

Medicare-for-All and Public Plan Buy-In Proposals: Overview and Key Issues

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Introduction

As policymakers debate next steps for expanding health insurance coverage and lowering health costs, some have introduced legislation that would broaden the role of public programs, such as Medicare and Medicaid. During the 115th Congress, eight such proposals were introduced, ranging from bills that would create a new national health insurance program for all U.S. residents, replacing virtually all other sources of public and private insurance (Medicare-for-All), to more incremental approaches that would create a new public plan option, as a supplement to private sources of coverage and public programs.

These [eight legislative proposals](#) differ in ways that have important implications for consumers, health care providers and payers, including employers, states, the federal government, and taxpayers. Key policy differences relate to eligibility, the size and scope of the public plan, covered benefits and cost sharing, premiums, subsidies for premium and cost sharing, cost containment strategies, and the likely interactions with current public programs and private sources of coverage. They also vary in their level of detail; some bills, according to their sponsors, are intended to serve as blueprints for reform, and are expected to include greater specificity over time. Given the timing of the legislative calendar, these bills are unlikely to advance in the current Congressional session; however, they illustrate the range of options that will likely serve as prototypes for legislation that may be introduced in the next session of Congress.

Greatly simplified, these public plan proposals fall into four general categories:

- Two proposals would create Medicare-For-All, a single national health insurance program for all U.S. residents (Senator Sanders, [S. 1804](#); Rep. Ellison, [H.R. 676](#))¹;
- Three proposals would create a new public plan option, based on Medicare, that would be offered to individuals and some or all employers through the ACA marketplace (The Choice Act by Rep. Schakowsky, [H.R. 635](#), and Sen. Whitehouse, [S. 194](#)); The Medicare-X Choice Act by Sen. Bennett, [S. 1970](#), and Rep. Higgins, [H.R.4094](#); and the Choose Medicare Act by Sen. Merkley, [S. 2708](#) and Rep. Richmond, [H.R. 6117](#))
- Two proposals would create a Medicare buy-in option for older individuals not yet eligible for the current Medicare program (Sen. Stabenow, [S. 1742](#); Rep. Higgins, [H.R. 3748](#)); and
- One proposal would create a Medicaid buy-in option that states can elect to offer to individuals through the ACA marketplace. (Sen Schatz, [S. 2001](#) and Rep. Luján, [H.R. 4129](#)).

This policy brief summarizes key features of these proposals, highlights similarities and differences, and discusses key questions, trade-offs and potential implications. Several of these proposals have both a House and Senate sponsor; throughout the document, we refer to the sponsor who first introduced the legislation.

Overview of Current Proposals

MEDICARE-FOR-ALL

Medicare-for-All, an approach championed most recently by Senator Sanders in the Senate and Representative Ellison in the House, represents the most sweeping proposed change to the U.S. health insurance system among these proposals. Once fully implemented, a single, federal, government-administered program would provide coverage to all U.S. residents. Medicare-for-All would replace virtually all other sources of private health coverage (employment-sponsored plans and insurance offered inside and outside ACA marketplaces) and most public programs, including Medicare, Medicaid and CHIP. Medicare-for-All would result in a major shift in the way in which health care is financed in the U.S. -- away from households, employers and states to the federal government and taxpayers.

The new Medicare-For-All program would cover all medically necessary services, with defined categories of benefits to be covered, as well as dental and vision services -- a broader definition of benefits than is currently covered by Medicare or by the ACA essential health benefits. Under the Ellison bill, the new public plan would also cover long-term services and supports (LTSS), whereas under the Sanders bill, Medicaid would continue to provide LTSS. The Sanders bill would have the public plan cover all reproductive health services, including abortion, and would repeal the Hyde Amendment. Under both bills, there would be no premium or cost-sharing requirements, other than limited cost sharing (up to \$200 per year) on prescription drugs to encourage the use of generics under the Sanders bill. The Sanders bill would establish a beneficiary ombudsman program to help consumers with complaints, grievances, and requests for information, and to track and identify for the Secretary of Health and Human Services issues and problems in payment or coverage policies.

Both Medicare-for-All proposals would establish a global budget for health expenditures. In addition, they would create a national fee schedule to make payments to hospitals and other facilities, doctors and other health professionals, and prohibit balance billing. The Sanders bill would establish a fee schedule consistent with Medicare payment rates, and a new process for updating such rates. The Ellison bill would take a somewhat different approach, establishing Medicare payment rates through negotiations between providers and State and regional directors, subject to the approval of the Medicare director. The Sanders bill would leave an option for providers and patients to enter into private contracts instead of using Medicare, while the Ellison bill has no similar provision. The Ellison bill would prohibit participation in Medicare by for-profit hospitals and facilities and by investor-owned provider practices. Both bills would require the Secretary to negotiate drug prices with manufacturers.

