Artemis Consulting Appendix

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Universal Health Plan Governance Board Report: March 2026 Focus Groups

PREPARED BY DIANA BIANCO, ARTEMIS CONSULTING
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Introduction

The Universal Health Plan Governance board (UHPGB) held a series of focus groups in March 2026 to gather input on its preliminary recommendations to the Oregon Legislature.

The focus groups are part of the UHPGB's effort to collect input from the public. Since its inception in 2024, the board and its committees have held more than 100 public meetings and have accepted written and verbal public comment. Since 2024, the board has received more than 500 pieces of written and oral testimony from the public offering input on its ideas, analysis, and recommendations. The UHPGB's engagement efforts build on the work of its predecessor, the Taskforce on Universal Health Care, which conducted roundtables, community listening sessions, and specialty interest forums across Oregon to inform its blueprint for a universal health plan.

The March 2026 focus groups, facilitated by Artemis Consulting, sought input from targeted groups on specific questions and were not intended as a broad community engagement initiative; instead the effort was designed to inform particular aspects of the board's preliminary recommendations, meet legislative direction, and help address questions that the board and its committees had considered but not yet resolved.

This report to the board presents the input gathered organized by major topics.[1] The report also suggests potential actions the board might take based on the feedback and questions it could explore. Importantly, input from these groups does not reflect all perspectives within any sector; as is always the case with groups like this, participants self-selected. Nor was the process designed to address every aspect of the board's recommendations. Instead, questions were tailored to each group's role and experience. Further, while participants heard the board's preliminary recommendations, they did not have details on all of the board's deliberations; therefore some of their input and requests may have already been considered by the board.

The Co-Chairs of the Community Engagement and Communications Committee (CECC) and UHPGB staff oversaw the focus group process. This work included identifying participants and questions, preparing summary materials in partnership with a communications consultant, and ensuring a sound and consistent process. To encourage open dialogue, we assured all participants that comments would not be attributed to individuals or organizations, and board members did not participate in the sessions. Additional details about the process are in Appendix A.

The summary materials provided to focus group participants reflected board decisions and deliberations through mid-February 2026; since then, the board has continued to update its materials and preliminary recommendations. Materials shared with focus group participants are attached as Appendix B.

1. Throughout this report, *"participants said"* reflects input provided in focus groups; it is not a statement of consensus or universal agreement.

We held focus groups with the following sectors:

- Community members
- Community-based organizations
- Coordinated Care Organizations
- Culturally-specific healthcare providers
- Disability-led organizations
- Health insurers
- Hospitals and health systems
- Labor unions
- Large businesses
- Outpatient care providers
- Persons who are Deaf and Hard of Hearing[2]
- Small businesses

We hope this input adds to the important feedback the board has received over time through public comment and other engagement efforts and that it will assist the UHPGB as it finalizes its recommendations to the Oregon Legislature and considers its next steps.

Input from Focus Groups

POSSIBILITIES FOR A UNIVERSAL HEALTH PLAN

Participants identified multiple potential benefits of a universal health plan (UHP) for Oregonians, including simplification of coverage, financial relief, and improved access to comprehensive care.

Participants shared that a well-designed and effectively implemented plan could:

- Reduce complexity and financial burden for Oregonians.
- Eliminate churn across insurance plans (public and private).
- Provide simplicity and clarity in a single benefit plan and formulary.
- Decouple insurance from employment, which would be particularly important for people with disabilities and smaller businesses.
- Align payment rates across Medicaid and commercial insurance to reduce differences in what providers are paid.
- Eliminate differences in reimbursement based on insurance plan.
- Lessen administrative burden for providers.
- Address challenges presented by H.R. 1[3], which will reduce access to care for many Oregonians.
- Treat the whole person by including behavioral health.
- Improve health and help retain and recruit primary care providers by dedicating 15% of dollars to primary care.
- Reduce disparities through improved access and quality.
- Shift energy and excitement—from a crisis mentality to the possibilities of a new system.

> **"The burden that's placed on families and patients and family members trying to navigate our current system… it's just a travesty.**
>
> –FOCUS GROUP PARTICIPANT

> **"I'm excited for the first time in my career that there's hope for the people of our state.**
>
> –FOCUS GROUP PARTICIPANT

2. This focus group will be held in May. Input from this group will be an addendum to the final report.
3. H.R. 1 is the "One Big Beautiful Bill Act," a budget reconciliation law signed by President Trump on July 4, 2025, that made significant changes to healthcare programs including Medicaid, the Affordable Care Act, and other federal safety net programs. The law cuts federal Medicaid funding by approximately $1 trillion over 10 years and is estimated to result in nearly 15 million people losing health coverage.

UNDERLYING CHALLENGES IN THE CURRENT HEALTH SYSTEM

Across the focus groups, participants agreed that the current system is not working. At the same time, participants raised questions about whether a UHP would address the significant underlying structural problems in the health care delivery system.

- Participants shared that moving to one payer would likely not address many of the perverse incentives in the current payment system. Nor would it address workforce challenges present across the state, including a dearth of primary care providers.
- Focus group members worry about the sustainability of a UHP, given the multitude of complexities in the current system and the possibility of unintended consequences.
- Participants also said that building a UHP on the chassis of the existing system may not eliminate many of the problems people experience.

BENEFITS / SERVICES

Participants shared input and feedback about what should be included in the UHP benefit package and which providers would be eligible to participate.

Participant recommendations on benefits

- The UHP should start with comprehensive coverage that supports whole-person care and invests in prevention.
- Benefits should not go backwards—participants do not want to lose important Medicaid programs like EPSDT (Early and Periodic Screening, Diagnostic and Treatment).
- Participants suggested that the board consider the following services and benefits for coverage (in addition to what the board already has recommended):
    - Navigation, care coordination, and case management.
    - Respite and caregiver supports.
    - Accessibility supports such as translation services and home modifications for people with disabilities.
    - Timely and streamlined access to Durable Medical Equipment (DME).
    - Mobile health and mobile crisis services.
    - Lactation services and providers.
- Participants said it is critical to maintain services for people with disabilities and suggested that enhanced benefit packages might be needed for that population.
- While long-term care is not included in the UHP, participants shared that although it is expensive, it may be important to consider for inclusion.
- There were questions about the availability of and possible problems presented by supplemental insurance for benefits not covered by the UHP.

> **"I would just encourage us to try to figure out how to treat the whole person and not leave things undone that could essentially drive other healthcare costs up.**
>
> –FOCUS GROUP PARTICIPANT

Access to providers

- Participant input on workforce included:
    - There should be a variety of providers who could provide care under a UHP, including Traditional Health Workers (THWs), Community Health Workers (CHWs), and doulas.

- Avoid siloing clinical services from community-based care: health and well-being are also promoted outside the clinic's walls.
- Bring public health into the system.
- Address questions and concerns about the ability to see providers in other states, especially for those living along Oregon's borders.

Coverage of non-medical services

- Participants expressed differing opinions about coverage of non-medical services that address health-related social needs (HRSN).
  - Participants are concerned that covering HRSN through the UHP will add significant costs to an already expensive plan and system. They feel that medical systems and insurers are not set up to provide such benefits and that these services can divert resources from basic health care services.
  - Others feel strongly that we need to address root causes of ill health and that doing so will save money and improve health in the longer term.
- Participants highlighted the need for coverage of non-emergency transportation services, especially in rural Oregon.
- Participants felt that providers need more flexibility in what they can bill for to meet patient needs.

Expensive or experimental treatments

- Coverage of fertility services drew mixed input; some participants thought they should not be covered, others thought they should. Still other participants shared that it could be a limited benefit or offered on a sliding scale basis, depending on income.
- A number of participants asked about the process for obtaining a service that is not in the benefits package. They said a strong grievances and appeals process is important, including processes that allow people to advocate for coverage of experimental or expensive services, especially those they are currently receiving.

Dental coverage

- There was significant support for dental coverage. Participants shared the following:
  - Dental care can impact productivity and quality of life.
  - Prevention in dental care works.
  - Once dental is excluded, it will be hard to add it back.
  - Some suggested that the lowest-income populations should receive dental coverage with a fee schedule based on income.
  - People with disabilities may need more specialized dental care, raising questions about how that would be covered.

Vision coverage

- A number of participants shared that vision coverage is important to quality of life, but also acknowledged that if forced to choose, they might prioritize dental benefits.

