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2018 State Single Payer & Public Option Legislation Tracker

— Active Legislation —

Newly Included Legislation and Procedural Updates

- August 15: Introduced in the Michigan House, the MIcare Act (HB 6285) would establish a single payer health care system in the state.

Active Single Payer & Public Option Bills

Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
CALIFORNIA ***Healthy California Act*** (S. 562) **Current Status**: Stalled until further notice	*Private Carrier*. Prohibits a carrier from offering duplicative coverage (i.e., coverage that is offered to individuals under the Program) Does not prohibit a carrier from offering: • Coverage that is not offered under the Program • Any benefits to/for individuals who are employed or self-employed in California but are not residents of	Establishes the Healthy California Board to establish and implement the Healthy California Program Establishes a public advisory committee to advise the Board on all matters of policy for the Program	Provides covered health care benefits including: • All medical care determined to be medically appropriate by the member's health care provider[1] • All health care services required to be covered under any of the following: - The state's Children's Health Insurance Program - Medi-Cal - Medicare - Health care service plans pursuant to the Knox-Keene Health Care	Provides coverage to every resident of California Authorizes the Board to determine when individuals may enroll in the Program and to establish an implementation period Authorizes higher education institutions to purchase coverage under the Program for a student (or	Does not require members to pay any fee, payment, or other charge for enrolling in or being a member under the program Does not require members to pay any premium,	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 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	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 Does not preempt any city/county from adopting additional coverage for residents in that

[1] 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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	California • Any benefits during the implementation period to individuals who enrolled or may enroll as members of the Program *Employer.* Does not create any employment benefit or require, prohibit, or limit the provision of any employment benefit		Service Plan Act of 1975 - Health insurers - Any additional health care services authorized to be added to the Program's benefits by the Program - All of the ACA's EHBs	dependent thereof) who is not a California resident	copayment, coinsurance, deductible, or any other form of cost sharing for all covered benefits	obtained from the above legislation; federal payments received as a result of any waiver of requirements granted for Medicare, federally-matched programs, and the ACA; etc.)	city/county Requires the Board to seek all federal waivers necessary to operate the Program Requires the Board to develop proposals on long-term care coverage, coverage of retirees, and services currently covered under the workers' compensation system Establishes qualifications for participating health care providers, care coordination, and associated payment methodologies
MASSACHUSETTS ***"Improved Medicare for All Bill"*** (H 2987/S 619) **Current Status**: Introduced; referred to the joint committee of jurisdiction	*Private Carrier.* Prohibits insurers from charging premiums to eligible participants for coverage of services already covered by the Trust *Other Provider.* Ensures that participants eligible for federal program coverage receive access to care/coverage equal to that of all other Massachusetts residents by: • Paying for all services covered by the Trust that	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	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: • 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	Recognizes the following persons as eligible participants in the Trust: • All Massachusetts residents • All non-residents who - Work 20 hours or more per week in the state; - Pay all applicable state personal	Imposes no deductibles, copayments, coinsurance, or other cost sharing with respect to covered benefits	Establishes the Health Care Trust Fund to operate the Trust Receives funding from the following sources: • A 7.5% employer payroll tax (exempting the first $30,000 of payroll per establishment), replacing previous spending by employers on health premiums • A 0.44% additional	Requires the trust to develop an integrated population-based health care database to support health care planning/monitor quality of care Upon passage, implements a statewide education program to ensure that all residents understand the bill's impact

