



Healthcare on the Mid-Term Ballot 2026

A national and state reference guide

Implications for providers, payers,
patients and consumers

November 3, 2026 election

24 selected statewide measures • 13 states • 1 local funding case



Contents

This report examines how selected November 2026 ballot proposals could affect healthcare financing, clinical services, insurance and patient access. Each profile explains what approval would change, what would remain if the proposal failed, and the implications for providers, payers, patients and consumers. Legal and fiscal information is current through October 19, 2026.

Section	Purpose	Page
National overview	Main findings and their meaning for the country	3
The national pattern	Issue groups and routes to healthcare effects	4
State directory	State profiles and the Marin local case	5
Reading the outcomes	Scope, evidence and scenario definitions	6
State profiles	25 profiles with provider, payer and patient columns	7
Appendix A Combined outcomes	Interacting California and Colorado proposals	32
Appendix B Implementation dates	Early changes and longer funding horizons	34
Appendix C Fiscal reference	Amounts, periods and funding distinctions	36
Appendix D Approval thresholds	Rules for adoption and certification	38
Appendix E Insurance and Medicaid	Plan types and changes outside these ballot votes	39
Appendix F Glossary	Plain-language terms used in the report	42
Appendix G Results and sources	Election outcomes, implementation and annotated sources	44
About Black Book Research	Organization, founder and research contact	52

Flag sources

South Dakota's flag image is from its Secretary of State; the other flag files are from Wikimedia Commons. [United States](#) · [California](#) · [Colorado](#) · [Idaho](#) · [Massachusetts](#) · [Missouri](#) · [Nevada](#) · [New Mexico](#) · [North Carolina](#) · [Rhode Island](#) · [South Dakota](#) · [Virginia](#) · [Washington](#) · [Wisconsin](#)

National overview

The November 3, 2026 election could change how healthcare is financed, which services state law protects or restricts, and how public institutions deliver health-related services. This reference examines 24 selected statewide measures in 13 states, plus one local healthcare tax in California. The measures range from Medicaid and reproductive care to clinic finances, research bonds, school health information and broader tax rules.

The central finding is that the consequences will reach people through different routes and on different schedules. Some proposals change a legal right or restriction soon after the election. Others authorize money that must still be collected, allocated or borrowed. Several change future budget choices without directly changing anyone's insurance benefits.

Funding proposals have different meanings

California Proposition 3 concerns revenue that otherwise expires after 2030; Proposition 40 proposes a one-time wealth tax with 90% of receipts directed to public healthcare. Colorado Amendment 87 designates new revenue for several purposes, including healthcare, without assigning healthcare a fixed share. Washington IP26-645 would repeal a tax with first collections due in 2029. [1, 9, 25, 66]

Legal access and payment remain separate

Idaho, Missouri, Nevada and Virginia ask different questions about reproductive care. Missouri and Colorado also address specified treatment of minors. A change in what state law permits or protects does not by itself tell a patient whether a plan pays, how much a visit costs or whether an appointment is available. [31, 39, 41, 43, 60, 28]

The Medicaid vote is conditional

South Dakota Amendment I would remove the constitutional expansion requirement if the specified federal matching percentage falls below 90%. The attorney general explains the change as ending expanded coverage upon that funding change. Approval would not itself end coverage while that percentage remains 90%. Separate federal Medicaid rules continue under either result. [57, 78, 79]

What remains after defeat

A failed proposal generally leaves its existing-law starting point intact. Nevada would retain statutory abortion access if Question 6 fails. North Carolina's already enacted individual tax schedule would continue if its lower constitutional ceiling is rejected. Rejection of a bond or a new local tax does not itself order a facility to close. [43, 49, 45, 75]

The national pattern

Across the country, these votes could widen differences between state healthcare systems. A patient's experience would still depend on the service involved, the state's implementation, the health plan's rules and the availability of a clinician. The analysis below describes those connections without predicting election outcomes or assigning a national dollar value to unlike measures.

The categories below are mutually exclusive for this report's 24 statewide measures. Some measures have several effects; the grouping identifies their principal route to healthcare. The Marin local tax is additional and is excluded from these counts.

Principal issue	Count	Selected statewide measures	Route to healthcare effects
Funding and tax rules	11	California 3 and 40–44; Colorado 87 and 136; North Carolina's two tax amendments; Washington IP26-645.	The route is through state or local revenue, spending constraints, oversight or covered clinic finances. Most measures do not directly amend a patient's benefit package.
Clinical access and Medicaid	6	Colorado 135; Idaho Proposition One; Missouri 3; Nevada 6; South Dakota I; Virginia 1.	The route is through legal protections, clinical restrictions or a condition on the constitutional Medicaid expansion requirement.
Capital and research	3	California 38; New Mexico Bond Question 1; Rhode Island Question 1.	Borrowing can support research or facilities. Grants, construction, staffing and operating support determine when people benefit.
School information and other health-related policy	4	Idaho HJR 4; Massachusetts 8; Washington IL26-001; Wisconsin 2.	The route is through school information rules, drug-policy authority, the adult-use marijuana market or emergency powers.

For healthcare providers. Hospitals, clinics and clinicians may encounter new service restrictions, documentation duties or financing conditions. Funding measures can support future care, but a statewide collection estimate is not the amount a particular provider will receive. Clinics, public institutions and private practices may be affected differently by the same vote.

For payers. Insurers, employer health plans and Medicaid managed-care organizations need separate treatment. A ballot measure may affect the care available in a state while leaving the plan's benefit terms unchanged. Public-program payment changes require the relevant budget, contract and federal processes.

For patients and consumers. The practical questions are whether care remains lawful, whether it is covered, where it is available, how much the patient pays and what personal information is disclosed. Tax measures also affect some households as taxpayers. The report's patient column keeps those effects distinct from provider finances.

These state decisions affect healthcare through different funding and policy mechanisms. Bond authorizations, annual revenue, one-time taxes and repayment costs measure different obligations and resources; they do not form a comparable national funding total.

State directory

State names and page numbers link to the first profile. Each profile includes the official source references and separate passage and defeat impacts for providers, payers, patients and consumers.

State or district	Measures and topics	Page
California	Propositions 3, 38 and 40–44 Revenue, research bonds, tax rules and clinic spending.	7
Colorado	Amendment 87 and Propositions 135–136 Income taxes, healthcare funding and specified surgeries.	14
Idaho	Proposition One and HJR 4 Reproductive care and authority over drug legalization.	17
Massachusetts	Question 8 Adult-use marijuana retail repeal and the medical market.	19
Missouri	Amendment 3 Reproductive care and specified treatment of minors.	20
Nevada	Question 6 Second vote on constitutional abortion protection.	21
New Mexico	Bond Question 1 Capital projects for facilities serving older adults.	22
North Carolina	Income-tax and property-tax amendments A lower state tax ceiling and future local levy limits.	23
Rhode Island	Question 1 College facilities including URI's health building.	25
South Dakota	Constitutional Amendment I A federal-match condition on Medicaid expansion.	26
Virginia	Question 1 Constitutional reproductive freedom.	27
Washington	IP26-645 and IL26-001 Income-tax repeal and school health information.	28
Wisconsin	Question 2 Worship gatherings during declared emergencies.	30
Marin Healthcare District	Local Measure CC in California A new dedicated local healthcare parcel tax.	31

Reading the outcomes

What the report covers

Selection focuses on measures with a direct healthcare rule or a material connection to healthcare financing, public services, research or facilities. The 24 statewide profiles are a selected reference set, not a count of every healthcare-relevant question nationwide. Candidate contests, all general fiscal measures and a complete inventory of local elections are outside the scope. Marin Healthcare District appears as a clearly identified local case.

What the outcome labels mean

“Pass” and “Fail” mean adoption and rejection of the proposal, including ballots labeled Yes/No, For/Against or Approve/Reject. The passage scenario assumes the required approval threshold is met and the relevant provision becomes operative. A defeat scenario retains current law, including future changes already enacted separately.

Evidence and analysis

The analysis draws on official ballot materials, operative texts, fiscal analyses and agency guidance available on October 19, 2026. Numbered references connect the profiles to the source guide. Black Book assesses potential consequences for providers, payers and patients under the legal and fiscal conditions described in each profile.

How to interpret uncertainty

An authorization, a legal effective date, a cash receipt and an available service are different milestones. Litigation, competing proposals, regulations, appropriations and project execution can change the path. Where an outcome depends on a later decision, the report identifies that dependency instead of assuming a benefit, closure or cost saving.

The patient and consumer column

The patient and consumer analysis considers access, continuity of care, affordability, confidentiality and household tax exposure. Legal protections, insurance benefits, available clinicians and service costs can change independently. A funded facility adds practical capacity when construction, staffing and service arrangements are complete.

The appendices explain plan types, implementation dates, voting rules, fiscal estimates and the sources supporting the analysis.



Proposition 3

Keeping the existing high income tax after 2030

Voters decide whether to make existing higher income-tax rates permanent, preserving revenue for schools and other public services, including healthcare, after their scheduled expiration.

Official source guide [1, 2, 3, 4, 5]

Current rules. Higher rates approved in 2012 and extended in 2016 remain through 2030. Existing funding rules support education and include a conditional healthcare allocation of up to \$2 billion annually when the specified revenue and budget calculation leaves money available.

If approved. The higher rates become permanent. The Legislative Analyst estimates that this preserves \$5 billion to \$15 billion annually from 2031. Existing education allocations and the conditional healthcare funding formula continue; the proposition does not promise a fixed annual healthcare payment.

If rejected. The higher rates remain scheduled to expire in 2031. They continue through 2030, and rejection does not immediately cancel Medi-Cal coverage, reduce provider payments or close services.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Hospitals and clinics dependent on public funding retain a potential revenue base beyond 2030. Actual healthcare payments still depend on funding conditions and program decisions.	Medi-Cal financing retains access to the existing tax framework and conditional healthcare allocation. The vote itself does not increase plan payments or expand covered benefits.	Affected high-income taxpayers continue paying the higher rates after 2030. Publicly supported care may benefit from continued revenue, but appointments and patient charges are not guaranteed.
Fail	Providers face the scheduled loss of this state revenue source from 2031. Whether that leads to payment or service changes depends on subsequent budgets.	Public coverage faces a future revenue expiration, while existing insurance arrangements continue. Any change to benefits, eligibility or payments would require separate policy decisions.	Affected taxpayers would receive the scheduled rate reduction in 2031. Patients retain current coverage rules, with future healthcare funding determined through later budget and program decisions.

Timing. The amendment takes legal effect after election certification under California’s constitutional rules, but the main tax and revenue difference begins in 2031. Collections will still vary with high-income earnings and investment markets, and the healthcare allocation remains conditional.

Key distinction. The \$5 billion to \$15 billion estimate covers total preserved state revenue. The separate healthcare formula allows up to \$2 billion in qualifying years; neither figure is a guaranteed hospital payment.



Proposition 38

Borrowing for immune system research and treatments

The proposition would authorize \$8.4 billion in borrowing for research on the immune system and treatments, with repayment from the state budget and conditions on resulting products.

Official source guide [6, 7, 8, 5]

Current rules. Medical research already receives public and private funding. Earlier California ballot measures authorized separate stem-cell research bonds. Proposition 38 would create additional borrowing authority for immunology and immunotherapy, rather than renew insurance coverage or existing treatment benefits.

If approved. California may issue \$8.4 billion in general obligation bonds. About half supports a qualifying research institute and half supports competitive grants. At least \$4.2 billion targets cancer, heart disease and Alzheimer’s research. The law also sets reporting, revenue-sharing and California pricing requirements.

If rejected. This borrowing authority is not created. Research proposals relying on it would need other financing, while existing research awards, available treatments and insurance coverage continue under their own rules.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Eligible research institutions could receive funding and develop clinical collaborations. Hospitals might eventually use resulting therapies, but research success and new operating revenue are uncertain.	Future therapies could change treatment options and costs. California purchasers receive specified pricing protections for resulting products, but coverage and overall insurance savings are not assured.	Patients could eventually benefit from successful research and California pricing protections for resulting products. Taxpayers assume bond repayment costs; access still depends on approved treatments and coverage.
Fail	Institutions lose this proposed funding opportunity, not their existing awards. Projects dependent on these bonds may be delayed or require another public or private funding source.	Insurers’ existing coverage and payment rules do not change. Future treatment development would continue through other research funding, without this bond program’s California pricing requirements.	Taxpayers avoid this additional bond obligation. Patients keep existing treatments and coverage, while potential discoveries from projects dependent on these funds may require other research support.

Timing. Selection, grants and research follow authorization; useful treatments may take years to develop. The Legislative Analyst estimates repayment of \$500 million to \$600 million annually for about 20 years. Revenue from discoveries is uncertain and could take decades to offset costs.

Key distinction. The eventual 20% discount compares resulting products with the national average excluding California. First-year prices cannot exceed prices elsewhere in the United States; neither rule discounts every medical bill.



Proposition 40

A one time billionaire wealth tax for healthcare and other services

The proposition would impose a one-time wealth tax on qualifying billionaires and reserve 90% of receipts for public healthcare, with potential conflicts involving two other California measures.

Official source guide [9, 10, 11, 12, 13, 5]

Current rules. California taxes income but does not currently impose this proposed billionaire wealth tax. Medi-Cal and other public healthcare services draw on existing state and federal financing. The proposed receipts would be temporary additional funding, rather than a permanent annual tax stream.

If approved. Qualifying billionaires resident on January 1, 2026 owe a one-time tax generally equal to 5% of taxable net worth, valued December 31, 2026. Payment is due in 2027, with an extra-cost installment option. Ninety percent supports public healthcare; the remainder supports education, food assistance and administration.

