2022 Health System Costs Tracker

State	Bill	Category	Status	Summary	Sponsor
AK	SB 41	Transparency	Failed, sine die	This measure requires a health care insurer to establish an interactive mechanism for use by a covered person on the publicly accessible website of the insurer that allows a covered person to request and obtain information on the payments made by the insurer to network health care providers for services. The mechanism must allow a covered person to compare prices for the cost of a particular health care service among network providers. The measure also establishes a right to shop act, requiring health care insurers to develop and implement a program providing incentives for a covered person to elect to receive a health care service from a covered provider that charges less than the average price paid by the insurer for that service. The insurer must make an incentive program available as a component of all health insurance plans offered in the state. If a covered person participates in the incentive program and elects to receive services from an out-of-network provider that results in savings for the insurer, the insurer shall apply the amount paid for the service toward the cost sharing owed by the covered person as if the services were provided by an in-network provider.	Sen. Shelley Hughes (R)

State	Bill	Category	Status	Summary	Sponsor
AZ	SB 1088	Transparency	Enacted, signed by Governor	This measure requires that a health care facility with more than 50 inpatient beds make available upon request or online the direct pay price for at least the 50 most used diagnostic-related group (DRG) codes and at least the 50 most used outpatient service codes. A facility with 50 or fewer inpatient beds must make available the direct pay price for at least the 35 most used DRG codes and at least the 35 most used outpatient service codes. Each health care facility must update the direct pay prices at least annually. The measure requires that an enrollee's payment to an out-of-network health care provider for services covered under the enrollee's plan, the amount paid shall first be applied to the enrollee's in-network deductible, with any remaining monies being applied to the enrollee's out-of-network deductible, if applicable.	Sen. Nancy Barto (R)
CO	HB 22-1285	Transparency	Enacted, signed by Governor	This measure prohibits a hospital, including critical access hospitals, from initiating or pursuing collection actions against a patient for debt incurred by the patient on a date of service when the hospital was not in compliance with federal hospital price transparency laws.	Rep. Daneya Esgar (D) and Rep. Patrick Neville (R)
CO	SB 22-068	Transparency	Enacted, signed by Governor	The measure requires the administrator of the all-payer health claims database (APCD) to create a tool to facilitate the review of certain health claims reimbursement data that are included in the APCD. The tool must include 2018 health claims reimbursement data as the first year of available data. The legislation includes minimum requirements for the design of the tool, including how the information will be displayed and searchable by users of the tool. The legislation also requires the administrator to update the tool at least annually.	Sen. Robert Rodriguez (D), Sen. Chris Kolker (D), Sen. Susan Lontine (D), and Sen. Dan Woog (R)

State	Bill	Category	Status	Summary	Sponsor
FL	HB 1527	Transparency	Failed, sine die	This measure requires licensed facilities to provide timely and accurate financial information and quality of service measures to patients and prospective patients of the facility. Each facility shall post on its website a list of standard charges for at least 300 shoppable health care services.	Rep. Josie Tomkow (R)
FL	SB 296	Transparency	Failed, sine die	This measure requires each licensed health care facility to make available a public list of the facility's standard charges for all items and services provided by the facility.	Sen. Ileana Garcia (R)
GA	HB 834	Transparency	Failed, sine die	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)
GA	HB 1276	Transparency	Enacted, signed by Governor	This measure requires the Department of Community Health to report, biannually or more frequently, data relating to state health plans on the department's website. Reports must include: data on hospital utilization and costs (amounts paid per facility, plan paid amounts, and net payment per admission); the number, type of, and changes in enrolled providers; and county-level data on primary care providers with indications on which counties fall below defined benchmarks.	Rep. Lee Hawking (R) and Rep. Karen Bennett (D)
IA	HF 2248	Transparency	Failed, sine die	This measure requires that a health care provider who determines that a patient is a candidate for outpatient surgery, and refers the patient to an ambulatory surgical center as an option for surgery, must provide the patient with a written document listing the factors that a patient should consider to make a fully informed decision about their recommended course of care. The considerations should include, but not be limited to, the following: differences in ownership, licensure, accreditation, or certification; payment alternatives between the ambulatory center and the hospital; capacity of the ambulatory center and hospital to comply with personnel requirements; capacity of the ambulatory center and the hospital to respond to emergencies that may arise; and the proximity of the ambulatory center to the hospital and protocols in place for transfer of the patient for emergency care.	Sen. Jeff Edler (R) and Rep. Jacob Bossman (R)

State	Bill	Category	Status	Summary	Sponsor
IA	SF 5	Transparency	Failed, sine die	This measure requires disclosure of the chargemaster prices for health services rendered by health care providers and hospitals.	Sen. Brad Zaun (R)
IL	HB 5327	Transparency	Failed, sine die	This measure required the Department of Insurance to establish an All Payer Claims database (APCD) for sharing limited use health care data. The Department must make available to the public on its website a public limited use health care data set for purposes of facilitating transparency in health care costs, and the public limited use health care data set must be publicly accessible, publicly searchable, contain current information, and have easy to use online tools and be published in a standardized, consumer-friendly format. In presenting limited use health care data for public access, the Department must make comparative considerations regarding geography, demographics, general economic factors, and institutional size. The legislation requires all health care payers to annually submit health insurance claims information as claims data without personally identifying information to the Department. The measure also requires that licensed hospitals must provide in writing or by electronic means a good faith estimate of reasonably anticipated charges by the hospital for the treatment of the patient's specific condition before providing any nonemergency medical services. This estimate must be provided to the patient within 7 business days after recommending a specific course of treatment or set of services. A hospital may not charge the patient more than 110% of the estimate.	Sen. Denyse Stoneback (D)

State	Bill	Category	Status	Summary	Sponsor
IL	HB 5539	Transparency	Failed, sine die	This measure requires an insurer to make available on its website or through a phone number a mechanism where any member of the public may: compare payment amounts and obtain an estimate of the average amount accepted by in-network providers from the insurer for a particular health care service for each health benefit policy offered; obtain an estimate of the out-of-pocket costs that the covered person would owe their provider following the provision of specific services; compare quality metrics applicable to in-network providers for major diagnostic categories; and access any all-payer claims database that may be maintained by the Department.	Rep. Michael Kelly (D)
KY	SB 374	Transparency	Failed, sine die	This measure requires each health facility to furnish a patient, within 30 days of patient discharge or within seven days of the patient's request, whichever is sooner, a consolidated, itemized statement detailing, in plain language comprehensible to an ordinary layperson, the specific nature of the charges for health care services received by the patient at the facility.	Sen. David Yates (D)

State	Bill	Category	Status	Summary	Sponsor
LA	HB 882	Transparency	Failed, sine die	Thies measure establishes the Louisiana Right to Shop Act, requiring a health insurance issuer to implement a shopping and decision support program for enrollees in a health benefit plan. The issuer may provide incentives for an enrollee that elects to receive a comparable health care service from a network provider that is: covered by the health benefit plan and paid less than the average allowed amount paid by the issuer to network providers for the comparable health care service before and after an enrollee's out-of-pocket limit has been met. The shopping and decision support program may provide each enrollee with at least 50% of the issuer's saved costs for each comparable health care service. The measure also requires an issuer to make available an interactive member portal that enables an enrollee to request and obtain from the issuer information on out-of-pocket costs to the enrollee for the comparable health care services, as well as quality data for those providers, to the extent available.	Rep. Bob Owen (R)

State	Bill	Category	Status	Summary	Sponsor
MA	H 1261 / S 795	Transparency	Failed, sine die	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	H 1293 / S 780	Transparency	Failed, sine die	This measure requires all managed care entities to report annually in a public document: each managed care entity's spending, in total and as a percentage of total expenditure, on MassHealth members for primary care, behavioral health services, acute care costs, emergency services, pharmacy, and other specialties; percentage of members eligible for enhanced care coordination and percentage of coordination services provided by the managed care entities.	Rep. Liz Malia (D) / Sen. John Keenan (D)

State	Bill	Category	Status	Summary	Sponsor
MA	S 783	Transparency	Accompanied study order S 2800	This measure requires the Center for Health Information Analysis to calculate and report each individually licensed acute care hospital's contribution to growth in total medical expense, including on the following parameters: contribution to total medical expense on both inpatient and outpatient parameters, and the ten acute care hospitals with the largest contribution to growth in total medical expense in the commercial market. In any fiscal year, the center is required to calculate and report each individually licensed acute care hospital's case-mix-adjusted discharge cost and revenue, including the hospital's operating margins by market segment. The measure also requires the center to promulgate regulations to establish a uniform methodology for calculating and reporting inpatient and outpatient costs for all hospitals	Sen. John Keenan (D)
MA	S 814	Transparency	Accompanied study order S 2800	This measure requires that the Center for Health Information and Analysis shall release at least annually all hospital data, including payment and utilization information for services in connection with the 100 most common inpatient stays. The center shall release claims data on the 100 most common outpatient procedures. The center must also release physician, practitioner, and other supplier payment and utilization data consisting of information on services and procedures provided by healthcare professionals. The center shall also release claims data on the 100 most frequently prescribed drugs and 10 most expensive drugs on average by payer.	Sen. Bruce Tarr (R)

State	Bill	Category	Status	Summary	Sponsor
MA	S 1287	Transparency	Failed, sine die	This measure requires the Health Policy Commission to hold public hearings based on the report submitted by the Center for Health Information and Analysis 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 behavioral health expenditures for the previous calendar year to the aggregate behavioral health expenditure target. The hearing shall examine health care provider, provider organization, and private and public health payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth.	Sen. Cindy Friedman (D)
MN	HF 2311 / SF 2110	Transparency	Failed, sine die	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 non-covered 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)

State	Bill	Category	Status	Summary	Sponsor
MN	HF 4450 / SF 3870	Transparency	Failed, sine die	This measure requires a hospital or outpatient surgical center to provide a written or electronic estimate of the cost of a specific service or stay upon the request of a patient, doctor, advanced practice registered nurse, or patient's representative. The measure also requires a hospital to make public: a list of the hospital's standard charges, including payer-specific negotiated charges, for all items and services provided by the hospital; and a list of standard charges for shoppable services.	Rep. Steve Elkins (D) / Sen. Rich Draheim (R)
MO	HB 1525	Transparency	Failed, sine die	This measure requires the Department of Health and Senior Services to annually publish on their website a report detailing the annual adjustment and adjusted fees related to a health care provider furnishing patients' health records. A health care provider or facility is not authorized to charge a fee for medical or mental health records requested by the patient for use in supporting an application for benefits.	Rep. Mark Ellebracht (D)

State	Bill	Category	Status	Summary	Sponsor
NH	SB 372	Transparency	Referred to interim study	This measure requires any provider of medical services, including physicians, facilities, an employee leasing company working under written contract and providing direct patient care as a part of a hospital's services, and nursing homes, to provide the person receiving such services with an itemized statement within 30 days of service. When billing self-pay patients for services rendered, a hospital or an employee leasing company shall accept as payment in full an amount no greater than the amount generally billed and received by the hospital for that service for patients covered by health insurance. The measure requires hospitals to make an annual report to the attorney general including, but not limited to: the hospital's financial relationships with physician hospital organizations and employee leasing companies working under written contract and providing direct patient care as part of the hospital's services; number and type of providers employed by the hospital; frequency of contract negotiations with providers, physician hospital organizations, and employee leasing companies; and number of primary and specialty care physicians employed by each hospital or affiliate.	Sen. Jeb Bradley (R)
NJ	A 1255	Transparency	Referred to Assembly Financial Institutions and Insurance Committee (Rolled over to 2023)	This measure requires a utilization review entity to make any current prior authorization requirements and restrictions readily accessible on its website to subscribers, health care providers, and the general public. If a utilization review entity intends to amend or implement a new prior authorization requirement or restriction, the review entity is required to notify contracted in-network health care providers no less than 60 days before the requirement or restriction is implemented. Statistics must be made available online regarding prior authorization approvals and denials, including categories for: physician specialty, medication or diagnostic tests and procedures, indication offered, and reason for denial.	Asm. Sterley Stanley (D) and Asm. Herb Conaway (D)

