
# How to Curb Health Care Spending

## BETTER ALIGN WHAT HOSPITALS CHARGE COMMERCIALLY INSURED PATIENTS WITH HOSPITALS' EXPENSES

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# Executive summary

**HEALTH CARE** and health insurance are expensive, imposing a financial burden on consumers, employers and taxpayers. The high cost of health care services provided by hospitals contributes to this financial burden.[1]

Bringing the amount paid to hospitals into closer alignment with their costs of caring for patients could help reduce commercial health insurance premiums and ease the burden of high health care costs on Oregonians.

Hospitals charge commercial payers far more than is needed to cover their expenses, with people who pay insurance premiums ultimately paying the price. Information on how much commercial insurance companies paid to Oregon hospitals in 2018 and 2019 reveals hospitals received amounts well above their "break-even amount" — the amount needed to cover the cost of providing care to commercially insured patients plus make up for any deficit from government health care programs, uncompensated care, expenses disallowed under Medicare cost rules (excluding physician direct patient care reimbursed under other methods), and other income and expenses.[2]

- In 2019, 51 out of 55 hospitals charged* commercial payers** more than what was needed to cover their expenses. At those hospitals, payments made for care delivered to commercially insured patients were a median of 60% higher than their break-even amount.[3] Payments in 2018 were comparable to those in 2019.† See Table ES-1.

**TABLE ES-1. MOST OREGON HOSPITALS CHARGED COMMERCIAL PAYERS FAR MORE THAN THEIR BREAK-EVEN AMOUNT[4]**

| | Hospitals with data available | Hospitals that received more from commercial payers than their break-even amount | Median above break-even amount paid by commercial payers |
|---|---|---|---|
| 2018 | 56 | 50 | 57% |
| 2019 | 55 | 51 | 60% |

* "Charged" in this report means the amount hospitals were actually paid, not the amount that hospitals listed on their official price lists, which are also known as chargemaster lists.

** Throughout this report, the term "commercial payers" includes all payers who make payments for care delivered to commercially insured patients. This includes payments from private insurers, from self-pay patients, group health plans, and from any other entity making payments on behalf of commercially insured patients.

† In this calculation of payments versus expenses, only hospital expense numbers change from 2018 to 2019. The RAND Corp. collected commercial payment data for 2018 through 2020 and aggregated it into a single three-year figure for each hospital.

Most hospitals that received commercial payments above their break-even amount earned an operating profit (defined as net patient revenue minus operating costs).

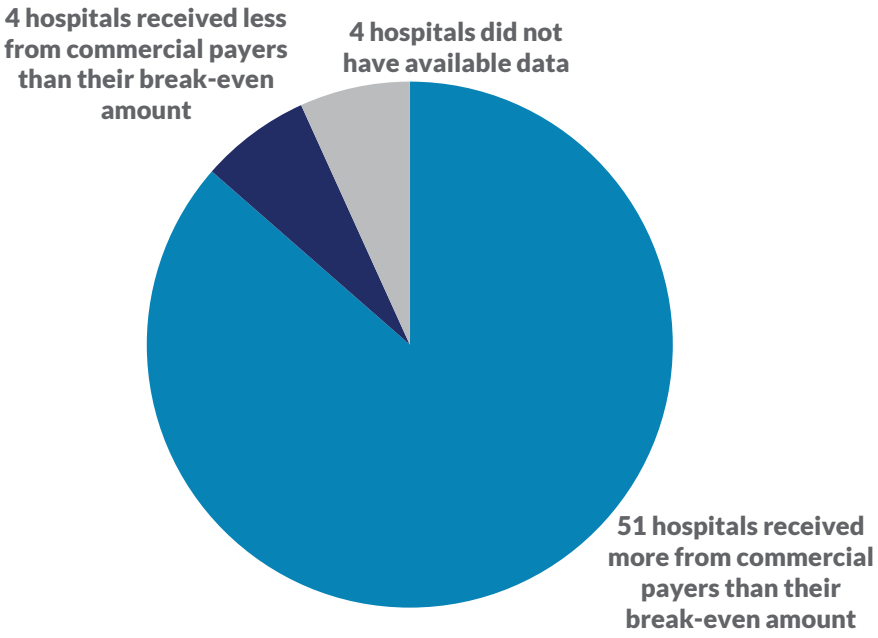
- In 2019, the 51 hospitals with commercial payments above their break-even amounts had a collective operating profit of $2.2 billion, with a median operating profit margin of 17%.[5]
- Several of the hospitals that received commercial payments above their break-even amounts are notable for their high operating profit margins. Adventist Health Portland had an operating profit margin of 34% in 2018 and 36% in 2019, while Willamette Valley Medical Center in McMinnville had an operating profit margin of 39% in 2018 and 34% in 2019.

The high amounts paid to hospitals contribute to the high price of commercial insurance — the insurance that people obtain through their employer or purchase directly for themselves.[6] The expense of commercial insurance is a major financial burden on these Oregonians.

- In 2019, 55% of Oregonians relied on commercial insurance.[7] Nearly 90% of those people obtained insurance through an employer, while the remainder purchased theirs directly, either through the state's Affordable Care Act marketplace or straight from an insurance company.
- Oregonians with employer-provided insurance paid an average of 10% of Oregon median income for premiums and deductibles in 2019.[8] This is in addition to the amount paid by their employer.

The price of health care has been rising faster than other consumer expenses and income. From 2013 to 2019 in Oregon, per-person health care costs grew by 45% in the commercial insurance market.[9] In contrast, per-person income grew 32% and average wages increased 22% in that period.[10]

**FIGURE ES-1.** IN 2019, MOST OREGON HOSPITALS RECEIVED MORE FROM COMMERCIAL PAYERS THAN THEY NEEDED TO COVER THEIR EXPENSES



Overall inflation in that same period increased 10%. (See Figure ES-2.)

If hospitals charged an amount closer to the cost of providing care, total health care spending could be lower. Lower spending could potentially enable a reduction in premiums for commercial insurance and decrease financial pressures on consumers, while still enabling hospitals to cover their costs.

- The Oregon Health Authority estimates that if commercial insurers paid for inpatient and outpatient procedures at 200% of the rate paid by Medicare, Oregonians could have saved $180 million on health care costs in 2019.[12]
- 200% of the Medicare rate is well above Oregon hospitals' median break-even amount: In 2019, hospitals' median break-even amount was 149% of the Medicare payment rate.[13]
- 200% of the Medicare rate is lower than the rates typically paid to Oregon hospitals by commercial payers: Median commercial payments at all hospitals were approximately 225% of the Medicare payment rate in 2018 through 2020.[14]

Oregon could reduce the price of commercial insurance for some patients by requiring private insurance companies to offer a state-designed health plan that meets spending reduction targets while still providing the same health coverage benefits of plans sold in the commercial marketplace.

- Colorado and Nevada both require insurers to offer plans that have lower premiums and robust coverage. Both states also include provisions to help insurers bring payments to hospitals into closer alignment with the cost of providing care to make premium reductions possible.

**FIGURE ES-2.** HEALTH CARE COSTS HAVE INCREASED FASTER THAN OTHER EXPENSES OR INCOME IN OREGON[11]

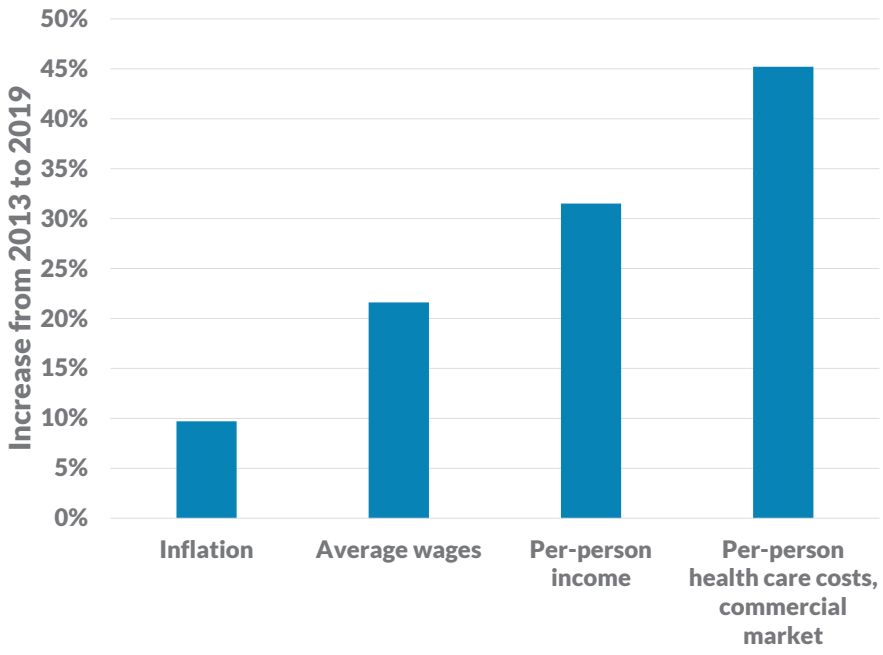
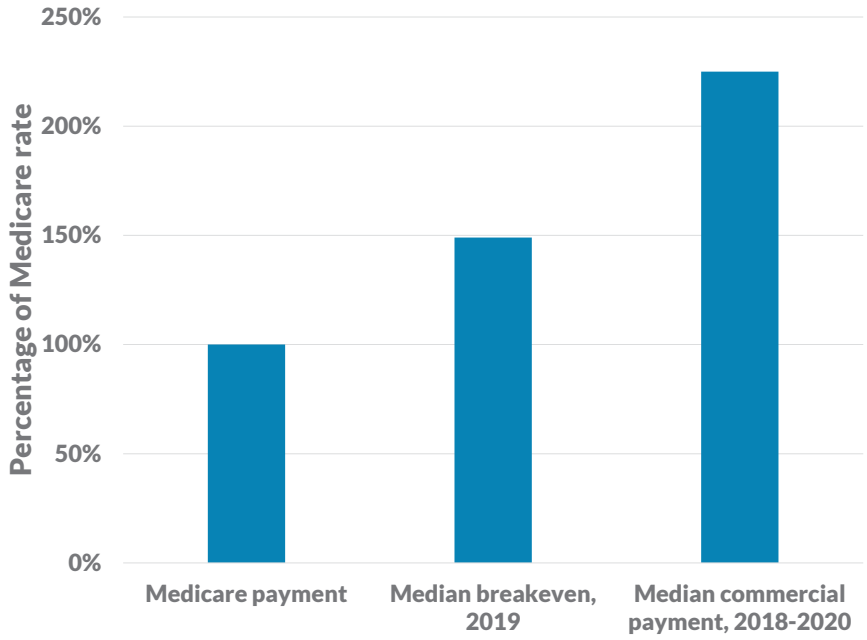


