Oregon
Tina Kotek, Governor

Universal Health Plan Governance Board

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Universal Health Plan Governance Board (UHPGB) Meeting
Thursday, February 19, 2026
Minutes
Approved at the March 19, 2026, UHPGB meeting

Web link to the meeting video recording
Web link to the meeting materials:

- Agenda
- PowerPoint presentation

Call to order:
Chair Helen Bellanca called the meeting to order at 9:00 a.m.

Board members:

P	Helen Bellanca (Chair)		Bruce Goldberg (on leave)
P	Judy Richardson (Vice Chair)	P	Mary Lou Hennrich
P	Chunhuei Chi	P	Cherryl Ramirez
P	Amy Fellows	P	Michael Leahy
P	Michelle Glass (virtual)		

Welcome and Roll Call (00:00:04)
Chair Bellanca briefly summarized the agenda. The Board will discuss the overall plan and timeline for the next few months, and will have a detailed discussion of expenditures. Dr. Chi will present insights on global efforts for universal care. There are a number of proposals that will be covered in committee updates, and will end with public comment.

Chair Bellanca reminded the Board that everyone is here to create meaningful and lasting change in the health care system. The Board has an enormous task and limited resources, and needs to treat resources appropriately in order to manage their tasks. We are all on the same team and ask for people to extend grace to the staff and Board members

Approve Consent Agenda (00:04:57)
The consent agenda includes the January meeting minutes and the delegation policy.

Judy moved to approve the consent agenda, Mike seconded. 8 yes, 0 no. Consent agenda approved.

Public Comment on Voting Topics (00:06:31)
Chair Bellanca summarized the written public comment. Began with summary of comments from last month that were not mentioned during the meeting: joint testimony from 282 OR residents requesting more opportunities for public engagement. There was other testimony on One Medical model with salaried clinicians, concern expressed that plan will include a public option, questions about potential for state-owned pharmacy and provisions to offset cost of medical and nursing education, expressed that many people would not be opposed to small co-pays, clarification under specialty care payments.

This month, testimony includes comments that a 9% income tax is far too high and that plan needs to ta millionaires and billionaires. Opposition to household size adjustment. Received joint testimony on recommendation that financing plan should tax the wealthy more. Testimony

calling for termination of Milliman contract. Testimony from Canada on drawbacks of a universal system. Received general support for work. Comment in opposition to characterization of plan as a unified financing system. Joint testimony with over 200 signatures in opposition to value-based care. Comments with over 200 signatures encouraging use of a progressive tax, and same effective tax rate for all Oregonians, implementing wealth proceeds tax, and to continue the Finance and Revenue meetings and contract with tax policy experts.

Tom Sincic provided comments. Shared language from portions of ORS 751 on establishment of Board processes and meeting logistics and shared perspective that it is the role of advocates to ask for resources to continue the work.

Executive Director Report (00:11:13)
Executive Director McDonell provided the Board with updates. Staff have been working on a policy option package for 2027-2029 biennium. Includes funding of public engagement and financial consultation. In March, staff are supporting committees as well as 15-20 engagement meetings. There may be a need for additional virtual Board meetings in the next few months if key decisions are required outside of regular meeting schedule. Reiterated policy 13 requiring Board members to coordinate speaking engagements regarding the UHPGB with staff and use approved communications materials.

Director McDonell provided a budget update. In December 2025 there was about $61,00 remaining. This will be reduced slightly following an increase in charges from the state. The Milliman, ECONW, and Wentz-Jackson consultant contracts were all increased between 10-25%.

Board Discussion (00:18:40)
Chair Bellanca discussed the Board's timeline regarding committee work and the September report to the Legislature. A report to the Legislature in September means the final report must be approved by August, with an initial draft available in July. Three committees are ending work in March, but will still see proposals from those committees through April. May is first opportunity to consider all proposals in context.

Board is committed to designing a playbook to cover everyone in OR under a unified financing strategy. Need to think about how to roll this out long-term and how to bring in different markets. Committees are ending because the Board has determined their deliverables will be met, consultant contracts will have run out, and time is needed for the Board to reconcile proposals. Additionally, the engagement meetings need clear information to present to participants for meaningful feedback. Transition committee will be launching and needs to figure out how to get from current state to proposed state, and can only do that if decisions are made. Finally, funding for this work ends June 30, 2027. Must be able to make the case in 2027 session for the work to continue. Imperative to get buy-in from legislative partners. The report will not be perfect but needs to outline a clear way forward.

Building a playbook – not something that will be submitted to Legislature and then immediately implemented. Need to show how this could work in order to continue funding and work on building out the details. The Board will need key details on revenue strategy, to have a plan for cost containment, to show how this is better for businesses, and to build support.