State	Bill	Category	Status	Summary	Sponsor
OH	HB 160	Transparency	Failed, sine die	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 3048 / HB 3060	Transparency	Failed, sine die	This measure creates penalties for health care providers that fail to comply with the Transparency in Health Care Prices Act.	Rep. Carol Bush (R) / Rep. Carol Bush (R)
OK	SB 462	Transparency	Enacted, approved by Governor	This measure establishes the Oklahoma Right to Shop Act, which allows an insurance carrier to offer an enrollee a shared savings incentive when the enrollee obtains a comparable health service from providers that are covered by the carrier and charge less than the average allowed amount paid by that carrier to network providers. Incentives may be calculated by any reasonable methodology approved by the Insurance Department, but shall be provided as a cash payment to the enrollee or credit to the annual in-network deductible and out-of-pocket limit of the enrollee. A shared savings incentive shall not be less than 25% of the savings generated by the participation of the enrollee in any shared savings incentive program offered by the insurance carrier. The carrier must submit an annual report to the Insurance Department which includes information on participation in the program. The measure requires the Office of Management and Enterprise Services to conduct an analysis on the cost-effectiveness of implementing a shared savings incentive program for current enrollees of the Oklahoma Employees Insurance Plan. If the program is found to be cost-effective, it shall be included as part of the next open enrollment.	Sen. Zack Taylor (R) and Rep. Avery Frix (R)
PA	HB 322	Transparency	Failed, sine die	This measure requires health care providers to publish the cost of health care procedures.	Rep. Greg Rothman (R)

State	Bill	Category	Status	Summary	Sponsor
PA	HB 2704	Transparency	Failed, sine die	This measure requires a hospital or hospital system to establish, update, and publish on its publicly accessible website a list of its standard charges for each item or service that it provides, including: a description of each item or service provided, the gross charge that applies to each item or service when provided in the hospital inpatient or outpatient setting, the payer-specific negotiated charge that applies to each item or service, and the de-identified minimum and maximum charges for each item or service. The measure prohibits a person from engaging in the acquisition of a hospital or hospital system without first having applied for and received the necessary approval. An application must include: the name of the hospital or hospital system being acquired, name of the acquiring person, acquisition price, a full description of the acquisition agreement, a copy of the acquisition agreement, copies of community needs assesments, a statement from the hospital's board of directors explaining what effect(s) the acquisition will have on delivery and cost of health services to the community served by each facility, a description of charity care provided in the last three years and projected charity care for the three years following acquisition a description of any community benefit program provided during the past five years with an annual cost of at least $10,000, and other details pertaining to provided services.	Rep. Dan Williams (D)
SC	S 289	Transparency	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
UT	HB 210	Transparency	Enacted, signed by Governor	This measure requires the Health Data Committee to establish a plan for collecting data from data suppliers to determine measurements of cost and reimbursements for risk-adjusted episodes of health care; assist the Legislature and the public with awareness and promotion of transparency in the health care market by reporting on, among other things, rate and price increases by health care providers; and publish an annual report on primary care spending within the state.	Rep. Candice Pierucci (R) and Sen. Mike Kennedy (R)
VA	HB 481	Transparency	Enacted, approved by Governor	This measure requires every hospital to make available to the public on its website a file containing a list of all standard charges for items and services provided by the hospital. Every hospital is required to, at the request of a patient scheduled to receive an elective service, furnish the patient with an estimate of the payment amount for which the participant will be responsible.	Del. Dan Helmer (D)
WA	SB 5420	Transparency	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
CT	SB 375	Facility Fees	Failed, sine die	This measure prohibits a telehealth provider from charging a facility fee for a telehealth service provided from May 10, 2021 to June 30, 2024.	Joint Committee on Public Health
CT	SB 412	Facility Fees	Failed, sine die	This measure prohibits a telehealth provider or hospital from charging a facility fee for telehealth services. This prohibition applies to hospital telehealth services whether provided on-campus or otherwise.	Joint Committee on Insurance and Real Estate
MA	H 1199 / S 695	Facility Fees	Accompanied a study order	This measure requires any any coverage offered to a current or retired employee of the commonwealth insured under the group insurance commission, when requiring the distribution of patient-specific medication to a physician's office, hospital, or clinic for administration, to offer site neutral payment for such medication to the providers administering the medication. Such costs shall include the payment for providers to intake, store, and dispose of such medications. The measure includes Medicaid contracted health insurers, health plans, health maintenance organizations, third party administrators, organizations under preferred provider contracts, health plans through the connector, any insurance plan issued within the commonwealth, and any individual or group maintenance contract under the site neutral payment provision.	Rep. Jon Santiago (D) / Sen. Jason Lewis (D)
MA	H 1261 / S 795	Facility Fees	Accompanied a study order	This measure requires any hospital-based facility that charges facility fees for services to inform a patient, prior to receiving non-emergency services, that the patient may receive a separate charge in addition to and separate from the professional fee charged by the provider. If a hospital or health system designates a location as a hospital-based facility, the facility is required to be clearly identified as being hospital-based.	Rep. Bill Driscoll (D) / Sen. Jason Lewis (D)

State	Bill	Category	Status	Summary	Sponsor
MA	S 700	Facility Fees	Failed, sine die	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)
NH	SB 408	Facility Fees	Enacted, signed by Governor	This measure amends the Medicaid facility fee reimbursement rate for freestanding birthing centers to ensure that the rate is comparable to that for hospitals.	Sen. Sue Prentiss (D)
NY	A 9516	Facility Fees	Failed, sine die	This measure requires a corporation or health care plan to establish an agreement with the physician, hospital, or clinic responsible for receiving and administering patient-specific medication, and a provision of that agreement must be the offer of site neutral payment for such medications.	Asm. Linda Rosenthal (D)
NY	S 2521	Facility Fees	Enacted, signed by Governor	This measure requires notice to patients when a facility fee will be charged and whether the patient's health coverage will cover the fee.	Sen. Gustavo Rivera (D)

State	Bill	Category	Status	Summary	Sponsor
OH	HB 122	Facility Fees	Enacted	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	Failed, sine die	This measure prohibits health care providers from charging, billing, or collecting facilities fees for services 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)
VA	HB 770	Facility Fees	Failed, left in Health, Welfare and Institutions Committee	This measure requires freestanding emergency departments to conspicuously and clearly disclose that a freestanding emergency department is a department of a hospital and will charge facility and professional fees comparable to those on a primary hospital campus. It is also required that at the time of patient registration, the freestanding emergency department shall orally and in writing disclose to each patient the name of the hospital under whose license the emergency department operates and that for services that can also be rendered in an urgent care setting, urgent care centers are often a significantly lower-cost alternative to a freestanding emergency department.	Del. Keith Hodges (R)

State	Bill	Category	Status	Summary	Sponsor
VA	SB 340	Facility Fees	Failed, left in Education and Health Committee	This measure requires freestanding emergency departments to conspicuously and clearly disclose that a freestanding emergency department is a department of a hospital and will charge facility and professional fees comparable to those on a primary hospital campus. It is also required that at the time of patient registration, the freestanding emergency department shall orally and in writing disclose to each patient the name of the hospital under whose license the emergency department operates and that for services that can also be rendered in an urgent care setting, urgent care centers are often a significantly lower-cost alternative to a freestanding emergency department.	Sen. George Barker (D)
WA	HB 1708	Facility Fees	Enacted, signed by Governor	This measure prohibits a hospital that is an originating site or distant site for audio-only telemedicine from charging a facility fee, regardless of payor.	Rep. Eileen Cody (D)
WA	HB 1862	Facility Fees	Failed, sine die	This measure prohibits a health care provider from charging a facility fee for services provided to a patient outside of the hospital's campus. Critical access hsopitals and sole community hospitals are exempt. However, the exemption for clinics exclusively providing laboratory, testing, therapy, pharmacy, or education services is eliminated.	Rep. Nicole Macri (D)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 1130	Competition	Failed	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 416	Competition	Failed, sine die	This measure prohibits anti-steering clauses, anti-tiering clauses, and all-or-nothing clauses in contracts between health carriers and health care providers.	Joint Committee on Insurance and Real Estate
IN	SB 298	Competition	Enacted, signed by Governor	This measure defines "merger" and "merger agreeement" for the purposes of the certificate of public advantage (COPA) for certain hospital mergers. The Department of Health (IDOH) would be required to actively supervise a merger. Additionally, IDOH would be allowed to enter into an agreement with a nonprofit organization or a postsecondary educational institution to study the impacts of the COPA on the community's health metrics and outcomes.	Sen. Ed Charbonneau (R), Sen. Jon Ford (R), and Sen. Alan Morrison (R)

State	Bill	Category	Status	Summary	Sponsor
IN	HB 1117	Competition	Failed, sine die	This measure prohibits certain contracting terms in contracts between providers and insurers including all-or-nothing clauses, anti-tiering/steering clauses, and most-favored-nations clauses. The insurance commissioner may grant a waiver to allow these provisions in a health provider contract if the proposed agreement or policy would result in an increase in the welfare of consumers that could not be accomplished through less restrictive means.	Rep. Donna Schaibley (R)
MA	H 4262	Competition	Failed, sine die	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 under 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	No Sponsors
MS	SB 2907 / HB 934	Competition	Failed in Committee	This measure prohibits certain types of contracting between health care entities including prohibiting insurers from offering to a provider or entering into a contract with a provider that includes an all-products clause or a most-favored-nations clauses. All-products clauses require physicians to accept all insurance products offered by a particular insurer as a condition of participating in any of the insurer's products.	Sen. Daniel Sparks (R) / Rep. Clay Deweese (R)

State	Bill	Category	Status	Summary	Sponsor
NJ	S 1124	Competition	Referred to Senate Commerce Committee (Carried over to 2023)	This measure prohibits anti-tiering clauses in contracts between providers and managed care plans.	Sen. Joe Vitale (D)
NJ	S 1128	Competition	Referred to Senate Commerce Committee(Carried over to 2023)	This measure establishes a Health Care Patient Ombudsman in the Division of Consumer Affairs and requires the Commissioner of Banking and Insurance to create a universal contract for managed care plans and providers. Among other things, it prohibits all-products clauses and most-favored-nations clauses in contracts between providers and managed care plans.	Sen. Joe Vitale (D)
NY	A 3583	Competition	Failed, sine die	This measure gives the Public Health and Health Planning Council (PHHPC) greater authority to review provider mergers and acquisitions. Providers that propose merging, acquiring or affiliating with another provider would be required to demonstrate to PHHPC how such transaction will improve access to medically underserved individuals, lower the costs to consumers, and advance the public health goals of the state. PHHPC would have the ability to prohibit the applicant from increasing prices for services that exceed the CPI for medical care for the five years immediately following any approval. Entities would be required to submit an annual report for five years following an approval identifying the steps they have taken to limit or lower costs to consumers and otherwise benefit patients in the service area of the applicant.	Asm. Pam Hunter (D)
NY	A 3659 / S 8029	Competition	Failed, sine die	This measure prohibits certain contracting terms in contracts between providers and insurers or health maintenance organization including all-or-nothing clauses, anti-tiering/steering clauses, gag clauses, and most-favored-nations clauses.	Asm. Pam Hunter (D) / Sen. Cordell Cleare (D)

State	Bill	Category	Status	Summary	Sponsor
NY	A 8169	Competition	Failed, sine die	This measure prohibits certain contracting terms in contracts between providers and insurer or health maintenance organization, including all-or-nothing clauses, anti-tiering/steering clauses, gag clauses, and most-favored-nations clauses.	Asm. Catalina Cruz (D)
NY	S 7199	Competition	Enacted, signed by Governor	This measure prohibits insurers from entering into contracts with most-favored-nation clauses and anti-disclosure clauses. The bill had language stripped out that would have explicitly prohibited all-or-nothing clauses, anti-tiering/steering clauses, and exclusive contracting clauses.	Sen. Andrew Gounardes (D)
NY	S 1007	Competition	Failed, sine die	This measure prohibits certain contracting terms in contracts between providers and insurer or health maintenance organization, including all-or-nothing clauses, anti-tiering/steering clauses, gag clauses, and most-favored-nations clauses.	Sen. Brian Benjamin (D)
RI	SB 2349	Competition	Enacted, signed by Governor	This measure requires the transacting parties and the new hospital seeking conversion to supply additional information in their application for review by the Department of Health and the Department of the Attorney General relating to staffing levels, pension plans and impact for the affected communities before and after the proposed conversion.	Sen. Mike McCaffrey (D)

