



The National Voice for Direct-Care RNs

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**Testimony of Jean Ross, RN
On Behalf of National Nurses United
Before the
Subcommittee on Health
of the House Energy & Commerce Committee
December 10, 2019**

Hearing on “Proposals to Achieve Universal Health Care Coverage”

Good morning and thank you, Chairwoman Eshoo, Ranking Member Burgess, and members of the subcommittee for holding this important hearing today. My name is Jean Ross. I have been a registered nurse (RN) in Minnesota for over 40 years, and I am President of National Nurses United (NNU), the largest union representing RNs in the United States. We represent over 150,000 members who work as bedside healthcare professionals in every state in the nation.

In my testimony today, I will use my experiences as a registered nurse to illustrate two main points to you: first, the patchwork health system of public programs and private for-profit insurers that we currently have in the United States is ineffective, inefficient, and unjustifiably unaffordable for our patients and for our country; second, the only way that we can guarantee every person living in this country receives the healthcare that they need is by adopting a single payer, Medicare for All system, which would excise the complexity and corporate profiteering that pervades our health system today.

As a registered nurse, I have cared for people in their darkest hours, when they are sick, injured, and dying. Every single day, nurses bear witness to the failures of our current health care system. I have watched as patients refuse the medications, procedures, and care they need because they cannot afford the costs of their copays or deductibles. I have watched as insurance corporations refuse to cover the care that is required for the health and wellbeing of my patients. I've seen hundreds of patients who show up in the emergency room because they cannot afford the costs of preventive care, both those with and without insurance coverage.

I'd like to share with you a few specific experiences I've had as a nurse, and as a mother and grandmother, that demonstrate the failings of our current system.

A few years ago, while working as a nurse on the IV team, which is responsible for providing expertise and support when a patient needs fluids, medications, or nutrition delivered intravenously, we were treating a patient for cancer. But this particular patient already had been through her course of chemo and medications, which meant that her veins were significantly deteriorated.

The first time I provided care to her, she came into the hospital with complications from chemo and she needed IV treatment from our team. Typically, for the kind of longer-term, caustic treatment we were giving this patient, we would insert a central IV line into a major central vein rather than a peripheral IV through their hand or arm. Our medical and nursing team knew that a peripheral line would be caustic to her remaining veins, it could cause more pain and inflammation than simple fluids or antibiotics. To preserve her remaining veins, the team recommended that she have a central line put in instead of a peripheral line. A central line was ordered by her treating physician but the patient told us that her insurance plan had an annual cap on the amount of money they would cover for her care, and she had exceeded this cap through the course of her cancer treatment. The insurance company was not going to cover the costs of any IV treatment. Because of her financial situation, the patient was forced to choose the cheapest care. So, she chose to have a peripheral IV inserted because a central line would be significantly more expensive. This caused significant damage to her remaining veins. The doctors and nurses had to provide care based on the economic calculation of an insurance adjuster, rather than on our best professional judgment.

The second time I saw this patient, she had returned to the hospital for testing. We needed to perform a CT scan, which involves an injection of dye, which normally should be delivered through a peripheral IV. But because of the damage that had been previously done to her veins, she no longer had any veins that were usable for a peripheral IV. We were forced to insert a central line, when she should not have required one. If we could have delivered the correct care in the first instance, we would not have been in a situation where health care professionals must provide higher risk and higher cost treatment in the long-run because of arbitrary decisions by an insurer to deny care and save money in the short run. After this experience, the nurses and doctors on the team all felt that we had let our patient down, because we had not been able to do what was best for her in the course of her treatment.

Under a single payer, Medicare for All system, these kinds of health care delivery—where money drives my patient’s treatment plan and not the professional judgment of doctors and nurses— would never have happened. This patient’s veins would have been preserved for any testing or treatment she may

need later in her life. But because of our failing health insurance system, her veins are forever damaged, and care that she needs in the future will continue to be more complex, costly, and painful.

I worked as an ER nurse for many years, and I had countless experiences with patients who had not been able to receive preventive care and showed up to our ER with severe illness which could have been prevented. One patient always stands out to me. He arrived in the ER in a hypertensive crisis, and we treated him immediately for an imminent stroke which we thankfully were able to prevent. As I was providing nursing care to him, I became aware that he had been rationing his prescribed blood pressure medication. He should have been taking it every day, and instead he was taking it every two days. He had not told his doctor that he was doing this, because he knew he was going against his doctor's orders, and he knew he needed those pills every day to avoid the very kinds of life-threatening situations that had just landed him in the ER. But he could not afford the medication, even with his private insurance plan.

He arrived at the ER not because his health was failing him that day, but because his private health insurance plan was failing him, and our system was failing him. His visit to the ER was entirely preventable.

While I am a nurse, I am also a mother and a grandmother. And normally, as a nurse leader and a president of my union, I discuss the broad experiences of our union's members. But today I also want to tell you about the way this fractured system has affected me and my family.

When my son Tony was born, he was born with several congenital heart defects, most of which were repaired shortly after his birth, but still left him with a leaky valve. These kinds of congenital heart defects can necessitate complex care throughout a person's life. Tony is now 40 years old, and at one point had not been to see a cardiologist for at least a decade. During one phase of his employment, he qualified for a low-cost plan on the exchange. He saw a cardiologist then, but is now again without an insurance plan. He still has a leaky valve. Tony has been consistently unable to afford the costs of his cardiology care. Sometimes he has not been able to afford insurance. But other times, when he has had employer-sponsored insurance, he has not been able to afford the copays and deductibles. As a nurse who understands his medical conditions, I know that his leaky valve could lead to heart failure. As his mother, the fear that this could happen to my son because he simply cannot afford to pay for the care that he needs is devastating.

I am also a grandmother, and my daughter has three children. As a single parent, my daughter has struggled to afford the costs of the copays for my grandchildren's care. Over the past ten years, I have received numerous calls from my daughter asking for advice on whether or not she really needed to take the kids to see the doctor, because the copays were too much for her to keep up with on her income. A few years ago, when my grandson Evan was an infant, I got one of these calls from my daughter. Evan was sick but my daughter did not have the money to take him to the doctor. After she described his symptoms to me, I knew that Evan needed immediate medical attention. So, I told her that I would pay for the copays and that she needed to bring him to the ER right away. I was right; my grandson was suffering from Encephalitis, swelling in the brain. Encephalitis can cause permanent brain damage and even death. I am so grateful that I had the economic resources in that moment to help my daughter, because if I had not, like so many other patients who do not have the means, Evan would have been in severe trouble if he didn't get that care immediately.

As a grandmother, I want to leave my grandchildren with a country where health care is a right. I want my grandchildren to know that when they or their own children get sick, they will only have to focus on their health, and not worry about their bank accounts.

As a registered nurse for 40 years, I know that these stories are not unique to me, these particular patients, or my family. They happen every single day in hospitals, clinics, and communities across the country. The system we have now is ineffective at providing quality, therapeutic care to our patients because it is beholden to the for-profit interests that determine who gets treatment, and what treatment they get. Ineffective care leads to inefficiencies in the system, because it prioritizes short term cost-savings, rather than long term investments in our health. This all culminates in a system that is entirely unaffordable for our patients and our country – patients cannot afford the costs of their care individually, the country can't afford the financial burdens of a system that makes poor decisions, and our society cannot afford the consequences to our public health.

As you know, the United States leads internationally in healthcare in two unfortunate ways. We spend way more money on health care than any other nation in the world even though nearly 30 million people are uninsured and tens of millions more are underinsured. Instead of providing comprehensive health care for all people in America, we waste hundreds of billions of dollars each year on unnecessary administrative costs, huge profit margins for corporations, and inefficiencies. And despite paying top dollar for our health care, we get poor results for what we do spend, mediocre results if we're lucky. Our country ranks near the bottom on many international health indicators, including on critical

barometers such as average life expectancy, infant mortality, maternal mortality, and death from preventable diseases. High costs and poor health outcomes persist because access to an insurance plan is not the same as guaranteed health care for all. Our country must do better.

This brings me to my second point. The only way to solve the health care crisis in this country, is to enact a single payer, Medicare for All system.

Under Medicare for All, we will transform our profit-driven health insurance system into a health care system that prioritizes patient care. In a Medicare for All system, no patient will go without necessary and lifesaving preventive care because they can't afford it. Patients will never have to ration their medication. Doctors and nurses will be able to provide care based on their best professional judgment without insurance company interference.

Under a Medicare for All system, every person living in the United States would get comprehensive health care services. Your health will no longer depend on your ability to pay. You will get quality, therapeutic care without premiums, without copayments, without deductibles, without coinsurance, without preauthorization requirements or out-of-network costs, without arbitrary annual or lifetime limits on health care spending, and without surprise medical bills.

By improving the existing Medicare program and expanding it to cover everyone, we will improve patient care, and drastically reduce the inefficiencies that riddle the existing system. We will reduce the unnecessary illness, suffering, and financial expense we incur now due to our failure to provide guaranteed preventive care. By providing the medical and nursing care guided by the professional judgment of their health care providers--instead of the financial concerns of the insurance companies--we'll have better patient outcomes and we'll save money overall. We will reduce the stress and anxiety that the current complex system causes to patients and providers, while also saving billions of dollars in administrative waste.

A single payer system is the ONLY way that this country can provide guaranteed healthcare while also reducing the amount of money we spend on health care overall. Economic analyses have shown that our country would save between two and five trillion dollars over ten years if we implemented a single payer Medicare for All program.

Right now, we waste billions of dollars in administrative costs associated with private for-profit insurers, including money used for marketing, executive compensation, and processing and denying insurance claims. Providers and patients alike waste money, time, and resources dealing with our complex insurance system. Providers must maintain cumbersome billing systems needed to bill dozens of different insurance providers and to track deductibles, copays, and preauthorizations. As patients, we dispute denials of care and surprise charges.

Billions more are wasted in exorbitant charges from hospitals and health systems and price-gouging pharmaceutical companies. Under a Medicare for All system, because there is only one insurer, health care profiteering would come to an end. By leveraging its buying power as the single payer for health care, the government would be able to negotiate better, fairer prices for everyone. The prices of prescription drugs would be drastically reduced.

Finally, our system today pays out billions of dollars to CEO's and other executives. In a Medicare for All system, health care corporations could no longer siphon off money to line their pockets with profits. H.R. 1384 limits executive pay and prohibits bonuses and other financial incentives for upcoding.

The only bill before the subcommittee today that will guarantee high quality, therapeutic healthcare to every person in this country, while reducing our overall health care costs, is H.R. 1384, the Medicare for All Act of 2019, authored by Congresswoman Jayapal and Congresswoman Dingell.

I want to urge members of the subcommittee to remember that the choices that Congress makes on the details of health care system design--whether on coverage, provider participation, cost sharing, or cost containment--have a human price beyond dollars and cents.

It is important to remember that having private insurance coverage does not mean that patients are guaranteed the quality, therapeutic health care that they need. The business of private health insurance views health treatments, life-saving medications, and each and every doctor's visit or diagnostic test as a liability to the bottom line. To widen margins, health insurers erect every barrier to stop patients from going to the doctor or hospital. They create complex schemes to deny care. Denial of care is what copays, deductibles, preauthorizations, and preferred network plans are meant to accomplish. Simply put, private health insurance profits from the denial of health care. The health of my patients is a threat to corporations and their shareholders.

Medicare for All would end the fundamental inequality that all systems of private health insurance, as structures organized to maximize corporate profits, are built on.

The innate cruelty of our system was underscored by two courageous people who testified in congressional hearings before your colleagues earlier this year. Ady Barkan— a brilliant lawyer and advocate for an economic system that benefits all working people, a dedicated husband to Rachel, and a loving father of two young children—testified before the Rules Committee in April. Ady talked about his terminal diagnosis of ALS and his struggle to afford the treatments he needs to stay alive despite having good health insurance. Only through the generous financial support from his family, friends, and anonymous donors on GoFundMe is Ady able to afford the 24 hours care and medical equipment needed to keep him breathing.

Rebecca Wood, the courageous and hard-working mother of Charlie who was born three months premature, spoke before the Ways & Means Committee in June. Rebecca had health insurance from her husband’s private employer-sponsored plan. Rebecca described how the copays, deductibles, automatic denials, and exclusions for Charlie’s care drained her family’s savings. When it came time to pay either for therapy for Charlie or an expensive dental procedure for herself, Rebecca—like any mother—chose Charlie. But that impossible choice resulted in an infection spreading through Rebecca’s entire mouth and to her jaw. Rebecca had to get all her teeth pulled and parts of her jaw removed—and she could only afford local anesthesia through the 6-hour procedure.

It is morally unacceptable to allow this kind of corporate-made cruelty to persist. But every proposal before the subcommittee apart from Medicare for All would retain a system of private health insurance in some form. By maintaining the private insurance system, these proposals may ultimately be fated to fail. They would allow private insurers to cherry-pick coverage of only the healthiest people and leave the public programs and plans to care for the sickest and most expensive cases.

Even worse, these proposals would place limits on coverage and eligibility. They still impose costly premiums and out-of-pocket costs on patients. And by virtue of maintaining a multi-payer system, they would limit choice of provider. Further, sticking with the existing commercial insurance system does nothing to rein in our skyrocketing health care costs because these plans also retain the existing administrative complexity and would not achieve the financial savings that we can capture with a true single-payer Medicare for All program.

Medicare for All is the only viable solution.

The primary responsibility of a registered nurse is to protect the health and wellbeing of our patients by providing quality therapeutic nursing care when they need it. Right now, our ability to do our job well is made exceedingly difficult and nearly impossible by our broken system of private health insurance. Making money off people's illness and misery is wrong and deserves no place in health care. This violates our values as nurses and violates our ethical responsibility to help people and to put our patients first.

In my professional judgment as a nurse, the only way nurses can put our patients first--as we are ethically and morally bound to do--and the only way we can truly heal America is through Medicare for All. I urge every Member of Congress to support H.R. 1384, the Medicare for All Act of 2019.

ATTACHMENTS

1. National Nurses United, Letter in Support of the Medicare for All Act of 2019, H.R. 1384
2. Medicare for All Act of 2019: Summary
3. Issue Brief, Medicare for All Act of 2019: Eliminating Health & Health Care Disparities
4. Issue Brief, Too Little, Too Late: The Limits of a Public Plan Option
5. Comparison Chart: Medicare for All Act of 2019 and Other Legislation
6. Issue Brief, Medicare for All Act of 2019: Program Design
7. Issue Brief, Medicare for All Act of 2019: Ensuring Access to Care
8. Issue Brief, Medicare for All Act of 2019: Ending the Burden of Medical Debt
9. Issue Brief, Medicare for All Act of 2019: Long-Term Supports & Services
10. Issue Brief, Medicare for All Act of 2019: Global Budgets & Other Reimbursements
11. Issue Brief: Medicare for All Act of 2019: Cost & Savings Analyses
12. Issue Brief: Medicare for All Act of 2019: Canada, Taiwan & U.S. Comparison
13. Issue Brief, Medicare for All Act of 2019: Frequently Asked Questions



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December 10, 2019

The Honorable Anna Eshoo, Chairwoman
Subcommittee on Health
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael Burgess, Ranking Member
Subcommittee on Health
House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, DC 20515

**RE: Letter in Support of the Medicare for All Act of 2019, H.R. 1384, Hearing on
“Proposals to Achieve Universal Health Care Coverage.”**

Dear Chairwoman Eshoo, Ranking Member Burgess, and Subcommittee Members:

National Nurses United (“NNU”), the largest union representing registered nurses (“RNs”) in the United States, submits this testimony in support of the Medicare for All Act of 2019, H.R. 1384, introduced by Reps. Pramilla Jayapal (D-WA) and Debbie Dingell (D-MI). With over 150,000 registered nurse members across the country, NNU proudly endorses the Medicare for All Act of 2019 and we urge the Subcommittee to support H.R. 1384. NNU members, as registered nurses, care for people in their most difficult hours, when they are sick, injured, and dying. We witness the personal impacts of a flawed health care system in our hospitals and clinics every single day. Our primary responsibility is to protect the health and wellbeing of our patients by providing safe, therapeutic care at the bedside, but this is made increasingly difficult by our country’s broken health care system.

