

**2018 State Single Payer & Public Option Legislation Tracker**

— Active Legislation —

**Active Single Payer & Public Option Bills**

Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
<p><b>CALIFORNIA</b></p> <p><b>Healthy California Act</b> (<a href="#">S. 562</a>)</p> <p><b>Current Status:</b> Stalled until further notice</p>	<p><i>Private Carrier.</i> Prohibits a carrier from offering duplicative coverage (i.e., coverage that is offered to individuals under the Program)</p> <p>Does <u>not</u> prohibit a carrier from offering:</p> <ul style="list-style-type: none"> <li>Coverage that is not offered under the Program</li> <li>Any benefits to/for individuals who are employed or self-employed in California but are not residents of California</li> <li>Any benefits during the implementation period to individuals who enrolled or may enroll as members of the Program</li> </ul>	<p>Establishes the Healthy California Board to establish and implement the Healthy California Program (i.e., the single-payer program)</p> <p>Establishes a public advisory committee to advise the Board on all matters of policy for the Program</p>	<p>Provides covered health care benefits including:</p> <ul style="list-style-type: none"> <li>All medical care determined to be medically appropriate by the member’s health care provider<sup>1</sup></li> <li>All health care services required to be covered under any of the following: <ul style="list-style-type: none"> <li>The state’s Children’s Health Insurance Program</li> <li>Medi-Cal</li> <li>Medicare</li> <li>Health care service plans pursuant to the Knox-Keene Health Care Service Plan Act of 1975</li> <li>Health insurers</li> <li>Any additional health care services authorized to be added to the Program’s benefits by the Program</li> </ul> </li> </ul>	<p>Provides coverage to every resident of California</p> <p>Authorizes the Board to determine when individuals may enroll in the Program and to establish an implementation period</p> <p>Authorizes higher education institutions to purchase coverage under the Program for a student (or dependent thereof) who is not a California resident</p>	<p>Does not require members to pay any fee, payment, or other charge for enrolling in or being a member under the program</p> <p>Does not require members to pay any premium, copayment, coinsurance, deductible, or any other form of cost sharing</p>	<p>States the legislature’s intent to enact legislation that would (1) develop a revenue plan and (2) require state revenues from the program to be deposited in an account within the Healthy California Account</p> <p>Establishes the Healthy California Trust Fund which will be made up of state and federal funds received for the purposes of the act (e.g., all moneys obtained from the above legislation; federal payments received as a result of any waiver of requirements granted for Medicare, federally-</p>	<p>Provides for the collection and public disclosure of certain data (e.g., inpatient discharge data, emergency department and ambulatory surgery data, and hospital annual financial data, etc.); such data must not contain personally identifiable information</p> <p>Does not preempt any city/county from adopting additional coverage for residents in that city/county</p> <p>Requires the Board to seek all federal waivers necessary to operate the Program</p>

<sup>1</sup> Such benefits include, but are not limited to: (1) licensed inpatient/outpatient medical and health facility services; (2) inpatient/outpatient professional health care provider medical services; (3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services; (4) medical equipment, appliances, and assistive technology; (5) inpatient and outpatient rehabilitative care; (6) emergency care services; (7) emergency transportation; (8) necessary transportation for health services for persons with disabilities or who may qualify as low income; (9) child and adult immunizations and preventive care; (10) health and wellness education; (11) hospice care; (12) care in a skilled nursing facility; (13) home health care, including health care provided in an assisted living facility; (14) mental health services; (15) substance abuse treatment; (16) dental care; (17) vision care; (18) prescription drugs; (19) pediatric care; (20) prenatal and postnatal care; (21) podiatric care; (22) chiropractic care; (23) acupuncture; (24) therapies that are shown by the National Institutes of Health, National Center for Complementary and Integrative Health to be safe and effective; (25) blood and blood products; (26) dialysis; (27) adult day care; (28) rehabilitative and habilitative services; (29) ancillary health care or social services previously covered by county integrated health and human services programs or regional centers for persons with developmental disabilities; (30) case management and care coordination; (31) language interpretation and translation for health care services; and (32) health care and long-term supportive services currently covered under Medi-Cal or the state’s Children’s Health Insurance Program.

