Joint Committee on Health Care Financing
2025-2026 (194th) Bill Summary

Bill Number: House, No. 1405

Title: AN ACT ESTABLISHING MEDICARE FOR ALL IN MASSACHUSETTS

Sponsor: Representatives Lindsay N. Sabadosa (Northampton) and Margaret R. Scarsdale (Pepperell)

Hearing Date: June 18, 2025

Reporting Deadline: August 17, 2025

Prior History:* 2023-2024 (H1239): Ordered to a House Study
2021-2022 (H1267): Ordered to a House Study
2019-2020 (H1194): Reporting date extended to December 31, 2020; No further action taken
2017-2018 (H2987): H2987 accompanied, but not incorporated into *An Act establishing the Honorable Peter V. Kocot Act to enhance access to high quality, affordable and transparent health care in the Commonwealth*; No further action taken
2015-2016 (H1026): Ordered to a House Study
2013-2014 (H1035): Ordered to a House Study
2011-2012 (H0338): Ordered to a House Study
2009-2010 (H2127): Ordered to a House Study

Similar Matters: S860 (Eldridge – Identical, Health Care Financing)

Current Law: The proposed legislation outlines a total restructuring of the state, federal and private health care insurance markets and the financing and delivery of the health care delivery system. As the proposed legislation makes no changes to current law, necessitating the filing of additional legislation at a later date, a complete presentation of the Massachusetts General Laws and regulations, federal authorities, and other pertinent statutory and legal authorities that would be impacted by the passage of this bill is beyond the scope of a single bill summary.

Summary:
SECTION 1 of the proposed legislation inserts a new chapter into the General Laws, Chapter 176X, consisting of, Chapter 176N, comprised of the following 22 sections:

Section 1 of the proposed Chapter 176N defines certain terms as they are to be understood in the context of new chapter, including:

- *"Board"*, the Board of Trustees of the Massachusetts Health Care Trust.
- *"Health care"*, care provided to a specific individual by a licensed health care professional to promote physical and mental health, to treat illness and injury and to prevent illness and injury.
- *"Health care provider"*, any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by law to provide professional health care services to an individual in the Commonwealth.

- *"Institutional provider"*, an inpatient hospital, nursing facility, rehabilitation facility, and other health care facilities that provide overnight or ambulatory care.
- *"Noninstitutional provider"*, an individual provider and other health care practitioner that does not provide overnight or ambulatory care.
- *"Professional advisory committee"*, a committee of advisors appointed by the director of the Administrative, Planning, Information, Technology, or any Regional division of the Massachusetts Health Care Trust.
- *"Resident"*, a person who lives in Massachusetts as evidenced by an intent to continue to live in Massachusetts and to return to Massachusetts if temporarily absent, coupled with an act or acts consistent with that intent. The Trust shall adopt standards and procedures for determining whether a person is a resident. Such rules shall include: (1) a provision requiring that the person seeking resident status has the burden of proof in such determination; (2) a provision that a residence established for the purpose of seeking health care shall not by itself establish that a person is a resident of the Commonwealth; and (3) a provision that, for the purposes of this chapter, the terms "domicile" and "dwelling place" are not limited to any particular structure or interest in real property and specifically include homeless individuals, individuals incarcerated in Massachusetts, and undocumented individuals.

SECTION 2 of the proposed Chapter 176N declares health care as a right in Massachusetts and states that the intent of the chapter is to establish a Massachusetts Health Care Trust (the Trust) as the single-payer body responsible for the collection and disbursement of funds to provide health care services to every resident of the Commonwealth. This Section outlines in broad terms the purposes for which the Trust is created. Within this Section:

- The Trust is described as having sole authority to determine the process for replacing public and private health care options with a "uniform" health benefit plan financed through a single-payer system that operates according to the dictates of the Trust.
- The system to be designed by the Trust is described as providing guaranteed, continuous health care coverage with no patient cost-sharing "to all residents", as defined in Section 1, that shall be "comprehensive" and provides "access to dental care, behavioral health, eyeglasses, hearing aids, home health care, nursing home care, long-term care, hospice care, and other important health care needs."
- The Trust is empowered to "to fund, approve and coordinate" capital improvements sought by health care providers in excess of a threshold to be determined annually by the executive director.
- The Trust is directed to fund "training and re-training programs for professional and non-professional workers in the health care sector displaced as a direct result of implementation of this chapter."