**FIGURE ES-3.** MEDIAN BREAK-EVEN AMOUNT AND COMMERCIAL PAYMENT RELATIVE TO MEDICARE PAYMENT RATE[15]




- Colorado has set a goal of reducing premiums by 15% by 2025, and Nevada has set a goal of at least a 15% reduction over four years.[16]
- Insurance plans with lower premiums than current plans and with broad provider participation could also help to drive down premiums for all commercial insurance plans.[17]

To begin to address the high price of commercial health insurance, Oregon should create a standardized plan to be offered by insurance carriers and/or coordinated care organizations (the networks of providers who serve patients through the Oregon Health Plan, Oregon's Medicaid program). For example, Oregon could expand the Bridge Plan that is already in development to serve patients who earn less than 200% of the federal poverty level but too much to qualify for Medicaid. The Bridge Plan, which will be offered by coordinated care organizations, will pay a lower rate to hospitals than the commercial plans that can be purchased by these patients.

To address high prices and improve the quality of health care in Oregon, the expanded Bridge Plan should be made available to people who earn more than 200% of the federal poverty level and to small businesses. The expanded plan should:

- Offer lower premiums than other commercial plans.
- Promote alternative payment models that can both lower costs and improve care. These models pay providers based on the quality of care provided rather than just on than the volume of care.
- Adhere to the state's cost growth target. Oregon's cost growth target of 3.4%, which applies to most health care payers and providers, is intended to limit how quickly health care prices rise.[18]
- Prioritize high-value services such as integrated primary care by, for example, readjusting payment schedules to pay primary care providers more.

# Introduction

**THE U.S. SPENDS** more on health care than other developed nations. In 2020, the U.S. spent nearly $12,000 per person on health care.[19] Our international peers, countries with similar incomes per person such as Australia, Canada, Austria and Germany, spent an average of $5,736 per person. Overall, the U.S. spent 18.8% of its economic output on health care, compared to 12% of gross domestic product (GDP) by our peer nations. Oregon is no exception — the amount we spend on health care aligns with U.S. national patterns.[20]

This high spending is not because we're receiving better care: U.S. health outcomes are no better than those of our peers. In 2020, life expectancy in the U.S. was 77 years versus an average of 82 in peer nations.[21] The death rate from treatment-preventable deaths is higher in the U.S. than in other countries. For example, our maternal mortality rate is four times higher than the average in peer nations. U.S. hospitals also perform worse than hospitals in many other countries on a number of safety measures, such as postoperative pulmonary embolisms.

Study after study has concluded that the driving factor behind high U.S. health care spending is high prices. A 2003 study, titled "It's the Prices, Stupid," found that health care use in the U.S. was lower than the average in other similarly wealthy countries and that our higher spending is the result of higher prices.[22] A 2019 follow-up paper reaffirmed that conclusion and called for a greater focus on prices paid by private payers, such as commercial insurers.[23] 2018 research at Harvard University and the London School of Economics concluded that prices and administrative costs, not health care use or social spending, explain why the U.S. spends so much on health care.[24] Another analysis, by the Health Care Cost Institute, looked at spending by commercial payers and found that nearly two-thirds of the increase in spending from 2015 to 2019 was due to higher prices.[25]

One contributing factor to high prices in the U.S. is that hospitals charge commercial payers far more than it costs to provide care. The data presented in this report focuses on how much hospitals in Oregon are paid versus how much they need to be paid by commercial payers in order to cover their expenses and finds a large gap between the two.

This difference provides an opportunity for Oregon's policymakers to begin to rein in high health care spending. The state has already adopted some measures, such as a cost growth target, that could help slow the growth in overall health care spending, and should pursue additional policies to address high health care prices, such as requiring commercial insurers to offer plans with lower premiums, which could entail lower reimbursement rates for hospitals.

# Oregon hospitals charge commercial payers far more than what it costs those hospitals to provide care to patients

**MANY HOSPITALS** in Oregon charge* much more to commercial payers** than is required to cover all their expenses. This creates an opportunity to lower commercial payments to hospitals to an amount that will more than cover hospitals' expenses while still paying less than current commercial rates.

## How hospital billing works: Hospitals balance income from various payers

Hospitals, whether nonprofit, for-profit or government-run, need sufficient revenue to cover their expenses, provide a financial cushion in case of a future shortfall, maintain their infrastructure, and, in the case of for-profit hospitals, provide income to shareholders. Hospitals receive revenue from multiple payers, including Medicare, Medicaid and commercial insurance, as well as grants, donations, investments, the 340B federal drug program and other sources.[26]

Hospitals assert that payments from some payers, such as Medicare and Medicaid, do not cover the full cost of providing care to those patients, and thus hospitals must charge higher amounts to other payers, such as commercial payers, to make up for the shortfall.[27] However, hospitals typically charge far more to commercial payers than is necessary to cover the deficit from treating Medicare and Medicaid patients, charity care, bad debt and other costs.

To understand how much more hospitals charge commercial payers than is necessary to cover hospital expenses, the National Academy for State Health Policy (NASHP) assembled and analyzed hospital financial data self-reported by hospitals in their annual Medicare Cost Reports.[28] Hospitals report detailed information about their finances to the federal government each year.[29]

Using the self-reported data for each hospital, NASHP researchers calculated the "break-even" amount, which they define as "the reimbursement rate a hospital needs to receive from commercial payers to cover all of its expenses for hospital inpatient and outpatient services, without profit."[30] Expenses include not just caring for patients, but also other expenses such as hospital administration and operation costs; charity care and bad debt; research expenses; cafeteria operations; and costs from treating Medicare and Medicaid patients that weren't paid by those programs.

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* "Charged" in this report means the amount hospitals were actually paid, not the amount that hospitals listed on their official price lists, which are also known as chargemaster lists.

** Throughout this report, the term "commercial payers" includes all payers who make payments for care delivered to commercial insured patients. This includes payments from private insurers, from self-pay patients, group health plans, and from any other entity making payments on behalf of commercially insured patients.

NASHP then compared this break-even amount to how much hospitals are actually paid by commercial payers, using data collected by the RAND Corp. on how much selected commercial health insurers paid to hospitals from 2018 to 2020. RAND's *Prices Paid to Hospitals by Private Health Plans* includes data from commercial payers who spent $78.8 billion at more than 4,000 hospitals and hospital-owned facilities across the country.[31]

With this information, NASHP created a Hospital Cost Tool that allows a comparison of how much each hospital is paid by commercial payers versus how much it needs to be paid to cover the cost of caring for patients and operating the hospital. NASHP presents this information not in specific dollar amounts but relative to the size of payments from Medicare, facilitating comparisons among hospitals.

Data is available for almost all of Oregon's 59 short-term and critical-access hospitals. The following analysis includes information for 56 hospitals in 2018 and 55 hospitals in 2019. Hospitals were excluded if their break-even amount was not available for a particular year or if it was such an outlier that it may have been an error. (See Methodology for details.)

## Oregon hospitals generally charge far more than their break-even amount

Data from Oregon hospitals shows that many collect more from commercial payers than is required for them to cover all of their expenses.

### In 2018-2019, many hospitals charged commercial payers much more than their break-even amount

Information is available on how much Oregon hospitals were paid by commercial payers compared with each hospital's break-even amount in 2018 through 2020. This analysis will focus on 2018 and 2019 data because the COVID-19 pandemic created unusual circumstances in 2020.

In 2019, 51 out of 55 Oregon hospitals were paid more by commercial payers than they needed to cover their expenses (excludes hospitals for which sufficient data was not available).[32] Those 51 hospitals received commercial payments that were a median of 60% above their break-even amount.

Payment rates in 2018 were similar to 2019 rates. In 2018, when 50 out of 56 hospitals charged commercial payers far more than what was needed to cover their expenses, commercial payments were a median of 57% above hospitals' break-even amounts.*

- Several hospitals stand out for consistently charging commercial payers far more than their break-even amounts. Mercy Medical Center in Roseburg received 271% more than its break-even amount in 2018 and 156% in 2019, while PeaceHealth Cottage Grove Community Medical Center received 144% more than its break-even amount in 2018 and 235% in 2019, and Sky Lakes Medical Center in Klamath Falls received 215% above its break-even amount in 2018 and 137% in 2019. (See Appendix A for the difference between commercial payments and break-even amounts for each hospital.)

* In this calculation of payments versus expenses, only hospital expense numbers change. The RAND Corp. collected commercial payment data for 2018 through 2020 and aggregated it into a single three-year figure for each hospital.

- Three hospitals received commercial payments below their break-even amounts in both 2018 and 2019: Legacy Emanuel Medical Center in Portland, Harney District Hospital in Burns, and PeaceHealth Peace Harbor Medical Center in Florence. Providence Hood River Memorial Hospital, Providence Medford Medical Center and Kaiser Westside Medical Center in Hillsboro received commercial payments below their break-even amounts in 2018, as did Asante Ashland Community Hospital in 2019.