State	Bill	Category	Status	Summary	Sponsor
WA	HB 1160	Competition	Failed, sine die	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	SB 5335	Competition	Failed, sine die	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
WA	HB 1741	Competition	Failed, sine die	This measure prohibits certain contracting terms in contracts between providers and carriers, including all-or-nothing clauses, anti-tiering/steering clauses, gag clauses, and most-favored-nations clauses.	Rep. Eileen Cody (D)
WA	HB 1809 / SB 5688	Competition	Failed, sine die	This measure modifies reporting requirements for mergers, acquisitions, or contracting affiliations between hospitals, hospital systems, or provider organizations. It also requires certain reporting around charity care, reproductive, gender-affirming- and end-of-life care. It gives the attorney general the authority to determine if a transaction will impact the continued existence of accessible, affordable health care.	Rep. Tarra Simmons (D) / Sen. Emily Randall (D)
AK	HB 77 / SB 26	CON	Failed, sine die	This measure repeals the certificate-of-need program for health care facilities.	Rep. George Rauscher (R) / Sen. David Wilson (R)
AL	HB 126	CON	Failed, sine die	This measure exempts air ambulance services from certificate of need review.	Rep. Andrew Sorrell (R)
AL	HB 130	CON	Failed, sine die	This measure repeals the certificate of need program for health care facilities.	Rep. Andrew Sorrell (R)
AL	HB 486	CON	Failed, sine die	This measure exempts veterans homes located in specific towns in the state from the certificate of need process.	Rep. Rex Reynolds (R)
CT	HB 5449	CON	Failed, sine die	This measure prohibits any health care provider that is required to receive approval for a certificate of need to build or expand a facility from breaking ground on these projects before receiving approval.	Joint Committee on Insurance and Real Estate

State	Bill	Category	Status	Summary	Sponsor
CT	HB 5506	CON	Enacted, signed by Governor	This measure establishes a task force to study and make recommendations no later than Jan. 15, 2023 concerning certificates of need, including the following matters: - Instituting a price increase cap tied to the cost growth benchmark for consolidations - Guaranteed local representation of communities on hospital boards - Changes to the Office of Health Strategy (OHS)'s state-wide health plan to include an analysis of services and the impact of such services on equity and underserved populations - Setting standards for measuring quality as a result of consolidation; - Enacting higher penalties for noncompliance; among others - The Attorney General's authority to stop activities as the result of a certificate of need application or complaint; - The ability of representatives of the workforce and the community to intervene or appeal decisions; - Giving the OHS the authority to require an ongoing investment to address community needs; - Capturing lost property taxes from hospitals that have converted to nonprofit entities; and - The timeliness of decisions or approvals relating to the certificate of need process and relief available through such process	Rep. Matt Ritter (D)
CT	SB 286	CON	Enacted, signed by Governor	This measure allows the state's Department of Social Services (DSS) to approve requests for certificates of need to build nontraditional, small-house style nursing homes under certain conditions. It sets factors the state must consider when deciding on these requests. It also broadens other exemptions to the general moratorium on nursing home beds. This measure also allows the DSS Commissioner to place conditions on an approved CON request for long-term care facilities.	Joint Committee on Human Services
CT	SB 290	CON	Failed, sine die	This measure requires applicants submit specific certificate of need documentation when applying to create or transfer certain long-term care facilities.	Joint Committee on Human Services

State	Bill	Category	Status	Summary	Sponsor
DC	B 24-0888 / B 24-0889	CON	Enacted on an emergency and temporary basis.	This measure provides a waiver from the need to renew a certificate of need (CON) to hospitals and health care service providers with a valid CON that expired during or within 30 days prior to the declaration of the public emergency. This waiver is in effect for 120 days after the end of the public emergency – the public emergency ended on April 16, 2022, meaning the waiver would expire on August 14, 2022. To be eligible for the waiver, hospitals and health care service providers must be currently treating at least five patients, and they must apply for a license within 30 days of the bill's effective date. DC Health must review these license applications within 90 days of receipt.	Councilmember Vincent Gray (D)
GA	HB 697	CON	Failed, sine die	This measure exempts certain health care services from certificate of need approval, including: an acute care hospital in any rural county, regardless of whether it increases bed capacity.	Rep. Mark Newton (R)
GA	HB 1403	CON	Failed, sine die	This measure amends current certificate of need law to exempt acute care hospitals established after July 1, 2022 in rural counties from the certificate of need requirement. The hospital must meet certain conditions to be classified as exempt.	Rep. Clint Crowe (R)
HI	HR2021 18 / HCR2021 26 / SR2021 4 / SCR2021 4	CON	Failed, sine die	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	HB 224	CON	Failed, sine die	This measure gives authority to the Department of Health to prepare and revise as necessary the state health services and facilities plan every five years. The bill also details the penalties for failing to meet the certificate of need requirement, and creates exemptions from the certificate of need program for certain health care providers and facilities.	Rep. Ryan Yamane (D)

State	Bill	Category	Status	Summary	Sponsor
HI	HB 2205	CON	Failed, sine die	This measure repeals the state's certificate of need requirement for all health care facilities and services except nursing homes, hospices, intermediate care facilities for the intellectually disabled, and ambulance service providers. The measure would create a state health services and facilities plan addressing the health care facility and service needs of the state. The plan shall depict the most economical and efficient system of care commensurate with adequate quality of care, including standards for utilization of health care facilities and major medical equipment. The plan shall provide for the reduction or elimination of underutilized, redundant, or inappropriate health care facilities and services.	Rep. Sam Kong (D) and Rep. Greggor Ilagan (D)
HI	SB 1231	CON	Failed, sine die	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 2255	CON	Failed, sine die	This measure creates requirements for and exclusions from the certificate of need program in the state. A new or changed institutional health service shall not be offered or developed in the state without prior application to and receipt of a certificate of need. The bill particularly emphasizes under which circumstances a nursing facility does or does not require a certificate of need.	Sen. Jeff Edler (R)

State	Bill	Category	Status	Summary	Sponsor
IA	SSB 3035	CON	Failed, sine die	This measure excludes from certificate of need a new institutional health service or changed institutional health service that either will be developed or offered within a county in which a hospital requires immunization against COVID-19 by the hospital's employees as a condition of employment, or will be developed or offered in or through an institutional health facility, health maintenance organization, health care provider, or group of health care providers that does not require immunization against COVID-19 by its employees as a condition of employment.	Senate Committee on Commerce
IA	SSB 3105	CON	Failed, sine die	This measure eliminates the application of certificate of need requirements for any institutional health facility or other entity that furnished new or changed health services, with the exception of nursing facilities.	Sen. Jeff Edler (R)
KY	HB 505	CON	Failed, sine die	This measure exempts from specific health care centers and services from current certificate of need requirements.	Rep. Ken Fleming (R) and Rep. Kim Moser (R)
KY	HB 777	CON	Enacted, signed by Governor	This measure allows a hospital to run an ambulance service without obtaining a certificate of need if the service is for the sole purpose of providing non-emergency and emergency transport services originating from the hospital.	Rep. Ken Fleming (R)
MD	HB 972 / SB 804	CON	Enacted	This measure creates exceptions to the certificate of need requirement for providers of "continuing care," defined as services related to continuing care in a retirement community or at home.	Del. Ariana Kelly (D) / Sen. Pam Beidle (D)
ME	LD 250	CON	Failed, sine die	This measure allows a nursing facility that voluntarily reduces the number of its licensed beds for any reason to convert the beds back and thereby increase the number of beds to no more than the previously licensed number of beds after obtaining a certificate of need and meeting certain conditions, as long as the nursing facility has been in continuous operation without change of ownership.	Rep. Anne Perry (D)

State	Bill	Category	Status	Summary	Sponsor
MI	HB 5074	CON	Failed, sine die	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	CON	Failed, sine die	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 5385	CON	Failed, sine die	This measure directs the Department of Licensing and Regulatory Affairs to assess fees and other assessments for health facility and agency licenses and certificates of need on an annual basis as provided in this bill.	Rep. Sue Allor (R)
MI	SB 12	CON	Failed, sine die	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	CON	Failed, sine die	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	CON	Failed, sine die	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	CON	Enacted, signed by Governor	This measure allows a hospital to transfer more than 35% of its licensed beds to another hospital or freestanding surgical outpatient facility more than once if the hospital is located in a city that has a population of 750,000 or more.	Sen. Michael MacDonald (R)

State	Bill	Category	Status	Summary	Sponsor
MN	HF 44 / SF 38	CON	Failed, sine die	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 3458	CON	Failed, sine die	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, and issuing certificates of need based on the state health care plan. 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 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)

State	Bill	Category	Status	Summary	Sponsor
MN	SF 953	CON	Failed, sine die	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)
MN	SF 2916	CON	Failed, sine die	This measure creates the Health Care Commission. The commission is granted the ability to set an application fee for a certificate of need, and is required to adopt rules for applying for and issuing certificates of need. The commission shall also develop and adopt rules establishing standards and policies for certificate of need review that are consistent with the state health care plan. The measure requires a person to have a certificate of need issued by the commission before developing, operating, or participating in any of the health care projects for which a certificate of need is required. A certificate of need is required before: a new health care facility is built, developed, or established; an existing or previously approved health care facility is moved to another site; bed capacity of a hospital is changed; a hospital is closed; the type or scope of any health care service is changed; and any expenditure that is not properly chargeable as an operating or maintenance expense is made.	Sen. Erin Murphy (D)
MO	SB 727	CON	Failed, sine die	This measure repeals provisions of the certificate of need law relating to hospitals, excluding long-term care beds in hospitals, and major medical equipment.	Sen. Bob Onder (R)
MO	SB 890	CON	Failed, sine die	This measure repeals the certificate of need law .	Sen. Mike Moon (R)
MO	HB 1616	CON	Failed, sine die	This measure repeals the certificate of need law.	Rep. Dean VanSchoiack (R)
MS	HB 110	CON	Failed, died in committee	This measure exempts end-stage renal disease facilities from certificate of need requirements.	Rep. Bryant Clark (D)

State	Bill	Category	Status	Summary	Sponsor
MS	HB 282	CON	Failed, died in committee	This measure allows the State Department of Health to issue a 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 330	CON	Failed, died in committee	This measure excepts the State Department Of Health from the moratorium on the issuance of certificates of need (CONs) for home health agencies. This bill allows the department to issue uo to five CONs to the five new recipients of hospice licenses.	Rep. John Hines (D)
MS	HB 1471	CON	Failed, died in committee	This measure repeals the state's certificate of need law.	Rep. Chris Brown (R)
MS	SB 2174	CON	Failed, died in committee	This measure repeals the state's certificate of need law.	Sen. Angela Hill (R)
MS	SB 2733	CON	Failed, died in committee	This measure authorizes the issuance of a certificate of need for the construction of a 60-bed nursing facility in any underserved minority zip code area. The zip code area must have a population of more than 30,000 of which over 75% are racial minorities, be wholly or partially located in a county that has a 2018 projected need of at least 400 additional nursing facility beds, and have no existing or approved nonpublic nursing facility.	Sen. John Horhn (D)

