Patient Cost Sharing in Oregon:

State and Market-Level Trends, 2015-2022

April 2024

Oregon Health Authority

HEALTH CARE COST GROWTH TARGET

APAC ALL PAYER • ALL CLAIMS

Executive Summary

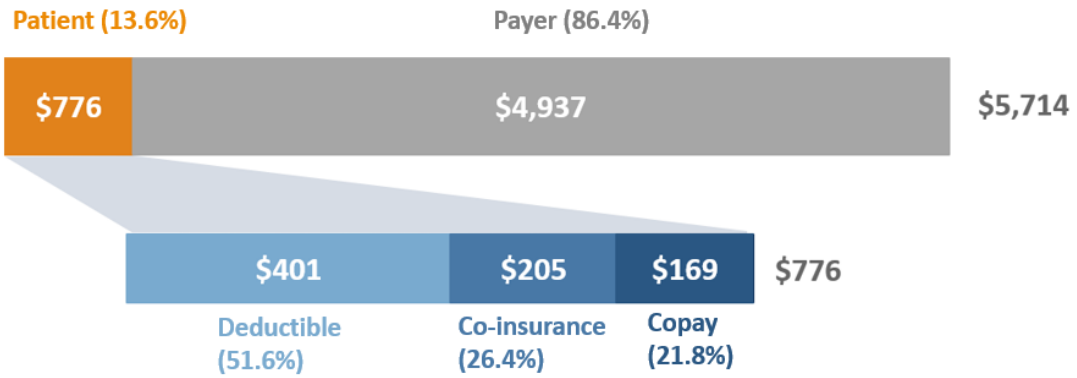
Although more people than ever in Oregon have health insurance, the rising cost of health care continues to have an outsized impact on the ability of households to make ends meet. In 2021, Oregon households spent nearly 22% of their budget on health-related expenses, and around a third of people in the state reported struggling to pay their medical bills.[1]

As Oregon expands its efforts to rein in health care costs, is it important to understand the amount that people with health insurance pay for their care – known as patient responsibility or patient cost sharing.

Using data from the state's All Payer All Claims database (APAC), this report explores cost sharing for people in Oregon with Commercial and Medicare Advantage health insurance from 2015 to 2022.[2] The report includes trends for three types of patient cost sharing – deductibles, copays, and co-insurance.

Key Findings – Commercial

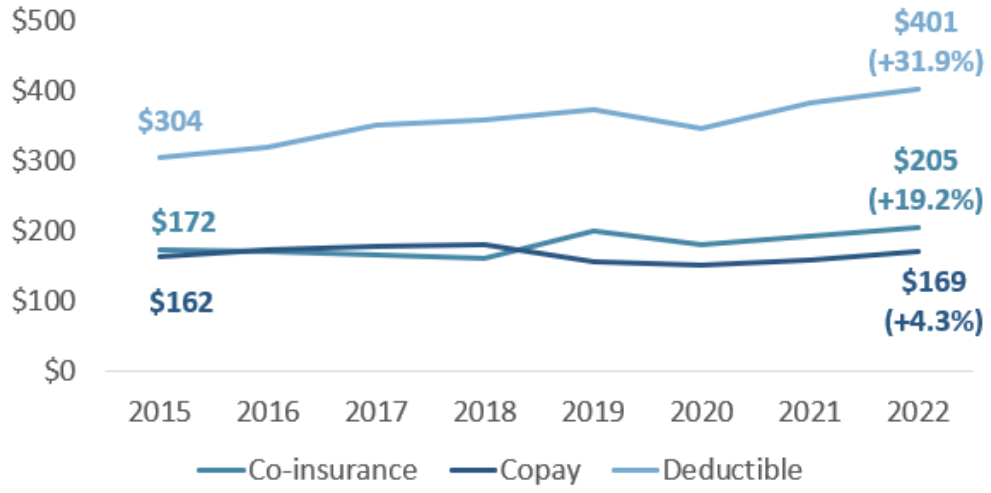
- **In 2022, people in Oregon with Commercial health insurance paid for 13.6% of their total health care costs, about $776 on average**. Deductibles made up more than half of Commercial patient cost sharing.



[1] Oregon Health Authority. Impact of Health Care Costs on People in Oregon, 2021. Portland, Oregon. Sept 2023.
[2] Cost-sharing for Medicaid beneficiaries in Oregon is usually $0, so data on patient paid for consumers with Medicaid coverage has not been included in this report. Medicare Fee-for-Service (Medicare FFS) data are also excluded due to the lack of information on Medicare supplemental insurance in APAC. See Appendix A for additional information on some pertinent issues in Medicare FFS cost sharing.

- **Since 2015, cost sharing for people in Oregon with Commercial health insurance has continued to increase, as overall Commercial health care costs rise**. Commercial cost sharing grew 17.4% (from $661 per person per year in 2015 to $776 in 2022). The average per person amount that Commercial health insurance plans paid increased 42.4% during this same period.

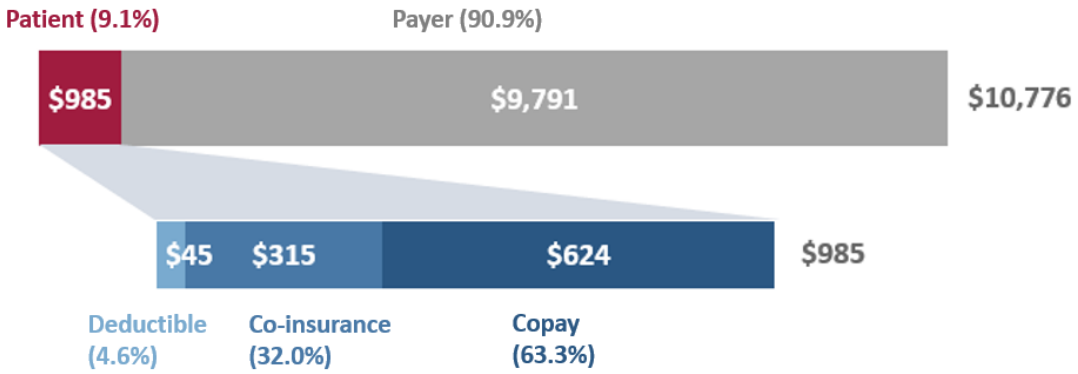
- **The amount paid in deductibles by patients each year is increasing and is growing faster than the amount paid in co-insurance and copays.** The average amount paid in deductibles grew 31.9% from 2015, compared to 19.2% for co-insurance and 4.3% for copays.



- **People with high deductible health plans (HDHP) in the Commercial market paid more for their health care than others, even though their average annual health care costs were lower.** In 2022, while Commercial HDHPs held their members responsible for 22.9% of health care costs, members of other Commercial health plans were responsible for 13.2% of costs. However, the total annual cost of health care for people with HDHP was lower ($4,539 for HDHP compared to $5,783 non-HDHP).

Key Findings – Medicare Advantage

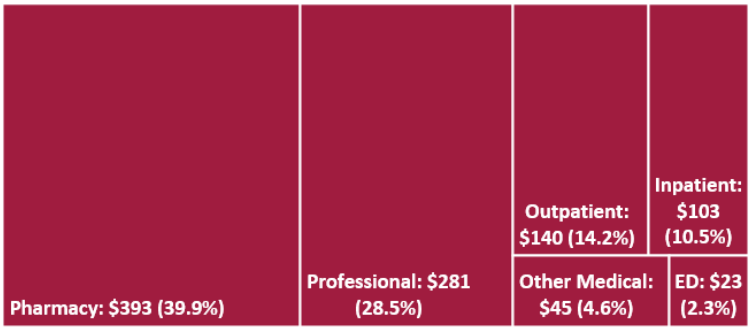
- **In 2022, people in Oregon with Medicare Advantage health insurance paid for 9.1% of their total health care costs, about $985 on average**. Copays made up the largest proportion of patient cost sharing, at 63.3%, while the amount paid in deductibles was less than 5%. Total per-person health care costs ($10,776) were higher than costs for Commercial patients ($5,714).



- **Since 2015, cost sharing for people in Oregon with Medicare Advantage insurance has grown, but inconsistently.** The cumulative growth in the amount paid by patients each year from 2015-2022 was higher than growth in the payer paid amount, 17.7% for patients ($837 to $985) versus 8.6% for payers ($9,014 to $9,791). However, most of the growth in patient cost sharing was concentrated from 2015 to 2016.

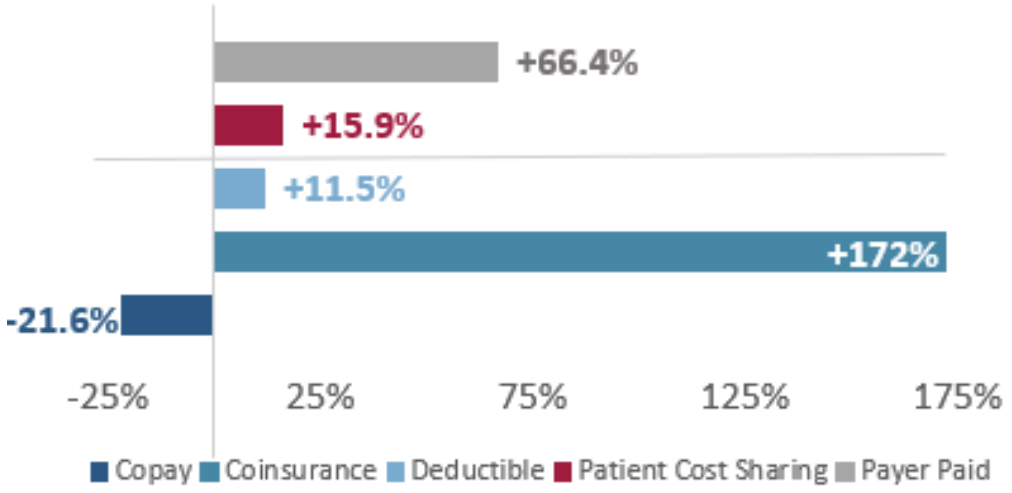
- **In each year, prescription drugs made up the largest share of patient cost sharing for people with Medicare Advantage health insurance.** Of the $985 average amount of patient cost sharing in 2022, almost 40% was for prescription drugs. Between 2015-2022, patient cost sharing for prescription drugs grew 15.9%.

Retail pharmacy made up almost 40% of patient cost sharing in 2022.



- **Patients are paying an increasing amount of co-insurance on specialty drugs.**
  The amount of patient cost sharing for retail pharmacy going to co-insurance skyrocketed from 2015 to 2022. Since co-insurance is mostly paid on specialty drug tiers in Medicare Advantage plans, this shift was likely a sign of the increasing dominance of these high-priced drugs over the period. Despite the growth in the amount paid in co-insurance, overall patient cost sharing for retail pharmacy grew more slowly than the amount paid by payers.

Cumulative growth in the amount paid per person by the payer and patient and in deductibles, co-insurance, and copays for retail pharmacy, 2015-2022



Click here to explore the dashboard: Patient Cost sharing in Oregon, 2015-2022

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Data Source

Data from the Oregon All Payer All Claims database, Release 17, refreshed Q1 2024.

Questions

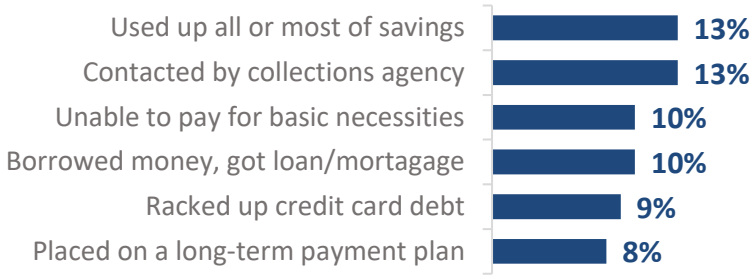
For questions about this report, please contact: HealthCare.CostTarget@oha.oregon.gov

Introduction

In recent years the rate of health insurance coverage in Oregon has increased significantly, with data from the Oregon Health Insurance Survey indicating that 95.4% of people in Oregon had health insurance in 2021, up from 85.5% in 2013. Despite improved coverage, there is abundant evidence that people in Oregon today are struggling to pay for the health care they receive.

Individuals and families in Oregon continue to spend a large portion – about 22% in 2021 – of their household budgets on healthcare. Around a third of people in the state reported struggling to pay their medical bills (see Figure 1) and at least 28% of Oregonians were considered underinsured in 2021, meaning that their out-of-pocket expenses were high in relation to their income.[3]

Figure 1. Percent of Oregon adults who reported the following struggles to pay medical bills, 2021



Patient cost sharing – the amount of money that insured individuals and households pay for the medical services that they receive – is one piece of the puzzle explaining why people in Oregon are shouldering high health care costs despite improved coverage. As health care costs continue to grow, so does the amount that patients are paying in deductibles, co-insurance and copays. Over time and in times of need, this cost sharing can be more than an individual or their family can afford.