## Most hospitals earn more than they spend

Most hospitals that received commercial payments above their break-even amounts earned more overall than they spent. There are several metrics that measure how much income hospitals earn versus how much they spend.

Ninety-six percent of hospitals that received commercial payments above their break-even amounts earned an *operating profit* in 2019.*

Operating profit is the amount that a hospital retains after subtracting the cost of caring for patients from the amount the hospital was paid to care for those patients and operate the hospital. Collectively, the 51 hospitals that received commercial payments higher than their break-even amounts earned an operating profit of $2.2 billion in 2019.

The hospitals that received commercial payments above their break-even amounts and with some of the highest operating profit margins in 2018 and 2019 include Willamette Valley Medical Center in McMinnville, with an operating profit margin of 39% in 2018 and 34% in 2019. Providence Newberg Medical Center had an operating profit margin of 32% in 2018 and 35% in 2019, while Adventist Health Portland had operating profit margins of 34% in 2018 and 36% in 2019. Table 1 lists the 10 hospitals in 2019 that received commercial payments above break-even amounts and that had the highest operating profit margins.

**TABLE 1. TOP 10 HOSPITALS IN 2019 THAT RECEIVED COMMERCIAL PAYMENTS ABOVE BREAK-EVEN AMOUNTS AND HAD THE HIGHEST OPERATING PROFIT MARGIN**

| Facility | City | 2019 operating profit margin |
|---|---|---|
| PeaceHealth Cottage Grove Community Medical Center | Cottage Grove | 37% |
| Adventist Health Portland | Portland | 36% |
| Providence Newberg Medical Center | Newberg | 35% |
| Willamette Valley Medical Center | McMinnville | 34% |
| Providence Hood River Memorial Hospital | Hood River | 29% |
| Providence St. Vincent Medical Center | Portland | 27% |
| PeaceHealth Sacred Heart Medical Center at RiverBend | Springfield | 27% |
| Columbia Memorial Hospital | Astoria | 26% |
| Good Samaritan Hospital Corvallis | Corvallis | 25% |
| Santiam Memorial Hospital | Stayton | 25% |

* Note that the profit calculations in this paragraph exclude Kaiser Sunnyside Medical Center. Though the facility received commercial payments greater than its break-even amount, profit data is not available.

*Net profit* is a broader measure than operating profit and includes not only operating costs and revenues, but other expenses and income, too. Payments from commercial payers are one component of a hospital's income, and the cost of treating patients is just one component of a hospital's expenses. Other sources of income include investment income, donations and grants, while other expenses include costs such as research and cafeteria operations.[33]

In 2019, the 51 hospitals with commercial payments above their break-even amounts had a collective net profit of $924 million, with a median profit margin of 5%.[34]*

Of the hospitals that received commercial payments above their break-even amounts, several are notable for their high net profit margins. PeaceHealth Cottage Grove Community Medical Center reported a net profit margin of 32% in 2019, while St. Anthony Hospital in Pendleton had a net profit margin of 19%. Table 2 shows the top 10 hospitals in 2019 that received commercial payments above break-even amounts and had the highest net profit margins.

Six hospitals that received commercial payments above their break-even amounts reported net losses in both 2018 and 2019. Six additional hospitals reported a net loss in just 2018 and one hospital reported a net loss in just 2019.

**TABLE 2. TOP 10 HOSPITALS IN 2019 THAT RECEIVED COMMERCIAL PAYMENTS ABOVE BREAK-EVEN AMOUNTS AND HAD THE HIGHEST NET TOTAL PROFIT MARGIN**

| Facility | City | 2019 net profit margin |
|---|---|---|
| PeaceHealth Cottage Grove Community Medical Center | Cottage Grove | 32% |
| St. Charles Medical Center – Bend | Bend | 25% |
| St. Anthony Hospital | Pendleton | 19% |
| Providence Newberg Medical Center | Newberg | 15% |
| Providence St. Vincent Medical Center | Portland | 15% |
| Columbia Memorial Hospital | Astoria | 14% |
| Mercy Medical Center | Roseburg | 14% |
| Legacy Meridian Park Medical Center | Tualatin | 14% |
| Wallowa Memorial Hospital | Enterprise | 13% |
| Salem Health Salem Hospital | Salem | 12% |

* Note that the profit calculations in this paragraph exclude Kaiser Sunnyside Medical Center. Though the facility received commercial payments greater than its break-even amount, no profit data is not available.

## Profits at hospitals for which a valid comparison of commercial payment to break-even amount is not available

Valid comparison of commercial payments to break-even amounts was not possible for three hospitals in 2018 and for four hospitals in 2019. However, profit information is available for some of these hospitals.

In 2019, three of the excluded hospitals had higher net profit margins than any other hospitals in the state. St. Charles Medical Center – Prineville had a 35% net profit margin, St. Charles Medical Center – Redmond had a 33% net profit margin, and St. Charles Medical Center – Madras had a 32% net profit margin. The fourth excluded hospital in 2019 was Kaiser Westside Medical Center in Hillsboro, which, because of Kaiser's unique structure, does not report profit information.

If these hospitals were included, the list of the top 10 hospitals in 2019 with the highest net total profit margin would look like Table 3 instead of Table 2.

**TABLE 3.** TOP 10 HOSPITALS WITH THE HIGHEST NET PROFIT MARGIN, REGARDLESS OF AVAILABILITY OF VALID COMPARISON OF COMMERCIAL PAYMENTS VERSUS BREAK-EVEN AMOUNT

| Facility | City | 2019 net profit margin | Valid commercial payment versus break-even amount comparison possible? |
|---|---|---|---|
| St. Charles Medical Center – Prineville | Prineville | 35% | N |
| St. Charles Medical Center – Redmond | Redmond | 33% | N |
| St. Charles Medical Center – Madras | Madras | 32% | N |
| PeaceHealth Cottage Grove Community Medical Center | Cottage Grove | 32% | Y |
| St. Charles Medical Center – Bend | Bend | 25% | Y |
| St. Anthony Hospital | Pendleton | 19% | Y |
| Providence Newberg Medical Center | Newberg | 15% | Y |
| Providence St. Vincent Medical Center | Portland | 15% | Y |
| Columbia Memorial Hospital | Astoria | 14% | Y |
| Mercy Medical Center | Roseburg | 14% | Y |

### Hospitals received commercial payments above their break-even amount regardless of hospital size, location or ownership

The pattern of hospitals charging significantly more than their break-even amount holds true for hospitals of a variety of sizes, in locations across the state, and regardless of ownership type.

Hospitals of all sizes received higher commercial payments than needed to cover their costs. Hospitals that were paid more than their break-even amount ranged in size from 14 beds to 562 beds. Table 4 shows for hospitals of various sizes the median amount by which commercial payments exceeded hospitals' break-even amounts.

Hospitals that received commercial payments greater than their break-even amounts are located across the state, including in the Portland area, on the coast, in the Willamette Valley, and in southern, central and eastern Oregon.[35] Table 5 shows the median amount by which commercial payments exceeded hospitals' break-even amounts by region.

**TABLE 4.** MEDIAN AMOUNT BY WHICH COMMERCIAL PAYMENT WAS ABOVE BREAK-EVEN AMOUNT, BY HOSPITAL SIZE

| Beds | Number of hospitals, 2018 | Commercial payment above breakeven, 2018 | Number of hospitals, 2019 | Commercial payment above breakeven, 2019 |
|---|---|---|---|---|
| 0–25 | 23 | 54% | 23 | 65% |
| 26–100 | 11 | 74% | 11 | 55% |
| 101–250 | 14 | 56% | 12 | 45% |
| 251 and over | 8 | 44% | 9 | 44% |

Note: The number of hospitals in each category changes from 2018 to 2019 because St. Charles Medical Center – Bend added beds and switched to the "251 and over" category in 2019, while Kaiser Westside Medical Center in Hillsboro, which is in the "101–250" category, had analyzable data only for 2018.

**TABLE 5.** MEDIAN AMOUNT BY WHICH COMMERCIAL PAYMENT WAS ABOVE BREAK-EVEN AMOUNT, BY HOSPITAL LOCATION

| Region | Number of hospitals, 2018 | Commercial payment above breakeven, 2018 | Number of hospitals, 2019 | Commercial payment above breakeven, 2019 |
|---|---|---|---|---|
| Portland | 13 | 16% | 12 | 36% |
| Coast | 11 | 54% | 11 | 53% |
| Willamette Valley | 13 | 94% | 13 | 104% |
| Southern | 7 | 48% | 7 | 25% |
| Central/Columbia Gorge | 4 | 115% | 3 | 88% |
| Eastern | 8 | 51% | 9 | 81% |

Note: The number of hospitals each category changes from 2018 to 2019 because some hospitals have analyzable data for only one year. The list of hospitals in each region can be found in Appendix B.

Most of the hospitals that were paid more than their break-even amount are nonprofit institutions, meaning they do not pay property or income tax and thus sometimes are referred to as "tax-exempt hospitals."[36] In 2019, 42 were nonprofit hospitals and had analyzable data, 11 were government-owned, and two were for-profit.[37] (See Table 6.) Government-owned hospitals include facilities such as the Bay Area Hospital in Coos Bay and OHSU Hospital in Portland. The two for-profit hospitals are McKenzie-Willamette Medical Center in Springfield and Willamette Valley Medical Center in McMinnville.

