

Draft 10/5/2026:

UHPGB Legislative Report

Not approved by the board

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Board Process and Decision Framework

The Oregon Universal Health Plan Governance Board (the "Board") was established under Senate Bill 1089 (2023), now in state law as Oregon Revised Statutes (ORS) Chapter 751. The Board is charged with developing a comprehensive, implementable plan to finance and administer a universal health plan for all people living in Oregon and to submit recommendations to the Legislative Assembly by September 15, 2026. At a special meeting on August 6, 2026, the Board voted unanimously to deliver this report by December 1, 2026, to allow more time to complete the work. The legislative sponsors of Senate Bill 1089 agreed to the new date in writing on August 17, 2026. The statute directs the Board to evaluate financing, benefit design, administrative structure, and implementation pathways, while prioritizing affordability, equity, and quality within existing state and federal legal constraints.

The Board's nine members were appointed by the Governor and confirmed by the Senate. The Board organized its work across five committees which brought proposals forth to the Board for consideration as well as drawing from the work of consultants Milliman, ECONorthwest, and Health Management Associates. The full reports from consultants are available in the Appendix.

Guiding Principles

Five overarching guiding principles were adopted by the Board to guide its work and considerations of tradeoffs. The principles include statutory considerations in addition to values adopted by the Board.

- **Health Equity:** Health care is a fundamental element of a just society, and must be secured for all individuals on an equitable basis by public means, similar to public education, public safety and public infrastructure (ORS 751.002(3)(a)(A)).
- **Maximize Health:** Maximize health includes individual satisfaction and agency in care and public health concerns for the community as a whole. Improving the health status of individuals, families and communities (ORS 751.002(2)(a)).

- **Fair Distribution of Medical Resources:** Establishing and ensuring a fair distribution of medical resources is a principle in ORS chapter 751 and an overarching principle of the Governance Board
- **Minimize Financial Hardship for Individuals and Families from Medical Costs:** Protecting individuals from the financial consequences of ill health; and (SB 1089 Section 2 (2)(c)) Removing cost as a barrier to accessing health care. (ORS 751.002(2)(c) and ORS 751.002(2)(e)).
- **Community Sense of Ownership and Governance:** In any policy or program that will directly and intimately affect a community, that community should have voice in final decision making.

Board Vote

On October 15, 2026, the Board voted to approve this report for submission to the Oregon Legislature in fulfillment of its statutory charge.

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.

Board Members

	Bruce Goldberg	Lee Hastings, Senior Policy Advisor
Helen Bellanca (chair)	Mary Lou Hennrich	
Judy Richardson (vice chair)	Michael Leahy	
Cherryl Ramirez	UHPGB Staff	Past Board Members
Chunhuei Chi	Miriam McDonell, Executive Director	Debra Diaz
Amy Fellows	Isabel Courtelis, Executive Assistant	Warren George
Michelle Glass		

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Advisor

PROPOSED MODEL

The Board proposes a universal health plan that would cover all Oregon residents with a common core set of benefits, and with limited out-of-pocket costs. Eligibility for the universal health plan would not depend on employment status. Under a replacement financing approach, a universal health plan could be paid for mostly through an employer payroll tax and a health care personal income tax. The plan would be managed by a public nonprofit corporation with several regional hubs to ensure local community voices are heard. Actuarial modeling suggests a universal health plan would result in lower total statewide spending, broader coverage, and improve transparency and equity.

Today, the health care coverage and access to care a person in Oregon has depends on their job, their income, and whether they qualify for state or federal assistance programs. When any of 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 have insurance, many face premiums, deductibles, and copays they cannot afford. Many businesses struggle to provide health insurance to their employees, and many cannot. A universal health plan would create a statewide public coverage system capable of better coordination with federal programs and other insurance providers, and a system that would provide continuity of health care coverage for those living in Oregon.

The proposed 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 would use Oregon residency as the single standard for eligibility. Residency would be defined under ORS 316.027, including those domiciled in the state or residing in Oregon for more than 200 days of the tax year. People who state that Oregon is their primary home and that they intend to stay would be eligible immediately, with verification required within 60 days to ensure coverage.

Children would be enrolled automatically when claimed by a parent or guardian as a dependent. Each covered person would receive their own eligibility and member identification. Rules for dependents would 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.

Special Populations

Additional populations would be eligible for the universal health plan as special exceptions to the general residency requirement.

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

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

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

Students from other states who attend school in Oregon would be eligible, assuming they meet the 200 or more days in the state standard. Individuals domiciled in Oregon who attend school out of state can keep coverage under their family's plan, following the dependent rules above.

People who live outside Oregon would not be eligible for coverage.

Enrollment

Today, people who qualify for health care coverage may lose coverage 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 basic 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 must 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 (for example, Medicaid matching funds) and determine eligibility for Medicaid-required benefits
- **Proof of identity**, to support program integrity, coordination with federal programs, and member communication

Acceptable proof may include a lease, a utility bill, employer verification, or other approved documents. Wherever possible, the plan would check existing state and federal data systems instead of asking members for paperwork, reducing the burden on individuals.

Automatic Re-Enrollment and Continuity of Coverage

The plan would keep people covered through largely automatic renewal of eligibility. The main pathway for renewal would be the filing of an Oregon personal income tax return or being claimed as a dependent on a personal income tax return with Oregon residency indicated. This is expected to automatically re-enroll approximately 75 to 85% of eligible people.¹

The plan would also renew people by matching records with other state programs that already verify residency, including:

- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)

¹ UHPGB, Eligibility/Enrollment Proposal, approved February 19, 2026, <https://www.oregon.gov/uhpGB/Documents/board-meetings/2026/20260219/proposal-enrollment-20260122.pdf>.

- 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% of eligible people with no action on their part.²

Ex Parte Review and Member Outreach

For the smaller number of people the automatic steps miss, the plan would conduct ex parte review of their eligibility using existing state data. Direct member enrollment would only occur when existing state data cannot confirm individual eligibility. While this review is underway, the individual would maintain coverage for a 90-day grace period, unless the plan learns they no longer qualify.

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

Integration with Federal Programs

Enrollment and verification are built to work with federal programs including Medicaid (Oregon Health Plan) and Medicare. Where the plan seeks to maintain federal funding, it must follow all federal rules for eligibility and documentation. The plan must also verify whether a member is Medicaid or Medicare eligible, for purposes of federal funding and compliance with applicable program rules.

Scope of Benefits During Initial Enrollment

Newly enrolled members would start with a basic set of services and gain full coverage after six months of continuous coverage. In the first six months, members would have access to:

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

² UHPGB, Eligibility/Enrollment Proposal, approved February 19, 2026, <https://www.oregon.gov/uhp/ Documents/board-meetings/2026/20260219/proposal-enrollment-20260122.pdf>.

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 dental, vision, and behavioral health. The universal health plan would establish one common core benefit package. The core benefit package would be based off the standard benefits available to Oregon's public employees through the Public Employee Benefits Board (PEBB), with targeted improvements in behavioral health coverage. This report calls that package PEBB+.

Scope of Covered Benefits

The proposed benefit package for the universal health plan would covers the full range of medically necessary care including, but 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 for children and adults
- **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**

Individuals who qualify for Medicaid (OHP) would 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

The universal health would expand typical behavioral health benefits available through commercial insurance to include:

- **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**

An expanded continuum of behavioral health providers deliver this care, including licensed clinicians, certified providers, and supervised paraprofessionals. The design is intended to support more continuous, integrated care and address identified gaps in access.

Cost Sharing and Financial Protection

Even people with insurance today may skip care because of the cost of deductibles and copays. The universal health plan would aim to cover most, and ideally all, services with no point-of-service cost-sharing. 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 proposed to be part of the universal health plan benefit package. These include:

- Long-term services and supports for people who are not eligible for Medicaid;
- Certain health-related social needs services authorized under federal waivers for those not eligible for Medicaid; and
- Services for populations covered under federally administered programs, where federal funding and authority remain in place.

In alignment with the Joint Task Force on Universal Health Care , the Board proposes keeping these services in the programs that deliver them now.