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	are not covered by the relevant federal plan • Paying for all such services during any federally-mandated gaps in participants' coverage • Paying for any deductibles, copayments, coinsurance, or other cost sharing incurred by such participants	Establishes a board of trustees to govern the Trust and appoint administrators of the trust (e.g., directors of the regional, administrative, planning, information technology, and quality assurance divisions)	therapy, chiropractic and podiatric services) • Promotion and maintenance of individual health through appropriate screening, counseling and health education • Rehabilitation (e.g., physical, psychological, and other specialized therapies) • Mental health services • Prenatal, perinatal and maternity care, family planning, fertility and reproductive health care • Home health care • Long term care in institutional and community-based settings • Hospice care • Language interpretation • Emergency and other medically necessary transportation; • The full scale of dental services (not cosmetic dentistry) • Basic vision care and correction • Hearing evaluation and treatment • Prescription drugs • Durable and non-durable	income and payroll taxes; - Pay any additional premiums established by the Trust to cover non-residents; and - Have complied with the preceding requirements for at least 90 days • All non-resident patients requiring emergency treatment for illness or injury (but the Trust will recoup expenses for such patients wherever possible) Provides all residents with a health care card that will cover all necessary medical care up front		employer payroll tax on establishments with 100 or more employees • A 2.5% employee payroll tax, replacing previous spending by employees on health premiums and out-of-pocket expenses[2] • A 10% payroll tax on the self-employed (exempting the first $30,000 of payroll per self-employed resident) • 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) • Consolidation of public spending on health insurance • Consolidation of state and municipal health care spending	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 Establishes qualifications for eligible health care providers/facilities and rules governing reimbursement Provides patients with free choice of participating providers Provides that whenever individuals receive health care services under the Trust and they are entitled to coverage, reimbursement, etc. from a collateral source[3], they must notify the health care provider or facility and provide information identifying the collateral source and prove other relevant information

[2] 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.

[3] 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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			medical equipment, supplies, and appliances Provides coverage that is continuous without the need for repeated reenrollments or changes			• Federal sources of revenue	
MICHIGAN ***MIcare Act*** (HB 6285) **Current Status**: Introduced; referred to the committee of jurisdiction	Does not require an individual with health coverage other than MIcare to terminate that coverage Authorizes an individual enrolled in the Program to elect to maintain supplemental health insurance if they so choose *Private Carrier.* Requires the Program to act as the secondary payer with respect to any health service that may be covered in whole or in part by any other health benefit plan (e.g., private health insurance, retiree health benefits, or federal health benefit plans offered by the VA, by the military, or to federal employees) *Other Coverage*. If waivers are not obtained, provides that the Program will be the secondary payer with respect to any health service that may	Establishes the MIcare Program to be administered by the Department of Health and Human Services	Provides coverage for medically necessary benefits, including but not limited to: • Primary care • Preventive care • Chronic care • Acute episodic care • Hospital services • Mental health services • Prescription drugs • Medical devices • Dental, vision, and hearing care • Care for substance use disorder • Reproductive health care and obstetrical care • Long-term care • Laboratory services • Gender transition • Organ donation and transplantation • Treatment of autism spectrum disorders • Ambulance services • Hospice care Requires the benefits package to, at	Provides coverage to all residents of Michigan (a person who is not a resident of Michigan is not eligible under the Program) On implementation, makes a resident eligible under the Program, regardless of whether an employer offers health insurance for which he or she is eligible Allows health care professionals to presume an individual is eligible (makes necessary information available to health care professionals to ensure immediate enrollment for individuals at the point of service or treatment)	Prohibits inclusion of premiums or cost-sharing requirements Prohibits the imposition of deductibles, coinsurance, co-pays, or individual caps on coverage amounts	Creates the MIcare Fund as the single source to finance the Program, including all of the following: • Transfers or appropriations from the general fund, authorized by the legislature • If authorized by waiver, federal funds for Medicaid, Medicare, MIChild, and the exchange • The proceeds from grants, donations, contributions, taxes, and any other sources of revenue as may be provided by statute or rule • Administrative fines collected Requires the legislature to enact a separate piece of legislation establishing the state financing for the Program	Requires the Department to contract with outside entities to allow for the appropriate portability of coverage for Michigan residents who are temporarily out of state Prohibits the Program from discriminating in the design and administration of benefits or in the payment of claims based on sexual orientation, gender identity, disability, or other protected status Prohibits the Program from limiting coverage of preexisting conditions Requires the Department to monitor the extent to which residents of other states move to Michigan for the purpose of receiving health care Requires the insurance

