

To: Members of the Universal Health Plan Governance Board

From: Michelle Glass, Chair, Legislative Report Workgroup

Date: September 10, 2026

Subject: UHPGB Report Draft

Dear Board members,

The workgroup is sending you a working draft of the report to the Legislature, using the July 8, 2026, staff report draft at its base. Our approach to redrafting has been based on Board member written feedback to staff in July, Board direction from the July and August Board meeting discussions, and the letter from Senators Patterson, Manning, and Reynolds and Representatives Nosse, Nelson, and Tran asking for:

- Information about benefit design and payment structures.
- Information about plan governance and administration.
- Identification of one or more financing models that the Legislature may consider.
- Description of a suggested implementation framework, including legislative actions that would be necessary to implement a Universal Health Plan.

New content: the 4 revenue model options sent out last week are in this draft and the Information Technology and Data Infrastructure section has been drafted instead of being an empty header. These add to the overall report length.

What we focused on

1. **Frame the revenue section as options, not a final recommendation.** The draft describes the work that has been accomplished and the options that have been analyzed while making it clear that it is not recommending a single financing and revenue plan for UHP in Oregon.
2. **Write so a person can read it once.** The report has been re-written in plain language using the messaging and style guides developed by CECC. Acronyms are defined the first time they appear and sentences that had to be read twice were split.
3. **Start from what the current system costs people now.** The plan is a restructuring of money Oregon already spends in fragmented and hidden ways, not a new cost stacked on top of the old one. The draft works to benchmark from the current status quo.
4. **Be positive and forward looking.** The workgroup worked to balance a tone that affirmed the feasibility of a UHP while being honest about what the board's analysis shows and what work still needs to be completed. Tentative or hedging language was dropped where the board's work supported it and was kept for things that are still being worked out.
5. **Keep the report focused and put the technical record in the appendices.** The Governor's office asked that the report be specific enough that others can build analysis on it. The legislature asked for specific sections. Legislators asked for 4 specific components.

Our approach has been to focus on a readable body, and we are looking for Board direction of what else might move to appendices to make the report shorter.

Crosswalk: what we heard and what changed

What we heard	Where you will see it in the September 17 draft
Present the financing work as draft options, not a Board recommendation. Nine responses said this in different words, and the Board affirmed it on August 20.	The F+R section now opens by stating that the Board has not adopted or recommended a single financing plan. The content is organized as five labeled revenue model options. Language describing future action reads as would rather than will, and the phrase proposed financing framework is gone.
Write plainly.	Every section was rewritten in plain language using the Board's messaging and style guides.
Tighten it up and stop repeating content.	The draft has been reviewed for repetition. The full process descriptions, consultant reports, and supporting spreadsheets will be in the appendices. A closing section called Where to Find More Details tells the reader what is in them.
Say clearly whether the plan costs more, less, or about the same as the status quo costs now, including what this looks like for businesses and for households below the median income.	What the Board Has Learned opens with key findings, including that the modeling projects lower total spending and that most households and most businesses would pay less. How Oregon Pays for Health Care Today makes the point that these revenue model options are replacement for current fragmented spending. What This Would Mean for Households and Businesses gives effective rates by income and the comparison for employers.
Show our work. Explain how we reached the revenue replacement target and add some simple comparisons of current costs to model option 1 costs by who pays.	Revenue Replacement Target: Table 1 walks step by step from \$85.5 billion in projected 2032 spending down to a target of \$30.2 to \$35.5 billion and says why 2032 is the base year. Table 2 sets out the five revenue mechanisms. Add a simple comparison of current costs to plan costs by who pays: Two draft figures are mocked up for your review: how the funding sources combine, and how a household's costs arrive today compared with Option 1.
Name the tension between broadening the tax base and the progressivity concerns raised in public comment.	This is described as a tradeoff rather than a settled design choice and why a proposed soft cap was dropped.
Describe how separating health coverage from employment would	A new part called Coverage That Belongs to the Person, Not the Job explains what changes for workers and employers.

What we heard	Where you will see it in the September 17 draft
benefit workers, and name it as a feature of the model.	
Answer the practical questions legislators and the public will ask how the ERISA decision gets made, out-of-state coverage, aggregate provider payment effects, and what happens to people on Medicare.	Administrative Structure covers legal authorities, ERISA, and provider payment, with more detail in an appendix. Proposed Model covers coverage outside Oregon. The finance section describes covering Medicare Part B premiums so people on Medicare do not pay twice.
Frame the moment as crisis and opportunity and move the voice from tentative to confident where the analysis supports it.	Risks and Tradeoffs leads with the cost of doing nothing using 2026 Oregon rate increases, Marketplace premium and deductible data, and examples of how this impacts Oregon families from our Board messaging guide.
Add a short summary for legislators who will not read the full report.	Planned and not yet drafted. The executive summary, a plain language question and answer companion for a general audience, and a press release will be written once the body of the report is settled so they describe the report you adopt.
Keep the numbers honest and make clear they may change.	Every figure appears as a best current estimate with a range, pending Legislative Revenue Office review. The section states that all revenue estimates are static and that dynamic analysis has not been done. What Remains to Be Done lists the work the Board is asking the Legislature to fund.

For Board Consideration and Direction

These items are open and would benefit from direction at the September 17 meeting.

1. **Dollar figures in the body.** Whether the revenue model options appear with dollar amounts, with percentages, or in narrative terms only. **A Board vote is requested.**
2. **Length of the report.** Due to the tight timeline, the workgroup has reviewed feedback and reviewed the July 8 staff draft report, identified an approach for re-drafting the report, and completed a first re-draft of that staff report using that approach. We did not have time to work on shortening the report or discuss what sections could be removed while still meeting legislative direction. **The workgroup would like clear guidance from the Board about length and level of detail for the final report, including what sections might be trimmed or moved to appendices.**
3. **Consider suggestion to rename HCPIT to Health Care Premium.** To make it clear that this is a restructuring of existing health care spending vs a new tax stacked on top of what people pay today. The current draft uses HCPIT pending a Board decision to change it.

4. **Option for additional Board meeting.** The workgroup has a scheduled remote meeting on October 1st from 8am – 9am. We are offering this as an additional Board meeting for reviewing an updated report draft ahead of an October 15th Board vote on the final report. **Does the Board want to make this an optional Board meeting for discussing the report and giving additional direction to the workgroup?**

Next steps

The target date for a Board vote on the report is the October 15th Board meeting.

That leaves four weeks for final editing before the Board vote in time to send to DCBS for formatting in time to make a December 1 submission to the legislature.

Your feedback: The workgroup will take back Board direction from the September 17 Board meeting to work through at our weekly meetings and welcomes feedback from individual Board members via email to Mimi. Please send written feedback by October 1st to give the workgroup time to address it by the materials deadline for the October 15th Board meeting.

With thanks

This draft has been improved by review and edits by many people beyond workgroup members. Thank you to Helen for coordination and reviewing drafts. Thanks Lee, and Mimi for technical review and workgroup support. Thank you to Richard Gibson and Charlie Swanson for reviewing the finance and revenue drafts. Thank you to members of the public who have joined workgroup meetings and to Linda Krygier for sending feedback on drafts.

With appreciation for your work on this,

Michelle Glass
Chair, Legislative Report Workgroup
Oregon Universal Health Plan Governance Board

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EXECUTIVE SUMMARY

This will be written after Board feedback at the September 17th Board meeting. The current proposal is to structure the executive summary around the four specific requests in the letter from legislators.

BOARD PROCESS AND DECISION FRAMEWORK

The Legislature created the Universal Health Plan Governance Board in 2023 with Senate Bill 1089 and charged it with designing a universal health plan for Oregon and reporting back to the Legislature. The Board's nine members were appointed by the Governor and confirmed by the Senate in early 2024. The Board organized its work into five committees, drew on actuarial modeling by Milliman, economic analysis by ECONorthwest, and policy analysis from Health Management Associates, and brought each committee's findings to the full Board to build one connected plan. The Appendix describes in more detail the Board's legal charge, its members, the committee structure and process, and the analysis behind the recommendations, including reports from Milliman, ECONorthwest and Health Management Associates.

Guiding Principles

Five guiding principles were consistently used by the Board and its committees to consider options and settle difficult tradeoffs as the plan was drafted. Some come directly from state law, shown by their citations to the Oregon Revised Statutes (ORS). Others are principles the Board adopted on its own.

- **Health Equity:** Health care is basic to a fair society. It should be secured for everyone on an equitable basis through public means, like public education, public safety, public libraries, fire safety, and other public infrastructure. (ORS 751.002(3)(a)(A))
- **Maximize Health:** The plan should improve the health of individuals, families, and communities, and give people satisfaction and a say in their own care. (ORS 751.002(2)(a))
- **Fair Distribution of Medical Resources:** Medical resources should be shared fairly across the state. This is both a requirement in ORS Chapter 751 and an overarching commitment of the Board.
- **Minimize Financial Hardship for Individuals and Families from Medical Costs:** People should be protected from the financial harm that illness can bring, and cost should never stop someone from getting care. (ORS 751.002(2)(c) and 751.002(2)(e))

- **Community Sense of Ownership and Governance:** When a policy or program will directly and closely affect a community, that community should have a voice in the final decisions.

Community Input

The Board heard from people across Oregon throughout its work. Anyone could give public comment at Board and committee meetings, and written comment was accepted at any time. In spring 2026 the Board also held twelve focused engagement sessions with community members. What people shared helped the Board understand the barriers to getting care, the strain of costs, and the risks of putting a new plan in place. The Board weighed this input alongside its technical and financial analysis in shaping its recommendations.

Between April 2024 and April 2026, the Board and its committees received 385 public comments across 108 public meetings. Most came in writing, and the rest were spoken as testimony at meetings. Six petitions and sign-on letters carried more than 1,300 signatures together. The Board is grateful to every person who took the time to comment. Many shared their own experiences with the health care system, and that input made the plan stronger.

The comments covered many parts of the work. The most common themes were:

- How the Board governs itself and stays accountable to the public
- How the plan would be paid for, and who would pay
- General support for a universal health plan in Oregon
- Making public meetings and public comment easier to take part in
- What care and services the plan would cover
- Whether Oregon has enough providers to deliver that care

The Board and its committees made changes in response to what people said, throughout the process. A few examples:

- The Board named health equity as the first of its guiding principles, reflecting comment received early in the work.
- The committee that leads community engagement moved its meetings to the evening and set aside an hour for public comment, so more people could take part outside of work hours.
- The Board added focus group sessions with labor unions, after repeated requests for a formal role.
- The Board published a plain-language guide on how to submit public comment and provided Spanish translation and interpretation at meetings.

A fuller account of the public comment received, the themes it raised, and the changes the Board and its committees made in response is in the Public Comment Process appendix, along with the findings from the engagement sessions.

Board Vote

On [date of vote], the Board voted to approve this report as an accurate accounting of our work in service to the Oregon state legislature and the people of Oregon. [Motion summary/language.]

Recorded Vote:

Acknowledgements

The Universal Health Plan Governance Board (UHPGB) thanks the many people who gave their time, expertise, and public service to this report. The work reflects the efforts of current and former Board members, committee members, staff, consultants, and partners who supported the Board's charge and helped move its work forward.

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PROPOSED MODEL

The Board proposes a Universal Health Plan (UHP) that covers everyone living in Oregon with a full set of benefits, including behavioral health, vision, and dental care, and with very limited out-of-pocket costs. It would separate health coverage from employment and deliver on the commitment people in Oregon have made to health care as a right. It would be paid for mostly through an employer payroll tax and a health care personal income tax that applies only above certain incomes. A public nonprofit corporation would run it, with a focus on efficiency, quality, and fair distribution of health care resources. Compared with the current system, it would be less expensive, simpler, more transparent, and more equitable.

Today, the health care coverage a person in Oregon has depends on their job, their income, and whether they qualify for state or federal assistance programs. When those things change, coverage can change or disappear, and people fall through the cracks. Their health needs may go unmet, or they may face severe financial strain to get those needs met. Even when people are insured, many face premiums, deductibles, and copays they cannot afford. Many businesses struggle to provide health insurance to their employees. A universal health plan replaces that patchwork with one statewide system open to everyone who lives in Oregon. Instead of adjusting existing programs one at a time, the plan brings eligibility, benefits, financing, and administration together, so care is simpler to reach, more affordable, and less fragmented.