The on-budget cost of the new Medicare-for-All program would be partially offset by the elimination of current federal spending obligations for public programs (e.g., Medicare, Medicaid, CHIP), tax

expenditures for employer-sponsored coverage and subsidies for ACA marketplace coverage. Both bills envision administrative savings associated with having one payer, and with having a single, Medicare-for-All fee schedule with lower rates than would otherwise be paid by employers and private insurers. The Ellison bill generally describes new revenue sources to cover additional costs; the Sanders bill, as drafted, does not specify further financing, although other financing options are described in a separate [white paper](#).

The Sanders bill envisions a four-year phase-in period for implementation. During this time, a transitional public plan option, similar to Medicare, would be offered through the marketplace with enhanced income-related subsidies available. Also during the phase-in period, the current Medicare program would be enhanced with a new out-of-pocket limit on annual cost sharing for Medicare-covered services, coverage of dental and vision benefits, and by expediting Medicare coverage for people with disabilities on SSDI by eliminating the 24-month waiting period.

FEDERAL PUBLIC PLAN OPTION

Three proposals would establish a federal public plan option to build upon, rather than replace, the current blend of private insurance and public coverage. In general, the bills aim to address some of the shortcomings in ACA marketplaces by giving individuals and employers a new option that may provide more affordable coverage. Two of these proposals invoke Medicare in naming the public plan (Medicare Part E and Medicare-X); the Schakowsky bill incorporates many of Medicare's features in the public plan, without using its name.

Under all three bills, the public plan option would be offered alongside private insurance through the ACA marketplace to individuals and small employers eligible to purchase coverage there. Two of the bills would also offer the public plan in the individual and small group markets outside of the marketplace. The Merkley bill would further extend eligibility to large employers who could obtain coverage under the public plan on behalf of their employees, while remaining in compliance with ACA requirements. The Merkley bill would allow large employers to buy fully insured large group policies from Medicare Part E, transferring risk to the public program. It would also allow self-insured group plans to retain risk and contract with Medicare Part E for third-party administrative services, such as paying claims and establishing a provider network and fee schedule. The Bennet bill would phase in the public program, beginning in areas with limited competition.

All three bills would make the public plan eligible for marketplace premium and cost-sharing subsidies for eligible individuals. The Merkley bill would expand income eligibility for both premium and cost-sharing subsidies throughout the marketplace and enhance these subsidies for all participants by tying them to Gold-level plans. None of the bills would affect ACA subsidies for small employers.

Under each of the three proposals, the new public plan would cover (at a minimum) all ACA essential health benefits. The Merkley Medicare Part E plan would also cover all Medicare benefits (Parts A, B and D), all reproductive services, and abortion. The Schakowsky and Bennet bills would offer the public plan

at all ACA metal levels and would apply the ACA annual out-of-pocket limit on cost sharing. Under the Merkley bill, the public plan would be offered at the Gold metal tier, and all marketplace subsidies would be tied to the Gold tier (vs. the Silver tier under current law), which would result in reduced cost sharing for most marketplace participants. The Merkley bill would also enhance financial protections under the current Medicare program by adding an out-of-pocket limit on cost sharing, which could affect program spending and premiums.

All three bills would set the public plan premium to cover all costs for covered benefits and require the public plan to follow ACA rating rules. The Merkley bill would also extend ACA rating rules to the large group market, a departure from current law.

Two of the proposals contain new consumer assistance provisions. The Schakowsky bill would establish an office of the ombudsman for the public plan to educate consumers about this coverage option and help them resolve complaints and grievances. The Merkley bill would authorize direct federal spending for marketplace navigator programs (vs current law funding by marketplaces) at funding levels needed to address capacity limitations. The Merkley bill also would require employers that do not offer health benefits to refer their employees to navigators.

All three proposals would require hospitals, physicians and other health care providers participating in Medicare to participate in the new public plan; this would result in a broad network of providers because [the vast majority of all hospitals and physicians participate in the current Medicare program](#). The Schakowsky and Bennet bills would also require Medicaid providers to participate in the public plan which would include pediatricians and others who may be less likely to treat the current Medicare population. Providers would have the ability to opt out of participating in the public plan without penalty under the Schakowsky bill. The three proposals would also require the Secretary to allow other providers to participate in the public plan – an important consideration in providing health coverage for children, and for meeting the needs of individuals with special needs.

