Federal Authorities Required for Universal Health Plan Implementation in Oregon

2025 Report

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Introduction and Background

Senate Bill 1089 (2023)

In 2022, Oregon's Joint Task Force on Universal Health Care (Task Force) developed a blueprint for state-based universal care, and recommended the state adopt a "unified financing system" as its revenue approach.[1] A unified financing system pools state, federal and private dollars to finance a universal health plan, offering more nuanced approaches to reimbursement and revenues than a pure single-payer system. In 2023, The Oregon Legislature formed the Universal Health Plan Governance Board (The Board) with Senate Bill (SB) 1089 with the charge to develop a comprehensive plan to finance and administer a universal health plan. SB 1089 (2023) directs the Board to engage with the Oregon Health Authority (OHA) to describe what federal waivers or other options to secure federal and state funding would be needed to implement a universal health plan.

This report intends to provide a high-level overview of the federal authorities that would likely be required to implement a unified financing system in Oregon. An in-depth analysis at this stage is hindered by a range of uncertainties—including the details of the universal health plan that the Board is currently developing, state and federal government's receptiveness to state-led health care reform initiatives, and the impacts of evolving federal policies on Oregon's current health system. The federal authorities that the state may choose to pursue could vary drastically depending on the outcome of these uncertainties. Similarly, the design of the unified financing system may need to adapt if federal authorities are not attained.

Universal Health Plan and Unified Financing System Overview

The following key elements recommended by the Task Force on Universal Health Care are the components that OHA is using for this report:[1]



Eligibility and Enrollment. All people who live in Oregon will qualify for the universal health plan no matter their job, income, immigration status, or tribal membership.



Affordability. The universal health plan will not require patients to pay when receiving care—no co-pays or deductibles. Patients will no longer incur medical debt. Instead, people will pay new taxes based on their ability to pay.



Covered Benefits. The universal health plan is based on benefits that Oregon public employees receive now; will continue covering services currently offered to people on Medicaid, Medicare, or Affordable Care Act plans; and will increase funding for behavioral health services.



Long-Term Supports and Services. People who qualify for long-term care will continue to receive benefits and services through Medicaid and the Oregon Department of Human Services (DHS).



Social Determinants of Health (SDOH). Conditions in people's lives — including housing, education, job opportunities, nutrition and factors such as racism, discrimination and violence — affect health outcomes. The universal health plan will seek, whenever possible, to address these conditions.



Medicare. People who qualify for Medicare will be covered by the universal health plan to the extent that the federal government will allow. Those who qualify for Medicare will have all the benefits currently available in Medicare plus new benefits offered in the universal health plan.



Nine Federally Recognized Tribes of Oregon. People who are eligible to receive care through Indian Health Care Providers or Indian Health Service facilities will have the choice to enroll in the universal health plan as it will not change the services that Indian Health Services or tribal health systems currently provide. Tribal providers can participate in the universal health plan.



Health Care Providers. The universal health plan will work with doctors, nurses, behavioral health providers, tradition al health workers, and others. The plan will prioritize a more diverse workforce, reflecting Oregon's diverse communities and offering culturally appropriate care.



Provider Reimbursement. The universal health plan will pay providers directly. Rates of pay will be set by region to account for different health care needs across the state. The plan will eliminate the current system of different reimbursement rates by payer. The plan will use global budgets and other alternative payment arrangements to improve outcomes and value over time.



Private Insurance. Insurers will have a more limited role than in the current system, offering extra insurance to cover benefits or services not offered by the universal health plan. The plan will serve as the main administrator of health care benefits in Oregon.



Employers and Employees. The universal health plan will uncouple health insurance from employment. This means that employers will no longer need to provide health benefits. In funding scenarios considered by the Task Force, employers would contribute to the health of all Oregonians through a payroll tax with rates based on employee wages.



Funding. A public trust fund, separate from Oregon's General Fund, will combine federal and state revenues along with contributions from employers and households. The Task Force considered revenue scenarios in which employers

would contribute through a payroll tax, as above. The Task Force also considered, in addition to the payroll tax, a health care income tax on households with income above 200 percent of the federal poverty level (FPL).



Governance. The universal health plan will be overseen by a nonprofit public corporation subject to Oregon's transparency laws (public meetings, public records, ethics, and administrative procedures). A board will govern the public corporation, and it shall report to the Legislative Assembly and the Governor. Board members are to represent a variety of health care professionals and community voices. Regional groups will advise the board to respond to the unique needs of the diverse communities across Oregon.



Transition Plan. The Task Force recommendation to the 2023 Legislative Assembly was to appoint a governance board consistent with SB 770 (2019). The governance board, established by SB 1089 (2023) will complete a full single-payer plan proposal for review and consideration by the 2027 Legislative Assembly. Additional state legislation and federal negotiations will be necessary to advance the board's plan.

Federal-State Health Care Authority Framework

The implementation of a unified financing system would require careful navigation of federal-state boundaries that have evolved through decades of health care policy development, constitutional interpretation and regulatory precedent. This includes the Employee Retirement Income Security Act (ERISA) of 1974, which preempts state laws that relate to employee benefit plans, effectively preventing states from regulating or mandating changes to employer-sponsored health insurance.[2] Integrating federal funds into a state-based health program would require compliance with federal statutory and regulatory frameworks, and/or receiving federal "waiver authority," to redirect federal funding streams. Moreover, as in our current health system, there would likely be services and populations—such as certain reproductive health services and people of varying immigration status—that Oregon wishes to cover in its universal health plan that the federal government won't support. These services and populations will need to be funded fully through state dollars.

Federal Authorities Required for a Unified Financing System in Oregon

Federal funding for health care coverage and service delivery historically flows to state health programs and residents through a range of programs. This includes Medicaid, Affordable Care Act programs, Medicare, Veterans Affairs, TriCare, Indian Health Services and tribal facilities, and Federally Qualified Health Centers, among others. The Task Force recommended that Veterans Affairs and TriCare remain fully operational and independent to the universal health plan, with veterans and military personnel continuing to receive

their benefits through Veterans Affairs and TriCare. As noted above, the Task Force recommended that Indian Health Services and tribal health systems remain independent, but unlike veterans and military personnel, people who are eligible to receive care through Indian Health Care Providers, including Indian Health Services, will have the choice to enroll in the plan. No recommendations were offered by the Task Force regarding federally Qualified Health Centers. As a result, this report focuses solely on the federal authorities related to Medicaid, Affordable Care Act and Medicare.

