Hospital Association of Oregon

August 1, 2026

Oregon Health Policy Board
Oregon Health Authority
500 Summer Street, NE, E-20
Salem, OR 97301

RE: Hospital Association of Oregon opposes OHPB Affordability Committee reference-based pricing policy proposal

Members of the Oregon Health Policy Board:

Thank you for the opportunity to provide public comment to the Oregon Health Policy Board (OHPB) regarding the Affordability Committee's reference-based pricing policy proposal.

The hospital association opposes the Affordability Committee's policy proposal to advance reference-based pricing by subjecting all Oregon hospitals to a reference-based price cap for inpatient and outpatient services at 200% of Medicare, along with other recommendations.[1]

There is near universal agreement that the health care system is fragmented, confusing, and expensive. We need a system that works better for patients, is less complicated for providers, and less expensive for employers, patients and governments. Reforming our current system requires a deep understanding of the interconnectedness of the current system, and thoughtful analysis of the impacts of any proposed changes. Absent that, misguided attempts to change parts of the system could unintentionally collapse the health care safety net in our communities.

Applying the proposed reference-based pricing proposal to all hospitals is such a concept. This policy idea would be a gift to insurers at the expense of community hospitals and the people who need them. This proposal is not well-vetted, adequate analysis of its impacts has not been conducted, and it would be disastrous for communities throughout the state. Capping what hospitals receive from insurers without accounting for the factors driving the cost of care is a math equation that ends in disaster. The hospital

[1] Affordability Committee's Draft Recommendation, Oregon Health Authority (July 7, 2026), available at https://www.oregon.gov/oha/OHPB/MtgDocs/6.%20Affordability%20Committee%20Draft%20Recs.07.07.26.pdf.

association welcomes a conversation on affordability. We welcome opportunities to work together to address health care cost drivers and build policy that directs resources to the greatest extent possible toward providing and protecting patient care.

We urge OHPB members to reject advancing the Affordability Committee's reference-based pricing proposal to legislation.

This is the second time the hospital association has urged OHPB members to reject advancing the Affordability Committee's reference-based pricing proposal. (See June 2, 2026 public comment). We encourage OHPB to review that letter as we build upon our prior comments here.

The proposal enriches insurers at the expense of Oregonians

The reference-based pricing policy proposal will ultimately enrich insurance companies at the expense of Oregonians' access to care.

Insurance companies are already protecting their interests at the expense of patients and providers by using tactics like prior authorization to delay and deny necessary care. In Oregon, commercial health insurers deny one in five prior authorization requests.[2] Additionally, 44% of Oregon health care providers report that the prior authorization process has led to a serious adverse event.[3] These requirements are also becoming even more burdensome. Nine in 10 Oregon health care providers have said that the prior authorization requirements for medical services have increased over the past five years.[4]

Even after care is provided, insurers withhold payments. The American Hospital Association has estimated that hospitals spent $43 billion trying to collect payments insurers owe for care that was already delivered.[5] When insurers refuse to pay for care already delivered, community hospitals face severe financial strain and must constantly battle to secure the very resources that keep their doors open.

The Affordability Committee's proposal would be another tool in insurers' toolbox and would add to the growing questions regarding the value that insurers provide for the health care dollars they consume. For example, Becker's Payer Issues ranked Blue Cross Blue Shield plans by 2025 profits, noting that "Regence BCBS in Oregon posted 1.5% net income on $3.18 billion in revenue."[6] The version of the Affordability

---

[2] Prior Authorization, Health Insurance, Oregon Department of Financial Regulation (2025), available at https://dfr.oregon.gov/insure/health/pages/prior-authorization.aspx.

[3] 2024 OMA Prior Authorization and Utilization Management Survey, Oregon Medical Association (Dec. 18, 2024), available at https://olis.oregonlegislature.gov/liz/2025R1/Downloads/PublicTestimonyDocument/169426.

[4] *Id*.

[5] Cost of Caring, American Hospital Association (March 2026), available at https://www.aha.org/system/files/media/file/2026/03/Costs-of-Caring-2026.pdf.

[6] Blue Cross Blue Shield Plans Ranked by 2025 Profits, Becker's Payer Issues (June 15, 2026), available at https://www.beckerspayer.com/financial/blue-cross-blue-shield-plans-ranked-by-2025-profits/.

Committee proposal presented to OHPB on July 7, 2026, states that "the value of the policy is that patients feel the impact via lower costs…"[7] That appears to be a hope, not a promise. In fact, Oregonians may not see any benefit. The proposal does not guarantee lower premiums, deductibles, or co-pays for those with insurance. The proposal enriches insurers with no way to deliver savings to patients.

This process excluded a key partner; we request a seat at the table

This process has intentionally excluded a key partner—Oregon hospitals. The voices of those who understand and operate hospitals should be at the decision-making table. When appropriate stakeholders, including hospital leaders, are not at the table to directly engage in the development of policy, there is a significant risk of ill-informed policy decisions that carry unintended consequences, including jeopardizing access to care. Robust data analysis and discussion by experienced and knowledgeable partners is necessary to inform the development of a policy proposal of this significance.

The structure of the Affordability Committee and the Industry Advisory Committee (IAC) intentionally sidelined hospitals and granted only perfunctory opportunities for hospital operators to provide feedback on the reference-based pricing policy proposal. The IAC is the only committee where hospital representatives are invited to give feedback. Since the start of the IAC, two hospital representatives vacated their IAC positions. OHA staff have not prioritized filling these vacancies with new hospital representatives in an expeditious manner. OHPB is responsible for appointing new members and is behind schedule based on communication with the IAC members during monthly meetings. We are concerned about these delays. In July, OHA staff told members of the IAC that the hospital seats are still empty due to a lack of applicants. However, our members have applied during the two recruitment periods.

The hospital association had one short opportunity to present the dire financial situation of Oregon hospitals and the consequences for patients and communities at the April meeting of the Affordability Committee. We had hoped for meaningful dialogue and were concerned that some members of the Affordability Committee appeared to dismiss the urgency and severity of the situation.

The proposal will unravel the health care safety net

The precarious financial condition of Oregon hospitals should give this committee great pause. Hospitals are not just a part of the health care system; they are the safety net, always open and available to all who need care. That safety net is fraying. In 2025, Oregon hospitals collectively lost more than $450 million caring for patients. Between 2022 and 2025, Oregon hospitals lost more than $1.25 billion caring for their communities. Facing steep financial losses, health care workers have lost their jobs, service lines have been cut, and inpatient beds have been closed.

It does not appear that the committee made a significant effort to quantify the impact of this proposal on hospitals. Given the tenuous financial condition of Oregon hospitals, this lack of due diligence undercuts the seriousness of the work and the focus that is required to protect patient access to care.

