

Universal Health Plan Governance Board

Report to the Oregon Legislature | December 2026

Universal Health Plan
Governance Board

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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. Yet Oregon's health care system remains fragmented, increasingly expensive, and deeply inequitable. Businesses face rising and unpredictable health care costs, while individuals and families face uncertainty about their coverage, premiums, and out-of-pocket expenses. Access to affordable care and financial protection depends heavily on employment, income, and insurance status, rather than health care needs.

A universal health plan offers Oregon an opportunity to replace this fragmented system with one that provides greater stability and predictability for businesses and individuals while fundamentally changing how health care costs and access are distributed. By establishing consistent coverage, restructuring health care contributions to better reflect ability to pay, and creating more coordinated approaches to provider payment and cost containment, a universal health plan could reduce financial uncertainty, strengthen Oregon's economy, and address structural inequities in the current system.

The Universal Health Plan Governance Board was established by Senate Bill 1089 (2023), subsequently codified in ORS chapter 751, 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 § 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.

This report presents the board's proposed framework for administering, financing, and implementing a universal health plan in Oregon, including:

- **Benefit design.** All Oregon residents would be covered, with recognition that certain populations, such as veterans and Native Americans, would retain the right to access care through other systems. Coverage would no longer depend on employment, providing greater continuity and security for individuals and families. Benefits would be modeled after current public employee benefits plus enhanced behavioral health benefits, dental, vision, and hearing benefits, and preserved services for Oregonians on the Oregon Health Plan.
- **Provider payment structures.** Hospitals would transition to payments based predominantly on global budgets, providing greater financial stability and predictability, and clinicians would be paid through a combination of fee-for-service and value-based payment models, prioritizing primary care services and behavioral health. Standardized payment methodologies would normalize payments and simplify billing, reducing administrative burdens on providers.

- **Plan governance and administration.** A universal health plan would be administered by an independent nonprofit public corporation, similar to the State Accident Insurance Fund (SAIF). Regional offices would be established to assist in local engagement, health resource planning, and community accountability. Each regional office would convene advisory groups of providers, plan members, and community members. A dedicated trust fund held in the state treasury would provide a stable, transparent financial foundation, with a governing board responsible for policy and oversight.
- **Provider choice and patient-centered care.** Residents would be able to see any participating provider in the state with no prescribed networks. Participating providers would be prohibited from balance billing universal health plan members. Payment structures, particularly those for primary care and behavioral health, would encourage integrated, patient-centered care that contributes to better health outcomes.
- **Estimated expenditures.** Under conservative actuarial estimates targeted for 2032, a universal health plan could cover all Oregon residents with robust benefits, including dental, vision, and hearing, and minimal, if any, cost-sharing, for approximately $77.7 billion annually, or about $0.6 billion less than the projected $78.3 billion the current system will cost. Anticipated administrative and pharmaceutical savings would reduce expenditures further, while providing more benefits to more people. Once mature, a universal health plan is estimated to save approximately $6.6 billion annually compared to the status quo.
- **Predictable and equitable financing.** 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 presented assume continued state and federal health care contributions and restructure the contributions of businesses and households so that they are predictable, progressive, and easier to contain. The primary financing would come from an employer payroll tax combined with a household health care contribution. The board presents five models for consideration and recommends further analysis of economic and distributional impacts. Across the models the majority of households are expected to pay less than they currently do for health care.
- **Implementation pathways.** The board evaluated three implementation pathways: a population phase-in beginning with groups not requiring federal approval; a hybrid approach that would also include Medicaid and subsidized Marketplace populations, subject to federal approval; and a simultaneous transition, including Medicare and Medicaid, of all residents. The board discussed tradeoffs between providing stable coverage sooner, achieving administrative simplification, and managing federal approval requirements and implementation risks, and recommends public and interested party input prior to making a decision.
- **A legislative action plan.** The board identified additional work needed before implementation, particularly analysis of the economic and distributional impacts of revenue models and public engagement regarding tradeoffs and risks. The board asks the Legislature to authorize and fund this second phase of the board's work. The board also asks legislators to establish a pathway toward implementation, either through comprehensive legislation or a two-step process beginning with framework legislation and followed by implementation legislation. Either approach could be referred to voters.

Oregon has the resources and the potential to lead the nation by covering everyone who lives here with robust benefits, minimal, if any, cost-sharing, and protection from medical debt. A universal health plan offers the opportunity to replace today's fragmented and inequitable system with one that provides stable coverage, predictable costs for businesses and households, and access to care based on need rather than ability to pay. A universal health plan would provide health care coverage regardless of employment, giving families and individuals greater security and freedom. Oregon has the opportunity to choose a system that asks people to

contribute according to their ability to pay, reduces administrative burdens on providers, and creates greater financial stability across the health care system.

The board's work establishes a framework for achieving these goals while identifying the decisions and tradeoffs that remain. The following sections detail the proposed model, its anticipated costs and benefits, financing options, administration, implementation options, the risks of both action and inaction, and the legislative steps needed to advance Oregon toward a more stable, equitable, and sustainable health care system.

The Appendices contain further details from consultants and staff and are provided at the conclusion of this report for reference.

Board process

The Oregon Universal Health Plan Governance Board was established under Senate Bill 1089 (2023), codified as Oregon Revised Statutes (ORS) chapter 751. The board was 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. 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 volunteer 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. Committees included more than 40 people with expertise and experience in health care systems and community engagement. The board engaged multiple regional and national consultant groups, including Health Management Associates for structure and policy expertise; Milliman Inc. for actuarial analysis of expenditures; ECOnorthwest for revenue strategies, start-up costs, and reserves; Wentz Jackson Consulting for communications; and Artemis Consulting for outreach to key interest groups. The Oregon Health Authority (OHA) fulfilled legislative requirements by creating a report on the federal authorities required for universal health plan implementation in Oregon and a report on OHA system readiness for universal health plan integration. Full reports and key memos from consultants are available in the Appendices.

The board prioritized community engagement across all aspects of its work. Board and committee meetings were open to the public with written and oral comments encouraged. Targeted engagement sessions were held with hospitals, health care providers, insurers, coordinated care organizations, and other involved parties to gather direct input.[1] Outreach and engagement with the nine federally recognized Indian Tribes in Oregon was facilitated through the OHA Office of Tribal Affairs and the Department of Consumer and Business Services tribal liaison.

Guiding principles

Five overarching 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.

1 See Appendix F: March 2026 Focus Groups with Addendum, UHPGB

- **Minimize Financial Hardship for Individuals and Families from Medical Costs:** Protecting individuals from the financial consequences of ill health; and 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 Oct. 15 and Oct. 29, 2026, the board voted to approve this report for submission to the Oregon Legislature in fulfillment of its statutory charge.

Recorded vote: Vote 9 in favor, 0 opposed

Acknowledgments

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

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Proposed model

Today, health care coverage depends on a person's income, age, job, immigration status, and whether they qualify for state or federal health care programs. When any of those things change, coverage can shift or disappear. During this time, health needs may go unmet or people may face financial strain to get health care. Even when people have insurance, many face premiums, deductibles, and copays they cannot afford. Businesses may struggle to provide health insurance to their employees, and some cannot provide it at all. A universal health plan would create a statewide public coverage system that would provide continuity of health care coverage for those living in Oregon.

The board proposes a universal health plan that would cover all people living in Oregon with a common core set of benefits and limited out-of-pocket costs. Eligibility for the universal health plan would be based on residency and would not depend on employment status.

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 receive, and how the universal health plan could interact with other coverage.

Eligibility

The universal health plan would use Oregon residency as the starting standard for eligibility. Residency would be generally defined in accordance with 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 could choose to take part in the universal health plan but would not be required to in acknowledgment of Tribal sovereignty.

Seasonal farm workers, as defined in 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 appropriate facilities in accordance with applicable federal and state rules.

Students from other states who attend school in Oregon would be eligible. 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 or are otherwise considered nonresidents under ORS 316.027 domicile standards 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 overseeing body. Enrollment includes:

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

The board recommends that people who are new to Oregon could enroll initially by stating they intend to live in Oregon, with basic coverage beginning immediately. 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. Upon enrollment, people could list their dependents to sign them up as well.

Eligibility verification

To verify accurate enrollment, members would be required to provide proof of residency within 60 days of enrolling. The universal health plan would collect only the minimum information to meet federal rules and determine applicable federal funding sources, including the following:

- **Proof of residency**, to establish eligibility for the universal health plan.
- **Proof of income**, to support federal funding eligibility and determine eligibility for Medicaid-required benefits.
- **Proof of identity**, to support program integrity, coordination with federal programs, and member communication.

Acceptable proof could include a lease, a utility bill, employer verification, or other approved documents. Wherever possible, the universal health plan should 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 universal health plan would keep people covered through largely automatic eligibility renewal. The primary 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.[2]

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

2 UHPGB, Eligibility/Enrollment Proposal

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

This step in conjunction with review of Oregon tax filings is expected to renew about 90% to 95% of eligible people with no action on their part.[3]

Ex parte review and member outreach

For the smaller number of people the automatic steps miss, the universal health plan would conduct an *ex parte* review, which would check 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 or until the universal health plan learns they no longer qualify.

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

Integration with federal programs

Enrollment and verification would be built to work with federal programs, including Medicaid and Medicare. Where the universal health plan seeks to maintain federal funding, it must follow all federal rules for eligibility and documentation. The universal health 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 residency. In the first six months, members would have access to:

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

After six months of continuous residency, members would become eligible for the full benefit package, including elective outpatient procedures and fertility services.

Benefit structure

Today, a person's health insurance dictates what services are covered and to what extent. Many plans leave gaps, especially in dental care, vision, and behavioral health. The universal health plan would establish one common core benefit package. The core benefit package would be based on the standard benefits available to Oregon public employees through the Public Employee Benefits Board (PEBB) with expansions in behavioral health coverage. This benefit package is referred to as "PEBB+" throughout this report.

3 UHPGB, Eligibility/Enrollment Proposal

Scope of covered benefits

The proposed benefit package would cover the full range of medically necessary care, including, but not limited to, the following:

- **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 care**
- **Vision services**
- **Durable medical equipment and prosthetics**
- **Fertility and reproductive health services**

Individuals who qualify for Medicaid would retain expanded benefits in alignment with Medicaid requirements, including long-term services and supports, nonemergency medical transportation, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for children. Long-term services and supports would continue to be administered through the Oregon Department of Human Services.

Behavioral health

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

- **Integrated behavioral health and primary care**, based on the Certified Community Behavioral Health Clinic (CCBHC) and Patient-Centered Primary Care Home (PCPCH) models, with support for referral-based care as well.
- **Expanded outpatient and community-based services**, including case management, navigation, and early intervention services.
- **Crisis response infrastructure**, including 24/7 crisis lines, mobile outreach, crisis stabilization, and respite services.
- **Residential and inpatient treatment**, including acute, subacute, and intermediate levels of care.

- **Preventive and population-based services**, including school-based mental health and early psychosis intervention.
- **Peer-delivered and recovery support services.**

A broad continuum of behavioral health providers would deliver this care, including licensed clinicians, certified providers, and supervised paraprofessionals. The goal is to support more continuous, integrated care and address current gaps in the system.