For decades Oregon has sought to maximize federal funding from Medicaid, Affordable Care Act programs and Medicare to increase health coverage among state residents. As part of this effort, Oregon has used a variety of federal mechanisms that offer flexibility in how the state uses federal funds to expand services beyond what's traditionally allowable under standard federal rules. These mechanisms include state plan amendments, waivers and specialized program authorities. The application of each tool hinges upon the state's ability to meet certain federal requirements to demonstrate capacity to achieve measurable improvements in health outcomes, quality of care, access to care and/or cost control without exceeding what the federal government would have spent under traditional program rules. The federal government's approach to states' use of these authorities can also differ widely between different federal administrations. The following sections outline the key state plan amendments, waivers and program authorities that would likely have significant implications on Oregon's transition to a unified financing system.

Medicaid Authorities

Oregon's Medicaid Program, the Oregon Health Plan, has been providing coverage to Oregonians since 1994, and has evolved significantly over the past three decades to further improve health outcomes, quality of care, access to care and cost control. The two main mechanisms through which states can alter their Medicaid programs with federal approval are through state plan amendments and waivers.

Medicaid State Plan & State Plan Amendments

A Medicaid state plan is a comprehensive document that states must submit to the federal Centers for Medicare & Medicaid Services (CMS) that outlines how the state will administer its Medicaid program.[3] It serves as a contract between the state and federal government, detailing the state's commitment to provide medical assistance to eligible individuals according to federal Medicaid requirements laid out in Section 1902 of the Social Security Act. This includes requirements to cover certain mandatory populations and to provide certain mandatory services statewide.

If states wish to change benefits or the way in which services are provided while remaining within the bounds of existing Medicaid regulations, they can alter their state plan through state plan amendments (SPAs), which must be approved by CMS before being implemented.[4] Oregon currently has 96 approved SPAs spanning service provision, reimbursement methodologies, eligibility and administrative activities.[4] Once a SPA is approved, it remains in effect indefinitely unless the state wishes to make changes or if CMS requires an update to maintain compliance with federal law changes.

A transition to a unified financing system would only require new or updated SPAs for policies where the state is currently not pursuing an available Medicaid option but would like to do so in a universal health plan. For example, current Medicaid regulations under 42 CFR 435.218 allow state agencies to provide Medicaid to adults under the age of 65 who earn above 133% of the federal poverty level who meet certain criteria.[5] Oregon currently covers this population through the state's OHP Bridge Program, rather than Medicaid. If the state wanted to extend Medicaid coverage to this optional eligible group in a universal health plan, it could submit a SPA to do so. [5] Conversely, Oregon's existing approved SPAs—such as the K Plan, which allows states to provide home and community-based services and supports—are codified into the state's Medicaid plan and therefore would remain in place in a universal health plan that includes Medicaid.[6]

The application requirements and process by which Oregon would obtain new or updated state plan amendments are as follows:

- **Application Requirements**: States must provide financial projections showing the federal fiscal impact of proposed changes.
- **Public Process**: CMS does not mandate public comment periods for all SPAs, but there are exceptions. For instance, Tribal consultations are required for SPAs that may affect people who are eligible to receive care through Indian Health Care Providers or Indian Health Service facilities. Additionally, Oregon has authority to conduct public engagement beyond federal minimums and often chooses to do so as a matter of state policy.
- **Application Timeline**: Once CMS has received a SPA application, it has 90 calendar days to approve or deny the SPA or send a formal Request for Additional Information.
- **Approval Authority**: CMS is responsible for reviewing and approving state SPA applications.

Medicaid Waivers

While SPAs allow states to modify their state plan framework under existing Medicaid rules, waivers allow states to test innovative approaches outside normal Medicaid

requirements for specified time periods. States may choose to incorporate certain waiver elements into their permanent state plans through SPAs, however, not all components of waivers can be incorporated in state plans. For example, Oregon tested the coordinated care model through waivers before embedding aspects of this model into the state plan. States primarily use three types of Medicaid waivers: Section 1115 waivers for research and demonstration projects, Section 1915(c) waivers for home and community-based services for long-term care and Section 1915(b) waivers for managed care.[7] In addition to these main types, other authorities like Sections 1915(i), (j) and (k) allow states to offer various home and community-based services under their state plan for those already enrolled in Medicaid. Within each waiver type, states can operate multiple active waivers to focus on different populations, specialized services or federal funding opportunities. For example, Oregon is currently operating multiple 1915(c) waivers, including one serving individuals with intellectual and developmental disabilities and another serving children with complex medical needs, among others.

Section 1115 Research and Demonstration Waivers provide states with broad flexibility to test innovative approaches to Medicaid program delivery, benefits, eligibility and financing and may even enable states to claim enhanced federal matching funds up to a set expenditure authority over the five-year waiver period for services that are not otherwise covered under standard Medicaid. Oregon currently operates one of the nation's most comprehensive 1115 waivers, running from October 2022 to September 2027, which gives the state the ability to broaden eligibility criteria, expand covered services beyond traditional medical care to include social determinants of health and community health interventions and implement alternative payment and delivery systems that reward population health outcomes and shared savings.