Benefit Design Flexibility

The universal health plan would establish a common core benefit package. The governing body would have authority to adjust benefits over time as clinical evidence, community health needs, the plan's finances, and federal rules and opportunities change, within statutory standards

Interaction with Other Coverage

A universal plan would not be the only payer in Oregon. Federal law governs several kinds of coverage, and the state of Oregon does not have the authority to regulate federal programs. Some federal programs, including Medicare, Veterans Affairs, TRICARE, and the Federal Employees Health Benefits program, currently offer no pathway mechanism for integration into a state-based health plan.

The universal health plan would 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. Participation and coordination with Tribal health systems would remain voluntary and require continued government-to-government consultation with Tribal Nations.

The universal health plan would 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) limits how states can regulate employer-sponsored health plans, particularly self-funded plans. Because of that, the universal health plan would not eliminate the option of employer-based coverage. Employers could continue offering coverage or discontinue it, while eligible employees would be enrolled in the state universal health plan. The universal health plan is designed to be a simpler, lower-cost option that could remove considerable complexity from employers managing their own health benefits. To the extent permitted under ERISA and other federal law, the state will need to establish coordination requirements for how the universal health plan will interact with non-federal employer coverage.

Under a primary coverage approach, the universal health plan would pay first for covered services, and any employer coverage would fill in around it. The advantages are simpler administration for providers, more ability for the universal health plan to drive payment and delivery reform, and a greater payment and administrative consolidation. The drawbacks would include higher upfront financing for the plan, disruption to benefits won through collective bargaining, and added legal and operational risk tied to ERISA. The Technical Report 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 advantages would be lower initial cost for the plan, less disruption to current employer arrangements, and no direct role in employer plan administration. The drawbacks would be continued administrative complexity, less room to simplify the system and reform payment for care providers, smaller 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 universal health plan should function as primary or secondary insurance. The Task Force 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 universal health plan would need to align with existing laws regarding third-party insurance, such as liability coverage and worker's compensation.

The proposed public corporation is recommended to have legal authority to recover costs from a party responsible for an injury, a process known as subrogation. Members would receive care regardless of who is at fault, and the public corporation would pursue repayment afterward on its own.

Oregon's workers' compensation program would also continue operating on its own. The two programs would coordinate so the universal health plan can be repaid for medical costs related to workers' compensation claims.

Out-of-State Coverage

The universal health plan would cover eligible Oregon residents both in state and out of state. It may contract with a national provider network, or set up other arrangements, to achieve out-of-state coverage. Out-of-state care may carry some cost-sharing, especially for non-emergency services. The universal health 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 resides in Oregon. Residency-based eligibility, immediate enrollment on a person's own statement, alternative ways to verify, automatic re-enrollment, and automatic review using information the state already has all work to remove the administrative barriers that fall hardest on individuals 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 is intended to reduce financial and service disparities. A PEBB+ package, including expanded behavioral health, dental and vision coverage, and strong primary care, all work to improve access to preventive, routine, and necessary care. The plan's aim to cover most, and ideally all, services with no deductible, copay, or coinsurance would remove a key financial barrier at the point of service. These choices often matter most for people and communities that face delayed care, unmet behavioral health needs, high out-of-pocket charges, 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 larger numbers of uninsured and individuals on Medicaid or Medicare generally operate on thinner margins than providers who serve more patients with private insurance. Lower reimbursement can contribute to financial and workforce pressures, particularly for rural and safety net providers, and may impact provider access.

A single statewide payment system would use standardized payment methodologies rather than variable rates by source of coverage. It would also let the universal health plan adjust rates based on factors such as rural access and other policy objectives.

Whether the plan actually 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 other barriers. It must account for provider participation, regional access, and coordination for individuals who remain enrolled in federal programs or employer-sponsored insurance. Meeting these goals will take ongoing data monitoring and analysis, community engagement, public accountability, and course correction as the universal health plan rolls out.

Expenditure and Revenue

Expenditure

Expenditures

In order to estimate the cost of a universal health plan, the board looked at estimates of what health care in Oregon costs now, where that money comes from, and what health care for everyone living in Oregon would cost under a universal health plan.

Anticipated expenditures for a universal health plan were developed through the analysis of :

- Current Oregon health care expenditures
- Anticipated population changes between 2026 and 2032
- Estimates of the increase in the cost of health care (medical trend) from 2026 to 2032
- Evaluation of additional expenses and savings that are likely to happen with universal health care

The Expenditures section describes those steps in detail, including references to data sources and rationales behind cost estimate assumptions.

Milliman Current Cost Estimates

Milliman, Inc., a global actuarial consulting firm, was contracted by the UHPGB to develop a cost analysis for a proposed Oregon universal health plan. Milliman created a baseline estimate of health care costs in Oregon in 2026, and then developed low, best, and high estimates of the anticipated expenditures if the health care system remains the same and estimates if a universal health plan is in effect in 2032³. 2032 was chosen as the basis year for future expenditure and revenue estimates, as it is the earliest year in which the plan could be fully implemented, given the legislative, federal and operational steps required.⁴

The following table, adapted from the Milliman Report Figure 27, demonstrates 2026 Oregon major medical and prescription drug costs. It **excludes** health plan administrative costs, long term services and supports (LTSS), dental, vision, and fertility costs.

³ Milliman report

⁴ OHA

Oregon 2026 Status Quo Baseline Estimates		
Enrollment & Medical and Prescription Drug Costs		
Type of Health Insurance (Market)	Number of People (Enrollment)	Total in Billions
Public Employer	712,000	\$6.0
Private Employer	929,000	\$7.8
Individual	165,000	\$1.4
Medicaid	1,360,000	\$11.4
Medicare	1,004,000	\$17.5
Uninsured	122,000	\$0.6
Total	4,293,000	\$44.6 Billion

Milliman Report Figure 27(exclusive of administrative costs & dental, vision, fertility, LTSS costs)

Milliman Predicted Costs in 2032- Status Quo System

Population shifts and expenditure changes are projected to substantially increase the cost of healthcare in Oregon over the next several years. Estimates of projected changes are incorporated into the Milliman analysis.

Oregon population growth and shifts from 2026 to 2032 were estimated using Oregon Office of Economic Analysis data. While the total population of Oregon is expected to grow by only 3% from 2026 to 2032, the share of Oregonians who are over age 65 is expected to increase by 8.6%. ⁵ Since older adults on average use more medical services than younger

⁵ Milliman figure 28

people, this population shift has an important impact on the expected cost of health care in 2032. In addition, it is anticipated that if the current healthcare system continues, in 2032 the number of people living in Oregon without insurance will **triple**.

Milliman calculated that the 2032 health care expenditures under the current system would likely be between \$63.5 billion and \$72.6 billion⁶. These estimates include health care costs medical trend increasing by 5.3% -7.4% each year. Also included in the estimates are anticipated increases in prescription drug expenses, related to GLP-1 drugs for diabetes and weight loss, and increased use of advanced treatments such as immunotherapy and gene therapy.

Oregon 2032 Status Quo Projected Estimates				
Enrollment & Medical and Prescription Drug Costs				
Type of Health Insurance (Market)	Number of People (Enrollment)	Total in Billions		
		Low	Best	High
Public Employer	720,000	\$8.3	\$8.9	\$9.5
Private Employer	935,000	\$10.9	\$11.6	\$12.4
Individual	179,000	\$2.0	\$2.2	\$2.3
Medicaid	1,150,000	\$13.1	\$14.0	\$14.9
Medicare	1,091,000	\$26.1	\$28.0	\$29.8
Uninsured	348,000	\$2.3	\$2.5	\$2.6
Total	4,423,000	\$62.7	\$67.1	\$71.5

Milliman Report Figure 30(exclusive of administrative costs & dental, vision, fertility, LTSS costs)

Best Estimate 2032 Status Quo Cost Including Dental and Administrative Costs

⁶ Milliman figure 29 & 30

In order to compare the status quo costs in 2032 to costs of a universal health plan, the cost of covering dental services must be included, and also the administrative costs of all health insurance plans currently operating in Oregon. Dental services in Oregon in 2019 were \$2.35 billion⁷. Projecting to 2032⁸ at a modest 4% increase per year creates an estimate of \$3.9 billion in 2032. Although commercial health plans often have administrative costs of 15-20%, administrative costs for Medicare and Medicaid are substantially lower. Nationally, health plan administrative costs, when private and public insurance plan costs are combined, average roughly 7% of the total cost of healthcare.⁹

Oregon 2032 Status Quo Projected Estimates Including Dental and Administrative Costs (Billions)	
2032 Milliman	Best Estimate
Status Quo Major Benefits	+\$67.1
Oregon Behavioral Health	+\$0.9
Status Quo Dental Cost	+\$3.9
Health Plans Combined Administrative Costs (7%)	+\$5.0
2032 Best Status Quo with Dental and Administrative Costs (does not include vision and fertility expenses)	= \$76.9

Source: Milliman Appendix 4

Milliman Estimated Cost of a Universal Health Plan

There are several features of a universal health plan that uniquely increase costs.

