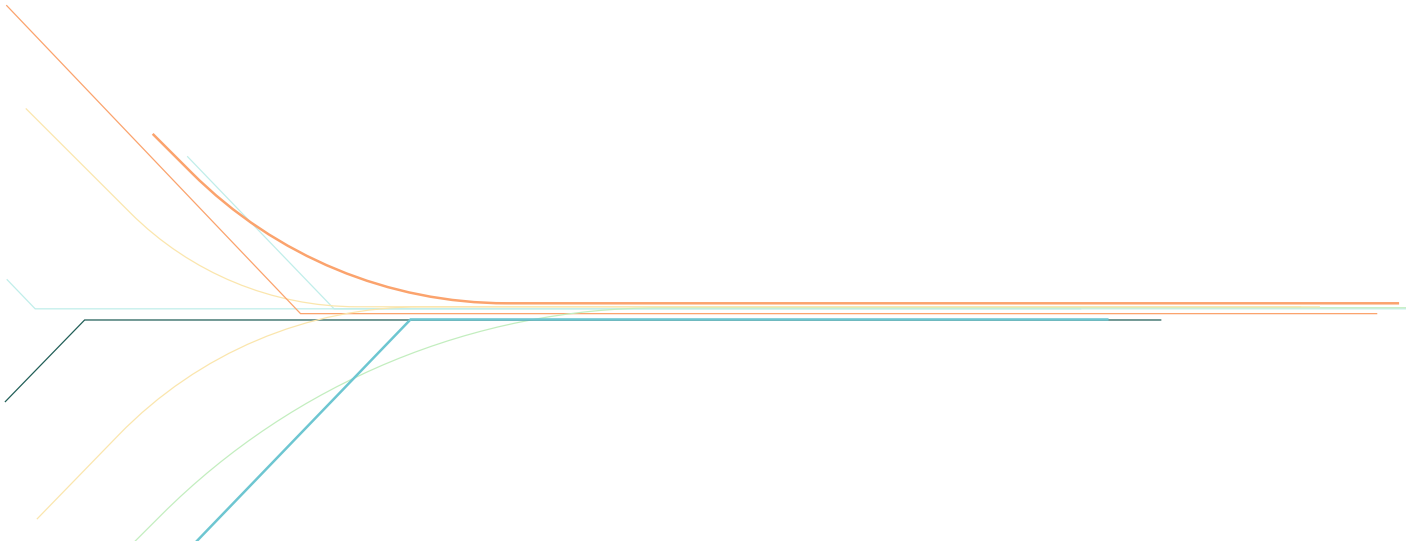


June 2026

Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board

Universal Health Plan Governance Board

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Acknowledgments

This report was prepared by ECOnorthwest in support of the Universal Health Plan Governance Board (UHPGB) and its Finance & Revenue Committee. The substance of the revenue framework documented here reflects the Committee's deliberations and decisions over the course of its work. ECOnorthwest's role was to support and supplement that effort by providing analytic tools, scenario testing, and draft materials that helped the Committee evaluate tradeoffs, respond to Board feedback, and refine the proposal for consideration by the UHPGB.

We are grateful for the time and leadership provided by UHPGB members and staff, and especially for the engagement of the Finance & Revenue Committee members who drove the policy design and interpretation of results.

That assistance notwithstanding, ECOnorthwest is responsible for the content of this report. The staff at ECOnorthwest prepared this report based on their general knowledge of the economics of recreation, amenities, and regional economies. ECOnorthwest staff contributing to this study included Morgan Shook, Sarah Emmans, Megan Waldo, Sadie Shoemaker, Akhila Bandlora, Zach Lescher, and Willa Van Liew. ECOnorthwest also relied on information derived from government agencies, private statistical services, the reports of others, interviews of individuals, or other sources believed to be reliable. ECOnorthwest has not independently verified the accuracy of all such information and makes no representation regarding its accuracy or completeness. Any statements nonfactual in nature constitute the authors' current opinions, which may change as more information becomes available.

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Executive Summary

This report documents the Finance & Revenue Committee's work in developing a financing framework for Oregon's Universal Health Plan (UHP), as charged under SB 1089. It consolidates the Committee's design choices, analytical findings, and recommendations as a structured record for the UHP Governance Board's continued work. The Committee acknowledges it completed only the first five tasks and the first deliverable of its charter before being disbanded.

The Committee's central premise is that Oregon does not need to raise UHP funding from scratch. Health care is already extensively financed through a fragmented mix of employer contributions, household premiums, out-of-pocket spending, and public programs. The framework is designed to replace and restructure these existing payments rather than impose new net costs. Against baseline Oregon health care spending of approximately $46.4 billion (2022 dollars), the Committee derived a Revenue Replacement Target of $16.9 billion (2022 dollars) after accounting for preserved Medicare and Medicaid funding. A placeholder target of approximately $26.0 billion in 2032 dollars has been calculated pending reconciliation with the updated Milliman cost estimate.

The package is built around a small set of structurally integrated, broadly applicable instruments:

- Corporate Income/Excise Tax surcharge of 3.0% (~$608M);
- Corporate Activity Tax add-on of 0.10% (~$215M);
- Employer Payroll Tax (EPT) of 9.6% above a $500,000 firm threshold (~$8.7B), structured as a generally applicable levy to minimize ERISA risk;
- Health Care Personal Income Tax (HCPIT) of 10.1% on AGI above 200% FPL;
- Household Size Rate Readjustment protecting larger households at low and moderate incomes;
- 50% EPT credit against HCPIT liability to prevent double-taxation of wages; and
- 100% Medicare Part B premium credit to prevent double payment for Medicare beneficiaries.

The proposal functions primarily as a reorganization of existing payments. In aggregate, every major payer class contributes less than under the status quo in the 2022 calibration: private employers approximately $0.42B lower, state and local government employers $0.14B lower, federal government employers $0.17B lower, and individuals approximately $0.52B lower. Effective HCPIT rates rise smoothly from 0.4% at the lowest income band to 9.1% at the highest, and most representative household typologies face lower total costs than under the status quo. The Committee considered but did not recommend a soft cap on high-income liability, sumptuary taxes, or a state sales tax, primarily on grounds of regressivity, scale, or structural fit.

In terms of transition cost and reserves reconciliation, the Committee voted 5–2 to recommend a three-month operating reserve with a one-month trigger for corrective action. At Milliman's 2032 expenditure estimate, this implies approximately $21.3 billion in capitalization, a scale that will likely require a hybrid "capital stack" combining internal public sources, structured bridge financing, and limited accelerated revenue.

1. Introduction and Background

The Finance and Revenue Committee was formed from the workplan set forth by the Universal Health Plan Governance Board in December 2023, because of Senate Bill (SB) 1089.[1] The Committee exists to recommend a viable, legally compliant, and equitable financing structure for Oregon's Universal Health Plan (UHP). As such, the Committee has taken care to align decisions surrounding, and recommendations for, financing mechanisms and funding structures with the Universal Health Plan Governance Board's (UHPGB) core values for a comprehensive health plan.

Consultant Role in Supporting F&R Committee

Throughout the development of the UHP funding proposal, ECONorthwest served in a supporting and analytic capacity to the Finance & Revenue Committee and, ultimately, to the Universal Health Plan Governance Board. The committee led the conceptual development of the revenue structure—identifying the core policy choices, evaluating tradeoffs, and shaping the overall direction of the financing approach. ECONorthwest's role was to provide targeted analytical support to inform the committee's deliberations and to assist in translating those deliberations into materials suitable for Board review.

Specifically, ECOnorthwest supplied quantitative analysis, modeling, and policy research in areas where committee members were not themselves generating the technical work. We worked iteratively with committee members to explore design options, evaluate distributional and revenue impacts, and prepare decision-ready comparisons across alternative financing structures. In parallel, ECOnorthwest coordinated closely with UHP staff to ensure that analytical outputs were aligned with program assumptions, could be integrated into board briefing materials, and reflected the evolving guidance of the committee.

In its facilitative role, ECONorthwest helped structure meeting-to-meeting discussions, frame design questions for committee consideration, and synthesize feedback to support consensus-building. This work contributed to a more efficient decision process and helped guide the committee toward a coherent set of recommended financing elements for Board review.

Purpose of This Report

This report is, above all, a reflection of the work undertaken by the Finance & Revenue Committee over the course of its deliberations. It consolidates the Committee's design choices, the major questions explored, and the conclusions reached to date, and presents

[1] The UHPGB was created by the Oregon Legislature in 2023 under Senate Bill (SB) 1089 to develop a comprehensive plan to finance and administer a universal health plan by September 2026. Senate Bill (SB) 1089 arose from a recommendation by the Joint Task Force on Universal Health Care, which itself was created under SB 770 in 2019. https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/SB1089, https://www.oregon.gov/uhpgb/about/Pages/resources.aspx

them in a structured format for the benefit of the UHP Governance Board. While ECOnorthwest prepared the document, its content is grounded in the Committee's collective direction, feedback, and decision-making.

The report serves as a milestone in the ongoing development of the UHP financing strategy. It documents the analytical work that supported the Committee's considerations, summarizes the current recommended financing structure, and highlights the remaining questions and dependencies that will need to be addressed as the Board continues toward a finalized plan.

In doing so, this report provides the UHPGB with the technical foundation necessary for its next phase of work: aligning the proposed revenue structure with projected program costs, evaluating long-term sustainability, and preparing for legislative engagement. It is not intended as an endpoint, but rather as a clear record of progress and a platform for the Board's forward-looking analysis and decision-making.

Finance & Revenue Committee Review and Status of Committee Work

This report was prepared by ECOnorthwest to document and synthesize the Finance & Revenue Committee's work products, analyses, and recommendations developed for the UHPG). The report is intended to serve as a structured record of the Committee's work and a foundation for subsequent Board-level decision-making and legislative development.

At the Committee's request, ECOnorthwest agreed to share a near-final draft of the report to gather feedback. The Committee discussed how to treat the report for purposes of Committee action and, by a 5–2 vote, adopted the following position (as amended): ECOnorthwest's "Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board" describes, in part, the work of the Committee; the Committee did not have sufficient time to formally approve or disapprove the report, but would provide ECOnorthwest with comments and suggestions, with the understanding that ECOnorthwest would incorporate those comments at its discretion.

In the same motion, the Committee acknowledged that it did not complete its work to the full standards contemplated in the guiding document approved by the UHPGB on January 10, 2025. The Committee further acknowledged that it completed only the initial set of tasks described in its charter approved by the UHPGB on July 18, 2024, specifically, the first five task items and the first of two deliverables contemplated in that charter. The Committee also noted its understanding of the Board's decision to disband the Committee before the remaining work was completed.

Purpose of the Committee and Official Charge

The Finance and Revenue Committee was created with three other committees by the UHPGB to support its work in designing a plan to finance a UHP for all Oregon residents.[2] The Committee is responsible for analyzing how different elements of the ultimate UHP structure may adversely affect Oregon's citizens, employers, families, and economy, and appropriately incorporating those findings into the final UHP.

More specifically, the Finance and Revenue Committee's objective is defined in the UHPGB's 2024 workplan: to "design a unified financing structure for the Universal Health Plan, including creating a Universal Health Plan Trust Fund in the State Treasury with sufficient reserves. [In addition,] study and address the impacts of the Universal Health plan with respect to specific types of employers and households and consider funding mechanisms within context of prospective of Employee Retirement Income Security Act (ERISA) challenges."[3] These objectives are based on the official charge for the UHPGB outlined in the Joint Task Force on Universal Health Care's Final Report and Recommendations and in SB 770.[4] Subsequently, the Finance and Revenue Committee's official charge includes:

- Developing a sound financial plan lucid of current health care spending patterns,
- Establishing realistic and viable revenue and spending targets,
- Updating these plans based on ERISA challenges,
- Identifying the impact of UHP spending on businesses, individuals, and households,
- Identifying startup and transition costs for the new system, and
- Other financial strategy goals.[5]

As identified in the UHPGB's workplan, workstream three, revenue options for funding the UHP should be based on the UHP as outlined in the 2022 Joint Task Force report on universal health care. The report details recommendations for key plan components and considerations such as ERISA preemptions, Medicare, federal waivers, etc.[6] Per Section 2 of SB 770, Establishment of the Task Force on Universal Health Care, Joint Task Force is charged with delivering a Health Care for All Oregon Plan that ensures access to comprehensive, quality, patient-centered, equitable, affordable, and publicly funded health care for all individuals living or working in Oregon, to improve the whole of the public's

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[2] Universal Health Plan Governance Board. "About Committees: Committees." n.d. Oregon.gov. Accessed December 8, 2025. https://www.oregon.gov/uhpgb/committees/Pages/about-committees.aspx.

[3] Universal Health Plan Governance Board. "Objectives, Tasks and Deliverables." Oregon.gov. 2024. https://www.oregon.gov/uhpgb/Documents/about/071824-workplan.pdf.

[4] The official charge for the UHPGB is recommending to Legislative Assembly the design of Health Care for All Oregon Plan, administered by Health Care for All Oregon Board, to provide publicly funded, equitable, affordable, comprehensive and high-quality health care to all Oregon residents.

[5] For the complete list of charges outlined in the Finance and Revenue Committee Charter, see the Chapter 1 appendix.

[6] Legislative Policy and Research Office. "Joint Task Force on Universal Health Care: Final Report and Recommendations." Oregon.gov. 2022. https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20Oct%202022.pdf.

health and control the costs of care.[7] These values are consistently reiterated throughout the 2022 Joint Task Force proposals, and are thus are core principles applied to the official charge of the Finance and Revenue Committee.

Relationship to Broader UHP Implementation

The Committee's UHP financing strategy recommendations serve as a foundation from which the Board can build its approach for moving from the current health system into the UHP. The UHP revenue proposal informs key stakeholders for discussion through its inherent structure, as well as identifies groups that may be more burdened by the proposed changes. In addition, it provides a foundational understanding of Oregon's current health care financing landscape and interactions with proposed changes. Combined with work from other Committees, the Finance and Revenue Committee's deliverables provide important context for the plan's equity, legal defensibility, and sustainability considerations.

Additionally, work from the Committee has culminated in a "unified financing strategy for the Universal Health Plan that may include an income tax, a payroll tax, or other options that take into considerations ERISA." The plan is ready to present as a preliminary proposal to large and small employers to check on whether it could be supported, and to find what changes might make it better. This is a deliverable outlined in SB 1089 Section 2(3) i and j.[8]

Guiding Principles and Operating Assumptions

To ensure Committee discussions and decisions surrounding UHP financing mechanisms were clearly aligned with the values outlined for the UHPGB in SB 1089, the Committee approved a Guiding Discussion Document with a list of guiding revenue principles.[9] Each principle is an important element to defining a successful financial plan for implementation of a UHP in Oregon. While principles are listed individually in the Guiding Discussion Document, they have been grouped together and expanded upon below for readability. The groupings of principles below attempt to accentuate key themes in considerations made by the Committee.

1. **Stable, Predictable, Scalable and Adequate Long-Term.**
    - A health care financing system should be able to weather various economic and demographic changes. Because no financing mechanism generates consistent revenue over time, considerations should be given to options for increasing overall stability.
    - Government officials should be able to fairly predict how much revenue will be generated under the plan.

[7] 80th Oregon Legislative Assembly. "Enrolled Senate Bill 770." Oregon Legislature. 2019. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Enrolled.
[8] Universal Health Plan Governance Board. "Objectives, Tasks and Deliverables." Oregon.gov. 2024. https://www.oregon.gov/uhpgb/Documents/about/071824-workplan.pdf.
[9] Universal Health Plan Governance Board. "Finance and Revenue Committee: Guiding Discussion Document." Oregon.gov. 2025. https://www.oregon.gov/uhpgb/committees/Documents/fin-rev/fin-rev-guiding-discussion-document-011025.pdf.

- The revenue sources should be able to meet the needs of full UHP implementation over time.

2. **Progressive, Broad Base, Easy to Understand, and Avoids Unequal Burden and Cliffs.**
   - The tax rate should increase as the taxpayer's income, or ability to pay, increases.
   - To the extent possible, the plan should avoid imposing an unequal tax burden on wage-income versus other types of income (e.g. self-employed-income).
   - To the extent possible, the plan should avoid tax cliffs or benefit cliffs. A cliff happens when a household's income increases slightly but the increase causes a large, sudden loss in net resources because eligibility for a tax credit or public benefit ends abruptly.[10]
   - Having a broad tax base with a lower rate is better than relying on a higher rate for a narrower group.
   - The new revenue streams should be easy to understand by those having to pay for it – total costs should be clear and easy to predict.
3. **Maximize Federal Dollars, Avoid Economic Hardship and Limit Movement.**
   - When determining the financing structure, consider opportunities to maximize federal match dollars before turning to new revenue streams.
   - Avoid the economic harm via the loss of federal tax expenditures in Oregon on employer and employee contributions to employer-sponsored health insurance (both income tax and contributions from the Federal Insurance Contributions Act (FICA)) when moving away from employer sponsorship. Current federal law allows contributions to employer-sponsored health insurance to be excluded from taxable income, thus decreasing the money flowing from Oregon employers and employees (and thus out of the Oregon economy in general) to federal taxes.[11]

[10] NCSL. "Introduction to Benefits Cliffs and Public Assistance Programs." National Conference of State Legislatures. 2024. https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs.

[11] Tax Policy Center. "How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?" Urban Institute and Brookings. 2024. https://taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work.

- Any revenue plan should be structured to limit creating a financial incentive for migration into, or out of, the state.

4. **Dedicated Trust Fund.** As opposed to pulling from the general fund, the Committee seeks a dedicated trust fund to support the plan that is not subject to the state kicker tax credit. The state kicker is a tax credit calculated as a percentage of taxpayer income after all credits on their return for the previous year.[12]
5. **Employee Retirement Income Security Act (ERISA) Considerations.** The plan should be cognizant of vulnerabilities to ERISA court challenges and should attempt to avoid such challenges. Consideration should be given to automatic triggers on other revenue streams if there is an effective ERISA challenge.[13]
6. **Multiple Streams.** The revenue plan must consider all costs of operations, start-up, reserves, and transition, including bond sales.
7. **Permanent.** The system should be as permanent as possible. There should be no automatic sunset of a revenue stream.

SB 1089 SECTION 2(3)A

- **Health care, as a fundamental element of a just society, must be secured for all individuals on an equitable basis by public means, like public education, public safety and public infrastructure**
- **Race, color, national origin, age, disability, wealth, income, citizenship status, primary language, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and pregnancy-related medical conditions may not create barriers to health care nor result in disparities in health outcomes due to the lack of access to care.**
- **The components of the Universal Health Plan must be accountable and fully transparent to the public regarding information, decision-making and management through meaningful public participation.**
- **Funding for the Universal Health Plan is a public trust, and any savings or excess revenue must be returned to the public trust.**

Using the guiding principles outlined above, the Committee also developed a set of financial assumptions and conditions for consideration in the development of the UHP. The Finance and Revenue Committee recommended these assumptions be incorporated into other

[12] Oregon Department of Revenue. "Oregon Surplus 'Kicker' Credit: Individuals." Oregon.gov. 2025. https://www.oregon.gov/dor/programs/individuals/pages/kicker.aspx.
[13] ERISA is a federal law that establishes minimum standards for benefits protections within most voluntarily established retirement and health plans in the private industry;
U.S. Department of Labor. n.d. "Employee Retirement Income Security Act (ERISA)." Dol.gov. https://www.dol.gov/general/topic/retirement/erisa.

Committee workflows surrounding plan design, implementation, legal structure, governance, and public communication. It is important that the different efforts put towards building a comprehensive plan be aligned on their assumptions to ensure the final UHP is consistent throughout all elements.

1. **Covered Populations and Services Must Be Clearly Defined.** The financial modeling assumes a specific set of services and a defined eligible population. System design decisions must align with these assumptions to ensure consistency in cost estimates. Outreach and public materials also need to reflect these definitions accurately to avoid confusion or misrepresentation.

2. **Implementation Phasing Must Match Funding Capacity.** The proposed financing structure supports a phased rollout. Any plan to expand coverage by geography, age, or income group must be coordinated with the timing of available revenue. Communications should be clear about when different groups will be included and why.

3. **Financing Design Must Avoid Legal Conflicts with ERISA.** The structure of employer-related revenue sources must be carefully designed to avoid federal preemption under the Employee Retirement Income Security Act (ERISA). Financing approaches should be framed as broad-based state taxes or contributions rather than mandates on employer benefit offerings.

4. **A Dedicated Trust Fund Is Required.** As outlined above in the Committee's guiding principles, the plan assumes all revenues will be held in a dedicated health care trust fund, not the general fund. This is to ensure transparency and fiscal integrity of the plan. Governance planning should include oversight mechanisms for the fund, and messaging should emphasize this structure to build public confidence.

5. **Federal Program Integration Must Be Seamless.** The financing model relies on leveraging federal funding streams such as Medicaid, Medicare, and ACA subsidies.[6] System design must ensure that individuals can move between programs without sudden losses of coverage or tax burdens. Communications should clearly convey how federal programs will be integrated or replaced.

6. **Workforce and Economic Behavior Will Likely Shift.** It is possible that in the process of unlinking health coverage from employment, changes in workforce participation may occur. For example, some individuals may retire earlier or reduce hours. These shifts can affect income and tax revenues and should be factored into both economic

analysis and system design. Messaging should reflect the increased flexibility the new system offers.

7. **Common Data Sources and Time Periods Are Essential.** Financial analyses are based on multi-year data from national sources like the National Health Expenditure Accounts. All committees should use consistent timeframes and baselines for planning purposes. Avoid relying on single-year or pandemic-era data unless explicitly justified.

8. **State "Kicker" Law May Affect Revenue Stability.** Oregon's "kicker" law, which refunds surplus personal income tax revenue to taxpayers, could limit the ability to build reserves or rely on volatile revenue streams.[5] Any proposal that uses income tax as a financing source must account for how the kicker affects long-term revenue stability. Legal and governance teams may need to explore exemptions or legislative changes, and communications should anticipate public questions about why health care funds are or are not subject to the kicker.

9. **Administrative Costs Must Be Accurately Estimated.** The financial model depends on a full accounting of administrative overhead, including billing systems, payer functions, data reporting, and regulatory compliance. System design decisions, such as whether to centralize payments, can significantly affect these costs. Committees working on operations, governance, and IT infrastructure should coordinate closely with fiscal analysts to ensure administrative assumptions remain realistic.

COMMON DATA SOURCES

- **Kaiser Family Foundation (KFF)**
- **National Health Expenditure Accounts (NHEA)**
- **Oregon Employment Department Quarterly Census of Employment and Wages (QCEW)**
- **U.S. Census Bureau Current Population Survey (CPS), Service Annual Survey (SAS)**
- **Oregon Department of Revenue**
- **Oregon Health Authority (OHA)**
- **Centers for Medicare and Medicaid Services, Medicaid Budget and Expenditures System (MBES)**
- **Oregon Department of Consumer and Business Services (DCBS)**
- **National Association of Insurance Commissioners (NAIC),**

10. **Reserves and Existing Program Funds Need a Transition Plan.** Several existing public programs hold reserve funds or carryover balances that may be repurposed under a universal system. The financial plan assumes that these reserves can help support transition costs or reduce initial tax burdens. Legal and program design should

inventory these funds, assess restrictions on their use, and propose a clear strategy for how they will be integrated or liquidated as the new system is implemented.

Together these principles and assumptions make up the framework from which the Finance and Revenue Committee has developed its proposal for financing the UHP- though, as noted earlier, the Committee did not have the time or resources to complete its work to the standards described here.

Structure of Work Meetings

Every third Tuesday at 9 a.m., the Finance and Revenue Committee convened to discuss iterations of financing mechanisms that best represented the guiding principles for a successful UHP (many months also used a Supplemental Meeting that had the committee meeting every other week). Working from the established principles of equity, affordability, and revenue adequacy, the Committee and its consultants worked throughout the process to map interactions between key UHP revenue instruments. The Committee's modeling efforts focused on revenue generation, but also upon distributional impacts across households and firms, potential administrative feasibility, other existing tax structures and alignment with the policy objectives established by the UHP Governance Board. F&R members Charlie Swanson and Richard Gibson were instrumental in surfacing key policy levers and analyzing the fiscal impact of various plan design choices.

Evaluation Criteria and Governance

To develop sustainable, equitable, and adaptable financing strategies for Oregon's UHP, the Committee established a framework of nine key principles to guide its evaluation of funding options. These criteria represent the Committee's collective values and UHPGB policy goals, emphasizing fiscal responsibility, equity, transparency, legal durability, and alignment with Oregon's long-term health system transformation.