This report, and its associated dashboard, has been developed using medical claims data from the state's All Payer All Claims database to increase visibility into the amounts and types of cost sharing being paid by people in Oregon with Commercial and Medicare Advantage health insurance.[4] The report provides background and context and highlights key trends, while the dashboard can be used to delve deeper into the data.

[3] Oregon Health Authority. Impact of Health Care Costs on People in Oregon, 2021. Portland, Oregon. Sept 2023.
[4] Cost-sharing for Medicaid beneficiaries in Oregon is usually $0, so data on patient paid amounts for people with Medicaid coverage has not been included in this report. Medicare Fee-for-Service (Medicare FFS) data are also excluded due to the lack of information on Medicare supplemental insurance in APAC. See Appendix A for additional information on some pertinent issues in Medicare FFS cost sharing.

What is patient cost sharing?

When an individual or a household purchases health care insurance, they agree to a certain set of arrangements for what health care services are covered by the insurer and how much of the cost the health insurance plan will pay. The portion of the cost of covered services that the patient is responsible for is patient cost sharing. Unlike health insurance premiums, which are paid to the health plan whether any services are used or not, cost sharing only applies when services are used.

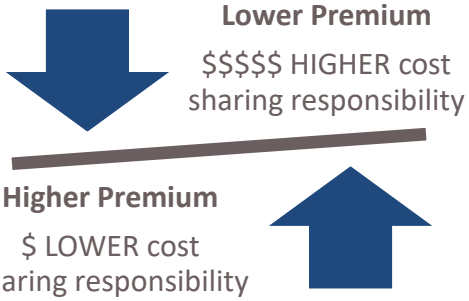
Types of patient cost sharing

- **Deductible:** A deductible is the amount a person with health insurance is required to pay for certain services each year before an insurance company will start covering the cost of care. Often, deductibles do not apply to preventive care like visits with a primary care physician.
- **Copay:** A copay is a set amount of money an insured individual pays for a given service, for example $15 for a visit to a primary care physician. Insurance covers the rest of the cost.
- **Co-insurance:** For some services, people with health insurance are required to cover a percentage of the rate negotiated by a provider and their insurance company. For example, a patient may pay for 25% of the cost of an x-ray, after meeting their yearly deductible.

How do health insurance plans use cost sharing?

Patient cost sharing is one tool that insurers have for containing health care costs, primarily by helping them manage utilization of health care services. Its role in American health insurance plans was solidified following the RAND Health Insurance Experiment of the 1970s, which was a massive social experiment that showed that the higher a patient's cost sharing requirement, the less likely they are to use health care services. Importantly, the study found that increased cost sharing could reduce health care spending with minimal negative impact on health care status for patients of average health.[5]

The findings of the RAND HIE seemed to justify the use of cost sharing as a tool to motivate patients to make cost-effective choices about their health care usage. The logic was that patients were less likely to use low-value, unnecessary, or higher-priced services if they had to cover a part of the cost.



Cost sharing is related to, but not the same thing as, health care premiums. A premium is the

[5] Gruber, Jonathan. The role of consumer copayments for health care: Lessons from the RAND health insurance experiment and beyond. Report prepared for the Kaiser Family Foundation. October 2006.

upfront cost of purchasing health insurance and is paid to the insurance plan. In general, plans that have a higher premium may have lower cost sharing requirements. For decades, health insurance plans and employers have viewed cost sharing as a way to minimize premium increases.

Cost sharing: a blunt tool for reining in health care costs

In recent years, Oregon has made a commitment to controlling health care cost growth to make health care more affordable and to support equitable health outcomes across the state.

Patient cost sharing may have a role to play in reducing health care spending, because it can influence utilization of low-value health care services. However, cost sharing can also create a barrier to health care access and drain people's financial resources. Blunt and indiscriminate application of high cost sharing requirements may ultimately prove counterproductive in the pursuit of improved affordability and the health and well-being of people in Oregon.

Cost sharing can decrease utilization of necessary services

Beyond the financial impact of high medical bills, poorly designed or excessive cost sharing can reduce utilization of necessary treatment. Studies have shown that utilization of services including preventive and primary care, vaccinations, prescription drugs, mental health care and inpatient and outpatient care is reduced with even small amounts of cost sharing.[6] [7]

Although the literature suggests that the health of people in average condition may not be adversely impacted, there is evidence that people in poorer health, with lower incomes, and older adults may forgo needed health care in response to cost sharing and suffer health consequences as a result.[8]

Cost sharing requirements now may lead to more costly services later

Ultimately, decreased utilization of necessary services resulting from high cost sharing can result in increased utilization of more costly services later. One study of the impact of copays on health care utilization among Medicaid beneficiaries in Oregon in the early 2000s found that the addition of a copay was associated with reduced use of some types of services like prescription drugs but *increased* use of hospital inpatient and outpatient services with no overall savings.[9] Other studies have found that total health care spending remained the same or increased with more cost sharing, even though the types of services may have shifted.[10]

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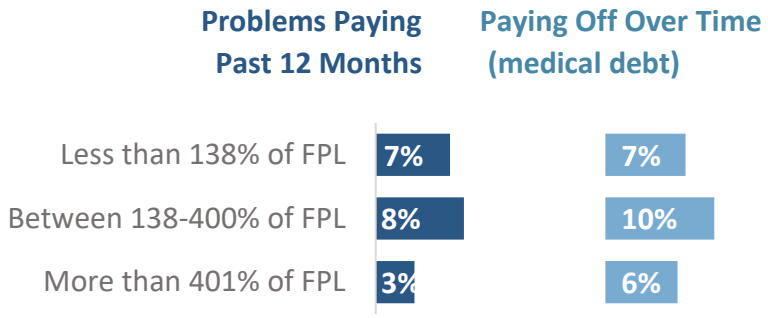
[6] Artiga, Samatha et al. The effects of premiums and cost sharing on low-income populations: updated review of research findings. The Henry J. Kaiser Family Foundation Issue Brief. June 2017.
[7] Remler, Dahlia and Jessica Greene. Cost sharing: a blunt instrument. Annual Review of Public Health 30. 2009.
[8] Swartz, Katherine. Cost-sharing: effects on spending and outcomes. The Synthesis Project. Research Synthesis Report 20(2010): 1-36. December 1, 2010.
[9] Wallace, Neal et al. How effective are copayments in reducing expenditures for low-income adult Medicaid beneficiaries? Experience from the Oregon Health Plan. Health Services Research 43, No. 2:515-530. 2008.
[10] Fusco, Nicole et al. Cost sharing and adherence, clinical outcomes, health care utilization and costs: A systematic literature review. Journal of Managed Care and Specialty Pharmacy 29 No. 1: 4-16. April 2023.

People with lower incomes are particularly vulnerable

People with health insurance do not experience medical bills equally. People who have fewer resources to cover cost sharing requirements may be more acutely affected.

Figure 2. Percent of people in Oregon reporting they had problems paying their medical bills, 2021



In Oregon in 2021, people with incomes of 400% or less of the federal poverty level (FPL) and people of Middle Eastern and North African, Hispanic, or American Indian or Alaska Native race/ethnicity were more likely to report having medical debt or using up all or most of their savings on medical bills.

What support is available to help people with low income afford health care?

State and Federal policies and programs help a subset of the poor and near-poor population cover their share of medical bills. In Oregon, people with an income that is at or below 138% of the federal poverty level (FPL) - $38,295 for a family of four in 2022 – qualify for Medicaid. Medicaid members in Oregon do not pay cost sharing ($0 deductible, coinsurance, and copay).

People over the age of 65 are eligible for Medicare, which has different programs including Medicare Savings Programs, the Medicare "Extra Help" program and the Low Income Subsidy, which help cover premiums and some cost sharing for Medicare parts A, B and D for people at or near the FPL. Some people with Medicare have low enough income for secondary coverage through Medicaid, which brings their cost sharing down to $0.

Support to cover cost sharing in the Commercial market is harder to come by. For people who don't qualify for Medicare and Medicaid but who purchase individual health care on the state health care marketplace and have incomes of up to 250% of the FPL, cost sharing reductions are available for people who use Silver-level plans.

Finally, hospital charity care is one way that people both with and without insurance may afford their care. Nonprofit hospitals in Oregon are required by law to cover the health care costs of patients earning up to 200 percent of the FPL and provide discounted care on a sliding scale for patients earning up to 400 percent of the FPL.

Commercial Market Cost Sharing

In Oregon, about 50.9% of households had commercial insurance in 2021, with the majority of them (92.7%) getting their insurance through a group plan with an employer and the remaining 7.3% insured on the individual market.[11] While people with commercial insurance are less likely to be elderly and therefore may have fewer health needs on average than the Medicare population, they must contend with high and growing prices. Previous analysis found that health care costs in Oregon's Commercial market grew 45.2% from 2013 to 2019, and that this growth was driven by price, as opposed to increased utilization.[12]

In recent years, there has been an increase in the size of deductibles and other cost sharing requirements in the Commercial market at the national level.[13] In Oregon, average deductible amounts for Commercial health insurance plans grew from $2,462 to $3,994 for family plans and from $1,496 to $2,110 for single plans from 2015-2022, increases of 62.2% and 41.0% respectively.[14] This increase came even as premiums rose 18.8% and 21.8% respectively for family and single plans during the same period.[15]

Key Findings:

- Commercial cost sharing data in this report reflect national trends, with a demonstrated increase in the proportion of cost sharing going to deductibles.

- Cumulative growth in the amount of patient cost sharing from 2015-2022 (17.4%) was less than cumulative growth in the amount paid by payers (42.4%). The proportion of the total cost of care covered by the patient decreased, from 16.0% in 2015 to 13.6% in 2022.

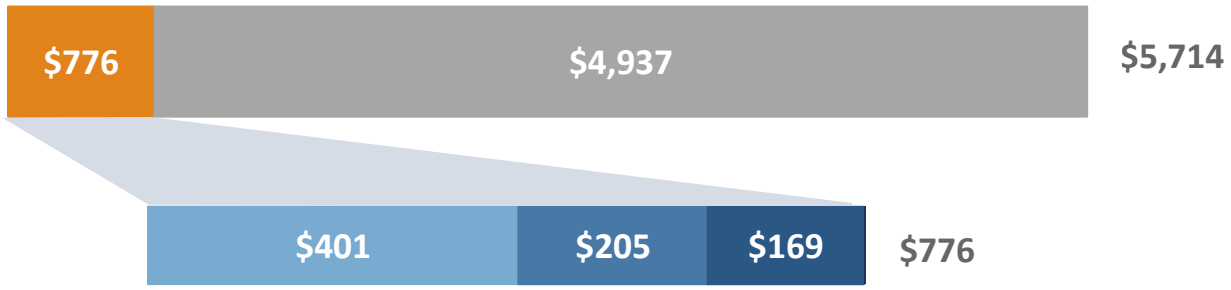
- However, High Deductible Health Plans are becoming increasingly common and as a result some people are paying more for less health care than they were before.

[11] Oregon Health Insurance Survey. Health insurance coverage in Oregon. Portland, Oregon. January 2022.
[12] Oregon Health Authority. Health Care Cost Trends: Price and Utilization. Portland, Oregon. November 2022.
[13] Hughs, Sam et al. Health insurance costs are squeezing workers and employers. Center for American Progress. November 2022.
[14] Agency for Healthcare Research and Quality (AHRQ). Medical expenditure panel survey (MEPS) insurance component (IC). 2022. Accessed April 2024.
[15] Ibid.

Commercial cost sharing in 2022

In 2022, people in Oregon with commercial health insurance paid $776 on average in cost sharing, or 13.6% of the total cost of care for the year. Deductibles made up the largest portion ($401, or 51.6%) of the amount of cost sharing paid by people with commercial health insurance, followed by co-insurance ($205, or 26.4%) and copays ($169, or 21.8%).