If rejected. The proposed tax and its dedicated funding are not created. Existing healthcare programs retain their governing laws and budgets; rejection itself does not reduce benefits or order service closures.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Public healthcare funding could support services or provider payments when collections are available and allocated. Individual hospitals and clinics are not promised a particular payment.	The state gains a potential source for public healthcare spending. Insurance coverage and plan payments depend on how funds are allocated, not simply on tax approval.	Patients could benefit through publicly supported services once funds are collected and distributed. Qualifying billionaires owe the tax; broader coverage or lower medical bills are not automatic.
Fail	Providers cannot receive support from this proposed tax. Any resulting service changes depend on their other funding, costs and later state decisions, rather than rejection alone.	Public coverage remains financed through existing or later-approved resources. The failed tax would not itself narrow Medi-Cal eligibility or require commercial insurers to raise premiums.	The proposed tax is not owed and its healthcare funds are unavailable. Current patient coverage and charges remain governed by existing policies and subsequent program decisions.

Timing. Collections could total tens of billions over several years, according to the Legislative Analyst, with uncertain timing. If approved Proposition 41 or 42 receives more affirmative votes, courts could find a conflict that prevents Proposition 40 from taking effect.

Key distinction. This is temporary funding. The Legislative Analyst also identifies possible ongoing income-tax losses below \$1 billion annually; neither the revenue estimate nor the 90% allocation predicts a particular provider's receipts.



Proposition 41

More audits and limits on taxes outside the state spending cap

The proposition adds audits for programs supported by new or increased state special taxes and restricts new taxes excluded from the state spending limit, potentially affecting healthcare financing.

Official source guide [10, 14, 15, 5]

Current rules. A special tax reserves its revenue for a particular purpose. California already audits public programs and has a constitutional spending limit with exclusions, but it does not have this proposed combination of mandatory preliminary and recurring special-tax audits.

If approved. Affected programs receive preliminary and recurring audits, including recommendations for annual savings of at least 10%. A separate provision prohibits collecting covered state taxes enacted or taking effect from January 1, 2026 if exempted from the spending limit. Audit recommendations do not automatically reduce program budgets.

If rejected. The new audit framework and spending-limit prohibition are not adopted. Existing oversight continues, and the result does not direct healthcare agencies to change payments, benefits or services.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Providers in affected publicly funded programs could face additional scrutiny of costs and results. Funding effects depend on audit responses and whether particular tax revenues remain available.	Public purchasers may face added cost and performance reviews. The instruction to identify 10% savings is not an automatic 10% reduction in insurance or provider payments.	Voters gain additional public information about affected programs. Any service changes require further decisions; a successful challenge involving Proposition 40 could prevent its proposed healthcare funding.
Fail	Providers retain existing audit and reporting obligations without this added framework. Their public funding still depends on the relevant taxes, appropriations and program rules.	Public purchasers continue under existing oversight rules. Rejection removes this proposed financing restriction, but does not determine Proposition 40's separate result or any future healthcare allocation.	Existing oversight and patient coverage rules continue. Patients gain no automatic reduction in bills or expansion of services, and other tax measures retain their separate outcomes.

Timing. Preliminary audits begin after proponents report collecting 25% of required signatures. Recurring audits apply every four years to programs funded by covered special taxes enacted on or after January 1, 2026. Spending-limit restrictions also reach qualifying measures on this ballot.

Key distinction. The spending-limit restriction reaches covered state taxes generally; the audit rules concern special taxes. Proposition 40 could be blocked if both measures pass, Proposition 41 receives more affirmative votes and a court finds conflict.



Proposition 42

Restricting new wealth taxes and retroactive state taxes

The proposition would bar specified new state taxes on owning personal property and restrict retroactive taxes, narrowing financing options and potentially preventing the proposed billionaire wealth tax.

Official source guide [11, 9, 16, 17, 5]

Current rules. California taxes income from investments but generally does not tax simply owning financial assets. Some personal property, such as vehicles and business equipment, is already taxed. The state retains options for future taxes subject to existing constitutional and statutory requirements.

If approved. The constitution bars specified new state taxes on personal-property ownership and restricts retroactive taxation, with limited emergency exceptions. Taxes in effect, imposed and first collected by December 31, 2025 remain protected. The measure does not change constitutional rules for taxing real estate.

If rejected. The state keeps its current options for these future taxes. Rejection creates no tax or healthcare appropriation and does not itself change household medical bills or insurance coverage.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	The state has fewer potential revenue options for public programs. Providers expecting Proposition 40 funding could lose that prospective source if the competing measures conflict.	Public healthcare financing may face fewer future tax options. Insurance benefits and reimbursement rates are not directly changed, and Proposition 40’s outcome remains legally interdependent.	The specified new ownership taxes and retroactive taxes would be prohibited, subject to the measure’s exceptions. Healthcare effects are indirect, including possible loss of Proposition 40’s proposed public healthcare revenue.
Fail	This proposed restriction does not narrow future financing choices. Providers receive no new operating funds from rejection itself; support still requires an enacted funding source.	Public purchasers retain the existing range of state financing options. Their available budgets and insurance contracts remain dependent on actual revenue laws and spending decisions.	Rejection neither imposes a tax nor changes current medical bills. Future taxes and any healthcare services they support would require separate legal and funding decisions.

Timing. The restrictions reach covered state laws and constitutional provisions enacted on or after January 1, 2026, including this ballot. If both measures pass and Proposition 42 receives more affirmative votes, a court could find a conflict preventing Proposition 40 from taking effect.

Key distinction. Personal property excludes real estate. The grandfather rule protects taxes in effect, imposed and first collected by December 31, 2025; it does not automatically protect every tax enacted in 2026.



Proposition 43

Requiring two thirds support for future local special tax initiatives

The proposition would require two-thirds voter approval for future citizen-initiated local special taxes, including extensions, changing a financing route that can support hospitals and other community services.

Official source guide [18, 19, 20, 5]

Current rules. Local special taxes dedicate revenue to stated purposes. Governing-board proposals generally require two-thirds approval, while court decisions allow qualifying citizen initiatives to pass by a majority. Some taxes continue permanently; others must be renewed before they expire.

If approved. From January 1, 2027, new, increased or extended citizen-initiated local special taxes require two-thirds voter approval. The higher threshold can affect future healthcare operating or capital proposals. It does not itself end an existing tax or order a service reduction.

If rejected. Qualifying citizen-initiated local special taxes retain the majority-vote route under existing law. Rejection creates no new tax and provides no healthcare funding without a separate successful local proposal.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Hospitals and other local providers seeking future special-tax support face a higher approval threshold. Existing grants or services are not automatically canceled by this vote.	Future local funding decisions could affect providers serving insurance networks. Those effects depend on later tax votes and service decisions; benefit restrictions are not mandated.	Future special-tax proposals need broader voter support, potentially limiting new taxpayer charges and healthcare funding. Current benefits and local services do not automatically end.
Fail	Providers retain the current citizen-initiative financing route. Additional support still requires a qualifying local proposal, voter approval and spending according to that proposal's terms.	The existing local financing option remains available to communities. Insurers gain no automatic funding, network expansion or change in payment obligations from this result alone.	Local voters retain the existing majority route for qualifying initiatives. Future proposals may support community care and add tax costs, depending on their specific terms.

Timing. The new local-vote requirement starts January 1, 2027 and includes later extensions of expiring special taxes. Financial effects depend on which proposals communities put forward, whether they reach the required support and how any resulting revenue is used.

Key distinction. Proposition 43 itself needs a statewide majority. Its proposed two-thirds threshold concerns covered future local taxes; it is not the approval threshold for this statewide amendment.



Proposition 44

A 90 percent mission spending rule for covered nonprofit community clinics

The proposition sets a minimum share of revenue that covered nonprofit community clinics must spend on their charitable work, with reporting, fees, financial penalties and patient enforcement rights.

Official source guide [21, 22, 23, 24, 5]

Current rules. Covered entities are nonprofit clinic corporations qualifying as federally qualified health centers, including designated look-alikes that meet program requirements without receiving the federal award. Specified tribal and urban Indian entities are excluded. These clinics already report finances, but this 90% revenue-based requirement does not apply.

If approved. Covered clinics must devote at least 90% of revenue to qualifying program services under Attorney General guidance. They face reporting duties, fees and penalties equal to spending shortfalls, with temporary waivers available. Patients may bring enforcement actions; specified knowing misreporting or manipulation can lead to criminal penalties.

If rejected. The proposed spending ratio, related fees, penalties and patient enforcement mechanism are not adopted. Existing nonprofit reporting obligations and patient protections continue without this additional clinic-finance requirement.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Clinics may increase program spending or face financial strain. Shortfall penalties can be returned within five years after compliance and an approved spending plan; temporary waivers may reduce the burden.	Plans using covered clinics could encounter changes in service availability or clinic finances. The measure neither sets insurer spending ratios nor requires higher reimbursements to clinics.	Patients at covered clinics gain a specified enforcement right. Changes in clinic spending could improve services or strain access, without guaranteeing lower charges or more appointments.
Fail	Clinics continue under existing financial and reporting rules, avoiding this proposal's added obligations. Their ability to maintain services still depends on revenues, expenses and other requirements.	Clinic contracts face no new spending-ratio requirement from this proposition. Insurers' existing coverage, payment and provider-access obligations continue, including any current exposure to financially stressed clinics.	Patients retain existing protections but gain no enforcement right under this proposal. Avoiding its compliance burden does not itself guarantee clinic stability, lower bills or additional services.

Timing. The ratio applies to each clinic's first full fiscal year beginning at least six months after passage: July 1, 2027, for clinics whose fiscal year begins July 1, or January 1, 2028, for calendar-year clinics. Final guidance and waiver decisions affect implementation.

Key distinction. Qualifying program services include charitable-purpose work beyond bedside care. A spending shortfall carries an administrative penalty; the separate criminal provision concerns specified knowing misreporting or manipulation, not every shortfall.



Amendment 87

Graduated income taxes with additional funding for public services

The amendment replaces Colorado’s flat income tax with graduated rates and reserves additional revenue for education, healthcare and early childhood services, while a separate rate-cap proposal could complicate implementation.

Official source guide [25, 26, 27, 28, 29]

Current rules. Colorado’s constitution requires a single income-tax rate, currently 4.4% for individuals and corporations. Existing revenue supports general public services. Current constitutional revenue limits and refund rules apply, and healthcare receives funding through existing state and federal arrangements.

If approved. The constitutional flat-rate requirement is removed and graduated rates begin in 2027. Additional revenue is exempt from the constitutional revenue limit and must supplement existing education, healthcare and early childhood funding. Healthcare uses include Medicaid funding replacement and primary, behavioral, rural and long-term care; no fixed healthcare share is set.

If rejected. The constitutional flat-rate requirement remains, and this measure creates neither graduated rates nor its additional funding account. Existing healthcare budgets and independently enacted federal requirements remain in place.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Healthcare allocations could support services, but organizations receive no guaranteed share. Taxable provider businesses and practice owners also face their own tax changes under the graduated rates.	Public healthcare could receive funding for services or federal-policy implementation. Plan payments and benefits depend on actual allocations; state revenue does not change federal matching rules.	Lower taxable-income brackets receive lower rates and higher brackets face increases. Healthcare benefits depend on allocations; each rate applies only to the income within its bracket.
Fail	Providers receive no funding from this proposed account. Existing payments continue under their governing rules, with any service or payment reductions requiring separate decisions.	Public coverage continues within existing funding arrangements and later budgets. Rejection does not itself change commercial premiums, Medicaid eligibility or insurers’ payment obligations to providers.	Households remain under the flat-tax framework and gain no new healthcare funding from this measure. Current coverage and medical charges remain governed by existing policies.

Timing. Rates apply in tax year 2027. Official estimates add \$958.4 million in fiscal 2026–27 and \$1.972 billion in 2027–28. If Proposition 136 also passes, the legislature or a court must resolve conflicting provisions, and the revenue outcome may differ.

Key distinction. The ballot’s \$2.7 billion figure is a maximum first-full-year estimate, not an assigned healthcare budget. The graduated brackets are not inflation-adjusted, and the exact joint outcome with Proposition 136 is unclear.



Proposition 135

Restrictions on specified surgery and related insurance payments for minors

Proposition 135 would prohibit certain surgeries on minors when performed in response to their perception of sex or gender, and would prohibit public or insurance payment for those surgeries.

Official source guide [28, 26, 101]

Current rules. State law protects access to the relevant surgeries, while federal rules separately govern Medicaid payment. CMS-2451-F restricts payment for defined treatment of patients under eighteen, with a stated October 13, 2026 effective date and implementation subject to applicable court orders. State analysts report that three large pediatric surgical providers do not perform these surgeries on transgender patients under eighteen.

If approved. The statute would prohibit surgeries altering a minor's biological sex characteristics when performed in response to the minor's perception of sex or gender. It would prohibit government funding, Medicaid reimbursement and insurance coverage for those surgeries. Specified medical exceptions would remain; the measure does not generally prohibit nonsurgical counseling or medication.

If rejected. The proposed surgery and payment prohibitions would not become Colorado law. Existing requirements and applicable court orders would remain relevant. Rejection would not compel a hospital to offer a procedure or guarantee insurance payment.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	The restriction would turn on the surgery's purpose and statutory exceptions, potentially affecting planned cases. Unrelated surgery and nonsurgical treatment would not be prohibited merely because a patient is transgender.	Payments for prohibited surgeries would be barred within the measure's legal reach. State analysts expect minimal fiscal effects; coverage for other services would depend on existing rules and benefits.	Minors could not obtain the specified surgeries in Colorado unless an exception applies. The measure would not generally prohibit counseling, medication or care unrelated to its defined surgical purpose.
Fail	Providers would retain the existing state legal framework. Whether a procedure is offered would still depend on the facility, clinician, clinical eligibility and other applicable requirements.	Defeat would create no new state payment exclusion. Federal Medicaid restrictions would remain separate; private coverage would depend on applicable insurance law, plan benefits and contracts.	Patients would face no new prohibition from this measure. Access would still depend on clinical eligibility, providers offering the procedure, applicable law and their insurance benefits.