---

[7] Affordability Committee's Draft Recommendation, Oregon Health Authority (July 7, 2026), available at https://www.oregon.gov/oha/OHPB/MtgDocs/6.%20Affordability%20Committee%20Draft%20Recs.07.07.26.pdf.

This proposal would dramatically and catastrophically harm the ability of hospitals to provide critical services in their communities, pushing some hospitals to failure. Its purpose is to control costs by capping what hospitals are paid, yet it does nothing to address the underlying cost of providing care. The disastrous consequences of this proposal should be abundantly clear.

The hospital association recently published a report—2025 Hospital utilization and financial analysis, A fraying safety net: Oregon hospitals in crisis—that describes the ongoing financial distress in Oregon hospitals. The report is enclosed below for members of the OHPB to review and consider as you deliberate the disastrous consequences this proposal would have on Oregonians seeking care from community hospitals.

The proposal will add to looming federal Medicaid cuts

The fragility of hospitals, clinics, and other health care providers will come into sharper focus in the days and years ahead. Federal law (H.R.1) will set in motion a tectonic shift, creating state budget challenges, increasing the number of people without health insurance, and straining the health care system. With Oregon facing the loss of an estimated $12 billion in federal Medicaid funds due to H.R. 1, the current crisis in Oregon's health care system will accelerate.[8]

The hospital association appreciates that members of OHPB have questioned how the reference-based pricing policy proposal will affect hospitals considering the pending Medicaid budget gaps and expected increase in uncompensated care. Those are important questions to explore and when they are adequately answered, the flaws in this proposal will be obvious.

Hospitals receive payments primarily from three sources: Medicaid, Medicare, and commercial insurance. Medicaid and Medicare use more than two-thirds of hospital services in Oregon and payments from both programs fail to cover the cost of care. Medicaid pays the least of all payer categories, covering on average only about half the cost of providing hospital care. Medicare isn't much better, covering on average only 70%, compared to 82% nationally.[9] In 2025, Oregon hospitals lost $3.2 billion serving Medicare patients—a 20% increase over 2024 underpayment.[10]

H.R.1 will create major holes in the Medicaid budget that will grow over time. This proposal will deepen that state budget gap. Reducing revenue to hospitals, which this proposal intends to do, will also reduce the amount of provider tax hospitals pay to the state. The primary purpose of the provider tax is to help fund the

[8] Estimated Impacts of H.R. 1, Oregon Department of Administrative Services (Aug. 11, 2025), available at https://www.oregon.gov/das/Financial/Documents/Federal-Impact-HR1-Initial-Analysis.pdf.
[9] 2025 Hospital Utilization and Financial Analysis, A fraying safety net: Oregon hospitals in crisis, Hospital Association of Oregon, available at https://oregonhospitals.org/wp-content/uploads/2026/07/2025-Oregon-Hospital-Utilization-and-Financial-Analysis_A-fraying-safety-net-Oregon-hospitals-in-crisis-5.pdf.
[10] *Id.*

state Medicaid program. Advancing a proposal that exacerbates the state's Medicaid budget problems without understanding the magnitude of that impact would be both unwise and irresponsible.

H.R.1 will also result in many Oregonians losing their Medicaid coverage. Due to the work requirements in H.R.1, the Oregon Health Authority predicted approximately 200,000 Oregonians will lose Medicaid coverage.[11] We fear this already significant number will increase due to additional federal policy decisions. A report from Manatt Health estimates Oregon will have the highest annual percentage reduction in total Medicaid enrollment in the nation with up to 22%, or 290,000, of Oregon Medicaid enrollees losing coverage.[12] When these newly uninsured Oregonians need care, they will go to a hospital. But hospitals often will not be paid for the care that is provided.

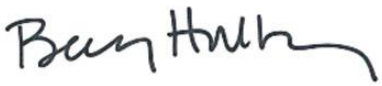
The methodology for setting the cap is flawed and not well-vetted

We have already written extensively on our concerns with the methodology in prior letters, which we submitted to the OHPB on June 2, 2026 (see public comment packet, page 3). Most importantly, while the state has already applied hospital price caps to a small portion of the commercial market, PEBB and OEBB, this was a much smaller cut to reimbursement for Oregon hospitals than this proposal. Expanding price caps through the Affordability Committee's reference-based pricing policy proposal to the entire population in the state (via price caps on all inpatient and outpatient services) will have devastating consequences. If payments to hospitals are capped but costs, including those outside the hospital's control, continue to grow at a rate higher than the rate cap, the result will be a crisis in access to care—such as the closure of services and hospitals.

Conclusion

The hospital association welcomes policy discussions to improve health care access and affordability. The reference-based pricing policy proposal from the Affordability Committee is not the solution.

Sincerely,



Becky Hultberg
President and CEO
Hospital Association of Oregon

---

[11] Impact of Federal Requirements & Funding Cuts to Oregon Health Plan (OHP/Medicaid), Oregon Health Authority (June 4, 2025), available at https://www.oregon.gov/oha/Documents/Federal-Budget-Impacts-Medicaid.pdf.

[12] Boozang, et al. Mannat Health, CMS' Medicaid Work Requirements Rule: A 50-State Analysis of Additional Coverage Losses, FFY 2027-2034 (July 2026), available at https://assets-us-01.kc-usercontent.com/9fd8e81d-74db-00ef-d0b1-5d17c12fdda9/23b961e2-a654-4fd1-9358-1e3d42205358/Vital%20Signs%2050-State%20Tracking_CMS%20Medicaid%20Work%20Requirements%20Rule.pdf.

Hospital Association of Oregon

2025 hospital utilization and financial analysis

A fraying safety net: Oregon hospitals in crisis

Day or night, in moments of need or crisis, people turn to hospitals for care. Hospitals are not just a part of the health care system; they are the safety net, always open and available to all who need care.

That safety net is fraying. Faced with rising expenses, payments that do not cover the cost of care, bad insurer behavior, and crippling state policies, hospitals are struggling to maintain services and keep their doors open.

In 2025, Oregon hospitals collectively lost more than $450 million caring for patients. This is not just one bad year. Between 2022 and 2025, Oregon hospitals lost more than $1.25 billion caring for their communities, a staggering number. Financial distress is not unique to one type of hospital or community. It is occurring across the state, at small, rural hospitals, urban hospitals, independent hospitals, and health systems.

Continuing external financial challenges have forced hospitals to make hard decisions. Since 2025, more than 1,000 health care workers have lost their jobs, service lines have been cut, and inpatient beds have been closed.

