2021 Health System Costs Tracker

State	Bill	Category	Status	Summary	Sponsor
AK	HB 113 / SB 93	APCD	Referred to House Committee on Labor and Commerce / Referred to Senate Committee on Finance	This measure establishes an all-payer health claims database.	By Request of the Governor
CT	HB 6397	APCD	Referred to House Committee on Labor and Public Employees	This measure requires employers that pay for employees' workers' compensation medical claims to submit such claims to the all-payer claims database.	Public Health Committee
CT	SB 217	APCD	Referred to House Committee on Insurance and Real Estate	This measure expands reporting requirements that are imposed on the Insurance Commissioner, health carriers, and managed care organizations concerning the all-payer claims database and mental and behavioral health.	Sen. Kevin Kelly (R)
GA	SB 1	APCD	Referred to Senate Committee on Health and Human Services	This measure amends definitions related to the Georgia All-Payer Claims Database so that entities that receive certain tax credits and that provide self-funded, employer sponsored health insurance plans are considered submitting entities.	Sen. Dean Burke (R)
IN	HB 1402	APCD	Signed by Governor	This measure establishes the all-payer claims database advisory board and provides requirements for the development and administration of an all-payer claims database. The bill also requires the establishment of a fee formula for data licensing and claims data collection and release.	Rep. Donna Schaibley (R)
KY	HB 74	APCD	Introduced	This measure requires the executive director of the Office of Health Data and Analytics to establish an advisory board to make recommendations regarding the creation of a Kentucky all-payer claims database, establishes the Kentucky all-payer claims database fund, requires the executive director to establish the database if certain conditions are met, sets forth requirements for the database, requires the commissioner of the Department of Insurance to assist, and requires the commissioner to promulgate administrative regulations designating the assessment of a fine for persons that do not comply with reporting requirements. The executive director shall seek and accept grants or raise funds from any available source, public or private, to support the development, implementation, operation, and maintenance of a Kentucky all-payer claims database. All funds raised by the executive director and any fees or fines collected under this Act shall be deposited into the Kentucky all-payer claims database fund.	Rep. Cherlynn Stevenson (D)

MN	HF 59 / SF 128	APCD	Passed House Committee on Judiciary Finance and Civil Law; rereferred to House Committee on Commerce Finance and Policy / Referred to Senate Committee on Health and Human Services Finance and Policy	This measure amends the all-payer claims database data submission and use provisions so that all health plan companies and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. All-payer claims data may be used to identify individual payers and individual providers, and the data published may identify individual hospitals, clinics, or other providers. This bill also directs the commissioner of health to develop recommendations to expand access to data in the all-payer claims database.	Rep. Steve Elkins (D) / Sen. Rich Draheim (R)
NV	AB 348	APCD	Signed by Governor	This measure transfers the Patient Protection Commission from the Office of the Governor to the Office of the Director of the Department of Health and Human Services and revises the membership of the commission. Under the bill, the commission is required to establish a plan to increase access by patients to their medical records and provide for the interoperability of medical records between providers of health care, and make certain recommendations to the director and the legislature concerning the use and availability of data relating to health care. Additionally, the bill designates the commission as the sole agency responsible for administering and coordinating matters relating to the state's participation in the Peterson-Milbank Program for Sustainable Health Care Costs. The bill had language stripped out that would have required the commission to establish an all-payer claims database of information relating to health insurance claims resulting from medical, dental, or pharmacy benefits provided in the state. Any public or private insurer that provides health benefits and is regulated by state law would be required to submit data to the database. The original bill would have also created the Patient Protection Commission Advisory Committee, made up of providers of health care and related services, to advise the Commission.	Asm. Maggie Carlton (D)
NV	SB 40	APCD	Passed Senate; referred to Assembly Committee on Ways and Means	This measure authorizes the Patient Protection Commission to request reports concerning certain issues relating to health care from a state or local governmental entity, and requires any data contained in such a report to be presented in a manner that complies with applicable privacy laws; and requires the Department of Health and Human Services to establish an all-payer claims database of information relating to health insurance claims resulting from medical, dental, or pharmacy benefits provided in this state. The department is authorized to establish an advisory committee to assist the department in establishing and maintaining the database. Any public or private insurer that provides health benefits and is regulated under state law is required to submit data to the database, and certain insurers that are regulated under federal law are authorized to submit data to the database.	Senate Committee on Health and Human Services
OR	HB 2044	APCD	Failed House with possible reconsideration	This measure allows the Department of Consumer and Business Services to access data in the All-Payer All Claims database by certifying data will only be used to carry out the department's duties.	Gov. Kate Brown (D)
TN	HB 114	APCD	Withdrawn	This measure adds reporting on the cost, utilization, and effectiveness of the all-payer claims database to the general assembly annually on Feb. 15 to the commissioner of finance and administration's duties related to the database.	Rep. Robin Smith (R)

TN	HB 766 / SB 725	APCD	Signed by Governor / Companion House bill substituted	This measure clarifies that "patient certificate and license numbers," instead of "patient certificate/license numbers," are prohibited from being included in transmissions by a group health plan or health insurance issuer to designated entities for the all payer claims database.	Rep. William Lamberth (R) / Sen. Jack Johnson (R)
TN	HB 1258 / SB 1278	APCD	Deferred to Summer Study in House Committee on Insurance / Introduced	This measure requires the Commissioner of Finance and Administration to report annually on Feb. 15 to the General Assembly on the cost, utilization, and effectiveness of the all payer claims database.	Rep. Robin Smith (R) / Sen. Reeves (R)
TX	HB 1907 / SB 1135	APCD	Passed House; referred to Senate Committee on Business and Commerce / Referred to Senate Committee on Business and Commerce	This measure establishes a statewide all-payer claims database to store publicly accessible information.	Rep. Armando Walle (D) / Sen. Lois Kolkhorst (R)

State	Bill	Category	Status	Summary	Sponsor
AR	HB 1064	Transparency	Sine Die at Adjournment	This measure requires a hospital licensed by the state to submit information on reimbursement rates to the Insurance Commissioner who shall compile and publish an insurer's reimbursement rate for a hospital in the state as collected by the department from the insurer and a hospital licensed in the state. The Insurance Commissioner shall release and publish on the State Insurance Department's website reimbursement rate information.	Rep. Aaron Pilkington (R)
CT	HB 5991	Transparency	Referred to Joint Committee on Public Health	This measure requires for-profit hospitals to release to the public information contained on their Internal Revenue Service Form 990, including, but not limited to, executive compensation, community donations, identification of board of directors members and profit and loss statements.	Rep. Peter Tercyak (D)
FL	HB 1067 / SB 1952	Transparency	Passed House; Died in Senate Committee on Appropriations / Died in Senate Committee on Judiciary	This measure requires a licensed facility to post on its website a consumer-friendly list of standard charges for at least 300 shoppable health care services; requires a licensed facility to establish an internal grievance process for patients to dispute charges; and requires a licensed facility to provide a cost estimate to a patient or prospective patient and the patient's health insurer, and the subsequent charge cannot exceed 110% of the estimate.	Rep. Bob Rommel (R) / Sen. Ray Rodrigues (R)
GA	HB 834	Transparency	Filed	This measure requires health care facilities, ambulatory surgical centers, and imaging centers to report additional financial data relating to medical debt and extraordinary collection actions.	Rep. Mark Newton (R)
IN	SB 325	Transparency	Signed by Governor	This measure requires nonprofit hospitals to hold an annual public forum for the purposes of obtaining feedback from the community about the nonprofit hospital's performance in the previous year; discussing the pricing of health services provided at the nonprofit hospital; and discussing the contributions made by the nonprofit hospital to the community. The nonprofit hospital, at least 14 days before the public forum, to post on the nonprofit hospital's Internet web site a notice stating the date, time, location, and purposes of the public forum; and information relating to the subjects to be discussed at the public forum. The bill also changes the date that ambulatory outpatient surgical centers are required to begin posting certain pricing information from March 31, 2021, to December 31, 2021; and specifies that the pricing information posted is the standard charge rather than the weighted average negotiated charge and sets forth what is included in the standard charge. The bill also specifies that if an ambulatory outpatient surgical center offers less than 30 additional services, the center is required to post all of the services the center provides. Additionally, if the federal Hospital Price Transparency Rule is repealed or stopped, a hospital shall continue to post pricing information in compliance with the federal rule as if it were not repealed or stopped. The bill had language stripped out that would have increased the number of common services that a hospital and ambulatory outpatient surgical center are required to post to the hospital price disclosure list to at least 300.	Sen. Justin Busch (R)
IA	SF 5	Transparency	Referred to Senate Committee on Human Resources	This measure requires disclosure of the chargemaster prices for health services rendered by health care providers and hospitals.	Sen. Brad Zaun (R)

MA	H 1164/S 718	Transparency	Moved to 2021 Session	This measure requires the Health Policy Commission (HPC) to hold an annual public hearing based on the report submitted by the Center for Health Information Analysis (CHIA). The hearing must examine health care provider, provider organization, and private and public payer costs, prices, and weighted average payer rates. A weighted average payer rate (WAPR) is defined as a measure by which a sum of the inpatient revenue per discharge and outpatient revenue per visit is separately calculated for commercial insurers, Medicare, and Medicaid. A weighted average of the three resulting values is derived, with the net patient service revenue-based payer mix of the three payers serving as weights.	Rep. Kevin Honan (D)/Sen. Michael Rush (D)
MA	HB 1261 / SB 795	Transparency	Referred to Joint Committee on Health Care Financing / Referred to Joint Committee on Health Care Financing	This measure requires: A hospital-based facility that charges or bills a facility fee for services shall inform the patient prior to the delivery of non-emergency services that it is licensed as part of the hospital and the patient may receive a separate charge that is in addition to and separate from the professional fee charged by the provider. The patient may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and Information on how the patient can obtain financial liability for the known services through the hospital or the patient's insurance carrier, along with information that the actual liability may change depending on the actual services provided. The bill also requires locations designated as a hospital-based facility to clearly identify the facility as being hospital-based, including stating the name of the hospital or health system in the facility's signage, marketing materials, internet web sites and stationery, and by posting notices in designated locations accessible to and visible by patients in a manner proscribed by the commissioner.	Rep. William Driscoll (D) / Sen. Jason Lewis (D)
MA	S 693	Transparency	Moved to 2021 Session	This measure requires the Center for Health Information Analysis to identify hospitals that are in financial distress, including hospitals that are at risk of closing or discontinuing health services. The center must report a list of at-risk hospitals to the secretary of Health and Human Services, commissioner of Public Health, and the executive director of the Health Policy Commission. This bill also requires health facilities to provide 90-day notice prior to the discontinuation of an essential health service and a 120-day notice prior to the closure of a hospital.	Sen. John Keenan (D)
MD	HB 565 / SB 514	Transparency	Signed by Governor	This bill outlines requirements relating to hospital debt collection policies and payment plans and prohibits a hospital from taking specified actions when collecting debt. A hospital must annually submit its policy on the collection of debts owed by patients as well as a specified report to the Health Services Cost Review Commission (HSCRC), which HSCRC must compile into an annual medical debt collection report. By December 1, 2021, the Maryland Health Care Commission (MHCC) must examine and report on the feasibility of using the State-designated Health Information Exchange (HIE) to support determination of patients' financial status for determining eligibility for free or reduced-cost care or an income-based payment plan. By January 1, 2022, HSCRC must develop and report on guidelines for an income-based payment plan and study the impact on uncompensated care of providing specified refunds or requiring hospitals to forgive specified judgments or strike specified adverse information.	Del. Lorig Charkoudian (D) / Sen. Brian Feldman (D)

