MEMO

To: Democratic Members, *Committee on Ways and Means*

From: Ways and Means Subcommittee on Health Staff

Date: June 7, 2019

Re: Hearing on the Pathways to Universal Health Coverage

The Committee on Ways and Means will hold a hearing on **Wednesday, June 12th, at 10 a.m. in 1100 Longworth**, entitled, "*Pathways to Universal Health Coverage*."

Despite the gains in health insurance coverage following passage of the Affordable Care Act (ACA) nearly a decade ago, many Americans continue to face affordability and coverage barriers to health services. To address these concerns, Democrats have introduced a number of bills that move to universal coverage, decrease patient costs, and provide stability in the health care marketplaces. Each of these proposals brings tradeoffs to consider and discuss. This hearing will advance the public dialogue on pathways to achieve universal coverage. Accordingly, the goals of this hearing are to:

- Develop an understanding of key health reform proposals;
- Discuss the tradeoffs and key considerations of each proposal; and
- Understand the implications of such proposals on key constituencies with a specific focus on vulnerable populations.

I. WITNESSES

This hearing will include six witnesses – five witnesses invited by the Democrats and one invited by the Republicans:

Rebecca Wood is a patient advocate and mother who lives outside of Boston, Massachusetts. She will describe her experience with the birth of her daughter, Charlie. Charlie was born at 26 weeks after Ms. Wood experienced early onset preeclampsia and Charlie spent three months in the neonatal intensive care unit. Despite having health insurance, Ms. Wood and her family were financially drained by these events, and they are still feeling the effects more than seven years later. Ms. Wood will explain that even with health insurance, many Americans still cannot access necessary health services due to affordability barriers.

Donald M. Berwick, M.D., M.P.P., is a President Emeritus and Senior Fellow at the Institute for Healthcare Improvement; he is also a former Administrator of the Centers for Medicare & Medicaid Services (CMS), where he helped implement the ACA under the Obama Administration from 2010 to 2011. Dr. Berwick will discuss the tradeoffs and considerations associated with a Medicare for All health reform approach.

Pam MacEwan is the Chief Executive Officer for the Washington Health Benefit Exchange in the State of Washington, where she has worked since 2012. Ms. MacEwan will discuss the tradeoffs and considerations associated with a health reform approach focused on strengthening the ACA as well as the State of Washington's public option plan.

Chiquita Brooks-LaSure, M.P.P., is a Managing Director at Manatt Health, where she examines state and federal health reform proposals, including buy-in and public option plans. She has held key positions in the Executive and Legislative branches and was instrumental in the passage and implementation of the ACA. Ms. Brooks-LaSure will discuss the tradeoffs and considerations associated with various state/federal buy-in and public option health reform proposals.

Tricia Neuman, D.Sc., is the Director of the Program on Medicare Policy at the Henry J. Kaiser Family Foundation, where she oversees the research and analysis of the foundation's work related to Medicare policy. She has previously held positions in the Legislative branch, having focusing on aging and long-term care health policy. Dr. Neuman will provide context for the health reform proposals, comparing and contrasting the various policies and considerations to provide a framework for discussion during the hearing.

Republican Witness: **Grace-Marie Turner** is the President of the Galen Institute, which she founded in 1995 to promote free-market health reform solutions. Ms. Turner previously testified before the Rules Committee for its Medicare for All hearing in April as the Republican-invited witness.[1]

II. DEMOCRATIC MESSAGES

The key Democratic messages of this hearing are:

- **Americans continue to call for Congress to improve health care affordability and drug coverage – particularly for those who have preexisting health conditions.** According to a Kaiser Family Foundation poll, a majority of Americans want the federal government to do more to help them afford their health care coverage, including expanding the role of public programs.[2]

- **Democrats support expanding health care coverage with the ultimate goal of achieving universal coverage for all Americans.** For decades, Democrats have worked together to develop policies that not only expand health care coverage for all Americans but also improve affordability. Since passage of the ACA, Democrats have continued to work for the American people to build on those policies, ensure stability in federal and state health care marketplaces, and work on ways to improve affordability with the goal of progressing toward universal coverage.

[1] https://docs.house.gov/meetings/RU/RU00/20190430/109356/HHRG-116-RU00-Wstate-TurnerG-20190430.pdf
[2] https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/

- **There are many ways to achieve universal coverage – and each policy has different tradeoffs.** It is the responsibility of Congress to weigh all of these options and determine an approach that works for all Americans. This hearing is a way for Congress to continue this public dialogue necessary for building a pathway to universal coverage.

- **Republicans and the Trump Administration continue to push a health care agenda that undermines Americans' health. Their actions reduce access to comprehensive health care coverage and discriminate against individuals with preexisting conditions.** The Department of Justice refuses to defend the ACA as the law of the land, threatening to take coverage away from more than 100 million Americans with pre-existing conditions – and the Administration continues to create policies that undermine the stability of the health care marketplaces through the proliferation of junk plans that fail to cover Americans when they get sick and need it most.[3]

III. BACKGROUND

A. Health Care Affordability

American consumers frequently name "health care costs" as the most important financial problem facing their families. In 2018, the average family of four spent $28,166 on health care alone and Americans collectively borrowed $88 billion in 2018 to pay for health care.[4,5] More broadly, one in four Americans skipped a medical treatment due to cost, and 40 percent of Americans report they cannot afford a $400 additional health care expense.[6] Health care expenses have even become unaffordable for individuals with insurance: Forty-three percent of adults with health insurance say they have difficulty affording their deductible, and roughly a third say they have trouble paying their premiums and other cost-sharing obligations.