State	Bill	Category	Status	Summary	Sponsor
MS	SB 2448	CON	Failed, died in committee	This measure prohibits a person from engaging in certain activities without first acquiring a certificate of need, including: the construction, development, or establishment of a new health care facility, including the reopening of a facility that has not been in operation for 60 months or more; relocation of a health care facility or major medical equipment, unless the relocation is within 5,280 feet from the main entrance of a health care facility; changing the existing bed complement of any health care facility; relocation of one of more services from one physical facility to another facility, unless the relocation is within 5,280 feet from the main entrance where the service is located; the acquisition of major medical equipment; and changes in ownership of any health care facility in which a notice of intent has not been filed. The bill also details in which counties a certificate of need is not required for the construction or expansion of new nursing facilities.	Sen. Brice Wiggins (R)
MS	SB 2842	CON	Failed, died in conference	This measure creates specific certificate of need requirements on health care industry zones and their business.	Sen. Josh Harkins (R)
NC	HB 149	CON	Failed, sine die	This measure allows the Department of Health to make exemptions from the certificate of need requirement for certain circumstances or health care facilities.	Rep. Donny Lambeth (R)
NC	HB 410 / SB 309	CON	Failed, sine die	This measure repeals certificate of need laws in the state.	Rep. Keith Kidwell (R) / Sen. Ralph Hise (R)
NC	HB 660	CON	Failed, sine die	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	SB 641	CON	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
NJ	A 417	CON	Referred to Assembly Health Committee (Carried over to 2023)	This measure requires an emergency medical services (EMS) provider to obtain a certificate of need (CON). Existing licensed EMS providers must apply for CON within three calendar years of the bill's effective date.	Asm. Ralph Caputo (D)
NJ	S 1979	CON	Referred to Senate Health, Human Services and Senior Citizens Committee (Carried over to 2023)	This measure requires that applications for certificates of approval for a substance abuse disorder treatment center located within 500 feet of any school or educational building meet certain approval requirements.	Sen. Jim Beach (D)
NJ	A 4017	CON	Referred to Assembly Human Services Committee (Carried over to 2023)	This measure establishes an enhanced NJ FamilyCare reimbursement rate for nursing facilities that voluntarily delicense beds that are part of an unimplemented certificate of need in order to create single occupancy rooms.	Asm. Dan Benson (D) and Asm. Angela McKnight (D)
NY	A 9509	CON	Failed, sine die	This measure requires all determinations of need to be consistent with the state emergency medical system plan. The department of health shall only issue a new emergency medical system agency certificate upon determination that a public need for the proposed service has been established. The measure allows the commissioner to promulgate regulations to provide for the issuance of an emergency medical system agency certificate without a determination of public need.	Asm. Steve Otis (D)
NY	S 6793	CON	Failed, sine die	This measure reduces the time lag between determination of need and actual occupancy thereof, to expedite construction, acquisition, or improvement of mental hygiene facilities for the care, maintenance, and treatment of individuals with intellectual disabilities.	Sen. Todd Kaminsky (D)

State	Bill	Category	Status	Summary	Sponsor
NY	S 8432	CON	Failed, sine die	This measure requires that all determinations of need be consistent with the state emergency medical system plan. The commissioner may promulgate regulations to provide for standards on the determination of need. Notwithstanding certain provisions, the commissioner may promulgate regulations providing for the issuance of an emergency medical system agency certificate without a determination of need.	Sen. Shelley Mayer (D)
OH	HB 371	CON	Enacted, signed by Governor	This measure makes temporary changes regarding certificates of need (CON) due to COVID-19. These temporary changes apply to any CON granted between March 9, 2020 and June 18, 2021. The bill requires the Director of Health to grant a 24-month extension to CON holders to obligate capital expenditures and begin construction on a proposed project. It also allows a CON to be transferred without voiding the approval. Finally, it allows an approved CON for a capital expenditure to be between 110% - 150% of the approved project cost without an civil penalties.	Rep. Jean Schmidt (R) and Rep. Sedrick Denson (D)
OH	HB 466	CON	Failed, sine die	This measure makes temporary changes regarding certificates of need (CON); the changes apply to any CON granted between March 9, 2020 and June 18, 2021. The bill requires the Director of Health to grant a 24 month extension to CON holders and to obligate capital expenditures and commence construction for a proposed project. The transfer of a CON prior to completion of the activity for which the CON was granted, does not void the CON.	Rep. Jay Edwards (R)
OH	HB 645	CON	Failed, sine die	This measure requires a pharmacy be granted approval through a demonstration of need, among meeting other requirements, in order to operate as a remote dispensing pharmacy in the state.	Rep. Mark Fraizer (R) and Rep. Adam Holmes (R)
OK	HB 3867	CON	Enacted, signed by Governor	This measure creates a carve-out to exempt the University Hospital Authority and its affiliated nonprofit entities from regulations requiring a certificate of need for psychiatric and chemical dependency facilities.	Rep. Jeff Boatman (R) and Sen. Chuck Hall (R)

State	Bill	Category	Status	Summary	Sponsor
OK	SB 286	CON	Failed, sine die	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	HB 6610	CON	Failed, sine die	This measure makes changes to the definitions in current determination of need law in the state.	Rep. Jackie Baginski (D), Rep. Julie Casimiro (D), and Rep. David Bennett (D)
RI	HB 8287	CON	Failed, sine die	This measure prohibits the licensing agency from increasing the licensed bed capacity of any existing nursing facility to greater than the level of the facility's bed capacity, plus the greater of ten beds or 10% of the bed capacity, through July 1, 2025.	Rep. Bob Craven (D) and Rep. Evan Shanley (D)
SC	H 4546	CON	Failed, sine die	This measure would make certificate of need requirements inapplicable to home health agencies.	Rep. Mark "Marvin" Smith (R)
SC	H 4549	CON	Failed, sine die	This measure would exempt acute hospital care at home programs and services from the certificate of need program.	Rep. Mark "Marvin" Smith (R)

State	Bill	Category	Status	Summary	Sponsor
SC	S 370	CON	Failed, sine die	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	CON	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
TN	HB 231 / SB 1243	CON	Failed, sine die	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	CON	Failed, sine die	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	CON	Failed, sine die	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 1208 / SB 1329	CON	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
VT	H 654	CON	Enacted, signed by Governor	This measure relates to the Green Mountain Care Board's authority to waive or permit variances to state programs such as certificate of need to prioritize and maximize direct patient care and safeguard the stability of health care providers responsive to the COVID-19 pandemic. The legislation changes the expiration of this authority from 6-months after the public health emergency to March 31, 2023. This measure also requires the Green Mountain Care Board to consider a hospital's extraordinary labor costs and investments as part of any proceeding to establish or enforce a hospital's fiscal year 2022 or 2023 budget.	House Committee on Health Care
VT	S 204	CON	Failed, sine die	This measure requires a health care facility other than a hospital be issued a certificate of need prior to developing a new health care project, including the construction, development, purchase, or lease of an ambulatory surgical center or a freestanding birth center.	Sen. Ginny Lyons (D) and Sen. Cheryl Hooker (D)
WV	HB 4013	CON	Failed, sine die	This measure repeals the certificate of need program.	Del. Amy Summers (R)
WV	HB 4573	CON	Failed, sine die	This measure removes the certificate of need moratorium on opioid treatment facilities	Del. Mike Pushkin (D)
WV	HB 4607	CON	Failed, sine die	This measure removes opioid treatment programs from the list of health care services requiring a certificate of need.	Del. Buck Jennings (R)
WV	HB 4660	CON	Failed, sine die	This measure prohibits certain health care services from being issued a certificate of need, including: a health care facility adding intermediate care or skilled nursing beds to its current licensed bed complement; or a person developing, constructing, or replacing a skilled nursing facility except in the case of facilities designed to replace existing beds.	Del. Matthew Rohrbach (R)

State	Bill	Category	Status	Summary	Sponsor
WV	HB 4677	CON	Failed, sine die	This measure exempts certain health care services from certificate of need approval, including: creating a private office of one of more health professionals; dispensaries and first aid stations maintained solely for the use of employees that do not contain inpatient beds; telehealth; a facility owned or operated by one or more authorized health professional, or ambulatory health care facility offering laboratory services or diagnostic imaging; any hospital may transfer their certificate of need to any person purchasing the hospital; the acquisition by a qualified hospital of a hospital within a distance of 20 miles of the main campus; the acquisition by a hospital of a physician practice group that owns an ambulatory surgical center; and a hospital located in the same county as an academic medical center may provide any health service provided by the academic medical center.	Del. Dianna Graves (R)
CA	AB 510	Surprise Billing	Failed	This bill would authorize a noncontracting individual health professional to bill or collect the out-of-network cost-sharing amount directly from the enrollee if the enrollee consents in writing or electronically at least 72 hours in advance of care. The bill would require the consent to include a list of contracted providers at the facility who are able to provide the services and to be provided in the 15 most commonly used languages in the facility's geographic region.	Asm. Jim Wood (D)
CA	AB 988	Surprise Billing	Enacted, signed by Governor	This measure stipulates that an enrollee receiving medically necessary treatment for a mental health or substance use disorder from a 988 center, mobile crisis team, or other provider of behavioral crisis services outside the plan network shall not pay more than the same cost-sharing that the enrollee would pay for the same covered services from an in-network provider. An out-of-network 988 center, mobile crisis team, or other provider of behavioral health crisis services shall not bill or collect an amount from the enrollee for services except for the in-network cost-sharing amount.	Asm. Rebecca Bauer-Kahan (D)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 2709	Surprise Billing	Failed	This bill would require a health care service plan to require an enrollee who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the enrollee would pay for the same covered services received from a contracting ground ambulance provider. The bill would require the plan or insurer to reimburse a noncontracting ground ambulance provider the greater of the average contracted rate or 125% of the Medicare reimbursement rate for those services.	Asm. Tasha Boerner Horvath (D)
CA	SB 1473	Surprise Billing	Enacted, signed by Governor	This measure removes the requirement that a health care service plan or disability insurer must cover the cost sharing for COVID-19 testing and immunizations provided by an out-of-network provider, applicable 6 months after the expiration of the federal public health emergency.	Sen. Richard Pan (D)
CT	HB 5001	Surprise Billing	Enacted, signed by Governor	This measure is part of a larger package on children's mental health. Among other things, it establishes the maximum allowable billable and reimbursable amounts for out-of-network acute inpatient psychiatric services. For these services, a provider may bill up to the greatest of the: (1) in-network rate, (2) usual and customary rate, or (3) Medicare rate. As with existing law for out-of-network emergency services, a provider and carrier may agree to a higher reimbursement rate. The bill makes it a Connecticut Unfair Trade Practices Act violation for a health care provider to “balance bill” an insured for covered out-of-network acute inpatient psychiatric services (i.e., bill more than the collectable cost-sharing under the policy).	Joint Committee on Public Health

State	Bill	Category	Status	Summary	Sponsor
CO	HB 22-1284	Surprise Billing	Enacted, signed by Governor	This measure changes current state law to align with the federal "No Surprises Act" by allowing a covered person to request an independent external review of a health care coverage decision determining if services provided by an out-of-network provider or facility are subject to an in-network benefit level of coverage; requiring that payments made for services provided at an in-network facility or by an out-of-network provider be applied to the covered person's in-network deductible; requiring that in-network services, regardless of facility, are covered at the in-network benefit level; and requiring the insurance commissioner to adopt rules concerning disclosure requirements, including a list of services for which a balance bill may not be charged.	Rep. Daneya Esgar (D) and Rep. Marc Catlin (R)
GA	SB 566	Surprise Billing	Enacted, signed by Governor	This measure adds to the Surprise Billing Consumer Protection Act a provision that includes mental health and substance use disorders under medical conditions in the definition of 'emergency medical services'. Medical services rendered after an individual is stabilized are also included under the 'emergency medical services' definition.	Sen. Dean Burke (R)
IL	HB 4703	Surprise Billing	Enacted, signed by Governor	Previously, under Illinois law, protections for nonemergency services emergency services provided by out-of-network providers at in-network facilities were limited to designated specialties (radiology, anesthesiology, pathology, neonatology, and emergency physicians). This measure applies protections to all covered ancillary reasons. It also removes the restriction around holding consumers harmless only for facility-based providers. It specifies that balance billing law does not apply to air or ground ambulance and gives the Department of Insurance enforcement authority over any balance or surprise billing covered under the No Surprises Act.	Rep. Bob Morgan (D)
IN	HB 1238 / SB 249	Surprise Billing	Enacted, signed by Governor	This measure specifies that a provider can satisfy state requirements for a good faith estimate of nonemergency health care services based on fulfilling requirements in the No Surprises Act.	Rep. Matt Lehman (R) / Sen. Liz Brown (R)

