MILLIMAN REPORT

Expenditure Analysis for the Oregon Universal Health Plan

Commissioned by the State of Oregon

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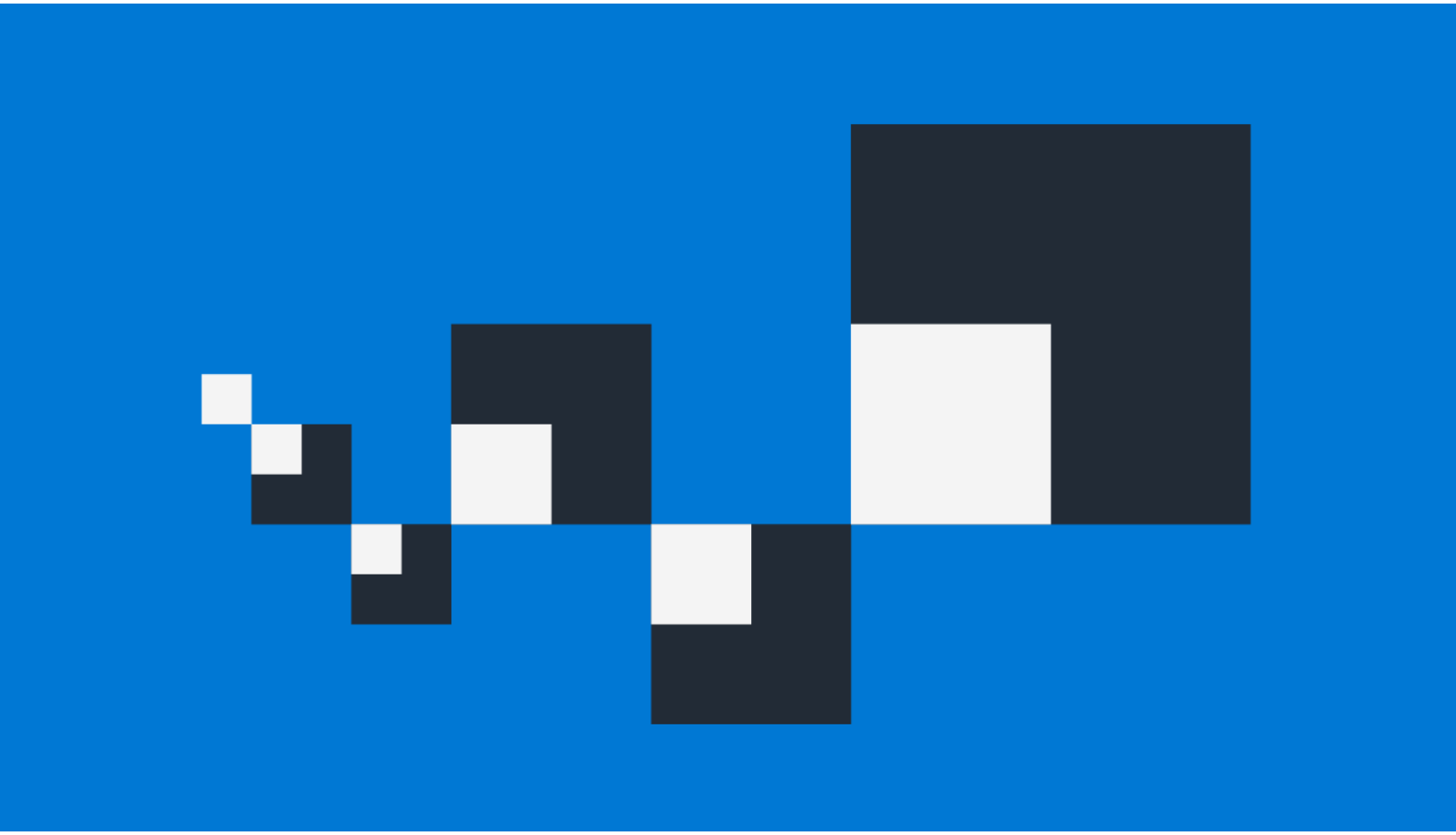

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1 Executive Summary

The Oregon Department of Consumer and Business Services, through the Universal Health Plan Governance Board (UHPGB), engaged Milliman to provide actuarial services in support of UHPGB's development of a Universal Health Plan (designed to provide coverage for Oregon's entire population). The scope of this engagement was to estimate the benefit costs under two different program benefit structures, as well as estimated administrative costs with the program. The scope of this report specifically excludes estimation of the mode or actual amounts of revenue generated under federal waivers and state tax structures. This report presents the results of our analysis of the associated medical and prescription drug costs and administrative costs, as well as assumptions and methodologies used to project the cost of Oregon's proposed Universal Health Plan (UHP).

While a few select states are currently exploring the possibility of a UHP, this has the potential to be the first UHP implemented in the United States. Cost estimates have been projected to 2026 and to 2032 (the assumed operational start of the UHP). We also discuss provider reimbursement strategies, resource usage, cost containment measures, prescription drug and other considerations that will be important in implementation of the UHP. The analysis details modifications to the UHP framework to identify differences in projected costs.

It is expected that there will be significant changes in the healthcare landscape between the present time (2026) and the projection period of 2032 through 2041. As a result, actual healthcare claims costs and UHP enrollment figures will undoubtedly differ from the estimates presented in this report. Additionally, as new information emerges, the underlying assumptions used in this analysis will likely need to be updated, which may result in different estimates than those shown here.

1.1 SUMMARY OF RESULTS

The 2032 expenditures for the UHP are summarized in Figure 1. For each plan design, there is a corresponding low estimate, high estimate, and best estimate.[1] Sections 4 through 8 contain more detail on the specific assumptions and benefits associated with the respective scenarios.

FIGURE 1
OREGON UNIVERSAL HEALTH PLAN
2032 EXPENDITURE ESTIMATES ($ BILLIONS)

		(a)	(b)	(c)	(d)	(e) = (a) + (b) + (c) + (d)
PLAN DESIGN	SCENARIO	MAJOR BENEFITS*	PEBB PLUS BENEFITS**	COST SHARING	ADMINISTRATIVE COSTS	TOTAL UHP COST
Zero Cost Sharing	Low	$69.2	$4.5	$0.0	$3.6	$77.4
	Best Estimate	$75.3	$5.1	$0.0	$5.1	$85.5
	High	$81.3	$5.6	$0.0	$7.0	$94.0
Low Cost Sharing	Low	$68.6	$0.0	-$1.1	$3.6	$71.2
	Best Estimate	$74.6	$0.0	-$1.2	$5.1	$78.5
	High	$80.6	$0.0	-$1.3	$7.0	$86.4

*Inpatient, Outpatient, Physician, Prescription Drugs, Other.
**Dental, Vision, Fertility, Other Benefits. "PEBB" is the Public Employees Benefit Board.

Key Cost Considerations

- Provider reimbursement is assumed to be at current system levels under a UHP but reduced provider administrative costs under a UHP are estimated to improve net revenue for providers[2] as currently modeled. Provider reimbursement could be adjusted to re-capture the net revenue increase and lower overall UHP costs.
  - Provider administrative costs allocated to eligibility and billing are estimated to be worth between **$4 and $5 billion.**
  - Collection of cost-sharing is difficult for providers in the current status quo healthcare system. Assuming a current 50% collectability rate goes to 100% collectable (due to zero cost-sharing under the UHP), this could result in a **$3 to $3.5 billion** improvement to provider reimbursements.

[1] Best estimate is defined as an estimate that has no intentional sources of bias towards being conservatism or aggressive in assumptions.
[2] Individual provider revenue changes may vary significantly from aggregate provider experience.

  - Together, these result in a material opportunity when considering provider reimbursements in the UHP. However, careful consideration should be given to implementation, as these savings would likely not be realized in the first year of implementation and would need to be implemented through lower provider reimbursements from the UHP.
- A zero-cost sharing cost sharing plan design has potential trade-offs.
  - Zero-cost sharing reduces financial barriers to care for Oregonians. However, zero-cost sharing may also increase service utilization, which for some services may not be necessary. However, zero-cost sharing may also increase service utilization, which for some services may not be necessary.
  - Medical management and provider supply serve to dampen demand under a UHP but not entirely.

Other Results / Observations

- Underlying annual medical and prescription drug trend assumptions vary from 5.3% (low estimate) to 7.4% (high estimate), based on historical ranges of values coming from Oregon-specific national health expenditures data.
- Underlying medical management, payment integrity and fraud, waste and abuse assumptions imply the UHP will maintain current industry level performance to control costs.
- The preliminary operating model and organizational structure for the UHP includes a variety of operating efficiencies based upon the final strategy of the plan. Oregon will need to make many operational model decisions, including what functions will be centralized, decentralized, or delegated to other parties, which will impact the actual efficiencies and program impact, as well as the actual staffing and costs.
- Administrative cost and staffing estimates range from highly efficient ('low') to less efficient ('high') and take into account the plan size, benefit scope and complexity, the complexity of the populations managed, and regulatory requirements. The best estimate[3] leans slightly more towards highly efficient, which is expected given the potential administrative efficiencies of the UHP due to scale and centralization.

The remainder of this report provides support for, and additional detail related to, a summary of these results.

1.2 DATA RELIANCE AND IMPORTANT CAVEATS

This report has been prepared for the use of and is to be relied upon by the management of Oregon's Department of Consumer and Business Services, Universal Health Plan Governance Board. We understand that this report will be made public, and we consent to the distribution of this report. Milliman makes no representations or warranties to any third party. Third parties are instructed to place no reliance on this report that would result in the creation of any duty or liability under any theory of law by Milliman or its employees such third parties. Any reliance on the Milliman report is entirely at one's own risk. Milliman shall not be liable for any loss, damage, or expense of any nature caused by one's reliance upon the Milliman report.

Material events may occur after the date of this report, which are not considered in the development of the estimates contained in this report.

In preparing this analysis, Milliman relied on data and other information provided by or on behalf of Oregon's Department of Consumer and Business Services, Universal Health Plan Governance Board, as well as public information. We reviewed this data for reasonableness and made certain adjustments where appropriate, but we have not audited or verified this data and information. If the underlying data or information is inaccurate or incomplete, this document may likewise be inaccurate or incomplete.

Differences between Milliman's projections and actual amounts rely on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual future experience will not conform exactly to the assumptions used in this analysis. Projected results will differ from actual results to the extent that actual experience deviates from expected experience. Moreover, actual results are dependent on CMS approval of various waiver applications from the State of Oregon. There is uncertainty related to these events. Our estimates are provided under the assumption of approval.

[3] Best estimate is defined as an estimate that has no intentional sources of bias towards being conservatism or aggressive in assumptions.

We developed certain models to estimate the values included in this report. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output may not be appropriate for any other purpose.

This report is designed to provide the Universal Health Plan Governance Board with an analysis estimating total healthcare expenditures and administrative costs resulting from the implementation of the Universal Health Plan. This information may not be appropriate and should not be used for other purposes. Milliman recommends that the user of this information should possess expertise in health insurance or be advised by professionals with such expertise so as not to misinterpret the information contained herein.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. Fritz Busch, Kenneth Laskowski, and Tom Wrigley are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses presented.

2 Background

2.1 OREGON UNIVERSAL HEALTH PLAN BACKGROUND

In 2023, Oregon enacted Senate Bill 1089 which required Oregon to establish a publicly funded, single health care system to cover all residents of Oregon, create a governance board charged with developing a comprehensive plan to finance and administer a UHP, and provide that plan to the legislature no later than September 15, 2026. The law's goal is to provide affordable, equitable, and high-quality health care to everyone in Oregon, regardless of income, location, or employment status. This builds on the work of Oregon's 2019 Task Force on Universal Health Care, where a conceptual blueprint and feasibility analysis was created for Oregon's UHP.

The UHP in Oregon will provide healthcare coverage to all residents based on eligibility requirements set by the UHPGB. It will build on the existing Public Employees Benefit Board (PEBB) and Oregon Educators Benefits Board (OEBB) programs as a basis for covered benefits and maintain the expanded behavioral health services included in the 2025 to 2027 Governor's Budget. The proposed plan eliminates patient cost sharing, such as co-pays and deductibles, and funds services through new revenue sources rather than insurance premiums to prevent financial hardship. It aims for equitable provider payments and generally maintains current benefit levels. All licensed providers in good standing can participate in the UHP, with direct payments adjusted regionally. Health insurance companies will only offer supplementary coverage, and the plan will decouple health insurance from employment. The plan also seeks to address social determinants of health and will be managed by a nonprofit organization.

In 2025, the UHPGB established committees to organize the development of a UHP into functional areas. These committees include:

- Community Engagement and Communications
- Finance and Revenue (F&R)
- Plan Design and Expenditures (PD&E)
- Operations
- Transition

The work of the UHPGB was preceded by the Joint Task Force on Universal Health Care, established in 2019, which produced their report in 2022.[4]

The State of Oregon contracted with Milliman to provide actuarial and other healthcare management consulting services supporting the UHPGB and primarily the PD&E and Operations Committees.

2.2 SCOPE OF ENGAGEMENT

Milliman's scope of work under the engagement includes:

- Plan Design and Expenditures
  - Development of actuarial estimates for medical and prescription drug healthcare cost estimates under a "status quo" (i.e., current system, no UHP). This is developed for both 2026 and 2032 effective dates.
  - Development of UHP healthcare cost scenarios with transparency around assumptions and transitions from the status quo scenario to UHP scenarios. UHP plan healthcare costs are projected out five and ten years.
  - Initial plan design recommendations under the UHP include a) no patient cost sharing and b) a covered benefits scope based on the Public Employee Benefit Board (PEBB) benefits as a minimum and additionally covering any services required by federal law for residents that would otherwise qualify for Medicaid.
  - Development of additional scenarios related to alternate plan designs and provide sensitivity analysis and ranges of outcomes for all financial projections.
  - Support analysis of eligibility rules and provide limited support for provider reimbursement and cost containment strategies.

[4] https://www.oregaon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20September%202022.pdf

- Operations
  - Review complex, large scale health care organizations including approaches to claims management, quality control, population health and security, licensure filing, policy development (e.g., claims processing, provider relations, member services, and compliance), hiring staff, engaging vendors, testing operational processes, implementing appropriate and secure technology systems to develop an administrative structure for consideration, including a potential organizational structure (reporting structures and lines of authority).
  - Provide estimates for staffing needed to operate a universal health plan public corporation based on assumed structure.
  - Based on administrative structure, develop ongoing operating administrative costs for the UHP.
  - Additional policy analysis.
  - General health policy analysis and research support for additional questions as needed from committees and UHP governance board as needed.
- Legislative Report
  - Provide a written report of our analysis to be included in the final report from the UHPGB. Provide opportunities for and responsiveness to Board feedback and supporting the UHP Project Team in developing and revising drafts of the final report to the legislature. Ultimately, the UHPGB is responsible for the final report to the legislature.

2.3 KEY TERMS AND OVERVIEW OF ANALYSIS / ASSUMPTIONS

Milliman's analysis for both the benefit costs under a UHP and the costs to administer such a plan were built independently and from the ground up. This approach differs from previous analysis performed by the Joint Task Force on Universal Health Care. The differences in the respective approaches are discussed in more detail in Section 2.3.4. Estimates for benefit expense and administrative expense are combined to arrive at total projected 2032 UHP expenditures.

2.3.1 Glossary of Key Terms

A list of key terms and their definitions as used in this report are below:

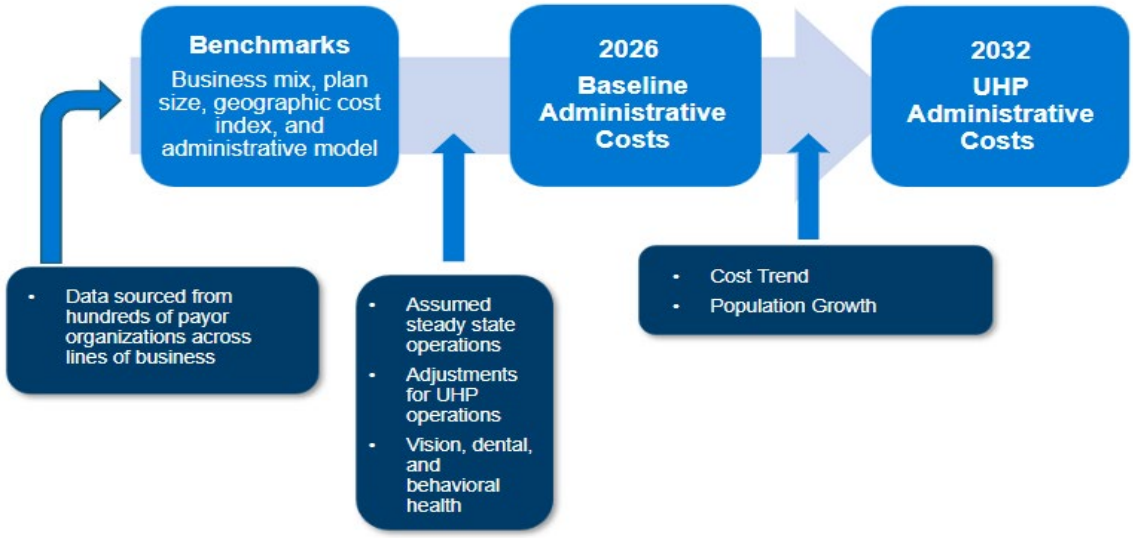
- **Allowed Cost:** Total payment made to a provider for the delivery of a service. This includes both the amount paid by a payer such as an insurer, Medicaid, employer or the UHP (benefit cost), and the portion paid by the enrollee (cost sharing).
- **Benefit Cost:** The portion of the allowed cost covered by the payer, paid as a benefit due under the insurance plan, self-funded employer program or public program, excluding the enrollees portion.
- **Cost Sharing / Out-of-Pocket Expense:** The portion paid by the enrollee for healthcare services received. This can take the form of deductible, coinsurance (percentage of costs), or copay (flat dollar amount per service or visit).
- **Administrative Cost:** Costs needed to operate a health plan, distinct from the benefits for medical and prescription drug expenses paid under the plan.
- **Plus Benefits / Plus Package:** A set of ancillary benefits under consideration by the UHPGB consisting of additional services that are covered by the PEBB plan that are generally above standard covered benefits in other markets. Plus Benefits include dental, vision, glasses/vision hardware, fertility, sleep studies, doula, hearing aids, massage therapy, and complementary medicine.
- **Major Medical Benefits:** Includes all benefit costs except prescription drugs. Specifically inpatient care, outpatient care, professional / physician care, and other items such as ambulance, and durable medical equipment. When combined with prescription drugs, these benefits form the benefits underlying healthcare costs.
- **Healthcare Cost:** Major medical benefits and prescription drug services combined. Excludes Plus benefits.
- **Expenditure:** The total amount of dollars spent on costs / expenses. Equal to the sum of benefit costs and administrative costs.
- **Baseline:** 2026 present day healthcare environment.

- **Status Quo:** 2032 healthcare environment without implementation of the UHP.
- **Adverse Selection:** The anticipated cost changes from individuals choosing healthcare coverage that is financially optimal while meeting their needs. For example, those with a higher level of healthcare costs seek more coverage, while those with a lower level seek less coverage, thereby altering the risk pool.
- **Induced Utilization:** The increase in the amount of health care people use because the level of coverage richness changes the incentives that affect patient and provider behavior.

2.3.2 Administrative Costs of the UHP

Administrative cost estimates reflect the total cost of administering the universal health plan and efficiencies of that operating model. These costs exclude providers' administrative costs and focus solely on the single payer's administrative costs. This section provides a high-level summary of the process Milliman used to derive estimates of administrative expenses under the UHP. Detailed descriptions of a potential administrative structure and administrative costs are included in Sections 3 and 4.

FIGURE 2: KEY STEPS IN DEVELOPING THE UHP STAFFING AND ADMINISTRATIVE COSTS FOR A 2032 IMPLEMENTATION



Key steps in developing the administrative cost and staffing estimates include:

- **Starting Cost Data:** Milliman administrative benchmarks are based on data collected from hundreds of payer organizations across all lines of business. This includes Medicare Advantage, commercial individual, small group, large group, and self-funded products. These industry benchmarks are updated annually.
- **Establishing Population / 2026 Enrollment and Costs:** As the UHP intends to cover all Oregon residents, 2026 enrollment and benefit costs were used to develop the baseline administrative costs.
- **Determining UHP Strategy:** Milliman engaged in strategic conversations related to goals and success metrics for operating the UHP and discussed potential structural changes that will vary from traditional payer operations. Adjustments were made to the baseline benchmarks to account for future efficiencies and steady state operations of the UHP.
- **Applying UHP Impacts:** Additional costs due to the UHP administering vision, dental, and behavioral health were incorporated into the benchmarks along with population growth and cost trend to 2032.

Other UHP Assumptions

In addition to adjustments for trend, population growth and the explicit adjustments for UHP impacts noted above, we made assumptions related to the following:

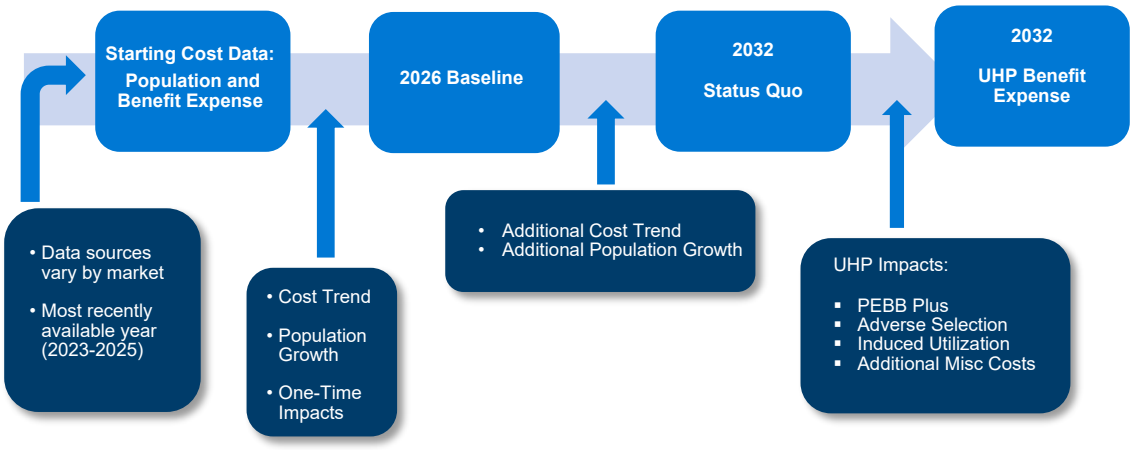
- The administrative costs are for steady state operations and do not include start-up costs, which will be substantial.

- The potential organizational structure created is based upon discussions with the Oregon UHPGB to date. Actual future structure may vary based upon final benefit designs, operational decisions, regulatory requirements, and organizational priorities.
- All costs are presented in a range from highly efficient to less efficient operations. Actual efficiency will vary by functional area as performance in one functional area may impact efficiency in another functional area. Staffing needs are highly dependent on program design and operational model.
- Costs include administrative expenses for dental, vision, and behavioral health benefits in addition to medical. Costs for administrative oversight of pharmacy management are included but not staffing or expense to administer pharmacy benefits.

2.3.3 Benefit Costs of the UHP

This section provides a high-level summary of the process Milliman used to derive estimates of benefit expenses under the UHP. Detailed descriptions are included in Sections 6 through 8.

FIGURE 3: KEY STEPS IN DEVELOPING THE UHP BENEFIT COSTS FOR A 2032 IMPLEMENTATION



Key steps for developing the UHP benefit cost estimates include:

- **Starting Cost Data:** Medical and prescription drug costs were obtained by market (small group, large group, Medicaid, etc.), from Oregon-specific public sources. These costs are generally expressed as a per member per month (PMPM) amount. Summaries of these sources can be found in Section 8.1.
- **Establishing Population / UHP Enrollment:** Since the UHP intends to cover all Oregon residents, current and projected total state population figures are used to project total costs. See Section 8.2 for additional information on eligibility and Figure 64 for population and growth sources.
- **Determining Medical Cost Trend Ranges for Projections:** High, low, and best estimate annual inflation figures for medical and prescription drug costs were estimated using National Health Expenditure data for the State of Oregon, as well as Milliman's *Health Cost Guidelines*™ (*HCGs*).
- **Applying UHP Impacts:** Additional costs due to UHP are discussed and quantified in detail in Section 6.4 but include material adjustments for induced utilization (6.3.3), adverse selection (6.3.2), and additional benefits covered under Plus Benefits but not contained in starting costs (6.3.5).

Other UHP Assumptions

In addition to adjustments for trend, population growth and the explicit adjustments for UHP impacts noted above, we made assumptions related to the following:

- We assumed overall provider reimbursement and drug acquisition costs will remain at similar levels in aggregate, moving from the 2032 status quo to the 2032 UHP scenarios. Considerations related to material changes in provider reimbursement are considered in depth in Section 7.1.
- Likewise, this analysis assumes that the managed care industry average medical management practices and cost impacts will persist from the status quo scenario into the UHP scenario. Detailed discussion of medical management as a cost containment lever is covered in Section 7.2.
- Both provider reimbursement and medical management are significant areas of cost control for the UHP. However, wholesale changes to these practices will have trade-offs and most likely will be subject to multi-year stakeholder negotiations and implementation timelines. Moreover, as of the date of this report, no specifics around strategies or policies related to these items have been developed. Therefore, our aggregate assumption related to both changes in provider reimbursement and medical management is zero.
- Cost estimates reflect changes in individual behavior and utilization of services because of richer coverage (induced utilization).
- Current limits on physician and hospital capacity will not immediately be remedied under a UHP, and could be exacerbated under a UHP.
- Taken together, utilization increases due to zero enrollee cost sharing, but that increase is dampened due to provider supply not increasing at the same rate (i.e., unmet demand).

Other savings initiatives the UHP may undertake need to have detailed specifics mapped out to properly evaluate and model, and many of these details will be developed by the UHPGB over the next few years.

2.3.4 Total UHP Expenditures

When the UHP is implemented, one goal of the UHPGB is to eliminate cost sharing as much as possible. This means that upon implementation of the Zero Cost Sharing scenario, UHP allowed costs are equal to benefit costs and total UHP expenditures are the sum of the benefit costs and the cost to administer the plan as shown below.

FIGURE 4: TOTAL UHP ZERO COST SHARING EXPENDITURES



In the Low Cost Sharing scenario, this equation still holds, however allowed costs are no longer equal to benefit costs due to the presence of copays on select services. This scenario is discussed in detail in Section 7.6.