1. More people and better benefits

⁷ [KFF Expenditures by State](#)

⁸ [Health Affairs National Health Expenditure Projections 2024-2033](#)

⁹ [Statranker NHE Administrative Cost](#)

In 2032, a universal health plan would cover about 348,000 more people than the status quo system. Those who were previously uninsured will likely have pent-up demand for health care services. Pent-up demand is modified, however, by the limited availability of health care services, especially in some parts of rural and frontier Oregon. There is also the potential for adverse selection, such as an increase in migration to Oregon of people with high health care costs, either temporarily as medical tourists or permanently, to utilize a state universal health plan.¹⁰

2. No (or minimal) cost sharing^{111213 14}

The portion of health care costs that consumers pay whenever they use a service or purchase medications or durable medical equipment is known as a cost sharing. Removing all cost sharing has been shown to lead to an increase in utilization of health care (Footnote 9 here) and can lead to higher health care costs. This can lead to *better* patient care, such as an increase in cancer screening tests, and improvements in patients regularly taking the medications they have been prescribed. (Footnote 10) However, it can also lead to overuse of some unnecessary or avoidable services (Footnote 11).

Milliman quantified the impact the factors of increased utilization, pent-up demand and adverse selection to low, best, and high estimates of Oregon 2032 medical, prescription drug, and additional behavioral healthcare costs in Milliman Figure 38. The following table summarizes the results.

Oregon 2032 Universal Health Plan Major Medical Cost Estimates (Billions)			
2032 Milliman Universal Health Plan	Low	Best	High
Medical and Prescription Drug Status Quo	\$64.6	\$67.1	\$73.4

¹⁰ Baker MC, Stratmann T. Moving opportunistically: Interstate migration after medicaid expansion. *Soc Sci Med.* 2025 Feb;367:117771. doi: 10.1016/j.socscimed.2025.117771. Epub 2025 Jan 28. PMID: 39893838.

¹¹ Iizuka, T., & Shigeoka, H. (2022). Is Zero a Special Price? Evidence from Child Health Care. *American Economic Journal: Applied Economics*, 14(4), 381–410. <https://www.jstor.org/stable/27181360>

¹² Bhandari NR, Li C. Impact of The Affordable Care Act's Elimination of Cost-Sharing on the Guideline-Concordant Utilization of Cancer Preventive Screenings in the United States Using Medical Expenditure Panel Survey. *Healthcare (Basel)*. 2019 Mar 1;7(1):36. doi: 10.3390/healthcare7010036. PMID: 30832276; PMCID: PMC6473889.

¹³ Dahlia K. Remler, Jessica Greene. 2009. Cost-Sharing: A Blunt Instrument. *Annual Review of Public Health* 30:293-311. <https://doi.org/10.1146/annurev.publhealth.29.020907.090804>

¹⁴ [Quantifying Changes to Healthcare Utilization](#)

Increased Population, Increased Utilization, Adverse Selection Predicted Impact	+ \$3.8	+\$6.2	+\$6.8
Medical and Prescription Drug UHP	=\$68.4	=\$73.3	=\$80.2
Additional Behavioral Health from the 2025-2027 Governor's Budget page 32 Milliman	+\$0.8	+\$0.9	+\$1.1
Universal Health Plan Major Medical Estimates	\$69.2	\$75.3	\$81.3

Source: Milliman Figures 37,38,39

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 from \$77.4 billion (low) to \$94.0 billion (high) depending on utilization, 2032 cost trends, and operational assumptions. This includes reducing payer side administrative costs from current levels of 7% down to 6%, but it does not include potential savings on the provider side or from other sources.

Oregon 2032 Universal Health Plan Major Medical, Dental, Vision, and Plan Administration Cost Estimates (Billions)				
	A	B	C	A+B+C= Total
	Major Benefits	Dental ,* Vision, & More	Administrative Costs	Total
Low	\$69.2	\$4.5	\$3.6	\$77.4
Best	\$75.3	\$5.1	\$5.1	\$85.5
High	\$81.3	\$5.6	\$7.0	\$94.0

Source: Milliman Figure 41 *Dental, Vision, & More includes dental, vision, fertility, complementary medicine, hearing aids, massage therapy, and doula services

Milliman Predicted Savings Under a Universal Health Plan

The Milliman modeling applies two adjustments to the 2032 universal health plan cost estimates. Provider administrative savings related to significant reduction in billing complexity and substantially improved collection of payments reduce the best estimate to

\$77.7 billion; Milliman sizes these at \$4 billion to \$5 billion in reduced eligibility and billing costs and \$3 billion to \$3.5 billion from collections improving when cost sharing ends.

Importantly, realizing the cost savings from collectability would require renegotiating payment rates with providers. With current cost sharing, providers do not collect all that they charge as people are sometimes unable to pay their portion of the charges. Under a universal health plan with a standardized fee schedule, providers would always receive the full amount charged, resulting in an effective increase in reimbursement. Realizing cost savings from collectability requires renegotiating payment rates to a lower amount so that providers would be paid the same as they are now.

Oregon 2032 Universal Health Plan Major Medical, Dental, Vision, and Plan Administration Cost Estimates Including Milliman Estimated Savings (Billions)				
	A	B	C	A-B-C = Revised Plan Expenditures
	Plan Expenditures	Collectability Savings	Provider Administration Savings	Revised Plan Expenditures
Low	\$77.4	\$3.0	\$5.0	\$69.4
Best	\$85.5	\$3.3	\$4.5	\$77.7
High	\$94.0	\$3.5	\$4.0	\$86.5

Source: Milliman Figure 50

In summary, a conservative estimate of expenditures for a universal health plan in 2032 would be \$77.7 billion, compared to \$76.9 billion in expected expenditures under the status quo. That is, we could convert the current fragmented system that leaves many residents uninsured and underinsured into a universal health plan with simplified billing and payment, where everyone has good benefits including dental and vision with little to no cost sharing for about \$1.2 billion more, a 1.6% increase in expenditures.

Universal Health Plan Governance Board Expenditure Analysis

The UHPGB, staff, consultants, and committees spent a considerable amount of time evaluating potential additional savings related to the restructuring of health care administration and payment systems under a universal health plan. ¹⁵Literature review and expert analysis reflect a broad range of potential savings. ¹⁶While a state unified financing system is not expected to generate the same amount of savings that a national system could produce, the potential remains for significant system improvement with resulting expenditure reductions. The areas in which a universal health plan would provide the largest amount of health care cost savings are:

Health plan and provider administrative costs- Combined administrative costs of payers and providers across the current system make up roughly 25% of total health care costs. Streamlined, unified financing systems have been estimated to reduce administrative spend by 10% to 50%.(footnote 13)

Reduction in fraud, waste, and abuse-¹⁷In the United States, it is estimated that fraud alone accounts for 3% to 10% of health expenditures. A unified payment system has the potential for enhanced fraud and abuse detection, resulting in significant savings.

Prescription drug and durable medical equipment costs ¹⁸¹⁹⁻²⁰ The United States pays substantially more for prescription drugs than comparable nations. One recent study estimated outpatient prescription medication savings of 35-62% if medications in the United States were priced at rates similar to those in Canada, France, Germany, Japan, and the United Kingdom. (foot note 18) . While a single state would not be able to realize the savings of a national program, bulk purchasing and consolidated pharmacy benefit management opportunities can reduce the cost of prescription drugs and durable medical equipment. One example of state universal health plan savings comes from the state of New York. Prescription drug costs are estimated to be reduced by 24% under the New York single-payer health plan. ²¹ Array Rx²², a multi-state cooperative started in Oregon, currently achieves prescription drug price reduction through bulk purchasing power.