Under our current multi-payer system that is dominated by insurance, hospital, and pharmaceutical corporations, the basic health needs of tens of millions in the United States go unmet while health corporations soak-up billions of health care dollars. Today, the United States spends more money on health care than any other nation in the world, wasting hundreds of billions of dollars each year on unnecessary administrative costs, huge profit margins, and inefficiencies in our current system. Navigating the complex web of private insurers and public programs necessitates over \$470 billion per year in administrative-related activities for doctors and hospitals.¹ Total administrative costs of our current multi-payer system to insurers, employers, hospitals, physicians, and other health care facilities combined were estimated to reach \$1.05 trillion in 2017, which represents 30 percent of U.S. health care costs.² Despite spending more money on health care than any other country, our country ranks

¹ Woolhandler, Steffie and Himmelstein, David. “Single-Payer Reform: The Only Way to Fulfill the President’s Pledge of More Coverage, Better Benefits, and Lower Costs.” *Ann. Intern. Med.* (2017) 166(8): 587-588 (see Table), available at <https://annals.org/aim/fullarticle/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more>.

² *Id.* Percentage calculated using Centers for Medicare and Medicaid Services data, reporting national health expenditures as \$3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. “National Health Expenditure Accounts (2017).” U.S. Department of Health and Human Services (accessed on April 26, 2019), available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>.

near the bottom on many international health indicators, including on such critical barometers as average life expectancy, infant mortality, maternal mortality, and death from preventable diseases.³

The ever-rising cost of health care and the discriminatory characteristics of our patchwork system of private for-profit insurers contribute to the growing national chasm in wealth inequality and health disparities. Of those uninsured, 59 percent are people of color.⁴ African-Americans suffer higher death rates than whites at an earlier age due to heart disease, diabetes, cancer, HIV, and infant mortality,⁵ and African-American women are three to four times more likely than white women to die during childbirth.⁶ High costs and poor health outcomes persist because access to an insurance plan is not the same as guaranteed health care for all. Our country must do better.

As the Subcommittee considers how to achieve universal health coverage, NNU urges members not to lose sight of the fundamental ethical question of equity underpinning the task of health care system design. Preoccupation with the financial costs of Medicare for All should not distract us from the real impact of national health policy decisions can have on our lives, especially since Medicare for All will save the country trillions of dollars. A question that the late health economist Uwe Reinhardt first posed to health policy pundits in 1997 is pertinent here:

As a matter of national policy, and to the extent that a nation’s healthcare system can make it possible, should the child of a poor American family have the same chance of avoiding preventable illness or of being cured from a given illness as does the child of a rich American family?⁷

Dr. Reinhardt, by posing this question, asks us to place our ethical goals and principles into the foreground when considering health care system design.⁸ This question should remind the Subcommittee that all health care system design choices—whether on benefits, coverage, provider participation, cost sharing, or cost containment—are all ethical choices that may have a human price beyond dollars and cents. If the answer to Dr. Reinhardt’s question is a resounding ‘yes’, then the Medicare for All Act of 2019 is the only bill under consideration today that can ensure this principle of equity is fulfilled.

Despite the fact that we—as nurses—believe that our ethical starting point must be one of health equity for all, the Medicare for All program also would create huge cost-savings for the country. The two leading studies on the costs and savings of Medicare for All each find that the program would result in overall savings in national health expenditures. Robert Pollin and his colleagues at the University of Massachusetts Amherst found that Medicare for All would result in \$5.1 trillion in savings on national

³ Organization for Economic Cooperation and Development. “Health at a Glance 2019.” OECD Publishing (2019), accessed on December, available at <https://www.oecd.org/health/health-systems/health-at-a-glance-19991312.htm>; Organization for Economic Cooperation and Development. “OECD Health Statistics 2019.” OECD Stat (Updated Nov. 2019), accessed on December 5, 2019, available at <http://www.oecd.org/els/health-systems/health-data.htm>.

⁴ Kaiser Family Foundation. “Key Facts about the Uninsured Population.” (Dec. 2018), available at <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

⁵ U.S. Department of Health and Human Services. Office of Minority Health. “Infant Mortality and African Americans.” (Last Updated Nov. 2017), accessed on April 26, 2019, available at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=23>; Cunningham, Timothy et al. “Vital Signs: Racial Disparities in Age-Specific Mortality Among Blacks or African Americans — United States, 1999–2015.” *Morbidity and Mortality Weekly Report* (May 5, 2017), available at <https://www.cdc.gov/mmwr/volumes/66/wr/mm6617e1.htm>; American Cancer Society. “Cancer Facts & Figures for African Americans 2019–2021.” *Amer. Cancer Society*, 2019.

⁶ Centers for Disease Control and Prevention. CDC Public Health Grand Rounds. “Meeting the Challenges of Measuring and Preventing Maternal Mortality in the United States.” Presented on Nov. 14, 2017, available at <https://www.cdc.gov/grand-rounds/pp/2017/20171114-maternal-mortality.html>.

⁷ Reinhardt, Uwe. “Wanted: A Clearly Articulated Social Ethic for American HealthCare.” *JAMA* (Nov. 1997), Vol. 278:17, pp.1446–47.

⁸ Dr. Reinhardt continues to ask policy-makers this basic question about our ethical goals and principles on health care and health equity. Just last week, he posthumously published a book reasserting these same questions onto current health care debates. See Reinhardt, Uwe. *Priced Out: The Economic and Ethical Costs of American Health Care*. Princeton University Press (May 2019).

health spending over 10 years.⁹ Similarly, the findings of a study by Charles Blahous of the Mercatus Institute of George Mason University demonstrate that Medicare for All could result in over \$2 trillion in savings over 10 years in national health expenditures.¹⁰ Both Blahous’s and Pollin’s findings demonstrate that savings captured by Medicare for All would far exceed any increases in costs. Medicare for All would simplify our health system and cut administrative costs dramatically. By improving payment systems to hospitals and other providers and by reducing the costs of prescription drugs through leveraged negotiations as a single-payer, the Medicare for All program would save the country trillions of dollars while also guaranteeing comprehensive, quality health care to every person living in the United States.

Too many Americans—as individuals, families, businesses, and taxpayers—have been driven past their breaking point as a result of soaring health insurance costs. Health insurers, as market-driven corporations, enrich themselves by imposing harsh limitations in coverage and through perpetually increasing insurance premiums, deductibles, and co-pays. Private insurers deny between 11 percent to 24 percent of all claims for care,¹¹ and they restrict patient choice through narrow provider networks, limited drug formularies, and other barriers to care. More than 40 percent of all U.S. adults under the age of 65 forego needed medical care, and 30 percent fail to fill a prescription or take less than the recommended dose.¹² One third of U.S. adults say that, in the past year, they have had to choose between paying for food, heating, housing, or health care.¹³ The inability to pay medical bills continues to be a contributor to indebtedness. The Consumer Financial Protection Bureau reported that medical bills account for more than half of all unpaid bills sent to collection agencies.¹⁴ Of those whose illnesses contributed to bankruptcy, 75.7 percent had insurance at the onset of their illness.¹⁵

Even though the Patient Protection and Affordable Care Act enacted important improvements that have enabled more Americans to enroll in health insurance, out-of-pocket health costs continue to rapidly increase and tens of millions remain severely underinsured. These reform efforts temper but do not resolve the fundamental problems embedded in the market-driven, multi-payer system of health care delivery. The rate of uninsured people in the U.S. stands at 27.5 million.¹⁶ An estimated 44 million more are underinsured,¹⁷ meaning that they have insurance but cannot obtain the care they need because they cannot afford their co-payments or deductibles.

The Medicare for All Act of 2019, H.R. 1384, improves and expands the overwhelmingly successful and popular Medicare program so that every person living in the United States has

⁹ Pollin, Robert, et al. “Economic Analysis of Medicare for All.” Political Economy Research Institute (PERI), University of Massachusetts Amherst (2018), at p. 3, available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

¹⁰ Blahous, Charles. “The Costs of a National Single-Payer Healthcare System.” Mercatus Center, George Mason University (2018), available at https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf, at 7 (summing 10-year reductions in health care spending (\$482 billion) and administrative cost savings (\$1.572 Trillion) in Table 2 for 2022-2031).

¹¹ U.S. Government Accountability Office. “Private Health Insurance: Data on Application and Coverage Denials.” GAO-11-268 (Mar. 2011), available at <https://www.gao.gov/new.items/d11268.pdf>.

¹² West Health Institute and NORC at the University of Chicago. “Americans’ Views of Healthcare Costs, Coverage, and Policy.” (Mar. 2018), available at <https://www.westhealth.org/wp-content/uploads/2018/03/WHI-Healthcare-Costs-Coverage-and-Policy-Issue-Brief.pdf>.

¹³ *Id.*

¹⁴ Consumer Financial Protection Bureau. *Consumer credit reports: A study of medical and non-medical collections.* (Dec. 2014), available at https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

¹⁵ Himmelstein, David, Elizabeth Warren, Deborah Thorne, Steffie Woolhandler. “Illness and Injury as Contributors to Bankruptcy.” *Health Affairs* (2005).

¹⁶ Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton. “Health Insurance Coverage in the United States: 2018.” United States Census Bureau (November 2019), available at <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>.

¹⁷ Collins, Sara R., Herman K. Bhupal, and Michelle M. Doty. “Health Insurance Coverage Eight Years After the ACA.” Commonwealth Fund (February 7, 2019), available at <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>. Other studies estimate that up to 85 million people in the United States are underinsured based on different criteria. Pollin, Robert et al. “Economic Analysis of Medicare for All.” Political Economy Research Institute (PERI), (Nov. 2018), available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

guaranteed access to health care. Medicare benefits would be improved so that all health services are covered, including dental, vision, prescription drugs, women's reproductive health, and long-term services and supports. It would require no out-of-pocket costs for patients for any services and would give all patients the freedom to choose the doctors, hospitals, and other providers they wish to see.

Importantly, "gatekeeper" obstacles to receiving care—like insurance pre-authorization requirements, lifetime or annual limits, or network restrictions—would be eliminated under the Medicare for All Act of 2019. Health care choices would be a decision between you and your doctor and would no longer be a decision made by insurance company administrators. Similarly, the benefits under the program would be completely portable across the United States. There would no longer be gaps in coverage if you change jobs or move. And our health care would no longer be subject to the unpredictable network changes or the ability of your employer to annually negotiate a health plan.

Medicare for All is the only solution to the health care crisis in our country. On behalf of National Nurses United, we urge the Subcommittee to support the Medicare for All Act of 2019, H.R. 1384.

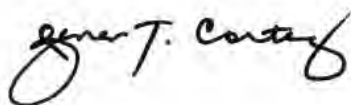
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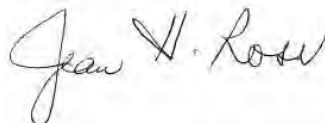
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National Nurses United

Medicare for All Act of 2019: Summary

Today’s health care system fails to provide quality, therapeutic health care as a right to all people living in the United States. Nearly 30 million Americans are uninsured, and at least 44 million more are underinsured, meaning that they cannot afford the costs of their copays and deductibles. The United States spends more money per capita on health care than any other major nation, yet the quality of our health care is much worse: life expectancy in the United States is lower, while our infant and maternal mortality rates are much higher. We waste hundreds of billions of dollars every year on unnecessary administrative costs, while health care industry executives measure success in profits, instead of patient care.

The current health care system in the United States is ineffective, inefficient, and outrageously expensive. It is time to remove the profit motive in health care, to resolve the inefficiencies, and to guarantee quality, therapeutic health care to every person living in the United States.

The Medicare for All Act of 2019, H.R. 1384 improves and expands the overwhelmingly successful and popular Medicare program, so that every person living in the United States has guaranteed access to health care with comprehensive benefits.

COMPREHENSIVE BENEFITS AND FREEDOM OF CHOICE

- The legislation provides comprehensive health care coverage, including all primary care, hospital and outpatient services, prescription drugs, dental, vision, audiology, women’s reproductive health services, maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more.
- Patients will have complete freedom to choose the doctors, hospitals, and other providers they wish to see, without worrying about whether a provider is “in-network.”

NO PREMIUMS, COPAYS, OR DEDUCTIBLES

- Enrollment in Medicare for All would not require any premiums or deductibles. Upon receiving care, patients would not be charged any copays or other out-of-pocket costs.

LONG-TERM SERVICES AND SUPPORTS FOR PEOPLE WITH DISABILITIES AND OLDER AMERICANS

- Long-term services and supports will be fully covered by the Medicare for All program.
- The legislation requires that the program presume that recipients of all ages and disabilities will receive long-term services and supports through home and community-based services unless the individual chooses otherwise.

REDUCING HEALTH CARE SPENDING AND IMPROVING CARE

- Medicare for All would simplify the health care system by moving to a single-payer model. This will reduce the hundreds of billions of dollars wasted on the administration of the current inefficient multi-payer system, allowing providers to focus on patient care instead.
- The legislation would prevent health care corporations from overcharging for the costs of their services and profiting off illness and injury. The legislation prevents providers from using payments from the program for profit, union-busting, marketing, or federal campaign contributions.

- The Medicare for All program would provide global budgets to each institutional provider to help contain the exorbitant costs present in the system today while also funding all needed care and will allow the public to know where our health care dollars are being spent.

REDUCING THE COSTS OF PRESCRIPTION DRUGS

- The United States currently pays the highest prescription drug costs in the world. This legislation would allow Medicare to negotiate drug prices, as other countries do, to substantially lower the costs of prescription drugs.
- The legislation authorizes Medicare to issue competitive licenses to allow generic production if a pharmaceutical company refuses to negotiate a reasonable price.

TRANSITION

- The transition to Medicare for All would occur in two years.
- One year after the date of enactment, persons over the age of 55 and under the age of 19 would be eligible for the program.
- Two years after the date of enactment, all people living in the United States would be eligible for the program.
- The legislation provides funding to help private insurance industry workers transition to other employment.

CARE FOR VETERANS AND NATIVE AMERICANS

- This legislation preserves the ability of veterans to receive their medical benefits and services through the Veterans Health Administration, and of Native Americans to receive their medical benefits and services through the Indian Health Service.

Medicare for All Act of 2019: Eliminating Health and Health Care Disparities

Despite spending more on health care per capita than any other country in the world,¹ the United States has extreme health and health care disparities among racial and ethnic populations.² These disparities typically impact African Americans, American Indians, and Alaskan Natives the hardest, with the Latinx and immigrant communities also experiencing significant disparities.³ H.R. 1384, the Medicare for All Act of 2019, contains provisions that address these disparities.⁴

Unlike our current market-driven system, the Medicare for All Act would guarantee quality, therapeutic health care for all individuals in every community in the United States, including our medically underserved rural and urban areas. It begins to address the structures that drive income, racial, and ethnic inequality in our health and health care by providing comprehensive health care benefits to all without regard to the ability to pay—with no deductibles, copayments, or other out-of-pocket costs. This would remove the financial and administrative barriers to care created by private insurers seeking to extract profit at the cost of our health.

Currently, many low-income and minority communities face overcrowded hospitals and clinics, hospital closures, and shortages of nurses, doctors, and other health care professionals. H.R. 1384 would ensure that our safety-net and critical access hospitals, both rural and urban, are sufficiently resourced and that our communities are staffed with sufficient nurses, doctors, and other providers to promote good health and provide therapeutic care where needed.

The Medicare for All Act would end our tiered system of health care by directing funds based on human need and explicitly targeting health care disparities. The national health budget, allocated regionally, includes separate funding for day-to-day operating expenses such as wages, medical supplies, overhead; capital expenses such as renovating facilities or building new ones as well as major equipment purchases; and special projects that address needs in medically underserved and health professional shortage areas.⁵ Each of these budget components takes health care disparities into account, particularly the funding for capital expenses and special projects.

Funding of Provider Operating Expenses

- H.R. 1384 explicitly includes “efforts to decrease health care disparities in rural or medically underserved areas” as one factor in determining operating expenses.⁶ Such efforts could include funding for additional staff, extended operating hours, and additional supplies.

Funding of Provider Capital Expenses

- Health care providers must apply for, and the Secretary of the U.S. Department of Health and Human Services (Secretary) must approve, funding to renovate or build new health care facilities or to purchase major equipment. The Secretary prioritizes funding “to improve service in a medically

¹ Organization for Economic Cooperation and Development. “How Does the United States Compare?” (2017). Accessed April 26, 2019. <https://www.oecd.org/unitedstates/Health-at-a-Glance-2017-Key-Findings-UNITED-STATES.pdf>.

