Universal Health Plan Governance Board Meeting

February 19, 2026

9:00 AM- 12:30 PM

350 Winter St, NE

Room 260

Salem, OR 97301

Welcome Remarks
Chair Bellanca

Roll Call

Agenda Review

Agenda

- Public Comments- Written Synopsis and Voting Topics
- Consent Agenda
- Executive Director Report
- Board Discussion
- Expenditure Review
- Universal Health Care Global Efforts
- Committee Updates
- Federal and State Policy Updates
- Next Steps
  - Board Outreach, Meeting Take-aways, and Next Meeting Topics
- Public Comment
- Reflection

Written Comment Synopsis & Public Comment on Voting Topics

Chair Bellanca

Consent Agenda

Chair Bellanca

Executive Director’s Report

Executive Director McDonell

Updates

- Policy Option Package 2027-2029
  - Substantial funding for information technology, public engagement and financial/economic consultation
- Staff support for 15-20 targeted engagement meetings in March
- Potential for additional virtual board meetings as needed
- Board Outreach
  - Board Member Glass
  - Vice-Chair Richardson
  - Chair Bellanca
  - Executive Director McDonell

Budget Update as of Dec 2025

	Working Biennial Budget	Actuals to Date 12/2025	Actual and Planned	(Over) / Under
Personal Services	$994,889	$204,200	$909,883	$85,006
Services and Supplies	$781,022	$453,511	$836,601*	($55,579)
Special Payments	$38,285	0	$6,000	$32,285
Expenditure Total	$1,814,196	$657,710	$1,752,484	$61,712

Consultant Groups

Consultant	Actual to Date (12/25)	Budget	Balance	Contract End Date
ECOnorthwest	$225,873	$296,000*	$70,127	3/31/2027
Milliman	$350,000	$385,000*	$35,000	7/31/2027
Wentz Jackson	$16,931	$31,250*	$14,319	1/31/2027
Artemis	$7,425	$55,000	$47,575	9/30/2026
OCIN translation	$1,849	$10,000	$8,150	10/27/2026
OCIN interpretation	$3,103	$15,000	$11,896	8/30/2026

Board Discussion

Short Term Timeline

March

Reconciliation of Revenue and Expenditures

Committee Proposals

April

Reconciliation of Revenue and Expenditures

Committee Proposals

Plan for 2027-2029

May

Consider Feedback from Targeted Engagement Groups

Discuss Adjustments to Plan

June

Final Elements of Plan Reconciliation

Transition Strategy

July

Review First Draft of Report

Transition Strategy

August

Approve Final Draft

Plan to Build Support

Board Considerations

- The UHPGB is absolutely committed to delivering a report to the legislature that provides a playbook on how to cover everyone in Oregon under a unified financing strategy.
- And we also need to consider:

  -how different markets might be brought into UHP in different ways or on different timelines

  -how to ease the economic impact of a UHP on households, businesses, health care industry and the state

Why are the F&R, PD&E and Ops committees scheduled to end in March?

- Deliverables have been met, or will be by March
- Board needs time to reconcile all recommendations from all committees
- Consultant contracts for ECOnorthwest and Milliman have run out, and they will not be available to the committees after March
- Supporting the committees takes a great deal of staff time, and staff attention is needed elsewhere

Why are the F&R, PD&E and Ops committees scheduled to end in March?

- Artemis consulting is charged with presenting our plan to various interest groups (business community, health care industry, etc.), and details of our plan are needed for that outreach

- Transition committee needs to launch in March, and it pulls several people from current committees to figure out how to get from here to there -- they need details of our plan

- Although final report due in September, first draft needs to come to the board in July

Staff work for the next few months

- Planning, staffing and supporting the revenue committee
- Supporting the 15-20 targeted outreach meetings with Artemis
- Consolidating all the work of all 4 committees into a cohesive set of recommendations
- Ensuring contractors submit their final technical reports
- Drafting our final report
- Building a timeline, workplan and budget for 2027-2029

Tasks for the board after September

- Build interest and support among legislators and their committees
- Build support from advocates, health care and business leaders
- Currently we are funded until June 30, 2027. We need to make the case for continued funding on this work.
- What will the board need for the next phase of work?

Where we are in this journey

- Developing a playbook of how a UHP would work
  - Gain interest
  - Answer key questions about how the revenue strategy would work
  - Have a plan for cost containment
  - Show that it is better for businesses
  - Don’t need all the details worked out

- If we can demonstrate the feasibility of this plan, and build a coalition of support, that gives us the best chance of continuing to work out the details.

Public input
Board meeting time and location

- CCEC will change its meeting time to 4-6:30pm once a month starting in March for more opportunity for public engagement
- HCAO hosting a series of town halls
- Current plan is to continue once a month meetings on the first Thursday from 9am to 12:30pm
  - All meetings remain virtual and recorded
- Discussion?