While the ACA has helped slow health care spending growth, costs are still high and continuing to grow in the United States. Earlier this year, the Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary (OACT) reported that national health expenditures are expected to grow an average of 5.5 percent annually over 2018-2027 to reach $6.0 trillion by 2027. This rate is 0.8 percent over projected Gross Domestic Product (GDP) and will result in growth of health spending from 17.9 percent of GDP in 2017 to 19.4 percent by 2027.[7]

This steady growth in spending has not improved patient outcomes. The United States annually spends $10,224 per person on health care – double the average annual amount other

[3] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/preexisting.html
[4] http://www.milliman.com/mmi/
[5] https://thehill.com/policy/healthcare/436910-americans-borrowed-total-of-88-billion-last-year-to-pay-for-health-care
[6] https://www.cnbc.com/2018/05/22/fed-survey-40-percent-of-adults-cant-cover-400-emergency-expense.html
[7] https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountsprojected.html

industrialized countries spend on health care per person (approximately $5,280 per person).[8,9] Common measures of population health, such as maternal mortality and life expectancy, show that the U.S. health care system is performing worse than other industrialized nations.[10,11] In fact, compared to all other developed nations, the United States has the highest maternal mortality rate.[12]

B. Republican Sabotage of The Affordable Care Act

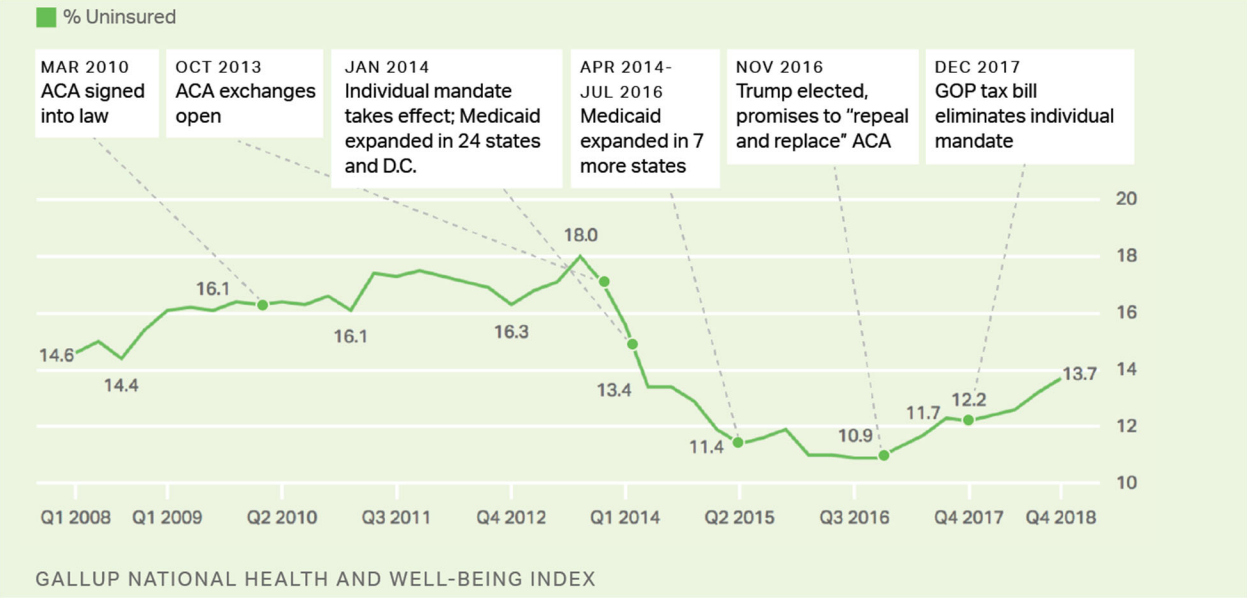
While the ACA led to historic gains in health insurance coverage – decreasing the number of uninsured non-elderly from 44 million in 2013 to 27 million in 2016 – recent Republican ACA sabotage has begun reversing the trend (see Figure 1) with women, young adults, and those living in households with annual incomes less than $48,000 hit the hardest.[13, 14]

A number of Republicans actions have specifically reversed the trend toward universal coverage and increased the rate of uninsured and underinsured Americans. These include:

1. The reduction of funding for ACA "navigators" – to help Americans choose the right health plan for them – from $63 million in 2016 down to only $10 million in 2018.[15]
2. The purposeful undermining of public confidence about the future of the ACA, creating instability in the marketplaces. For example, in 2017 Donald Trump announced, "I want people to know Obamacare is dead; it's a dead health care plan."[16]
3. Numerous high-profile attempts to repeal and replace the ACA on the part of Congressional Republicans, which created further instability and confusion for consumers.
4. Elimination of the ACA's individual mandate penalty as part of the December 2017 Republican tax law may have reduced participation in the insurance marketplace in the most recent Open Enrollment period.
5. Trump's decision in October 2017 to end cost-sharing-reduction payments likely increased the number of uninsured Americans.[17] The Administration previously made cost-sharing payments to insurers in the marketplaces to offset some of their costs for offering lower cost plans to lower income Americans.[18]