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	<p><i>Employer.</i> Does not create any employment benefit or require, prohibit, or limit the provision of any employment benefit</p>		<p>- All of the ACA’s EHBs</p>		<p>for all covered benefits</p>	<p>matched programs, and the ACA; etc.)</p>	<p>Requires the Board to develop proposals on long-term care coverage, coverage of retirees, and services currently covered under the workers’ compensation system</p> <p>Establishes qualifications for participating health care providers, care coordination, and associated payment methodologies</p>
<p><b>MASSACHUSETTS</b></p> <p><b>“Improved Medicare for All Bill”</b> (<a href="#">H 2987/S 619</a>)</p> <p><b>Current Status:</b> Introduced; referred to the joint committee of jurisdiction</p>	<p><i>Private Carrier.</i> Prohibits insurers from charging premiums to eligible participants for coverage of services already covered by the Trust</p> <p><i>Other Provider.</i> Ensures that participants eligible for federal program coverage receive access to care/coverage equal to that of all other Massachusetts residents by:</p> <ul style="list-style-type: none"> <li>• Paying for all services covered by the Trust that are not covered by the relevant federal plan</li> <li>• Paying for all such services during any federally-mandated gaps in participants’ coverage</li> </ul>	<p>Establishes the Massachusetts Health Care Trust within the Executive Office of the Health and Human Services to function as the “single payer” responsible for the collection and disbursement of funds for health services</p> <p>Establishes a board of trustees to govern the Trust and appoint administrators of the trust (e.g.,</p>	<p>Provides access to covered benefits, which include all high quality health care determined to be medically necessary or appropriate by the Trust, including but not limited to:</p> <ul style="list-style-type: none"> <li>• Prevention, diagnosis and treatment of illness and injury (i.e., laboratory, diagnostic imaging, inpatient, ambulatory and emergency medical care, blood and blood products, dialysis, mental health services, palliative care, dental care, acupuncture, physical therapy, chiropractic and podiatric services)</li> <li>• Promotion and maintenance of individual health through appropriate screening,</li> </ul>	<p>Recognizes the following persons as eligible participants in the Trust:</p> <ul style="list-style-type: none"> <li>• All Massachusetts residents</li> <li>• All non-residents who <ul style="list-style-type: none"> <li>- Work 20 hours or more per week in the state;</li> <li>- Pay all applicable state personal income and payroll taxes;</li> <li>- Pay any additional premiums established</li> </ul> </li> </ul>	<p>Imposes no deductibles, copayments, coinsurance, or other cost sharing with respect to covered benefits</p>	<p>Establishes the Health Care Trust Fund to operate the Trust</p> <p>Receives funding from the following sources:</p> <ul style="list-style-type: none"> <li>• A 7.5% employer payroll tax (exempting the first \$30,000 of payroll per establishment), replacing previous spending by employers on health premiums</li> <li>• A 0.44% additional employer payroll tax on establishments with 100 or more employees</li> <li>• A 2.5% employee payroll tax, replacing</li> </ul>	<p>Requires the trust to develop an integrated population-based health care database to support health care planning/monitor quality of care</p> <p>Upon passage, implements a statewide education program to ensure that all residents understand the bill’s impact</p> <p>Requires the Trust to seek all federal waivers necessary so that all current federal payments for health care are paid directly to the Trust Fund</p>

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	<ul style="list-style-type: none"> <li>Paying for any deductibles, copayments, coinsurance, or other cost sharing incurred by such participants</li> </ul>	<p>directors of the regional, administrative, planning, information technology, and quality assurance divisions)</p>	<p>counseling and health education</p> <ul style="list-style-type: none"> <li>Rehabilitation (e.g., physical, psychological, and other specialized therapies)</li> <li>Mental health services</li> <li>Prenatal, perinatal and maternity care, family planning, fertility and reproductive health care</li> <li>Home health care</li> <li>Long term care in institutional and community-based settings</li> <li>Hospice care</li> <li>Language interpretation</li> <li>Emergency and other medically necessary transportation;</li> <li>The full scale of dental services (<u>not</u> cosmetic dentistry)</li> <li>Basic vision care and correction</li> <li>Hearing evaluation and treatment</li> <li>Prescription drugs</li> <li>Durable and non-durable medical equipment, supplies, and appliances</li> </ul>	<p>by the Trust to cover non-residents; <u>and</u></p> <ul style="list-style-type: none"> <li>Have complied with the preceding requirements for at least 90 days</li> <li>All non-resident patients requiring emergency treatment for illness or injury (but the Trust will recoup expenses for such patients wherever possible)</li> </ul> <p>Provides all residents with a health care card that will cover all necessary medical care up front</p> <p>Provides coverage that is continuous without the need for repeated reenrollments or changes</p>		<p>previous spending by employees on health premiums and out-of-pocket expenses<sup>2</sup></p> <ul style="list-style-type: none"> <li>A 10% payroll tax on the self-employed (exempting the first \$30,000 of payroll per self-employed resident)</li> <li>A 10% tax on unearned income (e.g., dividends, capital gains, rents, and profits) above \$30,000 (excluding Social Security, SSI, SSDI, unemployment benefits, and pension payments)</li> <li>Consolidation of public spending on health insurance</li> <li>Consolidation of state and municipal health care spending</li> <li>Federal sources of revenue</li> </ul>	<p>Establishes qualifications for eligible health care providers/facilities and rules governing reimbursement</p> <p>Provides patients with free choice of participating providers</p> <p>Provides that whenever individuals receive health care services under the Trust and they are entitled to coverage, reimbursement, etc. from a collateral source<sup>3</sup>, they must notify the health care provider or facility and provide information identifying the collateral source and prove other relevant information</p>

<sup>2</sup> An employer—private or public—may agree to pay all or part of an employee’s payroll tax obligation. Such payment will not be considered income for Massachusetts income tax purposes.

