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MEMORANDUM August 31, 2018

To: House Energy and Commerce Committee
House Ways and Means Committee
[redacted]

From: [redacted]

Subject: **Information Requested about H.R. 676, as Introduced in the 115th Congress**

This memorandum responds to your request for answers to a set of questions you provided to the Congressional Research Service (CRS) about H.R. 676, the "Expanded & Improved Medicare For All Act," as introduced by Representative Conyers in the 115th Congress.[1] The first section of this memorandum provides a high-level overview of H.R. 676, generally organized by topic. The second section provides answers to your specific questions, within the following subcategories you provided:

(1) Health programs and services,

(2) Health care providers (physicians, nurses, etc.),

(3) Health insurance plans,

(4) Individuals who are not U.S. citizens,

(5) Authorities, and

(6) Health care spending.

H.R. 676 is intended to create a health system that would cover all individuals residing in the United States and that would be run by the federal government in partnership with regional offices and state governments.[2] A number of your questions refer to the potential impacts of this legislation, if enacted. In

[1] Introduced January 24, 2017. See: https://www.congress.gov/bill/115th-congress/house-bill/676. Following Representative Conyers' retirement, Representative Ellison assumed leadership of the bill in March 2018.

[2] While many consider H.R. 676 to be a single-payer bill, that term does not appear in the legislation. Also note that there is not a single definition of *single-payer*, and proposals that bear the single-payer label take a variety of forms. See, for example, Jodi Liu and Robert Brook, *What is Single-Payer Health Care? A Review of Definitions and Proposals in the U.S.*, Journal of General Internal Medicine, July 2017, at https://link.springer.com/article/10.1007/s11606-017-4063-5.

response to some questions, CRS's analysis is limited to information about the provisions of the bill that directly address the topic of a given question for a number of reasons, including that the bill lacks detail in many of its provisions and is not structured in legislative language that references or amends existing statutes or U.S. Code sections, making it difficult to provide an in-depth analysis of the legislation and how it may impact existing statute. For example, the bill does not make reference to amending or repealing the Medicare or Medicaid programs. Rather, it states that federal funds allocated to these programs would be used to fund the health system outlined in the legislation. In addition, CRS analysis indicates that the current version of the bill is substantially and substantively identical to legislation introduced prior to the enactment of the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). This complicates efforts to consider the potential impacts of H.R. 676 on current law. There is also no committee report or comparable language that may indicate legislative intent on any items.

Additionally, this memorandum does not provide budgetary or economic information related to H.R. 676. No public score of this bill is available from the Congressional Budget Office. More broadly, the impacts of this legislation on federal and state governments and various consumer and industry stakeholder groups would depend on many complex behavioral and economic reactions by and interactions of those groups. Given the limitations noted above and here, there may not be enough information available for CRS to provide analysis of potential actions and impacts. For example, the bill would provide that health programs of the Indian Health Service (IHS) remain independent for a 5-year period beginning the date of the establishment of the proposed Medicare For All program, after which such IHS programs would be integrated into the Medicare For All program. Even in the five years prior to its integration in the Medicare For All program, there could be impacts on the IHS and its beneficiaries resulting from changes to other parts of the health care system per this bill (or otherwise), but there is not enough information for CRS to describe the potential IHS-related impacts before or after integration.

This memorandum refers to the bill as introduced in the 115th Congress. It has not been amended in this Congress as of the date of this memorandum, but subsequent amendments could change the information provided below.

Given that issues related to H.R. 676 and similar proposals are of general interest to many in Congress, the information included in this memorandum may be provided to other congressional requesters or incorporated into other CRS products for general distribution. Your identity as a requester would not be disclosed in either case.

Summary of H.R. 676: "Expanded & Improved Medicare For All Act"

H.R. 676 is intended to create a health system that would cover all individuals residing in the United States and that would be run by the federal government in partnership with regional offices and state governments.[3] Though the legislation would establish a program entitled "Medicare For All" (hereafter referred to as the Program), it would not amend the current Medicare program itself, but rather would institute a new program. H.R. 676 would take effect on the first day of the first year that would begin more than one year after the date of the enactment of H.R. 676, and would apply to items and services furnished on or after such date.[4]

A high-level narrative summary of the bill is provided in this section. This summary is not meant to provide a comprehensive description of each provision of the bill. It is meant to provide an overview of the bill and context for the answers to the questions submitted to CRS. Where relevant, brief references to specific questions submitted to CRS are included.

[3] See footnote 2.

[4] H.R. 676, § 501.

Following this summary of the bill are answers to the specific questions submitted to CRS, many of which provide further detail on the initial summary information. The initial summary is organized by general topics (administration, eligibility and benefits, health care providers and insurers, program budget and payments, and financing) and the questions are organized as submitted to CRS.

Administration

In general, the Program would be administered by the Secretary of the Department of Health and Human Services (HHS) through a Director (hereafter referred to as the Director) appointed by the HHS Secretary.[5] See question 5.a. below for authorities granted to the HHS Secretary and Director.