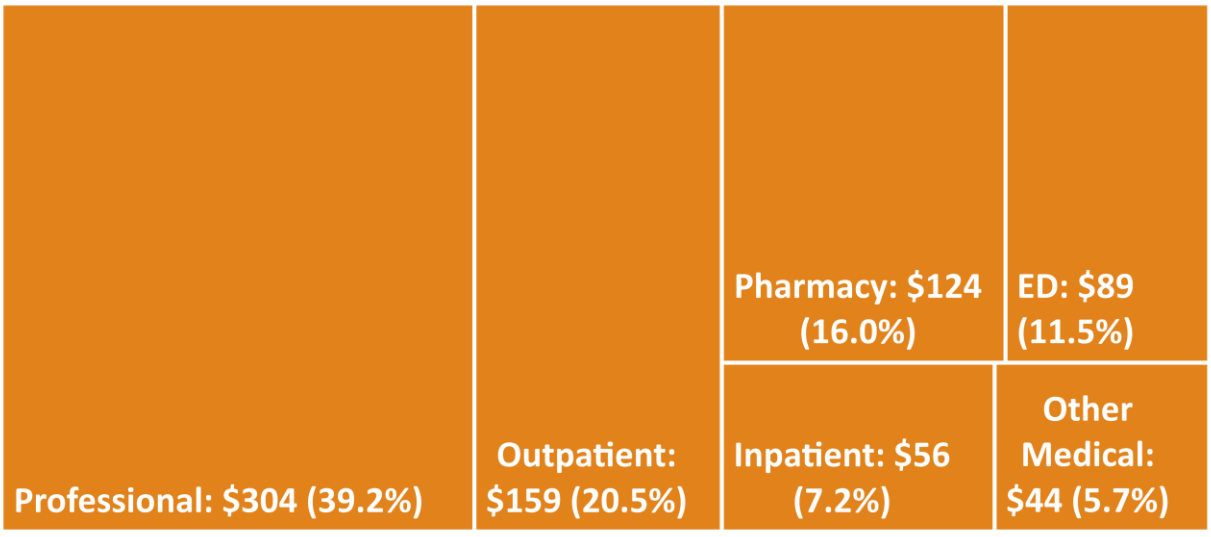
Figure 3. Average per-person cost sharing compared to health plan-paid amounts in 2022, Commercial market, with cost sharing broken into deductible, co-insurance, and copay*



* $2 was also paid in the "Other" cost sharing category.

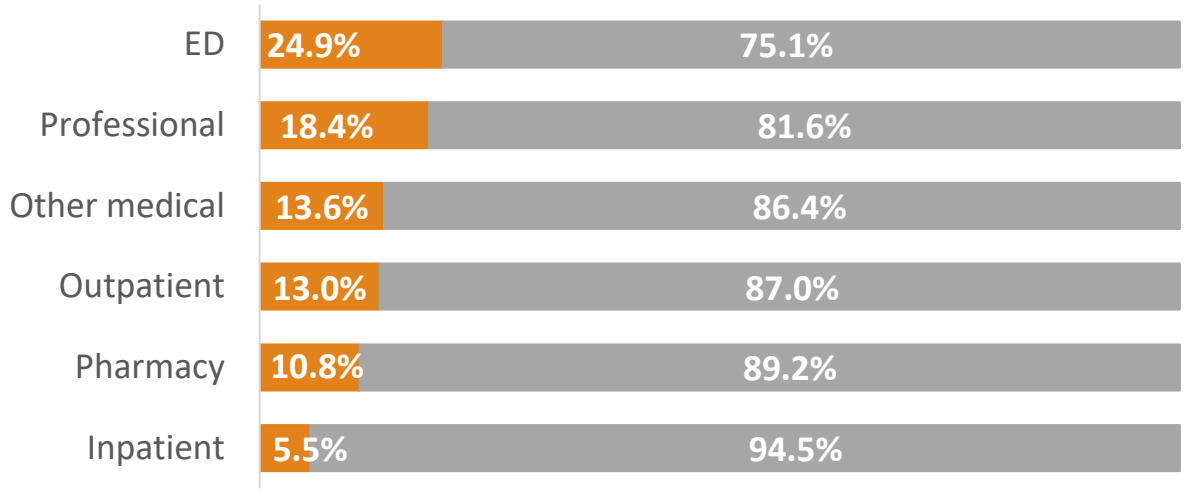
By service category, people with Commercial insurance paid the most in cost sharing for professional services in 2022 - $304 – which made up 39.2% of the average annual per-person cost sharing amount of $776. Hospital outpatient and retail pharmacy followed, making up 20.5% and 16.0% of patient cost sharing respectively.

Figure 4. Average per-person cost sharing by service category in 2022, Commercial market



The proportion of costs that were covered by the individual also varied by service category. Even though the average amount paid in cost sharing for Emergency Department (ED) visits was relatively low at $89, patients covered 24.9% of the cost of the ED visits that did happen in 2022.[16] After ED visits, patients paid the highest proportion of total costs for professional services (18.4%), which were also the largest source of patient cost sharing among all service categories.

Figure 5. Percent of per-person annual health care costs paid by the patient versus the health plan by service category in 2022, Commercial market



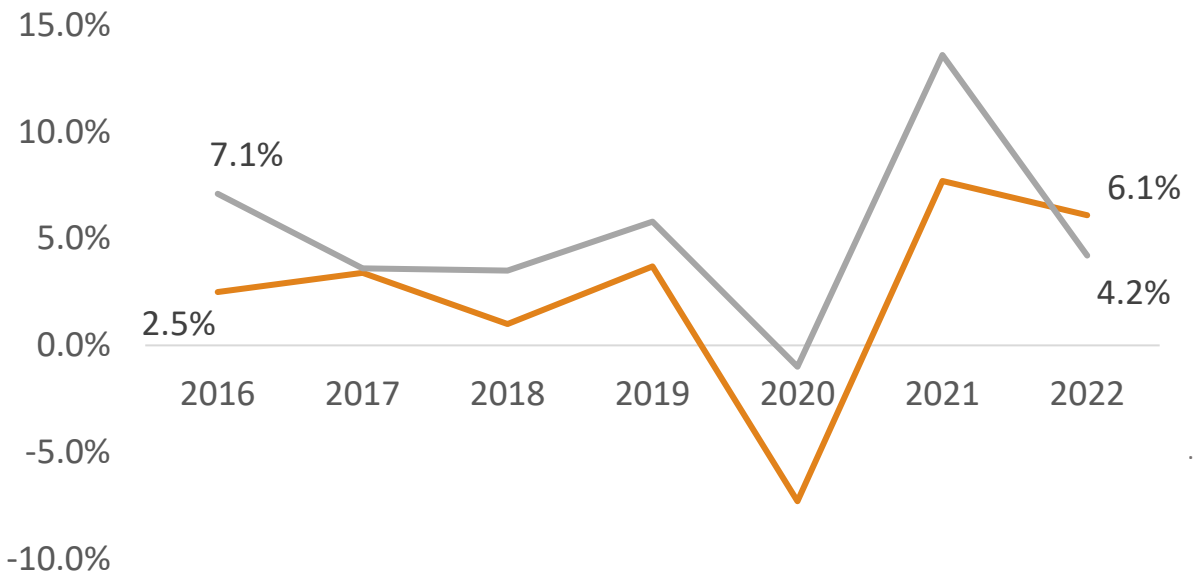
Commercial cost sharing from 2015-2022

From 2015-2022, the average amount of cost sharing paid by patients on a per-person basis in the Commercial market grew 17.4%, from $661 in 2015 to $776 in 2022. The amount paid by health plans grew faster at 42.3%, from $3,470 in 2015 to $4,937 in 2022.

On a year-to-year basis, growth fluctuated for both the amount paid in cost sharing and the amount paid by health plans, but was always positive except from 2019 to 2020, when patient paid and payer paid amounts decreased due to the COVID-19 pandemic. High growth in cost sharing and payer paid amounts in 2021 was most likely due to a bounce-back in health care utilization as the pandemic eased. See Figure 6 below.

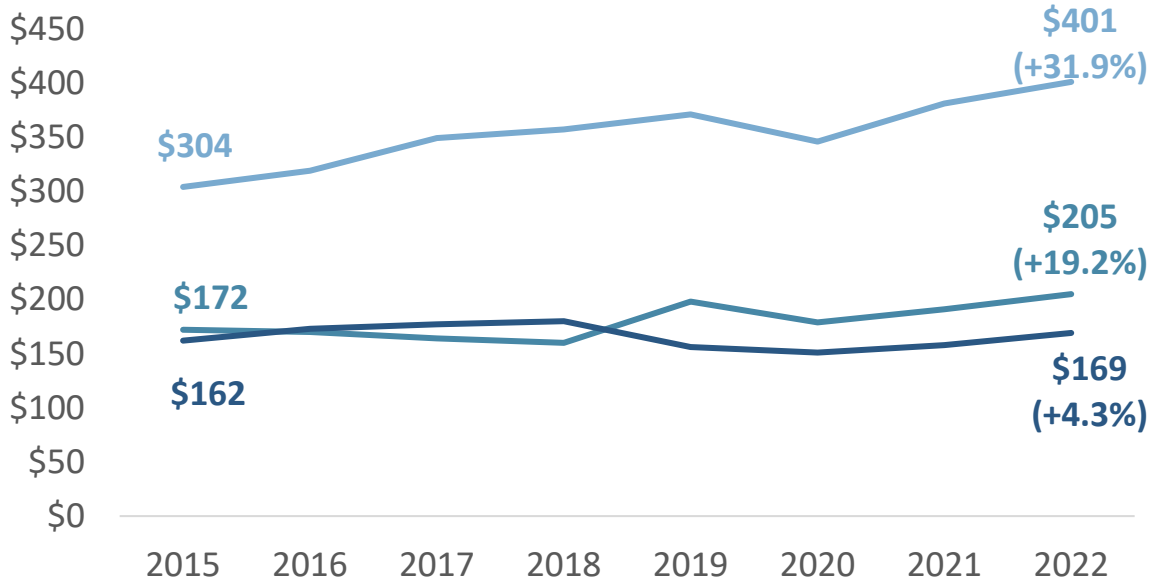
[16] The average amount paid per Emergency Department visit was low because the typical patient had no ED visits during the year. The median amount paid per patient for ED visits in 2021 was $0.

Figure 6. Rate of growth in annual per-person health care costs paid by health plans versus patients from 2015-2022, Commercial market



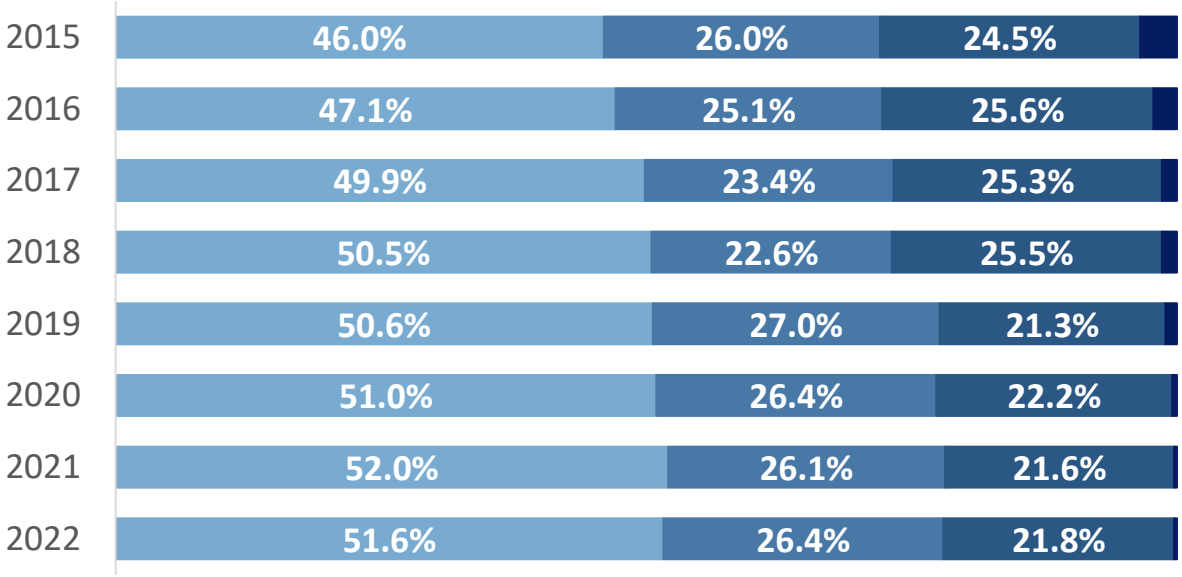
While total cumulative growth in patient cost sharing was relatively modest, there were meaningful differences in the rate of growth by type of cost sharing. From 2015-2022, the amount paid in deductibles grew 31.9% (increasing from $304 per person in 2015 to $401 in 2022), while the amount paid in co-insurance increased 19.2% ($172 in 2015 versus $205 in 2022) and the amount paid in copays increased just 4.3% ($162 in 2015 versus $169 in 2022).

Figure 7. Amount of annual per-person patient cost sharing paid in deductibles, co-insurance, and copays from 2015-2022, Commercial market



As a result of relatively higher growth in deductibles, the proportion of annual per-person patient cost sharing going towards deductibles grew from 46.0% in 2015 to 51.6% in 2022, while the proportion of patient cost sharing in the form of copays decreased.