> "
>
> **Dental in particular is critical. There are so many cascading health consequences that can happen for folks if they are not maintaining dental care alongside primary care.**
>
> –FOCUS GROUP PARTICIPANT

IMPACTS ON PROVIDERS

Participants discussed how a UHP could change provider operations, including administrative workload, payment levels, and financial risk arrangements such as global budgets. The discussion surfaced questions related to sustainability, incentives, fee schedules, and provider participation.

Administrative simplification for providers under a UHP

- Participants identified a number of ways a UHP could reduce administrative burden:
  - One plan for billing and contracting could simplify provider operations.
  - A universal set of quality metrics is appealing.
  - One provider credentialing system would reduce duplication.
  - A UHP could improve revenue cycle complexity, contract negotiation uncertainty, and denial-driven length of stay disputes.
  - Participants said that a consistent prior authorization system would streamline processes, but also wondered whether a UHP will simplify or complicate those processes.
  - Participants shared that there needs to be utilization management, but have concerns about how it will be implemented.

Participants also highlighted the importance of effective implementation and shared that a UHP might not result in administrative simplification if processes became overly bureaucratic and complicated.

Rates, fee schedules, and payment models

- Input about rates included the following:
  - Rates need to be equitable and appropriate.
  - The rate setting process has to be transparent and take into consideration the complexities of the system.
  - Concern about lack of competition and rates being too low.
  - Concern that 115% of Medicare is insufficient and likely to have negative consequences for some providers; one estimate was that certain hospitals would need 140% of Medicare to operate under this system.
- Regarding a universal fee schedule, focus group members said it must reflect Oregon's competitive labor market. Certain specialties that are difficult to recruit, serve high-need populations, or represent sole-provider situations in a region may warrant protected funding streams or differential rates.
- We also heard that payment mechanisms for providers should build on value-based payment (VBP) and should not be strictly fee-for-service.
  - Payment structures and misaligned incentives in the current system are critical considerations for the board.

> **"By eliminating that administrative burden, we also help our provider shortage. We would attract additional clinicians to the state.**
>
> –FOCUS GROUP PARTICIPANT

> **"There's an assumption of administrative efficiency that fails to recognize the value of competition in a marketplace.**
>
> –FOCUS GROUP PARTICIPANT

> **"Who's paying the bill has a lot less to do with why the system is broken. It's *how* we pay.**
>
> –FOCUS GROUP PARTICIPANT

    - Some participants want payment models to include upside and downside risk, with rewards and penalties.
- Participants highlighted that geography has to be considered; rural Oregon will need special attention when it comes to setting rates and payment strategies.
- Participants also asked about capital investment and where it will come from under a UHP.

Hospital global budgets

- Some participants think hospital global budgets are a good idea; others do not (with a global budget, hospitals receive a set annual amount to cover most or all inpatient and outpatient services for a defined population).
    - Some felt global budgets would reduce costs in the system.
    - Others felt that global budgets could stifle innovation, lead to hardships for hospitals, encourage provider consolidation, and reduce access.
    - Global budgets rely on a strong continuum of care, which Oregon lacks, according to participants.
    - Some suggest there should be both upside and downside risk for hospitals, others worry that hospitals might have to make "rationing" decisions.

Recruitment and retention of providers

- A number of participants liked the "any willing provider" approach.
    - There is support for centralized credentialing.
    - Participants want to ensure non-physician providers are included.
    - Some expressed concerns about maintaining provider quality under this model.
- Participants question whether UHP will result in more providers coming to Oregon, especially rural areas, or whether it would discourage clinicians from moving to the state and rural regions.

IMPACTS ON EMPLOYERS AND EMPLOYEES

Participants had a variety of opinions regarding the impacts of the UHP on employers, employees, and organized labor. Participants shared beliefs that a UHP could simplify health insurance benefits and the process by which they are administered, but could also fail to ease and might even aggravate complexities for employers and labor unions. Participants also expressed concern and uncertainty about the impact of a UHP on the economic climate.

Decoupling insurance from employment

- Participants shared the following:
    - One plan could simplify the system for employers.
    - Small businesses and nonprofits might particularly benefit from a UHP.
    - A UHP could reduce bargaining complexity for unions, though unions could end up bargaining over niche issues, like vision benefits.
    - Concern about having one plan and no other choices.

> "
>
> **People with disabilities are chronically underemployed and sometimes have to say no to promotions or more hours because if they move to full-time and get employer benefits, they lose long-term services and supports or other Medicaid coverage.**
>
> –FOCUS GROUP PARTICIPANT

Multi-state employers and labor organizations

- Participants asked how the board will address complexities for businesses that employ people in multiple states.
    - They shared that employers that operate in other states might not see a reduction in overall administrative costs and could see an increase in complexity.
    - We also heard that some labor organizations bargain for members in multiple states and also could face similar or additional complexity.

Business climate and competitiveness

- Participants questioned how a UHP aligns with broader efforts to improve the business climate in the state. Participants shared the following:
    - Concerns about high corporate taxes since the proposal to fund the UHP would increase those taxes; others felt the corporate tax revenue structure was an appropriate revenue approach.
    - Worry that higher taxes could present challenges recruiting high-wage earners and executives.
    - Questions about whether higher taxes might deter young, healthy people from moving to Oregon.
- Some felt a UHP might attract businesses and encourage entrepreneurship; other participants felt differently and thought businesses might leave the state due to a high tax burden and/or increased costs.

> **"Generally I love the idea of a graduated tax and protecting people under 200% of the federal poverty line, but there's a real economic reality about how we attract and retain skilled workers to Oregon and whether the universal plan is enough to balance a higher tax.**
>
> –FOCUS GROUP PARTICIPANT

> **"This would be great for smaller nonprofits. It's a challenge to align our benefits with our values.**
>
> –FOCUS GROUP PARTICIPANT

COST, REVENUE, AND ECONOMIC IMPACTS

Participants provided input about overall program cost, revenue strategies, and long-term economic implications of a UHP, including wages, migration, and program growth. They also questioned the political viability of proposed taxes and the resilience of a UHP during recessions.

Cost of the plan

- Participants had questions about the cost estimate of the plan. They shared the following:
    - It is not clear that the cost analysis reflects underlying system costs.
    - The cost analysis for employers does not include ERISA plans, which makes it incomplete.
    - Costs for building the system, including reserve needs, are not included; actual costs will be higher.
    - Additional and possibly unanticipated costs will be required for claims migration, enrollment systems, provider contracting, and potential litigation.
- Participants are concerned that people will pay more and receive less.
    - Those concerns extend beyond high-income earners to working-class people, including union members, who have fought hard to maintain their current benefits.
- Participants expressed worry about program growth and rising costs over time and how that would be addressed.

Revenue

- Participants shared that the revenue strategy is not politically viable.
- While a progressive tax is appreciated by participants, there are concerns about high taxes for businesses and higher wage earners.
- Participants worry about losing high earners, which would reduce revenue. This could include specialists who are critical to the UHP's success.
- Participants said some of the people they serve and/or who live in their regions would appreciate and see the benefits of a progressive income tax, while others might not due to their general opposition to new taxes.
- Participants suggested reducing taxes by considering alternate revenue sources such as a bond measure or sales tax.
- Participants suggested modeling and comparing different mixes of revenue sources (for example, taxes, Medicaid and Medicare).
- Participants also wondered about people moving to Oregon for coverage and whether that would increase costs without a commensurate rise in revenue.

> "Program growth over years and decades is a concern… what mechanisms protect the promise of cost containment?"
>
> –FOCUS GROUP PARTICIPANT

Impacts on wages and long-term costs

- Participants expressed concern that higher employer taxes could lead employers to reduce wages.
- Participants said it isn't clear that employer savings would be passed on to employees and believe they likely would not.

Economic downturns and prioritization

- Participants asked what would happen during a recession or economic downturn.
  - Participants were worried about what would happen when the economy is underperforming—how will decisions be made about what to cut? How will the benefit be managed?
  - Participants said a clear process and evidence-based decision making will be necessary and Oregon should consider existing structures, like the Health Evidence Review Commission (HERC).

