2018 State Single-Payer Health Care Proposals

Legislative Tracking Chart

(September 11, 2018)

Single-Payer Proposal Status:

- Eleven states (FL, HI, IA, MD, MA, MI, NH, NY, OH, PA, and RI) have carried over or introduced single-payer health care bills to date in the 2018 legislative session.
- NJ has introduced a public option bill.
- HI also has a single payer study bill.
- Bills in FL, HI, IA, MD, MA, MN, MO, NH, NY, RI, WY have died.

Key Provisions of Bills:

- **Scope:** FL, HI, IA, MD, MI, NH, NY, OH, PA, and RI would impose a comprehensive single-payer health care system offering all state residents a defined set of benefits (or benefit categories).
  - RI also has a bill that would establish a single payer program for primary care services on a statewide basis.

- **Prohibition on Plans Offering Insurance:** FL, HI, MD, NH, NY, OH, and RI prohibit health insurers from providing health benefits or coverage for services offered under the state program.
  - NJ's public option would be one that would compete with existing health care plans.

- **Financing:** FL, NH, NJ, NY, OH establish a trust fund comprised of state and federal funds to finance the single payer system. Both states do provide some specifics (e.g., federal matching funds, premiums, taxes on employers) with respect to how funding will be provided.
  - HI does not discuss funding.
  - MI and RI require the governing authority to come up with a financing proposal.

- **Governing Authority:** FL, HI, IA, MD, MI, NH, NY, OH, PA, and RI establish a board to govern the single-payer health care system.

- **Study Bill:** MA has a bill requiring the review of single payer health care systems in other states and countries.

Medicaid Buy-in Proposal Status: Several states that are looking at bills this legislative session that are not single-payer proposals in the traditional sense, but which propose Medicaid buy-in programs.

Nine states (CA, HI, IA, MD, MA, MN, MO, NM, and WY) have introduced bills that address a Medicaid buy-in program.

- IA, MN, MO have bills requiring application of federal waivers to implement a Medicaid buy-in program. Bills in HI, IA, MD, and WY have died.
- CA, HI, MD, NM, and WY have introduced study bills exploring the feasibility of a Medicaid buy-in program.
  - NM is the only study bill that has been enacted.

- CA's bill has passed both chambers and has been sent to the governor for his signature.

State	Status	Provisions
California CA AB 2472	Introduced 2/14/2018. Passed the Assembly 5/25/2018 with amendments. Passed the Senate 8/20/2018 with amendments. Assembly concurs with Senate amendments 8/22/2018. Enrolled and presented to the governor for signature 9/5/2018.	**Medicaid Buy-In:** • Requires the Council on Health Care Delivery Systems to prepare a feasibility analysis to determine the feasibility of a public health insurance plan option. Requires the analysis to contain, among other things, an actuarial and economic analysis of a public health insurance plan and an analysis of the extent to which a new public health insurance plan option could address the underlying factors that limit health plan choices in some regions. • Requires the Council to submit the analysis to the legislature and the governor on or before October 1, 2021.
Florida HB 1385	**DIED**	**Establishment of Program**: Establishes Healthy Florida to provide universal health coverage for Floridians through a single payer coverage program. Would consolidate all existing state programs into one program. Would seek necessary waivers. **Governing Authority:** Creates a governing board (Board) for the program. **Funding:** Does not address funding of the program except to say that the Board shall file for appropriate waivers to ensure any federal funding from existing programs being now covered by the Healthy Florida program. **Prohibitions:** • Prohibits health carriers from offering benefits or covering services for which coverage is offered to individuals under the program but may offer benefits to cover health services not offered. ▪ A member may enroll with and receive program care coordination and ancillary health care services form a health care organization. Requires such organization to be a not-for-profit or governmental entity that is approved by the Board that is either: a county integrated health and human services program, or a reginal center for persons with developmental disabilities.

