

Analyses on the Implementation of a Statewide Universal Health Plan in Oregon

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Purpose and scope

This technical report brings together four distinct analyses developed in support of the Universal Health Plan Governance Board's December 2026 legislative report. These analyses address complementary questions relevant to implementation of a statewide universal health plan. The analyses were not originally developed as a single integrated product and address different aspects of system design and implementation. Taken together, however, they provide additional detail regarding the legal and federal constraints affecting implementation, potential sequencing pathways for transitioning populations into a universal health plan, opportunities to reduce administrative burden and address health care workforce challenges, and a framework for developing a statewide quality strategy.

These sections should be read as supporting technical analyses rather than as a single comprehensive implementation plan. They identify constraints, trade-offs, design considerations, and areas requiring further development as Oregon considers how to move from the board's proposed universal health plan framework toward legislation and eventual implementation.

These analyses do not represent formal board findings, recommendations, or policy decisions. They are intended to identify relevant legal, operational, administrative, workforce, and quality considerations, describe potential trade-offs and opportunities, and inform future legislative, board, and implementation deliberations. Staff assessments or conclusions identified within individual sections reflect staff technical analysis and should not be interpreted as board recommendations or decisions.

The report is structured as follows:

- **Part I: Legal road map for state-based universal health plan implementation**
  What can Oregon legally do in designing a universal health plan?
- **Part II: Implementation sequencing**
  Given those constraints, how could Oregon actually get from here to the desired end state?
- **Part III: Review of administrative burdens in the health care workforce**
  As Oregon designs the operating system, what existing problems should it deliberately avoid reproducing?
- **Part IV: Quality of care strategy**
  How should Oregon establish a statewide quality framework that supports accountability while minimizing unnecessary administrative burden?

Glossary of acronyms	
Acronym	**Definition**
ACA	Affordable Care Act
ACO	Accountable care organization
AHEAD	States Advancing All-Payer Health Equity Approaches and Development
AMA	American Medical Association
BHP	Basic health plan
CCO	Coordinated care organization
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
EHR	Electronic health record
ERISA	Employee Retirement Income Security Act
ESI	Employer-sponsored insurance
FEHB	Federal employee health benefits
FTE	Full-time equivalent
HCPIP	Health Care Provider Incentive Program
HIPAA	Health Insurance Portability and Accountability Act
HOWTO	Healthy Oregon Workforce Training Opportunity
IHS	Indian Health Service
MIPS	Merit-Based Incentive Payment System
OEBB	Oregon Educator Benefits Board
OECD	Organisation for Economic Co-operation and Development
OHA	Oregon Health Authority
OHPB	Oregon Health Policy Board

Glossary of acronyms	
ORS	Oregon Revised Statutes
PCPCM	Person-Centered Primary Care Measure
PEBB	Public Employees' Benefits Board
PSHB	Postal Service Health Benefits
PRO-PM	Patient-reported outcome performance measure
VA	U.S. Department of Veterans Affairs

Part I

Legal road map for state-based universal health plan implementation

The goal of this document is to identify the major legal and federal constraints that affect implementation of a state-based universal health plan. This document is not a formal legal opinion and does not resolve every issue that would arise in drafting implementing legislation, negotiating with federal agencies, or defending the state in litigation. Rather, it provides a practical legal roadmap for implementation. The central question is not whether Oregon's long-term universal health care goals are legally permissible in the abstract. The central question is how Oregon can design and implement a state-based universal health plan within the divided federal-state structure of the United States health care system.

Overview

Oregon has a path to implementation of a universal health plan, but not a simple one. Unlike a national government, Oregon cannot align eligibility, financing, provider payment, federal tax treatment, employer obligations, and public program administration through a single legal framework. Current law does not allow the state to immediately consolidate Medicare, Medicaid, Marketplace subsidies, employer-sponsored coverage, and other federal health care funding into one state-administered fund. Federal health program rules, ERISA, federal tax law, tribal sovereignty, and program-specific funding requirements create real constraints on state authority.

Those constraints do not foreclose state action. They do require legal precision. The phrase "universal health plan" can describe the state's coverage goal, but it does not by itself identify the legal authority for each population, payer, funding stream, or administrative function. Each major coverage category must be analyzed through its own governing authority: Medicaid through state plan, waiver, and federal matching rules; Marketplace subsidies through ACA authorities, especially Section 1332; Medicare through Medicare statute, Medicare Advantage, CMMI/payment demonstrations, or future federal legislation; and employer-sponsored coverage through ERISA.

This distinction matters because coverage integration, financing integration, and administrative integration are related but not legally identical. Oregon may be able to provide supplemental or wraparound coverage for a population before it can fully integrate that population's federal funding. It may be able to align provider payment before it can replace an existing federal program. It may be able to create a public financing structure without requiring employers to change the design or administration of ERISA-covered plans.

Medicaid and CHIP offer meaningful but bounded flexibility. Oregon may use Medicaid state plan amendments, Section 1115 demonstration authority, and other Medicaid authorities to align Medicaid financing, benefits, eligibility, delivery systems, and payment methods with the universal health plan. However, federal Medicaid dollars remain tied to Medicaid eligibility, covered benefits, federal claiming rules, budget neutrality, consumer protections, public process requirements, and federal approval.[1]

ACA Marketplace integration is legally plausible but conditional. Section 1332 provides a recognized pathway for state innovation related to Marketplace coverage, premium tax credits, cost-sharing reductions, and certain ACA requirements. However, a Section 1332 waiver must satisfy federal guardrails for coverage, affordability, comprehensiveness, and deficit neutrality. Section 1332 does not waive ERISA, does not solve Medicare, and does not create a general federal "super waiver" for state universal health plan needs.[2]

Medicare is the hardest federal program boundary. Current law does not provide a legal pathway allowing Oregon to redirect Medicare Parts A and B into a state-administered universal health fund or compel Medicare beneficiaries to receive their Medicare entitlement through a state plan. Oregon may pursue Medicare alignment through wraparound benefits, provider payment alignment, CMMI demonstrations, all-payer models, or future federal legislation. Those approaches may support incremental alignment, but they are not equivalent to full Medicare integration.[3]

ERISA substantially limits Oregon's ability to directly regulate employer-sponsored coverage, especially self-funded employer plans. Oregon should not design the universal health plan as a mandate requiring employers to enroll employees in the state plan, change benefit design, submit plan-specific claims data, or administer coverage through a state-created structure. More defensible approaches include broadly applicable financing mechanisms, public coverage structures that operate outside ERISA plan administration, voluntary employer participation, and continued regulation of fully insured products where state insurance authority remains available.[4]

Federal legislation could materially improve the path but should not be treated as an implementation assumption. The State-Based Universal Health Care Act has been introduced in multiple Congresses since 2018 and would create broader waiver authority for states seeking to implement universal health care systems. However, despite repeated introduction, the legislation has not been enacted. Oregon may support and monitor federal legislation, but state implementation planning should not depend on congressional action that has not occurred.[5]

The practical conclusion is direct: Oregon should neither wait for perfect federal authority before beginning nor pretend federal authority is unnecessary. The viable path is to build governance, financing, enrollment, provider payment, and administrative capacity, pursue Medicaid and Marketplace approvals, design employer financing to reduce ERISA risk, align with Medicare where current law permits, and preserve authority to expand as federal approvals or federal law evolve.

1 42 U.S.C. § 1315; Health Management Associates, *Potential Federal Waiver Considerations* (2025), Medicaid Section 1115 discussion; Oregon Health Authority, *Federal Authorities Required* (2025), Medicaid Authorities discussion.

2 42 U.S.C. § 18052; Oregon Health Authority, *Federal Authorities Required* (2025), Section 1332 State Innovation Waiver discussion.

3 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Medicare Waiver Authority discussion; Oregon Health Authority, *Federal Authorities Required* (2025), Medicare Authorities discussion.

4 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1144; Joint Task Force on Universal Health Care, *Final Report and Recommendations* (2022), Appendix A, "Analysis of ERISA Preemption Issues for Universal Plan Proposal Memo."

5 H.R. 6097, 115th Cong. (2018); H.R. 5010, 116th Cong. (2019); H.R. 3775, 117th Cong. (2021); H.R. 6270, 118th Cong. (2023); S. 4817, 118th Cong. (2024); H.R. 4406 and S. 2286, 119th Cong. (2025), State-Based Universal Health Care Act.

Medicaid and CHIP

Medicaid and CHIP are among the most important federal workstreams for universal health plan implementation because, unlike Medicare, they already operate through a federal-state partnership. Oregon has long experience using Medicaid authority to expand coverage, test delivery system reforms, and draw down federal matching funds. Oregon's current Medicaid structure includes state plan provisions, Section 1115 demonstration authority, managed care arrangements, and home and community-based services authorities.[6]

Medicaid is one of the clearest federal pathways available to Oregon for universal health plan alignment, but it is not a source of unrestricted federal revenue. State plan amendments may allow Oregon to make changes that are already authorized under federal Medicaid law, while Section 1115 demonstrations may allow Oregon to test broader changes to eligibility, benefits, delivery systems, payment, and financing. Oregon may also need to preserve or amend other Medicaid authorities, including managed care and home- and community-based services authorities, depending on how the universal health plan is designed.[7]

Federal Medicaid financial participation remains tied to federal Medicaid rules. Oregon would need to continue identifying which individuals are Medicaid-eligible, which services are Medicaid coverable, which expenditures are matchable, and which program requirements continue to apply. That tracking requirement may create tension with the policy goal of seamless universal enrollment, but it is central to maintaining federal funding.[8]

A universal health plan that includes Medicaid would also need to preserve Medicaid-specific benefits and protections. Medicaid covers services that may not be part of typical commercial coverage, including nonemergency medical transportation and Early and Periodic Screening, Diagnostic, and Treatment benefits for children. Medicaid also includes federally prescribed appeals, grievances, due process, network adequacy, access, and oversight requirements. Oregon may integrate or simplify administration from the resident's perspective, but federal Medicaid obligations would still need to be met for Medicaid-eligible individuals.[9]

Delivery system design is another major Medicaid implementation consideration. Oregon's current Medicaid program relies heavily on coordinated care organizations (CCOs). A universal health plan would need to decide whether CCOs continue, are replaced, are reconfigured, or are phased out over time. If the state seeks to operate the universal health plan as a Medicaid managed care structure, the plan would need to satisfy federal managed care requirements. If the state shifts Medicaid populations toward fee-for-service or another state-administered model, that choice could affect the state's flexibility to use global budgets, value-based payment, regional entities, or other payment methods. The legal issue is not simply whether Oregon can move Medicaid into the universal health plan; it is what Medicaid delivery system the federal government is being asked to approve.[10]

6 Oregon Health Authority, *Federal Authorities Required for Universal Health Plan Implementation in Oregon* (Nov. 5, 2025), Medicaid Authorities; Health Management Associates, *Operations Committee Report to the UHPGB: Potential Federal Waiver Considerations for a Universal Health Plan* (2025), Medicaid: Section 1115 Demonstration Waiver.

7 Oregon Health Authority, *Federal Authorities Required* (2025), Medicaid State Plan & State Plan Amendments and Medicaid Waivers; 42 U.S.C. § 1315; 42 U.S.C. § 1396n.

8 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Eligibility.

9 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Covered Benefits and Operations/Payment; 42 U.S.C. § 1396d(r); 42 C.F.R. Part 438.

10 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Delivery System; Oregon Health Authority, *Federal Authorities Required* (2025), Medicaid Waivers.

Federal budget neutrality is likely to be one of the central constraints in any Medicaid waiver strategy. Section 1115 demonstrations generally require the state to show that the proposed waiver will not cost the federal government more than the expected cost of the Medicaid program without the waiver. This becomes especially important if Oregon proposes higher provider reimbursement, broader benefits, new community investments, regional infrastructure, or expanded eligibility. Those choices may be good policy, but they must be justified within the federal financing framework or funded with state-only dollars.[11]

Maintenance of effort is also important. To maintain federal financial participation, Oregon would need to avoid designing a transition that appears to reduce state Medicaid investment, shrink eligibility, or weaken required protections for current Medicaid beneficiaries. For universal health plan purposes, this is both a compliance issue and a beneficiary-protection issue: Medicaid beneficiaries should not lose required benefits, protections, or access during system redesign.[12]

The practical path is to treat Medicaid and CHIP as serious implementation workstreams rather than as a single waiver request at the end of design. Oregon should identify all of the following:

- Which Medicaid functions remain unchanged
- Which changes can be made through state plan amendments
- Which changes require Section 1115 or other waiver authority
- How eligibility and claiming will be tracked
- How Medicaid-only benefits and protections will be preserved
- How CCO or successor functions will operate
- Which benefits, populations, or services may require state-only funding

Medicaid offers an opportunity to move toward a universal health plan, but only if Oregon is realistic about the scope of Medicaid authorities and waiver elements. Oregon can align, but it cannot erase the legal distinction between Medicaid-eligible individuals and the rest of the population, nor can it assume that federal Medicaid dollars will support services or provider rates that go above and beyond Medicaid neutrality requirements.[13]

ACA Marketplace, Section 1332, and basic health program

Oregon's Marketplace currently serves residents who do not have access to affordable employer-sponsored coverage and are not eligible for Medicaid. Many Marketplace enrollees receive federal advance premium tax credits and cost-sharing reductions. A universal health plan that seeks to replace or significantly reduce reliance on Marketplace coverage would, therefore, need a strategy for federal Marketplace subsidies and related ACA requirements.[14]

11 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Federal Budget Neutrality; Oregon Health Authority, *Federal Authorities Required* (2025), Section 1115 Research and Demonstration Waivers.
12 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Maintenance of Effort; Oregon Health Authority, *Federal Authorities Required* (2025), Medicaid Waivers.
13 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Medicaid Section 1115 Demonstration Waiver.
14 Oregon Health Authority, *Federal Authorities Required for Universal Health Plan Implementation in Oregon* (Nov. 5, 2025), Affordable Care Act Authorities.

