

The Public Option: Single Payer on the Installment Plan

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KEY TAKEAWAYS

Although touted as less radical than “Medicare for All,” a government health plan would still result in government control of America’s health care system.

More lawmakers are proposing the incremental approach to government-controlled health care through a public option health insurance plan.

A public option would impose rules that favor the government while reducing personal choices and costing taxpayers more.

Whether conceived as an expansion of Medicare or the creation of a government health-care plan, the public option is a Trojan horse with single-payer hiding inside.

—Seema Verma, Administrator,
Centers for Medicare and Medicaid Services,
The Washington Post, July 24, 2019

Tactical differences aside, many liberal Democrats in Congress are diligently pursuing a common strategic goal: a government takeover of American health care.

The two leading legislative proposals to achieve that goal, the so-called Medicare for All proposals, S. 1129, sponsored by Senator Bernie Sanders (I-VT),¹ and H.R. 1384, sponsored by Representative Pramila Jayapal (D-WA),² would abolish virtually all existing

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coverage arrangements, private and public, and replace them with a single, national health insurance plan, centrally controlled and directed by federal officials in Washington, DC.

Short of such a drastic and direct federal takeover of American health care, a number of prominent congressional leaders and presidential candidates are proposing a more incremental approach to a government-controlled health care system through a “public option.” A public option (public = government) is a new government health plan that would compete directly against private health plans. Proponents of this approach purport that it would enhance competition in the nation’s health insurance markets, expand choice for consumers, and reduce America’s overall health care costs.

Yet, the dynamics inherent in the leading public option proposals would guarantee an outcome quite the opposite of the claims. The underlying components of these proposals—the power of the government to drive out private competition and coverage, compel provider participation in the government plan, consolidate enrollment into the government plan, and shift costs to taxpayers and providers—are the cornerstones of a single payer, government-run health system. Although touted as less radical than “Medicare for All,” a government option would ultimately result in near-total government control of American health care.

The Public Option Concept

The public option and its purpose are not new. Helen Halpin, director of the Center for Health and Public Policy Studies at the University of California, and public option advocate Peter Harbage traced the origins of the public option concept to a 2001 state health care reform project in California.³ From there, a national version of the public option concept was introduced in 2003 as part of the *Covering America Series*, funded by the Robert Wood Johnson Foundation. At the time Halpin wrote in a piece for the series that the public option, then called the CHOICE program, “is a new approach to health care reform that very quickly achieves nearly universal access to a single-payer health insurance system for all U.S. residents.”⁴ For liberals in Congress, arming the government with strong statutory and regulatory advantages to undercut private insurance emerged as the mechanism to achieve their long-sought single payer victory.

A Down Payment for Single Payer. In 2008, Democratic presidential candidate Barack Obama incorporated a version of the “public option” as a key component of his comprehensive health care reform agenda.⁵ A public

option was also a part of the 2009 legislative debate over the Affordable Care Act's (ACA's) creation. Though this public option was later excluded from the final version, during the 2009 congressional debate, then-Representative Barney Frank (D-MA) said: "I think that if we get a good public option it could lead to single payer and that is the best way to reach single payer. Saying you'll do nothing till you get single payer is a sure way never to get it.... [T]he only way, is to have a public option and demonstrate the strength of its power."⁶

Fully arming the government with powerful statutory or regulatory advantages, the public option would be the mechanism to, over time, undercut private insurance, and pave the way for a single payer, government-run health care system.

The Leading Public Option Proposals: Single Payer on the Installment Plan

Short of launching an immediate, full-scale government takeover of American health care, as provided under the House and Senate "Medicare for All" bills, a number of House and Senate Democrats are sponsoring bills that create a "public option."⁷ These proposals would grant the government the power to drive out private competition and coverage, coerce provider participation in the government plans, consolidate enrollment in favor of the government option, and shift costs of the government plan to taxpayers and health care providers. While these public options do not explicitly outlaw private coverage, all of these proposals put in place the infrastructure to facilitate a transition to a single payer system of government-run health care and an end to private coverage as we know it.

The Medicare for America Act of 2019 (H.R. 2452). Representative Rosa DeLauro (D-CT) is sponsoring H.R. 2452, the Medicare for America Act,⁸ which has 24 Democratic co-sponsors and no Republican co-sponsors.⁹ This proposal would establish a temporary public option and transition to a more robust government-run health plan, which lays the foundation for a potential single payer model in the future.

A Transitional Public Option. The bill would establish a temporary public option that would be offered through the ACA exchanges for two years, and would be made available to those individuals eligible to purchase coverage through the exchanges and who are in an area where the Secretary of Health and Human Services (HHS) offers the public option.¹⁰ This temporary public option must meet the benefit requirement of a qualified health plan as defined under the ACA, including ACA essential benefits.¹¹

The HHS Secretary would set premiums for the public option. Premiums would be capped so that no individual or household will pay more than 8 percent of adjusted gross monthly income toward premiums. Federal subsidies would be set so that individuals with household incomes below 200 percent of the federal poverty level (FPL) (\$24,980 for an individual/\$51,500 for a family of four) would pay no premium, and those between 200 percent of FPL and 600 percent of FPL (\$74,940 for an individual/\$154,500 for a family of four) would receive a sliding scale subsidy.¹²

Payment rates for reimbursing services would be based on Medicare rates and set as necessary to “maintain network adequacy.”¹³ A health care professional who is a participating provider in Medicare or Medicaid on the date of enactment would be a participating provider for the public option. The HHS Secretary would be required to establish a process to allow additional providers that are not in Medicare or Medicaid to participate in the public option.¹⁴

The act also states that “health care providers may not be prohibited from participating in the public health insurance option for reasons other than their ability to provide covered services.”¹⁵ Further, health care providers, hospitals or other institutions would be prohibited from denying individuals access to *any* covered benefits or services because of “religious objections.”

