Universal Health Plan Governance Board

Comprehensive Plan to Finance and Administer a Universal Health Plan in Oregon

Report to the Legislative Assembly

September 2026

[INSERT TOC]

EXECUTIVE SUMMARY

BOARD PROCESS AND DECISION FRAMEWORK

STATUTORY MANDATE

The Universal Health Plan Governance Board (the "Board") was established under Senate Bill 1089 (2023), subsequently codified in ORS Chapter 751. The Board is charged with developing a comprehensive, implementable plan to finance and administer a universal health plan for all Oregon residents and to submit recommendations to the Legislative Assembly by September 15, 2026. The statute directs the Board to evaluate financing, benefit design, administrative structure, and implementation pathways, while prioritizing affordability, equity, and quality within existing state and federal legal constraints.

BOARD COMPOSITION

The Board consists of nine Governor-appointed, Senate-confirmed members with expertise in health care delivery, finance, operations, and public administration, along with members representing public and community perspectives. The Board operates under a quorum requirement with formal decisions made by majority vote. In practice, the Board used a consensus-oriented approach, relying on iterative deliberation to refine recommendations and align across policy domains.

GUIDING PRINCIPLES

The Board applied a defined set of guiding principles to evaluate policy options, resolve tradeoffs, and ensure alignment with statutory priorities. These principles were used consistently across workstreams and during integration to support development of a single, coherent model.

The five principles that served as a framework for the Board's decisions are:

1. **Health Equity:** Health care is a fundamental element of a just society, and must be secured for all individuals on an equitable basis by public means, similar to public education, public safety and public infrastructure. (ORS 751.002(3)(a)(A)).

2. **Maximize Health:** Maximize health includes individual satisfaction and agency in care and public health concerns for the community as a whole. Improving the health status of individuals, families and communities; (ORS 751.002(2)(a)).

3. **Fair Distribution of Medical Resources:** Establishing and ensuring a fair distribution of medical resources is a principle in ORS ch. 751 and an overarching principle of the Governance Board.

4. **Minimize Financial Hardship for Individuals and Families from Medical Costs:** Protecting individuals from the financial consequences of ill health; and (ORS 751.002(2)(c)) Removing cost as a barrier to accessing health care. (ORS 751.002(2)(e)).

5. **Community Sense of Ownership and Governance:** In any policy or program that will directly and intimately affect a community, that community should have voice in final decision making.

WORKSTREAMS AND TECHNICAL COMMITTEES

To support development of a comprehensive plan, the Board organized its work across five primary workstreams:

- Community Engagement and Communications
- Finance and Revenue
- Operations
- Plan Design and Expenditures
- Transition

Each workstream was supported by a technical advisory committee, responsible for developing recommendations within its domain supported by subject matter experts, stakeholder input, and commissioned analysis. Workstreams operated in parallel but were not independent; findings were brought to the full Board for cross-domain integration, refinement, and decision-making. This structure enabled detailed technical development while ensuring that financing, benefits, administration, and implementation decisions remained aligned within a single, coherent model.

COMMUNITY INPUT

The Board incorporated community input through public comment, available at all Board and committee meetings, written comment accepted at any time, and twelve targeted stakeholder engagement sessions held in Spring 2026. These inputs informed understanding of access barriers, affordability challenges, and implementation risks, and were considered alongside technical and financial analyses in developing final recommendations.

A detailed summary of community input is provided in the Appendix, including engagement session findings and public comment analysis.

ANALYTICAL METHODS

The Board's recommendations are informed by actuarial analysis, economic modeling, policy evaluation, and stakeholder input. These analyses were used to define cost ranges, evaluate financing options, and identify implementation constraints rather than to produce a single deterministic model.

Actuarial modeling by Milliman provided system cost estimates and financing scale. Economic analysis by ECONorthwest evaluated revenue options, distributional impacts, and feasibility. Health Management Associates provided policy evaluation and federal waiver information. Additional staff policy and comparative analysis informed design choices and implementation

risks. The Board used these inputs to identify decision-relevant tradeoffs, recognizing that final outcomes depend on policy choices related to payment, utilization, and administrative structure.

The full reports of Milliman, ECOnorthwest, and Health Management Associates analyses are included in the Appendix.

BOARD VOTE

On DATE, the Universal Health Plan Governance Board voted on the recommendation for the administration and financing of a statewide, universal health plan for all Oregonians as outlined in this report. The vote reflects the Board's recommendation of a single, integrated model for legislative consideration.

Voting in favor:

Voting against:

ACKNOWLEDGEMENTS

The Board gratefully acknowledges the many individuals who contributed time, expertise, and public service to the development of this report. The work reflected here was shaped by the efforts of current and former Board members, committee members, staff, consultants, and partners who supported the Board's charge and helped advance its deliberations.

Board Members
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Judy Richardson (vice chair)
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Amy Fellows
Michelle Glass
Bruce Goldberg
Mary Lou Hennrich
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Cherryl Ramirez

UHPGB Staff
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Isabel Courtelis, Executive Assistant
Lee Hastings, Senior Policy Advisor

Past Board Members
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Warren George

Past UHPGB Staff

Morgan Cowling, Executive Director
Katy DeLuca, Executive Assistant
Jennifer Donovan, Senior Policy Advisor
Kim Yee, Senior Policy Advisor

Committee Members

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Ann Lovejoy
Antonio Germann
Bethany Stairs
Betsy Boyd-Flynn
Brian Frank
Charlie Swanon
Chris Hogan
Christine Zinter
Collin Stackhouse
Craig Newton
Doris Kiragu
Douglas (Doug) Flow
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John Santa
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Mike Durbin
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Richard Gibson
Robert Fisette
Rosalind Lindsay
Rosemarie Hemmings
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Sara Fouche
Tashrique Rahman

I. PROPOSED MODEL

A universal health plan represents a unified, statewide framework for delivering health coverage to all Oregon residents. Rather than modifying existing programs in isolation, the proposed model integrates eligibility, benefits, financing, and administration into a single system designed to reduce fragmentation, improve affordability, and simplify access to care.

The model is structured to operate within current legal and fiscal constraints, including continued coordination with federal programs and employer-sponsored coverage. The following sections describe the core components of the proposed model, including eligibility and enrollment, benefit design, and interactions with other insurance.

ELIGIBILITY

The universal health plan will provide coverage to Oregon residents, with eligibility defined to ensure broad access while maintaining administrative clarity and program integrity. Eligibility for the universal health plan will be based on Oregon residency, as defined in ORS 316.027. Under this statute, individuals are considered residents if they maintain a permanent place of abode in Oregon and are present in the state for more than 200 days of the taxable year. This definition will serve as the primary standard for eligibility. Individuals who attest that Oregon is their primary place of residence and intend to remain residents are eligible pending verification.

Coverage for minors will be established through enrollment by a parent or guardian who claims the individual as a dependent. Each covered individual will receive independent eligibility and identification within the system. Dependent coverage definitions will align with state and federal standards, including Affordable Care Act (ACA) and Public Employee Benefits Board (PEBB) coverage rules for individuals up to age 26, and existing Oregon Health Plan policies for children and youth.

Consistent with the Board's commitment to equity and access, eligibility will be extended regardless of immigration or housing status.

Special Populations

Residents who are enrolled members of federally recognized Tribes may choose to participate in the universal health plan but would not be required to do so in recognition of Tribal sovereignty.

Seasonal farmworkers, as defined in ORS 652.145(2), will be eligible for coverage during periods of employment in Oregon.

Individuals who are incarcerated in Oregon will be eligible for coverage, with payment and reimbursement structures coordinated with carceral institutions and subject to federal requirements.

Non-resident students attending school in Oregon will be considered eligible based on the presumed in-state residency for the majority of the year. Oregon residents attending school out of state may retain eligibility under family coverage consistent with dependent coverage standards.

Individuals residing outside of Oregon are not eligible for coverage. For individuals who work in Oregon but reside out of state, mechanisms for ensuring appropriate coverage and employer participation will be defined in implementation, balancing workforce mobility with program integrity.

ENROLLMENT

Enrollment in the universal health plan is designed to be simple, continuous, and administratively efficient, while maintaining program integrity and compliance with state and federal requirements. The model prioritizes ease of access for members and streamlined administration for the state, with enrollment processes structured around three core functions:

- Initial enrollment for new residents
- Verification of eligibility
- Ongoing re-enrollment and eligibility maintenance

Eligible individuals may enroll upon attestation of intent to reside in Oregon with coverage beginning immediately and no waiting period. At the time of enrollment, individuals may identify dependents, enabling simultaneous household enrollment. This approach aligns with federal requirements prohibiting durational residency requirements for Medicaid and reduced administrative barriers to entry.

Eligibility Verification

Documentation of residency will be required within 60 days of enrollment. The universal health plan will collect only the minimum necessary information required for program administration and federal compliance, including:

- Proof of residency, to establish eligibility for the universal health plan
- Proof of income, to support federal funding eligibility (e.g., Medicaid matching funds) and determine eligibility for certain benefits
- Proof of identity, to support program integrity, coordination with federal programs, and member communication

Acceptable documentation may include lease agreements, utility bills, employer verification, or other approved forms of proof. Verification processes will leverage existing state and federal data systems wherever possible, reducing the need for manual documentation and minimizing burden on members. Individuals without traditional documentation or recent tax filings may establish eligibility through alternative verification pathways, including participation in state-administered programs or other identity-verified systems.

Automatic Re-Enrollment and Continuity of Coverage

The universal health plan will prioritize continuous coverage through automatic re-enrollment mechanisms. The primary mechanism for re-enrollment will be automatic renewal based on filing an Oregon personal income tax return or being claimed as a dependent on such a return. This process is expected to capture approximately 75-85 percent of eligible individuals.

Secondary mechanisms will include automated data matching with participation in other state-administered programs that require proof of residency, including:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Women, Infants, and Children (WIC)
- Medicaid
- Unemployment Insurance (UI)

Together, these mechanisms are expected to support seamless re-enrollment for approximately 90-95 percent of eligible individuals without requiring member action.

