

EXECUTIVE SUMMARY

Oregon has been a national leader in health care innovation for decades, and the state's efforts have always aimed to provide better care for more people while containing costs. We are now in the midst of a national and state level crisis in health care, with threats to Oregon's business environment, its economy and the health and wellbeing of all Oregon residents. The Universal Health Plan Governance Board was established by ORS 751 (2023) and charged with creating a comprehensive plan to finance and administer a Universal Health Plan that is responsive to the needs and expectations of the residents of Oregon. It builds on the constitutional amendment passed in 2022 (Oregon Constitution section 47) which guarantees access to affordable health care as a fundamental right for all residents, as well as the work of the Joint Task Force on Universal Care which submitted its findings to the legislature in 2022.

The **Universal Health Plan Governance Board** consists of 9 volunteer board members, plus a small staff consisting of an Executive Director, a Senior Policy Advisor, and an Executive Assistant. We convened in April of 2024 and spent the next 2 ½ years developing a comprehensive plan as directed in the legislation. We established 5 committees, which included more than 45 members of the public, we contracted with multiple consultants including Milliman, ECONorthwest, Health Management Associates and others, and we conducted outreach to various interest groups including businesses, health industry leaders, tribes and unions. We engaged in an open and transparent process and welcomed robust public participation in our work.

The Board based its work on **five principles**: prioritizing health equity, maximizing the health of individuals and the community, creating a fair distribution of medical resources, minimizing financial hardship on individuals, families and businesses, and establishing a community sense of ownership and governance.

This report provides a detailed accounting of the **Universal Health Plan (UHP)** we designed, including:

The benefit design and provider payment structures – All Oregon residents would be covered, with recognition that members of federally recognized tribes, veterans and Medicare beneficiaries retain the right to access care through other systems. Benefits would be modeled after current public employee benefits plus enhanced behavioral health benefits, dental and vision benefits, and preserved services for Oregonians on the Oregon Health Plan. Hospitals would transition to payments based predominantly on global budgets, and clinicians would be paid through a combination of fee for service and value-based payment models, prioritizing primary care services and behavioral health. Importantly, there would be a standardized fee schedule to normalize payments and simplify billing.

Details of plan governance and administration The UHP would be administered by an independent nonprofit public corporation, modeled after SAIF. The public corporation would be the only risk bearing entity. Regional offices would be responsible for local engagement, health resource planning, and community accountability, and each would host advisory groups of providers, plan members, and community members. Regional offices would not bear risk, and residents would be able to see any participating provider in the state with no prescribed networks. There would be a dedicated trust in the state treasury to fund the plan, and a governance board that would oversee administration.

An estimate of projected expenditures of the UHP compared to status quo spending Actuarial modeling demonstrates that while the direct costs of paying for care would increase due to more residents being covered and having enhanced benefits, the overall cost of a UHP would be less than the status quo spending (which does not cover all residents) due to substantial administrative savings.

Multiple financing models for the legislature to consider Working with our consultants and committees, the board found that sufficient funds to finance a UHP are already in the system. The current payment system of premiums, deductibles, copays, and coinsurance, along with state and federal funding, is complex, unpredictable, inequitable, and unrelated to ability to pay. The revenue models we present assume continued state and federal contributions, and they restructure the contributions of businesses and households so that they are predictable, progressive, and easier to contain. In nearly every scenario, most households are projected to pay less for health care than they do under the current system. The primary financing would come from an employer payroll tax combined with a health care personal income tax. Small corporate activity taxes and corporate income taxes are also included, and a lodging tax in one plan. Variations on the revenue strategy include altering the proportion of revenue coming from the payroll tax versus the health care personal income tax, inclusion of an employer payroll tax credit, and varying extents of tiering of the payroll tax and personal income tax to change the degree of progressivity. The board felt it was not in a position to make a clear recommendation for one revenue strategy over the others, as they all require deeper analysis of the impacts on various sectors of the economy and the population.

Several suggested implementation pathways The board recognizes that given the federal authorities needed to implement a Universal Health Plan, as well as the sheer magnitude of the change, a phased implementation could be considered. For example, the board considered covering the uninsured and those in the individual and small group markets first, with other commercially insured populations following. Self-insured businesses could opt to continue to cover their own employees or not under any implementation strategy, although they would still participate in the financing. Medicaid and Medicare could be brought on as those legal pathways became clear. The UHP would exist in parallel with the Indian Health Service, the VA/Tricare system and Medicare fee for service if beneficiaries opted to continue with traditional Medicare. In addition, supplemental health plans could exist to cover benefits not included in the plan.

A legislative action plan The board identified multiple tasks that remain in its work, particularly around evaluating the economic impact of the revenue models and engaging the public on various tradeoffs and risks. The board lays out a legislative action plan, which includes funding this second phase of the board’s work, developing policy around various unresolved aspects of the plan, and putting the plan to the voters either as an initial framework with later final approval, or as a complete ready-to-implement plan.

Appendices The appendices contain further details from our consultants and staff and are provided for reference.

This board’s work, which builds on previous efforts toward universal care, shows that a universal health plan is feasible and affordable. Oregon could provide every resident with needed health care services, decoupling health coverage from employment while reducing or eliminating financial hardship from medical costs. A universal health plan run by a nonprofit public corporation could significantly reduce administrative expenses and overall medical costs and be built upon predictable revenue sources. Succeeding in this effort would be another substantial step in Oregon’s proud journey of health care reform.

Board Vote

On October 15, 2026, the Board voted to approve this report as an accurate accounting of its work in service to the Oregon Legislature and the people of Oregon.

Recorded Vote:

Acknowledgements

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

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Helen Bellanca (chair)	Chunhuei Chi	Mary Lou Hennrich
Judy Richardson (vice chair)	Amy Fellows	Michael Leahy
	Michelle Glass	

Commented [MG1]: The additional acknowledgements were recommended to be moved to appendices:

APPENDICES

Being developed/compiled by staff.

Proposed moved from body draft to appendices:

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Special Acknowledgement for their many contributions to the board's work

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