THE COUNCIL
The Council of Insurance Agents & Brokers

Steptoe
STEPTOE & JOHNSON LLP

2019 Federal Single Payer & Public Option Legislation

March 19, 2019

Below are brief summaries of active federal legislation containing single-payer, public option, or "buy-in" healthcare proposals. The document is divided into the different types of proposals:

"Single-Payer" legislation (e.g., Medicare for All) – establishes one government-administered health plan to replace or phase out current sources of public and private coverage.

"Buy-In" or "Public Option" legislation – leverages existing government-run programs to offer an additional coverage option to consumers (sometimes a target population based, for example, on age or income) that would typically be sold alongside existing coverage options.

Single-Payer Proposals

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Medicare for All Act of 2019 (H.R. 1384) Rep. Pramila Jayapal (D-WA) Single payer; establishes the Medicare for All Program House Summary	Prohibits employers from providing benefits that duplicate benefits provided under Medicare (also amends ERISA to prohibit employee benefit plans from providing duplicative benefits) Allows employers to provide additional benefits—i.e., those not otherwise covered by Medicare—to employees Amends ERISA's continuation of coverage requirements to apply only to plans	Makes all U.S. residents eligible For individuals 0-18 or 55+, makes benefits available 1 year after the date of enactment For all others, makes benefits available 2 years after the date of enactment (in the intervening two years, individuals can retain coverage provided by another federal program or from the private health market) Establishes a Medicare Transition buy-in plan during the intervening two years that will be offered on the state and federal exchanges Requires HHS to develop a process for automatic	Authorizes payments to providers for comprehensive benefits (i.e., EHBs plus a few additions) that are "medically necessary;" "appropriate for the maintenance of health;" or "appropriate for the diagnosis, treatment, or rehabilitation of a health condition" Allows HHS to—at least annually—evaluate whether the benefits package should be improved or adjusted Permits states to provide additional benefits Entitles covered individuals to specific long-term care services/supports in certain circumstances	Does not offer cost-sharing (including deductibles, coinsurance, or copayments) for any of the comprehensive benefits	Does not propose any specific funding mechanism Establishes the Universal Medicare Trust Fund (and requires amounts equal to those appropriated to Medicare, Medicaid, and other federal health programs be deposited in the fund during the first fiscal year benefits are available)	*Treatment of Other Coverage.* Retains the Veterans Affairs health system and the Indian Health Services (other federal programs would be transitioned) *Provider Participation.* Authorizes all state-licensed or certified providers to participate in the program *Balance Billing*. Prohibits balance billing *Private Contracts.* Prohibits participating providers from entering into private contracts for covered benefits with eligible individuals and authorizes participating providers to enter into private contracts with ineligible individuals for noncovered benefits *Data Collection.* Requires participating providers to report any data required by the provider's state, certain annual financial data, etc. *Individual Mandate.* Enrollment satisfies the individual mandate (i.e., qualifies as minimum essential coverage) under the ACA *Prescription Drugs.* Requires HHS to negotiate prices for pharmaceuticals, medical supplies, and medically

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
	that do not duplicate payment for covered benefits	enrollment at the time of an individual's birth (or upon establishing residency) Provides enrolled individuals with a Universal Medicare card for the purposes of identification and processing of claims Authorizes states to provide benefits to individuals who may not be otherwise be eligible for coverage				necessary equipment based on several facts (e.g., comparative clinical and cost effectiveness, budget impact of providing coverage, etc.) Contains other provisions regarding: • Non-discrimination • Long-term care coverage • Specific provisions related to participating providers and payments to such providers • Administration of the program (at the federal, regional, and state level) • Quality standards for the program • Termination of the ACA infrastructure (e.g., the federal and state exchanges) • Treatment of reproductive services