SECTION 3 of the proposed Chapter 176N outlines the creation of the Trust as an independent authority within, but not subject to, the executive office of the health and human services and not subject to the supervision or control of any state agency or officer. The Trust is to function as the "single payer" agency responsible for the collection and disbursement of funds required to provide health care services for every resident. This Section also provides for certain exemptions from conflict of interest and state purchasing and contracting statutes.

SECTION 4 of the proposed Chapter 176N outlines certain powers of the Trust, including the power to make, amend, and repeal by-laws, rules and regulations; sue under its own name, acquire, own, hold dispose of and encumber personal, real or intellectual property of any nature; and to appoint, employ, and set the salaries of officers, employees, consultants, agents and advisors.

This Section also empowers the Trust "to do anything necessary and convenient to carry out the purposes of this chapter."

SECTION 5 of the proposed Chapter 176N states that the Trust shall be governed by a 29-member board of trustees (the Board) that "shall have final say over the Trust." The initial members of the Board will serve for truncated, staggered terms. The Governor may remove their appointees for "just cause" and the Attorney General may remove their appointees for "just cause". Bill language excludes the ability to remove the 8 individuals appointed by the Governor's Council. The Board will elect a chair every 2 years and meet at least 10 times annually. Trustees will be reimbursed for "actual and necessary expenses and loss of income incurred." Language ambiguous on whom or which agency is reimbursing.

The full membership of the Trust shall be appointed by various elected officials, to serve 5-year terms and be comprised as follows:

- Secretary of Executive Office of Health and Human Services (EOHHS);
- Secretary of Executive Office of Administration and Finance;
- Commissioner of the Department of Public Health;
- 8 individuals appointed by the Governor:
  - 3 nominated by "organizations of health care professionals who deliver direct patient care";
  - 1 individual nominated by "a statewide organization of health care facilities";
  - 1 individual nominated by "an organization representing non-health care employers";
  - 1 individual nominated by "a disability rights organization";
  - 1 individual nominated by "an organization advocating for mental health care";
  - 1 "health care economist";
- 10 individuals appointed by the Attorney General:
  - 2 individuals nominated by "a statewide labor organization";
  - 2 individuals nominated by "statewide organizations who have a record of advocating for universal single-payer health care in Massachusetts";
  - 1 individual nominated by "an organization representing Massachusetts senior citizens";
  - 1 individual nominated by "a statewide organization defending the rights of children";
  - 1 individual nominated by "an organization providing legal services to low-income clients";
  - 1 "epidemiologist";
  - 1 individual "expert in racial disparities in health care nominated by a statewide public health organization";
  - 1 individual "expert in women's health care nominated by a statewide public health organization"; and
- 8 individuals appointed by the Governor's Councilor representing the district in which the individual resides.

Of 29 appointed members, one member must demonstrate expertise or professional, lived or academic experience in each of the following 3 characteristics: homelessness; LGBTQIA+ rights or advocacy; and patients' rights or advocacy.

Board Voting:
A majority of Trustees present constitutes a quorum. For the Board to act, trustees must be present and eligible to vote. Board members shall not influence a governmental decision in which the Trustee knows or has reason to know that themselves, a family member, business partner, or colleague, has a financial interest. Bill lacks requirements for Board members conflict of interest and ethics disclosures.

Summary Prepared by the House Staff of the Joint Committee on Health Care Financing

Section 5 states that it is the responsibility of the Board to ensure "universal access to high quality health care for every resident of the Commonwealth" and requires the Board to specifically:

- establish policy on medical, population-based public health issues; research priorities, scope of services, expanding access to care, and evaluation of the performance of the system;
- evaluate proposals for innovative approaches to health promotion, disease and injury prevention, health education and research, health care delivery; and
- establish standards and criteria for requests from health facilities for capital improvement evaluation.