[8] https://www.reuters.com/article/us-health-spending/u-s-health-spending-twice-other-countries-with-worse-results-idUSKCN1GP2YN
[9] https://www.healthsystemtracker.org/indicator/spending/per-capita-spending/
[10] https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world
[11] https://www.nap.edu/catalog/13497/us-health-in-international-perspective-shorter-lives-poorer-health
[12] https://www.npr.org/2017/05/12/528098789/u-s-has-the-worst-rate-of-maternal-deaths-in-the-developed-world
[13] https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/
[14] https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/
[15] https://www.cms.gov/newsroom/press-releases/grants-awarded-federally-facilitated-exchange-navigator-program
[16] https://obamacarefacts.com/obamacare-open-enrollment-2018
[17] https://www.hhs.gov/about/news/2017/10/12/trump-administration-takes-action-abide-law-constitution-discontinue-csr-payments.html
[18] https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx

Figure 1. Percentage of U.S. Adults without health insurance, 2008-2018[19]



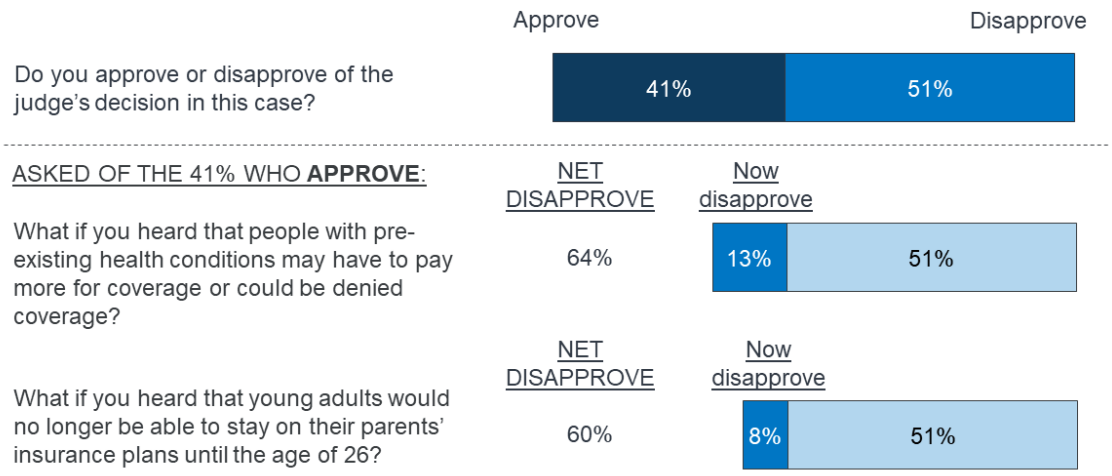
C. Public Opinion

Americans feel more strongly than ever that health care coverage should protect people with pre-existing conditions. In the 2018 mid-term elections, voters went to the polls to protect Americans with preexisting conditions, bringing a "blue wave," that brought Democrats the majority in the House of Representatives. This was the first time since the economic downturn in 2008 that the economy was not the most important issue area for voters.[20] Nearly seven in 10 voters (68 percent) – regardless of political party affiliation – believe people with pre-existing health conditions should have access to coverage without paying more, according to a survey conducted just before the 2018 midterm elections.[21]

Furthermore, 51 percent of Americans disapprove of the recent decision in *Texas v. United States*, in which a federal judge ruled that the ACA is no longer constitutional.[22] And when Americans understood that eliminating the ACA would also eliminate preexisting condition protections, the net disapproval of the ruling increased to 64 percent (see Figure 2).

[19] https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx
[20] https://www.healthcaredive.com/news/almost-70-of-voters-support-protection-for-pre-existing-conditions/543124/
[21]https://www.fightcancer.org/releases/poll-shows-voters-expect-health-coverage-pre-existing-conditions-without-caveats-or-extra
[22] https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/

Figure 2. Majorities disapprove of judges ruling after hearing how it impacts protections for preexisting conditions and young adults[23]



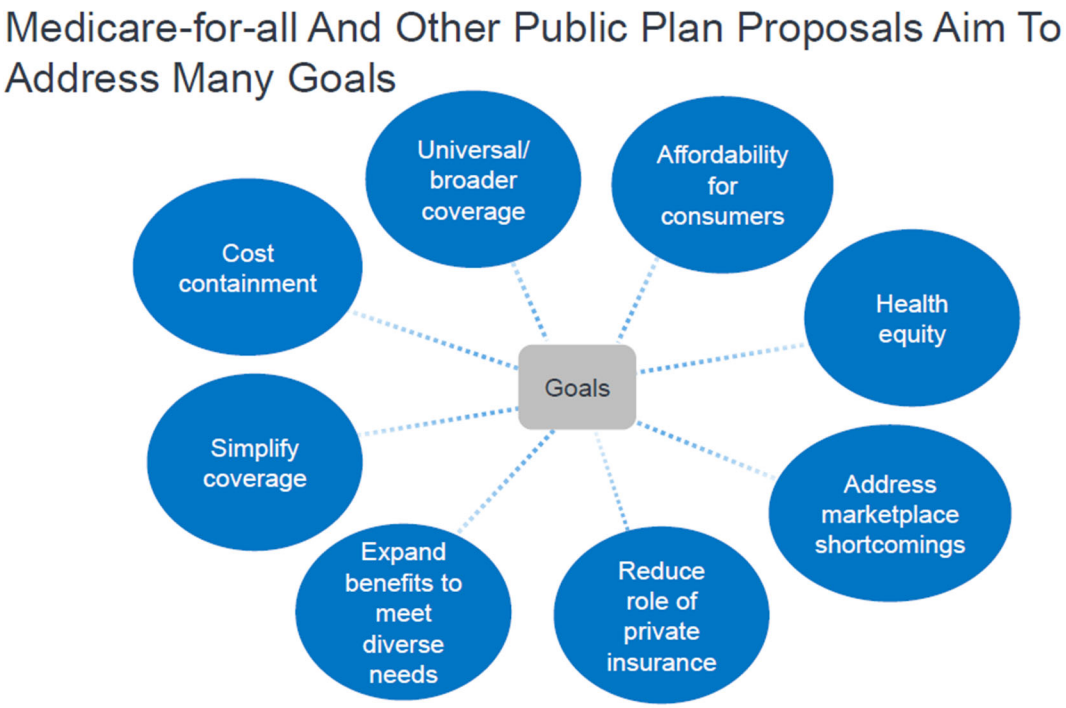
Proposals to expand health coverage to all Americans are popular – but language matters. One poll found a majority (56 percent) support the federal government doing more to help provide health insurance for more Americans.[24] But the level of support depends on the syntax used. For example, the term "Universal Health Coverage" or "Medicare for all" elicits support from 63 percent of Americans. Even the term "National Health Plan" enjoys an almost 60 percent approval rating. But the phrases "single-payer" or "socialized medicine" do not poll well: The favorability rating goes down to just less than 50 percent.