State	Status	Provisions
		• Prohibits residents enrolling in the program from paying a fee for enrolling or paying a premium, copayment, coinsurance, deductible other cost sharing for enrollment into the program. **Benefits:** Covered benefits under the program include all medical care determined to be medically appropriate by the member's health care provider. Covered benefits include but not limited to: • licensed inpatient and outpatient medical and health facility services; • inpatient and outpatient professional health care provider medical services; • diagnostic imaging, laboratory services, and other diagnostic and evaluative services; • medical equipment, appliances, assistive technology including prosthetics, eyeglasses, and hearing aids; • impatient and outpatient rehabilitative care; • emergency services and transportation; • child and adult immunizations and preventive care; • health and wellness education; • hospice, skilled nursing services, home health care; • mental health and substance abuse services and treatment; • dental and vision care; • prescription drugs; • pediatric care, pre-and post-natal care; • podiatric, chiropractic, and acupuncture care; • therapies shown by the NIH as safe and effective; • blood, blood products, and dialysis; • adult day care and long-term supportive services; • rehabilitative and habilitative services; • care coordination; and • any benefit currently covered by Medicaid, CHIP, health care service plans, health insurers, essential health benefits. **Reimbursement for Health Services:** • Requires the Board to adopt rules for contracting for, and establishing payment methodologies for, covered health care services and care coordination provided. • Services, except care coordination, must be paid for on a FFS basis unless another payment methodology is established by the Board. • All payment rates must be "reasonable and reasonably related to the cost of efficiently providing the health care services and ensuring adequate and accessible supply of services.

State	Status	Provisions
		• Integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive and coordinated services may choose to be reimbursed based on a capitated system operating budget or a non-capitated system operating budget that covers all costs of providing health care services. • Prohibits providers from charging any member any rate more than the payment established for provided services. **Standards of Care:** Requires the establishment of a single standard of safe therapeutic care for all residents consistent with applicable professional practice and licensure standards of health care providers and health care professionals.
Hawaii **SB 2050**	**DIED**	**Medicaid Buy-In:** • Requires DHS to allow an earned income disregard (which allows individuals with disabilities to earn income and not lose their Medicaid benefits) of 138% FPL for people with disabilities between ages 16 and 64. Requires Department to evaluate the program annually and assess whether, when, and how a full Medicaid buy-in program may be implemented.
Hawaii HB 1717	**DIED**	**Study:** Requires the Legislative Reference Bureau to conduct a study on the costs and effects in the state of implementing a single-payer health care system similar to the federal Medicare program. Appropriates funds to conduct the study.
Hawaii SB 2207	**DIED**	**Establishment of Program:** Establishes a single-payer universal health care insurance system to provide medically necessary health care to all Hawaii residents. **Governing Authority:** Establishes within the Department of Health, the state Health Care Insurance Planning and Financing Authority (Authority) to determine the costs of the system and to gather the needed financing methods and transition mechanisms. **Prohibitions:** • Prohibits private health care insurers from duplicating the coverages provided by the single-payer universal health care insurance system.
Iowa	**DIED**	**Medicaid Buy-In:**

