Executive Summary

The overarching challenge facing our healthcare system today is the total cost of care—which has become increasingly unaffordable for individual consumers, the government and for employers. Reducing the total cost of care, therefore must be our primary objective – but it must be achieved without compromising quality or access.

Without reducing the total cost of care, all of us – healthcare consumers, providers, insurers, businesses and labor—will remain caught in a toxic downward spiral that feeds on itself and serves no one. Providers struggle because, in many cases, the reimbursement they receive does not cover the cost of the care they provide. Payers—including individual Oregonians, the state government and Oregon employers—are increasingly *unable to afford* the cost of care being provided.

When reimbursement to providers fails to cover the cost of the care they provide, the difference is shifted to employers through higher premiums. Employers either stop offering coverage altogether or shift the cost back to their employees by increasing copayments and deductibles. The result is that a growing number of Oregon consumers cannot afford their medical care which, in turn, increases the burden of uncompensated or undercompensated care on providers. Providers then shift the cost back to employers, perpetuating this vicious cycle.

We recognize that there is no one, single factor driving the growing crisis in cost, access and economic sustainability. On the contrary, multiple factors must be addressed in a balanced strategy. Therefore, these Recommendations are organized around the seven issue areas we have identified as major drivers of medical cost inflation:

1. The Lack of a Strong Primary Care Infrastructure
2. A Fragmented & Ineffective Behavioral Health System
3. The Cost of Administrative, Regulatory and Reporting Overhead
4. The Delivery System and Payment Model
5. Labor and Workforce
6. The Cost of Prescription Drugs
7. The Lack of Primary Prevention

The first two areas—Primary Care and Behavioral Health—have their own separate set of recommendations (summarized in this document) because they are so foundational to reaching our long-term 2033 Policy Vision. These recommendations are being developed by two groups of subject experts and will be brought forward alongside of the recommendations from the HSSG.

While the full Primary Care and Behavioral Health recommendations are not included in this document, the HSSG endorses the goals of that work and looks forward to engaging with primary care and behavioral health providers as part of a holistic effort to

transform Oregon's health care system into one that is more affordable, sustainable and financially stable.

There is also a section addressing the relationship between Oregon's business climate and our heavy reliance on public payers (Medicaid and Medicare) rather than commercial payers. While this "payer mix" is not a cost driver per se, it drives much of the cost shift reflected in the steadily increasing employer premiums. For these reasons, Oregon's business community should be engaged as a full partner in this important work.

Finally, there is a section on the contribution that labor/workforce makes to healthcare cost inflation, that should be considered as part of a balanced solution. In this section we are recommending the establishment of a new table to foster productive conversations between labor and healthcare management, as we seek a shared path forward.

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Creating a New Table for Labor and Management
Use the convening power of the Governor, to create a new table to foster productive conversations between labor and healthcare management, as we seek a shared path forward to address/resolve the deepening crisis in healthcare cost, access and system sustainability.

Establish Criteria for Evaluating 2027 Health Policy Legislative Proposals
To ensure that they do not add complexity and cost to the system, at a time when we are trying to move in the opposite direction.

Administrative, Regulatory and Reporting Relief

1. Adopt principles for assessing and implementing regulation, data collection and reporting requirements.

2. CCO Specific Recommendations

3. Issues that Require Executive and/or Legislative Action
   - Cost Growth Target Program
   - Hospital Staffing Law
   - Health Care Market Oversight (HCMO) Program

   Use the convening power of the Governor, to bring together the affected parties, to gain clarity and consensus about: (1) the policy goals we are seeking as a state, (2) whether the way these laws are being interpreted and implemented is moving us toward those policy goals, and (3) what modifications need to be made.

Delivery System and Payment Model

1. Reducing Clinical Variation
   Introduce legislation to establish an independent public-private collaborative to identify and review certain high-variation or high-utilization health care services and adopt best practice guidelines, and an independent credentialing body.

2. Stabilizing the Individual and Small Group Markets
   Direct the Division of Financial Regulation (DFR), within the Department of Consumer and Business Services, to cost out a program to introduce a uniform fee schedule to the Individual Market, with an enhanced level of reinsurance, for both plans and providers, to offset a portion of this risk.

Healthcare and the Oregon Economy

The stability of Oregon's healthcare system, and the health of the larger economy of which it is a part, are inextricably linked, their fates intertwined. The healthcare sector is one of the state's largest employers, and in many rural regions and communities, it is the single largest employer. It contributes over $38 billion each year to Oregon's economy. And since 2020, the healthcare sector has propped up the state's economy, by adding jobs that offset losses in other industries.

Today, however, the relentless increase in the total cost of care threatens not only the stability of the healthcare system itself, but also of the larger Oregon economy of which it is an important part. As we pointed out in the Executive Summary, there are multiple factors driving medical inflation, all of which must be addressed in a balanced strategy.

That means this crisis can only be solved by working together. It cannot be effectively addressed as long as individual stakeholders are operating in their respective silos. It will require engagement and compromise from everyone—payers, providers, labor, businesses and health care consumers.

The Commercial Market and the Stability of Oregon's Healthcare System
There is a strong, positive and reciprocal correlation between the health of Oregon's economy and the size of its commercial health insurance market. Economic growth typically expands commercial insurance enrollment, while a robust insurance industry directly injects capital, wages, and local tax revenues into the state economy.

The size of the commercial market is important for supporting a positive "payer mix" — the percent, or "mix" of a healthcare provider's patient revenue or volume originating from commercial insurers, government programs (Medicare and Medicaid), and self-paying patients (those who are uninsured or underinsured).

Public programs, like the Oregon Health Plan and Medicare, systematically underpay providers for the care they provide. The state's healthcare system relies heavily on the commercially insured population to make up this financial difference. In essence, the underpayment in public programs is shifted to commercial payers through increased premiums.

In other words, the commercially insured population subsidizes Medicaid, Medicare and the rest of the state's healthcare system. And because the majority of commercial insurance is employer-sponsored, states with strong GDPs, low unemployment rates, and high business concentrations have larger commercial markets.