MN	HF 2311 / SF 2110	Transparency	Referred to House Committee on Commerce FInance and Policy / Referred to Senate Committee on Health and Human Services Finance and Policy	This measure requires providers to give patients and Medicare enrollees prior to provision of any health care service a copy of a bill, which must contain the dollar amount the provider is willing to accept as payment in full, the Medicare-allowable, fee-for-service payment rate, and the provider's Medicare percent. For patients covered by a health plan, a provider must also include a copy of the Medicare percent disclosure form signed by the patient or the patient's representative. If any of the health care services are not covered by the patient's health plan, the provider or the provider's designee must provide the patient with a notice specifying the services not covered by the patient's health plan and must retain a copy of the notice signed by the patient. If a provider fails to disclose to a patient that a service is not covered, the provider is prohibited from billing the patient for that noncovered service. If a provider complies with the disclosure and signature requirements of this paragraph, and the patient receives the noncovered services from the provider, the patient must pay for the services received.	Rep. Steve Elkins (D) / Sen. Rich Draheim (R)
MT	SB 236	Transparency	Passed Senate; Died in House Committee on Human Services	This measure requires health care facilities to provide a patient or a patient's authorized agent with the estimated charge for a health care treatment, surgery, or procedure that has been recommended for the patient and is expected to exceed $500.	Sen. Shane Morigeau (D)
NM	SB 382	Transparency	Passed Senate Committee on Health and Public Affairs	This measure requires a hospital to ensure that all billing related to a single episode of care that occurs on the site of that same hospital is made in a single statement that the hospital provides to the patient within 60 days of discharge. If the hospital is unable to provide that statement to the patient within 60 days of discharge due to negotiations with third-party payers, the hospital shall provide that statement to the patient within 90 days of discharge.	Sen. Craig Brandt (R)
OH	HB 160	Transparency	Referred to House Committee on Insurance	This measure requires a health care provider to provide a cost estimate for a health care product, service, or procedure before providing the product, service, or procedure to a patient. This requirement does not apply when a patient seeks emergency services or when a provider believes that a delay in care could harm the patient.	Rep. Adam Holmes (R)
OK	HB 1006	Transparency	Prefiled	This measure requires health care providers and facilities to make available the health care prices for at least the twenty most common health care services the health care provider or facility provides; if the health care provider or facility regularly provides fewer than 20 health care services, the health care provider or facility shall make available the health care prices for the health care services the provider most commonly provides. This act prohibits review of health care prices by government agencies.	Rep. Carol Bush (R)
OK	SB 462	Transparency	Passed Senate, passed House Committee on Appropriations and Budget	This measure, to be known as the Oklahoma Right to Shop Act, authorizes insurance carriers to create and implement a shared savings incentive program to provide incentives to an enrollee when the enrollee obtains a comparable health care service that is covered by the carrier from providers that charge less than the average allowed amount paid by that carrier to network providers for that, comparable health care service.	Sen. Zack Taylor (R)
OK	SB 2807	Transparency	Referred to House Committee on Insurance	This measure requires all state-regulated health benefit plans to reference the usual, customary, and reasonable rate for the purpose of providing an enrollee with reimbursement transparency for out-of-network health care providers and facilities. If a health benefit plan issuer or administrator has restricted or prohibited a health care provider or health care facility from billing an insured, participant, or enrollee for applicable copayment, coinsurance, and deductible amounts required under the Oklahoma Out-of-Network Surprise Billing and Transparency Act, the Attorney General may bring a civil action in the name of the state to ensure the health care provider, health care facility or administrator may bill an enrollee the applicable copayment, coinsurance, and deductible amounts.	Rep. Chris Sneed (R)

OR	HB 2326	Transparency	Referred to House Committee on Health Care	This measure requires hospitals, ambulatory surgical centers and health systems to report specified financial and other information to the Oregon Health Authority. Additionally, a provider-based clinic, owned or operated by a hospital, that charges a facility fee shall notify a patient before providing a nonemergency service that the clinic is licensed as part of the hospital and that the patient may receive a separate charge or billing for the service, which may result in higher out-of-pocket costs to the patient.	Rep. Andrea Salinas (D)
PA	HB 322	Transparency	Referred to House Committee on Health	This measure requires health care providers to publish the cost of health care procedures.	Rep. Greg Rothman (R)
SC	S 289	Transparency	Referred to Senate Committee on Banking and Insurance	This measure requires a carrier to develop and implement a program that provides incentives for the enrollees who elect to receive a shoppable health care service from providers that charge less than the average price paid by the carrier.	Sen. Wes Climer (R)
TX	HB 2487 / SB 914 / SB 1137	Transparency	Referred to House Committee on Public Health / Referred to Senate Committee on Business and Commerce / Signed by Governor	This measure requires disclosure by hospitals of standard charges for all hospital services and items. The list of standard charges must be maintained and publicly available. The bill also codifies into state law the CMS rule Price Transparency Requirements for Hospitals To Make Standard Charges Public.	Rep. Tom Oliverson (R) / Sen. Kelly Hancock (R) / Sen. Lois Kolkhorst (R)
WA	HS 1272	Transparency	Signed by Governor	This measure directs the Department of Health to revise the financial and patient discharge data that hospitals report to provide additional detail about specific categories of expenses and revenues. Beginning July 1, 2022, health systems that operate a hospital must annually submit a consolidated income statement and balance sheet to the Department regarding the facilities that they operate in in the state, including hospitals, ambulatory surgical facilities, health clinics, urgent care clinics, physician groups, health-related laboratories, long-term care facilities, home health agencies, dialysis facilities, ambulance services, behavioral health settings, and virtual care entities. Additionally, the bill eliminates the exemption for off-campus clinics or providers that are located within 250 yards from the main hospital buildings or as determined by CMS eliminated from the definition of "provider-based clinic," as the term relates to providing notice of facility fees and reporting facility fee information.	Rep. Nicole Macri (D)
WA	SB 5420	Transparency	Passed Senate Committee on Health and Longterm Care with substantial amendments	This measure had language stripped out which would have prohibited the Health Department, the Health Care Authority, or any other state agency from establishing any new requirement for a hospital to report data or information. This limitation on establishing new data and information reporting requirements included data or information related to the Health Care Cost Transparency Board. The department would have been able to establish new data and information reporting requirements reasonably necessary to address the COVID-19 pandemic for patient care and vaccines. This bill would have remained in effect until either Dec. 31, 2022 or the end of the COVID-19 state of emergency, whichever is later. The bill's new language directs the joint legislative audit and review committee to conduct a comprehensive review of all state and federal data or information reporting obligations on acute care and psychiatric hospitals in the state.	Sen. Ron Muzzall (R)

WV	HB 2005	Transparency	Signed by Governor	This measure requires the Insurance Commissioner to enforce the federal No Surprises Act and permits the commissioner to assess a fine for violations. The bill had language stripped out that contained several provisions relating to health care costs and transparency. The bill requires nonprofit hospitals to file a summary of every contract or an amendment to an existing contract for the payment of patient care services between a purchaser or third-party payer and a hospital to the health care authority. Additionally, when making an appointment to receive health care services, a patient shall receive the cost estimate, and a hospital may not charge a facility fee.	Del. Dean Jeffries (R)
WV	HB 2173	Transparency	Referred to House Committee on Health and Human Resources	This measure directs the Bureau for Public Health to produce an estimate for creating and maintaining a health care price transparency tool, with technical support from the Health Care Authority, that is accessible by the public. The Bureau for Public Health shall publish compilations or reports that compare and identify health care providers or data suppliers from the data it collects.	Del. Dean Jeffries (R)

State	Bill	Category	Status	Summary	Sponsor
CT	HB 6488	Facility Fees	Joint Committee on Public Health	This measure requires each hospital and health system to report to the executive director of the Office of Health Strategy the number of patients who contacted the hospital or health system to request a reduction of a facility fee for the preceding calendar year; the number of such patients who received a reduction of a facility fee; the total amount of facility fees charged to patients who requested reductions of facility fees; and the total amount of reduced facility fees charged to such patients; all disaggregated by payer mix. The bill also includes other reporting specifications.	Committee on Public Health
FL	HB 1157 / SB 1976	Facility Fees	Signed by Governor / Companion House bill substituted	This measure prohibits hospital-based off campus emergency departments from identifying to the public as an urgent care center, and requires such departments to post signs containing specified statements including the facility's average facility fee.	Rep. Traci Koster (R) / Sen. Jason Brodeur (R)
MA	S 700	Facility Fees	Moved to 2021 session	This measure requires that prior to the delivery of non-emergency services, a hospital-based facility that charges or bills a facility fee for services shall inform patients that: 1) It is licensed as part of the hospital and the patient may receive a separate charge that is in addition to and separate from the professional fee charged by the provider; 2) They may incur financial liability that is greater than the patient would incur if the professional medical services were not provided by a hospital-based facility; and 3) Information detailing how patients can obtain financial liability for the known services through the hospital or patients' insurance carrier, along with information that the actual liability may change depending on the actual services provided. If a hospital or health system designates a location as a hospital-based facility, the facility shall clearly identify the facility as being hospital-based, including by stating the name of the hospital or health system in the facility's signage, marketing materials, Internet websites and stationery and by posting notices in designated locations accessible to and visible by patients in a manner prescribed by the commissioner.	Sen. Jason Lewis (D)
MS	SB 2772	Facility Fees	Died in Committee	This measure prohibits health insurance and employee benefit plans from limiting coverage to provider-to-provider consultations only. Telemedicine consultations between a patient and a provider are to be covered to the same extent as the services would be covered if provided through in-person consultations. Patients in a patient-to-provider consultation shall not be entitled to receive a facility fee.	Sen. Nicole Boyd (R)
NY	AB 3470 / SB 2521	Facility Fees	Referred to Assembly Committee on Ways and Means / Passed Senate; Referred to Assembly Committee on Ways and Means	This measure prohibits hospitals, health systems, or health care providers from billing or seeking payment from a patient for a facility fee that is not covered by the patient's health insurance carrier unless the patient was notified prior to the date of service. The notice must be provided in writing at least seven days prior to the date of service and must explain the amount of the fee; purpose of the fee; whether the patient's insurance plan will pay the fee; and, for uninsured patients; how to apply for financial assistance. The bill had language stripped out that would have prohibited hospitals and health systems from billing or seeking payment from a patient for a facility fee related to the provision of preventive care service or where the facility is not covered by a third-party payer. Additionally, the bill required a hospital-based facility provide to the patient or to the patient's survivor or legal guardian, as appropriate, a consolidated itemized bill and a uniform patient financial liability form after a patient's discharge or release from a general hospital, or completion of a discrete course of treatment by the facility. The initial consolidated itemized bill shall be provided no more than seven days after the patient's discharge, or release or completion of the episode or course of treatment, or after a request for such bill, whichever is earlier.	Asm. Richard Gottfried (D) / Sen. Gustavo Rivera (D)

OH	HB 122	Facility Fees	Passed House; referred to Senate Committee on Health	This measure prohibits a health care professional providing telehealth services from charging a health plan issuer covering telehealth services a facility fee, an origination fee, or any fee associated with the cost of the equipment used at the provider site to provide telehealth services. A health care professional may charge a health plan issuer for durable medical equipment used at a patient or client site.	Rep. Mark Fraizer (R)
PA	HB 1723	Facility Fees	Referred to House Committee on Health	provided in an off-campus health care facility; outpatient evaluation and management services; or any outpatient, diagnostic, or imaging service to be identified annually by the Department of Health. The bill also prohibits providers from charging, billing, or collecting COVID-19 fees, defined as any fee charged or billed by a health care provider for additional personal protective equipment, cleaning supplies or cleaning services utilized as a result of the pandemic.	Rep. Dan Frankel (D)
TX	SB 2038	Facility Fees	Signed by Governor	that provide testing or vaccination for an infectious disease based on a state of disaster to disclose to each patient the prices the facility charges for the test or vaccine and any facility fees, supply costs, and other costs associated with the test or vaccine. The bill also prohibits a facility is prohibited from charging an individual an "unconscionable price" for a product or service provided at the facility; or knowingly or intentionally charging a third-party payor, including a health benefit plan insurer, a price higher than the price charged to an individual for the same product or service based on the payor ’s liability for payment or partial payment of the product or service. The original language prohibited a facility that provides a health care service, including testing and vaccination, to an individual accessing the service from the individual's vehicle from charging the individual or a third-party payer any fee other than for administering the provided service and any related laboratory fees. The facility may not charge the individual or payor any additional fees, including a facility fee,	Sen. Jose Menendez (D)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 1132	Consolidation	Referred to Assembly Committees on Health and Judiciary	This measure would prohibit a contract between a health care service plan or health insurer and a health care provider or health facility from containing terms that restrict the plan or insurer from steering an enrollee or insured to another provider or facility or require the plan or insurer to contract with other affiliated providers or facilities. The bill would also require a medical group, hospital or hospital system, health care service plan, or health insurer that intends to purchase, merge, or consolidate with, initiate a corporate affiliation with, or enter into an agreement resulting in its purchase, acquisition, or control by, another entity, to provide written notice to the Attorney General at least 90 days before entering an agreement with a value of $3,000,000 or more. The bill would authorize the Attorney General to consent to, give conditional consent to, or not consent to that agreement, and would require the Attorney General to notify the entity of the decision within 90 days, which may be extended by one 45-day period if specified conditions are met.	Asm. Jim Wood (D)
CT	SB 238	Consolidation	Passed Joint Committee on Appropriations	This measure requires every group practice, regardless of the number of physicians, to file a written report concerning the group practice with the Attorney General and Office of Health Strategy; and permits the Office of Health Strategy to require a certificate of need for the acquisition or merger of a group practice of any size, rather than only large group practices of eight or more physicians.	Sen. Martin Looney (D)
FL	HB 1219 / SB 1064	Consolidation	Referred to House Committees on Appropriations and Health & Human Services	This measure imposes certain reporting requirements when a transaction between two entities in the health care market results in an affiliation or a material change to the health care market that could create a monopoly. An entity that fails to comply with these reporting requirements is subject to a civil penalty up to $500,000. The notice requirements will provide a mechanism for the Office of the Attorney General to review transactions before they occur to determine whether a proposed transaction has antitrust implications and, if warranted, pursue action to prevent coercive monopolies from forming in the health care market.	Rep. Erin Grall (R) / Sen. Jason Brodeur (R)
IN	HB 1421	Consolidation	Signed by Governor	This measure had language stripped out in committee relating to hospital consolidation. The removed language would have required the attorney general to review mergers, acquisitions, and other transactions concerning hospitals, hospital systems, and investors of hedge funds and public equity funds, authorized the attorney general to approve or deny the merger, acquisition, or transaction, and allowed for a waiver under certain circumstances. The current version of the bill specifies that the state employee health plan statute does not prohibit the state personnel department from directly contracting with health care providers for health care services for state employees, and requires a hospital to post pricing information in compliance with the federal Hospital Price Transparency Rule of the Centers for Medicare & Medicaid Services if the federal Hospital Price Transparency Rule is repealed or federal enforcement of the rule is stopped. Additionally, the bill changes the date that ambulatory outpatient surgical centers are required to begin posting certain pricing information from March 31, 2021, to Dec. 31, 2021, and specifies that if an ambulatory outpatient surgical center offers less than 30 additional services, the center is required to post all of the services the center provides.	Rep. Donna Schaibley (R)