Cost sharing and financial protection

Today, even people with insurance may skip care because of the cost of deductibles and copays. The universal health plan would aim to cover most, if not all, services with no point-of-service cost sharing. Removing point-of-service expenses eliminates a key financial barrier that prevents people from getting care when they need it, in addition to simplifying administration 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.
- 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 of the universal health plan should be granted authority to adjust specific benefits over time as clinical evidence, community health needs, finances, and federal rules and opportunities change.

Interaction with other coverage

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

A 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 could choose to participate in the universal health plan. However, 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, a universal health plan would not eliminate the option of employer-based coverage. While employers could continue offering their own health coverage if desired, all eligible employees would be enrolled in the universal health plan. Employers offering their own health benefits would still contribute to the funding of the universal health plan through payroll tax. The universal health plan is designed to provide employers with a robust, predictable-cost option that could remove considerable complexity from employers managing their own health benefits. Still to be determined, subject to ERISA and other federal law, are coordination requirements for how the universal health plan will interact with nonfederal employer coverage.

Under a primary coverage approach, the universal health plan would pay first for covered services and employer coverage would be responsible only for noncovered services or costs. The advantages of having the universal health plan function as the primary payer include simpler administration for providers and greater ability for the universal health plan to drive payment and delivery reform. The drawbacks include higher upfront financing to account for more covered lives, possible disruption to benefits won through collective bargaining, and legal and operational risks tied to ERISA. The technical report discusses ERISA and related legal questions in more detail.

Alternatively, employer-sponsored insurance could be designated as the primary payer where multiple coverage options exist. Under a secondary coverage approach, employer insurance would pay first and the universal health plan would wrap around it, covering cost-sharing and noncovered services under the employer plan. The advantages include lower initial cost for the plan, minimal disruption to current employer arrangements, and avoidance of ERISA challenges. The drawbacks would be prolonged administrative complexity with more payers remaining in the system and reduced leverage for the universal health plan to simplify administration, enact payment reforms, and achieve savings.

The Joint Task Force on Universal Health Care did not state 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 workers' compensation.

The board recommends the governing body of the universal health plan 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 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 people living in Oregon 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 nonemergency services. The universal health plan may pursue reciprocal agreements with other states where that is workable.

Health equity impact

The universal health plan is designed 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 upon attestation, automatic re-enrollment, and automatic review using public program information all work to remove the administrative barriers that fall hardest on people with unstable housing, limited documentation, income that changes month to month, language access needs, disability-related barriers, or on-and-off contact with state systems.

The benefit design is intended to reduce financial and service disparities. The PEBB+ package, including dental care, vision, and expanded behavioral health coverage, will provide Oregon residents access to necessary routine care that improves long-term health outcomes. The universal health plan's commitment to cover most, if not all, services with zero point-of-service cost sharing would also remove a key financial barrier to accessing care.

Additionally, providers are currently paid different amounts for the same service depending on what kind of insurance a patient has. Clinics and hospitals that care for a larger proportion of people without insurance and people 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 access when maintaining essential services becomes unsustainable.

A universal health plan would use standardized payment methodologies rather than variable rates by source of coverage. This would smooth price variation based on payer mix while allowing for rate adjustment based on factors such as rural designation, essential services, and other policy objectives.

Whether the universal health 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 people 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

What the board has learned

Modeling shows that a universal health plan for Oregon is financially feasible. The Universal Health Plan Governance Board (UHPGB) expenditure analysis demonstrates that Oregon could cover everyone, provide better benefits, and reduce costs for most households with lower total spending than the current fragmented system.

Building on the 2022 Joint Task Force on Universal Health Care Final Report and Recommendations, 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 Oregon Legislative Revenue Office,[4] which developed an estimate of the amount of revenue that would be created under each of the proposed models in 2032.[5]

Three findings stand out

First, the expenditure analysis demonstrates 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 UHPGB analysis 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 health plan itself. The board built assumptions into the model that it believes are consistent with available research and data.

Third, the modeling shows that many households would pay less overall than they do under the current system when premiums, out-of-pocket costs, deductibles, copays, and coinsurance are all considered.[6]

Taken together, the analysis shows that a universal health plan is financially feasible, would reduce overall systemwide spending through administrative efficiencies, and would lower total health care costs for many households compared to the current system.

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.

4 Milliman, Expenditure Analysis for the Oregon Universal Health Plan, April 3, 2026; ECOnorthwest, Final 2032 Revenue Replacement Targets and Tax Rates, July 16, 2026

5 Appendix C: UHPGB Supporting Documents and Presentations

6 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman

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 expenditure estimates

Milliman Inc., a global actuarial consulting firm, was contracted by the board to develop a cost analysis for a proposed universal health plan in Oregon. The firm developed a baseline, or status quo estimate, of Oregon's 2026 health care costs and produced low, best, and high projections for future expenditures under both the current system and a universal health plan scenario in 2032.[7] The year 2032 was selected as being the earliest year in which the plan could be fully implemented, given the legislative, federal, and operational steps required.[8]

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, hearing, and fertility costs.

Table E1

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
Without Health Insurance	122,000	$0.6
Total	**4,292,000**	**$44.6**

Table E1 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 27 (exclusive of administrative costs and dental, vision, hearing, fertility, LTSS costs)

7 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman
8 Appendix G: Federal Authorities Required for Universal Health Plan Implementation in Oregon, Oregon Health Authority

Milliman predicted expenditures in 2032 status quo system

Population shifts and cost changes are projected to substantially increase health care expenditure 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 people living in Oregon who are over age 65 is expected to increase by 8.6%.[9] Since older adults on average use more medical services than younger 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 health care system continues, in 2032, the number of people living in Oregon without health care insurance will triple.

Milliman calculated the 2032 health care expenditures under the current system would be between $63.5 billion and $72.6 billion.[10] These estimates include health care costs increasing by 5.3% to 7.4% each year. This percentage increase is commonly referred to as the medical trend. 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.

Table E2

Oregon 2032 Status Quo Projected Estimates Enrollment, Medical, and Prescription Drug Expenditures				
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
Without Insurance	348,000	$2.3	$2.5	$2.6
Oregon Behavioral Health[11]	---	$0.8	$0.9	$1.1
Total	**4,423,000**	**$63.5**	**$68.0**	**$72.6**

Table E2 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 30 (exclusive of administrative costs, unreimbursed Medicaid calculation, dental, vision, fertility, LTSS costs)

9 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman, Figure 28
10 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman, Figures 29, 30
11 Milliman 6.1.4 Cost Projections from Source Data to 2026

Best estimate 2032 status quo expenditure including dental and administrative costs

To compare the status quo health care expenditures in 2032 to those under the proposed universal health plan, the cost of covering dental services must be included, in addition to the expenses related to administering multiple health plans.

Dental expenditures in Oregon in 2019 were $2.35 billion.[12] Projecting to 2032[13] at a 4% increase per year creates an estimate of $3.9 billion in 2032.

Averaging commercial and government health plans, administrative costs are projected to account for roughly 9.0% of total annual health care expenditure[14] from 2026 to 2032.

Table E3

Oregon 2032 Status Quo Best Projected Estimates *Including Dental and Administrative Expenditures (Billions)*	
2032 Milliman	**Best Projected Estimate**
Milliman Status Quo Major Benefits	+$67.1
Oregon Behavioral Health	+$0.9
Status Quo Dental Cost	+$3.9
Health Plans Combined Administrative Costs (9%)	+$6.4
2032 Best Status Quo with Dental and Administrative Costs	**= $78.3**

Table E3 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Appendix 4

12 KFF Expenditures by State
13 Health Affairs National Health Expenditure Projections 2024-2033
14 NHEA Data

Table E4

Oregon 2032 Status Quo Low Projected Estimates *Including Dental and Administrative Costs (Billions)*	
2032 Milliman	**Low Estimate**
Milliman Status Quo Major Benefits	+$62.7
Oregon Behavioral Health	+$0.8
Status Quo Dental Cost	+$3.7
Health Plans Combined Administrative Costs (9%)	+5.6
2032 Low Status Quo with Dental and Administrative Costs	**= $72.8**

Table E4 Source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Appendix 4

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

In 2032, a universal health plan would cover about 340,000 more people than the status quo system. Those who were previously without insurance 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 Oregon. There is also the potential for 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.[15]

2. No (or minimal) cost sharing

The portion of health care costs that consumers pay whenever they use a service or purchase medications or durable medical equipment is known as cost sharing. Removing all cost sharing has been shown to lead to an increase in utilization of health care and can lead to higher costs. This can lead to *better* patient care, such as an increase in cancer screening tests,[16] and improvements in patients regularly taking medications they have been prescribed.[17] However, it can also lead to overuse of some unnecessary or avoidable services.[18]

15 Baker, M. C., & Stratmann, T. (2025). Moving opportunistically: Interstate migration after Medicaid expansion. *Social Science & Medicine*, 367, 117771.

16 Bhandari, N. R., & Li, C. (2019). 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)*, 7(1), 36.

17 Remler, D. K., & Greene, J. (2009). *Cost sharing: A blunt instrument. Annual Review of Public Health*, 30, 293-311.

18 Wain, K., Ritzwoller, D. P., & Coca Perraillon, M. (2025). *Quantifying changes to healthcare utilization after a reduction in cost-sharing among deductible plan enrollees* [Preprint]. arXiv.

Milliman quantified the impact of the factors of increased utilization, pent-up demand and adverse selection and calculated low, best, and high estimates of those increased costs. Those estimates are included with the Oregon 2032 medical, prescription drug, and behavioral health care costs to develop 2032 Universal Health Plan major medical expenditure projections. The following table summarizes the results.

Table E5

Oregon 2032 Universal Health Plan Major Medical Cost Estimates (Billions)			
2032 Milliman Universal Health Plan	**Low**	**Best**	**High**
Medical and Prescription Drug Status Quo	$62.7	$67.1	$71.5
Increased Population, Increased Utilization, Adverse Selection Predicted Impact	+$5.7	+$7.2	+$8.7
Oregon Behavioral Health	+$0.8	+$0.9	+$1.1
Universal Health Plan Major Medical Estimates	**$69.2**	**$75.3**	**$81.3**

Table E5 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 30

Addition of dental, vision, and plan administration costs

Administrative costs and the projected costs of dental, vision, hearing, and other services are added to the major medical cost to complete expenditure estimates of a 2032 universal health plan. 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, cost trends, and operational assumptions. This, however, is before savings related to a universal health plan have been accounted for in the estimates.

Table E6

Oregon 2032 Universal Health Plan Major Medical, Dental, Vision, and Plan Administration Cost Estimates (Billions)				
	A Major Benefits	**B** Dental, Vision, Hearing, & More[19]	**C** Administrative Costs	**A+B+C= Total** 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**

Table E6 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 41

19 Dental, Vision, & More includes dental, vision, fertility, complementary medicine, hearing aids, massage therapy, and doula services from Milliman 6.3.6

Milliman predicted savings under a universal health plan

The Milliman modeling applies two adjustments to the 2032 universal health plan cost estimates.[20] 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 estimates these at $4 billion to $5 billion in reduced eligibility and billing costs and $3 billion to $3.5 billion from providers collecting 100% of billed charges from the universal health plan and no longer needing to bill individuals.

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 approximately the same as they are now.

Similarly, realizing savings from billing and insurance related charges would require renegotiating rates with providers. Current provider charges account for their administrative costs for billing. With a significantly simplified system, providers will no longer need to maintain a staff dedicated to insurance and billing functions. As part of future planning, payment rates should be structured in collaboration with provider groups to reflect these reduced administrative costs and ensure the plan supports sustainable, high-quality care.