State	Bill	Category	Status	Summary	Sponsor
KS	HB 2325	Surprise Billing	Failed, died in committee	This measure prohibits surprise bills and requires that an enrollee will only be liable for the in-network cost-sharing amounts if surprise billed. The Insurance Commissioner will establish an independent dispute resolution process for resolving payment disputes.	House Committee on Insurance and Pensions
MD	SB 180	Surprise Billing	Enacted, signed by Governor	This measure applies the No Surprises Act and gag clause prohibition from the Consolidated Appropriations Act, 2021 to all insurers, nonprofit health service plans, and health maintenance organizations that issue policies or contracts for a health benefit plan. It also applies certain transaprency requirements around compensation for brokers and consultants and policies around parity in mental health and substance use disorder benefits. It gives the Insurance Commissioner the authority to enforce these provisions.	Senate Committee on Finance
MA	H 1039 / S 636	Surprise Billing	Failed, sine die	This measure would allow any insured individual engaged in a continuing course of treatment with a mental health provider covered under the plan to continue treatment through an out-of-network option in the event the provider has been voluntarily or involuntarily disenrolled, other than for quality-related reasons or fraud. The mental health care professional shall be reimbursed by the carrier at the usual network per-unit reimbursement rate for the relevant service. The non-network option to the insured may require that the individual pay a higher copayment, only if the higher copayment results from increased costs caused by the use of a non-network provider.	Rep. Ruth Balser (D) and Rep. Tricia Farley-Bouvier (D) / Sen. Jo Comerford (D)
MA	H 1197 / S 680	Surprise Billing	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
MA	S 674	Surprise Billing	Failed, sine die	This measure prohibits a health care provider from billing an insured, except for any applicable copayment, coinsurance, or deductible, when receiving services by an out-of-network provider to treat an emergency medical condition. In such instances, the carrier network shall pay that provider the in-network contracted rate for each delivered service. The measure requires that a hospital's summary of payments form include a description of the out-of-network consumer protections, including the prohibition of certain billing practices. The measure also requires that the division of insurance, in consultation with the health policy commission, the center for health information and analysis, and the executive office of health and human services establish the non-contracted commercial rates for both emergency and nonemergency services.	Sen. Cindy Friedman (D)
MA	H 1066	Surprise Billing	Failed, sine die	This measures requires the Health Policy Commission (HPC), upon advice or other evidence, recommend the non-contracted commercial rate for emergency services and nonemergency services. In recommending rates, the HPC will consider: (i) the impact of each rate on the growth of total health care expenditures; (ii) the impact of each rate on premiums (iii) the impact of each rate on in-network participation by health care providers and the risk of reducing network participation by health care providers; and (iv) whether each rate is easily understandable and administrable by health care providers and carriers.	Rep. Paul Donato (D)
MN	HF 4706	Surprise Billing	Failed, sine die	This measure makes several changes to statute in order to conform to the No Surprises Act.	Rep. Tina Liebling (D)

State	Bill	Category	Status	Summary	Sponsor
NC	SB 505	Surprise Billing	Failed, sine die	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)
NH	HB 343	Surprise Billing	Interim Study Report: Not Recommended for Future Legislation	This bill prohibits balance billing for ambulance services under the managed care law and requires insurers to reimburse ambulance providers directly.	Rep. Joyce Weston (D)

State	Bill	Category	Status	Summary	Sponsor
NH	SB 287	Surprise Billing	Interim Study Report: Not Recommended for Future Legislation	This measure requires that a patient be fully informed in writing of requirements and prohibitions relating to balance billing, and of their rights when receiving care or services from a provider that is outside the patient's insurance or plan network. Providers of emergency or air ambulance services are prohibited from balance billing a patient for fees other than copayments, deductibles, or coinsurance for emergency services performed in the facility. This prohibition applies whether or not the provider is a participating provider, and all services must be billed as if the services were provided at a participating facility. The measure also requires that contracts between a health carrier and any health care provider contain a provision ensuring that covered individuals will have continued access to the provider in the event that the contract is terminated for any reason; this access shall be made available for 90 days from the date the covered person is notified.	Sen. Jeb Bradley (R)
NJ	A 1390	Surprise Billing	Referred to Assembly Financial Institutions and Insurance Committee (Carried over to 2023)	This measure requires that at the time of a non-emergency medical procedure or other scheduled health, a physician shall disclose to the patient whether or not the physician is a participating physician in the health benefits plan in which the covered person is a member. Facilities must make available a list of the facility's standard charges and a cost estimate if requested.	Asm. Bob Auth (R)

State	Bill	Category	Status	Summary	Sponsor
NJ	A 2451 / S 1692	Surprise Billing	Referred to Assembly Financial Institutions and Insurance Committee / Referred to Senate Commerce Committee (Both carried over to 2023)	This measure requires a health plan providing hospital or medical expense benefits to provide coverage for health care services provided by an out-of-network provider, if the services are provided to a child diagnosed with a catastrophic illness, and the services were performed on the basis of a referral from an in-network provider. Benefits shall be provided to the same extent as for any other condition for which benefits are provided in-network under the policy.	Asm. DiAnne Gove (R) / Sen. Chris Connors (R)
NJ	A 2789	Surprise Billing	Referred to Assembly Health Committee (Carried over to 2023)	This measure requires hospital, bio-analytical, and clinical laboratories to offer an HIV screening test to an individual that lives in an area with a high prevalence of HIV. If the lab performing the screening test is out of the individual's network, the health plan carrier must reimburse the laboratory for the cost of the screening test at the individual's in-network rate. Under such circumstances, a laboratory is prohibited from billing a covered person, except for the covered person's applicable copayment, coinsurance, or deductible.	Asm. Herb Conaway (D)
NJ	A 3595	Surprise Billing	Referred to Assembly Financial Institutions and Insurance Committee (Carried over to 2023)	This measure requires a carrier that provides coverage for out-of-network mental health services delivered through telemedicine or telehealth to provide coverage on the same basis as when the services are delivered through in-person contact and consultation in the state, and at a provider reimbursement rate of not less than the Medicaid provider reimbursement rate. A carrier shall not charge any deductible, copayment, or coinsurance for a mental health service delivered through telemedicine or telehealth in an amount exceeding the deductible, copayment, or coinsurance applicable to an in-person, in-network consultation.	Asm. Pam Lampitt (D), Asm. Ellen Park (D), and Asm. John McKeon (D)

State	Bill	Category	Status	Summary	Sponsor
NJ	A 4048 / S 2535	Surprise Billing	Referred to Assembly Financial Institutions and Insurance Committee / Referred to Senate Commerce Committee (Both carried over to 2023)	This measure requires an individual or group health insurance policy, small or school employee health benefits plan, health maintenance organization, or a hospital, medical, or health service corportation contract to provide coverage for medically necessary expenses incurred in the purchase of a hearing aid or cochlear implant for a covered person 21 years of age or younger. If a contract does not have an in-network provider who can provide a part, attachment, or accessory to a preexisting cochlear implant, the contract shall cover necessary parts purchased from and provided by an out-of-network provider and only impose cost sharing as if the provider were in network.	Asm. Angela McKnight (D) and Asm. Dan Benson (D) / Sen. Vince Polistina (R)
NJ	A 4294	Surprise Billing	Referred to Assembly Financial Institutions and Insurance Committee (Carried over to 2023)	This measure prohibits cost sharing from exceeding the maximum out-of-pocket limits as established in the federal Patient Protection and Affordable Care Act. The measure also allows the board of directors of the New Jersey Small Employer Health Benefits Program to annually adjust the design of the small employer health benefits plans, including the out-of-pocket limits under those plans, to ensure premium affordability. Adjustments shall be based on the board's annual review, and proposals for adjustments to plan design that improve affordability from carriers may be considered by the board.	Asm. John McKeon (D)
NJ	A 4422	Surprise Billing	Referred to Assembly Financial Institutions and Insurance Committee (Carried over to 2023)	The measure stipulates that the provisions of the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" apply to transportation by emergency medical service helicopter, and prohibit the total amount paid by a covered person receiving transportation by emergency medical service helicopter from exceeding $1000, inclusive of cost sharing.	Asm. Herb Conaway (D)

State	Bill	Category	Status	Summary	Sponsor
NJ	S 1177	Surprise Billing	Enacted, signed by Governor	This measure stipulates that a covered person receiving inadvertent out-of-network services, or services at an in-network or out-of-network health facility on an emergency or urgent basis, shall not incur greater out-of-pocket costs than would be incurred with an in-network health care provider for covered services. The out-of-network provider shall not bill the covered person except for applicable deductible, copayment, or coinsurance amounts that would apply if the covered person utilized an in-network provider. The measure also revises New Jersey's existing out-of-network arbitration process. It extends the amount of time a carrier and provider have to negotiate from 30 to 60 days. It also changes the price threshold for what triggers arbitration -- if the difference between a carrier's and provider's final offers is $1,000 or higher for a billed amount of $2,500 or $500 or higher for a billed amount less than $2,500 then arbitration is initiated.	Sen. Joe Lagana (D)
NJ	S 1129	Surprise Billing	Referred to Senate Commerce Committee (Carried over to 2023)	This measure requires a health care facility to disclose to an enrollee if a participating provider in the enrollee's network. If the health care facility does not participate in the enrollee's plan then the facility must inform the enrollee and provide a cost estimate.	Sen. Joe Vitale (D)
NJ	S 1952	Surprise Billing	Referred to Senate Health, Human Services, and Senior Citizens Committee (Carried over to 2023)	This measure requires hospital, bio-analytical, and clinical laboratories to offer a Hepatitis C screening test to an individual born between 1945 and 1965. If the lab performing the screening test is out of the individual's network, the health plan carrier must reimburse the laboratory for the cost of the screening test at the individual's in-network rate. Under such circumstances, a laboratory is prohibited from billing a covered person, except for the covered person's applicable copayment, coinsurance, or deductible.	Sen. Nilsa Cruz-Perez (D)

State	Bill	Category	Status	Summary	Sponsor
NY	A 9007 / S 8007	Surprise Billing	Enacted, signed by Governor	As part of the health and mental hygiene budget for the 2022 - 2023 state fiscal year, this measure also includes language to clarify provisions regarding emergency medical services and surprise bills and compliance with the federal No Surprises Act. It requires that payment disputes must be submitted to the independent dispute resolution (IDR) entity within 3 years of the original payment on the claim. It also dds that the IDR entity will consider the “median of the rate recognized by the health care plan to reimburse qualified providers for the same or similar services in the same region that are participating with the health care plan” for establishing a “reasonable fee.” Previously, balance-billing protections attached when the consumer assigned the benefit to the provider. But this measure updates New York's law to hold harmless any enrollees for emergency services and surprise bills and places an explicit prohibition on surprise billing for providers. Finally, it gives the Superintendent of Insurance the authority to assess penalties if an insurer is found to have willfully violated the federal No Surprises Act or certain provisions of Consolidated Appropriations Act, 2021.	No Sponsors
NY	A 1983 / S 4787	Surprise Billing	Failed, sine die	This measure requires notification to enrollees if an out-of-network physician may be used in their procedure, test or surgery and such physician's services shall not be covered by their insurance policy; such services must be covered if the insured person does not receive notification prior to such services or procedure.	Asm. Erik Dilan (D) / Sen. Kevin Parker (D)