SECTION 6 of the proposed Chapter 176N establishes the position of Executive Director (Director), and is comprised of the following 4 subsections:

- <u>Subsection (a)</u> directs the Board to hire Director to serve as the executive and administrative head responsible for administering and enforcing the provisions of law relative to the Trust.
- <u>Subsection (b)</u> authorizes the Director, as they "necessary or suitable for the effective administration and proper performance of the duties of the Trust", subject to approval of the Board, to act as follows:
  - (b)(1) adopt, amend, alter, repeal, and enforce, all such reasonable rules, regulations, and orders as may be necessary; and
  - (b)(2) "appoint and remove employees and consultants: provided, however, that, subject to the availability of funds in the Trust, at least one employee shall be hired to serve as director of each of the divisions created in Sections 7 through 11, inclusive, of the proposed Chapter 176N.
- <u>Subsection (c)</u> requires the Director to perform the following duties:
  - (c)(1) establish an enrollment system that ensures all eligible residents are "formally enrolled";
  - (c)(2) use the purchasing power of the state to negotiate price discounts for prescription drugs and all needed durable and nondurable medical equipment and supplies;
  - (c)(3) negotiate or establish terms and conditions for the provision of high quality health care services and rates of reimbursement for such services on behalf of the residents;
  - (c)(4) develop prospective and retrospective payment systems for covered services to provide prompt and fair payment to eligible providers;
  - (c)(5) oversee preparation of annual operating and capital budgets for the statewide delivery of health care services;
  - (c)(6) oversee preparation of annual benefits reviews to determine the adequacy of covered services; and
  - (c)(7) prepare an annual report to be submitted to the Governor, the President of the Senate, and Speaker of the House of Representatives and to be easily accessible to every Massachusetts resident.
- <u>Subsection (d)</u> authorizes the Director to utilize and coordinate with the offices, staff, and resources of any agencies of the executive branch including, but not limited to, EOHHS, the Center for Health Information and Analysis, the Department of Revenue, the Division of Insurance, the Group Insurance Commission, the Department of Employment and Training, the Industrial Accidents Board, the Health and Educational Finance Authority.

SECTIONS 7-11, inclusive, of the proposed Chapter 176N establish 5 separate divisional offices within the Trust, each under the supervision of a division director appointed by and subject to the direction, control, and supervision the Director. The divisional offices are required to consult with each other in the performance of their duties and to develop short term and long-term plans, and may, at the discretion of the division director's discretion, establish a "a professional advisory committee to provide expert advice." The divisional offices created are:

- The Regional Division, charged with the creation of regional offices throughout the state that must be "professionally staffed" to perform local outreach and informational duties and respond to questions and complaints. The director of the Regional Division is authorized to implement remedies to address unmet health needs and poor quality of care, as identified by the regional offices through annual hearings to determine unmet health needs and other issues. The Regional Division is directed to establish a "statewide education program" to promote the single-payer system and inform residents about tax increases required to fund the Trust.
- The Administrative Division, established in Section 8, charged with the "day-to-day" responsibility for: (1) "prompt payment" to providers; (2) collection of reimbursements due from private and public third-party payers and ineligible individuals; (3) developing IT systems for payments, rebate collection, and utilization review; (4) investment of Trust fund assets; (5) development of the Trust's operating budgets
- The Planning Division, established in Section 9, authorized to coordinate health care resources and capital expenditures to ensure "reasonable access to covered services". The Planning Division is required to conduct an annual review of (1) 'the adequacy of health care resources", and (2) "capital health care needs", which includes recommendations for a budget for all health care facilities, evaluating capital expensive above an undetermined threshold, and coordinating "capital health planning and investment". The Planning Division must hold annual hearings and report recommendations to the Board by October 1.
- The Information Technology Division, established in Section 10, authorized to establish a patient database, a "confidential" EMR, a "prescription system, and develop an IT system that: is "compatible with all medical and dental facilities in Massachusetts"; tracks quality and safety; promotes preventative care guidelines, and; simplifies billing. The confidential EMR must permit patients to seal any portion of their medical records. The Information Technology Division must annually report recommendations to the Board by October 1.
- The Quality Assurance Division, established in Section 11, charged with developing universal "best quality standard of care using best practices" on: (1) appropriate hospital staffing; (2) clinical practice; (3) "scope of work" in the health workplace; (4) access to "needed' medical and dental care; (5) integrated medical home care; (6) end-of-life care. The Quality Assurance Division must hold annual hearings on health care quality and outcomes and make a report recommending universal standards of care to the Board by October 1.