The HHS Secretary would establish and maintain regional offices for the Program for the purpose of "(1) coordinating funding to health care providers and physicians; and (2) coordinating billing and reimbursements with physicians and health care providers through a state-based reimbursement system."[6]Any existing Medicare infrastructure (in terms of regional offices) would be incorporated when possible. In each of the regional offices, there would be one regional director appointed by the Director.[7]

For each state in the region, the governor of that state would appoint a deputy director (also known as a state director).[8] State directors would be responsible for (1) providing an annual state health care needs assessment report to the National Board of Universal Quality and Access (discussed later in this section) and the regional board, (2) planning and oversight of the placement of new health care facilities, (3) planning and oversight of the purchase and placement of new health equipment, (4) submitting global budgets to the regional director, (5) recommending changes in provider reimbursement or payment in the state, (6) establishing a quality assurance mechanism in the state, and (7) reviewing program disbursements on a quarterly basis and recommending fee schedule adjustments to achieve budgetary targets and assure access to care.[9] The Director would also appoint directors for long-term care, mental health, and for an Office of Quality Control.[10]

H.R. 676 would establish a National Board of Universal Quality and Access (hereafter referred to as the Board), with 15 members appointed by the President with the advice and consent of the Senate.[11] The Board would advise the HHS Secretary and Program Director "on a regular basis" and would report to the Secretary, Director, Congress, and the President about access to care, quality improvement, efficiency of administration, adequacy of budget and funding, appropriateness of reimbursement levels, capital expenditure needs, long-term care, mental health and substance abuse services, and staffing levels and working conditions within health care facilities. The bill includes some requirements for stakeholder representation, membership duration and timing, and timing of Board meetings, and otherwise notes that certain matters would apply in the same manner as they currently apply to the Medicare Payment Advisory Commission (MedPAC).

See questions 2.c.-e. below for further discussion of the state directors' and the Board's roles in issues relating to the health care workforce.

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[5] H.R. 676, § 301(a).

[6] H.R. 676, §§ 303(a) and (c).

[7] H.R. 676, § 303(b)(1).

[8] H.R. 676, § 303(b)(2).

[9] H.R. 676, § 303(d). Note that this provision mentions a "regional board" but the bill does not otherwise mention such a board.

[10] H.R. 676, §§ 301(b-c) and 302.

[11] H.R. 676, § 305.

Finally, H.R. 676 would require the Secretary to establish an electronic patient record system and the Director to create an electronic billing system.[12] Physicians would submit bills to their regional directors "on a simple form, or via computer."[13] Patients would have the option of keeping any portion of their medical records separate from their electronic medical record.[14]

Eligibility and Benefits

All individuals residing in the United States would be eligible to receive care under the Program.[15] See question 1.a. below. The HHS Secretary would be directed to provide, through rulemaking, "criteria for determining residency for eligibility purposes" under the Program.[16] The HHS Secretary also would be directed to promulgate a rule regarding care for foreign visitors who seek "premeditated non-emergency surgical procedures" in the U.S.[17] See questions 4.a-b. below.

The Program would cover all "medically necessary services" including at minimum the following: primary care and prevention, approved dietary and nutritional therapies, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, palliative care, mental health services, dental services, substance abuse treatment services, chiropractic services, basic vision care and vision correction, hearing services, and podiatric care.[18]

The bill does not specifically refer to reproductive health services. See questions 1.d-e. below for this topic.

Covered benefits would be provided without "deductibles, copayments, coinsurance, or other cost-sharing."[19]

Health Care Providers and Insurers

Individuals could choose to receive care from any physicians and other clinicians, hospitals, or inpatient care facilities that participate in the Program.[20]

H.R. 676 would require that all institutions participating in the Program be public or not-for-profit. Private physicians, private clinics, and private health care providers would continue to operate as private entities, but could not be investor-owned. For-profit "providers of care" would have to convert to not-for-profit status to participate in the Program.[21] The proposal would direct that for-profit providers of care that convert be "compensated for reasonable financial losses incurred as a result of the conversion from for-profit to non-profit status."[22]

H.R. 676 would make it "unlawful" for private health insurers to sell health insurance coverage that would duplicate any of the benefits covered under the Program. They would, however, be able to sell

[12] H.R. 676, §§304(a) and 202(b)(2)(G).

[13] H.R. 676, § 202(b)(2)(E).

[14] H.R. 676, § 304(b).

[15] H.R. 676, § 101(a).

[16] H.R. 676, § 101(d).

[17] H.R. 676, § 101(e).

[18] H.R. 676, § 102(a).

[19] H.R. 676, § 102(c).

[20] H.R. 676, § 103(d).

[21] H.R. 676, §§ 103(a)(1-3). Although this provision initially appears to distinguish between institutions and individual providers, it subsequently refers to "providers of care" more generally.

[22] H.R. 676, § 103(a)(4).

insurance covering benefits not covered under the Program (e.g., "cosmetic surgery or other services and items that are not medically necessary").[23]

Health maintenance organizations (HMOs) may be treated as providers or insurers depending on how they are structured.[24]

See questions 2.a-b. and 3.a. below for more information about these and other aspects of the bill that would affect providers and insurers.

See questions 2.c-e. below for information related to the health care workforce.

Program Budget and Payments

H.R. 676 would require annual establishment of an operating budget, a capital expenditures budget, reimbursement levels for providers, and a health professional education budget.[25] After amounts are appropriated for the annual budget for the Program, the Director would then provide regional offices "an annual funding allotment to cover the costs of each region's expenditures."[26]

Overall, the Program, through its regional offices, would pay each institutional provider (e.g., hospitals) a monthly lump sum to cover all operating expenses under a global budget.[27] The global budgets would be set annually through negotiations between providers, State directors, and regional directors, and would be subject to Director approval. Such budgets would be based on past and projected future expenditures, and other measures.[28]

The Program would pay physicians and certain other health professionals via one of three methods: (1) fee-for-service (FFS), (2) salaried positions within institutions that would receive global payments, or (3) salaried positions within group practices or non-profit HMOs that would receive capitation payments.[29] See question 2.a. below for more information about negotiations for payments for physicians and certain other health professionals.