2.3.5 Prior Analysis

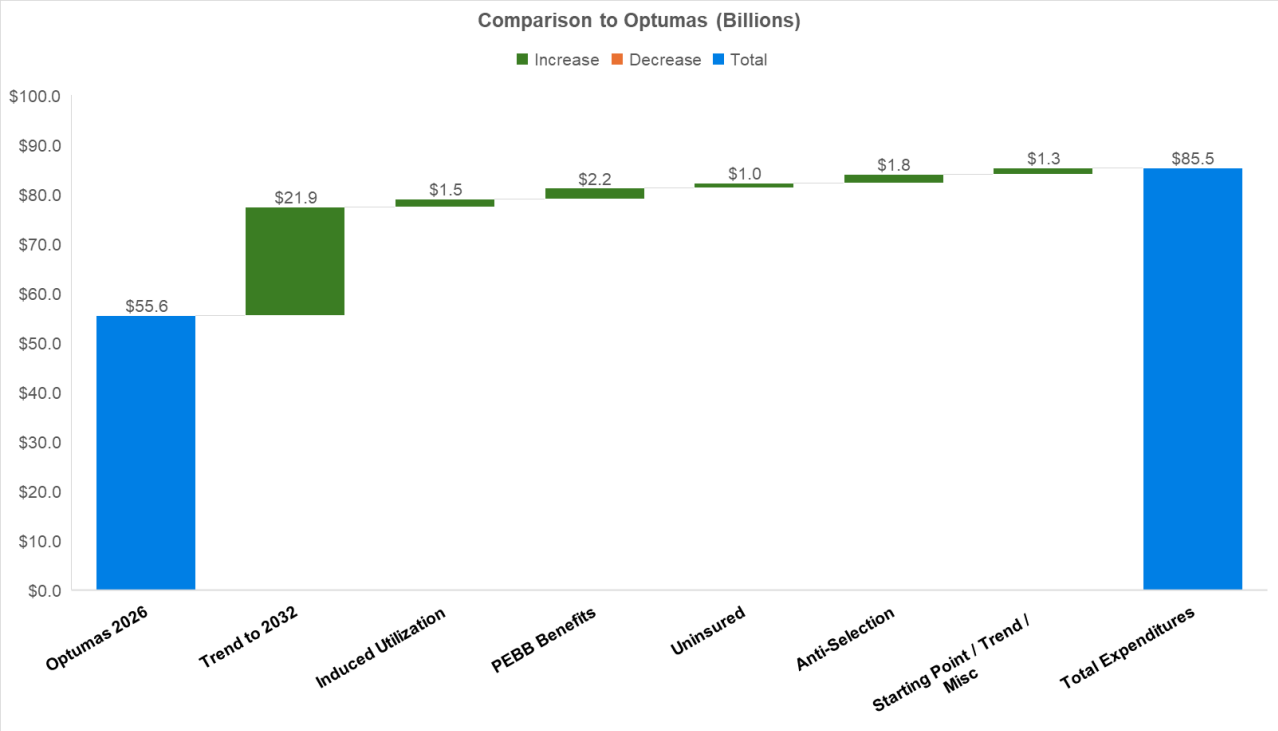
The Joint Task Force on Universal Health Care (JTFUHC), created in 2019, contracted with the firm Optumas to perform a feasibility analysis on a Universal Health Care Financial Model as seen in Appendix B of the Task Force Report.[5] This report served as the foundational understanding of feasibility of a UHP and its associated costs and required revenues. The Joint Task Force's report and its findings, particularly the Optumas findings, were reviewed and considered in this analysis, but the Optumas methodology was materially different than that employed to produce the results in this report.

However, insofar as meaningful comparisons can be made, we summarize the key differences that are crucial when referencing the prior report (Figure 5) and provide a waterfall graphic (Figure 6) to demonstrate how the costs of a UHP in this report differ from those in the Optumas report. The purpose of this reconciliation is not to precisely account for every difference in data sources or methodology between the previous analysis and this one. Rather, it serves as high level of comparison of the material differences in the cost outcomes of each analysis.

[5] https://www.oregaon.gov/oha/HPA/HP/TFUHC%20Meeting%20Documents/Joint%20Task%20Force%20on%20Universal%20Health%20Care%20Final%20Report%20%20Recommendations%20September%202022.pdf

FIGURE 5 OREGON UNIVERSAL HEALTH PLAN METHODOLOGY COMPARISON		
	JTFUHC / OPTUMAS REPORT	**MILLIMAN REPORT**
UHP IMPLEMENTATION YEAR	**2026**	**2032**
Underlying Data Sources	National Health Expenditure Accounts	Medical / prescription drug: Oregon-specific public sources Administrative expenses: proprietary Milliman benchmarks comprised of health insurance sector data
Methodology	Incremental changes for UHP applied to total (combined medical / prescription drug and administrative) expenditures	Medical and prescription drug expenses are built from the ground up Administrative costs are built from the ground up and added to medical / drug costs to get total cost
Material Differences	Milliman analysis: ▪ Applies six years of additional administrative and medical trend to get to 2032 implementation date ▪ Assumes higher induced utilization due to zero patient cost sharing ▪ Assumes higher cost of additional benefits such as dental ▪ Assumes higher costs under UHP for previously uninsured ▪ Projects greater adverse selection, including interstate migration ▪ Includes other changes in healthcare (i.e., GLP-1, H.R. 1,[6] population movements)	

FIGURE 6: 2032 UHP ESTIMATED EXPENDITURES COMPARED TO OPTUMAS 2026 UHP ESTIMATED EXPENDITURES



[6] "H.R. 1" refers to the One Big Beautiful Bill Act signed into law on July 4, 2025.

2.4 HEALTH PLAN BACKGROUND

While the UHP could be the first of its kind (state-based, universal coverage, single payer, inclusive benefits), it will nonetheless be a health plan in every meaningful way. Again, while the UHP will be different in unprecedented ways, the current healthcare systems managed care plan's organizational and operational structures can serve as a reasonable starting point for understanding the scope of functions the UHP must undertake.

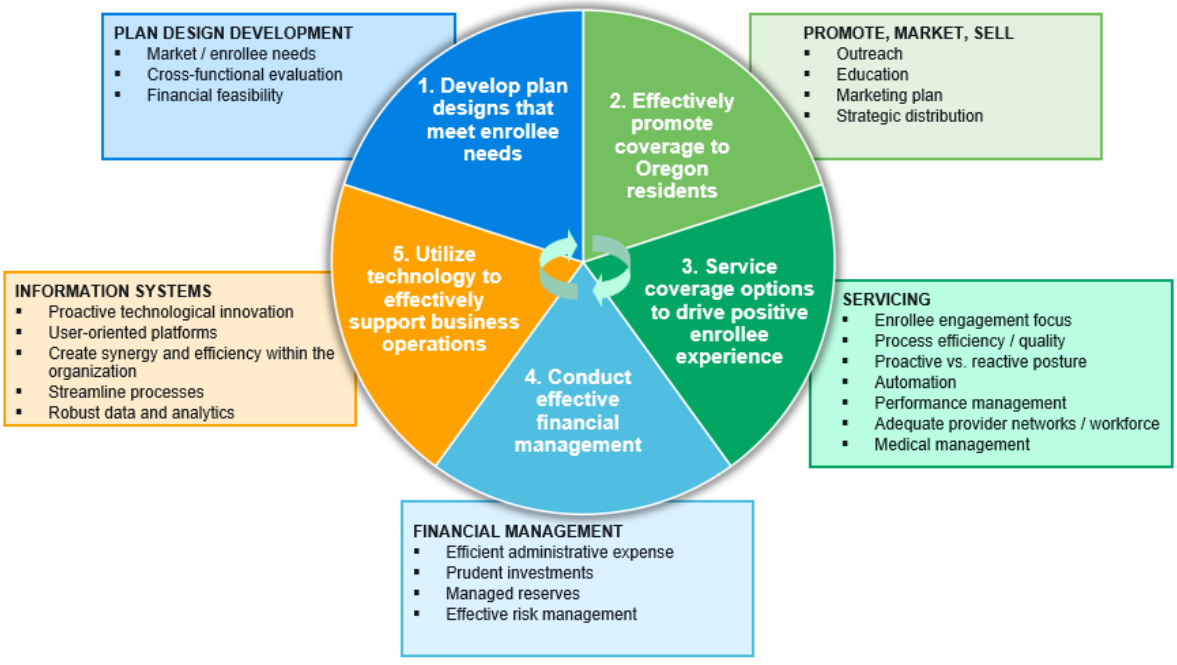
As such, Figure 7 outlines the operational considerations of a universal health plan, highlighting five key functional areas that support effective plan operations. Please note, certain functional areas in traditional plans do not appear or are modified materially. As an example, ongoing plan design development functions are largely eliminated and replaced with potential changes to coverage (covered benefits or enrollee cost sharing) to meet enrollee needs and manage costs. Plan design in this context would focus more on coverage gaps, population health considerations, conducting a cross-functional evaluation across policy, clinical, and operational teams, and ensuring the financial feasibility of benefit designs.

Second, the UHP must effectively promote coverage through clear communication plans and strategies to ensure Oregonians understand UHP coverage. However, this would look considerably different than the Marketing and Sales function in current health plans, instead focusing on outreach and education to ensure all Oregonians are enrolled, assigned a primary care physician (PCP) and can access needed services.

In other respects, UHP operation may look very similar to how today's health plans operate. For example, it is important that the future UHP drives a positive beneficiary experience and ultimately improves access to care and health outcomes. Operationally, the plan will need to implement efficient processes for enrollment and claims, support provider networks and workforce capacity, implement performance management systems, and ensure robust medical management.

The plan should also have effective financial management, controlling administrative expenses, maintaining appropriate reserves, and managing financial risk to ensure long-term sustainability. Lastly, the plan should utilize technology to effectively support future operations. This may include building modern information systems, investing in interoperable technology platforms, streamlining processes, and leveraging data and analytics to support decision-making and operational efficiency. Together, these operational pillars illustrate key foundational capabilities to support, implement, and manage a universal health plan.

FIGURE 7: OPERATIONAL CONSIDERATIONS OF A UNIVERSAL HEALTH PLAN



With the possibility of being the first state-based UHP, Oregon's plan will provide ample opportunities for health system improvement, access to coverage, elimination of uninsured, improvement in provider pay and work-life balance and improved overall health. Those opportunities are not without corresponding challenges both to get to a 2032 implementation and then to operate efficiently and in a fiscally sound manner beyond that. The challenges the UHP will face are not unlike the challenges faced by plans today but in certain cases, the UHP as a new plan and a new type of plan, it should be expected to have its share of unique challenges.

For example, generous covered benefits (the PEBB Plus construct; see Glossary in Section 2.3.1) and no / low cost sharing can drive overuse as enrollees seek care for marginal conditions or prefer higher-cost settings. This could strain an already strained provider capacity situation. Likewise, this could lengthen wait times, lead to forgone services (i.e., unmet demand) and ultimately unfavorable health outcomes. Moreover, with reduced out-of-pocket costs, enrollees and even providers may become less price sensitive,[7,8] shifting care unnecessarily to more expensive treatments unless care management and utilization controls are in place. Conversely, as noted before, as the UHP develops over time, there is potential for improvements in health outcomes due to greater access health care driven by low to no financial barriers, gains in administrative and clinical efficiency, and what some may perceive as a more conducive practice environment for physicians.

Network design and provider contracting is another challenge: if the UHP functions similar to an HMO with a primary care gatekeeper, referral requirements, and prior authorization, enrollees may view these access constraints as rationing (given that the UHP will be a public program), generating complaints, appeals, and political pressure. However, loosening these controls risks further cost growth. The challenge for the UHP will be to balance the competing interests of many constituents.

Paying under a fee schedule can also encourage overtreatment and overutilization. For example, under a fee-for-service reimbursement model providers may have incentives towards more frequent visits, tests, or procedures which creates the necessity for safeguards, such as evidence-based guidelines, audits, bundled payments, or value-based purchasing to reduce induced demand. The UHP, with a single plan design and unified administrative systems across the State, will likely have additional opportunities not afforded to health plans in Oregon today (due to fragmentation) to build effective provider reimbursement arrangements that incent providers and patients to seek out the most efficient care and improve health outcomes.

Finally, the program may create migration incentives, prompting individuals in other states with significant health needs to move to Oregon to gain coverage. This is a unique challenge that traditional health plans would not face and the UHP, as a "first mover" state, will have to design stringent residency verification, and potentially waiting periods, as some form of coordination with employers with employees in other states. The plan must also address coverage portability for out-of-state travel and cross-border care to avoid surprise gaps.

[7] The classic study on the effect of cost sharing on healthcare utilization by enrollees is the Rand Study found here: https://www.rand.org/pubs/research_briefs/RB9174.html

[8] While not directly related to a providers knowledge of a patients cost sharing, professional providers do seem to respond to financial incentives such as fees schedule changes, shown here: https://www.sciencedirect.com/science/article/abs/pii/S0047272717301640?via%3Dihub

3 Organizational Structure

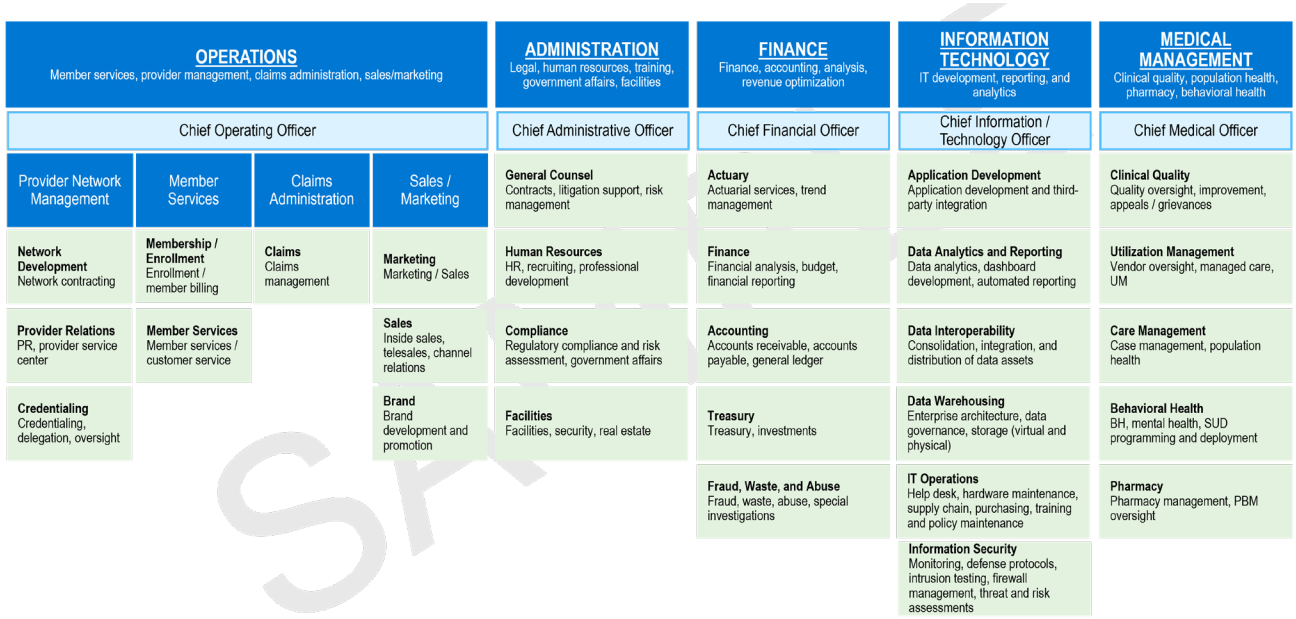
3.1 INTRODUCTION

Milliman engaged in strategic conversations with the UHP staff and Operations Committee to design a blueprint for its organizational structure. After better understanding goals and success metrics for operating the UHP and relevant historical context, the structure for key leadership positions, departments, and reporting structures was created.

3.2 METHODOLOGY

The Milliman team began with a typical health plan organizational structure (Figure 8). This can be used to illustrate the major functional areas and how responsibilities are typically distributed across a plan.

FIGURE 8: SAMPLE ORGANIZATIONAL STRUCTURE



The five major functional areas and how responsibilities are typically distributed across a plan are below:

1. **Operations:** Often serves as the core engine of a plan. It handles provider network management, member services, claims, and sales / marketing.
2. **Administration:** Provides the infrastructure to enable the health plan including legal oversight, human resources, compliance, facilities management, and ensures the plan meets regulatory requirements.
3. **Finance:** Oversees actuarial services, financial planning accounting, and treasury functions, as well as fraud, waste, and abuse prevention. They play a key role in rate setting, trend analysis, and forecasting, as well as financial management and stewardship of plan resources.
4. **Information Technology:** Supports data-driven operations through analytics, application development, and information technology (IT) infrastructure essential for performance monitoring, utilization insights, and compliance.
5. **Medical Management:** Focuses on clinical quality, utilization management, care management, behavioral health, and pharmacy operations.

In typical health plans, organizational structures commonly vary by line of business, benefit designs administered, regulatory requirements, scale, and strategic or organizational approach. This is especially true when planning for Oregon's UHP.

Beyond typical health plan organizational structures in the U.S., Milliman researched organizational structures used globally for single-payer plans. These systems vary in their degree of centralization, financing mechanisms, and roles, but they share common design principles intended to balance national standards, fiscal control, and local responsiveness. Below are some overarching themes of these plans:

- **Robust administrative capacity supports cost control and system integrity.** Mature universal systems invest heavily in administrative functions beyond claims payment. Common elements include centralized finance and audit offices, legal services, health policy divisions, digital transformation units, communications and public affairs, and dedicated evaluation bodies. Extensive administrative functions can support strong stewardship of public funds. In Canada, federal health institutions maintain extensive internal audit, evaluation, regulatory, and enforcement functions to support transparency and compliance.[9]
- **Regional and local entities play a critical role in integration and population health.** Many systems explicitly embed public health, community engagement, and workforce planning into their organizational structures. England assigns public health responsibilities to local authorities,[10] while Norway uses formal "healthcare communities" to coordinate across municipal and hospital sectors.[11] This can facilitate innovation but also introduce complexity. These approaches require careful coordination, strong federal incentives, and clear accountability to avoid fragmentation or inequitable access.
- **Clear separation between policy, financing, and service delivery roles enhance accountability.** Across systems reviewed, national ministries or departments typically focus on policy development, funding allocation, and regulatory oversight, while operational responsibilities are delegated to regional authorities. England, for example, combines centralized policy leadership with regionally organized Integrated Care Systems.[12]
- **Single-payer systems benefit from centralized budgeting and data infrastructure.** Centralized global budgets, standardized fee schedules, and real-time data sharing enable tighter cost control, more active care management, and rapid policy adjustment are features often cited as strengths of mature single-payer models.[13] Taiwan has demonstrated the advantages of unified budgeting and national health information systems through minimal administrative overhead and a centralized database covering nearly the entire population with near real-time claims submission and processing.[14, 15]
- **Hybrid public-private models remain viable under strong regulation.** Switzerland[16] and the Netherlands[17] illustrate that universal coverage can coexist with private insurers when participation is mandatory, benefit packages are standardized, and competition is tightly regulated. These systems require significant administrative oversight to ensure equity, cost containment, and consumer protection.

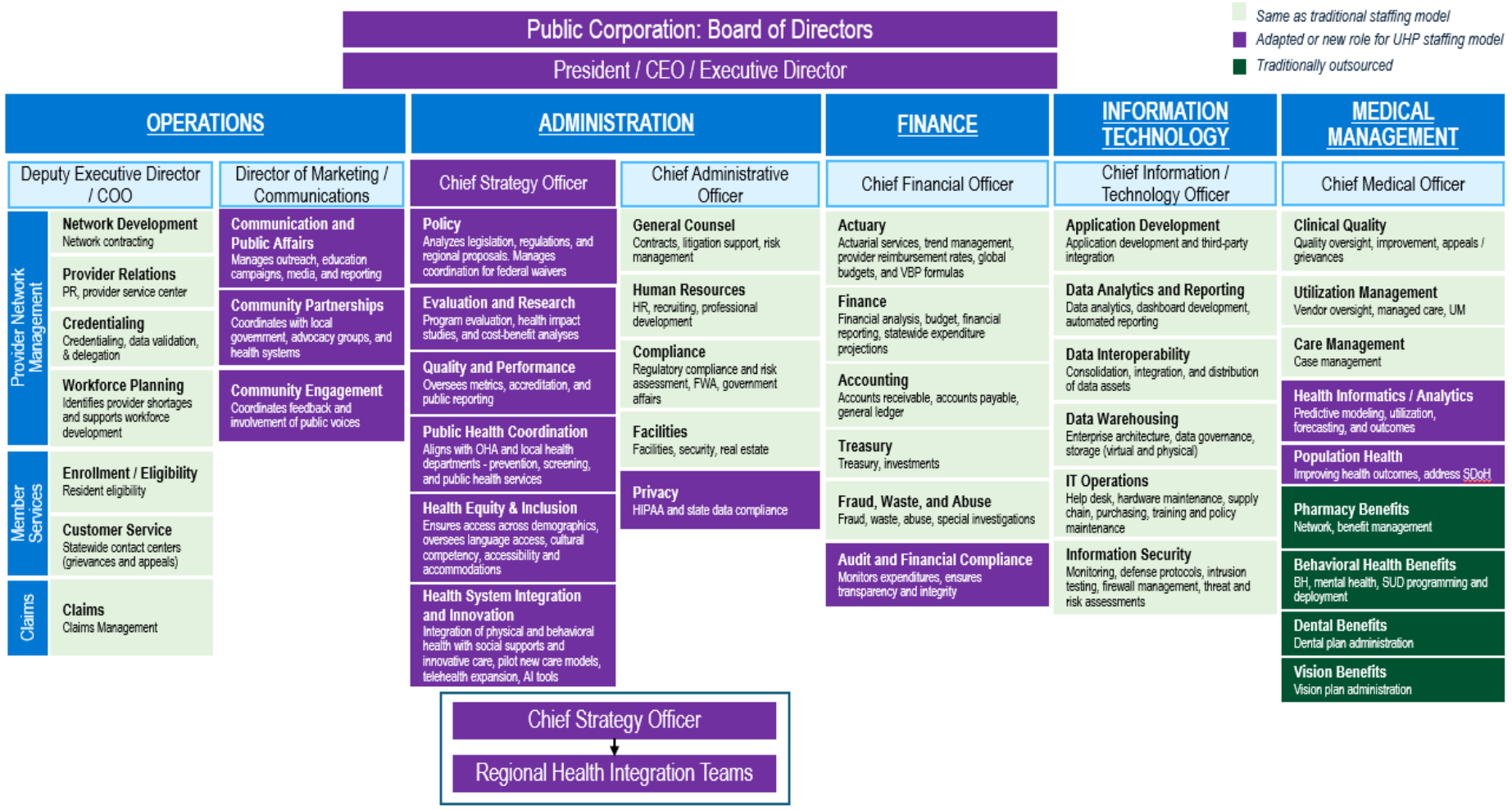
Combining typical U.S.-based organizational structure and lessons learned from global universal health plans, a proposed organizational structure was created for Oregon's future UHP. This adapted model incorporates past board discussions, committee ideas, straw proposals, and future state goals to build a model that can easily be adapted as implementation begins.

3.3 POTENTIAL ORGANIZATIONAL STRUCTURE

The proposed structure below (see Figure 9) includes the assumptions that the Oregon UHP will be a statewide public entity with a governance and management structure designed to support transparency, accountability, and operational effectiveness at scale. Oregon has stated it is firmly committed to improving population health outcomes and providing equitable access for all.[18] The UHP would operate as a public corporation overseen by a Board of Directors, with executive leadership led by a President / Chief Executive Officer or Executive Director. Core executive roles include oversight of operations, medical management, finance, information technology, administration, and strategy. These functions are intended to ensure coordinated leadership and integration across each column in the organizational chart below.

[9] World Health Organization. (2010). Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and Their Measurement Strategies.
[10] UK Department of Health and Social Care. 2012. Health and Social Care Act 2012: Public Health Responsibilities.
[11] Norwegian Ministry of Health and Care Services. The Coordination Reform – Proper treatment at the right place and right time. (2012)
[12] The Commonwealth Fund. https://www.commonwealthfund.org/international-health-policy-center/system-features/how-does-universal-health-coverage-work
[13] Organisation for Economic Co-operation and Development (2020). *Health Systems Characteristics Survey.*
[14] Hsiao, W. C., & Shaw, R. P. (2007). *Social Health Insurance for Developing Nations.* Washington, DC: World Bank.
[15] Brookings Institution. Cheng, T.-M. (2015). *Taiwan's health care system: The next 20 years*. Brookings Institution. https://www.brookings.edu
[16] The Commonwealth Fund. International Health Care System Profiles – Switzerland.
[17] The Commonwealth Fund. International Health Care System Profiles – Netherlands.
[18] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-1194924a_25.pdf. Page 6

FIGURE 9: POTENTIAL ORGANIZATIONAL STRUCTURE FOR THE OREGON UHP



The potential organizational structure above is designed for Oregon's UHP. It has roles that were adapted or added in purple and roles that are traditionally outsourced in dark green. Light green positions are those that have remained the same as the traditional staffing model. This structure may vary based on final benefit design, operational approaches, regulatory requirements, and organizational priorities. More discussion on each change is noted below:

- **Operations:** Moving away from typical marketing and sales activities to support competition among plans, these roles are focused on marketing and communication to promote the existence of the UHP and the steps to enroll. This will provide staffing focused on 1) outreach and communication during implementation of the UHP, 2) coordination and strengthening of community partnerships, and 3) continuous community feedback and involvement of public voices. This key change reflects Oregon's goal of transparency and building a trusted model of care.
- **Medical Management:** Additional roles here may focus on health informatics and analytics that will help in understanding utilization trends and using that data to focus on improving population health. In addition, pharmacy, behavioral health, dental, and vision typically involves staff to oversee outsourced contracts and providers for these services, though this could vary based on the final plan design.
- **Administration:** The largest change to the proposed structure lies in the Chief Strategy Officer role and positions that report through this function. This functional category includes policy, evaluation, quality, public health coordination, health equity and inclusion, and health system integration and innovation. In a UHP, these capabilities are centralized to support long-term system planning, cross-agency coordination, and continuous improvement. The function also helps align clinical, operational, and policy priorities while monitoring system performance and identifying opportunities for innovation and integration across the broader health ecosystem. Any regional health integration teams would also be included.
- **Other:** Additional roles focused on privacy and compliance were incorporated to reflect the heightened governance needs of a universal health system. Because an ideal UHP would likely rely on a single, integrated platform handling large volumes of member, provider, and financial data, dedicated oversight for HIPAA compliance, financial auditing and expenditure monitoring would help ensure transparency and accountability to state stakeholders.

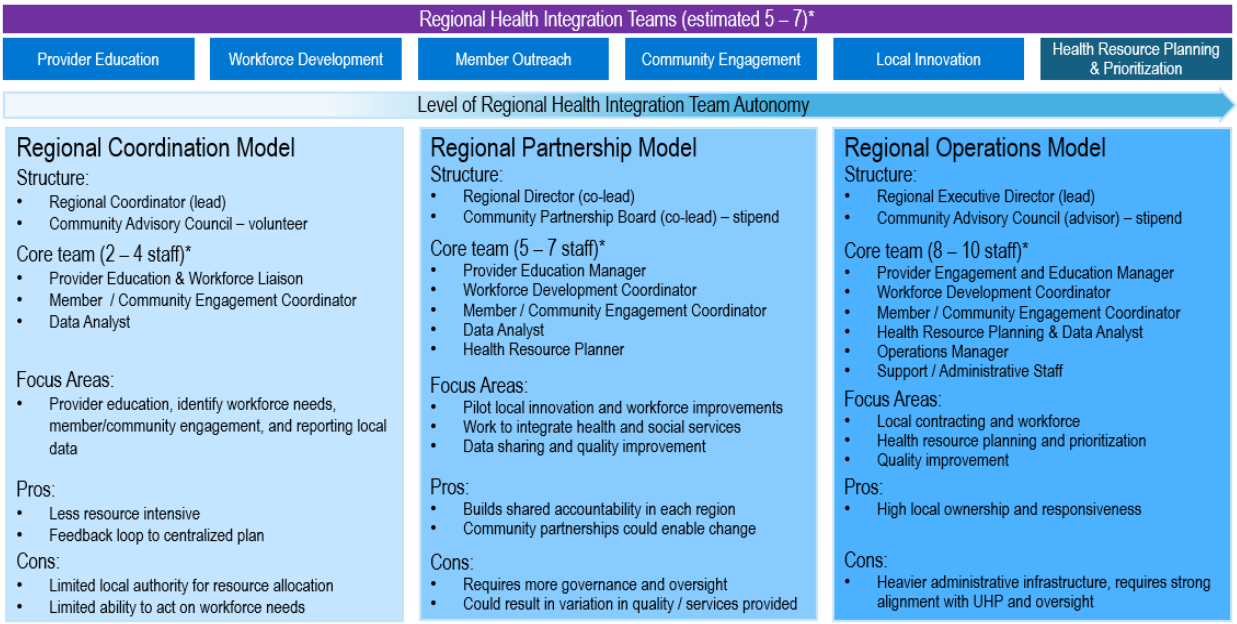
3.4 REGIONAL STRUCTURE MODELS

In addition to centralized operations, Oregon is continuing to explore how regional structures may support the UHP. Informed by the UHPGB's Administrative Structure Proposal and global structures, Milliman evaluated multiple approaches to incorporate regional structures into the statewide UHP framework. Global models often rely on regional entities to strengthen coordination with providers, integrate public health and social services, and respond to variation in population health needs, workforce availability, and healthcare infrastructure. At the same time, these systems underscore the importance of maintaining strong central oversight to ensure equity, consistency, and fiscal discipline.