Two ACA authorities are most relevant: Section 1331 Basic Health Program authority and Section 1332 State Innovation Waiver authority. Section 1331 allows states to establish a basic health program (BHP) as an alternative to qualified health plan coverage for certain lower-income residents who would otherwise be eligible for Marketplace coverage. For universal health plan purposes, BHP authority may be useful for a defined income band, but it is not a comprehensive financing strategy for all Marketplace-eligible residents.[15]

Section 1332 is the broader ACA innovation pathway. It allows states to waive specified ACA and Internal Revenue Code provisions related to Marketplace coverage, premium tax credits, cost-sharing reductions, qualified health plans, essential health benefits, single risk pool requirements, and certain Marketplace functions. Oregon already has experience with Section 1332 through its state-based reinsurance program, which uses federal pass-through funding generated by federal premium tax credit savings. Other states have used or pursued Section 1332 waivers for reinsurance, public option-style plans, state premium assistance, and expanded Marketplace eligibility.[16]

A public option could also be evaluated as a narrower ACA-based transition tool. Public option models generally operate through the Marketplace rather than replacing the full health financing system. They may provide a legally available way to test public plan design, affordability policy, provider payment approaches, and Section 1332 pass-through funding. However, a public option would not, by itself, integrate Medicare, Medicaid, employer-sponsored coverage, or other federal programs, and should not be treated as a substitute for a universal health plan.[17]

For a universal health plan, Section 1332 could potentially allow Oregon to receive federal pass-through funding based on federal savings from waived ACA provisions, potentially including amounts that otherwise would have been paid as Marketplace subsidies for Oregon residents. That pass-through funding could then help support coverage through the universal health plan, if the state demonstrates that the new coverage model satisfies federal requirements. This makes Section 1332 one of the most important federal financing tools available for integrating the individual market into a state universal coverage structure.[18]

However, Section 1332 is not an unrestricted waiver. To receive approval, Oregon would need to show that the waiver provides coverage that is at least as comprehensive as Marketplace coverage, provides coverage and cost-sharing protections that are at least as affordable, covers at least a comparable number of residents, and does not increase the federal deficit. These guardrails would require detailed actuarial, fiscal, and coverage modeling. Even if a universal health plan improves affordability for many residents, Oregon would still need to prove compliance with each federal guardrail over the required federal budget window.[19]

15 Oregon Health Authority, *Federal Authorities Required* (2025), Section 1331 Basic Health Program Authority; 42 U.S.C. § 18051.

16 Oregon Health Authority, *Federal Authorities Required* (2025), Section 1332 State Innovation Waivers; Health Management Associates, *Operations Committee Report to the UHPGB: Potential Federal Waiver Considerations for a Universal Health Plan* (2025), Affordable Care Act and Section 1332 Waiver Authority; 42 U.S.C. § 18052.

17 Oregon Health Authority, *Federal Authorities Required for Universal Health Plan Implementation in Oregon* (Nov. 5, 2025), Section 1332 State Innovation Waivers; Joint Task Force on Universal Health Care, *Final Report and Recommendations* (Sept. 2022), "Brief History of Oregon Universal Care Efforts," noting that Oregon previously studied a public option alongside publicly financed universal health care models.

18 Oregon Health Authority, Federal Authorities Required (2025), Section 1332 State Innovation Waivers.

19 42 U.S.C. § 18052; Health Management Associates, *Potential Federal Waiver Considerations* (2025), Section 1332 Waiver Authority; Oregon Health Authority, *Federal Authorities Required* (2025), Appendix A: Federal Authority Application Process Chart.

A further implementation issue is the interaction between Section 1332 and BHP authority. Oregon should not assume that every Marketplace-related dollar can be captured through a single mechanism without affecting BHP eligibility, Marketplace enrollment, insurer participation, risk pools, or federal pass-through calculations.[20]

Section 1332 can help Oregon redirect certain Marketplace-related federal funding into a new coverage model if the state satisfies federal guardrails. It cannot, standing alone, create a fully unified financing system or override the separate legal constraints governing Medicaid, Medicare, ERISA plans, tribal health systems, or other federal programs.[21]

Medicare

Medicare is the most significant federal program constraint for state-based universal health plan implementation. Unlike Medicaid, Medicare is not administered through a state-federal partnership in which the state receives federal matching funds and operates the program under an approved state plan or waiver. Medicare is a federal entitlement program administered by CMS, with federal rules governing eligibility, enrollment, benefits, provider payment, Medicare Advantage, prescription drug coverage, beneficiary choice, appeals, and program oversight. Medicare operates entirely outside the state budget, with Medicare funds paid directly to plans, providers, and beneficiaries rather than a single funding stream that can be redirected into a universal health plan.[22]

Current law does not provide a general waiver allowing a state to take over Medicare Parts A and B, receive Medicare funds as a block payment, or compel Medicare beneficiaries to receive their federal Medicare entitlement through a state-administered plan. Prior Oregon work has consistently recognized this boundary: full inclusion of Medicare beneficiaries in a state single-payer structure would likely require congressional action or a novel and unprecedented federal approval pathway.[23]

Medicare Advantage offers one possible, but limited, alignment strategy. A state could explore sponsoring, facilitating, or partnering with a Medicare Advantage plan that provides supplemental benefits or otherwise aligns with the universal health plan's benefit and payment design. However, Medicare Advantage is built around beneficiary choice among traditional Medicare and available Medicare Advantage plans. A state-sponsored Medicare Advantage strategy would therefore be voluntary unless federal law changed. It would not allow Oregon to require all Medicare beneficiaries to enroll in the state plan or to exclude competing Medicare Advantage plans from the market.[24]

20 Oregon Health Authority, *Federal Authorities Required* (2025), Section 1331 Basic Health Program Authority and Section 1332 State Innovation Waivers.

21 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Table 1: Summary of Federal Programs' Waivers Potential Barriers and Strategies.

22 Oregon Health Authority, *Federal Authorities Required for Universal Health Plan Implementation in Oregon* (Nov. 5, 2025), Medicare Authorities; Joint Task Force on Universal Health Care, *Final Report and Recommendations* (Sept. 2022), "Medicare."

23 Health Management Associates, *Operations Committee Report to the UHPGB: Potential Federal Waiver Considerations for a Universal Health Plan* (2025), Medicare Waiver Authority; Joint Task Force on Universal Health Care, *Final Report and Recommendations* (2022), "Medicare."

24 Joint Task Force on Universal Health Care, *Final Report and Recommendations* (2022), Medicare Advantage discussion; 42 U.S.C. § 1395w-21; 42 C.F.R. § 422.402.

CMMI and other Medicare demonstration authorities may provide another pathway for payment alignment, but they should not be confused with full financing integration. CMMI can test Medicare payment and delivery models, including all-payer and total cost of care models. Maryland's all-payer and Total Cost of Care models, Vermont's All-Payer ACO Model, Pennsylvania's Rural Health Model, and the newer AHEAD Model show that CMS can permit states to align Medicare payment with broader state cost-growth, hospital-budget, primary care, or total cost of care strategies. These models may be valuable for provider payment alignment, but they do not make Medicare a state-administered entitlement or give a state unrestricted control over Medicare funds.[25]

Maryland is instructive but not easily replicable. Its Medicare payment model built on decades of hospital rate-setting infrastructure and a unique federal-state history. It demonstrates that Medicare payment can be aligned with state all-payer cost-control strategies, not that a state can replace Medicare with a universal health plan. Similarly, AHEAD may provide a relevant model for future Medicare payment alignment, but it is not a general Medicare waiver available on demand.[26]

Oregon can still pursue Medicare alignment through supplemental or wraparound benefits, Medicaid coordination for dual-eligible individuals, provider payment alignment, state-sponsored Medicare Advantage concepts, and future CMMI or federal demonstration opportunities. Those strategies may improve affordability, continuity, and system alignment for older adults and people with disabilities. But they are not the same as redirecting Medicare Parts A and B into the universal health plan.[27]

Oregon should continue planning for Medicare alignment, but acknowledge that current law supports alignment, supplementation, and payment demonstrations, not state assumption of Medicare financing. Any universal health plan design should therefore preserve the ability to operate without assuming Medicare Parts A and B can be redirected into the state plan absent new federal authority.[28]

ERISA and employer-sponsored insurance

ERISA is one of the most important legal constraints for any state-based universal health plan because employer-sponsored coverage remains a major source of private health coverage, including for workers enrolled in self-funded employer plans. ERISA establishes federal rules for private employer-sponsored benefit plans and broadly preempts state laws that "relate to" those plans. ERISA does not prohibit every state law that affects employers or health coverage, but it sharply limits state efforts to require employers to provide specific benefits, change plan administration, report plan-specific data, or participate in a state coverage structure through their ERISA plans.[29]

25 Oregon Health Authority, *Federal Authorities Required* (2025), Medicare Authorities and Maryland's All-Payer Model; Health Management Associates, *Potential Federal Waiver Considerations* (2025), Medicare Waiver Authority and AHEAD Model discussion; 42 U.S.C. § 1315a; 42 U.S.C. § 1395b-1.

26 Oregon Health Authority, *Federal Authorities Required* (2025), Maryland's All-Payer Model and AHEAD Model discussion; Centers for Medicare & Medicaid Services, *Maryland Total Cost of Care Model*; Centers for Medicare & Medicaid Services, *AHEAD Model*.

27 Joint Task Force on Universal Health Care, *Final Report and Recommendations* (2022), Medicare.

28 Health Management Associates, *Potential Federal Waiver Considerations* (2025), Table 1: Summary of Federal Programs' Waivers Potential Barriers and Strategies.

29 Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq.; 29 U.S.C. § 1144(a); Joint Task Force on Universal Health Care, *Final Report and Recommendations* (Sept. 2022), Appendix A, "Analysis of ERISA Preemption Issues for Universal Plan Proposal Memo."

The basic doctrine has three parts. First, ERISA's preemption clause supersedes state laws insofar as they "relate to" covered employee benefit plans. Second, ERISA's saving clause preserves state laws that regulate insurance, banking, or securities. Third, ERISA's deemer clause prevents states from treating self-funded employer plans as insurers for purposes of state insurance regulation. The practical result is that Oregon has more authority over fully insured products sold by insurance carriers than over self-funded employer plans, which remain the central ERISA problem for state universal health care design.[30]

Modern ERISA doctrine focuses less on the literal phrase "relate to" and more on whether a state law has an impermissible "reference to" or "connection with" ERISA plans. A state law is more vulnerable if it acts immediately and exclusively on ERISA plans, makes the existence of an ERISA plan essential to the law's operation, governs a central matter of plan administration, interferes with nationally uniform plan administration, or effectively forces an employer plan to adopt a particular benefit structure or coverage arrangement. State laws involving plan reporting, claims administration, benefit design, eligibility rules, appeals, or mandatory plan participation are, therefore, high risk.[31]

For universal health plan implementation, the most important design distinction is between creating a public financing and coverage system outside ERISA plans and requiring employers or plan administrators to operate through ERISA plans. Oregon should not assume it can require self-funded employers to enroll employees in the universal health plan, terminate existing coverage, modify benefit design, submit plan-specific claims data, or use a state claims or appeals system. Those approaches would make ERISA plan administration central to the state law and would create substantial litigation risk.[32]

That does not mean employers must be absent from universal health plan financing. A broadly applicable payroll tax or employer assessment is more defensible when it is keyed to wages, payroll, business activity, or another general measure rather than to an employer's benefit-plan design or spending. The Joint Task Force's ERISA analysis concluded that a payroll tax based on employee wages likely avoids the type of direct connection to employer benefit choices that triggers ERISA preemption, especially if employers remain legally free to offer benefits outside the universal health plan. The key point is that the tax should not require employers to create, maintain, alter, or administer an ERISA plan.[33]

A tax or assessment could face greater ERISA risk if it is structured as a penalty for offering or not offering particular benefits, is directly calculated based on ERISA plan spending, or is so large that it effectively forces employers to make a specific benefit decision. Courts have generally allowed state laws with indirect economic effects on ERISA plans, but there is no bright-line rule identifying when a tax becomes coercive. For this reason, employer financing should be designed to operate independently of benefit-plan choices and should be supported by clear legislative findings describing the tax as a broad public financing mechanism rather than a mandate on employer coverage.[34]

30 29 U.S.C. § 1144(a), (b)(2)(A), (b)(2)(B); Joint Task Force on Universal Health Care, Appendix A, ERISA Preemption Issues & Design Options for State Single-Payer Plans.

31 *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *Gobeille v. Liberty Mutual Insurance Co.*, 577 U.S. 312 (2016).

32 Joint Task Force on Universal Health Care, Appendix A.

33 Joint Task Force on Universal Health Care, Appendix A, Payroll Tax; *Rutledge v. Pharmaceutical Care Management Association*, 592 U.S. 80 (2020).

34 Joint Task Force on Universal Health Care, Appendix A, Payroll Tax; *Travelers*, 514 U.S. 645; *Golden Gate Restaurant Association v. City and County of San Francisco*, 546 F.3d 639 (9th Cir. 2008); *ERISA Industry Committee v. City of Seattle*, 840 F. App'x 248 (9th Cir. 2021).