² Caruso, Dominic F., David U. Himmelstein, Steffie Woolhandler. “Single-Payer Health Reform: A Step Toward Reducing Structural Racism in Health Care.” *Harvard Public Health Review* (2015). Accessed April 26, 2019. <http://harvardpublichealthreview.org/single-payer-health-reform-a-step-toward-reducing-structural-racism-in-health-care/>.

³ *Id.*

⁴ H.R. 1384 contains several sections related to funding that are discussed and cited below. It also contains robust non-discrimination language (Section 104) and detailed reporting requirements on health and health care disparities based on race, ethnicity, gender, geography, and socioeconomic status so that funding can be directed where needed (Sections 401 and 502).

⁵ The national health budget in H.R. 1384 also includes funding for quality assessment, health professional education, and other expenditures. See Section 601.

⁶ H.R. 1384, Sec. 611(b)(2)(G)(ii).

underserved area ... or to address health disparities among racial, income, or ethnic groups, or based on geographic regions”.⁷

- In contrast, current private funding for renovating or building new health care facilities and purchasing major equipment generally is based on whether, and how quickly, the expense will be recouped based on the revenue it generates. Thus, privately owned or funded organizations, even those that are not-for-profit, typically favor investing in affluent suburban and urban neighborhoods where people have more generous health plans and low numbers of uninsured.
- Publicly-funded facilities—such as health care provided by safety net hospitals and clinics—have been seriously underfunded leaving many minority, low-income, and rural communities with overcrowded facilities or no facilities at all. Under the Medicare for All Act, funding for capital expenses will be allocated based on need—with the express aim of reducing, and ultimately eliminating, health care disparities—rather than on maximizing revenue. This creates a strong foundation for publicly-funded health care facilities.

Funding of Special Projects

- Special projects funding is used exclusively “for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas ... including areas designated as health professional shortage areas ...”.⁸
- Medically underserved areas are geographically defined areas with a shortage of primary care services as well as sub-groups of people living within these areas including people who are homeless, low-income, Medicaid-eligible, Native American, or migrant farm workers. Medically underserved areas are designated based on the Index of Medical Underservice which is calculated based on four criteria: the ratio of providers to the population, the percentage of the population with income below the federal poverty level, the percentage of the population over the age of 65, and the infant mortality rate.⁹
- Health professional shortage areas—areas that have a shortage of primary care providers, mental health practitioners, or dentists—are primarily rural and low-income urban areas, but also include specific population groups within a geographic area such as those described above, and facilities such as state mental hospitals, federally qualified health centers, Indian health facilities, and tribal hospitals.¹⁰
- In addition to purchasing new equipment and building or renovating health care facilities, special projects funds could be used to provide scholarships for medical education, loan repayment in exchange for practicing in rural or medically underserved areas or areas with a shortage of health care professionals, additional compensation to attract and retain health care professionals, and other programs.
- By redirecting money to care based on need that currently is diverted to profit and high administrative costs in our complex multi-payer system, the Medicare for All Act ensures that everyone living in the United States receives the care they need.

⁷ H.R. 1384, Sec. 614(c)(2).

⁸ H.R. 1384, Sec. 601(a)(7).

⁹ Health Resources and Services Administration (HRSA). “Medically Underserved Areas and Populations (MUA/Ps).” U.S. Department of Health & Human Services (Reviewed Oct. 2016). Accessed April 25, 2019. <https://bhwh.hrsa.gov/shortage-designation/muap>.

¹⁰ Health Resources and Services Administration (HRSA). “Health Professional Shortage Areas.” U.S. Department of Health & Human Services (Reviewed Oct. 2016). Accessed April 25, 2019. <https://bhwh.hrsa.gov/shortage-designation/hpsas>.

Too Little, Too Late: The Limits of a Public Plan Option

Members of Congress and Democratic Party presidential candidates alike contend that it is better to build upon the current “system” of health insurance coverage by adding a public plan option—i.e., an insurance plan offered by the government alongside private insurance plans on the Patient Protection and Affordable Care Act (ACA) marketplaces—than to switch to a single-payer program that guarantees improved Medicare for All. Yet, health insurance coverage in the United States currently consists of a highly fragmented collection of employer-sponsored coverage, various public programs, and direct purchase in the government-subsidized ACA marketplaces. The lack of insurance coverage for 27.5 million¹ people coupled with high out-of-pocket costs for the 44 million² more who are underinsured results in premature death, unnecessary illness, untreated injuries, and impairs the quality of life of those affected. Simply building on this multi-payer arrangement means that we would forego the hundreds of billions in savings that a Medicare for All program would achieve through administrative simplicity and the negotiating power it would command as the single purchaser for health care services, prescription drugs, and other medical products. In contrast to a public plan option, which at best would extend coverage to a fraction of the uninsured, Medicare for All would use the billions it saves to provide a comprehensive set of health benefits to all without premiums, deductibles, or copayments.

This brief discusses the general problems inherent in a public plan option as well as some of the specifics of the House public plan option bills being considered today—H.R. 2000 (Delgado) and H.R. 2463 (Richmond). Although these bills go beyond providing a public plan option on the ACA individual health insurance marketplaces, the brief will focus on this aspect of the bills.

Why a Public Plan Option?

Arguments in support of adding a public plan option to the ACA marketplaces claim that it would reduce the number of uninsured and, through competition, drive down insurance premiums by providing a low-cost option. According to proponents, a public plan would have a competitive edge because it would not need to cover lavish executive compensation packages, turn a profit, or pay dividends to shareholders and, because of its size and scope, it could reduce administrative costs and negotiate lower provider reimbursements and prescription drug costs. However, it is unlikely that a public plan option could drive down private insurance prices because these plans would need to compete with profit-driven insurers who employ unethical tactics to attract healthier, less costly enrollees.

Unfair Competition Sets Public Plan Options Up to Fail

The arguments in favor of a public plan option assume that health insurance markets function like other markets for goods and services. However, health insurance markets and other consumer markets differ dramatically. One crucial difference is that the private insurance business model conflicts with the very reason most people have for purchasing health insurance—the basic human need for health care and the effect of illness and injury on our quality of life. Unlike most consumer markets that increase their revenue by increasing the goods or services they sell or provide, private health insurers’

¹ Berchick, Edward R., Jessica C. Barnett, and Rachel D. Upton. “Health Insurance Coverage in the United States: 2018.” United States Census Bureau (November 2019), available at <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>.

² Collins, Sara R., Herman K. Bhupal, and Michelle M. Doty. “Health Insurance Coverage Eight Years After the ACA.” Commonwealth Fund (February 7, 2019), available at <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

revenue decreases when policyholders receive covered health care goods and services.³ They prefer to collect their premiums and pay out as little as possible for the actual care they agreed to cover. In order to maximize their profits, they strive to limit how much they pay for enrollees’ health care by limiting health care services up front and by rejecting insurance claims once care has been received. They do not simply compete for any and all customers or to maximize policy sales. Rather, they aim to maximize sales to individuals who will pay more in premiums than they cost in care and minimize sales to those that will use services that exceed the cost of their premiums. In other words, health insurers earn higher profits when they insure healthier people and avoid people who are sick or more likely to use costly services. They did very well in 2018: insurers in the individual market on average paid out only \$392 per person in claims while collecting \$559 per person in premiums.⁴ That’s a difference of \$167 per person compared to \$78.52 in 2017 and \$14.36 in 2016.⁵ In other words, per person profit for individual marketplace insurers grew by 1,100% in just two years.

Given that private insurers employ unethical tactics to sell policies to healthier individuals and avoid those who are likely to be high-cost individuals, it is likely that the sickest and most costly individuals will be pushed into a public plan option. Despite language in the ACA and reams of regulations meant to reign in the harmful practices of health insurance corporations, they have continued to “cherry pick”⁶ healthy individuals. Numerous studies have documented discriminatory insurance practices regarding policies sold through the ACA marketplaces. For example, some policies place key HIV/AIDS, cancer, and multiple sclerosis drugs in the highest cost sharing tier in a drug formulary—a practice meant to deter individuals from signing up for these policies.⁷ Selective provider network design is another means of excluding costly patients. For example, the network may include a limited number of oncologists and other specialists or exclude academic medical centers and cancer treatment centers.⁸ Private insurers create barriers to care through limiting provider networks, imposing deductibles and cost-sharing, referral and prior authorization requirements, and utilization review to hold down costs. This creates a dilemma for a public plan option, either adopt similar tactics or risk the plan’s financial stability. Not only would this defeat the purpose of providing a public plan option, it would undermine the faith that people have in what the Centers for Medicare and Medicaid does well—running the social-insurance we have now, i.e., the traditional Medicare program.

The House Public Plan Option Bills

Both House public plan option bills require the Secretary of the U.S. Department of Health and Human Services (Secretary) to set premiums to cover 100% of benefits and administrative costs. Whether the public plan can offer premiums that are lower than private insurance plans will depend on the health of the participants and the ability to control costs in other areas such as provider payments, prescription drugs and other medical products, and administrative overhead.

³ Insurers refer to money spent on patient health care claims as “medical loss”.

⁴ Cox, Cynthia, Rachel Fehr, and Larry Levitt. “Individual Insurance Market Performance in 2018.” Kaiser Family Foundation. May 7, 2019, available at <https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2018/>.

⁵ *Ibid.* As the ACA requires insurers to spend a minimum of 80% of premiums on health care or quality improvement and rebate the difference to customers, insurers will have to rebate an estimated \$800 million to customers for 2018.

⁶ Technically called “adverse selection”, “cherry picking” refers to practices geared to enrolling healthier individuals and avoiding those who are sick, elderly, or otherwise likely to be high-cost individuals.

⁷ Jacobs, Douglas B. and Benjamin .D. Sommers. “Using Drugs to Discriminate — Adverse Selection in the Insurance Marketplace.” *New England Journal of Medicine*. January 29, 2015, 372:399-402, available <http://www.nejm.org/doi/full/10.1056/NEJMp1411376>; Avalere. “Analysis of Prescription Drug Tier Placement and Cost Sharing in Health Insurance Exchange Plan.” February 11, 2015, available at http://go.avalere.com/acton/attachment/12909/f-017c/1/-/-/-/20150211_Avalere%20Planscape%202015_Class%20Tiering%20Analysis.pdf.

⁸ Gaffney, Adam, and Danny McCormick. “The Affordable Care Act: implications for health-care equity.” *The Lancet*. 389:1442-1452. April 8, 2017, available at [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(17\)30786-9.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(17)30786-9.pdf); Bertko, John. “What Risk Adjustment Does — The Perspective of a Health Insurance Actuary Who Relies on It.” *Health Affairs Blog*. March 29, 2016, available at <http://healthaffairs.org/blog/2016/03/29/what-risk-adjustment-does-the-perspective-of-a-health-insurance-actuary-who-relies-on-it/>.

As cherry picking by competing private plans is predictable, a public plan must either replicate the unethical practices of private insurers or be saddled with the most costly individuals. The Congressional Budget Office reports “that the public plan would be less inclined than private plans to use benefit management techniques (such as narrow provider networks, utilization review, and prior-approval requirements) to control spending.”⁹ Moreover, it confirms that “[t]he public plan would also tend to cover people who were, on average, less healthy—and therefore more costly—than the average enrollee in a private plan.”¹⁰ Thus, a public plan would likely end up serving as a safety net for the sicker, costlier individuals that private insurers seek to remove from their rolls. Unless the public plan is able to offset the increased cost of care with a similar level of savings, the premiums for a public plan would be considerably higher than private plans on the ACA marketplaces, making them uncompetitive and attractive to only the sickest and most costly enrollees.¹¹

Although a public plan option may have a competitive edge in negotiating provider reimbursement, the ability of the public plan to maintain an adequate network of providers while holding down reimbursement rates will depend on the degree to which they are able to leverage the Medicare program. This will hold similarly with the government’s ability to wield adequate negotiating power over prescription drug prices. Unlike single-player programs such as Medicare for All, public options must compete with private plans for a share of both the provider and patient markets and may have limited success in lowering health care prices by holding down provider reimbursement rates and prescription drug prices.

The overview below suggests that the public plan option bills will have difficulty in holding down provider rates sufficiently to offset a sicker, costlier group of enrollees while at the same time maintaining an adequate network of providers.

➤ Provider reimbursement

- Medicare-X Choice Act of 2019, H.R. 2000 (Delgado): This bill would use Medicare fee-for-service rates under parts A and B as base rates but allow the Secretary to increase these rates by 25% for rural areas. The Secretary would establish rates for services not covered by these rates such as well-child visits. The bill also requires providers who participate in Medicare or Medicaid to participate in the public plan. The Secretary would establish a process to allow other providers to participate as well. However, the public plan’s ability to maintain adequate provider participation will turn on the specifics of the opt-out process the Secretary is required to establish.
- Choose Medicare Act, H.R. 2463 (Richmond): The Secretary would negotiate rates with providers that could be no lower than Medicare rates and not higher, in the aggregate, than rates paid by other insurers in marketplace plans. The bill states that providers who participate in Medicare shall participate in the public plan. The Secretary would establish a process to allow other providers to participate. The bill does not provide for an opt-out process for providers and is unclear about whether providers who do not participate in the public plan option would be barred from participating in Medicare.

Both bills would negotiate prescription drug prices for, at most, the public plan and Medicare and, thus, both bills would provide far less purchasing power than a Medicare for All program would.

⁹ Congressional Budget Office. “Add a ‘Public Plan’ to the Health Insurance Exchanges.” CBO Publications (November 13, 2013), available at <https://www.cbo.gov/budget-options/2013/44890>.

¹⁰ *Ibid.*

¹¹ Both bills have reinsurance provisions that may mitigate the cost of premiums somewhat but at taxpayer expense.

➤ Prescription drug negotiation

- Medicare-X Choice Act of 2019, H.R. 2000 (Delgado): The Secretary is required to negotiate payment rates for the public plan. The negotiations *may* be in conjunction with covered Medicare part D drugs. If the Secretary does not also negotiate for Medicare part D, it will undercut bargaining power and savings.
- Choose Medicare Act, H.R. 2463 (Richmond): The Secretary is authorized to negotiate drug prices for the public plan and the Medicare program. If unsuccessful after one year of negotiations, prices would be set at the lesser of prices paid by the Veterans Health Administration or the federal supply schedule.

Financial Barriers to Care Would Persist

Both public plan option bills expand premium tax credits and H.R. 2463 also expands income-based cost-sharing reduction subsidies that are offered for ACA marketplace plans. This is likely to increase enrollment and reduce the number of uninsured. Because ACA subsidies and tax credits apply across the board to public and private plans alike, they also would be a boon to the private insurance industry which is also likely to see increased enrollment. However, even though the ACA marketplace plans offer financial relief for some, high out-of-pocket limits would continue for many. For 2020, the out-of-pocket limits for ACA marketplace plan enrollees without a cost-sharing reduction subsidy are \$8,200 for an individual and \$16,400 for a family.¹² Premium payments do not count towards this maximum. High deductibles and copayments would continue to leave many families underinsured. Unfortunately, even small deductibles or copayments can be a barrier to care. Some details on how the bills address these issues are provided below.

➤ Premiums and Cost-Sharing

- Medicare-X Choice Act of 2019, H.R. 2000 (Delgado):
 - Offers silver and gold level public plans and may also offer bronze and platinum level plans.
 - Reduces the limit on premiums as a percentage of household income needed to qualify for a premium tax credit for all current income levels.
 - Adds two new income limits at 400% to 600% of federal poverty line and more than 600% of federal poverty line.
 - Makes no changes to cost-sharing reduction subsidies.
- Choose Medicare Act, H.R. 2463 (Richmond):
 - Offers gold level public plan only.
 - Uses the gold level plan rather than the silver level plan as the benchmark for the premium tax credit.
 - Raises the highest income level to qualify for a tax credit from 400% of the federal poverty line to 600%.
 - Limits on premiums at 400% to 600% of the federal poverty line are left unchanged at no more than 9.5% of household income.
 - Provides enhanced cost-sharing reduction subsidies that limit cost-sharing on a sliding scale to no more than 6% for those with a household income of 100% to 133% of the federal poverty line to no more than 20% for those with a household income of 300% to 400% of the federal poverty line.