¹⁵ Appendix HMA Memorandum on Administrative Costs, Transition Committee Presentation 5/14/2026, UHPGB Presentation 5/21/2026

¹⁶ [CBO Single-Payer Health Care System](#)

¹⁷ [Fraud and Abuse in Healthcare Claims](#)

¹⁸ [PNAS US Savings on Prescription Pharmaceuticals](#)

¹⁹ [PLOS Projected Costs Single-Payer](#)

²⁰ [CBO Prescription Drug](#)

²¹ [Analysis New York Health Act](#)

²² [Array Rx Legislative Brief 2026](#)

Health care cost trends- When estimating annual increases in health care costs, the Milliman Report provided a low trend estimate of 5.3% and a high trend estimate of 7.4%. A recent CMS report ²³projects health care cost increases to slow somewhat after 2026, with the annual National Health Expenditure Growth to average 5.4% from 2025-2034. The Board has decided to utilize the Milliman Low estimates as the 5.3% trend is in alignment with NHEA data and CMS cost growth estimates.

Expenditure Analysis Summary- After careful deliberation of presented literature, expert testimony from Dr. William Hsaio and Dr. James Kahn,²⁴ and consultant presentations, the Board concluded that additional savings can reasonably be applied to the Milliman forecast. The following table summarizes the amended expenditure analysis, including savings related to further reductions in administrative expenses, reductions in fraud, waste, and abuse, and lowered prescription drug costs.

.Realizing these savings would require significant interventions, including renegotiating provider payments to account for their lower administrative costs, consolidating pharmaceutical purchasing, and creating a system for better oversight of quality and fraud. With one state-wide payer, these efforts would be substantially easier than under the current multi-payer system, but still necessary to maximize the efficiency of a universal health plan.

Universal Health Plan Governance Board 2032 Expenditure Summary Table

Milliman Report Appendix 4 Expenditure	
2032 Milliman Expenditures	Low Estimate (Billions)
Status Quo Major Benefits	\$62.7
Low Administrative Cost (4.7%)	+\$3.6
Enhanced Behavioral Health	+ \$0.8
PEBB + Benefits	+ \$4.5
UHP Adjustments	+ \$5.7
Milliman UHP Low Estimate	=\$77.4
Milliman Estimated Savings	
Low Collectability Savings	-\$3.0 B
Low Provider Administrative Savings	-\$5.0 B

²³ [CMS NHE Projections 2025-2034](#)

²⁴ Cite

Milliman UHP Low Estimate With Savings	=\$69.4
UHPGB Additional Savings	
Prescription Drug Savings ²⁵	-\$1.0
FWA Savings ²⁶	-\$0.8
Additional Savings from Administrative Cost estimate of 3% (instead of 4.6%)	-\$1.4
UHPGB 2032 UHP Estimate	= \$66.2

Source: Milliman Appendix 4. Milliman Figure 30

These expenditure forecasts are a static view of estimated costs, envisioning an Oregon universal health plan that is fully operational and serving all those living in Oregon. The forecasts do not include start-up costs or health plan reserve funding. The Finance and Revenue Committee and ECONorthwest did preliminary research regarding these topics, which can be found in Appendix_____, however significantly more evaluation is required.

As shown in the following table, Oregon health care expenditures in 2032 under the current system are estimated to be \$76.9 billion. The Milliman Best estimate of a universal health plan in Oregon in 2032 is very similar to the status quo estimate even with the health care coverage of an additional 340,000 people with enhanced benefits. The Universal Health Plan Governance Board, with additional anticipated savings related to lowered administrative costs, improved fraud, waste, and abuse detection, and reduced prescription drug prices, arrived at a 2032 estimate of \$65.8 billion, roughly 15% lower than the status quo estimate.

In the most optimistic savings scenario, it is possible that Oregon could provide robust health benefits to all residents with no cost sharing for about \$11 billion less than under the status quo system, which does not cover everyone and leaves many residents underinsured and facing serious financial hardship from medical costs.

2032 Oregon Health Care Expenditure Estimates (Billions)			
Status Quo	Milliman UHP Best	Milliman UHP Low	UHPGB UHP
\$76.9	\$77.7	\$69.4	\$66.2

²⁵ [PLOS Medicine](#)

²⁶ [PLOS Projected Cost of Single Payer](#)

Revenue Replacement Target

The revenue replacement target (RRT) describes the amount of revenue needed to cover health care expenditures under a universal health plan that is **not** contributed by state and federal funding. This revenue replaces all the money that currently comes from employers and households via premium payments, deductibles, and out-of-pocket costs with payroll and other taxes. The RRT is calculated by subtracting the amount of money projected to be contributed by state and federal funds from anticipated expenditures.

2032 Federal and State Funding Estimates

Federal and state funding for Oregon health care will continue under a universal health plan. In 2026 the amount of federal and state funds was estimated at \$28.5 billion.²⁷

Assuming an annual health care cost growth rate of 5.3%, these funding sources increase to \$38.9 billion by 2032. The addition of Medicaid funding for dental coverage²⁸, estimated at \$0.5 billion in 2032, increases the total estimated funds available from the federal government and the Oregon general fund to be \$39.4 billion.

2032 Federal and State Projected Contributions	Table #
Funding Source	Amount (billions)
2026 CMS Waiver Funding (individual, Medicaid, Medicare)	\$23.4
2026 State General Fund Medicaid Contribution	+\$4.3
2026 Behavioral Health Funding	+\$0.8
Total 2026 Federal and State Funding	=\$28.5
Trend to 2032 at 5.3%	=\$38.9
State and Federal 2032 Dental Funding	+\$0.5
Total 2032 Federal and State Funding	= \$39.4

Source: Milliman Figure 43

²⁷ Milliman Report Figure 43

²⁸ [OHA Oral Health](#)

Revenue Replacement Target Estimates

Utilizing the 2032 Expenditure estimates and the 2032 projected federal and state funding, the revenue replacement target ranges from \$26.8 billion to \$38.3 billion

2032 Revenue Replacement Target Estimates (Billions)			
	Milliman UHP Best	Milliman UHP Low	UHPGB UHP
2032 Expenditure Estimates	\$77.7	\$69.4	\$66.2
2032 Projected Federal and State Funding	-\$39.4	-\$39.4	-\$39.4
Revenue Replacement Target Estimates	=\$38.3	=\$30.0	=\$26.8

Revenue

Workgroup Revenue Section Edit 10.4.2026

Revenue

FINANCE AND REVENUE

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. The detailed analysis behind them is in the appendix.

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 fragmented system, Oregon could cover everyone, with better benefits, and most households and businesses would pay less than they currently do.

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. It is also the first to pair actuarial modeling of what the whole system would cost, built from the ground up, with an analysis of several revenue model options. Key design elements of those options 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).

Three 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. A universal plan would restructure how that money is collected and paid out.

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 all the savings a consolidated system could achieve.

Third, the modeling projects that many households would pay less in total than under the current system once current insurance premiums, out-of-pocket costs, deductibles, copays, 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 yet 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.

Core Financing Principles

The Universal Health Plan Governance Board, with significant input from the Finance and Revenue Committee, developed revenue models for the Oregon Legislature to consider. 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. It should run through existing tax systems rather than require 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.

Revenue Models

The revenue model options are grounded in the understanding that Oregon does not need to generate new funding to implement a universal health plan. Health care in the state is already financed through employer-sponsored insurance payments, individual premium payments, out-of-pocket expenses such as co-payments, coinsurance, and deductibles, as well as a range of state and federal programs including Medicare and Medicaid. The Board's model options redirect the majority of these existing payments into a centralized fund, enabling comprehensive and progressive financing administered by a single-payer entity.

Under these models, businesses will continue to finance a portion of health care costs, but in a manner that provides advantages to small Oregon businesses while ensuring that all larger businesses participate. Individuals and households will also continue to support health care financing; however, their contributions will be determined by their ability to pay rather than the volume or type of health care services they use.

Revenue Mechanisms

The proposed revenue models are built around a small number of revenue mechanisms, chosen with the core financing principles in mind to create a stable and equitable public financing system. The mechanisms function as an integrated system and can be adapted to balance changing priorities and needs. A short description of each mechanism is provided, followed by the five proposed revenue model options.

