HOUSE . . . . . No. 5590

The Commonwealth of Massachusetts

HOUSE OF REPRESENTATIVES, July 20, 2026.

The committee on Health Care Financing, to whom was referred the petition (accompanied by bill, House, No. 1405) of Lindsay N. Sabadosa, Margaret R. Scarsdale and others for legislation to provide equitable access to quality, affordable healthcare services by establishing Medicare for all persons in the Commonwealth, reports recommending that the accompanying bill (House, No. 5590) ought to pass [Cost: Greater than $100,000.00].

For the committee,

JOHN J. LAWN, JR..

FILED ON: 7/17/2026

HOUSE . . . . . No. 5590

The Commonwealth of Massachusetts

In the One Hundred and Ninety-Fourth General Court
(2025-2026)

An Act establishing Medicare for All in Massachusetts.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

SECTION 1. (a) There shall be a special commission on universal health care implementation to: (i) conduct an investigation and study single-payer models, assess costs, and analyze the feasibility of establishing a single-payer health care financing system in the commonwealth; (ii) develop and issue recommendations based on its findings relative to the implementation of a single-payer health care system or how best to achieve universal health care in the commonwealth, and the proposed health care financing of said system; and (iii) ensure equitable access to quality health care services for all residents of all identities to support health care as a human right, without discrimination based on age, financial or employment status, ethnicity, race, religion, gender, gender identity or expression, sexual orientation, marital status, national origin, disability, previous health conditions or diagnoses, and geographic location.

(b) As used in this section, "single-payer health care financing system" means a universal system used by the state to pay the cost of health care services and goods in which:

(i) Institutional providers are paid directly for health care services or goods by the state or paid by an administrator that does not bear risk in contracting with the state;

(ii) Institutional providers are paid with global budgets that separate capital budgets, established through regional planning, and operational budgets;

(iii) Group practices are paid directly for health care services or goods by the state, by an administrator that does not bear risk in contracting with the state, by the employer of the group practice or by an institutional provider; and

(iv) Individual health care providers are paid directly for health care services or goods by the state, by their employers, by an administrator that does not bear risk in contracting with the state, by an institutional provider or by a group practice.

(c) The commission shall consist of: the executive director of the health policy commission or a designee, who shall serve as chair; the secretary of health and human services or a designee; the secretary of administration and finance or a designee; the secretary of labor and workforce development or a designee; the commissioner of revenue or a designee; the commissioner of insurance or a designee; the executive director of the center for health information and analysis or a designee; the chairs of the joint committee on health care financing or their designees; the assistant secretary for MassHealth or a designee; the executive director of the Massachusetts Health Connector or a designee; the executive director of the Massachusetts Campaign for Single Payer Healthcare (Mass-Care); and 19 members to be appointed by the governor, 1 of whom shall be a member of the Massachusetts Biotechnology Council; 1 of whom shall be a member of the AFL-CIO; 1 of whom shall be a member of the Massachusetts Health & Hospital Association; 1 of whom shall be a member of the Massachusetts Association of Health

Plans, Inc.; 1 of whom shall be a member of the Massachusetts Nurses Association; 1 of whom shall be a member of the Associated Industries of Massachusetts (AIM); 1 of whom shall be a member of the Retailers Association of Massachusetts, Inc.; 1 of whom shall be a member of the Blue Cross Blue Shield of Massachusetts, Inc.; 1 of whom shall be a member of the Massachusetts League of Community Health Centers; 1 of whom shall be a member of Health Care for All, Inc.; 1 of whom shall be a member of the Massachusetts Medical Society; 1 of whom shall be a member of the Massachusetts Health Quality Partners; 1 of whom shall be a member of the Massachusetts Public Health Association; 1 of whom shall be the president and chief executive officer of the Massachusetts Association for Mental Health or a designee; 1 of whom shall be a member of The Arc of Massachusetts or a designee; 1 of whom shall be a health economist from a Massachusetts academic institution; 1 of whom shall be a health economist with expertise in payment reform; and 2 of whom shall be persons with lived experience accessing health care services and navigating the health care system. The chair of the universal health care implementation commission may use their discretion to appoint no more than two additional members to assist in carrying out the duties of the commission.

(d) The commission shall issue a report and develop recommendations evaluating single-payer health care financing systems and models of health care delivery, and the feasibility of implementing such systems in the commonwealth. Such recommendations shall include, but not limited to: (i) models pursued by other states and implemented by other countries in which health care is publicly administered and is financed by taxes; (ii) methods to ensure that all residents have access to the health care that they need including, but not limited to, primary care, behavioral health care, mental health care, dental care, vision care, hearing aids, home health care, nursing home care, long-term care, hospice care, and any other important health care needs;

(iii) the cost of implementing a single-payer health care model to the commonwealth's health care system over 1, 2, 5 and 10 years; (iv) cost control methods, including the reduction of administrative cost and inefficiencies, (v) methods and models for funding the single-payer system, including, but not limited to, federal funding opportunities and federal matching funds; (vi) resource planning, including an assessment of available resources to avoid unnecessary duplication and any additional resources needed for underserved populations and geographic areas; (vii) the effects on the labor market, including an evaluation of current workforce capabilities, displacement of commercial insurer workforce, and additional needs to ensure appropriate staffing levels and quality, culturally and linguistically competent care is delivered; (viii) the utilization of services under a single payer system; (ix) methods to ensure timely access to needed medical and dental care; (x) methods to ensure compliance and integration with federal law, including any federal waiver requests, Medicare integration, and any ERISA limitations; (xi) effect on providers, including reimbursement methods and the transition from existing public and private payment systems to a single-payer reimbursement model; (xii) the impact of a single-payer health care financing system on health care facilities, including rural and safety-net hospitals, employers, and the health care industry within the commonwealth; and (xiii) estimated transition costs, including the information technology infrastructure, claims processing systems, and administrative resources required to implement and operate a single-payer health care financing system; (xiv) patient satisfaction in jurisdictions using such systems; (xv) the impact of a single-payer health care financing system on collectively bargained health benefits, including union-sponsored and multiemployer health plans; (xvi) an assessment on the readiness of key health care and public institutions to carry out a single-payer health care model and strategies to reduce the complexities and administrative burdens on participants in the health care workforce

and to address workforce challenges; and (xvii) any further research the commission deems necessary to fulfill its obligations as established in this section and complete its duties.

(e) The commission may, in consultation with the center for health information analysis, recommend a methodology to develop a single-payer health care financing system benchmark and may compare health care expenditures from calendar years 2024, 2025 and 2026 calendar years to the single-payer health care financing system benchmark.

(f) The commission shall meet quarterly, with the ability of the chair to convene additional meetings and subgroups as needed to carry out the duties of the commission.

(g) The health policy commission shall issue a report of the special commission's findings with recommendations to the clerks of the house of representatives and the senate, the house and senate committees on ways and means, the joint committee on health care financing, the executive office of health and human services, and the division of insurance not later than July 31, 2028.