MEDICARE FOR ALL: ASSESSING THE POLITICAL LANDSCAPE AND OUTLOOK

I. EXECUTIVE SUMMARY

The political and public discourse around single-payer and "Medicare for All" proposals has rapidly gained momentum in 2019. Whereas in 2016, Medicare for All was championed most prominently and singularly by unsuccessful Democratic primary challenger Bernie Sanders (I-VT), in 2020 we will see nearly every Democratic presidential contender endorse a variation on the theme and will most certainly see the debate carried forward in the general election. However, major questions remain regarding the outlook and viability of such proposals, even within the Democratic party.

In this issue brief, we seek to reveal the topography of the current Medicare for All landscape. First, we examine the political landscape (Section II), including dynamics within and between the two parties. In Section III, we compare the key design elements of the leading legislative proposals to enact Medicare for All. Next, we review recent milestones, such as the first congressional hearing on Medicare for All proposals, a preliminary analysis of single payer scoring considerations from the Congressional Budget Office (CBO), and attempts to advance public option plans at the state level (Section IV). We discuss the potential outlook for Medicare for All concepts after 2020 and beyond (Section V). Finally, in Appendix A, we provide a side-by-side comparison of 11 key bills, including Medicare for All and public option proposals.

II. POLITICAL LANDSCAPE

In a poll conducted by Kaiser Family Foundation, 56 percent of individuals favored a national health plan in which all Americans would get their insurance from a single government plan.[1] Kaiser noted that this represented a slight increase overtime since 2016, demonstrating increased interest in the topic. Along party lines, a majority of Republicans (57 percent) strongly opposed a national health plan, while the majority of Democrats (54 percent) strongly supported a national health plan.

Democratic members of Congress agree on the need to expand health care coverage for Americans, but they are divided on the best way to achieve this. Major Democratic presidential nominees have offered up varying versions of Medicare for All that range from covering all Americans and eliminating private insurers, to allowing Americans to buy into government insurance or private insurance. More establishment Democratic members assert that change can be achieved more incrementally. House Speaker Rep. Nancy Pelosi (D-CA) claimed she was "agnostic" on the topic in an interview with the *Washington Post* and

[1] https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/

suggested that Congress should build upon the Affordable Care Act (ACA), rather than pushing an untested system.[2] Whatever the vehicle, House members are determined to bring the topic to the forefront leading up to the 2020 election.

On the other side of the aisle, President Trump and the Administration have been vocal on their disapproval of Medicare for All proposals, claiming they would be expensive and harmful to the health of Americans. In the President's annual Economic Report, Medicare for All is described "socialized" medicine that would eliminate choice and competition in the free market.[3] In a plenary session with American Hospital Association members, Senate Majority Leader Mitch McConnell (R-KY) stated that Medicare for All would "lead to more than 180 million Americans being thrown off their private health plans that many of them like – no choices, no options, no alternatives."[4] In an additional interview with Fox News, Sen. McConnell said Medicare for All would never pass through the Senate as long as Republicans were in control.[5]

III. THE CURRENT LANDSCAPE OF MEDICARE FOR ALL PROPOSALS

While Medicare for All has become the singular tagline for the single-payer movement, the proposals underlying this banner exist along a spectrum, each presenting a slightly different approach. Some proposals lay out the design for a full-blown single-payer system, with the federal government administering one public plan available to all U.S. residents. At the other end of the spectrum, lawmakers propose a public plan option that would make available to individuals in the Exchange market a Medicare- (or, in some cases, Medicaid-) like plan which could compete alongside other private Exchange plans. Proposals in between these two endpoints feature their own hybrid approaches. We discuss key similarities and differences across these categories below. We also outline specifics on the 11 bills considered here in a side-by-side chart in Appendix A.

A. Full Single-Payer Proposals

At present, three legislative proposals exist that would implement a U.S. single-payer system. The first is perhaps the most well-known: the Medicare for All Act of 2019, advanced by Senator Bernie Sanders.[6] The other shares its namesake on the House side, introduced by Representative Pramila Jayapal (D-WA).[7] The last, which has not yet been reintroduced since last Congress, is the Expanded & Improved Medicare for All Act.[8]

In nearly all important respects, the two plans introduced in this Congress are similar and would implement almost identical systems. The program would be open to all U.S. residents; would cover all medically