Tax-exempt hospitals function much like for-profit hospitals. Both need to earn revenue greater than their expenses to keep their doors open. Both need to be able to pay for infrastructure maintenance and perhaps upgrades.[38] Both pay high CEO salaries and spend money on political lobbying.[39] And both types of hospitals may spend money on categories of care that lose money, such as maternity and trauma services and general medicine — expenses that they seek to cover with other revenue streams.[40]

The largest difference between the two hospital ownership categories is that tax-exempt hospitals do not pay property or income tax, nor do they need to pay a profit to shareholders or investors. A tax-exempt hospital may earn a profit, but it does not distribute that profit as for-profit hospitals do.[41] In exchange for tax-exempt status, hospitals are expected to provide other benefits to their community, such as providing charity care to uninsured or underinsured patients, training health care professionals or improving community health.[42]

In theory, their tax-exempt status should enable these hospitals to set lower prices or provide additional other services to their communities. However, academic research suggests that neither of these are consistently true of tax-exempt hospitals nationally. One of the authors of a study of 2007-2011 payments to hospitals by three major insurers who provide private employer-sponsored insurance noted that "One of the things we found is that not-for-profit hospitals don't price any less aggressively than for-profits."[43]

Studies of the amount of charity care provided by different types of hospitals have found no clear difference. An analysis of 2018 self-reported data from hospitals found no significant difference in the amount of charity care provided by tax-exempt versus for-profit hospitals.[44]

With the passage of the Affordable Care Act and the expansion of Medicaid (as the Oregon Health Plan), more patients are insured, reducing the number of patients for whom hospitals need to provide charity care. This reduction in charity care should have enabled tax-exempt hospitals to spend more on other forms of community health

**TABLE 6. MEDIAN AMOUNT BY WHICH COMMERCIAL PAYMENT WAS ABOVE BREAK-EVEN AMOUNT, BY HOSPITAL OWNERSHIP TYPE**

| Ownership type | Number of hospitals, 2018 | Commercial payment above breakeven, 2018 | Number of hospitals, 2019 | Commercial payment above breakeven, 2019 |
|---|---|---|---|---|
| Nonprofit | 44 | 53% | 42 | 55% |
| Governmental | 10 | 42% | 11 | 53% |
| For-Profit | 2 | 103% | 2 | 94% |

support. However, a national study of tax-exempt hospitals found that they did not increase their community spending even though Medicaid expansion reduced some of the financial burden of caring for uninsured patients from 2011 to 2017.[45]

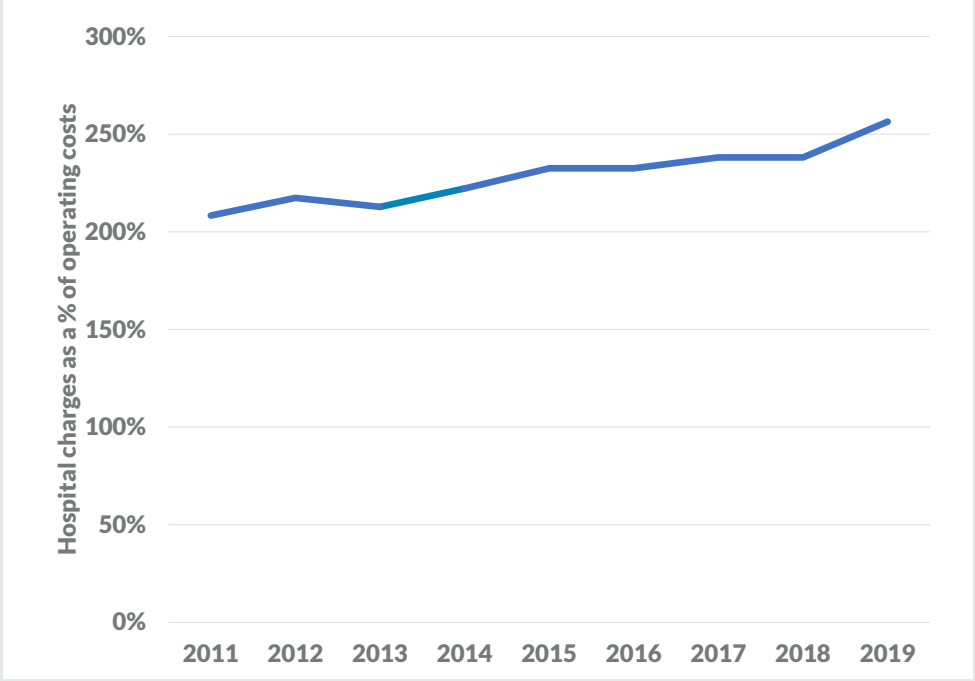
## Why this analysis does not include official hospital prices

Official hospital price lists are of limited usefulness in determining how much it costs a hospital to provide a particular type of care or how much they should be paid.[46] A hospital's listed price for a service is similar to the manufacturer's suggested retail price (MSRP) that consumers encounter for other products. It is not closely tied to a hospital's cost of providing care and thus is not a useful benchmark for understanding opportunities to reduce health care spending.

Figure 1 shows the difference between the amount Oregon hospitals would have charged for care based on their official price lists versus how much it actually cost for them to provide care. The theoretical amount charged is the total amount each hospital would charge for the volume of inpatient and outpatient services multiplied by official list prices.[47] The costs of providing patient care include only types of costs that can be reimbursed under federal Medicare regulations. These costs exclude expenses such as research activities that do not provide patient care or professional services to individual patients that are covered through other channels.[48]

As Figure 1 shows, the median gap between charges and costs grew from 2011 to 2019. In 2011, median charges based on listed prices were more than twice reported costs. By 2019, median charges were 2.5 times above reported costs.

**FIGURE 1.** MEDIAN OREGON HOSPITAL LISTED CHARGES COMPARED TO REPORTED COSTS[49]



# The high price of commercial insurance burdens Oregonians

**COMMERCIAL HEALTH INSURANCE** — the insurance that many people obtain through their employer or purchase for themselves on the marketplace — is costly, a reflection of the price that insurers pay to providers. The cost of commercial insurance is a major financial burden on Oregon households.

## Many Oregonians rely on commercial health insurance

In 2019, 55% of Oregonians, or 2.3 million people, had commercial insurance.[50] Nearly 90% of those people obtained insurance through an employer, while the remainder had insurance they purchased directly, either through the marketplace or straight from an insurance company.

The other major sources of health insurance for Oregonians include Medicaid, Medicare and military insurance. Of the state's residents, 7.1% — or 293,500 Oregonians — were uninsured in 2019, though the number of uninsured Oregonians declined during the pandemic, as more patients were able to retain their Medicaid coverage.[51]

## Commercial insurance is expensive

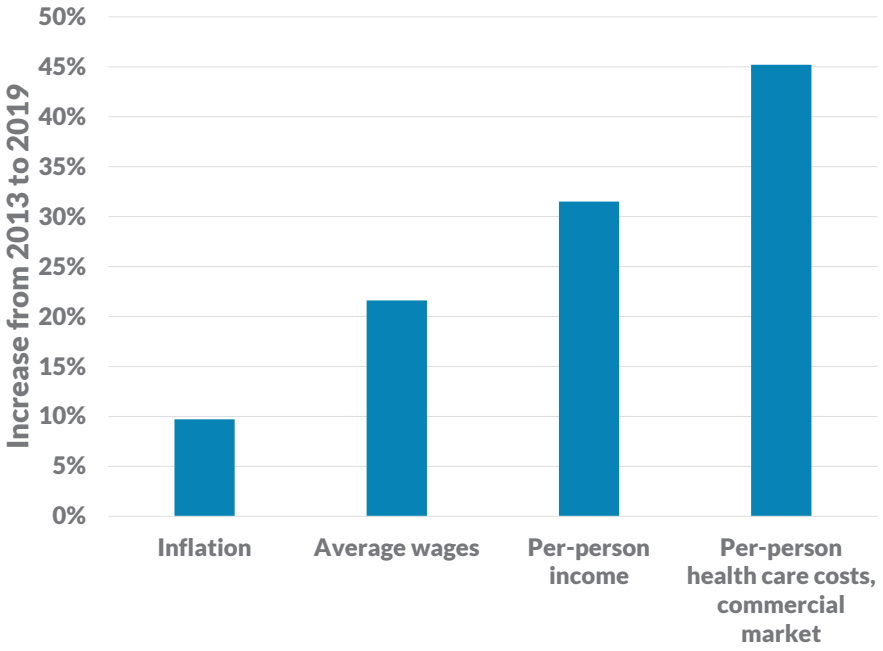
Commercial insurance is expensive for Oregon consumers and employers, creating a burden on households. Insurance costs include premiums and deductibles. Premiums for commercial insurance cost thousands of dollars each year. The average annual premium was $6,651 for an individual and $19,405 for a family in Oregon in 2019.[52] For people with employer-provided coverage, the cost of the premium is typically split between the employee and employer. The average employee with individual insurance paid $1,155 of their premium in 2019, while employees with family plans paid $5,404.[53] An employee with individual coverage paid 44% more for their premium in 2019 than 2013, while an employee with family coverage paid 25% more.[54]

Patients who obtain insurance through the state's Affordable Care Act marketplace typically pay a portion of their premium themselves and receive a federal tax credit to cover the rest of the cost. In 2019, the average Oregonian purchasing insurance through the marketplace paid $2,664 of the annual premium.[55]

In addition to paying for some or all of the insurance premium, patients also pay a deductible before insurance begins to pay for their care. In 2019, the typical individual in Oregon with commercial insurance had a $1,958 deductible and an average family had a $3,634 deductible.[56] Deductibles increased 51% for individuals and 40% for families from 2013 to 2019.