Other possible ERISA sensitive strategies require more caution. The Joint Task Force's ERISA memo identified provider participation restrictions and secondary payer or pay and recoup structures as potential design options. A provider participation rule could require providers participating in the universal health plan to bill only the public plan or accept universal health plan payment rules, thereby shifting the practical provider network toward the public system without directly ordering employers to change their plans. A secondary payer structure could allow the universal health plan to pay for services and then seek reimbursement from employer coverage when a resident has dual coverage. These approaches may have defensible arguments, but they are more complex than a general payroll tax and should be treated as litigation sensitive implementation design choices, not settled safe harbors.[35]

The legal strategy should be to make employer transition a consequence of a functioning public alternative, not a direct state mandate to change ERISA plans. Oregon can build a public plan, payment infrastructure, enrollment system, and state financing mechanism without requiring self-funded employers to administer the universal health plan. Over time, employers may have less practical reason to sponsor duplicative coverage if the universal health plan provides reliable, affordable, and comprehensive coverage. But state law should not depend on compelling ERISA plans to become implementation vehicles for the public system.[36]

Summary of legal constraints and design strategies

	Core constraint	Design strategy
Medicaid/CHIP	Federal funds remain tied to Medicaid/CHIP eligibility, covered benefits, claiming rules, consumer protections, budget neutrality, and approved state plan or waiver authority.	Use state plan amendments, Section 1115, and other Medicaid authorities; preserve Medicaid-specific tracking, required benefits, protections, and federal claiming integrity.
ACA Marketplace/ Section 1332	Section 1332 can waive specified ACA provisions only if federal guardrails are met. It does not waive ERISA, Medicare, or Medicaid requirements.	Develop a 1332 strategy coordinated with Medicaid planning, actuarial modeling, federal pass-through funding analysis, and any BHP interaction.
Medicare	No current general waiver allows a state to assume Medicare Parts A and B or compel Medicare beneficiaries into a state plan.	Use supplemental/wraparound coverage, voluntary Medicare Advantage concepts, provider payment alignment, CMMI models, and federal legislation strategy.

35 Joint Task Force on Universal Health Care, Appendix A, Provider Participation & Reimbursement
36 Joint Task Force on Universal Health Care, Appendix A, Conclusion.

	Core constraint	Design strategy
ERISA/employer-sponsored coverage	ERISA limits state laws that directly regulate employer benefit plan design or administration, especially self-funded plans.	Use broad financing mechanisms, preserve employer choice, avoid plan-specific mandates, and do not require employers to administer a universal health plan through ERISA plans.
Other federal programs and tribal health systems	FEHB, Tricare, VA, IHS, and tribal health systems operate under distinct federal or sovereign frameworks.	Preserve existing program access; pursue coordination, supplemental coverage, and government-to-government consultation where applicable.
Litigation and implementation risk	Major reform may be challenged even where state arguments are defensible.	Include severability, fallback authority, contingency provisions, and authority to continue implementation if one approval or provision is delayed.

Conclusion

The legal and federal constraints described in this document are significant. Oregon cannot implement a universal health plan as though it were a national government with plenary authority over Medicare, Medicaid, Marketplace subsidies, employer-sponsored coverage, federal tax treatment, tribal health systems, and other federal programs. Current law divides authority across state government, federal agencies, Congress, employers, federal programs, and sovereign tribal governments. That divided authority is the central legal reality for any state-based universal health care effort.

However, significant is not the same as insurmountable. The conclusion of this memorandum is not that state-based universal health care is unavailable. It is that implementation must be designed around the federal system that exists. Medicaid and CHIP must be addressed through state plan, waiver, and federal claiming rules. Marketplace populations must be addressed through ACA authorities such as Section 1332 and, where appropriate, BHP authority. Medicare requires alignment strategies, demonstration opportunities, supplemental coverage approaches, or federal legislation rather than assumed state control. Employer-sponsored coverage must be addressed without making self-funded ERISA plans mandatory state implementation vehicles. Federally governed programs and tribal health systems require separate coordination, respect for existing authority, and, in some cases, congressional action.

This creates a practical implementation discipline. Oregon should build state governance, financing, enrollment, provider payment, data, claims, and public accountability capacity while simultaneously pursuing federal approvals through the pathways that exist. It also means preserving contingency authority, severability, fallback options, and partial implementation authority so that one delayed federal approval or one legal challenge does not prevent the state from making progress where its authority is clearer.

A state-based universal health plan requires legal realism, federal negotiation, administrative capacity, and disciplined public expectations. It also requires rejecting two equally dangerous narratives: that federal barriers make state action impossible, and that legal barriers will disappear if the state simply commits hard enough.

Neither is true. The viable path is to build what the state can lawfully build, seek federal approvals where existing law allows, design around the boundaries current law imposes, and continue pursuing broader federal authority over time. With that approach, state-based universal health care remains challenging, but legally and operationally possible.

Part II
Implementation sequencing

This document provides additional technical analysis regarding the implementation sequencing options described in the Universal Health Plan Governance Board's December 2026 legislative report. Implementation sequencing determines the order in which populations could transition from the current multi-payer system into a universal health plan and is a central operational question for future legislative and implementation planning.

This analysis is intended to compare the relative feasibility, risks, and trade-offs of the sequencing approaches considered by the board, including population phase-in, hybrid phase-in, and simultaneous transition. It evaluates these approaches based on population reach, federal authority requirements, estimated implementation timelines, administrative simplification, operational risk, financing considerations, and equity impacts.

This analysis does not alter the proposed end-state structure for the universal health plan. Rather, it assesses potential pathways for moving toward that structure given current legal, federal, fiscal, and operational constraints. Final selection of an implementation pathway would require further legislative direction, federal engagement, actuarial analysis, and public input.

Evaluation criteria

Staff evaluated implementation sequencing options according to several technical and policy criteria relevant to launch feasibility, operational risk, and progress toward the board's proposed universal health plan structure. No single criterion determines the preferred pathway. Instead, the analysis considered how each approach balanced near-term implementation feasibility with long-term system integration.

The primary evaluation criteria were:

- **Population reach.** The share of Oregon residents who could be incorporated into the universal health plan at launch and in later phases.
- **Federal dependency.** The degree to which implementation depends on federal approvals, federal financing arrangements, new federal authority, or participation by programs outside direct state control.
- **Implementation timeline.** The estimated time required after state authorizing legislation to launch coverage for each population group or sequencing option.
- **Administrative simplification.** The degree to which each option would reduce provider-facing administrative complexity, including variation in plan design, billing rules, prior authorization requirements, network rules, and payment processes.
- **Operational risk.** The complexity of standing up enrollment systems, claims administration, payment operations, provider onboarding, reserves, data systems, customer service, and public corporation governance.

- **Financing and reserve requirements.** The amount of startup funding, operating reserve, and revenue transition capacity likely needed to support implementation at launch and during ramp-up.
- **Equity and transition impacts.** The extent to which each option creates differential timing of benefit eligibility, financing obligations, provider access, or administrative treatment across populations during transition.
- **Long-term alignment with the board's end-state model.** The degree to which each option preserves a pathway toward full population integration, statewide payment consistency, and administrative simplification over time.

These criteria are intended to distinguish between the universal health plan's proposed end state and the practical question of how Oregon could move toward that end state under current legal, federal, fiscal, and operational constraints.

Population and authority baseline

The population baseline identifies the Oregon population on the basis of their primary health care coverage. Cohorts are presented as nonfederal, meaning their coverage is not dependent on obtaining approval or agreements from the federal government; and federal, where such approvals would be necessary to maintain current federal financing.

Table 1: Primary coverage in Oregon and nonfederal populations

Primary coverage	Covered lives (primary coverage)	Legal authorities required	Locus of control	Estimated timing to integrate population
PEBB + OEBB	281,028	State	State	1-2 years (procurement cycle)
Nonfederal OHP expansion programs	115,387	State	State	0-2 years
Employer-sponsored insurance (ESI) – self-insured	880,359	State, with caveat that cannot preempt ERISA-based coverage	State + private employer	0-5 years
Employer-sponsored insurance (ESI) – fully insured	692,321	State	State + private employer	0-5 years
Unsubsidized Marketplace	47,437	State	State	0-2 years
Non-Marketplace individual purchase	32,777	State	State	1-2 years
State and county corrections	11,966	State	Mixed – depends on whether seeking federal funding	Unknown for federal
Uninsured	170,943	State	State	Immediate
TOTAL	**2,232,218**	**State statute**	**State**	**Could be immediate, ESI likely to phase-in**

Table 2: Primary coverage in Oregon and federal populations

Primary coverage	Covered lives (primary coverage)	Legal authorities required	Locus of control	Estimated timing to integrate population
Medicare	614,836	No existing pathway - CMMI demonstration waiver or federal legislation possible	Federal	Unknown
Medicaid and CHIP	1,205,151	Medicaid Section 1115 demonstration authority	Mixed (state designs; federal approves)	2-5 years after state legislation
Federal Employee Health Benefits (FEHB)/ Postal Service Health Benefits (PSHB)	48,292	No existing pathway - inclusion would require congressional action	Federal	Unknown
Subsidized Marketplace	71,369	ACA Section 1332 Waiver	State, federal for ACA premium subsidies	1-2 years
Tricare	31,625	No existing pathway	Federal	Unknown
Federal corrections	1,709	No existing pathway	Federal	Unknown
VA health care	22,650	No existing pathway	Federal	Not planned for integration
IHS/Tribal health	3,000	No existing pathway – legally unlikely	Tribal + mixed federal/state	Not planned for integration
TOTAL	**1,998,632 46.8%**	**Various waivers, new federal legislation for some cohorts**	**Federal and others**	**Ranges 2-10+ years**

Note: Population estimates draw on the Oregon Health Insurance Survey, Oregon Health Authority enrollment reports, federal administrative data, and other publicly available sources. Where possible, enrollment counts were adjusted to reflect primary rather than secondary health coverage and to avoid double-counting individuals enrolled in multiple programs. Estimates also incorporate assumptions about coverage overlap and

residual populations where direct data were unavailable. Because sources represent different reporting periods and employ different methodologies, figures should be interpreted as approximate estimates for planning purposes rather than exact, independently verified enrollment totals. Approximately 1% of Oregon residents have unverified sources of coverage and are not accounted for in either table.

A list of sources used is provided at the end of this document.

Administrative simplification analysis

Administrative simplification was a central consideration in evaluating implementation sequencing options. The universal health plan's long-term administrative simplification benefits depend on reducing the number of separate payer rules, benefit designs, billing requirements, prior authorization processes, provider networks, and payment methodologies that providers must navigate. Full administrative simplification would be greatest under near-complete payer integration; however, meaningful simplification may be achievable before all federally governed populations are incorporated.

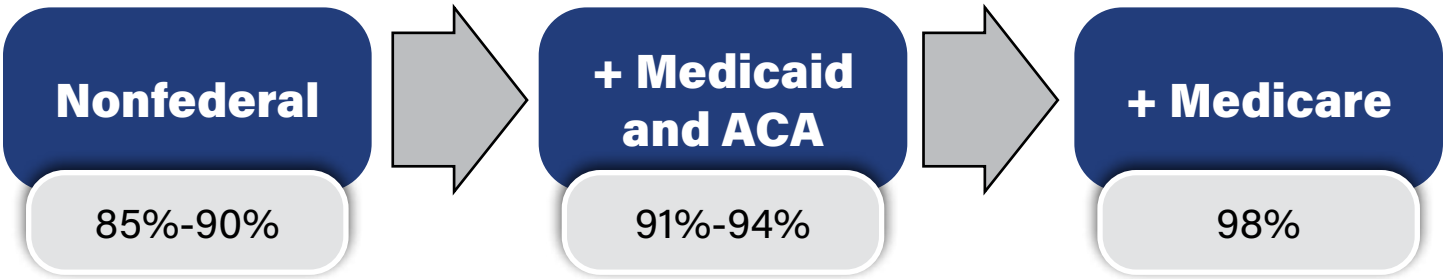
A key distinction in evaluating administrative simplification is that covered lives and administrative complexity are not distributed evenly across market segments. Federally financed populations represent a substantial share of Oregon residents, but commercial coverage accounts for a disproportionate share of variation in plan design, billing rules, prior authorization requirements, network structures, and provider contracting arrangements. As a result, integrating nonfederal and commercially insured populations into a unified administrative structure could reduce a substantial share of provider-facing administrative variation even before Medicare, Medicaid, and other federally governed populations are fully incorporated.

The administrative simplification estimates used in this analysis are planning estimates intended to compare the relative effect of different sequencing pathways. They should not be interpreted as actuarial projections or as estimates of total system savings. The estimates are based on the relative number of provider-facing plan configurations and administrative workstreams that could be reduced as populations move into a unified payment and administrative framework.

Table 3: Estimated provider-facing plan configurations by primary coverage

Primary coverage	# of plan configurations (low estimate)	# of plan configurations (high estimate)
Employer-sponsored insurance	400	1,200
PEBB	10	20
OEBB	8	15
Medicaid	16	16
ACA Marketplace	15	30
Medicare	30	60
Federal Employee Health Benefits	10	20
Tricare	2	4

Figure 1: Percent of provider administrative simplification by sequencing phase



Under a population phase-in approach, the universal health plan would initially incorporate populations more directly reachable through state legislation or state-governed implementation mechanisms. Although this approach would not immediately incorporate all major federally governed populations, staff estimate that it could achieve approximately 85% to 90% of potential provider-facing administrative simplification because it would address much of the variation associated with commercial and other non-federal coverage arrangements.

Under a hybrid phase-in approach, the universal health plan would launch with nonfederal populations as well as Medicaid, CHIP, and Marketplace populations requiring federal approval or subsidy pass-through arrangements. This approach is estimated to achieve approximately 91% to 94% of potential provider-facing administrative simplification at launch. The additional simplification reflects broader population integration and a greater ability to align payment and administrative processes across Medicaid and Marketplace populations, assuming necessary federal approvals are obtained.

Under a simultaneous transition approach, all major coverage populations would enter the universal health plan at launch. This approach would produce the greatest administrative simplification, estimated at approximately 98% of potential provider-facing simplification, because nearly all major payer-specific administrative workstreams would be consolidated. However, this level of simplification would depend on obtaining federal approvals or new federal authority for Medicare, Medicaid, Marketplace subsidies, Federal Employee Health Benefits, and other federally governed programs before launch.