Figure 8. Proportion of annual per-person patient cost sharing paid in deductibles, co-insurance, and copays from 2015-2022, Commercial market*



* The navy blue section of the bars at the far right is the amount paid in "Other" cost sharing, which was minimal.

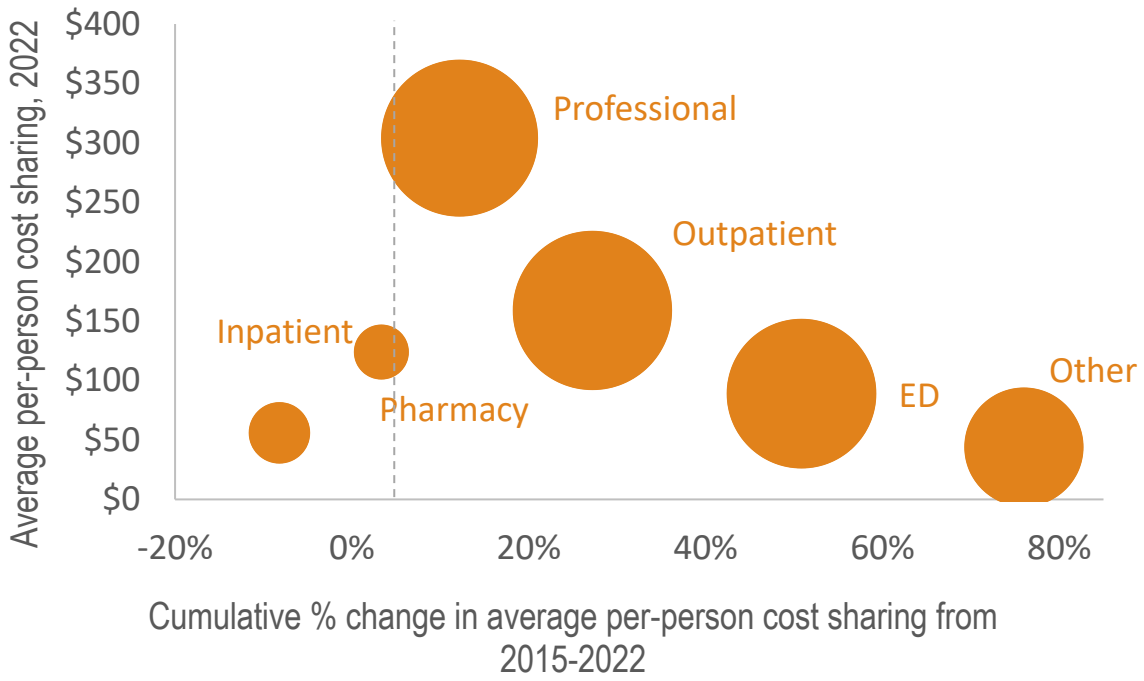
> "I have noticed over the last few years especially my medical insurance premium is at least $100 a month more each year, my deductible goes up every year and now there is a co-insurance payment on all transactions. (I call it "transaction" because our health care is more of a business out to make money than it is to help people who are sick.) This co-insurance is something new within the last few years (ie, I am responsible for paying part of the bill instead of it being covered by my insurance). I am less apt to go to the doctor now for anything because I can't afford it even with insurance."
>
> -Public comment submitted for Oregon's Cost Growth Target Public Hearing, 2023

Commercial cost sharing by service category

By service category, the cumulative change in per-person patient cost sharing from 2015 to 2022 was explained primarily by increases in outpatient, professional, and Emergency Department (ED) spending. The size of the bubbles in Figure 8 below is the absolute dollar change in per person cost sharing in that service category between 2015 and 2022.

Patient cost sharing for visits to the ED grew by 50.8% over this period, from $59 in 2015 to $89 in 2022. Patient cost sharing for outpatient and professional services grew more slowly, but together the increases in these two categories accounted for 53.6% of the overall increase in patient cost sharing from 2015 to 2022.

Figure 9. Cumulative growth in annual per-person cost sharing from 2015 to 2022, by service category, Commercial market*



* The size of the bubbles is the absolute change in per-person cost sharing in the service category from 2015 to 2022.

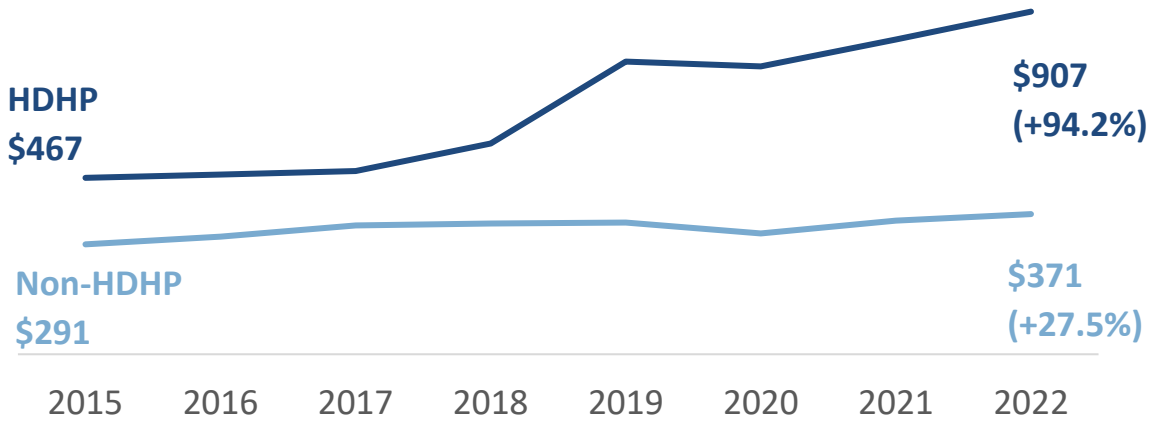
High Deductible Health Plans in the commercial market

The increasing proportion of patient cost sharing going towards deductibles is a sign that they are becoming a more prominent feature of commercial health plans in Oregon. In large part, this is due to the increasing popularity of High Deductible Health Plans (HDHP), defined by the Internal Revenue Service in 2022 as a plan with a deductible of at least $1,400 for individual plans and $2,800 for family coverage.

High deductible health plans are an attractive option for employers and households because they are less expensive upfront, with lower premiums. Often, HDHPs are paired with a health savings account (HSA), where members can save pre-tax dollars towards their health care costs. Since the Affordable Care Act was enacted, HDHP are required to cover certain preventive health care services even before the deductible is met.[17]

Even while HDHPs are becoming more common, Oregon data suggest that they may be becoming less generous. From 2015 to 2021, the proportion of employer-sponsored plans defined as HDHPs in Oregon grew from 37.2% to 58.7%, dropping modestly to 57.8% in 2022.[18] At the same time, within high deductible health plans, the average amount paid in deductibles grew rapidly in Oregon. From 2015 to 2022, the average amount paid in deductibles for people with HDHPs grew by 94.2% in total, compared to 27.5% for people with non-HDHPs.

Figure 10. Average per-person amount paid in deductibles each year from 2015-2022 in HDHP vs. Non-HDHP, Commercial market



[17] Dolan, Rachel. High-deductible Health Plans. Health Affairs Policy Brief. February 2016.
[18] SHADAC analysis of Medical Expenditure Panel Survey – Insurance Component. State Health Compare, SHADAC, University of Minnesota. Accessed November 2023.

High deductible health plans are meant to cut costs by encouraging people to shop for their care and to reduce their use of low-value care. However, there is little evidence that patients make decisions about their health care based on its cost. One study of health care spending among employees of a large company that switched to an HDHP from a plan with free care (no cost sharing for in-network services) found that members reduced their utilization of health care before meeting their deductible each year but were no more likely than before to compare prices.[19] Other studies have shown that having a HDHP is associated with lower use of preventive care, even after such care was made free under the Affordable Care Act.[20]

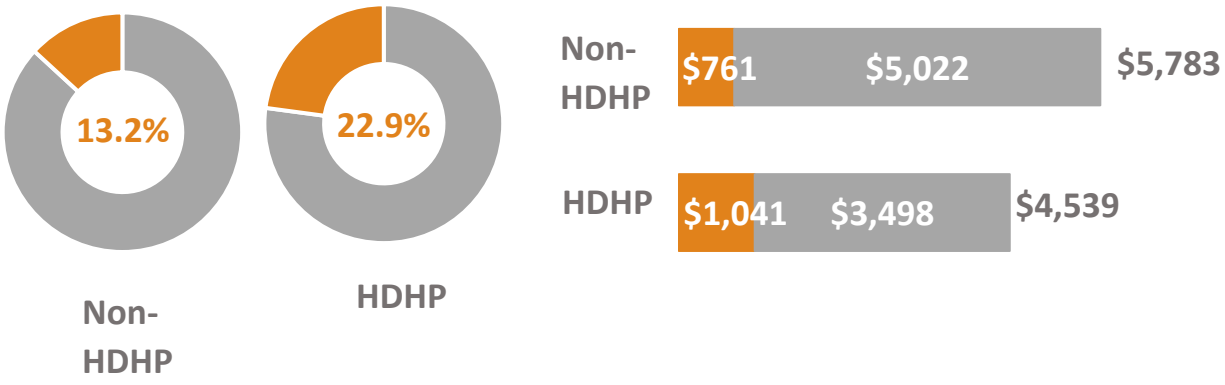
Overall, the total average per-person costs for people with Commercial HDHPs in Oregon were 27.4% lower than those of people with non-HDHP in 2022. The difference in total health care costs could reflect lower utilization among people with HDHPs. It could also stem from a difference in who is most likely to purchase each kind of plan, with individuals with fewer health care needs self-selecting into plans with lower premiums and higher deductibles.

Even though total health care costs were lower among people with HDHPs, people with these plans were paying more for care when compared to those with non-HDHP. The average amount of money paid by people with HDHPs on a per-person basis in 2021 was $1,041, or 22.9% of the $4,593 total health care costs. On the other hand, people with non-HDHP paid $762, or 13.2% of the average per-person cost of care.

> "I currently have a high-deductible health plan that covers nothing until my $8,000 deductible is met each year. I pay nearly $500/month for what really is catastrophic coverage. I use my Health Savings Account to pay out of pocket for all of my health care expenses… Given I pay for all health care out of pocket, I try to inquire about and negotiate rates with providers - a nearly impossible task. As a consumer, I have no idea what something will cost before having to "buy" it. If providers do offer a "cash rate" it would often cost less than going through my insurance company, which also means those payments don't count towards my deductible each year."
>
> -Public comment submitted for Oregon's Cost Growth Target Public Hearing, 2022

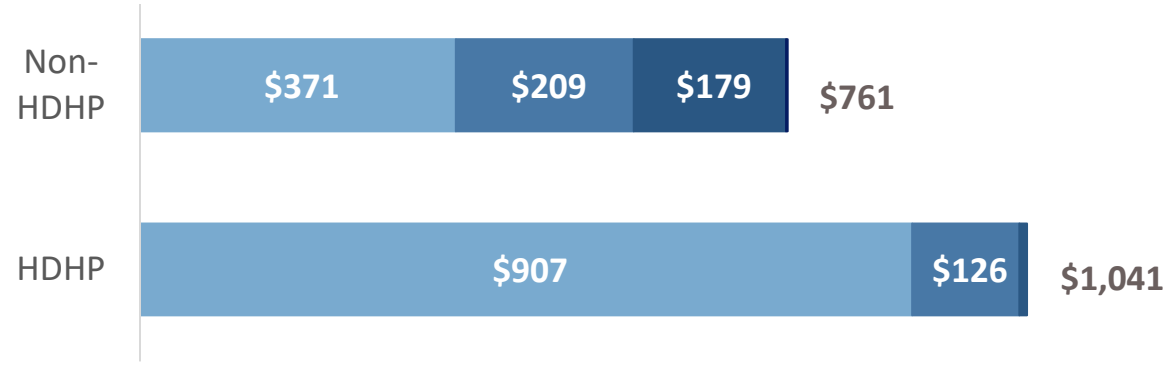
[19] Brot-Goldberg, Zarek et al. What does a deductible do? The impact of cost-sharing on health care prices, quantities, and spending dynamics. National Bureau of Economic Research Working Paper Series. October 2015.
[20] Dolan, Rachel. High-deductible Health Plans. Health Affairs Policy Brief. February 2016.

Figure 11. Percent (left) and amount (right) of total health care costs paid for by the patient versus the health plan for non-HDHP versus HDHP in 2022, Commercial market



Unsurprisingly, a much larger portion of cost sharing for people with HDHP (87.1%) was being paid out in deductibles when compared to those with non-HDHP (48.8%). Since the average amount of deductible paid by people with HDHP - $907 - was lower than the IRS-defined minimum individual deductible of $1,400 for an HDHP, it is likely that most enrollees of these plans didn't have enough health care spending to meet the deductible and begin using their benefits, beyond those for preventive care.

