| Specification | Oregon Single Payer Proposal | Vermont Single Payer (VT128)[1] | Maine Single Payer (HP1169) | Washington Health Security Trust bill | OR Health Care Ingenuity Plan Proposal | CA state subsidy/ coverage | Cascade Care (Public Option in Progress) |
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| **Summary** | | | | | | | |
| **Model overview** | Law required analysis of: State designed plan with standardized benefits, covering all state residents | Legislation: State designed plan with standardized benefits available to all state residents (use of public and private plans to be determined by design board) | Legislation: Establishes Board to design and implement State designed standardized benefits covering all state residents, with phased implementation based on resident income | Legislation (2020: HB 1104) creates Washington health security trust, a single health financing entity to design and implement coverage with standardized benefits for all state residents | State-designed managed competition covers all state residents except those with federal plans (Medicare, federal employee coverage, IHS, Veterans coverage) | State funds support Medicaid coverage for undocumented young adults, premium support for Marketplace consumers of varying income levels | State-designed and procured plans with standardized benefits and structure to be offered on the state Marketplace |
| **Eligibility for health coverage** | | | | | | | |
| **U.S. citizens who are state residents** | Yes | Yes | Yes | Yes | Yes, if not a Medicare beneficiary | Yes (eligibility based on income) | Yes – if Exchange eligible (individual market only) |
| **Lawfully present immigrants who are state residents** | Yes | Yes | Yes | Yes | Yes, if not a Medicare beneficiary | Yes (eligibility based on income) | Yes – if Exchange eligible |
| **Undocumented immigrants** | Yes | Yes | Yes | Yes | Yes | Medicaid: yes, up to age 26<br>Commercial: yes, 0-138% & 200-600% FPL | No |
| **Scope of benefits** | | | | | | | |
| **Essential Health Benefits (EHB)** | Yes | Yes, details to be determined by Board | Yes (list includes services in EHB) | Yes | Yes | Medicaid eligible: Medicaid EHBs, EPSDT, dental, vision, hearing<br><br>Commercial: follows QHP standard (adult | Yes |
| **Early and periodic screening, diagnosis and treatment (EPSDT) for children** | Yes | Yes for Medicaid, not specified for other coverage | Not addressed | Not addressed | No | | No |

[1] Vermont eventually explored several options, including one that would have allowed a mix of public and private coverage. The State abandoned its plan for universal coverage in 2014.

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| **Adult dental, vision, and hearing** | No | To be determined by Board | Yes: dental, vision; hearing not addressed | Yes | No | Dental, vision, hearing not required) | Uses Exchange's Qualified Health Plan (QHP) standard: adult dental, vision, hearing not required |
| **Consumer Financial Participation** | | | | | | | |
| **Cost sharing for covered benefits**<br><br>**(AV = Actuarial Value, the % of total plan costs for covered benefits paid for by the health plan = "value" to the individual)** | • Below 250% FPL[2]: no cost sharing<br>• 250%+ FPL: 96% AV (means 4% of costs are paid by the individual; 96% by the plan) | 94% AV for all<br><br>Mechanism not specified, anticipated co-pays or co-insurance[3] | To be determined by implementation task force | To be determined by Trust Board | • > 138% FPL: small co-pays ($1-3) allowed<br>• 138-150% FPL: 94% AV[4]<br>• 150-200% FPL: 87% AV<br>• 200-250% FPL: 73% AV<br>• 250%+ FPL: 70% AV | Medicaid: No<br><br>Commercial: NA | Yes |
| **Premiums** | None | None | To be determined by implementation task force | Monthly health security premium for residents with incomes over 200% FPL, with exemptions for Medicare, Medicaid beneficiaries and those under 18 | None for second-lowest cost plan in an area, though insurers with higher premiums can collect an additional premium, and insurers and employers can | Medicaid: NA<br><br>Commercial: state pays part of premium for consumers with income 0-138% and 200-600% FPL (federal | Estimated to be 5-10% lower than other QHPs on exchange |

[2] The Federal Poverty Level (FPL) is a measure of income issued annually by the federal Department of Health and Human Services. FPL is used to determine eligibility for certain programs and benefits, including savings on Marketplace health insurance, and Medicaid and CHIP coverage. The 2019 FPL is $25,750 for a family of four in the contiguous United States (The 2019 FPL is in place in 2020, with 2020 updates published in late January or early February)