Milliman proposed a range of potential regional models for Oregon that vary in scope, staffing, and decision-making authority. These approaches are intended to complement, rather than replace, centralized administration and are designed to scale based on policy decisions, available resources, and implementation priorities. Across all models, core objectives include improving provider engagement, supporting workforce development, enhancing community outreach, and strengthening the feedback loop between local communities and statewide leadership.

The regional models below (Figure 10) differ primarily in the number of staff and the level of autonomy delegated to regional teams. The more limited coordination-focused model emphasizes information sharing, provider education, and community engagement, while more robust operational models include expanded responsibility for local planning, contracting support, and quality improvement initiatives. As regional authority increases, so does administrative complexity and governance requirements, reinforcing the need to clear accountability structures and alignment with statewide standards.

FIGURE 10: POTENTIAL REGIONAL STRUCTURE WITH VARIATION BY SIZE OF STAFF AND LEVEL OF AUTONOMY



*Staffing sizes may vary based on final number of regional teams and the total population served by each regional team.

Under all approaches, the regional teams would operate within a clearly defined statewide framework for benefits, financing, and performance measurement. This balance is intended to support innovation and local problem-solving without introducing unwarranted variation in access, quality, or cost. As Oregon continues to refine the UHP design, decisions regarding the number of regions, staffing levels, and functional responsibilities of the regional teams will be informed by further operational planning and stakeholder engagement. The proposed organizational structure is intentionally flexible to allow regional capacity to evolve over time as the program matures.

Taken together, the staffing models presented in this section are intended to provide a reasonable planning framework for the initial implementation and early operation of Oregon's UHP. These estimates reflect current assumptions on enrollment, benefit design, administrative approach, and the balance between centralized and regional functions. Actual staffing levels will ultimately depend on the final policy decisions, operational efficiencies, the extent of vendor support, and the pace at which the program is implemented and scaled. As the UHP matures, staffing needs are expected to evolve, with opportunities to refine roles, improve productivity through technology and data integration, and achieve efficiencies consistent with a large, statewide public program. Ongoing monitoring, performance measurement, and adjustment will be essential to ensure that staffing resources remain aligned with program goals, fiscal stewardship, and Oregon's commitment to equitable, high-quality coverage for all residents.

4 Estimated Staffing and Administrative Costs

4.1 INTRODUCTION

We relied on administrative benchmarks to estimate the future costs and staffing needs of the UHP. Milliman administrative benchmarks are derived from a database of administrative cost, staffing, productivity, and quality information we developed using data collected from more than 100 commercial health plans, Medicaid managed care organizations, Medicare Advantage Plans, third party administrators (TPAs), and other organizations that administer health insurance benefits. We update our benchmark information and model annually.

We customize our benchmarking model to account for each client's unique scope of services, mix of business, enrollment, geographic location, and the intensity of administrative services to develop a comparable basis of comparison.

4.2 METHODOLOGY

To appropriately customize our benchmarking model to reflect the factors described above for the UHP, we used the actuarial estimates for 2032 enrollment and expected premiums. Our administrative benchmarking model uses membership and premium information by product to adjust for appropriate business mix (i.e., resource and workload differences among products) and reflect the impact of economies of scale on administrative costs (plan size factor).

Additionally, we used information based on the distribution of responsibilities, including staffing, technology systems, and other operational demands, across different operational areas from conversations with the State and our staffing model. Efficiencies were assumed in key functional areas:

- **Provider Contracting:** Assumed efficiencies for reduced contracting and rate negotiation activity
- **Premium Billing and Reconciliation:** Assumed efficiencies for limited premium billing and accounts receivable reconciliation
- **Coordination of Benefits:** Assumed efficiencies for reduced coordination of benefit (COB) activity supported by simplified payer arrangements
- **Sales and Marketing:** Assumed expense for communication and collateral only
- **Corporate Services:** Assumed efficiencies for plan size and administrative simplification

4.3 ESTIMATED STAFFING NEEDS

From the administrative benchmarking tool, we modeled staffing estimates and developed a range of estimates for staffing needs by major administrative function based on Milliman's understanding of program design, operational model, and estimated enrollment. This range contains three different scenarios: highly efficient, best estimate, and less efficient. Figure 11 below shows the expected range of staffing needs for the UHP, assuming regular, steady-state operations and the inclusion of Medicare members in 2032. This is a total estimate across insourcing and outsourcing operations, so depending on Oregon's future decisions, some of these staff may be employed by the State and some may be employed by vendors. In addition, operational decisions made by the State in one functional area may impact the staffing needs in another functional area. For example, the decisions the UHP makes on operating its information technology infrastructure and systems could impact how many operations FTEs are needed.

FIGURE 11: 2032 ESTIMATED STAFFING NEED BY FUNCTIONAL AREA (VALUES SHOWN IN FTE HUNDREDS AND FTE THOUSANDS)

FUNCTIONAL AREA	HIGHLY EFFICIENT (ANNUAL)	BEST ESTIMATE (ANNUAL)	LESS EFFICIENT (ANNUAL)	CONTEXT
OPERATIONS	7,200	8,000	13,300	Includes provider network management, member services, claims management, and marketing / communications
ADMINISTRATION	540	580	1,300	Includes corporate services and administrative functions and activities under the chief strategy officer related to policy and public health alignment
FINANCE	640	890	1,400	All actuary, finance, accounting, and treasury activities including oversight of audit and financial compliance
INFORMATION TECHNOLOGY	1,400	2,000	3,000	Includes application development, analytics and reporting, interoperability, warehousing, IT operations, and information security
MEDICAL MANAGEMENT	3,300	4,300	5,900	Medical management functions, including utilization management, care management, disease management, population health, and oversight of pharmaceutical services
ESTIMATED TOTAL STAFFING*	**13,100**	**15,800**	**24,800**	

*Note, values are rounded. Actual efficiency will vary by functional area as performance in one functional area may impact efficiency in another functional area. Staffing needs are highly dependent on program design and operational model. Actual staffing could be outside the range presented here due to programmatic design choices. Best estimate represents expected value based on information known at the time of modeling. All numerical values shown have been rounded for ease of presentation. Accordingly, individual line items may not always add exactly to the displayed totals.

Staffing ranges have variances due to multiple factors including but not limited to:

- **Unknown Levels of Automation:** The future plan may involve a range of system automation. The UHP may choose to aggressively pursue automation and administrative simplification or may choose a higher-touch, flexible process-oriented approach. By 2032, advancements in technology could have meaningful impact on the operational systems and processes the UHP decides to implement, including the potential use of agentic artificial intelligence to autonomously manage workflows, make real-time decisions, and coordinate systems with minimal human intervention.
- **Unknown Insourcing / Outsourcing Levels:** Often insourced models may carry a higher staffing load than outsourced models as outsourced models enable vendors to spread workloads of multiple clients across commoditized FTE activities, such as claims processing, while insourced models cannot always take advantage of this flexibility and economies of scale.
- **Unknown Care and Medical Management Models:** Medical Management models are often customized to meet the benefit requirements and specific needs of populations being served. The final benefit design for the UHP is not entirely known and may require significant clinical oversight or not. Population complexity also influences Information Systems staffing levels. With more complex benefits and populations requiring more resources to support clinical programs, reporting, and more frequent and varied member interactions.

Given these variables, the “Best Estimate” staffing value represents the most likely estimate for staffing needs for the UHP. Milliman did not conduct a current state workforce assessment of Oregon’s healthcare insurance industry across the public and private sectors.

1. The National Association of Insurance Commissioners (NAIC) third quarter 2025 data for Oregon shows approximately 2,649 insurance-related establishments with 21,833 employees in the private sector. This number includes the following NAIC categories: 52411 (direct life, health, and medical insurance carriers), 52413 (reinsurance carriers), 52421 (insurance agencies and brokerages), and 52429 (other insurance related activities).[19] This data is not indicative of Oregon’s entire healthcare insurance industry as it does exclude the

[19] U.S. Bureau of Labor Statistics. Employment and Wages Data Viewer. https://data.bls.gov/cew/apps/data_views/data_views.htm#tab=Tables

public sector, likely excludes some operational technology vendors, and likely includes some non-healthcare insurance related establishments or employees.

2. America's Health Insurance Plans (AHIP) – the trade association for health plans – released a state-by-state workforce data report[20] for 2024 to 2025 that included approximately 14,400 health plan employees in Oregon. That estimate includes employees working for Medicaid CCOs, Medicare Advantage plans, and commercial insurers. This data is not indicative of Oregon's entire healthcare insurance industry as it does not include staffing from the Oregon Health Authority, Medicaid-adjacent staff (e.g., eligibility, policy, administrative), or vendors that cover dental, vision, and behavioral health services.

When Oregon is ready to implement the UHP, a current state assessment of the state's healthcare insurance industry workforce will be a critical step to understand the employment and impact across the state.

4.4 ESTIMATED ADMINISTRATIVE COSTS

From the above information, we modeled administrative costs using our benchmarking tool and developed a range of estimates for administrative costs and staffing from the output. This range contains three different scenarios: highly efficient, best estimate, and less efficient. Best estimate is defined as an estimate that has no intentional sources of bias towards being conservative or aggressive in assumptions. Figure 12 below shows the expected range of administrative costs for the UHP, assuming regular, steady-state operations and the inclusion of the entire population.

FIGURE 12: 2032 ESTIMATED ADMINISTRATIVE COSTS (VALUES SHOWN IN $ MILLIONS AND $ BILLIONS)

FUNCTIONAL AREA	HIGHLY EFFICIENT (ANNUAL)	BEST ESTIMATE (ANNUAL)	LESS EFFICIENT (ANNUAL)	CONTEXT
OPERATIONS	$1.23B	$1.69B	$2.23B	Includes provider network management, member services, claims management, and marketing / communications
ADMINISTRATION	$205M	$257M	$444M	Includes corporate services and administrative functions and activities under the chief strategy officer related to policy and public health alignment
FINANCE	$179M	$276M	$378M	All actuary, finance, accounting, and treasury activities, including oversight of audit and financial compliance
INFORMATION SYSTEMS	$595M	$921M	$1.16B	Includes application development, analytics and reporting, interoperability, warehousing, IT operations, and information security
MEDICAL MANAGEMENT	$1.24B	$1.69B	$2.45B	Medical management functions that include utilization management, care management, disease management, population health, and oversight of pharmaceutical services
DENTAL AND VISION	$191M	$268M	$370M	Includes costs for administering vision and dental benefits
ESTIMATED OVERALL ADMINISTRATIVE COST (PER YEAR)	**$3.6B**	**$5.1B**	**$7.0B**	**This estimate is on a per year basis**
ESTIMATED ADMINISTRATIVE COST*	**4.3%**	**6.0%**	**8.1%**	**% of Total UHP Expense**

*Note, values are rounded. Actual efficiency will vary by functional area as performance in one functional area may impact efficiency in another functional area. Administrative costs are highly dependent on program design and operational model. Actual administrative costs could be outside the range presented here due to programmatic design choices. Best estimate represents expected value based on information known at the time of modeling. Administrative costs as a percentage of premium are expected to go down to a steady state level as program matures. All numerical values shown have been rounded for ease of presentation. Accordingly, individual line items may not always add exactly to the displayed totals.

[20] https://ahiporg-production.s3.amazonaws.com/documents/State-Data-Book/202510-AHIP_StateDataBook_Oregon.pdf

Figure 13 below shows the expected range of administrative costs for the UHP, assuming regular, steady-state operations without Medicare beneficiaries (both FFS and Medicare Advantage) included in the costs. The variation between Figure 12 and Figure 13 is explained below in Section 4.5.

FIGURE 13: 2032 ESTIMATED ADMINISTRATIVE COSTS WITHOUT MEDICARE (VALUES SHOWN IN $ MILLIONS AND $ BILLIONS)

FUNCTIONAL AREA	HIGHLY EFFICIENT (ANNUAL)	BEST ESTIMATE (ANNUAL)	LESS EFFICIENT (ANNUAL)	CONTEXT
OPERATIONS	$ 636M	$880M	$1.16B	Includes provider network management, member services, claims management, and marketing / communications
ADMINISTRATION	$133M	$166M	$287M	Includes corporate services and administrative functions and activities under the chief strategy officer related to policy and public health alignment
FINANCE	$111M	$171M	$234M	All actuary, finance, accounting, and treasury activities, including oversight of audit and financial compliance
INFORMATION SYSTEMS	$368M	$570M	$720M	Includes application development, analytics and reporting, interoperability, warehousing, IT operations, and information security
MEDICAL MANAGEMENT	$644M	$879M	$1.27B	Medical management functions, including utilization management, care management, disease management, population health, and oversight of pharmaceutical services
DENTAL AND VISION	$113M	$177M	$244M	Includes costs for administering vision and dental benefits
ESTIMATED OVERALL ADMINISTRATIVE COST (PER YEAR)	**$2.0B**	**$2.8B**	**$3.9B**	**This estimate is on a per year basis**
ESTIMATED ADMINISTRATIVE COST*	**3.9%**	**5.4%**	**7.4%**	**% of Total UHP Expense**

*Note, values are rounded. Actual efficiency will vary by functional area as performance in one functional area may impact efficiency in another functional area. Administrative costs are highly dependent on program design and operational model. Actual administrative costs could be outside the range presented here due to programmatic design choices. Best estimate represents expected value based on information known at the time of modeling. Administrative costs as a percentage of premium are expected to go down to a steady state level as program matures. All numerical values shown have been rounded for ease of presentation. Accordingly, individual line items may not always add exactly to the displayed totals.

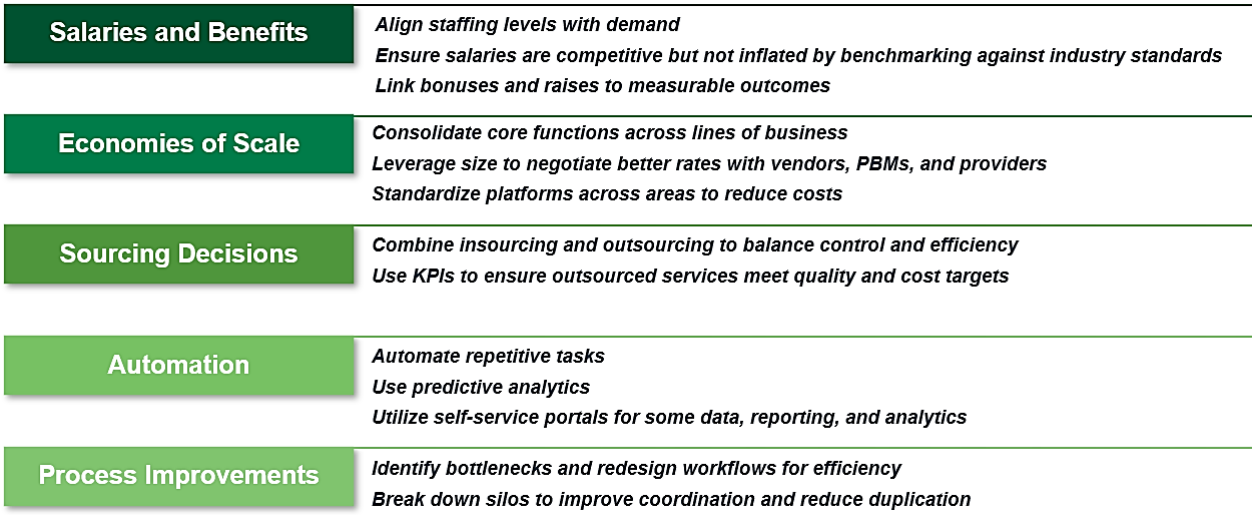
4.5 INTERPRETING THE ADMINISTRATIVE COSTS

Benchmarks are produced as ranges from most to least efficient as depicted above. The “highly efficient” and “less efficient” represent the lowest and highest observed data points, respectively, from our UHP administrative expense benchmarks. The “best estimate” data point represents a mid-range scenario for administrative costs.

When interpreting the administrative costs in the context of the total cost of the UHP, the “less efficient” administrative cost scenario may not always align with the high total cost UHP scenario (see Figure 1). For example, being administratively “less efficient” (investing more) in medical management could potentially result in lower total healthcare costs for certain enrollees by better managing their health. The intent of the scenarios is to illustrate the widest range of potential costs the UHP could encounter based on the modeled scenarios.

In traditional health plans, total expense is typically around 85% to 90% cost of care and 10% to 15% administrative costs (including profit margin), though administrative costs can be lower or higher depending on plan size, product complexity, market segment, distribution strategy, and the degree of operational efficiency. Typically, around 60% of the administrative costs are related to staffing expenses. Figure 14 below details some of the strategies that health plans use to support administrative cost efficiency.

FIGURE 14: ADMINISTRATIVE EXPENSE MANAGEMENT LEVERS



In a universal or single payer health plan, we would expect administrative expenses to be lower than a typical health plan due to opportunities for standardization and uniformity in plan administration, simplified data integration and collection modalities, centralization, and economies of scale, including volume contracts and fixed cost investments. The projected administrative expenses for Oregon's UHP reflected this expectation.

Based on the current program design and operational model, we would expect administrative costs in 2032 to be between 4.3% and 8.1% of the total universal health plan expenses, which equates to a dollar range of approximately $3.6 to $7.0 billion dollars per year. The best estimate of approximately $5.1 billion dollars (~6.0%) leans slightly more towards the highly efficient scenario, which is expected given the potential administrative efficiencies of the UHP.

If the State excludes Medicare enrollees from the UHP, we anticipate that administrative costs would be between 3.9% and 7.4% of total expenses, and the costs would likely fall between $2.0 to $3.9 billion dollars per year for the plan. When excluding Medicare enrollees, the projected UHP administrative costs are less than when these enrollees are included. This change is predominately driven by two factors:

1. The decrease in total plan enrollment – see Figure 28 where Medicare enrollees (~1.1 million) comprise approximately 24.7% of total 2032 UHP enrollment. Decreasing total enrollment by this amount impacts the demand on staffing, operations, and associated administrative costs.
2. The medical complexity of the Medicare population – numerous data sources show that individuals covered by Medicare have higher illness burden, comorbid and chronic conditions, medication use, and healthcare utilization compared to the general adult population. Supporting this population is more administratively burdensome (e.g., medical management) for a plan than supporting the general adult population. When excluding this more complex population, it also impacts staffing, operations, and associated administrative costs.

As presented above, we expect the UHP to operate at a more efficient administrative expense rate than a traditional health plan. The UHP can also anticipate that it will be less efficient in the beginning and become more efficient with time as automation is adopted and operational rigor is enhanced.

4.6 TECHNOLOGY NEEDS

An integrated technology ecosystem that automates workflows, delivers reliable member and provider experiences, and meets strict security and privacy obligations is foundational to Oregon's UHP operations. Key technology domains to consider include claims processing, provider network and credentialing, call center operations, member and provider portals, medical management, insurance card production, reporting and analytics, and core infrastructure systems (e.g., financial, webpages, data management). Two strategic imperatives cut across all domains – robust health information exchange capabilities and unified cybersecurity and privacy controls. While detailing the domains needed for Oregon's UHP below, it is important to note that prioritizing automation, interoperability, and unified security will

enable efficient operations, regulatory compliance, and ideally, a better experience and outcomes for UHP enrollees and providers. Across all of technology domains, Oregon's UHPGB will have to make operational decisions about insourcing and outsourcing these capabilities.

Claims Processing: A modern claims platform should provide easy-to-use, end-to-end adjudication that reliably handles all claim types with high accuracy and minimal manual touch. These claim types include professional, institutional, and pharmaceutical. The platform should orchestrate automated workflows for common processes, such as claim edits, prior authorization linkage, coordination of benefits, payment integrity reviews, and denial management to reduce rework and ensure speedy resolution. Standards-based Electronic Data Interchange (EDI) must be supported with direct integration to clearing houses and payment vendors. Pending the UHP's final decisions, the system could need flexible configuration capabilities for benefits, fee schedules, plan designs, and real-time eligibility checks. To monitor performance, comprehensive dashboards and audit trails are essential to maintain throughput, accuracy, and compliance.

Provider Network and Credentialing*:* Provider network management should cover the full lifecycle of credentialing, contracting, onboarding, and ongoing performance management for the entire network. For the UHP, this includes the capability to manage all providers across the State of Oregon. Automated workflows should support primary source verification, sanctions monitoring, re-credentialing, and contract approvals to maintain network quality and compliance. The platform should integrate with external data sources such as the Council for Affordable Quality Healthcare (CAQH) and National Plan and Provider Enumeration System (NPPES) to validate provider data. In addition, a network adequacy monitoring tool with insightful analytics is important to understand where provider and specialty gaps may exist across the State. Configurability for different reimbursement models and tracking of quality programs will help ensure the state-wide network can evolve with UHP strategies and state or federal regulatory requirements.

Call Center: The communications network should enable omnichannel engagement (phone, chat, email, portal messaging, and SMS) so enrollees and providers can reach the UHP through their preferred method. Clear, actionable metrics and reporting, such as first-call resolution, average call time, and abandonment rate are needed alongside quality monitoring and recording to drive continuous improvement. Given the membership and provider network size, the UHP will require 24/7 capabilities. This will include CRM integration and intelligent routing to give member / provider service agents a unified view of member and provider histories. Knowledge management systems and scripting will help ensure standard responses and maintain consistent experiences for Oregon enrollees.

Member Portal: A member portal should offer intuitive access to coverage information, claims and explanations of benefits (EOBs), and communication channels. Leading solutions also include telehealth options, care management, and wellness programs. Self-service capabilities are foundational, like viewing ID cards, provider searches, cost estimates, and filing or tracking appeals and grievances. The population distribution within the UHP means that the member portal must be mobile-responsive, meet accessibility standards, and provide multilingual support for broad usability. A strong identity verification process and privacy controls will help safeguard personal health information and build member trust in the UHP.

Provider Portal: A provider portal should predominately aim to reduce the administrative burden and give straightforward access to claims status, authorizations, reimbursement details, and population health insights. It must support secure messaging with care teams and offer capabilities that help close care gaps by surfacing actionable information at the point of need (e.g., what additional information may be needed for approval). Ideally, the portal will connect directly to the claims processing system to provide real-time status updates and reduce the volume of support calls.

Medical Management: To coordinate care efficiently across the entire population and state, an advanced medical management system will be required. Central to this system are interoperable electronic health records (EHRs) that allow providers, hospitals, pharmacies, and public health agencies to securely share patient information in real time. Integrated data platforms will help track patient histories, manage chronic diseases, and reduce duplication of tests and procedures. Telemedicine systems expand access to care, especially in rural or underserved areas, while clinical decision-support tools use data analytics and artificial intelligence to help clinicians choose effective treatments and identify high-risk patients early. This technology will help monitor population and patient outcomes while controlling costs and ensuring that care delivery remains coordinated across the entire state.

Insurance Card Production / Management: The system for insurance card management must securely and efficiently handle the production and full lifecycle of both physical and digital ID cards. Capabilities should include digital wallet support and instant issuance to accommodate new enrollments or changes without delay. Complete audit trails will be critical to ensure efficient reprints and replacements. These functions need to integrate seamlessly with potential enrollment systems and the member portal to streamline operations and improve member experience. Oregon will need

to decide on its operational approach for insurance cards as there are other global universal systems that do not use them as they rely on other government provided identification.

Reporting Systems / Tools: Reporting should be integrated across all operational systems to deliver near-real-time dashboards for day-to-day management and to automate regulatory submissions. A state-wide enterprise data warehouse or lakehouse, paired with data quality tooling, underpins reliable self-service analytics and business intelligence for leaders across the UHP. The reporting environment must support compliance and performance measurement needs (e.g., HEDIS) to ensure the UHP can meet federal regulatory obligations and drive state-wide quality improvement efforts.

Foundational Infrastructure Systems: To operate the UHP, there are foundational business capabilities that will be required, like a financial management system covering general ledger, accounts payable / receivable, reconciliation, and potential capitation payments or risk adjustment revenue. A modern website and content management system should power the public-facing site, maintain accurate plan and provider directory information, and enable self-service features. To support the aforementioned reporting systems, the underlying data and infrastructure management should leverage cloud or hybrid architectures with strong backup and disaster recovery. Given the sensitive nature of the protected health information (PHI) that the UHP will house, comprehensive observability and logging, disciplined configuration, and secure, master data management will be critical to maintain consistent member and provider data across the State. While there are risks with building this infrastructure and managing this data, it gives Oregon an opportunity to have a comprehensive health information exchange across its State.

5 Benefits and Plan Design

5.1 BASELINE 2026 HEALTHCARE COVERAGE SOURCES IN OREGON

Access to health insurance coverage, in the United States broadly and Oregon specifically, comes from a variety of sources. Essentially, the system is primarily employer-based with exceptions for other eligibility categories based on income, age, or disability status. Citizens can qualify for Medicare on the basis of age (above 65) or disability status. Medicaid provides coverage for those with eligibility primarily tied to income level but also disability status and other special eligibility groups. For those without employer coverage and not qualifying for either Medicare or Medicaid, the individual market provides coverage on a voluntary basis on either a federally subsidized or non-subsidized basis.

Current sources of coverage by market as of 2026 specific to Oregon are summarized in Figure 15 below.

FIGURE 15
OREGON UNIVERSAL HEALTH PLAN
SOURCES OF HEALTHCARE COVERAGE BY MARKET

MARKET	SUB-MARKET	INSURANCE TYPE	MEMBERS
Commercial	**Public**	PEBB	Public Employees Benefit Board – employer coverage for all public employees of the State of Oregon, excluding educators.
		OEBB	Oregon Educators Benefit Board – employer coverage for those in the Oregon public educational system.
		Other Public	Federal employees.
	Employer - LG	Fully Insured	Employees and dependents of an employer with 50 eligible employees or more. Premiums for insurance coverage paid primarily by the employer with a smaller employee contribution.
		Self-Funded	Employees and dependents of an employer of any size. Funded primarily by the employer with an employee contribution. Employer is at varying degrees of risk for costs of the plan.
	Employer - SG	Fully Insured	Employees and dependents of an employer with less than 50 eligible employees. Premiums for insurance coverage paid primarily by the employer with a smaller employee contribution.
	Individual	Health Insurance Marketplaces or off-Marketplace	Individuals and families that do not qualify for employer-based coverage or any other public program and have income of at least 200% of the Federal Poverty Level (FPL). Federally subsidized coverage or non-subsidized coverage can be obtained through the Marketplace.
Medicaid	**Medicaid**	Oregon Health Plan	Under 65 adults with an income of 138% FPL or less.
	CHIP	Oregon Health Plan	Uninsured children under age 19 and some pregnant women dependent on income.
	Bridge	Oregon Health Plan	Under 65 adults with an income between 138% to 200% FPL.
Medicare	**Medicare**	Fee For Service (FFS) Part A	Hospital Insurance for 65 and older eligible adults.
		FFS Part B	Non-hospital Insurance for 65 and older eligible adults.
		Advantage Part C	Private alternative to FFS. Includes Part A and B and may include additional benefits.
		Advantage Part D	Prescription drug private coverage for 65 and older adults.
		Medigap	Originally known as Medicare Supplement, a premium is paid to reduce out-of-pocket spending for FFS members.
		Dual Eligibles	Individuals enrolled in both Medicare and Medicaid.

For convenient reference, the estimates for baseline 2026 enrollment corresponding to the market definitions above are shown in Figure 16 below with dual eligibles included with the Medicare population. A description of the development of this figure and further discussion of baseline 2026 estimates can be found in Section 6.1 in this report.