Figure 12. Average per-person patient cost sharing paid in deductibles, co-insurance, and copays, 2022, Commercial market*



* The navy blue section of the bars at the far right is the amount paid in "Other" cost sharing, which was minimal.

Medicare Advantage Cost Sharing

In 2021, about 15.2% of the population in Oregon had health care coverage through Medicare.[21] People on Medicare choose between Medicare Fee-for-Service ("traditional" Medicare) and Medicare Advantage. This report looks at cost sharing for Medicare Advantage members,[22] who represented approximately 51.6% of the Medicare-eligible population in Oregon in 2022.[23]

Cost sharing structures in Medicare Advantage plans are determined by the individual payers that run these plans but must meet some minimal Federal guidelines. In 2022:

- Medicare Advantage plans were required to include a maximum limit on member out-of-pocket costs of $7,550 for in-network care and $11,300 for out-of-network care.[24]
- Prescription drugs are not included in the out-of-pocket maximum and have a separate out-of-pocket limit of $7,050, above which members may pay a small amount in copays or co-insurance, usually 5%.[25] Prescription drug deductibles were limited to $480.[26]

Insurers offering Medicare Advantage plans receive a fixed amount of money from the federal government for each person they cover. Plans then manage their costs to stay under the total amount received based on their enrollment, generally by requiring prior approvals for more expensive care or negotiating lower rates with a network of preferred providers. Plans may also manage their costs using different cost sharing arrangements to guide utilization, as long as these arrangements are equivalent to or more generous than the standard benefit structure.

Medicare Advantage plans have historically kept their costs low compared to the amount received from the federal government and are able to funnel these savings back into reduced premiums or cost sharing and increased service offerings for members. However, up to 22% of people with Medicare Advantage nationwide may be underinsured and 41% of people with Medicare Advantage report problems accessing health care due to the cost.[27]

Medicare members typically have relatively high health needs and are particularly impacted by high and increasing drug prices. Oregon data reflect these trends, including the increasing burden of prescription drug costs.

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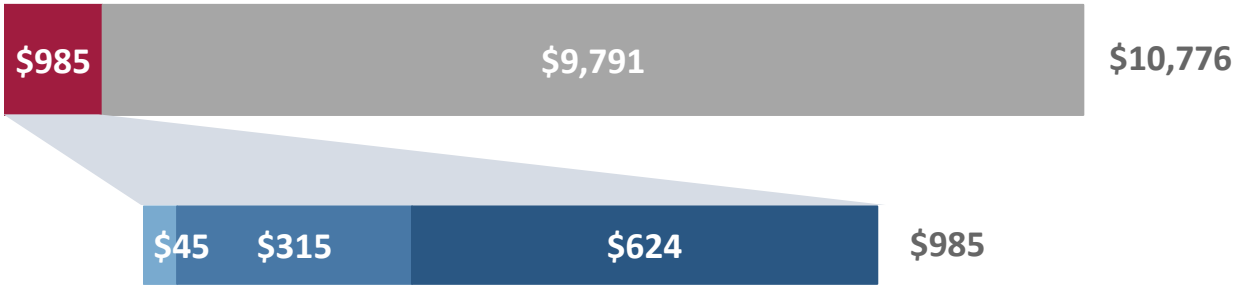
[21] Oregon Health Insurance Survey. Health insurance coverage in Oregon. Portland, Oregon. January 2022.
[22] See appendix for information on Medicare FFS cost sharing, which is not included in this report.
[23] In December of 2022, there were approximately 474,145 people enrolled in Medicare Advantage in Oregon, out of 919,006 Medicare-eligible Oregonians. Data taken from CMS monthly enrollment files.
[24] O'Brien, Sarah. 'Here's what to know about your 2022 Medicare costs.' CNBC. December 2021.
[25] In 2024, the 5% coinsurance on catastrophic drug costs has been eliminated by the Inflation Reduction Act.
[26] O'Brien, Sarah. 'Here's what to know about your 2022 Medicare costs.' CNBC. December 2021.
[27] Leonard, Faith et al. Medicare's affordability problem: a look at the cost burdens faced by older enrollees. Commonwealth Fund Issue Brief. September 2023.

Medicare Advantage cost sharing in 2022

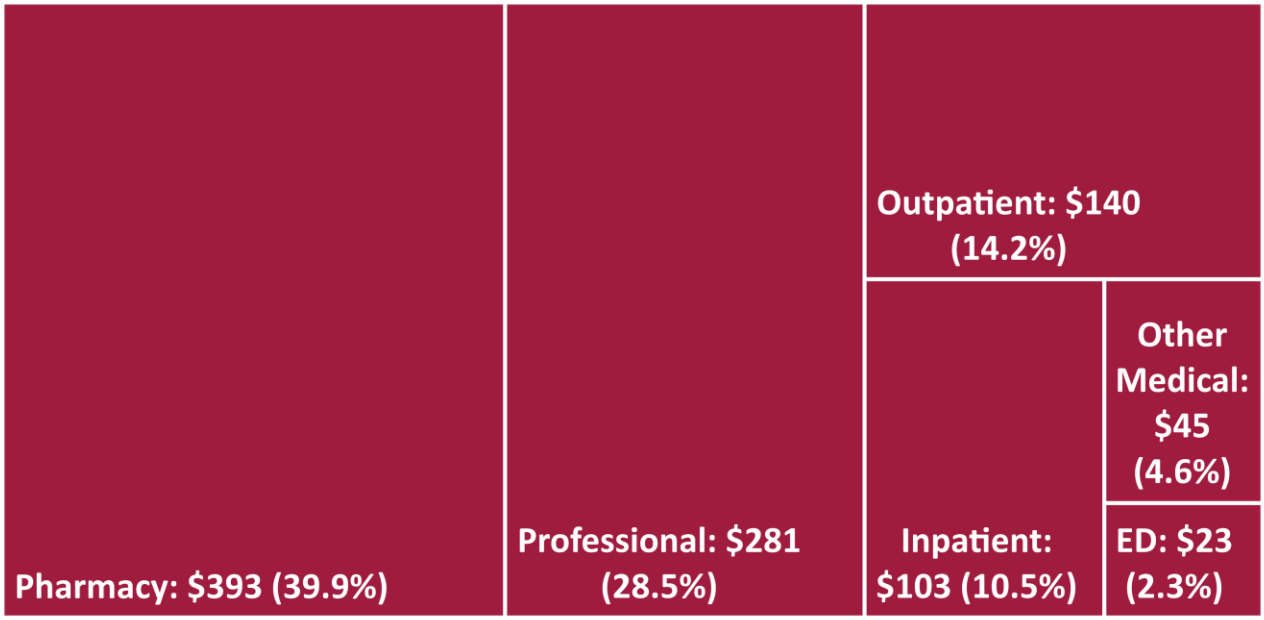
In 2022, people in Oregon with Medicare Advantage health insurance paid $985 on average in cost sharing, or 9.1% of the total cost of care for the year. Most Medicare Advantage cost sharing was in the form of copays ($624, or 63.3%). The average co-insurance paid was $315 (32% of cost sharing) while the average amount of deductible paid was $45 (4.6%).

Figure 13. Average per-person cost sharing versus health plan-paid amount in 2022, Medicare Advantage, with cost sharing broken into deductible, co-insurance and copay



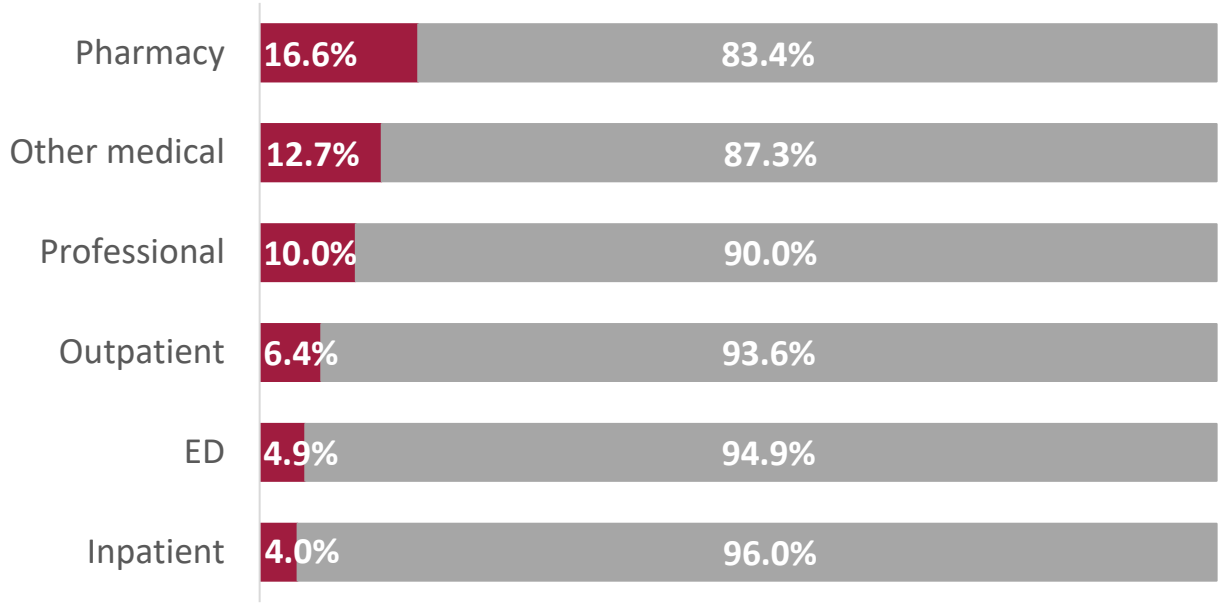
In 2022, retail pharmacy costs were by far the largest contributor to the total average amount of cost sharing per person. People with Medicare Advantage coverage spent an average of $393 on prescription drug cost sharing (almost 40% of all cost sharing). The next largest portion of cost sharing was paid for professional services ($281, or 28.5%) and outpatient visits ($140, or 14.2%).

Figure 14. Average per person patient cost sharing by service category in 2022, Medicare Advantage



In addition to paying the most money for prescription drugs in absolute terms, people in Oregon with Medicare Advantage coverage paid the highest percent of cost sharing for retail pharmacy out of all the service categories. On average, patients were responsible for 16.6% of (gross, or pre-rebate) retail pharmacy costs. Patients also paid 12.7% of other medical costs and 10% of the cost of professional services.

Figure 15. Percent of per-person annual health care costs paid by the patient versus the health plan by service category in 2022, Medicare Advantage

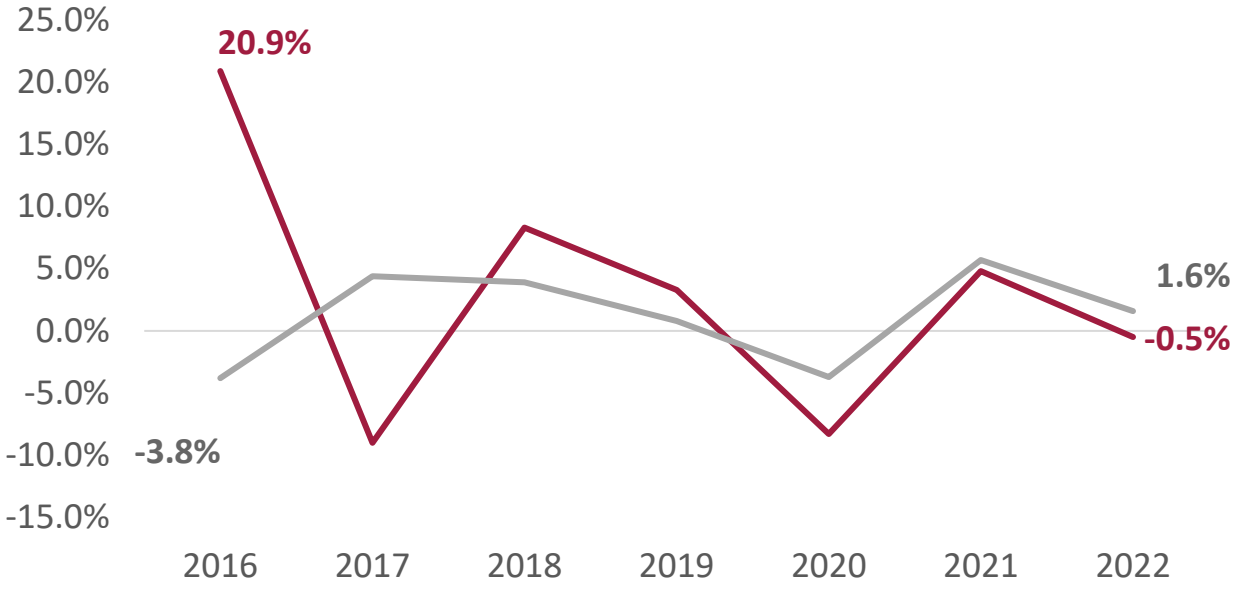


Medicare Advantage cost sharing from 2015-2022

From 2015-2022, the average amount of cost sharing paid by patients on a per-person basis in the Medicare Advantage market varied from year to year. While patient cost sharing increased rapidly between 2015-2016, it decreased and moderated in the following years.