IV. FRAMEWORK FOR UNDERSTANDING COVERAGE PROPOSALS

Although the numerous Democratic proposals for post-ACA health reform address the issues of affordability and coverage in different ways, they all have similar goals and must ultimately include several basic structural elements if they are to progress through Congress and become law. Figure 3 shows a number of common goals many of the current health reform plans share.

[23] https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/
[24] https://www.kff.org/health-reform/poll-finding/kff-health-tracking-poll-january-2019/

Figure 3. Unifying goals of Democratic health reform plans[25]



Regardless of the plan, all health proposals must address the following factors:

1. **Coverage**: Who will be eligible for coverage? Will there be any exemptions for particular populations (e.g., Veterans Administration (VA) or Indian Health Services (IHS))?

2. **Benefits**: What types of health services and drugs are covered? What will be excluded? Will benefits include services not traditionally covered by Medicare (and most other plans), including dental services, visions services, and hearing services as well as long-term services and supports? How will populations with unique health needs, such as children with developmental needs or people with disabilities, be ensured access to robust coverage?

3. **Public Insurance and Administration:** How large a role will public payers (e.g., Medicare, Medicaid, etc.) compared to private payers play? What entity(ies) will administer the system? Will administration be centralized?

4. **Beneficiary Costs**: What will the cost-sharing structures look like? How much will beneficiaries pay through premiums, deductibles, cost-sharing, or coinsurance when they use their plan to access services or purchase drugs? Who will determine the actuarial value of particular plans? Will there be a limit on out-of-pocket costs?

[25] https://www.kff.org/wp-content/uploads/2019/05/KFF-Web-Briefing-Slides-5.21.19-1.pdf

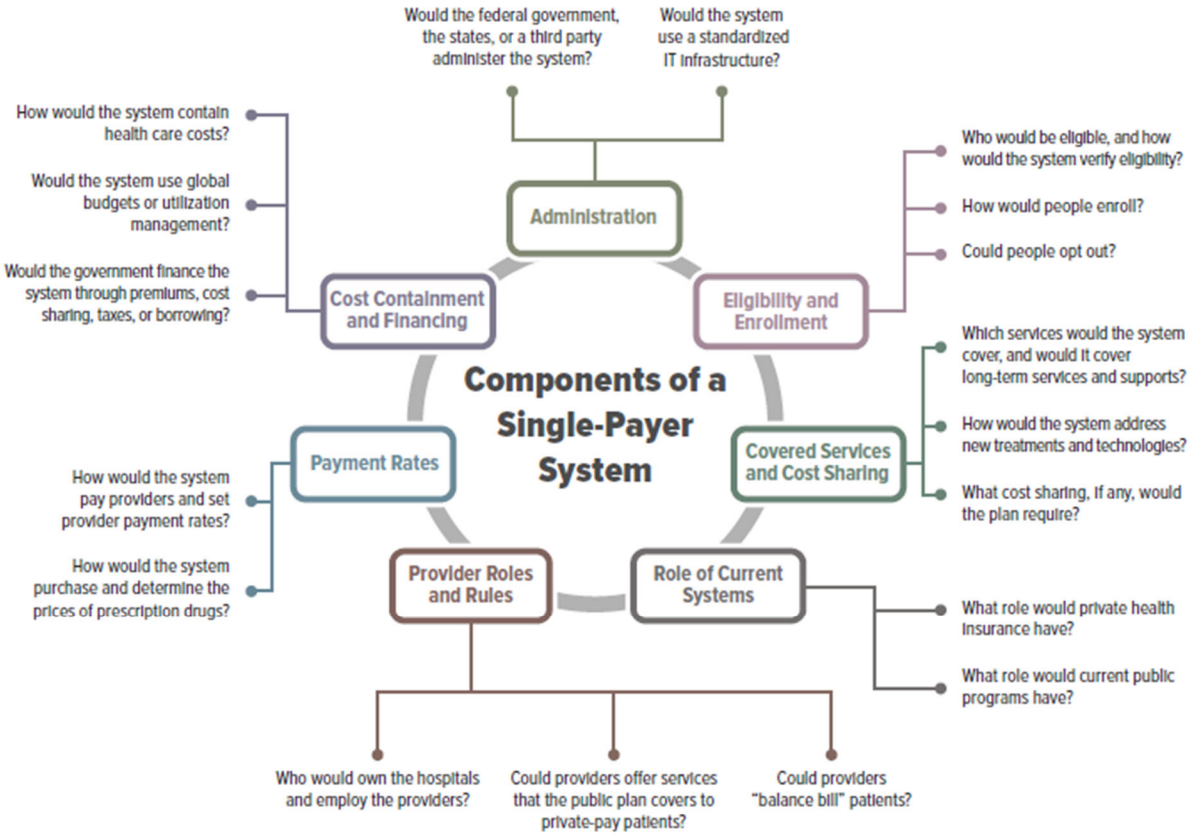
5. **Provider Payment and Configuration**: How much will providers (i.e., physicians, non-physician providers, and hospitals) be paid? Who will determine the rate? Which providers will participate in the plan? How will contractual arrangements be designed? Will physicians be employed, contract privately, or both?