As proposed by the Committee earlier in 2025, the nine key criteria for plan evaluation are as follows:

1. Clarity and Transparency,
2. Equity and Progressivity,
3. Fiscal Stability and Permanence,
4. Scalability and Flexibility,
5. Legal Viability,
6. Dedicated Health Care Trust Fund,
7. Optimization of Federal Funds,
8. Comprehensive and Broad-Based Revenue Model, and
9. Economic Neutrality and Efficiency.

These criteria provide a consistent and structured approach for comparing options, identifying trade-offs, and increasing the likelihood that the final financing plan meets the expectations of the public, policymakers, and implementation partners. This framework is intended for use throughout the planning and implementation process and should inform technical analysis, legal review, stakeholder engagement, and legislative deliberation. In addition, these criteria are intended to be referenced throughout the governance of the UHP. It should be noted that the Universal Healthcare Governance Board accepted these criteria before the Finance and Revenue Committee had a chance to them.

Clarity and Transparency

As a part of the UHPGB's goals for the UHP to be equitable and transparent, the financing mechanism must be easy to understand by the public and policy makers. There are four key metrics for evaluating the clarity and transparency of the financing mechanism:

1. Comprehensibility,
2. Documentation,
3. Traceability, and
4. Comparability.

Comprehensibility ensures that individuals can interpret how revenues are raised, how funds flow through the system, how the financing model compares to the status quo, and how the plan applies to them. Thorough documentation is essential: revenue sources, tax bases, rate structures, and modeling assumptions must be fully described and publicly accessible. Doing so builds public trust and helps guard against misinterpretation or misuse of information.

Traceability requires that all data sources, modeling inputs, and analytic methods be disclosed and replicable so that independent researchers and stakeholders can assess the validity of the plan's estimates. This transparency safeguards analytic integrity and helps ensure that decisions about financing are grounded in verifiable evidence. Comparability strengthens this further by enabling clear, side-by-side analyses of the proposed financing model versus existing systems, such as comparing taxes to current insurance premiums at the household or business level. By enabling a direct comparison of cost burdens and benefits, comparability helps stakeholders understand trade-offs and evaluate whether the new system provides greater fairness, affordability, and value.

Guiding questions to consider while evaluating the plan's level of clarity and transparency are summarized below by criteria in Exhibit 1.

Exhibit 1. Evaluation Criteria for UHP Clarity and Transparency

Criteria	Guiding Question(s)
Comprehensibility	Can the plan's structure be explained with clear visuals or summaries?
Documentation	Are revenue sources, tax bases, and assumptions fully documented and publicly available?
Traceability	Are data sources and modeling methods disclosed, cited, and replicable?
Comparability	Does the proposal provide a side-by-side comparison with the existing system (e.g., taxes vs. premiums) at the household or business level?

Equity and Progressivity

A universal health plan must demonstrate that its financing model reduces disparities rather than reinforcing them. To evaluate the equity of the plan, the structure must be progressive and based on ability to pay. A progressive financing model requires higher-income households to contribute proportionally more, aligning contributions with economic capacity. This principle ensures that the financial burden is distributed equitably and that the UHP supports broad access to care across all income levels. By fully covering medically necessary services, the plan also aims to eliminate medical debt for covered services, thereby reducing financial hardship for lower-income households.[6]

Evaluating equity requires robust metrics, such as effective tax rates and incidence models, to understand how contributions vary across income groups and business types. These tools help identify which households and employers would bear greater or lesser financial responsibility under the proposed financing model compared to the current system.

There are three key metrics for evaluating the equity and progressivity of the plan:

1. Distributional analysis,
2. Progressivity metrics,
3. Inclusivity.

Exhibit 2 pairs each metric with a guiding question to be considered during the evaluation. Together, these criteria assess whether the financing model meaningfully enhances fairness and reduces disparities.

Exhibit 2. Evaluation Criteria for UHP Equity and Progressivity

Criteria	Guiding Question(s)
Distributional Analysis	Has a formal distributional analysis (e.g., by income quintile) been completed?
Progressivity Metrics	Are measures such as effective tax rates or incidence models used to assess fairness?
Inclusivity	Does the revenue system account for non-traditional income sources or wealth indicators?

Fiscal Stability and Permanence

Revenue sources must be stable, predictable, and sustainable across economic cycles. Evaluating the resilience of revenue sources requires assessing how each respond to recessionary pressures, unemployment shifts, or fluctuations in business profitability. Revenue diversification helps mitigate volatility by reducing reliance on any single economic driver. A stable system is one that continues to support uninterrupted access to health care without requiring frequent legislative intervention or sudden budget adjustments.

Fiscal permanence also depends on predictable year-over-year revenue performance, supported by clear statutory frameworks and mechanisms for reserve accumulation. Predictability allows the UHP to plan for expenditures with confidence and maintain provider payments and service quality over time. Long-term sustainability requires evaluating whether revenue sources can keep pace with health care cost growth and population changes. The goal is to ensure that financing mechanisms remain viable decades into the future, not only at the moment of implementation.

There are four key components needed for evaluating the stability and permanence of the plan:

1. Volatility Analysis,
2. Diversification,
3. Elasticity, and
4. Contingency Planning.

Exhibit 3 captures guiding questions associated with the key components for evaluating the fiscal stability and permanence of the plan. Together, these criteria clarify whether the financing model can expand over time, accommodate new demands, and adjust to future conditions without jeopardizing financial stability or operational effectiveness. By assessing these elements, the Board can evaluate whether the UHP financing structure is sufficiently resilient to evolve alongside Oregon's health care needs.

Exhibit 3. Evaluation Criteria for UHP Fiscal Stability and Permanence

Criteria	Guiding Question(s)
Volatility Analysis	Does the proposal include stress testing or performance modeling under recession and boom scenarios? Are there way to address volatility? How can the Committee make up for times when stability is less than ideal?
Diversification	Are multiple revenue streams proposed to mitigate reliance on a single economic sector?
Elasticity	How responsive are the tax bases to long-term economic and demographic trends?
Contingency Planning	Are rainy-day reserves or automatic adjustment mechanisms (e.g., rate bands) included?

Scalability and Flexibility

Financing must support phased implementation and system evolution. By ensuring scalability in the UHP, the financing structure can support phased implementation, allowing the state to roll out components of the plan in a way that minimizes disruption and manages operational risk. A scalable UHP design helps to create a health care system that can handle increases in enrollment, changes in utilization patterns, and the incorporation of new services without compromising fiscal integrity or service quality.

Flexibility is equally critical, given the constant evolution of health care delivery, population needs, and economic conditions. The financing model must be able to adjust without requiring fundamental restructuring. Flexible systems incorporate mechanisms that allow for periodic assessment and recalibration of revenue sources, reimbursement rates, and cost-containment strategies. This adaptability helps the UHP remain functional and effective in an environment that has consistently shifting supply and demand needs.

There are four key criteria for evaluating the scalability and flexibility of the UHP:

1. Phase alignment,
2. Adaptability,
3. Modularity, and
4. Fallback scenarios.

Together, these criteria create a financing framework capable of supporting both immediate implementation and ongoing system improvement. Exhibit 4 pairs each criterion for evaluating scalability and flexibility with a guiding question to consider throughout the UHP implementation process.

Exhibit 4. Evaluation Criteria for UHP Scalability and Flexibility

Criteria	Guiding Question(s)
Phase Alignment	Are funding milestones aligned with expected implementation phases and service expansion?
Adaptability	Can the funding approach be adjusted as new populations, services, or technologies are added?
Modularity	Can specific funding streams be activated independently for pilot programs or partial rollouts?
Fallback Scenarios	Does the proposal identify contingencies if implementation timelines shift or if uptake varies?

Legal Viability

Financing must be resilient to legal challenges, particularly under federal ERISA law. ERISA is a central consideration, as states must design employer-related financing mechanisms carefully to avoid triggering federal preemption. Ensuring contributions are structured in

ways that comply with existing legal standards strengthens the durability of the plan and reduces risks of litigation that could delay implementation.

Additional legal considerations include state constitutional requirements, statutory authority, administrative rulemaking, and fiscal governance frameworks. Clear legislative language and robust governance structures provide the legal foundation for administering the plan effectively over time. Anticipating potential legal challenges and developing defensible policy structures enhances long-term stability and public confidence.

There are four key components needed for evaluating the legal viability of the plan:

1. ERISA analysis,
2. Employer neutrality,
3. Precedent review, and
4. Alternative structures.

Exhibit 5 captures guiding questions associated with the key components for evaluating legal viability. These criteria help determine whether the financing model is legally sound, appropriately authorized, and protected against challenges. Together, they indicate whether the UHP can be implemented and sustained within established legal frameworks.

Exhibit 5. Evaluation Criteria for UHP Legal Viability

Criteria	Guiding Question(s)
ERISA Analysis	Has a legal analysis been conducted to determine compliance with ERISA and other federal statutes?
Employer Neutrality	Are revenue mechanisms structured as taxes or assessments that avoid direct mandates on employers?
Precedent Review	Does the proposal incorporate lessons from other states or legal rulings?
Alternative Structures	Are backup financing pathways available if a primary mechanism is successfully challenged?

Dedicated Health Care Trust Fund

In alignment with the Joint Task force recommendations to establish a public trust fund that is distinct from Oregon's General Fund, the UHP should be evaluated to ensure funds are isolated from the general fund and used only for health care.[6] This separation enhances transparency, builds public trust, and safeguards the financial integrity of the plan. In addition, the fund allows for consolidation of federal and state-generated revenues, along with contributions from employers and households. Federal funds may include, but are not limited to, Medicare, Affordable Care Act subsidies, Medicaid, and CHIP contributions and revenues that the legislature designates specifically for implementing and supporting the UHP.[6]

Long-term stability also requires the trust fund to support reserve accumulation, enabling the plan to withstand economic downturns or unexpected expenditure spikes. Oregon's "kicker" provision may complicate this process, particularly because pieces of the UHP's proposed personal income tax may be subject to the "kicker" provision. Considerations should be given to determining how the UHP will acquire the reserves needed to withstand changes to expenditures and revenues.[6]

There are four key components needed for evaluating the dedicated health care trust fund:

1. Fund structure,
2. Revenue flow,
3. Oversight mechanism,
4. Firewalls, and
5. Legal question.

Exhibit 6 captures guiding questions associated with the key components for evaluating the trust fund. These criteria clarify whether the financing model ensures strong stewardship of funds, supports transparency, and allows for reserve accumulation. Together, they reflect the financial foundation of the UHP and the mechanisms required to maintain stability over time.

Exhibit 6. Evaluation Criteria for UHP's Dedicated Health Care Trust Fund

Criteria	Guiding Question(s)
Fund Structure	Is a statutory trust fund with fiduciary safeguards proposed?
Revenue Flow	Are inflows from each revenue source tracked separately within the fund?
Oversight Mechanism	Is an independent body tasked with monitoring fund use, investments, and disbursements?
Firewalls	Are legal or constitutional restrictions proposed to prevent diversion of funds to non-healthcare uses?
Legal question	Can we raise revenue (income tax) not subject to the kicker?

Optimization of Federal Funds

Based on the key assumptions proposed by the Committee, the UHP should maximize federal contributions and avoid funding or eligibility cliffs. Federal waivers are essential for securing funds for the UHP public trust fund.[6] Waivers of federal requirements may allow the UHP to incorporate Medicare, Medicaid or ACA funds into its structure.[14] For example, federal waiver 1115 is a Medicaid waiver that offers states an avenue to test new approaches to Medicaid that differ from federal statute. Additionally, Section 1332 of the Affordable Care

[14] Legislative Policy and Research Office. "Joint Task Force on Universal Health Care: Final Report and Recommendations." Oregon.gov. 2022. https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20Oct%202022.pdf.

Act (ACA) allows states to apply for a "State Innovation Waiver," to pursue new strategies for providing residents with access to health insurance while retaining basic protections of the ACA. [15]

There are four key criteria for evaluating the optimization of federal funds:

1. Federal leverage,
2. Waiver strategy,
3. Cliff avoidance, and
4. Coordination.

Exhibit 7 captures guiding questions associated with the key components for optimizing federal funds. These criteria help evaluate whether the financing model captures all available federal revenue, minimizes inefficiencies, and supports coordinated program design.

Exhibit 7. Evaluation Criteria for UHP's Optimization of Federal Funds

Criteria	Guiding Question(s)
Federal Leverage	Does the proposal identify and incorporate all major federal funding streams (e.g., Medicaid, Medicare, CHIP, ACA subsidies)?
Waiver Strategy	Are federal waivers (e.g., 1115, 1332) sought or assumed to enable integration or redirection of funds?
Cliff Avoidance	Has the proposal modeled transition points to avoid sudden losses in benefits or large tax jumps at specific income thresholds?
Coordination	Are state and federal tax and benefit interactions analyzed to prevent duplication or unintended cost shifts?

Comprehensive and Broad-Based Revenue Model

Funding must reflect the full cost of the plan and be drawn from a diverse set of sources. A broad-based approach, drawing on multiple revenue sources, reduces vulnerability to economic fluctuations and enhances equity. This inclusive framework ensures that households and employers contribute in a manner aligned with ability to pay.

Clarity and predictability in revenue administration are equally important. A well-structured regulatory environment ensures transparency in how revenues are collected and managed and supports the plan's ability to build reserves. Adaptability to changing economic or demographic conditions is also necessary to maintain financial viability over time.

There are four key components needed for evaluating a comprehensive revenue model:

1. Cost coverage,

[15]KFF. 2025. "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State." KFF. 2025. https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

2. Revenue mapping,
3. Base breadth, and
4. Reserve planning

Exhibit 8 captures guiding questions associated with these components. Together, the criteria help determine whether the revenue model is sufficiently robust, equitable, and administratively sound to support long-term UHP operations. They provide the foundation for assessing the financing system's ability to reliably and transparently fund the plan.

Exhibit 8. Evaluation Criteria for UHP's Revenue Model Comprehensibility and Broad-Base

Criteria	Guiding Question(s)
Cost Coverage	Does the proposal account for all operational, administrative, and start-up costs, including IT systems and outreach?
Revenue Mapping	Are all potential sources (e.g., payroll taxes, individual income taxes, business assessments, provider fees) explored?
Base Breadth	Are proposed tax bases large and inclusive enough to ensure low rates and revenue resilience?
Reserve Planning	Is there an initial capitalization plan, and are reserves or stabilization funds included?

Economic Neutrality and Efficiency

Funding must reflect the full cost of the plan and be drawn from a diverse set of sources. Economic neutrality ensures that the financing model does not distort economic behavior or impose disproportionate burdens on specific industries or populations. A neutral system maintains fairness by minimizing disincentives for work, hiring, or business expansion. This principle is critical in transitioning from insurance premiums to tax-based financing without creating unintended economic impacts.

Efficiency emphasizes reducing administrative burdens and maximizing the share of revenue dedicated directly to health care services. Streamlined financing structures reduce overhead costs for employers, providers, and the state. A more efficient system enables resources to be spent on care delivery rather than administrative processing, improving both economic outcomes and patient experience.

There are four key components needed for evaluating economic neutrality and efficiency:

1. Dynamic modeling,
2. Migration effects,
3. Interaction with tax preferences, and
4. Neutrality tests.

These elements help determine whether the financing model supports a stable economic environment, minimizes unnecessary administrative complexity, and distributes responsibilities fairly across stakeholders. Exhibit 9 pairs a guiding question with each criterion, together they ensure that the UHP operates efficiently and equitably while promoting overall economic well-being.

Exhibit 9. Evaluation Criteria for UHP Economic Neutrality and Efficiency

Criteria	Guiding Question(s)
Dynamic Modeling	Has the impact of the proposal on employment, wages, business costs, and productivity been modeled?
Migration Effects	Are risks of individual or business relocation assessed, particularly at key income or profit thresholds?
Interaction with Tax Preferences	Does the proposal account for the potential loss of federal tax exclusions for employer-sponsored insurance?
Neutrality Tests	Has the proposal been evaluated for distortions to labor supply, retirement timing, or employer behavior?

Lifecycle Review Framework

A lifecycle review framework provides the structure necessary to monitor, assess, and recalibrate the Universal Health Plan's financing strategy over time. Because the UHP is designed to evolve alongside Oregon's broader health system transformation, an ongoing review process ensures that financing mechanisms continue to align with the guiding principles established by the Committee, clarity, equity, fiscal stability, legal durability, and efficiency. This framework creates a continuous feedback loop that evaluates performance against expectations and adapts funding strategies based on new information, emerging risks, and stakeholder experience.

At its core, the lifecycle review process operationalizes the nine evaluation criteria by using them as checkpoints for assessing whether the financing model remains sustainable, transparent, equitable, and compliant with legal and regulatory constraints. Regular review cycles would examine the stability of revenue streams across economic conditions, the performance of federal funding interactions and waivers, and the integration and sufficiency of the dedicated trust fund. The framework also enables assessment of system scalability as the UHP phases in new populations or benefits and helps determine whether the financing model continues to support flexible implementation without undermining fiscal discipline.

Finally, the lifecycle review framework institutionalizes accountability by embedding regular reporting, stakeholder consultation, and data-driven recalibration into the governance of the UHP. This ensures that policymakers, the UHP Governing Board, and the public can trace how financing decisions are made and understand the rationale behind adjustments. By systematically evaluating outcomes relative to expectations, such as equity impacts, economic neutrality, administrative efficiency, and alignment with legislative intent, the lifecycle framework provides the tools to refine the plan over time. Ultimately, it helps

safeguard the UHP's long-term viability while reinforcing the values of transparency, responsiveness, and continuous system improvement.

Revenue Design and Legal Compliance

To evaluate the durability of financing options for Oregon's Universal Health Plan (UHP), the Finance and Revenue Committee assessed a range of funding mechanisms, including payroll, income, provider, gross receipts, and consumption-based taxes. Throughout the evaluation, any design needed to fit within the federal regulatory framework governing employer-sponsored insurance, particularly the Employee Retirement Income Security Act (ERISA). This was essential because employer-sponsored insurance is the largest source of private health coverage in Oregon, making ERISA a central consideration in determining viable financing strategies.

Legal Constraints

ERISA preempts state laws that relate to employer benefit plans, which limits how states may access employer health care spending. This constraint challenges the development of a publicly financed health system, as employer contributions are typically needed to replace current private spending. Oregon must therefore design policy tools that do not regulate employer benefit decisions or pressure employers to modify or eliminate existing coverage.

Recent Supreme Court rulings clarify that state laws with indirect economic effects on employer plans do not necessarily trigger preemption when they do not dictate plan structure or coverage. This flexibility allows Oregon to pursue revenue options grounded in general taxation and state-level regulation of the insurance and health care sectors, rather than mechanisms tied directly to employer benefit choices.[16]

Legal Risk Mitigation

National research on state universal health plans consistently identifies ERISA preemption as the most significant legal barrier to state-level health system reform. Oregon's strategy for the Universal Health Plan should therefore be shaped by several key considerations. First, court decisions interpreting ERISA distinguish between permissible state actions, such as general taxation and regulation of the insurance market, and impermissible actions that directly regulate employer-sponsored benefit plans.[17] Understanding this distinction is critical to designing revenue mechanisms and regulatory structures that avoid triggering preemption. Second, ERISA contains no waiver authority, meaning Oregon must work entirely

[16] Bulleit, Thomas N., Margaux J. Hall, Harvey D. Cotton, Christopher M. Gillis, and Samuel Perrone. "Rutledge vs. PCMA: SCOTUS Greenlights State Regulation of Pharmacy Benefit Manager Drug Reimbursement." Ropes & Gray 2021. https://www.ropesgray.com/en/insights/alerts/2021/01/rutledge-vs-pcma-scotus-greenlights-state-regulation-of-pharmacy-benefit-manager-drug-reimbursement; Rutledge v. PCMA. 141 S. Ct. 474 (2020).

[17] Employment Retirement Income Security Plan (ERISA) Statute (29 U.S.C. Chapter 18). https://www.law.cornell.edu/uscode/text/29/chapter-18.

within the statute's existing limitations when developing the UHP.[17] Third, experiences from other states offer important lessons. Vermont's Green Mountain Care and Washington's Universal Health Care Work Group both identified ERISA-related constraints as major obstacles to advancing comprehensive public financing systems, demonstrating the need for careful legal design from the outset.[18, 19] Collectively, these insights form the foundation for constructing an ERISA-conscious approach to UHP financing and implementation.

A consistent note throughout all UHP planning has been that Oregon needs a financing structure that is resilient to legal challenge and aligned with the statutory direction to build an affordable, publicly funded universal system. An ERISA-conscious financing framework includes three core components:

1. A broad-based employer payroll tax applied as general revenue,
2. Restrictions on duplicative insured products to maintain the UHP as the comprehensive statewide plan, and
3. Provider participation and reimbursement rules enabling coordination with employer-funded coverage while avoiding regulation of employer benefit design.

Together, these elements reflect the Committee's assessment of legally viable mechanisms and align with national research on feasible approaches to state-level universal health care. These elements align with elements proposed in the Joint Task force report on Universal Health Care Plan in June 2022.

PAYROLL TAX CONSIDERATIONS

A uniform employer payroll tax remains one of the more viable revenue mechanisms available to Oregon under ERISA that also helps avoid the economic harm due to the loss of federal tax expenditure for employer-sponsored health insurance. Research evaluating state options indicates that payroll taxes avoid ERISA preemption when they apply to all employers and do not depend on the employer's decision to offer or structure health benefits. This is because a general tax of broad applicability does not constitute regulation of an employer-sponsored plan and does not interfere with plan administration or benefit design.

For the UHP proposal, the payroll tax is structured as a general revenue measure rather than a substitute for providing health benefits. This distinction is important because taxes designed as alternatives to employer coverage have historically been viewed by courts as exerting impermissible pressure on employer benefit decisions. The tax must also not be set at a level that effectively forces employers to drop coverage, modify benefits, or otherwise change their plan offerings, as such effects could materially increase preemption risk. Oregon's fiscal modeling work has shown that employer participation is essential to replacing

[18] Green Mountain Care Board. "About GMCB." Vermont.gov. 2025. https://gmcboard.vermont.gov/gmcboard/doc/gmcboard/doc/gmcboard/doc/board.

[19] Healthcare for All Washington. "2025 Legislative Successes." HCFA WA. 2025. https://www.hcfawa.org/current_legislation.

current private-sector health care spending, and a generally applicable payroll tax provides a mechanism to collect that revenue while decreasing the risk of triggering legal conflict. Because ERISA does not include a waiver pathway, Oregon's payroll tax must rely solely on permissible state taxing authority.

COVERAGE DUPLICATION

Oregon holds authority to regulate insurers operating within the state, and this authority provides an opportunity to limit the sale of health insurance plans that duplicate benefits included in the Universal Health Plan. Under ERISA, state regulation of insurers is explicitly protected, meaning that states may define which insured products may or may not be offered within their markets. Governance Board materials indicate that restricting duplicative insured coverage is a central design feature intended to maintain the UHP as the comprehensive statewide benefit while reducing administrative complexity and fragmentation.

These restrictions, however, must apply only to insured products and not to self-funded employer plans. Self-funded plans fall under exclusive federal regulation and cannot be restricted or prohibited by state law. This distinction ensures legal compliance while acknowledging that employers may continue offering self-funded duplicative or supplementary coverage if they choose.

Regulating duplicative insured products also supports the financial sustainability of the UHP. By ensuring that the public plan remains the primary comprehensive coverage source for benefits defined in statute, Oregon can reduce segmentation and premium-driven risk selection. This approach aligns with state authority and experiences in other universal coverage efforts, such as those in Vermont and Washington, which highlight the importance of clearly distinguishing between state-regulated insured plans and federally protected self-funded employer plans.[18, 19]

PROVIDER PARTICIPATION AND REIMBURSEMENT

State authority over providers is broad, giving Oregon flexibility to design participation and reimbursement structures that support the Universal Health Plan while avoiding ERISA-related constraints. Oregon may establish reimbursement rules requiring the UHP to recover costs from employer-funded coverage when that coverage functions as the primary payer. Such coordination rules are rooted in the state's general regulatory authority over providers and do not constitute regulation of employer-provided benefit plans, making them legally durable.

Oregon may further consider allowing providers to join the UHP on a voluntary but exclusive basis, under which participating providers agree not to contract with other insured products offered in the state. Because participation would be voluntary and directed at providers rather than employers, this approach is viewed as generally permissible under ERISA so long as it does not condition provider participation on employer benefit behavior.