¹² Healthcare.gov. “Out-of-pocket maximum/limit.” Available at <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/>.

Limited Cost Containment—at Best

Unlike a Medicare for All program, a public plan option added to the ACA marketplaces would remain only one health plan among numerous other plans, across multiple insurance markets, each with its own profit-driven set of requirements for billing, cost-sharing, and processing claims. This means that public option bills would leave the vast majority of administrative costs for our current multi-payer system untouched. Total insurance and billing-related administrative costs for insurers, hospitals, physicians, other health care facilities, and employers were estimated at \$1.05 trillion in 2017,¹³ representing 30 percent of U.S. health care costs.¹⁴ Under Medicare for All, these costs would be reduced to an estimated \$503 billion, a savings of nearly 50 percent in administrative costs alone.¹⁵ In addition, because the fragmented risk pools endemic to a multi-payer system result in some insurers covering a disproportionate number of high-cost patients, the public plan option bills call for a total of \$30 billion for a reinsurance program covering the years 2020-2021, thereby adding another layer of complexity to our health system. Even if a public plan were able to reduce or eliminate some insurance-related administrative functions for its plan—such as monitoring provider networks, managing referral and prior authorization requirements, and marketing their plans—it would leave the profit-driven private health insurance market and the billing and insurance-related costs of a multi-payer system virtually untouched. Similarly, because a public plan option would not be bargaining for prescription drugs for the entire U.S. population as a Medicare for All program would, public plan options would fall far short of the estimated savings of \$113 billion in prescription drug costs that could be captured under Medicare for All.¹⁶

We won't know the total cost of the public plan option bills unless and until they are scored by the Congressional Budget Office. Yet, we do know that the costs for the substantial enhancement of premium tax credits in H.R. 2000 and the enhancement of both the premium tax credits and cost-sharing reduction subsidies in H.R. 2463 would likely amount to tens of billions in new costs to the federal government—a significant portion of which would accrue to the private insurance industry in the form of increased cost-sharing subsidies and premium tax credits that are likely to increase the number of enrollees.¹⁷

Conclusion

Even if a public plan option succeeded in covering all the remaining uninsured, it would not ensure that Americans receive the health care they need. Under a public plan option some will be unable to afford the out-of-pocket costs required to access it. A public plan option also does not help those who are underinsured through the ACA marketplaces, employer-sponsored coverage, or some of our public programs. Additionally, to the degree that a public plan option goes beyond the individual market, it does so at far greater expense than Medicare for All because it leaves most of the bloated, wasteful profit-driven insurance markets in place. Finally, and more importantly, a public plan option would leave far too many without the care that they need. There is a better way: Medicare for All that provides comprehensive health care that is free at the point of delivery.

¹³ Woolhandler, Steffie and Himmelstein, David. “Single-Payer Reform: The Only Way to Fulfill the President’s Pledge of More Coverage, Better Benefits, and Lower Costs.” *Ann. Intern. Med.* (2017) 166(8): 587-588 (see Table), available at <https://annals.org/aim/fullarticle/2605414/single-payer-reform-only-way-fulfill-president-s-pledge-more>.

¹⁴ *Ibid.* Based on National Nurses United calculation using data from the Centers for Medicare and Medicaid Services. “Historical National Expenditures.” National Health Expenditure Accounts (2017), available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccounts/historical.html>.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ Congressional Budget Office. “Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2019 to 2029.” CBO Publications (May 2, 2019), available at <https://www.cbo.gov/publication/55085>. According to this publication, Federal subsidies for coverage obtained through the ACA marketplaces together with the Basic Health Program accounted for \$62 billion in 2019.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation							
Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
GENERAL INFORMATION							
Sponsor and Bill Number	Jayapal & Dingell H.R. 1384	DeLauro & Schakowsky H.R. 2452	Richmond H.R. 2463	Delgado H.R. 2000	Luján H.R. 1277	Malinowski H.R. 4527	Higgins H.R. 1346
Bill Name	Medicare for All Act of 2019	Medicare for America Act of 2019	Choose Medicare Act	Medicare-X Choice Act of 2019	State Public Option Act	Expanding Health Care Options for Early Retirees Act	Medicare Buy-In and Health Care Stabilization Act of 2019
Approach	Medicare for All, Single Payer	Public Program with Opt-Out	Public Plan Option	Public Plan Option	Permits State Public Plan Options/Medicaid Buy-In	Limited Medicare Buy-In	Medicare Buy-In
Overview	Single federal program with comprehensive benefits for all US residents. No premiums or cost-sharing. Publicly financed, privately delivered care.	Federal public program with comprehensive benefits available to all US residents. Offered alongside qualified employer-sponsored group plans. Public program allows private Medicare Advantage for America plan options.	Federal public plan option offered to individuals eligible to participate in ACA marketplace plans, and in large and small markets.	Federal public plan option offered to individuals eligible to participate in ACA marketplace plans. A public plan shall be made available in the small group market in 2025.	Permits states to offer state public plan options based on Medicaid, or in other words, a state could offer a Medicaid buy-in option.	Option for first responders who are 50 years old and over to buy into Medicare. Buy-in enrollees can also buy Medicare Advantage plans.	Option for individuals 50 years old and over to buy into Medicare. Buy-in enrollees can also buy Medicare Advantage plans.
HEALTH CARE MARKET COMPLEXITY							
Eliminates Complexity in Government Programs?	Yes. Replaces Medicaid, Medicare, and CHIP. Single plan with comprehensive benefits under public program. Single plan with no added administrative complexity from cost-sharing or premiums.	No. Replaces Medicare, Medicaid, and CHIP. Retains complexity by allowing for multiple plans within public program, such as Medicare Advantage for America Plans. Retains complexity from administration of various cost-sharing and premium requirements.	No. Retains all current public programs. Adds complexity by creating a public plan option. Retains complexity by allowing HHS Secretary to administer self-insured employer plans as a third-party administrator.	No. Retains all current public programs. Adds complexity by creating a public plan option.	No. Retains all current public programs. Adds complexity by creating a state Medicaid buy-in.	No. Retains all current public programs. Adds complexity by creating a Medicare buy-in.	No. Retains all current public programs. Adds complexity by creating a Medicare buy-in.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation

Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
Eliminates Competing Private Plans?	Yes. Prohibits private plans with duplicative benefits.	No. Allows employer group plans and private insurer Medicare for America Advantage plans. Prohibits surprise medical bills, step therapy, and prior authorization under private plans.	No. Applies ACA rating rules to large group market. Gives HHS Secretary authority to deny unreasonable rate increases in states where state regulators do not take action to correct unreasonable rate increases. Extends ACA rate review to grandfathered health plans.	No. No changes to private insurance markets.	No. No changes to private insurance markets.	No. No changes to private insurance markets.	No. No changes to private insurance markets.
Eliminates Complexity in Individual Marketplaces?	Yes. Replaces individual ACA marketplaces.	Yes. Replaces individual ACA marketplaces.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.
Eliminates Complexity in Employer-Sponsored Plans?	Yes. Replaces all private insurance, including employer plans, that have duplicate coverage.	No. Employers may offer qualified group plan coverage or pay 8% of payroll for employee coverage in Medicare for America.	No. Retains current sources of private and public coverage. HHS Secretary can administer self-insured employer plans as a third-party administrator.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.	No. Retains current sources of private and public coverage.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation

Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
Eliminates Administrative Complexity for Providers?	Yes. Single program with single billing and administrative process.	No. Retains complexity for providers in administering multiple plans within public program, such as Medicare Advantage for America Plans, and multiple employer-sponsored group coverage. This includes administrative complexity and costs to providers related to billing and collecting coinsurance for both Medicare for America and Medicare for America Advantage plans.	No. Retains complexity for providers in administering multiple plans within public programs and multiple private plans. Adds to administrative complexity and costs for providers related to billing and collecting cost-sharing, including new billing and collections related to the public program.	No. Retains complexity for providers in administering multiple plans within public programs and multiple private plans. Adds to administrative complexity and costs for providers related to billing and collecting cost-sharing, including new billing and collections related to the public program.	No. Retains complexity for providers in administering multiple plans within public programs and multiple private plans. Adds to administrative complexity and costs for providers related to billing and collecting cost-sharing, including new billing and collections related to the new state Medicaid buy-in programs.	No. Retains complexity for providers in administering multiple plans within public programs and multiple private plans. Adds to administrative complexity and costs for providers related to billing and collecting cost-sharing, including new billing and collections related to Medicare buy-in enrollees.	No. Retains complexity for providers in administering multiple plans within public programs and multiple private plans. Adds to administrative complexity and costs for providers related to billing and collecting cost-sharing, including new billing and collections related to Medicare buy-in enrollees.
ELIGIBILITY & ENROLLMENT							
Universal Coverage?	Yes. With no financial barriers to care.	Yes. But premiums and cost-sharing could create financial barriers to care.	No. But may increase coverage by enhancing premium tax credits and cost-sharing subsidies.	No. But may increase coverage by enhancing premium tax credits.	No. But may increase coverage if a state that chooses to provide a state Medicaid buy-in also chooses to reduce premiums or enhance cost-sharing subsidies.	No. Only available to qualified first responders aged 50 to 64 who are U.S. citizens or nationals residing in the U.S., or lawfully admitted for permanent residence. Must not be eligible for Medicare Parts A or B benefits. Qualified first responders include, law enforcement officers, firefighters, and emergency medical service providers.	No. Only available to individuals aged 50 to 64 who are U.S. citizens or nationals residing in the U.S., or lawfully admitted for permanent residence. Must not be eligible for Medicare Parts A or B benefits.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation

Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
Enrollment Period	Lifetime enrollment. Auto-enrollment at birth or at establishment of residency. Enrollment for children under age 19 and adults over 55 one year after enactment, and all others two years after enactment.	Lifetime, with opt-out available each year. Auto-enrollment at birth. Auto-enrollment of others must include opt-out option.	Enrollment generally for one year at a time.	Enrollment generally for one year at a time.	Enrollment generally for one year at a time. State may limit enrollment to ACA marketplace enrollment period.	Enrollment generally for one year at a time. Same as ACA marketplace enrollment period.	Enrollment generally for one year at a time. Established in coordination with ACA marketplace enrollment period.
COST-SHARING GENERALLY							
Financial Barriers to Care	None. All premiums and cost-sharing eliminated.	Yes. Premiums and sliding scale income-related cost-sharing.	Yes. Premiums and sliding scale income-related premiums with tax credits and cost-sharing subsidies for public plan.	Yes. Premiums and sliding scale income-related premiums with tax credits and cost-sharing subsidies for public plan.	Yes. Premiums and cost-sharing with subsidies for Medicaid buy-in plan.	Yes. Premiums and cost-sharing with subsidies for Medicare buy-in enrollees.	Yes. Premiums for Medicare buy-in enrollees. Cost-sharing same as under current Medicare.
Copayments or Coinsurance	None. All cost-sharing eliminated.	Yes. 20% coinsurance for most benefits, except for preventive care, chronic disease services, long-term supports and services, certain drugs, care for certain individuals with special medical needs, pregnancy care, emergency services, and care for children under age 21.	Yes. For public plan, premiums and cost-sharing offered as a gold-level plan.	Yes. For public plan, premiums and cost-sharing offered as a gold-level plan and as a silver-level plan. May be offered as a bronze and platinum level plan. HHS Secretary may offer up to two public plan options at each metal level.	Yes. For Medicaid buy-in plan, states may charge premiums, deductibles, cost-sharing, or other similar charges that are “actuarially fair.”	Yes. Cost-sharing same as under current Medicare but Medicare cost-sharing subsidies are not available.	Yes. Cost-sharing same as under current Medicare.
Cost-Sharing Reductions (CSR)	Not applicable. No cost-sharing. During transition, enhanced CSR subsidies available.	Out-of-pocket limits apply. During transition, enhanced CSR subsidies for ACA marketplace plans.	CSR subsidies apply to Gold-level public option plans. Enhanced CSR subsidies apply.	CSR subsidies apply to Silver-level plan options.	CSR subsidies apply to Silver-level plan options.	CSR subsidies apply as if Medicare buy-in plan was a Silver-level plan option. No Medicare cost-sharing subsidies available.	CSR subsidies generally apply to Medicare buy-in plan. Enhanced CSR subsidies apply.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation

Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
Max Out-of-Pocket	Not applicable. No cost-sharing.	Out-of-pocket limit of \$3,500/individual or \$5,000/family. Linear sliding scale limit up to max limit for families between 200%-600% of the FPL.	ACA out-of-pocket max applies. Annual out-of-pocket limit applies (\$8,200 individual/ \$16,400 family in 2020); lower for those receiving CSR subsidies.	ACA out-of-pocket max applies. Annual out-of-pocket limit applies (\$8,200 individual/ \$16,400 family in 2020); lower for those receiving CSR subsidies.	ACA out-of-pocket max applies. Annual out-of-pocket limit applies (\$8,200 individual/ \$16,400 family in 2020); lower for those receiving CSR subsidies.	No annual limit on out-of-pocket cost-sharing, unless CSR subsidies apply.	No annual limit on out-of-pocket cost-sharing, unless enrolled in Medicare Advantage plan or CSR subsidies apply.
PREMIUMS							
Premium Rates & Differentials for Public Plan	Not applicable. No premiums.	Premiums vary. Set by the HHS Secretary to “sufficiently finance” benefits and administrative costs. Varies by family size, income, and “applicable rating area.” Varies for individuals who opt-in from qualified employer coverage - pays the lesser of the income-related premium, or the full premium reduced by amount their employer would have contributed. Varies for current Medicare recipients – pays the lesser of past Medicare premium or Medicare for America premium.	Premiums vary. Set by the HHS Secretary to cover 100% of benefits and administrative costs. Premiums for public plan can vary only by factors allowed by ACA rating rules (including age, geography, family size, and tobacco use) and whether plan is offered in the individual, small group, or large group market.	Premiums vary. Set by HHS Secretary to cover 100% of benefits and administrative costs. Premiums for public plan can vary only by geography and between the small group market and the individual market. After 2021, each state will have a single risk pool except that the Secretary may set separate risk pools for the individual and small markets if the state does not elect to merge the individual and small group markets.	Premiums vary. Set by states. Premiums for state Medicaid buy-in must be “actuarially fair” and can only vary by factors allowed by ACA rating rules (including age, geography, family size, and tobacco use).	Premium set to cover 100% of benefits and administrative costs for the buy-in population and based on average per capita costs for expenses under Parts A, B and D. Buy-in enrollees who select Medicare Advantage or Part D prescription drug plans with premiums above the average would be required to pay additional amount. No adjustment for geography, age, family status, or tobacco use.	Premiums vary. Premium set to cover 100% of benefits and administrative costs for the buy-in population and based on average per capita costs for expenses under Parts A, B and D. Buy-in enrollees who select Medicare Advantage or Part D prescription drug plans with premiums above the average would be required to pay additional amount. Premium for buy-in plan shall be adjusted for geography and may be adjusted by age. No adjustment for family status or tobacco use.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation

Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
Premium Income Limits & Tax Credits	Not applicable. No premiums. During transition, enhanced ACA premium tax credits available.	Varies. No premiums for public plan below 200% of FPL. Sliding scale for families between 200%-600% of the FPL. Premiums for public plan are no more than 8% of individuals' or households' monthly income. During transition, enhanced ACA premium tax credits available.	Varies. Enhanced and expanded eligibility for premium tax credits. Increases income threshold for tax credit caps on tax credit reconciliation/ repayment to 600% FPL. No upper limit to premiums.	Varies. Enhanced and expanded eligibility for premium tax credits. Caps tax credit reconciliation/ repayment amount for people with income over 400% FPL to no more than \$5,000. Otherwise, no upper limit to premiums.	Varies. Annual premiums capped at 9.5% of household income for households whose income is less than 250% of the FPL. ACA premium tax credits apply for state Medicaid buy-in participants.	Varies. ACA premium tax credits apply for Medicare buy-in participants. No upper limit to premiums.	Varies. ACA premium tax credits apply for Medicare buy-in participants and comparable subsidies apply to Medicare. No upper limit to premiums.
BENEFITS							
Generally	All medically necessary or appropriate services in 14 benefit categories, which overlap with ACA 10 essential health benefits, and as determined by an individual's health care provider. No Hyde Amendment limitations.	Comprehensive benefit package including ACA 10 essential health benefits, dental, hearing, vision, abortion. No Hyde Amendment limitations.	ACA 10 essential health benefits and Medicare Parts A, B and D benefits. No Hyde Amendment limitations.	ACA 10 essential health benefits.	Medicaid alternative benefits plan, which must include ACA 10 essential health benefits.	Medicare Parts A, B and D benefits, including eligibility to enroll in a Medicare Advantage Plan.	Medicare Parts A, B and D benefits, including eligibility to enroll in a Medicare Advantage Plan.
Long-Term Supports & Services	Yes, home and community-based as well as institutional long-term services and supports with a presumption of home and community based-services and supports.	Yes, with an emphasis on home and community based-services and supports.	No.	No.	No.	No.	No.
Dental, Hearing & Vision	Yes. Includes dental, vision, and hearing.	Yes. Includes dental, vision, and hearing.	No.	No.	No.	No.	No.