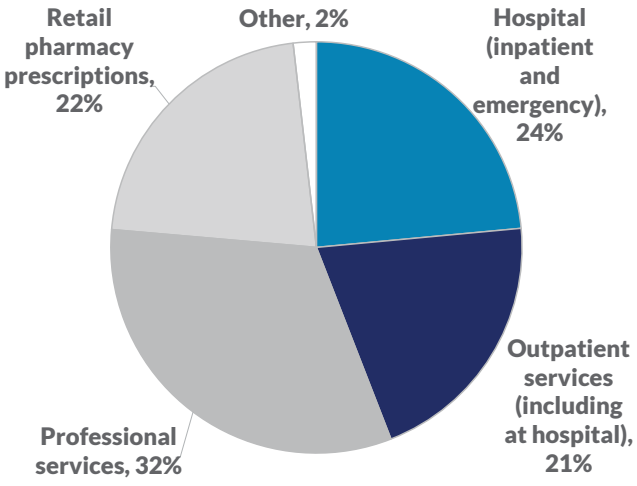
The result is that Oregonians with commercial insurance pay a significant amount of their household income for health insurance and health care. Individuals paid an average of 5% of their income for premiums and deductibles in 2019.[57] Families paid 14% of their household income for premiums and deductibles. In total, Oregonians spend a larger share of their household income on health care than on any other category of expense except housing, more than on food or transportation.[58]

**FIGURE 2.** HEALTH CARE COSTS HAVE INCREASED FASTER THAN OTHER EXPENSES OR INCOME[61]




Adding to the burden, health care costs have grown faster than other household expenses. From 2013 to 2019, total medical spending increased by 45% in Oregon's commercial market.[59] In contrast, per-person income grew just 32% and average wages increased 22% in that period.[60] Overall inflation in that same period increased 10%. (See Figure 2.)

**FIGURE 3.** HOW HEALTH CARE DOLLARS WERE SPENT FOR PATIENTS WITH COMMERCIAL INSURANCE, 2019[65]




Rising health care and health insurance costs can cut into consumers' income or discretionary funds. For example, in response to higher insurance premiums, employers may not raise wages as quickly or may ask employees to pay for a larger share of insurance premiums.[62]

Hospital-based care is a significant portion of health care spending for Oregonians with commercial insurance. In 2019, nearly a quarter of health care spending for people with commercial insurance was for inpatient hospital care or emergency department visits.[63] An additional one-fifth of spending is for outpatient care, some of which is provided at hospitals.[64] (See Figure 3 for details.)

## High costs are a health and financial burden on Oregonians

The high price of insurance and health care impacts many Oregonians' willingness to seek medical care. Once people do seek care, underinsured people may struggle to pay their medical bills.

Concern about the price of care deters people from going to the doctor. Nearly one-quarter of patients with individual commercial plans reported delaying medical care due to the price.[66] Patients with employer-provided insurance were less frequently deterred, with fewer than 10% reporting that the high price of care caused them to delay seeking help.

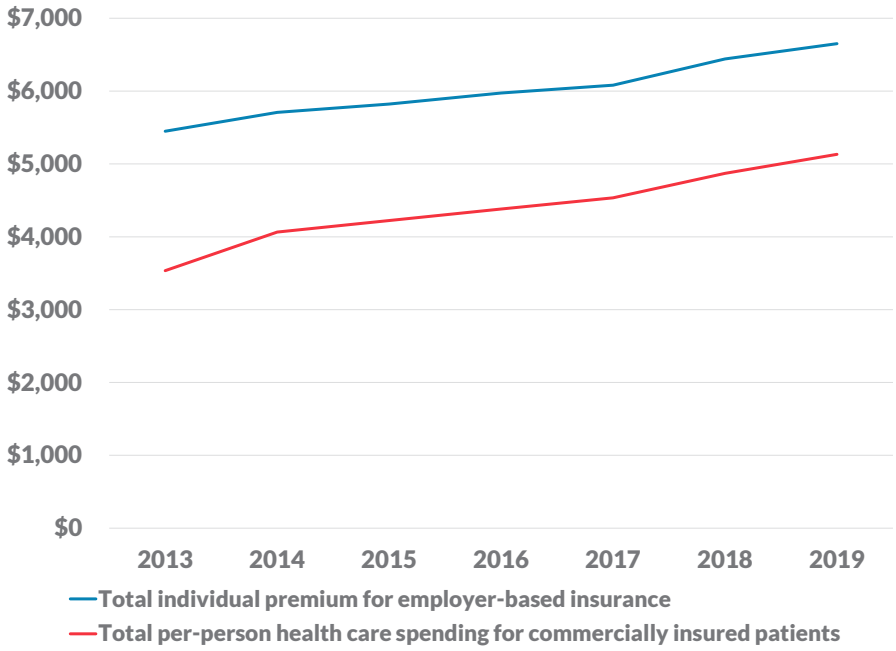
After receiving care, patients are often unable to pay the bill. In 2019, 14% of patients with individual commercial plans were unable to pay medical bills, not much lower than the 15% of uninsured patients who reported an inability to pay.[67] Six percent of patients with employer-provided insurance reported being unable to pay a bill.

Medical bills add to household debt and can be a contributing factor causing people to file for bankruptcy. An analysis of 2019 bankruptcy filings by OSPIRG Foundation discovered that 60% of personal bankruptcy filers reported owing medical debt.[68]

## The price of commercial insurance reflects the high price of care

The price of insurance to consumers partially reflects the price that hospitals expect insurers to pay for care. Insurance companies set the price of health insurance high enough to cover anticipated health care expenditures for the group of patients that are expected to purchase a particular health insurance policy, and to provide some profit for the insurer. Figure 4 depicts how health insurance premiums for individuals with employer-provided insurance have increased in tandem with total per capita spending for individuals with commercial insurance.

**FIGURE 4.** INSURANCE PREMIUMS VERSUS TOTAL HEALTH CARE SPENDING IN OREGON[69]



State and federal policies help ensure that insurance prices are linked to the actual cost of providing care, and do not rise too far above it.

Every year, Oregon regulators review some proposed insurance prices to confirm that the insurance company is accurately assessing likely costs. The state's Division of Financial Regulation reviews proposed rate increases from insurers who intend to sell plans directly to individuals or to employers with 50 employees or less.[70] (Plans offered by larger employers are not reviewed by the state.) Regulators examine proposed rates to make sure they will cover the insurer's costs of paying for health care without being overpriced. Insurers are allowed to make a profit and to earn surplus funds to provide a hedge against unexpected claims or additional risk. If rates are set too low, insurers may withdraw from the market. From 2010 to 2015, Oregon's insurance rate review program cut $179 million of unjustified costs from premiums.[71] No such program or oversight exists for hospital prices.

Another factor that keeps insurance prices somewhat close to the amount of spending on medical care within a particular insurance plan is a federal policy that sets a floor on insurers' "medical loss ratio" — how much insurers spend on care versus on administrative costs and profits.[72] For plans sold directly to individuals or to small employers, insurers must spend at least 80% of premiums on health care (such as hospital care) and on measures to improve the quality of care. For plans sold to larger employers, insurers must spend at least 85%. If insurers fail to meet these benchmarks, they must provide rebates to policyholders.

Policies that link insurance prices to the amount insurers spend on care are an important protection for consumers against overcharging by commercial insurers. But they do not address the underlying issue of hospital charges that dramatically exceed the cost of providing care. Bringing those charges more in line with hospitals' cost of doing business would likely result in at least some of the savings being passed through to purchasers of commercial insurance.

# State-designed insurance plans could reduce how much Oregonians pay for commercial health insurance

**COMMERCIAL INSURANCE** could be less expensive if hospitals were paid an amount closer to the cost of providing care and operating a hospital. One way to achieve that could be through a plan designed by the state to be offered by commercial insurers, with lower premiums and comprehensive coverage as specified by the Affordable Care Act.[73]

A state-designed plan could improve value, save money for consumers and reduce overall health care spending. Modeling of state-designed plans in Colorado and Nevada suggest that premiums for these plans could be lower than other commercial insurance plans, offering patients who purchase those plans a less-expensive choice than others currently available on the marketplace. In addition, competition from such plans has the potential to strengthen insurers' ability to negotiate for lower health care costs for all insurance plans, thereby allowing insurers to lower premiums.

## Paying hospitals an amount closer to their cost of providing care could reduce health care spending

If commercial insurers could pay hospitals at rates closer to the cost of caring for patients, hospitals would still receive more than their break-even amount, but less than current rates. This could allow commercial insurers to reduce costs for consumers by lowering premiums and overall health care costs.

The Oregon Health Authority (OHA) calculated the potential savings if commercial payers paid hospitals at a lower rate than they currently receive. The OHA estimated that if commercial payers paid for inpatient and outpatient procedures at 200% of the rate paid by Medicare, health care spending would have been $180 million lower in 2019.[74] (Using Medicare rates as the benchmark payment allows for easier comparison of payment rates for hospitals across the state.)

**If commercial payers paid for inpatient and outpatient procedures at 200% of the rate paid by Medicare, health care spending would have been $180 million lower in 2019.**

Two hundred percent of the Medicare rate is higher than hospitals' break-even amounts but lower than the amount they receive. In 2019, Oregon hospitals' median break-even amount was 149% of the Medicare payment rate.[75] In contrast, median commercial payments, measured from 2018 through 2020, were approximately 225% of the Medicare payment rate.

## State-designed health plans in Colorado and Nevada are expected to reduce premiums

Colorado and Nevada are attempting to lower insurance premiums in their state-designed commercial insurance plans through multiple measures, including by reducing the amount that hospitals are paid. Both states have adopted policies that rely on private insurers and private purchasers to meet price-reduction targets. Their experiences and plans offer insight into the potential for reducing overall spending on health care and commercial health insurance premiums in Oregon.

State-designed health insurance plans are available in Colorado to individuals and small group purchasers.[76] The state has specified the benefits and cost-sharing elements of these plans and requires that plans be priced 5% lower than the previous year's rates for each of the first three years, adjusted for medical inflation.[77] For 2023, the first year that state-designed plans have been offered, few insurers have met the state's premium-reduction target.[78] However, if insurers fail to meet premium-reduction targets, the state can set payment rates for hospitals and providers and require them to accept the state-designed insurance plan.[79] Those rates, for hospitals, will be at least 155% of Medicare rates.[80] Small, rural and critical-access hospitals qualify for different rates. Providers (including physicians) must receive at least 135% of Medicare rates.

For 2023, there are at least two state-designed plans at three levels of coverage available in all but one Colorado county.[81] Colorado projects this will reduce federal spending on health insurance premium subsidies by $214 million in 2023 and by more than $350 million in 2027. The federal government will pass these savings along to the state so it can offer other premium and cost-sharing subsidies.

