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2018 Federal Single Payer & Public Option Legislation

Since the start of the 115th Congress, several single payer and public option bills have been introduced.

Generally, single payer legislation (e.g., "Medicare for All" legislation) establishes one government-administered (federal or state) health plan to replace the existing public and private health systems. Public option bills, on the other hand, typically offer Medicare and Medicaid buy-in options (for everyone or some targeted subset of the population), allowing government-run health plans to be sold alongside existing private options.

Medicare for All Proposals

Legislation	Employer Participation	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Medicare for All Act of 2017 (S. 1804) Sen. Bernie Sanders (I-VT) Single payer; establishes the Universal Medicare Program	Prohibited Once effective, benefits covered by the Program may not be covered by others (e.g., by a private insurer or employer)	All U.S. residents are eligible For children 0-18, benefits are available on Jan. 1 of the first calendar year following enactment For all others, benefits will be available on Jan. 1 of the fourth calendar year following enactment (in the intervening four years, individuals can retain coverage provided by another federal program or from the private health market) • Establishes a "Medicare	Program covers an array of benefits (similar to EHBs with a few additions) States can require additional benefits	No out-of-pocket costs (including deductibles, coinsurance, or copayments) for any of the enumerated benefits, except for prescription drugs	N/A, though Sen. Sanders subsequently and separately offered several options to finance the bill, including: • 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 payroll and income) • 4% income-based premium paid by households; • Reform of the personal income	Retains the Veterans Affairs health system and the Indian Health Services (other federal programs would be transitioned into the Program)

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		transition program" (i.e., a Medicare buy-in option) during the intervening four years. During the first year, the eligibility age would be 55; during the second year, 45; and during the third year, 35 Provides enrolled individuals with a Universal Medicare card for the purposes of identification and processing of claims			tax system, among others Establishes the Universal Medicare Trust Fund	
Expanded & Improved Medicare For All Act (H.R. 676) Rep. Keith Ellison (D-MN) Single payer; establishes the Medicare for All Program	Prohibited Private health insurers cannot sell coverage that duplicates the benefits otherwise covered by the Program	All U.S. residents are eligible one year following enactment Upon registration at a health care provider, individuals and families will receive a Medicare for All Program Card Establishes a presumption that individuals who present themselves	Program covers an array of benefits (broader than EHBs, includes approved dietary and nutritional therapies, long-term care, dental services, chiropractic services)	No out-of-pocket costs (including deductibles, coinsurance, or copayments) for any of the covered benefits	Funding sources include: • Existing sources of federal government revenues for health care • Increasing personal income taxes on the top 5% income earner • Instituting a modest and progressive excise tax on payroll and	Requires participating providers to be a public or not-for-profit institution

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		for covered services are eligible/registered to receive such services			self-employment income • Instituting a modest tax on unearned income • Instituting a small tax on stock and bond transactions Appropriates additional sums as needed to "maintain maximum quality, efficiency, and access" under the Program Establishes the Medicare for All Trust Fund	
State-Based Universal Health Care Act of 2018 (H.R. 6097)[1] Rep. Pramila Jayapal (D-WA) Grants states waivers to implement a universal health care system	Waives the ACA's employer mandate	All state residents (except individuals eligible for benefits through the Indian Health Service, or veterans benefits) State plans must provide public education activities to raise awareness of the availability of QHPs and the facilitation of enrollment	State plans must offer coverage that is "at least as comprehensive" as what residents receive now Must provide coverage and cost-sharing protections against excessive out-of-pocket spending to state residents that	Waives provisions of law related to exchanges, CSRs, and the ACA's premium tax credit States must provide a ten-year budget plan.	Combines funding streams of existing federal health programs Authorizes to be appropriated "such sums as may be necessary for providing funds to states with a waiver" for their education campaigns Plans must not increase the federal deficit	Plans must show how states will achieve coverage for at least 95% of state residents within 5 years, with 5% not spending more than 10% of their annual income on coverage (subject to 5-

[1] Provisions of law that are waived include those related to exchanges, CSRs, the ACA's premium tax credit and employer mandate, Medicare, Medicaid, CHIP, FEHBP, TRICARE, and ERISA preemption. *See* the Section-by-Section.

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(replaces 1332 waiver system)			are at least as affordable as the protections under existing federal health programs Must not preclude the purchase of supplemental insurance			year report/review requirements). If after 5 years, the necessary metrics aren't achieved, then a 6-month grace period begins (after which, if health coverage is still not achieved, then the waiver is terminated) Authorizes multiple states in one region to submit one plan Establishes a panel to review waivers (authorizes such appropriations as may be necessary to carry out the duties of the panel from 2018-2023) Current 1332 waivers would be grandfathered until their expiration dates

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Medicare Buy-In Proposals

Legislation	Employer Participation	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Medicare-X Choice Act of 2017 (S. 1970/H.R. 4094) Sen. Michael Bennet (D-CO)/Rep. Brian Higgins (D-NY) Medicare buy-in; establishes the Medicare Exchange Health Plan	N/A	"Qualified individuals," as defined by the ACA, are eligible to enroll in the Plan, provided they are not eligible for benefits under the Medicare program The Plan's availability would transition over time • In 2020, offered in individual and small business health exchanges in rating areas where there is only one or no option on the exchange; • By 2023, offered throughout the individual market; and • By 2024, offered throughout the	Plan covers EHBs (must meet the same requirements as exchange plans under the ACA) Requires HHS to make available options in at least the silver and gold metal levels (with flexibility to add bronze and platinum options)	HHS to establish premiums that cover the full actuarial cost of offering the Plan (including administrative costs)	Establishes the Plan Reserve Fund Appropriates $100 billion to the Plan Reserve Fund to establish and administer the Plan	All enrollees in the Plan within a state will be members of a single risk pool (HHS is permitted to establish a mechanism to pool the costs of the highest-cost patients on a nationwide basis)