FIGURE 16
OREGON UNIVERSAL HEALTH PLAN
2026 BASELINE ENROLLMENT ESTIMATES

MARKET	BASELINE
Public	712,000
Employer	929,000
Individual	165,000
Medicaid	1,360,000
Medicare	1,004,000
Uninsured	122,000
Total	**4,293,000**

Not listed in the figure above is care obtained through Veterans Affairs (VA), Tri-Care, or the Indian Health Service (IHS). As directed by the PD&E committee, we assume for modeling purposes that medical and prescription drug services obtained under these programs are captured in the costs of the other coverage sources listed above. In particular, both the VA and the IHS function as a provider of services rather than a source of health insurance coverage. Any Oregonian that is qualified to receive services from these facilities and is enrolled in the UHP would still be able to access the VA or IHS as a provider, as is the case under the current system.

5.2 BENEFITS UNDER THE UHP

As directed by the PD&E committee and the UHPGB, covered benefits under the UHP will be based on the current PEBB benefits[21] offered to Oregon's public employees. Major medical plans in the 2026 baseline generally cover the services shown in Figure 17 below, which outlines the benefits covered by PEBB, ACA essential benefits, and Medicaid.

FIGURE 17
OREGON UNIVERSAL HEALTH PLAN
MAJOR MEDICAL AND PRESCRIPTION DRUG BENEFITS UNDER THE UHP

SERVICE CATEGORY	INPATIENT	OUTPATIENT	PHYSICIAN	OTHER	PRESCRIPTION DRUGS
Services	Medical / Rehab / Surgical Admissions	Emergency	Preventive	Home Health	Generic
	Psychiatric / Substance Abuse Admissions	Radiology / Pathology	Urgent Care	Ambulance	Brand
	Maternity	Therapy	Office Visits	DME / Prosthetics	Specialty
	Skilled Nursing Facility	Psychiatric / Substance Abuse	Exams		

The UHP will cover all benefits in the figure above for all eligible enrollees. This figure represents what is referred to as major medical and prescription drug benefits.

With regard to Medicare drug coverage, standard Medicare FFS does not have prescription drug coverage unless it is purchased separately under the Part D program. Likewise, Medicare Advantage, does not cover retail prescription drugs unless either an MA-PD (Medicare Advantage with Part D) plan or an MA Plan and a separate PD plan is purchased. Regardless, prescription drug coverage for Medicare enrollees is effectively voluntary and not every enrollee purchases it.

[21] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-698450_2.pdf

Under the UHP, all Medicare eligible enrollees would receive integrated prescription drug coverage as a standard benefit, eliminating in some cases the need to enroll in separate drug plans and multiple coverage programs. This consolidation will increase the number of Oregon state residents / enrollees with access to prescription medications but consequently increases costs under the UHP.

5.3 "PLUS" BENEFITS

The PEBB plan covers a broader range of services than most other health insurance markets. Inclusion of these additional benefits for all Oregonians in the UHP would result in a material increase in benefits attributable to markets or plans where no such coverage is offered, resulting in an increase in costs of the UHP relative to the status quo scenario.

Figure 18 below highlights the additional services covered for adults by the PEBB plan compared to other insurance options. In this report we refer to this specific package under consideration by the UHPGB as the "Plus" set of ancillary benefits.[22]

Additionally, for simplicity, we list several benefits as optional which may have different implications depending on the market. For example, dental is listed as optional in many markets. Most large group employers offer dental coverage options and often contribute towards that cost, but it is up to the employee whether they elect coverage or not.

In the individual market and Medicare Advantage market, many plans include dental but the additional premium, fully born by the enrollee, directly impacts the individual deciding on coverage. In the Individual market, take up rates on dental coverage are often very low, given that unsubsidized health premiums are already perceived as very expensive, or for lower income subsidized individuals, the additional premium is viewed as unaffordable.

FIGURE 18
OREGON UNIVERSAL HEALTH PLAN
"PLUS" ANCILLARY BENEFITS COVERAGE FOR ADULTS BY MARKET

MARKET	PUBLIC	LARGE & SMALL GROUP	INDIVIDUAL	MEDICAID	MEDICARE ADVANTAGE	MEDICARE FFS
Dental	Optional	Optional	Optional	Partial	Optional	No
Vision	Optional	Optional	Optional	Yes	Optional	No
Glasses	Optional	Optional	Optional	Partial	Optional	No
Fertility Services	Yes	Optional	No	No	No	No
Sleep Studies	Yes	Optional	No	No	Optional	No
Doula Services	Yes	No	No	Yes	No	No
Hearing Aids	Yes	Optional	Optional	Yes	Optional	No
Massage Therapy	Yes	Optional	Optional	No	Optional	No
Complementary Medicine	Yes	Optional	Optional	Yes	Optional	No

Key: Green = Increase in benefits under UHP for all current enrollees. Yellow = Increase in benefits under UHP for some of the current enrollees.

As shown by the color coding, Medicare FFS enrollees will see an increase in benefits as none of the "Plus" benefits are available under the current system. Individual and Medicare Advantage also stand to gain benefits, on average, relative to the current system. By expanding the benefit package to include additional services, enrollees will see lower out-of-pocket costs for care that they previously paid themselves or purchased through separate standalone policies. Integrating these services into the UHP plan reduces the need for enrollees to maintain multiple insurances, simplifies benefit navigation, and provides stronger financial protection, especially for enrollees with ongoing clinical or functional needs.

5.4 COVERED BENEFITS ADJUSTMENTS

External forces such as political changes and pressures can impact the baseline, status quo, and UHP estimates. The 2026 baseline estimates adjust for legislative requirements implemented prior to the baseline year but are not reflected in the underlying data. Figure 19 below summarizes these adjustments.

[22] In the figure, only adults are shown for simplicity. A number of these markets require coverage of select listed benefits for children, such as pediatric dental, which is required coverage in the Individual and Medicaid markets.

FIGURE 19 OREGON UNIVERSAL HEALTH PLAN BENEFITS COVERED BY RECENT LEGISLATION	
Gender Affirming Care[23]	House Bill 2002 prohibits health insurers from denying claims for medically necessary gender-affirming treatment that is prescribed in accordance with accepted standards of care
Insulin Cap[24]	Senate Bill 1508 caps insulin at $35
Enhanced Behavioral Health[25]	The 2025 to 2027 Governor's Budget sets aside $1.82 Billion Biennium

In addition, the healthcare landscape remains a constantly evolving and fluctuating system. There are always new treatments and prescription drugs in development that have could have a material impact on expenditure estimates. However, it is difficult to predict many of these outcomes and our estimates primarily assume that there will be no net impact. We do make explicit adjustments for specific emerging treatments, such as GLP-1 for weight loss, Cell and Gene Therapies, and monoclonal antibodies. These adjustments are discussed in detail in Section 6 of this report. Adjustments for these specific impacts are made because extensive research has already been completed to inform estimates, and impacts are highly likely to increase healthcare expenditures in the future. Figure 20 below outlines current coverage levels for these treatments. In Figure 20, strict prior authorization (PA) is rule based where approval is granted only if specific criteria such as step therapy are met, variable PA is case-by-case depending on detail such as diagnosis or provider justification, and limited is where review only occurs in certain situations or under certain criteria such as age limits or number of office visits.

FIGURE 20
OREGON UNIVERSAL HEALTH PLAN
GLP-1 / CELL AND GENE THERAPY BASELINE 2026 COVERAGE BY MARKET

MARKET	PUBLIC	LG	SG	INDIVIDUAL	MEDICAID	MEDICARE ADVANTAGE	MEDICARE FFS
GLP-1 for Weight Loss	No	Variable and Strict	Variable and Strict	Variable and Strict	Very limited	No	No
Cell and Gene Therapy	Strict PA	Strict PA	Strict PA	Strict PA	Case-by-case medical review board	Limited	Limited
Monoclonal Antibodies – Alzheimer's	Strict PA	Strict PA	Strict PA	Strict PA	Limited	Covered	Covered

5.5 BENEFITS ACCESSED THROUGH MEDICAID

Medicaid typically has state requirements that include additional coverages or coverage levels of benefits in excess of the ACA essential health benefits or employer market plans to serve Medicaid population health needs better. The UHP intends to comply with a requirement that no individual be subject to fewer benefits than they are currently eligible for. The estimates in this report reflect this requirement other than where these additional benefits are carved out and funded through alternate mechanisms.

The UHPGB requested that Long-Term Services and Supports (LTSS) be excluded from UHP cost estimates. LTSS costs make up a material portion of Medicaid expenditures – approximately $5.3 billion dollars in 2024. This means that individuals who currently receive LTSS will continue to access these benefits through Medicaid, rather than through the UHP.

Accordingly, all LTSS expenditures, including costs associated with institutional care (such as nursing facilities) and home and community-based services, have been excluded from our financial projections for the UHP. While those who currently receive LTSS are still included in our overall enrollment projections, their projected costs under the UHP reflect only non-LTSS healthcare services. In other words, our cost estimates for those receiving LTSS benefits do not include any expenses related to LTSS, and only services that are covered by the UHP.

[23] https://dfr.oregon.gov/insure/health/pages/gender-affirming-care.aspx
[24] https://www.oregonlegislature.gov/senatedemocrats/Documents/240213%20SB%201508.pdf
[25] https://www.oregon.gov/das/financial/documents/2025-27_gb.pdf

5.6 PLAN DESIGN

UHP estimates assume that all the benefits discussed in this section are covered with no cost sharing to the member. This level of cost sharing represents a richer plan design than currently offered in every market other than Medicaid. The level of plan richness is often called "Actuarial Value" or "AV." The AV of a particular plan is the average amount of benefits covered by a health insurance plan relative to the total cost of the plan, with the remaining amount paid in cost sharing by the member. Since a portion of all healthcare costs is currently paid through enrollee cost sharing, this amount will be absorbed by the State under the UHP, representing an increase in costs over the status quo scenario. We estimated the average deductible, maximum out-of-pocket, and AV in each market to help understand the increase in plan richness or AV when moving to the UHP.

Figure 21 below provides a comparison of deductibles and maximum out-of-pocket amounts for the PEBB plan and the average plan in other markets in 2023. Please note that the benefit cost increase due to AV is an illustrative amount to show an approximation of how much additional cost is a result of the elimination of cost sharing.

FIGURE 21
OREGON UNIVERSAL HEALTH PLAN
OREGON PLAN DIFFERENCES BY MARKET - 2023

MARKET	SUB-MARKET	AVERAGE DEDUCTIBLE	MAX OUT OF POCKET	ACTUARIAL VALUE	UHP COST INCREASE DUE TO AV	SAMPLE PLANS
Public	PEBB / OEBB / Other Public	$250	$1,500	95%	5%	Kaiser Deductible and Moda - $250 Ded, $1,500 MOOP Kaiser Traditional - $0 Ded, $600 MOOP Providence Statewide PPO - $250 Ded, $1,900 MOOP
Large Employer	Fully Insured / Self-Funded	$2,000	$4,500	85%	18%	Ded/Coins/Copay - $500 Ded, $3,000 MOOP HDHP - $5,000 Ded, $7,200 MOOP
Small Employer	Fully Insured	$2,500	$5,500	80%	25%	Ded/Coins/Copay - $500 Ded, $3,000 MOOP HDHP - $5,000 Ded, $7,200 MOOP Gold - $1,800 Ded, $7300 MOOP Silver - $4,800 Ded, $9,100 MOOP
Individual	Exchange / Off-Exchange	$3,500	$6,000	75%	33%	Gold - $1,800 Ded, $7,300 MOOP Silver - $4,800 Ded, $9,100 MOOP Bronze - $8,800 Ded, $8,800 MOOP Silver CSR 94 - $125 Ded, $1,000 MOOP
Medicaid	Medicaid / Bridge / CHIP	$0	$0	100%	0%	Oregon Health Plan (OHP) - $0 Cost Sharing
Medicare Advantage	Medicare Part C	$125	$4,750	85%	18%	HMO - $0 Ded, $3,000 MOOP PPO - $500 Ded, $8,000 MOOP
	Medicare Part D	$50	No Max*	85%	18%	Defined Standard (DS) - $505 Ded, No Max OOP Actuarially Equivalent (AE) - $200 Ded, No Max OOP Basic Alternative (BA) - $505 Ded, No Max OOP Enhanced Alternative (EA) - $0 Ded, No Max OOP
Medicare FFS	Medicare Part A + B	$1,826	No Max	80%	25%	Part A: $1,600 Ded, No Max OOP Part B: $226 Ded, No Max OOP

*Max of $2,000 began in 2025.

While the UHP with zero cost sharing is our main scenario, as directed by UHPGB, an alternate benefit scenario defined as the "low cost sharing" scenario is also modeled, as presented in Figure 22 below. This second scenario removes the Plus benefits and introduces copays on Emergency Room and Prescription Drug services and is discussed in further detail in Section 7.6.

FIGURE 22
OREGON UNIVERSAL HEALTH PLAN
SCENARIO DESCRIPTIONS

SCENARIO	COST SHARING	PLUS BENEFITS INCLUDED*
Zero Cost Sharing	All services will be available for no charge to eligible enrollees. Some annual limits for dental may apply.	Yes
Low-Cost Sharing	**Emergency Room**: $200 copay **Prescription Drugs**: $5 / $75 / $150 copay for Generic / Preferred Brand / Specialty and Non-Preferred Brand. **Member Out-of-Pocket Maximum**: $1,250 per year.	No

*Dental, Vision, Fertility, Fitness, Sleep Studies, Doula Services, Hearing Aids, Massage Therapy, and Complementary Medicine.

It is important to emphasize that the second scenario analyzed is intended solely as an illustrative example. While a reasonable alternative, it is not a recommendation or endorsement of this design, or any specific UHP plan design. However, the alternative scenario reflects considerations already commonplace across markets today: that enrollee cost sharing is useful, when applied thoughtfully, to promote cost conscious decision making by enrollees, thereby reducing overall program costs.

It should also be cautioned that while member cost-share amounts can offset plan spending, introducing copays or coinsurance typically requires additional administrative burden and collectability challenges. This can reduce the net savings attributable to cost sharing, meaning the actual cost difference realized from member contributions may be lower than projections after netting out increased administrative costs.

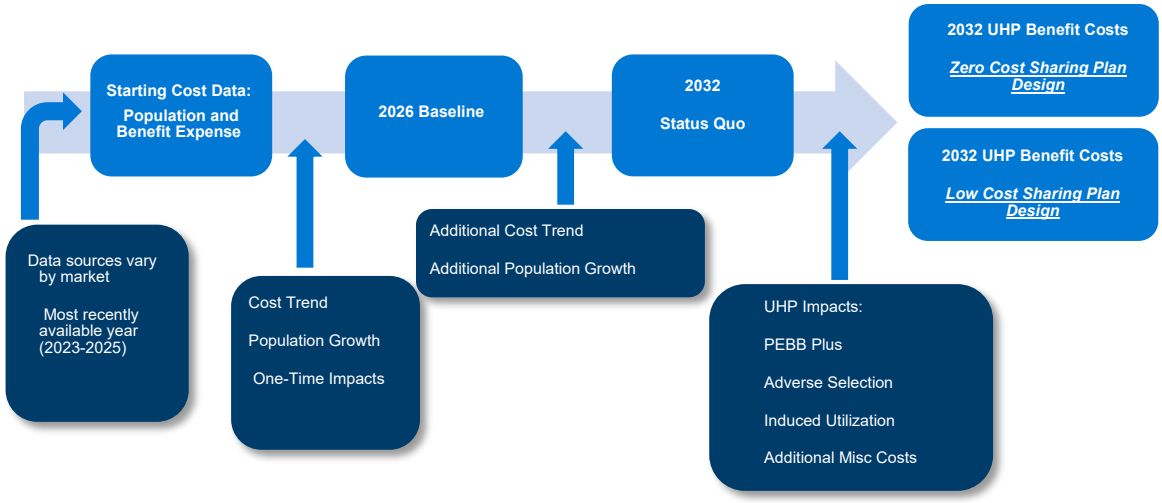
6 Actuarial Analysis

This following section details the actuarial modeling of healthcare expenditures in Oregon under a UHP starting in 2032.

The approach begins with developing a baseline estimate of Oregon expenditures as of 2026. That baseline is projected forward for impacts, such as annual increases in health care costs (trend), population growth, and one-time market impacts related to legislative changes to arrive at a status quo projection as of 2032. This status quo estimate for 2032 is then adjusted for estimated impacts related to the implementation of the UHP.

Note that this graphic includes both UHP scenarios, Zero Cost Sharing and Low Cost Sharing. However, development of estimates and results in this section are shown for the ***Zero Cost Sharing scenario only***. The Low Cost Sharing scenario is discussed in more detail in Section 7.6.

FIGURE 23: KEY STEPS IN DEVELOPING THE UHP BENEFIT COSTS FOR A 2032 IMPLEMENTATION



6.1 DEVELOPING 2026 BASELINE ESTIMATES

6.1.1 Enrollment

Enrollment is built from various public sources specific to each market defined in Section 5.1 above. The most recent data for each market that is reasonable is used, ranging from 2023 to 2025 depending on the market. Data sources for these estimates are listed in Section 8.1.3.

Source data is adjusted for general population growth to 2026. Adjustments are also made for known population changes due to legislative and market changes, listed in Figure 24 below.

FIGURE 24
OREGON UNIVERSAL HEALTH PLAN
2026 BASELINE ENROLLMENT ADJUSTMENTS

MARKET	BASE DATA YEAR	ADJUSTMENT(S) TO 2026
Public	2023 to 2024	None
Employer LG FI	2024	None
Employer SG FI	2024	Continued decline in membership (8% annual reduction)
Employer Self-Insured	2024	Increase from SG decline
Individual	2025	Decline for end of Enhanced Advance Premium Tax Credits (eAPTCs): 5% reduction and increase from SG decline
Medicaid	2025	None
Medicare	2023	Decline for HR1 Impacts (1% reduction)[26]
Uninsured	2024	Increase from Individual market due to end of eAPTCs

[26] https://www.congress.gov/bill/119th-congress/house-bill/1

Consistent with guidance from the UHPGB, public employees who reside outside the State have been excluded from enrollment estimates, as they do not meet eligibility requirements. As such, enrollment totals for 2026 are set to balance to the projected statewide total of 4.293 million residents, estimated by the Oregon Office of Economic Analysis.[27] This results in a baseline 2026 estimate for enrollment shown in Figure 25 below. Note that dual eligibles are included with the Medicare population in the figure below.

FIGURE 25
OREGON UNIVERSAL HEALTH PLAN
2026 BASELINE ENROLLMENT ESTIMATES

MARKET	BASELINE
Public	712,000
Employer	929,000
Individual	165,000
Medicaid	1,360,000
Medicare	1,004,000
Uninsured	122,000
Total Oregon Population	**4,293,000**

Enrollment assumptions are based on CMS, Oregon Health Authority (OHA) reporting, All-Payer All-Claims (APAC) data, and other Oregon reports (See Figure 56 in Section 8.1.3 for source links). These sources produce a specific distribution of enrollment across markets that may differ if other sources are used. For example, there are inconsistencies when reconciling with the Oregon Department of Consumer and Business Services (DCBS) quarterly health enrollment reports.[28] However, these differences have no material impact on statewide enrollment totals used in the baseline 2026 (or on projected UHP enrollment for 2032).

6.1.2 Medical and Prescription Drug Healthcare Cost Estimates

Source data for baseline healthcare costs are expressed either on an "allowed" cost basis or a "benefit" cost basis.

- **Allowed Cost:** Refers to the total payment made to a provider for the delivery of a service. This includes both the amount paid by the payer (i.e., insurer, Medicaid, employer etc.), and the portion paid by the enrollee (cost sharing).
- **Benefit Cost:** Represents the portion of the allowed cost covered by the payer, paid as a benefit due under the insurance program, self-funded employer program or public program, excluding the enrollees portion.

Note that in baseline 2026 and status quo in this section and Section 6.2, we only display allowed cost estimates which are a sum of benefit costs and cost sharing. Under the UHP, the primary proposal calls for zero enrollee cost sharing, making the allowed cost equal to the benefit cost.

In cases where only benefit costs were available, benefit costs from the public sources is converted to allowed costs by dividing by the ratio of benefit costs to allowed costs taken from Oregon's All-Payer All-Claims (APAC) data and the Milliman *HCGs*. Figure 26 in Section 6.1.4 outlines the cost basis for base data in each market.

6.1.3 Trend

Future healthcare costs are projected by applying annual trend assumptions to account for expected changes in price, utilization, and mix of services over a period of time. This typically excludes one-time impacts. Milliman's trend assumption is based on Oregon-specific information from national healthcare expenditure (NHE) data.[29] Specifically, the annualized annual percentage growth from 1991 through 2019 is used. Covid / pandemic years starting in 2020 were intentionally excluded when calculating an average annual increase. The resulting base trend used for healthcare costs is 5.3%. This trend forms the basis for low-projection estimates.

A multiplicative 2% increase to this trend is used to set the trend underlying the high-projection estimates (1.053 x 1.020 = 1.074). This represents the 83rd percentile of historical annual changes in the health expenditures for Oregon. While it is less likely that this high level of trend is sustained for six or more years, recent trends, particularly

[27] https://www.oregon.gov/das/OEA/Pages/forecastdemographic.aspx
[28] https://dfr.oregon.gov/business/reg/reports-data/annual-health-insurance-report/pages/health-ins-enrollment.aspx
[29] https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected

for prescription drugs, have been materially higher than historical levels. The high trend estimate represents a more conservative position on a reasonable range of trend estimates.

Healthcare expenditures, both nationally and within Oregon, have consistently outpaced wage growth and inflation. Nationwide expenditure trends are slightly lower than those observed in Oregon. While Oregon-specific data may better reflect state-specific reimbursement levels, cost of care, utilization patterns, and prescription drug use, multiple trend assumptions can be justified. Conducting sensitivity testing is important to assess the impact of fluctuations in trend assumptions on the results, as any chosen trend assumption is likely to deviate from actual future trends. We discuss sensitivity testing in Section 6.6 below.

Oregon's sustainable health care cost growth target annual report sets a target of 3.4%.[30] Since this goal has not been met in recent years, we use a trend consistent with actual historical experience.

6.1.4 Cost Projection from Source Data to 2026

Consistent with the approach to enrollment estimates, costs were built from various sources specific to each market. When available, the most recent reasonable source was selected, with sources ranging from 2023 to 2024, depending on the market. Specific sources with notations can be found in Section 8 in this report.

Costs from the source year are projected for two or three years to arrive at 2026 baseline costs. Note for the baseline projection, a more recent isolated trend of 5.0% is used, based on the Oregon health Care Cost Trends Report.[31]

FIGURE 26
OREGON UNIVERSAL HEALTH PLAN
2026 BASELINE MEDICAL AND PRESCRIPTION DRUG COSTS

MARKET	SOURCE DATA YEAR	BASIS	PMPM	ANNUAL TREND	YEARS OF TREND	OTHER ADJUSTMENTS	2026 PROJECTED ALLOWED PMPM
Public	2023	Allowed	$568	5.0%	3	6%	$698
Employer	2024	Benefit	$544	5.0%	2	17%	$701
Individual	2024	Benefit	$512	5.0%	2	22%	$692
Medicaid	2024	Benefit	$631	5.0%	2	0%	$697
Medicare	2023	Allowed	$1,264	5.0%	3	0%	$1,452
Uninsured	2023	Allowed	$344	5.0%	3	0%	$399
Total			**$732**				**$866**

In addition to trend, sources are then adjusted for the following:

- If the source data was on a Benefit basis, it is grossed up using its average AV to convert to an allowed basis.
- The 2025 to 2027 Governor's Budget set aside $1.819 billion on a biennial basis for expanded behavioral health services. We remove approximately $168 million from the $1.819 billion for residential treatment capacity expansion, workforce development, Oregon State Hospital stabilization, and Certified Community Behavioral Health Clinic expansion. Since this amount is biennial, we then apply half of the remaining amount, for a total of $800 million.
- Insulin caps and gender affirming care results in minor adjustments applied (each less than $20 million) and both are reflected in market totals.
- Unreimbursed Medicaid in Oregon is for treatments and services for Medicaid members where the provider was not reimbursed for the care provided. This assumption is sourced from the 2025 Oregon Community Benefit Report and trended forward to 2026.[32] Note that this is a distinct amount from costs related to the uninsured, which are based on charity care and subsidized health services, specifically for those without any type of coverage.
- Figure 27 presents the estimated 2026 baseline for major medical and prescription drug allowed costs by market, reported both on a per member per month (PMPM) basis and as a total annual amount (calculated as

[30] https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf
[31] https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf
[32] https://oregonhospitals.org/wp-content/uploads/2025/02/50284-2025-Community-Benefit-Report_2-24-25.pdf

enrollment x 12 x PMPM), along with the associated additional costs. reflects major medical and prescription drug costs only. This data does not include administrative costs or any of the Plus benefits.

FIGURE 27
OREGON UNIVERSAL HEALTH PLAN
2026 BASELINE MEDICAL AND PRESCRIPTION DRUG COSTS

MARKET	ENROLLMENT	PMPM	TOTAL (BILLIONS)
Public	712,000	$698	$6.0
Employer	929,000	$701	$7.8
Individual	165,000	$692	$1.4
Medicaid	1,360,000	$697	$11.4
Medicare	1,004,000	$1,452	$17.5
Uninsured	122,000	$399	$0.6
Sub-Total	**4,293,000**	**$866**	**$44.6**
Behavioral Health	N/A	N/A	$0.8
Unreimbursed Medicaid	N/A	N/A	$1.2
Total	**4,293,000**	**$931**	**$47.9**

6.2 PROJECTING STATUS QUO 2032 ESTIMATES

Using the 2026 baseline estimates in Section 6.1 above, we project enrollment and costs to 2032 by applying market-level trend and population growth factors, as well as adjustments anticipated to have a material impact between the baseline and future years.

6.2.1 Status Quo 2032 Enrollment

Enrollment change between 2026 and 2032 is driven by two factors:

- **Population Growth and Aging:** Total population growth by age is based on the same OEA data source used in developing the baseline.[33] OEA projections indicate faster growth for Medicare markets relative to non-Medicare markets as the share of residents over age 65 increases in the 2026 to 2032 projection period. This is important since per member costs are higher in the Medicare population relative to the non-Medicare population as seen in baseline 2026 cost estimates.
- **Market Movement:** We estimate a further decline in small group employer membership, shifting this population to the Individual market. We estimate a material change in membership in the Medicaid market due to impacts of HR1 based on the Manatt Medicaid Modeling Toolkit and articles from Oregon Public Broadcasting.[34,35] This membership is shifted to uninsured, resulting in a large increase to the number of insured in Oregon.

FIGURE 28
OREGON UNIVERSAL HEALTH PLAN
PROJECTION TO STATUS QUO 2032 ENROLLMENT

		CHANGE FACTORS		
MARKET	2026 ENROLLMENT	ANNUALIZED POPULATION GROWTH	MARKET MOVEMENT	2032 STATUS QUO ENROLLMENT
Public	712,000	1.10%	0.00%	720,000
Employer	929,000	1.90%	-1.20%	935,000
Individual	165,000	1.10%	7.00%	179,000
Medicaid	1,360,000	1.10%	-16.40%	1,150,000
Medicare	1,004,000	8.60%	0.00%	1,091,000
Uninsured	122,000	1.10%	182.70%	348,000
Total	**4,293,000**	**3.00%**		**4,423,000**

[33] https://www.oregon.gov/das/OEA/Pages/forecastdemographic.aspx
[34] https://shvs.org/resource/house-budget-bill-medicaid-proposals-state-by-state-estimates-of-impacts-on-expenditures-and-enrollment/
[35] https://www.opb.org/article/2025/06/04/medicaid-cuts-could-impact-oregon-more-than-most-states-analysts-say/

6.2.2 Status Quo 2032 Medical and Prescription Drug Healthcare Cost Estimates

Cost changes between the 2026 and 2032 baseline are driven by two adjustments:

- Trend is applied as described in Section 6.1.3 above.
- An adjustment factor for additional impacts not reflected in the baseline but expected to materially affect costs by 2032. This adjustment factor includes estimated costs related to prescription drug changes, including cost of GLP-1 drugs for weight loss and estimated costs for increased advance treatments such as cell and gene therapy and monoclonal antibodies.