Roughly 48 percent of Oregonians have commercial health insurance coverage, which puts us in the middle of the pack (25th) among states (average = 48.6 percent). But Medicaid enrollment, at 33 percent, is far above the national average of 21.7 percent. This negatively impacts our payer mix, increasing the burden on commercial payers to subsidize the difference.

The point is that the health of the economy is reflected in the unemployment rate, and the unemployment rate is reflected in the size of the Medicaid population. The HSSG recognizes this dynamic and therefore supports the Governor's Prosperity Roadmap: a multi-year economic plan designed to reverse sluggish job growth, boost state GDP, and restore Oregon's competitive edge for business investment and job creation.

Large employers (firms with over 500 workers) play a vital and outsized role in Oregon's economy, generating about 36% of the state's new jobs. These firms are most likely to provide good, employer sponsored-health insurance coverage, thus improving the overall payer mix. Over the past decade, however, Oregon's, economic growth has leaned heavily on the small and medium-sized employer (SME) sector which accounted for roughly 64% of all new private-sector jobs.

Roughly 90% of all businesses in Oregon employ fewer than 20 workers, and 96% employ fewer than 50 workers. These businesses have traditionally obtained health insurance coverage through the Small Group Market. Oregon has also experienced a recent boom in non-employer business (solo entrepreneurs), who have relied on the Individual (non-group) Market for obtaining health insurance.

The Cost of Healthcare and the Stability of Oregon's Commercial Market
While the stability of Oregon's healthcare system depends on a healthy economy, rising cost of healthcare is, ironically, undermining the stability of the very commercial market on which it depends.

The escalating cost of healthcare is becoming a significant burden for large employers in Oregon—those most likely to offer commercial coverage. The cost of health benefits has reached record highs—averaging $24,688 for family coverage and $8,400 for individual workers. Employers are facing cumulative cost spikes and increasingly unsustainable budgets. While these cost increases are impacting all Oregon employers, they are particularly burdensome for Oregon's small and medium size companies. These businesses and entrepreneurial individuals rely largely on the individual and small group markets— which have seen the most significant rate increases.

These rising premiums are pricing individuals out of the commercial market, forcing them to look for cheaper, leaner plans or drop coverage altogether, which further shrinks the market size and places a heavier financial burden on the remaining enrollees. For small businesses, these costs cut into payroll budgets and can force layoffs which, in turn, reduce the state's corporate and personal income tax revenues, significantly impacting Oregon's bottom line.

In short, Oregon is caught in a vicious cycle, in which the escalating cost of healthcare leads to premium increases that drive healthier Oregonians to drop coverage. This forces those who remain to downgrade to cheaper, higher-deductible plans, which further degrades the risk pool and forces insurers to raise premiums again. Without some intervention, both the individual and small markets are on a path to collapse (see Stabilizing the Individual and Small Group Markets, pages 20-23).

It is crucial, therefore, that Oregon's business community be engaged as a full partner in a shared effort to transition our healthcare system into one that is not only financially stable and sustainable, but also affordable for businesses of all sizes, and for Oregon consumers.

Creating a New Table for Labor and Healthcare Management

As we noted in the Executive Summary, there are multiple factors driving the growing crisis in cost, access and economic sustainability. One of those factors is the cost of labor. For example, the cost of labor accounts for over 55% of most hospital operating budgets. At an academic institution like OHSU, it may be over 65%. The question, then, becomes: how do we reduce the hospital cost structure, in order to keep these institutions solvent, so they can continue to provide the care that Oregonians need, when over half of that cost is in payroll and benefits?

Answering that question is central to our success—and it cannot be answered in the abstract, but only within the context of the central importance of the role our healthcare workforce plays in providing access to the quality care that Oregonians need and deserve. It is also important to remember that only four years ago, in the depth of the pandemic, this workforce shouldered the stress and the human tragedy of COVID-19, risking their lives, working for hours and days at a time, often lacking adequate protective equipment, as well as oxygen and other vital supplies, to save lives and keeping the rest of us safe.

These workers deserve to be paid, and to be paid well. That is not the question. The question is simply this: how do we make the difficult transition to a system that is more affordable and sustainable without having an honest conversation about all the factors contributing to healthcare cost inflation.

Today, for example, many of our hospitals are financially unsustainable, with some 50% operating at a loss on any given day. And without the ability to shift some of their operating cost to employers through premium increases, few of our hospitals could survive today. Together, Oregon hospitals directly employ nearly 70,000 people and indirectly support another 90,000 indirect and induced jobs through local purchasing, construction, and supply chain effects.

The question is, how do we create a space to have a constructive conversation around what is essentially a math problem: many of our hospitals cannot sustain their operating budgets, and nearly 60% of those budgets go labor costs. The reality is that conversations about the cost of labor cannot take place in a vacuum, or only across the

bargaining table. These conversations must be part of addressing the larger shared challenge of maintaining the integrity of our delivery system, while we make the structural changes necessary to reduce the total cost of care over time.

We recognize that there will always be tension within the collective bargaining process. Right now, however, the relationship between labor and healthcare management is largely confrontational—which is getting in the way of the larger conversation that must take place around our respective roles and shared responsibilities to put Oregon's healthcare system on a more affordable and sustainable trajectory. All of us will be impacted if our system fails and averting that outcome can only be achieved by doing it together.

The question is, how do we move beyond that and create a different kind of table.

RECOMMENDATION to the Governor

Use the convening power of your office to create a new table to foster productive conversations between labor and healthcare management, as we seek a shared path forward to address/resolve the deepening crisis in healthcare cost, access and system sustainability.

This might be modeled after the 1990 Oregon Management Labor Advisory Committee to resolve issues regarding the state's workers' compensation system, or other models that shift the focus of the conversation from "position-based" to "interest-based" approach.