6. **Public Financing**: What sources of financing will cover the costs? What portion of the cost will be covered by public financing and what portion by patients and others?

7. **Other Considerations**: What types of health information technology systems will be used and will new ones need to be created? What level of interoperability will exist? Who will control patient data? What will the enrollment process look like and who will verify eligibility?

Figure 4 shows the key levers the Congressional Budget Office (CBO) identified in a report it released on considerations related to a single-payer system in May 2019. While CBO's analysis was specific to a single-payer system, similar considerations would apply to any policy aimed at moving toward universal coverage. *For the full report, please see the attachment to this memorandum.*

Figure 4. CBO's assessment of key design elements specific to a single-payer health system



Source: Congressional Budget Office.

IT = information technology.

V. KEY HEALTH REFORM PROPOSALS

Democrats have proposed a number of key policies that improve affordability of health care services. These proposals all aim to increase the generosity of health care benefits and decrease consumer out-of-pocket costs while attempting to insert a level of stability and rationality to the currently opaque health care system. The health reform proposals we outline below include:

- Strengthening the ACA
- Public options
- Medicare/Medicaid buy-in proposals
- Medicare for America
- Medicare for All
- ACA repeal

The material below groups similar ideas together to help capture the broad range of policies for the purposes of discussion. It does not seek to diminish any of the ideas relative to any other but merely to provide a framework for understanding the current breadth of ideas that policymakers continue to discuss and refine. Furthermore, Republican health reform ideas are included here not to create a policy equivalency but to present the comprehensive picture of ideas Americans have encountered in the decade since the passage of the ACA.

A. Proposals to Strengthen the ACA

Proposals to build on and strengthen the ACA focus on protecting consumers with preexisting conditions, lowering consumer-out-of-pocket costs, and reversing Trump Administration policies that damaged or undercut the individual marketplaces. Table 1 provides additional details on these proposals.

Table 1. Snapshot of ACA strengthening proposals

Associated Bills: ***H.R. 1884***[26] *Pallone (NJ-06), Neal (MA-01), and Scott (VA-03). Note: H.R. 1884 represents a compilation of H.R. 986,*[27] *Kuster (NH-02); H.R. 1010,*[28] *Castor (FL-14);, H.R. 1385,*[29] *Kim (NJ-03); H.R. 1386,*[30] *Castor (FL-14); H.R. 1425,*[31] *Craig (MN-02); H.R. 1868,*[32] *Underwood (IL-14); H.R. 1870,*[33] *Wild (PA-07).*

Ways and Means Co-Sponsors: **H.R. 1884** - Richard Neal (MA-01), Brendan Boyle (PA-02), Lloyd Doggett (TX-35), Jimmy Gomez (CA-34), Terri Sewell (AL-07), John Larson (CT-01), John Lewis (GA-05), Linda Sanchez (CA-38), Stephanie Murphy (FL-07), Mike Thompson (CA-05), Brian Higgins (NY-26), Bill Pascrell (NJ-09), Earl Blumenauer (OR-03), Jimmy, Panetta (CA-20), Dan Kildee (MI-05), Tom Suozzi (NY-03), Ron Kind (WI-03), Steven Horsford (NV-04), Judy Chu (CA-27), Danny Davis (IL-07), Brad Schneider (IL-10), Suzan DelBene (WA-01)

Plan element	Description
Coverage	Building on the ACA's provisions related to enhancing consumer protections, health services affordability, and access to care, this legislation aims at expanding the number of Americans covered by comprehensive health insurance. Expanded tax credits would address affordability for nearly 20 million Americans, including nine million who are currently uninsured. The proposal also funds innovative state work to increase coverage. The

[26] https://www.congress.gov/bill/116th-congress/house-bill/18843/text
[27] https://www.congress.gov/bill/116th-congress/house-bill/986/text
[28] https://www.congress.gov/bill/116th-congress/house-bill/1010/text
[29] https://www.congress.gov/bill/116th-congress/house-bill/1385/text
[30] https://www.congress.gov/bill/116th-congress/house-bill/1386/text
[31] https://www.congress.gov/bill/116th-congress/house-bill/1425/text
[32] https://www.congress.gov/bill/116th-congress/house-bill/1868/text
[33] https://www.congress.gov/bill/116th-congress/house-bill/1870/text