In a transition to a unified financing system Oregon would likely need to seek approval for new 1115 waivers to demonstrate how Medicaid services would be delivered, measured and funded under the new system in a manner that meets federal requirements. Additionally, the Task Force recommended a greater expansion of Medicaid eligibility, benefits, provider reimbursement and program delivery that go beyond the scope of Oregon’s current 1115 waiver. Such unprecedented federal flexibility and investment would require the state to build a compelling case that the new system would generate even greater efficiencies and outcomes while maintaining budget neutrality. It may additionally require new federal guidance or regulations to expand allowable waiver scope; this may even require changes to federal statute. Approval of a state Medicaid waiver requires federal government support, via CMS leadership, for the state’s vision for innovation. The current federal administration has announced that they do not intend to

approve new state proposals or extend existing section 1115 demonstration expenditure authority for DSHP/DSIP funding, continuous eligibility or workforce initiatives.[8]

The application requirements and process by which Oregon would obtain a new 1115 Research and Demonstration Waiver are as follows:

- **Application Requirements**: States must provide comprehensive program descriptions, actuarial analyses, concept papers, evaluation plans and detailed maintenance of effort and budget neutrality calculations.
    - *Maintenance of effort:* To apply for an 1115 waiver, Medicaid requires "maintenance of effort," meaning that the state must not reduce its contribution to the program or shrink program eligibility compared to prior periods.
    - *Federal budget neutrality*: States must demonstrate that proposed program changes will not increase the federal budget deficit or cost the federal government more for the same level of care for the same number of people covered without a waiver. While this core component of the waiver application has been longstanding policy, H.R.1 – One Big Beautiful Bill Act (2025) codifies budget neutrality requirements into federal law, effective January 1, 2027, and requires the CMS Chief Actuary to certify that any waiver will not increase federal expenditures compared to baseline spending. This change from policy to statutory requirement is estimated to reduce federal spending by $3.2 billion over ten years by making waiver approvals more restrictive.[9]
- **Public Process**: CMS requires 30-day notice, at least two public hearings and tribal consultation (where applicable). Oregon has authority to conduct public engagement beyond federal minimums and often chooses to do so as a matter of state policy.
- **Application Timeline**: Once CMS has certified the application is complete, 6-8 months of application review, negotiations and federal comment periods commence.
- **Approval Authority**: The Health and Human Services (HHS) Secretary is responsible for reviewing and approving 1115 Research and Demonstration Waivers.

Affordable Care Act Authorities

Since 2014, Oregon's Affordable Care Act (ACA) marketplace has provided access to qualified health plans (QHP) for thousands of Oregonians who do not have access to affordable health coverage offered by an employer and are not eligible for Medicaid.[10]

Individuals purchasing QHPs through the Oregon Health Insurance Marketplace (Marketplace) may qualify for Advance Premium Tax Credits (APTC) that reduce the cost of monthly premiums, and may be eligible for cost-sharing reductions that reduce the cost of deductibles, copayments and other out-of-pocket costs.

Oregon has pursued innovative approaches to integrate ACA coverage with other state health programs to maximize federal funding and coverage coordination. The primary mechanisms through which states can modify their ACA implementation with federal approval are through basic health program authority and state innovation waivers.

Section 1331 Basic Health Program Authority

Section 1331 Basic Health Program Authority is a built-in ACA option that allows states to establish a basic health program (BHP) as an alternative to qualified Marketplace coverage for citizens, U.S. nationals and lawfully present residents who make more than 138% of the federal poverty level on a monthly basis and 133-200% of the federal poverty level on an annual basis. States can generate federal funds roughly equal to 95% of the amount of the premium tax credits and cost-sharing reductions that would have been provided to beneficiaries if they were enrolled in Marketplace plans instead of the BHP. It is unclear if under a unified financing model the state could maintain a BHP to generate federal funds on behalf of this population or whether this group would need to be included in other strategies to generate federal funds on behalf of people who would otherwise be eligible for Marketplace coverage.

Comparing Insurance Programs

	Medicaid	Marketplace	Public Option	Basic Health Program
Income Eligibility	Up to 133% FPL	For subsidies, above 100% FPL and not eligible for Medicaid, BHP, or ESI. Anyone can purchase without subsidies.	Same as Marketplace	133% to 200% FPL on an annual basis
Financing	State budgets with federal support	Federal	Federal with pass-through under ACA Section 1332 Waiver	Federal with pass-through under ACA Section 1331 Authority

Note: FPL = federal poverty level; BHP = basic health program; ESI = employer-sponsored insurance

Since the passage of the ACA, only three states have used Section 1331 program authority to establish basic health programs: Minnesota, Oregon and New York. Minnesota was the first state to implement a BHP, reestablishing its "MinnesotaCare" program as a BHP in January 2015.[11]

Oregon established its BHP, OHP Bridge, in July 2024. OHP Bridge was first established to maximize the number of individuals who were able to maintain the Medicaid coverage they gained under the COVID-19 public health emergency. It then began enrolling individuals within the 133-200% FPL income range – a group that often "churns" between Medicaid and private insurance due to income fluctuations, leading to gaps in coverage.

New York implemented a BHP, named the "Essential Plan," in April 2015 to offer Medicaid coverage to adults up to 200% FPL and to lawfully present immigrants below 138% FPL who were previously in state-funded Medicaid.[12] New York suspended its implementation of the Essential Plan in April 2024 as they transitioned to a state innovation waiver under Section 1332 Waiver authority, which enabled an expansion of Essential Plan eligibility to individuals up to 250% FPL.[11] However, in September 2025 New York announced that due to federal funding cuts from H.R.1. the state will terminate its Section 1332 Waiver and revert back to a BHP, starting in July 2026. At that point the Essential Plan will return to its original 200% FPL income limit.[13]

New York's experience shows how BHPs can provide states with operational and federal funding experience that can be leveraged through a 1332 waiver to achieve greater program flexibility, increase federal funding and broaden coverage. However, the state's experience also demonstrates how state-level health care innovation is highly contingent upon collaboration and shared goals with the federal government. More information on 1332 waivers, and the relationship between 1332 waivers and 1331 program authorities, can be found in the next section.

The application requirements and process by which Oregon would update its Basic Health Program Option are as follows:

- **Application Requirements**: States must submit a detailed "BHP Blueprint" to CMS demonstrating compliance with federal regulations related to program design, eligibility rules, benefits, provider networks, and financial projections that demonstrate financial sustainability.
- **Public Process**: Minimum 30-day state public comment period, tribal consultation (where applicable), and federal public comment period after submission. Oregon has authority to conduct public engagement beyond federal minimums and often chooses to do so as a matter of state policy.