Detail of Recommendations to the Governor

Recommendation on Maintaining Focus in the 2027 Session

Problem Statement
As we approach the 2027-2029 biennium, the healthcare sector is facing significant headwinds, many of which are beyond our immediate control. Changes such as federal cuts from HR1, destabilization of the individual exchange market and changes in the provider / payor landscape in the state. The path forward requires discipline in prioritization. We cannot advance policies in 2027 that introduce new financial or operational pressure on the healthcare system unless they directly address root causes of healthcare cost inflation, not just symptoms.

Solution framework
To move forward, any proposal should meet at least one of the following criteria:

1. Measurably improve Medicaid funding adequacy and patient access. *If a proposal does not strengthen Medicaid viability, it risks exacerbating system instability.*

2. Preserve or improve affordability and network access for individuals on the individual or small group markets. *Maintaining a stable, competitive market with strong provider networks and points of access is essential to coverage continuity.*

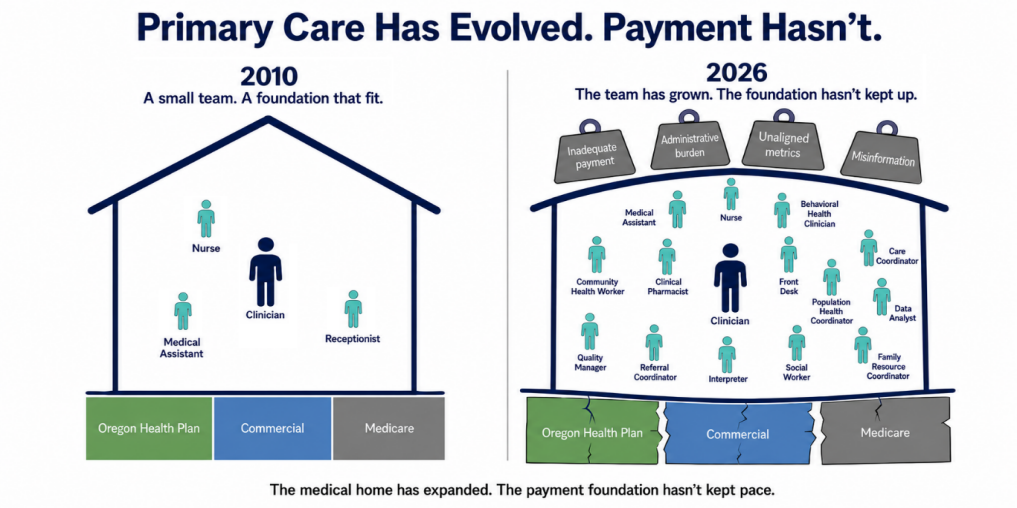
3. Demonstrably reduce overhead or administrative burden, and redirect resources to patient care. *Policies should simplify, streamline, or eliminate costs that do not directly support patient care, outcomes, or access.*

RECOMMENDATION to the Governor
Adopt recommendations to ensure that 2027 healthcare legislation is focused on addressing the root causes of healthcare cost inflation and lack of access does not add cost and/or administrative complexity.

Primary Care

The HSSG recognizes that primary care serves as the foundational pillar of a high-performing healthcare system. By prioritizing preventive medicine, chronic disease management, and care coordination, primary care providers lower overall healthcare costs, reduce preventable emergency room visits, and improve population health and life expectancy. Primary care providers also act as the frontline for mental health, screening for depression, anxiety, and substance use during routine visits, which prevents these conditions from escalating into more serious health issues.

Since 2009, Oregon has embraced the Patient-Centered Primary Care Home (PCPCH) model, which replaces fragmented care with a centralized, physician-led care team. Today, over 600 PCPCH clinics **serve more than** 3 million Oregonians across 35 counties.



As we approach the fiscal crisis precipitated by the passage of HR 1, however, the foundation of Oregon's primary care system has been compromised by a number of interacting structural failures, including an outdated and inadequate reimbursement model, administrative waste and unaligned quality metrics—compounded by a workforce collapse.

Multiple efforts are underway to revitalize and reinvest in Oregon's primary care infrastructure – including those led by the Oregon Academy Family Physicians and the Oregon Health Policy Board. The HSSG endorses the goal of this work and looks forward to working with primary care providers as part of a holistic effort to transform Oregon's heath care system into one that is more affordable, sustainable and financially stable.

The HSSG endorses the goals of this work and looks forward to working with behavioral health providers as part of a holistic effort to transform Oregon's heath care system into one that is more affordable, sustainable and financially stable.

Administrative and Regulatory Relief

The HSSG recognizes the importance of accountability and transparency, and the role that regulation and reporting play. At the same time, we believe that the steady increase in prescriptive rules, new reports, and changing requirements has added a substantial administrative burden that diverts resources away from direct patient care. At a time, when our health care system is under enormous fiscal stress—and the ability of tens of thousands of Oregonians to access needed care is at risk—it is important we take steps to minimize unnecessary and/or redundant administrative burden.

These recommendations are broken into three categories: (1) Principles for assessing/implementing regulation, data collection and reporting requirements; (2) CCO-specific actions, and (3) Issues requiring legislative modification

Principles for assessing and implementing regulation, data collection and reporting requirements

RECOMMENDATIONS to the Governor

1. Treat providers and payers as having value in the process.
   Payers and providers want (and deserve) to be full partners with OHA and your administration in defining the problem we are trying to solve, and the steps we must take to address it. Providers and payers can bring to the table a deep understanding of healthcare finance and delivery that should inform the discussion and help avoid untoward consequences.

   We understand the important regulatory role that OHA plays in protecting patients and communities. At the same time, payers and providers have an important role as well. Treating them as respected partners can significantly improve not only the relationship with the agency, but also the outcomes for patients and communities. Providers and payers should be invited to the table and participate in all discussions that affect them, and their patients or members. Partnership does not mean we will always agree, but it does require a commitment to mutual respect and listening.

