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2019 Federal Single Payer & Public Option Legislation

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 (S. 1129/H.R. 1384) Sen. Bernie Sanders (I-VT)/Rep. Pramila Jayapal (D-WA) Single payer; establishes the Medicare for All Program (***House version***)/Universal Medicare Program (***Senate version***) Senate Summary; 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	Makes all U.S. residents eligible For individuals 0-18 (and 55+ ***in the House version***), 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) (***House version***) • 4 years after the date of enactment—phases in eligibility during that time, so during the first year, the	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" (***House version***: 14 benefit categories; ***Senate version***: 13 benefit categories) Allows HHS to—at least annually (***House version***) and on a regular	Does not offer cost-sharing (including deductibles, coinsurance, or copayments) for any of the comprehensive benefits Authorizes HHS to require cost-sharing for prescription drugs, provided that such cost-sharing: • Does not exceed $200 and	Does not propose any specific funding mechanism (***Senate version*** has a separate white paper that offers several options to finance the bill, including, among other things: • 7.5% income-based premium paid by employers; • Elimination of several tax breaks that subsidize health care (e.g., the exclusion of employer-paid premiums from	*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 (***House version***) Allows providers to enter into private contracts with enrolled individuals for covered services, provided certain requirements are met (***Senate version***)

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	by Medicare—to employees Amends ERISA's continuation of coverage requirements to apply only to plans that do not duplicate payment for covered benefits	eligibility age would be 55; during the second year, 45; and during the third year, 35 (***Senate version***) Allows eligible individuals to maintain any coverage (including private health insurance) during the transition period Establishes a Medicare transition plan during the intervening years that will be offered on the state and federal exchanges Requires HHS to develop a process for automatic 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	basis—evaluate whether the benefits package should be improved or adjusted Authorizes states to provide additional benefits Entitles covered individuals to specific long-term care services/supports in certain circumstances	• Is not imposed on individuals with incomes at or below 200% of the federal poverty line (***Senate version only***)	payroll and income) • 4% income-based premium paid by households; • Reform of the personal income tax system, among others) 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)	*Data Collection.* Requires participating providers to report any data required by the provider's state, certain annual financial data, etc. (***House version only***) *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 necessary equipment (***more expansive provisions in House version***) Contains other provisions regarding: • Non-discrimination (***similar***) • Long-term care coverage (***more expansive provisions in Senate version*** (e.g., institutional long-term services and supports covered under Medicaid)) • Specific provisions related to participating providers and payments to such providers (***House version only***) • Annual report to Congress regarding the operation of the universal health program (***Senate version only***) • Administration of the program (at the federal, regional, and state level) • Transitional Medicare reforms (***Senate version only***) • 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 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)	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 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	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 access to the Medicare Beneficiary Ombudsman)	*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 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)	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 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	*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 *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

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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/nationals residing in the U.S. 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 basis each time they enroll in the buy-in plan	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 be eligible for premium assistance/CSRs under the ACA (treats the buy-in plan as a silver-level marketplace plan in determining eligibility)	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 assistance	*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
Medicare-X Choice Act of 2019 (S. 981/H.R. 2000) Sen. Michael Bennet (D-CO)/Rep. Antonio Delgado (D-NY) Medicare buy-in	Does not directly address employer participation	Makes individuals that are currently considered "qualified" under the ACA eligible for participation in the Medicare Exchange health plan, provided they are not eligible for Medicare benefits *Plan Availability.* The plan's availability would increase over time	Requires the plan—which qualifies as a QHP —to cover EHBs (must meet the same requirements as exchange plans under the ACA) Requires HHS to make available	*Premiums*. Directs HHS to establish premiums that cover the full actuarial cost of offering the plan, including administrative costs If the amount collected in premiums exceeds the amount required for benefits, allows such excess amounts to remain available to HHS for subsequent	Sets premiums to cover the full actuarial cost of the plan, including administrative costs Establishes the Plan Reserve Fund—consisting of the amounts appropriated to the fund—to	*Prescription Drugs.* Authorizes HHS to negotiate drug prices for Medicare Part D prescription drugs *Reinsurance Program.* Establishes a nationwide reinsurance program and appropriates $10 billion annually for FY2021-FY2023 *Risk Pool*. Places all plan enrollees within in a state in a single risk pool; authorizes HHS to establish separate risk pools for individual and

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Senate Summary		• In 2021, offered in the individual market in rating areas where there is only one or no option on the exchange; • By 2024, offered throughout the individual market; and • By 2025, offered throughout the small group market Makes the plan available on the ACA exchanges	options in at least the silver and gold metal levels (with flexibility to add bronze and platinum options)	years For plan year 2021, directs HHS to set premiums for the plan in each rating area where plan is available, considering other premium rates for plans offered in the area in the 2020 plan year *Payment Rates.* Requires provider reimbursement at rates determined for equivalent items and services under Medicare Parts A and B and for any additional items and services not covered under Medicare (with additional flexibility for rural areas) Authorizes HHS to utilize innovative payment methods and polices to determine payments (e.g., value-based purchasing, bundling of services, telehealth, etc.)	establish and administer the plan Appropriates $1 billion for FY2020 for the establishment and administration of the plan Authorizes HHS to use excess premium payments (if the amount collected for premiums exceeds the amount required for health care benefits and administration of the plan) to administer the plan	small group market if the state has not done so *Eligibility for Premium Assistance*. Extends eligibility for the premium tax credit to those at and above 400% federal poverty level *Data Collection.* Establishes the Data and Technology Fund to be administered by HHS for the purposes of updating technology and performing data collection to establish premium rates "appropriate" for all geographic regions in the U.S. Authorizes HHS to collect data from state insurance commissioners and other relevant entities to establish premium rates and other purposes (e.g., improve quality; reduce racial, ethnic, and other disparities with respect to the health plan; etc.) *Provider Participation.* Prohibits health care providers from participating in Medicare or a state Medicaid plan, unless the provider also participates in the plan Contains other provisions regarding: • Administrative contracting • Alternative/innovative payment models • Experimentation with delivery system reform for an enhanced health plan • The plan's lack of impact/effect on benefits offered through Medicare Fee-for-Service, Medicare Advantage, or the Medicare trust fund
Choose Medicare	Offers Medicare	***Beginning in 2020,*** makes all	Requires the plan—	*Premiums. Requires* HHS to	Appropriates $2	*Participating Providers*. Treats providers that

