SPOTLIGHT:

a chro education series by the

MEDICARE

american health policy institute

FOR ALL ACT

Part Four of Six

AMERICAN
HEALTH
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OBJECTIVES OF THE SERIES

We hope this CHRO Education Series will increase member awareness of the spectrum of potential future health care reforms that may be proposed over the next two years—and will help senior HR leaders assess the implications of various types of reform on their future business and talent strategies. We will also use these papers as the basis for follow up discussions with members in 2019 that will help shape the Association's work with policymakers.

IV. Spotlight: The Medicare for All Act

PART FOUR of SIX

Nearly a decade after the passage of the Affordable Care Act, health care continues to be a top issue among voters in the U.S., with the two major parties offering distinctly different visions of the direction of future reform. To help CHROs, their teams, stakeholders, and the public better understand the health care landscape and the prospects for change, we're launching a series of short papers that will discuss the various types of reform proposals being discussed among policy makers, political candidates and other key stakeholders.

IV. Spotlight: The Medicare for All Act

PART FOUR of SIX

Introduction

Health care remains a top issue for Americans, as voters in the 2018 midterm election ranked it above the economy and immigration as a topic of concern.[i] But policymakers differ on what direction reform should take.

In Parts I and II of this series, we examined the unique role employers play in the U.S. health care system, and the seemingly intractable problems of high costs and poor relative outcomes. We set forth a framework to examine the issue, based on four ways government can play a role in health insurance:

- Provide financial incentives for the purchase of private insurance;
- Provide direct coverage to specific populations (*e.g.*, Medicare, Medicaid);
- Influence supply and demand for insurance, primarily through regulation; and
- Exerts full control (single-payer).

In Part III, we discussed the key elements of reform proposals being discussed by Republicans in Congress and by conservative thought leaders and policy experts. Republican reform proposals focus on actions that will increase consumer choice and competition and reduce benefit mandates and drug prices. Republicans seek a future that encourages free market competition, discourages government mandates, favors individual choice, and gives flexibility and control to the states.

In this installment of our series, we examine the other end of the reform spectrum—a vision where government plays a leading role in how individuals get health insurance by acting as the "single-payer" of health care for all citizens. In this model, the government is responsible for financing the health care services provided to individuals by both private and public providers. We'll analyze this scenario by reviewing the provisions of the Medicare for All Act (S. 1804, 115th), which was introduced by Senator Bernie Sanders (I-VT) and has become a rallying cry for many progressive Democrats.

What is "Single-Payer Health Care"?

In the current debate on health care reform, the term "single-payer" is used broadly to describe a variety of different systems. For our purposes, we define a single-payer system as one where costs for medically necessary services are paid by the government and private insurance that duplicates government coverage is not permitted; health care services are delivered by both public and private providers; enrollment is universal and automatic; and all medically necessary services are covered with little or no cost sharing by consumers.

History of the Medicare for All Act

When he introduced the Medicare for All Act in September 2017, Senator Sanders noted, "It has been the goal of Democrats since Franklin D. Roosevelt to create a universal health care system guaranteeing health care to all people."[ii]

In the eight decades since the New Deal, however, Democrats' attempts to transform America's unique employment-based health care system have largely failed to generate any meaningful popular support, aside from Medicare and Medicaid. America's private, employment-based system remains in place and is still popular among those with employer-sponsored coverage. In a March 2016 survey, 83% of respondents with employer-sponsored coverage rated their health insurance as excellent or good.[iii]

But in the decade since the 2008 financial crisis, public sentiment has begun to shift. Rising health care premiums and out-of-pocket costs have combined to make health care costs a top concern for many Americans. While initially unpopular, the Affordable Care Act was viewed favorably by a slim majority of Americans for the first time in 2017.

And public support for reform that goes beyond the ACA is growing. In several polls, a majority of Americans expressed support for a "Medicare for All" type program—however, support levels drop at the prospect of higher taxes to fund such a program, or when told that it would eliminate employer provided health care benefits.

While the Medicare for All Act has little chance of becoming law with Republicans in control of the Senate and the White House, debate over single payer is expected to be a top priority in the House of Representatives, governed by a new Democratic majority—78 of which are members of a Medicare for All caucus.

