2018 Single-Payer/Universal Health Care Legislation Tracker

State	Measure	Status	Content
California	Healthy California Act (S. 562)	**Current Status**: Assembly Speaker, Anthony Rendon, stalled S. 562 until further notice. *The bill will be stalled for at least the remainder of the 2017 calendar year* (06/24/17).	• Mandates that state covers all medical expenses for every resident, including inpatient, outpatient, emergency services, dental, vision, mental health and nursing home care; • Prohibits insurers from offering benefits that cover the same services as state; • Eliminates co-pays and deductibles; • Creates an unpaid, nine-person board appointed by the governor and the legislature to administer the system; and • Discontinues employer-sponsored insurance.
	AB 2489	02/14/18: Introduced.	• Requires the Secretary of the California Health and Human Services Agency to report to the legislature the options for achieving universal health care including: (1) the options for financing universal health coverage; (2) the institutional mechanism(s) by which universal health coverage may be delivered; and (3) the extent and scope of such health coverage; and • Repeals the reporting obligation in January 2023.
	AB 2517	02/14/18: Introduced. 04/02/18: Referred to the Assembly Health Committee. 05/01/18: Re-referred to the Assembly Appropriations Committee.	• Establishes the Advisory Panel on Health Care Delivery Systems and Universal Coverage ("Panel") to develop a universal health coverage plan and publicly financed health system, including a stakeholder engagement and analytical process to develop the plan's features (e.g., covered benefits, eligibility, service delivery, etc.); establishment of data collection systems; a multi-year financial model; and consideration of the requirements necessary for the state to seek all necessary federal waivers and approvals, among other things; and • Requires the Panel to submit a report to the state legislature with a proposal to control health care costs, to seek necessary federal waivers and statutory changes, and a proposal of state constitutional and statutory amendments necessary to create a public health system.
Florida	Healthy Florida Act (SB 1872/HB 1385)	**Current Status**: *Died in Health Innovation Subcommittee* (03/10/18).	• Establishes The Healthy Florida Program ("Program"), as administered by the Healthy Florida Board ("Board"), to provide a single-payer health care program and cost control system for all state residents; • Directs the State Surgeon General of the Department of Health to establish a Public Advisory Committee to advise the board on all policy matters for the program; • Allocates to the Board all powers and duties necessary to establish and implement the Program; • Generally prohibits carriers from offering benefits or covering any services for which coverage is offered under the Program (but such carriers may, if authorized, offer benefits or coverage that are not offered to individuals under the Program);

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			• Requires the Board to provide funds from the Healthy Florida Trust Fund (or funds otherwise appropriated) to a program for retaining/assisting individuals previously employed in the fields of health insurance with the job transition; • Requires the Board to collect and disclose certain data (e.g., inpatient discharge data, emergency department and ambulatory surgery data, and hospital annual financial data); • Requires the Board to adopt rules regarding contracting for, and establishing payment methodologies for, covered health care services and care coordination provided by the Program; • Directs the program to adopt rules establishing program requirements and standards for the program; and • Directs the Board to seek all necessary federal waivers and approvals/submit state plan amendments as needed to operate the Program. *It warrants noting that this bill is related to two other bills introduced during the 2018 session:* • *SB 1760 (governing treatment of the personal identifying information of any member of the Program); and* • *SB 1764 (creating the Healthy Florida Trust Fund and describing its operation).*
Hawaii	HB 1717	01/12/18: Prefiled for the 2018 session. 01/31/18: Reported from Health and Human Services Committee; passed second reading and referred to the House Consumer Protection and Commerce Committee. 2/5/18: Re-referred to Committee on Health and Human Services and Finance Committee.	• Requires the Legislative Reference Bureau ("Bureau") to conduct a study on the projected costs and effects associated with the state implementing a single-payer health care system, including (1) the estimated costs (and associated savings) of implementing such a system; (2) potential means of financing such a system; and (3) the projected effect of such a system on health insurance enrollment, employer-union benefits, prescription drug costs, and the financial and social impact on families and businesses in the state; • Requires the Director of the Bureau to submit a report with its findings and recommendations to the legislature; and • Appropriates funds to conduct a study on the costs and effects associated with implementing a single-payer health care system.
	SB 2207	01/21/18: Introduced. 01/22/18: Referred to Senate Committee on Commerce, Consumer Protection, and Health;	• Establishes a single-payer healthcare system (and an associated health care insurance planning and financing authority), within the Department of Health, for all Hawaii residents; • Prohibits private healthcare insurers from duplicating coverages offered through the single-payer health care system;