Ex Parte Review and Member Outreach

For individuals not captured through automatic processes, the Universal health plan will apply ex parte review procedures, using all available data sources to verify continued eligibility before requiring member action. Only when eligibility cannot be confirmed through available data will the plan initiate outreach to the member through their last known contact information. Individuals undergoing this process will retain coverage during a 90-day grace period, unless information is received indicating loss of eligibility, such as relocation out of state or death. Individuals who are disenrolled due to inability to verify eligibility remain eligible to re-enroll upon attestation if they continue to meet residency requirements.

Integration with Federal Programs

Enrollment and verification processes will be designed to support coordination with federally administered programs, including Medicaid and Medicare, where applicable. Where federal funding is pursued, enrollment processes will comply with all applicable federal requirements, including eligibility verification and documentation standards. Enrollment and verification processes will include coordination-of-benefits mechanisms to identify enrollment in federally administered programs, including Medicaid and Medicare, and to ensure appropriate designation of the universal health plan as the primary or secondary payer.

Scope of Benefits During Initial Enrollment

To support program integrity and continuity of care, the universal health plan will implement a staged benefit structure for newly enrolled individuals. For the first six months of continuous enrollment, individuals will have access to a core set of services, including:

- Primary care
- Behavioral health services
- Medically necessary services
- Emergency services

Following six months of continuous enrollment, individuals will receive access to the full benefit package, including outpatient elective procedures and fertility services.

BENEFIT STRUCTURE

The universal health plan will provide a comprehensive set of covered benefits aligned with the Oregon Public Employees' Benefit Board (PEBB) standard, supplemented with targeted enhancements to address identified gaps in in behavioral health coverage. This approach, hereafter referred to as "PEBB+," leverages an existing, widely understood benefit structure while enabling modifications to improve access, reduce administrative complexity, and align with the goals of a universal system.

Scope of Covered Benefits

The universal health plan will include coverage across the full continuum of medically necessary care. Covered services will include, but are not limited to:

- Hospital services, including inpatient and outpatient surgical care
- Emergency services, including ambulance transportation
- Primary and specialty care, including office, clinic, and home-based services
- Preventive services, including screenings, immunizations, and wellness visits
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs, including specialty medications
- Rehabilitative and habilitative services
- Diagnostic services, including laboratory and imaging
- Chronic disease management
- Hospice and palliative care
- Dental and vision services
- Durable medical equipment and prosthetics
- Fertility and reproductive health services

Medicaid-eligible residents will retain access to certain additional services including long-term services and supports, non-emergency medical transport, and Early and Periodic Screening, Diagnostic, and Treatment services for children.

Behavioral Health Integration

The universal health plan will provide a fully integrated continuum of behavioral health services, expanding beyond traditional commercial coverage to include services currently available through public programs and additional community-based supports.

This includes:

- Bidirectional integration of behavioral health and primary care, including screening, treatment, and referral within primary care settings

- Expanded outpatient and community-based services, including case management, navigation, and early intervention services
- Crisis response infrastructure, including 24/7 crisis lines, mobile outreach, crisis stabilization, and respite services
- Residential and inpatient treatment, including acute, subacute, and intermediate levels of care
- Preventive and population-based services, including school-based mental health and early psychosis intervention
- Peer-delivered and recovery support services

The plan will support delivery across a broad workforce, including licensed clinicians, certified providers, and supervised paraprofessionals, consistent with existing Oregon behavioral health system models. This approach reflects a shift from episodic behavioral health coverage to a continuum-based model of care, addressing longstanding gaps in access, fragmentation, and service availability.

Cost Sharing and Financial Protection

The universal health plan will minimize or eliminate point-of-service cost sharing for covered benefits. Under the PEBB+ framework, the intent is to provide most, if not all, covered services without deductibles, copayments, or coinsurance. This approach is intended to reduce financial barriers to care, improve access to preventive and early intervention services, and simplify provider payment and administrative burden.

Services Excluded or Deferred

Certain services are not recommended for inclusion in the initial benefit structure of a universal health plan. These include:

- Long-term services and supports for non-Medicaid eligible individuals
- Certain health-related social needs services authorized under federal waivers
- Services for populations covered under federally administered programs, where federal funding and authority remain in place

In alignment with the previous recommendation of the Joint Task Force, the Board recommends that these services continue to be delivered through existing programs until such time as federal approvals and financing mechanisms allow for integration.

Benefit Design Flexibility

The universal health plan will establish a standardized core benefit package, with authority delegated to the governing entity to refine benefits over time based on clinical evidence, population health needs, fiscal sustainability, and federal requirements and opportunities.

INTERACTION WITH OTHER COVERAGE

Due to the nature of health care laws and regulations, a universal health plan will continue to operate within a multi-payer environment, requiring structured coordination with federal programs and employer-sponsored coverage. Certain federal programs, such as Veteran's Affairs, TRICARE, and the federal employee health benefit, offer no pathway for integration.

Additionally, the universal health plan would not replace or alter the Indian Health Service, Tribal health programs, or urban Indian health programs. Eligible Tribal members residing in Oregon may elect to participate in the universal health plan but would not be required to do so, consistent with Tribal sovereignty and subject to continued consultation with Tribal Nations.

Employer-Sponsored Insurance

The Employee Retirement Income Security Act (ERISA) prohibits states from regulating health plans established by employers. As such, employer-sponsored coverage is not eliminated under this proposal. Employers may choose to maintain existing coverage arrangements or transition employees to the universal health plan. The universal health plan is designed to offer a simplified, lower administrative alternative that is expected to become the preferred option due to cost savings relative to offering separate insurance. However, options exist for maximizing the administrative simplification of a universal health plan by regulating coordination of benefits for non-federal employer-sponsored health care coverage.

Under a primary coverage approach, the universal health plan would serve as the first payer for covered services, with employer-sponsored coverage functioning as supplemental coverage where retained. Potential advantages of this model include greater administrative simplification for providers and members, increased ability for the universal health plan to influence payment and delivery reform, and stronger incentives for voluntary migration toward a unified system. Potential disadvantages include increased upfront financing requirements for the universal health plan, possible disruption to collectively bargained benefits, and increased legal and operational risks related to employer participation and ERISA constraints. Additional discussion of ERISA and other legal considerations is included in the Appendix.

Under a secondary coverage approach, employer-sponsored insurance would continue as the first payer and the universal health plan would provide wraparound coverage for cost sharing, uncovered services, or defined supplemental benefits. Potential advantages include lower initial fiscal exposure for the universal health plan, reduced disruption to existing employer arrangements, and avoidance of direct interaction with employer plan administration. Potential disadvantages include continued administrative complexity, reduced opportunity for system simplification and payment reform, and operational challenges related to coordination of benefits, provider credentialing, and delays associated with claim sequencing.

The Joint Task Force on Universal Health Care did not establish a specific recommendation regarding whether a future universal health plan should operate as primary or secondary coverage. Its recommendations contemplated a reduced role for private insurance over time and continued employer contributions through financing mechanisms but did not specify a final coordination-of-benefits structure.

Ultimately, the Board determined the question of coordination of benefits with commercial insurance should be deferred pending additional research and consultation with Oregon employers. Future implementation work should further evaluate likely employer responses under each model, including variation across employer size, funding structure, and geographic footprint, as well as the risk of ERISA-related challenges. Additional employer engagement and survey work is necessary to understand likely participation patterns and implications prior to final policy design.

Liability Coverage & Worker's Compensation

Beyond coordination with employer-sponsored coverage, the universal health plan will also interact with existing statutory payment and liability frameworks that allocate financial responsibility outside the health insurance system. These interactions differ from employer coverage coordination because they generally involve established reimbursement and recovery mechanisms rather than member enrollment or plan participation decisions.

The public corporation will have statutory authority to pursue subrogation and third-party recovery, allowing it to recoup costs from liable parties where applicable. Medical care will be provided to members without regard to liability, with recovery pursued administratively by the public corporation.

Oregon's worker's compensation program will continue to operate independently, with coordination to ensure reimbursement of medical costs covered under the universal health plan.

Out-of-State Coverage

The universal health plan will ensure access to care for Oregon residents when services are required outside the state. The plan will contract with a national network or establish alternative arrangements to provide coverage for out-of-state care. Coverage for out-of-state services may include cost-sharing requirements, particularly for non-emergency services. For specialty care delivered by out-of-state providers with prior authorization, the plan will align with existing Oregon Health Plan guidelines. Reciprocal agreements with other states may be pursued where feasible.

HEALTH EQUITY IMPACT

The proposed model is designed to advance health equity by replacing fragmented coverage arrangements with a statewide coverage framework available to Oregon residents on a consistent basis. Residency-based eligibility, immediate enrollment upon attestation, alternative verification pathways, automatic re-enrollment, and ex parte review are intended to reduce administrative barriers that disproportionately affect people with unstable housing, limited documentation, income volatility, language access needs, disability-related barriers, or intermittent engagement with state systems.

The proposed benefit structure also advances equity by reducing financial and service-based barriers to care. A standardized PEBB+ benefit package, expanded behavioral health continuum,

dental and vision coverage, primary care access, and elimination of point-of-service cost sharing are intended to improve access to preventive, routine, and medically necessary care. These design choices are particularly important for individuals and communities that experience delayed care, unmet behavioral health needs, high out-of-pocket exposure, or inconsistent access due to coverage churn.

The model may also reduce structural inequities created by payer fragmentation. Under the current system, access to benefits, provider networks, cost-sharing protections, and administrative requirements varies substantially by employment status, income, program eligibility, and payer source. A universal health plan would create a more uniform coverage and administrative structure over time, reducing differential treatment across coverage categories and simplifying access for members and providers.

At the same time, the equity impact of the proposed model will depend on implementation. Future work should ensure that eligibility and enrollment processes are accessible to people with limited English proficiency, disabilities, housing instability, limited digital access, and distrust of government systems. Implementation should also monitor provider participation, regional access, culturally and linguistically responsive care, disability access, and continuity for populations remaining temporarily connected to federal or employer-sponsored coverage during transition. Equity goals will require ongoing data collection, community engagement, public accountability, and corrective action as the universal health plan is implemented.