[2] https://www.washingtonpost.com/politics/im-agnostic-pelosi-questions-whether-medicare-for-all-can-deliver-benefits-of-obamacare/2019/04/04/fe2942c0-56ed-11e9-aa83-504f086bf5d6_story.html?utm_term=.cd760a20aed2
[3] https://www.whitehouse.gov/wp-content/uploads/2019/03/ERP-2019.pdf
[4] https://www.aha.org/news/headline/2019-04-09-mcconnell-medicare-all-raw-deal-american-people
[5] https://thehill.com/blogs/floor-action/senate/438354-mcconnell-dismisses-medicare-for-all-not-while-gop-controls-senate
[6] https://www.congress.gov/bill/116th-congress/senate-bill/1129
[7] https://www.congress.gov/bill/116th-congress/house-bill/1384
[8] https://www.congress.gov/bill/115th-congress/house-bill/676

necessary services in 13 benefit categories, including long-term services and supports; would require no cost-sharing of beneficiaries; and would finance all such services through increased taxation. Of note, these plans would also authorize the HHS Secretary to directly negotiate drug prices with manufacturers, which proponents tout as an important cost-savings measure. Finally, the plans would effectively eliminate private insurance options, leaving the public plan as the only option for consumers.

B. Public Option Proposals

A large share of proposals exists at the other end of the proverbial spectrum and would instead create public plan options for individuals to purchase on the Exchanges.[9, 10, 11, 12] While such plans could serve as the catalyst toward generating a single-payer system (i.e., if public plans were to overtake their private plan counterparts over time), the proposals sketch an arguably more measured approach. In sum, these plans establish a public option plan that States would offer on their Exchange markets. Most proposals base these plans – and, therefore provider reimbursement rates – on Medicare. One, however, calls for a *Medicaid* public option plan.[13] Each of the Medicare-based plans would cover all 10 ACA essential health benefits, while the Medicaid plan would cover all Medicaid services, and would add comprehensive reproductive health care services. Like any other Exchange plan, enrollees would pay premiums adjusted based on geography, and would be able to apply Exchange subsidies.

Some important differences exist, however. For example, only some address the issue of balance billing through direct prohibitions of such activities. Importantly, some allow Medicare providers to opt out, which potentially threatens the network adequacy of these plans. As for individual market stabilization, some propose a reinsurance program, some extend the eligibility for premium tax credits, and some employ both.

C. Hybrids

The remaining proposals feature aspects of those outlined above, but take a slightly different approach. For example, two bills currently exist (one in the Senate[14] and one in the House[15]) that would create a Medicare buy-in program, allowing individuals between the age of 50 and 64 to "buy into" Medicare. While these plans strongly resemble the those for a public option – offering these plans on the Exchanges and paying providers at Medicare rates – they only open these plans up to individuals beginning at age 50.

In addition, one plan – the Medicare for America Act[16] – takes a deliberate approach to the issue. If enacted, it would implement a public option plan on all state Exchanges for the first two years. Then, in the third year, the system would transition into a single-payer program closely resembling the other existing Medicare for All proposals. It does differ from other Medicare for All proposals in some respects – for one,

[9] https://www.congress.gov/bill/116th-congress/senate-bill/1261/
[10] https://www.congress.gov/bill/116th-congress/senate-bill/3
[11] https://www.congress.gov/bill/116th-congress/house-bill/2000
[12] https://www.congress.gov/bill/116th-congress/senate-bill/1033
[13] https://www.congress.gov/bill/116th-congress/senate-bill/489
[14] https://www.congress.gov/bill/116th-congress/senate-bill/470
[15] https://www.congress.gov/bill/116th-congress/house-bill/1346
[16] https://www.congress.gov/bill/116th-congress/house-bill/2452

it covers more benefit categories, and it would also authorize the federal government to procure intellectual property to develop pharmaceuticals itself, if necessary.

D. Discussion: Taking Stock

Taken together, these plans comprise a mounting list of legislative options that policymakers have to consider in devising a Medicare for All-like system. Again, while the political viability of such a shift in the near-term is low, this suite of options reflects the breadth of current thinking on advancing the move to universal coverage.

IV. RECENT DEVELOPMENTS

Recent developments at both the federal and state level suggest the following: 1) Medicare for All, given its political implications, is not likely to pass at the federal level; and 2) the path to achieving the goal of Medicare for All – universal coverage – may begin at the state level instead. Specifically, key states have begun exploring public option plans within their own Exchanges. Many see such plans as an important intermediary step toward a Medicare for All-like system.