Nevada's state-designed insurance coverage will be available to consumers beginning in 2026.[82] The plans will be available to individuals who purchase their own insurance directly, and may also be available to small employers. The state intends to reduce the price of these commercial insurance plans by requiring that they be priced 5% less than the "benchmark" plan on the exchange.[83] Hospitals must offer care at rates that are comparable to Medicare rates, or use a payment model that delivers greater value than a fee-for-service model.[84] According to a preliminary analysis by the independent actuarial firm Milliman, Inc., premiums for these insurance plans in Nevada could drop by at least 15% by the fifth year of the program.[85] This would reduce health care spending by $341 million to $464 million over five years.[86] Like Colorado, Nevada's plans will reduce the amount the federal government spends subsidizing premiums in the marketplace. These savings will be passed through to the state, allowing it to further subsidize premiums, among other actions.

## State-designed plans could lower premiums for commercial insurance plans

By requiring insurers to offer some commercial plans with lower premiums than current plans, states could help to drive down premiums for all commercial insurance plans.[87] In order to draw customers, insurers offering commercial plans would need to offer premiums priced competitively with state-designed insurance offerings. One way that insurers might accomplish this would be to change their negotiating tactics with hospitals to drive down provider reimbursement rates.

The Urban Institute published an analysis in 2019 to better understand the possible broader insurance market impact of lower

premiums for a subset of plans. The analysis used plans offered by managed care organizations (MCOs), which play a role similar to that of coordinated care organizations (CCOs) in Oregon, as a proxy for state-designed insurance plans. The Urban Institute concluded that geographic areas with a health insurance plan offered by an MCO had lower-priced commercial benchmark plans than areas without a plan offered by an MCO.[88] In addition, the least-expensive commercial plan offered by non-MCO insurers was cheaper in areas that had a plan offered by an MCO compared to areas that did not.

# Policy recommendations

**THE HIGH PRICE** of health care and health insurance is a burden for Oregonians. Those who have commercial insurance, whether provided by an employer or purchased individually, pay high premiums, co-pays and deductibles, and may skip care or go into debt to pay for it. The high cost of care also contributes to the decision of thousands of Oregonians to forgo purchasing health insurance entirely, leaving them vulnerable to high medical expenses if they get sick. In order to address the high price of commercial insurance and lower the price of care, Oregon should pursue several policy strategies.

### Implement the Bridge Plan.

The Bridge Plan that is under development in Oregon for people who earn less than 200% of the federal poverty level but too much to qualify for Medicaid coverage will pay a lower rate to hospitals than other commercial plans available to these patients.

The Bridge Plan will be offered through the same coordinated care organizations (CCOs) that participate in the Oregon Health Plan. The CCOs negotiate with hospitals and other providers for care at payment rates well below commercial rates.[89] The Bridge Plan will follow a similar rate-setting process.[90]

Implementation of the Bridge Plan will deliver additional benefits.

- It will provide more consistent access to health care for qualifying patients. Oregonians who qualify for Medicaid often lose access when their income rises slightly, and then become eligible again when their income drops. This "churning" in and out of Medicaid eligibility disrupts their access to health care and continuity of coverage as patients must switch between CCO provider networks and commercial provider networks.[91] The Bridge Plan will ensure stable access to care for these patients.
- It will provide high-quality care. The Bridge Plan, like the Oregon Health Plan, will use an alternative payment model rather than a fee-for-service model that may both lower costs and improve care. A recent meta-analysis of value-based payment models in the commercial insurance market confirmed that this payment method may reduce spending and also improve outcomes for patients.[92]
- It will provide broader insurance benefits than commercial plans. In line with the rules governing a Basic Health Program, the Bridge Plan will receive federal "pass-through funding," which will enable Oregon to offer additional medical benefits and reduce costs for patients.[93]

### Expand the Bridge Plan.

To further address the high price of commercial health insurance, Oregon should expand the Bridge Plan that it is already developing to make it available to more Oregonians. The expanded Bridge Plan should mirror the Basic Health Program as much as possible in terms of costs and benefits, and should be available to individuals who earn more than 200%

of the federal poverty level and to small businesses.

As with the Bridge Plan that is in development, an expanded Bridge Plan should:

- Offer lower premiums than other commercial plans.
- Promote alternative payment models that can both lower costs and improve care. These models pay providers based on the quality of care provided rather than just on than the volume of care.
- Adhere to the state's cost growth target. Oregon's cost growth target of 3.4%, which applies to most health care payers and providers, is intended to limit how quickly health care prices rise.[94]
- Prioritize high-value services such as integrated primary care by, for example, readjusting payment schedules to pay primary providers more.

**Move to a state-based marketplace, which will provide Oregon with more flexibility in insurance plan design.**

Currently, Oregon uses the federal healthcare.gov website for the core functions of its health insurance marketplace. This reliance on the federal website restricts the state's ability to pursue cost-saving strategies and to tailor health plans to Oregonians' needs. In addition, the federal government does not share all the data the state needs for insight into the makeup and needs of the people purchasing insurance. By establishing a fully state-based marketplace website, Oregon will have the flexibility and independence to adjust marketplace offerings, simplify enrollment, gain the data it needs to better serve Oregonians and provide customer service tailored to the state.

**Implement the state's cost growth benchmark program.**

Oregon's health care cost growth target is a new tool to slow the increase in health care spending by establishing a statewide spending growth target of 3.4% annually through 2025. The spending goal after 2025 will be lower (at 3.0%), but may be adjusted to account for inflation, wages, income and other factors.[95] The program will evaluate spending increases by hospitals and other providers. For organizations that exceed the spending growth target, the initial accountability mechanisms are designed to help organizations meet the goal in the future.[96] While there are financial penalties eventually, they do not take effect for some time and are adjustable based on good-faith efforts to meet the cost growth target. The cost growth target program should be implemented for several years and then evaluated before any revisions are considered.

**Continue to scrutinize mergers and acquisitions.**

Consolidation in the health care market can increase prices and reduce the quality of care.[97] Oregon's Health Care Market Oversight (HCMO) program scrutinizes some proposed health care mergers to confirm they support Oregon's broad goals for health care, such as lower costs and better quality. HCMO can approve, reject or require modifications to planned mergers. The program also monitors the impacts of health care consolidation transactions on Oregonians.[98] Currently, the HCMO only requires large entities to provide notice of transactions with other large entities, meaning that small independent practices may be absorbed by larger health systems without any oversight.[99] The HCMO's review should expand to include these smaller mergers to protect Oregonians from the effects of consolidated markets.

# Methodology

**THIS ANALYSIS** includes data from 2016 through 2019. The COVID-19 pandemic altered hospitals' expenses and revenues as hospitals had to change the volume and types of services they provided, and as the federal government provided emergency payments. The 2016 through 2019 data thus are perhaps more representative of hospitals' "normal" finances than are data from more recent years.

## 2018 and 2019 analysis

Information on hospital costs came from data presented by the National Academy for State Health Policy (NASHP) in the Hospital Cost Tool 2.0 (https://www.nashp.org/hospital-cost-tool/). The spreadsheet with data was downloaded 8 December 2022.

In the Hospital Cost Tool, NASHP incorporates and analyzes data from hospitals' Medicare Cost Reports.[100] Hospitals report detailed information annually about their finances and operations, including the size of the hospital, whether it is a nonprofit or for-profit institution, how many patients it cared for, total inpatient and outpatient charges, total costs, charity care and bad debt.[101] Hospitals report this information for each fiscal year, which may start in different months for different hospitals.

Using this data, NASHP researchers calculated a "break-even" amount for each hospital each fiscal year. They define the commercial break-even amount as "the reimbursement rate a hospital needs to receive from commercial payers to cover all of its expenses for hospital inpatient and outpatient services, without profit."[102] Expenses include not just caring for patients, but also hospital administration and operation costs, charity care and bad debt. Expenses also include costs disallowed under Medicare Cost rules (excluding physician direct patient care reimbursed under other methods). Though Medicare and Medicaid pay for most of the cost of caring for those patients, some costs are not covered by the programs and are included in the break-even rate to be covered by commercial payers.

NASHP then calculated how much hospitals are actually paid by commercial payers, using data collected by the RAND Corp. RAND's *Prices Paid to Hospitals by Private Health Plans* includes data from commercial payers who spent $78.8 billion at more than 4,000 hospitals and hospital-owned facilities across the country in 2018, 2019 and 2020.[103] The commercial payment data in RAND's analysis comes from self-insured employers who chose to participate in the study and all-payer claims databases from 11 states, including Oregon's.[104] Payments from commercial payers include "amounts paid by the health plan and any amounts due from the patient, including deductibles, copayments, and coinsurance."[105]

RAND aggregated payment data for each hospital for 2018 through 2020 to create a three-year average. RAND did not calculate a unique commercial payment number for each year.

Using the commercial payment data collected by RAND, NASHP calculated a commercial payment rate for each hospital that includes the same set of expenses as are incorporated in the break-even amount. Both the break-even amount and the commercial payment rate are presented as a percentage of the Medicare payment rate for that hospital, facilitating comparisons between different hospitals.

Tables in this report comparing commercial payment rates to break-even amounts present the difference as a percentage, rather than as percentage points.