Comparison Chart: Medicare for All, Public Option Plans, ACA Expansion, and Medicare Buy-In Legislation

Program	Medicare for All Act H.R. 1384	Medicare for America Act H.R. 2452	Choose Medicare Act (Medicare Part E) H.R. 2463	Medicare-X Choice Act H.R. 2000	State Public Option Act H.R. 1277	Expanding Health Care Options for Early Retirees Act H.R. 4527	Medicare Buy-In and Health Care Stabilization Act H.R. 1346
PROVIDER PARTICIPATION							
Provider Payment Rates	<p>See Issue Brief on Global Budgets & Other Reimbursements of NNU testimony for more detail on Pages 44-45.</p> <p>Institutional providers paid through global budgets annually negotiated with regional directors.</p> <p>Physicians and group practices have two options: (1) salaries based on global budget negotiations; or (2) reimbursement initially based on Medicare fee schedule established by HHS Secretary in consultation with doctors and regional directors.</p> <p>Additional funds for rural and underserved areas through special projects budget.</p>	<p>Medicare or Medicaid rates generally.</p> <p>Hospitals rates at 110% of Medicare or Medicaid rates and more for underserved areas.</p> <p>Primary care and behavioral health services rates increased by at least 30%.</p> <p>Medicare for America Advantage plans pay same rates as Medicare for America.</p>	<p>The Secretary shall negotiate a rate schedule sufficient to maintain network adequacy that is not lower than Medicare rates and not higher, in the aggregate, than rates paid by other insurers in ACA marketplace plans.</p>	<p>Medicare payment rates. HHS Secretary can increase by 25% for rural areas.</p> <p>HHS Secretary establishes rates for services not otherwise covered under Medicare fee for service.</p>	<p>States required to pay primary care providers at least Medicare rates for the Medicaid buy-in plan. Medicaid rates used for other providers.</p>	<p>Medicare payment rates.</p>	<p>Medicare payment rates.</p>
PRESCRIPTION DRUGS							
Prescription Drugs	<p>HHS Secretary negotiates nationwide with manufacturers. If negotiations unsuccessful, HHS Secretary shall authorize licenses for the generic manufacture of drug.</p>	<p>HHS Secretary negotiates drug prices for Medicare for America and Medicare Advantage for America plans. If negotiations unsuccessful, HHS Secretary shall authorize licenses for the generic manufacture of drug.</p>	<p>HHS Secretary is authorized to negotiate drug prices for Medicare Part E and current Medicare program. If unsuccessful, prices are set at the lesser of prices paid by the VA or federal supply schedule.</p>	<p>HHS Secretary negotiates drug prices for Medicare-X and may also negotiate for current Medicare program.</p>	<p>No provision.</p>	<p>No provision.</p>	<p>HHS Secretary shall negotiate drug prices for Medicare and the buy-in plan.</p>

Medicare for All Act of 2019: Program Design

How does the Medicare for All Act of 2019, H.R. 1384, answer the program design questions posed by the Congressional Budget Office’s May 2019 report?

This issue brief adopts the question-based format of the Congressional Budget Office’s May 2019 report, “Key Design Components and Considerations for Establishing a Single-Payer Health Care System.”¹

How would the government administer a single-payer health plan?

- **Federal Governance.** The Secretary of the U.S. Department of Health and Human Services (Secretary) would oversee the Medicare for All Program (Program) at the federal level and would be responsible for developing policies, procedures, and regulations to carry it out. In so doing, the Secretary would consult with a broad range of entities including federal agencies, professional organizations, and labor unions. Program accountability measures include requiring the Secretary to provide annual reports to Congress and audits by the U.S. Comptroller General every 5 years.²
- **Regional Administration.** The Secretary would establish regional offices and appoint regional directors as well as deputy directors to represent American Indian and Alaska Native tribes in each region. The Secretary would incorporate the existing offices of the Centers for Medicare & Medicaid Services (CMS) where possible. The regional directors would be responsible for performing health care needs assessments, recommending changes in provider payments, and establishing quality assurance mechanisms in their respective regions. Finally, the Secretary would appoint a beneficiary ombudsman to receive complaints and grievances and provide assistance to individuals entitled to Program benefits.³

Who would be eligible for the plan, and how would people enroll?

- **Two-year eligibility phase-in.** The Program has a two-year transition period. In the first year, persons over the age of 55 and under the age of 19 would be eligible for the Program, and in the second year, all people living in the United States would be eligible.⁴
- **Enrollment.** The Program would include a mechanism for automatic enrollment at birth and upon immigration into the U.S. or attainment of qualified resident status. Eligible individuals would be able to enroll for benefits and obtain a Medicare card in order to receive services under the Program. The Program could build on the current Medicare enrollment system.⁵

What health care services would the plan cover?

- **Universal benefits.** Current Medicare benefits would be expanded and improved in order to provide comprehensive health care coverage to all Program enrollees.⁶
- **Comprehensive benefits.** The benefits would include all primary care, hospital and outpatient services, prescription drugs, dental, vision, audiology, women’s reproductive health services,

¹ Congressional Budget Office. “Key Design Components and Considerations for Establishing a Single-Payer Health Care System.” CBO Publications (May 1, 2019), available at <https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf>.

² H.R. 1384 §§ 401-404.

³ H.R. 1384 §§ 401-404.

⁴ H.R. 1384 § 106.

⁵ H.R. 1384 § 105.

⁶ H.R. 1384 §§ 201, 204.

maternity and newborn care, long-term services and supports, prescription drugs, mental health and substance abuse treatment, laboratory and diagnostic services, ambulatory services, and more.⁷

What cost sharing, if any, would the plan require?

The plan prohibits cost sharing for all covered benefits. No premiums, deductibles, coinsurance, copayments, or balance billing are allowed.⁸

What role would private health insurance have?

The bill allows private health insurance coverage only for benefits that are not covered under the Program but prohibits private health insurance coverage for covered benefits. Because the Program provides comprehensive benefits and provides comprehensive coverage, private health insurance is expected to have only a small role (e.g., non-medically necessary cosmetic care or for international tourists).⁹

What role would other public programs have?

After the two-year transition period, all those receiving health care coverage through Medicare, Medicaid, the State Children’s Health Insurance Program, or health marketplaces established under the Patient Protection and Affordable Care Act would be covered by the Medicare for All Program. These programs would sunset. School-related health programs and existing medical benefits or services under the Department of Veteran Affairs and the Indian Health Service would be maintained, though veterans and Native Americans would also be entitled to full Program benefits.¹⁰

What rules would participating providers be required to follow?

To become a participating provider under the Program, the provider must be eligible to participate and must enter into a participation agreement with the Secretary which includes, as described below, disclosure requirements and other checks on provider participation.¹¹

- **Provider qualifications.** Providers are qualified to participate in the Program if they have the requisite license from the state in which they practice and meet minimum provider standards adopted by the Program, including adequate facilities, safe staffing, and patient access. Providers are only eligible to be participating providers for care that they provide directly to individuals.¹²
- **Private contracting limitations.** Participating providers are prohibited from entering into private contracts for covered services with individuals eligible for Program benefits. Any provider that furnishes covered services through a private contract will be ineligible to participate in the Program for two years. Participating providers may enter into private contracts with individuals who are ineligible to enroll in the Program and may enter into contracts with any individual for noncovered services. Disclosure requirements are established for private contracts.¹³
- **Prohibitions on discrimination.** Providers are prohibited from denying benefits, reducing benefits, or otherwise discriminating against patients based on race, color, national origin, age, disability, marital status, citizenship status, primary language use, genetic conditions, previous or

⁷ H.R. 1384 §§ 201, 204.

⁸ H.R. 1384 § 202.

⁹ H.R. 1384 § 107.

¹⁰ H.R. 1384 §§ 901, 902.

¹¹ H.R. 1384 § 301.

¹² H.R. 1384 § 302.

¹³ H.R. 1384 § 303.

existing medical conditions, religion, or sex, including sex stereotyping, gender identity, sexual orientation, and pregnancy and related medical conditions (including termination of pregnancy).¹⁴

- **Prohibition on balance billing.** Participating providers are prohibited from balance billing or otherwise charging a Program enrollee for any covered benefit.¹⁵
- **Checks on upcoding and other reimbursement inflation.** To ensure that coding and billing practices are not being manipulated to inflate provider reimbursement, participating providers are required to disclose any patient or procedure coding or classification system that they use. Additionally, participating providers are prohibited from using any coding or classification system to establish financial incentives or disincentives for doctors or other health care professionals or that may otherwise interfere with clinical practice.¹⁶
- **Provider duty of ethics and prohibitions on financial interests that interfere with clinical practice.** The bill establishes a requirement for participating physicians, hospitals, and other health care providers to advocate for and act in the exclusive interest of patients. This means that participating providers shall not have any financial interest or relationship that impairs that provider’s ability to care for patients.¹⁷

In order to implement the provider duty of ethics, the bill would:

- Prohibit providers from entering bonus, incentive payment, profit-sharing, or compensation-based arrangements related to utilization of services or the financial results of any health care provider and requires providers to disclose financial interests or relationships with other providers to the Secretary.
- Prohibits providers or their board members from serving on the board of or receiving compensation, stock, or other financial investments in any other entity that furnishes items and services (including pharmaceuticals and medical devices) to the provider.
- **Data reporting requirements.** Participating providers are required to furnish information necessary for establishing reimbursements, quality review, and other data reporting, including current data reported under Medicare or state programs, data on costs, quality, outcomes, health equity, and financial data.¹⁸
- **Application of existing anti-fraud and abuse statutes.** The bill applies existing Medicare and Medicaid measures against provider fraud and abuse to the Program, including prohibitions on self-referrals.¹⁹
- **Whistleblower protections.** The bill establishes whistleblower protections for participating providers and individuals that report potential violations of the Act.²⁰
- **Separation of Operating Funds and Capital Funds.** To ensure that providers are using operating funds for health care benefits, Program funds for operating expenditures and capital expenditures are disbursed through separate mechanisms, and providers are prohibited from comingling operating funds with capital funds.²¹

¹⁴ H.R. 1384 §§ 104, 301(b).

¹⁵ H.R. 1384 § 202(b), 301(b).

¹⁶ H.R. 1384 § 301(b)(1)(G).

¹⁷ H.R. 1384 § 301(b)(2).

¹⁸ H.R. 1384 §§ 301(b), 401(b)(1).

¹⁹ H.R. 1384 § 411.

²⁰ H.R. 1384 § 301.

²¹ H.R. 1384 §§ 611, 614(c).

- **Prohibited Uses of Reimbursements.** To ensure that provider reimbursements are used for the provision of benefits under the Program, the bill prohibits program funds from being used for:
- Compensation for any institutional provider employee, contractor, or subcontractor above existing compensation caps established for federal contractors under the Bipartisan Budget Act of 2013.²²
 - Marketing.²³
 - Profit or net revenue.²⁴
 - Incentive payments, bonuses, or other compensation based on patient utilization or other financial measures.²⁵
 - Union-busting consultants.²⁶
 - Federal campaign contributions.²⁷

Who would own the hospitals and employ the providers?

Hospital ownership and provider employment would be unchanged. Thus, most of the health care delivery system would remain in the private sector.

How would a single-payer system pay providers and set payment rates?

- **National Health Budget.** The Secretary would establish a national health budget that would be allocated regionally. Regional allocations would include payments for the region’s providers, capital expenditures, special projects, health professional education, administrative expenses, and prevention and public health activities.
- **Institutional Providers & Global Budgeting.** Institutional providers—including hospitals, skilled nursing facilities, federally qualified health centers, home health agencies, and independent dialysis facilities—would negotiate an annual lump sum global operating budget with the regional director which would be paid on a quarterly basis.²⁸ The global operating budget would be based on:
- the historical volume of services in the previous 3-year period and provider capacity,
 - the actual expenditures as compared to other providers within the region and normative payment rates to be established,
 - projected changes in volume and type of items and services to be furnished,
 - employee wages,
 - education and prevention programs, and
 - other relevant factors and adjustments.

Each regional director would review institutional providers’ performance on a quarterly basis and determine whether adjustments to the budget are needed, including additional funding needed for unanticipated care for individuals with complex medical needs or for changes in the market.

- **Individual Providers & Group Practices.**²⁹

²² H.R. 1384 § 611(b)(5).

²³ H.R. 1384 § 614(b)(1).

²⁴ H.R. 1384 § 614(b)(2).

²⁵ H.R. 1384 § 614(b)(3).

²⁶ H.R. 1384 § 614(b)(4).

²⁷ H.R. 1384 § 614(b)(5).

²⁸ H.R. 1384 §§ 611-615.

²⁹ H.R. 1384 §§ 611-615.

- **Fee Schedule.** Individual providers, including those in medical group practices, would be paid on a fee-for-service basis using a national fee schedule established by the Secretary. The fee schedule would consider the prevailing rates under Medicare, provider expertise, and the value of the items and services furnished. The bill establishes both a standardized documentation and review process of the relative values of physician services to determine appropriate fee payments and a physician consultation review board to review quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.
- **Option for Salaried Payments.** However, as determined by the Secretary, certain group practices and other health care providers with agreements to provide health care services at a specific institutional provider may choose to be paid a salary through such institutional provider’s global budget instead of on a fee-for-service basis.
- **Capital Expenditures.** Providers seeking funding for capital expenditures—defined as expenses for the purchase, lease, construction, or renovation of capital facilities and for major equipment—are required to apply to the applicable regional director for funding and are subject to approval by the Secretary. The Secretary shall prioritize capital projects that improve services in a medically underserved area or that address health disparities among racial, income, or ethnic groups, or based on geographic regions. Regional directors seeking funding for special projects—which can be used for the construction of new facilities, major equipment purchases, and staffing in rural or medically underserved areas—must present a budget to the Secretary for review. The bill prohibits comingling of funding for operating expenses with funding for capital projects.

How would the single-payer system purchase prescription drugs?

The Secretary would negotiate prices for prescription drugs. If a pharmaceutical company refuses to negotiate a reasonable price for a prescription drug, the bill authorizes the Program to issue competitive licenses for generic production of the drug.³⁰

How would a single-payer system contain health care costs?

Studies have shown that Medicare for All would not only contain costs, but would save the country up to \$5.1 trillion over 10 years.³¹ Conservative estimates conducted by the Mercatus Center demonstrate that the U.S. would save more than \$2 trillion over a ten-year period under Medicare for All.³² Specifically, H.R. 1384 would contain costs and produce savings primarily by reducing administrative costs, negotiating prescription drug and medical device prices, and controlling provider payments.

- **Administrative Costs.** Under our current fragmented, multi-payer system, we spend about 31 percent of total health expenditures on administrative costs. This amounted to an estimated \$1.1 trillion in 2017.³³ Implementing a single payer system with a single, comprehensive benefits plan would create uniformity in claims and billing processing. Insurer costs such as care denial and

³⁰ H.R. 1384 § 616.

³¹ Pollin, Robert et al. “Economic Analysis of Medicare for All.” Political Economy Research Institute (PERI), (Nov. 2018), available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

³² Blahous, Charles. “The Costs of a National Single-Payer Healthcare System.” Mercatus Working Paper. Mercatus Center, George Mason University: Arlington, VA (Jul. 2018), available at https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

³³ Woolhandler, Steffie and Himmelstein, David. “Single-Payer Reform: The Only Way to Fulfill the President’s Pledge of More Coverage, Better Benefits, and Lower Costs.” *Ann. Intern. Med.* (2017) 166(8): 587-588. According to the Centers for Medicare and Medicaid Services, national health expenditures was \$3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. “National Health Expenditure Accounts (2017).” U.S. Department of Health and Human Services (accessed on April 26, 2019), available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>.

containment, marketing, profit, and executive compensation would be eliminated. Health care providers would no longer need large billing departments to manage the manifold insurance cost-sharing schemes, collect unpaid bills from the uninsured and the underinsured, or obtain preauthorization for tests and treatments.

