

Universal Health Plan Governance Board



Legislative Brief

In Response to the Legislature's August 17, 2026 Request

December 2026

PURPOSE AND SCOPE

The Oregon Universal Health Plan Governance Board was established by Senate Bill 1089 (2023), subsequently codified in ORS chapter 751, and directed to develop a comprehensive plan to finance and administer a universal health plan for Oregon residents. The Board's charge requires consideration of financing, benefit design, administrative structure, and implementation pathways, with attention to affordability, equity, quality, and applicable state and federal legal constraints. This brief is intended to support the Board's report to the Legislative Assembly by documenting the status of major policy and implementation questions as they related to potential future legislation of a universal health plan.

The scope of this document is organized around the four areas specifically identified by members of the Legislative Assembly in their August 17, 2026 letter to the Board. In that letter, legislators emphasized that the Board's comprehensive plan should provide the Legislature with information necessary to make informed decisions about the path forward and specifically requested:

- (1) Information about benefit design and payment structures;
- (2) Information about plan governance and administration;
- (3) Identification of one or more financing models the Legislature may consider; and
- (4) Description of a suggested implementation framework, including the legislative actions necessary to implement a universal health plan.

This brief addresses the four items requested, providing additional detail regarding outstanding policy questions and cross-functional dependencies.

ACKNOWLEDGEMENTS

Development of the Board's work has relied on substantial technical and policy contributions from consultants, committee members, Board members, and staff. Staff particularly acknowledge the actuarial analysis conducted by Milliman and the economic and revenue analysis conducted by ECONorthwest, which provide much of the quantitative foundation for the financing and expenditure analysis discussed in this supplement. Staff also acknowledge the significant technical contributions of Finance and Revenue Committee members Charlie Swanson and Richard Gibson, whose analysis and review informed development and refinement of the financing models presented to the Board.

I. BENEFIT DESIGN & PROVIDER PAYMENT

Benefit design and provider payment together establish what services a universal health plan would finance, the financial protections available to members, and how plan resources would be distributed across the health care delivery system. The Board has established substantial policy direction in both areas as outlined below.

BENEFIT DESIGN

The Board's benefit framework builds on the work of the Joint Task Force on Universal Health Care, which recommended using benefits available through the Oregon Public Employees' Benefit Board (PEBB) as the basis for a comprehensive benefit package. PEBB was selected as the base because it covers a broader range of benefit categories than the Affordable Care Act essential health benefits. It was also recommended that a universal health plan preserve benefits required for Medicaid and Medicare populations.

The Board retained PEBB benefits as the starting point for a universal health plan and approved additional benefit design policies, including:

- **Enhanced behavioral health benefits.** The approved behavioral health framework is materially broader than a conventional commercial behavioral health benefit including integrated primary and behavioral health care, outpatient and community-based services, crisis response and stabilization, residential and inpatient treatment, preventive and population-based services, and peer-delivered and recovery supports.¹
- **Continued protection of federally required benefits.** Individuals whose federal program eligibility carries additional benefit requirements would retain those benefits consistent with applicable federal law.
- **Long-term services and supports (LTSS) would remain outside the core universal health plan benefit for populations not otherwise entitled to those services.** Existing Medicaid LTSS entitlements would continue rather than being replaced by the core universal health plan benefit.
- **Administrative flexibility within a statutory benefit floor.** Detailed clinical coverage policies would be administered and updated over time based on clinical evidence, federal requirements, population needs, and available resources.

The Board has also consistently expressed a preference to avoid point-of-service cost-sharing. However, the Board has not established a final cost-sharing policy. Discussions have continued regarding whether limited or value-based cost sharing could be appropriate for selected high cost pharmaceuticals or elective services, including fertility treatment. This is both an access and expenditure decision. Eliminating cost-sharing would increase plan expenditures relative to

¹ [Behavioral Health Expanded Services Proposal](#), approved March 20, 2025.

otherwise comparable designs, while targeted cost-sharing introduces affordability and administrative burden considerations.