> "We can't even pass a gas tax in Oregon. How would we pass all these new taxes?"
>
> –FOCUS GROUP PARTICIPANT

STATEWIDE STRUCTURE, GOVERNANCE, AND LOCAL NEEDS

- Participants questioned the state's ability to implement and manage a UHP. They worried about a lack of innovation, more complexity, and a large bureaucracy.
- Participants expressed concern about onerous regulations, stating that they believe Oregon already over-regulates the health care system.
- Participants believe there should be significant local involvement in the administration of a plan. There is concern about losing sight of local community needs.

> "The only thing more local than politics is healthcare."
>
> –FOCUS GROUP PARTICIPANT

- Participants expressed appreciation that some CCOs are very responsive to community needs and worry that would be lost.

TRANSITION PLANNING

There was agreement that the transition to UHP is risky and complex for patients, providers, businesses, and employees. Participants emphasized the need for community input, significant transition planning and communication, transparency, and education.

Support during the transition to a UHP

- Participants shared the following about the transition:
  - Helping the public, providers, insurers, and businesses understand what is coming and giving them time to plan and adjust is critical.
  - Clear communication about the details of a UHP is paramount. Reducing complexity will allow more people to participate in the discussion.
  - Information should be broken down for different audiences so they understand the benefits, what will change, and how they will benefit.
  - All materials must use plain language.
  - There is some concern about people losing health care jobs (especially administrative) due to a UHP; those people may need assistance, but it is not clear whose responsibility that would be.

> **"My big thorny question is: how does the transition work? Because that seems fraught with peril.**
>
> –FOCUS GROUP PARTICIPANT

> **"There's the tension of: we desperately need this, and this is a terrible time.**
>
> –FOCUS GROUP PARTICIPANT

Viability of the plan and timing

- Participants said that gaining bipartisan, statewide support for the plan is critical and that data needs to demonstrate that the UHP is good for businesses and would benefit the majority of Oregonians.
- Participants questioned whether a UHP is politically and practically achievable in the current climate, especially given the revenue reliance on federal waivers and new taxes.
- Participants believe there is a low likelihood of obtaining Medicare or Medicaid waivers and believe basing the plan on getting waivers is risky. They asked whether the board has done analysis and contingency planning if waivers do not come through.
- A UHP would mean a group of people would pay more in new taxes and get less than they currently receive; there is concern that the public may not support this change.
- Participants also shared that H.R. 1 impacts are significant and must be taken into consideration; participants noted the federal legislation "cuts both ways."
- In light of federal changes, a UHP feels more urgent than ever to some participants. Others felt that H.R. 1 was reducing access which made the proposal even more challenging.
- Given the timing and political realities, participants worry that the proposal could damage the long-term viability of getting to a UHP.

INCREMENTAL CHANGE

Participants suggested an incremental, proof-of-concept approach that leverages existing programs and infrastructure rather than moving immediately to a full UHP. They offered specific ideas for aligning public programs and using that alignment to create conditions for future universal coverage.

- Participants said the UHPGB should consider an incremental approach.
    - They recommend starting with proof-of-concept approaches.
        - The board could draft a five-year incremental plan focused on aligning programs including the Oregon Health Insurance Marketplace, the Public Employees Benefit board (PEBB), the Oregon Educators Benefit board (OEBB), and Coordinated Care Organizations (CCOs).
    - The board could pursue initiatives such as:
        - Encouraging local governments to join PEBB.
        - Combining PEBB and OEBB.
        - Placing PEBB/OEBB within the CCO model.
        - Offering a universal plan on the exchange.
        - Exploring a "Medicare Advantage for All" concept.
- Participants suggested that an incremental pathway could lead to more constructive conversations about a UHP in the future. They asked the board to consider creating the conditions for UHP through other significant but incremental changes.

> **There is an [incremental] pathway to get there…and a way to have this conversation that I think could be more powerful.**
>
> –FOCUS GROUP PARTICIPANT

> **I do think that there is a way to transition this where you take chunks over time and move closer to alignment [across plans and the system].**
>
> –FOCUS GROUP PARTICIPANT

Recommendations

In response to the issues raised through the focus groups, the board may want to consider the following approaches and actions as it finalizes its recommendations.

Define and communicate the pathway to a Universal Health Plan

The board should consider squarely addressing and sharing its perspective on a phased incremental approach that builds on and leverages existing state programs, such as PEBB, OEBB, the CCOs, and the marketplace. It might also consider outlining alternative pathways or contingencies, so that progress toward universal coverage continues even if some elements (such as specific taxes or waivers) are not approved.

Direct targeted analytic work to address key questions

If it hasn't already done so, the board could request additional analytic work where focus group participants highlighted major uncertainties. For example, modeling provider payment levels by geography and specialty; clarifying system build-out and transition costs; and assessing employer, union, and business-climate impacts. Those analyses could inform recommendations or identify issues that might require further legislative or administrative attention.

Continue to elevate transition planning and risk mitigation

Whether supportive of a UHP or not, participants highlighted the enormity of the transition to a UHP. The board's transition committee should continue to gather input from the public as well as targeted groups to understand and address the risks in transitioning to a UHP.

Explore the use of transparent, evidence-based processes for difficult trade-offs

The board should consider what frameworks it will use to guide decisions about benefits prioritization during economic downturns, and adjustments if costs or revenues diverge from expectations.

Commit to continued community and public engagement during transition planning and beyond

The board should continue to explore avenues for broad public input and community engagement as well as deeper, ongoing dialogue with affected sectors. This might include a commitment to continued targeted engagement as implementation details are developed, recognizing that many design questions will need additional input. Participants in the focus groups shared that they wished they had been directly engaged earlier in a targeted fashion like the focus groups.

Questions for Future Consideration

Focus group participants provided input that highlights additional questions the board might consider if they have not already been addressed in prior deliberations.

Benefits / Services

- As final decisions are made about the inclusion of dental coverage, how will it be determined whether these benefits are included at launch, phased in over time, or offered in a tiered structure?
- Under a UHP, how will decisions be made about potentially high-value but costly benefits (such as dental, vision, and expensive or experimental treatments) under constrained revenue, and what explicit criteria will be used to make benefit decisions in a changing economic environment?
- How is the board thinking about supplemental insurance for benefits not covered by the UHP and the impacts it might have on the system?
- If there is a waiting period, how will people get coverage before they are eligible?
- How will the board handle coverage of non-medical services, including health-related social needs?

Impacts on providers

- What guidelines and measures will be in place to ensure the UHP delivers on and demonstrates meaningful administrative simplification?
- Should fee schedules be modeled by specialty and geography to understand potential impacts on hospital and clinic viability?
- Could different design options for payment approaches (e.g., global budgets, value-based payments, limited fee-for-service) be modeled and vetted with providers?
- Could the board do an in-depth workforce impact analysis to estimate UHP impacts on recruitment and retention as well as targeted strategies to support rural and safety-net providers?
- Should hospital global budgets be recommended, and if so, how can unintended consequences such as consolidation be guarded against?

Impacts on employers, employees, and the economy

- What employer-focused financial impact analyses might be helpful to show wage, tax, and benefit trade-offs across employer sizes?
- How can complexity be minimized for employers and unions that operate across multiple states?

Cost, revenue, and economic impacts

- How can / when will the UHP cost estimate be refined to incorporate system build-out and transition costs?
- Can the board model different revenue mix scenarios to address waiver uncertainties and resistance to specific taxes?

- How should sustainability in a recession be considered, and what approaches or frameworks could be used to expand or contract covered services as revenues rise or fall?
- What mechanisms will be in place to manage program growth and costs over time?
- How will the impact on Oregon's business climate be assessed—including potential migration of businesses and high-wage workers—and what options will be considered to mitigate potential competitive disadvantages?

Statewide structure, governance, and local needs

- How will existing regulatory structures be mapped and where can the UHP streamline regulatory requirements to address concerns about excessive regulation?
- What models should be explored for ensuring responsiveness to local community needs within the model of a statewide system?

Transition planning

- Will transition planning incorporate detailed analysis and transition roadmaps for individuals and families, providers, and employers?
- Will transition planning incorporate tailored communications to distinct audiences (community members, disability-led organizations, rural communities, businesses, providers, etc.)?
- What are plans for ongoing community input and engagement?

Viability of the plan, timing and incremental changes

- What is the board's position on incremental changes instead of recommending moving directly to a UHP?
- What are undertakings that would result in significant improvement in the health care system that might be included in an incremental approach?
- How might the board address concerns about the political viability of a UHP?