Expenditure Review 2026 & 2032

Executive Director McDonell

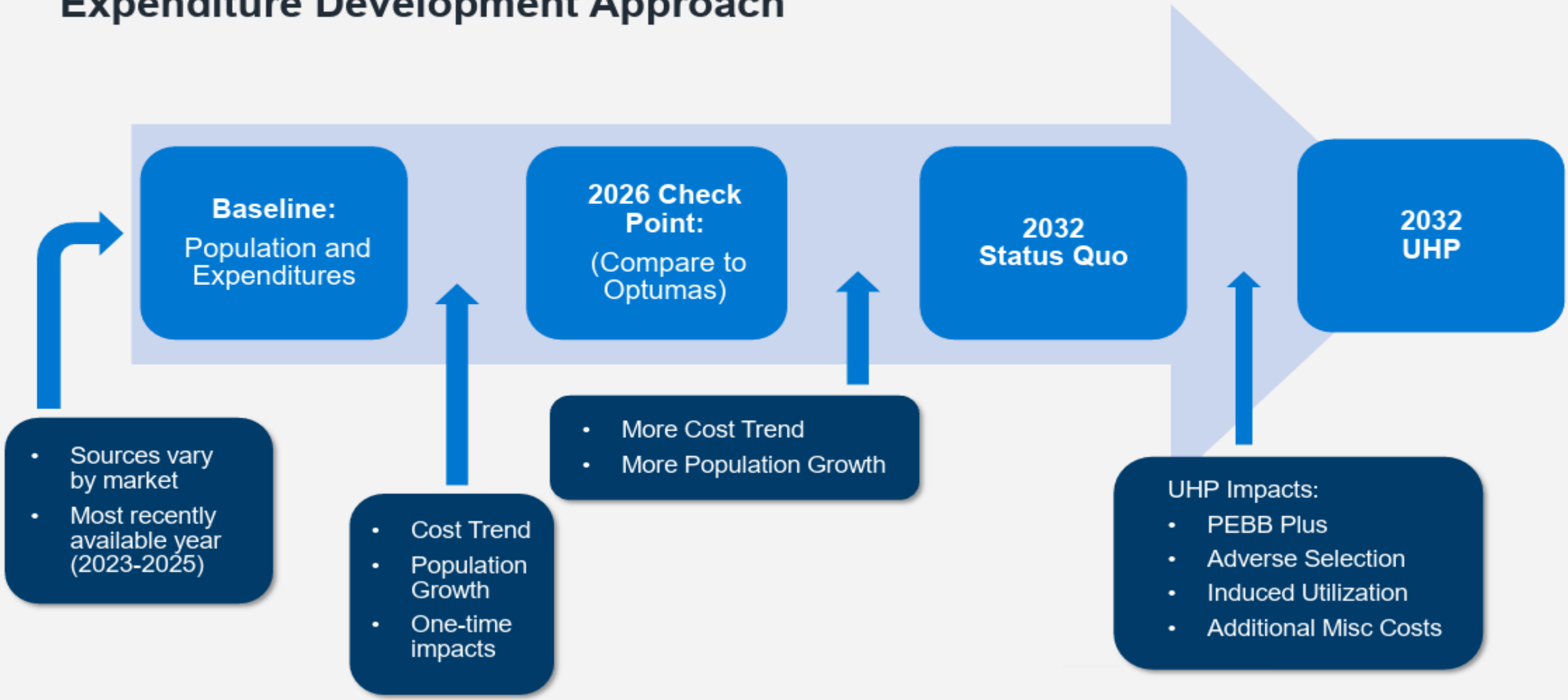
Milliman- Fritz Busch and Ken Laskowski

Expenditure Review
2026 & 2032

- Level set by looking at Optumas 2026 (2019 data) and Milliman 2026 (2023-2025 sources) status quo projections
- Review enrollment and cost projections
- Healthcare cost trend assumptions from 2026-2032
- Review cost impact of a universal health plan
  - Increased Benefits
  - Increased Utilization
  - Potential for Migration
- Opportunities

UHPGB FINANCE AND REVENUE COMMITTEE FEBRUARY 2026

Expenditure Development Approach



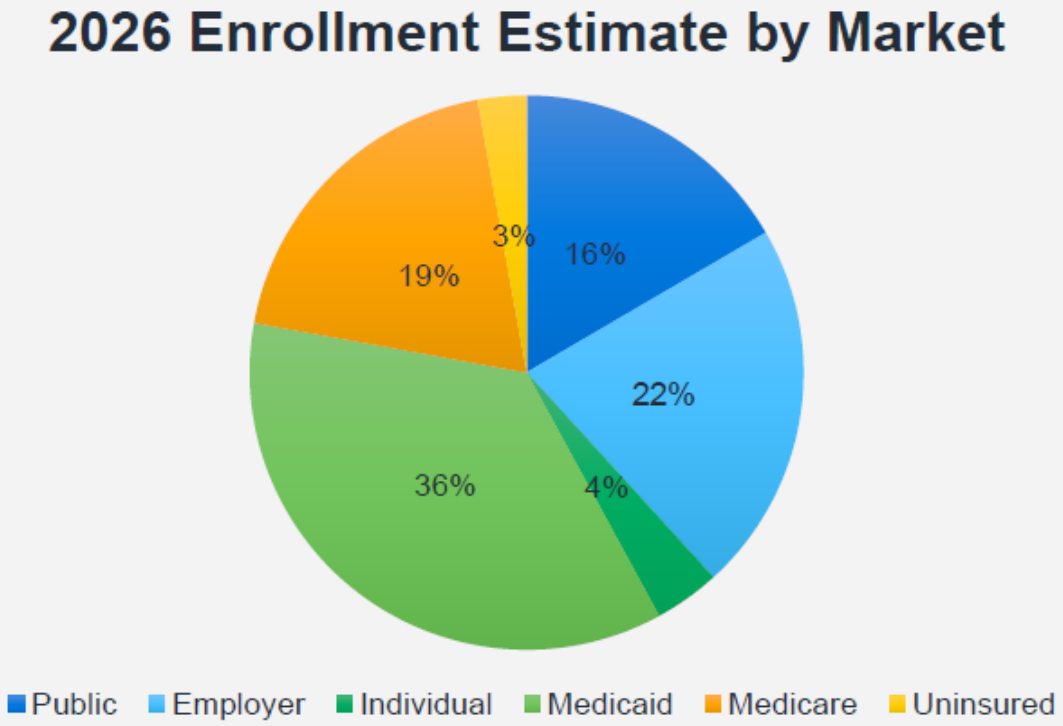
Finance and Revenue Committee [Milliman February 3 2026]