At last meeting, it was requested that the Board dedicate time today to discussing public engagement and Board meeting times and location. Since then, Communications and Community Engagement committee has changed its meeting time to 4-6:30pm and allocated 5-6pm for dedicated public comment. The goal is to allow more opportunity for public participation

outside of typical work hours. CECC co-chairs will summarize the public comment for the Board at their meetings.

Board questions/discussion:

- Mary Lou expressed her thanks to the CECC for changing their meeting time to address that concern, and with that change, feels there is no need to alter the Board meeting schedule.
- Amy noted that the committee typically meets on the fourth Wednesday of a month, but will meet on March 11 next month to avoid conflicts with spring break.
- Michelle noted her excitement to hear from members of the public and thanked the staff for supporting the meetings despite being outside of normal working hours.
- Chunhuei asked about original budget and charge to engage select stakeholders. Is there capacity to engage general public, or what is the minimum amount of general public to engage to ensure support? Particularly interested in what the public will consider an acceptable level of tax.
- Michelle noted the CECC public testimony is one opportunity to get general public feedback. CECC is also going to be exploring other creative solutions to work within the resource constraints of the UHPGB. In report to the Legislature, will recommend appropriate funding for widespread engagement.
- Mary Lou shared that the Board can request an extension for submitting the final report by asking the state healthcare committee.
- Cherryl noted that getting a bill through the long session is difficult and the Board will need time in advance of the session to speak to legislators, socialize the report, and build a strong legislative concept. HR 1 is going to make 2027 session a very difficult one as well from a budget perspective.
- Chunhuei noted that with the time constraints, need to be thoughtful about what the final product – the playbook – prioritizes. The bill itself doesn't need to include all the details, but a framework. The law should identify key principles, and in implementation the details get worked out in the spirit of the law.
- Mike asked if there is a reasonable middle ground between September and December. Been a part of many successful and failed efforts, and feel it is best to focus as if submitting in September, otherwise there can be a tendency is to keep deferring things.
- Helen noted that Executive Director has been hired to manage timeline. If the Director determines a change is needed she can bring that forward, but that is not the case today.
- Amy suggested Board should look at legislative days and build a plan for being involved pre-session on strategy. Perhaps have a standing agenda item to note those dates and include all members of the Board in that work.

Expenditure Review (00:51:25)
Executive Director McDonell led a discussion comparing expenditure estimates from Optumas (2026) and Milliman (2032). Noted that the numbers do not include administrative savings. Status quo projections mean with no changes to the healthcare system. Milliman developed expenditures by taking baseline and projecting cost growth. Then estimated impacts of a UHP. Mimi walked through a comparison of Optumas and Milliman per member per month (PMPM) cost by market segment. Milliman projected slightly lower costs but a higher overall spend due to changes in the market.

Cost growth is projected to be between 5.3% and 7.4% annually, equating to expected expenditures between $66 and $76 billion by 2032. Additional costs anticipated from PEBB-level benefits, induced utilization, and adverse selection. With additions, expenditure ranges from $73 to $87 billion. Removing dental, vision, and fertility care would save $7 billion, and a

UHP could still have those services as supplemental. Some of that difference is also estimates for added cost-sharing.

Under this model providers would get 100% of fees without having to spend time working with payers and trying to collect, which could allow for provider-side savings. Additionally, will simplify billing and administration. Opportunities for savings with pharmacy and global budgeting as well. Staff are working with Dr. James Kahn to develop a cost calculator.

Board questions/discussion:

- How does LTSS factor in? Medical and pharmacy costs included, but other LTSS to remain outside UHP. Plan Design and Expenditure (PD&E) to continue examining how LTSS will be structured.
- Behavioral health totals will need to carve out institutional care portion of OHA budget.
- Have spoken about adding dental, but has PD&E explored what is included in dental? It would be what is included in PEBB. Would like better understanding of what PEBB-level dental includes.
- Not sure how to make decisions on benefits level without knowing administrative savings. Consultants can only model based on existing data, administrative savings will have to be assumptions the Board makes. Director McDonell noted that Dr. James Kahn is preparing a memo on potential savings and will share his expertise on this topic with the Board.
- Estimated medical trend is critical because one can anticipate a universal health plan budget would increase each year, even after administrative savings. Revenue strategy needs to either keep pace with medical trend or manage medical trend that is currently around 5-7% a year. If based on personal income, people's personal income does not increase this much annually. Need to build a plan with long-term sustainability.
- There are some ideas that leveling the amount of payment under a closed system can control costs. Finance and Revenue committee member Swanson has shared data that shows incomes actually increased slightly more than medical costs.
- Noted that until prices are standardized, there is no chance of controlling costs. Implementing a universal fee schedule can be done outside of the timeline for a UHP. Things that can be done prior to implementation and that will make implementation easier.