The bill includes separate provisions on payments for long-term care and mental health services. The former would be through global payments; the latter would be through the same methods as for other physicians and health professionals.[30]

The Program would annually negotiate prices to be paid for "covered pharmaceuticals, medical supplies, and medically necessary assistive equipment,"[31] and the Program would establish a prescription drug formulary.

In general, reimbursement levels would be set after close consultation with regional and state directors and after the annual meeting of the Board.[32]

[23] H.R. 676, §§ 104(a-b).

[24] H.R. 676, § 103(c).

[25] H.R. 676, § 201(a)(1).

[26] H.R. 676, § 201(a)(2).

[27] H.R. 676, § 202(a)(1).

[28] H.R. 676, § 202(a)(2).

[29] H.R. 676, § 202(b)(1).

[30] H.R. 676, §§ 203 and 204.

[31] H.R. 676, § 205.

[32] H.R. 676, § 206.

Financing

H.R. 676 would establish a "Medicare For All Trust Fund" in which funds would be deposited and from which expenditures under the Program would be made.[33] See question 6.b. below for information about proposed funding sources.

Responses to Specific Questions Provided to CRS

Below are responses to the questions received by CRS from you. The questions are listed as the subheadings below, as they were received by CRS in terms of wording and order; corrections were made to numbering of the last two sections and within section 1, and 5.a. and 5.b. were combined as 5.a. to minimize duplication.[34] The questions are organized in the following subcategories (as submitted to CRS):

(1) Health programs and services,

(2) Health care providers (physicians, nurses, etc.),

(3) Health insurance plans,

(4) Individuals who are not U.S. citizens,

(5) Authorities, and

(6) Health care spending.

A number of your questions refer to potential impacts of the legislation, if enacted. As stated where applicable, and given the factors outlined in the introduction of this memorandum (e.g., limited specificity in the bill, lack of budgetary scoring or committee report language, and insufficient information to analyze stakeholder behavioral and economic reactions), CRS's responses are limited to information about the provisions of the bill that directly address the given topic. Depending on availability of information, CRS is able to provide more detailed answers to some questions than others.

1. Health Programs and Services

a. What impact would the proposed legislation have on the Indian Health Service?

CRS is only able to address "impact" in terms of explaining the provisions of the bill that directly address the Indian Health Service (IHS).

Under current law, the IHS provides health services, directly or through contracts or compacts with Indian Tribes or Tribal Organizations or through grants to Urban Indian Organizations, to members of Indian Tribes.[35] IHS-funded facilities generally provide services directly to eligible beneficiaries. In instances when needed services are not available, IHS purchases these services from outside providers. Members of Indian Tribes are not required to use IHS. Some tribal members may also have sources of insurance coverage including both private insurance and government programs (e.g., Medicare, Medicaid, or the Veterans Health Administration). In instances where IHS beneficiaries receive services at facilities funded

[33] H.R. 676, § 211(b).

[34] The questions were submitted in sections 1-7; however there was no section 5. Thus the last two sections are renumbered 5 and 6. Within section 1, the questions were submitted as a, b, c, a, b, and have been renumbered a-e.

[35] Certain other individuals may also be eligible to receive services from facilities funded by the Indian Health Service. For more information, see "IHS Eligibility" section in CRS Report R43330, *The Indian Health Service (IHS): An Overview*.

by IHS and have other sources of payment for services, IHS bills these programs and retains the payments received.

H.R. 676 would provide that health programs of the Indian Health Service remain independent for a 5-year period beginning the date of the establishment of the Program, after which such IHS programs would be integrated into the Medicare For All Program.[36]

b. What impact would the proposed legislation have on Department of Veteran's Affairs?

CRS is only able to address "impact" in terms of explaining the provisions of the bill that directly address the Department of Veterans Affairs (VA).

Under current law, the VA, through the Veterans Health Administration (VHA), operates the nation's largest integrated direct health care delivery system and is generally not considered a health insurance program. In general, eligibility for VA health care is based on veteran status, presence of service-connected disabilities or exposures, income, and/or other factors, such as status as a former prisoner of war or receipt of a Medal of Honor or Purple Heart. The VHA also pays for care provided to veterans by private-sector providers through programs such as the Veterans Choice Program (VCP), and its successor program the Veterans Community Care Program (VCCP), that would be implemented in June 2019. Additionally, inpatient and outpatient care are also provided in the private sector to eligible dependents of veterans under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA). All enrolled veterans are offered a standard medical benefits package. Under current law, VA is statutorily prohibited from receiving Medicare payments for services provided to Medicare-covered veterans (42 U.S.C § 1395f(c), and 38 U.S.C. §1729(i)(1)(B)(i)).

Under H.R. 676, health care services provided to veterans and certain eligible dependents through the VA health care system would remain independent for a period of 10 years beginning on the date of the establishment of the Program. Following this 10-year period, the proposal would direct that Congress reevaluate whether health care services provided to veterans and certain eligible dependents by the VA would remain independent or would be integrated into the Program.[37]

c. Does this legislation create a new entitlement?

If enacted as introduced, H.R. 676 would provide that "[a]ll individuals residing in the United States (including any territory of the United States) are covered under the Medicare For All Program *entitling* them to a universal, best quality standard of care."[38] (Emphasis added.)

There are various possible definitions of the term "entitlement" that may be used in different contexts. Most definitions of entitlement include some element of a right to a governmental benefit that is granted upon meeting some eligibility criteria.[39] In other cases, certain government programs are expressly designated as "entitlements."[40] However, for purposes of federal law, the term "entitlement" is primarily

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[36] H.R. 676, § 401(b).

[37] H.R. 676, § 401(a).

[38] H.R. 676, § 101(a).