II. FINANCING ARCHITECTURE

Oregon's health care financing system is increasingly unstable, unaffordable, and administratively fragmented. While coverage rates have improved over time through Medicaid expansion and Marketplace subsidies, the underlying structure used to finance care remains diffuse, opaque, and difficult to sustain.

Health care costs are already paid by Oregon households, employers, and governments through a combination of insurance premiums, deductibles, copayments, payroll contributions, taxes, and indirect economic effects such as wage suppression and cost-shifting. However, these costs are distributed across multiple payers and financing mechanisms with limited coordination or transparency. As a result, total system spending continues to rise while accountability for those costs remains fragmented.

Under the current system, health care spending increases are experienced differently depending on the payer:

- Households experience rising premiums, deductibles, and out-of-pocket costs;
- Employers experience increasing compensation pressure and administrative burden;
- Public programs experience growing budgetary pressure and competition with other state priorities; and
- Providers experience administrative complexity, payment variation, and instability tied to payer mix and reimbursement structures.

This fragmentation creates structural inefficiencies that extend beyond the direct cost of care. Providers maintain extensive administrative systems to navigate differing billing requirements, payment methodologies, utilization management protocols, and reporting obligations across multiple insurers and public programs. Employers finance and administer health benefits separately from wages and other compensation. Individuals frequently transition between coverage sources due to changes in employment, income, or eligibility status, resulting in interruptions in coverage, duplicative administrative processes, and inconsistent access to care.

At the same time, the current financing structure obscures the true cost of health care. Much of what households and employers already spend on health care is embedded indirectly in premiums, forgone wages, cost-sharing, or business expenditures rather than experienced as a single transparent financing mechanism. This fragmentation contributes to the perception that new public financing mechanisms represent wholly new costs, even where they primarily replace existing private expenditures.

These pressures are expected to intensify over time. Actuarial analysis commissioned by the Board projects continued growth in total health system expenditures under current system assumptions, driven primarily by medical cost trend, utilization growth, and administrative complexity. Existing analyses further demonstrate that maintaining current payment and administrative structures results in continued upward pressure on employers, households, and state budgets without resolving underlying inefficiencies.

The challenge facing Oregon is therefore not whether the state already spends substantial resources on health care. It does. The challenge is that the current financing structure distributes those costs through a fragmented system that limits transparency, complicates administration, weakens cost control, and produces unequal financial burdens across households and employers. The financing architecture proposed in this report is intended to address these structural problems by consolidating fragmented financing streams into a coordinated statewide framework capable of supporting universal coverage, improving administrative efficiency, and creating a more stable long-term financing structure for health care in Oregon.

DESIGN PRINCIPLES

The financing structure for the universal health plan was developed to support long-term system stability, equitable contribution, administrative feasibility, and legal durability. In developing the proposed financing framework, the Board evaluated financing mechanisms not only on the ability to generate sufficient revenue, but also on how different approaches would affect households, employers, state administration, economic behavior, and long-term sustainability. The proposed financing architecture is guided by the following core principles.

Stable, Predictable, and Adequate Financing. A universal health plan requires financing mechanisms capable of supporting ongoing health care expenditures across changing economic and demographic conditions. Revenue sources must therefore generate sufficient funding to support operations, benefits, reserves, and transition costs while maintaining relative predictability over time. Because individual revenue streams vary in volatility and economic sensitivity, the proposed financing framework relies on multiple revenue sources rather than a single financing mechanism.

Progressive Contribution Structure. The proposed financing structure is intended to align contribution responsibility with ability to pay while avoiding abrupt cliffs or disproportionate burdens on specific groups. The financing framework prioritizes broad-based financing approaches with lower effective rates over narrower financing structures requiring substantially higher contribution levels from smaller groups of taxpayers.

The framework further seeks to avoid substantially unequal treatment between different forms of income or employment arrangements wherever possible. Particular consideration was given to interactions between payroll-based contributions, household income taxes, self-employment income, and employer-sponsored coverage arrangements.

Transparency and Administrative Simplicity. The current health care financing system distributes costs through premiums, cost-sharing, employer benefit expenditures, and multiple public financing streams, making the total cost of health care difficult for households and employers to fully understand. The proposed financing framework seeks to replace portions of this fragmented financing structure with more transparent and predictable mechanisms.

The proposed framework prioritizes financing approaches that can be administered using existing tax and public finance infrastructure where possible, minimizing the need for entirely new collection systems or complex eligibility determinations. Administrative simplicity is

important both for operational feasibility and for reducing unnecessary compliance burden on households, employers, providers, and the state.

Federal Integration and Legal Durability. The proposed financing structure assumes continued coordination with existing federal funding streams and programs, including Medicaid, Medicare, and Marketplace subsidy structures. Maximizing federal funding participation and preserving federal financial flows to Oregon were significant considerations throughout development of the financing proposal.

The proposed framework also considers legal constraints associated with employer-sponsored insurance and federal preemption under ERISA. Financing mechanisms involving employers were evaluated with attention to whether they function as broad-based revenue structures rather than mandates tied directly to employer health benefit offerings.

Dedicated and Protected Financing Structure. The proposed financing framework assumes creation of a dedicated Universal Health Plan Trust Fund separate and distinct from the General Fund.[1] Revenues deposited into the trust fund would be continuously appropriated for purposes related to operation and administration of the universal health plan and retained across biennia rather than reverting at the end of budget cycles.

A dedicated trust structure is intended to support:

- Transparency and public accountability;
- Long-term fiscal planning;
- Reserve management and solvency protection;
- Separation from unrelated state budget pressures; and
- Public confidence that health care financing revenues remain dedicated to health system purposes.

THE FINANCING MODEL

The proposed financing model is structured around a coordinated set of broad-based revenue mechanisms designed to replace fragmented private health care spending with a stable, publicly administered financing structure. Rather than relying on a single tax source, the framework distributes responsibility across employer, household, business, and limited consumption-based revenue streams to improve stability, reduce overreliance on any one tax base, and align contributions with existing patterns of health care spending.

The financing structure was developed to support the projected scale of statewide health care expenditures modeled under the universal health plan. Actuarial modeling conducted for the Board by Milliman estimates total annual expenditures in 2032 of approximately $85.5 billion under the central “best estimate” scenario, with a modeled range between approximately $77.4 billion and $94.0 billion depending on utilization, trend, and operational assumptions.

[INSERT description of new expenditure and RRT]

[1] See section III for more on the Universal Health Plan Trust Fund.

The proposed revenue framework includes five primary tax instruments.

Employer Payroll Tax (EPT)

Health Care Personal Income Tax (HCPIT)

Corporate Income Tax Add-On

Corporate Activity Tax (CAT) Add-On

Lodging Tax Increase

Integrated Revenue Structure

These financing mechanisms are intended to operate as a coordinated system rather than as isolated taxes. Payroll, household income, corporate income, business activity, and limited consumption-based financing each serve different functions within the broader structure:

- Payroll financing captures existing employer health spending;
- Household income financing provides progressivity;
- Business taxes broaden participation and improve stability; and
- Consumption-based financing modestly diversifies the revenue base.

Together, these mechanisms are intended to generate sufficient revenue to support the universal health plan while distributing financing responsibility across multiple sectors of the Oregon economy. The model also assumes continued receipt and integration of existing federal health care funding streams, including Medicaid, Medicare, and Marketplace subsidies, which substantially reduce the amount of new state-generated revenue required.

REPLACEMENT VERSUS NEW SPENDING

A central consideration in evaluating the proposed financing model is the distinction between new public revenue collection and new overall health care spending. While the universal health plan would require substantial publicly administered revenue streams, much of that financing represents a replacement or consolidation of health care spending that already occurs through convoluted and opaque pathways.

Under the current system, health care is financed through a fragmented combination of employer-sponsored insurance premiums, employee premium contributions, deductibles and other cost-sharing, direct household out-of-pocket spending, state and federal tax-supported programs, and indirect compensation impacts, including wage suppression associated with

employer health benefit costs. The proposed financing framework would shift a significant portion of these existing expenditures into a centralized public financing structure. As a result, the taxes required to support the universal health plan should not be interpreted as new economic burdens, but rather as visible replacements for costs that are already paid through less transparent and less coordinated mechanisms.

This distinction is particularly important because the current system obscures much of the true cost of health care. Employer-sponsored insurance costs are often partially hidden within compensation structures, with employer premium contributions reducing available wage growth over time. Similarly, household exposure under the current system varies substantially depending on employer coverage, health status, utilization patterns, and insurance design. Individuals with similar incomes may face dramatically different financial obligations based on factors largely outside their control. Under the proposed financing structure, these variable and fragmented expenditures would increasingly be replaced by standardized contribution mechanisms tied more directly to payroll, taxable income, and broad economic participation. In practice, this results in a shift from premium-based and out-of-pocket financing toward tax-based financing that is more visible, more predictable, and more systematically distributed.

The visibility of tax-based financing creates an important political and economic dynamic. Existing private health care expenditures are often experienced incrementally and indirectly through premiums, payroll deductions, network restrictions, cost-sharing obligations, and compensation tradeoffs. By contrast, public financing mechanisms are generally more transparent and easier to quantify. As a result, the proposed financing model may appear to increase costs even in circumstances where households or employers experience comparable or lower total health care spending relative to the current system.

At the same time, replacement financing is not the same as neutrality. Some households and employers would contribute more under the proposed financing structure than they do today, while others would contribute less. Higher-income households would generally contribute a larger share through progressive income-based financing mechanisms, while some employers with relatively low current health benefit spending could experience increased obligations under a standardized payroll contribution structure. Conversely, households facing high premium costs, unstable coverage, or significant out-of-pocket exposure may experience substantial reductions in financial risk and variability. The proposed financing structure therefore represents both a replacement of large portions of existing private health care spending and a redistribution of financing responsibility intended to improve equity, predictability, transparency, and long-term system stability.