PROVIDER PAYMENT

The Board has approved a provider payment framework intended to shift payment away from incentives based primarily on service volume while supporting access, provider stability, primary care investment, and expenditure control. Detailed rates and payment formulas would be established administratively within the policy framework set by statute.

- **Primary care.** A universal health plan would use the Primary Care Payment Reform Collaborative value-based payment model. The model combines prospective capitated payment for defined primary care services, fee-for-service payment for services not appropriate for capitation, infrastructure payments supporting practice capacity and care coordination, and performance-based payments tied to quality. The Board also approved a requirement that at least 15 percent of universal health plan expenditures should be allocated to primary care, treating primary care investment as a foundational component of the delivery system.²
- **Hospital care.** Acute care hospitals would be paid using prospective global budgets rather than relying primarily on payment for the volume of individual services delivered. The Board-approved model includes adjustments necessary to account for differences in patient complexity, rural and regional access, critical access hospitals, essential services, teaching and specialty functions, and other material differences among hospitals. The approved proposal recommends phased transition with global budgets eventually accounting for approximately 70 percent of hospital expenditures.³
- **Behavioral health.** The Board has approved an integrated behavioral health payment approach designed to support both clinical services and the infrastructure and capacity necessary to maintain behavioral health access. Payment design is intended to support integration with primary care while preserving behavioral health capacity rather than shifting resources from behavioral health to physical health services.⁴
- **Other provider sectors.** The Board opted to not require a single payment methodology for all providers. Specialty care, oral health, pharmacy, rehabilitation, and other services may appropriately use different combinations of fee-for-service, prospective payment, bundled payment, global budgeting, infrastructure payment, or other approaches based on the characteristics of the service and provider market.⁵

A universal health plan framework also preserves two longstanding principles, namely that members should have broad provider choice, and qualified providers should not be excluded based on provider type when they are authorized to deliver a covered service within their scope

² [Primary Care Payment Proposal](#), approved August 21, 2025.

³ [Hospital Payment Proposal](#), approved November 20, 2025.

⁴ [Behavioral Health Care Delivery Proposal](#), approved February 19, 2026.

⁵ [Specialty Care Payment Proposal](#), approved November 15, 2025.

of practice. These principles are intended to maximize access to care and patient choice by eliminating restrictive provider networks and allowing any qualified provider willing to accept the plan's terms to participate. Participating providers would accept universal health plan payment for covered services and would not be permitted to balance bill members above the amount authorized by the plan.

The Board did not discuss whether participation in a universal health plan should be required of otherwise qualified Oregon providers. Mandatory participation would support broad access, while voluntary participation preserves provider choice but could create access problems if enough providers in a region declined to participate.

II. GOVERNANCE AND ADMINISTRATION

The Board has established a governance and administrative framework intended to combine statewide public accountability with sufficient operational flexibility to administer a large health financing and delivery system. The model centers responsibility in a not-for-profit public corporation, with statewide policy, financing, payment, and data functions administered centrally and regional offices supporting local engagement, innovation, and health resource planning.

GOVERNANCE

The universal health plan would be administered through a not-for-profit public corporation.⁶ The Board selected this structure to provide greater operational flexibility than a traditional state agency while retaining public ownership and accountability. Additional elements of the proposed administrative model include:

- **Transparency.** The public corporation would be subject to Oregon public meetings, public records, and ethics requirements. Its establishing statute would define its specific powers and determine the applicability of other state laws governing matters such as administrative procedure, personnel, procurement, contracting, and financial administration.
- **Governing Board.** The governance model distinguishes between policy and strategic oversight and professional administration. A governing board would establish major policy and financial direction and oversee executive leadership, while an executive director and staff would be responsible for routine operations, staffing, contracting, implementation of Board policy, claims and payment administration, data operations, compliance, and other delegated operational functions. The Board has not established the composition or appointment structure of the permanent governing board that would oversee the universal health plan.
- **Contracting authority.** The public corporation structure allows administrative or technical functions to be performed either internally or through contracted entities. The Board has not determined which functions should ultimately be contracted, the number or structure of

⁶ [Public Corporation Proposal](#), approved March 20, 2025.

administrative contractors, or whether particular capabilities should transition in-house over time. Regardless of operating model, the public corporation would retain ultimate responsibility for universal health plan policy, finances, member and provider protections, and contractor oversight.