Table E7

Oregon 2032 Universal Health Plan
Major Medical, Dental, Vision, and Plan Administration Cost Estimates
Including Milliman Estimated Savings (Billions)

Estimates	**A** Plan Expenditures	**B** Collectability Savings	**C** Provider Administration Savings	**A-B-C = Revised Plan Expenditures** 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**

Table E7 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 50

In summary, a conservative estimate of expenditures for a universal health plan in 2032 would be $77.7 billion, compared to $78.3 billion[21] in expected expenditures under the status quo. That is, we could convert the current fragmented system that leaves many people living in Oregon with limited coverage or without health insurance 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 $0.6 billion less.

20 Milliman 7.1.2
21 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 40

Universal Health Plan Governance Board expenditure analysis

Universal Health Plan Governance Board 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.[22] Literature review and expert analysis indicate a broad range of potential savings.[23] While 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 administrative costs: Administrative costs make up roughly 25% of total health care costs. Streamlined, unified financing systems have been estimated to reduce administrative spending by 10% to 50%.[24] Administrative costs, including profit margins, typically run from 10% to 15% of the total expenditure of private health plans.[25]

The board and committees had multiple presentations and discussions regarding examples of reduced administrative costs under universal health plans. Board member Dr. Chunhuei Chi provided expert testimony and analysis of Taiwan's National Health Insurance system,[26] which averages administrative costs of less than 2% annually. In the United States, administrative costs for Medicare Fee-for-Service are often cited as being 1.3% to 2.0% of total costs,[27] however, NHEA data sources estimate higher values.[28]

In Organization for Economic Co-operation and Development (OECD) countries, such as Canada, France, Germany, and the United Kingdom, the range of governance and financing-related administrative spending at the macrolevel has remained stable over the past decade at slightly over 3% of total health spending.[29]

In light of this information, the board decided to use 3% of total expenditure as the administrative cost estimate for an Oregon universal health plan. Board members discussed that this could be considered an ambitiously low estimate, but given the documented low administrative cost of many national health plans and the as yet unknown potential for savings related to artificial intelligence over the next few years, a 3% administrative cost is believed to be attainable.

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

23 CBO Single-Payer Health Care System

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

25 Milliman Report Section 4.5

26 Cheng, T.-M. (2015). Reflections On The 20th Anniversary Of Taiwan's Single-Payer National Health Insurance System. Health Affairs (Project Hope).

27 2026 Medicare Trustees Report

28 Baranoff, D., Baranoff, E. G., Sager, T. W., & Shi, B. (2021). Comparing apples with oranges: Administrative expenses and finances in Medicare systems. The American Journal of Managed Care, 27(4), e123–e129.

29 Hagenaars, L. L., Klazinga, N. S., Mueller, M., Morgan, D. J., & Jeurissen, P. P. T. (2018). How and why do countries differ in their governance and financing related administrative expenditure in health care? An analysis of OECD countries by health care system typology. *International Journal of Health Planning and Management*, 33(1), e263–e278.

Reduction in fraud, waste, and abuse: In the United States, it is estimated that fraud alone accounts for 3% to 10% of health expenditures.[30] A fragmented payment system allows for billing inconsistencies and irregularities. A unified claims system enables detection of improper billing. One recent study estimated the United States could save $285 billion in 2024 dollars related to fraudulent billing reduction if there were a single-payer universal health care system.[31]

Prescription drug and durable medical equipment costs: The United States pays substantially more for prescription drugs than comparable nations. One recent study estimated outpatient prescription medication savings of 35% to 62% if medications in the United States were priced at rates similar to those in Canada, France, Germany, Japan, and the United Kingdom.[32] 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 New York. Prescription drug costs are estimated to be reduced by 24% under the New York single-payer health plan.[33] Array Rx,[34] a multi-state cooperative started in Oregon, currently achieves prescription drug price reduction through bulk purchasing power.

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[35] projects health care cost increases to slow somewhat after 2026, with the annual National Health Expenditure Growth to average 5.4% from 2025 to 2034. The board has decided to utilize the Milliman low estimates as the 5.3% trend is aligned with NHEA data and CMS cost growth estimates.

Expenditure analysis summary: After careful deliberation of presented literature, expert testimony from Dr. William Hsiao and Dr. James Kahn, 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 lowered prescription drug costs.

30 Fraud and Abuse in Healthcare Claims
31 Projected economic gains and lives saved under a universal healthcare in the US
32 Ye, Y., Pandey, A., Fitzpatrick, M. C., Potter Schwartz, L., Bawden, C., Bilori, B., Singer, B. H., & Galvani, A. P. (2026). Estimating US savings on outpatient prescription pharmaceuticals from international reference pricing. *Proceedings of the National Academy of Sciences of the United States of America*, 123(2).
33 Analysis New York Health Act
34 Array Rx Legislative Brief 2026
35 CMS NHE Projections 2025-2034

Table E8

UHPGB 2032 Expenditures with Savings	
UHP 2032 Low Estimate With Savings (Billions)	=$69.4
UHPGB Additional Savings	---
Prescription Drug Savings[36]	-$1.0
FWA Savings[37]	-$0.8
Additional Savings from Administrative Cost estimate of 3% (instead of 4.6%)	-$1.4
UHPGB 2032 UHP Estimate	**= $66.2**

Table E8 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 30

Savings realization: As noted previously, 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 statewide 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.

Forecast limitations: 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 B, however, significantly more evaluation is required.

Expenditure estimate summary: As shown in Table E9, Oregon health care expenditures in 2032 under the current system are estimated to be $72.8 billion to $78.3 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 $66.2 billion, roughly 8% lower than the status quo estimate.

In the most optimistic savings scenario, it is possible that Oregon could provide robust health benefits to all people living in Oregon with no cost sharing for about $6.6 billion less than under the status quo system, which does not cover everyone and leaves many people living in Oregon without health care coverage or underinsured and facing serious financial hardship from medical costs.

36 Cai C, Runte J, Ostrer I, Berry K, Ponce N, Rodriguez M, et al. (2020) Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses. PLoS Med 17(1): e1003013.

37 Cai C, Runte J, Ostrer I, Berry K, Ponce N, Rodriguez M, et al. (2020) Projected costs of single-payer healthcare financing in the United States: A systematic review of economic analyses. PLoS Med 17(1): e1003013.

Table E9

2032 Status Quo and Universal Health Plan Projections Summary Table (Billions)			
2032	**Milliman Best**	**Milliman Low**	**UHPGB UHP**
Status Quo	$78.3	$72.8	$72.8
Universal Health Plan	$77.7	$69.4	$66.2
Universal Health Plan Savings Compared to Status Quo	**$0.6**	**$3.4**	**$6.6**

Table E9 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 50

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 directed towards health care was estimated at $28.5 billion.[38] Assuming an annual health care cost growth rate range of 5.3% to 6.4%, these funding sources increase to $38.9 billion to $41.4 billion by 2032. The addition of Medicaid funding for dental coverage,[39] estimated at $0.8 billion in 2032, increases the total estimated funds available from the federal government and the Oregon general fund to be $39.7 billion to $42.2 billion.

38 Milliman Report Figure 4
39 CMS Medicaid Financial Management Report FY 2024

Table E10

2032 Federal and State Projected Contributions		
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	Low 5.3%	Best 6.4%
	=$38.9	= $41.4
State and Federal 2032 Dental Funding[40] [41]	+$0.8	
Total 2032 Federal and State Funding	**= Low $39.7**	**Best $42.2**

Table E10 source: Appendix D (Expenditure Analysis for the Oregon Universal Health Plan, Milliman), Figure 43

Medicare Part B premium payment

The UHPGB Revenue Model Options include payment of Medicare Part B premiums for people living in Oregon who are Medicare eligible and whose premiums are not covered by Medicaid. Medicare Part B provides coverage of outpatient medical services, with funding coming from the general federal revenue (75%) and enrollee premiums (25%).[42] Payment of these premiums is required to receive Medicare Part B benefits, which, on average, provide two and a half to three times the value of the premiums paid. Any federal waiver or agreement allowing continued Medicare Part B benefits is expected to maintain this requirement.

Unlike other premiums or out of pocket expenses that would no longer require direct payment under a universal health plan, Medicare Part B premiums must still be paid to the federal government. As a result, they require additional revenue to be raised by the universal health plan. Covering these premiums ensures the state continues to receive substantial federal Medicare funding. In 2026, every $1 paid in Medicare Part B premiums generated approximately $3 in federal contributions for Medicare coverage.[43]

Therefore, the cost of Medicare Part B premiums, including Income Related Monthly Adjustment Amounts (IRMAA), is added as an additional expense to the revenue required to replace current contributions. The Legislature could consider not including Medicare Part B premiums in the expenses of a universal health plan, instead relying on individuals to make Part B premium payments.

40 OHA Oral Health 2025-2027
41 NHEA historical and projected
42 MedicareFAQ.com
43 MedicareFAQ.com

Table E11

2032 Universal Health Plan Projections Summary Cost of Medicare Part B Premium Payments (Including IRMAA) (Billions)			
	2032 Expenditure Projections	**Medicare Part B Premium Cost**	**Total Including Part B Premiums**
UHP Best	$77.7	$3.5	$81.2
UHP Low	$69.4	$3.5	$72.9
UHPGB UHP	$66.2	$3.5	$69.7

Table E11 Source: Appendix D

Medicare Part D: An evaluation for incorporation of Medicare Part D payments into the proposed universal health plan has not yet occurred, due to time and resource constraints. Funding for Medicare Part D comes from federal contributions (75%), enrollee premiums (13%), and state contributions (12%).[44] This topic requires in-depth analysis to accurately determine the cost of Part D Premiums for Medicare eligible people living in Oregon and further consideration. Medicare Part D premium costs are not included in the current version of the UHPGB universal health plan proposal.

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.

Revenue replacement target estimates

Utilizing the 2032 expenditure estimates and the 2032 projected federal and state funding, the revenue replacement target ranges from $30.0 billion to $39.0 billion. The Universal Health Plan Governance Board members, based on alignment with NHEA data and CMS projections of a 5.3% medical cost trend, support the revenue replacement target range as most likely to be between $30.0 billion and $33.2 billion.

44 KFF Medicare Part D

Table E12

2032 Revenue Replacement Target Estimates (Billions)			
	Milliman UHP Best	**Milliman UHP** Low	**UHPGB UHP**
2032 Expenditure Estimates	$77.7	$69.4	$66.2
Medicare Part B Paid by UHP to CMS	+$3.5	+$3.5	+$3.5
2032 Projected Continuing Federal and State Funding	-$42.2	-$39.7	-$39.7
Revenue Replacement Target Estimates	**=$39.0**	**=$33.2**	**=$30.0**

Table E12 Source: Appendix D

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 in developing the models, and trade-offs and tensions the board navigated.

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 would be used only 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.
2. **Funding must be progressive.** A progressive tax system is one in which the tax rate increases as a person's income or wealth increases. Contributions should follow capacity 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 a person needs to pay.
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 mechanisms and models

The revenue model options are grounded in the understanding that Oregon does not need to spend more on health care 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 copayments, 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 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 (CIT/CET) add-on

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 over $1 million.

2. Corporate Activity Tax (CAT) Add-On

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% on taxable commercial activity over $1 million. Currently, one hundred percent of net CAT revenue goes to the Fund for Student Success.