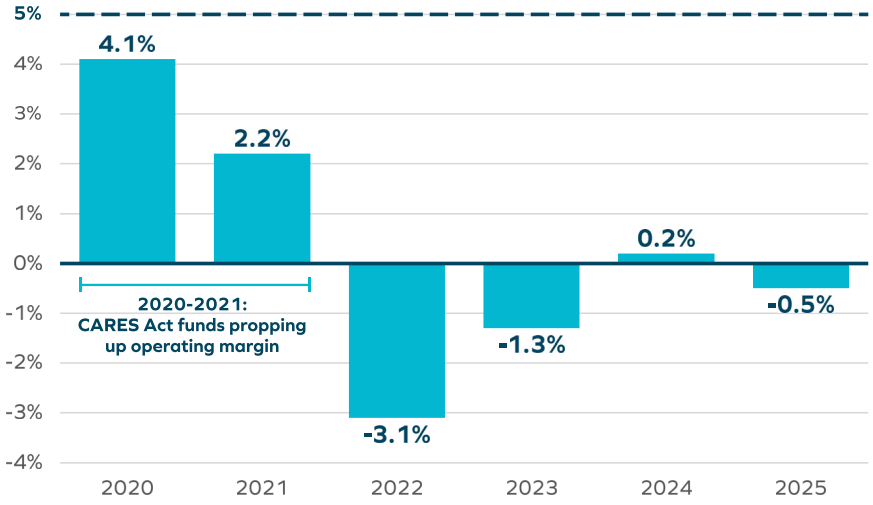
The fragility of hospitals, clinics, and other health care providers will come into sharper focus in the days and years ahead. Federal law (H.R.1) will set in motion a tectonic shift, creating state budget challenges, increasing the number of people without health insurance, and straining the health care system. With Oregon facing the loss of an estimated $12 billion in federal Medicaid funds due to H.R. 1, the current crisis in Oregon's health care system will accelerate.

This report provides an overview of why Oregon hospitals are at a breaking point, what is driving this crisis, how it affects patients and communities, and the actions needed to protect the state's safety net. As policymakers and community leaders consider health care policy in Oregon, this data serves as a foundation for informed decision-making and a call to action.

The hospital math equation no longer works

Hospitals must have positive operating margins (the difference between what it costs to provide care and what hospitals receive in payment) to pay staff, maintain facilities, and provide services patients need. Yet in Oregon, hospitals have struggled to cover the cost of operations since the pandemic.

Median operating margin percent by year (2020–2025)[1]



According to KFF, **"positive but relatively modest margins of less than 5%...may signal financial challenges for hospitals."** [2]

Staggering hospital losses continue

$450 million
lost caring for patients in 2025 [3]

$1.25 billion
lost caring for patients since CARES Act funds ran out at the end of 2021 [4]

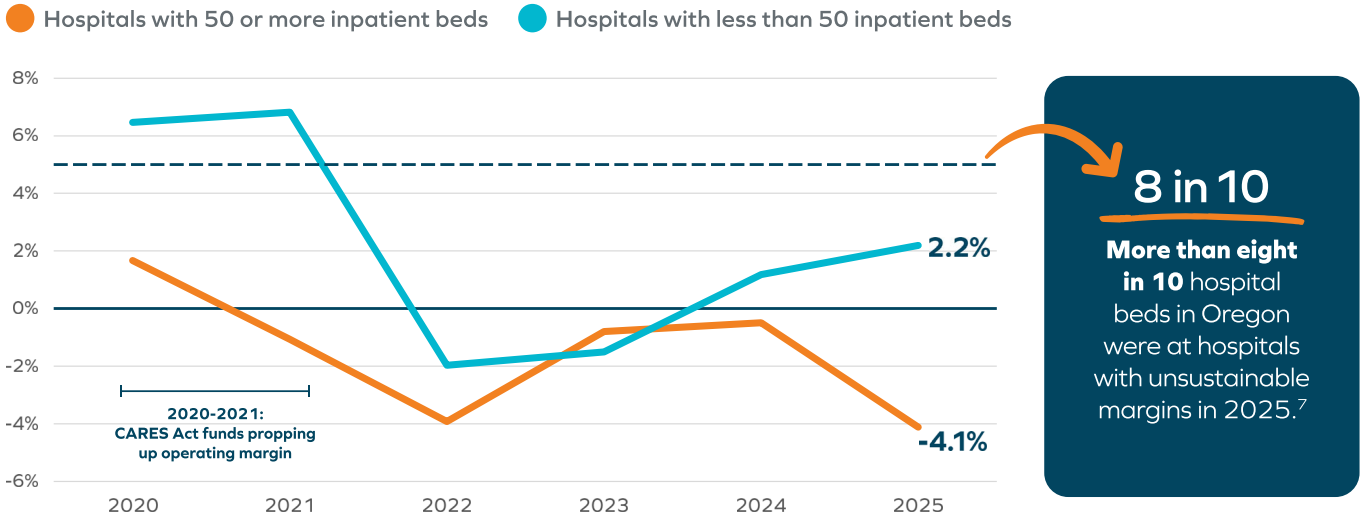
70%
of Oregon hospitals had margins in 2025 that may signal financial challenges [5]

> *There isn't a silver lining in these numbers. After five years of deepening losses at many hospitals, communities are losing services, patients have fewer options for care, and more than 1,000 Oregonians have lost their jobs."*
>
> **Becky Hultberg, president and CEO, Hospital Association of Oregon**

Oregon's health care safety net is fraying across the state

In 2025, more than half of Oregon hospitals operated at a loss, including most of the state's larger hospitals (50 or more inpatient beds) and more than 40% of smaller, often rural hospitals (fewer than 50 inpatient beds).[6] Notably, it marked the fifth straight year of losses for the state's larger hospitals, which offer the highest levels of care.

Median operating margin

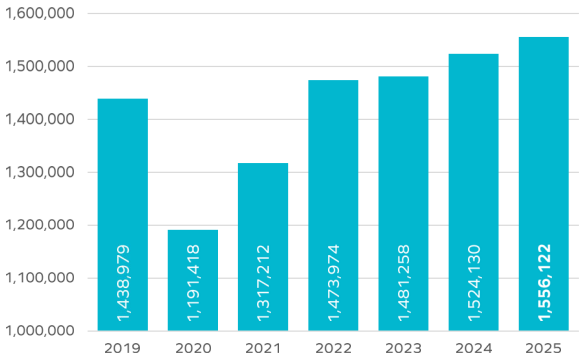


Hospitals' losses continue despite record-breaking need

The financial challenges of Oregon hospitals are not the result of people needing less care. In fact, demand for hospital care is growing in Oregon, which means that Oregon hospitals need resources to meet that demand.

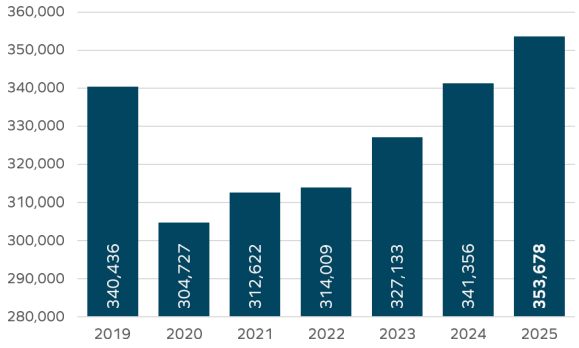
Emergency department visits

Hospitals saw **32,100** more emergency department visits than 2024.[8]



Inpatient discharges

Hospitals saw **12,300** more inpatient discharges than 2024.[9]



Why is the math not working?