- **Centralized administration with regional hubs.** The Board approved a model in which statewide financing, payment, policy, and data responsibilities remain centralized within the public corporation. Non-overlapping regional offices, organized around natural service areas, would function as local branches of the corporation rather than independent organizations or separate risk-bearing entities. Regional offices would have direct responsibility for community and provider engagement, local innovation, and health resource planning and would advise the central organization regarding payment, quality, budgets, and regional needs.⁷

ELIGIBILITY AND ENROLLMENT

The Board approved an eligibility and enrollment framework intended to provide broad access while minimizing administrative burden. Eligibility would be generally based on Oregon residency, with specified treatment of particular populations.⁸

Enrollment would occur upon attestation of intent to reside in Oregon with minimum necessary documentation and extensive use of automatic re-enrollment and existing state data sources. Detailed enrollment procedures, verification processes, and information-system requirements would be established administratively consistent with applicable federal requirements.⁹

FINANCIAL ADMINISTRATION

The Board proposed the creation of a dedicated Universal Health Plan Trust Fund in the State Treasury, separate from the General Fund, and a hybrid “captive and exempt” Treasury-management model.¹⁰ Under the proposal, universal health plan revenues would be deposited in and held by the Trust Fund, while statutory authority could permit the corporation to use non-Treasury banking or cash-management services where needed for operational flexibility. This structure is intended to retain public custody and accountability for universal health plan funds while allowing the financial operations of a statewide health plan to function differently from those of a conventional state agency.

The Board also proposed that the public corporation assume responsibility for third-party liability recovery, with statutory authority to recover health care costs from liable third parties, while maintaining workers’ compensation as a separate program that reimburses the universal health plan for covered medical expenses.¹¹

⁷ [Administrative Structure Proposal](#), approved November 20, 2025.

⁸ [Eligibility Proposal](#), approved June 12, 2025.

⁹ [Enrollment Proposal](#), approved February 19, 2026.

¹⁰ [Trust Fund Proposal](#), approved June 12, 2025.

¹¹ [Subrogation and Third-Party Liability Proposal](#), approved February 19, 2026.

III. FINANCING MODELS

A key component of the Board's statutory charge was to examine financing options for a statewide universal health plan. To that end, the Board spent substantial time examining data around health care expenditure estimates and revenue requirements. While the Board did not establish a single recommended financing model, their work provides a starting point for the fundamentals of how a financing strategy could operate and presents a series of revenue options that illustrate the tradeoffs of different choices.

This legislative brief provides a summary. More comprehensive details regarding the Board's work on financing are available in the following reports:

Expenditure Analysis for the Oregon Universal Health Plan- Milliman
Report on the Finance & Revenue Committee's Recommendations to the UHP Governance
Board- ECONorthwest
UHPGB Legislative Report

EXPENDITURE ESTIMATES

The Board commissioned Milliman to estimate the cost of operating a universal health plan using Oregon-specific health care spending and enrollment data, projected population growth and medical cost trends, the Board's proposed benefit structure, expected changes in utilization, and estimated administrative costs.¹² Milliman modeled a range of possible 2032 expenditures rather than a single forecast. For a plan that would cover all Oregon residents and provide enhanced PEBB-like benefits with no cost-sharing, Milliman estimated annual expenditures ranging from approximately \$77.4 billion to \$94.0 billion, with a best estimate of \$85.5 billion.