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		and the Senate Committee on Ways and Means.	• Requires the healthcare insurance planning and financing authority to (1) create a trust fund and a reserve fund; (2) negotiate all appropriate revenue; (3) assess temporary surcharges on income, general excise taxes, and emergency costs; and (4) conduct a continuous and ongoing enrollment program; and • Appropriates funds for the establishment and operation of the program.
	HR 163	03/09/18: Introduced. 03/13/18: Referred to the House Health and Human Services Committee and the House Committee on Finance.	• Urges federal legislators to enact legislation to provide universal health care to all individuals residing in the U.S. and U.S. territories.
	SB 1120/SB 1199	SB 1120 01/25/17: Introduced. 01/27/17: Referred to Senate Committees on Commerce, Consumer Protection, and Health; and Ways and Means. 11/30/17: Carried over to 2018 regular session. SB 1199 01/25/17: Introduced. 01/27/17: Referred to Senate Committees on Commerce, Consumer Protection, and Health; and Ways and Means. 11/30/17: Carried over to 2018 regular session.	• Establishes a universal health care insurance system; • Creates a state health care insurance planning and financing authority (the authority) to determine system costs and financing mechanisms; and • Mandates that the authority maintain the Hawaii employer-union health benefits trust fund and establishes an additional trust fund and reserve fund for state health insurance payments. *It warrants noting that these bills are nearly identical; there are a few technical differences throughout the bill.*

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Iowa	HF 2352	02/14/18: Introduced; referred to House Human Resources Committee.	• Establishes the Healthy Iowa Program ("Program")—a single-payer program for every state resident that replaces all existing federally regulated programs operating within the state (i.e., Medicaid)—to be run by the Healthy Iowa Agency ("Agency"); • Does not impact existing authority for employers to create an employment benefit or to limit the provision of any employment benefit; • Creates the Healthy Iowa Board ("Board"), run by a director, to adopt rules for, advise the Agency on, and establish policy for the Program; • Establishes the Healthy Iowa Advisory Committee to advise the Board on all policy matters; • Establishes mechanisms for participating healthcare providers to negotiate administrative matters (i.e., payment rates for services, cost of prescription and non-prescription drugs, and payment methods for the Program services); • Prohibits an insurer or health carrier from (1) offering benefits or (2) covering services that are offered under the Program; • Permits State residents to opt out of the Program in favor of employer-sponsored health plans; • Directs the Board to seek all necessary federal waivers and approvals/submit state plan amendments as needed to operate the Program; and • Creates a Healthy Iowa Trust Fund to be administered by the Board to contain funds used to implement the Program.
Maryland	Healthy Maryland Act (SB 1002/HB 1516)	SB 1002 02/05/18: Introduced; referred to the Senate Finance Committee. 03/07/18: A hearing was held on the legislation. HB 1516 02/09/18: Introduced; referred to	• Establishes the Healthy Maryland Program ("Program")—a public corporation and unit of state government—to provide comprehensive, universal, single-payer health care services for all Maryland residents; • Creates the Healthy Maryland Board ("Board") to develop and administer the Program; • Prohibits a carrier from offering benefits or covering services for which coverage is offered to individuals under the Program (but a Maryland-licensed carrier may offer benefits that do not duplicate the services covered by the Program); • Permits Maryland residents who are employed outside the state to receive health insurance benefits through their employer and to opt out of participation in the Program; • Requires the Board to report certain data (e.g., inpatient discharge data; hospital annual financial data; prescription drug cost data, among others) to the Health Services Cost Review Commission and