All three bills would extend Medicare payment rates, or some variation on those rates, to providers participating in the public plan to help lower the overall cost of the program, which in turn would reduce premiums and out-of-pocket cost sharing for patients. The Schakowsky proposal would have the Secretary negotiate rates with providers, using Medicare payment rates as a back-up, if negotiations are not successful. The Bennet proposals would use Medicare rates for the new Medicare-X plan, and authorize the Secretary to increase rates by up to 25% in rural areas. The Merkley proposal directs the Secretary to negotiate payment rates for Medicare Part E, between Medicare and private insurance plan rates.

None of the public plan option bills specifically prohibits balance billing by physicians and other providers who treat patients enrolled in the public plan; however to the extent that they adopt Medicare payment rates and rules, these bills would appear to apply Medicare limits on balanced billing to the public plan. Under current rules, participating providers agree to accept assignment for all of their Medicare patients,

and are prohibited from balance billing; non-participating providers do not agree to accept assignment for all patients or all services, and may choose to charge patients higher fees, up to a certain limit.

All three bills acknowledge [ongoing public concern about prescription drug costs](#) by authorizing the Secretary to negotiate drug prices for the new public plan; two of the three proposals (Bennet and Merkley) would extend this policy to the current Medicare program. Under current law, [the Secretary is prohibited from negotiating payments with drug manufacturers](#) on behalf of Medicare Part D enrollees. The Merkley proposal is the only one of the three bills to include a failsafe to leverage lower drug prices under Medicare Part E and the current Medicare program. If negotiations are not successful in obtaining an appropriate price as determined by the Secretary, prices would be paid based on the lesser of those paid by the [Veterans Administration](#) or the [federal supply schedule](#). In other respects, the three bills do not change the current Medicare program, other than the limit on out-of-pocket spending added to the current Medicare program under the Merkley proposal.

MEDICARE BUY-IN FOR OLDER ADULTS

Two proposals focus specifically on creating a new Medicare buy-in option for older adults – ages 55-64 in the Stabenow bill and 50-64 in the Higgins bill. These proposals would give eligible individuals the option to buy into Medicare. (This differs from an alternative approach that would simply lower the age of Medicare eligibility from age 65 to age 50 or 55.) The Higgins bill would also allow adults ages 50-64 who are eligible for job-based coverage to elect the Medicare buy-in option, and allow employers to pay Medicare premiums on their behalf – a feature that could expand the number of older working individuals who select the buy-in option.

Under the Stabenow bill, enrollment in the buy-in plan would be managed by Medicare, while under the Higgins bill enrollment in the buy-in plan would be conducted through the marketplace. Both bills would allow marketplace subsidies to apply to the buy-in plan for individuals otherwise eligible for subsidies, so the marketplace would continue to be the place where people apply for financial assistance.

Under both bills, the Medicare buy-in plan would offer Medicare benefits rather than ACA benefits. Under both bills, Medicare cost-sharing standards would apply, with no annual out-of-pocket limit on cost sharing for individuals who enroll in Medicare (unless they enroll in private Medicare Advantage plans (assuming current rules apply) or qualify for cost-sharing subsidies through the marketplace. Both proposals would give buy-in enrollees the option to buy Medicare Advantage plans instead of fee-for-service coverage, and both would require private Medigap policies to be offered on a guaranteed-issue basis to buy-in enrollees. In other words, older adults not yet eligible for the current Medicare program would potentially have access to private marketplace plans, private Medicare Advantage plans, and traditional Medicare (Parts A, B and D) with an option to purchase Medigap – each with different guaranteed benefits, rating rules, premium and cost-sharing subsidies and provider networks.

Under both bills, rating rules for the buy-in plan would be somewhat different from those for marketplace plans. The bills would set the buy-in premium to cover the full cost of benefits provided under Medicare

Parts A, B and D for enrollees, plus administrative expenses. The Stabenow bill would establish a single, national premium while the Higgins bill would apply a geographic adjustment. Neither proposal would adjust buy-in premiums for age, in contrast to current marketplace rules.

Buy-in enrollees would be eligible for ACA-based premium and cost-sharing subsidies. The Higgins bill would also enhance cost-sharing subsidies available through all Silver plans in the marketplace and would extend these subsidies to individuals with income up to 400% of the federal poverty level (FPL). When buy-in enrollees become eligible for the current Medicare program, at age 65, [premium and cost-sharing subsidies](#), and other coverage features, would revert to those applicable to Medicare beneficiaries under current law.

Marketplace premium subsidy amounts would be calculated somewhat differently for buy-in enrollees. Presumably because rating rules would be different than for other private plans, the Medicare buy-in option would not “compete” with other marketplace plans to be the second-lowest-cost Silver plan; rather the Secretary would determine how subsidies would be calculated for buy-in enrollees.