Any calculation of net profit or loss is based on the data NASHP lists as "Net Income (Loss)" and defines as "Net Patient Revenue, less Operating Expenses, plus Other Income and Expense. Represents earnings retained by the hospital."[106]

We excluded data for some hospitals in some or all years. Data reported by hospitals through the federal Healthcare Cost Report Information System includes some errors. Prior to undertaking its analysis, NASHP reviewed the data for invalid values and removed obvious errors, which sometimes meant it could not calculate a break-even amount. Some errors may remain. We noticed several entries where a hospital's commercial payment rate was more than 500% greater than its break-even rate. We excluded these as outliers. We dealt with unusual data as follows:

- St. Charles Medical Center – Redmond. Excluded from the list of hospitals with valid data for both 2018 and 2019. NASHP marked the 2018 break-even amount as invalid and we excluded 2019 data as an outlier.
- St. Charles Medical Center – Prineville. Excluded from the list of hospitals with valid data for both 2018 and 2019. The 2019 data met our definition of an outlier. The 2018 data did not technically meet our definition of an outlier, but the hospital's break-even amount in 2018 was so different from that for previous and following years we were concerned there might have been a reporting error.
- St. Anthony Hospital in Pendleton. Excluded from the list of hospitals with valid data for 2018 as an outlier.
- St. Charles Medical Center – Madras. Excluded from the list of hospitals with valid data for 2019 because NASHP marked the break-even amount as invalid.
- Kaiser Westside Medical Center in Hillsboro. Excluded from the list of hospitals with valid data for 2019 because NASHP marked the break-even amount as invalid.
- Asante Ashland Community Hospital filed two cost reports for 2018, one for the first seven months of the fiscal year and the other for the remaining five months. Any calculations in this report that include Asante Ashland Community Hospital, for which commercial payment data is not available, use the data containing seven months of information. Any error this introduces is insignificant in aggregate figures.

## 2016 and 2017 analysis

Appendix A includes 2016 and 2017 data for 24 hospitals. The commercial payment data for 2016 and 2017 is more limited than the information for subsequent years.

To produce 2016 and 2017 break-even amounts, NASHP analyzed RAND's *Nationwide Evaluation of Health Care Price Paid by Private Health Plans*, which includes data from commercial payers at more than 3,000 hospitals across the country in 2016, 2017 and 2018.[107] The commercial payment

data in RAND's analysis comes from self-insured employers who chose to participate in the study, state employee health plans in selected states, and all-payer claims databases from six states. RAND did not include information from Oregon's all-payer claims database, and does not indicate if it included information from Oregon's state employee health plans.[108]

RAND presented commercial payment information for individual hospitals only if it collected a sufficient volume of claims.[109] For Oregon, RAND collected sufficient payment data to present information for 24 of the state's 59 hospitals. RAND aggregated payment data for each hospital for 2016 through 2018 to create a three-year average. RAND did not calculate a unique commercial payment number for each year.

# Appendix A. Commercial payment relative to break-even amount, and operating profit margin by hospital

| | | | | Commercial payment above/below breakeven | | | | Operating profit margin | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Region** | **Hospital** | **City** | **Included in 2018-2019 analysis?** | **2016** | **2017** | **2018** | **2019** | **2016** | **2017** | **2018** | **2019** |
| Central/ ColumbiaGorge | Mid-Columbia Medical Center | The Dalles | Yes | | | 115% | 141% | | | 21% | 17% |
| Central/Columbia Gorge | Providence Hood River Memorial Hospital | Hood River | Yes | | | -13% | 13% | | | 30% | 29% |
| Central/Columbia Gorge | St. Charles Medical Center - Bend | Bend | Yes | 280% | 283% | 116% | 88% | 14% | 11% | 19% | 15% |
| Central/Columbia Gorge | St. Charles Medical Center - Madras | Madras | 2018 only | | | 181% | NA | | | 14% | 22% |
| Central/Columbia Gorge | St. Charles Medical Center - Prineville | Prineville | No | | | * | * | | | -4% | 9% |
| Central/Columbia Gorge | St. Charles Medical Center - Redmond | Redmond | No | | | NA | * | | | 11% | 24% |
| Coast | Adventist Health Tillamook | Tillamook | Yes | | | 64% | 38% | | | 6% | 3% |
| Coast | Bay Area Hospital | Coos Bay | Yes | 26% | 17% | 60% | 107% | 12% | 15% | 14% | 13% |
| Coast | Columbia Memorial Hospital | Astoria | Yes | 63% | 84% | 54% | 133% | 27% | 28% | 33% | 26% |
| Coast | Coquille Valley Hospital | Coquille | Yes | | | 48% | 53% | | | 10% | 10% |
| Coast | Curry General Hospital | Gold Beach | Yes | | | 84% | 127% | | | 13% | 14% |
| Coast | Lower Umpqua Hospital | Reedsport | Yes | | | 148% | 152% | | | 6% | 12% |
| Coast | PeaceHealth Peace Harbor Medical Center | Florence | Yes | 175% | 107% | -27% | -4% | 34% | 8% | 5% | 23% |

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"NA" means NASHP marked the data as invalid.
"*" indicates data was removed because it was an outlier.
"." denotes data missing from the original source.

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| | | | | Commercial payment above/below breakeven | | | | Operating profit margin | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Region | Hospital | City | Included in 2018-2019 analysis? | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 |
| Coast | Providence Seaside Hospital | Seaside | Yes | | | 12% | 30% | | | 14% | 11% |
| Coast | Samaritan North Lincoln Hospital | Lincoln City | Yes | | | 54% | 67% | | | 15% | 13% |
| Coast | Samaritan Pacific Communities Hospital | Newport | Yes | | | 18% | 39% | | | 26% | 22% |
| Coast | Southern Coos Hospital & Health Center | Bandon | Yes | | | 8% | 25% | | | 10% | 14% |
| Eastern | Blue Mountain Hospital | John Day | Yes | | | 16% | 28% | | | 6% | 11% |
| Eastern | Good Shepherd Medical Center | Hermiston | Yes | | | 39% | 60% | | | 22% | 19% |
| Eastern | Grande Ronde Hospital | La Grande | Yes | | | 88% | 95% | | | 10% | 15% |
| Eastern | Harney District Hospital | Burns | Yes | | | -8% | -17% | | | 1% | 3% |
| Eastern | Pioneer Memorial Hospital | Heppner | Yes | | | 46% | 81% | | | -17% | -24% |
| Eastern | Saint Alphonsus Medical Center Baker City | Baker City | Yes | | | 57% | 65% | | | 14% | 10% |
| Eastern | Saint Alphonsus Medical Center Ontario | Ontario | Yes | | | 150% | 122% | | | 14% | 23% |
| Eastern | St. Anthony Hospital | Pendleton | 2019 only | -4% | 20% | * | 125% | 15% | 17% | 17% | 21% |
| Eastern | Wallowa Memorial Hospital | Enterprise | Yes | | | 79% | 92% | | | 12% | 12% |
| Portland | Adventist Health Portland | Portland | Yes | 146% | 68% | 36% | 39% | 38% | 27% | 34% | 36% |
| Portland | Hillsboro Medical Center | Hillsboro | Yes | | | 80% | 51% | | | 16% | 1% |
| Portland | Kaiser Sunnyside Medical Center | Clackamas | Yes | | | 48% | 32% | | | . | . |
| Portland | Kaiser Westside Medical Center | Hillsboro | 2018 only | | | -64% | NA | | | . | . |
| Portland | Legacy Emanuel Medical Center | Portland | Yes | -1% | -23% | -24% | -21% | 30% | 29% | 26% | 27% |

"NA" means NASHP marked the data as invalid.
"*" indicates data was removed because it was an outlier.
"." denotes data missing from the original source.

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| | | | | Commercial payment above/below breakeven | | | | Operating profit margin | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Region | Hospital | City | Included in 2018-2019 analysis? | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 |
| Portland | Legacy Good Samaritan Medical Center | Portland | Yes | 33% | 24% | 20% | 24% | 13% | 12% | 12% | 16% |
| Portland | Legacy Meridian Park Medical Center | Tualatin | Yes | 33% | 129% | 52% | 36% | 19% | 18% | 14% | 18% |
| Portland | Legacy Mount Hood Medical Center | Gresham | Yes | 24% | 9% | 15% | 43% | 12% | 9% | 9% | 12% |
| Portland | OHSU Hospital | Portland | Yes | 51% | 32% | 39% | 39% | 15% | 16% | 13% | 14% |
| Portland | Providence Milwaukie Hospital | Milwaukie | Yes | 64% | 95% | 12% | 35% | 25% | 22% | 21% | 25% |
| Portland | Providence Portland Medical Center | Portland | Yes | 52% | 49% | 12% | 37% | 22% | 22% | 22% | 21% |
| Portland | Providence St. Vincent Medical Center | Portland | Yes | 54% | 74% | 16% | 44% | 27% | 26% | 24% | 27% |
| Portland | Providence Willamette Falls Med Center | Oregon City | Yes | 64% | 59% | 9% | 21% | 15% | 18% | 17% | 18% |
| Southern | Asante Ashland Community Hospital | Ashland | Yes | | | 85% | -3% | | | 20% | 13% |
| Southern | Asante Rogue Regional Medical Center | Medford | Yes | 47% | 32% | 48% | 54% | 15% | 10% | 13% | 15% |
| Southern | Asante Three Rivers Medical Center | Grants Pass | Yes | 20% | 34% | 20% | 21% | 12% | 12% | 13% | 9% |
| Southern | Lake District Hospital | Lakeview | Yes | | | 18% | 25% | | | -3% | -3% |
| Southern | Mercy Medical Center | Roseburg | Yes | 164% | 314% | 271% | 156% | 18% | 16% | 18% | 20% |
| Southern | Providence Medford Medical Center | Medford | Yes | -27% | -20% | -25% | 16% | 14% | 14% | 9% | 14% |
| Southern | Sky Lakes Medical Center | Klamath Falls | Yes | 108% | 149% | 215% | 137% | 20% | 18% | 20% | 18% |
| Willamette Valley | Good Samaritan Regional Medical Center | Corvallis | Yes | 96% | 88% | 106% | 125% | 23% | 24% | 25% | 25% |
| Willamette Valley | Legacy Silverton Medical Center | Silverton | Yes | | | 94% | 63% | | | 11% | 22% |
| Willamette Valley | McKenzie-Willamette Medical Center | Springfield | Yes | 121% | 78% | 148% | 154% | 35% | 33% | 34% | 24% |