Administrative simplification therefore presents an important trade-off. Simultaneous transition would produce the greatest simplification if all federal authorities were secured, but it also creates the greatest risk that implementation would be delayed or prevented. Population phase-in produces less complete simplification at launch but may allow Oregon to capture a substantial share of provider-facing simplification earlier while continuing to pursue broader federal integration over time.

Timeline and federal dependency

Implementation timing is largely shaped by the extent to which each option depends on federal approval, federal financing arrangements, or new federal authority. The greater the number of federally governed populations included at launch, the greater the risk that implementation timing will be determined by federal approval processes rather than by Oregon's own legislative and operational readiness.

Under a population phase-in approach, Oregon could begin implementation with populations more directly reachable through state legislation. This approach would have the lowest federal dependency at launch because implementation would not be contingent on securing Medicaid, Marketplace, Medicare, Federal Employee Health Benefits, or other federal participation pathways before beginning. Federal approvals would remain necessary for later phases, and ideally be under negotiation, but launch would not depend on all approvals

being secured in advance. Launch via population-phase-in could begin as soon as one to two years following enabling state legislation, allowing for OEBB, PEBB, and employer-sponsored insurance procurement cycles to transition smoothly.

Under a hybrid phase-in approach, Oregon would delay launch until Medicaid, CHIP, and Marketplace populations could be incorporated along with non-federal populations. This approach would produce broader population integration and greater administrative simplification at launch, but it would also make implementation dependent on successful federal approval or financing arrangements for Medicaid and Marketplace populations. As a result, the timeline would be less fully within state control than under a population phase-in approach. Based on typical federal waiver development, negotiation, and approval timelines, staff estimate a hybrid approach could take between two and five years to launch, assuming a federal administration willing to engage in ongoing negotiations.

Under a simultaneous transition approach, all major populations would enter the universal health plan at launch. This option would require the greatest degree of federal coordination and approval before implementation could begin. In addition to Medicaid and Marketplace approvals, simultaneous transition would require viable pathways for Medicare and other federally governed populations for which no established state integration pathway currently exists. As a result, this approach carries the highest risk of delay or non-implementation if federal approvals, federal legislation, or federal financing arrangements do not materialize.

Federal dependency, therefore, creates a major sequencing trade-off. Waiting for broader federal approvals may increase population reach and administrative simplification at launch, but it also increases the risk that implementation is delayed, narrowed, or prevented before Oregon can begin operating the universal health plan. Beginning with populations more directly reachable through state action reduces launch dependency on federal approvals, but requires Oregon to manage a longer transition period in which some residents remain covered through existing federal programs while the state continues to pursue broader integration.

Vermont experience

Vermont's experience with Green Mountain Care illustrates the implementation risks associated with prolonged timelines and unresolved federal coordination. Vermont enacted single-payer framework legislation in 2011, but implementation planning continued for several years without launch. By late 2014, the state halted implementation before Green Mountain Care became operational.

Vermont's experience should not be treated as directly predictive for Oregon. Oregon's proposed universal health plan, financing structure, political context, and implementation assumptions differ from Vermont's. However, Vermont provides a cautionary example of the risks that arise when implementation depends on uncertain federal financing, unresolved coordination across federal programs, changing fiscal projections, and extended timelines before residents experience concrete coverage or system change.

For Oregon, the central lesson is that political and public support may be difficult to sustain if implementation remains contingent on federal decisions for an extended period. A sequencing strategy that allows the state to begin implementation while continuing to pursue federal integration may reduce this risk, although it would require careful management of financing equity, public communication, and transition design.

Equity, financing, and transition risks

Each implementation sequencing option creates distinct equity, financing, and transition risks. These risks do not determine the preferred pathway by themselves, but they are central to whether implementation would be administratively workable, publicly understandable, and politically durable.

A population phase-in approach would allow Oregon to begin implementation sooner for populations more directly reachable through state legislation. However, it would also create a transition period in which some residents receive coverage through the universal health plan while others remain covered through existing federal programs. This creates a risk of differential treatment across populations, particularly if benefit design, provider payment rules, cost-sharing protections, or provider access differ during the transition period.

Financing design is a major equity issue under any phased approach. If new universal health plan revenues begin before all populations are eligible to receive universal health plan benefits, some residents could be asked to contribute financially before directly receiving coverage through the plan. This concern is especially significant for Medicare beneficiaries, who may continue to pay Medicare premiums or otherwise remain in federally governed coverage while also being subject to state financing mechanisms. Future implementation work should evaluate whether Medicare-covered populations, or other populations not yet eligible for universal health plan coverage, should be excluded from certain financing requirements until they are incorporated into the plan.

Medicaid alignment presents a separate equity concern. A population phase-in could create or preserve differences between Medicaid-covered residents and residents enrolled in the universal health plan. This could undermine the goal of a unified system if Medicaid populations remain subject to separate administrative structures, provider access rules, or care coordination arrangements for an extended period. A hybrid approach may reduce this risk by incorporating Medicaid, CHIP, and Marketplace populations earlier, but doing so would increase federal dependency and implementation complexity at launch.

Transition sequencing also affects reserve and startup financing. A population phase-in may reduce initial reserve requirements because fewer covered lives would transition at launch and operational systems could scale over time. However, it may also require parallel systems during the transition period, including continued coordination with existing federal coverage programs. A hybrid or simultaneous approach may produce broader integration sooner, but would likely require larger upfront reserves, more mature administrative systems at launch, and greater readiness across enrollment, claims, payment, data, customer service, and provider-facing operations.

Public communication is another major transition risk. Phased implementation may be harder to explain than simultaneous transition because residents may become eligible at different times, may be subject to different financing rules, or may remain temporarily covered through existing programs while the universal health plan develops. If residents are asked to pay before they understand when or how they will benefit, opponents may be able to frame the transition as inequitable or incomplete. Implementation planning should therefore include clear public communication regarding eligibility timing, financing obligations, transition protections, and the pathway toward full integration.

These risks are more likely to be manageable if they are addressed directly in implementation design. Future work should evaluate financing exemptions or offsets for populations not yet incorporated into the universal health plan, alignment strategies for Medicaid and Marketplace populations, treatment of Medicare beneficiaries during transition, reserve requirements by phase, and public-facing transition rules. Without this additional

analysis, a phased approach could reduce federal dependency and launch risk while creating avoidable equity and communication risks during implementation.

Option comparison

The following table compares the three implementation sequencing options across the primary criteria used in this analysis. The estimates are intended to illustrate relative differences in implementation feasibility, population reach, administrative simplification, federal dependency, and operational risk. They should be interpreted as planning estimates rather than final implementation determinations.

Table 4: Implementation sequencing options compared

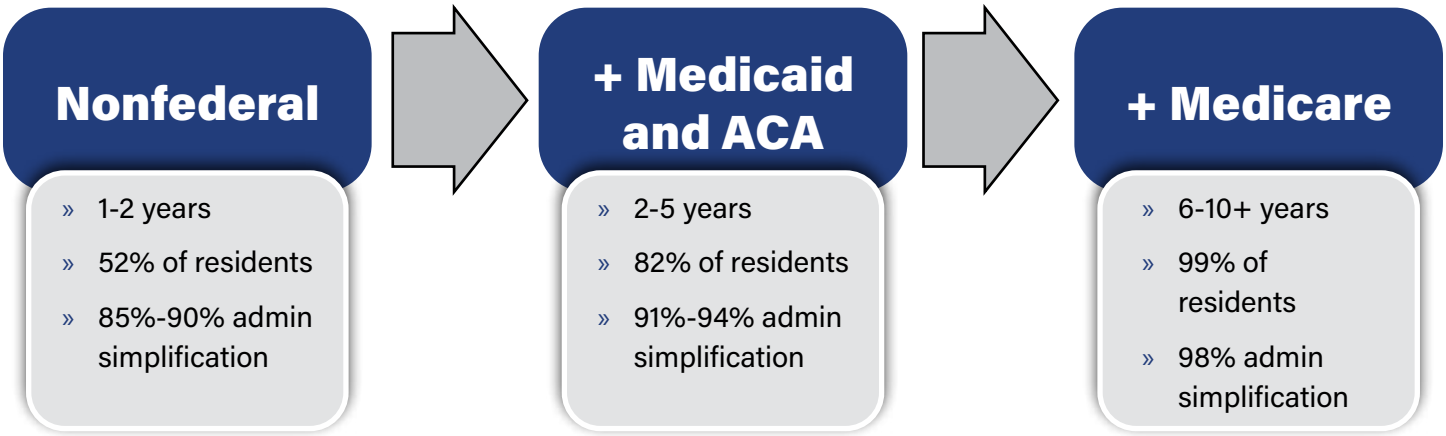
	Population phase-in	Hybrid	Simultaneous transition
Launch population	Nonfederal/state-reachable populations	Non-federal plus Medicaid, CHIP, Marketplace	All major populations
Time to launch (following state legislation)	1-2 years	2-5 years	6-10+ years
Population covered	Phase 1: 2.3M, 52% Phase 2: 3.5M, 82% Phase 3: 4.2M, 99%	Phase 1: 3.5M, 82% Phase 2: 4.2M, 99%	4.2M, 99%
Administrative simplification	Phase 1: 85-90% Phase 2: 91-94% Phase 3: 98%	Phase 1: 91-94% Phase 2: 98%	98%
Federal dependency to launch	**Low** No approval needed, consideration of ERISA	**Moderate** Medicaid and Marketplace via defined approval pathways	**High** Separate approvals for Medicaid, Medicare, Marketplace, and FEHB with no existing pathway for Medicare and FEHB
Reserve/startup burden	Lower initial burden	Larger initial burden	Highest initial burden
Main risk	Transitional inequity and continued multi-payer environment	Federal approval timing and launch complexity	Delay or failure if approvals do not materialize
Best use case	Begin implementation while federal integration continues	Launch broader system once Medicaid/ Marketplace pathways are secured	Maximum consolidation if all approvals are available

Staff technical assessment

Based on the criteria reviewed above, staff identify population phase-in as the most operationally feasible implementation pathway for further planning under current legal, federal, fiscal, and administrative constraints. This assessment is not a recommendation to change the board's proposed end state. Rather, it identifies the pathway most likely to allow Oregon to begin implementation while preserving a long-term transition toward full payer integration.

Population phase-in offers the strongest balance of launch feasibility, reduced federal dependency, operational scalability, and near-term administrative simplification. It allows Oregon to begin with populations more directly reachable through state legislation, including public employees, non-subsidized commercially insured, and uninsured residents (Phase 1). Phase 2 would integrate Medicaid and Marketplace populations upon receiving federal approvals. Medicare and other federally governed populations would be incorporated in Phase 3 as approval pathways become available. This approach also creates an opportunity to develop enrollment systems, provider payment infrastructure, claims operations, reserve policy, and public corporation capacity incrementally before broader population integration.

Figure 2: Population phase-in approach



Staff also recognize that population phase-in carries significant trade-offs. It would prolong Oregon's operation within a multi-payer environment, delay full provider administrative simplification, and require careful financing design to avoid inequities between residents who receive universal health plan coverage and those who remain temporarily covered through existing federal programs. These concerns should be central to future legislative, actuarial, legal, and public engagement work.

On balance, staff conclude that population phase-in is the most practical sequencing option for continued implementation planning. This approach prioritizes achieving guaranteed federal or state health care coverage for all Oregonians through a combination of universal health plan enrollment and continued federal coverage pathways during transition, while producing substantial early administrative simplification for providers. A population phase-in would allow Oregon to begin moving toward the board's universal health plan model without making launch contingent on all federal approvals being secured in advance. It would also provide a pathway to address urgent affordability concerns, including rapidly increasing premiums through the Marketplace and increasingly unaffordable cost-sharing in employer-sponsored coverage. A phased approach would allow the state an opportunity to demonstrate proof of concept, build public corporation capacity, and scale enrollment, payment, claims, and reserve functions over time. Finally, population phase-in aligns with

focus group participants who supported a universal health plan, but expressed concern about relying on federal approvals before implementation can begin.

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Part III

Review of administrative burdens in the health care workforce

ORS 751.002(3)(h) directs the Universal Health Plan Governance Board, in developing a comprehensive plan related to the financing and administration of a universal health plan, to "engage with regional organizations to identify strategies to reduce the complexities and administrative burdens on participants in the health care workforce and to otherwise address workforce challenges." Accordingly, this memorandum provides a foundational synthesis of documented administrative burdens and workforce challenges identified through existing analyses, reports, and stakeholder engagement conducted by Oregon agencies, boards, commissions, and other entities with explicit workforce authority. This analysis is intended to inform future engagement activities and support the board's development of a comprehensive plan and related legislative recommendations.

Organization of the memorandum

This memorandum addresses, in turn, all of the following:

(1) Key sources of complexity and administrative burden affecting participants in Oregon's health care workforce, as documented in existing state and national analyses

(2) Strategies that have been identified to reduce complexity and administrative burden on the health care workforce

(3) Broader health care workforce challenges identified by Oregon agencies, boards, and commissions that are statutorily charged with health care workforce planning, regulation, and oversight

(4) Implications for the board's work

Sources of complexity and administrative burden on the health care workforce

Administrative burden is a term that refers to the documentation and reporting requirements placed on health care providers. These requirements may be regulatory or contractual and typically vary across payers. Federal and state policymakers increasingly treat this burden as a patient access and safety issue (delays, abandoned treatment, avoidable utilization), as well as a workforce sustainability issue (burnout, attrition, reduced clinical hours). In this section, we examine the current state of administrative burden on the health care workforce and how that creates challenges to both patient care and workforce sustainability. Importantly, administrative burdens fall on both clinical and nonclinical members of the health care workforce. The term "provider" is intended to refer to the workforce as a whole, while "clinician" refers to direct care providers and "staff" to nonclinician health care employees.