Hearings are expected in several House committees this year, and it's anticipated that a new bill will be introduced that is similar to S.1804.

Health Care Reform Attempts in the U.S. Since Medicare and Medicaid

1974 Comprehensive Health Insurance Plan Act – *Failed in Congress*

- Employers mandated to purchase insurance for their employees
- Provided a federal health plan that any American could join by paying on a sliding scale based on income

1985 Consolidated Omnibus Budget Reconciliation Act (COBRA) – *Enacted*

- Amended ERISA to give employees the ability to continue health insurance coverage after leaving employment

1993 Health Security Act – *Failed in Congress*

- Mandated employers provide health insurance coverage to all of their employees
- Required each U.S. citizen and permanent resident alien to become enrolled in a qualified health plan
- Listed minimum coverage and maximum annual out-of-pocket expenses for each plan.
- Established corporate "regional alliances" of health providers to be subject to a fee-for-service schedule
- Provided subsidies to lower-income individuals

1997 Children's Health Insurance Program (CHIP) – *Enacted*

- Like Medicaid, CHIP is jointly administered by federal and state governments
- Expanded coverage for uninsured children in low-income families with incomes that are too high to qualify for Medicaid

2001-2004 Patients' Bill of Rights – *Failed in Congress*

- Established broad rights for patients regarding access to care, medical decision making, and recourse if denied care

2003 Medicare Prescription Drug, Improvement and Modernization Act – *Enacted*

- Created Medicare Part D prescription drug benefit
- Created Medicare Advantage plans—beneficiaries have choice of receiving Medicare benefits through private health insurance plans or through original Medicare Parts A and B
- Provided subsidies for large employers to discourage them from eliminating private prescription coverage to retired workers
- Prohibited the federal government from negotiating discounts with drug companies and prevents the government from establishing a formulary

2010 Affordable Care Act – *Enacted*

- Required most Americans to have health insurance coverage or pay a penalty
- Required employers to offer coverage or pay a penalty
- Created state-based exchanges for the purchase of insurance, with income-based subsidies
- Expanded Medicaid eligibility
- Prohibited insurers from denying coverage based on pre-existing conditions

Medicare for All: The Details

The Medicare for All Act would represent the most sweeping reform of the U.S. health care system in history, creating a single government-run program that provides health care coverage to all U.S. residents. Private insurance coverage that duplicates government benefits—including employer plans—would not be permitted.

All U.S. residents would be eligible for coverage and would be enrolled at birth and provide life-time enrollment. The program would cover all medically-necessary services in 10 benefit categories, with no premiums, no deductibles and no co-pays. States may provide additional benefits at state expense. An exception to the no co-pay rule would be allowed for prescription drugs—to encourage the use of generics, a cost-sharing of up to $200 per year on drugs would be allowed.

Physicians and health care providers would be required to meet federal quality and performance standards to participate in the program. States would be permitted to set additional standards. They would be paid based on a fee schedule consistent with Medicare payment rates, within the context of an overall national budget for health care spending. The government would negotiate drug prices directly with pharmaceutical manufacturers. Balance billing would be prohibited; however providers would be permitted to enter into private contracts with patients subject to constraints imposed under current law.[iv]

There would be a four-year transition to the new program. During the first year, eligibility for Medicare would be lowered to age 55 and benefits expanded to include dental, vision and hearing aids. Children up to age 18 would also be added. In the second year, eligibility would drop to age 45, and in the third year to age 35. By the fourth year, everyone would be covered.

Medicare for All would be far more comprehensive compared to the single-payer systems in other countries. For example, Medicare for All would cover dental and vision care, whereas the single-payer systems in Canada, the Netherlands, and Australia do not cover these types of services.

Medicare for All would also not require any out-of-pocket payments for health care services apart from prescription drugs. There would be no copays to visit the doctor or the emergency room. Single-payer systems in other countries, on the other hand, do often require out-of-pocket payments for health care services. [v]

As such, the Medicare for All plan would stand alone among other single-payer systems.

Using the four-part framework from Part II of our series, the following chart shows how the Medicare for All Act would compare with the current state under the ACA.

