ECOnorthwest Appendix

Table of Contents

Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board **2**

Summary of Final Deliverables to UHPGB **100**

Workplan and Research Framework for the Finance & Revenue Committee **103**

Principles for a Viable and Just Financing Approach **119**

Key Financial Assumptions for Cross-Committee Alignment **125**

Preliminary UHP Funding Plan Straw Proposal **128**

Revised Revenue Structures for Universal Health Plan: Response to Board Feedback and Updated Modeling Approach **141**

Transitions and Reserves Research and Case Studies **154**

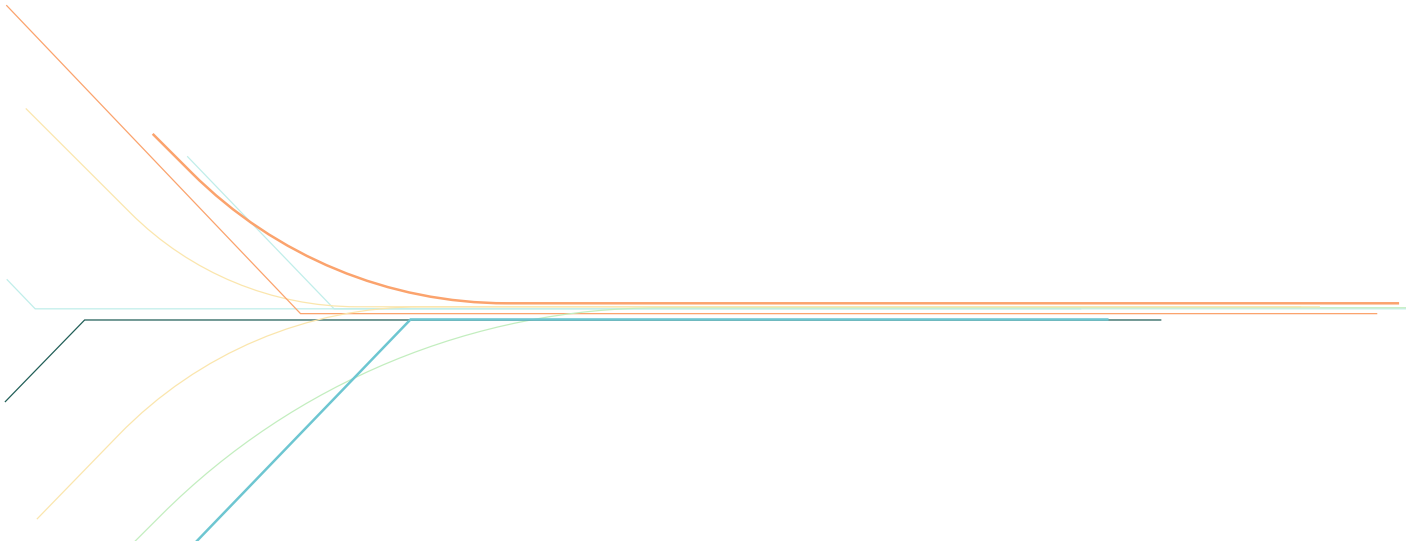
Reserves Financing and Funding Options and Examples for the UHP **169**

Proposal Comparison to LRO Revisions and Estimates **186**

Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework **193**

Economic Effects of Oregon's Universal Health Plan: A Framework for Evaluating Fiscal, Economic, Distributional, and Welfare Impacts **198**

2032 Revenue Replacement Targets **229**



June 2026

Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board

Universal Health Plan Governance Board

ECOnorthwest
920 SW 6th Ave • Suite 1400 • Portland, OR 97204 • 503-222-6060

Acknowledgments

This report was prepared by ECOnorthwest in support of the Universal Health Plan Governance Board (UHPGB) and its Finance & Revenue Committee. The substance of the revenue framework documented here reflects the Committee's deliberations and decisions over the course of its work. ECOnorthwest's role was to support and supplement that effort by providing analytic tools, scenario testing, and draft materials that helped the Committee evaluate tradeoffs, respond to Board feedback, and refine the proposal for consideration by the UHPGB.

We are grateful for the time and leadership provided by UHPGB members and staff, and especially for the engagement of the Finance & Revenue Committee members who drove the policy design and interpretation of results.

That assistance notwithstanding, ECOnorthwest is responsible for the content of this report. The staff at ECOnorthwest prepared this report based on their general knowledge of the economics of recreation, amenities, and regional economies. ECOnorthwest staff contributing to this study included Morgan Shook, Sarah Emmans, Megan Waldo, Sadie Shoemaker, Akhila Bandlora, Zach Lescher, and Willa Van Liew. ECOnorthwest also relied on information derived from government agencies, private statistical services, the reports of others, interviews of individuals, or other sources believed to be reliable. ECOnorthwest has not independently verified the accuracy of all such information and makes no representation regarding its accuracy or completeness. Any statements nonfactual in nature constitute the authors' current opinions, which may change as more information becomes available.

For more information about this report please contact:

Morgan Shook
shook@econw.com
ECOnorthwest
503-222-6060

Table of Contents

Executive Summary **1**

1. Introduction and Background **3**

2. The Revenue Proposal Framework **25**

3. Proposal to Fund On-Going UHP Expenses **40**

4. Impact on Households and Businesses **48**

5. Considerations Related to Funding Transition Costs and Reserve Capitalization **74**

6. Appendices **95**

Executive Summary

This report documents the Finance & Revenue Committee's work in developing a financing framework for Oregon's Universal Health Plan (UHP), as charged under SB 1089. It consolidates the Committee's design choices, analytical findings, and recommendations as a structured record for the UHP Governance Board's continued work. The Committee acknowledges it completed only the first five tasks and the first deliverable of its charter before being disbanded.

The Committee's central premise is that Oregon does not need to raise UHP funding from scratch. Health care is already extensively financed through a fragmented mix of employer contributions, household premiums, out-of-pocket spending, and public programs. The framework is designed to replace and restructure these existing payments rather than impose new net costs. Against baseline Oregon health care spending of approximately $46.4 billion (2022 dollars), the Committee derived a Revenue Replacement Target of $16.9 billion (2022 dollars) after accounting for preserved Medicare and Medicaid funding. A placeholder target of approximately $26.0 billion in 2032 dollars has been calculated pending reconciliation with the updated Milliman cost estimate.

The package is built around a small set of structurally integrated, broadly applicable instruments:

- Corporate Income/Excise Tax surcharge of 3.0% (~$608M);
- Corporate Activity Tax add-on of 0.10% (~$215M);
- Employer Payroll Tax (EPT) of 9.6% above a $500,000 firm threshold (~$8.7B), structured as a generally applicable levy to minimize ERISA risk;
- Health Care Personal Income Tax (HCPIT) of 10.1% on AGI above 200% FPL;
- Household Size Rate Readjustment protecting larger households at low and moderate incomes;
- 50% EPT credit against HCPIT liability to prevent double-taxation of wages; and
- 100% Medicare Part B premium credit to prevent double payment for Medicare beneficiaries.

The proposal functions primarily as a reorganization of existing payments. In aggregate, every major payer class contributes less than under the status quo in the 2022 calibration: private employers approximately $0.42B lower, state and local government employers $0.14B lower, federal government employers $0.17B lower, and individuals approximately $0.52B lower. Effective HCPIT rates rise smoothly from 0.4% at the lowest income band to 9.1% at the highest, and most representative household typologies face lower total costs than under the status quo. The Committee considered but did not recommend a soft cap on high-income liability, sumptuary taxes, or a state sales tax, primarily on grounds of regressivity, scale, or structural fit.

In terms of transition cost and reserves reconciliation, the Committee voted 5–2 to recommend a three-month operating reserve with a one-month trigger for corrective action. At Milliman's 2032 expenditure estimate, this implies approximately $21.3 billion in capitalization, a scale that will likely require a hybrid "capital stack" combining internal public sources, structured bridge financing, and limited accelerated revenue.

1. Introduction and Background

The Finance and Revenue Committee was formed from the workplan set forth by the Universal Health Plan Governance Board in December 2023, because of Senate Bill (SB) 1089.[1] The Committee exists to recommend a viable, legally compliant, and equitable financing structure for Oregon's Universal Health Plan (UHP). As such, the Committee has taken care to align decisions surrounding, and recommendations for, financing mechanisms and funding structures with the Universal Health Plan Governance Board's (UHPGB) core values for a comprehensive health plan.

Consultant Role in Supporting F&R Committee

Throughout the development of the UHP funding proposal, ECONorthwest served in a supporting and analytic capacity to the Finance & Revenue Committee and, ultimately, to the Universal Health Plan Governance Board. The committee led the conceptual development of the revenue structure—identifying the core policy choices, evaluating tradeoffs, and shaping the overall direction of the financing approach. ECONorthwest's role was to provide targeted analytical support to inform the committee's deliberations and to assist in translating those deliberations into materials suitable for Board review.

Specifically, ECOnorthwest supplied quantitative analysis, modeling, and policy research in areas where committee members were not themselves generating the technical work. We worked iteratively with committee members to explore design options, evaluate distributional and revenue impacts, and prepare decision-ready comparisons across alternative financing structures. In parallel, ECOnorthwest coordinated closely with UHP staff to ensure that analytical outputs were aligned with program assumptions, could be integrated into board briefing materials, and reflected the evolving guidance of the committee.

In its facilitative role, ECONorthwest helped structure meeting-to-meeting discussions, frame design questions for committee consideration, and synthesize feedback to support consensus-building. This work contributed to a more efficient decision process and helped guide the committee toward a coherent set of recommended financing elements for Board review.

Purpose of This Report

This report is, above all, a reflection of the work undertaken by the Finance & Revenue Committee over the course of its deliberations. It consolidates the Committee's design choices, the major questions explored, and the conclusions reached to date, and presents

[1] The UHPGB was created by the Oregon Legislature in 2023 under Senate Bill (SB) 1089 to develop a comprehensive plan to finance and administer a universal health plan by September 2026. Senate Bill (SB) 1089 arose from a recommendation by the Joint Task Force on Universal Health Care, which itself was created under SB 770 in 2019. https://olis.oregonlegislature.gov/liz/2023R1/Measures/Overview/SB1089, https://www.oregon.gov/uhpgb/about/Pages/resources.aspx

them in a structured format for the benefit of the UHP Governance Board. While ECOnorthwest prepared the document, its content is grounded in the Committee's collective direction, feedback, and decision-making.

The report serves as a milestone in the ongoing development of the UHP financing strategy. It documents the analytical work that supported the Committee's considerations, summarizes the current recommended financing structure, and highlights the remaining questions and dependencies that will need to be addressed as the Board continues toward a finalized plan.

In doing so, this report provides the UHPGB with the technical foundation necessary for its next phase of work: aligning the proposed revenue structure with projected program costs, evaluating long-term sustainability, and preparing for legislative engagement. It is not intended as an endpoint, but rather as a clear record of progress and a platform for the Board's forward-looking analysis and decision-making.

Finance & Revenue Committee Review and Status of Committee Work

This report was prepared by ECOnorthwest to document and synthesize the Finance & Revenue Committee's work products, analyses, and recommendations developed for the UHPG). The report is intended to serve as a structured record of the Committee's work and a foundation for subsequent Board-level decision-making and legislative development.

At the Committee's request, ECOnorthwest agreed to share a near-final draft of the report to gather feedback. The Committee discussed how to treat the report for purposes of Committee action and, by a 5–2 vote, adopted the following position (as amended): ECOnorthwest's "Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board" describes, in part, the work of the Committee; the Committee did not have sufficient time to formally approve or disapprove the report, but would provide ECOnorthwest with comments and suggestions, with the understanding that ECOnorthwest would incorporate those comments at its discretion.

In the same motion, the Committee acknowledged that it did not complete its work to the full standards contemplated in the guiding document approved by the UHPGB on January 10, 2025. The Committee further acknowledged that it completed only the initial set of tasks described in its charter approved by the UHPGB on July 18, 2024, specifically, the first five task items and the first of two deliverables contemplated in that charter. The Committee also noted its understanding of the Board's decision to disband the Committee before the remaining work was completed.

Purpose of the Committee and Official Charge

The Finance and Revenue Committee was created with three other committees by the UHPGB to support its work in designing a plan to finance a UHP for all Oregon residents.[2] The Committee is responsible for analyzing how different elements of the ultimate UHP structure may adversely affect Oregon's citizens, employers, families, and economy, and appropriately incorporating those findings into the final UHP.

More specifically, the Finance and Revenue Committee's objective is defined in the UHPGB's 2024 workplan: to "design a unified financing structure for the Universal Health Plan, including creating a Universal Health Plan Trust Fund in the State Treasury with sufficient reserves. [In addition,] study and address the impacts of the Universal Health plan with respect to specific types of employers and households and consider funding mechanisms within context of prospective of Employee Retirement Income Security Act (ERISA) challenges."[3] These objectives are based on the official charge for the UHPGB outlined in the Joint Task Force on Universal Health Care's Final Report and Recommendations and in SB 770.[4] Subsequently, the Finance and Revenue Committee's official charge includes:

- Developing a sound financial plan lucid of current health care spending patterns,
- Establishing realistic and viable revenue and spending targets,
- Updating these plans based on ERISA challenges,
- Identifying the impact of UHP spending on businesses, individuals, and households,
- Identifying startup and transition costs for the new system, and
- Other financial strategy goals.[5]

As identified in the UHPGB's workplan, workstream three, revenue options for funding the UHP should be based on the UHP as outlined in the 2022 Joint Task Force report on universal health care. The report details recommendations for key plan components and considerations such as ERISA preemptions, Medicare, federal waivers, etc.[6] Per Section 2 of SB 770, Establishment of the Task Force on Universal Health Care, Joint Task Force is charged with delivering a Health Care for All Oregon Plan that ensures access to comprehensive, quality, patient-centered, equitable, affordable, and publicly funded health care for all individuals living or working in Oregon, to improve the whole of the public's

---

[2] Universal Health Plan Governance Board. "About Committees: Committees." n.d. Oregon.gov. Accessed December 8, 2025. https://www.oregon.gov/uhpgb/committees/Pages/about-committees.aspx.

[3] Universal Health Plan Governance Board. "Objectives, Tasks and Deliverables." Oregon.gov. 2024. https://www.oregon.gov/uhpgb/Documents/about/071824-workplan.pdf.

[4] The official charge for the UHPGB is recommending to Legislative Assembly the design of Health Care for All Oregon Plan, administered by Health Care for All Oregon Board, to provide publicly funded, equitable, affordable, comprehensive and high-quality health care to all Oregon residents.

[5] For the complete list of charges outlined in the Finance and Revenue Committee Charter, see the Chapter 1 appendix.

[6] Legislative Policy and Research Office. "Joint Task Force on Universal Health Care: Final Report and Recommendations." Oregon.gov. 2022. https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20Oct%202022.pdf.

health and control the costs of care.[7] These values are consistently reiterated throughout the 2022 Joint Task Force proposals, and are thus are core principles applied to the official charge of the Finance and Revenue Committee.

Relationship to Broader UHP Implementation

The Committee's UHP financing strategy recommendations serve as a foundation from which the Board can build its approach for moving from the current health system into the UHP. The UHP revenue proposal informs key stakeholders for discussion through its inherent structure, as well as identifies groups that may be more burdened by the proposed changes. In addition, it provides a foundational understanding of Oregon's current health care financing landscape and interactions with proposed changes. Combined with work from other Committees, the Finance and Revenue Committee's deliverables provide important context for the plan's equity, legal defensibility, and sustainability considerations.

Additionally, work from the Committee has culminated in a "unified financing strategy for the Universal Health Plan that may include an income tax, a payroll tax, or other options that take into considerations ERISA." The plan is ready to present as a preliminary proposal to large and small employers to check on whether it could be supported, and to find what changes might make it better. This is a deliverable outlined in SB 1089 Section 2(3) i and j.[8]

Guiding Principles and Operating Assumptions

To ensure Committee discussions and decisions surrounding UHP financing mechanisms were clearly aligned with the values outlined for the UHPGB in SB 1089, the Committee approved a Guiding Discussion Document with a list of guiding revenue principles.[9] Each principle is an important element to defining a successful financial plan for implementation of a UHP in Oregon. While principles are listed individually in the Guiding Discussion Document, they have been grouped together and expanded upon below for readability. The groupings of principles below attempt to accentuate key themes in considerations made by the Committee.

1. **Stable, Predictable, Scalable and Adequate Long-Term.**
    - A health care financing system should be able to weather various economic and demographic changes. Because no financing mechanism generates consistent revenue over time, considerations should be given to options for increasing overall stability.
    - Government officials should be able to fairly predict how much revenue will be generated under the plan.

[7] 80th Oregon Legislative Assembly. "Enrolled Senate Bill 770." Oregon Legislature. 2019. https://olis.oregonlegislature.gov/liz/2019R1/Downloads/MeasureDocument/SB770/Enrolled.
[8] Universal Health Plan Governance Board. "Objectives, Tasks and Deliverables." Oregon.gov. 2024. https://www.oregon.gov/uhpgb/Documents/about/071824-workplan.pdf.
[9] Universal Health Plan Governance Board. "Finance and Revenue Committee: Guiding Discussion Document." Oregon.gov. 2025. https://www.oregon.gov/uhpgb/committees/Documents/fin-rev/fin-rev-guiding-discussion-document-011025.pdf.

- The revenue sources should be able to meet the needs of full UHP implementation over time.

2. **Progressive, Broad Base, Easy to Understand, and Avoids Unequal Burden and Cliffs.**
   - The tax rate should increase as the taxpayer's income, or ability to pay, increases.
   - To the extent possible, the plan should avoid imposing an unequal tax burden on wage-income versus other types of income (e.g. self-employed-income).
   - To the extent possible, the plan should avoid tax cliffs or benefit cliffs. A cliff happens when a household's income increases slightly but the increase causes a large, sudden loss in net resources because eligibility for a tax credit or public benefit ends abruptly.[10]
   - Having a broad tax base with a lower rate is better than relying on a higher rate for a narrower group.
   - The new revenue streams should be easy to understand by those having to pay for it – total costs should be clear and easy to predict.
3. **Maximize Federal Dollars, Avoid Economic Hardship and Limit Movement.**
   - When determining the financing structure, consider opportunities to maximize federal match dollars before turning to new revenue streams.
   - Avoid the economic harm via the loss of federal tax expenditures in Oregon on employer and employee contributions to employer-sponsored health insurance (both income tax and contributions from the Federal Insurance Contributions Act (FICA)) when moving away from employer sponsorship. Current federal law allows contributions to employer-sponsored health insurance to be excluded from taxable income, thus decreasing the money flowing from Oregon employers and employees (and thus out of the Oregon economy in general) to federal taxes.[11]

[10] NCSL. "Introduction to Benefits Cliffs and Public Assistance Programs." National Conference of State Legislatures. 2024. https://www.ncsl.org/human-services/introduction-to-benefits-cliffs-and-public-assistance-programs.

[11] Tax Policy Center. "How Does the Tax Exclusion for Employer-Sponsored Health Insurance Work?" Urban Institute and Brookings. 2024. https://taxpolicycenter.org/briefing-book/how-does-tax-exclusion-employer-sponsored-health-insurance-work.

- Any revenue plan should be structured to limit creating a financial incentive for migration into, or out of, the state.

4. **Dedicated Trust Fund.** As opposed to pulling from the general fund, the Committee seeks a dedicated trust fund to support the plan that is not subject to the state kicker tax credit. The state kicker is a tax credit calculated as a percentage of taxpayer income after all credits on their return for the previous year.[12]
5. **Employee Retirement Income Security Act (ERISA) Considerations.** The plan should be cognizant of vulnerabilities to ERISA court challenges and should attempt to avoid such challenges. Consideration should be given to automatic triggers on other revenue streams if there is an effective ERISA challenge.[13]
6. **Multiple Streams.** The revenue plan must consider all costs of operations, start-up, reserves, and transition, including bond sales.
7. **Permanent.** The system should be as permanent as possible. There should be no automatic sunset of a revenue stream.

SB 1089 SECTION 2(3)A

- **Health care, as a fundamental element of a just society, must be secured for all individuals on an equitable basis by public means, like public education, public safety and public infrastructure**
- **Race, color, national origin, age, disability, wealth, income, citizenship status, primary language, genetic conditions, previous or existing medical conditions, religion or sex, including sex stereotyping, gender identity, sexual orientation and pregnancy and pregnancy-related medical conditions may not create barriers to health care nor result in disparities in health outcomes due to the lack of access to care.**
- **The components of the Universal Health Plan must be accountable and fully transparent to the public regarding information, decision-making and management through meaningful public participation.**
- **Funding for the Universal Health Plan is a public trust, and any savings or excess revenue must be returned to the public trust.**

Using the guiding principles outlined above, the Committee also developed a set of financial assumptions and conditions for consideration in the development of the UHP. The Finance and Revenue Committee recommended these assumptions be incorporated into other

[12] Oregon Department of Revenue. "Oregon Surplus 'Kicker' Credit: Individuals." Oregon.gov. 2025. https://www.oregon.gov/dor/programs/individuals/pages/kicker.aspx.
[13] ERISA is a federal law that establishes minimum standards for benefits protections within most voluntarily established retirement and health plans in the private industry;
U.S. Department of Labor. n.d. "Employee Retirement Income Security Act (ERISA)." Dol.gov. https://www.dol.gov/general/topic/retirement/erisa.

Committee workflows surrounding plan design, implementation, legal structure, governance, and public communication. It is important that the different efforts put towards building a comprehensive plan be aligned on their assumptions to ensure the final UHP is consistent throughout all elements.

1. **Covered Populations and Services Must Be Clearly Defined.** The financial modeling assumes a specific set of services and a defined eligible population. System design decisions must align with these assumptions to ensure consistency in cost estimates. Outreach and public materials also need to reflect these definitions accurately to avoid confusion or misrepresentation.

2. **Implementation Phasing Must Match Funding Capacity.** The proposed financing structure supports a phased rollout. Any plan to expand coverage by geography, age, or income group must be coordinated with the timing of available revenue. Communications should be clear about when different groups will be included and why.

3. **Financing Design Must Avoid Legal Conflicts with ERISA.** The structure of employer-related revenue sources must be carefully designed to avoid federal preemption under the Employee Retirement Income Security Act (ERISA). Financing approaches should be framed as broad-based state taxes or contributions rather than mandates on employer benefit offerings.

4. **A Dedicated Trust Fund Is Required.** As outlined above in the Committee's guiding principles, the plan assumes all revenues will be held in a dedicated health care trust fund, not the general fund. This is to ensure transparency and fiscal integrity of the plan. Governance planning should include oversight mechanisms for the fund, and messaging should emphasize this structure to build public confidence.

5. **Federal Program Integration Must Be Seamless.** The financing model relies on leveraging federal funding streams such as Medicaid, Medicare, and ACA subsidies.[6] System design must ensure that individuals can move between programs without sudden losses of coverage or tax burdens. Communications should clearly convey how federal programs will be integrated or replaced.

6. **Workforce and Economic Behavior Will Likely Shift.** It is possible that in the process of unlinking health coverage from employment, changes in workforce participation may occur. For example, some individuals may retire earlier or reduce hours. These shifts can affect income and tax revenues and should be factored into both economic

analysis and system design. Messaging should reflect the increased flexibility the new system offers.

7. **Common Data Sources and Time Periods Are Essential.** Financial analyses are based on multi-year data from national sources like the National Health Expenditure Accounts. All committees should use consistent timeframes and baselines for planning purposes. Avoid relying on single-year or pandemic-era data unless explicitly justified.

8. **State "Kicker" Law May Affect Revenue Stability.** Oregon's "kicker" law, which refunds surplus personal income tax revenue to taxpayers, could limit the ability to build reserves or rely on volatile revenue streams.[5] Any proposal that uses income tax as a financing source must account for how the kicker affects long-term revenue stability. Legal and governance teams may need to explore exemptions or legislative changes, and communications should anticipate public questions about why health care funds are or are not subject to the kicker.

9. **Administrative Costs Must Be Accurately Estimated.** The financial model depends on a full accounting of administrative overhead, including billing systems, payer functions, data reporting, and regulatory compliance. System design decisions, such as whether to centralize payments, can significantly affect these costs. Committees working on operations, governance, and IT infrastructure should coordinate closely with fiscal analysts to ensure administrative assumptions remain realistic.

COMMON DATA SOURCES

- **Kaiser Family Foundation (KFF)**
- **National Health Expenditure Accounts (NHEA)**
- **Oregon Employment Department Quarterly Census of Employment and Wages (QCEW)**
- **U.S. Census Bureau Current Population Survey (CPS), Service Annual Survey (SAS)**
- **Oregon Department of Revenue**
- **Oregon Health Authority (OHA)**
- **Centers for Medicare and Medicaid Services, Medicaid Budget and Expenditures System (MBES)**
- **Oregon Department of Consumer and Business Services (DCBS)**
- **National Association of Insurance Commissioners (NAIC),**

10. **Reserves and Existing Program Funds Need a Transition Plan.** Several existing public programs hold reserve funds or carryover balances that may be repurposed under a universal system. The financial plan assumes that these reserves can help support transition costs or reduce initial tax burdens. Legal and program design should

inventory these funds, assess restrictions on their use, and propose a clear strategy for how they will be integrated or liquidated as the new system is implemented.

Together these principles and assumptions make up the framework from which the Finance and Revenue Committee has developed its proposal for financing the UHP- though, as noted earlier, the Committee did not have the time or resources to complete its work to the standards described here.

Structure of Work Meetings

Every third Tuesday at 9 a.m., the Finance and Revenue Committee convened to discuss iterations of financing mechanisms that best represented the guiding principles for a successful UHP (many months also used a Supplemental Meeting that had the committee meeting every other week). Working from the established principles of equity, affordability, and revenue adequacy, the Committee and its consultants worked throughout the process to map interactions between key UHP revenue instruments. The Committee's modeling efforts focused on revenue generation, but also upon distributional impacts across households and firms, potential administrative feasibility, other existing tax structures and alignment with the policy objectives established by the UHP Governance Board. F&R members Charlie Swanson and Richard Gibson were instrumental in surfacing key policy levers and analyzing the fiscal impact of various plan design choices.

Evaluation Criteria and Governance

To develop sustainable, equitable, and adaptable financing strategies for Oregon's UHP, the Committee established a framework of nine key principles to guide its evaluation of funding options. These criteria represent the Committee's collective values and UHPGB policy goals, emphasizing fiscal responsibility, equity, transparency, legal durability, and alignment with Oregon's long-term health system transformation.

As proposed by the Committee earlier in 2025, the nine key criteria for plan evaluation are as follows:

1. Clarity and Transparency,
2. Equity and Progressivity,
3. Fiscal Stability and Permanence,
4. Scalability and Flexibility,
5. Legal Viability,
6. Dedicated Health Care Trust Fund,
7. Optimization of Federal Funds,
8. Comprehensive and Broad-Based Revenue Model, and
9. Economic Neutrality and Efficiency.

These criteria provide a consistent and structured approach for comparing options, identifying trade-offs, and increasing the likelihood that the final financing plan meets the expectations of the public, policymakers, and implementation partners. This framework is intended for use throughout the planning and implementation process and should inform technical analysis, legal review, stakeholder engagement, and legislative deliberation. In addition, these criteria are intended to be referenced throughout the governance of the UHP. It should be noted that the Universal Healthcare Governance Board accepted these criteria before the Finance and Revenue Committee had a chance to them.

Clarity and Transparency

As a part of the UHPGB's goals for the UHP to be equitable and transparent, the financing mechanism must be easy to understand by the public and policy makers. There are four key metrics for evaluating the clarity and transparency of the financing mechanism:

1. Comprehensibility,
2. Documentation,
3. Traceability, and
4. Comparability.

Comprehensibility ensures that individuals can interpret how revenues are raised, how funds flow through the system, how the financing model compares to the status quo, and how the plan applies to them. Thorough documentation is essential: revenue sources, tax bases, rate structures, and modeling assumptions must be fully described and publicly accessible. Doing so builds public trust and helps guard against misinterpretation or misuse of information.

Traceability requires that all data sources, modeling inputs, and analytic methods be disclosed and replicable so that independent researchers and stakeholders can assess the validity of the plan's estimates. This transparency safeguards analytic integrity and helps ensure that decisions about financing are grounded in verifiable evidence. Comparability strengthens this further by enabling clear, side-by-side analyses of the proposed financing model versus existing systems, such as comparing taxes to current insurance premiums at the household or business level. By enabling a direct comparison of cost burdens and benefits, comparability helps stakeholders understand trade-offs and evaluate whether the new system provides greater fairness, affordability, and value.

Guiding questions to consider while evaluating the plan's level of clarity and transparency are summarized below by criteria in Exhibit 1.

Exhibit 1. Evaluation Criteria for UHP Clarity and Transparency

Criteria	Guiding Question(s)
Comprehensibility	Can the plan's structure be explained with clear visuals or summaries?
Documentation	Are revenue sources, tax bases, and assumptions fully documented and publicly available?
Traceability	Are data sources and modeling methods disclosed, cited, and replicable?
Comparability	Does the proposal provide a side-by-side comparison with the existing system (e.g., taxes vs. premiums) at the household or business level?

Equity and Progressivity

A universal health plan must demonstrate that its financing model reduces disparities rather than reinforcing them. To evaluate the equity of the plan, the structure must be progressive and based on ability to pay. A progressive financing model requires higher-income households to contribute proportionally more, aligning contributions with economic capacity. This principle ensures that the financial burden is distributed equitably and that the UHP supports broad access to care across all income levels. By fully covering medically necessary services, the plan also aims to eliminate medical debt for covered services, thereby reducing financial hardship for lower-income households.[6]

Evaluating equity requires robust metrics, such as effective tax rates and incidence models, to understand how contributions vary across income groups and business types. These tools help identify which households and employers would bear greater or lesser financial responsibility under the proposed financing model compared to the current system.

There are three key metrics for evaluating the equity and progressivity of the plan:

1. Distributional analysis,
2. Progressivity metrics,
3. Inclusivity.

Exhibit 2 pairs each metric with a guiding question to be considered during the evaluation. Together, these criteria assess whether the financing model meaningfully enhances fairness and reduces disparities.

Exhibit 2. Evaluation Criteria for UHP Equity and Progressivity

Criteria	Guiding Question(s)
Distributional Analysis	Has a formal distributional analysis (e.g., by income quintile) been completed?
Progressivity Metrics	Are measures such as effective tax rates or incidence models used to assess fairness?
Inclusivity	Does the revenue system account for non-traditional income sources or wealth indicators?

Fiscal Stability and Permanence

Revenue sources must be stable, predictable, and sustainable across economic cycles. Evaluating the resilience of revenue sources requires assessing how each respond to recessionary pressures, unemployment shifts, or fluctuations in business profitability. Revenue diversification helps mitigate volatility by reducing reliance on any single economic driver. A stable system is one that continues to support uninterrupted access to health care without requiring frequent legislative intervention or sudden budget adjustments.

Fiscal permanence also depends on predictable year-over-year revenue performance, supported by clear statutory frameworks and mechanisms for reserve accumulation. Predictability allows the UHP to plan for expenditures with confidence and maintain provider payments and service quality over time. Long-term sustainability requires evaluating whether revenue sources can keep pace with health care cost growth and population changes. The goal is to ensure that financing mechanisms remain viable decades into the future, not only at the moment of implementation.

There are four key components needed for evaluating the stability and permanence of the plan:

1. Volatility Analysis,
2. Diversification,
3. Elasticity, and
4. Contingency Planning.

Exhibit 3 captures guiding questions associated with the key components for evaluating the fiscal stability and permanence of the plan. Together, these criteria clarify whether the financing model can expand over time, accommodate new demands, and adjust to future conditions without jeopardizing financial stability or operational effectiveness. By assessing these elements, the Board can evaluate whether the UHP financing structure is sufficiently resilient to evolve alongside Oregon's health care needs.

Exhibit 3. Evaluation Criteria for UHP Fiscal Stability and Permanence

Criteria	Guiding Question(s)
Volatility Analysis	Does the proposal include stress testing or performance modeling under recession and boom scenarios? Are there way to address volatility? How can the Committee make up for times when stability is less than ideal?
Diversification	Are multiple revenue streams proposed to mitigate reliance on a single economic sector?
Elasticity	How responsive are the tax bases to long-term economic and demographic trends?
Contingency Planning	Are rainy-day reserves or automatic adjustment mechanisms (e.g., rate bands) included?

Scalability and Flexibility

Financing must support phased implementation and system evolution. By ensuring scalability in the UHP, the financing structure can support phased implementation, allowing the state to roll out components of the plan in a way that minimizes disruption and manages operational risk. A scalable UHP design helps to create a health care system that can handle increases in enrollment, changes in utilization patterns, and the incorporation of new services without compromising fiscal integrity or service quality.

Flexibility is equally critical, given the constant evolution of health care delivery, population needs, and economic conditions. The financing model must be able to adjust without requiring fundamental restructuring. Flexible systems incorporate mechanisms that allow for periodic assessment and recalibration of revenue sources, reimbursement rates, and cost-containment strategies. This adaptability helps the UHP remain functional and effective in an environment that has consistently shifting supply and demand needs.

There are four key criteria for evaluating the scalability and flexibility of the UHP:

1. Phase alignment,
2. Adaptability,
3. Modularity, and
4. Fallback scenarios.

Together, these criteria create a financing framework capable of supporting both immediate implementation and ongoing system improvement. Exhibit 4 pairs each criterion for evaluating scalability and flexibility with a guiding question to consider throughout the UHP implementation process.

Exhibit 4. Evaluation Criteria for UHP Scalability and Flexibility

Criteria	Guiding Question(s)
Phase Alignment	Are funding milestones aligned with expected implementation phases and service expansion?
Adaptability	Can the funding approach be adjusted as new populations, services, or technologies are added?
Modularity	Can specific funding streams be activated independently for pilot programs or partial rollouts?
Fallback Scenarios	Does the proposal identify contingencies if implementation timelines shift or if uptake varies?

Legal Viability

Financing must be resilient to legal challenges, particularly under federal ERISA law. ERISA is a central consideration, as states must design employer-related financing mechanisms carefully to avoid triggering federal preemption. Ensuring contributions are structured in

ways that comply with existing legal standards strengthens the durability of the plan and reduces risks of litigation that could delay implementation.

Additional legal considerations include state constitutional requirements, statutory authority, administrative rulemaking, and fiscal governance frameworks. Clear legislative language and robust governance structures provide the legal foundation for administering the plan effectively over time. Anticipating potential legal challenges and developing defensible policy structures enhances long-term stability and public confidence.

There are four key components needed for evaluating the legal viability of the plan:

1. ERISA analysis,
2. Employer neutrality,
3. Precedent review, and
4. Alternative structures.

Exhibit 5 captures guiding questions associated with the key components for evaluating legal viability. These criteria help determine whether the financing model is legally sound, appropriately authorized, and protected against challenges. Together, they indicate whether the UHP can be implemented and sustained within established legal frameworks.

Exhibit 5. Evaluation Criteria for UHP Legal Viability

Criteria	Guiding Question(s)
ERISA Analysis	Has a legal analysis been conducted to determine compliance with ERISA and other federal statutes?
Employer Neutrality	Are revenue mechanisms structured as taxes or assessments that avoid direct mandates on employers?
Precedent Review	Does the proposal incorporate lessons from other states or legal rulings?
Alternative Structures	Are backup financing pathways available if a primary mechanism is successfully challenged?

Dedicated Health Care Trust Fund

In alignment with the Joint Task force recommendations to establish a public trust fund that is distinct from Oregon's General Fund, the UHP should be evaluated to ensure funds are isolated from the general fund and used only for health care.[6] This separation enhances transparency, builds public trust, and safeguards the financial integrity of the plan. In addition, the fund allows for consolidation of federal and state-generated revenues, along with contributions from employers and households. Federal funds may include, but are not limited to, Medicare, Affordable Care Act subsidies, Medicaid, and CHIP contributions and revenues that the legislature designates specifically for implementing and supporting the UHP.[6]

Long-term stability also requires the trust fund to support reserve accumulation, enabling the plan to withstand economic downturns or unexpected expenditure spikes. Oregon's "kicker" provision may complicate this process, particularly because pieces of the UHP's proposed personal income tax may be subject to the "kicker" provision. Considerations should be given to determining how the UHP will acquire the reserves needed to withstand changes to expenditures and revenues.[6]

There are four key components needed for evaluating the dedicated health care trust fund:

1. Fund structure,
2. Revenue flow,
3. Oversight mechanism,
4. Firewalls, and
5. Legal question.

Exhibit 6 captures guiding questions associated with the key components for evaluating the trust fund. These criteria clarify whether the financing model ensures strong stewardship of funds, supports transparency, and allows for reserve accumulation. Together, they reflect the financial foundation of the UHP and the mechanisms required to maintain stability over time.

Exhibit 6. Evaluation Criteria for UHP's Dedicated Health Care Trust Fund

Criteria	Guiding Question(s)
Fund Structure	Is a statutory trust fund with fiduciary safeguards proposed?
Revenue Flow	Are inflows from each revenue source tracked separately within the fund?
Oversight Mechanism	Is an independent body tasked with monitoring fund use, investments, and disbursements?
Firewalls	Are legal or constitutional restrictions proposed to prevent diversion of funds to non-healthcare uses?
Legal question	Can we raise revenue (income tax) not subject to the kicker?

Optimization of Federal Funds

Based on the key assumptions proposed by the Committee, the UHP should maximize federal contributions and avoid funding or eligibility cliffs. Federal waivers are essential for securing funds for the UHP public trust fund.[6] Waivers of federal requirements may allow the UHP to incorporate Medicare, Medicaid or ACA funds into its structure.[14] For example, federal waiver 1115 is a Medicaid waiver that offers states an avenue to test new approaches to Medicaid that differ from federal statute. Additionally, Section 1332 of the Affordable Care

[14] Legislative Policy and Research Office. "Joint Task Force on Universal Health Care: Final Report and Recommendations." Oregon.gov. 2022. https://www.oregon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20Oct%202022.pdf.

Act (ACA) allows states to apply for a "State Innovation Waiver," to pursue new strategies for providing residents with access to health insurance while retaining basic protections of the ACA. [15]

There are four key criteria for evaluating the optimization of federal funds:

1. Federal leverage,
2. Waiver strategy,
3. Cliff avoidance, and
4. Coordination.

Exhibit 7 captures guiding questions associated with the key components for optimizing federal funds. These criteria help evaluate whether the financing model captures all available federal revenue, minimizes inefficiencies, and supports coordinated program design.

Exhibit 7. Evaluation Criteria for UHP's Optimization of Federal Funds

Criteria	Guiding Question(s)
Federal Leverage	Does the proposal identify and incorporate all major federal funding streams (e.g., Medicaid, Medicare, CHIP, ACA subsidies)?
Waiver Strategy	Are federal waivers (e.g., 1115, 1332) sought or assumed to enable integration or redirection of funds?
Cliff Avoidance	Has the proposal modeled transition points to avoid sudden losses in benefits or large tax jumps at specific income thresholds?
Coordination	Are state and federal tax and benefit interactions analyzed to prevent duplication or unintended cost shifts?

Comprehensive and Broad-Based Revenue Model

Funding must reflect the full cost of the plan and be drawn from a diverse set of sources. A broad-based approach, drawing on multiple revenue sources, reduces vulnerability to economic fluctuations and enhances equity. This inclusive framework ensures that households and employers contribute in a manner aligned with ability to pay.

Clarity and predictability in revenue administration are equally important. A well-structured regulatory environment ensures transparency in how revenues are collected and managed and supports the plan's ability to build reserves. Adaptability to changing economic or demographic conditions is also necessary to maintain financial viability over time.

There are four key components needed for evaluating a comprehensive revenue model:

1. Cost coverage,

[15]KFF. 2025. "Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State." KFF. 2025. https://www.kff.org/medicaid/medicaid-waiver-tracker-approved-and-pending-section-1115-waivers-by-state/.

2. Revenue mapping,
3. Base breadth, and
4. Reserve planning

Exhibit 8 captures guiding questions associated with these components. Together, the criteria help determine whether the revenue model is sufficiently robust, equitable, and administratively sound to support long-term UHP operations. They provide the foundation for assessing the financing system's ability to reliably and transparently fund the plan.

Exhibit 8. Evaluation Criteria for UHP's Revenue Model Comprehensibility and Broad-Base

Criteria	Guiding Question(s)
Cost Coverage	Does the proposal account for all operational, administrative, and start-up costs, including IT systems and outreach?
Revenue Mapping	Are all potential sources (e.g., payroll taxes, individual income taxes, business assessments, provider fees) explored?
Base Breadth	Are proposed tax bases large and inclusive enough to ensure low rates and revenue resilience?
Reserve Planning	Is there an initial capitalization plan, and are reserves or stabilization funds included?

Economic Neutrality and Efficiency

Funding must reflect the full cost of the plan and be drawn from a diverse set of sources. Economic neutrality ensures that the financing model does not distort economic behavior or impose disproportionate burdens on specific industries or populations. A neutral system maintains fairness by minimizing disincentives for work, hiring, or business expansion. This principle is critical in transitioning from insurance premiums to tax-based financing without creating unintended economic impacts.

Efficiency emphasizes reducing administrative burdens and maximizing the share of revenue dedicated directly to health care services. Streamlined financing structures reduce overhead costs for employers, providers, and the state. A more efficient system enables resources to be spent on care delivery rather than administrative processing, improving both economic outcomes and patient experience.

There are four key components needed for evaluating economic neutrality and efficiency:

1. Dynamic modeling,
2. Migration effects,
3. Interaction with tax preferences, and
4. Neutrality tests.

These elements help determine whether the financing model supports a stable economic environment, minimizes unnecessary administrative complexity, and distributes responsibilities fairly across stakeholders. Exhibit 9 pairs a guiding question with each criterion, together they ensure that the UHP operates efficiently and equitably while promoting overall economic well-being.

Exhibit 9. Evaluation Criteria for UHP Economic Neutrality and Efficiency

Criteria	Guiding Question(s)
Dynamic Modeling	Has the impact of the proposal on employment, wages, business costs, and productivity been modeled?
Migration Effects	Are risks of individual or business relocation assessed, particularly at key income or profit thresholds?
Interaction with Tax Preferences	Does the proposal account for the potential loss of federal tax exclusions for employer-sponsored insurance?
Neutrality Tests	Has the proposal been evaluated for distortions to labor supply, retirement timing, or employer behavior?

Lifecycle Review Framework

A lifecycle review framework provides the structure necessary to monitor, assess, and recalibrate the Universal Health Plan's financing strategy over time. Because the UHP is designed to evolve alongside Oregon's broader health system transformation, an ongoing review process ensures that financing mechanisms continue to align with the guiding principles established by the Committee, clarity, equity, fiscal stability, legal durability, and efficiency. This framework creates a continuous feedback loop that evaluates performance against expectations and adapts funding strategies based on new information, emerging risks, and stakeholder experience.

At its core, the lifecycle review process operationalizes the nine evaluation criteria by using them as checkpoints for assessing whether the financing model remains sustainable, transparent, equitable, and compliant with legal and regulatory constraints. Regular review cycles would examine the stability of revenue streams across economic conditions, the performance of federal funding interactions and waivers, and the integration and sufficiency of the dedicated trust fund. The framework also enables assessment of system scalability as the UHP phases in new populations or benefits and helps determine whether the financing model continues to support flexible implementation without undermining fiscal discipline.

Finally, the lifecycle review framework institutionalizes accountability by embedding regular reporting, stakeholder consultation, and data-driven recalibration into the governance of the UHP. This ensures that policymakers, the UHP Governing Board, and the public can trace how financing decisions are made and understand the rationale behind adjustments. By systematically evaluating outcomes relative to expectations, such as equity impacts, economic neutrality, administrative efficiency, and alignment with legislative intent, the lifecycle framework provides the tools to refine the plan over time. Ultimately, it helps

safeguard the UHP's long-term viability while reinforcing the values of transparency, responsiveness, and continuous system improvement.

Revenue Design and Legal Compliance

To evaluate the durability of financing options for Oregon's Universal Health Plan (UHP), the Finance and Revenue Committee assessed a range of funding mechanisms, including payroll, income, provider, gross receipts, and consumption-based taxes. Throughout the evaluation, any design needed to fit within the federal regulatory framework governing employer-sponsored insurance, particularly the Employee Retirement Income Security Act (ERISA). This was essential because employer-sponsored insurance is the largest source of private health coverage in Oregon, making ERISA a central consideration in determining viable financing strategies.

Legal Constraints

ERISA preempts state laws that relate to employer benefit plans, which limits how states may access employer health care spending. This constraint challenges the development of a publicly financed health system, as employer contributions are typically needed to replace current private spending. Oregon must therefore design policy tools that do not regulate employer benefit decisions or pressure employers to modify or eliminate existing coverage.

Recent Supreme Court rulings clarify that state laws with indirect economic effects on employer plans do not necessarily trigger preemption when they do not dictate plan structure or coverage. This flexibility allows Oregon to pursue revenue options grounded in general taxation and state-level regulation of the insurance and health care sectors, rather than mechanisms tied directly to employer benefit choices.[16]

Legal Risk Mitigation

National research on state universal health plans consistently identifies ERISA preemption as the most significant legal barrier to state-level health system reform. Oregon's strategy for the Universal Health Plan should therefore be shaped by several key considerations. First, court decisions interpreting ERISA distinguish between permissible state actions, such as general taxation and regulation of the insurance market, and impermissible actions that directly regulate employer-sponsored benefit plans.[17] Understanding this distinction is critical to designing revenue mechanisms and regulatory structures that avoid triggering preemption. Second, ERISA contains no waiver authority, meaning Oregon must work entirely

[16] Bulleit, Thomas N., Margaux J. Hall, Harvey D. Cotton, Christopher M. Gillis, and Samuel Perrone. "Rutledge vs. PCMA: SCOTUS Greenlights State Regulation of Pharmacy Benefit Manager Drug Reimbursement." Ropes & Gray 2021. https://www.ropesgray.com/en/insights/alerts/2021/01/rutledge-vs-pcma-scotus-greenlights-state-regulation-of-pharmacy-benefit-manager-drug-reimbursement; Rutledge v. PCMA. 141 S. Ct. 474 (2020).

[17] Employment Retirement Income Security Plan (ERISA) Statute (29 U.S.C. Chapter 18). https://www.law.cornell.edu/uscode/text/29/chapter-18.

within the statute's existing limitations when developing the UHP.[17] Third, experiences from other states offer important lessons. Vermont's Green Mountain Care and Washington's Universal Health Care Work Group both identified ERISA-related constraints as major obstacles to advancing comprehensive public financing systems, demonstrating the need for careful legal design from the outset.[18, 19] Collectively, these insights form the foundation for constructing an ERISA-conscious approach to UHP financing and implementation.

A consistent note throughout all UHP planning has been that Oregon needs a financing structure that is resilient to legal challenge and aligned with the statutory direction to build an affordable, publicly funded universal system. An ERISA-conscious financing framework includes three core components:

1. A broad-based employer payroll tax applied as general revenue,
2. Restrictions on duplicative insured products to maintain the UHP as the comprehensive statewide plan, and
3. Provider participation and reimbursement rules enabling coordination with employer-funded coverage while avoiding regulation of employer benefit design.

Together, these elements reflect the Committee's assessment of legally viable mechanisms and align with national research on feasible approaches to state-level universal health care. These elements align with elements proposed in the Joint Task force report on Universal Health Care Plan in June 2022.

PAYROLL TAX CONSIDERATIONS

A uniform employer payroll tax remains one of the more viable revenue mechanisms available to Oregon under ERISA that also helps avoid the economic harm due to the loss of federal tax expenditure for employer-sponsored health insurance. Research evaluating state options indicates that payroll taxes avoid ERISA preemption when they apply to all employers and do not depend on the employer's decision to offer or structure health benefits. This is because a general tax of broad applicability does not constitute regulation of an employer-sponsored plan and does not interfere with plan administration or benefit design.

For the UHP proposal, the payroll tax is structured as a general revenue measure rather than a substitute for providing health benefits. This distinction is important because taxes designed as alternatives to employer coverage have historically been viewed by courts as exerting impermissible pressure on employer benefit decisions. The tax must also not be set at a level that effectively forces employers to drop coverage, modify benefits, or otherwise change their plan offerings, as such effects could materially increase preemption risk. Oregon's fiscal modeling work has shown that employer participation is essential to replacing

[18] Green Mountain Care Board. "About GMCB." Vermont.gov. 2025. https://gmcboard.vermont.gov/gmcboard/doc/gmcboard/doc/gmcboard/doc/board.

[19] Healthcare for All Washington. "2025 Legislative Successes." HCFA WA. 2025. https://www.hcfawa.org/current_legislation.

current private-sector health care spending, and a generally applicable payroll tax provides a mechanism to collect that revenue while decreasing the risk of triggering legal conflict. Because ERISA does not include a waiver pathway, Oregon's payroll tax must rely solely on permissible state taxing authority.

COVERAGE DUPLICATION

Oregon holds authority to regulate insurers operating within the state, and this authority provides an opportunity to limit the sale of health insurance plans that duplicate benefits included in the Universal Health Plan. Under ERISA, state regulation of insurers is explicitly protected, meaning that states may define which insured products may or may not be offered within their markets. Governance Board materials indicate that restricting duplicative insured coverage is a central design feature intended to maintain the UHP as the comprehensive statewide benefit while reducing administrative complexity and fragmentation.

These restrictions, however, must apply only to insured products and not to self-funded employer plans. Self-funded plans fall under exclusive federal regulation and cannot be restricted or prohibited by state law. This distinction ensures legal compliance while acknowledging that employers may continue offering self-funded duplicative or supplementary coverage if they choose.

Regulating duplicative insured products also supports the financial sustainability of the UHP. By ensuring that the public plan remains the primary comprehensive coverage source for benefits defined in statute, Oregon can reduce segmentation and premium-driven risk selection. This approach aligns with state authority and experiences in other universal coverage efforts, such as those in Vermont and Washington, which highlight the importance of clearly distinguishing between state-regulated insured plans and federally protected self-funded employer plans.[18, 19]

PROVIDER PARTICIPATION AND REIMBURSEMENT

State authority over providers is broad, giving Oregon flexibility to design participation and reimbursement structures that support the Universal Health Plan while avoiding ERISA-related constraints. Oregon may establish reimbursement rules requiring the UHP to recover costs from employer-funded coverage when that coverage functions as the primary payer. Such coordination rules are rooted in the state's general regulatory authority over providers and do not constitute regulation of employer-provided benefit plans, making them legally durable.

Oregon may further consider allowing providers to join the UHP on a voluntary but exclusive basis, under which participating providers agree not to contract with other insured products offered in the state. Because participation would be voluntary and directed at providers rather than employers, this approach is viewed as generally permissible under ERISA so long as it does not condition provider participation on employer benefit behavior.

Primary-payer rules and provider alignment strategies require clear reimbursement coordination to prevent disproportionate shifts in costs from current employer plans and the UHP. A well-defined participation and reimbursement framework ensures consistent payment rules, supports financial stability, and strengthens integration across Oregon's health system. When paired with uniform taxes and insurance market regulation, provider policy design forms the final of the three legally viable pillars supporting Oregon's UHP financing structure.

2. The Revenue Proposal Framework

Introduction

This chapter lays out the framework of the Finance and Revenue Committee's UHP revenue proposal. The main component of the Committee's UHP recommendation is described in Chapter 3, which presents a tax plan to fund "ongoing" annual UHP expenses. Chapter 3 discusses the specific parameters for the ongoing revenue plan and describes in concrete terms how the proposal will impact individuals and businesses in Oregon.

Chapter 4 delineates the key issues surrounding the funding of "one-time" UHP costs to start up the program. The chapter focuses on lessons learned from public fund creations in comparable large-scale program launches in recent history at the federal and state levels. This chapter establishes the logic, structure, and constraints of the Committee's recommended revenue framework, providing the context needed to interpret the detailed tax design in Chapter 3 and the start-up strategy in Chapter 4.

The UHP revenue proposal described in this report, developed with ECOnorthwest's assistance and expertise, reflects the Committee's deliberations on how to equitably, sustainably, and realistically fund a universal, publicly administered health care system. Not by creating new net financial obligations, but by redirecting and restructuring existing health care spending in a more transparent and equitable funding model.

Revenue Design Premises

A central premise of the Committee's work is that Oregon does not need to raise health care funding "from scratch" in order to implement a Universal Health Plan. Healthcare in Oregon is already extensively financed through a fragmented combination of employer-sponsored insurance contributions, individual premiums, household out-of-pocket spending, and state and federal public programs, including Medicare and Medicaid.

The Committee's proposed financing model builds on this existing multi-payer landscape by consolidating these payments into a unified framework. In doing so, it replaces a haphazard and administratively complex system with a more coherent single-payer structure that provides universal benefits more efficiently and equitably.

The Committee recognizes that the proposal is not a strict *Pareto* improvement relative to the current system: some households and firms will contribute more under the UHP than they do today. However, in the aggregate, the proposal comes close to that standard. The Committee's analysis indicates that a substantial majority of individuals and businesses would be financially better off under the UHP than under the status quo, while also benefiting from improved coverage stability and health outcomes.

At a system level, the proposal is designed to decouple health care access from employment, improve predictability of health care costs for businesses, and reduce total health care spending through administrative simplification and economies of scale. By eliminating redundancies inherent in the multi-payer system and enabling greater bargaining power in the procurement of drugs and medical services, the UHP also creates the conditions to moderate long-term health care cost growth, even as broader federal reforms continue to evolve.

Design Objectives

The Committee's analysis and deliberations were guided by three core design objectives, which served as the evaluative framework for assessing alternative revenue mechanisms and parameter choices:

Economic Objectives

- Achieve universal health care coverage for all Oregonians
- Capture administrative efficiencies and economies of scale from a single-payer system
- Decouple health care coverage from employment
- Help contain long-term health care cost growth

Financial Objectives

- Preserve federal Medicare and Medicaid funding streams
- Maintain existing Oregon corporate income tax deductibility benefits
- Ensure revenue adequacy, financial sustainability, and administrative feasibility

Legal Objectives

- Avoid ERISA preemption by relying on broad-based, non-employer-specific levies and universal coverage mandates

From both a financial and legal standpoint, the proposal is structured to preserve existing federal health care pathways. Seniors would continue to qualify for Medicare through the Social Security Administration and would continue paying Medicare Part B (and, where applicable, Part A and IRMAA premiums). To avoid double payment, the proposal includes a non-refundable Oregon health care tax credit for Medicare Part B premiums paid by beneficiaries.

Similarly, lower-income Oregonians would continue to qualify for Medicaid under existing state and federal rules, allowing Oregon to retain federal matching funds while integrating Medicaid recipients into the broader UHP benefit structure.

Distributional Impacts and Equity Adjustments

A central element of the Committee's mandate was to assess the distributional effects of the UHP revenue plan and ensure that the financing structure aligns with the Board's equity and affordability objectives. The Committee developed and refined the proposal through an iterative process anchored by two complementary workstreams:

- **Tax Incidence and "Pre/Post" Analysis.** The Committee evaluated how contributions change under the proposal relative to the status quo for households and employers. For households, analysis examined outcomes across income levels and household types, including key distinctions such as income decile, employment arrangement (employed versus self-employed), and Medicare status. For businesses, analysis focused on how outcomes vary by employer size (primarily payroll scale).
- **Equity and Affordability Design Features.** The Committee tested and incorporated a set of practical adjustment mechanisms—such as credits, exemptions, phase-ins, and other structural features—to improve affordability for lower- and middle-income households, maintain broad-based participation, and support reasonable contribution expectations across the income distribution.

Chapters 3 and 4 summarizes the Committee's principal distributional findings and describes how these analytic results informed the final set of recommended parameters and equity-focused design features.

Start-Up Costs and Reserves

Chapter 5 analyzes the other two kinds of cost the UHP will need to provide for – the "one-time" start-up/transition costs and the costs of capitalizing the system's operating reserve. Specifically, the chapter highlights the following considerations the Board's submission must consider.

- **Reserve Requirements:** Sizing early-year reserves to ensure solvency and payment stability.
- **Up-Front Infrastructure Costs:** Administrative, IT, marketing, staff, and oversight expenditures.
- **Pre-Funding Options:** Bridge financing strategies, such as state appropriation or state loan, pre-collecting or temporarily increasing a dedicated tax, federal waivers, and other mechanisms.
- **Risks and Contingency Planning:** Disruption scenarios and fallback provisions.

Chapter 4 also collates a series of important lessons learned from several recent program implementation comparators of relevance for Oregon's UHP.

Calibrating the Revenue Framework to Plan Costs and Replacement Funding

The Finance & Revenue Committee's work to date has focused on defining a sound and internally consistent revenue structure, using the most recent year with complete and reliable data at the time the analysis started—tax year 2022—as a common analytical baseline. This approach allowed the Committee to evaluate the relative performance of different revenue instruments, assess distributional impacts, and test design features using a single, transparent calibration year.

Importantly, the Committee's work at this stage was structural rather than forward budgetary. The revenue proposal is calibrated to 2022 conditions to demonstrate how a coherent financing system could replace existing health care spending and support a universal benefit, not to establish final tax rates or revenue levels for the first year of UHP operations.

As the UHP Governance Board moves toward implementation, several interrelated components will need to be recalibrated from this 2022 baseline to the anticipated first year of operations (currently assumed to be 2032):

1. The cost of the UHP benefit in the first year of implementation, and
2. The amount of existing health care spending that the UHP revenue system is intended to replace or redirect in that year.
3. Payroll and income (and distribution), both individual and business.

Current-System Spending and the Replacement Funding Target

A central concept underlying the Committee's work is the distinction between total UHP plan costs and the replacement funding target. The replacement funding target represents the amount of health care spending already occurring in Oregon's economy that would be supplanted by UHP financing, modified by changes expected with the UHP. This includes, most notably:

- Employer and employee contributions toward employer-sponsored insurance (ESI),
- Individual premium payments, such as ACA Marketplace premiums,
- Certain household out-of-pocket expenditures,
- Additions due things such as to more people being covered, perhaps more services being covered, and no or minimal out-of-pocket expenditures for most services, and
- Subtractions due things such as administrative simplification, monopsony purchasing, and fraud reduction.

The Committee's revenue framework is designed first and foremost to replace these existing payment streams, rather than layer new net costs on top of the current system. In this sense, the revenue proposal answers the question: How can Oregon redirect what it already spends on health care into a single, publicly administered system in a more equitable and efficient way?

Current Health Care Funding in Oregon: Baseline for Revenue Replacement Analysis

Oregon's health care system is already supported by a large and diverse set of public, private, and household funding streams. Understanding the scale and composition of this existing funding is essential for evaluating the UHP replacement funding target—that is, the amount of current health care spending that would be redirected into a unified financing system under the UHP.

The Joint Task Force on Universal Health Care developed a relatively comprehensive baseline of health care expenditures using calendar year 2019 data, which was subsequently redone by the Finance and Revenue Committee to inform 2022-era analysis. These estimates capture the major payer categories that finance health care services in Oregon today, including employer-sponsored insurance, individual premiums, Medicare, Medicaid, out-of-pocket spending, and other public and charitable programs. In aggregate, baseline health care spending included in the UHP modeling totals approximately $38.7 billion (2019 dollars), including certain services not contemplated for inclusion in the UHP benefit, such as state hospitals, corrections and public health, as seen in Exhibit 10 below.

A substantial share of this spending is associated with employer-sponsored insurance and other employment-linked coverage arrangements, underscoring the degree to which health care financing in Oregon is currently tied to employment. Federal programs (particularly Medicare and Medicaid) also represent a large portion of total expenditures and are assumed, under the UHP framework, to continue flowing to Oregon subject to federal approval and possible waiver authority or other methods.

From a financing perspective, these existing funding streams define the baseline for the replacement funding target for the UHP. Rather than financing the full cost of the UHP as an entirely new expenditure, the revenue framework developed by the Finance & Revenue Committee is designed to replace and restructure these existing payments, redirecting them into a single, publicly administered trust fund. The intent is that out-of-pocket expenditures and expenditures that flow through private insurers will not continue, and so will be generally replaced by new or modified revenue mechanisms. There will be both new expenditures and savings that lead to adjustments described below in "Accounting Framework for Cost Target."

Exhibit 10: Current Health Care Spending by Funding Source in Oregon

Coverage / Expenditure Type	Expenditures ($M)			Notes on Funding Conditions
	2019 Dollars	2022 Dollars	2026 Dollars	
Out-of-Pocket (OOP)	**$3,782**	**$4,287**	**$6,020**	
Out-of-Pocket (OOP) without non-durables	$3,075	$3,335	$5,068	
Health Insurance	**$30,572**	**$35,829**	**$42,828**	
Private Health Insurance	**$14,318**	**$15,999**	**$15,999**	
Employer sponsored	**$12,422**	**$14,171**	**$14,171**	
Private & non-PEBB/OEBB Public	$9,992	$11,521	$11,521	
PEBB & OEBB	$1,876	$2,073	$2,073	
Federal	$554	$577	$577	
Individual	**$1,143**	**$1,173**	**$1,173**	
Market (Exchange)	$820	$908	$908	
Other	$322	$265	$265	
Medigap	**$501**	**$435**	**$435**	
Medicare Advantage not from CMS	**$252**	**$220**	**$220**	
Public Programs	**$16,254**	**$19,830**	**$24,419**	
Medicare	$8,716	$9,533	$10,065	
Medicaid (Title XIX)	$7,089	$9,638	$13,696	
CHIP (Title XIX and Title XXI)	$448	$604	$604	
HOP and CAK	$0	$55	$55	
DOD	$549	$588	$588	*A portion of these funds are spent on providers in the general public system.*
Department of Veterans Affairs	$1,422	$1,822	$1,822	
Other Third Party Payers	**$2,500**	**$3,078**	**$3,956**	
Worksite Health Care	$96	$109	$109	*These funds are for independent health services that may or may not continue*
School Health	$79	$93	$93	
Workers' Compensation	$356	$391	$391	*These funds are spent on providers in the general public system.*
Other Private Revenues	$2,034	$1,916	$1,916	
Auto, Property, & Casualty	$469	$391	$435	
General Assistance	$81	$88	$88	*These funds are from the state government and may be affected by UHP*
Non-Medicaid HSD (Other State/Local)	$208	$555	$555	
Maternal/Child Health	$24	$25	$25	*A portion of these funds are spent on providers in the general public system.*
Vocational Rehabilitation (Medical Portion)	$8	$8	$8	
Other Federal Programs	$180	$429	$429	
SAMHSA	$47	$145	$145	
Indian Health Services	$196	$196	$196	
Not part of UHP	**$1,825**	**$3,177**	**$3,177**	
State Hospital	$298	$362	$362	
Corrections	$141	$173	$173	
Public Health	$1,387	$2,641	$2,641	
Total Baseline Health Care Expenditures	**$38,680**	**$46,371**	**$55,981**	

Source: National Health Expenditure Accounts, Finance and Revenue Committee
Notes: Enrollment figures are adjusted to avoid double-counting due to dual eligibility across programs. Out-of-pocket costs for services not contemplated under the UHP benefit are included. Non-post acute Long-term Services and Supports (LTSS) are excluded. Totals may not sum due to rounding.