In total, cumulative growth from 2015-2022 was higher for patient cost sharing compared to the health plan-paid amount. The amount paid by patients grew 17.7% (from $837 to $985) while the amount paid by payers grew only 8.6% (from $9,014 to $9,791), with the most growth in the patient cost sharing concentrated from 2015-2016.

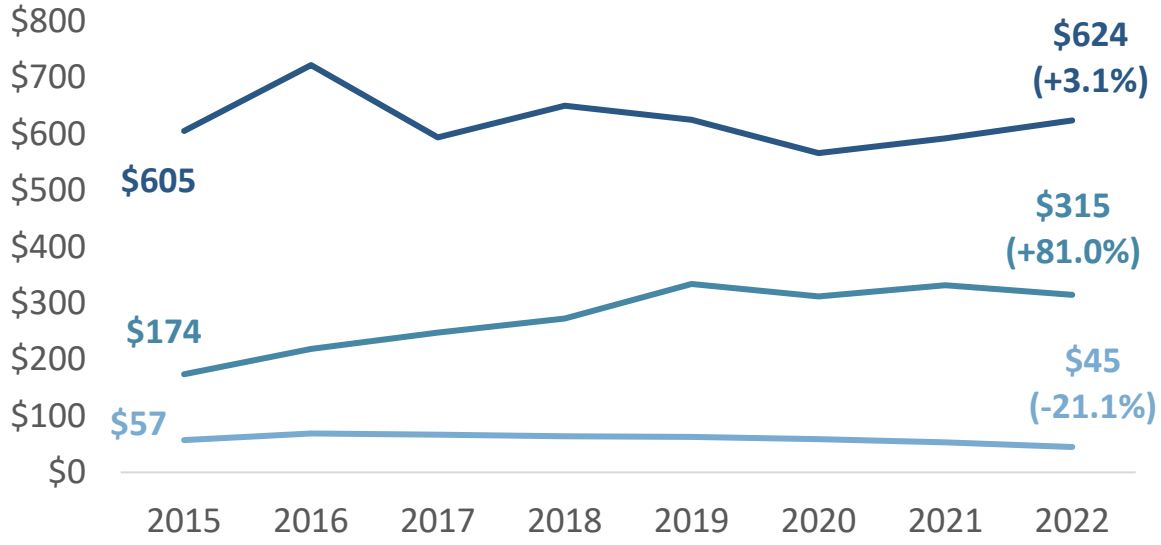
Figure 16. Growth in per-person annual health care costs paid by the patient versus the health plan, 2015-2022 Medicare Advantage



Labels on the horizontal axis refer to the second year of growth; for example, "2016" is growth from 2015-16.

Across the entire period, cumulative growth in co-insurance stood out relative to growth in deductibles and copays. From 2015-2022, the total increase in co-insurance paid by patients each year was 81.0%, compared to 3.1% for copays and -21.1% for deductibles. The growth in co-insurance was concentrated in the retail pharmacy category, and is discussed in greater detail below.

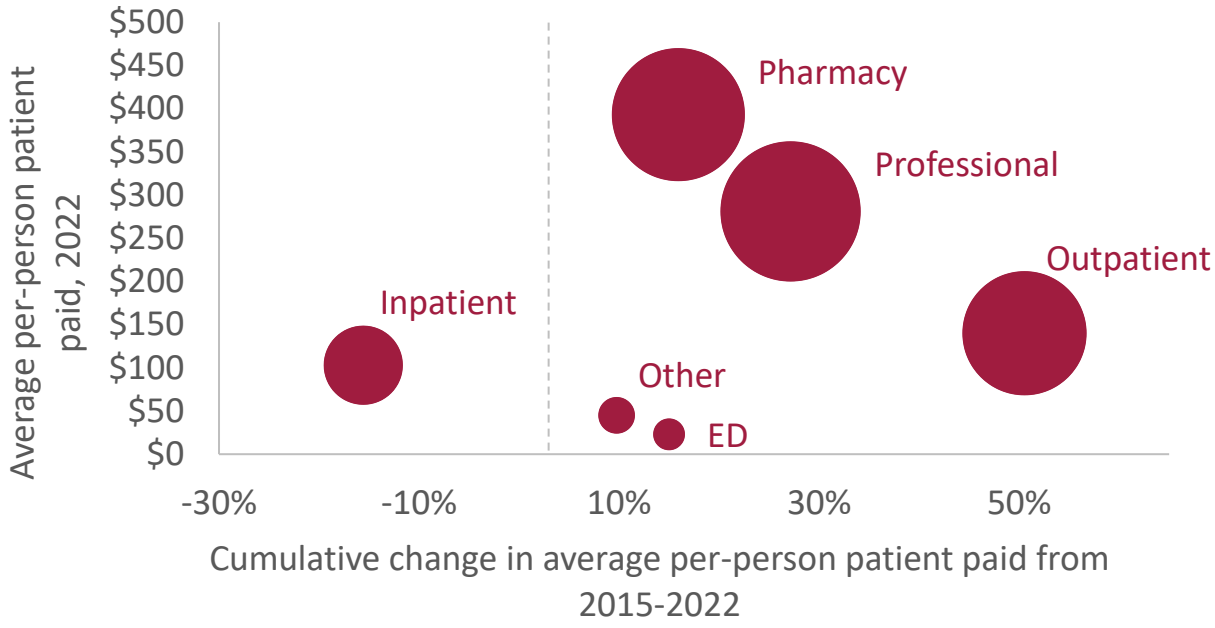
Figure 17. Proportion of annual per-person patient cost sharing paid in deductibles, co-insurance, and copays from 2015-2022, Medicare Advantage



Medicare Advantage cost sharing by service category

By service category, growth in professional services, retail pharmacy, and hospital outpatient costs had the most influence on the amount of cost sharing paid by Medicare Advantage enrollees in Oregon from 2015 to 2022. Cost sharing for professional services grew by 27.1% from 2015 to 2022 (from $221 to $281) while retail pharmacy cost sharing grew 15.9% (from $339 to $393) and outpatient cost sharing grew 50.5%, from $93 to $140.

Figure 18. Cumulative growth in annual per-person cost sharing from 2015 to 2022, by service category, Medicare Advantage



* The size of the bubbles is the absolute change in per-person cost sharing in the service category from 2015 to 2022.

> "Though [my husband and I] are double insured (his employee insurance plus our Medicare), we are still responsible for 20% cash payment of all services received in addition to expenses. His out-of-pocket medications exceed $500 per month. That is $6,000 per year. I am a cancer patient and should be monitored with extensive blood work testing and physical exam four times per year. I have deferred, at my request to only twice a year… I simply cannot afford to go to the oncologist…even being "double insured" it is too expensive."
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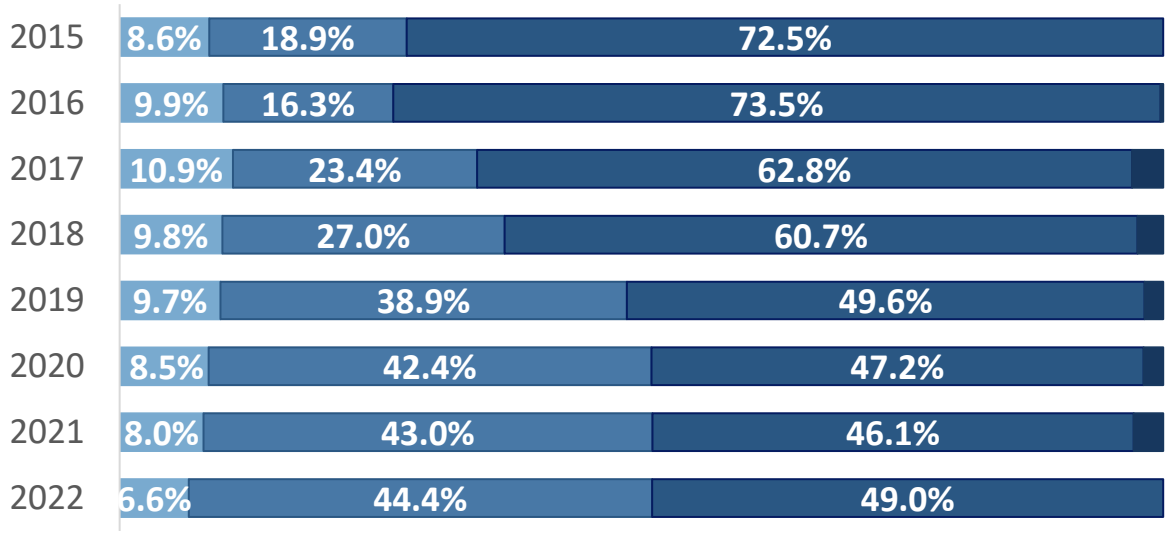
> -Public comment submitted for Oregon's Cost Growth Target Public Hearing, 2023

Prescription drug cost sharing in Medicare Advantage

Between 2015 and 2022, there was a shift in the structure of cost sharing in the retail pharmacy service category that did not happen in the other service categories. In this period, the proportion of cost sharing for retail pharmacy services that is co-insurance more than doubled, while the proportion of cost sharing for copays shrank (see Figure 19 below).

In 2015, patients paid an average of $64 in co-insurance for retail pharmacy services. This grew to $174 by 2022, an increase of more than 170%. Conversely, the amount paid in co-insurance decreased by 21.6%, from $245 to $192.

Figure 19. Relative share of deductibles, co-insurance, and copays for retail pharmacy payments from 2015-2022, Medicare Advantage



The shift towards co-insurance and away from copayments as the primary form of patient cost sharing for retail pharmacy is likely due to increased spending on drugs in specialty tiers. Most Medicare Advantage prescription drug formularies are structured so that patients pay copays on generic and preferred brand tiers but co-insurance on specialty tiers and on some non-preferred brand drugs.[28] [29]

Between 2015 and 2022, utilization of high-cost specialty drugs increased, as manufacturers released new high-priced drugs to treat conditions ranging from cancer and diabetes to rheumatoid arthritis.[30] In 2021, spending on the top ten drugs in Medicare Part D[31] accounted

[28] Specialty drugs are defined by CMS as drugs costing at least $830 per month in 2022.
[29] Cubanski, Juliette, and Anthony Damico. Key facts about Medicare part D enrollment and costs in 2022. KFF. August 17, 2022.
[30] Medicare Payment Advisory Commission (MedPac). The Medicare prescription drug program (Part D): Status report. Chapter 13 of the Medpac Medicare Payment Policy Report to Congress. March 2022.
[31] Ranked by total gross spending per drug.

for 22% of total program spending, even though they made up only 0.3% of the 3,500 drugs covered by Medicare. Furthermore, between 2018 and 2021 spending on these drugs in Part D had more than doubled.[32]

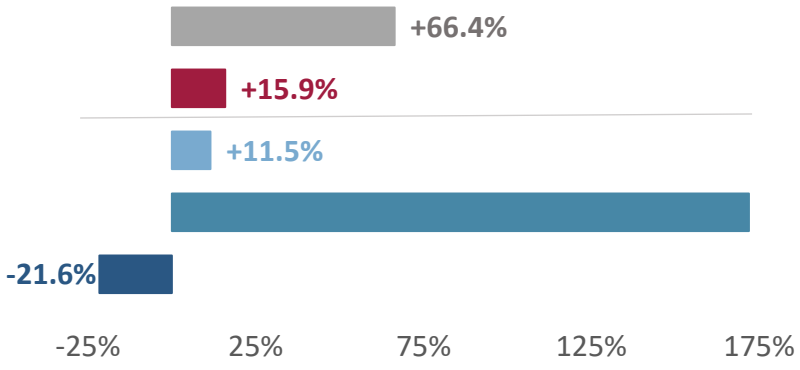
> "One drug was proposed [for osteoporosis] but the Medicare Advantage copayment for it was larger than my entire social security check. So that was a no-starter…Then a new drug appeared on the market. After being offered this drug, at an out of pocket cost of just over half of my annual income, I was then told I didn't qualify for it. There are other similarly effective drugs on the market which don't seem to be available through my Medicare plan."
>
> -Public comment submitted for Oregon's Cost Growth Target Public Hearing, 2023

Patients paying co-insurance on high-priced specialty drugs are particularly exposed to cost growth, since they are covering a percentage of the drug cost instead of a flat amount as they would with a copay.