DISTRIBUTIONAL IMPACTS

RESERVES AND TRANSITION FUNDING

FEDERAL FUNDING AND COORDINATION

The proposed universal health plan financing framework assumes continued coordination with existing federal health care programs and preservation of current federal funding streams wherever legally and operationally feasible. Federal participation is a foundational component of the proposed financing structure, and total state-generated revenue requirements are substantially reduced by continued receipt of federal health care dollars associated with Medicaid, Medicare, Marketplace subsidies, and other federal health programs.

The proposed model therefore does not assume that Oregon would independently replace the full cost of all health care expenditures using only state-generated revenue. Instead, the financing structure is designed around a combined financing framework integrating state-generated revenue mechanisms and federal matching funds and subsidies.

Medicaid and Affordable Care Act Funding

The proposed financing framework assumes continued participation in Medicaid financing arrangements and continued receipt of associated federal matching funds. Oregon currently receives substantial federal financial participation through the Oregon Health Plan and related Medicaid programs, and preservation of these funds is critical to long-term fiscal sustainability of the universal health plan. The financing framework also assumes continued coordination with Affordable Care Act-related federal subsidies and Marketplace funding mechanisms.

The model recognizes that substantial elements of implementation would likely require ongoing federal negotiation, waiver approval, or phased integration strategies. As a result, financing assumptions related to Medicaid and Marketplace integration remain dependent on future federal policy and operational coordination.

Medicare Coordination

The proposed financing structure also assumes continued interaction with Medicare financing and federal Medicare payment systems. Because Medicare operates under distinct federal statutory and financing authorities, immediate full integration into a state-administered financing structure may not be operationally or legally feasible absent significant federal action. As a result, future implementation work contemplates consideration of:

- Maintaining Medicare as a primary federal payer during a transition period;
- Supplemental coverage coordination;
- Aligned provider payment structures; or
- Future federal waiver or demonstration opportunities if available.

The financing framework recognizes that Medicare integration presents both operational opportunities and significant policy complexity. In particular, financing structures must avoid creating incentives that unintentionally destabilize federal participation or shift costs to the state without corresponding federal funding transfers.

Federal Policy and Fiscal Risk

Because the proposed financing framework depends substantially on continued federal participation, changes in federal policy, waiver authority, funding formulas, or program structure could materially affect financing requirements and operational feasibility.

Potential federal risks include:

- Changes to Medicaid matching formulas or eligibility rules;
- Modification or reduction of Marketplace subsidies;
- Limitations on federal waiver authority;
- Changes in Medicare payment or coordination rules;
- Delays in federal approval processes;
- Federal administrative or legal challenges; and
- Broader federal fiscal or policy shifts affecting health program financing.

Implementation of a universal health plan requires ongoing intergovernmental coordination and cannot be evaluated solely as a state financing exercise. Financing sustainability depends in significant part on Oregon's ability to preserve and effectively integrate federal health care funding within the broader universal health plan financing structure.

The proposed financing framework ultimately seeks to create greater alignment between state and federal health financing systems while preserving continuity of coverage and minimizing disruption for individuals, providers, and public programs.

Long-term sustainability of the universal health plan depends not only on state revenue generation, but also on Oregon's continued ability to maximize federal financial participation, coordinate effectively across state and federal financing systems, maintain operational compliance with federal program requirements, and adapt to future changes in federal health policy and financing structures over time.

FISCAL MODELING CONSIDERATIONS AND LIMITATIONS

The financing estimates and expenditure projections included in this report are intended to support policy evaluation, comparative analysis, and implementation planning rather than function as precise forecasts of future health system spending. Long-term health care financing projections are inherently sensitive to underlying assumptions regarding utilization, demographic change, medical trend, provider payment methodologies, implementation sequencing, administrative structure, federal participation, and economic conditions.

The actuarial modeling prepared for the Board was designed to estimate projected system expenditures and financing requirements under specified assumptions and policy scenarios. These models necessarily simplify elements of real-world system behavior and should therefore be interpreted as bounded planning estimates rather than exact predictions of future program costs.

Importantly, the Milliman expenditure modeling generally assumed continuation of many underlying health care cost structures currently present within Oregon's health system, including existing utilization patterns, provider payment dynamics, and portions of current administrative

arrangements. As a result, modeled expenditure estimates should not be interpreted as representing the maximum potential savings that could theoretically occur under a fully integrated or highly centralized single-payer-style system.

Long-term system expenditures may ultimately be affected by policy and operational changes not fully reflected within baseline modeling assumptions, including:

- Reductions in administrative complexity;
- Changes in provider payment methodologies;
- Global budgeting approaches;
- Negotiated pharmaceutical pricing;
- Integrated care management strategies;
- Changes in uncompensated care burden;
- Shifts in utilization associated with expanded access to primary and preventive care; and
- Broader delivery system transformation over time.

At the same time, implementation of a universal health plan may also generate costs or operational pressures not fully captured in baseline estimates, including:

- Transition and startup expenditures;
- Implementation delays;
- Utilization increases associated with expanded coverage stability;
- Workforce capacity constraints;
- Information technology and operational infrastructure costs; and
- Federal coordination or compliance requirements.

As a result, actual expenditures under a universal health plan could differ materially from modeled estimates depending on final program design decisions and implementation conditions. Financing estimates are similarly dependent on modeling assumptions and available tax data. Revenue projections associated with payroll taxes, household income taxes, and other financing mechanisms were modeled using existing state economic and tax data under specified assumptions regarding tax base structure, contribution thresholds, employer behavior, and economic activity.

Final revenue estimates may change depending on future legislative and technical review of tax base definitions and implementation mechanics. Accordingly, financing projections included in this report should be interpreted as policy modeling estimates rather than finalized statutory revenue determinations. While the modeling provides a useful framework for evaluating the scale, structure, and feasibility of a universal health plan, actual fiscal outcomes would ultimately depend on future legislative decisions, federal coordination, economic conditions, implementation sequencing, operational execution, and long-term health system behavior over time.

III. ADMINISTRATIVE STRUCTURE

Implementation of a universal health plan requires an administrative structure capable of managing a statewide health system at substantial scale while remaining operationally flexible, publicly accountable, financially stable, and responsive to local community needs. In developing the proposed administrative framework, the Board considered how responsibility for financing, policy, operations, provider payment, accountability, and community engagement should be structured within a statewide universal health plan. The Board also considered limitations associated with the current fragmented administrative environment, including duplicative systems, inconsistent standards, administrative burden for providers and patients, and instability associated with changing contractor or insurance market participation.

The proposed framework therefore seeks to balance several administrative goals:

- Centralized accountability and fiscal oversight;
- Statewide consistency in core standards and benefits;
- Operational flexibility and adaptability over time;
- Meaningful regional and community engagement;
- Transparency and public accountability; and
- Administrative simplification for providers, patients, and participating organizations.

Legislation establishing a universal health plan cannot reasonably specify every operational, payment, technical, or administrative detail necessary to manage a statewide health system over time. As a result, the proposed framework assumes the Legislature would establish the core structure, authorities, financing framework, and accountability standards for the universal health plan while delegating operational and technical implementation authority through rulemaking and administrative processes. The proposed administrative structure is designed to support long-term statewide coordination while maintaining operational adaptability, public accountability, and responsiveness to the needs of Oregon communities over time.

LEGAL STRUCTURE & AUTHORITIES

The Board proposes that the universal health plan be administered through a public corporation established in state law. The proposed public corporation would function as a publicly accountable entity responsible for administration, financing, operations, provider payment, contracting, and implementation of the Universal Health Plan.

The Board concluded that a public corporation structure provides the most appropriate balance between public accountability, operational flexibility, and long-term administrative stability for management of a statewide health system. Public corporations are public bodies that operate with a specific mission and with transparency to the public. A public corporation would allow the universal health plan to be structured as a non-profit entity subject to public ethics, meetings and records laws, while providing flexibility in organizing its financial structure, adherence to government contracting, procurement, personnel, and bonding laws. Designing the corporation to specifically serve the purpose, mission and goals laid out in the final plan can be accomplished in statutory construction of the corporation.

The proposed structure is intended to support:

- Centralized administration of financing and provider payment systems;
- Long-term fiscal planning and reserve management;
- Statewide operational consistency;
- Flexibility in contracting, procurement, and staffing;
- Phased implementation and operational scaling;
- Federal waiver negotiation and intergovernmental coordination; and
- Adaptation to future changes in health system operations and financing.

The administration of a universal health plan will require operational authorities that are difficult to manage efficiently through highly prescriptive statutory structures alone. As a result, the proposed framework assumes the Legislature will establish the core legal framework, governance structure, financing authorities, and accountability standards for the universal health plan while delegating operational implementation authority to the public corporation through statute and rulemaking authority. Consistent with existing Oregon public entities and health programs, the proposed public corporation should be granted authority to:

- Promulgate administrative rules;
- Hire staff and delegate operational responsibilities;
- Enter into contracts and administer programs;
- Establish provider payment methodologies and rates;
- Collect, manage, and report data;
- Administer funds and reserves;
- Negotiate and administer federal waivers;
- Conduct audits and compliance activities; and
- Issue administrative orders and oversee appeals processes.

Over-specifying operational detail in statute could reduce the ability of the universal health plan to adapt to changing utilization patterns, financing conditions, federal requirements, workforce needs, and technological developments over time, while insufficient statutory direction could create operational ambiguity or undermine public accountability. The proposed framework therefore seeks to establish core structural authorities in statute while allowing operational and technical detail to be managed administratively through rulemaking and Board oversight.

Under the proposed structure, the public corporation would remain subject to:

- Public meetings and public records laws;
- Ethics and conflict-of-interest requirements;
- State auditing and financial reporting requirements;
- Legislative oversight and statutory limitations; and
- Other applicable accountability and transparency standards governing public entities.

The Board also considered operational risks associated with reliance on independent regional contractors or fragmented administrative entities. As a result, the proposed framework favors centralized administration through the public corporation, including establishment of regional offices as components of the public corporation rather than independently operated risk-bearing organizations. This structure is intended to improve statewide consistency, avoid duplicative

reserve requirements, maintain centralized fiscal accountability, and reduce operational instability associated with contractor turnover or regional fragmentation.