Primary-payer rules and provider alignment strategies require clear reimbursement coordination to prevent disproportionate shifts in costs from current employer plans and the UHP. A well-defined participation and reimbursement framework ensures consistent payment rules, supports financial stability, and strengthens integration across Oregon's health system. When paired with uniform taxes and insurance market regulation, provider policy design forms the final of the three legally viable pillars supporting Oregon's UHP financing structure.

2. The Revenue Proposal Framework

Introduction

This chapter lays out the framework of the Finance and Revenue Committee's UHP revenue proposal. The main component of the Committee's UHP recommendation is described in Chapter 3, which presents a tax plan to fund "ongoing" annual UHP expenses. Chapter 3 discusses the specific parameters for the ongoing revenue plan and describes in concrete terms how the proposal will impact individuals and businesses in Oregon.

Chapter 4 delineates the key issues surrounding the funding of "one-time" UHP costs to start up the program. The chapter focuses on lessons learned from public fund creations in comparable large-scale program launches in recent history at the federal and state levels. This chapter establishes the logic, structure, and constraints of the Committee's recommended revenue framework, providing the context needed to interpret the detailed tax design in Chapter 3 and the start-up strategy in Chapter 4.

The UHP revenue proposal described in this report, developed with ECOnorthwest's assistance and expertise, reflects the Committee's deliberations on how to equitably, sustainably, and realistically fund a universal, publicly administered health care system. Not by creating new net financial obligations, but by redirecting and restructuring existing health care spending in a more transparent and equitable funding model.

Revenue Design Premises

A central premise of the Committee's work is that Oregon does not need to raise health care funding "from scratch" in order to implement a Universal Health Plan. Healthcare in Oregon is already extensively financed through a fragmented combination of employer-sponsored insurance contributions, individual premiums, household out-of-pocket spending, and state and federal public programs, including Medicare and Medicaid.

The Committee's proposed financing model builds on this existing multi-payer landscape by consolidating these payments into a unified framework. In doing so, it replaces a haphazard and administratively complex system with a more coherent single-payer structure that provides universal benefits more efficiently and equitably.

The Committee recognizes that the proposal is not a strict *Pareto* improvement relative to the current system: some households and firms will contribute more under the UHP than they do today. However, in the aggregate, the proposal comes close to that standard. The Committee's analysis indicates that a substantial majority of individuals and businesses would be financially better off under the UHP than under the status quo, while also benefiting from improved coverage stability and health outcomes.

At a system level, the proposal is designed to decouple health care access from employment, improve predictability of health care costs for businesses, and reduce total health care spending through administrative simplification and economies of scale. By eliminating redundancies inherent in the multi-payer system and enabling greater bargaining power in the procurement of drugs and medical services, the UHP also creates the conditions to moderate long-term health care cost growth, even as broader federal reforms continue to evolve.

Design Objectives

The Committee's analysis and deliberations were guided by three core design objectives, which served as the evaluative framework for assessing alternative revenue mechanisms and parameter choices:

Economic Objectives

- Achieve universal health care coverage for all Oregonians
- Capture administrative efficiencies and economies of scale from a single-payer system
- Decouple health care coverage from employment
- Help contain long-term health care cost growth

Financial Objectives

- Preserve federal Medicare and Medicaid funding streams
- Maintain existing Oregon corporate income tax deductibility benefits
- Ensure revenue adequacy, financial sustainability, and administrative feasibility

Legal Objectives

- Avoid ERISA preemption by relying on broad-based, non-employer-specific levies and universal coverage mandates

From both a financial and legal standpoint, the proposal is structured to preserve existing federal health care pathways. Seniors would continue to qualify for Medicare through the Social Security Administration and would continue paying Medicare Part B (and, where applicable, Part A and IRMAA premiums). To avoid double payment, the proposal includes a non-refundable Oregon health care tax credit for Medicare Part B premiums paid by beneficiaries.

Similarly, lower-income Oregonians would continue to qualify for Medicaid under existing state and federal rules, allowing Oregon to retain federal matching funds while integrating Medicaid recipients into the broader UHP benefit structure.

Distributional Impacts and Equity Adjustments

A central element of the Committee's mandate was to assess the distributional effects of the UHP revenue plan and ensure that the financing structure aligns with the Board's equity and affordability objectives. The Committee developed and refined the proposal through an iterative process anchored by two complementary workstreams:

- **Tax Incidence and "Pre/Post" Analysis.** The Committee evaluated how contributions change under the proposal relative to the status quo for households and employers. For households, analysis examined outcomes across income levels and household types, including key distinctions such as income decile, employment arrangement (employed versus self-employed), and Medicare status. For businesses, analysis focused on how outcomes vary by employer size (primarily payroll scale).
- **Equity and Affordability Design Features.** The Committee tested and incorporated a set of practical adjustment mechanisms—such as credits, exemptions, phase-ins, and other structural features—to improve affordability for lower- and middle-income households, maintain broad-based participation, and support reasonable contribution expectations across the income distribution.

Chapters 3 and 4 summarizes the Committee's principal distributional findings and describes how these analytic results informed the final set of recommended parameters and equity-focused design features.

Start-Up Costs and Reserves

Chapter 5 analyzes the other two kinds of cost the UHP will need to provide for – the "one-time" start-up/transition costs and the costs of capitalizing the system's operating reserve. Specifically, the chapter highlights the following considerations the Board's submission must consider.

- **Reserve Requirements:** Sizing early-year reserves to ensure solvency and payment stability.
- **Up-Front Infrastructure Costs:** Administrative, IT, marketing, staff, and oversight expenditures.
- **Pre-Funding Options:** Bridge financing strategies, such as state appropriation or state loan, pre-collecting or temporarily increasing a dedicated tax, federal waivers, and other mechanisms.
- **Risks and Contingency Planning:** Disruption scenarios and fallback provisions.

Chapter 4 also collates a series of important lessons learned from several recent program implementation comparators of relevance for Oregon's UHP.

Calibrating the Revenue Framework to Plan Costs and Replacement Funding

The Finance & Revenue Committee's work to date has focused on defining a sound and internally consistent revenue structure, using the most recent year with complete and reliable data at the time the analysis started—tax year 2022—as a common analytical baseline. This approach allowed the Committee to evaluate the relative performance of different revenue instruments, assess distributional impacts, and test design features using a single, transparent calibration year.

Importantly, the Committee's work at this stage was structural rather than forward budgetary. The revenue proposal is calibrated to 2022 conditions to demonstrate how a coherent financing system could replace existing health care spending and support a universal benefit, not to establish final tax rates or revenue levels for the first year of UHP operations.

As the UHP Governance Board moves toward implementation, several interrelated components will need to be recalibrated from this 2022 baseline to the anticipated first year of operations (currently assumed to be 2032):

1. The cost of the UHP benefit in the first year of implementation, and
2. The amount of existing health care spending that the UHP revenue system is intended to replace or redirect in that year.
3. Payroll and income (and distribution), both individual and business.

Current-System Spending and the Replacement Funding Target

A central concept underlying the Committee's work is the distinction between total UHP plan costs and the replacement funding target. The replacement funding target represents the amount of health care spending already occurring in Oregon's economy that would be supplanted by UHP financing, modified by changes expected with the UHP. This includes, most notably:

- Employer and employee contributions toward employer-sponsored insurance (ESI),
- Individual premium payments, such as ACA Marketplace premiums,
- Certain household out-of-pocket expenditures,
- Additions due things such as to more people being covered, perhaps more services being covered, and no or minimal out-of-pocket expenditures for most services, and
- Subtractions due things such as administrative simplification, monopsony purchasing, and fraud reduction.

The Committee's revenue framework is designed first and foremost to replace these existing payment streams, rather than layer new net costs on top of the current system. In this sense, the revenue proposal answers the question: How can Oregon redirect what it already spends on health care into a single, publicly administered system in a more equitable and efficient way?

Current Health Care Funding in Oregon: Baseline for Revenue Replacement Analysis

Oregon's health care system is already supported by a large and diverse set of public, private, and household funding streams. Understanding the scale and composition of this existing funding is essential for evaluating the UHP replacement funding target—that is, the amount of current health care spending that would be redirected into a unified financing system under the UHP.

The Joint Task Force on Universal Health Care developed a relatively comprehensive baseline of health care expenditures using calendar year 2019 data, which was subsequently redone by the Finance and Revenue Committee to inform 2022-era analysis. These estimates capture the major payer categories that finance health care services in Oregon today, including employer-sponsored insurance, individual premiums, Medicare, Medicaid, out-of-pocket spending, and other public and charitable programs. In aggregate, baseline health care spending included in the UHP modeling totals approximately $38.7 billion (2019 dollars), including certain services not contemplated for inclusion in the UHP benefit, such as state hospitals, corrections and public health, as seen in Exhibit 10 below.

A substantial share of this spending is associated with employer-sponsored insurance and other employment-linked coverage arrangements, underscoring the degree to which health care financing in Oregon is currently tied to employment. Federal programs (particularly Medicare and Medicaid) also represent a large portion of total expenditures and are assumed, under the UHP framework, to continue flowing to Oregon subject to federal approval and possible waiver authority or other methods.

From a financing perspective, these existing funding streams define the baseline for the replacement funding target for the UHP. Rather than financing the full cost of the UHP as an entirely new expenditure, the revenue framework developed by the Finance & Revenue Committee is designed to replace and restructure these existing payments, redirecting them into a single, publicly administered trust fund. The intent is that out-of-pocket expenditures and expenditures that flow through private insurers will not continue, and so will be generally replaced by new or modified revenue mechanisms. There will be both new expenditures and savings that lead to adjustments described below in "Accounting Framework for Cost Target."

Exhibit 10: Current Health Care Spending by Funding Source in Oregon

Coverage / Expenditure Type	Expenditures ($M)			Notes on Funding Conditions
	2019 Dollars	2022 Dollars	2026 Dollars	
Out-of-Pocket (OOP)	**$3,782**	**$4,287**	**$6,020**	
Out-of-Pocket (OOP) without non-durables	$3,075	$3,335	$5,068	
Health Insurance	**$30,572**	**$35,829**	**$42,828**	
Private Health Insurance	**$14,318**	**$15,999**	**$15,999**	
Employer sponsored	**$12,422**	**$14,171**	**$14,171**	
Private & non-PEBB/OEBB Public	$9,992	$11,521	$11,521	
PEBB & OEBB	$1,876	$2,073	$2,073	
Federal	$554	$577	$577	
Individual	**$1,143**	**$1,173**	**$1,173**	
Market (Exchange)	$820	$908	$908	
Other	$322	$265	$265	
Medigap	**$501**	**$435**	**$435**	
Medicare Advantage not from CMS	**$252**	**$220**	**$220**	
Public Programs	**$16,254**	**$19,830**	**$24,419**	
Medicare	$8,716	$9,533	$10,065	
Medicaid (Title XIX)	$7,089	$9,638	$13,696	
CHIP (Title XIX and Title XXI)	$448	$604	$604	
HOP and CAK	$0	$55	$55	
DOD	$549	$588	$588	*A portion of these funds are spent on providers in the general public system.*
Department of Veterans Affairs	$1,422	$1,822	$1,822	
Other Third Party Payers	**$2,500**	**$3,078**	**$3,956**	
Worksite Health Care	$96	$109	$109	*These funds are for independent health services that may or may not continue*
School Health	$79	$93	$93	
Workers' Compensation	$356	$391	$391	*These funds are spent on providers in the general public system.*
Other Private Revenues	$2,034	$1,916	$1,916	
Auto, Property, & Casualty	$469	$391	$435	
General Assistance	$81	$88	$88	*These funds are from the state government and may be affected by UHP*
Non-Medicaid HSD (Other State/Local)	$208	$555	$555	
Maternal/Child Health	$24	$25	$25	*A portion of these funds are spent on providers in the general public system.*
Vocational Rehabilitation (Medical Portion)	$8	$8	$8	
Other Federal Programs	$180	$429	$429	
SAMHSA	$47	$145	$145	
Indian Health Services	$196	$196	$196	
Not part of UHP	**$1,825**	**$3,177**	**$3,177**	
State Hospital	$298	$362	$362	
Corrections	$141	$173	$173	
Public Health	$1,387	$2,641	$2,641	
Total Baseline Health Care Expenditures	**$38,680**	**$46,371**	**$55,981**	

Source: National Health Expenditure Accounts, Finance and Revenue Committee
Notes: Enrollment figures are adjusted to avoid double-counting due to dual eligibility across programs. Out-of-pocket costs for services not contemplated under the UHP benefit are included. Non-post acute Long-term Services and Supports (LTSS) are excluded. Totals may not sum due to rounding.

From Baseline Health Care Spending to the UHP Cost Target

Exhibit 10 summarizes current health care spending in Oregon by funding source, expressed in 2022 dollars. Total baseline expenditures included in the Universal Health Plan (UHP) modeling are approximately $46.4 billion, reflecting the combined cost of employer-sponsored insurance, individual premiums, federal and state public programs, and household-based spending in Oregon's existing multi-payer system.

This baseline does not represent the cost of a universal system. Instead, it provides the empirical foundation from which the Finance & Revenue Committee derived a counterfactual cost target for the UHP—defined as the cost of providing universal, PEBB+ coverage to all Oregonians under a single-payer structure.

Rather than attempting to calculate UHP costs directly from unit prices and utilization rates, the Committee adopted an accounting-based approach (using the Joint Task Force and Optumas methodology as a foundation) that adjusts observed current spending to reflect the key structural differences between the status quo and a universal system.

Accounting Framework for the UHP Cost Target

Starting from total current-system spending, the UHP cost target is derived by applying a series of conceptual adjustments that reflect both efficiencies gained under a single-payer model and costs associated with expanded coverage and benefits:

UHP Estimated Total Expenditure = (Private Insurance Expenditures + Applicable Out-of-Pocket Spending) – Administrative Efficiency Savings + Cost of Covering Uninsured Populations + Cost of Benefit Standardization to PEBB+ Standard

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Step 1: Baseline Health Care Spending. As shown in Exhibit 10, total baseline health care expenditures included in the UHP modeling equal $46.4 billion (2022 dollars). This represents both private insurance expenditures and applicable out-of-pocket spending under the current multi-payer system and serves as the starting point for estimating the cost of a universal system.

Step 2: Administrative Efficiency Savings. A universal, publicly administered health care system eliminates many duplicative administrative functions inherent in the current multi-payer structure, including marketing, underwriting, enrollment, provider contracting, and claims processing across multiple insurers. Consistent with the Committee's direction for illustrative modeling, an 8 percent administrative efficiency capture is applied to baseline spending. This assumption reflects provider-side and system-wide efficiencies achievable under a single-payer model and reduces total spending relative to the status quo.

Step 3: Coverage Expansion. Under the UHP, coverage is extended to individuals who are currently uninsured or underinsured. Based on Joint Task Force estimates, this includes

approximately 314,000 additional people who would receive comprehensive health coverage under a universal system. The cost of covering these additional individuals is added to the baseline after efficiency savings are accounted for, reflecting increased utilization and service access relative to the status quo.

Step 4: Benefit Standardization to PEBB+. The current system provides widely varying benefit levels depending on coverage source. The UHP cost target assumes a uniform PEBB-plus benefit standard, which entails:

- Raising coverage for individuals currently enrolled in plans with lower actuarial value,
- Adding dental benefits for populations that do not currently receive them, and
- Expanding and standardizing behavioral health benefits across the entire population.

These benefit enhancements represent a deliberate policy choice embedded in the UHP design and increase total system costs relative to current spending.

Taken together, these adjustments define the cost of a counterfactual universal PEBB+ health care system in Oregon. This cost target represents the total annual funding required to operate the UHP at the proposed benefit level, before accounting for which portions of that cost are financed through redirected existing spending versus new state revenue.

From the UHP Plan Cost Target to the Revenue Replacement Target

Once the UHP Plan Cost Target was established, the Finance & Revenue Committee's next task was to determine how much state-level revenue must be raised to replace health care payments that would no longer occur under a Universal Health Plan. The Committee refers to this amount as the **Revenue Replacement Target.**

Importantly, the Committee did not frame the UHP financing challenge as raising the full cost of the universal system from scratch. Instead, it assumed that a significant share of current health care funding would either be preserved (e.g., Medicare and Medicaid) or eliminated and replaced (e.g., private premiums and out-of-pocket payments). The Committee therefore focused on identifying the net amount of revenue that must be replaced through new state taxes.

SPENDING ELIMINATED UNDER A UHP

Under a UHP, several categories of current health care spending would no longer occur in their present form. These include:

- Employer contributions to employer-sponsored insurance (ESI),
- Employee contributions to ESI,
- Individual insurance premiums such as ACA Marketplace premiums, and

- Household out-of-pocket expenditures for services covered by the UHP.

Together, these payments represent existing dollars already being paid by Oregonians that would be redirected into the UHP financing system rather than continuing as fragmented private payments.

FUNDING PRESERVED UNDER A UHP

At the same time, the Committee assumed that major public funding streams would continue to support health care under the UHP, subject to federal approval. These preserved sources include:

- Medicare payments (with beneficiaries continuing to pay Medicare premiums),
- Medicaid funding, including federal matching dollars, and
- Other existing state and other federal public health expenditures.

Because these funds are assumed to remain available to the system, they do not need to be replaced by state revenue and therefore reduce the size of the revenue problem the Committee is solving.

Anchoring the Revenue Strategy: The $16.9B Revenue Replacement Target (2022 dollars)

To support disciplined revenue design, the Finance & Revenue Committee determined that it was essential to anchor its analysis to a single, internally consistent replacement target rather than continually revisiting total system cost estimates that are inherently uncertain and forward-looking. Accordingly, the Committee settled on a Revenue Replacement Target of $16.9 billion (2022 dollars) as the reference point for evaluating revenue mechanisms, tax bases, and distributional impacts. This value reflects the Committee's preferred 2022 calibration of: The UHP Plan Revenue Replacement Target, preserved public funding (particularly Medicare and Medicaid), and status-quo private and household spending that would be eliminated under a UHP.

The $16.9 billion figure was not intended to represent a precise forecast of first-year implementation needs. Rather, it served as a stable analytical anchor that allowed the Committee to:

- Compare alternative revenue instruments on a common footing,
- Evaluate progressivity and distributional outcomes,
- Test crediting, caps, and exemptions, and
- Ensure internal consistency across scenarios.

By fixing the replacement target in 2022 dollars, the Committee was able to focus its work on structure and equity, while deferring forward-year recalibration to the UHP Governance Board as plan costs, benefit design, and federal participation assumptions are refined.

DEFINING THE REVENUE REPLACEMENT TARGET

Formally, the Committee defined the Revenue Replacement Target as:

Revenue Replacement Target = (UHP Plan Estimated Expenditure for Current Care + Utilization & Coverage Adjustments) – System Efficiency Savings – Preserved Public Funding

This is the metric against which the Finance & Revenue Committee evaluated alternative revenue structures and design parameters. The table below illustrates how the Revenue Replacement Target relates to alternative 2022 estimates examined by the Committee.

Exhibit 11: Revenue Replacement Target (2022$)

Scenario	Revenue Replacement Target ($M)	Key Assumptions
Committee Anchor (2022)	$16,900	Preferred calibration used for revenue design
June F&R Baseline	$18,390	Optumas assumptions and status-quo expenditure estimates
Optimistic Scenario	$14,594	Higher federal participation and stronger administrative savings
Conservative Scenario	$22,500	Reduced Medicaid transfers under recent federal reforms

Note: All values are expressed in 2022 dollars and assume plan coverage comparable to Joint Task Force recommendations.

Anchoring the revenue strategy to a $16.9B Revenue Replacement Target clarifies that the Committee's work was focused on replacing existing health care payments, not expanding the overall cost burden on the Oregon economy. This framing provides a transparent and defensible basis for revenue design and sets up the Board's next phase of work: recalibrating the replacement target to the first year of UHP operations and aligning revenue rates accordingly.

SOURCES OF UNCERTAINTY AFFECTING THE REVENUE REPLACEMENT TARGET

Any revenue proposal for a state-run universal health care system must rest on a set of assumptions about factors that determine how much existing health care spending must be replaced by state-level revenue. While the Finance & Revenue Committee anchored its

revenue design to a $16.9 billion Revenue Replacement Target (2022 dollars), the Committee recognizes that this target will need to be recalibrated as key uncertainties are resolved.

The uncertainties described below do not undermine the structural validity of the Committee's revenue framework. Rather, they define the parameters the UHP Governance Board will need to refine as it transitions from structural design to implementation planning. The most consequential sources of uncertainty affecting the Revenue Replacement Target are summarized and discussed below.

1. Administrative Savings Under the UHP

The Revenue Replacement Target reflects assumed administrative efficiencies achievable under a single-payer system. As in Oregon's 2022 Joint Task Force (JTF) report, the Committee's cost estimates incorporate savings from eliminating duplicative administrative activities inherent in the multi-payer system, including marketing, enrollment, insurer-specific provider contracting, claims processing, and private insurance margins.

The JTF assumed provider-side administrative savings equal to approximately 4 percent of total health system expenditures, reflecting reduced billing complexity for providers. The Task Force recognized potential provider administrative savings of 8% to 12% but chose to use some of the expected savings to increase provider net compensation. The Finance & Revenue Committee chose to estimate realizing more of those savings - 8 percent of total provider payments as savings under a unified, publicly administered system. This result reduces the Revenue Replacement Target by approximately $1.3 billion (2022 dollars).

Recent studies indicate that mature single-payer systems typically operate with payer side administrative overhead in the range of 2 to 5 percent, compared to 12 to 15 percent in the U.S. multi-payer model. The JTF fiscal model used only a 3% of total expenditure payer side administrative savings, and the Committee retained that conservative value.

2. Federal Contributions Preserved Under the UHP

A second major determinant of the Revenue Replacement Target is the extent to which federal health care funding can be preserved and integrated into the UHP. The Committee's proposal assumes that federal dollars currently flowing to Oregon through Medicare and the federal share of Medicaid will continue under the UHP, subject to federal approval and waiver authority or some other mechanism.

Under the proposal, existing eligibility and enrollment pathways are preserved. Seniors would continue to qualify for Medicare through the Social Security Administration and would continue paying Part B premiums (and, where applicable, Part A premiums and IRMAA). To avoid double payment, Medicare beneficiaries would receive a credit for paid Part B premiums against their Health Care Personal Income Tax liability. Similarly, lower-income Oregonians would continue to qualify for Medicaid under existing state and federal rules, allowing Oregon to retain federal matching funds.

The largest source of uncertainty arises from recent and potential changes in federal Medicaid policy, including the effects of H.R. 1 (2025). According to Congressional Budget Office estimates, tightened eligibility and reduced state-directed payment limits could lower federal Medicaid funding to Oregon by more than $3 billion by 2030. Conversely, UHP-required provider price parity could increase federal matching payments by more than $4 billion under certain assumptions.

Taken together, uncertainty in federal participation could plausibly shift the Revenue Replacement Target by as much as a $1 billion decrease or a $3 billion increase.

3. Health Care Cost Growth

The Committee believes that a revenue framework broadly consistent with the 2022 proposal can support the UHP on an ongoing basis once implemented. However, this conclusion is contingent on the system's ability to keep pace with health care cost growth.

Between the 2022 calibration year and the anticipated first year of UHP operations, tax rates and revenue parameters will need to be adjusted to reflect medical inflation and utilization trends. Cost growth will also remain a long-term governance issue after implementation, requiring revenue mechanisms that can scale with expenditures over time.

Accordingly, uncertainty around future health care cost growth affects the forward calibration of the Revenue Replacement Target rather than the underlying structure of the Committee's proposal.

4. Other Accounting and Data Uncertainties

Finally, there are residual uncertainties in baseline expenditure data that affect estimates of both the UHP Plan Total Estimated Expenditure and the Revenue Replacement Target. In particular, approximately $1.5 billion (2022 dollars) in "structures and equipment" spending within the National Health Expenditure Accounts is not clearly attributable to provider payments or separate capital expenditures.

Clarifying how these costs are treated—whether embedded in provider rates or requiring separate financing—will be important for finalizing the revenue target but does not alter the Committee's core financing logic.

Implications for Board Action

Together, these uncertainties define the range within which the Revenue Replacement Target will ultimately be set, rather than calling into question the Committee's recommended revenue framework. The Finance & Revenue Committee intentionally anchored its analysis to a 2022-based replacement target to focus on structure, equity, and feasibility. The UHP Governance Board's next phase of work will involve recalibrating that target to the first year of operations as these uncertainties are resolved.

Calibrating the Milliman Cost Estimate to the Revenue Replacement Target

A key issue for the Finance & Revenue Committee in 2026 was how to incorporate the updated Milliman Universal Health Plan cost estimate into a revenue framework that had originally been built using the earlier Optumas work and 2022 revenue data. The Committee's original revenue plan was designed around a distinction between the overall UHP estimated expenditure and the revenue replacement target.