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		House Committees on Health and Government Operations. 03/05/18: A hearing was held on the legislation. 03/08/18: Referred to House Ways and Means Committee.	make certain data available to the public; • Establishes a Healthy Maryland Public Advisory Committee to advise the Board on all policy matters related to the Program; • Requires the Board to establish requirements and standards to replace and merge with any health care/ancillary services currently provided by other programs (e.g., Medicare, the ACA, and federally matched public health programs); • Directs the Board to seek all necessary federal waivers and approvals/submit state plan amendments as needed to operate the Program; and • Creates a Healthy Maryland Trust Fund to be administered by the Board to contain funds used to implement the Program.
Massachusetts	Medicare for All (H 2987/S 619)	01/23/2017: Introduced; referred to the Joint Committee on Health Care Financing. 06/20/2017: A joint hearing was held on Alternative Payment Systems in which H. 2987 was discussed.	• Establishes the Massachusetts Healthcare Trust, a single-payer healthcare system; • Pools state and federal outlays for current public programs; and • Eliminates premiums, co-pays, co-insurance, and deductibles.
	S 2211/S 2202/2190	10/26/17: S 2190 reported from the Special Committee on Health Care Cost Containment and Reform; referred to the Committee on Ways and Means. 11/02/17: S 2190 was passed with an amendment and substituted for a new draft (S 2202). 11/09/17: Passed by the Senate 33-6; reprinted as amended as S 2211.	• Requires the Center for Health Information and Analysis ("Center") to recommend a methodology to develop a single-payer benchmark; • Requires the Center, in conjunction with the Health Policy Commission ("Commission") and the Division of Insurance, to provide an annual report comparing the actual health care expenditures in the state from 2016-2018 with the single-payer benchmark for that time period, indicating whether the state would have saved money while expanding access to care under a single-payer health care system; and • If the results of the report find that the single-payer benchmark outperformed the actual total health care expenditures from 2016-2018, requires the Commission to submit a proposed single-payer health care implementation plan to the State House and Senate within a year of filing the report. *It warrants noting that all of these bills are "emergency laws" that are "necessary for the immediate preservation of the public health." As such, they appear to function as health care omnibus bills, including provisions well beyond those mentioned here.*

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	H 596/S610	01/23/17: Introduced; referred to the Joint Committee on Health Care Financing. 06/20/17: Hearing held on the legislation.	• Requires the Center for Health Information and Analysis ("Center") to monitor, review, and evaluate reports related to single-payer health care (including the performance of single-payer health care systems in other states and countries); • Requires the Center to establish a single-payer benchmark which estimates the total cost of providing universal health care to all state residents; • Requires the Center, with the Health Policy Commission ("Commission"), to compare the single-payer benchmark with the actual health care spending in the state in its annual report, indicating whether the state would have saved money under the single-payer system; • If the state finds that the single-payer benchmark has outperformed the actual total health care spending in the state, requires the Commission to submit a "Single-Payer Health Care Implementation Plan" to the legislature for consideration.
Missouri	HB 1833	01/03/18: Introduced.	• Establishes the Missouri Universal Health Assurance Program ("Program"), as administered by the Health Assurance Board of Governors ("Board"), comprehensive health program for all Missouri residents; • Requires the Board to establish budget and policy guidelines for the Program and to file a report with members of the General Assembly and the Program's Governor concerning recommended changes in the state's insurance and health care laws to improve access to health care in the state; • Requires the Board to develop a comprehensive state health care plan that, among other things, includes (1) a comprehensive budget; (2) specific goals for the total portion of funds in the health services account; (3) an evaluation of the health care and mental health needs to the state; (4) goals for geographic distribution of health care providers and personnel; and (5) prescription drug cost containment measures; • Requires the health plan to seek to assure the most cost-effective delivery of health care; • Requires the Board to establish and administer the Missouri Health Care Trust Fund; • Allows insurers, employers, and other plans to offer benefits, provided they do not duplicate services that are offered by the Program; and • Imposes a health insurance tax on all Missouri taxable income of resident individuals (i.e., a 1% tax on taxable incomes of $5,000-$25,000; up to a 5% tax on taxable income exceeding $500,000).

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New Hampshire	HB 1793	01/03/18: Introduced; referred to Committee on Commerce and Consumer Affairs; scheduled for public hearing 01/12/18. 01/11/18: Scheduled a subcommittee work session (01/16/18); scheduled an executive session (01/18/18).	• Establishes the New Hampshire Health Services Program ("Program"), as administered by the Health Services Governing Board, to provide universal access to health care for all residents of New Hampshire; • Creates a non-lapsing, continually-appropriated Health Services Trust Fund to provide payment and reimbursement for the program; • Prohibits a private health insurer from selling health insurance coverage that duplicates the benefits provided under the Program; • Requires the Board to establish funding for long-term care services, among other things; and • Requires the Board to initiate steps for a transition to a "no-fault" system for medical liability, away from the current tort-based approach.
	SB 383/HB 1241	SB 383 **Current Status:** *Died in Committee* (05/02/18). HB 1241 **Current Status:** *Died in Committee* (03/06/18).	• Establishes a Commission to study developing a "Health Care for All" Program for all residents of the state; • Directs the Commission to review the costs and benefits of establishing a comprehensively publicly funded health insurance program to cover all state residents (i.e., the impact of the program on residents with insurance; impact of the program on the state budget; the amount of money preserved by establishing the program, among others); and • Requires the Commission to file an interim report with its findings and recommendations for proposed legislation to the state legislature.
New Jersey	New Jersey Public Option Health Care Act (A 1343/S 561)	SB 561 01/09/2018: Introduced; referred to the Senate Commerce Committee. HB 1343 01/10/18: Introduced; referred to House Committee on Rules.	• Creates the New Jersey Public Option Health Care Program ("Program"), as administered by the New Jersey Public Option Health Care Board ("Board") in the state Department of Health, to provide a comprehensive health insurance coverage option to every New Jersey resident (such coverage will compete in the market with insurance offered by private health insurers); • Directs the Commissioner of Health ("Commissioner"), in consultation with the Commissioner of Banking and Insurance, to establish premiums and other charges for enrolling in the Program; • Requires the Commissioner to establish and maintain procedures and standards for health care providers to be qualified to participate in the Program; • Directs the Commissioner to seek all necessary federal waivers and approvals/submit state plan amendments as needed to operate the Program; • Creates the New Jersey Public Option Health Care Trust Fund, a non-lapsing, revolving fund that will hold the money obtained from premiums, federal payments, and state funds.
	A 2269	02/01/18: Introduced; referred to Assembly Health and Senior	• Provides all residents of New Jersey with Medicare coverage regardless of age, health, or disability status;