The projection to status quo 2032 healthcare cost estimates is shown in Figure 29 below.

FIGURE 29
OREGON UNIVERSAL HEALTH PLAN
PROJECTION TO STATUS QUO 2032 COSTS

MARKET	2026 ALLOWED PMPM	LOW TREND	ADJ. FACTOR	2032 COST PMPM LOW	HIGH TREND	ADJ. FACTOR	2032 COST PMPM HIGH
Public	$698	5.3%	1.0%	$962	7.4%	2.5%	$1,097
Employer	$701	5.3%	1.2%	$968	7.4%	2.7%	$1,104
Individual	$692	5.3%	1.0%	$953	7.4%	2.5%	$1,087
Medicaid	$697	5.3%	-0.5%	$947	7.4%	1.0%	$1,080
Medicare	$1,452	5.3%	0.8%	$1,998	7.4%	2.3%	$2,279
Uninsured	$399	5.3%	1.0%	$549	7.4%	2.5%	$627
Total Healthcare Costs	**$866**	**5.3%**		**$1,182**	**7.4%**		**$1,348**
Behavioral Health	$16			$15			$21
Unreimbursed Medicaid	$22			$27			$29
Total incl. Adjustments	**$931**			**$1,255**			**$1,436**

Figure 30 summarizes the total status quo 2032 healthcare cost estimates.

FIGURE 30
OREGON UNIVERSAL HEALTH PLAN
STATUS QUO 2032 ENROLLMENT AND TOTAL COSTS (BILLIONS)

		2032 TOTAL COSTS		
MARKET	ENROLLMENT	LOW	BEST ESTIMATE	HIGH
Public	720,000	$8.3	$8.9	$9.5
Employer	935,000	$10.9	$11.6	$12.4
Individual	179,000	$2.0	$2.2	$2.3
Medicaid	1,150,000	$13.1	$14.0	$14.9
Medicare	1,091,000	$26.1	$28.0	$29.8
Uninsured	348,000	$2.3	$2.5	$2.6
Total Healthcare Costs	**4,423,000**	**$62.7**	**$67.1**	**$71.5**
Behavioral Health	N/A	$0.8	$0.9	$1.1
Unreimbursed Medicaid	N/A	$1.4	$1.5	$1.5
Total incl. Adjustments	**4,423,000**	**$64.9**	**$69.6**	**$74.2**

6.3 PROJECTING UHP EXPENDITURES

The implementation of the UHP in 2032 will transform healthcare in Oregon. Conceptualizing the shifts that may occur from UHP implementation in Oregon requires evaluating at a minimum, the following impacts relative to the status quo:

- Induced utilization
- Adverse selection
- Addition of the Plus benefits package
- Staffing and administrative costs

Staffing and administrative costs are covered in detail in Sections 3 and 4 above and are layered on top of UHP medical and prescription drug costs to form 2032 UHP expenditure estimate totals. Detailed discussion of the Plus package can be found in Section 5 above, and we discuss the estimation of these increased benefits in further detail below. Also covered in detailed sections below is the estimation of adverse selection and induced utilization.

It is important to remember that these estimates are built ground up from existing cost levels using the most recent available information. This means that all current data is from numerous markets with the presence of health insurance carriers underlying numbers. Implementing a UHP in place of a multi-carrier environment will have a broad impact. UHP expenditure estimates below are developed assuming:

- The single payer system functions with the same level of medical management as the status quo
- Health outcomes remain at the same level
- Providers are reimbursed at the same levels when adjusting for trend

There exists several potential cost containment measures not reflected in the estimates below. The savings related to these cost containment measures will depend on the organization and specific programs and measurements established by Oregon when implementing the UHP and it may be appropriate to consider the possible potential cost containment measures when reviewing these estimates. Cost containment measures are discussed in further detail in Section 8.

6.3.1 UHP 2032 Enrollment

UHP enrollment is consistent with status quo 2032 enrollment in Oregon with an additional adjustment to account for estimated increases in population, and therefore enrollment in the UHP, due to interstate migration.

Figure 31 shows the projected impact of adverse selection from interstate migration on UHP enrollment in 2032, which is between 0.45% and 0.9% of population.

FIGURE 31
OREGON UNIVERSAL HEALTH PLAN
UHP 2032 ENROLLMENT ESTIMATES

		LOW ESTIMATE		HIGH ESTIMATE	
	STATUS QUO	ADVERSE SELECTION IMPACT	TOTAL UHP ENROLLMENT	ADVERSE SELECTION IMPACT	TOTAL UHP ENROLLMENT
Total	4,423,000	19,000	4,442,000	36,000	4,459,000

The following Section 6.3.2 develops this estimate along with the impact on overall costs.

6.3.2 Adverse Selection Development

From the analysis comparing current benefits to what is anticipated under the UHP in Section 5, it is evident that most Oregonians will see a material increase in covered benefits. It is possible that this level of benefits (assuming Oregon's current system is similar to other states) could cause the migration of individuals and families with more health needs, such as those with high cost and chronic conditions, to Oregon. This generalized phenomena of "adverse selection" arises when people who know they are higher risk are more likely to seek out coverage that financially benefits them than lower-risk people. This skews enrollment towards higher-risk individuals, thereby raising average overall costs.

Because the United States has porous borders between states and no material barriers to establishing residency in a new state, residents of one state can (and often do) move to other state for any number of reasons.[36] Limited research on the reasons for interstate movement do not support large "magnet" effects when one state offers richer social services and programs than another. However, the effect is not zero and given that the UHP is unprecedented and no data exists for this type of change, prudence would suggest some attempt to quantify is appropriate.[37]

To determine the impact of adverse selection we reviewed the following information:

- We estimated the prevalence and costs of chronic condition across the United States. Chronic conditions are such that healthcare needs will extend over a number of years and, unlike acute or emergent conditions, can be known with some certainty to be non-zero across these years.

Chronic conditions reviewed include chronic lung disease, mental health/substance use, diabetes, musculoskeletal conditions, cardiovascular conditions, cancer, and a broad set of conditions that employ cell and gene therapies as treatments (referred to in Figure 32 as just cell and gene therapies). These conditions are chosen as some of the most common chronic conditions in the United States.[38,39]

Estimates of prior year costs and populations by state are developed through Milliman research using a proprietary database Milliman Consolidated *HCG* Sources Database (*CHSD*). The average cost for each condition and treatment is high relative to average population.

- We estimate the distance each of the continental states is from Oregon (using location of state capitals) and assign a relative probability of migration that is inversely related to this distance (i.e., the further the distance, the lower the probability of migrating to Oregon, all else equal).

Figure 32 below shows the development of the costs of adverse selection from interstate migration:

FIGURE 32
OREGON UNIVERSAL HEALTH PLAN
UHP 2032 ADVERSE SELECTION COST DEVELOPMENT

CHRONIC CONDITION	MEMBER MOVEMENT*	AVERAGE COST PMPM	TOTAL ANNUAL COST (BILLIONS)	
			LOW	HIGH
Lung	2,000 to 7,000	$2,600	$0.07	$0.22
MHSUD	1,000 to 4,000	$2,400	$0.03	$0.10
Diabetes	8,000 to 18,000	$3,200	$0.33	$0.67
MSK	1,000 to 2,000	$4,300	$0.05	$0.09
Cardiovascular	4,000 to 9,000	$5,300	$0.26	$0.52
Cancer	4,000 to 7,000	$3,800	$0.20	$0.28
Cell and Gene Therapy	0 to 1,000		$0.30	$0.60
LTSS	0 to 1,000		$0.04	$0.09
Total	**22,000 to 44,000**		**$1.29**	**$2.56**
Population Leaving Oregon	**(2,000) to (8,000)**		-$0.04	-$0.13
Combined	**19,000 t 36,000**		**$1.25**	**$2.43**

* Minor differences in totals due to rounding.

As reasonableness checks to this ground-up migration estimate, IRS data for 2024 shows that Oregon had approximately 140,000 residents that had moved into the State in the last year, or about 3.3% of the population.[40] An estimate below that number would account for the varied reasons for interstate movement other than for health-related reasons (job, weather, retirement, etc.). Accordingly, the assumption that between 20,000 and 40,000 individuals might

[36] https://www.thepolicycircle.org/minibrief/migration-between-states/
[37] Supporting studies for a non-zero magnet affect include "Welfare Magnets: A New Case for a National Standard" by Paul E. Peterson and Mark C. Rom (Washington, DC: Brookings Institute Press 1990) and https://www.cbpp.org/research/state-budget-and-tax/state-taxes-have-a-negligible-impact-on-americans-interstate-moves as well as sources listed in Figure 60 in Section 8.1.7.
[38] https://www.cdc.gov/chronic-disease/about/index.html
[39] https://nihcm.org/publications/the-growing-burden-of-chronic-diseases
[40] https://www.census.gov/data/tables/time-series/demo/geographic-mobility/state-to-state-migration.html

move to Oregon in response to a relatively rich healthcare program appears reasonable. An additional study looking at interstate migration after Medicaid expansion[41] shows that after expanding Medicaid, interstate migration from the target population (e.g. individuals who would be eligible for expanded Medicaid but not eligible for Medicaid without the expansion) was approximately 0.23% higher than total population growth. This study reviewed the Medicaid expansion population, which may not have the means to migrate as easily as higher income populations, lending more credibility to the UHP member movement estimates above.

6.3.3 Induced Utilization

Induced utilization in health insurance refers to the increase in the amount of health care people use because the level of coverage richness (the coverage's actuarial value or AV) changes the incentives facing patients and providers. When a coverage lowers an individual's out-of-pocket cost, as is the case in the UHP (with zero out-of-pocket cost), they may use more services than when the enrollees cost sharing contribution was higher.

We adjust the medical and pharmacy costs to account for anticipated decreases in member cost sharing under the UHP and the associated increase in utilization. To determine the estimated induced utilization, we took the following steps into our analysis:

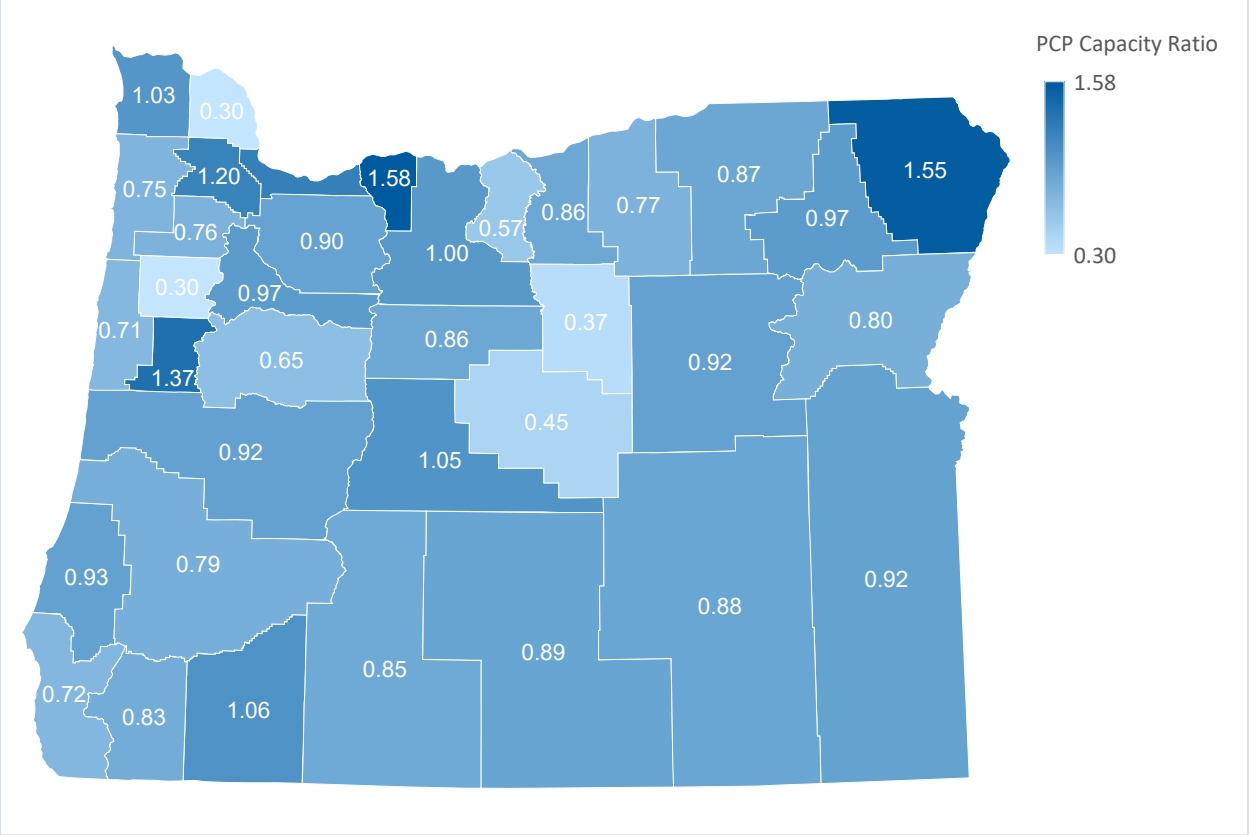
- Compared the UHP plan to average coverage in each market as described in Section 5 above.
- Use Milliman's *HCGs* to estimate the level of induced utilization. The *HCGs* were used to estimate the value of cost-sharing and relative utilization of services for plans in each market prior to the implementation of the UHP, as well as the UHP plan itself.
- Adjust the estimates to account for provider capacity considerations described further below.
- Adjusted the previously uninsured for pent-up demand.

While the concept is well known among actuaries, estimating induced utilization depends on several factors such as existing levels of cost sharing, the level of understanding of available benefits, and attempting to predict human behavior. An additional question arises of how provider capacity might limit any increases in utilization caused by richer benefits under the UHP. In other words, if providers are, or will be under the UHP, at their full capacity, the increased utilization may be dampened.

To understand capacity and resources in Oregon, we reviewed Primary Care Physician (PCP) supply and hospital occupancy rates. According to the 2024 and 2025 HRSA State of the Primary Care Workforce reports, Oregon ranks in the top 10 states for ratio of PCP per 100,000 population.[42] This is informative but potentially misleading in a state like Oregon with a wide-ranging geography. When reviewing the Oregon Office of Rural Health Report PCP Capacity Ratio data, PCP capacity is lower in rural and frontier areas relative to urban areas. In reviewing this report, a PCP capacity ratio of 1.00 represents the supply of physicians meeting the demand for care, meaning that a number above 1.00 implies enough PCPs are practicing in a given region to meet demand. Figure 33 below shows PCP capacity ratio by county from the referenced report.[43]

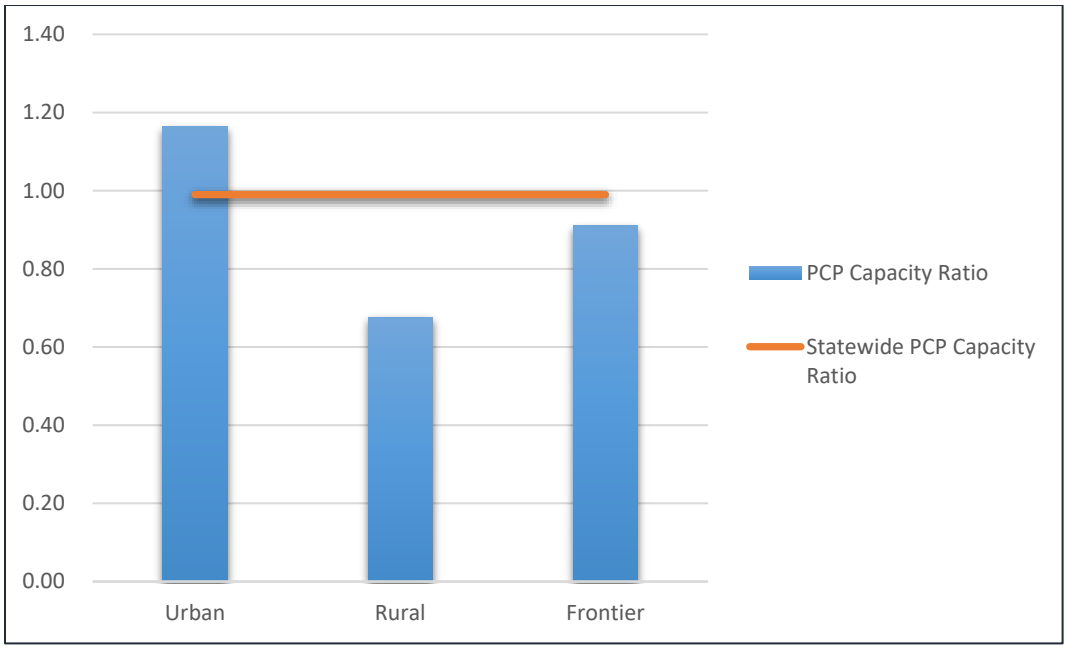
[41] https://pubmed.ncbi.nlm.nih.gov/39893838/
[42] https://www.iafp.org/assets/docs/2025_IFMRLN/2024%20state-of-the-primary-care-workforce-report-2024.pdf
[43] https://www.ohsu.edu/sites/default/files/2024-09/AUHCN%20Report_2024%20-%20FINAL%209-17-24%206.pdf

FIGURE 33: PRIMARY CARE CAPACITY RATIO BY COUNTY



As a result, we assume service areas with a PCP capacity ratio below 1.00 will not have an increase in utilization for professional services due to workforce constraints and we assume ER utilization increases in these service areas. Figure 34 below shows the primary care capacity ratio by geographic designation as defined the report (rural is an area 10 or more miles from the centroid of a city of 40,000 or more, frontier is a county with 6 or fewer people per square mile).

FIGURE 34: PRIMARY CARE CAPACITY RATIO BY GEOGRAPHICAL DESIGNATION



Hospital occupancy issues are an area of increasing concern in Oregon and nationally as well. There are several articles and sources indicating the rising problem and potential capacity crisis, including the Portland Business Journal[44], Oregon Capital Chronicle[45], Hospital Association of Oregon[46], and OHSU.edu.[47]

These sources indicate that OHSU Hospitals are at 100% capacity and Oregon is 85% statewide. According to the Journal of the American Medical Association (JAMA), this compares to 75% nationwide and is at the critical threshold of 85%.[48] Interestingly, the Milliman *HCGs* indicate that Oregon inpatient utilizations per 1,000 people are materially lower compared to nationwide benchmarks after adjusting for morbidity. This is consistent across geographies in Oregon. In some cases, this can be seen as a potential for *increased* utilization. In Oregon's case, the JAMA report referenced earlier in this paragraph cites staffing issues and discharge delays as contributing to lower utilization. Additionally, a large Medicaid population reduces the level of funding for hospitals, which can result in an inability to address staffing and bed needs.

As a result, the additional demand for inpatient hospitalizations is likely to remain in the UHP, capacity may just put a limit on realized utilization. Upon reviewing the *HCGs,* hospital beds per capita,[49] and historical[50] and recent[51] studies, we assume that a 12% to 24% of costs will be immune to induced utilization because of capacity issues.

[44] https://www.bizjournals.com/portland/news/2025/03/12/ohsu-capacity-crisis-hospital-legacy.html
[45] https://oregoncapitalchronicle.com/2024/11/12/oregon-task-force-find-ways-to-prevent-patients-from-boarding-in-hospitals/
[46] https://oregonhospitals.org/wp-content/uploads/2025/04/2025.04.25_Report_Oregon-Hospitals-on-the-Brink_FINAL.pdf
[47] https://news.ohsu.edu/2025/03/14/ohsu-roundtable-understanding-addressing-oregons-hospital-capacity-crisis
[48] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830387?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=021925
[49] https://www.kff.org/state-health-policy-data/state-indicator/total-hospital-beds/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[50] https://www.ncbi.nlm.nih.gov/books/NBK585014/
[51] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2830389

These assumptions result in an induced utilization increase ranging from 3.3% to 5.2% as outlined in the figure below:

FIGURE 35
OREGON UNIVERSAL HEALTH PLAN
INDUCED UTILIZATION DEVELOPMENT

LOW SCENARIO

MARKET	STARTING IU	PROVIDER CAPACITY	FINAL IU
Public	1.080	0.981	1.059
Employer	1.109	0.981	1.087
Individual	1.173	0.981	1.150
Medicaid	1.000	1.000	1.000
Medicare	1.026	0.984	1.009
Total			**1.033**

HIGH SCENARIO

MARKET	STARTING IU	PROVIDER CAPACITY	FINAL IU
Public	1.113	0.953	1.060
Employer	1.147	0.953	1.092
Individual	1.219	0.953	1.162
Medicaid	1.000	1.000	1.000
Medicare	1.092	0.961	1.050
Total			**1.052**

6.3.4 Uninsured and Other Adjustments

Upon implementation of the UHP, we assume that 348,000 previously uninsured in Oregon will become enrollees of the UHP. Instead of estimating their 2032 costs from charity care we assume that this population will have costs consistent with the specific large group low scenario employer population and apply the employer low induced utilization factor as well. We then apply an adjustment for pent-up demand in this population ranging from 7.5% to 20%. We use a wide range for pent-up demand supported by the variance observed in numerous sources.[52,53,54] Figure 36 below outlines the development of the estimated 2032 healthcare costs of the previously uninsured population.

FIGURE 36
OREGON UNIVERSAL HEALTH PLAN
ESTIMATED UHP 2032 HEALTHCARE COSTS FOR THE PREVIOUSLY UNINSURED

SCENARIO	ESTIMATED UHP 2032 STATUS QUO LG EMPLOYER COST PMPM	INDUCED UTILIZATION	PENT-UP DEMAND	ADVERSE SELECTION	OTHER ADJUSTMENTS	2032 COST PMPM
Low	$977	1.087	1.075	1.018	0.996	$1,158
High	$977	1.087	1.197	1.031	0.992	$1,300

The other adjustment factor shown in Figure 36 above, which is applied globally to UHP costs to account for adjustments made, is a result of the following:

- Elimination of unreimbursed Medicaid
- Remove impacts of induced utilization related to prescription drug changes including cost of GLP-1 drugs for weight loss
- Estimated costs for increased advance treatments such as cell and gene therapy and monoclonal antibodies that is captured in the induced utilization calculations in Section 6.3.3

[52] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420
[53] https://www.kff.org/affordable-care-act/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/
[54] https://www.rand.org/pubs/research_briefs/RB9174.html

6.3.5 UHP 2032 Benefit Cost Estimates

The adjustments from status quo (SQ) to UHP 2032 cost estimates shown in Section 6.3 are shown in Figure 37 below for the low scenario. Note, estimates and results in this section are shown for the ***Zero Cost Sharing scenario only***.

FIGURE 37
OREGON UNIVERSAL HEALTH PLAN
PROJECTION TO UHP 2032 LOW COST ESTIMATES

MARKET	2032 SQ LOW	INDUCED UTILIZATION	ADVERSE SELECTION	OTHER ADJUSTMENTS	2032 COST PMPM LOW	2032 UHP ENROLLMENT	2032 TOTAL COSTS
Public	$962	1.059	1.018	0.996	$1,033	723,000	$9.0
Employer	$968	1.087	1.018	0.996	$1,067	940,000	$12.0
Individual	$953	1.150	1.018	0.996	$1,112	180,000	$2.4
Medicaid	$947	1.000	1.018	0.996	$960	1,155,000	$13.3
Medicare	$1,998	1.009	1.018	0.996	$2,045	1,095,000	$26.9
Uninsured	$977	1.169	1.018	0.996	$1,158	349,000	$4.9
Total					**$1,284**	4,442,000	**$68.4**
BH					$15		$0.8
Unreimbursed Medicaid					$0		$0.0
Total incl. Adjustments					**$1,299**		**$69.2**

The adjustments from status quo to UHP 2032 cost estimates shown in Section 6.3 are shown in Figure 38 below for the high scenario.

FIGURE 38
OREGON UNIVERSAL HEALTH PLAN
PROJECTION TO UHP 2032 HIGH COST ESTIMATES

MARKET	2032 SQ HIGH	INDUCED UTILIZATION	ADVERSE SELECTION	OTHER ADJUSTMENTS	2032 COST PMPM HIGH	2032 UHP ENROLLMENT	2032 TOTAL COSTS
Public	$1,097	1.060	1.031	0.992	$1,190	726,000	$10.4
Employer	$1,104	1.092	1.031	0.992	$1,233	943,000	$14.0
Individual	$1,087	1.162	1.031	0.992	$1,291	180,000	$2.8
Medicaid	$1,080	1.000	1.031	0.992	$1,104	1,159,000	$15.4
Medicare	$2,279	1.050	1.031	0.992	$2,446	1,100,000	$32.3
Uninsured	$977	1.301	1.031	0.992	$1,300	351,000	$5.5
Total					**$1,499**	4,459,000	**$80.2**
BH					$20		$1.1
Unreimbursed Medicaid					$0		$0.0
Total incl. Adjustments					**$1,520**		**$81.3**

Figure 39 below includes the best estimate, taken as the midpoint between the low and high scenarios and summarizes the total UHP 2032 cost estimates prior to the addition of Plus benefits and administrative costs.

FIGURE 39
OREGON UNIVERSAL HEALTH PLAN
UHP 2032 ENROLLMENT AND TOTAL COST ESTIMATES (BILLIONS)

	ENROLLMENT			COST ESTIMATES		
MARKET	LOW	BEST ESTIMATE	HIGH	LOW	BEST ESTIMATE	HIGH
Medical and Prescription Drug	4,442,000	4,451,000	4,459,000	$68.4	$74.3	$80.2
Behavioral Health				$0.8	$0.9	$1.1
Total Major Medical Benefit Costs				**$69.2**	**$75.3**	**$81.3**

6.3.6 Plus Benefits

As described in Section 5.3 above, benefits included as part of the Plus package are listed below. In this list we detail existing baseline (and status quo) coverage, proposed UHP coverage, and implications on pricing:

- Dental
  - Baseline / Status Quo – Existing 2026 PEBB dental offerings are consistent with what is generally offered for dental coverage across the United States.[55] Typically, there is a deductible ranging from $0 to $150 and an annual maximum of $1,000 to $2,000, meaning that when the annual maximum is hit, the member pays the remaining claims for the year. Benefits are categorized into three tiers:
    1) Preventive: typically with 100% coinsurance (exams, cleanings routine x-rays).
    2) Basic: typically with 60% to 80% coinsurance (fillings, simple extractions, periodontal scaling).
    3) Major: typically with 40% to 50% coinsurance (crowns, bridges, dentures, implants).

    Many benefits such as orthodontics are subject to a lifetime dollar maximum, such as $1,000 to $2,000, or frequency limits such as two cleanings per year.
  - UHP – The proposed UHP dental benefits eliminate all deductibles and coinsurance amounts, but keeps an annual maximum of $1,750, a lifetime orthodontia maximum of $1,800, sets maximum frequencies on cleanings, and maintains medically necessary requirements for benefits.
  - Modeling and Considerations – Dental estimates are based on the Milliman Dental *HCGs*. Similar to medical and prescription drug benefits, we expect and apply estimates for induced utilization resulting from the richness of dental coverage and higher level of Oregonians without status quo dental coverage compared to major medical. While some Medicare Advantage plans include some dental coverage, Medicare FFS does not cover routine dental. Similar to major medical, dental costs are higher for the Medicare population; however, use of dental benefits can be very different from use of medical benefits. The maximums and tiered coverage contribute to limits on use and dental plans frequently have a waiting period to prevent people from obtaining coverage for one year just to use services needed before terminating again. These factors all contribute to induced utilization, though the question of dental capacity arises. We have not adjusted for dental capacity in our dental estimates. UHP dental estimates can be found in Figure 40 below.
- Vision
  - Baseline / Status Quo – Existing 2026 PEBB vision offerings are also consistent with what is generally offered across the United States.[56] Vision insurance is primarily a routine vision benefit for exams and eyewear, while medical eye conditions like glaucoma are within the umbrella of major medical coverage. There is usually a low copay for a routine eye exam (with retinal imaging included). For hardware, vision insurance usually includes an allowance for frames and a copay for lenses with the option to substitute contact lenses instead. Much like dental, these benefits are accompanied by frequency limits, typically one exam per year and one set of hardware every 12 to 24 months.