From Baseline Health Care Spending to the UHP Cost Target

Exhibit 10 summarizes current health care spending in Oregon by funding source, expressed in 2022 dollars. Total baseline expenditures included in the Universal Health Plan (UHP) modeling are approximately $46.4 billion, reflecting the combined cost of employer-sponsored insurance, individual premiums, federal and state public programs, and household-based spending in Oregon's existing multi-payer system.

This baseline does not represent the cost of a universal system. Instead, it provides the empirical foundation from which the Finance & Revenue Committee derived a counterfactual cost target for the UHP—defined as the cost of providing universal, PEBB+ coverage to all Oregonians under a single-payer structure.

Rather than attempting to calculate UHP costs directly from unit prices and utilization rates, the Committee adopted an accounting-based approach (using the Joint Task Force and Optumas methodology as a foundation) that adjusts observed current spending to reflect the key structural differences between the status quo and a universal system.

Accounting Framework for the UHP Cost Target

Starting from total current-system spending, the UHP cost target is derived by applying a series of conceptual adjustments that reflect both efficiencies gained under a single-payer model and costs associated with expanded coverage and benefits:

UHP Estimated Total Expenditure = (Private Insurance Expenditures + Applicable Out-of-Pocket Spending) – Administrative Efficiency Savings + Cost of Covering Uninsured Populations + Cost of Benefit Standardization to PEBB+ Standard

---

Step 1: Baseline Health Care Spending. As shown in Exhibit 10, total baseline health care expenditures included in the UHP modeling equal $46.4 billion (2022 dollars). This represents both private insurance expenditures and applicable out-of-pocket spending under the current multi-payer system and serves as the starting point for estimating the cost of a universal system.

Step 2: Administrative Efficiency Savings. A universal, publicly administered health care system eliminates many duplicative administrative functions inherent in the current multi-payer structure, including marketing, underwriting, enrollment, provider contracting, and claims processing across multiple insurers. Consistent with the Committee's direction for illustrative modeling, an 8 percent administrative efficiency capture is applied to baseline spending. This assumption reflects provider-side and system-wide efficiencies achievable under a single-payer model and reduces total spending relative to the status quo.

Step 3: Coverage Expansion. Under the UHP, coverage is extended to individuals who are currently uninsured or underinsured. Based on Joint Task Force estimates, this includes

approximately 314,000 additional people who would receive comprehensive health coverage under a universal system. The cost of covering these additional individuals is added to the baseline after efficiency savings are accounted for, reflecting increased utilization and service access relative to the status quo.

Step 4: Benefit Standardization to PEBB+. The current system provides widely varying benefit levels depending on coverage source. The UHP cost target assumes a uniform PEBB-plus benefit standard, which entails:

- Raising coverage for individuals currently enrolled in plans with lower actuarial value,
- Adding dental benefits for populations that do not currently receive them, and
- Expanding and standardizing behavioral health benefits across the entire population.

These benefit enhancements represent a deliberate policy choice embedded in the UHP design and increase total system costs relative to current spending.

Taken together, these adjustments define the cost of a counterfactual universal PEBB+ health care system in Oregon. This cost target represents the total annual funding required to operate the UHP at the proposed benefit level, before accounting for which portions of that cost are financed through redirected existing spending versus new state revenue.

From the UHP Plan Cost Target to the Revenue Replacement Target

Once the UHP Plan Cost Target was established, the Finance & Revenue Committee's next task was to determine how much state-level revenue must be raised to replace health care payments that would no longer occur under a Universal Health Plan. The Committee refers to this amount as the **Revenue Replacement Target.**

Importantly, the Committee did not frame the UHP financing challenge as raising the full cost of the universal system from scratch. Instead, it assumed that a significant share of current health care funding would either be preserved (e.g., Medicare and Medicaid) or eliminated and replaced (e.g., private premiums and out-of-pocket payments). The Committee therefore focused on identifying the net amount of revenue that must be replaced through new state taxes.

SPENDING ELIMINATED UNDER A UHP

Under a UHP, several categories of current health care spending would no longer occur in their present form. These include:

- Employer contributions to employer-sponsored insurance (ESI),
- Employee contributions to ESI,
- Individual insurance premiums such as ACA Marketplace premiums, and

- Household out-of-pocket expenditures for services covered by the UHP.

Together, these payments represent existing dollars already being paid by Oregonians that would be redirected into the UHP financing system rather than continuing as fragmented private payments.

FUNDING PRESERVED UNDER A UHP

At the same time, the Committee assumed that major public funding streams would continue to support health care under the UHP, subject to federal approval. These preserved sources include:

- Medicare payments (with beneficiaries continuing to pay Medicare premiums),
- Medicaid funding, including federal matching dollars, and
- Other existing state and other federal public health expenditures.

Because these funds are assumed to remain available to the system, they do not need to be replaced by state revenue and therefore reduce the size of the revenue problem the Committee is solving.

Anchoring the Revenue Strategy: The $16.9B Revenue Replacement Target (2022 dollars)

To support disciplined revenue design, the Finance & Revenue Committee determined that it was essential to anchor its analysis to a single, internally consistent replacement target rather than continually revisiting total system cost estimates that are inherently uncertain and forward-looking. Accordingly, the Committee settled on a Revenue Replacement Target of $16.9 billion (2022 dollars) as the reference point for evaluating revenue mechanisms, tax bases, and distributional impacts. This value reflects the Committee's preferred 2022 calibration of: The UHP Plan Revenue Replacement Target, preserved public funding (particularly Medicare and Medicaid), and status-quo private and household spending that would be eliminated under a UHP.

The $16.9 billion figure was not intended to represent a precise forecast of first-year implementation needs. Rather, it served as a stable analytical anchor that allowed the Committee to:

- Compare alternative revenue instruments on a common footing,
- Evaluate progressivity and distributional outcomes,
- Test crediting, caps, and exemptions, and
- Ensure internal consistency across scenarios.

By fixing the replacement target in 2022 dollars, the Committee was able to focus its work on structure and equity, while deferring forward-year recalibration to the UHP Governance Board as plan costs, benefit design, and federal participation assumptions are refined.

DEFINING THE REVENUE REPLACEMENT TARGET

Formally, the Committee defined the Revenue Replacement Target as:

Revenue Replacement Target = (UHP Plan Estimated Expenditure for Current Care + Utilization & Coverage Adjustments) – System Efficiency Savings – Preserved Public Funding

This is the metric against which the Finance & Revenue Committee evaluated alternative revenue structures and design parameters. The table below illustrates how the Revenue Replacement Target relates to alternative 2022 estimates examined by the Committee.

Exhibit 11: Revenue Replacement Target (2022$)

Scenario	Revenue Replacement Target ($M)	Key Assumptions
Committee Anchor (2022)	$16,900	Preferred calibration used for revenue design
June F&R Baseline	$18,390	Optumas assumptions and status-quo expenditure estimates
Optimistic Scenario	$14,594	Higher federal participation and stronger administrative savings
Conservative Scenario	$22,500	Reduced Medicaid transfers under recent federal reforms

Note: All values are expressed in 2022 dollars and assume plan coverage comparable to Joint Task Force recommendations.

Anchoring the revenue strategy to a $16.9B Revenue Replacement Target clarifies that the Committee's work was focused on replacing existing health care payments, not expanding the overall cost burden on the Oregon economy. This framing provides a transparent and defensible basis for revenue design and sets up the Board's next phase of work: recalibrating the replacement target to the first year of UHP operations and aligning revenue rates accordingly.

SOURCES OF UNCERTAINTY AFFECTING THE REVENUE REPLACEMENT TARGET

Any revenue proposal for a state-run universal health care system must rest on a set of assumptions about factors that determine how much existing health care spending must be replaced by state-level revenue. While the Finance & Revenue Committee anchored its

revenue design to a $16.9 billion Revenue Replacement Target (2022 dollars), the Committee recognizes that this target will need to be recalibrated as key uncertainties are resolved.

The uncertainties described below do not undermine the structural validity of the Committee's revenue framework. Rather, they define the parameters the UHP Governance Board will need to refine as it transitions from structural design to implementation planning. The most consequential sources of uncertainty affecting the Revenue Replacement Target are summarized and discussed below.

1. Administrative Savings Under the UHP

The Revenue Replacement Target reflects assumed administrative efficiencies achievable under a single-payer system. As in Oregon's 2022 Joint Task Force (JTF) report, the Committee's cost estimates incorporate savings from eliminating duplicative administrative activities inherent in the multi-payer system, including marketing, enrollment, insurer-specific provider contracting, claims processing, and private insurance margins.

The JTF assumed provider-side administrative savings equal to approximately 4 percent of total health system expenditures, reflecting reduced billing complexity for providers. The Task Force recognized potential provider administrative savings of 8% to 12% but chose to use some of the expected savings to increase provider net compensation. The Finance & Revenue Committee chose to estimate realizing more of those savings - 8 percent of total provider payments as savings under a unified, publicly administered system. This result reduces the Revenue Replacement Target by approximately $1.3 billion (2022 dollars).

Recent studies indicate that mature single-payer systems typically operate with payer side administrative overhead in the range of 2 to 5 percent, compared to 12 to 15 percent in the U.S. multi-payer model. The JTF fiscal model used only a 3% of total expenditure payer side administrative savings, and the Committee retained that conservative value.

2. Federal Contributions Preserved Under the UHP

A second major determinant of the Revenue Replacement Target is the extent to which federal health care funding can be preserved and integrated into the UHP. The Committee's proposal assumes that federal dollars currently flowing to Oregon through Medicare and the federal share of Medicaid will continue under the UHP, subject to federal approval and waiver authority or some other mechanism.

Under the proposal, existing eligibility and enrollment pathways are preserved. Seniors would continue to qualify for Medicare through the Social Security Administration and would continue paying Part B premiums (and, where applicable, Part A premiums and IRMAA). To avoid double payment, Medicare beneficiaries would receive a credit for paid Part B premiums against their Health Care Personal Income Tax liability. Similarly, lower-income Oregonians would continue to qualify for Medicaid under existing state and federal rules, allowing Oregon to retain federal matching funds.

The largest source of uncertainty arises from recent and potential changes in federal Medicaid policy, including the effects of H.R. 1 (2025). According to Congressional Budget Office estimates, tightened eligibility and reduced state-directed payment limits could lower federal Medicaid funding to Oregon by more than $3 billion by 2030. Conversely, UHP-required provider price parity could increase federal matching payments by more than $4 billion under certain assumptions.

Taken together, uncertainty in federal participation could plausibly shift the Revenue Replacement Target by as much as a $1 billion decrease or a $3 billion increase.

3. Health Care Cost Growth

The Committee believes that a revenue framework broadly consistent with the 2022 proposal can support the UHP on an ongoing basis once implemented. However, this conclusion is contingent on the system's ability to keep pace with health care cost growth.

Between the 2022 calibration year and the anticipated first year of UHP operations, tax rates and revenue parameters will need to be adjusted to reflect medical inflation and utilization trends. Cost growth will also remain a long-term governance issue after implementation, requiring revenue mechanisms that can scale with expenditures over time.

Accordingly, uncertainty around future health care cost growth affects the forward calibration of the Revenue Replacement Target rather than the underlying structure of the Committee's proposal.

4. Other Accounting and Data Uncertainties

Finally, there are residual uncertainties in baseline expenditure data that affect estimates of both the UHP Plan Total Estimated Expenditure and the Revenue Replacement Target. In particular, approximately $1.5 billion (2022 dollars) in "structures and equipment" spending within the National Health Expenditure Accounts is not clearly attributable to provider payments or separate capital expenditures.

Clarifying how these costs are treated—whether embedded in provider rates or requiring separate financing—will be important for finalizing the revenue target but does not alter the Committee's core financing logic.

Implications for Board Action

Together, these uncertainties define the range within which the Revenue Replacement Target will ultimately be set, rather than calling into question the Committee's recommended revenue framework. The Finance & Revenue Committee intentionally anchored its analysis to a 2022-based replacement target to focus on structure, equity, and feasibility. The UHP Governance Board's next phase of work will involve recalibrating that target to the first year of operations as these uncertainties are resolved.

Calibrating the Milliman Cost Estimate to the Revenue Replacement Target

A key issue for the Finance & Revenue Committee in 2026 was how to incorporate the updated Milliman Universal Health Plan cost estimate into a revenue framework that had originally been built using the earlier Optumas work and 2022 revenue data. The Committee's original revenue plan was designed around a distinction between the overall UHP estimated expenditure and the revenue replacement target.

Two Different Accounting Frames

The Committee's challenge is that the Milliman and Optumas estimates are not directly comparable on a line-by-line basis because they are built using different accounting frames. Milliman organizes the UHP estimate by line of business or insurance market segment, such as employer, individual, Medicaid, Medicare, public employees, and uninsured populations, and separately identifies assumed federal waiver capture. By contrast, the Optumas-based Finance & Revenue work was built from a health expenditure framework that is closer to a National Health Expenditure Accounts approach, focused on who pays today and what categories of spending exist in the current system. As a result, Milliman is oriented around who is covered and what the UHP would cost for those populations, while the Finance & Revenue framework is oriented around which current payment streams disappear and therefore must be replaced through new revenue.

This difference matters because the revenue replacement target depends not only on total UHP cost, but also on identifying which current funding sources are transferable, preserved, or outside the UHP. Put differently, even if the Board has a refined estimate of what the UHP costs in total, that does not automatically tell the Committee how much new tax revenue must be raised. The answer depends on the extent to which Medicare, Medicaid, ACA subsidies, current state and local government health spending, and other public funding streams can continue to support the program.

Why a Full Reconciliation Is Difficult

The Committee's review of the Milliman update suggests that the gap between the two estimates is driven less by a single error than by a series of definitional and methodological differences. These include differences in how administrative costs are treated, how provider payment normalization and efficiency assumptions are applied, what benefits are included in scope, and how covered populations are defined.

Even relatively small differences in items such as dental coverage, behavioral health scope, Medicare Part B premiums and credits, or assumed administrative savings can move the estimate materially. For that reason, any attempt to immediately allocate the Milliman total back into the exact "sources and uses" structure of the Optumas revenue framework would risk introducing false precision.

The Committee therefore recognized that calibrating the Milliman estimate is not simply an exercise in plugging a new cost number into the old model. It requires a more careful reconciliation of the underlying assumptions about scope, funding flows, and treatment of preserved versus replaceable revenues. Until those allocation rules are fully agreed upon, a precise recalculation of the revenue replacement target remains provisional.

The Intended Analytical Path

The Committee identified a two-step analytical path for connecting the updated UHP estimate to the revenue plan. The first step is to recompute the revenue replacement target using the updated UHP cost estimate and a reconciled view of transferable and preserved funding. Conceptually, this means starting with the UHP plan cost estimate, subtracting Medicare, Medicaid, ACA subsidies, state and local government health spending, and other public or redirectable funding that is expected to remain available to support the UHP, and then identifying the net amount that must be raised through new state revenue. The intended deliverable is a reconciled "sources and uses" table that ties the updated estimate to the revised target.

The second step is to convert that updated target into a 2032 implementation-year financing package suitable for legislative consideration. The Committee anticipated that this would ultimately require Legislative Revenue Office modeling to bring the relevant tax bases forward to the plan year, align assumptions with legislative forecasting conventions, and solve for the tax rates, thresholds, and credits needed to meet the target in the implementation year.

Practical Placeholder for Board Deliberation

Because the full reconciliation work was still underway, the Committee concluded that the most practical near-term approach was to use a placeholder revenue replacement target to support Board discussion and scenario testing. Rather than back-casting a premature and potentially arbitrary allocation from the Milliman total, the Committee proposed trending forward the previously adopted 2022 revenue replacement target of $16.9 billion using a 4.4 percent annual growth assumption.

That growth rate was selected to reflect expenditure growth in the spending categories that most closely align with the revenues being replaced. On that basis, the implied placeholder target is approximately $20.1 billion in 2026 and $26.0 billion in 2032. The Committee's view was that the $26.0 billion 2032 target could serve as a practical working figure until the reconciliation between updated UHP costs and transferable funding could be refined further.

This approach does not resolve the underlying accounting differences, but it provides a workable bridge between the older revenue framework and the newer cost estimate. It allows the Board and staff to continue evaluating the overall tax package, testing policy choices, and discussing burden allocation without waiting for every definitional issue to be fully settled. At the same time, it preserves room for later refinement once the Committee, Milliman, and

legislative staff have a clearer basis for reconciling the updated UHP estimate with the existing revenue structure.

Policy Significance

The calibration issue has an important policy dimension. If the eventual revenue replacement target is higher or lower than the placeholder amount, the Board will need to decide whether to scale the existing revenue structure up or down proportionally or to rebalance the mix of revenue instruments. The Committee identified these as distinct pathways. A scaling approach would preserve the current structure and simply adjust rates uniformly. A rebalancing approach would retain the same instruments but shift where marginal dollars are raised, such as altering the relative roles of the employer payroll tax and the health care personal income tax or adjusting thresholds and rate shapes. That means the calibration of the Milliman estimate is not only a technical exercise; it also sets up later decisions about how the burden of financing the UHP should be distributed if the final target differs from current expectations.

3. Proposal to Fund On-Going UHP Expenses

Introduction

This chapter presents the Finance & Revenue Committee's consensus recommendations for funding the Universal Health Plan's on-going annual expenses. Chapter 4 addresses the distinct question of one-time start-up, transition, and reserve capitalization costs. The focus here is on the core revenue framework designed to finance the UHP once it is fully operational.

Building on the analytical foundation established in Chapter 2, this chapter documents how the Committee translated its Revenue Replacement Target into a coherent set of revenue instruments. It summarizes the key design choices, parameter selections, and policy rationales that underpin the proposed funding approach, and it presents evidence developed by the Committee to assess revenue sufficiency, equity, and administrative feasibility.

Central to this chapter are the exhibits that show how health care contributions would change for different types of households and businesses under the proposed UHP relative to the status quo. These comparisons provide the most direct insight into how the revenue proposal reallocates existing health care payments and distributes responsibility across the Oregon economy.

What the Committee's Revenue Proposal Is Designed to Do

The Committee's proposal establishes an integrated system of UHP-specific revenue streams to finance the Plan's on-going costs. Some components are paid by employers and others by individuals, primarily through the state's personal income tax system. Together, these revenue sources are designed to meet four overarching objectives:

- **Replace existing private health care payments,** particularly employer-sponsored insurance contributions, individual premiums, and out-of-pocket expenditures, with a unified public financing system;
- **Protect low- and middle-income households** through income-based thresholds, credits, and exemptions, while maintaining a sense of shared responsibility for the system;
- **Ensure broad-based**, predictable contributions from employers and individuals to support long-term financial stability; and
- **Minimize legal risk,** including ERISA vulnerability, by relying on generally applicable, non-employer-specific revenue mechanisms.

As described in Chapter 2, the Committee anchored its revenue design to a Revenue Replacement Target of approximately $16.9 billion (2022 dollars)—the estimated amount of state-level revenue required after accounting for preserved public funding (notably Medicare and Medicaid) and the elimination of private premiums and out-of-pocket payments under a universal system. Accordingly, the revenue plan presented in this chapter is calibrated to raise $16.9 billion in 2022 dollars, providing a consistent analytical basis for evaluating tax bases, rates, credits, and distributional outcomes.

UHP Revenue Mechanisms

The Universal Health Plan revenue proposal is built around a small number of structurally integrated revenue mechanisms designed to replace existing private health care payments with a stable, equitable, and administratively feasible public financing system. Rather than relying on a wide array of narrowly targeted taxes, the Finance & Revenue Committee prioritized a limited set of broadly applicable instruments that align with how health care is currently financed in Oregon and that can be scaled over time as costs evolve.

Together, these mechanisms are intended to meet the Revenue Replacement Target by:

- capturing employer-sponsored health care spending through payroll-based contributions,
- collecting income-based contributions from individuals in proportion to ability to pay,
- avoiding double payment through carefully designed credits and adjustments, and
- maintaining continuity with existing compensation and tax systems to reduce disruption.

The mechanisms described below operate as a coordinated system. Individual tax rates, credits, and adjustments are designed to work in combination—rather than in isolation—to balance revenue sufficiency, equity, and legal durability. Subsequent sections describe each mechanism in turn, followed by analysis of how they interact and how resulting payment obligations compare to the status quo for different types of households and businesses.

1. Corporate Income Tax Add-On (CIT/CET)

Why it is included. The Corporate Income Tax add-on is included to ensure that profitable corporations contribute directly to financing the UHP and to diversify the revenue base beyond wage-linked sources. It captures a portion of UHP financing from firms with positive taxable income, including firms that may have relatively low Oregon payroll but substantial in-state profits.

What it does. The proposal applies a 3.0% UHP-dedicated surcharge on top of Oregon's existing 7.6% corporate income tax rate. The add-on uses the current CIT base and administrative framework, increasing liability in proportion to taxable income.

How it aligns with Committee principles. The CIT add-on advances (1) revenue diversification by adding a profit-based component to the overall mix, (2) administrative feasibility by leveraging an existing tax system and definitions, and (3) equity across business types by ensuring that profitability—not only payroll—contributes to UHP financing.

2. Corporate Activity Tax Add-On (CAT)

Why it is included. The Corporate Activity Tax add-on is included to broaden business participation beyond firms that report taxable income, and to provide a steadier business-based revenue stream across economic cycles and corporate tax planning strategies. It helps ensure that businesses with significant Oregon market activity contribute to UHP financing even if taxable income is low or volatile.

What it does. The proposal applies a 0.10% UHP-dedicated add-on on top of Oregon's existing 0.57% CAT rate. The add-on is assessed on the existing CAT base and administered through the current CAT structure.

How it aligns with Committee principles. The CAT add-on supports (1) revenue adequacy and stability by drawing on a broad activity base, (2) risk diversification by complementing payroll- and income-based mechanisms, and (3) administrative feasibility by using an established tax base and collection system, while maintaining generally applicable treatment across firms.

3. Employer Payroll Tax (EPT)

Why it is included. The Employer Payroll Tax is the proposal's primary tool for replacing the employer share of today's employer-sponsored insurance (ESI) spending. It ensures that employers continue to participate in financing health care in a way that is broad-based and predictable, without tying coverage to any specific employer.

What it does. The EPT applies a payroll-based contribution above a firmwide payroll threshold. In effect, it helps to shape a fragmented, privately negotiated benefit cost into a transparent, statewide contribution that better aligns with the UHP's universal benefit.

How it aligns with Committee principles. The EPT supports (1) revenue adequacy and stability by drawing from a broad wage base, (2) equity by shielding small firms, and (3) legal durability by relying on a generally applicable payroll levy rather than an employer-specific benefit mandate (reducing ERISA exposure).

4. Health Care Personal Income Tax (HCPIT)

Why it is included. The Health Care Personal Income Tax is the central mechanism for individual contributions, designed to replace private premiums and a portion of household out-of-pocket costs with an income-based contribution that reflects ability to pay.

What it does. The HCPIT is administered through Oregon's existing personal income tax system and applies above an income threshold tied to the federal poverty level. It provides the primary vehicle for progressivity in the overall financing package and ensures that individuals contribute regardless of employment arrangement (wage earners, self-employed, retirees).

How it aligns with Committee principles. The HCPIT advances (1) equity through income sensitivity and built-in protections for low- and middle-income households, (2) administrative feasibility by using an existing tax system, and (3) broad-based participation consistent with a universal public program.

5. Household Size Rate Readjustment (HSRR) in the HCPIT

Why it is included. Household size adjustments are included to ensure that contributions reflect not only income, but also the number of people using health care in that (if the household income is large enough)—without relying on a separate per-person premium.

What it does. The Household Size Rate Readjustment (HSRR) modifies net HCPIT liability by household size at high enough incomes. It does not affect low-income households. At higher incomes, it counteracts the mechanical decline in liability that would otherwise occur as household size increases (e.g., through exemptions or filing structure.

How it aligns with Committee principles. HSRR supports (1) equity by protecting larger low- and moderate-income households, and (2) distributional integrity by preventing unintended regressivity or high-income windfalls tied to household size.

6. EPT Credit Against Individual HCPIT Liability

Why it is included. Because the proposal uses both employer- and individual-based contributions, a credit is necessary to avoid "stacking" the employer payroll contribution and the individual income-based contribution on the same wage-based compensation—especially for households least able to absorb abrupt changes.

What it does. The proposal provides a credit against HCPIT liability linked to a portion of the EPT paid on a worker's behalf. This recognizes employer participation in financing the UHP and reduces the risk that wage earners face higher combined burdens simply because their compensation is structured through employer coverage in the status quo.

How it aligns with Committee principles. The credit promotes (1) fairness and transition stability by preventing double-counting of compensation, (2) equity by limiting stacked burdens for low- and middle-wage households, and (3) neutrality across payer types by improving comparability between wage earners and the self-employed. The Committee continues to refine the credit level to balance these goals against revenue needs and progressivity at the top of the income distribution.

7. Medicare Part B Premium Credit

Why it is included. Medicare beneficiaries already finance a portion of their coverage through federal premiums. Without an offset, Medicare households could face double payment—once through federal Part B premiums and again through Oregon's HCPIT.

What it does. The proposal includes a non-refundable credit for Medicare Part B premiums against HCPIT liability. This preserves continuity with Medicare's existing financing structure while integrating Medicare beneficiaries into the UHP contribution framework in a manner that avoids duplicate charges.

How it aligns with Committee principles. The Part B credit supports (1) equity by preventing overpayment by seniors and other Medicare eligible residents, (2) administrative clarity by using a definable, documentable premium amount, and (3) system coherence by preserving federal program financing while aligning state contributions with the UHP's universal structure.

Current Plan Parameters by Revenue Instrument

This section documents the current parameter settings for each revenue instrument in the Committee's working plan and briefly describes how each mechanism operates within the integrated model. Parameters function as a system and should be interpreted together.

Corporate Income Tax Add-On

Parameter: +3.0% surcharge on top of Oregon's existing 7.6% CIT rate. The 6.6% rate on taxable income up to $1M for c-corporation filers remains unchanged.

How it works: This is an incremental UHP-dedicated surcharge applied to the existing corporate income tax base and filing structure. It increases liability for firms with taxable income under current CIT rules.

Corporate Activity Tax Add-On

Parameter: +0.10% add-on on top of Oregon's existing 0.57% CAT rate.

How it works: This add-on applies to the existing CAT base (gross receipts-style activity base) using current CAT administration. It broadens the business contribution beyond firms with taxable income.

Employer Payroll Tax

Parameters: A marginal rate of 9.6% on total firm payroll above $500,000. Public employers pay the EPT on their total payroll with no exemption.

How it works: Employers with firmwide payroll above the threshold pay the EPT on applicable payroll. The firm threshold excludes private employers below $500,000 payroll from EPT liability.

EPT Credit

Parameter: 50% EPT credit.

How it works: Individuals receive a credit against their HCPIT liability equal to 50% of the EPT paid on their behalf by their employer. The credit reduces net HCPIT owed, decreasing stacked employer/individual contributions on wage-based compensation.

Health Care Personal Income Tax

Parameter: A marginal rate of 10.1% of federal AGI above the 200% FPL threshold.

How it works: The HCPIT is assessed through Oregon's personal income tax system. Net liability is determined after applying the income exemption, household-size adjustments (HSRR), and credits (including the EPT credit and Medicare Part B credit where applicable). HCPIT liability is zero if federal AGI (minus federally taxable social security benefits) are below the exemption threshold (200% of the model's federal poverty benchmark). HCPIT liability begins at 200% of FPL.

Medicare Part B Premium Credit

Parameter: 100% credit of Part B premiums paid.

How it works: Medicare beneficiaries receive a non-refundable credit against HCPIT liability equal to Part B premiums paid. This credit is applied within the same net-liability calculation as other adjustments.

Household Size Rate Readjustment (HSRR)

Parameters: The HSRR results in an amount of up to $1,325 per exemption above one, so it applies to household size 2 and above if their federal AGI is greater than 260% of FPL.

How it works: The HSRR is applied within the HCPIT calculation to adjust net liability by household size consistent with the model's household-size logic. It modifies the way exemptions/credits interact with household composition so that liability does not mechanically decline with larger household size at higher incomes while preserving relief for larger households at lower incomes. A higher marginal tax rate begins at 260% of FPL it a filer claims more than one exemption. The higher marginal rate is designed so that the extra HCPIT liability increases linearly from 0 to $1,325 times (number of exemptions minus 1) by 520% of FPL.

Lodging Tax

Parameters: Increase Oregon's state lodging tax from 1.5% to 1.7% (+0.20%).

How it works: This option would increase the existing state transient lodging tax by 0.20 percentage points using Oregon's current lodging tax base and administrative framework. It is intended to capture a small share of health care costs associated with out-of-state visitors by drawing on visitor-related spending rather than relying entirely on Oregon residents or employers. Under the Committee's 2022 calibration, this increase was estimated to raise about $5 million annually.

Estimated Revenue by Revenue Instrument (2022 Dollars)

This section summarizes the estimated annual revenue generated by each component of the Committee's revenue proposal, expressed in 2022 dollars and calibrated to the current parameter set. Because several mechanisms interact—most notably the EPT credit against personal income tax liability and the Medicare Part B credit—the figures below should be read as model outputs under the integrated structure, not as standalone, additive tax calculations applied in isolation.

Exhibit 12: Estimated Revenue by Revenue Instrument (2022 Dollars)

Revenue Instrument	Estimated Revenue ($M)	Percent of Total	What the Estimate Represents
CIT	$639	3.8%	Additional CIT revenue from the user-defined increase over Oregon's existing corporate income tax structure (7.6% marginal rate on taxable income above $1M; 6.6% under $1M), applied to the 7.6% CIT base and filing system.
CAT	$215	1.3%	Additional CAT revenue from the user-defined increase over the current 0.57% CAT rate on corporate "activity" above $1M, using the existing CAT base and administration.
EPT	$8,715	51.5%	Payroll tax paid by employers; treated as a contribution made on behalf of employees and linked to an employee-level credit against personal income tax liability. This figure reflects gross EPT receipts.
HCPIT (net of Part B credit)	$6,317	40.0%	Net additional personal income tax revenue dedicated to UHP after accounting for reductions in individual liability due to the EPT credit.
HSSR	$962	3.4%	Net revenue associated with the household-size adjustment reflecting the FPL-based phase-in structure and reductions due to Medicare Part B credits.
Lodging tax	$5	<0.1%	Additional lodging tax revenue above Oregon's current 1.5% state lodging tax, intended to capture a small share of costs associated with care provided to out-of-state visitors.

Source: Finance and Revenue Committee

Because the proposal's instruments are designed to work as an integrated system, several entries in the table reflect net results after credits and offsets rather than standalone gross collections:

- **EPT and the EPT credit are modeled together.** The EPT is collected from employers, while a portion of that payment is credited against workers' HCPIT liability. Accordingly, the EPT line shows employer-side receipts, and the HCPIT/PIT line shows the portion of individual income-tax revenue remaining after the EPT credit is applied.
- **The Medicare Part B credit reduces net individual revenue.** The Part B premium credit is taken against individual HCPIT liability. In the revenue accounting, this credit shows up as a reduction in net receipts within the household/premium-equivalent component (reported here as the HSRR line).

4. Impact on Households and Businesses

Purpose and Approach

This section assesses the financial impacts of the UHP revenue proposal by quantifying how the plan changes who pays, how much they pay, and through which payment channel, relative to the status quo. The intent is to translate the proposal's structure and parameters into clear, comparable measures of financial responsibility across employers, households, and key subpopulations.

The core analytical construct throughout is a before-and-after comparison. On the "before" side, we summarize current health care payments made through premiums, employer contributions, and out-of-pocket spending. On the "after" side, we estimate contributions under the proposed UHP revenue instruments—primarily the Employer Payroll Tax (EPT) and the Health Care Personal Income Tax (HCPIT), as modified by the EPT credit, Household Size Rate Readjustment (HSRR), and the Medicare Part B premium credit—along with smaller business levies included in the proposal.

Impacts are presented using two complementary lenses. First, we evaluate system-level distributional shifts across broad payer classes, showing how aggregate payment responsibility moves from employer-sponsored insurance and private household payments to UHP-dedicated taxes and credits. Second, the analysis presents practical impacts through typologies and illustrative cases that demonstrate how the proposal operates for representative businesses and households, and how outcomes vary across common payer types and circumstances.

System-Level Shift in Payments: Status Quo vs. F&R Proposal

This section establishes the "big picture" change in how health care is financed under the Finance & Revenue proposal, using the model's 2022-dollar calibration. Exhibit 13 and Exhibit 14 summarize the proposed redistribution of payments away from fragmented premiums and out-of-pocket spending and toward a unified set of UHP-dedicated tax instruments.

Under the status quo, health care financing is fragmented across several payment channels:

- **Employers (by sector):** Employer-sponsored insurance (ESI) contributions paid by private employers, state and local government employers, and federal government employers. These payments are typically embedded in compensation and vary by coverage offering and plan design.
- **Households and individuals:** Employees' premium shares, premiums paid directly in the individual market, and out-of-pocket spending.

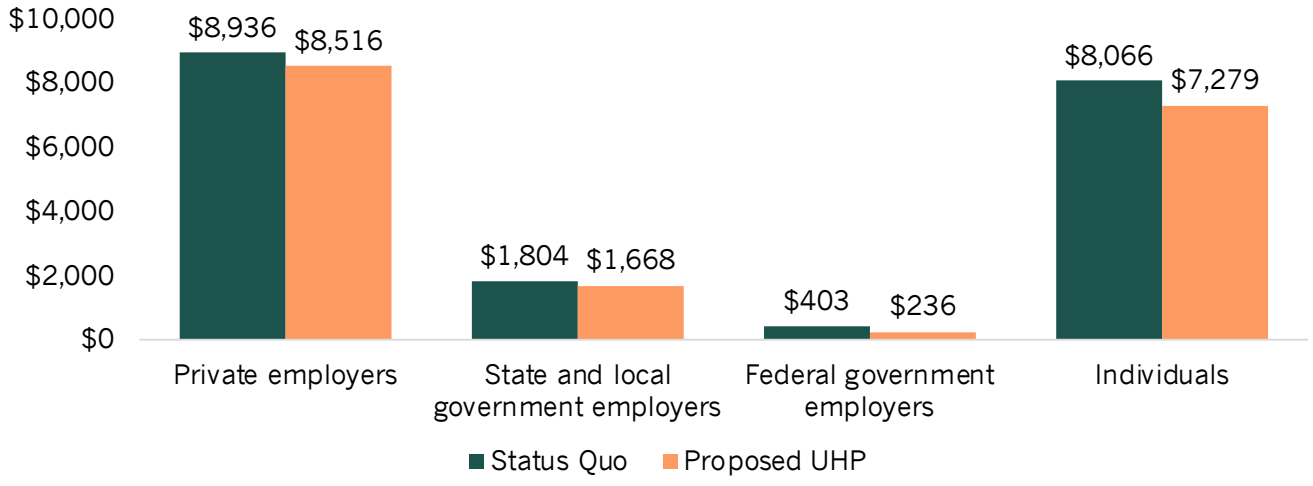
- **Public programs:** Medicare and Medicaid funding flows continue to finance a large share of care today; Medicare beneficiaries also pay Part B premiums directly. In the Committee's framework, these public flows are treated as largely preserved/transferable under the UHP (with appropriate credits to avoid double payment).

Under the F&R proposal, the same broad payer classes contribute through UHP-specific revenue mechanisms:

- **Employers:** Primarily through the Employer Payroll Tax (EPT) (with small business protections embedded through thresholds and exclusions). Minor business levies (e.g., CAT/CIT add-ons) are also included in the overall funding package but are not the main driver of the payer-class comparison shown here.
- **Individuals/households**: Primarily through the Health Care Personal Income Tax (HCPIT), net of:
  - the EPT credit (which offsets a portion of individual liability to prevent stacking employer and individual contributions on wage compensation),
  - Household Size Rate Readjustment (HSRR) effects embedded in the household calculation, and
  - the Medicare Part B premium credit (applied against individual liability to avoid double payment for Medicare beneficiaries).

These interactions matter for interpretation: the revenue shown for individuals in Exhibit 13 is net of credits that reduce liability for certain households and Medicare payers.

Exhibit 13. Net Proposed UHP Revenue by Source and Change Relative to Status Quo (in millions of 2022 dollars)



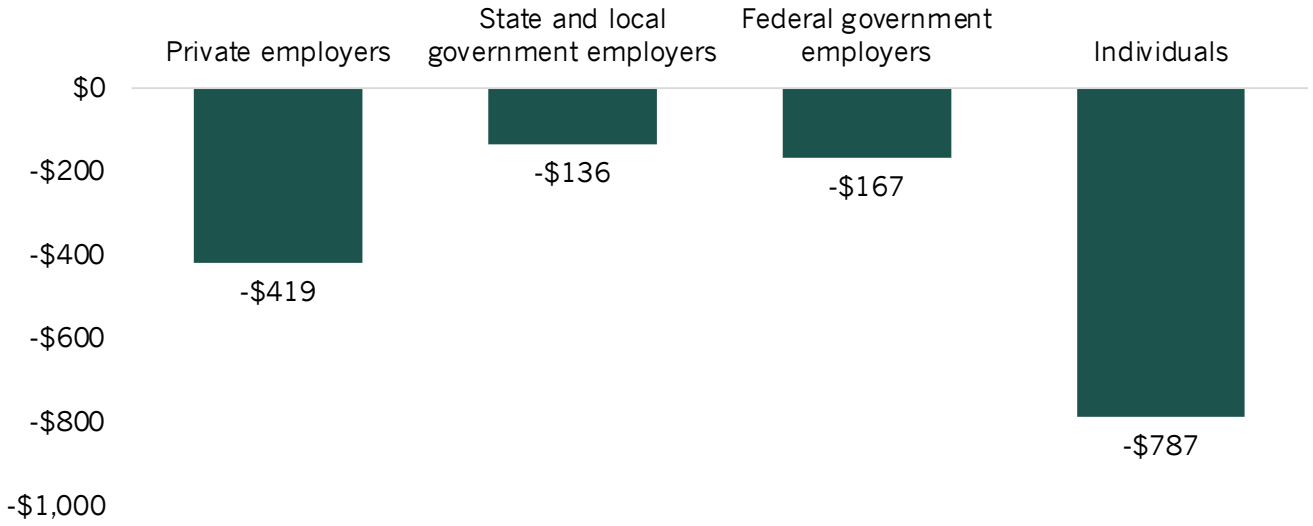
Source: Finance and Revenue Committee

Exhibit 14 shows that, in aggregate, the F&R proposal shifts payment responsibilities in a way that is predominantly replacement rather than net-new burden.

All payer classes shown contribute less under the proposal than in the status quo in the 2022 calibration. Exhibit 14 reports negative differences (savings) for each payer class:

- Private employers: approximately $0.42B lower under the proposal than under status quo payments.
- State & local government employers: approximately $0.14B lower.
- Federal government employers: approximately $0.17B lower.
- Individuals: the largest reduction, approximately $0.78B lower.

Exhibit 14. Difference in Contributions by Sector under F&R Proposal, 2022 ($Millions)



Source: Finance and Revenue Committee

Note: Negative differences indicate UHP savings within the sector.

Individuals' aggregate payments decline from roughly $8.0B in the status quo to about $7.2B under the F&R proposal, consistent with the proposal's replacement of premiums and out-of-pocket payments with income-based contributions and credits. Employer-side contributions decline modestly across sectors. Private employers remain the largest employer payer class (roughly $8.5B under the proposal) decrease, reflecting the replacement of ESI spending with a standardized financing structure.

Overall, these exhibits show that the proposal's financing shift is primarily a reorganization of how health care is paid for, moving away from premiums and point-of-service costs and toward UHP-dedicated taxes, while the 2022 calibration indicates a net reduction in aggregate payments for the payer classes shown. Subsequent subsections build on this high-level picture by examining (1) distributional impacts across business size/industry and (2) household impacts by income, employment type (wage vs. self-employed), Medicare status, and representative payer typologies.

UHP Business-Based Revenue Instruments

The proposal relies on three primary business-based instruments to fund the UHP and replace a significant share of today's employer-sponsored insurance spending with a consistent, statewide contribution structure:

1. **Corporate Income and Excise Taxes (CIT/CET):** A modest UHP-dedicated add-on to existing corporate income/excise tax structures, capturing a share of contributions from profitable firms.
2. **Corporate Activity Tax (CAT):** A small add-on to Oregon's gross-receipts-style activity tax, broadening contributions across firms with significant Oregon sales activity, including firms with low taxable income.
3. **Employer Payroll Tax (EPT):** The main employer-side funding mechanism, assessed on payroll above a firm threshold and designed to replace employer health benefit spending currently embedded in compensation.

Key Questions for the Business Impact Assessment

This section evaluates how the proposal reallocates employer obligations relative to the status quo, with a focus on both aggregate effects and variation across employer types:

- **How do business health care payments look today?** What employers currently pay through ESI (including differences by firm size and industry).
- **How do proposed UHP contributions compare to current spending?** What employers would pay under EPT (and the CIT/CAT add-ons), and how those obligations scale with payroll and firm characteristics.
- **Which employers see increases or decreases—and why**? How impacts differ across small vs. large employers and across industries.

CIT/CET Current Structure and Revenue Impact

Oregon's corporate tax system includes both the Corporate Income Tax (CIT) and the Corporate Excise Tax (CET). As shown in the current structure slide, the practical distinction is based on whether the corporation is considered to be doing business in Oregon. The CIT applies to corporations not doing business in Oregon, while the CET applies to corporations doing business in Oregon. The key difference for purposes of this analysis is that CET includes a minimum tax feature, while the CIT does not.

Both taxes share the same statutory rate structure on taxable income: 6.6% on taxable income below $1 million and 7.6% on taxable income above $1 million. This is the baseline structure the Committee uses when describing how a UHP-dedicated CIT/CET add-on would "ride on top of" the existing system.

CET MINIMUM TAX STRUCTURE (HOW LIABILITY WORKS)

A defining feature of the Corporate Excise Tax is that businesses pay the greater of:

1. the calculated tax based on taxable income, or
2. the minimum tax, which is determined based on Oregon sales.

The minimum tax schedule increases with Oregon sales—beginning at $150 for firms with Oregon sales below $500,000, rising through a series of brackets, and reaching $100,000 for firms with $100 million or more in Oregon sales (Exhibit 15). In addition, there are two special cases: S-corporations face a flat $150 minimum excise tax, and insurance corporations are subject to Oregon excise tax filing requirements when doing business in Oregon, including Oregon-source solicitation and premium-related income.

Exhibit 15: C-Corporation Minimum Excise Tax, Oregon, 2022

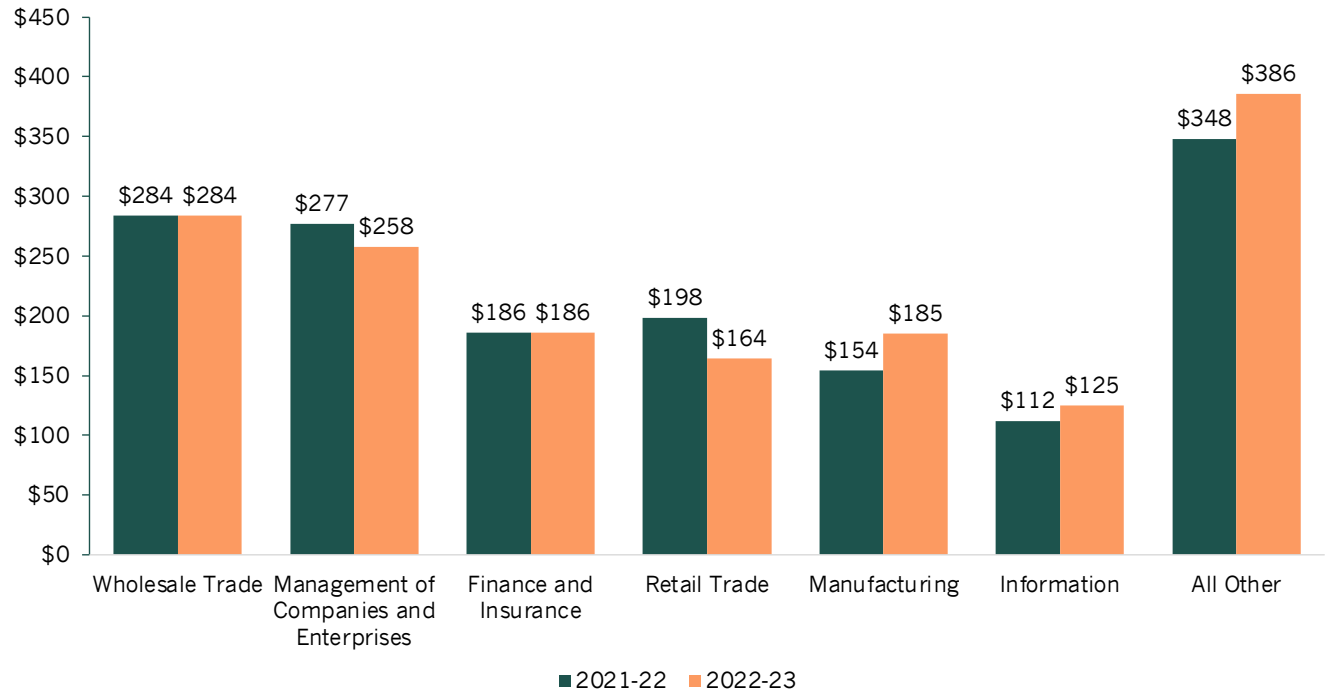
Oregon Sales	Minimum Tax
< $500,000	$150
$500,000 to $1 million	$500
$1 million to $2 million	$1,000
$2 million to $3 million	$1,500
$3 million to $5 million	$2,000
$5 million to $7 million	$4,000
$7 million to $10 million	$7,500
$10 million to $25 million	$15,000
$25 million to $50 million	$30,000
$50 million to $75 million	$50,000
$75 million to $100 million	$75,000
$100 million or more	$100,000

Source: Oregon Department of Revenue

CIT/CET REVENUE DISTRIBUTION (WHO PAYS TODAY)

Exhibit 16 summarizes how CIT/CET revenues are distributed across industries. In FY22, total CIT/CET revenue is shown as approximately $1,539 million (in 2022 dollars), and the mix is heavily weighted toward the excise tax: about 95% from CET and 5% from CIT. This reinforces that, in practice, Oregon's corporate revenues are primarily collected from corporations doing business in the state and subject to the minimum-tax framework.

Exhibit 16: CIT/CET Revenue Distribution, Oregon, FY22 and FY23 (in millions of dollars)



Source: Oregon Department of Revenue

By industry, corporate tax receipts are spread across multiple sectors, with a large "All Other" category and meaningful contributions from Wholesale Trade, Management of Companies and Enterprises, Finance and Insurance, Retail Trade, Manufacturing, and Information. The FY22 and FY23 bars indicate that sector contributions are broadly stable year-over-year, but with variation consistent with corporate income tax bases being influenced by profit cycles, sector performance, and firm-specific income reporting.

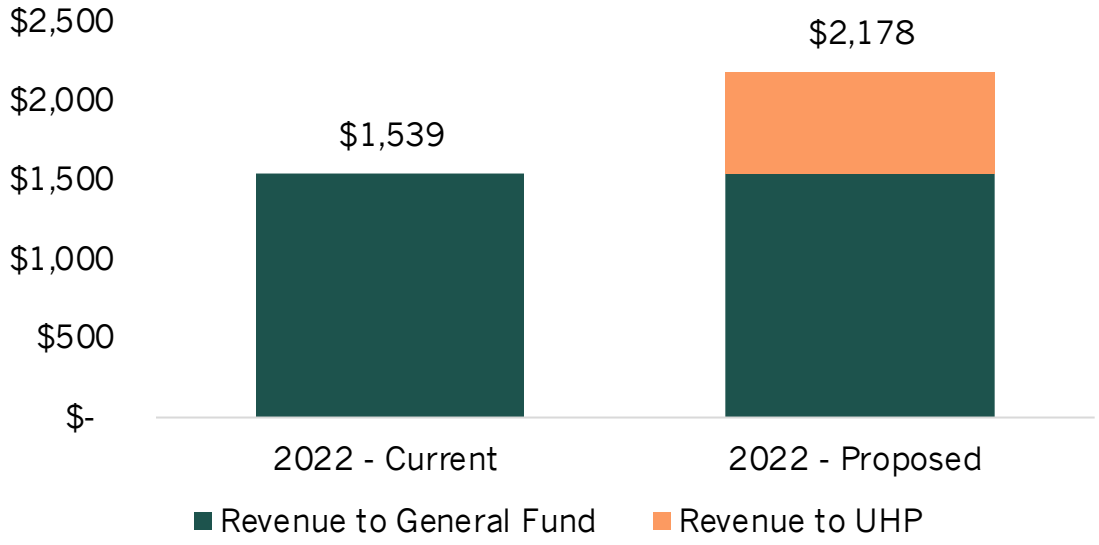
INCREMENTAL REVENUE GENERATED BY THE PROPOSED CIT/CET ADD-ON

Under the Finance & Revenue Committee's current parameter set, the proposal includes an incremental 3.0 percentage point add-on to Oregon's existing CIT/CET rate structure. The add-on is applied only to the existing 7.6% rate on taxable income above $1 million, the 6.6% rate on taxable income below $1 million is preserved.

- 10.6% on taxable income above $1 million (7.6% current + 3.0% UHP add-on).

Importantly, the proposal is structured as a dedicated surcharge: it generates revenue for the UHP without reducing existing corporate tax revenue currently deposited in the General Fund.

Exhibit 17: CIT/CET Revenue (in millions of 2022 dollars)



Source: Oregon Department of Revenue, Finance and Revenue Committee, and ECOnorthwest.

As illustrated in Exhibit 17, the total CIT/CET revenue in 2022 is estimated at $1,539 million (in 2022 dollars) under current law. Under the proposed add-on, total CIT/CET collections are estimated at $2,178 million, with the difference—approximately $639 million (2022$)—representing new, UHP-dedicated revenue. The existing $1,539 million remains allocated to the General Fund, while the incremental surcharge is earmarked for the UHP.

CAT Current Structure and Revenue Impact

Oregon's Corporate Activity Tax (CAT) is a modified gross receipts tax that applies to businesses with taxable Oregon commercial activity exceeding $1 million. The CAT applies to both goods and services sold in Oregon, and it applies to businesses located outside Oregon when they are conducting taxable commercial activity in the state. Under current law, 100% of CAT revenue is dedicated to the State Student Success Fund.

CAT STRUCTURE (HOW LIABILITY WORKS)

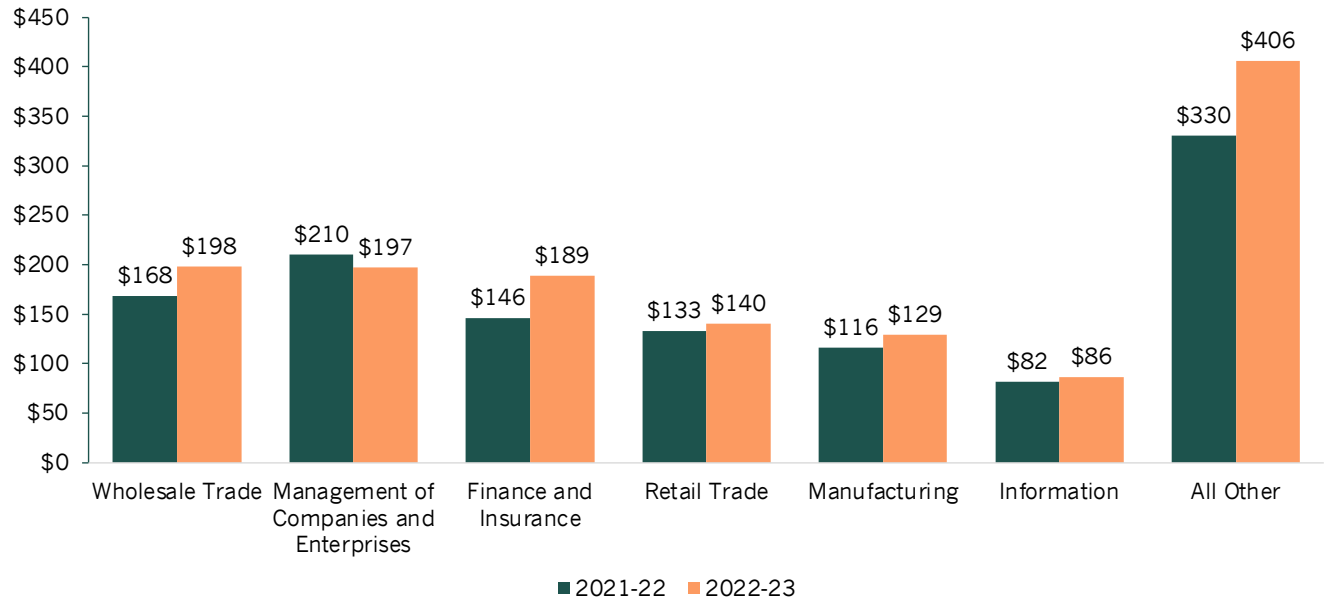
The CAT is levied as a $250 flat amount plus 0.57% of taxable Oregon commercial activity above $1 million. The CAT also includes statutory exemptions for certain entities, including nonprofits, governmental entities, and health care entities subject to Oregon's Medical Provider Taxes.

CAT REVENUE DISTRIBUTION (WHO PAYS TODAY)

Exhibit 18 summarizes how CAT revenues are distributed across industries. In FY22, total CAT revenue is shown as approximately $1,228 million (in 2022 dollars). Receipts are spread across major sectors, with meaningful contributions from Retail Trade, Wholesale Trade, Manufacturing, Management of Companies and Enterprises, Construction, and Information, alongside a large "All Other" category. The FY22 and FY23 bars indicate that sector

contributions are generally stable year-over-year, with expected variation consistent with differences in sales volumes and taxable activity across industries.

Exhibit 18: CAT Revenue Distribution, Oregon, FY22 and FY23 (in millions of dollars)



Source: Oregon Department of Revenue

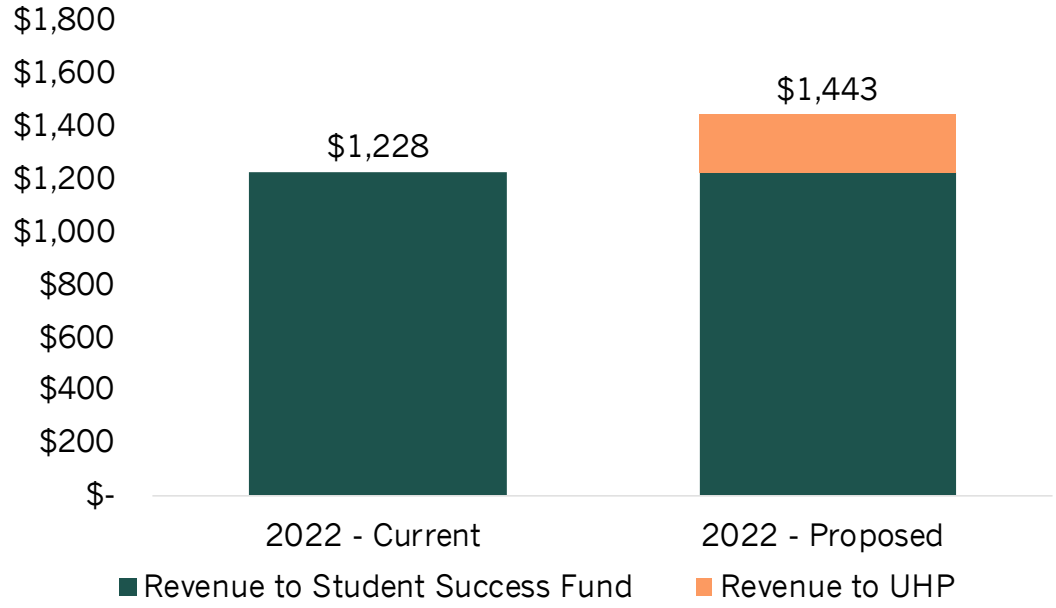
INCREMENTAL REVENUE GENERATED BY THE PROPOSED CAT ADD-ON

Under the Finance & Revenue Committee's current parameter set, the proposal includes a 0.10% incremental add-on to the existing CAT rate to generate UHP-dedicated revenue. The add-on is applied to the same taxable commercial activity base and preserves the CAT's current structure, meaning the proposed CAT rate becomes: $250 plus 0.67% of taxable Oregon commercial activity above $1 million (0.57% current + 0.10% UHP add-on).

Importantly, the proposal is structured as a dedicated surcharge: it generates incremental revenue for the UHP without reducing existing CAT revenue currently dedicated to the State Student Success Fund.

As illustrated in Exhibit 19, total CAT revenue in 2022 is estimated at $1,228 million (in 2022 dollars) under current law. Under the proposed add-on, total CAT collections are estimated at $1,443 million, with the difference—approximately $215 million (2022$)—representing new, UHP-dedicated revenue. The existing $1,228 million continues to flow to the Student Success Fund, while the incremental add-on is earmarked for the UHP.

Exhibit 19: CAT Revenue (in millions of 2022 dollars)



Source: Oregon Department of Revenue and ECOnorthwest

EPT Current Structure and Proposed UHP Add-On

Oregon already administers several payroll-based taxes that apply broadly to employers with paid employees working in the state, and corporations without employees must also register to report compensation paid to corporate officers. Exhibit 20 displays the FY22 estimates of total revenue from Oregon's current state payroll tax. Collectively, these existing employer payroll taxes "roughly sum to 3.6%" and include major components such as Unemployment Insurance, Paid Leave Oregon, the Workers' Benefit Fund assessment, and the Statewide Transit Tax.

Exhibit 20: Statewide EPT Current Structure

Oregon State Payroll Tax	Revenue
Unemployment Insurance, 0.9% - 5.4%	FY22 revenue was $1.3 billion
Paid Leave Oregon, 0.6% for employees, 0.4% for employers with more than 25 employees	FY24 revenue was $841 million
Workers Benefit Fund Assessment, $0.01 per hour worked	FY22 revenue collected $68.7 million in assessments
Statewide Transit Tax, 0.1% (does not include upcoming bill)	FY22 revenue was $122.1 million

Source: Oregon Department of Revenue, Oregon State Legislature

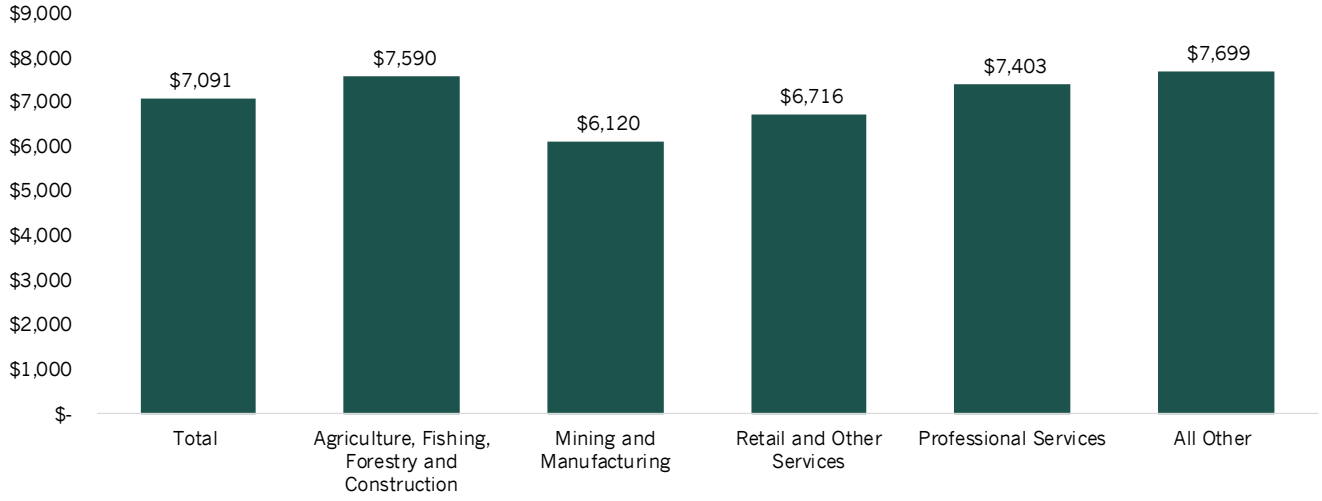
To provide a broader benchmark, there is also a parallel federal payroll-tax framework under FICA, where employees pay 7.65% (6.2% Social Security up to the wage base and 1.45% Medicare with no wage limit) and employers match that rate.