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	be covered in whole or in part by Medicaid, MIChild, or Medicare		a minimum, include any EHBs for plans under federal law For individuals eligible for Medicaid, Medicare, or MIChild, requires the benefit package to include the benefits required by federal law, as well as any additional benefits provided as part of the Program's package				commissioner to apply to the federal government for state innovation waivers as necessary
NEW HAMPSHIRE ***New Hampshire Single Cure Act*** (HB 1793) **Current Status**: Introduced; referred to committees of jurisdiction; scheduled for public hearing/work sessions	*Private Carrier.* Prohibits a private health insurer from selling health insurance coverage that duplicates benefits under the program Does not affirmatively prohibit the sale of health insurance coverage for any additional benefits not covered under the program	Establishes the New Hampshire Health Services Governing Board	Provides covered benefits that include but are not limited to: • Primary care and prevention • Specialty care other than elective cosmetic • Inpatient care • Outpatient care • Emergency care • Prescription drugs • Durable medical equipment • Long-term care • Mental health services • The full scope of dental services, other than elective cosmetic dentistry • Substance abuse treatment services • Chiropractic services • Basic vision care and vision correction • Medical devices for appropriate clinical indication *Portability*. Benefits available through any licensed	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) Requires residents to fill out an application form, after which individuals will receive a program insurance card	Prohibits imposition of deductibles, co-payments, coinsurance, or other cost sharing with respect to covered benefits	Creates a non-lapsing, continually-appropriated Health Services Trust Fund to provide payment and reimbursement for the program 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.	Requires the program to "protect the rights and privacy of patients" in accordance with state and federal law Grants patients the right to access their medical records on demand Requires the insurance commissioner to apply to the federal government for state innovation waivers as necessary Requires the Board to initiate steps for a transition to a "no-fault" system for medical liability, away from the current tort-based approach. Establishes qualifications for participating providers

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			practitioner/facility anywhere in New Hampshire and 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.				and rules governing reimbursement Specifically addresses funding of long-term care services and mental health services, and reimbursement of prescription medications
NEW JERSEY ***New Jersey Public Option Health Care Act*** (A 1343/S 561) **Current Status**: Introduced; referred to the committees of jurisdiction	*Private Carrier.* Provides that coverage offered by the Program will compete in the market with insurance offered by private health insurers	Establishes the New Jersey Public Option Health Care Program within the New Jersey Department of Health Establishes the New Jersey Public Option Health Care Board to assist the Department of Health in administering the Program	Provides health care services required to be covered under any of the following: • NJ Family Care • Medicaid • Medicare • New Jersey Individual Health Coverage Program • New Jersey Small Employer Health Benefits Program • Any additional health care service authorized to be added to the Program's benefits by the Program	Provides coverage to every New Jersey resident Requires the health commissioner to determine when individuals may begin enrolling in the program and to establish an implementation period	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)	Establishes the New Jersey Public Option Health Care Trust Fund—a non-lapsing resolving fund that is the repository for monies collected/received to run the Program, including: • All monies obtained from premiums collected • Federal payments received as a result of any waiver granted or other arrangements agreed to by HHS • 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 • State monies for	Requires aggregate data of the Program to be public information Establishes qualifications for participating providers and rules governing reimbursement/payment methodologies 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