[55] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-698450_2.pdf
[56] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-698450_2.pdf

- UHP – The proposed UHP vision benefits eliminate all cost sharing amounts, but maintains the frame / contact allowances and frequency limits of the 2026 PEBB basic plan offering.
- Modeling and Considerations – Vision cost is estimated using nationwide 2023 allowed claim cost levels obtained from the Milliman *CHSD*. These estimates are developed at the market level and then blended by projected UHP population. Vision tends to be a coverage subject to adverse selection, where it is elected only by those that need it. As a result, we do not apply induced utilization to vision, and account for the proportion of individuals expected to utilize benefits. UHP vision estimates can be found in Figure 40 below.

- Fertility treatments
  - Baseline / Status Quo – As shown in Section 4.3, fertility benefits exist primarily within employer markets, with coverage varying widely by employer, but more frequently offered by larger employers to attract workers. Coverage includes several treatments (see the PEBB benefits for an example) and usually is limited by a yearly maximum.[57]
  - UHP – The proposed UHP fertility benefits eliminate any cost sharing and maintain the $25,000 maximum per enrolled individual per year from the PEBB plan referenced above.
  - Modeling and Considerations – We reviewed the population of Oregon and estimated approximately 900k eligible females aged 18 to 44. Using a nationwide CDC fertility rate[58] of 6% and 15% of females needing fertility services, we assume 7,700 people per year are attempting pregnancy and also need fertility services in Oregon. A fifteen percent fertility need is based on fertility studies by KFF[59] and UCLA[60] and includes the adult LGBT population in need of fertility services. We then use several sources including the KFF study, IVF studies,[61] Kind Body unit costs,[62] advanced fertility treatment costs,[63] NIH studies,[64] and Milliman *CHSD* information to estimate utilizations and costs of each service. Notably, the majority of fertility costs can be attributed to intrauterine insemination and in vitro fertilization. UHP fertility cost estimates can be found in Figure 40 below.
- Other benefits (sleep studies, hearing aids, complementary medicine, massage therapy, doula services):
  - Baseline / Status Quo - As shown in Section 5.3, these additional benefits exist on Medicare Advantage plans and within employer markets with coverage again varying widely. These benefits typically have a copay or coinsurance for services, when covered and several of them (hearing aids, sleep studies) have higher utilization in the Medicare eligible population.
  - UHP – Proposed benefits in the UHP cover these services with no cost sharing.
  - Modeling and Considerations – Costs for these benefits are estimated using nationwide 2023 allowed claim cost levels obtained from the Milliman *CHSD*. These estimates are developed at the market level and then blended by projected UHP population. Cost estimates can be found in Figure 40 below.

FIGURE 40
OREGON UNIVERSAL HEALTH PLAN
2032 PLUS BENEFITS COSTS (BILLIONS)

SERVICE CATEGORY	LOW ESTIMATE	HIGH ESTIMATE
Dental	$3.3	$4.1
Vision	$0.5	$0.6
Fertility	$0.3	$0.4
Other*	$0.5	$0.6
Total	**$4.5**	**$5.6**

* Other includes sleep studies, hearing aids, complementary medicine, massage therapy, and doula services.

[57] https://www.oregon.gov/oha/PEBB/Documents/PEBB_FertilityBenefitComparison_2025.pdf
[58] https://www.cdc.gov/nchs/fastats/births.htm
[59] https://www.kff.org/womens-health-policy/issue-brief/coverage-and-use-of-fertility-services-in-the-u-s/
[60] https://williamsinstitute.law.ucla.edu/publications/adult-lgbt-pop-us/
[61] https://www.pfcla.com/blog/donor-egg-ivf#:~:text=According%20to%20a%20feature%20article,rates%20can%20be%20even%20higher
[62] https://kindbody.com/services-pricing/
[63] https://advancedfertility.com/fertility-treatment/affording-care/fertility-treatment-costs/
[64] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3043157/

6.3.7 UHP 2032 Total Expenditure Estimates

We then include Plus benefits and administrative costs as shown in Section 4.4 to estimate total UHP 2032 expenditures as shown in Figure 41 below.

FIGURE 41
OREGON UNIVERSAL HEALTH PLAN
2032 EXPENDITURE PROJECTION ESTIMATES (BILLIONS)

	(A)	(B)	(C)	(D) = (A) + (B) + (C)
	MAJOR BENEFITS	PLUS BENEFITS	ADMINISTRATIVE COSTS	TOTAL UHP EXPENDITURES
Low	$69.20	$4.50	$3.60	$77.40
Best Estimate	$75.30	$5.10	$5.10	$85.50
High	$81.30	$5.60	$7.00	$94.00

6.4 ESTIMATING 2032 UHP EXPENDITURES ON A 2026 BASIS

Per request of the F&R committee, we adjusted the 2032 UHP Zero Cost Sharing scenario estimates to be on a 2026 basis in order to allow the UHPGB to develop an understanding of the expenditures of the UHP in present day terms and to match up with revenue sources analysis being conducted by F&R in order to determine the cost-to-revenue gap.

Furthermore, we estimated amounts expected to be recovered by Oregon from CMS to assist the F&R committee with revenue projections. To evaluate 2032 UHP expenditure estimates on a 2026 basis we made the following adjustments:

- Shifted the Zero Cost Sharing scenario projection to use 2026 baseline enrollment by market by using 2032 UHP per member costs
- De-trended the medical and pharmacy costs from 2032 to 2026
- De-trended the Dental, Admin, and other benefits costs at their respective trends
- Behavioral Health costs are not adjusted since this estimate is based on the governor's budget

Figure 42 below shows the 2032 UHP expenditures on a 2026 basis both in total and on a PMPM level.

FIGURE 42
OREGON UNIVERSAL HEALTH PLAN
ESTIMATED UHP EXPENDITURE RANGE TRENDED TO A 2026 BASIS

EXPENDITURES		LOW		BEST ESTIMATE		HIGH	
LINE OF BUSINESS	**ENROLLMENT**	**COST**	**PMPM**	**COST**	**PMPM**	**COST**	**PMPM**
Public	712,000	$6.50	$759	$7.00	$816	$7.50	$873
Employer	929,000	$8.70	$783	$9.40	$844	$10.10	$905
Individual	165,000	$1.60	$817	$1.80	$883	$1.90	$948
Medicaid	1,360,000	$11.50	$705	$12.40	$758	$13.20	$811
Medicare	1,004,000	$18.10	$1,502	$19.90	$1,649	$21.60	$1,796
Uninsured	122,000	$1.20	$851	$1.30	$903	$1.40	$955
Total	**4,293,000**	**$47.70**	**$926**	**$51.70**	**$1,004**	**$55.70**	**$1,082**
ADDITIONAL BENEFITS							
Behavioral Health	N/A	$0.80	$16	$0.80	$16	$0.80	$16
Dental	N/A	$2.40	$47	$2.70	$53	$3.00	$58
Other Plus Benefits	N/A	$0.80	$16	$1.00	$19	$1.10	$21
Total Admin	N/A	$2.90	$57	$4.10	$79	$5.60	$109
Total UHP Expenditures	**4,293,000**	**$54.70**	**$1,062**	**$60.30**	**$1,170**	**$66.20**	**$1,286**

As part of the UHP revenue, Oregon expects to receive funds from CMS equal to the funding that CMS would have paid in the absence of the UHP. This collection is usually achieved through CMS waivers, specific examples include Section 1115 and 1332 waivers for Medicaid and the ACA, respectively. The process behind these waivers is very rigorous, with extensive applications, documentation, and actuarial analysis along with showing proof that certain requirements are met. For example, to obtain a Section 1332 waiver, a state must demonstrate that the state plan will provide coverage as comprehensive and affordable as the ACA, cover the same or more residents, and not increase the federal deficit.

To estimate the funding received from CMS for Medicare, we convert total allowed cost estimates to a paid basis. CMS will not fund Oregon the amounts paid through cost sharing by Oregon residents. For Medicare FFS we assume that CMS will reimburse for the full paid amount. For Medicare Advantage CMS reimburses for the benefits covered by FFS, which we assume the same as FFS on a per person basis.

In the case of Medicaid, there is no cost sharing, but the State shares in the cost burden of Medicaid and CMS pays what is known as the Federal Medical Assistance Program (FMAP) percentage. We assume an FMAP percentage of 71%, consistent with recent years in Oregon (based on the Medicaid expenditure reports used in developing baseline estimates) and apply this percentage to total estimated Medicaid costs.

Funds paid by CMS for the individual ACA market are based on the amount covered by advanced premium tax credit subsidies (APTCs). APTCs are sliding scale income-based subsidies that lower monthly health insurance premium for plans purchased through an ACA Marketplace. In 2021, enhanced APTCs (eAPTCs) were rolled out which increased the subsidy percentage at each income level and extended the maximum income level at which subsidies would still be provided. These eAPTCs have expired as of 2026. CMS publicly releases the average premium and average premium after APTC each year.[65] We use 2025 information in Oregon as a basis and adjust for the expiration of the eAPTCs based on internal research underlying this Milliman study.[66]

Figure 43 below outlines the projected CMS funding estimates Oregon could receive on a 2026 basis, contingent upon the approval of all relevant waivers.

FIGURE 43
OREGON UNIVERSAL HEALTH PLAN
BEST ESTIMATE UHP COSTS TRENDED TO A 2026 BASIS AND ESTIMATED 2026 WAIVER COLLECTIONS (BILLIONS)

EXPENDITURES		BEST ESTIMATE		ESTIMATED CMS COLLECTION	
LINE OF BUSINESS	**ENROLLMENT**	**COST**	**PMPM**	**TOTAL**	**PMPM**
Public	712,000	$7.00	$816	$0.00	$0
Employer	929,000	$9.40	$844	$0.00	$0
Individual	165,000	$1.80	$883	$0.60	$322
Medicaid	1,360,000	$12.40	$758	$8.1	$498
Medicare	1,004,000	$19.90	$1,649	$14.7	$1,218
Uninsured	122,000	$1.30	$903	$0.0	$0
Total	**4,293,000**	**$51.70**	**$1,004**	**$23.4**	**$455**
ADDITIONAL BENEFITS					
Behavioral Health	N/A	$0.80	$16	$0.0	$0
Dental	N/A	$2.70	$53	$0.0	$0
Other Plus Benefits	N/A	$1.00	$19	$0.0	$0
Total Admin	N/A	$4.10	$79	$0.0	$0
Total UHP Cost	**4,293,000**	**$60.30**	**$1,170**	**$23.4**	**$455**

[65] https://www.cms.gov/data-research/statistics-trends-reports/marketplace-products/2025-marketplace-open-enrollment-period-public-use-files
[66] https://www.milliman.com/en/insight/2026-aca-premium-landscape-health-insurers

6.5 10-YEAR PROJECTION ESTIMATES

As part of the actuarial analysis, we project UHP estimates out over a 10-year horizon. Given the uncertainty underlying a 10-year projection that begins in 2032, we take a simplified approach. We applied annual trend rates of 5.3% (low scenario) and 7.4% (high scenario) for medical and pharmacy (consistent with our claims trend assumptions), 4.7% for dental, and 3.0% for administrative expenses. Medical / prescription drug trends were varied between scenarios due to their greater historical volatility, whereas dental and administrative trends were held constant across scenarios given their more stable historical patterns. We also made minor adjustments to lower claims over the first four years on the previously uninsured population who are likely to have decreases in utilization from the pent-up demand in the implementation year.

Figure 44 summarizes the five- and ten-year projected expenditure estimates and enrollment for the Zero Cost Sharing Scenario. The appendices provide market-level annual cost projections from 2032 through 2041, showing the expected cost for each year.

FIGURE 44
OREGON UNIVERSAL HEALTH PLAN
FIVE YEAR AND TEN YEAR EXPENDITURES (MILLIONS) AND ENROLLMENT ($ BILLIONS)
PROJECTION ESTIMATES

5 YEAR PROJECTION		
SCENARIO	**2037 EXPENDITURE ESTIMATES**	**2037 ENROLLMENT**
Low	$100.7	4.5
Best Estimate	$116.6	4.6
High	$132.5	4.6
10 YEAR PROJECTION		
SCENARIO	**2041 EXPENDITURE ESTIMATES**	**2041 PROJECTED ENROLLMENT**
Low	$124.9	4.6
Best Estimate	$150.6	4.6
High	$176.3	4.6

6.6 SENSITIVITY TESTS

To help the UHPGB understand a broader range of outcomes and value the impact of changing key projection assumptions, we conducted sensitivity testing on the Zero Cost Sharing scenario. Figure 45 below shows the results of the sensitivity analysis.

FIGURE 45
OREGON UNIVERSAL HEALTH PLAN
SENSITIVITY TESTING 2032 IMPACT ON EXPENDITURES ($ BILLIONS)

	IMPACT TO UHP ESTIMATE	
SENSITIVITY TESTING	**LOW**	**HIGH**
2026 to 2032 Trend +1% per year	$4.0	$4.7
Adverse Selection 1k In-Migration	$0.1	$0.1
Adverse Selection 1k Out-Migration	$0.0	$0.0
Induced Utilization +1%	$0.6	$0.7
Population Growth from 2026 to 2032 +0.25% per year	$1.1	$1.3

The sensitivity tests are described in further detail below, along with observations.

- **Trend:** Tests how higher or lower medical/pharmacy trend paths move total and per-member costs, recognizing that trend is the largest long-term driver and is volatile. We tested the impact of a +/- 1% change in trend and found that changing trend has a $4 to $5 billion impact on results. This means that trends have a critical impact on estimates and even small fluctuations impact Oregon's budget at a material magnitude. This places a strong emphasis on cost containment and cost management, which is discussed more in Section 8 below.

- **Adverse Selection:** We modeled the combined effects of increased in-migration to Oregon (with entrants exhibiting higher morbidity than current residents) and selective out-migration of healthier individuals, which raises average morbidity among those who remain. Given uncertainty in these assumptions, the low-end estimate reflects a smaller adverse-selection effect, while the high-end estimate reflects a larger effect. We tested the impact of a +/- 1,000 people change to in-migration, as well as a +/- 1,000 people change to out-migration. Adverse Selection results in $60 to $80 million more in total expenditures for every 1,000 migrating in and $16 to $20 million less in expenditures per 1,000 migrating out.
- **Induced Utilization:** This tests the induced utilization assumption described in Section 6.3.3 . This assumption is a result of individuals with existing coverage utilizing services more as their own out-of-pocket expenses decrease. Recognizing the capacity concerns discussed, we tested a +/- 1% change to the induced utilization assumption and found a $0.6 to $0.7 billion impact to results indicating that Oregon needs to continue monitoring hospital capacity and physician numbers.
- **General Population Growth:** Current population growth is based on OEA estimates but higher or lower growth will affect estimates. Notably, changes in population growth would also affect revenue projections as well. We tested the impact of a +/- 0.25% change to the Oregon population growth rate per year, roughly equivalent to about 10,000 to 11,000 additional people per year and found the impact to be over $1 billion.

6.7 SUMMARY

Appendix 1 provides a full summary of the projection from 2026 baseline estimates to 2032 UHP expenditure estimates. Appendix 2 provides additional detail regarding the 5 and 10 year projection expenditure estimates.

7 Cost Considerations

The expenditure estimates in this report are built from the ground up based on existing claim information in a pre-UHP environment. The claims data basis and the assumptions to transition to 2026 baseline and then to 2032 status quo scenarios are reasonable and supportable. The assumptions related to further transitioning to the UHP in 2032 from the status quo are, by necessity, more general since many of the specific details of the UHP program are yet to be specified. Once a strategic direction is specified, implementation of these strategies could have planning, negotiation and execution timelines on the order of years. At that point, more detailed modeling should be undertaken to gain a deeper understanding of the impacts of the various initiatives on overall UHP program costs.

This section details some of the additional considerations when related to the overall cost of the UHP program that might help inform future specifications of the UHP related to cost controls and the modeling of those specifications.

7.1 PROVIDER REIMBURSEMENT

Expenditure estimates assume that provider reimbursement levels will stay at the same level in aggregate after implementation of the UHP in 2032.[67] The reality that Oregon will face to prepare for a 2032 implementation may be more complex. It will likely require reimbursement levels to be analyzed, precisely quantified in terms of each type of provider's percentage of Medicare and any proposed changes modeled to understand the direct fiscal impact, as well as the potential indirect effects, such as responses from providers to such changes. In practice, the provider reimbursement changes and overall provider reimbursement strategy will be one of the largest single determinants of the UHP's long-term costs and overall long-term financial viability. Moreover, these changes have downstream impacts on provider supply and enrollee access, particularly in rural and frontier communities that already have fewer providers.

Oregon will need to determine whether the UHP's reimbursement approach is intended to broadly mirror current reimbursement levels, converge toward a single statewide fee schedule, or implement more structural reforms such as all-payer rate setting for certain services (e.g., hospital care) or global budgets for facilities. In each case, Oregon will need to evaluate the magnitude of rate changes relative to current payment levels, the transition timeline, and the safeguards needed to avoid destabilizing provider operations.

7.1.1 Provider Reimbursement Estimates in Oregon

To begin understanding provider reimbursement in more depth, Milliman estimated the statewide medical provider reimbursement levels as a percentage of Medicare in each market. Percent of Medicare is a common method, an industry benchmarking standard, of comparing provider reimbursement levels, since Medicare sets specific fee schedules (the amount that Medicare pays to the provider) for every service offered by geographical area. Figure 46 below shows 2026 medical provider reimbursement estimates as a percentage of Medicare by market and in aggregate.

FIGURE 46
OREGON UNIVERSAL HEALTH PLAN
OREGON 2026 MEDICAL PROVIDER REIMBURSEMENT ESTIMATES

MARKET	% OF MEDICARE REIMBURSEMENT	RANGE
PEBB / OEBB[68]	192%	175% to 200%
Commercial	219%	211% to 236%
Medicaid	88%	80% to 100%
Medicare	100%	100%
Statewide	**117%**	**110% to 125%**

Notes on Figure 46:

- Commercial provider reimbursement estimates are based on Milliman research.
- PEBB / OEBB are based on Milliman research while accounting for the contracted maximum of 200% of Medicare reimbursement for providers.

[67] In the previous analysis performed by Optumas, a "fee schedule normalization" assumed that provider revenues could be redistributed by provider types, with certain specialties or facilities getting more or less than under the current system. By definition, a "normalization" is revenue neutral and has not impact on aggregate costs.

[68] https://oregon.public.law/statutes/ors_243.256

- Medicaid reimbursements are based on APAC data adjusted for state directed payments.
- Reimbursements are estimated for Inpatient Facility, Outpatient Facility, PCP, and Professional Specialist and then aggregated. Prescription drug costs are excluded.
- Reimbursement levels are reviewed against market-wide data from APAC as a verification step.
- These estimates exclude care provided for the uninsured.

Important considerations when reviewing this figure in the context of the UHP include:

- **Market Mix:** Just as the overall statewide composite percentage of Medicare is influenced by population mix, the overall level of reimbursement by area and for any given provider is determined likewise. Generally, Oregon has a higher percentage of people obtaining coverage through Medicaid compared to other states (See Figure 49 below). The higher the percentage of the population served through Medicaid or Medicare, the lower the total state reimbursement will be when compared to a state with a higher proportion commercial population. This is true for any specific physician, facility or geographic area as well and this dynamic is discussed in more detail in Section 7.1.2 below.
- **Medicaid:** Oregon is targeting a percent of Medicare reimbursement of 80% for services obtained through Medicaid.[69] Sources indicate that the physician fee schedule is closer to 88%[70] and inpatient facility is being reimbursed at approximately 73%.[71] However, this is complicated by state directed Medicaid payments made under separate terms, which approach nearly $2 billion.[72] The year over year change in state directed payments impacts the annual estimated level of reimbursement observed.
- **Geography:** As noted above, reimbursement levels vary materially by geography since even the Medicare fee schedule varies by geography. Reimbursement policy under the UHP will need to consider geography as provider capacity and provider access differ in urban versus rural and frontier counties.

7.1.2 Cost Containment Opportunities and Risks

This presents opportunities and risks when establishing provider reimbursement levels in the UHP.

- **Collectability:** The UHP is expected to improve collectability for providers. Providers struggle with cost-sharing collections, with some sources indicating providers collect less than 50% of patient owed deductibles and copays.[73] If the UHP has no cost sharing, the issue of collectability could be virtually eliminated. With no patient cost sharing and a higher percentage of claims paid directly by the single-payer system, providers will also spend less time and resources collecting payments from patients. This should result in more reliable and timely revenue streams for providers compared to the current landscape and increase provider willingness to accept changes in provider reimbursement levels. The 2032 status quo cost sharing is estimated at **$6 to $7 billion**.

  Assuming a 50% collectability rate could result in a **$3 to $3.5 billion** improvement to provider reimbursements or an incremental increase of 5% to 6%. Section 7.1.3 below details potential estimated impacts to the UHP.

FIGURE 47
OREGON UNIVERSAL HEALTH PLAN
COLLECTABILITY IMPACT (BILLIONS)

	2032 STATUS QUO LOW	2032 STATUS QUO HIGH
Current Cost Sharing	$6.0	$7.0
Collectability	50%	50%
Collected	$3.0	$3.5
Collectability Under UHP	100%	100%
Increase Under UHP	$3.0	$3.5
% Change in Reimbursement	6.4%	5.0%

[69] OHA PowerPoint Template
[70] Medicaid-to-Medicare Fee Index | KFF State Health Facts
[71] Oregon Hospital Payment Report
[72] https://www.medicaid.gov/medicaid/managed-care/guidance/state-directed-payments/approved-state-directed-payment-preprints?q=Oregon&filter%5Bfield_approval_date%5D%5Bgte%5D=&filter%5Bfield_approval_date%5D%5Blte%5D=&filter%5Bfield_state_rating_period%5D%5
[73] https://www.benefitspro.com/2025/09/17/health-care-providers-are-accepting-less/

- **Provider Administration:** While it is outside the scope of this analysis to do detailed quantification of potential provider side administrative costs savings under the UHP, we offer the following limited analysis and commentary to support the idea that provider reimbursement, as a percentage of Medicare, could decrease under the UHP while leaving overall provider net revenue (after expenses) at the same level, due to reductions in provider administrative expenses afforded by the UHP.

  Generally, the UHP should streamline the provider administration processes due to a single payer construct. After a one-time, transitional increase in costs from a provider's current system(s) to the single administration of a UHP,[74] provider administration costs should decline. However, the exact timing and length of this transition is uncertain, making this an important consideration when establishing provider reimbursements under the UHP.

  One example is provider contracting, where the UHP will eliminate the need for providers to negotiate with multiple health plans. Internal Milliman research indicates that providers spend approximately 20% of administrative costs on contracting activity for health plans. Contracting costs for health plans are generally more complex than for individual provider groups. Figure 48 contrasts provider and health plan contracting.

FIGURE 48
OREGON UNIVERSAL HEALTH PLAN
PROVIDER AND HEALTH PLAN CONTRACTING

FACTOR	PROVIDER GROUP	HEALTH PLAN
Number of Contracts	Few to dozens	Hundreds to thousands
Typical Annual Cost	$1,000s to $10,000s+	$10,000s to $1,000,000s+
Staffing	Small admin / legal team	Large, dedicated departments
Technology	Basic contract management	Enterprise-level systems
Legal / Consulting Fees	Per-contract or hourly	Ongoing, high-volume
Complexity	Moderate	High

  Provider costs for contracting with multiple payers is estimated from $0.18 to $0.28 PMPM, which translates to $9.5 million to $14.3 million in total. In this case, the UHP offers less of an opportunity provider-side administrative savings.

  However, a second, more material example would be provider administrative costs allocated to eligibility and billing. Again, consolidating multiple payers into a single entity should reduce the staffing and time needed to ensure patient eligibility and bill the UHP for services rendered. A 2018 study published in the Journal of the American Medical Association[75] notes that between 3% and 25% of professional (not facility) revenue is consumed with administrative activity for insurance related activity. Using a weighted average of 14% and applying this to the portion of estimated UHP healthcare costs associated with professional services, this represents $4 to $5 billion of annual UHP expenditures. This results in a material opportunity when considering provider reimbursements in the UHP. Section 7.1.3 below details potential estimated impacts to the UHP.

- **Standardization:** The UHP could consider fee schedule standardization across providers where reimbursement rates for all patients across all current markets (Medicare, Medicaid, Commercial) are the same for the same service.

  Fee schedule standardization under the UHP will create "winners and losers" depending on a provider's mix of patients by market under the current system. Providers currently serving heavily Medicare and Medicaid populations will see an increase in revenue while providers currently serving more commercial populations will see a decrease. This re-allocation will also skew along geographical lines as well, as urban providers will have different impacts compared to rural providers, again due to current market mix.

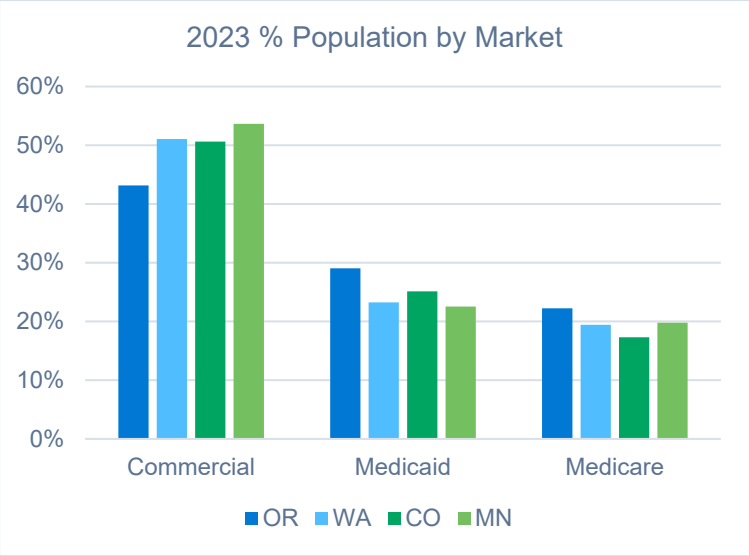
  Other considerations related to a standardization initiative include:

[74] It is possible that Oregon providers will still have administration related to other payers outside of Oregon or otherwise different than the single-payer under the UHP.
[75] https://jamanetwork.com/journals/jama/fullarticle/2673148

- Should fee schedules be standardized across geography? Or should the UHP adopt a single fee schedule across the State? If by geography, how granular should the areas be (county level, MSA, or by current Coordinated Care Organization structure)?[76]
- For professional services, should standardization be done at the specialty level? Or more broadly by primary care versus non-primary care?

Furthermore, current provider reimbursement rates in Oregon are approximately 110% to 125% of Medicare levels. Due to Oregon's relatively high Medicaid and Medicare population, the total aggregate reimbursement level is likely lower than relatively similar states. The 2023 population by market in Oregon, Washington, Colorado, and Minnesota is shown in Figure 49.[77]

FIGURE 49: 2023 OREGON POPULATION DISTRIBUTION BY MARKET COMPARED TO SIMILAR STATES



While there may be differences in commercial and Medicaid provider reimbursement levels by state, when holding Medicaid reimbursement the same across states, Oregon composite provider reimbursement could be 4% to 11% lower than other states. As Oregon composite provider reimbursement is already estimated to be lower than peer states, further lowering reimbursement under the UHP may result in a reduction in the number of participating providers choosing to leave the state due to the reimbursement changes (which may materialize over the course of several years).