2. Be clear about the problem we are trying to address.
   Clearly identify the desired outcomes of a regulatory or data collection/reporting process in terms of patient care and patient access to care. What is the problem the regulation or data collection/reporting is trying to address? How will it improve patient care or experience?

3. Focus on desired outcomes, not process.
   OHA does not have full visibility into the systems, workflows, and technologies used by providers and payers. As a result, prescriptive requirements can lead to duplication, inefficiencies, or the creation of parallel systems. Rather than building new or competing structures, the state should consistently leverage and maximize existing provider and payer systems to achieve shared goals more effectively and efficiently.

4. Implementation impact assessment
   Establish a realistic implementation impact assessment review before adopting a new regulation or data collection/reporting requirement. Often the regulatory and administrative environment has costs, that are not considered in parallel efforts, like the Cost Growth Target Program (see pages 14-15). Rather than doubling down on requirements that are not working as intended, there should be an expectation of continuous improvement — creating space to reassess, refine, and adjust policies based on real-world experience and impact.

5. Consider cumulative impacts
   Consider the *cumulative impact* of requirements on regulated entities. Programs and regulations should be considered within an ecosystem, rather than from the narrower, siloed perspective of the divisions that promulgate them.

CCO Specific Actions

We understand that Medicaid is not technically in our "lane," and are respectful that your Medicaid Advisory Group is developing long-term recommendations for this program, as Oregon confronts the significant policy and fiscal impacts of recent federal legislation. At the same time, the Medicaid Program has a huge impact on both the stability of the commercial market and the cost ultimately paid by employers and employees. Since our central charge is to look at system sustainability and total cost of care, we offer these recommendations as actions that could slow the cost shift to the commercial market by stabilizing CCOs for the remainder of the biennium.

RECOMMENDATIONS to the Governor

Carried Over from our February 2026 Recommendations

- Continue evidence-based prioritization and "right-size" the benefit to align with the resources available.
- Define the "core function" and "core population" for our Medicaid Program.
- Consider designing different benefits for different populations.

High Priority

1. Return to CMS expectations for intensive care coordination and allow CCOs to manage membership using patient-centered risk stratification models.
   Current requirements impose one-size-fits-all processes, such as care plans for all Long-Term Services and Supports (LTSS) members, twice-monthly interdisciplinary team meetings for LTSS, and health risk assessments following changes in health status. These requirements consume approximately 400 staff hours annually and force CCOs to focus on compliance processes rather than individualized member needs.

2. Eliminate or streamline reports; slow the pace of new benefits and programs.
   A. *Eliminate several reports that are not federally required.* These include the CAC demographic report, facility-level PCPCH assignment report, lien templates, grievance and appeal notice templates, NEMT call center script, TQS report, IIBHT referrals and enrollment report, language access and interpreter services report, THW annual report, and the HIT roadmap. These deliverables require approximately 442 staff hours annually, not including time spent by providers compiling supporting data.

   B. *Streamline the grievance and appeal reporting template.* Frequent revisions to the template and limited compatibility with existing systems require extensive manual configuration and review. CCOs currently spend about 150 staff hours annually managing these reporting changes and responding to error logs.

   C. *Remove protected health information from public reporting requirements where it ultimately must be redacted before publication.* Eliminating this requirement could reduce approximately 80 staff hours annually spent redacting data and responding to follow-up questions.

   D. *Reduce the frequency of new benefits and new regulations*. OHA's requirements on CCOs evolve almost monthly with new deliverables, policies, and operational adjustments. This dynamic environment requires roughly 340 staff hours annually for policy development, meeting participation, partner communication, provider relations, and claims configuration changes.

3. Eliminate the SHARE program**.** SHARE is not required by law and creates a duplicative layer of planning, reporting, and fund distribution. Oregon should instead focus on the CMS-aligned Flexible Services process (formerly HRS). SHARE requires approximately 180 staff hours annually for tasks such as developing grant RFPs, reviewing proposals, coordinating governance approvals, distributing funds, and completing additional financial reporting. It also carries roughly $4,000 annually in software costs, in addition to variable financial contributions tied to underwriting cycles.

4. Discontinue the requirement that CCOs participate in the National Association of Insurance Commissioners (NAIC) reporting framework. NAIC standards were

developed for commercial insurers and are not required for Medicaid programs. Compliance requires approximately one full-time staff position (2,000 hours annually) as well as roughly $67,000 per year in certification, platform, consulting, audit, and actuarial costs, many of which duplicate existing Medicaid audit requirements.

Medium Priority:

1. Eliminate the long-term requirement for National Committee for Quality Assurance (NCQA) accreditation. OHA has indicated that CCOs may be required to achieve or make meaningful progress toward NCQA accreditation by December 31, 2027. Even repeated one-year delays still require organizations to continue planning and budgeting. Preparing for accreditation requires approximately 200 staff hours and roughly $20,000 in certification costs, without clear evidence that it adds value beyond existing Medicaid oversight mechanisms.

2. Make permanent the current allowance for electronic distribution of member handbooks and NEMT rider guides, with hard copies provided upon request**.** Continuing this policy would avoid roughly $330,000 annually in printing and postage costs.

3. Eliminate THW network standards and workforce development mandates that lack a dedicated funding source. These requirements require around 20 staff hours annually for reporting and payment grid development, while also requiring approximately $80,000 per year in workforce grants and communications spending—all without a stable Medicaid funding stream.

Issues that Require Executive and/or Legislative Action

The HSSG recognizes that the three issues below are controversial. We want to emphasize that our concerns are not with the fundamental policy objectives themselves, but rather with the way we are seeking to achieve them. We are asking that you use the convening authority of your office to bring together the affected parties, to gain clarity and consensus about: (1) the policy goals we are seeking as a state, (2) whether the way these laws are being interpreted and implemented is moving us toward those policy goals, and (3) what modifications need to be made.

Below we have outlined what we believe the policy objectives of these laws were intended to be, and how the ways in which they are being interpreted and implemented, is undermining our ability as a state to achieve those objectives. We have also included some of the initial steps we believe should be taken. We look forward to working with you and the other affected parties to find a path forward to achieve these important goals.