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						services and benefits covered under the Program	
NEW YORK ***New York Health Act*** (A 4738/S 4840/S 4371) *See* Memo in Support **Current Status**: Introduced; referred to committees of jurisdiction	*Private Carrier.* Allows an insurer to offer benefits that do not cover any service for which coverage is offered under the Program Prohibits a carrier from offering benefits that duplicate coverage offered under the Program Does not prohibit: • The offering of benefits to/for individuals who are employed or self-employed in the state but who are not residents of the state • The offering of benefits during the implementation period to individuals who enrolled or may enroll in the Program • The offering of retiree health benefits	Establishes the New York Health Program in the Department of Health	Provides comprehensive coverage, which includes all health care services required to be covered under any of the following: • Child Health Plus • Medicaid • Medicare • Entities regulated under state law (e.g., HMOs; life, accident and health, annuities; and non-profit medical and dental indemnity, etc.) • Health Benefits for State and Retired State Employees • Any additional health care service authorized to be added by the Program Provides that the Program will provide for payment for: • 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	Provides coverage to every resident of New York Authorizes the Department to determine when individuals may enroll in the Program and to establish an implementation period	Provides that no individual will be required to pay any premium or other charge (e.g., deductibles, copayments, or coinsurance) for enrolling in or being a member under the Program	Establishes the New York Health Trust Fund for monies collected/received to run the Program Provides that the Fund will consist of: • All monies obtained from taxes[4] • Federal payments received as a result of any waiver/other arrangements agreed to by the federal government • 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	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 Establishes qualifications for participating providers and rules governing reimbursement/payment methodologies

[4] 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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	Other Provider. 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 Allows the Department to apply for coverage under any 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		care coordinator • 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			benefits that are covered under the Program • Federal and state funds for the purposes of the provision of services authorized under Title XX of the Social Security Act • State monies that otherwise be appropriated to any governmental agency which provides health services covered under the Program	
OHIO SB 91/HB 440 *See* Legislative Analysis by the Ohio Legislative Service Commission[5]	*Employer (Generally).* 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	Establishes the Ohio Health Care Agency to administer the Ohio Health Care Plan Establishes the Ohio Health Care	Requires the Board to establish a benefits package that includes but is not limited to: • Inpatient and outpatient provider care, both primary and secondary • Emergency services • Emergency and other	Provides coverage to all Ohio residents and individuals employed in Ohio (including the homeless and migrant workers) Requires the Board to establish a procedure	Prohibits participants from being subject to copayments, deductibles, point-of-service charges or any	Establishes the Ohio Health Care Fund to finance the Plan Obtains funds from the following sources: • Federal financial participation following	Prohibits the Plan from excluding or limiting coverage due to preexisting conditions Contains anti-discrimination rules Grants participants

[5] 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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Current Status: Introduced; referred to the committees of jurisdiction	benefits so that, until the expiration of the employer's plan, the employer's benefits are at least equal to the Plan *Out-of-State Employer.* Provides that employee health coverage provided by an out-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 *In-State Employer.* 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 *Private Carrier.* 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 Prohibits insurers from providing benefits that	Board to direct the Agency in the performance of all its duties/develop health policy	transportation services to covered health care services; • Rehabilitation services, (e.g., speech, occupational, and physical therapy) • Inpatient and outpatient mental health services and substance abuse treatment • Hospice care • Prescription drugs and prescribed medical nutrition • Vision care, aids, and equipment • Hearing care, hearing aids, and equipment • Diagnostic medical tests, including laboratory tests and imaging procedures • Medical supplies and prescribed medical equipment • Immunizations, preventive care, health maintenance care, and screening • Dental care • Home health care services Excludes certain procedures/treatments from coverage (e.g., cosmetic surgery unless required to correct a congenital defect) Authorizes the Board to remove or exclude procedures, treatments,	to enroll eligible individuals and provide each covered individual with identification that providers may use to determine eligibility for health care services (presumption of eligibility exists when a person arrives at a health care facility unconscious or otherwise unable to document eligibility due to their mental/physical condition)	other fee or charge for a service within the package Prohibits participants from being directly billed by providers for covered health care services	approval of necessary waivers • Funds obtained from other federal, state, and local governmental sources and programs • Receipts from the 3.85% payroll tax[6] levied on employers • Receipts from the 3% tax levied on businesses' gross receipts • Receipts from 6.2% income tax on an individual's compensation in excess of the amount subject to the social security payroll tax • Receipts from a 5% income tax on all of an individual's Ohio adjusted gross income, less exemptions, in excess of $200,000	freedom to choose from participating providers Prohibits providers from being compelled to offer any particular service (provided it does not result in discrimination among patients) 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 Establishes qualifications for participating providers and rules governing reimbursement

[6] 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.