A. CBO Single Payer Analysis

The Congressional Budget Office (CBO) released a report outlining design considerations for establishing a single-payer health care system.[17] While the report did not score any specific legislative proposals, and therefore provided no budgetary impact estimates, the report laid out the specific considerations policymakers would need to address in designing a single-payer system. Several such considerations would impact government costs, including the rate at which the government would reimburse providers; the level of administrative costs; cost containment tools such as global budgets and utilization management; how the system would purchase prescription drugs; and whether and how the government chooses to cover additional services such as medical innovations and long-term support services, among others. Regardless of the precise design of these features, however, the CBO noted that a single-payer system "would significantly increase government spending and require substantial additional government resources."

Last, the CBO noted that the federal government could finance a single-payer system through a combination of premiums, cost sharing, and taxes. Notably, current mainstream proposals such as Medicare for All would generally allow no cost sharing or premiums and would instead finance the program solely through taxation.

B. House Rules Committee Hearing on Medicare for All

On April 30, 2019, the House Committee on Rules held Congress' first hearing on Medicare for All.[18] Overall, committee members followed party lines. Republicans primarily highlighted the prohibitive costs of the program, threats to medical innovation, and fears around rationing of and restricted access to care.

[17] https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf
[18] https://rules.house.gov/bill/116/hr-1384

Democrats, by contrast, lauded the prospect of universal coverage, while maintaining the program was affordable and that providers would not need to ration care due to an increase in preventive medicine.

While the hearing ultimately did not serve to advance the standing of either party's agenda, the hearing was groundbreaking in itself, demonstrating that American politics can now entertain a national discourse on single-payer policies. Moreover, other congressional committees with wider jurisdiction over health care are also planning to hold their own hearings on Medicare for All. In particular, the Budget Committee is slated to hold its own single-payer hearing on May 22, 2019, and Ways & Means has hinted at hosting a hearing as well. However, while discussions around Medicare for All continue at the federal level, the political feasibility of advancing such a plan in this Congress remains low.

C. State Legislative Approaches

Meanwhile, certain states are seeking to implement policies of their own as an intermediary step toward universal coverage. For example, Washington state has advanced legislation that would create a Medicare-like public option plan to be offered on the state's Exchange.[19] The Washington State legislature has passed the bill, which the Governor is expected to sign imminently. Enrollees would be able to purchase these plans like any others offered on the Exchanges. The public plan is expected to present a more affordable option than those currently on the Exchanges, due primarily to setting provider reimbursement at Medicare rates. The plan would also meet all of the qualified health plan requirements mandated by the ACA. In addition, Colorado has begun exploring a public option for its Exchange market, with the state legislature working on a bill to instruct the state health department to develop a proposal for a public option plan.[20] Connecticut has introduced a legislative option to create public option plan as well, which is working its way through the state legislature.[21]

States working to develop their own public option proposals indicate that the path to universal coverage can begin from the ground up. As states continue making progress on this front, policymakers will be able to assess the effects of a public option plan, which may serve to influence the conversation about Medicare for All at the national level.

D. Trump Administration's 1332 Waiver Design Changes

Recent changes at the federal level may lend additional support to state-based initiatives. Through section 1332 of the ACA, states are allowed to apply for State Innovation Waivers (1332 waivers), which allow states to pursue innovative approaches to providing high-quality and affordable coverage to residents.[22]

The Obama Administration originally released guidance around 1332 waivers in 2015. This guidance codified certain guardrails meant to ensure states could only implement programs that would increase the number of covered individuals, paid special consideration to its effects on vulnerable sub-populations, and

[19] https://app.leg.wa.gov/billsummary?BillNumber=5526&Year=2019
[20] https://leg.colorado.gov/bills/hb19-1004
[21] https://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&which_year=2019&bill_num=1004
[22] https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/section_1332_state_innovation_waivers-.html

included coverage options that were at least as comprehensive as ACA-mandated policies. However, the Trump Administration released updated guidance in October 2018 that loosened many of the original guardrails set forth in 2015.[23] In addition, while the ACA stipulated that states must enact a new law to implement a 1332 waiver program, the new guidance allows states to authorize 1332 waivers through existing legislation that "provides statutory authority to enforce [ACA] provisions and the state waiver plan" together with a "duly-enacted state regulation or an executive order."

Through a loosening of both the original guardrails and state-level legislative requirements for authorizing these waivers, states now have access to a wider latitude of innovative options. Such options could include, for example, public-option-type plans. Certain states may prefer this approach if a legislative pathway – such as those undertaken by Washington, Connecticut, and Colorado – would prove too cumbersome.

