Chart: Democratic Presidential Candidates' Health Care Proposals

October 16, 2019

The following chart reflects WHG's analysis of key provisions of the proposals for comprehensive health reform that have been released by Democratic presidential candidates thus far.[1] Specifically:

- **Vice President Joe Biden** proposes to establish a Medicare-like buy-in public option and to expand tax credit eligibility for premium assistance.[2]
- **Sen. Kamala Harris (CA)** proposes to establish a public Medicare plan with a 10-year transition period; and allow private insurance plans to contract through Medicare (like Medicare Advantage) and to compete with public plans.[3]
- **Sen. Bernie Sanders (VT)** proposes in the Medicare for All Act of 2019 (S. 1129) to establish a single-payer health care system with a four-year transition period. Cosponsors include Democratic presidential candidates Sens. Harris, Booker, and Warren.[4]
- **Sen. Michael Bennet (CO)** proposes in the Medicare-X Choice Act of 2019 (S. 981) to establish the Medicare Exchange health plan, made incrementally available in Exchanges in areas with low competition. Cosponsors include Democratic presidential candidates Sens. Harris, Booker, and Klobuchar.[5]
- **Rep. Beto O'Rourke (TX)** proposes in the Medicare for America Act (H.R. 2452), originally introduced by Rep. Rosa DeLauro (D-CT), to establish a public health insurance program with a two-year transition period; and to preserve employer-sponsored insurance offering qualified health coverage.[6]
- **Mayor Pete Buttigieg (South Bend, IN)** proposes "Medicare for All Who Want It," which establishes a Medicare-like buy-in public option and expands tax credit eligibility for premium assistance. Mayor Buttigieg also proposes drug pricing reforms, including policies similar to those included in the Lower Drug Costs Now Act of 2019 (H.R. 3).[7]

Though not reflected in the chart below, other presidential candidates have issued broad policy proposals regarding their respective positions on comprehensive health reform, including:

- **Sen. Elizabeth Warren (MA)** has endorsed Medicare for All, as proposed by Sen. Sanders.[8]

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[1] This analysis includes only candidates that qualified for the third Democratic presidential debate on September 12.
[2] https://joebiden.com/healthcare/
[3] https://kamalaharris.org/medicare-for-all/
[4] https://berniesanders.com/issues/health-care-for-all/
[5] https://michaelbennet.com/high-quality-affordable-health-care-for-rural-america/
[6] https://betoorourke.com/#plans?p=health-care&tab=universal-high-quality-guaranteed-health-care
[7] https://storage.googleapis.com/pfa-webapp/documents/Medicare_for_All_Who_Want_It_WP.pdf; https://storage.googleapis.com/pfa-webapp/documents/PFA_Affordable%20Medicines%20for%20All_%20white%20paper.pdf.
[8] https://medium.com/@teamwarren/my-plan-to-invest-in-rural-america-94e3a80d88aa

- **Sen. Cory Booker (NJ)** proposes to "fight for Medicare for All," but he also supports more incremental changes by establishing a public option and lowering the eligibility age for Medicare to 50.[9]

- **Sen. Amy Klobuchar (MN)** proposes to establish a non-profit public option that allows individuals to purchase health insurance coverage through Medicare or Medicaid; and to expand premium subsidies and provide cost-sharing reductions.[10]

- **Former Housing and Urban Development Secretary Julián Castro** supports a Medicare for All system that allows individuals to purchase supplemental private insurance or opt out of Medicare if they prefer their private insurance and enrolls newborns individuals who lose employer-sponsored insurance into Medicare. He also supports authorizing Medicare to negotiate drug prices, reforming intellectual property laws to promote generic drugs, and allowing drug importation.[11]

- **Entrepreneur Andrew Yang** has expressed strong support for Medicare for All.[12]

