ECOnorthwest

DATE:	April 10, 2026
TO:	UHPGB
FROM:	Morgan Shook
SUBJECT:	Considerations Related to Funding Transition Costs and Reserve Capitalization

Introduction & Key Considerations

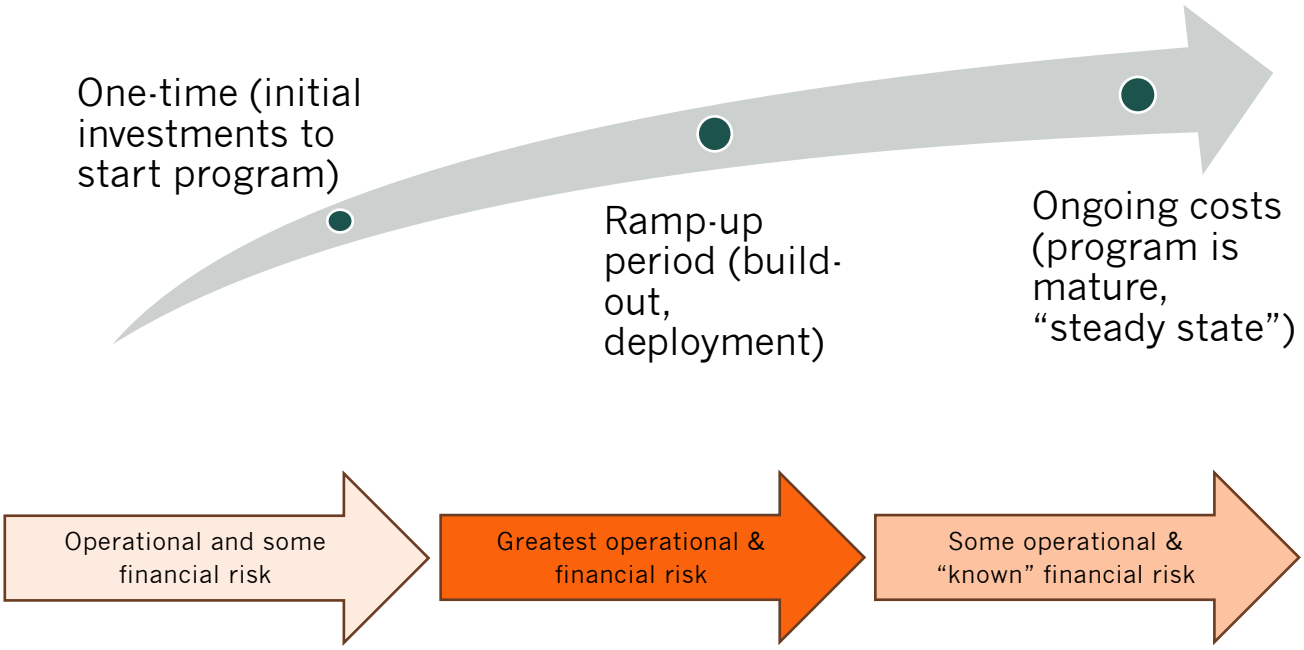
At financial maturity, the UHP will ideally have relatively stable dedicated revenues covering relatively expected costs. Prior to achieving maturity, the program will require funding for start-up and implementation costs related to launch and build-out. After achieving maturity, the program will continue to need reserves to ensure stable cash flow, uphold actuarial best practices for an insurance program, and meet legal requirements. Funding (the sources of revenue) and financing (the strategy and tools for covering costs) will depend on a variety of considerations, including the scale of costs, whether they are one-time or ongoing, the nature and extent of risk, and the type of organization or entity that the UHP operates under. This chapter will explore the options available for funding and financing, and presents the following key takeaways from a scan of other insurance programs:

- It is likely that a variety of funding sources will be necessary to finance UHP through its early stages and seed a reserve sufficient to ensure the program is fiscally sustainable. Oregon's Coordinated care organizations (CCO) were funded with federal waivers and state dollars. Washington's paid family medical leave insurance program required both general fund appropriations and a one-year period of premium collection prior to covering claims.
- Authorizing legislation and actuarial standards will likely dictate a variety of reserve requirements. These can be calculated as a percentage of revenues or expenditures, a cash-on-hand requirement, and capital surplus requirements in the event of insolvency.
- It may be prudent for legislation authorizing a UHP to include requirements for both alerting decision-makers of financial distress and for accessing reserves. Washington's PFML program requires an alert to executive and legislative fiscal officers if premiums will be insufficient to cover projected claims. North Carolina's Medicaid contingency fund requires legislative appropriation.
- Taiwan's national insurance program experienced financial stress related to behavior by foreign nationals who were accessing healthcare but not contributing premiums, and may provide lessons learned for Oregon.

Implementation and Transition Cost Phases

The UHP's implementation entails three phases of costs: a start-up period of one-time costs, a ramp-up period of both one-time and ongoing costs, and a mature program with relatively stable costs and relatively stable revenues. Operational risk – primarily that the program roll-out will run into delays – tends to decrease with time through the above phases. Financial risk – primarily that the program will experience cost overruns, revenue shortfalls, cash flow instability, or insolvency – is highest in the ramp-up phase, ideally stabilizing at a known level through program maturity.

Exhibit 1. UHP Implementation Phases



Potential costs during each phase include:

Start-Up Phase (One-Time Cost)	Ramp-Up Phase (One-Time and Initial Ongoing Costs)	Program Maturity (Ongoing Costs)
Provider network readiness and payment system alignment efforts and resources	Continued technology build-out	Ongoing administrative operations (fully staffed program)
Information technology systems design and build-out (claims processing, eligibility, data integration)	1-2 years of administrative operations (staffing, professional services) prior to benefit deployment	Technology maintenance and operations costs
Other capital needs related to program implementation	Early benefit "bumps" due to misalignment of timing related to revenues and expenditures	Forecasted caseload and payments
Temporary dual systems support (human or IT) during ramp-down of legacy systems	Early benefit "bumps" due to caseloads or costs exceeding forecast	Fully enrolled and engaged providers
Public communications and enrollment campaigns	Seed funding for operating contingency and programmatic reserves	Self-funded reserves
	Continued public and provider engagement	

Covering the above costs will require a financial strategy that acknowledges the level of risk and utilizes the variety of funding sources and tools available to the UHP.

Funding and Financing Transition Costs

There are a number of potential fund sources available to cover the UHP's start-up, transition, and reserve costs listed above. **Funding** refers to the source of revenue used to cover costs. In the UHP context, funding may include dedicated payroll or income-based taxes, federal funds (e.g., Medicaid waivers, 1332 innovation waivers), a state general fund appropriation, or private sources of revenue. **Financing** refers to the strategy or method used to cover costs. Financing strategies may include borrowing from the state, bonding or other public debt instruments where legally permissible, pre-collecting a portion of tax revenues, or temporarily increasing tax revenues to cover start-up costs.

State Budget Appropriation. Once a detailed implementation budget estimate is developed, start-up funding could be requested through the state budget process. This could be structured as 1-2 years of operating support while staff are hired and systems implemented. This approach allows for transparency and budget accountability, especially if funding is proviso-ed or attached to a bill that requires regular budget updates and with specificity regarding use of funds.

State Budget Loan. A state budget appropriation could also include proviso language or be attached to statutory requirements to repay the general fund over time from UHP dedicated tax revenues, especially once premium revenue reaches stability.

Information Technology Funding. Funding for IT system upgrades and development could be requested through the state budget process, likely subject to the state's Joint Enterprise Information Services / Legislative Fiscal Office State Gate Oversight process.