Finally, the proposed public corporation structure is intended to support long-term operational evolution. The framework assumes certain administrative functions may initially be administered through contracted third-party arrangements while long-term internal operational capacity is developed over time. The public corporation structure is therefore designed to provide sufficient administrative flexibility to support both early implementation and long-term statewide administration of the universal health plan.

GOVERNANCE

The Board recommends the establishment of a governing board responsible for oversight of the universal health plan public corporation. The governing board will provide strategic direction, establish major policy frameworks, oversee financial stewardship, and ensure public accountability for administration of the universal health plan. Membership of this board should be structured to meet the challenges of managing a statewide universal health plan, emphasizing individuals with expertise in health care finance and system delivery.

In distinguishing between governance responsibilities and day-to-day administration of the universal health plan, the governing board would primarily focus on:

- Major policy and strategic decisions;
- Approval of budgets and financial policies;
- Establishment of high-level provider payment methodologies;
- Oversight of reserve and trust fund management;
- Adoption of administrative rules;
- Appointment and oversight of the executive director;
- Accountability and performance oversight; and
- Major implementation or program design changes.

Day-to-day administration and operational management would be delegated to the Executive Director and administrative staff of the public corporation. Administrative leadership would hold responsibility for:

- Routine operational management;
- Staffing and internal administration;
- Procurement and contracting activities;
- Implementation of board policy;
- Technical and operational adjustments;
- Administration of claims and payment systems;
- Data and reporting operations;
- Compliance and auditing activities; and
- Routine operational decision-making delegated through rule or Board policy.

Administration of a statewide health plan requires substantial operational flexibility and technical expertise that cannot reasonably be managed solely through direct board action. The

proposed governance structure therefore emphasizes a distinction between policy governance and strategic oversight by the governing board and operational administration and technical implementation by professional staff.

Importantly however, the proposed framework maintains public accountability through public meetings and transparency requirements, legislative oversight, financial reporting and auditing, ethics and conflict-of-interest standards, and formal governing board approval requirements for major policy and financial decisions. This governance structure is intended to support both democratic accountability and effective long-term administration of a statewide universal health plan.

UNIVERSAL HEALTH PLAN TRUST FUND

The Board recommends establishment of a dedicated Universal Health Plan Trust Fund to support financing and operation of the universal health plan. The trust fund would function as the central financial structure for receipt, management, and disbursement of revenues associated with the universal health plan and would exist separately and distinctly from Oregon's General Fund. The Universal Health Plan Trust Fund will operate under a hybrid "captive and exempt" Treasury model, balancing public accountability with operational flexibility. Under this model:

- All moneys will be held by the State Treasurer and deposited into the trust fund
- The public corporation may utilize non-Treasury financial services for certain functions, including front-end cash management, payment processing, and financial operations
- Statutory exemptions may be established to allow flexibility in banking, procurement, and financial administration where necessary to support efficient plan operations

This approach reflects models used by existing Oregon public corporations and enables access to Treasury investment and liquidity tools, while avoiding operational constraints associated with fully captive Treasury management.

The administration of a statewide health plan requires a financing structure capable of supporting long-term fiscal stability, multi-year planning, reserve management, and operational continuity. Because health care expenditures occur continuously and do not align neatly with biennial budgeting cycles, the Board determined that the universal health plan should operate through a dedicated trust structure that allows revenues and reserves to remain available across fiscal periods rather than reverting at the end of a budget cycle.

Under the proposed framework, revenues dedicated to the universal health plan would be deposited directly into the trust fund and continuously appropriated for purposes related to operation of the universal health plan. This structure is intended to provide greater financial predictability and operational stability while ensuring that revenues collected for health system purposes remain dedicated to those purposes. Fiscal separation from the General Fund was viewed as particularly important for maintaining transparency, public accountability, and confidence that health care financing revenues would be adequate to support the state's commitment to universal care.

The trust fund would support payment of health care claims, provider reimbursements, administrative operations, reserve requirements, contracted services, and other expenditures associated with operation of the universal health plan. Federal funding streams associated with Medicaid, Affordable Care Act programs, Medicare, and other coordinated federal health financing mechanisms would also be integrated into the trust structure to the extent permitted under federal law and program requirements.

Administration of a statewide health plan requires substantial reserve capacity to maintain continuity of operations during periods of economic volatility, utilization changes, or temporary funding disruption. As discussed in the financing section of this report, the proposed framework assumes maintenance of operating reserves sufficient to support solvency and payment continuity. The trust fund structure is intended to support accumulation, management, and protection of these reserves over time.

The proposed framework contemplates that the governing board of the public corporation would adopt financial policies governing reserve targets, solvency protections, investment practices, reporting requirements, and corrective actions in the event reserves fall below established thresholds. While the Legislature would establish the overarching statutory framework for the trust fund, ongoing financial management requires operational flexibility and technical oversight that are more appropriately administered through board policy and rulemaking processes.

The Board additionally considered the importance of centralized fiscal accountability. Under the proposed structure, the trust fund would operate as a unified statewide financing mechanism rather than a collection of separate regional reserves or independently managed funding pools. Centralized reserve management and financing authority would improve fiscal stability, reduce duplication, and allow more equitable distribution of resources across the state while maintaining statewide accountability for cost control and financial stewardship. At the same time, the creation of a dedicated trust structure carries significant governance responsibilities. The proposed framework therefore assumes ongoing auditing, public reporting, legislative oversight, and financial transparency requirements consistent with administration of a large public financing entity.

The creation of a Universal Health Plan Trust Fund is intended to create a stable and transparent financial foundation capable of supporting long-term operation of a statewide universal health plan while preserving fiscal accountability, reserve protection, and operational continuity over time.

ADMINISTRATIVE AND OPERATIONAL MODEL

The Board proposes a centralized administrative model in which the public corporation holds primary responsibility for financing, payment, policy implementation, data systems, and overall operational oversight of the universal health plan. The Board concluded that centralized administration is necessary to support statewide consistency, fiscal accountability, uniform standards, and administrative simplification while reducing fragmentation associated with the current multi-payer environment.

At the same time, the proposed framework recognizes that regional input is invaluable to ensure equity across differently positioned participants and broad public engagement. The operational model therefore combines centralized financing and policy authority with regional structures responsible for local engagement, innovation, health resource planning, and community accountability.

Under the proposed framework, the central office of the public corporation would maintain primary responsibility for:

- Administration of the Universal Health Plan Trust Fund;
- Provider payment systems and methodologies;
- Claims and payment oversight;
- Statewide data collection and reporting systems;
- Quality measurement and accountability structures;
- Eligibility and enrollment standards;
- Promulgation of administrative rules and policies;
- Contracting and procurement;
- Federal waiver coordination and compliance; and
- Overall fiscal and operational oversight of the universal health plan.

The Board concluded that these functions require centralized administration to maintain statewide consistency and avoid the duplication, payment variation, and administrative complexity that characterize the current fragmented health care system. The proposed model assumes that core financing, payment, and policy functions would operate uniformly across the state regardless of region.

Regional offices would function as operational components of the public corporation rather than independently contracted entities or separate risk-bearing organizations. The Board specifically rejected a model in which regional organizations independently administer financing risk or maintain separate payment structures. Instead, regional offices are intended to support local responsiveness within a unified statewide administrative framework.

Under the proposed structure, regional offices would focus primarily on:

- Provider and community engagement;
- Regional health planning;
- Workforce and resource assessment;
- Local innovation initiatives;
- Coordination with public health and community organizations;
- Quality and care coordination support; and
- Communication between local communities and the statewide public corporation.

The Board concluded that regional structures are necessary to ensure that a statewide universal health plan remains responsive to differences in geography, workforce capacity, population health needs, and existing care infrastructure across Oregon communities. At the same time, maintaining regional offices within the public corporation structure preserves centralized fiscal

accountability, avoids duplicative reserve requirements, and ensures uniform statewide standards for financing and provider payment.

The framework contemplates establishment of non-overlapping regions based, to the extent practicable, on existing health service patterns, public health infrastructure, and natural referral relationships. While the Board discussed a range of potential regional structures, preliminary operational discussions contemplated approximately five to nine regions statewide.
To support community accountability and local engagement, regional offices would also maintain advisory structures representing providers, plan participants, and community stakeholders. These advisory functions are intended to ensure that local operational concerns, resource needs, and innovation opportunities are communicated to the statewide public corporation and governing board.

Overall, the proposed operational model seeks to balance centralized statewide administration with meaningful regional engagement and operational flexibility. This structure provides the strongest opportunity to improve administrative consistency, support long-term fiscal accountability, and reduce fragmentation while remaining responsive to the needs of Oregon communities over time.

Importantly, this centralized administrative model does not require the public corporation to internalize every technical or administrative function at launch. Implementation of a statewide universal health plan will likely require substantial operational development over time, and the Board did not foreclose the use of contracted third-party support arrangements where necessary to support implementation, continuity of operations, or specialized administrative capacity. Such functions may include claims administration, information technology infrastructure, payment processing, customer service operations, enrollment systems, and other technical administrative services.

Allowing for phased operational development is both operationally realistic and financially prudent. Under this approach, the public corporation would retain ultimate responsibility for financing, policy direction, oversight, and accountability, while using contracted support where appropriate as it develops long-term internal capacity.

INFORMATION TECHNOLOGY AND DATA INFRASTRUCTURE

PROVIDER PAYMENT & DELIVERY SYSTEM STRATEGY

Provider payment methodology is one of the most significant operational and policy components of a universal health plan. Payment systems influence not only total system expenditures, but also provider stability, workforce development, access to care, care coordination, service utilization, and long-term health system behavior.

Oregon's current provider payment environment is highly fragmented. Providers operate across numerous payment systems with differing fee schedules, reimbursement methodologies, billing requirements, quality programs, prior authorization standards, and reporting obligations. This

fragmentation contributes to administrative burden, financial instability, and misalignment between payment incentives and broader population health goals.

The universal health plan will implement a unified provider payment system designed to promote cost control, administrative simplicity, equitable access, and workforce stability. The plan will pay providers and provider organizations directly through a combination of prospective and value-based payment methodologies tailored to care setting and service type.