SECTION 12 of the proposed Chapter 176N outlines eligibility for health care in Massachusetts. "Eligible participants" as provided in the following 3 subsections:

- Subsection (a) establishes 3 categories of "eligible participants":
  - (a)(1) All Massachusetts residents, as defined in Section 1 of the proposed Chapter 175N;
  - (a)(2)All non-residents who:
    - (a)(2)(i) work 20 hours per week in Massachusetts;
    - (a)(2)(ii) pay Massachusetts personal income and payroll taxes; and
    - (a)(2)(iii) pay any additional "non-resident" premiums that may be established by the Trust.
  - (a)(3)All non-residents requiring emergency treatment for illness or injury, provided tha the Trust is required to "recoup expenses for such patients wherever possible."
- Subsection (b) directs the Director to establish rates for emergency services provided to Massachusetts residents who are treated out-of-state at "prevailing rates where the service occurred" and authorizes the Director to require a Massachusetts residents to return for care "when prolonged treatment of an emergency condition is necessary."
- Subsection (c) requires visitors to Massachusetts to be "billed for all services received under the system" and permits the Director to enter into "intergovernmental arrangements with other states and countries to provide reciprocal coverage for temporary visitors."

SECTION 13 of the proposed Chapter 176N outlines the criteria for being deemed an eligible health care provider by the Trust. Eligible providers or facilities include an agency, facility, corporation, individual or other entity "directly rendering any covered benefit" to an eligible patient, provided that the provider:

- Holds a license to operate or practice in the Commonwealth;
- "Does not accept payment from other sources for services provided for by the Trust";
- Agrees in writing to:
  - provide services without discrimination;
  - comply with patient privacy laws;
  - refrain from unauthorized balanced billing;
  - refrain from applying unauthorized out-of-pocket charges; and,
  - furnish any information required by the Trust for payment, reimbursement, rebates, utilization reviews, statistical and fiscals studies, and legal compliance;
- Meets state and federal "quality guidelines", including for: (1) safe staffing; (2) quality of care; (3) "efficient use of funds" for direct patient care;
- "Meets whatever additional requirements that may be established by the Trust"; and,
- "Since a hospital's purpose is to serve patients and not to enrich private shareholders, the department of public health shall not issue a license or renew a license for a hospital under section 51 of chapter 111 unless said hospital is organized as a non-profit entity under section 501(c)(3) of the Internal Revenue Code."

SECTION 14 of the proposed Chapter 176N outlines budgeting and payments to eligible health care providers as determined annually by the Trust, and is comprised of the following 7 subsections:

- Subsection (a) requires the trust to annually perform the following fiscal duties:
  - (a)(1) set an operating budget;
  - (a)(2) set a capital expenditures budget;
  - (a)(3) set non-institutional provider "reimbursement levels…consistent with rates set by the Trust" that ensure (i) total costs of services are reasonable and (ii) aggregate rates are reasonably related to aggregate costs for a non-institutional provider;
  - (a)(4) set institutional provider budgets, consisting of both an operating budget and a capital budget, that are individually set for each provider "to cover its anticipated health care services for the next year based on past performance and projected changes in prices and health care service and utilization levels."
- Subsection (b) requires the Trust to utilize its operating budget for both its own administrative expenses and to issue payments for the services of "physicians and other clinicians and non-institutional providers" and the budgets of institutional providers.
- Subsection (c) includes the following additional provisions related to payments made by the Trust:
  - Payments may not be used to finance capital expenditures;
  - Payments may not be used to finance activities in support or in opposition to unionization efforts;
  - Requires annual adjustments to prospective payment rates and schedules to incorporate retrospective adjustments and instructs the Trust to claw back prospective payments made in excess of actual costs for covered services.
- Subsection (d) requires retrospective adjustments to payments reflect the difference between projected and actual use and expenditures for covered services and account for greater than anticipated use and costs against the statewide average.

- Subsections (e) and (f) restrict the allocation of funds for capital budgets to the construction and renovation of health care facilities, the purchase of "major equipment", or "reasonable expenditures…for the replacement and purchase of equipment", as determined through negotiations between the Trust and the provider.
- Subsection (g) states that, on the effective day of the Act, the Trust will assume full responsibility for debt service payments on all outstanding bonds and shall become the sole source of future funding, whether directly or indirectly, through the payment of debt service, for capital expenditures by health care providers covered by the Trust in excess of a threshold amount to be determined annually by the Director.

SECTION 15 of the proposed Chapter 176N states that the Trust shall pay for all professional services provided by eligible providers to eligible participants. No deductibles, co-payments, co-insurance, or other cost sharing shall be imposed for covered benefits, and patients are to have free choice of participating physicians and other clinicians, hospitals, inpatient care facilities and other providers.