Two Different Accounting Frames

The Committee's challenge is that the Milliman and Optumas estimates are not directly comparable on a line-by-line basis because they are built using different accounting frames. Milliman organizes the UHP estimate by line of business or insurance market segment, such as employer, individual, Medicaid, Medicare, public employees, and uninsured populations, and separately identifies assumed federal waiver capture. By contrast, the Optumas-based Finance & Revenue work was built from a health expenditure framework that is closer to a National Health Expenditure Accounts approach, focused on who pays today and what categories of spending exist in the current system. As a result, Milliman is oriented around who is covered and what the UHP would cost for those populations, while the Finance & Revenue framework is oriented around which current payment streams disappear and therefore must be replaced through new revenue.

This difference matters because the revenue replacement target depends not only on total UHP cost, but also on identifying which current funding sources are transferable, preserved, or outside the UHP. Put differently, even if the Board has a refined estimate of what the UHP costs in total, that does not automatically tell the Committee how much new tax revenue must be raised. The answer depends on the extent to which Medicare, Medicaid, ACA subsidies, current state and local government health spending, and other public funding streams can continue to support the program.

Why a Full Reconciliation Is Difficult

The Committee's review of the Milliman update suggests that the gap between the two estimates is driven less by a single error than by a series of definitional and methodological differences. These include differences in how administrative costs are treated, how provider payment normalization and efficiency assumptions are applied, what benefits are included in scope, and how covered populations are defined.

Even relatively small differences in items such as dental coverage, behavioral health scope, Medicare Part B premiums and credits, or assumed administrative savings can move the estimate materially. For that reason, any attempt to immediately allocate the Milliman total back into the exact "sources and uses" structure of the Optumas revenue framework would risk introducing false precision.

The Committee therefore recognized that calibrating the Milliman estimate is not simply an exercise in plugging a new cost number into the old model. It requires a more careful reconciliation of the underlying assumptions about scope, funding flows, and treatment of preserved versus replaceable revenues. Until those allocation rules are fully agreed upon, a precise recalculation of the revenue replacement target remains provisional.

The Intended Analytical Path

The Committee identified a two-step analytical path for connecting the updated UHP estimate to the revenue plan. The first step is to recompute the revenue replacement target using the updated UHP cost estimate and a reconciled view of transferable and preserved funding. Conceptually, this means starting with the UHP plan cost estimate, subtracting Medicare, Medicaid, ACA subsidies, state and local government health spending, and other public or redirectable funding that is expected to remain available to support the UHP, and then identifying the net amount that must be raised through new state revenue. The intended deliverable is a reconciled "sources and uses" table that ties the updated estimate to the revised target.

The second step is to convert that updated target into a 2032 implementation-year financing package suitable for legislative consideration. The Committee anticipated that this would ultimately require Legislative Revenue Office modeling to bring the relevant tax bases forward to the plan year, align assumptions with legislative forecasting conventions, and solve for the tax rates, thresholds, and credits needed to meet the target in the implementation year.

Practical Placeholder for Board Deliberation

Because the full reconciliation work was still underway, the Committee concluded that the most practical near-term approach was to use a placeholder revenue replacement target to support Board discussion and scenario testing. Rather than back-casting a premature and potentially arbitrary allocation from the Milliman total, the Committee proposed trending forward the previously adopted 2022 revenue replacement target of $16.9 billion using a 4.4 percent annual growth assumption.

That growth rate was selected to reflect expenditure growth in the spending categories that most closely align with the revenues being replaced. On that basis, the implied placeholder target is approximately $20.1 billion in 2026 and $26.0 billion in 2032. The Committee's view was that the $26.0 billion 2032 target could serve as a practical working figure until the reconciliation between updated UHP costs and transferable funding could be refined further.

This approach does not resolve the underlying accounting differences, but it provides a workable bridge between the older revenue framework and the newer cost estimate. It allows the Board and staff to continue evaluating the overall tax package, testing policy choices, and discussing burden allocation without waiting for every definitional issue to be fully settled. At the same time, it preserves room for later refinement once the Committee, Milliman, and

legislative staff have a clearer basis for reconciling the updated UHP estimate with the existing revenue structure.

Policy Significance

The calibration issue has an important policy dimension. If the eventual revenue replacement target is higher or lower than the placeholder amount, the Board will need to decide whether to scale the existing revenue structure up or down proportionally or to rebalance the mix of revenue instruments. The Committee identified these as distinct pathways. A scaling approach would preserve the current structure and simply adjust rates uniformly. A rebalancing approach would retain the same instruments but shift where marginal dollars are raised, such as altering the relative roles of the employer payroll tax and the health care personal income tax or adjusting thresholds and rate shapes. That means the calibration of the Milliman estimate is not only a technical exercise; it also sets up later decisions about how the burden of financing the UHP should be distributed if the final target differs from current expectations.

3. Proposal to Fund On-Going UHP Expenses

Introduction

This chapter presents the Finance & Revenue Committee's consensus recommendations for funding the Universal Health Plan's on-going annual expenses. Chapter 4 addresses the distinct question of one-time start-up, transition, and reserve capitalization costs. The focus here is on the core revenue framework designed to finance the UHP once it is fully operational.

Building on the analytical foundation established in Chapter 2, this chapter documents how the Committee translated its Revenue Replacement Target into a coherent set of revenue instruments. It summarizes the key design choices, parameter selections, and policy rationales that underpin the proposed funding approach, and it presents evidence developed by the Committee to assess revenue sufficiency, equity, and administrative feasibility.

Central to this chapter are the exhibits that show how health care contributions would change for different types of households and businesses under the proposed UHP relative to the status quo. These comparisons provide the most direct insight into how the revenue proposal reallocates existing health care payments and distributes responsibility across the Oregon economy.

What the Committee's Revenue Proposal Is Designed to Do

The Committee's proposal establishes an integrated system of UHP-specific revenue streams to finance the Plan's on-going costs. Some components are paid by employers and others by individuals, primarily through the state's personal income tax system. Together, these revenue sources are designed to meet four overarching objectives:

- **Replace existing private health care payments,** particularly employer-sponsored insurance contributions, individual premiums, and out-of-pocket expenditures, with a unified public financing system;
- **Protect low- and middle-income households** through income-based thresholds, credits, and exemptions, while maintaining a sense of shared responsibility for the system;
- **Ensure broad-based**, predictable contributions from employers and individuals to support long-term financial stability; and
- **Minimize legal risk,** including ERISA vulnerability, by relying on generally applicable, non-employer-specific revenue mechanisms.

As described in Chapter 2, the Committee anchored its revenue design to a Revenue Replacement Target of approximately $16.9 billion (2022 dollars)—the estimated amount of state-level revenue required after accounting for preserved public funding (notably Medicare and Medicaid) and the elimination of private premiums and out-of-pocket payments under a universal system. Accordingly, the revenue plan presented in this chapter is calibrated to raise $16.9 billion in 2022 dollars, providing a consistent analytical basis for evaluating tax bases, rates, credits, and distributional outcomes.

UHP Revenue Mechanisms

The Universal Health Plan revenue proposal is built around a small number of structurally integrated revenue mechanisms designed to replace existing private health care payments with a stable, equitable, and administratively feasible public financing system. Rather than relying on a wide array of narrowly targeted taxes, the Finance & Revenue Committee prioritized a limited set of broadly applicable instruments that align with how health care is currently financed in Oregon and that can be scaled over time as costs evolve.

Together, these mechanisms are intended to meet the Revenue Replacement Target by:

- capturing employer-sponsored health care spending through payroll-based contributions,
- collecting income-based contributions from individuals in proportion to ability to pay,
- avoiding double payment through carefully designed credits and adjustments, and
- maintaining continuity with existing compensation and tax systems to reduce disruption.

The mechanisms described below operate as a coordinated system. Individual tax rates, credits, and adjustments are designed to work in combination—rather than in isolation—to balance revenue sufficiency, equity, and legal durability. Subsequent sections describe each mechanism in turn, followed by analysis of how they interact and how resulting payment obligations compare to the status quo for different types of households and businesses.

1. Corporate Income Tax Add-On (CIT/CET)

Why it is included. The Corporate Income Tax add-on is included to ensure that profitable corporations contribute directly to financing the UHP and to diversify the revenue base beyond wage-linked sources. It captures a portion of UHP financing from firms with positive taxable income, including firms that may have relatively low Oregon payroll but substantial in-state profits.

What it does. The proposal applies a 3.0% UHP-dedicated surcharge on top of Oregon's existing 7.6% corporate income tax rate. The add-on uses the current CIT base and administrative framework, increasing liability in proportion to taxable income.

How it aligns with Committee principles. The CIT add-on advances (1) revenue diversification by adding a profit-based component to the overall mix, (2) administrative feasibility by leveraging an existing tax system and definitions, and (3) equity across business types by ensuring that profitability—not only payroll—contributes to UHP financing.

2. Corporate Activity Tax Add-On (CAT)

Why it is included. The Corporate Activity Tax add-on is included to broaden business participation beyond firms that report taxable income, and to provide a steadier business-based revenue stream across economic cycles and corporate tax planning strategies. It helps ensure that businesses with significant Oregon market activity contribute to UHP financing even if taxable income is low or volatile.

What it does. The proposal applies a 0.10% UHP-dedicated add-on on top of Oregon's existing 0.57% CAT rate. The add-on is assessed on the existing CAT base and administered through the current CAT structure.

How it aligns with Committee principles. The CAT add-on supports (1) revenue adequacy and stability by drawing on a broad activity base, (2) risk diversification by complementing payroll- and income-based mechanisms, and (3) administrative feasibility by using an established tax base and collection system, while maintaining generally applicable treatment across firms.

3. Employer Payroll Tax (EPT)

Why it is included. The Employer Payroll Tax is the proposal's primary tool for replacing the employer share of today's employer-sponsored insurance (ESI) spending. It ensures that employers continue to participate in financing health care in a way that is broad-based and predictable, without tying coverage to any specific employer.

What it does. The EPT applies a payroll-based contribution above a firmwide payroll threshold. In effect, it helps to shape a fragmented, privately negotiated benefit cost into a transparent, statewide contribution that better aligns with the UHP's universal benefit.

How it aligns with Committee principles. The EPT supports (1) revenue adequacy and stability by drawing from a broad wage base, (2) equity by shielding small firms, and (3) legal durability by relying on a generally applicable payroll levy rather than an employer-specific benefit mandate (reducing ERISA exposure).

4. Health Care Personal Income Tax (HCPIT)

Why it is included. The Health Care Personal Income Tax is the central mechanism for individual contributions, designed to replace private premiums and a portion of household out-of-pocket costs with an income-based contribution that reflects ability to pay.

What it does. The HCPIT is administered through Oregon's existing personal income tax system and applies above an income threshold tied to the federal poverty level. It provides the primary vehicle for progressivity in the overall financing package and ensures that individuals contribute regardless of employment arrangement (wage earners, self-employed, retirees).

How it aligns with Committee principles. The HCPIT advances (1) equity through income sensitivity and built-in protections for low- and middle-income households, (2) administrative feasibility by using an existing tax system, and (3) broad-based participation consistent with a universal public program.

5. Household Size Rate Readjustment (HSRR) in the HCPIT

Why it is included. Household size adjustments are included to ensure that contributions reflect not only income, but also the number of people using health care in that (if the household income is large enough)—without relying on a separate per-person premium.

What it does. The Household Size Rate Readjustment (HSRR) modifies net HCPIT liability by household size at high enough incomes. It does not affect low-income households. At higher incomes, it counteracts the mechanical decline in liability that would otherwise occur as household size increases (e.g., through exemptions or filing structure.

How it aligns with Committee principles. HSRR supports (1) equity by protecting larger low- and moderate-income households, and (2) distributional integrity by preventing unintended regressivity or high-income windfalls tied to household size.

6. EPT Credit Against Individual HCPIT Liability

Why it is included. Because the proposal uses both employer- and individual-based contributions, a credit is necessary to avoid "stacking" the employer payroll contribution and the individual income-based contribution on the same wage-based compensation—especially for households least able to absorb abrupt changes.

What it does. The proposal provides a credit against HCPIT liability linked to a portion of the EPT paid on a worker's behalf. This recognizes employer participation in financing the UHP and reduces the risk that wage earners face higher combined burdens simply because their compensation is structured through employer coverage in the status quo.

How it aligns with Committee principles. The credit promotes (1) fairness and transition stability by preventing double-counting of compensation, (2) equity by limiting stacked burdens for low- and middle-wage households, and (3) neutrality across payer types by improving comparability between wage earners and the self-employed. The Committee continues to refine the credit level to balance these goals against revenue needs and progressivity at the top of the income distribution.

7. Medicare Part B Premium Credit

Why it is included. Medicare beneficiaries already finance a portion of their coverage through federal premiums. Without an offset, Medicare households could face double payment—once through federal Part B premiums and again through Oregon's HCPIT.

What it does. The proposal includes a non-refundable credit for Medicare Part B premiums against HCPIT liability. This preserves continuity with Medicare's existing financing structure while integrating Medicare beneficiaries into the UHP contribution framework in a manner that avoids duplicate charges.

How it aligns with Committee principles. The Part B credit supports (1) equity by preventing overpayment by seniors and other Medicare eligible residents, (2) administrative clarity by using a definable, documentable premium amount, and (3) system coherence by preserving federal program financing while aligning state contributions with the UHP's universal structure.

Current Plan Parameters by Revenue Instrument

This section documents the current parameter settings for each revenue instrument in the Committee's working plan and briefly describes how each mechanism operates within the integrated model. Parameters function as a system and should be interpreted together.

Corporate Income Tax Add-On

Parameter: +3.0% surcharge on top of Oregon's existing 7.6% CIT rate. The 6.6% rate on taxable income up to $1M for c-corporation filers remains unchanged.

How it works: This is an incremental UHP-dedicated surcharge applied to the existing corporate income tax base and filing structure. It increases liability for firms with taxable income under current CIT rules.

Corporate Activity Tax Add-On

Parameter: +0.10% add-on on top of Oregon's existing 0.57% CAT rate.

How it works: This add-on applies to the existing CAT base (gross receipts-style activity base) using current CAT administration. It broadens the business contribution beyond firms with taxable income.

Employer Payroll Tax

Parameters: A marginal rate of 9.6% on total firm payroll above $500,000. Public employers pay the EPT on their total payroll with no exemption.

How it works: Employers with firmwide payroll above the threshold pay the EPT on applicable payroll. The firm threshold excludes private employers below $500,000 payroll from EPT liability.

EPT Credit

Parameter: 50% EPT credit.

How it works: Individuals receive a credit against their HCPIT liability equal to 50% of the EPT paid on their behalf by their employer. The credit reduces net HCPIT owed, decreasing stacked employer/individual contributions on wage-based compensation.

Health Care Personal Income Tax

Parameter: A marginal rate of 10.1% of federal AGI above the 200% FPL threshold.

How it works: The HCPIT is assessed through Oregon's personal income tax system. Net liability is determined after applying the income exemption, household-size adjustments (HSRR), and credits (including the EPT credit and Medicare Part B credit where applicable). HCPIT liability is zero if federal AGI (minus federally taxable social security benefits) are below the exemption threshold (200% of the model's federal poverty benchmark). HCPIT liability begins at 200% of FPL.

Medicare Part B Premium Credit

Parameter: 100% credit of Part B premiums paid.

How it works: Medicare beneficiaries receive a non-refundable credit against HCPIT liability equal to Part B premiums paid. This credit is applied within the same net-liability calculation as other adjustments.

Household Size Rate Readjustment (HSRR)

Parameters: The HSRR results in an amount of up to $1,325 per exemption above one, so it applies to household size 2 and above if their federal AGI is greater than 260% of FPL.

How it works: The HSRR is applied within the HCPIT calculation to adjust net liability by household size consistent with the model's household-size logic. It modifies the way exemptions/credits interact with household composition so that liability does not mechanically decline with larger household size at higher incomes while preserving relief for larger households at lower incomes. A higher marginal tax rate begins at 260% of FPL it a filer claims more than one exemption. The higher marginal rate is designed so that the extra HCPIT liability increases linearly from 0 to $1,325 times (number of exemptions minus 1) by 520% of FPL.

Lodging Tax

Parameters: Increase Oregon's state lodging tax from 1.5% to 1.7% (+0.20%).

How it works: This option would increase the existing state transient lodging tax by 0.20 percentage points using Oregon's current lodging tax base and administrative framework. It is intended to capture a small share of health care costs associated with out-of-state visitors by drawing on visitor-related spending rather than relying entirely on Oregon residents or employers. Under the Committee's 2022 calibration, this increase was estimated to raise about $5 million annually.

Estimated Revenue by Revenue Instrument (2022 Dollars)

This section summarizes the estimated annual revenue generated by each component of the Committee's revenue proposal, expressed in 2022 dollars and calibrated to the current parameter set. Because several mechanisms interact—most notably the EPT credit against personal income tax liability and the Medicare Part B credit—the figures below should be read as model outputs under the integrated structure, not as standalone, additive tax calculations applied in isolation.

Exhibit 12: Estimated Revenue by Revenue Instrument (2022 Dollars)

Revenue Instrument	Estimated Revenue ($M)	Percent of Total	What the Estimate Represents
CIT	$639	3.8%	Additional CIT revenue from the user-defined increase over Oregon's existing corporate income tax structure (7.6% marginal rate on taxable income above $1M; 6.6% under $1M), applied to the 7.6% CIT base and filing system.
CAT	$215	1.3%	Additional CAT revenue from the user-defined increase over the current 0.57% CAT rate on corporate "activity" above $1M, using the existing CAT base and administration.
EPT	$8,715	51.5%	Payroll tax paid by employers; treated as a contribution made on behalf of employees and linked to an employee-level credit against personal income tax liability. This figure reflects gross EPT receipts.
HCPIT (net of Part B credit)	$6,317	40.0%	Net additional personal income tax revenue dedicated to UHP after accounting for reductions in individual liability due to the EPT credit.
HSSR	$962	3.4%	Net revenue associated with the household-size adjustment reflecting the FPL-based phase-in structure and reductions due to Medicare Part B credits.
Lodging tax	$5	<0.1%	Additional lodging tax revenue above Oregon's current 1.5% state lodging tax, intended to capture a small share of costs associated with care provided to out-of-state visitors.

Source: Finance and Revenue Committee

Because the proposal's instruments are designed to work as an integrated system, several entries in the table reflect net results after credits and offsets rather than standalone gross collections:

- **EPT and the EPT credit are modeled together.** The EPT is collected from employers, while a portion of that payment is credited against workers' HCPIT liability. Accordingly, the EPT line shows employer-side receipts, and the HCPIT/PIT line shows the portion of individual income-tax revenue remaining after the EPT credit is applied.
- **The Medicare Part B credit reduces net individual revenue.** The Part B premium credit is taken against individual HCPIT liability. In the revenue accounting, this credit shows up as a reduction in net receipts within the household/premium-equivalent component (reported here as the HSRR line).

4. Impact on Households and Businesses

Purpose and Approach

This section assesses the financial impacts of the UHP revenue proposal by quantifying how the plan changes who pays, how much they pay, and through which payment channel, relative to the status quo. The intent is to translate the proposal's structure and parameters into clear, comparable measures of financial responsibility across employers, households, and key subpopulations.

The core analytical construct throughout is a before-and-after comparison. On the "before" side, we summarize current health care payments made through premiums, employer contributions, and out-of-pocket spending. On the "after" side, we estimate contributions under the proposed UHP revenue instruments—primarily the Employer Payroll Tax (EPT) and the Health Care Personal Income Tax (HCPIT), as modified by the EPT credit, Household Size Rate Readjustment (HSRR), and the Medicare Part B premium credit—along with smaller business levies included in the proposal.

Impacts are presented using two complementary lenses. First, we evaluate system-level distributional shifts across broad payer classes, showing how aggregate payment responsibility moves from employer-sponsored insurance and private household payments to UHP-dedicated taxes and credits. Second, the analysis presents practical impacts through typologies and illustrative cases that demonstrate how the proposal operates for representative businesses and households, and how outcomes vary across common payer types and circumstances.

System-Level Shift in Payments: Status Quo vs. F&R Proposal

This section establishes the "big picture" change in how health care is financed under the Finance & Revenue proposal, using the model's 2022-dollar calibration. Exhibit 13 and Exhibit 14 summarize the proposed redistribution of payments away from fragmented premiums and out-of-pocket spending and toward a unified set of UHP-dedicated tax instruments.

Under the status quo, health care financing is fragmented across several payment channels:

- **Employers (by sector):** Employer-sponsored insurance (ESI) contributions paid by private employers, state and local government employers, and federal government employers. These payments are typically embedded in compensation and vary by coverage offering and plan design.
- **Households and individuals:** Employees' premium shares, premiums paid directly in the individual market, and out-of-pocket spending.

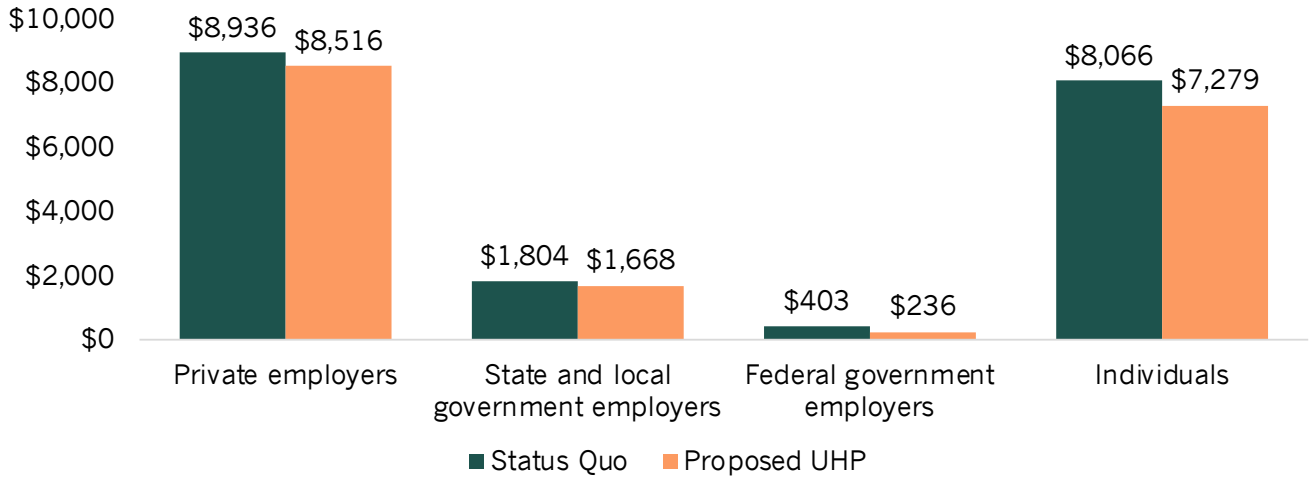
- **Public programs:** Medicare and Medicaid funding flows continue to finance a large share of care today; Medicare beneficiaries also pay Part B premiums directly. In the Committee's framework, these public flows are treated as largely preserved/transferable under the UHP (with appropriate credits to avoid double payment).

Under the F&R proposal, the same broad payer classes contribute through UHP-specific revenue mechanisms:

- **Employers:** Primarily through the Employer Payroll Tax (EPT) (with small business protections embedded through thresholds and exclusions). Minor business levies (e.g., CAT/CIT add-ons) are also included in the overall funding package but are not the main driver of the payer-class comparison shown here.
- **Individuals/households**: Primarily through the Health Care Personal Income Tax (HCPIT), net of:
  - the EPT credit (which offsets a portion of individual liability to prevent stacking employer and individual contributions on wage compensation),
  - Household Size Rate Readjustment (HSRR) effects embedded in the household calculation, and
  - the Medicare Part B premium credit (applied against individual liability to avoid double payment for Medicare beneficiaries).

These interactions matter for interpretation: the revenue shown for individuals in Exhibit 13 is net of credits that reduce liability for certain households and Medicare payers.