Timing. The measure specifies January 1, 2027, if approved. Its effects would depend on the purposes of individual surgeries and the application of exceptions. Federal requirements, the legal reach of state insurance rules and any court orders could affect implementation of the payment provisions.

Key distinction. Proposition 135 concerns surgeries defined by their purpose; it is not a general ban on all gender-related healthcare. Colorado's 55% rule for certain constitutional amendments does not govern this statutory proposition.



Proposition 136

Setting the current 4.4 percent income tax rate as a statutory ceiling

The proposition sets Colorado’s current income-tax rate as a maximum, with no standalone fiscal change, but conflicts with the higher brackets proposed in Amendment 87.

Official source guide [30, 26, 27, 28]

Current rules. Colorado currently applies a 4.4% income-tax rate to individuals and corporations. The constitution already requires voter approval for tax-rate increases. Proposition 136 would add a statutory maximum equal to the current rate, rather than reduce that rate.

If approved. A 4.4% statutory ceiling applies to individual and corporate income-tax rates from tax year 2027. Because that is the existing rate, the official standalone analysis estimates no revenue or spending change. Simultaneous approval of Amendment 87 would create conflicting provisions requiring resolution.

If rejected. The proposed ceiling is not added, and rejection alone does not change the current rate. Amendment 87 must pass separately for its graduated rates and associated funding provisions to proceed.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	The ceiling alone does not change provider payments or current tax bills. Potential funding from Amendment 87 remains uncertain if voters approve both measures.	The standalone measure changes no current insurance benefit or public-plan payment. If both tax measures pass, unresolved revenue rules could affect prospective healthcare funding.	The ceiling alone leaves current tax bills and medical charges unchanged. A joint victory with Amendment 87 requires resolution before its potential healthcare funding becomes clear.
Fail	Providers see no direct payment change from this result. Any additional support associated with Amendment 87 depends on that amendment’s separate approval and funding allocations.	No additional ceiling enters state law. Public healthcare funding still depends on other enacted measures and budget decisions, with no automatic change in coverage or premiums.	Rejection does not itself change household taxes or coverage. If Amendment 87 separately passes, its tax and funding provisions face no conflict from this proposed ceiling.

Timing. The proposition takes effect upon the governor’s proclamation, no later than 30 days after the official canvass, and applies from January 1, 2027. The official Blue Book says the legislature or a court would determine the result if Amendment 87 also passes.

Key distinction. The ceiling is statutory, and current law already requires voters to approve rate increases. Its standalone zero-impact estimate does not settle the consequences of simultaneous approval of Amendment 87.



Proposition One

Statutory protection for reproductive decisions and abortion access

Idaho voters would decide whether to establish reproductive rights in state law, including broader abortion access, while leaving insurance coverage and available appointments as separate questions.

Official source guide [31, 32]

Current rules. Idaho generally prohibits abortion, with exceptions to prevent death and specified first-trimester rape or incest exceptions. Applicable court orders also affect care. Existing law does not provide the broader reproductive-freedom standard proposed here, covering contraception, fertility treatment and pregnancy care as well as abortion.

If approved. The statute would protect reproductive decisions and abortion before fetal viability. After viability, its medical-emergency exception would cover physician-determined physical conditions threatening life or creating serious health jeopardy, bodily impairment or organ dysfunction. Conflicting state restrictions would yield within the act's scope; the act expressly creates no state obligation to pay for protected care.

If rejected. The proposed reproductive-rights statute would not take effect. Existing abortion restrictions, exceptions and applicable court orders would continue. Rejection would create no additional prohibition on other reproductive care and would not itself change insurance benefits.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Clinicians would have broader legal grounds to provide reproductive care and make emergency judgments. Actual expansion of local services would still depend on available staff, facilities and participating practices.	Protected care would not become an automatic state-funded benefit. Insurance payments and any travel coverage would continue to depend on the applicable program, plan contract and funding rules.	Patients would gain broader legal access to abortion and protection for other reproductive decisions. Available clinicians and insurance benefits would still determine where care can be obtained and how it is paid.
Fail	Providers would continue operating under existing restrictions, exceptions and court orders. Referrals and transfers would remain relevant when a patient needs lawful care unavailable at the treating facility.	Existing coverage and funding rules would remain. Rejection would neither establish a new travel benefit nor automatically exclude otherwise covered care received lawfully outside Idaho.	Existing restrictions and court orders would remain. Some patients could still need referrals or travel for unavailable care; rejection would not itself pay those costs or change their insurance benefits.

Timing. The initiative specifies January 1, 2027, if approved on November 3. Questions about how it interacts with remaining statutes could require legal interpretation. The effective date establishes the new legal standard; it does not establish when additional clinics or appointments would become available.

Key distinction. The post-viability exception includes defined physical health emergencies beyond imminent death. Protecting reproductive decisions under this measure would not create an obligation for state programs to pay for that care.



HJR 4

Who may legalize marijuana and other specified substances

The amendment would reserve authority to legalize marijuana and other specified substances to the Idaho Legislature, removing the citizen-initiative route.

Official source guide [31, 32, 33]

Current rules. Idaho's initiative process can be used to propose changes to drug laws. Neither the Medical Cannabis Act nor the separate marijuana-decriminalization initiative qualified for November 2026. HJR 4 addresses who may authorize legalization, rather than offering voters a cannabis-access program.

If approved. Only the Idaho Legislature would have authority to legalize growing, selling, prescribing, possessing or otherwise handling marijuana, narcotics and other psychoactive substances within the amendment's scope. Voters could no longer use an ordinary citizen initiative to enact that legalization. No new medical program or insurance benefit is established.

If rejected. The constitution would retain the existing allocation of lawmaking authority, including the citizen-initiative route. Rejection would not itself legalize marijuana, authorize a new treatment or establish a medical-cannabis program.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Future services depending on newly legalized substances would require legislative authorization. Existing lawful prescribing and treatment would not become prohibited merely because this amendment passes.	The amendment creates no coverage requirement or reimbursement program. Existing benefits would remain governed by their current rules; a future legalization law would require separate coverage decisions.	Patients would gain no new access to medical cannabis or insurance coverage. Future legalization would require legislative action, while currently lawful medications would remain subject to existing prescribing rules.
Fail	Providers would retain the current legal framework. A future successful initiative could change it, but rejection alone would authorize no additional clinical service or controlled substance.	Insurance benefits and payment rules would remain unchanged by this vote. A later drug-policy initiative would need to pass before its possible coverage implications could arise.	Voters would retain the initiative route for future drug-law changes. Patients would receive no immediate new medical program, prescription right or insurance benefit from rejecting this amendment.

Timing. The text makes the constitutional change effective immediately upon voter adoption. Any resulting change in access to a substance would require a later legalization decision. There is no date for a new medical-cannabis program because this amendment creates none.

Key distinction. The proposal concerns authority over future legalization. The Medical Cannabis Act and separate marijuana-decriminalization initiative did not qualify for the November 2026 ballot.



Question 8

Ending adult use marijuana retail sales while retaining medical access

Question 8 would end Massachusetts' adult-use marijuana retail and nonmedical cultivation framework in January 2028, while preserving medical marijuana and specified limited adult possession and transfers.

Official source guide [36, 37, 38]

Current rules. Massachusetts regulates adult-use marijuana retail sales alongside its medical program. The official fiscal statement reports approximately \$280 million in state adult-use tax revenue and \$50 million locally in fiscal 2025. The medical-marijuana law does not require insurers or government agencies to reimburse medical marijuana expenses.

If approved. Adult-use retail sales and nonmedical cultivation would lose their legal framework, and possession penalties would change. The medical program and specified limited adult possession and transfers would remain. Existing adult-use businesses could seek expedited medical licensing, and the Cannabis Control Commission would continue regulating the medical market.

If rejected. The current adult-use marijuana regulatory and tax framework would remain, alongside the medical program. Rejection would not introduce a medical-certification requirement for existing lawful adult-use purchases or create new insurance coverage.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Clinicians could receive more questions about medical-program eligibility as retail access ends. Former retail customers would not automatically qualify as medical patients, and provider authorization would remain a separate clinical decision.	Medical-market retention would not require insurance reimbursement for cannabis products. Adult-use tax receipts would end under the repeal; any resulting change to healthcare budgets would depend on separate funding decisions.	Adult-use retail access would end in January 2028, while medical access would require medical-program eligibility. Limited lawful adult possession would remain; retaining the medical program would not create insurance reimbursement.
Fail	The existing adult-use and medical access routes would continue. Rejection would not require clinicians to certify former retail customers or create an additional medical-program workload by law.	Existing coverage rules and tax arrangements would continue. Healthcare allocations would still depend on actual sales, tax receipts and separate state and local budget decisions.	Adults could continue using the current regulated retail market, and eligible patients could retain medical access. Rejection would create no new certification requirement or insurance benefit for existing lawful purchases.

Timing. The proposed law takes effect January 1, 2028, rather than immediately after the election. That leaves 2027 before the retail repeal. Medical-license conversions and the disposition of remaining inventory would follow the proposed transition provisions; continued medical access would still depend on eligible patients and participating businesses.

Key distinction. The repeal would preserve the medical program and limited adult possession. The state and local tax totals describe cannabis revenue, not a dedicated healthcare allocation automatically lost to providers.



Amendment 3

Replacement of reproductive rights protections and restrictions on treatment of minors

Amendment 3 would replace Missouri’s 2024 reproductive-rights protection with abortion and public-funding limits and constitutional restrictions on specified surgery and medication for minors.

Official source guide [39, 40, 41, 42, 101, 102]

Current rules. The 2024 constitutional provision protects reproductive freedom, including abortion through viability; litigation affects particular restrictions. RSMo 191.1720 separately restricts specified treatment of minors. Its medication subsection preserves certain treatment begun before August 28, 2023, and expires August 28, 2027. RSMo 208.152.15 separately excludes MO HealthNet payment for specified gender-transition surgery, cross-sex hormones and puberty blockers.

If approved. The amendment would repeal the 2024 protection and permit abortion restrictions, with exceptions for medical emergencies, defined fatal fetal anomalies, and rape or incest no later than twelve weeks’ gestational age. It would require written consent from an unemancipated minor and a parent or legal guardian, except when consent cannot be obtained in a medical emergency; lawmakers could authorize court-approved consent. It would restrict public abortion funding and prohibit specified gender-transition surgery and medication for minors, with medical-condition exceptions.

If rejected. The 2024 reproductive-rights provision and separate law restricting treatment of minors would remain, subject to applicable court orders. Rejection would not automatically authorize all such care.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Providers would face narrower abortion rules and constitutional limits on specified treatment of minors. Existing medication grandfathering could not be assumed to survive the amendment.	Public abortion funding would be limited to medical emergency, rape and incest exceptions. The fatal-fetal-anomaly exception alone would not authorize public payment.	Patients would face narrower lawful abortion access and constitutional limits on specified treatment of minors. A permitted procedure would not necessarily qualify for public payment.
Fail	Reproductive care would remain under the 2024 constitutional framework and court orders. Specified treatment of minors would remain subject to separate statutory restrictions and exceptions.	Existing reproductive-benefit rules and MO HealthNet payment exclusions remain subject to law and court orders. Defeat neither overrides federal funding limits nor creates benefits or reimbursement rates.	The 2024 reproductive-rights protection would remain. Existing restrictions on specified treatment of minors would continue; rejection would not automatically authorize care or guarantee coverage.

Timing. If approved, the amendment would take effect December 3, 2026, thirty days after the election, subject to applicable court orders. If rejected, the August 28, 2027 sunset would still apply only to the separate medication subsection.

Key distinction. The 2024 and 2026 proposals both use “Amendment 3.” Rejection would preserve the 2024 provision and separate minors-treatment law.



Question 6

Second vote on constitutional abortion protection

Question 6 asks for the second approval needed to place abortion rights in Nevada's constitution. Abortion already has statutory protection, which would remain if the proposal fails.

Official source guide [43, 44]

Current rules. Nevada law permits abortion within twenty-four weeks and afterward when necessary to preserve the pregnant patient's life or health. Question 6 received its first required approval in 2024. The November 2026 vote determines whether its additional constitutional protection takes effect.

If approved. The constitution would protect abortion until fetal viability and later when needed to protect the pregnant patient's life or health. State or local interference would require a compelling health-related justification meeting the amendment's standard. The legal protection would not itself establish a universal insurance benefit.

If rejected. The proposal would fail its required second approval, leaving the constitution without this addition. Existing statutory abortion access would remain, including the twenty-four-week rule and later life-or-health exception.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Clinicians would have an additional constitutional protection for lawful abortion care. Its viability standard could affect existing restrictions, while actual service availability would still depend on practitioners and facilities.	The amendment would protect legal access without specifying reimbursement rates or universal benefits. Coverage would still depend on the plan and funding rules, including federal Medicaid restrictions.	Patients would gain constitutional protection under the viability and life-or-health standards. Insurance coverage, available appointments and any need for travel would remain separate practical questions.
Fail	Existing abortion services would not become unlawful because Question 6 failed. Providers would continue under the statutory framework, with service availability affected by staffing, facilities and other applicable requirements.	Existing coverage and payment arrangements would not end because of this result alone. Insurers and public programs would remain subject to their current benefits, contracts and governing law.	Patients would retain existing statutory abortion access. Rejection would not itself close clinics or remove insurance benefits, although available providers and each patient's coverage would still affect access.

Timing. The Nevada Constitution identifies November 24, 2026, as the effective date if the proposal receives its second approval. The first vote occurred in 2024. Questions about particular restrictions could continue afterward, and constitutional protection would not establish a schedule for additional clinical services.

Key distinction. Fetal viability is a clinical judgment defined in the proposed amendment. That definition differs from the fixed twenty-four-week threshold in existing state law and does not establish one universal gestational week.



Bond Question 1

Borrowing to improve facilities serving older adults

Bond Question 1 would authorize up to \$21,582,213 for senior-facility construction, improvements and equipment, with repayment supported by a statewide property tax on taxable property.