[39] For example, dictionary definitions of the term have described it as an "absolute right to a (usu[ally] monetary) benefit, such as social security, granted immediately upon meeting a legal requirement" or as a "government program guaranteeing certain benefits, such as financial aid or government-provided services, to people or entities that meet the criteria set by law" where "[q]ualified beneficiaries have an enforceable right to participate in the programs." *E.g.*, *Entitlement, Entitlement Program,* BLACK'S LAW DICTIONARY (10th ed. 2014).

[40] For example, 2 U.S.C. § 622(9) expressly designates the food stamp program as an entitlement, in addition to providing a more

used as a term of art in the context of federal spending, to refer to particular types of budget authority. Therefore, the remainder of this section discusses whether H.R. 676 creates an entitlement as that term is used in the budgetary context.

Section 3 of the Congressional Budget and Impoundment Act of 1974 ("the Congressional Budget Act") defines "entitlement authority" in the following manner:[41]

> the term "entitlement authority" means . . . the authority to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing that authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by that law; . . . .[42]

This definition appears to set forth two distinct elements that must be met before a type of budget authority qualifies as entitlement authority. First, it must be budget authority "which is not provided for in advance by appropriation Acts" for the purpose of making payments to any person or government. Second, the United States must be obligated to make those payments to persons or governments who meet the requirements established in the law authorizing such payments. Each of these elements is discussed in turn below, in the context of the Medicare For All Program contemplated by H.R. 676.

Turning to the first element of the Congressional Budget Act definition, H.R. 676, as currently proposed, expressly provides that the Medicare For All Program "shall pay" various categories of providers. For example, the proposed legislation provides that the Medicare For All Program shall pay each institutional provider of care (such as hospitals and nursing homes) "a monthly lump sum to cover all operating expenses."[43] Additionally, it appears that H.R. 676 contemplates that funding for the Medicare For All Program would be at least partially derived from budget authority that is not provided in advance by appropriation acts. For purposes of the Congressional Budget Act definition, an "appropriation act" refers to an act with the title "An Act making appropriations (here insert the object) for the year ending September 30 (here insert the calendar year)."[44] If enacted as introduced, H.R. 676 would additionally expressly appropriate amounts derived from "[e]xisting sources of Federal Government revenues for health care" and amounts "equivalent to the amounts the Secretary estimates would have been appropriated and expended for Federal public health care programs" for the purposes of carrying out the Medicare For All Program.[45]

Thus, it appears H.R. 676, if enacted as introduced, would authorize the Medicare For All Program to make payments using budget authority that is not provided in advance in appropriation acts. To satisfy the second element of the Congressional Budget Act definition of an entitlement, H.R. 676 would need to create an obligation on the part of the United States to make such payments to providers. It is possible that a court would have the opportunity to address this question in an action brought by participating providers to recover amounts that were allegedly unpaid to them for covered services under the Medicare For All Program. The U.S. Court of Appeals for the Federal Circuit (Federal Circuit), in *Moda Health Plan, Inc.*

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generalized definition, for purposes of the Congressional Budget and Impoundment Act. Another example in which certain specific programs are designated in law as entitlements without using a generalized definition is in the context of the Balanced Budget and Emergency Deficit Control Act which expressly identifies certain named programs as entitlement authority. 2 U.S.C. § 900(c)(17). None of these explicit lists include the Medicare For All Program that would be established by H.R. 676.

[41] Pub. L. No. 93-344, § 3, 88 Stat. 297, 299 (1974) (codified as amended at 2 U.S.C. § 622(9). For a more detailed discussion of the consequences of designating legislation as "entitlement authority," *see* CRS Report RS20129, *Entitlements and Appropriated Entitlements in the Federal Budget Process*, by Bill Heniff Jr.

[42] *Id.*

[43] H.R. 676, § 202(a)(1).

[44] 2 U.S.C. § 622(5) (citing 1 U.S.C. § 105).

[45] H.R. 676, §§ 211(c)(1)(A) and 212.

v. United States, recently considered whether statutory language created a government obligation to pay participants in a federal program.[46] In *Moda*, health insurers had sued the federal government to recover amounts unpaid under a statutory "risk corridors" program enacted by the Patient Protection and Affordable Care Act (ACA).[47] In rejecting the government's claim that the statute did not create an obligation to pay the insurers, the Federal Circuit held that language providing that the "Secretary shall establish and administer" a risk corridors program and that the "Secretary shall pay" an amount determined by a statutory formula is "unambiguously mandatory."[48] Accordingly, the Federal Circuit concluded that "the plain language of [the risk corridors provision of the ACA] created an obligation of the government to pay participants . . . the full amount indicated by the statutory formula."[49] As introduced, H.R. 676 uses similarly mandatory language, for example when stating that the "Medicare For All Program, through its regional offices, *shall pay* each institutional provider of care."[50] Insofar as a court were to conclude that the language in H.R. 676, if enacted as introduced, obligates the United States to make such payments to the relevant providers, it could be argued that H.R. 676 creates new entitlement authority as that term is defined for purposes of the Congressional Budget Act.

d. Does the new government-run health care program in the legislation conform to the Hyde Amendment?

The Hyde Amendment refers to provisions in the annual appropriations law for the Departments of Labor, Health and Human Services, and Education (Labor/HHS/Education) that limit the use of appropriated funds to pay for abortions provided through the Medicaid program.[51] In its most recent incarnation, section 506(a) in Division H of the Consolidated Appropriations Act, 2018,[52] the Hyde Amendment states: "None of the funds appropriated in this Act, and none of the funds in any trust fund to which funds are appropriated in this Act, shall be expended for any abortion."[53] The phrase "any trust fund" in the Hyde Amendment, at least currently, appears to be a reference to the Federal Hospital Insurance Trust Fund, which provides funds to pay for services available to Medicare beneficiaries under Part A of the program.[54]

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[46] 892 F.3d 1311, 1320 (Fed. Cir. 2018).