- **Application Timeline**: Typically, six or more months from complete application to approval, with states able to implement once approved.
- **Approval Authority**: Joint approval is required from the HHS Secretary and Department of Treasury.

Section 1332 State Innovation Waivers

Section 1332 State Innovation Waivers allow states to waive ACA requirements to pursue innovative strategies and alternatives for providing individual Marketplace insurance. This includes the potential to waive how federal Marketplace subsidies are used, Essential Health Benefit requirements, enrollment and claims data requirements, Marketplace functions and plans, and single risk pool requirements—which require insurers to consider all enrollees across all plans within a specific market when setting premiums—allowing for the establishment of reinsurance programs to offset the cost of high-cost patients.[14] Since 2018, Oregon has used a 1332 waiver to waive single risk pool requirements and operate a state-based reinsurance program for individual marketplace plans.[15] Through the reinsurance program, the state reimburses marketplace insurers for a portion of high-cost claims. With less financial burden, Marketplace insurers can lower the cost of premiums, which in turn reduces the amount that the federal government pays in premium tax credits.[16] Those reductions, or savings, in federal premium tax credits are then recaptured by Oregon as pass-through dollars that are used to help fund the reinsurance program.

States can use Section 1332 Innovation Waivers in conjunction with a Section 1331 Basic Health Program. To avoid the possibility of a reinsurance program inadvertently reducing federal BHP funding, the federal BHP funding formula takes the interaction between BHPs and reinsurance programs into account when calculating federal payment to states for reinsurance programs.[17] However, there's uncertainty as to how other 1332 waivers could interact with a BHP.

In addition to reinsurance programs, states have used 1332 waivers to:

- **Establish state public option plans**: These plans often involve state-level initiatives aimed at improving affordability through various mechanisms, including potentially using pass-through funding to offer larger or broader subsidies or establish provider incentive programs. Colorado is the first state to implement a public option plan.[18] Nevada will be the second, starting in 2026.[19]
- **Expand Marketplace eligibility**: States can expand eligibility for ACA Marketplace coverage to populations not typically eligible under federal rules. Washington uses this waiver option to expand Marketplace eligibility to all Washingtonians regardless of immigration status.[20] New York uses this option to expand BHP eligibility to higher income levels and DACA recipients, though they will be rolling this back in July

2026, as noted above.[21] Maryland has been approved to expand Marketplace eligibility, starting in November 2025.[22]

- **Create state-specific premium assistance programs**: States have used pass-through funding generated by 1332 waivers to finance their own state-funded premium subsidies. Colorado uses this authority to create state premium assistance using the federal savings generated by its public option plan.[23]

States Implementing Section 1332 Waivers through PY 2023

TABLE 1
Types of Section 1332 State Waiver Programs Implemented

State	Type of Waiver Program	Provisions Waived
Alaska, Colorado,[4] Delaware, Georgia,[5] Idaho, Maine,[6] Maryland, Minnesota, Montana, New Hampshire, New Jersey, North Dakota, Oregon, Pennsylvania, Rhode Island, Virginia, Wisconsin	Individual market reinsurance program	ACA section 1312(c)(1)
Hawaii	SHOP waiver to implement the Hawaii Prepaid Health Care Act and associated requirements for employers in the small group market	ACA sections 1311(b)(1)(B), 1312(c)(1), 1312(a)(2), 1312(f)(2)(A), 1304(b)(4)(D)(i) and (ii), 1301(a)(1)(C)(ii), 1301(a)(2)[7]
Colorado	State-based standard health benefit plan for the individual and small group markets that requires premium reduction targets and is subject to regulatory and programmatic mechanisms	ACA sections 1312(c)(1) and 1312(c)(2)
Maine	Merged individual and small group markets with reinsurance applied to the newly pooled market; allows for quarterly adjustments for small group plans that do not renew on a calendar year basis	ACA sections 1312(c)(1)-1312(c)(3)

Footnotes from table:
[4] For PYs 2020-2021.
[5] Part I of Georgia's section 1332 approved waiver plan.
[6] For PYs 2019-2021.
[7] The Departments' regulations, policy statements, and guidance implementing these provisions with respect to SHOPs and small employers are also waived.

Source: CCIIO Data Brief Series (2024)[24]

In a unified financing system, a 1332 waiver could be used to allow states to receive federal pass-through funding equal to the amount of premium tax credits that would have otherwise gone to Oregon residents to purchase coverage on the Marketplace. Thus, Oregon could use this pass-through funding to broadly contribute to the costs of the universal health plan developed, if the plan provides coverage that meets the federal requirements for a 1332 waiver. This strategy was a core pillar of the unified financing model behind Vermont's efforts to establish a universal health plan.[25]

The application requirements and process by which Oregon would update its 1332 State Innovation Waiver are as follows:

- **Application Requirements**: Four statutory "guardrails" must be met: Coverage must be at least as comprehensive as Marketplace coverage, at least as affordable as Marketplace coverage, cover a comparable number of residents to the Marketplace, and not increase federal deficit. States can submit a joint application for 1332 and Medicaid waivers to coordinate changes across Medicaid and State Based Marketplaces, but the waivers will be evaluated independently.[26]
- **Public Process**: CMS requires state and federal public comment periods, and tribal consultations and (where applicable). Oregon has authority to conduct public engagement beyond federal minimums and often chooses to do so as a matter of state policy.
- **Application Timeline**: 18 months to 2 years. Once the applicated has been marked complete, CMS has 180 days to approve is disapprove the application.
- **Approval Authority**: Joint approval is required from CMS and the U.S. Department of Treasury.

