Santiam Hospital & Clinics
embrace HEALTH

January 13, 2026
Oregon State Legislature
Senate Interim Committee on Health Care
900 Court Street NE
Salem, OR 97301

Submitted electronically via OLIS

Re: Insurance reimbursement hearing

Chair Patterson and Members of the Committee,

I appreciate the opportunity to share with you Santiam Hospital & Clinics' challenges with insurance reimbursement and the impact it is having on our small, independent health system.

I have been with Santiam since 1993 and spent nearly two decades as the chief financial officer before taking the helm as CEO, so I am familiar with hospital billing and payments.

Something cataclysmic is happening in Oregon right now. And part of it stems from commercial payers shifting more costs and administrative burden onto health care providers, so it is harder for them to be paid for services they have provided.

Currently, there is no true oversight of commercial payer practices in our state. But there should be, and this could a be role the Oregon Legislature fills. In fact, the legislature has taken steps in the past, such as ORS 743B.450, which requires insurers to process a claim within 30 days of receipt of that claim. Unfortunately, these rules do not apply to appealed claims—a loophole that commercial insurers are exploiting. On average, we see the processing of these appeals taking between 90 and 120 days.

Commercial health insurance payers are utilizing AI tools to unilaterally downcode and deny ER visits at rates that are unmanageable for health systems to address and an intentional way to avoid payment of services. These are not targeted audits, but rather blanket denials that ignore clinical records.

If you only take one thing away from my testimony, it is this: It is *never* acceptable to deny or downcode a claim without a review of the medical record.

This is nothing more than rationing payments by administrative burden or by volume to overwhelm. And it is working. We cannot hire enough people to track and fight denials, appeals, and downcoding, because the volume is simply too great. Insurers receive premiums to pay for services. Yet insurers are choosing to keep those dollars instead of paying for services needed by their members.

Over the past several years, we have seen commercial insurers lean more on claim denials to avoid payment of services and as a means to delay payment. Because when you deny a claim, you buy some time. The provider must first catch the denial, track all the claims, and file an appeal. When the appeal is successful—as is the case 85% of the time—the insurer then takes 90 to 120 days to pay us.

This deny-and-wait-for-an-appeal tactic is a way for commercial insurers to get around CMS rules about prompt payment. There's a chance that we'll miss something, and they won't have to pay us at all for services. And, mind you, these are big companies, and the longer they hold onto those dollars, the more interest they can earn. This is a money-making scheme.

This issue has been building now for years, but it has been supercharged over the last year and a half when a new product was put on the market by the for-profit, publicly traded company OPTUM Health. The tool, called the "Emergency Department Claim (EDC) Analyzer," by Optum Business, was developed specifically to help insurance companies deny and delay payments for people visiting hospital emergency departments—something in my decades of work I've never seen before. And most of the commercial insurers in our Oregon market are utilizing this tool.

We have all built entire internal infrastructures around navigating the labyrinth of prior authorization hoops; but when someone walks through the doors of our emergency department, we must serve them. We should be paid fairly and timely, based upon CMS facility coding guidelines.

What is most egregious is that insurers are using this AI tool to automatically deny higher-acuity emergency department visits. The claims that we are talking about are for people who should be seeking emergency care.

With more than 23,000 emergency department visits in our facility alone, we are facing a future of tracking, monitoring, and fighting thousands and thousands of claims per year. It is simply not possible to fight. This will result in further financial distress for Oregon hospitals.

We are a small, independent health system in the Santiam Canyon. We just don't have the resources to fight this. How are we supposed to survive?

As you continue your work to explore this issue, please consider the challenges hospitals like ours are experiencing with automatic downcoding and denials, especially as insurers employ the use of AI tools like OPTUM's. These insurer tactics are adding an impossible administrative burden and increasing costs to our already fragile health care system. Ultimately, these practices are undermining the stability of Oregon's hospitals and the broader health care system.

Sincerely,

Maggie Hudson
Chief Executive Officer
Santiam Hospital & Clinics