- **Prescription Drug and Medical Device Prices.** The Secretary would wield tremendous bargaining power by negotiating on behalf of the entire U.S. population. This would enable the Secretary to drive down costs for prescription drugs and medical devices. As noted above, if the Secretary were unable to negotiate a reasonable price for a prescription drug, competitive licenses for generic production of the drug would be issued.³⁴
- **Provider Payments.** As the single payer, the Medicare for All Program would have the power to regulate provider payments. Payment inequities would also be addressed; some providers would see their reimbursement rates reduced³⁵ while others would see their rates increased.
 - **Institutional providers**—Massive consolidation among private hospitals and other institutional providers, as well as the acquisition of physician practices, have enabled some hospital and health systems to charge exorbitant prices, while hospitals in rural and underserved areas close and funding for public hospitals dwindles. Whereas the former would see their bargaining power—based on market share—diminished and with it their ability to extract exorbitant reimbursement rates, the latter would see reimbursement rates increase and funding stabilize.
 - **Health care professionals**—Rates also may change based on the type of medicine a physician or other health care professional practices. The bill addresses a pay inequity that undervalues the cognitive-based services that primary care physicians provide and overvalues procedure-based services that specialists tend to provide³⁶ by establishing both a review process of the relative values of physician services³⁷ and a physician consultation review board to review quality, cost effectiveness, and fair reimbursement of services and items delivered by physicians.³⁸

How would a single-payer system be financed?

Current U.S. expenditures provide sufficient funding for the Program, but they must be captured in a new way. Amounts equal to federal expenditures for programs that the bill sunsets—including Medicare, Medicaid, the State Children’s Health Insurance Program, and the ACA marketplaces—would be deposited annually into a newly established Universal Medicare Trust Fund. These deposits would be adjusted annually for cost savings resulting from implementation of the Program and for changes in the consumer price index. Although the bill does not specify how the balance of the national expenditures would be financed, there are many options. These could include a corporate gross receipts tax, progressive personal income tax, financial transaction tax, and repealing the corporate tax cuts passed in 2017.³⁹

³⁴ H.R. 1384 § 616.

³⁵ As discussed above, reductions in reimbursement rates would be offset by significant administrative savings.

³⁶ Goodson, J. D. “Patient Protection and Affordable Care Act: Promise and Peril for Primary Care.” *Ann Intern Med.* (2010), 152(11):742-744.

³⁷ H.R. 1384 § 613.

³⁸ H.R. 1384 § 612(d).

³⁹ H.R. 1384 § 701.

Medicare for All Act of 2019: Ensuring Access to Care

The Medicare for All Act of 2019, which would establish the Medicare for All Program (Program) includes key design features to eliminate barriers to care that occur in our current health system and to ensure that new barriers to care are not created.

Ending Wait Times and Rationing Due to Unaffordability.

- Wait times and rationing occur today under our system of private insurance. This is often self-imposed. For example, people delay seeking medical care or filling a prescription because they cannot afford it. Even those who have insurance delay care because they cannot afford the copayments or deductibles.
- Because financial barriers imposed by premiums, deductibles, and cost-sharing would be eliminated under the Medicare for All Program, self-imposed delays in care related to affordability, which are common in our current private insurance system and public programs, would no longer occur.

Emphasizing Primary Care and Prevention to Reduce Demand for Emergency or Specialist Care.

- Medicare for All emphasizes primary care and prevention rather than waiting to treat illnesses that must be addressed by a specialist or require hospitalization. With increased access to and use of primary and preventive care, people will be more likely to seek care before their health conditions become severe enough to require the high-cost acute, emergency, or specialty care that currently represents half of the country’s health care spending.¹
- The bill would establish an Office of Primary Care that would focus on increasing the supply of primary care providers—for example, by paying for these providers’ medical education—as well as evaluating payment to physicians, including primary care physicians. Doctors would be more likely to enter into primary or family care practices if they were not saddled with massive debt for their education and the gap between primary and specialty care reimbursement narrowed.

Attracting Provider Participation by Capturing Demand in a Single Patient Pool Under Medicare for All.

- Medicare for All strongly encourages providers to participate in Medicare for All by capturing everyone in the pool of patients and by prohibiting private plans with duplicate coverage. In other words, the Program is designed to capture all health care demand (through comprehensive benefits and no cost-sharing). Operating as a nonparticipating provider would not be a suitable option for the vast majority of providers.

Prohibitions on Private Contracting to Prevent Tiered Access to Care.

- As the May 2019 Congressional Budget Office report on single payer health system design states, wait times may result if a single payer system allows providers to provide private care or simultaneously see patients with substitutive private plans alongside public plan patients.² By limiting both substitutive private plans and private contracting, the Medicare for All Act of 2019 avoids these issues and stops providers from offering two tiers of services where individuals can pay to jump the queue ahead of Medicare for All enrollees.

¹ See Agency for Healthcare Research and Quality. “Medical Expenditure Panel Survey, Total expenditures in millions by condition, United States, 2015.” U.S. Department of Health and Human Services (2015), available at <https://meps.ahrq.gov/mepstrends/home/index.html>.

² Congressional Budget Office. “Key Design Components and Considerations for Establishing a Single-Payer Health Care System.” CBO Publications (May 2019), pp. 13, 23.

- Medicare for All also prevents providers from creating tiered waiting lines for care by placing strict limits on when a participating provider can see non-Medicare for All patients and by prohibiting participating providers from entering into private contracts for covered services. If a provider furnishes covered services through a private contract, they will be ineligible to participate in the Medicare for All Program for two years.

Creating Reliable Sources of Funding for Hospitals and Strengthening Our Safety Net Health Care Institutions.

- The Medicare for All Act of 2019’s reimbursement structure and special projects budget are designed to create reliable funding streams for hospitals and other institutional providers. Reimbursing hospitals through global budgeting aligns hospital payments with actual costs. Special projects funding is designed to be directed towards increasing staffing and improving facility capacity in medically underserved and health professional shortage areas.
- Medicare for All would ensure that safety-net health care institutions would be sufficiently funded. Through transparent reimbursement negotiations, the Program would ensure that variations in provider prices are no longer exacerbating health and health care inequality. The Program’s global budgeting and reimbursement structure is designed to create reliable and stable funding streams for hospitals and other institutional providers. The special projects budget would ensure that safety net hospitals and other providers in rural and urban underserved areas have sufficient resources and staffing to meet demand in their areas.
- In the long-term, Medicare for All will more fairly and effectively distribute care across the system, funding and directing health care resources where they are needed most and where health inequities have been identified. The Program could use special project funds to increase staffing and expand provider capacity in rural or underserved areas. Through global budgeting reviews and adjustments, regional directors can increase funding for hospitals with increases in patient care populations or that need resources to respond to new or emerging public health conditions.

Increasing Access to Health Care Professionals.

- The Medicare for All Program directs resources into educating new health care professionals to enter into the system by including in the national budget a component for health professional education expenditures to cover costs associated with clinical education of new health care professionals.
- Under Medicare for All, precious time that doctors and other health care providers currently spend on billing and coding would be freed up, allowing providers to do more of what they do best—care for patients. Medicare for All would simplify the administrative process for doctors and other providers by having one payer.

Medicare for All Act of 2019: Ending the Burden of Medical Debt

The Medicare for All Act of 2019, by eliminating copayments, coinsurance, deductibles, and other out-of-pocket health care costs, would put an end to the crushing burden of medical debt that millions of uninsured and underinsured Americans face today due to the inability to pay unanticipated medical costs and surprise bills.

Medical Debt is Ubiquitous, Reaching Both the Uninsured and the Insured.

The number of Americans burdened with medical debt is staggering. In 2014, the Consumer Financial Protection Bureau reported that 43 million Americans had unpaid medical debts,¹ accounting for approximately 13% of the population in the United States.² About 1 in 5 of all adults and about 1 in 4 of non-Medicare age adults have past-due medical bills.³ Medical debt is a particularly acute problem for African American families with nearly 1 in 3 African American adults under 65 having past-due medical bills.⁴ Medical bills also account for more than half of all unpaid debts sent to collection agencies.⁵ Finally, about 250,000 people set up GoFundMe campaigns to pay for health care costs each year.⁶

➤ **Most patients who incur medical debt have health insurance coverage.**

Medical debt is not only crushing for the tens of millions in America who are uninsured, but it can also upend the lives of the estimated 44 million underinsured⁷ who pay premiums for health plans but may not be able to afford the care they need because of other out-of-pocket costs like copayments, coinsurance, and deductibles. Among adults with medical debt, 7 in 10 report that they and their families had health insurance when they incurred their medical bills.⁸ A recent study found that 30.5% of uninsured adults and 22.8% of insured adults report past-due medical bills.⁹ Another study reported that 1 in 6 Americans who have employer-sponsored health plans say they had to make “difficult sacrifices” to pay for health care in the last year, like cutting back on food, moving in with friends or family, or taking extra jobs.¹⁰

Working Families Are Most Vulnerable to Medical Debt.

Working people living paycheck-to-paycheck are the most vulnerable to unanticipated medical debt. As out-of-pocket costs and premiums continue to rise, many who work cannot afford health insurance, but their incomes and assets are not low enough to qualify for Medicaid. Other working families may have an employer-sponsored health plan but still have difficulty paying medical bills that accumulate from high deductibles, copayments, coinsurance, and costs from out-of-network care that their insurer

¹ Consumer Financial Protection Bureau. “Consumer credit reports: A study of medical and non-medical collections.” (Dec. 2014), available at https://files.consumerfinance.gov/f/201412_cfpb_reports_consumer-credit-medical-and-non-medical-collections.pdf.

² See U.S Census Bureau. U.S. Population (2014).

³ Karpman, Michael and Long, Sharon K. “Most Adults with Medical Debt Had Health Insurance at the Time the Debt was Incurred.” Urban Institute (May 2015), available at <http://hrms.urban.org/briefs/Most-Adults-with-Medical-Debt-Had-Health-Insurance-at-the-Time-the-Debt-Was-Incurred.pdf>.

⁴ Karpman, Michael and Caswell, Kyle J. “Past-Due Medical Debt among Nonelderly Adults, 2012-15.” *Urban Institute* (Mar. 2017), available at https://www.urban.org/sites/default/files/publication/88586/past_due_medical_debt.pdf.

⁵ Consumer Financial Protection Bureau (2014), *supra*, note 1.

⁶ According to GoFundMe .com on its website at <https://www.gofundme.com/start/medical-fundraising>.

⁷ Collins, Sara R., Herman K. Bhupal, and Michelle M. Doty. “Health Insurance Coverage Eight Years After the ACA.” Commonwealth Fund (February 7, 2019), available at <https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca>.

⁸ Karpman and Long (2015), *supra*, note 3.

⁹ Karpman and Caswell (2017), *supra*, note 4.

¹⁰ Hamel, Liz et al. “Kaiser Family Foundation / LA Times Survey of Adults With Employer-Sponsored Health Insurance.” *Kaiser Family Foundation* (May 2019), available at <http://files.kff.org/attachment/Report-KFF-LA-Times-Survey-of-Adults-with-Employer-Sponsored-Health-Insurance>.

declines to cover. The persistent fear of many Americans that they are one major illness away from financial ruin would end with Medicare for All.

➤ **Working families have trouble paying for medical bills.**

In a survey by the Kaiser Family Foundation and New York Times, more than a quarter of respondents said they or someone in their household had a problem paying for medical bills and, of those, 11% said they declared bankruptcy in part due to medical bills.¹¹ A 2018 poll reported that one third of U.S. adults say that, in the past year, they have had to choose between paying for food, heating, housing, or health care.¹²

➤ **Patients forego recommended medical care because of costs.**

Medical debt can exacerbate existing personal financial hardship and often has direct consequences for patients and their families. The 2018 poll cited above found that Americans are forgoing care at high rates because of cost, with 40% of Americans skipping a recommended medical test or treatment and 44% responding that they did not go to a doctor when they were sick or injured in the last year.¹³ Furthermore, according to a 2017 Federal Reserve report on the economic well-being of U.S. households, 44% of adults said that if confronted with an unexpected \$400 emergency expense, they would not be able to pay it without selling personal items or borrowing money.¹⁴

As Health Care Prices Rise, Health Insurance Plans and Employers are Paying for Less.

As health care prices continue to soar in the U.S., the burden of paying for such increases are ultimately borne by America’s workers. As health plans become more costly, employers have increasingly shifted health plan costs to employees rather than paying for increases in premiums. As a result of rising health care costs, workers have faced decades of rising out-of-pocket health care costs from deductibles, copayments, coinsurance, out-of-network charges, and other unanticipated or surprise medical bills. By eliminating out-of-pocket payments and reigning in health care prices, the precipitous climb in health care costs and resulting medical indebtedness of working families would end under Medicare for All.

➤ **Deductibles, copayments, and other out-of-pocket costs are rising in employer-sponsored plans.**

Out-of-pocket health care costs, not including premiums paid by individuals, have risen from \$555 per year in 1990 to more than \$1,100 in 2017.¹⁵ In the past 12 years, deductibles in employer-sponsored health plans have nearly quadrupled.¹⁶ Today, 82 percent of employers’ health plans have a deductible with an average of \$1,655 annually.¹⁷ Additionally, 21% of adults with employer-

¹¹ Hamel, Liz et al. “The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey.” *Kaiser Family Foundation* (Jan. 2016), available at <https://www.kff.org/wp-content/uploads/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>.

¹² West Health Institute, “Issue Brief, Americans’ Views of Healthcare Costs, Coverage, and Policy.” NORC at the University of Chicago (Mar. 2018), available at <http://www.norc.org/PDFs/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy/WHI%20Healthcare%20Costs%20Coverage%20and%20Policy%20Issue%20Brief.pdf>.

¹³ Id.

¹⁴ Board of Governors of the Federal Reserve System. “Federal Reserve Board Issues Report on the Economic Well-Being of U.S. Households in 2017.” (May 2018), available at <https://www.federalreserve.gov/publications/files/2017-report-economic-well-being-ushouseholds-201805.pdf>. The sample of respondents is designed to be representative of U.S. residents ages 18 and older.

¹⁵ Figures calculated by dividing out-of-pocket personal health care spending as defined and reported by the Centers for Medicare & Medicaid Services by reported U.S. population for the relevant year. See National Health Expenditures by year at Centers for Medicare & Medicaid Services. U.S. Department of Health and Human Services. “National Health Expenditures by type of services and sources of funds, CY 1960-2017.” National Health Expenditure Accounts (Last Modified Dec. 2018), available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>; see also U.S. Census Bureau. Population and Housing Unit Estimates Datasets, available at <https://www.census.gov/programs-surveys/popest/data/data-sets.html>.

¹⁶ Hamel et al. (2019), , *supra*, note 10.

¹⁷ Claxton, Gary et al. “Employer Health Benefits, 2019 Annual Survey.” *Kaiser Family Foundation* (Sept. 2019), available at <http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2019>.

sponsored health plans reported having annual deductibles over \$3,000 for individuals or over \$5,000 for families.¹⁸ Importantly, ballooning health insurance costs have outpaced average growth in median income over the past decade with the average deductible reaching 4.7% of income.

➤ **Out-of-pocket costs of individual marketplace plans are unaffordable for many.**

For those who do not have access to an employer-sponsored health plan, 45% of non-Medicare-aged adults without health insurance could not afford private insurance plans even after implementation of the Patient Protection and Affordable Care Act.¹⁹ Plans sold through the ACA marketplaces only cover between 60% to 90% of costs and can have high caps on out-of-pocket spending. In 2020, out-of-pocket maximums for ACA plans are \$8,200 for an individual and \$16,400 for a family.²⁰

➤ **Surprise medical bills are also growing.**

A recent JAMA study found that surprise medical bills are also ballooning.²¹ From 2010 to 2016, out-of-network bills grew from \$220 to \$628 for emergency department visits. In 2016, 42.8% of emergency department visits resulted in an out-of-network bill. For inpatient admissions, out-of-network bills grew from \$804 in 2010 and \$2,040 in 2016. In 2016, 42% of inpatient admissions resulted in an out-of-network bill.