Background

Administrative expenses account for approximately 15% to 25% of total health care expenditures in the United States, with recent studies trending towards the higher side.[37] Increasing administrative requirements have been linked to burnout in the health care workforce, decreased time for direct patient care, and growing disparities between large and small providers who must address the same number of administrative requirements with substantially smaller staff.[38] Burnout in particular has broader implications for health care, both potentially reducing the number of available clinicians and staff as well as increasing system costs. Turnover amongst health care professionals who identify as burned out is twice the rate of other clinicians, and the cost of turnover ranges from two to three times clinician annual salary.[39]

Notably, this level of administrative cost is not typical, as research indicates that the U.S. spends substantially more on health care administration than comparable nations.[40] One estimate based on 2021 data found that the U.S. spent $1,055 per capita on administrative costs, while the next highest OECD nation (Germany) spent $306 per capita.[41] Compared to Canada, the U.S. health system has 44% more administrative staff[42] and in one study Canadian practitioners reported needing only 27% of the time that U.S.-based offices required to interact with payers.[43] These comparisons suggest that administrative costs are influenced by structural features of the U.S. health care financing system.

For purposes of this discussion, administrative burden will be examined across the following two categories:

- Payment administration (clinical documentation, prior authorization)
- Program and quality reporting (measure sets, duplicative submissions, documentation standards)

Importantly, several administrative functions play a critical role in the health care system related to fraud prevention, safety, civil rights compliance, and quality oversight. The goal of this synthesis is to highlight those administrative areas that may be creating unnecessary friction and that could plausibly be addressed within a universal health plan to reduce costs without negatively impacting program integrity.

37 Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17): 1679–1680. doi:10.1001/jama.2021.17318. Rios Partners, Administrative Burden in U.S. Healthcare: A Focus on Rural Systems and Workforce Sustainability - Health of Health Index, 2024.

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40 The Role Of Administrative Waste In Excess US Health Spending, Health Affairs Research Brief, October 6, 2022. DOI: 10.1377/hpb20220909.830296. Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17):1679–1680. doi:10.1001/jama.2021.17318

41 Peter G. Peterson Foundation, How Does U.S. Healthcare Compare to Other Countries?

42 Cutler, D. M. & Ly D. P., The (Paper)Work of Medicine: Understanding International Medical Costs, *Journal of Economic Perspectives*, 25(2), 3-25, 2011.

43 Morra D, Nicholson S, Levinson W, Gans DN, Hammons T, Casalino LP. US physician practices versus Canadians: spending nearly four times as much money interacting with payers. Health Affairs. 2011 Aug;30(8):1443-50. doi: 10.1377/hlthaff.2010.0893.

Payment administration

Over the past two decades, the adoption of electronic health records (EHR) has transformed the way providers do business, and yet it is often cited as a key reason for increased complexity and administrative burden. Many documentation requirements remain holdovers from paper-based systems and were developed prior to recognition of chronic conditions and the need for long-term coordinated care.[44] While some of that is changing, EHRs have also made more apparent the vulnerabilities of operating within a highly fragmented system such as the U.S.

EHRs, while designed to simplify workflows, cannot effectively respond to the dozens of different workflows expected from different payers or cleanly integrate with providers who may be using other systems. One study found that for every hour of face time U.S. providers spent with patients, nearly two additional hours were spent on EHR documentation, including one to two hours outside of scheduled work time to meet payer billing standards.[45] Additionally, coordinating between multiple EHR platforms adds significant complexity and can result in inefficiencies during care coordination. Given the excess time on administration, it is not surprising that clinical documentation is the most commonly cited reason for health care workforce burnout.[46]

Among the core issues with EHRs are the competing needs to document and review patient clinical needs and ensure adequate documentation for billing purposes.[47] In order to ensure adequate documentation, especially in the face of changing requirements, clinicians often include excess information about patient history and related conditions. A frequently recommended solution of copy-pasting information leads to unwieldy patient records that satisfy billing requirements but fail to effectively convey the information needed for high quality patient care.[48] This phenomenon, sometimes referred to as "note bloat," is exacerbated by the lack of standardization across payers that leaves health care providers unsure about specific payer billing requirements.[49]

Within the category of payment administration, perhaps nothing is so reviled as prior authorization. Prior authorization is a process that requires health care clinicians to obtain advance approval before medications or health care services are covered by the health plan. Intended as a cost control measure, clinicians often cite these programs as time-consuming, administratively burdensome barriers to delivering treatment.[50] Prior authorization processes are often developed on an ad hoc basis by payers, resulting in myriad templates, requirements, and prerequisites for providers, none of which are standardized.[51]

44 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
45 Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, Westbrook J, Tutty M, Blike G. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016 Dec 6;165(11):753-760. doi: 10.7326/M16-0961.
46 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
47 The Rising Burden of Administrative Work in Hospitals: Challenges and Solutions
48 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
49 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
50 AMA prior authorization (PA) physician survey | AMA
51 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.

The American Medical Association (AMA) has been a particularly vocal opponent of prior authorization and annually publishes a survey indicating the extent to which prior authorization is perceived by physicians to negatively impact patient outcomes. The AMA survey indicates that physicians complete approximately 39 prior authorizations per week, with a weekly time cost of 13 hours.[52] Forty percent of physicians report having staff whose role is exclusively prior authorization and 89% of physicians surveyed opined that prior authorization somewhat or significantly increased provider burnout.[53] In particular, providers note the burden of requiring prior authorizations for frequently ordered drugs, advanced imaging, and durable medical equipment for patients with chronic conditions.[54]

In Oregon, fragmented prior authorization is particularly an issue for Medicaid, where providers must identify whether to seek prior authorization from the Oregon Health Authority for fee-for-service members or one of the 16 coordinated care organizations.[55] An analysis of prior authorization by the Oregon Health Authority demonstrates that the process can take up to 118 days from request to appeal resolution if the original claim is denied, a category that includes 11% of prior authorization requests.[56]

Challenges with EHR implementation and prior authorization are among the most frequently cited sources of administrative complexity and waste. Most concerning, these challenges often fall disproportionately on primary care providers, a cohort that is already disadvantaged relative to payment and resources.[57]

Finally, efforts to contain costs through benefit design create yet another layer of complexity for staff. Payers have different out-of-pocket provisions, including across their own product offerings, requiring health care organizations to engage in fee collection processes from both patients and payers. With differences in the cost-sharing arrangement – copayment, coinsurance, or deductible – provider staff frequently must engage first with the payer to understand the patient's financial obligation, and then subsequently collect that amount, possibly the most administratively costly dollars received in health care.[58]

Program and quality reporting

In addition to meeting requirements to ensure payment, health care providers are also subject to a wide range of reporting requirements, all of which must be documented, reported, and validated. Commonly cited regulatory burdens include HIPAA and licensing requirements, however, programs that mandate reporting of performance data are the source of this category's substantial expansion. Currently, CMS lists more than 2,200 metrics used across its programs alone.[59] State and local agencies and private payers add hundreds more metrics to the list.

52 AMA prior authorization (PA) physician survey | AMA
53 AMA prior authorization (PA) physician survey | AMA
54 Administrative Burden in Primary Care: Causes, Potential Solutions | Commonwealth Fund, 2025.
55 Oregon Health Authority: How to Submit Prior Authorization Requests to OHA: Oregon Health Plan: State of Oregon
56 Oregon Health Authority, 2023 CCO Prior Authorization Report, March 2024.
57 Administrative Burden in Primary Care: Causes, Potential Solutions | Commonwealth Fund, 2025.
58 Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17): 1679–1680. doi:10.1001/jama.2021.17318
59 Cutler, D.M, Reducing Administrative Costs in U.S. Health Care, The Hamilton Project, March 2020.

At the federal level, the Promoting Interoperability Program, formerly known as the Medicare and Medicaid EHR Incentive Program, and the Merit-Based Incentive Payment System (MIPS) come under frequent criticism.[60] In the first MIPS reporting year, CMS estimated the new requirements imposed more than $1.3 billion in reporting burden on health care providers.[61] More recent estimates find that the cost of MIPS reporting continues to be high, with one study reporting an average per-physician cost of $12,881, with more than 200 hours needed from clinicians and staff to fulfill reporting requirements.[62] Yet failure to report MIPS performance measures results in a 9% penalty to Medicare payments, leaving health care organizations in an impossible situation.

Hospital providers face competing requirements to report both electronically in the Promoting Interoperability Program for Hospitals as well as through paper-based chart abstraction in the Hospital Inpatient Quality Reporting Program.[63] Across the many federal programs requiring data reporting, timelines are often misaligned and programs subject to frequent updates, requiring additional investments to ensure annual compliance.[64]

While few would argue that the shift to value-based models of care over the past couple decades should be reversed, it is undeniable that these models exacerbate the administrative burden of performance measure reporting, particularly for primary care. Initiatives like pay-for-performance and alternative payment models that depend on quality metrics have significantly expanded the use of quality reporting and the associated burden.[65] While some measures are helpful, experts have questioned the reliability, validity, and usefulness of many.[66] Primary care providers who manage most chronic conditions, often end up with the bulk of the reporting burden, spending much more time than specialists entering data for external reporting.[67]

Oregon, largely via its Medicaid program, has experienced a similar growth in the program reporting burden placed on the health care workforce. Quality measurement is central to Oregon's CCOs model and contracted CCOs are required to submit numerous reports on finances and performance, the latter of which cascade into provider reporting requirements.

In addition to significant Medicaid reporting, Oregon has another distinct regulatory requirement in the health care cost growth target program. This program imposes a nonclinical documentation requirement on providers to develop and submit data files or face penalties for noncompliance.[68]

60 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
61 MedPAC, Moving Beyond the Merit-Based Incentive Payment System, March 2018.
62 Khullar D, Bond AM, O'Donnell EM, Qian Y, Gans DN, Casalino LP. Time and Financial Costs for Physician Practices to Participate in the Medicare Merit-based Incentive Payment System: A Qualitative Study. *JAMA Health Forum*. 2021;2(5):e210527. doi:10.1001/jamahealthforum.2021.0527
63 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
64 The Office of the National Coordinator for Health Information Technology, Strategy on Reducing Regulatory and Administrative Burden Relating to the Use of Health IT and EHRs, 2020.
65 Administrative Burden in Primary Care: Causes, Potential Solutions | Commonwealth Fund, 2025.
66 Administrative Burden in Primary Care: Causes, Potential Solutions | Commonwealth Fund, 2025.
67 Casalino, L. P., et al., US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures | Health Affairs, 35(3), March 2016.
68 OAR ch. 409.

Reporting requirements for the health care workforce are extensive, covering a wide range of financial and quality performance, being subject to frequent updates, and often requiring unique reporting processes. This analysis makes no judgement on the value of reporting requirements but must acknowledge that amongst the complexity and administrative burdens placed on the health care workforce, performance measure reporting is significant. A 2014 survey found that health care clinicians and staff spent 785.2 hours per physician per year tracking measure specifications, developing and implementing data collection processes, entering information into the medical record, and collecting and transmitting data; amounting to an "average cost of $40,069 per physician per year, or a combined total of $15.4 billion annually for general internists, family physicians, cardiologists, and orthopedists in the United States."[69] Given the growth of value-based models of care and related reporting on quality and cost containment measures, there is little doubt this administrative cost is even greater today.

Strategies identified to reduce complexity and administrative burden

The preceding section identified the primary drivers of complexity and administrative burden affecting participants in the health care workforce. This section summarizes categories of strategies that have been identified in existing analyses to reduce administrative burden, without evaluating, prioritizing, or recommending specific interventions.

As discussed above, administrative burden in health care is not the result of a single policy choice or operational failure but rather reflects structural features of a fragmented financing and regulatory environment. Accordingly, strategies to reduce complexity and administrative burden in health care consistently identify a limited set of strategy categories that aim to reduce transaction volume, minimize variation, and enable automation, while preserving functions related to payment integrity, quality oversight, and patient safety.[70]

The strategies summarized below are drawn from existing state and national analyses and are presented to inform future engagement activities. This section does not assess feasibility, cost, or potential implementation.

Reduction of transaction volume and low-value administrative requirements

Across analyses of clinician well-being and workforce sustainability, the most frequently identified strategy to reduce administrative burden is the reduction or elimination of low-value administrative transactions. These approaches focus on decreasing the sheer volume of documentation, reporting, and authorization activities required of clinicians and staff.

Commonly cited examples include:

» Elimination of prior authorization requirements for services and medications with consistently high approval rates or strong clinical consensus[71]

69 Casalino, L. P., et al., US Physician Practices Spend More Than $15.4 Billion Annually To Report Quality Measures | Health Affairs, 35(3), March 2016.

70 Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17): 1679–1680. doi:10.1001/jama.2021.17318. Centers for Medicare & Medicaid Services. *CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS*, Jan. 17, 2024. OECD. *Health Care System Efficiency and Administrative Spending Comparisons*.

71 AMA prior authorization (PA) physician survey | AMA

- Reduction in the number of required quality measures and reporting elements, particularly where measures are duplicative or rarely used for management or oversight purposes
- Sunset review or periodic reassessment of reporting and documentation requirements to identify candidates for elimination or consolidation

Reducing low-value administration is repeatedly identified as foundational because administrative burden scales with transaction volume. Greater savings are achieved through reducing the total number of required interactions, rather than incremental efficiency gains per transaction. Thus, many agree that the first step to reducing administrative burden should be the elimination of low-value administrative requirements.[72]

Standardization across payers and programs

A second category of strategies focuses on reducing variation across payers and programs. Variation in documentation standards, authorization criteria, measure specifications, and reporting formats is widely identified as a primary driver of administrative complexity as it requires health care staff and clinicians to learn and maintain multiple parallel workflows for substantively similar activities.[73]

Strategies in this category include:

- Standardize data elements and documentation requirements for common administrative functions such as claims submission and reporting[74]
- Establish uniform prior authorization criteria, templates, and submission processes across payers and programs
- Harmonize quality measure sets and align reporting timelines
- Create consistent definitions and specifications for performance, utilization, and cost metrics

Standardization is frequently discussed in conjunction with automation, as variability across payers and programs limits the ability to automate administrative processes. Analyses consistently note that administrative functions such as claims submission, prior authorization, and quality reporting are particularly suitable for standardization.[75]

Automation and centralization of administrative functions

A third category of strategies emphasizes the use of automation and centralized infrastructure to reduce manual administrative work performed by clinicians and staff. These approaches aim to shift administrative effort away from individualized, labor-intensive workflows and toward standardized, system-level processes.