State	Bill	Category	Status	Summary	Sponsor
OK	HB 2807	Surprise Billing	Failed, sine die	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)
OK	HB 3216	Surprise Billing	Failed, sine die	This measure requires that health insurance coverage which includes any benefits for emergency services shall not make any distinction in regard to network status of an emergency care provider or facility. An enrollee's cost-sharing amount shall not be greater than if the emergency services were provided in-network.	Rep. Shane Jett (R) and Rep. Mark Lepak (R)
OK	HB2125 / SB1813	Surprise Billing	Failed, sine die	This measure gives the Attorney General the authority to bring a civil action against a health care provider that bills an enrollee amounts beyond what's allowed under Oklahoma's Surprise Billing Protection Act. The measure also authorizes licensing boards and agencies to take disciplinary action against violators. It requires issuers of health benefit plans to reimburse care from out-of-network providers in an emergency as defined in the measure. Any out-of- network provider may not bill an enrollee an amount greater than an applicable copayment, coinsurance, and deductible under the insured’s exclusive provider benefit plan.	Rep. Marcus McEntire (R) / Sen. Adam Pugh (R)

State	Bill	Category	Status	Summary	Sponsor
OR	HB 4134	Surprise Billing	Enacted, signed by Governor	This measure requires insurers and health care service contractors to cover labor and delivery services provided at out-of-network health care facilities, and medical transport of individuals presenting with signs of labor from in-network facilities to out-of-network facilities, if services provided at out-of-network facilities are due solely to diversion of patient from the in-network health care facility for reasons related to state or federal declaration of public health emergency.	Rep. Duane Stark (R)
PA	HB 98	Surprise Billing	Failed, sine die	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	SB 2195	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. Steve Archambault (D), Sen. Joshua Miller (D), Sen. Mike McCaffrey (D), Sen. Dominick Ruggerio (D), Sen. Frank Lombardo (D), Sen. Dawn Euer (D), and Sen. Bridget Valverde (D)
SC	H 3401 / S 314	Surprise Billing	Failed, sine die	This measure prohibits insurers and providers from engaging in surprise billing. If a surprise bill occurs, the enrollee may only be required to pay the applicable coinsurance, copayment, deductible, or other out of pocket close that would be imposed if the service was rendered by an in-network provider.	Rep. Kambrell Garvin (D) / Sen. Mike Fanning (D)

State	Bill	Category	Status	Summary	Sponsor
TN	HB 2 / SB 1	Surprise Billing	Failed, sine die	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)
VT	H 489	Surprise Billing	Enacted, signed by Governor	This measure requires carriers to comply with requirements in the No Surprise Act (NSA) and requires the state Insurance Commissioner to enforce NSA requirements. The bill instructs the Department of Financial Regulation and Department of Health and Vermont Health Access to inform providers of their responsibilities under NSA.	Rep. Bill Lippert (D)
WA	SB 5618	Surprise Billing	Failed, sine die	This measure aligns state surprise billing protections with the No Surprise Act. It expands the scope of services protected from balance billing to include services provided following an emergency once a patient has been stabilized, a broader set of non-emergency services provided at in- network hospitals or facilities, and air ambulance services. It adds behavioral health emergency services as emergency services and retains the state dispute resolution process until Jan. 1, 2023 and thereafter aligns with the federal system for independent dispute resolution. The bill requires the Insurance Commissioner to submit recommendation son how balance billing for ground ambulance services can be prevented.	Sen. Annette Cleveland (D)

State	Bill	Category	Status	Summary	Sponsor
WA	HB 1688	Surprise Billing	Enacted, signed by Governor	This measure aligns state surprise billing protections with the federal No Surprises Act and addresses treatment for emergency conditions. The state's arbitration process and service payment amounts will apply until July 1, 2023 and thereafter aligns with the federal dispute resolution process and payment amounts as long as it is available to the state. It authorizes the Insurance Commissioner to enforce provisions of the No Surprises Act and provides authority for a $100/day civil penalty for NSA violations. On or before Oct. 1, 2023, the Commissioner must submit a report with recommendations on preventing balance billing for ground ambulance services.	Rep. Eileen Cody (D)
WI	AB 1185	Surprise Billing	Failed	This bill requires plans to cover emergency benefits without requiring a prior authorization determination and without regard to whether or not the health care provider is a participating provider or facility. If the emergency medical services for which coverage is required are provided by a nonparticipating provider, the plan must not impose a prior authorization requirement; not impose cost sharing on the enrollee that is greater than the cost sharing required for a participating provider; calculate the cost-sharing amount to be equal to the amount that would have been charged if the service was provided by a participating provider; provide, within 30 days of the provider's or facility's bill, an initial payment or denial notice to the provider or facility; and count any cost-sharing payment made by the enrollee for the emergency medical services toward any in-network deductible or out-of-pocket maximum.	Asm. Sara Rodriguez (D)
WV	HB 2226	Surprise Billing	Failed, sine die	This measure requires providers to disclose to patients their plan and hospital affiliations prior to the provision of nonemergency services. Out-of-network providers must inform the patient of the estimated cost of services. It requires insurers to have processes in place to protect covered individuals who obtain services at in-network facilities but receive care from non-participating providers.	Rep. Barbara Fleischauer (D)

State	Bill	Category	Status	Summary	Sponsor
CA	AB 133	Community Benefit	Enacted	This measure allows the Department of Healthcare Access and Finance to impose a fine up to $5,000 on hospitals for failing to submit community benefit plans consistent with the law. It also allows the department to grant a 60-day extension for submission. The department will post a report online with information from hospital community benefit plans, including specified details on spending.	Assembly Committee on Budget
CA	AB 1204	Community Benefit	Enacted	This measure would add racial and ethnic groups experiencing disparate health outcomes and socially disadvantaged groups to the definition of “vulnerable populations” for community benefits reporting purposes. It would also require a hospital to prepare and annually submit an equity report to the department. This equity report must include, among other things, an analysis of health status and access to care disparities on the basis of specified categories, including age, sex, and race, and a health equity plan to reduce disparities. The measure would authorize the department to impose up to a $5,000 fine against a hospital that fails to adopt, update, or submit an equity report, and would require the department to list online those that failed to submit an equity report. The bill would require the department to convene a Health Care Equity Measures Advisory Committee with specified membership to assist and advise the director relative to equity reports.	Asm. Buffy Wicks (D)

State	Bill	Category	Status	Summary	Sponsor
CT	HB 5500	Community Benefit	Enacted	As part of a larger public health bill, this measure shifts oversight of existing community benefit law from the Office of the Healthcare Advocate (OHA) to the Office of Health Strategy (OHS). It would requires hospitals to regularly submit their community health needs assessments, related implementation strategies, and community benefit status reports, including several specified reporting requirements. It requires for-profit acute care hospitals to submit community benefit program reporting consistent with the bill's reporting schedules and reasonably similar to what they would report to the IRS, where applicable. It requires OHS to make data from the state's all-payer claims database available to hospitals for the purposes of fulfilling these requirements; and it would require OHS to annually summarize and analyze community benefit program reporting data and solicit stakeholder input through a public comment period. Lastly, the measure removes managed care organizations from the requirements of community benefit law.	Joint Committee on Public Health
CT	SB 476	Community Benefit	Failed, sine die	This measure would shift oversight of existing community benefit law from the Office of the Healthcare Advocate (OHA) to the Office of Health Strategy (OHS). It would also require hospitals to regularly submit their community health needs assessments, related implementation strategies, and community benefit status reports, including several specified reporting requirements. It would require for-profit acute care hospitals to submit community benefit program reporting consistent with the bill's reporting schedules and reasonably similar to what they would report to the IRS, where applicable. It would require OHS to make data from the state's all-payer claims database available to hospitals for the purposes of fulfilling these requirements; and it would require OHS to annually summarize and analyze community benefit program reporting data and solicit stakeholder input through a public comment period. Lastly, the measure would remove managed care organizations from the requirements of community benefit law.	Joint Committee on Public Health

State	Bill	Category	Status	Summary	Sponsor
IN	HB 1270	Community Benefit	Failed, sine die	This measure requires a nonprofit hospital with more than 100 beds to annually report specified financial information to the state department of health, including information found in a hospital's community benefit reporting to the federal government. It requires a nonprofit hospital and a health carrier to post and send certain information at least 45 days before a community benefit public forum. It modifies requirements concerning the: (1) date on which the public forum must be held; (2) topics that must be discussed at a public forum; (3) submission of questions and feedback at a public forum; and (4) use of technology to allow attendance through real time audio and video through the Internet. The measure also requires the insurance commissioner to report to the legislative council if the federal Transparency in Health Coverage rule is repealed or enforcement is stopped, and it requires health payers to continue to post pricing information in compliance with the federal rule after the federal rule is repealed or stopped. Lastly, the measure modifies the definition of "health payer" for purposes of the all-payer claims data base.	Rep. Donna Schaibley (R), Rep. Earl Harris (D)
MD	SB 802	Community Benefit	Enacted, signed by Governor	This measure establishes and funds coordinated community supports partnerships across education, health, and other stakeholders to meet students' behavioral health needs and provide community services and supports to students. It allows a non-profit hospital that receives funding for coordinating or participating in a partnership to include the value of the services provided as part of its community benefit spending.	Sen. Guy Guzzone (D) and Sen. Katie Hester (D)

State	Bill	Category	Status	Summary	Sponsor
OR	HB 4039	Community Benefit	Failed, sine die	This measure would modify financial requirements for coordinated care organization (CCO) expenditures on social determinants of health (SDoH) and health equity. It states a need for investments in community benefit initiatives to address SDoH and health equity for CCO members. It specifies 14 areas of spending for CCOs to invest and directs the Oregon Health Authority to prescribe by rule the types of qualifying expenditures. Investment areas include community-level interventions, enhanced provider payments that address community needs, funding for supportive housing initiatives, and more. This measure would require a CCO to spend less than or equal to three percent of its administrative budget on services within these to address health disparities and SDoH consistent with the CCO's community health improvement plan.	Rep. Suzanne Weber (R)
RI	SB 2349	Community Benefit	Enacted, signed by Governor	This measure amends the transaction review process for new hospitals/ parties involved in a transaction by requiring additional information in parties' applications to the department of health and department of the attorney general. This information includes copies of any impact analysis for the affected communities both before conversion and after proposed conversion, including benefits to the community, economic impact, and staffing. In reviewing the application, the department of the attorney general shall consider, among other criteria, whether the board established appropriate criteria for any impact analysis. Existing law requires each transacting party/ new hospital to include in its report a description of the plan as to how the new hospital will provide community benefit and charity care during the first three years of operation, and a description of how the new hospital will monitor and value charity care services and community benefit.	Sen. Mike McCaffrey (D)

State	Bill	Category	Status	Summary	Sponsor
RI	SB 2600	Community Benefit	Failed, sine die	This measure places limitations on the tax exempt real and personal property a nonprofit college, university or hospital may hold. It recognizes that hospitals hold property for for-profit ventures such as parking garages and other operations not directly related to the provision of hospital medical care. It allows each city or town to impose a property tax on specified property owned, leased, or operated in whole or in part by any nonprofit hospital. This property includes vacant lots, parking structures, and any property not used wholly and exclusively for the purposes for which the nonprofit was incorporated. The measure requires the valuation be performed by the assessor in the first year.	Sen. Tiara Mack (D)
VA	HB 1071	Community Benefit	Enacted, signed by Governor	This measure requires every hospital to make reasonable efforts to screen every uninsured patient to determine whether the individual is eligible for Medicaid or hospital financial assistance, and to inform every financial assistance-eligible, uninsured patient of the option to enter a payment plan with the hospital, with payments based upon the patient's ability to pay. It requires every hospital to annually report the amount of charity care, discounted care, or other financial assistance provided by the hospital under its financial assistance policy and the amount of uncollected bad debt, including any uncollected bad debt from payment plans. The State Health Commissioner is required to report this collected data annually to the legislature by November 1. The measure requires hospitals receiving federal financial assistance to make written information about the hospital's charity care policies available to persons with limited English proficiency in accordance with the most recent U.S. Department of Health and Human Services' Guidance. It also prohibits hospitals from engaging in certain actions to recover medical debt.	Rep. Kathy Tran (D)