When comparing growth in the amount of cost sharing paid by patients on retail pharmacy to the amount paid by payers, cost growth for payers was higher.

The amount paid for retail pharmacy by payers grew 66.4% from 2015 to 2022 (from $1,189 to $1,979), compared to 15.9% for patients ($339 to $393). However, the amount paid by patients in co-insurance increased by 172%.

Figure 20. Cumulative growth in average per person payer paid, patient cost sharing, deductibles, co-insurance and copays from 2015 to 2022 for retail pharmacy, Medicare Advantage



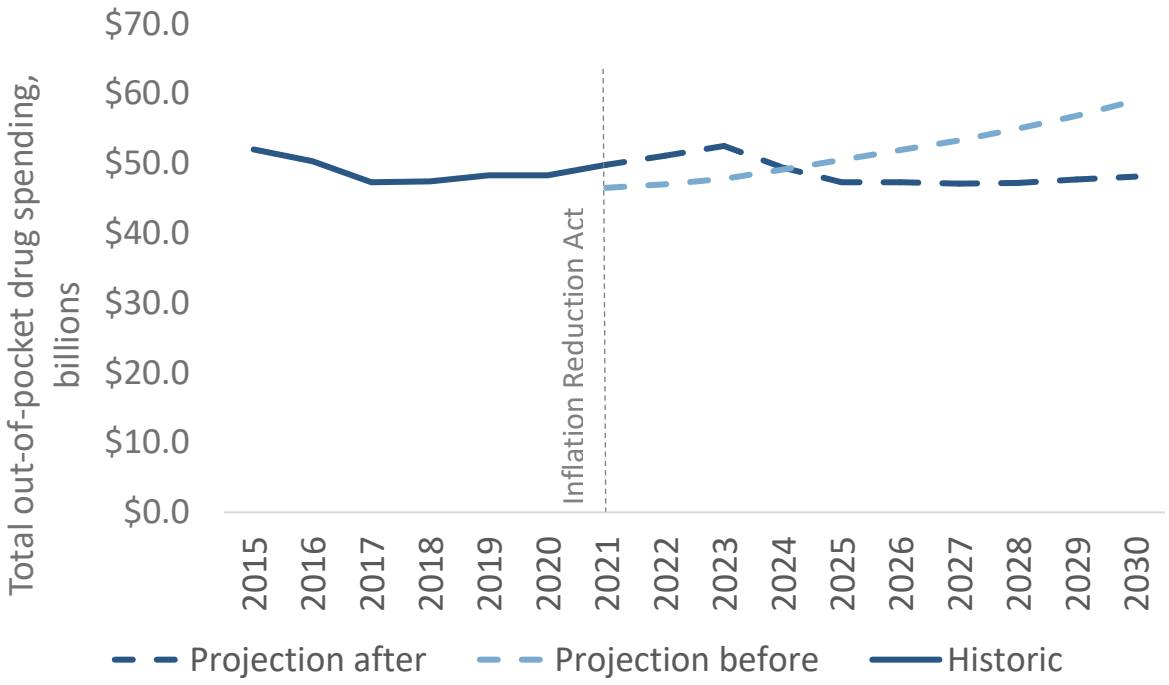
[32] Cubanski, Juliette and Tricia Neuman. A small number of drugs account for a large share of Medicare Part D spending. KFF. July 12, 2023. Accessed March 2024.

Federal actions to address prescription drug costs in Medicare

Although spending on retail pharmacy made up a significant portion of patient cost sharing in Medicare Advantage, current and upcoming reforms as a part of the Inflation Reduction Act might help attenuate the impact of drug spending on patients.

This law included numerous provisions to limit drug price growth in Medicare plans, requiring pharmaceutical manufacturers to pay a rebate to Medicare if their drug prices rise faster than overall inflation and granting the federal government the ability to negotiate the price of high-cost drugs. It also changes Medicare policy so members will no longer be responsible for 5% co-insurance on drug costs over the catastrophic limit beginning in 2024 and establishes a lower annual out-of-pocket limit of $2,000 on drugs starting in 2025.[33]

Figure 21. Historic and projected out-of-pocket retail drug spending before and after the passage of the Inflation Reduction Act, United States



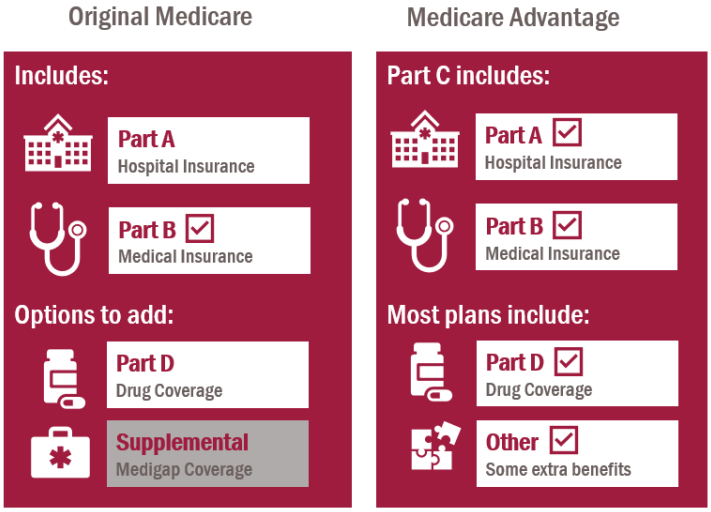
[33] Figures and graph in Inflation Reduction Act from Wagner, Emma, et al. What are the recent and forecasted trends in prescription drug spending? Peterson-KFF Health System Tracker. September 2023. Accessed March 2024.

Appendix A: Medicare Fee-for-Service

This report focuses on cost sharing trends in Medicare Advantage, which is operated by commercial insurers, but these trends only tell a part of the story when it comes to describing the cost sharing burden faced by people with Medicare in Oregon. In 2022, about half of people who were eligible for Medicare in Oregon were covered by Medicare Fee-for-Service (FFS), also known as "traditional" or "original" Medicare, which is run directly by the federal government.

Medigap plans are a type of supplementary insurance run by commercial insurers that offer enrollees expanded benefits beyond what is covered by Medicare FFS plans. Often, Medigap plans cover much of the cost sharing burden to which enrollees would otherwise be subject.

Nationally, about 36% of Medicare FFS enrollees had Medigap in 2020, while 31% had supplementary coverage from an employer, 17% had Medicaid, 1% had another type of supplemental coverage, and 14% had no supplemental coverage.[34]



APAC doesn't contain data on Medigap coverage for Original Medicare enrollees.

Although Oregon's All Payer All Claims database contains data on claims processed for Medicare FFS enrollees, it does not include claims paid through Medigap plans. Because a large portion of people with Medicare FFS have their cost sharing reduced by Medigap, estimates of patient cost sharing that do not adjust for what is covered by Medigap – such as those available through APAC – are likely to be an over-estimate.

For this reason, estimates of cost sharing in Medicare FFS in Oregon are not included in this report. Despite this, analyses comparing the experiences of Medicare FFS enrollees to Medicare Advantage enrollees at the national level offer some insight into the comparative health care cost burden faced by these two different groups.

[34] Clerveau, Gabrielle et al. A snapshot of sources of coverage among Medicare beneficiaries. KFF. August 2023.

Medicare FFS enrollees may pay more upfront than people with Medicare Advantage but experience a similar overall health care cost burden in the end

Due to the risk of high cost sharing under the basic Medicare medical benefit, many Medicare FFS enrollees purchase additional coverage through Medigap plans and Part D. Together, the premiums on these plans can be more costly than those for Medicare Advantage. See Table A1.

In 2022, the monthly premium for Medicare Part B was $170.10.[35] This premium had to be paid by both Medicare FFS and Medicare Advantage enrollees to access medical benefits. Medicare Advantage enrollees also paid a premium for their plans, which often includes enhanced medical and drug coverage. In Oregon in 2022, the average Medicare Advantage premium was $39.77. [36]

In contrast, to avoid the hazards of high cost sharing in the base Part B benefit (e.g., no out of pocket limits, see the next section for more detail), Medicare FFS enrollees had to pay premiums for both a standalone Part D prescription drug plan and a supplemental insurance plan.

Standalone Part D prescription drug plan premiums ranged from $7.70 to $114.50 monthly in Oregon in 2022, and Medigap plans cost anywhere from $26 to $480 a month.[37] The average Part D premium nationally in 2022 was $39.87.[38] Premiums for supplemental insurance varied by plan type and beneficiary age. High deductible plans offered the lowest premiums; plans without a high deductible often cost upwards of $100 or even $200 a month.[39]

Table A1. Medicare FFS vs. Medicare Advantage Monthly Premiums in Oregon, 2022

	Medicare Fee For Service	Medicare Advantage
Medicare Part B	$170.10	$170.10
Medicare Advantage Premium	-	$0 to $211 $39.77 on average
Supplemental Insurance	$27 to $944	-
Part D Drug Coverage	$7.70 to $114.50	-

[35] These premiums are adjusted down for people considered low income enough to qualify for a subsidy.
[36] Centers for Medicare and Medicaid Services (CMS). Medicare Advantage and Part D Fact Sheets 2022. September 29, 2021.
[37] Hunsberger, Brent. Medicare guide 2022: The basics of Medicare open enrollment. The Oregonian. November 12, 2021.
[38] Cubanski, Juliette, and Anthony Damico. Key facts about Medicare part D enrollment and costs in 2022. KFF. August 17, 2022.
[39] Senior Health Insurance Benefits Assistance (SHIBA). 2022 Oregon guide to Medicare Insurance Plans. 2021.

Even though Medicare FFS enrollees may pay more upfront, some evidence has indicated that they may not experience more affordability issues than people with Medicare Advantage:

- The 2021 National Health Interview Survey found only a small difference in the percent of people with Medicare FFS (9.8%) experiencing difficulties paying medical bills in the prior 12 months when compared to people with Medicare Advantage (8.9%).[40]

- Data from the 2018 Current Beneficiary Survey analyzed by KFF showed that *fewer* people (15%) with Medicare FFS had health care cost-related problems compared to people with Medicare Advantage (19%).[41] Most of the improved affordability for Medicare FFS was due to the better benefits received by people who paid for or otherwise benefitted from some kind of supplementary insurance.

Medicare FFS enrollees without supplemental medical insurance are exposed to a potentially high cost sharing burden

For people with Medicare FFS, having supplementary insurance is a major determinant of how much cost sharing they end up paying, and the overall affordability of their health care. Without such coverage, the standard Medicare FFS cost sharing can be high.

Medicare Part A pays for hospitalizations and came with a $1,556 annual deductible in 2022. Co-insurance on hospitalizations lasting longer than 60 days started at $389 per day for days 61-90, with 60 additional "lifetime reserve" days available for $778/day after that. Medicare Part B (medical insurance) had a deductible of $233 in 2022[42] and co-insurance on covered services was generally around 20%. However, there was also no out-of-pocket maximum through the standard Medicare FFS Part B benefit.

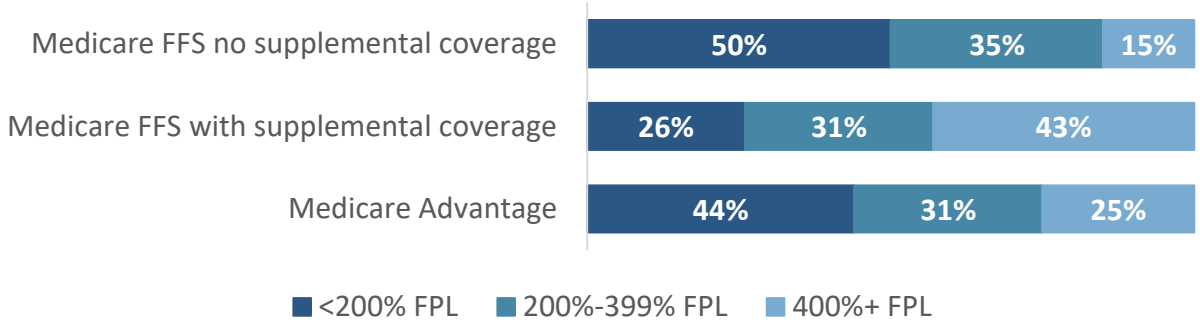
Supplemental coverage can ease the burden of potentially high cost sharing in Medicare FFS by covering deductibles, co-insurance and copays and in some cases establishing an out-of-pocket maximum. However, the upfront cost of Medigap premiums for people who don't also have Medicaid or help paying for premiums from an employer may not be affordable for some people with limited financial resources.