3. Lodging Tax add-on

An increase in the statewide lodging tax is proposed in one model 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. Household Health Care Contribution (HHCC)

The Household Health Care Contribution (HHCC) 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 HHCC would be administered through Oregon's existing personal income tax system and, depending on the model option, applied only above an income threshold of 138% or 200% of the federal poverty level (FPL).

6. Employer Payroll Tax (EPT) credit

Under both status quo and a universal health plan, employers help pay for health care for their employees. The EPT credit recognizes these employer contributions by allowing a portion of the EPT paid on the employee's behalf to be credited against their HHCC liability. A larger credit reduces the HHCC collected from wages, shifting a greater share of household contributions toward non-wage income. A small or 0% EPT credit increases the share collected from wages while allowing for lower overall HHCC rates.

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 financial responsibility is distributed across different income levels.

All revenue estimates for the five options are static. 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 analysis is the next step needed for a deeper understanding of potential economic impact.

Revenue Model 1

Revenue Model 1 uses all six revenue mechanisms described above. The employer payroll tax has two tiers: no tax on the first $500,000 of payroll and 9.89% above that. The household health care contribution 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 model 1, about 55% of tax filers in Oregon would pay no Household Health Care Contribution.

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 and rates that were utilized by the Legislative Revenue Office to meet the projected 2032 revenue replacement target of $30.2 billion.[45]

45 UHPGB Sept. 17, 2026 Presentation by LRO – Overview of Universal Health Care Taxes: Scaling of Estimates

Table R1

Legislative Revenue Office 2032 Revenue Projections For Revenue Model Option 1					
Mechanism	**% Share of Revenue**	**Additional Tax/ Contribution Rate**	**Amount Raised (Billions)**	**Tiers/ Brackets**	**Exemption**
Corporate Income/Excise Tax	3.5%	4.25%	$1.15	---	---
Corporate Activity Tax	1.2%	0.11%	$0.39	---	---
Employer Payroll Tax	47.8%	9.89%	$15.5	2	No tax on first $500,000
Household Health Care Contribution	47.2%	12.0%	$15.3	2	No tax on income < 200% Federal Poverty Level
Lodging Tax	<0.1%	0.2%	$0.01	---	---
Employer Payroll Tax Credit 50%	---	---	---	---	---
---	Total = 100%	---	Total = $32.4	**---**	**---**

Table R1 Source Appendix C—LRO Model Scenarios, Supporting Document Expenditure and Revenue Memo C. Swanson

Variables in model options 2-5

Model options 2 through 5 are all adaptations of Model 1. To allow for direct comparisons across models the examples that follow adjust Model 1 EPT and HHCC rates of 9.89% and 12.0% to 9.6% and 13.5%, respectively. The models differ by alterations in the following aspects of the revenue mechanisms.

1. Employer Payroll Tax tiers

Revenue Model 1 has two EPT tiers. The first tier of $0 to $500,000 in annual payroll is not taxed. Above $500,000, the tax rate is 9.6%. Model options 2 through 5 all have three 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%. Having a higher rate for large employers increases

the share of revenue raised from the Employer Payroll Tax and reduces the revenue share that households contribute through the household health care contribution.

Public employers typically devote a larger share of their budgets to employee health benefits than private employers. Under a universal health plan, one option to ensure those resources continue supporting health care would be to require public employers to contribute at the highest EPT rate, regardless of payroll size. This approach would need substantial additional analysis and in-depth discussion with all parties involved.

2. Employer Payroll Tax credit

Either a 50% EPT credit is modeled or 0% EPT credit. A 50% EPT credit allows for more revenue to be collected from nonwage earnings. A 0% EPT credit has a lower top HHCC rate, with more revenue being collected from wage earners. With a 0% EPT credit, more households will pay a household health care contribution.

3. Household Health Care Contribution exemption threshold

Revenue model options 1, 2, and 3 use 200% of the Federal Poverty Level (FPL) as the HHCC exemption. Revenue model options 4 and 5 use 138% of FPL as the exemption. A lower threshold (138% of FPL) creates a broader contribution base from which to draw revenue, allowing for a lower top HHCC rate. A lower threshold adds a financial impact on households with lower incomes.[46] Table R2 shows 2026 annual incomes by household size, and the corresponding Federal Poverty Level.

Table R2

2026 Federal Poverty Level Annual Income Amounts			
Household Size	**100% FPL**	**138% FPL**	**200% FPL**
1 person	$ 15,960	$ 22,025	$ 31,920
2 people	$ 21,640	$ 29,863	$ 43,280
3 people	$ 27,320	$ 37,702	$ 54,640
4 people	$ 33,000	$ 45,540	$ 66,000
5 people	$ 38,680	$ 53,378	$ 77,360

Table R2 Source: Federal Poverty Level Calculator

4. Household Health Care Contribution brackets

Revenue model options 1, 2, and 3 have two contribution brackets. Model 4 has five brackets and Revenue Model 5 has six brackets. A model with more contribution brackets can create more progressivity. In a progressive financing model, those with lower incomes pay lower contribution rates; those with higher incomes pay higher rates. More progressivity increases the top HHCC rate for the highest earners, as the distribution of revenue payment is shifted toward upper income earners.

46 At the Jan. 15, 2026 UHPGB meeting, the board voted 8-0 in favor of a 200% FPL exemption.

Revenue model options details

The revenue model options are shown together in Table R3. The models are presented with specific rates to enable an analysis of potential 2032 revenue. As previously noted, to compare model 1 to the other models, the percentage rates of the EPT and HHCC in model 1 are revised from the initial LRO modeling so all options generate roughly the same projected 2032 revenue.

All the revenue model options have the same proposed CIT/CET and CAT rates. Only Model 1 contains a lodging tax as a mechanism for raising revenue.

The percentage of total revenue that is derived from the EPT and the HHCC is noted for each model option. The maximum HHCC rate is also noted, but it should be emphasized that the average effective HHCC rate is much lower than the maximum for most contributors. Average HHCC rates can be found in the quintile share analysis Table R9.

The percentage of tax filers who would have an estimated $0 Household Health Care Contribution is included at the bottom of the table to enable comparisons between the models regarding percentages of households contributing via the HHCC.

Table R3

Revenue Model Options Overview					
	RMO 1	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
CIT/CET rate	4.25%	4.25%	4.25%	4.25%	4.25%
CAT rate	0.12%	0.12%	0.12%	0.12%	0.12%
Lodging Tax rate	0.21%	0.0%	0.0%	0.0%	0.0%
Employer Payroll Tax					
% of Revenue	43% 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
EPT 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%
Household Health Care Contribution					
% of Revenue	52%	40%	40%	40%	40%
Exemption	0%-200% FPL	0%-200% FPL	0%-200% FPL	0%-138% FPL	0%-138% FPL
HHCC Brackets	2	2	2	5	6
Maximum HHCC Rate	13.5%	12.05%	7.69%	11.7%	10.4%
% of Returns with 0% HHCC Liability	54.5%	60.4%	40.3%	64.9%	31.2%

Table R3 Source: Supporting Document Expenditure and Revenue Memo C. Swanson

2032 Projected Revenue

The Oregon Legislative Revenue Office created a high-level preliminary analysis of the described revenue models and developed revenue estimates for the year 2032 for each revenue mechanism.[47] This is a static estimate with no behavioral response or macroeconomic feedback incorporated, nor is the tax base adjusted to reflect changes to the health insurance environment.

Table R4

2032 Revenue Projections (Billions)					
	RMO 1	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
CIT/CET	$1.15	$1.15	$1.15	$1.15	$1.15
CAT	$0.39	$0.39	$0.39	$0.39	$0.39
Lodging	$0.01	$0	$0	$0	$0
EPT	$15.1	$19.2	$19.2	$19.2	$19.2
HHCC	$18.2	$14.0	$14.1	$14.1	$14.1
Total	**$34.85**	**$34.74**	**$34.84**	**$34.84**	**$34.84**

Table R4 Source Appendix C LRO UHP Model Scenarios, Supporting Document Expenditure and Revenue Memo C. Swanson

Revenue Model Option Considerations

While the model options produce comparable total revenues, the key distinctions lie in the sources of those revenues, the share derived from wages versus other income, and how contributions are distributed among income groups.

The board presents all the developed models with the desire to have further engagement and discussion. The following are some pertinent features of the mechanisms and the models.

- **Lodging Tax**
  - Only in RMO 1
  - Estimated to generate roughly $7 million in 2032[48]
  - The lodging tax was recommended to broaden the base of revenue strategies and account for the health care costs incurred by visitors to Oregon, but the board recognizes this is a very small tax that may decrease the feasibility of passing the whole package

47 Appendix C: UHPGB Supporting Documents and Presentations
48 Appendix B: ECOnorthwest Memo 2032 Revenue Replacement Targets

- **Employer Payroll Tax**
  - The two-tiered Employer Payroll Tax and lower maximum EPT rate of 9.6% in the original LRO estimate of RMO 1 raises $4.1 billion less than the three-tiered options with a maximum rate of 14.0% in models 2-5
- **Employer Payroll Tax Credit**
  - 50% EPT credit in models 1, 2, and 4
  - Elimination of the credit shifts the burden of contributions towards lower wage earners, with a higher percentage of households having some HHCC liability in models 3 and 5
  - 0% EPT credit results in models 3 and 5 having lower maximum HHCC rates
- **Household Health Care Contribution**
  - Liability Exemption Levels
    - RMOs 1, 2, and 3 have HHCC liability exemption levels of 200% of FPL
    - RMOs 4 and 5 have HHCC liability exemption levels of 138% of FPL
    - An HHCC exemption level of 200% poverty level was recommended by the board in January 2026, prior to other RMOs being developed
    - A higher exemption protects lower-income households but requires increased contributions from other households
  - **Contribution Brackets**
    - Models 4 and 5 have more HHCC brackets than models 1, 2, and 3
    - Additional brackets in models 4 and 5 enable more precision in determining effective HHCC contributions by income levels

Alternate Rate Revenue Estimates

In addition to calculating 2032 projected revenues for specific rates, the LRO provided estimates on how revenue amounts would change related to increases or decreases in the proposed rates or tiering parameters. This is highly beneficial information as it enables further understanding of revenue model options and the ability to easily calculate different revenue amount totals or a redistribution of contributions.

Table R5

Alternate Employer Payroll Tax Rate 2032 Revenue Estimates	
EPT Rate	**Revenue Estimate** (Billions)
13% over $10 million	$18.2
14% over $10 million	$19.2
15% over $10 million	$20.1

Table R5 Source: Appendix C—LRO Model Scenarios

Table R6

Alternate HHCC Tax Rate 2032 Revenue Estimates			
RMO	**Description of HHCC Change**	**Original Revenue** (Billions)	**New Revenue** (Billions)
RMO 1	12% → 13.0%	$15.3	$17.1
RMO 2	12.05% → 13.05%	$14.0	$15.8
RMO 4	+1% to each rate	$14.1	$16.1

Table R6 Source: Appendix C—LRO Model Scenarios

Quintile Share Analysis

The revenue model options distribute the liability of contributions to the universal health plan in unique ways. In the following analysis, Oregon households are divided into five groups designated as quintiles. The quintiles are defined by Adjusted Gross Income (AGI) levels and the number of people represented on tax returns, with residents who are not represented on Oregon tax returns placed in the first quintile. Each quintile represents approximately 856,000 people in 2026.