STATUS QUO EMPLOYER-SPONSORED INSURANCE (ESI) CONTEXT (WHAT EPT IS REPLACING)

Because the UHP EPT is intended to replace the employer share of today's ESI spending, the analysis also documents how ESI costs and coverage patterns vary across the economy. The exhibits below demonstrate Oregon 2022 data on average total single premiums by industry and by firm size, as well as the share of workers employed at firms that do not offer health insurance.

Exhibit 21 demonstrates that on average, industries like agriculture, fishing, forestry and construction as well as professional services have some of the highest annual premiums from single employees. While mining and manufacturing and retail and other services have lower average total premiums, $6,120 and $6,716 respectively. On average across all industries, ESI is roughly $7,000 per person.

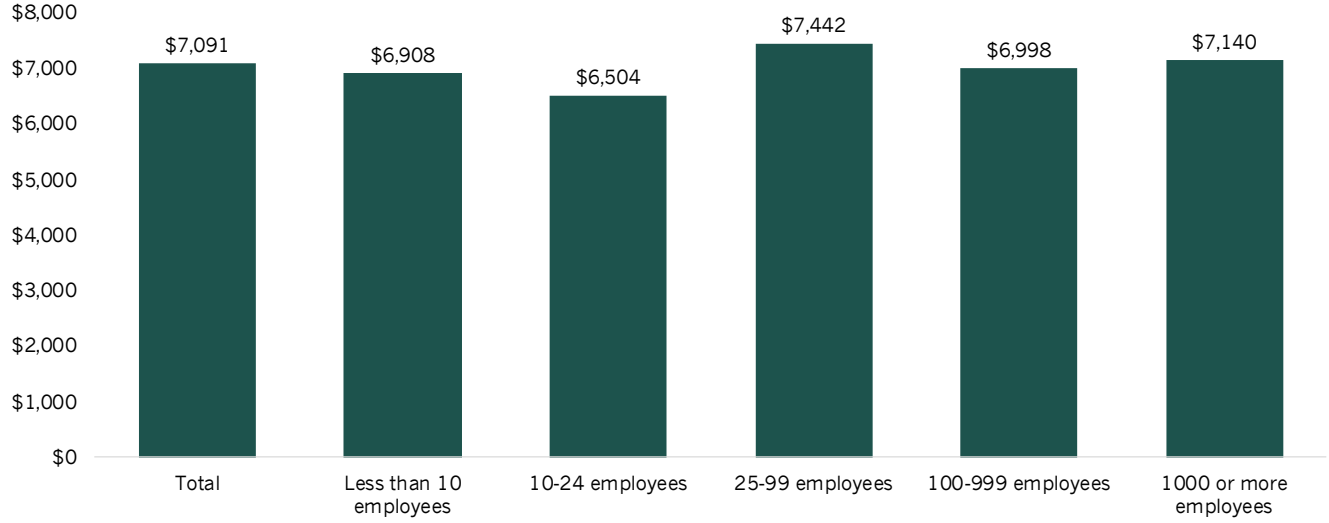
Exhibit 21: Average ESI by Industry Grouping, Oregon, 2022



Note: Average total single premium per enrolled employee at private-sector establishments that offer health insurance by industry groupings, Oregon, 2022
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2022 Medical Expenditure Panel Survey Insurance Component

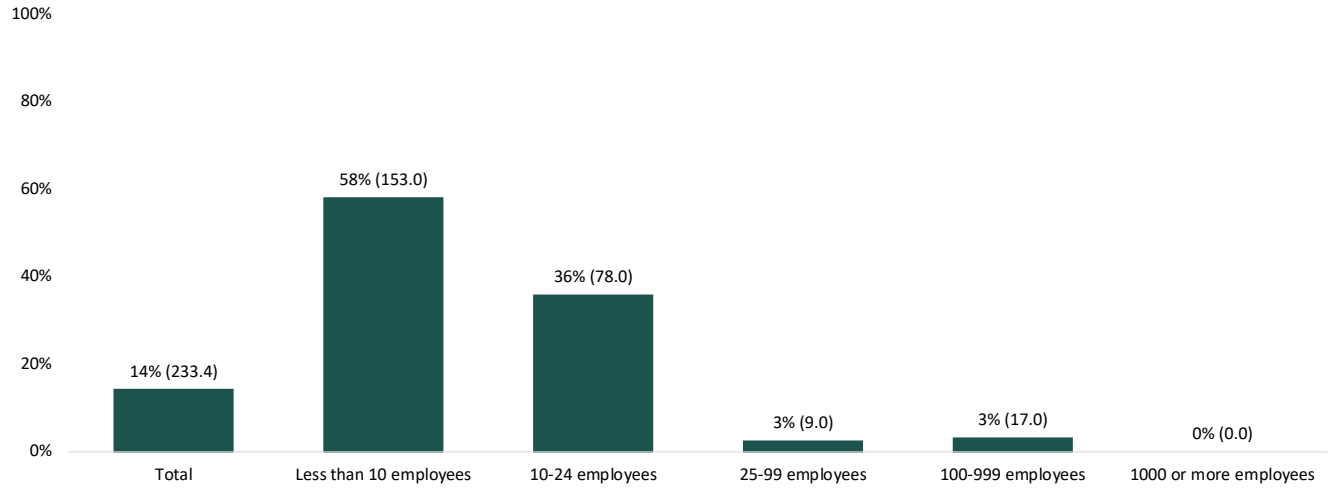
In Exhibit 22, we can see that medium to larger sized firms tend to have higher average ESI totals per person. Comparatively in Exhibit 23, firms that are smaller tend to not offer health insurance at all.

Exhibit 22: Average ESI by Firm Size, Oregon, 2022



Note: Average total single premium (in dollars) per enrolled employee at private-sector establishments that offer health insurance by firm size, Oregon, 2022
Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2022 Medical Expenditure Panel Survey Insurance Component

Exhibit 23: Percent of private-sector employees in firms that do not offer health insurance by firm size, in thousands, Oregon, 2022



Source: Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2022 Medical Expenditure Panel Survey Insurance Component, Oregon Employment Department Quarterly Census of Employment and Wages, ECOnorthwest

Taken together, these exhibits highlight two structural features of the status quo that are central to the Committee's financing design. First, employer health care spending is highly uneven—not only across sectors, but also across firms of similar size depending on whether they offer coverage and how generous that coverage is. Second, because ESI is voluntary and unevenly distributed, employer-financed coverage does not provide a consistent or universal financing base. The EPT is intended to replace this patchwork with a broad, predictable, and transparent employer-side contribution that aligns with universal benefits while still allowing

the analysis to evaluate how different types of employers, by size, industry, and coverage posture, compare under the "pre/post" framework.

PROPOSED CHANGES TO EPT UNDER THE UHP PROPOSAL (HOW THE ADD-ON IS STRUCTURED)

Under the Finance & Revenue Committee's proposal, the UHP would add a new, dedicated EPT layer on top of the existing payroll-tax environment of 9.6%. This is an additional payroll tax paid by employers, structured with a key design feature: a firmwide payroll threshold for positive liability set at $500,000 in payroll liabilities.

INCREMENTAL REVENUE GENERATED BY THE PROPOSED EPT

In the Committee's modeling, the EPT is the single largest employer-side revenue instrument in the package. The revenue under the UHP EPT of $8,715 million (in 2022 dollars), representing the gross employer-side collections prior to accounting for how much is ultimately used to offset household liability through the credit mechanism (i.e., the HCPIT).

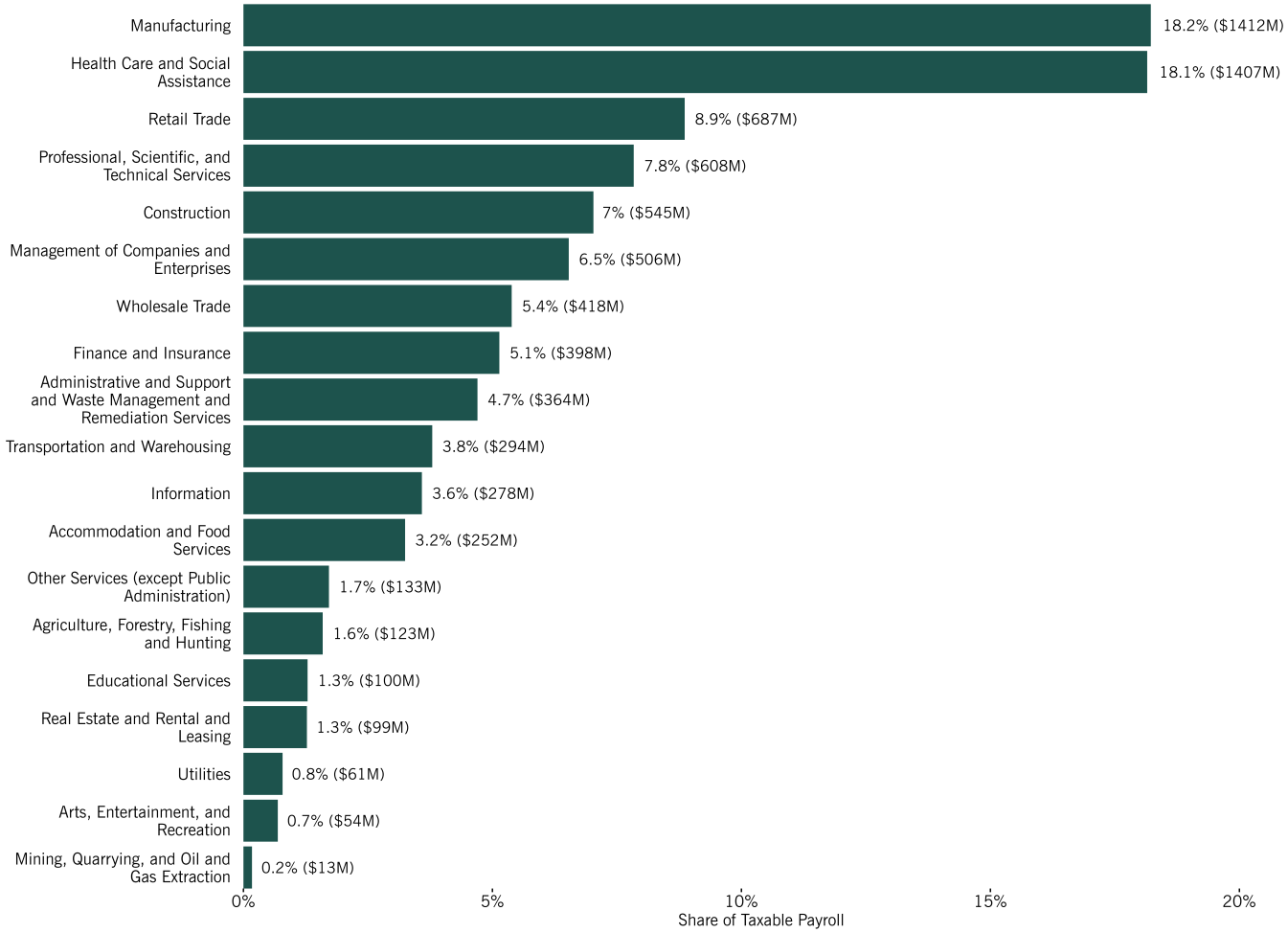
DISTRIBUTION OF PROPOSED EPT PAYMENTS (INDUSTRY AND BUSINESS SIZE)

Because the EPT is payroll-based, its incidence across employers will vary systematically by wage base and employment scale. The following exhibits (Exhibit 24 and Exhibit 25) summarize how proposed EPT receipts are distributed across private industry sectors and across average firm-size groupings using Oregon Employment Department Quarterly Census of Employment and Wages (QCEW) data.

The exhibits summarize how the proposed EPT receipts are distributed across the private economy. Because the EPT is assessed on payroll, the distribution of payments largely follows two structural features of Oregon's labor market: where payroll is concentrated by sector and how employment is distributed across firm sizes. The purpose of these exhibits is to show, at a high level, which parts of the economy generate most employer-side revenue under a payroll-based mechanism and to provide context for the "pre/post" comparisons that follow.

Exhibit 24 shows the EPT revenue distribution by industry. The largest shares of proposed EPT receipts come from sectors with the largest payroll bases. This reflects a combination of employment scale and wage levels: sectors with large workforces and/or higher average wages generate more taxable payroll and therefore contribute a larger share of total EPT revenue. The distribution also highlights that the EPT is not narrowly concentrated in a single industry but is instead broadly sourced across major sectors of the Oregon economy, consistent with the Committee's goal of a stable, diversified employer-side contribution base.

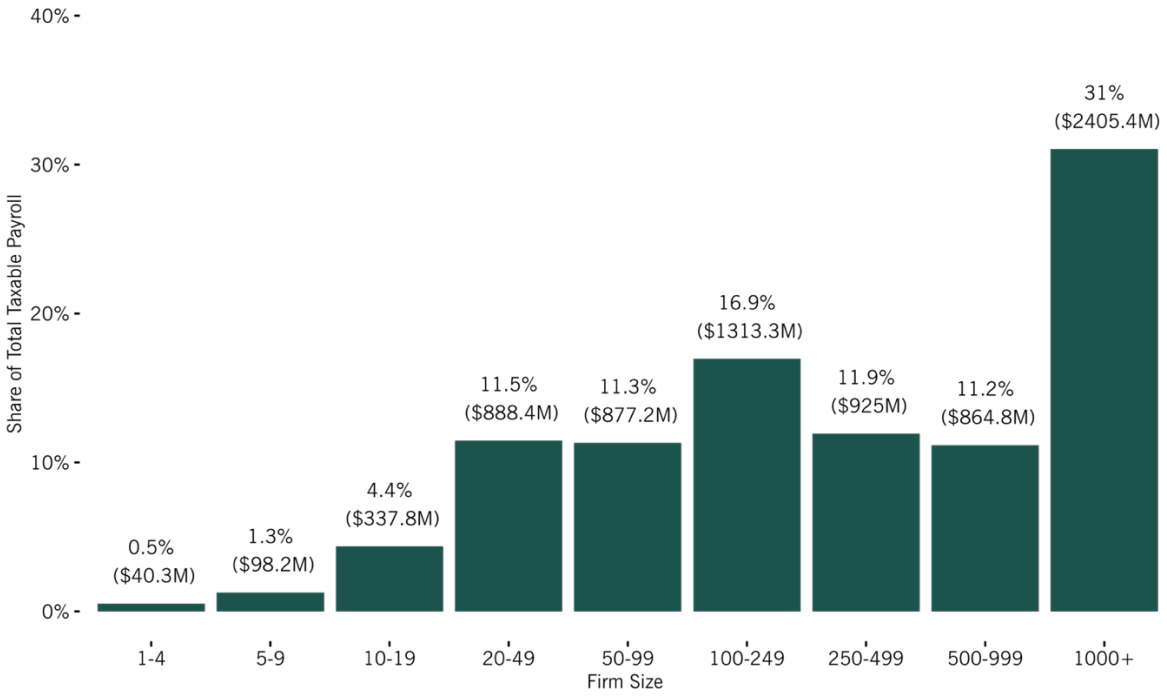
Exhibit 24: EPT Revenue by Industry Sector, Oregon, 2022



Source: Oregon Employment Department, Quarterly Census of Employment and Wages, ECOnorthwest

By firm size, proposed EPT receipts are concentrated among larger employers, as shown in Exhibit 25 below. This is a predictable result of payroll concentration: large firms employ a disproportionate share of workers and therefore account for a disproportionate share of total payroll. In addition, the proposal's firm threshold reduces the relative contribution from the smallest employers, further shifting receipts toward larger firms. Importantly, this distribution describes where receipts come from; it does not, by itself, indicate whether any given employer pays more or less than it does today for health benefits.

Exhibit 25: EPT Revenue by Firm Size, Oregon, 2022



Source: Oregon Employment Department, Quarterly Census of Employment and Wages, ECOnorthwest
Note: Firm size is based on average annual private employment.

Household and Individual Impacts

To understand the differences in UHP impacts for individuals and households, the progressivity and neutrality of the plan has been assessed across work types, Medicare treatment and practical examples. One of the best measures for assessing individual and household impacts is to consider the adjusted gross income, a measure of income net of specific contributions such as HSA contributions or student loan payments. As mentioned previously in section 4, there are three components that help determine an individual/household's tax liability through the Healthcare Personal Income Tax (HCPIT):

1. **The EPT credit.** This credit helps to balance the tax liability burden by preventing a stack of employer contributions on top of individual contributions.
2. **The Household Size Rate Readjustment (HSSR).** These "readjustments" are integrated into the household size calculation used to determine the total tax liability.
3. **The Medicare Part B Premium.** The among of part B premiums paid by those represented in the tax return gets applied as a credit to prevent a "double taxation" on top of existing Medicare liabilities.

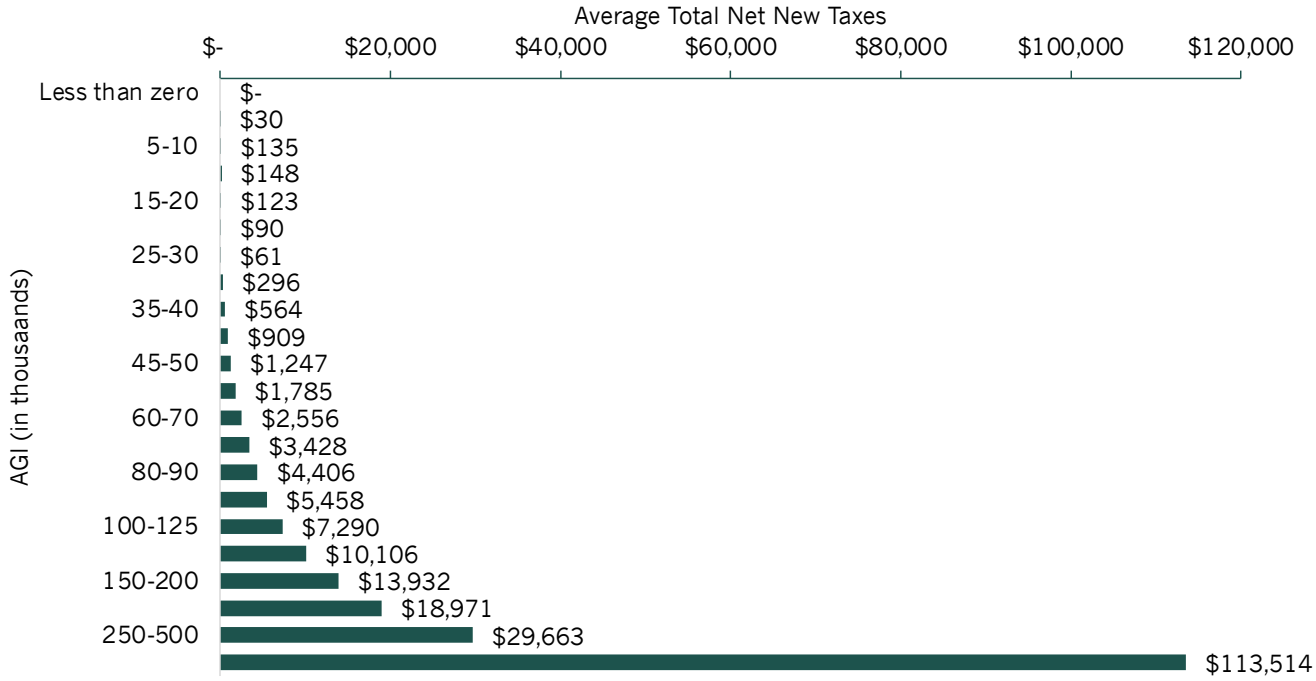
These adjustments operate within a single net-liability calculation rather than as separate instruments, and the progressivity and practical impacts of the HCPIT should be understood considering all three.

Progressivity Across Income Levels

One of the clearest measures of how the proposal distributes individual burdens is the effective HCPIT rate across adjusted gross income (AGI) bands. AGI is used as the primary income measure here because it reflects income net of specific deductions, such as HSA contributions or student loan interest, and therefore provides a more accurate picture of a household's practical ability to pay than gross income alone.

Net revenue from the HCPIT (net of the part B credit) is estimated at $6,317 million. The proposal is designed so that absolute tax liability rises with income, households with higher AGI pay more in dollar terms than those with lower incomes, reflecting the structure of the exemption threshold, phase-in, and the statutory 10.1% rate. Exhibit 26 illustrates this pattern by showing average total net new tax liability in dollar terms across AGI bands. Households in the lowest income band face near-zero average liability, consistent with the exemption below 200% of the federal poverty level, while those at the top of the distribution face substantially higher absolute contributions. The reason there are low tax liability in the lower AGI bands is because zero-exemption filers (those who can be claimed as a dependent on another return) would pay some HCPIT. No other filers in the lowest AGI groups (below $25k) would pay any HCPIT.

Exhibit 26. Average Total Net New Taxes for Individuals by AGI, 2022



Source: Oregon Department of Revenue, Finance and Revenue Committee

As discussed in Section 4 and shown in Exhibit 14, individuals and households see the largest reduction in contributions of any payer class under the F&R proposal. Estimated individual contributions decline by approximately $787 million, from roughly $8.0 billion under the status quo to approximately $7.3 billion under the proposal. This reduction

reflects the replacement of private premiums and out-of-pocket costs with income-based HCPIT contributions that are, on average, lower for most households, particularly after credits are applied.

Effective rates have a similar increasing pattern to the absolute liability for individuals, as shown below in Exhibit 27. The table presents average HCPIT rates by AGI band, with effective rates rising from 0.4% at the lowest income band (averaging approximately $21,500 annually) to 9.0% at the highest (averaging approximately $1.28 million annually). Mid-range households face rates of 3.4% and 6.0% at average incomes of roughly $51,700 and $103,500 respectively, with higher-income households (with $214,500 AGI on average) facing a 7.8% effective rate.

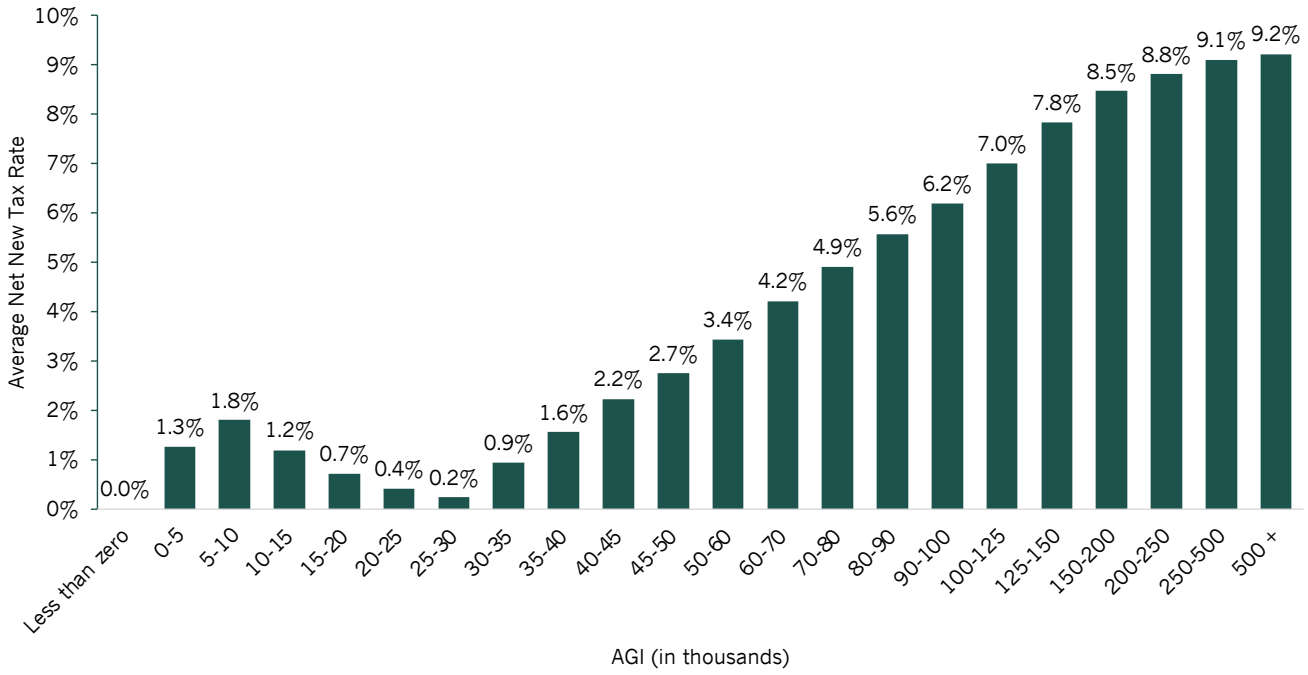
Exhibit 27. Average HCPIT rate by Average Adjusted Gross Income, 2022

AGI Level (in thousands)	Average AGI	Average Tax Liability	Average HCPIT Rate
$20-25	$21,918	$90	0.4%
$50-60	$51,914	$1,757	3.4%
$100-125	$104,240	$6,270	6.0%
$200-250	$215,307	$16,892	7.8%
$500 +	$1,232,295	$111,390	9.0%

Source: Finance and Revenue Committee, Oregon Department of Revenue
Note: Average AGI does not include social security income, whereas the AGI level categories originate from the Oregon Department of Revenue and include social security income. This distinction is relevant for interpreting results for lower-income retirees and others with significant Social Security income, and should be kept in mind when comparing effective rates across bands.

Below in Exhibit 28, which shows how the rate structure behaves across the full income distribution, the chart confirms that the rate gradient is broadly smooth and progressive. Rates rise steadily with income rather than concentrating the burden at a single point in the distribution. It also makes visible the flattening of the effective rate at the top of the distribution as rates approach but do not reach the statutory ceiling, consistent with the effect of the income-based credits that reduce net liability for all filers.

Exhibit 28. Average Total Net New HCPIT Rate Paid for Individuals by AGI, 2022



Source: Finance and Revenue Committee, Oregon Department of Revenue

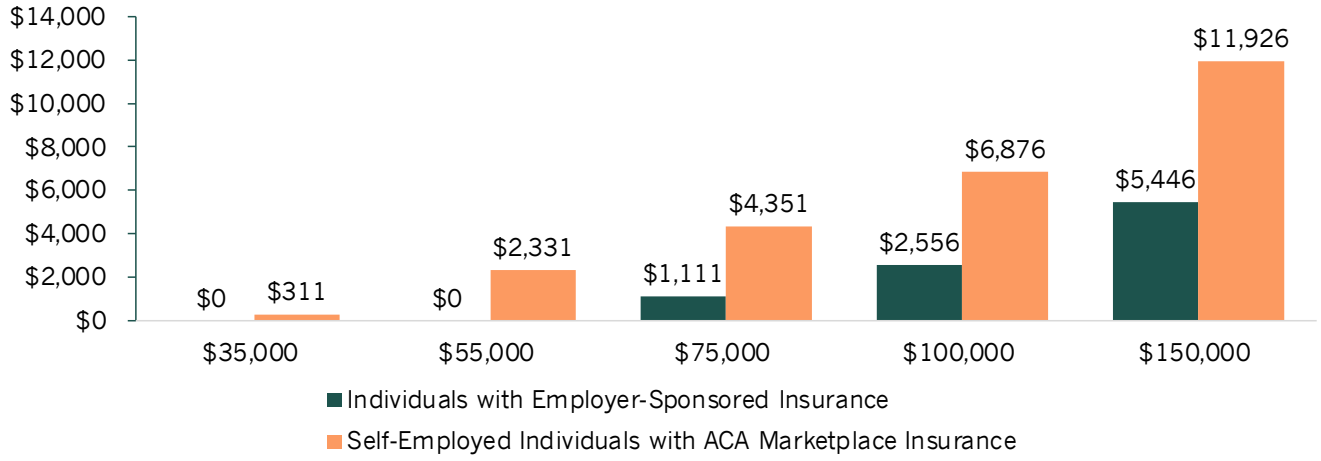
Note: All HCPIT liability for AGI groups $20-25 and below is calculated using zero-exemptions returns.

Employed vs Self-Employed Comparisons

For individuals with wage and salary income, the HCPIT does not operate in isolation. Because their employers pay the EPT on their behalf, wage earners are eligible for the EPT credit, equal to 50% of the EPT paid on their wages, applied directly against their HCPIT liability. This credit prevents the same compensation from being taxed twice and reduces net individual contributions relative to what a standalone income-based tax would otherwise require. The offset is proportionally larger at low and middle incomes, where the credit represents a greater share of total HCPIT liability.

Self-employed individuals, however, face a structurally different situation. Because no employer pays the EPT on self-employed individual's behalf, they are not eligible for the EPT credit, and their HCPIT liability is determined solely by income, household size, and applicable exemptions and phase-ins. At comparable income levels, this means self-employed individuals generally face higher net HCPIT contributions than wage earners at firms subject to the EPT. Exhibit 29 illustrates this difference directly, presenting side-by-side net contributions for a wage earner and a self-employed individual at the same income level. The gap between the two reflects the value of the EPT credit and highlights the structural distinction in how the two employment types interact with the HCPIT.

Exhibit 29. Wage and Salary Employee vs. Self-Employed Individual Contribution UHP Scenario, 2022



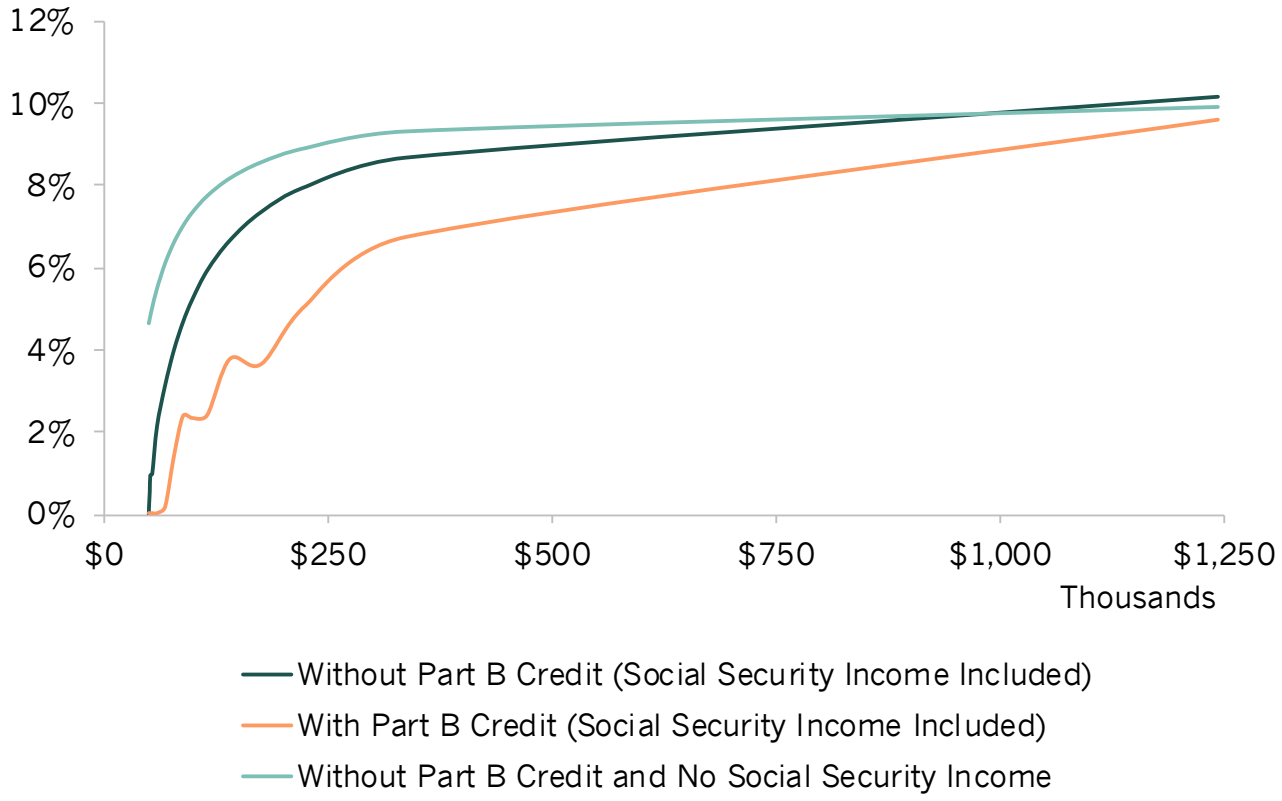
Source: Kaiser Family Foundation and Peterson Center on Healthcare, Finance and Revenue Committee.

Medicare Population Impacts

Medicare beneficiaries present a distinct situation within the individual contribution framework. Because Medicare enrollees already pay Part B premiums directly to the federal government, subjecting them to the full HCPIT without adjustment would effectively require them to pay twice for a portion of their coverage. The proposal addresses this through a non-refundable Medicare Part B premium credit, applied against HCPIT liability, equal to 100% of Part B premiums paid, calculated within the same net-liability framework as the EPT credit and HSRR adjustments.

Exhibit 30 shows the resulting net HCPIT rate for a single Medicare tax filer across income levels. At lower incomes, the Part B credit fully or substantially offsets HCPIT liability. At higher incomes, a residual net rate remains after the credit is applied. The exhibit illustrates that the Part B credit meaningfully reduces effective contribution rates for Medicare beneficiaries, particularly those with modest fixed incomes, while preserving a progressive contribution structure above the credit threshold.

Exhibit 30. Net HCPIT Tax Rate for Single Medicare Tax-Filer, 2022



Source: Source: Finance and Revenue Committee, Oregon Department of Revenue

Illustrative Household Typologies and Case Studies

The aggregate and distributional scenarios presented above describe how the proposal performs across the full population of Oregon filers and employers. To complement that picture, this section presents four representative household typologies that translate the proposal's mechanics into practical, comparable cost estimates for specific household circumstances. Each typology shows estimated annual health care costs under the status quo, including premiums, employer contributions, and out-of-pocket spending, alongside projected UHP contributions net of applicable credits and adjustments. The typologies are drawn from a range of income levels, employment arrangements, and coverage types to illustrate how outcomes vary depending on which mechanisms are active for a given household.

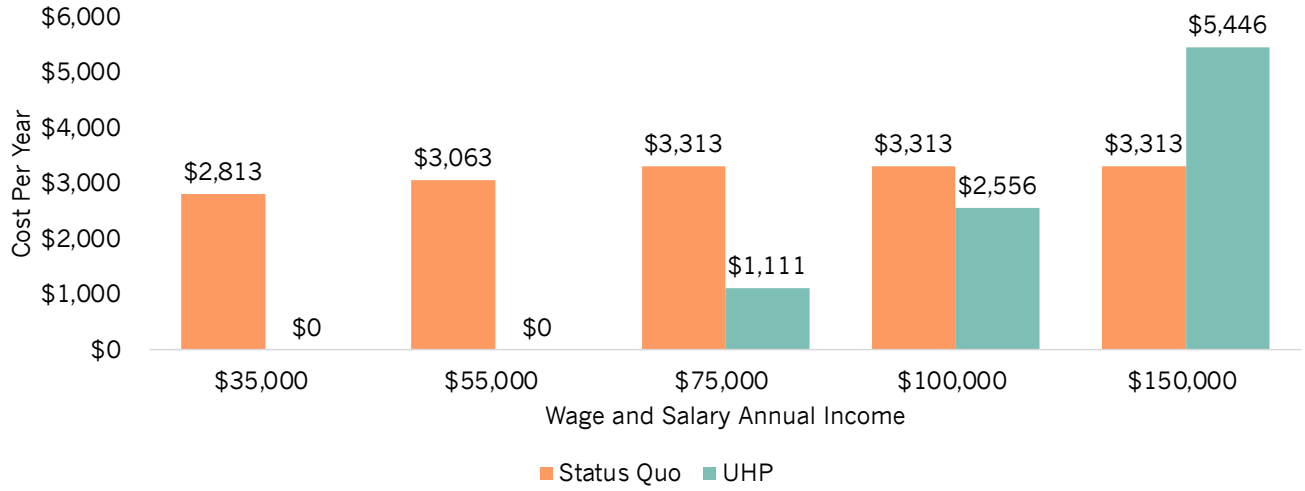
They are not intended to be exhaustive, but rather to make visible the logic of the proposal for the kinds of households most commonly affected by the transition from employer-sponsored and marketplace coverage to a universal public plan. An important note on the figures presented in this section: all status quo cost estimates have been adjusted to 2026 dollars to allow for meaningful comparison with UHP contribution estimates, which are expressed in 2026 terms. These figures are estimates based on available survey and

administrative data, not reported household-level expenditures, and involve assumptions about average premium levels, cost-sharing utilization, and inflation that will vary across individual circumstances. They should be interpreted as illustrative of typical cost patterns rather than as precise predictions for any specific household.

Employer-Sponsored Insurance Comparisons

Exhibit 31 compares the annual health care costs for a single employed adult with employer-sponsored insurance under the UHP and "status quo" across a range of income levels. Status quo cost estimates draw primarily on the Peterson-KFF Health System Tracker's Household Health Spending Calculator, which aggregates data from several publicly available sources on what individuals and families actually spend on health care, including both premium contributions and cost sharing. For a low-income individual below the HCPIT exemption threshold, UHP liability is zero and total costs under the proposal are lower than status quo premiums and out-of-pocket spending, as seen in Exhibit 31below. For a higher-income individual, the EPT credit moderates individual-side liability, and the net cost comparison depends on the generosity of current coverage and the applicable effective rate.

Exhibit 31. Individual, Employed with Wage and Salary Income, Employer-Sponsored Insurance, Status Quo vs. UHP Annual Cost, 2026



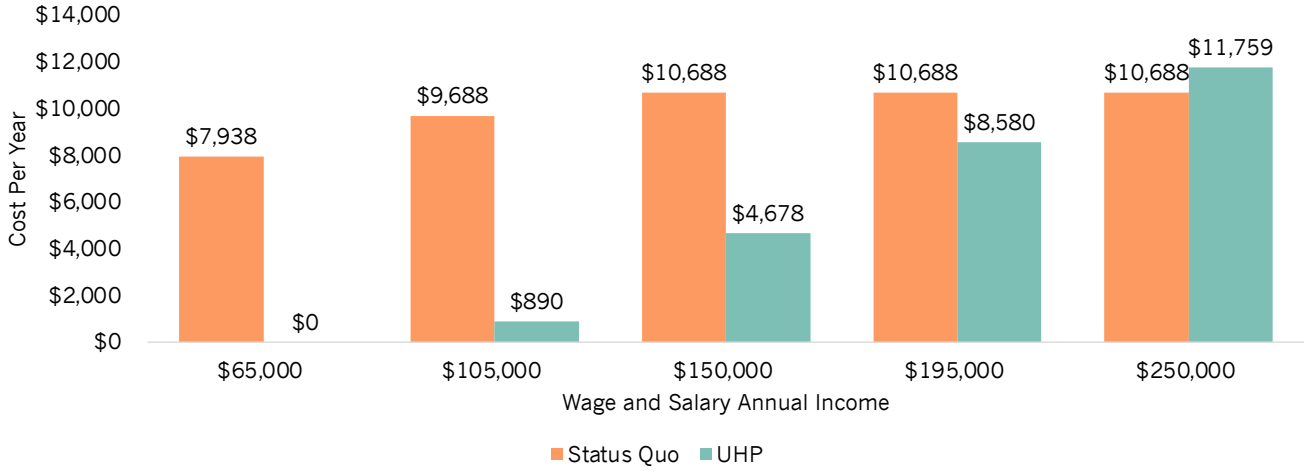
Source: Kaiser Family Foundation and Peterson Center on Healthcare, Finance and Revenue Committee

Note: KFF data underlying the employer-sponsored and ACA typologies are benchmarked to 2022. A 25% inflation adjustment was applied to bring those estimates to 2026 dollars.

A family of four with wage and salary income above 260% federal poverty level, represents a household type where both the income phase-in and the HSRR are simultaneously active (though the HSRR does not fully phase in until 520% FPL). Status quo costs for this typology also draw on the Peterson-KFF Household Health Spending Calculator, which reports premium and cost-sharing data for families of four by income tier; the KFF data do not include household sizes between an individual and a family of four, so the family-of-four typology reflects the closest available benchmark. Exhibit 32 shows that, for a moderate-

income family in this range, UHP contributions are generally lower than status quo premium and out-of-pocket costs.

Exhibit 32. Family of Four with Wage and Salary Income, Employer-Sponsored Insurance, Status Quo vs. UHP Annual Cost, 2026



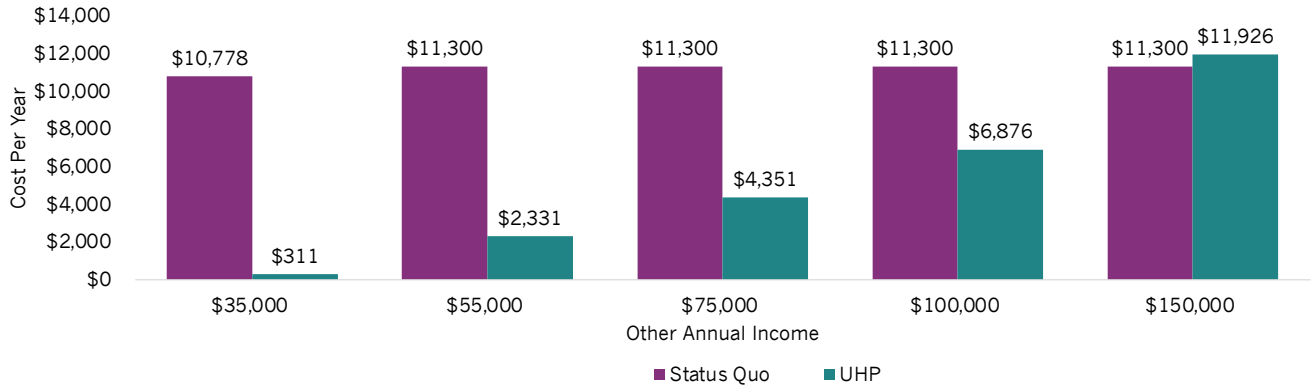
Source: Kaiser Family Foundation and Peterson Center on Healthcare, Finance and Revenue Committee

Affordable Care Act Marketplace Insurance Comparisons

For self-employed individuals purchasing coverage through the ACA marketplace, the cost comparison is shaped by the absence of the EPT credit. Status quo ACA premium estimates for this typology are based on average Oregon Silver Plan premiums, with premium tax credits calculated under the post-HR1 (2025) structure, under which credits phase from 2.1% of income at 133% of the federal poverty level to 9.96% at 400% FPL, with no credits available above 400% FPL.

Exhibit 33 illustrates that a self-employed individual's HCPIT liability is not offset by employer participation, and the net outcome relative to the status quo depends on current premium levels and subsidy eligibility. For those currently paying full or near-full ACA marketplace premiums without significant subsidy, UHP contributions may represent a reduction in total health care costs even without the EPT credit. For those receiving substantial ACA subsidies, the comparison is more variable and turns on income level and household size.

Exhibit 33. Self-Employed Individual with Other Income, ACA Marketplace Insurance, Status Quo vs. UHP Annual Costs, 2026



Source: Finance and Revenue Committee

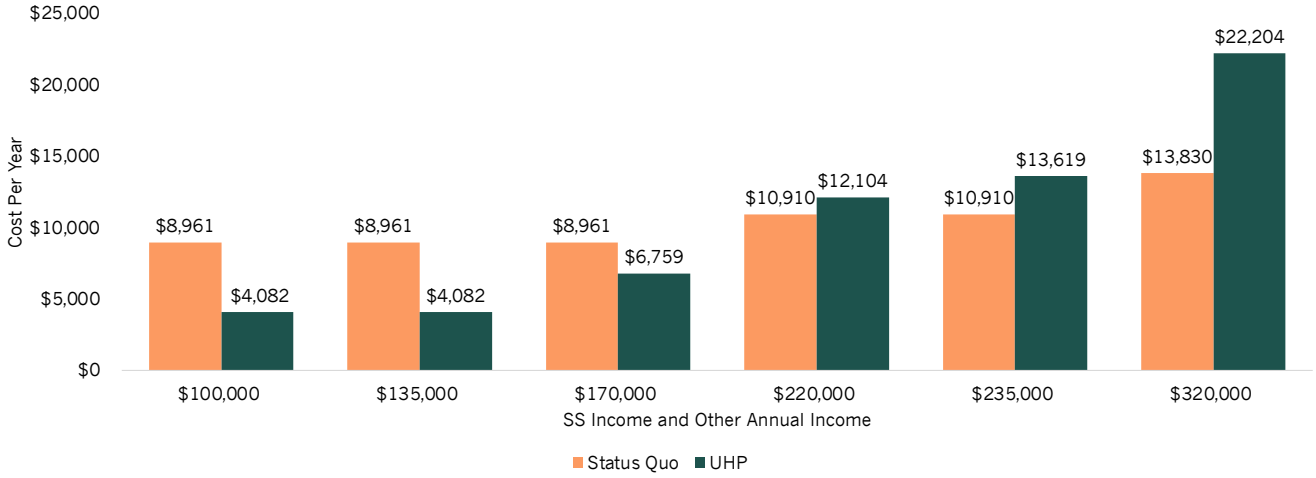
Medicare Advantage Insurance Comparisons

For Medicare households, the non-taxability of social security benefits and the Part B premium credit have important roles in the cost comparison. Status quo cost estimates for this typology draw on KFF data on Medicare Advantage plan premiums and out-of-pocket limits. According to KFF, approximately 75% of Medicare Advantage (MA) enrollees pay no premiums above the required Part B premium, and average additional MA premiums across all enrollees are approximately $168 annually.[20] Out-of-pocket cost sharing was estimated based on KFF-reported enrollment-weighted average out-of-pocket limits for MA plans, with actual spending estimated at approximately 35% of the applicable limit, a conservative assumption given the considerable variation in individual health experience.

Exhibit 34 presents a retired couple, both of whom have Medicare Advantage coverage and average social security benefits for their income, showing how the couple's combined Part B premiums are credited in full against HCPIT liability, reducing net contributions and avoiding double payment for coverage already financed through federal premiums. For a moderate-income Medicare household, the Part B credit substantially reduces or eliminates net HCPIT liability, and UHP contributions are generally lower than the combined cost of Medicare premiums and supplemental out-of-pocket spending in the status quo.

[20] KFF, Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization. https://www.kff.org/medicare/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/

Exhibit 34. Couple's Medicare Advantage Insurance, Status Quo vs. UHP Annual Costs, 2026



Source: Kaiser Family Foundation and Peterson Center on Healthcare, Centers for Medicare and Medicaid Services, Finance and Revenue Committee.[21,22]

Note: Medicare estimates, drawn from 2024 data, were adjusted upward by approximately 9% to reflect estimated cost growth for 2025 and 2026.

Tax Mechanisms Considered but Not Recommended

In addition to the instruments included in the recommended package, the Finance & Revenue Committee evaluated a broad menu of alternative revenue approaches—both to test whether they could meaningfully contribute toward the Revenue Replacement Target and to understand how different tools would perform against the Committee's design principles (revenue adequacy, equity and progressivity, administrative feasibility, and legal durability). Several options were discussed repeatedly because they offered attractive features on one dimension but introduced clear drawbacks on others. The Committee did not advance the following mechanisms as part of the recommended plan; however, they are documented here because they may remain relevant as calibration advances (e.g., as plan costs and transferable funding are updated for the first year of operations) or as the Board considers contingencies and design refinements.

[21] Centers for Medicare & Medicaid Services. (2025, November 14). *2026 Medicare Parts A & B premiums and deductibles* [Fact sheet]. U.S. Department of Health and Human Services. https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles

[22] Ochieng, N., Cubanski, J., & Neuman, T. (2025, December 19). *A snapshot of sources of coverage among Medicare beneficiaries*. KFF. https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/

Soft Cap Mechanism (High-Income Calibration and Behavioral Risk Management)

The Committee discussed "soft cap" concepts as a way to manage contributions at the very top of the income distribution—particularly to address behavioral and tax-planning risks that can arise when marginal contribution rates become materially higher than what high-income households currently pay for health care through premiums and out-of-pocket spending. In this context, a soft cap is not a separate revenue source. It is a rate-shaping feature that changes how HCPIT liability grows above a high-income threshold by decreasing marginal rates, limiting incremental liability growth, or otherwise moderating the top-end schedule.

A principal motivation for considering a soft cap was to reduce incentives for tax avoidance and tax base erosion, including:

- Income sheltering or timing strategies (e.g., shifting income into non-taxed forms, deferring realization, or reclassifying income where feasible) that can reduce the personal income tax base; and
- migration or domicile responses for a small number of very high-income taxpayers who may be more mobile, particularly if their modeled HCPIT obligations substantially exceed their current health care expenditures under the status quo.

The Committee recognized that these responses may be limited for most households, but that even a small number of high-income taxpayers can represent meaningful revenue exposure because of the concentration of taxable income at the top of the distribution. The soft cap was therefore evaluated as a practical tool to balance two competing objectives: maintaining progressivity and revenue adequacy on the one hand, while avoiding a contribution schedule that could be perceived as punitive relative to current health care payments and therefore more likely to trigger avoidance behavior on the other.

The Committee did not include a soft cap as a default element of the recommended package primarily because it is regressive. A soft cap is primarily a distributional calibration lever that materially affects revenue adequacy and requires explicit offsets elsewhere in the financing structure (e.g., adjustments to rates, credits, or other parameters) to maintain the Revenue Replacement Target. It also introduces additional thresholds and interaction effects—especially in combination with the EPT credit and household adjustments—that increase parameter sensitivity and complicate communication.

For these reasons, the Committee treated soft caps as an optional design dial for the Board's consideration during forward-year calibration and final parameter setting. If the Board chooses to pursue a soft cap, the key design question is how to moderate top-end liabilities enough to reduce avoidance incentives while preserving the overall progressivity and revenue sufficiency of the financing framework.

Sumptuary Taxes

The Committee evaluated taxes on goods associated with negative health externalities—such as alcohol, tobacco, marijuana, and sugar-sweetened beverages. Two conclusions emerged consistently. First, the revenue base is not large enough to make sumptuary taxes a meaningful pillar of UHP financing at the scale implied by the Revenue Replacement Target. Even aggressive rates typically generate comparatively modest revenue relative to the magnitude of on-going UHP funding needs. Second, these taxes raise distributional concerns. Consumption of many taxed goods can be regressive relative to income, and rate increases can place disproportionate burden on lower-income households absent explicit offsets.

That said, the Committee also recognized that sumptuary taxes can serve a different purpose from the core financing instruments: they can support secondary health-policy objectives by discouraging harmful consumption and partially internalizing the public costs associated with preventable health conditions. If the Board wishes to pursue this pathway, the Committee's view is that sumptuary taxes are best framed as supplemental (and potentially earmarked for targeted public health initiatives or reserve/risk buffers), rather than as a core component of the on-going financing structure.

State Sales Tax

Given its capacity and stability—and its widespread use in other states—the Committee considered a statewide sales tax as a possible revenue source for the UHP. The Committee did not recommend a sales tax in the package for several reasons tied to core design objectives:

- **Equity and regressivity.** A broad-based sales tax is generally regressive absent substantial offsets or exemptions, and it would require additional compensating mechanisms to maintain the progressivity goals embedded in the HCPIT and related credits.
- **Structural change and implementation risk.** Oregon does not currently have a general sales tax. Establishing one would be a major structural change with significant administrative, compliance, and political considerations that extend beyond the scope of calibrating the UHP's replacement-financing structure.
- **Fit with the replacement framing.** The Committee emphasized replacing and restructuring existing health-care payments in a way that tracks ability to pay and employer participation. A broad consumption tax is less directly linked to the current financing system and would shift the composition of who pays in ways that may be difficult to align with the Committee's distributional objectives.

For the Board's reference, the Committee notes a key benchmark from the Oregon Legislative Revenue Office (LRO): the latest LRO estimate indicates that a 5% sales tax would raise approximately $5,853 million in FY 2026–27 terms if implemented July 1, 2026, assuming it is in place for the full fiscal year. The revenue raised per sales tax percentage would decrease as offsets or exemptions to make it less regressive are added. The estimate is easily scalable

to alternative rates but does not incorporate behavioral responses, border effects, or other non-linearities that could emerge at higher rates.

How the Board might Consider These Taxes and Mechanisms

The Committee's recommended package reflects a deliberate preference for mechanisms that are closely tied to existing health-care payment channels (payroll-linked employer financing and income-linked household financing), that have an existing infrastructure so that there is minimal additional administrative cost, and that can be updated as plan costs and transferable funding are recalibrated for implementation. The mechanisms above remain relevant as policy levers, particularly for contingency planning, fine-tuning distributional outcomes at the top end, or advancing secondary public health objectives, but they were not selected as central components of the Committee's baseline revenue framework.

5. Considerations Related to Funding Transition Costs and Reserve Capitalization

Introduction & Key Considerations

At financial maturity, the UHP will ideally have relatively stable dedicated revenues covering relatively expected costs. Prior to achieving maturity, the program will require funding for start-up and implementation costs related to launch and build-out. After achieving maturity, the program will continue to need reserves to ensure stable cash flow, uphold actuarial best practices for an insurance program, and meet legal requirements. Funding (the sources of revenue) and financing (the strategy and tools for covering costs) will depend on a variety of considerations, including the scale of costs, whether they are one-time or ongoing, the nature and extent of risk, and the type of organization or entity that the UHP operates under. It should be noted that the Finance and Revenue Committee did not have time to reasonably review and make recommendations regarding transition costs and reserve capitalization.

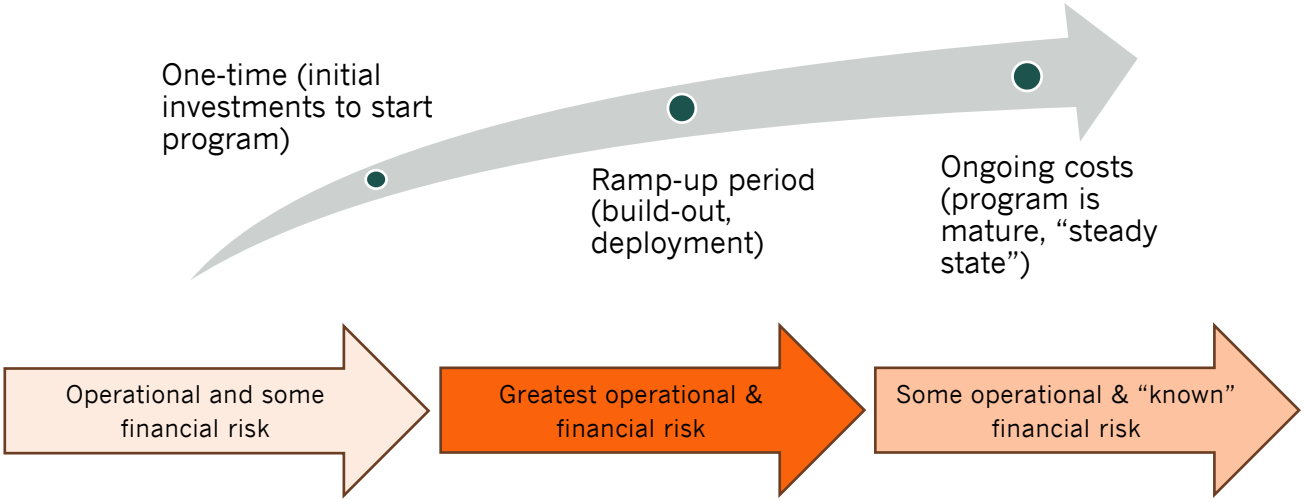
This chapter will explore the options available for funding and financing, and presents the following key takeaways from a scan of other insurance programs:

- It is likely that a variety of funding sources will be necessary to finance UHP through its early stages and seed a reserve sufficient to ensure the program is fiscally sustainable. Oregon's Coordinated care organizations (CCO) were funded with federal waivers and state dollars. Washington's paid family medical leave insurance program required both general fund appropriations and a one-year period of premium collection prior to covering claims.
- Authorizing legislation and actuarial standards will likely dictate a variety of reserve requirements. These can be calculated as a percentage of revenues or expenditures, a cash-on-hand requirement, and capital surplus requirements in the event of insolvency.
- It may be prudent for legislation authorizing a UHP to include requirements for both alerting decision-makers of financial distress and for accessing reserves. Washington's PFML program requires an alert to executive and legislative fiscal officers if premiums will be insufficient to cover projected claims. North Carolina's Medicaid contingency fund requires legislative appropriation.
- Taiwan's national insurance program experienced financial stress related to behavior by foreign nationals who were accessing health care but not contributing premiums, and may provide lessons learned for Oregon.

Implementation and Transition Cost Phases

The UHP's implementation entails three phases of costs: a start-up period of one-time costs, a ramp-up period of both one-time and ongoing costs, and a mature program with relatively stable costs and relatively stable revenues. Operational risk – primarily that the program roll-out will run into delays – tends to decrease with time through the above phases. Financial risk – primarily that the program will experience cost overruns, revenue shortfalls, cash flow instability, or insolvency – is highest in the ramp-up phase, ideally stabilizing at a known level through program maturity.

Exhibit 35. UHP Implementation Phases



Potential costs during each phase include:

Start-Up Phase (One-Time Cost)	Ramp-Up Phase (One-Time and Initial Ongoing Costs)	Program Maturity (Ongoing Costs)
Provider network readiness and payment system alignment efforts and resources	Continued technology build-out	Ongoing administrative operations (fully staffed program)
Information technology systems design and build-out (claims processing, eligibility, data integration)	1-2 years of administrative operations (staffing, professional services) prior to benefit deployment	Technology maintenance and operations costs
Other capital needs related to program implementation	Early benefit "bumps" due to misalignment of timing related to revenues and expenditures	Forecasted caseload and payments
Temporary dual systems support (human or IT) during ramp-down of legacy systems	Early benefit "bumps" due to caseloads or costs exceeding forecast	Fully enrolled and engaged providers
Public communications and enrollment campaigns	Seed funding for operating contingency and programmatic reserves	Self-funded reserves
	Continued public and provider engagement	

Covering the above costs will require a financial strategy that acknowledges the level of risk and utilizes the variety of funding sources and tools available to the UHP.

Funding and Financing Transition Costs

There are a number of potential fund sources available to cover the UHP's start-up, transition, and reserve costs listed above. **Funding** refers to the source of revenue used to cover costs. In the UHP context, funding may include dedicated payroll or income-based taxes, federal funds (e.g., Medicaid waivers, 1332 innovation waivers), a state general fund appropriation, or private sources of revenue. **Financing** refers to the strategy or method used to cover costs. Financing strategies may include borrowing from the state, bonding or other public debt instruments where legally permissible, pre-collecting a portion of tax revenues, or temporarily increasing tax revenues to cover start-up costs.

State Budget Appropriation. Once a detailed implementation budget estimate is developed, start-up funding could be requested through the state budget process. This could be structured as 1-2 years of operating support while staff are hired and systems implemented. This approach allows for transparency and budget accountability, especially if funding is proviso-ed or attached to a bill that requires regular budget updates and with specificity regarding use of funds.

State Budget Loan. A state budget appropriation could also include proviso language or be attached to statutory requirements to repay the general fund over time from UHP dedicated tax revenues, especially once premium revenue reaches stability.

Information Technology Funding. Funding for IT system upgrades and development could be requested through the state budget process, likely subject to the state's Joint Enterprise Information Services / Legislative Fiscal Office Stage Gate Oversight process.[23]

Reallocation of Existing Spending. In the transition from the current Oregon Health Plan to a new, single-payer system, there may be current expenditures that can be reallocated to the new program. State spending on administration of OHP may be reallocated to the administrative costs of the new program. Coordinated care organizations' (CCO) mandatory reserves and some surpluses may

From the fiscal note for Washington SB 5975 (2017), establishing the state's new paid family medical leave program:

"The 2017-2019 Operating Budget appropriated **$82 million** to the Employment Security Department for implementation of the Family and Medical Leave Insurance Program (FMLI). This appropriation must be paid back using the FMLI premium collections by June 30, 2019, including interest as determined by the State Treasurer. The ongoing administrative and operating costs will be funded through premium collections."

Actual costs in the 2017-19 Biennium were **$53.5 million** (fiscal.wa.gov, Spending by Biennium), though the program experienced significant cost overruns in later years (see case study).

[23] Oregon Enterprise Information Services: Project Portfolio Performance. "Project Oversight." Oregon.gov. n.d. https://www.oregon.gov/eis/project-portfolio-performance/pages/it-investment-oversight.aspx.

potentially be another source of funding, pending a full review including legal analysis. Because CCOs are creatures of state statute and operate under contracts with the Oregon Health Authority that already allow for rate adjustments, claw-backs, and termination provisions, the Legislature could potentially direct the transfer or partial transfer of these reserves (especially risk-based capital and restricted net assets held by nonprofit CCOs) to the new public corporation or health care trust during the wind-down or integration of the CCO model, provided just compensation is addressed for any for-profit entities.

Timing of Tax Collection, or Temporary Tax Increase. If a tax funding the UHP can legally be implemented before program payments are made, a portion of the tax could be dedicated to one-time costs including the funding for a reserve to be effective when the program is live. An example is the Preschool For All tax in Multnomah County, which was implemented in 2021; the tax – which has exceeded forecasts – is intentionally designed to build a balance prior to fully universal preschool.[24] Another option is to temporarily increase the tax rate to seed a reserve funding or to cover implementation costs.