Universal Health Care Global Efforts (01:43:51)
Dr. Chunhuei Chi presented on international trends in universal health care based on insights from two recent conferences on universal health care. Some slides are for reference and will not be discussed in detail.

- A big question is whether to treat health care as an industry or social institution? There are implications for what that means and how to treat people – as individuals or consumers, as well as goals of system.
- Taiwan is a model for the role of information technology. Improved health care significantly. Taiwan did not launch IT right away, but made steady progress, which today can be faster because of technological improvements.
- Taiwan tracks satisfaction quarterly and it is above 90%. There have been dips when taxes increased, but it has always come back up. Taiwan is widely considered the best health care system in the world.
- Identitifed importance of payment methods and rates – that this drives clinical behaviors.
- Another key lesson is long-term financing. Do not fail to forecast future rates, suggest looking ahead 40 years.

- Taiwan's governance could be stronger in being protected from political pressure and stakeholder politics. There is still waste that can be improved, periodic fiscal crises, and shortages of certain provider types.
- Another presentation covered capacity for response and building proactive public health. How to facilitate the public's understanding of the system and truth in adversarial contexts? Need for open and compassionate communication and monitoring to counter misinformation. Health should be framed as a priority.
- In Europe, trend is de-emphasizing wage-based taxes because of concerns with employment and an aging tax base. More flexible models that unlink entitlement from contribution. More European countries are having a mix of funds that go into health care budget. Convergence toward single/unified provider payment system. Political sustainability is crucial to universal health. Role of health technology assessment to determine clinical effectiveness, cost and economic considerations, ethical, social, and legal issues.
- Application of smart health care looks at incorporating AI into health, aiding in health promotion. Acknowledging climate crisis and environmental health as an important component of health care. Consider medical resilience in response to disaster.
- Health care workforce challenges in Taiwan with shortage of workforce and uneven distribution geographically. Using AI and technology to connect people to health care.
- Insights: tradeoffs between long term financial stability and short term public support. Community ownership is vital. Health technology assessment is essential for equity and efficiency of system. Innovation and adaptation is key, use of AI and technology. Common goals of health system financing for universal health: financial equity, health equity, population health, sustainability and resilience, public satisfaction. Common challenges: quality improvement, cost control, access, IT. Sustainability is core issue of people's willingness to share – a political challenge. How to make health system kind and friendly?
- For the "best" health system – always ask "for whom?" and "in what?" Importance of presenting normative statements as positive. Health systems that care for communities should be run in a manner reflecting values of the community. Community determines what is health system goal, while professionals determine how to reach that goal. Health care as community commodity. How does the health care system encourage a better relationship with our community? The health care system as a test of who we are – to comfort or inflict, to enrich society or individuals?

Board questions/discussion:

- Helen noted one takeaway was de-emphasizing wage-based taxes, what is the alternative? Generally, income tax is used. By adding capital gains and interest, able to capture more of the wealthy. Not saying stay away from payroll tax, but also include other sources of income.
- Noted that thinking of health care as public commodity and mutual obligations are cultural, depends on society believing those things. Policy can also influence, for example avoid a rebate for not using health care services, because it goes against principle of sharing. Policy must encourage community mindset and sharing. The question the Board needs to wrestle with is transforming health care in Oregon from industry to a public good. In a future Board meeting, Judy has offered to take on conversation of health care as a public utility.
- Michelle noted political sustainability as a key theme. Given political instability of the current system, it is important to be ready when reach a tipping point. Also noticed emphasis on public health and wondered if UHPGB's financing includes public health? It does not. Mary Lou noted $115 million is total biennial budget for public health in OR, might want to reconsider bringing public health into our plan.

- Chunhuei noted in Taiwan a lot of funding for vaccination and other preventative actions contribute to public health. But from time to time there are national health priorities identified and then extra budget is funneled into universal health plan for screening or whatever response is needed.

COMMITTEE UPDATES

Operations (02:24:43)
Committee Chair Richardson provided updates. There are two proposals to approve. The first is on enrollment: enrollment in the plan would occur immediately upon attestation, re-enrollment would be based on tax filings and state records. Asking Plan Design and Expenditure committee to weigh in regarding whether all benefits should be available immediately or phased in.

Board questions/discussion:
- Initial enrollment of all residents at plan implementation would follow re-enrollment processes. The majority of existing OR residents would be enrolled via this process.

