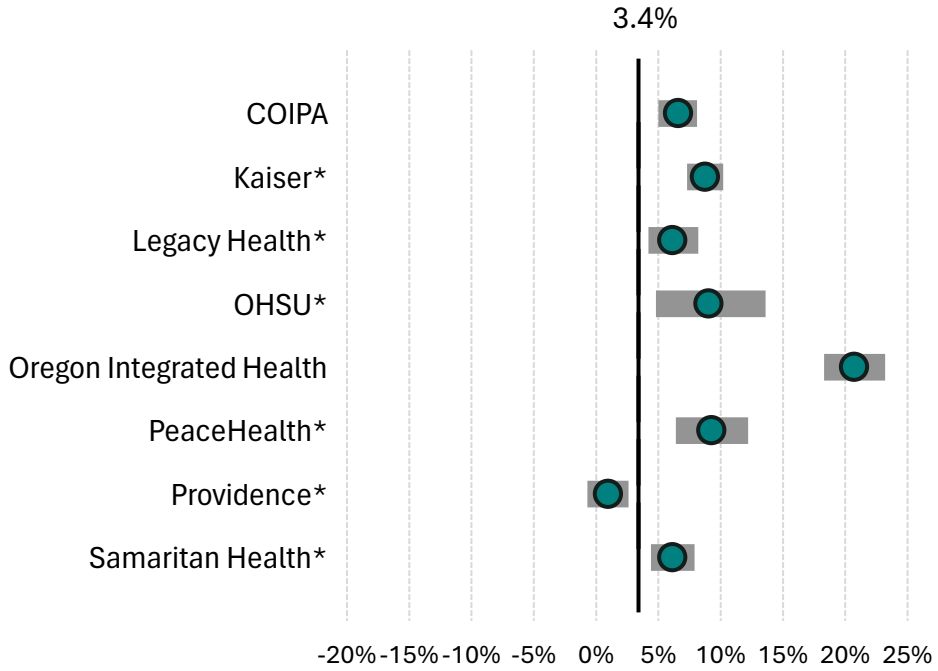
Medicaid Market – By Provider and IPA, 2023-2024

Large Provider Organizations and IPAs

This group includes seven provider organizations and one IPA, each with more than 20,000 attributed patients with Medicaid coverage. Cost growth for this group ranged from 1.0% to 20.7%. One provider organization met the target with statistical confidence.

Medicaid Cost Growth for Large Provider Organizations, 2023-2024

More than 20,000 Attributed Patients in 2024



Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
COIPA	Not Met	6.6%
Kaiser*	Not Met	8.8%
Legacy Health*	Not Met	6.1%
OHSU*	Not Met	9.0%
Oregon Integrated Health	Not Met	20.7%
PeaceHealth*	Not Met	9.3%
Providence*	Met	1.0%
Samaritan Health*	Not Met	6.1%

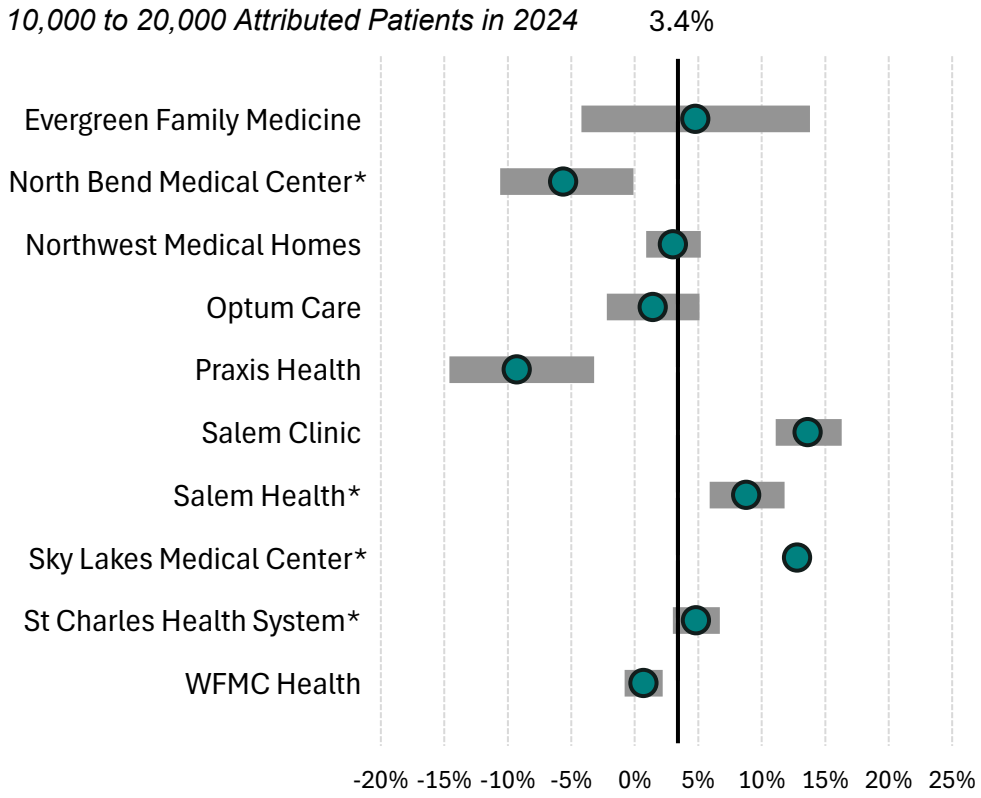
* Provider organizations that include hospitals.

Mid-Sized Provider Organizations and IPAs

This group includes 10 provider organizations, each with 10,000 to 20,000 attributed patients with Medicaid coverage. Cost growth for this group ranged from -14.6% to 12.3%. Three provider organization met the target with statistical confidence.

Medicaid Cost Growth for Mid-Sized Provider Organizations, 2023-2024

10,000 to 20,000 Attributed Patients in 2024



* Provider organizations that include hospitals.

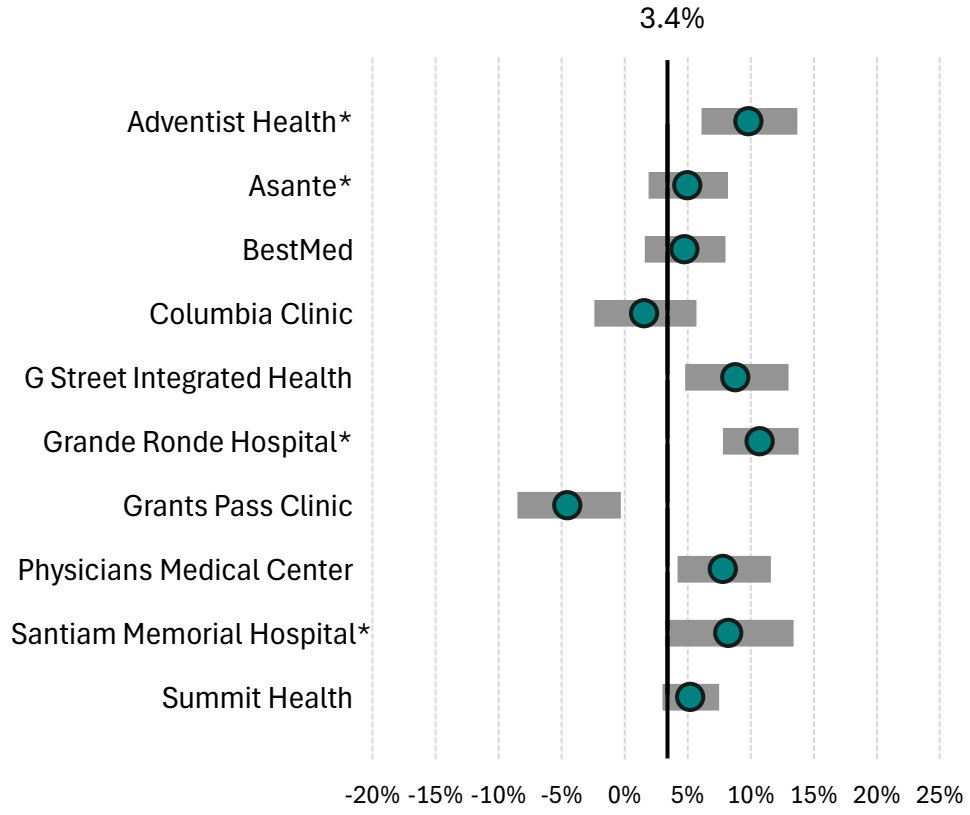
Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Evergreen Family Medicine	Indeterminate	-4.2%
North Bend Medical Center*	Met	-10.6%
Northwest Medical Homes	Indeterminate	0.9%
Optum Care	Indeterminate	-2.2%
Praxis Health	Met	-14.6%
Salem Clinic	Not Met	11.1%
Salem Health*	Not Met	5.9%
Sky Lakes Medical Center*	Not Met	12.3%
St Charles Health System*	Indeterminate	3.0%
WFMC Health	Met	-0.8%

Smaller Provider Organizations and IPAs

This group includes 10 provider organizations, each with fewer than 10,000 attributed patients with Medicaid coverage. Cost growth for this group ranged from -4.5% to 10.7%. One provider organization met the target with statistical confidence.

Medicaid Cost Growth for Small Provider Organizations, 2023-2024

Fewer than 10,000 Attributed Patients in 2024



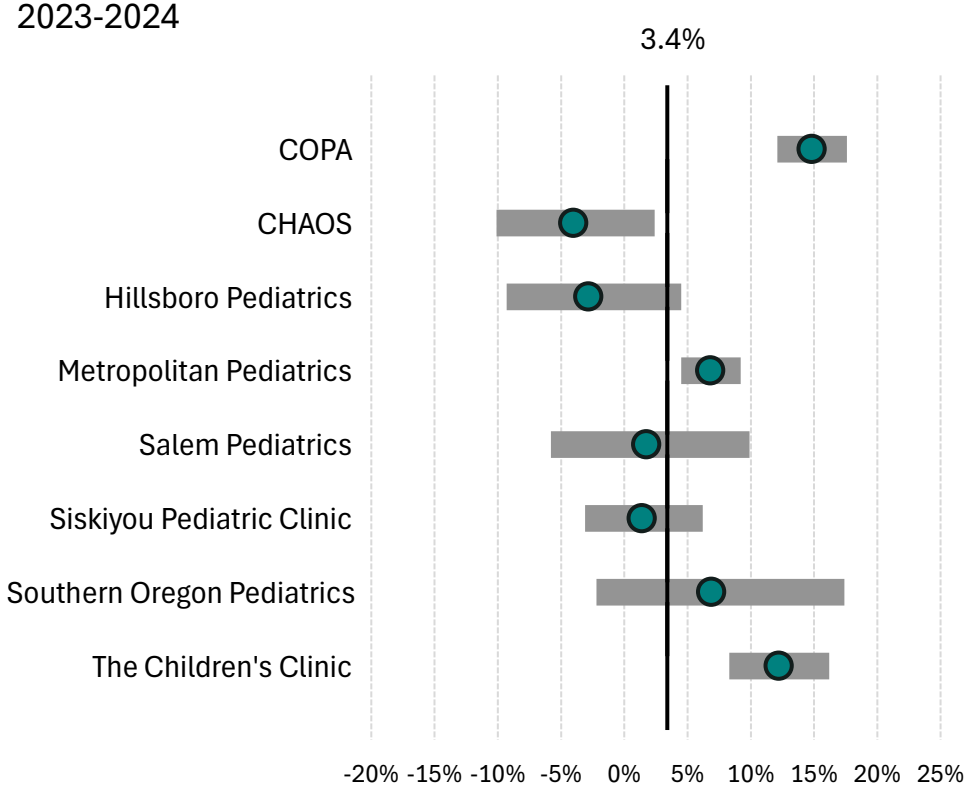
Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Adventist Health*	Not Met	9.9%
Asante*	Indeterminate	5.0%
BestMed	Indeterminate	4.8%
Columbia Clinic	Indeterminate	1.6%
G Street Integrated Health	Not Met	8.8%
Grande Ronde Hospital*	Not Met	10.7%
Grants Pass Clinic	Met	-4.5%
Physicians Medical Center	Not Met	7.8%
Santiam Memorial Hospital*	Indeterminate	8.2%
Summit Health	Indeterminate	5.2%

* Provider organizations that include hospitals.

Pediatric Provider Organizations

Eight pediatric provider organizations had attributed patients with Medicaid coverage. Cost growth for this group ranged from -4.0% to 14.8%. One provider organization met the target with statistical confidence.
OHA understands that pediatric providers play a critical role in managing health care costs by focusing on preventative care and early intervention. By addressing health issues in children before they escalate, pediatric providers help mitigate the need for costly treatments later in life. Medicaid pediatric provider organizations play a crucial role in providing health care access and services to traditionally underserved youth and this critical function is key to understanding and interpreting cost growth.

Medicaid Cost Growth for Pediatric Provider Organizations, 2023-2024



Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
COPA	Not Met	14.8%
CHAOS	Met	-4.0%
Hillsboro Pediatrics	Indeterminate	-2.8%
Metropolitan Pediatrics	Not Met	6.8%
Salem Pediatrics	Indeterminate	1.8%
Siskiyou Pediatric Clinic	Indeterminate	1.4%
Southern Oregon Pediatrics	Indeterminate	6.9%
The Children's Clinic	Not Met	12.2%

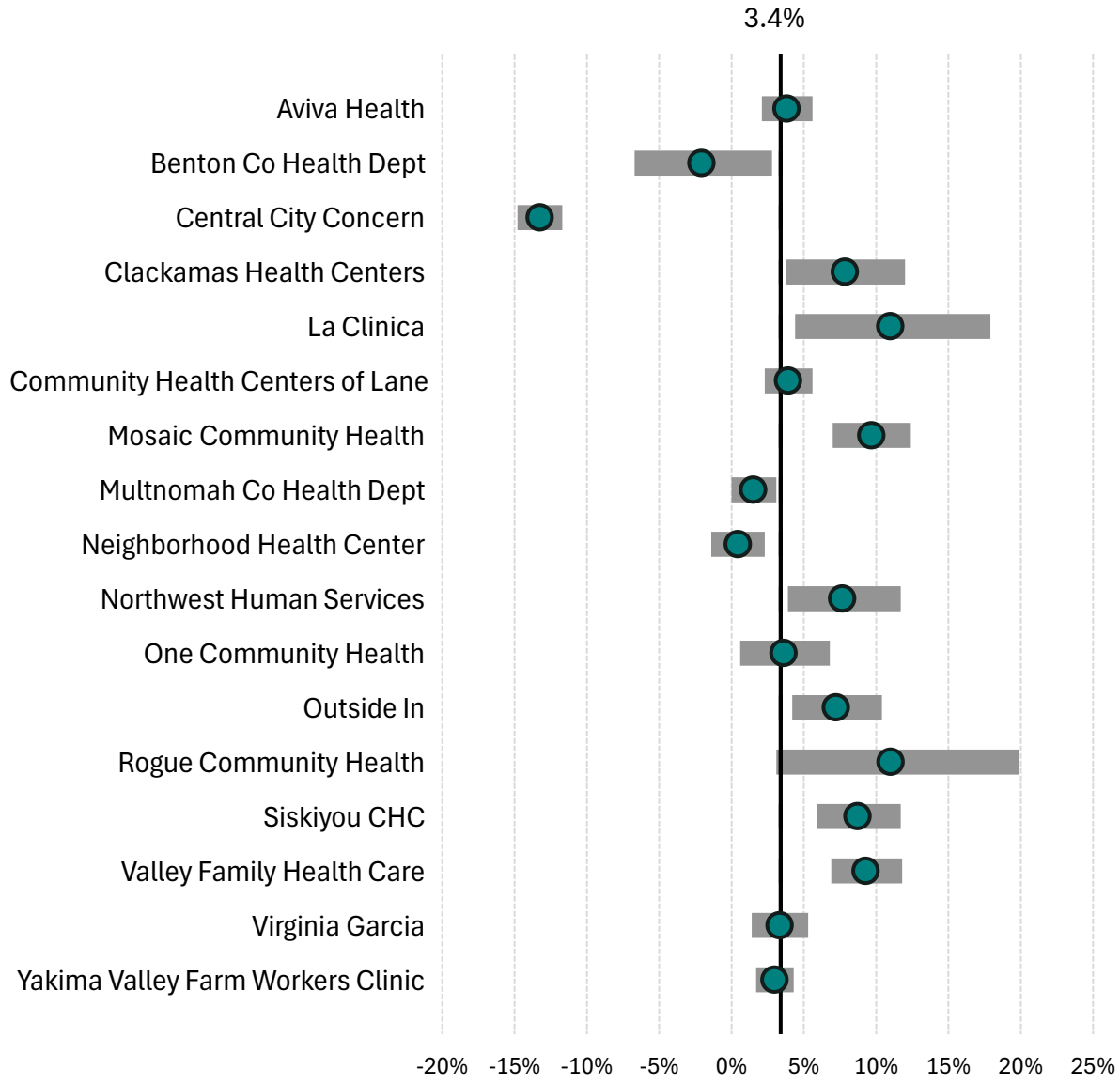
Federally Qualified Health Centers

A Federally Qualified Health Center (FQHC), also known as a Community Health Center, is a primary care center that is community-based and patient-directed. By mission and design, FQHCs exist to serve those who have limited access to health care and welcome low-income individuals, the uninsured, and the underinsured.FQHCs play a crucial role in providing health care access and services to the groups experiencing the most disadvantage across the state and this critical function is key to understanding and interpreting their cost growth. While FQHCs may exceed the cost growth target with statistical certainty in some years, their cost growth is almost certainly for an acceptable reason.