[47] 42 U.S.C. § 18062.

[48] *Moda*, 892 F.3d at 1320.

[49] *Id.* at 1322. The Federal Circuit also held that subsequent legislation by Congress imposing limitations on appropriated funds had partially eliminated the federal government's obligation to make risk corridor payments. *Id.* at 1329. This raises the possibility that if H.R. 676 does obligate the government to pay certain providers, such an obligation may be modified by subsequent legislation. However, an analysis of that possibility is beyond the scope of this memorandum, which is limited to discussing the text of H.R. 676 itself.

[50] H.R. 676, § 202(a)(1).

[51] The Hyde Amendment is named after an amendment originally offered by Rep. Henry J. Hyde to the FY1977 appropriations measure for the Departments of Labor and Health, Education, and Welfare. *See* Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976) ("None of the funds contained in the Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term.").

[52] Division H of the Consolidated Appropriations Act, 2018, Pub. L. No. 115-141 (2018), is titled "Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2018." Section 3 of the Consolidated Appropriations Act, 2018, states: "Except as expressly provided otherwise, any reference to 'this Act' contained in any division of this Act shall be treated as referring only to the provisions of that division."

[53] Pub. L. No. 115-141, div. H, tit. V, § 506(a) (2018). An exception to the general prohibition on using appropriated funds for abortions is provided in section 507(a) of the omnibus measure: "The limitations established in the preceding section shall not apply to an abortion – (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."

[54] Whether any funds from the Federal Hospital Insurance Trust Fund have ever been used for abortions is not clear. The Hyde

Section 211(b) of H.R. 676, if enacted as introduced, would provide for the establishment of a Medicare For All Trust Fund, which would make expenditures for the proposed Medicare For All Program. It appears that the proposed legislation contemplates that payments for services rendered by physicians and other health professionals would be made from this fund. Although proposed section 211(c) indicates that amounts appropriated to the Medicare For All Trust Fund would come from various sources, including "[e]xisting sources of Federal Government revenues for health care," it is not entirely clear that the legislation contemplates amounts from the annual Labor/HHS/Education Appropriations Act would be appropriated to the fund. Because the Hyde Amendment applies only to money appropriated under that measure, a trust fund that does not include such appropriated funds would likely not be subject to the amendment.

Further, H.R. 676 does not include a separate abortion restriction that would, if enacted as introduced, apply to the proposed Medicare For All Trust Fund or funds appropriated under the bill. Restrictions on the use of federal funds for abortion have been included in several federal laws other than the Labor/HHS/Education appropriations measure. For example, section 1008 of the Public Health Service Act states: "None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."[55] This kind of provision restricts the use of applicable funds regardless of whether such funds are provided in the Labor/HHS/Education Appropriations Act. Because, at this time, it is not yet known whether the funds in the proposed Medicare For All Trust Fund include funds derived from the Labor/HHS/Education appropriations measure for the relevant fiscal year and H.R. 676 does not include a separate abortion restriction, it is not entirely certain whether the proposed Medicare For All Program would be restricted from paying for abortion services if H.R. 676 were enacted into law.[56]

e. What reproductive services are allowed to be covered under the new government-run health care program?

H.R. 676 would require the Program to cover all "medically necessary services," including at minimum the following: primary care and prevention, approved dietary and nutritional therapies, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long-term care, palliative care, mental health services, dental services, substance abuse treatment services, chiropractic services, basic vision care and vision correction, hearing services, and podiatric care.[57]

The bill does not specifically refer to reproductive health services.

Amendment was intended to limit the use of Medicaid dollars for abortion. *See* Harris v. McRae, 448 U.S. 297, 302 ("Since September 1976, Congress has prohibited – either by an amendment to the annual appropriations bill for the Department of Health, Education, and Welfare or by a joint resolution – the use of any federal funds to reimburse the cost of abortions under the Medicaid program except under certain specified circumstances.").

[55] 42 U.S.C. § 300a-6. *See also* Indian Health Care Improvement Act, § 806(a), 25 U.S.C. § 1676(a) ("Any limitation on the use of funds contained in an Act providing appropriations for the Department of Health and Human Services for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Indian health Service.").

[56] This determination presumes the continued inclusion of the Hyde Amendment in future appropriations laws for the Departments of Labor, Health and Human Services, and Education. The funding restrictions imposed by the Hyde Amendment are limited to the relevant fiscal year of each appropriation law.

[57] H.R. 676, § 102(a).

2. Health Care Providers (Physicians, Nurses, Etc.)

a. How does this legislation impact private health care providers?

CRS is only able to address "impact" in terms of explaining the provisions of the bill that directly address health care providers. This question asks specifically about *private providers*; this response addresses provisions of the bill that would be relevant to *all providers participating* in the Program. Per the phrasing of the question and section heading, this response focuses on individual providers (e.g., physicians) and includes less information about institutional providers and facilities (e.g., hospitals). See "Program Budget and Payments" in the first section of this memorandum for a brief discussion of payments to institutional providers.