Section 15 also outlines the following covered benefits: prevention, diagnosis and treatment of illness and injury, including laboratory, diagnostic imaging; inpatient, ambulatory and emergency medical care; blood and blood products; dialysis; palliative care; audiology care; acupuncture, physical therapy, chiropractic and podiatric services; screening, counseling and health education; the rehabilitation of sick and disabled persons, including physical, psychological, and other specialized therapies; all medically necessary mental health, behavioral health and substance use disorder services, including supportive residences, occupational therapy, and ongoing outpatient services; prenatal, perinatal and maternity care, family planning, fertility and reproductive health care, including abortion; home health care including personal care; long term care in institutional and community-based settings; hospice care; language interpretation and such other medical or remedial services as the Trust shall determine; emergency and other medically necessary transportation; the full scale of dental services, other than cosmetic dentistry; basic vision care and correction, including glasses, other than laser vision correction for cosmetic purposes; hearing evaluation and treatment including hearing aids; prescription drugs; durable and non-durable medical equipment, supplies, and appliances, including complex rehabilitation technology products and services as medically necessary, individually-configured manual and power wheelchair systems, adaptive seating systems, alternative positioning systems, and other mobility devices that require evaluation, fitting, configuration, adjustment, or programming; all new emerging technologies irrespective of where the parent company is located, such as telemedicine and telehealth practitioners; and infection by the virus that causes COVID-19 and any long-term effects, known as post-COVID conditions (PCC) or Long COVID.

SECTION 16 of the proposed Chapter 176N states that, absent necessary federal waivers to direct funds to support the single-payer health system, the Commonwealth of Massachusetts will still provide full benefits to individuals covered by federal health programs, pay for all covered benefits provided by the Trust and assume responsibility for the payment of all cost-sharing imposed by federally funded health coverage.

SECTION 17 of the proposed Chapter 176N outlines the creation of a "Health Care Trust Fund" into which all monies necessary for the administration of the Trust are to be deposited. The fund is to be administered by the executive director of the Trust.

SECTION 18 of the proposed Chapter 176N outlines the purposes to which monies in the trust fund may be utilized and caps the amounts available for certain purposes. Monies in the trust fund are to be directed toward all payments to eligible providers for covered services rendered to eligible individuals, and to fund all capital expenditures about a threshold amount to be set by the executive director of the Trust for those capital projects that have been approved by the Trust.

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Section 18 also reserves and caps on an annual basis the amount of monies available from the trust for certain purposes as follows:

- a 1% annual deposit into a reserve account for anticipated long-term increases in costs, not to exceed 5% of the total amount of monies in the trust fund;
- no more than 5% for preventive care, education, outreach, and public health risk education initiatives;
- no more than 5% for the administrative costs of the Trust after the 2nd year of full implementation; prior to then, there is no cap on the amount of funds that may be used for the administrative costs of the Trust;
- no more than 2% for supplemental financing for education and training of the health care workforce;
- no more than1% for the financing of medical research and innovation;
- no more than 2% of the trust to for training and retraining persons who become unemployed due to the effects of the transition to a single-payer health system, provided that persons deemed eligible for such assistance enroll in a program by the 3rd year of "full implementation" of the Trust.

SECTION 19 of the proposed Chapter 176N outlines the taxation and financing scheme necessary to support the single-payer system, comprised of the following 19 subsections:

- Subsection (a) states that "a fairly apportioned, dedicated health care tax on employers, works and citizens will replace spending on insurance premiums and out-of-pocket spending for services covered by the Trust", as well as "collateral sources of revenue" to be recovered by the Trust from the federal government, non-residents receiving care, or from personal liability.
    - Subsection (a) also authorizes the Trust to "enact provisions ensuring a smooth transition to a universal health care system for employees and residents."
- Subsection (b) establishes the following single-payer financing taxes:
    - 10% payroll tax on the self-employed, exempting the first $20,000 of payroll per self-employed individual;
    - 10% tax on income derived from dividends, assessed on income above $20,000;
    - 10% tax on "unearned income", assessed on such "unearned income" above $20,000. Exclusions not taxed:
        - Social Security, Supplemental Security Income (SSI), Social Security Disability Income (SSDI);
        - unemployment benefits;
        - workers compensation benefits;
        - sick pay;
        - paid family and medical leave;
        - defined contribution and defined benefit pension payments;
        - capital gains resulting from the sale of owner-occupied two- or three-family rental property, provider, however, that capital gains from the portion attributed to a primary residence in excess of the exclusion allowed by Massachusetts law will be subject to the tax.
    - 8% employer payroll tax on employers with 100 or more employees;
    - 7.5% employer payroll tax on employers with 99 or fewer employees, exempting the first $20,000 of payroll per establishment, and an additional 0.5% on employers with 100 or more employees;
    - 2.5% employee payroll tax, exempting the first $20,000 of income.
- Subsection (c) permits an employer to cover all or a portion of the 2.5% employee payroll tax and excludes any such contribution from the calculation of the state income tax.
- Subsection (d) authorizes the Trust to impose penalties for failure to pay single-payer financing taxes.