Official source guide [45, 46, 47]

Current rules. New Mexico uses capital funding to improve senior centers and buy equipment. The aging department administers projects involving local and tribal governments. This question asks voters to approve additional borrowing for specified facilities; existing service and benefit programs operate under their separate rules.

If approved. The state could issue up to \$21,582,213 in bonds for the specified projects. A statewide property-tax levy would support repayment, interest and authorized costs. The final tax rate would be determined after the election using financing terms and statewide property values.

If rejected. The state could not issue these bonds. Project sponsors would need other financing, changes or delays. Defeat would not itself end senior-center operations, Medicaid services at home or nursing-facility coverage.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Improved buildings and equipment could strengthen community services for older adults. Additional service capacity would still depend on staffing, operating funds and each project's completion.	Completed projects could offer additional community resources for members. The bond does not create insurance coverage, a new contracted provider or different payments to health plans.	Older adults could benefit from improved community facilities after projects open. Property owners would help repay the debt; individual tax costs remain undetermined, and insurance benefits would not automatically expand.
Fail	Projects relying on these bonds would lack that financing. Existing providers and services would continue under their current funding arrangements unless separate decisions change them.	Current benefits and payment arrangements would remain. Any effect on community resources available to members would depend on which projects proceed with other funding.	Property owners would avoid the debt obligation proposed here. Existing senior services and coverage would not automatically end, but planned improvements could need other funding or face delays.

Timing. Approval would be followed by bond issuance and individual project schedules; the question sets no common opening date. The State Board of Finance would publish tax-cost estimates before issuance, reflecting debt service, interest rates, taxable property values and available balances.

Key distinction. The certified authorization is \$21,582,213. It funds buildings and equipment; it does not establish a new Medicaid benefit or a known increase in each household's tax bill.



Income tax amendment

A lower constitutional ceiling on income taxes

North Carolina voters would lower the maximum permitted income-tax rate from 7% to 3.5%, narrowing future tax options without changing the already enacted 2027 individual rate.

Official source guide [48, 49, 50]

Current rules. The constitutional ceiling is 7%. Enacted law sets individual rates at 3.99% in 2026, 3.49% for 2027–2029, 3.24% for 2030–2032 and 2.99% from 2033, with later reductions possible. These scheduled rates are below the proposed ceiling from 2027 onward.

If approved. The constitutional maximum for individual and corporate income-tax rates would fall to 3.5%. Lawmakers could not raise either rate above that limit through ordinary legislation. The already enacted 2027 individual rate of 3.49% would remain in place.

If rejected. The 7% constitutional ceiling would remain. Defeat would leave the enacted tax schedule intact, including the 3.49% individual rate for 2027–2029. It would neither raise taxes nor allocate additional healthcare funding.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Future public healthcare funding would depend on budgets made with less income-tax flexibility. The amendment itself would neither lower reimbursement nor require hospitals or clinics to reduce services.	Medicaid plans could be affected by later state budget choices. No insurance benefit, member eligibility rule, premium or payment to a plan changes automatically.	The enacted 2027 individual rate is already below 3.5%, so passage adds no immediate rate cut. Future healthcare access could depend on later state funding decisions.
Fail	Lawmakers would retain the option of higher income-tax rates within the 7% ceiling. Providers would receive additional public funding only if later legislation and budgets supply it.	Existing coverage and state financing rules would continue. Keeping a higher tax ceiling creates no new insurance benefit or requirement for plans to expand their networks.	The scheduled 2027 rate cut would still take effect. Patients would retain current coverage rules, while any added public healthcare spending would need separate approval.

Timing. The amendment becomes effective after certification and applies to tax years beginning January 1, 2027. Later healthcare effects would depend on budgets and payment policies. The enacted tax cuts occur in both election scenarios, independently of this amendment.

Key distinction. The 3.5% figure is a constitutional maximum. Actual statutory rates and future reductions already enacted are separate from that ceiling.



Property tax amendment

Requiring limits on local property tax increases

The amendment would require lawmakers to limit increases in local property-tax levies. The ballot text leaves the size of those limits and possible exceptions to later legislation.

Official source guide [51]

Current rules. The constitution already limits local property taxation to purposes authorized by general statewide law, unless local voters approve otherwise. The proposed amendment would add a separate instruction to limit increases in the total property taxes local governments levy.

If approved. Lawmakers would be required to pass laws limiting increases in local property-tax levies and could include exceptions. The amendment supplies no percentage limit, automatic reduction in an individual tax bill or required reduction in any particular local service.

If rejected. The proposed instruction would not enter the constitution. Existing property-tax law would remain in place, and local governments would make future tax and spending decisions under those rules. Defeat would not itself increase taxes.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Later limits could affect funding for locally supported clinics, public health or emergency services. The scale would depend on the implementing law and local budgets.	Insurance benefits and payments would not change directly. Any consequences for plans would arise through changes in locally funded services available to their members.	Property owners could face smaller future tax increases, depending on the implementing law. Local health and emergency services could also be affected by resulting budget choices.
Fail	Locally supported providers would continue under existing funding rules. Their resources could still change with local budgets, but this amendment would impose no additional constraint.	Plans would retain their existing coverage obligations. Local services available to members would continue to depend on actual budgets, staffing and service decisions in each community.	There would be no new tax limit from this vote and no automatic tax increase. Patients’ access to local services would still depend on community funding decisions.

Timing. Certification would activate the legislature’s duty to write limits, but the amendment gives no implementation deadline or numerical cap. The later law would determine the limits and exceptions. Local budget decisions would determine when any healthcare consequences reach residents.

Key distinction. The proposal sets no percentage cap and promises no particular property-tax saving. Healthcare consequences depend on the later law and local spending choices.



Question 1

Borrowing for college facilities including a health education building

Question 1 would authorize \$275 million in college construction borrowing, including \$165 million for a University of Rhode Island building supporting health education and clinical training.

Official source guide [52, 53]

Current rules. The proposal needs voter authorization before this borrowing can proceed. It assigns \$165 million to URI’s Integrated Health Building, \$50 million to Rhode Island College’s library and student-success project, and \$60 million to a community-college workforce center serving several industries.

If approved. Approval authorizes \$275 million in state borrowing for the three projects. The voter guide estimates total principal and interest of about \$441.3 million, assuming 5% interest and 20-year repayment. Actual borrowing terms determine the eventual cost.

If rejected. The state would not receive this borrowing authorization. Projects would need another funding source, changes or delays. Existing colleges and healthcare programs would not be closed or discontinued by the vote itself.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	New training facilities could strengthen future recruitment. Additional clinicians would depend on faculty, clinical placements, student completion and graduates entering practice, rather than construction alone.	A larger local healthcare workforce could eventually improve network access. The bond creates no immediate coverage expansion, payment change or guaranteed reduction in claims costs.	Patients could benefit from more locally trained clinicians over time, while taxpayers assume repayment costs. The bond offers no immediate new insurance benefit or guarantee of shorter waits.
Fail	Providers would lose this proposed source of training-facility investment. Existing recruitment and education partnerships would continue, while the future of the projects would require separate decisions.	Coverage obligations would continue. Any effect on future provider availability would depend on whether the facilities are delayed, redesigned or financed through another source.	Taxpayers would avoid this additional borrowing obligation. Patients would retain existing coverage, while any future workforce or access effects would depend on subsequent education and investment decisions.

Timing. The voter guide expects URI’s building ready in 2031 and Rhode Island College’s project in 2030. Community-college construction is planned for 2028–2030. These are project estimates; new training opportunities and additional clinicians would follow their own schedules.

Key distinction. URI’s health building accounts for \$165 million of the \$275 million bond. Educational construction, healthcare workforce growth and patient access are separate steps.



Constitutional Amendment I

Making Medicaid expansion’s constitutional guarantee conditional on federal funding

The amendment would condition South Dakota’s constitutional Medicaid expansion requirement on the federal government continuing to cover at least 90% of the specified expansion costs.

Official source guide [56, 57, 58, 59]

Current rules. The state constitution requires Medicaid expansion for qualifying low-income adults ages 19 through 64. Federal law currently supplies a 90% expansion matching rate. Enrollment remains subject to applicable eligibility rules, while other federal administrative and financing changes operate separately.

If approved. The constitutional requirement to cover the expansion population ends if the specified federal matching percentage falls below 90%. The Attorney General describes this as ending expanded coverage upon that funding change. Approval itself does not end coverage while the matching rate remains 90%.

If rejected. The constitutional expansion requirement remains without this proposed funding trigger. If federal support later changes, the state would still have that coverage obligation and would need to address the resulting financing requirements.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	No immediate expansion coverage loss follows at the current match. If coverage later ends, providers could face unpaid care and disrupted treatment among affected patients.	The state faces a potential expansion-coverage transition if the condition is triggered. People losing eligibility would not necessarily qualify for or purchase replacement private insurance.	Current expansion coverage does not end solely because of passage. A later reduction below the specified federal match puts coverage at risk, with potential treatment interruptions and added personal costs.
Fail	The constitutional coverage obligation continues without this trigger. Providers retain that protection for expansion patients, although state financing pressures and other policy changes may still affect care.	The state’s constitutional expansion obligation continues. Federal eligibility, renewal and financing rules still apply independently, and maintaining coverage may require additional state resources if federal support falls.	Expansion patients retain the constitutional coverage requirement without this new funding condition. Federal eligibility and renewal requirements still apply, so rejection does not guarantee unchanged enrollment circumstances.

Timing. Under the state’s published election rules, an approved amendment becomes effective July 1, 2027. The material coverage consequence depends on a later reduction in the specified expansion matching percentage; a decline in total federal dollars alone does not establish that trigger.

Key distinction. The text ends a constitutional requirement at the funding threshold; the Attorney General describes a resulting end to expansion. Provider-tax restrictions are distinct from a reduction in the specified 90% match.



Question 1

Constitutional protection for reproductive healthcare decisions

Virginia voters would decide whether to protect reproductive decisions in the state constitution, including pregnancy care, contraception, abortion and fertility care, with specified exceptions for later abortion regulation.

Official source guide [60, 61, 62, 63, 64]

Current rules. Virginia permits abortion under state statutes, including provisions for the first and second trimesters. The state constitution currently has no explicit reproductive-freedom guarantee. Existing service rules and insurance arrangements govern care; the proposed amendment would add a constitutional standard for government restrictions.

If approved. The constitution would protect decisions about pregnancy, childbirth, postpartum care, contraception, abortion, miscarriage management and fertility care. Third-trimester regulation would remain permissible, but could not prohibit abortions a physician considers medically indicated for the patient's life or physical or mental health, or when the fetus is not viable. People assisting protected decisions would also receive protection.

If rejected. Virginia's constitution would remain without this explicit guarantee. Existing lawful reproductive services would not become prohibited merely because the amendment failed. Current statutes, insurance requirements and applicable court orders would continue to govern care.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Clinicians and people assisting protected reproductive decisions would gain constitutional safeguards against state punishment. Whether a particular existing restriction survives would depend on how the amendment applies to it.	Reproductive decisions would gain constitutional protection, but the text does not establish unlimited fertility coverage or a reimbursement schedule. Each insurance product and public program would retain distinct funding rules.	Patients would gain constitutional protection for reproductive decisions, including fertility care. That protection would not itself guarantee appointments, comprehensive IVF coverage or payment for every protected service.
Fail	Providers could continue lawful reproductive services under existing requirements. Rejection would add no new ban, although future legislation and court decisions could still change the legal framework.	Existing covered services would remain subject to current law and contracts. Rejection alone would neither remove fertility benefits nor require new exclusions for reproductive care.	Patients could continue obtaining lawful reproductive care under current requirements. They would not gain the proposed constitutional protection, but rejection alone would not cancel services or insurance benefits.

Timing. If approved, the amendment takes effect January 1, 2027. Its self-executing language means a separate implementing statute is not required for the right to exist. Courts could still interpret its effect on particular laws, practices and restrictions after that date.

Key distinction. The proposed amendment uses a third-trimester rule with physician-judgment exceptions. Constitutional protection for fertility decisions would not itself require IVF insurance coverage.



IP26-645

Repealing the high income tax scheduled to begin in 2028

The initiative would repeal Washington’s newly enacted high-income tax before collections begin, reducing projected public revenue while leaving separately enacted non-income-tax relief in place.

Official source guide [65, 66, 67, 68]

Current rules. A 2026 law schedules a 9.9% tax on qualifying income above a \$1 million deduction from 2028. Married couples and domestic partners share that deduction. Ninety-five percent of receipts supports the General Fund and 5% supports childcare and early learning.

If approved. The initiative repeals the high-income tax and prohibits specified state and local taxes on individual income or measured by it. Accompanying non-income-tax exemptions, deductions and credits remain, including the removal of a business-tax surcharge for healthcare providers, hospitals and prescription-drug resellers.

If rejected. The enacted tax remains scheduled to begin, subject to other legal developments. Its revenue supports the designated state accounts, but rejection creates no automatic healthcare benefit or provider-payment increase.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Projected state revenue falls, potentially affecting future healthcare budgets. The separate healthcare business-tax relief remains; the vote does not itself cut hospitals’ reimbursement rates.	Public healthcare faces less projected state revenue for future budgets. Changes in benefits or plan payments require further decisions; commercial insurance premiums are not directly set.	Affected taxpayers avoid the tax whose first payments otherwise fall due in April 2029. Separate consumer tax relief remains, while future healthcare effects depend on budget decisions.
Fail	The anticipated state revenue source remains, potentially supporting public services. Healthcare organizations receive additional funding only through applicable allocation and payment decisions, while separate tax relief continues.	The state retains projected revenue that can support public coverage. Insurance benefits, eligibility and payment levels still depend on program law, budgets and contracts.	Affected households remain subject to the scheduled tax and applicable deductions. Retained revenue may support public care, but expanded benefits or lower patient charges are not guaranteed.