<sup>3</sup> A “collateral source” includes (1) insurance policies written by insurers, including the medical components of automobile, homeowners, workers’ compensation, and other forms of insurance; (2) health care service plans and pension plans; (3) employee benefit contracts; (4) government benefit programs; (5) a judgment for damages for personal injury; and (6) any third party who is or may be liable to an individual for health care services or costs. It does not include a contract or plan that is subject to federal preemption or any governmental unit, agency, or service, to the extent that subrogation is prohibited by law.

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<p><b>NEW HAMPSHIRE</b></p> <p><i>New Hampshire Single Cure Act</i> (<a href="#">HB 1793</a>)</p> <p><b>Current Status:</b> Introduced; referred to committees of jurisdiction; scheduled for public hearing/work sessions</p>	<p><i>Private Carrier.</i> Prohibits a private health insurer from selling health insurance coverage that duplicates benefits under the program</p> <p>Does not affirmatively prohibit the sale of health insurance coverage for any <u>additional</u> benefits not covered under the program</p>	<p>Establishes the New Hampshire Health Services Governing Board</p>	<p>Provides covered benefits that include but are not limited to:</p> <ul style="list-style-type: none"> <li>• Primary care and prevention</li> <li>• Specialty care other than elective cosmetic</li> <li>• Inpatient care</li> <li>• Outpatient care</li> <li>• Emergency care</li> <li>• Prescription drugs</li> <li>• Durable medical equipment</li> <li>• Long-term care</li> <li>• Mental health services</li> <li>• The full scope of dental services, other than elective cosmetic dentistry</li> <li>• Substance abuse treatment services</li> <li>• Chiropractic services</li> <li>• Basic vision care and vision correction</li> <li>• Medical devices for appropriate clinical indication</li> </ul> <p><i>Portability.</i> Benefits available through any licensed practitioner/facility anywhere in New Hampshire <u>and</u> for emergency outpatient/inpatient care anywhere in the U.S. Out-of-state emergency services are covered when they are not available in New Hampshire.</p>	<p>Provides coverage to all individuals legally residing in New Hampshire (presumption of eligibility exists when a person presents themselves for covered services from a participating provider)</p> <p>Requires residents to fill out an application form, after which individuals will receive a program insurance card</p>	<p>Prohibits imposition of deductibles, co-payments, coinsurance, or other cost sharing with respect to covered benefits</p>	<p>Creates a non-lapsing, continually-appropriated Health Services Trust Fund to provide payment and reimbursement for the program</p> <p>Provides that funding includes all funds appropriated for healthcare as outlined by the state, all federal funds designated for health care (e.g., Medicaid), public and private grants, etc.</p>	<p>Requires the program to “protect the rights and privacy of patients” in accordance with state and federal law</p> <p>Grants patients the right to access their medical records on demand</p> <p>Requires the insurance commissioner to apply to the federal government for state innovation waivers as necessary</p> <p>Requires the Board to initiate steps for a transition to a “no-fault” system for medical liability, away from the current tort-based approach.</p> <p>Establishes qualifications for participating providers and rules governing reimbursement</p> <p>Specifically addresses funding of long-term care services and mental health services, and reimbursement of prescription medications</p>