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	duplicate the health benefit package *Other Provider.* 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 secondary or supplemental coverage 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		equipment, drugs, etc. from the benefit package that the Board deems unsafe, experimental, of no proven value, etc.				
PENNSYLVANIA ***Pennsylvania Health Care Plan Act*** (SB 1014/HB 1688) **Current Status**: Introduced; referred to the committees of jurisdiction	*Private Carrier.* Authorizes private health insurers to offer coverage supplemental to the Plan's health benefits package *Other Provider.* 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 Serves as secondary or supplemental plan for veterans (unless reasonable/timely	Establishes the Pennsylvania Health Care Agency to administer the Pennsylvania Health Care Plan Establishes the Pennsylvania Health Care Board to direct the agency in the performance of its duties	Requires the Board to establish a benefits package that includes but is not limited to: • All medically necessary inpatient and outpatient care and treatment for both primary and specialty care • Emergency services • Emergency and other medically necessary transport to covered health services • Rehabilitation services (e.g., speech, occupational, physical, and evidence-based alternative therapy)	Provides coverage to: • Residents who file a Pennsylvania individual income tax return and any dependent thereof • Students from out-of-state who are attending school and file an individual income tax return in Pennsylvania • Part-year residents who file a	Prohibits participants from being subject to copayments, deductibles, point-of-service charges or any other fee or charge for a service within the package	Develops a Pennsylvania Health Care Trust Fund to finance the Plan Obtains funds from: • Money obtained through federal health care programs • Money from dedicated sources specified by the General Assembly • Receipts from the 10% payroll tax (generated as a result of an employer conducting	Prohibits the Plan from excluding or limiting coverage due to preexisting conditions Contains anti-discrimination rules Grants participants freedom to choose from participating providers (unless engaging in patterns of wasteful/abusive self-referrals to specialists)

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	access is denied or unavailable from the VA) *Out-of-State Employer.* Serves as secondary plan for Pennsylvania residents who work outside the state and receive coverage from an out-of-state employer	Establishes quality of care panels (e.g., health professional quality panel; health institution quality panel; health supplier quality panel) Establishes the Office of Health Care Ombudsman to represent the interests of plan and prospective participants	• Inpatient and outpatient mental health services and substance abuse treatment • Hospice care • Prescription drugs and prescribed medical nutrition • Vision care, aids, and equipment • Hearing care, hearing aids, and equipment • Diagnostic medical tests (e.g., laboratory testing and imaging procedures) • Medical supplies and prescribed medical equipment • Immunizations, preventive care, health maintenance, and screening • Dental care • Home health care services • Chiropractic • Complementary and alternative modalities that have been shown by BIH to be safe and effective for possible inclusion as covered benefits Excludes certain procedures/treatments from coverage (e.g., cosmetic surgery unless required to correct a congenital defect)	Pennsylvania individual income tax return Requires the Board to establish standards/procedure to demonstrate proof of eligibility (presumption of eligibility exists when a person arrives at a health care facility unconscious or otherwise unable to document eligibility due to a medical condition) Requires the Board to establish enrollment procedures Provides participants with smart technology cards with proof of identity technology		business within Pennsylvania)[7] • Receipts from the additional 3% personal income tax	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 Requires the development of an integrated health care database for health care planning and quality assurance Establishes qualifications for participating providers and rules governing reimbursement

[7] The bill prohibits employers from offsetting the payroll tax by reducing compensation or benefits paid to employees.