Comprehensive Health Reform Plans

Democratic Candidate	Vice President Joe Biden	Sen. Kamala Harris (CA)	Sen. Bernie Sanders (VT)	Sen. Michael Bennet (CO)	Rep. Beto O'Rourke (TX)	Mayor Pete Buttigieg (South Bend, IN)
Implementation	• Establishes a Medicare-like buy-in public option.	• Allows eligible individuals to immediately buy into a Medicare Transition Plan during a 10-year phase-in period; • Provides a path for employers, employees, the underinsured, children, and others on federal programs (Medicaid, ACA exchanges) to transition into Medicare	• Allows eligible individuals to immediately buy into a Medicare Transition Plan during a four-year phase-in period; • Lowers the Medicare eligibility age to 55 in year one, 45 in year two, and 35 in year three; • Ensures private health insurance coverage continues uninterrupted during the	• Establishes the Medicare Exchange health plan beginning Plan Year (PY) 2021	• Allows eligible individuals to buy into a transitional public health option plan for PYs 2021 and 2022; and • Establishes a public health insurance program, beginning 2023	• Establishes a Medicare-like buy-in public option

[9] https://corybooker.com/issues/health-care/. In addition to S. 1129 and S. 981, Sen. Booker is a co-sponsor of the Choose Medicare Act (S. 1261); The CHOICE Act (S. 1033); and Medicare at 50 Act (S. 470).
[10] https://amyklobuchar.com/turning-ideas-into-action-senator-klobuchar-on-health-care-and-prescription-drugs/
[11] https://issues.juliancastro.com/health-care/
[12] https://www.yang2020.com/policies/medicare-for-all/

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		Transition Plan[13]; and • After transition period, establishes a framework allowing both public Medicare plans and private Medicare Advantage (MA)-like plans	transition period; and • After transition period, establishes a single-payer health care system			
Eligibility	• All U.S. residents are eligible to purchase the public option; and • Individuals in states that did not expand Medicaid would be offered premium-free access to the public option[14] • Note: Medicaid expansion states could elect to move their expansion population to premium-free public option if they continue to	• Automatically enrolls newborns and the uninsured into the Medicare Transition Plan[15] into which all individuals may buy in; and • After transition period, all U.S. residents are eligible to purchase the public Medicare plan or private Medicare plans, which would be subject to strict parameters	All U.S. residents, according to criteria set by the HHS Secretary	• All individuals eligible to participate in Exchanges and not eligible for Medicare; • In 2021, 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; and	• Automatically enrolls newborns, current Medicare beneficiaries, and individuals without qualified health coverage beginning PY 2023[16]; • All U.S. residents, according to criteria set by the HHS Secretary	• All U.S. residents are eligible to purchase the public option; • Low-income individuals in states that did not expand Medicaid would be automatically enrolled in the public option[17]; • Individuals unable to afford coverage through their employer would be able to enroll in the public option and receive income-

[13] During the 10-year transition period, Medicare beneficiaries would be able to keep their Medicare plan and immediately receive coverage of additional benefits such as dental, vision, and hearing aids. Medicare Advantage would continue uninterrupted during the transition. Employers will have the option (1) to continue providing private health coverage; or (2) to provide coverage through the Medicare Transition Plan "with a shared responsibility payment." Employees will have option to buy into Medicare Transition Plan. After the transition period, employees can choose to be in an (1) employer Medicare plan; (2) a different private Medicare plan; or (3) the public Medicare plan.

[14] Individuals who make below 138 percent of the federal poverty level and "interact with certain institutions (such as public schools) or other programs for low-income populations (such as SNAP)" will be automatically enrolled in the public option.

[15] Families with employer-sponsored insurance can choose to opt out of public option coverage for newborns.

[16] Individuals who age into Medicare are automatically enrolled beginning PY 2023. Individuals dually eligible in Medicare and Medicare are automatically enrolled beginning PY 2025.

[17] Medicaid work requirements would be overturned.

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	pay their state share			• By 2025, available in small group market in all rating areas		based subsidies; and • Middle-income individuals and families unable to afford coverage will be eligible for subsidized coverage through the marketplace for either private insurance or the public option Note: Individuals eligible for free coverage in Medicaid or the public option will be automatically enrolled; individuals could opt out if they choose to enroll in another insurance plan
Benefit Design	• Not specified, but would likely require compliance with ACA QHP requirements and cover ACA 10	• All medically necessary services, including emergency room visits, doctor visits, hearing aids, vision,	• All medically necessary services in 13 benefit categories, including long-term services and supports[18];	• Requires compliance with ACA QHP requirements; • ACA 10 essential health benefits; and	• All medically necessary services in 29 benefit categories, including long-term services and supports[19]	• ACA 10 essential health benefits

[18] 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.