This model is built to work within current legal and financial limits, including continued coordination with federal programs and employer coverage. This section describes the core of the proposed model: who is eligible, how people enroll, what benefits they get, and how the plan fits with other coverage.

Eligibility

Under today's system, whether a person qualifies for coverage depends on their income, age, job, or immigration status, and the rules differ from program to program. The universal health plan uses one clear standard for eligibility: living in Oregon. Eligibility is based on Oregon residency, as defined in Oregon law (ORS 316.027). Under that law, a person is a resident if

they keep a permanent home in Oregon and are in the state for more than 200 days of the tax year. People who state that Oregon is their primary home and that they intend to stay are eligible right away, pending verification. Program rules call this an attestation.

Children are enrolled by a parent or guardian who claims them as a dependent. Each covered person gets their own eligibility and member identification. Rules for dependents follow state and federal standards, including the Affordable Care Act (ACA) and the Public Employees' Benefit Board (PEBB) rules that cover dependents up to age 26, and the Oregon Health Plan (OHP) rules for children and youth.

Eligibility does not depend on immigration status or housing status. Everyone who meets the residency standard can enroll.

Special Populations

People who are enrolled members of federally recognized Tribes can choose to take part in the universal health plan, but they are not required to. This respects Tribal sovereignty.

Seasonal farmworkers, as defined in Oregon law (ORS 652.145(2)), are eligible for coverage while they are employed in Oregon.

People who are incarcerated in Oregon are eligible for coverage. Payment and reimbursement are coordinated with the facilities that hold them and follow federal and state rules.

Students from other states who attend school in Oregon are eligible, because they live in the state for most of the year. Oregon residents who attend school out of state can keep coverage under their family's plan, following the dependent rules above.

People who live outside Oregon are not eligible. Some people work in Oregon but live in another state. How the plan covers them, and how their employers take part, will be worked out during implementation, balancing the need to keep workers mobile with the need to protect the plan.

Enrollment

Today, people often lose coverage not because they stop qualifying, but because they miss a renewal deadline or make a mistake on a form. The universal health plan is built to prevent that. Enrolling is meant to be simple and continuous, easy for members and efficient for the state. Enrollment covers three tasks:

- Initial enrollment for people new to Oregon
- Verification of eligibility
- Ongoing re-enrollment and eligibility maintenance

People can enroll by stating that they intend to live in Oregon, and coverage starts right away with no waiting period. When they enroll, they can list their dependents so the whole household signs up at once. This follows the federal rule barring waiting periods based on how long someone has lived in the state for Medicaid, and it lowers the barriers to getting covered.

Eligibility Verification

Members provide proof of residency within 60 days of enrolling. The plan collects only the minimum information it needs to run the program and meet federal rules:

- **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 proof can include a lease, a utility bill, employer verification, or other approved documents. Wherever possible, the plan checks existing state and federal data systems instead of asking members for paperwork, which reduces the burden on them. People without standard documents or a recent tax filing can prove eligibility another way, such as through a state-administered program or another system that has already verified their identity.

Automatic Re-Enrollment and Continuity of Coverage

The plan keeps people covered by renewing them automatically. The main way this happens is through the Oregon personal income tax return: anyone who files a return, or who is claimed as a dependent on one, is renewed without doing anything else. This is expected to reach about 75 to 85 percent of eligible people.

The plan also renews people by matching records with other state programs that already verify residency:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- Women, Infants, and Children (WIC)
- Medicaid (the Oregon Health Plan, or OHP)
- Unemployment Insurance (UI)

Together, these methods are expected to renew about 90 to 95 percent of eligible people with no action on their part.

Ex Parte Review and Member Outreach

For the smaller number of people the automatic steps miss, the plan reviews their eligibility on its own first, using the data it already has, before asking them to do anything (ex parte review.) The plan only reaches out, using a member's last known contact information, when the data cannot confirm they still qualify. While this review is underway, the person keeps coverage for a 90-day grace period, unless the plan learns they no longer qualify, for example because they moved out of state or died.

Anyone dropped because their eligibility could not be verified can re-enroll by stating that they still meet the residency standard.

Integration with Federal Programs

Enrollment and verification are built to work with federal programs, mainly Medicaid (Oregon Health Plan) and Medicare. Where the plan seeks federal funding, it follows all the federal rules for checking eligibility and documentation. The plan also checks whether a member is enrolled in Medicaid or Medicare, so it can act correctly as either the primary or the secondary payer (the insurer that pays first or second) and coordinate benefits between them.

Scope of Benefits During Initial Enrollment

New members start with a core set of services and gain full coverage after six months of continuous coverage. This staged start protects the plan while making sure people can get essential care right away. In the first six months, members have:

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

After six months of continuous coverage, members get the full benefit package, including planned (elective) outpatient procedures and fertility services.

Benefit Structure

What a person's insurance covers today depends on their plan, and many plans leave gaps, especially in behavioral health. The universal health plan sets one comprehensive benefit package for everyone. It matches the standard plan that covers Oregon's public employees, run by PEBB, and adds targeted improvements to fill gaps in behavioral health coverage. This report calls that package PEBB+. Building on a plan people already know keeps the benefits familiar while allowing changes that improve access and reduce administrative complexity.

Scope of Covered Benefits

The plan covers the full range of medically necessary care. Covered services 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, health education and promotion 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**

People who qualify for Medicaid (OHP) keep access to every service Medicaid requires, including long-term services and supports, non-emergency medical transportation, and Early and Periodic Screening, Diagnostic, and Treatment services for children.

Behavioral Health Integration

Commercial insurance often covers behavioral health thinly, with few providers and high out-of-pocket costs. The universal health plan treats behavioral health as part of whole-person care. It brings together services that today are split between commercial plans and public programs and adds community-based support.

This includes:

- **Behavioral health and primary care working together**, based on the Certified Community Behavioral Health Clinic (CCBHC) and Patient-Centered Primary Care Home (PCPCH) models, with support for referral-based care as well
- **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**

A broad workforce delivers this care, including licensed clinicians, certified providers, and supervised paraprofessionals, in line with Oregon's existing behavioral health models. The result is a shift from occasional, piecemeal coverage to steady, connected care that closes long-standing gaps in access and availability.

Cost Sharing and Financial Protection

Even people with insurance today often skip care because of the cost of deductibles and copays. The universal health plan aims to cover most, and ideally all, services with no deductible, copay, or coinsurance. Removing these charges lowers the financial barriers that keep people from getting care early, and it simplifies payments for providers.

Services Excluded or Deferred

Some services are not part of the plan's first phase. These are:

- 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

As the Joint Task Force recommended earlier, the Board proposes keeping these services in the programs that deliver them now, until federal approvals and financing make it possible to fold them in.

Benefit Design Flexibility

The plan sets one standard core benefit package. It gives the governing body authority to adjust benefits over time as clinical evidence, community health needs, the plan's finances, and federal rules and opportunities change.

Interaction with Other Coverage

Even a universal plan will not be the only payer in Oregon. Federal law keeps several kinds of coverage in place, so the plan is built to work alongside them. Some federal programs, including Veterans Affairs, TRICARE, and the Federal Employees Health Benefits program, currently offer no pathway for integration.

The plan does not replace or change the Indian Health Service, Tribal health programs, or urban Indian health programs. Tribal members living in Oregon can choose to take part in the

universal health plan, but they are not required to. This respects Tribal sovereignty and depends on continued consultation with Tribal Nations.

The plan does not restrict the offering of supplemental health benefits by commercial health insurers in Oregon.

Employer-Sponsored Insurance

The federal Employee Retirement Income Security Act (ERISA) bars states from regulating health plans that employers set up. Because of that, the universal health plan does not eliminate employer coverage. Employers can keep the coverage they offer now or choose to move their employees to the universal plan. The plan is designed to be a simpler, lower-cost option, and the Board expects many employers to prefer it because it costs less than running their own insurance. The state can still simplify the system by setting rules for how the universal plan coordinates with non-federal employer coverage.

Under a primary coverage approach, the universal health plan would pay first for covered services, and any employer coverage people keep would fill in around it. The likely advantages are simpler administration for providers and members, more ability for the plan to drive payment and delivery reform, and a stronger pull toward one unified system. The likely drawbacks are higher up-front financing for the plan, possible disruption to benefits won through collective bargaining, and added legal and operational risk tied to employer participation and ERISA. The Appendix discusses ERISA and related legal questions in more detail.

Under a secondary coverage approach, employer insurance would keep paying first, and the universal health plan would wrap around it, covering cost sharing, services the employer plan leaves out, or defined extra benefits. The likely advantages are lower initial cost for the plan, less disruption to current employer arrangements, and no direct role in employer plan administration. The likely drawbacks are continued administrative complexity, less room to simplify the system and reform payment, less savings, and coordination problems around benefits, provider credentialing, and the delays that come with sequencing claims.

The Joint Task Force on Universal Health Care did not say whether a future plan should be primary or secondary. It expected private insurance to shrink over time and employers to keep contributing through the financing, but it did not settle on a final coordination structure.

The Board decided to leave this choice open for now, pending more research and direct consultation with Oregon employers. Future work should test how employers would likely respond under each approach, including differences by employer size, funding structure, and location, and the risk of ERISA-based legal challenges. More employer engagement and survey work are needed before the design is final.

Liability Coverage and Workers' Compensation

The plan also works with existing laws that decide who pays for certain injuries outside the health insurance system, such as auto accidents and on-the-job injuries. These are different from employer coordination: they rely on established ways of paying and recovering costs, not on whether a person enrolls in the plan.

The plan's public corporation will have legal authority to recover costs from a party responsible for an injury, a process known as subrogation. Members get care regardless of who is at fault, and the public corporation pursues repayment afterward on its own.

Oregon's workers' compensation program keeps operating on its own, and the two systems coordinate so the plan is repaid for medical costs it covers that workers' compensation is responsible for.

Out-of-State Coverage

The plan covers Oregon residents when they need care outside the state. It will contract with a national provider network, or set up other arrangements, to make that coverage work. Out-of-state care may carry some cost sharing, especially for non-emergency services. For specialty care from out-of-state providers that needs prior approval, the plan follows the Oregon Health Plan's existing rules. The plan may pursue reciprocal agreements with other states where that is workable.

Health Equity Impact

The plan is built to advance health equity by replacing today's fragmented coverage with one statewide framework open to everyone who lives in Oregon on the same terms. Residency-based eligibility, immediate enrollment on a person's own statement, alternative ways to verify, automatic re-enrollment, and ex parte review all work to remove the administrative barriers that fall hardest on people with unstable housing, limited documentation, income that changes month to month, language access needs, disability-related barriers, or on-and-off contact with state systems.

The benefit design advances equity too, by lowering the financial and service barriers to care. A standard PEBB+ package, an expanded behavioral health continuum, dental and vision coverage, strong primary care, and the end of point-of-service cost sharing all work to improve access to preventive, routine, and necessary care. These choices matter most for people and communities that face delayed care, unmet behavioral health needs, high out-of-pocket costs, or coverage that keeps churning.

Today, providers are paid different amounts for the same service depending on what kind of insurance a patient has. Clinics and hospitals that care for large numbers of people on Medicaid or Medicare, people without health insurance, and people who are medically underserved generally take in less money than providers serving patients with private insurance that pays more. That gap affects which providers can afford to keep enough staff, stay open, and take new patients. It shows up in communities that already have the fewest options as longer waits and less care nearby.

A single statewide payment system would pay the same rate for the same care, no matter who covers the patient. It would also let the state set rates with other needs in mind, such as keeping providers in rural areas, supporting the health care workforce, and closing gaps in who can get care.

At the same time, whether the plan delivers on equity depends on how it is carried out. Implementation must make eligibility and enrollment usable for people with limited English, disabilities, unstable housing, little digital access, or good reason to distrust government systems. It must watch provider participation, regional access, culturally and linguistically responsive care, disability access, and continuity for people who stay temporarily on federal or employer coverage during the transition. Meeting these goals will take ongoing data and analysis, community engagement, public accountability, and course correction as the plan rolls out.