Of course, ultimate approval for 1332 waiver programs depends on the Administration. Though a recently released request for information indicates the Administration is seeking new 1332 waiver concepts for states to use,[24] it is unlikely that a 1332 waiver design proposing a public-option plan would receive HHS approval. Developments of this kind instead may be more viable were the 2020 election to yield a Democratic president. In fact, because enacting Medicare for All may still prove a political impossibility for a Democratic president in 2020, advancing universal coverage through state-based changes may be the more viable option in the near-term.

V. OUTLOOK

Considering the political polarization surrounding health care, the dramatic reforms envisioned in a single-payer health care system remain aspirational under this Congress. However, a wide range of proposals using Medicare as a framework for expanding health care coverage reflect the shift in thinking among Democrats. Still, what remains to be seen is whether they can unite behind a single approach.

The ongoing negotiations relating to prescription drug pricing have brought to the forefront the philosophical divisions among Democrats. Recently, the Congressional Progressive Caucus raised concerns over Speaker Nancy Pelosi's (D-CA) discussions with the Trump Administration to use arbitration as a cost control measure. Facing pressure from Progressive Democrats, House Energy and Commerce (E&C) Chairman Frank Pallone, Jr. (D-NJ) and Ways and Means (W&M) Chairman Richard Neal (D-MA) reassured them that direct negotiation of Medicare Part D covered drugs – a critical component of Medicare for All as well as other public option proposals – is still under consideration. Though such a concession may be unsubstantial in the long-term, it signals the growing influence of the Congressional Progressive Caucus to advance their agenda.

As noted earlier, several of the Democratic presidential candidates have formally supported Sen. Sanders' Medicare for All bill as well as the narrower public option proposals. Still, the disconnect between sponsoring bills, campaigning, and reality is becoming clearer as the 2020 election nears. As such, it is left

[23] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/SRE-Waiver-Fact-Sheet.pdf
[24] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/RFI-1332-Fact-Sheet.pdf

to be seen whether Democrats who support these measures on the campaign trail would pursue Medicare for All if elected. Moreover, the political repercussions of advancing such drastic reform may lead them to pursue more incremental reforms.

Moreover, Democrats may face procedural challenges if they attempt to pass Medicare for All through the budget reconciliation process after the 2020 elections. Based on the cost-related criteria of the Byrd rule – which prohibits provisions from increasing the deficit beyond a timeframe specified in the budget resolution – legislation proposed by Sen. Sanders and Rep. Jayapal may be considered "extraneous" to the reconciliation process.[25] In addition, the looming insolvency of Medicare's hospital trust fund – which is expected to run out of money by 2026, according to the most recent Medicare Trustees report – questions whether expanding coverage through Medicare is feasible, without major changes to sustain the program.[26]

While Medicare for All does not stand to advance in the near future, the increased public attention has pushed lawmakers as well as presidential candidates to vigorously debate the viability of a single-payer health care system and to discuss potential transition plans. In the short-term, as potentially more Democrats support Medicare for All or a public option approach, Republicans may have a greater appetite to compromise on legislation to lower health care costs by shoring up the ACA and perhaps strengthening Medicare. Additionally, states in the meantime may press forward with public option plans of their own, serving as laboratories for innovation as policymakers assess such an approach's viability.

VI. CONCLUSION

We hope this is a helpful overview of considerations affecting the Medicare for All debate. We are happy to answer any questions or discuss at your convenience.

[25] https://fas.org/sgp/crs/misc/RL30862.pdf
[26] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

Appendix A: Side-by-Side Comparison of Medicare-for-All and Public Option Proposals