Exhibit 13. Net Proposed UHP Revenue by Source and Change Relative to Status Quo (in millions of 2022 dollars)



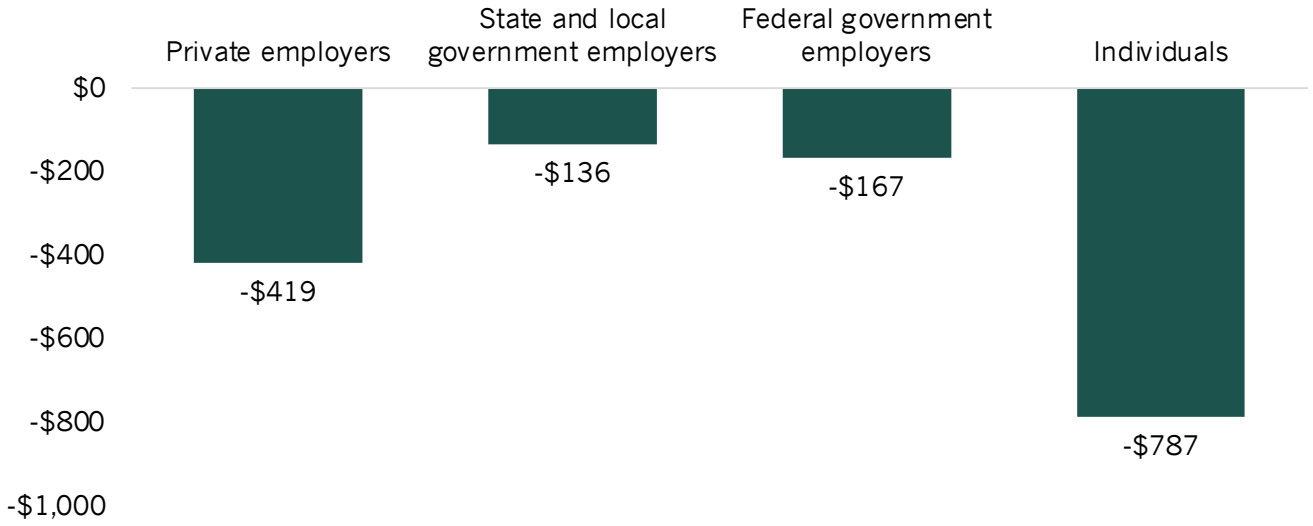
Source: Finance and Revenue Committee

Exhibit 14 shows that, in aggregate, the F&R proposal shifts payment responsibilities in a way that is predominantly replacement rather than net-new burden.

All payer classes shown contribute less under the proposal than in the status quo in the 2022 calibration. Exhibit 14 reports negative differences (savings) for each payer class:

- Private employers: approximately $0.42B lower under the proposal than under status quo payments.
- State & local government employers: approximately $0.14B lower.
- Federal government employers: approximately $0.17B lower.
- Individuals: the largest reduction, approximately $0.78B lower.

Exhibit 14. Difference in Contributions by Sector under F&R Proposal, 2022 ($Millions)



Source: Finance and Revenue Committee

Note: Negative differences indicate UHP savings within the sector.

Individuals' aggregate payments decline from roughly $8.0B in the status quo to about $7.2B under the F&R proposal, consistent with the proposal's replacement of premiums and out-of-pocket payments with income-based contributions and credits. Employer-side contributions decline modestly across sectors. Private employers remain the largest employer payer class (roughly $8.5B under the proposal) decrease, reflecting the replacement of ESI spending with a standardized financing structure.

Overall, these exhibits show that the proposal's financing shift is primarily a reorganization of how health care is paid for, moving away from premiums and point-of-service costs and toward UHP-dedicated taxes, while the 2022 calibration indicates a net reduction in aggregate payments for the payer classes shown. Subsequent subsections build on this high-level picture by examining (1) distributional impacts across business size/industry and (2) household impacts by income, employment type (wage vs. self-employed), Medicare status, and representative payer typologies.

UHP Business-Based Revenue Instruments

The proposal relies on three primary business-based instruments to fund the UHP and replace a significant share of today's employer-sponsored insurance spending with a consistent, statewide contribution structure:

1. **Corporate Income and Excise Taxes (CIT/CET):** A modest UHP-dedicated add-on to existing corporate income/excise tax structures, capturing a share of contributions from profitable firms.
2. **Corporate Activity Tax (CAT):** A small add-on to Oregon's gross-receipts-style activity tax, broadening contributions across firms with significant Oregon sales activity, including firms with low taxable income.
3. **Employer Payroll Tax (EPT):** The main employer-side funding mechanism, assessed on payroll above a firm threshold and designed to replace employer health benefit spending currently embedded in compensation.

Key Questions for the Business Impact Assessment

This section evaluates how the proposal reallocates employer obligations relative to the status quo, with a focus on both aggregate effects and variation across employer types:

- **How do business health care payments look today?** What employers currently pay through ESI (including differences by firm size and industry).
- **How do proposed UHP contributions compare to current spending?** What employers would pay under EPT (and the CIT/CAT add-ons), and how those obligations scale with payroll and firm characteristics.
- **Which employers see increases or decreases—and why**? How impacts differ across small vs. large employers and across industries.

CIT/CET Current Structure and Revenue Impact

Oregon's corporate tax system includes both the Corporate Income Tax (CIT) and the Corporate Excise Tax (CET). As shown in the current structure slide, the practical distinction is based on whether the corporation is considered to be doing business in Oregon. The CIT applies to corporations not doing business in Oregon, while the CET applies to corporations doing business in Oregon. The key difference for purposes of this analysis is that CET includes a minimum tax feature, while the CIT does not.

Both taxes share the same statutory rate structure on taxable income: 6.6% on taxable income below $1 million and 7.6% on taxable income above $1 million. This is the baseline structure the Committee uses when describing how a UHP-dedicated CIT/CET add-on would "ride on top of" the existing system.

CET MINIMUM TAX STRUCTURE (HOW LIABILITY WORKS)

A defining feature of the Corporate Excise Tax is that businesses pay the greater of:

1. the calculated tax based on taxable income, or
2. the minimum tax, which is determined based on Oregon sales.

The minimum tax schedule increases with Oregon sales—beginning at $150 for firms with Oregon sales below $500,000, rising through a series of brackets, and reaching $100,000 for firms with $100 million or more in Oregon sales (Exhibit 15). In addition, there are two special cases: S-corporations face a flat $150 minimum excise tax, and insurance corporations are subject to Oregon excise tax filing requirements when doing business in Oregon, including Oregon-source solicitation and premium-related income.

Exhibit 15: C-Corporation Minimum Excise Tax, Oregon, 2022

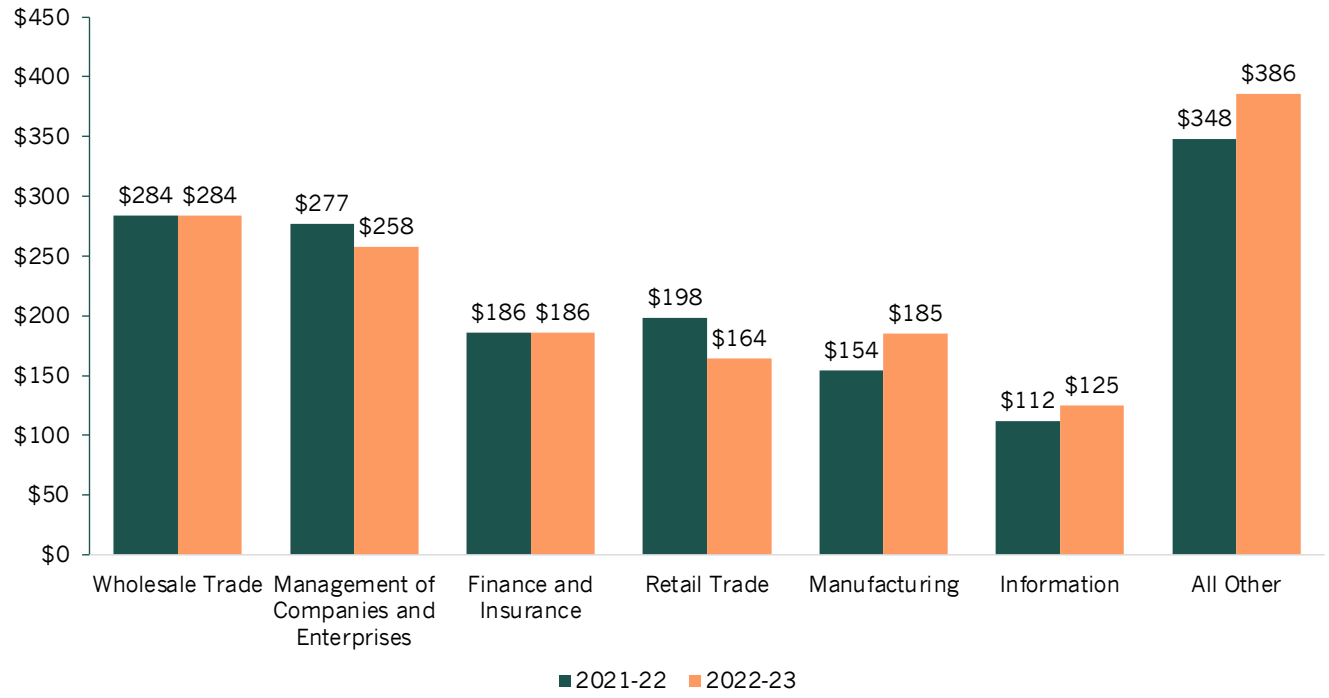
Oregon Sales	Minimum Tax
< $500,000	$150
$500,000 to $1 million	$500
$1 million to $2 million	$1,000
$2 million to $3 million	$1,500
$3 million to $5 million	$2,000
$5 million to $7 million	$4,000
$7 million to $10 million	$7,500
$10 million to $25 million	$15,000
$25 million to $50 million	$30,000
$50 million to $75 million	$50,000
$75 million to $100 million	$75,000
$100 million or more	$100,000

Source: Oregon Department of Revenue

CIT/CET REVENUE DISTRIBUTION (WHO PAYS TODAY)

Exhibit 16 summarizes how CIT/CET revenues are distributed across industries. In FY22, total CIT/CET revenue is shown as approximately $1,539 million (in 2022 dollars), and the mix is heavily weighted toward the excise tax: about 95% from CET and 5% from CIT. This reinforces that, in practice, Oregon's corporate revenues are primarily collected from corporations doing business in the state and subject to the minimum-tax framework.

Exhibit 16: CIT/CET Revenue Distribution, Oregon, FY22 and FY23 (in millions of dollars)



Source: Oregon Department of Revenue

By industry, corporate tax receipts are spread across multiple sectors, with a large "All Other" category and meaningful contributions from Wholesale Trade, Management of Companies and Enterprises, Finance and Insurance, Retail Trade, Manufacturing, and Information. The FY22 and FY23 bars indicate that sector contributions are broadly stable year-over-year, but with variation consistent with corporate income tax bases being influenced by profit cycles, sector performance, and firm-specific income reporting.

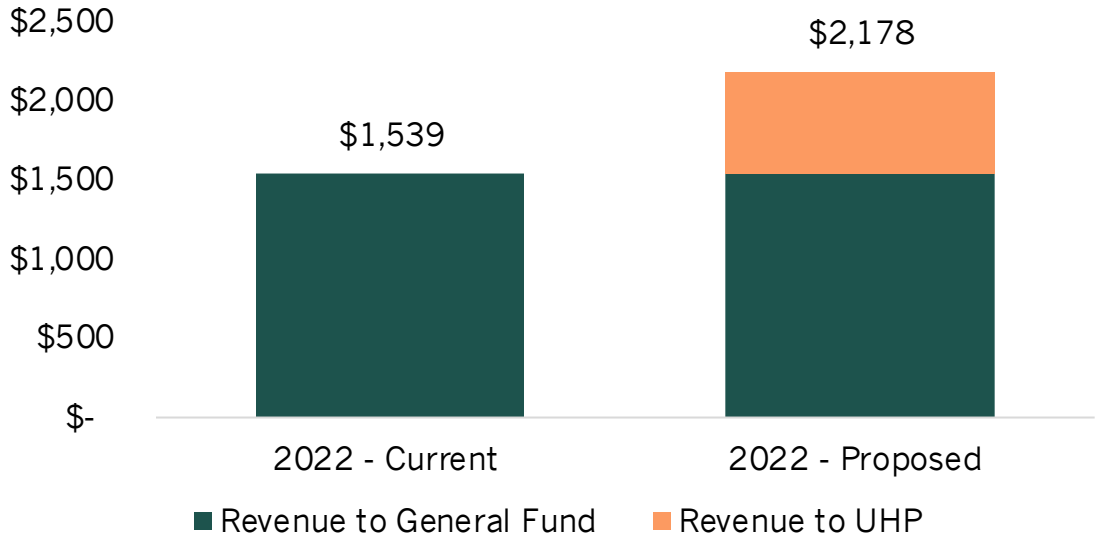
INCREMENTAL REVENUE GENERATED BY THE PROPOSED CIT/CET ADD-ON

Under the Finance & Revenue Committee's current parameter set, the proposal includes an incremental 3.0 percentage point add-on to Oregon's existing CIT/CET rate structure. The add-on is applied only to the existing 7.6% rate on taxable income above $1 million, the 6.6% rate on taxable income below $1 million is preserved.

- 10.6% on taxable income above $1 million (7.6% current + 3.0% UHP add-on).

Importantly, the proposal is structured as a dedicated surcharge: it generates revenue for the UHP without reducing existing corporate tax revenue currently deposited in the General Fund.

Exhibit 17: CIT/CET Revenue (in millions of 2022 dollars)



Source: Oregon Department of Revenue, Finance and Revenue Committee, and ECOnorthwest.

As illustrated in Exhibit 17, the total CIT/CET revenue in 2022 is estimated at $1,539 million (in 2022 dollars) under current law. Under the proposed add-on, total CIT/CET collections are estimated at $2,178 million, with the difference—approximately $639 million (2022$)—representing new, UHP-dedicated revenue. The existing $1,539 million remains allocated to the General Fund, while the incremental surcharge is earmarked for the UHP.

CAT Current Structure and Revenue Impact

Oregon's Corporate Activity Tax (CAT) is a modified gross receipts tax that applies to businesses with taxable Oregon commercial activity exceeding $1 million. The CAT applies to both goods and services sold in Oregon, and it applies to businesses located outside Oregon when they are conducting taxable commercial activity in the state. Under current law, 100% of CAT revenue is dedicated to the State Student Success Fund.

CAT STRUCTURE (HOW LIABILITY WORKS)

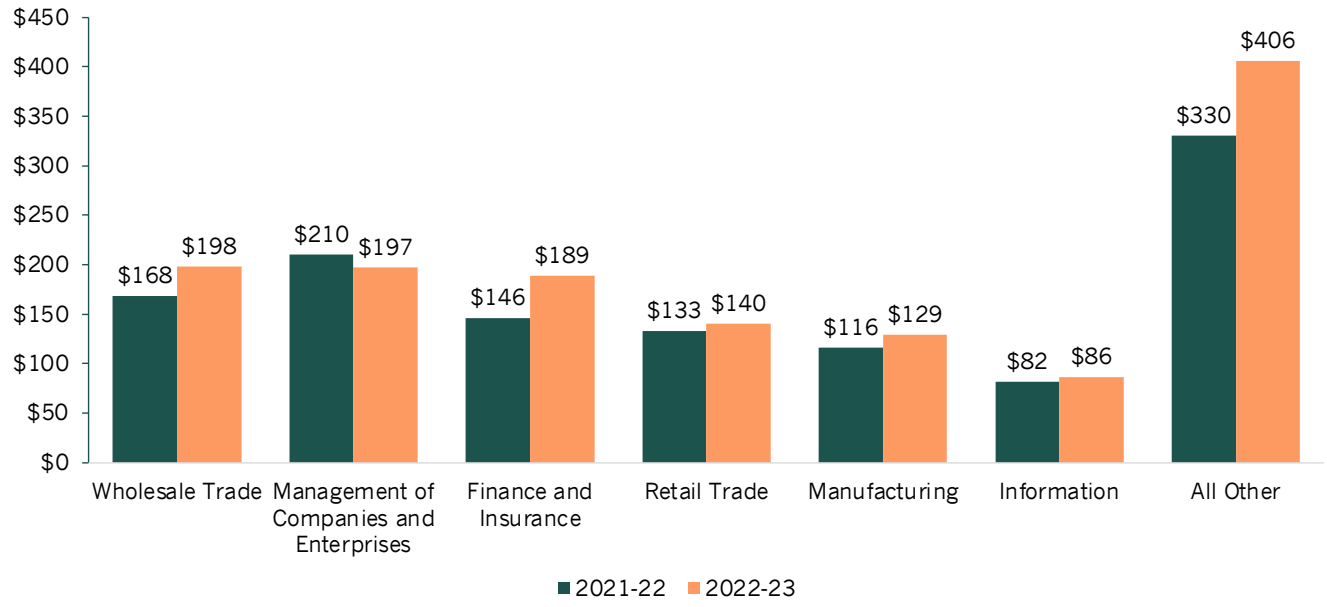
The CAT is levied as a $250 flat amount plus 0.57% of taxable Oregon commercial activity above $1 million. The CAT also includes statutory exemptions for certain entities, including nonprofits, governmental entities, and health care entities subject to Oregon's Medical Provider Taxes.

CAT REVENUE DISTRIBUTION (WHO PAYS TODAY)

Exhibit 18 summarizes how CAT revenues are distributed across industries. In FY22, total CAT revenue is shown as approximately $1,228 million (in 2022 dollars). Receipts are spread across major sectors, with meaningful contributions from Retail Trade, Wholesale Trade, Manufacturing, Management of Companies and Enterprises, Construction, and Information, alongside a large "All Other" category. The FY22 and FY23 bars indicate that sector

contributions are generally stable year-over-year, with expected variation consistent with differences in sales volumes and taxable activity across industries.

Exhibit 18: CAT Revenue Distribution, Oregon, FY22 and FY23 (in millions of dollars)



Source: Oregon Department of Revenue

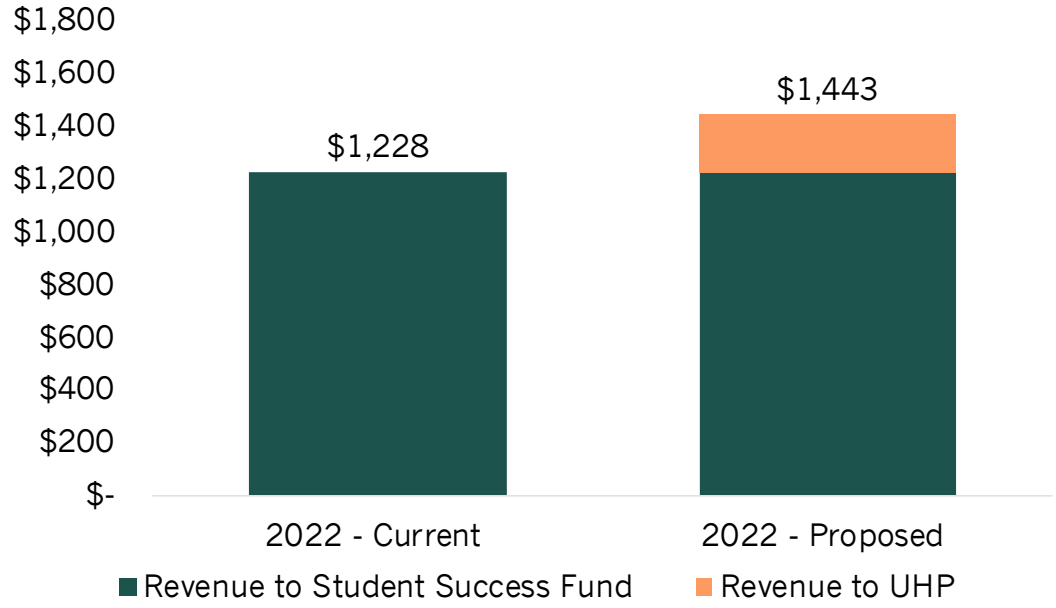
INCREMENTAL REVENUE GENERATED BY THE PROPOSED CAT ADD-ON

Under the Finance & Revenue Committee's current parameter set, the proposal includes a 0.10% incremental add-on to the existing CAT rate to generate UHP-dedicated revenue. The add-on is applied to the same taxable commercial activity base and preserves the CAT's current structure, meaning the proposed CAT rate becomes: $250 plus 0.67% of taxable Oregon commercial activity above $1 million (0.57% current + 0.10% UHP add-on).

Importantly, the proposal is structured as a dedicated surcharge: it generates incremental revenue for the UHP without reducing existing CAT revenue currently dedicated to the State Student Success Fund.

As illustrated in Exhibit 19, total CAT revenue in 2022 is estimated at $1,228 million (in 2022 dollars) under current law. Under the proposed add-on, total CAT collections are estimated at $1,443 million, with the difference—approximately $215 million (2022$)—representing new, UHP-dedicated revenue. The existing $1,228 million continues to flow to the Student Success Fund, while the incremental add-on is earmarked for the UHP.

Exhibit 19: CAT Revenue (in millions of 2022 dollars)



Source: Oregon Department of Revenue and ECOnorthwest

EPT Current Structure and Proposed UHP Add-On

Oregon already administers several payroll-based taxes that apply broadly to employers with paid employees working in the state, and corporations without employees must also register to report compensation paid to corporate officers. Exhibit 20 displays the FY22 estimates of total revenue from Oregon's current state payroll tax. Collectively, these existing employer payroll taxes "roughly sum to 3.6%" and include major components such as Unemployment Insurance, Paid Leave Oregon, the Workers' Benefit Fund assessment, and the Statewide Transit Tax.

Exhibit 20: Statewide EPT Current Structure

Oregon State Payroll Tax	Revenue
Unemployment Insurance, 0.9% - 5.4%	FY22 revenue was $1.3 billion
Paid Leave Oregon, 0.6% for employees, 0.4% for employers with more than 25 employees	FY24 revenue was $841 million
Workers Benefit Fund Assessment, $0.01 per hour worked	FY22 revenue collected $68.7 million in assessments
Statewide Transit Tax, 0.1% (does not include upcoming bill)	FY22 revenue was $122.1 million

Source: Oregon Department of Revenue, Oregon State Legislature

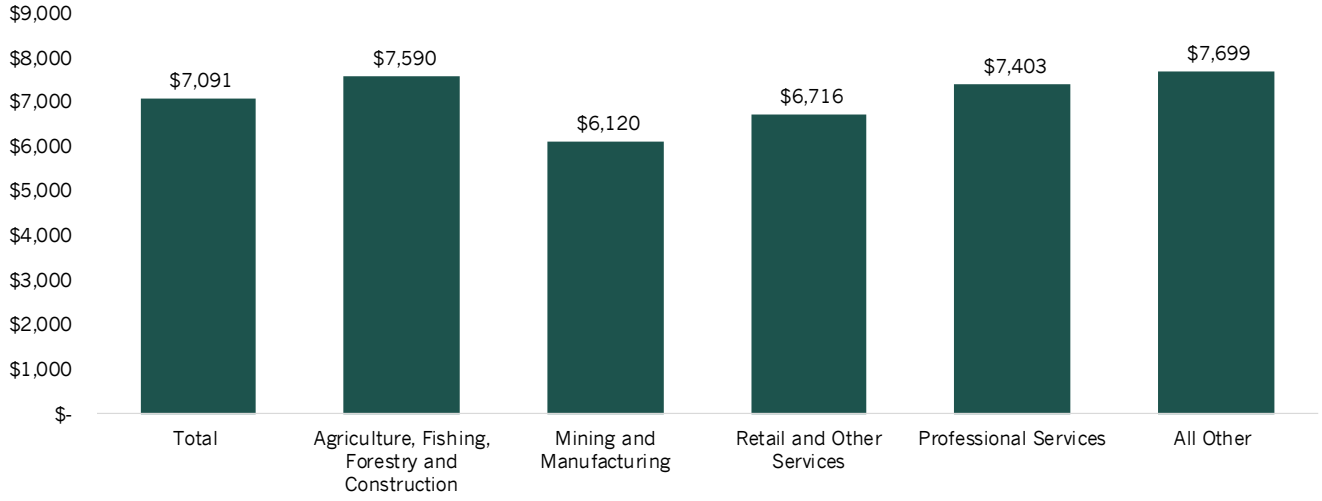
To provide a broader benchmark, there is also a parallel federal payroll-tax framework under FICA, where employees pay 7.65% (6.2% Social Security up to the wage base and 1.45% Medicare with no wage limit) and employers match that rate.

STATUS QUO EMPLOYER-SPONSORED INSURANCE (ESI) CONTEXT (WHAT EPT IS REPLACING)

Because the UHP EPT is intended to replace the employer share of today's ESI spending, the analysis also documents how ESI costs and coverage patterns vary across the economy. The exhibits below demonstrate Oregon 2022 data on average total single premiums by industry and by firm size, as well as the share of workers employed at firms that do not offer health insurance.