State	Status	Provisions
SF 2035/HF 2002		• The DHS shall establish a public health care option using the Medicaid program as a buy-in option. • Requires the submission of necessary waivers to CMS.
Iowa HB 2352	**DIED**	**Establishment of Program:** Establishes a Healthy Iowa Agency as an independent agency responsible for the planning, development, implementation, and regulation of comprehensive, universal single-payer health care coverage and a health care cost control system. By July 1, 2020 requires the Board (see below) to develop a proposal to implement a universal single-payer health care system for the state of Iowa. **Governing Authority:** Creates a Healthy Iowa Board to oversee the administration of the Health Iowa program. Establishes the Healthy Iowa Advisory Committee to advise the Board on all maters of policy related to the Healthy Iowa program. **Funding:** Creates a special fund within the state treasury, separate for other public moneys to be known as the Healthy Iowa Trust Fund. The fund shall consist of: • All moneys appropriate by the state; • All moneys received by the federal government as the result of waive requirements for other programs; • All moneys transferred to the fund via Medicare and Medicaid; and • State taxes for imposed for the program. **Prohibitions:** • Prohibits insurers, carriers, or HMOs from offering benefits or coverage for any services for which coverage is offered to individuals under the Healthy Iowa program. They may only offer benefits (1) that do not duplicate the health care services available under Health Iowa; (2) benefits available to individuals and their families who are employed or self-employed in the state but who are not residents; and (3) benefits available during the implementation period to individuals who enroll or may enroll in the Healthy Iowa program. **Eligibility and Enrollment:** Each resident is eligible and entitled to enroll as a covered member in and receive benefits for health care services covered by the Healthy Iowa program. Members shall not pay a fee, payment or other charge for enrolling in the program. Prohibits providers from requiring members to pay a premium, copayment, coinsurance, or deductible for any covered health care service. **Benefits:** Covered benefits include all medical care that is medically necessary as determined by the member's treating physician in accordance with standards established by the program. Covered services include inpatient and outpatient care, preventive services, emergency services and transportation,

State	Status	Provisions
		prescription drugs, lab services, hospice, rehabilitative care, medical equipment, dental, podiatric, chiropractic and acupuncture, language interpretation and translation. **Rates and Payment:** • Requires the Board to adopt rules regarding contracting and establishing payment methodologies. • Requires payment methodologies to be reasonable and reasonably related to the cost of efficiently providing care. • Providers shall be paid on a FFS basis unless the Board establishes another payment methodology. • Prohibits balance billing. Payment to providers are considered payment in full. • The program shall negotiate in good faith negotiations with provider representatives to develop payment rates for health care services and prescription and nonprescription drugs.
Maryland HB 1312/ SB 878	**DIED**	**Medicaid Buy-In:** HB 1312 - Establishes a Medicaid buy-in task force to make recommendations regarding the feasibility of a Medicaid buy-in program to expand coverage choices for Maryland residents. SB 878 – Establishes a Medicaid buy-in commission to study and make recommendations regarding the feasibility of a Medicaid buy-in program to expand coverage choices for Maryland residents.
Maryland HB 1516/SB 1002	**DIED**	**Establishment of Program:** Establishes the Healthy Maryland program to provide comprehensive universal single-payer health care services for all residents of the state. **Governing Authority:** Establishes the Healthy Maryland Board to oversee and administer the program. **Prohibitions:** Prohibits carriers from offering benefits or coverage of any services for which coverage is offered to individuals under Healthy Maryland. **Funding:** Establishes a trust fund to collect money from various sources to fund the program. Funding shall come from: • federal funding via Medicare, Medicaid, CHIP, ACA or other federal programs; • state appropriations; and • payroll premiums. **Reimbursement for Health Services:**

State	Status	Provisions
		• Requires the Board to adopt regulations regarding establishing payment methodologies. Methodologies must be reasonable and reasonably related to the cost of efficiently providing the health care service and ensuring an adequate and accessible supply of health care services. • Except for care coordination, health care services shall be paid for on a FFS basis unless the Board establishes another payment methodology. Medicare rate of reimbursement constitutes a reasonable FFS payment rate. • Integrated health care delivery systems, essential community providers, and group medical practices that provide comprehensive and coordinated services shall be reimbursement based on a capitated or non-capitated system operating budget. • Prohibits balance billing. Provider payments by the state are considered payment in full. **Benefits:** Benefits include all medical care provided to a member that is medically necessary as determined by the member's treating physician. They include: care coordination, inpatient and outpatient care medical care, medical equipment, rehabilitative care, emergency services and transportation, preventive care, hospice, mental health and substance abuse services, prescription drugs, vision and dental care, podiatric, chiropractic and acupuncture services, adult day care, long-term services and supports, language interpretation, and all services mandated as essential health benefits.
Massachusetts SB 2211	Introduced 11/9/2017. Passed Senate 11/9/2017. Carried over to 2018 session.	**Medicaid Buy-In:** Gives the state the option to offer a Medicaid product that includes employers of Medicaid eligible individuals, and to expand coverage options to consumers. Requires the Health Connector to study the feasibility of establishing a small employer premium sharing program for coverage of nondisabled, non-elderly adults with incomes below 138% of FPL and their dependents for participation in Medicaid.
Massachusetts HB 596	**DIED**	Requires the Center for Health Information and Analysis (Center) to monitor, review and evaluate reports related to a single payer health care system in other states and countries. Requires the Center to establish a single payer benchmark that shall be an estimate of the total cost of providing health care to all residents of Massachusetts. If at the outset of FY 2018 the Health Policy Commission Board (Board) determines that the single payer benchmark has outperformed the actual total health care spending and spending growth in the state, to, no later than June 30, 2019, submit a Single Payer Health Care Implementation Plan to the legislature for consideration.