The FQHC group includes 17 provider organizations with attributed patients with Medicaid coverage. Cost growth ranged from -13.2% to 11.0%. Five FQHCs met the cost growth target with statistical confidence.

Provider Organization	Target Performance	'23-'24 Commercial Cost Growth
Aviva Health	Indeterminate	3.8%
Benton Co Health Dept	Met	-2.1%
Central City Concern	Met	-13.2%
Clackamas Health Centers	Not Met	7.8%
La Clinica	Not Met	11.0%
Community Health Centers of Lane	Indeterminate	3.9%
Mosaic Community Health	Not Met	9.7%
Multnomah Co Health Dept	Met	1.5%
Neighborhood Health Center	Met	0.5%
Northwest Human Services	Not Met	7.7%
One Community Health	Indeterminate	3.6%
Outside In	Not Met	7.2%
Rogue Community Health	Indeterminate	11.0%
Siskiyou CHC	Not Met	8.7%
Valley Family Health Care	Not Met	9.3%
Virginia Garcia	Indeterminate	3.4%
Yakima Valley Farm Workers Clinic	Indeterminate	3.0%

Medicaid Cost Growth for Federally Qualified Health Centers, 2023-2024



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 the following year.	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 2023-2024 was collected in the 2025 CGT data submissions. These files were submitted by mandatory data reporters in September 2025.

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 since 2022 differs from the methods used in previous years. In earlier data cycles, only Open Card members with enrollment data during the year and at least one claim were included, and that claim did not need 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.

Since the 2022-2023 data cycle, 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.

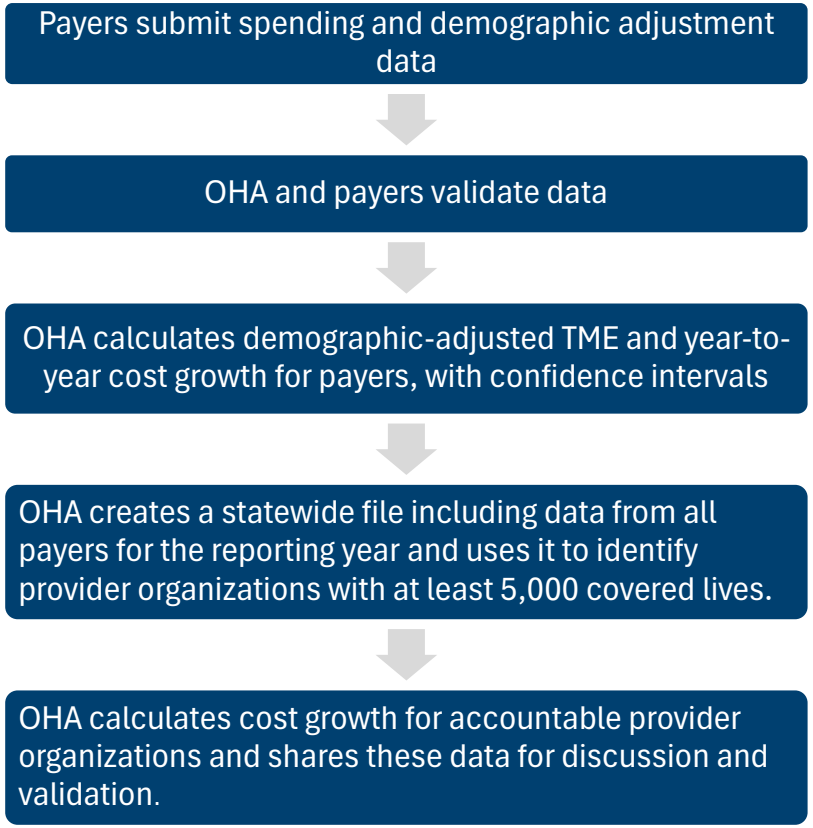
Stage 3: Data review and finalization

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 2023-2024, 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 2023-2024.

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 2023-2024.

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, provider organizations, and IPAs

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 organization cost growth is presented as the percent increase in per person spending from 2023 to 2-24; 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.

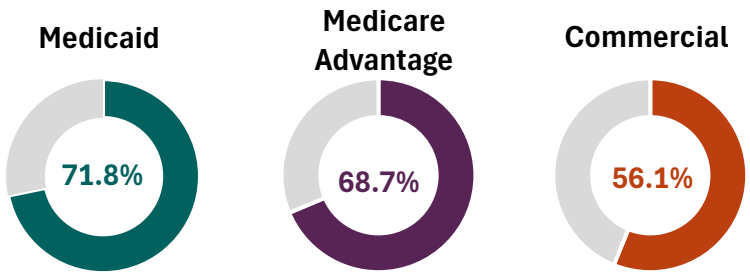
2. **Contract arrangement:** Members not included in #1 who were attributed to a primary care provider or a primary care home during the measurement period pursuant to a contract between the payer and provider, should be attributed to that primary care

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 home based on the member's utilization, using the payer's own attribution methodology.

Reporting Provider Organizations and IPAs

Not all members are attributed to provider organizations. In 2024, about 64% of all individuals were attributed to provider organizations; the graphs below show the percent of members attributed in each market.



Only provider organizations and IPAs with at least 60,000 attributed member months (or 5,000 patients) in each measurement year are included in public cost growth target reporting.

To avoid inaccurate comparisons, provider organizations are grouped by insurance market, attributed patient volume, and organization type.

Commercial

- Large health hsystems, group practices, and IPAs (>20,000 attributed patients)
- Mid-sized health systems, group practices, and IPAs (10,000 – 20,000 attributed patients)
- Smaller health systems, group practices, and IPAs (<10,000 attributed patients)
- Pediatric practices

Medicare Advantage

- All

Medicaid

- Large health hsystems, group practices, and IPAs (>20,000 attributed patients)
- Mid-sized health systems, group practices, and IPAs (10,000 – 20,000 attributed patients)
- Smaller health systems, group practices, and IPAs (<10,000 attributed patients)
- Pediatric practices
- Federally Qualified Health Centers (FQHCs)

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 health care 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 28 of the Oregon All Payer All Claims (APAC) database, which was refreshed in Q4 2025 and published on March 19, 2026. 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 2018-2024 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, long-term care, 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, long-term care, 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 • Revenue codes start with 01, 020, 021 • Revenue codes are between 1000 and 1005 • Place of service codes are 21, 51, 52, 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, 43, 71-77, 79, 85, 89 • Place of service codes are 19, 22 • Revenue codes start with 050-052 • Revenue codes are 0905, 0982, 0983

Service Category	Specifications
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, 12, 17, 20, 24, 49, 50, 53, 57, 58, 60, 62, 65, 71, 72 • Place of services codes are 02, 10 • Place of services codes are 99 and modifiers are 93, 95, GT, GQ, FQ • Types of bill code start with 83 • Revenue codes start with 049
Long-Term Care	Claims not categorized as inpatient care, ED, outpatient care, or professional with at least one claim line meets one of more the following conditions. • Types of bill code start with 21, 22, 23, 28, 32, 33, 34, 81, 82, 16, 17, 45, 47, 65, 66 • Revenue codes start with 055-059 • Revenue codes are 0022, 0023 • Place of service codes are 13, 14, 31-34
Other	Medical claims that are not categorized as inpatient, ED, outpatient, or professional.
Retail pharmacy	All the pharmaceutical claims

Medical Pharmacy

To measure medical pharmacy costs, price, and utilization, OHA pulled any medical claim lines that matched the specifications below. Medical pharmacy services are flagged at the claim-line level.

- 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.

The list of codes above for medical pharmacy is also shared with cost growth target mandatory data submitters for the 2024 data submission, available here.

Some medical pharmacy payments have a line-level amount of $0 because their costs are bundled with other lines in the claim. This occurs much more frequently in the inpatient setting; therefore, medical pharmacy in the inpatient category was excluded from the analysis. In addition, medical pharmacy costs overlap with costs reported in other claims categories, with the exception of Inpatient and Retail Pharmacy, which do not overlap with Medical Pharmacy.

Behavioral Health

Behavioral health (BH) services are identified based on the diagnosis codes in the combination of procedure codes, revenue codes. BH services 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	

ICD-10 Code	Description	Exclusions
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** • **Long-Term Care** • **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 • 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-

Service Category	Specifications
	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.
- Retail 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 encounters, defined as the count of unique combinations of individuals and service dates.

- The unit of analysis for medical pharmacy is the number of procedures, defined as the count of unique combinations of individuals, service dates, and procedure codes, revenue codes, or NDC codes.
- Claims with paid amounts less than or equal to zero are included in utilization.

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.

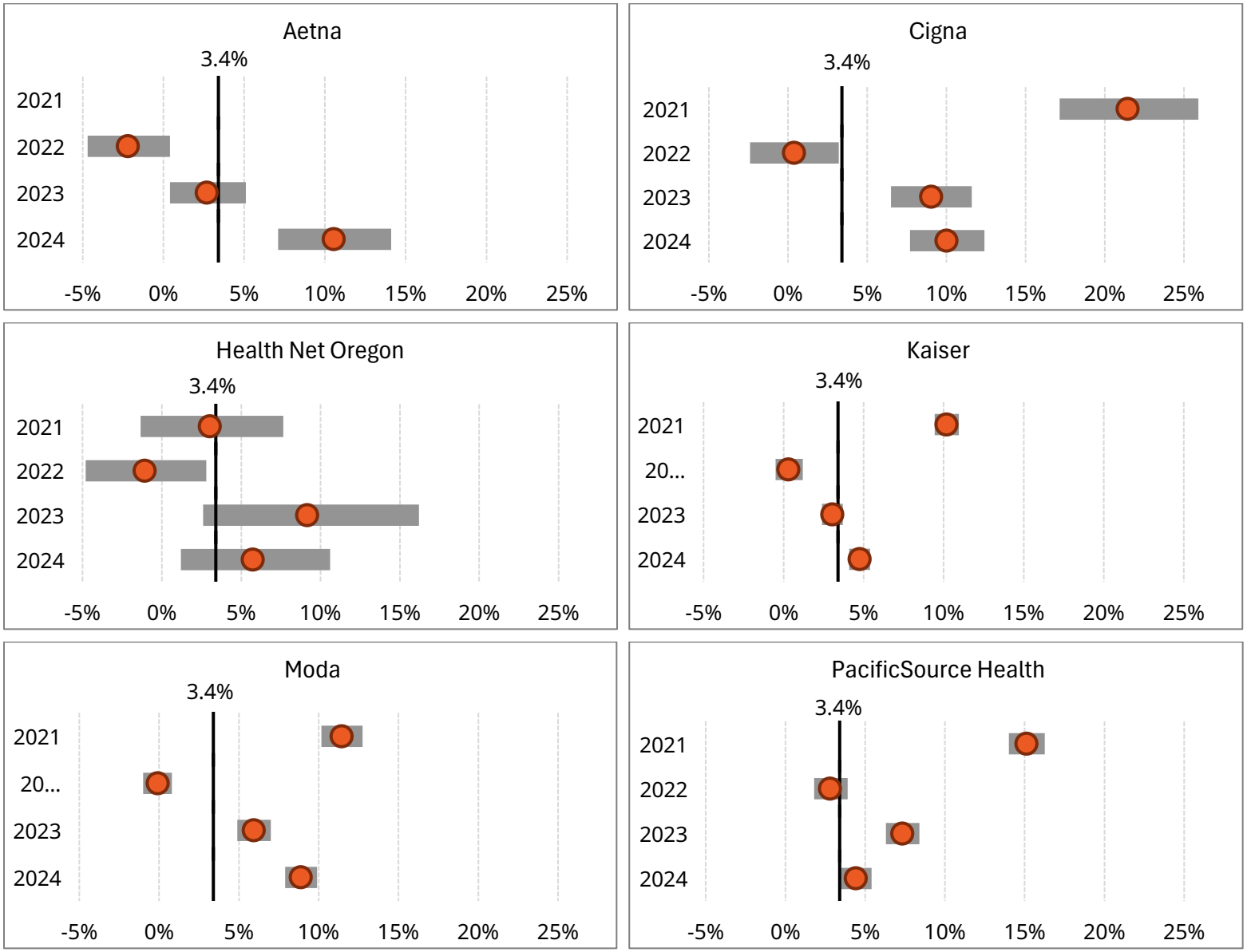
Appendix B: Historical Cost Growth Performance

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.

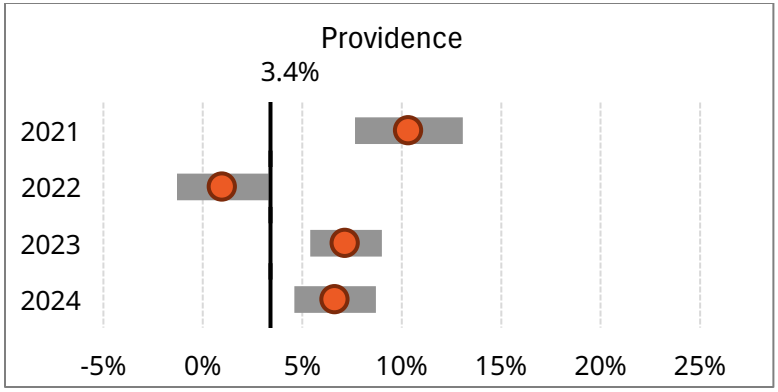
The Cost Growth Target Program has flexibility to consider multi-year trends when determining accountability. Before putting a payer or provider organization on a Performance Improvement Plan (PIP) when their cost growth exceeds the target, OHA and the entity discuss whether cost growth was due to an acceptable reason (see Introduction). If growth was low one year and above the target the next year for an acceptable reason, OHA may 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.

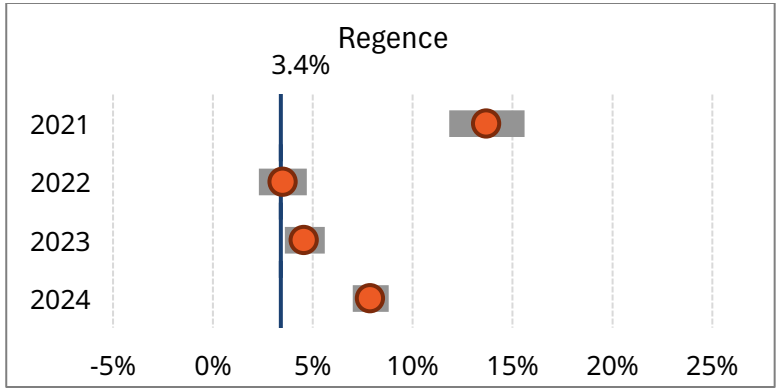
Although cost growth during 2023-2024 is the focus of this report, OHA is committed to explaining and contextualizing payer and provider organization cost growth trends. The tables and graphs in this appendix provide an easy reference for each payer's cost growth over the most recent four years of reporting. Similar tables and graphs will be shared for providers when their data have been validated for the period.