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

The Corporate Income Tax add-on is included to ensure that profitable corporations contribute directly to financing the universal health plan and to broaden the revenue base beyond wage-based contributions. It captures a portion of financing from firms with a positive income, including those that may have relatively low Oregon payroll but substantial in-state profits. Oregon currently taxes corporate profits from sales and services in Oregon. In 2026, the rate is 6.6% on profits up to \$1 million and 7.6% on profits above \$1 million.

2. Corporate Activity Tax Add-On (CAT)

The Corporate Activity Tax add-on is included to broaden business participation beyond firms that report taxable income, and to provide a steadier business-based revenue stream across economic cycles and corporate tax planning strategies. The 2026 rate is 0.57%.

3. Lodging Tax Add-On

An increase in the state-wide lodging tax is proposed to offset the cost of providing unreimbursed medical care to out-of-state visitors. In 2027 the lodging tax rate will be 2.75%.

4. Employer Payroll Tax (EPT)

An employer payroll tax (EPT) would replace most of what employers now spend on health insurance for their workers. The EPT applies a payroll-based contribution above a firmwide payroll threshold of \$500,000. It ensures that employers continue to participate in financing health care in a way that is broad-based and predictable. Contributions by employers to the EPT will be exempt from state and federal taxes in the same manner as current employer health care contributions.

5. Health Care Personal Income Tax (HCPIT)

The Health Care Personal Income Tax (HCPIT) is the central mechanism for individual contributions, designed to replace household out-of-pocket costs and premiums paid by individuals and families with an income-based contribution that is based on ability to pay. The HCPIT is administered through Oregon's existing personal income tax system and depending on the model option, is applied only above an income threshold of 138% or 200% of the federal poverty level.

6. Employer Payroll Tax Credit (EPT Credit)

The employer payroll tax credit against individual HCPIT liability was developed as a lever to impact the proportion of revenue contributions that come from wages versus revenue contributions that come from non-wage taxable income. A larger EPT credit decreases the

revenue raised by wages, whereas a smaller or 0% EPT credit decreases the revenue raised by non-wage taxable income.

Revenue Model Options

The revenue model options each generate approximately the same overall level of funding; however, they differ in several important ways. Specifically, they vary in how much of the total contribution comes from businesses versus households, in how revenue is divided between income earned from wages and income derived from other sources, and in how the financial responsibility is distributed across different income levels. All revenue estimates for the five options 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 their behavior in response to a health care payment system change, how the wider economy might respond, or how the health insurance market might change. Dynamic economic analysis is a needed next step. The Board has not yet had the time and resources to complete it.

Revenue Model Option 1

Revenue Model Option 1 uses all five taxes described above. The payroll tax has two tiers: no tax on the first \$500,000 of payroll and 9.89% percent above that. The health care personal income tax also has two tiers: no tax on income up to 200 % of FPL and 12.0% on income above that. Workers would get a credit equal to 50 % of the payroll tax their employer paid on their wages. Under Option 1, about 55 % of tax filers in Oregon would pay no health care personal income tax.

Revenue Model 1 was the model initially developed by the Finance and Revenue Committee, with feedback and modifications from the Board. The following table depicts the revenue mechanisms which were utilized by the Legislative Revenue Office to create 2032 revenue projections ²⁹ for a revenue replacement target of \$30.2 billion.

Legislative Revenue Office 2032 Revenue Projections For Revenue Model Option 1					
Mechanism	% Share of Revenue	Additional Tax Rate	Amount Raised (Billions)	Tiers/ Brackets	Exemption
Corporate Income/Excise Tax	3.8%	4.25%	\$1.15		

²⁹ UHPGB 9/17/2026 Presentation by LRO – Overview of Universal Health Care Taxes: Scaling of Estimates

Corporate Activity Tax	1.3%	0.113%	\$0.39		
Employer Payroll Tax	51.5%	9.89%	\$15.55	2	No tax on first \$500,000
Health Care Personal Income Tax	43.4%	12.0%	\$13.1 ³⁰	2	No tax on income < 200% Federal Poverty Level
Lodging Tax	<1%	0.2%	\$0.01		
	Total = 100%		Total = \$30.2		
Employer Payroll Tax Credit of 50%					

Variables in Model Options 2-5

Model options 2 through 5 are all adaptations of Model 1. The models differ by alterations in the following aspects of the revenue mechanisms.

1. Employer Payroll Tax Tiers

Model options 2 through 5 all have 3 tiers of the employer payroll tax. The first tier of 0 to \$500,000 in annual payroll is not taxed. Above \$500,000 to \$10 million the tax rate is 9.6%. Payroll amounts above \$10 million are taxed at a rate of 14%. This **increases** the total amount of revenue raised from the Employer Payroll tax and **reduces** the revenue share that households contribute through the health care personal income tax from 43% of total revenue to 40% of total revenue.

2. Employer Payroll Tax Credit

Either a 50% EPT credit is modelled, or 0% EPT credit. A 50% EPT credit allows for more revenue to be collected from non-wage earnings. A 0% EPT credit has a lower top HCPIT rate, with more revenue being collected from wage earners. With a 0% EPT credit, more households will pay some health care personal income tax.

3. Health Care Personal Income Tax Exemption Threshold

Revenue Model Options 1,2, and 3 use 200% of the Federal Poverty Level (FPL) as the HCPIT exemption. Revenue Model Options 4 and 5 use 138% of FPL as the exemption. A lower threshold (138% of FPL) creates a broader tax base from which to draw revenue, allowing for a lower top HCPIT rate. A lower threshold add a financial impact on households with lower incomes.³¹

³⁰ Without 100% Medicare Part B credit, HCPIT amount raised roughly \$14.1 billion

³¹ At the 1/15/2026 UHPGB meeting, the Board voted 8-0 in favor of a 200% FPL exemption

4. Health Care Personal Income Tax Brackets

Revenue Model Options 1,2, and 3 have two tax brackets. Revenue Model Option 4 has five brackets, and Revenue Model Option 5 has six brackets. A model with more tax brackets is more progressive. Those with lower incomes pay lower tax rates, those with higher incomes pay higher tax rates. More progressivity increases the top HCPIT for the highest earners.

The following table summarizes the key components of the Revenue Model Options.

Note- with the exception of RMO 1, dollar amounts have not been estimated by LRO. Those values will be available the week of October 12

	RMO 1	RMO 2	RMO 3	RMO 4	RMO 5
CIT/CET	Add-On Tax Rate of 4.25% %				
CAT	Add-On Tax Rate of 0.113%				
Employer Payroll Tax					
% of Revenue	51.5% of Revenue	55 % of Revenue	55 % of Revenue	55 % of Revenue	55 % of Revenue
Exemption	0-\$500,000	0-\$500,000	0-\$500,000	0-\$500,000	0-\$500,000
Tiers	2 Tiers 0-\$500,000 >\$500,000	3 Tiers 0-\$500,000 \$500,000-\$10 M >\$10 M	3 Tiers 0-\$500,000 \$500,000-\$10 M >\$10 M	3 Tiers 0-\$500,000 \$500,000-\$10 M >\$10 M	3 Tiers 0-\$500,000 \$500,000-\$10 M >\$10 M
Tier Tax Rates	0% 9.6%	0% 9.6% 14.0%	0% 9.6% 14.0%	0% 9.6% 14.0%	0% 9.6% 14.0%
Employer Payroll Tax Credit					
Tax Credit %	50%	50%	0%	50%	0%
Health Care Personal Income Tax					
% of Revenue	43%	40%	40%	40%	40%
Exemption	200% FPL	200% FPL	200% FPL	138% FPL	138% FPL
Maximum Tax Rate	12.0%	12.05%	7.69%	11.7%	10.4%
% of Returns with 0% HCPIT Liability	54.5%	60.4%	40.3%	64.9%	31.2%
Lodging Tax Add-On Rate	0.2%	0%	0%	0%	0%

To Be Inserted- Summary sentence about the models and how they can be used

To Be Inserted- Scenarios under the various tax options

Tradeoffs and Tensions

The Board's work brought to light tensions between important goals where there is not 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 for overall lower tax rates, but people with lower incomes pay more. Exemptions and credits protect those households, but each one adds complexity. There was a lot of public comment submitted to the Board on this topic. Comments on progressivity led the Board in January of 2026 to recommend setting the Health Care Personal Income Tax exemption at 200% of the Federal Poverty Level. even though this narrowed the contribution base. The Board considered, but did not include in the models, a soft cap(reduction in tax rate after a certain amount of taxes have been paid) on high-income households, on grounds that it would make the structure less progressive. Some of these tensions are visible in the revenue model options described later.