From the fiscal note for Washington SB 5975 (2017), establishing the state's new paid family medical leave program: "The 2017-2019 Operating Budget appropriated **$82 million** to the Employment Security Department for implementation of the Family and Medical Leave Insurance Program. This appropriation must be paid back using the FMLI premium collections by June 30, 2019, including interest as determined by the State Treasurer. The ongoing administrative and operating costs will be funded through premium collections."

Actual costs in the 2017-19 Biennium were **$53.5 million** (fiscal.wa.gov, Spending by Biennium), though the program experienced significant cost overruns in later years (see case study).

Reallocation of Existing Spending. In the transition from the current Oregon Health Plan to a new, single-payer system, there may be current expenditures that can be reallocated to the new program. State spending on administration of OHP may be reallocated to the administrative costs of the new program. Coordinated care organizations' (CCO) mandatory reserves may potentially be another source of funding, pending a full review including legal analysis. Because CCOs are creatures of state statute and operate under contracts with the Oregon Health Authority that already allow for rate adjustments, claw-backs, and termination provisions, the Legislature could potentially direct the transfer or partial transfer of these reserves (especially risk-based capital and restricted net assets held by nonprofit CCOs) to the new public corporation or health care trust during the wind-down or integration of the CCO model, provided just compensation is addressed for any for-profit entities.

Timing of Tax Collection, or Temporary Tax Increase. If a tax funding the UHP can legally be implemented before program payments are made, a portion of the tax could be dedicated to one-time costs including the funding for a reserve to be effective when the program is live. An example is the Preschool For All tax in Multnomah County, which was implemented in 2021; the tax – which has exceeded forecasts – is intentionally designed to build a balance prior to fully universal preschool.[1] Another option is to temporarily increase the tax rate to seed a reserve funding or to cover implementation costs.

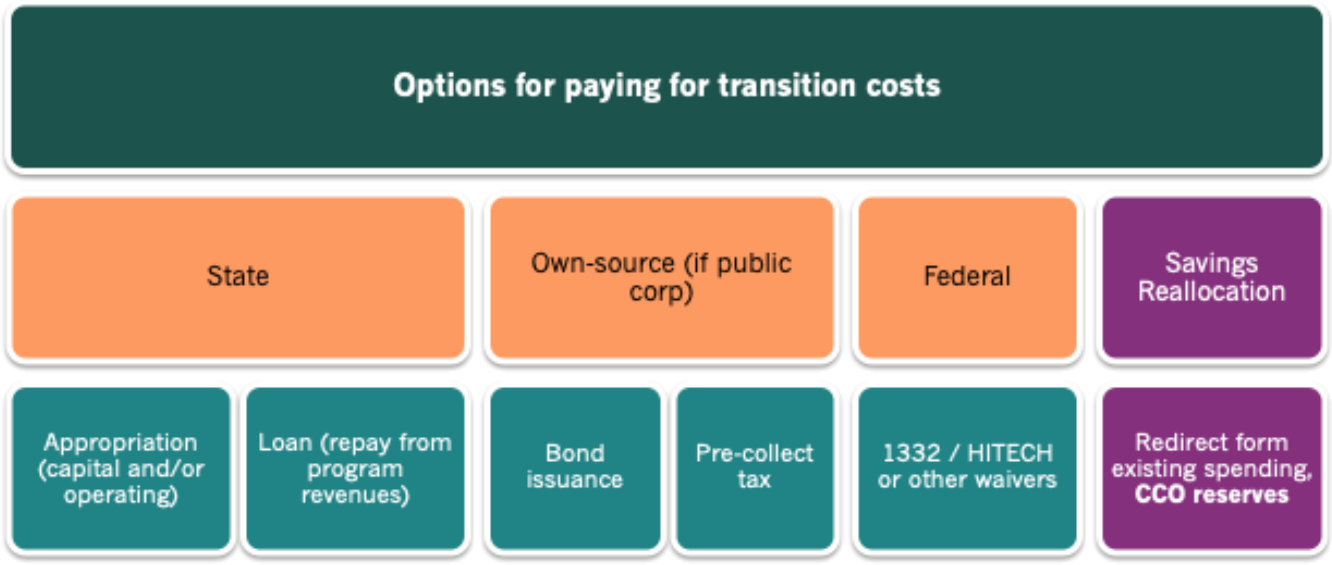
[1] Office of the Multnomah County Auditor. "Preschool for All: The program is largely achieving its equity goals, but needs to address risks to expansion." Multnomah County. 2025. https://multco.us/info/preschool-all-program-largely-achieving-its-equity-goals-needs-address-risks-expansion.

Debt Issuance. States typically issue bonds for long-term capital infrastructure like roads and bridges and do not use debt for operating budget needs. States have balanced budget requirements and debt limits that preclude the use of debt to fund ongoing needs, even one-time needs. It is possible that the state may consider (or may need to consider) a bond issuance to finance the technology component of UHP implementation, but typically largescale, statewide IT investments subject to planning and gated funding requirements under the EIS / LFO model.[2] It is also uncommon for state entities or any governments other than smaller municipalities to take out private loans.

Federal Funds. State Medicaid programs rely on federal waivers to redirect federal Medicare and Medicaid funding toward technology transformations.[3, 4, 5] Most recently, states have been utilizing the enhanced federal funds participation (FFP) match of 90 / 10 to draw down federal support for technology. Though it is possible the state could use federal funding to pay for a portion of transition costs, this option comes with many unknowns and exogeneous factors, and therefore should be considered with less certainty than a state funding source. Use of federal waivers or grant funding depend on federal appropriation, state eligibility for grants, and other unknown factors. Additionally, federal funding may be structured as reimbursements, buying down costs later rather than providing immediate budget support – and thus would not negate the need for initial investment by the state.

[2] Oregon Enterprise Information Systems: Project Portfolio Performance. "Project Oversight." Oregon.gov. n.d. https://www.oregon.gov/eis/project-portfolio-performance/Pages/it-investment-oversight.aspx.
[3] Wiley, Lindsay F. "State-Level Single-Payer Health Care from a Public Health Perspective." *Am J Public Health*. [109], no. 11 (2019):1515–1516. https://pmc.ncbi.nlm.nih.gov/articles/PMC6775895/.
[4] HITECH, or the "Health Information Technology for Economic and Clinical Health Act," is a law passed as part of Obama's American Recovery and Reinvestment Act of 2009 (ARRA). The policy seeks to strengthen data privacy for healthcare recipients through promoting widespread adoption of electronic health records and information technology. More recently, states have relied on the 1115 waivers to leverage 90 percent enhanced federal financial participation (FFP) for Medicaid technology investment.
[5] HIMSS State Government Affairs. "State-Led Innovations Leveraging Medicaid Section 1115 Waivers." HIMSS North America. 2018. https://www.himss.org/sites/hde/files/Medicaid%201115%20Waiver%20Brief_Final_0.pdf.

Exhibit 2. Potential UHP Start-up & Transition Cost Funding Sources



Reserve Funding

Financial reserves are a prudent financial management tool designed to cushion against administrative cost overruns and provide a buffer against programmatic strains (caseload forecasts or revenue underperformance). Especially during the second and third phases of implementation when operational and financial risk are greatest, reserves are necessary given the unknowns around costs (utilization rates, benefit costs) and revenues (premiums, tax revenues, federal reimbursement). Coverage of previously uninsured or underinsured individuals may exceed forecasted expectations. When the program reaches stable revenues and costs, reserves may be self-funded through a portion of dedicated revenues or premium payments. Prior to this point, reserve funding should be built into the budget for an implementation plan.