7.1.3 Cost Containment Estimates

Section 7.1.2 discusses potential considerations om establishing provider reimbursement strategies under the UHP. It is outside of the scope of this analysis to execute a full provider reimbursement analysis. Furthermore, the provider reimbursement schedule for the UHP is not yet established and is still in development. As a result, we took a high-level approach to estimating potential opportunities when establishing provider reimbursements and do not apply any savings from these opportunities at this time. The outcomes of removing the discussed collectability and provider administration estimates from UHP total expenditures is shown in Figure 50.

[76] A map of these organizations can be found here: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8116.pdf
[77] From the 2023 Milliman Calibrated US Healthcare Census. The States of Washington, Colorado and Minnesota were chosen as comparison for their similarities in incomes, political leanings, income levels, urban-rural splits and health care structures (1332 Waivers, BHPs etc.)

FIGURE 50
OREGON UNIVERSAL HEALTH PLAN
2032 EXPENDITURE ESTIMATES ACCOUNTIG FOR PROVIDER REIMBURSEMENT OPPORTUNITIES (BILLIONS)

	(A)	(B)	(C)	(D) = (A) - (B) - (C)
	UHP EXPENDITURES	COLLECTABILITY	PROVIDER ADMINISTRATION	ADJUSTED UHP EXPENDITURES
Low	$77.4	$3.0	$5.0	$69.4
Best Estimate	$85.5	$3.3	$4.5	$77.7
High	$94.0	$3.5	$4.0	$86.5

Implementation of these savings would occur through an overall lowering of the provider reimbursement levels in section 7.1.1. Changes to provider reimbursement levels under the UHP will be driven by policy considerations that come with tradeoffs. While the details of any particular provider reimbursement program design are important to those tradeoffs, every policy will have an aggregate cost effect. Communication to providers and helping them understand these savings will be crucial when attempting any lowering of provider reimbursement.

To help understand the impact of these decisions, Milliman estimated the result of a 1% reduction in provider reimbursements to all provider types in the State, excluding prescription drug expenditures, would decrease costs by approximately **$0.5 billion**. See Figure 45 for additional sensitivity tests.

7.1.4 Interactive Effects

The previous section outlines a non-exhaustive list of considerations when undertaking provider reimbursement policy changes under a UHP. Collectability, administrative savings and fee schedule normalization were considered in isolation. However, these three considerations also have interactions among each other when considering individual providers.

Generally, fee schedule standardization will favor providers that are serving heavily Medicaid populations under the current system, while those with a heavily commercial panel, will fare worse. Again, providers who currently have proportionately higher billing, eligibility and payer contracting expenses will also tend to benefit from the UHP. Those providers that have already invested heavily in more efficient administrative systems and staff will most likely be less enthusiastic about a conversion to a single UHP system as at least some of that investment may not be recouped.

Again, the considerations discussed above are likely only a short list of all relevant impacts to providers transitioning to the UHP and subject to an entirely new payment structure. It may be necessary to do more granular analysis to understand the impacts of all payment changes and policies taken together.

7.2 MEDICAL MANAGEMENT AND PRIOR AUTHORIZATION

UHP 2032 expenditure estimates assume a level of medical management consistent with current prevailing industry managed care standards and practice reflected in the Oregon-specific claims experience for the employer-sponsored markets (large group small group and self-funded), the individual market, managed Medicaid and managed Medicare under the Medicare Advantage program.[78]

Actual experience and ultimate costs of the UHP will vary depending on the degree of healthcare management implemented. Medical management may be particularly important under a UHP plan design that substantially reduces or eliminates enrollee cost sharing. As we have noted previously, a zero-cost sharing design will put upward pressure on utilization relative to the status quo system which contains material amounts of enrollee cost sharing (except for Medicaid). This upward pressure will be felt most for services that are currently cost-sensitive to patients and elective in nature.

However, medical management can serve to control this utilization in a manner that optimizes costs and clinical outcomes. As such, Oregon will need to define an approach that balances member and provider experience, administrative costs, patient access to care, optimized healthcare costs and clinically appropriate care paths.

[78] There is a very small amount of fee-for-service Medicare and Medicaid that could be considered medically unmanaged.

Medical management programs include programs intended to either lower unit costs or lower or shift utilization of services to different sites of service or modes of delivery. The goal of these programs is not to prevent people from getting the care they need, but to improve patient outcomes and program efficiency. Some common management programs include (but are not limited to):

- **Prior Authorization (prospective review):** Health plan (in this case the single-payer) must approve certain services before they are obtained.
- **Case Management:** Targeted programs for chronic and high-cost enrollees that assist them in care transitions (for example discharge planning) and accessing community resources.
- **Disease Management:** For various chronic illnesses that focuses on education, monitoring, medication and care plan adherence and prevention of acute exacerbations.
- **Pharmacy Management:** Includes step therapies, prior authorization and therapy management.

Other areas of claims management outside of strictly medical management include payment integrity programs and fraud, waste and abuse (FWA) prevention.

Again, the estimates in this report assume that these claims management functions collectively are in place at a minimum to the degree the current system executes them.

7.2.1 Cost Containment Estimates

While the PD&E committee has discussed numerous payment options and medical management programs, a full analysis of the various intended programs and their savings is beyond the scope of this analysis. Based on our experience with these programs and Milliman's *HCGs*, **we estimate that the level of medical management employed can influence costs up to 10% in either direction, with a more likely range of +/- 5% relative to the estimates in this report.**

For every 1% reduction resulting from medical management initiatives, total 2032 best estimate expenditures would decrease by approximately **$0.7 billion**.

7.3 PRESCRIPTION DRUGS

Prescription drug costs represent a material (and growing) component of total UHP expenditures, based on current trends. The 2032 UHP estimates are built from the ground up with adjustments made for certain emerging therapies and patterns. This means that there is an implicit assumption that the existing prescription drug environment will carry over into the UHP.

However, the list of drugs covered, known as a formulary, varies widely by market due to various regulations and managed care practices. Existing health plans place cost sharing on prescription drugs to influence members to utilize lower cost alternatives (e.g., generics and biosimilars) over more expensive brand drugs, but this structure is not feasible with the absence of copays in the UHPs primary benefit design.

There are few details regarding UHP prescription drug program design including formularies, rebates, and management programs. However, there are many considerations in program design that will impact the total prescription drug costs under the UHP:

- **Pharmacy Network Design:**

  A pharmacy network establishes a group of pharmacies that agree to dispense medication to a given plan sponsor population based on certain contracted terms. The UHP should evaluate whether to include all pharmacies within the State in its network. Generally, narrower or tiered networks lower pharmacy costs by increasing negotiating leverage and steering to lower-cost channels and higher-performing pharmacies, while broader networks improve choice but usually come with higher per-claim costs.

- **Rebate Management:**

  Rebates are a significant lever for reducing pharmacy spend. Rebates are offered by pharmaceutical manufacturers in exchange for payers meeting defined coverage criteria. Plan sponsors can negotiate rebates directly with manufacturers, with a rebate group purchasing organization (GPO), or gain access to negotiated rebates through their pharmacy benefit manager (PBM) or rebate aggregator. The magnitude of rebates depends heavily on formulary design and utilization management criteria. Typically, manufacturers will offer higher rebates

for drugs that are in preferred formulary positioning, particularly relative to competitor products in the same therapeutic class, and limited utilization management.

- **Formulary Design:**

  The structure of the formulary must be determined. Options include open formularies, which provide broad drug access, and closed formularies, which restrict coverage to a defined subset of drugs and require exceptions for non-covered medications. Open formularies cover most drugs with few restrictions, which reduces negotiating leverage and limits steering to lower-cost options, leading to smaller rebates, more use of higher-priced brands over generics/biosimilars, and looser utilization controls that expand use of expensive therapies. While they can improve access, the net effect on the pharmacy benefit is typically higher drug spend than with more selective or closed formularies. UHP should also consider that $0 cost sharing may reduce enrollees' incentives to select generics/biosimilars, potentially increasing brand utilization and overall costs.

- **Utilization Management (UM):**

  Similar to formulary management, there is a balance between cost efficiency and member experience when making UM decisions. UM is highly interdependent with rebates and must be evaluated alongside detailed rebate information and coordination with those responsible for negotiating drug rebates and managing drug formularies.

- **Coverage of Weight Loss Medications:**

  If weight loss medications are covered, the UHP should establish clear eligibility criteria and consider impact of any UM criteria on rebates.

- **Pharmacy Reimbursement:**

  There are several reimbursement arrangements that a plan sponsor can implement. Each arrangement has distinct implications for cost control, transparency, and the relationships between the plan sponsor, PBM, and pharmacies. Examples of pharmacy network reimbursement models include traditional spread pricing models, pass through pricing models, and cost-plus models. While spread pricing and pass through pricing models are based on average wholesale price (AWP) discounts, cost plus models are often based on pharmacy acquisition cost plus a set mark-up.

- **Specialty Pharmacy Management:**

  Targeted strategies should be developed for the management of high-cost specialty medications. This includes the establishment of clinical support programs for complex disease states to optimize patient outcomes and manage overall costs.

7.3.1 Cost Containment Estimates

To help understand the impact of potential prescription drug changes, Milliman estimated the result of a 1% reduction to pharmacy costs as a result of management practices and rebates:

For every 1% reduction, total 2032 best estimate expenditures would decrease by approximately **$0.1 billion**.

7.4 RESOURCE MANAGEMENT

Implementation of the UHP requires that Oregon attempt to meet enrollee demand with available provider supply, including workforce, facility capacity, and care delivery infrastructure. In a UHP that reduces financial barriers to care with low to no cost sharing, Oregon should expect changes in care-seeking behavior referred to as induced utilization, including increases in demand for primary care, behavioral health, and elective services that were previously deferred.

As described in the induced utilization discussion in Section 6.4.3 of this report, Oregon's ability to absorb increased utilization is constrained by provider capacity. The induced utilization analysis explicitly reflected these capacity constraints. While capacity constraints may mitigate some utilization increases in the short term, they can also create access issues, such as longer wait times, and shift utilization to inappropriate higher-cost settings such as the emergency room. Figure 51 below summarizes the trade-offs with increasing net (after expenses) provider income to attract more providers and meet the anticipated increase in demand under the UHP.

FIGURE 51: RESOURCE MANAGEMENT TRADEOFFS

RESOURCE MANAGEMENT TRADEOFFS			
Metric	**↑ Increase Net Provider Reimbursement**	**↓ Decrease Reimbursement**	**Key Insights**
Provider Supply	↑ More providers attracted	↓ Providers leave state	Higher pay drives supply
Healthcare Utilization	↑ Higher demand met	↓ Unmet demand	More providers = more access
High-Cost, Less Efficient Care	↓ Reduced (better care allocation)	↑ Increased (worse outcomes)	Better access = better screening & prevention, lower ED utilization etc.
Short-Term Costs	↑ Increases (higher pay + more services)	↓ Decreases (lower pay + fewer services)	Immediate spend effect
Long-Term Costs	↓ Decreases (healthier population)	↑ Increases (sicker population)	Prevention + care quality matter

Key: Green = Favorable program outcomes; Yellow = Neutral or mixed outcomes; Red = Unfavorable program outcomes

As Figure 51 above shows, in the short term, reducing (or simply not addressing) provider reimbursement as a primary driver of provider recruitment will lead to longer term unfavorable cost and quality outcomes. As mentioned in Section 7.1, it may be possible under the UHP to reduce provider reimbursement costs on a gross basis relative to the current system but increase provider revenue on a net basis (after provider administrative expenses) by reducing their administrative costs under the new plan.

Further analysis into resource management is recommended, including a more detailed look into Relative Value Units (RVUs), which are the standardized metric used by CMS to quantify resources. As discussed in the sensitivity analysis in Section 6.7, we tested a +/- 1% change to the induced utilization assumption and found a $0.6 to $0.7 billion impact to results indicating that Oregon needs to continue monitoring hospital capacity and physician numbers.

7.5 COVERED BENEFITS

The UHP is planning to offer a foundation of major medical and prescription drug benefits discussed in detail in Section 5.2. Beyond that coverage, the UHP also plans to provide additional benefits to enhance member well-being and address more specialized needs such as dental care as part of the Plus package discussed in Section 5.3. The level of coverage planned for the UHP includes a list of benefits that is more expansive than coverage received by most of the Oregon population currently (See Figure 18 in Section 5.3).

As a method of reducing costs when revenue will not match expenditure in Medicaid, the OHP will add or remove certain procedures in a given year. This method is also common for self-insured plans experiencing high costs with a need to reduce expenses. Benefit reduction (and correspondingly increasing enrollee cost sharing) represents one possible method of reducing total costs to the State; however, this solution is not ideal given the overall mission and goals of the UHP. It does not actually reduce costs overall but rather shifts costs from the UHP to enrollees. It is a level of detail beyond our scope to model the changes in costs from removing any specific procedures; however, total estimated benefit costs of the Plus package is reiterated in Figure 52 below to help provide context for potential reductions to costs from benefit changes.

FIGURE 52 OREGON UNIVERSAL HEALTH PLAN 2032 PLUS BENEFITS COSTS ($ BILLIONS)		
SERVICE CATEGORY	**LOW ESTIMATE**	**HIGH ESTIMATE**
Dental	$3.3	$4.1
Vision	$0.5	$0.6
Fertility	$0.3	$0.4
Other*	$0.5	$0.6
Total	**$4.5**	**$5.6**

* Other includes sleep studies, hearing aids, complementary medicine, massage therapy, and doula services.

This report reflects that Long-Term Services and Supports (LTSS), currently covered under Medicaid are excluded from UHP cost estimates. If LTSS were later included in the UHP scope, it would represent a material incremental increase in costs ($5.3B) and would require separate benefit definition and analysis.

7.6 PLAN DESIGN

Existing health insurance plan designs use enrollee cost sharing including deductibles, coinsurance and copays, as well as contracted networks to help lower costs through steerage. Steerage is an attempt to shift enrollees from higher to lower cost services without sacrificing level of care, or in the case of networks shift enrollees from higher to lower cost providers. For example, emergency department use has higher total healthcare cost than urgent care, and is often utilized for care that could have been obtained at an urgent care setting or even in a primary care office. Another example is that certain providers are more efficient in treatment and on average are a lower cost of care for a total episode than others.

The UHP plan design is set with no cost sharing to achieve access goals by completely removing any financial barriers to needed care. To still meet those goals with a plan design that includes enrollee cost sharing, it should be with the intent to guide enrollees to low cost alternative treatments rather than choosing the more expensive alternative since enrollees have little insight or incentive to care about the cost implications to the UHP.

Drawbacks of including cost sharing as part of a UHP plan include:

- Concerns with access goals: Cost sharing brings back the stigma behind requiring payment for care and could lead to lower income enrollees choosing to forego care again, particularly if cost sharing is too high.
- Greater administrative complexity and costs: It was out of scope to estimate administration and staffing with cost sharing implemented, but an increase in administrative costs (both plan and provider) can be expected.
- Reintroduction of collectability issues: Small amounts of thoughtful cost sharing can incent enrollees to make better choices when seeking out treatment. That said, even small amounts of cost sharing mean that providers must collect it, chase it, or forget it altogether.
- Enforcement: As noted above, with the amount of cost sharing being relatively small and with the overall UHP goal of access, cost sharing could potentially be ignored or side-stepped by providers, eliminating any steerage benefits.

7.6.1 Quantitative Analysis of Cost Sharing

The UHPGB requested actuarial analysis of one additional plan design as part of this report, referred to as the Low Cost Sharing scenario. This second plan design introduces the following cost sharing characteristics to the 2032 UHP benefit design:

- Emergency room copay: $200
- Prescription drug copays: $5 generic / $75 brand / $150 specialty
- Enrollee maximum out-of-pocket: $1,250 per year

Note that this plan design still does not have any deductible or coinsurances which have a level of complexity for both the payer and the enrollee that the UHPGB considers incompatible with the UHP goals.

This plan design was chosen to help put context around steerage and cost containment concepts and not be viewed as an endorsement of cost sharing on the UHP or an endorsement of this specific design. Actual design of any cost

sharing plan design requires additional thoughtful consideration related to the specific services that will apply a copay, the reasonability and impacts of copay amounts, the spread between prescription drug copays, and the appropriate level of maximum out-of-pocket, which is the total amount of money an enrollee would spend before cost sharing is eliminated for the rest of the year.

Emergency room and prescription drug copays were modeled for reasons alluded to in this report, listed below:

- They are two of the benefits that are most responsible for material increases to costs when less expensive alternative options exist.
- Copays are designed around steerage rather than access. For example, there are many generic prescription drugs with the same efficacy as their brand name counterparts, but a materially lower cost. When the price is the same, brands are frequently requested due to advertising and name recognition. The idea behind this cost sharing is to influence the enrollee to the less expensive choice to contain costs for all Oregonians. That said, there are still access concerns created since there are many legitimate needs for emergency care and certain brand and specialty drugs.

Figure 53 below shows 2032 UHP total expenditure estimates for the low cost sharing plan design alternative in comparison to the estimates for the estimates discussed in Section 6. A third scenario is in this figure that also shows the full estimated expenditure impact if the Plus benefits are removed in the Low Cost Sharing plan design to give a full range of the covered benefits and plan design cost considerations.

FIGURE 53
OREGON UNIVERSAL HEALTH PLAN
2032 EXPENDITURE PROJECTIONS ($ BILLIONS)

		(a)	(b)	(c)	(d)	(e) = (a) + (b) + (c) + (d)	
PLAN DESIGN	**SCENARIO**	**MAJOR BENEFITS***	**PLUS BENEFITS****	**COST SHARING**	**ADMIN COSTS**	**TOTAL UHP COST**	**DIFFERENCE**
Zero Cost Sharing	Low	$69.2	$4.5	$0.0	$3.6	$77.4	
	Best Estimate	$75.3	$5.1	$0.0	$5.1	$85.5	N/A
	High	$81.3	$5.6	$0.0	$7.0	$94.0	
Low Cost Sharing Including Plus	Low	$68.6	$4.5	-$1.1	$3.6	$75.7	$1.7
	Best Estimate	$74.6	$5.1	-$1.2	$5.1	$83.6	$1.8
	High	$80.6	$5.6	-$1.3	$7.0	$92.0	$2.0
Low Cost Sharing Excluding Plus	Low	$68.6	$0.0	-$1.1	$3.6	$71.2	$6.2
	Best Estimate	$74.6	$0.0	-$1.2	$5.1	$78.5	$6.9
	High	$80.6	$0.0	-$1.3	$7.0	$86.4	$7.6

*Inpatient, Outpatient, Physician, Prescription Drugs, Other.
**Dental, Vision, Fertility, Other Benefits.

When cost sharing is introduced, induced utilization can be expected to decrease. The estimates in Figure 53 above include an adjustment to induce utilization resulting from the cost sharing plan design alternative. As noted above, it was out of scope to estimate administration and staffing with cost sharing implemented so this figure assumes equal administrative costs for each plan design presented.

7.7 DEMOGRAPHICS

OEA forecasts used to help inform population changes between 2026 and 2032 indicate an aging population in Oregon.[79] Growth in the over 65 population is annualized at 1.6% per year between 2026 and 2032, compared to 0.5% for the entire state. This leads to a higher percentage of the State eligible for Medicare in both 2032 status quo and 2032 UHP estimates relative to 2026 baseline. On average healthcare costs increase with age, creating an age curve where a higher level of costs can be expected for the Medicare eligible population. Referring to Figure 26 in Section 6.1.4, the baseline 2026 estimated allowed benefit cost in Medicare is over $1,400 PMPM, compared to approximately $700 PMPM in the commercial markets. This is in part due to differences in coverage and induced utilization; however, under the UHP the spread is still material. The 2032 best estimate allowed benefit cost for the

[79] https://www.oregon.gov/das/OEA/Pages/forecastdemographic.aspx

Medicare eligible population is over $2,200 PMPM, compared to over $1,100 PMPM for the non-Medicare eligible population.

As a result, the proportion of the total population that is over 65 will have a material impact on total 2032 UHP expenditures. The UHPGB requested assistance in understanding the total proportion of benefit costs and expenditures attributed to the Medicare eligible population versus the non-Medicare eligible population. Figure 54 displays total UHP benefit costs estimated for the Medicare and non-Medicare populations. Estimates shown in this figure include the Plus package.

FIGURE 54
OREGON UNIVERSAL HEALTH PLAN
2032 UHP TOTAL BENEFIT COST ESTIMATES BY AGED POPULATION
($ BILLIONS)

SCENARIO	MEDICARE POPULATION	NON-MEDICARE POPULATION	TOTAL
Low	$28.1	$45.7	**$73.7**
Best Estimate	$30.9	$49.4	**$80.3**
High	$33.8	$53.2	**$87.0**

Figure 55 displays total 2032 UHP expenditures without the Medicare population included. This figure includes adjustments to estimated administrative costs for the reduced enrollment.

FIGURE 55
OREGON UNIVERSAL HEALTH PLAN
2032 TOTAL UHP EXPENDITURE ESTIMATES EXCLUDING MEDICARE POPULATION
($ BILLIONS)

SCENARIO	BENEFIT COSTS	ADMINISTRATIVE COSTS	TOTAL
Low	$45.70	$2.00	**$47.70**
Best Estimate	$49.40	$2.80	**$52.30**
High	$53.20	$3.90	**$57.10**

While the Medicare population represents a material portion of costs, there are complexities and nuances related to revenue generation and to UHP implementation with this population. While Maryland has had success related to establishing a Medicare waiver[80], it remains a largely unexplored option. Estimates in the figure above could represent a possible scenario in which implementation year is delayed for the Medicare population.

7.8 SUMMARY

Appendix 3 provides additional detail summarizing the extent of potential cost containment estimates.

[80] https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model

8 Data

8.1 DATA SOURCES

8.1.1 Staffing and Administrative Costs

Milliman's administrative benchmarks were used to estimate administrative costs and staffing for the UHP. The proprietary, baseline benchmarks rely on data collected from hundreds of payer organizations across all lines of business. To customize the benchmarks to the UHP, key adjustments were made for plan size, geographic cost index, business mix, and the operating model. The data used for enrollment and total costs is from publicly available data sources and aligns with the data sources identified below in Figure 56.

8.1.2 Benefits and Plan Design

Figure 56 below sources plan designs and information referenced in evaluating benefit coverage in Oregon.

FIGURE 56
OREGON UNIVERSAL HEALTH PLAN
BENEFIT COVERAGE SOURCES AND LINKS

MARKET	COMPONENT	SOURCE
Public	PEBB / OEBB	Oregon Health Authority : Public Employees' Benefit Board : Public Employees' Benefit Board : State of Oregon
Employer	Employer LG	SERFF Filing Access - Oregon
		Specific plan benefit pdfs obtained through insurance carrier websites including Kaiser, Regence BCBS, Providence, Moda Health, Health Net, Samaritan, and others
	Employer SG	2025 Marketplace Open Enrollment Period Public Use Files | CMS
Individual		2025 Marketplace Open Enrollment Period Public Use Files | CMS
Medicaid		Oregon Health Authority : Oregon Health Plan (OHP) Benefits : Oregon Health Plan : State of Oregon
Medicare FFS		Health & drug plans | Medicare
Medicare Advantage		Milliman MACVAT (Medicare Advantage Competitive Value Added Tool) | Milliman | Worldwide

8.1.3 Baseline Enrollment

Figure 57 below sources data and information used to develop baseline enrollment estimates.

FIGURE 57
OREGON UNIVERSAL HEALTH PLAN
BASELINE ENROLLMENT SOURCES AND LINKS

MARKET	COMPONENT	SOURCE	LINK
Public	PEBB / OEBB	2023 Public Reports	OEBB Insurance 101
			OEBB Demographic Report 2023-2024.pdf
Employer	Employer LG Fully Insured	2023 CMS MLR Reports	Medical Loss Ratio Data and System Resources | CMS
	Employer SG Fully Insured	2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
	Employer Self-Insured	Balancing Item	N/A
Individual		2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
Medicaid	Includes CHIP, BHP	2025 OHA Enrollment Report	Oregon Health Authority : Medicaid Enrollment Report : Office of Health Analytics : State of Oregon
Medicare	Includes Duals	2023 APAC Data	N/A
		2025 CMS Enrollment Reports	Monthly Enrollment by State | CMS
Uninsured		2024 OHA Health Insurance Survey	Oregon Health Authority : Oregon Health Insurance Survey (OHIS) Coverage Dashboard : Office of Health Analytics : State of Oregon
Total Population		Oregon Office of Economic Analysis	Department of Administrative Services : Demographic Forecast : Office of Economic Analysis : State of Oregon

8.1.4 Baseline Benefit Costs

Figure 58 below sources data and information used to develop baseline benefit cost estimates.

FIGURE 58 OREGON UNIVERSAL HEALTH PLAN BASELINE BENEFIT COST SOURCES AND LINKS			
MARKET	**COMPONENT**	**SOURCE**	**LINK**
Public	PEBB / OEBB	2023 Public Reports	OEBB Insurance 101
Employer	Employer LG Fully Insured	2023 CMS MLR Reports	Medical Loss Ratio Data and System Resources | CMS
	Employer SG Fully Insured	2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
	Employer Self-Insured	Same as LG FI	N/A
Individual		2024 CMS Risk Adjustment Reports	SUMMARY REPORT ON INDIVIDUAL AND SMALL GROUP MARKET RISK ADJUSTMENT TRANSFERS
Medicaid	Includes CHIP, BHP	Medicaid Expenditure Reports	Expenditure Reports From MBES/CBES | Medicaid
Medicare	Includes Duals	OHA Health Care Cost Trends Report	Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf
Uninsured		Oregon Community Benefit Report	50284-2025-Community-Benefit-Report_2-24-25.pdf
Total Population		Composite	N/A

8.1.5 Trends

Figure 59 below sources data and information underlying and referenced when developing trend assumptions.

FIGURE 59 OREGON UNIVERSAL HEALTH PLAN TREND SOURCES AND LINKS	
SOURCE	**LINK**
National Healthcare Expenditure Data	Projected | CMS
Oregon Healthcare Cost Trends Report	Oregon-Health-Care-Cost-Trends-Report-2022-2023.pdf
Milliman Health Trend Guidelines	https://www.milliman.com/en/products/milliman-health-trend-guidelines

8.1.6 Induced Utilization

Figure 60 below sources data and information used in the development of induced utilization estimates.

FIGURE 60 OREGON UNIVERSAL HEALTH PLAN INDUCED UTILIZATION SOURCES AND LINKS	
SOURCE	**LINK**
Milliman *HCGs*	https://www.milliman.com/en/products/health-cost-guidelines-suite
State of the Primary Care Workforce 2024	State of the Primary Care Workforce, 2024
State of the Primary Care Workforce 2025	State of the Primary Care Workforce, 2025
Oregon Office of Rural Health	AUHCN Report_2024 - FINAL 9-17-24 6.pdf
Portland Business Journal	OHSU leaders sound alarms about ongoing 'capacity crisis' at Oregon hospitals - Portland Business Journal
Oregon Capital Chronicle	Oregon task force finds ways to prevent patients from boarding in hospitals • Oregon Capital Chronicle
Hospital Association of Oregon	2025.04.25_Report_Oregon-Hospitals-on-the-Brink_FINAL.pdf
OHSU	OHSU roundtable: Understanding, addressing Oregon's hospital capacity crisis | OHSU News

FIGURE 60 OREGON UNIVERSAL HEALTH PLAN INDUCED UTILIZATION SOURCES AND LINKS	
SOURCE	**LINK**
JAMA	Health Care Staffing Shortages and Potential National Hospital Bed Shortage | Health Policy | JAMA Network Open | JAMA Network
	Understanding and Addressing the US Hospital Bed Shortage—Build, Baby, Build | Health Policy | JAMA Network Open | JAMA Network
KFF	Total Hospital Beds | KFF State Health Facts
National Library of Medicine	Hospital Capacity, Utilization, and Outcomes - The Dartmouth Atlas of Health Care in the United States - NCBI Bookshelf

8.1.7 Adverse Selection

Figure 61 below sources data and information used in the development of adverse selection estimates.