Conclusion

All participants who attended the focus groups came in good faith to discuss a UHP, and they were thoughtful in their questions and input. Across sectors, participants identified possibilities for a universal health plan, while also raising questions and concerns about cost, sustainability, viability, implementation, and whether the model will address the structural problems in Oregon's health care system. At the same time, participants agreed that the current system is not working; their feedback underscores both the need for change and the importance of continued careful and transparent decisionmaking as the board refines its recommendations.

Appendix A

Planning and conducting the focus groups

A planning team led by the Co-Chairs of the Community Engagement and Communications Committee (CECC) worked together to identify the targeted focus groups and invitees, create questions for the focus groups, prepare summary materials, and draft agendas.

Focus groups

Representatives from the following groups participated.

- Community-based organizations
- Community members
- Coordinated Care Organizations
- Culturally-specific healthcare providers
- Disability-led organizations
- Health insurers
- Hospitals and health systems
- Labor organizations
- Large businesses
- Outpatient care providers
- Persons who are Deaf and Hard of Hearing[1]
- Small businesses

The Co-Chairs of the CECC drafted invitation lists for each targeted group, drawing on recommendations from CECC committee members, board members, and external groups and community members who submitted suggestions after observing recruitment discussions at public board and committee meetings. Additional contacts were gathered by reaching out directly to industry and trade associations to ensure representation of specific perspectives. This was necessary because the board did not have an existing contact database or directory to utilize. Efforts focused on obtaining feedback from a variety of organizations and groups, not just those supporting a UHP. The participation rate in the focus groups was approximately thirty percent of the total invited. Forty-four people participated across 11 focus groups. This does not include the focus group for persons who are Deaf and Hard of Hearing since that focus group has not yet been conducted.

Questions and materials

Questions were drafted for each group based on interviews with and feedback from the chairs of each UHPGB committee. One additional board member from each committee also participated in these interviews and provided feedback on the questions. In consultation with UHPGB staff and consultants, the CECC Co-Chairs made the final determination about the questions that would be asked of each focus group.

1. This focus group will be held in May. Input from this group will be an addendum to the final report. Questions posed to this group are not included either because they are still being formulated.

Invitees who registered for their focus group received a summary of UHPGB decisions to date (current as of the end of February 2026) before the meeting. Staff presented a high-level overview of the content from the summary at the start of each focus group.

Questions

In addition to a shared opening question and a final closing question, each focus group was asked a series of questions specific to the expertise and perspective of that group. In some focus groups, participants did not directly answer certain inquiries. Across the groups, participants often provided additional input on a variety of topics, such as political viability or communications strategies.

QUESTION	FOCUS GROUPS THAT WERE ASKED TO RESPOND
What are the problems in the current system that a Universal Health Plan (UHP) could alleviate? (First question)	• All focus groups
Is there other input you'd like to provide in addition to what you've already shared? (Final question)	• All focus groups
The board believes that a UHP will result in an administratively streamlined health care system. What is the primary administrative burden for your organization that would be relieved if there were only one payer of health care?	• Culturally-specific healthcare providers • Hospitals and health systems • Labor unions • Large businesses • Outpatient care providers • Small businesses
Dental care can be very expensive and is often not covered under many insurance plans. The same is true for vision. The board is weighing the pros and cons of including dental and/or vision, which would make the UHP more expensive. Would people prefer to have a more expensive and comprehensive plan or a less expensive plan that didn't include dental or vision? • If you had to choose between the inclusion of dental or vision, what would you choose? • Similarly, what are the pros and cons of covering services like fertility treatments and/or very expensive medications and procedures? • If services including dental, vision, fertility services and other very expensive medications/services weren't offered, there would be supplemental insurance that people could buy. What are your thoughts about those different scenarios?	• Community members • Disability-led organizations • Labor unions • Outpatient care providers

In addition to coverage of medical care, are there other supportive or social services that should be considered for coverage that are outside of what we think of as medical care, such as supportive non-emergency and emergency transportation services? • There are social services that are funded through the state's General Fund—are there specific services that should be considered for coverage under the UHP? • What are lessons learned from CCOs and their work with health related social needs as part of the Medicaid benefit?	• Community-based organizations • Community members • Coordinated Care Organizations • Culturally-specific healthcare providers • Disability-led organizations • Labor unions • Outpatient care providers
In addition to medical care, some people have suggested including supportive or social services that help people access care, such as non-emergency transportation or other support services. Expanding coverage to include additional services would also require additional revenue. • From your perspective, are there non-medical services that should be considered for inclusion in a universal health plan, and how should the state think about balancing those benefits with the cost of funding them?	• Hospitals and health systems
When designing a health plan, policymakers have to make choices about which services are included in the core benefit package. • Thinking about the needs you see in the community, what types of services feel most important to include in the core coverage of a universal health plan?	• Community-based organizations
If difficult trade-offs had to be made, how should policymakers think about prioritizing services such as dental care, vision care, fertility services, or very high-cost medications and treatments?	• Community-based organizations
Drawing on your experience implementing Oregon's CCO model over the past decade, what lessons should inform the development and potential implementation of a Universal Health Plan in Oregon? In particular, what policy approaches or operational strategies helped improve access, care coordination, and health equity – and where did well-intended policies lead to unintended consequences or challenges in practice? • What policies, incentives, or operational approaches helped improve care coordination? • What policy decisions or requirements created operational challenges or unintended consequences? • What would you recommend the board keep, change, or avoid as we consider a statewide universal health plan?	• Coordinated Care Organizations

We recognize that a universal health plan would significantly change the role of commercial insurers in Oregon. Our goal in this conversation is not to debate the concept itself, but to learn from your operational expertise. Health plans manage many of the systems that make healthcare function day-to-day, and we want to understand what lessons from those experiences should inform the design and potential implementation of a statewide plan. • Based on your experience, where are the opportunities to reduce administrative overhead and improve efficiencies while protecting and improving patient care? • Successfully implementing UHP would require a thoughtful transition to avoid disruptions in coverage, provider payments, transfer of records and other elements of care. From your perspective, what transition timeline or sequencing realities would recommend the board include for consideration?	• Health insurers
Drawing on your experience implementing major health care reforms over the past decade, what are some operational realities that are overlooked and are critical for successful implementation? What lessons should inform the development and potential implementation of a Universal Health Plan in Oregon? In particular, what policy approaches or operational strategies helped improve access, care coordination, and health equity—and where did well-intended policies lead to unintended consequences or challenges in practice? • What policies, incentives, or operational approaches helped improve care coordination? • What policy decisions or requirements created operational challenges or unintended consequences? • What would you recommend the board keep, change, or avoid as we consider a statewide universal health plan?	• Health insurers
From your experience providing care in culturally specific settings / serving people in your community, what policies, structures, or investments should be built into a Universal Health Plan to meaningfully reduce health disparities and improve outcomes for the communities you serve?	• Community-based organizations • Culturally-specific healthcare providers
As Oregon considers a Universal Health Plan, what unintended consequences should we watch for that could negatively impact culturally specific providers or the communities you serve?	• Community-based organizations • Culturally-specific healthcare providers
The board is considering moving to a universal fee schedule as part of the transition to universal coverage. Would that put providers on stronger financial footing? • Would that help with recruitment and retention? • Does that help with administrative simplification?	• Outpatient care providers

The board is considering moving to a universal fee schedule as part of the transition to universal coverage. The board estimates that with a universal fee schedule, the UHP could pay hospitals approximately 115% of Medicare rates across the board. Would that put providers (including hospitals) on stronger financial footing? • Would that help with recruitment and retention? • Does that help with administrative simplification?	• Hospitals and health systems
Would a universal fee schedule and reference pricing for hospitals change reimbursement for specialist clinicians (especially procedure-focused clinicians) enough to cause them to leave the state or no longer practice? How could that be mitigated? Are there some categories of specialists that would warrant a protected funding stream to help with retention of that specialty in the state?	• Hospitals and health systems
The board is considering global budgets for hospitals. What are the pros and cons? Would it help hospitals financially?	• Coordinated Care Organizations • Health insurers • Hospitals and health systems
Would a universal health plan with a required 15% allocation to primary care make it easier or harder to recruit primary care clinicians to the state?	• Outpatient care providers
If health insurance is de-coupled from employment and employers paid a payroll tax to support a Universal Health Plan, how would that play out for your business? Overall, what do you see as the pros and cons of a payroll tax vs. individual businesses paying for insurance for their employees? For example, is it better or worse for recruitment and retention of workers?	• Large businesses • Small businesses
The board has been considering how to address Oregon businesses that have employees who live outside of the state. If Oregon had a public option for health care that all Oregon residents could access, how complicated would it be for your business to have a two-tiered system, where you pay a payroll tax for Oregon employees but continue to cover non-Oregon residents with some sort of health benefit or subsidy/ICHRA (Individual Coverage Health Reimbursement Arrangement) plan?	• Large businesses • Small businesses
The proposal includes an employer payroll contribution of about 9.6% of payroll, with the first $500,000 in payroll exempt to help protect small businesses and startups. • From your perspective, does this structure appropriately protect smaller employers? If not, what changes would make it work better?	• Small businesses