[19] 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.

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	essential health benefits; • Expands access to contraception and protects constitutional right to abortion; and • Ensures protections for all, regardless of gender, gender identity, or sexual orientation	dental, mental health and substance use disorder treatment, and comprehensive reproductive health care services; • Expands coverage of mental health services, including telehealth; • Provides comprehensive maternal and child health program; • Phases in coverage of comprehensive long-term services and supports; and • Includes all currently available Medicaid supplemental benefits to children, such as EPSDT	• Requires HHS Secretary to regularly evaluate benefits and make recommendations to Congress, as necessary; and • Allows states to provide additional benefits at their expense	• Requires silver and gold coverage		
Cost Sharing	• Eliminates the 400 percent income cap on tax credit eligibility; • Lowers the limit on the cost of coverage from 9.86 percent of	• Medicare Transition Plan requires limited cost-sharing and provides financial assistance based on income; and • Public Medicare plan requires no	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	• For PY 2021, HHS Secretary sets premiums, adjusted by market and geography, to fully fund cost of health benefits,	• HHS Secretary sets premiums, which will vary based on household income; • Premiums will not exceed 8 percent of	• Lowers the limit on the cost of coverage (i.e., premium payments) to 8.5 percent of income; • Increases tax credits by

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	income to 8.5 percent; • Increases tax credits by calculating them based on the cost of a gold plan rather than a silver plan; • Charges no copays for primary care; and • Waives premiums in the public option for Medicaid-eligible individuals[20]	deductibles and copays on all medically necessary services, places "strong caps on out-of-pocket costs"	with a household income at or below 200 percent of FPL	administration; and • For PY 2022 and beyond, enrollees are placed in a single risk pool, and HHS Secretary sets premium rates	household income; • No co-pays for seven service categories[21]; and • Sets annual out-of-pocket limit at $3,500 for individuals and $5,000 for households.	calculating them based on the cost of a gold plan rather than a silver plan; and • Establishes an out-of-pocket cap for Medicare
Balance Billing	Prohibits out-of-network providers, who patients have no control over choosing, at in-network hospitals from balance billing patients	Not specified	Prohibits balance billing	Prohibits balance billing[22]	Prohibits balance billing	• Requires all bills related to in-network facilities to be billed as in-network, including for services from physicians and laboratories that may not be in-network; and • Caps the amount out-of-network providers, including ambulances and air ambulance services, can charge at twice

[20] States are required to pay their current share of the cost of covering Medicaid-eligible individuals for premiums to be waived.

[21] 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.

[22] https://michaelbennet.com/health-care/

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						the rate of Medicare
Prescription Drugs	• Authorizes the HHS Secretary to negotiate prices for Medicare drugs; • Establishes an independent review board to assess the value of new specialty drugs and to recommend prices based on external reference pricing for Medicare and the public option[23]; • Imposes tax penalties on drug manufacturers that increase the price of "brand, biotech, and abusively priced generic drugs" faster than inflation; • Allows importation of prescription drugs, provided	• Authorizes the HHS Secretary to negotiate prices for prescription drugs; and • Conducts audits to ensure the U.S. does not pay more for prescription drugs than other comparable countries	• Authorizes the HHS Secretary to negotiate prices for prescription drugs; • Establishes national formulary; • Allows drug importation from Canada and other industrialized countries[26]; and • Pegs prescription drugs prices to the median drug price in Canada, the United Kingdom, France, Germany, and Japan[27]	• Authorizes the HHS Secretary to negotiate prices for Medicare drugs; • Ends pay-for-delay and other anticompetitive tactics; • Implements value-based reimbursements for prescription drugs; and • Requires manufacturers to justify price increases; and • Imposes tax penalties on drug manufacturers that increase prices faster than inflation	• Authorizes the HHS Secretary to negotiate prices for Medicare Part D drugs; • If negotiations are unsuccessful, the HHS Secretary may authorize the use of any intellectual property for a drug to manufacture it for sale under Medicare for America; • Prohibits step therapy and prior authorization in group health plans; • Prohibits a manufacturer from charging an "excessive" price for drugs; and • Prohibits direct-to-consumer advertising for a three-year period	• Authorizes the HHS Secretary to negotiate prices for as many drugs as needed each year for the public option plan (annual minimum of 25 drugs)[28]; • Caps monthly out-of-pocket costs for the public option at $250; • Establishes an annual Part D out-of-pocket cap at $2,400 ($200 monthly cap)[29]; • Redistributes insurers' and pharmaceutical companies' share in the catastrophic phase of the Part D benefit (shares not specified); • Eliminates co-pays on all generic and biosimilar drugs

