UNIVERSITY OF OREGON
Department of Economics

November 26, 2025

To: Dr. Sejal Hathi, Director, Oregon Health Authority; Sarah Bartelmann, Cost Programs Manager, Oregon Health Authority; and others as appropriate
From: Dr. Keaton Miller, Associate Professor of Economics, University of Oregon
Subject: Comments Regarding 2026-2030 Cost Growth Target Recommendations

Dear Director Hathi, Ms. Bartelmann, and other OHA leaders and interested parties,

I am writing to express concerns about the majority recommendation coming out of the Cost Growth Target Workgroup. The majority recommended that OHA should calculate the Cost Growth Target (CGT) for 2026-2030 using a 50/50 blend of the growth rate in median wages in Oregon and the growth rate in national health consumption expenditures (NHCE) over the past 5 years. This methodology results in a CGT of 5.5%, considerably higher than the original recommendation of 3% for this period or the current target of 3.4%.

While I empathize with the desire of industry participants to address cost drivers which are outside of their control, using NHCE as the metric for those costs sends a confusing message.

NHCE is an expenditure metric, meaning it can be calculated by taking the price paid for each medical service or good provided, multiplying it by the quantity delivered, and summing the result over all goods and services. By definition, it includes not only the costs incurred by providers (wages, supplies), but also any margins/profits retained by hospitals, insurers, pharmaceutical companies, medical device/supply manufacturers, and others engaged in the healthcare industry.

If we use NHCE to set the target, especially with a 50/50 blend, we would be telling Oregonians: *"Maintaining industry profits is just as important as keeping pace with your income."*[1]

It is hard for me to square this with the legislative history of the Cost Growth Target program.

One solution would be to adopt a metric focused on input prices to the industry with a minimal profit contribution. Two metrics come to mind. The first is the Hospital Market Basket Index calculated by the Centers for Medicare and Medicaid Services, which measures changes in the price of a fixed basket of goods and services that hospitals purchase to provide care (e.g. wages for nurses, prices of surgical supplies, energy costs, malpractice insurance premiums). The second is the Employment Cost Index for

[1] I do not object to the for-profit nature of many entities involved in the healthcare system. Profit motives play important roles in driving innovation throughout the sector. What I am specifically concerned about is a methodology where past profits automatically justify (and even create the expectation of) future profits. For-profit entities should be encouraged to earn their returns through providing Oregonians with superior products at competitive prices. It is also important to note that many entities in Oregon operate at zero or even negative net margins, and my statements here are not intended to suggest differently.

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Health Care & Social Assistance workers calculated by the Bureau of Labor Statistics, which measures the change in the biggest component of the cost of labor for employers in the healthcare sector.

That said, the workgroup's majority did not convince me that any state-wide target adjustment for input costs is necessary, thanks to the mechanisms within the CGT program to account for unavoidable cost increases if an entity exceeds the target during a specific year.[2] If you too are unconvinced, I encourage you to adopt the minority recommendation (a blend of historical median wage growth and CPI minus a percentage), my proposal (forecasted median wage growth minus a percentage), or another formula which does not include a direct adjustment for input costs.

Other levers may be available to you as well. While we were charged with considering the target taking the rest of the details of the program (e.g. accountability measures) as given, it became clear in the discussions that there is a belief among industry participants that OHA has at least some discretion with respect to enforcement. If you choose to adopt the majority proposal as-is, for example, I encourage you to use whatever discretionary power you have to enforce that CGT; it may well be that a higher target that is more strictly enforced creates better incentives and a better healthcare system for Oregonians than a lower target with looser enforcement.

I do not envy the position you are in. Industry representatives are correct when they point out Oregon's diminished health workforce capacity, changing demographics, and recent broad-spectrum inflation as serious challenges to the sector's ability to provide quality care at affordable prices. Many non-profit entities throughout the state find themselves under substantial financial pressure. The CGT system itself is a blunt instrument that cannot solve all of Oregon's healthcare issues, and OHA must play a role in supporting the long-term stability of the healthcare sector.

Thank you for the opportunity to participate in this important process. I look forward to working with OHA in the future and building deeper connections between Oregon's academic and policy institutions.

Sincerely,

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[2] The main objection I heard to this mechanism focused on the expense involved in justifying cost increases to OHA. No one provided data to support that assertion.