How do you see a shift to a Universal Health Plan impacting hospitals as employers?	• Hospitals and health systems
The board is considering a health care income tax that would be progressive. This income tax would replace many of the individual costs that people now pay out of pocket. Looking at the table shared in the slide (and in the summary), knowing the people you serve, what are your thoughts on individuals paying a set tax on income (regardless of whether you use any care), and having no out-of-pocket expenses for health care? Or do you prefer to keep the system as it is?	• Community-based organizations
The board is exploring a progressive health care income tax that could replace many of the costs people currently pay through premiums, deductibles, and other out-of-pocket expenses. We shared examples comparing what people typically pay today with what they might pay under this approach. • From your perspective as a labor organization, what potential benefits or concerns do you see with a system where health care is financed through a predictable tax rather than through premiums, deductibles, and other out-of-pocket costs?	• Labor unions
When designing a health plan, policymakers have to make decisions about which services are included in the core benefit package. Thinking about the needs of your members and their families, what types of services feel most important to include in the core coverage of a universal health plan? • If difficult trade-offs had to be made when designing the core benefit package, how should policymakers think about prioritizing services such as dental care, vision care, fertility services, or very high-cost medications and treatments? • Are there services that you think should be guaranteed in the universal health plan so that workers do not have to rely on collective bargaining to access them?	• Labor unions
How would a UHP impact you as an employer?	• Community-based organizations

Appendix B

Universal Health Plan Governance Board

Universal Health Plan Vision:

Everyone should be able to get care when they need it – no matter where they live, what job they have, or how much they earn.

Universal Health Plan Governance Board Mission:

We're creating a strong, workable plan so everyone in Oregon can get the high-quality, equitable health care they deserve. This new system will be simpler, more affordable, and more sustainable—cutting costs for families and businesses while building a healthier, more stable future for our state.

Thank you for participating in one of the Universal Health Plan Governance Board Focus Groups. Your feedback is essential to the Board's work toward developing recommendations to the legislature for a comprehensive plan to finance and administer a universal health plan for Oregon residents.

Please review this material before your group session. The packet provides background on the work of the Board and its committees, including summaries of their early recommendations and key considerations. There will be time in each meeting for you to ask clarifying questions and then we will ask you to weigh in on key questions that will help the Board finalize the recommendations to the legislature that will be submitted in September 2026.

Background:

Health care costs more in America than other industrialized countries and it's hurting Oregon. Across our state, families, employers, providers, and communities are feeling the strain of rising costs, workforce challenges, and a system that is fragmented and difficult to navigate. For many years, Oregon has been working toward a more equitable, affordable, and sustainable approach to health care.

In 2022, the Universal Health Plan Task Force conducted extensive statewide public engagement and set a vision shaped by Oregonians' values. Building on that work, in 2023, lawmakers created the Universal Health Plan Governance Board ("the Board") with the passage of Senate Bill 1089. The Board is charged with developing preliminary recommendations to the legislature on how to finance and administer a universal health plan for Oregon residents.

The recommendations will be submitted to the legislature no later than September 15, 2026.

Oregonians across the state - employers, workers, health care providers, patients, and community leaders - have been living with a system that is increasingly expensive, complicated, and difficult to navigate. Many families experience these challenges every day: rising premiums, workforce strain, billing complexity, administrative burden, gaps in coverage, and uncertainty about long-term sustainability.

The people closest to the system understand its strengths and its flaws better than anyone. Your insight into how coverage works in practice, how care is delivered, how costs are managed, and where barriers show up is essential.

This draft plan builds on years of conversations across Oregon and is meant to reflect what we've heard from people working within and relying on the current system. It is not a finished product. We are asking for your candid feedback to help us pressure-test the design, identify unintended consequences, and strengthen what works. Your expertise will help ensure any future system reflects real-world experience and practical realities.

The Board's mandate from the legislature is to:

- **Design** publicly funded, statewide health plan options that guarantee coverage for all Oregon residents.
- **Recommend** how the plan should be governed, financed, implemented, and evaluated
- **Address** federal and state legal requirements, including Medicaid waivers, ERISA considerations, and alignment with existing state health reforms.
- **Identify** strategies for cost control, quality improvement, and equitable access that reflect Oregon's longstanding commitment to fairness, inclusion, and sustainability.

As the Board works toward delivering plan recommendations in 2026, it must do so in the context of a dramatically changed health care landscape — one shaped by reduced federal funding for Medicaid, new eligibility restrictions, and the profound post-pandemic upheaval affecting providers, workforce, patient access, and the financial viability of hospitals and clinics. These realities make the Board's charge both more challenging and more urgent.

A new urgency to act

Proposed federal policy changes — including Medicaid funding caps, stricter eligibility and reporting requirements, and reduced support for safety net programs — have caused thousands of Oregonians to lose coverage. Without state-level reform:

- **Coverage gaps will continue to widen**, especially for rural and low-income residents.
- **Cuts in coverage will continue to drive up overall costs**, as more people delay needed care until their conditions become more serious and expensive to treat.
- **Health systems will be further strained**, with hospitals, clinics, and providers facing higher uncompensated care costs and greater pressure on already limited capacity.
- **Health care costs are expected to continue to rise faster than income**, worsening affordability for families, employers, and communities.

It is clear that the current system is not sustainable.

- **Spending growth:** Per-person health spending in Oregon has risen nearly 40% since 2015, now topping $9,000 per year — outpacing wages, inflation, the state's health care cost growth target, and the economy overall.[1]
- **Financial insecurity:** In 2023, 1 in 8 households reported that medical bills used up most or all of their savings.
- **Barriers to care:** 15% of Oregonians delay or skip needed care due to cost; in several rural counties, the figure rises to 20%.
- **Provider stress:** Workforce shortages and burnout are widespread.[2]
- **Reduced access:** Health care users are facing delays in getting care, birth centers are shutting down in rural Oregon, and rural hospitals are at risk.[3] [4]
- **Employer strain:** Small businesses are squeezed between rising premiums and the need to retain staff — often forced to reduce benefits or absorb higher costs at the expense of wages and investment.[5]

1. "Impact of Health Care Costs on Oregonians," June 2025, Oregon Health Authority.
2. Oregon's Health Care Workforce Needs Assessment 2025, January 2025, Oregon Health Authority.
3. Oregon hospitals on the brink, Hospital Association of Oregon, 2024 hospital utilization and financial analysis.
4. Rural hospitals are closing maternity wards. People are seeking options to give birth closer to home | AP News, September 17, 2023.
5. Rising health care prices burden Oregon employers and residents 2017-2021, Health Care Cost Institute.

Oregon's Five Overarching Principles for the Universal Health Plan

As the Board does its work, it is following these five principles. They reflect long-standing values in Oregon's health system and guide how decisions should be made. They were adopted by the Board in 2024.

The principles are: Health equity | Maximize health | Fair distribution of medical resources | Minimize financial hardship for individuals and families | Community sense of ownership and governance

More background on the history of universal health care in Oregon can be found in this summary document and in the Board's 2025 annual report to the legislature.

In this packet:

This packet outlines the following recommendations from the Universal Health Plan Governance Board:

- Who would be covered
- What would be covered
- How it would be financed
- How it would be governed

Snapshot of UHP preliminary recommendations:

Eligibility. All people who live in Oregon qualify for the plan.

Guaranteed Coverage. Health care coverage is not connected to employment.

Benefits. Plan benefits will be based on state employee health plans with enhanced behavioral health coverage.