Examples identified in the literature include:

- Automated eligibility, benefits verification, and utilization management processes

72 National Academies of Sciences, Engineering, and Medicine. *Taking Action Against Clinician Burnout*. Agency for Healthcare Research and Quality (AHRQ). *Measuring Documentation Burden and Administrative Task Distribution*. U.S. Surgeon General, *Addressing Health Worker Burnout*, 2022.

73 Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17): 1679–1680. doi:10.1001/jama.2021.17318. Centers for Medicare & Medicaid Services. *CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS*, Jan. 17, 2024.

74 Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17): 1679–1680. doi:10.1001/jama.2021.17318

75 Centers for Medicare & Medicaid Services. *CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS*, Jan. 17, 2024. U.S. Surgeon General, *Addressing Health Worker Burnout*, 2022.

- Centralized platforms for prior authorization submission and tracking
- Single submission points for quality and program reporting
- Improved integration between electronic health record systems and administrative platforms

Analyses caution that automation alone does not reduce burden if applied to highly variable or poorly designed processes. Advances in artificial intelligence (AI) hold some promise of helping with automation. However, within a highly variable and fragmented system, automation efforts are inherently limited by the need to use multiple pathways for different payers. As a result, automation strategies are most appropriate alongside efforts that standardize requirements.[76]

Measurement and monitoring of administrative burden

Finally, a subset of analyses emphasizes the importance of measuring administrative burden itself. Without consistent measurement, assessments of burden rely on anecdote and are less able to support continuous improvement.[77]

Identified approaches include:

- Development of standardized measures of documentation time and administrative task distribution
- Tracking administrative burden across clinical and nonclinical roles
- Incorporation of burden measurement into program evaluation and oversight activities

These approaches are most often framed as enabling strategies that support the identification, evaluation, and refinement of burden-reduction efforts over time, rather than as stand-alone interventions.

Taken together, these strategies reflect a consistent emphasis across analyses on reducing transaction volume, minimizing variation, and enabling automation, rather than redistributing administrative tasks among members of the health care workforce.[78]

Workforce challenges broadly

There is no shortage of agencies, boards, and commissions that have examined the broader challenges related to the health care workforce. While it is not the charge of the board to directly address health care workforce issues, this section provides a brief overview of the current state of the health care workforce in Oregon as well as existing efforts to address challenges.

76 Centers for Medicare & Medicaid Services. *CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS*, Jan. 17, 2024. Saving Time Playbook: Build a Well-Run Ambulatory Practice by Optimizing Teamwork and Clinical Operations | Workflow and Process | AMA STEPS Forward | AMA Ed Hub.

77 Agency for Healthcare Research and Quality (AHRQ), *Technical Brief No. 47: Measuring Documentation Burden in Healthcare*, May 2024. Sinsky C, Colligan L, Li L, Prgomet M, Reynolds S, Goeders L, Westbrook J, Tutty M, Blike G. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. Ann Intern Med. 2016 Dec 6;165(11):753-760. doi: 10.7326/M16-0961.

78 Chernew M, Mintz H. Administrative Expenses in the US Health Care System: Why So High? JAMA. 2021;326(17): 1679–1680. doi:10.1001/jama.2021.17318. Centers for Medicare & Medicaid Services. *CMS Interoperability and Prior Authorization Final Rule CMS-0057-F | CMS*, Jan. 17, 2024. AMA prior authorization (PA) physician survey | AMA

Current state of health care workforce in Oregon

The health care industry is a major employer both nationally and in Oregon. An estimated 11% of employed Oregonians work as health care professionals or within a health care system.[79] Health care by its nature is a highly labor-driven commodity, with access to health care closely tied to the local availability of licensed health care practitioners. As the population ages and experiences a higher incidence of chronic medical conditions, demand for health care occupations is anticipated to increase.[80]

The Oregon Health Authority (OHA) actively monitors the number of licensed and practicing clinicians, as well as the full-time equivalency (FTE) of clinicians providing direct patient care. Oregon's workforce is described as growing across all three measures, but with an increasing gap between licensees and practicing professionals as well as practicing professionals and direct patient care FTEs.[81] Statewide, OHA reports a health care workforce consisting of more than 209,000 licensed providers and over 103,000 direct patient care FTEs across licensed practitioners.[82]

The nursing workforce is by far the largest group with 108,772 individuals (52% of the licensed health care workforce), followed by the medical, pharmacy and dentistry groups. However, it is important to note that of 75,358 registered nurses (RNs) holding an active Oregon license, just 75% were providing direct nursing care, for a combined full-time equivalency of 31,486 as of January 2024.[83]

The gap between health system capacity and licensure is particularly stark in the behavioral health sector. OHA reports that Oregon has 16,582 practicing behavioral health licensees; however, estimated direct patient care capacity is 9,214 FTE, or 56% of what it would be if all licensees were providing full-time patient care.[84] This amount is significantly lower than the licensee to direct care FTE gap observed in primary care (74%), oral health (80%), and maternal health (80%).[85]

The National Center for Health Workforce Analysis provides a useful comparison regarding Oregon's available physician population. In a 2024 report, the agency noted that Oregon had 2.74 patient care practicing physicians per 1,000 population, compared with 2.44 in Washington state and 2.46 in California.[86] While Oregon's per capita availability is stronger than many other states, it lags substantially behind the OECD country average of 3.7 physicians per 1,000 population.[87]

79 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
80 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
81 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
82 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
83 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
84 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
85 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
86 National Center for Health Workforce Analysis, State of the U.S. Health Care Workforce, November 2024.
87 National Center for Health Workforce Analysis, State of the U.S. Health Care Workforce, November 2024.

Importantly, the health care workforce consists not just of licensed care clinicians but sizable administrative and support staff, although there is much less data regarding the administrative health care workforce. Total health care and social assistance jobs in Oregon numbered 301,000 in 2024.[88] Given 164,989 practicing licensed health care professionals, approximately 45% (around 136,000) of individuals in Oregon's health care workforce are employed on the administrative side.[89]

Compared to other employment sectors, health care accounts for nearly one-third (32%) of all job vacancies in Oregon, or approximately 18,800 available positions, across both clinical and nonclinical roles.[90] Approximately 80% of health care vacancies are classified as "difficult to fill" in the Oregon Job Vacancy Survey, meaning a job that an employer has trouble staffing over a sustained period.[91]

Multiple examinations of the health care industry converge on similar sets of workforce challenge drivers, including burnout and injury, pipeline or training constraints, and disparities between urban/rural access. Burnout is more common in the health care workforce than other industries due to frequent issues with understaffing, the emotionally taxing nature of the work, and administrative complexities discussed in the previous section. This was recently exacerbated by the COVID-19 pandemic, which placed heightened pressure on the health care workforce.[92]

Even as the pandemic is fading from memory, however negative emotions remain high. The Oregon Center for Nursing reported improvements from 2022 to 2025 but chronically high rates of stress (69%), frustration (68%), anxiety (78%), exhaustion (56%), and overwhelm (68%) from Oregon nurses.[93] These figures represent more than general dissatisfaction, as they report that more than 30% of Oregon nurses leave their jobs within the first year, leaving providers heavily reliant on in-migration to staff nursing positions.[94]

Burnout, however, is not limited to nurses, but ubiquitous across the health care workforce. Increasingly researchers suggest that the high administrative burden imposed on the health care workforce, taking time away from the meaningful elements of providing direct patient care, is to blame.[95] These dynamics can create reinforcing pressures where increased administrative demands reduce clinical time, creating the circumstances for burnout, often resulting in reduced hours or exit from the field, leaving fewer staff to absorb patient care and associated administration.[96]

88 State of Oregon, Employment Department, Growing Demand and Workforce Needs in Oregon's Health Care and Social Assistance Sector - QualityInfo - QualityInfo, June 26, 2025.
89 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
90 Oregon State University, College of Health, 2025 Oregon's Health Care Workforce Needs Assessment, January 2025. State of Oregon, Employment Department, Growing Demand and Workforce Needs in Oregon's Health Care and Social Assistance Sector - QualityInfo - QualityInfo, June 26, 2025.
91 Oregon State University, College of Health, 2025 Oregon's Health Care Workforce Needs Assessment, January 2025.
92 Oregon State University, College of Health, 2025 Oregon's Health Care Workforce Needs Assessment, January 2025. National Center for Health Workforce Analysis, State of the U.S. Health Care Workforce, November 2024.
93 Oregon Center for Nursing, 2022-2025 Oregon's Nurse Well-Being, December 2025.
94 Oregon Center for Nursing, Oregon's Nurse Vacancy Crisis, December 2024.
95 National Academy of Sciences, Taking Action Against Clinician Burnout, 2020.
96 National Academy of Sciences, Taking Action Against Clinician Burnout, 2020.

In addition to losses due to burnout, the health care workforce is presently retiring at rates greater than what current training pipelines provide. Training is particularly an issue for nursing, as Oregon nursing education programs graduate the third lowest number of nurses per capita in the US, and graduates of Oregon programs account for just 72% of the annual increase in demand.[97] The number of nursing education programs in Oregon has not changed for more than a decade, however, challenges appear to lie more with clinical training and placement requirements than simply increasing enrollment.[98]

Complicating workforce issues for nonurban providers is the fact that workforce availability in Oregon is not evenly distributed, with multiple Oregon agencies documenting additional access constraints for rural and remote communities. The Oregon Office of Rural Health annually scores unmet health care needs by primary care service area, with a score of 90 being the best and a score of 0 indicating fully unmet needs. In 2025, urban service areas (those within 10 miles of a center of 40,000 or more people) averaged 63.1 while rural areas averaged just 46.5.[99] Of the 65 primary care service areas determined to have unmet needs, all but one was classified as rural.[100]

Behavioral health displays the greatest disparity between urban and rural access, with licensed behavioral health practitioners highly concentrated in Multnomah county (38.4 providers per 10,000) as compared to the statewide average (20.4 per 10,000).[101] Primary care is more evenly distributed, with a statewide average of 17.0 primary care providers (PCPs) per 10,000 people, ranging from a low of 4.6 per 10,000 in Sherman County to 34.6 per 10,000 in Wallowa County, but more than half of Oregon counties falling between 14 and 20 PCPs per 10,000 people.[102]

Efforts to address Oregon workforce challenges

Oregon has a long history of tackling the complex issues associated with maintaining a robust and ready health care workforce. Oregon has operated the Rural Medical Practitioner Tax Credit since 1989.[103] This program provides annual tax credits of approximately $3,000 to $5,000 for eligible physicians, nurse practitioners, physician associates, certified registered nurse anesthetists, dentists, optometrists, and podiatrists practicing in qualifying rural locations.[104] Additionally, since 2009, the Health Care Workforce Reporting Program has issued a biennial report on the licensed health care workforce describing workforce supply, practice patterns, demographics, and distribution.[105]

97 Oregon State University, College of Health, 2025 Oregon's Health Care Workforce Needs Assessment, January 2025.
98 Philip R. Lee Institute for Health Policy Studies, The Future of Oregon's Nursing Workforce: Analysis and Recommendations, Nov. 1, 2022.
99 Oregon Office of Rural Health, Oregon Areas of Unmet Health Care Need Report, September 2025.
100 Oregon Office of Rural Health, Oregon Areas of Unmet Health Care Need Report, September 2025.
101 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.
102 Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024. Specifically, 20 of Oregon's 36 counties fall within the range of 14-20 PCPs per 10,000 people.
103 ORS 315.613.
104 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.
105 ORS 413.017. Oregon Health Authority, Health Care Workforce Reporting Program, Oregon's Licensed Health Care Workforce Supply 2024, November 2024.

Oregon's modern workforce strategy is built on the statutory framework created by House Bill (HB) 3261 (2017), codified in ORS 676.450-467, as well as subsequent targeted legislation, ongoing data collection, and planning and evaluation efforts. Oregon's expanded workforce strategy includes financial incentive programs, workforce data reporting and needs assessments, and sector-specific workforce initiatives. HB 3261 (2017) established the Health Care Provider Incentive Program (HCPIP) within OHA to support access to care in underserved communities. The HCPIP offers incentives to both students and providers who commit to serving patients in underserved areas of the state, such as loan repayment options, malpractice insurance subsidies and scholarships.[106]

The bill also established the Health Care Provider Incentive Fund, which serves as the primary funding mechanism for these incentives, and directed the state to conduct biennial assessments of workforce needs to inform incentive distribution.[107] Workforce incentive funding for the 2023-2025 biennium totaled $25.2 million, and since 2018, more than 7,200 individuals have received support through provider incentive programs to enter or remain in the health care workforce at sites serving patients experiencing health inequities.[108]

HB 3261 formalized the state's workforce planning and reporting functions. The Oregon Health Policy Board (OHPB) serves as the primary statewide advisory body for health care workforce policy, supported by its Health Care Workforce Committee. The committee has produced a series of planning documents, including an Equity Framework (2021), a Strategic Framework (2023), and three strategy papers in 2024 addressing diversity, wellness and resiliency, and development and retention.[109]

Finally, HB 3261 created the Healthy Oregon Workforce Training Opportunity (HOWTO) program, which provides grants to community-based training initiatives designed to address workforce shortages and expand workforce diversity. Approximately $12 million was allocated for HOWTO grants in the 2023-2025 biennium. [110]

More recent legislation has focused workforce efforts specifically on behavioral health and nursing. HB 2949 (2021) created a Behavioral Health Incentive subaccount within the Health Care Provider Incentive Fund to support recruitment, retention, and pipeline development for the behavioral health workforce.[111] These programs provide scholarships, stipends, loan repayment, and related incentives for behavioral health professionals. HB 2235 (2023) further directed OHA to convene a workgroup to study recruitment and retention barriers in Oregon's publicly financed behavioral health system. The final report was due Dec. 15, 2025, but does not appear to have been completed as of this memorandum.[112]

In the hospital and nursing sector, HB 4003 (2022) established nurse internship provisions and directed a formal study of the nursing workforce shortage. The resulting report analyzes workforce pressures in hospital settings, including staffing, retention, working conditions, and training pipelines.[113]

106 Oregon Health Authority: Health Care Provider Incentive Program: Primary Care Office: State of Oregon
107 HB 3261 (2017).
108 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025. ORS 676.450–676.467.
109 Oregon Health Policy Board, Health Care Workforce Committee, *Equity Framework (2021); Strategy Paper: Workforce Diversity (2024)*; *Strategy Paper: Workforce Wellness and Resiliency* (2024); *Strategy Paper: Workforce Development and Retention* (2024).
110 HB 3261 (2017). Oregon Health Authority: HOWTO Grant Program: Primary Care Office: State of Oregon
111 HB 2949 (2021).
112 Oregon Health Authority: House Bill 2235 Workgroup: Behavioral Health Division: State of Oregon
113 Philip R. Lee Institute for Health Policy Studies, The Future of Oregon's Nursing Workforce: Analysis and Recommendations, Nov. 1, 2022.