Role	Current State	Medicare for All Act (S.1804)
Financial incentives	• Tax policy encourages employer-sponsored health coverage • Subsidies for low income to purchase coverage on Exchanges	• Replace private insurance coverage, including employer-sponsored health coverage, that duplicates government coverage • Eliminates individual premiums, deductibles, and copays (exception: up to $200 per year cost sharing for prescription drugs) • Eliminates Exchanges
Direct coverage to select populations	• Medicaid/CHIP • Medicare • Veterans/Armed Forces • Federal Employees	• Replaces Medicare after a four-year phase in period • Replaces Medicaid/Chip (exception: Medicaid would continue to cover long-term services and supports) • Veterans' health programs would continue

Role	Current State	Medicare for All Act (S.1804)
Influence Supply and Demand	• Employer mandate • "Minimum Essential Coverage" standards	• Replaces private health coverage—including employer-sponsored health coverage, Federal Employees Health Benefits (FEHB), marketplace coverage, and TriCare—that duplicates government coverage • Government establishes fee scale for providers within a global health care budget • Government negotiates prices directly with drug manufacturers • Individuals and providers may enter private contracts for payment outside of the government program
Fully control	N/A	• Single government program where costs for medically necessary services (in 10 benefit categories including dental, hearing, and vision; provides coverage of reproductive health services) are paid by the government; services would be delivered by both public and private providers with scheduled payments to providers • States may provide additional benefits at state expense

Other Single-Payer Reform Proposals

In addition to the Medicare for All Act, there have been several proposals at the state level that would create a "single-payer" system on a smaller scale. While none of these proposals has been implemented, local experimentation has continued as reform at the federal level has stalled. Two proposals of interest are Vermont's Green Mountain Care and Healthy California.

Vermont's Green Mountain Care

In 2011, Vermont became the first state to attempt the implementation of a single payer health care system called Green Mountain Care. Under the plan, most private health insurance would be replaced with a public-private single payer system financed through payroll taxes. The system was to be governed by an independent board consisting of payer representatives (employers, the state and families) and beneficiary representatives (patients and providers). However, the plan encountered both fiscal and political challenges and was abandoned in 2014.

Healthy California

In 2017, the California State Senate passed SB 562, the Healthy California Act, which would create a single payer system in the state. The plan would completely replace private insurance and would cover all residents. Under the plan, covered individuals would not have to pay premiums, copayments or deductibles; they would be able to see any provider without a referral, and would be able to get any medically appropriate service. While SB 562 was shelved by State Assembly Speaker Anthony Rendon, who claimed it was "woefully incomplete[vi]," the issue is expected to get renewed attention with the election of Democrat Gavin Newsom as Governor. A supporter of SB 562 in the past, Newsom made health care a prominent issue in his campaign—and on his first day in office, announced plans to expand Medi-Cal (California's version of Medicaid) to undocumented immigrants, impose a state-level individual mandate for coverage, and give the state power to negotiate drug prices.

Next Up: "Medicare Extra for All"

As the debate on health care reform continues, both Republicans and Democrats will work to refine their positions on the issue as large segments of the electorate continue to push for reform. Meanwhile, activity at the state and local level is also expected to increase, with governments experimenting with new ways of solving the health care crisis.

The next piece in our series will provide a deep dive look at the "Medicare Extra for All" proposal released by the Center for American Progress in 2018. Stopping short of a full single-payer approach, this proposal envisions preserving the private employer-based system while extending access to Medicare to all Americans.

Endnotes

[i] https://www.cnbc.com/2018/11/07/healthcare-topped-the-economy-as-the-biggest-issue-for-voters-now-heres-why.html
[ii] https://www.sanders.senate.gov/newsroom/press-releases/17-senators-introduce-medicare-for-all-act
[iii] https://www.vox.com/policy-and-politics/2018/12/14/18117917/medicare-for-all-single-payer-pros-cons-work-health-insurance
[iv] www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals
[v] https://www.vox.com/policy-and-politics/2017/9/13/16296656/bernie-sanders-single-payer
[vi] https://www.sacbee.com/news/politics-government/capitol-alert/article195025409.html