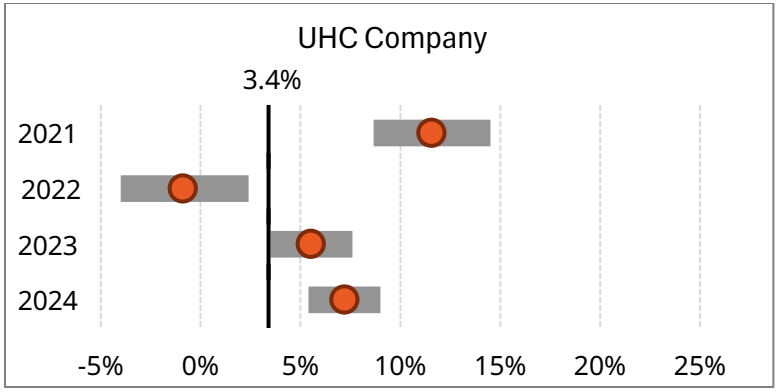
Cost Growth for Commercial Payers, 2021-2024



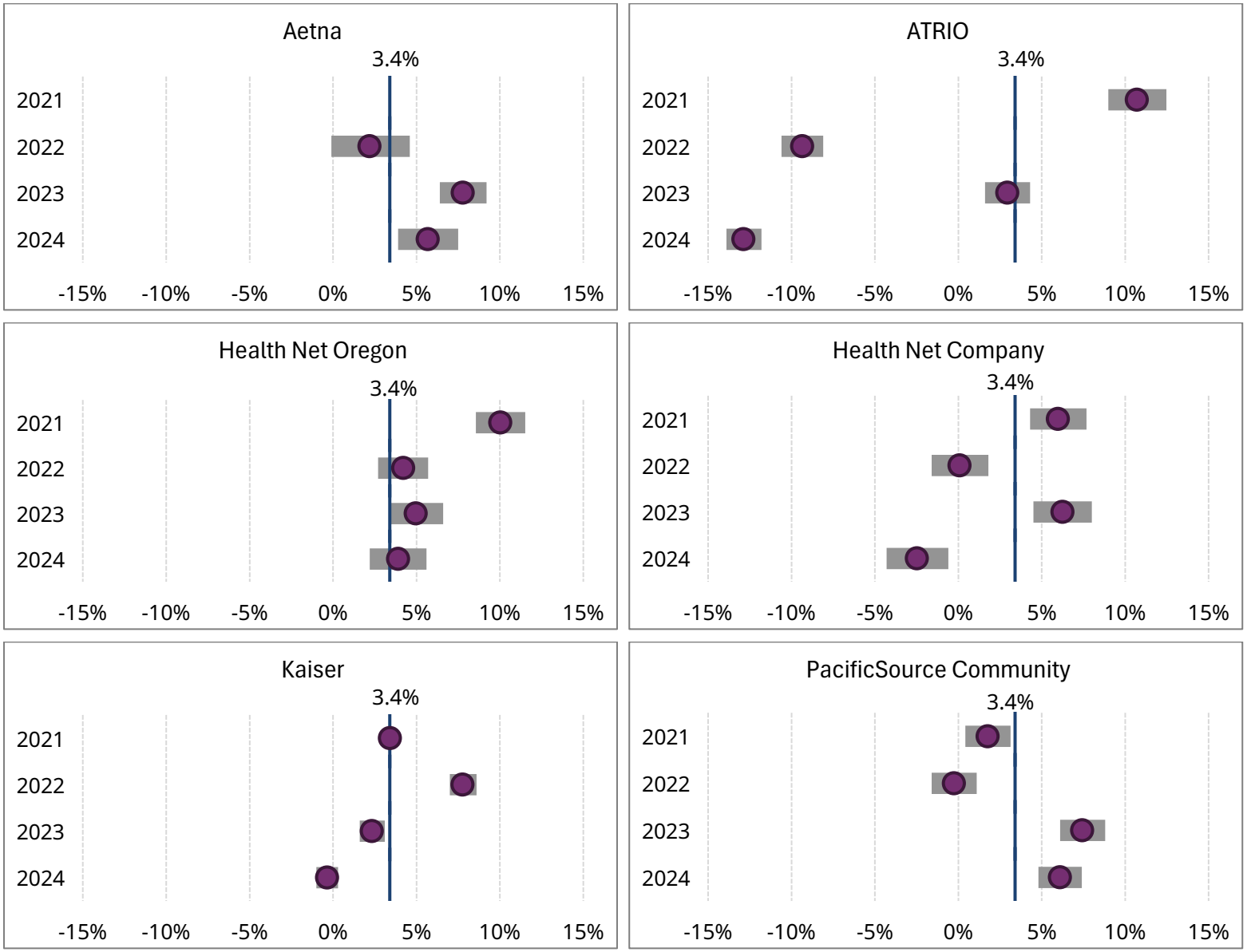
Appendix B


Providence
3.4%
2021
2022
2023
2024
-5%
0%
5%
10%
15%
20%
25%

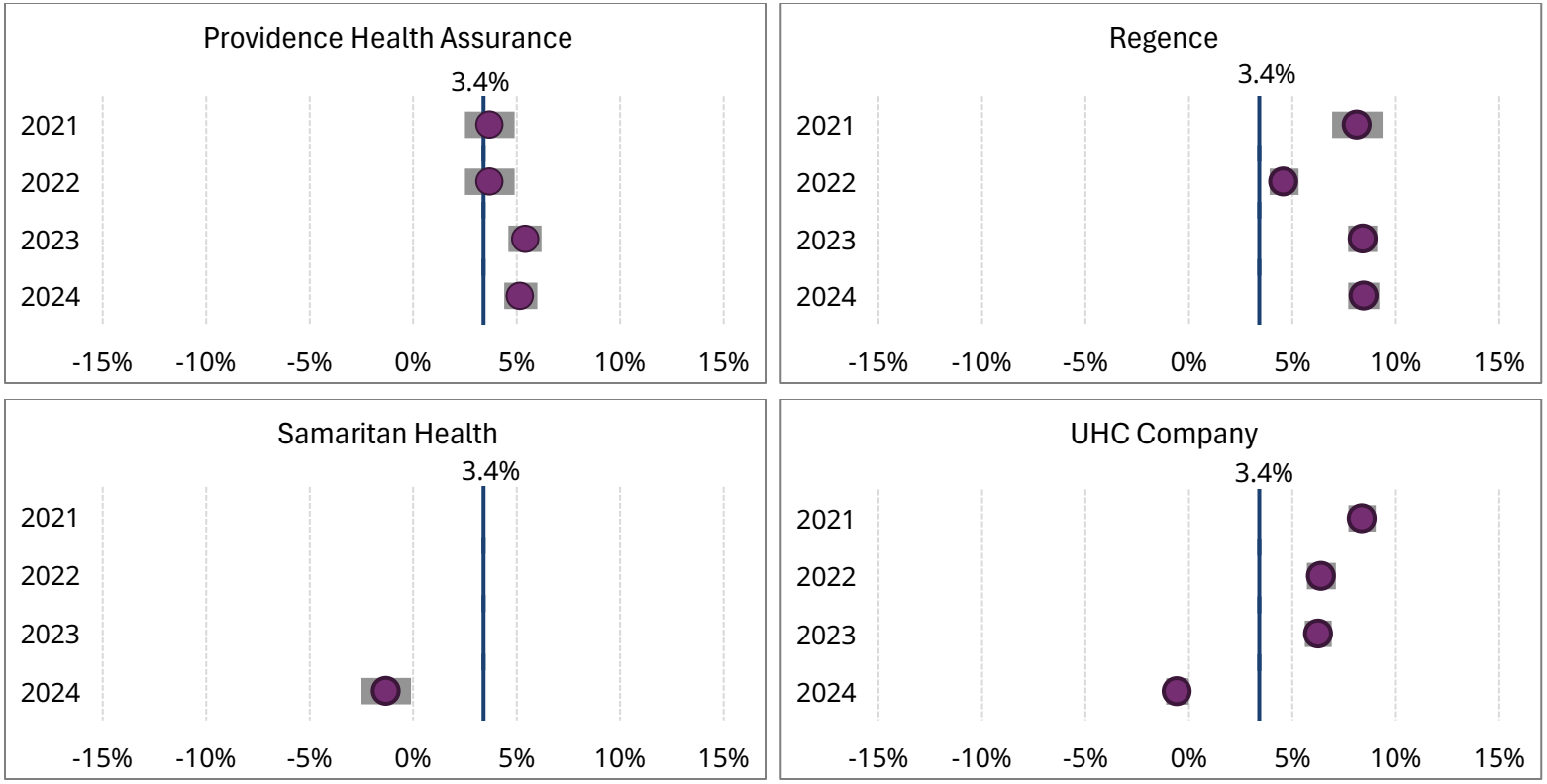

Regence
3.4%
2021
2022
2023
2024
-5%
0%
5%
10%
15%
20%
25%


UHC Company
3.4%
2021
2022
2023
2024
-5%
0%
5%
10%
15%
20%
25%

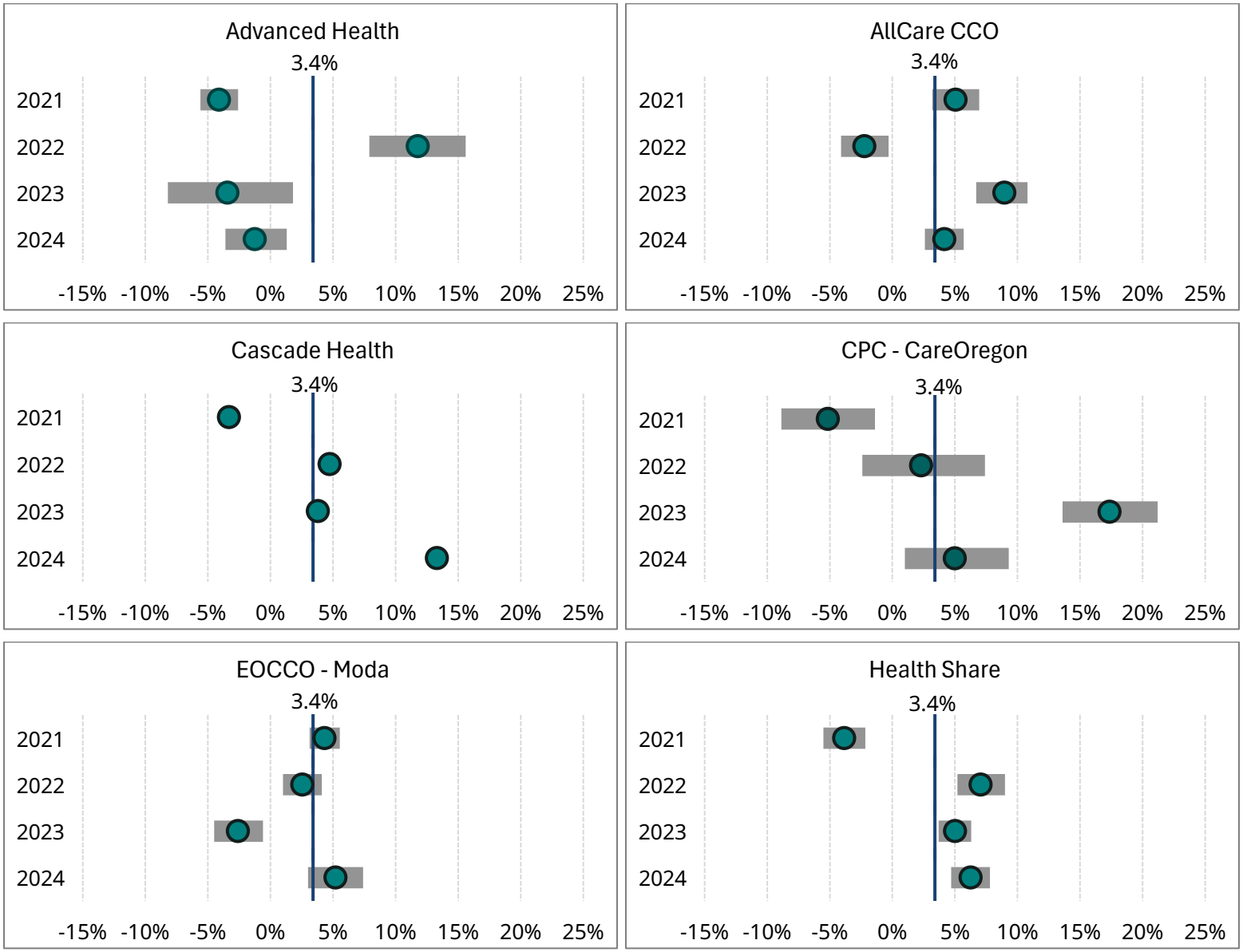
Cost Growth for Medicare Advantage Payers, 2021-2024

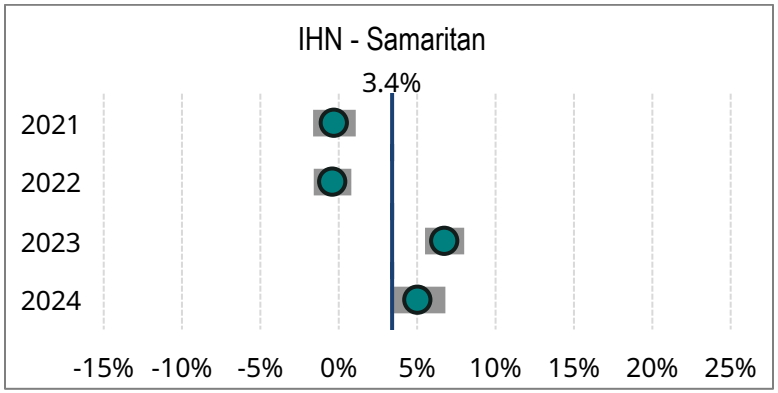


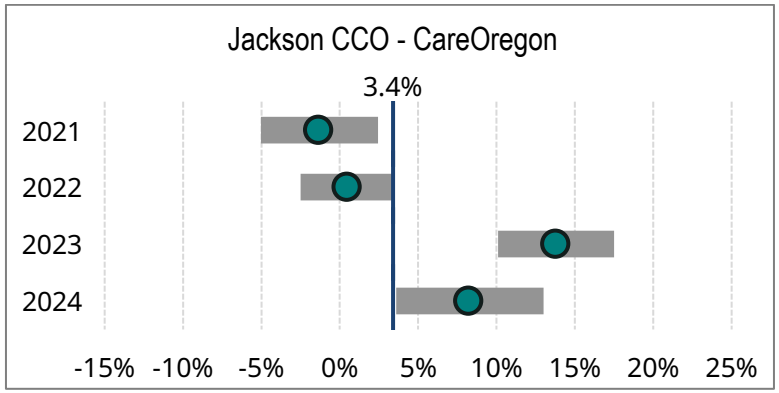
Appendix B

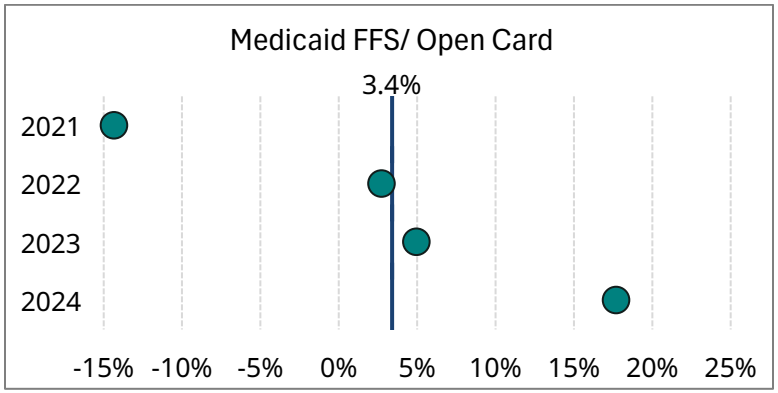

Providence Health Assurance
3.4%
2021
2022
2023
2024
-15%
-10%
-5%
0%
5%
10%
15%
Regence
3.4%
2021
2022
2023
2024
-15%
-10%
-5%
0%
5%
10%
15%
Samaritan Health
3.4%
2021
2022
2023
2024
-15%
-10%
-5%
0%
5%
10%
15%
UHC Company
3.4%
2021
2022
2023
2024
-15%
-10%
-5%
0%
5%
10%
15%

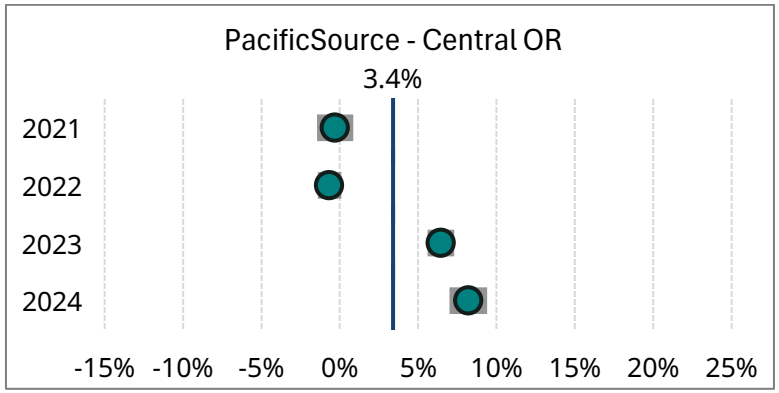
Cost Growth for Medicaid Payers, 2021-2024