State	Status	Provisions
Michigan HB 6285	Introduced 8/15/2018 and referred to House Committee on Health Policy. Session is in recess.	**Establishment of Program:** Establishes MIcare as the universal health care system designed to provide health coverage through a public administrative system and single claims payment system. Requires all necessary waivers and exemptions to be obtained by the federal government in order to implement the program. **Governing Authority:** Creates the mechanism for the MIcare Board to administer the program. Requires the Board to develop, among other things, • an administration and delivery system that is publicly financed and administered including receipt of a waiver from the federal health benefit Exchange requirement from HHS; • a strategic plan that includes time lines and allocations of the responsibilities associated with health care reform, including to improve outcomes; • appropriations and planning necessary to ensure adequate, well trained primary care workforce; • a plan to consolidate multiple payment sources into a single payment system; • a plan to unify health system planning, regulation, and public health; • a quality improvement plan; • enforcement mechanisms; • set rates for health professionals and make adjustments to rules on reimbursement methodologies; • a method for cost containment and limiting the growth in expenditures for health services; • adequacy of supply and distribution of health resources; and • a benefit package. Establishes eligibility requirements for Board appointments. **Funding:** Before implementing MIcare and annually thereafter, requires the Board to recommend to the legislature and governor a 3-year MIcare budget, to be adjusted annually in response to realized revenues and expenditures, that includes appropriations, revenue estimates, and necessary modifications to tax rates, feels and other assessments. **Eligibility:** All residents of Michigan are eligible for MIcare. **Benefits:** Requires the Board to use the benefit package for qualified health plans under the Exchange as a basis for creating the benefits under MIcare.

State	Status	Provisions
Minnesota SB 58	**DIED**	**Medicaid Buy-In:** • Requires the Commissioner of Human Services to seek necessary federal waivers to establish a program that allows individuals with income above the maximum income eligibility limit under MinnesotaCare, who otherwise meet MinnesotaCare eligibility, that allow such individuals the option of purchasing coverage through MinnesotaCare instead of purchasing a qualified health plan through MNsure. • Waivers shall also be sought to allow such individuals who choose to purchase the MinnesotaCare option to use advanced tax credits and cost sharing credits, if eligible to purchase this option.
Missouri HB 1603	**DIED**	**Medicaid Buy-In**: Establishes the Missouri Health Care Plan within the Missouri HealthNet program to allow individuals who are not otherwise eligible for Medicaid to purchase coverage through the plan. Requires the department to apply to CMS for necessary waivers to implement the program.
New Hampshire HB 1793	**DIED**	**Establishment of Program:** Establishes the New Hampshire Health Services Program to provide universal access to health care for all individuals residing in New Hampshire. **Governing Authority:** Creates a governing board for the program. **Funding:** Establishes the New Hampshire Health Services Trust (NHHST) Fund for funding the program. Funding of the NHHST shall include, but is not limited to, all of the following: • Funds appropriated for health care as outlined by the state on a yearly basis. • All federal funds that are designated for health care, including, but not limited to, all funds designated for Medicaid. The trust shall be authorized to negotiate with the federal government for funding of Medicare recipients. • Public and private grants and contributions. • Any other funds specifically ear-marked for health care or health care education such as settlements from litigation. The total overhead and administrative portion of the program budget shall not exceed 12% of the total operating budget of the program for the first 2 years that the program is in operation; 8 percent for the following 2 years; and 5 percent for each year thereafter. **Benefits:**