The Milliman model included increased costs related to Oregon's projected population growth and aging, induced utilization of services, and the potential for in-migration to Oregon by individuals with high health care needs. Milliman's estimates generally assume that aggregate provider reimbursement and medical management practices remain similar to the current system. Milliman also identified areas in which a universal plan could potentially reduce costs, particularly through lower provider administrative burden and more efficient payment collection, while cautioning that the timing and magnitude of those savings would depend on future payment and implementation decisions.

Subsequent Board work examined expenditure assumptions below Milliman's best estimate by incorporating additional assumptions related to reduced provider and payer administrative costs, improved payment collection, lower prescription drug costs, and enhanced fraud, waste, and abuse detection. Under the Board's savings assumptions, the 2032 expenditure estimate is approximately \$66.2 billion.¹³ This illustrates the potential effect of additional cost reduction

¹² Milliman report available [HERE](#)

¹³ UHPGB Legislative Report Table E 9

assumptions and should not be interpreted as replacing Milliman’s estimate or as a final expenditure forecast.

All these estimates should be treated as planning ranges rather than precise forecasts. Final expenditures will depend on benefit design, provider payment, administration, implementation sequencing, health care cost growth, and the extent to which assumed efficiencies are realized. Additional analysis of expenditures will be necessary prior to implementation.

FROM EXPENDITURES TO REVENUE TARGET

Total plan expenditures are not the same as the amount Oregon must raise through new state revenue mechanisms. The Board’s work explicitly calls for a universal health plan to draw on existing state and federal health care funding, which would continue to finance a substantial portion of covered expenditures. The remaining amount, referred to as the revenue replacement target, determines the dollar value of additional financing required to operate a universal health plan.

Federal and state funding for Oregon health care will continue under a universal health plan. In 2026 the amount of federal and state funds directed towards health care was estimated at \$28.5 billion.¹⁴ Assuming an annual health care cost growth rate range of 5.3% to 6.4%, these funding sources are estimated to increase to between \$38.9 and \$41.4 billion by 2032. The addition of Medicaid funding for dental coverage, estimated at \$0.8 billion in 2032, increases the total estimated funds available from the federal government and the Oregon General Fund to approximately \$39.7 to \$42.2 billion in 2032.¹⁵

Utilizing the 2032 expenditure estimates, and accounting for 2032 projected federal and state contributions, the 2032 revenue replacement target is estimated to fall between the Milliman best estimate of \$39.0 billion and the Board’s estimate of \$30.0 billion.

The revenue model options discussed below should be understood as design scenarios rather than final tax schedules. Options 2-5 were modeled using 2022 tax data with a \$20.385 billion revenue target.¹⁶ That target provides a common basis for examining how different tax structures distribute a specified revenue requirement, but the final rates and amounts would need to be recalculated using an updated expenditure target, implementation year, federal funding assumptions, and current tax data before implementation.

REPLACEMENT FINANCING

A central feature of the financing architecture is that the revenue replacement target would be generated by reconfiguring current household and employer health care spending. Oregon households and businesses already finance health care through premium contributions, payroll

¹⁴ Milliman Report Figure

¹⁵ [OHA Oral Health 2025-2027](#)

¹⁶ Expenditure and Revenue Appendix

deductions, cost-sharing requirements, and direct payments to providers. The proposed financing structure would convert those fragmented expenditures into standardized public contributions.

The risk is the perception of new costs and redistribution. Because health care costs today are paid in different ways, they are difficult to see and compare. For households, proposed contributions would replace premiums and out-of-pocket costs. For employers, payroll and business-based contributions could replace current spending on employee health benefits and their administration. Under a universal health plan, these private expenditures would become more visible.

Replacement financing for a universal health plan, while expected to be lower than current spending in the aggregate, is not distributionally neutral. Different collection mechanisms change who contributes and how much they contribute. Some households and employers may contribute more than under their current arrangements while others may contribute less. Accordingly, evaluation of a financing model should consider both the amount of revenue generated and the distribution of replacement spending across households, employers, and other businesses.