Bill Title & Number	Medicare for All Act of 2019 (S. 1129)	Medicare for All Act of 2019 (H.R. 1384)	Expanded & Improved Medicare For All Act (115th, H.R. 676)	Choose Medicare Act (S.1261 / H.R. 2463)	Keeping Health Insurance Affordable Act of 2019 (S.3)	Medicare-X Choice Act of 2019 (S. 981 / H.R. 2000)	The CHOICE Act (S. 1033 / H.R. 2085)	Medicare for America Act (H.R. 2452)	Medicare at 50 Act (S. 470)	Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346)	State Public Option Act (S. 489 / H.R. 1277),
Sponsor	Sen. Bernie Sanders (I-VT)	Rep. Pramila Jayapal (D-WA)	Rep. John Conyers, Jr. (D-MI)	Sen. Jeff Merkley (D-OR), Rep. Cedric Richmond (D-LA)	Sen. Ben Cardin (D-MD)	Sen. Michael Bennet (D-CO), Rep. Antonio Delgado (D-NY)	Sen. Sheldon Whitehouse (D-RI), Rep. Jan Schakowsky (D-IL)	Rep. Rosa DeLauro (D-CT)	Sen. Debbie Stabenow (D-MI)	Rep. Brian Higgins (D-NY)	Sen. Brian Schatz (D-HI), Rep. Luján (D-NM)
Summary	Establishes a single-payer health care system	Establishes a national health insurance program that would be administered by HHS	Establishes a Medicare for All Program to provide individuals in the U.S. free health care	Establishes Medicare Part E public health plans, available in Exchanges	Establishes a public health insurance option, available in Exchanges	Establishes the Medicare Exchange health plan, increment-ally available in Exchanges in areas with low competition	Establishes a public health insurance option, available in Exchanges	As a two-year transition plan, establishes a public health insurance option, available in Exchanges[1] Then, transitions into a national health insurance program that would be administered by HHS	Establishes a Medicare buy-in option, available in Exchanges, for individuals ages 50 to 64 years	Establishes a Medicare buy-in option, available in Exchanges, for individuals ages 50 to 64 years	Establishes a Medicaid buy-in options that States must offer through the Exchange market
Implemen-tation Date	On the first day of the first year that begins one year after enactment	2 years after date of enactment	On the first day of the first year that begins one year after enactment	January 1, 2020	PY 2020	PY 2021	PY 2020	National health insurance program would begin PY 2023	On the first day of the first year that begins *at least* one year after enactment	On the first day of the first year that begins *at least* one year after enactment	January 1, 2020

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Eligibility	All U.S. residents, according to criteria set by the HHS Secretary	All U.S. residents, according to criteria set by the HHS Secretary	All individuals residing in the U.S. Social security numbers will be used for registration	All U.S. residents, according to criteria set by the HHS Secretary and excluding individuals eligible for Medicare, Medicaid, and CHIP	All individuals eligible to participate in Exchanges	All individuals eligible to participate in Exchanges and not eligible for Medicare In 2020, available in areas where only one or no insurer offers plans on the Exchange, health provider shortage areas, and rural areas By 2024, available in individual market in all rating areas By 2025, available in small group market in all rating areas	All individuals eligible to participate in Exchanges	All U.S. residents, according to criteria set by the HHS Secretary	All individuals ages 50 to 64 years who are not entitled to or eligible for Medicare Part A and Part B Prohibits states from purchasing a Medicare buy-in option for Medicaid beneficiaries ages 50 to 64	All individuals ages 50 to 64 years who are not entitled to or eligible for Medicare Part A and Part B Prohibits states from purchasing a Medicare buy-in option for Medicaid beneficiaries ages 50 to 64	All individuals eligible to participate in Exchanges
Benefit Design	All medically necessary services in 13 benefit categories, including long-term services and supports.[2]	All medically necessary services in 13 benefit categories, including long-term services and supports.[3]	All medically necessary services in 16 benefit categories, including long-term services and supports.[4]	Requires compliance with ACA qualified health plan (QHP) requirements[5]	Requires compliance with ACA QHP requirements ACA 10 essential health benefits	Requires compliance with ACA QHP requirements ACA 10 essential health benefits	Requires compliance with ACA QHP requirements Comprehensive benefit package, including	All medically necessary services in 29 benefit categories, including long-term services and supports.[6]	Medicare Parts A, B, and D benefits Requires silver-level coverage	Medicare Parts A, B, and D benefits Authorizes CMMI demonstrations to include Medicare	All services currently covered by Medicaid Also adds comprehensive reproductive

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	Preempts Hyde Amendment restricting use of federal funds for reproductive health services Requires HHS Secretary to regularly evaluate benefits and make recommendations to Congress, as necessary Allows states to provide additional benefits at their expense	Requires HHS Secretary to regularly evaluate benefits and make recommendations to Congress, as necessary		ACA 10 essential health benefits, and Medicare Parts A, B, and D benefits Preempts Hyde Amendment restricting use of federal funds for reproductive health services Requires gold-level coverage	Requires bronze, silver, and gold coverage; platinum plans are optional	Requires silver and gold coverage	ACA 10 essential health benefits Preempts Hyde Amendment restricting use of federal funds for reproductive health services Requires silver and gold coverage; bronze plans are optional			enrollees ages 50 to 64 years	health care services
Cost Sharing	No cost sharing, but allows HHS Secretary to set cost sharing schedule for prescription drugs and biological products, not to exceed $200/year and exempts individuals	No cost sharing for any benefit.	No cost sharing for any benefit.	HHS Secretary sets premiums, adjusted by market (individual or small group) and rating area, to fully fund cost of health benefits, administration	HHS Secretary sets premiums, adjusted by geography, to fully fund cost of health benefits, administration	For PY 2021, HHS Secretary sets premiums, adjusted by market and geography, to fully fund cost of health benefits, administration	HHS Secretary sets premiums, adjusted by geography, to fully fund cost of health benefits, administration Prohibits discrimina-tory	HHS Secretary sets premiums, which will vary based on household income Premiums will not exceed 8% of household income	HHS Secretary sets premium based on average per capita costs, to fully fund health benefits and administrative expenses under Parts A, B, and D	HHS Secretary sets premium based on average per capita costs, adjusted by geography, to fully fund health benefits and administrative expenses under Parts A, B, and D	States may charge premiums and other cost-sharing that are "actuarially fair" Premiums may vary based on whether the plan covers an individual