A UHP operated out of its own state fund has aspects of both government funds and of insurance pools, each of which have different reserve requirements and best practices. These reserve requirements are best thought of in the context of the two broad categories of expenditures incurred by a UHP: administrative costs and program payments or benefits.

OPERATING RESERVES

The Government Finance Officers Association (GFOA) has various recommendations for budgeting governmental fund reserves and budgeted fund balances. General funds are recommended to maintain balances of at least two months of regular general fund operating revenues or regular general fund operating expenditures.[6] Oregon has specific policies

[6] Kavanagh, Shayne C., Vincent Reitano PhD, Peter A Jones PhD. "Rethinking Budgeting: Should We Rethink Reserves? A Multimillion-Dollar Question." Government Finance Officers Association (GFOA). 2023. https://gfoa-craftcms.files.svdcdn.com/production/general/Rethinking-ReservesR2.pdf?dm=1759231581.

related to its Rainy Day Fund, which can only be used under particular circumstances (a three-fifths vote of the Legislature, a prolonged employment decline, or a state of emergency) and its Education Stability Fund (ESF), which receives 18 percent of net lottery proceeds. In FY 2024,[7] about 30 percent of funding for Medicaid came from the state (general and other dedicated funds), and state spending on Medicaid accounted for 28 percent of all spending. Given its share of total state budget in Oregon, there is no Medicaid dedicated reserve fund outside of the general fund.[8]

ACTUARIAL RESERVES

Insurance pools and insurance funds have various targets for reserve funding. Actuarial methods include cash-on-hand targets, wherein a period of benefits are held in reserve for liquidity purposes; reserves intended to meet future liabilities, such as through claim or unearned premium reserves; or risk-based capitalization, wherein a targeted amount of capital is held on-hand based on the likelihood that a catastrophic event will occur. These methods are typical requirements or recommendations for regulation of smaller health plans or health pools.

[7] Oregon Secretary of State, Oregon Blue Book. "Government Finance: State Government." Oregon Secretary of State. n.d. https://sos.oregon.gov/blue-book/Pages/facts/finance-state.aspx.
[8] National Association of State Budget Offices. "2024 State Expenditure Report: Medicaid Tables." NASBO. 2024. https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2024_SER/Medicaid_Tables_-_2024_State_Expenditure_Report.pdf.

Coordinated Care Organizations (CCOs) are community-level entities that operate under a global budget to provide healthcare services to Medicaid members through a partnership among providers, payers, and community-based organizations. Per statute, CCOs are required to hold **restricted reserves** in the amount of $250,000 plus half of the CCO's total actual or projected liabilities above $250,000, as well as capital or surplus at a minimum of $2.5 million and "any additional amounts necessary to ensure the solvency of the CCO" as determined by rule. (ORS 414.572). Among other key financial metrics, CCOs report Premium Deficiency Reserve (Expense) amounts which are recorded when an insurer or managing care organization (MCO) determines that the unearned premiums for a current period may not be sufficient to meet future medical claims and expense. (OHA 2024 Public Brief – CCO Financial Reporting.)

Claim reserves, premium reserves. These are reserves typically set aside to ensure that insurers can meet future liabilities. Claims reserves are estimates of future claims that may be paid out under a policy. Unearned premium reserves are set aside in an amount sufficient to ensure that an insurer can refund a policy holder in the event that a policy is terminated before the end of a coverage period.[9]

Liquidity method. The Society of Actuaries has guidelines for premium reserve setting that entail using historical data to inform future projections of cash flows and reserves.[10] Healthcare reserves are typically set from revenue coming from premiums that policyholders pay.[11] This method is familiar in a healthcare setting; the metric for measuring primary reserves/reserve target funding for healthcare providers is "days cash on hand" (DCOH), which refers to the number of days a company can operate using only available cash reserves if no new revenue were to be generated. DCOH is calculated by dividing the entity's cash (and cash equivalents) by average daily operating expenses.[12]

[9] National Association of Insurance Commissioners, NAIC Model Laws, Regulations, Guidelines and Other Resources—2nd Quarter 2017. "HEALTH INSURANCE RESERVES MODEL REGULATION." NAIC. 2017. https://content.naic.org/sites/default/files/model-law-10.pdf.
[10] Smith, David V. "Gross Premium Valuation Reserves: What Are They and How Are They Calculated?" Society of Actuaries. *Small Talk Newsletter* issue no. 23, November 2004. https://www.soa.org/globalassets/assets/library/newsletters/small-talk/2004/november/stn-2004-iss23-smith.pdf.
[11] Fish-Parcham, Cheryl. "Challenging Health Insurance Premium Rate Increases: Part 4 – How to Challenge the Amounts Health Insurers Keep for Administrative Expenses, Reserves, and Surpluses." Families USA. May 29 2014. https://familiesusa.org/resources/challenging-health-insurance-premium-rate-increases-part-4-how-to-challenge-the-amounts-health-insurers-keep-for-administrative-expenses-reserves-and-surpluses.
[12] Allianz Trade. "Days Cash on Hand (DCOH): Definition, Formula, & Examples." n.d. accessed October 21 2025. https://www.allianz-trade.com/en_US/insights/days-cash-on-hand.html.

Risk-based capitalization. Risk based capitalization entails a target amount of capital on-hand in the event of a catastrophic event. Most states have adopted the NAIC's risk-based capital model as the primary framework for reserve targets for health insurance companies; this model sets a statutory minimum capital requirement based on the insurer's specific size and risks.[1] However, in a publicly-funded UHP context the scale of capital required (in the hundreds of millions) may not be feasible nor fair to taxpayers. This is particularly true if the UHP has the full faith and credit backing of the state of Oregon.[13, 14]

Portland's Health Insurance Operating Fund policy illustrates NAIC recommendations.[1] One of its two reserves requirements are Risked Base Capital reserves (RBC) outlined by NAICs requirements and which consists of four components:

1. Underwriting risk (insufficient premiums relative to expense),
2. Asset risk (default, reinsurance failure),
3. Credit risk (stop loss recoveries, fully insured medical, dental and vision premiums, ASO fees and prescription rebates),
4. Business risk (expense overruns).

The RBC requirement replaced previous policy requirements for large claim and contingency reserves; for large claims, the City utilizes secondary insurance.

POTENTIAL RESERVE TARGET FOR A UHP

At program maturity, UHP reserves could be structured as a percentage of revenues or expenditures. If revenues are pre-collected, a percentage of revenues may make the most sense until the program is launched, at which point a portion of expenditures may make more sense. A one-month reserve is 8.3 percent of revenues of expenditures. This is similar to days cash on hand (DCOH): a metric indicating the number of days an entity can operate (covering its members expenses) without additional funding. It is calculated by dividing the entity's cash and cash equivalents by average daily operating expenses and is generated through income or the company's holdings.[15]

FINANCING RESERVES

Strategies for funding reserves depend upon the scale of revenues and expenditures, the type of government fund structure the new program will be subject to, and the organizational structure of the program or entity.

[13] A 2009 state report by the Oregon Health Fund Board determined that a state public health plan may not need large reserves if guaranteed by the full faith and credit of the state or through a regular legislative fund appropriation.
[14] Oregon Health Fund Board. "Aim High: Building a Healthy Oregon [DRAFT for public review and comment]." Oregon.gov. September 3 2008. https://www.oregon.gov/oha/HPA/HP/HealthFundBoard/Draft-Report-for-Public-Comment.pdf.
[15] Oregon Health Authority: Financial Operations Division: Office of Actuarial and Financial Analytics. "Memorandum: 2024 Public Brief – CCO Financial Performance." Oregon Health Authority. 2025. https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.