REVENUE MODEL DESIGN AND TRADEOFFS

The five revenue models considered by the Board do not represent five fundamentally different financing options. Rather, they combine a limited number of policy choices in different ways. All revenue model options are primarily structured around an employer payroll tax (EPT) and household health care contribution (HHCC). Smaller amounts are proposed to be collected from the Corporate Income Tax and Corporate Activity Tax (CAT), while Model 1 also includes a nominal lodging tax component.

Across the modeled options, the EPT would provide a little more than half of the revenue replacement target and therefore represents a central component of the financing structure. All models exempt the first \$500,000 of annual payroll. Model 1 applies a single rate to all payroll amounts greater than \$500,000 while Models 2-5 use a three-tier structure, with a higher rate applied to payroll greater than \$10 million. Choices regarding EPT thresholds and rates affect the distribution of financing across employers. In models that include an EPT-related HHCC credit, the two instruments are further linked by reducing household HHCC liability to account for employer payroll contributions attributable to wages.

The revenue model options were primarily developed to better understand the effect of design choices on the HHCC. The variables examined include:

- A two or three-tiered EPT based on total firm payroll;
- Whether employees receive a 0% or 50% EPT-related tax credit against their HHCC;
- The income level at which the HHCC begins to apply (138% FPL or 200% FPL); and
- The number of HHCC brackets (2, 5, or 6).

Model	EPT Tiers	EPT tax credit	HHCC threshold	HHCC brackets	Other Features
1	2 tiers	50%	200% FPL	2	CIT + CAT + lodging tax

2	3 tiers	50%	200% FPL	2	CIT + CAT
3	3 tiers	--	200% FPL	2	CIT + CAT
4	3 tiers	50%	138% FPL	5	CIT + CAT
5	3 tiers	--	138% FPL	6	CIT + CAT

These design choices produce materially different distributional outcomes as demonstrated below.

- Across the models, the estimated share of resident returns with no HHCC liability ranges from 31.2% to 64.9%.
- Estimated wage-based HHCC contributions from households with adjusted gross income below \$250,000 range from approximately \$1.8 billion to \$3.4 billion.
- The average net HHCC rate for the middle-income quintile, as modeled for comparative purposes and not to be considered final, ranges from 0.8% to 2.5%, while the share of HHCC liability borne by the top 1% ranges from approximately 25% to 40%.

Model	Returns with no HHCC liability	Middle quintile average effective HHCC rate	Max HHCC rate	Top 1% share of HHCC
1	54.5%	2.0%	12.0%	30.7%
2	60.4%	1.1%	12.05%	33.9%
3	40.3%	2.5%	7.69%	25.3%
4	64.9%	0.8%	11.7%	39.9%
5	31.2%	2.0%	10.4%	35.6%

Note: These figures have been modeled for comparative purposes only and should not be considered final. Actual rates and distributions will depend on updated expenditure figures related to plan design, launch date, and included populations.

The revenue model options reflect different balances of financing principles such as simplicity, ease of understanding, progressivity, and breadth of participation. A model can provide greater protection for lower and middle-income households while concentrating liability among a smaller tax base. Others spread contributions across more households while using lower rates.

Higher income exemptions and EPT-related tax credits generally reduce or eliminate HHCC liability for more tax returns, while requiring the remaining tax base to generate a larger share of the required revenue. Model 2 and Model 3 provide the clearest comparison, both use a 200% FPL threshold and two HHCC brackets, but Model 2 includes a 50% EPT tax credit. Model 2 therefore shows a larger share of returns with no HHCC liability and a higher maximum HHCC rate than Model 3. More graduated bracket structures can also change how liability is distributed within the HHCC base, although the effects observed in Models 4 and 5 contain other variability in design.

LRO ASSESSMENT HERE

FURTHER REFINEMENT

The current models are sufficient to demonstrate potential financing architectures and the consequences of major design choices, but they should not be treated as final revenue estimates. Before final rates are established, additional work will be necessary to update the revenue requirement and tax bases, incorporate final benefit, provider payment, and implementation assumptions, refine estimates of federal and state funding, evaluate economic incidence across households, employers, industries, and regions, and account for employer behavior.