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	with a household income at or below 200 percent of FPL			Sets annual out-of-pocket limit at $6,700 for 2021		For PY 2022 and beyond, enrollees are placed in a single risk pool, and HHS Secretary sets premium rates	premium rates, as defined in ACA[7]	No co-pays for seven service categories[8] Sets annual out-of-pocket limit at $3,500 for individuals and $5,000 for households.	Individuals enrolled in MA plans or Part D plan may be charged an increased premium	Individuals enrolled in Part D plans may be charged an increased premium	or household, the state rating area, beneficiary's age, and tobacco use Premiums cannot exceed 9.5% of household income Applies same cost-sharing limitations as those for QHPs under the ACA
Balance Billing	Prohibits balance billing	Prohibits balance billing	Prohibits balance billing	Applies Medicare limits on balance billing	Applies Medicare limits on balance billing	Not addressed	Not addressed	Prohibits balance billing	Not addressed	Not addressed	Not addressed
Prescription Drugs	Directs HHS Secretary to negotiate prices for prescription drugs Establishes national formulary	Directs HHS Secretary to negotiate prices for prescription drugs	Directs the Program to negotiate prices annually Established a national formulary that promotes the use of generic drugs	Directs HHS Secretary to negotiate prices for Medicare Part D drugs and if unsuccessful, authorizes the Secretary to set prices equal to or lesser than the prices paid by the VA	Directs HHS Secretary to negotiate prices for Medicare Part D drugs Prohibits establish-ment of national formulary Requires drug manufacturer to provide drug rebates	Directs HHS Secretary to negotiate prices for Medicare Part D drugs	Directs HHS Secretary to negotiate prices for Medicare Part D drugs and if unsuccessful, authorizes the Secretary to use prices set by the Medicare fee-for-service program	Directs HHS Secretary to negotiate prices for Medicare Part D drugs If negotiations are unsuccessful, the Secretary may authorize the use of any intellectual property for a drug to	Directs HHS Secretary to negotiate prices for Medicare Part D drugs	Directs HHS Secretary to negotiate prices for Medicare Part D drugs;	Not addressed

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					for drugs dispenses to low-income individuals Ensures enrollees have access to at least three prescription drug plans Eliminate the "true-out-of-pocket" limitation for qualified retiree prescription drug plans			manufacture it for sale under Medicare for America Prohibits a manufacturer from charging an "excessive" price for drugs Prohibits DTC advertising for a three-year period			
Provider Implications	Requires providers to sign participation agreement, prohibiting discrimina-tion of any kind Allows providers to enter into private contracts to furnish services paid by beneficiaries fully out-of-pocket	A health care provider is qualified to furnish benefits if they are licensed in the state to do so. Allows providers to enter into private contracts to furnish services paid by beneficiaries fully out-of-pocket	Only public or not-for-profit providers may participate in the Program Physicians may be paid through fee-for-service or salaried positions through global budgets Payments to providers institutions will be based on global	Providers participating in Medicare also participate in Part E; other providers may opt in HHS Secretary sets a payment rate schedule – necessary to maintain network adequacy – through negotiation, using Medicare rates as a	Providers participating in Medicare also participate in the public health insurance option, but they may opt out For FY 2020-2022, HHS Secretary sets payment rates equal to Medicare Parts A and B payment rates, and modifies	Providers participating in Medicare are required to participate in the health plan, but they may opt out; other providers may opt in HHS Secretary sets payment rates equal to Medicare Parts A and B payment rates, and has authority to increase	Providers participating in Medicare and Medicaid also participate in the public health insurance option, but they may opt out and other providers may opt in Directs HHS Secretary to negotiate with providers to establish reimburseme	Sets provider reimburseme nt at the higher of Medicare or Medicaid rates for a particular service. Sets hospital reimburseme nt at 110% of Medicare and Medicaid rates, except for rural hospitals which would receive higher reimburseme	Providers participating in Medicare also participate in the buy-in option Applies Medicare rates	Providers participating in Medicare also participate in the buy-in option Applies Medicare rates	Applies Medicaid rates to all services except primary care For primary care services, payment rates are increased to match those of Medicare rates Medicaid providers participate would participate in buy-in plans