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<p><b>NEW JERSEY</b></p> <p><i>New Jersey Public Option Health Care Act</i> (<a href="#">A 1343/S 561</a>)</p> <p><b>Current Status:</b> Introduced; referred to the committees of jurisdiction</p>	<p><i>Private Carrier.</i> Provides that coverage offered by the Program will compete in the market with insurance offered by private health insurers</p>	<p>Establishes the New Jersey Public Option Health Care Program within the New Jersey Department of Health</p> <p>Establishes the New Jersey Public Option Health Care Board to assist the Department of Health in administering the Program</p>	<p>Provides health care services required to be covered under any of the following:</p> <ul style="list-style-type: none"> <li>• NJ Family Care</li> <li>• Medicaid</li> <li>• Medicare</li> <li>• New Jersey Individual Health Coverage Program</li> <li>• New Jersey Small Employer Health Benefits Program</li> <li>• Any additional health care service authorized to be added to the Program’s benefits by the Program</li> </ul>	<p>Provides coverage to every New Jersey resident</p> <p>Requires the health commissioner to determine when individuals may begin enrolling in the program and to establish an implementation period</p>	<p>Requires the health commissioner to establish premiums and other charges for enrolling in/being a member of the Program (e.g., deductibles, co-payments, or co-insurance)</p>	<p>Establishes the New Jersey Public Option Health Care Trust Fund—a non-lapsing revolving fund that is the repository for monies collected/received to run the Program, including:</p> <ul style="list-style-type: none"> <li>• All monies obtained from premiums collected</li> <li>• Federal payments received as a result of any waiver granted or other arrangements agreed to by HHS</li> <li>• The amounts paid by the Department of Health that are equivalent to those amounts paid on behalf of New Jersey residents under Medicare, any federally-matched public health program, or the ACA</li> <li>• State monies for services and benefits covered under the Program</li> </ul>	<p>Requires aggregate data of the Program to be public information</p> <p>Establishes qualifications for participating providers and rules governing reimbursement/payment methodologies</p> <p>Requires the health commissioner to seek all federal waivers/approvals (e.g., waivers of requirements under Medicare, federally-matched programs, the ACA, etc.) and submit state plan amendments necessary to operate the Program</p>
<p><b>NEW YORK</b></p> <p><i>New York Health Act</i> (<a href="#">A 4738/S 4840/S 4371</a>)</p>	<p><i>Private Carrier.</i> Allows an insurer to offer benefits that do <u>not</u> cover any service for which coverage is offered under the Program</p>	<p>Establishes the New York Health Program in the Department of Health</p>	<p>Provides comprehensive coverage, which includes all health care services required to be covered under any of the following:</p> <ul style="list-style-type: none"> <li>• Child Health Plus</li> </ul>	<p>Provides coverage to every resident of New York</p>	<p>Provides that no individual will be required to pay any premium</p>	<p>Establishes the New York Health Trust Fund for monies collected/received to run the Program</p>	<p>Requires the health commissioner to seek all federal waivers/approvals (e.g., waivers of requirements under</p>

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<p>See <a href="#">Memo in Support</a></p> <p><b>Current Status:</b> Introduced; referred to committees of jurisdiction</p>	<p>Prohibits a carrier from offering benefits that duplicate coverage offered under the Program</p> <p>Does <u>not</u> prohibit:</p> <ul style="list-style-type: none"> <li>The offering of benefits to/for individuals who are employed or self-employed in the state but who are not residents of the state</li> <li>The offering of benefits during the implementation period to individuals who enrolled or may enroll in the Program</li> <li>The offering of retiree health benefits</li> </ul> <p><i>Other Provider.</i> Allows the Department to administer Medicare, create a Medicare managed care plan (“Medicare Advantage”), and be a provider of drug coverage under Medicare Part D</p> <p>Allows the Department to apply for coverage under any</p>		<ul style="list-style-type: none"> <li>Medicaid</li> <li>Medicare</li> <li>Entities regulated under state law (e.g., HMOs; life, accident and health, annuities; and non-profit medical and dental indemnity, etc.)</li> <li>Health Benefits for State and Retired State Employees</li> <li>Any additional health care service authorized to be added by the Program</li> </ul> <p>Provides that the Program will provide for payment for:</p> <ul style="list-style-type: none"> <li>Emergency and temporary health care services provided to a member/individual who has not had a reasonable opportunity to become a member or to enroll with a care coordinator</li> <li>Health care services provided in an emergency to an individual who is entitled to become a member or enrolled with a care coordinator, regardless of having had an opportunity to do so</li> </ul>	<p>Authorizes the Department to determine when individuals may enroll in the Program and to establish an implementation period</p>	<p>or other charge (e.g., deductibles, copayments, or coinsurance) for enrolling in or being a member under the Program</p>	<p>Provides that the Fund will consist of:</p> <ul style="list-style-type: none"> <li>All monies obtained from taxes<sup>4</sup></li> <li>Federal payments received as a result of any waiver/other arrangements agreed to by the federal government</li> <li>The amounts paid by the Department of Health that are equivalent to those amounts that are paid on behalf of New York residents under Medicare, any federally-matched public health program or the ACA for benefits that are covered under the Program</li> <li>Federal and state funds for the purposes of the provision of services authorized under Title XX of the Social Security Act</li> </ul>	<p>Medicare, federally-matched programs, the ACA, etc.) and submit state plan amendments necessary to operate the Program</p> <p>Establishes qualifications for participating providers and rules governing reimbursement/payment methodologies</p>

<sup>4</sup> The taxes will be determined based on a revenue proposal drafted by the governor. The basic structure of the revenue proposal will be as follows: revenue for the program will come from two taxes. First, there will be a progressively graduated tax on all payroll and self-employed income paid by employers, employees, and self-employed individuals. Second, there will be a progressively graduated tax on taxable income (e.g., interest, dividends, and capital gains) not subject to the payroll tax (i.e., the “non-payroll tax”). Per the legislation, the income subject to the payroll tax will be the same income subject to the Medicare Part A tax. The tax will be set at a percentage of that income, which will be progressively graduated (i.e., the percentage is higher on higher brackets of income). For employed individuals, the employer will pay 80% of the tax and the employee will pay 20% of the tax (except that an employer may agree to pay all or part of the employee’s share). A self-employed individual is required to pay 100% of the tax. The so-called non-payroll tax will be set at a percentage of income that will be progressively graduated (i.e., the percentage is higher on higher brackets of income). The legislation further describes the impact and application of these taxes on out-of-state residents employed in the state and cross-border employees.