[3] Co-pays are usually a fixed amount paid at the time of service; co-insurance is usually a percentage of the overall visit/service that is billed to the individual afterwards. Can vary usually from 0 to 40%, occasionally higher

[4] OR Health Care Ingenuity Plan has small copays for individuals at the lowest income, and then increasing cost sharing at higher incomes

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| | | | | | charge premiums for supplemental coverage | funds for 100-400% still in place) | |
| **Program Structure and Administration** | | | | | | | |
| **Administration** | State contracts with entities managing coverage | Green Mountain Care (new, independent public agency) | Planning and implementation of Maine Single-payer Health Care Program by Single-payer Implementation Task Force<br><br>MSPHC Program to administer | Single health financing entity, Washington Health Security Trust | State contracts with carriers managing coverage | State agency (Department of Health Care Services) administers Medicaid<br><br>State entity (Covered CA) administers exchange | State sets requirements for participating insurers |
| **Health plans** | A single, state-sponsored health plan will pool all sources of financing, and contract directly with providers and provider groups | One or more commercial health plans | To be determined by implementation task force | State directly pays providers, no health plan involvement | Multiple competing commercial health plans | Medicaid plans<br><br>Commercial plans sold on Exchange | Voluntary participation by individual market insurers (commercial plans sold on Exchange) |
| **Provider payment rates** | 10% below Status Quo on average for hospitals, physicians and other clinicians | To be determined by Board | To be determined by implementation task force – legislation requires "fair rates of compensation" | Trust board will annually negotiate with each hospital and facility a prospective global budget for operational and other costs to be covered by the trust. Group practices may also negotiate on a global budget basis. Hospitals | Negotiated between commercial health plans and providers | Not impacted by program, subject to the same rates in effect for Medicaid and commercial respectively | Provider reimbursement is capped at aggregate of 160% of Medicare; rates for some rural hospitals are capped at 101% of allowable costs under Federal programs (incl. Medicare) Primary care providers must be paid at least 135% |

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| | | | | and other facilities will be paid on a FFS or case rate basis, within the limits of their prospective annual budget. | | | of Medicare<br><br>Carrier may not require providers to accept the public option plan rates to participate in other plans offered by that carrier |
| **Financing sources** | Federal funding in lieu of:<br>• federal match for Medicaid<br>• Marketplace advance premium tax credits and cost sharing reductions (CSRs)<br>• outlays for Medicare<br>• health benefits for federal workers, veterans, and other federal programs<br><br>State funding for Medicaid<br><br>New state tax revenues:<br>• 83% increase in income tax | Tiered taxes with payment based on income<br><br>To be determined by Secretary, may include income tax, payroll tax, consumption taxes, provider assessments employer assessment, other new or existing taxes, and additional options | To be determined by implementation task force | The joint select committee on health care oversight will contract with actuary for assessment of financing required, then recommend a funding mechanism to the House, Senate and Governor<br>Funding will include:<br>• health security assessment on employers<br>• health security premium on residents (with exemptions noted under premiums)<br>• Any | Federal funding in lieu of:<br>• federal match for Medicaid<br>• Marketplace APTCs and CSRs<br>• tax expenditure for employer-sponsored insurance<br><br>New dedicated 8.4% sales tax on nonessential goods and services | State general funds for state subsidies and Medicaid | NA – at least initially, no additional funding beyond consumer's premium payments and any premium tax credits for which the consumer is eligible |

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| | revenues<br>• 6.5% payroll tax on employers with at least 20 workers | | | additional funding sources | | | |
| **Other key provisions** | Employers whose premium savings exceed new payroll tax obligations would be required to pass savings back to employees | NA | Phased implementation: non-Medicaid under 250% FPL; 250-400% FPL; above 400% FPL | NA | NA | NA | Standard plan design at Bronze, Silver, Gold levels (including deductibles, cost-sharing, premiums)<br>Plans must meet quality and value standards that align with state purchasing for Medicaid, PEBB and SEBB |
| **Other specifications** | NA | Medicare, Medicaid, Veterans, military coverage continue as before, as do plans for local employees and retirees of out-of-state companies, and tourists and other visitors<br><br>Unified claims administration, payment system includes Medicare, Medicaid | Implementation Task Force to design the program and bring proposal to legislature for approval prior to implementation | Residents with private coverage use that coverage first, state coverage second | Employers can offer supplemental plans to cover cost sharing and additional benefits | NA | NA |

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