IV. IMPLEMENTATION FRAMEWORK

Implementation of a universal health plan requires distinguishing the Board's desired end state from the legal and operational pathway needed to reach it. The Board's objective is a statewide universal health plan covering all Oregon residents and integrating existing coverage and financing arrangements to the greatest extent permitted by state and federal law. Certain federal and Tribal delivery systems, including the Veterans Health Administration and Indian Health Service and Tribal health systems, would remain separate, while the state would seek to integrate or coordinate other populations and funding streams as authority becomes available.

However, Oregon cannot implement that end state through a single state action or federal approval process. Different populations and funding streams are governed by different legal authorities. Medicaid and CHIP provide established federal-state mechanisms, including Section 1115 demonstration authority, ACA Section 1332 provides an established pathway for Marketplace-related state innovation subject to federal guardrails, Medicare does not currently offer a general mechanism allowing Oregon to assume administration of Medicare Parts A and B, and ERISA limits state authority over employer-sponsored benefit plan design and administration. A detailed accounting of these authorities and constraints is provided in Appendix X, Staff Technical Analysis: Legal Roadmap for State-Based Universal Health Plan Implementation.

IMPLEMENTATION SEQUENCING

The Board considered three broad approaches to moving from the current coverage system toward the proposed universal health plan:

- **Population phase-in**, beginning with populations more directly reachable through state authority and incorporating federally governed populations as approval is obtained and approval pathways become available;
- **Hybrid phase-in**, beginning with state-reachable populations as well as Medicaid, CHIP, and Marketplace populations following necessary federal approvals; and
- **Simultaneous transition**, under which major coverage populations would transition together after required state and federal authorities were secured, including waiting for the availability of certain approval pathways.

The Board did not select a final sequencing approach. Board discussion reflected significant concern about making initial implementation dependent on federal authorities for which no established integration pathway currently exists (i.e. simultaneous transition). The Board also considered the tradeoffs associated with phased implementation, including continued operation within a multi-payer environment, differential timing of coverage, and financing treatment for populations that have not yet transitioned.

Any phased implementation pathway would also require a corresponding financing transition. Legislative design will need to address when employer and household financing begins, how contributions apply to populations that have not yet transitioned to universal health plan coverage, how existing federal and private expenditures are treated during transition, and how to minimize overlapping payment obligations.

Detailed comparison of the sequencing approaches, including federal dependencies, population reach, administrative implications, implementation timing, financing considerations, and transition risks, is available in Technical Report Part X.

FEDERAL PROGRAM INTEGRATION

The financing framework, as discussed in the previous section, assumes federal coordination to retain access to existing federal funding rather than replacement of federal funding with state-only revenue. Medicaid and CHIP may be aligned with the universal health plan through available federal-state authorities. Marketplace integration could use Section 1332 or related ACA authorities where federal requirements can be met. Use of these approval pathways could align federal financing with a universal health plan, although certain aspects such as Medicaid-specific eligibility tracking, benefits, protections, and federal claiming requirements would almost certainly need to remain in place.

Medicare presents a greater challenge. Current law does not provide a general pathway allowing Oregon to redirect Medicare Parts A and B financing into a state-administered universal health plan. Given the Board's stated preference to not await uncertain changes to federal law, implementation should seek to preserve Medicare coverage while pursuing available alignment strategies, demonstrations, supplemental coverage approaches, or future federal authority. The administering entity should be granted sufficient authority to pursue and administer federal waivers, demonstrations, agreements, and other approvals and to add populations or funding streams as authority becomes available, without assuming that all federal approvals must precede initial implementation.

EMPLOYER-SPONSORED COVERAGE

The Joint Task Force contemplated that employers could continue to offer health benefits after the establishment of a universal health plan. The Board has not separately revisited that policy or determined how employer-sponsored coverage would interact with the universal health plan when both are available.

