Updated as of 10/11/2018

Side-by-Side Comparison of Medicare-for-All and Public Plan Proposals Introduced in the 115th Congress

	Single Payer (Medicare-for-All)		Public Plan Option (Federal/Medicare)			Medicare Buy-In for Older Adults		Medicaid Buy-In
	Sanders	**Ellison**	**Schakowsky/ Whitehouse**	**Bennet/Higgins**	**Merkley/Richmond**	**Stabenow**	**Higgins**	**Schatz/Luján**
Title & Bill Number	S. 1804, Medicare for all Act of 2017	H.R. 676, Expanded and Improved Medicare for All Act	H.R. 635 / S. 194, The CHOICE Act	S. 1970 / H.R. 4094, Medicare-X Choice Act of 2017	S. 2708 / H.R. 6117, Choose Medicare Act	S. 1742, Medicare at 55 Act	H.R. 3748, Medicare Buy-In and Health Care Stabilization Act of 2017	S. 2001 / H.R. 4129, State Public Option Act
ELIGIBILITY								
Individuals	All US residents	All US residents	All individuals eligible to participate in the marketplace (citizens, lawfully admitted permanent residents, not incarcerated)	All individuals eligible to participate in the marketplace (citizens, lawfully admitted permanent residents, not incarcerated) and not otherwise eligible for Medicare Medicare-X offered in the individual market beginning in 2020 in areas with one issuer or high costs due to provider shortages, then in all areas by 2023	All US residents who are not eligible for Medicaid, or traditional Medicare, or not enrolled in CHIP	Individuals ages 55 to 64 who are U.S. citizens or nationals residing in the U.S. or lawfully admitted for permanent residence in the U.S., and who are not otherwise entitled to/eligible for benefits under Medicare Parts A or B	Individuals ages 50 to 64 who are not otherwise entitled to Medicare Part A or eligible to enroll under Medicare Part A or B, who would be eligible/entitled if age 65 or older	Individuals who are residents of states electing to establish the Medicaid buy-in option, who are eligible to participate in the marketplace, and who are not concurrently enrolled in other health coverage
Employers	Not applicable	Not applicable	Small employers and their employees/participants have access through the SHOP marketplace	Small employers and their employees and dependents have access through the small group insurance market Medicare-X offered in small group market beginning in 2024	Employers (large and small firms) can offer Medicare Part E option to their employees Individuals enrolled in Medicare Part E through employer-sponsored plans may remain enrolled after termination of employment relationship	No provision	Employers of eligible individuals may pay premiums on their behalf, if enrollment is choice of the individual and not the employer	No provision

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ENROLLMENT								
Duration	Lifetime enrollment	Lifetime enrollment	Enrollment generally for one year at a time	Enrollment generally for one year at a time	Enrollment generally for one year at a time	Enrollment continues unless individual elects to disenroll	Enrollment generally for one year at a time	Enrollment generally for one year at a time
Enrollment Process	Auto-enrollment of newborns at birth; transitional enrollment for others within 4 years, beginning with children in year one	Individuals and families required to apply at health care provider offices, with presumptive eligibility for those who seek covered benefits from participating providers	Public plan offered only through the marketplace Follows ACA marketplace enrollment procedures and rules	Medicare-X offered through the individual and SHOP marketplaces Follows ACA marketplace and SHOP enrollment procedures and rules	Medicare Part E offered in individual and small group and large group markets and through the individual marketplace and SHOP marketplace Follows ACA enrollment procedures and rules	Enrollment period consistent with Medicare enrollment periods Eligible individuals needing subsidies required to apply for those annually through the marketplace Eligible individuals can enroll in Medicare plan (similar to traditional Medicare) or in Medicare Advantage plans offered exclusively to buy-in enrollees Eligible individuals continue to have option to enroll in private coverage and could do so during the applicable open enrollment period for that coverage	Enrollment period for Medicare buy-in option consistent with ACA marketplace enrollment periods, using ACA marketplace enrollment procedures and rules Eligible individuals continue to have option to enroll in private coverage and could do so during the marketplace open enrollment period	Medicaid buy-in plan offered through the ACA marketplace in states electing the option States may limit enrollment to the ACA marketplace enrollment periods
Medigap Enrollment	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Individuals can apply for Medigap on a guaranteed issue basis each time they enroll in the Medicare buy-in plan	Individuals can apply for Medigap on a guaranteed issue basis each time they enroll in the Medicare buy-in plan	Not applicable