[23] External reference pricing uses the average price in other countries. The Biden Plan would allow private plans participating in the individual market to apply similar prices.
[26] This proposal is based on the Affordable and Safe Prescription Drug Importation Act (S. 469), introduced by Sen. Sanders.
[27] This proposal is based on the Prescription Drug Price Relief Act (S. 102), introduced by Sen. Sanders.
[28] The negotiated rates will be available to other public plans, including Medicaid, and private plans. The criteria for negotiating prices will include: (1) the therapeutic gain offered by the drug; (2) the cost of bring the therapeutic class of drugs to market; (3) the current costs treating the indicated disease; and (4) international prices charged for these drugs. Manufacturers who decline to negotiate after being selected will be assessed an escalating excise tax on the manufacturers' annual gross sales. The excise tax would begin at 65 percent and increase by 10 percent quarterly until the manufacturer is compliant and caps out at 95 percent.
[29] Seniors with lower incomes will have lower caps.

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	HHS has certified their safety; • Eliminates the tax deduction for prescription drug ads[24]; and • Accelerates the development of generic drugs[25]					covered under Medicaid, and for low-income people in the public plan and Medicare; • Supports Part D plans and the public plan covering generics and biosimilars in their lowest formulary tier and identifying additional incentives to encourage use; • Plans to acquire intellectual property rights from "worst offender" manufacturers for "irresponsible pricing," as allowed under 28 U.S.C. § 1498 and the Bayh-Dole Act, and identify a supplier capable of making the drug at an affordable price; • Increases the annual Branded Prescription Drug Fee on

[24] This proposal is based on the End Taxpayer Subsidies for Drug Ads Act (S. 73), introduced by Sen. Jeanne Shaheen (D-NH).
[25] This proposal is based on the CREATES Act of 2019 (S. 340), introduced by Sen. Patrick Leahy (D-VT).

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						manufacturers and importers; • Requires branded manufacturers to pay a rebate for increasing prices faster than inflation; • Ends pay-for-delay tactics and supports patent transparency measures[30]; • Expands funding to support development and domestic manufacturing of medicines; • Reduces regulatory and financial barriers to innovative approaches (e.g., value-based contracting, importation) • Requires manufacturers participating in Medicaid, Medicare, and the public plan to report spending and supply chain information; • Requires participating PBMs to report

[30] Supports the Protecting Consumer Access to Generic Drugs Act (H.R. 1499), incorporated into the Strengthening Health Care and Lowering Prescription Drug Costs Act (H.R. 987) passed by the House.

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						• information on sales, spread pricing, and rebates; • Boosts FDA funding for bioequivalence research to $100 million and streamlines regulation and approval of complex generics and biosimilars; and • Increase capacity for foreign inspections and tracking and tracing initiatives
Provider Implications	• Public option will negotiate prices with providers	• Promises individuals can keep their current doctor under Medicare for All; and • Does not specify impact of public Medicare plan on providers	• Requires providers to sign participation agreement, prohibiting discrimination of any kind; • Allows providers to enter into private contracts to furnish services paid by beneficiaries fully out-of-pocket; and • Uses Medicare payment process, and requires HHS Secretary to establish a new process for	• 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 rates in rural areas; and • Allows Secretary to use innovative payment methods	• Sets provider reimbursement at the higher of Medicare or Medicaid rates for a particular service; • Sets hospital reimbursement at 110 percent of Medicare and Medicaid rates, except for rural hospitals which would receive higher reimbursement as necessary; • Requires Medicare and Medicaid providers to	• Establishes a backstop fund to reimburse providers for unpaid care to uninsured patients; uninsured individuals would be retroactively enrolled in the public option; • Strengthens community benefit requirements by defining standards for what spending counts as meaningfully and setting baseline

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			updating the fee schedule		participate in Medicare for America; and • Prohibits providers from entering into private contracts with Medicare for America enrollees to furnish any item or service covered under Medicare for America	expectations for community benefits in which non-profit hospitals should invest in; • Caps out-of-network rates at twice what Medicare pays[31] • Increase funding for federal antitrust authorities to bring more cases against health care-related anticompetitive behavior; and lowers reporting thresholds for mergers (Note: applies to health insurers, pharmaceutical companies, and other health care entities); and • Authorizes the Federal Trade Commission to monitor the conduct of non-profit hospitals and take action against anti-competitive behavior

[31] The cap will be looser for Critical Access Hospitals to ensure access to care is not jeopardized.