Both proposals would require all Medicare participating providers and facilities to participate in the buy-in plan for older adults; and, to help constrain costs, reimburse [hospitals, physicians](#) and other participating providers using Medicare payment rates, which [typically are lower and less variable](#) than the [rates paid by commercial insurers](#). Using Medicare payment rates would tend to make the buy-in plan more cost competitive relative to private plan options. Though the bills do not address balance billing specifically, by adopting Medicare provider payment rules, it appears that Medicare limits on balance billing would also apply to enrollees in the buy-in plan.

The Higgins proposal would also authorize the Secretary to negotiate lower drug prices for the buy-in population and for the current Medicare program – the only change in the bill that would directly affect the current Medicare program.²

The Higgins bill would make other changes aimed at stabilizing the private individual insurance market. It would establish a federal reinsurance program to help cover high-cost medical claims, and reauthorize the temporary ACA risk corridor program through the year 2020. It also would appropriate \$500 million per year, in 2018 through 2020, for consumer assistance programs to raise awareness about new subsidy and coverage options and help people enroll.

Both bills specify that the buy-in program would be financially separate from the current Medicare program, and that benefits under the current program, and the Medicare trust funds would not be affected. The Higgins proposal establishes a separate trust fund for the purpose of collecting premiums and making payments for services provided to individuals enrolled in the Medicare buy-in plan.

STATE PUBLIC PLAN OPTION

The public plan option envisioned under the Schatz bill would build on the Medicaid program rather than Medicare. Under this approach, states would have the option of creating a Medicaid buy-in program that would be offered through the marketplace alongside other private plans.

For states that elect this option, the bill would allow individuals at all income levels to buy into Medicaid, as long as they are not enrolled in other coverage. The Medicaid buy-in option would be offered as a Silver-level plan through the marketplace. Medicaid buy-in enrollees would receive an alternative benefit package (ABP), which includes the ACA essential health benefits, and could be defined by states to include the full Medicaid benefit package.

States may set premiums for the public plan that are “actuarially fair.” States may vary premiums by the same factors as ACA marketplace plans (age, geography, family size and tobacco use). Deductibles and other cost sharing amounts would also be determined by the electing state to be actuarially fair, with an annual out-of-pocket limit on cost sharing (set at \$7,350 in 2018).

The bill does not require that premiums and cost-sharing payments cover the full costs of the buy-in program. Instead, states would receive federal matching payments for any costs for the Medicaid buy-in program that are not covered by premiums and cost-sharing payments. With this flexibility, states could promote enrollment in the public plan by setting premiums lower than commercial plans, and count on the federal government to make up some of the cost; though as under the current Medicaid program, they would be required to finance the state share of these costs. The bill also provides an enhanced 90% federal matching rate for administrative costs associated with the buy-in program.

This proposal would extend current law ACA premium and cost-sharing subsidies to people purchasing Medicaid buy-in coverage. In addition, it would cap premiums for the public plan at 9.5% of family income, which would make the Medicaid buy-in option more affordable than other marketplace plans for people with incomes above 400% FPL, the eligibility threshold for premium tax credits.

The Medicaid buy-in would rely on Medicaid participating providers, including Medicaid managed care organizations (MCOs) to deliver services. In an effort to improve access to care in the Medicaid program, including the buy-in option, the bill would require Medicaid to use Medicare payment rates as a floor for paying primary care providers and would appropriate \$100 billion in grants to states to enhance Medicaid provider payment rates. The grants would be available to all states, not just those establishing a buy-in program.

Additionally, the bill would extend to any state newly adopting the Medicaid expansion the 100% federal funding for three years and the phase-down of federal funding to 90%.

Key Policy Considerations

The eight bills introduced during the 115th Congress are similar in that they would each establish a public program, yet they differ in ways that could have significant implications for consumers, payers, health care professionals, and the federal budget. As of yet, CBO has not formally estimated the effects of these bills on costs or coverage. Below are key questions regarding the policy implications and tradeoffs involved in these various proposals.

1. HOW WOULD THE PROPOSALS PROVIDE AND EXPAND COVERAGE?

These eight proposals span a broad spectrum in terms of eligibility rules that are likely to affect the number of people who would gain coverage and the size of the public program. The two Medicare-for-All proposals would build a single, national public program, replacing all other forms of coverage, to cover all individuals residing in the U.S. The Medicare-for-All bills would adopt a broader definition of eligibility than is used for Medicare, Medicaid or marketplace plans, which limit eligibility based on citizenship and immigration status, potentially benefiting [millions of lawfully present and undocumented immigrants](#).