Medicare Authorities

Oregon's Medicare beneficiaries represent nearly one million residents who receive coverage through the federal Medicare program, with approximately half enrolled in traditional fee-for-service Medicare and half in Medicare Advantage plans administered by private insurers under federal contracts. State governments do not receive direct funding from the federal Medicare program, as Medicare funds are administered by CMS and paid directly to providers for Medicare beneficiary claims. However, states do interact with Medicare funding through several mechanisms, including "state buy-in" programs.[27] All 50 states participate in a Medicare Part B Buy-In program, which allows states to use Medicaid funds to pay Medicare Part B premiums for people who are eligible for both Medicare and Medicaid.[28] Additionally, Oregon participates in a Part A buy-in program specified in Section 3.2 of Oregon's Medicaid State Plan, which pays Part A premiums for qualified individuals.[29]

In 2010, the Affordable Care Act established the Center for Medicare and Medicaid Innovation (CMMI), creating new pathways for Medicaid and Medicare innovation.[30] CMMI has authority to approve state demonstrations and was granted unprecedented power to turn successful demonstrations into permanent programs without Congressional approval.[31] Several states have secured Medicare payment and financing waivers through CMMI.

Maryland's All-Payer Model

Maryland has operated the most successful Medicare waiver program to date. The state's unique position stems from the 1970s hospital cost crisis, when Maryland established its Health Services Cost Review Commission with broad rate-setting powers and negotiated a groundbreaking 1977 Medicare waiver, codified in Section 1814(b) of the Social Security Act, during a period when states were experimenting with cost control mechanisms.[32] [33] Since then, the state has been allowed to set prices for hospital services for all payers, including Medicare.[32] Building on this foundation, CMS approved Maryland's All Payer Model in 2014 using new CMMI authority codified in Section 1115A of the Social Security Act, which established Medicare global budgets for most inpatient and outpatient services at each hospital in the state.[34] Upon renewal in 2019 the model was updated and expanded using the same Section 1115A authority into the Total Cost of Care Model, which extended Maryland's approach beyond hospital services to include total Medicare spending per beneficiary, holding the state accountable for quality outcomes and cost growth across all care settings, again utilizing CMMI's authority.[35] Despite positive outcomes, Maryland's approach is unlikely to be replicated by other states today, as it required decades of established state rate-setting infrastructure and was negotiated during a unique period of federal openness to state experimentation that no longer exists under current Medicare policy. CMS announced in March 2025 the intention to end Maryland's Total Cost of Care model as of December 31, 2025.[36]

Similar models include Vermont's All-Payer Accountable Care Organization Model and Pennsylvania's Rural Health Model,[37] [38] both of which, alongside Maryland's Total Cost of Care Model, were used as a foundation for the new Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model, launched by CMS in 2023.[39] AHEAD is a state total cost of care model that seeks to drive state and regional health care transformation and multi-payer alignment. The current AHEAD program is scheduled to operate for a total of 11 years, from 2024 through 2034, and the application window has closed. For states that were accepted into the program, his new development in Medicare authority represents a pathway for including Medicare in innovative payment arrangements through existing CMMI innovation authority, rather than securing a comprehensive Medicare waiver.[40]

If CMS reopens AHEAD participation to additional states in the future, or provides the opportunity to negotiate a waiver for a standalone state model in line with what was done for Maryland, Pennsylvania and Vermont, using CMMI authority seems to be the most realistic pathway for modifying Medicare payment structures and integrating Medicare funds into a unified financing system. AHEAD could serve as both a practical first step to

demonstrate successful Medicare cost control and a strategic foundation for building the infrastructure and political momentum needed for more comprehensive single-payer reforms that would ultimately require Congressional action.

Federal Congressional Action

While state plan amendments, waivers and program options can provide opportunities for health system innovation, the most comprehensive authority to enable the implementation of a unified financing system is federal congressional action. Congress has the authority to make statutory changes that could remove fundamental legal barriers and core limitations that no waiver authority has or likely could overcome, including ERISA preemption of employer-sponsored insurance, Medicare payment restrictions and the creation of dedicated federal funding streams for state universal health plans. While the political feasibility of such federal legislation is highly uncertain and would depend on significant shifts in federal political prioritization of state-led health system reform, several pieces of legislation have been introduced that aim to create new legal pathways for state-based universal health care.

State-Based Universal Health Care Act. This federal legislation, introduced multiple times in Congress, would create a comprehensive framework for states to implement universal health care systems while maintaining federal support.[41] The bill would provide states with enhanced Medicaid matching funds, allow states to redirect federal Marketplace subsidies and Medicare funds into state universal health plans and provide ERISA preemption relief to enable states to integrate employer-sponsored insurance into unified systems.[42] Key provisions include streamlined waiver processes, protection of existing federal funding levels and standardized criteria for state universal health plan approval. While the legislation has garnered support from progressive members of Congress and several state governments, it faces significant political obstacles and has not advanced beyond committee consideration in recent congressional sessions.

Medicare for All Act. The Medicare for All Act would establish a national single-payer system administered by the federal government, effectively creating the federal infrastructure that could support or supersede state-based unified financing efforts.[43] While this approach differs from state-based models, its passage could create precedent for comprehensive health system restructuring and potentially include provisions for state demonstration programs or alternative implementation pathways. The legislation would eliminate many of the federal barriers that currently constrain state universal health efforts, including ERISA preemption and Medicare payment limitations.[43] However, the Medicare for All Act faces even greater political challenges than state-based approaches,

with limited bipartisan support and substantial opposition from insurance and pharmaceutical industries.

Conclusion

While Oregon has significant experience navigating the federal health care authority landscape, implementing a comprehensive unified financing system as recommended by the Task Force on Universal Health Care and described in SB 1089 (2023) would require unprecedented federal flexibility that exceeds current waiver and program options. At a minimum, Oregon would likely need to secure Medicaid authorities including a Section 1115 Research and Demonstration Waiver to modify eligibility, benefits and service delivery while maintaining federal budget neutrality, as well as an Affordable Care Act Section 1332 State Innovation Waiver to redirect federal premium tax credits and Marketplace subsidies into a new unified system. The state would need to build a compelling case that under these authorities, Oregon would generate even greater efficiencies and outcomes than under its current model, without running a deficit and while meeting all other federal requirements. Such a complex undertaking demands significant time, sustained political will, strong state-federal relationships and ongoing state policy to continue the necessary funding and operational mechanisms of a multi-year effort.