Cost Growth Target

Policy Goal

The primary policy goal of the Sustainable Health Care Cost Growth Program is to make health care affordable and sustainable for all Oregonians by limiting annual spending increases to an economically defensible percentage.

The HSSG supports the goal of a realistic cost growth target that promotes affordability and sustainability. What is more important, however, is to address the multiple factors driving health care cost inflation in the first place—some of which are beyond the control of providers and payers (see Executive Summary, page 1). As a general principle, the HSSG believes that the healthcare system should be held accountable for costs it can control, but not for costs attributable to "external" factors that it cannot control. The issue is not the goal of affordability – it is that the program does not accurately measure cost, does not assign accountability appropriately, and does not provide the transparency needed to improve performance.

Problems with the Current Cost Growth Target (CGT) Program

1. Context
   The 3.4% per-member-per-year cost growth target, agreed to in 2012 as part of the Section 1115 waiver, which allowed Oregon to implement its CCO model, was never intended to be a fixed rate for the future. The state agreed to reduce the Medicaid trend rate by two percentage points by the second year of the waiver. In 2012, the trend rate was 5.4% per member per year. Oregon's commitment was to reduce the trend by two percentage points to 3.4%. It is important to recognize that Oregon did not agree to a fixed 3.4% growth rate over time, but rather to a growth rate that was at least 2% below the medical trend.

2. CGT does not account for external cost drivers
   The cost growth cap does not accurately account for external economic realities, such as generalized inflation, high prescription drug costs, and necessary wage increases for frontline healthcare workers.

3. Persistent CGT breaches
   It should not be surprising then, that with the exception of 2020 during the COVID-19 pandemic, healthcare spending in Oregon has consistently exceeded the 3.4% target.

4. Complexity in targeting drivers
   State reviews show that entities frequently exceed the target for acceptable reasons—such as increased Medicaid utilization or expanding services to meet community needs—making it difficult to penalize actual "waste."

5. The current program is punitive, rather than collaborative
   While the HSSG recognizes the need for the ability to enforce compliance with a realistic cost growth target, the current program is designed to impose penalties for failing to control costs, even when some of the significant cost drivers of medical inflation are outside the direct control of the healthcare system itself.

This is punitive and undermines the program's intended goal. It is like saying "the flogging will continue until morale improves." We can do better.

RECOMMENDATIONS to the Governor

1. Suspend the Sustainable Health Care Cost Growth Program until January 2029 to allow time for program redesign and alignment with broader system transformation efforts.

2. Direct OHA to improve cost measurement and transparency. Align cost measurement with actual reimbursement and total cost of care, rather than billed charges or incomplete proxies. Provide providers and payers with timely access to the underlying data, attribution methods, and calculation methodologies used to assess performance.

Hospital Staffing Law

Policy Goal

The primary goal of the hospital staffing law (HB 2697) was to ensure minimum RN-to-patient ratios. The HSSG supports appropriate hospital staffing to ensure high-quality care and patient safety.

Problems with the Hospital Staffing Law

1. How the law is being interpreted
   The central problem with the staffing law is not with the ratios established by HB 2697, but misalignment between legislative intent and how the law has been implemented by the OHA.

2. Staffing ratios versus "staffing plans'
   The staffing ratios have been replaced with mandated "staffing plans" that all parties must approve. That is, any party can reject the plan, but only the hospitals pay fines for not having a staffing plan in place.

3. How fines are being assessed
   Fines are assessed even when a hospital is in compliance with statutory staffing ratios, Asante, for example, has accrued $950,000 in fines under HB 2697, but only 3% have been for violating staffing ratios. The balance has been for not having an approved "staffing plan" in place.

4. Investigations and timelines
   The current investigative process does not consistently adhere to statutory timelines established in ORS 441.791, resulting in prolonged investigations and duplicative review of similar complaints. The absence of timely resolution creates unnecessary administrative burden, extends uncertainty for hospitals, and exposes providers to ongoing liability without clear closure.

5. Administrative burden and inefficiency
   The cumulative impact of staffing plan requirements, investigations, and documentation obligations diverts significant time and resources away from patient care operations and toward compliance activities, without improving patient outcomes.

RECOMMENDATIONS to the Governor

1. Issue an interpretive directive to OHA, that hospitals operating at or above the statutory minimum staffing ratio are not in violation solely for lacking an approved staffing plan.

2. Direct OHA to streamline investigations using its existing authority, including batching similar complaints and meeting ORS 441.791 timelines. Focus enforcement on substantive staffing compliance, not process violations. Limit documentation to statutory requirements and simplify submissions.

HCMO

Policy Goal

The HSSG agrees with the overarching goal of HCMO: to prevent the unchecked consolidation of hospitals, clinics and insurers that: (1) reduces competition, (2) drives up cost, (3) limits access to essential services, or (4) undermines independent practices.

Problems with HCMO

1. Unpredictable, tolling and delays.
   The open-ended review/process to decide whether to approve/deny an application, creates unpredictable and prolonged review timeline, undermines the Legislature's intent to provide timely, 180-day decision-making, and introducing significant uncertainty for transactions.

2. The lack of an expedited review for financially distressed entities, to prevent regulatory delay that might turn a recoverable crisis into a closure.
   There is a lack of recognition that the status quo is not an option for many organizations. Discouraging beneficial transactions, partnerships and investments that could preserve or expand access to care, particularly in fragile environments means Oregonians will continue to lose access.

3. The need to clarify and codify in statute, the criteria on which an approval or denial of an application will be based, and what evidence must be weighed to arrive at that decision. (The current standard "contrary to public interest," is overly vague).

4. The lack of a "safe harbor" for independent practice affiliations with non-dominant entities (less than 20% market share).

5. The cost of compliance
   The HCMO process imposes significant transaction and compliance costs, including legal, consulting, and administrative expenses, which ultimately increase health care costs system-wide and deter necessary restructuring and partnerships. Even before the process begins there is significant cost and uncertainty, as entities must expend resources to determine whether a transaction is subject to HCMO oversight.