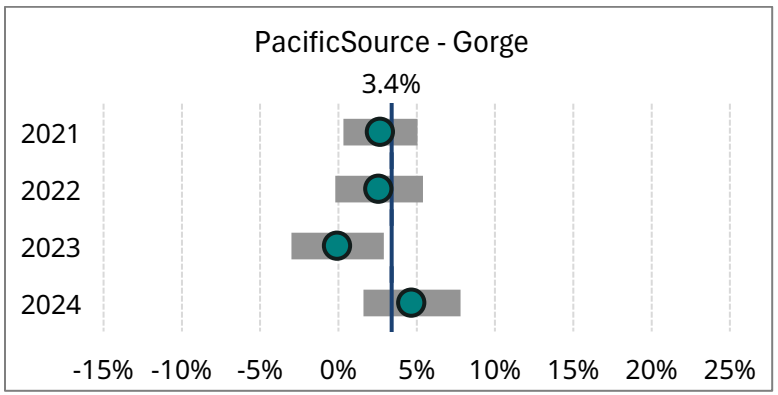


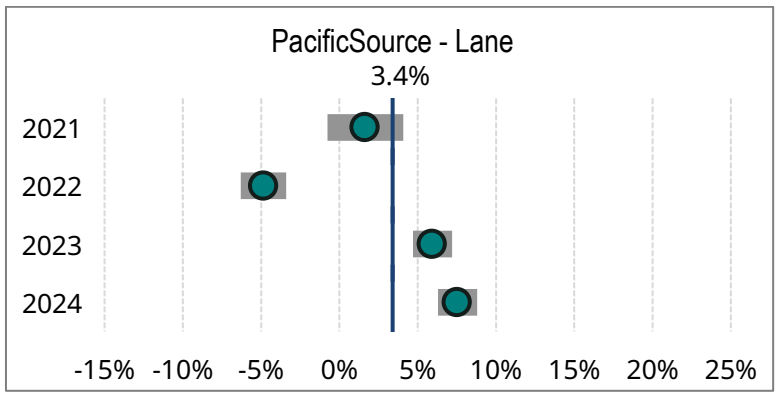

IHN - Samaritan
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

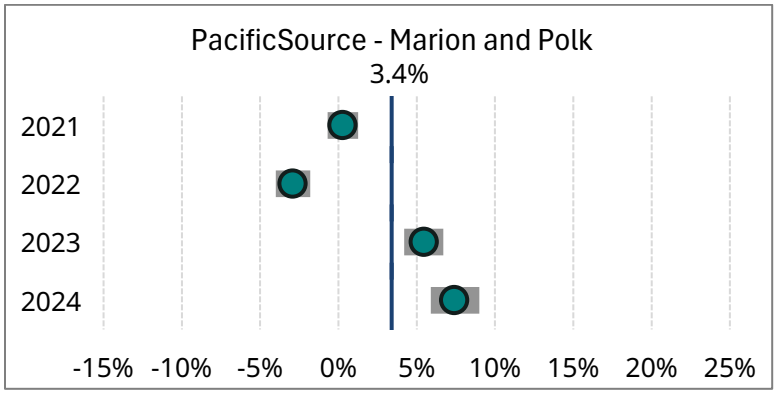

Jackson CCO - CareOregon
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

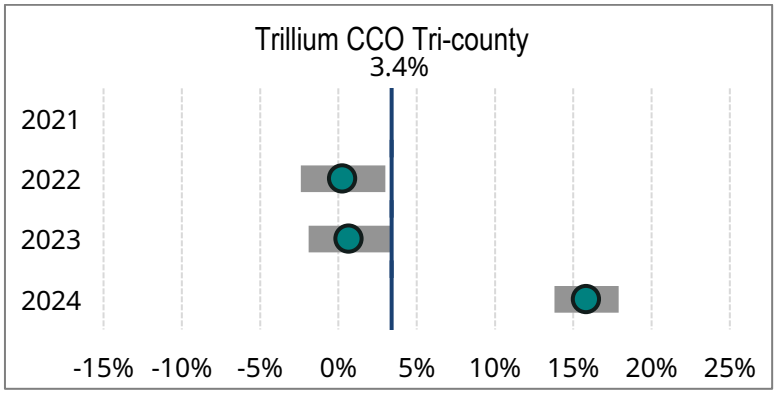

Medicaid FFS/ Open Card
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

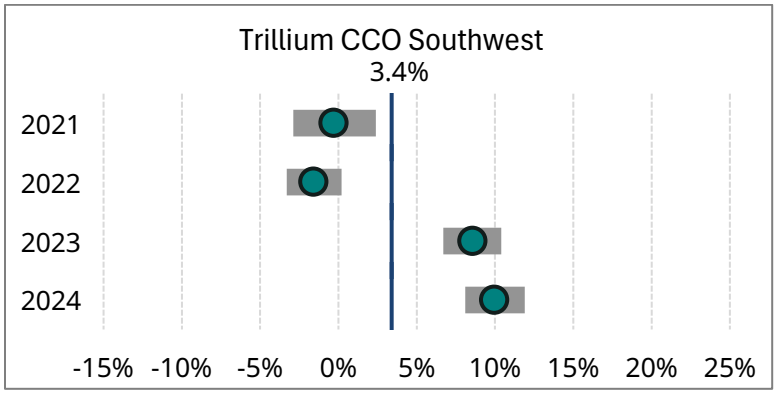

PacificSource - Central OR
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

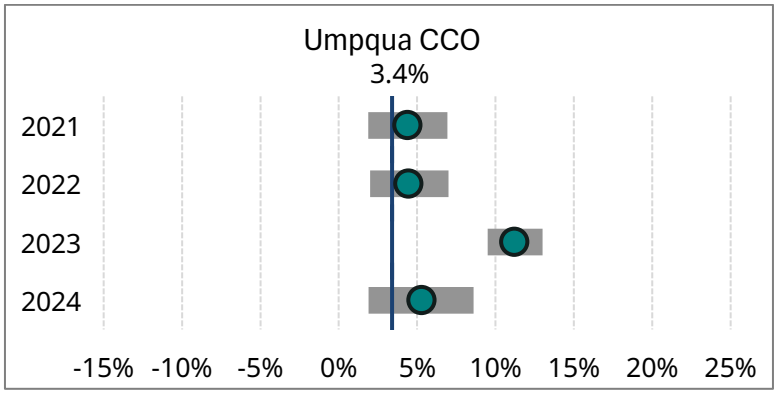

PacificSource - Gorge
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

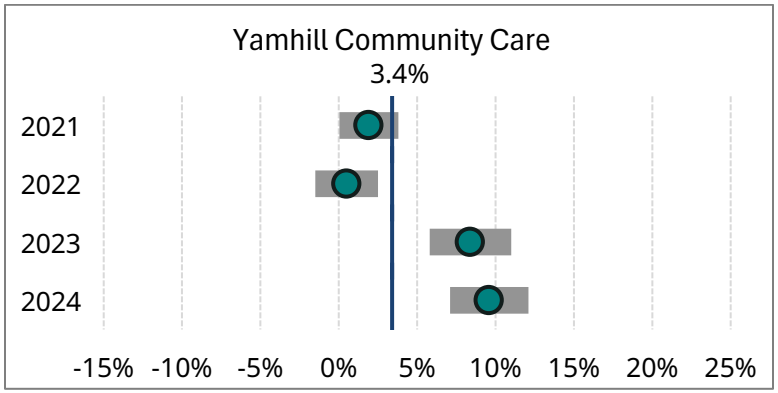

PacificSource - Lane
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%


PacificSource - Marion and Polk
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

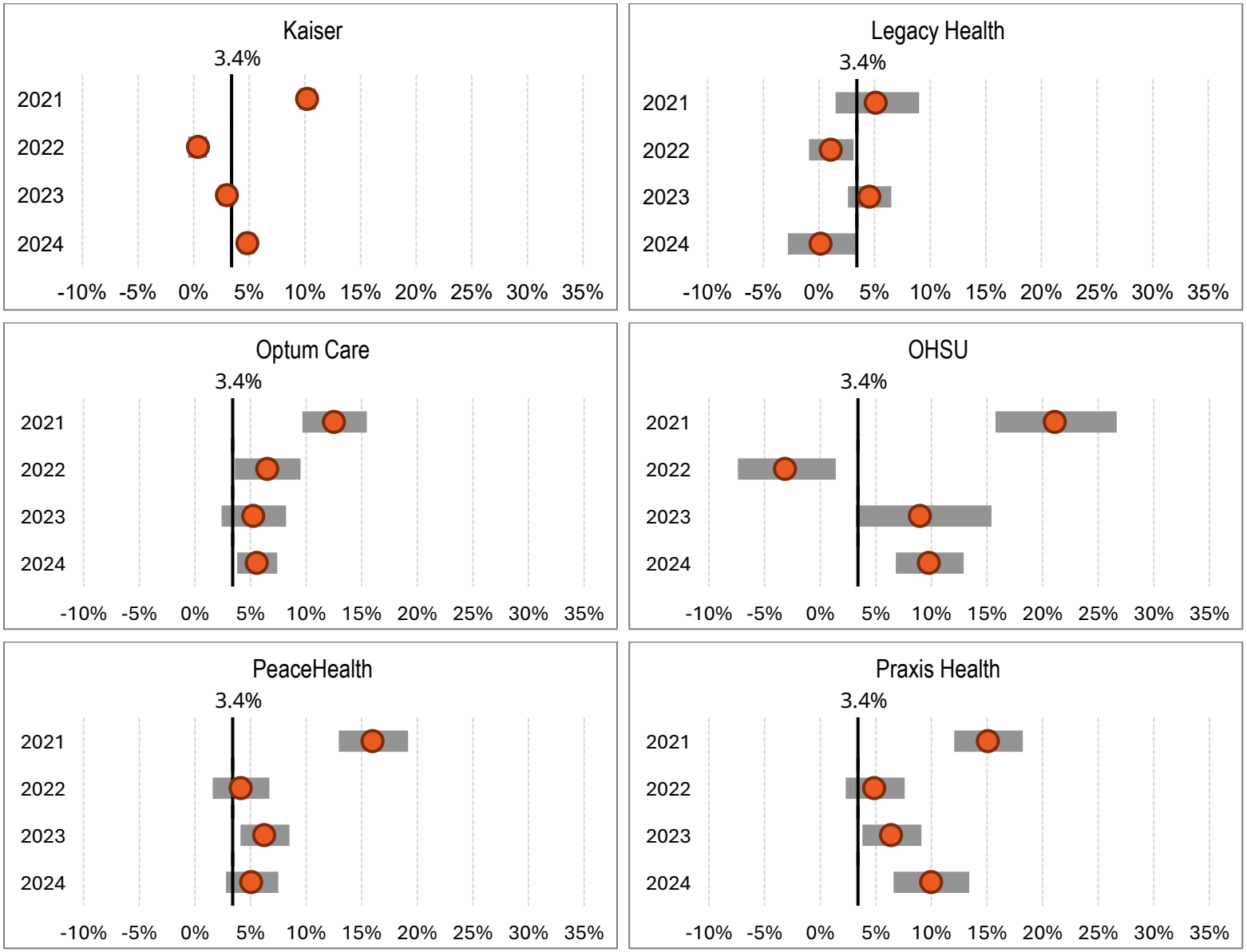

Trillium CCO Tri-county
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%


Trillium CCO Southwest
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

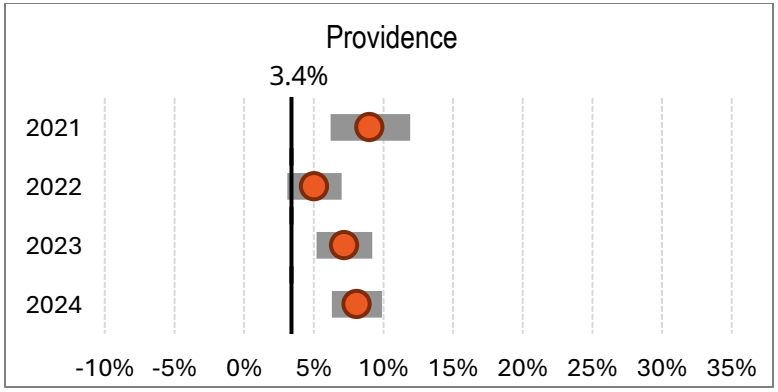

Umpqua CCO
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

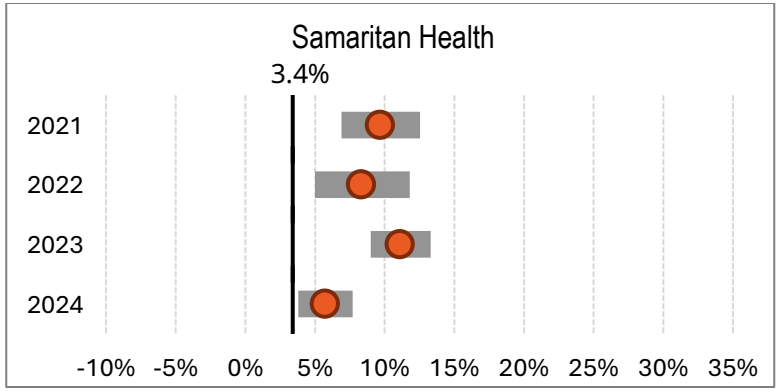

Yamhill Community Care
3.4%
2021
2022
2023
2024
-15% -10% -5% 0% 5% 10% 15% 20% 25%