The government does not pay its fair share for patient care, and commercial insurance companies delay and deny care and payment

Hospitals' costs to provide care are rising steeply

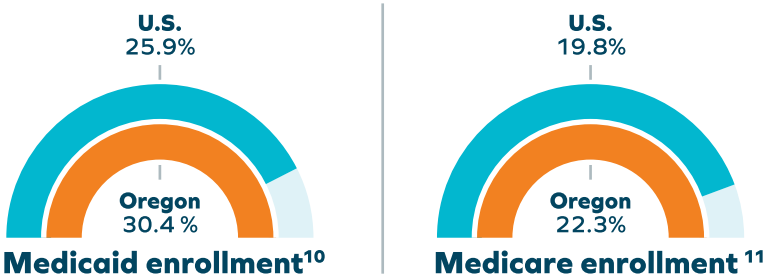
Oregonians are older, sicker, and need more care

Oregon's regulatory landscape is increasing costs and creating operational challenges

The government does not pay its fair share for patient care

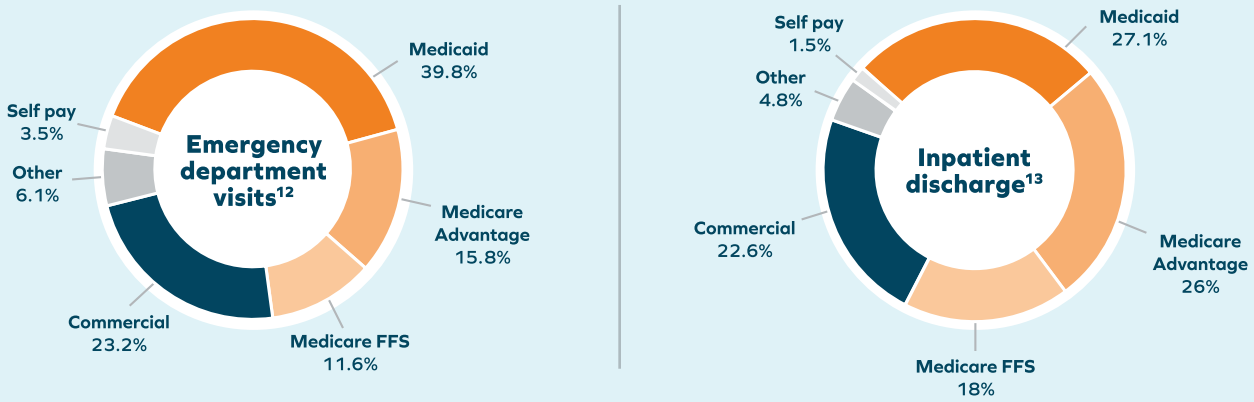
Chronic underpayment from Medicaid and Medicare—the largest payers for hospital services—is putting unsustainable financial pressure on hospitals.

Oregon is more dependent on government insurance than many other states.



Medicaid and Medicare use two-thirds of hospital services

Discharge percent by payer (2025)



Medicaid and Medicare use **more than two-thirds of hospitals services in Oregon**[14] and payments from both programs fail to cover the cost of care. Medicaid patients use more hospital services (emergency department and inpatient) than patients covered by any other payer. Yet Medicaid pays the least of all payer categories, covering on average only about half the cost of providing hospital care.

Medicare isn't much better, covering on average only 70 percent,[15] compared to 82 percent nationally.[16] In 2025, Oregon hospitals lost $3.2 billion serving Medicare patients—a 20% increase over 2024 underpayment.[17]

Medicaid only pays on average about half of what it costs to provide hospital care, and Medicare isn't much better, paying on average about 70%.[18]

Commercial health insurers delay and deny payments

Insurance companies are increasingly using tactics like prior authorization to delay and deny necessary care. Prior authorization means that a health insurance company must approve a medical service, treatment, medication, or medical device before the insurer pays for it. Delays and denials affect people's lives and health, and hurt the hospitals that provide care and then don't get paid.

1 in 5

Commercial health insurers deny **one in five prior authorization requests** in Oregon.[19]

9 in 10

Nine in 10 Oregon health care providers say **prior authorization requirements are a high burden** on their teams—and that these requirements have **increased** over the past five years.[20]

9 in 10

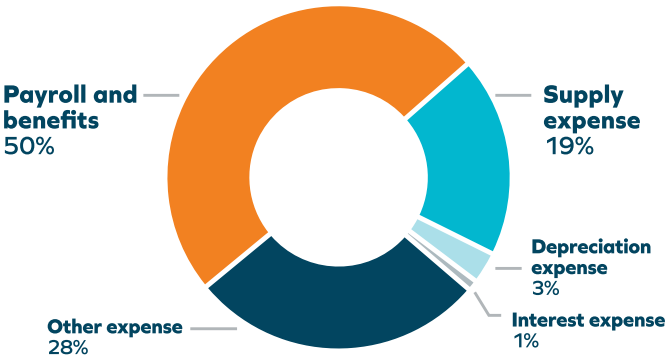
Nine in 10 Oregon health care providers say that prior authorization often results in **delayed care for patients**, with four in 10 saying that it has led to a **serious adverse event**.[21]

> *We're a small health system in the Santiam Canyon. There is a growing threat to health care access across Oregon. Commercial insurers are increasingly denying, downcoding, and delaying payment for care that has already been delivered, creating significant financial and administrative burdens for providers. At Santiam, we successfully overturn a majority of appealed denials, which raises an important question: If the claim ultimately meets coverage requirements, why was it denied in the first place? Too often, insurers are overriding established CMS facility coding guidelines and delaying reimbursement for appropriately coded services. Hospitals and clinics should be focused on caring for patients—not spending months fighting for payment. Greater accountability and oversight are needed to ensure providers are paid fairly, promptly, and according to recognized coding standards so patients can continue to access care close to home."*
>
> **Maggie Hudson, MBA, president and CEO, Santiam Hospital & Clinics**

Hospitals' costs to provide care are rising steeply

Between 2020 and 2025, operating expenses for Oregon's hospitals increased 57.5%—from $14.7 billion to more than $22.2 billion.[22] General inflation, tariffs, unsustainable pharmaceutical and supply cost increases, labor cost escalation, and a challenging regulatory environment drove these increases.