The three federal public plan proposals would offer a public option to augment the current mix of public and private sources of coverage. Among these three plans, the Merkley proposal would extend eligibility to all U.S. residents, permit large and small employers to offer public plan coverage, and enhance cost-sharing subsidies, all of which could lead to larger public plan enrollment than under the two other public plan proposals. None of the public plan proposals would address the coverage gap that persists in states that have not expanded Medicaid, in which more than [two million adults](#) have incomes too high to qualify for Medicaid eligibility yet below the lower limit of 100% FPL for marketplace premium tax credits.

The two Medicare buy-in proposals for older adults who are not yet eligible for the current Medicare program would likely lead to a smaller public plan than the aforementioned proposals due to age restrictions. Of these two proposals, the Higgins bill could reach a larger number of older adults because it defines eligibility somewhat more broadly (ages 50-64, rather than age 55-64), allows employers to pay premiums for their older employees if they opt in, and enhances premiums and cost-sharing subsidies.

The Medicaid buy-in proposal would make the public plan an option for states. This approach would limit its availability to residents of states that elect to establish a Medicaid buy-in.

2. HOW WOULD THE PROPOSALS AFFECT THE AFFORDABILITY OF COVERAGE FOR CONSUMERS?

While the ACA has made significant inroads in [reducing the number of people without health insurance](#), [affordability challenges](#) have continued, particularly among people with significant health needs. In 2017, more than one-in-four insured non-elderly adults [skipped or delayed care due to costs](#) or had problems paying out-of-pocket medical bills; among the insured in fair to poor health, nearly one-in-three faced such affordability problems. The Medicare-for-All bills take the most comprehensive approach to improving affordability by eliminating premiums and cost-sharing requirements, and adding benefits, such

as dental and vision. However, these costs would ultimately be shifted back to some individuals in the form of higher taxes, meaning some people would end up paying more while others would pay less.

Several of the other bills would address affordability issues in the marketplace by enhancing premium and cost-sharing subsidies for currently eligible individuals, by capping premiums for individuals not eligible for premium tax credits, and, in some cases, by making more people eligible for subsidies. Limits on provider payments (Medicare payment rates) would be expected to put downward pressure on premiums and other costs. Two of the bills would enhance financial protections for individuals by prohibiting balance billing by providers. The others are silent on balance billing, although to the extent those proposals use Medicare or Medicaid provider payment rates, they would appear to incorporate into the public plan limits and prohibitions on balance billing that apply under those programs today.

In addition, one of the bills would address [the financial burden of health care for people covered under the current Medicare program](#) by adding an annual out-of-pocket limit. Virtually all of the proposals aim to make prescription drugs more affordable for people in both the current Medicare program and the new buy-in proposal by giving the Secretary the authority to negotiate lower drug prices.

3. HOW WOULD THE PROPOSALS AFFECT MARKETPLACE COVERAGE?

As of early 2018, more than [14 million](#) people obtained non-group coverage through ACA marketplaces or outside in the individual market. The introduction of a new public plan could change marketplace dynamics and premiums. Premiums for the public plan could be higher or lower than private marketplace plans depending on a number of factors, including the level of fees paid to providers, rating rules, the comparability of benefits, and other features. For example, as noted above, the use of Medicare provider payments in the public plan would put downward pressure on costs, which would likely lead to lower premiums for coverage under the public plan compared to marketplace plans.

At the same time, the methodology used to set premiums could potentially mitigate the cost advantage of the public plan. Premiums for a Medicare buy-in for older adults could conceivably be higher than premiums for marketplace plans for people of a similar age because the risk pool is restricted to older, higher-cost adults. Further, if the public plan uses a uniform, national premium and private insurers set premiums based on local costs, the public plan could be more competitive in high cost areas, and less competitive in low cost areas. To the extent that the rules for setting premiums are not aligned for private plans and the public program, individuals may be more attracted to one over the other, potentially destabilizing the marketplaces.

Several of the public plan option proposals include provisions to stabilize or strengthen marketplaces generally – for example, by enhancing the value of cost-sharing subsidies, establishing new risk-stabilization programs, and/or by enhancing consumer enrollment assistance and outreach.

4. HOW WOULD THE PROPOSALS AFFECT PRIVATE EMPLOYER-SPONSORED HEALTH COVERAGE?

Currently, a majority of the non-elderly U.S. population – [more than 150 million people](#) – have job-based health benefits. The Medicare-for-All bills would replace employment-based (and virtually all other forms of coverage) with the new plan. The other six public plan proposals would retain a role for employer-sponsored coverage, while giving employers access to the public plan to varying degrees. Under one proposal, all employers, including large employer-sponsored plans, could opt to obtain coverage under the public plan on behalf of their employees. Others would allow small (but not large) employers to offer the public plan to their employees by purchasing public plan coverage through the small group market or the SHOP marketplace. One plan would allow employers to pay premiums on behalf of their enrollees who choose to opt into the public plan, a departure from current law.