Payment policy will be established in statute at a framework level, with the public corporation authorized through rulemaking to administratively set, update, and adjust payment rates and methodologies on behalf of the universal health plan. This approach aligns with existing public programs such as Medicare and Medicaid and enables timely adjustments to maintain fiscal sustainability and system performance.

In exercising this authority, the public corporation will be required to:

- Ensure adequate provider participation and access to care
- Maintain transparency in rate-setting methodologies and decisions
- Align payment levels with available plan revenues and trust fund sustainability

Regional entities will serve advisory and implementation support roles and will not independently set payment rates or benefit structures.

During initial implementation, the public corporation may utilize a third-party administrator (TPA) to support claims processing, payment administration, and certain operational functions. Contracts with providers will remain with the public corporation, with the TPA operating in a delegated administrative capacity. Over time, administrative functions may be transitioned, consolidated, or modified as system capabilities mature.

Hospital Payment

The Board proposes that hospital payment under the universal health plan utilize a global budgeting framework designed to improve financial predictability, reduce administrative complexity, and support long-term system sustainability. Global budgets are a prospective, predetermined payment amount that is paid to a provider based on historical spending, typically updated on an annual basis to account for population changes and inflation.

Under the proposed approach, hospitals would receive prospectively established global budgets intended to support provision of covered services for defined populations or service areas rather than relying primarily on fee-for-service reimbursement tied to individual claims volume. A global budgeting structure may provide several advantages over the current system, including:

- Greater financial stability for hospitals;
- Reduced incentives for unnecessary utilization growth;
- Improved ability to support rural and safety-net facilities;
- Simplified administrative and billing processes; and
- Greater alignment between financing and population health goals.

The global budget would cover inpatient, outpatient, and physician services rendered at acute care hospitals, and account for approximately 70 percent of hospital total payments. The remaining 30 percent would consist of activity-based (i.e. fee-for-service / DRG) reimbursement as well as quality and performance payment.

Critical access hospitals would also be paid under global budgets; however, their reimbursement may reflect a greater portion of reasonable costs in acknowledgement of their essential role in keeping hospital services available. Other factors recommended for inclusion in the global budgeting methodology include:

- Patient acuity and complexity;
- Regional and rural access needs;
- Essential community services;
- Teaching and specialty functions; and
- Broader population health and socioeconomic factors.

To smooth provider adoption, the Board recommends a phased approach over three to five years, in which the proportion of payment included in the global budget is steadily increased. Global budgets will be structured to support hospital financial stability while advancing system-wide goals of reduced avoidable utilization and improved population health.

Primary Care

The Board repeatedly identified inadequate investment in primary care as a major contributor to fragmentation, delayed treatment, avoidable emergency utilization, and workforce strain within the current health system. As a result, the proposed payment structure prioritizes investment in primary care services and integration of primary care.

Primary care payment under a universal health plan would be based on the Primary Care Value-Based Payment model as developed by the Primary Care Payment Reform Collaborative. Under this model primary care would be reimbursed via four value-based components:

1. Prospective capitated payments for a defined set of primary care services that are widely performed by primary care practices, represent a preponderance of primary care spending, and could potentially be overutilized in the traditional model of fee-for-service;
2. Fee-for-service payments for all other covered services such as prenatal visits, end of life and advanced care planning, home visits and after-hours care;
3. Infrastructure per-member-per-month payments that include: 1) a base payment tied to PCPCH tier, and 2) additional payments for specific high-value services (including advanced care coordination and management efforts); and
4. Performance-based incentive payments based on an aligned set of quality measures.

Under the universal health plan, primary care funding will be treated as a foundational system investment. Payment levels for primary care will be designed to support access, workforce stability, and care transformation, and will be protected from disproportionate reductions in response to short-term fiscal pressures. Annually 15 percent of universal health plan expenditures

will be allocated exclusively for primary care that prioritizes routine well-care and reduces utilization of more costly services. The 15 percent target builds on Oregon's existing primary care spending policy framework, including the 12 percent primary care expenditure requirement for Coordinated Care Organizations and statewide reporting of primary care spending across major payers. Recent Oregon data also show that Medicaid primary care spending reached 15 percent of expenditures, indicating that this target is achievable while advancing the state's broader cost growth and care transformation goals.

Specialty and Other Provider Payment

Specialty care, behavioral health, oral health, pharmacy services, and other provider sectors play critical roles within the broader health system and require payment methodologies capable of supporting access, quality, and long-term workforce sustainability. Specialty care payment reform under a universal health plan should be guided by several core principles:

- Maintain access to specialty services across geographic regions and populations;
- Reduce administrative burden and payment fragmentation across payers;
- Promote financial stability and predictability for providers and health systems;
- Avoid incentives that reward unnecessary volume or intensity of services;
- Support integration between primary, specialty, behavioral health, and hospital care;
- Preserve flexibility to address workforce shortages and regional access disparities;
- Align payment methodologies with quality, outcomes, and long-term system sustainability; and
- Allow phased implementation and adaptation over time as operational capacity and data systems mature.

No single specialty payment methodology is appropriate across all specialties, provider types, or care settings. As a result, implementation may require a combination of payment approaches, including fee-for-service, prospective payment, bundled payment, global budgeting, or other alternative payment methodologies depending on the characteristics of the specialty, provider market, and population served.

Quality and Performance Alignment

The public corporation will establish and maintain a statewide quality strategy to support accountability, transparency, and continuous improvement across the delivery system. Payment models may incorporate a limited set of standardized performance measures, with an emphasis on minimizing administrative burden and aligning with existing data systems where possible. More information regarding the Board's recommendation regarding a quality strategy is located in the Appendix.

IV. COST CONTAINMENT

The long-term affordability of a universal health plan will require active management of health care cost growth across multiple parts of the health system. In this section, cost containment refers to strategies intended to moderate long-term cost growth while maintaining access to medically necessary care, supporting provider and workforce stability, reducing unnecessary administrative burden, and improving system accountability.

The Board did not identify any single cost-containment mechanism as sufficient. Instead, the Board recommends a layered strategy across system-level, provider payment and delivery-level, and pharmaceutical domains. These strategies should be treated as implementation priorities and ongoing management tools, rather than as guaranteed savings assumptions.

The Board's approach was guided by the following principles:

- Cost-containment strategies should operate across system, provider, and pharmaceutical domains;
- Strategies should prioritize high-impact approaches that improve upon the current system while minimizing unnecessary new administrative burden;
- Near-term operational improvements and long-term structural reforms should reinforce one another; and
- Cost-containment efforts should support continuity of care, equitable access, provider stability, and long-term system sustainability.

Traditional cost-containment approaches often rely heavily on shifting costs or administrative burden to patients through deductibles, cost sharing, prior authorization requirements, step therapy, or other utilization barriers. While these approaches may reduce expenditures in some circumstances, they can also create equity concerns, delay necessary care, increase administrative complexity, and contribute to unintended negative patient outcomes. Accordingly, the Board's proposed approach prioritizes structural and system-level reforms intended to better align incentives, simplify administration, and improve long-term sustainability.

SYSTEM-LEVEL STRATEGIES

Oregon has already established foundational infrastructure for monitoring and accountability, including the health care cost growth benchmark program, All Payer All Claims reporting infrastructure, the Prescription Drug Affordability Board, and related transparency initiatives. The Board recommends building on these systems rather than creating new oversight structures where current infrastructure can be strengthened or adapted.

System-level strategies may include:

- Monitoring health care cost growth relative to economic indicators;
- Reducing duplicative administrative processes;
- Strengthening fraud prevention, waste reduction, and redundancy elimination;
- Consolidating purchasing for pharmaceuticals, durable medical equipment, implantable devices, and other high-cost products or services where feasible;

- Standardizing administrative processes where appropriate; and
- Developing statewide data and accountability infrastructure to support ongoing oversight.

Administrative simplification should be understood as a cost-containment strategy in its own right. Oregon's current multi-payer environment requires providers, employers, and patients to navigate substantial variation in billing systems, prior authorization requirements, network rules, payment methodologies, and reporting obligations. Reducing fragmentation and standardizing administrative processes may improve efficiency while reducing costs associated with payer complexity. Additional staff analysis on administrative burden and potential simplification strategies is included in the Appendix.

PROVIDER PAYMENT AND DELIVERY SYSTEM STRATEGIES

Provider payment structures strongly influence utilization patterns, delivery system behavior, and long-term expenditure growth. The Board recommends continued development of payment approaches that align financing, quality, access, and sustainability.

Provider-focused strategies may include:

- Global budgeting methodologies for hospitals and other institutional providers;
- Standardized or simplified payment methodologies where operationally appropriate;
- Streamlined administrative requirements for providers;
- Strengthened investment in primary care and behavioral health;
- Evidence-informed standards of care;
- Processes for moderating excessive price growth; and
- Long-term evaluation of fee schedule or rate-setting approaches where feasible.

Provider stability remains an essential implementation consideration. Cost containment efforts should balance expenditure management with access to care, workforce sustainability, and the financial viability of providers serving rural, underserved, or otherwise vulnerable communities.

PHARMACEUTICAL COST CONTAINMENT

Prescription drug spending is a major cost-growth driver and involves significant pricing complexity, limited transparency, and multiple intermediary entities, including pharmacy benefit managers, manufacturers, pharmacies, wholesalers, and payers. The Board recommends continued development of a pharmaceutical strategy focused on affordability, transparency, and long-term sustainability while maintaining access to medically necessary medications.

Pharmaceutical strategies may include:

- Consolidated pharmaceutical purchasing;
- Development of a statewide formulary structure;
- Prioritization of generic and biosimilar utilization where clinically appropriate;
- Strategies to address manufacturer steering toward higher-cost brand-name drugs;
- Enhanced transparency and accountability standards for pharmacy benefit managers;
- Coordination with the Prescription Drug Affordability Board;

- Evaluation of upper payment limit authority and related affordability mechanisms; and
- Long-term approaches related to specialty pharmaceuticals and other high-cost medications.