Under the Program, individuals could choose to receive care from any physician or other clinician who participates in the Program.[58] H.R. 676 would require for-profit "providers of care" to convert to not-for-profit status to participate in the Program.[59] The proposal would direct that for-profit providers of care that convert be "compensated for reasonable financial losses incurred as a result of the conversion from for-profit to non-profit status."[60] In addition, participating clinicians would be required to meet their state quality and licensing guidelines.[61] Clinicians whose licenses are under suspension or who are under disciplinary action in any state would not be able to participate in the Program.[62]

H.R. 676 specifies several payment methods for physicians and certain other health professionals. The Program would pay these individuals by the following payment methods: (1) fee-for-service, (2) salaried positions within institutions that would receive global payments, and (3) salaried positions within group practices or within non-profit HMOs that would receive capitation payments.[63]

In regard to fee-for-service payments and salaried positions within institutions that would receive global payments, the Program would negotiate fee schedules and salaries with physicians and other clinician representatives, with consultation with the National Board of Universal Quality and Access, regional directors, and state directors.[64] For the salaried positions, those salaries would be part of the institutions' global budgets. Initially, the "current prevailing fees or reimbursements would be the basis for the fee negotiation."[65] The Director of the program would be responsible for promulgating final guidelines to all providers.[66] In establishing these payment amounts, H.R. 676 would require the Director to take into consideration the need for a uniform national standard and the goal that medical professionals be compensated at a rate which reflects their expertise and value of their services, regardless of geographic region and past fee schedules.[67]

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[58] H.R. 676, § 103(d). This provision also provides for free choice of participating hospitals and inpatient care facilities.

[59] H.R. 676, §§ 103(a)(1-3). Also see question 2.b. in this memorandum. Although this provision initially appears to distinguish between institutions and individual providers, it subsequently refers to "providers of care" more generally.

[60] H.R. 676, § 103(a)(4). Also see question 2.b. in this memorandum.

[61] H.R. 676, § 103(b). This provision also applies to facilities.

[62] Ibid.

[63] H.R. 676, § 202(b)(1).

[64] H.R. 676, §§ 202(b)(2-3). Section 202(b)(2)(c) would also require each State director to establish and appoint a physician practice review board to assure quality, cost effectiveness, and fair reimbursement for physician delivered services. However the bill does not specify what role this board would play in fee negotiations or consultations, as opposed to the National Board of Universal Quality and Access.

[65] H.R. 676, § 202(b)(2)(A). The bill does not specify a source for "current prevailing fees or reimbursements."

[66] H.R. 676, § 202(b)(2)(D).

[67] H.R. 676, § 202(b)(2)(B).

In regard to salaried positions within group practices or within non-profit HMOs that would receive capitation payments, these capitation payments would include the costs of services of licensed physicians and practitioners. Other costs of inpatient and institutional care would be excluded from these capitation payments and would be covered under institutions' global budgets.[68] HMOs would be required to reimburse physicians based on salary and would be prohibited from providing financial incentives based on utilization.[69] Patients would be permitted to enroll or disenroll from group practices or non-profit HMOs that would receive capitation payments without discrimination and with appropriate notice.[70]

The bill includes separate provisions on payments for long-term care and mental health services. The former would be through global payments; the latter would be through the same methods as for other physicians and health professionals.[71]

In general, reimbursement levels would be set after close consultation with regional and state directors and after the annual meeting of the National Board of Universal Quality and Access.[72]

As stated in the first section of this memorandum, H.R. 676 would require the implementation of a uniform computerized electronic billing system.[73] All physicians would be required to submit bills to the regional director on a simple form or via computer. The proposal would direct that providers who are not reimbursed within 30 days of submission be paid interest.[74]

In addition, any clinician who accepts payment under the Program would not be allowed to "balance bill" any patient for any covered service.[75]

b. Does the legislation allow for-profit health care providers to participate in the new government-run health program created under this legislation?

H.R. 676 would require that all institutions participating in the Program be public or not-for-profit. Private physicians, private clinics, and private health care providers would continue to operate as private entities, but could not be investor-owned. For-profit "providers of care" would have to convert to not-for-profit status to participate in the Program.[76]

The proposal would direct that for-profit providers of care that convert be "compensated for reasonable financial losses incurred as a result of the conversion from for-profit to non-profit status."[77] However, such compensation would not be made for loss of business profits.[78] H.R. 676 would authorize the subsequent appropriation of such sums as are necessary to compensate such providers. The proposal contemplates that payments would be made over a 15-year period, and funds to pay such institutions

[68] H.R. 676, §§ 202(b)(4)(A-B). The bill does not otherwise specifically refer to setting of these salary ranges as it does with the other two payment mechanisms.

[69] H.R. 676, §§ 202(b)(4)(D).

[70] H.R. 676, § 202(b)(4)(C).

[71] H.R. 676, §§ 203 and 204.

[72] H.R. 676, § 206. Also see footnotes 64 and 68.

[73] H.R. 676, § 202(b)(2)(G).

[74] H.R. 676, § 202(b)(2)(E).

[75] H.R. 676, § 202(b)(2)(F).

[76] H.R. 676, §§ 103(a)(1-3). Although this provision initially appears to distinguish between institutions and individual providers, it subsequently refers to "providers of care" more generally.

[77] H.R. 676, § 103(a)(4).

[78] H.R. 676, § 103(a)(6).

would come from the sale of U.S. Treasury Bonds. The HHS Secretary, through rulemaking, would provide a mechanism for conversion of for-profit providers that choose to participate in the Program.[79]

Non-profit health maintenance organizations (HMOs) that "deliver care in their own facilities and employ clinicians on a salaried basis" would be able to participate in the Program and receive payments as specified in section 202 of the bill. Other HMOs that mainly "contract to pay for services delivered by non-employees" would be classified as insurance plans and would not be eligible to participate in the Program.[80]

c. The Health Resources and Services Administration at HHS current projects a shortage of health care providers across the country. Does the legislation include any provisions to address workforce challenges that already exist under current law?

H.R. 676 would require the annual establishment of a "health professional education budget, including amounts for the continued funding of resident physician training programs."[81] The bill does not include additional workforce-related provisions.