Baseline 2026 Enrollment Estimate

Enrollment estimate built from various 2023-2025 sources and adjusted for legislative and market changes
Enrollment is compared to projected Optumas 2026

Table 1 Oregon Universal Health Plan 2026 Enrollment Estimate		
Market	**Baseline**	**Optumas**
Public	712,000	707,000
Employer	929,000	1,353,000
Individual	165,000	156,000
Medicaid	1,360,000	1,039,000
Medicare*	1,004,000	823,000
Uninsured	122,000	315,000
Total Oregon Population	**4,293,000**	**4,237,000**

*Includes 177,000 Full and Partial Dual Eligibles



Baseline 2026 Expenditures Estimate

Costs built from various 2023-2025 sources and adjusted for trend

Table 2
Oregon Universal Health Plan
2026 Allowed Claims Estimate Comparison

Market	Per Member Per Month (PMPM) Basis			Total Expenditures		
	Baseline	Optumas	Baseline/ Optumas	Baseline	Optumas	Baseline/ Optumas
Public	$698	$747	-6.6%	$5,965	$6,340	-5.9%
Employer	$701	$744	-5.8%	$7,815	$12,077	-35.3%
Individual	$692	$742	-6.8%	$1,372	$1,389	-1.2%
Medicaid	$697	$1,223	-43.0%	$11,382	$15,249	-25.4%
Medicare	$1,452	$1,600	-9.2%	$17,501	$15,804	10.7%
Uninsured	$399	$426	-6.4%	$583	$1,610	-63.8%
Total	**$866**	**$1,032**	**-16.1%**	**$44,618**	**$52,469**	**-15.0%**

- Costs are lower relative to Optumas projections on a per member basis. This is offset by increases in overall population and some mix change by market.
- Note – this table excludes certain items such as out of pocket, behavioral health, unreimbursed Medicaid. This table also excludes Baseline dental, vision, fertility, and other enhanced benefits.

2032 Status Quo Enrollment Estimate

2026 baseline enrollment is projected out to 2032

Table 4
Oregon Universal Health Plan
Projection to Status Quo 2032 Enrollment

Market	2026 Enrollment	Change Factors: Population Growth	Change Factors: Market Movement	2032 Status Quo Enrollment
Public	712,000	1.1%	0.0%	720,000
Employer	929,000	1.9%	-1.2%	935,000
Individual	165,000	1.1%	7.0%	179,000
Medicaid	1,360,000	1.1%	-16.4%	1,150,000
Medicare	1,004,000	8.6%	0.0%	1,091,000
Uninsured	122,000	1.1%	182.7%	348,000
Total	**4,293,000**	**3.0%**		**4,423,000**

- Medicaid market impacted by HR1 beginning in 2027 – membership shifted to uninsured
- Population growth varies by market
- Total population and growth by age is based on Oregon Office of Economic Analysis projections resulting in larger growth in the Medicare market

Trend Estimate Assumption

Trend assumption variance provides a starting point for the low and high end of the range for 2030 Status Quo and UHP

- **Low** • 5.3% ← Based on Oregon specific information from national health expenditure data
- **High** • 7.4% ← High estimate builds in additional conservatism and contingency
- **OR Target** • 3.4% ← Oregon cost growth targets (Not used)

2032 Draft Expenditures Estimate Summary

Low and High Estimates

Table 3

Oregon Universal Health Plan

2032 Expenditure Projections

Scenario	Expenditures (Billions) Total	Membership (Millions)*
2032 Status Quo Estimate – Low	**$66.6**	4.4
2032 Status Quo Estimate – High	**$76.2**	4.4

**Our estimates include adverse selection population shifts*

2032 Status Quo Expenditures Estimate

2026 baseline expenditures are projected out to 2032 on an allowed basis

Table 5
Oregon Universal Health Plan
Projection to Status Quo 2032 Costs[1]

Market	2026 Allowed PMPM	Low Trend	Adj. Factor[2]	2032 Cost PMPM Low	High Trend	Adj. Factor[2]	2032 Cost PMPM High
Public	$698	5.3%	1.0%	$962	7.4%	2.5%	$1,097
Employer	$701	5.3%	1.2%	$968	7.4%	2.7%	$1,104
Individual	$692	5.3%	1.0%	$953	7.4%	2.5%	$1,087
Medicaid	$697	5.3%	-0.5%	$947	7.4%	1.0%	$1,080
Medicare	$1,452	5.3%	0.8%	$1,998	7.4%	2.3%	$2,279
Uninsured[3]	$399	5.3%	1.0%	$549	7.4%	2.5%	$627
Total	**$866**	5.3%		**$1,182**	7.4%		**$1,348**
Additional Costs							
Behavioral Health[4]	$16			$15			$21
Unreimbursed Medicaid[3]	$22			$27			$29

[1] Dental, Vision, Fertility, and other enhanced benefits are excluded from status quo PMPMs shown above

[2] Adjustment factor includes additional impacts not included in the baseline expected to change in Status Quo by 2032