State agency model. If the UHP is established as a new program under an existing state agency that is all or partially funded by the state general fund (such as an office under the Oregon Health Authority), then it may not be appropriate to request an operating contingency for program implementation and administrative costs. Any administrative or operational cost overruns would likely be requested in additional appropriations from the Legislature. However, it may be appropriate to maintain a benefit reserve balance in a separate fund for liquidity purposes; this approach should be considered within the context of liquidity and financial management practices of the state, including the Office of the State Treasurer. As a safeguard to prevent program insolvency, accessing this reserve could be attached in statute to requirements to update the forecast and provide a formal alert to the Governor's Office and the Legislature until legislative action could be taken to provide additional operating funds, adjust program premiums, or reduce payments.

Outside agency model. If the UHP will be an entity separate from a state agency, such as a public corporation operating with its own entity budget and without the automatic backstop of the state general fund, the reserve needs will likely be greater and more complicated. In this case, requesting from the state an operating reserve as a small percentage of forecasted administrative costs and a liquidity reserve (to be repaid to the state upon program maturity) should be a part of the financing strategy.

Examples and Case Studies

Following are some examples of similar programs in the domestic setting – Oregon coordinated care organizations, Oregon public corporations, relatively new state paid family medical leave programs, and states with Medicaid contingency funds – and international examples of universal health plans. Given the differences in budgetary contexts, the state programs provide more direct lessons learned, though the Taiwan experience provides insights into one country's response to the threat of insolvency.

OREGON COORDINATED CARE ORGANIZATIONS

Oregon's CCOs were established under the authority of HB 3650 (2011) and with funding from the state's 1115 Medicaid waiver and a state innovation model (SIM) grant from the Center for Medicare and Medicaid Innovation.[16] In creating its network of 16 CCOs, Oregon partnered with pre-existing organizations that are a mix of non-profit and for-profit groups.[17] Oregon is the only state with a statewide system of CCOs serving Oregon Health

[16] United States of Care. "Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities." n.d. https://unitedstatesofcare.org/wp-content/uploads/2022/04/CCO-Oregon-Overview.pdf.
[17] Kaye, Neva. "Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health." National Academy for State Health Policy. February 5 2021. https://nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health.

Plan members, typically providing physical, behavioral, and oral care services.[18] CCOs serve an estimated 1 million Medicaid members (out of about 1.27 million total).[19, 20]

Oregon's CCOs operate under a global budget with fixed per-person payments (capitation payments, or "per caps") based on the number served rather than the service type. The state then withholds a certain amount of CCO payments in an incentive pool which can be earned back depending on the CCO's performance on certain health outcome metrics.[21] CCOs can delegate both a portion of capitation payments to "sub-capitated entities" and, importantly, a portion of their risk.[22]

CCOs are required by state statute and rule to hold reserves. Primary and secondary reserve balances are calculated based on incurred average monthly medical expenses.[23] Among other requirements, CCOs have calculated premium deficiency reserves, which are based on the determination that unearned premiums/rate for a current period may not be sufficient to meet future medical claims and expenses.[24] CCOs reserves are held in the event of insolvency -- assuring all outstanding payments to providers can be made and/or that the CCO will continue to function after terminating its contract with the government.[25]

In aggregate, CCOs operate at a fairly narrow margin, especially following the pandemic. Over the past 10 years, CCOs' aggregate net income or loss (which includes the premium deficiency reserve) has fluctuated from 7.5 percent to -0.3 percent. In 2022, it was as high as $325 million (around 4.6 percent of operating expenditures) but negative again in 2024. See Exhibit 3 below for a chart showing CCO net operating income over the twelve-year period ending 2024.

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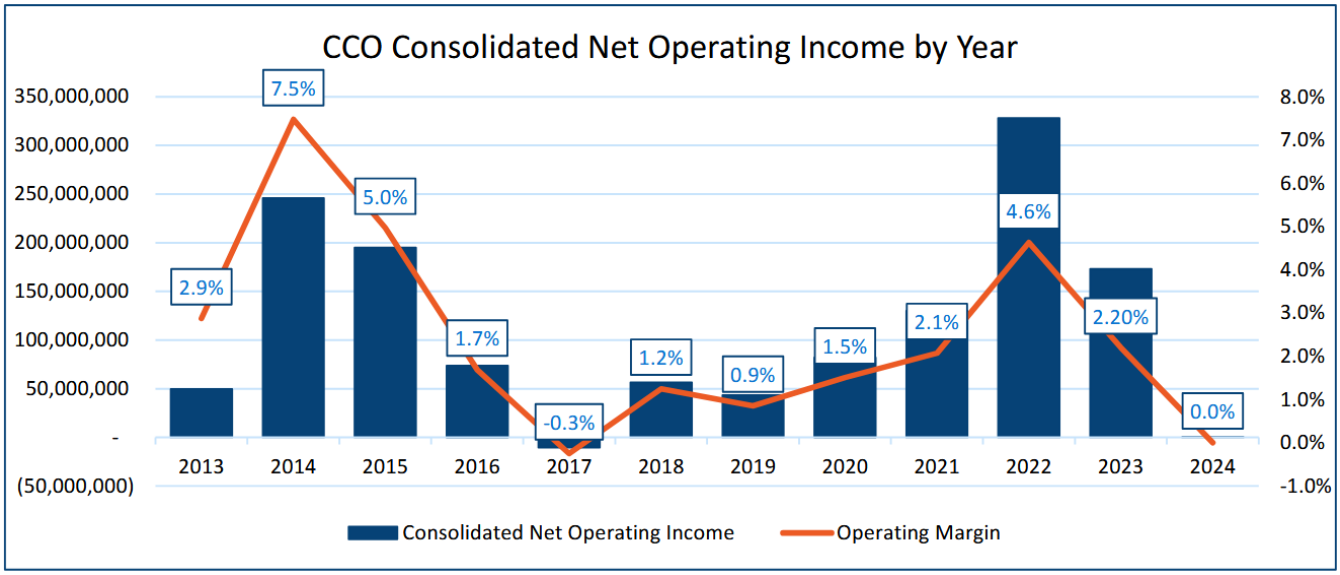
[18] United States of Care. "Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities." n.d. https://unitedstatesofcare.org/wp-content/uploads/2022/04/CCO-Oregon-Overview.pdf.
[19] Bonney, Jennie and Debbie Cheng. "Case Study: Medicaid and Public Health Collaboration in Oregon," April 24 2017, https://nam.edu/perspectives/case-study-medicaid-and-public-health-collaboration-in-oregon/.
[20] KFF. "Medicaid in Oregon Fact Sheet," KFF. May 2025, https://files.kff.org/attachment/fact-sheet-medicaid-state-OR.
[21] Bonney, Jennie and Debbie Cheng. "Case Study: Medicaid and Public Health Collaboration in Oregon." National Academy of Medicine. April 24 2017. https://nam.edu/perspectives/case-study-medicaid-and-public-health-collaboration-in-oregon/.
[22] McConnell, K. John. "Oregon's Medicaid coordinated care organizations." *Jama* 315, no. 9 (2016): 869-870.
[23] Oregon Laws. "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account." May 26 2025. https://oregon.public.law/rules/oar_410-141-5185.
[24] Oregon Health Authority: Financial Operations Division: Office of Actuarial and Financial Analytics. "2024 Public Brief – CCO Financial Performance." Oregon Health Authority. August 2025. https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.
[25] Oregon Laws. "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account." May 26 2025, https://oregon.public.law/rules/oar_410-141-5185.