RECOMMENDATIONS to the Governor

1. Establish 120-day maximum review timeline with automatic approval if OHA fails to act — providing transaction certainty that the open-ended review currently denies.

2. Create a 45-day expedited review track for financially distressed entities (two consecutive quarters of negative margin or imminent payroll risk) — preventing regulatory delay from turning a recoverable crisis into a closure.

3. Limit application requirements by allowing review to begin with preliminary agreements, or term sheets, limiting submissions to information needed to evaluate statutory criteria, avoid duplicative documentation, and clearly define expectations, required materials, and timelines at the outset.

4. Create a safe harbor for independent practice affiliations with non-dominant entities.

Delivery System and Payment Model

Reducing Clinical Variation

Improving Quality and Patient Safety
Reducing Cost and Payer-Provider Friction

The existence of unwarranted variation in care within and across provider systems is broadly accepted, informed by published research, observations of healthcare systems and payers, and the personal experience of clinicians.

In 2017, for example, HealthInsight (now Comagine Health) was part of the Network for Regional Healthcare Improvement (NRHI), that analyzed cost and utilization across five similar regional commercial markets (Oregon, Utah, Maryland, St. Louis and

Minnesota) and aggregated data from seven Oregon health plans, which include one-third of commercially insured Oregonians.

The 2017 report showed that Oregon's health care utilization was lower than in the other regions, but our average prices were the highest (17% above the regional average). The Oregon-specific data in the report came from 143 primary care clinics from across the state. The only prerequisite for being included in the study was to have a minimum of 600 commercially insured patients. The report documented wide variation in cost and quality across the state. [1]

HealthInsight did a preliminary analysis of the Oregon data from the NRHI study which suggested that moving all clinics toward the average of the top 25% of the clinics, in terms of high quality and low cost, could result in an 11% annual savings—upwards of $2 billion across public (Medicaid and Medicare) and private commercial payers.

Obviously bending down the total cost of care (TCOC) growth curve cannot happen overnight, but we have demonstrated with our CCOs (especially during the first 5-year waiver period) that, given a glide path and a clear target, it can be done without sacrificing enrollment, quality or outcomes.

Reducing unwanted clinical variation is not just a cost issue, it is also an issue of quality and patient safety. Furthermore, it creates friction and unnecessary, costly administrative complexity between payers and providers.

Recognizing that all healthcare interventions have some degree of risk, reducing unwarranted care is a unique opportunity to reduce harm, improve patient and clinician experience, and reduce cost. The Health System Sustainability Group agrees that these challenges exist.

In the current healthcare environment, payers respond to unwarranted variation in care by implementing processes, generally consolidated under the broadly used term "prior authorization," in an attempt to minimize unwarranted care. Most of these efforts use policies and procedures developed through a review of the medical literature, consultation with clinical experts, and observations of medical trends gathered through analysis of billed services. These policies and procedures are used to determine if a service is covered according to the terms of member and provider contracts with the payer.

As most payers independently develop these policies and procedures, clinical organizations trying to comply with the requirements of such are faced with a complex patchwork of policies that vary in their methodology and criteria. The resulting complexity not only creates friction between payers and providers, but increases both the cost and the difficulty of developing standards at the point of care that would consistently comply with coverage rules.

[1] We have commissioned Comagine Health to update these data for calendar years 2024-2025

Fortunately, for many common clinical activities that demonstrate variation in application, clinical standards have been developed by specialty experts, broad stakeholder groups, and/or government agencies. Achieving broad community adoption of clinical standards can enable transformation.

Specifically, the adoption of clinical standards at the point of care with effective governance practices that monitor adherence to standards, provide feedback to clinicians, and enable continuous improvement, can help substantially reduce unwarranted variation, reducing risk, improving safety, and reducing healthcare costs.

Additionally, adoption with effective implementation and maintenance of governance practices could eliminate the need for payers to conduct prior authorization for those activities, reducing administrative burden, administrative cost, and friction between healthcare systems and payers.

Observing experiences in other communities (e.g. the Washington State Bree Collaborative) the Health System Sustainability Group makes this recommendation

RECOMMENDATIONS to the Governor

1. Legislation to establish an independent public-private collaborative to identify and review certain high-variation or high-utilization health care services[2] and adopt best practice guidelines related to those services and strategies to promote the use of those guidelines.

2. Legislation to establish an independent credentialing body that:
    a. Certifies if health systems, medical clinics and practices have adopted clinical standards at the point of care with effective governance practices that monitor adherence to standards, provide feedback to clinicians, and enable continuous improvement.

    b. Conducts independent reviews of the statewide effectiveness of the adoption and impact of clinical standards, makes such reviews publicly available, and makes recommendations for improvements that would further reduce unwarranted variation in care.

3. Prior authorization, on a procedure-specific basis, will not be required for health systems, medical clinics and practices that have adopted the best practice standards described in 2(a) above.

[2] **Examples of some high-variation or high-utilization health care services**

Bariatric surgery
Elective knee replacement
Elective hip replacement
Elective endoscopic procedures
Elective coronary artery bypass graft
Evidence-based cancer screening and treatment
Elective coronary artery bypass graft
Elective diagnostic cardiac catheterization
Elective advanced imaging procedures
Lumbar fusion
Elective advanced imaging procedures

4. Recertification will be required every [to be determined] years, to ensure continued compliance with best evidence.

Stabilizing the Individual and Small Group Markets

Individual Market

The escalating cost of medical care is creating a growing barrier to access for hundreds of thousands of Oregonians. Among the most vulnerable are those who earn more than 138% of the federal poverty level—and are therefore ineligible for Medicaid—but are not offered health insurance through their employer. For these Oregonians, the individual market is their only option.