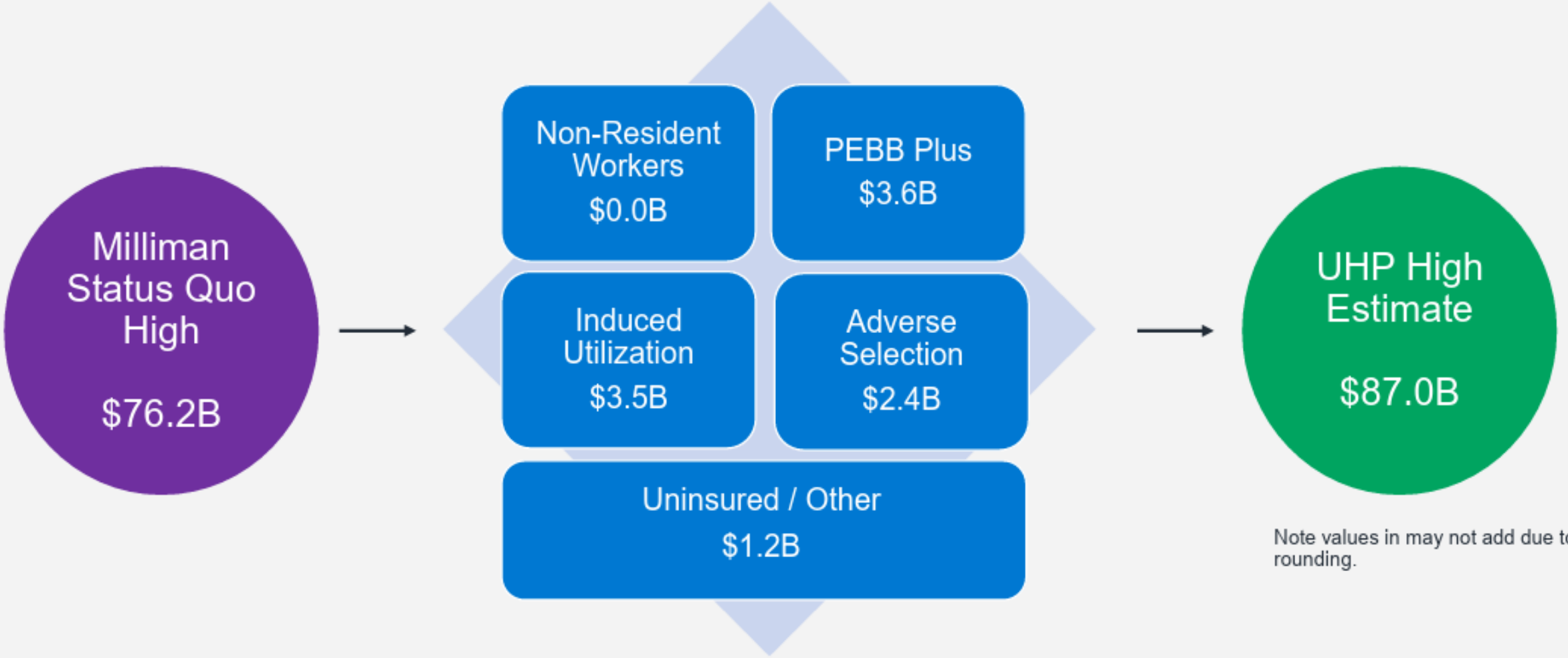
- Prescription drug changes (GLP-1, rebates) - Legislative changes (insulin cap, gender affirming care) - Other (Cell and Gene Therapy)

[3] Uninsured costs based on charity care and subsidized health services which do not include costs of unreimbursed Medicaid

[4] Behavioral Health spending is estimated using the Oregon Health Authority 2025-27 Governor's Budget as a basis

2032 UHP Main Impacts

Estimating changes resulting from implementation of the UHP



Note values in may not add due to rounding.

2032 Induced Utilization Estimate

Moral hazard leads individuals to use more healthcare than they otherwise would if paying the full cost themselves

Table 4 Oregon Universal Health Plan Induced Utilization		
Statewide Estimate	**UHP Low**	**UHP High**
Round 1	4.3%	8.0%
Round 2	3.3%	5.2%

- PCP capacity and hospital occupancy research considered in adjusting induced utilization estimates
  - Professional physician services adjusted by region
  - Facility induced utilization impacts reduced
- Capacity is subject to material change over a seven-year period

2032 Adverse Selection Estimate

Estimating the total cost of population moving to and exiting Oregon

2032 Estimate

- Low $1.3B
- High $2.4B

- Refinements made based on more research and investigation looking at interstate migration after Medicaid expansion
  - 0.23% greater annual population growth in the target population
- Adverse Selection now includes migration of LTSS users – the study linked above indicates higher migration from disabled population
- Round 1 estimated $2.4 - $3.5 billion in 2030

2032 Benefit Package Estimates

Round 2 additional PEBB benefit package costs

Table 7 Oregon Universal Health Plan 2032 Ancillary Benefit Cost ($ Billions)		
Benefit	**UHP Low**	**UHP High**
Dental	$3.3	$4.1
Vision	$0.5	$0.6
Fertility Services	$0.3	$0.4
Sleep Studies	$0.1	$0.1
Hearing Aids	$0.0	$0.1
Massage Therapy	$0.2	$0.3
Complementary Medicine	$0.1	$0.1
Total	**$4.5**	**$5.6**
Enhanced Behavioral Health	$0.8	$1.1
Total Plus BH	**$5.3**	**$6.7**

2032 Draft Expenditures Estimate Summary

Low and High Estimates

We estimate total 2032 UHP Expenditures ranging from $73.7 to $87.0 billion

Table 3 Oregon Universal Health Plan 2032 Expenditure Projections		
Scenario	**Expenditures (Billions) Total**	**Membership (Millions)***
2032 Status Quo Estimate – Low	**$66.6**	4.4
2032 Status Quo Estimate – High	**$76.2**	4.4
2032 UHP Estimate – Low	**$73.7**	4.4
2032 UHP Estimate – High	**$87.0**	4.5
**Our estimates include adverse selection population shifts*		