Exhibit 3. CCO Consolidated Net Operating Income



Source: Oregon Health Authority[26]

CCOs may hold more in assets than their reserve requirements. The proposed merger of one CCO, CareOregon, with a California entity generated questions about the amount of capital held by a nonprofit CCO. At the end of 2022, CareOregon held $1 billion in cash and investments[27]; like most CCOs, the pandemic resulted in temporary increases in revenues and decreases in expenditures resulting in higher-than-usual operating margins (see above in Exhibit 3). Given the fluctuating operating margins and the fact that at least some amount of CCO reserves are contractually obligated, a statutory reappropriation of CCO reserves should be preceded by thorough financial and legal analysis.

OREGON PUBLIC CORPORATIONS

There are four Oregon public corporations. These are entities created by the state with the purpose of carrying out public missions and services; to do so, they conduct activities or provide services that are also provided by the sector. These kinds of entities have more operating flexibility than their private counterparts but are also held to the principles of public accountability and public policy. In these entities, the board is appointed by the Governor and then confirmed by the Senate.[28]

SAIF Corporation.

[26] Oregon Health Authority: Financial Operations Division: Office of Actuarial and Financial Analytics. "2024 Public Brief – CCO Financial Performance Memorandum." Oregon Health Authority. August 2025. https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.
[27] Wihtol, Christian. "CareOregon's Wealth in Spotlight as Merger Nears Key Review." The Lund Report. 2024. https://www.thelundreport.org/content/careoregons-wealth-spotlight-merger-nears-key-review.
[28] Oregon Laws. "ORS 353.010." https://oregon.public.law/statutes/ors_353.010.

SAIF, a not-for-profit workers' compensation insurance company, was the first public corporation in Oregon established in 1979. SAIF receives no state funding; instead, all revenue comes from policyholder premiums and investment returns. As part of its accounting policy, SAIF holds various reserves including unearned premiums ($250 million in 2024), premium deficiency reserves if a premium deficiency is expected, and losses and loss adjustment expense reserves. SAIF adheres to the risk-based capital (RBC) standards developed by the NAIC for surplus management.[29]

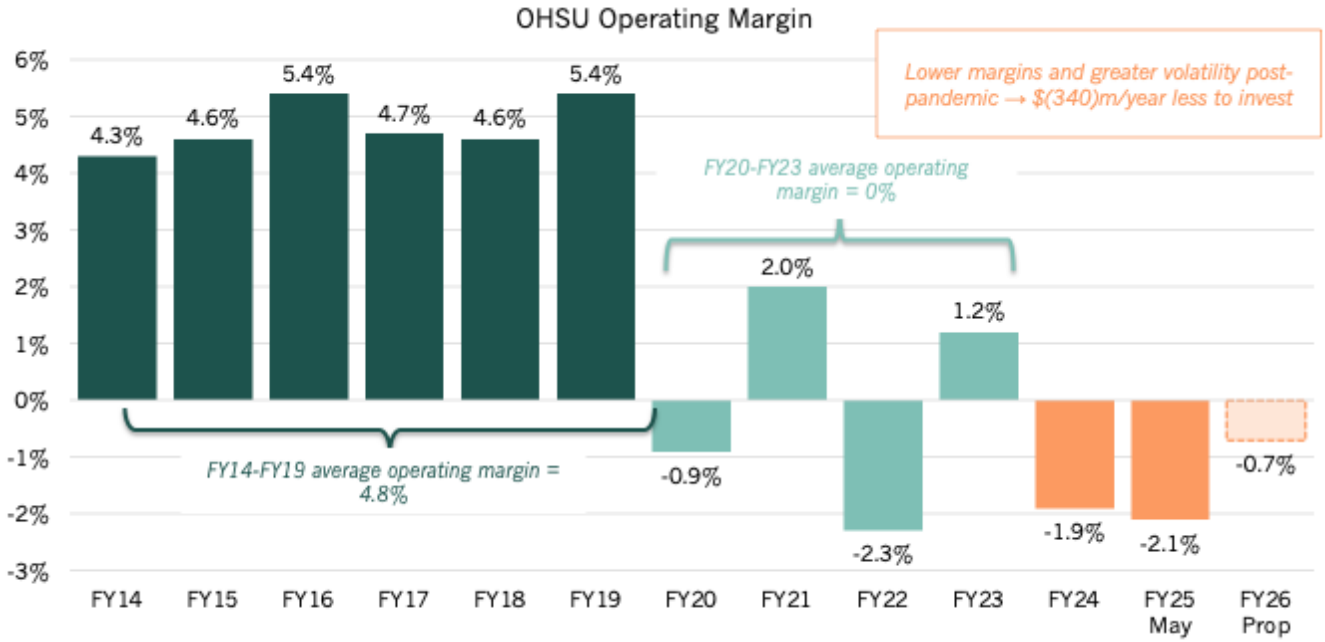
Oregon Health and Sciences University.

Oregon Health and Sciences University (OHSU) is the state's only public, academic health center. OHSU is not structured as a nonprofit but instead as an independent public corporation. OHSU was established in 1995. OHSU received state appropriations totaling $62.7 million in FY 2023 and $72.9 million in FY 2024, about 1.5 percent of its total operating revenue of $5 billion. Most funding comes from patient service revenues.[30] Like CCO, OHSU must hold restricted reserves to cover liabilities, calculated as a "days cash on hand" metric.

OHSU has experienced operating losses in recent years and in 2024, S&P Global downgraded its credit rating due to financial strain ahead of a planned major capital expansion (acquisition of Legacy Health).[31] In April 2025, the OHSU Finance & Audit Committee reported drawing down $181 million in reserves, largely to balance its capital budget in FY 2026.[32] See Exhibit 4 below for the operating margins of OHSU from FY 2024 through FY 2026.

[29] SAIF Corporation. "Financial Statements—Statutory Basis as of and for the Years Ended December 31, 2024 and 2023, Supplementary Schedules as of December 31, 2024, and Report of Independent Auditors." SAIF Corporation. July 29 2025. https://sos.oregon.gov/audits/Documents/2025-20.pdf.
[30] KPMG. "Oregon Health & Science University (A Component Unit of the State of Oregon): Financial Statements and Supplementary Information." OHSU. October 25 2024. https://www.ohsu.edu/sites/default/files/2024-12/ohsu-financial-stmt-audited-fy24.pdf.
[31] S&P Global. "Oregon Health & Science University Debt Rating Lowered to A+ on Operating Losses." December 6, 2024. https://www.spglobal.com/ratings/en/regulatory/article/-/view/sourceId/13353071.
[32] OHSU Finance & Audit Committee. "OHSU Onward: FY25 March YTD Results & FY26 Preliminary Budget Plan." April 24 2024. https://www.ohsu.edu/sites/default/files/2025-04/FAC-FY25-Q3-FY26-Prelim-4-24-25.pdf.

Exhibit 4. OHSU Financial Statement, FY 2024 - FY 2026.



Source: OHSU[33]

The State Fair Council.

The Oregon State Fair & Exposition Center was established as a public corporation in 2013; it had previously been a state agency. The Center hosts fairs and events but also serves as a gathering place in times of public emergencies. The State Fair Council received $1 million from the General Fund in 2025-27 for operations and $855,000 in General Fund capital support for an expanded regional emergency center.[34] Total operating expenses for the Council was $9.1 million and "ordinary income" was $10.2 million, leaving a margin of $1.1 million.[35]

Willamette Falls Locks Authority.