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BENEFITS AND COST SHARING								
Benefits	All medically necessary services in 10 benefit categories, including dental, hearing, and vision; provides coverage of reproductive health services (repeals Hyde amendment) Long-term services and supports (LTSS) covered under Medicaid States may provide additional benefits at state expense	All medically necessary services in 16 benefit categories including dental, hearing, vision, palliative care, and LTSS	ACA 10 essential health benefits	ACA 10 essential health benefits	ACA 10 essential health benefits and Medicare Parts A, B and D benefits; covers abortions and all other reproductive services	Medicare Parts A, B and D benefits	Medicare Parts A, B and D benefits	Medicaid alternative benefit plan, which must include ACA 10 essential health benefits
Cost Sharing	No cost sharing, except Secretary has authority to include cost sharing for prescription drugs (up to $200/year, indexed) to encourage use of generics	No cost sharing	Cost sharing follows ACA marketplace rules Annual out-of-pocket limit applies ($7,350 in 2018) Public plan offered at the Bronze, Silver, and Gold metal levels	Cost sharing follows ACA marketplace rules Annual out-of-pocket limit applies ($7,350 in 2018) Medicare-X offered at ACA Silver- and Gold-plan levels, may also be offered at Bronze and Platinum level Secretary may offer up to two Medicare-X options at each metal level	Cost sharing set at level of Gold-tier ACA plans Annual out-of-pocket limit applies ($7,350 in 2018) Sets benchmark plan at Gold-level for all marketplace participants Adds an annual out-of-pocket limit to current Medicare program for Parts A and B benefits of $6,700 in 2020 (indexed)	Cost sharing same as under current Medicare No annual limit on out-of-pocket cost sharing, unless enrolled in Medicare Advantage plan, or unless cost-sharing subsidies apply (see below)	Cost sharing same as under current Medicare No annual limit on out-of-pocket cost sharing unless ACA cost-sharing subsidies apply (see below)	Cost sharing set by state to be actuarially fair Annual out-of-pocket limit applies ($7,350 in 2018)

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PREMIUMS AND PREMIUM SUBSIDIES/TAX CREDITS								
Premiums	No premiums	No premiums	Premiums for public plan set by Secretary to cover 100% of benefits and administrative costs plus a contingency margin Premiums for public plan shall be geographically adjusted and can vary only by factors allowed by ACA rating rules (age up to 3:1, family size, tobacco use) Public plan exempt from state premium taxes	Premiums for Medicare-X set by Secretary to cover 100% of benefits and administrative costs Premiums can vary only by factors allowed by ACA rating rules (age up to 3:1, family size, tobacco use)	Premiums for Medicare Part E would be set to cover 100% of benefits and administrative costs Premiums can vary only by factors allowed by ACA rating rules (age up to 3:1, geography, family size and tobacco use) and whether plan is offered in the individual, small group, or large group market Extends ACA rating rules to large group market	Single, national premium set at average annual per capita amount for benefits and administrative costs Buy-in enrollees who select MA or Part D plans with premiums above the average required to pay additional amount	Premium for buy-in plan set to cover 100% of benefit and administrative costs Premiums for buy-in plan adjusted for geography, but not age, family status or tobacco use Buy-in enrollees who select MA or Part D plans with premiums above the average required to pay additional amount	Premiums set by states to be actuarially fair States may vary premiums by factors allowed by ACA rating rules (age, up to 3:1, geography, family size, tobacco use) Annual premiums limited to no more than 9.5% of household income
Applicability of Premium Subsidies/Tax Credits to Public Plan	Not applicable	Not applicable	ACA premium subsidies apply	ACA premium subsidies apply	ACA premium subsidies apply	ACA premium subsidies apply Buy-in plan considered a qualified marketplace plan for determining eligibility for ACA subsidies Secretary shall determine the applicable second lowest cost Silver plan for purposes of determining premium tax credit amounts for buy-in individuals	ACA premium subsidies apply	ACA premium subsidies apply Deems Medicaid buy-in plan as the second lowest cost Silver plan in areas where no other Silver plan is offered