MA	H 1259	Consolidation	Redrafted as H 4248	This measure would strengthen market oversight in health care by giving the Health Policy Commission authority to deny provider material transactions. It includes "the methods used by the provider or provider organization to direct patient care to the appropriate and lowest-cost setting within its system and to eliminate unnecessary duplication of health care services within the system" as a factor that can be examined during a cost and market impact review (CMIR), and requires the preliminary report on the CMIR within 180 days. Based on the CMIR, the Health Policy Commission may deny the provider's request for a material change based on certain criteria layed out in the legislation.	Rep. Paul J. Donato (D)
MA	H 4248	Consolidation	Substituted by H 4253	This measure would amend the health care market review process. The bill expands what constitutes a material change eligible for review to include the application for issuance of a new freestanding ambulatory surgery center license or a clinic license or a new satellite facility unde an existing license. The bill also includes the inventory of health care resources maintained by the department of public health and any related data or reports from the health planning council as a factor that can be examined during a cost and market impact review (CMIR). The bill also declares that any provider identified by the Health Policy Commission as meeting certain outlined criteria in the CMIR is assumed to have engaged in an unfair practice rather than first having to undergo investigating by the Attorney General. The bill also establishes a council to develop a state health plan.	Joint Committee on Health Care Financing
MA	H 4253	Consolidation	Substituted by H 4262	This measure is similar to H 4253, but makes the measure an emergency law.	House Committee on Ways and Means
MA	H 4262	Consolidation	Passed House	This measure would amend the health care market review process. The bill expands what constitutes a material change eligible for review to include the submission of an application for issuance of a new freestanding ambulatory surgery center license or a clinic license or a new satellite facility unde an existing license. The bill also includes the inventory of health care resources maintained by the department of public health and any related data or reports from the health planning council as a factor that can be examined during a cost and market impact review (CMIR). The bill also declares that any provider identified by the Health Policy Commission as meeting certain outlined criteria in the CMIR is assumed to have engaged in an unfair practice rather than first having to undergo investigating by the Attorney General. The bill also establishes a council to develop a state health plan. The bill also establishes a task force to examine the funding sources and assessment algorithm to ensure a sustainable and equitable funding stream for the work of the health policy commission	N/A
NV	AB 47	Consolidation	Referred to Assembly Committee on Commerce and Labor	This measure requires certain notice be provided to the Attorney General before the consummation of certain mergers and acquisitions; and requires a person who wishes to enter into certain agreements or adopt certain policies related to health care to submit the proposed agreement or policy to the Attorney General for approval if it contains certain provisions that relate to the exclusivity of a provider or provider organization, prohibit certain purchases and sales of health care services or restrict the ability of a health carrier to encourage a person to obtain a health care service from certain hospitals or hospital systems. The Attorney General may approve the proposed agreement or policy if he or she determines that the agreement or policy is likely to result in an increase in the welfare of consumers, such increase cannot be accomplished through alternative means that are less restrictive, and the agreement or policy does not constitute a contract, combination, or conspiracy in restraint of trade.	House Committee on Commerce and Labor
OR	HB 2079	Consolidation	Referred to House Committee on Health Care	This measure requires health care entities to obtain approval from the Oregon Health Authority before any mergers, acquisitions or affiliations of entities that had $25 million or more in net patient revenue in prior fiscal year or before mergers, acquisitions or affiliations that will result in one entity having increase in net patient revenue of $10 million or more. The bill also directs the Oregon Health Policy Board to establish criteria for approval of mergers, acquisitions and affiliations.	Gov. Kate Brown (D)

OR	HB 2362	Consolidation	Signed by Governor	This measure authorizes the Oregon Health Authority (OHA) to review health care mergers, acquisitions, or affiliations to ensure they maintain access to affordable health care. Transactions that meet the threshold for review occur when at least one party had average revenue of $25 million or more in the preceding three fiscal years, and the other party had average revenue of at least $10 million in the preceding three fiscal years. OHA can impose a civil penalty for violation, not to exceed $10,000 for each offense, or $1,000 for each offense by an individual healthcare professional. The operative date for OHA's authority to begin reviewing these transactions is March 1st, 2022. OHA is also directed to commission studies of the impact of consolidation in the state every 4 years. The original language required approval of mergers, acquisitions, or affiliations of entities that had $25 million or more in net patient revenue in prior fiscal year or before mergers, acquisitions or affiliations that will result in one entity having increase in net patient revenue of $1 million or more. The bill also directs the Oregon Health Policy Board to establish criteria for approval of mergers, acquisitions and affiliations.	Rep. Andrea Salinas (D)
TN	HB 231	Consolidation	Filed	This measure reduces from 30 days to 25 days the time during which a health care institution must notify the health services and development agency of a change of ownership and provide documentation of the commitment from the subsequent owner to comply with all conditions placed on the original certificate of need and on the license.	Rep. Kevin Vaughan (R)
WA	HB 1160	Consolidation	Passed House; Referred to Senate Committee on Health and Long Term Care	This measure prohibits anti-competitive contracting between a hospital or any affiliate of a hospital and a health carrier. The prohibited contract provisions include setting provider compensation agreements or other terms for affiliates of the hospital out of the carrier's network; requiring the health carrier to contract with multiple hospitals owned or controlled by the same single entity; requiring health carriers to place a hospital or affiliate in an enrollee cost-sharing tier that reflects the lowest or lower enrollee cost-sharing amounts; requiring the health carriers to keep the contracts payment rates confidential from any existing or potential payor that is or may become financially responsible for the payments, though these communications may be subject to a reasonable nondisclosure agreement; and prohibiting the disclosure of health care service claims data to employers providing the coverage.	Rep. Eileen Cody (D)
WA	HB 5335	Consolidation	Referred to House Committee on Health & Long Term Care.	This measure prohibits a person from engaging in the acquisition of a hospital or hospital system without first having applied for and received the approval of the State Department of Health. An application must be submitted to the department and must include the information the department determines is required, in addition to the information laid out in the bill. The department shall engage an independent contractor to prepare an independent health care impact statement for any acquisition that directly affects a hospital that has more than 50 acute care beds; or if there is a reasonable basis to conclude that the acquisition may significantly reduce the availability, accessibility, or cost of any existing health care service. The department shall only approve an application if the acquisition in question will not detrimentally affect the continued existence of accessible, affordable health care that is responsive to the needs of the communities in which the hospital or hospital system health facilities are located.	Sen. Emily Randall (D)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 1130	Cost Growth Benchmark	Passed Assembly; referred to Senate Committee on Health and Judiciary	This measure would require the Director of Public Health to establish a statewide health care cost target for total and per capita health care expenditures by 2024 and specific targets by health care sector, including fully integrated delivery system sector, geographic region, or other category of individual health care entity by 2027. This bill would also establish the Office of Health Care Affordability to set standards for various health care metrics, to analyze the health care market for cost trends and drivers of spending, develop data-informed policies for lowering health care costs for consumers, set and enforce a statewide health care cost target for total health care expenditures and specific targets by health care sector and geographic region, and create a state strategy for controlling the cost of health care and ensuring affordability for consumers and purchasers. The office would be required to take progressive actions against health care entities for failing to meet the cost targets, including corrective action plans and escalating administrative penalties. The bill would also establish an 11-member Health Care Affordability Advisory Board to recommend health care cost targets and to make recommendations to the Director of Statewide Health Planning and Development and the office. Additionally, the bill would require the office to examine health care mergers, acquisitions, corporate affiliations, or other transactions that entail material changes to ownership, operations, or governance of health care service plans, insurers, hospitals or hospital systems, physician organizations, pharmacy benefit managers, and other health care entities.	Asm. Jim Wood (D)
CT	HB 5689	Cost Growth Benchmark	Referred to Joint Committee on Insurance and Real Estate	This measure requires the Office of Health Strategy to establish and implement health care cost growth benchmarks.	Rep. Cara Pavalock-D'Amato (R)
CT	SB 218	Cost Growth Benchmark	Referred to Joint Com	This measure requires the Office of Health Strategy to establish and implement health care cost growth benchmarks.	Sen. Kevin Kelly (R)
CT	SB 502	Cost Growth Benchmark	Referred to Joint Committee on Insurance and Real Estate	This measure requires the Office of Health Strategy to establish and implement health care cost growth benchmarks.	Sen. Kevin Kelly (R)
CT	SB 1006	Cost Growth Benchmark	Referred to Joint Committee on Insurance and Real Estate	This measure requires the Office of Health Strategy to set an annual health care cost-growth benchmark to address the average growth in total health care expenditures across all payers and populations in this state. The executive director shall include within such health care cost growth benchmark a primary care target to ensure primary care spending as a percentage of total health care expenditures reaches a goal of 10% for the calendar year beginning Jan. 1, 2026. Additionally, the bill requires institutional providers to submit to the executive director data concerning service utilization; charges, prices imposed, and payments receives; costs incurred and revenues earned; and any other information deemed relevant.	Joint Committee on Insurance and Real Estate

MA	H 975/S 655	Cost Growth Benchmark	Ruled ought NOT to p	This measure sets certain standards for ambulance payments and requires that the rate patients pay reflect the municipality where the patient is transported from. An ambulance service provider receiving payment for an ambulance service shall be deemed to have been paid in full for the ambulance service provided to the insured, and shall have no further right or recourse to further bill the insured for said ambulance service with the exception of coinsurance, copayments, or deductibles for which the insured is responsible under the insured's insurance policy or insurance contract. It requires municipalities to report their municipally established ambulance rates to the Center for Health Information Analysis to be included in its transparency Initiative. Municipalities shall not increase their municipally established ambulance rates by a percentage that exceeds the current Health Care Cost Growth Benchmark set by the Health Policy Commission unless approved by the secretary of health and human services. A municipality may appeal to the secretary for a municipally established ambulance rate increase that is in excess of the current Health Care Cost Benchmark. There shall be an ambulance service advisory council to advise the secretary on such requests	Rep. Carole Fiola (D)/Sen. Walter Timilty (D)
MA	HB 1247 / SB 782	Cost Growth Benchmark	Redrafted as H 4248 / Referred to Joint Committee on Health Care Financing	This measure establishes a health care consumer cost growth benchmark for the average aggregate growth in out-of-pocket health care cost growth and premium cost growth in the commonwealth for the next calendar year as determined by the center for health information and analysis. The annual benchmark shall be prominently published on the commission's website along with the commonwealth's overall health care cost growth benchmark.	Rep. Christine Barber (D) / Sen. John Keenan (D)
MA	HB 1259	Cost Growth Benchmark	Referred to Joint Committee on Health Care Financing	This measure makes amendments to current cost growth benchmark provisions. The bill prohibits any provider or provider organization that has been identified by the Center for Health Information and Analysis as exceeding the health care cost growth benchmark for any given year from making any material change to its operations or governance structure that would otherwise require notice to the commission. The commission may exclude a provider or provider organization from this prohibition if the market share of the provider or provider organization is below a threshold as determined by the commission, or if the provider or provider organization's total medical expenses or relative price are below the statewide median. The prohibition shall continue until the center has determined that the provider or provider organization has lowered its relative price and total medical expenses to a level at or below the cost growth benchmark.	Rep. Paul Donato (D)
MA	HB 1275 / SB 812	Cost Growth Benchmark	Redrafted as H 4248	This measure adds "weighted average payer rate" (WAPR) as a measure included in reports related to the state's health care cost growth benchmark. WAPR is a measure by which a sum of the inpatient revenue per discharge and outpatient revenue per visit is separately calculated for Commercial, Medicare, and Medicaid. A weighted average of the three resulting values is derived, with the Net Patient Service Revenue - based payer mix of the three payers serving as weights.	Rep. Kevin Honan (D) / Sen. Michael Rush (D)