Medicare Buy-In Proposals

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Medicare Buy-In and Health Care Stabilization Act of 2019 (H.R. 1346) Rep. Brian Higgins (D-NY) Medicare buy-in for ages 50-64	Does not appear to disrupt employer-sponsored coverage (i.e., eligible individuals continue to have the option to enroll in private coverage) The ***prior legislation's*** section-by-section notes that HHS will need to set guidelines for how employers provide eligible employees with	Makes U.S. residents between ages 50-64 eligible, provided they are not otherwise entitled to benefits under Part A or eligible to enroll under Part A or Part B (but would be eligible under Parts A or B if the individual were 65 years of age) ***but*** prohibits: • States from buying Medicaid beneficiaries ages 50-64 into the Medicare buy-in option; and • Individuals otherwise eligible for a State's Medicaid plan	Provides the same benefits as those offered to individuals entitled to benefits under Part A and enrolled under Parts B and D (including the ability to enroll in an MA prescription drug plan and	*Premiums.* Requires HHS to determine premium, set at average annual per capita amount for benefits and administrative costs Authorizes HHS to calculate premiums separately for different ages if doing so would increase enrollment and reduce the risk of adverse selection Allows individuals to choose MA or Part D plans that require	Sets the premium for the buy-in plan to cover benefit and administrative costs Establishes a Medicare Buy-In Trust Fund—which is funded by premiums and transfers based on financial	*Reinsurance Fund.* Establishes an individual market reinsurance fund to provide funding for an individual market stabilization reinsurance program in each compliant state *Prescription Drugs*. Authorizes HHS to negotiate with pharmaceutical manufacturers the drug pricing (including discounts, rebates, and other price concessions) that may be charged with PDP sponsors and MA organizations for covered part D drugs *Minimum Essential Coverage.* Treats enrollment as minimum essential coverage

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
	information on covered benefits and cost-sharing responsibilities under the group plan compared to early Medicare (requires such information to be provided to eligible employees when they are hired and in advance of open enrollment annually)	from receiving coverage under the Medicare buy-in option (unless the Medicaid coverage does not provide minimum essential coverage) Requires enrollment options to be available through state and federal exchanges Authorizes grants to carry out, among other things, enrollment activities to raise awareness of the availability of such plans and appropriates $500 million over the course of two fiscal years for such grants	access to the Medicare Beneficiary Ombudsman)	payment of additional premiums (but individual would be responsible for the increased monthly premium) *Financial Assistance*. Allows individuals to receive financial assistance that is "substantially similar" to the assistance the individual would have received if the individual were enrolled in a QHP through an exchange *Cost-Sharing.* Improves/enhances CSR payments (increases the percentages by which cost-sharing would be reduced for households up to 400% of the federal poverty line)	assistance—to reduce the premiums and cost-sharing for coverage of individuals who would be eligible for cost-sharing reductions and premium assistance under the ACA	*Medicare Direct Supplemental Insurance Option*. Requires HHS to offer a voluntary program to supplement the benefits provided by Medicare Parts A and B Contains other provisions regarding: • Access to Medigap and development of new standards for certain Medicare supplemental policies • Establishment of a Medicare Buy In Oversight Board • Outreach and enrollment • Extension of the ACA's risk corridor program • Integration into health demonstrations
Medicare at 50 Act (S. 470) Sen. Debbie Stabenow (D-MI) Medicare buy-in for ages 50-64	Does not disrupt employer-sponsored coverage (i.e., eligible individuals continue to have the option to enroll in private coverage)	Makes U.S. residents between ages 50-64 eligible, provided they are not otherwise entitled to benefits under Part A or eligible to enroll under Part A or Part B (but would be eligible for benefits under Part A or Part B if the individual were 65) Requires HHS to establish coverage and enrollment periods that are consistent with ACA enrollment periods Allows individuals to apply for Medigap on a guaranteed issue	Provides the same benefits as those offered to individuals entitled to benefits under Part A and enrolled under Parts B and D or a Medicare Advantage plan	*Premiums.* Requires HHS to determine premium, set at average annual per capita amount for benefits and administrative costs Allows individuals to choose MA or Part D plans that require payment of additional premiums (but individual would be responsible for the increased monthly premium) *Cost-Sharing.* Does not treat enrollees as eligible for Medicare cost-sharing assistance, but would	Sets the premium for the buy-in plan to cover benefit and administrative costs Establishes the Medicare Buy-In Trust Fund—which is funded by premiums paid by new enrollees—to provide cost-sharing	*Individual Mandate*. Satisfies the individual mandate/treats the plan as a QHP *Grant Program*. Establishes a grant program to carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of the buy-in plan (appropriates $500 million annually for outreach and enrollment grants) *Prescription Drugs*. Authorizes HHS to negotiate drug prices for Medicare prescription drugs

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
		basis each time they enroll in the buy-in plan		be eligible for premium assistance/CSRs under the ACA (treats the buy-in plan as a silver-level marketplace plan in determining eligibility)	assistance	