Choice of Provider. Individuals covered by the plan will be eligible to see any authorized provider.

High Quality. A streamlined and efficient health care quality policy and strategy will be developed.

Affordability. Minimal to zero cost-sharing will be required at the point of care.

Patient Centered. Delivery systems will be centered on the well-established Patient Centered Primary Care Home model and the Certified Community Behavioral Health model, and build on the innovations of Coordinated Care Organizations.

Behavioral Health. Additional funding will be provided for behavioral health services.

Structure. An Oregon-based, nonprofit public corporation will administer the plan, retaining public accountability with operating flexibility. Funds will be held in a trust in the State Treasury, and exempt from the kicker laws.

Governance. A Board of Directors, appointed by the Governor and confirmed by the Senate, will govern the public corporation.

Oregon Universal Health Plan Recommendations as of February 2026

Who would be covered under the Universal Health Plan:

Oregon residents of all ages would be covered, as defined by ORS 316.027: persons maintaining a permanent place of abode in Oregon and spending more than 200 days of the taxable year in the state (ORS 316.027(1)(a)(B)).

This includes:

- Residents regardless of housing status.
- Residents regardless of immigration status, including seasonal farmworkers, defined in ORS 652.145(2).

Also,

- Out-of-state students attending school in Oregon.
- Oregon students who are under 26 and attending school in other states would be covered by a universal health plan working with a national carrier network.
- People who are in Oregon carceral settings, i.e., jails and prisons.

Who would not be covered:

- People who work in Oregon but reside in another state or country. Their employers may provide an alternate method for covering their health care costs.
- People who temporarily reside in Oregon, or who travel or visit here.

People with options to be covered:

Members of the nine federally recognized Indian tribes, including tribal providers, would have the option to participate in a universal health plan in addition to Indian Health Service coverage.

People living in Oregon who travel out of state and need urgent, or emergency care would be covered by a universal health plan via a contract with a national carrier network.

Enrollment:

The Board proposes making enrollment accessible for individuals and more streamlined than today's system for public and private coverage.

The current proposal is:

1. New member enrollment would occur immediately after stating intent to reside in Oregon, with verification required within 90 days.
2. Only the minimum necessary documentation would be required for enrollment, including items that establish residency, determine eligibility for Medicaid or Medicare, and allow a universal health plan to communicate with the member.
3. Members would be automatically re-enrolled in the universal health plan based on filing an Oregon tax return or participation in other state programs. Affirmative member re-enrollment would be required only if all other verification attempts were unsuccessful.

Benefits:
What would be covered in the Universal Health Plan

All licensed or credentialed providers in the state would be eligible to provide services covered by a universal health plan, with no network restrictions. The recommendations include a comprehensive benefits package that includes:

Physical and behavioral health:
Services ordered or provided by any participating provider in Oregon, including:

- Primary care
- Physical and behavioral health visits
- Therapies (such as physical or speech therapy)
- Diagnostic tests and treatments
- Specialty care
- Outpatient procedures and surgeries (where you don't have to stay overnight in a hospital or surgery center)
- Inpatient care (hospitalizations and stays in skilled nursing facilities)
- Behavioral health and substance use disorder treatments, including crisis care, peer support specialists and detox treatment
- Durable medical equipment (for example ankle braces or wheelchairs) that are ordered by licensed health care practitioners
- A limited amount of fertility care

Primary care: The Board recommends dedicating 15% of total health care expenditures to primary care services.

Prescription drugs: A universal health plan would cover a specific list of prescription medications. The formulary list would be created by an independent board of pharmacists and health care clinicians, working with a research entity such as the Center for Evidence Based Policy, similar to how the Oregon Health Plan formulary is created now. There **may** be an additional cost for medications that are not on the list.

Dental health: Routine dental care and a limited amount of orthodontic care.

Vision: Routine vision care, with limited coverage of glasses or contacts.

Long term services and supports: A limited amount of long-term services and supports would continue to be offered. Most would be financed and administered separately from the UHP.

People eligible for long-term services and supports through Medicaid (OHP) would continue to receive those services through the Oregon Department of Human Services. Others would likely need to purchase long-term care insurance or pay out of pocket.

Medicaid: People who are eligible for Oregon Medicaid services (OHP) would receive any additional benefits that are covered for that population per Oregon law and federal regulations. For example, non-emergent medical transportation would be covered for OHP/Medicaid-eligible participants.

To reduce the cost of a universal health plan for all Oregonians, a universal health plan is considering revising the above list of benefits. Benefits that **may be excluded include vision, dental, and/or fertility services.*

Cost and Funding for a Universal Health Plan

A universal health plan would enable all those living in Oregon to have health care coverage, regardless of whether they have a job or how much they earn. Instead of private insurance companies, health care would be paid for through a unified financing system.

Preliminary analysis shows most individuals would pay less for their health care under a universal health plan, and most businesses would also pay less in health care costs for employees.

Overall costs:

The goal is to provide coverage to everyone who today is covered by their employer, on the Exchange, covered by Medicaid, Medicare, the OHP Bridge Plan, Healthier Oregon and the uninsured.

Preliminary analysis of total estimated cost in 2032 to deliver the recommended level of benefits to everyone in Oregon would be between $69.7 billion and $76.9 billion per year. The estimate includes - at this time - a conservative 10% reduction in administrative costs to the system. The Board is continuing to review academic and industry research regarding plan administration to further incorporate opportunities for cost reductions.

Estimated cost comparisons

These numbers are estimates for comparison, using 2026 dollars.[6] [7] The Board continues to work on how the plan will be administered and financed, and is reviewing academic and industry research to build a proposal that reduces administrative complexity and lowers overhead compared to today's fragmented system.

Individuals with employer-provided health insurance[8]

Income	Current Cost Per Year	UHP Cost Per Year
$35,000	$2,813	$0
$55,000	$3,063	$0
$75,000	$3,313	$1,111
$100,000	$3,313	$2,556
$150,000	$3,313	$5,446

Household of four with employer-provided health insurance

Income	Current Cost Per Year	UHP Cost Per Year
$65,000	$7,938	$0
$105,000	$9,688	$890
$150,000	$10,688	$4,678
$195,000	$10,688	$8,580
$250,000	$10,688	$11,759

6. Annual costs including premiums, co-pays, co-insurance, deductibles.
7. Wage income is assumed to be equal to Federal Adjusted Gross Income, on which the HCPIT is based.
8. All employers are assumed to be medium to large employers with payrolls of at least $5 million.

Individuals with ACA coverage.[9] Self-employed: Aged 30

Income	Current Cost Per Year*	UHP Cost Per Year
$35,000	$2,576	$311
$55,000	$5,478	$2,331
$75,000	$6,000	$4,351
$100,000	$6,000	$6,876
$150,000	$6,000	$11,926

Couples with ACA coverage. Self-employed: Age 55

Income	Current Cost Per Year*	UHP Cost Per Year
$65,000	$6,474	$2,399
$105,000	$20,904	$7,381
$150,000	$20,904	$12,104
$200,000	$20,904	$17,154
$250,000	$20,904	$22,204

Household of four with ACA coverage. Principal: Age 40

Income	Current Cost Per Year*	UHP Cost Per Year
$65,000	$4,220	$0
$105,000	$10,458	$4,829
$150,000	$21,600	$11,458
$195,000	$21,600	$17,004
$250,000	$21,600	$22,559

*Because of the wide differences between plans, this doesn't include out-of-pocket costs.

9. "Silver plan" for the ACA plans.

Couple with Medicare Advantage coverage

Social Security	Other Income	Total Income	Current Cost Per Year (Status Quo)	UHP Cost Per Year
$50,000	$50,000	$100,000	$8,961	$4,082
$60,000	$75,000	$135,000	$8,961	$4,082
$70,000	$100,000	$170,000	$8,961	$6,759
$70,000	$150,000	$220,000	$10,910	$12,104
$70,000	$165,000	$235,000	$10,910	$12,104
$70,000	$250,000	$320,000	$13,830	$22,204

Couple with Medicare Supplemental coverage

Social Security	Other Income	Total Income	Current Cost Per Year	UHP Cost Per Year
$50,000	$50,000	$100,000	$11,246	$4,082
$60,000	$75,000	$135,000	$11,246	$4,082
$70,000	$100,000	$170,000	$11,246	$6,759
$70,000	$150,000	$220,000	$13,195	$12,104
$70,000	$230,000	$300,000	$16,116	$20,184
$70,000	$250,000	$320,000	$16,166	$22,204

There is a wide variation between employers when it comes to health care offerings. Nearly 40% of Oregon workers currently do not have coverage through their job. Employers can determine the change in the costs to them by looking at the funding proposals below.