Commercial Cost Growth for Large Provider Organizations, 2021-2024

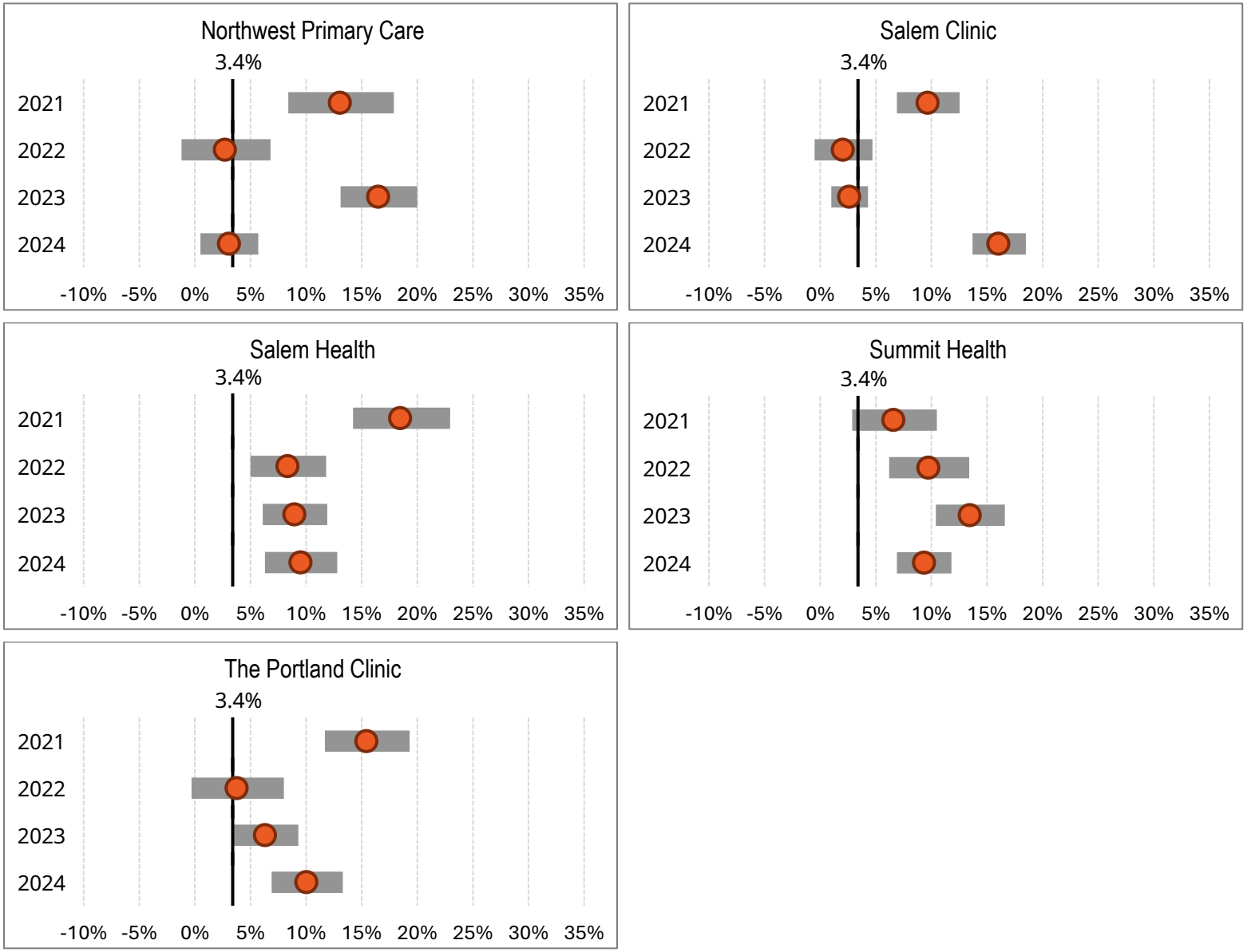


Appendix B

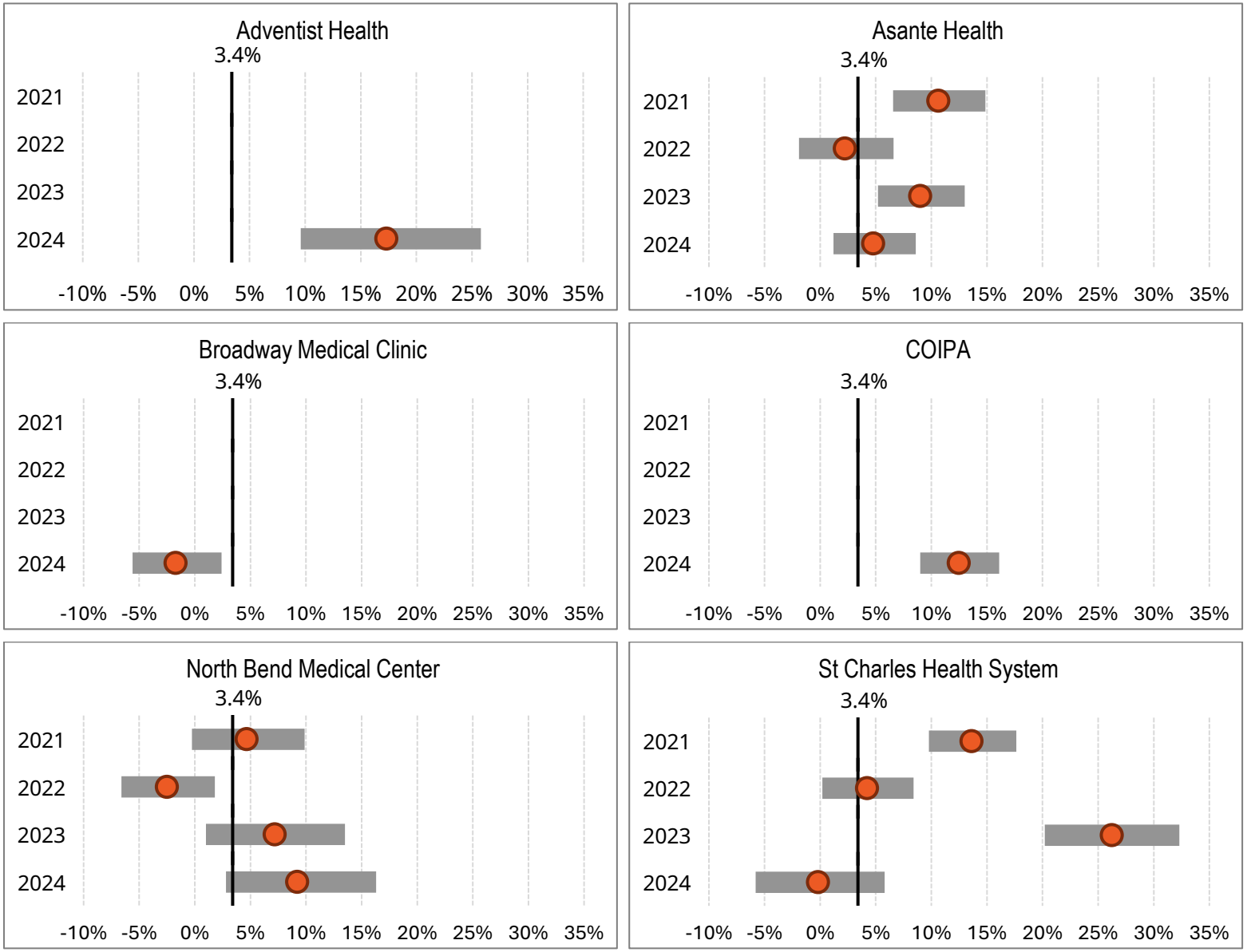

Providence
3.4%
2021
2022
2023
2024
-10%
-5%
0%
5%
10%
15%
20%
25%
30%
35%


Samaritan Health
3.4%
2021
2022
2023
2024
-10%
-5%
0%
5%
10%
15%
20%
25%
30%
35%

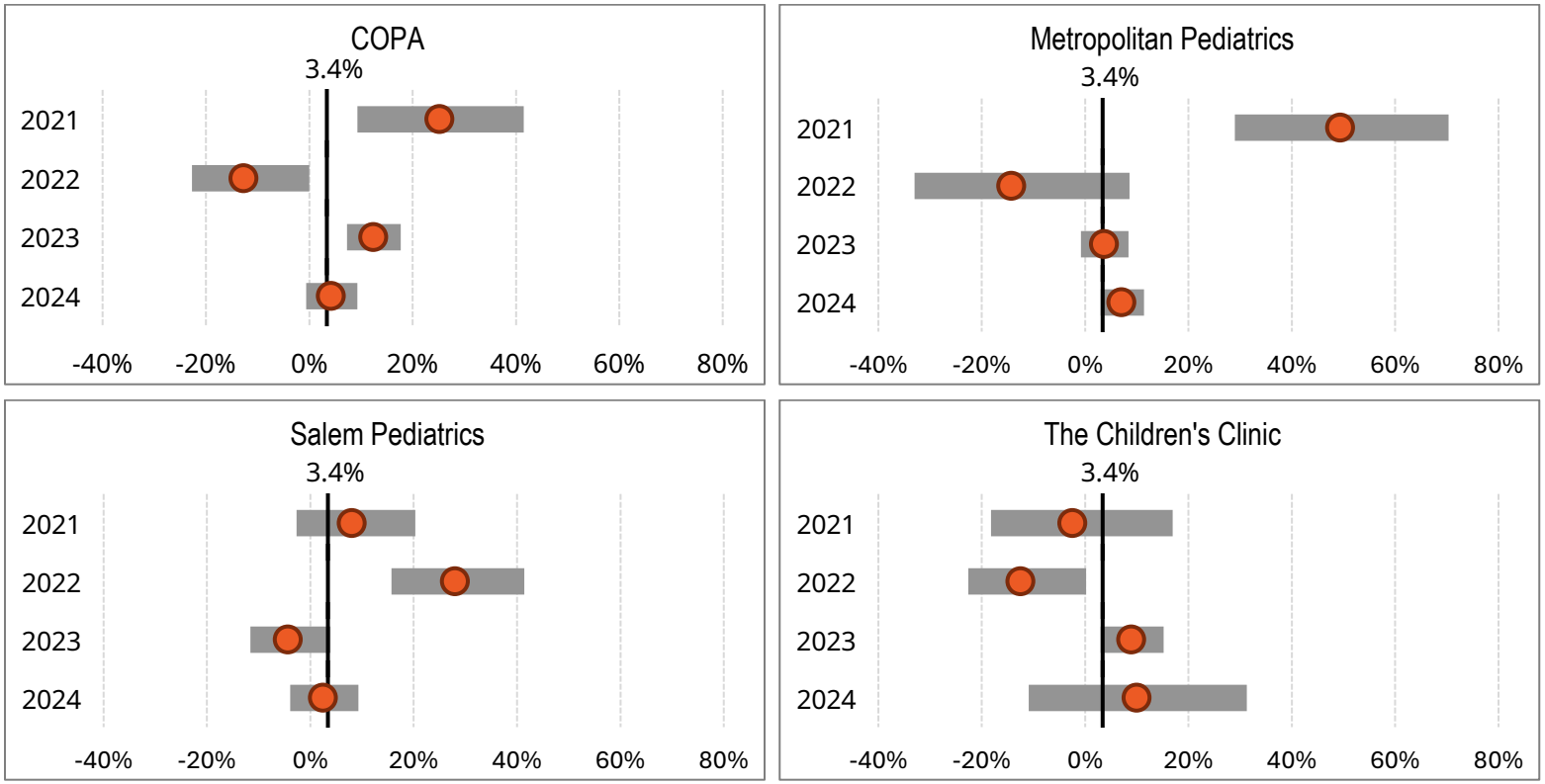
Commercial Cost Growth for Mid-Sized Provider Organizations, 2021-2024



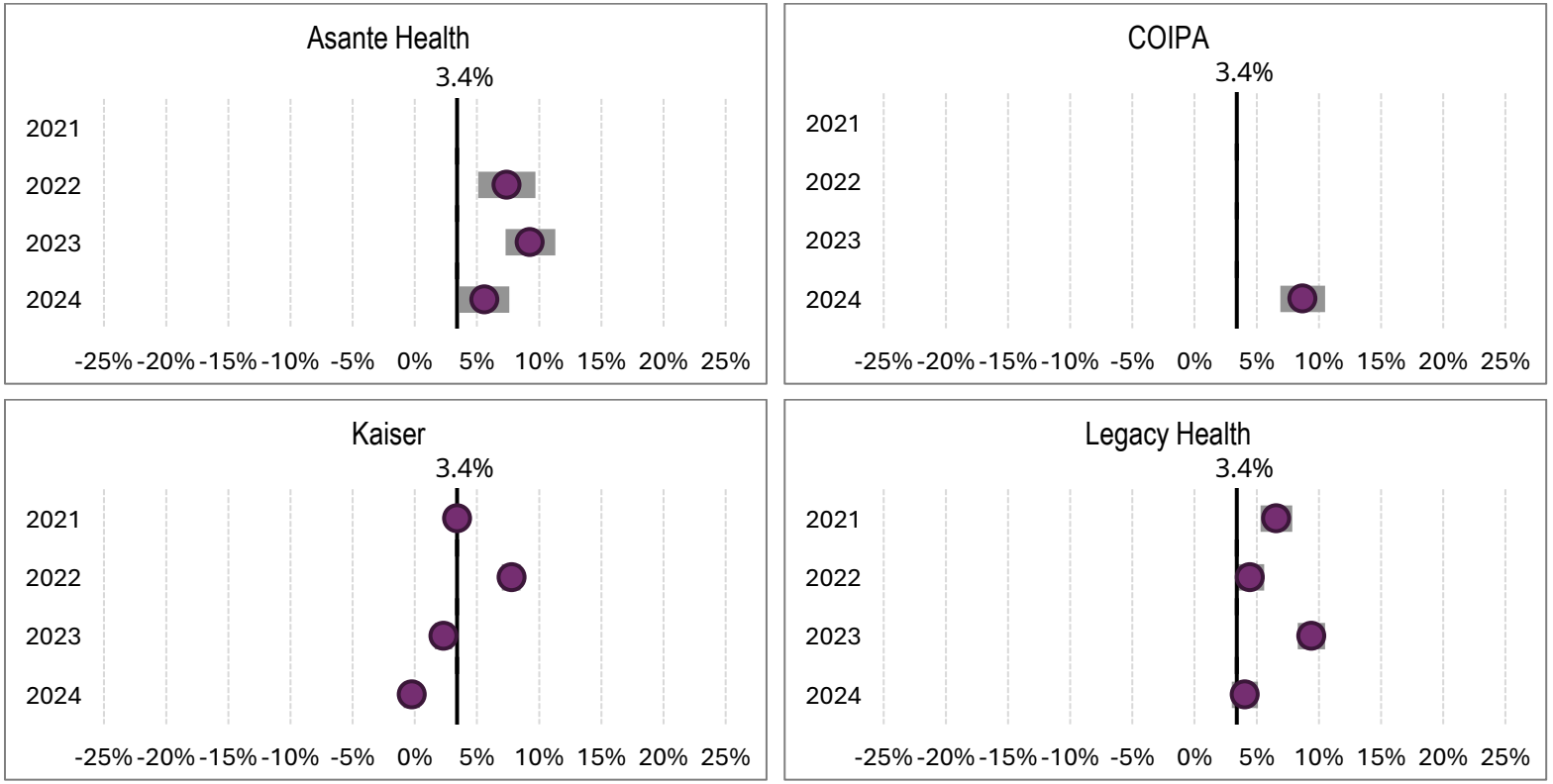
Commercial Cost Growth for Small Provider Organizations, 2021-2024

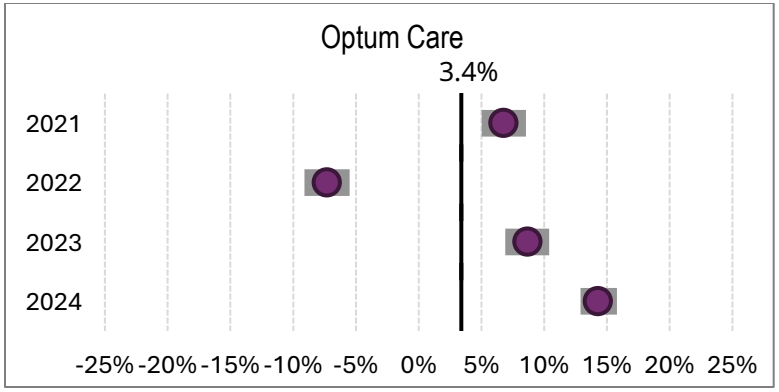


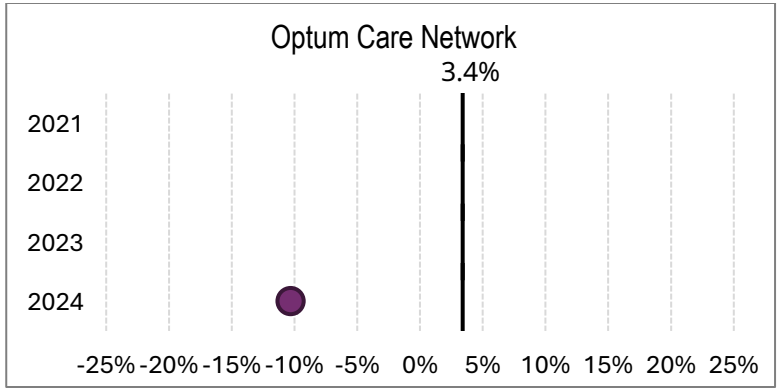
Commercial Cost Growth for Pediatric Provider Organizations, 2021-2024

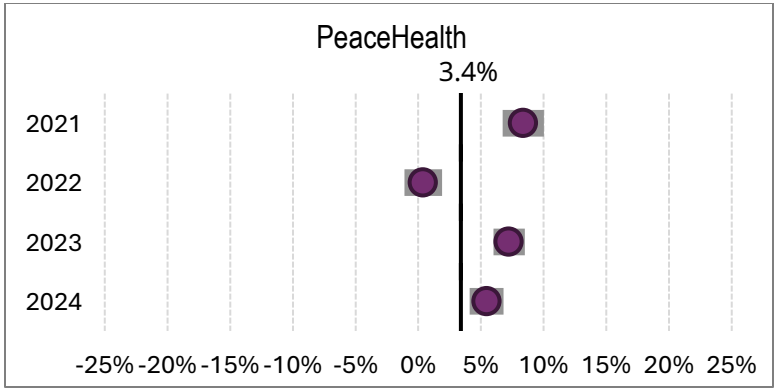


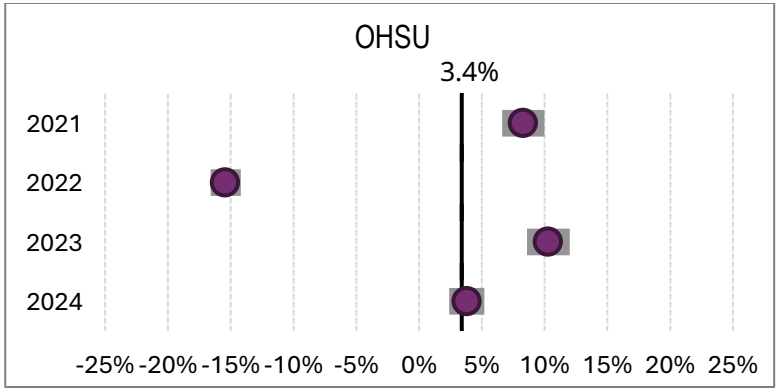
Medicare Advantage cost growth for provider organizations, 2021-2024