Operating expenses[23]



> *"The equation is deceptively simple, yet undeniably harsh: Expenses are up and revenue is down, creating an unsustainable trajectory."*
>
> Marty Cahill, president and CEO, Samaritan Health Services

Operating expenses increase (2020-2025)[24]

Hospitals are powered by people

Payroll and benefits drive increases in operating costs, and Oregon leads the nation in health care worker wages.

2nd

Oregon is second in the nation for median wage for health care practitioners.[25]

30%

The median wage for health care practitioners in Oregon is **30% higher than the national average.**[26]

Highest

Adjusted for cost of living, **Oregon nurses have the highest hourly wage in the nation.**[27]

Oregonians are older, sicker, and need more care

As hospitals work to maintain services amid ongoing financial losses, they face growing pressure to care for an older, sicker population. Oregon is aging faster than most states and has one of the nation's lowest birth rates in the nation, reshaping health care demand and who pays for care.

To meet increasing community needs, hospitals must have resources to invest in the workforce, facilities, and infrastructure that support patient care for an aging population.

Oldest
Oregon is the oldest state west of the Mississippi [28]

65+
In 2023, adults age 65+ outnumbered children under 18 [29]

40%
By 2035, Oregon is projected to have 40% more adults aged 65+ than children [30]

5th lowest
Oregon has the fifth-lowest birth rate in the U.S. [31]

> *"To keep up with an aging and growing population, our community needs to add about 150 hospital beds every 10 years. Financial constraints make it difficult for hospitals to save up for needed expansion and equipment. Oregon already has the second lowest number of hospital beds per capita in the nation. Skimping on investment today will leave the next generation to grapple with consequences."*
>
> **James Parr, executive vice president of operations and CFO, Salem Health**

Older patients are in the hospital longer than other groups

1 in 4

Medicare patients account for more than **one in four emergency department visits** in Oregon.[32]

On average, each visit is two to four hours longer than for those with Medicaid or commercial insurance.[33]

44%

Medicare patients account for **44% of all inpatient stays** in Oregon.[34]

On average, inpatient stays for those on Medicare are 16-36 hours longer than for those with Medicaid or commercial insurance.[35]

Regulatory landscape increases costs, creates operational challenges

Hospitals' growing regulatory burden is driving health care dollars towards paperwork and away from patient care.

Over the last decade, Oregon has layered on an increasingly complex and costly regulatory framework, diverting hospital staff and resources away from patient care. Some of these laws are unique to the state of Oregon. The cumulative impact of disconnected public policies has created one of the most difficult operating environments in the country for hospitals.

> *"When a regulation is passed, and in many cases it's absolutely well-intended and understandable, there's a whole administrative cost to that. It just keeps driving the cost of health care up in our state."*
>
> **Cheryl Nester Wolf, CEO, Salem Health**

Spotlight on the hospital staffing law

During the 2023 legislative session, a coalition representing hospitals and labor worked together to pass a package of bills to support Oregon's health care workforce. One of those bills was HB 2697, the hospital staffing law. Rather than create a program that followed legislative intent and statutory requirements, the Oregon Health Authority (OHA) took enforcement positions that represent significant, fundamental departures from what the coalition expected. The results have been devastating.

In a time of declining state and federal funds, limited resources must be directed to where they matter most: The bedside. OHA's implementation and enforcement are diverting dollars from the bedside, forcing hospitals to waste resources in an overly burdensome process and directing dollars to bureaucracy instead of patient care.

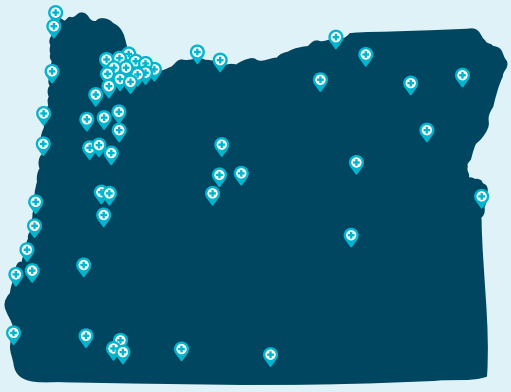
> *"OHA's choices are driving affordability challenges that will impact Oregonians. At a time when Oregon hospitals are struggling to keep their doors open and some have already shut their doors or service lines, OHA's decision to enforce the law differently than expected is draining resources and creating a serious threat to jobs and services Oregon communities rely on. The status quo is unsustainable."*
>
> **Becky Hultberg, president and CEO, Hospital Association of Oregon**

Staggering losses force hospital closures, cuts

When hospitals cannot cover the cost of providing care, the consequences threaten access to care for patients and communities today and for generations to come. Losing a hospital isn't just losing a building—it's losing emergency care, obstetrics, surgery, behavioral health services, jobs, and an economic anchor for communities. In response to ongoing losses, hospitals have taken a variety of steps to meet communities' needs today, while safeguarding access to care for the future.

Facing economic factors beyond their control, hospitals have been forced to make difficult decisions:

- Citing ongoing financial challenges, Oregon's only long-term acute care facility, Vibra Specialty Hospital of Portland, closed.[36]
- As a result of Oregon's worsening financial and regulatory landscape for hospitals, Ashland Community Hospital closed its hospital license, transitioning to a satellite campus of Rogue Regional Medical Center.[37]
- Through a last-minute effort, the legislature provided help for Bay Area Hospital that will enable the hospital to keep its doors open.[38]
- Throughout the state, other services shuttered including labor and delivery units, a pediatric intensive care unit, urgent care clinics, and specialty clinics that focus on heart care, eye care, occupational health, cardiac and pulmonary rehab, and pain management.



4.2 million
Oregon residents

59
community hospitals

2nd fewest
hospital beds per capita

*In a state of 4.2 million,[39] Oregon has just 59 community hospitals—down from 62 in the past three years.[40] With the **second fewest hospital beds per capita in the nation**,[41] Oregon is especially vulnerable to the impacts of lost services or reduced access to hospital beds.*

Service closures affect people's jobs and livelihoods

Since 2025, more than 1,000 health care workers have lost their jobs,[42] impacting families and communities across Oregon. Hospitals employ nearly 70,000 Oregonians,[43] making them a pillar of the state's economy and a critical source of stability in a weakening labor market.

H.R. 1 accelerates the strain on a fraying safety net

In a health care landscape already rife with challenges, the federal law, H.R. 1, is triggering a tectonic shift, and those changes are already happening.

Over the next six years, provisions of this law will be phased in, affecting how the state funds and administers its Medicaid program, how much money it receives from the federal government, and eligibility standards for coverage.