Exhibit 21 demonstrates that on average, industries like agriculture, fishing, forestry and construction as well as professional services have some of the highest annual premiums from single employees. While mining and manufacturing and retail and other services have lower average total premiums, $6,120 and $6,716 respectively. On average across all industries, ESI is roughly $7,000 per person.

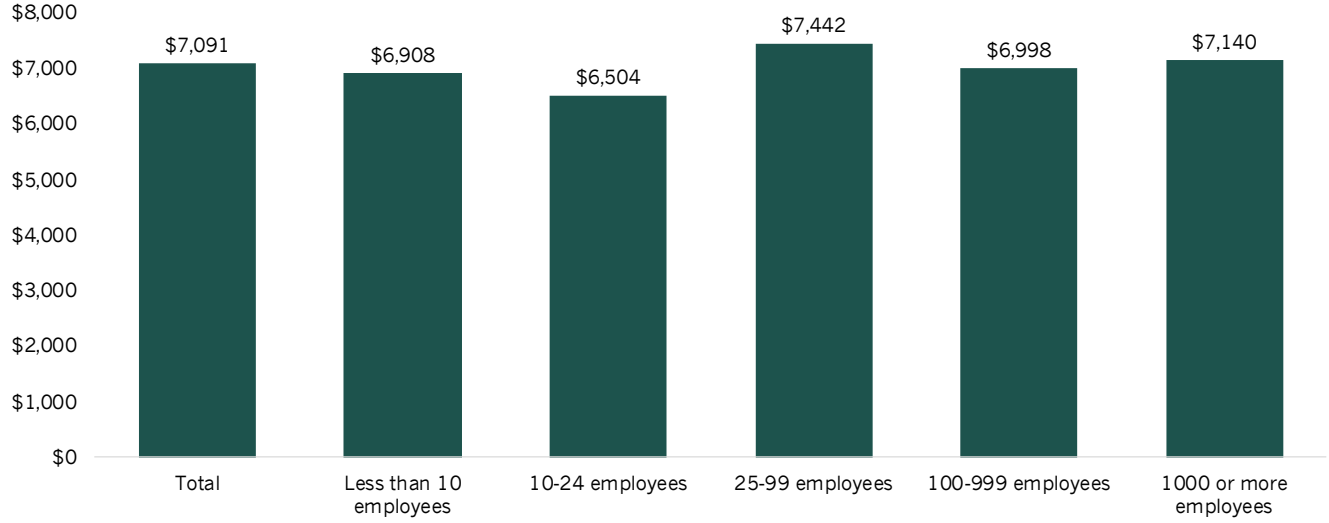
Exhibit 21: Average ESI by Industry Grouping, Oregon, 2022



Note: Average total single premium per enrolled employee at private-sector establishments that offer health insurance by industry groupings, Oregon, 2022
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2022 Medical Expenditure Panel Survey Insurance Component

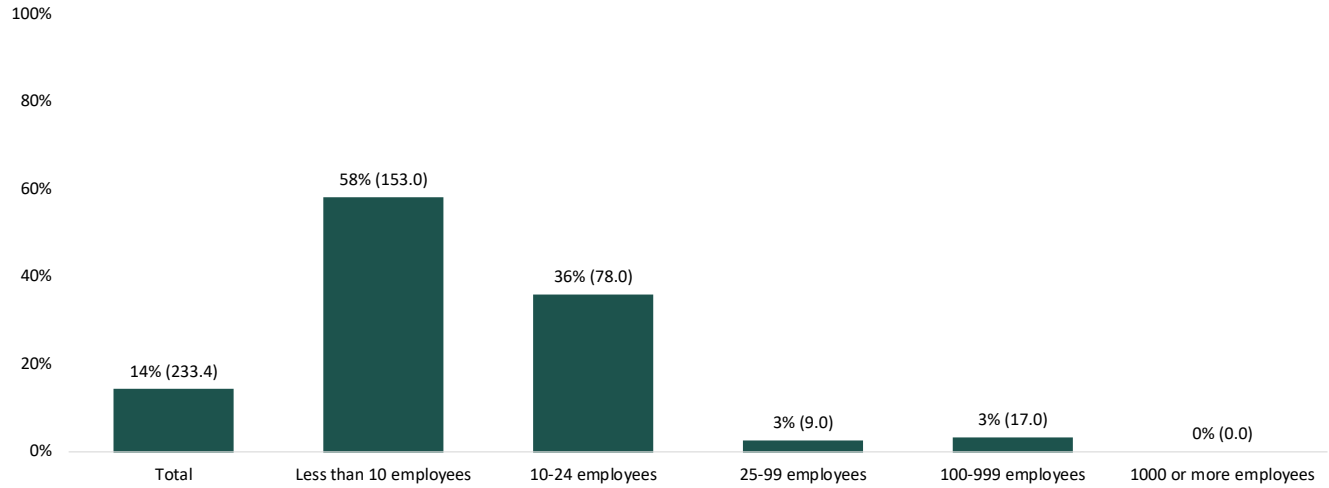
In Exhibit 22, we can see that medium to larger sized firms tend to have higher average ESI totals per person. Comparatively in Exhibit 23, firms that are smaller tend to not offer health insurance at all.

Exhibit 22: Average ESI by Firm Size, Oregon, 2022



Note: Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size, Oregon, 2022
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2022 Medical Expenditure Panel Survey Insurance Component

Exhibit 23: Percent of private-sector employees in firms that do not offer health insurance by firm size, in thousands, Oregon, 2022



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2022 Medical Expenditure Panel Survey Insurance Component, Oregon Employment Department Quarterly Census of Employment and Wages, ECOnorthwest

Taken together, these exhibits highlight two structural features of the status quo that are central to the Committee's financing design. First, employer health care spending is highly uneven—not only across sectors, but also across firms of similar size depending on whether they offer coverage and how generous that coverage is. Second, because ESI is voluntary and unevenly distributed, employer-financed coverage does not provide a consistent or universal financing base. The EPT is intended to replace this patchwork with a broad, predictable, and transparent employer-side contribution that aligns with universal benefits while still allowing

the analysis to evaluate how different types of employers, by size, industry, and coverage posture, compare under the "pre/post" framework.

PROPOSED CHANGES TO EPT UNDER THE UHP PROPOSAL (HOW THE ADD-ON IS STRUCTURED)

Under the Finance & Revenue Committee's proposal, the UHP would add a new, dedicated EPT layer on top of the existing payroll-tax environment of 9.6%. This is an additional payroll tax paid by employers, structured with a key design feature: a firmwide payroll threshold for positive liability set at $500,000 in payroll liabilities.

INCREMENTAL REVENUE GENERATED BY THE PROPOSED EPT

In the Committee's modeling, the EPT is the single largest employer-side revenue instrument in the package. The revenue under the UHP EPT of $8,715 million (in 2022 dollars), representing the gross employer-side collections prior to accounting for how much is ultimately used to offset household liability through the credit mechanism (i.e., the HCPIT).

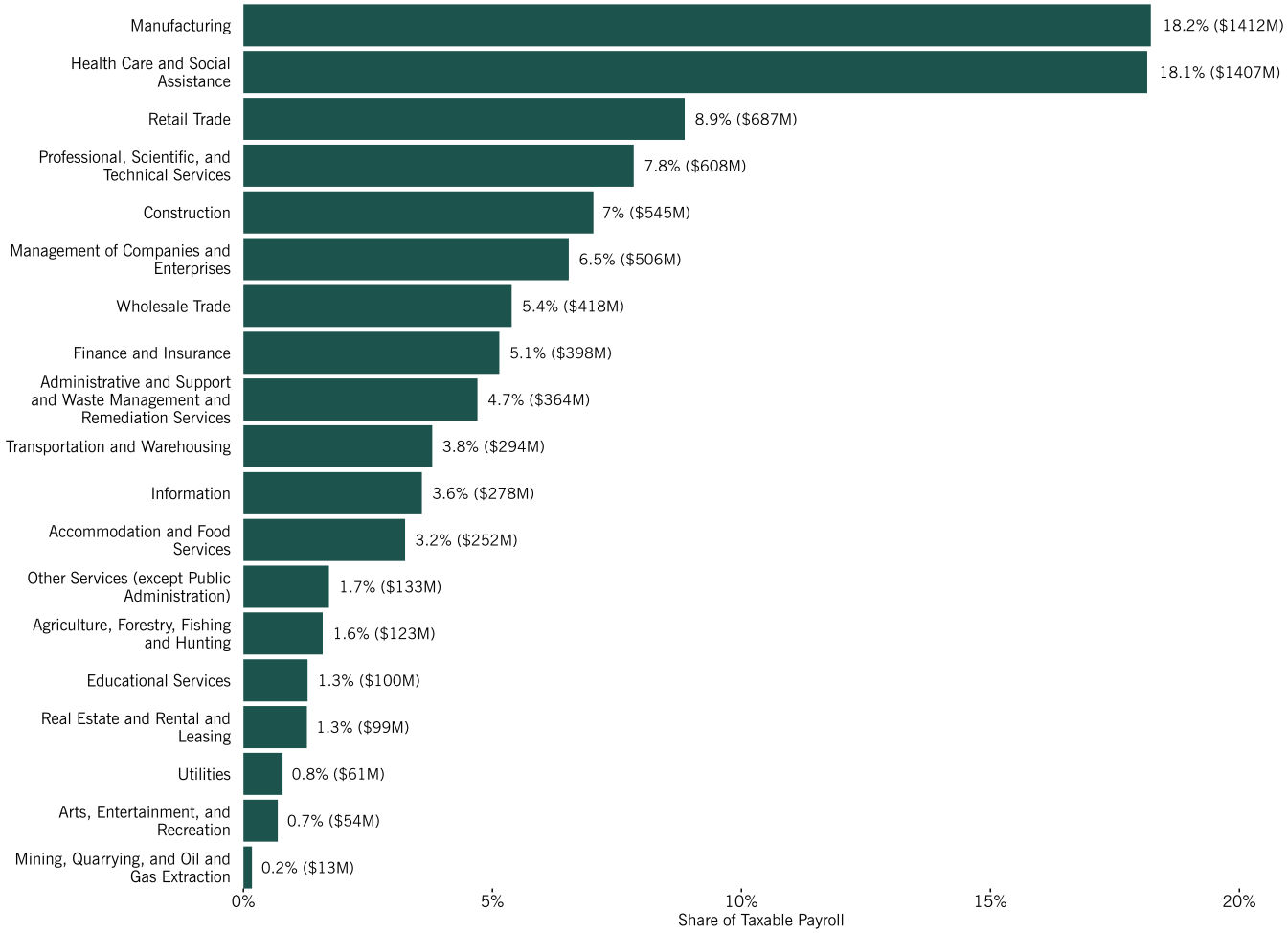
DISTRIBUTION OF PROPOSED EPT PAYMENTS (INDUSTRY AND BUSINESS SIZE)

Because the EPT is payroll-based, its incidence across employers will vary systematically by wage base and employment scale. The following exhibits (Exhibit 24 and Exhibit 25) summarize how proposed EPT receipts are distributed across private industry sectors and across average firm-size groupings using Oregon Employment Department Quarterly Census of Employment and Wages (QCEW) data.

The exhibits summarize how the proposed EPT receipts are distributed across the private economy. Because the EPT is assessed on payroll, the distribution of payments largely follows two structural features of Oregon's labor market: where payroll is concentrated by sector and how employment is distributed across firm sizes. The purpose of these exhibits is to show, at a high level, which parts of the economy generate most employer-side revenue under a payroll-based mechanism and to provide context for the "pre/post" comparisons that follow.

Exhibit 24 shows the EPT revenue distribution by industry. The largest shares of proposed EPT receipts come from sectors with the largest payroll bases. This reflects a combination of employment scale and wage levels: sectors with large workforces and/or higher average wages generate more taxable payroll and therefore contribute a larger share of total EPT revenue. The distribution also highlights that the EPT is not narrowly concentrated in a single industry but is instead broadly sourced across major sectors of the Oregon economy, consistent with the Committee's goal of a stable, diversified employer-side contribution base.

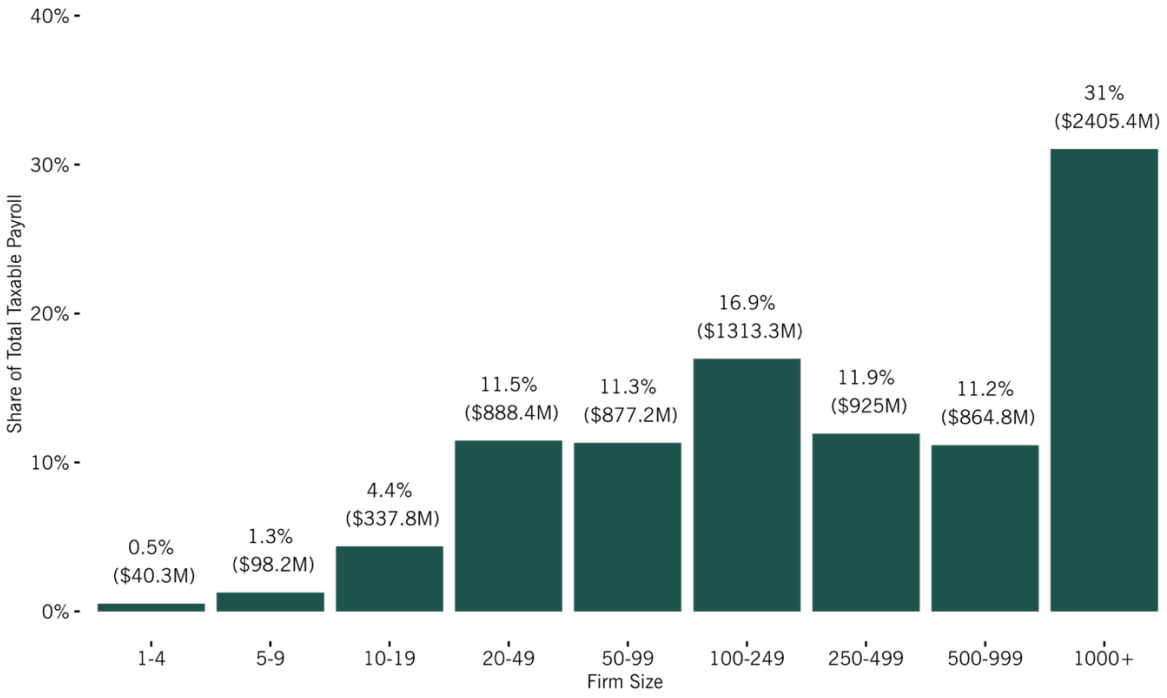
Exhibit 24: EPT Revenue by Industry Sector, Oregon, 2022



Source: Oregon Employment Department, Quarterly Census of Employment and Wages, ECOnorthwest

By firm size, proposed EPT receipts are concentrated among larger employers, as shown in Exhibit 25 below. This is a predictable result of payroll concentration: large firms employ a disproportionate share of workers and therefore account for a disproportionate share of total payroll. In addition, the proposal's firm threshold reduces the relative contribution from the smallest employers, further shifting receipts toward larger firms. Importantly, this distribution describes where receipts come from; it does not, by itself, indicate whether any given employer pays more or less than it does today for health benefits.

Exhibit 25: EPT Revenue by Firm Size, Oregon, 2022



Source: Oregon Employment Department, Quarterly Census of Employment and Wages, ECOnorthwest
Note: Firm size is based on average annual private employment.

Household and Individual Impacts

To understand the differences in UHP impacts for individuals and households, the progressivity and neutrality of the plan has been assessed across work types, Medicare treatment and practical examples. One of the best measures for assessing individual and household impacts is to consider the adjusted gross income, a measure of income net of specific contributions such as HSA contributions or student loan payments. As mentioned previously in section 4, there are three components that help determine an individual/household's tax liability through the Healthcare Personal Income Tax (HCPIT):

1. **The EPT credit.** This credit helps to balance the tax liability burden by preventing a stack of employer contributions on top of individual contributions.
2. **The Household Size Rate Readjustment (HSSR).** These "readjustments" are integrated into the household size calculation used to determine the total tax liability.
3. **The Medicare Part B Premium.** The among of part B premiums paid by those represented in the tax return gets applied as a credit to prevent a "double taxation" on top of existing Medicare liabilities.

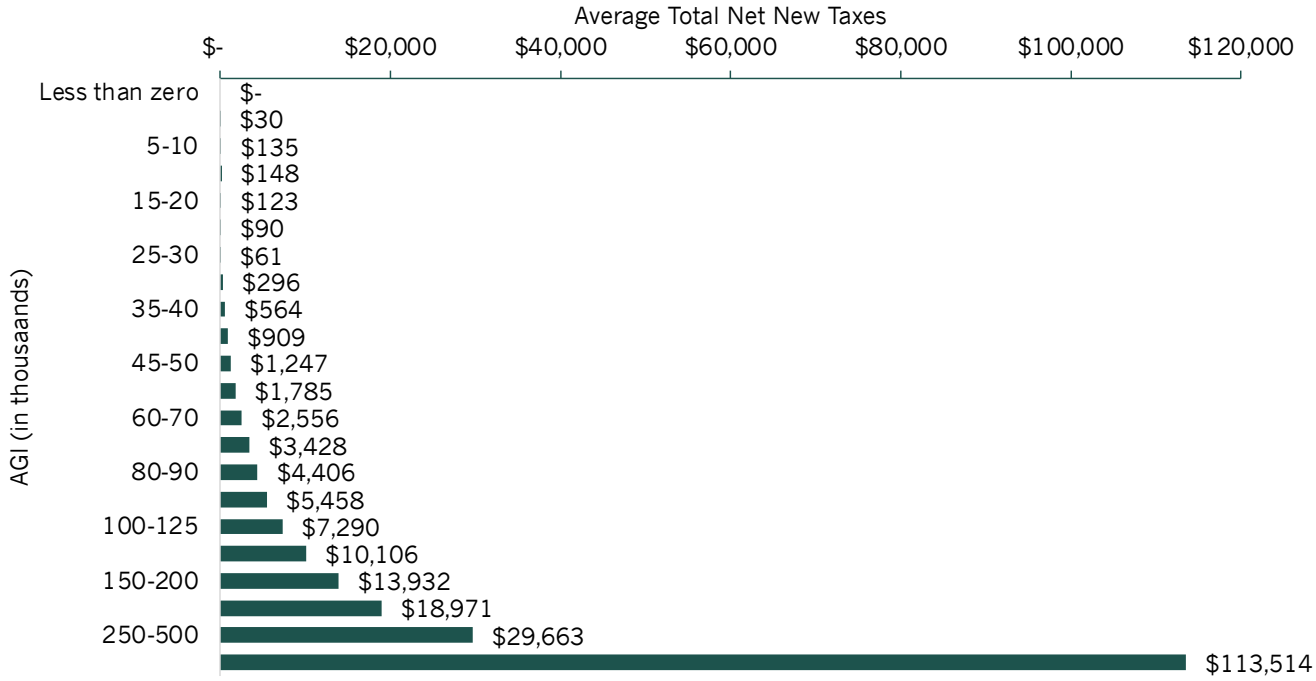
These adjustments operate within a single net-liability calculation rather than as separate instruments, and the progressivity and practical impacts of the HCPIT should be understood considering all three.

Progressivity Across Income Levels

One of the clearest measures of how the proposal distributes individual burdens is the effective HCPIT rate across adjusted gross income (AGI) bands. AGI is used as the primary income measure here because it reflects income net of specific deductions, such as HSA contributions or student loan interest, and therefore provides a more accurate picture of a household's practical ability to pay than gross income alone.

Net revenue from the HCPIT (net of the part B credit) is estimated at $6,317 million. The proposal is designed so that absolute tax liability rises with income, households with higher AGI pay more in dollar terms than those with lower incomes, reflecting the structure of the exemption threshold, phase-in, and the statutory 10.1% rate. Exhibit 26 illustrates this pattern by showing average total net new tax liability in dollar terms across AGI bands. Households in the lowest income band face near-zero average liability, consistent with the exemption below 200% of the federal poverty level, while those at the top of the distribution face substantially higher absolute contributions. The reason there are low tax liability in the lower AGI bands is because zero-exemption filers (those who can be claimed as a dependent on another return) would pay some HCPIT. No other filers in the lowest AGI groups (below $25k) would pay any HCPIT.

Exhibit 26. Average Total Net New Taxes for Individuals by AGI, 2022



Source: Oregon Department of Revenue, Finance and Revenue Committee

As discussed in Section 4 and shown in Exhibit 14, individuals and households see the largest reduction in contributions of any payer class under the F&R proposal. Estimated individual contributions decline by approximately $787 million, from roughly $8.0 billion under the status quo to approximately $7.3 billion under the proposal. This reduction

reflects the replacement of private premiums and out-of-pocket costs with income-based HCPIT contributions that are, on average, lower for most households, particularly after credits are applied.

Effective rates have a similar increasing pattern to the absolute liability for individuals, as shown below in Exhibit 27. The table presents average HCPIT rates by AGI band, with effective rates rising from 0.4% at the lowest income band (averaging approximately $21,500 annually) to 9.0% at the highest (averaging approximately $1.28 million annually). Mid-range households face rates of 3.4% and 6.0% at average incomes of roughly $51,700 and $103,500 respectively, with higher-income households (with $214,500 AGI on average) facing a 7.8% effective rate.

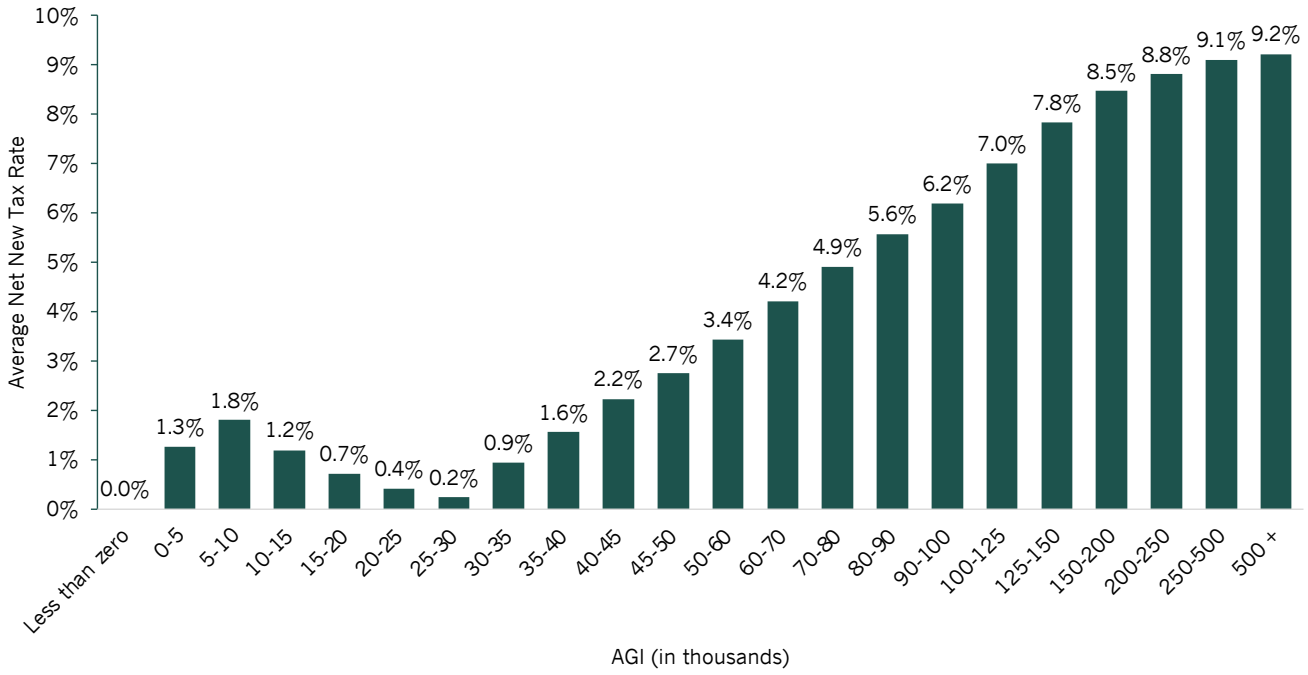
Exhibit 27. Average HCPIT rate by Average Adjusted Gross Income, 2022

AGI Level (in thousands)	Average AGI	Average Tax Liability	Average HCPIT Rate
$20-25	$21,918	$90	0.4%
$50-60	$51,914	$1,757	3.4%
$100-125	$104,240	$6,270	6.0%
$200-250	$215,307	$16,892	7.8%
$500 +	$1,232,295	$111,390	9.0%

Source: Finance and Revenue Committee, Oregon Department of Revenue
Note: Average AGI does not include social security income, whereas the AGI level categories originate from the Oregon Department of Revenue and include social security income. This distinction is relevant for interpreting results for lower-income retirees and others with significant Social Security income, and should be kept in mind when comparing effective rates across bands.