2032 Draft Estimates Detail – including Administrative Costs

Estimates For Each Plan – including Low, Best Estimate (BE), and High

UHP Total Expenditure best estimates: $86 billion for full and $79 billion for lean benefits

Table 1
Oregon Universal Health Plan
2032 Expenditure Estimates ($ Billions)

Annotation	(a)	(b)	(c)	(d)	(e) = (a) + (b) + (c) + (d)
Scenario	Major Benefits*	PEBB Plus Benefits**	Cost Sharing	Administrative Costs	Total UHP Cost
Full Benefits – Low	$69.2	$4.5	$0.0	$3.6 (4.6%)	$77.4
Full Benefits – BE	$75.3	$5.1	$0.0	$5.1 (5.9%)	$85.5
Full Benefits – High	$81.3	$5.6	$0.0	$7.0 (7.4%)	$94.0

Inpatient, Outpatient, Physician, Prescription Drugs, Other

***Dental, Vision, Fertility, Other Benefits*

2032 Draft Estimates Detail – including Administrative Costs

Estimates For Each Plan – including Low, Best Estimate (BE), and High

UHP Total Expenditure best estimates: $86 billion for full and $79 billion for lean benefits

Table 1 Oregon Universal Health Plan 2032 Expenditure Estimates ($ Billions)					
Annotation	(a)	(b)	(c)	(d)	(e) = (a) + (b) + (c) + (d)
Scenario	Major Benefits*	PEBB Plus Benefits**	Cost Sharing	Administrative Costs	Total UHP Cost
Full Benefits – Low	$69.2	$4.5	$0.0	$3.6	$77.4
Full Benefits – BE	$75.3	$5.1	$0.0	$5.1	$85.5
Full Benefits – High	$81.3	$5.6	$0.0	$7.0	$94.0
Lean Benefits – Low	$68.6	$0.0	-$1.1	$3.6	$71.2
Lean Benefits - BE	$74.6	$0.0	-$1.2	$5.1	$78.5
Lean Benefits – High	$80.6	$0.0	-$1.3	$7.0	$86.4

Inpatient, Outpatient, Physician, Prescription Drugs, Other

***Dental, Vision, Fertility, Other Benefits*

2032 Draft Estimates – Medicare Eligible vs Non-Medicare Eligible

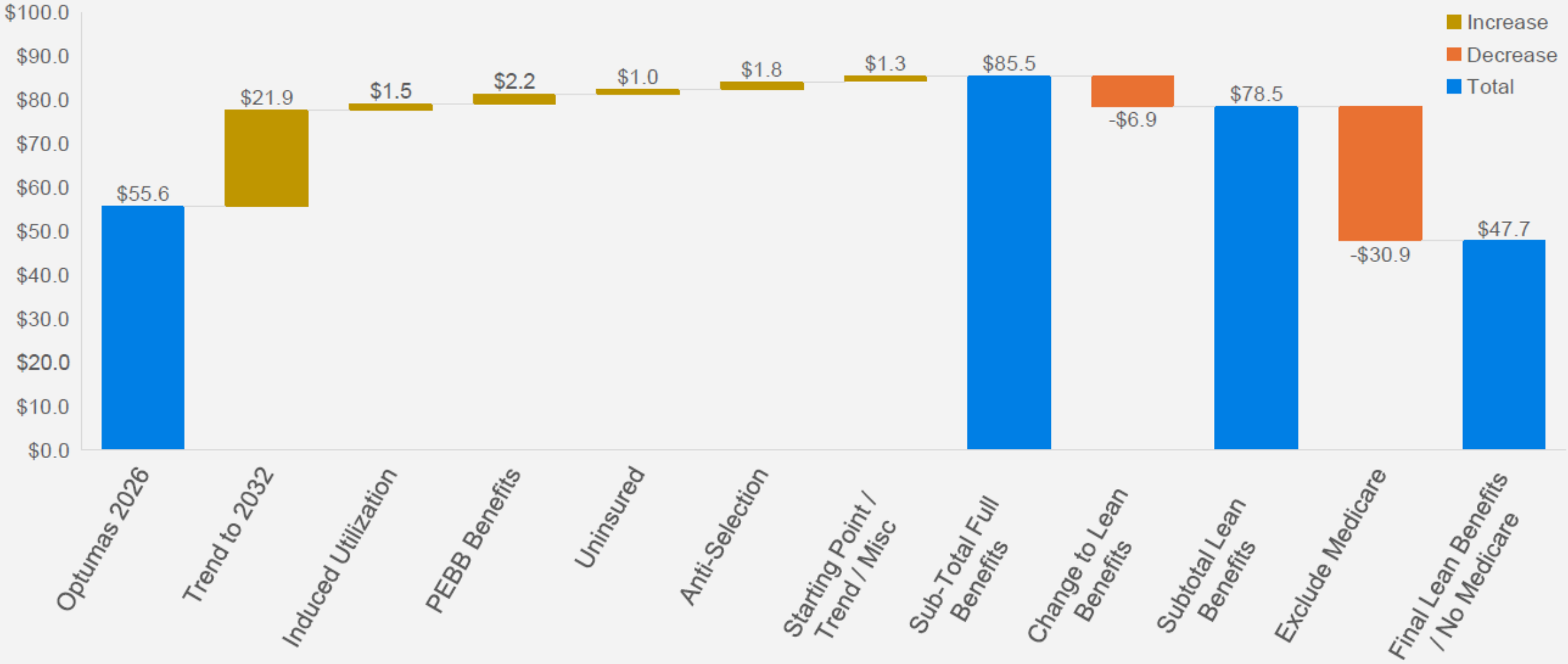
Estimates For Each Plan – including Low, Best Estimate, and High – Excludes Administrative Costs, Net of Cost Sharing