MA	SB 770	Cost Growth Benchmark	Referred to Joint Committee on Health Care Financing	This measure establishes the aggregate primary care expenditure target that will be the targeted percentage change in expenditures on primary care by or attributed to an individual health care entity compared to the entity's primary care baseline expenditures. The health commission must hold public hearings comparing the growth in total health care expenditures to the health care cost growth benchmark for the previous calendar year and comparing the growth in actual aggregate primary care expenditures for the previous calendar year to the aggregate primary care expenditure target. For the three-year period ending with calendar year 2024, the aggregate primary care expenditure target for each of the three years shall be equal to a 30% increase above aggregate primary care baseline expenditures, and the primary care expenditure target for each of the three years shall be equal to a 30% increase above primary care baseline expenditures. For calendar years 2025 and beyond, the commission may modify the primary care expenditure target and aggregate primary care expenditure target, to be effective for each year of a three-year period, provided that the primary care expenditure target and aggregate primary care expenditure target shall be approved by a two-thirds vote of the board.	Sen. Cindy Friedman (D)
OR	HB 2081	Cost Growth Benchmark	Signed by Governor	This measure modifies the Health Care Cost Growth Target Program and the Health Care Cost Growth Target Implementation Committee. Under these amendments, the term "Health Care Cost Growth Benchmark" is modified to "Health Care Cost Growth Target," "Health Care Cost Growth Benchmark Implementation Committee" is modified to "Health Care Cost Growth Target Implementation Committee," and "total health expenditures" may include expenditures for care provided to out-of-state residents by in-state providers to the extent practicable. The bill requires the Oregon Health Authority (OHA) to adopt by rule criteria for waiving the requirement that payers or providers undertake a performance improvement plan if necessitated by unforeseen market conditions or other equitable factors, and requires OHA to collaborate with payers and providers on performance improvement plans and specifies required elements of the plan. The bill also requires OHA to adopt by rule criteria for imposing financial penalties on providers or payers who exceed the cost growth target without reasonable cause in three out of five calendar years or on any provider or payer who does not participate in the program. Additionally, the bill prohibits OHA from imposing penalties before Jan. 1, 2026 for performance during calendar years 2021 to 2025.	Gov. Kate Brown (D)
RI	H 6122	Cost Growth Benchmark	Signed by Governor	This measure has language stripped out that establishes the Health Spending Transparency and Containment Program to maintain an annual health care cost growth target that will be used as a voluntary benchmark to measure Rhode Island health care spending performance relative to the target, which performance will be publicly reported annually. The program will use data to determine what factors are causing increased health spending in the state, and create actionable analysis to drive changes in practice and policy and develop cost reduction strategies.	Rep. Marvin Abney (D)
RI	S 984	Cost Growth Benchmark	Passed Senate	This measure establishes the Health Spending Transparency and Containment Program to utilize health care claims data to help reduce health care costs. The program will maintain an annual Health Care Cost Growth Target that will be used as a voluntary benchmark to measure Rhode Island health care spending performance. The program will determine what factors are causing increasing health spending and create actionable analysis to address these factors. The bill also imposes a funding contribution for each enrollee of an insurer to be determined by the Secretary of Health and Human Services not to exceed one dollar to the Health Spending Transparency and Containment Program. The program would provide annual reports to the public and recommendations to the Governor and General Assembly.	Sen. Joshua Miller (D)

State	Bill	Category	Status	Summary	Sponsor
AL	HB 363	Certificate of Need	Referred to House Committee on State Government	This measure would repeal the certificate-of-need program and abolish the state agencies, councils, and boards that exist to operate the certificate-of-need program and collect data to support the operation of the certificate-of-need program, and would update related code sections to remove references both to the program and to these agencies, councils, and boards.	Rep. Andrew Sorrell (R)
AK	HB 77 / SB 26	Certificate of Need	Referred to House Committee on Health and Social Services / Referred to Senate Committee on Labor and Commerce	This measure repeals the certificate-of-need program for health care facilities.	Rep. George Rauscher (R) / Sen. David Wilson (R)
CT	SB 53	Certificate of Need	Referred to Joint Committee on Public Health	This measure eliminates the requirement for a certificate of need for cardiac health care providers to invest in new facilities or equipment.	Sen. Saud Anwar (D)
CT	SB 54	Certificate of Need	Referred to Joint Committee on Public Health	This measure establishes a task force to evaluate the efficacy of the state's certificate of need program and its impact on the health care system.	Sen. Saud Anwar (D)
CT	SB 108	Certificate of Need	Referred to Joint Committee on Public Health	This measure eliminates the requirement for a certificate of need for substance use disorder treatment facilities.	Sen. Saud Anwar (D)
DC	BC24 307	Certificate of Need	Signed by Mayor	This measure amends the Health Services Planning Program Re-establishment Act of 1996 to provide hospitals and health care service providers with a valid certificate of need that expired during or within 30 days prior to the declaration of a public health emergency a waiver from the need to renew the certificate of need until 60 days after the end of the public health emergency.	Councilmember Vincent Gray (D)
DC	BC24 308	Certificate of Need	On Mayor's Desk	This measure amends the Health Services Planning Program Re-establishment Act of 1996 to provide hospitals and health care service providers with a valid certificate of need that expired during or within 30 days prior to the declaration of a public health emergency a waiver from the need to renew the certificate of need until 60 days after the end of the public health emergency.	Councilmember Vincent Gray (D)
DC	PR24 281	Certificate of Need	Adopted	This measure declares the existence of an emergency with respect to the need to amend the Health Services Planning Program Re-establishment Act of 1996 to provide hospitals and health care service providers with a valid certificate of need that expired during or within 30 days prior to the declaration of a public health emergency a waiver from the need to renew the certificate of need until 60 days after the end of the public health emergency.	Councilmember Vincent Gray (D)
FL	HB 989	Certificate of Need	Withdrawn	This measure removes the authority of local health departments to provide the state health agency with data required by rule for the review of certificate-of-need applications and the projection of need for health services in the district. This authority still remains with relation to health facilities.	Rep. Nicholas Duran (D)
HI	HB 224	Certificate of Need	Passed both chambers; in conference	This measure exempts chronic renal dialysis services in Oahu regional government hospitals; psychiatric services; and hospice, psychiatric, and substance abuse facilities from the certificate-of-need requirements and authorizes fines for persons who do not comply with an approved certificate of need.	Rep. Ryan Yamane (D)

HI	HR2021 18/HCR2021 26/SR2021 4/SCR 2021 4	Certificate of Need	Referred to House Committees on Consumer Protection and Commerce and Finance/Referred to House Committees on Consumer Protection and Commerce and Finance/Referred to Senate Committees on Government Operations; and Judiciary / Died in Senate Committee on Government Operations	This measure requests that the Legislative Reference Bureau conduct a study of the necessity for the certificate-of-need (CON) process with respect to the role of the CON program; whether certain facilities, types of facilities, or services should be exempt from the CON process; and whether modifications made to the CON process in other states may be beneficial to implement in Hawaii.	Rep. Roy Takumi (D) / Rep. Roy Takumi (D) / Sen. Jarrett Keohokalole (D) / Sen. Jarrett Keohokalole (D)
HI	SB 1231	Certificate of Need	Passed Senate; Referred to House Committees on Consumer Protection and Commerce; Finance; and Health, Human Services, and Homelessness	This measure seeks to establish a more coordinated and cost-effective statewide health planning and resource development program. A part of this effort is authorizing the Department of Health to administer the certificate of need program, rather than only the State Health Planning and Development Agency.	Sen. Jarrett Keohokalole (D)
IA	SF 4	Certificate of Need	Referred to Senate Committee on Human Resources Committee on	This measure eliminates the certificate of need process relating to the development of a new or changed institutional health service.	Sen. Brad Zaun (R)
ME	LD 250	Certificate of Need	Passed Legislature	This measure restores the ability of nursing facilities to voluntarily reduce the number of their licensed beds and then later increase the number of their licensed beds to the prior level after obtaining a certificate of need (CON) and meeting certain conditions. The bill also modifies the process to obtain CON approval to reopen reserved beds.	Rep. Anne Perry (D)
MA	HB 1282	Certificate of Need	Redrafted as H 4248	This measure establishes a special commission to study the costs and benefits that existing certificate of need laws impose on the Commonwealth's health care system. Factors to be considered include, but are not limited to: access to health care - such as the number of hospitals per capita, the number of hospital beds per capita, the number of dialysis clinics, and the number of ambulatory surgical centers; quality of health care services received - such as mortality rate following heart attacks, heart failure, and pneumonia, as well as the number of post-surgery complications; and the cost of health care services, such as the cost per medical procedure, and healthcare spending per patient.	Rep. Bradley Jones (R)
MI	HB 4502	Certificate of Need	Referred to House Committee on Health Policy	This measure exempts outpatient cardiac catheterization services for which the Centers for Medicare & Medicaid Services has approved a current procedural terminology code as an outpatient service.	Rep. Luke Meerman (R)

MI	HB 4862 / SB 440	Certificate of Need	Referred to House Committee on Health Policy / Signed by Governor	This measure exempts positron emission tomography (PET) scanner services from certificate of need regulations.	Rep. Like Meerman (R) / Sen. Winnie Brinks (D)
MI	HB 5074	Certificate of Need	Passed House Committee on Health Policy	This measure states that if the certificate of need commission proposes to develop, approve, disapprove, or revise certificate of need review standards under this subsection, the commission shall make the proposed review standards available to the public not less than 30 days before conducting a hearing.	Rep. Bronna Kahle (R)
MI	HB 5075	Certificate of Need	Passed House Committee on Health Policy	This measure requires the joint legislative committee created to focus on proposed actions of the commission regarding the certificate of need program and certificate of need standards and to review other certificate of need issues to hold an annual hearing to review actions taken in the preceding year; proposed actions; impact on access to, and quality and cost of care; and any other relevant information.	Rep. David LaGrand (D)
MI	HB 5076	Certificate of Need	Passed House Committee on Health Policy	This measure requires reports to the certificate of need commission on the performance of the department's duties to be made public within 7 days.	Rep. Andrew Beeler (R)
MI	HB 5077	Certificate of Need	Passed House Committee on Health Policy	This measure requires the certificate of need commission to post meeting agendas on a public website at least 3 business days prior to the meeting. A transcript, minutes, and a record of actions taken by the commission must also be made available within 7 business days of the meeting's adjournment.	Rep. Sara Cambensy (D)
MI	SB 12	Certificate of Need	Passed Senate Committee on Health Policy and Human Services	This measure amends the requirement to obtain a certificate of need for cardiac catheterization services to exclude an outpatient service for which the US Centers for Medicare & Medicaid Services has approved a current procedural terminology code as an outpatient service.	Sen. Dale Zorn (R)
MI	SB 181	Certificate of Need	Passed Senate, referred to House Committee on Health Policy	This measure exempts increases in licensed psychiatric beds and, until June 1, air ambulance services from certificate-of-need requirements.	Sen. Curt VanderWall (R)
MI	SB 182	Certificate of Need	Passed Senate, referred to House Committee on Health Policy	This measure adds two representatives to the certificate of need commission. These two individuals must represent the general public, with one being from a county with a population of less than 40,000.	Sen. Lana Theis (R)
MI	SB 183	Certificate of Need	Passed Senate, referred to House Committee on Health Policy	This measure amends limitations on hospital bed relocation. Under the bill, a hospital is no longer prohibited from transferring more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility, or more than one time if the hospital seeking to relocate its licensed beds or another hospital owned by or under common control of is located in a city that has a population of 750,000 or more.	Sen. Michael MacDonald (R)
MN	HF 44 / SF 38	Certificate of Need	Referred to House Committee on Health Finance and Policy / Referred to Senate Committee on Rules and Administration	This measure exempts from certificate-of-need requirements a project to add 45 licensed beds in an existing safety net, Level I trauma center hospital in Ramsey County; as well as a project to add 30 new beds in an existing psychiatric hospital in Hennepin County that is exclusively for patients who are under 21 years of age on the date of admission.	Rep. Dave Baker (R) / Sen. Michelle Benson (R)

MN	HF 61 / SF 67	Certificate of Need	Referred to House Committee on Health Finance and Policy / Referred to Senate Committee on Rules and Administration	This measure establishes the Health Care Commission, consisting of 7 governor-appointed members, to promote the development of a health care regulatory system that provides financial and geographic access to quality health care services at a reasonable cost by developing a state health care plan, facilitating development of regional health care plans, developing and implementing the regulatory powers of the commission consistent with the state health care plan, and issuing certificates of need based on the state health care plan. The commission shall periodically participate in or perform analyses and studies that relate to adequacy of health care services and financial resources to meet the needs of the population, distribution of health care resources, allocation of health care resources, or any other appropriate matter. Additionally, the commission shall provide for a study of regional capacity in health care services. On or before October 1 each year, the commission shall adopt a state health care plan that includes methodologies, standards, and criteria for certificate of need review. The bill also outlines certificate of need requirements. A person must have a certificate of need issued by the commission before the person develops, operates, or participates in certain health care projects including building, developing, or establishing a new health care facility; moving an existing or previously approved but not yet built health care facility to another site; changing bed capacity of a hospital, closing a hospital; changing the type or scope of any health care service; or making any expenditure that is not properly chargeable as an operating or maintenance expense under generally accepted accounting principles or that is made to lease or obtain any plant or equipment for the health care facility other than a hospital. The commission shall develop and adopt rules for applying for and granting exceptions from required certificates of need for small and independent health care companies, particularly with respect to facilities located in rural areas.	Rep. Todd Lippert (D) / Sen. Erin Murphy (D)
MN	SF 953	Certificate of Need	Referred to Senate Committee on Health and Human Services Finance and Policy	This measure exempts from certificate-of-need requirements a project to add 45 licensed beds in an existing safety net, Level I trauma center hospital in Ramsey County. The commissioner conducted a public interest review of the construction and expansion of this hospital in 2018. No further public interest review shall be conducted for the project.	Sen. Michelle Benson (R)
MS	HB 249	Certificate of Need	Died in Committee	This measure removes end-stage renal disease facilities from the application of the Health Care Certificate of Need Law.	Rep. Bryant Clark (D)
MS	HB 602	Certificate of Need	Died in Committee	This measure removes health care services and equipment from the requirement for the issuance of a certificate of need, so that only certain health care facilities will require certificate-of-need (CON) review; removes end-stage renal disease facilities and ambulatory surgical facilities from the requirement for a CON; and deletes the moratorium on the issuance of CON for home health agencies.	Rep. Dana Criswell (R)
MS	HB 848 / SB 2414	Certificate of Need	Died in Committee / Died in Committee	This measure directs the Department of Health to issue certificates of need for the acquisition, conversion, and operation of child/adolescent psychiatric beds and the conversion of chemical dependency beds to child/adolescent psychiatric beds at North Mississippi Medical Center in Lee County.	Rep. Jerry Turner (R) / Sen. Chad McMahan (R)
MS	HB 1304	Certificate of Need	Died in Committee	This measure directs the state Department of Health to issue a single certificate of need upon an application for provision of comprehensive medical rehabilitation beds and services in a free-standing facility to be located in Rankin County, with not more than 40 beds. The application must request only that number of Level I beds as is within the recognized need in the 2018 State Health Plan, with the remaining beds up to a total of 40 to be Level II beds.	Rep. Lee Yancey (R)
MS	HB 1305 / SB 2160	Certificate of Need	Died in Committee / Died in Committee	This measure repeals the Health Care Certificate of Need Law of 1979.	Rep. Lee Yancey (R) / Sen. Angela Hill (R)