Timing. Official fiscal assumptions put repeal on December 3, 2026, with first forgone tax payments in April 2029. Fiscal 2027–31 estimates are \$11.4 billion in total revenue losses and \$150.5 million in net agency spending savings, mainly from discontinued tax administration.

Key distinction. The revenue estimate covers statewide accounts rather than a healthcare-only budget. Agency savings concern administration, not clinical care. Separate tax relief survives repeal, including healthcare business-tax and specified consumer sales-tax provisions.



IL26-001

School health notices and parents' access to student records

IL26-001 would restore earlier parental-rights provisions, including school medical notices and faster access to student records, while changing exceptions relevant to sensitive information about students.

Official source guide [69, 70, 71, 72, 68]

Current rules. The current parental-rights statute reflects 2025 revisions. Education-record requests generally allow up to forty-five days, and healthcare disclosure follows separate laws. The statute protects certain sensitive records when a parent faces a qualifying abuse investigation or a criminal proceeding naming the student as victim.

If approved. Schools would restore advance medical-service notices and notices of emergency care, financial effects and arranged follow-up treatment. Record requests would have a ten-business-day deadline. The text retains an exception during investigations of parental abuse or neglect but removes this section's separate protection tied to a criminal case naming the student as victim.

If rejected. The present parental-rights statute would remain, including existing record-access rights, notice obligations and confidentiality provisions. Rejection would neither remove all parental access to information nor create a new insurance benefit or restriction.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	School nurses and clinical partners would face changed notice and record-sharing duties. Independently held clinical records and other confidentiality laws would remain separate considerations from records maintained by schools.	School notices would include services with possible insurance or copayment effects. The initiative would create no new benefit or reimbursement rate and would not itself authorize disclosure of every adolescent claim.	Parents would receive additional school health notices and faster record access. Students could face changed disclosure of school-held information, while other confidentiality protections and legal exceptions would remain relevant.
Fail	School health providers would continue under existing disclosure and notice requirements. Rejection would not eliminate parental information rights or authorize disclosures barred by other applicable laws.	Existing school-service coverage and claims confidentiality arrangements would continue. Rejection would not add the proposed notification duties or independently change a family's covered benefits or payments.	Students and parents would retain the current school health-information framework, including existing parental rights and confidentiality protections. Rejection would not itself change insurance benefits or eliminate record access.

Timing. The legislative analysis sets effectiveness thirty days after voter approval, corresponding to December 3, 2026. Schools would then face the shorter record deadline and restored notice duties. Interactions with separate healthcare-disclosure laws could require interpretation when particular records are requested.

Key distinction. The initiative's medical notices would not create a universal parental-consent requirement. It changes school-records rules; separate clinical-record and healthcare-confidentiality laws would remain relevant.



Question 2

Limits on emergency orders closing places of worship

Wisconsin's Question 2 would prohibit state and local emergency orders closing places of worship or forbidding gatherings there, including during public-health emergencies, without changing healthcare benefits.

Official source guide [73, 74]

Current rules. Wisconsin's constitution already protects religious liberty, and emergency orders remain subject to constitutional and legal limits. It does not contain the specific prohibition proposed here against state or local government closing places of worship or forbidding gatherings there in response to an emergency.

If approved. The constitution would expressly bar those government closure and gathering orders in response to a state of emergency, including a public-health emergency. The restriction concerns places of worship. It would not itself require a religious venue to remain open, establish a healthcare program or alter insurance benefits.

If rejected. The proposed additional restriction would not enter the constitution. Existing religious-liberty protections and legal limits on emergency powers would remain. Rejection would neither order a closure nor grant officials unlimited emergency authority.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Public-health agencies would face an explicit constitutional bar on the specified emergency orders. Health activities hosted by religious organizations would still depend on venue decisions and other applicable rules.	The amendment would change emergency authority rather than insurance eligibility, benefits or payment rates. Any effect on service use or medical spending would depend on subsequent events.	Worshippers would gain explicit protection against the specified government emergency orders. The amendment would not guarantee that a venue stays open, provides healthcare or changes anyone's insurance benefits.
Fail	Existing emergency coordination would continue under governing law. The vote alone would neither require religious venues to close nor determine whether a particular health service could operate.	Coverage and reimbursement would remain unchanged by this vote. Emergency-related access and spending would depend on actual conditions, lawful orders and available services in affected communities.	Existing religious-liberty protections would remain. Rejection would not itself close places of worship or change healthcare benefits; practical effects would depend on actual emergency decisions and circumstances.

Timing. If approved, the amendment would take effect upon certification of the statewide canvass. Its practical consequences would arise during emergencies affecting places of worship. It creates no healthcare-payment timetable; local service effects would depend on the circumstances.

Key distinction. This proposal appears as Question 2 on the November 2026 ballot. The earlier legislative proposal used a different question label.



Local Measure CC

A local property tax for hospital and healthcare services

Marin Healthcare District voters would create a 30-year tax of \$0.14 per square foot of improved building area to fund specified healthcare facilities and services.

Official source guide [75, 76, 77]

Current rules. This is a local citizen initiative for the Marin Healthcare District, not a statewide California tax. The new parcel tax requires a simple majority. Existing hospital services and funding would not be legally terminated if this proposal fails.

If approved. A new annual tax would raise an estimated \$12.4 million for 30 years. Funds could support specified facilities, equipment, clinical staffing and behavioral-health services, with audits and citizen oversight. Administrator salaries and benefits are excluded. Property otherwise exempt from property tax would remain exempt.

If rejected. The new parcel tax would not be enacted. The district would have to consider existing resources or other funding for proposed improvements. Rejection does not order the hospital, emergency department or trauma services to close.

Black Book impact assessment

Result	Providers	Payers	Patients and consumers
Pass	Dedicated revenue could finance eligible upgrades and clinical staffing. Borrowing against proceeds could accelerate capital work but would commit future tax collections to debt repayment.	Additional staffed facilities could improve access for members after implementation. Insurance contracts and covered benefits would remain unchanged unless separately revised; claims costs would not automatically fall.	Taxable property would incur the new \$0.14 annual charge per square foot for 30 years. Patients could benefit from funded improvements, without guaranteed lower hospital bills or shorter waits.
Fail	Providers would lack this additional funding source. The fate of particular upgrades or services would depend on existing resources and later financing and operating decisions.	Plans would keep existing coverage and network obligations. The vote would not automatically remove a hospital from a network or determine future service availability.	No new CC tax would be owed. Patients' existing coverage would remain, while future access would depend on actual hospital operations, project decisions and other available funding.

Timing. With normal certification, collection would begin July 1, 2027 and continue for 30 years. Proposition 43's higher threshold would apply to voter-proposed special taxes approved after January 1, 2027, leaving this November 2026 vote's simple-majority threshold intact. Project schedules depend on implementation.

Key distinction. The \$12.4 million annual figure is an estimate, and CC creates a new tax. Neither improved care after passage nor service closures after defeat are automatic.



APPENDIX A

California combined ballot outcomes

California Proposition 40 interacts with Propositions 41 and 42. The official analyses identify a possible conflict if the wealth tax and either competing measure pass. An approved competing measure with more affirmative votes can prevent the wealth tax from taking effect if the provisions are determined to conflict. [9, 10, 11]

Result combination	Financing and implementation	Patients and consumers
Proposition 40 fails	The proposed wealth-tax revenue is unavailable. Any approved provisions in 41 or 42 still require their own implementation.	No care is financed by this proposed tax. Existing services continue under their current sources and rules unless separately changed.
40 passes and 41 and 42 fail	The tax can proceed under its terms, subject to other legal and administrative requirements. Collections and healthcare allocations remain separate steps.	Public healthcare could receive support after implementation. No individual benefit or lower bill follows solely from the vote.
40 and at least one competing proposal pass	Certified affirmative-vote totals and determinations of conflict matter. An approved conflicting proposal with more yes votes may prevent the wealth tax from taking effect.	Care dependent on the new revenue remains uncertain until the conflict and funding questions are resolved.

What a result can establish

The certified count can establish which proposals met the voting threshold and their affirmative-vote totals. The count alone cannot settle every question of legal conflict or establish how much money is available for a particular healthcare program.

Providers and payers could receive additional support only after the relevant legal, collection and allocation steps. For consumers, the practical evidence would be an actual benefit, funded service, operating facility or revised charge, rather than the statewide revenue estimate by itself.



APPENDIX A

Colorado combined ballot outcomes

Colorado Amendment 87 would establish graduated income-tax rates, while Proposition 136 would impose a 4.4% maximum. The official Blue Book identifies a conflict if both pass and says the exact outcome is unclear. Legislative action or a court decision would be needed to resolve the competing rules. [25, 30, 26]

Result combination	Tax and budget consequence	Patients and consumers
87 passes and 136 fails	Graduated income-tax rates and designated revenue proceed under Amendment 87, subject to implementation.	Household tax effects vary by taxable income. Healthcare benefits require actual allocations and service decisions.
87 fails and 136 passes	The 4.4% ceiling is adopted. The official standalone analysis of Proposition 136 projects no revenue or spending change.	The ceiling alone creates no new insurance benefit or immediate change in current tax payments.
Both pass	The proposals contain conflicting tax rules. The official Blue Book says the outcome is unclear and would need legislative or court resolution.	Tax effects and services dependent on additional revenue remain uncertain while the conflict is resolved.
Both fail	Neither proposed tax change is adopted. The enacted-law baseline remains.	Neither proposal changes household taxes or medical benefits; later changes would arise from other decisions.

What remains a separate decision

Additional revenue under Amendment 87 is available for several designated purposes. Healthcare does not receive a fixed percentage in the measure. Funding for a particular health program would depend on a later allocation. [25]

The official analysis describes no standalone revenue or spending change from Proposition 136 because the existing rate is already 4.4%. Simultaneous approval of both proposals creates a separate unresolved tax scenario. [26]

APPENDIX B

Implementation dates after the election

These are conditional implementation milestones, not election results. Approval, certification, a legal effective date and the start of an actual service can occur at different times. The full profiles identify exceptions and dependencies.

Date or milestone	Measure	What the date means
Adoption and certification	Idaho HJR 4; California measures; North Carolina tax instructions; Wisconsin Question 2	Idaho's authority change begins immediately upon voter adoption. Other measures use their state certification procedures; later operative dates and implementing laws still control specific obligations. [31, 5, 48, 51, 74]
November 24, 2026	Nevada Question 6	Conditional date for the constitutional amendment after the second required approval. [44]
December 3, 2026	Missouri Amendment 3	Default 30-day post-election effective date if approved, subject to applicable court orders. [42]
December 3, 2026	Washington IL26-001 and IP26-645	School information changes and the income-tax repeal become operative under the applicable initiative rule; revenue consequences occur later. [70, 66, 68]
January 1, 2027	Idaho Proposition One; Virginia Question 1; Colorado Proposition 135	The measures specify or implement new clinical legal standards from this date. Actual appointments and benefits remain separate. [31, 61, 28]
Tax year 2027	Colorado Amendment 87 and Proposition 136; North Carolina income-tax ceiling	Tax-year rules apply, subject to conflict resolution in Colorado. North Carolina's enacted 2027 rate remains a separate law. [26, 48, 49]
Measures approved after January 1, 2027	California Proposition 43	The proposed two-thirds local special-tax threshold is prospective. It does not change the November 2026 Marin Measure CC threshold. [18, 77]
July 1, 2027	South Dakota Amendment I; expected Marin CC collections	South Dakota's constitutional change becomes effective, but the Medicaid consequence remains tied to the federal-match condition. Marin tax collections are expected to start with the new fiscal year. [58, 76]

APPENDIX B

Longer funding and service timelines

Date or dependency	Measure	What remains to happen
2027 payments and possible installments	California Proposition 40	Tax receipts would arrive after implementation. Legal conflicts, collection timing and spending decisions determine when healthcare organizations benefit. [9, 10, 11]
Each clinic's fiscal year	California Proposition 44	The first full fiscal year beginning at least six months after passage is the key period. A July-start clinic and a calendar-year clinic can begin in different years. [22]
January 1, 2028	Massachusetts Question 8	The proposed repeal of adult-use retail sales and nonmedical cultivation takes effect. Medical-marijuana law and specified limited adult possession remain. [36]
April 2029 first collections under current law	Washington IP26-645	The income tax being considered for repeal applies from 2028, with first payments in 2029. Most revenue effects therefore fall beyond 2027. [66, 65]
2031	California Proposition 3; Rhode Island Question 1	California's principal revenue difference begins after the present rates would expire. Rhode Island's URI health building is expected to be ready in 2031. [1, 52]
Bond issuance and project completion	California Proposition 38; New Mexico Bond Question 1	Borrowing, awards and construction or research proceed on separate schedules. Approval does not establish a common date for a treatment or a new service. [6, 45]
A future change in the specified federal match	South Dakota Amendment I	The Medicaid expansion consequence depends on the matching percentage falling below 90%. Broader provider-tax or payment restrictions do not by themselves trigger this amendment. [57]

When funding reaches services

Voter authorization, a tax's effective date, a grant award and the start of patient services are separate milestones. Collection, allocation, construction and staffing determine when a financing measure reaches a patient. Projected opening years remain estimates until the relevant work is complete.

APPENDIX C

Fiscal figures for California and Colorado

These selected figures retain the units and periods used by the official sources. They are useful for comparison of mechanisms, but they cannot be added to produce a meaningful national healthcare funding total.

Measure	Official amount and type	Interpretation
California Proposition 3	\$5 billion–\$15 billion a year Revenue maintained from 2031	An official estimate of state revenue retained relative to expiration, not a new annual healthcare allocation. [1]
California Proposition 38	\$8.4 billion authorized; \$500 million–\$600 million annual repayment for about 20 years Borrowing and estimated debt service	Research funding and repayment costs are different measures. Approval does not establish that a therapy will result. [6]
California Proposition 40	One-time tax generally equal to 5% of taxable net worth; 90% of proceeds for public healthcare Tax design and earmark	Collections, legal conflicts and allocations determine usable funding. The earmark is not an annual benefit guarantee. [9, 10, 11]
Colorado Amendment 87	\$958.4 million in FY 2026–2027; \$1.972 billion in FY 2027–2028 Official state revenue estimates	Healthcare is one permitted use. The \$2.7 billion ballot maximum is a different figure and is not the healthcare allocation. [26, 25]

Four different financial questions

Revenue. How much a tax is expected to collect, and over what period.