Presenting the percentage share of the revenue raised for each income quintile under the five revenue model options allows a comparison between options of how higher and lower income levels are impacted by the proposed HHCCs, EPTs, and EPT credits. Please see Supporting Documents Expenditure and Revenue Memo C. Swanson for additional details.

Quintile Share of HHCC Liability

The quintile distributions of income and HHCC liability are shown in Table R7. RMOs 2 and 4 shift the largest portion of the HHCC revenue contribution to the upper quintile of households, with RMO 4 shifting almost 40% of the revenue raised from the HHCC to the top 1% income households. Models 3 and 5, with no EPT credit, shift some of the tax burden from the highest quintile into the middle three quintiles.

Table R7

Quintile Share of HHCC Liability							
Quintile	**2026 Income Range**	**Quintile Share of Income**	**RMO1**	**RMO2**	**RMO3**	**RMO4**	**RMO5**
First 20%	$0-$15,000	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%
Second 20%	$15,000-$44,000	7.9%	0.0%	0.0%	0.6%	0.1%	0.8%
Middle 20%	$44,000-$74,000	15.4%	4.9%	3.5%	8.2%	2.5%	6.5%
Fourth 20%	$74,000-$118,000	22.5%	17.5%	15.9%	19.8%	12.0%	15.1%
Fifth 20%	$118,000+	53.8%	77.5%	80.6%	71.4%	85.4%	77.6%
Top 20% Detail							
80-95%	$118,000-$285,000	23.8%	27.1%	26.5%	27.5%	23.7%	23.1%
95-99%	$285,000-$571,000	13.5%	19.7%	20.2%	18.5%	21.8%	18.8%
Top 1%	$571,000+	16.4%	30.7%	33.9%	25.3%	39.9%	35.6%

Table R7 Source: Supporting Documents Expenditure and Revenue Memo C. Swanson.

Quintile Share of HHCC and EPT Liability

Combining the liability associated with the Employer Payroll Tax with the HHCC liability, shown here in Table R8, provides a more complete picture of how income levels contribute to the entire universal health plan under the various models.

Table R8

Quintile Share of HHCC+ EPT Liability						
	Quintile Share of income	**Model 1**	**Model 2**	**Model 3**	**Model 4**	**Model 5**
First 20%	0.4%	0.3%	0.4%	0.4%	0.4%	0.4%
Second 20%	7.9%	4.2%	5.4%	5.6%	5.4%	5.7%
Middle 20%	15.4%	11.0%	12.0%	14.0%	11.6%	13.3%
Fourth 20%	22.5%	20.6%	20.8%	22.5%	19.2%	20.5%
Fifth 20%	53.8%	63.9%	61.4%	57.5%	63.5%	60.2%
Top 20% Detail						
80-95%	23.8%	26.7%	26.3%	26.7%	25.1%	24.9%
95-99%	13.5%	16.7%	16.1%	15.4%	16.8%	15.5%
Top 1%	16.4%	20.5%	19.0%	15.4%	21.5%	19.7%

Table R8 Source: Supporting Documents Expenditure and Revenue Memo C. Swanson.

Quintile Net HHCC Rate Average

Table R9 shows the average HHCC rate for all households within each quintile. The rate increases substantially with higher AGI, which demonstrates progressivity of the revenue model options.

Table R9

Net HHCC Rate Quintile Average					
	Model 1	**Model 2**	**Model 3**	**Model 4**	**Model 5**
First 20%	0.0%	0.0%	0.0%	0.0%	0.0%
Second 20%	0.0%	0.0%	0.4%	0.1%	0.5%
Middle 20%	2.0%	1.1%	2.5%	0.8%	2.0%
Fourth 20%	4.8%	3.4%	4.2%	2.5%	3.2%
Fifth 20%	8.9%	7.1%	6.3%	7.6%	6.9%
Top 20% Detail					
80-95%	7.1%	5.3%	5.5%	4.8%	4.6%
95-99%	9.0%	7.1%	6.5%	7.7%	6.6%
Top 1%	11.6%	9.9%	7.4%	11.7%	10.4%

Table R9 Source: Supporting Documents Expenditure and Revenue Memo C. Swanson.

Quintile Net HHCC and EPT Rate Average

Table R10 shows the average combined rate for EPT plus HHCC in each of the quintiles.

Table R10

Net HHCC+EPT Rate - Quintile Average					
	Model 1	**Model 2**	**Model 3**	**Model 4**	**Model 5**
First 20% (adjusted)	7.6%	9.7%	9.7%	9.7%	9.7%
Second 20%	6.1%	7.8%	8.1%	7.8%	8.2%
Middle 20%	8.1%	8.9%	10.4%	8.6%	9.9%
Fourth 20%	10.4%	10.5%	11.4%	9.7%	10.4%
Fifth 20%	13.5%	13.0%	12.2%	13.5%	12.8%
Top 20% Detail					
80-95%	12.8%	12.6%	12.8%	12.1%	11.9%
95-99%	14.1%	13.6%	13.0%	14.2%	13.1%
Top 1%	14.2%	13.2%	10.7%	15.0%	13.7%

Table R10 source: Supporting Documents Expenditure and Revenue Memo C. Swanson.

Scenarios

While the majority of people living in Oregon will pay the same amount or less for health care under a universal health plan, individual circumstances will vary. The following scenarios provide illustrations of the impact of the revenue model options on four household types in Oregon.

The following four scenarios demonstrate:

1. People covered by individual insurance (4% of people living in Oregon). This includes those working as a sole proprietor or for a very small employer who does not pay for employer-sponsored health insurance (ESI).
2. People covered by ESI from a private employer (33% of people living in Oregon).
3. People covered by ESI from a public employer (13% of people living in Oregon).
4. People covered by Medicare and collecting Social Security benefits (20% of people living in Oregon).

The majority of the other 30% of people living in Oregon are covered by the Oregon Health Plan (OHP). Most who would be eligible for OHP by income will have no health care costs under a universal health plan.

Dollar values and Federal Poverty Level values used in calculations are for 2026. Please see Supporting Document Expenditure and Revenue Memo C. Swanson for FPL tables.

The Employer Payroll Tax is based only on wage income. Adjusted Gross Income (AGI) in these tables is based on wage income only for illustrative purposes. Some households that have an HHCC liability will have other income in addition to wages, which may increase liability.

Scenario 1

Individual household of 45-year-old person who is the sole proprietor or the employee of a small firm, with a payroll of less than $500,000 a year.

Status quo: Individual annual payment varies based on income level

Universal Health Plan: Employer payroll tax rate = 0.0%

- If they earned $20,000 a year, estimated annual payment of $0 under the status quo and $0 under a universal health plan.
- If they earned $45,000 a year, estimated annual payment of $5,211 under the status quo. Under all revenue model options, they would pay less than the status quo.
- If they earned $90,000 a year, they would pay less than the status quo under models 3, 4, and 5, and more under models 1 and 2.
- If they earned $180,000 a year, they would pay more than the status quo under all models.

Table R11

Individual Household, Self-Employed or Small Employer						
Total Income (AGI)	**Status Quo**	**RMO 1**	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
$20,000	$0	$0	$0	$0	$0	$0
$45,000	$5,211	$1,766	$1,576	$1,006	$1,474	$823
$90,000	$6,900	$7,841	$6,999	$4,466	$6,462	$3,699
$180,000	$6,900	$19,991	$17,844	$11,387	$18,701	$11,220

Table R11 Source: Supporting Documents Expenditure and Revenue Memo C. Swanson; Green-filled cells indicate the person or household is expected to pay less under a universal health plan than under the status quo.

Scenario 2

Household of two, working for a private employer with the Oregon median payroll of $8.5 million a year, covered by employer-sponsored insurance.

Status quo: The household pays $2,900 in premiums and $1,800 in out-of-pocket costs for a total of $4,700 in health care costs each year.

The employer pays $16,700 in premiums each year.

Universal Health Plan: Employer Payroll Tax is 9.6%.

- If they earned $40,000 a year, estimated annual payment of $0 under the status quo and $0 or $203 under a universal health plan.
- If they earned $85,000 a year, estimated annual payment of $4,700 under the status quo. Under all revenue model options, they would pay less than the status quo.
- If they earned $110,000 a year, they would pay less than the status quo under models 1, 2, 4, and 5 and more under model 3.
- If they earned $170,000 a year (and above), they would pay more than the status quo under all models.

Table R12

Household of Two, Medium Size Employer							
Total Income (AGI)		**Status Quo**	**RMO 1**	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
$40,000	Household Pays	$0	$0	$0	$0	$0	$203
	Employer Pays	$0	$3,600	$3,600	$3,600	$3,600	$3,600
$85,000	Household Pays	$4,700	$2,032	$1,427	$3,208	$557	$2,263
	Employer Pays	$16,700	$7,200	$7,200	$7,200	$7,200	$7,200
$110,000	Household Pays	$4,700	$4,507	$3,540	$5,131	$1,907	$3,458
	Employer Pays	$16,700	$9,000	$9,000	$9,000	$9,000	$9,000
$170,000	Household Pays	$4,700	$10,357	$8,520	$9,745	$6,634	$7,492
	Employer Pays	$16,700	$13,500	$13,500	$13,500	$13,500	$13,500
$220,000	Household Pays	$4,700	$14,857	$12,295	$13,590	$10,384	$10,992
	Employer Pays	$16,700	$18,000	$18,000	$18,000	$18,000	$18,000

Table R12 Source: Supporting Documents Expenditure and Revenue Memo C. Swanson; Wage Income = AGI; Green filled cells indicate the person or household is expected to pay less under a universal health plan than under the status quo.

Scenario 3

Public employers tend to contribute a larger percentage of their total budget to employee health benefits compared to private employers. Under a universal health plan, one potential option to ensure those funds continue to contribute to health care is for public employers to contribute at the highest EPT rate, regardless of annual payroll. This topic requires significantly more evaluation and discussion, however, is modeled in this scenario.

Individual household, with wages from a public employer.

Status quo: The individual pays $120 in premiums and $500 in out-of-pocket costs, for a total of $620.

The public employer pays $12,000 in premiums each year.

Universal Health Plan: Public employer effective Employer Payroll Tax is 9.6% in RMO 1, 14.0% in all other RMOs.

- If they earned $40,000 a year, estimated annual payment of $620 under the status quo, and $0, $581, or $621 under a universal health plan
- If they earned $51,000 a year, estimated annual payment of $620 under the status quo. Under revenue model options 1, 2, and 4, they would pay less than the status quo; under models 3 and 5, they would pay more.
- If they earned $66,000 a year, they would pay less than the status quo under models 2 and 4, and more under models 1, 3, and 5.
- If they earned $85,000 a year, they would pay less than the status quo under model 4, and more under all other models.
- If they earned $110,000 a year, they would pay more under all five models.

Table R13

Individual Household, Public Employer							
Total Income (AGI)		**Status Quo**	**RMO 1**	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
$40,000	Individual Pays	$620	$0	$0	$621	$0	$581
	Employer Pays	$12,000	$3,840	$5,600	$5,600	$5,600	$5,600
$51,000	Individual Pays	$620	$176	$0	$1,467	$0	$1,110
	Employer Pays	$12,000	$4,800	$7,000	$7,000	$7,000	$7,000
$66,000	Individual Pays	$620	$1,529	$0	$2,621	$0	$1,989
	Employer Pays	$12,000	$6,144	$8,960	$8,960	$8,960	$8,960
$85,000	Individual Pays	$620	$3,326	$796	$4,082	$262	$3,319
	Employer Pays	$12,000	$7,680	$11,200	$11,200	$11,200	$11,200
$110,000	Individual Pays	$620	$5,741	$2,409	$6,004	$1,862	$5,069
	Employer Pays	$12,000	$9,600	$14,000	$14,000	$14,000	$14,000

Table R13 Sources: Supporting Documents Expenditure and Revenue Memo C. Swanson; Wage Income = AGI; Note: Green-filled cells indicate the person or household is expected to pay less under a universal health plan than under the status quo.