However, Section 305 of the bill would provide for a National Board of Universal Quality and Access (see "Administration" in the first section of this memorandum for a summary of this Board). In addition to the functions described in the summary, the Board also would establish a "universal, best quality of standard of care" with respect to appropriate staffing level, appropriate medical technology, design and scope of work in health workplaces, best practices, and salary level and working conditions of medical professionals and appropriate support staff.[82] Section 303(d)(1) would require that State Directors assess their state health needs, which would contribute to the work done by the Board including the twice yearly reports required by Section 305. These reports would be made to the Director, the President, and the Congress and include assessments of the adequacy of a number of Program elements including access to care and appropriate medical staffing levels.

H.R. 676 also, in Section 211(c)(3), would authorize additional funds to be appropriated "annually as needed to maintain maximum quality, efficiency, and access under the Program."

d. What impact would the proposed legislation have on the health care workforce (and which types of providers could be most affected)?

CRS is only able to address "impact" in terms of explaining the provisions of the bill that directly address the health care workforce.

As noted in question 2.c., the bill does specify that a "health professional education budget" would be established, including amounts for the continued funding of resident physician training programs.[83] It would also require access to care to be regularly assessed by the Board.[84]

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[79] H.R. 676, §§ 103(a)(5-7).

[80] H.R. 676, § 103(c).

[81] H.R. 676, § 201(a)(1)(D).

[82] H.R. 676, § 305(b)(3).

[83] 201(a)(1)(D).

[84] 305(b).

The bill would also provide that individuals whose jobs were eliminated due to reduced administration would have first priority for retraining and job placements in the new system set up by H.R. 676.[85] These individuals would also be eligible to receive two years of employment transition benefits equivalent to an individual's salary earned in the last 12 months of employment (not to exceed $100,000).

To pay for these transition benefits, H.R. 676 would require the HHS Secretary to establish a "Medicare For All Employment Transition Fund."[86] H.R. 676 would authorize funds to be appropriated annually as needed to fund the Medicare For All Employment Transition Benefits.[87] Receipt of funds through the Medicare For All Employment Transition Benefits would not preclude an individual from receiving federal and state unemployment benefits.[88]

e. Could this new government-run plan exacerbate current shortages of physicians, especially amongst primary care physicians and other medical specialists—including those in underserved areas and rural communities? Could increased provider shortages result in decreased quality of care or longer wait times to access care?

Given the factors outlined in the introduction of this memorandum and referenced in the introduction of this section, CRS is unable to speculate on how the implementation of the Program included in H.R. 676 would impact the health care workforce, specific provider types, or populations located in specific areas.

See questions 2.c-d. for discussion of provisions of the bill addressing the health care workforce.

3. Health Insurance Plans

a. How will current health insurance plans – including large and small employer coverage and union health insurance plans – be impacted by this legislation?

CRS is only able to address "impact" in terms of explaining the provisions of the bill that directly address current health insurance plans.

As stated earlier, H.R. 676 is intended to create a health system that would cover all individuals residing in the United States and that would be run by the federal government in partnership with regional offices and state governments. The Program would cover all "medically necessary services" as described in question 1.e.

H.R. 676 would make it "unlawful" for private health insurers to sell health insurance coverage that would duplicate any of the benefits covered under the Program. [89] They would, however, be able to sell insurance covering benefits not covered under the Program (e.g., "cosmetic surgery or other services and items that are not medically necessary").[90]

The bill does not specifically mention individual or group (i.e., employer or union) coverage.

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[85] H.R. 676, § 303(e).

[86] H.R. 676, § 303(f).

[87] H.R. 676, § 303(g).

[88] H.R. 676, § 303(g).

[89] H.R. 676, § 104(a).

[90] H.R. 676, § 104(b).

As stated in question 2.b., non-profit HMOs that "deliver care in their own facilities and employ clinicians on a salaried basis" would be able to participate in the Program and receive payments as specified in section 202 of the bill. Other HMOs that mainly "contract to pay for services delivered by non-employees" would be classified as insurance plans and would not be eligible to participate in the Program.[91]

4. Individuals Who Are Not U.S. Citizens

a. Section 101(d) requires the Secretary of HHS to promulgate a rule for determining residency for eligibility purposes under this legislation. As drafted, are there any restrictions in this legislation as drafted which would prohibit the Secretary from allowing the new program outlined in the bill from providing health coverage for individuals who are not lawfully present in the U.S.?

For purposes of the ACA, "lawfully present" has been defined in regulation and includes lawful permanent residents (LPRs), asylees, refugees, foreign nationals admitted under any nonimmigrant visa who are in status, and certain other classifications under the Immigration and Nationality Act (INA). Aliens who are "lawfully present in the United States" are generally subject to the mandate to have health coverage and are allowed to purchase insurance in the health insurance exchanges ("marketplaces"). Lawfully present individuals who meet eligibility criteria may receive premium tax credit and cost-sharing subsidies available to certain individuals who purchase insurance through an exchange.

H.R. 676 does not address individuals who are or are not "lawfully present." As discussed in the introduction of this memorandum, the language of H.R. 676 has not been substantially updated to account for related health reform legislation, such as the ACA, that has been enacted since an earlier version of this bill was first introduced.

b. Section 101(e) requires the Secretary of HHS to "promulgate a rule regarding visitors from other countries who seek premeditated non-emergency surgical procedures. Such a rule should facilitate the establishment of country-to-country reimbursement arrangements or self -pay arrangements between the visitor and the provider of care." Does this section require the rule cover the full cost to a provider of the provision of such care?