Funding:

When considering how a universal health plan would be paid for, the Finance and Revenue Committee followed these principles:

Funding must be: Dedicated to UHP | Progressive & Broad Based | Easy to Understand | Stable and Predictable | Adequate and Scalable | Designed to leverage federal funds

For individuals: Reduced or eliminated cost-sharing

A universal health plan would reduce or completely eliminate payment at the point of care. The following types of costs would be eliminated or significantly reduced under a universal health plan:

- Insurance Premiums
- Deductibles
- Co-Pays
- Co-Insurance
- Balance Billing

For employers: No more insurance administration

According to the Kaiser Family Foundation, the average annual premium for single coverage in Oregon is $8,382 per employee, with employers covering approximately 85 percent of that cost.[10] That represents a significant and ongoing expense tied directly to workforce size.

Under a universal health plan, employers would no longer be responsible for sponsoring or administering health coverage for employees. Instead of absorbing rising premiums year after year, businesses would gain cost predictability and be relieved of the administrative responsibilities that come with negotiating insurance contracts.

In practical terms, this would allow employers to redirect time, capital, and leadership focus toward core operations, workforce development, and growth, rather than serving as intermediaries in the health insurance system.

Because of the Employee Retirement Income Security Act of 1974 (ERISA) preemption, employers retain the right to provide health coverage to their employees, however, they would be required to pay the employer payroll tax regardless.

10. Average Annual Single Premium per Enrolled Employee For Employer-Based Health Insurance, KFF.

Revenue Proposal Objectives

Economic	Financial	Legal
Achieve universal health care for all Oregonians Cut administrative costs and save money by using one public plan instead of many different insurance companies. Health coverage would stay with the person, not the employer. Slow the rise in health care costs over time.	Keep federal Medicaid and Medicare funding streams. Keep current Oregon business tax deductions where they apply. Ensure the plan is fully funded, built to last, and practical to operate.	Avoid ERISA preemption by relying on broad-based, non-employer-specific levies and universal coverage mandates.

Funding Sources:

Proposed revenue sources are estimated as of February 2026. These figures will change as the Board continues its analysis of administrative savings.

Proposed Financing Breakdown

Replacing Today's Employer and Individual Health Spending

Federal Funding Foundation
If Oregon received approval from CMS, dollars from the Federal Government for programs such as Medicaid (OHP), Medicare, and other sources would continue to fund health care in Oregon.

Business Contributions
Designed to replace employer premium spending and ensure stable business participation

- **Employer Payroll Contribution**
  ~9.6% payroll rate. First $500,000 in payroll exempt from the contribution
- **Corporate Income Tax Adjustment**
  +3.0% surcharge on existing 7.6% rate
- **Corporate Activity Tax Adjustment**
  +0.10% add-on to existing 0.57% rate

Household Contributions
Instead of premiums, deductibles, and copays

- **Health Care Personal Income Contribution**
- Income up to 200% of the FPL will not be taxed. Households earning under that limit will pay nothing. Households above that limit will pay a personal income tax of 10.1%, but **only on the portion of their income above the 200% FPL amount.** This creates a progressive tax structure.

Supplemental Contribution

- **Lodging Tax Adjustment (<0.1%)**
  +0.2% surcharge on existing statewide rate

Built-In Protections for Individuals

- **Employer Payroll Tax Credit**
  A tax credit for people employed by businesses paying the payroll tax. Amount would be 50% of the payroll tax.
- **Medicare Part B Credit (100%)**
  Offsets premiums paid by Medicare beneficiaries

Governance and Structure

Under the Board's current framework, a universal health plan would be administered by a legislatively created public corporation. A public corporation is an entity that is created by the state to carry out public missions and services. SAIF, Oregon's workers' compensation insurance company, is an example of a public corporation.

Public corporations offer:

- Increased operating flexibility (as compared to a state agency) to best ensure its success, while retaining the principles of public accountability.
- A board of directors, appointed by the Governor and confirmed by the Oregon State Senate, would govern the public corporation and have the authority to set policy and manage the operations of the public corporation.
- A centralized administrative structure under the public corporation, to maximize consistency and simplicity for health plan users and providers.

How it would work:

Provider payments: Providers would be paid directly by a universal health plan using a standardized fee schedule, significantly reducing the administrative burden on clinics and hospitals.

- Primary care payments would include population-based payments to support infrastructure and care coordination as well as fee-for service payments. Fifteen percent of the UHP budget would be allocated to primary care.
- Specialty care payments would be largely fee-for-service, with some value-based payments that have evidence of effectively improving quality and reducing costs. Strategies would be implemented to protect payments for highly specialized services so that payment reductions do not cause out-migration of those specialties.
- Behavioral health payments would include population-based payments to support infrastructure, outreach and currently unreimbursed services as well as fee for service payments. Behavioral health funding and payment amounts will be integrated with primary care funding as much as possible, County Financial Assistance Agreements (CFAA) treatment dollars that cover crisis and forensic services should not be integrated into a universal health plan, as they fund functionally distinct and capacity based services closely tied to public safety.

Global budgets for hospitals:

Many hospitals would operate with global budgets, giving them more control over operations and predictability in financing. It would help contain costs, eliminate cost-shifting, and protect services in rural areas.

Prescription drugs: A standardized pharmacy list (formulary) would be fully covered by the plan, likely with a tiered system (brand name drugs and specialty drugs may require cost sharing).

Benefits administration: Everyone in Oregon would have the same level of benefits, with the option to purchase supplemental insurance for any benefits not covered under the plan.

Regional Advisory Councils: The administrative structure would include the creation of regional advisory councils, with the current proposal recommending seven regions that are aligned with public health and behavioral health collaboration patterns. The regional councils would provide input on community engagement, provider education, member outreach, local innovation, health resource planning and prioritization, and workforce development. Regions would not constitute networks, but sites for local engagement with patients and providers.

Trust fund: A universal health plan Trust Fund would be created within the Oregon State Treasury separate and distinct from the general fund. The Board recommends a hybrid trust structure, with investment funds managed by the Oregon Treasury and appropriate operational funds managed via non-Treasury banking services for flexibility and administrative efficiency.

How would things be different under the recommendations in the universal health plan?

Individuals eligible for UHP

Today	Under UHP
Cost	
Today: Costs are disconnected from income. Unpredictable premiums, co-pays, co-insurance, deductibles, out-of-pocket costs, surprise billings.	**Under UHP:** Progressive income tax: • Below 200% of federal poverty level: No charge • Above 200% of federal poverty level: a progressive income tax based on income level
Experience of care	
Today: Care is delayed or deferred due to unaffordable copays. People have to search for services that are in their network.	**Under UHP:** People get the care they need, when they need it, and costs do not factor into their decision of whether to access needed care.
Provider access	
Today: Network limits and referrals	**Under UHP:** All licensed clinicians in good standing who offer services covered under the UHP
Whole Person Access	
Today: Payment policies and network rules can limit the use of certain provider types.	**Under UHP:** Broader integration of behavioral health, oral health, and other licensed providers within a unified system.
Coverage access	
Today: Coverage and costs are based on ability to pay, employment status and utilization of health care services. Coverage comes primarily from employer plans. Others who are not covered by federal and state programs pay out of pocket for health care.	**Under UHP:** Everyone, no matter how much they earn or how much health care they use, would have comprehensive health care. Everyone, no matter their job status or income level would have comprehensive health care.

Employers

Today	Under UHP
Cost	
Today: Health care costs account for significant expenditures, dictated by rising and unsustainable costs. High costs for contract negotiations and plan administration. Employers compete with other employers in recruiting based on robustness of benefits and increasing costs.	**Under UHP:** No costs for plan administration or expanding workforce. Costs are predictable. Employers will be able to draw workers to Oregon with an offer of universal care. Businesses will be incentivized to locate in Oregon due to lower health care costs that employer is responsible for. Smaller businesses can afford to be more competitive to hire talent.