Scenario 4

Household of two, both of whom are Medicare eligible. The household collects Social Security and has no wages. Social Security benefits are not taxable in Oregon. All revenue model options pay Part B premiums.

Status quo: The household pays Medicare Part B premiums (IRMAA not included) of $4,800, and $4,800 of out-of-pocket costs for a total of $9,600.

Universal Health Plan:

- A household of two with an AGI (without federally taxed Social Security income) of $40,000 to $110,000 will pay less under all models than under the status quo.
- A household of two with an AGI (without federally taxed Social Security income) of $157,500 will pay less under models 3 and 5 than under the status quo; they will pay more under models 1, 2, and 4.
- A household of two with an AGI (without federally taxed Social Security income) of $215,000 will pay more under all models.

Table R14

Household of two, Medicare eligible, no wage income Estimated 2026 Household Payment						
AGI without Federally Taxed Social Security	**Status Quo OOP + Part B premium**	**RMO 1**	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
$40,000	$9,600	$0	$0	$0	$304	$203
$75,000	$9,600	$4,282	$3,822	$2,439	$3,257	$1,785
$110,000	$9,600	$9,007	$8,040	$5,131	$6,402	$3,458
$157,500	$9,600	$15,420	$13,764	$8,784	$11,884	$6,617
$215,000	$9,600	$23,182	$20,692	$13,205	$18,784	$10,642

Table R14 Source: Supporting Documents Expenditure and Revenue Memo C. Swanson; Green-filled cells indicate the person or household is expected to pay less under a universal health plan than under the status quo.

Trade-offs 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 trade-offs to be handled in a new universal health plan.

Progressivity and simplicity often exist in tension. A broad tax base with few exemptions is easier to explain and administer, and it can support lower overall tax rates. However, such an approach may increase the burden on lower income households. Exemptions and credits can mitigate these impacts, but each one adds complexity

to the system. The board received extensive public comment on this issue. In response to concerns about progressivity, the board recommended in January 2026 that the Health Care Personal Income Tax exemption be set at 200% of the Federal Poverty Level, despite the resulting narrowing of the contribution base. The board also considered – but ultimately chose not to include – a soft cap, which would have reduced the tax rate after a household reached a certain tax threshold, on the grounds that such a mechanism would reduce the overall progressivity of the structure.

Employer spending on health insurance is generally exempt from taxation, and employees' contributions are usually tax free as well. Preserving this tax advantaged status is a key reason the proposed revenue model options rely on an employer payroll tax. Routing health care contributions through payroll maintains a tax benefit that wages do not receive, allowing more resources to remain within Oregon's economy rather than leaving the state as increased federal tax payments.

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 proposed tax or contribution can appear as if people will need to pay more under a new plan. A fair comparison considers what people would **stop** paying, not only a new tax or contribution.

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.

Reserves, transition costs, and start-up

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. Operational and financial risk are greatest during the implementation of a universal health plan, as there are many unknowns around costs and revenues. Once the plan has reached stability, reserves may be self-funded through a portion of dedicated revenues. Prior to that steady state, reserve funding must be built into the budget of an implementation plan. The Finance and Revenue Committee recommended a reserve target of three months of operating expenditures, with corrective action triggered if reserves fall below one month.[49] ECOnorthwest's Reserve Funding Financing Memo[50] provides detail regarding operating reserve targets and describes three tiers of financing options. Further analysis of administrative feasibility; legal authority; constitutional or statutory constraints; conditions under which funds may be transferred, loaned, or reprogrammed; and timing restriction tied to biennial budgeting processes are required.

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

49 Finance and Revenue Meeting March 17, 2026
50 Appendix B: ECOnorthwest Consultant Report, Memoranda and Technical Papers

should not be considered as part of the plan's ongoing annual cost.

Future evaluation

As has been noted throughout this report, further exploration and deliberation of many of the financial components of a universal health plan are necessary. The ECOnorthwest memo *Economic Effects of Oregon's Universal Health Plan: A Framework for Evaluating Fiscal, Economic, Distributional, and Welfare Impacts* (found in Appendix B) defines a framework for investigation. In addition to dynamic economic impact analysis, updated evaluations of projected expenditures and an in-depth analysis of Oregon tax laws are required. The Future Work of the Board section of this report provides additional details.

Administrative structure

Health care operates through many separate arrangements today. That fragmentation drives duplication, inconsistent standards, and administrative burden for providers. 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.

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 community engagement
- Transparency and public accountability
- Simpler administration for providers and partner organizations

The universal health plan's core authorities, financing, framework, and accountability provisions should be established in statute that delegates operational and technical details to rulemaking.

Legal structure and authorities

The board recommends that a public corporation oversee the universal health plan. This public corporation would be accountable to the people of Oregon and responsible for implementation, administration, financing, operations, provider payment, and contracting on behalf of the universal health plan.

The board concluded that a public corporation strikes the best balance among public accountability, operational flexibility, and long-term stability. 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 negotiation and coordination with other governments
- Adaptability to future changes

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 establish 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 do the following:

- 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, as well as ethics and conflict-of-interest rules. The public corporation would also participate in state auditing and financial reporting, as well as remain subject to legislative oversight. Like any public body, it would be obligated to act within its statutory limits in all rulemaking and operations.

The structure is deliberately designed for operational flexibility. Some functions may run through contracted third parties while the corporation builds its own capacity. This provides options to the universal health plan regarding start-up capabilities, allowing for longer-term development without delaying implementation.

Central and regional functions

The board proposes a centralized model in which the public corporation carries primary responsibility for financing, payment, policy, data systems, and overall operational oversight. This centralization is needed to ensure consistency, fiscal accountability, and simplified administration for providers. However, the board also recommends the creation of regional offices to ensure local representation. The regional offices would provide input across different communities and enhance transparency. The operational structure would allow regional hubs to lead efforts around local engagement, innovation, health resource planning, and community accountability.

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

- Universal Health Plan Trust Fund management
- 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
- Administrative rules and policies adoption
- 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.

Regional offices will help the universal health plan stay 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 and avoids fragmented administrative requirements.

The universal health plan would designate nonoverlapping regions based on existing patterns of care, public health infrastructure, and natural referral relationships. Board discussion suggests between five and nine regions statewide would be appropriate. To support community accountability and local engagement, each regional office would convene patient and provider advisory groups.

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. An executive director and staff should oversee the day-to-day operation of the universal health plan. The board proposes the following division of responsibilities between the governing board of the universal health plan and its executive director.

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	» Routine operations
» Approving budgets and financial policies	» Staffing and internal administration
» Setting high-level provider payment methods	» Procurement and contracting
» Overseeing reserve and trust fund management	» Carrying out board policy
» Appointing and overseeing the executive director	» Technical and operational adjustments
» Accountability and performance oversight	» Running claims and payment systems
» Major changes to the plan's design or rollout	» Data and reporting
	» Compliance and auditing
	» Routine decisions delegated by rule or board policy
	» Establishing administrative rules
	» Setting provider payment rates

Universal health plan trust fund

The board recommends the creation of a dedicated universal health plan trust fund, separate from Oregon's General Fund, to hold funds for the universal health plan. The trust fund would be where the plan's money is received and managed, and payments issued. Revenues dedicated to the universal health plan would flow directly to the trust fund and be continuously appropriated to the universal health plan. 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 Oregon State Treasury 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 that helps the universal health plan run efficiently.

This approach was informed by financial management structures used by existing Oregon public corporations. It would give the universal health plan access to Treasury investment and liquidity tools while avoiding the constraints of fully captive Treasury management.

The trust fund would pay for health care claims, administration, contracted services, and other costs of running the plan. Reserves for the universal health plan would also be maintained in the trust fund. Federal and state funding previously tied to Medicaid, Affordable Care Act programs, Medicare, and other programs would flow into the trust, to the extent federal law and program rules allow. A dedicated trust of this size should be established with ongoing audits, public reporting, legislative oversight, and financial transparency on par with any large public financing entity.

The trust fund is designed to provide the universal health plan with a stable, transparent financial foundation for the long term. Establishing a dedicated trust fund for the universal health plan will protect reserves, provide financial stability for operations, and hold the universal health plan accountable for managing both short and long-term costs.

Provider payment and delivery system strategy

How the universal health 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 long-term.

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

The universal health plan would establish standardized payment systems designed to reduce administrative burden, improve access, and control costs. It would pay providers using a mix of payment methods matched to the care setting and service, including fee-for-service, prospective, and value-based 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 work with providers and provider organizations to set, update, and adjust rates in accordance with statutory principles through rulemaking. Suggested statutory principles for payment policy include protecting access to care, provider sustainability, and transparency in decision-making.

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 would provide more predictable financing for hospitals, incentives to support preventive care, and simpler administration and billing.

The global budget would cover inpatient, outpatient, and physician services provided at acute care hospitals. The 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 in global budgeting implementation 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 for population health.

Primary care

The board identified inadequate primary care investment as a contributor to costs and negative health care outcomes. The board proposes a primary care payment structure that would place a priority on funding primary care and functioning as the foundation of the delivery system.

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 would 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 would treat primary care funding as a foundational investment. Payment levels would be set to support access, as well as a stable workforce. Each year, at least 15% of universal health care expenditures would be allocated specifically to primary care, including routine well-care and prevention. The 15% target builds on Oregon's existing primary care spending policy, in which coordinated care organizations (CCOs) are currently required to achieve a 12% primary care spending target.

Specialty and other provider payment

Specialty care, including behavioral health, oral health, pharmacy, and other sectors, play critical roles and will require payment methods that support access and quality. The board did not address each of these specialties directly, but identified several core principles for specialty payment, including:

- 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 settings
- 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 will fit every specialty, provider type, or care setting. Implementation may require a mix of approaches, including fee-for-service, prospective payments, bundled payments, global budgets, or other models. Additional work will be required to design appropriate payment methodology recommendations prior to implementation.

Additionally, further work needs to be done to determine if providers will be paid more, less, or the same under a universal health plan. Multiple factors will determine that, including how the standardized payment is structured and each provider's payer mix. The effects of changes can be mitigated with a variety of strategies, including phasing in new rates and methodologies and adjustments to protect rural, safety net, or other vulnerable providers.

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 Part IV contains more information on considerations for developing a quality strategy.

Information technology and data infrastructure

A universal health plan would require integrated data infrastructure supporting eligibility, claims, payment, care coordination, and reporting. It also provides an opportunity to invest in 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 universal health plan running

Privacy, security, and access must be part of the design from the beginning. The universal health plan must follow federal and state privacy and security laws, 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, should be embedded in the information technology (IT) design. Security should 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, nor have startup technology costs been estimated. These analyses are proposed for the next phase of the board's work.

Cost containment

No single strategy can contain health care 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 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 often included patient-focused financial incentives, such as deductibles and copayments, or utilization management tools, such as prior authorization and step therapy. These tools can lower spending, but they raise serious equity concerns regarding those who choose to delay or skip needed care, and patients who are harmed by delays in accessing higher-level care. The board recommends that a universal health plan take a more modern approach to cost containment, focusing instead on approaches that tackle costs at the system level, provider payment, and pharmaceuticals.