If employers are able to reduce health costs by offering coverage under the public plan, the public plan could take on a relatively large role as a source of coverage. Employers could realize savings by gaining access to the lower provider payment rates in the public plan. In addition, although none of the bills allow employers to selectively enroll high-cost enrollees in the public plan, employers with higher than average medical costs might realize savings by shifting their employees to the public plan, which in turn could lead to adverse selection and higher costs in the public plan. Most of these bills also would retain current law rules that make people ineligible for subsidies if they are eligible for employer-sponsored coverage that meets minimum standards; this “firewall” would limit the ability of individuals to shift from job-based coverage into the public plan.

5. WOULD THE NEW PUBLIC PLAN OPTIONS BE THE SAME AS THE CURRENT MEDICARE PROGRAM?

Six of the eight bills invoke Medicare’s name for the public plan, likely in part because [Medicare enjoys broad support among the public](#). Yet, the proposed public plans differ from the current Medicare program in several ways, including covered benefits, the methodology used to calculate premiums, and the availability of premium and cost-sharing subsidies. The two Medicare buy-in bills for older adults would adopt current Medicare benefits and cost sharing for the public plan; the two Medicare-for-All bills would cover far more expansive benefits; and the other proposals align either with ACA-required essential health benefits or with a combination of ACA and Medicare benefits.

None of the bills would set premiums for the public plan using the same methodology used in the current Medicare program. In general, the proposals set premiums for public plan enrollees to cover 100% of benefit costs, including administrative expenses. In contrast, premiums for the current Medicare program are not set to cover full program costs. Further, the buy-in bills tend to use premium and cost-sharing subsidies, and eligibility levels, established for the ACA marketplace, rather than those that apply to people covered under the current Medicare program (such as those used for the Medicare Savings Programs or the Part D low-income subsidy program.) To the extent public plan enrollees receive more

generous subsidies, lower-income individuals would face a financial “cliff” when they age onto the current Medicare program.

The Medicare-for-All and public plan proposals tend to track the current Medicare program when it comes to provider participation and in using Medicare provider payment rates to leverage overall savings in health spending (with some variation, as noted below).

6. HOW WOULD THE PROPOSALS AFFECT THE CURRENT MEDICARE PROGRAM?

Six of the eight public plan proposals leave the current Medicare program generally intact, with the notable exception of the Medicare-for-All bills that would replace the current Medicare program with a new and more comprehensive Medicare program. Four of the public plan bills would modify rules pertaining to the Medicare Part D benefit, by allowing the Secretary to negotiate drug prices. One proposal would enhance the current Medicare program by adding an out-of-pocket limit to Medicare Parts A, B and D, which would help align financial protections under the new and existing Medicare programs, but would also lead to higher Medicare spending and higher premiums. The Sanders bill would enhance the current Medicare program during an interim implementation phase, by adding an out-of-pocket limit, covering vision and dental, and by expediting eligibility for people with disabilities.

Several of the public plan buy-in bills include explicit language to protect the Medicare trust funds and Medicare benefits from changes made under the proposal.

7. HOW WOULD THE PROPOSALS AFFECT THE CURRENT MEDICAID AND CHIP PROGRAMS?

The two Medicare-for-All proposals would replace or fundamentally restructure Medicaid’s role in providing health coverage to low-income and other vulnerable populations. The Ellison proposal would eliminate Medicaid entirely while the Sanders bill would retain Medicaid for purposes of providing long-term services and supports. The Sanders bill would impose requirements on states to maintain eligibility standards and expenditures on long-term services and supports at 2017 levels. Both proposals would eliminate the CHIP program.

The remaining bills, including the Medicaid buy-in bill, would leave the Medicaid and CHIP programs intact. The Schatz proposal would address Medicaid provider payment rates and access-to-care issues by requiring states to increase payments to primary care providers and by providing funding for states to increase payments to other providers. However, the one-time allocation of federal grant funds to finance the state share of the payment increase would not likely compensate states for the increased costs associated with the payment rate increase over the long term.

The proposals also mostly do not address the failure of 17 states to adopt the ACA’s Medicaid expansion. One proposal would extend the 100% federal financing to states newly adopting the expansion to

encourage state action, while the two Medicare-for-All bills would federalize coverage for all low-income adults.