The Willamette Falls Locks Authority was established in 2021 to establish ownership, oversight, and management of the historic navigational locks in Clackamas County.[36] The

[33] KPMG. "Oregon Health & Science University (A Component Unit of the State of Oregon): Financial Statements and Supplementary Information," pg. 14. OHSU. October 25 2024. https://www.ohsu.edu/sites/default/files/2024-12/ohsu-financial-stmt-audited-fy24.pdf.
[34] Legislative Fiscal Office. "2025-27 Budget Highlights." Oregon.gov. October 2025. https://www.oregonlegislature.gov/lfo/Documents/2025-27%20Budget%20Highlights.pdf.
[35] Oregon State Fair Council. "Oregon State Fair Council Meeting Notice & Agenda Thursday, January 30th, 2025, at 1:30 P.M." January 30 2025. https://img1.wsimg.com/blobby/go/acf78612-03e4-4000-8ec5-438339cbe01d/downloads/cd2a[...]ing%20Minutes%20-%20Updated%201-30-2025.pdf?ver=1758730246817. (Financial statements begin on page 8 of 19.)
[36] Willamette Falls Locks Authority. "About." 2024. https://www.willamettefallslocks.org/about.

Authority is still in very early stages of capital development and as such financial information is not relevant to this exploration.

STATE PAID FAMILY MEDICAL LEAVE (PFML) PROGRAMS

In the past 5 to 7 years, several states have implemented state-funded insurance programs to provide paid family medical leave (PFML) to workers. These programs provide wages to individuals needing to take leave for qualifying reasons (federal law only requires job security but does not mandate paid leave). Individuals must participate in the program for a certain length of time to be eligible, and in general the program is financed through employer and employee payroll taxes. The goal for these programs is to be self-sustaining through mandatory contributions made up of a certain percentage of an employee's gross wages defined by the state, as well as contributions from the employer.[37]

Contribution rates are typically structured as a percentage of gross wages. Massachusetts' contribution rates are 0.88 percent of eligible wages for employers with 25 or more covered employees.[38] In Oregon, the total contribution rate in 2025 is 1 percent of gross wages, shared between employees and large employers.[39] In Washington, 2025 rates are 0.92 percent – of which employers pay 28.48 percent and employees pay 71.52 percent.

Washington's PFML program went insolvent in 2023, when claims exceeded expectations and premium rates initially set in statute did not increase fast enough. The program required a $200 million appropriation from the Legislature to resolve the deficit. See Figure X below for the revenues, expenses, and net income of the PFML program, including the large jump in revenue in 2023 which includes a state general fund appropriation. Premium rates have more than doubled since the program was implemented in 2019.[40, 41]

[37] Ritter, Sarah. "Funding Mechanisms for State Paid Family and Medical Leave Programs." Prenatal-to-3 Policy Impact Center. December 2024. https://pn3policy.org/wp-content/uploads/2025/01/PN3_PFML-Funding-Brief_FINAL.pdf.
[38] Massachusetts Department of Family and Medical Leave. "Paid Family and Medical Leave employer contribution rates and calculator." Mass.gov. October 1 2025. https://www.mass.gov/info-details/paid-family-and-medical-leave-employer-contribution-rates-and-calculator.
[39] Paid Leave Oregon. "Employers Overview." n.d. https://paidleave.oregon.gov/employers-overview/.
[40] Washington State Legislature Joint Legislative Audit and Review Committee (JLARC). "Paid Family and Medical Leave Program." WA.gov. January 2025. https://leg.wa.gov/jlarc/reports/2024/PFML/f_01/default.html.
[41] Washington State Employment Security Department. "Actuarial Annual Report for Paid Family and Medical Leave." WA.gov. November 2023. https://esd.wa.gov/media/pdf/2751/pfml-actuarial-annual-report-2024pdf/download?inline.

Exhibit 5. Washington PFML Revenues, Expenses, and Net Income, 2020 – 2028

(Dollars in Millions)	Actual				Forecast (Dollars in Millions)				
	2020	2021	2022	2023	2024	2025	2026	2027	2028
Revenue	$678	$701	$1,109	$1,635	$1,750	$2,318	$2,348	$2,398	$2,560
Expenses	-$665	-$959	-$1,258	-$1,538	-$1,846	-$2,014	-$2,203	-$2,408	-$2,629
Net Income	**$13**	**-$258**	**-$149**	**$97**	**-$96**	**$304**	**$145**	**-$10**	**-$69**

Source: Washington Joint Legislative Audit Review Commission, 2025.[42]

Like unemployment insurance, also funded with payroll taxes, PFML rates can adjust relatively automatically, typically based on actuarial reports but at least based on annual projections. Often laws set a cap on the premium rate, which limits the program's ability to raise funds in the future.

Washington's PFML statutory rate formula is not set actuarially but instead through a statutory formula of 140 percent of prior year expenses, minus the FMLI account balance, divided by taxable wages. Statute allows for a reserve cap (an upper threshold on the premium rate, *i.e.*, rates may be adjusted downward if it is determined they will result in a fund balance that exceeds three months' worth of benefits) but not a lower threshold (such as a minimum below which the rate may be adjusted upward. Beginning in 2026, statute requires the Office of Actuarial Services to review premium rates quarterly and report immediately to the Governor, the Legislature and an advisory board if they project that a deficit in the account will not be recovered through the next quarterly premium collections.[43]

NORTH CAROLINA

The state of North Carolina has a formal contingency reserve requirement for Medicaid and Medicare, which is to be used only when the Medicaid program has budgeting shortfalls.[44] The state currently holds $500 million in a Medicaid Contingency Plan, which is approximately 3.4 percent of annual state Medicaid expenditures in FY 2023 (~ $14 billion).[45] Statute requires legislative approval to access contingency funds. In October 2025, the Department of Health and Human Services cut reimbursement rates because state lawmakers only came up with $600 million out of the needed $819 million for this fiscal

[42] Washington State Legislature Joint Legislative Audit and Review Committee (JLARC). "Paid Family and Medical Leave Program." WA.gov. January 2025. https://leg.wa.gov/jlarc/reports/2024/PFML/f_01/default.html.
[43] ESSHB 1213, Chapter 304, Laws of 2025. WA.gov. https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1213-S2.SL.pdf?cite=2025%20c%20304%20s%203
[44] North Carolina General Assembly. "143C-4-11. Medicaid Contingency Reserve." NCLeg. n.d. https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_143C/GS_143C-4-11.pdf.
[45] State of North Carolina, Department of Health and Human Services, NC Medicaid. "North Carolina Medicaid Annual Report for the State Fiscal Year 2023." FY2023. https://www.ncdhhs.gov/sl-2023-134-section-9e1-medicaid-annual-report/open.

year's state Medicaid funds.[46] Indiana created a Medicaid contingency and reserve account (not a separate fund) in 2024 to provide payments for Medicaid claims, obligations, and liabilities.[47] In 2024 the State Budget Director requested that $271 million from the account be transferred to the Family and Social Services Administration's Medicaid Assistance fund due to an unexpected deficit from a forecasting revision.[48]

