Updated Medicare for All for 116th Congress - Proposed Top Five Policy Improvements - December 11, 2018

POLICY	ORIGINAL HR 676	S. 1804	UPDATED HR 676
Coverage of comprehensive services	Included a list of comprehensive services, but did not include coverage for women's reproductive health services; rehabilitative services and devices; early and periodic screening, diagnostic and treatment services; laboratory and diagnostic services; and transportation for people with disabilities and low-income Americans.	Includes a comprehensive list of services, although it does not include a few categories of services listed in the original and new HR 676, including approved dietary and nutrition therapies; podiatric care; emergency services and transportation; early and periodic screening, diagnostic and treatment services; transportation for people with disabilities and low income individuals; and long term care services and supports. S. 1804 does include women's reproductive health services.	Brings together the lists of covered services from both S. 1804 and the original HR 676, for the most comprehensive coverage. The full list of covered services: **(benefits added to 1804 language in bold)** 1. Hospital services, including inpatient and outpatient hospital care, including 24-hour-a-day emergency services and inpatient prescription drugs. 2. Ambulatory patient services. 3. Primary and preventive services, including chronic disease management. 4. Prescription drugs, medical devices, biological products, including outpatient prescription drugs, medical devices, and biological products. 5. Mental health and substance abuse treatment services, including inpatient care. 6. Laboratory and diagnostic services. 7. Comprehensive reproductive, maternity, and newborn care. 8. Pediatrics. 9. Oral health, audiology, and vision services. 10. Rehabilitative and habilitative services and devices. **11. Approved dietary and nutritional therapies.** **12. Podiatric care.** **13. Emergency services and transportation.** **14. Early and periodic screening, diagnostic, and treatment services.** **15. Necessary transportation for health care services for persons with disabilities or who may qualify as low income.** **16. Long Term Care Services and Supports**
No Co-Pays or Deductibles	Did not include any co-pays or deductibles for any items or services.	Includes co-pays for prescription drugs, with a cap of $200 per year for each person enrolled in the program.	No co-pays or deductibles for any items or services.
Long Term Care Services and Supports	Included long term care in list of covered services, but did not offer any detail for the part of the program.	Does not include coverage for long term care services within Medicare for All. Preserves existing Medicaid program for the purpose of providing long term care services and supports for people with disabilities and older Americans.	Long term care services and supports are fully covered by the Medicare for All program, including nursing and medical services to support activities of daily living and instrumental activities of daily living whether provided in an institution, home, or community-based setting. The draft bill requires that the program presume that recipients of all ages and disabilities will receive long-term services and supports through home and community based services unless the individual chooses otherwise. The draft bill requires that the Secretary develop regulations in consultation with an advisory commission that includes those who use long-term supports and services, their representatives and family caregivers; providers of such supports and services; and disability rights, academic, and labor organizations

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Transition Period to Medicare for All Program	One year transition period for the entire program.	Four year transition period, during which eligible individuals would have to pay a premium to be enrolled. Those premiums would stop after the transition period was complete. The bill also sets up a Medicare Buy-In option, so that individuals not yet eligible for the program can buy-in to different parts of existing Medicare, with existing cost-sharing structures in Medicare still in place. - One year after the enactment of the act, children under the age of 19 and adults over the age of 55 would be eligible for the program. - Two years after the enactment of the act, adults over the age of 45 would be eligible. - Three years after the enactment of the act, adults over the age of 35 would be eligible. - Four years after the enactment of the act, all residents would be covered.	Two-year transition period for the program: - In the first year after enactment, Medicare would collapse its different components (Parts A, B, C, and D) into one program, that includes all comprehensive services covered by the Act, including dental, vision, long term care, and audiology services. - One year after enactment, adults over the age of 55 and children under the age of 19 would be eligible for enrollment. There would be no premiums or cost-sharing for eligible individuals during the transition. - Two years after enactment, all remaining residents would be eligible for enrollment. - During the transition, a Medicare buy-in plan would be made available on the ACA exchanges. Individuals not yet eligible for the program could purchase the plan, which would include all the comprehensive services in the Act, provided without cost sharing.
Updated Plan for Payments to Providers and National Health Budget	Would pay institutional providers through global budgets that are negotiated annually between providers, state directors, and regional directors. Would pay physicians and other health professionals fee for service payments, salaries through institutions receiving global budgets, or salaries within group practice or non-profit health maintenance organizations receiving capitation payments. Does not incorporate value-based payment models.	Maintains current Medicare payment models, including MACRA reforms that prioritize value-based payment systems. Payment provided on a fee for service model, after taking into consideration “quality-assessment.”	Maintains the principles for payments to providers established in the original HR 676, which reflects policy practices from international single payer programs. - The National Health Budget would have separate components for operating expenses and capital expenses, and includes a newly created special projects budget, to fund the building and staffing of healthcare facilities in rural and underserved communities. - All institutional providers would be paid through a global operating budget, that would cover all necessary operating expenses including staffing, medical technology and devices, supplies, prescription drugs, and all costs associated with patient care. This budget would not include capital expenditures, which would be paid for through a separate budget. - All individual providers would be paid through a fee for service schedule that would not include value based payment adjustments. - Payments to providers would not be used to fund marketing, union busters, or political activity, and would be prohibited from use as profit or revenue