FIGURE 61 OREGON UNIVERSAL HEALTH PLAN ADVERSE SELECTION SOURCES AND LINKS	
Source	**Link**
Milliman *HCGs*	https://www.milliman.com/en/products/health-cost-guidelines-suite
Milliman C*HSD*	https://us.milliman.com/en/health/life-sciences/data-assets
National Library of Medicine	Moving opportunistically: Interstate migration after Medicaid expansion - PubMed
Medicaid Expenditure Reports	Expenditure Reports From MBES/CBES | Medicaid
Medicaid Expenditure Reports	Expenditure Reports From MBES/CBES | Medicaid
Center on Budget and Policy Priorities	State Taxes Have a Minimal Impact on People's Interstate Moves | Center on Budget and Policy Priorities
Income by Zip Code	Oregon Income Statistics | Current Census Data for Oregon Zip Codes

8.1.8 Plus Benefits

Figure 62 below sources data and information used in the development of Plus benefit cost and utilization estimates.

FIGURE 62 OREGON UNIVERSAL HEALTH PLAN PLUS BENEFITS SOURCES AND LINKS	
SOURCE	**LINK**
Milliman *HCGs*	https://www.milliman.com/en/products/health-cost-guidelines-suite
Milliman *DCGs*	https://us.milliman.com/en/products/health-cost-guidelines-suite
Milliman C*HSD*	https://us.milliman.com/en/health/life-sciences/data-assets
PEBB Fertility	Microsoft Word - PEBB_Fertility Benefit Comparison_2025_final011425
CDC	FastStats - Births and Natality
KFF	Coverage and Use of Fertility Services in the U.S. | KFF
UCLA Williams Institute	Adult LGBT Population in the United States - Williams Institute
Pacific Fertility Center	IVF with donor eggs: What to expect, success rates, and more
Kind Body	Fertility Pricing Made Simple and Affordable - Kindbody
Advanced Fertility	Cost of Fertility Treatment - Insemination, IUI and IVF
National Library of Medicine	Costs of infertility treatment: Results from an 18-month prospective cohort study - PMC

8.1.9 Other Adjustments

Figure 63 below sources data and information referenced or used in the development of additional assumptions and aspects of enrollment, benefit cost, and utilization estimates.

FIGURE 63
OREGON UNIVERSAL HEALTH PLAN
OTHER SOURCES AND LINKS

USE	SOURCE	LINK
Enhanced Behavioral Health	2025-2027 Governors Budget	2025-27_gb.pdf
Unreimbursed Medicaid	Hospital Association of Oregon	50284-2025-Community-Benefit-Report_2-24-25.pdf
Population Growth	OEA	Department of Administrative Services : Demographic Forecast : Office of Economic Analysis : State of Oregon
APTCs	CMS	2025 Marketplace Open Enrollment Period Public Use Files | CMS
Enhanced APTCs	Milliman	2026 ACA premium landscape: What health insurers need to know—and do—now
Provider Reimbursements	OHA	OHA PowerPoint Template
Provider Reimbursements	KFF	Medicaid-to-Medicare Fee Index | KFF State Health Facts
Provider Reimbursements	OHA	Oregon Hospital Payment Report
Provider Reimbursements	Medicaid.gov	Approved State Directed Payment Preprints | Medicaid
Provider Reimbursements	Benefits Pro	Health care providers are accepting less
Provider Reimbursements	JAMA	Health care providers are accepting less
Comparison and Reasonability	Prior Report	Joint Task Force on Universal Health Care Final Report Recommendations September 2022.pdf
Comparison and Reasonability	OHA Databook	Oregon Health Authority : Cost Growth Target Reports : Office of Health Policy : State of Oregon
Statutory Reporting Sources	S&P Global	Essential Intelligence | S&P Global
LTSS	PD&E Committee	Plan Design & Expenditure Presentation: Nov. 6, 2025
Uninsured Pent-Up Demand	KFF	The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020 | KFF
Uninsured Pent-Up Demand	JAMA	Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance | Health Care Economics, Insurance, Payment | JAMA Internal Medicine | JAMA Network
Uninsured Pent-Up Demand	Rand	The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate | RAND
Market Shifts	OPB	Medicaid cuts could affect Oregon more than most states, analysts say - OPB
Market Shifts	SHVS	House Budget Bill Medicaid Proposals: State-by-State Estimates of Impacts on Expenditures and Enrollment
Market Shifts	KFF	Allocating CBO's Estimates of Federal Medicaid Spending Reductions Across the States: Enacted Reconciliation Package | KFF
Market Shifts	Oregon Department of Administrative Services	Federal-Impact-HR1-Initial-Analysis.pdf
Market Shifts	ACA Signups	2026 FINAL Gross Rate Changes - Oregon: +9.7% (updated) | ACA Signups
Market Shifts	CMS	National Health Expenditure Projections 2024-2033 Forecast Summary
Market Shifts	HR 1	H.R.1 - 119th Congress (2025-2026): An act to provide for reconciliation pursuant to title II of H. Con. Res. 14. | Congress.gov | Library of Congress

8.1.10 Proprietary Milliman Data and Research

Throughout this section and entire report, we reference the use of proprietary Milliman data sources, including the Milliman *HCGs*, Milliman *Dental Cost Guidelines*, Milliman Health Trend Guidelines, Milliman Consolidated *HCG* Sources Database, Milliman Calibrated US Healthcare Census, and Milliman Commercial Reimbursement Benchmarking Model.

The *HCGs* are developed as a result of Milliman's continuing research on health care costs. They were first developed in 1954 and have been updated and expanded annually since then. These guidelines are continually monitored as we use them in measuring the experience or evaluating the rates of our clients and as we compare them to other data sources.

The *HCGs* are a cooperative effort of all Milliman health actuaries and represent a combination of their experience, research, and judgment. An extensive amount of data is used in developing these guidelines, including published and unpublished data. In most instances, cost assumptions are based upon our evaluation of several data sources and, hence, are not specifically attributable to a single source. Since these guidelines are a proprietary document of Milliman, they are only available for release to specific clients that lease these guidelines and to Milliman consulting health actuaries.

8.1.11 Oregon All Payer All Claims (APAC) Database

Select 2023 calendar year claims, utilization, and enrollment information was acquired through the Oregon Health Authority (OHA). We reviewed the APAC data for reasonableness and compared against publicly available sources and excluded underlying information that was deemed unreasonable. We summarized key fields by various cohorts to gauge overall reasonableness of the data. The APAC provided three dataset which had the following elements shown in Figure 64 below:

FIGURE 64
OREGON UNIVERSAL HEALTH PLAN
APAC DATA ELEMENTS

MEDICAL CLAIMS	PRESCRIPTION DRUG CLAIMS	ENROLLMENT
Line Of Business	NDC	Month Start
NPI	Line Of Business	Plan Termination Date
Claim Status	Quantity dispensed	Line Of Business
Self-insured flag	Compound code	Medicare Type
Payer type	Payer Paid amount	Dual Coverage Flag
Admit date	Member coinsurance amount	Subscriber Relationship Flag
Discharge date	Member copay amount	Gender
ICD codes	Member deductible amount	Market Segment
Procedure codes	Patient Pay amount	County
Revenue code		
Claim type		
Service quantity		
Charge amount		
Payer Paid amount		
Member coinsurance amount		
Member copay amount		
Member deductible amount		
Patient Pay amount		
Gender		

Attachment A

CHALLENGES ASSOCIATED WITH UNIVERSAL HEALTHCARE PLANS GLOBALLY

Beyond typical U.S. based structures, Milliman researched organizational structures used globally for single-payer plans. These systems vary in their degree of centralization, financing mechanisms, and roles, but they share common design principles intended to balance national standards, fiscal control, and local responsiveness.

While an exhaustive review of all single payer and / or universal health plans was beyond the scope of our engagement, we did conduct a limited review of select nations and their universal healthcare systems. This review was undertaken to ensure that when forming any assumptions around cost or utilization on the UHP, we had considered the real-world experience of already established program and applied those learnings to Oregon where appropriate. Other national systems are the sole basis for this type of information, as in the United States, no states have implemented a single payer universal health system, though many states have had and continue to have discussions around the planning and feasibility.[81,82,83] Across countries commonly cited as having "universal health care" (including systems associated with the United Kingdom, Canada, Taiwan, Germany, the Netherlands, and the Nordic countries), there is no single uniform program design or funding mechanism. Universal systems reflect each nation's choices about who is covered, what is covered, how coverage is financed, governance structure, benefit administration, and how providers are paid and held accountable.

For example:

- Canada runs a largely single-payer system for medically necessary hospital and physician care, administered by provinces under national standards. While major services related to hospitalization and professional services are covered, outpatient prescription drugs, dental, and vision are not universally covered and are often financed via provincial programs or private supplemental insurance.
- Norway has a tax-funded National Health Service model with hospitals managed by regional health authorities and primary, long-term, and public health services delivered by municipalities Coverage is broad, but there are regulated copays that stop at an annual cap and strong General Practitioner (GP) gatekeeping via patient lists. Public hospitals are run by four Regional Health Authorities (RHA) overseen by the Ministry of Health and Care Services while local authorities at a municipal level organize primary care. In Norway, providers are government employees.[84,85]
- The United Kingdom's NHS is a government run system that provides comprehensive hospital and primary care with no copays for GP or inpatient services. Prescription drugs carry standardized charges in England that are free elsewhere within the UK and dental/optical care has set patient charges with exemptions.[86] Ireland operates a mixed public–private system overseen by the Health Service Executive (HSE), offering broad public hospital coverage, means-tested Medical Cards for free primary care and prescription drugs, expanded GP Visit Cards for free GP visits, and a Drug Payment Scheme that caps monthly household spending; private insurance is common and used to access private hospitals or private care in public hospitals.[87]
- Taiwan has a single-payer system where the Ministry of Health and Welfare set health policy and determine the annual budget, but the National Health Insurance Administration oversees and administers the program with support from regional offices and a digital "smartcard" system that allows for real-time sharing of patient information.[88]

These varying organizational set-ups have resulted in numerous challenges:

- Canada faces persistent wait times for elective and specialist care,[89] uneven access to primary care,[90] gaps for outpatient drugs,[91] and dental / vision that create patchwork protections and out-of-pocket costs; rural access and workforce distribution are ongoing challenges.

[81] CA: https://legalclarity.org/universal-healthcare-in-california-how-it-would-work/
[82] CO: Marchman Bill to Analyze a Statewide Single-Payer Health Care System Advances — Colorado Senate Democrats
[83] VA: https://www.vermontpublic.org/vpr-news/2022-03-01/eight-years-after-shumlins-crushing-reversal-single-payer-health-care-movement-presses-on
[84] https://norwayexplained.com/the-norwegian-public-healthcare-system/
[85] https://www.lifeinnorway.net/healthcare/
[86] https://www.commonwealthfund.org/international-health-policy-center/countries/england
[87] https://relocatingtoireland.com/irish-essentials/healthcare-in-ireland/
[88] https://www.commonwealthfund.org/international-health-policy-center/countries/taiwan
[89] https://www.fraserinstitute.org/sites/default/files/2025-12/waiting-your-turn-2025-17913.pdf
[90] https://www.cihi.ca/en/primary-and-virtual-care-access-emergency-department-visits-for-primary-care-conditions/access-to-primary-care-many-canadians-face-challenges
[91] https://www.canada.ca/en/health-canada/services/publications/health-system-services/report-national-pharmacare-committee-experts.html#a2

- Norway faces workforce shortages and long wait times for non-critical operations, certain facilities closing has limited access to certain services.[92]
- The UK contends with long waiting times,[93] staffing shortages, and capital investment backlogs; dental access is uneven, and policy differences across regional teams produce variation in patient services and coverage based on where citizens live.
- Ireland has a pronounced two-tier dynamic, with long waits in the public system and higher out-of-pocket costs for many adults (especially GP and dental) unless covered by Medical/GP Visit Cards; reliance on private insurance, capacity constraints, and the gradual pace of reforms.[94,95]

In addition to these challenges, any state in the United States faces substantial, fragmented federal program interactions, and cross-border market dynamics that make building and sustaining universal health care more complex than for a Canadian province. Oregon will need to understand and adapt to the challenges it faces to operate a UHP.

CHALLENGES WITH ESTABLISHING A UNIVERSAL HEALTH PLAN IN OREGON

In developing a plan for UHP implementation, the UHPGB is tasked with defining resident eligibility, a comprehensive benefits package with minimal cost sharing, simplified provider payment models, and progressive public financing that consolidates existing federal and state health dollars with various taxes.

To achieve this, Oregon will need to seek federal waivers to obtain the federal funds that would otherwise be paid for Medicaid, the Affordable Care Act (ACA), and Medicare and use those funds under the UHP. A waiver mechanism exists for Medicaid (Section 1115 and 1915) and for the ACA (Section 1332). However, there has been no Medicaid waiver, as of this writing that has sought to receive the full federal contribution towards a state's Medicaid costs for use under a different program altogether.

Medicare is a federally administered program and to date, only Maryland has received a Medicare waiver (Section 1115A), which permits Maryland to operate a unique all-payer hospital rate-setting system. According to the Centers for Medicare & Medicaid Services (CMS), "the primary purpose [of these waivers] is to test innovative payment and service delivery models aimed at reducing program expenditures while preserving or enhancing the quality of care for individuals under applicable titles." While this is somewhat different from allowing a state such as Oregon to administer Medicare insurance directly, the goals of the UHP certainly align with the message of this waiver.

These waivers will establish a foundation from which Oregon will collect funds from CMS as part of the revenue stream needed to fund the UHP. Estimates of those CMS amounts are discussed in this report.

As a comparison, implementing universal health care at the level of a U.S. state faces a set of structural, legal, fiscal, and political hurdles.

- Federal program fragmentation from the various waivers discussed above.
- Financing constraints and fiscal federalism:
  - Most U.S. states have balanced-budget requirements and limited deficit-financing capacity, making large, countercyclical health budgets hard to sustain in recessions. Canada's provinces have more flexibility and receive stable federal cash transfers (e.g., the Canada Health Transfer).
  - States have narrower and more mobile tax bases; high-income taxpayers and employers can relocate across state lines, increasing political and economic resistance to large payroll or income taxes. Canadian provinces rely on national equalization and intergovernmental transfers that blunt these pressures.
- Scale, risk pooling, and border effects:
  - A single state is a smaller risk pool than a nation, increasing volatility and reinsurance needs. It is also exposed to medical tourism and cross-border care-seeking (both inbound and outbound), complicating cost control and provider contracting.

[92] https://www.newsinenglish.no/2023/03/01/public-roars-over-health-care-crisis/
[93] https://eurohealthobservatory.who.int/publications/i/health-systems-in-action-united-kingdom
[94] https://www.rte.ie/brainstorm/2024/0109/1425519-ireland-healthcare-access-reform-challenges/
[95] https://www.thejournal.ie/ireland-outpatient-waiting-lists-6773711-Jul2025/

  - Out-of-state care is hard to control, and providers elsewhere may not accept a state's payment rules. Canada's provinces have portability arrangements and more standardized interprovincial norms for medically necessary services.

- Provider market power and rate regulation:
  - Many U.S. hospital markets are highly consolidated; a state attempting to set all-payer rates or pay Medicare-like rates may face strong resistance and potential service disruptions. Maryland shows rate-setting is possible but politically fragile and technically complex.
  - States cannot compel participation from federally oriented providers or plans. Conversely, Canada's provinces negotiate directly with provincial medical associations and hospital systems with clearer authority over core services.
- Drug pricing and benefit scope:
  - U.S. states have limited leverage over prescription drug prices (e.g., constrained by Medicaid "best price" rules and federal import restrictions). Canada has national institutions (like the Patented Medicine Prices Review Board) and coordinated provincial bulk purchasing, giving their provinces stronger tools.
- Administrative complexity:
  - A state would have to build or expand large-scale enrollment, eligibility, claims adjudication, data systems, fraud control, and provider contracting while still interfacing with multiple federal programs and ERISA plans.
  - Canada's provincial single-payer systems developed over decades, with national standards under the Canada Health Act simplifying the core scope and rules.
- Legal and litigation risk:
  - States face higher litigation risk from employers, insurers, and providers. Courts have struck down state policies seen as interfering with ERISA plans (e.g., certain employer mandates; claims database reporting requirements). This legal uncertainty raises costs and delays.
  - Canada's provinces operate in a legal environment with established national principles (universality, accessibility, portability, comprehensiveness for core services) and fewer private-plan preemption issues for hospital / physician services.
- Political fragmentation and stakeholder opposition:
  - U.S. states must navigate polarized politics, ballot initiatives, supermajority tax requirements, and well-resourced interest groups (insurers, hospitals, employers, unions with Taft-Hartley plans). This complicates consensus and durability.
  - In Canada, national principles and federal transfers create a baseline expectation of coverage that stabilizes provincial reforms.
- Equity and eligibility issues:
  - Covering undocumented residents requires state-only funding, as federal dollars generally cannot be used. That is a significant budget and policy decision for many states whereas Canadian provinces face less of this constraint.
  - Ensuring portability when residents travel or move is harder without interstate compacts; Canada's portability principle and interprovincial arrangements reduce friction.
- Labor markets and provider supply:
  - If a state cuts payment rates to control costs, it risks provider exit to neighboring states or reduced service availability, especially in already thin rural markets. Provinces can standardize participation and payment within their borders with fewer outside alternatives.

Attachment B

NARRATIVE OF MILLIMAN ENGAGEMENT WITH UHPGB

Our team of consultants includes both healthcare management experts and actuaries. The healthcare management team worked alongside the Operations Committee while the actuaries supported the Plan Design and Expenditures (PD&E) committee. Milliman actuaries also collaborated with the Finance and Revenue (F&R) committee during the later months of the project engagement.

The healthcare management team supporting the Operations Committee met with the UHP staff on a biweekly basis and attended monthly committee meetings from August 2025 to early 2026. The Milliman team studied past committee work and spent time validating assumptions for the future UHP. Deliverables included draft organizational charts, estimated staffing projections, and estimated administrative costs through an iterative process. The team refined and adjusted content based on discussion, questions, and feedback from the UHP staff, committee, and board. The final information in this report closely aligns with the work of the operations committee straw proposal for regional teams. We presented to the Operations Committee in August and November and the Governance Board in September 2025 and March 2026.

The actuarial team likewise met with PD&E membership several times a month throughout August 2025 into early 2026 with monthly presentations at the publicly presented PD&E meetings in October through January. Early collaborations and presentations to the PD&E committee and leadership focused on member eligibility, covered services, and cost-sharing parameters as well as how Milliman would translate considerations and scenarios around these decisions into a structured model. At the November PD&E meeting, Milliman presented assumptions, methodology, and preliminary UHP cost estimates, answered questions, and documented feedback from the Governance Board and any public attendees.

The actuaries then refined eligibility definitions, benefit specifications, and key assumptions based on that input and updated the analyses. Each update was documented and presented at subsequent meetings, providing a transparent, iterative process that was intended to link design changes to projected costs.

In addition to walking through the additional analysis and refinements to the initial UHP cost estimate, the December presentation to the PD&E committee introduced several new concepts and actuarial analyses. We performed sensitivity testing of key assumptions and displayed results, and introduced cost containment levers, provider reimbursement considerations, and prescription drug concepts.

The January presentation to the PD&E further built on this work by layering the single payer administrative cost estimates on to the plan expenditure estimates and extending the projection out an additional 10 years. Our contract with the State of Oregon required that we model a second plan option, and this presentation presented results with the introduction of copays into the UHP and with costs separated by population age group to help the committees understand drivers of costs and the importance of developing cost containment measures.

January was Milliman’s first presentation to the F&R committee, which reflected the same materials and results as provided to PD&E. Throughout early 2026, we met with the F&R committee and its members to help them review our estimates, gather feedback, and understand any additional needs. The F&R Committee asked that we value our projection on a 2026 basis and to value the total funding coming from CMS provided for the Medicare, Medicaid, and ACA populations.

APPENDIX 1
OREGON UNIVERSAL HEALTH PLAN
2032 - 2041 UHP ENROLLMENT

Low Estimate

Line of Business	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041
Public	723,000	726,000	729,000	732,000	735,000	738,000	741,000	744,000	747,000	750,000
Employer	940,000	944,000	948,000	952,000	956,000	960,000	964,000	968,000	972,000	976,000
Individual	180,000	181,000	182,000	183,000	184,000	185,000	186,000	187,000	188,000	189,000
Medicaid	1,155,000	1,160,000	1,165,000	1,170,000	1,175,000	1,180,000	1,185,000	1,190,000	1,195,000	1,200,000
Medicare	1,095,000	1,100,000	1,105,000	1,110,000	1,115,000	1,120,000	1,125,000	1,130,000	1,135,000	1,140,000
Uninsured	349,000	351,000	353,000	355,000	357,000	359,000	361,000	363,000	365,000	367,000
Total	**4,442,000**	**4,462,000**	**4,482,000**	**4,502,000**	**4,522,000**	**4,542,000**	**4,562,000**	**4,582,000**	**4,602,000**	**4,622,000**

High Estimate

Line of Business	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041
Public	726,000	729,000	732,000	735,000	738,000	741,000	744,000	747,000	750,000	753,000
Employer	943,000	947,000	951,000	955,000	959,000	963,000	967,000	971,000	975,000	979,000
Individual	180,000	181,000	182,000	183,000	184,000	185,000	186,000	187,000	188,000	189,000
Medicaid	1,159,000	1,164,000	1,169,000	1,174,000	1,179,000	1,184,000	1,189,000	1,194,000	1,199,000	1,204,000
Medicare	1,100,000	1,105,000	1,110,000	1,115,000	1,120,000	1,125,000	1,130,000	1,135,000	1,140,000	1,145,000
Uninsured	351,000	353,000	355,000	357,000	359,000	361,000	363,000	365,000	367,000	369,000
Total	**4,459,000**	**4,479,000**	**4,499,000**	**4,519,000**	**4,539,000**	**4,559,000**	**4,579,000**	**4,599,000**	**4,619,000**	**4,639,000**

APPENDIX 2
OREGON UNIVERSAL HEALTH PLAN
2032 - 2041 HEALTHCARE BENEFIT COSTS - ZERO COST SHARING (BILLIONS)

Low Estimate

Line of Business	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041
Medical and Prescription Drug	$69.2	$73.1	$77.2	$81.5	$86.1	$91.1	$96.3	$101.9	$107.7	$113.9
Plus Benefits	$4.5	$4.7	$4.8	$5.0	$5.2	$5.4	$5.6	$5.8	$6.0	$6.2
Administrative Costs	$3.6	$3.7	$3.9	$4.0	$4.1	$4.2	$4.3	$4.5	$4.6	$4.7
Total UHP Expenditures	**$77.4**	**$81.5**	**$85.9**	**$90.4**	**$95.4**	**$100.7**	**$106.3**	**$112.1**	**$118.4**	**$124.9**

High Estimate

Line of Business	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041
Medical and Prescription Drug	$81.3	$87.3	$93.8	$100.8	$108.8	$117.3	$126.6	$136.5	$147.3	$158.9
Plus Benefits	$5.6	$5.9	$6.1	$6.4	$6.7	$7.0	$7.3	$7.6	$7.9	$8.3
Administrative Costs	$7.0	$7.2	$7.5	$7.7	$7.9	$8.2	$8.4	$8.7	$8.9	$9.2
Total UHP Expenditures	**$94.0**	**$100.5**	**$107.4**	**$114.9**	**$123.4**	**$132.5**	**$142.2**	**$152.8**	**$164.1**	**$176.3**

APPENDIX 3
OREGON UNIVERSAL HEALTH PLAN
2032 - 2041 HEALTHCARE BENEFIT COSTS - LOW COST SHARING EXCLUDING PLUS (BILLIONS)

Low Estimate

Line of Business	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041
Medical and Prescription Drug	$67.5	$71.2	$75.3	$79.5	$84.1	$88.9	$94.0	$99.4	$105.2	$111.2
Plus Benefits	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Administrative Costs	$3.6	$3.7	$3.9	$4.0	$4.1	$4.2	$4.3	$4.5	$4.6	$4.7
Total UHP Expenditures	**$71.2**	**$75.0**	**$79.1**	**$83.5**	**$88.2**	**$93.1**	**$98.4**	**$103.9**	**$109.8**	**$116.0**

High Estimate

Line of Business	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041
Medical and Prescription Drug	$79.3	$85.1	$91.6	$98.5	$106.3	$114.6	$123.7	$133.4	$143.9	$155.2
Plus Benefits	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Administrative Costs	$7.0	$7.2	$7.5	$7.7	$7.9	$8.2	$8.4	$8.7	$8.9	$9.2
Total UHP Expenditures	**$86.4**	**$92.4**	**$99.0**	**$106.2**	**$114.2**	**$122.8**	**$132.1**	**$142.0**	**$152.8**	**$164.4**

APPENDIX 4
OREGON UNIVERSAL HEALTH PLAN
SUMMARY OF PROJECTION FROM BASELINE TO UHP 2032 EXPENDITURE ESTIMATES (BILLIONS)

2026 Baseline			
Medical and Prescription Drug Healthcare Costs		**$44.6**	
Enhanced Behavioral Health		**$0.8**	
Unreimbursed Medicaid		**$1.2**	
	Low Estimate	**Zero Cost Sharing Best Estimate**	**High Estimate**
Annualized Population Increase 2026 to 2032		0.5%	
Annualized Trend Rate	5.3%		7.4%
Rate Adjustment for Prescription Drug, Legislative, and Healthcare Changes	-0.5% to 1.2%		1.0% to 2.7%
Composite Rate Adjustment Factor	0.2%		1.5%
2032 Status Quo Healthcare Expenditures (excl. Enhanced Behavioral Health)	**$62.7**	**$67.1**	**$71.5**
2032 Enhanced Behavioral Health	**$0.8**	**$0.9**	**$1.1**
2032 Plus Benefits			
Dental	$3.3	$3.7	$4.1
Vision	$0.5	$0.5	$0.6
Fertility	$0.3	$0.3	$0.4
Other	$0.5	$0.5	$0.6
Sub-Total	**$4.5**	**$5.1**	**$5.6**
UHP Adjustments			
Induced Utilization	$2.0	$2.8	$3.6
Adverse Selection	$1.3	$1.8	$2.4
Uninsured Benefit Cost Increase and Other Adjustments	$2.4	$2.5	$2.6
Sub-Total	**$5.7**	**$7.2**	**$8.7**
2032 UHP Total Benefit Costs	**$73.7**	**$80.3**	**$87.0**
2032 Administrative Costs	**$3.6**	**$5.1**	**$7.0**
Total 2032 UHP Expenditures	**$77.4**	**$85.5**	**$94.0**

APPENDIX 5
OREGON UNIVERSAL HEALTH PLAN
SUMMARY OF COST CONSIDERATIONS (BILLIONS)

		Estimated Expenditure Reduction Compared to Zero Cost Sharing		
Cost Consideration	**Description**	**Low**	**Best Estimate**	**High**
Provider Reimbursement	Collectability	$3.0	$3.3	$3.5
	Provider Administration	$4.0	$4.4	$4.7
	1% Reduction In Provider Reimbursement	$0.6	$0.7	$0.7
Medical Management and Prior Authorization	1% Improvement in Medical Costs	$0.7	$0.8	$0.8
Prescription Drugs	1% Improvement in Prescription Drug Costs	$0.1	$0.1	$0.1
Resource Management	1% Decrease in Induced Utilization	$0.6	$0.7	$0.7
Covered Benefits	Removal of Plus Benefits	$4.5	$5.1	$5.6
Plan Design	Low Cost Sharing	$1.7	$1.8	$2.0
	Low Cost Sharing and Removal of Plus Benefits	$6.2	$6.9	$7.6
Demographics	Non-Medicare Eligibility Only	$29.7	$33.2	$36.9

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