FINANCE AND REVENUE

About This Section

This section is a record of the Board's financing work and describes financing model options that the Legislature may consider. It describes the principles the Board used, the tradeoffs and tensions the Board encountered, and draft revenue model options with the analysis behind them.

The Board was supported by the work of the Finance and Revenue Committee, with modeling and analysis. The committee's process, the consultant reports, and the detailed analysis behind the figures in this section are available in the appendices.

What the Board Has Learned

The modeling shows that a universal health plan for Oregon is financially feasible: at lower total spending than the current system, Oregon could cover everyone, with better benefits, and most households and businesses would pay less.

Building on the analysis prepared for the Joint Task Force on Universal Health Care in 2022, the Board has produced the most complete financial analysis of universal health care Oregon has had to date, and the first to pair ground-up actuarial modeling of system costs. Specified revenue structure elements were reviewed with the Legislative Revenue Office (Milliman, Expenditure Analysis for the Oregon Universal Health Plan, April 3, 2026; ECONorthwest, Final 2032 Revenue Replacement Targets and Tax Rates, July 16, 2026).

Four findings stand out.

First, the modeling shows that a universal health plan is feasible. Oregon already spends enough on health care to cover everyone who lives here. The question is not whether the money exists. It is how the money is collected and distributed.

Second, the modeling projects that total health care spending under a universal health plan would be lower than under the current system, mainly because a single system would spend far less on administration for providers and for the plan itself. The Board built assumptions into the model that it believes are conservative based on the available data, and the model did not count every savings a consolidated system could achieve.

Third, the modeling projects that most households and employers would pay less in total than under the current system once premiums, out-of-pocket costs, and taxes are all counted. (ECONorthwest, Report on the Finance & Revenue Committee's Recommendations, June 2026), These are group totals. The analysis available to the Board does not show how

many individual households or businesses would pay more or less, and health care spending is uneven enough today that group totals cannot answer that question. Completing that household-level analysis is among the recommended next steps. The section on tradeoffs below provides more detail.

Finally, the Board has gained clarity on the next steps necessary for a universal health plan in Oregon to become a reality. Reaching this point taught the Board a great deal. It also did what innovative work often does, it turned broad uncertainty into specific, answerable questions. This section summarizes the board's analysis available today, and some aspects could shift as more is learned. The specific requests and next steps for the finance and revenue plan are summarized at the end of this section.

How Oregon Pays for Health Care Today

People living in Oregon already pay for health care many times over, in ways that are hard to see. A universal health plan would mostly replace that spending, not add to it.

Households, employers, and governments already pay for health care through premiums, deductibles, copayments, payroll contributions, and taxes. They also pay in ways that never show up on a bill. When an employer's premium costs rise, wages grow more slowly. When someone cannot pay for emergency room care, those costs shift to everyone else. Providers spend a lot on billing and paperwork across many different insurers, and everyone pays for that overhead. The pressure is also getting worse. The Risks and Tradeoffs section sets out how fast premiums and deductibles are now rising.

Because health care costs are paid in so many ways, they are hard to see and hard to add up. That makes it harder to compare today's costs with a universal health plan proposal. A new way to publicly fund health care can look like a whole new cost even though it replaces money that households and employers are already spending. The modeling in this section treats the revenue mechanisms described below as replacements for existing premiums and out-of-pocket spending, not as additions on top of them. Whether a particular household or business would pay more or less depends on what it pays now.

Expenditures

Before looking at how to raise money, it helps to see what health care in Oregon costs now, where that money comes from today, and what the same care would cost under a universal health plan.

The Finance and Revenue Committee used state and national data sources to build an accounting of status quo health care expenditures. The year 2022 was chosen because it was

the latest year with relatively complete data. The Committee started with 2022 status quo numbers to construct a revenue and expenditure model of the same care delivered under UHP. Numbers for 2022 are then aged forward to 2032 numbers for both status quo and UHP.

This model projects costs for the year 2032 because that is the assumed operational start of the plan, the earliest year it could realistically be fully operating given the legislative, federal, and operational steps required (Milliman, April 3, 2026).

The following table shows the source of actual funds for Oregon 2022 status quo health care costs and how those same costs would be covered by UHP. The table shows that we expect that generally the same Medicare and Medicaid funding will continue to come into Oregon. (Note: not all funding sources are shown for example, the table does not include Department of Defense, VA, Indian Health Service, and others.) The table is intended to show that UHP restructures some but not all of the revenue for Oregon health care.

2022 Expenditures in Millions				
Status Quo Sources	Status quo	UHP (Plan C)	UHP (Plan C) Sources	
Out of pocket costs covered by private insurance	\$4,558	\$8,167	Health Care Personal Income Tax (HCPIT)	
Private Insurance	\$15,291	\$11,341	Employer Payroll Tax (EPT)	
Subtotal out of pocket costs and private insurance	\$19,849	\$19,508	Subtotal HCPIT and EPT	
Medicare	\$9,113	\$9,113		
Medicaid and Children's Health Insurance Program (CHIP)	\$9,392	\$9,392		
Total	\$38,354	\$38,013		

The starting point is what the whole system would spend. Milliman projects total annual health care spending under a universal health plan at approximately \$85.5 billion in 2032 under its best estimate, within a range of about \$77.4 billion to \$94.0 billion depending on utilization, cost trends, and operational assumptions. The modeling then applies two adjustments. Provider administrative savings and improved collection of existing payments reduce the best estimate to \$77.7 billion; Milliman sizes these at \$4 to 5 billion in reduced eligibility and billing costs and \$3 to 3.5 billion from collections improving when cost sharing ends. Reducing the plan's own administrative costs from 6 percent to 3 percent of spending, a level consistent with mature

single-payer systems and retained from the Task Force's analysis as a conservative estimate, brings it to \$75.2 billion.

Continuing federal and state funding, estimated as a range of \$36.5 billion to \$39.7 billion depending on the scenario and contingent on federal waiver approvals, would cover roughly half of that. What remains is the Revenue Replacement Target: the amount the new revenue mechanisms would need to raise. Across scenarios it ranges from about \$30.2 billion to \$35.5 billion per year, with a middle estimate near \$32 billion (ECONorthwest, July 16, 2026).

Table 1. From projected 2032 spending to the Revenue Replacement Target. All figures are modeling estimates pending outside vetting.

Step	2032 amount, in billions
Total projected spending under a universal health plan (Milliman best estimate; scenario range \$77.4B to \$94.0B)	\$85.5
Provider administrative savings and improved collection of existing payments	subtract \$7.8, leaving \$77.7
Plan administrative costs fall from 6 percent to 3 percent	subtract \$2.5, leaving \$75.2
Continuing federal and state funding (varies by scenario)	subtract \$36.5 to \$39.7
Revenue Replacement Target: new revenue needed each year	\$30.2 to \$35.5

These figures rest on stated assumptions about the benefits covered, provider payment levels, administrative savings, fraud and abuse reduction, pharmacy costs, and continued federal participation. The full list of assumptions, with sources, and what happens to the target when each assumption moves, are in the appendix. Milliman's sensitivity testing shows a single percentage point of cost trend moves the estimate by \$4 to 5 billion, which is why every figure in this section is presented as a range.

Core Financing Principles

The Board evaluated financing mechanisms against key principles, summarized here, asking not only whether an option could raise enough money but how it would affect households, employers, the state, and the economy over time.

1. **Funding must be dedicated to the plan.** Revenue would go into a Universal Health Plan Trust Fund, separate from the state General Fund. This revenue can only be used for the Universal Health Plan. This separation protects health care dollars from unrelated

budget pressures and supports public confidence. The money would be continuously appropriated, so it stays available across state budget cycles instead of lapsing at the end of one.

2. **Funding must be progressive.** Contributions should follow ability to pay, so that people with higher incomes contribute at higher rates, without sharp cliffs where a small increase in income triggers a large jump in what someone owes.
3. **Funding must come from a broad base.** A wider base at lower rates is more stable and less likely to change economic decision making for people or employers than a narrow base at higher rates. Progressivity and breadth pull against each other and the Board worked to balance both: a broad base overall with an income exemption and rate structure that protect lower paid workers and keep contributions tied to ability to pay.
4. **Funding must be easy to understand.** The current system hides the cost of care. The plan's financing should be visible and predictable and should run through existing tax systems rather than new collection bureaucracies.
5. **Funding must be stable and predictable.** Health care costs continue through recessions. Because any single revenue source rises and falls with the economy, the model draws on several sources rather than depending on one.
6. **Funding must be adequate and scalable.** Revenue must cover benefits, operations, reserves, and transition costs, and must be able to grow as costs grow.
7. **Funding must be designed to keep federal dollars flowing.** The model assumes Oregon continues to receive federal funding through Medicaid, Medicare, and Marketplace subsidies, and it is structured with attention to federal law, including ERISA, which limits how states can regulate employer health benefits.

Tradeoffs and Tensions

The Board's work brought to light tensions between important goals where there isn't one clear answer. It will take more public input to determine how people in Oregon want these tradeoffs to be handled in a new universal health plan.

Progressivity and simplicity can pull against each other. A broad tax base with few exemptions is simpler to explain and allows overall lower rates, but it asks more of people with lower incomes. Exemptions and credits protect those households, but each one adds complexity. There was a lot of public comment to the Board on this topic. Comments on progressivity led the committee to keep the exemption for household income below 200 percent of the federal poverty level and the exemption for the first \$500,000 of employer payroll, even

though some committee members wanted to broaden the contribution base. The committee also considered, and did not recommend, a soft cap on high-income liability, on grounds that it would make the structure less progressive. These tensions are visible in the revenue model options described later.

Health benefits are part of what some workers earn, but federal tax law treats them differently from wages. Money an employer spends on health insurance is not taxed, and the employee's share usually isn't either. Keeping that money tax-free is a central reason the proposed revenue model options use an employer payroll tax: routing health care contributions through payroll keeps the tax advantage that wages don't get, which keeps more money invested in Oregon businesses and families instead of leaving Oregon as increased federal taxes.

This design choice carries a tradeoff. For many workers, the cost of employer health benefits has held wages down over time. Replacing an employer's insurance cost with a payroll tax will likely keep wages at that lower level because nothing forces wages up when the premium cost goes away. To address the fairness problem this creates, Revenue Model Option 1 includes an employer payroll tax credit that protects workers from effectively paying twice. The credit does its job, but creates complexity, making the revenue plan less easy to understand.

Visible costs must be compared with hidden ones. Today's health care costs arrive in fragments that make them hard to track: a premium here, a deductible there, copays when a prescription is filled, wages that grow more slowly, paying out of pocket for services that are not covered. A tax is a single visible number. A fair comparison counts what people would stop paying, not only the new tax, and this section is written to make that comparison possible.

Moving out of a deeply inequitable system takes more than one step. The current system distributes costs in ways that have little to do with ability to pay. People with similar incomes pay very different amounts depending on their employer, their health, and their luck. No single step can fix every inequity at once.

The single-payer principle and a phased reality. The Board continues to affirm the goal of a single, unified system with one public payer (insurer) for everyone, as defined in ORS chapter 751. The financing work has also shown that getting there would probably run through a period in which Medicare and some other coverage continue to operate alongside the plan, because full federal integration requires federal action that Oregon cannot control. The Board has discussed this gap, and potential phased options to support adequate planning for this reality.

Revenue Model Options

The Board presents five revenue model options for the Legislature to consider. Option 1 is the full financing package and the most fully analyzed. Options 2 through 5, labeled here by the plan letters used in the source analysis as Plans C, D, G, and I, keep that basic package and change the tax structure.

This section presents those five options. Option 1 is described first and in the most detail. Options 2 through 5 are built on 2022 data and raise a common revenue target of about \$20.385 billion in 2022 dollars, which includes the cost of covering Medicare Part B premiums. Inflated forward, that target is about \$33.8 billion in 2032, inside the range shown in Table 1. Each of these options raises the target through the same two taxes, an employer payroll tax and a health care personal income tax, together with a corporate income tax and a corporate activity tax calibrated to raise about \$0.88 billion; none of the four modifications includes a lodging tax. They differ in the income tax tiers, the income exemption level, and whether employees receive a payroll tax credit, and all would be re-run for projected implementation year 2032 numbers by the Legislative Revenue Office once the Board finalizes model options.