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	federally-matched public health program on behalf of any member and enroll them if eligible  Allows institutions of higher education to purchase coverage under the Program for students who are not residents of the state					<ul style="list-style-type: none"> <li>State monies that otherwise be appropriated to any governmental agency which provides health services covered under the Program</li> </ul>	
<p><b>OHIO</b></p> <p><a href="#">SB 91/HB 440</a></p> <p>See <a href="#">Legislative Analysis by the Ohio Legislative Service Commission</a><sup>5</sup></p> <p><b>Current Status:</b> Introduced; referred to the committees of jurisdiction</p>	<p><i>Employer (Generally).</i> Provides that an employer operating in Ohio and providing employees with benefits that, as of the date of the bill, are less valuable than those provided in the Plan, may participate in the Plan or must provide additional benefits so that, until the expiration of the employer’s plan, the employer’s benefits are at least equal to the Plan</p> <p><i>Out-of-State Employer.</i> Provides that employee health coverage provided by an out-</p>	<p>Establishes the Ohio Health Care Agency to administer the Ohio Health Care Plan</p> <p>Establishes the Ohio Health Care Board to direct the Agency in the performance of all its duties/develop health policy</p>	<p>Requires the Board to establish a benefits package that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>Inpatient and outpatient provider care, both primary and secondary</li> <li>Emergency services</li> <li>Emergency and other transportation services to covered health care services;</li> <li>Rehabilitation services, (e.g., speech, occupational, and physical therapy)</li> <li>Inpatient and outpatient mental health services and substance abuse treatment</li> <li>Hospice care</li> </ul>	<p>Provides coverage to all Ohio residents and individuals employed in Ohio (including the homeless and migrant workers)</p> <p>Requires the Board to establish a procedure to enroll eligible individuals and provide each covered individual with identification that providers may use to determine eligibility for health care services (presumption of</p>	<p>Prohibits participants from being subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package</p> <p>Prohibits participants from being directly billed</p>	<p>Establishes the Ohio Health Care Fund to finance the Plan</p> <p>Obtains funds from the following sources:</p> <ul style="list-style-type: none"> <li>Federal financial participation following approval of necessary waivers</li> <li>Funds obtained from other federal, state, and local governmental sources and programs</li> </ul>	<p>Prohibits the Plan from excluding or limiting coverage due to preexisting conditions</p> <p>Contains anti-discrimination rules</p> <p>Grants participants freedom to choose from participating providers</p> <p>Prohibits providers from being compelled to offer any particular service (provided it does not result in discrimination among patients)</p>

<sup>5</sup> The Ohio Legislative Service Commission notes that it is possible that this bill would interact with Article I, Section 21 of the Ohio Constitution, which places limitations on what state law can do regarding health care and health insurance. In particular, it points to the following provisions which:

- Compel, directly or indirectly, any person, employer, or health care provider to participate in a health care system (any public or private entity or program that manages, processes, enrolls individuals for, or pays for health care services, health care data, or health care information for its participants)
- Prohibit the purchase or sale of health care or health insurance
- Impose a penalty or fine for the sale or purchase of health care or health insurance