Unlike nearly every other major health care program that receives substantial public subsidy—including Medicare, Medicaid, the VA, CHIP, and TRICARE—the ACA individual market operates with no uniform fee schedule. Rates are negotiated annually between insurers and providers and have risen steadily, with gross premiums growing 26% since 2020.

Oregon's Bridge Program, established in July 2024, extended relief to residents with incomes between 138% and 200% of the federal poverty level—individuals who would otherwise be enrolled in the ACA individual market. Roughly 34,000 people are now enrolled in the Bridge Program, giving them access to the full Oregon Health Plan benefit with no cost sharing.

While the Bridge Program has meaningfully helped Oregonians, who meet its income requirements, it has also contributed to the deterioration of the individual market for those earning between 200% and 400% of the federal poverty level. The program both shrank the individual market by 34,000 people and, because many of those who left were relatively healthy, raised the average risk of those who remained.

While the gross premiums in this market have grown 26% since 2020, net out-of-pocket payments for consumers have grown 58%, as many enrollees have downgraded to cheaper, higher-deductible plans to manage cost. The scheduled expiration of the enhanced premium tax credits will add an estimated $127 to $456 per month in additional cost. Middle-income earners ($50,000–$75,000) are disproportionately affected, since they shoulder a larger share of these costs without government assistance.

In Oregon, roughly 15% of ACA individual market enrollees—about 21,600 people—have already dropped coverage because of cost. These departures skew toward healthier individuals, leaving a sicker remaining risk pool and pushing insurers to raise premiums further. The result of this vicious cycle is more uncompensated and undercompensated care, costs that are ultimately shifted back to employers through higher premiums.

Small Group Market

Oregon employers with fewer than 50 employees are not required under the ACA to offer health insurance coverage. 96% of Oregon's businesses fall into this category. Health insurance, however, is important to attract and maintain a good workforce, and these small employers have traditionally purchased coverage through the small group market.

The problem is that the Oregon small group market, which has been shrinking for several years, faces the same challenge as the individual market: risk concentration. As premium costs continue to increase, healthier groups seek more affordable options (e.g. level funding, self-funding, ICHRA, etc.). This not only shrinks the size of the risk pool, but those who remain are sicker, which pushes insurers to raise premiums further.

This situation is difficult to manage in both of these markets, because there are mandatory benefits and proscribed rules around the actuarial value of each of the metallic levels for plans. In short, there is very little room to adjust the product and the benefit in order to attract a broader risk pool and stabilize these markets.

Given these constraints, the only path to sustainability depends on non-product/benefit solutions that increase the size and stability of the risk pool. The following proposal aims to stabilize these markets by breaking the vicious cycle: relentless premium increases drive out healthier members, which forces those who remain to downgrade to cheaper, higher-deductible plans, which further degrades the risk pool and forces insurers to raise premiums again.

Proposal

1. Manage cost growth in the market by establishing a fee schedule set at a [to be determined] percentage of Medicare—positioned between Medicaid and commercial rates.

2. Link the fee schedule to a realistic, [to be determined] cost growth target.
   Note: The fee schedule would not function as a hard rate cap. Instead, it would serve as the basis for calculating a "capitation" rate, derived from the fee schedule, the benefit plan design, and moderately well-managed utilization. Providers could earn more than the fee schedule by managing utilization effectively and reducing low-value care.

3. Because the risk pool has deteriorated so rapidly for the reasons described above, this approach will only work if there is an enhanced level of reinsurance in these markets — for both plans and providers— to offset a portion of this risk. Below are mechanisms that can improve affordability and reduce volatility of the insurance risk carriers face in both the individual and small group markets:

- State supported premium and cost share subsidies to fill the gap left by the sunsetting of federal enhanced subsidies.
- State funded augmentation to the risk adjustment transfer payment model to increase the level of risk adjustment funding to payers

- Enhancement of the state high-risk pool to broaden coverage

- Tighter regulation of the reinsurance markets to ensure carriers have affordable coverage for their uncontrollable/unmanageable insurance risk

The HSSG recognizes that most of these options will be difficult to implement given the state's budget challenges. Nonetheless, we feel that they are worth proposing because they address the *root cause* of the unsustainability of these markets. Furthermore—and notwithstanding the current budget constraints—we recommend that resources to fund some of these options be prioritized in your 2027-29 recommended budget.

We believe that without some form of intervention along these lines, the individual market will collapse – followed, shortly thereafter, by the small group market. Obviously, the individual market is the immediate priority.

As you know, the OHA has projected that around 200,000 Oregonians will lose Medicaid coverage due to the new work requirements. Unless we can do something to stabilize and manage cost in the individual market, they have nowhere to go. They will simply accelerate the uncompensated cost burden being shifted to the commercial market, driving and accelerating the vicious downward cycle in which our healthcare system is trapped.

RECOMMENDATIONS to the Governor

Direct the Division of Financial Regulation (DFR), within the Department of Consumer and Business Services, to:

1. Cost out a program built on these parameters.

2. Ensure that the initial fee schedule be set high enough to prevent a shock to the payer mix that inadvertently undermines provider and payer participation.

3. Modernize Oregon's fully insured premium tax by reducing the 2% assessment and making it more targeted, transparent and focused on affordability.[3]

4. If the resources can be found to offset a portion of the risk, consider implementing this in the Individual Market for the second year of the biennium.

[3] Oregon should reduce the fully insured health insurance premium assessment from 2.0% to 1.0% overtime, while preserving funding for reinsurance through a broader, more balanced financing model. The current tax is effectively built into premiums, which increases cost for employers and consumers who remain in fully insured coverage. Modernization should lower the burden on fully insured purchasers, improve transparency on how the funds are used, and avoid creating incentives for employers to move away from fully insured coverage (especially in the Small Group Markets) in part for tax reasons.

- If it is successful in stabilizing the Individual Market, consider extending a similar program to Oregon's Small Group Market in 2029.

The Importance of Primary Prevention

We know that among those factors that have the greatest impact on lifetime health status, our medical system is a relatively minor contributor. Far more important are things like healthy pregnancies, stable families and stable housing, nutritious food, safe communities, a good education and economic opportunity.