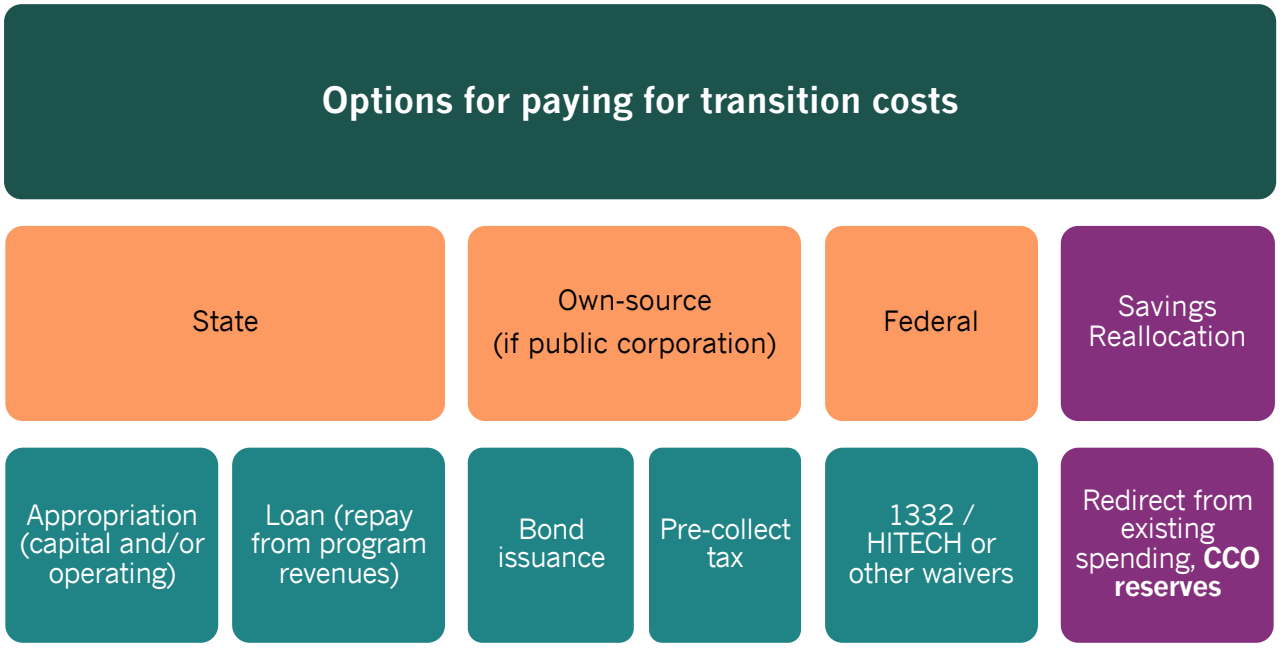
Debt Issuance. States typically issue bonds for long-term capital infrastructure like roads and bridges and do not use debt for operating budget needs. States have balanced budget requirements and debt limits that preclude the use of debt to fund ongoing needs, even one-time needs. It is possible that the state may consider (or may need to consider) a bond issuance to finance the technology component of UHP implementation, but typically largescale, statewide IT investments subject to planning and gated funding requirements under the EIS / LFO model.[25] It is also uncommon for state entities or any governments other than smaller municipalities to take out private loans.

Federal Funds. State Medicaid programs rely on federal waivers to redirect federal Medicare and Medicaid funding toward technology transformations.[26, 27, 28] Most recently, states have been utilizing the enhanced federal funds participation (FFP) match of 90 / 10 to draw down federal support for technology. Though it is possible the state could use federal funding to pay for a portion of transition costs, this option comes with many unknowns and exogeneous factors, and therefore should be considered with less certainty than a state funding source. Use of federal waivers or grant funding depend on federal appropriation, state eligibility for grants, and other unknown factors. Additionally, federal funding may be structured as

[24] Office of the Multnomah County Auditor. “Preschool for All: The program is largely achieving its equity goals, but needs to address risks to expansion.” Multnomah County. 2025. https://multco.us/info/preschool-all-program-largely-achieving-its-equity-goals-needs-address-risks-expansion.
[25] Oregon Enterprise Information Systems: Project Portfolio Performance. “Project Oversight.” Oregon.gov. n.d. https://www.oregon.gov/eis/project-portfolio-performance/Pages/it-investment-oversight.aspx.
[26] Wiley, Lindsay F. “State-Level Single-Payer Health Care from a Public Health Perspective.” *Am J Public Health*. [109], no. 11 (2019):1515–1516. https://pmc.ncbi.nlm.nih.gov/articles/PMC6775895/.
[27] HITECH, or the "Health Information Technology for Economic and Clinical Health Act," is a law passed as part of Obama's American Recovery and Reinvestment Act of 2009 (ARRA). The policy seeks to strengthen data privacy for health care recipients through promoting widespread adoption of electronic health records and information technology. More recently, states have relied on the 1115 waivers to leverage 90 percent enhanced federal financial participation (FFP) for Medicaid technology investment.
[28] HIMSS State Government Affairs. “State-Led Innovations Leveraging Medicaid Section 1115 Waivers.” HIMSS North America. 2018. https://www.himss.org/sites/hde/files/Medicaid%201115%20Waiver%20Brief_Final_0.pdf.

reimbursements, buying down costs later rather than providing immediate budget support – and thus would not negate the need for initial investment by the state.

Exhibit 36. Potential UHP Start-up & Transition Cost Funding Sources



Source: ECOnorthwest

Reserve Funding

Financial reserves are a prudent financial management tool designed to cushion against administrative cost overruns and provide a buffer against programmatic strains (caseload forecasts or revenue underperformance). Especially during the second and third phases of implementation when operational and financial risk are greatest, reserves are necessary given the unknowns around costs (utilization rates, benefit costs) and revenues (tax revenues, federal reimbursement). Coverage of previously uninsured or underinsured individuals may exceed forecasted expectations. When the program reaches stable revenues and costs, reserves may be self-funded through a portion of dedicated revenues. Prior to this point, reserve funding should be built into the budget for an implementation plan.

A UHP operated out of its own state fund has aspects of both government funds and of insurance pools, each of which have different reserve requirements and best practices. These reserve requirements are best thought of in the context of the two broad categories of expenditures incurred by a UHP: administrative costs and program payments or benefits.

OPERATING RESERVES

The Government Finance Officers Association (GFOA) has various recommendations for budgeting governmental fund reserves and budgeted fund balances. General funds are recommended to maintain balances of at least two months of regular general fund operating revenues or regular general fund operating expenditures.[29] Oregon has specific policies related to its Rainy Day Fund, which can only be used under particular circumstances (a three-fifths vote of the Legislature and a prolonged employment decline or a state of emergency) and its Education Stability Fund (ESF), which receives 18 percent of net lottery proceeds. In FY 2024,[30] about 30 percent of funding for Medicaid came from the state (general and other dedicated funds), and state spending on Medicaid accounted for 28 percent of all spending. Given its share of total state budget in Oregon, there is no Medicaid dedicated reserve fund outside of the general fund.[31]

ACTUARIAL RESERVES

Insurance pools and insurance funds have various targets for reserve funding. Actuarial methods include cash-on-hand targets, wherein a period of benefits are held in reserve for liquidity purposes; reserves intended to meet future liabilities, such as through claim or unearned premium reserves; or risk-based capitalization, wherein a targeted amount of capital is held on-hand based on the likelihood that a catastrophic event will occur. These methods are typical requirements or recommendations for regulation of smaller health plans or health pools.

[29] Kavanagh, Shayne C., Vincent Reitano PhD, Peter A Jones PhD. "Rethinking Budgeting: Should We Rethink Reserves? A Multimillion-Dollar Question." Government Finance Officers Association (GFOA). 2023. https://gfoa-craftcms.files.svdcdn.com/production/general/Rethinking-ReservesR2.pdf?dm=1759231581.

[30] Oregon Secretary of State, Oregon Blue Book. "Government Finance: State Government." Oregon Secretary of State. n.d. https://sos.oregon.gov/blue-book/Pages/facts/finance-state.aspx.

[31] National Association of State Budget Offices. "2024 State Expenditure Report: Medicaid Tables." NASBO. 2024. https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2024_SER/Medicaid_Tables_-_2024_State_Expenditure_Report.pdf.

Coordinated Care Organizations (CCOs) are community-level entities that operate under a global budget to pay for health care services to Medicaid members through a partnership among providers, payers, and community-based organizations. Per statute, CCOs are required to hold **restricted reserves** in the amount of $250,000 plus half of the CCO's total actual or projected liabilities above $250,000, as well as capital or surplus at a minimum of $2.5 million and "any additional amounts necessary to ensure the solvency of the CCO" as determined by rule. (ORS 414.572). Among other key financial metrics, CCOs report Premium Deficiency Reserve (Expense) amounts which are recorded when an insurer or managed care organization (MCO) determines that the unearned premiums for a current period may not be sufficient to meet future medical claims and expense. (OHA 2024 Public Brief – CCO Financial Reporting.)

Claim reserves, premium reserves. These are reserves typically set aside to ensure that insurers can meet future liabilities. Claims reserves are estimates of future claims that may be paid out under a policy. Unearned premium reserves are set aside in an amount sufficient to ensure that an insurer can refund a policy holder in the event that a policy is terminated before the end of a coverage period.[32]

Liquidity method. The Society of Actuaries has guidelines for premium reserve setting that entail using historical data to inform future projections of cash flows and reserves.[33] Healthcare reserves are typically set from revenue coming from premiums that policyholders pay.[34] This method is familiar in a health care setting; the metric for measuring primary reserves/reserve target funding for health care providers is "days cash on hand" (DCOH), which refers to the number of days a company can operate using only available cash reserves if no new revenue were to be generated. DCOH is calculated by dividing the entity's cash (and cash equivalents) by average daily operating expenses.[35]

[32] National Association of Insurance Commissioners, NAIC Model Laws, Regulations, Guidelines and Other Resources—2nd Quarter 2017. "HEALTH INSURANCE RESERVES MODEL REGULATION." NAIC. 2017. https://content.naic.org/sites/default/files/model-law-10.pdf.

[33] Smith, David V. "Gross Premium Valuation Reserves: What Are They and How Are They Calculated?" Society of Actuaries. *Small Talk Newsletter* issue no. 23, November 2004. https://www.soa.org/globalassets/assets/library/newsletters/small-talk/2004/november/stn-2004-iss23-smith.pdf.

[34] Fish-Parcham, Cheryl. "Challenging Health Insurance Premium Rate Increases: Part 4 – How to Challenge the Amounts Health Insurers Keep for Administrative Expenses, Reserves, and Surpluses." Families USA. May 29 2014. https://familiesusa.org/resources/challenging-health-insurance-premium-rate-increases-part-4-how-to-challenge-the-amounts-health-insurers-keep-for-administrative-expenses-reserves-and-surpluses.

[35] Allianz Trade. "Days Cash on Hand (DCOH): Definition, Formula, & Examples." n.d. accessed October 21 2025. https://www.allianz-trade.com/en_US/insights/days-cash-on-hand.html.

Risk-based capitalization. Risk based capitalization entails a target amount of capital on-hand in the event of a catastrophic event. Most states have adopted the NAIC's risk-based capital model as the primary framework for reserve targets for health insurance companies; this model sets a statutory minimum capital requirement based on the insurer's specific size and risks.[1] However, in a publicly-funded UHP context the scale of capital required (in the hundreds of millions) may not be feasible nor fair to taxpayers. This is particularly true if the UHP has the full faith and credit backing of the state of Oregon.[36, 37]

Portland's Health Insurance Operating Fund policy illustrates NAIC recommendations.[1] One of its two reserves requirements are Risked Base Capital reserves (RBC) outlined by NAICs requirements and which consists of four components:

1. Underwriting risk (insufficient premiums relative to expense),
2. Asset risk (default, reinsurance failure),
3. Credit risk (stop loss recoveries, fully insured medical, dental and vision premiums, ASO fees and prescription rebates),
4. Business risk (expense overruns).

The RBC requirement replaced previous policy requirements for large claim and contingency reserves; for large claims, the City utilizes secondary insurance.

POTENTIAL RESERVE TARGET FOR A UHP

At program maturity, UHP reserves could be structured as a percentage of revenues or expenditures. If revenues are pre-collected, a percentage of revenues may make the most sense until the program is launched, at which point a portion of expenditures may make more sense. A one-month reserve is 8.3 percent of revenues or expenditures. This is similar to days cash on hand (DCOH): a metric indicating the number of days an entity can operate (covering its members expenses) without additional funding.

FINANCING RESERVES

Strategies for funding reserves depend upon the scale of revenues and expenditures, the type of government fund structure the new program will be subject to, and the organizational structure of the program or entity.

State agency model. If the UHP is established as a new program under an existing state agency that is all or partially funded by the state general fund (such as an office under the Oregon Health Authority), then it may not be appropriate to request an operating contingency for program implementation and administrative costs. Any administrative or operational cost overruns would likely be requested in additional appropriations from the Legislature. However, it may be appropriate to maintain a benefit reserve balance in a separate fund for liquidity purposes; this approach should be considered within the context of liquidity and financial

[36] A 2009 state report by the Oregon Health Fund Board determined that a state public health plan may not need large reserves if guaranteed by the full faith and credit of the state or through a regular legislative fund appropriation.

[37] Oregon Health Fund Board. "Aim High: Building a Healthy Oregon [DRAFT for public review and comment]." Oregon.gov. September 3 2008. https://www.oregon.gov/oha/HPA/HP/HealthFundBoard/Draft-Report-for-Public-Comment.pdf.

management practices of the state, including the Office of the State Treasurer. As a safeguard to prevent program insolvency, accessing this reserve could be attached in statute to requirements to update the forecast and provide a formal alert to the Governor's Office and the Legislature until legislative action could be taken to provide additional operating funds, adjust program premiums, or reduce payments.

Outside agency model. If the UHP will be an entity separate from a state agency, such as a public corporation operating with its own entity budget and without the automatic backstop of the state general fund, the reserve needs will likely be greater and more complicated. In this case, requesting from the state an operating reserve as a small percentage of forecasted administrative costs and a liquidity reserve (to be repaid to the state upon program maturity) should be a part of the financing strategy.

Examples and Case Studies

Following are some examples of similar programs in the domestic setting – Oregon coordinated care organizations, Oregon public corporations, relatively new state paid family medical leave programs, and states with Medicaid contingency funds – and international examples of universal health plans. Given the differences in budgetary contexts, the state programs provide more direct lessons learned, though the Taiwan experience provides insights into one country's response to the threat of insolvency.

OREGON COORDINATED CARE ORGANIZATIONS

Oregon's CCOs were established under the authority of HB 3650 (2011) and with funding from the state's 1115 Medicaid waiver and a state innovation model (SIM) grant from the Center for Medicare and Medicaid Innovation.[38] In creating its network of 16 CCOs, Oregon partnered with pre-existing organizations that are a mix of non-profit and for-profit groups.[39] Oregon is the only state with a statewide system of CCOs serving Oregon Health Plan members, typically providing physical, behavioral, and oral care services.[40] CCOs serve an estimated 1 million Medicaid members (out of about 1.27 million total).[41, 42]

Oregon's CCOs operate under a global budget with fixed per-person payments (capitation payments, or "per caps") based on the number served rather than the service type. The state then withholds a certain amount of CCO payments in an incentive pool which can be earned

[38] United States of Care. "Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities." n.d. https://unitedstatesofcare.org/wp-content/uploads/2022/04/CCO-Oregon-Overview.pdf.
[39] Kaye, Neva. "Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health." National Academy for State Health Policy. February 5 2021. https://nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health.
[40] United States of Care. "Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities." n.d. https://unitedstatesofcare.org/wp-content/uploads/2022/04/CCO-Oregon-Overview.pdf.
[41] Bonney, Jennie and Debbie Cheng. "Case Study: Medicaid and Public Health Collaboration in Oregon," April 24 2017, https://nam.edu/perspectives/case-study-medicaid-and-public-health-collaboration-in-oregon/.
[42] KFF. "Medicaid in Oregon Fact Sheet," KFF. May 2025, https://files.kff.org/attachment/fact-sheet-medicaid-state-OR.

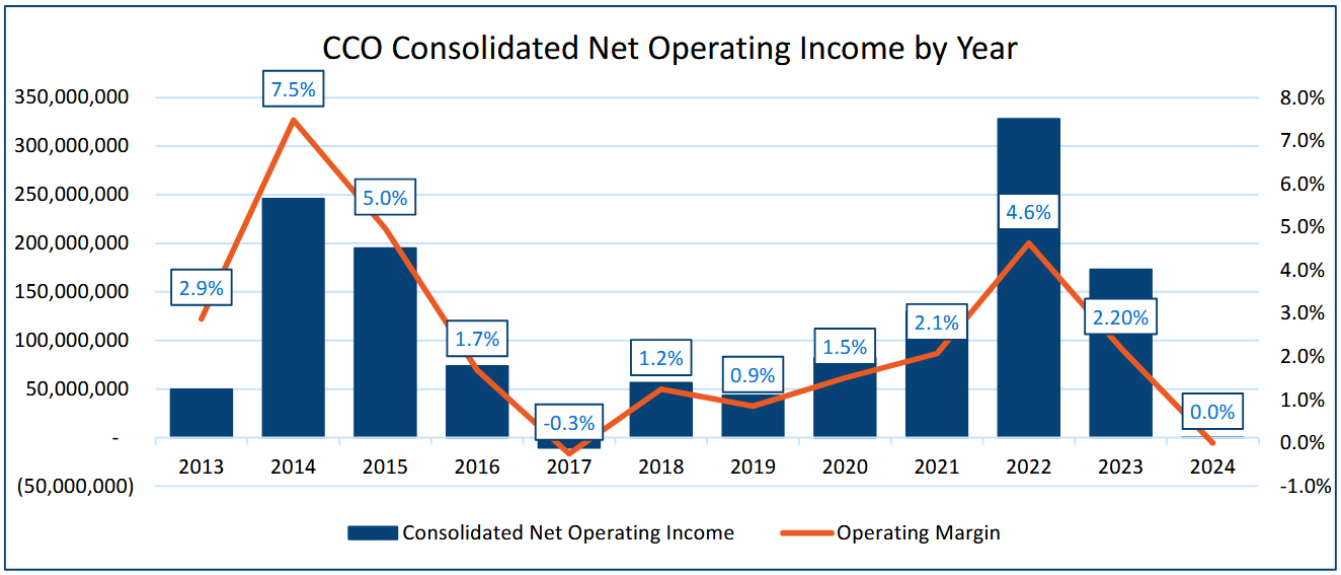
back depending on the CCO's performance on certain health outcome metrics.[43] CCOs can delegate both a portion of capitation payments to "sub-capitated entities" and, importantly, a portion of their risk.[44]

CCOs are required by state statute and rule to hold reserves. Primary and secondary reserve balances are calculated based on incurred average monthly medical expenses.[45] Among other requirements, CCOs have calculated premium deficiency reserves, which are based on the determination that unearned premiums/rate for a current period may not be sufficient to meet future medical claims and expenses.[46] CCOs reserves are held in the event of insolvency, assuring all outstanding payments to providers can be made and/or that the CCO will continue to function after terminating its contract with the government.[47]

In aggregate, CCOs operate at a fairly narrow margin, especially following the pandemic. Over the past 10 years, CCOs' aggregate net income or loss (which includes the premium deficiency reserve) has fluctuated from 7.5 percent to -0.3 percent. In 2022, it was as high as $325 million (around 4.6 percent of operating expenditures) but negative again in 2024. See

Exhibit **37** below for a chart showing CCO net operating income over the twelve-year period ending 2024.

Exhibit 37. CCO Consolidated Net Operating Income



[43] Bonney, Jennie and Debbie Cheng. "Case Study: Medicaid and Public Health Collaboration in Oregon." National Academy of Medicine. April 24 2017. https://nam.edu/perspectives/case-study-medicaid-and-public-health-collaboration-in-oregon/.
[44] McConnell, K. John. "Oregon's Medicaid coordinated care organizations." *Jama* 315, no. 9 (2016): 869-870.
[45] Oregon Laws. "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account." May 26 2025. https://oregon.public.law/rules/oar_410-141-5185.
[46] Oregon Health Authority: Financial Operations Division: Office of Actuarial and Financial Analytics. "2024 Public Brief – CCO Financial Performance." Oregon Health Authority. August 2025. https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.
[47] Oregon Laws. "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account." May 26 2025, https://oregon.public.law/rules/oar_410-141-5185.

Source: Oregon Health Authority[48]

CCOs may hold more in assets than their reserve requirements. The proposed merger of one CCO, CareOregon, with a California entity generated questions about the amount of capital held by a nonprofit CCO. At the end of 2022, CareOregon held $1 billion in cash and investments[49]; like most CCOs, the pandemic resulted in temporary increases in revenues and decreases in expenditures resulting in higher-than-usual operating margins (see above in

Exhibit 37). Given the fluctuating operating margins and the fact that at least some amount of CCO reserves are contractually obligated, a statutory reappropriation of CCO reserves should be preceded by thorough financial and legal analysis.

OREGON PUBLIC CORPORATIONS

There are four Oregon public corporations. These are entities created by the state with the purpose of carrying out public missions and services; to do so, they conduct activities or provide services that are also provided by the sector. These kinds of entities have more operating flexibility than their private counterparts but are also held to the principles of public accountability and public policy. In these entities, the board is appointed by the Governor and then confirmed by the Senate.[50]

SAIF Corporation.

SAIF, a not-for-profit workers' compensation insurance company, was the first public corporation in Oregon established in 1979. SAIF receives no state funding; instead, all revenue comes from policyholder premiums and investment returns. As part of its accounting policy, SAIF holds various reserves including unearned premiums ($250 million in 2024), premium deficiency reserves if a premium deficiency is expected, and losses and loss adjustment expense reserves. SAIF adheres to the risk-based capital (RBC) standards developed by the NAIC for surplus management.[51]

Oregon Health and Sciences University.

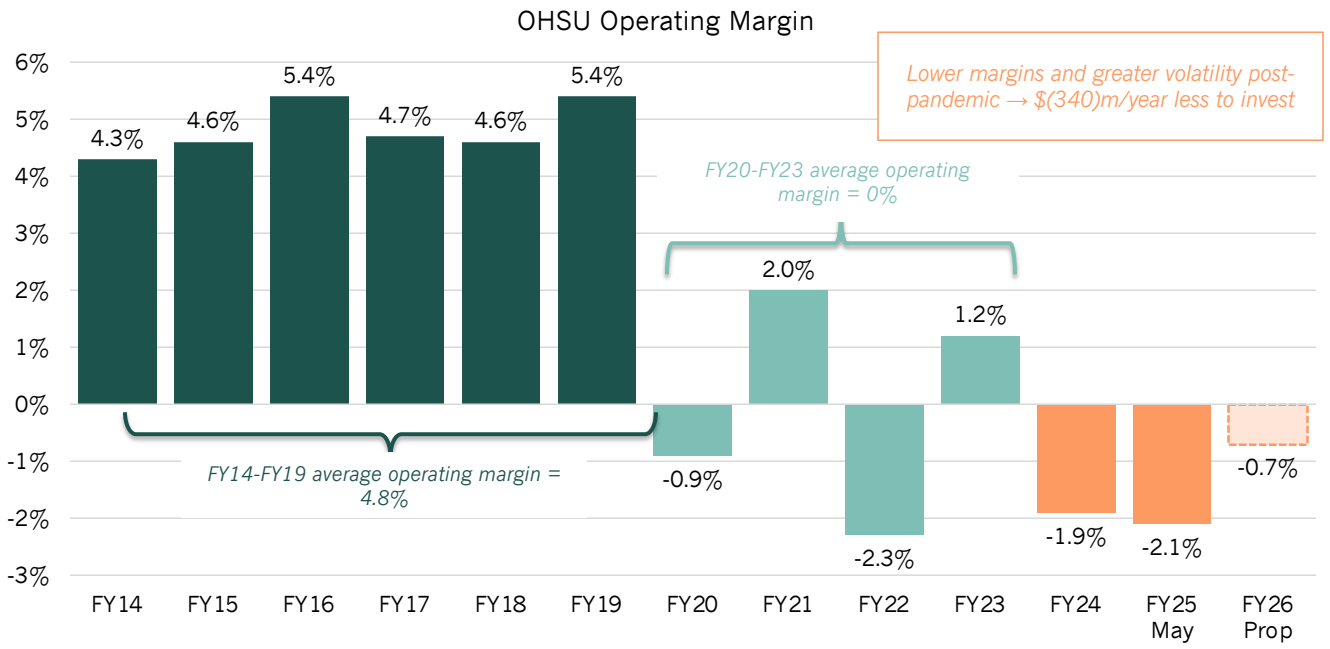
Oregon Health and Sciences University (OHSU) is the state's only public, academic health center. OHSU is not structured as a nonprofit but instead as an independent public corporation. OHSU was established in 1995. OHSU received state appropriations totaling $62.7 million in FY 2023 and $72.9 million in FY 2024, about 1.5 percent of its total

[48] Oregon Health Authority: Financial Operations Division: Office of Actuarial and Financial Analytics. "2024 Public Brief – CCO Financial Performance Memorandum." Oregon Health Authority. August 2025. https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.
[49] Wihtol, Christian. "CareOregon's Wealth in Spotlight as Merger Nears Key Review." The Lund Report. 2024. https://www.thelundreport.org/content/careoregons-wealth-spotlight-merger-nears-key-review.
[50] Oregon Laws. "ORS 353.010." https://oregon.public.law/statutes/ors_353.010.
[51] SAIF Corporation. "Financial Statements—Statutory Basis as of and for the Years Ended December 31, 2024 and 2023, Supplementary Schedules as of December 31, 2024, and Report of Independent Auditors." SAIF Corporation. July 29 2025. https://sos.oregon.gov/audits/Documents/2025-20.pdf.

operating revenue of $5 billion. Most funding comes from patient service revenues.[52] Like CCOs, OHSU must hold restricted reserves to cover liabilities, calculated as a "days cash on hand" metric.

OHSU has experienced operating losses in recent years and in 2024, S&P Global downgraded its credit rating due to financial strain ahead of a planned major capital expansion (acquisition of Legacy Health).[53] In April 2025, the OHSU Finance & Audit Committee reported drawing down $181 million in reserves, largely to balance its capital budget in FY 2026.[54] See Exhibit 38 below for the operating margins of OHSU from FY 2024 through FY 2026.

Exhibit 38. OHSU Financial Statement, FY 2024 - FY 2026.



Source: OHSU[55]

The State Fair Council.

The Oregon State Fair & Exposition Center was established as a public corporation in 2013; it had previously been a state agency. The Center hosts fairs and events but also serves as a gathering place in times of public emergencies. The State Fair Council received $1 million from the General Fund in 2025-27 for operations and $855,000 in General Fund capital

[52] KPMG. "Oregon Health & Science University (A Component Unit of the State of Oregon): Financial Statements and Supplementary Information." OHSU. October 25 2024. https://www.ohsu.edu/sites/default/files/2024-12/ohsu-financial-stmt-audited-fy24.pdf.

[53] S&P Global. "Oregon Health & Science University Debt Rating Lowered to A+ on Operating Losses." December 6, 2024. https://www.spglobal.com/ratings/en/regulatory/article/-/view/sourceId/13353071.

[54] OHSU Finance & Audit Committee. "OHSU Onward: FY25 March YTD Results & FY26 Preliminary Budget Plan." April 24 2024. https://www.ohsu.edu/sites/default/files/2025-04/FAC-FY25-Q3-FY26-Prelim-4-24-25.pdf.

[55] KPMG. "Oregon Health & Science University (A Component Unit of the State of Oregon): Financial Statements and Supplementary Information," pg. 14. OHSU. October 25 2024. https://www.ohsu.edu/sites/default/files/2024-12/ohsu-financial-stmt-audited-fy24.pdf.

support for an expanded regional emergency center.[56] Total operating expenses for the Council was $9.1 million and "ordinary income" was $10.2 million, leaving a margin of $1.1 million.[57]

Willamette Falls Locks Authority.

The Willamette Falls Locks Authority was established in 2021 to establish ownership, oversight, and management of the historic navigational locks in Clackamas County.[58] The Authority is still in very early stages of capital development and as such financial information is not relevant to this exploration.

STATE PAID FAMILY MEDICAL LEAVE (PFML) PROGRAMS

In the past 5 to 7 years, several states have implemented state-funded insurance programs to provide paid family medical leave (PFML) to workers. These programs provide wages to individuals needing to take leave for qualifying reasons (federal law only requires job security but does not mandate paid leave). Individuals must participate in the program for a certain length of time to be eligible, and in general the program is financed through employer and employee payroll taxes. The goal for these programs is to be self-sustaining through mandatory contributions made up of a certain percentage of an employee's gross wages defined by the state, as well as contributions from the employer.[59]

Contribution rates are typically structured as a percentage of gross wages. Massachusetts' contribution rates are 0.88 percent of eligible wages for employers with 25 or more covered employees.[60] In Oregon, the total contribution rate in 2025 is 1 percent of gross wages, shared between employees and large employers.[61] In Washington, 2025 rates are 0.92 percent – of which employers pay 28.48 percent and employees pay 71.52 percent.

Washington's PFML program went insolvent in 2023, when claims exceeded expectations and premium rates initially set in statute did not increase fast enough. The program required a $200 million appropriation from the Legislature to resolve the deficit. See Exhibit 39 below for the revenues, expenses, and net income of the PFML program, including the large jump in

[56] Legislative Fiscal Office. "2025-27 Budget Highlights." Oregon.gov. October 2025. https://www.oregonlegislature.gov/lfo/Documents/2025-27%20Budget%20Highlights.pdf.
[57] Oregon State Fair Council. "Oregon State Fair Council Meeting Notice & Agenda Thursday, January 30th, 2025, at 1:30 P.M." January 30 2025. https://img1.wsimg.com/blobby/go/acf78612-03e4-4000-8ec5-438339cbe01d/downloads/cd2a[...]ing%20Minutes%20-%20Updated%201-30-2025.pdf?ver=1758730246817. (Financial statements begin on page 8 of 19.)
[58] Willamette Falls Locks Authority. "About." 2024. https://www.willamettefallslocks.org/about.
[59] Ritter, Sarah. "Funding Mechanisms for State Paid Family and Medical Leave Programs." Prenatal-to-3 Policy Impact Center. December 2024. https://pn3policy.org/wp-content/uploads/2025/01/PN3_PFML-Funding-Brief_FINAL.pdf.
[60] Massachusetts Department of Family and Medical Leave. "Paid Family and Medical Leave employer contribution rates and calculator." Mass.gov. October 1 2025. https://www.mass.gov/info-details/paid-family-and-medical-leave-employer-contribution-rates-and-calculator.
[61] Paid Leave Oregon. "Employers Overview." n.d. https://paidleave.oregon.gov/employers-overview/.

revenue in 2023 which includes a state general fund appropriation. Premium rates have more than doubled since the program was implemented in 2019.[62, 63]

Exhibit 39. Washington PFML Revenues, Expenses, and Net Income, 2020 – 2028

(Dollars in Millions)	Actual				Forecast (Dollars in Millions)				
	2020	2021	2022	2023	2024	2025	2026	2027	2028
Revenue	$678	$701	$1,109	$1,635	$1,750	$2,318	$2,348	$2,398	$2,560
Expenses	-$665	-$959	-$1,258	-$1,538	-$1,846	-$2,014	-$2,203	-$2,408	-$2,629
Net Income	**$13**	**-$258**	**-$149**	**$97**	**-$96**	**$304**	**$145**	**-$10**	**-$69**

Source: Washington Joint Legislative Audit Review Commission, 2025.[64]

Like unemployment insurance, also funded with payroll taxes, PFML rates can adjust relatively automatically, typically based on actuarial reports but at least based on annual projections. Often laws set a cap on the premium rate, which limits the program's ability to raise funds in the future.

Washington's PFML statutory rate formula is not set actuarially but instead through a statutory formula of 140 percent of prior year expenses, minus the Family and Medical Leave Insurance (FMLI) program account balance, divided by taxable wages. Statute allows for a reserve cap (an upper threshold on the premium rate, *i.e.*, rates may be adjusted downward if it is determined they will result in a fund balance that exceeds three months' worth of benefits) but not a lower threshold (such as a minimum below which the rate may be adjusted upward. Beginning in 2026, statute requires the Office of Actuarial Services to review premium rates quarterly and report immediately to the Governor, the Legislature and an advisory board if they project that a deficit in the account will not be recovered through the next quarterly premium collections.[65]

NORTH CAROLINA

The state of North Carolina has a formal contingency reserve requirement for Medicaid, which is to be used only when the Medicaid program has budgeting shortfalls.[66] The state currently holds $500 million in a Medicaid Contingency Plan, which is approximately 3.4 percent of annual state Medicaid expenditures in FY 2023 (~ $14 billion).[67] Statute requires legislative

[62] Washington State Legislature Joint Legislative Audit and Review Committee (JLARC). "Paid Family and Medical Leave Program." WA.gov. January 2025. https://leg.wa.gov/jlarc/reports/2024/PFML/f_01/default.html.
[63] Washington State Employment Security Department. "Actuarial Annual Report for Paid Family and Medical Leave." WA.gov. November 2023. https://esd.wa.gov/media/pdf/2751/pfml-actuarial-annual-report-2024pdf/download?inline.
[64] Washington State Legislature Joint Legislative Audit and Review Committee (JLARC). "Paid Family and Medical Leave Program." WA.gov. January 2025. https://leg.wa.gov/jlarc/reports/2024/PFML/f_01/default.html.
[65] ESSHB 1213, Chapter 304, Laws of 2025. WA.gov. https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1213-S2.SL.pdf?cite=2025%20c%20304%20s%203
[66] North Carolina General Assembly. "143C-4-11. Medicaid Contingency Reserve." NCLeg. n.d. https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_143C/GS_143C-4-11.pdf.
[67] State of North Carolina, Department of Health and Human Services, NC Medicaid. "North Carolina Medicaid Annual Report for the State Fiscal Year 2023." FY2023. https://www.ncdhhs.gov/sl-2023-134-section-9e1-medicaid-annual-report/open.

approval to access contingency funds. In October 2025, the Department of Health and Human Services cut reimbursement rates because state lawmakers only came up with $600 million out of the needed $819 million for this fiscal year's state Medicaid funds.[68] Indiana created a Medicaid contingency and reserve account (not a separate fund) in 2024 to provide payments for Medicaid claims, obligations, and liabilities.[69] In 2024 the State Budget Director requested that $271 million from the account be transferred to the Family and Social Services Administration's Medicaid Assistance fund due to an unexpected deficit from a forecasting revision.[70]

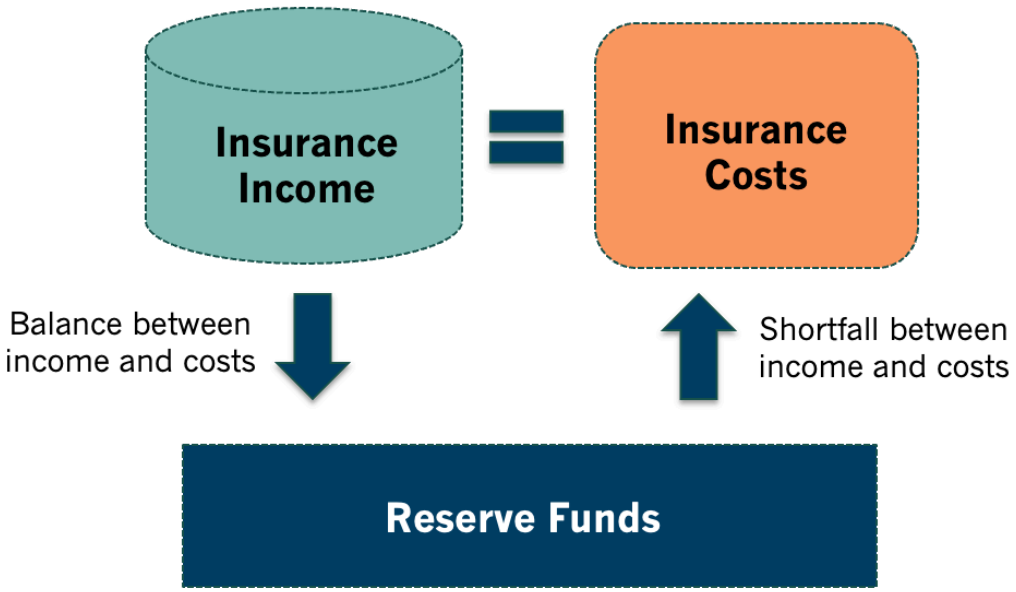
NEW YORK CITY

New York City requires that Managed Care Organizations (MCOs) hold 7.25 percent of net premium income from Medicare Managed Care (MMC) health and recovery plans and the HIV Special Needs Plan (SNP) programs.[71] MCOs are integrated into health care systems and exist to reduce health care expenditure costs through preventative medicine strategies, financial provisioning, and treatment guidelines. They often take the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[72]

[68] Specht , Paul and Eric Miller. "NC Medicaid cuts under scrutiny amid funding stalemate." WRAL News. October 14 2025. https://www.wral.com/news/local/nc-medicaid-cuts-scrutiny-funding-stalemate-oct-2025/.
[69] Indiana General Assembly. "IC 4-12-1-15.5 Medicaid contingency and reserve account." IN.gov. n.d. Accessed October 21 2025. https://iga.in.gov/laws/2024/ic/titles/4#4-12-1-15.5.
[70] State of Indiana State Budget Agency. "Medicaid Contingency and Reserve Account Transfer." IN.gov. February 14 2024. https://www.in.gov/sba/files/Medicaid-Contingency-Transfer-Memo-FY2024.pdf.
[71] State of New York Commissioner of Health. "Regulatory Impact Statement." NY.gov. n.d. https://regs.health.ny.gov/sites/default/files/proposed-regulations/Contingent%20Reserve%20Requirements%20for%20Managed%20Care%20Organizations%20%28MCOs%29_1.pdf.
[72] Heaton, Joseph and Prasanna Tadi. "Managed Care Organization." NIH National Library of Medicine. March 6 2023. https://www.ncbi.nlm.nih.gov/books/NBK557797/.

TAIWAN

Exhibit 40. Taiwan NHI, Correlation of Reserve Fund, Insurance Income, and Insurance Costs[73]



Taiwan implemented its National Health Insurance (NHI) universal health care system in 1995. The program's success is marked by accessibility, comprehensive population coverage, short waiting times, low cost, and national data collection systems for planning and research that streamline administrative processes.[74] In principle, the aggregate amount of the reserve fund was set equal to the aggregate amount of benefit payments in the most recent 1 to 3 months, based on actuarial principles. The actuarial calculation of the premium rate adopts the method of "adjust income to expense", and the premium rate is calculated based on the principle of covering insurance costs and maintaining the total reserve fund for 1–3 months of the insurance payment.[75]

In the past five years, the Taiwan NHI has faced growing financial strain and medical professional shortages. The NHI model is based on low premiums and high demand, which leads to hospitals cutting costs, poor working environments for nurses and doctors, high patient ratios, and other poor outcomes.[76] In 2024, with NHI on the brink of insolvency, the Taiwan government implemented reforms to NHI including eliminating their "suspension-and-resumption" mechanism. This mechanism initially existed for temporary overseas residents to pause coverage while out of the country and resume upon return, but in an increasingly

[73] Lee, Po-Chang. "Introduction to the National health insurance of Taiwan." In *Digital Health Care in Taiwan: Innovations of National Health Insurance*, pp. 1-15. Cham: Springer International Publishing, 2022.
[74] Wu, Tai-Yin, Azeem Majeed, Ken N Kuo, "An overview of the health care system in Taiwan," *London Journal of Primary Care* 3(2):115–119. December 2010. https://pmc.ncbi.nlm.nih.gov/articles/PMC3960712/.
[75] Lee, Po-Chang. "Introduction to the National health insurance of Taiwan." In *Digital Health Care in Taiwan: Innovations of National Health Insurance*, pp. 1-15. Cham: Springer International Publishing, 2022.
[76] Shelton, Paul. "Taiwan's national health care system." *Euroview.* April 22, 2025. https://euroview.ecct.com.tw/category-inside.php?id=2364.

globally mobile world was allowing wealthier individuals living in the US or China to return to Taiwan to take advantage of low-cost health care for which they were not paying premiums. This behavior not only drove up costs for the NHI but unfairly shifted the burden to relatively less well-off Taiwanese natives. Now, all Taiwanese nationals, regardless of location, must pay NHI premiums.[77] Through this major reform Taiwan aims to extract tax revenue from foreign nationals.

DENMARK

Denmark's universal health care system is decentralized. Their government provides block grants from tax revenues to the regions and municipalities, which deliver health services, but the state itself does not have a direct role in the delivery of services.[78] The country's health expenditures equated 9.42 percent of their GDP in 2023, down from 10.75 percent in 2021.[79] Because Denmark's health care appropriations are made on a pay-as-you-go basis, rather than with revenues specifically earmarked for health care, it does not appear to be a perfect corollary for an Oregon UHP given that budgeting systems are very different.

ENGLAND

All England residents get free public health care through the National Health Service (NHS), which is primarily funded by general taxation and started in 1948. The country's health expenditures equated to 10.87 percent of their GDP in 2023, down from 12.02 percent in 2021.[80] Most NHS funding comes from general taxes, but 20 percent comes from national insurance (payroll tax paid by employees and employers). The NHS also has an income stream from copayments and those using NHS services as private patients (11.8 percent of the UK has private health insurance as of 2025).[81, 82] As in Denmark, differences between sovereign nation appropriations and the United States federalist context, along with differences in budgeting requirements and best practices, make England an imperfect corollary for implementation of reserve financing.

---

[77] Yang, Y Tony. "Reforming Taiwan's National Health Insurance: From Exploitation to Equitable Participation." Global Taiwan Institute. January 22 2025. https://globaltaiwan.org/2025/01/reforming-taiwans-national-health-insurance-from-exploitation-to-equitable-participation.

[78] Vrangbæk, Karsten. "International Health Care System Profiles, Denmark." The Commonwealth Fund. June 5 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/denmark;

[79] World Bank Group Data. "Current health expenditure (% of GDP) – Denmark." Accessed October 21 2025. https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=DK.

[80] World Bank Group Data. "Current health expenditure (% of GDP) – United Kingdom." Accessed October 21 2025. http://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=GB.

[81] Thorlby, Ruth. "International Health Care System Profiles, England," The Commonwealth Fund. June 5 2020. https://www.commonwealthfund.org/international-health-policy-center/countries/england.

[82] Campbell, Denis. "Almost one in eight Britons now has private medical insurance, say health care analysts." The Guardian. 2025. https://www.theguardian.com/society/2025/jan/30/almost-one-in-eight-britons-now-has-private-medical-insurance-say-health care-analysts.

Reserve Funding and Financing Approach

Why Reserve Funding Matters

Once the UHP's operating reserve target is established, the next question is not whether the reserve is needed, but how it should be capitalized. In practical terms, this is a question of both funding and financing. Funding refers to the ultimate source of revenue used to support the reserve, such as state appropriations, redirected public funds, dedicated UHP taxes, or temporary transition revenues. Financing refers to the method and timing by which the reserve is assembled, such as pay-as-you-go accumulation, interfund borrowing, or other structured repayment arrangements. This distinction matters because the UHP is likely to face a mismatch between when reserve dollars are needed and when stable UHP revenues are fully available.

The Scale of the Reserve Requirement

The scale of the reserve requirement makes this an important policy choice rather than a minor implementation detail. Using the current Milliman estimate of approximately $85 billion in annual UHP expenditures in 2032 dollars, an operating reserve equal to one month of expenditures would be about $7.1 billion, a two-month reserve would be about $14.2 billion, and a three-month reserve would be about $21.3 billion. These figures represent liquidity targets rather than a full private-insurance-style risk-based capital standard, which would likely imply substantially larger capitalization and may not be appropriate for a publicly backed program. Even so, the magnitude of these amounts makes clear that Oregon is unlikely to capitalize the reserve through any single source alone.

A Capital Stack Approach

For that reason, the most practical reserve strategy is a capital stack approach that prioritizes the lowest-cost and most flexible sources of capital first, then turns to structured financing tools, and relies on new or accelerated revenue only to the extent necessary. This approach reflects a consistent Committee preference to minimize new tax structures where possible and to preserve flexibility as the Board refines the final plan cost and implementation schedule. Put differently, the reserve target decision and the reserve funding strategy are directly linked: the higher the target, the more likely it is that Oregon will need to rely on new taxes, temporary surcharges, or earlier revenue collection to fully capitalize the reserve at launch.

TIER 1: INTERNAL AND EXISTING PUBLIC SOURCES

Under this framework, the first tier of reserve funding consists of lower-cost internal or already-public sources. These may include one-time legislative appropriations, existing state balances, reallocated administrative spending, certain Oregon Health Authority or Oregon

Health Plan resources, and potentially some portion of reserves or net assets associated with existing health system entities, subject to further legal and operational review.

The analysis identifies the Rainy Day Fund, OHA-related balances, Coordinated Care Organization reserves, and Emergency Board allocations as examples of the kinds of resources that may be relevant to a Tier 1 analysis, while making clear that accessibility varies significantly and that some sources may ultimately prove infeasible or only partially available. The value of Tier 1 is not that it solves the full capitalization problem on its own, but that each dollar available from these sources reduces the amount that must be financed externally or raised through new revenue.

TIER 2: STRUCTURED FINANCING TOOLS

The second tier consists of structured financing mechanisms that can provide liquidity up front while spreading repayment over time. These tools include interfund loans, treasury-backed loans repaid from future UHP revenues, and potentially other state-authorized bridge financing structures. In concept, Tier 2 sources are more costly than existing internal funds because they create repayment obligations, but they may still be preferable to immediately expanding the long-term tax structure.

Structured financing may be especially useful if the Board concludes that a meaningful reserve should be in place at launch, but also wishes to avoid collecting the full reserve amount in advance through taxes. As with Tier 1, however, the availability, legal authority, and practical scale of these tools would need to be confirmed through additional fiscal and legal analysis.

TIER 3: NEW OR ACCELERATED REVENUE

The third tier consists of new or accelerated revenue sources. These are the most visible and politically costly tools, but they may be necessary if the selected reserve target exceeds what can reasonably be supported through internal funds and structured financing. Options in this category include beginning UHP tax collection before benefit delivery, imposing a temporary transition tax or fee outside the core UHP structure, or applying temporary surcharges to existing revenue sources until the reserve reaches its target level.

These mechanisms are powerful because they can generate substantial dollars at scale, but they also directly increase the near-term fiscal burden associated with implementation. For that reason, they are best treated as backstop tools rather than the preferred first source of capitalization.

Pay-As-You-Go Versus Borrowing

This framework also helps clarify the tradeoff between pay-as-you-go capitalization and borrowing. Under a pay-as-you-go approach, reserve dollars are accumulated from revenues collected before or alongside benefit payments. This avoids interest costs, but it implies either starting taxes earlier than benefit delivery or collecting more revenue than is needed for steady-state operations in the early years.

Under a borrowing approach, the state capitalizes the reserve upfront and repays the obligation over time from future UHP revenues. This reduces the need for early tax accumulation, but increases total program cost and creates an ongoing debt service obligation. This illustrates the scale of this tradeoff: borrowing $1 billion at 3.0 percent over 20 years would imply annual debt service of about $67.2 million and total repayment of roughly $1.34 billion, including about $344 million of interest. At larger reserve scales, these obligations become materially more significant.

A Hybrid Strategy Is Most Feasible

Taken together, these considerations suggest that the most feasible reserve strategy for the UHP is likely to be hybrid rather than singular. A practical approach would combine as much Tier 1 funding as is legally and operationally available, supplement it with limited Tier 2 financing to address timing and launch needs, and rely on Tier 3 revenue only to close the remaining gap or to phase in reserve capitalization over time.

This is consistent with the Committee's discussion framing, which has focused on whether the reserve should be fully capitalized at launch or built gradually, and whether a combination of appropriation, phased revenue allocation, and limited borrowing may provide the strongest balance of feasibility and fiscal resilience.

Finance & Revenue Committee Recommendation

Three-Month Operating Reserve with One-Month Trigger

The Finance & Revenue Committee voted 5–2 to recommend an operating reserve target of three months, with a one-month trigger (to be defined) that would prompt early warning and corrective action. This recommendation reflects a preference for strong launch-period liquidity while pairing that long-term standard with an operational "signal point" to guide monitoring and intervention.

From a policy standpoint, the Board does not need to identify and secure every specific reserve funding source before confirming a reserve target. Many implementation details can be developed through subsequent legislative, fiscal, and administrative work. However, the reserve target is not a neutral technical assumption: it materially shapes the set of feasible capitalization strategies, the timing of implementation, and the degree to which the state may need to rely on accelerated revenues, transition tools, or borrowing.

A three-month reserve provides the strongest liquidity position of the options considered. It improves the program's ability to manage revenue timing mismatches, expenditure variation, and early operational disruption without requiring immediate corrective action. It can also strengthen confidence among providers, policymakers, and the public that the UHP has the financial resilience to operate reliably during the early years.

At the same time, a three-month target has clearer front-end implications. Capitalizing a reserve of this scale would likely require a more deliberate and robust strategy, potentially

including earlier or accelerated revenue collection, structured bridge financing, temporary transition mechanisms, or a phased approach that builds toward the target over time. The Committee's one-month trigger concept is intended to complement this strategy by establishing a practical monitoring threshold: if reserve levels approach that trigger point, the system would have clear authority and expectations for timely corrective actions, such as adjusting timing of transfers, drawing on predefined backstops, or recommending revenue or expenditure adjustments.

The Board should therefore view reserve sizing as a governance decision about launch strategy and risk tolerance. In practical terms, the three-month target sets the desired level of financial stability, while the one-month trigger creates an operational framework for managing downside risk. This structure also supports a viable implementation pathway in which Oregon can establish a long-term reserve standard while retaining flexibility in how the reserve is capitalized—particularly if the Board wishes to balance early feasibility with long-run financial discipline.

6. Appendices

Official Charge of the Finance and Revenue Committee

The Finance and Revenue Committee is tasked with the following deliverables under their Committee Charter:

1. To develop a list of attributes of a sound financial plan;
2. Review and understand current health spending in Oregon;
3. Develop an annual Universal Health Plan cost target that can be supported with new revenue and existing health spending;
4. Review methods of revenue collection to withstand an ERISA challenge;
5. Review, update, and build on revenue options to pay for universal health plan as outlined in the Joint Task Force Report;
6. Describe the impact of revenue or taxes on large and small businesses and households;
7. Identify required startup costs and plan reserves and develop strategies for building the needed reserves;
8. And compare and contrast current mechanisms for funding for health care with the proposed financing strategy.

As delegated in sections 2(3) i and j of SB 1089, F&R is tasked with providing a unified financing strategy for the Universal Health Plan that may include an income tax, a payroll tax, or other options that take into considerations ERISA and has support from large and small employers, as well as an analysis of the impact of Universal Health Plan on Oregon's economy.[83]

[83] Universal Health Plan Governance Board. "Committee Charters: Finance and Revenue Committee: Committee Charter." Oregon.gov. 2024. https://www.oregon.gov/uhpgb/committees/Documents/fin-rev/finance-and-revenue-committee-charter.pdf.

ECOnorthwest

DATE:	October 21, 2026
TO:	Mimi McDonell, Universal Health Plan Governance Board
FROM:	Megan Waldo, ECOnorthwest
SUBJECT:	Summary of Final Deliverables to UHPGB

Purpose and Summary

This memo identifies the final versions of the deliverables ECOnorthwest prepared for the Finance & Revenue Committee and the Universal Health Plan Governance Board (UHPGB), for inclusion in the appendices of the UHP legislative report. The final files are attached to the accompanying email. Exhibit 1 lists the 14 files UHPGB shared with ECOnorthwest on August 25, 2026, a mix of draft and final versions, some still labeled "DRAFT." Exhibit 2 is the confirmed list of 12 final versions UHPGB should use in the appendix.

The two tables differ in four ways:

- **Duplicates removed (14 to 12 files).** The Workplan memo appeared twice (Word and PDF), and the Straw Proposal appeared in both its October 9 draft and October 10 final versions. Each now appears once.
- **Draft labels removed.** The Key Financial Assumptions memo, Reserve and Transition memo, LRO Revenue Proposal Amendments memo, and Economic Impacts White Paper no longer carry "DRAFT" in their titles or file names.
- **Dates and file names standardized.** Each file name now ends with its date in YYYY_MMDD format, and that date matches the date printed on the document. This resolves two mismatches in Exhibit 1: the Key Financial Assumptions file name carried a June 3 date for a June 20, 2025 memo, and the Reserve and Transition memo, listed as November 4 and named "DECEMBER," is dated December 2, 2025. Documents are listed in chronological order.
- **No substantive changes.** We compared each final file against the version UHPGB sent on August 25. Apart from the label, title, date, and file-name updates above and two typo corrections, the content is unchanged.

Exhibit 1. Files shared by UHPGB with ECOnorthwest on August 25, 2026 (draft and final versions)

#	TITLE/SUBJECT	FILE NAME	DATE
1	WORKING DRAFT – Workplan and Research Framework for the Finance & Revenue Committee	Technical Support for UHPGB Revenue and Finance 2025_0512.docx V2.docx	12-May-25

2	WORKING DRAFT – Workplan and Research Framework for the Finance & Revenue Committee	technical-support-for-fin-rev-052025.pdf	12-May-25
3	Principles for a Viable and Just Financing Approach	Principles for a Viable and Just Financing Approach 2025_0603.docx	3-Jun-25
4	Key Financial Assumptions for Cross-Committee Alignment	DRAFT Key Financial Assumptions for Cross-Committee Alignment 2025_0603.docx	20-Jun-25
5	DRAFT Preliminary UHP Funding Plan Straw Proposal	DRAFT Preliminary Straw Proposal 2025_1006 ECOnw V2.docx	9-Oct-25
6	Preliminary UHP Funding Plan Straw Proposal	FR Straw Proposal 2025_1010.docx	10-Oct-25
7	Transitions and Reserves Research and Case Studies	DRAFT Reserve & Transition 2025_DECEMBER.docx	4-Nov-25
8	Revised Revenue Structures for Universal Health Plan: Response to Board Feedback and Updated Modeling Approach	UHPGB Feedback Memo 2025_1114.docx	14-Nov-25
9	Reserves Financing and Funding Options and Examples for the UHP	Reserves Funding & Financing Memo_2026-03-07.docx	7-Mar-26
10	Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board	FR Full Report_2026-06-05_FINAL.pdf	5-Jun-26
11	Proposal Comparison to LRO Revisions and Estimates	DRAFT_LRO Revenue Proposal Amendments Memo_20260604.docx	6-Jun-26
12	Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework	Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework 2026_0624.docx	24-Jun-26
13	DRAFT Economic Effects of Oregon's Universal Health Plan: A Framework for Evaluating Fiscal, Economic, Distributional, and Welfare Impacts	DRAFT UHP Economic Impacts White Paper 2026_0628.docx	28-Jun-26
14	2032 Revenue Replacement Targets	LRO Revisions and Estimates Memo_20260716.docx	16-Jul-26

Exhibit 2. Final versions of ECOnorthwest deliverables for the UHP legislative report appendix

#	TITLE/SUBJECT	FILE NAME	DATE
1	Workplan and Research Framework for the Finance & Revenue Committee	Technical Support for UHPGB Revenue and Finance 2025_0512.pdf	12-May-25
2	Principles for a Viable and Just Financing Approach	Principles for a Viable and Just Financing Approach 2025_0603.pdf	3-Jun-25
3	Key Financial Assumptions for Cross-Committee Alignment	Key Financial Assumptions for Cross-Committee Alignment 2025_0620.pdf	20-Jun-25
4	Preliminary UHP Funding Plan Straw Proposal	Preliminary Straw Proposal 2025_1010.pdf	10-Oct-25
5	Revised Revenue Structures for Universal Health Plan: Response to Board Feedback and Updated Modeling Approach	UHPGB Feedback Memo 2025_1114.pdf	14-Nov-25
6	Transitions and Reserves Research and Case Studies	Reserve and Transition 2025_1202.pdf	2-Dec-25
7	Reserves Financing and Funding Options and Examples for the UHP	Reserves Funding & Financing Memo 2026_0307.pdf	7-Mar-26
8	Report on the Finance & Revenue Committee's Recommendations to the UHP Governance Board	F&R Full Report 2026_0605.pdf	5-Jun-26
9	Proposal Comparison to LRO Revisions and Estimates	LRO Revenue Proposal Amendments Memo 2026_0606.pdf	6-Jun-26
10	Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework	Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework 2026_0624.pdf	24-Jun-26
11	Economic Effects of Oregon's Universal Health Plan: A Framework for Evaluating Fiscal, Economic, Distributional, and Welfare Impacts	UHP Economic Impacts White Paper 2026_0628.pdf	28-Jun-26
12	2032 Revenue Replacement Targets	LRO Revisions and Estimates Memo 2026_0716.pdf	16-Jul-26

ECOnorthwest

DATE:	May 12, 2025
TO:	UHPGB Staff
FROM:	Morgan Shook, Andrew Dyke, and Will Terry (ECO)
SUBJECT:	Workplan and Research Framework for the Finance & Revenue Committee

Introduction

The Finance & Revenue Committee plays a central role in shaping a sustainable, equitable, and legally sound financing strategy for Oregon's Universal Health Plan. Convened under the direction of the Universal Health Plan Governance Board (UHPGB), the Committee is charged with evaluating options to fund a comprehensive, statewide health system that replaces existing forms of public and private insurance with a unified, publicly financed approach.

This memo outlines a proposed workplan and research framework for the Committee's activities, structured around an eight-meeting schedule. The plan is designed to ensure that the Committee fulfills its full charge by progressing through a series of interrelated questions and decision points that culminate in a set of recommendations to the UHPGB. These include identifying a preferred financing framework, understanding economic and legal trade-offs, developing strategies for start-up and reserve funding, and evaluating pathways for a system-wide transition.

The eight meetings represent the primary structure for Committee deliberation and are intended to build cumulatively toward final recommendations. However, this timeline is flexible: supplementary meetings, focused work sessions, or deep-dive discussions may be scheduled as needed to accommodate additional questions, accommodate modeling updates, or respond to direction from the UHPGB. Some topics may require more time than initially allocated, and it is anticipated that certain subjects—such as trade-off evaluation or revenue design—may span multiple meetings.

Finally, it is acknowledged that the full scope and sequence of this workplan may evolve following further strategic direction from the UHPGB. A forthcoming strategy session with the Board may clarify priorities, adjust deliverable timing, or reframe key assumptions. The workplan presented here is therefore a structured starting point—intended to promote clarity, transparency, and momentum—while remaining adaptable to guidance from UHP leadership and developments in the broader policy environment.

Finance and Revenue Committee Charge

The Committee is tasked with assessing the fiscal and policy components of health system financing and recommending a revenue plan capable of sustaining a universal health system. This includes evaluating the alignment of new revenue mechanisms with existing health care

spending, understanding the legal landscape for taxation, and analyzing the distributional and economic impacts of various financing approaches.

REQUIRED AREAS OF STUDY

Over the course of its work, the Committee has been charged to:

- Develop a list of attributes that define a sound and sustainable financial plan for universal health care.
- Review Oregon's current health care spending patterns across public and private sources and identify which components may be redirected to support a universal system.
- Estimate the total cost of the Universal Health Plan and define an annual cost target that balances comprehensiveness with financial feasibility.
- Evaluate potential revenue mechanisms—including income, payroll, provider, gross receipts, and consumption-based taxes—and determine their compatibility with legal requirements such as ERISA.
- Assess how different revenue options impact households, employers (large and small), and self-insured entities, including their potential for cost savings or new liabilities.
- Identify start-up funding needs and reserve requirements, and explore options to build reserves during the plan's early phases.
- Compare current health care financing mechanisms (including employer-based insurance and Medicaid) with proposed models under the Universal Health Plan.
- Evaluate transition strategies, including phased implementation, to ensure minimal disruption during the shift from the current system to a new financing structure.

This set of tasks can be translated into more accessible work program in a draft of the Research Framework for the Finance & Revenue Committee. This is intended to structure and guide the Committee's work and align its outputs with the Board's decision-making needs.

PURPOSE OF THE RESEARCH FRAMEWORK

The Research Framework organizes the Finance & Revenue Committee's work into a structured set of research questions and analytical themes. It is designed to ensure that all selected aspects of Universal Health Plan financing—fiscal, legal, and economic—are examined in a coherent and decision-ready manner that are under the Committee's charge.

The framework supports the Committee in evaluating the full lifecycle of a new health care funding model: from understanding Oregon's current spending landscape, to developing a viable funding structure, to identifying transition strategies and implementation risks.

CORE DOMAINS OF INQUIRY

1. Financial Foundations
    a. What are the essential attributes of a sound and sustainable financial plan?
    b. How much is currently spent on health care in Oregon, and by whom?
    c. How much will the Universal Health Plan cost on an annual basis?
    d. How much of this cost can be offset by existing spending sources or efficiencies?
2. Revenue Design and Legal Compliance
    a. What tax revenue mechanisms are available (e.g., payroll, income, provider, sales, gross receipts)?
    b. How do these options compare in terms of yield, equity, economic impact, and volatility?
    c. What legal constraints—particularly under ERISA—must be addressed in structuring new revenue streams?
3. Impact Analysis
    a. How would different financing mechanisms affect individuals, households, small businesses, and large employers?
    b. What changes in financial liability, coverage, or administrative burden are expected for key payer groups?
    c. What strategies can mitigate potential burdens or unintended consequences (e.g., tax credits, exemptions, phase-ins)?
4. Start-up and Operational Readiness
    a. What are the one-time start-up costs and reserve levels required to safely launch and maintain the plan?
    b. What strategies are available to pre-fund reserves and implementation infrastructure?
5. System Transition and Scenario Planning
    a. How do Oregon's current financing mechanisms compare to the proposed tax-based model?
    b. What are the transition options (e.g., phased implementation vs. full switch) and their trade-offs?
    c. How will Oregon maintain system stability during the transition period?
6. Evaluation Criteria and Governance
    a. What decision criteria should the Board use to select among financing options (e.g., equity, efficiency, simplicity, resilience)?

b. How can these criteria be used to evaluate and adjust the plan over time?