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		• Benefits shall be available through any licensed health care practitioner or facility in the state that is legally qualified to provide such benefits and for emergency out-patient and inpatient care anywhere in the U.S. • Out-of-state non-emergency services shall be covered if not available within New Hampshire. • There will be no deductibles, co-payments, coinsurance or other cost sharing except for services that exceed "basic covered benefits." • Covered services include primary care, specialty care other than elective cosmetic, inpatient and outpatient care, emergency care, prescription drugs, DME, long-term care, mental health services, dental services (except cosmetic), substance abuse treatment, chiropractic services, basic vision care and correction, and medical devices for appropriate clinical indication. **Reimbursement for Health Services:** • Providers can choose to be paid on a fee-for-service basis, or salaried by institutions or salaried by group practices. FFS providers shall be paid according to a fee schedule negotiated between physician representatives and the program on an annual basis. • Facilities shall be paid a monthly lump sum payment to cover all operating expenses. The hospital and program shall negotiate the amount of this payment annually based on past budgets, clinical performance, and projected changes in demand for services and input costs and proposed new programs. Hospitals shall not bill patients for services covered by the program and shall not use any of their operating budgets for expansion, profit, excessive executive income, marketing, or major capital purchases or leases. The program budget shall separately fund major capital expenditures including the construction of new health facilities and the purchase of durable equipment. • The program shall pay for all covered prescription drugs, devices, and durable medical supplies according to a fee schedule negotiated between the program and manufacturers, vendors and suppliers on an annual basis. Where therapeutically equivalent drugs are available, the formulary shall specify the use of the lowest-cost medication, with exceptions available in the case of medical necessity. **Prohibitions:** • Prohibits private health insurers from selling health insurance coverage that duplicates the benefits provided by the program. Nothing in this chapter shall be construed as prohibiting the sale of health insurance coverage for any additional benefits not covered by the program.
New Jersey AB 1343	Introduced 1/9/2018 and referred to Assembly Committee on Financial Institutions and Insurance.	**Establishment of Program:** Creates the "New Jersey Public Option" within the Department of Health. Requires the Commissioner of Health, in consultation with the Commissioner of Banking and Insurance, to establish and implement the program, which will provide a comprehensive health insurance coverage option to every State resident who enrolls in the program.

State	Status	Provisions
		• The health insurance coverage offered by the program shall compete in the market with insurance offered by private health insurers. **Governing Authority:** Creates the New Jersey Public Option Health Care Board to oversee the program. **Funding:** • Requires the commissioner to seek all federal waivers and other federal approvals to appropriate federal moneys under Medicare, Medicaid, other federally-matched public health program, the Affordable Care Act, and any other federal programs that provide federal funds for payment for health care services, that are necessary to enable all New Jersey Public Option Health Care Program. • Requires the Commissioner of Health is to establish premiums for which members are responsible and other charges for enrolling in or being a member under the program. The premium shall be determined in a manner to make the program viable, but at the lowest possible cost to members. **Eligibility:** All residents of the State are eligible to enroll as a member under the program. **Benefits:** The program shall provide comprehensive health coverage to every member. The commissioner shall also determine premiums, deductibles, co-payments or co-insurance under the program. **Standards of Care:** • The commissioner is also required to establish and maintain procedures and standards for health care providers to be qualified to participate in the program. • Every participating provider is required to furnish to the program such information to, and permit examination of its records by, the program, as may be reasonably required for purposes of reviewing accessibility and utilization of health care services, quality assurance, and cost containment, the making of payments, and statistical or other studies of the operation of the program or for protection and promotion of public, environmental and occupational health. **Reimbursement for Health Services:** The program shall engage in good faith negotiations with health care providers' representatives including, but not limited to, in relation to rates of payment and payment methodologies.
New Mexico	**ENACTED**	**Medicaid Buy-In:**