IMPLEMENTATION AND MONITORING

Because cost containment outcomes will depend on final program design, federal coordination, provider participation, market behavior, utilization patterns, and implementation timing, the Board does not assume that these strategies will produce fixed or guaranteed savings. Instead, the public corporation should be authorized and expected to monitor cost growth, evaluate the impact of adopted strategies, publicly report on performance, and refine approaches over time.

Cost containment should therefore be understood as an ongoing governance and operational responsibility of the universal health plan, not as a one-time financing adjustment. Successful implementation will require continued monitoring, public transparency, policy refinement, and corrective action as Oregon's health care system evolves.

V. IMPLEMENTATION PATHWAYS

Implementation sequencing refers to the order and approach through which Oregon would transition from the current multi-payer environment to a universal health plan. While the Board has defined a proposed end-state for the universal health plan, implementation sequencing determines how and when populations transition into that structure.

Approximately 52.5% of Oregon residents currently receive primary coverage through populations that may be more directly reachable through state legislation or state-governed implementation mechanisms, including public employees, employer-sponsored insurance, uninsured populations, and other state-governed coverage arrangements. Employer-sponsored coverage would still require careful implementation design due to federal ERISA constraints and private employer behavior.

Approximately 47.5% of residents receive primary coverage through programs requiring federal approvals, federal participation, or authorities outside direct state control, including Medicare, Medicaid, Marketplace subsidies, Federal Employee Health Benefits, and other federally administered programs. As a result, implementation sequencing involves balancing two competing goals: maximizing administrative simplification through payer consolidation while maintaining an implementation pathway substantially within Oregon's ability to execute.

Administrative complexity also differs across market segments. While federally financed populations represent a substantial share of covered lives, commercial coverage currently drives much of the variation in plan design, prior authorization requirements, network rules, and billing workflows. As a result, significant provider administrative simplification may be achievable prior to full federal integration, though maximum simplification is not realized until most major coverage populations participate. Estimated administrative simplification ranges from approximately 85-90% under a non-federal transition to approximately 98% under near-complete payer integration.

The Transition Committee also considered a service phase-in model under which all Oregon residents would receive a limited set of benefits (for example, primary care) prior to broader implementation. This approach was not recommended due to concerns regarding fragmentation of care, multiple coverage arrangements, and limited ability to realize broader system simplification benefits.

Three implementation approaches were explored, outlined in detail below.

POPULATION PHASE-IN

Under a population phase-in approach, the universal health plan would launch for populations more directly reachable through state legislation and expand over time as federal approvals and participation pathways become available. Phase 1 would include non-federal populations, Phase 2 would incorporate Phase 2 would incorporate Medicaid, CHIP, and Marketplace populations requiring federal approval or subsidy pass-through arrangements, and Phase 3 would incorporate

Medicare and remaining federally governed populations. This approach reaches approximately 55% of residents in Phase 1, 82% in Phase 2, and 99% following federal integration.

Potential advantages include faster implementation timelines, reduced dependence on uncertain federal approvals, lower initial reserve requirements, operational scalability, earlier relief for populations experiencing rising commercial costs, and the opportunity to demonstrate administrative and operational proof of concept before pursuing broader federal participation. This model also allows financing, enrollment systems, provider onboarding, and administrative functions to mature over time.

Potential disadvantages include prolonged operation within a multi-payer environment, reduced ability to immediately influence statewide payment dynamics, delayed realization of full provider simplification, and equity concerns where residents transition at different times while financing mechanisms may begin earlier than benefit receipt. This approach may also require ongoing communication regarding eligibility, expectations, and timing across implementation phases.

HYBRID PHASE-IN

Under a hybrid approach, the universal health plan would launch once all populations with existing approval pathways are included, combining non-federal populations with Medicaid, CHIP, and Marketplace populations. Remaining populations without existing pathways, primarily Medicare and certain federal programs, would transition later. This approach reaches approximately 82% of residents at launch while preserving a pathway for later federal integration.

Potential advantages include greater immediate administrative simplification, stronger ability to influence provider payment dynamics, and broader population participation at launch while continuing to operate within known approval authorities. This model may better support payment normalization and create earlier opportunities for system-wide provider simplification. Potential disadvantages include longer implementation timelines than population phase-in, continued dependence on successful federal approvals for Medicaid and Marketplace populations, larger initial reserve and operational requirements, and greater transition complexity at launch. This approach also creates risk if anticipated approval timelines change.

SIMULTANEOUS TRANSITION

Under a simultaneous transition approach, all major populations would transition into the universal health plan at launch. Implementation would be contingent upon obtaining all required federal approvals and developing operational capacity sufficient to support statewide transition. Potential advantages include maximum administrative simplification, immediate alignment of payment systems and provider incentives, earlier realization of economies of scale, and the clearest transition experience for residents and providers.

Potential disadvantages include the highest dependence on federal approvals, including authorities for which no established pathway currently exists, the greatest upfront reserve and

implementation requirements, and elevated operational risk associated with simultaneous statewide transition. This approach may also delay implementation substantially if approvals or financing conditions change. Transition Committee discussion referenced Vermont's experience as a caution regarding prolonged implementation timelines, unresolved federal coordination, and reliance on uncertain federal pathways.

BOARD DISCUSSION

The Board elected to not provide a formal recommendation regarding implementation sequencing, acknowledging the importance of public and legislative feedback. However, Board discussion reflected greater interest in population phase-in and hybrid approaches than in a simultaneous transition. Members generally recognized that simultaneous transition would offer the greatest administrative simplification in theory, but raised concerns that reliance on multiple federal approvals, including approvals for populations without established integration pathways, could substantially delay or prevent implementation.

Members who expressed interest in a population phase-in approach emphasized the ability to begin implementation sooner, provide earlier relief to uninsured and underinsured residents and those facing rising commercial coverage costs, and demonstrate operational proof of concept before pursuing broader federal integration. Discussion also noted that a phased approach could allow the state to build operational capacity over time while continuing to seek Medicaid, Medicare, and other federal participation pathways.

Members also identified concerns with population phase-in. These included the risk of prolonged multi-payer complexity, inequities between populations that transition at different times, public communication challenges, and financing concerns if some residents are asked to contribute before receiving universal health plan coverage. Members specifically raised concerns regarding Medicare beneficiaries paying into a plan before they are eligible to receive benefits and discussed the possibility that Medicare-covered populations could be excluded from certain financing requirements until they are incorporated into the universal health plan.

Board discussion also reflected interest in a hybrid approach that would launch the universal health plan with non-federal populations and populations with existing federal approval pathways, including Medicaid, CHIP, and Marketplace populations. Members noted that this approach could reduce the risk of creating separate systems for Medicaid and non-Medicaid populations and could produce broader administrative simplification at launch. At the same time, members recognized that this approach would require successful federal approvals and could lengthen the implementation timeline compared with a population phase-in.

A key unresolved issue identified during Board discussion was whether and how Medicaid populations could be aligned with the universal health plan prior to obtaining new federal approvals. An option raised was an implementation approach between the population phase-in and hybrid, in which a universal health plan launches for non-federal populations while maximizing administrative alignment with current Medicaid and Marketplace requirements.

Staff technical analysis of implementation sequencing is included in Appendix. That analysis identifies population phase-in as a technically feasible pathway for further planning under current legal and operational constraints, while recognizing that additional Board, legislative, federal, and public engagement is required before selecting an implementation sequence.

Also in the Appendix related to this topic are the Oregon Health Authority's reports on federal authorities and system readiness.

VI. RISKS & TRADEOFFS

Implementation of a statewide universal health plan would be a significant undertaking requiring major changes to Oregon's health care financing, administration, provider payment, enrollment, and public accountability structures. The proposed model would operate within a complex federal and economic environment, and many implementation details would require additional legislative direction, federal coordination, operational planning, and ongoing public oversight. The Board recognizes that no implementation pathway eliminates risk or resolves every tradeoff in advance.

At the same time, maintaining the current system also carries substantial and growing risk. Oregon's existing health care system continues to experience rising costs, administrative fragmentation, affordability pressures, provider instability, and uneven access to care. The central question before the state is therefore not whether reform involves risk, but whether Oregon can manage the risks of transition more effectively than the risks of continued fragmentation, cost growth, and instability under the current system. This section summarizes the major cross-cutting risks and tradeoffs identified across the proposed model and identifies areas requiring further analysis, implementation planning, or legislative decision-making.

RISK OF MAINTAINING STATUS QUO

The risks of implementing a universal health plan must be evaluated against the risks of maintaining Oregon's current health care financing and coverage structure. The current system is not stable or cost-neutral. Premiums, deductibles, and out-of-pocket costs continue to rise for households and employers, while coverage remains tied to employment, income, age, program eligibility, and federal policy. In Oregon, final approved 2026 rate increases averaged 9.7 percent in the individual market and 11.5 percent in the small group market.[2] Nationally, employer-sponsored family coverage reached nearly $27,000 annually in 2025, with average family premiums increasing 6 percent in one year.[3]

Affordability pressures are especially acute for individuals who purchase coverage through the Marketplace. Following expiration of enhanced federal premium tax credits, KFF reported sharp increases in Marketplace premium payments, declining plan selections, and movement into higher-deductible coverage. Average monthly premium payments rose 58 percent from 2025 to 2026, while average Marketplace deductibles increased 37 percent to a record high.[4] KFF also reported that 9 percent of 2025 Marketplace enrollees were uninsured in early 2026, and one in six returning enrollees were not confident they could afford premiums for the full year.[5] These trends indicate that nominal coverage availability does not ensure affordable or continuous coverage.

[2] https://apps.oregon.gov/oregon-newsroom/OR/DCBS/Posts/Post/2026-health-insurance-rates
[3] /https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey-Summary-of-Findings.pdf
[4] https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/
[5] https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/

Employer-sponsored insurance also does not fully protect households from financial exposure. KFF found that 88 percent of covered workers in employer plans had a general annual deductible in 2025, and 34 percent of covered workers were enrolled in plans with a deductible of at least $2,000 for single coverage.[6] One-third of covered workers were enrolled in a high-deductible plan with a savings option. At the same time, among small firms not offering health benefits, the most common reason cited was that the cost of insurance was too high.[7] These trends increase the risk that coverage will become less protective over time, even for individuals who remain insured.