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	<p>of-state employer to an Ohio resident working outside the state will serve as the employee’s primary coverage and the Plan will serve as the secondary or supplemental coverage</p> <p><i>In-State Employer.</i> Permits any employer operating in Ohio to purchase coverage under the Plan for an employee who lives out-of-state but works in the state</p> <p><i>Private Carrier.</i> Allows health insurers/persons selling or providing health care benefits to “deliver, issue for delivery, renew, or provide health benefit packages” that do <u>not</u> duplicate the health benefit package provided by the Plan</p> <p>Prohibits insurers from providing benefits that duplicate the health benefit package</p> <p><i>Other Provider.</i> If waivers are not obtained, provides that medical assistance and Medicare programs will act as the primary insurers and the Plan will serve as the</p>		<ul style="list-style-type: none"> <li>• Prescription drugs and prescribed medical nutrition</li> <li>• Vision care, aids, and equipment</li> <li>• Hearing care, hearing aids, and equipment</li> <li>• Diagnostic medical tests, including laboratory tests and imaging procedures</li> <li>• Medical supplies and prescribed medical equipment</li> <li>• Immunizations, preventive care, health maintenance care, and screening</li> <li>• Dental care</li> <li>• Home health care services</li> </ul> <p>Excludes certain procedures/treatments from coverage (e.g., cosmetic surgery unless required to correct a congenital defect)</p> <p>Authorizes the Board to remove or exclude procedures, treatments, equipment, drugs, etc. from the benefit package that the Board deems unsafe, experimental, of no proven value, etc.</p>	<p>eligibility exists when a person arrives at a health care facility unconscious or otherwise unable to document eligibility due to their mental/physical condition)</p>	<p>by providers for covered health care services</p>	<ul style="list-style-type: none"> <li>• Receipts from the 3.85% payroll tax<sup>6</sup> levied on employers</li> <li>• Receipts from the 3% tax levied on businesses’ gross receipts</li> <li>• Receipts from 6.2% income tax on an individual’s compensation in excess of the amount subject to the social security payroll tax</li> <li>• Receipts from a 5% income tax on all of an individual’s Ohio adjusted gross income, less exemptions, in excess of \$200,000</li> </ul>	<p>Provides that persons covered by a health care policy that has premiums paid with public money is covered under the Plan on the day that benefits become available</p> <p>Establishes qualifications for participating providers and rules governing reimbursement</p>

<sup>6</sup> The bill exempts employers from all health taxes imposed under the bill until the expiration of their respective plans, at which point the employer and the employer’s employees become participants in the Plan.



Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
	<p>secondary or supplemental coverage</p> <p>Permits any Ohio institution of higher education to purchase coverage under the Plan for a student who does not otherwise have status as an Ohio resident</p>						
<p><b>PENNSYLVANIA</b></p> <p><i>Pennsylvania Health Care Plan Act</i> (<a href="#">SB 1014/HB 1688</a>)</p> <p><b>Current Status:</b> Introduced; referred to the committees of jurisdiction</p>	<p><i>Private Carrier.</i> Authorizes private health insurers to offer coverage supplemental to the Plan’s health benefits package</p> <p><i>Other Provider.</i> If waivers are not obtained, the medical assistance or Medicare program will act as the primary insurer and the Plan will serve as secondary or supplemental coverage</p> <p>Serves as secondary or supplemental plan for veterans (unless reasonable/timely access is denied or unavailable from the VA)</p> <p><i>Out-of-State Employer.</i> Serves as secondary plan for Pennsylvania residents who work outside the state and receive coverage from an out-of-state employer</p>	<p>Establishes the Pennsylvania Health Care Agency to administer the Pennsylvania Health Care Plan</p> <p>Establishes the Pennsylvania Health Care Board to direct the agency in the performance of its duties</p> <p>Establishes quality of care panels (e.g., health professional quality panel; health institution quality panel;</p>	<p>Requires the Board to establish a benefits package that includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• All medically necessary inpatient and outpatient care and treatment for both primary and specialty care</li> <li>• Emergency services</li> <li>• Emergency and other medically necessary transport to covered health services</li> <li>• Rehabilitation services (e.g., speech, occupational, physical, and evidence-based alternative therapy)</li> <li>• Inpatient and outpatient mental health services and substance abuse treatment</li> <li>• Hospice care</li> <li>• Prescription drugs and prescribed medical nutrition</li> <li>• Vision care, aids, and equipment</li> </ul>	<p>Provides coverage to:</p> <ul style="list-style-type: none"> <li>• Residents who file a Pennsylvania individual income tax return and any dependent thereof</li> <li>• Students from out-of-state who are attending school and file an individual income tax return in Pennsylvania</li> <li>• Part-year residents who file a Pennsylvania individual income tax return</li> </ul> <p>Requires the Board to establish standards/procedure to demonstrate proof of eligibility (presumption of</p>	<p>Prohibits participants from being subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package</p>	<p>Develops a Pennsylvania Health Care Trust Fund to finance the Plan</p> <p>Obtains funds from:</p> <ul style="list-style-type: none"> <li>• Money obtained through federal health care programs</li> <li>• Money from dedicated sources specified by the General Assembly</li> <li>• Receipts from the 10% payroll tax (generated as a result of an employer conducting business within Pennsylvania)<sup>7</sup></li> <li>• Receipts from the additional 3% personal income tax</li> </ul>	<p>Prohibits the Plan from excluding or limiting coverage due to preexisting conditions</p> <p>Contains anti-discrimination rules</p> <p>Grants participants freedom to choose from participating providers (unless engaging in patterns of wasteful/abusive self-referrals to specialists)</p> <p>Requires non-participating providers to advise participants that they do not participate in the Plan and that the recipient will be personally responsible for the entire cost of the service</p>

<sup>7</sup> The bill prohibits employers from offsetting the payroll tax by reducing compensation or benefits paid to employees.

Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
		<p>health supplier quality panel)</p> <p>Establishes the Office of Health Care Ombudsman to represent the interests of plan and prospective participants</p>	<ul style="list-style-type: none"> <li>• Hearing care, hearing aids, and equipment</li> <li>• Diagnostic medical tests (e.g., laboratory testing and imaging procedures)</li> <li>• Medical supplies and prescribed medical equipment</li> <li>• Immunizations, preventive care, health maintenance, and screening</li> <li>• Dental care</li> <li>• Home health care services</li> <li>• Chiropractic</li> <li>• Complementary and alternative modalities that have been shown by BIH to be safe and effective for possible inclusion as covered benefits</li> </ul> <p>Excludes certain procedures/treatments from coverage (e.g., cosmetic surgery unless required to correct a congenital defect)</p>	<p>eligibility exists when a person arrives at a health care facility unconscious or otherwise unable to document eligibility due to a medical condition)</p> <p>Requires the Board to establish enrollment procedures</p> <p>Provides participants with smart technology cards with proof of identity technology</p>			<p>Requires the development of an integrated health care database for health care planning and quality assurance</p> <p>Establishes qualifications for participating providers and rules governing reimbursement</p>
<p><b>RHODE ISLAND</b></p> <p><i>Rhode Island Comprehensive Health Insurance Act</i> (<a href="#">S 2237/H 7285</a>)</p> <p><b>Current Status:</b> Introduced; referred to the relevant</p>	<p><i>Private Carrier.</i> Prohibits the sale of duplicative coverage</p> <p>Does <u>not</u> prohibit the sale of coverage for additional benefits not covered by the Program, including additional benefits that an employer may provide to employees (e.g., permits multiemployer plans to continue to provide wrap-around coverage for any</p>	<p>Establishes the Rhode Island Comprehensive Health Insurance Program, an independent agency</p> <p>Establishes an advisory committee to provide analyses</p>	<p>Provides coverage for services and goods deemed medically necessary by a qualified health care provider that is currently covered under:</p> <ul style="list-style-type: none"> <li>• Medicare</li> <li>• Medicaid</li> <li>• The state’s Children’s Health Insurance Program</li> <li>• All EHBs mandated by the ACA (along with some additional benefits like</li> </ul>	<p>Provides coverage to all qualified Rhode Island residents</p> <p>As a condition of eligibility, requires residents eligible for benefits under Medicare to enroll therein</p>	<p>Replaces current health insurance payments (e.g., premiums, copays, deductibles, and costs in excess of caps) with progressive contributions</p>	<p>Establishes a trust fund to finance the Program</p> <p>Obtains funds from:</p> <ul style="list-style-type: none"> <li>• Waivers related to Medicaid, CHIP, Medicare, and the ACA so that federal funds that would otherwise be paid to Rhode Island are</li> </ul>	<p>Requires the health commissioner to seek all federal waivers/approvals</p> <p>Establishes qualifications for participating providers and rules governing reimbursement</p> <p>Requires the establishment of a</p>

Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
committees of jurisdiction	<p>benefits not provided by the Program)</p> <p><i>Employer.</i> Does not create any employment benefit or require, prohibit, or limit the provision of any employment benefit</p> <p><i>Other Provider.</i> If necessary federal waivers are obtained, allows qualified Rhode Island residents who are eligible for Medicare to continue to pay required fees to the federal government</p> <p>Makes the Program the equivalent of qualifying coverage under Part D and Medicare Advantage programs</p> <p>If necessary federal waivers are obtained, makes the Program the state’s sole Medicaid provider</p> <p>If necessary waivers are <u>not</u> granted, retains Medicare and Medicaid as the primary insurers for those eligible for such coverage; leaves the</p>	and recommendations about the Program, and collect general concerns of program participants	<p>palliative care, approved dietary and nutritional therapies, podiatric care, etc.)</p> <p>Requires the Program to create a procedure that permits additional medically necessary goods/services beyond what is currently provided for by federal laws</p>	Requires the Program to establish procedures to determine eligibility, enrollment, disenrollment, and disqualification		<p>deposited in the trust fund</p> <ul style="list-style-type: none"> <li>• State funds that would otherwise be appropriated for services/benefits covered under the Program</li> <li>• Private grants and other funds specifically earmarked for health care</li> <li>• Assignments from Program participants</li> <li>• Progressive contributions</li> <li>• Contributions based on earned income (e.g., a 10% payroll tax)<sup>8</sup></li> <li>• Contributions based on unearned income (e.g., a 10% tax)</li> </ul> <p>Requires the Program to submit a revenue plan to the governor and general assembly considering (1) anticipated savings, (2) government funds available, (3) private funds available, and (4) replacing</p>	prescription drug formulary system

<sup>8</sup> The payroll tax obligations for employers may be impacted by cross-border employees. As such, the bill provides that if an individual is employed out-of-state by an employer that is subject to Rhode Island law, then the employer and employee will be required to pay the payroll taxes as if that employment were in the state. If the individual is employed out-of-state by an employer that is not subject to Rhode Island law, then the employee health coverage provided by the out-of-state employer to a resident working out-of-state will serve as the employee’s primary coverage and the Program will serve as the employee’s secondary or supplemental plan.