State	Status	Provisions
HM 9/SM 3		• Charges New Mexico legislative council to charge the legislative Health and Human Services Committee with exploring the policy and fiscal implications of offering a Medicaid buy-in plan.
New York AB 4738	**DIED**	**Establishment of Program:** Creates the New York Health Program to provide a universal single payer health plan for every New Yorker. Requires all necessary waivers and exemptions to be applied for with the federal government. **Governing Authority:** Creates the Board of the New York Health Program to administer the program. Establishes criteria for Board participation. **Funding:** Requires funding to come from broad-based revenue based on ability to pay. **Prohibitions:** Prohibits insurers from offering coverage of benefits within the Program. They may provide coverage for services not provided by the Program. **Reimbursement for Health Services:** Move away from FFS toward alternative payment methodologies such as global or capitated payments to providers or health care organizations that promote quality, efficiency, investment in primary and preventive care, and innovation and integration in the organizing of health care. **Eligibility and Enrollment:** Every resident of New York is eligible to enroll in the Program. No individual is required to pay any premium or other change for enrolling in or being a member under the Program. **Benefits:** Requires the program to provide comprehensive health coverage to every member which shall include all health care services required to be covered under any of the following, without regard to whether the member would otherwise be eligible for or covered by the program referenced: • Child Health Plus, • Medicaid and Medicare, • Individual and group health insurance contracts, and • Nonprofit medical and dental indemnity or health and hospice services.
Ohio HB 440	Introduced 12/7/2017. Session is in recess.	**Establishment of Program:** Creates the Ohio Health Care Plan, to provide universal and affordable health care coverage for all Ohio residents, consisting of a comprehensive benefit package that includes benefits for prescription drugs.

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		Governing Authority: The program shall be administered by the Ohio health care agency under the direction of the Ohio health care board. Creates seven regional health advisory committees to assist the board in overseeing management of the program across the state. **Funding:** • The Ohio health care board shall prepare and recommend to the general assembly an annual budget for health care that specifies and establishes a limit on total annual state expenditures for health care provided. • The budget shall include all of the following components: (1) A system budget covering all expenditures for the system; (2) Provider budgets for the fee-for-service and integrated health delivery system and for individual health care facilities and their associated clinics; (3) A capital investment budget; (4) A purchasing budget; (5) A research and innovation budget. Funding of the Ohio health care plan shall be obtained from state and local appropriated programs, federal appropriate programs, payroll taxes on employers, taxes on business gross receipts, and individual income taxes. The Ohio health care board shall limit administrative costs to 5% of the system budget and shall annually evaluate methods to reduce administrative costs and report the results of that evaluation to the general assembly. **Prohibitions:** • Health care insurers, health insuring corporations, and other persons selling or providing health care benefits may deliver, issue for delivery, renew, or provide health benefit packages that do not duplicate the health benefit package provided by the Ohio health care plan, but shall not, except as provided by division **Reimbursement for Health Services:** • Providers shall choose whether they will be compensated as fee-for-service providers or as part of a capitated provider network. • The budget for fee-for-service providers shall be divided among categories of licensed health care providers in order to establish a total annual budget for each category. • The board shall negotiate fee-for-service reimbursement rates or salaries for licensed health care providers. In the event negotiations are not concluded in a timely manner, the board shall establish the reimbursement rates. **Benefits:** The Ohio health care board shall establish a single health benefits package that shall include, but not be limited to, all of the following:

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		• Inpatient and outpatient provider care, both primary and secondary; • Emergency services, including transportation services to covered health care services; • Rehabilitation services, including 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, both durable and nondurable; • Immunizations, preventive care, health maintenance care, and screening; • Dental care; and • Home health care services. The Ohio health care plan shall not exclude or limit coverage of its participants' pre-existing conditions. Residents enrolled in the Ohio health care plan are not subject to copayments, point-of-service charges, or any other fee or charge, and shall not be directly billed by providers for covered health care services provided to the resident. Any employer operating in this state and providing employees with benefits under a public or private health care policy, plan, or agreement as of the date that benefits are initially provided, which benefits are less valuable than those provided by the Ohio health care plan, may participate in the Ohio health care plan or shall provide additional benefits so that, until the expiration of the policy, plan, or agreement, the benefits provided by the employer at least equal the amount and scope of the benefits provided by the Ohio health care plan. If an employer chooses to provide additional benefits to match or exceed the benefits provided by the Ohio health care plan, the additional benefits shall include the employer's payment of any employee premium contributions, copayments, and deductible payments called for by the policy, contract, or agreement. Employers are exempt from all health taxes imposed until the expiration of the policy, plan, or agreement, at which point the employer and the employer's employees become participants in the Ohio health care program.
Pennsylvania SB 1014/ HB 1688	SB 1014 Carried over from 2017 session.	**Establishment of Program:** Establishes the Pennsylvania Health Care Plan to provide health care coverage for residents of the state. **Governing Authority:** Creates the Pennsylvania Health Care Board. Outlines criteria for Board appointees.

State	Status	Provisions
	Referred to Senate Committee on Banking and Insurance 2/9/2018. HB 1688 Carried over from 2017 session.	**Funding:** • Establishes the Pennsylvania Health Care Trust Fund. • Revenue sources shall include funds obtained through federal health care programs and funds from dedicated sources specified by the General Assembly. • Imposes a 10% payroll tax from employers in the state. **Benefits:** • Requires the Board to annually adopt a health care benefits package for plan participants. • Requires the package to include: ▪ all medically necessary inpatient and outpatient care and treatment for both primary and specialty care; ▪ emergency services including transport services; ▪ rehabilitation services including speech, occupational, physical, and evidence-based alternative therapy; ▪ inpatient and outpatient mental health and substance abuse treatment; ▪ hospice care; ▪ prescription drugs and prescribed medical nutrition; ▪ vision and hearing care including aids and equipment; ▪ medical supplies and prescribed medical equipment; ▪ immunizations, preventive care, health maintenance care and screening; ▪ dental care; ▪ home health care; ▪ chiropractic; • Plan participants are not subject to copayments, deductibles, point-of-service charges, or any other fee or charge for a service within the package. • Prohibits balance billing. **Eligibility:** • Requires the Board to implement statutory eligibility standards for health care benefits. • Requires the Board to establish an enrollment system that will ensure that eligible residents are knowledgeable and aware of their rights to health care and are formally enrolled in the plan. • Individuals may enroll as participants of the Plan if they are residents of the state who files a Pennsylvania individual income tax return; students from out-of-state who are attending school in the state and file a Pennsylvania tax return; or part-year residents who file a Pennsylvania individual tax return.