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		Services Committee.	• Directs the state to apply for all necessary federal waivers and approvals needed to effectuate the expansion of Medicare; • Requires CMS to estimate the cost of providing Medicare for all residents and establish premiums for such residents; and • Upon enactment, prohibits carriers from offering plans that include coverage for health care services covered by Medicare.
New York	New York Health Act (A 4738/S 4840/S 4371)	S 4371 **Current Status:** *Stricken from the legislative docket* (02/28/17). S 4840 03/03/17: Introduced; referred to the Senate Health Committee. 01/03/18: Re-referred to the Senate Health Committee. 02/02/18: Amended and recommitted to the Senate Health Committee. A 4738 02/03/17: Introduced; referred to the Health Committee. 01/03/18: Failed in Senate; returned to the Assembly. 01/09/18: Committed to House Health Committee.	• Establishes the New York Health Program ("Program"), a comprehensive system of access to health insurance for New York residents, within the Department of Health to be implemented by the Commissioner; • Establishes the New York Health Board of trustees to effectuate the New York Health Program and advise the Commissioner; • Requires the Commissioner to seek all necessary federal waivers and approvals/submit state plan amendments as needed to operate the Program; • Maintains employer-sponsored health insurance; • Maintains an income-based payroll tax (i.e., all income that is subject to the Medicare Part A tax) and a non-payroll income-based income tax (i.e., tax on income that is subject to personal income tax); • Combines the state funding with federal funds that are currently received for Medicaid, Medicare, and Child Health Plus in order to provide care to residents with the New York Health Trust Fund; and • Eliminates copays and deductibles.

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State	Measure	Status	Content
		02/02/18: Amended and Recommitted to House Health Committee.	
Ohio	SB 91/HB 440	SB 91 03/15/17: Introduced; referred to the Committee on Insurance and Financial Institutions. HB 440 12/07/17: Introduced.	• Establishes the Ohio Health Care Plan (the Plan); • Establishes the Ohio Health Care Agency (the Agency) to administer the Plan; • Creates the Ohio Health Care Board to (1) oversee the Agency and (2) develop and implement health policy; • Maintains employer-sponsored health insurance; • Establishes the Ohio health care fund; and • Eliminates copays and deductibles.
Pennsylvania	Pennsylvania Health Care Plan Act (SB 1014/HB 1688)	HB 1688 10/02/17: Introduced; referred to the House Committee on Health. SB 1014 02/09/18: Introduced; referred to the Senate Committee on Banking and Insurance.	• Creates the Pennsylvania Health Care Agency to establish the Pennsylvania Health Care Plan (the Plan); • Establishes the Pennsylvania Health Care Board to oversee the Pennsylvania Health Care Agency; • Creates an Office of Healthcare Ombudsman to represent plan participants' interests; • Maintains employer-sponsored health insurance; • Institutes a 10% employer tax paid on payroll and 3% personal income tax; • Develops a Pennsylvania Health Care Trust Fund whereby all money collected and received in the Plan is deposited into the fund and used to finance the Plan; and • Eliminates copays and deductibles.
Rhode Island	S 2082/H 7284	S 2082 01/18/18: Introduced; referred to the Senate Health and Human Services Committee. H 7284 01/25/18: Introduced; referred to House Finance Committee.	• Implores Congress to pass Medicare-For-All legislation (i.e., S. 1804 and H.R. 676).
	S 2237/H 7285	S 2237	• Establishes the Rhode Island Comprehensive Health Insurance Program (RICHIP), an independent