8. HOW WOULD THE PROPOSALS ADDRESS THE NEEDS OF SPECIFIC POPULATIONS?

While the bills intend to improve the affordability, and in some cases, the comprehensiveness, of health coverage, in general they vary in how they would address the specific needs of special populations, such as children, women of reproductive age, and people with disabilities and high health care needs,

Children, in particular, have special needs and special providers that serve them. While most of the bills incorporate the ACA's 10 essential health benefits, which include pediatric services and dental and vision services for children, none of the bills define a specific benefit package for children. Except for the two Medicare-for-All proposals, the other bills would retain the Medicaid and CHIP programs and their important role in covering low-income children. However, the special EPSDT protections provided to children through the comprehensive coverage requirements in Medicaid are not extended to children who would gain coverage under Medicare-for-all, the federal public plans, or the Medicaid buy-in plan. The three public plan proposals recognize the importance of including providers that serve children in the plan networks, by requiring participation of both Medicare and Medicaid providers and/or including a process for allowing other providers to participate.

For people with disabilities and high health care needs, the adequacy of health plan provider networks matters can be especially important. [Most marketplace plans](#) today and a [smaller share of job-based plans](#) used closed or narrow provider networks. By contrast, nearly all of the public plan proposals would significantly expand provider networks for their enrollees. Proposals that eliminate or lower out-of-pocket costs, which several of the proposals do, would remove or reduce cost as a barrier to accessing care for those with high health care needs. While most of the proposals would retain Medicaid as the primary payer of long-term services and supports for people with disabilities, one proposal (Ellison) would incorporate these services into the plan's benefit package. It also proposes a payment methodology that emphasizes the provision of long-term services and supports and mental health services in community-based settings, thus significantly expanding access to these services.

Finally, several bills specify that reproductive services, including abortion, should be a covered benefit and some bills (Sanders; Merkley) include explicit language to repeal the Hyde amendment restrictions on public funding for abortion. The [Hyde amendment](#), first adopted more than 40 years ago, prohibits federal funds from being used for abortion, other than in the case of rape, incest or if the pregnancy is determined to endanger the life of the woman. If the Hyde amendment is not repealed and if its restrictions attach to the public plan, then fewer women of reproductive age could have access to abortion services in the future. Numerous efforts to repeal the Hyde amendment have failed in the past.

9. HOW WOULD THE PROPOSALS AFFECT PAYMENTS TO PROVIDERS?

Most of these proposals would result in broader use of Medicare rates – or some similar approach -- to reimburse hospital and medical care. In general, the proposals would adopt a fee schedule for the public plan with the goal of reducing total health spending (and premiums) by reducing high fees paid by commercial insurers relative to Medicare, and, in the case of Medicare-for-All, by eliminating excess administrative costs attributable to having multiple payers, with multiple fee schedules and multiple rules pertaining to coverage. The Medicare-for-All proposals would establish global budgets, under which there would be a fee schedule for providers. The public plan and Medicare buy-in proposals typically adopt Medicare payment rates, or anchor their provider rates to Medicare levels in some fashion, which would tend to be lower than private insurance and higher than Medicaid.

The impact of using Medicare payment rates on provider revenues would vary across the eight proposals, with the greatest effect under the Medicare-for-All proposals. Under the Medicare-for-All plans, the shift toward a payment system that is tied more directly to Medicare rates could significantly lower revenues for hospitals, physicians and other providers. The reduction in payments for private patients would be offset partially by the higher fees paid to providers for Medicaid and previously uninsured patients – a change that would be particularly beneficial to health care professionals who care for those patients. The public plan buy-in proposals would also have an effect on provider revenue, but to a lesser extent, depending on the number of additional patients covered under the new public plan.

The Schatz proposal, which builds on Medicaid rather than Medicare, would increase payments to primary care providers to Medicare rates, and establish a \$100 billion fund to increase Medicaid reimbursement rates generally in order to expand provider participation.

10. WHAT COST CONTAINMENT FEATURES ARE IN THE PROPOSALS?

Despite the recent slowdown in health care spending, health care costs are projected to increase at a [faster pace](#) than general inflation in the future. All of the bills include provisions that would restrain the growth in health care spending in varying ways. The Medicare-for-All bills would establish global budgets for health care. All of the bills would expand the use of Medicare provider payment rates (or a variation of Medicare rates) by applying them to providers participating in the public plan. Where public plans compete with private plans for enrollees, this could create an incentive for commercial insurers to reduce the relatively high and variable fees they currently pay and reduce overall costs. Most proposals would authorize the Secretary to negotiate drug prices for the public plan and for the current Medicare program, recognizing strong public support to address the high cost of pharmaceuticals. In addition, most of the plans would encourage payment and delivery system reforms that aim to improve quality and reduce costs.