All revenue estimates in this section are static estimates. They show what people and businesses would owe under conditions as they stand today. They do not account for how households and businesses might change what they do, how the wider economy might respond, or how the health insurance market might change. Completing dynamic economic analysis is a next step the Board has identified the need for but has not yet had the time and resources to complete.

Revenue Model Option 1: The Full Financing Package

Option 1 is the full financing package. It is built to raise the Revenue Replacement Target described in the Expenditures subsection above.

Option 1 would raise the Revenue Replacement Target through five coordinated revenue mechanisms. Each replaces a specific kind of health care spending that households and employers already do. The rates below are shown two ways: the first is the single design rate the committee set using 2022 as its baseline year, chosen because it was the most recent year with complete data. The second is the estimated range required to meet the 2032 target, which is higher because health care costs grow between the calibration year (2022) and the plan's estimated first year of operation (2032).

A health care personal income tax (HCPIT) would replace what households now pay in premiums, deductibles, and copayments. Household income up to 200 percent of the federal poverty level would not be taxed at all. Above the exemption, the tax would apply only to the portion of income above that line. The design rate is 10.1 percent; meeting the 2032 target is estimated to require 13.5 to 15.9 percent, net of the credit described next.

To protect people on Medicare from paying twice, once through federal premiums and again through the HCPIT, this model proposes covering Medicare Part B premiums. This also helps to ensure there is not an incentive for Medicare enrollees to stop paying their Part B premiums. This matters for two reasons: for people on Medicare who move out of state and need to prove they stayed eligible and for federal funding to support the UHP services Medicare eligible people are using.

An employer payroll tax (EPT) would replace what employers now spend on premiums. The design rate is 9.6 percent of payroll, with the first \$500,000 of an employer's annual payroll exempt, so the smallest businesses would pay nothing; meeting the 2032 target is estimated to require 9.9 to 11.6 percent. Employers that today provide comprehensive coverage would trade unpredictable annual premium increases for a single predictable rate and would shed the administrative work of running health benefits.

An employer payroll tax credit would protect workers from paying twice. Because health benefits are part of what some workers earn, and nothing guarantees a raise when an employer's premium costs disappear, people who work for companies that pay the payroll tax would receive a credit against their health care personal income tax, linked to a portion of the payroll tax paid on their behalf and set at 50 percent (ECONorthwest, June 2026).

Employed Scenario 1 - Family of 4		Employed at Small Firm – Family of 4	
Employee wage	\$100,000	Employee wage	\$100,000
10% EPT paid by employer	\$10,000	Firm is under the \$500,000 total payroll cap and does not pay EPT	\$0
Health care personal income tax (HCPIT) paid by employee	\$4,080	Health care personal income tax (HCPIT) paid by employee	\$4,080
Final cost of Health Care Personal Income Tax to employee	\$0	Final cost of Health Care Personal Income Tax to employee	\$4,080
Employed Scenario 2 – Family of 4		Self-Employed – Family of 4	
Employee wage	\$200,000	Employee wage	\$100,000
10% EPT paid by employer	\$20,000	No employer to pay EPT	\$0
Health care personal income tax (HCPIT) paid by employee	\$16,080	Health care personal income tax (HCPIT) paid by employee	\$4,080
Final cost of Health Care Personal Income Tax to employee	\$6,080	Final cost of Health Care Personal Income Tax to employee	\$4,080

A corporate income tax add-on would apply to firms with taxable profits above \$1 million: a design rate of 3.0 percentage points on the existing 7.6 percent rate, estimated at 4.25 to 5.0 points for the 2032 target. A corporate activity tax add-on of 0.10 percentage points on the existing 0.57 percent rate, estimated at 0.11 to 0.13 points for 2032, applies across a broader base of firms doing business in Oregon. Together these broaden participation to businesses that benefit from a healthy workforce but may have small payrolls in the state.

A lodging tax increase of 0.2 percentage points on the statewide rate would help to offset costs to the UHP for visitors who need care while in Oregon. Under current law the add-on would sit on the new 2.75 percent statewide baseline. It is the smallest instrument by far, raising roughly \$10 million, and the Board keeps it in the package for breadth rather than scale.

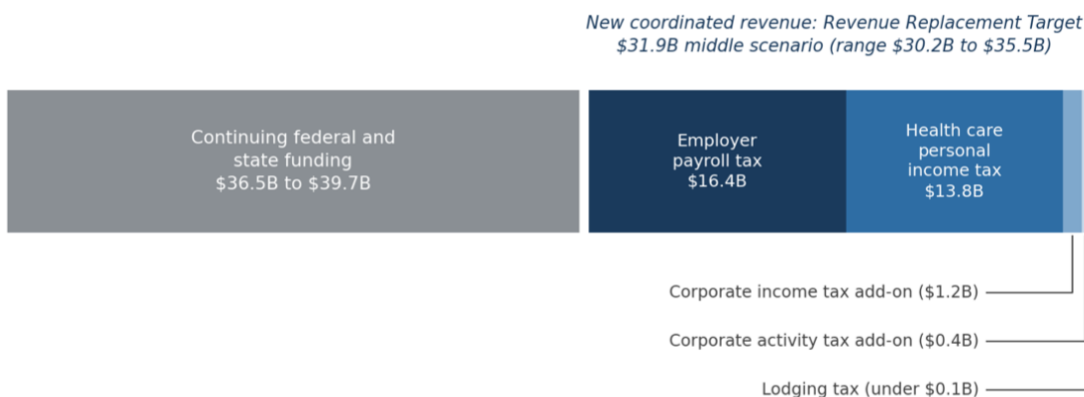
Table 2. The five revenue mechanisms: design rates from the committee's 2022 calibration, and the estimated 2032 rates and revenue required to meet the Revenue Replacement Target (ECOnorthwest, July 16, 2026). All figures pending LRO vetting. FPL is Federal poverty level.

Mechanism	Design rate (2022 calibration)	Estimated 2032 rate	Estimated 2032 revenue
Employer payroll tax (EPT)	9.6% on payroll above \$500,000	9.9% to 11.6%	\$15.6B to \$18.3B
Health care personal income tax (HCPIT), net of 50% EPT credit	10.1% above 200% FPL	13.5% to 15.9%	\$13.1B to \$15.4B
Corporate income tax add-on	+3.0 points on 7.6% (profits above \$1M)	+4.25 to +5.0 points	\$1.15B to \$1.35B
Corporate activity tax add-on	+0.10 points on 0.57%	+0.11 to +0.13 points	\$0.39B to \$0.46B
Lodging tax increase	+0.2 points statewide	+0.2 to +0.23 points	about \$0.01B

These mechanisms are designed to work together as one system. The payroll tax captures money employers already spend on health care. The income tax replaces household spending on premiums, deductibles, and copays adjusted for households' ability to pay. The business taxes spread responsibility across the economy, and the lodging tax adds a small stream from outside it. The package is concentrated in the payroll and income taxes, which together account for about 95 percent of the target; that concentration is part of the broad-base tradeoff named above. The committee also considered and did not present other instruments, including a state sales tax, sumptuary taxes on goods such as alcohol and tobacco,

and a value-added tax, on grounds of regressivity, scale, or fit with the existing tax system (ECONorthwest, June 2026).

Where the money would come from under Revenue Model Option 1 (2032)

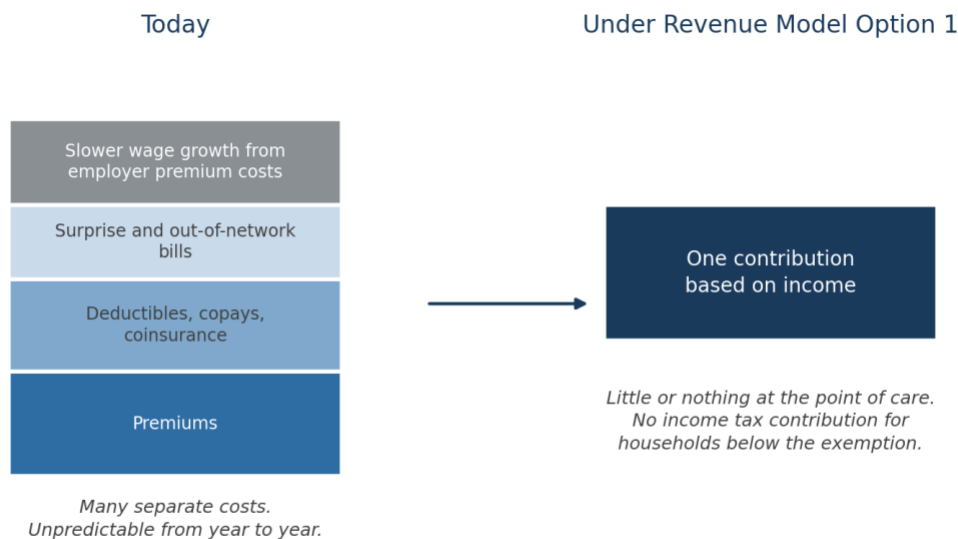


Draft mock-up. Middle scenario per ECONorthwest, July 16, 2026; pending LRO vetting.

Figure 1. Draft mock-up: how continuing federal and state funding and the five revenue mechanisms would combine to fund the plan in 2032. Shares reflect the July 16, 2026, estimates, middle scenario.

Coverage That Belongs to the Person, Not the Job

Under a universal health plan, coverage would belong to the person, and no one would lose insurance by losing a job, changing jobs, cutting back hours, retiring before 65, or starting a business. Workers could take risks the current system punishes, and small employers could compete for talent without competing on benefits. Ending the constant movement of people between coverage types would also eliminate a costly layer of administrative churn. The Board believes this decoupling is a benefit to workers, employers, and the state economy.



Draft mock-up, schematic only. Not to scale; individual results vary with income and current coverage.

Figure 2. Draft mock-up: how a household's health care costs arrive today compared with under Revenue Model Option 1.

What This Would Mean for Households and Businesses

The modeling projects that households below 200 percent of the federal poverty level would pay no health care personal income tax, and that most households in the lower half of Oregon incomes (median income) and most employers would pay less in total than they do now, once replaced premiums, deductible payments, and out-of-pocket costs are counted. Effective rates rise smoothly with income, from 0.4 percent in the lowest contributing band to 9.1 percent in the highest, before the payroll tax credit; a single filer earning \$50,000 would face an effective rate of about 5.2 percent before the credit, because the tax applies only to income above the exemption (ECONorthwest, June 2026; July 16, 2026, Board discussion). Higher income households would generally pay more, consistent with the principle that contributions follow ability to pay.

For businesses, the committee designed the combined business taxes to total about the same as, and slightly less than, what private employers pay for insurance today. Employers that currently provide coverage would generally see stable or lower costs; employers with little or no current health spending would take on new obligations.

These are static modeling estimates under stated assumptions, not final measures of the full economic effect, and the Board is clear that the model deliberately rebalances how Oregon already pays for care to improve equity and affordability.

Revenue Model Option 2 (Plan C)

Option 2, called Plan C, builds on Option 1 and changes the employer payroll tax by splitting it into three levels. Employers would pay nothing on the first \$500,000 of annual payroll, 9.6 percent on payroll between \$500,000 and \$10 million, and 14 percent on payroll above \$10 million, so employers with the largest payrolls would pay the highest rate on their top dollars. Plan C keeps the 50 percent employer payroll tax credit, which workers apply against their health care personal income tax. The health care personal income tax has two brackets. Income up to 200 percent of the federal poverty level would not be taxed, and only the portion of income above that line would be taxed, at 12.05 percent before the credit is applied. That rate is lower than the 13.5 percent Option 1 would require, because the third payroll tax tier brings in more revenue from the largest employers. Plan C does not include the lodging tax, and it sets the corporate income tax and corporate activity tax rates to raise about \$880 million together. Under this design, about 60 percent of the total revenue would come from the employer payroll tax, the corporate income tax, and the corporate activity tax combined.