Strategies identified related to the health care workforce

Across both federal and Oregon-specific analyses of health care workforce challenges, strategies generally fall into a consistent set of categories related to supply, retention, incentives, care models, and maximizing provider time. In Oregon, these approaches are reflected in the work of OHA, the Oregon Health Policy Board's Workforce Committee, the HCPIP, and the Healthy Oregon Workforce Training Opportunity grants. These strategies are summarized below to provide context for the board's work; however, most fall within the authority of agencies and programs with explicit workforce mandates rather than the board's direct scope.

Administrative burden reduction. Multiple Oregon and national analyses identify administrative burden as a contributing factor to burnout, reduced clinical hours, and workforce attrition. Strategies in this category, which mirror the burden-reduction categories identified in Section II, focus on reducing time spent on documentation, reporting, and payer interactions.

- Reducing low-value administrative transactions
- Standardizing administrative requirements across payers and programs
- Automating eligibility, authorization, and reporting processes
- Measuring and monitoring administrative burden over time

Among the strategy categories described in this section, administrative simplification is the area most directly connected to the board's statutory charge, as it relates to plan financing and administrative structure rather than workforce pipeline or licensure policy.

Training capacity and pipeline expansion. Many analyses identify training capacity as a primary constraint on workforce supply. These constraints include faculty shortages, limited clinical placement sites, supervision requirements, and insufficient graduate medical education positions. Common strategies include:

- Expanding education program capacity in high need professions
- Increasing clinical training slots and supervision capacity
- Supporting rural and community-based training sites
- Providing scholarships or stipends tied to service commitments
- Developing career pathway and bridge programs

In the context of Oregon's workforce, these approaches are reflected in the HCPIP and HOWTO grant program. These programs provide scholarships, loan repayment, stipends, and training supports tied to service in underserved communities. Survey data shows that for two initiatives – loan forgiveness and loan repayment programs – most participants stay in Oregon at sites serving medically underserved patients for up to five years after their service obligation ends.[114]

114 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.

Between 2018 and 2024, the HCPIP supported primary care loan forgiveness for 72 recipients, loan repayment for 335 primary care, behavioral health, and oral health care professionals, and 171 medical scholarships.[115] During that same time frame, HOWTO grants supported community-based training initiatives for 1,212 recipients.[116]

Retention, Working Conditions, and Burnout Reduction. A second category focuses on stabilizing the existing workforce and reducing attrition, particularly in high-stress settings such as behavioral health, primary care, and hospital nursing. Common approaches include:

- Improving staffing levels and team composition
- Providing behavioral health and peer support services for the workforce
- Expanding scheduling flexibility and workload controls
- Developing career ladders and professional development opportunities

These approaches are reflected in the Oregon Health Policy Board (OHPB) Workforce Committee's Strategic Framework (2023) and subsequent strategy papers (2024), which identify workforce wellness, retention, and practice environment improvements as core priorities.[117] Oregon Center for Nursing and OHPB analyses report persistent levels of stress, burnout, and early-career attrition, with retention strategies identified as a key lever for stabilizing workforce supply.[118]

Financial Incentives. Financial incentives remain a central component of many workforce strategies, particularly in rural and underserved settings. These approaches are intended to influence recruitment, retention, or practice location decisions. Common approaches include:

- Retention bonuses or stipends for high-need settings
- Rural or underserved practice tax credits

Oregon has long relied on financial incentives as a core workforce strategy, primarily through the Rural Medical Practitioner Insurance Subsidy and Rural Medical Practitioner Tax Credit. From 2018 to 2024, 920 unique practicing clinicians have benefited from the insurance subsidy program, receiving discounts ranging from 15% to 80%. The use of this subsidy has decreased every cycle, however, as increasingly rural facilities pay clinicians' premiums as part of their internal recruitment efforts.[119]

115 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.
116 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.
117 Oregon Health Policy Board, Health Care Workforce Committee, *Equity Framework (2021); Strategy Paper: Workforce Diversity* (2024); *Strategy Paper: Workforce Wellness and Resiliency* (2024); *Strategy Paper: Workforce Development and Retention* (2024).
118 Oregon Center for Nursing, Not Just Resilience: What It Really Takes to Support the Nursing Workforce | Oregon Center for Nursing, Dec. 4, 2025.
119 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.

The Rural Medical Provider Tax Credit is one of the longest-running initiatives, having begun in 1989, providing medical providers working in rural areas the opportunity to receive a tax credit between $3,000-$5,000 per year. From 2018 to 2024, tax credits were provided to 3,677 unique medical professionals, 46% of whom were physicians, 30% nurse practitioners, 18% physician associates, and 6% certified registered nurse anesthetists and dentists (DDS/DMD).[120]

Program evaluations indicate that these incentives are effective at recruiting and retaining providers in underserved areas, but that demand for incentives significantly exceeds available funding, limiting statewide impact.[121]

Scope of practice and team-based care models. Several analyses identify expanded scope of practice and team-based care as ways to increase effective workforce capacity without relying solely on new entrants. Common strategies include:

- Expanding scope of practice for certain licensed professionals
- Increasing use of advanced practice clinicians and allied health staff
- Supporting interdisciplinary care teams
- Integrating behavioral health into primary care settings
- Expanding roles for community health workers and peer support specialists

These strategies are reflected in multiple Oregon workforce planning documents, including the OHPB Workforce Committee's Strategic Framework (2023) and related strategy papers addressing diversity, retention, and team-based care models.[122] State initiatives to integrate behavioral health into primary care and expand community-based workforce roles are consistent with this approach. Decisions regarding scope of practice and professional licensure are primarily governed through state licensing boards and therefore fall largely outside of the board's authority.

Implications for the board's work

The board is charged with designing the financing and administrative structure of a universal health plan, not with resolving underlying health care workforce challenges facing the state. The analysis in this memorandum suggests that certain workforce pressures, particularly those related to administrative burden, payment complexity, and care delivery processes, are closely tied to plan design and therefore fall within the board's sphere of influence. Other challenges, such as training capacity, licensure pipelines, and broader labor market dynamics are shaped by policy domains outside the scope of the board's work. This section addresses those workforce challenges that have the potential to be impacted through the implementation of a universal health plan.

120 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.

121 Oregon Health Authority, Health Policy and Analytics Division, Evaluation of the Effectiveness of Health Care Provider Incentive Programs in Oregon, June 2025.

122 Oregon Health Policy Board, Health Care Workforce Committee, Equity Framework (2021); Strategy Paper: Workforce Diversity (2024); Strategy Paper: Workforce Wellness and Resiliency (2024); Strategy Paper: Workforce Development and Retention (2024).

Opportunities to reduce administrative burden through unified plan design

The bulk of the administrative challenges described in Section I are closely tied to the fragmented financing structure of the current system in which providers interact with multiple payers, each with distinct documentation requirements, prior authorization rules, quality measures, and reporting timelines. A universal health plan with unified financing and governance would create structural opportunities to reduce administrative burden by standardizing and simplifying these requirements.

Specifically, the board's proposal for a universal health plan has the potential for high impact regarding administrative simplification by:

- Establishing a single set of documentation and billing standards
- Creating uniform prior authorization criteria and processes
- Consolidating quality measures into a single aligned set with consistent reporting timelines
- Implementing a single submission pathway for claims and performance reporting
- Eliminating the need for provider staff to manage multiple benefit designs, cost-sharing structures, and payer rules

These types of changes could reduce the volume and variability of administrative tasks performed by clinicians and staff, potentially increasing the amount of time available for direct patient care. While a fully unified financing structure would offer the greatest opportunity for simplification, meaningful reductions in administrative complexity could also be achieved through consolidation and alignment across payers. It is also important to note that inclusion of Medicare and Medicaid in simplification efforts is not guaranteed given the need for approval by the federal government. To ensure maximal alignment as well as smoothing of the federal waiver process, processes that operate in parallel to current federal Medicare or Medicaid requirements could be considered.

Opportunities to establish interoperable and standardized administrative infrastructure

Beyond administrative processes, implementation of a universal health plan would create opportunities to establish consistent information technology and interoperability standards across participating providers. Under the current system, administrative and clinical systems must accommodate multiple payer-specific workflows, which limits the effectiveness of automation and integration. A unified plan could:

- Establish common data elements and reporting specifications
- Require interoperable systems for eligibility, claims, and prior authorization
- Support centralized or standardized administrative platforms
- Enable automation of routine administrative functions at the system level

These types of infrastructure decisions would be foundational to reducing manual administrative work and enabling automation at scale. Importantly though, this type of serious investment in information technology for all providers across the state would require substantial time to implement, as well as resources, adding to both start-up costs and implementation timeline unless explicitly phased in.

Potential demand-side effects of expanded coverage and reduced cost sharing

While a universal health plan may reduce administrative burden and improve workforce sustainability in some respects, it may also increase demand for services. Expanded coverage, reduced cost sharing, and simplified enrollment processes may result in more individuals seeking care to make up for previously unmet medical needs. In the absence of corresponding increases in workforce capacity, this increase in demand may increase wait times for appointments or procedures, exacerbate shortages in certain specialties or geographic areas, and place additional pressure on providers. These demand-side effects may be particularly pronounced in primary care, behavioral health, and rural settings, where shortages are already documented.

These dynamics reflect implementation and capacity considerations, not a judgement about the value of expanded coverage. However, this suggests careful attention should be paid to the sequencing of coverage and benefit expansion, administrative simplification, and workforce capacity planning.

Transition trade-offs and sequencing considerations

The interaction between administrative simplification and increased demand suggests several potential trade-offs that may need to be considered in plan design:

- Reducing administrative burden may improve workforce retention, but expanded coverage may increase service utilization
- Simplified benefit structures may reduce staff workload related to cost sharing, while also increasing patient demand for services
- Centralized administrative systems may reduce duplicative processes but require significant upfront implementation and transition efforts

As a result, the timing and sequencing of administrative reforms, coverage expansions, and workforce investments are important considerations for the board. Aligning administrative simplification with workforce stabilization strategies could help mitigate the risk of increased demand outpacing available workforce capacity.

Finally, administrative simplification, on both the commercial payer and provider side, is likely to change the composition and distribution of nonclinical health care roles over time. These changes would likely reflect a shift in administrative functions and skills needs rather than a reduction in workforce, underscoring the importance of transition planning with respect to implementation. The board may want to consider how to phase in changes to allow for smoother transition from status quo to a universal health plan, given the real impact it will generate on employment.

Conclusion

Taken together, the findings in this memorandum suggest that the design of a universal health plan has the potential to substantially affect administrative burden on the health care workforce, while also creating new pressures related to increased utilization. Careful attention to administrative simplification, interoperability standards, and workforce capacity are therefore necessary considerations of plan design and implementation.

Part IV
Quality of care strategy

Staff recommend the development of a statewide health care quality policy and health care quality strategy, incorporating well-developed, evidence-based frameworks that support the quintuple aim of improving population health and patient experience, reducing costs, supporting health care team well-being and advancing health equity.[123]

A statewide health care quality policy and strategy will enable alignment and realization of state and regional health priorities. The policy and strategy will be developed with an emphasis on simplicity, reliability, efficacy, efficiency, and transparency. This proposal does not create a specific health care quality policy and strategy for a universal health plan, but rather outlines a roadmap for the development of a policy and strategy which can meet the needs of a dynamic health care system and serve the people of Oregon. Staff underscore the importance of a quality policy and strategy that enhances care, allows for innovation, and reduces administrative burden.

Staff recommend utilizing the following key elements adapted from the World Health Organization Handbook for National Quality Policy and Strategy[124] to develop an Oregon universal health plan quality policy and strategy:

1. Identify State Health Goals and Priorities
2. Create a Statewide Definition of Quality
3. Develop Key Participant Mapping and Engagement
4. Create Situational Analysis with a State of Quality Report
5. Ensure Development of Governance and Organizational Structure for Quality
6. Describe Improvement Methods and Interventions Including the Potential for Innovation
7. Identify Health Management Information Systems and Data Systems
8. Utilize Standardized Quality Indicators and Core Measures

123 Bodenheimer T, Sinsky C. From triple to quadruple aim: care of the patient requires care of the provider. Ann Fam Med. 2014 Nov-Dec;12(6):573-6. doi: 10.1370/afm.1713. PMID: 25384822; PMCID: PMC4226781. Nundy S, Cooper LA, Mate KS.
The Quintuple Aim for Health Care Improvement: A New Imperative to Advance Health Equity. JAMA. 2022;327(6): 521–522. doi:10.1001/jama.2021.25181

124 Handbook for national quality policy and strategy: a practical approach for developing policy and strategy to improve quality of care. Geneva: World Health Organization; 2018. License: CC BY-NC-SA 3.0 IGO.