Hospitals and Other Providers Engage in Predatory Medical Debt Collection Practices.

Medical debt collection, in particular medical debt collection lawsuits, can disrupt the lives of working people in financially toxic ways, including wage and property garnishments, bankruptcies, foreclosures, precipitous drops in credit scores, and the risk of further financial marginalization and income inequality. When health care providers or debt collectors hired by providers initiate litigation against their patients, often times patients do not have the resources to respond or access to the courts, resulting in arrest warrants being issued against them and even jail time.²² Hospitals, among other providers, seek to collect on medical debts against their patients even though many of these hospitals purport to be charitable nonprofits with missions to provide care regardless of a person’s ability to pay and even as they receive generous taxpayer and philanthropic support.

➤ **Extraordinary Collections Actions by Hospitals and other Providers.**

Many hospitals and other providers employ aggressive, punitive practices against their own patients to collect on amounts that are trivial when compared to the revenues of their multibillion-dollar institutions and executive pay. Indeed, medical debt collection has become a multibillion-dollar industry and represents almost half of the \$11 billion in debt collected every year.²³

As creditors of unpaid medical debts, hospitals and other providers sometimes use what are called “extraordinary collections actions” against patients to obtain payment for care.²⁴ These extreme debt collection actions include the use of courts to garnish an individual’s wages to pay off the medical debt. Similarly, these providers use the courts to issue bank levies against patients, which grant them access to the patient’s bank account to siphon off funds. Providers may garnish wages

¹⁸ Hamel et al. (2019), *supra*, note 10.

¹⁹ “Key Facts about the Uninsured Population.” The Henry J. Kaiser Family Foundation, Dec. 7, 2018, available at www.kff.org/uninsured/factsheet/key-facts-about-the-uninsured-population/

²⁰ See U.S. Centers for Medicare & Medicaid Services. “Out-of-pocket maximum/limit.” U.S. Department of Health and Human Services, available at <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (Accessed on Dec. 4, 2019).

²¹ Sun, Eric C. et al. “Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-Network Hospitals.” *JAMA Intern. Med.* 179(11) (2019), available at <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2740802>.

²² For example, see the case of medical debt collection litigation in Coffeyville, Kansas described in an October 2019 ProPublica investigative report. Presser, Lizzie. “When Medical Debt Collectors Decide Who Gets Arrested.” *ProPublica* (Oct. 16, 2019), available at <https://features.propublica.org/medical-debt/when-medical-debt-collectors-decide-who-gets-arrested-coffeyville-kansas/>.

²³ *Ibid.*

²⁴ See 26 CFR § 1.501(r)-6.

and bank accounts until the debt is fully paid. In order to stop garnishment actions, a patient may have to file for bankruptcy.

Extraordinary collections actions include:

- Selling patient medical debt to a third party
- Reporting adverse information about a patient to consumer credit reporting agencies or bureaus
- Deterring, denying, or requiring payment before providing medically necessary care because of a patient’s nonpayment of one or more bills for previously provided care
- Taking legal action such as:
 - Garnishing a patient’s wages
 - Placing a lien on a patient’s property
 - Foreclosing on a patient’s real property
 - Attaching or seizing a patient’s bank account or any other personal property
 - Commencing a civil action against a patient
 - Causing a patient’s arrest
 - Causing a patient to be subject to a writ of body attachment where a court orders law enforcement to bring in the individual or to arrest an individual for civil contempt.

Although the ACA requires that hospitals make “reasonable efforts” to determine whether a patient is eligible for free or reduced costs under the hospital’s financial assistance policy before engaging in extraordinary debt collection practices, receiving financial assistance is typically an arduous and complicated process that varies wildly between states and individual hospitals. With little federal and state oversight of financial assistance policies and medical debt collection practices, hospitals and other providers are largely free to exercise their own discretion as to when and whether to engage in these extreme debt collection practices.

➤ **By ending medical debt, Medicare for All would end medical debt lawsuits.**

Medicare for All would end charging patients directly as the federal government would be the single payer involved in the financial transactions related to health care payments. By ending balance billing and prohibiting out-of-pocket charges, Medicare for All would end medical debt thereby eliminating the associated medical debt lawsuits and other extreme collections actions.

Medicare for All Act of 2019: Long-Term Services and Supports

What are long-term services and supports (LTSS)?

Long-term services and supports (LTSS) are a critical health care benefit for people with disabilities and older adults. LTSS provides assistance for daily life activities, like bathing, eating, chores, and accessing the community. While LTSS can be provided in institutional settings like nursing homes, the vast majority of people with disabilities and older adults want to—and with LTSS can—live and participate in their own communities. LTSS are not just another service. LTSS are essential for people with disabilities to fully exercise their civil and human rights and fulfill the goals of the Americans with Disabilities Act: equality of opportunity, full participation, independent living, and economic self-sufficiency.

Current Coverage of LTSS

In our current health care system, LTSS are generally not covered by private insurance or the existing Medicare system, and few individuals or their families have the means to pay for these daily services out of pocket. The Medicaid program has become the primary payer of LTSS for people with disabilities and low-income older adults. But Medicaid has many disadvantages that restrict access to care. Medicaid’s strict limits on assets and income force people into poverty to access LTSS. Medicaid also has an “institutional bias” that requires states to provide care in institutions but makes optional community-based LTSS—called Home and Community Based Services (HCBS). People are forced to wait on years-long waitlists for HCBS, having to rely on unpaid family caregivers (often women who are forced to leave the workforce) to avoid unwanted institutional care. There is a critical and growing need for HCBS as this country’s population ages and more people want to age in place.

The Medicare for All Act of 2019 & LTSS

The Medicare for All Act of 2019 represents a major step forward for health care and particularly in providing LTSS for people with disabilities and older adults. It would dramatically expand and improve access to LTSS by eliminating all financial barriers to care, providing LTSS to all individuals regardless of income status, and replacing the institutional bias that currently exists in Medicaid with a presumption that services be provided to individuals in their own homes and communities instead.

Guaranteed Health Care for All Includes LTSS

- For people with disabilities and older adults, health care is both a matter of life and death and of liberty and civil rights. LTSS are vital to individuals’ self-determination, independence, empowerment, and integration and inclusion in their communities.
- Medicaid’s current eligibility guidelines trap individuals into poverty as a pre-condition to receiving services, hindering their economic opportunities and ability to save money for their future. Additionally, the coverage and quality of Medicaid-funded LTSS vary by state, making access dependent more on their zip code than their needs.
- This legislation would ensure that all people with disabilities and older adults have access to the LTSS they need, including nursing and medical services, long-term rehabilitative and habilitative services, and services to support activities of daily living and instrumental activities of daily living, with an emphasis on services being provided in the community.
- LTSS would not require any co-pays, deductibles, or premiums.
- LTSS would be provided when an illness, injury, or age limits an individual’s ability to perform one or more activities of daily living or instrumental activities of daily living. Individuals with both physical and mental disabilities would be eligible.

Providing Community First Care

- The Medicaid program’s institutional bias means that many states have limited access to LTSS provided to help people live in their own homes and communities, even though that is what the vast majority of people with disabilities and older Americans want. Over 500,000 individuals are currently on waitlists for HCBS.²⁵
- People currently have to wait years, sometimes even a decade or more, to receive HCBS. They are forced to rely on unpaid caregivers—often family members (and most often women) who have to leave the workforce to provide uncompensated care. Too many people are forced into unwanted institutional care because they cannot access HCBS in a timely manner.
- This legislation will reverse Medicaid’s institutional bias by ensuring that all eligible individuals have timely access to HCBS and presuming that recipients of all ages and types of disabilities will receive LTSS to help them live in the community unless the individual affirmatively chooses institutional care.

Community Consultation

- The legislation requires that the Secretary develop regulations in consultation with people who use LTSS, their families and caregivers, providers of LTSS, and disability rights, academic, and labor organizations.

²⁵ Kaiser Family Foundation, “Waiting List Enrollment for Medicaid Section 1915(c) Home and Community-Based Services Waivers”. 2016.

Medicare for All Act of 2019: Global Budgets & Other Provider Reimbursements

Medicare for All: Putting Patient Care Over Pocketbooks

The program outlined in the Medicare for All Act of 2019, H.R. 1384, takes several steps to ensure that providers can focus on patient care rather than on their pocketbooks.

- **Less Time on Billing, More Time for Patients.** Medicare for All would simplify the administrative process for doctors and other providers by having one payer. Precious time that doctors and other health care providers spend on billing and coding would be freed up, allowing providers to do what they do best—care for patients.
- **Negotiating Lower Prices.** Under the Medicare for All program, health care corporations would no longer be able to overcharge for their services. By leveraging its buying power as the single payer for health care, Medicare for All would be able to negotiate better, fairer health care prices for everyone. Reimbursement rates for hospitals and doctors will be based on negotiations with the regional directors. Negotiations over health care prices would include prescription drug price negotiations. The Medicare for All Act would also allow the Secretary of the U.S. Department of Health and Human Services to issue competitive licenses to allow generic production if unable to negotiate a reasonable price with pharmaceutical corporations.
- **Health Care Dollars No Longer Line Pockets.** The Medicare for All program would bar Medicare for All providers from siphoning off health care dollars to line their pockets. H.R. 1384 does so through limits on executive pay and prohibitions on bonuses and other financial incentives for upcoding. Importantly, provider reimbursement must be used for the costs of providing care and not for profit. The bill also prohibits Medicare for All providers from entering into financial relationships that could interfere with decisions on patient care. Health corporation board members would no longer be able to receive bonuses from pharmaceutical or medical device manufacturers for entering into exclusive contracts.

Global Budgeting for Hospitals & Other Institutional Providers

Under the Medicare for All Act, each hospital and each institutional provider—including skilled nursing facilities, federally qualified health centers, home health agencies, and independent dialysis facilities—will be paid through an institution-specific “global budget”.

- **Negotiated Annually.** Each global budget would be negotiated annually between institutional providers and regional directors. Institutional providers would receive a fixed annual allowance, paid and reviewed quarterly, to fund operating expenses related to furnishing health care to Medicare for All members. Major factors included in negotiations are historical volume and costs of care, projected changes in volume and type of care, and wages for all employees, including physicians that work directly for the hospitals. Capital expenditures for costs such as renovating facilities or building new ones would require separate approval from the regional director.
- **Aligning Hospital Reimbursements With Actual Costs.** Global budgeting simplifies the reimbursement system so that payments more closely reflect the actual costs of providing health care to the population served by each hospital and institutional provider.²⁶ The global budgeting process would allow the Medicare for All program to ensure that providers get the appropriate funding for the health care services that their patients need—providers would be accountable for their spending and would no longer be able to overcharge.

²⁶ Dredge, Robert. *Hospital Global Budgeting*. World Bank Health Nutrition and Population Discussion Paper. World Bank (2004), pp. 37-38.

- **Simplification of Hospital Reimbursements.** By eliminating the billing process, global budgets result in administrative simplicity and associated savings for hospitals and other institutional providers. Information necessary to predict annual global budgets—including financial cost data, case mix, and volume of services—is readily available and already captured by hospitals and other institutions.²⁷ Additionally, this information is already reported to the Centers for Medicare and Medicaid Services in Medicare cost reports.
- **Transparent and Accountable Spending.** Global budgets allow the public to track where our health care dollars are going and to ensure that rural hospitals and hospitals in underserved areas are getting the funding that they need. Providers must report all relevant data associated with operational costs and justify their spending during annual negotiations. With periodic audits and review, providers would be held accountable for their projected spending and the program could monitor whether the provider is meeting program goals and standards. Budget shortfalls, unexpected or emergent public health conditions, or other marginal cost differences between planned and actual health care spending can be addressed through budget adjustments year-over-year or through quarterly reviews.
- **Funding Certainty for Hospitals Serving Vulnerable Communities.** Global budgets can be a blessing to hospitals that serve rural or underserved communities and that currently have inconsistent or undependable funding streams. Global budgets would ensure that our safety net hospitals that provide care to low-income, rural, and minority communities are sufficiently funded and resourced.
- **International Use of Hospital Global Budgeting.** Many countries with publicly-funded health care—Canada, Scotland, Wales, New Zealand, Australia, Denmark, Sweden, Switzerland, Norway, Iceland, Ireland, and Singapore—use global budgets as key components of their hospital payment methodologies.²⁸
- **Successes in Hospital Global Budgeting in the U.S.** Notably, Maryland has been successfully paying all hospitals in the state through global budgets since 2014, and the city of Rochester, NY successfully implemented hospital global budgets in the 1980s for almost a decade under a Medicare waiver. In Rochester, hospital global budgets led to lower overall health care costs for families and a 17% reduction in the hospital component of total health care spending. Administrative costs were 7% compared to 14-24% nationally. In Maryland, hospital global budgeting resulted in \$429 million in hospital savings for Medicare within 3 years of implementation outperforming Medicare’s initial goal of \$330 million in savings over 5 years.²⁹ Following Maryland’s successes, Pennsylvania recently adopted global budgets for its rural hospitals.

Payment Options for Doctors & Medical Group Practices

There are two payment options for doctors and doctor groups under the Medicare for All Act of 2019—reimbursements based on the Medicare fee schedule or salaries based on negotiated global budgets. The Secretary of the U.S. Department of Health and Human Services would establish a national fee schedule in consultation with doctors and regional directors. Instead of payments based on the national fee schedule, individual providers and group practices could opt to receive salaries through an institutional provider’s global budgeting process.

²⁷ *Id.* at pp.18, 37-38.

²⁸ See Mossialos, Elias et al. “International Profiles of Health Care Systems.” *The Commonwealth Fund* (May 2017); Wolfe, Patrice and Moran, Donald. “Global Budgeting in OECD Countries.” *Health Care Fin. Rev.* (1993) Vol 14:3.

²⁹ Sabatini, Nelson et al. “Maryland’s All-Payer Model—Achievements, Challenges, And Next Steps.” *Health Affairs Blog* (Jan. 31, 2017), available at <https://www.healthaffairs.org/doi/10.1377/hblog20170131.058550/full/>.

Medicare for All Act of 2019: Cost & Savings Analyses

The tables below summarize the findings from two major cost and savings analyses of national implementation of Medicare for All. The first study was conducted by Robert Pollin and his colleagues with the Political Economy Research Institute (PERI) of the University of Massachusetts Amherst.¹ The second study was conducted by Charles Blahous with the Mercatus Center of George Mason University.² Blahous testified at the April 30, 2019, House Rules Committee hearing on “H.R. 1384 - Medicare for All Act of 2019”. These two studies contain the most rigorous methodologies for analyzing potential savings in addition to increases in cost that would result from implementation of Medicare for All.

Both the Pollin study and Blahous study show that the savings produced by Medicare for All would exceed increases in cost. Findings in Blahous’ demonstrate that Medicare for All could result in over \$2 trillion in savings over 10 years in National Health Expenditures (Table 1).³ Pollin’s analysis found that Medicare for All would result in \$5.1 trillion in savings over ten years (Table 1).⁴ Breaking those results down, Pollin’s findings show that although there could be, on the high-end, a \$390 Billion increase in costs as a result of an increase in health care demand, Medicare for All would also capture \$697 Billion (18.78%) in savings in administration, pharmaceutical payments, provider rates, and reduced waste, fraud, and abuse (Table 2).⁵ Blahous’ study similarly demonstrates that although Medicare for All would increase health care demand by \$435 Billion, the program would also produce \$528 Billion (10.56%) in savings on administration, pharmaceutical payments, and provider rates (Table 2).⁶

Some minor adjustments have been made to Pollin’s percentages below in order to reflect percentages of National Health Expenditures rather than National Health Consumption, which Pollin uses in his study. Blahous’ percentages of increases and savings are percentages of National Health Expenditures.

Table 1. Projected Savings in National Health Expenditures, Pollin & Blahous

	Pollin Study	Blahous Study
Projected Savings MFA (10 Years) in National Health Expenditures	\$5.1 Trillion	\$2.1 Trillion*
Years	2017-2026	2022-2031
Projected Savings MFA (First Year) in National Health Expenditures	\$310 Billion	\$93 Billion**
Year	2017	2022
* Calculated from Blahous’ projected changes in health care spending between 2022 to 2031, in the aggregate, (decrease of \$482 billion) summed with administrative cost savings, in the aggregate, for that same period (\$1.572 trillion). See Blahous, at p. 7, in Table 2 for both figures.		
** Calculated from Blahous’ projected changes in health care spending for 2022 (\$10 billion) summed with administrative cost savings for 2022 (\$83 billion). See Blahous, at p. 7, in Table 2 for both figures.		