To compare the options, the analysis looks closely at one group: workers who earn less than \$250,000 a year. It estimates what this group would pay in health care personal income tax on their wages, then compares that to what they pay today for job-based coverage. Today this group pays somewhere between about \$2.8 billion and \$3.6 billion. A plan that collects less than about \$2.8 billion from their wages would leave the typical worker in this group paying less than today. A plan that collects more than about \$3.6 billion would have them paying more. In between, it is close to a wash. Under Plan C, this group would pay about \$2.244 billion, which is below the \$2.8 billion line, so the typical worker earning under \$250,000 would likely pay somewhat less than they do now. These figures are averages, and health spending is very uneven from one person to the next, so they point to a general direction, not a fixed result for any single household.

Revenue Model Option 3 (Plan D)

Option 3, called Plan D, is the same as Plan C but removes the payroll tax credit for workers. Its health care personal income tax also has two brackets and keeps the exemption for income up to 200 percent of the federal poverty level, with a lower top rate of 7.69 percent. The rate is lower than Plan C's 12.05 percent for a simple reason. Plan C sets a higher rate to make up for the credit it gives back, while Plan D gives no credit and so does not need as high a rate to raise the same money. The three-level payroll tax stays the same as in Plan C. Under Plan D, workers earning less than \$250,000 would pay about \$3.334 billion on their wages. That falls between the \$2.8 billion and \$3.6 billion lines, toward the higher end, so the typical worker in this group would come out close to even, if anything paying a little more than today. As with

the other plans, this is an average and points to a general direction, not a household-by-household result.

Revenue Model Option 4 (Plan G)

Option 4, called Plan G, keeps Plan C's three-level payroll tax and its 50 percent credit but reshapes the health care personal income tax. Instead of two brackets, this tax has five, and the exemption is set lower, at 138 percent of the federal poverty level rather than 200 percent. The lower exemption brings more income into the tax, which widens the base. The top rate is 14.3 percent. Under Plan G, workers earning less than \$250,000 would pay about \$1.794 billion on their wages. That is the lowest of the four modified options and well below the \$2.8 billion line, so the typical worker in this group would likely pay less than they do now. This is an average and points to a general direction, not a household-by-household result.

Revenue Model Option 5 (Plan I)

Option 5, called Plan I, is like Plan G with two changes. It adds one more bracket to the health care personal income tax at the high end, and it removes the payroll tax credit. The exemption stays at 138 percent of the federal poverty level, there are six tiers, and the top rate is 12.0 percent. Under Plan I, workers earning less than \$250,000 would pay about \$2.733 billion on their wages. That is just under the \$2.8 billion line, by a small margin, so the typical worker in this group would likely pay a little less than they do now, though the margin is thin enough that it could go either way for many households. Like the others, this is an average and points to a general direction, not a household-by-household result.

Reserves, Transition Costs, and Startup

Starting the plan would take one-time investments and reserves. Those are different from what the plan would cost to run each year.

The plan would need operating reserves to keep paying providers through economic downturns, unexpected utilization changes, or federal funding delays. The Board has estimated the need for a reserve target of three months of operating expenditures, with corrective action triggered if reserves fall below one month. At the 2032 scale of the plan, three months is roughly \$21 billion, and ECONorthwest concludes that capitalizing it would likely require a hybrid approach combining internal public sources, structured bridge financing, and limited accelerated revenue (ECONorthwest, Reserves Financing and Funding Options, March 2026; June 2026). Completing analysis to create a demonstrated path to reserves at this scale is included in the What Remains to Be Done section.

Starting the plan would also require one-time investments before it serves its first member: information technology (IT), claims administration, enrollment systems, staffing, provider onboarding, and public communication. Milliman describes the technology and operational needs, but startup costs have not been estimated, and Oregon's experience with large system launches argues for estimating them early and conservatively. Startup could be financed through phased reserve capitalization, transitional appropriations, bonding, or federal implementation funding. Startup spending is a one-time investment in infrastructure and should not be read as part of the plan's ongoing annual cost.

What Remains to Be Done

Significant progress has been made, and plan feasibility has been demonstrated. Here are the next steps toward a universal health plan for Oregon:

For successful plan implementation, the following work would need to be completed, and the Board recommends it as the next phase.

All figures need outside vetting. The Legislative Revenue Office has begun engaging with the Board, and the Board recommends full LRO review of the revenue model options, tax bases, and rate estimates.

Statewide economic impact analysis. Dynamic analysis of how households, businesses, and the broader economy would respond, including effects on wages, prices, employment, migration, and business competitiveness.

Additional distributional analysis. More analysis is needed to show impacts for households at different income levels and family sizes, for workers with 1099 income, for people receiving Social Security, and for businesses of different sizes and industries, including workers in the insurance industry and the specific types of employers the statute directs the Board to study.

A vetted reserve capitalization plan and an information technology cost estimate need to be developed.

Federal coordination must be confirmed and negotiated. The model depends on preserving federal Medicaid, Medicare, and Marketplace funding, which requires waivers and agreements that can only be pursued once the Legislature acts, and the specific approvals the Medicaid assumptions require need verification now.

Broad public engagement on the tax structure itself. Developing these revenue model options took most of the available time, so the Board has not yet been able to hear broad public feedback on the tradeoffs they pose. The Board regards that feedback as essential before rates

are finalized. The public should help make the value judgments that determine the final revenue design.

ADMINISTRATIVE STRUCTURE

Oregon runs its health care through many separate systems today. That fragmentation drives duplicative administration, inconsistent standards, and heavy paperwork for providers and patients, and leaves people in Oregon vulnerable to disruptions in access to providers and services if an insurer leaves the market. A universal health plan needs a single administrative structure that can run a statewide system, stay financially stable, answer to the public, and still respond to local community needs. In designing that structure, the Board looked at how to organize financing, policy, operations, provider payment, accountability, and community engagement under one plan.

The Board's proposed structure balances several goals:

- Central accountability and fiscal oversight
- Consistent core standards and benefits statewide
- Room to adapt operations over time
- Meaningful regional and community engagement
- Transparency and public accountability
- Simpler administration for providers, patients, and partner organizations

No statute can spell out every operational and technical detail needed to run a statewide health system for years to come. The Board proposes that the Legislature set the core structure, authorities, financing framework, and accountability standards, then delegate the operational and technical details to rulemaking. This split lets the plan hold steady on public accountability while adapting how it operates as conditions change.

Legal Structure and Authorities

The Board recommends that a public corporation, created in state law, run the universal health plan. This public corporation would be accountable to the people of Oregon and responsible for administration, financing, operations, provider payment, contracting, and putting the plan in place.

The Board concluded that a public corporation strikes the best balance among public accountability, operational flexibility, and long-term stability for a statewide health system. Public corporations are public bodies with a defined mission and with transparency to the public. This structure would let the plan operate as a nonprofit governed by public ethics, meetings, and records laws, while giving it room to organize its finances and to follow government contracting, procurement, personnel, and bonding rules.

This structure is built to support:

- Central administration of financing and provider payment
- Long-term budget planning and reserve management
- Consistent operations statewide
- Flexibility in contracting, procurement, and staffing
- Phased rollout and scaling
- Federal waiver talks and coordination with other governments
- Adapting to future changes in how the system runs and is paid for

Running the plan will take operational authority that rigid statutory detail cannot manage well on its own. The Board recommends that the Legislature write the corporation's founding statute to serve the specific purpose, mission, and goals in the final plan, and delegate operational authority to the corporation through rulemaking.

In line with other Oregon public bodies and health programs, the corporation should have authority to: adopt administrative rules; hire staff and assign operational duties; enter contracts and run programs; set provider payment methods and rates; collect, manage and report data; manage funds and reserves; negotiate and manage federal waivers; conduct audits and compliance work; issue administrative orders and oversee appeals.

Too much operational detail in statute would make it hard for the plan to adapt as use of care, financing, federal rules, workforce needs, and technology change. Too little direction would create confusion or weaken public accountability.

The public corporation would remain subject to:

- Public meetings and public records laws
- Ethics and conflict-of-interest rules
- State auditing and financial reporting
- Legislative oversight and statutory limits
- Other accountability and transparency standards for public bodies

The Board also weighed the risks of relying on independent regional contractors or a patchwork of administrative entities. It favors central administration through the public corporation, with regional offices that are part of the corporation rather than separate risk-bearing organizations. This reduces the instability that comes with contractor turnover.

The structure is also built to evolve. Some functions may run through contracted third parties at first while the corporation builds its own capacity over time. This gives the plan enough flexibility for both early implementation and long-term statewide operation.

Governance

The Board recommends a governing board to oversee the public corporation. This governing board will set strategic direction. Its membership should be built for the demands of a statewide plan, with strong expertise in health care finance and in how care is delivered.

The governing board would focus on the following:	The Executive Director and staff would manage day-to-day operations, such as:
• Major policy and strategic decisions • Approving budgets and financial policies • Setting high-level provider payment methods • Overseeing reserve and trust fund management • Adopting administrative rules • Appointing and overseeing the executive director • Accountability and performance oversight • Major changes to the plan's design or rollout	• Routine operations • Staffing and internal administration • Procurement and contracting • Carrying out board policy • Technical and operational adjustments • Running claims and payment systems • Data and reporting • Compliance and auditing • Routine decisions delegated by rule or board policy

A statewide plan needs day-to-day flexibility and technical skill that a board cannot supply on its own. Even with that split, the plan stays publicly accountable. Public meetings and transparency rules, legislative oversight, financial reporting and audits, ethics and conflict-of-interest standards, and board approval for major policy and financial decisions all apply. The result supports both democratic accountability and effective long-term management.

Universal Health Plan Trust Fund

The Board recommends a dedicated Universal Health Plan Trust Fund to pay for and run the plan. The trust fund would be the central place where the plan's money is received, managed, and paid out, held separately from Oregon's General Fund. It would operate under a hybrid "captive and exempt" Treasury model that balances public accountability with operational flexibility. Under this model:

- All money would be held by the State Treasurer and deposited into the trust fund
- The public corporation could use non-Treasury financial services for some functions, such as front-end cash management, payment processing, and financial operations
- The Legislature could set statutory exemptions to allow flexibility in banking, procurement, and financial administration where that helps the plan run efficiently

This approach follows models already used by Oregon public corporations. It would give the plan access to Treasury investment and liquidity tools while avoiding the constraints of fully captive Treasury management.

A statewide plan needs a financing structure that supports long-term stability, multi-year planning, reserve management, and steady operations. Health care spending happens every day and does not fit neatly into two-year budget cycles. For that reason, the Board determined the plan should run through a dedicated trust so revenues and reserves stay available across budget periods instead of lapsing at the end of a cycle.

Revenues dedicated to the plan would flow straight into the trust fund and be continuously appropriated for running the plan. That gives the plan more predictable finances and keeps money raised for health care dedicated to health care. The Board saw separation from the General Fund as especially important for transparency, public accountability, and public confidence that the money will be there to keep the state's promise of universal care.

The trust fund would pay for health care claims, provider payments, administration, reserves, contracted services, and other costs of running the plan. Federal funding tied to Medicaid, Affordable Care Act programs, Medicare, and other coordinated federal health financing would also flow into the trust, to the extent federal law and program rules allow.

A statewide health plan needs cash reserves to keep paying claims when the economy dips, when people use more care than expected, or when funding arrives late. The plan builds and protects those reserves through the trust fund. The financing section explains how large the reserves need to be.

The governing board would adopt financial policies for reserve targets, solvency protections, investment practices, reporting, and steps to take if reserves fall below set thresholds. The Legislature would set the trust fund's statutory framework, while day-to-day financial management, which needs flexibility and technical oversight, would run through board policy and rulemaking.

The Board also weighed the value of central fiscal accountability. The trust fund would work as one statewide financing mechanism, not a set of separate regional reserves or independent pools. Managing reserves and financing centrally would improve stability, cut duplication, and let the state spread resources more fairly while keeping one line of accountability for cost control and stewardship. A dedicated trust of this size also carries real governance duties. It would come with ongoing audits, public reporting, legislative oversight, and financial transparency on par with any large public financing entity.