MS	HB 1306 / SB 2747	Certificate of Need	Died in Committee / Died in Committee	This measure eliminates the moratorium on the establishment or expansion of a currently approved service area of a home health agency or the contracting of a branch office of such home health agency.	Rep. Lee Yancey (R) / Sen. Jeremy England (R)
MS	HB 1307	Certificate of Need	Died in Committee	This measure grants exemptions from certificate-of-need requirements for any activity in counties that have received a certificate of public convenience and necessity from the Mississippi Development Authority as a growth and prosperity county.	Rep. William Brown (D)
MS	HB 1308	Certificate of Need	Died in Committee	This measure authorizes the issuance of a health care certificate of need for the construction or expansion of nursing facility beds or the conversion of other beds to nursing facility beds in Jones County, not to exceed 60 beds.	Rep. Omeria Scott (D)
MS	HB 1309	Certificate of Need	Died in Committee	This measure authorizes the state Department of Health to issue up to five certificates of need to the recipients of the five new hospice licenses to provide home health services to: -Persons of any age who are eligible for home health services, but with a focus on providing services to pediatric patients; -Persons who were initially eligible for hospice services but later become ineligible and would have to be discharged to a home health agency; and -Persons who are referred to a home health agency for palliative care but are not eligible for hospice services.	Rep. John Hines (D)
MS	HB 1310	Certificate of Need	Died in Committee	This measure removes health care services and equipment from the requirement for the issuance of a certificate of need (CON), so that only certain health care facilities will require CON review.	Rep. John Hines (D)
MS	HB 1317 / SB 2292	Certificate of Need	Died in Committee / Died in Committee	This measure directs the Department of Health to issue a certificate of need (CON) to Panola Medical Center in Batesville for the acquisition, conversion, and operation of 25 adult psychiatric beds in its existing facility in Panola County; and provides that the authorization for the CON for those adult psychiatric beds shall be exempt from the CON review process. The exemption from the CON process is valid for two years from the effective date of this act and will expire if actual operation of the 25 adult psychiatric beds is not accomplished by Panola Medical Center within that two-year period. The bill additionally authorizes and directs the state Department of Health to issue a health care CON for the acquisition, conversion, and operation of child/adolescent psychiatric beds participating in the Medicaid program and the conversion of acute care beds to geriatric psychiatric beds in Lee County.	Rep. John Lamar (R) / Sen. Chad McMahan (R)
MS	SB 2004	Certificate of Need	Substitute with Modified Language Passed Senate; Died in House Committee on Public Health and Human Services	This substitute measure modifies amended language in the original bill relating to the issuance of a health care certificate of need for the construction or conversion of child/adolescent psychiatric or chemical dependency beds participating in the Medicaid program. The remaining language pertains to the Health Care Certificate of Need Law of 1979.	Sen. Kevin Blackwell (R)
MS	SB 2028	Certificate of Need	Died in Committee	This measure requires any party requesting a hearing on an application for a health care certificate of need who does not prevail at the hearing to pay associated costs and attorney fees. This requirement also applies to any party who appeals an order of the hearing officer to the proper court and loses on appeal.	Sen. Kevin Blackwell (R)

MS	SB 2124	Certificate of Need	Died in Committee	This measure directs the Department of Health to issue a certificate of need (CON) to Panola Medical Center in Batesville for the acquisition, conversion, and operation of 25 adult psychiatric beds in its existing facility in Panola County; and provides that the authorization for the CON for those adult psychiatric beds shall be exempt from the CON review process. The exemption from the CON process is valid for two years from the effective date of this act and will expire if actual operation of the 25 adult psychiatric beds is not accomplished by Panola Medical Center within that two-year period. The bill additionally authorizes and directs the state Department of Health to issue a health care CON for the acquisition, conversion, and operation of child/adolescent psychiatric beds participating in the Medicaid program and the conversion of acute care beds to geriatric psychiatric beds in Lee County.	Sen. Nicole Boyd (R)
MS	SB 2341	Certificate of Need	Died in Committee	This measure directs the Department of Health to transfer beds formerly approved under a certificate of need (CON) issued to Newton Regional Hospital to the City of Newton to be bid to a licensed entity and used in the renovation of the regional hospital for the acquisition and operation of 25 adult psychiatric beds, which are eligible for participation in the Medicaid program. The authorization for the transfer and issuance of the CON for those adult psychiatric beds shall be exempt from the CON review process, and the exemption is valid for three years and will expire if substantial commencement of construction of the beds is not accomplished by the facility receiving the bid from the City of Newton.	Sen. Tyler McCaughn (R)
MS	SB 2408	Certificate of Need	Died in Committee	This measure states that any beds placed into and operated for at least 10 years by an entity which does not own the beds may be transferred to the operator without requiring a certificate of need. In cases wherein the owner does not agree to transfer the beds to the operator, the operator may petition the department for a change of ownership of the beds and, if granted, the owner from whom the beds are transferred shall be granted a certificate of need for the same number and type of beds so that the owner is made whole regarding the beds	Sen. Nicole Boyd (R)
MS	SB 2410	Certificate of Need	Died in Committee	This measure directs the Department of Health to issue multi-specialty certificates of need to include two OR multi-specialty rooms in Canton to reopen the Ambulatory Surgery Center. These certificates shall not be moved or relocated from this facility.	Sen. Barbara Blackmon (D)
MS	SB 2413	Certificate of Need	Died in Committee	This measure directs the Department of Health to issue a certificate of need (CON) for the construction and operation of a comprehensive medical rehabilitation facility that will be a free-standing facility with not more than 40 beds located in Rankin County and providing Level I and Level II services. The application shall otherwise comply with all CON requirements as set forth by applicable law or regulation at the time of the application, except that the facility may contain fewer than 60 beds; be within a 45-mile radius of any other comprehensive medical rehabilitation facility; and consist of a combination of both Level I and Level II beds.	Sen. Dean Kirby (R)
MS	SB 2743	Certificate of Need	Died in Committee	This measure directs the Department of Health to issue a health care certificate of need to the Mississippi Department of Mental Health for the conversion of 500 beds to be utilized as crisis or substance abuse treatment beds at existing state mental retardation facilities.	Sen. Angela Turner-Ford (D)
MS	SB 2748	Certificate of Need	Died in Committee	This measure authorizes the issuance of a health care certificate of need for the construction of a 60-bed nursing facility in any underserved minority zip code area in the state.	Sen. John Horhn (D)
MS	SB 2799	Certificate of Need	Law without governor's signature	This measure relates to the Mississippi Medicaid Program. One portion of the bill eliminates the moratorium on the authority of the state department of health to issue a health care certificate of need for the construction or conversion of child/adolescent psychiatric or chemical dependency beds participating in the Medicaid program.	Sen. Kevin Blackwell (R)
MO	SB 192	Certificate of Need	Referred to Senate Committee on Health and Pensions	This measure exempts long-term care beds in hospitals and major medical equipment from certificate-of-need requirements.	Sen. Bob Onder (R)

MO	HB 1222	Certificate of Need	Passed House	This measure repeals the Missouri Certificate of Need Law.	Rep. Dean VanSchoiack (R)
MO	HB 1342	Certificate of Need	Passed House Committee on Downsizing State Government	This measure repeals the Missouri Certificate of Need Law.	Rep. Bishop Davidson (R)
MT	HB 231	Certificate of Need	Signed by Governor	This measure revises certificate-of-need requirements to include only long-term care facilities and services.	Rep. Matt Regier (R)
NJ	A 4177	Certificate of Need	Referred to Assembly Committee on Health	This measure requires the issuance of a certificate of need (CON) to lawfully operate as an emergency medical services provider. An emergency medical services provider must reapply for a CON with the Department of Health on a triennial basis. This bill requires that when applying for a CON, an emergency medical services provider must supply a list of services to be provided to patients and the expected cost to patients for each of those services, and a plan to provide patients an itemized receipt listing the cost of each service provided to the patient and detailed information that is easily understandable to the general public on how a patient may formally dispute the costs charged to the patient by the emergency medical services provider.	Asm. Ralph R. Caputo (D)
NC	HB 410 / SB 309	Certificate of Need	Referred to House Committee on Rules, Calendar, and Operations / Referred to Senate Committee on Rules and Operations	This measure repeals certificate-of-need laws in the state.	Rep. Keith Kidwell (R) / Sen. Ralph Hise (R)
NC	HB 660	Certificate of Need	Referred to House Committee on Rules, Calendar, and Operations	This measure removes psychiatric facilities, chemical dependency treatment facilities, kidney disease treatment centers, and certain ocular surgical procedures from certificate-of-need review requirements.	Rep. Keith Kidwell (R)
NC	HB 834 / SB 462	Certificate of Need	Passed Senate / Signed by Governor	This measure increases monetary value thresholds for requiring a certificate of need (CON) for diagnostic centers, major medical equipment, and new institutional health services. Each threshold shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1. Additionally, a CON issued for the construction of a health service facility expires if the holder of the CON fails to initiate construction of the project authorized by the CON within the specified time frame.	Rep. Harry Warren (R) / Sen. Joyce Krawiec (R)
NC	SB 641	Certificate of Need	Referred to Senate Committee on Rules and Operations	This measure eliminates certificate-of-need requirements for psychiatric hospitals, intermediate care facilities for individuals for intellectual disabilities, and opioid use disorder treatment centers located in tier one and tier two counties.	Sen. Jim Burgin (R)
OK	SB 286	Certificate of Need	Referred to Senate Committee on Health and Human Services	This measure creates exemptions from certificate-of-need requirements for intermediate care facility for individuals with intellectual disabilities as well as psychiatric and chemical dependency facilities.	Sen. Dave Rader (R)

RI	H 5794	Certificate of Need	Held for further study	This measure would require non-emergency medical transportation service providers seeking to do business in the state to obtain a certificate of need. The bill also contains provisions relating to setting Medicaid fee for services and reimbursement rate for non-emergency medical transportation service providers that is at least comparable to the rates paid for similar services in neighboring states; and setting a minimum fee for service at $147 per trip and $1.50 per mile.	Rep. Patricia Serpa (D)
SC	S 370	Certificate of Need	Referred to Senate Committee on Medical Affairs	This measure exempts the addition of beds from certificate-of-need (CON) requirements if in the immediately preceding calendar year if: - The average occupancy of the total number of beds in the same license category at the health care facility where the beds will be added exceeded 75% capacity, including beds considered as observational status; - For licensed general acute care hospital beds, the number of beds exempt from review under this section does not exceed 50 beds or 10% of the total number of licensed general acute care hospital beds, whichever is greater, at the health care facility where the beds will be added; and - For beds in license categories other than general acute care hospital beds, the number of beds exempt from review under this section does not exceed 10% of the total number of beds in the same license category at the health care facility where the beds will be added. This measure also exempts the replacement of equipment for which a CON has been issued which does not constitute a new service from CON requirements. There shall be no judicial review of final decisions issued by the Administrative Law Court for a contested case arising from the department's decision to grant or deny a certificate-of-need application.	Sen. Scott Talley (R)
SC	S 717	Certificate of Need	Passed Senate	This measure exempts from certificate-of-need requirements diabetes screening facilities, including, but not limited to, freestanding angiogram imaging centers in areas of the state that exceed the national diabetes-diagnosed percentages as published by the Centers for Disease Control and Prevention in the current or previous calendar year.	Sen. Darrell Jackson (D)
TN	HB 231 / SB 1243	Certificate of Need	Passed House Committee on Health / Referred to Senate Committee on Health and Welfare	This measure reduces, from 30 to 25 days, the time within which a health care institution must notify the health services and development agency of a change of ownership and provide documentation of the commitment from the subsequent owner to comply with all conditions placed on the original certificate of need and on the license.	Rep. Kevin Vaughan (R) Sen. Shane Reeves (R)
TN	HB 710 / SB 255	Certificate of Need	Referred to House Committee on Government Operations / Passed Senate Committee on Health and Welfare	The measure creates a process by which the owner of a hospital closed for 15 years or less may submit an application to the health services and development agency to resume operations without a certificate of need if the hospital was previously licensed under this title or another hospital was previously licensed under this title at the proposed location. Additionally, the hospital must be located in a county designated by the Department of Economic and Community Development as a Tier 2, Tier 3, or Tier 4 enhancement county or with a population less than 49,000. The bill requires the Health Service and Development Agency to review and notify the applicant of its determination within 60 days.	Rep. Chris Hurt (R) / Sen. Page Walley (R)
TN	HB 839 / SB 1244	Certificate of Need	Filed / Referred to Senate Committee on Commerce and Labor	This measure increases, from 60 to 70 days, the period within which the departments of health, mental health and substance abuse services, and intellectual and developmental disabilities must file a written report with the health services and development agency detailing findings of a review of an application for a certificate of need.	Rep. Tim Hicks (R) / Sen. Shane Reeves (R)