State	Status	Provisions
		Reimbursement to Providers: • Requires the Board to annually review the appropriateness and sufficiency of reimbursements for health care services and consider whether a charge is fair and reasonable for its metropolitan statistical area. • Requires the Board to provide for timely payments to participating providers through a structure that is well organized and that eliminates unnecessary administrative costs. • Requires the Board to implement standardized claims and reporting methods for use by the plan. • Requires the Board to develop a system of centralized electronic claims and payments accounting. • The Plan shall reimburse providers practicing outside of the state at plan rates. Services provided to a participant outside of Pennsylvania by other than a participating provider shall be reimbursed to the participant or the provide at plan rates. • Reimbursements shall be determined by the Board to assure that participating provider receives compensation for services that fairly and fully reflect the skill, training, outcomes, etc… of the provider. • The Plan shall review fee schedules and may offer reimbursement mechanism, including capitation, salary and bonuses.
Rhode Island HB 7285/SB 2237	**BILLS DIED**	Repeals the Rhode Island Health Care Reform Act of 2004. **Establishment of Program:** Establishes the Rhode Island Comprehensive Health Insurance Program (RICHIP) to provide universal comprehensive affordable single-payer health care insurance program. **Governing Authority:** Creates RICHIP as an independent state government authority. **Funding:** • Establishes a trust fund to hold funds collected. • Requires the RICHIP to submit to the governor and general assembly a plan to provide revenue necessary to finance the program. The proposal shall consider savings by moving to a single payer system, government funding available, and private funding available. **Benefits:** Establishes comprehensive benefits including primary care, inpatient and outpatient care, emergency services and transportation, mental health and substance abuse services, prescription drugs, vision and dental care, approved nutritional and dietary therapies, palliative care, physical therapy, chiropractic care, lab services, medical devises, hearing services, and all services mandated as an essential health benefit under the ACA.

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		Reimbursement for Health Services: • RICHIP reimbursements to providers shall match the highest reimbursement rates offered by Medicare or Medicaid in Rhode Island. • Prohibits balance billing. Reimbursements by the state are considered payment in full. **Prohibitions:** • Prohibits private health insurers to sell health insurance coverage that duplicates the benefits provided under the program. • Allows private health insurance coverage for any additional benefits not covered by the program.
Rhode Island SB 2610	**BILL DIED**	**Single Payer for Primary Care:** • Requires the Office of the Health Commissioner (OHC) to establish a statewide system to ensure that affordable and quality primary care are available and accessible to all residents. • Requires the OHC to: ▪ identify one or more geographic regions of the state's primary care community health districts; ▪ designate one or more nonprofit organizations as a primary care trust responsible for the delivery of primary care and essential health services in each primary care community health district; ▪ in consultation with the department of health, establish a program and administrative standards for a primary care trust; ▪ monitor the capacity and ability of each primary care trust fulfill their responsibilities to residents of the community health district; and ▪ establish standards and procedures to fund the primary care trusts by annual primary care trust assessments paid by health insurers. **Single Payer Primary Care Trusts:** ▪ Requires the OHC to establish annually, through a rate-setting process, a primary care trust assessment to fund the primary care trust program. The assessment shall be equal to 10.7% of total projected medical spending by each health insurer doing business in the state. ▪ At the conclusion of the rate-setting process, the office shall issue an allocation order apportioning each insurer's assessment among designated primary care trusts based on the population of the community health region and the essential health needs of the community health region. ▪ The office may permit variations from the 10.7% assessment, not to exceed plus or minus 0.5% to account for changed circumstances and the primary care and essential health care

State	Status	Provisions
		needs of residents. The OHC shall have jurisdiction over all health insurers in the state for purposes of imposing the primary trust fund assessment. ▪ The primary care trust assessment shall constitute a health care service funding contribution. The primary care trust assessment shall be administered, collected, and enforced as a health care services funding contribution, except that each health insurer shall pay its assessment directly to one or more primary care trusts with the allocation order issued by the office at the conclusion of the annual rate-setting process. ▪ The primary care trust will be, among other things, responsible for the delivery of primary care services within its community health district; provide primary care services to all residents of the community health district; and provide essential health services and expand the availability of essential health services to all residents of the community health district.
Wyoming SB 88	**DIED**	**Medicaid Buy-In:** • To the extent authorized under federal law, the Department of Health shall make coverage through Medicaid available for purchase to any person who is not otherwise covered by Medicaid through an application made to the department in a manner established by rule or if the federal HHS grants any necessary waiver through the federal health benefits exchange. • Monthly premiums charged shall be set through the department. Allows age rating, and the imposition of cost sharing. • Imposes an annual open enrollment period for buy-in. Allows employers to contribute toward the premium on behalf of an employee if the employee chooses to forgo any private health benefit plan offered by the employer.