- Subsection (e) declares that "eligibility for benefits shall not be impaired by any default, underpayment, or late payment of any tax obligation or other obligation imposed by the Trust."
- Subsection (f) states that "public spending on health insurance will be consolidated to the greatest extent possible", and that until the role of all other payers has been terminated, costs shall be collected from "collateral sources" whenever medical services are, or may be, covered under a policy be a collateral source.
- Subsection (g) directs the legislature to transfer from the General Fund monies sufficient to cover the difference between revenues collected from the dedicated health care taxes to be imposed under subsection (b) and the projected expenses of the Trust.
- Subsection (h) directs the executive director of the Trust to seek any waivers, exemptions, agreements, or legislation, necessary in order to direct federal funds to the Trust.
- Subsections (i) through (p), inclusive, define "collateral sources" and obligates individuals who have coverage through "collateral sources" and who receive care or obtain benefits provided by the Trust to notify the health care provider, who then notifies the executive director of the Trust, who then shall seek reimbursement for all or a portion of the money paid by the Trust for services rendered.
- Subsections (q) and (r) outline "transitional provisions". These subsections state that employers with health insurance contact as of the effective date of the Act are entitled to an income tax credit equal to the amount paid towards premiums. Insurers will be subject to an assessment equal to the premium that would have been paid by the employer.
- Subsection (s) repeals "all laws and regulations requiring health insurance carriers to maintain cash reserves for purposes of commercial stability" 6 months prior to the establishment of the Trust, and requires that in their place the Director impose a new "annual health care stabilization fee" assessment upon carriers "amounting to the same sum previously required to be held in reserves."

SECTION 20 of the proposed Chapter 176N prohibits insurers regulated by DOI from charging premiums for services covered by the Trust and requires DOI to "adopt, amend, alter, repeal, and enforce all such reasonable rules and regulations and orders as may be necessary to implement this section".

SECTION 21 of the proposed Chapter 176N authorizes the Trust to adopt regulations to implement a single-payer health care system and declares that such regulations are to be adopted as "emergency regulations."

SECTION 22 of the proposed Chapter 176N requires the entire Act to be "fully implemented" within 1 year following enactment, and also requires the Governor, Attorney General and Governor's Councilors to make their initial appointments to the Board within 45 days of enactment, with the first meeting of the Board to take place within 10 days of those appointments.

Section 22 further outlines the following activities to implement this Act:

- The Board is instructed to:
  - "immediately begin the process of hiring an Executive Director";
  - review enabling legislation, educating itself regarding general purposes, economics, and authority of the Trust;
  - develop a budget "for the transition";
  - initiate the process of obtaining federal waivers and agreements concerning payments from Medicare, Medicaid, and other public programs; and,
  - set a general timeframe for establishing the Trust with a launch date "no less than" 1 year following enactment.

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- In “the first phase of transition”, providers are required to “develop plans for transitioning to the Trust”, and the Director is instructed to:
    - begin hiring staff;
    - establish the administrative and information technology infrastructure for the Trust; and
    - negotiate reimbursement rates for health care services, pharmaceuticals, and medical equipment.
- In “the second phase of transition”, the following activities are to be completed:
  - the infrastructure of the Trust shall be established, including Regional Offices to provide public education about the new system;
  - health care providers’ staff are to be trained on systems for processing bills to the Trust;
  - accounting regulations for the imposition of the payroll taxes established pursuant to Section 19 of the proposed Chapter 176N are to be introduced;
  - the Trust is required to collect the “annual health care stabilization fee” assessment, established pursuant to Section 19 of the proposed Chapter 176N; and,
  - residents a to receive a health care identification cards with an explanation of benefits and contact information for their Regional office.
- The legislature is instructed to “fund the establishment of the Trust during the transition period… supplemented by the reserve funds of private insurers.”