Mike moved to approve the preliminary proposal on enrollment, Cherryl seconded. 8 yes, 0 no. Discussion above. Proposal approved.

Judy reviewed the proposal on subrogation and worker's compensation, noting that under the proposal medical care would be available immediately through the UHP and providers will bill the UHP. The UHP would in turn have a statutory right to pursue liability claims and would work with the worker's compensation program to recoup associated medical expenses.

Board questions/discussion:
- Mary Lou shared that she had imagined a UHP would bifurcate worker's compensation and medical money currently paid by employers would go to UHPGB. When people access services for an injury currently, they are asked if it is work-related or not, and that has an administrative burden. Thinking that a UHP could divide SAIF/worker's comp so they continue paying for people who are unable to work, etc. while the UHP handles the medical benefit. Curious if there was discussion about why to keep it with SAIF?
- Judy noted the committee had presentations from SAIF and it is a very high-functioning system. Lee Hastings noted Oregon has one of the top-rated worker's compensation programs and the system is running smoothly.
- Michelle thanked the committee for its work, noting it was timely given some questions she had received about the plan.
- Chunhuei noted different auto insurances may have different reimbursement rates and that should be worked out.

Chunhuei moved to approve the preliminary proposal on subrogation and worker's compensation with an amendment to normalize provider rates, Amy seconded. 8 yes, 0 no. Discussion above. Proposal approved.

Transition Committee (02:41:02)
Chair Bellanca shared that the Transition committee will begin in March. Three members of the Board (Judy Richardson, Mike Leahy, Mary Lou Hennrich) have volunteered for this committee.

Cherryl moved to approve the Board member volunteers for the Transition committee, Judy seconded. 8 yes, 0 no. Motion passes.

Committee Co-Chair Richardson shared the proposed committee charter.

Mary Lou moved to approve the Transition Committee charter, Judy seconded. 8 yes, 0 no. Motion passes.

Committee Co-Chair Richardson noted that existing members of committees were asked to serve on the Transition committee based on their thoughtful involvement to date and subject matter expertise. The list of additional Transition committee members (Charlie Swanson, Richard Gibson, Jamie Osborn, Paula Weldon, Antonio Germann, Ann Lovejoy, Eve Gray, Mickie Derting, Jensina Hawkins) was presented for approval.

Cherryl moved to approve the Transition Committee roster, Mike seconded. 8 yes, 0 no. Motion passes.

Community Engagement and Communications Committee (CECC) (02:49:53)
Committee Co-chair Michelle Glass provided updates. CECC focus group engagement effort is on schedule. Artemis Consulting is working on planning and pulling materials together. All of the suggestions from Board and committees for focus group participants are being consolidated. Have identified a set of criteria to ensure balanced input across sectors and geography. Wentz Jackson Consulting has been updating UHPGB website with support from the DCBS communication team.

Finance and Revenue (F&R) (02:56:40)
Committee Chair Cherryl Ramirez provided updates. In March, committee plans to vote on basic tenets of revenue plan. Will also be reviewing reserves strategy and EcoNW's report on their work with the committee. Expect committee to revisit household size rate readjustment (HSRR). May also discuss Medicare Part B refunds.

Cherryl shared that the committee voted to propose continuing meeting through September. Cherryl moved for a vote to continue, Mary Lou seconded. 0 yes, 8 no. Motion fails.

Board member questions/discussion:

- Michelle noted the importance of committee's work getting to this point, but also that CECC had to go on hold while F&R finished their work. CECC going on hold allowed staff to have the capacity to support F&R during that time. Now, CECC needs that staff capacity for their engagement work to happen.
- Cherryl noted she did not support the committee's motion for similar reasons.
- Mary Lou noted that she had voted yes in committee meeting, but today she would vote no. Two key F&R members are going to the Transition committee which will allow the work that needs to be done to get done.
- Chunhuei noted that now, need members of different committees to begin working together and not separately.
    - It is the role of the Board to bring the committee work together, not for committees to meet together.

Plan Design & Expenditures (PD&E) (03:08:45)
Interim Committee Chair Helen Bellanca provided updates. The committee has approved a behavioral health payment proposal that recommends funding for public safety remain outside the UHP, behavioral health payment would consist of payment for clinical services as well as infrastructure, and regions would be able to select their model of integration based on behavioral health needs and resources.

Board member questions/discussion:

- Amy expressed concern about whether anyone can go to any health provider and if that would be true in practice. There are two distinct integrations – funding and care delivery. Under this proposal, any licensed provider can participate.
- Mary Lou raised concerns about which parts of behavioral health system are public safety and whether they would maintain their current levels of funding, since they already do a lot with so little.
- The idea of integrating funding is to achieve behavioral health parity. Integration model was developed using Operations framework and is a first step.