The trust fund is meant to give the plan a stable, transparent financial foundation for the long term, one that protects reserves, keeps operations steady, and holds the plan accountable for the money it manages.

Administrative and Operational Model

The Board proposes a centralized model in which the public corporation carries primary responsibility for financing, payment, policy, data systems, and overall operational oversight. The Board concluded that central administration is needed for statewide consistency, fiscal accountability, uniform standards, and simpler administration, and to cut the fragmentation of today's system, in which many separate payers (insurers and public programs) each pay for care.

The plan also builds in regional input to stay fair across very different communities and to keep the public involved as it runs. The model pairs central financing and policy authority with regional structures that handle local engagement, innovation, health resource planning, and community accountability.

The corporation's central office would hold primary responsibility for:

- Managing the Universal Health Plan Trust Fund
- Provider payment systems and methods
- Claims and payment oversight
- Statewide data collection and reporting
- Quality measurement and accountability
- Eligibility and enrollment standards
- Adopting administrative rules and policies
- Contracting and procurement
- Federal waiver coordination and compliance
- Overall fiscal and operational oversight of the plan

Core financing, payment, and policy functions would work the same way across the state, no matter the region.

Regional offices would be part of the public corporation, not independent contractors or separate risk-bearing organizations. The Board rejected a model in which regional organizations carry financing risk on their own or run their own payment structures.

The Board concluded that regional structures are needed so the plan stays responsive to differences in geography, workforce, population health, and existing care infrastructure across Oregon. Keeping those offices inside the public corporation preserves central fiscal

accountability, avoids duplicate reserve requirements, and holds financing and provider payment to one statewide standard.

The plan would draw non-overlapping regions, as far as practical, around existing patterns of care, public health infrastructure, and natural referral relationships. The Board discussed a range of options. Early operational discussions pointed to roughly five to nine regions statewide, though the number is not yet settled.

To support community accountability and local engagement, each regional office would also host advisory groups that represent providers, plan members, and community members. These groups would raise local concerns, resource needs, and new ideas to the statewide corporation and the governing board.

The operational model balances central statewide administration with real regional engagement and room to adapt. It offers the best path to more consistent administration, long-term fiscal accountability, and less fragmentation, while staying responsive to Oregon communities over time.

A central model does not mean the corporation must build every technical function in-house on day one. Standing up a statewide plan will take real operational development over time, and the Board left room for contracted third-party support where it helps with launch, continuity, or specialized capacity. That support could cover claims administration, information technology, payment processing, customer service, enrollment systems, and other technical services.

Phasing in operations this way is both realistic and financially prudent. The corporation would keep final responsibility for financing, policy, oversight, and accountability, and use contracted support where it makes sense while it builds its own capacity over time.

Information Technology and Data Infrastructure

Today, someone who changes jobs or moves across the state often must start over with their health coverage. They fill in the same information a second time and prove all over again that they qualify, then wait to learn whether their new plan and their doctor can see any of their health history. Providers deal with the same problem from the other direction. They send the same information to many different insurers and public programs, each in its own format, and still cannot always see the full picture of a patient's care.

A universal health plan removes most of that duplication, because one plan holds the record. The technology must be built for that job. The plan's information systems will handle eligibility and enrollment, member services, provider management, claims processing and payment, care coordination, quality measurement, financial oversight, and public reporting. They will also

connect the plan to providers, health systems, community-based organizations, and state and federal agencies, so information moves once instead of many times.

This technology does more than keep the plan running. It also helps people get care and take part in their own health. Oregon law directs the Board to maximize health and defines that to include giving people satisfaction and a say in their own care. The plan's tools will support that goal by making it easier for members to reach their care team, see their own health information, and act on it early. They will also support prevention and early intervention, which the plan already prioritizes by removing the cost barriers that keep people from getting care in time.

The public corporation would build toward a target architecture, meaning a written plan for how the plan's business processes, data, applications, and technology fit together. That architecture would be modular and interoperable. Modular means the whole is built from separate parts, each of which can be upgraded or replaced on its own. Interoperable means those parts can exchange information with each other and with the technology other organizations run. Building this way costs less over time than one large, fixed design, because Oregon can replace a single piece when technology or federal rules change instead of rebuilding everything. It also keeps the plan from becoming dependent on any one vendor.

The plan would use the data standards the rest of health care already uses, so Oregon does not have to invent its own. These include Fast Healthcare Interoperability Resources (FHIR) for clinical information, the X12 standards for claims and other transactions, and the National Council for Prescription Drug Programs (NCPDP) standards for pharmacy.

The plan needs core capabilities in these areas:

- Enrollment, eligibility, and member services that people can use
- Provider directories, credentialing, claims, and payment
- Support for global budgets, meaning set amounts paid to a provider in advance, along with review of how care is used, quality measurement, and accurate payment
- Data and analysis tools for daily oversight, public reporting, and evaluation
- Secure information exchange across clinical, administrative, public health, and social care organizations
- Identity, access, security, and monitoring that protect sensitive information and keep the plan running

Privacy, security, and access would be part of the design from the beginning. What members see and use would be simple and reliable, usable by people with disabilities, available in languages other than English, and workable for people with little internet access. Clear rules would govern who can see a member's information, what they may use it for, how long it is kept, and who answers when something goes wrong.

The plan must follow federal and state privacy and security law. That includes the Health Insurance Portability and Accountability Act (HIPAA), which sets national rules for protecting health information. It includes 42 CFR Part 2, the federal rule giving added protection to substance use disorder treatment records, and the federal interoperability rules. It includes Section 1557 of the Affordable Care Act, which bars discrimination in health programs, along with Oregon's own privacy and security laws. Security would follow a zero-trust approach, meaning no user, device, application, or vendor is trusted by default and each is given only the access needed for an authorized task.

The plan would build new IT infrastructure in phases. The first step is an assessment of what the state already has in place, what the plan needs, what order to build in, and how much of the work Oregon can handle with its own staff versus contracted help. Early operations may run on existing technology and qualified vendors while the public corporation develops its own capacity. This matches the phased approach to administrative functions described earlier in this section.

Whoever does the work, responsibility stays with the public corporation. It governs this infrastructure, protects the data, defends against cyberattack, oversees vendors, and answers for how the technology performs.

Several things are not yet decided. The detailed architecture, staffing, procurement approach, build sequence, and cost estimates all require further technical and financial analysis during implementation planning. This report does not carry a cost estimate for the plan's information technology. Startup technology costs are covered in the Finance and Revenue section, under Reserves, Transition Costs, and Startup.

Provider Payment and Delivery System Strategy

How the plan pays providers is one of its most important choices. Payment methods shape not just total spending but also provider stability, workforce growth, access to care, care coordination, how much care people use, and how the system behaves over the long run.

Oregon's payment system is deeply fragmented today. Providers work across many payers, each with its own fee schedule, payment methods, billing rules, quality programs, prior authorization standards, and reporting demands. That fragmentation adds paperwork, destabilizes provider finances, and pulls payment incentives away from population health goals.

The universal health plan will use one unified payment system built to control costs, cut paperwork, keep access fair, and steady the workforce. It will pay providers and provider organizations directly, using a mix of payment methods matched to the care setting and service, including payments set in advance and payments tied to quality and outcomes. Participating providers may not balance bill plan participants for covered services or otherwise charge a participant the difference between the amount paid by the universal health plan and the provider's normal charge.

Statute will set payment policy at the framework level, and the public corporation will set, update, and adjust rates and methods through rulemaking. This mirrors how Medicare and Medicaid already work and lets the plan adjust in time to protect its finances and performance.

In using that authority, the public corporation will be required to:

- Make sure there are enough providers in the plan and protect access to care
- Keep rate-setting methods and decisions transparent
- Match payment levels to available revenues and trust fund sustainability

Regional offices will advise and help carry out payment policy. They will not set rates or benefit structures on their own.

Early on, the public corporation may use a third-party administrator (TPA) to help with claims processing, payment, and some operations. Provider contracts would stay with the corporation, and the TPA would act only in a delegated role. Over time, the plan may bring these functions in-house, combine them, or change them as its systems mature.

Hospital Payment

The Board proposes paying hospitals and health systems through global budgets to make their finances more predictable, cut administrative complexity, and support the long-term health of Oregon's hospital system overall. A global budget is a set amount paid to a provider in advance, based on past spending and usually updated each year for population changes and inflation.

Under this approach, global budgets are set in advance to cover services for defined populations or service areas, rather than being paid mainly per claim through fee-for-service. Compared with today's system, global budgets could offer several advantages:

- More financial stability for hospitals and health systems
- Fewer incentives to increase unnecessary care
- Better support for rural and safety-net facilities
- Simpler administration and billing
- Closer alignment between payment and population health goals

The global budget will cover inpatient, outpatient, and physician services at acute care hospitals, about 70 percent of a hospital's total payments. The other 30 percent will come from activity-based payment, meaning fee-for-service or diagnosis-related group (DRG) payment, plus quality and performance payments.

Critical access hospitals will also be paid through global budgets, but their payments may cover a larger share of reasonable costs, in recognition of their essential role in keeping hospital care available. The Board recommends the global budget method also account for:

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

To ease the transition, the Board recommends phasing this in over three to five years, raising the share of payment inside the global budget step by step. Global budgets will be built to steady hospital finances while advancing system-wide goals of less avoidable care and better population health.

Primary Care

The Board found again and again that not enough funding for primary care drives fragmentation, delayed treatment, avoidable emergency visits, and workforce strain in the current system. The proposed payment structure puts a priority on funding primary care and keeping it connected to the rest of care.

Primary care payment would follow the Primary Care Value-Based Payment model developed by the Primary Care Payment Reform Collaborative. Under this model, primary care will be paid through four value-based parts:

1. Set per-person payments made in advance (capitation) for common primary care services that make up most primary care spending and that fee-for-service could push toward overuse;
2. Fee-for-service payments for other covered services, such as prenatal visits, end-of-life and advance care planning, home visits, and after-hours care.
3. Monthly per-member infrastructure payments, with a base amount tied to the practice's Patient-Centered Primary Care Home (PCPCH) tier plus extra payments for specific high-value services such as advanced care coordination and management.
4. Performance payments tied to a shared set of quality measures.

The plan will treat primary care funding as a foundational investment. Payment levels will be set to support access, a stable workforce, and better care, and will be shielded from outsized cuts when short-term budget pressures hit. Each year, 15 percent of the plan's spending will go specifically to primary care that emphasizes routine well-care and heads off more costly services later. The 15 percent target builds on Oregon's existing primary care spending policy, including

the 12 percent primary care spending currently required for Coordinated Care Organizations (CCOs) and statewide reporting of primary care spending across major payers. Recent Oregon data show Medicaid primary care spending reached 15 percent, which shows the target is achievable while advancing the state's cost growth and care transformation goals.

Specialty and Other Provider Payment

Specialty care, behavioral health, oral health, pharmacy, and other sectors all play critical roles, and each needs payment methods that support access, quality, and a sustainable workforce over the long term. Specialty payment reform under the plan should follow several core principles:

- Keep access to specialty care across regions and populations
- Reduce paperwork and payment fragmentation across payers
- Support financial stability and predictability for providers and health systems
- Avoid rewarding unnecessary volume or intensity of care
- Support integration across primary, specialty, behavioral health, and hospital care
- Keep flexibility to address workforce shortages and regional access gaps
- Align payment with quality, outcomes, and long-term sustainability
- Allow phased rollout and adjustment as capacity and data systems mature

No single method fits every specialty, provider type, or care setting. Implementation may need a mix of approaches, including fee-for-service, prospective payment, bundled payment, global budgeting, or other alternatives, depending on the specialty, the provider market, and the population served.

Quality and Performance Alignment

The public corporation will build and maintain a statewide quality strategy to support accountability, transparency, and steady improvement across the delivery system. Payment models may include a small set of standard performance measures, chosen to limit paperwork and to fit existing data systems where possible. The Appendix has more on the Board's quality strategy recommendation.

COST CONTAINMENT

Keeping the universal health plan affordable over time will take active management of health care cost growth across many parts of the system. In this section, cost containment means the strategies the plan will use to slow long-term cost growth while keeping access to needed care, supporting providers and the workforce, cutting unnecessary paperwork, and improving accountability.