In total, the state estimates that:

- It will receive **$12 billion less in federal funding for Medicaid over the next 10 years.**[44]
- **200,000 Oregonians could lose health coverage,** as more than half a million Medicaid enrollees become subject to more frequent eligibility checks.[45]
- **It will lose a significant funding source for its "local match"** as the maximum allowable provider tax rate is reduced from 6% to 3.5% by FY 2032.[46]

Alongside these Medicaid changes, H.R. 1 also reduces Affordable Care Act (ACA) Marketplace premium tax credits, leading to higher premiums for enrollees. When these changes took effect in late 2025, Oregon experienced a **15.25% decline in ACA Marketplace enrollment**.[47]

With fewer Oregonians insured and reduced funding flowing to critical services, hospitals could experience further financial shocks.

We must act now to protect the safety net for everyone

Oregon hospitals are the safety net for our communities, open and available to all. Yet they are at a breaking point. Year-over-year losses have weakened Oregon's hospitals, and changes in federal law threaten to deepen the crisis. Without intentional action to strengthen this safety net, it will continue to fray.

Policymakers must act now to safeguard the care every Oregonian depends on. What can we do?

- **Protect and strengthen Medicaid payment to hospitals:** The fragility of hospitals and the catastrophic changes due to H.R. 1 mean we need to act now to save the hospital safety net.
- **Make government work:** State policies should reduce unnecessary administration or bureaucracy.
- **Hold insurers accountable:** Insurer policies should facilitate and promote good health care, rather than serving as a barrier to it.

Endnotes

1 Apprise Health Insights analysis of Oregon Health Authority DATABANK data

2 KFF, Hospital Margins Rebounded in 2023, But Rural Hospitals and Those With High Medicaid Shares Were Struggling More Than Others, Dec. 18, 2024

3 Oregon Health Authority Hospital Reporting Program. (2026). Hospital Financial & Utilization Dashboard. Interactive display (Metric: Operating margin) accessed July 21, 2026. Portland, OR: Oregon Health Authority. https://visual-data.dhsoha.state.or.us/t/OHA/views/databankdashboardappendix/FinancialDash?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y

4 Oregon Health Authority Hospital Reporting Program. (2026). Hospital Financial & Utilization Dashboard. Interactive display (Metric: Operating margin) accessed July 21, 2026. Portland, OR: Oregon Health Authority. https://visual-data.dhsoha.state.or.us/t/OHA/views/databankdashboardappendix/FinancialDash?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y

5 Apprise Health Insights analysis of Oregon DATABANK data

6 Oregon Health Authority Hospital Reporting Program. (2026). Hospital Financial & Utilization Dashboard. Interactive display (Metric: Operating margin) accessed July 21, 2026. Portland, OR: Oregon Health Authority. https://visual-data.dhsoha.state.or.us/t/OHA/views/databankdashboardappendix/FinancialDash?%3AshowAppBanner=false&%3Adisplay_count=n&%3AshowVizHome=n&%3Aorigin=viz_share_link&%3AisGuestRedirectFromVizportal=y&%3Aembed=y

7 Apprise Health Insights analysis of Oregon Health Authority DATABANK data; Number of licensed beds per hospital pulled from the AHA Annual Survey; 66% of beds were at hospitals with negative operating margins in 2025, 18% were at hospitals with margins of 0-5%, and 16% were at hospitals with margins of 5%+

8 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends/By payer/Emergency department visits) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

9 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends/By payer/Inpatient discharges) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

10 USA Facts, How many people are on Medicaid in Oregon? (2024), https://usafacts.org/answers/how-many-people-are-on-medicaid-in-the-us/state/oregon/

11 The Commonwealth Fund, State Scorecard on Medicare Performance, October 2025, Appendix G, https://www.commonwealthfund.org/sites/default/files/2025-10/Jacobson_medicare_state_scorecard_APPENDICES_final.pdf

12 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends/By payer/Emergency department visits) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

13 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends/By payer/Emergency department visits) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

14 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends/By payer/Inpatient discharges and Emergency department visits) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

15 Apprise Health Insights analysis of Oregon hospitals claims data (five-year average, 2021-2025)

16 American Hospital Association, Medicare Significantly Underpays Hospitals for Cost of Patient Care, https://www.aha.org/2024-01-10-infographic-medicare-significantly-underpays-hospitals-cost-patient-care

17 Apprise Health Insights analysis of Oregon hospitals claims data (2024 and 2025)

18 Apprise Health Insights analysis of Oregon hospitals claims data (five-year average, 2021-2025)

19 Oregon Department of Financial Regulation, Health Insurance, Prior Authorization (2025): https://dfr.oregon.gov/insure/health/pages/prior-authorization.aspx

20 Oregon Medical Association, 2024 OMA Prior Authorization and Utilization Management Survey, https://olis.oregonlegislature.gov/liz/2025R1/Downloads/PublicTestimonyDocument/169426

21 Oregon Medical Association, 2024 OMA Prior Authorization and Utilization Management Survey, https://olis.oregonlegislature.gov/liz/2025R1/Downloads/PublicTestimonyDocument/169426

22 Apprise Health Insights analysis of Oregon hospitals expense data

23 Apprise Health Insights analysis of Oregon hospitals expense data

24 Apprise Health Insights analysis of Oregon hospitals expense data

25 U.S. Bureau of Labor Statistics, Annual Median Wage for Healthcare Practitioners and Technical Occupations, by State, May 2024

26 U.S. Bureau of Labor Statistics, Annual Median Wages, Selected Occupations, Oregon and U.S., May 2024

27 Beckers Hospital Review, RN pay by state, adjusted for cost of living, May 16, 2026, https://www.beckershospitalreview.com/hr/rn-pay-by-state-adjusted-for-cost-of-living/

28 The Oregonian, Oregon is the oldest state in the West, and it's getting even older, July 11, 2023, https://www.oregonlive.com/business/2023/07/oregon-is-the-oldest-state-in-the-west-and-its-getting-even-older.html

29 Oregon Department of Administrative Services, Oregon Economic and Revenue Forecast, March 2026, page 36, https://www.oregon.gov/das/oea/Documents/OEA-Forecast-0326.pdf

30 The Oregonian, Oregon seniors outnumber children for the first time, creating a looming demographic challenge, May 25, 2025, https://www.oregonlive.com/business/2025/05/oregon-seniors-outnumber-children-for-the-first-time-creating-a-looming-demographic-challenge.html

31 Centers for Disease Control & Prevention, Live births per 1,000 women ages 15–44, 2024, Fertility rate, https://www.cdc.gov/nchs/state-stats/births/fertility-rate.html

32 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends by payer, Inclusive of both Medicare and Medicare Advantage) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

33 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends by payer, Comparing ED length of stay between Medicare/Medicare Advantage and Commercial/Medicaid) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

34 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends by payer, Inclusive of both Medicare and Medicare Advantage) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

35 Oregon Hospital Discharge Data Dashboard (2026). Interactive display (Statewide trends by payer, Comparing inpatient length of stay between Medicare/Medicare Advantage and Commercial/Medicaid) accessed July 21, 2026. Salem, OR: Oregon Health Authority. https://www.oregon.gov/oha/hpa/analytics/pages/discharge-data-dashboard.aspx