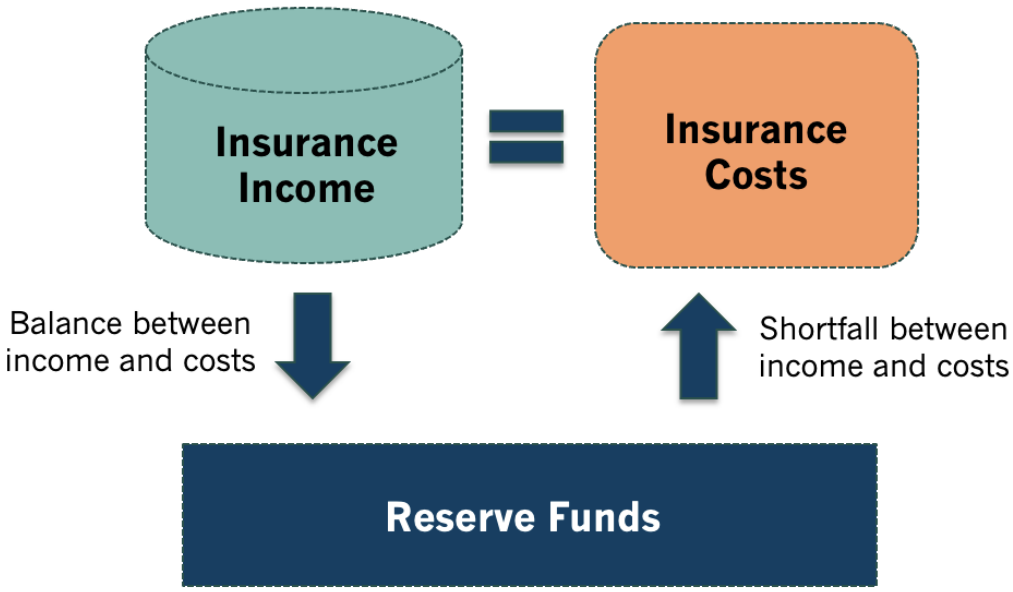
NEW YORK CITY

New York City requires that Managed Care Organizations (MCOs) hold 7.25 percent of net premium income from Medicare Managed Care (MMC) health and recovery plans and the HIV Special Needs Plan (SNP) programs.[49] MCOs are integrated into healthcare systems and exist to reduce healthcare expenditure costs through preventative medicine strategies, financial provisioning, and treatment guidelines. They often take the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[50]

[46] Specht , Paul and Eric Miller. "NC Medicaid cuts under scrutiny amid funding stalemate." WRAL News. October 14 2025. https://www.wral.com/news/local/nc-medicaid-cuts-scrutiny-funding-stalemate-oct-2025/.
[47] Indiana General Assembly. "IC 4-12-1-15.5 Medicaid contingency and reserve account." IN.gov. n.d. Accessed October 21 2025. https://iga.in.gov/laws/2024/ic/titles/4#4-12-1-15.5.
[48] State of Indiana State Budget Agency. "Medicaid Contingency and Reserve Account Transfer." IN.gov. February 14 2024. https://www.in.gov/sba/files/Medicaid-Contingency-Transfer-Memo-FY2024.pdf.
[49] State of New York Commissioner of Health. "Regulatory Impact Statement." NY.gov. n.d. https://regs.health.ny.gov/sites/default/files/proposed-regulations/Contingent%20Reserve%20Requirements%20for%20Managed%20Care%20Organizations%20%28MCOs%29_1.pdf.
[50] Heaton, Joseph and Prasanna Tadi. "Managed Care Organization." NIH National Library of Medicine. March 6 2023. https://www.ncbi.nlm.nih.gov/books/NBK557797/.

TAIWAN

Exhibit 6. Taiwan NHI, Correlation of Reserve Fund, Insurance Income, and Insurance Costs[51]



Taiwan implemented its National Health Insurance (NHI) universal healthcare system in 1995. The program's success is marked by accessibility, comprehensive population coverage, short waiting times, low cost, and national data collection systems for planning and research that streamline administrative processes.[52] In principle, the aggregate amount of the reserve fund was set equal to the aggregate amount of benefit payments in the most recent 1 to 3 months, based on actuarial principles. The actuarial calculation of the premium rate adopts the method of "adjust income to expense", and the premium rate is calculated based on the principle of covering insurance costs and maintaining the total reserve fund for 1–3 months of the insurance payment.[53]

In the past five years, the Taiwan NHI has faced growing financial strain and medical professional shortages. The NHI model is based on low premiums and high demand, which leads to hospitals cutting costs, poor working environments for nurses and doctors, high patient ratios, and other poor outcomes.[54] In 2024, with NHI on the brink of insolvency, the Taiwan government implemented reforms to NHI including eliminating their "suspension-

[51] Lee, Po-Chang. "Introduction to the National health insurance of Taiwan." In *Digital Health Care in Taiwan: Innovations of National Health Insurance*, pp. 1-15. Cham: Springer International Publishing, 2022.
[52] Wu, Tai-Yin, Azeem Majeed, Ken N Kuo, "An overview of the healthcare system in Taiwan," *London Journal of Primary Care* 3(2):115–119. December 2010. https://pmc.ncbi.nlm.nih.gov/articles/PMC3960712/.
[53] Lee, Po-Chang. "Introduction to the National health insurance of Taiwan." In *Digital Health Care in Taiwan: Innovations of National Health Insurance*, pp. 1-15. Cham: Springer International Publishing, 2022.
[54] Shelton, Paul. "Taiwan's national healthcare system." *Euroview.* April 22, 2025. https://euroview.ecct.com.tw/category-inside.php?id=2364.

and-resumption" mechanism. This mechanism initially existed for temporary overseas residents to pause coverage while out of the country and resume upon return, but in an increasingly globally mobile world was allowing wealthier individuals living in the US or China to return to Taiwan to take advantage of low-cost health care for which they were not paying premiums. This behavior not only drove up costs for the NHI but unfairly shifted the burden to relatively less well-off Taiwanese natives. Now, all Taiwanese nationals, regardless of location, must pay NHI premiums.[55] Through this major reform Taiwan aims to extract tax revenue from foreign nationals.

DENMARK

Denmark's universal healthcare system is decentralized. Their government provides block grants from tax revenues to the regions and municipalities, which deliver health services, but the state itself does not have a direct role in the delivery of services.[56] The country's health expenditures equated 9.42 percent of their GDP in 2023, down from 10.75 percent in 2021.[57] Because Denmark's healthcare appropriations are made on a pay-as-you-go basis, rather than with revenues specifically earmarked for healthcare, it does not appear to be a perfect corollary for an Oregon UHP given that budgeting systems are very different.

ENGLAND

All England residents get free public healthcare through the National Health Service (NHS), which is primarily funded by general taxation and started in 1948. The country's health expenditures equated to 10.87 percent of their GDP in 2023, down from 12.02 percent in 2021.[58] Most NHS funding comes from general taxes, but 20 percent comes from national insurance (payroll tax paid by employees and employers). The NHS also has an income stream from copayments and those using NHS services as private patients (11.8 percent of the UK has private health insurance as of 2025).[59, 60] As in Denmark, differences between sovereign nation appropriations and the United States federalist context, along with differences in budgeting requirements and best practices, make England an imperfect corollary for implementation or reserve financing.

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[55] Yang, Y Tony. "Reforming Taiwan's National Health Insurance: From Exploitation to Equitable Participation." Global Taiwan Institute. January 22 2025. https://globaltaiwan.org/2025/01/reforming-taiwans-national-health-insurance-from-exploitation-to-equitable-participation.
[56] Vrangbæk, Karsten. "International Health Care System Profiles, Denmark." The Commonwealth Fund. June 5 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/denmark;
[57] World Bank Group Data. "Current health expenditure (% of GDP) – Denmark." Accessed October 21 2025. https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=DK.
[58] World Bank Group Data. "Current health expenditure (% of GDP) – United Kingdom." Accessed October 21 2025. http://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=GB.
[59] Thorlby, Ruth. "International Health Care System Profiles, England," The Commonwealth Fund. June 5 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/england.
[60] Campbell, Denis. "Almost one in eight Britons now has private medical insurance, say healthcare analysts." The Guardian. 2025. https://www.theguardian.com/society/2025/jan/30/almost-one-in-eight-britons-now-has-private-medical-insurance-say-healthcare-analysts.