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Changes to ACA Subsidies	Not applicable	Not applicable	No provision	No provision	Enhances tax credits for all marketplace plans by changing benchmark plan from second-lowest cost Silver to second-lowest cost Gold plan Expands tax credit eligibility to income 100%-600% FPL and increases income threshold for tax credit reconciliation/ repayment to 600% FPL	No provision	No provision	No provision Caps premiums for Medicaid buy-in plan at 9.5% of income for individuals who are not eligible for ACA premium tax credits
COST-SHARING REDUCTION (CSR) SUBSIDIES								
Applicability of CSR Subsidies to Public Plan	Not applicable	Not applicable	CSR subsidies apply to Silver-level plan options	CSR subsidies apply to Silver-level plan options	CSR subsidies apply to Gold-level plan options	CSR subsidies apply to Medicare-buy in plan Buy-in plan is considered to be a Silver-level marketplace health plan in determining an individual's eligibility for CSR subsidies	CSR subsidies apply to Medicare-buy in plan Buy-in plan is considered to be a Silver-level marketplace health plan in determining an individual's eligibility for CSR subsidies	CSR subsidies apply to Medicaid buy-in plan Buy-in plan is considered to be a Silver-level marketplace health plan in determining an individual's eligibility for CSR subsidies
Changes to ACA CSR Subsidies	Not applicable	Not applicable	No provision	No provision	Enhances CSR subsidies for all marketplace participants by applying them to Gold-level plans and increases actuarial values for Gold plans to the following: • 100-133% FPL: 94% AV • 133-150% FPL: 92% AV	No provision	Enhances CSR subsidies for all marketplace participants by increasing actuarial values for Silver plan to the following: • 100-200% FPL: 95% AV • 200-300% FPL: 90% AV • 300-400% FPL: 85% AV	No provision

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					• 150-200% FPL: 90% AV • 200-300% FPL: 85% AV • Above 300% FPL: AV remains at 80% (Current law sets CSR AV for Silver plan at 94% for income 100-150% FPL; 87% for income 150-200% FPL, 73% for income 200-250% FPL, and 70% for all others)		• Above 400% FPL: AV remains at 70% (Current law sets CSR AV for Silver plan at 94% for income 100-150% FPL; 87% for income 150-200% FPL, 73% for income 200-250% FPL, and 70% for all others)	
PROVIDER PARTICIPATION, PROVIDER PAYMENTS, AND BALANCE BILLING								
Provider Participation	All state-licensed or certified providers and facilities can participate Federal standards relating to nondiscrimination, compliance with billing practices apply and federal minimum standards relating to quality, training, performance, and patient satisfaction also apply States may set additional standards	State-licensed or certified providers and facilities can participate, except for-profit and investor-owned facilities are prohibited Owners of for-profit, providers can convert to non-profit status and receive reasonable compensation for resulting financial loss State licensing and quality standards apply	Medicare and Medicaid participating providers also participate in public plan unless they opt out under a process established by the Secretary Secretary shall establish process for allowing other providers to participate	Medicare and Medicaid participating providers and facilities also participate in Medicare-X; Secretary shall establish a process to allow health care providers to opt out of the public plan; however, once fully implemented, a provider who opts out of public plan would not be allowed to participate in Medicare Secretary shall develop process to allow additional providers to participate in Medicare-X	Medicare participating providers and facilities also participate in Medicare Part E Secretary shall allow additional providers to participate in Medicare Part E	Medicare participating providers and facilities also participate in the buy-in plan	Medicare participating providers and facilities also participate in the buy-in plan	Medicaid providers, including Medicaid managed care organizations (MCOs) also participate in the buy-in

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Balance Billing	Balance billing is prohibited; however, providers are permitted to enter into private contracts with patients, subject to constraints imposed under current law	Balance billing is prohibited Providers must submit bills directly to Medicare	Not specified To the extent proposal adopts Medicare payment rules, Medicare limits on balance billing would apply	Not specified To the extent proposal adopts Medicare payment rules, Medicare limits on balance billing would apply	Not specified To the extent proposal adopts Medicare payment rules, Medicare limits on balance billing would apply	Not specified To the extent proposal adopts Medicare payment rules, Medicare limits on balance billing would apply	Not specified To the extent proposal adopts Medicare payment rules, Medicare limits on balance billing would apply	Not specified To the extent proposal adopts Medicaid payment rules, balance billing would be prohibited
Provider Payment Rates	The Secretary establishes a fee schedule in a manner consistent with the processes for determining payments made under Medicare and establishes a new process for updating fees	Medicare payments established through global budget process and negotiations Hospitals/facilities paid monthly lump sum to cover operating expenses under a global budget Physicians/clinicians paid in one of three ways: (1) fee-for-service payments based on fee schedule; (2) salary from institutions receiving global budgets; or (3) salary from group practices or non-profit HMOs receiving capitation payments	Secretary negotiates provider payment rates for the public plan. If the Secretary is unable to reach a negotiated agreement, Medicare payment rates will be used. Medicare rates modified to accommodate payment for pediatric and other services not otherwise covered under Medicare fee for service	Medicare payment rates used in Medicare-X Secretary has authority to increase provider payment rates up to 25% for items and services provided in rural areas Secretary shall establish reimbursement rates for services not otherwise covered under Medicare fee for service Secretary may utilize innovative payment methods, including bundled, value-based, performance-based payments and others	Secretary negotiates payment rates used in Medicare Part E that would not be lower than the rates paid under the current Medicare program and not higher, in aggregate, than rates paid by insurers offering health insurance through the marketplaces Use of alternative payment models is encouraged	Medicare payment rates used in the buy-in plan	Medicare payment rates used in the buy-in plan Use of alternative payment models is encouraged	All states required to pay primary care providers at least Medicare rates Medicaid rates used for other providers Provides $100 billion in grant funding to enhance provider payments and provider participation in all states
PRESCRIPTION DRUG PRICES AND OTHER COST CONTAINMENT MEASURES								
Prescription Drug Prices	Secretary negotiates drug prices	Secretary negotiates drug prices. National formulary shall encourage best practices in prescribing and	Secretary negotiates drug prices for the public plan	Secretary negotiates drug prices for Medicare-X and current Medicare program	Secretary negotiates drug prices for Medicare Part E and current Medicare program, with fall back to the lesser of	Not specified	Secretary negotiates drug prices for Medicare buy-in plan and current Medicare program	No provision