No single tool can contain costs on its own. The Board recommends a layered set of strategies that work across three areas: the system as a whole, provider payment and the delivery system, and prescription drugs. These strategies are implementation priorities and ongoing management tools. They are not treated as guaranteed savings.

The Board's approach follows a few principles. Cost-containment work should reach across the system, provider, and pharmaceutical areas rather than lean on any one of them. It should focus on high-impact changes that improve on today's system without adding unnecessary paperwork. Near-term operating improvements and long-term structural reforms should reinforce each other. And every strategy should protect continuity of care, fair access, provider stability, and the plan's long-term health.

Health plans have often tried to control costs by shifting more of them onto patients, through deductibles, copays, prior authorization, step therapy, and similar barriers. These tools can lower spending in some cases, but they also raise fairness concerns, delay needed care, add complexity, and can increase disparities and lead to worse health outcomes. The Board's approach takes a different path. It puts structural and system-level reforms first, so that incentives line up better, administration gets simpler, and the system stays sustainable.

System-Level Strategies

Oregon already has much of the groundwork for monitoring costs and holding the system accountable. This includes the Sustainable Health Care Cost Growth Target program, the All Payer All Claims (APAC) reporting system, the Prescription Drug Affordability Board, and related transparency efforts. The Board recommends building on these tools rather than creating new oversight bodies where the current ones can be strengthened or adapted.

Administrative simplification is a cost-containment strategy in its own right. Oregon's current system, with its many payers (insurers and public programs), forces providers, employers, and patients to work through wide variation in billing, prior authorization, network rules, payment methods, and reporting. Reducing this fragmentation and standardizing processes can improve efficiency and lower the costs that come with payer complexity. Further analysis of administrative burden and simplification options is included in the Appendix.

At the system level, the plan can track health care cost growth against measures of the wider economy, reduce duplicative administrative processes, and strengthen efforts to prevent fraud, cut waste, and remove redundancy. It can consolidate purchasing for prescription drugs, durable medical equipment, implantable devices, and other high-cost products and services where that is workable. It can standardize administrative processes where it makes sense, and it can build statewide data and accountability systems to support ongoing oversight.

Provider Payment and Delivery System Strategies

Today, providers are paid mainly through fee-for-service billing across many payers, each with its own rates and rules. This plan would greatly simplify that system while continuing to develop payment approaches that align financing, quality, access, and sustainability. The plan's specific payment design, including global budgets for hospitals, is described in the Administrative Structure section; this section explains how those choices support cost containment.

The plan will pay hospitals through global budgets and will strengthen investment in primary care and behavioral health. It can also use standardized or simplified payment methods where that works operationally, streamline administrative requirements for providers, and rely on evidence-informed standards of care. Over time, it can moderate excessive price growth and take a longer-term look at fee schedule or rate-setting approaches where feasible.

Provider stability remains essential. Cost-containment efforts should balance managing spending with access to care, a sustainable workforce, and the financial health of providers who serve rural communities, communities that are medically underserved, and other communities at risk.

Pharmaceutical Cost Containment

Prescription drugs are one of the fastest-growing parts of health care spending. The market is complex and hard to see into, with many players between the manufacturer and the patient, including pharmacy benefit managers (PBMs), manufacturers, pharmacies, wholesalers, and payers. The Board recommends continuing to develop a drug strategy focused on affordability, transparency, and long-term sustainability, while keeping access to medically necessary medications.

A pharmaceutical strategy can include consolidated purchasing and a statewide formulary structure. It can prioritize generic and biosimilar drugs where they are clinically appropriate, and address manufacturer practices that steer patients toward higher-cost brand-name drugs. It can set stronger transparency and accountability standards for pharmacy benefit managers, coordinate with the Prescription Drug Affordability Board, and evaluate upper payment limit authority and related affordability tools. It can also develop longer-term approaches for specialty drugs and other high-cost medications.

Because the plan intends to minimize or eliminate point-of-service cost sharing, it has looked at formulary design, purchasing, and negotiations with manufacturers as the main tools for managing drug costs.

Implementation and Monitoring

Cost-containment results will depend on the final program design, federal coordination, provider participation, market behavior, how people use care, and the timing of implementation. For that reason, the Board does not assume these strategies will produce fixed or guaranteed savings. Instead, the public corporation should be authorized and expected to monitor cost growth, measure how well adopted strategies work, report publicly on performance, and adjust approaches over time.

Cost containment is therefore an ongoing responsibility of the universal health plan's governance and operations, not a one-time financing fix. Doing it well will take continued monitoring, public transparency, policy adjustments, and corrective action as Oregon's health care system changes.

IMPLEMENTATION PATHWAYS

Today, people in Oregon get their health coverage through many separate programs and payers (insurers and public programs). Moving to one universal health plan means deciding the order in which those groups join. That order, called sequencing, is what this section covers.

The Board has defined the structure of the finished plan. It has not chosen how to get there. Sequencing is about how and when each group of people moves into the plan, not about the design of the plan itself.

About 52.5 percent of people in Oregon get their primary coverage through groups the state can reach more directly through its own laws and programs. These include public employees, people with employer-sponsored insurance, people without health insurance, and other state-run coverage. Employer coverage will still take careful design, because ERISA limits how states can regulate employer health plans, and because private employers make their own choices.

About 47.5 percent of people get their primary coverage through programs that need federal approval or federal participation, or that are outside of direct state control. These include Medicare, Medicaid, Marketplace subsidies, Federal Employees Health Benefits, and other federal programs. Sequencing therefore has to balance two goals that are in tension with each other: simplifying administration by combining payers and keeping the transition within what Oregon can do on its own.

The gains from simpler administration do not all arrive at once. Federally funded groups cover a large share of people, but commercial insurance drives most of the variation in plan design, prior authorization, network rules, and billing. Providers can see much simpler administration before full federal integration, though the largest gains come only when most major coverage groups take part. Current estimates put administrative simplification at about 85 to 90 percent under a transition that does not include federal programs, rising to about 98 percent under near-complete integration of payers.

The Transition Committee also looked at a service phase-in, in which everyone in Oregon would first receive a limited set of benefits, such as primary care, before broader rollout. The Committee did not recommend it, because it would split people's care across several coverage arrangements and would capture few of the system-wide gains from simplification.

The Board explored three ways to sequence the transition. Each one is described below, and none has been adopted.

Population Phase-In

Under a population phase-in, the plan would start with the groups the state can reach through its own laws, then add more groups over time as federal approvals and participation pathways become available. Phase 1 would cover non-federal groups. Phase 2 would add Medicaid, the Children's Health Insurance Program (CHIP), and Marketplace groups that need federal approval or subsidy pass-through. Phase 3 would add Medicare and the remaining federally governed groups. This path would reach about 55 percent of people in Phase 1, 82 percent in Phase 2, and 99 percent after federal integration.

The main advantages would be speed and control. The plan could launch sooner, depend less on uncertain federal approvals, and start with lower reserve requirements. It could bring earlier relief to people facing rising commercial costs and prove the model works before Oregon seeks broader federal participation. Financing, enrollment systems, provider onboarding, and other functions could mature over time.

The main drawbacks would be a longer stretch inside a multi-payer system. Oregon would have less immediate influence over statewide payment, and full provider simplification would arrive later, which means fewer immediate administrative savings. Fairness is a concern if some people move into the plan while financing starts before they receive benefits. This path would also call for steady communication about who is eligible, when, and what to expect at each phase.

Hybrid Phase-In

Under a hybrid approach, the plan would launch once every group with an existing approval pathway is included. That combines non-federal groups with Medicaid, CHIP, and Marketplace groups. Groups without an existing pathway, mainly Medicare and certain federal programs, would join later. This path would reach about 82 percent of people at launch while keeping a route open for later federal integration.

The main advantages would be greater simplification at the start, a stronger hand in shaping provider payment, and broader participation at launch, all within known approval authorities.

This approach could support payment normalization sooner and open earlier chances for system-wide provider simplification.

The main drawbacks would be longer wait time for starting the plan than population phase-in and continued reliance on federal approvals for Medicaid and Marketplace groups. It would need larger reserves and more operational capacity at launch, and it would carry more complexity at the start. If approval timelines shift, that risk lands on the launch.

Simultaneous Transition

Under a simultaneous transition, all major groups would move into the plan at launch. This would depend on securing every required federal approval and building enough operational capacity to run a statewide transition at once.

The main advantages would be the fullest administrative simplification, immediate alignment of payment systems and provider incentives, earlier economies of scale, and the clearest single transition for people and providers.

The main drawbacks would be the heaviest dependence on federal approvals, including authorities with no established pathway today. It would carry the largest upfront reserve and build-out and the highest operational risk from moving the whole state at once. If approvals or financing conditions change, implementation could be delayed for a long time. In its discussion, the Transition Committee pointed to Vermont's experience as a caution about long timelines, unresolved federal coordination, and reliance on uncertain federal pathways.

Board Discussion

The Board chose not to make a formal recommendation on sequencing, recognizing the importance of public and legislative feedback. Even so, members showed more interest in the population phase-in and hybrid approaches than in a simultaneous transition. Members generally agreed that a simultaneous transition would offer the most administrative simplification in theory, but worried that depending on many federal approvals, including approvals for groups with no established pathway, could delay or prevent implementation.

Members who favored a population phase-in pointed to starting sooner, bringing earlier relief to people without health insurance, people whose coverage falls short, and people facing rising commercial costs, and proving the model works before seeking broader federal integration. They noted that a phased approach could let the state build capacity over time while it continues to seek Medicaid, Medicare, and other federal participation.

Members also named concerns with a population phase-in. These included the risk of a long stretch of multi-payer complexity, gaps in fairness between groups that transition at different times, communication challenges, and financing worries if some people are asked to pay in before they receive coverage. Members specifically raised the case of Medicare beneficiaries paying into the plan before they can receive benefits and discussed excluding Medicare-covered groups from certain financing requirements until they join the plan.

Members also showed interest in a hybrid approach that would launch with non-federal groups and groups that already have federal approval pathways, including Medicaid, CHIP, and Marketplace groups. Members noted that this could lower the risk of building separate systems for Medicaid and non-Medicaid groups and could produce broader simplification at launch. At the same time, members recognized that it would depend on successful federal approvals and could lengthen the timeline compared with a population phase-in.

A key open issue was whether and how Medicaid groups could be aligned with the plan before new federal approvals are in hand. One option raised was a path between the population phase-in and the hybrid, in which the plan launches for non-federal groups while matching current Medicaid and Marketplace requirements as closely as possible.

Staff technical analysis of sequencing appears in the Appendix. That analysis identifies population phase-in as a technically feasible path for further planning under current legal and operational limits, while recognizing that more Board, legislative, federal, and public engagement is needed before Oregon selects a sequence.

The Appendix also includes the Oregon Health Authority (OHA) reports on federal authorities and on system readiness.

RISKS AND TRADEOFFS

Every path forward carries risk and so does standing still. Oregon's current health care system is not stable. Every year, fewer people can get the care they need, and the system keeps getting more expensive. Premiums, deductibles, and out-of-pocket costs keep rising for families and employers, and coverage still depends on a person's job, income, age, program eligibility, and federal policy that can change from year to year. Keeping the current system is a choice that carries its own growing costs.

Building a universal health plan would change how Oregon pays for care, runs coverage, pays providers, and reports to the public, all inside a complex federal and economic setting where many details still depend on future legislative direction, federal coordination, and careful planning. No path removes risk or settles every tradeoff in advance. The question is which set of risks Oregon can manage better: the risks of a planned transition, or the risks of rising costs,

fragmentation, declining access, and instability if the system stays as it is. This section looks at both options, including areas of uncertainty.

Risks of Keeping the Current System

The costs of the current system are real and rising. In Oregon, the Department of Consumer and Business Services (DCBS) approved 2026 rate increases that averaged 9.7 percent in the individual market and 11.5 percent in the small group market.¹ Nationally, employer-sponsored family coverage reached nearly \$27,000 a year in 2025, and average family premiums rose 6 percent in a single year.²

These costs are hurting people and families in Oregon. About 1 in 8 households say medical bills have eaten up all or most of their savings, and 1 in 7 delay or avoid care because of cost.³ In rural southwest Oregon, that rises to 1 in 5, the highest rate in the state.