	legislation requires the Administration conduct and/or fund open enrollment outreach, education, and funding for navigators.
Benefits	This legislation curtails efforts to weaken standards for Essential Health Benefits, which would leave consumers with less comprehensive plans that do not cover needed services, such as prescription drugs, maternity care, and substance use disorder treatment. The legislation stops Trump Administration efforts to expand "skimpy junk plans" through association health plans and short-term limited-duration plans that offer paltry benefits and little financial protection from high health care costs.
Role of Insurance	Private health insurance remains the method of providing coverage in the individual market while most Americans would continue to get health insurance through the group market. The legislation provides funding for reinsurance to help with high cost claims and improve Marketplace stability. H.R. 1884 does not address Medicaid expansion, but those opportunities remain for states in current law.
Beneficiary Costs	The bill would enhance ACA premium subsidies to remove the current cliff at 400 percent of the federal poverty level (FPL) and lower the affordability threshold for those currently eligible for tax credits. Additionally, the legislation would address the "family glitch" that establishes affordability of employer-sponsored insurance on individual coverage costs and not family coverage.
Provider Reimbursement	Insurance companies, Medicare, or Medicaid would continue to negotiate reimbursement rates with providers.
Public Financing	These proposals would increase federal spending.

B. Public Option Proposals

The public option proposals would create a federal public plan to be offered on the ACA-created individual marketplaces. The State of Washington recently passed legislation to create a state-level public plan offered on the state marketplace that the Washington Medicaid agency will manage. Table 2 provides additional details on these proposals.

Table 2. Snapshot of public option proposals

Associated Bills: ***S. 3*** *Cardin*[34]*,* ***S. 1261***[35]***/H.R. 2463***[36] *Merkely/Richmond (LA-02),* ***S. 981***[37]***/ H.R. 2000***[38] *Bennet/Kaine/Delgado (NY-19),* ***H.R. 2085***[39]***/S. 1033***[40] *Schakowsky (IL-09)/Whitehouse.*

Ways and Means Co-Sponsors: **H.R. 2000** - John Larson (CT-01), Brian Higgins (NY-26); **H.R. 2085** - Gwen Moore (WI-04), Judy Chu (CA-27)

Plan element	Description
Coverage	The public option bills would only impact those who purchase coverage through the ACA Marketplaces, though the Merkely/Richmond plan would create an option for employers to offer the plan to their employees, and the Bennet/Kaine plan would eventually create a small employer group option. It could encourage uninsured individuals eligible for marketplace plans to enroll in coverage. The Washington state plan will be offered to individuals eligible for Marketplace plans only.
Benefits	Benefits for all the public options are based on the ACA-established Essential Health Benefits, and plans must meet Qualified Health Plan requirements to be offered in the Marketplace.
Role of Insurance	These plans will be offered in conjunction with the existing private insurance options available on the Marketplaces. They would allow the federal government to offer an insurance plan to compete with private plans offered through the ACA Marketplace with the goal of providing stability to the markets and lowering costs. The Secretary is authorized to negotiate for drug prices in the federal options.
Beneficiary Costs	Beneficiary costs would be similar to private insurance plans with premiums, cost-sharing, and an out of pocket cap. The Cardin plan also creates a national Part D plan with a base premium of $37 per month and would mandate drug manufacturer rebates for dual-eligible individuals and low-income seniors.
Provider Reimbursement	Provider reimbursement would continue to be fee-for-service, with incentives to move toward alternate payment methods. All plans except Bennet/Kaine would allow the Secretary to establish provider reimbursement rates. The Bennet/Kaine proposal sets provider reimbursement at Medicare rates for everything reimbursed by Medicare, with the remaining services provided at rates negotiated by the Secretary.

[34] https://www.congress.gov/bill/116th-congress/senate-bill/3/text
[35] https://www.congress.gov/bill/116th-congress/senate-bill/1261/text
[36] https://www.congress.gov/bill/116th-congress/house-bill/2463/text
[37] https://www.congress.gov/bill/116th-congress/senate-bill/981/text
[38] https://www.congress.gov/bill/116th-congress/house-bill/2000/text
[39] https://www.congress.gov/bill/116th-congress/house-bill/2085/text
[40] https://www.congress.gov/bill/116th-congress/senate-bill/1033/text

Public Financing	ACA premium subsidies and cost-sharing reduction subsidies would apply to all of these plans, and some of them expand applicability of the subsidies, which would increase federal spending. All of these plans are self-financing; all but the Schakowsky/Whitehouse plan include start-up costs of $1-2 billion to be repaid over 10 years.

C. Medicare/Medicaid Buy-in

The Medicare buy-in proposals would allow individuals over 50 to buy into Medicare ahead of the traditional age qualification of 65. The Medicaid buy-in option would allow states to create a mechanism for individuals to buy into the existing state Medicaid program without meeting Medicaid's qualifying criteria (e.g., low-income, qualified pregnant woman or child, etc.). Table 3 provides additional details on these proposals.

Table 3. Snapshot of buy-in proposals

Associated Bills: Medicare – ***S. 470***[41] *Stabenow,* ***H.R. 1346***[42] *Higgins (NY-26); Medicaid –* ***S. 489***[43]***/H.R. 1277***[44] *Schatz/Lujan (NM-03).*

Ways and Means Co-Sponsors: **H.R. 1346** – Brian Higgins (NY-26, Sponsor), John Larson (CT-01), Brendan Boyle (PA-02), Suzan DelBene (WA-01), Lloyd Doggett (TX-35); **H.R. 1277 -** Earl Blumenauer (OR-03), Gwen Moore (WI-04).