Beyond this provision, the payroll tax will apply to any out-of-state resident who is employed or self-employed in the state. Though a credit system will be in place for out-of-state residents who spend on health benefits that would otherwise be covered by the Program.

Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
	<p>Program as the secondary or supplemental plan</p> <p>Upholds the Program as secondary or supplemental coverage for veterans</p>					the current “regressive health insurance payments” with “progressive contributions to a single payer”	

**Exploratory Legislation**

Legislation	Legislation/Status	Overview
CALIFORNIA	<p><a href="#">AB 2489</a></p> <p><b>Current Status:</b> Introduced</p>	<p>Requires California’s Health and Human Services Agency to report to the legislature on the options for achieving universal health coverage, including:</p> <ul style="list-style-type: none"> <li>• The options for financing universal health coverage</li> <li>• The institutional mechanism by which universal coverage may be delivered</li> <li>• The extent and scope of the health coverage which all California residents may have</li> </ul> <p>Requires the report be submitted by January 1, 2023</p>
	<p><a href="#">AB 2517</a></p> <p><b>Current Status:</b> Introduced; referred to committees of jurisdiction</p>	<p>Establishes the Advisory Panel on Health Care Delivery Systems and Universal Coverage within the California Health and Human Services Agency to develop a plan to achieve universal coverage and a unified publicly financed health care system</p> <p>Requires the Advisory Panel to develop a plan that includes a timeline of (and submit reports to the legislature on) the benchmarks and steps necessary to implement a universal and unified publicly financed health care system, including:</p> <ul style="list-style-type: none"> <li>• A stakeholder engagement and analytical process by which key design features (e.g., covered benefits, eligibility, service delivery, etc.) are developed</li> <li>• The establishment of data collection and reporting systems to support management, evaluation, transparency, and public accountability</li> <li>• A multiyear financial model that includes state budgetary implications, an assessment of options for raising revenues and managing costs, and identification of the size and potential revenue sources for a prudent reserve</li> <li>• A consideration of the requirements necessary to seek federal waivers and federal statutory changes</li> <li>• A consideration of the requirements for state constitutional amendments</li> <li>• An initial scope and recommendations to build an information technology system and a financial management system capable of administering a universal and unified publicly financed health care system</li> <li>• A feasible financing system and an analysis of the need for voter approval of any financing mechanism</li> </ul>

Legislation	Legislation/Status	Overview
<b>DELAWARE</b>	<a href="#">SCR 70</a>  <b>Current Status:</b> Passed the House by voice vote	Creates a Medicaid Buy-In Study Group to study the adoption of an expanded Medicaid Buy-In program in Delaware, including federal requirements and approvals, eligibility criteria, potential premiums and levels of coverage, and potential positive and negative consequences of creating an expanded Medicaid Buy-In Program  Authorizes the Governor and the Secretary of Health and Social Services to apply for a 1332 waiver (and, if approved, may implement a state plan of innovation that meets the waiver requirements)  Requires the Study Group to compile a report containing a summary of its work
<b>MASSACHUSETTS</b>	<a href="#">H 596/S 610</a>  <b>Current Status:</b> Introduced; referred to committees of jurisdiction	Requires the Center for Health Information and Analysis to monitor, review, and evaluate reports related to single-payer health care and the performance of single-payer health care systems in other states and countries  Requires the Center to establish a single-payer benchmark that estimates the total cost of providing health care to all Massachusetts residents under a single-payer health care system during the previous year  Requires the Center—in conjunction with the Health Policy Commission—to include in its annual report a comparison of the single-payer benchmark with the actual health care spending in the state for the previous year (i.e., determining whether Massachusetts would have saved money)  If the Commission determines that the single-payer benchmark outperformed the actual total health care spending, then the Commission must submit a “Single-Payer Health Care Implementation Plan” to the legislature for consideration
<b>NEW JERSEY</b>	<a href="#">A 2269</a>  <b>Current Status:</b> Introduced; referred to committees of jurisdiction	Expands Medicare coverage to all New Jersey residents  Requires the state to apply to CMS for a waiver to allow all residents to be eligible for Medicare, regardless of the person's age, health, or disability status (allowing New Jersey to replace federal, state, and local health care programs with universal coverage through New Jersey Medicare).  Once universal Medicare coverage is enacted, prohibits any health insurance carrier from offering a health benefits plan that includes coverage for health care services covered by Medicare