36 The Oregonian, Portland long-term acute care hospital will shutter, lay off 310 employees, Dec. 1, 2025, https://www.oregonlive.com/health/2025/12/portland-long-term-acute-care-hospital-will-shutter-lay-off-310-employees.html

37 Asante, Changes coming for Ashland Community Hospital in 2026, Dec. 3, 2025, https://www.asante.org/about-us/news/2025/changes-coming-for-ashland-community-hospital-in-2026/

38 Oregon Public Broadcasting, Coos Bay hospital gets lifeline from Oregon lawmakers, March 18, 2026, https://www.opb.org/article/2026/03/18/coos-bay-area-hospital-loan-guarantee/

39 US Census Bureau, Quick Facts: Oregon, Population estimates, July 1, 2024, https://www.census.gov/quickfacts/fact/table/OR/PST045224

40 This does not include the Oregon State Hospital or Veteran's Administration Hospital.

41 KFF, Hospital Beds per 1,000 Population by Ownership Type (2024), https://www.kff.org/state-health-policy-data/state-indicator/beds-by-ownership/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

42 Number is inclusive of job losses at Providence, Legacy, Samaritan, Blue Mountain Hospital, Bay Area Hospital, PeaceHealth, Vibra Specialty Hospital, Asante, and St. Charles.

43 EcoNorthwest analysis of the economic impact of Oregon hospitals (2025)

44 Oregon Department of Administrative Services, Estimated Impacts of H.R. 1, August 2025, page 6, https://www.oregon.gov/das/Financial/Documents/Federal-Impact-HR1-Initial-Analysis.pdf

45 Oregon Health Authority, Impact of Federal Requirements & Funding Cuts to Oregon Health Plan (OHP/Medicaid), https://www.oregon.gov/oha/Documents/Federal-Budget-Impacts-Medicaid.pdf

46 Oregon Health Authority, Federal Impacts to Medicaid, Marketplace, and Rural Health, Sept. 29, 2025, https://olis.oregonlegislature.gov/liz/2025I1/Downloads/CommitteeMeetingDocument/310040

47 OregonHealthcare.gov Annual Report (2025), page 12, Oregon Health Insurance Marketplace | 2025 Annual Report, https://healthcare.oregon.gov/Documents/Governance%20&%20Transparency/2025%20Annual%20Report%20-%20FINAL%20-%20ENGLISH.pdf

ASANTE®

Public Comment Regarding the Affordability Committee Recommendations regarding Hospital Reference Based Pricing

Submitted to the Oregon Health Policy Board on July 31, 2026

Dear Members of the Oregon Health Policy Board:

We understand that at your meeting on August 4, you will be considering the Affordability Committee's recommendation to impose Medicare-based reference pricing caps on hospital reimbursement in Oregon's commercial insurance market. We strongly urge you to reject this proposal in its entirety as this will irreparably harm Oregon's healthcare delivery system and financially devastate Oregon hospitals.

Importantly, we acknowledge the challenges in Oregon regarding affordability for patients seeking health care services, and we would be in strong support of measures that would reduce patient costs without putting hospitals and doctors, particularly those who serve rural and underserved patients, at risk of closure.

These reforms could include:

- Eliminating unnecessary and unfunded administrative burden on hospitals, providers and the system as whole by recommending the sunsetting of costly and overlapping regulations that do not impact patient care;
- Target pharmaceutical pricing to hospitals;
- Address unfair insurance tactics around prior authorizations, denials, downcoding and payment delays;
- Alleviate workforce shortages through suggesting measures adopted by other states to encourage in-migration of nurses, doctors and other allied professionals;
- Address the chronic underfunding of Medicaid – which pushes costs back on providers and the commercial insurance market.

Commercial insurance caps are not the appropriate policy tool, but instead a regressive penalty on rural and underserved communities in already economically disadvantaged parts of the state.

The Affordability Committee's proposal is not a modest affordability initiative or targeted reform but instead would impose one of the largest reimbursement reductions in Oregon

hospital history on a hospital sector that is already financially distressed. This financial distress has been well-documented, including most recently in last week's Hospital Association of Oregon report, "A Fraying safety net: Oregon Hospitals in crisis."[1]

The projected financial impact of this proposal on Asante is around **$185 million annually**. This is greater than the projected impact on our system than the oft-maligned One Big Beautiful Bill Act (i.e. HR.1). Please let that sink in.

The Board should evaluate this proposal with a clear understanding of its predictable consequences. If adopted, hospitals will be forced to reduce workforce and close service lines and likely, some entire hospitals will close. Patients will have diminished access to care, longer travel times and worsening health disparities. Hospitals are often the largest employers in rural communities and closures and job losses will greatly impact local economies. And non-healthcare companies will not want to set up businesses in cities and towns that lack basic healthcare.

The Affordability Committee's own charter states that affordability initiatives should lead to "real world changes for patients and consumers to access the care they need" and should ensure that "access, quality, and equity are not compromised."[2]

A proposal that undermines hospitals serving Oregon's most vulnerable communities fails that test. If a policy reduces access to care, closes services or forces patients to travel hundreds of miles for treatment, neither equity, nor affordability has been improved. The burden has merely been shifted onto patients and communities least able to bear it.

Current Health Care Dynamics

Before discussing the impact of commercial insurance price caps, it is important to understand the financial reality facing Oregon hospitals. While we describe Asante's experience below, the same fundamental dynamics apply across much of rural Oregon and to many hospitals throughout the state.

Hospitals in Oregon have four primary categories of payers:

---

[1] Hospital Association of Oregon. A fraying safety net: Oregon hospitals in crisis (https://oregonhospitals.org/wp-content/uploads/2026/07/2025-Oregon-Hospital-Utilization-and-Financial-Analysis_A-fraying-safety-net-Oregon-hospitals-in-crisis-5.pdf)

[2] https://www.oregon.gov/oha/HPA/HP/AccDocs/Affordability-Committee_Charter.pdf

- Medicare
- Medicaid (Oregon Health Plan)
- Uninsured and self-pay patients
- Commercial insurance

The first two categories pay less than our cost of providing care – for every $79 we receive from Medicare for providing patient care, it costs us $100 (paying nurses, doctors, technicians, cleaning staff, supplies, equipment, etc.). For Medicaid, we receive $67 dollars for every $100 that we incur in expenses.

Uninsured patients *currently* make up a small percentage of patients who receive services at our facilities; though this is expected to dramatically increase once the implementation of H.R. 1 begins next year, with State officials warning that as many as 200,000 Oregonians could lose coverage.

Most uninsured patients in our region are eligible for charity care. Many of these patients pay nothing for their care – it is entirely uncompensated. Nonprofit hospitals within the State are expected and required to see these patients and absorb these costs.

