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Five Unanswered Questions on the Medicare for All Act

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On February 27, 2019, Representative Pramila Jayapal (D-WA) and more than 100 co-sponsors in the House of Representatives introduced the Medicare for All Act (HR 1384). The bill, like its predecessors, creates a single payer, government-funded health care program. The new program would cover enumerated medical benefits, prescription drugs, vision, dental, mental health and substance abuse services.

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As expected, progressive House Democrats are using Medicare for All to message their position on coverage expansion heading into the 2020 election. The legislation threatens to expose divides in the Democratic Party, with some Democratic leaders publicly silent on the bill as the left flank of the party tries to advance the proposal. In previous years, other Democrats introduced competing proposals aimed at tackling coverage, including Medicaid and Medicare Buy-In approaches. Messaging the future of the Affordable Care Act (ACA), covering the un- and underinsured, and reducing costs promise to dominate the airwaves in the lead-up to the 2020 presidential election.

It is unclear whether Medicare for All will see a vote on the House floor, either as a whole or in its component parts. Even if the bill were to pass in the House, it is almost certainly doomed in the Republican-controlled Senate. Regardless of the bill's fate, stakeholders should take this opportunity to prepare for forthcoming conversations about how to address the uninsured population and the rising cost of health care.

Many components of the bill are consistent with versions introduced in previous congressional sessions. There are many questions raised by the legislation: This +Insight focuses on five big ones for stakeholders to consider as they evaluate Medicare for All:

1. Is Medicare for All the Democrats' "Repeal and Replace"?

Since the enactment of the ACA, congressional Republicans have run on "Repeal and Replace" as a counter message to the Democrats' signature legislative achievement. When the balance of power shifted in Washington after the 2016 election, pressure intensified on Republican lawmakers to come up with an alternative to the ACA. Ultimately, efforts to repeal and replace the ACA failed legislatively, and efforts to modify the law have been piecemeal and primarily regulatory.

Similarly, Medicare for All and other single payer proposals have largely been Democratic messaging tools, with many of the details unspecified or unaddressed, and many aspects of the proposals ambiguous. If Democrats were to see a presidential victory in 2020, will they be in the same "dog that caught the car" position?

2. How much time is necessary to revamp the US health care system?

Medicare for All is a fundamental, sweeping policy change to the way the United States pays for health care. The legislation reorganizes nearly one-fifth of the nation's economy. Rep. Jayapal's proposal envisions a very quick transition to the new system—a two-year period, with certain individuals eligible to enroll in Medicare for All beginning one year after the date of enactment. Other proposals, including Senator Bernie Sanders' (I-VT) Medicare for All plan, have contemplated longer transition periods (four years in the case of the Sanders plan).

In interviews following the bill's release, Rep. Jayapal stated that the swift transition was necessary because a longer transition period would provide perverse incentives in the marketplace.

As a messaging tool, the short transition period serves its purpose: to illustrate that the bill's supporters are serious and are taking quick action to reform the health care marketplace. Practically speaking, however, if this or a similar bill were to make it across the finish line, the aggressive timeline could create additional challenges. To ensure success while preventing delay requires a delicate balance.

For example, when the ACA passed in 2010, states were mandated to expand Medicaid coverage and given a four-year transition period to make the necessary changes.[1] That was a far smaller expansion than the one envisioned by Medicare for All, and lawmakers provided twice the time to implement it. Nine years later, legal complications and administration changes mean the outlook is still murky. At the same time, if the transition is too long, advocates risk giving opponents time to pressure Congress for delays, as evidenced by the repeated delays and suspension of some of the taxes imposed by the ACA.

3. What might supplemental coverage look like?

Like previous single payer bills, this bill outlaws the sale of private health coverage that duplicates the benefits provided under Medicare for All. It similarly prohibits an employer from providing benefits to employees, retirees and their dependents. The bill also covers many services currently served by a supplemental market—vision, dental, hearing, long-term care and prescription medication, for example.

The bill contains two provisions, however, that leave open the potential for a private market to exist. First, the bill allows the sale of insurance for additional benefits not covered by the Act.[2] Second, like others before it, this bill leaves significant discretion to the Secretary of Health and Human Services regarding coverage for certain categories of services. If the Secretary promulgates rules and regulations that provide minimal coverage, could a private supplemental market thrive? If the Secretary goes the other direction, what would be left for the private market to profitably cover?

4. What is the role of the states?

Under this legislation, states may provide additional benefits for their residents, and may provide benefits to individuals not eligible under the Act at the state's expense, provided that the state's rules provide equal or greater eligibility and access than the single payer plan.

States thus could potentially treat Medicare for All as a floor and build policies to expand services and coverage within state lines. However, this would all be on the state's dime. The bill effectively ends the Medicaid program, which is where many states have the opportunity to innovate with service and coverage expansion. What would states be able to accomplish without a federal matching rate?

5. What becomes of value-based purchasing?

The legislation would require the Secretary to establish a national fee schedule for items and services provided under the Act. The Secretary is required to take into account the value of items and services provided and amounts currently paid. The Secretary will negotiate annually the prices to be paid for pharmaceuticals, medical supplies, medical technology and equipment.[3]

The legislation sunsets all federal pay-for-performance programs and terminates value-based purchasing, including the merit-based incentive payment system, incentives for meaningful use of electronic health records technology, alternative payment models, hospital value-based purchasing, payment adjustments for health-care-acquired infections, the Medicare Shared Savings Program, independence at home and the hospital readmissions reduction program.[4]

The bill's approach of shifting back to fee-for-service payments (as evidenced by the programs the bill would eliminate) is interesting, coming as it does after years of congressional, administration and private market efforts to move toward a value-based payment system. Do the bill's authors envision reinstituting these types of programs once the new system settles? Do the authors believe these programs are no longer necessary given the global payments approach included in the bill?

Conclusion

There will be ample opportunities to draw out the consequences (intended and unintended) of implementing this sweeping change in how health care is provided in the United States. The House Rules and Budget Committees have already confirmed intentions to hold hearings on this bill. The House Energy and Commerce and Ways and

Means Committees, which notably are the committees of jurisdiction, do not have immediate plans to hold hearings on the bill as a whole, but they are already discussing specific policy provisions. The Democratic presidential primary will certainly keep this issue at the forefront of health care policy in 2019 and 2020.

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[1] In *National Federation of Independent Business v. Sebelius*, the Supreme Court of the United States ruled that Congress could not require states to expand the Medicaid program. Medicaid expansion then became an option for states.

[2] Section 107.

[3] Section 616.

[4] Section 903.