Plan element	Description
Coverage	The Medicare plans would allow individuals 50-64 to buy into Medicare or Medicare Advantage if they are not otherwise eligible. The Medicare buy-in plans would be eligible for Marketplace subsidies, and the Higgins proposal would enhance subsidies for enrollees. States would be prohibited from buying these plans for Medicaid enrollees. The Medicaid buy-in would allow states to create an option for residents who are eligible for Marketplace plans to buy into Medicaid.
Benefits	The Medicare plans will include either Parts A, B, and D, or all benefits provided in the Medicare Advantage plan. The Medicaid plans must include the 10 ACA Essential Health Benefits.
Role of Insurance	These plans would expand access to existing coverage through Medicare, Medicare Advantage, and Medicaid. The Medicare buy-in options

[41] https://www.congress.gov/bill/116th-congress/senate-bill/470/text
[42] https://www.congress.gov/bill/116th-congress/house-bill/1346/text
[43] https://www.congress.gov/bill/116th-congress/senate-bill/489/text
[44] https://www.congress.gov/bill/116th-congress/house-bill/1277/text

	expand Medigap provisions to cover the buy-in population on a guaranteed issue basis. There would be no other change to existing coverage options. The Stabenow plan allows the Secretary to negotiate for drug prices, while the Higgins plan requires negotiation for both Medicare and the buy-in.
Beneficiary Costs	Beneficiaries would have the same cost-sharing responsibilities as current Medicare enrollees, including premiums, deductibles, copays and coinsurance. Enrollees would be encouraged to get a Medigap plan to limit out-of-pocket liability if not otherwise provided through Medicare Advantage or Marketplace subsidies. The state would determine the Medicaid buy-in cost-sharing amount, so long as it is "actuarily fair," with an out-of-pocket cap no higher than the ACA cap. It should be considered a silver-level plan for actuarial purposes.
Provider Reimbursement	The Medicare buy-in plans would use current Medicare participating providers and would reimburse at Medicare rates. The Medicaid buy-in proposals would reimburse primary care doctors not less than Medicare rates for the entire Medicaid population (not just buy-in participants) and pay Medicaid rates for all other services.
Public Financing	The Medicare buy-in must be self-financing and premiums are to be deposited into a new Medicare buy-in trust fund to cover benefits and administrative costs. Additional federal dollars would be required for expanded ACA premium subsidies and for any cost sharing reduction subsidies used by the buy-in population. The Medicaid buy-in will provide $200 million to states to implement quality metrics around the buy-in and will provide 100 percent matching funds for three years to any state choosing to expand Medicaid. The federal government would match 90 percent of administrative costs for the buy-in program. Costs for buy-in participants would be covered by premiums, with any additional costs covered like traditional Medicaid with a federal match. Any excess revenues would be shared with the federal government.

D. Medicare for America

This proposal would create a single plan to replace Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and the Marketplace plans. Employers could continue to offer private health insurance. Table 4 provides additional details on these proposals.

Table 4. Snapshot of Medicare for America proposal

Associated Bills: ***H.R. 2452***[45] *DeLauro (CT-03)/Schakowsky (IL-09),*

Ways and Means Co-Sponsors: **H.R. 2452** – Gwen Moore (WI-04), Brian Higgins (NY-26), Lloyd Doggett (TX-35)

Plan element	Description
Coverage	The Medicare for America proposal would replace the ACA Marketplaces, individual insurance, Medicare, Medicaid, CHIP, and would cover the uninsured. Employer-sponsored insurance would remain separate, and there would be an option to choose a privately run Medicare Advantage-type plan. This proposal is designed to achieve universal coverage. Employers must either offer comprehensive health insurance or pay eight percent payroll tax to the Medicare Trust Fund. Those covered under the VA, IHS, or a Federal Employees Health Benefits Program (FEHBP) can elect to enroll in Medicare for America or keep their current coverage.
Benefits	The proposal includes comprehensive coverage including ACA Essential Health Benefits, dental, vision, hearing, home- and community-based long-term services and supports, nursing facilities, non-emergency medical transportation, and other benefits. States may provide additional services at their expense.
Role of Insurance	This program will combine current public coverage, with the exception of the IHS and VA, into one federal health care program. Private insurers will still be providing employer-based health care coverage and administering Medicare Advantage-like options for those in the public program.
Beneficiary Costs	There is no premium or cost-sharing below 200 percent of FPL, with a sliding scale from 200 percent-600 percent FPL – up to eight percent of income or full premium amount, whichever is lower. The plan does not include a deductible but includes 20 percent coinsurance up to the annual out-of-pocket cap ($3500 individual/$5000 family, indexed to Consumer Price Index (CPI)-medical). There is no cost-sharing for preventive, pediatric, maternity, and long-term services and supports, and no cost-sharing for those with special needs. The Secretary would determine premiums, with annual adjustments.

[45] https://www.congress.gov/bill/116th-congress/house-bill/2452/text

Provider Reimbursement	The Secretary sets rates based on current Medicare rates and as needed to maintain network adequacy. Hospital rates will be set at minimum of 110 percent of current Medicare, with higher rates in underserved areas. Primary care and behavioral health reimbursement will be increased by at least 30 percent over current rates. Payments to Medicare Advantage-like plans will be capitated and set at 95 percent of average Medicare for America plan costs for that county.
Public Financing	Funding of this program would come from a combination of sources. States would be required to pay an annual maintenance-of-effort amount equal to the state's spending on Medicaid and CHIP for the year before enactment and indexed annually at GDP per capita growth plus 0.7 percent (0.4 percent for expansion states until 2033). Covered beneficiaries will pay premiums and coinsurance up to the out-of-pocket cap and large employers that do not provide adequate coverage will pay an eight percent payroll tax to the Medicare Trust Fund. Any increases in federal revenue associated with Medicare for America will be contributed to the Trust Fund, along with all current federal Medicaid contributions. Additional federal funds will come from a five percent income tax on individuals making more than $500,000, and increases in excise taxes for alcohol and tobacco, among other actions.