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		promote use of generics but allow use of brand-name and off-formulary medications. Formulary shall be updated frequently			prices paid by the VA or federal supply schedule if negotiations are not successful in obtaining an appropriate price as determined by the Secretary		Part D sponsors would be permitted to obtain discounts or price reductions below the rate negotiated by the Secretary	
Other Cost Containment	Establishes a global budget specifying total spending for covered services, administrative costs, capital expenditures, health professions education, reserve fund, and other categories Allows for continuation of payment and delivery system reforms	Permits states to establish a global budget for program operations and capital expenditures. Congress appropriates funds on an annual basis Medicare Director allots funding to regional offices Provider payments adjusted annually to achieve the budget target after close consultation with regional and state directors and the National Board of Quality and Access	Permits states to establish advisory councils to make recommendations to Secretary on various policies to promote cost containment, including alternative payment models and value based insurance	Allows for alternative payment models to achieve savings and/or promote quality Secretary shall implement delivery system and payment reforms found to reduce costs on as large a geographic scale as practical and economical Secretary shall establish processes and, when appropriate, collaborate with other agencies to integrate medical care with other social services and income assistance, and to use telehealth, if it will reduce spending without hurting quality or improve quality without raising spending	Allows for alternative payment models to achieve savings and/or promote quality	No provision	Establishes technical advisory committee to identify savings through delivery system reforms and other mechanisms	No provision

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CONSUMER ASSISTANCE								
Consumer Assistance	Secretary appoints Beneficiary Ombudsman to assist consumers, including help with filing and resolving appeals	No provision	Establishes an Office of Ombudsman for Public Insurance Option to provide information and notice that the public plan is an available option; other duties similar to Medicare Beneficiary Ombudsman	No provision	Authorizes funding to address capacity limitations of navigator programs Requires employers that do not offer health benefits meeting ACA standards for affordability and minimum value to refer employees to navigators	No provision	Appropriates $500 million per year for 3 years for grants to states and eligible nonprofits to conduct consumer assistance, education and outreach	No provision
CHANGES TO OTHER COVERAGE (MEDICARE, MARKETPLACE, MEDICAID AND VA/IHS)								
Changes to Current Medicare Program	Replaces current Medicare program During implementation phase in, adds annual OOP cost-sharing limit to Medicare ($1,500), eliminates Parts A and B deductibles and adds a vision and dental benefits. Also eliminates the 24-month waiting period for Medicare for people receiving SSDI payments	Replaces current Medicare program	No provision Establishes a separate account in Treasury for public plan option	Secretary negotiates drug prices for Medicare Part D program Medicare-X will not affect benefits under the current Medicare program, or impact the Medicare trust funds	Secretary negotiates drug prices for Medicare Part D program Adds annual OOP limit on cost sharing for benefits under Parts A, B, and D set at $6,700 in 2020 and indexed thereafter	No provision The Medicare buy-in plan will not affect benefits under the current Medicare program or negatively affect the Federal HI and SMI Trust Funds	Secretary negotiates drug prices for Medicare Part D program Establishes technical advisory committee to recommend changes to enhance the stability of the Medicare trust funds, improve quality of care, improve health, and reduce costs, and promote system reform Nothing in this proposal would adversely affect benefits or the Medicare HI Trust Fund for individuals otherwise entitled to or covered under the current Medicare program. The	No provision