Healthcare allocation. How much of that money may be used for healthcare, and how much is actually assigned to a program.

Borrowing authority. How much debt can be issued for a stated purpose. This is not recurring operating revenue.

Debt service. The principal and interest to be repaid. Financing assumptions can change the estimated total cost.

APPENDIX C

Fiscal figures for other jurisdictions

Measure	Official amount and type	Interpretation
Washington IP26-645	About \$11.4 billion less revenue; \$150.5 million agency savings Official five-year estimate, FY2027–FY2031	Revenue loss and administrative savings are separate. Income-tax collections otherwise begin in April 2029. [66]
Rhode Island Question 1	\$275 million bonds; \$165 million for URI health building; about \$441.3 million total repayment Authorization, project allocation and estimated debt service	The full bond serves several education projects. Repayment assumes 5% interest and 20 years. [52]
New Mexico Bond Question 1	Up to \$21,582,213 Borrowing authority	Senior-facility capital, with property-tax-backed repayment; no uniform opening date or fixed household tax bill. [45]
Marin Healthcare District Measure CC	\$0.14 annually per taxable improved square foot; about \$12.4 million annual revenue for 30 years Local tax rate and revenue estimate	This is a local case, excluded from the statewide count. Collections would fund the ordinance's specified purposes. [75, 76]

A household tax example

Under Marin Measure CC's stated formula, 2,000 taxable square feet of improved building area would generate a \$280 annual charge: $2,000 \times \$0.14$. The ordinance's definitions and applicable exemptions determine the actual taxable area and assessed charge. [76]

What the figures do not establish

A public revenue estimate does not establish a hospital's receipts, an insurer's premium change or a patient's savings. A facility allocation does not establish the number of appointments or graduates it will produce. Such outcomes require program, contract and operating evidence after implementation.

APPENDIX D

Approval thresholds and certification

Approval depends on the rule for the particular question. The table identifies the adoption standards established by official sources. Vote counts remain unofficial until certification by the responsible election authority. Implementation dates appear separately in Appendix B.

Jurisdiction	Approval rule for the profiled measures
California	A majority of votes cast on each statewide proposition. The two-thirds rule proposed in Proposition 43 concerns future covered local special-tax votes. [5, 18]
Colorado	A majority of votes cast on each of the three measures. The official Blue Book specifies majority approval for Amendment 87 as well as the two statutory propositions. [28]
Idaho	A majority of votes cast on Proposition One; HJR 4 also requires majority ratification. The two proposals are separate questions. [34, 35, 33]
Massachusetts	A majority of votes cast on the question, and YES votes equal to at least 30% of all ballots cast at the state election. [38]
Missouri	A majority of votes cast on the amendment. [42]
Nevada	Majority approval at two consecutive general elections. Question 6 received its first approval in 2024 and needs a second majority approval in 2026. [43, 44]
New Mexico	Majority approval of the bond question. [45]
North Carolina	A majority of votes cast on each question; the two amendments are decided separately. [48, 51]
Rhode Island	A majority of people voting on the proposition. [54, 55]
South Dakota	A majority of votes cast on Amendment I under the current constitutional-amendment rules. [58]
Virginia	A majority of votes cast on the amendment. [64]
Washington	A majority of votes cast on each initiative, with votes cast on the measure reaching at least one-third of total votes cast at the election. [68]
Wisconsin	A majority of electors voting on the amendment. [74]
Marin Healthcare District	A simple majority of votes cast on Measure CC. Proposition 43 does not retroactively change this November 2026 threshold. [75, 77]

Massachusetts also requires YES votes equal to at least 30% of all state-election ballots. Washington requires participation on the measure to reach one-third of total election votes. Nevada Question 6 is a second required constitutional vote. Colorado Amendment 87 has a majority threshold.

APPENDIX E

Insurance coverage and state policy

The word “payer” includes several arrangements governed by different rules. A state vote can affect the availability or legal status of care without automatically changing every plan’s benefits. The type of coverage helps determine a patient’s benefits and costs.

Coverage type	Implications of a state result
Medicaid and Medicaid managed care	Federal and state rules jointly govern coverage and financing. Payments to managed-care plans must follow actuarial standards and the federal review process. A new revenue source does not automatically change those payments. [92]
State-regulated insured coverage	Applicable state insurance requirements operate alongside federal law. A new clinical right is not necessarily a new covered benefit; the actual law and insurance contract matter. [93]
Private-employer self-funded plans	The employer pays claims, even when an insurance company administers them. State insurance benefit mandates generally do not apply to self-funded ERISA plans. Governmental, church and multiple-employer arrangements require separate treatment. [94, 93]
Medicare Advantage	Federal standards generally supersede state standards for the plans, except for specified licensing and solvency rules. Local provider capacity and the separate legal status of clinical services still matter. [95]

Three questions about care and coverage

- Is the service lawful?** The answer depends on the state rule, treatment, patient group and any applicable exception or court order.
- Will the plan pay?** Coverage depends on the actual program or benefit contract, including authorization, provider-network and cost-sharing rules.
- Can the patient obtain care?** Access depends on participating providers, staffing, appointments or referrals, and any travel or other costs. Legal protection and coverage alone do not establish local availability.

APPENDIX E

Medicaid changes outside these ballot votes

New Medicaid eligibility checks and financing limits are already taking effect under federal law and state implementation. Their timing does not depend on passage or defeat of the ballot measures in this report. Application dates, renewal notices and exemptions determine when individual patients are affected. [78, 79, 80]

Policy or state	Timing and implications for members
Nebraska	From May 1, 2026; renewal timing varies. Work requirements began for applicable Medicaid expansion applicants and members on May 1. Members whose renewals fell in May or June 2026 do not have to demonstrate compliance until their 2027 renewal. Exemptions and temporary hardship rules apply; a program start date is not every member's reporting deadline. [81]
Montana	From July 1, 2026; additional changes in October and January. Requirements began July 1 for applicable expansion adults; renewal checks generally look for three qualifying months since the previous review. Marketplace applications became subject to state checks on October 1. From January 2027, six-month reviews can bring some renewal dates forward. Exclusions apply, and the state first checks existing records. [82, 83]
Iowa	Applications from December 1, 2026; renewals from February 2027. New Iowa Health and Wellness Plan applicants must meet the requirement for the month before applying. Current members encounter it at renewals scheduled on or after February 2027 and must meet it for two months since their previous eligibility review. Iowa first checks existing records; exclusions and requested documentation matter. [84]
Federal work and activity requirements	Generally by January 1, 2027; some states started earlier. Certain adults aged 19–64 must meet work or activity conditions to qualify for Medicaid. Options include 80 monthly hours of qualifying activities, sufficient earnings or at least half-time education. Exemptions include pregnancy, specified caregiving responsibilities and certain medical conditions. People receive an opportunity to show compliance or exemption before a denial or loss of coverage. [78]
More frequent Medicaid renewals	Transition begins January 1, 2027. Most adults in Medicaid expansion move from annual to six-month eligibility reviews. States can bring some existing renewal dates forward or transition members at their next scheduled review. An exemption from work requirements does not generally exempt someone from these renewals; specified American Indian and Alaska Native members retain a separate exemption. [79]

What patients need to know. A work-rule exemption, an activity reporting request and a renewal notice are different matters. State notices explain the applicable deadline and any evidence required. Patients can seek help from their Medicaid agency if a notice appears inconsistent with their circumstances; a ballot result does not replace that process. [81, 82, 84, 79]

APPENDIX E

Medicaid financing and additional ballot scope

The following financing changes arise independently of the selected state ballot measures. They remain part of the healthcare policy environment under either passage or defeat.

Policy	Timing and meaning
Taxes used to help finance Medicaid	October 1, 2026; further limits from October 1, 2027. Federal law now limits certain taxes states use to finance their share of Medicaid, with further restrictions for most provider classes in expansion states beginning in October 2027. These are financing rules, separate from the federal expansion matching percentage. Changes in patient services would depend on state funding and payment decisions. [80]
Payments directed through Medicaid health plans	Existing limits; protected arrangements begin phasing down from 2028. Federal limits already apply to certain payments states require Medicaid health plans to make to providers. Qualifying existing arrangements have temporary protection and begin phasing down in annual payment periods starting on or after January 1, 2028. Provider revenue effects depend on the arrangement; the rule does not itself cancel patient coverage. [85]
Rural Health Transformation funding	Annual federal funding from 2026 through 2030. All 50 states received approval for 2026 awards under the \$50 billion, five-year program, which makes \$10 billion available annually. State projects can support rural services, facilities and workforce development. A federal award is not a guarantee that every hospital receives funding or that any particular patient service expands. [86]

Federal payment restrictions for specified treatment of minors

CMS-2451-F specifies an October 13, 2026 effective date for payment restrictions on defined gender-transition surgery and medication: under eighteen in Medicaid and under nineteen in separate CHIP. Medical exceptions apply. Up to six months of federal funding remains available for qualifying cross-sex hormone therapy already being received on October 13. The rule does not bar otherwise lawful private financing or state-only programs outside federally matched Medicaid and CHIP. Implementation remains subject to applicable court orders. These restrictions arise independently of state ballot results. [101]

Florida and Oklahoma

Florida. Florida's official November 2026 amendment booklet contains no Medicaid-expansion question. The proposed expansion initiative did not qualify for this election. Other fiscal proposals on the ballot have separate scopes. [87, 88]

Oklahoma. Oklahoma's November ballot lists State Questions 845 and 847, concerning judicial nominations and property-tax valuation limits. Neither asks voters to adopt or repeal Medicaid expansion. Potential local-budget effects are separate from an expansion referendum. [89, 90, 91]

These scope notes address Medicaid expansion questions specifically. They do not mean that elections, candidate contests or other fiscal measures in those states have no healthcare implications.

APPENDIX F

Glossary of financing and election terms

These plain-language definitions explain how terms are used in this report. The exact wording of each measure controls its legal scope.

Appropriation. Legal authority to spend public money for a stated purpose. A revenue estimate does not itself grant an organization a payment.

Ballot initiative. A proposal placed before voters through the initiative process. It may change a statute or, where allowed, a constitution.

Bond. Borrowed money that the government repays with interest. A general obligation bond is backed by the government's repayment commitment under applicable law.

Capitation. A payment to a health plan for each enrolled member for a specified period. It pays for the plan's covered responsibilities rather than each individual visit.

Capital funding. Money for assets such as buildings and equipment. Staff pay, utilities and recurring services generally need operating funds.

Certification or canvass. The official process that verifies and declares election totals. Election-night returns may change before the result is final.

Constitutional amendment. A change to a state's foundational law. A statutory proposal changes an ordinary law. Their adoption and later amendment rules can differ.

Earmark. A requirement reserving revenue for specified uses. An earmark can still leave decisions about recipients, timing and program design.

Effective date and operative date. The date a measure becomes law and the date a particular rule starts to apply. They may be different.

ERISA. The Employee Retirement Income Security Act, a federal law governing many private-employer benefit plans. Plan funding and legal status affect which state rules apply.

APPENDIX F

Glossary of healthcare and tax terms

Federal matching percentage. The federal share of eligible Medicaid spending. South Dakota's measure concerns the specified expansion share falling below 90%, a different issue from limits on provider taxes.

FQHC and look-alike. A federally qualified health center is a qualifying community health provider. A look-alike meets Health Center Program requirements without receiving a Health Center Program award. Exact entity definitions matter in California Proposition 44.

Managed care. An arrangement in which a health plan organizes and pays for covered services under a contract, often using a provider network.

Medicaid expansion. The eligibility group for certain adults added under the Affordable Care Act. The expansion group is only one part of a state's Medicaid program.

Payer. An organization or program that pays healthcare claims, including an insurer, Medicaid program, Medicare plan or employer health plan.

Provider. A clinician, hospital, clinic or other organization delivering healthcare services.

Special tax and parcel tax. A special tax funds designated purposes. A parcel tax is a property charge set by the measure's formula; Marin's proposal uses taxable improved building area.

Tax ceiling and tax rate. A ceiling is the maximum legally permitted rate. The enacted rate is what the law actually applies to taxable income and may be much lower.

Viability. A clinical and legal concept concerning a fetus's ability to survive outside the uterus. The relevant measure's own definition and exceptions govern.

For the regulatory distinctions behind these definitions, see the health-plan sources, the Medicaid guidance and the full text of California Proposition 44 and South Dakota Amendment I. [94, 92, 79, 22, 57]

APPENDIX G

Understanding results and implementation

An election result establishes whether voters adopted a proposal. The legal provisions, implementation process and funding arrangements determine how that decision affects healthcare. The following distinctions apply across the measures in this report.

1 The exact proposal. The state, measure number or letter, election date and question text identify the proposal. Similar titles in different states can describe different laws. Local measures apply within the named district or jurisdiction.

2 The official result. Election-night returns are preliminary. Adoption depends on the applicable approval rule and the certified result. Some questions also require a minimum level of participation, a minimum number of affirmative votes or approval at a second election.

3 The legal change. The operative text defines the people, services and activities affected, along with exceptions, enforcement provisions, protections for existing arrangements and start dates. Official explanations summarize the proposal; the full text establishes its legal terms.

4 The outcome if a proposal fails. Existing statutes, applicable court orders and separately enacted future changes generally remain in place. Rejection does not necessarily prohibit a service, increase a tax or close a facility.

5 The funding process. Tax rates, projected annual revenue, multiyear collections, borrowing authority and debt service describe different financial quantities. Healthcare funding may require separate appropriations, grants, contracts or other allocations after approval.