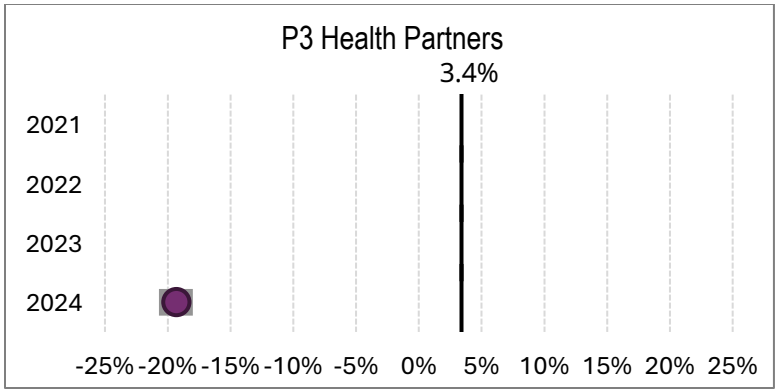


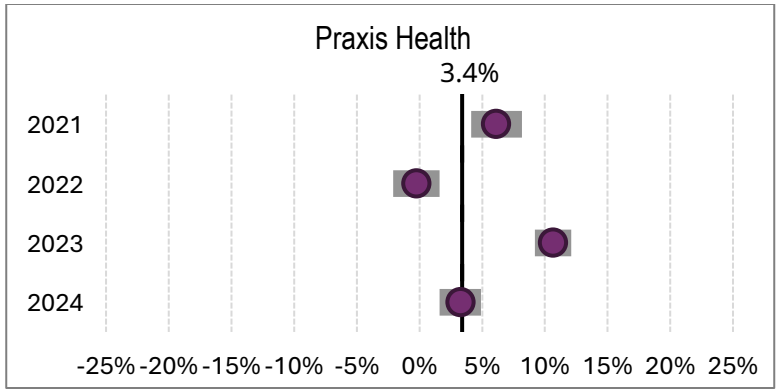

Optum Care
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

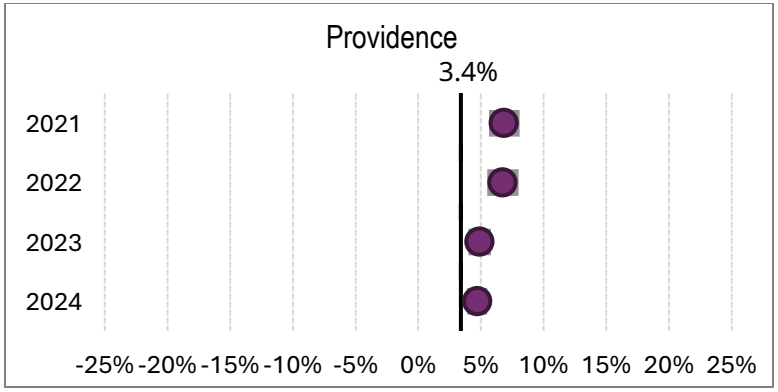

Optum Care Network
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

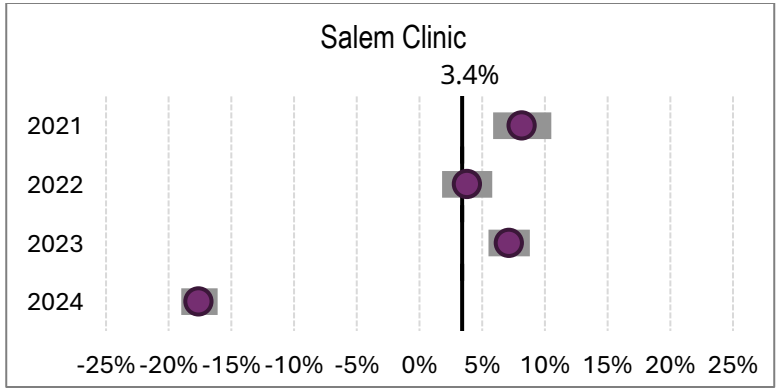

PeaceHealth
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

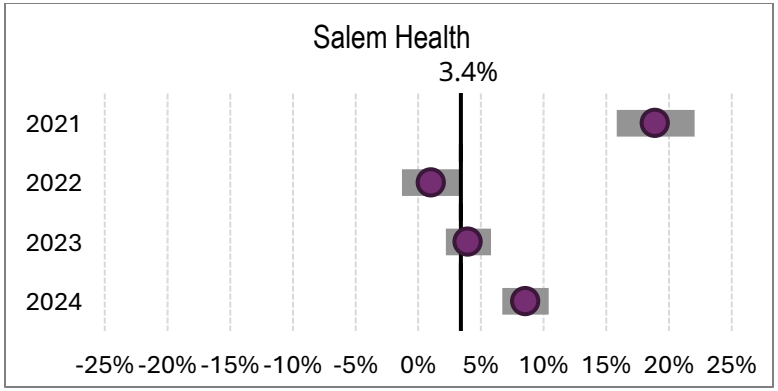

OHSU
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

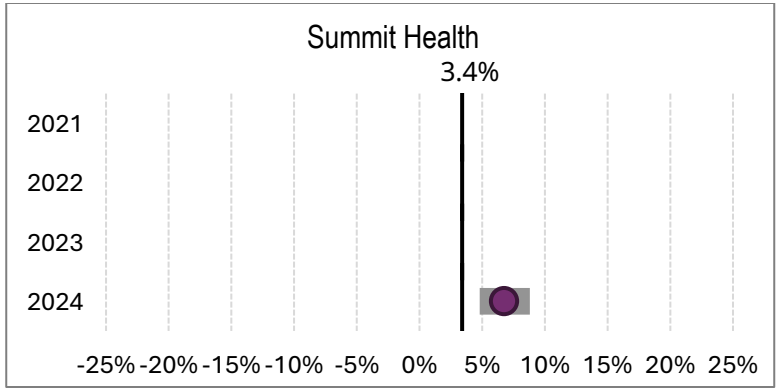

P3 Health Partners
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

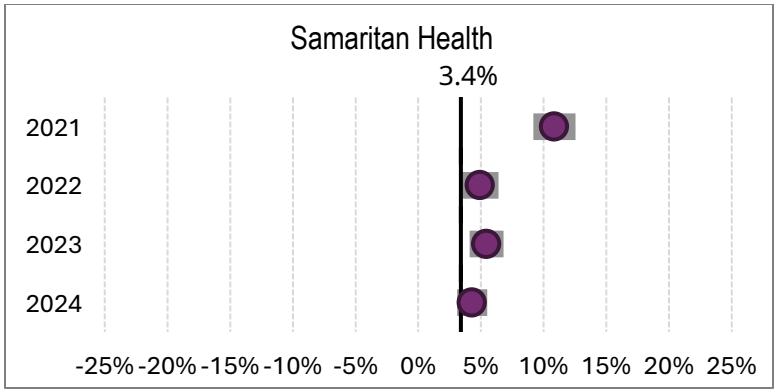

Praxis Health
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

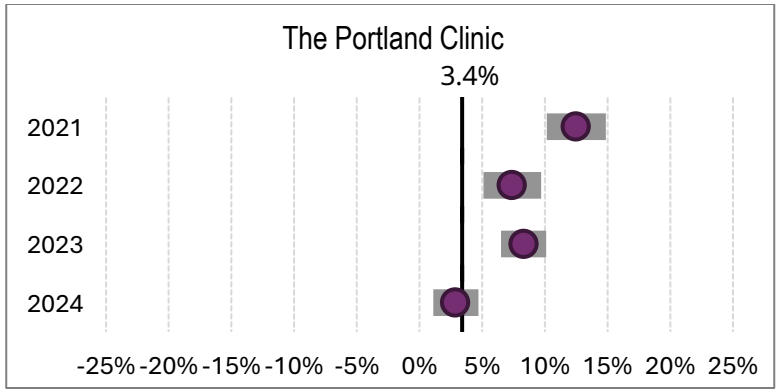

Providence
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Salem Clinic
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

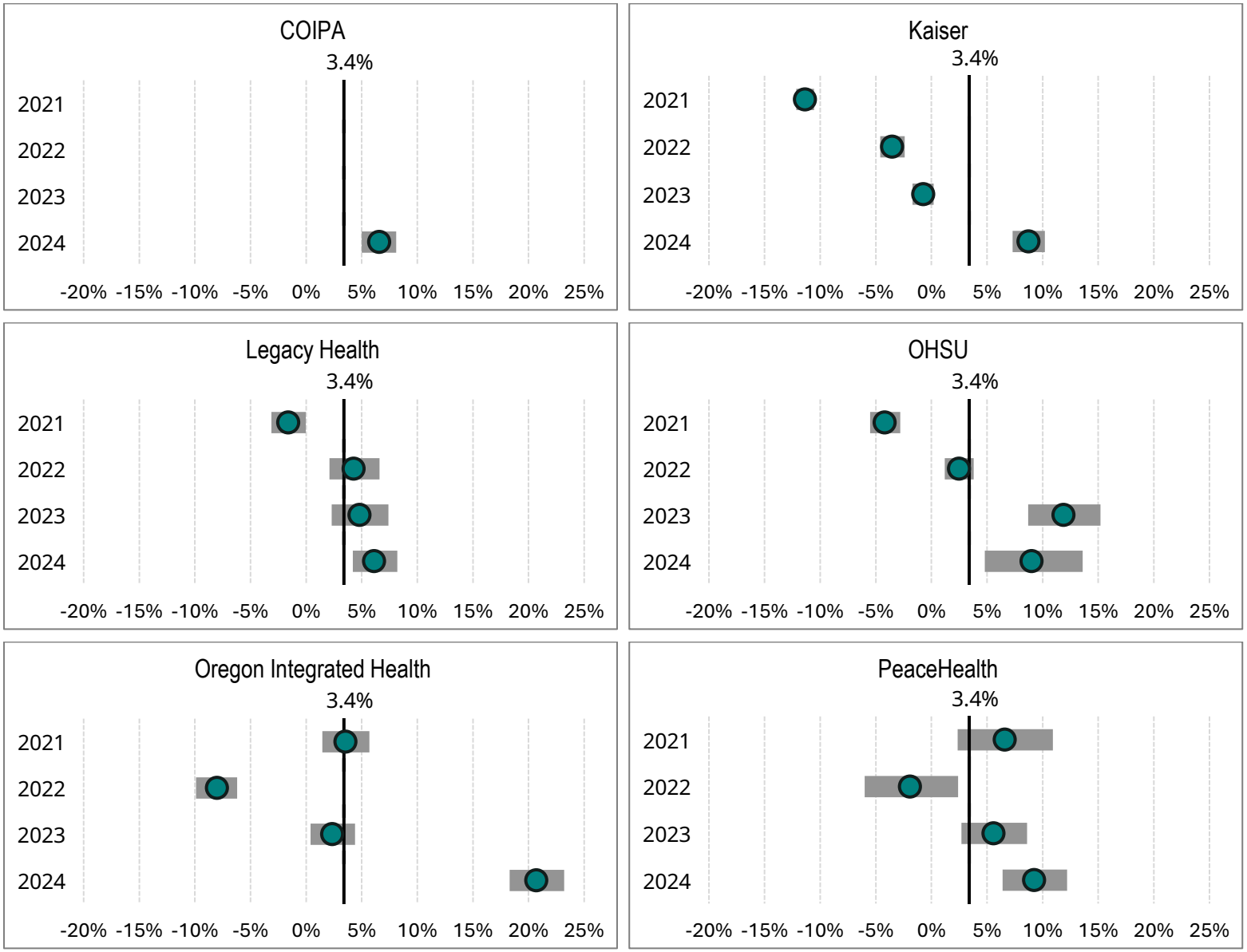

Salem Health
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

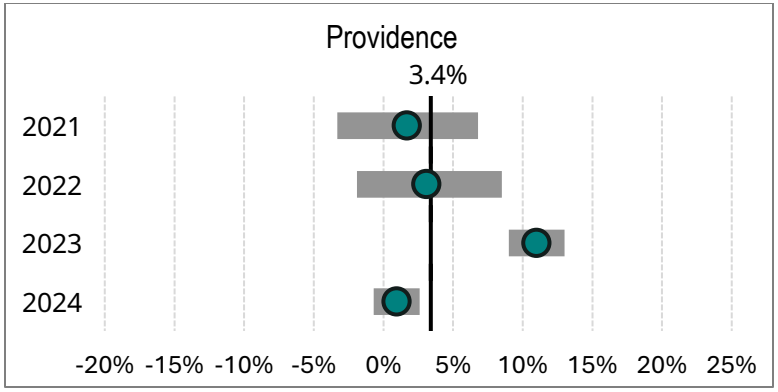

Summit Health
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

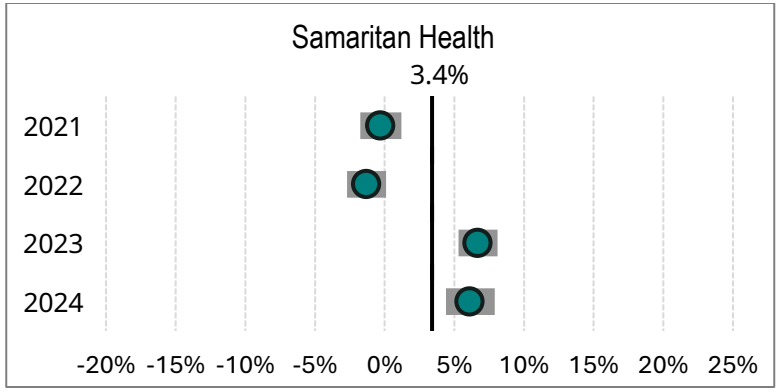

Samaritan Health
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


The Portland Clinic
3.4%
2021
2022
2023
2024
-25% -20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

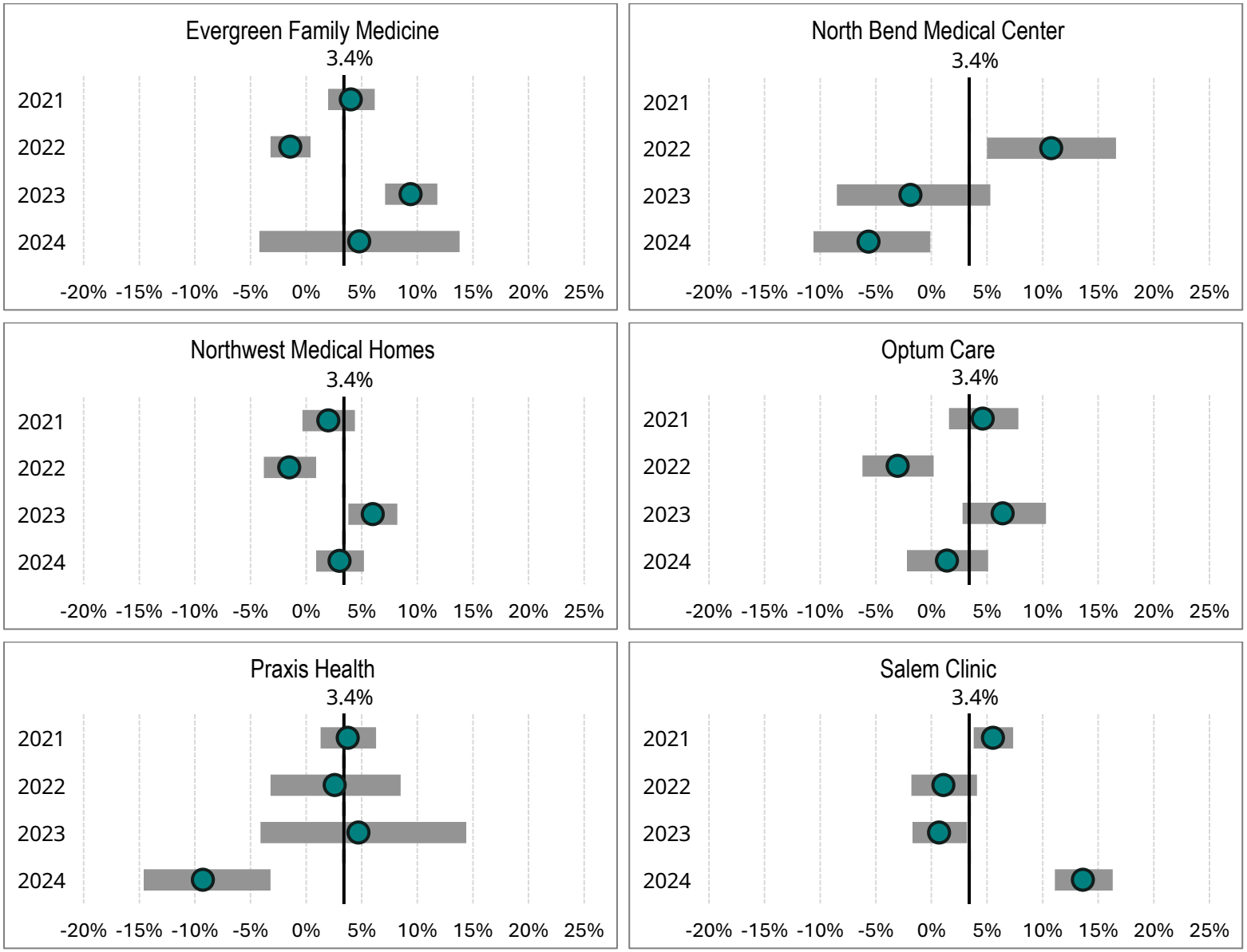
Medicaid Cost Growth for Large Provider Organizations, 2021-2024