The squeeze is worst for people who buy their own coverage through the Marketplace. After enhanced federal premium tax credits expired in 2025, the Kaiser Family Foundation (KFF) found that Marketplace costs jumped, fewer people picked plans and more moved into higher-deductible coverage. Average monthly premium payments rose 58 percent from 2025 to 2026, and average Marketplace deductibles climbed 37 percent to a record high.⁴ KFF also found that 9 percent of people who had Marketplace coverage in 2025 had no health insurance by early 2026, and one in six returning enrollees were not sure they could afford their premiums for the whole year.⁵ Having a plan available on paper does not mean coverage people can actually afford or keep.

Job-based insurance does not fully protect families either. KFF found that 88 percent of covered workers in employer plans had an annual deductible in 2025, and 34 percent had a deductible of at least \$2,000 for single coverage. One-third were in a high-deductible plan with a savings

¹Oregon Department of Consumer and Business Services, 2026 health insurance rates.
<https://apps.oregon.gov/oregon-newsroom/OR/DCBS/Posts/Post/2026-health-insurance-rates>

²KFF, Employer Health Benefits Survey 2025, Summary of Findings. <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey-Summary-of-Findings.pdf>

³ Impact of Health Care Costs on People in Oregon, 2024, Oregon Health Authority.
https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2024-Impact-of-Health-Care-Costs-on-Oregonians_FINAL.pdf

⁴KFF, What we know so far about 2026 ACA Marketplace enrollment, premiums, and deductibles.
<https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/>

⁵KFF, What we know so far about 2026 ACA Marketplace enrollment, premiums, and deductibles.
<https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/>

option.⁶ Among small firms that did not offer health benefits, the most common reason was that the cost was too high.⁷ Coverage is becoming less protective over time, even for people who stay insured. Employers feel the strain too, especially small businesses. As premiums rise year after year, some are forced to choose between offering coverage and staying open, and others raise employee costs, freeze wages, or drop coverage.

Keeping the current system carries real risks to the state's finances, to fairness, and to access. Rising premiums and deductibles push people into medical debt, delayed care, and financial stress. A fragmented system keeps paperwork high for providers and employers, weakens Oregon's ability to control costs statewide, and leaves the state exposed to federal subsidy changes and a volatile insurance market. The state cannot avoid risk either way. The real choice is whether to keep absorbing the growing costs and instability of the current system or manage a planned move toward one that is more stable, fair, and accountable. The current system also strains the providers people rely on. Workforce shortages, thin margins, and heavy administrative work make it harder to deliver care, and the pressure falls hardest on rural communities and safety net providers.

Risks of Making the Change

Federal Authorities

Oregon does not control every part of health care financing on its own. Medicaid, Marketplace subsidies, Medicare, the Federal Employees Health Benefits (FEHB) program, the military's TRICARE program, Veterans Affairs coverage, and some employer plans run under federal law or federal administration, and not all of them have a clear path to fold into a state-run plan. Federal approval timelines, waiver conditions, how agencies read the rules, and future changes in Congress could slow the work, limit how much can be combined, or affect the financing. The plan lowers this risk by keeping existing federal funding wherever possible, working with federal programs rather than assuming they can be replaced right away, and looking at phased pathways that let Oregon start with the populations and authorities it controls while it pursues federal approvals over time. Federal coordination will be required. It remains to be seen how quickly, and under what conditions, federal populations and funding can be brought in. For that reason, the planning points toward phased or hybrid approaches rather than making launch depend on full federal integration at the start.

⁶KFF, 2025 Employer Health Benefits Survey. <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>

⁷KFF, Americans' challenges with health care costs. <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>

Financing Transition

Moving from today's scattered and often hidden health care spending to clear public financing is a second risk. Right now, families and employers already pay a lot for care through premiums, payroll contributions, deductibles, cost sharing, lost wages, and business expenses, but those costs are spread across many private and public channels. A universal health plan would make more of that spending visible through taxes or other public revenue, which can create political and public trust risks even when the new revenue replaces money people already spend. The plan reduces this risk by drawing on several broad revenue sources, relying on progressive contributions, dedicating the revenue to a Universal Health Plan Trust Fund, and separating money that replaces existing spending from money that pays for new costs. Even so, the change would not affect everyone equally. Some households and employers would pay more than they do today, while others would pay less or face less financial risk. Future legislative work will need to refine who contributes what, set the timing of the transition, protect the groups hit hardest, and explain the change clearly, so people understand it as a consolidation of health care money they already spend rather than a brand-new tax.

Employer Behavior

Whether employers move to the universal health plan is another open risk, especially for self-funded employers protected by ERISA. Because Oregon cannot force employer plans to end or change, some employers may keep their current coverage even after the universal plan is available. If employers move over more slowly than expected, the system of many payers (insurers and public programs) stays more complex for longer, providers see less near-term relief from paperwork, and the plan has to keep coordinating with employer coverage. This matters most for large, multi-state, or self-funded employers that may have less reason or ability to line up with an Oregon plan. The model tries to limit this by making the universal plan a lower-cost, lower-hassle option than separate employer coverage, while staying on firm legal ground by not directly regulating ERISA plans. How many employers would move is still unknown. Future work should include additional direct outreach to employers, survey research, more analysis of how self-funded employers behave, and legislative decisions about whether the universal plan pays first or second where employer coverage stays in place. The Proposed Model section describes those two approaches and what each would mean.

Provider Payment and Access

A universal health plan would mean big changes to how providers are paid: new payment methods, rate-setting, billing, administrative rules, and contracting. Some providers and health systems may resist, especially where standard rates, global budgets, or simpler administration would change the revenue they count on. At the same time, Oregon's hospitals, rural providers, safety-net clinics, behavioral health providers, and primary care practices already work under

staffing shortages and thin margins, so transition planning is critical to keeping access steady. The plan addresses this by phasing in hospital global budgets, protecting investment in primary care, letting payment methods vary by provider type and service, and using the public corporation's rulemaking authority to adjust rates and methods over time. Even so, this will take ongoing work with providers, transparent rate-setting, transition support for financially fragile providers, and close monitoring of the workforce, provider participation, regional access, and continuity of care.

Administrative Capacity

Standing up and running the plan is a further risk. A universal health plan would require Oregon to build or oversee large operations: eligibility and enrollment, claims, provider contracting, payments, customer service, data systems, purchasing, compliance, financial management, and reserves. Problems in any one of these could disrupt coverage, provider payment, public confidence, and legislative support. The plan reduces this risk by setting up a public corporation to run core financing, payment, policy, and operations; allowing contracted help during the build-out; and creating a trust fund and reserves to keep operations steady. Getting it right will take detailed operational planning, realistic timelines, strong oversight of vendors, staged system build-out, hiring, backup plans, and regular public reporting, so the plan's capacity grows fast enough to support statewide coverage.

Conclusion

Together, these risks show that building a universal health plan would take sustained work with the Legislature, state agencies, the federal government, providers, employers, and the public. They also show why continued planning makes sense. The current system is already straining families who cannot afford premiums, deductibles, or medical debt; employers facing rising benefit costs; and providers working under thin margins, staffing shortages, and heavy paperwork. Moving to a universal health plan would not erase these pressures right away, and it would bring real transition challenges. But keeping the current system is also a choice with costs to the state's finances, fairness, access, and stability. The Board's proposed model is best understood as a way to manage the risks of transition while facing the growing risks of cost, fragmentation, and instability under the current system.

LEGISLATIVE ACTION AND NEXT STEPS

This section lays out what the Legislature would need to do to turn the Board's plan into law and put it into effect. It answers the Legislature's request for a suggested implementation framework and the specific actions needed to make a universal health plan real.

Oregon now knows enough to set the direction of a universal health plan. The next phase is not more preliminary study. It is the work of turning that direction into legislation that is workable, financially sound, and accountable to the public. The Board recommends treating the next phase as a build-out phase, focused on the decisions, analysis, public engagement, and law changes needed to determine when and how Oregon moves from planning to launch. The six steps below can run partly in parallel, and their order reflects how the pieces depend on one another more than a strict timeline.

Step 1: Authorize a Phase 2 implementation blueprint

First, direct the Board to build on this plan for the implementation, authorizing the next phase of work toward a Universal Health Plan for Oregon. That work would cover financing and revenue. It would cover governance, administration, and institutional design. It would cover the capacity, infrastructure, and geographic reach of the care delivery system, and the health care workforce, including shortages and transition needs. It would cover operational readiness, meaning claims, enrollment, data systems, contracting, and procurement. It would cover federal coordination across Medicaid, Medicare, Marketplace subsidies, ERISA, and waiver pathways, along with federal fiscal risk; employer and labor market effects; a public engagement and communications strategy; the statutory and regulatory changes implementation would require; and the actual legislation needed to put a universal health plan in place.

Step 2: Pass framework legislation

Pass framework legislation that sets the plan's legal structure, its governing authorities, its institutional design, and the principles that guide it. This gives the plan a stable legal foundation to build on while the remaining details are worked out.

Step 3: Continue developing the revenue plan

Keep developing the revenue plan. This means more fiscal and actuarial analysis of projected spending, revenue needs, reserves, and long-term sustainability, and refining the revenue mechanisms, tax bases, thresholds, credits, exemptions, and timing. It also means studying how the plan would affect households, employers, workers, businesses, and regions differently, and completing a statewide economic impact analysis of the effects on households, employers, workers, wages, and the wider economy.

Step 4: Build a formal transition plan

Build a detailed transition plan. It would cover sequencing, enrollment, provider participation, claims, data systems, appeals, contracting, and member communications. It would identify which populations and programs Oregon can bring in under existing authority and which need

federal approval or new state law. It would set transition protections for patients, providers, rural communities, collectively bargained arrangements, and people who stay connected for a time to federal or employer coverage. And it would estimate startup costs, staffing, procurement, information technology needs, and operational milestones.

Step 5: Run a formal public engagement process

Run a formal, statewide public engagement process. The Board has said throughout that the public should help make the value choices built into the plan, and the revenue design in particular has not yet been tested with broad public input. This step would gather public understanding and concerns, provide clear information on the major design choices, tradeoffs, financing, and timelines, and reach the communities most affected by unstable coverage, medical debt, access barriers, and provider shortages. It would include targeted engagement with rural communities, Tribal governments and Tribal communities, communities of color, immigrant communities, people with disabilities, the behavioral health community, labor organizations, small businesses, providers, and safety-net institutions. What people say would then shape the sequencing, communications, enrollment, and transition protections.

Step 6: Return to the Legislature with an implementation package

Finally, return to the Legislature with a complete implementation package by a set date. The package would lay out the key decisions still to make, including financing, the sequence of implementation, where the plan depends on federal action, governance authority, and transition protections. It would include the recommended law changes, revenue legislation, the implementation plan, fiscal estimates, administrative authorities, transition protections, and the accountability measures that let the public track progress.

Together with the Implementation Pathways section, these steps are the Board's answer to the Legislature's request for an implementation framework and the actions needed to put a universal health plan in place. They set a clear path forward while being honest that the major financing, sequencing, and federal-coordination decisions still rest with the Legislature.

Where To Find More Details

This section summarizes work that is documented at full technical depth in the appendices. The appendices include a fuller account of the Finance and Revenue Committee's process. They include the detailed financing analysis, with the specifications for each revenue instrument, the assumptions behind the Revenue Replacement Target, and a note explaining how the estimates changed as the actuarial work was completed. They include the Milliman expenditure analysis (April 3, 2026), the ECONorthwest committee report (June 2026), and the final targets and rates (July 16, 2026). They also include the Finance and Revenue Committee's Revenue

Proposal Summary (March 3, 2026), its reserves report (March 7, 2026), the minority report (April 13, 2026) in full, and the committee's supporting spreadsheets.

FREQUENTLY ASKED QUESTIONS

An existing draft written by Wentz Jackson Consulting is being reviewed and updated by the workgroup.

APPENDICES

Being developed/compiled by staff.