That leaves commercial insurance, which is the only major payer category that consistently reimburses hospitals above the cost of care.

The distinction is important because the proposal under consideration would use Medicare reimbursement as the benchmark for determining commercial hospital payment rates through reference pricing. While Medicare serves an important role as a federal payment program, it was never designed to reflect the full cost of providing care in every market or community. For hospitals such as Asante, Medicare reimbursement falls substantially below the cost of delivering care. Establishing commercial payment rates based on Medicare reimbursement therefore risks importing Medicare's existing funding shortfall into the commercial market, reducing the revenue that currently supports access to care for all patients.

Hospitals are expected to provide care to every patient who presents for emergency treatment regardless of insurance status. At the same time, reimbursement from

government programs falls below the cost of delivering that care, meaning commercial insurance reimbursement makes up the shortfall.

Whether one believes that system is well designed or poorly designed is beside the point - Oregon's health care system is built around these realities. Simplified solutions to complex problems are a recipe for breaking the system.

Treatment of patients who are uninsured or on Medicaid and Medicare are core to our mission; however, the losses associated with those patients do not disappear. For many hospitals, including ours, commercial reimbursement is the only source of revenue that offsets those losses and allows critical community services to remain available.

This challenge is especially acute for hospitals outside the Portland metropolitan area (though also impacts safety-net hospitals within Portland), where providers serve older populations, lower-income populations and larger percentages of Medicare beneficiaries and OHP Members.

Fair or not, the simple reality is that many safety-net hospitals depend on a relatively small population of commercially insured patients to keep their doors open. Placing a cap on commercial reimbursement will result in substantial service line cuts and closures, and loss of access for patients.

Projected Impact on Asante

Asante is the largest health care system and employer in Jackson and Josephine Counties, with its flagship hospital Rogue Regional having the only Level II trauma center in the region. We serve around 600,000 people in 9 counties in southern Oregon and northern California.

Hospitals rarely collect the full contractual reimbursement due to insurer denials, downcoding, prior authorization barriers, payment delays and other claims practices. Given these considerations, if the cap is 200% of Medicare, we would anticipate collecting at a rate of around 175% of Medicare – at that rate, the total financial annual impact would be around **$185 million**.

This fiscal year, Asante is operating at a negative margin of approximately $25 million, through 9 months. We have already eliminated approximately 350 full time positions and are now evaluating service line reductions. We announced last week that we are closing

outpatient physical, speech and occupational therapies because we can no longer sustain these service lines.

This is before the impacts of H.R. 1 hit.

The reason for these operating losses is not difficult to understand – roughly 75% of patients are covered by Medicare or Medicaid – which do not cover our costs – leaving the roughly 14-15% of our patients have commercial insurance to cover these excess costs. This commercial insurance percentage has been on the decline, down from around 20% ten years ago.

Meanwhile, labor, pharmaceuticals, supplies and regulatory requirements continue to rise while reimbursement has failed to keep pace.

Oregon hospitals face among the highest labor costs in the nation – our largest group of employees, registered nurses, have the highest wages in the country when adjusted for cost of living. This is compounded with Oregon's mandatory nurse staffing requirements, which has driven up labor costs further.

These challenges are not unique to Asante. Oregon's own Cost Growth Target process has repeatedly documented rising healthcare costs and the pressure those costs place on providers.

Asante's hospitals, like other health care systems in rural Oregon, cannot offset reimbursement reductions through volume growth or raising prices because most patient care is already reimbursed below cost at set rates. Thus, the more volume we manage, the larger losses we have. The small slice of commercial insurance market is the only mechanism through which hospitals currently fund the care they provide to Medicare beneficiaries, Medicaid members, uninsured patients and everyone else who depends on local access to care. Remove that support and the services it funds cannot be maintained.

As referenced above, this gets worse next year. Once H.R. 1 materializes in 2027, many Oregonians who currently have Medicaid coverage are expected to lose that coverage altogether. Those individuals will not stop needing health care. They will continue to seek care in emergency departments, hospitals and clinics throughout Oregon.

In practical terms, hospitals will be forced to absorb growing levels of uncompensated care at precisely the same moment this proposal would dramatically reduce the commercial reimbursement that currently subsidizes those losses.

For rural and safety-net hospitals, that combination is an existential threat.

What this means for patients

The Affordability Committee's charter specifically requires that affordability recommendations protect equity. This proposal is regressive and does the opposite.

Patients living in affluent urban communities generally have alternatives. They often have multiple hospitals nearby, access to specialists and greater ability to travel when services change or move. Rural and economically distressed communities do not.

When a service closes in Portland, patients may have another option a few miles away. When a service closes in Medford, Klamath Falls, Ontario or Coos Bay, patients may be forced to travel hours for treatment. Some will delay care or forgo care entirely.

The people most likely to bear the burden of this proposal are precisely those populations Oregon's health equity efforts are intended to protect - lower-income families, seniors, people with disabilities, Native communities, rural residents and patients already facing transportation and access barriers.

A policy that disproportionately harms rural, poorer, older and medically vulnerable Oregonians so that commercial premiums may be modestly lower elsewhere is not an equity policy.

Hospital closures, trauma center closures, increased travel times and reduced access to care are associated with worse health outcomes and increased mortality, particularly for rural populations and patients requiring time-sensitive care.

The bottom line is that this isn't just a penalty on hospitals – it will lead to real suffering and early death for members of our community.

Responsibility for Foreseeable Consequences

The Affordability Committee's recommendation appears to evaluate the proposed price cap largely in isolation - the Board has a responsibility to look at the entire health care system and evaluate this in light of the economic realities and federal legislation that is already placing immense pressure on Oregon hospitals.

Oregon hospitals are not being asked to absorb these cuts during a period of financial stability. They are being asked to absorb them while preparing for rising uncompensated care, persistent workforce shortages, inflationary pressure on labor and pharmaceutical costs and growing regulatory obligations. Evaluating this proposal without considering those simultaneous pressures materially understates the risk it poses to patient access and hospital sustainability.

The Board is being asked to make a decision with significant and foreseeable consequences of removing a substantial portion of the revenue that currently sustains care delivery.

If implemented, hospitals will first likely try cutting workforce and services, including those that are not financially sustainable such as birthing units and behavioral health services. After that, hospitals will be required to either close entirely, or merge with larger, out-of-state systems, who are the only ones who may be able to subsidize the losses with offsetting revenue from other states.

In all these scenarios, the patients, nurses, doctors and communities lose. A vote in favor of this policy is a vote in favor of service cuts and closures for rural and underserved populations across the state.

For these reasons, we urge the Oregon Health Policy Board to reject the Affordability Committee's recommendation.

Sincerely,

Kristen Roy
Chief Public Affairs Officer and General Counsel
Asante