State	Bill	Category	Status	Summary	Sponsor
WA	HB 1272	Community Benefit	Enacted, signed by Governor	This measure aims to make hospital operations more transparent, and it includes a requirement that non-profit hospitals identify community health improvement activities that cost $5,000 or more and that designated critical access or sole community hospitals report information for the 10 highest cost community health improvement activities. These activities are reported through an addendum to their CHNA starting July 1, 2022. Additionally, the law requires that hospitals report demographic data about the people involved with the CHNA process and requires that hospitals include specified groups: community organizations that provide community health improvement services; communities impacted by health inequities; health care workers; hospitals; and the governor's interagency coordinating council on health disparities.	Rep. Nicole Macri (D)
WA	HB 1616	Community Benefit	Enacted, signed by Governor	This measure requires hospitals to develop, implement, and maintain a policy to enable indigent persons access to charity care. Policies must include identifying patients who may be eligible for coverage through Medicaid or the state's health benefits exchange. It requires that all hospitals include full charity care for patients with income up to 200 percent of the federal poverty level (FPL), 75 percent discount for patients with incomes between 201 and 250 percent FPL, and 50 percent discount for patients with income between 251 and 300 percent FPL. It establishes higher income thresholds for hospitals of a certain bed size or owned or operated by a health system (e.g., full charity care for patients with income up to 300 percent FPL).	Rep. Tara Simmons (D)
CA	SB 717	Reference Rates	Enacted without relevant provisions	This measure has language stripped out that would have required that reimbursement for specific medical equipment be priced at the lesser of an amount not exceeding 80% of the lowest maximum allowance for California established by the federal Medicare program, the amount billed pursuant to the California Code of Regulations, or the guaranteed acquisition cost plus a percentage markup to be established by the department.	Sen. Bill Dodd (D)

State	Bill	Category	Status	Summary	Sponsor
FL	SB 216	Reference Rates	Failed, sine die	This measure prohibits compensation to a health care provider providing services to an incarcerated individual from exceeding 100% of the Medicare allowable rate unless the provider has a contract with the department housing the incarcerated person. Compensation to an entity providing emergency medical transportation services to an incarcerated person may also not exceed 110% of the Medicare allowable rate if the entity does not have a contract with the department.	Sen. Gary Farmer (D)
IA	SSB 3158	Reference Rates	Failed, sine die	This measure requires reimbursement rates for hospices and acute psychiatric hospitals be increased in accordance with increases under the federal Medicare program or as supported by their Medicare audited costs. Reimbursement rates for home health agencies shall continue to be based on Medicare low utilization payment adjustment methodology with state geographic wage adjustments. Reimbursement rates for emergency medical service providers shall remain at the rates approved by CMS.	Senate Committee on Appropriations
MA	HB 1267 / S766	Reference Rates	Failed, sine die	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	S 747	Reference Rates	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
MI	HB 5870 / HB 6114 / SB 946 / SB 947	Reference Rates	Failed, sine die	This measure prohibits a physician, hospital, clinic, or other person that provides treatment or rehabilitative occupational training to a person covered by personal protection insurance from payment or reimbursement exceeding a specific percent of the amount payable to the provider for treatment under Medicare. It is also prohibited for a hospital that is a level I or level II trauma center that provides treatment for an emergency medical condition to a person covered by personal protection insurance from payment or reimbursement exceeding a specific percent of the amount payable to the hospital for treatment under Medicare. In any aforementioned circumstance, the payment or reimbursement must not exceed the average amount charged by the physician, hospital, clinic, or other person for the treatment. This measure also explains specifics on personal protection insurance payments.	Rep. Ryan Berman (R) / Rep. Mark Tisdel (R) / Sen. Erika Geiss (D) / Sen. Mallory McMorrow (D)
MI	HB 5966	Reference Rates	Failed, sine die	This measure, establishes a universal health care system as well as a board to oversee it. As a base rate for any benefit that is covered by Medicare Part A or B, the board shall set a rate that is 25% more than the rate provided by Medicare. The board may adjust the base rate to ensure access to services in specific geographic areas or types of care, or to improve outcomes or control costs.	Rep. Yousef Rabhi (D)

State	Bill	Category	Status	Summary	Sponsor
MS	HB 83 / HB 300 / HB 317 / HB 454 / HB 658 / SB 2313 / SB 2345 / SB 2664	Reference Rates	Failed, sine die	This measure gives rural hospitals with fifty or fewer licensed beds the option to be reimbursed for outpatient hospital services based on 101% of the rate established under Medicare for outpatient hospital services. Fees for physician's services that are covered only by Medicaid shall be reimbursed at 90% of the rate established under Medicare. A reimbursement rate of up to 100% may be provided for physician's services provided after the normal working hours of the physician. Eligible providers, obstetricians, gynecologists, and psychiatrists providing certain services shall also be reimbursed at 100% of the Medicare rate. The measure also allows the division of Medicaid to establish a Medicare Upper Payment Limits (UPL) Program for hospitals, nursing facilities, physicians employed or contracted by hospitals, and emergency ambulance transportation providers. Subject to approval by CMS, the division shall make additional reimbursement to hospitals, nursing facilities, and emergency ambulance providers for the Medicare UPL Program.	Rep. Bryant Clark (D) / Rep. Omeria Scott (D) / Rep. John Hines (D) / Rep. Becky Currie (R) / Rep. Joey Hood (R) / Sen. Barbara Blackmon (D) / Sen. Bobby Jackson (D) / Sen. Kevin Blackwell (R)
MS	SB 2340	Reference Rates	Failed, sine die	This measure requires the Division of Medicaid to establish a Medicare Upper Payment Limits (UPL) Program for emergency ambulance transportation providers.	Sen. Kevin Blackwell (R)
NC	SB 415	Reference Rates	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
NJ	A 1249	Reference Rates	Referred to Assembly Budget Committee (Carried over to 2023)	This measure requires NJ's SHBP and SEHBP to implement a referenced based pricing program and bundled payment program.	Asm. Eliana Pintor Marin (D)
NY	S 7625	Reference Rates	Failed, sine die	This measure requires general hospitals to establish financial assistance policies and procedures for reducing hospital charges otherwise applicable to low-income individuals without third-party health coverage, or with health coverage that does not cover or limits coverage of the service, and for reducing the collection of copays and deductible payments from individuals who can demonstrate an inability to pay such amounts. The reductions from charges for patients with incomes below 600% of the federal poverty level shall result in a charge that does not exceed the amount that would have been paid for the same services pursuant to the federal social security act (Medicare), and that amount shall be further adjusted according to income level. Such policies shall be clear, understandable, in writing, and publicly available in summary form, and each general hospital shall ensure that every patient is made aware of the existence of the policies.	Sen. Gustavo Rivera (D)
RI	HB 6327 / SB 2073	Reference Rates	Failed, sine die	This measure requires Medicaid and contracted managed care organizations to increase Medicaid primary care payment rates to not lower than federal Medicare payment rates for the same service. On or before July 2023, Rhode Island Medicaid will ensure that all primary care reimbursement rates are not lower than 100% of federal Medicare rates.	Rep. Jackie Baginski (D) / Sen. Alana DiMario (D)

State	Bill	Category	Status	Summary	Sponsor
TN	HB 939 / SB 838	Reference Rates	Failed, sine die	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)
VT	H 735	Reference Rates	Failed, sine die	This measure directs the Department of Human Resources to convene a working group comprised of representatives of the department, labor organizations representing state employees and teachers, and the Vermont State Teachers' Retirement System to explore options for designing and implementing a system of reference-based pricing based on a multiple of Medicare reimbursement rates for inpatient and outpatient hospital services and other health care services covered under the health plans, for active and retired state employees and teachers. The measure would require the working group to report recommendations for how best to structure a reference-based pricing program in Vermont beginning in 2023.	Rep. Gabrielle Stebbins (D)

State	Bill	Category	Status	Summary	Sponsor
WI	SB 129	Reference Rates	Failed, sine die	This measure requires a health plan to reimburse an insured's out-of-network health care provider at 225% of the federal Medicare rate for a service, treatment, or supply for the diagnosis or treatment of COVID-19 because a participating, in-network provider is unavailable. The measure also prohibits a network plan, including a health maintenance organization or preferred provider plan, from requiring an enrollee to pay more for a service or treatment provided by an out-of-network provider for the treatment of COVID-19. Any health care provider or facility providing a service or treatment to an enrollee of a plan but is not a participating provider of that plan may not charge an enrollee an amount that exceeds the amount that the provider or facility is reimbursed by the plan.	Sen. Janet Bewley (D)
CA	AB 184 / SB 184	Primary Care Investments	Enacted, signed by Governor	This measure makes amendments to the state budget bill. This measure requires the Office of Health Care Affordability to measure and promote a sustained systemwide investment in primary care and behavioral health by measuring the percentage of total health care expenditures allocated to primary care and behavioral health and set spending benchmarks. The office shall also promote improved outcomes for primary care and behavioral health, including health care entities making investments in, or adopting models that do, any of the following: increase access to advanced primary care models and adoption of measures that demonstrate their success; integrate primary care and behavioral health services, including screenings for behavioral health conditions in primary care settings; leverage alternative payment models that provide resources at the practice level to enable improved access and team-based approaches for care coordination, patient engagement, quality, and population health.	Assembly Budget Committee / Senate Committee on Budget and Fiscal Review

State	Bill	Category	Status	Summary	Sponsor
CO	HB 22-1325	Primary Care Investments	Enacted, signed by Governor	This measure requires the Division of Insurance to collaborate with the Department of Health Care Policy and Financing, the Department of Personnel, the Department of Public Health and Environment, and the Primary Care Payment Reform Collaborative to develop and promulgate rules for alternative payment model parameters for primary care services offered through health benefit plans. The alternative payment model parameters must include transparent risk adjustment parameters that ensure that primary care providers are not penalized for or disincentivized from accepting vulnerable, high-risk patients and are rewarded for caring for patients with more severe or complex health conditions and patients who have inadequate access to affordable housing, healthy food, or other social determinants of health. The parameters must also utilize patient attribution methodologies that are transparent and reattribute patients on a regular basis, which must ensure that population-based payments are made to a patient's primary care provider rather than other providers who may only offer sporadic primary care services to the patient and include a process for correcting misattribution that minimizes the administrative burden on providers and patients. Additionally, the parameters must include a set of core competencies around whole-person care delivery that primary care providers should incorporate in practice transformation efforts to take full advantage of various types of alternative payment models. Finally, the parameters must require an aligned quality measure set that considers the quality measures and the types of quality reporting that carriers and providers are engaging in under current state and federal law and includes quality measures that are patient-centered and patient-informed and address pediatric, perinatal, and other critical populations; the prevention, treatment, and management of chronic diseases; and the screening for and treatment of behavioral health conditions.	Rep. Chris Kennedy (D), Rep. Yadira Caraveo (D), and Rep. Joann Ginal (D)

State	Bill	Category	Status	Summary	Sponsor
GA	HB 1042	Primary Care Investments	Enacted, signed by Governor	This measure requires the establishment and administration of a grant program which shall serve the purpose of awarding grants to establish primary care medical facilities in health professional shortage areas, as designated by the Department of Community Health. A development authority may enter into a lease-purchase agreement with one or more primary care medical providers to lease and operate the primary care medical facility established with the funds provided.	Rep. Rick Jasperse (R)
MD	SB 734	Primary Care Investments	Enacted, signed by Governor	This measure requires the Maryland Health Care Commission to provide a report to the Governor and General Assembly that includes: an analysis of primary care investment in relation to total health care spending over the immediately preceding year; ways to improve the quality and access to primary care, with special attention to increasing health care equity, reducing health disparities, and avoiding increased costs to patients and the health care system; and any findings and recommendations of the Commission. The Commission shall form a workgroup to develop the report, including by interpreting the results of the required analysis.	Sen. Clarence Lam (D)
MA	S 770	Primary Care Investments	Failed	This measure requires the establishment of an aggregate primary care expenditure target for the commonwealth, which the commission shall publish on its website. The aggregate primary care expenditure target for the three-year period ending with 2024 shall be equal to a 30% increase above aggregate primary care baseline expenditures for each of the three years.	Sen. Cindy Friedman (D)
NE	LB 737	Primary Care Investments	Failed, indefinitely postponed	This measure establishes the Primary Care Investment Council. The council would be responsible for measuring the current level of primary care investment as a part of overall health care spending, conducting a comparison of primary care services and health outcomes in Nebraska with surrounding states and nationally, developing an appropriate target level of primary care investment by public and private payers, and identifying the public health benefits and estimated cost savings, among other tasks.	Sen. Eliot Bostar (I)