Appendix A: Federal Authority Application Process Chart

Authority	Scope	Duration	Application Requirements	Public Process[1]	Application Timeline	Approval Authority
State Plan Amendment	When states want to change how they operate Medicaid within existing federal regulations, they can submit a state plan amendment (SPA) to CMS.	SPAs remain in effect indefinitely or until a new SPA modifies an existing SPA.	States must provide financial projections showing the federal fiscal impact of proposed changes.	CMS does not mandate public comment periods for all SPAs, but there are exceptions. For instance, Tribal consultations are required for SPAs that may affect people who are eligible to receive care through Indian Health Care Providers or Indian Health Service facilities.	Once CMS has received a SPA application, it has 90 calendar days to approve or deny the SPA or send a formal Request for Additional Information.	CMS

[1] "Public Process" - Oregon has authority to conduct public engagement beyond federal minimums and often chooses to do so as a matter of state policy.

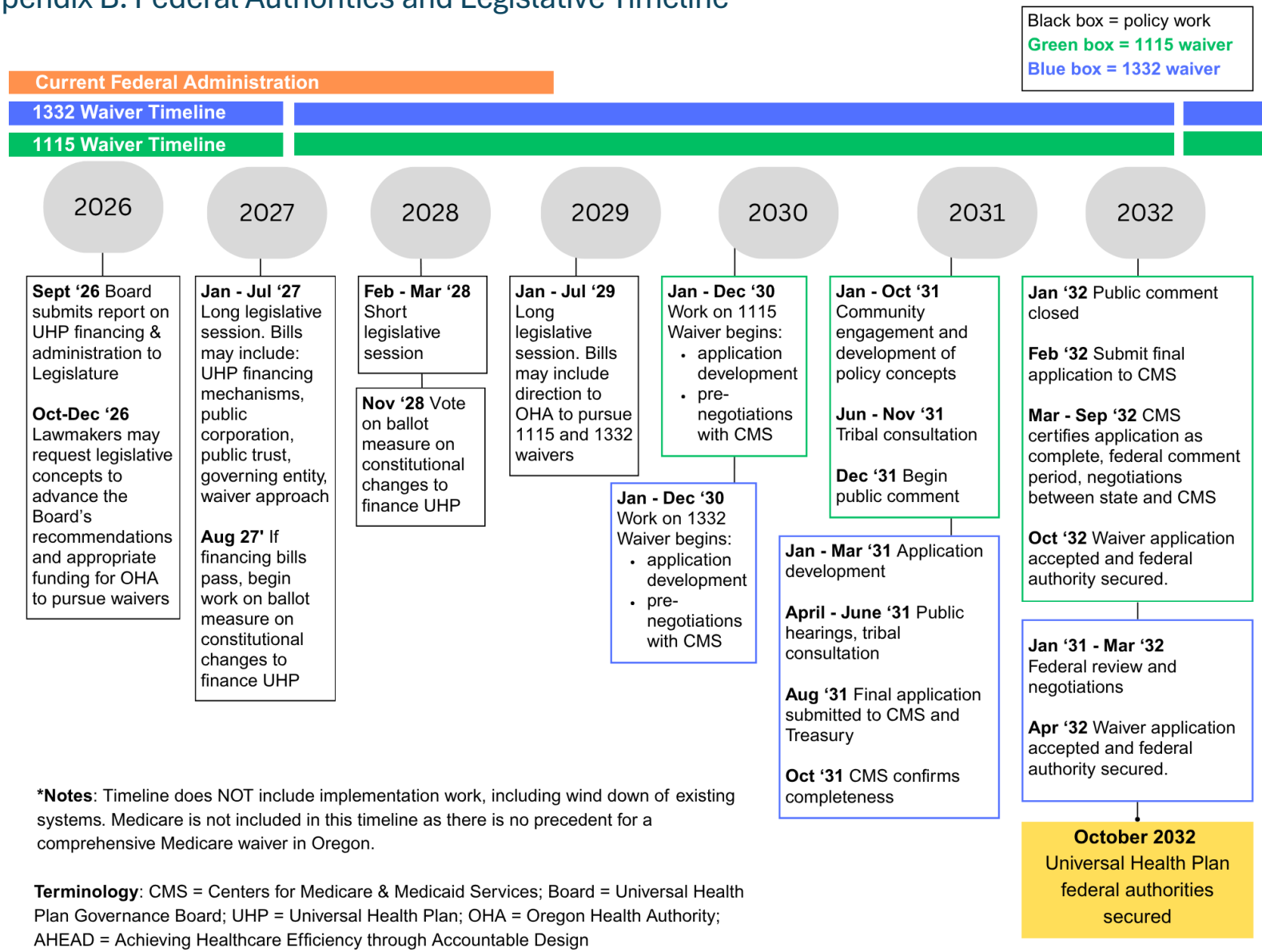
1115 Research and Demonstration Waiver	Section 1115 of the Social Security Act provides states with broad flexibility to test innovative approaches to Medicaid program delivery, benefits, eligibility and financing.	1115 waivers remain in effect for 5 years.	States must provide comprehensive program descriptions, actuarial analyses, concept papers, evaluation plans and maintenance of effort[2] and detailed budget neutrality calculations.[3]	CMS requires 30-day notice, at least 2 public hearings and tribal consultation (where applicable).	Once CMS has certified the application is complete, 6-8 months of application review, negotiations and federal comment periods commence.	HHS Secretary

[2] "Maintenance of effort" - The state must prove that I will not reduce its contribution to the program or shrink program eligibility compared to prior periods.

[3] "Budget neutrality calculations" - Waiver applicants must demonstrate that proposed program changes will not increase the federal budget deficit or cost the federal government more for the same level of care for the same number of people covered without a waiver. While budget neutrality calculations have long been a statutory requirement, H.R.1 codifies this requirement into federal law, effective January 1, 2027 and requires the CMS Chief Actuary to certify that any waiver will not increase federal expenditures compared to baseline spending.