Section 101(e) is silent on the amount of provider payment for premeditated non-emergency surgical services received by foreign visitors.

5. Authorities

a. Please list the new authorities granted to the HHS Secretary and the Director appointed under Section 301 of under the legislation.

H.R. 676, if enacted as introduced, would generally authorize the HHS Secretary to carry out the functions of the Medicare For All Program, subject to exception.[92] Additionally, the legislation would

[91] H.R. 676, § 103(c).

[92] *See* Summary of H.R. 676: "Expanded & Improved Medicare For All Act" *supra* for an overview of the functions of the

expressly instruct either the HHS Secretary or the Medicare for All Program Director to take numerous actions. This bulleted list summarizes provisions of the legislation that would explicitly direct (1) the HHS Secretary or (2) the Medicare For All Program Director, respectively, to take action under the bill.[93]

HHS Secretary

- The Secretary must promulgate a rule regarding criteria for determining residency for eligibility purposes under the Medicare For All Program.[94]
- The Secretary must promulgate a rule regarding care for foreign visitors who seek "premeditated non-emergency surgical procedures" under the Program.[95]
- In light of the legislation's requirement that certain participating Program providers must convert to not-for-profit status, the Secretary must promulgate a rule to create a mechanism for furthering the timely, efficient, and feasible conversion of for-profit providers of care to a not-for-profit status.[96]
- Subject to exception, the Secretary must administer the provisions of the proposed Act through a Director appointed by the Secretary.[97]
- The Secretary must establish and maintain Program regional offices for the purpose of distributing funds to providers of care.[98]
- The Secretary must establish a trust fund to make expenditures to certain workers whose jobs are eliminated due to reduced health care administration.[99]
- The Secretary must create a standardized, confidential electronic patient record system to maintain accurate patient records and to simplify billing processes.[100]

Medicare For All Program Director

- After amounts are appropriated for the annual budget of the Program, the Director must provide Program regional offices with an annual funding allotment to cover the costs of each region's expenditures.[101]

Medicare For All Program. The proposed Act specifies that "the terms 'Medicare For All Program' and 'Program' mean the program of benefits provided under this Act and, unless the context otherwise requires, the Secretary with respect to functions relating to carrying out such program." H.R. 676, § 2(1), 115th Cong. (2018). Accordingly, the Director or another governmental entity may also be tasked with certain roles and responsibilities with respect to the Program.

[93] It is difficult to determine whether the proposed legislation would grant to the Secretary or the Director any potential implied authority without information on the precise circumstances under which they would exercise such authority. Consequently, a discussion of any implied authority H.R. 676, if enacted, may bestow upon these government officials is beyond the scope of this memorandum.

[94] H.R. 676, § 101(d), 115th Cong. (2018).

[95] *Id.* § 101(e).

[96] *Id.* § 103(a)(7).

[97] *Id.* § 301(a).

[98] *Id.* § 303(a).

[99] *Id.* § 303(f).

[100] *Id.* § 304(a).

[101] *Id.* § 201(a)(2).

- Budgets of Program institutional providers, such as hospitals, must be set through negotiations between providers, State directors, and regional directors, subject to the approval of the Director.[102]
- The Director is responsible for issuing final guidelines concerning provider payment.[103]
- The Director must create a uniform computerized electronic billing system, including for those areas of the United States that have not yet established such billing.[104]
- The Director must appoint directors to address issues relating to long-term care and mental health. These directors are responsible for administration of the Act and ensuring the availability and accessibility of high quality services.[105]
- The Director must appoint a director for an Office of Quality Control. This director must conduct annual reviews on the adequacy of medically necessary services and make certain recommendations.[106]
- The Director must appoint regional directors for each regional office of the Program.[107]

6. Health Care Spending

a. According to the National Health Expenditure data from CMS, what is the aggregate total spending on private/public health care services in the United States?

According to the Centers for Medicare & Medicaid Services (CMS), National Health Expenditures (NHE) totaled $3.33 trillion in 2016.[108] This included $3.18 trillion in health consumption expenditures (HCE) and $157 million in investments. Investments include research as well as structures and equipment. HCE include spending by individuals (including those who were uninsured), health insurers, and federal and state governments on personal health care, government administration and the net cost of private health insurance, and government public health activities.[109]

b. Under section 211(c), is there limitation on the amount of funds used in this new government-run program that come from "existing sources of Federal Government Revenues for health care"?

If enacted as introduced, H.R. 676 would establish a "Medicare For All Trust Fund" in which the funds discussed below would be deposited. The legislation contemplates that the Medicare For All Trust Fund would be the source of all Program expenditures.[110]

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[102] *Id.* § 202(a)(2).

[103] *Id.* § 202(b)(2)(D).

[104] *Id.* § 202(b)(2)(G).

[105] *Id.* § 301(b)-(c).

[106] *Id.* § 302.

[107] *Id.* § 303(b)(1).

[108] See CMS, *National Health Expenditure Data: Historical*, January 8, 2018, at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical html.

[109] Health care expenditures are further discussed in CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*.

[110] H.R. 676, § 211.

In addition to transfers of amounts that would have been appropriated and expended for federal public health programs, or amounts that might subsequently be annually appropriated, H.R. 676 would appropriate to the Medicare For All Trust Fund amounts sufficient to operate the Program from the following sources:

(1) "existing sources of federal government revenues for health care,

(2) "increasing personal income tax on the top 5% income earners,

(3) "instituting a modest and progressive excise tax on payroll and self-employment income,

(4) "instituting a modest tax on unearned income, and

(5) "instituting a small tax on stock and bond transactions."

H.R. 676 does not indicate specific percentages or amounts related to each of these categories.[111]

[111] Ibid.