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| | | | | Commercial payment above/below breakeven | | | | Operating profit margin | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Region | Hospital | City | Included in 2018-2019 analysis? | 2016 | 2017 | 2018 | 2019 | 2016 | 2017 | 2018 | 2019 |
| Willamette Valley | PeaceHealth Cottage Grove Community Medical Center | Cottage Grove | Yes | | | 144% | 235% | | | 22% | 37% |
| Willamette Valley | PeaceHealth Sacred Heart Medical Center at RiverBend | Springfield | Yes | 75% | 116% | 80% | 66% | 5% | 24% | 27% | 27% |
| Willamette Valley | PeaceHealth Sacred Heart Medical Center University District | Eugene | Yes | | | 43% | 55% | | | 0% | 3% |
| Willamette Valley | Providence Newberg Medical Center | Newberg | Yes | | | 18% | 36% | | | 32% | 35% |
| Willamette Valley | Salem Health Salem Hospital | Salem | Yes | 67% | 94% | 103% | 115% | 17% | 17% | 16% | 18% |
| Willamette Valley | Salem Health West Valley Hospital | Dallas | Yes | | | 134% | 86% | | | 11% | 14% |
| Willamette Valley | Samaritan Albany General Hospital | Albany | Yes | | | 74% | 104% | | | 24% | 22% |
| Willamette Valley | Samaritan Lebanon Community Hospital | Lebanon | Yes | | | 60% | 109% | | | 27% | 20% |
| Willamette Valley | Santiam Memorial Hospital | Stayton | Yes | | | 94% | 146% | | | 23% | 25% |
| Willamette Valley | Willamette Valley Medical Center | McMinnville | Yes | | | 57% | 34% | | | 39% | 34% |

# Appendix B. Hospital characteristics

| Region | Hospital | City | Health system | Hospital ownership type | Hospital type | Number of beds |
|---|---|---|---|---|---|---|
| Central/Columbia Gorge | Mid-Columbia Medical Center | The Dalles | Mid-Columbia Medical Center | Nonprofit | Short-term | 43 |
| Central/Columbia Gorge | Providence Hood River Memorial Hospital | Hood River | Providence Saint Joseph Health | Nonprofit | Critical-access | 25 |
| Central/Columbia Gorge | St. Charles Medical Center – Bend | Bend | St. Charles Health System | Nonprofit | Short-term | 251 |
| Central/Columbia Gorge | St. Charles Medical Center – Madras | Madras | St. Charles Health System | Nonprofit | Critical-access | 25 |
| Central/Columbia Gorge | St. Charles Medical Center – Prineville | Prineville | St. Charles Health System | Nonprofit | Critical-access | 16 |
| Central/Columbia Gorge | St. Charles Medical Center – Redmond | Redmond | St. Charles Health System | Nonprofit | Short-term | 42 |
| Coast | Adventist Health Tillamook | Tillamook | Adventist Health | Nonprofit | Critical-access | 25 |
| Coast | Bay Area Hospital | Coos Bay | Independent | Governmental | Short-term | 130 |
| Coast | Columbia Memorial Hospital | Astoria | Independent | Nonprofit | Critical-access | 25 |
| Coast | Coquille Valley Hospital | Coquille | Independent | Governmental | Critical-access | 17 |
| Coast | Curry General Hospital | Gold Beach | Independent | Governmental | Critical-access | 16 |
| Coast | Lower Umpqua Hospital | Reedsport | Independent | Governmental | Critical-access | 16 |
| Coast | PeaceHealth Peace Harbor Medical Center | Florence | PeaceHealth | Nonprofit | Critical-access | 21 |
| Coast | Providence Seaside Hospital | Seaside | Providence Saint Joseph Health | Nonprofit | Critical-access | 23 |
| Coast | Samaritan North Lincoln Hospital | Lincoln City | Samaritan Health Services | Nonprofit | Critical-access | 25 |
| Coast | Samaritan Pacific Communities Hospital | Newport | Samaritan Health Services | Nonprofit | Critical-access | 25 |
| Coast | Southern Coos Hospital & Health Center | Bandon | Independent | Governmental | Critical-access | 19 |
| Eastern | Blue Mountain Hospital | John Day | Independent | Governmental | Critical-access | 14 |

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| Region | Hospital | City | Health system | Hospital ownership type | Hospital type | Number of beds |
|---|---|---|---|---|---|---|
| Eastern | Good Shepherd Medical Center | Hermiston | Independent | Nonprofit | Critical-access | 25 |
| Eastern | Grande Ronde Hospital | La Grande | Independent | Nonprofit | Critical-access | 25 |
| Eastern | Harney District Hospital | Burns | Independent | Governmental | Critical-access | 19 |
| Eastern | Pioneer Memorial Hospital | Heppner | Independent | Governmental | Critical-access | 21 |
| Eastern | Saint Alphonsus Medical Center Baker City | Baker City | Trinity Health MI | Nonprofit | Critical-access | 21 |
| Eastern | Saint Alphonsus Medical Center Ontario | Ontario | Trinity Health MI | Nonprofit | Short-term | 44 |
| Eastern | St. Anthony Hospital | Pendleton | Catholic Health Initiatives | Nonprofit | Critical-access | 25 |
| Eastern | Wallowa Memorial Hospital | Enterprise | Adventist Health | Governmental | Critical-access | 23 |
| Portland | Adventist Health Portland | Portland | Adventist Health | Nonprofit | Short-term | 168 |
| Portland | Hillsboro Medical Center | Hillsboro | Tuality Healthcare | Nonprofit | Short-term | 101 |
| Portland | Kaiser Sunnyside Medical Center | Clackamas | Kaiser Permanente | Nonprofit | Short-term | 302 |
| Portland | Kaiser Westside Medical Center | Hillsboro | Kaiser Permanente | Nonprofit | Short-term | 122 |
| Portland | Legacy Emanuel Medical Center | Portland | Legacy Health | Nonprofit | Short-term | 384 |
| Portland | Legacy Good Samaritan Medical Center | Portland | Legacy Health | Nonprofit | Short-term | 164 |
| Portland | Legacy Meridian Park Medical Center | Tualatin | Legacy Health | Nonprofit | Short-term | 117 |
| Portland | Legacy Mount Hood Medical Center | Gresham | Legacy Health | Nonprofit | Short-term | 93 |
| Portland | OHSU Hospital | Portland | Oregon Health and Science University | Governmental | Short-term | 562 |
| Portland | Providence Milwaukie Hospital | Milwaukie | Providence Saint Joseph Health | Nonprofit | Short-term | 40 |
| Portland | Providence Portland Medical Center | Portland | Providence Saint Joseph Health | Nonprofit | Short-term | 368 |

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CONTINUED FROM PAGE 34

| Region | Hospital | City | Health system | Hospital ownership type | Hospital type | Number of beds |
|---|---|---|---|---|---|---|
| Portland | Providence St. Vincent Medical Center | Portland | Providence Saint Joseph Health | Nonprofit | Short-term | 501 |
| Portland | Providence Willamette Falls Med Center | Oregon City | Providence Saint Joseph Health | Nonprofit | Short-term | 111 |
| Southern | Asante Ashland Community Hospital | Ashland | Asante Health System | Nonprofit | Short-term | 38 |
| Southern | Asante Rogue Regional Medical Center | Medford | Asante Health System | Nonprofit | Short-term | 307 |
| Southern | Asante Three Rivers Medical Center | Grants Pass | Asante Health System | Nonprofit | Short-term | 122 |
| Southern | Lake District Hospital | Lakeview | Legacy Health | Governmental | Critical-access | 24 |
| Southern | Mercy Medical Center | Roseburg | Catholic Health Initiatives | Nonprofit | Short-term | 140 |
| Southern | Providence Medford Medical Center | Medford | Providence Saint Joseph Health | Nonprofit | Short-term | 126 |
| Southern | Sky Lakes Medical Center | Klamath Falls | Sky Lakes Medical Center | Nonprofit | Short-term | 105 |
| Willamette Valley | Good Samaritan Regional Medical Center | Corvallis | Samaritan Health Services | Nonprofit | Short-term | 169 |
| Willamette Valley | Legacy Silverton Medical Center | Silverton | Legacy Health | Nonprofit | Short-term | 29 |
| Willamette Valley | McKenzie-Willamette Medical Center | Springfield | Independent | For-profit | Short-term | 113 |
| Willamette Valley | PeaceHealth Cottage Grove Community Medical Center | Cottage Grove | PeaceHealth | Nonprofit | Critical-access | 14 |
| Willamette Valley | PeaceHealth Sacred Heart Medical Center at RiverBend | Springfield | PeaceHealth | Nonprofit | Short-term | 383 |
| Willamette Valley | PeaceHealth Sacred Heart Medical Center University District | Eugene | PeaceHealth | Nonprofit | Short-term | 40 |
| Willamette Valley | Providence Newberg Medical Center | Newberg | Providence Saint Joseph Health | Nonprofit | Short-term | 40 |
| Willamette Valley | Salem Health Salem Hospital | Salem | Salem Health | Nonprofit | Short-term | 421 |

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CONTINUED FROM PAGE 34

| Region | Hospital | City | Health system | Hospital ownership type | Hospital type | Number of beds |
|---|---|---|---|---|---|---|
| Willamette Valley | Salem Health West Valley Hospital | Dallas | Salem Health | Nonprofit | Critical-access | 15 |
| Willamette Valley | Samaritan Albany General Hospital | Albany | Samaritan Health Services | Nonprofit | Short-term | 67 |
| Willamette Valley | Samaritan Lebanon Community Hospital | Lebanon | Samaritan Health Services | Nonprofit | Critical-access | 25 |
| Willamette Valley | Santiam Memorial Hospital | Stayton | Independent | Nonprofit | Short-term | 40 |
| Willamette Valley | Willamette Valley Medical Center | McMinnville | Lifepoint Health | For-profit | Short-term | 50 |

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