Below in Exhibit 28, which shows how the rate structure behaves across the full income distribution, the chart confirms that the rate gradient is broadly smooth and progressive. Rates rise steadily with income rather than concentrating the burden at a single point in the distribution. It also makes visible the flattening of the effective rate at the top of the distribution as rates approach but do not reach the statutory ceiling, consistent with the effect of the income-based credits that reduce net liability for all filers.

Exhibit 28. Average Total Net New HCPIT Rate Paid for Individuals by AGI, 2022



Source: Finance and Revenue Committee, Oregon Department of Revenue

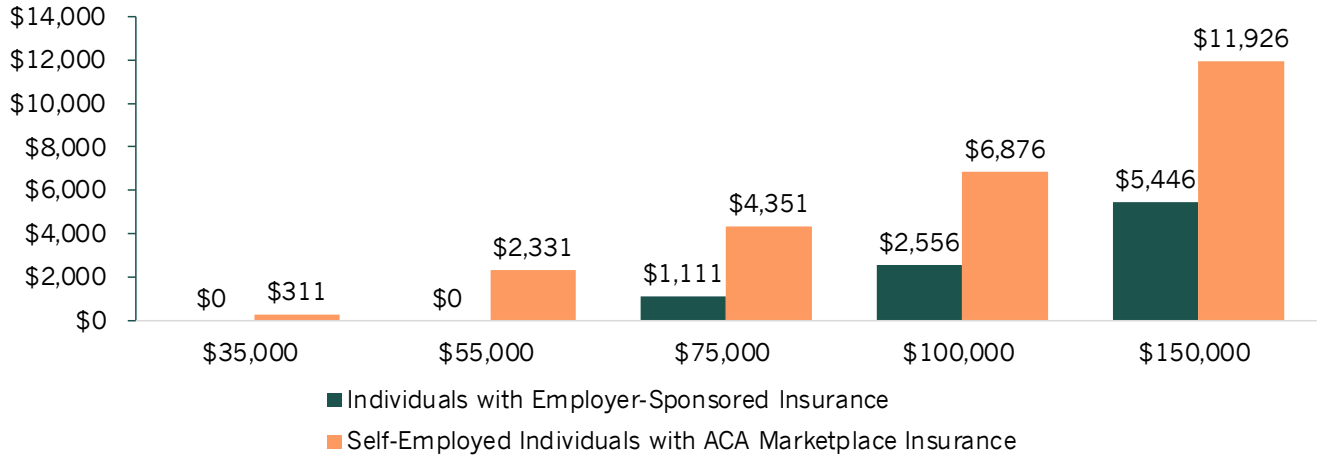
Note: All HCPIT liability for AGI groups $20-25 and below is calculated using zero-exemptions returns.

Employed vs Self-Employed Comparisons

For individuals with wage and salary income, the HCPIT does not operate in isolation. Because their employers pay the EPT on their behalf, wage earners are eligible for the EPT credit, equal to 50% of the EPT paid on their wages, applied directly against their HCPIT liability. This credit prevents the same compensation from being taxed twice and reduces net individual contributions relative to what a standalone income-based tax would otherwise require. The offset is proportionally larger at low and middle incomes, where the credit represents a greater share of total HCPIT liability.

Self-employed individuals, however, face a structurally different situation. Because no employer pays the EPT on self-employed individual's behalf, they are not eligible for the EPT credit, and their HCPIT liability is determined solely by income, household size, and applicable exemptions and phase-ins. At comparable income levels, this means self-employed individuals generally face higher net HCPIT contributions than wage earners at firms subject to the EPT. Exhibit 29 illustrates this difference directly, presenting side-by-side net contributions for a wage earner and a self-employed individual at the same income level. The gap between the two reflects the value of the EPT credit and highlights the structural distinction in how the two employment types interact with the HCPIT.

Exhibit 29. Wage and Salary Employee vs. Self-Employed Individual Contribution UHP Scenario, 2022



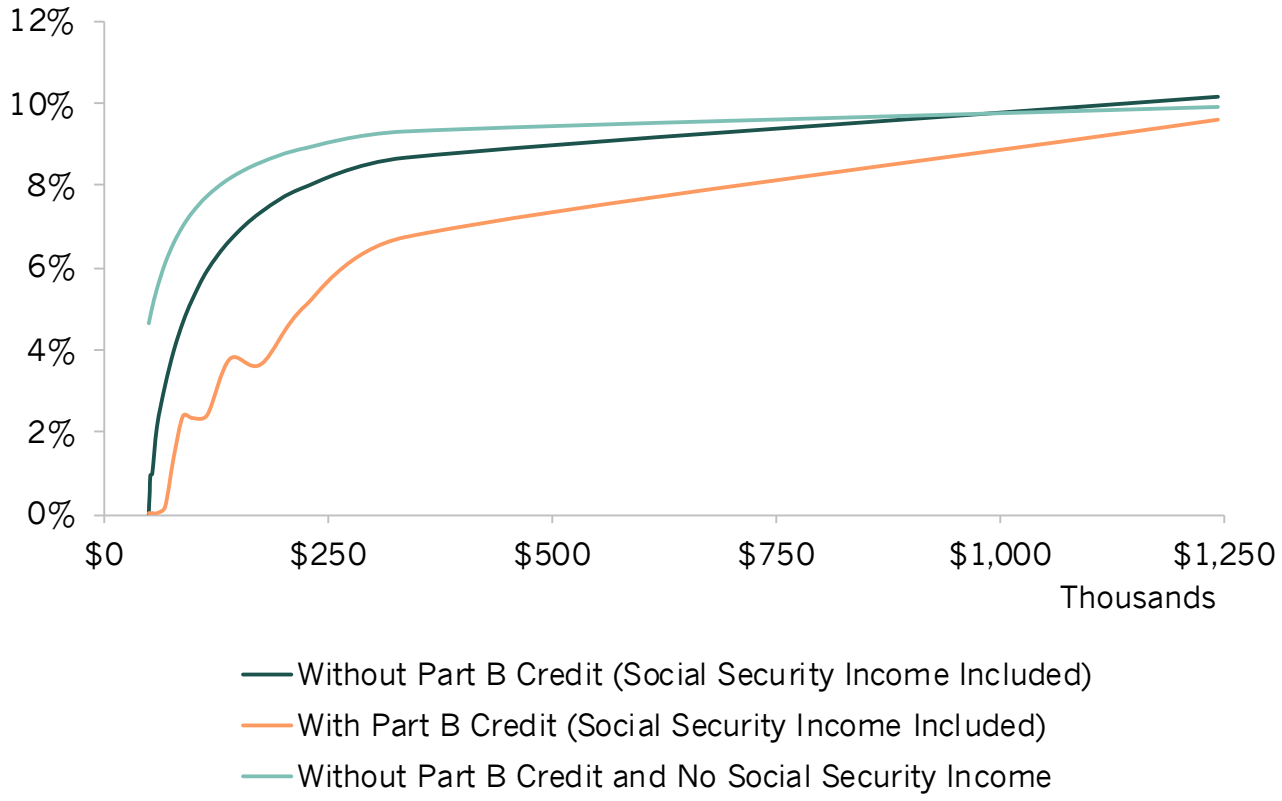
Source: Kaiser Family Foundation and Peterson Center on Healthcare, Finance and Revenue Committee.

Medicare Population Impacts

Medicare beneficiaries present a distinct situation within the individual contribution framework. Because Medicare enrollees already pay Part B premiums directly to the federal government, subjecting them to the full HCPIT without adjustment would effectively require them to pay twice for a portion of their coverage. The proposal addresses this through a non-refundable Medicare Part B premium credit, applied against HCPIT liability, equal to 100% of Part B premiums paid, calculated within the same net-liability framework as the EPT credit and HSRR adjustments.

Exhibit 30 shows the resulting net HCPIT rate for a single Medicare tax filer across income levels. At lower incomes, the Part B credit fully or substantially offsets HCPIT liability. At higher incomes, a residual net rate remains after the credit is applied. The exhibit illustrates that the Part B credit meaningfully reduces effective contribution rates for Medicare beneficiaries, particularly those with modest fixed incomes, while preserving a progressive contribution structure above the credit threshold.

Exhibit 30. Net HCPIT Tax Rate for Single Medicare Tax-Filer, 2022



Source: Source: Finance and Revenue Committee, Oregon Department of Revenue

Illustrative Household Typologies and Case Studies

The aggregate and distributional scenarios presented above describe how the proposal performs across the full population of Oregon filers and employers. To complement that picture, this section presents four representative household typologies that translate the proposal's mechanics into practical, comparable cost estimates for specific household circumstances. Each typology shows estimated annual health care costs under the status quo, including premiums, employer contributions, and out-of-pocket spending, alongside projected UHP contributions net of applicable credits and adjustments. The typologies are drawn from a range of income levels, employment arrangements, and coverage types to illustrate how outcomes vary depending on which mechanisms are active for a given household.

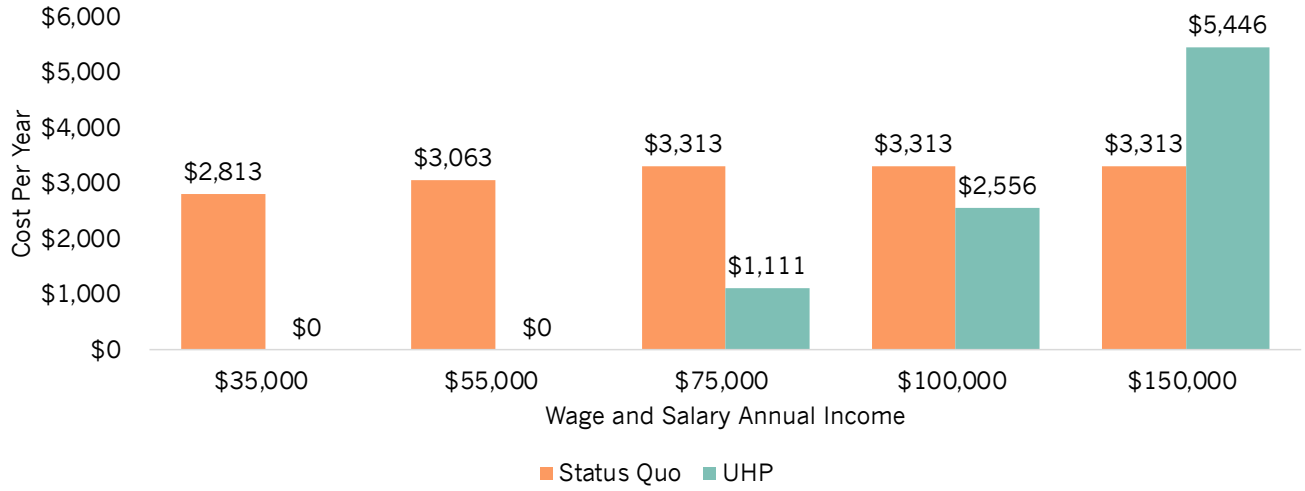
They are not intended to be exhaustive, but rather to make visible the logic of the proposal for the kinds of households most commonly affected by the transition from employer-sponsored and marketplace coverage to a universal public plan. An important note on the figures presented in this section: all status quo cost estimates have been adjusted to 2026 dollars to allow for meaningful comparison with UHP contribution estimates, which are expressed in 2026 terms. These figures are estimates based on available survey and

administrative data, not reported household-level expenditures, and involve assumptions about average premium levels, cost-sharing utilization, and inflation that will vary across individual circumstances. They should be interpreted as illustrative of typical cost patterns rather than as precise predictions for any specific household.

Employer-Sponsored Insurance Comparisons

Exhibit 31 compares the annual health care costs for a single employed adult with employer-sponsored insurance under the UHP and "status quo" across a range of income levels. Status quo cost estimates draw primarily on the Peterson-KFF Health System Tracker's Household Health Spending Calculator, which aggregates data from several publicly available sources on what individuals and families actually spend on health care, including both premium contributions and cost sharing. For a low-income individual below the HCPIT exemption threshold, UHP liability is zero and total costs under the proposal are lower than status quo premiums and out-of-pocket spending, as seen in Exhibit 31below. For a higher-income individual, the EPT credit moderates individual-side liability, and the net cost comparison depends on the generosity of current coverage and the applicable effective rate.

Exhibit 31. Individual, Employed with Wage and Salary Income, Employer-Sponsored Insurance, Status Quo vs. UHP Annual Cost, 2026



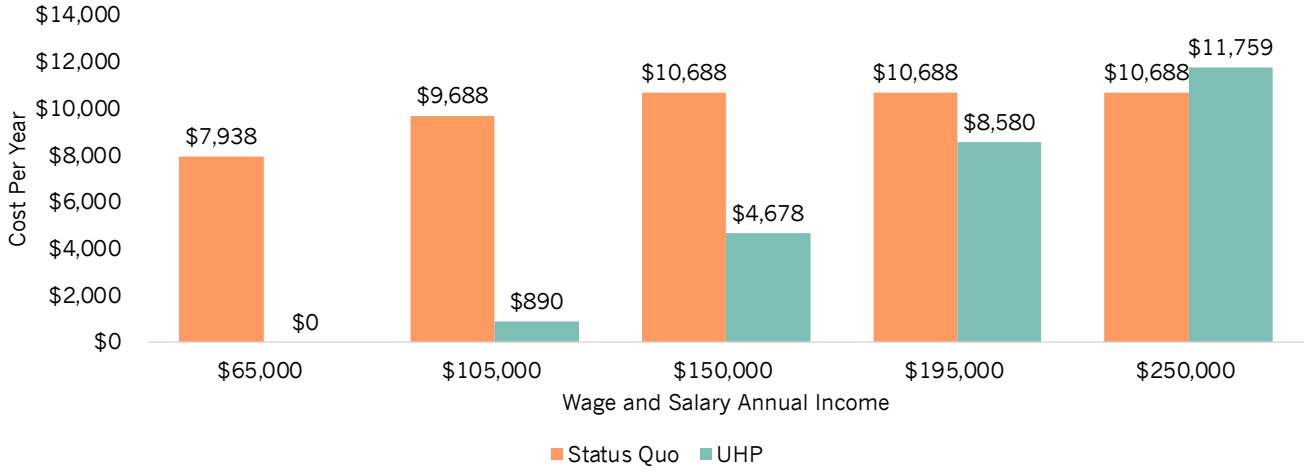
Source: Kaiser Family Foundation and Peterson Center on Healthcare, Finance and Revenue Committee

Note: KFF data underlying the employer-sponsored and ACA typologies are benchmarked to 2022. A 25% inflation adjustment was applied to bring those estimates to 2026 dollars.

A family of four with wage and salary income above 260% federal poverty level, represents a household type where both the income phase-in and the HSRR are simultaneously active (though the HSRR does not fully phase in until 520% FPL). Status quo costs for this typology also draw on the Peterson-KFF Household Health Spending Calculator, which reports premium and cost-sharing data for families of four by income tier; the KFF data do not include household sizes between an individual and a family of four, so the family-of-four typology reflects the closest available benchmark. Exhibit 32 shows that, for a moderate-

income family in this range, UHP contributions are generally lower than status quo premium and out-of-pocket costs.

Exhibit 32. Family of Four with Wage and Salary Income, Employer-Sponsored Insurance, Status Quo vs. UHP Annual Cost, 2026



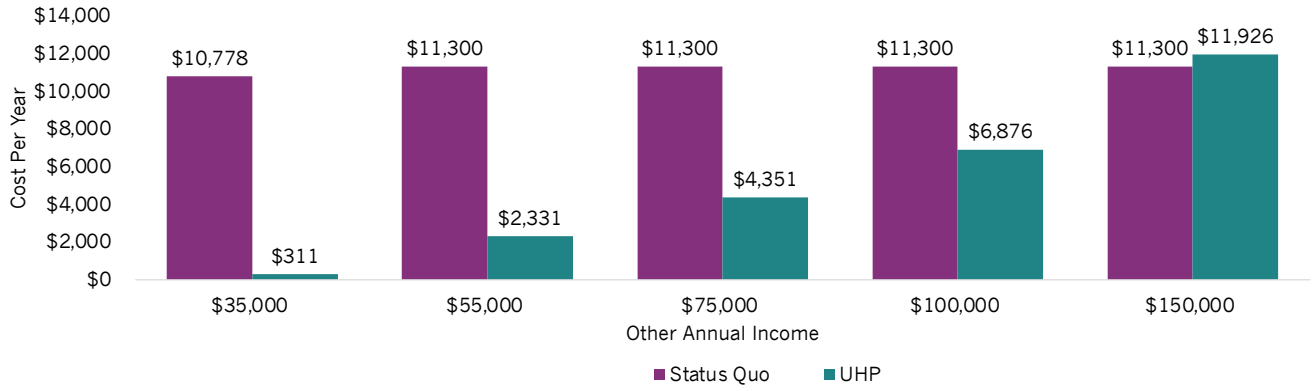
Source: Kaiser Family Foundation and Peterson Center on Healthcare, Finance and Revenue Committee

Affordable Care Act Marketplace Insurance Comparisons

For self-employed individuals purchasing coverage through the ACA marketplace, the cost comparison is shaped by the absence of the EPT credit. Status quo ACA premium estimates for this typology are based on average Oregon Silver Plan premiums, with premium tax credits calculated under the post-HR1 (2025) structure, under which credits phase from 2.1% of income at 133% of the federal poverty level to 9.96% at 400% FPL, with no credits available above 400% FPL.

Exhibit 33 illustrates that a self-employed individual's HCPIT liability is not offset by employer participation, and the net outcome relative to the status quo depends on current premium levels and subsidy eligibility. For those currently paying full or near-full ACA marketplace premiums without significant subsidy, UHP contributions may represent a reduction in total health care costs even without the EPT credit. For those receiving substantial ACA subsidies, the comparison is more variable and turns on income level and household size.

Exhibit 33. Self-Employed Individual with Other Income, ACA Marketplace Insurance, Status Quo vs. UHP Annual Costs, 2026



Source: Finance and Revenue Committee

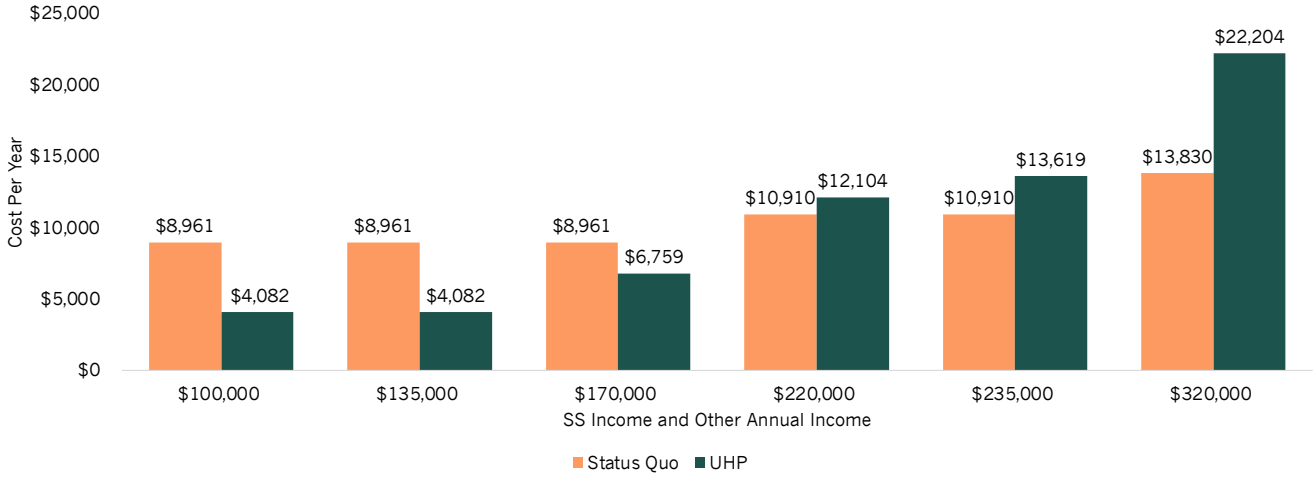
Medicare Advantage Insurance Comparisons

For Medicare households, the non-taxability of social security benefits and the Part B premium credit have important roles in the cost comparison. Status quo cost estimates for this typology draw on KFF data on Medicare Advantage plan premiums and out-of-pocket limits. According to KFF, approximately 75% of Medicare Advantage (MA) enrollees pay no premiums above the required Part B premium, and average additional MA premiums across all enrollees are approximately $168 annually.[20] Out-of-pocket cost sharing was estimated based on KFF-reported enrollment-weighted average out-of-pocket limits for MA plans, with actual spending estimated at approximately 35% of the applicable limit, a conservative assumption given the considerable variation in individual health experience.

Exhibit 34 presents a retired couple, both of whom have Medicare Advantage coverage and average social security benefits for their income, showing how the couple's combined Part B premiums are credited in full against HCPIT liability, reducing net contributions and avoiding double payment for coverage already financed through federal premiums. For a moderate-income Medicare household, the Part B credit substantially reduces or eliminates net HCPIT liability, and UHP contributions are generally lower than the combined cost of Medicare premiums and supplemental out-of-pocket spending in the status quo.

[20] KFF, Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization. https://www.kff.org/medicare/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

Exhibit 34. Couple's Medicare Advantage Insurance, Status Quo vs. UHP Annual Costs, 2026



Source: Kaiser Family Foundation and Peterson Center on Healthcare, Centers for Medicare and Medicaid Services, Finance and Revenue Committee.[21,22]

Note: Medicare estimates, drawn from 2024 data, were adjusted upward by approximately 9% to reflect estimated cost growth for 2025 and 2026.

Tax Mechanisms Considered but Not Recommended

In addition to the instruments included in the recommended package, the Finance & Revenue Committee evaluated a broad menu of alternative revenue approaches—both to test whether they could meaningfully contribute toward the Revenue Replacement Target and to understand how different tools would perform against the Committee's design principles (revenue adequacy, equity and progressivity, administrative feasibility, and legal durability). Several options were discussed repeatedly because they offered attractive features on one dimension but introduced clear drawbacks on others. The Committee did not advance the following mechanisms as part of the recommended plan; however, they are documented here because they may remain relevant as calibration advances (e.g., as plan costs and transferable funding are updated for the first year of operations) or as the Board considers contingencies and design refinements.

[21] Centers for Medicare & Medicaid Services. (2025, November 14). *2026 Medicare Parts A & B premiums and deductibles* [Fact sheet]. U.S. Department of Health and Human Services. https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles

[22] Ochieng, N., Cubanski, J., & Neuman, T. (2025, December 19). *A snapshot of sources of coverage among Medicare beneficiaries*. KFF. https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/

Soft Cap Mechanism (High-Income Calibration and Behavioral Risk Management)

The Committee discussed "soft cap" concepts as a way to manage contributions at the very top of the income distribution—particularly to address behavioral and tax-planning risks that can arise when marginal contribution rates become materially higher than what high-income households currently pay for health care through premiums and out-of-pocket spending. In this context, a soft cap is not a separate revenue source. It is a rate-shaping feature that changes how HCPIT liability grows above a high-income threshold by decreasing marginal rates, limiting incremental liability growth, or otherwise moderating the top-end schedule.

A principal motivation for considering a soft cap was to reduce incentives for tax avoidance and tax base erosion, including:

- Income sheltering or timing strategies (e.g., shifting income into non-taxed forms, deferring realization, or reclassifying income where feasible) that can reduce the personal income tax base; and
- migration or domicile responses for a small number of very high-income taxpayers who may be more mobile, particularly if their modeled HCPIT obligations substantially exceed their current health care expenditures under the status quo.

The Committee recognized that these responses may be limited for most households, but that even a small number of high-income taxpayers can represent meaningful revenue exposure because of the concentration of taxable income at the top of the distribution. The soft cap was therefore evaluated as a practical tool to balance two competing objectives: maintaining progressivity and revenue adequacy on the one hand, while avoiding a contribution schedule that could be perceived as punitive relative to current health care payments and therefore more likely to trigger avoidance behavior on the other.

The Committee did not include a soft cap as a default element of the recommended package primarily because it is regressive. A soft cap is primarily a distributional calibration lever that materially affects revenue adequacy and requires explicit offsets elsewhere in the financing structure (e.g., adjustments to rates, credits, or other parameters) to maintain the Revenue Replacement Target. It also introduces additional thresholds and interaction effects—especially in combination with the EPT credit and household adjustments—that increase parameter sensitivity and complicate communication.

