



Written Testimony on HB 4038

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On behalf of Salem Clinic, P.C.

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Re: Testimony in Support of HB 4038

Chair Nosse, Vice-Chair Diehl, Vice-Chair Nelson, and Members of the Committee:

My name is Henry T. O’Keeffe, and I am testifying on behalf of Salem Clinic. **Salem Clinic was founded in 1925** and today is a multi-specialty group practice with more than fifty providers representing family medicine, internal medicine, obstetrics and gynecology, urgent care, and behavioral health, serving patients throughout Salem and Keizer.

We appreciate Representative Nosse bringing forward **HB 4038**, which would prohibit enforcement actions under the Health Care Cost Growth Target Program for ten years. While we understand that the bill will not advance this session because it received its public hearing after the chamber of origin deadline, **the policy conversation it raises is both important and necessary.**

HB 4038 would have created space to recalibrate the program before financial penalties begin to reshape the delivery system in unintended ways.

Salem Clinic acknowledges the need for health care cost control. Like many Oregon employers, Salem Clinic provides medical benefits to its staff, and **the cost of those benefits is growing faster than revenue.** That creates a difficult dilemma, especially because Salem Clinic’s revenue comes from health care.

This is the core issue. The Cost Growth Target Program attempts to regulate cost growth across the health care industry as though escalation occurs evenly across all sectors. It does not.

Year over year, the state issued cost growth scorecard highlights excessive growth concentrated in two primary categories: **hospital claims and pharmacy claims.**

Hospitals continue to drive large increases in spending. Major capital projects and high cost operational decisions establish a new baseline, and that baseline is then used to justify higher reimbursement and higher total medical expense in subsequent years.

Prescription drugs are another significant driver. Manufacturers price successful drugs to recoup enormous research and development investments. Whatever one's view of that model, drug pricing remains largely outside the control of employers, patients, and primary care providers.

The data used to calculate total medical expense and assign accountability comes from insurance companies. Insurers determine attribution, calculate total cost of care, and report the data that forms the foundation of the state scorecard. At the same time, insurers negotiate hospital contracts, negotiate drug coverage, and control reimbursement structures.

Yet when total cost growth exceeds the target, primary care providers are placed in the position of explaining growth they did not cause and cannot control.

This is the structural tension that HB 4038 sought to address.

The bill would not have eliminated the Cost Growth Target Program. It would have paused enforcement actions. It would have prevented analysis, mandatory performance improvement plans, and financial penalties until 2036. **That pause would have allowed the Legislature and stakeholders to examine whether accountability is properly aligned with control.**

A primary care organization cannot explain why hospital spending increases. It cannot explain why pharmaceutical pricing rises. It cannot explain why insurers justify double digit premium increases while offering minimal reimbursement increases to the providers delivering care. The relevant information is embedded in payer contracts, proprietary pricing arrangements, and internal financial decisions that are not transparent to providers.

If the state's goal is to curb cost growth, the levers must match the drivers.

One obvious lever is the premium rate setting process. Premium growth is a pricing decision. If premiums are approved at levels far exceeding the cost growth target, the entire downstream system adjusts accordingly. Holding premium growth closer to the target would influence hospital negotiations, drug coverage decisions, and reimbursement structures across the system.

Instead, the current framework assigns accountability to primary care for costs generated elsewhere.

That creates a fundamental fairness issue.

In what world should an entity with no control, no input, and no influence be exposed to financial penalties for decisions made between insurance companies and hospitals, insurance companies and drug manufacturers, or insurance companies and other institutional providers? Primary care does not sit at those negotiating tables in a meaningful way. Primary care does not set those prices. Primary care often does not have access to the underlying data needed to justify those prices.

Yet primary care is asked to defend the total.

That misalignment risks harming the very part of the system we most need to strengthen.

To remain under an arbitrary growth target, a primary care organization may feel pressure to slow expansion, limit hiring, or restrict service growth. Those decisions would not be based on patient need. They would be driven by a mathematical threshold disconnected from the true sources of cost escalation.

Neither outcome benefits Oregonians.

Salem Clinic supports cost control. Salem Clinic supports transparency. Salem Clinic supports accountability.

But accountability must align with control and influence.

HB 4038 would have provided time to ensure that alignment before penalties reshape the delivery system in ways that undermine access to care.

Even though the bill will not advance this session, we urge the Committee to continue this conversation and to examine whether the enforcement structure of the Cost Growth Target Program appropriately targets the actors and decisions that actually drive cost growth.

Thank you for your time and consideration.