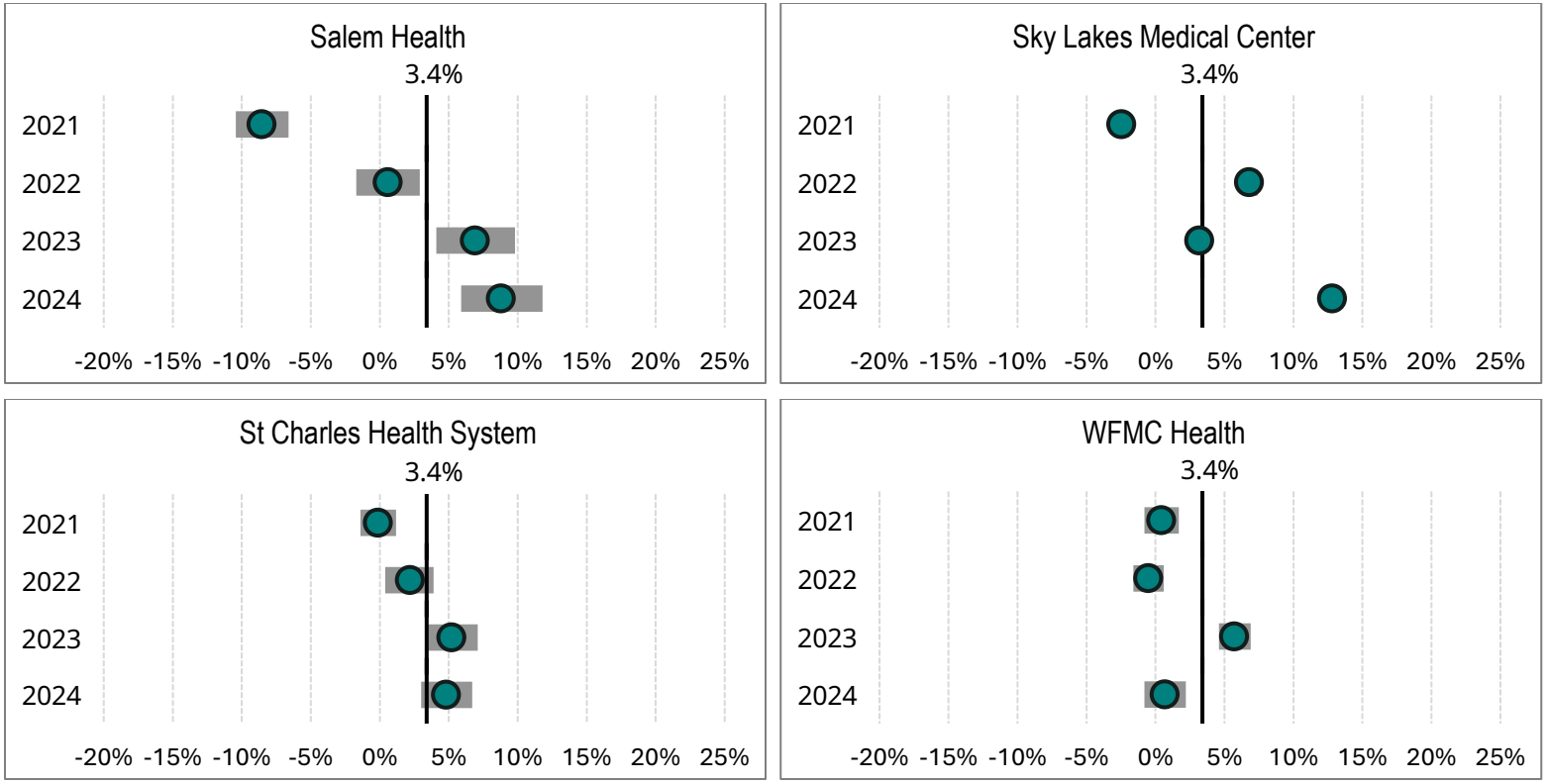

Providence
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Samaritan Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

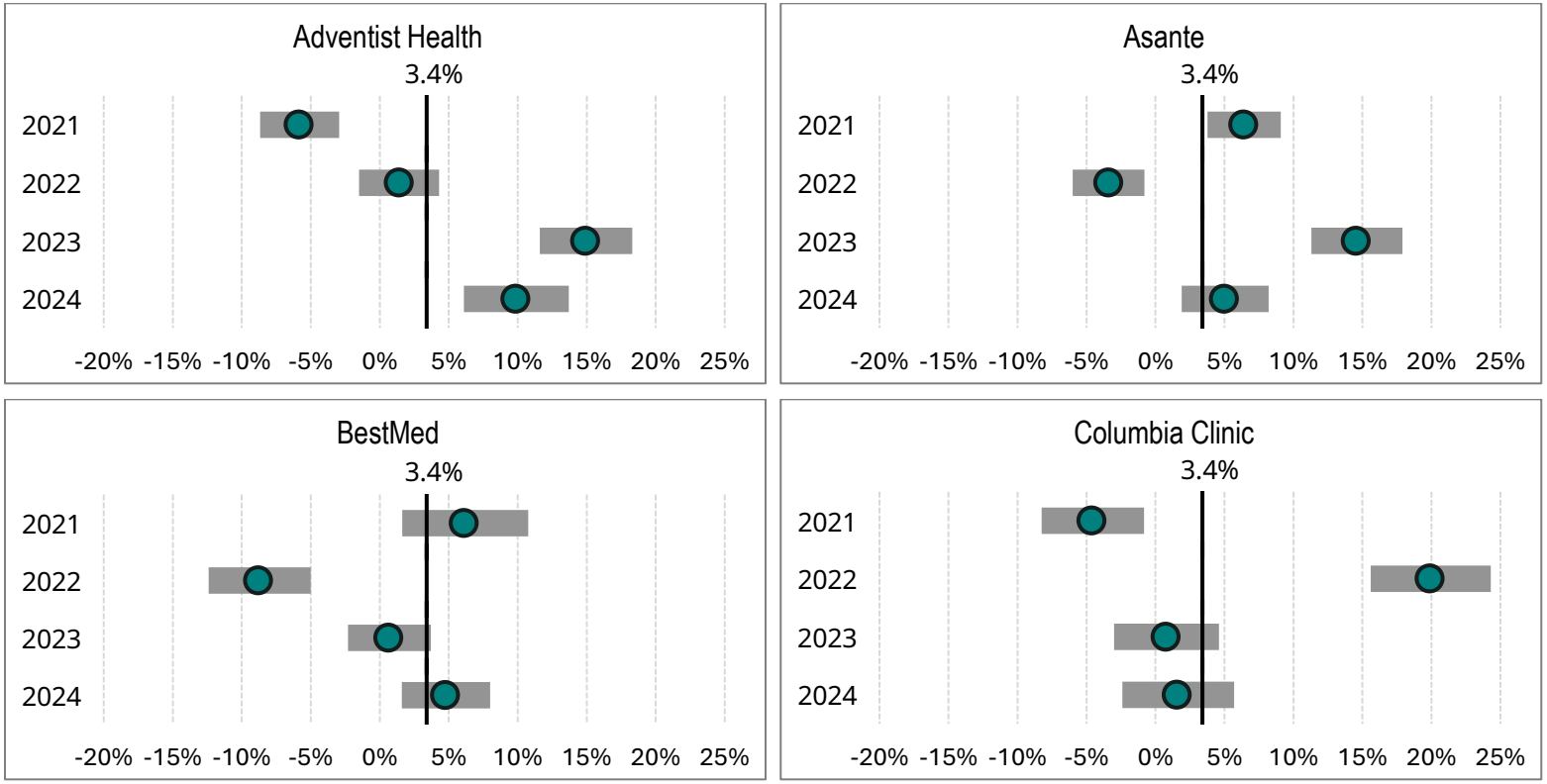
Medicaid Cost Growth for Mid-Size Provider Organizations, 2021-2024

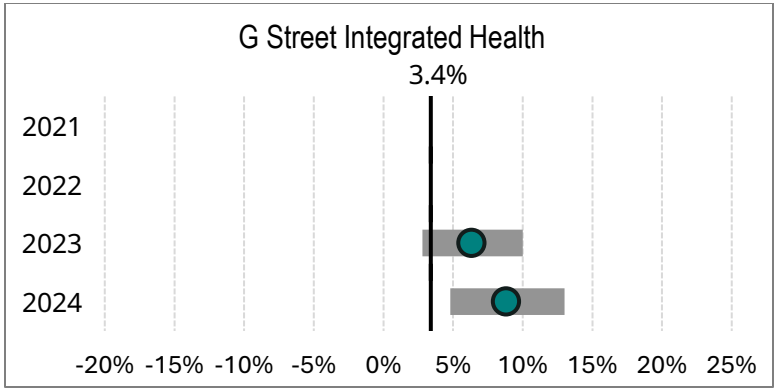


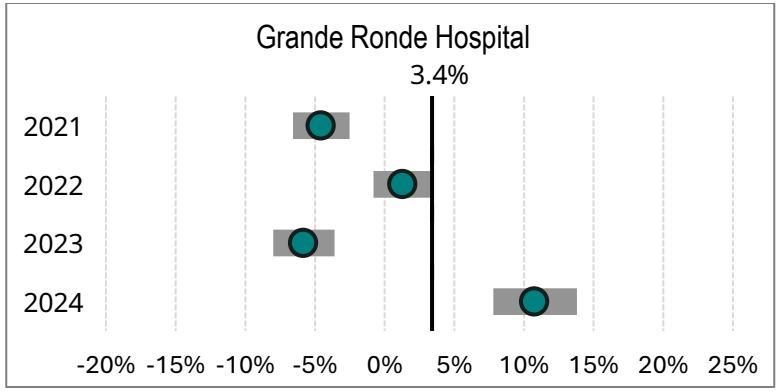
Appendix B

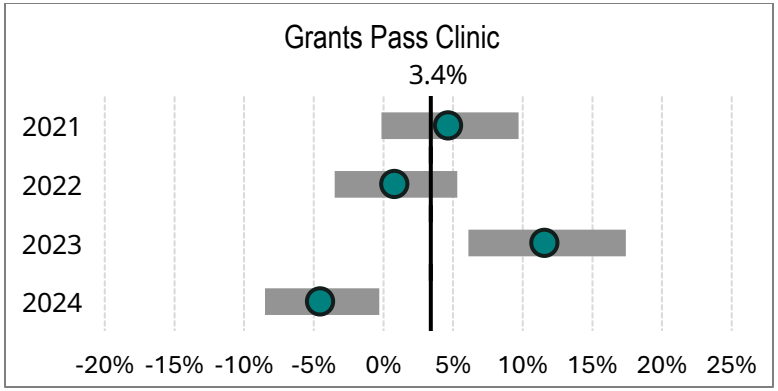

Salem Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%
Sky Lakes Medical Center
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%
St Charles Health System
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%
WFMC Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

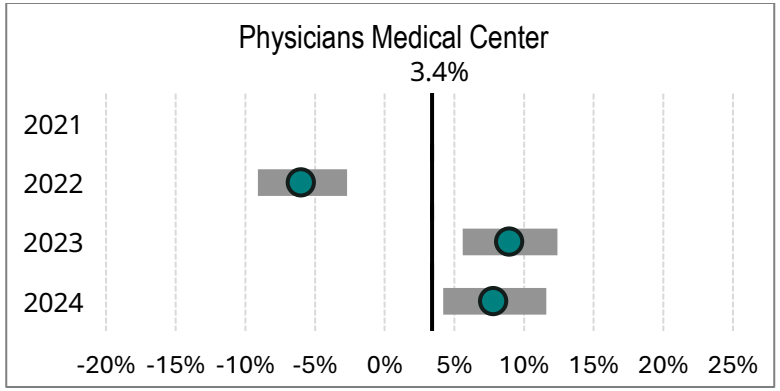
Medicaid Cost Growth for Small Provider Organizations, 2021-2024

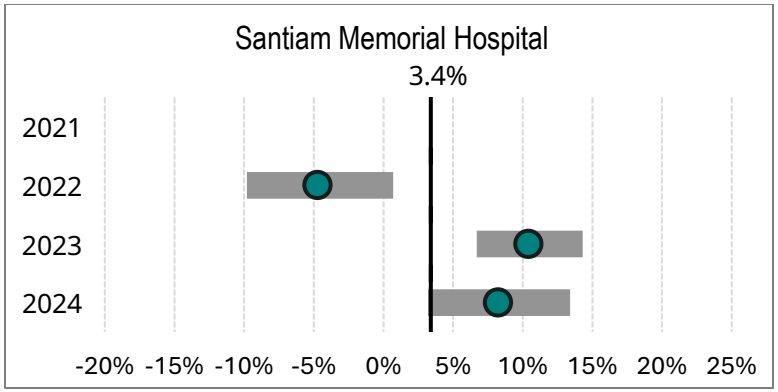


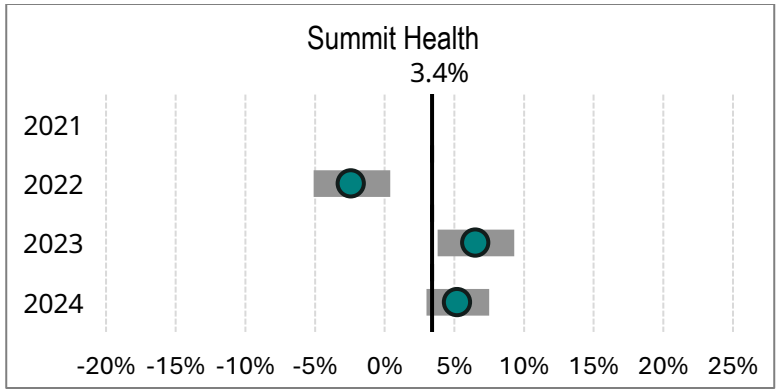

G Street Integrated Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Grande Ronde Hospital
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

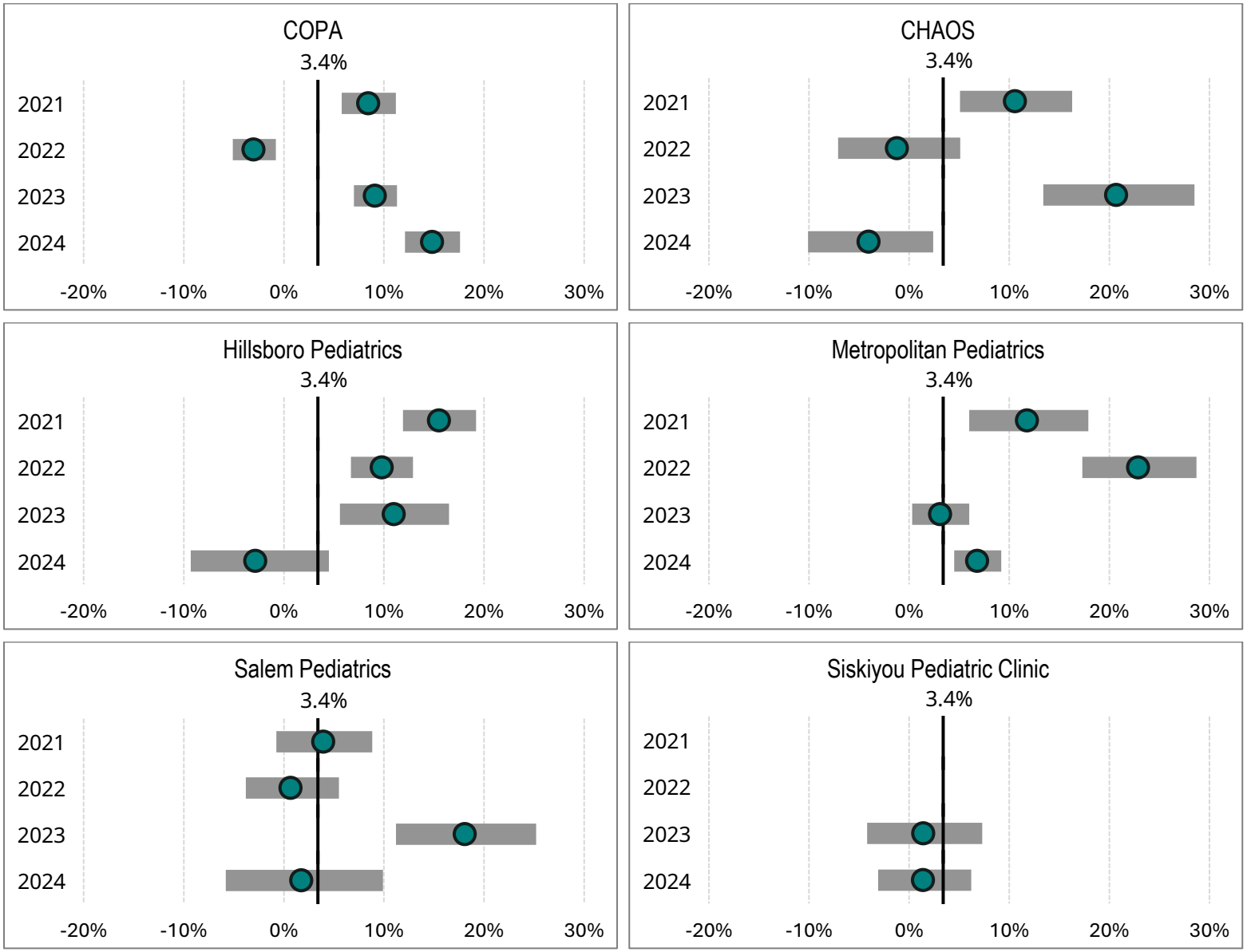

Grants Pass Clinic
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

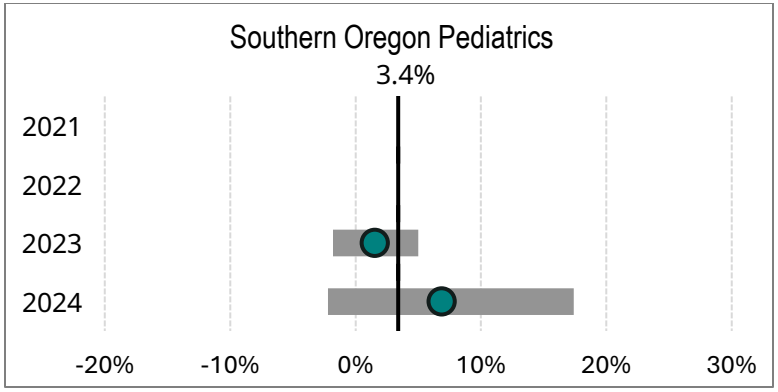

Physicians Medical Center
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

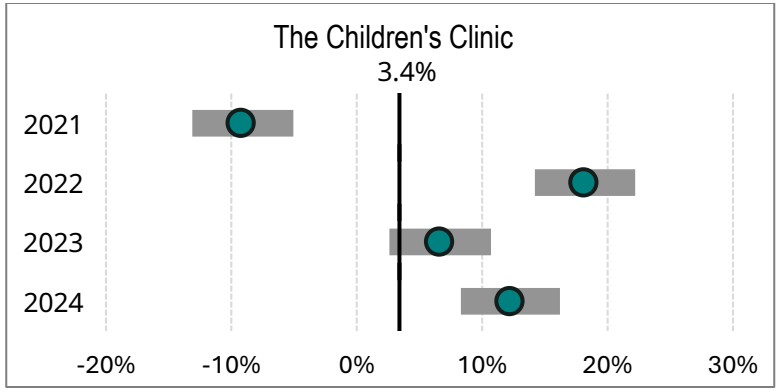

Santiam Memorial Hospital
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Summit Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