Medicaid Buy-In Proposals

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
State Public Option Act (S. 489/H.R. 1227) Sen. Brian Schatz (D-HI)/Rep. Ben Ray Lujan (D-NM) Medicaid buy-in	Does not disrupt employer-sponsored coverage (i.e., extends coverage only to residents that are not concurrently enrolled in other health insurance coverage)	Makes residents of states: • that select to establish a Medicaid buy-in option, • who are not concurrently enrolled in other health insurance coverage, and • who are eligible to participate in the marketplace eligible for participation Requires states that allow individuals to buy into Medicaid to facilitate enrollment through federal and state exchanges (also allows states to limit enrollment periods)	Requires the plan to offer a benefit plan that includes the ACA's EHBs	*Cost-Sharing.* Authorizes states to impose deductibles, cost-sharing, or other similar charges that are actuarially fair Provides that other cost-sharing protections (e.g., out-of-pocket limits) are consistent with the ACA *Premiums*. Authorizes states to impose premiums that are actuarially fair Allows states to vary the premium rate based on the factors allowed by the ACA rating rules Limits total amount of premiums imposed for a year to 9.5% of the family's household income	Partially finances the buy-in program through premiums Increases the federal medical assistance percentages (i.e., costs for the buy-in program would be financed with federal matching payments in the same way as the current Medicaid program)	*Eligibility for Premium Assistance.* Makes individuals who buy-in eligible for CSR payments (subject to the income eligibility threshold) and the premium tax credit (deems enrollment in the buy-in plan to be treated as coverage under a QHP in the silver level of coverage) Contains other provisions regarding: • Development of state-level metrics on access to/satisfaction with providers, with respect to individuals enrolled in Medicaid • Renewal of the application of the Medicare payment rate floor to primary care services furnished under Medicaid

Other Public Option Proposals

Legislation	Private Market Impact	Eligibility/ Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Keeping Health Insurance Affordable Act of 2019 (S. 3)***/Public Option Deficit Reduction Act*** (H.R. 1419) (***similar***)[1] Sen. Ben Cardin (D-MD)/Rep. Peter DeFazio (D-OR) Public option offered ***only*** through exchanges alongside private plans Senate Summary	Offers the public option on exchanges alongside private plans Does not directly address employer participation	Offers enrollment in the public option exclusively through the exchanges	Offers bronze, silver, and gold-level plans (may also offer platinum-level plans) Requires the public option—which qualifies as a qualified health plan—to comply with requirements applicable to other health benefit plans offered on the exchanges (i.e., same benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing requirements)	*Premiums.* Requires HHS to set geographically adjusted premium rates at levels to fully fund the benefits and administrative costs provided under public option *Payment Rates.* Requires HHS to set payment rates for services/providers (provides greater payment rates from 2020-2023, requiring them to be at a level that is consistent with those for equivalent services/providers under Medicare Parts A and B ***(the House bill contains exceptions to the payment rates for certain practitioners' services)*** Authorizes HHS to utilize innovative payment mechanisms and policies to determine payments for certain items and services (e.g., care management payments, performance/ utilization-based payments, etc.) under the public option Authorizes HHS to modify cost sharing/payment rates to encourage use of services that promote health and value	Establishes an account for receipts and disbursements attributable to the public option Appropriates $2 billion in "startup funding" to establish the public option and appropriates any additional funding needed to cover 90 days of initial claims reserves based on projected enrollment Requires HHS to repay "startup funding" over a 10-year period beginning in 2020	*Data Collection.* Requires HHS to collect data necessary to establish premiums and payment rates, improve quality, etc. *Provider Participation.* Requires HHS to establish conditions for provider participation in the public option (classifies all Medicare providers as "participating providers" in the public option, unless they opt out) (***the House bill contains language governing incentives for participating providers***) Contains other provisions regarding: • Administrative contracting • Establishment of an office of the ombudsman and its duties • Enforcement in federal courts • Development of innovative payment mechanisms • Payment for providers under the public option

[1] The Keeping Health Insurance Affordable Act of 2019 (S. 3) contains provisions well beyond those that create a public option; the Public Option Deficit Reduction Act (H.R. 1419) contains language that is nearly identical to the public option provisions within S.3, but it does not go beyond those provisions. To the extent there are differences between the bills, they are explicitly noted in the tracker.