Money an employer spends on health insurance is not taxed, and the employee's share usually is not 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 do not 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 a lower level because nothing will force wages up when the premium cost goes away.

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, out-of-pocket costs 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.

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 can influence but cannot control. The Board has discussed this gap and possible phased options so planning can account for it.

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 an 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 Legislative Revenue Office 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.

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

A full financial plan. A complete plan showing expenditures and revenue should be produced. This would likely require the Department of Consumer and Business Services (DCBS) and the Oregon Health Authority (OHA) to work with the Board on estimates of current spending that are easier to use. The transition plan, including its financial side, also needs more work.

Estimates of savings the plan could realistically achieve. Less fraud, abuse, and clinical waste could lead to large savings that have not yet been measured. Savings from buying prescription drugs and durable medical equipment for the whole state also need more study.

Federal coordination must be requested 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

Health care operates through many separate systems today. That fragmentation drives duplicative administration, inconsistent standards, and administrative burden for providers, and leaves people in Oregon vulnerable to disruptions in access. A universal health plan would consolidate many disparate requirements into a single administrative structure that would be accountable to the public and responsive 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

A statutory structure should establish the universal health plan's core authorities, financing, framework, and accountability provisions while delegating the operational and technical details to rulemaking.

Legal Structure and Authorities

The Board recommends that a public corporation, created in state law, should 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 universal health plan operate on a nonprofit basis governed by public ethics, meetings, and records laws, while providing flexibility in how it

organizes its finances and how government contracting, procurement, personnel, and bonding laws apply.

This structure is built to support:

- Central administration of financing and provider payment
- Long-term budget planning and reserve management
- Consistent operations statewide
- Flexibility and legal authority 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

Managing the universal health 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 public 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.

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 recommends central administration through the public corporation, with regional offices that function to ensure local representation.

The structure is also built to evolve. Some functions may run through contracted third parties at first while the corporation builds its own capacity. This gives the universal health 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 reflect expertise in health care finance and health care delivery. The Board did not establish a final recommendation regarding governing board size, composition, or other requirements.

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 • 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 • Establishing administrative rules • Setting provider payment rates

A statewide plan needs day-to-day flexibility and technical skill that a board cannot supply on its own. Public meetings, transparency rules, legislative oversight, reporting, and ethics standards, ensure the public corporation remains accountable.

Universal Health Plan Trust Fund

The Board recommends the creation of a dedicated Universal Health Plan Trust Fund to hold fund for the universal health 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 was informed by financial management structures used by existing Oregon public corporations. It would give the plan access to Treasury investment and liquidity tools while avoiding the constraints of fully captive Treasury management.

Revenues dedicated to the plan would flow directly to the trust fund and be continuously appropriated to the universal health plan.

The trust fund would pay for health care claims, provider payments, administration, 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 universal health plan would build and protect those reserves through the trust fund.

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 end today's fragmented system, in which many separate insurers and public programs each pay for care.

The universal health plan would include offices for regional input across different communities and public transparency. The operational structure would pair central financing and policy authority with regional hubs for 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, analysis, and reporting
- Quality measurement, including health outcomes, 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. Regional offices would be part of the public corporation, not independent contractors or separate risk-bearing organizations.

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 universal health plan would designate non-overlapping regions based on existing patterns of care, public health infrastructure, and natural referral relationships. Board discussions suggested between five and nine regions statewide, though the final number would need to be settled by the future governing board. To support community accountability and local engagement, each regional office would convene patient and provider advisory groups.

The operational model balances central statewide administration with genuine regional engagement and room to adapt. The Board selected this structure to preserve statewide administrative and fiscal consistency while maintaining regional engagement.

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 would require integrated data infrastructure supporting eligibility, claims, payment, care coordination, and reporting, with interoperability across provider, public health, state, and federal systems. This technology could do more than keep the universal health plan running. It would help people get more efficient care and take part in their own health by making it easier for members to reach their care team and see their own health information.

The public corporation would need to develop 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. A modular architecture is intended to improve replaceability of components, reduce vendor lock-in, and limit technical debt as requirements change. Interoperability will allow more systems to exchange information with each other and improve care coordination.

The universal health plan would need core capabilities in these areas:

- Enrollment, eligibility, and member services
- Provider directories, credentialing, claims, and payment

- Support for payment methodologies and calculations
- 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. The universal health plan must follow federal and state privacy and security law including the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and federal interoperability rules. 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.

Section 1557 of the Affordable Care Act, which bars discrimination in health programs, along with Oregon's own privacy and security laws will be embedded in the IT design. 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.

Several things are not yet decided. The IT architecture, staffing, procurement approach, build sequence, and cost estimates all require technical and financial analysis prior to implementation planning. This report does not carry a cost estimate for the plan's information technology. Startup technology costs have not been estimated.

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, and how the system behaves over the long run.

Oregon's payment system is deeply fragmented today. Providers must coordinate across many payers, each with its own fee schedule, payment methods, billing rules, quality programs, prior authorization standards, and reporting requirements. That fragmentation adds complexity, takes time away from direct patient care, and add costs to the system.

The universal health plan will establish a unified payment system designed to control costs, reduce administrative burden, and improve access. It will pay providers and provider organizations 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 would not be able to 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.

Statutory language should establish framework payment policy, while the public corporation would set, update, and adjust rates in accordance with statutory principles through rulemaking.

Suggested statutory principles for payment policy include protecting access to care and transparency in decision-making

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 universal health plan may bring these functions in-house as its systems mature.

Hospital Payment

The Board proposes paying acute care hospitals through global budgets to make their finances more predictable and support the long-term health of Oregon's acute care hospitals. A global budget is a fixed amount paid to a provider in advance, based on past spending and anticipated changes in population and inflation.

Compared with today's complex hospital billing system, global budgets could offer the following advantages:

- More predictable financing for hospitals
- Incentives to support preventative care
- Better support for rural and safety net facilities
- Simpler administration and billing

The global budget would cover inpatient, outpatient, and physician services at acute care hospitals. The global amount would equal about 70% of a hospital's total payments, with the remaining 30% from activity-based, quality, and performance payments.

Critical access hospitals would also be paid through global budgets, but their payments may be structured in alignment with Medicare “reasonable cost” estimates based on

Medicare cost-based reimbursement requirements. 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 global budgeting in over a three-to-five-year period, raising the share of payment inside the global budget step by step. Global budgets will be designed to stabilize hospital finances while advancing systemwide goals of population health.

Primary Care

The Board identified inadequate primary care investment as a contributor to access, workforce, and care coordination challenges. The proposed payment structure would place a priority on funding primary care and keeping it connected to the rest of care.

Primary care payment would be based on 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.
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 universal health plan will treat primary care funding as a foundational investment. Payment levels will be set to support access, a stable workforce, and better care. Each year, at least 15% of universal health care expenditures will be allocated specifically to primary care that emphasizes routine well-care and prevention. The 15% target builds on Oregon's existing primary care spending policy, including the 12% 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%, providing precedent for achieving primary care spending at this level.

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 administrative burden and payment fragmentation across payers
- Support financial stability and predictability for providers
- Incentivize high value care in the right setting
- 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. The Board did not select detailed payment approaches for specialty care sectors. Additional work will be required to design appropriate methodology recommendations prior to implementation.

Quality and Performance Alignment

The public corporation will need to develop a statewide quality strategy to support accountability, transparency, and steady improvement across the delivery system. Quality criteria may include a small set of standard performance measures, chosen to align with existing requirements and data systems where possible. The Technical Report contains more information on considerations for developing a quality strategy.

COST CONTAINMENT

Keeping the universal health plan affordable over time will require active management of health care cost growth across many parts of the system.

No single strategy can contain costs on its own. To ensure the long-term sustainability of a universal health plan, the Board recommends a layered set of strategies that would 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 strategic framework is built on the following principles.