RESEARCH PRODUCTS AND INPUTS

To support the Committee's deliberation, this framework is populated with research and modeling work from:

- ECOnorthwest, providing funding analysis, tax incidence modeling, funding/financing structure design, and coordinating legal compliance consultations.
- Milliman, providing cost and actuarial impact modeling (health utilization costs) under baseline and UHP implementation scenarios.
- UHPGB staff, facilitating data sharing, meeting coordination, synthesis, and alignment with broader UHP implementation.

Each monthly Committee meeting is organized around a subset of this framework and is designed to both build understanding and advance specific decisions.

INTENDED OUTCOMES

By following this framework, the Finance & Revenue Committee will be positioned to:

- Recommend a revenue structure (or set of options) that meets the needs of the Universal Health Plan
- Clearly communicate trade-offs to policymakers and the public
- Help the Board evaluate financing strategies not just for how much they raise, but for how well they support long-term system goals

COMMITTEE DELIVERABLES & RECOMMENDATIONS AND WORK PROGRAM

At the conclusion of its 8-meeting work plan, the Committee will deliver a set of recommendations to the UHP Governance Board that includes:

- A preferred financing framework or set of revenue scenarios to fund the Universal Health Plan.
- A summary of key trade-offs related to revenue stability, equity, legality, and administrative feasibility.
- Recommended start-up and reserve strategies, including pre-implementation funding needs.
- Preferred transition pathways to move from Oregon's current health care financing model to a unified, publicly funded system.
- A clear set of decision criteria for evaluating financing approaches over time.

Preliminary 8 Meeting Program

The eight-meeting program is organized to guide the Finance & Revenue Committee through a logical progression of inquiry, analysis, and decision-making. The early meetings focus on building a shared foundation—reviewing Oregon's current health care spending, defining the cost target for a universal plan, and establishing key criteria for evaluating financing options. Midway through the schedule, the Committee transitions into detailed exploration of potential revenue mechanisms, including legal, economic, and equity implications.

In the final phase, the focus shifts to implementation readiness: assessing start-up and reserve requirements, evaluating transition strategies, and synthesizing findings into final recommendations. Each meeting is structured to both deepen understanding and prompt specific decisions, ensuring the Committee's work builds cumulatively toward its charge. While the plan is designed to unfold over eight core meetings, it remains flexible to allow for extended discussion, supplementary sessions, or iterative feedback as needed.

- **Meeting 1: Orientation & Framing**
    - Introduce Committee charge and deliverables
    - Establish attributes of a sound financial plan
    - Review the master research framework
- **Meeting 2: Current Health Care Spending**
    - Analyze existing public, private, and out-of-pocket spending in Oregon
    - Identify redirectable funding sources and system cost drivers
- **Meeting 3: Universal Health Plan Cost Target**
    - Review actuarial cost estimates and funding assumptions
    - Adopt a preliminary annual cost target to guide revenue planning
- **Meeting 4: Revenue Mechanisms & Legal Viability**
    - Present potential revenue options (e.g., payroll, provider, income taxes)
    - Evaluate legal considerations, including ERISA compliance
- **Meeting 5: Revenue Trade-Offs**
    - Assess stability, equity, and economic impacts of shortlisted revenue options
    - Narrow to 2–3 preferred revenue scenarios for further development
- **Meeting 6: Financial Impacts & Start-Up Planning**
    - Evaluate effects of proposed financing on households and businesses
    - Define start-up and reserve funding needs and potential mitigation strategies
- **Meeting 7: System Comparison & Transition Planning**

    - Compare current financing system to proposed tax-based model
    - Identify preferred transition approach and implementation timeline
- **Meeting 8: Final Recommendations**
    - Synthesize decisions across prior meetings
    - Finalize financing recommendations, start-up strategy, and evaluation criteria

Committee Decision-Making

The eight-meeting schedule has been intentionally designed to align with the key decision points outlined in the Committee's charge from the Universal Health Plan Governance Board. Each meeting incorporates focused discussions and targeted deliverables that support the Committee's responsibility to recommend a financing framework, assess trade-offs, and propose implementation strategies.

Decision points have been built into the structure of each session to ensure that the Committee's work progresses toward actionable outcomes, with opportunities for refinement as additional analysis and guidance from the Board become available. This structure balances the need for thorough deliberation with the urgency of delivering a comprehensive, evidence-based set of recommendations.

This crosswalk below evaluates whether each required deliverable of the Finance & Revenue Committee is reflected in the decision points included in the 8-meeting workplan.

Preferred financing framework or set of revenue scenarios

- Reflected in:
    - Meeting 4: Shortlist legally viable and high-potential revenue mechanisms
    - Meeting 5: Narrow to 2–3 preferred revenue packages for further modeling
    - Meeting 8: Approve final financing recommendations and documentation
- Notes: Progressively refined through Meetings 4, 5, and finalized in Meeting 8.

Summary of key trade-offs related to revenue stability, equity, legality, and administrative feasibility

- Reflected in:
    - Meeting 4: Revenue mechanisms and ERISA compliance
    - Meeting 5: Stability, equity, and employer behavior
    - Meeting 6: Start-up feasibility (implied administrative aspects)
- Notes: All components addressed; administrative feasibility explicitly surfaced in Meeting 6.

Recommended start-up and reserve strategies

- Reflected in:
    - Meeting 6: Agree on mitigation measures and set reserve/start-up assumptions
- Notes: Addressed in Meeting 6 with focused discussion and decision point.

Preferred transition pathways

- Reflected in:
    - Meeting 7: Choose preferred transition pathway and timeline approach
- Notes: Transition considerations are directly covered in Meeting 7.

Decision criteria for evaluating financing approaches over time

- Reflected in:
    - Meeting 1: Initial attributes of a sound financial plan
    - Meeting 8: (Updated) Adopt final evaluation criteria
- Notes: Added explicit adoption of decision criteria in Meeting 8 to close the loop from Meeting 1.

8-Meeting Work Plan with Decision Points

Meeting 1: Re-Orientation and Framing the Work

Purpose: Introduce project scope, Committee charge, and orient to the framework of financing research.

Agenda:

- Welcome and introductions – Set expectations for participation and outcomes; confirm roles and responsibilities.
- Overview of Universal Health Plan goals – Present policy objectives, values guiding the UHP, and how financing fits in.
- Overview of Committee charge and decision-making milestones – Clarify scope of the Committee's work and anticipated outcomes.
- Walkthrough of Core Research Questions – Introduce the research framework that will guide the Committee's work.
- Discuss attributes of a sound financial plan – Initiate a conversation to co-develop criteria such as sustainability, equity, stability, and administrative simplicity.

Supplementary Materials:

- Framing memo on Committee charge and deliverables
- Slide deck Attributes of a Sound Financial Plan
- Slide deck summarizing UHP context and strategic planning

Key Decision Points:

- Re-adopt draft list of attributes for a sound financial plan

Meeting 2: Understanding Current Health Care Spending in Oregon

Purpose: Review baseline spending to ground future discussions on funding needs and gaps.

Agenda:

- Presentation: Current health care spending in Oregon – Show total spending by public programs, private insurance, and out-of-pocket, and break down by payer.
- Discussion: Key cost drivers and leverage points – Explore what drives cost (e.g., utilization, pricing) and which elements may be redirected or restructured.
- Implications for financing strategy – Connect current spending patterns to potential UHP financing opportunities or constraints.

Supplementary Materials:

- Spending landscape memo
- Slide deck on breakdown of major funding streams
- Draft "Spending Map" visual

Key Decision Points:

- Confirm key categories and gaps to guide revenue planning

Meeting 3: Defining the Cost Target for the Universal Health Plan

Purpose: Establish the cost goal that revenue options must meet.

Agenda:

- Presentation: Estimated cost of Universal Health Plan – Walk through actuarial modeling assumptions for utilization, benefit design, admin costs.
- Presentation: Redirectable existing spending – Identify what proportion of current spending may offset new revenue needs.
- Cost assumptions and containment options – Discuss levers for cost control and how aggressive assumptions should be.
- Sensitivity testing: Cost variation impacts – Illustrate how changes in assumptions could significantly affect the target.

Supplementary Materials:

- Cost model summary memo
- Assumption tables and sensitivity charts

Key Decision Points:

- Adopt a preliminary annual cost target range for planning purposes

Meeting 4: Revenue Mechanisms – Options and Legal Constraints

Purpose: Review available revenue options and ERISA/legal compliance issues.

Agenda:

- Menu of potential revenue options – Present types (payroll, income, provider, sales, etc.), estimated yield, and political/legal feasibility.
- Briefing: ERISA compliance and legal risks – Legal advisors explain what revenue structures may or may not be vulnerable to challenge.
- Initial feedback on revenue mechanism types – Facilitate discussion around values-based evaluation (e.g., progressive, stable, administrable, etc.).

Supplementary Materials:

- Revenue Options Matrix
- Legal memo on ERISA-compliant financing
- Comparison slide deck

Key Decision Points:

- Shortlist legally viable and high-potential revenue mechanisms

Meeting 5: Evaluating Revenue Mechanisms – Stability, Equity, and Employer Impacts

Purpose: Analyze and discuss key dimensions of each revenue option.

Agenda:

- Revenue stability and economic cycles – Review which options are resilient in downturns, and which are volatile.
- Distributional equity by income group – Present tax incidence by income deciles and other demographic breakdowns.
- Employer cost and behavior effects – Discuss how different sectors (e.g., self-insured, small business) would react or benefit.
- Trade-offs across stability, equity, and business impacts – Work through the strengths and weaknesses of top revenue options.

Supplementary Materials:

- Stability analysis memo
- Distributional impact analysis and tables
- Employer impact modeling memo

Key Decision Points:

- Narrow to 2–3 preferred revenue packages for further modeling

Meeting 6: Business and Household Impacts; Start-up Costs and Reserve Planning

Purpose: Understand payer impacts and begin start-up cost planning.

Agenda:

- Financial impacts on businesses and households – Present estimated annual payment changes under new plan vs. current system.
- Mitigation strategies – Discuss mechanisms like tax credits, phase-ins, or exemptions for small businesses or low-income households.
- Start-up and reserve costs – Share projected early-year needs for reserves, IT systems, staff, and public engagement/marketing.
- Approaches to initial financing – Identify options to pre-fund start-up costs before full implementation.

Supplementary Materials:

- Full impact analysis memo
- Start-up and reserve planning memo
- Case study examples

Key Decision Points:

- Agree on mitigation measures (credits, exemptions, phase-ins)
- Set reserve funding and start-up cost planning assumptions

Meeting 7: Comparing Current vs. Proposed Financing Systems

Purpose: Understand transition from employer-based to tax-based financing.

Agenda:

- Current vs proposed systems – Walk through side-by-side comparison of existing employer-sponsored model and UHP tax model.
- Strengths, weaknesses, transition challenges – Identify where resistance or disruption is most likely and what needs careful planning.
- Phased vs full implementation – Evaluate implementation options and their administrative and political implications.

Supplementary Materials:

- System comparison chart
- Transition planning memo
- Draft implementation timeline

Key Decision Points:

- Choose preferred transition pathway and timeline approach

Meeting 8: Finalizing Financing Recommendations

Purpose: Synthesize prior discussions and agree on recommendations.

Agenda:

- Review findings and decisions from prior meetings – Recap all key decisions from earlier sessions and confirm alignment on foundational assumptions and trade-offs.
- Identify outstanding gaps or refinements – Surface final information needs or issues that require clarification before submitting recommendations.
- Agree on final recommendations to submit to Board – Refine preferred financing scenario(s), start-up plan, and transition pathway.
- Finalize decision criteria for ongoing evaluation – Confirm the criteria the Board can use to revisit or adjust financing structures over time.

Supplementary Materials:

- Draft financing recommendations summary
- Slide deck of key decision points
- Evaluation criteria checklist (based on attributes of a sound financial plan from Meeting 1)

Key Decision Points:

- Approve final financing recommendations and documentation
- Adopt final decision criteria for evaluating and updating financing approaches over time

PRELIMINARY MEETING SCHEDULE PLAN

The table below outlines the scheduled monthly meetings of the Finance & Revenue Committee beginning with the May 20 meeting, aligned with the agenda framework described above. Optional supplemental meetings are also listed as overflow sessions; these will be held only if needed and at the discretion of the Committee Chair.

Monthly Finance & Revenue Committee Meetings	Supplemental Meetings (if needed)
• Meeting #1: May 20, 2025 • Meeting #2: June 17, 2025 • Meeting #3: July 15, 2025 • Meeting #4: August 19, 2025 • Meeting #5: September 16, 2025 • Meeting #6: October 21, 2025 • Meeting#7: November 18, 2025 • Meeting #8: December 16, 2025	• Meeting # 1 Overflow: June 3, 2025 • Meeting # 2 Overflow: July 1, 2025 • Meeting # 3 Overflow: August 5, 2025 • Meeting # 4 Overflow: September 2, 2025 • Meeting # 5 Overflow: October 7, 2025 • Meeting # 6 Overflow: November 4, 2025 • Meeting # 7 Overflow: December 2, 2025

ECOnorthwest

DATE:	June 3, 2025
TO:	UHPGB Finance and Revenue Committee
FROM:	ECOnorthwest
SUBJECT:	Principles for a Viable and Just Financing Approach

Introduction to Financing Principles and Evaluation Criteria

As the Finance and Revenue Committee advances its work to identify sustainable funding strategies for Oregon's Universal Health Plan, it is essential to establish a clear framework for evaluating the viability, equity, and effectiveness of financing options. This document outlines a set of guiding principles and corresponding evaluation criteria that will inform the development and review of all financing proposals.

These principles represent the Committee's collective values and policy goals—emphasizing fiscal responsibility, equity, transparency, legal durability, and alignment with Oregon's long-term health system transformation. Each principle is paired with a set of practical criteria to assess whether proposed financing mechanisms uphold these standards.

Together, these principles and criteria provide a consistent, structured approach for comparing options, identifying trade-offs, and ensuring that any final financing plan meets the expectations of the public, policymakers, and implementation partners. This framework is intended for use throughout the planning process and will help guide technical analysis, legal review, stakeholder engagement, and legislative deliberation.

The Committee encourages all analysts, advisors, and stakeholders involved in the financing design process to apply this framework in a transparent and rigorous manner.

1. Clarity and Transparency

Principle: The financing mechanism must be easy to understand by the public and policymakers.

Evaluation Criteria:

- **Comprehensibility:** Can the plan's structure be explained with clear visuals or summaries?
- **Documentation:** Are revenue sources, tax bases, and assumptions fully documented and publicly available?
- **Traceability:** Are data sources and modeling methods disclosed, cited, and replicable?
- **Comparability:** Does the proposal provide a side-by-side comparison with the existing system (e.g., taxes vs. premiums) at the household or business level?

2. Equity and Progressivity

Principle: The system must be progressive and based on ability to pay.

Evaluation Criteria:

- **Distributional Analysis:** Has a formal distributional analysis (e.g., by income quintile) been completed?
- **Progressivity Metrics:** Are measures such as effective tax rates or incidence models used to assess fairness?
- **Inclusivity:** Does the revenue system account for non-traditional income sources or wealth indicators?

3. Fiscal Stability and Permanence

Principle: Revenue sources must be stable, predictable, and sustainable across economic cycles.

Evaluation Criteria:

- **Volatility Analysis:** Does the proposal include stress testing or performance modeling under recession and boom scenarios?
- **Diversification:** Are multiple revenue streams proposed to mitigate reliance on a single economic sector?
- **Elasticity:** How responsive are the tax bases to long-term economic and demographic trends?
- **Contingency Planning:** Are rainy-day reserves or automatic adjustment mechanisms (e.g., rate bands) included?

4. Scalability and Flexibility

Principle: Financing must support phased implementation and system evolution.

Evaluation Criteria:

- **Phase Alignment:** Are funding milestones aligned with expected implementation phases and service expansion?
- **Adaptability:** Can the funding approach be adjusted as new populations, services, or technologies are added?
- **Modularity:** Can specific funding streams be activated independently for pilot programs or partial rollouts?
- **Fallback Scenarios:** Does the proposal identify contingencies if implementation timelines shift or if uptake varies?

5. Legal Viability

Principle: Financing must be resilient to legal challenges, particularly under federal ERISA law.

Evaluation Criteria:

- **ERISA Analysis:** Has a legal analysis been conducted to determine compliance with ERISA and other federal statutes?
- **Employer Neutrality:** Are revenue mechanisms structured as taxes or assessments that avoid direct mandates on employers?
- **Precedent Review:** Does the proposal incorporate lessons from other states or legal rulings?
- **Alternative Structures**: Are backup financing pathways available if a primary mechanism is successfully challenged?

6. Dedicated Health Care Trust Fund

Principle: Funds must be isolated from the general fund and used only for health care.

Evaluation Criteria:

- **Fund Structure:** Is a statutory trust fund with fiduciary safeguards proposed?
- **Revenue Flow:** Are inflows from each revenue source tracked separately within the fund?
- **Oversight Mechanism:** Is an independent body tasked with monitoring fund use, investments, and disbursements?
- **Firewalls:** Are legal or constitutional restrictions proposed to prevent diversion of funds to non-healthcare uses?

7. Optimization of Federal Funds

Principle: Maximize federal contributions and avoid funding or eligibility cliffs.

Evaluation Criteria:

- **Federal Leverage:** Does the proposal identify and incorporate all major federal funding streams (e.g., Medicaid, Medicare, CHIP, ACA subsidies)?
- **Waiver Strategy:** Are federal waivers (e.g., 1115, 1332) sought or assumed to enable integration or redirection of funds?
- **Cliff Avoidance:** Has the proposal modeled transition points to avoid sudden losses in benefits or large tax jumps at specific income thresholds?

- **Coordination:** Are state and federal tax and benefit interactions analyzed to prevent duplication or unintended cost shifts?

8. Comprehensive and Broad-Based Revenue Model

Principle: Funding must reflect the full cost of the plan and be drawn from a diverse set of sources.

Evaluation Criteria:

- **Cost Coverage:** Does the proposal account for all operational, administrative, and start-up costs, including IT systems and outreach?
- **Revenue Mapping:** Are all potential sources (e.g., payroll taxes, individual income taxes, business assessments, provider fees) explored?
- **Base Breadth:** Are proposed tax bases large and inclusive enough to ensure low rates and revenue resilience?
- **Reserve Planning:** Is there an initial capitalization plan, and are reserves or stabilization funds included?

9. Economic Neutrality and Efficiency

Principle: Minimize adverse economic impacts and preserve federal tax preferences where possible.

Evaluation Criteria:

- **Dynamic Modeling:** Has the impact of the proposal on employment, wages, business costs, and productivity been modeled?
- **Migration Effects:** Are risks of individual or business relocation assessed, particularly at key income or profit thresholds?
- **Interaction with Tax Preferences:** Does the proposal account for the potential loss of federal tax exclusions for employer-sponsored insurance?
- **Neutrality Tests:** Has the proposal been evaluated for distortions to labor supply, retirement timing, or employer behavior?

Research Conditions and Technical Standards

To ensure consistency, transparency, and credibility across all analytical work that supports financing design, the following research principles and conditions must be met in any quantitative or qualitative analysis submitted to the Finance and Revenue Committee or the Governance Board.

Data Quality and Reliability

- Use externally verifiable data sources with transparent provenance (e.g., NHEA, CMS, BEA, OHA).
- Explain any deviations from benchmark datasets or national accounting standards.
- Include historical baselines and avoid reliance on a single year of data.

Total System Accounting

- Analyses must account for all system-wide financial flows—not just incremental changes—including public and private payers, household contributions, and employer expenditures.
- Differentiate between operating and capital expenditures.
- Disaggregate financial flows by geography and service type (e.g., behavioral health, dental, long-term care).

Transparency in Methods

- Document all assumptions, estimation techniques, and data transformations.
- Clearly define included populations and services.
- Provide model logic or formulas in appendices or technical notes.

Uncertainty and Risk Disclosure

- Report confidence intervals, error margins, and ranges for all key estimates.
- When statistical uncertainty cannot be quantified, describe and justify alternative methods for risk characterization.

Temporal Validity

- Base projections on historical trend analysis before applying forward-looking assumptions.
- Justify selection of study years, especially if including or excluding pandemic years.

- If future-year estimates are presented, show how results would differ under alternative base periods.

Comparability

- Provide cross-references to other major studies (e.g., RAND, Task Force reports).
- When results diverge from those studies, explain differences in assumptions or methods.

Savings and Consolidation Estimates

- Claims about system savings (e.g., through administrative simplification or single-payer models) must be supported by:
    - Multiple estimation methods
    - Documentation of persistence and limitations
    - Sensitivity analysis if payment consolidation is partial or phased

Macroeconomic and Fiscal Impact

- Include analysis of macroeconomic effects (e.g., jobs, income, productivity) and changes to public revenues (e.g., state income taxes due to health care reform).
- Explore behavioral responses such as labor force participation or changes in charitable giving.

Financing Feasibility

If the financing proposal includes bond sales or financing instruments, include:

- Investor demand analysis
- Interest rate and term structure assumptions
- Repayment and debt-service modeling

ECOnorthwest

DATE:	June 20, 2025
TO:	System Design, Governance, Legal, and Outreach Committees
FROM:	Finance & Revenue Committee
SUBJECT:	Key Financial Assumptions for Cross-Committee Alignment

Purpose

This memo highlights several financial assumptions and conditions developed by the Finance & Revenue Committee that should inform work across all committees. These elements affect decisions around benefit design, implementation planning, legal structure, governance, and public communication. Early coordination will help ensure a coherent, viable universal health care plan.

We recommend that each committee consider these cross-cutting financial conditions as they develop their respective components of the universal health care plan. The Finance & Revenue Committee is available for technical consultation and coordination.

Cross-Cutting Elements of a Sound Financial Plan

1. Covered Populations and Services Must Be Clearly Defined

The financial modeling assumes a specific set of services and a defined eligible population. System design decisions must align with these assumptions to ensure consistency in cost estimates. Outreach and public materials also need to reflect these definitions accurately to avoid confusion or misrepresentation.

2. Implementation Phasing Must Match Funding Capacity

The proposed financing structure supports phased rollout. Any plan to expand coverage by geography, age, or income group must be coordinated with the timing of available revenue. Communications should be clear about when different groups will be included and why.

3. Financing Design Must Avoid Legal Conflicts with ERISA

The structure of employer-related revenue sources must be carefully designed to avoid federal preemption under the Employee Retirement Income Security Act (ERISA). Financing approaches should be framed as broad-based state taxes or contributions rather than mandates on employer benefit offerings.

4. A Dedicated Trust Fund Is Required

The financial plan assumes all revenues will be held in a dedicated health care trust fund—not the general fund—to ensure transparency and fiscal integrity. Governance planning should include oversight mechanisms for the fund, and messaging should emphasize this structure to build public confidence.

5. Federal Program Integration Must Be Seamless

The financing model relies on leveraging federal funding streams such as Medicaid, Medicare, and ACA subsidies. System design must ensure that individuals can move between programs without sudden losses of coverage or tax burdens. Communications should clearly convey how federal programs will be integrated or replaced.

6. Workforce and Economic Behavior Will Likely Shift

Unlinking health coverage from employment may lead to changes in workforce participation—for example, some individuals may retire earlier or reduce hours. These shifts can affect income and tax revenues and should be factored into both economic analysis and system design. Messaging should reflect the increased flexibility the new system offers.

7. Common Data Sources and Time Periods Are Essential

Financial analyses are based on multi-year data from national sources like the National Health Expenditure Accounts. All committees should use consistent timeframes and baselines for planning purposes. Avoid relying on single-year or pandemic-era data unless explicitly justified.

8. State "Kicker" Law May Affect Revenue Stability

Oregon's "kicker" law, which refunds surplus personal income tax revenue to taxpayers, could limit the ability to build reserves or rely on volatile revenue streams. Any proposal that uses income tax as a financing source must account for how the kicker affects long-term revenue stability. Legal and governance teams may need to explore exemptions or legislative changes, and communications should anticipate public questions about why health care funds are or are not subject to the kicker.

9. Administrative Costs Must Be Accurately Estimated

The financial model depends on a full accounting of administrative overhead, including billing systems, payer functions, data reporting, and regulatory compliance. System design decisions—such as whether to centralize payments—can significantly affect these costs. Committees working on operations, governance, and IT infrastructure should coordinate closely with fiscal analysts to ensure administrative assumptions remain realistic.

10. Reserves and Existing Program Funds Need a Transition Plan

Several existing public programs hold reserve funds or carryover balances that may be repurposed under a universal system. The financial plan assumes that these reserves can help support transition costs or reduce initial tax burdens. Legal and program design should inventory these funds, assess restrictions on their use, and propose a clear strategy for how they will be integrated or liquidated as the new system is implemented.

ECOnorthwest

DATE:	October 10, 2025
TO:	The Oregon Universal Healthcare Governance Board
FROM:	UHGB Finance and Revenue Committee and ECOnorthwest
SUBJECT:	Preliminary UHP Funding Plan Straw Proposal

Introduction

This memorandum presents a "straw proposal" revenue package developed by the Finance & Revenue Committee to finance Oregon's Universal Health Plan (UHP). The proposal reflects the Committee's deliberations on how to equitably, sustainably, and realistically fund a universal, publicly administered health care system – not by creating new net financial obligations, but by redirecting and restructuring existing health care spending in a more transparent and equitable funding model.

A key premise of the proposal is that Oregon does not need to raise new money from scratch to implement a UHP. Health care in Oregon is already heavily financed through a combination of employer-sponsored insurance (ESI) payments (contributions from both employers and employees), premiums from individuals (e.g. - Medicare part B, Medigap, marketplace policies), households' out-of-pocket expenditures (OOP) and a variety of state and federal public programs (e.g., Medicare and Medicaid).

The committee's proposed UHP financing model builds on Oregon's existing multi-payer structure, by capturing payments in a comprehensive framework that is both meaningfully more coherent and less haphazard than the multi-payer system, and provides universal benefits more efficiently and equitably, in a single-payer framework.

Critically, this proposal is not a strict Pareto improvement relative to the current multi-payer system — some individuals and firms will pay more for healthcare under the proposal than they do under the status quo — but, by design, the proposal comes remarkably close to attaining that gold standard in the aggregate. The committee's analysis indicates that a revenue plan with the basic structure outlined here would deliver better health outcomes at lower total system cost, with progressive protections for low- and middle-income households and greater predictability for businesses. A significant majority of individuals and businesses would be appreciably better off under this UHP model than they are under the status quo.

What this Proposal Aims to Do

The revenue proposal outlined here provides a cogent, integrated system of UHP revenue streams — some of which would nominally be paid by businesses and some of which would nominally be paid by individuals, via the State's personal income tax.

In summary, the proposal is designed to raise approximately $16.9 billion annually (in 2022 dollars) — this "funding gap" represents the residual "ongoing" cost of funding the UHP on an annual basis after the presumptive transferable resources from the current system are integrated into the UHP (as discussed below and assuming PEBB+ benefit levels for all Oregonians).

The proposal assumes that federal money for Medicare as well as the federal government's share of Medicaid continues to flow to Oregon, after the state obtains federal waivers. The existence of the remaining "funding gap" this proposal covers is mostly due to the loss of employer-paid premiums for private health insurance under the UHP. The "funding gap" is also net of considerable cost savings that will be realized under a single-payer UHP, according to the best available evidence.

Proposed Contributions From Businesses and Individuals

It is useful to think of the proposed UHP revenue streams in terms of contributions from businesses, and contributions from individuals.

The proposal includes marginal increases in Oregon's corporate income tax (CIT) and corporate activity tax (CAT) rates. But the central mechanism for collecting health care contributions from businesses and employers is a statewide Employer Payroll Tax (EPT), which replaces the contributions employers currently make to Employer Sponsored Insurance (ESI) plans. Crucially, the committee assumes the proposed EPT will get the same federal corporate income tax treatment as employer-paid private health insurance premiums currently do. This would allow the UHP to leverage status quo federal tax law, which exempts benefits that firms pay on behalf of their employees from their corporate income tax base – the proposal thereby prevents the "leakage" of additional tax dollars from the Oregon economy.

The committee's EPT proposal has two noteworthy features. First, by design, the state UHP EPT approximates the expenditures employers currently contribute to private ESI premiums, rather than imposing new aggregate burdens. Second, the UHP revenue system presented here pairs the EPT payments that employers make on an employee's behalf dollar-for-dollar with a personal income tax credit that employee claims on her state income tax return – more on which follows.

In terms of contributions from individuals, that are two primary mechanisms for raising new net revenue:

1. A progressive **Health Care Personal Income Tax (HCPIT),** which is net of the EPT credit mentioned above and further described below.

2. A **per-person premium (PPP)**, intended to emulate the familiar structure of private health insurance premiums and Medicare Part B premiums or ESI payroll deductions in the current system.

The per-person premium (PPP) put forth in the proposal will be administered through the Oregon personal income tax system – these PPP are required healthcare contributions (i.e., the "premiums") that phase in linearly as one's income increases above certain Federal Poverty Level (FPL) thresholds, and level out once a maximum per-person premium is reached (e.g., $4,000 per adult and $2,000 per dependent in the proposal). The PPP mimics existing cost-sharing structures in the status quo multi-payer system but replaces what is currently a complicated system of regressive flat-rate premiums and out-of-pocket (OOP) costs with an income-sensitive contribution structure that protects lower- and middle-income households. The tiered structure speaks to the plan's progressivity and ability-to-pay objectives.

Key Features of the Revenue Proposal

The Committee's proposal has four key elements, each described in detail in the sections that follow:

- **Administrative Savings** – A PEBB+ single-payer UHP would realize an 8 percent systemwide savings rate (relative to 4 percent in prior estimates), reducing required revenue by roughly $1.3 billion annually.
- **Employer Payroll Tax** – Existing employer-sponsored insurance contributions would be replaced with an 11 percent payroll tax on payroll above a firmwide payroll threshold. It would be paired with a 100 percent HCPIT credit offset to avoid employees paying twice for their health care coverage.
- **Individuals' Contributions** – A two-part structure that combines a new Health Care Personal Income Tax (HCPIT) on income above 200 percent of the federal poverty level (FPL) and an income-sensitive per-person premium (phasing in at 350 percent FPL and maxing out at $4,000 per adult and $2,000 per dependent).
- **Supplemental Business & Consumption Taxes** – Modest increases to Oregon's existing state CIT, CAT, excise taxes (cigarettes, beer/wine, marijuana), and lodging tax to diversify the revenue base and capture targeted policy benefits.

Collectively, these components of the Committee's proposal are designed to:

- **Recover employer contributions** that currently pay for private health insurance.
- **Protect low- and middle-income households** through income-based thresholds and credits.

- **Ensure broad-based, predictable contributions** from employers and individuals.
- **Provide a revenue framework that can be refined and stress-tested** through further modeling, stakeholder engagement, and deliberation.

Structure of this Memo

In the next section, the memorandum presents the committee's critical underlying assumptions concerning UHP administrative cost savings and federal support for Oregon's UHP system. In the final section, the memo provides the specific tax parameters that define the revenue proposal. This section also explains the key features and rationale of the proposed tax features and describes how healthcare contributions change for various types of individuals and businesses under the proposed UHP plan relative to the status quo multi-payer system.

This proposal is intended as a starting point for feedback and future refinement. Assuming the Governance Board finds the proposal acceptable in broad form, the next phase of work will involve additional scenario modeling, sensitivity analysis, and stakeholder feedback, to bring key trade-offs into focus, test assumptions, and ultimately guide the development of a coherent financing framework that meets the UHP's goals of universality, equity, and sustainability.

Administrative Savings, Federal Transfers and other Important Modelling Assumptions

The Committee believes this proposal provides an elegant solution to finance Oregon's UHP that greatly simplifies the current healthcare system. Necessarily, however, any financing structure of this magnitude involves complex assumptions. This section describes the assumptions that are critical to the proposal.

First, the reader should understand the healthcare costs that this proposal is intended to cover and those it is not. Logically, any new healthcare system will incur costs of three kinds — "transition" costs, e.g., to switch administrative records to a single IT system; "reserve" costs, to capitalize the requisite reserve balance for a healthcare system covering 4 million persons; and "on-going" costs, which refers to the annual costs of providing healthcare once the UHP is up and running.

The committee's proposal is strictly concerned with covering "on-going" system costs. Specifically, because the precise plan described here is designed to fill the estimated hypothetical revenue gap for the year 2022 — the most recent year for which necessary high quality tax data is available — the committee feels that a funding plan akin to this proposal will have the capacity to do so on an annual basis once the UHP is implemented. The presumed 2022 funding gap is $16.9 billion. Given the widely noted escalation in health care costs, the Board will need to ensure that whatever revenue streams are ultimately implemented keep pace with cost growth.

Note that there are some very large uncertainties in the funding gap. Perhaps the largest uncertainty is related to the effects of H.R. 1 (2025) on federal Medicaid funds. Eligibility will be tightened, and state-directed payments will have lower limits. This is expected to lower federal Medicaid funds to Oregon by over $3 billion by 2030. On the other hand, the state will be paying providers substantially more for seeing Medicaid-eligible patients (UHP requires price parity) which could increase federal matching funds by over $4 billion by some estimates. Optumas had estimated the increase in federal funds due to price parity at $2 billion by 2026. The state could also implement programs (e.g. - enhanced volunteer opportunities) that could mitigate some of the decreased eligibility effects. Overall, this could lead to anywhere from a $1 billion decrease in the funding gap to a $3 billion increase in the funding gap.

There is also a nearly $1.5 billion uncertainty in "structures and equipment" spending in the National Health Expenditures (NHEA) dataset used to compute 2022 healthcare expenditures. It is not clear whether such expenditures are already accounted for in payments to providers, or if they are additional expenditures that may need to be dealt with.

Concerning the other kinds of necessary UHP funding, the F&R committee is developing transition financing and reserve capitalization recommendations with its consultants from ECOnorthwest and Milliman (forthcoming in a separate memo).

Next, any revenue proposal for financing a state-run single-payer system must necessarily make critical assumptions about two essential factors that determine how much revenue the UHP system will need to generate on an on-going annual basis). These assumptions concern:

1. **How much administrative cost savings will the UHP realize?**
2. **How many federal dollars will transfer to the UHP?**

Regarding administrative savings, the 2022 Joint Task Force report assumed that a single-payer system could realize administrative savings of 4 percent. The Committee feels the preponderance of evidence suggests 8 percent is a more realistic estimate of the provider cost savings attainable under a unified, publicly administered health care system. The Committee notes that recent national and international studies indicate streamlined, single-payer systems typically operate with administrative overhead in the range of 2 to 5 percent, compared to 12 to 15 percent in the U.S. multi-payer model. The Committee's assumption has the effect of reducing the requisite annual revenue the UHP tax proposal needs to raise by $1.3B (2022) relative to the JTF estimate.

Work by the Governance Board's Plan Design Committee — supported by Milliman Consulting — will produce an updated cost target with independent detailed assumptions about administrative savings and system efficiencies. The 8 percent savings estimate used in this proposal is intended as a reasonable placeholder until completion of that work.

Regarding federal funds, this proposal assumes federal dollars that currently come into Oregon for Medicare and the portion of Medicaid paid by the federal government (and the status quo Medicaid federal matching rules) will be available under the UHP (given presumptive waivers from CMS). Procuring these federal funds will require significant effort on the state's part and involves significant uncertainty but are crucial to the simplicity of the UHP.

In particular, the proposal does not interfere with the current process of seniors qualifying for Medicare through the Social Security Administration. Medicare recipients would continue to pay Part B, and some would continue paying part A premiums, including IRMAA (Income-related monthly adjustment amount). In the UHP proposal, Medicare recipients will receive a credit for paid Part B premiums against their per-person premium.

Moreover, under this proposal lower income Oregonians would similarly continue to apply for Medicaid coverage according to state and federal rules, so that Oregon can continue to pull down federal matching funds. As with Oregon's 2022 Joint Task Force (JTF) Report, the Committee's cost estimate already includes savings from avoiding current multi-payer administrative costs for marketing, enrollment, provider vetting and negotiation, claims

processing, and private profit margins. The JTF Report also assumed a 4 percent (of total health system expenditures) provider-side administrative savings would obtain in a UHP because providers would no longer need to apply to and bill to dozens of different insurance companies (the committee's view on administrative savings is more consistent with the literature).

The Proposed Revenue Plan

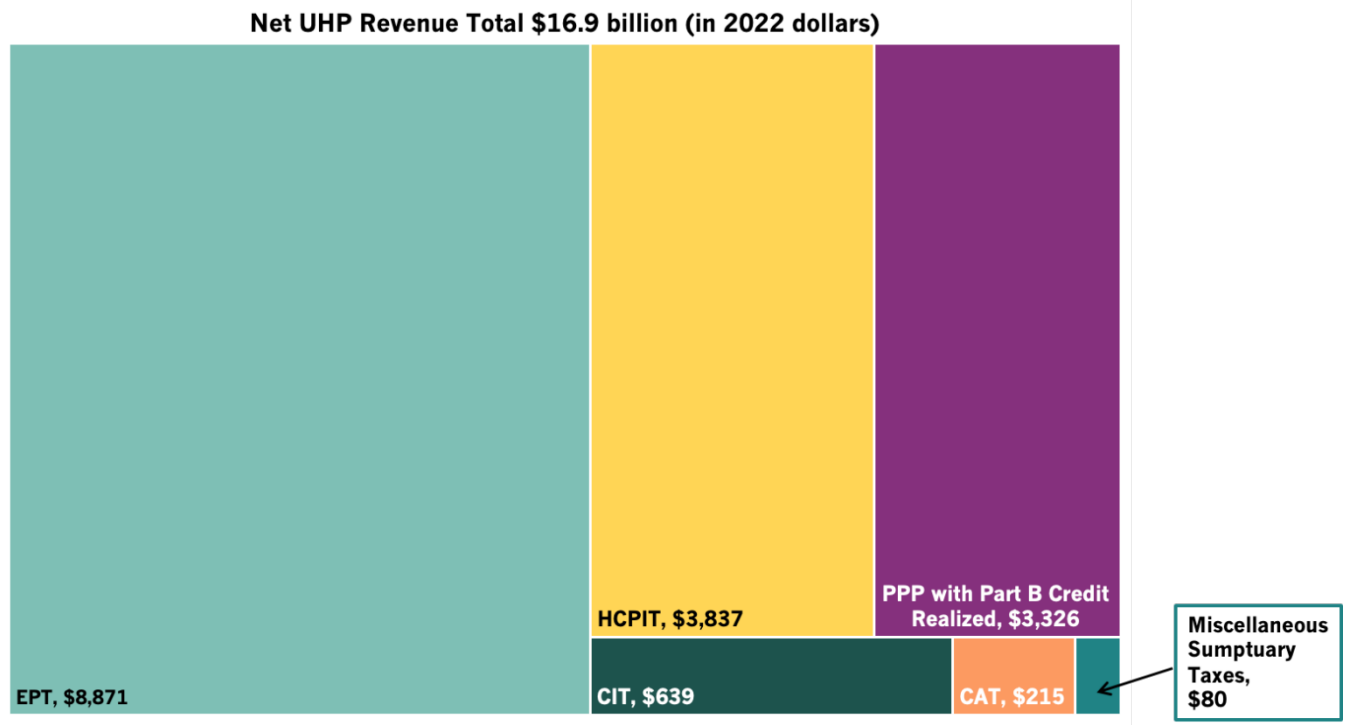
The UHP revenue proposal described in this section is the result of collaboration between the Finance & Revenue (F&R) Committee and its consultant ECOnorthwest. F&R members Charlie Swanson and Richard Gibson were instrumental in surfacing key policy levers and analyzing the fiscal impact of various design choices. Figure 1 provides the technical parameters which are described textually below.

Figure 1. Parameters of the Proposed UHP Revenue Plan

	Current Value	Proposed Incremental Increase to fund UHP
Employers' Contributions		
Corporate Income Tax (CIT)	6.6% rate on taxable earnings below $1M; 7.6% rate on taxable income above.	3.00%
Corporate Activity Tax (CAT)	$250 plus 0.57% of taxable Oregon commercial activity of more than $1M	0.10%
Employer Payroll Tax (EPT) Credit	Oregon payroll taxes sum to 3.6%. The federal government has a 6.75% FICA rate and many counties have EPTs as well.	11% (with 100% HCPIT credit)
EPT Firm Payroll Threshold	NA	$200,000
EPT Individual Wage Threshold	NA	100% FPL
Individuals' Contributions		
Healthcare Personal Income Tax Rate (HCPIT)	NA	9.00%
HCPIT Exemption Threshold	NA	200% FPL
HCPIT Soft Cap Threshold	NA	$30,000
HCPIT Soft Cap Rate	NA	3.00%
Personal Premium	Highly variable*	$4,000 per adult and $2,000 per dependent
Premium Phase-In Threshold	NA	350% FPL

The Committee and its consultants worked iteratively through the summer of 2025 to map the interactions between key prospective UHP revenue instruments — employer payroll tax (EPT), "health care" personal income tax (HCPIT), and per-person premiums (PPP) — and assess their implications with respect to established principles of equity, affordability, and revenue adequacy. The committee's modeling efforts focused on revenue generation, but also upon distributional impacts across households and firms, potential administrative feasibility, and alignment with the policy objectives established by the UHP Governance Board.

Figure 2. Net Proposed UHP Revenue by Source (in millions of 2022 dollars)



Based on its work, the Committee identified a set of preliminary parameters to advance to the Governance Board as a baseline for further deliberation. Figure 2 shows how the Committee's revenue proposal strikes a balance between business contributions that replace existing employer-sponsored spending, a system of income-sensitive contributions from individuals, and several supplemental consumption-based excise taxes that collect a relatively small share of total UHP revenue

Notice in Figure 2 the proposal includes roughly modest, revenue additions to Oregon's existing Corporate Income Tax (CIT) and Corporate Activity Tax (CAT). The CIT and CAT are expected to raise $639M and $215M per annum, respectively. These are devoted health care levies that augment existing revenue streams, broadening the base of contributions from Oregon businesses that will benefit from a healthier workforce and more predictable (frequently lower) healthcare costs.

Finally, the proposal includes supplemental excise taxes — notably a transient lodging tax and a suite of sumptuary taxes (e.g., on cigarettes, alcohol, marijuana). These taxes are not core funding mechanisms but included in the proposal to further secondary health policy objectives. For example, the lodging tax is designed to capture some of the costs associated with providing care to out-of-state visitors, including emergency services their own insurance does not cover. Sumptuary taxes in the proposal would help internalize the public health costs certain activities impose on the UHP system (in a standard Pigouvian sense).

Four Key Mechanisms Explained

1. The Employee Payroll Tax (EPT)

The proposal establishes a dedicated UHP Employer Payroll Tax (EPT) to function as a transparent, front-end replacement for current private health insurance premiums paid by employers. The proposal would replace current employer-sponsored insurance (ESI) spending with a restructured EPT that shifts the primary mechanism for business contributions from a fragmented and privately negotiated system to a uniform, public framework.

Under the current multi-payer system, businesses vary widely in their health care contributions. Some employers offer comprehensive, fully paid coverage; others provide limited support or no coverage at all. Employers that offer insurance typically pay premiums on behalf of all covered employees, in the current system, regardless of income level. Employers that do not offer insurance, moreover, face no obligation to contribute, even if their workers remain uninsured or rely on public programs.

The straw proposal features a 10.0 percent Employer Payroll Tax (EPT), which applies to all the (collective) payroll a firm expends above a (firmwide) threshold – described below. This structure ensures that most small businesses are excluded from the UHP's EPT entirely; large employers that currently offer ESI would make comparable contributions; firms that currently offer limited or no coverage contribute their fair share toward a universal system.

Specifically, under the proposal, the EPT is assessed on total wages paid above a specified firmwide threshold ($200,000 in the straw proposal). But wages paid to individual workers below the 100 percent FPL threshold are excluded from its tax base. Thus, for example, if a company has 20 employees that each earn $12,000 per year and the FPL is $15,000, even though the total payroll of $240,000 is above the threshold of $200,000, the firm will have no EPT liability.

The proposed EPT effectively has two marginal rates: zero below a specified threshold and positive for the portion of an individual employee's income above the threshold. Taxing all a worker's wages when their income rises above a threshold, and not just the portion of income above the threshold, would produce a "fiscal cliff", which the committee has

committed to avoid as a matter of principle. Only the portion of wages above the threshold is taxed, similar to how standard marginal rates work.

The individual wage threshold sets the floor at which wage-based EPT contributions begin. In this proposal, the threshold is defined as 100 percent of the Federal Poverty Level (FPL) for a single individual -- this means that wages paid to workers below this income level do not contribute to the EPT liability of their employer.

This design parallels elements of other federal and state tax systems (e.g., the Earned Income Tax Credit phase-in), in this case to exempt or reduce UHP liability for the lowest earners. It also modestly reduces EPT exposure for employers with a high concentration of part-time, seasonal, or low-wage workers, thereby reducing regressive effects across sectors like agriculture, hospitality, and care services.

2. Health Care Personal Income Tax (HCPIT)

One of the two central mechanisms for collecting health care revenue from individuals is the "health care" personal income tax (HCPIT). The "HC" in HCPIT distinguishes it from the existing Oregon personal income tax that will continue to flow to the state's general fund (not the UHP). The HCPIT is an administratively simple flat rate state personal income tax increment of 9.0% applied to income above an exempted income threshold – 200% FPL in the proposal. The straw proposal's HCPIT also features a soft cap on total contributions: once household HCPIT healthcare contributions (inclusive of PPP) reach a statutory threshold ($30,000 in the proposal), the marginal HCPIT rate drops to 3%. As noted below, non-self-employed individuals receive a personal income tax credit equal to the EPT their employer paid on their behalf.

3. HCPIT Credit for EPT Paid on a Worker's Behalf

Crucially, the EPT defined above is not designed to produce the majority of the net new revenue towards the UHP — up to 100 percent of it is credited back to workers through a credit against their HCPIT liability, preserving after-tax income and preventing employees from potentially paying twice for health care: once if employers were to reduce wages to pay for the payroll tax, and again when the employee pays their HCPIT. Per standard economic theory, without this credit (and depending on the relative labor supply and demand elasticities) workers could bear the incidence burden of the EPT through reduced wages over time and still pay full personal income taxes on the same wage base — essentially paying twice for their health coverage.

4. Per-Person Premiums (PPP)

Per-person premiums (PPP), in the committee's view, provide a familiar and transparent mechanism for collecting individual health care contributions — similar to Medicare Part B premiums or ESI payroll deductions in the status quo regime. The "premium" in this proposal is

not an insurance premium — rather an additional amount individuals pay in personal state income taxes — the PPP is intentionally structured to mimic the logic and visibility of status quo premia.

The proposed PPP provides households with a predictable contribution while ensuring affordability protections for those with limited resources. In the current multi-payer system, individuals pay flat, often regressive premiums for employer-sponsored coverage or plans on the individual market. In the proposed structure, PPP contributions are tied to the number of persons in the household, premiums phase-in beginning at 350% of FPL, exempting lower-income households from any obligation. Adjusting the phase-in point (e.g., to 300% of FPL) or the maximum premium would allow the plan to modify the balance between affordability, revenue adequacy, and equity. The maximum premium of $4,000 applies to adults in the household. Younger additional household members would carry a premium less than the adult premium.

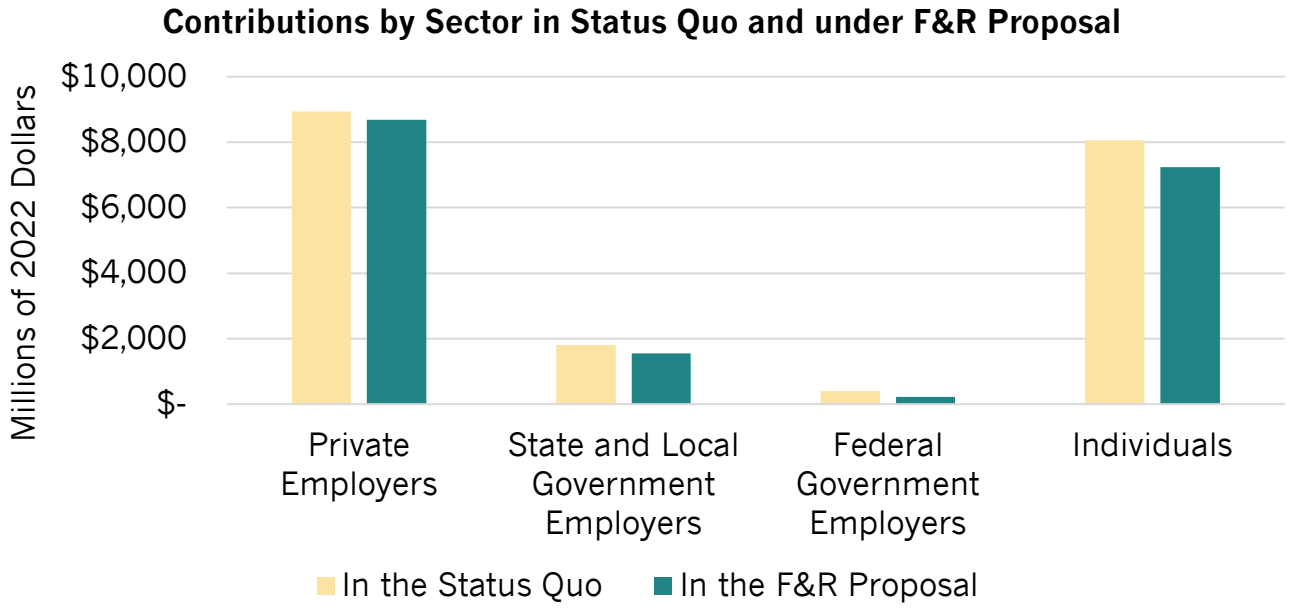
The Financial Implications for Individuals and Businesses

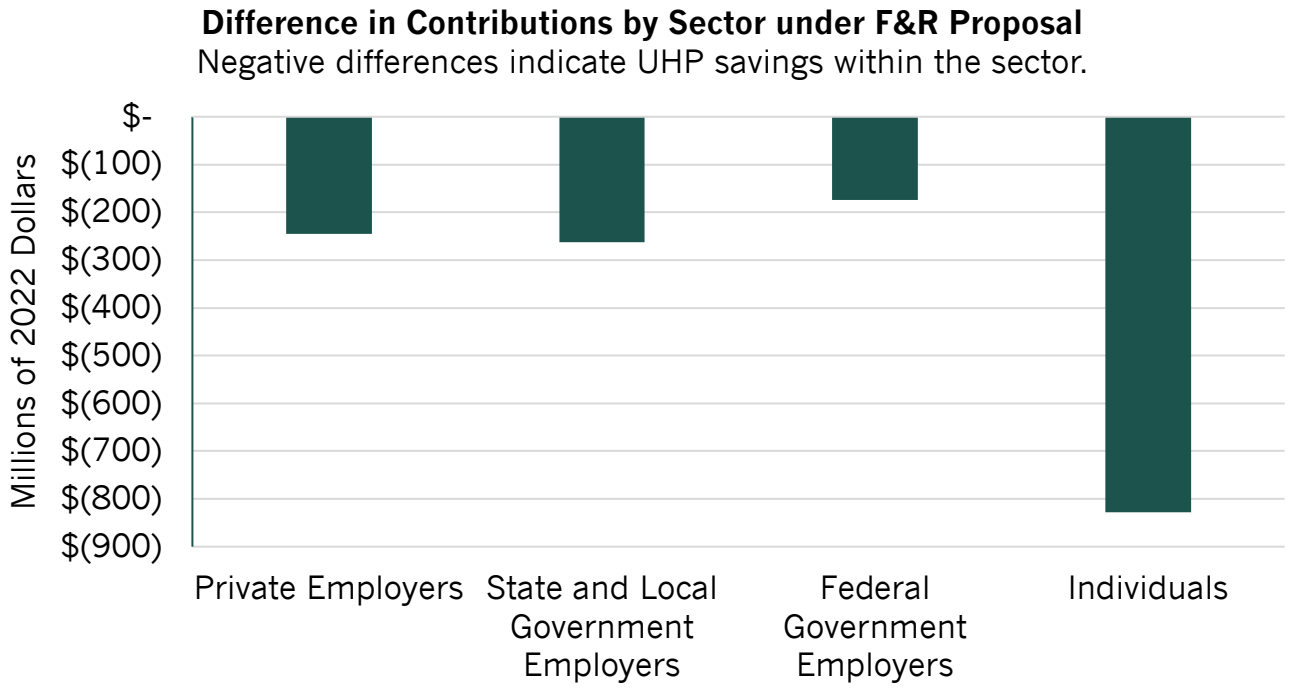
A critical question for equity considerations (and political feasibility) is how much the UHP proposal will affect individuals and businesses in Oregon relative to the status quo. At a high level, as Figure 3 illustrates, aggregate total business-sector payments are restructured — not increased under the proposal. But logically, a firm that does not contribute to its employees' health insurance in the status quo will be worse off under the UHP. Conversely, many firms that currently contribute towards health care will see their annual expenses fall.

How would individuals fare under the proposal relative to the status quo? Similarly to businesses, at the aggregate level, Figure 3 demonstrates that individuals will do better under the UHP proposal as a group, in terms of total individual contributions made. But on a person-by-person basis, again, some individuals will pay more for healthcare under the UHP, some less – depending on the particulars of the health care contributor under the status quo. The committee is developing a set of "before and after healthcare" expense scenarios for individuals with various life circumstances to help illustrate the implications of the plan.

Some observations are clear: a high earning household that opts to go without health insurance in the status quo, and pays no OOP health care expenses, will pay more under UHP. Ceteris paribus, insured less healthy individuals, who tend to pay more deductibles in the current system, will benefit more from the UHP than similarly situated healthy individuals.

Figure 3. Net Proposed UHP Revenue by Source and Change Relative to Status Quo (in millions of 2022 dollars)





ECOnorthwest

DATE:	November 14, 2025
TO:	Universal Health Plan Governing Board
FROM:	Finance and Revenue Committee
SUBJECT:	Revised Revenue Structures for Universal Health Plan: Response to Board Feedback and Updated Modeling Approach

Introduction

This memorandum outlines the Finance & Revenue Committee's revised recommendations for funding the Universal Health Plan (UHP), developed in response to Board and public feedback following the presentation of the Committee's October 16 straw proposal. These updates reflect the Committee's commitment to improving equity, transparency, and administrative simplicity in the plan's revenue structure, while still achieving the coverage and sustainability goals outlined in the UHP mandate.

The Committee's straw proposal of October 16 presented the Board with a single revenue proposal for funding the UHP, to which the Board provided feedback and direction for further exploration. In response, as described below, the Committee has strategically contemplated a series of alternative tax mechanisms that speak to the points raised by the Board. The Committee has not yet landed on a single revised tax plan; such a recommendation is in the works and forthcoming in the Committee's final report. Rather, the preliminary analytical exercises described below systematically vary key parameters of the mechanisms in the original proposal (or does away with them) to help illuminate their strengths and weaknesses or demonstrate how their further refinement might allow the Board to achieve its objectives.

More specifically, the alternatives contemplated here variously alter components of the original framework that were perceived as confusing or inequitable with more unified and income-sensitive mechanisms. In particular, the Per-Person Premium (PPP), the 100% Employer Payroll Tax (EPT) credit, and the soft cap on the personal healthcare contributions of high-end income earners are revised and grounded in updated modeling of the Healthcare Personal Income Tax (HCPIT).

The Committee continues to test alternative structures, such as exemption-based household adjustments, partial EPT credits, and the role of soft cap thresholds, based on how they affect burden distribution, labor market dynamics, and taxpayer equity. One clear implication of this initial work is that, at the margins, some of the Board's guiding principles invariably come into tension. The Committee is committed to helping the Board weigh the costs and benefits of the unavoidable tradeoffs involved as it calibrates a final revenue package.

The Committee eagerly awaits further feedback from the Board to guide its work. As reminder, the current proposal from the Finance & Revenue Committee focuses solely on

covering the ongoing annual costs of delivering healthcare under the Universal Health Plan. We recognize that additional funding will be needed for transition and reserve costs—such as system start-up and building reserves—and the Committee is working on a separate approach to address those needs.

Summary of Key Revisions

1. **Per-Person Premium (PPP) Eliminated and Replaced by Household-Based HCPIT Adjustments:** The Committee has removed the original Per-Person Premium (PPP) structure of the straw proposal in favor of a unified income tax structure that adjusts for household size using tax exemptions. The revised approach is universally applicable and will simplify administration and explanation of the revenue plan, whatever form it may ultimately take.

2. **EPT Credit Set Below 100%:** The original proposal allowed for 100% of the UHP Employee Payroll Tax (EPT) that an employer paid on behalf of an employee to be claimed as a (non-refundable) credit on the employee's personal income tax return. Consequently, under the former proposal, some high-income employees made rather modest direct healthcare contributions through their healthcare personal income tax payments. Based on feedback from the Board, we now recommend setting the EPT credit low enough (less than 100%) so that the chance of high wage earners paying no health care personal income tax is low. The Committee is testing various percentage values of less than 100% EPT credit. This work seeks to retain shared responsibility between employers and workers while minimizing distortions in tax rates.

3. **100% Medicare Premium Credit Adopted:** To prevent double payment for retirees, the Committee recommends a full credit (100%) for Medicare Part B premiums paid by the individual. This would eliminate the perception that the UHP would double tax seniors for coverage they already pay for through federal programs.

4. **Soft Cap Under Evaluation:** In response to concerns about regressivity and fairness at high incomes, the Committee is modeling scenarios both with and without a soft cap (a limit on personal healthcare liability). The goal is to weigh revenue and retention concerns against equity and progressivity.

Further refinements will follow based on updated analysis and Board direction.

Overview of the Original Revenue Proposal

The original proposal was built around five key components:

1. Employer Payroll Tax (EPT): A tax levied on employers based on total payroll above a defined threshold.

2. Healthcare Personal Income Tax (HCPIT): A flat-marginal rate applied to individual income above a threshold related to the federal poverty level (FPL).
3. Per-Person Premium (PPP): A capped individual contribution ($4,000 per adult; $2,000 per dependent), phased in at high incomes.
4. Employee Tax Credit: A credit to offset an employee's HCPIT liabilities for employees whose employers pay an EPT on their behalf, to compensate for the expected lower wages they might receive due to the employer's tax liabilities.
5. Soft Cap: A reduction in the HCPIT rate (from 9% to 3%) after an individual's combined direct UHP contributions exceed $30,000.

The initial plan aimed to balance shared responsibility, progressivity, and simplicity. However, feedback indicated that the proposed structure introduced avoidable complexity and raised equity concerns, especially as it related to middle-income earners, retirees, and the self-employed.

Summary of Feedback Themes from UHP Board

Feedback regarding the committee's initial proposal fell into three primary categories:

A. Equity Concerns

- The PPP and soft cap disproportionately benefit high-income households and create a burden for middle-income households.
- Middle-income and self-employed individuals might shoulder an undue burden.
- Treatment of social security beneficiaries and Medicare participants raised concerns about double-payment.

B. Structural Complexity

- The layering of taxes, credits, and thresholds creates confusion.
- The interplay between PPP, EPT, and HCPIT makes the plan difficult to explain.

C. Design Recommendations

- Remove the PPP in favor of a unified, income-based structure.
- Consider graduated HCPIT rates instead of a flat rate.
- Reevaluate the EPT and Medicare Part B credit structures

Response from Finance & Revenue Committee

1. Transition from the PPP Toward a Household-Adjusted HCPIT

In response to feedback that the Per-Person Premium (PPP) structure was confusing, duplicative, and difficult to explain, the Finance & Revenue Committee has decided to eliminate the PPP as a separate component of the funding model.

In its place, the Committee is evaluating the use of a household adjustment mechanism built directly into the HCPIT. Under this approach, a unified rate schedule would be applied to taxable income and adjusted for household size using the number of dependents claimed on annual tax filings. This would allow the tax to reflect both:

- the overall income of the household, and
- the number of people supported by that income.

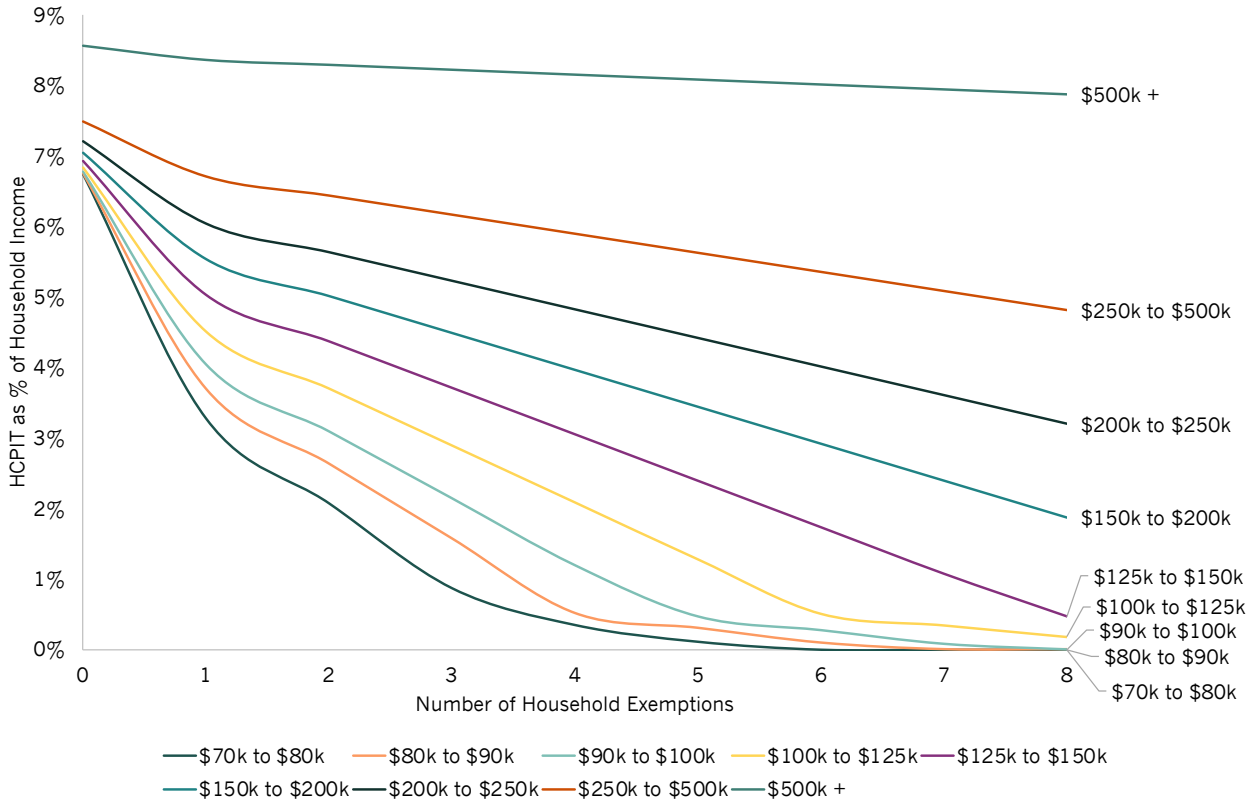
This shift simplifies the structure by consolidating all contributions into a single tax structure, administered through the existing Oregon state personal income tax system. It also improves transparency and allows for greater alignment between a household's contribution and its ability to pay.