Bill Title & Number	Medicare for All Act of 2019 (S. 1129)	Medicare for All Act of 2019 (H.R. 1384)	Expanded & Improved Medicare For All Act (115th, H.R. 676)	Choose Medicare Act (S.1261 / H.R. 2463)	Keeping Health Insurance Affordable Act of 2019 (S.3)	Medicare-X Choice Act of 2019 (S. 981 / H.R. 2000)	The CHOICE Act (S. 1033 / H.R. 2085)	Medicare for America Act (H.R. 2452)	Medicare at 50 Act (S. 470)	Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346)	State Public Option Act (S. 489 / H.R. 1277),
	Uses Medicare payment process, and requires HHS Secretary to establish a new process for updating the fee schedule	Payments to providers will be based on global budgets and payments will be determined that the beginning of each fiscal year	budgets and payments will be determined that the beginning of each fiscal year	price floor and Exchange rates as a price ceiling Encourages use of alternative payment models	rates for new services For FY 2023 and beyond, HHS Secretary sets payment rates through an administrative process Allows Secretary to use innovative payment mechanisms beginning in 2020[9]	rates in rural areas Allows Secretary to use innovative payment methods	nt rates; and if unsuccessful, authorizes the Secretary to set rates equal to Medicare Parts A and B rates, and modify rates for new services	nt as necessary Requires Medicare and Medicaid providers to participate in Medicare for America Prohibits providers from entering into private contracts with Medicare for America enrollees to furnish any item or service covered under Medicare for America			
Private Plan Implications	Eliminates employer-sponsored health benefits and other private insurance	Prohibits employers from offering health insurance plans that duplicate the benefits described in this act	Prohibits employers from offering health insurance plans that duplicate the benefits described in this act	Expands eligibility for premium tax credits, using gold level plan for benchmark Expands eligibility for reduced cost sharing	Expands eligibility for premium tax credits	Establishes a reinsurance program for the individual market, including plans not offered on Exchanges, and authorizes annual	Appears to have no direct implications, other than previously discussed impacts due to payment rate changes	Prohibits private insurers from offering health insurance plans that duplicate the benefits described in this act	Allows enrollees to purchase Medicare supplemental plans (Medigap) Ties premium assistance, cost-sharing reductions to	Allows enrollees to purchase Medicare supplemental plans (Medigap) Establishes the Individual Market Reinsurance	Not addressed

Bill Title & Number	Medicare for All Act of 2019 (S. 1129)	Medicare for All Act of 2019 (H.R. 1384)	Expanded & Improved Medicare For All Act (115th, H.R. 676)	Choose Medicare Act (S.1261 / H.R. 2463)	Keeping Health Insurance Affordable Act of 2019 (S.3)	Medicare-X Choice Act of 2019 (S. 981 / H.R. 2000)	The CHOICE Act (S. 1033 / H.R. 2085)	Medicare for America Act (H.R. 2452)	Medicare at 50 Act (S. 470)	Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346)	State Public Option Act (S. 489 / H.R. 1277),
				Establishes a reinsurance program for the individual market; appropriates $30 billion for FY 2020-2022 Applies ACA rating rules to large group market		appropriation of $10 billion for FY 2021-2023 Expands eligibility for premium tax credits		Allows employers to purchase Medicare for America plans for employees	second lowest cost silver plan	Fund to fund such programs in states Reauthorizes risk corridors for individual and small group markets for 2021 through 2024 Expands eligibility for cost-sharing reductions	
Financing Mechanism	Establishes the Universal Medicare Trust Fund, using tax dollars and redirecting funding for Medicare, Medicaid, FEHB, TRICARE, and maternal child health program to the Trust Fund Does not specify necessary changes to the Internal Revenue Code	Establishes the Universal Medicare Trust Fund, using tax dollars and redirecting funding for Medicare, Medicaid, FEHB, TRICARE, and maternal child health program to the Trust Fund	Establishes a Medicare for All Trust Fund, funded through existing sources of federal revenues for health care, an increase in personal taxes on the top 5 percent of income earners, a progressive excise tax on payroll and self-employed income, and taxes on unearned income and	Authorizes appropriation of $2 billion for FY 2020 to establish Medicare Part E, and additional funds as necessary to provide initial reserves to pay claims during first 90 days of plan year	Authorizes appropriation of $2 billion to establish the public health insurance option	Establishes the Plan Reserve Fund to administer the plan, and authorizes appropriation of $1 billion Establishes the Data and Technology Fund to perform data collection to inform setting of premium rates (appropriation not specified)	Authorizes appropriation of the necessary sums (not specified) to establish the public health insurance option and additional sums, as necessary.	Establishes a unified Medicare Trust Fund Sunsets recent Republican tax bill (Public Law 115-97) Imposes 5% surtax on incomes above $500,000 Increases the Medicare payroll tax to 4% Increases net investment tax to 6.9%	Monthly premiums are deposited in the Medicare Buy-In Trust Fund, used to reduce premiums and cost-sharing for individuals otherwise eligible for financial assistance in Exchanges	Monthly premiums are deposited in the Medicare Buy-In Trust Fund, used to reduce premiums and cost-sharing for individuals otherwise eligible for financial assistance in Exchanges	Buy-in plans would be financed through both premiums and federal matching payments