- Cost containment efforts should span the system, provider, and pharmacy rather than rely on any one of them.
- Cost containment should begin by focusing on high impact changes.
- Near-term operating improvements and long-term structural reforms should reinforce each other.
- Cost containment efforts should support continuity of care, access, provider stability, and long-term sustainability.

Traditional cost containment strategies include patient cost-sharing, such as deductibles and copayments. Utilization management tools, such as prior authorization and step therapy have also been used. These tools can lower spending, but they also raise equity concerns, can delay needed care, and create administrative complexity for providers. The Board's approach largely avoids strategies that impact consumer choice and instead focus on approaches that tackle costs at the system, provider, and pharma industry level.

System-Level Strategies

Oregon already has much of the groundwork for monitoring costs in place, including 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 programs rather than creating new oversight bodies where the current ones can be strengthened or adapted. This includes

using current data and reporting requirements to inform cost containment strategies of the universal health plan.

System-level strategies could include:

- Monitoring health care cost growth relative to economic indicators;
- Reducing duplicative administrative processes;
- Strengthening fraud prevention, waste reduction, and redundancy elimination;
- Consolidating purchasing for pharmaceuticals, durable medical equipment, implantable devices, and other high-cost products or services where feasible;
- Standardizing administrative processes where appropriate; and
- Developing statewide data and accountability infrastructure to support ongoing oversight.

Administrative simplification is a cost containment strategy in its own right. Oregon's current system, with its many payers, forces providers 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 contained in the Technical Report.

Provider Payment and Delivery System Strategies

Today, providers are paid mainly through fee-for-service billing across many payers, each with their own rates and rules. A universal health plan could greatly simplify the health care system by developing a payment uniform approach 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 could support cost containment.

Provider-focused strategies could include:

- Global budgeting methodologies for hospitals and other institutional providers;
- Standardized or simplified payment methodologies where operationally appropriate;

- Streamlined administrative requirements for providers;
- Strengthened investment in primary care and behavioral health;
- Evidence-informed standards of care;
- Processes for moderating excessive price growth; and
- Long-term evaluation of fee schedule or rate-setting approaches where feasible.

Provider stability remains essential. Cost containment efforts should balance 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 spending has been a major driver of health care cost growth in Oregon. Drug pricing is complex and lacks transparency, with many players between the manufacturer and the patient, including pharmacy benefit managers (PBMs), 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.

Pharmaceutical strategies may include:

- Consolidated pharmaceutical purchasing;
- Development of a statewide formulary structure;
- Prioritization of generic and biosimilar utilization where clinically appropriate;
- Strategies to address manufacturer steering toward higher-cost brand-name drugs;
- Enhanced transparency and accountability standards for pharmacy benefit managers;
- Coordination with the Prescription Drug Affordability Board;
- Evaluation of upper payment limit authority and related affordability mechanisms; and
- Long-term approaches related to specialty pharmaceuticals and other high-cost medications.

Implementation and Monitoring

A comprehensive cost containment strategy will depend on the final program design, federal coordination, provider participation, and market behavior. For that reason, the Board did not select a specific package of strategies to adopt but instead offers a menu. The public corporation should be authorized to establish a more detailed plan for cost containment and work in conjunction with other state agencies to monitor and report on the success of those strategies.

IMPLEMENTATION PATHWAYS

Today, people in Oregon get their health coverage through many separate programs and payers. Moving to a universal health plan will require the transition of four million people to a new system, some of whom may be able to move sooner than others. This section discusses key limitations in transitioning to a universal health plan and the order in which that could occur.

The Board has defined the structure of the finished plan. It has not chosen how to get there. Implementation sequencing involves separate decisions about when populations become eligible for universal health plan coverage, when existing coverage is integrated or coordinated, and when populations become subject to universal health plan financing. Those transitions may not occur at the same time.

About 52.5% of people in Oregon get their primary coverage through groups that do not require federal approval as a pre-condition to integration.³² These include public employees, people with employer-sponsored insurance, and the uninsured. Employer-sponsored coverage will require additional design because, although these employees are included among populations Oregon can reach more directly, ERISA limits the state's authority over self-funded employer health plans.

About 47.5% of people get their primary coverage through programs that would require federal approval to integrate into a state universal health plan. These include Medicare,

³² UHPGB, May 21, 2026 Board meeting presentation, slides 54-55, <https://www.oregon.gov/uhpGB/Documents/board-meetings/2026/20260521/20260521-UHPGB-board-meeting-presentation.pdf>

Medicaid, subsidized, and the Federal Employees Health Benefits. Sequencing therefore has to balance two goals that are in tension with each other: reducing fragmentation and providing relief quickly to Oregonians struggling with health care costs.

The gains from reducing fragmentation are not uniform. Federally funded groups cover a large share of people, but operate under more or less common standards and benefit structures. Commercial insurance, in particular the unique plans designed by self-funded employers, drive most of the variation in plan design, prior authorization, network rules, and billing. Providers therefore may see gains in administrative simplification even without full federal integration. Staff planning estimates based on the relative number of provider-facing plan configurations suggest approximately 85-90% of administrative simplification could be achieved under a transition that does not include federal programs.³³ This figure rises to an estimated 98% under near-complete integration of payers. These estimates assume substantial consolidation of commercial employer coverage; actual simplification would depend on the degree to which employers substitute their plans for universal health plan coverage.

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. The Board did not endorse any single strategy, recognizing that evolving conditions in the coming years may alter which transition approach is most appropriate.

Population Phase-In

Under a population phase-in, the universal health plan would launch 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 the non-federal groups discussed above. Phase 2 would add Medicaid, the Children's Health Insurance Program (CHIP), and those receiving Marketplace subsidies. Phase 3 would add Medicare and the

³³ UHPGB, May 21, 2026 Board meeting presentation, slide 51, <https://www.oregon.gov/uhpGB/Documents/board-meetings/2026/20260521/20260521-UHPGB-board-meeting-presentation.pdf>

remaining federal groups. This path would reach about 52.5% of people in Phase 1, 82% in Phase 2, and 99% after complete federal integration.

The main advantages to pursuing a population phase-in would be speed and control. Without requiring new federal approvals, the universal health plan could launch sooner, create an immediate entitlement to health care coverage for those not subject to another federal program, and begin with lower reserve requirements. A population phase-in could provide earlier access to universal health plan coverage for selected populations and generate valuable operation experience and evidence before broader federal integration. A population phase-in could potentially be launched within one to two years of enabling legislation.

The disadvantages include the universal health plan would have less immediate influence over statewide payment, and equity concerns as some people have access to the universal health plan and others do not. This path would require clear communication about who is eligible, when, and what to expect at each phase.

Hybrid Phase-In

Under a hybrid approach, Phases 1 and 2 would launch at the same time. This combines non-federal groups with Medicaid, CHIP, and Marketplace groups. These additional populations represent those for which existing federal waiver authorities may provide a pathway, subject to federal approval. Other populations, mainly Medicare and certain federal programs, would join later as potentially new waivers become available. A hybrid phase-in option would cover about 82%% of Oregon residents at launch while keeping a route open for later federal integration.

The advantages to a hybrid approach would be greater immediate administrative simplification, more stabilizing impact on provider payment, and broader participation at launch. This approach could support payment normalization sooner and open earlier chances for system-wide provider simplification. Assuming current waiver options prove a viable means of integrating the Medicaid and Marketplace populations, a hybrid phase-in could potentially launch within two to five years of enabling legislation.

The main drawbacks would be a longer wait to start the plan than a 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, the entire population would transition into the universal health plan at once. This would depend on securing every required federal approval, including in some cases new federal authorities, and building enough operational capacity to run a statewide transition at once.

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

The disadvantages would be the dependence on federal approvals, including the need to obtain authorities and federal approvals that do not exist today. A simultaneous transition would require the largest upfront reserve and build-out and the highest operational risk upon launch. If approvals or financing conditions change, implementation could be significantly delayed. In a best case scenario, in which the federal government created new waivers for Medicare and other federal program integration, a simultaneous transition might take six years. Far more likely however, is that awaiting such approvals and navigating novel negotiations would take a minimum of ten years, if such pathways even become available. 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 of implementation of a universal health plan. Even so, members showed more interest in the population phase-in and hybrid approaches than in a simultaneous transition. Board discussion reflected that while a simultaneous transition would offer the most administrative simplification in theory, 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 noted the ability to launch sooner, bringing earlier relief to the uninsured and underinsured as well as those facing rising commercial

costs, and proving the model works before seeking broader federal integration. It was noted that a phased approach could let the state build capacity over time while it continues to seek approvals for Medicaid, Medicare, and other federal programs.