State	Bill	Category	Status	Summary	Sponsor
NE	LB 863	Primary Care Investments	Enacted, approved by Governor	This measure establishes the Primary Care Investment Council. The council is responsible for measuring the current level of primary care investment as a part of overall health care spending, conducting a comparison of primary care services and health outcomes in Nebraska with surrounding states and nationally, developing an appropriate target level of primary care investment by public and private payers, and identifying the public health benefits and estimated cost savings, among other tasks.	Sen. Matt Williams (I)
NE	LB 1183	Primary Care Investments	Failed, indefinitely postponed	This measure would appropriate $25 million of federal Covid-19 relief funds to be distributed as grants to federally qualified health centers providing high-quality primary and preventive care, including medical, dental, behavioral, pharmacy, and support services. The grants shall be for costs associated with capital projects that will expand access to Nebraskans most impacted by the Covid-19 public health emergency.	Sen. Ray Aguilar (I)
NY	A 7230	Primary Care Investments	Failed, vetoed by Governor	This measure establishes the Primary Care Reform Commission, which shall review, examine, and make findings on the level of primary care spending by all payers in the context of all health care spending in the state, and shall publish an annual report on the findings. The Commission shall also make recommendations to increase spending on primary care and strengthen primary care infrastructure in the state. The Commission shall also publish, post on the department's website, and deliver an annual report to the Governor and members of the legislature.	Asm. Dick Gottfried (D)

State	Bill	Category	Status	Summary	Sponsor
VT	S 244	Primary Care Investments	Failed, sine die	This measure requires health insurers, the State Employees' Health Benefit Plan, and the health plans offered to school employees to increase the percentage of total health care spending they allocate to primary care to at least 12% and would require the next All-Payer Model agreement with the federal government to include a provision requiring annual increases in primary care spending in Medicare. The bill would direct the Agency of Human Services to increase primary care reimbursement rates in the Medicaid program to match Medicare levels and to implement certain Medicare primary care coding changes. It would also create the position of Chief Clinical Officer for Primary Care at the Green Mountain Care Board to coordinate efforts to evaluate, monitor, and implement solutions to strengthen primary care in Vermont.	Rep. Ginny Lyons (D)
AL	HB 286	Other	Enacted, signed by Governor	This measure requires that net patient revenue shall be determined using the data from each private hospital's fiscal year Medicare Cost Report, which shall be reviewed, and the hospital cost reports updated annually. The report for 2020, 2021, and 2022 shall be used for fiscal years 2023, 2024, and 2025, respectively.	Rep. Steve Clouse (R)
CT	HB 5042	Other	Failed, sine die	This measure expands the Office of Health Strategy's (OHS) duties to include setting annual health care cost growth benchmarks, health care quality benchmarks, and primary care spending targets. Additionally, the measure increases the nonrefundable certificate of need CON) application fee from $500 to a range of $1,000 to $10,000 depending on the proposed project's cost.	By request of the Governor

State	Bill	Category	Status	Summary	Sponsor
GA	SB 82	Other	Failed, sine die	This measure prohibits an insurer, during the term of a network participation contract between the insurer and a health care facility or provider, from implementing any unilateral changes to its policies or health benefit plans that would directly or indirectly: substantially alter or limit coverage or site of delivery support services, preclude or limit services from a healthcare facility or provider that was a participating facility or provider, or result in a higher cost-sharing requirement to the covered person.	Sen. Michelle Au (D), Sen. Ben Watson (R)
GA	HB 1526	Other	Failed, sine die	This measure establishes the Healthy Georgia Program to provide comprehensive universal single payer healthcare coverage and a healthcare cost control system for the benefit of all Georgia residents.	Rep. Matthew Wilson (D)
IL	HB 1465	Other	Failed, sine die	This measure enables the state to study rate setting approaches that may yield possible misalignments in the state's health insurance marketplace metal tiers. The measure also requires all individual and small group health policies written in compliance with the ACA must file rates with the Department of Insurance for approval. If the department finds rate increases to be unreasonable in relation to benefits, those rates shall be disapproved.	Rep. Bob Morgan (D)
KS	HB 2459	Other	Failed, died in committee	This measure establishes the Kansas Health Program, a universal single-payer guaranteed health coverage program. The Kansas Department of Health and Environment (KDHE) would be responsible for creating and implementing the program, which every resident of Kansas would be eligible for.	Rep. Aaron Coleman (D)

State	Bill	Category	Status	Summary	Sponsor
MD	HB 610 / SB 493	Other	Failed, sine die	This measure establishes the Commission on Universal Health Care to develop a plan for the State to establish a universal health care program to provide health benefits to all residents of the State through a single-payer system.	De. Sheila Ruth (D), Del. Heather Bagnall (D), Del. Sandy Bartlett (D), Del. Lisa Belcastro (D), Del. Chanel Branch (D), Del. Tony Bridges (D), Del. Lorig Charkoudian (D), Del. Eric Ebersole (D), Del. Wanika Fisher (D), Del. Linda Foley (D), Del. Cathi Forbes (D), Del. Dave Fraser-Hidalgo (D), Del. Michele Guyton (D), Del. Shaneka Henson (D), Del. Faye Howell (D), Del. Rachel Jones (D), Del. Mary Lehman (D), Del. David Moon (D), Del. Julie Palakovich Carr (D), Del. Jared Solomon (D), Del. Vaughn Stewart (D), Del. Jen Terrasa (D), Del. Karen Toles (D), Del. Jheanelle Wilkins (D), and Del. Nicole Williams (D) / Sen. Paul Pinsky (D), Sen. Clarence Lam (D), and Sen. Guy Guzzone (D)

State	Bill	Category	Status	Summary	Sponsor
MA	H 1174	Other	Accompanied a study order	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. Alice Peisch (D)
MN	HF 1612 / SF 90	Other	Failed, sine die	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)

State	Bill	Category	Status	Summary	Sponsor
MN	HF 4430	Other	Failed, sine die	This measure establishes a Health Care Affordability Board along with an Advisory Council to protect consumers, state and local governments, health plans, providers, and other stakeholders from unaffordable health care costs. The board is responsible for monitoring efforts to reform the health care delivery and payment system to understand emerging trends in theinsurance market and make recommendations for further reform. The board is also responsible for establishing a health care spending growth target program to limit health care spending growth in the state.	Rep. Jennifer Shultz (D)
NJ	A 4538	Other	Referred to Assembly Human Services Committee (Carried over to 2023)	This measure expands Medicare health care coverage to all New Jersey residents.	Asm. Angelica Jimenez (D)
NJ	A 5029 / S 1947	Other	Referred to Assembly Financial Institutions and Insurance Committee / Referred to Senate Commerce Committee (Both carried over to 2023)	This measure creates a New Jersey Public Option Health Care Program that includes as many providers as possible and comes at the lowest possible cost for New Jerseyans shopping for health insurance and that provides an efficient, competitive publicly-run alternative to the private insurance market.	Asm. Shavonda E. Sumter / Sen. Nia Gill (D)
NY	A 10664	Other	Referred to Committee on Health	This measure establishes the New York state public health care option program to provide a comprehensive and affordable health care insurance option for all residents of the state.	Asm. Ken Zebrowski (D)

State	Bill	Category	Status	Summary	Sponsor
NC	HB 674	Other	Enacted, signed by Governor	This measure requires hospital and ambulatory surgical facilities to abide by reasonable debt collections practices such as: not allow a hospital or surgical facility to refer a patient's unpaid bill to a collections agency during the pendency of a patient's application for charity care or financial assistance; a facility shall provide a patient with written notice that the patient's bill will be subject to collections at least 30 days prior to the referral being made; a facility that contracts with a collections agency must inform the patient of the facility's charity care and financial assistance policies when engaging in collections; a facility shall require a collections agency to obtain the written consent of the facility prior to the collections agency filing a lawsuit to collect the debt.	Rep. Billy Richardson (D), Rep. John Szoka (R), and Rep. Diane Wheatley (R)

State	Bill	Category	Status	Summary	Sponsor
NC	HB 1039	Other	Failed, sine die	This measure requires all large health care facilities to develop a written Medical Debt Mitigation Policy (MDMP), which must include: a written financial assistance policy that applies to all emergency and medically necessary health services, with a plain language summary of the policy; eligibility criteria for financial assistance; and the billing and collections policy, including actions that may be taken in the event of nonpayment. The MDMP must be widely publicized by the large health care facility and an annual report with the MDMP must be filed annually with the Department of Health and Human Services. The measure also requires all large health facilities to take specific steps prior to seeking payment for emergency or medically necessary care, and prohibits certain collection actions, including but not limited to: causing an individual's arrest, foreclosing on an individual's real property, or garnishing wages or state income tax refunds. The measure explains what patients qualify for financial assistance under the MDMP, applying to any charges for services that are not covered by insurance. The measure requires all large health care facilities to post price information on their websites, including at minimum: a lost of gross charges for all health care services, the amount Medicare would reimburse each health care service, and plain language titles or descriptions of services.	Rep. Billy Richardson (D), Rep. Howard Hunter (D), Rep. Bobby Hanig (R), and Rep. Ed Goodwin (R)

State	Bill	Category	Status	Summary	Sponsor
OK	SB 1396	Other	Enacted, signed by Governor	This measure relates to the Supplemental Hospital Offset Payment Program, requiring an assessed fee be imposed on each eligible hospital, in an amount calculated as a percentage of each eligible hospital's net hospital patient revenue. The measure creates specific guidelines for where the funds generated by payment program fees shall be disbursed. Net hospital patient revenue shall be determined using the data from each eligible hospital's Medicare Cost Report. A hospital may not charge any patient for a portion of the payment program fee. This measure also requires the Oklahoma Health Care Authority to make hospital access payments to eligible hospitals and critical access hospitals to supplement reimbursements for inpatient and outpatient services that are provided through Medicaid on both a fee-for-service and managed care basis.	Rep. Kevin Wallace (R) and Rep. Greg McCourtney (R)

State	Bill	Category	Status	Summary	Sponsor
PA	HB 44	Other	Failed, sine die	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)
PA	HB 2824	Other	Referred to House Committee on Health	This measure establishes the Pennsylvania Health Care Plan, a Statewide comprehensive health care system.	Rep. Pam Delissio (D)

State	Bill	Category	Status	Summary	Sponsor
RI	HB 8119 / SB 2769	Other	Failed, sine die	This measure establishes a universal, comprehensive, affordable single-payer health care insurance program and helps control health care costs, which would be referred to as, "The Rhode Island Comprehensive Health Insurance Program."	Rep. David Morales (D), Rep. Brianna Henries (D), Rep. Leonela Felix (D), Rep. Joshua Giraldo (D), Rep. Michelle McGaw (D), Rep. Brandon Potter (D), Rep. John Lombardi (D), Rep. Jose Batista (D), Rep. Marcia Ranglin-Vassell (D), and Rep. Teresa Tanzi (D) / Sen. Sam Bell (D), Sen. Jeanine Calkin (D), Sen. Tiara Mack (D), Sen. Alana DiMario (D), Sen. Kendra Anderson (D), Sen. Cynthia Mendes (D), Sen. Bridget Valverde (D), Sen. Meghan Kallman (D), Sen. Jon Acosta (D), and Sen. Ana Quezada (D)

State	Bill	Category	Status	Summary	Sponsor
VT	S132	Other	Failed, sine die	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)
VT	S 240	Other	Failed, sine die	This measure provides patients with certain protections against medical debt. It would also set minimum requirements for specified health care facilities' patient financial assistance policies.	Sen. Cheryl Hooker (D)
WV	HB 3001	Other	Failed, sine die	This measure creates a public option though Medicaid to provide West Virginia residents with a choice of a high-quality, low-cost health insurance plan.	Rep. Evan Worrell (R)