Bill Title & Number	Medicare for All Act of 2019 (S. 1129)	Medicare for All Act of 2019 (H.R. 1384)	Expanded & Improved Medicare For All Act (115th, H.R. 676)	Choose Medicare Act (S.1261 / H.R. 2463)	Keeping Health Insurance Affordable Act of 2019 (S.3)	Medicare-X Choice Act of 2019 (S. 981 / H.R. 2000)	The CHOICE Act (S. 1033 / H.R. 2085)	Medicare for America Act (H.R. 2452)	Medicare at 50 Act (S. 470)	Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346)	State Public Option Act (S. 489 / H.R. 1277),
			stocks and bonds.					Increases excise taxes on tobacco products, alcohol, and sugar-sweetened drinks			

[1] The subsequent information regarding Medicare for America pertains to all aspects of the bill envisioned in PY 2023 and beyond, when it would implement a national health insurance program. Information on the two-year transition plan is not included but resembles many common facets of other existing public option proposals.
[2] Comprehensive benefits include hospital services; ambulatory patient services; primary and preventive services; prescription drugs, medical devices, biological products; mental health and substance abuse treatment services; laboratory and diagnostic services, comprehensive reproductive, maternity, and newborn care; pediatrics; oral health, audiology, and vision services; short-term rehabilitative and habilitative services and devices; emergency services and transportation; necessary transportation to receive health care services for eligible individuals; and home and community-based long-term services and supports.
[3] See above.
[4] Comprehensive benefits include primary care and prevention, approved dietary and nutritional therapies, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, palliative care, mental health services, dental services, services, including periodontics, oral surgery, and endodontics, but not including cosmetic dentistry, substance abuse treatment services, chiropractic services, not including electrical stimulation, basic vision care and vision correction, hearing services, including coverage of hearing aids, and podiatric care.
[5] A Qualified Health Plan (QHP) is a health insurance policy sold on an Affordable Care Act (ACA) Exchange market that covers ACA-determined essential health benefits (EHBs) and meets other ACA requirements.
[6] Comprehensive benefits include ambulatory patient services; emergency are and urgent care services; hospitalization; maternity and newborn care; behavioral health services; prescription drugs; rehabilitative and habilitative services; laboratory services; preventive and wellness services and chronic disease management; pediatric services; dental care; vision services; hearing health services; home and community based services; chiropractic services; durable medical equipment; family planning, including abortion; gender-confirming medical procedures and treatments; screening, testing treatment, and counseling for STDs and HIV; dietary and nutrition counseling; medically necessary food and vitamins; nursing facilities; acupuncture; digital health therapeutics; telehealth; non-emergency medical transportation; care coordination; palliative care; and, any additional benefit or service not included but that is coverable by any State plan under title XIX.
[7] Section 2701 of the ACA requires premium rates vary only by whether such plan covers an individual or family; rating area; age; and tobacco use.

[8] The seven service categories for which there will be no co-pay amounts are: USPTF recommended preventive and chronic disease services; long-term services and supports; generic drugs and medically necessary prescription drugs; services for those with medical complexity, serious mental illness, substance use disorder, or those with developmental disabilities; pregnancy-related services; emergency services; and, services for children under age 21.

[9] Innovative payment mechanisms include patient-centered medical home and other care management payments, accountable care organizations, value-based purchasing, bundling of services, differential payment rates, performance or utilization-based payments, partial capitation, and direct contracting with providers