The Board 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 people on Medicare paying into the plan before they can receive benefits and discussed excluding Medicare-covered groups from certain financing requirements until they join the plan. In a separate financing transition discussion it was noted that financing could include only eligible groups in order to mitigate this concern.

The Board also showed interest in a hybrid approach that would launch with non-federal groups and groups that already have potential federal waiver pathways, including Medicaid, CHIP, and the subsidized Marketplace population. The Board discussed how 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 would 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 discussed was to align the universal health plan administrative processes and provider requirements with current Medicaid/Marketplace systems where state authority permits, creating a more streamlined set of requirements for providers even as federal waiver processes remain ongoing.

Staff technical analysis of sequencing appears in the Technical Report. That analysis identifies population phase-in as the most operationally feasible approach among the three pathways reviewed. This is not a recommendation on a board and depends on unresolved financing, employer coverage, federal, and readiness questions.

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

Finally, finance sequencing was not examined in depth and will require additional consideration and analysis as the Legislature and/or a future Board finalizes critical decisions regarding the financing of the universal health plan.

RISKS AND TRADEOFFS

Every path forward carries risk, including making no changes at all. This section outlines the risks and tradeoffs in both moving forward with a universal health plan and maintaining the status quo.

Building a universal health plan would change how Oregon residents receive coverage, pay for care, fund coverage, and how providers are paid. No path removes risk or settles every tradeoff in advance. The relevant tradeoffs include the risks of transition, risks associated with current trends, and the extent to which alternative policy approaches could mitigate either.

Risks of Status Quo

The costs of the current system are real and rising. In Oregon, the Department of Consumer and Business Services (DCBS) approved 2027 rate increases that averaged 21.6% in the individual market and 15.5% in the small group market.³⁴ Nationally, employer-sponsored family coverage reached nearly \$27,000 a year in 2025, and average family premiums rose 6% in a single year.³⁵

These costs are hurting people and families in Oregon. About 1 in 8 Oregon residents say medical bills have eaten up all or most of their savings, and 1 in 7 people delay or avoid care because of cost.³⁶ In rural southwest Oregon, that rises to 1 in 5, the highest rate in the state.

Marketplace enrollees have experienced particularly significant price increases. 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. Nationally, average monthly premium payments rose 58%

³⁴Oregon Department of Consumer and Business Services, 2027 health insurance rates. <https://apps.oregon.gov/oregon-newsroom/OR/DCBS/Posts/Post/260818-DFR-finalizes-2027-insurance-rates>

³⁵KFF, Employer Health Benefits Survey 2025, Summary of Findings. <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey-Summary-of-Findings.pdf>

³⁶ 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

from 2025 to 2026, and average Marketplace deductibles climbed 37% to a record high.³⁷ KFF also found that 9% of individuals who had Marketplace coverage in 2025 had no health insurance by early 2026, and 1 in 6 returning enrollees were not sure they could afford their premiums for the whole year.³⁸ All of this demonstrates that the availability of coverage does not by itself establish affordability or continuity of enrollment.

Job-based insurance does not fully protect families either. KFF found that 88% of covered workers in employer plans had an annual deductible in 2025, and 34% had a deductible of at least \$2,000 for single coverage. One-third were in a high-deductible plan with a savings option.³⁹ Among small firms that did not offer health benefits, the most common reason was that the cost was too high.⁴⁰ Coverage is becoming less affordable over time, even for people who stay insured. As premiums rise year after year, these changes can affect whether employers, particularly small employers, offer coverage.

Keeping the current system carries real risks to the state's finances and access. Rising premiums and deductibles push people into medical debt, delayed care, and financial stress. A fragmented system creates administrative burden for providers and leaves the state potentially more exposed to federal changes that impact the insurance market. The current system also strains the providers people rely on. Heavy administrative work makes it harder to deliver care, and the pressure falls hardest on rural communities and safety-net providers. The state cannot avoid risk either way.

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 TRICARE program, and Veterans Affairs, are governed by federal law, and not all of them

³⁷KFF, 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/>

³⁸KFF, 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/>

³⁹KFF, 2025 Employer Health Benefits Survey. <https://www.kff.org/health-costs/2025-employer-health-benefits-survey/>

⁴⁰KFF, Americans' challenges with health care costs. <https://www.kff.org/health-costs/americans-challenges-with-health-care-costs/>

have a clear path to fold into a state health 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 proposed approach seeks to mitigate this risk by prioritizing the maintenance of federal funding unless and until applicable federal authority allows for integration. Federal coordination will be required. It remains to be seen how quickly and under what conditions, federal populations and funding can be integrated. Board discussion and staff analysis gave greater attention to phased and hybrid approaches as they reduce dependence on obtaining all federal authorities before launch.

Financing Transition

Moving from today's fragmented health care spending to centralized public financing is another risk. Right now, families and employers already pay for care through premiums, payroll contributions, deductibles, and cost-sharing, but those costs are spread across many channels. A universal health plan would make more of that spending visible through taxes, which can create political and public trust risks even when the new revenue replaces money people already spend. The revenue options evaluated by the Board draw on a combination of revenue sources, including household income, employer payroll, and corporate taxes. The final distribution remains undecided. The options modeled by the Board are more progressive than current health care spending, meaning the change would not affect everyone equally. Some households and employers would pay more than they do today, while others would pay less. Future work will need to define a revenue model option to implement and analyze what that means with respect to distributional effects.

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 will stay more complex for longer and providers will see less near-term relief from administrative burden. This matters most for large, multi-state, or self-funded employers that may have less reason or ability to line up with an Oregon universal health plan. The proposal assumes that some employers will voluntarily discontinue separate coverage if the universal health plan offers a financially and administratively attractive alternative. How many employers would respond to a universal health plan is still unknown. Future work

should include additional direct outreach to employers, survey research, more analysis of how self-funded employers could 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 changes to how providers are paid including new payment methods, administrative rules, and contracting. Some providers and health systems may resist, especially where standard rates, global budgets, or simpler administration would decrease current revenue. Many Oregon 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. Proposed mitigation strategies include phasing in major payment reforms such as hospital global budgets, adopting the minimum primary care spending allocation, and implementing methodologies for other providers to smooth the transition. Even so, this will take ongoing work with providers, transition support for financially fragile providers, and monitoring of the workforce, provider participation, regional access, and continuity of care.

Administrative Capacity

Standing up the administration of a universal health plan is another risk. A universal health plan would require Oregon to build or oversee large operations including eligibility and enrollment, claims, provider contracting, payments, customer service, data systems, purchasing, compliance, and financial management. Problems in any one of these could disrupt coverage, provider payment, public confidence, and legislative support. The proposed governance structure would assign these functions to a public corporation with authority to contract with third-party vendors. At present, substantial risks remain as staffing, IT architecture, and startup capitalization policies are not complete. There are tradeoffs to building capabilities directly within the public corporation as compared to using contractors, all of which need to be examined in greater detail, taking into account Oregon's past experiences with major implementation projects. 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.¹

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. The current system is already straining families struggling with premiums, deductibles, and medical debt; employers facing rising benefit costs; and providers working under thin margins, staffing shortages, and substantial administrative burden. 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 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.

Should this section be included in the legislative report, or in the appendices?

LEGISLATIVE ACTION AND NEXT STEPS

This section lays out what the Legislature would need to do continue the work of developing a universal health plan concept that could become legislation.

The next phase 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. Steps 1 and 2 are the two actions the Board asks of the 2027 Legislature, as described in the executive summary. Steps 3 through 5 are the main parts of the Phase 2 work that Step 1 would fund. Step 6 brings that work back to the Legislature for decision.

Step 1: Authorize a Phase 2 implementation blueprint

First, authorize and fund the Board to build on this plan and carry out 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.

This step has not been approved by the Board

Step 3: Continue developing the revenue plan

Keep developing the revenue plan, starting from the options in this report or a variation of them. 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.