Chunhuei moved to approve the preliminary proposal on behavioral health integration, Judy seconded. 8 yes, 0 no. Discussion noted above. Proposal approved.

Federal and State Health Policy Update (03:20:58)
Senior Policy Advisor Hastings presented a brief overview of state health care laws that became effective at the start of 2026. Board members can contact her with any questions.

Next Steps (03:23:05)

Future Meeting Topics/Requests for Additional Information:

- Chunhuei requested an update on Washington state and California's single payer efforts.
- Amy asked when the Board will discuss long term supports and services and expressed a desire to be involved in refinements.
- Mary Lou noted that in past meeting minutes, the question was raised: "are we developing a single payer health care system?" and wondering if someone could speak to that. Helen noted she tried to cover that today but can discuss again more explicitly at next meeting.
- Michelle requested to talk about unlinking financing from employment and integrating public health into the system. Helen noted the Board has received several pieces of testimony related to this.
- Chunhuei asked if, given time constraints, could the Board discuss priorities since they will not be able to have everything? What are the big subjects that need to be settled on structure? Also need to discuss other potential savings under a universal health plan to reduce the tax burden.
- Other topics mentioned during the meeting:
    - Additional information on PEBB dental benefits
    - In a future Board meeting, Judy has offered to take on conversation of health care as a public utility.

Public Comments (03:28:28)
Members of the public provided oral comment.

Lou Sinniger provided comments. He stated that when going before legislature, be sure to lay out the plan and cost for the end product. With worker's compensation proposal, feels it denies taxpayers 50% of the savings. Expenditure work – think it is a disservice to ignore the savings of a single payer plan. Need to discuss administrative savings before reductions and cost-sharing. No more profits, no more pharmaceutical advertising.

Jacqueline Naganuma commented on behalf of over 200 HCAO members. Believe equity should be the guiding principle for the plan. Appreciate the corporate tax, the removal of the soft cap, and the Medicare part B credit, however feel the current proposal does not reflect realities of working and middle class households. Prioritize a truly progressive tax and encourage importance of a wealth tax. U.S. is unique in its extreme inequality and limited opportunity. Top

10% of Oregonians own 75% of wealth in state. A tax will not solve the wealth gap but new policy recommendations should reduce inequality.

Leon Bote commented that we need to take advantage of this opportunity to build a better system and not perpetuate more of the same. Noted that Taiwan does treat long term services and supports (LTSS) separately but that they are universal services. For disabled people who are relying on those services, how to reduce barriers. People with disabilities have to jump through additional hoops to access the same services and opportunities.

Patrick Leyshock shared Dr. King quote: the worst opponents to change are not those with hatred or profit in their hearts, they are everyday ordinary citizens who support the idea of change but want it to be slow, gradual, and cautious." Do not think incremental changes will achieve health justice. Urge the Board to use their power to propose a plan that boldly moves the state towards health as a social good.
Collin Stackhouse thanked the Board for their work. Shared invitation with the Board members to participate in in-person and virtual town halls HCAO is organizing around the state. Ideally would have a member of the Board at each meeting in whatever way they personally desire and are legally able to participate.

Valdez Bravo, President of HCAO, thanked the Board. Has participated in discussions on the Oregon health care access crisis. Have heard perspectives that there is a need for a "true north" or "mission control" to address this. Feel that is the role of the governance board and hope that health policy conversations in Salem center on the work the Board is doing. Short-term response to HR1 changes should get closer to the true north of a universal system.

Warren George sent written comment as well. In polling, common theme was dealing with the cost of health care so there is no need to reduce services. Feel that single payer is the only way to control health care costs. Need to be able to control the ways that the people who serve the public get paid. Want to emphasize the importance of staying the course on single payer, single way to get paid.

Rebecca Hirsch commented on behalf of HCAO to urge the Board to replace value-based care (VBC) with a simpler provider reimbursement model. VBC increases administrative cost without savings and increases administrative burden for providers, leading to burnout. Cost savings come from gaming the financial reward system. VBC does not improve quality or patient experience. Other universal systems have limited adoption of VBC. VBC worsens racial and regional health disparities due to incentives to practice in wealthier and whiter areas.

Chair Bellanca thanked the public for their comments, stories, and support.

Meeting Reflection (03:42:00)
Senior Policy Advisor Lee Hastings offered the reflection: "And the day came when the wish to remain tight in the bud was more painful than the risk it took to bloom" by Anaïs Nin.

Judy Richardson volunteered to do the reflection next month.

The meeting adjourned at 12:52 p.m.