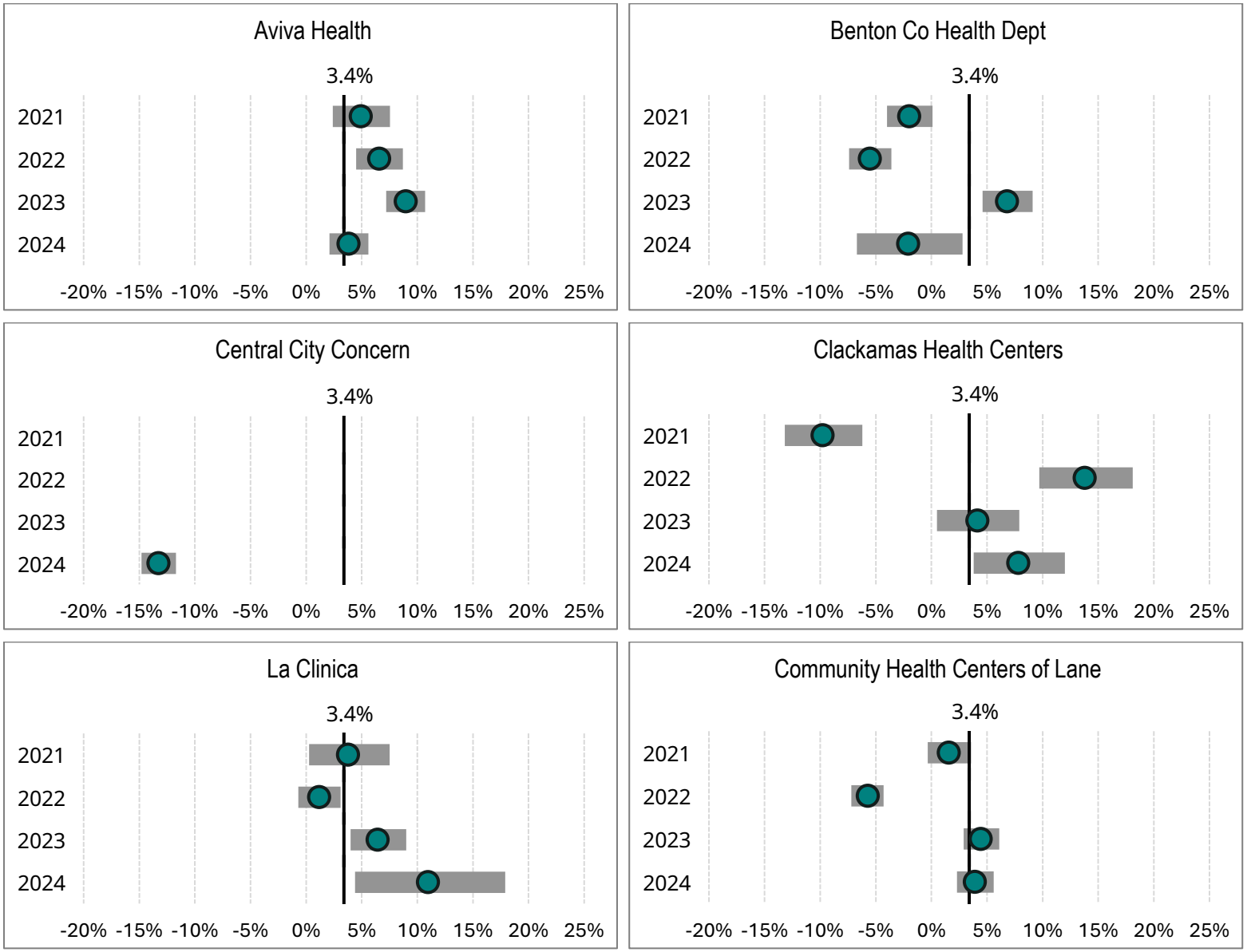
Medicaid Cost Growth for Pediatric Provider Organizations, 2021-2024

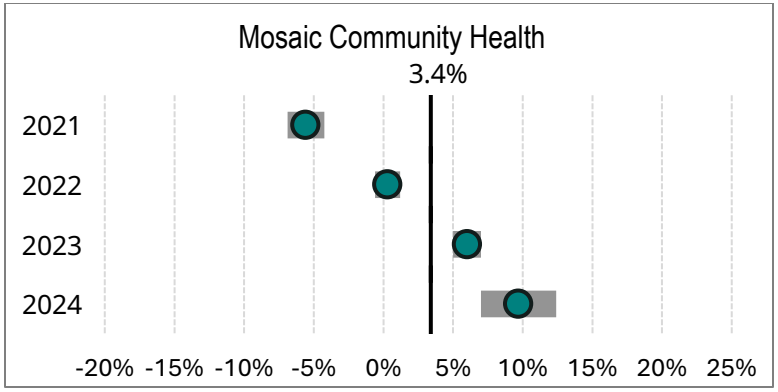


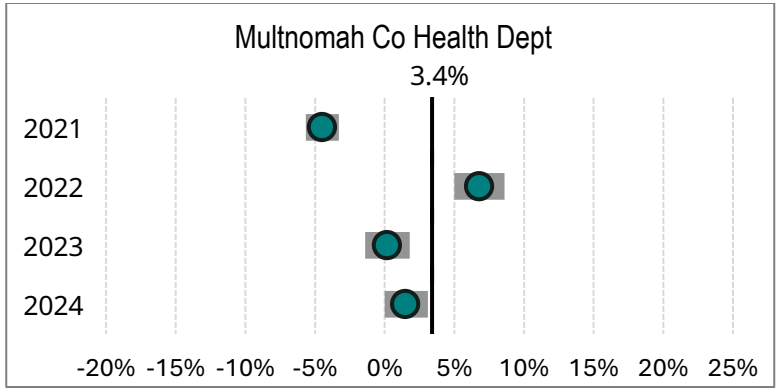

Southern Oregon Pediatrics
3.4%
2021
2022
2023
2024
-20%
-10%
0%
10%
20%
30%

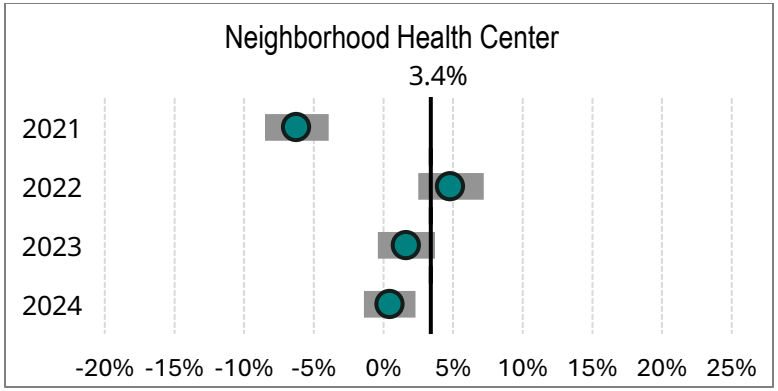

The Children's Clinic
3.4%
2021
2022
2023
2024
-20%
-10%
0%
10%
20%
30%

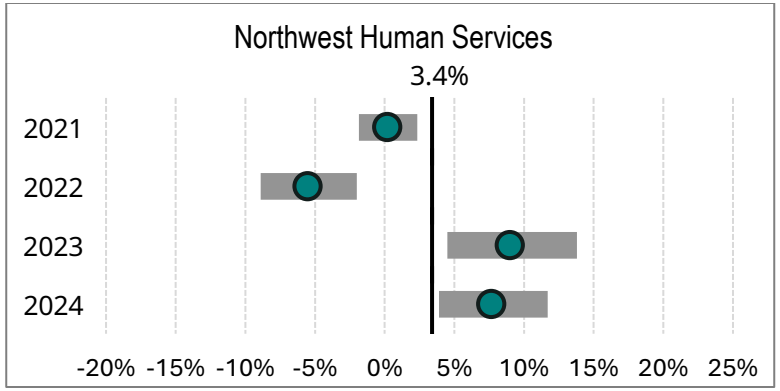
Medicaid Cost Growth for Federally Qualified Health Centers, 2021-2024

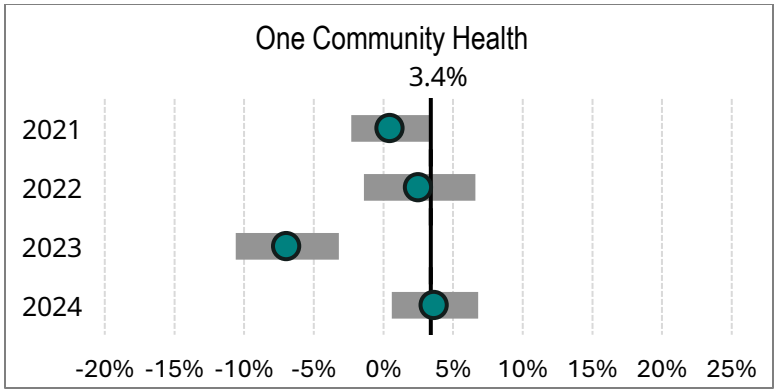


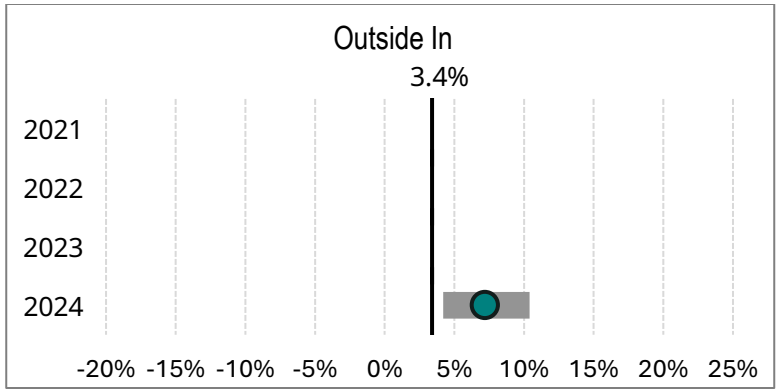

Mosaic Community Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

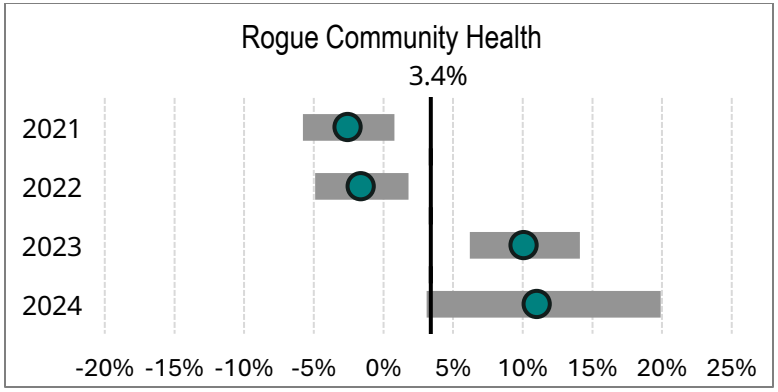

Multnomah Co Health Dept
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

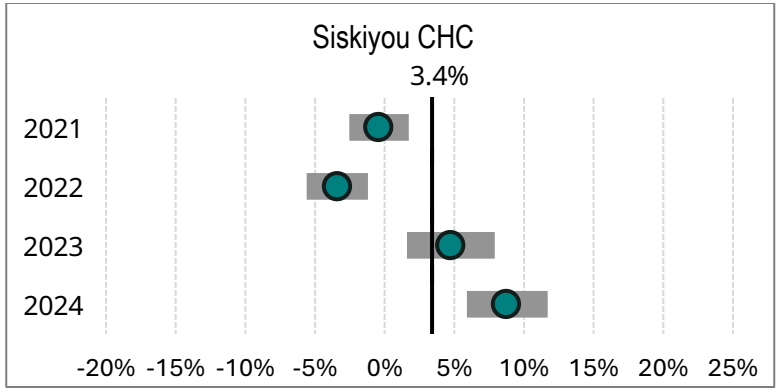

Neighborhood Health Center
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

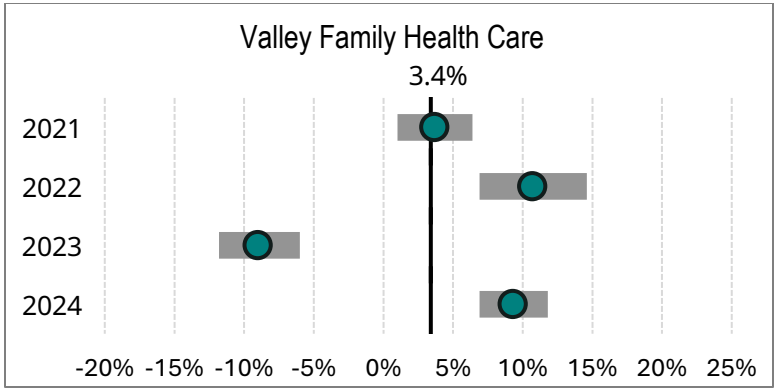

Northwest Human Services
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

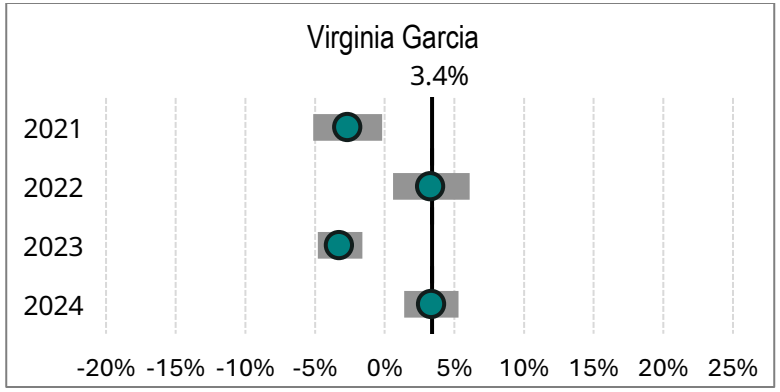

One Community Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%

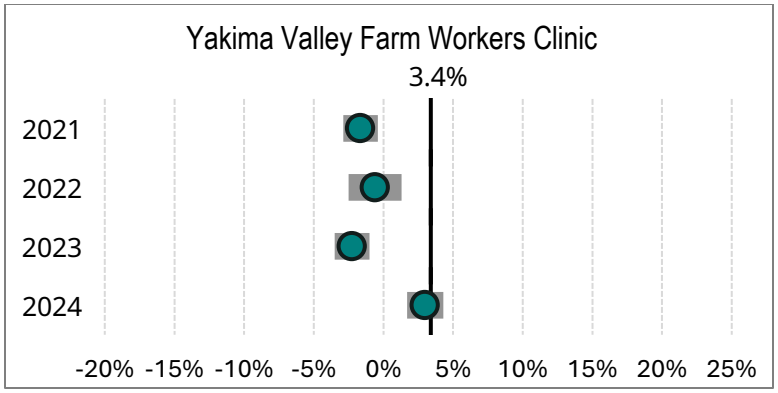

Outside In
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Rogue Community Health
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Siskiyou CHC
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Valley Family Health Care
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Virginia Garcia
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%


Yakima Valley Farm Workers Clinic
3.4%
2021
2022
2023
2024
-20% -15% -10% -5% 0% 5% 10% 15% 20% 25%