The Employee Retirement Income Security Act (ERISA) is a federal law that constrains state action involving self-funded employer plans. Self-funded employers cover approximately 67% of workers enrolled in employer-sponsored insurance.¹⁷ The legal framework therefore should avoid requiring employers to modify, terminate, or administer their ERISA plans through the universal health plan. Broad state financing mechanisms can be structured independently of employer benefit plan administration, while employers remain legally able to maintain separate coverage.

If employer-sponsored or other commercial insurance remains a viable option, the question remains whether the universal health plan should function as primary or secondary coverage when an individual has other insurance. Under a primary coverage structure, the universal health plan would provide first-dollar coverage and additional insurance would serve to cover any potential gaps. Under a secondary structure, the reverse would be true, with employer-sponsored insurance being the primary source billed for services and the universal health plan providing wrap coverage.

While a primary coverage approach would enhance administrative simplification efforts by prioritizing the universal health plan as the payer of first resort, this could also be vulnerable to ERISA legal challenges. In contrast, a secondary approach would offer clear ERISA deference but could cut against the administrative simplification sought in creating a single statewide health plan. The Board discussed this issue but deferred a policy decision.

OTHER COMMERCIAL INSURANCE

Separate from employer-sponsored coverage is the question of whether commercial insurance should be allowed to operate in the state once the universal health plan is in place. While federal law is clear regarding the rights of self-funded employers to establish their own health benefit plans, the state does have direct regulatory authority over commercial insurers offering plans through the Marketplace or directly to individuals and businesses.

This topic was not discussed by the Board. Future policy work would need to determine the intended role of fully insured commercial coverage, including whether overlapping coverage should remain available, whether commercial products would primarily serve a supplemental role, and how coverage would coordinate when both are available. Allowing overlapping coverage could preserve additional plan choice but would also retain multiple payer relationships and reduce some of the administrative simplification sought through a universal health plan. A more limited supplemental role could create a clearer statewide financing and payment structure but would require additional legal and consumer impact analysis.

LEGISLATIVE AND LAUNCH SEQUENCING

The Board has not established a coverage launch date or adopted specific readiness criteria governing when coverage should begin. Importantly, legislative enactment and coverage launch

¹⁷ KFF, Employer Health Benefits Survey, 2025. <https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2025-Annual-Survey.pdf>

are separate decisions. Legislation would need to establish the legal and administrative framework for a universal health plan before coverage begins, with launch occurring later based on a date certain, specified readiness criteria, subsequent legislative approval, or another statutory trigger. Different legislative approaches suggest different windows between legislation and launch.

Under a two-step approach the Legislature could pursue an initial “framework” legislation establishing the public corporation for the universal health plan and other elements for which policy direction as been established. With a framework in place, the administering entity could begin the work of additional planning, analysis, and negotiation as needed. A subsequent bill would establish financing mechanisms, resolve remaining major policy questions, and provide authority for coverage to begin. This approach would allow organizational and implementation work to begin before all financing and operational decisions are complete but would make implementation dependent on subsequent legislative action. The drawback is the reality that two significant efforts would be required for implementation.

A one-step approach would simplify the legislative strategy significantly by focusing on developing a single comprehensive bill to be passed. This approach would allow interdependent policy and financing decisions to be resolved within a single legislative framework but require substantially greater technical and policy readiness before legislation could be finalized, and may require longer between legislation and launch to stand up the administering entity.

Section V outlines the current legislative readiness for a comprehensive bill regarding a statewide universal health plan in Oregon. There are numerous outstanding policy questions and technical analyses recommended, particularly in the realms of financing and implementation planning. While the Board opted to defer legislative strategy to the Legislature, the implication is clear; a comprehensive implementation bill would require additional development, particularly regarding financing, coordination with other coverage, and launch readiness.