Medicare eligible population estimated at 1.1 million vs. 3.3 million Non-Medicare

Table 2 Oregon Universal Health Plan 2032 Total Cost Estimates Excluding Admin ($ Billions)			
Scenario	**Medicare Eligible**	**Non-Medicare Eligible**	**Total**
Full Benefits - Low	$28.1	$45.7	$73.7
Full Benefits - Best Estimate	$30.9	$49.4	$80.3
Full Benefits - High	$33.8	$53.2	$87.0
Lean Benefits - Low	$26.0	$41.5	$67.5
Lean Benefits - Best Estimate	$28.6	$44.8	$73.4
Lean Benefits - High	$31.2	$48.1	$79.3

Comparison to Optumas

Reconciling differences from Optumas 2026 estimate to Milliman 2032 estimate (including admin in Billions)



Opportunities

- Provider Savings due to UHP
  - 100% collectability of fees
  - Standardized fee schedule
  - Billing simplification
  - Contracting/credentialling simplification
  - Practitioner efficiency due to streamlined quality measures, uniform requirements, electronic PAs
- Pharmacy
- Administrative
- Increased Primary Care
- Hospital Global Budgeting

Discussion

Baseline Enrollment Estimate Sources & Links

Market	Component	Source	Link
Public	PEBB / OEBB	2023 Public Reports	OEBB Insurance 101 OEBB Demographic Report 2023-2024.pdf
Employer	Employer LG FI	2023 CMS MLR Reports	Medical Loss Ratio Data and System Resources | CMS
	Employer SG FI	2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
	Employer Self-Insured	Balancing Item	N/A
Individual		2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
Medicaid	Includes CHIP, BHP	2025 OHA Enrollment Report	Oregon Health Authority : Medicaid Enrollment Report : Office of Health Analytics : State of Oregon
Medicare	Includes Duals	2023 APAC Data	N/A
Uninsured		2024 OHA Health Insurance Survey	Oregon Health Authority : Oregon Health Insurance Survey (OHIS) Coverage Dashboard : Office of Health Analytics : State of Oregon
Total Population		Oregon Office of Economic Analysis	Department of Administrative Services : Demographic Forecast : Office of Economic Analysis : State of Oregon

Baseline Enrollment Estimate Sources & Links

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Employer	Employer LG FI	2023 CMS MLR Reports	Medical Loss Ratio Data and System Resources | CMS
	Employer SG FI	2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
	Employer Self-Insured	Balancing Item	N/A
Individual		2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
Medicaid	Includes CHIP, BHP	2025 OHA Enrollment Report	Oregon Health Authority : Medicaid Enrollment Report : Office of Health Analytics : State of Oregon
Medicare	Includes Duals	2023 APAC Data	N/A
Uninsured		2024 OHA Health Insurance Survey	Oregon Health Authority : Oregon Health Insurance Survey (OHIS) Coverage Dashboard : Office of Health Analytics : State of Oregon
Total Population		Oregon Office of Economic Analysis	Department of Administrative Services : Demographic Forecast : Office of Economic Analysis : State of Oregon

Universal Health Care Global Efforts

Break

Committee Updates

Committee Chairs

Operations

Chair: Judy Richardson

- Current work
- Questions for board or other committees
- Preliminary proposal
  - Enrollment
  - Subrogation
- Additional resources needed

Upcoming Meetings

- Thursday, February 26, 2026, 1:00PM-4:00PM

Enrollment

Senior Policy Advisor Hastings

Context: Eligibility

All people who live in Oregon will qualify for the Universal Health Plan no matter their job, income, immigration status, or tribal membership.

- Coverage for members of Oregon's nine federally recognized Tribes
- Coverage for out-of-state students attending universities and colleges in Oregon
- Coverage for dependents of Oregon residents up to age 26
- Coverage for seasonal farmworkers, defined in ORS 652.145(2), while working in Oregon
- Coverage for individuals incarcerated in Oregon

Operations Enrollment Proposal

- ☑ Enrollment verification
- ☑ Re-enrollment process
- ☑ Enrollment for new members

Enrollment Verification

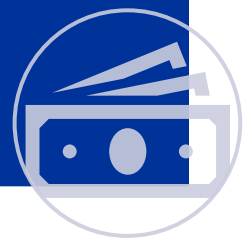
Goal: Prioritize ease of enrollment while collecting only the information needed to establish valid coverage and align with federal match rules

- Primary criteria for universal health plan eligibility
- Auto-enrollment with tax data
- Needed for newcomers, non-tax filers

Residency or intent to reside

- To determine Medicaid eligibility
- Necessary for federal matching fund
- May be eligible for additional/enhanced benefits

Income



- To determine Medicare eligibility
- Depending on arrangement with federal government, needed for funding or benefit adjustments

Identity

Re-enrollment: Automatic Process

Primary Mechanism: Filing Oregon Personal Income Tax

- Trigger: Filing an Oregon personal income tax return, or being claimed as a dependent on an Oregon tax return
- Coverage automatically extended for the next plan year unless individual opts out
- Estimated to capture 75-85% of eligible individuals

Secondary Mechanism: Participation in Verified State or Federal Programs

- Check non-filers for participation in programs that already require annual or periodic residency checks such as SNAP, TANF, WIC, Medicaid/OHP, state-funded long-term care programs, UI, etc.
- If an individual was active in any qualifying program within the past year, automatically re-enroll
- If an individual is aged 65 or older, automatically re-enroll