UHP Reserve Funding and Financing Approach

Why Reserve Funding Matters

Once the UHP's operating reserve target is established, the next question is not whether the reserve is needed, but how it should be capitalized. In practical terms, this is a question of both funding and financing. Funding refers to the ultimate source of revenue used to support the reserve, such as state appropriations, redirected public funds, dedicated UHP taxes, or temporary transition revenues. Financing refers to the method and timing by which the reserve is assembled, such as pay-as-you-go accumulation, interfund borrowing, or other structured repayment arrangements. This distinction matters because the UHP is likely to face a mismatch between when reserve dollars are needed and when stable UHP revenues are fully available.

The Scale of the Reserve Requirement

The scale of the reserve requirement makes this an important policy choice rather than a minor implementation detail. Using the current Milliman estimate of approximately $85 billion in annual UHP expenditures in 2032 dollars, an operating reserve equal to one month of expenditures would be about $7.1 billion, a two-month reserve would be about $14.2 billion, and a three-month reserve would be about $21.3 billion. These figures represent liquidity targets rather than a full private-insurance-style risk-based capital standard, which would likely imply substantially larger capitalization and may not be appropriate for a publicly backed program. Even so, the magnitude of these amounts makes clear that Oregon is unlikely to capitalize the reserve through any single source alone.

A Capital Stack Approach

For that reason, the most practical reserve strategy is a capital stack approach that prioritizes the lowest-cost and most flexible sources of capital first, then turns to structured financing tools, and relies on new or accelerated revenue only to the extent necessary. This approach reflects a consistent Committee preference to minimize new tax structures where possible and to preserve flexibility as the Board refines the final plan cost and implementation schedule. Put differently, the reserve target decision and the reserve funding strategy are directly linked: the higher the target, the more likely it is that Oregon will need to rely on new taxes, temporary surcharges, or earlier revenue collection to fully capitalize the reserve at launch.

TIER 1: INTERNAL AND EXISTING PUBLIC SOURCES

Under this framework, the first tier of reserve funding consists of lower-cost internal or already-public sources. These may include one-time legislative appropriations, existing state

balances, reallocated administrative spending, certain Oregon Health Authority or Oregon Health Plan resources, and potentially some portion of reserves or net assets associated with existing health system entities, subject to further legal and operational review.

The analysis identifies the Rainy Day Fund, OHA-related balances, Coordinated Care Organization reserves, and Emergency Board allocations as examples of the kinds of resources that may be relevant to a Tier 1 analysis, while making clear that accessibility varies significantly and that some sources may ultimately prove infeasible or only partially available. The value of Tier 1 is not that it solves the full capitalization problem on its own, but that each dollar available from these sources reduces the amount that must be financed externally or raised through new revenue.

TIER 2: STRUCTURED FINANCING TOOLS

The second tier consists of structured financing mechanisms that can provide liquidity up front while spreading repayment over time. These tools include interfund loans, treasury-backed loans repaid from future UHP revenues, and potentially other state-authorized bridge financing structures. In concept, Tier 2 sources are more costly than existing internal funds because they create repayment obligations, but they may still be preferable to immediately expanding the long-term tax structure.

Structured financing may be especially useful if the Board concludes that a meaningful reserve should be in place at launch, but also wishes to avoid collecting the full reserve amount in advance through taxes. As with Tier 1, however, the availability, legal authority, and practical scale of these tools would need to be confirmed through additional fiscal and legal analysis.

TIER 3: NEW OR ACCELERATED REVENUE

The third tier consists of new or accelerated revenue sources. These are the most visible and politically costly tools, but they may be necessary if the selected reserve target exceeds what can reasonably be supported through internal funds and structured financing. Options in this category include beginning UHP tax collection before benefit delivery, imposing a temporary transition tax or fee outside the core UHP structure, or applying temporary surcharges to existing revenue sources until the reserve reaches its target level.

These mechanisms are powerful because they can generate substantial dollars at scale, but they also directly increase the near-term fiscal burden associated with implementation. For that reason, they are best treated as backstop tools rather than the preferred first source of capitalization.

Pay-As-You-Go Versus Borrowing

This framework also helps clarify the tradeoff between pay-as-you-go capitalization and borrowing. Under a pay-as-you-go approach, reserve dollars are accumulated from revenues

collected before or alongside benefit payments. This avoids interest costs, but it implies either starting taxes earlier than benefit delivery or collecting more revenue than is needed for steady-state operations in the early years.

Under a borrowing approach, the state capitalizes the reserve upfront and repays the obligation over time from future UHP revenues. This reduces the need for early tax accumulation, but increases total program cost and creates an ongoing debt service obligation. The illustrates the scale of this tradeoff: borrowing $1 billion at 3.0 percent over 20 years would imply annual debt service of about $67.2 million and total repayment of roughly $1.34 billion, including about $344 million of interest. At larger reserve scales, these obligations become materially more significant.

A Hybrid Strategy Is Most Feasible

Taken together, these considerations suggest that the most feasible reserve strategy for the UHP is likely to be hybrid rather than singular. A practical approach would combine as much Tier 1 funding as is legally and operationally available, supplement it with limited Tier 2 financing to address timing and launch needs, and rely on Tier 3 revenue only to close the remaining gap or to phase in reserve capitalization over time.

This is consistent with the Committee's discussion framing, which has focused on whether the reserve should be fully capitalized at launch or built gradually, and whether a combination of appropriation, phased revenue allocation, and limited borrowing may provide the strongest balance of feasibility and fiscal resilience.

Finance & Revenue Committee Recommendation

Three-Month Operating Reserve with One-Month Trigger

The Finance & Revenue Committee voted 5–2 to recommend an operating reserve target of three months, with a one-month trigger (to be defined) that would prompt early warning and corrective action. This recommendation reflects a preference for strong launch-period liquidity while pairing that long-term standard with an operational "signal point" to guide monitoring and intervention.

From a policy standpoint, the Board does not need to identify and secure every specific reserve funding source before confirming a reserve target. Many implementation details can be developed through subsequent legislative, fiscal, and administrative work. However, the reserve target is not a neutral technical assumption: it materially shapes the set of feasible capitalization strategies, the timing of implementation, and the degree to which the state may need to rely on accelerated revenues, transition tools, or borrowing.

A three-month reserve provides the strongest liquidity position of the options considered. It improves the program's ability to manage revenue timing mismatches, expenditure

variation, and early operational disruption without requiring immediate corrective action. It can also strengthen confidence among providers, policymakers, and the public that the UHP has the financial resilience to operate reliably during the early years.

At the same time, a three-month target has clearer front-end implications. Capitalizing a reserve of this scale would likely require a more deliberate and robust strategy, potentially including earlier or accelerated revenue collection, structured bridge financing, temporary transition mechanisms, or a phased approach that builds toward the target over time. The Committee's one-month trigger concept is intended to complement this strategy by establishing a practical monitoring threshold: if reserve levels approach that trigger point, the system would have clear authority and expectations for timely corrective actions, such as adjusting timing of transfers, drawing on predefined backstops, or recommending revenue or expenditure adjustments.

The Board should therefore view reserve sizing as a governance decision about launch strategy and risk tolerance. In practical terms, the three-month target sets the desired level of financial stability, while the one-month trigger creates an operational framework for managing downside risk. This structure also supports a viable implementation pathway in which Oregon can establish a long-term reserve standard while retaining flexibility in how the reserve is capitalized, particularly if the Board wishes to balance early feasibility with long-run financial discipline.