TN	HB 948 / SB 1281	Certificate of Need	Signed by Governor / Companion House bill substituted	This measure increases, from 15 to 30 days, the period in which a party or any member of the health services and development agency may file notice to request the agency review an action of the executive director related to certificate of need.	Sen. Shane Reeves (R) / Rep. Clark Boyd (R)
TN	HB 1208 / SB 1329	Certificate of Need	Introduced / Referred to Senate Committee on Commerce and Labor	This measure increases, from 15 to 20, the number of days before a health services and development agency meeting at which a certificate of need application is originally scheduled that a health care institution wishing to oppose the application must file a written objection with the agency and serve a copy on the contact person for the applicant.	Rep. Ron Travis (R) / Sen. Joey Hensley (R)
TN	SB 21	Certificate of Need	Withdrawn	The measure creates a process by which the owner of a hospital closed for 15 years or less may submit an application to the health services and development agency to resume operations without a certificate of need if the facility, facility site service area, or proposed facility site service area previously operated pursuant to a certificate of need. The bill requires the Health Service and Development Agency to review and notify the applicant of its determination within 60 days.	Sen. Page Walley (R)
WA	SB 5236	Certificate of Need	Signed by Governor	This measure extends certificate-of-need (CON) exemptions relating to psychiatric facilities and equipment until June 30, 2023. The department shall suspend the CON requirement for a hospital that changes the use of licensed beds to increase the number of beds to provide psychiatric services, including involuntary treatment services. A CON exemption granted under this bill will be valid for two years. Additionally, the bill extends exemptions from CON requirements for the construction, development, or establishment of a psychiatric hospital that will have no more than 16 beds and provide treatment to adults on 90- or 180-day involuntary commitment orders. The bill also states that psychiatric hospitals are exempt from CON requirements for the one-time addition of up to thirty new psychiatric beds. Lastly, an entity seeking to construct, develop, or establish a psychiatric hospital is exempt from certificate-of-need requirements if the proposed psychiatric hospital will have no more than 16 beds and dedicate a portion of the beds to providing treatment to adults on 90- or 180-day involuntary commitment orders. The psychiatric hospital may also provide treatment to adults on a 72-hour detention or 14-day involuntary commitment order.	Sen. Judith Warnick (R)
WV	HB 2023 / SB 275	Certificate of Need	Referred to House Committee on Finance / Signed by Governor	This measure transfers jurisdiction over appeals of decisions of the Health Care Authority in certificate of need reviews from the Workers' Compensation Office of Administrative Law Judges and Circuit Court of Kanawha County to the Intermediate Court of Appeals.	Del. Roger Hanshaw (R) / Sen. Craig Blair (R)
WV	HB 2077	Certificate of Need	Referred to House Committee on Health and Human Resources	This measure eliminates the certificate-of-need program.	Del. Amy Summers (R)
WV	HB 2264	Certificate of Need	Passed House; Referred to Senate Committee on Health and Human Resources	This measure exempts hospital services performed at a hospital from certificate-of-need requirements.	Del. Larry Pack (R)

WV	HB 2441 / SB 155	Certificate of Need	Referred to House Committee on Government Organization / Referred to Senate Committee on Judiciary	This measure authorizes the Health Care Authority to promulgate a legislative rule relating to exemption from certificate of need review.	Del. Geoff Foster (R) / Sen. Dave Sypolt (R)
WV	HB 2835	Certificate of Need	Referred to House Committee on Health and Human Resources	This measure requires a certificate of need for the construction, development, acquisition or other establishment of an alcohol or drug treatment facility and drug and alcohol treatment services, regardless of the minimum expenditure.	Del. John Kelly (R)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 1400	Public Option	Introduced	This measure would create the California Guaranteed Health Care for All program, or CalCare, to provide comprehensive, universal single-payer health care coverage and a health care cost control system for the benefit of all residents of the state. The bill would authorize health care providers to collectively negotiate fee-for-service rates of payment for health care items and services using a third-party representative. The CalCare Board - which will be established to govern CalCare - shall use existing Medicare prospective payment systems to establish and serve as the comparative payment rate system in global budget negotiations, and there shall be a rebuttable presumption that the Medicare fee-for-service rates of reimbursement constitute reasonable fee-for-service payment rates.	Asm. Ash Kalra (D)
CO	HB 1232	Public Option	Signed by Governor	"This measure was amended substantially in committee. The amended measure directs the Commissioner of Insurance, on or before January 1, 2022, to develop a standardized health insurance plan that private health insurance carriers are required to offer in the individual and small group market segments. The plan must be developed through a stakeholder engagement process, must offer coverage at the bronze, silver, and gold coverage levels, and must include pediatric care and all essential health benefits Beginning January 1, 2023, insurance carriers are required to offer the standardized plan in any county where they offer coverage in the individual and/or small group markets. In addition, the commissioner may require a carrier to offer the standardized plan in specific counties where no carrier is offering the plan. Standardized plans must be offered at premium rates at least 6% less than the plans that carrier offered in the 2021 calendar year, adjusted for medical inflation. For 2024 and 2025, the plans must be offered at premium rates at least 12% and 15% less, respectively. Beginning in 2026, premiums may increase by no more than medical inflation. If a carrier is unable to meet the premium or network adequacy requirements for the standardized plan, the Department of Insurance must hold a public hearing to examine why the carrier failed to do so. The hearing is open to affected parties throughout the health care system. Based on evidence presented at the hearing and actuarial analysis, the commissioner may establish provider and hospital reimbursement rates as needed to meet the requirements. Rates may not be less than 135% of Medicare rates for providers and 155% for hospitals, and adjustments and exceptions for certain classes of hospitals are detailed in the bill. A provider may be fined up to $5,000 for refusal to participate. A hospital refusing to participate is subject to fines of up to $10,000 per day, increasing to $40,000 per day after 30 days, and state regulators may suspend, revoke, or impose conditions on its license. The original language required the Commissioner of Insurance in the Department of Regulatory Agencies to establish a standardized health benefit plan by rule to be offered by health insurance carriers in the individual and small group markets that will go live in 2023, and which private insurers will be encouraged to offer. In 2023, each carrier would set a goal of offering a standardized plan premium that is at least 10% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. In 2024, each carrier would set a goal of offering a standardized plan premium that is at least 20% less than the premium rate for health benefit plans offered by that carrier in the 2021 calendar year in the individual and small group market. In 2025 and each year thereafter, carriers are encouraged to limit annual premium rate increases for the standardized plan to no more than the consumer price index plus 1%, relative to the previous year. If the carriers do not meet the established	Rep. Dylan Roberts (D)

CT	SB 842	Public Option	Referred to Joint Committee on Insurance and Real Estate	This measure creates a "multi-employer plan" run by the state, and administered through the state's Health Insurance Exchange, that would be available to nonprofits and small employers (50 or fewer employees) and would place a 3% annual cap on premium increases for the plan. The plan is modeled after the Partnership Plan, which is the employee health plan available to municipal workers (described as non-state public employees).	Joint Committee on Insurance and Real Estate
GA	SB 83	Public Option	Referred to Senate Committee on Appropriations	Establishes the PeachCare Public Option Program to provide healthcare coverage to individuals not eligible for Medicare, Medicaid, or the PeachCare for Kids Program. Health care provider reimbursement rates would be subject to available funds, and the medical loss ratio for insurers offering the program would be set consistent with the ratio applicable to Medicaid.	Sen. Sally Harrell (D)
IA	HF 55	Public Option	Referred to House Committee on Human Resources	This measure establishes the Healthy Iowa Program, a universal healthcare program. Under the program, health care services provided to members shall be paid for on a fee-for-service basis unless the board establishes another payment methodology, with a rebuttable presumption that the Medicare rate of reimbursement constitutes a reasonable fee-for-service payment rate.	Rep. Bruce Hunter (D)
MD	HB 534	Public Option	Introduced	This measure establishes the Healthy Maryland Program as a public corporation and a unit of state government to provide comprehensive universal health coverage for every Maryland resident funded by broad-based revenue. Under the program, health care services provided to members shall be paid for on a fee-for-service basis unless the board establishes another payment methodology, with a rebuttable presumption that the Medicare rate of reimbursement constitutes a reasonable fee-for-service payment rate.	Del. Gabriel Acevero (D)
MA	HB 1243	Public Option	Referred to Joint Committee on Health Care Financing	This measure creates the MassHealth Medicaid buy-in program for purchase by an individual or by an employer as an employer-sponsored insurance plan. The office may establish premiums or cost-sharing requirements for an optional expanded plan that are equal to or exceed the costs of covering participating members based on the per-member-per-month expenditures or other measures. Additional revenue generated in excess of the cost to administer the expanded plan may be used to increase provider payment rates within the optional expanded plan and the MassHealth program. The bill makes no reference to how reimbursement rates will be calculated.	Rep. Christine Barber (D)
MA	HB 1267 / SB 766	Public Option	Referred to Joint Committee on Health Care Financing / Referred to Joint Committee on Health Care Financing	This measure establishes a single-payer Medicare for all health care financing system, in addition to establishing the Massachusetts Health Care Trust to design and implement the program. The bill does not specify what reimbursement for providers will look like under the program.	Rep. Denise Garlick (D) / Sen. James Eldridge (D)
MA	SB 747	Public Option	Referred to Joint Committee on Health Care Financing	This measure establishes a public option program, to be run by the Commonwealth Connector Authority. The Connector Board shall establish payment rates for the Public Health Insurance Option for services and providers based on parts A and B of Medicare. The Commonwealth Connector Board may determine the extent to which adjustments to base Medicare payment rates shall be made in order to fairly reimburse providers and medical goods and device makers, as well as to maintain a strong provider network.	Sen. Jason Lewis (D)

MA	SB 758	Public Option	Referred to Joint Committee on Health Care Financing	This measure directs the Center for Health Information to develop a single payer benchmark. The benchmark may consider the costs of a single-payer health care system at different actuarial values, levels of cost-sharing and levels of provider reimbursement; provided however that the benchmark shall include all actuarial values, levels of cost-sharing and levels of provider reimbursement considered by the center. In developing the methodology, the center shall 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. The Center for Health Information and Analysis, in conjunction with the Health Policy Commission and the Division of Insurance, shall provide an annual report detailing a comparison of the actual health care expenditures in the commonwealth for 2022, 2023, and 2024 with the single payer benchmark for 2022, 2023, and 2024, respectively, indicating whether the state would have saved money while expanding access to care under a single payer health care system. If a report determines that the single payer benchmark outperformed the actual total health care expenditures in the state in 2022, 2023, or 2024, the health policy commission shall submit a proposed single payer health care implementation plan to the legislature within one year of the date that the report is filed.	Sen. Julian Cyr (D)
MN	HF 11 / SF 1029	Public Option	Referred to House Committees on Commerce Finance & Policy and Health Finance & Policy / Referred to Senate Committee on Health and Human Services Finance and Policy	This measure creates a public option and expands eligibility for MinnesotaCare to undocumented citizens. The bill requires the commissioner to develop an implementation plan and recommendations for an alternative delivery and payment system that delivers care under fee-for-service through a primary care case management system and reimburses providers for high-quality, value-based care at levels sufficient to increase enrollee access to care, address racial and geographic inequities in the delivery of health care, and incentivize preventive care and other best practices.	Rep. Jennifer Schultz (D) / Sen. Melissa H. Wiklund (D)
MO	HB 1439	Public Option	Referred to House Committee on Health and Mental Health Policy	This measure establishes the Missouri Universal Health Assurance Program to provide a publicly financed, statewide insurance program for all residents of this state. The program shall reimburse independent providers of health care services on a fee-for-service basis, using the federal Medicare reimbursement fees as a guideline. The program would be funded through a health assurance tax on all Missouri taxable income of resident individuals that exceeds $5,000.	Rep. Emily Weber (D)