Collectively, these mechanisms should capture 90-95% of eligible individuals

Re-enrollment: Final 5-10%

Tertiary Mechanism

- Ex parte logic: attempt all data-source checks before requiring member action
- Outreach targeted to last known contact channels – last known address, employer, etc.
- Provide 90–day grace period in which coverage continues unless the state receives contrary information (change in residency, death, relocation out of state)

Enrollment of New Members

Initial Enrollment

Via attestation of intent to reside in Oregon, full verification within 90 days

Option A: Full benefits available upon attestation

Option B: new member waiting period during which certain high cost, elective procedures are not covered

Failure to verify within 90 days – public corporation recoups

Recommending referral to PDE

Discussion & Vote

Subrogation & Worker’s Comp

Subrogation

Right of an insurer to seek damages from a third party that caused a loss

Liability doctrine

Subrogation allows insurance companies to quickly pay out claims and then pursue reimbursement from the at-fault party's insurer

Single payer systems tend to cover medical expenses normally – but use statutory recovery rights to seek reimbursement from liability coverage

Cost Efficiency

- Ontario's public health plan recovers about $15 million annually through subrogation activities
- U.S. private health insurers typically recover about 0.2–0.3% of benefit payments via subrogation; approximately $2.9–$4.4 billion

Moral Hazard

- Avoids socializing costs that are tied to the risk-creating activities (e.g., dangerous driving, unsafe premises), sustaining deterrence

Worker's Compensation (WC)

WC is a **no-fault system** that allows injured workers to receive medical care and compensation for lost wages without proving employer liability

- **Scope of services:** WC is not just about medical care; it involves wage-replacement, vocational rehabilitation, and return-to-work programs
- **Employer incentives:** WC systems serve as a mechanism to hold employers financially accountable for workplace risk
- **Administrative / legal-differences:** WC involves specialized rules about causation and duration

Treatment of Worker's Compensation in Single Payer Systems
Even in robust single payer contexts; WC remains a separate social insurance system with its own premiums and benefits
Typically, payment rates for health care are aligned to the single payer to avoid negative incentives

Operations Proposal for Discussion

Subrogation and worker's compensation should continue to operate outside of a universal health plan

- Treatment agnostic – care is provided immediately and billed to the UHP
- Public corporation to have statutory recovery rights to recoup liability-based and worker's compensation costs

Transition

Co-Chairs: Judy Richardson & Mike Leahy

- Current work
- Questions for board or other committees
  - Board Member Appointment
  - Committee Member Approval
  - Charter Approval
- Additional resources needed

Upcoming Meetings
• March 19, 2026

Transition

- Board Member Volunteers
  - Judy Richardson
  - Mike Leahy
  - Mary Lou Hennrich
  - Others?
- Charter Review
- Committee Member Approvals

Committee Charter

“The primary purpose of the committee is to develop and recommend to the Board a consolidated transition roadmap that synthesizes outstanding issues, dependencies, and sequencing considerations for Board deliberation and decision-making”

Committee Members

- Judy Richardson
- Charlie Swanson
- Richard Gibson
- Jamie Osborne
- Paula Weldon
- Antonio Germann
- Mike Leahy
- Mary Lou Hennrich
- Ann Lovejoy
- Eve Gray
- Mickie Derting
- Jensina Hawkins

Community Engagement and Communications

Co-chairs: Michelle Glass and Amy Fellows

- Current work
- Questions for board or other committees
- Preliminary proposal
- Additional resources needed

Upcoming Meetings

- March 10th or 11th, 2026, 4:00PM-6:30PM*

UHPGB website updates

- Wentz Jackson Consulting coordinated with UHPGB staff, CECC co-chairs, and DCBS communications staff to update information on the website and improve accessibility.
- The mission statement, Board principles, and additional information about the Board have been added.
- Other updates included homepage text, committee descriptions, and public comment overview.
- Community engagement resources have been posted on the resources page, and staff plans to add additional resources, such as approved proposals, to this page.

https://www.oregon.gov/uhpgb/Pages/index.aspx

Finance and Revenue

Chair: Cherryl Ramirez

- Current work
- Questions for board or other committees
- Preliminary proposal
- Additional resources needed

Upcoming Meetings
• Tuesday, March 3, 9:00 AM- 12:00 PM

Plan Design and Expenditure

Interim Chair: Helen Bellanca

- Current work
- Questions for board or other committees
- Preliminary proposal – Behavioral Health
- Additional resources needed