¹ Pollin, Robert, et al. “Economic Analysis of Medicare for All.” Political Economy Research Institute (PERI), University of Massachusetts Amherst (2018), available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

² Blahous, Charles. “The Costs of a National Single-Payer Healthcare System.” Mercatus Center, George Mason University (2018), available at https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

³ *Id.* at 7 (Summing projected National Health Expenditures for 2022-2031 from Table 2).

⁴ Pollin (2018) at p. 3, 125-26.

⁵ See *Id.* at pp. 40-44 (adjusting percentages to reflect percentage savings of national health expenditures).

⁶ See Blahous (2018) at p. 4 (Table 1).

Table 2. Projected Increases, Projected Savings (Breakdown) in National Health Expenditures, Pollin & Blahous Comparison

	Pollin Study	Blahous Study⁺
Increases in National Health Expenditures due to Medicare for All		
Projected Increase in Utilization/Demand	\$390 Billion	\$435 Billion
Percentage Increase in Utilization/Demand	11.73%*	9.50%
Savings in National Health Expenditures due to Medicare for All		
Administrative Savings	\$327 Billion	\$83 Billion
Percentage	8.80%*	1.66% ⁺⁺
Drug Savings	\$214 Billion	\$61 Billion
Percentage	5.77%*	1.22% ⁺⁺
Medicare Rates	\$102 Billion	\$384 Billion
Percentage	2.74%*	7.68% ⁺⁺
Savings From Reduced Waste & Fraud	\$54 Billion	N/A
Percentage	1.47%*	N/A
TOTAL SAVINGS	\$697 Billion**	\$528 Billion
Percentage	18.78%*	10.56%
⁺ See Blahous’ projected increases in utilization/demand for 2022, at p. 4, Table 1. ⁺⁺ Percentage calculations based on spending after introduction of Medicare for All, which includes Blahous’ currently projected National Health Expenditures for 2022 (\$4,652 billion), p. 7, Table 2, plus Blahous’ projected increases in utilization/demand for 2022 (\$435 billion), p. 4, Table 1. [*] The Pollin Study used Health Consumption Expenditures and the Blahous Study used National Health Expenditures. To ensure compatibility in comparing the data, percentages from the Pollin Study were adjusted to reflect National Health Expenditures. See Pollin, p. 22, for explanation on use of Health Consumption Expenditures. ^{**} Projected National Health Expenditure savings in Table 1 are slightly different than total savings minus increases in Table 2 because of rounding in the Pollin Study.		

Medicare for All Act of 2019: Canada, Taiwan & U.S. Comparison

Two international examples of single-payer programs—Canada’s Medicare program and Taiwan’s National Health Insurance program—are detailed below in comparison to U.S. health spending and costs (Table 1) and to the system design of the Medicare for All Act of 2019, H.R. 1384.

The single-payer health systems of Canada and Taiwan are most similar in design to the single-payer program proposed under the Medicare for All Act of 2019. Similar to the United States, Canada and Taiwan both have a mix of publicly and privately delivered health care.

Table 1. Health Care Spending & Insurance Administrative Cost Comparison: Canada, Taiwan & U.S. (2017)

	Canada	Taiwan	U.S.
Total Spending on Health, % of total national GDP (2017)	10.7%*	6.1%**	16.9%*
Mean Spending on health per capita, PPPUSD	\$4,721*	\$3,047**	\$10,209*
Insurance administrative costs,*** by percentage	2.7% of total national health spending*	0.77% of NHI budget**	8.3% of total national health spending* 13% of private insurer spending** 7% of traditional Medicare and Medicare Advantage spending combined** 1.1% of traditional Medicare spending alone**
<p>* Organization for Economic Cooperation and Development. “OECD Health Statistics 2018.” OECD Stat (Updated Nov. 2019), available at http://www.oecd.org/els/health-systems/health-data.htm.</p> <p>** Cheng, Tsung-Mei. “Health Care Spending in the US and Taiwan: A Response to <i>It’s Still The Prices, Stupid, And a Tribute to Uwe Reinhardt</i>.” <i>Health Affairs</i> (Feb. 2019), available at https://www.healthaffairs.org/doi/10.1377/hblog20190206.305164/full/.</p> <p>*** Health care providers also incur substantial billing and insurance administrative costs that are not included in these figures.</p>			

Table 2. Program Design Comparison: Canada, Taiwan & H.R. 1384¹

Design Feature	Canada	Taiwan	H.R. 1384
Program Name	Medicare	National Health Insurance (NHI)	Medicare for All (MFA)
Level of Administration	Provincial or territorial government	National government	National government; regional subdivisions responsible for allocation of funds and negotiations with providers
Eligibility			
Universal coverage	Yes	Yes	Yes
Separate public programs for certain groups other than military	Yes	No	Yes. Although veterans and American Indians/Alaskan Natives may receive services through the Veterans Health Administration or Indian Health Services, respectively, they may also enroll in MFA.
Mandated Benefits Package			
Hospital and physicians’ services	Yes	Yes	Yes
Outpatient prescription drugs	No	Yes	Yes
Long-Term Services and Supports (LTSS)	No	Has a “Long-Term Care 2.0” plan to fully cover comprehensive home- and community-based care under NHI by 2026. Home-based care programs are currently being rolled out to expand coverage.	Yes, with a prioritization of home- and community-based services.
Dental, vision, and mental health services	No	Yes. Also, includes Chinese medicine, and home nursing care.	Yes
Private Health Insurance			
Supplemental	Yes	Yes, plays a non-substantive role; used primarily as a cash benefit for private rooms, co-pays, etc., and not used for coverage of services with the exception of long-term care.	Permitted for services not overlapping with Medicare for All, which would be extremely limited given the comprehensive benefits of the program.
Substitutive	No	No	No
Other types of private insurance	No	No	No

¹ Information compiled from: Congressional Budget Office. “Key Design Components and Considerations for Establishing a Single-Payer Health Care System.” CBO Publications (May 1, 2019), available at <https://www.cbo.gov/system/files/2019-05/55150-singlepayer.pdf>; and Mossialos, Elias et al. “International Profiles of Health Care Systems.” The Commonwealth Fund (May 2017).

Design Feature	Canada	Taiwan	H.R. 1384
Participating Provider Rules			
Balance billing allowed	No	No	No
Payments from private-pay patients for covered services	No	No	No
Hospitals			
Primary ownership	Mixed	Private	Private
Primary payment method	Global budget	FFS with overall hospital sector global budget	Global budget
Primary Care Physicians			
Primary employment	Private	Private	Private
Primary payment method	FFS	FFS with overall primary care global budget	FFS with option to elect salaried reimbursement through hospital global budgeting.
Outpatient Specialist Physicians			
Primary employment	Private	Private	Private
Primary payment method	FFS	Salary	FFS with option to elect salaried reimbursement through hospital global budgeting.

Medicare for All Act of 2019: Frequently Asked Questions

What is Medicare for All?

- The Medicare for All Act of 2019, H.R. 1384, would establish a single-payer health care system, which would expand the existing Medicare program to cover everyone in the United States and improve it so that everyone would be guaranteed comprehensive benefits without regard to their ability to pay.
- A single government agency would replace private insurance plans and provide public financing of health care. Because of the generous benefits package available under Medicare for All—including dental, vision, long-term services and supports, comprehensive reproductive services, and mental health services—with no cost-sharing, there would be no need for catastrophic or supplemental coverage to meet most health needs.

Would there be premiums, deductibles, copayments, or other out-of-pocket costs under Medicare for all?

- Under Medicare for All there would no premiums, co-pays, deductibles, or other out-of-pocket payments. There would be comprehensive benefits and a single standard of high-quality care—guaranteed health care for everyone no matter what the size of your wallet.
- Employers would no longer be burdened with annually negotiating health plans or paying private insurer premiums.
- Seniors would immediately benefit from coverage that would be more comprehensive than Medicare and would no longer need to purchase supplemental insurance to cover aspects of their care.

Would choice of doctors be limited?

- Medicare for All expands choice because you can see any doctor, go to any clinic, and be admitted at any hospital. Medicare for All is completely portable and not tied to any job, any doctor group, or any network.
- Medicare for All reforms only how health care dollars are collected and paid to providers; it does not dictate which providers individuals can visit.

Would the government be making decisions on care?

- Under the Medicare for All Act of 2019, the program would put health care decisions into the hands of you and your doctor instead of insurance companies and corporate boardrooms. Currently, unaccountable insurance companies call the shots on our health care and tell us which procedures are approved or what is necessary or unnecessary care.
- The Act also ensures that the professional judgment of doctors, nurses, and other health care professionals, in consultation with their patients, is the basis for health care decisions.

How is Medicare for All better than private insurance?

- With Medicare for All, Americans would no longer have to deal with persistent changes and disruptions to their health insurance when their employers annually renegotiate plans, and we would no longer be at the mercy of private insurers that suddenly change which doctors or hospitals are inside or outside their network. Even if you are unemployed or lose or change your job—your health coverage under Medicare for All stays with you.

- Even the best private insurance plans in this country do not cover the comprehensive list of services without any out-of-pocket costs or premiums paid by you or your employer. Under Medicare for All, everyone would have comprehensive benefits and full choice of provider without having to pay perpetually increasing premiums, copays, or deductibles.
- Under Medicare for All, everyone would have the same high standard of quality health care guaranteed from birth to death. On the other hand, private insurers, as for-profit corporations, have an incentive to deny necessary care in order to maximize profits. When enrollees receive health care services, health insurers consider these losses. Insurers also view vulnerable populations, rural areas, women, and minority groups as risks to the corporate ledger.

Shouldn't we try a Medicare buy-in or public option first?

- Medicare buy-ins and public plan options perpetuate current inequities in our system of health care. These stop-gap measures placed on existing private insurance systems shore up the profit-driven insurance system. Under a public option or Medicare buy-in, private plans would maximize revenue by cherry-picking coverage of only the healthiest people and leave the public plans to care for all the sickest and most expensive cases.
- Unlike Medicare for All, public options and buy-ins retain administrative complexity and will not produce the financial savings that we can capture with Medicare for All. These programs also cannot wield the massive negotiating power of a single payer system to reduce health care prices and contain skyrocketing costs.
- Even worse, the public option and Medicare buy-in still place limits on coverage and eligibility, restrict the choice of providers, and impose costly premiums and out-of-pocket costs in the form of deductibles and copayments. “Access” to a health plan is not a guarantee of health care.

How much will doctors get paid?

- Reimbursement rates may go up for some doctors and down for others Medicare rates have tended to fall in between Medicaid and private insurer rates. Changes, if any, in how much a provider makes will depend on each specific provider's payer mix (or the mixture of payment sources the doctor gets now).
- Rates may change based on the type of medicine a doctor practices because the Medicare for All program would ensure that primary care doctors in rural and underserved areas are sufficiently paid. Primary care physicians may see rates increase while specialists may see them reduced. Providers in rural and underserved areas would see reimbursements and funding stabilize.
- By reducing time on billing and paperwork, changes to rates could be offset because doctors have more time to spend on caring for patients and for other reimbursable services.

Would Medicare for All save taxpayer money?

- Taxpayers already finance nearly two-thirds of health care spending in the United States.¹ Medicare for All would produce savings because insurance industry profit, executive compensation, advertising, and marketing would no longer be necessary. We currently spend about 31 percent of total health expenditures on billing and insurance-related costs and other administrative costs.² And we spend at least \$30 billion per year on health care marketing.³

¹ Himmelstein, David and Woolhandler, Steffie. “The Current and Projected Taxpayer Shares of U.S. Health Costs.” *Amer. J. of Pub. Health* (Mar. 2016), Vol 106:3, pp. 449-452.

² Total administrative costs are estimated to be over \$1,097 billion in 2017. Steffie Woolhandler and David U. Himmelstein. “Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs.” *Ann Intern Med.* (2017) 166(8):587-588. According to the Centers for Medicare and Medicaid Services national health expenditures was \$3,492.1 billion in 2017. Centers for Medicare and Medicaid Services. “Historical National Expenditures.” *National Health Expenditure Accounts* (2017), accessed on

- Medicare for All would eliminate administrative waste created by private insurance and the attendant administrative complexity that comes with a multi-payer system.
- The Medicare for All Act would also control health care spending by eliminating health insurance marketing costs, prohibiting health industry profiteering, and capping excessive executive pay.
- The Medicare for All Program, through its bulk purchasing power, would negotiate not only lower drug and medical equipment prices but also lower prices for other health care costs through global budget negotiations with hospitals and other institutional providers.
- Studies have shown that Medicare for All would save the country up to \$5.1 trillion over 10 years.⁴ Conservative estimates conducted by the Mercatus Center also demonstrate that the U.S. could save \$2 trillion over 10 years under Medicare for All.⁵ The savings produced from reduced health care prices under Medicare for All would be allocated to expand benefits and to eliminate deductibles, copays, and out-of-pocket costs for everyone.

What impact would Medicare for All have on workers and is there a plan for a just transition?

- The Act would direct at least 1% of the Medicare for All budget for the first 5 years towards assistance programs for any workers displaced from the implementation of the program, including workers in health insurance and billing-related jobs.
- Just transition funding would include wage replacement, retirement benefits, job training, and education benefits.

Does the legislation provide comprehensive reproductive services to women?

- Medicare for All would dramatically improve access to important reproductive services, including contraception coverage, comprehensive maternity and newborn care, reproductive health screening, abortion care, and family planning services.
- Medicare for All ensures that women have access to comprehensive benefits including early and periodic screening, diagnostic, and treatment services. These services are important to prevent reproductive diseases and other illnesses that women are more at risk of developing, including lung and breast cancer.⁶
- The Act would ensure that any restrictions on the use of federal funds for reproductive health services, including the Hyde Amendment, would not apply to Medicare for All funds. The Act also includes a non-discrimination clause, which bars discrimination on the basis of pregnancy, including termination of pregnancy.
- Despite an international decline in maternal mortality rates, the United States has seen an increase. More women die of pregnancy-related complications in the U.S. than any other developed country.⁷

April 26, 2019, available at <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nationalhealthaccountshistorical.html>.

³ Schwartz, Lisa and Woloshin, Steven. “Medical Marketing in the United States, 1997-2016.” *JAMA* (2019) Vol 321:1, available at <https://jamanetwork.com/journals/jama/fullarticle/2720029>.

⁴ Pollin, Robert et al. “Economic Analysis of Medicare for All.” Political Economy Research Institute (PERI), (Nov. 2018), available at <https://www.peri.umass.edu/publication/item/1127-economic-analysis-of-medicare-for-all>.

⁵ Blahous, Charles. Mercatus Working Paper. “The Costs of a National Single-Payer Healthcare System.” Mercatus Center at George Mason University, Arlington, VA (Jul. 2018), available https://www.mercatus.org/system/files/blahous-costs-medicare-mercatus-working-paper-v1_1.pdf.

⁶ Jemal, Ahmedin et al. “Higher Lung Cancer Incidence in Young Women Than Young Men in the United States.” *New Eng. J. of Med.* (2018).

⁷ Martin, Nina and Montagne, Renee. “The Last Person You’d Expect to Die in Childbirth.” *ProPublica & National Public Radio* (May 12, 2017).

The Act includes comprehensive maternity and newborn care, which is critical to lowering mortality rates and improving health outcomes for women and babies.

How are community health care needs addressed under Medicare for All and how are preventive services covered?

- Medicare for All provides health planning by region through special projects and capital expenditure funds. Regional planning ensures that hospitals and clinics are built in communities where they are needed and ensures that providers who serve vulnerable communities, which insurers currently view as a risk to corporate bottom lines, are appropriately paid under Medicare for All. By increasing care capacity in local communities, many racial, economic, and geographic disparities in health and health care would be mitigated and life expectancy improved.
- By removing financial roadblocks to care, Medicare for All encourages preventive care. This not only reduces the occurrence of pain and illness, but it also decreases the societal cost of untreated disease and overuse of emergency rooms.