For these reasons, the Committee treated soft caps as an optional design dial for the Board's consideration during forward-year calibration and final parameter setting. If the Board chooses to pursue a soft cap, the key design question is how to moderate top-end liabilities enough to reduce avoidance incentives while preserving the overall progressivity and revenue sufficiency of the financing framework.

Sumptuary Taxes

The Committee evaluated taxes on goods associated with negative health externalities—such as alcohol, tobacco, marijuana, and sugar-sweetened beverages. Two conclusions emerged consistently. First, the revenue base is not large enough to make sumptuary taxes a meaningful pillar of UHP financing at the scale implied by the Revenue Replacement Target. Even aggressive rates typically generate comparatively modest revenue relative to the magnitude of on-going UHP funding needs. Second, these taxes raise distributional concerns. Consumption of many taxed goods can be regressive relative to income, and rate increases can place disproportionate burden on lower-income households absent explicit offsets.

That said, the Committee also recognized that sumptuary taxes can serve a different purpose from the core financing instruments: they can support secondary health-policy objectives by discouraging harmful consumption and partially internalizing the public costs associated with preventable health conditions. If the Board wishes to pursue this pathway, the Committee's view is that sumptuary taxes are best framed as supplemental (and potentially earmarked for targeted public health initiatives or reserve/risk buffers), rather than as a core component of the on-going financing structure.

State Sales Tax

Given its capacity and stability—and its widespread use in other states—the Committee considered a statewide sales tax as a possible revenue source for the UHP. The Committee did not recommend a sales tax in the package for several reasons tied to core design objectives:

- **Equity and regressivity.** A broad-based sales tax is generally regressive absent substantial offsets or exemptions, and it would require additional compensating mechanisms to maintain the progressivity goals embedded in the HCPIT and related credits.
- **Structural change and implementation risk.** Oregon does not currently have a general sales tax. Establishing one would be a major structural change with significant administrative, compliance, and political considerations that extend beyond the scope of calibrating the UHP's replacement-financing structure.
- **Fit with the replacement framing.** The Committee emphasized replacing and restructuring existing health-care payments in a way that tracks ability to pay and employer participation. A broad consumption tax is less directly linked to the current financing system and would shift the composition of who pays in ways that may be difficult to align with the Committee's distributional objectives.

For the Board's reference, the Committee notes a key benchmark from the Oregon Legislative Revenue Office (LRO): the latest LRO estimate indicates that a 5% sales tax would raise approximately $5,853 million in FY 2026–27 terms if implemented July 1, 2026, assuming it is in place for the full fiscal year. The revenue raised per sales tax percentage would decrease as offsets or exemptions to make it less regressive are added. The estimate is easily scalable

to alternative rates but does not incorporate behavioral responses, border effects, or other non-linearities that could emerge at higher rates.

How the Board might Consider These Taxes and Mechanisms

The Committee's recommended package reflects a deliberate preference for mechanisms that are closely tied to existing health-care payment channels (payroll-linked employer financing and income-linked household financing), that have an existing infrastructure so that there is minimal additional administrative cost, and that can be updated as plan costs and transferable funding are recalibrated for implementation. The mechanisms above remain relevant as policy levers, particularly for contingency planning, fine-tuning distributional outcomes at the top end, or advancing secondary public health objectives, but they were not selected as central components of the Committee's baseline revenue framework.

5. 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. It should be noted that the Finance and Revenue Committee did not have time to reasonably review and make recommendations regarding transition costs and reserve capitalization.

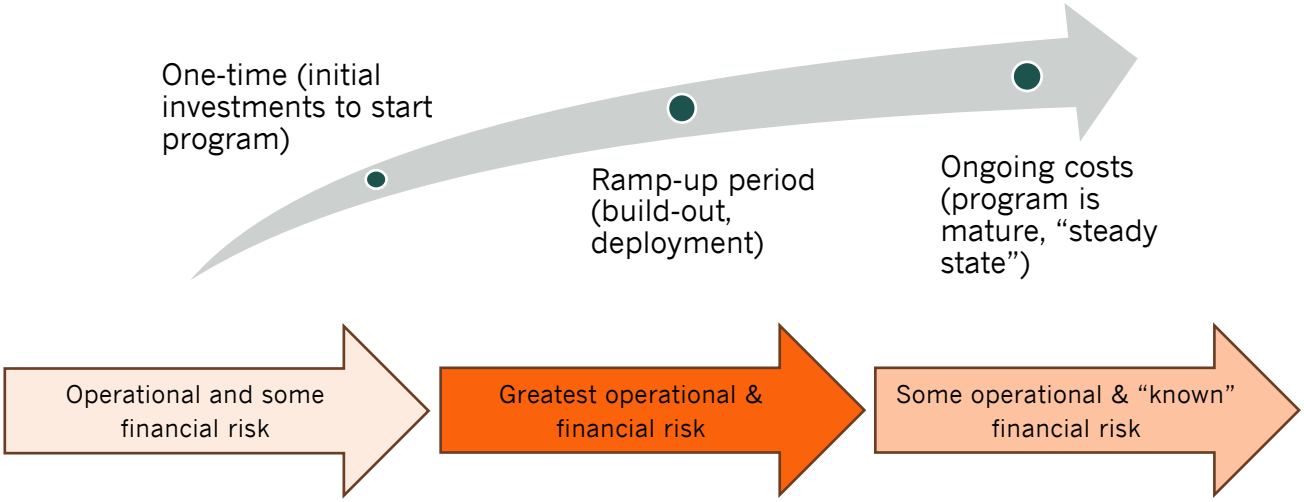
This chapter will explore the options available for funding and financing, and presents the following key takeaways from a scan of other insurance programs:

- 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 health care 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 35. 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 Stage Gate Oversight process.[23]

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 and some surpluses may

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 (FMLI). 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).

[23] Oregon Enterprise Information Services: Project Portfolio Performance. "Project Oversight." Oregon.gov. n.d. https://www.oregon.gov/eis/project-portfolio-performance/pages/it-investment-oversight.aspx.

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.[24] Another option is to temporarily increase the tax rate to seed a reserve funding or to cover implementation costs.

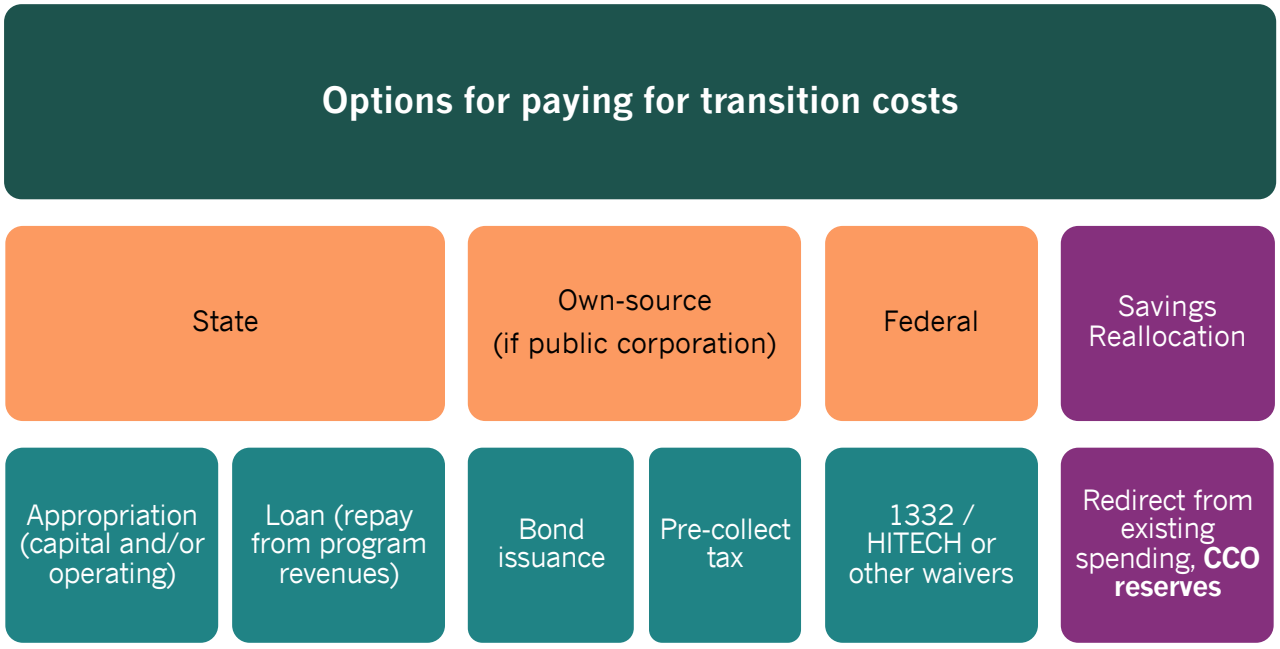
Debt Issuance. States typically issue bonds for long-term capital infrastructure like roads and bridges and do not use debt for operating budget needs. States have balanced budget requirements and debt limits that preclude the use of debt to fund ongoing needs, even one-time needs. It is possible that 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.[25] 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.[26, 27, 28] 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

[24] 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.
[25] 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.
[26] 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/.
[27] 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 health care 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.
[28] 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.

reimbursements, buying down costs later rather than providing immediate budget support – and thus would not negate the need for initial investment by the state.

Exhibit 36. Potential UHP Start-up & Transition Cost Funding Sources



Source: ECOnorthwest

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 (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. 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.[29] Oregon has specific policies related to its Rainy Day Fund, which can only be used under particular circumstances (a three-fifths vote of the Legislature and 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,[30] 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.[31]

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.

[29] 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.

[30] 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.

[31] 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 pay for health care 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 managed 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.[32]

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.[33] Healthcare reserves are typically set from revenue coming from premiums that policyholders pay.[34] This method is familiar in a health care setting; the metric for measuring primary reserves/reserve target funding for health care 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.[35]

[32] 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.

[33] 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.

[34] 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.

[35] 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.[36, 37]

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 or 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.

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.

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

[36] 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.

[37] 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.

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.[38] In creating its network of 16 CCOs, Oregon partnered with pre-existing organizations that are a mix of non-profit and for-profit groups.[39] Oregon is the only state with a statewide system of CCOs serving Oregon Health Plan members, typically providing physical, behavioral, and oral care services.[40] CCOs serve an estimated 1 million Medicaid members (out of about 1.27 million total).[41, 42]

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

[38] 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.
[39] 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.
[40] 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.
[41] 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/.
[42] KFF. "Medicaid in Oregon Fact Sheet," KFF. May 2025, https://files.kff.org/attachment/fact-sheet-medicaid-state-OR.

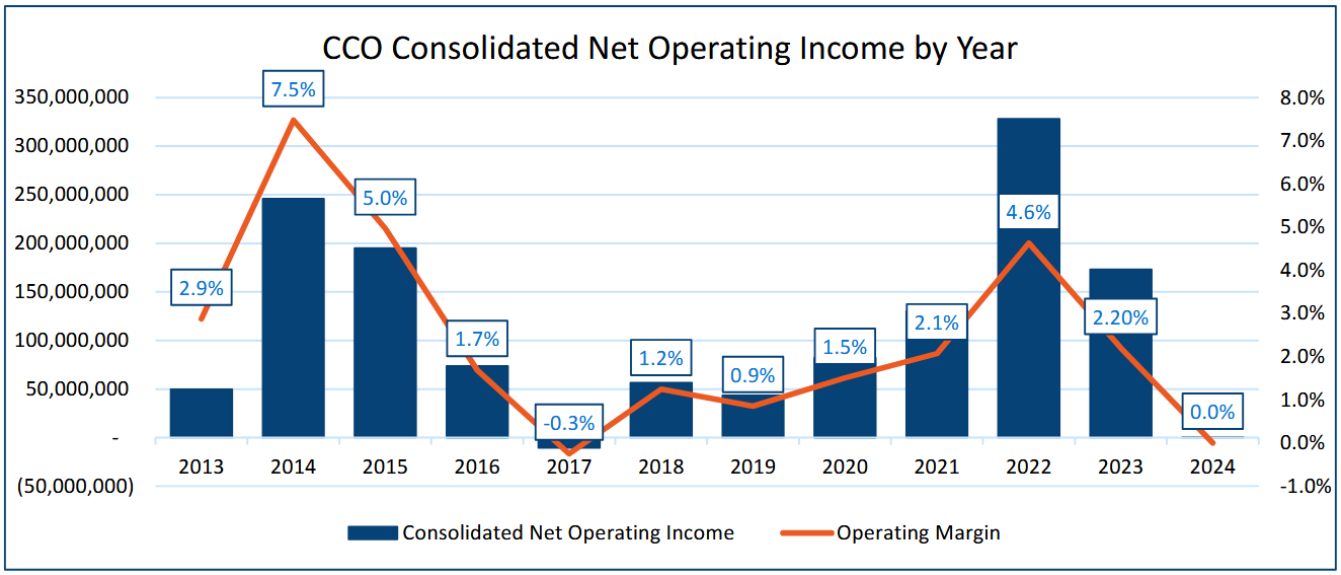
back depending on the CCO's performance on certain health outcome metrics.[43] CCOs can delegate both a portion of capitation payments to "sub-capitated entities" and, importantly, a portion of their risk.[44]

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.[45] 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.[46] 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.[47]

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 **37** below for a chart showing CCO net operating income over the twelve-year period ending 2024.

Exhibit 37. CCO Consolidated Net Operating Income



[43] 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/.
[44] McConnell, K. John. "Oregon's Medicaid coordinated care organizations." *Jama* 315, no. 9 (2016): 869-870.
[45] Oregon Laws. "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account." May 26 2025. https://oregon.public.law/rules/oar_410-141-5185.
[46] 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.
[47] Oregon Laws. "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account." May 26 2025, https://oregon.public.law/rules/oar_410-141-5185.

Source: Oregon Health Authority[48]

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[49]; 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 37). 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.[50]

SAIF Corporation.

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.[51]

Oregon Health and Sciences University.

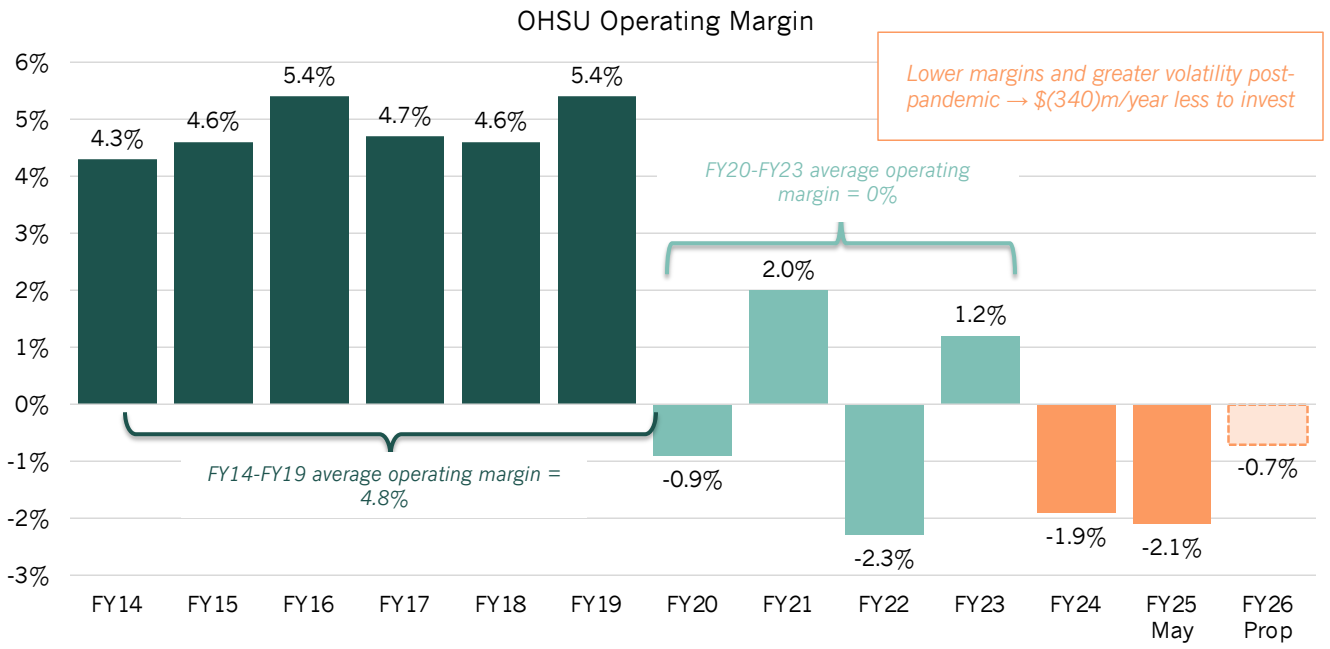
Oregon Health and Sciences University (OHSU) is the state's only public, academic health center. OHSU is not structured as a nonprofit but instead as an independent public corporation. OHSU was established in 1995. OHSU received state appropriations totaling $62.7 million in FY 2023 and $72.9 million in FY 2024, about 1.5 percent of its total

[48] 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.
[49] 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.
[50] Oregon Laws. "ORS 353.010." https://oregon.public.law/statutes/ors_353.010.
[51] 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.

operating revenue of $5 billion. Most funding comes from patient service revenues.[52] Like CCOs, 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).[53] In April 2025, the OHSU Finance & Audit Committee reported drawing down $181 million in reserves, largely to balance its capital budget in FY 2026.[54] See Exhibit 38 below for the operating margins of OHSU from FY 2024 through FY 2026.

Exhibit 38. OHSU Financial Statement, FY 2024 - FY 2026.



Source: OHSU[55]

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

[52] 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.

[53] 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.

[54] 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.

[55] 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.

support for an expanded regional emergency center.[56] Total operating expenses for the Council was $9.1 million and "ordinary income" was $10.2 million, leaving a margin of $1.1 million.[57]

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.[58] The 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.[59]

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.[60] In Oregon, the total contribution rate in 2025 is 1 percent of gross wages, shared between employees and large employers.[61] 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 Exhibit 39 below for the revenues, expenses, and net income of the PFML program, including the large jump in

[56] Legislative Fiscal Office. "2025-27 Budget Highlights." Oregon.gov. October 2025. https://www.oregonlegislature.gov/lfo/Documents/2025-27%20Budget%20Highlights.pdf.
[57] 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.)
[58] Willamette Falls Locks Authority. "About." 2024. https://www.willamettefallslocks.org/about.
[59] 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.
[60] 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.
[61] Paid Leave Oregon. "Employers Overview." n.d. https://paidleave.oregon.gov/employers-overview/.

revenue in 2023 which includes a state general fund appropriation. Premium rates have more than doubled since the program was implemented in 2019.[62, 63]

Exhibit 39. 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.[64]

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 Family and Medical Leave Insurance (FMLI) program 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.[65]

NORTH CAROLINA

The state of North Carolina has a formal contingency reserve requirement for Medicaid, which is to be used only when the Medicaid program has budgeting shortfalls.[66] 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).[67] Statute requires legislative

[62] 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.
[63] 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.
[64] 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.
[65] 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
[66] 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.
[67] 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.

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 year's state Medicaid funds.[68] Indiana created a Medicaid contingency and reserve account (not a separate fund) in 2024 to provide payments for Medicaid claims, obligations, and liabilities.[69] 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.[70]

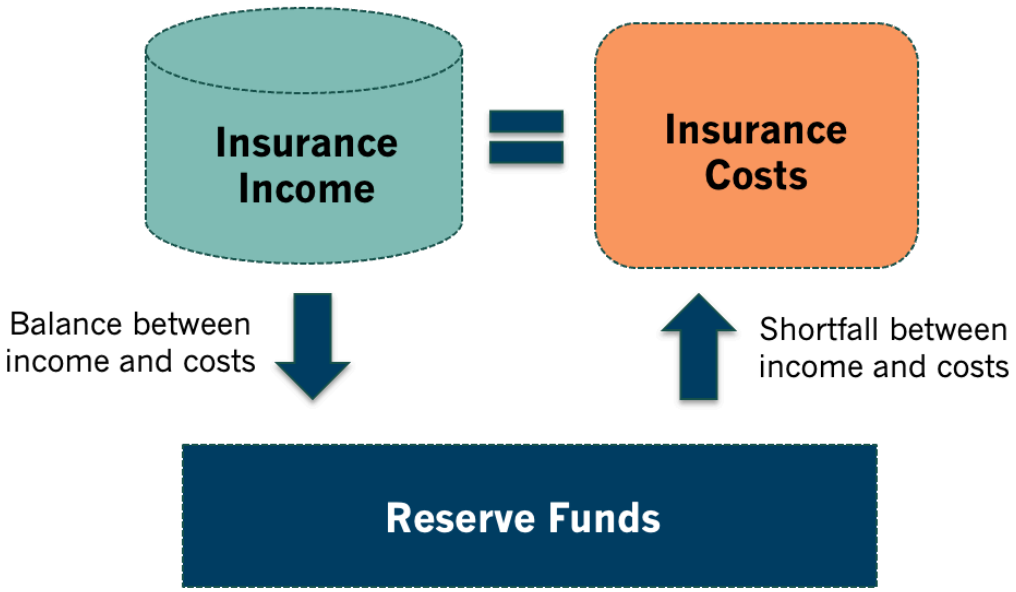
NEW YORK CITY

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.[71] MCOs are integrated into health care systems and exist to reduce health care 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).[72]

[68] 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/.
[69] 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.
[70] 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.
[71] 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.
[72] 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 40. Taiwan NHI, Correlation of Reserve Fund, Insurance Income, and Insurance Costs[73]



Taiwan implemented its National Health Insurance (NHI) universal health care 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.[74] 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.[75]

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.[76] In 2024, with NHI on the brink of insolvency, the Taiwan government implemented reforms to NHI including eliminating their "suspension-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

[73] 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.
[74] Wu, Tai-Yin, Azeem Majeed, Ken N Kuo, "An overview of the health care system in Taiwan," *London Journal of Primary Care* 3(2):115–119. December 2010. https://pmc.ncbi.nlm.nih.gov/articles/PMC3960712/.
[75] 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.
[76] Shelton, Paul. "Taiwan's national health care system." *Euroview.* April 22, 2025. https://euroview.ecct.com.tw/category-inside.php?id=2364.

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.[77] Through this major reform Taiwan aims to extract tax revenue from foreign nationals.

DENMARK

Denmark's universal health care 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.[78] The country's health expenditures equated 9.42 percent of their GDP in 2023, down from 10.75 percent in 2021.[79] Because Denmark's health care appropriations are made on a pay-as-you-go basis, rather than with revenues specifically earmarked for health care, 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 health care 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.[80] 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).[81, 82] 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 of reserve financing.

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[77] 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.

[78] Vrangbæk, Karsten. "International Health Care System Profiles, Denmark." The Commonwealth Fund. June 5 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/denmark;

[79] 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.

[80] 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.

[81] Thorlby, Ruth. "International Health Care System Profiles, England," The Commonwealth Fund. June 5 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/england.

[82] Campbell, Denis. "Almost one in eight Britons now has private medical insurance, say health care analysts." The Guardian. 2025. https://www.theguardian.com/society/2025/jan/30/almost-one-in-eight-britons-now-has-private-medical-insurance-say-health care-analysts.

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. This 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.

6. Appendices

Official Charge of the Finance and Revenue Committee

The Finance and Revenue Committee is tasked with the following deliverables under their Committee Charter:

1. To develop a list of attributes of a sound financial plan;
2. Review and understand current health spending in Oregon;
3. Develop an annual Universal Health Plan cost target that can be supported with new revenue and existing health spending;
4. Review methods of revenue collection to withstand an ERISA challenge;
5. Review, update, and build on revenue options to pay for universal health plan as outlined in the Joint Task Force Report;
6. Describe the impact of revenue or taxes on large and small businesses and households;
7. Identify required startup costs and plan reserves and develop strategies for building the needed reserves;
8. And compare and contrast current mechanisms for funding for health care with the proposed financing strategy.

As delegated in sections 2(3) i and j of SB 1089, F&R is tasked with providing a unified financing strategy for the Universal Health Plan that may include an income tax, a payroll tax, or other options that take into considerations ERISA and has support from large and small employers, as well as an analysis of the impact of Universal Health Plan on Oregon's economy.[83]

[83] Universal Health Plan Governance Board. "Committee Charters: Finance and Revenue Committee: Committee Charter." Oregon.gov. 2024. https://www.oregon.gov/uhpgb/committees/Documents/fin-rev/finance-and-revenue-committee-charter.pdf.