Basic Health Program Option	Section 1331 of the Affordable Care Act gives states the option to create a Basic Health Program for residents with an annual income of 133-200% of the federal poverty level.	BHPs remain in effect indefinitely.	States must submit a "Basic Health Program Blueprint" form to demonstrate compliance with federal regulations related to program design, eligibility rules, benefits, provider networks and financial projections that demonstrate financial sustainability.	CMS requires a minimum 30-day state public comment period, tribal consultation (where applicable), and federal public comment period after submission.	Typically 6+ months from complete application to approval, with states able to implement once approved.	Joint approval from the HHS Secretary and Department of Treasury
1332 State Innovation Waiver	1332 waivers allow states to modify ACA requirements to pursue innovative strategies and alternatives for providing individual marketplace insurance.	1332 waivers remain in effect for 5 years.	Four statutory “guardrails” must be met: Coverage must be at least as comprehensive as Marketplace coverage, at least as affordable as Marketplace coverage, cover a comparable number of residents, and not increase federal deficit.	CMS requires state and federal public comment periods, tribal consultations and (where applicable).	Once the applicated has been marked complete, CMS has 180 days to approve or disapprove the application.	Joint approval from the HHS Secretary and Department of Treasury.

Appendix B: Federal Authorities and Legislative Timeline



***Notes**: Timeline does NOT include implementation work, including wind down of existing systems. Medicare is not included in this timeline as there is no precedent for a comprehensive Medicare waiver in Oregon.

Terminology: CMS = Centers for Medicare & Medicaid Services; Board = Universal Health Plan Governance Board; UHP = Universal Health Plan; OHA = Oregon Health Authority; AHEAD = Achieving Healthcare Efficiency through Accountable Design

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

[2] McCuskey EY, Fuse Brown EC. Memorandum Re: Analysis of ERISA Preemption Issues for Universal Health Plan Proposal (June 2022) – Oregon Services PO Numbers 174361 & 174397. Oregon Joint Task Force on Universal Health Care; Oregon State Legislature. 2022 Jul 25. Available from: https://www.oregon.gov/uhpgb/Documents/board-meetings/2024/112124/memo-oregon-joint-task-force-erisa-preemption-072522.pdf

[3] Oregon Health Authority. Medicaid and CHIP State Plans. [cited 2025 Oct 23]. Available from: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/state-plans.aspx

[4] Oregon Health Authority. Medicaid and CHIP State Plans. [cited 2025 Oct 23]. Available from: https://www.oregon.gov/oha/hsd/medicaid-policy/pages/state-plans.aspx

[5] Individuals with MAGI-based income above 133 percent FPL. 42 CFR Sect. 435.218 (2024). Available from: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-435/subpart-C/subject-group-ECFR92b90bbfe1e24d9/section-435.218

[6] Oregon Department of Human Services. Medicaid Waivers and K Plan for APD Services. [cited 2025 Oct 23]. Available from: https://www.oregon.gov/odhs/providers-partners/seniors-disabilities/pages/waivers-kplan.aspx

[7] Medicaid and CHIP Payment and Access Commission. Waivers. [cited 2025 Oct 23]. Available from: https://www.macpac.gov/medicaid-101/waivers/

[8] Centers for Medicare and Medicaid Services. About section 1115 demonstrations. Medicaid.gov. [cited 2025 Oct 23]. Available from: https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations

[9] Park E, Corlette S. Medicaid, CHIP, and Affordable Care Act Marketplace Cuts and Other Health Provisions in the Budget Reconciliation Law, Explained. Center for Children and Families, Georgetown University McCourt School of Public Policy. 2025 Jul 22. [cited 2025 Oct 23]. Available from: https://ccf.georgetown.edu/2025/07/22/medicaid-chip-and-affordable-care-act-marketplace-cuts-and-other-health-provisions-in-the-budget-reconciliation-law-explained/

[10] Oregon Health Authority. Oregon Health Insurance Marketplace. [cited 2025 Oct 23]. Available from: https://healthcare.oregon.gov/marketplace/pages/index.aspx

[11] Norris L. Affordable Care Act's Basic Health Program. HealthInsurance.org. 2025 Oct 9. [cited 2025 Oct 23]. Available from: https://www.healthinsurance.org/obamacare/affordable-care-acts-basic-health-program/

[12] New York State Department of Health. Annual Report to the Governor and Legislature December 2015. Essential Plan New York's Basic Health Program. [cited 2025 Oct 23]. Available from: https://www.health.ny.gov/health_care/managed_care/essential/2015-dec_annual_rpt.htm

[13] New York State Department of Health. Following Devastating Federal Funding Cuts, New York State Takes New Action to Preserve Health Care for As Many New Yorkers As Possible. 2025 Sept 10. [cited 2025 Oct 23]. Available from: https://www.health.ny.gov/press/releases/2025/2025-09-10_federal_funding_cuts.htm

[14] Lueck S, Schubel J. Understanding the Affordable Care Act's State Innovation ("1332") Waivers. Center on Budget and Policy Priorities. 2017 Sept 5. Available from: https://www.cbpp.org/research/understanding-the-affordable-care-acts-state-innovation-1332-waivers

[15] Oregon Health Authority. Oregon Health Insurance Marketplace. [cited 2025 Oct 23]. Available from: https://healthcare.oregon.gov/marketplace/gov/pages/applications.aspx

[16] Oregon Department of Consumer and Business Services. Oregon Reinsurance Program. Division of Financial Regulation. [cited 2025 Oct 23]. Available from: https://dfr.oregon.gov/business/reg/health/pages/oregon-reinsurance-program.aspx