The ultimate creation of a statewide health care quality policy and strategy will be impacted by multiple factors related to the administration and operations of a universal health plan, such as provider payment mechanisms, universal health plan public corporation governance and administrative structure, and information systems and technology.

Introduction

A basic definition of health care quality must be agreed upon to develop a quality strategy or policy. The Institute of Medicine defines health care quality as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."[125] This definition is widely used in the global health community, and the concept of health care quality is an integral part of health care systems. The Oregon Legislature included the concepts of quality in the development of Oregon Revised Statute chapter 751, the Universal Health Plan Governance Board's enabling statute, which states that a universal health plan should establish measurable health care goals and guidelines that align with other state and federal health standards and promote continuous quality improvement and interorganizational collaboration.

An Oregon health care quality policy and strategy is an organized, statewide effort to promote and plan continued improvement in health care delivery and outcomes. Just as process improvement is iterative, implementation experience is incorporated in an ongoing fashion to inform and update quality policy and strategy. A quality policy is based upon agreed goals with an explicit statement of intention. A quality strategy provides a road map and outlines how a policy will be implemented. The World Health Organization provides a detailed framework for developing a robust and responsive health care quality policy and strategy.

Key framework elements

The World Health Organization, in its Handbook for National Quality Policy and Strategy, lists several key elements required to develop policy and strategy documents. This proposal adapts these elements to create a framework which can be utilized within the setting of a universal health plan to develop a comprehensive quality policy and strategy.

1. Identify state health goals and priorities

The identification of state and, in some instances, regional health goals and priorities is the critical first step in creating a meaningful quality policy and strategy. Without agreed upon endpoints, quality measures and metrics can become time-consuming "box-checking" activities that do not produce outcome change and add only to system inefficiencies and provider dissatisfaction. State health goals may be aspirational to set targets for future activities, yet they must also be clear and meet a particular need. The goals should be time bound, with a means to assess progress and attainment.

State health priorities help focus attention on critical areas that require attention. These priorities may be identified through county, state, and national health data; sentinel events; and they may be long-term or emerging priorities. Priorities may be clinical conditions (for example, diabetes or depression), populations (for example, children or the houseless population), or geographic regions (for example, frontier counties). When developing goals and priorities, it is important to balance the acute needs and resources of the population with the possibility to embark on long term improvements through effective policy-making and structured efforts.

125 Institute of Medicine (US) Committee on Quality of Health Care in America. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington (DC): National Academies Press (US); 2001. PMID: 25057539.

2. Develop a statewide definition of quality

In development of a statewide quality policy, it is important to utilize a definition of quality that ensures a shared understanding with developers and participants. It is highly recommended to use an existing quality framework, such as the one developed by the Institute of Medicine and adapted by the World Health Organization, and then refine the framework with Oregon-specific information. The framework should be adopted statewide to promote simplicity and efficiency, yet also allow the flexibility to emphasize regional priorities.

Institute of Medicine – Six Domains of Health Care Quality

Safe: Avoiding harm to people for whom the care is intended.

Effective: Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).

Patient-centered: Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.

Timely: Reducing waiting times and sometimes harmful delays for both those who receive and those who give care.

Equitable: Providing care that does not vary in quality on account of personal characteristics such as geographical location and socioeconomic status.

Efficient: Avoiding waste, including waste of equipment, supplies, ideas, and energy.

3. Key participant mapping and engagement

The entire health care system contributes to quality of care. To develop a policy and strategy, a wide range of participants, such as patients, providers, administrators, analysts, and others, must be involved early in development. Engagement is a key step in creating a successful quality system. Clear roles must be defined for lead architects and the core team, as well as for others who will support the process. To stimulate the necessary change in quality culture, it is crucial to engage with both public and private sectors. It is equally important for people and communities receiving services to contribute to the development of quality policy and strategy. A benefit of including a wide range of participants in the process is to better tailor the policy to various users and beneficiaries, as well as to enhance buy-in and innovation.

4. Situational analysis – state of quality

Identification of current quality measures that are in use, due to either regulatory requirements or other health care strategies, is vital for creating a robust quality policy and strategy. Early understanding of all federal and industry required processes and measures will avoid potential loss of revenue due to lack of alignment and may allow for simplification of data gathering and reduction in the number of separate measures. It is important to identify quality efforts that have been successful in attaining health care goals, as well as those that have not been successful, and understand related challenges. This step is integral to grounding the policy to address the real challenges that exist at the frontline of health care delivery, and to identify what actions could have the most impact.

5. Governance and organizational structure for quality

Governance, leadership, and technical capacity across the health system are necessary factors for improving quality and must be delineated clearly in policy and strategy. The roles of key participants in development and effectuation of quality policy and strategy must be clearly defined and communicated. The authority and

process by which policies and strategies will be enacted and enforced must be clearly defined, agreed upon, and understood by key participants.

6. Improvement methods and interventions

In health care, there is a vast array of improvement methods and interventions that have been implemented, with varying degrees of success. It is important to have a framework to develop a quality strategy and policy that can focus efforts and avoid duplication. The following are two distinct frameworks which can both be utilized to create a coherent policy and strategy.

The Juran Trilogy is a well-known quality management model, consisting of quality planning, quality control, and quality improvement.[126] Although this model was developed for manufacturing, it has been successfully adopted within health care systems, with an emphasis on quality planning. Within the component of quality planning, five key themes have been identified: culture and leadership for improvement; engaging and empowering staff; forming collaborations and networks; building improvement capacity and capability; spreading and sustaining change. When considering strategies, the inclusion of the key components of quality planning has been shown to enhance quality efforts.

The Donabedian model lists three parameters for evaluating quality of care: structure, process, and outcome.[127] This simple model can be useful in policy and strategy planning to conceptualize the wide range of potential interventions. Further refinements of this model have been developed and should be considered, such as the Quality Payment Program developed by CMS, which defines intermediate outcome measures and patient-reported outcome-based measures, among others.[128]

The selection of interventions is a daunting task, based on the sheer volume of possibilities. It is important to plan the process of selecting interventions for improvement. This may involve review of current evidence, key participant engagement to elicit knowledge of current implementation, and the use of approaches such as the Juran Trilogy alongside technical input. It is crucial to base the selection of interventions on those that will help to meet identified goals and priorities, along with the qualities of efficacy, simplicity, transparency, and reliability. An outline of the interventions which are chosen should be created, with information regarding how the interventions address identified priorities. Detailed description of interventions, including resource requirements, timescales, and responsibility for interventions can be later described in an operational plan.

While alignment and simplification of improvement methods and interventions across the state are goals of a successful quality policy and strategy, that does not preclude the opportunity for innovation. Oregon is well known for the creation and implementation of novel health care delivery systems,[129] and a statewide quality policy and strategy must include the flexibility to develop new interventions to meet the needs of a rapidly changing landscape.

A complete description and discussion of the use of financial incentives as part of a quality strategy and policy is beyond the scope of this proposal. However, it is worth emphasizing that to support and stabilize primary care, "down-side" risk strategies, in which a primary care clinic could lose funding if metrics were not met, should not be utilized.

126 Tallentire VR, Harley CA, Watson S. Quality planning for impactful improvement: a mixed methods review. BMJ Open Qual. 2019 Oct 14;8(4):e000724. doi: 10.1136/bmjoq-2019-000724. PMID: 31673645; PMCID: PMC6797245.
127 Donabedian A. Evaluating the quality of medical care. Milbank Memorial Fund Quarterly. 1966;44(3 Suppl):166-206.
128 Agency for Health Care Research and Quality Organizing Quality Measures to Reduce Information Overload
129 Glass, A. (1998), The Oregon Health Plan†. Cancer, 82: 1995-1999.

7. Health management information systems and data systems

Improving quality relies on the ability to easily extract, store, and analyze reliable and accurate performance data. With the public role of a universal health plan, it is also important that there be transparency with regard to data.

As described in the World Health Organization handbook, there are at least five integrated data and analysis capabilities needed to support a comprehensive statewide quality program:

- A statewide hierarchical data collection and reporting system
- A statewide executive information system and quality database
- Clinical decision support and patient recording systems at the front line
- Quality monitoring and feedback systems to assess individual performance against standards or targets and comparative benchmarking data
- Public and comparative reporting for transparency and accountability

The New Zealand Dashboard of Health System Quality provides an excellent example of data transparency.

8. Quality indicators and core measures

A comprehensive quality policy will include the aims for quality monitoring and feedback, and the compilation and demonstration of data and the evaluation of progress towards stated goals. Quality measures are key for judging whether quality improvement activities are effective or not. Without measurement, it is impossible to know whether improvement actions are actually producing better care, leading to any significant change in health outcomes, or both.

A comprehensive quality strategy includes the plan for:

- Monitoring for adherence against standards and guidelines
- Feedback to providers on quality improvement activities
- Transparency and accountability to the public
- Benchmarking to understand comparative performance
- Strategic or value-based purchasing and contracting
- Monitoring of the effectiveness of quality interventions

To ensure the appropriate and best use of existing systems, it is important to catalogue and understand the currently collected quality indicators. The following steps can be utilized to understand the current state of data systems:

- Catalog the various current data sources that can be used for quality indicators. This can include national data sources, donor data, clinical registries, patient surveys and accreditation reports.
- Clarify what existing frameworks for quality metrics and indicators are currently being used.
- Within each data source, catalog specific quality metrics that are currently being collected.
- Grade the data by assessing their accuracy and completeness.

Once the current set of data systems and quality indicators has been assessed and analyzed, a new or revised statewide framework can be developed. It should be stressed that it is recommended to **use existing quality metrics to the extent possible** to best align with current reporting systems and minimize additional data burden.

As mentioned in the improvement methods and interventions section, it is important to have a conceptual framework for quality indicator selection. The Agency for Health Care Research and Quality outlines ways to organize quality measures to reduce information overload.[130] Of note, multiple conceptual frameworks may be utilized at a time in developing a quality strategy.

Conceptual frameworks with examples include:

- Donabedian: Structure, Process, Outcome
- Domain: Safety, Effectiveness, Timeliness, Patient-Centeredness, Equity, Efficiency, Integration
- Health Care Condition: for example, Diabetes, Asthma, Heart Disease
- Data Source: Claims Data, Patient Survey, Medical Record
- Clinical Setting: Primary Care Office, Hospital, Skilled Nursing Facility

Additional consideration must be given to the selection of the individual measures.

The World Health Organization Handbook describes the following criteria for assessing quality indicators. These can be used for prioritizing existing quality indicators or measures for inclusion in a statewide quality indicator framework.

Criteria for assessing quality indicators

1. **Health priority.** Does the indicator measure a specific health priority?
2. **Scope of impact.** What is the scope of impact in measuring this indicator (e.g., population-size clinical outcomes)?
3. **Evidence base.** Is there sufficient available and credible evidence for this indicator to be consensual?
4. **Defensibility.** Is this indicator defensible both from a scientific point of view and from the perspective of what key decision-makers view as important?
5. **Feasibility.** What is feasible given the data that are already collected; how easy will this be to implement?
6. **Accuracy.** Are the data collected through this indicator accurate?
7. **Actionability.** Are clear actions and change in individual, institutional or system behaviors possible from looking at this indicator?
8. **Comparability.** Can this indicator be compared against a gold standard or with other countries or across regions?
9. **Credibility.** Is the indicator credible for those who need to take action and those whose performance is being measured and compared?
10. **Clarity.** Is the indicator described in clear and unambiguous terms?
11. **Health Equity and Health Disparities.** Does this indicator impact health equity and health disparities?

130 Agency for Health Care Research and Quality Organizing Quality Measures to Reduce Information Overload

An example of a simple and effective quality measure is the Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM).[131] Despite the length of the name, the PCPCM PRO-PM is a comprehensive and parsimonious set of 11 patient reported items which assess the broad scope of primary care.

Statutory considerations

Federal, state, and licensing regulations regarding data collection must be documented and all HIPAA regulations followed for any patient-reported activities in which protected health information is collected. Any federal regulations regarding specific data collection and/or quality measure benchmarks must be identified and complied with. The Centers for Medicare and Medicaid Services (CMS) develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs/CfCs.

Conclusion

There have been substantial improvements in the adoption and implementation of quality measures since 2001, when the landmark publication from the Institute of Medicine "Crossing the Quality Chasm: A New Health System for the 21st Century" was released. The development of national quality frameworks, pay-for-performance initiatives, technology integration, and data-driven approaches have all contributed to improvements in some aspects of patient care, such as a reduction in health care-associated infections in acute care hospitals.[132] The mixed results of some quality efforts,[133] along with the undeniable administrative burden that some of those efforts have placed on the health care system, highlight the importance of a carefully developed quality policy and strategy.

The thoughtful development of a statewide health care quality policy and strategy is an integral part of creating a health care system in which individuals receive the promotive, preventive, curative, rehabilitative, and palliative health services they need, while ensuring the well-being of providers and sustainability of the health care system.

131 Tracy Kuo Lin, et al. Individual performance-based incentives for health care workers in Organisation for Economic Co-operation and Development member countries: a systematic literature review, Health Policy, Volume 126, Issue 6, 2022, Pages 512-521. Li E, Latifovic L, Etz R, Ramji N, Glazier RH, Kiran T. How the Novel Person-Centered Primary Care Measure Performs in Canada. J Am Board Fam Med. 2022 Jul-Aug; 35(4):751-761. doi: 10.3122/jabfm.2022.04.210427. PMID: 35896458.

132 KFF Analysis of National Health Care Data

133 Tracy Kuo Lin, et al. Individual performance-based incentives for health care workers in Organisation for Economic Co-operation and Development member countries: a systematic literature review, Health Policy, Volume 126, Issue 6, 2022, Pages 512-521.



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