THE COUNCIL
The Council of Insurance Agents & Brokers

Steptoe

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117th Congress 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.

Medicaid Buy-In Proposals

Legislation	Private Market Impact	Eligibility and Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Medicare-X Choice Act of 2021 (H.R. 1227/S.386) Rep. Antonio Delgado (D-NY)/ Sen. Michael Bennet (D-CO) 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 • In 2022, offered in the individual market in rating areas where there is only one or no option on the exchange; • By 2025, offered throughout the individual market; and • By 2025, offered throughout the small group market Makes the plan available on the ACA exchanges	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 options in at least the silver and gold metal levels (with flexibility to add bronze and platinum options)	*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 years For plan year 2022, 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 2021 plan year *Payment Rates.* Requires provider reimbursement at rates determined for equivalent items	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 establish and administer the plan Appropriates $1 billion for FY2021 for the establishment and administration of the plan Authorizes HHS 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 FY2022-FY2024 *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 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.

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				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.)	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	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

Other Public Option Proposals

Legislation	Private Market Impact	Eligibility/ Enrollment	Benefits	Cost/Payment	Funding	Miscellaneous
Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act	Offers the public option on exchanges alongside private plans	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	*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 "startup funding"—i.e.,	*Preemption.* Preempts state laws that prohibit a public health insurance option *Data Collection.* Requires HHS to collect data necessary to establish premiums and payment rates, improve quality, improve quality, etc.

(S. 983) Sen. Sheldon Whitehouse (D-RI) Public option offered through the exchanges of qualified health plans	Does not directly address employer participation	Follows ACA marketplace enrollment procedures and rules	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	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 2023	*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