Providers

Today	Under UHP
Clinician recruitment, retention, and well-being	
Today: Shortage of clinicians due to burnout, moral injury, and frustration with a system that doesn't meet their patients' needs or their needs for a reasonable workload and enjoyment of their profession. A system built around financial incentives and profit instead of caring for the community.	**Under UHP:** A rational, simpler and less frustrating plan that ensures everyone can get the care they need. An environment that lets clinicians do clinical work instead of administrative work. A return to medical care as a service and a public good.

Cost and Administration	
Today: High administrative costs and overhead due to contracts with multiple payers with different billing systems, rules, contracts, benefits, prior authorization standards and formularies. Significant staff resources devoted to billing, coding, contract management, prior authorizations, and denial appeals.	**Under UHP:** Reduced administrative burden due to single payer for all UHP covered lives. One unified payment system with standardized rules, benefits, billing processes, and coverage policies. Potential reallocation of staffing toward care coordination, patient engagement, and clinical services.
Coverage Churn	
Today: Patients frequently move between OHP, Marketplace coverage, employer coverage, and uninsured status, disrupting provider relationship and continuity of care.	**Under UHP:** Continuous coverage reduces churn and supports stable, long-term patient-provider relationships.
Quality Measurement	
Today: Different insurers require numerous and various reporting metrics and value-based payment models.	**Under UHP:** Aligned quality measures, performance expectations, and payment models across the system.
Whole Person Care	
Today: Payment policies and network rules can limit the use of certain provider types.	**Under UHP:** Broader integration of behavioral health, oral health, and other licensed providers within a unified system.

Steps to implementing a Universal Health Plan for Oregon

Achieving universal health coverage for all Oregonians will be a lengthy process involving approvals from the state and federal government and massive transitions from the current system. Here are some key steps necessary.

Stage 1 — Design & Authorization

- Board will submit recommendations to legislature September, 2026.
- Statutory change: Legislation is passed by lawmakers or by voters (if lawmakers refer it to the ballot). Earliest dates of passage would be 2027 for legislation or 2028 for referral.
- Federal approval: Public corporation seeks federal waiver approval to bring Medicaid and Medicare into a universal health plan.

Stage 2 — Building the System

- Establish public corporation
- Stand up a governance board
- Contract with claims vendor
- Establish reserves/legal entities
- Establish an eligibility/enrollment process
- Build a universal IT platform for every hospital and clinic to communicate with the public corporation
- Determine payment rates and methods for hospitals, primary care clinicians and specialty care clinicians
- Transition hospitals to global budgets
- Work with providers and communities to prepare for transition

Stage 3 — Implementation

- Transition members from current plans to UHP
- Adjust as needed based on real-world experience

The Board encourages everyone in Oregon to stay engaged in the work to move our state towards universal health care. The Board has monthly public meetings and accepts public comment. See the schedule and get notified of all public meetings by the Board and committees at https://www.oregon.gov/uhpgb/.

Universal Health Plan Governance Board Report: Addendum

Input from Focus group for Persons who are Deaf and Hard of Hearing

PREPARED BY
DIANA BIANCO, ARTEMIS CONSULTING

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This addendum to *Universal Health Plan Governance Board Report: March 2026 Focus Groups* summarizes input from a virtual focus group with Persons who are Deaf and Hard of Hearing, held in May 2026. The focus group was arranged in partnership with Bridges Oregon.

Feedback is organized using the same categories as the March 2026 focus group report. As noted in the introduction to that report, participants' comments reflect individual input and are not statements of consensus or universal agreement. In addition, as stated in that report, input does not reflect all perspectives from the Deaf and Hard of Hearing community; as is always the case in groups like this, participants self-selected for participation.

POSSIBILITIES FOR A UNIVERSAL HEALTH PLAN

Participants identified potential benefits of a Universal Health Plan (UHP).

- A single system with one benefit package and one set of providers could improve access and provide consistent care for all.
- Behavioral health coverage is a priority; participants see it as central to whole-person care.

> *"I'm thinking about what universal means — does everyone get equal access? Is it the same type of care?"*
> *— Focus Group Participant*

BENEFITS / SERVICES

Accessibility and Communication Accommodations

Participants raised communication access as a foundational benefits issue. The group described ongoing systemic failures in the current system to provide effective interpretation in medical settings. Participants shared the following:

- ASL interpreter access must be a covered and provided medical accommodation.
- Video Remote Interpreting (VRI) is frequently substituted for in-person interpreters without notice. Participants described incidents where VRI failed due to poor Wi-Fi, leaving patients with no communication access during vulnerable moments.
- Individuals who are DeafBlind require tactile interpreters, a specialized group of practitioners who must be booked well in advance. This can pose a challenge in emergency medical situations.
- The burden of finding a qualified interpreter should not fall on the patient. Currently, it often does.
- The pool of qualified ASL interpreters in Oregon must be actively maintained and grown.

> *"We need a better system to provide this [communication] access. There have been so many complaints, and everyone points fingers, but no one takes responsibility."*
> *—Focus Group Participant*

Behavioral Health

Access to mental health care was identified as a top unmet need. Finding an ASL-fluent therapist in Oregon is extremely difficult; insurers typically offer a sign language interpreter for sessions instead. Participants raised concerns about this approach: in a small community, the interpreter and patient are likely to know each other, creating confidentiality issues.

> *"Getting good mental health care is a priority. In our community, that is really tough."*
> *— Focus Group Participant*

Dental and Vision

Participants strongly supported inclusion of both dental and vision coverage, with particular emphasis on vision.

- Participants noted that dental care is critical to health and there are cascading consequences of untreated dental problems. Affordability is a barrier for many.

- Vision coverage is uniquely critical for Persons who are Deaf and Hard of Hearing— it is the primary means of communication, navigation, and daily functioning.

> *"Vision— that's my main source of communication. That's my enjoyment. How I perceive the world. How I move through the world."*
> *— Focus Group Participant*

Expensive and High-Cost Treatments

Participants acknowledged the tension between the cost of treatments like IVF, HIV medications, and cancer therapies and the principle that everyone deserves care. Participants described patients who lost access to medications or treatments due to job changes, life disruptions, or a lack of funds and had resulting health consequences.

Supplemental Insurance

Participants responded positively to the concept of supplemental insurance for benefits not included in the UHP. The group liked the idea of choosing supplemental coverage based on individual needs and life circumstances.

COVERAGE OF NON-MEDICAL SERVICES

- Health literacy: Participants raised concerns about whether public health programs adequately engage Persons who are Deaf, DeafBlind, and Hard of Hearing. Participants shared a model from Michigan where Deaf and Hard of Hearing individuals are trained to deliver health education in ASL and suggested it be replicated in Oregon.

> *"The more we understand about our own health and access to care, the easier it is to maintain our health. Empowering people saves cost."*
> *— Focus Group Participant*

STATEWIDE STRUCTURE, GOVERNANCE, AND LOCAL NEEDS

- Participants asked and learned that there are no Deaf, DeafBlind or Hard of Hearing members on the UHPGB. Participants expressed a desire for representation on future related groups.

TRANSITION PLANNING

- Participants noted that a comprehensive cost analysis of the UHP has to include transition and start-up costs.
- Participants wanted to ensure that there would be consideration of how remote workers living in Oregon with out-of-state employers would be covered and how employer contributions will work for them.
- Participants emphasized that Persons who are Deaf, DeafBlind, and Hard of Hearing have historically been excluded from engagement processes due to lack of communication access. Transition planning should proactively address this.

SUGGESTED ACTIONS FOR THE BOARD

In response to input from this focus group, the board may want to consider the following:

Establish a universal and enforced standard for communication access. Ensure ASL interpretation and other communication accommodations are covered and provided uniformly across all providers, including for behavioral health appointments, medical procedures, and emergency situations.

Address VRI limitations in plan design. According to participants, VRI is not an adequate substitute for in-person ASL interpretation in many clinical contexts and is inaccessible to DeafBlind individuals.

Support the ASL interpreter workforce. Consider whether workforce investment strategies under the UHP should include support for recruiting and retaining qualified ASL and tactile interpreters in Oregon.

Consider the disproportionate impact on this community when making dental and vision benefit decisions. For Deaf and Persons who are Deaf and Hard of Hearing, vision is a primary means of communication. Any decision to phase or exclude vision from the base benefit package should account for this.