E. Medicare for All

Medicare for All would replace all existing health coverage (except the IHS and VA) with a comprehensive single plan administered at the federal level. Table 5 provides additional details on these proposals.

Table 5. Snapshot of Medicare for All proposals

Associated Bills: ***S. 1129***[46] *Sanders,* ***H.R. 1384***[47] *Jayapal (WA-07).*

Ways and Means Co-Sponsors: **H.R. 1384** - John Lewis (GA-05), Lloyd Doggett (TX-35), Mike Thompson (CA-05), Earl Blumenauer (OR-03), Danny Davis (IL-07), Judy Chu (CA-27), Brendan Boyle (PA-02), Jimmy Panetta (CA-20), Jimmy Gomez (CA-34)

Plan element	Description
Coverage	Medicare for All would cover all U.S. residents by replacing private insurance, Medicare, Medicaid, the ACA Marketplace, TRICARE, and CHIP.

[46] https://www.congress.gov/bill/116th-congress/senate-bill/1129/text
[47] https://www.congress.gov/bill/116th-congress/house-bill/1384/text

Benefits	All medically necessary or appropriate benefits including home- and community-based long-term services and supports, dental, vision, hearing, transportation to health services, and other services as a health provider deems necessary. The Jayapal proposal also covers institutional long-term services and supports, while the Sanders proposal leaves institutional long-term care to Medicaid at the state level. States can provide additional benefits at their expense. The Secretary would negotiate for drug prices – and the Jayapal proposal includes provisions for government manufacturing of drugs if negotiations break down, with adequate compensation to the manufacturer.
Role of Insurance	Private insurance would be eliminated under these plans. IHS and the VA would remain separate entities. Private insurance would be allowed for coverage of non-covered services only.
Beneficiary Costs	There are no premiums or deductibles. The Jayapal proposal would completely eliminate all cost-sharing. The Sanders proposal would allow limited cost-sharing on prescriptions up to $200 per year for those above 200 percent FPL, indexed to inflation.
Provider Reimbursement	Under the Sanders proposal, the Secretary would be responsible for setting a fee schedule. The Jayapal proposal would establish global budgets, negotiated on a regional basis to be paid quarterly to hospitals and facilities. Physicians would continue to be paid fee-for-service, with fees determined by the Secretary using the current Medicare Physician Fee Schedule and information from experts and national data-tracking programs. Both plans set a program-wide global budget for all health expenditures, including operations, capital expenditures, quality assessment activities, health profession education, prevention/public health, and administrative costs, as well as a reserve fund for epidemics, disasters, and other health emergencies
Public Financing	Current federal health spending would be appropriated to a new Universal Medicare Trust Fund. The Jayapal plan does not include other financing provisions, while the Sanders plan would use a progressive payroll tax, in addition to other mechanisms, to pay for ongoing costs.

F. ACA Repeal

Since passage of the ACA, Republican Members of Congress have introduced a number of bills aimed at "repealing and replacing" the ACA, with the American Health Care Act (AHCA) passing the House in May 2017. The focus of this proposal and others was on removing many consumer protections established under the ACA, eliminating the individual responsibility provision, and capping Medicaid. Table 6 provides additional details on these proposals.

Table 6. Snapshot of AHCA and ACA repeal proposals

Associated Bills: Associated Bills: ***H.R. 1628***[48] *Black (TN-06),* ***S.Amdt.1030***[49] *Graham.*

Ways and Means Co-Sponsors: No Democrats.

Plan element	Description
Coverage	These proposals increase both the number of uninsured and under-insured Americans. CBO estimated that if AHCA became law, 24 million fewer Americans would have insurance, including seven million Americans with employer-sponsored coverage. In addition, these proposals once again allow insurance companies to discriminate against people with preexisting conditions and charge higher premiums to older Americans as well as women. AHCA cuts billions from Medicaid – up to 25 percent of the current program – and directly slashes funding for people with disabilities.
Benefits	AHCA and other ACA repeal proposals undermine the Essential Health Benefits and consumer protections included in the ACA. Some proposals limit states' ability to protect their consumers.
Role of Insurance	Under these proposals, private health insurance remains the source of coverage in the individual market, while most Americans would continue to get health insurance through the group market.
Beneficiary Costs	These plans increase beneficiary costs by not covering all services and allowing discriminatory underwriting. Many proposals also rely on high deductibles, which put consumers at greater risk and often leads to avoiding care rather than selecting "high value" care.
Provider Reimbursement	Provider reimbursement would continue to be negotiated between providers and insurance companies, Medicare, or Medicaid.
Public Financing	Because of the cuts to tax credits, Medicaid, and other programs, the proposal reduces federal funding. According to CBO, AHCA would have cut $880 billion from Medicaid.

VI. ATTACHMENTS

a. CBO report on single-payer considerations
b. Kaiser Family Foundation overview slides

[48] https://www.congress.gov/bill/115th-congress/house-bill/1628/text
[49] https://www.congress.gov/amendment/115th-congress/senate-amendment/1030/text