11. WHAT ARE THE COSTS AND POTENTIAL TRADE-OFFS?

As noted above, CBO has not yet published estimates of how these proposals would affect health coverage or federal costs. All of the bills contain at least some provisions, such as expansion of current marketplace subsidies, or enhancements to current Medicare or Medicaid programs, that would result in

new federal spending. At the same time, these proposals, to varying degrees, would also result in reductions in out-of-pocket spending for individuals, by broadening eligibility rules, reducing premiums and/or cost-sharing liability, improving benefits, and limiting or eliminating balance billing and – by extension – [surprise medical bills](#). Proposals that significantly reduce patient out-of-pocket spending would tend to increase use of services and overall health spending. Some proposals could also result in significant savings for states and employers. Some of the proposals, notably the two Medicare-for-All bills, would result in a significant redistribution of costs, particularly after taxes are taken into account, which would create winners and losers, and tradeoffs that are likely to arise as the debate moves forward

The Medicare-for-All bills include features to rein in health spending, such as global budgets, a Medicare-like fee schedule, and administrative savings that would derive from having a single payer, but would increase on-budget federal spending by expanding coverage to more people and by enhancing the coverage people get under the public plan. Federal spending would increase as costs are shifted from households, employers and states to the federal government.

The public buy-in plans aim to give individuals and, in some instances, employers a more affordable option, that limit, to varying degrees, the on-budget costs for the federal government. They generally require enrollee premiums to cover 100% of program costs, including administrative expenses. Other features of these proposals, however, would likely impact cost estimates, such as premium and cost-sharing subsidies for public plan enrollees, premium and cost-sharing enhancements for private marketplace enrollees, and benefit enhancements for the current Medicare program.

Under all of the bills, hospitals, physicians and other health care professionals would shoulder some of the cost, assuming the public plan uses Medicare payment rates, rather than the higher rates typically paid by commercial insurers. Commercial insurers themselves could lose revenue depending on the size of the public plan; the impact would be far greater under Medicare-for-All than under some of the public plan options. The introduction of a public plan option could also have adverse effects on private insurance industry profits and jobs, although the Medicare-for-all proposals include provisions to address potential job loss. It is also possible that insurers could gain opportunities under some proposals, such as the Medicare buy-in bills, which would enable insurers to offer Medicare Advantage plans to adults who have not reached age 65. Further, if the Medicare buy-in plan draws higher-cost people away from private marketplace coverage, and premiums for younger enrollees decline (favorable selection), insurers may be able to expand their footprint in the marketplace.

Formal cost estimates, with specified financing, are needed by policymakers to fully assess the cost implications and the magnitude of tradeoffs involved for consumers, who are also taxpayers, and for other payers.

12. HOW WOULD THE PROPOSALS BE FINANCED?

The two Medicare-for-All proposals acknowledge the need for financing to cover the costs of the new program, after taking offsets into account. Senator Sanders released a [white paper](#) discussing financing

options; Rep Ellison's bill lists sources of financing that would be tapped to cover expenses (e.g. increase personal income tax on top 5% of earners). Both proposals envision a major shift in the way in which health care is financed in the U.S., away from households, employers, and states to the federal government (and taxpayers). Such a shift would no doubt create winners and losers, relative to the current system.

As noted above, several of the public plan buy-in proposals would have premiums cover the costs of covered benefits for people who buy into the public plan, although the financing for additional costs (not yet estimated) are not specified. The Schatz Medicaid buy-in bill would finance the public plan with a combination of premiums and other revenues along with federal Medicaid matching payments. How these additional federal costs will be financed is not specified.

Discussion

With health care reemerging as an issue for voters in the mid-term elections, the debate over the role of public programs in our health care system appears to be intensifying. Current proposals offer a range of approaches from those that would transform the existing system by creating a new national, Medicare-for-All plan to more incremental approaches that would offer a new public plan option alongside existing private coverage and public programs. With many details yet to be provided, these proposals raise a number of questions, the answers to which will have important implications for consumers, health care professionals, and health care payers, including employers, states, and the federal government. While these proposals are not expected to advance in their current form, they highlight the range of approaches that will likely emerge in legislation in the new session of Congress following the 2018 elections.

Public polling indicates that proposals to create a national Medicare-for-All plan or to expand Medicare through a public plan option or buy-in receive [favorable ratings](#). However, public opinion is malleable when information is presented in support of or in opposition to the proposals, suggesting that the specifics of how plans are designed and communicated will matter to future public support.

Endnotes

¹ H.R. 676 was introduced originally by Representative Conyers. On March 7, 2018, Representative Ellison received unanimous consent to be considered the first sponsor.

² The Stabenow bill does not include a provision to authorize the Secretary to negotiate lower drug prices; however, Senator Stabenow has co-sponsored other legislation that would do so.