[17] Murphy N. How States Can Use Section 1332 Waivers To Improve Health Care Affordability and Access. Center for American Progress. 2023 Oct 23. Available from: https://www.americanprogress.org/article/how-states-can-use-section-1332-waivers-to-improve-health-care-affordability-and-access/
[18] Colorado Department of Regulatory Agencies. Cover Letter - Colorado Division of Insurance Colorado Section 1332 Innovation Waiver Amendment Request - Colorado Option. 2021 Nov 30. Available from: https://drive.google.com/file/d/1SUy-iNz3i7IIRTPTqy2OJgNYH1oyN5mX/view
[19] Whitley R. Nevada Section 1332 Innovation Waiver Request - Battle Born State Plans (BBSPs) and Market Stabilization Program (MSP). Director's Office, Nevada Department of Health and Human Services. 2024 Jan 1. Available from: https://dhcfp.nv.gov/uploadedFiles/dhcfpnvgov/content/MarketStabilization/FinalNV1332Application_vF2024v2.pdf
[20] Washington Health Benefit Exchange. Section 1332 Waiver Information. [cited 2025 Oct 23]. Available from: https://www.wahbexchange.org/about-the-exchange/what-is-the-exchange/legislation/1332-waiver-information/
[21] Doolittle H. With Approval of Its 1332 Waiver, New York Expands Basic Health Program. National Academy for State Health Policy. 2024 Jun 10. Available from: https://nashp.org/with-approval-of-its-1332-waiver-new-york-expands-basic-health-program/
[22] Maryland Health Benefit Exchange. Maryland 1332 State Innovation Waiver Amendment Request. 2024 Jul 15. Available from: https://www.marylandhbe.com/wp-content/uploads/2024/08/MD-1332-Waiver-Amendment-Request-FINAL-w-updated-exhibits.pdf
[23] Monahan C, Giovannelli J, Lucia K. HHS Approves Nation's First Section 1332 Waiver for a Public Option–Style Health Care Plan in Colorado. The Commonwealth Fund. 2022 Jul 12. [cited 2025 Oct 24]. Available from: https://www.commonwealthfund.org/blog/2022/hhs-approves-nations-first-section-1332-waiver-public-option-plan-colorado
[24] Center for Consumer Information & Insurance Oversight. CCIIO Data Brief Series Data Brief on State Innovation Waivers: Section 1332 Waivers. Centers for Medicare and Medicaid Services. 2024 Apr. [cited 2025 Oct 24]. Available from: https://www.cms.gov/files/document/cciio-data-brief-042024-508-final.pdf
[25] https://www.nejm.org/doi/full/10.1056/NEJMp1501050
[26] Murphy N. How States Can Use Section 1332 Waivers To Improve Health Care Affordability and Access. Center for American Progress. 2023 Oct 23. [cited 2025 Oct 24]. Available from: https://www.americanprogress.org/article/how-states-can-use-section-1332-waivers-to-improve-health-care-affordability-and-access/
[27] Social Security Administration. HI 00815.001 State Payment of Medicare Premiums (Buy-In Program). Program Operations Manual System (POMS). 2024. [cited 2025 Oct 24]. Available from: https://secure.ssa.gov/poms.nsf/lnx/0600815001
[28] Centers for Medicare and Medicaid Services. (2025, January 16). *Manual for State Payment of Medicare Premiums,* Chapter 1: Program Overview and Policy Appendix 1D. [cited 2025 Oct 24]. Available from: https://www.cms.gov/files/document/chapter-1-program-overview-and-policy.pdf.
[29] Oregon Health Authority, State of Oregon. (2023, November 22). State Plan Under Title XIX of the Social Security Act Medical Assistance Program, Section 3.2. [cited 2025 Oct 24]. Available from: https://www.oregon.gov/oha/HSD/Medicaid-Policy/StatePlans/Medicaid-State-Plan.pdf.
[30] Center for Medicare and Medicaid Innovation. About the CMS Innovation Center. [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/about
[31] KFF. "What is CMMI?" and 11 other FAQs about the CMS Innovation Center. 2018 Feb 27. [cited 2025 Oct 24]. Available from: https://www.kff.org/affordable-care-act/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/
[32] Health Services Cost Review Commission. HSCRC Overview. Maryland.gov. [cited 2025 Oct 24]. Available from: https://hscrc.maryland.gov/Pages/About-Us.aspx
[33] Centers for Medicare & Medicaid Services. Maryland All-Payer Model. CMS.gov [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model

[34] Centers for Medicare & Medicaid Services. Maryland All-Payer Model. CMS.gov [cited 2025 Oct 24]. Available from: [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/maryland-all-payer-model

[35] Centers for Medicare & Medicaid Services. Maryland Total Cost of Care Model. CMS.gov. [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/md-tccm

[36] Brown DJ. Caution AHEAD: State officials nervous for Maryland hospitals under Trump administration. Maryland Matters. 2025 Mar 13. [cited 2025 Oct 24]. Available from: https://marylandmatters.org/2025/03/13/caution-ahead-state-officials-nervous-for-maryland-hospitals-under-trump-administration/

[37] Centers for Medicare and Medicaid Services. Vermont All-Payer ACO Model. CMS.gov. [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model

[38] Centers for Medicare and Medicaid Services. Pennsylvania Rural Health Model. CMS.gov [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/pa-rural-health-model

[39] Centers for Medicare and Medicaid Services. Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/ahead

[40] Centers for Medicare and Medicaid Services. Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. [cited 2025 Oct 24]. Available from: https://www.cms.gov/priorities/innovation/innovation-models/ahead

[41] Office of Congressman Ro Khanna. Release: Rep. Ro Khanna Introduces Legislation to Support State-Based Universal Health Care. 17th District of California. 2023 Nov 8. [cited 2025 Oct 24]. Available from: https://khanna.house.gov/media/press-releases/release-rep-ro-khanna-introduces-legislation-support-state-based-universal

[42] H.R.6270 - State-Based Universal Health Care Act of 2023.118th Congress (2023-2024). [cited 2025 Oct 24]. Available from: https://www.congress.gov/bill/118th-congress/house-bill/6270

[43] H.R.6270 - State-Based Universal Health Care Act of 2023.118th Congress (2023-2024). [cited 2025 Oct 24]. Available from: https://www.congress.gov/bill/118th-congress/senate-bill/1655