NV	SB 420	Public Option	Signed by Governor	This measure requires the Director of the Department, in consultation with the Executive Director of the Exchange and the Commissioner of Insurance, to design, establish and operate a public health benefit plan known as the Public Option, made available through the Exchange and for direct purchase. The Director must use a statewide competitive bidding process to solicit and enter into contracts with health carriers and other qualified persons to administer the Public Option, and health carriers that provide health care services to recipients of Medicaid through managed care are required to participate. Reimbursement rates under the Public Option must be, in the aggregate, comparable to or better than reimbursement rates available under Medicare. The bill also requires Medicaid managed care organizations to reimburse critical access hospitals and any affiliated federally-qualified health centers or rural health clinics for covered services at a rate that is equal to or greater than the rate those facilities receive for services provided to recipients of Medicaid on a fee-for-service basis.	Sen. Nicole Cannizzaro (D)
NY	AB 6058 / SB 5474	Public Option	Passed Assembly Committee on Health and referred to Assembly Committee on Codes / Referred to Senate Committee on Health	This measure establishes the New York Health program, a comprehensive system of health insurance for state residents. All payment methodologies and rates under the program shall be reasonably related to the cost of efficiently providing the health care service and assuring an adequate and accessible supply of the health care services. In determining such payment methodologies and rates, the commissioner shall consider factors including usual and customary rates; the level of training, education, and experience of the health care provider or providers involved; and the scope of services, complexity, and circumstances of care including geographic factors. Until and unless other applicable payment methodologies are established, health care services provided to members under the program shall be paid on a fee-for-service basis, except for care coordination. The plan will be funded by a progressively graduated New York health tax.	Asm. Richard Gottfried (D) / Sen. Gustavo Rivera (D)
OH	HB 446 / SB 253	Public Option	Referred to House Committee on Insurance / Referred to Senate Committee on Insurance	This measue establishes a universal health care program for all residents and employees in the state. The bill establishes the health care agency to administer the plan and a 15-member health care board to develop and mantain the plan. The board is also tasked with negotiating fee-for-service reimbursement rates for providers.	Rep. Mike Skindell (D) / Sen. Yeresa Fedor (D)
OK	HB 1808	Public Option	Referred to Appropriations and Budget Health Subcommittee	This measure directs the Oklahoma Health Care Authority to implement a Medicaid Buy-In Program that encourages choice based on value.	Rep. Forrest Bennett (D)

OR	HB 2010	Public Option	Signed by Governor	This measure directs the Oregon Health Authority (OHA), in collaboration with the Department of Consumer and Business Services (DCBS), to develop an implementation plan for a public health plan. The public health plan would be made available to individuals and families in the individual health insurance market, and to small employers whose employees struggle with health care costs. OHA and DCBS are directed to analyze federal funding opportunities, assess the need for this plan across specific populations, and determine the effect the plan would have on the overall stability of insurance markets in Oregon. The agencies are also directed to assess how recent federal program changes could improve affordability and access to coverage, benefits of a state-based technology platform, subsidy needs, and coverage strategies under development by the Task Force on Universal Health Care. DCBS and OHA are to report to the Legislative Assembly on this work no later than January 1, 2022. OHA is also directed to develop recommendations for a regional global budget health care delivery model pilot. OHA is to report these recommendations to the interim committees of the Legislative Assembly related to health no later than July 1, 2022. The bill had language stripped out that would create a public option to allow consumers to enroll in state-designed health plans through the health insurance exchange. Public option health plans under this bill must reimburse health care providers for the cost of services at no more than 100% of the reimbursement paid by Medicare, unless the public option provider can demonstrate that such rate is insufficient to recruit enough providers to meet standards established for network adequacy.	Rep. Andrea Salinas (D)
RI	H 5628 / S 233	Public Option	Held for further study / Held for further study	This measure establishes a universal, comprehensive, affordable single-payer health care insurance program which shall be referred to as, "the Rhode Island Comprehensive Health Insurance Program" (RICHIP). Under this program, RICHIP reimbursements to providers shall match the highest reimbursement rates offered by Medicare or Medicaid to Rhode Island qualified residents that are in effect at the time services and goods are provided. If the director determines that there are no such federal reimbursement rates or that such rates are significantly different from those in neighboring states, the director shall set additional or alternative rates in consultation with the RICHIP advisory committee such that rates of reimbursement are fair and reasonable. For-profit providers may continue to offer services and goods in Rhode Island, but are prohibited from charging patients more than RICHIP reimbursement rates for covered services and goods and must notify qualified Rhode Island residents when the services and goods they offer will not be reimbursed fully under RICHIP. The program shall pay out-of-state health care providers an amount not to exceed RICHIP rates; RICHIP participants are responsible for paying out-of-state providers for costs in excess of RICHIP reimbursements. The program shall pay for emergency and urgently needed services and goods that are obtained by the RICHIP participant anywhere outside of Rhode Island to the same extent allowed if such services or goods were provided in Rhode Island.	Rep. David Morales (D) / Sen. Samuel Bell (D)
SC	H 3573	Public Option	Referred to House Committee on Labor, Commerce, and Industry	This measure directs the South Carolina Department of Health and Human Services to establish a Medicaid buy-in plan available for purchase by any resident of the state who is ineligible for Medicaid, Medicare, and advance premium tax credits under the federal Patient Protection and Affordable Care Act; and whose employer has not unenrolled or denied the resident enrollment in employer-sponsored health insurance coverage on the basis that the resident would otherwise qualify for enrollment in Medicaid buy-in coverage. Health care provider reimbursement rates must be based on the state Medicaid fee schedule.	Rep. Ivory Thigpen (D)

TX	HB 4084	Public Option	Referred to House Committee on Appropriations	Establishes the Texas Care Plan Medicaid buy-in program. Under the bill, the Health and Human Services Commission, in consultation with the Commissioner of Insurance, is tasked with developing the program to allow residents of this state to purchase health benefit plan coverage through Medicaid by enrolling in a managed care plan offered by a Medicaid managed care organization. Eligibility would include household income limits, ineligibility under Medicaid, lack of coverage under another health benefit plan because the participant does not have access to or cannot afford coverage through an employer-sponsored health benefit plan, and financial participation.	Rep. James Talarico (D)
WA	HB 1093/SB 5091	Public Option	Referred to House Committee on Appropriations / Referred to Senate Committee on Ways & Means	This measure directs the health care authority to convene a work group on establishing a universal health care system. The work group must consist of a broad range of stakeholders with expertise in the health care financing and delivery system. The work group must study and make recommendations to the legislature on how to create, implement, maintain, and fund a universal health care system that may include publicly funded, publicly administered, and publicly and privately delivered health care that is sustainable and affordable to all Washington residents. The final report must include options for increasing coverage and access for uninsured and underinsured populations; transparency measures across major health system actors including carriers, hospitals, and other health care facilities, and provider groups that promote understanding and analyses to best manage and lower costs; and innovations that will promote quality, evidence-based practices leading to sustainability, and affordability in a universal health care system. Additionally, the law allocates funding to implement Substitute Senate Bill No. 5741 creating an all-payer claims database.	Rep. Timm Ormsby (D) / Sen. Christine Rolfes (D)
WA	S 5377	Public Option	Signed by Governor	This amended measure requires a hospital that receives payment from Medicaid or a public or school employee benefits program must, upon an offer from a public option plan, contract with at least one public option plan to provide in-network services to enrollees of the plan if a public option plan is not available in each county in plan year 2022 or later. A hospital owned and operated by a health maintenance organization is exempt from the contracting requirement. HCA must also contract with one or more carriers to provide public option plans in every county of the state or in each county within a region of the state. A health carrier or hospital cannot condition negotiations or participation in a health plan on the hospital's negotiation or participation in a public option plan. Additionally, the bill requires the health benefit exchange, in consultation with the insurance commissioner and the authority, to analyze public option plan rates paid to hospitals for in-network services and whether they have impacted hospital financial sustainability. The original language required hospital systems that own or operate four or more hospitals in the state to contract with at least two public option plans of the hospital's choosing in each geographic rating area in which the hospital system operates a hospital.	Sen. David Frockt (D)

WV	HB 2241	Public Option	Referred to House Committee on Banking and Insurance	This measure directs the Department of Health and Human Resources to establish an Affordable Medicaid Buy-In Plan. The plan shall be offered for purchase to residents who are ineligible for Medicaid, Medicare, and advance premium tax credits under the federal Patient Protection and Affordable Care Act; and whose employer has not disenrolled or denied the resident enrollment in employer-sponsored health coverage on the basis that the resident would otherwise qualify for enrollment in Affordable Medicaid buy-in coverage. Health care provider reimbursement rates shall be based on the Medicaid fee schedule. Contingent upon available funds, the department may increase reimbursement rates for health care providers, so long as these increases do not jeopardize the sustainability of Medicaid or the plan. The bill also establishes an advisory council to the Affordable Medicaid Buy-In Program. Unlike HB 3001, this bill creates the Health Care Affordability And Access Improvement Fund. Money in the Health Care Affordability and Access Improvement Fund shall be expended by the department to ensure affordability of the plan for enrollees in the plan, though the department may expend a maximum of 5% per year of the fund for the administrative costs related to the plan. Additionally, the bill calls for additional study to evaluate viability for offering the plan to a wider population of residents. The bill also appropriates $12 million for the implementation and administration of the plan, and $12 million to ensure affordability of the plan for enrollees in the plan.	Del. Evan Worrell (R)
WV	HB 3001	Public Option	Referred to House Committee on Health and Human Resources	This measure directs the Department of Health and Human Resources to establish an Affordable Medicaid Buy-in Plan. The plan shall be offered for purchase to residents who are ineligible for Medicaid and Medicare, and whose employer has not disenrolled or denied the resident enrollment in employer-sponsored health coverage on the basis that the resident would otherwise qualify for enrollment in Affordable Medicaid buy-in coverage. Health care provider reimbursement rates shall be based on the Medicaid fee schedule. Contingent upon available funds, the department may increase reimbursement rates for health care providers, so long as these increases do not jeopardize the sustainability of Medicaid or the plan. The bill also establishes an advisory council to the Affordable Medicaid Buy-In Program. Unlike HB 2241, this bill requires that the plan be offered in the individual health insurance market, but not be sold on the Health Insurance Marketplace; the plan be in the platinum metal tier; and the department establish an updated premium sliding scale for individuals under 200% of the federal poverty level who purchase the Medicaid Buy-in plan in its 1332 waiver application, prioritizing individuals transitioning from Medicaid coverage.	Del. Evan Worrell (R)

State	Bill	Category	Status	Summary	Sponsor
CT	SB 52	Surprise Billing	Referred to Joint Committee on Insurance and Real Estate	This measure requires an out-of-network health care provider to inform an insured that the provider is out-of-network, and provide the insured with an opportunity to decline to receive health care services from the provider, before the provider provides health care services to the insured.	Sen. Daniel Champagne (R)
GA	HB 234	Surprise Billing	Signed by Governor	This measure provides an option for self-funded healthcare plans, exempt from state regulation under federal law, to opt in to Georgia's Surprise Billing Consumer Protection Act	Rep. Lee Hawkins (R)
KY	SB 19	Surprise Billing	Referred to Senate Committee on Banking & Insurance	This measure requires the Commissioner of Insurance to establish a database of billed health care service charges; requires an insurer to reimburse for unanticipated out-of-network care; prohibits balance billing from a provider who has been reimbursed as required; and provides for an independent dispute resolution program to review reimbursements provided for unanticipated out-of-network care.	Sen. Ralph Alvarado (R)
ME	LD 1481	Surprise Billing	Died in Committee	This measure eliminates the use of independent medical claims databases in the laws governing surprise medical bills and bills for out-of-network emergency services.	Rep. Joshua Morris (R)
MA	HB 1197 / SB 680	Surprise Billing	Referred to Joint Committee on Financial Services / Referred to Joint Committee on Financial Services	This measure requires an item or service furnished by an out-of-network provider during a year and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, the total amount payable under such a plan, coverage, or issuer, respectively in the case of a participant, beneficiary, or enrollee covered under such plan or coverage and receiving such item or service from such an out-of-network provider, to be paid in accordance with the determination of the qualifying payment amount outlined in the bill.	Rep. Jon Santiago (D) / Sen. Adam Gomez (D)
MO	SB 261	Surprise Billing	Referred to Senate Committee on Insurance and Banking	This measure modifies the definition of "unanticipated out-of-network care" to no longer require that the patient shall present at the in-network facility "with an emergency medical condition".	Sen. Brian Williams (D)
NJ	A 3817	Surprise Billing	Reported out of Assembly Financial Institutions and Insurance Committee	This measure requires health care providers participating in carrier networks to give notice to covered persons of a provider's referral to an out-of-network provider.	Asm. Gary Schaer (D)
NC	SB 505	Surprise Billing	Passed Senate; Re-referred to House Committee on Rules, Calendar, and Operations	This measure requires all contracts or agreements for participation as an in-network health services facility between an insurer offering health benefit plans in this State and a health services facility at which there are out-of-network providers who may be part of the provision of services to an insured while receiving care at the health services facility to require that an in-network health services facility give at least 72 hours' advanced written notification to an insured that has scheduled an appointment at that health services facility of any out-of-network provider who will be part of the provision of the insured's health care services. If there is not at least 72 hours between the scheduling of the appointment and the appointment, then the in-network health services facility shall give the written notice to the insured on the day the appointment is scheduled. In the case of emergency services, the health services facility shall give written notice to the insured as soon as reasonably possible.	Sen. Joyce Krawiec (R)