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Private Plan Implications	• Does not specify impact of public option on private plans; • Ensures enforcement of mental health parity laws and expand funding for mental health services	• Allows private insurance plans to contract through Medicare and compete with the public Medicare plan (like a Medicare Advantage plan)[32]; • Allows individuals to purchase supplemental insurance covering services not included under Medicare for All (e.g., travel medical insurance, cosmetic surgery); and • Allows employers to offer employees retiree supplemental coverage through a private insurance plan	Eliminates employer-sponsored health benefits and other private insurance	Establishes a reinsurance program for the individual market, including plans not offered on Exchanges, and authorizes annual appropriation of $10 billion for FY 2021-2023 Expands eligibility for premium tax credits	• Prohibits private insurers from offering health insurance plans that duplicate the benefits described in this act; • Allows employers to purchase Medicare for America plans for employees; and • Allows individuals enrolled in qualified health coverage, including employer-sponsored plans, to opt out of Medicare for America[33]	• Reverses the Trump Administration's rules loosening restrictions on association health plans and short-term limited duration health plans; • Ensures enforcement of mental health parity, such as by requiring plans to annually report how they manage and meet parity; noncompliant plans will face fines and statutory penalties and plans with multiple violations will be publicly named; • Pushes insurers to improve price transparency tools; include price information in electronic health records; and improve

[32] Private Medicare plans will need to be certified by the Medicare program. They will also be subject to stricter consumer protection requirements, such as getting reimbursed by Medicare at a lower rate than the public Medicare plan.

[33] A qualified employer-sponsored plan is defined as a plan that covers benefits comparable to those offered under Medicare for America and "provides health coverage that is equivalent to an actuarial value of at least 80 percent of the coverage" and "makes a premium contribution of at least 70 percent." Large employers are required to offer a qualifying employer-sponsored plan or contribute 8 percent of their annual payroll to the Medicare Trust Fund. Small employers are not subject to the mandatory employer contribution. Individuals enrolled in TRICARE, VA, IHS, Medicaid, CHIP, and certain public service employees receiving qualified health coverage may opt out of Medicare of America.

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						provider directories, drug formulary comparisons, and plan quality ratings; • Harmonizes standards for transactions, including eligibility and benefit verification, prior authorization, claims attachment, and claim status inquiry; • Establishes a national All-Payer Claims Database; • Creates a central clearinghouse for claims; and • Requires integration of electronic health records, billing, and reporting systems

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Financing Mechanism	Not specified	• Taxes households making $100,000 and above an additional 4 percent income-based premium (and higher income thresholds for households in high-cost areas); and • Taxes Wall Street stock trades at 0.2 percent, bond trades at 0.1 percent, and derivative transactions at 0.002 percent[34]	• 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; • Provides several options finance a single-payer health care system. They include taxing employers a 7.5 percent income-based premium; taxing households making $29,000 and above an additional 4 percent income-based premium; and reforming the personal and estate tax system[35]	• Establishes the Plan Reserve Fund to administer the plan, and authorizes appropriation of $1 billion; and • Establishes the Data and Technology Fund to perform data collection to inform setting of premium rates (appropriation not specified)	• Establishes a unified Medicare Trust Fund; • Sunsets recent Republican tax bill (Public Law 115-97); • Imposes 5 percent surtax on incomes above $500,000; • Increases the Medicare payroll tax to 4 percent; • Increases net investment tax to 6.9 percent; and • Increases excise taxes on tobacco products, alcohol, and sugar-sweetened drinks	Not specified

[34] Financing proposals are estimated to generate over $2 trillion over 10 years.
[35] Additional details on options to finance a single-payer health care system available at: https://www.sanders.senate.gov/download/options-to-finance-medicare-for-all?inline=file