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							Secretary may adjust premiums for the buy-in population so that expenditures under Medicare do not rise due to the new buy-in option	
Changes to Other Marketplace Plans/Private Plans	Replaces private insurance (marketplace, employer, FEHB, TriCare) Prohibits employers from providing duplicative health benefits During implementation phase in, establishes transitional public plan option, based on Medicare, with Platinum level cost-sharing and expanded premium and CSR subsidies For first 5 years, 1% of budget set aside to offset economic dislocation of workers in private health insurance system	Replaces private insurance (marketplace and employer) Non-profit, staff-model HMOs can participate and receive global budgets or capitated payments Unlawful for private health insurers to sell duplicative health benefits. Private insurers may continue to sell coverage for cosmetic surgery or other items and services that are not medically necessary Administrative employees of private insurers who lose jobs are given priority in Medicare hiring for related positions and are eligible to receive two years of transitional salary replacement benefits up to $100,000 per year	No provision ACA “level playing field” requirement applies to public plan (must follow market rules applicable to other qualified health plans)	Authorizes Secretary to establish a reinsurance mechanism to pool costs of highest cost patients on a nationwide basis	Expands premium subsidy eligibility to 600% FPL Enhances premium tax credits by tying to Gold-level benchmark plan Eliminates failsafe provisions of ACA that require reduction of premium tax credits if spending exceeds a threshold Enhances cost-sharing subsidies for other marketplace plans Applies ACA rating rules to large group market Appropriates $10 billion to establish and administer reinsurance program for 3 years (2019-2021)	No provision Private insurers that offer Medicare Advantage plans would submit bids for the 55-64 year old population separately from the current Medicare population	Enhances cost-sharing subsidies for other marketplace plans Establishes reinsurance program for entire individual market. Covers 80% of high cost claims within specified corridor; financed by assessment on individual market plans sold through marketplace	No provision

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Changes to Medicaid	Replaces Medicaid for acute care benefits; Medicaid covers LTSS, with state maintenance of effort for LTSS	Replaces Medicaid No state maintenance of effort specified	No provision	No provision	No provision	No provision	No provision Bill specifies this will not affect benefits or eligibility of individuals otherwise entitled to Medicaid	New state option to offer Medicaid buy-in Requires states to pay at least Medicare rates to primary care providers and provides $100 billion in grant funding for state share of increased costs Requires the development of state-level metrics of access to and satisfaction with Medicaid providers and appropriates $200 million to support state implementation of the metrics Extends 100% federal matching funds for three years to any state newly adopting the Medicaid expansion
Changes to VA and Indian Health Service	No provision	No change initially. After 10 years, Congress evaluates whether VA remains or is incorporated into new program Incorporates IHS into new program after 5 years	No provision	No provision	No provision	No provision	No provision	No provision

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FINANCING								
Financing	Appropriates current federal health spending offsets (e.g., for marketplace subsidies, tax exclusion for employer-sponsored health coverage, Medicaid matching payments for acute care services and Medicare) to the Universal Medicare Trust Fund Other financing options not specified, addressed in separate white paper	Appropriates current federal health spending offsets (e.g. for Medicare, Medicaid, ACA marketplace subsidies) to new Medicare For All Trust Fund Additional offsets assumed for administrative savings and improved access to prevention New revenue sources include: increased personal income tax on top 5% of earners, progressive excise tax on payroll and self-employment income, tax on unearned income, tax on stock and bond transactions	Premium for public plan set to cover benefit and administrative costs The public option is self-financed and cannot contract with outside entities to transfer insurance risk Authorizes such sums as necessary to pay for start up costs and initial 90-day claims reserve; start up funds repaid to the Treasury over 10 years Authorizes such sums as necessary to pay for contracting costs for third party to handle administrative functions	Premium for Medicare-X set to cover benefit and administrative costs Appropriates $1 billion in initial claims reserves and authorizes such sums as necessary to establish a Data and Technology Fund The public option is self-financed and cannot contract with outside entities to transfer insurance risk No provision for other financing sources	Premium for Medicare Part E set to cover benefit and administrative costs Appropriates $2 billion in start up funds and such sums necessary to establish initial reserves Hyde restrictions do not apply to this funding No provision for other financing sources	Premium for the Medicare buy-in plan set to cover benefit and administrative costs, and deposited into the Federal HI and SMI Trust Funds	Premium for the Medicare buy-in plan set to cover benefit and administrative costs, and deposited into a new, separate, Medicare Buy-In Trust Fund for the sole purpose of financing benefits for the buy-in population Financing not specified for other provisions provision	Program costs partially financed through premiums Costs for the Medicaid buy-in not covered by premiums would be financed with federal matching payments in the same way as the current Medicaid program Any excess revenues would be shared with federal government at 50% matching rate Administrative costs for the Medicaid buy-in receive 90% federal matching payments