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RHODE ISLAND ***Rhode Island Comprehensive Health Insurance Act*** (S 2237/H 7285) **Current Status**: Introduced; referred to the relevant committees of jurisdiction	*Private Carrier*. Prohibits the sale of duplicative coverage Does not 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 benefits not provided by the Program) *Employer*. Does not create any employment benefit or require, prohibit, or limit the provision of any employment benefit *Other Provider*. 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 Makes the Program the equivalent of qualifying	Establishes the Rhode Island Comprehensive Health Insurance Program, an independent agency Establishes an advisory committee to provide analyses and recommendations about the Program, and collect general concerns of program participants	Provides coverage for services and goods deemed medically necessary by a qualified health care provider that is currently covered under: • Medicare • Medicaid • The state's Children's Health Insurance Program • All EHBs mandated by the ACA (along with some additional benefits like palliative care, approved dietary and nutritional therapies, podiatric care, etc.) Requires the Program to create a procedure that permits additional medically necessary goods/services beyond what is currently provided for by federal laws	Provides coverage to all qualified Rhode Island residents As a condition of eligibility, requires residents eligible for benefits under Medicare to enroll therein Requires the Program to establish procedures to determine eligibility, enrollment, disenrollment, and disqualification	Replaces current health insurance payments (e.g., premiums, copays, deductibles, and costs in excess of caps) with progressive contributions	Establishes a trust fund to finance the Program Obtains funds from: • Waivers related to Medicaid, CHIP, Medicare, and the ACA so that federal funds that would otherwise be paid to Rhode Island are deposited in the trust fund • State funds that would otherwise be appropriated for services/benefits covered under the Program • Private grants and other funds specifically earmarked for health care • Assignments from Program participants • Progressive contributions • Contributions based on earned income (e.g., a 10% payroll tax)[8]	Requires the health commissioner to seek all federal waivers/approvals Establishes qualifications for participating providers and rules governing reimbursement Requires the establishment of a prescription drug formulary system

[8] The payroll tax obligations for employers may be impacted by cross-border employees. As such, the bill providers 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 by covered by the Program.

Legislation	Employer, Private & Other Coverage	Governance	Benefits	Eligibility and Enrollment	Cost/Payment	Funding	Miscellaneous
	coverage under Part D and Medicare Advantage programs If necessary federal waivers are obtained, makes the Program the state's sole Medicaid provider If necessary waivers are not granted, retains Medicare and Medicaid as the primary insurers for those eligible for such coverage; leaves the Program as the secondary or supplemental plan Upholds the Program as secondary or supplemental coverage for veterans					• Contributions based on unearned income (e.g., a 10% tax) 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 the current "regressive health insurance payments" with "progressive contributions to a single payer"	

Exploratory Legislation

Legislation	Legislation/Status	Overview
CALIFORNIA	AB 2489 **Current Status**: Introduced	Requires California's Health and Human Services Agency to report to the legislature on the options for achieving universal health coverage, including: • The options for financing universal health coverage • The institutional mechanism by which universal coverage may be delivered • The extent and scope of the health coverage which all California residents may have Requires the report be submitted by January 1, 2023
	AB 2517 **Current Status**: Introduced; referred to	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 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

Legislation	Legislation/Status	Overview
	committees of jurisdiction	universal and unified publicly financed health care system, including: • A stakeholder engagement and analytical process by which key design features (e.g., covered benefits, eligibility, service delivery, etc.) are developed • The establishment of data collection and reporting systems to support management, evaluation, transparency, and public accountability • 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 • A consideration of the requirements necessary to seek federal waivers and federal statutory changes • A consideration of the requirements for state constitutional amendments • 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 • A feasible financing system and an analysis of the need for voter approval of any financing mechanism
DELAWARE	SCR 70 **Current Status**: 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
MASSACHUSETTS	H 596/S 610 **Current Status**: 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
NEW JERSEY	A 2269 **Current Status**:	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

Legislation	Legislation/Status	Overview
	Introduced; referred to committees of jurisdiction	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