OK	HB 2807	Surprise Billing	Referred to House Committee on Insurance	This measure requires all health insurance benefit policies to reference the usual, customary, and reasonable rate for the purpose of providing an enrollee with reimbursement transparency for out-of-network health care providers and facilities. If a health benefit plan issuer or administrator has restricted or prohibited a health care provider or health care facility from billing an insured, participant or enrollee for applicable copayment, coinsurance, and deductible amounts required under the Oklahoma Out-of-Network Surprise Billing and Transparency Act, the Attorney General may bring a civil action in the name of the state to ensure the health care provider, health care facility or administrator may bill an enrollee the applicable copayment, coinsurance, and deductible amounts.	Rep. Chris Sneed (R)
OR	HB 4042	Surprise Billing	Referred to House Committee on Health Care	This measure prohibits surprise billing for emergency services provided at out-of-network facility. Prohibits out-of-network health care provider or health care facility from billing or attempting to collect from enrollee in health benefit plan or health care service contract for emergency services provided at in-network facility or out-of-network facility or for other inpatient or outpatient services provided at in-network facility.	Gov. Kate Brown (D)
PA	HB 98	Surprise Billing	Referred to House Committee on Insurance	This measure prohibits an out-of-network provider that renders mental health care, substance use disorder treatment, or treatment for a disability to an eligible insured from billing an eligible insured for any amount in excess of the cost-sharing amounts that would have been imposed if the mental health care, substance use disorder treatment, or treatment for a disability had been rendered by an in-network provider.	Rep. Daniel Miller (D)
RI	S 304	Surprise Billing	Held for further study	This measure protects people with health insurance from surprise medical bills for emergency and other services by requiring a non-participating health care provider to bill an insured party only for a co-payment, or deductible.	Sen. Stephen Archambault (D)
TN	HB 2 / SB 1	Surprise Billing	Deferred to Summer Study in Insurance Subcommittee / Senate set for 1st Calendar of 2022	This measure establishes an independent dispute resolution process that ensures a fair reimbursement for out-of-network services; implements a balance bill prohibition for emergency services in an out-of-network facility and for facility-based non-emergency services; and creates opportunities for transparency and notice to a patient of unexpected medical bills that arise from receiving care from out-of-network providers.	Rep. Robin Smith (R) / Sen. Bo Watson (R)
TX	HB 4115 / SB 999	Surprise Billing	Left pending in committee / Passed Senate; passed House Committee on Insurance	This measure establishes consumer protections against certain medical and health care billing by out-of-network ground ambulance service providers, by prohibiting an individual or entity from billing an insured, participant, or enrollee in an amount greater than an applicable copayment, coinsurance, or deductible under the insured's, participant's, or enrollee's managed care plan or imposing a requirement related to that prohibition.	Rep. Tom Oliverson (R) / Sen. Kelly Hancock (R)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 1020	Other	Signed by Governor	This measure would require that uninsured patients or patients with high medical costs who earn at or below 400% of the federal poverty level be eligible for charity care or discount payments from a hospital, and would authorize a hospital to grant eligibility for charity care or discount payments to patients with incomes over 400% of the federal poverty level. A hospital would have to prominently display a notice of the hospital's policy for financially qualified and self-pay patients on the hospital's internet website with a link to the policy itself. Additionally, this bill would prohibit a hospital from selling patient debt to a debt buyer; prohibit a hospital or other assignee from using civil arrest to collect unpaid hospital bills for patients eligible under the hospital's charity care or discount payment policies; require an entity collecting patient debt to include in the initial notice to the debtor specified information, including how to obtain an itemized hospital bill; prohibit debt collection before 180 days after the initial billing, regardless of the patient's financial status; and require a hospital to provide the Department of Health Care Access and Information with a copy of its debt collection policy, and would require the office to make this policy, as well as the hospital's discount payment policy and charity care policy, available on the office's internet website.	Asm. Laura Friedman (D)
DE	SB 120	Other	Signed by Governor	This measure directs the Health Care Commission to monitor compliance with value-based care delivery models and develop, and monitor compliance with, alternative payment methods that promote value-based care; requires rate filings limit aggregate unit price growth for inpatient, outpatient, and other medical services, to certain percentage increases over the next four years; requires an insurance carrier to spend a certain percentage of its total cost on primary care over the next four years; and requires the Office of Value-Based Health Care Delivery to establish mandatory minimums for payment innovations, including alternative payment models, and evaluate annually whether primary care spending is increasing in compliance with the established mandatory minimums for payment innovations.	Sen. Bryan Townsend (D)
ID	S 1092	Other	Passed Senate Committee on Health and Welfare; Referred to House Committee on Health and Welfare	This measure amends existing law to provide for reimbursement for new in-state hospitals serving as Medicaid providers. New in-state hospitals, defined as those that have received first accreditation from the Centers for Medicare and Medicaid services (CMS) or other CMS-approved accreditation bodies and are designated as in-state noncritical access hospitals will be reimbursed at 91% of cost for a period of 36 months following receipt of accreditation approval. Following the initial 36 month period, the Department of Health will work with the hospital to establish value-based payment methods for inpatient and outpatient hospital services to replace existing cost-based reimbursement methods.	Health and Welfare Committee
ME	LD 120	Other	Law without Governor's signature	This measure establishes the Office of Affordable Health Care for the purpose of analyzing health care costs in the state. Duties include: analyzing health care cost growth trends and correlation to the quality of health care; analyzing health care spending trends by consumer categories, payer type, provider categories or any other measurement that presents available data in a manner that may assist the legislative oversight committee in understanding health care cost drivers, health care quality and utilization trends, consumer experience with the health care system or any other aspect of the health care system; monitoring the adoption of alternative payment methods that foster innovative health care delivery and payment models to reduce health care cost growth and improve the quality of health care; and developing proposals for consideration by the legislative oversight committee.	Sen. Troy Jackson (D)

MA	H 1174 / S 673	Other	Moved to 2021 session	This measure creates the Community Hospital and Health Center Reinvestment Trust Fund to provide annual financial support to eligible acute-care hospitals and community health centers. The secretary of the Department of Health and Human Services will administer the fund. An eligible hospital must be an acute care hospital, either a "high public payer facility" or a hospital with an average relative price below the statewide average price.	Rep. Elizabeth Malia (D)/Sen. Julian Cyr (D)
MN	HF 1612 / SF 90	Other	Referred to House Committee on Health Finance and Policy / Referred to Senate Committee on Health and Human Services Finance and Policy	This measure establishes an 15-member Health Policy Commission. The commission shall submit a report listing recommendations for changes in health care policy and finance by June 15 each year to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care. The reports are to be based upon the state's commercial health care costs and public health care program spending to that of other states; the state's commercial health care costs and public health care program spending in any given year to its costs and spending in previous years; factors that influence and contribute to Minnesota's ranking for commercial health care costs and public health care program spending, including the year over year and trend line change in total costs and spending in the state; and efforts to reform the health care delivery and payment system in Minnesota to understand emerging trends in the commercial health insurance market, including large self-insured employers, and the state's public health care programs. In making recommendations to the legislative committees, the commission shall consider how the recommendations might positively impact the cost-shifting interplay between public payer reimbursement rates and health insurance premiums. The commission shall also consider how public health care programs, where appropriate, may be utilized as a means to help prepare enrollees for an eventual transition to private sector coverage. The report shall include any draft legislation to implement the commission's recommendations.	Rep. Joe Schomacker (R) / Sen. Michelle Benson (R)

MN	HF 2128 / SF 2360	Other	Signed by Governor	This measure is a health and human services policy and finance omnibus bill which covered several different areas of health system cost reform. The bill had language stripped out that would have required that, when implementing prospective payment methodologies, the commissioner use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified. The bill also had language stripped out that would have directed the commissioner of health to conduct studies on telehealth. These studies include the use of audio-only communication in supporting equitable access to health care services, including behavioral health services for the elderly, rural communities, and communities of color, and eliminating barriers for vulnerable and underserved populations; the impacts of telehealth payment methodologies and expansion on access to health care services, quality of care, and value-based payments and innovation in care delivery; and other aspects of telehealth. The bill also had language stripped out that would have directed the Commissioner of Health to develop recommendations to expand access to data in the all-payer claims database to additional outside entities for public health and research purposes. It also required health plan companies and third-party administrators to submit encounter data to the all-payer claims database on a monthly basis, rather than every six months as in current law. The bill also had language stripped out that would have required the Commissioner of Human Services to develop a proposal for a public option program. The proposal could consider multiple public option structures, but at least one had to be through expanded enrollment into MinnesotaCare. The bill also had language stripped out that would have required, effective for services provided on or after July 1, 2023, payments to critical access hospitals for outpatient, emergency, and ambulatory surgery facility fee services to be increased for hospitals providing high levels of high-cost or 340B drugs, and required the adjustment to be based on each hospital's share of total reimbursement for 340B drugs to all critical access hospitals, but not to exceed three percentage points.	Rep. Tina Liebling (D) / Sen. Michelle R. Benson (R)
NJ	A 1088	Other	Referred to Assembly Committee on Health	This measure exempts certain specialty hospitals from paying a 0.53% assessment towards the Health Care Subsidy Fund.	Asm. Carol Murphy (D)
NC	SB 415	Other	Referred to Senate Committee on Health Care	This measure establishes a benchmark for balance billing. Under the bill, a health care provider's total payment for services provided outside an insurer's health care provider network or for emergency care services shall be presumed to be reasonable if the payment is equal to or higher than the benchmark amount. The benchmark amount shall be calculated at least annually and shall be the lesser of 100% of the current Medicare payment rate, the health care provider's actual charges, and the median contracted rate in the insurer's health care provider network.	Sen. Ralph Hise (R)
OR	HB 2082	Other	Referred to House Committee on Health Care	This measure creates the Value-Based Payments Advisory Subcommittee of Oregon Health Policy Board to develop recommendations for moving the state from a predominantly fee-for-service payment system to a predominantly value-based payment system.	Gov. Kate Brown (D)

PA	HB 44	Other	Referred to House Committee on Health	This measure directs the Health Department to implement, through the Medicaid outcome-based programs, targeted savings to the Medicaid program including averted costs by actions taken by hospitals or managed care organizations under the Medicaid outcome-based programs and reduced expenditures for the Medicaid program which result from actions taken by hospitals or managed care organizations under Medicaid outcome-based programs. Additionally, the bill directs the health department to establish performance-based financial incentives and penalties for hospitals under the Hospital Outcomes Program. Financial incentives provided by the department shall include an adjustment to the reimbursement a hospital receives under the Medicaid program based on whether the hospital successfully improved outcomes under the Hospital Outcomes Program concerning potentially avoidable readmissions and complications. The department is also directed to establish performance-based financial incentives and penalties for managed care organizations based on whether the managed care organization reduced avoidable admissions, readmissions, emergency visits or complications.	Rep. Seth Grove (R)
RI	H 6327 / S 878	Other	Held for further study / Held for further study	This measure raises Rhode Island Medicaid primary care payment rates to not less than federal Medicare rates for the same service.	
RI	S 880	Other	Held for further study	This measure establishes a medical assistance rate review process. Each provider rate would be reviewed at least once every 5 years. The bill also establishes a 24-member medical assistance provider rate review advisory committee.	Sen. Louis DiPalma (D)
TN	HB 939 / SB 838	Other	Deferred to Summer Study in House Committee on State Government / Referred to Senate Commerce and Labor Committee	This measure requires the state group insurance plan to have an alternate allowable charges schedule to allow enrollees to utilize the services of any licensed medical provider in the United States without being penalized with out-of-network cost sharing charges, except as provided in the schedule, and to have a preferred tier and non-preferred tier. The maximum allowable charges schedule must be the Medicare payment schedule plus 60% of the Medicare reimbursement rate for the service provided for facility fees, and the Medicare payment schedule plus 25% of the Medicare reimbursement rate for the service provided for medical provider charges. If there is no Medicare payment rate for a particular service, then the maximum allowable charges schedule for that particular service is 40% of the billed charges.	Rep. Mike Sparks (R) / Sen. Frank S. Nicely (R)
TX	HB 2612	Other	Died in House Committee on Public Health	This measure allows insurers to reimburse rural health clinics for a telehealth-originating site facility fee for a covered medical service delivered to a Medicaid enrollee. Additionally, the bill ensure that Medicaid recipients and child health plan program enrollees, regardless of whether receiving benefits through a managed care delivery model or another delivery model, have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology; and requires reimbursement for a telemedicine medical service or telehealth service at the same rate as the child health plan program reimburses for the same in-person service.	Rep. John Raney (R)
TX	HB 974	Other	Referred to House Committee on Public Health	This measure allows insurers to reimburse rural health clinics for a telehealth originating site facility fee for a covered medical service delivered to a Medicaid enrollee. Additionally, the law requires the executive commissioner, by January 2022, to implement reimbursement for telemedicine medical services and telehealth services for certain programs, services, and benefits, as well as implement audio-only benefits for behavioral health services	Rep. Four Price (R)

VT	S 132	Other	Referred to Senate Committee on Health and Welfare	This measure requires accountable care organizations (ACOs) to collect, analyze, and report quality data to the Green Mountain Care Board to enable the board to determine value-based payment amounts and the appropriate distribution of shared savings among the ACO's participating health care providers. It would also require accountable care organizations to provide the Office of the Auditor of Accounts with access to their records to enable the Auditor to audit their financial statements, receipt and use of federal and State monies, and performance. The bill would require the Green Mountain Care Board to review and approve proposed health care contracts and fee schedules between health plans and health care providers and would place certain conditions on the health care contracting process. It would seek to increase transparency in the purchase and lease of items of durable medical equipment. The bill would also require submission of reports to the General Assembly on inclusion of specialty care in the All-Payer ACO Model.	Sen. Virginia Lyons (D)