We also know, from the growing science of epigenetics, that poor nutrition and maternal stress–both before conception and during pregnancy–can alter the genetic expression in the unborn child, dramatically increasing the risk for poor cognitive functions, learning disabilities, emotional and behavioral health issues, including substance use disorder, *and the early adult onset of many chronic illnesses*, from diabetes to cardiovascular disease.

The same factors that cause epigenetic changes during pregnancy also put enormous stress on families, leading to a well-documented set of "adverse childhood experiences" or ACEs. These include emotional abuse and neglect, domestic violence, housing or food insecurity, a family member with a behavioral health or substance use disorder, or a parent who is absent.

This is important, because over 90% of health care spending goes toward managing chronic diseases, most of which are preventable or modifiable. In other words, the vast majority of what we treat in our practices, clinics and hospitals, are the medical consequences–the aftermath—of long-standing social and economic inequities that occur outside the healthcare system. The most toxic of these "social determinants of health is poverty—chronic economic insecurity—which, in this country is closely associated with race and, increasingly, with living in a rural community.

While not within the scope of these recommendations, the HSSG recognizes that any long-term and successful effort to reduce the total cost of care—and improve the health of the nation—must necessarily include a robust and intentional strategy to address the social determinants of health, especially in the earliest years of life.

Ongoing Conversations for Future Recommendations

Reducing Payer-Provider Friction & Cost

Interoperability

Continuing a conversation about how to accelerate the wide adoption of interoperability, as a way to dramatically simplify the business processes between payers and providers. This would include eligibility, benefits, determining cost shares at the point of care, filing claims, checking claim status, submitting and seeing the status of prior authorizations.

Developing the capacity for seamless communication around these high-volume activities can dramatically improve timelines, accuracy, and efficiency for most of the major administrative, clinical, and financial interactions between payers and providers.

The goal would be to identify the barriers that currently inhibit the widespread adoption of this kind of interoperability, and strategies to overcome them.

The Cost of Prescription Drugs

The high cost of prescription drugs is a significant and growing driver of medical cost inflation, impacting every aspect of our healthcare system — consumers, hospitals and employers.

Prescription drug costs directly affect patient access. High prices and out-of-pocket costs force millions of Americans to skip necessary medications, compromising treatment compliance and resulting in poorer health outcomes and higher hospitalization rates.

Hospitals are major purchasers of drugs for inpatient care. When the cost of specialty medicines and alternative therapies surges, it strains already narrow operating margins. Pharmacy spending is also the fastest-growing component of employer-sponsored healthcare. Increased drug costs strain corporate budgets, leading to higher insurance premiums, reduced productivity from employees skipping medications, and pressure on companies to pass costs onto workers.

We can do better.

We know that large group purchasing consortiums can effectively negotiate lower prescription drug prices. In Oregon—if we combine all those with employer-sponsored

coverage, coverage in the individual market and those on Medicare or Medicaid—the purchasing pool adds up to 4 million people. In Washington, the purchasing pool is 7.2 million lives, and in California the number is 40 million. A group purchasing pool between Oregon and Washington would encompass 11.7 million people. Adding California, would swell the pool to over 50 million lives.

The goal of this conversation would be to develop a strategy to move towards a multi-state public / private group purchasing consortium—perhaps using the West Coast Health Alliance as the vehicle.

This would necessarily involve a strategy to ensure the financial stability of hospitals, FQHCs and Coordinated Care Organizations during the transition period, given their current reliance on the complex and interrelated 340B and Medicaid Drug Rebate Programs.

Determining the True Cost of Care

Providers argue (with justification) that "the reimbursement we are getting does not cover the cost of the care we are providing." But what is the cost of the care being provided? Currently there is no clear answer.

If public payments are too low (and they are), we know that these uncompensated costs are shifted to private payers to offset low Medicare and Medicaid reimbursement. Logically, this means that what we are charging private payers is too high — because it covers not only the cost of the care being provided, but also the difference between the true cost of care and low public sector payment.

To put it another way:

- If the "Cost of Care Being Provided" is X
- And public sector payment is X – 10
- And if private sector payment in X + 10
- What is X?

The reality is that most provider systems cannot answer this question. Not because they are hiding it, but because their cost accounting system was never built to answer this question.

Hospital cost accounting, for example, is built around departmental budgets, charge masters, and Ratio of Cost to Charges (RCC) methodology. RCC takes total department cost and allocates it back to procedures using the charge as the divisor. The charge is set politically, not by activity. The resulting unit cost is therefore circular — it is whatever the charge says it is, scaled by a department average. When a system reports that reimbursement falls below cost, the operative question is: "how is cost calculated?"

A small number of systems have looked at other accounting methodologies that better calculate true cost. Time-Driven Activity-Based Costing (TDABC), for example, pioneered at Virginia Mason in Seattle, and later studied by Robert Kaplan and Michael Porter at Harvard Business School, builds unit cost from observed activity — clinician time, supplies, capital allocation by use, not by department average.

Where TDABC has been applied honestly, the result is consistent: true unit cost is materially lower than charged price. Furthermore, the variation between providers for identical procedures is far larger than reimbursement variation suggests. Intermountain, Geisinger, and the few academic medical centers that have published TDABC studies all point the same direction.

The goal of this conversation would be to explore how we might develop a strategy to build consensus on the true unit cost of the care being delivered in Oregon. This conversation would be informed by the fact that, while we can do a much better job of determining the true cost of care, there will still be variations from medical clinic to medical clinic and from hospital to hospital — due to a variety of local and regional factors from facility, labor, and energy cost, to volume and group purchasing.

This could be a game changer. For example, it would provide the data necessary to reset Medicaid and Medicare payment to cover the true cost of care. It would also move us beyond the embarrassment of a system that pays less to treat the elderly and those with low incomes than those with health insurance, for exactly the same things.

These Recommendation are Respectfully Submitted by,

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