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		02/01/18: Introduced; referred to Senate Health and Human Services Committee. H 7285 01/25/18: Introduced; referred to House Finance Committee.	state agency to operate a single-payer health program; • Appoints a Director to administer RICHIP, operate RICHIP budgets, and establish the RICHIP trust fund, subject to oversight by the Executive Board and Advisory Committee; • Directs the Director to obtain all necessary federal waivers and streamline federal funding and reimbursement (but also addresses how RICHIP will operate if all necessary federal waivers are not granted); • Requires Rhode Island providers to meet state licensing requirements in order to participate in RICHIP; • Allows for-profit providers to continue to offer covered goods and services in the state but prohibits them from charging patients more than RICHIP reimbursement rates for such goods and services; • Prohibits private health insurers from selling coverage that duplicates benefits offered under RICHIP; • Allows employers to provide coverage for any benefits not provided by RICHIP (e.g., multiemployer plans can continue to provide wraparound coverage for any benefits not provided by RICHIP); • Establishes a RICHIP Trust Fund to finance RICHIP; and • Replaces amounts currently paid by employers and employees for health insurance with a 10% payroll tax, based on the projected average payroll of employees over the 3 previous calendar years and to be marginally adjusted by the RICHIP Director.
	S 2610/H 7829	S 2610 03/01/18: Introduced; referred to Senate Health and Human Services Committee. H 7829 02/28/18: Introduced; referred to House Finance Committee.	• Requires the Office of the Health Insurance Commissioner (“Office”) to, among other things, (1) ensure that all state residents have access to affordable care; (2) designate one or more nonprofit organizations as a primary care trust responsible for the delivery of primary care and essential health services; (3) establish program and administrative standards for the Primary Care Trust Program (“Program”); and (4) establish standards and procedures to fund the Program by annual primary care trust assessments paid by health insurers; • Directs the Commissioner to establish a primary care trust (funded by insurers’ annual primary care trust assessments) to fund the Program; and • Directs the primary care trust to be responsible for (1) the delivery of primary care services and (2) the development and implementation of a community health plan for all residents.

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State	Measure	Status	Content
Vermont	S 53/H 248	S 53 01/27/17: Introduced and referred to the Senate Committee on Health and Welfare. 03/21/18: Passed Senate by a vote of 24-6. 03/27/18: Referred to the House Rules Committee. H 248 02/14/17: Introduced and referred to the House Committee on Health Care.	• Establishes the framework for a system of "universal, publicly financed primary care;" • Creates the Universal Primary Care Fund to be the funding source for the program; • Requires the Green Mountain Care Board to establish, monitor, and oversee payments to healthcare providers; • Covers all preventive care and services excluding dental care; and • Eliminates copays and deductibles.
Virginia	HJ 125	01/10/18: Introduced.	• Directs the Joint Legislative Audit and Review Commission to study the cost of implementing universal health care in the state and to issue a report.
Washington	Washington Health Security Trust (HB 1026)	01/09/17: Introduced. 01/08/18: Reintroduced; retained in present status.	• Requires the submission of a waiver to the federal government to create the Washington Health Security Trust; • Establishes a board of nine trustees and three standing committees: Financial Advisory Committee, Citizens' Advisory Committee, Technical Advisory Committee; • Creates a single benefits package covering health services; and • Does not limit an employer's right to maintain employee benefit plans under the Federal Employee Retirement Income Security.
	Healthy Washington Act (SB 5957)	06/16/17: Introduced; referred to the Committee on Health Care. 01/08/18: Reintroduced; retained in present status; referred to Senate Committee on Health & Long Term	• Creates the healthy Washington program that provides comprehensive, universal health care coverage and a health care cost control system; • Establishes a healthy Washington board to oversee the program; • Eliminates private health insurance for services or benefits covered under the program; and • Establishes a healthy Washington trust fund and corresponding account, whereby state revenues from the program are deposited.

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State	Measure	Status	Content
		Care. 01/18/18: Scheduled for public hearing in the Senate Committee on Health & Long Term Care.	
	SB 6032	**Current Status**: *Enacted* (03/27/18).	• Appropriates funds to the Washington State Institute for Public Policy to conduct a study of single-payer and universal coverage health care systems; and • Requires the study to (1) summarize the parameters used to define universal coverage, single-payer, and other innovative systems; (2) compare the characteristics of up to ten universal or single-payer models available in the U.S. or elsewhere; and (3) summarize any available research that examines the effect of existing universal coverage models (e.g., overall cost, quality of care, health outcomes, or in the uninsured rate).

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