V. LEGISLATIVE READINESS

The table below indicates the status of key concepts discussed in this brief for a potential bill establishing a universal health plan. Status indicators are as follows:

Key:



Board direction established



Additional technical analysis required



Minor policy decision needed



Major policy decision needed

Legislative Element		Status	Outstanding Question
Benefit design	Core benefit entitlement	?	Determine whether benefits beyond the adopted PEBB-based framework should be expressly guaranteed in statute
	Point-of-service cost sharing	!	Decide whether to prohibit cost sharing or authorize narrowly defined/value-based exceptions
Provider payment	Required payment models	✓	No major policy question if the Legislature codifies the Board's direction
	Other provider payment authority	✓	No policy questions if the Legislature provides administrative authority to establish and update methodologies within statutory fiscal, access, transparency, and quality guardrails
	Provider participation	!	Decide whether qualified providers may elect participation or whether participation is required under specified circumstances.
Governance	Public corporation and public accountability	✓	No major policy question if the Legislature codifies the Board's direction.
	Governing board	!	Establish the governing board's size, composition, appointment, qualifications, terms, compensation, and conflicts requirements.
	Centralized administration and regional structure	✓	Statute should establish regional offices as part of the public corporation structure and preserve the central/regional division of authority. Number, boundaries, staffing, and other operating procedures can be determined administratively.
	Universal Health Plan Trust Fund	✓	No major policy question if the Legislature codifies the Board's direction.
Eligibility	Eligibility and enrollment	✓	No major policy question if the Legislature codifies the Board's direction.
Financing framework	Replacement financing framework	✓	No major conceptual question if the Legislature adopts the Board's framework that state-generated revenues replace substantial existing household and employer health spending
	Revenue replacement target	! ✎	Establish the expenditure and federal/state funding assumptions to be used in determining the amount that must be raised through state financing mechanisms.
	Rate and threshold adjustment authority	!	Determine which rates and thresholds are fixed in statute and which may be updated administratively within statutory parameters as expenditures, revenues, and economic conditions change.
Revenue instruments	Revenue model architecture	! ✎	Determine which combination of employer payroll, household income, corporate income, corporate activity, or other revenue mechanisms should finance the revenue replacement target.

Legislative Element		Status	Outstanding Question
	Employer payroll tax (EPT)	⚠️ ✎	Establish payroll thresholds, number of tiers, rates, exemptions, and treatment of employers that retain separate health coverage.
	Health Care Personal Income Tax (HHCC)	⚠️ ✎	Establish the income exemption threshold, number of brackets, rates, treatment of wage and non-wage income, and other filing rules.
	EPT-related HHCC credit	⚠️ ✎	Determine whether and to what extent household liability should be reduced to account for employer payroll contributions attributable to wages.
Start-up and transition financing	Startup and reserve financing	⚠️ ✎	Establish the source and timing of startup funding and reserve capitalization and any statutory reserve or solvency requirements.
	Transition financing	⚠️ ✎	Determine how taxes and other financing mechanisms phase in as populations transition to the UHP, including treatment of employers and households that continue to finance other coverage during transition.
Integration with other insurance	Federal integration authority	✓	Authorize the universal health plan entity to pursue and administer federal waivers, demonstrations and agreements; preserve existing federal entitlements while populations remain outside the universal health plan; and permit additional populations and funding streams to be incorporated as approval and authority become available.
	Employer-sponsored coverage	⚠️	Determine how universal health plan coverage coordinates with employer coverage, including whether the universal health plan operates as primary or secondary coverage where both exist.
	Other commercial insurance	⚠️	Determine the extent to which commercial insurance may provide overlapping or supplemental coverage and establish coordination requirements where other coverage remains available.
Launch criteria	Implementation sequencing	⚠️	Selection of a sequencing pathway needed.
	Launch authority and readiness	⚠️	Determine whether legislation establishes a date certain, readiness conditions, subsequent legislative approval, or another mechanism for authorizing coverage to begin and additional populations to transition.