Upcoming Meeting

- Thursday, March 5, 1:00 PM – 4:00 PM

Behavioral Health Integration

Universal Health Plan Governance Board

February 2026

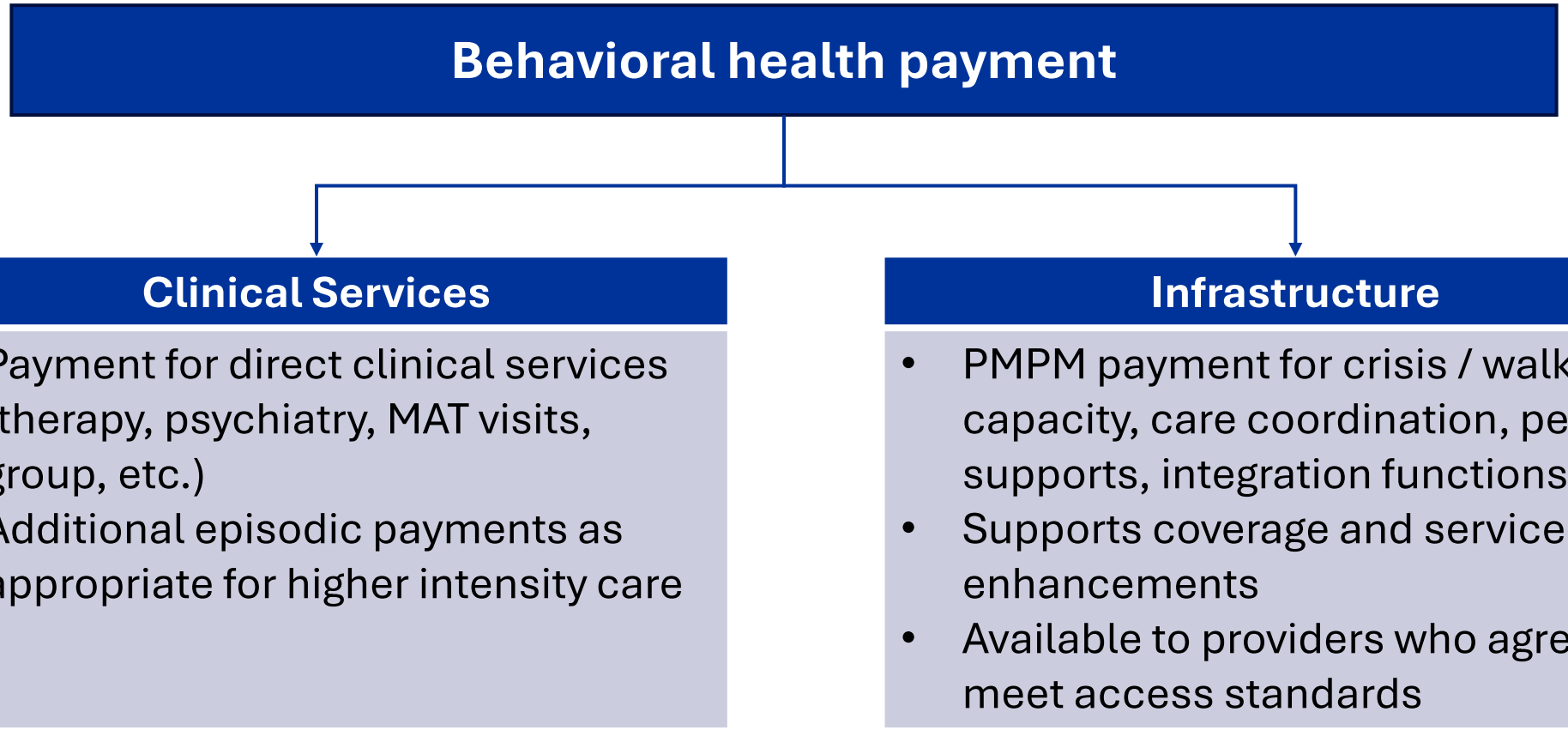
Proposal Elements

- ❑ Behavioral health funding alignment
- ❑ Behavioral health payment architecture
- ❑ Behavioral health / primary care integration models

Funding Alignment Principles

- Behavioral health funding that overlaps with public safety should remain independent of a UHP
  - County Financial Assistance Agreement (CFAA) dollars related to crisis services
  - CFAA dollars related to forensic behavioral health
  - Oregon State Hospital
- Behavioral health funding for services with no public safety component should be aligned pending relevant federal approvals
  - Medicaid
  - OHA Behavioral Health Division (BHD) Medicaid dollars used for federal matching
  - Federal SAMHSA block grants

Payment Architecture



Regional Access Models

- Regions may select a primary model based on capacity, with the option to blend elements where appropriate
- This flexible, regionally grounded structure ensures statewide consistency while meeting communities where they are

Model 1

- **Integrated hub**
- Local integrator coordinates PCPCH and BH networks
- Ideal for regions with robust infrastructure

Model 2

- **Virtual integrated network**
- Digital integration and episode-based BH payments
- Ideal for regions with fragmented or telehealth-driven BH capacity

Model 3

- **Community Home + Mobile Extension**
- Home Clinics combined with State-operated mobile and virtual BH supports
- Ideal for rural and frontier areas with limited local providers

Preliminary Proposal Summary & Vote

	Yes	Yes*	No
Approve the funding-alignment principles			
Approve the behavioral health payment architecture (clinical + infrastructure)			
Approve the regional model framework (3 models + ability to hybrid) with overarching standards set by public corporation			

Federal & State Policy Updates

State: Laws Effective January 1, 2026

- **Medical debt removed from credit reporting (SB 605)** prohibits health care providers from reporting medical debt to consumer reporting agencies and prohibits consumer reporting agencies from including medical debt on credit reports
- **Menopause/perimenopause treatment coverage (HB 3064)** requires health plans regulated by the state to cover treatment of perimenopause, menopause, and postmenopause
- **Perinatal services coverage (SB 692)** requires OHP and commercial health benefit plans to cover perinatal services, including services provided by doulas, lactation consultants, and lactation educators
- **Stronger network adequacy/access standards (SB 822)** establishes quantifiable standards for access to in-network covered services
- **Rate review transparency (HB 2564)** requires health insurance companies to include a consumer-friendly summary document as part of their rate filings, to better enable public engagement
- **Ground ambulance "surprise billing" protections (HB 3243)** prohibits ground ambulance service providers from balance billing an enrollee for covered ground ambulance services if the enrollee has paid the in-network cost-sharing amount

Next Steps

Board Outreach

Meeting Take-aways

Next Meeting Topics

Public Comment

Reflection

Senior Policy Advisor Lee Hastings

“And the day came when the wish to remain tight in the bud was more painful than the risk it took to bloom.”

-Anaïs Nin

Thank you for attending!