Research in Progress: Impact of Exemptions and Household Adjustments

As the Finance & Revenue Committee continues evaluating the role of household-size adjustments in the HCPIT, Exhibit 1 illustrates what happens when no such adjustment is applied. Call this the "Baseline Scenario." Each line represents a different household income level, and the vertical axis shows the effective UHP tax rate (i.e., the direct HCPIT contribution as a percentage of taxable income). In this scenario, the HCPIT applies a constant marginal rate, and exemptions function purely as income deductions. These income deductions are based on number of exemptions (household size) without any rate readjustments at higher incomes.

The key observation in Exhibit 1 is that for individuals at the same income level, those with more exemptions (i.e., larger households) pay less tax. This effect is most pronounced at lower income levels (e.g., $70,000–$150,000), where the exemption deductions are a significant fraction of total income, resulting in a steep decline in effective tax rate as household size increases. In higher income brackets, the slope is flatter, but the pattern holds: exemptions still reduce total liability, even if the relative effect diminishes.

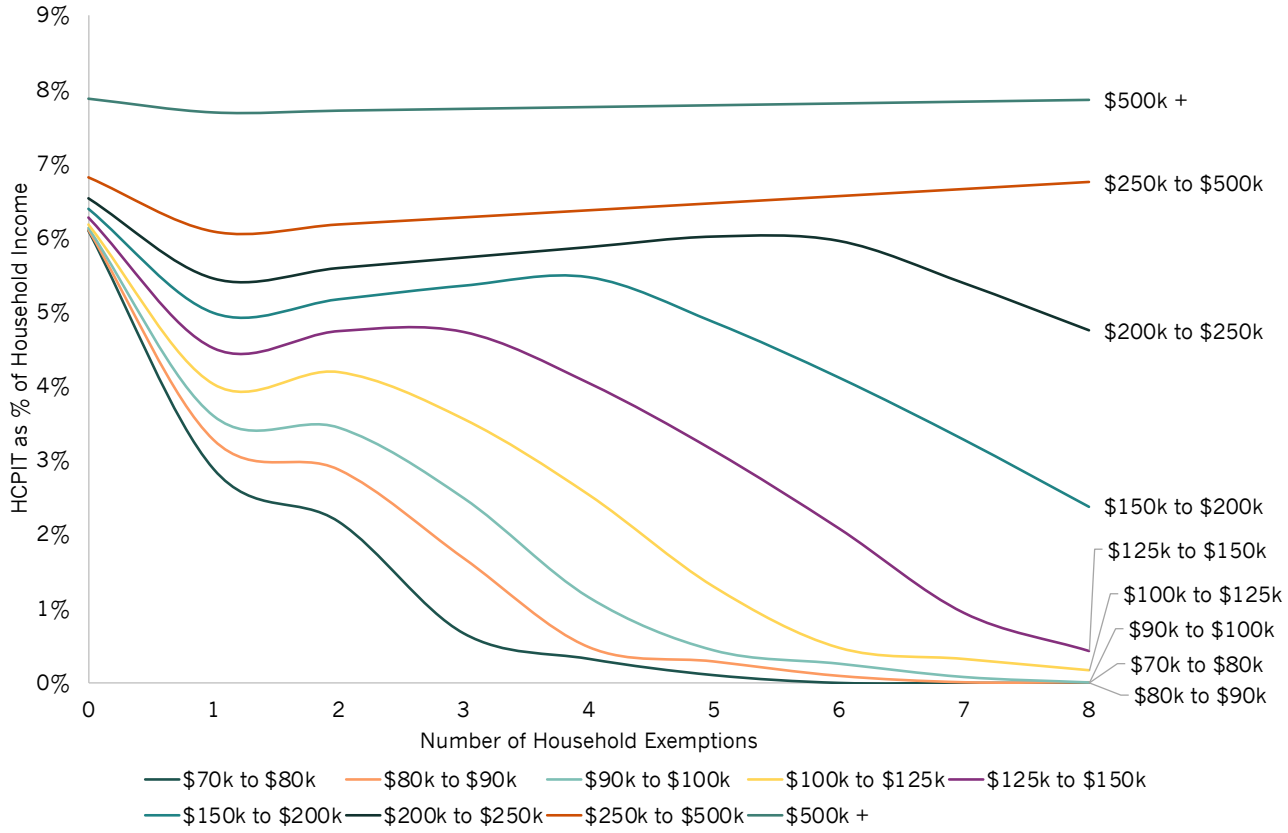
Exhibit 1. Baseline Scenario, Impact of Exemptions on HCPIT Without Household Adjustment



Source: Finance and Revenue Committee

However, as Exhibit 2 will show, once we introduce the household size rate adjustment into the rate structure itself, the burden can shift back toward larger households as income rises. This shift presents a key trade-off the Committee must consider when balancing revenue stability, fairness, and the appropriate structure of household adjustments.

Exhibit 2. Impact of Exemptions with Household Adjustment



Source: Finance and Revenue Committee

Unlike the baseline scenario, where more exemptions reduced effective tax rates, Exhibit 2 shows that at higher income levels, individuals with more exemptions (i.e., larger households) pay more. The positive slope of the lines at higher incomes indicates that the household adjustment increases the total tax liability for each additional household member.

As a result, the Finance & Revenue Committee recognizes that additional time and analysis are needed to reconcile its equity goals with the desire to reflect household composition in contribution levels. Further refinements to the adjustment mechanism, or alternative structures, may be necessary to ensure progressivity and simplicity.

Remaining Policy Considerations and Trade-Offs

As the Committee explores the implementation of household size adjustments, it is actively weighing several interrelated equity and revenue questions.

HIGH-INCOME PHASE-OUTS OR CAPS

The household size adjustment is intended to reflect the greater expected healthcare usage among larger households, and is only phased in after 300% FPL. If the adjustment is not

calibrated carefully, it may shift the burden away from high-income, smaller households and onto lower-income, larger ones (e.g., households above 450% FPL). To address this, the Committee is considering reducing or phasing out household size adjustment charges for lower-income households, particularly those with multiple exemptions. This approach would preserve the equity intent of the adjustment without overburdening the households least able to pay.

NO HOUSEHOLD SIZE ADJUSTMENT

The Committee is also considering a simpler alternative in which all households pay the same rate on income regardless of size, effectively removing household-based readjustments from the model altogether.

2. Reduction in the Employer Payroll Tax Credit (EPT Offset)

The Finance & Revenue Committee has decided not to offer a 100% credit against the HCPIT for individuals whose employers pay the Employer Payroll Tax (EPT). Instead, the Committee is exploring partial credit levels to address equity and revenue distribution concerns while recognizing that some committee members feel that there may be a tendency for employers that pay higher state taxes to pay lower wages as a result.

In the original design, a full 100% credit was intended to prevent "double taxation" of compensation: employees whose wages triggered employer-side contributions would have seen their HCPIT fully offset. However, the Committee found that a full credit created equity distortions, particularly across income and employment types.

The Committee is now focused on evaluating three key policy issues related to the credit.

1. AVOIDING OVERCOMPENSATION THROUGH FULL CREDIT

A 100% EPT credit means that employees in jobs subject to the EPT would see their entire HCPIT liability eliminated if their non-wage income is small enough, regardless of income. While this fully prevents "double payment" for employer-covered workers, it also removes any personal contribution from high-income earners, even though they receive significant value from universal coverage. The Committee is concerned that this structure may overcompensate high earners and undermine the principle of progressive individual responsibility. A partial credit allows the system to still recognize employer contributions while ensuring that all individuals, especially those with greater ability to pay, continue to share directly in the financing of the system through a personal tax liability.

2. EQUITY BETWEEN EMPLOYED AND SELF-EMPLOYED INDIVIDUALS

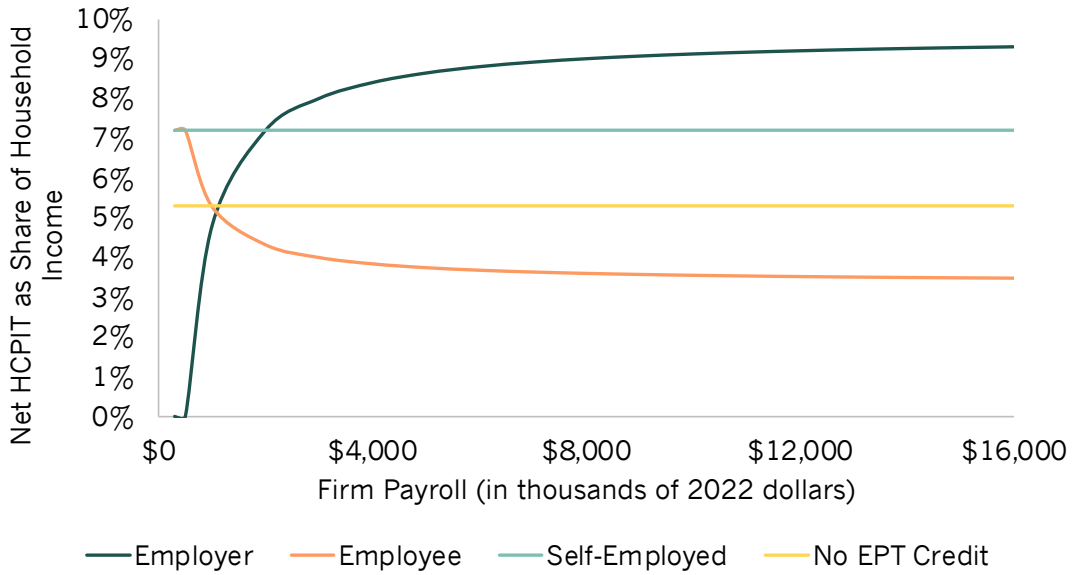
Because the EPT applies only to employer-based wages from large enough firms, the credit structure benefits only employees, while self-employed individuals, who do not generate

employer-side payroll contributions, remain fully liable for the HCPIT. This creates a horizontal equity concern: two people with the same income could face different tax obligations depending on employment type. Moreover, offering a large EPT credit requires raising the HCPIT rate for everyone to maintain overall UHP revenue, further increasing the burden on self-employed individuals who cannot access the credit. The Committee is examining whether a lower credit level better balances fairness between wage earners and self-employed taxpayers.

Exhibit 3 below illustrates how the EPT credit interacts with firm size and employment type. An employee benefits from the EPT credit only if their employer pays into the system. As Exhibit 3 shows, the larger the firm's payroll, the higher the employer's EPT contribution, and consequently, the greater the credit the employee receives against their HCPIT. This helps offset the fact that wages may be modestly reduced due to the employer's EPT obligation. For workers at large firms, this credit meaningfully reduces their net individual tax rate, as seen in the downward slope of the orange "employee" line relative to the yellow "no EPT credit" benchmark.

However, the chart also shows that the EPT credit does not benefit everyone equally. The "self-employed" line remains consistently higher, reflecting the lack of any employer-side offset. Similarly, employees at small firms with payroll below the EPT threshold receive little to no credit. These workers, along with those with income from sources not subject to EPT (such as retirement withdrawals or rental income), face higher net HCPIT rates. In effect, the credit structure introduces disparities for self-employed workers, while workers at EPT-paying firms receive a significant tax benefit.

Exhibit 3. Net Tax Rates by Employment Type and Firm Payroll Size for a Single Person with a $125,000 Annual Wage



Source: Finance and Revenue Committee

3. REVENUE MIX AND LABOR MARKET INCENTIVES

Any time a portion of the EPT is credited back to employees, it reduces the net contribution employers make to system funding. That gap must then be offset by higher revenue from the HCPIT), which means increasing the HCPIT rate for everyone. This creates a policy trade-off between UHP revenue balance and distribution of responsibility.

The level of the EPT credit directly influences who bears the cost of healthcare financing between employers and workers. A larger credit means that a greater share of the employer's payroll tax contribution is offset by a reduction in the employee's personal income tax liability. The employer contribution to the total tax revenue remains the same, as does the total that comes directly from individuals. The primary shift is in responsibility, e.g. which individuals the contributions to the UHP comes from (high- or low-wage workers).

Conversely, a smaller credit preserves more of the employer's contribution as a true cost to the firm. This may reinforce the role of healthcare as part of compensation and promote shared responsibility, but it could also influence business decisions related to hiring, compensation, or employment structure, particularly in sectors with narrow margins or large low-wage workforces.

The labor market effects of this balance can vary:

- In high-skill or high-wage jobs, where compensation is more flexible, employer-side costs may be absorbed with minimal disruption.
- In low-wage or price-sensitive sectors, added employer costs could translate into downward pressure on wages, reduced employment, or shifts toward nontraditional or contractor-based work to avoid EPT liability.

Within the Finance & Revenue Committee, there is a plurality of views on the magnitude and importance of these labor market effects. Some members believe they are central to evaluating long-term system viability, while others see them as second-order concerns relative to broader equity and coverage goals. This ongoing deliberation reflects the inherent complexity of aligning tax design with labor market realities.

The Committee is testing whether a 40% credit appropriately balances system sustainability with the goal of shared responsibility.

3. Medicare Premium Credit

The Finance & Revenue Committee has decided to provide a 100% credit against the HCPIT for individuals enrolled in Medicare, equal to the amount paid in Part B premiums.

This decision reflects the Committee's commitment to avoid "double payment" (requiring retirees to contribute both through federal Medicare premiums and through the new state-based HCPIT) and prioritize fairness. Because Medicare Part B premiums are already

withheld from Social Security benefits and represent a significant share of healthcare costs for seniors, offering a full credit acknowledges those existing payments and aligns with the principle of equitable treatment across populations.

Medicare-eligible individuals, especially those on fixed incomes, have limited capacity to take on additional tax burdens. Without a credit, these individuals would effectively be paying twice for healthcare: once through their existing Medicare premiums and again through the new HCPIT. By offering a 100% credit for Medicare Part B premiums, the Finance & Revenue Committee ensures that HCPIT obligations come only from those with high non-social security income.

To evaluate the implications of this approach, the Committee analyzed contributions for retired two-person households with Social Security and additional income at different income levels. Exhibit 4 compares the expected HCPIT payments from two-person retired households under a 0%, 50% and 100% credit policy with estimated out-of-pocket costs under current Medicare programs (Traditional Medicare and Medicare Advantage).

Exhibit 4. Medicare Credits vs. Medicare Premiums by Income and Source

SS Income	Other Income	Total Income	0% Part B Credit	50% Part B Credit	100% Part B Credit	Traditional Medicare	Medicare Advantage
$ 30,000	$ 30,000	$ 60,000	$ 4,082	$ 4,082	$ 4,082	$ 7,057	$ 6,159
$ 40,000	$ 50,000	$ 90,000	$ 5,267	$ 4,082	$ 4,082	$ 7,057	$ 6,159
$ 50,000	$ 75,000	$ 125,000	$ 7,899	$ 6,114	$ 4,122	$ 7,057	$ 6,159
$ 60,000	$ 100,000	$ 160,000	$ 10,635	$ 8,857	$ 7,078	$ 7,057	$ 6,159
$ 70,000	$ 150,000	$ 220,000	$ 16,899	$ 14,488	$ 12,078	$ 8,689	$ 7,791

Source: Finance and Revenue Committee

The Finance & Revenue Committee's modeling shows that applying a 100% credit for Medicare Part B premiums effectively aligns HCPIT contributions with what retirees currently pay for healthcare coverage. At most income levels analyzed, except for the $220,000 total income level, retirees would pay equal to or less than their existing Medicare out-of-pocket costs under this policy.[1] This is especially true for households earning between $60,000 and $125,000, where modeled HCPIT payments closely track current spending under Traditional Medicare or Medicare Advantage. Importantly, the credit preserves the overall progressivity of the system. Higher-income retirees continue to contribute more than they would under Medicare alone, ensuring that the system remains fair and income-sensitive at the upper end.

[1] Note that for all scenarios, the contribution amount does not consider how much social security income the filer's household had, as per the Oregon constitution.

4. Soft Cap Design: Balancing Equity, Fairness, and Revenue Considerations

Board Response and Current Committee Deliberation

The Finance & Revenue Committee has not reached a consensus position on the use of a soft cap in the HCPIT structure. Rather, members hold a range of views that reflect different interpretations of equity, fiscal responsibility, and taxpayer behavior. Some Committee members favor eliminating the soft cap altogether to preserve progressivity and transparency, while others believe some form of cap or rate adjustment may be warranted to address unique concerns around high-income contributions. The Committee believes it is important that the Board understand the range of considerations at play before offering guidance.

The current Committee discussion centers on three primary perspectives:

1. Fairness from the High-Income Taxpayer's Viewpoint

Some members of the Finance & Revenue Committee emphasize that under the proposed HCPIT structure, high-income taxpayers could face even higher total obligations in the form of income-based taxes, particularly if no soft cap or marginal rate reduction is applied at the upper end of the income scale. For many, this would represent a new and significantly larger financial burden, one that may not be offset by any visible increase in coverage or access.

From this perspective, the fairness concern is not whether high-income households should contribute more (they already do), but whether the new contribution exceeds what they currently pay by a disproportionate margin. Without safeguards like a soft cap or lower-tiered marginal rates, some Committee members worry that high earners will view the system as unfair.

2. Equity and Capacity to Pay

Other Committee members share the view that progressivity and the principle of ability to pay must guide the system's upper-income treatment. Because high-income households have substantially greater resources, a soft cap that results in a lower effective burden on top earners risks undermining vertical equity. In this framing, equity means ensuring that higher earners not only pay more in absolute terms but also contribute a greater share of their income than those with fewer resources.

3. Behavioral and Economic Incentives

A third view raises concerns about the potential for tax-induced behavioral changes. If aggregate taxes are too high, some high-income taxpayers (like those with portable employment or income) may choose to relocate. This could erode the tax base and create

longer-term revenue instability. From this perspective, a carefully designed soft cap (or marginal rate transition) may serve as a tool to retain high earners and preserve the plan's fiscal stability.

Committee Direction

The Finance & Revenue Committee has agreed to continue modeling and presenting two alternative approaches to the treatment of high-income contributions under the HCPIT: one that includes a soft cap mechanism and one that does not.

In the soft cap scenario, the Committee is using a contribution threshold in the range of $30,000, after which a proportional rate reduction is applied to moderate marginal tax burdens.

This dual approach will allow the Board to directly consider the implications of each structure: financial, behavioral, and perceptual. It will also allow the Board to weigh concerns about fairness, income sensitivity, and revenue stability. The Committee recognizes a range of views on this issue and believes continued exploration is necessary to ensure the final design reflects a well-balanced and transparent equity framework.

5. Illustrating How Different Oregonians Might Pay Under the UHP

To complement the broader tax design and equity issues addressed in this memo, the Finance & Revenue Committee has prepared a simple illustration showing how a single filer might experience the UHP across three common circumstances: an employed worker, a self-employed individual, and a Medicare enrollee.

This example is not comprehensive and does not represent final recommendations. Rather, it reflects the Committee's current thinking as it continues to work through the key trade-offs presented throughout this memo.

This snapshot is meant to help ground the Board's policy deliberations in a practical, real-world perspective. By holding other variables constant and varying only income level and employment type, the Committee hopes to show how UHP financing may affect different kinds of Oregonians—and how credit design, income structure, and coverage status interact to shape affordability.

Exhibit 5. Estimated Annual Healthcare Contributions for a Single Filer Under Status Quo and UHP Scenarios, by Income and Coverage Type

	Status Quo Contributions			UHP Contributions				
Income	Employed Individual paid premium & cost sharing	Self Employed Silver ACA premium & cost sharing	Soc Security Medicare Advantage premium & cost sharing	Employed EPT Credit: 40%	Employed EPT Credit: 0%	Self Employed EPT Credit: 40%	Self Employed EPT Credit: 0%	Soc Security Medicare EPT Credit: 40% 100% Part B credit
$55,000	$2,200	$4,467	$4,118	$659	$1,878	$2,559	$1,878	$2,041
$70,000	$2,200	$6,620	$4,118	$1,520	$2,890	$3,939	$2,890	$2,041
$100,000	$2,200	$7,263	$4,934	$3,243	$4,915	$6,899	$4,915	$3,134
$150,000	$2,200	$7,263	$7,385	$6,115	$8,290	$11,299	$8,290	$6,477
$250,000	$2,200	$7,263	$8,609	$11,859	$15,040	$20,499	$15,040	$14,117

Source: Finance and Revenue Committee

This table in Exhibit 5 presents a simplified comparison of how a single Oregonian at different income levels might contribute to healthcare costs today versus under the UHP. It includes three common coverage types under the status quo—employer-sponsored insurance, self-purchased ACA plans, and Medicare Advantage—and compares them to projected contributions under the UHP.

The left side of the table shows current estimated out-of-pocket costs (including premiums and cost-sharing) for individuals who are[2]:

- Employed (with employer-sponsored insurance),
- Self-employed (purchasing coverage through the ACA), and
- Retired (receiving Social Security and enrolled in Medicare Advantage).

The right side shows modeled UHP contributions for those same individuals, under different policy scenarios:

- Employed individuals are shown under two versions of the EPT credit: 40% and 0%, to highlight how this credit reduces individual liability when employers contribute.
- Medicare recipients are shown with a 100% Part B credit, reflecting the Committee's recommendation to fully offset HCPIT obligations for those already paying Medicare premiums.

This side-by-side view is intended to illustrate how the UHP might alter what individuals pay, depending on their income and coverage type. It also demonstrates how policy levers like the EPT credit and Medicare premium credit shape equity and affordability across the system.

[2] Status quo estimates for employer-sponsored insurance premiums and cost sharing are drawn from the Kaiser Family Foundation (KFF) 2023 Employer Health Benefits Survey, which provides average annual worker contributions for single coverage. ACA premium estimates are based on 2024 Oregon Health Insurance Marketplace data for benchmark silver plans before subsidies, assuming no premium tax credit. Medicare Advantage and Part B premium figures are derived from the Centers for Medicare & Medicaid Services (CMS) 2024 Medicare Costs overview, including average out-of-pocket spending and premium costs.

DATE:	December 2, 2025
TO:	UHP Governing Board Finance and Revenue Committee
FROM:	ECOnorthwest
SUBJECT:	Transitions and Reserves Research and Case Studies

Purpose

This memo provides considerations for financing start-up and transition costs for a universal health program (UHP) prior to its reaching financial maturity, summarizes research on operating and program reserve policies and best practices, and offers lessons learned from case studies of similar programs.

Key takeaways:

- Implementation of a UHP will require one-time investment (likely by the state) to cover administrative costs for a period of time prior to benefit delivery, and to seed a reserve fund prior to program stabilization.
- Financing these one-time needs depends on the scale and nature of the needed investments, as well as the structure of the UHP as an entity.
- One-time, start-up costs may be requested through an appropriation from the state, which may or may not be paid back with program revenues.
- Existing policies related to liquidity policies, large-scale information technology state investments, and prior state of Oregon agency formations (such as OHA in 2009 and Community Care Organizations in 2011) should be examined as actuarial and operational costs are developed.
- Reserve targets should include both operating costs and programmatic reserves, and reserve policies should include mechanisms for alerting appropriate stakeholders and fiscal decision-makers of potential insolvency.
- It is unlikely that the state could hold sufficient capital to meet a risk-based capitalization target given the scale of UHP benefits; therefore the UHGP may want to consider a reserve calculated based on a certain number of months of expected benefits.
- Reserve funding could be achieved through a combination of:
    - Direct state appropriations,
    - Timing strategies (e.g., tax collection ahead of benefit rollout), or
    - Self-financing mechanisms, such as modest adjustments to per-person premium rates or employer tax rates during initial implementation.

Start-up and Transition Costs

The goal of a UHP is to achieve financial maturity, with relatively stable dedicated revenues covering relatively expected costs. Prior to achieving this point, the program will require funding to cover start-up and implementation costs essential to ensure timely and effective launch of a program at the scale of UHP.

Start-up administrative costs include:

- Staffing, administration, organization change management
- Provider network readiness and payment system alignment efforts and resources
- IT systems design and build-out (claims processing, eligibility, data integration)
- Other capital needs related to program implementation
- Temporary dual systems support (human or IT) during ramp-down of legacy systems
- Public communications and enrollment campaigns

One-time programmatic costs may also be incurred, related to:

- Early benefit “bumps” due to misalignment of timing related to revenues and expenditures
- Early benefit “bumps” due to caseloads or costs exceeding forecast
- Seed funding for operating contingency and programmatic reserves

Reserves are necessary given the unknowns around costs (utilization rates, benefit costs) and revenues (premiums, tax revenues, federal reimbursement). Coverage of previously uninsured or underinsured individuals may exceed forecasted expectations. When the program reaches stable revenues and costs, reserves may be self-funded through a portion of dedicated revenues or premium payments. Prior to this point, reserve funding should be built into the budget for an implementation plan.

Funding and Financing Options

A clear understanding of how to pay for reserves and transition costs begins with distinguishing between funding and financing. Though often used interchangeably, these terms refer to fundamentally different concepts—especially important in the context of designing a large-scale public program like the Universal Health Plan (UHP).

Funding: The Ultimate Source of Revenue

Funding refers to the ongoing, dedicated sources of revenue that support a program over time. It is the “what” and “where” of the money—what type of tax, fee, or transfer is used, and where it originates from.

In the UHP context, funding may include:

- Dedicated payroll or income-based taxes
- Personal premium payments (PPP)
- Federal funds (e.g., Medicaid waivers, 1332 innovation waivers)
- General Fund transfers

These sources provide the sustainable, long-term support for program operations and benefits, including maintaining sufficient reserves.

Financing: The Method of Paying

Financing refers to the means by which costs are paid for or made available, especially when timing or cash flow is a concern. It addresses the "how" and "when"—how money is accessed and when it is deployed.

Common financing tools include:

- Pay-as-you-go spending from current revenues
- Inter-fund loans or internal borrowing from other state accounts
- Bonding or short-term debt instruments, where legally permissible
- Phased-in reserve accumulation, using a portion of incoming revenues over time

Financing mechanisms are often essential during the launch or transition period, when large upfront costs (e.g., building reserves, implementing new IT systems, workforce transitions) precede full revenue generation.

Why This Distinction Matters

Both reserves and transition costs are necessary for a stable and credible rollout of the UHP. But they require different approaches to funding and financing:

- Funding decisions determine the long-term fiscal sustainability of the program.
- Financing strategies address the short-term timing mismatch between costs and revenue availability.

Several options exist to fund these costs listed below.

State Budget Appropriation. Once a detailed implementation budget estimate is developed, start-up funding could be requested through the state budget process. This could be structured as 1-2 years of operating support while staff are hired and systems implemented. This approach allows for transparency and budget accountability, especially if funding is proviso-ed or attached to a bill that requires regular budget updates and with specificity regarding use of funds.

Information Technology Needs. Funding for IT system upgrades and development could be requested through the state budget process, likely subject to the state's Joint Enterprise Information Services / Legislative Fiscal Office State Gate Oversight process.

Reallocation of Existing Spending. In the transition from the current Oregon Health Plan to a new, single-payer system, there may be current expenditures that can be reallocated to the new program. State spending on administration of OHP may be reallocated to the administrative costs of the new program. CCO mandatory reserves may potentially be another source of funding, pending a full review including legal analysis. Because CCOs are creatures of state statute and operate under contracts with the Oregon Health Authority that already allow for rate adjustments, clawbacks, and termination provisions, the Legislature could direct the transfer or partial transfer of these reserves (especially risk-based capital and restricted net assets held by nonprofit CCOs) to the new public corporation or health care trust during the wind-down or integration of the CCO model, provided just compensation is addressed for any for-profit entities.

State Budget Loan. A state budget appropriation could also include proviso language or be attached to statutory requirements to repay the general fund over time from UHP dedicated tax revenues, especially once premium revenue reaches stability.

Timing of Tax Collection. If a tax can legally be implemented before program payments are made, a portion of the tax could be dedicated to one-time costs including the funding for a reserve to be effective when the program is live. An example is the Preschool For All tax in Multnomah County, which was implemented in 2021; the tax – which has exceeded forecasts – is intentionally designed to build a balance prior to fully universal preschool.[1]

[1] Office of the Multnomah County Auditor. "Preschool for All: The program is largely achieving its equity goals, but needs to address risks to expansion," April 8, 2025, https://multco.us/info/preschool-all-program-largely-achieving-its-equity-goals-needs-address-risks-expansion.

Debt Issuance. States typically issue bonds for long-term capital infrastructure like roads and bridges and do not use debt for operating budget needs. States have balanced budget requirements and debt limits that preclude the use of debt to fund ongoing needs, even one-time needs. It is possible that the state may consider (or may need to consider) a bond issuance to finance the technology component of UHP implementation, but typically largescale, statewide IT investments subject to planning and gated funding requirements under the EIS / LFO model.[2] It is also uncommon for state entities or any governments other than smaller municipalities to take out private loans.

From the fiscal note for Washington SB 5975 (2017): "The 2017-2019 Operating Budget appropriated $82 million to ESD for implementation of the Family and Medical Leave Insurance Program. This appropriation must be paid back using the FMLI premium collections by June 30, 2019, including interest as determined by the State Treasurer. The ongoing administrative and operating costs will be funded through premium collections."

Actual costs in the 2017-19 Biennium were $53.5 million (fiscal.wa.gov, Spending by Biennium).

Federal Funds. State Medicaid programs rely on federal waivers to redirect federal Medicare and Medicaid funding toward technology transformations.[3] Most recently, states have been utilizing the enhanced federal funds participation (FFP) match of 90 / 10 to draw down federal support for technology. Though it is possible the state could use federal funding to pay for a portion of transition costs, this option comes with many unknowns and exogeneous factors, and therefore should be considered with less certainty than a state funding source. Use of federal waivers or grant funding depend on federal appropriation, state eligibility for grants, and other unknown factors. Additionally, federal funding may be structured as reimbursements, buying down costs later rather than providing immediate budget support – and thus would not negate the need for initial investment by the state.

Two Types of Reserves: Operating & Programmatic

Financial reserves are a prudent financial management tool designed to cushion against administrative cost overruns and provide a buffer against programmatic strains (caseload forecasts or revenue underperformance). A UHP operated out of its own state fund has aspects of both government funds and of insurance pools, each of which have different

[2] Oregon Enterprise Information Systems: Project Portfolio Performance, "Project Oversight," accessed October 30 2025, https://www.oregon.gov/eis/project-portfolio-performance/Pages/it-investment-oversight.aspx.
[3] Lindsay F Wiley, "State-Level Single-Payer Health Care from a Public Health Perspective," *Am J Public Health*. [109], no. 11 (2019):1515–1516. https://pmc.ncbi.nlm.nih.gov/articles/PMC6775895/;
HITECH, or the "Health Information Technology for Economic and Clinical Health Act," is a law passed as part of Obama's American Recovery and Reinvestment Act of 2009 (ARRA). The policy seeks to strengthen data privacy for healthcare recipients through promoting widespread adoption of electronic health records and information technology. More recently, states have relied on the 1115 waivers to leverage 90 percent enhanced federal financial participation (FFP) for Medicaid technology investment;
HIMSS State Government Affairs, HIMSS North America, "State-Led Innovations Leveraging Medicaid Section 1115 Waivers," August 2018,
https://www.himss.org/sites/hde/files/Medicaid%201115%20Waiver%20Brief_Final_0.pdf.

reserve requirements and best practices. These reserve requirements are best thought of in the context of the two broad categories of expenditures incurred by a UHP: administrative costs and program payments or benefits.

OPERATING RESERVES

The Government Finance Officers Association (GFOA) has various recommendations for budgeting governmental fund reserves and budgeted fund balances. General funds are recommended to maintain balances of at least two months of regular general fund operating revenues or regular general fund operating expenditures.[4] Oregon has specific policies related to its Rainy Day Fund, which can only be used under particular circumstances (a three-fifths vote of the Legislature, a prolonged employment decline, or a state of emergency) and its Education Stability Fund (ESF), which receives 18 percent of net lottery proceeds. In FY 2024,[5] about 30 percent of funding for Medicaid came from the state (general and other dedicated funds), and state spending on Medicaid accounted for 28 percent of all spending. Given its share of total state budget in Oregon, there is no Medicaid dedicated reserve fund outside of the general fund.[6]

ACTUARIAL RESERVES

Insurance pools and insurance funds have various targets for reserve funding. Actuarial methods include cash-on-hand targets, wherein a period of benefits are held in reserve for liquidity purposes; reserves intended to meet future liabilities, such as through claim or unearned premium reserves; or risk-based capitalization, wherein a targeted amount of capital is held on-hand based on the likelihood that a catastrophic event will occur. These methods are typical requirements or recommendations for regulation of smaller health plans or health pools.

[4] Shayne C Kavanagh, Vincent Reitano PhD, Peter A Jones PhD, "Rethinking Budgeting: Should We Rethink Reserves? A Multimillion-Dollar Question," Government Finance Officers Association (GFOA), 2023, https://gfoa-craftcms.files.svdcdn.com/production/general/Rethinking-ReservesR2.pdf?dm=1759231581.
[5] Oregon Secretary of State, Oregon Blue Book, "Government Finance: State Government," accessed October 27 2025, https://sos.oregon.gov/blue-book/Pages/facts/finance-state.aspx.
[6] National Association of State Budget Offices, 2024 State Expenditure Report, "Medicaid Tables," 2024, https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/SER%20Archive/2024_SER/Medicaid_Tables_-_2024_State_Expenditure_Report.pdf.

Coordinated Care Organizations (CCOs) are community-level entities that operate under a global budget to provide healthcare services to Medicaid members through a partnership among providers, payers, and community-based organizations. Per statute, CCOs are required to hold **restricted reserves** in the amount of $250,000 plus half of the CCO's total actual or projected liabilities above $250,000, as well as capital or surplus at a minimum of $2.5 million and "any additional amounts necessary to ensure the solvency of the CCO" as determined by rule. (ORS 414.572). Among other key financial metrics, CCOs report Premium Deficiency Reserve (Expense) amounts which are recorded when an insurer or managing care organization (MCO) determines that the unearned premiums for a current period may not be sufficient to meet future medical claims and expense. (OHA 2024 Public Brief – CCO Financial Reporting.)

Claim reserves, premium reserves. These are reserves typically set aside to ensure that insurers can meet future liabilities. Claims reserves are estimates of future claims that may be paid out under a policy. Unearned premium reserves are set aside in an amount sufficient to ensure that an insurer can refund a policy holder in the event that a policy is terminated before the end of a coverage period.[7]

Liquidity method. The Society of Actuaries has guidelines for premium reserve setting that entail using historical data to inform future projections of cash flows and reserves.[8] Healthcare reserves are typically set from revenue coming from premiums that policyholders pay.[9] This method is familiar in a healthcare setting; the metric for measuring primary reserves/reserve target funding for healthcare providers is "days cash on hand" (DCOH), which refers to the number of days a company can operate using only available cash reserves if no new revenue were to be generated. DCOH is calculated by dividing the entity's cash (and cash equivalents) by average daily operating expenses.[10]

[7] National Association of Insurance Commissioners, NAIC Model Laws, Regulations, Guidelines and Other Resources—2nd Quarter 2017, "HEALTH INSURANCE RESERVES MODEL REGULATION," 2017, https://content.naic.org/sites/default/files/model-law-10.pdf.
[8] David V. Smith, Society of Actuaries, "Gross Premium Valuation Reserves: What Are They and How Are They Calculated?" *Small Talk Newsletter* issue no. 23, November 2004, https://www.soa.org/globalassets/assets/library/newsletters/small-talk/2004/november/stn-2004-iss23-smith.pdf.
[9] Cheryl Fish-Parcham, Families USA, "Challenging Health Insurance Premium Rate Increases: Part 4 – How to Challenge the Amounts Health Insurers Keep for Administrative Expenses, Reserves, and Surpluses," May 29 2014, https://familiesusa.org/resources/challenging-health-insurance-premium-rate-increases-part-4-how-to-challenge-the-amounts-health-insurers-keep-for-administrative-expenses-reserves-and-surpluses/#:~:text=The%20term%20%E2%80%9Creserves%E2%80%9D%20refers%20to,to%20maintain%20an%20adequate%20RBC.&text=The%20amount%20held%20for%20reserves,insurer%20will%20accumulate%20excessive%20surpluses.
[10] Allianz Trade, "Days Cash on Hand (DCOH): Definition, Formula, & Examples," accessed October 21 2025, https://www.allianz-trade.com/en_US/insights/days-cash-on-hand.html.

Risk-based capitalization. Risk based capitalization entails a target amount of capital on-hand in the event of a catastrophic event. Most states have adopted the NAIC's risk-based capital model as the primary framework for reserve targets for health insurance companies; this model sets a statutory minimum capital requirement based on the insurer's specific size and risks.[1] However, in a UHP context the scale of capital required (in the hundreds of millions) is neither feasible nor fair to taxpayers. This is particularly true if the UHP has the full faith and credit backing of the state of Oregon.[11]

Portland's Health Insurance Operating Fund policy illustrates NAIC recommendations.[1] One of its two reserves requirements are Risked Base Capital reserves (RBC) outlined by NAICs requirements and which consists of four components:

1. Underwriting risk (insufficient premiums relative to expense),
2. Asset risk (default, reinsurance failure),
3. Credit risk (stop loss recoveries, fully insured medical, dental and vision premiums, ASO fees and prescription rebates),
4. Business risk (expense overruns).

The RBC requirement replaced previous policy requirements for large claim and contingency reserves; for large claims, the City utilizes secondary insurance.

FINANCING RESERVES

Strategies for funding reserves depend upon the scale of revenues and expenditures, the type of government fund structure the new program will be subject to, and the organizational structure of the program or entity.

State agency model. If the UHP is established as a new program under an existing state agency that is all or partially funded by the state general fund (such as an office under the Oregon Health Authority), then it may not be appropriate to request an operating contingency for program implementation and administrative costs. Any administrative or operational cost overruns would likely be requested in additional appropriations from the Legislature. However, it may be appropriate to maintain a benefit reserve balance in a separate fund for liquidity purposes; this approach should be considered within the context of liquidity and financial management practices of the state, including the Office of the State Treasurer. As a safeguard to prevent program insolvency, accessing this reserve could be attached in statute to requirements to update the forecast and provide a formal alert to the Governor's Office and the Legislature until legislative action could be taken to provide additional operating funds, adjust program premiums, or reduce payments.

Outside agency model. If the UHP will be an entity separate from a state agency, such as a public corporation operating with its own entity budget and without the automatic backstop of

[11] A 2009 state report by the Oregon Health Fund Board determined that a state public health plan may not need large reserves if guaranteed by the full faith and credit of the state or through a regular legislative fund appropriation;
Oregon Health Fund Board, "Aim High: Building a Healthy Oregon [DRAFT for public review and comment]," September 3 2008, https://www.oregon.gov/oha/HPA/HP/HealthFundBoard/Draft-Report-for-Public-Comment.pdf.

the state general fund, the reserve needs will likely be greater and more complicated. In this case, requesting from the state an operating reserve as a small percentage of forecasted administrative costs and a liquidity reserve (to be repaid to the state upon program maturity) should be a part of the financing strategy.

Examples and Case Studies

Following are some examples of similar programs in the domestic setting – Oregon community care organizations, Oregon public corporations, relatively new state paid family medical leave programs, and states with Medicaid contingency funds – and international examples of universal health plans. Given the differences in budgetary contexts, the state programs provide more direct lessons learned, though the Taiwan experience provides insights into one country's response to the threat of insolvency.

OREGON COMMUNITY CARE ORGANIZATIONS

Oregon's CCOs were established under the authority of HB 3650 (2011) and with funding from the state's 1115 Medicaid waiver and a state innovation model (SIM) grant from the Center for Medicare and Medicaid Innovation.[12] In creating its network of 16 CCOs, Oregon partnered with pre-existing organizations that are a mix of non-profit and for-profit groups.[13] Oregon is the only state with a statewide system of CCOs serving Oregon Health Plan members, typically providing physical, behavioral, and oral care services.[14] CCOs serve an estimated 1 million Medicaid members (out of about 1.27 million total).[15]

Oregon's CCOs operate under a global budget with fixed per-person payments (capitation payments, or "per caps") based on the number served rather than the service type. The state then withholds a certain amount of CCO payments in an incentive pool which can be earned back depending on the CCO's performance on certain health outcome metrics.[16] CCOs can delegate both a portion of capitation payments to "sub-capitated entities" and, importantly, a portion of their risk.[17]

---

[12] United States of Care, "Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities," n.d., https://unitedstatesofcare.org/wp-content/uploads/2022/04/CCO-Oregon-Overview.pdf.
[13] Neva Kaye, National Academy for State Health Policy, "Oregon's Community Care Organization 2.0 Fosters Community Partnerships to Address Social Determinants of Health," February 5 2021, https://nashp.org/oregons-community-care-organization-2-0-fosters-community-partnerships-to-address-social-determinants-of-health.
[14] United States of Care, "Coordinated Care Organizations (CCOs) in Oregon: How they Work and Future Opportunities," n.d., https://unitedstatesofcare.org/wp-content/uploads/2022/04/CCO-Oregon-Overview.pdf.
[15] Jennie Bonney and Debbie Cheng, "Case Study: Medicaid and Public Health Collaboration in Oregon," April 24 2017, https://nam.edu/perspectives/case-study-medicaid-and-public-health-collaboration-in-oregon/; KFF, "Medicaid in Oregon Fact Sheet," May 2025, https://files.kff.org/attachment/fact-sheet-medicaid-state-OR.
[16] Jennie Bonney and Debbie Cheng, "Case Study: Medicaid and Public Health Collaboration in Oregon," April 24 2017, https://nam.edu/perspectives/case-study-medicaid-and-public-health-collaboration-in-oregon/.
[17] K John McConnell, "Oregon's Medicaid Coordinated Care Organizations," 2017, https://pmc.ncbi.nlm.nih.gov/articles/PMC4939819/.

CCOs are required by state statute and rule to hold reserves. Primary and secondary reserve balances are calculated based on incurred average monthly medical expenses.[18] Among other requirements, CCOs have calculated premium deficiency reserves, which are based on the determination that unearned premiums/rate for a current period may not be sufficient to meet future medical claims and expenses.[19] Over the past 10 years, CCOs' aggregate net income or loss (which includes the premium deficiency reserve) has fluctuated from 7.5 percent to -0.3 percent. In 2022, it was as high as $325 million (around 4.6 percent of operating expenditures) but negative again in 2024. CCOs reserves are held in the event of insolvency -- assuring all outstanding payments to providers can be made and/or that the CCO will continue to function after terminating its contract with the government.[20]

OREGON PUBLIC CORPORATIONS

There are four Oregon public corporations. These are entities created by the state with the purpose of carrying out public missions and services; to do so, they conduct activities or provide services that are also provided by the sector. These kinds of entities have more operating flexibility than their private counterparts but are also held to the principles of public accountability and public policy. In these entities, the board is appointed by the Governor and then confirmed by the Senate.[21]

SAIF Corporation.

SAIF, a not-for-profit workers' compensation insurance company, was the first public corporation in Oregon established in 1979. SAIF receives no state funding; instead, all revenue comes from policyholder premiums and investment returns. As part of its accounting policy, SAIF holds various reserves including unearned premiums ($250 million in 2024), premium deficiency reserves if a premium deficiency is expected, and losses and loss adjustment expense reserves. SAIF adheres to the risk-based capital (RBC) standards developed by the NAIC for surplus management.[22]

Oregon Health and Sciences University.

Oregon Health and Sciences University (OHSU) is the state's only public, academic health center. OHSU is not structured as a nonprofit but instead as an independent public corporation. OHSU was established in 1995. OHSU received state appropriations totaling

[18] Oregon Laws, "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account," May 26 2025, https://oregon.public.law/rules/oar_410-141-5185.
[19] Office of Actuarial and Financial Analytics: Financial Operations Division: Oregon Health Authority, "2024 Public Brief – CCO Financial Performance," August 2025, https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.
[20] Oregon Laws, "OAR 410-141-5185 CAPITALIZATION: Restricted Reserve Account," May 26 2025, https://oregon.public.law/rules/oar_410-141-5185.
[21] OregonLaws, "ORS 353.010," https://oregon.public.law/statutes/ors_353.010.
[22] SAIF Corporation, "Financial Statements—Statutory Basis as of and for the Years Ended December 31, 2024 and 2023, Supplementary Schedules as of December 31, 2024, and Report of Independent Auditors," July 29 2025, https://sos.oregon.gov/audits/Documents/2025-20.pdf.

$62.7 million in FY 2023 and $72.9 million in FY 2024, about 1.5 percent of its total operating revenue of $5 billion. Most funding comes from patient service revenues.[23] OHSU has experienced operating losses in recent years and in 2024, S&P Global downgraded its credit rating due to financial strain ahead of a planned major capital expansion (acquisition of Legacy Health).[24] In April 2025, the OHSU Finance & Audit Committee reported drawing down $181 million in reserves, largely to balance its capital budget in FY 2026.[25]

The State Fair Council.

The Oregon State Fair & Exposition Center was established as a public corporation in 2013; it had previously been a state agency. The Center hosts fairs and events but also serves as a gathering place in times of public emergencies. The State Fair Council received $1 million from the General Fund in 2025-27 for operations and $855,000 in General Fund capital support for an expanded regional emergency center.[26] Total operating expenses for the Council was $9.1 million and "ordinary income" was $10.2 million, leaving a margin of $1.1 million.[27]

Willamette Falls Locks Authority.

The Willamette Falls Locks Authority was established in 2021 to establish ownership, oversight, and management of the historic navigational locks in Clackamas County.[28] The Authority is still in very early stages of capital development and as such financial information is not relevant to this exploration.

STATE PAID FAMILY MEDICAL LEAVE (PFML) PROGRAMS

In the past 5 – 7 years, several states have implemented state-funded insurance programs to provide paid family medical leave (PFML) to workers. These programs provide wages to individuals needing to take leave for qualifying reasons (federal law only requires job security but does not mandate paid leave). Individuals must participate in the program for a certain length of time to be eligible, and in general the program is financed through employer and employee payroll taxes. The goal for these programs is to be self-sustaining through

---

[23] KPMG, "Oregon Health & Science University (A Component Unit of the State of Oregon): Financial Statements and Supplementary Information," October 25 2024, https://www.ohsu.edu/sites/default/files/2024-12/ohsu-financial-stmt-audited-fy24.pdf.
[24] S&P Global, "Oregon Health & Science University Debt Rating Lowered to A+ on Operating Losses," December 6, 2024, https://www.spglobal.com/ratings/en/regulatory/article/-/view/sourceId/13353071.
[25] OHSU Finance & Audit Committee, "OHSU Onward: FY25 March YTD Results & FY26 Preliminary Budget Plan," April 24 2025, https://www.ohsu.edu/sites/default/files/2025-04/FAC-FY25-Q3-FY26-Prelim-4-24-25.pdf.
[26] Legislative Fiscal Office, "2025-27 Budget Highlights," October 2025, https://www.oregonlegislature.gov/lfo/Documents/2025-27%20Budget%20Highlights.pdf.
[27] Oregon State Fair Council, "Oregon State Fair Council Meeting Notice & Agenda Thursday, January 30th, 2025, at 1:30 P.M.," January 30 2025, https://img1.wsimg.com/blobby/go/acf78612-03e4-4000-8ec5-438339cbe01d/downloads/cd2a[...]ing%20Minutes%20-%20Updated%201-30-2025.pdf?ver=1758730246817. (Financial statements begin on page 8 of 19.)
[28] https://www.willamettefallslocks.org/about.

mandatory contributions made up of a certain percentage of an employee's gross wages defined by the state, as well as contributions from the employer.[29]

Contribution rates are typically structured as a percentage of gross wages. Massachusetts' contribution rates are 0.88 percent of eligible wages for employers with 25 or more covered employees.[30] In Oregon, the total contribution rate in 2025 is 1 percent of gross wages, shared between employees and large employers.[31] In Washington, 2025 rates are 0.92 percent – of which employers pay 28.48 percent and employees pay 71.52 percent.

Washington's PFML program went insolvent in 2023, when claims exceeded expectations and premium rates initially set in statute did not increase fast enough. The program required a $200 million appropriation from the Legislature to resolve the deficit. Premium rates have more than doubled since the program was implemented in 2019.[32]

Like unemployment insurance, also funded with payroll taxes, PFML rates can adjust relatively automatically, typically based on actuarial reports but at least based on annual projections. Often laws set a cap on the premium rate, which limits the program's ability to raise funds in the future.

Washington's PFML statutory rate formula is not set actuarially but instead through a statutory formula of 140 percent of prior year expenses, minus the FMLI account balance, divided by taxable wages. Statute allows for a reserve cap (an upper threshold on the premium rate, *i.e.*, rates may be adjusted downward if it is determined they will result in a fund balance that exceeds three months' worth of benefits) but not a lower threshold (such as a minimum below which the rate may be adjusted upward. Beginning in 2026, statute requires the Office of Actuarial Services to review premium rates quarterly and report immediately to the Governor, the Legislature and an advisory board if they project that a deficit in the account will not be recovered through the next quarterly premium collections.[33]

---

[29] Sarah Ritter, Prenatal-to-3 Policy Impact Center, "Funding Mechanisms for State Paid Family and Medical Leave Programs," December 2024, https://pn3policy.org/wp-content/uploads/2025/01/PN3_PFML-Funding-Brief_FINAL.pdf.

[30] Massachusetts Department of Family and Medical Leave, "Paid Family and Medical Leave employer contribution rates and calculator," October 1 2025, https://www.mass.gov/info-details/paid-family-and-medical-leave-employer-contribution-rates-and-calculator.

[31] Paid Leave Oregon, "Employers Overview," accessed October 21 2025, https://paidleave.oregon.gov/employers-overview/#:~:text=How%20is%20Paid%20Leave%20Oregon,calculator%20to%20estimate%20their%20contribution.

[32] Washington State Legislature Joint Legislative Audit and Review Committee (JLARC), "Paid Family and Medical Leave Program," January 2025, https://leg.wa.gov/jlarc/reports/2024/PFML/f_01/default.html; Washington State Employment Security Department, "Actuarial Annual Report for Paid Family and Medical Leave," November 2023, https://esd.wa.gov/media/pdf/2751/pfml-actuarial-annual-report-2024pdf/download?inline.

[33] ESSHB 1213, Chapter 304, Laws of 2025. State of Washington. https://lawfilesext.leg.wa.gov/biennium/2025-26/Pdf/Bills/Session%20Laws/House/1213-S2.SL.pdf?cite=2025%20c%20304%20s%203

NORTH CAROLINA

The state of North Carolina has a formal contingency reserve requirement for Medicaid and Medicare, which is to be used only when the Medicaid program has budgeting shortfalls.[34] The state currently holds $500 million in a Medicaid Contingency Plan, which is approximately 3.4 percent of annual state Medicaid expenditures in FY 2023 (~ $14 billion).[35] Statute requires legislative approval to access contingency funds. In October 2025, the Department of Health and Human Services cut reimbursement rates because state lawmakers only came up with $600 million out of the needed $819 million for this fiscal year's state Medicaid funds.[36] Indiana created a Medicaid contingency and reserve account (not a separate fund) in 2024 to provide payments for Medicaid claims, obligations, and liabilities.[37] In 2024 the State Budget Director requested that $271 million from the account be transferred to the Family and Social Services Administration's Medicaid Assistance fund due to an unexpected deficit from a forecasting revision.[38]

NEW YORK CITY

New York City requires that Managed Care Organizations (MCOs) hold 7.25 percent of net premium income from Medicare Managed Care (MMC) health and recovery plans and the HIV Special Needs Plan (SNP) programs.[39] MCOs are integrated into healthcare systems and exist to reduce healthcare expenditure costs through preventative medicine strategies, financial provisioning, and treatment guidelines. They often take the form of health maintenance organizations (HMOs) and preferred provider organizations (PPOs).[40]

TAIWAN

Taiwan implemented its National Health Insurance (NHI) universal healthcare system in 1995. The program's success is marked by accessibility, comprehensive population coverage, short waiting times, low cost, and national data collection systems for planning and research that

---

[34] North Carolina General Assembly, "143C-4-11. Medicaid Contingency Reserve," n.d., https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_143C/GS_143C-4-11.pdf.
[35] State of North Carolina, Department of Health and Human Services, NC Medicaid, "North Carolina Medicaid Annual Report for the State Fiscal Year 2023," state FY2023, https://www.ncdhhs.gov/sl-2023-134-section-9e1-medicaid-annual-report/open.
[36] Paul Specht and Eric Miller, WRAL News, "NC Medicaid cuts under scrutiny amid funding stalemate," October 14 2025, https://www.wral.com/news/local/nc-medicaid-cuts-scrutiny-funding-stalemate-oct-2025/.
[37] Indiana General Assembly, "IC 4-12-1-15.5 Medicaid contingency and reserve account," accessed October 21 2025, https://iga.in.gov/laws/2024/ic/titles/4#4-12-1-15.5.
[38] State of Indiana, State Budget Agency, "Medicaid Contingency and Reserve Account Transfer," February 14 2024, https://www.in.gov/sba/files/Medicaid-Contingency-Transfer-Memo-FY2024.pdf.
[39] State of New York Commissioner of Health, "Regulatory Impact Statement," https://regs.health.ny.gov/sites/default/files/proposed-regulations/Contingent%20Reserve%20Requirements%20for%20Managed%20Care%20Organizations%20%28MCOs%29_1.pdf.
[40] Joseph Heaton and Prasanna Tadi, NIH National Library of Medicine, "Managed Care Organization," March 6 2023, https://www.ncbi.nlm.nih.gov/books/NBK557797/#:~:text=Definition/Introduction,of%20each%20are%20as%20follows:.

streamline administrative processes.[41] In principle, the aggregate amount of the reserve fund was set equal to the aggregate amount of benefit payments in the most recent 1 to 3 months, based on actuarial principles. The actuarial calculation of the premium rate adopts the method of "adjust income to expense", and the premium rate is calculated based on the principle of covering insurance costs and maintaining the total reserve fund for 1–3 months of the insurance payment.[42]

In the past five years, the Taiwan NHI has faced growing financial strain and medical professional shortages. The NHI model is based on low premiums and high demand, which leads to hospitals cutting costs, poor working environments for nurses and doctors, high patient ratios, and other poor outcomes.[43] In 2024, with NHI on the brink of insolvency, the Taiwan government implemented reforms to NHI including eliminating their "suspension-and-resumption" mechanism. This mechanism initially existed for temporary overseas residents to pause coverage while out of the country and resume upon return, but in an increasingly globally mobile world was allowing wealthier individuals living in the US or China to return to Taiwan to take advantage of low-cost health care for which they were not paying premiums. This behavior not only drove up costs for the NHI but unfairly shifted the burden to relatively less well-off Taiwanese natives. Now, all Taiwanese nationals, regardless of location, must pay NHI premiums.[44] Through this major reform Taiwan aims to extract tax revenue from foreign nationals.

DENMARK

Denmark's universal healthcare system is decentralized. Their government provides block grants from tax revenues to the regions and municipalities, which deliver health services, but the state itself does not have a direct role in the delivery of services.[45] The country's health expenditures equated 9.42 percent of their GDP in 2023, down from 10.75 percent in 2021.[46] Because Denmark's healthcare appropriations are made on a pay-as-you-go basis, rather than with revenues specifically earmarked for healthcare, it does not appear to be a perfect corollary for an Oregon UHP given that budgeting systems are very different.

---

[41] Tai-Yin Wu, Azeem Majeed, Ken N Kuo, "An overview of the healthcare system in Taiwan," *London Journal of Primary Care* 3(2):115–119, December 2010, https://pmc.ncbi.nlm.nih.gov/articles/PMC3960712/.
[42] Lee, Po-Chang. (2022). Introduction to the National Health Insurance of Taiwan. 10.1007/978-3-031-05160-9_1.
[43] Paul Shelton, "Taiwan's national healthcare system," *Euroview,* April 22, 2025, https://euroview.ecct.com.tw/category-inside.php?id=2364.
[44] Y Tony Yang, Global Taiwan Institute, "Reforming Taiwan's National Health Insurance: From Exploitation to Equitable Participation," January 22 2025, https://globaltaiwan.org/2025/01/reforming-taiwans-national-health-insurance-from-exploitation-to-equitable-participation/#:~:text=Taiwan's%20National%20Health%20Insurance%20(NHI,the%20world's%20leading%20healthcare%20systems.
[45] Karsten Vrangbæk, The Commonwealth Fund, "International Health Care System Profiles, Denmark," June 5 2020, https://www.commonwealthfund.org/international-health-policy-center/countries/denmark;
[46] World Bank Group Data, "Current health expenditure (% of GDP) – Denmark," accessed October 21 2025, https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=DK.

ENGLAND

All England residents get free public healthcare through the National Health Service (NHS), which is primarily funded by general taxation and started in 1948. The country's health expenditures equated to 10.87 percent of their GDP in 2023, down from 12.02 percent in 2021.[47] Most NHS funding comes from general taxes, but 20 percent comes from national insurance (payroll tax paid by employees and employers). The NHS also has an income stream from copayments and those using NHS services as private patients (11.8 percent of the UK has private health insurance as of 2025).[48] As in Denmark, differences between sovereign nation appropriations and the United States federalist context, along with differences in budgeting requirements and best practices, make England an imperfect corollary for implementation or reserve financing.

[47] World Bank Group Data, "Current health expenditure (% of GDP) – United Kingdom," accessed October 21 2025, http://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=GB.
[48] Ruth Thorlby, The Commonwealth Fund, "International Health Care System Profiles, England," June 5 2020, https://www.commonwealthfund.org/international-health-policy-center/countries/england;
Denis Campbell, The Guardian, "Almost one in eight Britons now has private medical insurance, say healthcare analysts," https://www.theguardian.com/society/2025/jan/30/almost-one-in-eight-britons-now-has-private-medical-insurance-say-healthcare-analysts.

ECOnorthwest

DATE:	March 7, 2026
TO:	UHPGB Finance & Revenue Committee
FROM:	Morgan Shook, Sarah Emmans, Megan Waldo, Ella Marrero, and David Wright, ECONorthwest
SUBJECT:	Reserves Financing and Funding Options and Examples for the UHP

Introduction

Up to this point ECOnorthwest has researched and outlined approaches and existing mechanisms for reserves funding. This memorandum takes that work one step further and details potential reserves funding and financing options to support the implementation and financial stabilization of the Universal Healthcare Program (UHP) in Oregon.

Establishing an adequate reserve is a core design requirement for program launch, rate stability, and risk management. A well-capitalized reserve mitigates early-year volatility in enrollment, utilization, and revenue collections, supports cash flow timing gaps, and strengthens fiscal credibility with providers, bond markets, and federal partners.

Reserve Target

The Government Finance Officers Association recommends that governments maintain a minimum unrestricted general fund balance equal to at least two months, or 16.7 percent, of regular operating revenues or expenditures, while Moody's typically looks for fund balances above 35 percent of annual revenue to support a AAA general obligation rating.[1,2] In contrast, healthcare reserves are generally built from premium revenue and may need to be calibrated to expenditures rather than revenues in the early years of a universal health plan, particularly if operations are not initially profitable.

GFOA also encourages governments to move away from rigid percentage targets toward a more risk-based, insurance-style framework that adjusts to changing fiscal conditions. For a new program such as a universal health plan, forecasting reserve needs is inherently difficult, but reviewing existing funds and their structures may provide insight towards financing strategies.

As described in the ECOnorthwest Reserve & Transition Memo from December 2025, reserve funding could be achieved through a combination of:

[1] Government Finance Officers Association. "Fund Balance Guidelines for the General Fund." n.d. Government Finance Officers Association. Accessed February 27, 2026. https://www.gfoa.org/materials/fund-balance-guidelines-for-the-general-fund.

[2] Jessup, E. Maintaining Your Fund Balance May be More Mmportant than Ever. Sanford Holshouser. May 8, 2025. https://shlawgroup.com/maintaining-your-fund-balance-may-be-more-important-than-ever/.

- Direct state appropriations,
- Timing strategies (e.g., tax collection ahead of benefit rollout), or
- Self-financing mechanisms, such as modest adjustments to per-person premium rates or employer tax rates during initial implementation.

Estimated Range of Operating Reserve Targets

To support Committee deliberation, this section provides an illustrative estimate of potential operating reserve levels based on a projected full UHP plan cost of approximately $85 billion annually in 2032 dollars (current estimate by Milliman). Because a universal health plan functions more like a large insurance pool than a traditional general fund program, reserve sizing is more appropriately calibrated to total annual expenditures, not just the state-funded share. Even if a substantial portion of expenditures is supported by federal reimbursement, the operational liquidity risk is tied to total claims and payment flows.