6 Access to care. Legal permission, insurance coverage and available care are separate conditions. Participating clinicians, appointments, referrals, travel costs, cost sharing and confidentiality rules help determine a patient's experience.

7 Estimates and potential effects. Official fiscal estimates depend on their stated assumptions and time periods. Black Book's assessments explain possible consequences of the underlying rules. Actual effects depend on implementation and the circumstances described in each profile.

8 Developments after the election. Certification, court decisions, agency rules, funding decisions and service changes may alter the expected consequences. This edition reflects information available on October 19, 2026.

APPENDIX G

Annotated source guide

Source titles link to the underlying documents and webpages. Numbers match the references in the profiles and appendices. The annotations explain what each source establishes. Official ballot, legal, fiscal and agency sources support the policy analysis; organizational and publisher references support the About Black Book section. Sources reflect information available through October 19, 2026.

Types of evidence

Ballot text establishes the proposal's legal language. Election-office explanations identify the question and summarize adoption or rejection. Legislative fiscal offices estimate costs and revenues for stated periods and assumptions. Agency guidance explains implementation. Official voter booklets may also contain campaign arguments, which are distinct from their legal and fiscal analyses.

Black Book's impact assessments apply the cited legal and fiscal provisions to potential consequences for providers, payers, patients and consumers. Organizational references support the About Black Book section.

California



- [1] [California LAO: Proposition 3 analysis](#) lao.ca.gov. Legislative Analyst baseline: existing rates continue through 2030 and their extension preserves an estimated \$5 billion–\$15 billion annually.
- [2] [California official voter guide: Proposition 3 analysis](#) voterguide.sos.ca.gov. Current November 2026 official analysis confirms the ballot number, revenue timing and broader budget effects.
- [3] [California official voter guide: Proposition 3 title and summary](#) voterguide.sos.ca.gov. Official summary distinguishes education allocations from General Fund resources available for healthcare and other services.
- [4] [California official voter guide: Proposition 3 proposed law](#) vig.cdn.sos.ca.gov. Article XIII, section 36 retains the conditional healthcare allocation, its \$2 billion annual ceiling, education allocation rules and emergency provisions.
- [5] [California Senate: 2025–26 California and United States Constitutions](#) senate.ca.gov. Articles II section 10 and XVIII section 4 establish majority approval, rules for approved conflicting measures, and a default effective date on the fifth day after the Secretary of State files the statement of vote. Later operative dates remain possible.
- [6] [California LAO: Proposition 38 analysis](#) lao.ca.gov. Legislative Analyst estimates the bond repayment burden and describes uncertain discovery revenue and healthcare cost effects.
- [7] [California official voter guide: Proposition 38 analysis](#) voterguide.sos.ca.gov. Current official analysis confirms the \$8.4 billion authorization, allocation structure, research purposes and non-guaranteed outcomes.
- [8] [California official voter guide: Proposition 38 proposed law](#) vig.cdn.sos.ca.gov. Sections 130352 and 130358 establish allocation, revenue-sharing and product-pricing conditions, including the first commercial year transition.
- [9] [California LAO: Proposition 40 analysis](#) lao.ca.gov. The Legislative Analyst explains the one-time wealth tax, its 90% healthcare allocation, temporary receipts, possible income-tax losses, and the risk that a conflict with Proposition 41 or 42 could prevent the proposed funding.
- [10] [California LAO: Proposition 41 analysis](#) lao.ca.gov. The Legislative Analyst explains the audits, their costs, uncertain savings, spending-limit restrictions and potential conflict with Proposition 40 if both measures pass.
- [11] [California LAO: Proposition 42 analysis](#) lao.ca.gov. The Legislative Analyst describes restrictions on ownership taxes and retroactive taxation, uncertain revenue effects, and the separate potential conflict with Proposition 40.
- [12] [California official voter guide: Proposition 40 analysis](#) voterguide.sos.ca.gov. Current official voter analysis verifies the 2026 ballot status and distinguishes collection estimates from spending choices.
- [13] [California official voter guide: Proposition 40 proposed law](#) vig.cdn.sos.ca.gov. The proposed law defines the January 1 tax-obligation date, December 31 valuation date, detailed tax rules and permitted expenditure categories.
- [14] [California official voter guide: Proposition 41 analysis](#) voterguide.sos.ca.gov. Current official analysis confirms preliminary review at 25% of signatures, four-year audits and the absence of guaranteed savings.

- [15] [California official voter guide: Proposition 41 proposed law](https://vig.cdn.sos.ca.gov) vig.cdn.sos.ca.gov. Proposed Article XXIV separates special-tax audit requirements from the broader covered-state-tax spending-limit prohibition and defines their reach.
- [16] [California official voter guide: Proposition 42 analysis](https://voterguide.sos.ca.gov) voterguide.sos.ca.gov. Current official analysis verifies the ballot number and distinguishes ownership of assets from income earned on them.
- [17] [California official voter guide: Proposition 42 proposed law](https://vig.cdn.sos.ca.gov) vig.cdn.sos.ca.gov. Proposed Article VIII defines personal property, protects qualifying pre-2026 taxes and permits limited emergency retroactivity of up to 365 days.
- [18] [California LAO: Proposition 43 analysis](https://lao.ca.gov) lao.ca.gov. Legislative Analyst describes existing local special-tax voting rules and uncertain future local revenue effects.
- [19] [California official voter guide: Proposition 43 analysis](https://voterguide.sos.ca.gov) voterguide.sos.ca.gov. Current official analysis establishes the January 1, 2027 application to new, increased and extended citizen-initiated local special taxes.
- [20] [California official voter guide: Proposition 43 proposed amendment](https://vig.cdn.sos.ca.gov) vig.cdn.sos.ca.gov. Proposed Article XIII A, section 4.5 supplies the precise local-government scope and constitutional exceptions.
- [21] [California LAO: Proposition 44 analysis](https://lao.ca.gov) lao.ca.gov. Legislative Analyst identifies clinic fees, state enforcement costs and possible service increases or financial distress without predicting outcomes.
- [22] [California Secretary of State: Proposition 44 proposed law](https://vig.cdn.sos.ca.gov) vig.cdn.sos.ca.gov. Sections 3–6 and 8 define covered corporations, exclusions, revenue calculation, penalties, waivers, patient actions, criminal intent and fiscal-year timing.
- [23] [California Secretary of State: Proposition 44 Attorney General summary](https://voterguide.sos.ca.gov) voterguide.sos.ca.gov. Attorney General summary states that program services advance charitable purposes and are not limited to patient services.
- [24] [California official voter guide: Proposition 44 analysis](https://voterguide.sos.ca.gov) voterguide.sos.ca.gov. Current official analysis explains the shortfall penalty and possible return of penalty money after compliance within five years.

Colorado



- [25] [Colorado Secretary of State: Initiative 195 final text / Amendment 87](https://sos.state.co.us) sos.state.co.us. Final text removes the constitutional flat-rate clause, sets individual and corporate brackets and requires supplemental spending on designated services.
- [26] [Colorado Legislative Council: 2026 Fiscal Impact Statements](https://content.leg.colorado.gov) content.leg.colorado.gov. The September 10 fiscal analyses distinguish Amendment 87's estimated additional revenue from its maximum ballot figure, explain Proposition 136's lack of standalone fiscal impact, and identify the conflict if both pass. The Proposition 135 analysis covers its minimal anticipated fiscal effects, reported pediatric-provider practices and January 1, 2027 effective date.
- [27] [Colorado Secretary of State: Certified 2026 ballot measures](https://sos.state.co.us) sos.state.co.us. The Secretary of State identifies Amendment 87 as initiative 195 and Proposition 136 as initiative 232, publishes the certified ballot questions, and states the applicable voter-approval requirements.
- [28] [Colorado Legislative Council: 2026 State Ballot Information Booklet](https://content.leg.colorado.gov) content.leg.colorado.gov. The official 2026 Blue Book supplies the majority-vote classifications and explains the existing and proposed rules for Amendment 87 and Propositions 135–136. It covers graduated taxation, existing refund mechanisms, the unresolved joint tax outcome, and Proposition 135's surgery-purpose limitation, payment provisions and medical exceptions.
- [29] [Colorado Legislative Council: Amendment 87 Blue Book analysis](https://leg.colorado.gov) leg.colorado.gov. Measure-specific official analysis explains tax brackets, lack of inflation adjustment and legislative discretion over allocations among permitted services.
- [30] [Colorado Secretary of State: Initiative 232 corrected final text / Proposition 136](https://sos.state.co.us) sos.state.co.us. Corrected final text establishes the 4.4% maximum, proclamation effective date and application to 2027 and later tax years.

Idaho



[31] Idaho Secretary of State — 2026 General Election: Proposition One and HJR 4, official explanations and full text voteidaho.gov. Official November 3 ballot title and explanation; existing exceptions; full text defining viability and medical emergency, preserving conscience and malpractice rules, disclaiming state payment, and specifying January 1, 2027. Official HJR 4 ballot explanation and constitutional text; scope of exclusive legislative authority and immediate effectiveness upon voter adoption.

[32] Idaho Secretary of State — Initiatives and Amendments: qualified and nonqualifying measures voteidaho.gov. The Reproductive Freedom and Privacy Act qualified for the November 2026 ballot. The medical-cannabis and marijuana-decriminalization initiatives failed to qualify for November 2026.

[33] Idaho Secretary of State — Idaho Constitution, Article XX, Section 1 archive.sos.idaho.gov. Current Secretary of State edition of the Idaho Constitution, Article XX, Section 1: majority ratification of amendments.

[34] Idaho Legislature — Idaho Code §34-1811, Manner of voting and conflicting measures legislature.idaho.gov. Idaho Code 34-1811 supplies the majority-of-votes-cast rule for adoption of a statutory initiative. The official Legislature citation is provided alongside the accessible county-hosted reproduction below.

[35] Idaho Secretary of State — Idaho Code §34-1811, 2022 official compilation hosted by Owyhee County (backup copy) owyheecounty.net. Accessible official backup reproducing Idaho Code 34-1811 and its majority rule. This is a 2022 compilation, identified as historical corroboration rather than a substitute for the current statutory citation.

Massachusetts



[36] Massachusetts Secretary of the Commonwealth — official 2026 Question 8 summary and fiscal consequences sec.state.ma.us. Official November 2026 Question 8; repeal scope, medical-market retention, possession/transfer provisions, medical-license transition, fiscal 2025 receipts and January 1, 2028 effective date.

[37] Massachusetts General Laws — Chapter 94I, Section 6, medical-marijuana reimbursement and authorization malegislature.gov. Current medical-marijuana law does not mandate insurance/government reimbursement or clinician authorization; Chapter 94I, Section 6.

[38] Massachusetts Constitution — Article LXXXI, Section 2, initiative-law approval malegislature.gov. Current initiative-law approval rule: majority on the question plus affirmative votes at least 30% of all state-election ballots; Article LXXXI, Section 2.

Missouri



[39] Missouri Secretary of State — Certified 2026 ballot measures, Amendment 3 sos.mo.gov. Current Secretary of State certification, Amendment 3 ballot identity, November 3 eligibility and official vote-effect statements.

[40] Missouri Revisor of Statutes — RSMo 191.1720 revisor.mo.gov. Separate minors-treatment statute; pre-August 28, 2023 medication grandfathering and August 28, 2027 expiration limited to subsection 4.

[41] Missouri General Assembly — HCS HJR 73, truly agreed and finally passed text documents.house.mo.gov. Operative amendment text; abortion exceptions and the rape/incest limit of no later than twelve weeks' gestational age; parental-consent requirements, emergency exception and legislative authority for court-approved consent; public-funding limits; and purpose-specific restrictions on treatment of minors.

[42] Missouri Constitution — Article XII, Section 2(b), approval and effective date revisor.mo.gov. Majority approval and the thirty-day constitutional effective-date rule; December 3 is calculated from November 3, 2026.

Nevada



[43] Nevada Secretary of State — 2026 Statewide Ballot Questions eurekacountynv.gov. Official 2026 Question 6 identity; first approval in 2024; existing twenty-four-week statute; proposed viability standard and retention of statutory access after defeat.

[44] Nevada Legislature — Constitution, Article I Section 25 conditional addition leg.state.nv.us. Article I, Section 25 proposed addition and its conditional November 24, 2026 effective date; Article 19, Section 2(4) requires majority approval at consecutive general elections and completion of the Supreme Court canvass.

New Mexico



[45] [New Mexico Secretary of State — 2026 General Election Voter Guide, Bond Question 1](https://sos.nm.gov) sos.nm.gov. The certified bond amount, purposes, majority vote, property-tax-backed repayment and publication of final financing estimates before issuance.

[46] [New Mexico Aging and Long-Term Services Department — Capital Outlay](https://aging.nm.gov) aging.nm.gov. The aging agency's senior-facility capital program and its work with local and tribal project sponsors.

[47] [New Mexico Secretary of State — 2026 Statewide Constitutional Amendments and General Obligation Bonds](https://sos.nm.gov) sos.nm.gov. The separately published official 2026 statewide ballot questions, including the senior-facility borrowing authorization.

North Carolina



[48] [North Carolina General Assembly — Session Law 2026-4, income-tax constitutional amendment](https://ncleg.gov) ncleg.gov. The November 3 ballot question, reduction from 7% to 3.5%, majority requirement, certification and application from tax year 2027.

[49] [North Carolina General Assembly — Session Law 2026-41, section 44.1, enacted individual income-tax schedule](https://ncleg.gov) ncleg.gov. Section 44.1 fixes the individual rates at 3.49% in 2027–2029, 3.24% in 2030–2032 and 2.99% after 2032; it replaces the former trigger schedule with later triggers beginning in 2035.

[50] [North Carolina Legislative Analysis Division — Senate Bill 1080 summary, individual and corporate tax ceiling](https://dashboard.ncleg.gov) dashboard.ncleg.gov. The proposed constitutional maximum applies to both individual and corporate income-tax rates.