Legislation	Employer Participation	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
		small group market				
Choose Medicare Act (S. 2708/H.R. 6117) Sen. Jeff Merkley (D-OR)/Rep. Cedric Richmond (D-LA) Medicare buy-in; creates Medicare Part E Plans	Part E plans would be offered in the individual, small group, and large group markets	U.S. residents are eligible, provided they are not entitled to/enrolled in benefits under Medicare; medical assistance under a state plan under Medicaid; child health assistance or pregnancy-related assistance under CHIP Enrollment options will be available through state and federal exchanges and through employers One year after enactment, HHS must provide options for Part E plans in the small and large group market that are voluntary; requires HHS to develop a process for portability of coverage (allowing an individual to	Plan covers EHBs (and all items/services for which benefits are available under Medicare); provides gold-level coverage; covers abortions and all other reproductive services Prohibits states from preventing a Part E plan from offering covered benefits	HHS to determine premiums Establishes an out-of-pocket maximum in Medicare (in 2020, $6,700)	Appropriates $2 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	Enhances the generosity of the premium tax credit by using a gold-level plan as the benchmark; 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%) Modifies CSR payment amounts to allow for further reductions Requires HHS to establish a program in each state to carry out a reinsurance program (appropriates $10 billion to establish and administer the program) Expands rating rules to the large group market

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		maintain their Part E plan even if the individual subsequently loses eligibility for enrollment)				
Medicare Buy-In and Health Care Stabilization Act of 2017 (H.R. 3748) Rep. Brian Higgins (D-NY) Medicare buy-in for ages 50-64	The 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; such information must be provided to eligible employees when they are hired and in advance of open enrollment annually	U.S. residents between ages 50-64 are 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) Enrollment options will 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; appropriates $500 million for such grants)	Same benefits as those offered to individuals entitled to benefits under Part A and enrolled under Parts B and D	HHS to determine premiums Premium tax credit or CSR payments could go toward premiums Eligible enrollees with access to employer-sponsored coverage could buy into Medicare and their employers could contribute to their premiums pre-tax	Establishes a Medicare Buy-In Trust Fund	Contains provisions addressing the individual mandate (pre-tax reform) Establishes an individual market reinsurance fund to provide funding for an individual market stabilization reinsurance program in each compliant state Extends the ACA's risk-corridor program through 2020 Improves/enhances CSR payments (increases the percentages by which cost-sharing would be reduced for households up to 400% of the federal poverty line) Establishes a technical advisory committee to address the long-term

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						costs of the country's health care system
Medicare at 55 Act (S. 1742) Sen. Debbie Stabenow (D-MI) Medicare buy-in for ages 55-64	N/A	U.S. residents between ages 55-64 are eligible, provided they are not otherwise entitled to benefits under Part A or eligible to enroll under Part A or Part B HHS establishes enrollment periods	Same benefits as those offered to individuals entitled to benefits under Part A and enrolled under Parts B and D	HHS to determine premiums Enrollees will not be eligible for Medicare cost-sharing assistance, but may be eligible for premium assistance/CSRs under the ACA	N/A	Contains provisions addressing the individual mandate (pre-tax reform)

Medicaid Buy-In Proposal

Legislation	Employer Participation	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
State Public Option Act (S. 2001/H.R. 4129) Sen. Brian Schatz (D-HI)/Rep. Ben Ray Lujan (D-NM) Medicaid buy-in	N/A	State residents who are not currently enrolled in other health insurance coverage/subject to payment of premiums or other cost-sharing charges are eligible A state that allows individuals to buy into Medicaid must allow enrollment through federal and state exchanges;	Plan must provide at least minimum coverage, as defined in the Social Security Act, though some articles note that the coverage would not be identical to traditional Medicaid coverage (rather, it would cover	States may impose premiums, deductibles, cost-sharing, etc. that are actuarially fair; may vary the premium rate, provided total amount of premiums cannot exceed 9.5% of the family's household income Premium tax credit or CSR payments	N/A	Individuals who buy-in are eligible for CSRs (subject to the income eligibility threshold) and the premium tax credit Requires federal regulators to develop standardized, state-level metrics on access to/satisfaction with providers, with respect to individuals enrolled in Medicaid Requires HHS to award grants to states that file applications containing ways to improve access to service for Medicaid

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		states can limit enrollment periods	the ACA's EHBs)	could go toward premiums		enrollees (appropriates $100 billion for these grants)

Other Proposals

Legislation	Employer Participation	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Bare County Buy-In Act of 2017 (H.R. 4394) Rep. Dina Titus (D-NV) Public option for bare counties	N/A	If HHS determines that individuals in a particular rating area do not have access to a QHP through an exchange, it is required to make a public option available to such individuals	Option covers EHBs; and consists of a silver-level plan	HHS to determine premiums	N/A	N/A