Exhibit 1. Illustrative Reserve Targets in 2032 (Based on $85B Annual Expenditures)

TARGET LEVEL	PERCENT OF ANNUAL COST	APPROXIMATE RESERVE (2032$)
1 month	8.3%	~$7.1 billion
2 months	16.7%	~$14.2 billion
3 months	25.0%	~$21.3 billion

These figures represent liquidity reserves only and do not reflect a full risk-based capital (RBC) standard typically applied to private insurers, which would likely require significantly larger capitalization and may not be appropriate for a publicly backed program. The selection of a reserve target materially affects the feasibility of the funding and financing strategy.

- 1-Month Target (~$7B)
  - Represents a minimum liquidity buffer.
  - May be defensible if the program has explicit state backing and statutory early-warning mechanisms.
  - Provides limited protection against multi-month utilization or revenue shocks.
- 2-Month Target (~$14B)
  - Aligns with public finance best practice ranges (GFOA guidance).
  - Provides meaningful liquidity coverage during enrollment ramp and early volatility.
  - May represent a pragmatic middle-ground between feasibility and prudence.
- 3-Month Target (~$21B)
  - Reflects a more insurance-style liquidity posture.
  - Provides strong stabilization capacity during launch and early years.

- Would require significant upfront capitalization and a robust multi-tier funding strategy.

These estimates are intended solely to frame discussion and:

- Reflect projected 2032 full plan costs, not the earlier revenue replacement target.
- Do not incorporate updated actuarial volatility modeling.
- Do not assume phased build-up; full capitalization at launch would require immediate access to the amounts shown.
- Do not incorporate potential offsets from reallocated system resources or federal timing mechanisms.
- Do not assume adoption of private-sector risk-based capital standards.

Finance and Revenue Approach to Funding Reserves

The scale of these figures underscores why the Committee's decision regarding the appropriate reserve target is foundational to determining the feasible mix of Tier 1 (internal), Tier 2 (structured), and Tier 3 (new revenue) sources.

At the projected scale of $85 billion annually, even a one-month operating reserve approaches $7 billion, while a three-month target exceeds $21 billion. The magnitude of these figures makes clear that the choice of reserve target directly drives the intensity of the funding strategy required to capitalize it.

The underlying strategy guiding this framework is to build the reserve using a capital stack approach, prioritizing the least costly and most flexible sources of capital first. In this context:

- **Tier 1 sources (existing internal funds) represent the lowest-cost dollars.** These may include existing state balances, reallocated administrative funds, or other system resources already within public control. Accessing these funds does not require creating new tax burdens and, where feasible, helps reduce the overall capitalization requirement that must be financed externally.
- **Tier 2 sources (structured, low-cost borrowing) provide liquidity with defined repayment terms.** While these funds must ultimately be repaid, they may smooth the reserve build without permanently increasing tax rates. Borrowing backed by future UHP revenues can allow capitalization at launch while spreading fiscal impact over time.
- **Tier 3 sources (new or accelerated revenue) represent the most costly form of capital, both economically and politically.** These would require new taxes, earlier implementation of UHP taxes, or temporary surcharges. While potentially necessary, these mechanisms increase the long-term revenue requirement of the program and may affect affordability, public perception, and legislative viability.

The Committee has consistently expressed a preference to minimize new tax structures to the extent possible. Accordingly, the strategic objective is to maximize the use of Tier 1 and Tier 2 resources before relying on Tier 3 mechanisms. The higher the selected reserve target, the more likely it becomes that Tier 3 funding will be required to fully capitalize the reserve at launch.

In this way, the reserve target decision is not simply a technical actuarial question, it is directly linked to the scale of new revenue that may be necessary for program implementation. Selecting a target within the 1–3 month range will determine whether capitalization can largely be achieved through existing resources and structured financing, or whether new tax capacity must be materially expanded.

Methods and Working Data of Reserve Funding Approach

For each tier, the relevant instruments, statutory or structural constraints, expected reliability, and potential scale are summarized. This framework is intended to clarify tradeoffs and support the Committee's deliberations regarding an appropriate reserve target and financing strategy for UHP implementation.

Importantly, the Committee has expressed a clear preference to **exhaust Tier 1 (internal, lower-cost) and Tier 2 (structured financing) options before relying on Tier 3 (new or accelerated revenue) sources.** Because Tier 3 dollars ultimately require new taxes or fee structures, they represent the costliest and politically sensitive form of capitalization. Minimizing reliance on Tier 3 funding is therefore a guiding objective of this tiered strategy.

Accordingly, this list of potential Tier 1 and Tier 2 sources should be viewed as a **work in progress.** Further refinement will be necessary, particularly with respect to:

- Administrative feasibility
- Legal authority to redirect or repurpose existing funds
- Constitutional or statutory constraints
- Conditions under which funds may be transferred, loaned, or reprogrammed
- Timing restrictions tied to biennial budgeting processes

Some identified sources may ultimately prove infeasible, partially accessible, or subject to significant conditions. Others may require legislative amendments or contractual modifications to implement. The purpose of this tiered inventory is not to assume availability, but **to identify and systematically evaluate all lower-cost capital pathways before advancing new revenue proposals**.

By organizing options in this manner, the Committee can better assess the fiscal and policy tradeoffs inherent in reserve capitalization and present the Board with a strategy that prioritizes financial prudence while minimizing unnecessary expansion of the long-term tax structure.

Tier 1 Reserves: Low-cost, Existing, or Internal Sources

Reallocated or existing funds represent the lowest-cost and most immediately accessible funding source in the reserve strategy, drawing on existing state reserves, balances, and reallocation opportunities. Because this approach avoids the creation of new fiscal obligations, it is generally considered more politically feasible than tax-based or borrowing mechanisms, though the degree of feasibility will depend on competing budget priorities and the willingness of stakeholders to redirect existing resources.

This tier serves as an anchor layer of the reserve, functioning alongside short-term financing to reduce pressure on higher-cost instruments like new taxes or debt. The potential scale of future dollars in this tier makes it a critical foundation for any reserve capitalization strategy.

Exhibit 2. Tier 1 Reserves Funding Options

Source	Description	Accessibility/ Flexibility	Reliability	Potential Scale	Recent Reserves/ Surplus Amount
Rainy Day Fund (General Fund Reserves)	Legislative Emergency Fund linked to the General Fund; may be used for any public purpose with legislative approval.[3]	Requires 3/5 legislative approval and one of the following: (1) 3% projected revenue decline in 2-year outlook; (2) unemployment increases for two consecutive quarters; or (3) 2% quarterly revenue forecast decline. Withdrawals capped at two-thirds of beginning	Deposits depend on sufficient ending biennium balance; deposits suspended in 2023–2025 biennium.	Up to roughly two-thirds of fund balance.[5] Forecast to grow to ~$2.16B by end of 2025-27 biennium.[6]	Estimated $1.9B balance in 2025.[7]

[3] Oregon Secretary of State. Government Finance: State Government. Oregon Blue Book. 2025. Accessed February 27, 2026. https://sos.oregon.gov/blue-book/Pages/facts/finance-state.aspx.
[5] Oregon Department of Administrative Services, Chief Financial Office. 2025-27 Governor's Budget. 2025. Accessed February 27, 2026. https://www.oregon.gov/das/financial/documents/2025-27_gb.pdf.
[6] Oregon Legislative Fiscal Office. 2025-27 Budget Highlights. October 22, 2025. Accessed February 27, 2026. https://www.oregonlegislature.gov/lfo/Documents/2025-27%20Budget%20Highlights.pdf.
[7] Oregon Legislative Assembly. 2025-27 Legislatively Adopted Budget (Committee Meeting Document No. 310944). November 19, 2025. Accessed February 27, 2026. https://olis.oregonlegislature.gov/liz/2025I1/Downloads/CommitteeMeetingDocument/310944.

		biennium balance.[4]			
OHA Medicaid / Oregon Health Plan Funds and Contingencies	Unspent or re-allocatable balances within OHA's ~$14B annual Medicaid budget, including administrative funds, incentive pools, and unallocated waiver funds. No dedicated contingency fund.	Often tied to federal match (1115/1332 waivers); requires legislative approval. Subject to federal policy risk and potential grant reductions.	Contingency-like balances typically 2–4% of program costs. Federal IT match (90/10) reimburses eligible expenditures but does not provide upfront reserves.	Contingency-like balances could be 2-4% of program costs (hundreds of millions depending on balances and waiver flexibility)	Illustrative analog of $271M transfer in other states; recent $117M federal grant reductions highlight volatility.[8]
CCOs (16 total)	Statutory reserves including primary, secondary, premium deficiency, and risk-based capital reserves.	Held for solvency and provider payment stability. Potential transfer dependent on legislative direction, contract modification, or CCO wind-down.[9]	Net income has ranged from -0.3% to 7.5% of expenditures over past decade; profits narrowed post-pandemic. [9]	Varies by CCO; aggregate net income/loss has ranged from -0.3% to 7.5% of expenditures over 10 years.[9]	$547.5M net assets (2023 dollars); $833M net assets in 2022 peak year.[10]
Emergency Board Allocations	Ad hoc legislative allocations to address emergent funding gaps.[11]	Requires Emergency Board approval; episodic use.	Not a standing reserve; discretionary and situational.	Typically tens of millions.	Increase in the Other Funds expenditure limitation established for the Oregon State

[4] Oregon Legislative Revenue Office. Reserve Funds (Report No. 1-24). January 25, 2024. Accessed February 27, 2026. https://olis.oregonlegislature.gov/liz/2024R1/Downloads/CommitteeMeetingDocument/281788.

[8] Oregon Department of Administrative Services, Chief Financial Office. 2025. Accessed February 27, 2026. 2025–27 governor's budget, p. 62. https://www.oregon.gov/das/financial/documents/2025-27_gb.pdf.

[9] Oregon Health Authority. Increased health care usage grew 2024 expenses for Oregon Medicaid insurers. Oregon.gov. Accessed February 27, 2026. https://www.oregon.gov/oha/ERD/Pages/Increased-health-care-usage-grew-2024-expenses-for-Oregon-Medicaid-insurers.aspx.

[10] Oregon Health Authority. Q4 2024 public brief. Oregon.gov. August, 2025. Accessed February 27, 2026. https://www.oregon.gov/oha/FOD/Documents/Q4%202024%20Public%20Brief.pdf.

[11] Oregon Legislative Fiscal Office. Emergency Board Summary, December 2024. Oregonlegislature.gov. December, 2024. Accessed February 27, 2026, from https://www.oregonlegislature.gov/lfo/eboard/EB%20Summary%20Dec%202024.pdf.

					Board of Nursing by $600,000 for increased administrative and pass-through costs in 2025.[12]

Source: ECOnorthwest research of Oregon Department of Revenue and State Legislature documents (e.g. ORS 293.144, 248.696, and 414.572), Medicaid contingency benchmark documents, and program information (e.g. OHSU, OHA, and OHP programs).

Additionally, there exist reserves that may serve as potential funding structure examples. Exhibit 3 below, outlines some pre-existing funds that may have beneficial features relevant to the UHP.

Exhibit 3. Tier 1 Reserves Funding Structure Examples

Source	Description	Accessibility/ Flexibility	Reliability	Potential Scale	Recent Reserves/ Surplus Amount
Legislative Appropriation	Appropriation or one-time reallocation of existing state revenues to fund the reserve.	Subject to state approval and legislative processes.	Subject to legislative discretion; higher political contingencies	Potentially hundreds of millions depending on available General Fund ending balance, program reallocations, and revenue forecast conditions.	2025–27 Legislatively Adopted Budget projects a General Fund ending balance of approximately $472.8 million; beginning balance was approximately $1.96 billion. Availability for reallocation depends on statutory deposits (e.g., Rainy Day

[12] Oregon Legislative Fiscal Office, Emergency Board Summary: December 2024. Accessed February 27, 2026. Oregon Legislature, https://www.oregonlegislature.gov/lfo/eboard/EB%20Summary%20Dec%202024.pdf.

					Fund) and prior commitment.[13]
Oregon Health and Science University (OHSU) Reserves	Operational and capital reserves supporting patient services; limited state appropriation share.[14]	Includes restricted funds (e.g., rural health). Transfers require legal review due to independent status and bond covenants. Credit rating considerations apply.	Fluctuates with operating margins; subject to rating agency scrutiny.	Significant but constrained by restrictions and institutional needs.	$181M drawdown in 2025 indicates meaningful reserve holdings.[14]
Paid Family Medical Leave (PMFL) Insurance Fund	Payroll tax-funded program building reserves for wage replacement during medical leave.[15]	Statutorily dedicated; quarterly solvency monitoring beginning 2026. Health-adjacent but not core health reserve.	Ongoing payroll-based revenue stream; early accumulation phase.	Growing balances pre-full utilization.[16]	Balance was $471 million as of January 2025.[17] Early accumulation period; specific balance evolving.
SAIF (Public Workers' Compensation Insurer)	Unearned premiums, premium deficiency reserves, and loss adjustment reserves under NAIC standards.[18]	Dedicated to workers' compensation obligations; limited health overlap.	Tied to premium collections and claims experience.	Material but legally restricted.	Total capital and surplus in 2024 was $2,077,783 thousand.[18]

[13] 2025-27 Legislatively Adopted Budget: LAB Summary 2025-27. Oregon Legislative Fiscal Office. 2025. Accessed February 27, 2026. https://www.oregonlegislature.gov/lfo/Documents/2025-2%20LAB%20Summary%202025-27.pdf.
[14] OHSU Financial Statements Audited FY25. Oregon Health & Science University. 2025. Accessed February 27, 2026. https://www.ohsu.edu/sites/default/files/2025-11/ohsu-financial-stmt-audited-fy25.pdf.
[15] ORS 657B.430. Paid Family and Medical Leave Insurance Fund. Oregon Revised Statutes. n.d. Accessed February 27, 2026. https://oregon.public.law/statutes/ors_657B.430.
[16] Paid Leave Oregon: Legislative Report July 2024. Oregon Employment Department. July, 2024. Accessed February 27, 2026. https://www.oregon.gov/employ/Agency/Documents/2025/Paid-Leave-Legislative-Report-July-2024.pdf.
[17] Committee Meeting Document 288520. Oregon Legislative Information System. January 27, 2025. Accessed February 27, 2026. https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/288520.
[18] 2025-20 Audit Report. Oregon Secretary of State Audits Division. 2025. Accessed February 27, 2026. https://sos.oregon.gov/audits/Documents/2025-20.pdf.

Other Federal Grants (e.g. 1115 Substance User Disorder (SUD) Waiver)	Federal funds for specific health purposes, including residential treatment and enhanced IT match.[19]	Restricted to waiver terms; subject to federal approval and renewal cycles.	Volatile; subject to federal budget changes.	Can reach hundreds of millions depending on award.	Federal grant awarded for $197.3M rural health funding in 2026; $117M federal cuts in 2025.[20]
IHS / Tribal 1115 Waiver Funds	Supplemental payments via 1115 waivers for uncompensated care in IHS/tribal facilities (e.g., primary care for incomes up to 133% FPL). Not traditional reserves but re-allocatable federal funds.[21]	Federal waiver-based; restricted to eligible populations and services.	Dependent on federal approvals and waiver renewals.	Targeted and limited to eligible services.	N/A - Programmatic funding; not structured as reserves.

Source: ECOnorthwest research of Oregon Department of Revenue and State Legislature documents (e.g. ORS 293.144, 248.696, and 414.572), and Medicaid contingency documents.

[19] Medicaid.gov. About Section 1115 Demonstrations. U.S. Department of Health & Human Services. n.d. Accessed February 27, 2026. https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations.

[20] Oregon Health Authority. Oregon to Receive $197.3M Federal Investment in Rural Healthcare. December 29, 2026.Accessed February 27, 2026, https://www.oregon.gov/oha/erd/pages/oregon-to-receive-$197.3m-federal-investment-in-rural-healthcare.aspx.

[21] Oregon Health Authority, 2022–2027 1115 Demonstration Approval. September 28, 2022. Accessed February 27, 2026, https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/2022-2027-1115-Demonstration-Approval.pdf.

Tier 2: Medium-cost, Borrowed, Structured Sources

Short-term financing mechanisms, including inter-fund loans and revenue-backed borrowing, serve as an anchor layer of the reserve strategy by reducing reliance on new taxes or longer-term debt instruments. This approach carries medium costs relative to other funding sources, though it requires structured repayment arrangements that constrain flexibility over time.

As a foundational tier of the reserve, short-term financing provides a practical bridge that can stabilize capitalization without triggering the political costs associated with new tax measures or large-scale borrowing.

Exhibit 4. Tier 2 Reserves Funding Options and Examples

Source	Description	Accessibility/ Flexibility	Reliability	Potential Scale	Recent Reserves/ Surplus Amount
Interfund Loans or Grants (e.g. Public Employees' Benefit Board (PEBB) or EBB or Oregon Watershed Enhancement Board (OWEB))	Short-term loans between state funds/entities to provide UHP reserve liquidity.[22]	Requires approval by administering authorities; repayment terms structured.[23,24]	Dependent on fund availability and state approval processes.	Varies by participating funds; typically moderate.[25]	Oregon Short Term Fund (OSTF) ~ $36.1 billion total assets reported in Dec 2025.[23,26] (Note this is not a direct reserve; it indicates overall state liquidity that may influence feasibility).

[22] ORS 294.468. Required Information in Annual Budgets. Oregon Revised Statutes. n.d. Accessed February 27, 2026. https://oregon.public.law/statutes/ors_294.468.
[23] Oregon State Treasury. FIN209. Public Financial Services Cash Management Policy. December, 2021. Accessed February 27, 2026. https://www.oregon.gov/treasury/public-financial-services/Documents/Public-Financial-Services-Cash-Management/FIN209.pdf.
[24] Oregon Legislative Assembly. Committee Meeting Document 288943. Accessed February 27, 2026. https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/288943.
[25] Oregon State Treasury. 2025 Q4 OSTF Fund Fact Page. December 31, 2025. Accessed February 27, 2026. https://www.oregon.gov/treasury/public-financial-services/oregon-short-term-funds/Documents/OSTF-Fund-Facts/2025/2025-Q4-OSTF-Fund-Fact-Page.pdf.
[26] Oregon State Treasury. Treasury Home Page. Accessed February 27, 2026. https://www.oregon.gov/treasury/pages/index.aspx.

					Budget for 2025 PEBB was $2.7B, and OWEB's budget was $2.16B.[27]
State Treasury Loan with Repayment from UHP Revenue	Treasury extends a loan to UHP, to be repaid from future UHP revenue streams.[28]	Requires state authorization and defined repayment plan using UHP revenue.[29]	Moderate; dependent on projected UHP revenue sufficiency.	Potentially substantial if revenue streams are stable.	N/A — hypothetical structuring option. Amount will be influenced by the General Fund ending balance ($472.8M in 2025-27 biennium) and reserves.[30]
State/Local Public Employer Sponsored Insurance (ESI) Payments (Excess of EPT)	Redirect excess employer-sponsored insurance (ESI) payments above the Employee Premium Tax (EPT)	Requires statutory authority; dependent on local/state ESI structures.	Moderate; tied to ongoing ESI payment flows.	Variable based on ESI payment excess.	N/A — hypothetical structuring option. PFML balances growing in early accumulation phase.

Source: ECOnorthwest research of Oregon Department of Revenue and State Legislature documents, and program information (e.g. OHSU, OHA, and OHP programs).

[27] Oregon Legislative Assembly. Committee Meeting Document 288943, p. 67. 2025. Accessed February 27, 2026. https://olis.oregonlegislature.gov/liz/2025R1/Downloads/CommitteeMeetingDocument/288943.
[28] Oregon State Treasury. Keeping Oregon's Money Moving. September 3, 2025. Accessed February 27, 2026. https://www.oregon.gov/treasury/news-data/the-ledger/pages/keeping-oregons-money-moving.aspx.
[29] Oregon State Treasury. Banking with Treasury. n.d. Accessed February 27, 2026. https://www.oregon.gov/treasury/public-financial-services/banking-with-treasury/pages/default.aspx.
[30] Oregon Legislative Fiscal Office. 2025–27 Legislatively Adopted Budget: LAB Summary 2025–27. 2025. Accessed February 27, 2026. https://www.oregonlegislature.gov/lfo/Documents/2025-2%20LAB%20Summary%202025-27.pdf.

Tier 3: High-cost, New Revenue Sources

New or early tax collections represent a high-cost, high-visibility funding mechanism that would serve as a backstop for full reserve capitalization if Tier 1 or 2 sources prove insufficient. This approach carries significant political and fiscal costs relative to other funding strategies, largely because new or accelerated tax measures are more transparent to the public and stakeholders than administrative or financial mechanisms.

That said, the potential scale is substantial making it one of the more powerful levers available when other tiers fall short. Its viability is highly policy-dependent, and deployment would likely require considerable political will and stakeholder alignment.

Exhibit 3. Tier 3 Reserves Funding Options and Examples

Source	Description	Accessibility/ Flexibility	Reliability	Potential Scale	Recent Reserves/ Surplus Amount
Start UHP Tax Before Benefit Delivery	New UHP tax; Implement UHP revenue collection before full benefit rollout to build reserves.	Requires legislative/policy approval, visible to stakeholders. Funds are separate and distinct from the General Fund.[31]	High if enacted; front-loads revenue.	Depends on tax rate and base; can generate significant annual revenue.[32]	N/A — policy option.
Temporary Transition Tax or Fee (Outside UHP)	Imposition of a one-time or limited duration tax/fee to generate transition reserve funding.	Requires legislative approval; time-limited structures.	Dependent on policy design and collection mechanisms.	Moderate to significant, depending on rate/duration.	N/A — policy option

[31] Oregon Secretary of State, Government Finance: State Government, Oregon Blue Book. 2025. Accessed February 27, 2026, https://sos.oregon.gov/blue-book/Pages/facts/finance-state.aspx.

[32] Oregon Legislative Fiscal Office, 2025–27 Legislatively Adopted Budget: LAB Summary 2025–27. 2025. Accessed February 27, 2026. https://www.oregonlegislature.gov/lfo/Documents/2025-2%20LAB%20Summary%202025-27.pdf.

Temporary Surcharges on Existing Revenues	Temporary surcharge on selected taxes or premiums to raise reserve funds.	Requires statutory authority; sunset provisions tied to reserve goals.	Moderate; visible and potentially controversial.	Varies by base and surcharge rate.	N/A — policy option.

Source: ECOnorthwest

Financing the Reserve: Pay-As-You-Go vs. Borrowing

Once the Committee determines an appropriate operating reserve target, the next question becomes how to finance that target. At its core, this is a timing decision: the reserve can either be built gradually through pay-as-you-go revenue collection, or it can be capitalized upfront through borrowing and repaid over time.

Under current projections, the 2032 annual revenue replacement target could approach $26 billion per year. Against that backdrop, the scale of potential reserve targets is significant:

- 1 month (~$7 billion)
- 2 months (~$14 billion)
- 3 months (~$21 billion)

Even at the low end of the range, the reserve requirement represents a substantial share of annual revenue. For example:

- A $7 billion reserve represents more than one-quarter of the projected $26 billion annual revenue requirement.
- A $21 billion reserve would approach nearly a full year of payroll tax collections in some rate structures.

This scale makes clear that the method of financing meaningfully affects both tax timing and fiscal exposure.

PAY-AS-YOU-GO APPROACH

Under a pay-as-you-go approach, the reserve is built by collecting revenue before or alongside benefit payments. This can occur in two primary ways:

1. Starting the UHP tax prior to benefit launch, allowing balances to accumulate before claims are paid; or
2. Building reserves incrementally after launch, dedicating a portion of annual revenue to reserve accumulation.

The practical implication is that taxes would either need to begin earlier than benefits, or the initial rate would need to be higher than steady-state program needs to generate surplus for reserve capitalization. While this approach avoids debt service and long-term financing costs, it requires earlier or higher tax collection in the initial years.

BORROWING APPROACH

Alternatively, the state could borrow funds to capitalize the reserve at launch and repay the principal and interest over time using future UHP revenues. Borrowing allows immediate

capitalization without starting taxes early or materially increasing initial rates. However, it increases total program cost through interest and creates a fixed repayment obligation layered on top of annual program expenditures.

As illustrated in the following section, even at moderate interest rates, borrowing materially increases the total cost of reserve capitalization and commits future revenue streams to debt service.

Illustrative Borrowing Scenario: Debt-Financed Reserve Capitalization

As part of the Committee's evaluation of Tier 3 mechanisms, it is helpful to illustrate the cost implications of borrowing to capitalize a portion of the operating reserve rather than building it on a pay-as-you-go basis.

For example, if the state were to borrow $1 billion in 2026 to fund a portion of the reserve, under the following illustrative conditions:

- Interest rate: 3.0 percent (a lower cost of capital rate than what is seen currently)
- Term: 20 years (term could be stretched to lower payments)
- Structure: Level annual debt service (different financing structures could lower early payments at the cost of higher effective rates)

The projected annual debt service payment would be approximately $67.2 million per year. Over the 20-year term, total repayment would equal approximately $1.34 billion, of which roughly $344 million represents interest cost beyond the original principal. This example demonstrates several important considerations:

1. Borrowing provides immediate capitalization without requiring upfront tax increases or immediate reserve accumulation.
2. Total cost increases materially over time, with interest adding roughly 34 percent above principal in this scenario.
3. Debt service becomes an ongoing structural obligation, reducing fiscal flexibility and requiring that future UHP revenues support both program costs and repayment.
4. At larger reserve targets, the fiscal scale becomes significant. For example:
    a. $5 billion borrowed under similar terms would imply roughly $336 million in annual payments and approximately $1.7 billion in total interest.
    b. $10 billion borrowed would imply roughly $672 million in annual payments and approximately $3.4 billion in total interest.

While borrowing may smooth near-term fiscal impacts and avoid early tax increases, it shifts costs forward to future ratepayers and increases the total cost of reserve capitalization. As such, debt-financing should be weighed carefully against pay-as-you-go approaches, particularly in light of the scale of potential reserve targets under consideration.

This example is illustrative only and does not reflect final borrowing authority, interest rate assumptions, statutory constraints, or market conditions. It is intended solely to frame the tradeoffs between immediate capitalization and long-term cost.

UNDERSTANDING TRADEOFFS

The decision between pay-as-you-go and borrowing is not about whether reserves are necessary, but rather about how and when the cost is borne.

- Pay-as-you-go shifts cost forward in time but avoids interest expense.
- Borrowing accelerates capitalization but increases total cost and creates a long-term obligation.

Given the projected scale of UHP expenditures, this financing decision has meaningful implications for rate design, tax timing, and long-term fiscal flexibility. The Committee's recommendation on reserve target will directly influence which financing pathway is feasible and how much early revenue must be generated.

ECOnorthwest

DATE:	June 06, 2026
TO:	Mimi McDonell, UHPGB
FROM:	Morgan Shook, Megan Waldo, ECOnorthwest
SUBJECT:	Proposal Comparison to LRO Revisions and Estimates

Introduction

The Legislative Revenue Office's (LRO) reviewed the UHP revenue proposal put forth by the Finance & Revenue Committee's (F&R) and produced a first pass of tax-year 2032 liability estimates based on the functionality of existing tax structures. This memo places the Finance & Revenue Committee's (F&R) original revenue proposal, calibrated in 2022 dollars and documented in the June 2026 Final Report, alongside LRO's preliminary 2032 estimates and the methodological and policy questions LRO has flagged.

Two framing points are important. First, LRO's estimates are tax-year liability estimates, not collections. They are static, do not incorporate behavioral or macroeconomic feedback, and do not yet account for deductibility against other tax bases. Conversion from liability to collections will require additional work and will introduce a roughly three-year settling period after a rate change, for the Corporate Income Tax (CIT) in particular. Second, several structural parameters in the original F&R proposal have been confirmed by LRO without modification; this memo provides an overview of the full structure but concentrates on the elements where new information from LRO meaningfully changes the picture, principally the EPT and the HCPIT.

UHP Revenue Proposal

The F&R Committee's revenue framework was anchored to a Revenue Replacement Target of approximately $16.9 billion in 2022 dollars, with a placeholder 2032 target of approximately $26.0 billion pending reconciliation with the Milliman cost estimate. The framework treats UHP financing as a reorganization of existing health care payments rather than a net-new burden: in the 2022 calibration, every major payer class contributes less in aggregate than under the status quo.

The proposal is built around an integrated set of instruments:

- **Corporate Income Tax (CIT)** add-on of 3.0% on Oregon's existing 7.6% rate, the 6.6% rate up to $1M is left unchanged (~$608M, 2022$);
- **Corporate Activity Tax (CAT)** add-on of 0.10% on the existing 0.57% rate (~$215M, 2022$);
- **Employer Payroll Tax (EPT)** of 9.6% on firmwide payroll above a $500,000 threshold (~$8.7B, 2022$), structured as a generally applicable levy to manage ERISA risk;

- **Health Care Personal Income Tax (HCPIT)** of 10.1% on AGI above 200% FPL, with a phase-in to 260% FPL;
- **Household Size Rate Readjustment (HSRR)** modifying HCPIT liability by household size between 260% and 520% FPL;
- **50% EPT credit against HCPIT liability** to prevent double taxation of wage compensation;
- **100% non-refundable credit for Medicare Part B premiums** against HCPIT liability; and
- **A 0.20 percentage-point increase to the state transient lodging tax** (from 1.5% to 1.7%, ~$5M).

The full structure, distributional analysis, and supporting calibration are documented in the June 2026 Final Report. The purpose of the LRO review was to convert the 2022-calibrated structure into a 2032 implementation-year financing package suitable for legislative consideration, to confirm that the F&R parameters can be administered through existing Oregon tax instruments, and to identify the design questions on which the Board will need to take a position.

LRO Review of the UHP Revenue Proposal

LRO's first-pass review retains the F&R framework's structural elements and confirms the proposed rates for the EPT and HCPIT. The LRO estimate should be treated as provisional until LRO documents the scaling methodology; the jump may reflect real base growth but warrants confirmation before it is used in legislative materials.

The principal changes from the original proposal fall into three categories: (1) updated 2032 dollar estimates for the two largest instruments; (2) methodological refinements that need to be reconciled with the F&R 2022 calibration; and (3) administrative and policy questions that affect both the size of the tax base and the feasibility of implementation through the Department of Revenue (DOR). The table below summarizes the comparison, the subsections that follow expand on the EPT and HCPIT, where LRO's work has produced the most substantive new information.

Exhibit 1. Proposal Comparisons

Instrument	F&R Proposal (2022$ calibration)	LRO Preliminary (2032 tax-year liability)	Comparison
Corporate Income Tax (CIT) Add-On	+3.0% surcharge on existing 7.6% CIT (6.6% rate on first $1M unchanged). ~$608M.	Stated as 9.6% up to $1M and 10.6% above $1M (equivalent +3.0 pp). Preliminary 2032 estimate: $660M.	Structurally aligned. Dollar estimate updated; see note below.
Corporate Activity Tax (CAT) Add-On	+0.10% on existing 0.57% CAT base. ~$215M.	LRO confirms structure; preliminary 2032 estimate: $346.5M.	Structurally aligned. Dollar estimate updated; see note below.
Employer Payroll Tax (EPT)	9.6% marginal rate on firmwide payroll above $500,000 threshold (public employers pay on total payroll). ~$8.7B.	9.6% rate, $500,000 firm exemption. Liability estimate: $15.1B in 2032.	Rate and threshold confirmed. Firm definition and anti-avoidance design are open issues (see EPT section below).
Health Care Personal Income Tax (HCPIT)	10.1% marginal rate on Federal AGI above 200% FPL, with phase-in to 260% FPL, HSRR, 50% EPT credit, and 100% Medicare Part B credit.	10.1% rate, 200%–260% FPL phase-in, 50% non-refundable EPT credit, Medicare Part B credit. Liability estimate: $9.7B in 2032. Approximately 50% above status-quo PIT.	Rate and structure confirmed. FPL threshold design and married filing separately incentive are open issues (see HCPIT section below).
Household Size Rate Readjustment (HSRR)	Up to $1,325 per exemption above one, phased in linearly from 260% to 520% FPL.	Reflected within HCPIT estimate.	Structurally aligned.
Lodging Tax	Increase state lodging tax from 1.5% to 1.7% (+0.20 pp). ~$5M.	Baseline is now 2.75% under HB 3141 (effective 2032). LRO would treat any UHP increase as linear on top of the new base.	Decision needed on whether to retain a UHP add-on or drop the instrument given the updated HB 3141 baseline.

Note: LRO's preliminary 2032 CIT estimate of $660M represents a roughly 8.5% increase over the 2022-calibrated $608M, which is consistent with a decade of nominal income growth. The CAT estimate of $346.5M, however, is approximately 61% above the 2022-calibrated $215M. LRO notes the CAT figure is scaled from 2023 revenue data.

Employer Payroll Tax (EPT)

LRO confirms the 9.6% rate and $500,000 firm exemption threshold without modification, and projects 2032 tax-year liability at $15.1 billion. Several design and methodology questions remain open.

- **Estimation methodology.** LRO based the EPT estimate on Oregon's existing Statewide Transit Tax (STT), which is imposed at 0.1% of wages. Because the proposed EPT rate of 9.6% is 96 times the STT rate applied to the same wage base, LRO scaled the STT revenue forecast accordingly. The STT applies to wages as defined in ORS 316.162, which excludes certain categories of workers, activities, and all self-employment income. The $500,000 per-firm annual payroll exemption is estimated to reduce the effective tax base by approximately 18% relative to the full STT base. As with all LRO estimates in this review, the figure is static: it does not incorporate behavioral response, macroeconomic feedback, or adjustments to the health insurance environment.
- **Firm definition and anti-avoidance.** The EPT exemption applies at the firm level, which creates an incentive for employers near the threshold to restructure to fall below it. LRO recommends adopting the firm definition used by Oregon's Paid Leave Tax (PLT), which defines an employer based on how businesses file their income taxes and applies the threshold based on number of employees (fewer than 25 employees versus 25 or more). This approach has established administrative precedent and aligns with existing DOR infrastructure. LRO notes, however, that creating additional taxes with varied definitions of applicability is likely to introduce administrative and compliance complexity and recommends that any departure from the PLT definition be weighed carefully against that cost. Other possible definitions include a single physical location; all entities under common ownership (requiring a minimum ownership threshold); or all entities under common ownership that share economic value across business lines (the "unitary" concept used for the corporate income tax). The Board will need to select a definition before legislative drafting.
- **Covered persons and wage base.** The STT applies to work performed in Oregon and to work performed by Oregon residents in other states, but the EPT proposal will need to clarify how several worker populations are treated: nonresidents working in Oregon; Oregon residents working partially or entirely in other states; and workers with multi-state payroll (e.g., construction workers). These coverage questions have direct implications for the size of the tax base and intersect with the parallel question under the HCPIT of how to treat Oregon residents who receive health insurance through a non-Oregon employer (see HCPIT section below). The wage base definition, whether to follow ORS 316.162 or adopt a different scope, should be resolved in conjunction with the covered-persons question.

- **EPT credit reporting on W-2 forms.** The F&R proposal includes a 50% EPT credit against HCPIT liability, which raises the question of whether EPT contributions should be reported on employee W-2 forms to facilitate credit claims. LRO's preliminary view is that this should be administratively feasible, drawing an analogy to the State Transportation Tax, which is currently listed on W-2s. LRO notes it is not deeply familiar with the specific federal coordination or coding requirements and treats this as a secondary item pending further review.

Health Care Personal Income Tax (HCPIT)

LRO confirms the 10.1% rate, the 200%–260% FPL phase-in, the 50% non-refundable EPT credit, and the Medicare Part B credit, and projects 2032 tax-year liability at $9.7 billion, approximately 50% above current personal income tax collections. Several design and administrative questions remain open.

- **Estimation methodology.** LRO constructed the HCPIT tax base beginning with adjusted gross income, minus federally taxable Social Security income, tax-exempt federal pension income, and interest earnings on U.S. debt (all three categories are exempt from state income tax under federal law or the Oregon Constitution). Taxpayers qualify for a standard deduction equal to 200% of FPL for their household size, determined at the tax return level. For example, a single taxpayer with two dependents would have a household size of three. Full tax liability phases in from 200% to 260% FPL. Two non-refundable credits are available: a payroll tax credit equal to 50% of EPT paid for the specific taxpayer, and a credit for Medicare Part B premiums paid during the tax year. As with the EPT, the estimate is static and does not incorporate behavioral response or macroeconomic feedback. FPL is not an existing personal income tax parameter in Oregon; how it is administered in practice will affect both compliance and the accuracy of future estimates.
- **Distributional concentration and marginal rate implications.** LRO's preliminary distributional analysis shows the HCPIT is highly concentrated among higher-income taxpayers, with effective tax rates rising progressively across income bands. The top 0.5% of taxpayers, those above $1 million in income, are estimated to account for approximately 25% of total HCPIT liability. LRO also flags that the HCPIT, layered on top of existing state and local income taxes, would produce a combined top marginal income tax rate of approximately 25% for a taxpayer in Portland. The Board should be prepared to address this in the legislative context, as it is likely to be raised as a competitiveness and taxpayer behavior concern, even though the F&R framework accounts for this through the EPT credit and the overall reorganization of health care payments.
- **Married filing separately incentive.** Because the HCPIT exemption is tied to FPL thresholds that scale with household size, married couples who file jointly face a higher combined threshold than if they filed as two single filers. This creates a

potential incentive to file separately to reduce taxable income. LRO has identified two options to mitigate this:

- **Formulaic FPL split.** Each spouse's standard deduction would equal 50% of the two-person FPL household size, with incremental amounts added for dependents claimed on the return. This preserves the FPL framework and neutralizes the filing-status incentive for couples without dependents.
- **Per-person exemption.** The FPL-linked threshold would be replaced with a flat per-person exemption amount. LRO notes this approach would likely understate the exemption for single filers and overstate it for joint filers and those with dependents relative to the FPL benchmark, introducing a different set of distributional tradeoffs.

LRO also notes that the decision about which option to adopt could be deferred, recognizing that taxpayers' choice of filing status reflects multiple considerations beyond the HCPIT alone. The Board should weigh whether to resolve this before legislative drafting or flag it as a known implementation issue to be addressed in rulemaking.

- **Non-residents and out-of-state workers.** LRO's preliminary HCPIT estimate excludes non-resident taxpayers. If non-residents working in Oregon will qualify for UHP coverage, they may need to be included in the tax base, which would increase the liability estimate. Separately, the treatment of Oregon residents who work in another state and receive health insurance through a non-Oregon employer is unresolved. This question is closely connected to the covered-persons question under the EPT: in both cases, the policy intent regarding coverage eligibility should drive the tax base definition, and the two instruments should be designed consistently.

Next Steps for Revenue Modeling

The purpose of LRO's initial review was to translate the Finance & Revenue Committee's 2022-calibrated proposal into a tax-year 2032 framework and identify the remaining analytical and implementation questions. The next phase of work should focus on refining the proposal into a legislative-ready financing package.

Key modeling tasks include:

- Reconcile the Revenue Replacement Target with the updated Milliman cost estimate and revised sources-and-uses framework, including assumptions regarding transferable federal, state, and local funding.
- Incorporate the full cost of the Medicare Part B premium credit and any other approved modifications into the HCPIT estimate.
- Update EPT and HCPIT revenue estimates using the final Revenue Replacement Target and tax-year 2032 economic assumptions.

- Refine the HCPIT exemption structure, including development of a filing-status adjustment that eliminates any incentive for married taxpayers to file separately while preserving the intended FPL-based framework.
- Continue evaluation of EPT and HCPIT tax base definitions, including treatment of non-resident workers, Oregon residents employed out of state, self-employed individuals, and the relationship between coverage eligibility and tax liability.
- Conduct additional review of EPT and HCPIT modeling assumptions with LRO economists to ensure alignment between policy intent, tax administration, and revenue estimation methodologies.
- Advance all major revenue instruments to a level of specificity sufficient for legislative review and drafting, including tax bases, rates, exemptions, credits, and administrative provisions.
- Prepare updated implementation-year estimates and distributional analyses reflecting the final modeled tax structure.

The objective of this work is to provide the Board with a fully specified financing package that can support future legislative review and deliberation.

DATE:	June 24, 2026
TO:	Chris Allanach and Legislative Revenue Office Staff
FROM:	UHPGB Staff and ECOnorthwest
SUBJECT:	Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework

Purpose

As the UHP Board transitions from the Finance & Revenue Committee's conceptual revenue framework toward implementation-year estimates, we have been working to reconcile the Milliman cost estimates, preserved federal and state funding streams, and the resulting Revenue Replacement Target (RRT).

The purpose of this memo is to summarize a preliminary range of potential 2032 Revenue Replacement Targets and provide a framework for translating those targets into required revenue by financing mechanism. We view these estimates as planning scenarios intended to support discussions with LRO regarding modeling approach, implementation-year tax rates, and legislative specification.

Estimating a Revenue Replacement Target Using Milliman Results

Milliman's analysis provides a range of expenditure estimates for the Universal Health Plan. Beginning with Milliman's revised expenditure estimates that account for provider administrative savings and collectability improvements, we then remove funding sources expected to continue supporting the UHP, including federal waiver funding, Medicaid state contributions, behavioral health funding, and related public funding streams.

The Milliman report provides a range of projected 2032 UHP expenditures. Figure 53 from the report presents total expenditures based on claims experience:

SCENARIO	2032 EXPENDITURES
Low	$77.4 B
Best Estimate	$85.5 B
High	$94.0 B

UHPGB staff have adjusted these estimates to account for savings associated with provider administrative simplification and improved collectability. Figure 50 presents the revised expenditure estimates:

SCENARIO	REVISED EXPENDITURES
Low	$69.4 B
Best Estimate	$77.7 B
High	$86.5 B

Preliminary Revenue Replacement Target Scenarios

To estimate the Revenue Replacement Target (RRT), existing federal and state funding sources that are expected to continue supporting the UHP must be removed from total expenditures.

Federal and State Contributions

Figure 43 in the Milliman report identifies approximately $28.5 billion in 2026 federal and state funding that would continue to support the UHP:

FUNDING SOURCE	2026 AMOUNT
CMS Waiver Funding (Individual, Medicaid, Medicare)	$23.4 B
State General Fund Medicaid Contribution	$4.3 B
Behavioral Health Funding	$0.8 B
Total Federal and State Funding	**$28.5 B**

Assuming annual growth of 5.3 percent (current rate of growth of health care expenditures per capita), these funding sources increase to approximately $38.9 billion by 2032. Adding an estimated $0.8 billion state contribution for Medicaid dental benefits results in a total 2032 federal and state contribution of approximately $39.7 billion.

Best Estimate Scenario

Starting with Milliman's revised best estimate of $77.7 billion and assuming additional savings from reducing payer administrative costs from 6 percent to 3 percent yields an adjusted expenditure estimate of approximately $75.2 billion.

CALCULATION	AMOUNT
Adjusted Best Estimate Expenditures	$75.2 B
Less Federal and State Contributions	($39.7 B)
Revenue Replacement Target	**$35.5 B**

Lower-Cost Scenario

Using Milliman's revised low estimate of $69.4 billion and applying the same payer administration adjustment results in total expenditures of approximately $68.4 billion.

To estimate the corresponding federal and state contribution, UHPGB staff assumed that public funding remains proportional to total expenditures. Under this approach, the 2026 federal and state contribution declines from $28.5 billion to approximately $26.2 billion, which trends to roughly $35.7 billion in 2032. Adding the estimated Medicaid dental contribution increases total federal and state funding to approximately $36.5 billion.

CALCULATION	AMOUNT
Adjusted Low Estimate Expenditures	$68.4 B
Less Federal and State Contributions	($36.5 B)
Revenue Replacement Target	**$31.9 B**

This estimate may be viewed as a middle scenario rather than a true low scenario. The assumed 5.3 percent annual growth rate exceeds both CMS projections for national health expenditure growth and Oregon's observed growth rate during the 2014–2019 period. As a result, the expenditure assumptions underlying the Milliman low estimate may still be conservative relative to other plausible trend assumptions.

Enhanced Savings Scenario

Additional savings may be achievable through a unified purchasing and administration structure. Assuming 1) 1.5 percent savings from prescription drug purchasing; and 2) 1.0 percent savings from improved fraud, waste, and abuse prevention; produces an additional 2.5 percent reduction in expenditures.

CALCULATION	AMOUNT
Adjusted Low Estimate Expenditures	$68.4 B
Less Additional Savings (2.5%)	($1.7 B)
Enhanced Savings Expenditures	$66.7 B
Less Federal and State Contributions	($36.5 B)
Revenue Replacement Target	**$30.2 B**

Under this framework, a reasonable range for the 2032 Revenue Replacement Target appears to be approximately $30 billion to $36 billion, with a central estimate near $32 billion.

UHP Tax Revenue Allocation Framework

The Finance & Revenue Committee's adopted financing framework allocated responsibility across the major revenue instruments as follows:

FINANCING MECHANISM	SHARE OF REVENUE
Corporate Income Tax (CIT)	3.8%
Corporate Activity Tax (CAT)	1.3%
Employer Payroll Tax (EPT)	51.5%
Health Care Personal Income Tax (HCPIT)	43.4%
Lodging Tax Increase	<1%

The HCPIT percentage reflects net revenue dedicated to the UHP after accounting for reductions in liability associated with the EPT credit. The lodging tax represents a proposed 0.2 percentage-point increase in the statewide lodging tax and contributes a relatively small share of total revenue.

Revenue Requirement by Financing Mechanism ($ Billions)

Applying these percentages to the potential Revenue Replacement Targets yields the following planning estimates.

FINANCING MECHANISM	SHARE	$30.2B RRT (LOW)	$31.9B RRT (MIDDLE)	$35.5B RRT (HIGH)
CIT	3.8%	1.15	1.21	1.35
CAT	1.3%	0.39	0.41	0.46
EPT	51.5%	15.55	16.43	18.28
HCPIT	43.4%	13.11	13.84	15.41
Lodging Tax	<1%	~0.01	~0.01	~0.01
Total	**100%**	**30.2**	**31.9**	**35.5**

Questions for LRO

As we move into the next phase of modeling, we would appreciate LRO's perspective on several implementation and modeling questions:

- Is LRO able to evaluate a tiered Employer Payroll Tax structure based on employer size and/or public vs. private status, either measured by total payroll, number of employees, or another administratively feasible metric?
    - If a tiered EPT structure is feasible, what data limitations or administrative considerations should be considered when developing and estimating alternative rate schedules?

- One consideration surrounding the potential tiered tax structure based on private or public status, is that state agencies have an increased payroll tax due to how much less they will be paying in premiums.

We appreciate LRO's continued assistance in translating the Board's financing framework into a legislative-ready proposal and look forward to discussing the next phase of work: modeling the rates required per financing mechanism to meet the low, middle and high revenue replacement targets outlined in this document.

ECOnorthwest

DATE:	June 28, 2026
TO:	Universal Health Plan Governance Board
FROM:	Morgan Shook
SUBJECT:	Economic Effects of Oregon's Universal Health Plan: A Framework for Evaluating Fiscal, Economic, Distributional, and Welfare Impacts

Executive Summary

Oregon's Universal Health Plan (UHP) is simultaneously a health-access reform and a health-financing reform. The Universal Health Plan Governance Board, created by Senate Bill 1089 (2023)[1] and building on the right to affordable care voters added to the state constitution through Measure 111 (2022),[2] is charged with delivering a comprehensive plan to finance and administer a single-payer universal system to the Legislature by September 15, 2026. Any legislative or ballot decision would follow, with implementation projected near the end of the decade. Designing that plan is at once a policy exercise and a fiscal and economic planning exercise.

This white paper does not estimate a single economic impact number. It defines a framework for evaluating UHP's likely economic effects: the channels through which the plan would move money and behavior, what existing research establishes, what remains uncertain, and what Oregon-specific analysis is needed to inform Board, legislative, and implementation decisions.

Its central argument is that UHP should not be evaluated as a new tax layered onto an unchanged economy. The current system already extracts large and uneven costs: premiums, cost-sharing, public-program spending, uncompensated care, billing and administrative overhead, medical debt, and forgone care. The correct comparison is between total current health-related payments and risks and total future UHP taxes, residual costs, and benefits. Comparing new taxes only to current taxes would overstate UHP's burden and understate the cost of the status quo.

The framework rests on four conclusions:

[1] Oregon Legislature, Senate Bill 1089 (2023); ORS 751.001-751.002. The Universal Health Plan Governance Board, housed in the Department of Consumer and Business Services, must present a comprehensive financing and implementation plan to the Legislature no later than September 15, 2026.
[2] Oregon Measure 111 (2022) amended the state constitution to establish a right to cost-effective, clinically appropriate, and affordable health care.

1. **Effects run through eight distinct channels,** not one fiscal pathway. They reach households, employers, providers, workers, public budgets, and the broader economy: some as benefits, some as transition risks.
2. **Many of the most important effects fall outside GDP.** Reduced medical debt, lower financial risk, less job lock, and better access for medically vulnerable residents are real welfare gains that traditional output measures miss, or even register as declines, since fewer avoidable hospitalizations lower measured health-sector output while making people better off.
3. **Federal funding is now the dominant external risk.** The federal reconciliation law enacted July 4, 2025 (H.R. 1) reduces federal Medicaid funding by roughly $1 trillion over ten years.[3] Because redirected federal dollars are foundational to UHP's financing, this change must be modeled explicitly rather than assumed away.
4. **A layered analysis is required**, combining fiscal modeling, distributional microsimulation, macroeconomic modeling, benefit-cost and welfare analysis, and fiscal stress testing, integrated through shared scenario assumptions.

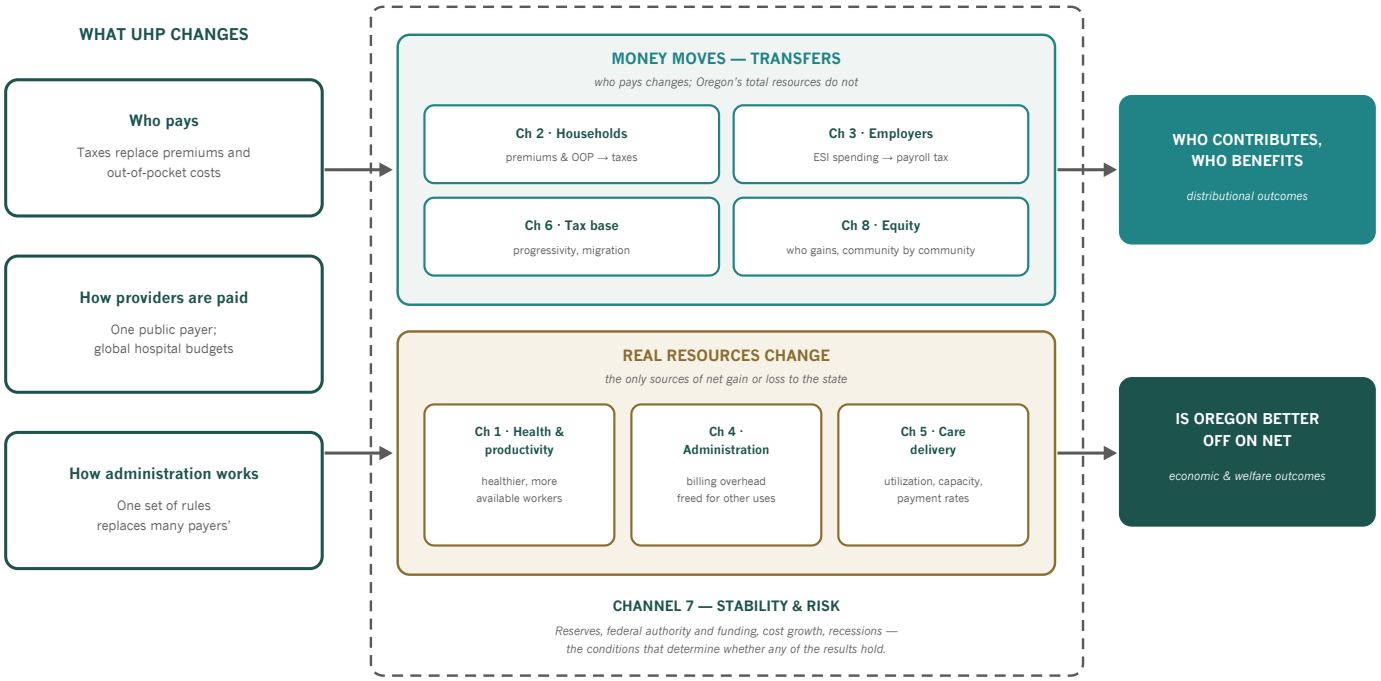
The better question is therefore not "What is the economic impact of raising taxes to pay for health care?" but "How would Oregon's economy, households, businesses, public finances, and overall welfare change if the state replaced much of today's fragmented financing system with a universal, publicly financed plan?"

[3] H.R. 1, the budget reconciliation act signed July 4, 2025, is estimated to reduce federal Medicaid funding by roughly $1 trillion over ten years, with substantial projected coverage losses nationally.

The Impact Channels at a Glance

#	Channel	Core economic question	Largest uncertainty
1	Health, productivity & labor markets	Does better access translate into measurable labor-market gains?	How much welfare gain becomes measured GDP/employment, and over what horizon
2	Household disposable income & financial security	Who pays less, who pays more, and whose risk falls?	Net effect depends on final financing design and which payments are replaced
3	Employer costs & business competitiveness	Which firms see costs fall, which see them rise, and where do savings go?	Tax design, exemptions, and pass-through to wages vs. profits
4	Administrative simplification & workforce transition	How much overhead is removed, and what happens to those jobs?	Magnitude of Oregon-specific savings; displacement and re-employment
5	Provider payment, utilization & capacity	Does financial access become real access to care?	Utilization surge, payment-rate response, rural and behavioral-health capacity
6	Tax design, revenue stability & migration	How stable is the revenue base, and who relocates or shifts income?	Behavioral response near the Portland-Vancouver border; in-migration of high-cost users
7	Public-finance stability & risk	Can the state carry the financing risk through a downturn?	Federal funding (post-H.R. 1), medical-cost growth, reserve adequacy
8	Equity & distribution	Do benefits and burdens land fairly across communities?	Whether universal financing produces universal access in practice

Figure 1. How UHP's effects flow through the eight channels



Channels 2, 3, 6, and 8 mainly move money among Oregonians and determine distribution; Channels 1, 4, and 5 change real resources and determine net gains; Channel 7 sets the stability conditions under which the results hold.

Purpose and Framing

This white paper responds to a question the Board's process set out to answer by September 2026: a dynamic economic analysis of how the Universal Health Plan would affect Oregon's economy. As framed in the scope of that work, a contractor was to use economic modeling to provide a dynamic analysis of the plan's impact on Oregon's economy, including its effects on small and large businesses, on households and individuals, and on employment and on individual and business income.

Given limitations in resources and timing, a full dynamic analysis on that schedule was not feasible. This paper is instead meant to provide guidance on that question and to lay out the broad context for how to think about these impacts, rather than to deliver the dynamic modeling itself. ECOnorthwest's earlier work with the Finance and Revenue Committee already quantified some of the static, point-in-time effects on households and businesses that this framework draws on, particularly in Channels 3, 4, and 6, but it did not attempt the larger dynamic changes that would unfold over time. Setting out the channels, evidence, and analysis those dynamics would require is the purpose of what follows. ("Dynamic" is used here in both of its common senses: behavioral and macroeconomic feedback, the sense standard in fiscal-impact modeling, and effects that unfold over time; where the distinction matters, the text names it.)

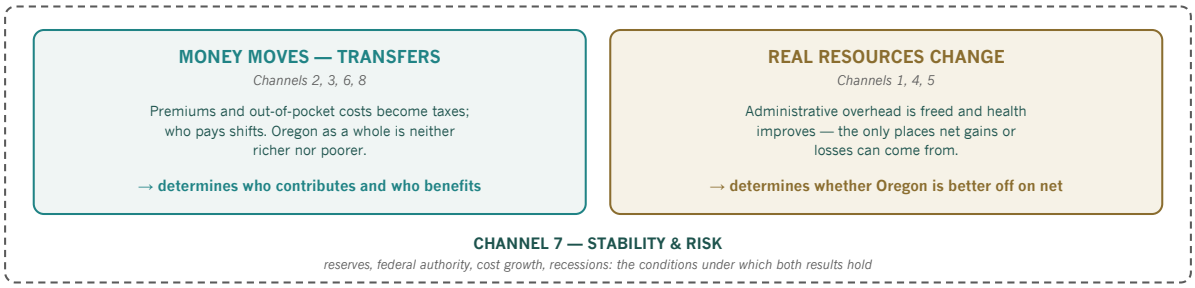
UHP would replace or consolidate much of today's mix of employer premiums, employee contributions, deductibles, co-pays, out-of-pocket costs, and state and federal funding into a more unified public system. Because it restructures financing rather than simply adding spending, its effects show up unevenly: some in conventional measures such as GDP, employment, wages, industry output, and consumer spending, and others (improved health, reduced medical debt, lower financial risk, less job lock, greater household stability) in welfare that those measures do not fully capture.

A second distinction should discipline the channels that follow: transfers versus real resource changes. Most of UHP's effects are transfers, in which one party's saving is another party's cost: the money changes pockets, but Oregon as a whole is neither richer nor poorer. Employer premium savings that pass through to wages, reductions in medical debt (in large part a transfer from providers and creditors to households, with the true welfare gain being the risk and distress avoided), and relieved uncompensated care move money among Oregonians without changing the state's total resources. Only two categories of effect are unambiguously real: administrative resources freed from billing and insurance functions, and improvements in health itself.

Transfers drive the distributional results; real resource changes drive the net economic and welfare results. Holding that line, and requiring the linked models described later to pass a simple accounting test — every dollar saved by one party must be traced to whoever bears

or forgoes it (a “sources-and-uses” check), is the framework’s main protection against counting the same gain in more than one channel.

Figure 2. Two kinds of effects — and the risk frame around them



For that reason this paper recommends a layered analytic approach combining fiscal modeling, distributional analysis, macroeconomic modeling, benefit-cost or welfare analysis, and fiscal stress testing. The sections that follow establish the baseline UHP would replace, work through the eight channels, set out a scenario framework, and specify the data, modeling, and monitoring required to support a credible assessment.

The Current-System Baseline: What UHP Would Replace

Any meaningful analysis must begin with a full accounting of how Oregonians already pay for health care, because UHP shifts and reorganizes existing payments more than it creates new ones.

Oregon residents and employers pay through many channels at once. Employers cover premiums for workers and dependents; workers pay their share of premiums plus deductibles, co-pays, and coinsurance; households without job-based coverage pay individual-market premiums or rely on public programs. Governments fund Medicaid, Medicare, ACA subsidies, public-employee benefits, and safety-net services. The cost burden is uneven: nearly 40 percent of Oregon workers currently lack coverage through their job, according to Board materials,[4] while others hold generous employer plans with substantial premium support.

The baseline also includes costs that are easy to overlook. Employers spend staff time and consulting fees selecting and administering benefits. Providers maintain billing, coding, collections, prior-authorization, contracting, and revenue-cycle operations. Insurers, brokers, third-party administrators, and consultants manage plan design, enrollment, claims, networks, and compliance. Households carry medical debt, delay care over cost, and bear uncertainty about future needs. KFF’s research finds health care debt is widespread and

[4] Oregon Universal Health Plan Governance Board, board and focus-group materials, 2025-2026, oregon.gov/uhpgb (including the estimate that roughly 40 percent of Oregon workers lack job-based coverage, and preliminary financing concepts such as a Health Care Personal Income Tax, employer payroll contributions, and global hospital budgets).

unevenly distributed, concentrated among the uninsured, lower-income households, women, Black and Hispanic adults, and parents.[5]

If future analysis compares UHP taxes only to current tax payments, it will overstate the plan's burden and understate the costs already embedded in the system. The correct comparison is total current health-related payments and risks against total future UHP taxes, residual costs, and benefits. A deeper analysis would therefore build a baseline financing model accounting for current payments by payer, household type, employer type, provider category, and level of government, the foundation for all subsequent modeling. That baseline must also be a projection rather than a snapshot: by the early 2030s the status quo itself will have changed, with premiums compounding and H.R. 1's Medicaid reductions adding uninsured residents and uncompensated care. The federal law therefore cuts both ways: it is a first-order risk to UHP's financing (Channel 7) and, at the same time, a deterioration of the system UHP would replace. Comparing UHP against today's system rather than the projected post-H.R. 1 counterfactual would understate the cost of the status quo, the very error this section warns against.

[5] KFF, research on medical debt and health care affordability, kff.org.

Channel 1: Health, Productivity, and Labor Markets

Does better access to care actually show up in the labor market, and how soon?

This channel traces the path from improved access, to better health, to labor-market effects: absenteeism, presenteeism (working while sick at reduced capacity), labor-force participation, disability, early retirement, job mobility, and entrepreneurship. By lowering barriers to preventive, chronic-disease, behavioral-health, prescription, and specialty care, and by decoupling coverage from employment, UHP could also reduce "job lock," the tendency to stay in a job mainly for its benefits. The stakes are real because health is a productive asset: poor health limits work capacity, earnings, and household stability, while better access lets people manage conditions before they become disabling. But improved access does not automatically raise statewide GDP in the short run; the size of any labor-market effect depends on which populations gain access, how much their health improves, whether they are of working age, and whether those gains show up in measurable outcomes.

The evidence linking coverage to access and financial protection is strong. National Academies work finds ACA expansions improved both, while persistent inequities remained,[6] and Oregon's own Medicaid lottery study, the Oregon Health Insurance Experiment, found coverage increased care use, improved self-reported health, and reduced financial strain, even where short-term physical-health effects were more mixed.[7]

Most of that evidence, however, concerns people gaining coverage for the first time. The large majority of Oregonians are already insured; for them, UHP mainly changes how much they pay when they use care and how the system is financed, not whether they are covered, and the RAND Health Insurance Experiment and the broader cost-sharing literature are the more relevant guides to that response. What remains genuinely uncertain is not whether better access has value but how much of that value becomes measurable statewide labor-market gain.