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Act (S. 1261/H.R. 2463) Sen. Jeff Merkley (D-OR)/Rep. Cedric Richmond (D-LA) Medicare buy-in; creates Medicare Part E Plans Senate Summary	Part E plans in the individual, small group, and large group markets alongside private health plans Opens Medicare to employers of all sizes (i.e., provides options for Part E plans in the small and large group markets that are voluntary and available to all employers) Requires HHS to develop a process for allowing individuals enrolled in a Part E plan offered in the small or large group market to maintain coverage through a Part E plan if the individual subsequently loses eligibility for enrollment based on termination of the employment relationship	U.S. residents eligible, provided they are not entitled to/enrolled in benefits under Medicare; medical assistance under a state plan under Medicaid; or child health assistance or pregnancy-related assistance under CHIP Offers enrollment options through state and federal exchanges and through employers	which qualifies as a QHP—to cover EHBs (and all items/services for which benefits are available under Medicare); provide gold-level coverage; and cover abortions and all other reproductive services Prevents a state from prohibiting a Part E plan from offering coverage for abortions and other reproductive services	establish premium rates that are sufficient to fully finance the costs of benefits provided and administrative costs related to operating the plans *Payment Rates*. Requires HHS to establish a rate schedule for reimbursing health care providers that furnish services under Part E plans *Cost-Sharing.* Establishes an out-of-pocket maximum in Medicare (in 2021, $6,700, and adjusted annually thereafter) Enhances CSR subsidies for marketplace participants by applying them to gold-level plans and changes actuarial values for CSR gold plans (i.e., modifies CSR payment amounts to allow for further reductions)	billion for the purpose of establishing Part E plans Appropriates such funds as may be necessary to provide reserves to pay claims filed during the first 90 days of the first plan year	are participating providers under the Medicare program as participating providers for Part E plans and requires HHS to establish a process to allow other health care providers to become participating providers for Part E plans *Prescription Drugs*. Authorizes HHS to negotiate with drug manufacturers the prices that may be charged to PDP sponsors and MA organizations for Part D drugs *Generosity of Premium Tax Credit.* Enhances the generosity of the premium tax credit by using a gold-level plan as the benchmark (instead of a silver-level plan) Expands eligibility for the premium tax credit (raising the eligibility threshold from individuals with annual incomes up to 400% of the federal poverty line to 600%) *Reinsurance Program.* Requires HHS to establish a program in each state to carry out a reinsurance program (appropriates $30 billion to establish and administer the program) *Rating Rules.* Extends ACA rating rules to the large group market *Balance Billing.* Imposes limitations on balance or surprise billing (i.e., applies Medicare balance billing limits to Part E plans) Contains other provisions regarding: • Alternative payment models • Navigator referrals • Protections for consumers from “excessive,

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						unjustified, or unfairly discriminatory rates"

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 Medicaid alternative 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

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 Follows ACA marketplace enrollment procedures and rules	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	Premiums set to cover benefits and administrative costs; 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***) *Prescription Drugs*. Authorizes HHS to negotiate payment rates for prescription drugs that are not paid for under Medicare Parts A and B. 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
Consumer Health Options and Insurance Competition Enhancement	Offers the public option on exchanges alongside private plans	Offers enrollment in the public option exclusively through the	Offers bronze, silver, and gold-level plans (may also offer platinum-level plans)	*Premiums.* Requires HHS to set geographically adjusted premium rates at levels to fully fund the benefits and administrative costs provided under public option	Premiums set to cover benefits and administrative costs; Requires HHS to repay	*Preemption.* Preempts state laws that prohibit a public health insurance option *Data Collection.* Requires HHS to collect data necessary to establish premiums and payment

[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.

Legislation	Private Market Impact	Eligibility/ Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
(CHOICE) Act (S.1033/H.R. 2085) Sen. Sheldon Whitehouse (D-RI)/Rep. Jan Schakowsky (D-IL) ***Similar to the Keeping Health Insurance Affordable Act of 2019/Public Option Deficit Reduction Act*** Public option offered through the exchanges of qualified health plans	Does not directly address employer participation	exchanges Follows ACA marketplace enrollment procedures and rules	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)	*Payment Rates.* Requires HHS to negotiate with health care providers to set payment rates for services/providers (including Medicare Part D prescription drugs) Authorizes HHS to modify cost sharing/payment rates to encourage use of services that promote health and value	"startup funding"—i.e., such sums as may be necessary to establish the public health insurance option and cover 90 days of claims reserves based on projected enrollment—over a 10-year period beginning in 2020	rates, improve quality, improve quality, etc. *Prescription Drugs*. Authorizes HHS to negotiate rates for prescription drugs. If HHS fails to reach a negotiated agreement, authorizes HHS to use rates determined for equivalent drugs paid for under the original Medicare fee-for-service program. *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) Contains other provisions regarding: • Administrative contracting • Establishment of a state advisory council • Transfer of insurance risk to HHS