Maintaining the current system therefore carries substantial fiscal, equity, and access risks. Rising premiums and deductibles increase medical debt, delayed care, and household financial insecurity. Continued fragmentation preserves administrative burden for providers and employers, weakens statewide cost-control capacity, and leaves Oregon vulnerable to federal subsidy changes and insurance market volatility. The choice before the state is not whether to accept risk, but whether to continue absorbing the compounding risks of the current system or pursue a managed transition toward a more stable, equitable, and accountable financing structure.

RISK OF IMPLEMENTING A UNIVERSAL HEALTH PLAN

Federal Authorities

A significant implementation risk is that Oregon does not control all health care financing and coverage authorities needed to fully consolidate the current system. Medicaid, Marketplace subsidies, Medicare, FEHB, TRICARE, Veterans Affairs coverage, and certain employer-sponsored arrangements operate under federal law or federal administration, and some have limited or uncertain pathways for integration into a state-administered universal health plan. This creates risk that federal approval timelines, waiver conditions, agency interpretation, congressional action, or future federal policy changes could delay implementation, limit the scope of integration, or affect projected financing. The proposed model mitigates this risk by preserving existing federal funding streams wherever possible, coordinating with federal programs rather than assuming immediate displacement, and considering phased implementation pathways that allow Oregon to begin with populations and authorities more directly within state control while continuing to pursue federal approvals over time.

The remaining unresolved question is not whether federal coordination will be required, but how quickly and under what conditions federal populations and funding streams can be incorporated into the universal health plan. For that reason, the implementation analysis supports continued planning around phased or hybrid pathways rather than making launch contingent on full federal integration at the outset.

Financing Transition

[6] https://www.kff.org/health-costs/2025-employer-health-benefits-survey/
[7] https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/

A second implementation risk is the financing transition required to move from today's fragmented and often hidden health care spending to a more transparent public financing structure. Under the current system, households and employers already pay substantial health care costs through premiums, employee contributions, deductibles, cost sharing, forgone wages, and business expenses, but those costs are distributed across multiple private and public mechanisms. A universal health plan would make more of these costs visible through taxes or other public revenue mechanisms, creating political and public trust risks even where new revenues replace existing private spending. The proposed financing model mitigates this risk by using multiple broad-based revenue sources, emphasizing progressive contribution structures, dedicating revenues to a Universal Health Plan Trust Fund, and clearly distinguishing replacement financing from new system spending. However, the transition would not be distributionally neutral. Some households and employers would contribute more than they do today, while others would contribute less or experience reduced financial exposure. Future legislative work will need to refine contribution structures, transition timing, protections for disproportionately affected groups, and public communication so that the financing model is understood as a redistribution and consolidation of existing health care spending, not simply as a new tax burden.

Employer Behavior

A related implementation risk concerns employer participation and migration to the universal health plan, particularly for self-funded employers protected by ERISA. Because Oregon cannot directly require employer-sponsored health plans to terminate or restructure coverage, some employers may continue existing coverage arrangements even after the universal health plan becomes available. Slower-than-expected employer migration would prolong multi-payer complexity, reduce near-term administrative simplification for providers, and require continued coordination between the universal health plan and employer-sponsored coverage. This risk is especially significant for large, multi-state, or self-funded employers that may have less incentive or ability to align with an Oregon-specific coverage model. The proposed model mitigates this risk by designing the universal health plan as a lower-cost, lower-burden alternative to separate employer coverage while preserving legal durability by avoiding direct regulation of ERISA plans. However, the degree of employer migration remains unresolved. Consistent with the Board's recommendation, future implementation work should include targeted employer engagement and survey research, further analysis of self-funded employer behavior, and legislative decisions regarding whether the universal health plan should operate as primary or secondary coverage where employer-sponsored insurance remains in place.

Provider Payment & Access

Provider payment and access present another key consideration. A universal health plan would require major changes to payment methodologies, rate-setting, billing processes, administrative requirements, and provider contracting. These changes may face resistance from providers and health systems, particularly where standardized payment rates, global budgets, or reduced administrative variation affect existing revenue expectations or business models. At the same time, Oregon's provider system includes hospitals, rural providers, safety-net organizations, behavioral health providers, and primary care practices operating under workforce shortages and

narrow financial margins, making transition planning critical to maintaining access. The proposed model mitigates this risk by recommending phased implementation of hospital global budgets, protecting primary care investment, allowing payment methodologies to vary by provider type and service category, and using the public corporation's rulemaking authority to adjust rates and methods over time. However, implementation will require continued provider engagement, transparent rate-setting, transition support for financially vulnerable providers, and ongoing monitoring of workforce capacity, provider participation, regional access, and continuity of care.

Administrative Capacity

Operational execution and administrative capacity present an additional implementation risk. A universal health plan would require Oregon to establish or oversee large-scale functions including eligibility and enrollment, claims administration, provider contracting, payment operations, customer service, data infrastructure, procurement, compliance, financial management, and reserve administration. Delays or failures in any of these areas could disrupt coverage, provider payment, public confidence, and legislative support. The proposed model mitigates this risk by establishing a public corporation with centralized responsibility for core financing, payment, policy, and operational oversight; authorizing use of contracted third-party support where needed during implementation; and creating a dedicated trust fund and reserve structure to support operational continuity. However, successful implementation will require detailed operational planning, realistic launch timelines, strong vendor oversight, staged system development, workforce recruitment, contingency planning, and ongoing public reporting to ensure that administrative capacity grows at the pace required to support statewide coverage.

CONCLUSION

Taken together, these risks demonstrate that implementation of a universal health plan would require sustained legislative, administrative, federal, provider, employer, and public engagement. They also demonstrate why continued planning is warranted. The current system is already placing growing pressure on households that cannot afford premiums, deductibles, or medical debt; on employers facing rising benefit costs; and on providers operating under thin margins, workforce shortages, and administrative burden. Moving to a universal health plan would not eliminate these pressures immediately and would introduce significant transition challenges. However, maintaining the current system is also a policy choice, with its own fiscal, equity, access, and stability consequences. The Board's proposed model therefore should be understood as a framework for managing transition risk while addressing the increasing risks of affordability, fragmentation, and instability under the status quo.

VII. LEGISLATIVE ACTION & NEXT STEPS

The recommendations in this report provide a framework for continued legislative and implementation planning. Establishing a universal health plan will require additional policy development, fiscal analysis, federal engagement, operational design, and public input before launch. This section identifies the major next steps needed to move from the Board's proposed model toward an implementation blueprint and legislative package for consideration by the Legislative Assembly.

The Board recommends that the Legislative Assembly treat the next phase as an implementation-development phase rather than a continuation of preliminary study. Oregon has sufficient information to define the proposed direction of a universal health plan, but additional work is necessary to translate that direction into operationally sound, fiscally responsible, and publicly accountable legislation. A Phase 2 implementation blueprint should therefore focus on the decisions, analyses, public engagement, and statutory changes necessary to determine when and how Oregon can move from plan development to implementation.

Step 1: Authorize a Phase 2 Implementation Blueprint

- Direct the Board to build on this comprehensive plan and develop recommendations related to:
  - Financing options and revenue mechanisms;
  - Governance, administration, and institutional design;
  - Health care delivery system capacity, infrastructure, and geographic access;
  - Workforce availability, shortages, and transition considerations;
  - Operational and administrative readiness, including claims administration, enrollment systems, data infrastructure, contracting, procurement, and governance capacity;
  - Federal coordination, including Medicaid, Medicare, Marketplace subsidies, ERISA, waiver pathways, and federal fiscal risk;
  - Employer and labor market analysis;
  - Public engagement and communications strategy;
  - Statutory and regulatory changes necessary to support implementation; and
  - Proposed legislation necessary to implement a universal health plan.

Step 2: Advance Framework Legislation

- Enact framework legislation establishing the legal structure, governing authorities, institutional design, and guiding principles a statewide universal health plan.

Step 3: Continue Development of the Revenue Plan

- Direct additional fiscal and actuarial analysis of projected expenditures, revenue requirements, reserve needs, and long-term sustainability.
- Refine revenue mechanisms, tax base definitions, thresholds, credits, exemptions, and implementation timing.
- Evaluate distributional impacts across households, employers, workers, businesses, and regions.

- Conduct statewide economic impact analysis including effects on Oregon households, employers, workers, wages, and the statewide economy.

Step 4: Develop a Formal Transition Plan

- Develop a detailed transition plan addressing sequencing, enrollment, provider participation, claims administration, data systems, appeals, contracting, and member communications.
- Identify which populations and programs can be integrated under existing authority and which require federal approval or further statutory action.
- Establish transition protections for patients, providers, rural communities, collectively bargained arrangements, and populations remaining temporarily connected to federal or employer-sponsored coverage.
- Identify startup costs, staffing needs, procurement requirements, information technology needs, and operational milestones.

Step 5: Conduct a Formal Public Engagement Process

- Conduct statewide public engagement to assess public understanding, concerns, implementation considerations, and anticipated participation.
- Provide accessible public information explaining major design choices, tradeoffs, financing implications, and implementation timelines.
- Engage communities most affected by coverage instability, medical debt, access barriers, administrative burden, and provider shortages.
- Include targeted engagement with rural communities, Tribal governments and Tribal communities, communities of color, immigrant communities, people with disabilities, behavioral health stakeholders, labor organizations, small businesses, providers, and safety-net institutions.
- Use public engagement findings to refine implementation sequencing, communication strategies, enrollment processes, and transition protections.

Step 6: Return to the Legislature with an Implementation Package

- Submit an implementation blueprint and recommended legislative package by a date certain.
- Identify key legislative decision points, including financing, implementation sequencing, federal dependency, governance authority, and transition protections.
- Include recommended statutory changes, revenue legislation, implementation plan, fiscal estimates, administrative authorities, transition protections, and accountability mechanisms.