Welfare can rise substantially without a large near-term GDP signal: better behavioral-health access may avert crises before it changes wages, and lower medical debt may stabilize households without registering in output. The analysis should also separate working-age access gains from gains for children, seniors, people with disabilities, and others outside the labor force, all valuable, but on different economic pathways.

---

[6] National Academies of Sciences, Engineering, and Medicine, Ending Unequal Treatment: Strategies to Achieve Equitable Health Care and Optimal Health for All (Washington, DC: National Academies Press, 2024), doi:10.17226/27820.

[7] Katherine Baicker et al., "The Oregon Experiment - Effects of Medicaid on Clinical Outcomes," New England Journal of Medicine 368, no. 18 (2013): 1713-1722; and Amy Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," Quarterly Journal of Economics 127, no. 3 (2012): 1057-1106.

The Analysis Ahead

The question here is causal and dynamic: how much does broader, more stable coverage change what people can do in the labor market, and how quickly? Answering it means identifying the populations most likely to gain access, mapping them to measurable outcomes (absenteeism, presenteeism, disability claims, labor-force participation, job changes, self-employment, retirement timing, and wages), and estimating the time horizons over which each would appear. Much of the method is accounting discipline: deciding in advance which effects belong in macroeconomic modeling and which belong in benefit-cost or welfare analysis, so that health gains that never pass through GDP are still counted.

The results would most likely show gains that are real but modest and that build over years rather than arriving as a single jump, concentrated among previously uninsured and underinsured workers, with some effects such as reduced job lock and easier entrepreneurship appearing as changes in the composition of work rather than its level. The central difficulty is attribution and timing. Health, employment, and wages move together for many reasons, so isolating UHP's contribution requires a careful picture of what would have happened without the plan; benefits accrue over years while budgets are annual; and the most important outcomes are the hardest to measure, since better health that prevents a hospitalization can register in conventional statistics as lower output even as it makes people better off.



Channel 2: Household Disposable Income and Financial Security

After the taxes and the savings net out, which households are net beneficiaries and which are net contributors, and whose financial risk falls regardless?

At its core this channel asks how UHP changes household finances once premiums, deductibles, co-pays, coinsurance, and out-of-pocket costs are replaced or reduced by tax financing. The decisive metric is not the change in taxes alone but the net change in total health-related payments and financial risk. That distinction matters because household financial security is itself an economic outcome: lower out-of-pocket exposure and more predictable costs improve balance sheets and can lift disposable income, particularly for lower- and middle-income households, which are more likely to spend additional income locally. There is also insurance value not captured by current spending: even households that use little care benefit from reduced exposure to catastrophic costs, a genuine welfare gain that never appears as a market transaction.

Affordability remains a major strain nationally; KFF reports many adults still struggle to afford care and that health debt takes many forms, from collections to credit-card balances to money borrowed from family,[8] and coverage expansions generally improve financial security; the Oregon experiment specifically found reduced financial strain for newly covered adults. The harder question for Oregon is distributional, and it hinges on the final financing design and exactly which payments are replaced. Higher-income households may pay more under progressive financing; middle-income outcomes will vary with current employer coverage, family size, health status, and contributions; and Medicare, Medicaid, self-employed, and high-need households each warrant separate treatment. A further wrinkle is how to treat employer-paid premiums: economists view them as part of total compensation, but households rarely experience them as direct out-of-pocket payments the way they experience taxes.

The Analysis Ahead

This is fundamentally a distributional question: not whether households pay more or less on average, but which households are net beneficiaries and which are net contributors, and how their exposure to financial risk changes. The natural tool is a household microsimulation model, which builds statewide answers from thousands of representative households one at a time, comparing each household's current health-related payments, including premiums, cost-sharing, and out-of-pocket spending, with its projected obligations and residual costs

[8] KFF, Health Care Debt in the U.S.: The Broad Consequences of Medical and Dental Bills (KFF Health Care Debt Survey, June 2022), kff.org. The survey measures health care debt broadly, including payment plans, credit-card balances, bank loans, and money borrowed from family and friends.

under UHP, built up from income, household size, age, insurance status, geography, utilization, and tax liability. The microsimulation should share its incidence assumptions with the employer analysis in Channel 3, so that employer premiums and payroll taxes are attributed to households on a consistent basis.

Reported well, the results would show both central tendencies and the full distribution: net beneficiaries and net contributors, the income ranges where the crossover occurs, and, importantly, the households whose financial risk falls even when their expected annual cost is roughly unchanged, because insurance value accrues to people who do not happen to fall ill in a given year. The difficulty is that being better off is more than a change in average spending. Capturing reduced medical debt, protection from catastrophic costs, and the value of predictability means modeling variance and tail risk rather than means alone, and the answer is sensitive to assumptions about utilization and to tax parameters that are still being set.

Channel 3: Employer Costs and Business Competitiveness

Which firms see costs fall, which see them rise, and where do the savings actually go?

This channel examines how replacing employer-sponsored benefit costs with public financing affects firms, and how those cost changes flow into wages, prices, profits, hiring, investment, entrepreneurship, and location decisions. Because health benefits are a large component of labor compensation, the stakes are substantial: UHP could cut cost volatility and administrative burden for firms that currently offer generous coverage, while imposing a new explicit cost on firms that offer little or none. The distribution across firms matters more than the statewide average; a roughly flat average can conceal large savings for some employers and large increases for others.

Oregon's draft working proposal makes that distribution concrete. Under the financing package now being prepared for legislative review, employers would contribute mainly through an Employer Payroll Tax (EPT) of 9.6 percent on firmwide payroll above a $500,000 threshold, by design the single largest instrument in the package, roughly half of all UHP gross revenue, and structured as a generally applicable levy to limit ERISA exposure, alongside smaller dedicated surcharges on the Corporate Income/Excise Tax (3.0 points on income above $1 million) and the Corporate Activity Tax (0.10 point).[9] Preliminary Legislative Revenue Office estimates place 2032 EPT liability near $15 billion.

The package is deliberately designed as replacement rather than net-new burden: in the committee's 2022 calibration, every employer class pays less in aggregate than under the status quo: private employers about $0.42 billion lower, state and local government employers about $0.14 billion lower, and federal employers about $0.17 billion lower, because a standardized payroll contribution replaces today's fragmented employer-sponsored insurance (ESI) spending.[10]

Two readings of those calibration figures should be kept apart: they describe legal liability, not economic incidence — in plain terms, who writes the check, not whose pocket the money ultimately comes from. Because economists generally expect both ESI premiums and payroll taxes to be borne largely by workers through wages over time, the employer-class comparisons here and the household analysis in Channel 2 must rest on a single, consistent

[9] Morgan Shook and Megan Waldo, ECOnorthwest, "Proposal Comparison to LRO Revisions and Estimates," memorandum to the Universal Health Plan Governance Board, June 6, 2026. Rate and threshold parameters reflect the Finance & Revenue Committee framework (2022 dollars) as reviewed by the Legislative Revenue Office; 2032 figures are preliminary, static liability estimates that do not incorporate behavioral or macroeconomic response.

[10] ECOnorthwest, "Illustrative Household Typologies and Case Studies" (status-quo-versus-proposal payer-class comparison and Oregon employer-sponsored-insurance context), 2026. Status-quo-versus-proposal differences use the model's 2022-dollar calibration.

set of incidence assumptions; run on different bases, they can appear to show every party gaining at once.

That ESI spending is precisely the patchwork the EPT would replace, and in Oregon it is highly uneven: average employer-sponsored single premiums ran about $7,000 per worker in 2022 but varied sharply by industry and firm size, and many smaller firms offered no coverage at all, a pattern that mirrors national data showing employer family premiums reaching $26,993 in 2025.[11] RAND's Oregon modeling similarly found a single-payer option would redistribute financing while leaving total system costs roughly unchanged.[12] What remains uncertain is how the effects land firm by firm.

The EPT would sit atop Oregon payroll taxes that already total roughly 3.6 percent, and the firm-level $500,000 threshold creates an incentive to restructure beneath it, which is why reviewers recommend borrowing the Paid Leave program's established employer definition. The companion Health Care Personal Income Tax would also push the top combined marginal income-tax rate for a high earner in Portland toward 25 percent, a competitiveness concern likely to surface in debate even though the package's EPT credit and overall payment reorganization are meant to offset it. And because the 2032 figures are static liability estimates, the eventual incidence (how much employers pass through to wages, prices, or profits) is still unmodeled.

The Analysis Ahead

The question is how net cost shifts across firms — which see health-related costs fall and which see them rise — and where the money ultimately goes. The analysis would compare current employer coverage spending with proposed Employer Payroll Tax and add-on liability, modeled by industry, firm size, wage level, labor intensity, unionization, full- and part-time mix, current coverage posture, and exposure to interstate competition, then test alternative assumptions about how the cost is passed through to wages, prices, or profits. It would benchmark Oregon's combined labor-and-tax cost against peer states, with particular attention to Washington across the Portland-Vancouver border, and evaluate the tiered-EPT options under discussion, including differentiation by firm size and by public versus private status.

Because the package is designed to replace employer coverage spending rather than add to it, the aggregate result is likely to be close to a wash, but with wide variation beneath the average: firms that offer generous coverage today may save, while low-wage firms that offer little may face a new net cost. The hard part is incidence. Economists generally expect payroll taxes to fall on wages over time, but the pace and completeness of that pass-through

[11] KFF, 2025 Employer Health Benefits Survey (October 2025): average annual family premium $26,993, with workers contributing an average of $6,850 toward family coverage.
[12] Chapin White et al., A Comprehensive Assessment of Four Options for Financing Health Care Delivery in Oregon (Santa Monica, CA: RAND Corporation, RR-1662-OHA, 2017).



are uncertain, behavioral responses such as restructuring around the firm-size threshold are difficult to predict, and competitiveness effects turn on how much weight mobile employers actually place on a single cost among many.

Channel 4: Administrative Simplification and Workforce Transition

How much overhead can the system shed, and what happens to the people who do that work today?

This channel asks whether UHP reduces the administrative cost of a multi-payer system (plan administration, billing, claims, prior authorization, eligibility, revenue-cycle management, brokerage, compliance, benefits administration) and how those reductions affect the workers and firms that perform them. Administrative simplification is one of the largest potential sources of system savings; reducing duplicative billing and insurance functions could redirect resources toward care, wages, investment, or public savings. But those same functions support jobs and businesses, so simplification carries a workforce-transition obligation. The real question is not how many administrative dollars could be removed, but which functions disappear, which move to the state, which remain with providers, and what happens to displaced workers.

U.S. administrative costs are high: published estimates put administrative expense at roughly 15-25 percent of national health spending, with billing, coding, physician administrative work, and insurance administration the main drivers,[13] and one analysis estimated administrative simplification could save on the order of $265 billion annually, about a quarter of administrative spending, without a full single-payer transition.[14] Simulation modeling of billing- and insurance-related costs suggests they could fall substantially under single-payer designs, though estimates vary widely with assumptions.[15]

Oregon's financing work now puts specific numbers on these savings rather than leaving them open. The expenditure estimates underlying the proposal already net out provider administrative simplification and improved collectability, lowering Milliman's 2032 best-estimate spending from roughly $85.5 billion to $77.7 billion. The Revenue Replacement Target then assumes payer administrative costs fall from 6 percent to 3 percent of spending, trimming a further $2.5 billion or so at the best estimate, and an enhanced-savings scenario layers on about 1.5 percent from unified prescription-drug purchasing and 1.0 percent from fraud, waste, and abuse prevention. Together these assumptions help bring the 2032 Revenue Replacement Target into a roughly $30-to-$36 billion range, with a central estimate

[13] William H. Shrank, Teresa L. Rogstad, and Natasha Parekh, "Waste in the US Health Care System: Estimated Costs and Potential for Savings," JAMA 322, no. 15 (2019): 1501-1509; see also the JAMA Viewpoint series on administrative expense, JAMA 326, no. 17 (2021).
[14] Nikhil R. Sahni, Brandon Carrus, and David M. Cutler, "Administrative Simplification and the Potential for Saving a Quarter-Trillion Dollars in Health Care," JAMA 326, no. 17 (2021): 1677-1678.
[15] David Scheinker, Barak D. Richman, Arnold Milstein, and Kevin A. Schulman, "Reducing administrative costs in US health care: Assessing single payer and its alternatives," Health Services Research 56, no. 4 (2021): 615-625.



near $32 billion.[16] The single, statewide payer would itself strip out much of the benefits-administration and brokerage activity that employers and insurers fund today, concentrating both the savings and the workforce transition.

The scale of what would be reorganized is easy to understate. Health care is one of Oregon's largest economic sectors. An ECOnorthwest analysis of 2024 data using IMPLAN (an economic modeling platform) finds it directly employs about 358,000 people, roughly 13 percent of all Oregon jobs, and once the supply-chain and worker-spending activity it supports is included, sustains about 546,000 jobs (near 20 percent of statewide employment), $57.8 billion in value added (about 17 percent of gross state product), and $94 billion in output.[17] Tables 1 and 2 summarize that footprint.

Table 1. Economic contribution of Oregon's health care sector, 2024

Contribution	Employment (jobs)	Labor income ($B)	Value added ($B)	Output ($B)
Direct	357,700	28.2	35.7	56.3
Indirect	93,700	7.0	10.8	19.4
Induced	95,000	5.4	11.4	18.2
Total (with multipliers)	**546,400**	**40.6**	**57.8**	**94.0**

Source: ECOnorthwest analysis using IMPLAN, 2024 data. Dollars in 2024 nominal terms. Totals include direct plus indirect and induced (multiplier) effects.

Table 2. Health care as a share of the Oregon economy, 2024

Measure	Direct	Including multiplier effects
Employment	13.0%	19.9%
Labor income	13.4%	19.2%
Value added (≈ GDP)	10.7%	17.4%
Output	9.6%	16.0%

Source: ECOnorthwest analysis using IMPLAN, 2024 data. Shares are relative to statewide totals of about 2.74 million jobs, $211 billion in labor income, $333 billion in value added, and $586 billion in output.

[16] UHPGB Staff and ECOnorthwest, "Preliminary Revenue Replacement Target Scenarios and Revenue Allocation Framework," memorandum to the Legislative Revenue Office, June 24, 2026. Expenditure figures derive from Milliman estimates as adjusted by UHPGB staff; the administrative-savings assumptions and the $30-36 billion Revenue Replacement Target range are preliminary planning scenarios.

[17] ECOnorthwest analysis using IMPLAN (2024 data, the latest available), State of Oregon. Health care is defined as NAICS 621 (ambulatory care), 622 (hospitals), 623 (nursing and residential care), 624 (social assistance), and 524114 (direct health and medical insurance carriers). Totals include direct, indirect, and induced (multiplier) effects; shares are measured against statewide 2024 totals of about 2.74 million jobs, $211 billion in labor income, $333 billion in value added, and $586 billion in output.

Because the base is this large, even modest percentage changes produce large absolute effects. The payer-administration reduction alone (from 6 to 3 percent of spending) removes billions of dollars of activity, and the sector's multipliers (roughly 1.5 jobs supported statewide for every direct health-care job, and about $1.6 of value added for every direct dollar) mean those reductions do not stay contained: they ripple through suppliers and the household spending of affected workers, just as dollars redirected to care or returned to households generate offsetting activity elsewhere. The insurance and billing functions most exposed to simplification sit squarely inside this footprint, which is what makes the workforce-transition question consequential rather than marginal. One caution applies in using these figures: they are gross-contribution multipliers, which hold prices fixed and assume no reallocation. They describe the sector's footprint, not the net statewide effect of shrinking one part of it while redirecting the dollars elsewhere; net effects require the price- and behavior-sensitive modeling described in the scenario section.

These are planning assumptions, not realized results. Not all functions vanish: some shift to a state UHP agency, and many remain necessary for oversight, fraud prevention, eligibility, claims, payment, data systems, grievances, and care management. Provider-side burden should fall, but by how much depends on benefit design, payment method, and administrative rules, and the workforce effect is likewise uncertain: workers in insurance, billing, brokerage, consulting, and revenue-cycle roles may be displaced even as others move into public administration, navigation, care coordination, data, or provider support.

The Analysis Ahead

Two questions run in parallel here: how much administrative cost the system can actually shed, and what happens to the people and firms whose livelihoods depend on that work. The analysis would map administrative functions across insurers, providers, employers, brokers, third-party administrators, and public agencies; estimate the spending and employment tied to each; and classify every function as eliminated, reduced, retained, or shifted to a public agency. It would pressure-test the proposal's own savings assumptions, namely the move from 6 to 3 percent payer administration, the provider-simplification and collectability gains, and the prescription-drug and fraud-prevention savings, against the realized experience of existing single-payer systems, and trace the transition through the sector's employment and output multipliers documented earlier in this channel.

The results would likely confirm meaningful gross savings but a smaller net figure, since some administrative work migrates to the state rather than disappearing, and would locate a concentrated set of affected occupations and communities that any transition plan must address. The challenge is that administrative savings are easier to project than to realize: they depend on execution, benefit design, and payment rules that are not yet settled; the jobs lost and the jobs created differ in skills, location, and pay; and the timing of savings and of workforce disruption may not align, which is why retraining, placement, and phased implementation belong inside the analysis rather than after it.



Channel 5: Provider Payment, Utilization, and System Capacity

Once cost is no longer the barrier, can residents actually get the care they're now entitled to?

This channel turns on whether expanded financial access becomes timely, practical access, taking in payment rates, utilization, provider participation, wait times, workforce supply, rural sustainability, behavioral-health capacity, and hospital finances. Coverage does not create appointment slots, specialists, clinicians, or hospital beds, so if residents are covered but cannot get timely care, the health and productivity benefits shrink. Payment rates set too low can drive providers to reduce participation, delay investment, or fall into distress, while rates set too high strain the plan's finances. Providers are also major employers and economic anchors, especially in rural communities, so payment and utilization changes ripple into local employment, wages, and access to essential services.

RAND's Oregon analysis found a single-payer option would raise enrollment and cut financial barriers but flagged possible system congestion and lower aggregate provider reimbursement, and more broadly, access depends not only on coverage but on provider availability, transportation, and other practical barriers, as frameworks like Healthy People 2030 emphasize.[18] The scale and composition of new utilization are unclear: some will be high-value care that improves health and averts downstream cost, some will be one-time pent-up demand during transition, and some may raise spending without proportional health gain. Economists call that last pattern moral hazard: when care costs little or nothing at the point of use, people use more of it, including some care of limited health value, as the RAND Health Insurance Experiment documented. The Oregon experiment's finding that emergency-department use rose among the newly covered is a further caution that new coverage changes the mix of utilization, not just its level. Provider responses to payment rates are equally uncertain and will vary by payer mix, cost structure, workforce constraints, and financial position across hospitals, specialists, behavioral-health, rural, and safety-net providers.

The Analysis Ahead

The question is whether expanded coverage becomes timely, usable care, which turns on utilization, payment rates, and capacity together. The analysis would estimate how utilization changes by population, geography, and service category (primary, specialty, behavioral health, dental, hospital, pharmacy, and long-term care, as relevant to the benefit design), and model payment-rate and provider-participation scenarios, including the global hospital

[18] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, Healthy People 2030: Access to Health Services, health.gov.

budgets the Board has been exploring. Alongside demand it would assess supply: whether Oregon's clinical workforce and physical capacity can absorb new use, and where the binding constraints sit.

The likely finding is a surge in use that is partly durable improvement and partly one-time pent-up demand, unevenly distributed, with rural and behavioral-health capacity the first places strain appears. The difficulty is that access is not created by coverage alone; it depends on appointment slots, clinicians, and beds that take years to expand. Payment rates cut both ways, since rates set too low can drive providers out while rates set too high strain the plan's finances, and separating high-value care that averts later cost from care that raises spending without improving health is central and hard, because both appear at first simply as more utilization.

Channel 6: Tax Design, Revenue Stability, and Migration

If the taxes replace today's spending in aggregate, does it matter that who pays shifts sharply toward the top?

This channel evaluates UHP's financing structure: incidence, progressivity, volatility, taxpayer concentration, business-cycle sensitivity, income shifting, avoidance, and the possibility of health-related in-migration if Oregon's coverage is more generous than its neighbors'. Its defining feature is a deliberate gap between aggregate and distribution: the package is engineered to replace today's health spending in aggregate (a reorganization rather than a net-new burden, in which every payer class contributes less than under the status quo in the 2022 calibration) while changing markedly who pays. The Health Care Personal Income Tax is steeply progressive (higher incomes pay a larger share of income, not just more dollars), the Employer Payroll Tax carries a small-firm threshold and an offsetting credit, and Medicare and federal-poverty-level provisions shield lower-income and Medicare households. Aggregate near-neutrality paired with a large distributional shift is what makes this a tax-policy question, not just a revenue-sizing exercise.

A sound way to weigh that shift is against the criteria commonly used to judge state tax systems. These principles are rarely all satisfied at once, strengthening one often weakens another, and UHP's progressivity sharpens several of the tensions.[19] Table 3 summarizes how the package fares against each.

Table 3. Evaluating the UHP financing package against standard tax-policy criteria

Principle	What it asks	Consideration under UHP
Adequacy	Raise enough revenue, and grow with the economy	Sized to replace current spending, but health costs may outpace revenue growth (see Channel 7)
Stability	Withstand short-term economic fluctuations	Leans on progressive income and business-income bases that are more volatile in downturns
Economic vitality & harmony	Avoid pushing activity out of state; limit double taxation and cross-border shifting	~25% top combined marginal rate; Portland-Vancouver border mobility

[19] The evaluation criteria in Table 3 follow the tax principles and taxpayer perspectives set out in Washington State Tax Structure Work Group, Preliminary Report: Results of Economic Analyses (December 2020), "Common Principles of Tax Policy," prepared for the Washington State Legislature by the Department of Revenue, dor.wa.gov; applied here to the UHP financing package.

Principle	What it asks	Consideration under UHP
Vertical equity	Greater ability to pay means paying more	The central design choice; steeply progressive (top 0.5% ≈ a quarter of HCPIT liability)
Horizontal equity	Similar ability to pay means similar tax	Wage earners vs. the self-employed; firms with vs. without current coverage
Transparency & simplicity	Clear and simple to comply with and enforce	New parameters (e.g., federal poverty level) across several instruments add complexity
Neutrality & efficiency	Avoid distorting economic decisions	Firm-size threshold and filing-status provisions create avoidance incentives

Criteria are standard public-finance principles applied to the UHP package.

On vertical equity the package is unusually strong by design: liability rises steeply with income, and the Legislative Revenue Office's review found the top 0.5 percent of taxpayers, those above $1 million in income, would account for roughly a quarter of all Health Care Personal Income Tax liability.[20] That is the intended reallocation, moving away from premiums and out-of-pocket costs, which fall heaviest on lower- and middle-income households, toward income-based contributions. The trade-off is concentration: leaning on high earners advances ability-to-pay but ties a large share of revenue to the most mobile and most cyclically variable incomes, a stability concern taken up in Channel 7.

Those same choices press on the other principles. Economic vitality and harmony with neighboring states is the most visible tension: layered on existing taxes, the income tax would push the top combined marginal rate for a high earner in Portland toward 25 percent, directly across the river from no-income-tax Washington, raising questions about residency and income-shifting at the Portland-Vancouver border. Neutrality is tested by the Employer Payroll Tax's firm-level threshold, which rewards restructuring beneath it, and by household-size provisions that can reward married couples for filing separately.

Horizontal-equity questions arise where similarly situated taxpayers are treated differently: wage earners versus the self-employed, or firms that currently offer coverage versus those that do not. And transparency and administrative simplicity are strained by introducing parameters new to Oregon's income tax, such as federal-poverty-level thresholds, across several instruments at once. The size of the behavioral responses is genuinely uncertain: CBO's single-payer modeling shows design and behavioral response can move

[20] Distributional and marginal-rate figures for the Health Care Personal Income Tax are drawn from the Legislative Revenue Office review summarized in Shook and Waldo, ECOnorthwest, "Proposal Comparison to LRO Revisions and Estimates" (June 6, 2026).

macroeconomic results from modestly negative to modestly positive,[21] and the tax-migration literature finds real but variable responses that scale with taxpayer type, mobility, and the size of the differential. The Board need not assume large migration; it should test how much response would be needed to threaten stability.

Behavioral response also has an efficiency dimension that Table 3 only gestures at: when a tax changes behavior — an hour not worked, an expansion not made, income reported differently — the value of that forgone activity is a real economic loss over and above the revenue collected (what economists call deadweight loss, or excess burden), and those responses arise well before anyone moves. That efficiency cost is a real cost of the financing and belongs in the benefit-cost analysis, set against the real resource savings the plan claims elsewhere.

Taxpayer psychology cuts more than one way here. A dedicated health tax funds a benefit residents can see, a strong tax-benefit linkage that can aid political feasibility even as it sits uneasily with the preference for taxes that go barely noticed; payroll withholding and income-tax installments spread the cost rather than presenting one large, salient bill; and because health coverage is not discretionary, these are not taxes households can escape by changing what they buy. Each shapes how the same dollar of tax is perceived, independent of its economic incidence.

The Analysis Ahead

The question is not only who pays, but whether a deliberately progressive financing structure can be stable and neutral enough to hold up in practice. The analysis would estimate both the legal and the economic incidence of the full package, that is, who remits each tax and who ultimately bears it, and compare that with the premiums and out-of-pocket costs it replaces, reporting the resulting distribution by income, household type, and employment status. It would score the design against each principle in Table 3, model the sensitivity of the most mobile taxpayers to migration and income-shifting, and test specific avoidance channels such as the firm-size threshold and the choice of filing status. It would also estimate the marginal excess burden of each instrument, so the efficiency cost of the financing carries into the benefit-cost and welfare analysis.

The expected picture is a clear gain in vertical equity, with low- and middle-income households paying less and high earners paying more, bought at some cost to stability and neutrality, because revenue concentrated at the top is both more volatile and more mobile. The hard questions are behavioral. Migration and income-shifting responses are real but variable and notoriously difficult to predict, especially for a structural change rather than a marginal rate adjustment; the Portland-Vancouver border sharpens the stakes; and the same

[21] Congressional Budget Office, Economic Effects of Five Illustrative Single-Payer Health Care Systems (February 2022), cbo.gov/publication/57637.

progressivity the Board wants for fairness feeds directly into the revenue-volatility problem taken up in the next channel.

Channel 7: Public-Finance Stability and Risk Management

Can the state carry this financing risk through a recession, and through a shrinking federal contribution?

This channel concerns the fiscal responsibility the state would assume under UHP: federal-funding assumptions, revenue timing, expenditure and medical-cost growth, utilization risk, recession exposure, reserve policy, cash-flow management, recapitalization triggers, and fiscal governance. Today that risk is spread across households, employers, insurers, providers, and federal and state government; under UHP, Oregon takes on a far larger coordinating and financing role.

Two tax-policy principles bear directly on whether that role is sustainable. Adequacy asks that a revenue system raise enough and grow at a pace similar to the economy; stability asks that it withstand short-term fluctuations. UHP tests both. Health costs are large and have historically grown faster than the broader economy, so a base that grows only with the economy can structurally lag expenditures; and revenues from income, payroll, and business taxes move with the business cycle. Misalignment creates real risk: with inadequate reserves, a downturn could force tax increases, benefit cuts, lower provider payments, delayed payments, or emergency legislative action, whereas strong fiscal governance can absorb shocks and support long-term stability.

The progressivity that makes the financing package strong on vertical equity carries a fiscal cost here. Revenue concentrated on high incomes and business profits is more cyclically volatile than a broad, flat base: it climbs quickly in expansions and drops sharply in downturns, precisely when health needs hold steady or rise. The feature that advances ability-to-pay therefore raises the premium on reserves, stabilization funds, and rate structures that can be adjusted to expenditure growth, making the stability tools in this channel more important, not less, the more progressive the tax design becomes.

National health spending continues to grow, sustaining cost pressure on households, employers, and budgets, and CBO's single-payer work stresses that assumptions about utilization, provider payment, administrative costs, and financing materially drive fiscal outcomes.[22] The most consequential recent development is federal: the reconciliation law H.R. 1, signed July 4, 2025, reduces federal Medicaid funding by roughly $1 trillion over ten years, with large projected coverage losses nationally. Because UHP's financing assumes substantial redirected federal funds, this is no longer a background assumption but a first-order risk that must be modeled explicitly: reduced federal match, waiver constraints, and

[22] Congressional Budget Office, How CBO Analyzes the Costs of Proposals for Single-Payer Health Care Systems That Are Based on Medicare's Fee-for-Service Program, Working Paper 2020-08 (December 2020), cbo.gov/publication/56811.

the interaction with Oregon's net revenue requirement. Beyond the federal picture, the largest uncertainties are how much federal funding can actually be redirected and on what terms, utilization growth, provider payment levels, the pace of administrative savings, and revenue performance; timing mismatches between revenue collection and claims payment can create cash-flow strain, and recessions are especially dangerous because revenues fall while health needs hold steady or rise.

Federal risk is also broader than funding levels. It includes authority risk: whether 1332 and 1115 waivers — the federal permissions Oregon needs to redirect ACA and Medicaid dollars into UHP — are approved and on what terms, whether Medicare can be integrated at all (authority no state has yet been granted), and whether the Employer Payroll Tax's design withstands litigation under ERISA, the federal law that governs employer benefit plans and limits how states may regulate them. These are largely yes-or-no outcomes that change the covered population and the revenue requirement themselves, not dials that can be turned a little at a time, and the scenario framework should treat them accordingly.

The Analysis Ahead

This is a question of resilience rather than of point estimates: can the financing structure meet its obligations through a downturn and through a shrinking federal contribution? The analysis would build a public-finance model that links revenues, expenditures, federal funds, reserves, and cash flow, and run it across a range of expenditure, revenue, and, critically, federal-funding scenarios rather than a single central case. It would test the adequacy gap directly, projecting health-expenditure growth against revenue growth to see whether rates or bases must change over time, and stress-test the revenue base for the added volatility its progressivity implies.

Well constructed, the results would take the form of probabilities and ranges: how large a reserve is needed to weather a typical recession, how quickly a federal funding cut would bind, and which combinations of shocks would force tax increases, benefit cuts, or provider-payment reductions. The core challenge is that the largest risks are external and correlated, since recessions cut revenue at exactly the moment health needs hold or rise, and the July 2025 federal Medicaid reductions have turned a key funding assumption into a moving target. Modeling these shocks together rather than in isolation, and pairing fiscal-stress indicators with pre-specified responses, is what separates a credible plan from an optimistic one.

Channel 8: Equity and Distributional Outcomes

Does universal financing translate into universal access in practice, and who bears the new costs?

This channel examines how costs and benefits are distributed across income, race, ethnicity, geography, age, disability, health status, employment type, current insurance status, and rural and urban communities: covering both financial equity (who pays more or less and who gains cost protection) and access equity (who can actually obtain timely, appropriate care). Equity here is not separate from economic impact: reducing medical debt, financial insecurity, and unmet need produces household- and community-level economic benefits, particularly for lower-income residents, rural communities, people with chronic conditions and disabilities, and communities of color. But universal financing does not by itself resolve provider shortages, language and transportation barriers, cultural access, or rural capacity gaps.

The National Academies' 2024 work finds racial and ethnic inequities in care remain persistent and are shaped by laws, payment and delivery systems, and gaps in data and research, and evidence on medical debt and affordability likewise shows burdens fall unevenly across the population. The Oregon question is whether UHP delivers practical access improvements across all communities: a household may face lower cost-sharing yet still struggle to find a provider, reach appointments, or obtain culturally responsive or behavioral-health care, and the distribution of costs needs equal scrutiny, since some households and employers will be net contributors and others net beneficiaries.

The Analysis Ahead

The question is whether universal financing actually produces universal access, and whether benefits and burdens land fairly across communities. The analysis would combine household distributional modeling with provider-access analysis, utilization and outcomes data, and regional analysis, reporting results by income, race, ethnicity, geography, age, disability, health status, employment type, and insurance status wherever the data allow. Its central move is to separate financial coverage from practical access, using indicators such as affordability, utilization, wait times, provider availability, medical debt, avoidable hospitalization, patient experience, and outcomes.

The results would likely show broad gains in financial protection that are not automatically matched by equal gains in real access, since a household can face lower cost-sharing and still lack a nearby provider, a timely appointment, or culturally responsive and behavioral-health care. The main challenges are data and definition: equity analysis requires disaggregated data that are often thin for the smallest and most affected populations, access

has both a financial and a practical dimension that move differently, and closing the gap between the two usually calls for targeted investment that the financing reform alone does not guarantee.

Scenario-Based Economic, Fiscal, and Welfare Analysis

The future channel analyses should be integrated through scenarios rather than collapsed into a single GDP figure. A complete assessment combines fiscal modeling, distributional analysis, macroeconomic modeling, benefit-cost analysis, and fiscal stress testing, and reports three distinct kinds of result:

1. **Market outcomes**: GDP, employment, wages, business output, household spending, industry composition.
2. **Distributional outcomes**: who pays more, who pays less, and how effects vary across households, employers, sectors, workers, and regions.
3. **Welfare and non-market outcomes**: improved health, reduced financial risk and medical debt, less job lock, and greater equity.

The distinction matters because some welfare gains appear in GDP as declines: fewer avoidable hospitalizations or lower administrative spending reduce measured output in certain industries while leaving residents better off. The freed resources do not vanish, however: over time they are redeployed to other uses, so the statewide effect is compositional rather than a permanent decline in the level of output, a further reason to report sectoral and statewide results separately.

Scenarios should be structured planning cases that vary the assumptions most likely to drive results (utilization, provider capacity and payment, administrative savings, federal funding, tax behavior, migration, revenue stability, and medical-cost growth) so the Board can see where risk concentrates and which policy levers (phasing, reserves, capacity investment, workforce support, tax design) most change the outcome. Because each scenario bundles several correlated assumptions, the scenarios should be paired with one-way sensitivity analysis that varies each assumption alone, so results can be attributed to specific drivers rather than to the bundle.

Scenario 1: Higher-Risk Implementation

Benefits emerge slowly while fiscal and operational pressures arrive early: higher-than-expected utilization, capacity bottlenecks, slower administrative savings, higher payment needs, limited productivity gains, some tax-base response, and elevated reserve needs. Used to surface downside risks and mitigations, not to assume failure, but to test whether the financing structure holds under strain.

Scenario 2: Managed Transition (core case)

Moderate utilization growth, achievable administrative savings, stable federal funding, manageable capacity issues, limited migration, and a functioning reserve strategy. The primary basis for comparing household, employer, provider, and public-finance impacts and identifying the assumptions most critical to stability.

Scenario 3: High Efficiency

Strong administrative savings, effective capacity planning, improved access to high-value care, limited tax-base response, and measurable productivity gains over time. Used to gauge upside potential and to separate GDP effects from broader resident well-being.

Scenario 4: Fiscal Stress

Recession or revenue underperformance: falling income, payroll, and business-tax revenue; steady or rising health needs; limited federal flexibility (a live risk given H.R. 1); and reserve drawdown. Not an expected case, used to design reserves, fiscal triggers, recapitalization policy, and contingency plans.

Data and Modeling Requirements

A credible analysis requires several linked models, not one. Each rests on establishing the current baseline and then estimating how UHP changes it under each scenario.

- **Baseline health financing.** Current payments by source: employer and employee premiums, individual-market premiums, deductibles, co-pays, out-of-pocket spending, Medicare, Medicaid, ACA subsidies, state health spending, federal funds, uncompensated care, and administrative costs. Purpose: the comparison baseline.
- **Household and distributional.** Representative household data on income, size, age, geography, insurance status, contributions, out-of-pocket spending, utilization, and tax liability. Purpose: who pays less, who pays more, how risk changes, supporting equity analysis by income, race, ethnicity, geography, disability, health, and insurance status where data allow.
- **Employer and business.** Firm size, industry, payroll, wages, current offerings, employer contributions, headcount, part-time/full-time mix, unionization, and interstate exposure. Purpose: compare current benefit costs to proposed employer-side taxes and estimate wage, hiring, price, profit, investment, and competitiveness effects.
- **Provider payment, utilization, and capacity.** Provider revenue, payer mix, reimbursement, utilization by service category, wait times, participation, workforce supply, facility finances, behavioral-health and rural capacity, and capital and workforce needs. Purpose: whether financial access becomes real access.



- **Administrative cost and workforce.** Insurance administration, claims, billing, revenue-cycle, prior authorization, eligibility systems, broker and consultant activity, benefits administration, and related occupations. Purpose: which functions are eliminated, reduced, retained, or shifted, and the workers, wages, occupations, industries, timing, and supports involved.
- **Tax and revenue.** Tax-return data, income distribution, payroll, business and corporate income, commercial-activity data, residency, and historical volatility. Purpose: legal liability, economic incidence, revenue stability, and behavioral response.
- **Federal funding and public finance.** Medicaid, Medicare, ACA subsidies, waiver opportunities and post-H.R. 1 constraints, state health spending, public-employee and local-government costs, and existing financing streams. Purpose: the size and reliability of redirected funding, the net revenue requirement, and federal-approval risk.
- **Migration and behavioral response.** Taxpayer movement, high-income mobility, business formation and relocation, cross-border commuting, income sourcing, remote-work patterns, and in-migration risk. Purpose: whether base erosion could threaten revenue or program costs.
- **Health outcomes and welfare.** Health status, mortality, morbidity, chronic-disease prevalence, behavioral-health outcomes, avoidable hospitalizations, medical debt, financial stress, disability, absenteeism, and quality-of-life measures. Purpose: benefit-cost and welfare analysis alongside traditional economic measures.

The linked toolset would include a baseline financing model, a household distributional model, an employer impact model, a provider utilization and capacity model, an administrative-savings and workforce-transition model, a tax-revenue and incidence model, a macroeconomic model in which prices, wages, and behavior adjust to the policy (a CGE- or REMI-class model; simpler input-output models such as IMPLAN hold prices fixed, which suits the footprint accounting in Channel 4 but cannot capture who ultimately bears a tax or how workers and dollars shift between sectors), a benefit-cost and welfare model, and a public-finance stress-test model. These must share common scenario assumptions (utilization, provider payment, administrative savings, tax behavior, federal funding, and migration) so the same inputs flow consistently through household, employer, provider, macroeconomic, and public-finance results.

Implementation and Monitoring Framework

Because many effects are uncertain, implementation should include monitoring that tracks whether assumptions hold and triggers adjustment when they do not. Monitoring should begin before launch to set baselines and continue afterward.

Indicators should span enrollment, utilization, wait times, provider participation, household costs, medical debt, employer costs, tax collections, revenue volatility, migration, health-sector employment, administrative costs, equity outcomes, and fiscal stability, organized into

leading indicators (enrollment growth, participation, wait times, early collections), annual measures (household costs, utilization, medical debt, administrative costs, provider financial condition), and long-term outcomes (health, labor-force participation, productivity, equity, fiscal sustainability).

Monitoring must connect to governance. If utilization exceeds projections, reserves fall below target, participation declines, or revenues underperform, the governing body should have defined processes to review the issue and recommend adjustments, closing the loop between measurement and decision.

Final Thoughts

The economic effects of Oregon's Universal Health Plan cannot be reduced to a single number. UHP would restructure how care is financed and reach households, employers, providers, workers, public budgets, and the broader economy in different ways.

The plan could generate real benefits: improved access and health, less medical debt, greater household financial security, lower or steadier employer costs, reduced administrative complexity, and a more equitable financing system. None of these is automatic. Each depends on benefit design, provider payment, system capacity, administrative transition, tax design, federal funding, reserve policy, and execution, and the federal funding picture, reshaped by the 2025 reconciliation law, now carries unusual weight.

The strongest analytic approach is therefore channel-based and scenario-based: each channel naming what is known, what is uncertain, and what Oregon-specific analysis is needed; scenarios integrating those assumptions to show how outcomes shift under different conditions. That framework lets the Board evaluate UHP not only by its effects on GDP, employment, and revenue, but by the fuller test of whether Oregonians are better off once health, financial security, equity, and risk reduction are counted.

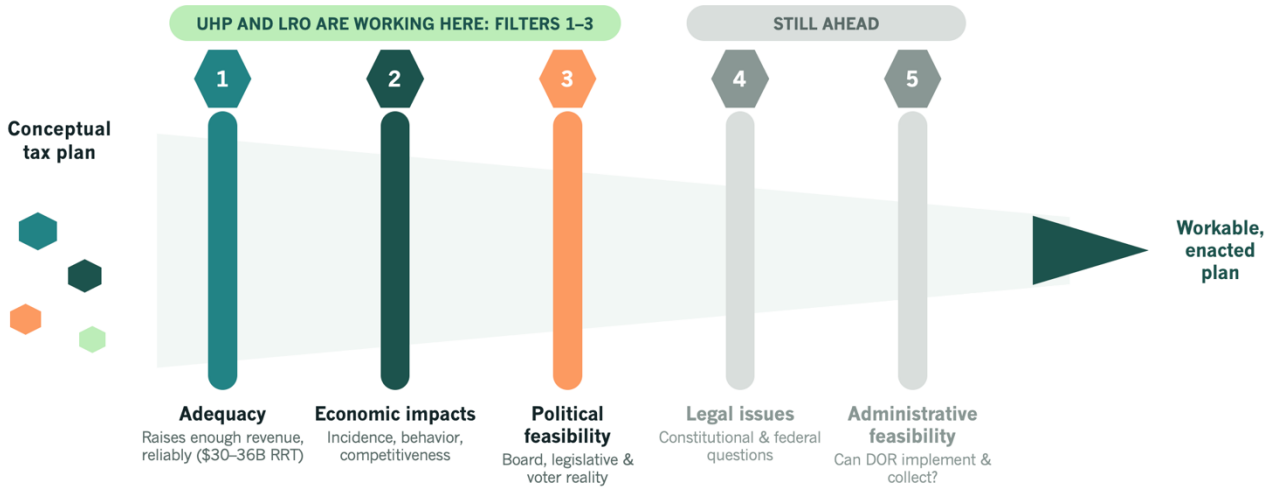
DATE:	July 16, 2026
TO:	Mimi McDonell, UHPGB
FROM:	Morgan Shook, Megan Waldo, ECOnorthwest
SUBJECT:	2032 Revenue Replacement Targets

Purpose

The purpose of this memo is to explain the methods used to translate 2032 Revenue Replacement Targets into a set of high, middle and low required revenue estimates and taxation rates by financing mechanism. These estimates are based on reconciled Milliman cost estimates and preserved federal and state funding streams.

The Finance & Revenue Committee's work is best understood as part of a broader process of refining a conceptual financing framework into a legislative-ready proposal. At each stage, the proposal must satisfy a different set of policy, analytical, and implementation tests before it can become an enacted financing system. The accompanying figure illustrates this progression. The current phase of work is focused primarily on the first three filters:

Framework for Advancing the UHP Financing Proposal



- Revenue adequacy — confirming that the proposed financing package generates sufficient revenue to support the Universal Health Plan under a range of plausible expenditure scenarios.
- Economic impacts — understanding how the financing package affects households, employers, and the broader Oregon economy, including distributional impacts and competitiveness considerations.

- Political feasibility — refining the proposal into a structure that is sufficiently specified to support Board deliberation, legislative review, and public discussion.

This memorandum focuses on these first three areas. In particular, it advances the work by:

- reconciling the emerging Revenue Replacement Target with the updated Milliman expenditure estimates;
- translating those targets into implementation-year revenue requirements by financing mechanism; and

The remaining filters—legal implementation and administrative feasibility—remain important but are not the primary focus of this memorandum. Questions regarding statutory authority, constitutional issues, Department of Revenue administration, and final legislative drafting are expected to be addressed as the proposal continues to mature.

Structure Review

The principal changes from the original 2022 UHP proposal fall into three categories: (1) updated 2032 dollar estimates for the two largest instruments (EPT and HCPIT); (2) methodological refinements reconciled with the F&R 2022 calibration; and (3) administrative and policy considerations that affect both the size of the tax base and the feasibility of implementation through the Department of Revenue (DOR). Exhibit 1 below summarizes the preliminary comparison, the subsections that follow expand on the EPT and HCPIT, where LRO's work has produced the most substantive changes to the structure of the UHP financing mechanisms.

Exhibit 1. UHP Key Considerations for Implementation by Financing Mechanism

Instrument	F&R Proposal (2022$ calibration)	Key Considerations for Implementation
Corporate Income Tax (CIT) Add-On	+3.0% surcharge on existing 7.6% CIT (6.6% rate on first $1M unchanged). ~$608M.	None, methods are structurally aligned.
Corporate Activity Tax (CAT) Add-On	+0.10% on existing 0.57% CAT base. ~$215M.	None, methods are structurally aligned.
Employer Payroll Tax (EPT)	9.6% marginal rate on firmwide payroll above $500,000 threshold (public employers pay on total payroll). ~$8.7B.	Firm definition and anti-avoidance design needs to be addressed (see EPT methods below).

Health Care Personal Income Tax (HCPIT)	10.1% marginal rate on Federal AGI above 200% FPL, with phase-in to 260% FPL, HSRR, 50% EPT credit, and 100% Medicare Part B credit.	FPL threshold design and married filing separately incentive must be further defined (see HCPIT methods below).
Household Size Rate Readjustment (HSRR)	Up to $1,325 per exemption above one, phased in linearly from 260% to 520% FPL.	None, methods are structurally aligned.
Lodging Tax	Increase state lodging tax from 1.5% to 1.7% (+0.20 pp). ~$5M.	Decision needed on whether to retain a UHP add-on or drop the instrument given the updated HB 3141 baseline.

Note: LRO's preliminary 2032 CIT estimate of $660M represents a roughly 8.5% increase over the 2022-calibrated $608M, which is consistent with a decade of nominal income growth. The CAT estimate of $346.5M, however, is approximately 61% above the 2022-calibrated $215M. LRO notes the CAT figure is scaled from 2023 revenue data.

Source: Finance and Revenue Committee, Legislative Revenue Office, ECOnorthwest.

Key Methodology Considerations

Employer Payroll Tax (EPT)

LRO confirms the 9.6% rate and $500,000 firm exemption threshold without modification, and projects 2032 tax-year liability at $15.1 billion. Several design and methodology questions remain open.

- **Estimation methodology.** LRO's EPT estimate is based on Oregon's existing Statewide Transit Tax (STT), which is imposed at 0.1% of wages. Because the proposed EPT rate of 9.6% is 96 times the STT rate applied to the same wage base, LRO scaled the STT revenue forecast accordingly. The STT applies to wages as defined in ORS 316.162, which excludes certain categories of workers, activities, and all self-employment income. The $500,000 per-firm annual payroll exemption is estimated to reduce the effective tax base by approximately 18% relative to the full STT base. As with all LRO estimates in this review, the figure is static: it does not incorporate behavioral response, macroeconomic feedback, or adjustments to the health insurance environment.
- **Firm definition and anti-avoidance.** The EPT exemption applies at the firm level, which creates an incentive for employers near the threshold to restructure to fall below it.

LRO recommends adopting the firm definition used by Oregon's Paid Leave Tax (PLT), which defines an employer based on how businesses file their income taxes and applies the threshold based on number of employees (fewer than 25 employees versus 25 or more). This approach has established administrative precedent and aligns with existing DOR infrastructure. LRO notes, however, that creating additional taxes with varied definitions of applicability is likely to introduce administrative and compliance complexity and recommends that any departure from the PLT definition be weighed carefully against that cost. Other possible definitions include a single physical location; all entities under common ownership (requiring a minimum ownership threshold); or all entities under common ownership that share economic value across business lines (the "unitary" concept used for the corporate income tax). The Board will need to select a definition before legislative drafting.

- **Covered persons and wage base.** The STT applies to work performed in Oregon and to work performed by Oregon residents in other states, but the EPT proposal will need to clarify how several worker populations are treated: nonresidents working in Oregon; Oregon residents working partially or entirely in other states; and workers with multi-state payroll (e.g., construction workers). These coverage questions have direct implications for the size of the tax base and intersect with the parallel question under the HCPIT of how to treat Oregon residents who receive health insurance through a non-Oregon employer (see HCPIT section below). The wage base definition, whether to follow ORS 316.162 or adopt a different scope, should be resolved in conjunction with the covered-persons question.
- **EPT credit reporting on W-2 forms.** The F&R proposal includes a 50% EPT credit against HCPIT liability, which raises the question of whether EPT contributions should be reported on employee W-2 forms to facilitate credit claims. LRO's preliminary view is that this should be administratively feasible, drawing an analogy to the State Transportation Tax, which is currently listed on W-2s. LRO notes it is not deeply familiar with the specific federal coordination or coding requirements and treats this as a secondary item pending further review.

Health Care Personal Income Tax (HCPIT)

LRO confirms the 10.1% rate, the 200%–260% FPL phase-in, the 50% non-refundable EPT credit, and the Medicare Part B credit, and projects 2032 tax-year liability at $9.7 billion, approximately 50% above current personal income tax collections.

- **Estimation methodology.** LRO constructed the HCPIT tax base beginning with adjusted gross income, minus federally taxable Social Security income, tax-exempt federal pension income, and interest earnings on U.S. debt (all three categories are exempt from state income tax under federal law or the Oregon Constitution). Taxpayers qualify for a standard deduction equal to 200% of FPL for their household size, determined at the tax return level. For example, a single taxpayer with two

dependents would have a household size of three. Full tax liability phases in from 200% to 260% FPL. Two non-refundable credits are available: a payroll tax credit equal to 50% of EPT paid for the specific taxpayer, and a credit for Medicare Part B premiums paid during the tax year – these are modeled within the HCPIT estimates. As with the EPT, the estimate is static and does not incorporate behavioral response or macroeconomic feedback. FPL is not an existing personal income tax parameter in Oregon; how it is administered in practice will affect both compliance and the accuracy of future estimates.

- **Distributional concentration and marginal rate implications.** LRO's preliminary distributional analysis shows the HCPIT is highly concentrated among higher-income taxpayers, with effective tax rates rising progressively across income bands. The top 0.5% of taxpayers, those above $1 million in income, are estimated to account for approximately 25% of total HCPIT liability. LRO also flags that the HCPIT, layered on top of existing state and local income taxes, would produce a combined top marginal income tax rate of approximately 25% for a taxpayer in Portland. The Board should be prepared to address this in the legislative context, as it is likely to be raised as a competitiveness and taxpayer behavior concern, even though the F&R framework accounts for this through the EPT credit and the overall reorganization of health care payments.
- **Married filing separately incentive.** Because the HCPIT exemption is tied to FPL thresholds that scale with household size, married couples who file jointly face a higher combined threshold than if they filed as two single filers. This creates a potential incentive to file separately to reduce taxable income. LRO has identified two options to mitigate this:
    - **Formulaic FPL split.** Each spouse's standard deduction would equal 50% of the two-person FPL household size, with incremental amounts added for dependents claimed on the return. This preserves the FPL framework and neutralizes the filing-status incentive for couples without dependents.
    - **Per-person exemption.** The FPL-linked threshold would be replaced with a flat per-person exemption amount. LRO notes this approach would likely understate the exemption for single filers and overstate it for joint filers and those with dependents relative to the FPL benchmark, introducing a different set of distributional tradeoffs.

LRO also notes that the decision about which option to adopt could be deferred, recognizing that taxpayers' choice of filing status reflects multiple considerations beyond the HCPIT alone. The Board should weigh whether to resolve this before legislative drafting or flag it as a known implementation issue to be addressed in rulemaking.

- **Non-residents and out-of-state workers.** LRO's HCPIT estimates exclude non-resident taxpayers. If non-residents working in Oregon will qualify for UHP coverage, they may

need to be included in the tax base, which would increase the liability estimate. Separately, the treatment of Oregon residents who work in another state and receive health insurance through a non-Oregon employer is unresolved. This question is closely connected to the covered-persons question under the EPT: in both cases, the policy intent regarding coverage eligibility should drive the tax base definition, and the two instruments should be designed consistently.

Corporate Income Tax (CIT) and Corporate Activity Tax (CAT)

Unlike the EPT and HCPIT, LRO did not independently model the CIT and CAT tax bases during its review. Estimates are based on fixed allocation shares.

- **Estimation methodology.** LRO estimates both instruments proportionally rather than through an independent tax-base analysis: it applies the F&R Committee's fixed allocation shares (3.8% for CIT and 1.3% for CAT) directly to each Revenue Replacement Target scenario to produce the dollar and rate figures shown later in this memo.

2032 UHP Expenditure Scenarios

The Milliman actuarial analysis provides the basis for estimating the total cost of operating the Universal Health Plan in 2032. These estimates represent the gross cost of providing covered health care services before accounting for existing federal and state funding that is expected to continue supporting the program.

Milliman presents two related expenditure estimates. Figure 53 reports total projected claims expenditures under low, best-estimate, and high scenarios. Figure 50 incorporates additional savings associated with provider administrative simplification and improved collectability that are expected under a unified financing system. Because these efficiencies represent expected characteristics of the proposed UHP, the revised Figure 50 estimates provide the more appropriate starting point for estimating the Revenue Replacement Target.

Milliman also confirmed the scope of long-term services and supports (LTSS) included in the analysis. The expenditure estimates exclude Medicaid-funded LTSS administered through Oregon DHS's Aging and People with Disabilities (APD) and Intellectual and Developmental Disabilities (I/DD) programs, including nursing facility services and home- and community-based waiver services. However, post-acute LTSS financed through Medicare and private insurance remain within the expenditure estimates, consistent with the UHP benefit design.

For reference, Exhibit 2 below summarizes Figure 53 from the Milliman report with the following total 2032 UHP expenditure estimates based on projected claims:

Exhibit 2. Oregon UHP 2032 Milliman Expenditure Projections ($ Billions)

SCENARIO	2032 EXPENDITURES
Low	$77.4 B
Best Estimate	$85.5 B
High	$94.0 B

Source: Milliman Report, "Expenditure Analysis for the Oregon Universal Health Plan," Figure 53, April 3, 2026.

After incorporating provider administrative and collectability savings, Figure 50 shows the following revised expenditure estimates, which serve as the basis for the Revenue Replacement Target analysis presented in this memorandum. For reference, Figure 50 has been summarized in Exhibit 3 below.

Exhibit 3. Oregon UHP 2032 Expenditure Estimates Accounting for Provider Reimbursement Opportunities ($ Billions)

SCENARIO	REVISED EXPENDITURES
Low	$69.4 B
Best Estimate	$77.7 B
High	$86.5 B

Source: Milliman Report, "Expenditure Analysis for the Oregon Universal Health Plan," Figure 50, April 3, 2026.

The next step is to estimate the portion of these expenditures that will continue to be financed through existing federal and state funding streams—including Medicare, Medicaid, ACA waiver funding, behavioral health funding, and other preserved public expenditures. Subtracting these preserved funding sources from total UHP expenditures produces the Revenue Replacement Target, or the amount of new revenue that must be generated through the Board's proposed financing package.

2032 UHP Revenue Replacement Target Scenarios

To estimate the Revenue Replacement Target (RRT), existing federal and state funding sources that are expected to continue supporting the UHP must be removed from total expenditures.

Federal and State Contributions

Figure 43 in the Milliman report identifies approximately $28.5 billion in 2026 federal and state funding that would continue to support the UHP. Key estimates derived from Figure 43 are summarized in Exhibit 4 below.

Exhibit 4. Oregon UHP Best Estimate and Estimated CMS Waiver Collection

FUNDING SOURCE	2026 AMOUNT
CMS Waiver Funding (Individual, Medicaid, Medicare)	$23.4 B
State General Fund Medicaid Contribution	$4.3 B
Behavioral Health Funding	$0.8 B
Total Federal and State Funding	**$28.5 B**

Source: Milliman Report, "Expenditure Analysis for the Oregon Universal Health Plan," Figure 43, April 3, 2026.

Assuming annual growth of 5.3 percent (current rate of growth of health care expenditures per capita), these funding sources increase to approximately $38.9 billion by 2032. Adding an estimated $0.8 billion state contribution for Medicaid dental benefits results in a total 2032 federal and state contribution of approximately $39.7 billion.

Best Estimate Scenario

Starting with Milliman's revised best estimate of $77.7 billion and assuming additional savings from reducing payer administrative costs from 6 percent to 3 percent yields an adjusted expenditure estimate of approximately $75.2 billion. A summary of the values per calculation step are summarized in Exhibit 5 below.

Exhibit 5. Best Estimate Scenario Calculations

CALCULATION	AMOUNT
Adjusted Best Estimate Expenditures	$75.2 B
Less Federal and State Contributions	($39.7 B)
Revenue Replacement Target	**$35.5 B**

Source: Finance and Revenue Committee.

Lower-Cost Scenario

Using Milliman's revised low estimate of $69.4 billion and applying the same payer administration adjustment results in total expenditures of approximately $68.4 billion.

To estimate the corresponding federal and state contribution, it was assumed that public funding remains proportional to total expenditures. Under this approach, the 2026 federal and state contribution declines from $28.5 billion to approximately $26.2 billion, which trends to roughly $35.7 billion in 2032. Adding the estimated Medicaid dental contribution increases total federal and state funding to approximately $36.5 billion, shown in the RRT row of Exhibit 6 below.

Exhibit 6. Lower-Cost Scenario Calculations

CALCULATION	AMOUNT
Adjusted Low Estimate Expenditures	$68.4 B
Less Federal and State Contributions	($36.5 B)
Revenue Replacement Target	**$31.9 B**

Source: Finance and Revenue Committee.

This estimate may be viewed as a middle scenario rather than a true low scenario. The assumed 5.3 percent annual growth rate exceeds both CMS projections for national health expenditure growth and Oregon's observed growth rate during the 2014–2019 period. As a result, the expenditure assumptions underlying the Milliman low estimate may still be conservative relative to other plausible trend assumptions.

Enhanced Savings Scenario

Additional savings may be achievable through a unified purchasing and administration structure. Assuming 1) 1.5 percent savings from prescription drug purchasing; and 2) 1.0 percent savings from improved fraud, waste, and abuse prevention; produces an additional 2.5 percent reduction in expenditures. Estimates based on these assumptions are summarized in Exhibit 7 below.

Exhibit 7. Enhanced Savings Scenario Calculations

CALCULATION	AMOUNT

Adjusted Low Estimate Expenditures	$68.4 B
Less Additional Savings (2.5%)	($1.7 B)
Enhanced Savings Expenditures	$66.7 B
Less Federal and State Contributions	($36.5 B)
Revenue Replacement Target	**$30.2 B**

Under this framework, a reasonable range for the 2032 Revenue Replacement Target appears to be approximately $30 billion to $36 billion, with a central estimate near $32 billion.

UHP Tax Revenue Allocation Framework

The Finance & Revenue Committee's adopted financing framework allocated responsibility across the major revenue instruments is summarized in Exhibit 8 below.

Exhibit 8. Allocation of Required Revenue by Financing Instrument

FINANCING MECHANISM	SHARE OF REVENUE
Corporate Income Tax (CIT)	3.8%
Corporate Activity Tax (CAT)	1.3%
Employer Payroll Tax (EPT)	51.5%
Health Care Personal Income Tax (HCPIT)	43.4%
Lodging Tax Increase	<1%

The HCPIT percentage reflects net revenue dedicated to the UHP after accounting for reductions in liability associated with the EPT credit. The lodging tax represents a proposed 0.2 percentage-point increase in the statewide lodging tax and contributes a relatively small share of total revenue.

Revenue and Tax Rate Requirements by Financing Mechanism

Applying the Finance & Revenue Committee's adopted revenue allocation shares to the three Revenue Replacement Target (RRT) scenarios produces the revenue requirements shown in Exhibit 9. These values represent the amount of revenue that would need to be generated by each financing mechanism if the Board elects to maintain the relative distribution of responsibility across the tax instruments.

Exhibit 9. Low, Middle and High Revenue Requirements by Financing Mechanism

FINANCING MECHANISM	SHARE	$30.2B RRT (LOW)	$31.9B RRT (MIDDLE)	$35.5B RRT (HIGH)
CIT	3.8%	1.15	1.21	1.35
CAT	1.3%	0.39	0.41	0.46

EPT	51.5%	15.55	16.43	18.28
HCPIT	43.4%	13.11	13.84	15.41
Lodging Tax	<1%	~0.01	~0.01	~0.01
Total	**100%**	**30.2**	**31.9**	**35.5**

The corresponding tax rates are presented in Exhibit 10. These estimates assume the same underlying tax bases and modeling methodology used in LRO's initial review, with the Revenue Replacement Target serving as the only changing input. As the target increases from approximately $30 billion to $35.5 billion, the required rates for each financing mechanism increase proportionally. These estimates should be viewed as planning scenarios that illustrate the relationship between the Revenue Replacement Target and the tax rates required to achieve it rather than as distinct policy alternatives.

Exhibit 10. Low, Middle, High Tax Rate Requirements by Financing Mechanism (%)

FINANCING MECHANISM	$30.2B RRT (LOW)	$31.9B RRT (MIDDLE)	$35.5B RRT (HIGH)
CIT	4.25%	4.49%	5%
CAT	0.11%	0.12%	0.13%
EPT	9.89%	10.44%	11.62%
HCPIT	13.5%	14.3%	15.9%
Lodging Tax	0.2%	0.21%	0.23%

Finally, these estimates assume that the Finance & Revenue Committee's original allocation of revenue responsibility across the financing mechanisms remains unchanged. As the Board continues its deliberations, it may choose to shift a greater or lesser share of the Revenue Replacement Target among the Employer Payroll Tax, Health Care Personal Income Tax, Corporate Income Tax, Corporate Activity Tax, or other financing mechanisms. Likewise, the estimates presented here are static tax-year liability estimates and do not incorporate behavioral responses, macroeconomic effects, or other dynamic changes that could influence revenues over time.