National data indicate that people with lower income are less likely to have supplementary insurance. The Commonwealth Fund's 2022 Biennial Health Insurance Survey found that

[40] Cohen, Robin, et al. Problems paying medical bills: United States, 2021. National Health Statistics Reports Number 180. January 2023.
[41] Fuglesten Biniek, Jeannie et al. Cost-related problems are less common among beneficiaries in traditional Medicare than in Medicare Advantage, mainly due to supplemental insurance. KFF. June 25, 2021.
[42] O'Brien, Sarah. 'Here's what to know about your 2022 Medicare costs.' CNBC. December 2021. Web article accessed March 2024.

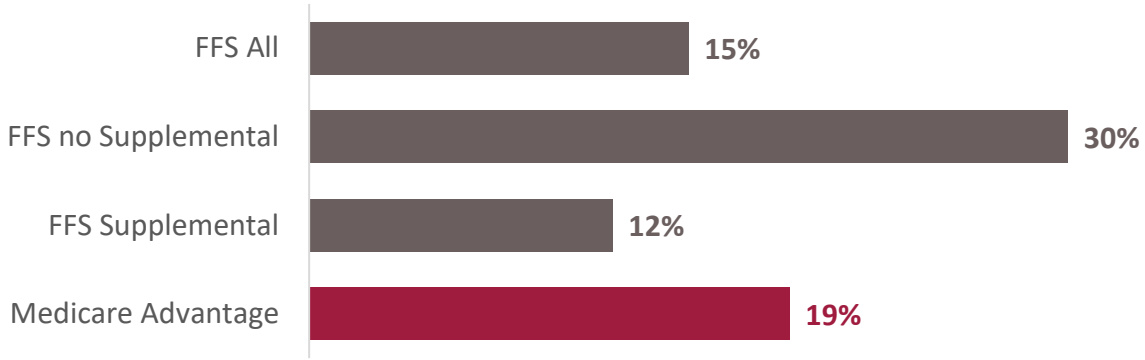
Medicare enrollees without supplemental coverage were poorer on average than those who had supplemental coverage (see Figure A1) and were more likely to be underinsured.[43]

Figure A1. Income of Medicare FFS enrollees with and without supplemental insurance and with Medicare Advantage, 2022



Another recent study found that the near-poor Medicare FFS beneficiaries who are most likely to struggle to pay for Medigap premiums accessed fewer health services and incurred an additional $2,288 in out-of-pocket costs over the course of two years.[44] Approximately 30% of people with Medicare FFS and no supplementary coverage experienced health care cost related problems in 2018, compared to 12% of Medicare FFS enrollees with supplementary coverage.[45]

Figure A2. Percent of beneficiaries reporting cost-related problems in Medicare FFS with and without supplemental insurance, compared to Medicare Advantage enrollees, 2018



[43] Leonard, Faith et al. Medicare's affordability problem: A look at the cost burdens faced by older enrollees. Commonwealth Fund Issue Brief. September 2023.
[44] Roberts, Eric et al. Medicare coverage 'cliff' increases expenses and decreases care for near-poor Medicare beneficiaries. Health Affairs 40(3). 2021.
[45] Fuglesten Biniek, Jeannie et al. Cost-related problems are less common among beneficiaries in traditional Medicare than in Medicare Advantage, mainly due to supplemental insurance. KFF. June 25, 2021.

Prescription drugs are a major expense for Medicare FFS enrollees

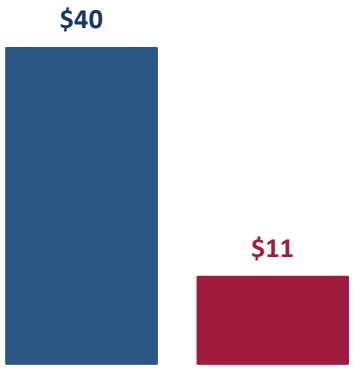
This report indicated that the single largest expense for people with Medicare Advantage each year is cost sharing for prescription drugs. Spending on prescription drugs is also a large and increasing amount of health care spending for Medicare FFS. One study found that 27.2% of Medicare FFS spending in 2019 went to prescription drugs, up from 24.0% in 2008.[46]

In order to receive prescription drug benefits, Medicare FFS enrollees must purchase additional coverage in the form of a Part D plan (PDP). Like prescription drug plans offered by Medicare Advantage (MA-PDs), PDPs are run by commercial insurers and must offer benefits that are at least as generous as the standard Medicare drug benefit determined by the Federal government each year.

However, in contrast to MA-PDs, health plans running standalone PDPS may have less ability to offer lower priced or enhanced benefits because they don't benefit from the rebates awarded to Medicare Advantage plans by the federal government for managing the overall costs of their patient population.

Data on the cost of premiums for PDPs versus MA-PDs reflect this, showing that in 2022, the average premium for a PDP ($39.87) was more than three times more costly than the enrollment-weighted monthly portion of the premium for drug coverage in MA-PDs ($11) across all plans nationally. [47]

Figure A3. Average enrollment-weighted premiums for Part D Plans and Medicare Advantage Prescription Drug Plans, United States, 2022

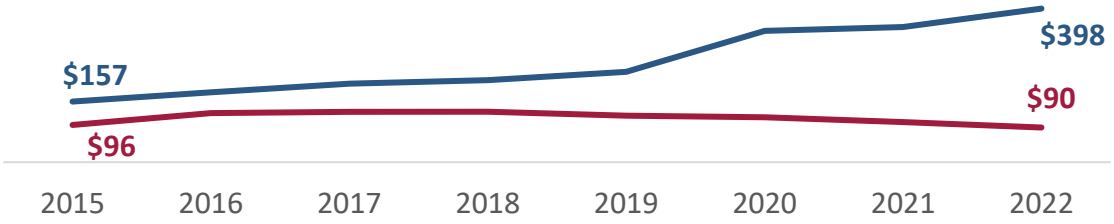


When it comes to cost-sharing, MA-PDs are more likely than PDPs to offer enhanced benefits. For MA-PD enrollees, enhanced benefits often come in the form of a reduced deductible.

In 2022, 86% of PDPs nationwide charged a deductible, compared to only 51% of MA-PDS. Deductibles for PDPs are also higher on average for those with MA-PDs and are growing rapidly, even as deductibles for MA-PDs have shrunk in recent years.[48]

[46] Dusetzina, Stacie et al. Prescription drug spending in fee-for-service Medicare, 2008-2019. JAMA 328(15): 1515-1522. October 18, 2022.
[47] Cubanski, Juliette, and Anthony Damico. Key facts about Medicare part D enrollment and costs in 2022. KFF. August 17, 2022.
[48] Ibid.

Figure A4. Average deductible for Part D Plans and Medicare Advantage Prescription Drug Plans, United States, 2015-2022



Beyond deductibles, the structure of cost sharing for PDPS differs from MA-PDs in that PDPs are more likely to charge coinsurance on brand-name drugs (especially Non-Preferred Brands), but also tend to have lower coinsurance rates on specialty drugs.[49] The differences in plan structure between PDPs and MA-PDs may not translate into substantive differences in patient cost sharing under either option, however. The negotiation of the placement of drugs on specific drug tiers and the drug prices is plan specific.

Table A2. Typical copay and coinsurance structures in Medicare FFS vs. Medicare Advantage, 2022

Tier	Medicare FFS	Medicare Advantage
Generic	$1 median copayment	$0 median copayment
Preferred Generic	$5 median copayment	$10 median copayment
Preferred Brand	$42 median copayment	$47 median copayment
Non-Preferred Brand	40% median coinsurance	$100 median copayment
Specialty	Coinsurance of 25%-33% but more likely to charge 25%	Coinsurance of 25%-33% but more likely to charge 33%

Overall, is likely that when it comes to paying for drugs, PDP enrollees have faced similar increases in cost sharing for specialty drugs when compared to enrollees with MA-PDs. This could be impacting the care they receive. For example, one 2022 study found that PDP beneficiaries without a low-income subsidy often failed to fill their prescriptions for a number of high-priced specialty drugs.[50] Future policy interventions including the upcoming implementation of the prescription drug components of the Inflation Reduction Act are likely to help reduce the strain of drug spending for Medicare enrollees, both those in Medicare Advantage and in Medicare FFS.

[49] Ibid.
[50] Dusetzina, et al. Many Medicare beneficiaries do not fill high-price specialty drug prescriptions. Health Affairs 41(4). April 2022.

Appendix B: Methodology

Data Source

The data source for this report is Release 17 of the Oregon All Payer All Claims (APAC) database, which was refreshed in Q3, 2023 and published on January 9, 2024. The APAC data used includes monthly eligibility data 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.[51]

Inclusion and Exclusion Criteria

Included in this report are data from medical and pharmaceutical claims for services rendered from 2015-2022, for Oregon residents with Commercial and Medicare Advantage insurance coverage. Spending on Medicare Advantage members with secondary coverage through Medicaid (the Oregon Health Plan), known as Medicare/Medicaid Duals, is excluded from this report.

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 plans, 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.

Individuals with only medical coverage and no pharmaceutical coverage in APAC were excluded to avoid under-estimating per-person pharmaceutical costs. Individuals with only pharmaceutical coverage and no medical coverage were also excluded.

Measures

This report tracks total medical and pharmaceutical claims spending per-person on an annual basis by Commercial and Medicare Advantage payers, as well as the total amount due to health care providers by patients in the form of deductibles, coinsurance and copays (patient cost sharing).

[51] Oregon Health Authority. All Payer All Claims Reporting Program. Website accessed April 2024.

The total amount paid per person is calculated as the sum of the payer paid amount plus patient cost sharing, divided by the total number of unique individuals who had both medical and pharmaceutical coverage in that market. The dollar amounts and trends in this report are not adjusted for inflation or risk-adjusted in any way.

In addition to the total payer paid and patient cost-sharing per person, this report also includes the percent of per-person spending covered by the payer vs. patient cost sharing, and the annual rate of growth in per-person payer paid and cost sharing amounts.

Service Categories

The service categories in this report were defined by place of service, bill type and revenue codes. All spending was categorized as inpatient, emergency department, outpatient, professional services or retail pharmacy. Any remaining costs that were not included in these categories were assigned to the "other" category. These categories are mutually exclusive and exhaustive. Detailed definitions of the service categories are as follows:

	**Inpatient care**	Hospital-based care after being admitted. Examples include childbirth and complex surgeries. Includes drugs that are administered to patients admitted in a hospital.
	**Professional Services**	Services provided by independent and hospital-affiliated physicians, nurse practitioners, physician's assistants and more. Includes costs associated with diagnosing and treating patients' medical issues.
	**Outpatient care**	Services provided in clinic settings; specifically excludes services that are rendered to patients admitted in a hospital.
	**Pharmacy**	Retail drugs obtained at a pharmacy, drug stores, or other location. This category does not include physician-administered medications.
	**Emergency Department**	Services provided in emergency departments. For hospital visits that started in the emergency department and resulted in an inpatient stay, costs are reflected in the inpatient care category.
	**Other**	All other services including ambulance rides, independent laboratories, and any service not categorized above.

Commercial Market

The Commercial market includes all health plan and self-insured employer spending in APAC. This includes fully-insured commercial plans, the Public Employee Benefit Board (PEBB) and the Oregon Educators Benefit Board (OEBB) plans, and self-insured plans.

A fully-insured Commercial plan is defined as a group health plan in which the employer or association purchases health insurance from a commercial insurer in order to provide coverage for its employees or association. Employers who purchase a fully-insured plan pay a fixed premium to a health insurance carrier, which assumes the financial risk of the plan. Self-insured health plans involve employers assuming all financial risk for providing benefits to employees, which offers potential cost savings but additional risk and administrative burden for the employer.

Note that as of 2016, states were no longer able to require ERISA-covered health plans to submit data to All Payer Claims Databases, due to the U.S. Supreme Court decision in *Gobeille vs. Liberty Mutual Insurance Company*. In Oregon, some self-insured plans continue to report claims data voluntarily, but the number of commercial plans submitting claims data to APAC decreased starting in 2016.

In addition to estimating costs for fully insured and self-insured patients, this report breaks out spending by High Deductible Health Plan (HDHP) vs. non-HDHP. A High Deductible Health Plan was defined by the IRS in 2022 as a plan with an annual deductible of at least $1,400 for individual coverage or $2,800 for family coverage. Individuals might be in and out of HDHP during the measurement period. Only the individuals with the full 12-month coverage of HDHP in a calendar year were considered having HDHP in that year for this analysis.

Medicare Advantage Market

The Medicare market includes Medicare Advantage, Medicare Fee For Services (FFS) and Medicaid dual eligibles. This report only includes Medicare Advantage members, excluding those with dual coverage from Medicaid and Medicare.