Under a universal health plan, Oregon will have access to the broadest set of population health data in the nation, offering a clearer view on the health needs of residents.

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 Universal Health Plan Governance Board recommends building on existing 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 the following:

- 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
- Developing statewide data and accountability infrastructure to support ongoing oversight

Administrative simplification is also a cost containment strategy. 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 would greatly simplify the health care system by developing a uniform payment approach that aligns 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 cost containment strategies could include the following:

- 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
- Long-term evaluation of fee schedule or rate-setting approaches when feasible

Even while considering how provider-level interventions can create cost savings, provider stability must remain a priority. 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 drug 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 prescription drug strategy focused on affordability, transparency, and long-term sustainability, while keeping access to medically necessary medications.

Pharmaceutical strategies may include:

- Coordination with the Prescription Drug Affordability Board
- 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

- Evaluation of upper payment limit authority and related affordability mechanisms
- 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 cost containment strategy to adopt but, instead, offered 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

The board has defined the structure of a universal health plan; however, it has not determined how to get there. Implementation sequencing involves decisions about when certain populations may 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 for all groups based on their current coverage.

About 52.5% of people in Oregon get their primary health care coverage in a manner that does not require federal approval as a pre-condition to integration.[51] These include state public employees, people with employer-sponsored insurance, and people without insurance. Employer-sponsored coverage will require additional design because, although these employees are included among populations Oregon can reach more directly, the Employee Retirement Income Security Act (ERISA) limits the state's authority over self-funded employer health plans.

The remaining 46.8% of Oregon residents get their primary coverage through programs that would require federal approval to integrate into a state universal health plan. These include Medicare, Medicaid, subsidized Marketplace, and the Federal Employees Health Benefits (FEHB) Program.

Sequencing the launch of a universal health plan must balance two goals that are in tension with each other: reducing fragmentation and quickly providing relief to people living in Oregon who are 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. Therefore, providers 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% to 90% of administrative simplification could be achieved under a transition that does not include federal programs.[52] 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, particularly self-funded employers, substitute their plans for universal health plan coverage.

The Transition Committee also considered 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 this option because it would split people's care across several coverage arrangements and would capture few of the systemwide 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.

51 UHPGB Staff Technical Report. Note: Percentages do not sum to 100% as approximately 1% of individuals have unclassified sources of health care coverage.

52 UHPGB Staff Technical Report, Implementation Sequencing

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 nonfederal groups, including those without insurance, with employer-sponsored insurance, and state public employees. Phase 2 would add Medicaid, the Children's Health Insurance Program (CHIP), and those receiving Marketplace subsidies. Phase 3 would add Medicare and the remaining federal groups. This option would encompass about 52.5% of people in Phase 1, 82% in Phase 2, and 99% after complete federal integration (Phase 3).

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 operational 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 less immediate influence over statewide payment and equity concerns as some people would have access to the universal health plan and others would not. This option 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 of the population phase-in approach would launch at the same time. This combines nonfederal groups with Medicaid, CHIP, and Marketplace groups. These additional populations represent those for which there exist federal waiver authorities that may provide a pathway to integration, subject to federal approval. Other populations, mainly Medicare and certain federal programs, would join later if and when new authorities became available. A hybrid phase-in option would cover about 82% of people living in Oregon at launch while keeping a route open for full federal integration once necessary legal pathways are in existence.

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 systemwide provider simplification. Assuming current waiver and federal approval pathways 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 universal health plan than a population phase-in and continued reliance on federal approvals for Medicaid and Marketplace groups. A hybrid approach would require larger reserves and more operational capacity at launch and carry more complexity at the start. If timelines for federal approval shift, that could threaten the launch of the universal health plan.

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 within the next year, 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 10 years, if such pathways even become available.

Board discussion

The board chose not to make a formal recommendation on implementation sequencing of a universal health plan launch. 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 people without insurance, 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 allow the public corporation to 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 universal health 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 to mitigate this concern.

The board also showed interest in a hybrid approach that would launch with nonfederal 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 universal health 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 and 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 Part II. That analysis identifies population phase-in as the most operationally feasible approach among the three pathways reviewed. This is not a recommendation from the 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 system readiness.

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

Risks and trade-offs

Building a universal health plan would change how people living in Oregon obtain health care coverage and pay for care, and how providers are paid. No path forward is risk-free, including persisting with the status quo. There are tradeoffs in the risks of transitioning the health care system, current health care 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.[53] Nationally, employer-sponsored family coverage reached nearly $27,000 a year in 2025, and average family premiums rose 6% in a single year.[54]

These costs are hurting people and families in Oregon. About one in eight people living in Oregon say medical bills have consumed all or most of their savings, and one in seven people delay or avoid care because of cost.[55] In rural southwest Oregon, that figure rises to one in five, 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% from 2025 to 2026, and average Marketplace deductibles climbed 37% to a record high.[56] KFF also found that 9% of individuals who had Marketplace coverage in 2025 had no health insurance by early 2026, and one in six returning enrollees were not sure they could afford their premiums for the whole year.[57] 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.[58] Among small firms that did not offer health benefits, the most common reason was that the cost was too high.[59] 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.

53 Oregon Department of Consumer and Business Services, 2027 health insurance rates.
54 KFF, Employer Health Benefits Survey 2025, Summary of Findings.
55 Impact of Health Care Costs on People in Oregon, 2024, Oregon Health Authority.
56 KFF, What we know so far about 2026 ACA Marketplace enrollment, premiums, and deductibles.
57 KFF, What we know so far about 2026 ACA Marketplace enrollment, premiums, and deductibles.
58 KFF, 2025 Employer Health Benefits Survey.
59 KFF, Americans' challenges with health care costs.

Keeping the current system carries real risks to the state's finances and access. Rising premiums and deductibles push people into medical debt, create financial stress, and encourage delayed care. A fragmented system creates huge administrative burdens for providers and leaves less time for direct patient care, exacerbating access issues. This pressure often falls hardest on rural communities and safety net providers. In recent years, the majority of providers state they are struggling financially.

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 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. Board discussion and staff analysis gave greater attention to population phase-in 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 and administrative rules. Some providers and health systems may resist, especially where a standard payment methodology could 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, providing 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, considering 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.

Risk considerations

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. However, the current system leaves many families struggling with premiums, deductibles, and medical debt; employers face rising health benefit costs; and providers are operating 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. However, keeping the current system is also a choice with costs to 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.

Future work of the board

The board's work to date establishes a foundation for advancing universal health coverage in Oregon, while recognizing that additional policy decisions, technical analysis, and implementation planning are necessary. Moving forward will require legislative direction regarding the authorization and funding of future work, consideration of an appropriate legislative pathway, and continued development of the financing, operational, and transition arrangements necessary to support implementation.

The board has identified the following priorities for Phase 2 work during the 2027-2029 biennium, subject to legislative authorization and funding:

Financing and distributional analysis. The expenditure estimates need to be verified and potentially redetermined using a model of universal health plan operations. In addition, the board would continue developing the revenue plan, beginning with the five financing models presented in this report or variations of them. Further fiscal and actuarial analysis should examine projected spending, revenue needs, reserves, and long-term sustainability, including how financing changes would affect different households and employers, while refining revenue mechanisms, tax bases, thresholds, credits, exemptions, and timing.

Statewide economic impact. The impact of a universal health plan on Oregon's economy needs to be modeled, including dynamic modeling that estimates how businesses, health care organizations, and residents may respond and assesses how economic impacts, benefits, and costs may differ across geographic regions of the state.

Transition planning. A detailed transition plan should address implementation sequencing, enrollment, provider participation, claims, data systems, appeals, contracting, and member communications. It should identify which populations and programs Oregon can bring into the universal health plan under existing authority and which require federal approval or new state law. This work should explicitly identify a viable legal and regulatory pathway for including Medicare beneficiaries and associated federal funding in the universal health plan. It must include the time and cost associated with developing and implementing new or significantly revised revenue collection mechanisms. The plan should also identify transition protections for patients, providers, rural communities, and other affected populations to minimize disruptions to coverage, care, and provider stability, while estimating startup costs, staffing, procurement, information technology needs, and operational milestones.

Operational and business planning. Milliman provided estimates of staffing needed to administer a universal health plan, but these estimates were based on the current insurance system rather than the proposed universal health plan's administrative structure. Phase 2 should refine staffing and information technology needs, assess opportunities for administrative simplification, including the potential role of AI, and develop more detailed estimates of operating costs and capacity requirements. Phase 2 should also assess potential AI-related workforce disruptions and identify opportunities for reskilling and retraining affected health care workers.

Information systems and health record access. Additional planning should identify the information systems and infrastructure necessary to administer the universal health plan, support interoperability across providers and care settings, and ensure all Oregonians can access their own health records. This work should also address data privacy, security, and the efficient exchange of health information.

Communication plan. Clear, accessible information about anticipated costs, benefits, and tradeoffs will be essential to informed public discussion and legislative decision-making. The board should develop a comprehensive communication strategy to explain to the public and stakeholders what a universal health plan would entail, how it would change health care, how the financing would work, and a realistic assessment of the benefits and risks of transitioning to a universal health plan.

Public engagement. A formal statewide public engagement process is essential to inform the policy and value choices that remain unresolved, particularly those related to financing, benefits, and implementation. This process should provide clear information on major design choices and tradeoffs, gather public preferences and concerns, and include targeted engagement with communities most affected by coverage instability, medical debt, access barriers, and provider shortages. Engagement should also include a broad range of community organizations and solicit input on plan design priorities, proposed financing models, and strategies for maintaining transparency and meaningful public participation as planning continues. Public input should directly inform the refinement of financing options, implementation sequencing, and transition protections.

Population health. A statewide universal health plan could provide opportunities to better understand population health needs and trends across Oregon. Phase 2 should examine how available health data could inform health promotion, disease prevention, and early intervention strategies to improve long-term health outcomes and support more effective use of resources.

Legislative action needed

1. Authorization and funding for Phase 2 of the board's work

Advancing Oregon's universal health plan framework will require legislative authorization and funding for the next phase of work detailed in the previous section. This phase would build on the board's work to date and support the development of a detailed implementation blueprint addressing financing and revenue, governance and administration, health care delivery capacity and workforce needs, operational readiness, federal coordination, and necessary statutory and regulatory changes. Continued funding would also support technical analysis, implementation planning, and public engagement to inform the policy and legislative decisions necessary to move Oregon toward implementation. The board recommends that legislative authorization for Phase 2 establish specific deliverables to guide this work and support legislative decision-making.

2. Develop a legislative pathway to a universal health plan

The Legislature will need to determine the appropriate legislative pathway for advancing a universal health plan. Options include a single comprehensive legislative package or a two-stage approach.

Under a single-stage approach, legislation would establish the plan's legal structure, governing authorities, financing, and implementation requirements, as well as set a launch date for the universal health plan in a single bill. This approach would likely require several more years of development but would provide legislators and, if referred, voters with a more complete proposal for consideration.

Under a two-stage approach, initial framework legislation would establish the plan's legal structure, governing authorities, and guiding principles, providing a stable legal foundation while remaining details are developed for subsequent implementation legislation. A two-step process would allow the state to conduct rigorous feasibility studies and "stress-test" the proposed system without the pressure of a launch date.