[51] [North Carolina General Assembly — Session Law 2026-5, property-tax constitutional amendment](https://ncleg.gov) ncleg.gov. The existing constitutional provision, added duty to enact levy limits with possible exceptions, November election and effectiveness upon certification; no numerical cap or legislative deadline appears in the text.

Rhode Island



[52] [Rhode Island Secretary of State — 2026 Voter Information Handbook, Question 1](https://vote.sos.ri.gov) vote.sos.ri.gov. Question 1 allocations, approval and rejection effects, \$441,333,250 estimated principal and interest, financing assumptions and the three project timetables.

[53] [Rhode Island Governor's Office — Signed FY2027 budget, final higher-education bond allocation](https://governor.ri.gov) governor.ri.gov. The enacted FY2027 budget's final \$275 million higher-education bond allocation, including \$165 million for URI; this supersedes the smaller January proposal.

[54] [Rhode Island General Assembly — Enacted FY2027 budget, Article 5, Capital Development Program, Section 3](https://webserver.rilegislature.gov) webserver.rilegislature.gov. Article 5 Section 3 requires a majority of those voting on the proposition. The enacted capital-development text covers the 2026 borrowing question; the public-law record below confirms enactment.

[55] [Rhode Island Public Laws 2026, Chapter 084 — Enacted H7127 Substitute A as amended, including Article 5](https://webserver.rilegislature.gov) webserver.rilegislature.gov. Public Laws 2026 Chapter 084 identifies the enacted budget and incorporates Article 5. Article 5 Section 3 contains the measure-specific voter-approval rule.

South Dakota



[56] [South Dakota Secretary of State: 2026 general election ballot measures](https://sdsos.gov) sdsos.gov. Secretary of State's current general-election list identifies this legislatively referred Medicaid measure as Amendment I.

[57] [Charles Mix County: Official 2026 statewide ballot measures, Amendment I text and AG explanation](https://charlesmixcounty.gov) charlesmixcounty.gov. Official county publication reproduces the amendment and AG explanation, including the specific federal matching provision in 42 U.S.C. 1396d(y).

[58] [South Dakota Secretary of State: 2026 ballot question pamphlet](https://sdsos.gov) sdsos.gov. Current state pamphlet confirms the AG's conditional coverage explanation, majority approval and July-after-canvass effective-date rule; campaign arguments are separately labeled.

[59] South Dakota Legislature: SDCL chapter 2-1, including effective-date section 2-1-12 sdlegislature.gov. SDCL 2-1-12 states that approved constitutional amendments take effect July 1 after completion of the state canvass.

Virginia



[60] Virginia Department of Elections — Question 1 explanation and full amendment elections.virginia.gov. Official Question 1 identity, current absence of an explicit constitutional right, enumerated protections, third-trimester exceptions and self-executing clause.

[61] Virginia Department of Elections — 2026 Summary of Election Law Changes elections.virginia.gov. November 3 referendum, majority approval and January 1, 2027 effective date in the official summary of HB781/SB449.

[62] Code of Virginia — Section 18.2-72, abortion during the first trimester law.lis.virginia.gov. Existing statutory permission for abortion in the first trimester, subject to specified practitioner requirements.

[63] Code of Virginia — Section 18.2-73, abortion during the second trimester law.lis.virginia.gov. Existing statutory permission for abortion in the second trimester, subject to specified requirements.

[64] Virginia Constitution — Article XII, Section 1, amendment approval and effective date law.lis.virginia.gov. Virginia Constitution Article XII Section 1 requires a majority of votes cast on the amendment and describes when a ratified amendment becomes effective.

Washington



[65] Washington Attorney General: IP26-645 explanatory statement sos.wa.gov. Attorney General explains the 9.9% tax, shared household deduction, account allocation and survival of accompanying non-income-tax relief.

[66] Washington OFM: Initiative 645 fiscal impact statement sos.wa.gov. Office of Financial Management supplies the assumed December 3 effective date, April 2029 first payments and five-year revenue and expenditure estimates.

[67] Washington Secretary of State: certification of November 2026 candidates and measures sos.wa.gov. Secretary of State confirms that IP26-645 completed verification and is certified for the November general election.

[68] Washington Legislature: Constitution, Article II, section 1(d) leg.wa.gov. Article II section 1(d) requires majority approval, sets the one-third participation condition and generally provides operation 30 days after the election.

[69] Washington Attorney General — official IL26-001 explanatory statement sos.wa.gov. Attorney General's July 21, 2026 explanation of current law and restored record-access and medical-notice provisions; notice is distinct from universal consent.

[70] Washington House Office of Program Research — Summary of Initiative 26-001, August 21, 2026 leg.wa.gov. Legislative analysis of initiative provisions and effectiveness thirty days after the approving election.

[71] Washington Secretary of State — IL26-001 full text sos.wa.gov. Operative initiative text, including school-held records and changes to the exception for a parent accused of abuse or neglect.

[72] Washington Legislature — Current parental-rights statute, RCW 28A.605.005 app.leg.wa.gov. Current RCW 28A.605.005, including the separate criminal-proceeding and active-investigation protections in subsection (3).

Wisconsin



[73] Vilas County Clerk — official November 3, 2026 referendum notice hosted by Town of Land O'Lakes landolakeswi.gov. Official county-clerk notice dated August 26, 2026: November 3 Question 2, precise emergency/worship scope, and identification of Assembly Joint Resolution 10.

[74] Wisconsin Constitution — Article XII, Section 1 annotation, certification and effective date docs.legis.wisconsin.gov. Article XII Section 1 states the majority-of-electors-voting-on-the-amendment requirement. Its current annotations address effectiveness upon certification of the statewide canvass.

Marin Healthcare District



[75] [Marin County Elections — Measure CC, ballot question and impartial County Counsel analysis](#) [marincounty.gov](#). County Counsel's impartial analysis confirms the simple-majority threshold, \$0.14 tax, 30-year term, estimated annual revenue and restricted uses; campaign arguments on the same page are separate.

[76] [Marin County Elections — Measure CC full proposed ordinance](#) [marincounty.gov](#). The operative ordinance sets the July 1 collection start after effectiveness, exemptions, permitted uses, borrowing authority and oversight, and excludes administrator pay.

[77] [California Secretary of State — Proposition 43 official title and summary](#) [voterguide.sos.ca.gov](#). Proposition 43's proposed two-thirds threshold applies to voter-proposed local special-tax measures approved after January 1, 2027.

Medicaid and national background

[78] [CMS — June 1, 2026 fact sheet on Medicaid community-engagement interim final rule](#) [cms.gov](#). General January 2027 deadline, affected adult groups, activity and education alternatives, exemptions, notice and a 30-day opportunity to establish compliance or exemption.

[79] [CMS — SMD 26-001, March 2026 guidance on six-month eligibility redeterminations](#) [medicaid.gov](#). Six-month renewals for the defined expansion groups, transition options and distinct exemptions; exemption from community engagement does not ordinarily remove the renewal requirement.

[80] [CMS — July 21, 2026 provider-tax proposed-rule fact sheet and statutory effective dates](#) [cms.gov](#). The July 2026 CMS explanation identifies statutory October 2026 and October 2027 dates. Its additional regulatory proposals remain described as proposals, not final rules.

[81] [Nebraska Department of Health and Human Services — Medicaid Work Requirements](#) [dhhs.ne.gov](#). May 1 implementation, the May/June 2026 renewal exception, exemptions, temporary hardships and member-specific verification.

[82] [Montana Department of Public Health and Human Services — Current Medicaid Changes](#) [dphhs.mt.gov](#). Current application and renewal verification; October 1 treatment of federal-marketplace applications; January 2027 six-month renewals and earlier review dates for some members.

[83] [Montana Department of Public Health and Human Services — June 30, 2026 announcement of July 1 requirements](#) [dphhs.mt.gov](#). The June 30 state announcement confirming July 1, 2026 implementation.

[84] [Iowa Health and Human Services — Iowa Health and Wellness Plan Community Engagement Requirements](#) [hhs.iowa.gov](#). December 1 application start, February 2027-or-later renewals for current members, one-month applicant and two-month member review requirements, exclusions and existing-data checks.

[85] [CMS — February 2, 2026 guidance on state-directed payments and temporary grandfathering](#) [medicaid.gov](#). CMS's February 2026 letter distinguishes arrangements already subject to payment limits from grandfathered arrangements and specifies the 2028 phase-down by rating period.

[86] [CMS — Rural Health Transformation awards and 2026–2030 funding framework](#) [cms.gov](#). All-state approval for first-year awards and the \$10-billion-per-year, 2026–2030 funding framework; the \$50 billion total is not a single-year award.

Additional ballot scope checks

[87] [Florida Department of State — Official 2026 constitutional-amendment booklet, updated September 3, 2026](#) [dos.fl.gov](#). The full certified November 2026 amendment booklet contains no Medicaid-expansion proposal.

[88] [Florida Department of State — 2026 constitutional-amendment initiative qualification notice](#) [dos.fl.gov](#). The Department of State states that all 22 active citizen initiatives failed to qualify for the 2026 general-election ballot.

[89] [Oklahoma State Election Board — November 3, 2026 state questions](#) [oklahoma.gov](#). The official list identifies exactly two November 2026 statewide questions: 845 and 847.

[90] [Oklahoma State Election Board — State Question 845 corrected final ballot title](#) [oklahoma.gov](#). The corrected final ballot title concerns the Judicial Nominating Commission.

[91] [Oklahoma State Election Board — State Question 847 final ballot title](#) oklahoma.gov. The final ballot title concerns limits on increases in taxable property values, not Medicaid expansion.

Health plan regulation

[92] [CMS: Medicaid Rate Review and Rate Guides](#) medicaid.gov. CMS describes the actuarial standards for Medicaid managed-care payments and links the 2026–2027 Rate Development Guide. Relevant to the distinction between state revenue, state spending authority and the rates actually paid to a health plan.

[93] [Texas Department of Insurance: Insured and self-funded plan jurisdiction](#) tdi.texas.gov. The Texas Department of Insurance explains fully insured and employer self-funded coverage, the role of a claims administrator and the relevant consumer assistance authorities. Texas-specific requirements apply within that jurisdiction.

[94] [U.S. Department of Labor — Employment Law Guide on employee benefit plans](#) webapps.dol.gov. Sections Who Is Covered and Relation to State, Local, and Other Federal Laws explain ERISA coverage, governmental and church-plan exclusions, and the interaction with state insurance regulation. The page identifies a December 2016 update date.

[95] [eCFR: 42 CFR 422.402, Medicare Advantage federal preemption](#) ecfr.gov. 42 CFR 422.402 establishes the federal preemption rule for Medicare Advantage standards, with state licensing and solvency exceptions. It does not itself determine whether a clinician may provide a service under state clinical law.

About Black Book

[96] [Black Book Research — Research library and methodology overview](#) blackbookmarketresearch.com. The company's description of its healthcare technology research, stakeholder feedback, performance benchmarking and research categories.

[97] [Black Book Research — Douglas Brown founder and president biography](#) blackbookmarketresearch.com. Identifies Black Book's founder and president and summarizes his experience in healthcare operations, managed care, technology and market research.

[98] [Black Book Research — Contact information](#) blackbookmarketresearch.com. Official research email, main telephone number and Tampa location, checked on October 19, 2026.

[99] [Wiley — The Black Book of Outsourcing by Douglas Brown and Scott Wilson](#) wiley.com. Publisher record confirming the coauthors and the book's original 2005 publication.

[100] [Wiley — The Black Book of Reshoring by Douglas Brown](#) wiley.com. Publisher record for Brown's 2026 book on manufacturing and sourcing.

Additional federal and state payment rules

[101] [Centers for Medicare & Medicaid Services — CMS-2451-F final rule, August 13, 2026](#) federalregister.gov. Stated October 13, 2026 effective date; Medicaid payment restrictions under eighteen and separate CHIP restrictions under nineteen; definitions, medical exceptions and limited continuation of existing cross-sex hormone therapy; otherwise lawful private or state-only financing outside federally matched programs; applicable court orders.

[102] [Missouri Revisor of Statutes — RSMo 208.152 subsection 15](#) revisor.mo.gov. Existing MO HealthNet payment exclusion for specified gender-transition surgery, cross-sex hormones and puberty-blocking drugs. Subsection 15 contains no age limit and is separate from the minors-treatment statute and proposed constitutional amendment.

About Black Book Research

Black Book Research provides healthcare market intelligence for organizations evaluating technology, services and operating performance. Its research covers hospitals and other care providers, health plans, digital health, interoperability, cybersecurity, revenue-cycle operations, managed services and related markets. The firm is based in Tampa, Florida. [96, 98]

Black Book's broader research draws on stakeholder feedback and performance measures to evaluate products and services. Its published methodology emphasizes vendor neutrality, validation and transparent scoring. This election guide draws on public legal, election and fiscal sources. [96]

Douglas "Doug" Brown is Black Book's founder and president. His career spans healthcare operations, managed care, technology and market research. He coauthored The Black Book of Outsourcing with Scott Wilson, first published by Wiley in 2005, and authored The Black Book of Reshoring, published by Wiley in 2026. [97, 99, 100]

Black Book Research provides this report as an independent, vendor-agnostic and nonpartisan analysis of selected healthcare-related ballot measures. The report does not endorse candidates, political parties, ballot campaigns, healthcare vendors or service providers. It examines the potential consequences of approval and rejection using official election materials, legal texts, fiscal analyses and agency guidance. Black Book's impact assessments explain potential implications for providers, payers, patients and consumers under the conditions described in each proposal.

Contact Black Book Research

Research and information [98]

Email research@blackbookmarketresearch.com

Telephone 1-800-863-7590

Website blackbookmarketresearch.com

Publication details

Healthcare on the Mid-Term Ballot 2026

A National and State Reference Guide

Final publication edition • October 19, 2026

Election date • November 3, 2026

© 2026 Black Book Research