Detailed Legislative History:*

2023-2024 Filed as H1239 & S0744 from the 2023-2024 legislative session. Referred to the Joint Committee on Health Care Financing. Public hearing on November 14, 2023. H1239 & S0744 accompanied a Study Order on May 9, 2024, see H4634. No further action taken.

2021-2022 (H1267) Filed as H1267 & S0766 in the 2021-2022 legislative session. Referred to the Joint Committee on Health Care Financing. Public hearing on October 26, 2021. Reporting deadline extended to Wednesday, June 1, 2022. S0766 accompanied a Study Order on June 9, 2022, see S2917. H1267 accompanied a Study Order on September 15, 2022, see H5222. No further action taken.

2019-2020 (H1194) Filed as H1194 & S0683 in the 2019-2020 legislative session. Referred to the Joint Committee on Health Care Financing. Public hearing on June 11, 2019. Reporting date extended to May 1, 2020. Reporting date extended to June 19, 2020. H1194 reporting date extended to December 31, 2020, pending concurrence. No further action taken on H1194. S0683 reporting date extended to December 31, 2020, pending concurrence. Reported Ought NOT to Pass under Joint Rule 10 on July 23, 2020. No further action taken on S0683.

2017-2018 (H2987) Filed as H2987 & S0619 in the 2017-2018 legislative session. Referred to the Joint Committee on Health Care Financing. Public Hearing on June 20, 2017. S0619 accompanied a study order on May 31, 2018, see: S2535. No further action. H2987 accompanied, but not incorporated into, “*An Act establishing the Honorable Peter V. Kocot Act to enhance access to high quality, affordable and transparent health care in the Commonwealth*”. H4605 reported ought to pass by the Joint Committee on Health Care Financing on June 13, 2018 and referred to House Ways & Means. Recommended ought to pass with an amendment, substituting therefor a bill with the same title, on June 14, 2018, and referred to the House Committee on Steering, Policy & Scheduling with the amendment pending; see: H4617. Reported that the matter be placed in the Orders of the Day for a second reading with the amendment pending on June 18, 2018. Rules suspended, read second and adopted as amended on June 19, 2018. Ordered to a third reading, rules suspended and read third on June 18, 2018. Engrossed and published as amended on June 19, 2018; see: H4639. Read, rules suspended and read second in the Senate on June 21, 2018. Amended, striking all after the enacting clause and inserting in place thereof the text of S2573, ordered to a third reading, read third, and passed to be engrossed on June 21, 2018. House NON-concurred with the Senate amendment, Senate insisted on its amendment, House committee on conference

appointed (Mariano, Roy, Hunt, R.), and Senate committee on conference appointed (Welch, Lewis, Tarr) on June 25, 2018. No further action taken.

2015-2016 (H1026) Filed as H1026 & S0579 in the 2015-2016 legislative session. Referred to the Joint Committee on Health Care Financing. Public hearing on March 22, 2016. H1026 accompanied a Study Order on May 9, 2016, see H4634. S0579 accompanied a Study Order on June 23, 2016, see S2356. No further action taken.

2013-2014 (H1035) Filed as H1035 & S0515 from the 2013-2014 legislative Session. Referred to the committee on Health Care Financing. Public Hearing on October 22, 2013. H1026 accompanied a Study Order on June 30, 2014, see H4234. S0515 accompanied a Study Order on May 21, 2014, see S2148. No further action taken.

2011-2012 (H0338) Similar matters filed as H0338 & S0501 in the 2011-2012 legislative session. Referred to the Joint Committee on Health Care Financing. Public hearing on December 15, 2011. Reporting date extended to June 1, 2012. Reporting date extended to June 29, 2020. H0338 & S0501 accompanied a Study Order on December 10, 2012, see H4533. No further action taken.

2009-2010 (H2127) Similar matter filed as H2127 in the 2009-2010 legislative session. Referred to the Joint Committee on Public Health. Public hearing on October 20, 2009. accompanied a Study Order on June 14, 2010, see H4755. No further action taken.

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