The Legislature must also determine whether to enact legislation directly or refer the proposal, or components of it, to Oregon voters. These decisions will inform the sequencing and scope of future implementation planning and legislative development.

Closing thoughts

The Universal Health Plan Governance Board was charged with developing a comprehensive, implementable proposal to finance and administer a universal health plan for all people living in Oregon. The work presented here represents the best efforts given time, staffing, and funding constraints, and the board is proud to share the results with the Legislature and the people of Oregon.

This work significantly advances the effort toward a universal health plan by estimating expenditures, presenting financing options, and recommending key elements of plan design, governance, and administration. Together, these findings provide a foundation for informed discussion among lawmakers, health care leaders, businesses, labor organizations, and the public about the opportunities, costs, and tradeoffs of reform.

Oregon has the resources and the potential to lead the nation by covering everyone who lives here with robust benefits, minimal point-of-service cost sharing, and greater financial protection. A universal health plan would expect Oregonians to contribute based on their ability to pay, rather than the amount of health care they need. By guaranteeing health care coverage, regardless of employment, the universal health plan would give individuals and families greater flexibility in employment decisions while reducing the risk of medical debt. Such a system could offer greater stability and predictability for businesses and households, more secure access to care, reduced administrative burdens on clinicians, and opportunities for greater efficiency and cost savings. Realizing these benefits will require careful planning, meaningful public engagement, and management of substantial transition risks. Yet maintaining the current system also carries significant risks to affordability, access, and economic stability. The framework presented here provides a foundation for evaluating these tradeoffs and advancing toward a more stable, equitable, and sustainable health care system for all Oregonians.



Appendices

Where to find more details

The appendices include a legislative brief, reports and memos from consultants, and a summary of community engagement work to date. Additional reference documents, including a detailed expenditure and revenue memo authored by Finance and Revenue Committee member Charlie Swanson, frequently asked questions, and staff technical summary, are on the UHPGB 2026 Legislative Report webpage, and also linked within this document where cited.

UHPGB Appendices		
	Title	**Author**
A	Legislative Brief	UHPGB Staff
B	ECOnorthwest Consultant Report, Memoranda and Technical Papers	ECOnorthwest
C	UHPGB Supporting Documents and Presentations	Legislative Revenue Office
D	Expenditure Analysis for the Oregon Universal Health Plan	Milliman
E	Community Engagement and Public Input Summary	Amy Fellows, Michelle Glass
F	UHPGB Report: March 2026 Focus Groups with Addendum	Artemis Consulting
G	Federal Authorities Required for Universal Health Plan Implementation in Oregon	OHA
H	How OHA Systems Could Integrate with a Universal Health Plan	OHA
I	HMA Memoranda and Technical Papers	HMA
J	Wentz Jackson Supporting Documents	Wentz Jackson

Universal Health Plan Governance Board

Legislative Brief

In Response to the Legislature's Aug. 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 several areas specifically identified by members of the Legislative Assembly in their Aug. 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

(5) The legislative actions necessary to implement a universal health plan.

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

Acknowledgments

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 and payment structures

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 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.

1 Behavioral Health Expanded Services Proposal, approved March 20, 2025.

- **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.

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 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.

2 Primary Care Payment Proposal, approved Aug. 21, 2025.
3 Hospital Payment Proposal, approved Nov. 20, 2025
4 Behavioral Health Care Delivery Proposal, approved Feb. 19, 2026.

Governance

The universal health plan would be administered through a not-for-profit public corporation. 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 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. Nonoverlapping 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.[5]

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.[6]

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.[7]

5 Administrative Structure Proposal, approved Nov. 20, 2025.
6 Eligibility Proposal, approved June 12, 2025.
7 Enrollment Proposal, approved Feb. 19, 2026.

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.[8] 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.[9]

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, Appendix D
- Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board: ECOnorthwest, Appendix B
- Expenditure and Revenue Memo C. Swanson
- UHPGB Supporting Documents and Presentations, Legislative Revenue Office, Appendix C

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.[10] 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 $69.4 billion to $86.5 billion, with a best estimate of $77.7 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

8 Trust Fund Proposal, approved June 12, 2025
9 Subrogation and Third-Party Liability Proposal, approved Feb. 19, 2026.
10 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman

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.[11] This illustrates the potential effect of additional cost reduction 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.[12] 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 billion 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 billion to $42.2 billion in 2032.[13]

Utilizing the 2032 expenditure estimates with a 5.3% cost growth trend, and accounting for 2032 projected federal and state contributions, the 2032 revenue replacement target is estimated to fall between the Milliman low estimate of $33.2 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 $20.38 billion revenue target.[14] 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.

11 UHPGB Legislative Report Table E9
12 Appendix D: Expenditure Analysis for the Oregon Universal Health Plan, Milliman
13 OHA Oral Health 2025-2027
14 Supporting Documents Expenditure and Revenue Memo C. Swanson

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 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/Corporate Excise Tax (CIT/CET) and Corporate Activity Tax (CAT), while Model 1 also includes a nominal lodging tax component.

Across options at the modeled rates, the EPT would provide 43% to 55% 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/CET + CAT + lodging tax
2	3 tiers	50%	200% FPL	2	CIT/CET + CAT
3	3 tiers	--	200% FPL	2	CIT/CET + CAT
4	3 tiers	50%	138% FPL	5	CIT/CET + CAT
5	3 tiers	--	138% FPL	6	CIT/CET + 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%	13.5%	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.

Legislative revenue office 2032 revenue projections

The Oregon Legislative Revenue Office created a high-level preliminary analysis of the described revenue model options (RMOs) and developed revenue estimates for the year 2032 for each revenue mechanism.[15] This is a static estimate with no behavioral response or macroeconomic feedback incorporated, nor is the tax base adjusted to reflect changes to the health insurance environment.

2032 Revenue Projections (Billions)					
	RMO 1*	**RMO 2**	**RMO 3**	**RMO 4**	**RMO 5**
CIT/CET	$1.15	$1.15	$1.15	$1.15	$1.15
CAT	$0.39	$0.39	$0.39	$0.39	$0.39
Lodging	$0.01	---	---	---	---
EPT	$15.1	$19.2	$19.2	$19.2	$19.2
HHCC	$18.2	$14.0	$14.1	$14.1	$14.1
Total	**$34.85**	**$34.74**	**$34.84**	**$34.84**	**$34.84**

* Model 1 values shown here are from the Expenditure and Revenue Memo C. Swanson with rates adjusted from initial modeling to create a revenue total similar to the other models.

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.

15 Appendix C: UHPGB Supporting Documents and Presentations, LRO UHP Model Scenarios

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 staff Technical Report Part 1: Legal road map 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
- **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 (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 staff technical report Part 2: Implementation sequencing.

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.

One commonly cited approach to Medicare alignment is the creation of a state-sponsored Medicare Advantage (MA) plan. Several factors make this an impractical solution. The reach of a state-sponsored MA plan would extend only to those beneficiaries who elect to enroll, and such a plan would remain subject to federal Medicare requirements governing benefits, enrollment, payment, and administration rather than operating under the universal health plan's policies. Oregon could not require Medicare beneficiaries to enroll in a state-sponsored MA plan, restrict their ability to select other available MA plans, or eliminate their option to remain in traditional Medicare.[16] Nor would a newly established plan be guaranteed sufficient enrollment to meaningfully consolidate Medicare financing or administration. Establishing a state-sponsored MA plan would require the state to create and manage another insurance entity without obtaining control over applicable requirements or the Medicare population at large. A state-sponsored MA plan would preserve separate financing, enrollment, and administration rather than consolidate them under the universal health plan, running directly counter to the key objective of administrative simplification.

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 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.

16 42 U.S.C. § 1395w–21; 42 U.S.C. § 1395w–26(b)(3).
17 KFF, Employer Health Benefits Survey, 2025.

The Joint Task Force's ERISA analysis identified an alternative potential solution to addressing the presence of self-funded plans with a universal health plan through provider requirements.[18] Provider exclusivity could require providers that participate in a universal health plan to accept payment only from the universal health plan. While this could strengthen administrative simplification and payment consistency, it also raises legal questions regarding ERISA preemption and the extent to which such restrictions could effectively limit self-funded employer plans. Provider exclusivity could also lead some providers to decline universal health plan participation, potentially limiting access or creating a parallel system of providers serving privately insured or self-paying patients. The board has not adopted this approach, and further legal and operational analysis would be necessary.

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.

The board's intended end state, drawing on the Joint Task Force recommendation, would prohibit state-regulated insurers from offering coverage duplicating universal health plan benefits, while permitting coverage for services outside the universal health plan benefit package. Further work would be necessary to establish the legal and regulatory mechanisms for implementing these restrictions and coordinating coverage where other insurance remains 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.

Medicare Advantage plans cannot be prohibited as duplicative coverage under current federal law, and other federally regulated coverage may be subject to similar restrictions on state authority. Additional legal and policy analysis is necessary to determine whether restrictions on duplicative insurance or provider participation could extend to out-of-state plans. Including these arrangements could further consolidate payment and administration but may conflict with federal protections or interfere with established provider networks. Excluding them could preserve necessary coverage arrangements while also limiting administrative simplification and maintaining multiple payer relationships.

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 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 initial "framework" legislation establishing the public corporation for the universal health plan and other elements for which policy direction has been established.

18 Joint Task Force on Universal Health Care, Final Report and Recommendations (2022), Appendix A, "Analysis of ERISA Preemption Issues for Universal Plan Proposal Memo."

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 significantly simplify the legislative strategy 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 board's work has established substantial policy direction regarding the structure and operation of a universal health plan, including a comprehensive benefit framework, provider payment reforms, a publicly accountable administrative structure, residency-based eligibility, and a proposed replacement financing approach. Collectively, these decisions provide a foundation for future legislation. However, several consequential policy and technical questions remain unresolved, particularly those affecting financing, integration with existing coverage arrangements, and implementation. As a result, the current framework provides a basis for further legislative development but does not yet constitute a fully specified implementation plan.

Among the most significant outstanding decisions are establishing the final expenditure and revenue requirements, determining how financing obligations would be distributed across households and employers, coordinating coverage with federally governed programs and employer-sponsored insurance, and establishing implementation sequencing and launch readiness criteria. Additional decisions regarding cost sharing, provider participation, and governance would also need to be resolved or appropriately delegated. The Legislature could pursue an initial framework bill to establish foundational authorities while remaining decisions are developed, or a comprehensive implementation bill once sufficient policy and technical work is complete.

The following table summarizes the current status of major legislative elements and identifies areas requiring additional analysis or policy direction.

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.

	Legislative Element	Status	Outstanding Question
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.
	Employer payroll tax (EPT)	⚠ ✎	Establish payroll thresholds, number of tiers, rates, exemptions, and treatment of employers that retain separate health coverage.
	Household Health Care Contribution (HHCC)	⚠ ✎	Establish the income exemption threshold, number of brackets, rates, treatment of wage and nonwage 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 universal health plan, including treatment of employers and households that continue to finance other coverage during transition.

	Legislative Element	Status	Outstanding Question
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. Evaluate the legal and operational implications of voluntary provider exclusivity, including ERISA risks and potential impacts on provider participation and access.
	Other commercial insurance	⚠	Establish the regulatory mechanisms for prohibiting duplicative fully insured commercial coverage while permitting coverage for services outside a universal health plan benefit package. Clarify the treatment of federally regulated and out-of-state coverage and coordination requirements where other insurance 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.



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