The Medicare for America Act would establish a fund for the administration of the public option and would appropriate “such sums as may be necessary” from funds not otherwise obligated to operate the public option.¹⁶ It also specifies that there would be no restriction on federal funds for the use toward *any* reproductive health services.¹⁷

The Medicare for America Plan. In 2023, the HHS Secretary would establish the “Medicare for America” plan, a more robust version of the initial, temporary public plan.

An individual who is a resident of the United States, who is lawfully present¹⁸ or would be eligible for coverage under immigration exceptions described in Medicaid at the time of enactment,¹⁹ would be eligible for enrollment in the Medicare for America plan.

Starting in 2023, the Secretary would automatically enroll in the Medicare for America government plan those individuals who are eligible at the time of birth, those Medicare beneficiaries enrolled in fee-for-service Medicare, future Medicare beneficiaries when they turn 65, and those individuals deemed to not have “qualified” health coverage as defined by the act.²⁰ Members of Congress and staff would also be enrolled.²¹

Under full implementation, traditional Medicare,²² Medicaid, CHIP, and the ACA exchanges would be terminated, and enrollees of those programs would be enrolled in the Medicare for America plan.²³

Individuals enrolled in “qualified” health plans, including newly defined qualified employer coverage,²⁴ military/TRICARE coverage, services through the Veterans Administration, the Federal Employees Health Benefit Program, and the Indian Health Services, would have the option of remaining on their existing plan or enrolling in the Medicare for America government plan.²⁵ The Secretary would also set up a process for allowing employers to enroll their employees into the plan.²⁶

Moreover, as part of the enrollment process, the Secretary would issue Medicare for America identification cards. Participating providers in the Medicare for America plan would be required to facilitate enrollment, as would state entities responsible for enrolling individuals in Medicaid and the Children’s Health Insurance Program (CHIP).²⁷

The Medicare for America plan would provide all benefits as covered under Medicare Parts A and B, Medicaid, and those “as determined to be medically necessary,” including an extensive and highly specified list of services.²⁸ The Medicare for America Act would also prohibit a private insurer from selling coverage that duplicates benefits under the Medicare for America plan.²⁹

Under the Medicare for America plan, individuals would pay a monthly community-rated premium set by the HHS Secretary. The premium would be based on benefit and administrative costs and family composition. Like under the transition, no individual or household would pay more than 8 percent of monthly income toward a premium, and federal subsidies would prevent individuals with household income below 200 percent of the FPL from paying a premium, and a sliding scale subsidy would be set for those individuals with household incomes between 200 percent and 600 percent of the FPL.³⁰ The Medicare for America Act would also set cost-sharing subsidies based on ACA gold-level coverage rather than silver-level coverage (as under the ACA), and would further reduce cost-sharing requirements by income.³¹

There would be no deductibles in the Medicare for America plan. The maximum out-of-pocket limit would not exceed \$3,500 for an individual or \$5,000 for a household, and there would be no lifetime or annual limits for services or benefits that are covered under the Medicare for America plan.³²

The HHS Secretary would set provider reimbursement rates based on Medicare or Medicaid, whichever is higher. If benefits or services are not covered under Medicare or Medicaid, the Secretary would set a rate to ensure “adequate access” to services. In addition to other payment changes, the bill provides exceptions for inpatient and outpatient hospital services, where the payment rate would be set at 110 percent of the Medicare or

Medicaid rate, whichever is higher. For hospitals serving underserved areas, the Secretary would increase the rate as necessary.³³ Moreover, providers would be prohibited from billing patients above government set payment rates, and providers would also be prohibited from entering into private contracts with individuals for services covered under the Medicare for America plan.³⁴

As with the temporary public option, a health care provider who is a participating provider under Medicare or Medicaid on the date of enactment would remain a provider under Medicare for America.³⁵ The HHS Secretary would also be required to establish a process to allow additional providers, who are not in Medicare or Medicaid, to participate in the public option.

The Secretary would “negotiate” rates for prescription drugs under the Medicare for America plan. If the Secretary is unable to reach an agreement with a manufacturer, the Secretary is authorized to use any patent, clinical trial data, or other exclusivity granted for the purposes of manufacturing the drug for sale to Medicare for America.³⁶ The bill also establishes a Prescription Drug and Medical Device Board to monitor and enforce a “prohibition on excessive drugs prices.”³⁷

The Medicare for America Act would establish a unified Medicare Trust Fund for the administration and operation of the Medicare for America plan. Any revenues attributable to Medicare for America and premiums collected would be taken from the general fund and deposited into the Trust Fund; as well as any amounts that would have been appropriated for Medicare and Medicaid³⁸ starting in 2027. Additional appropriations would be authorized “as needed to maintain maximum quality, efficiency, and access...”³⁹

The act also stipulates that there would be no restrictions on federal funds for any reproductive health service, including abortion. The act also states that providers may not be prohibited from participating in Medicare for America “for reasons other than their ability to provide covered services,” and that providers would be prohibited from “denying covered individuals access to covered benefits and services because of their [the providers’] religious objections” and would explicitly supersede any conscience protections.⁴⁰

While the Medicare for America plan would not eliminate the Medicare Advantage (MA) program, it does set new requirements for MA plans. For example, an insurer could only offer coverage in the individual market if the insurer also agrees to sponsor coverage under the new Medicare Advantage (MA) for America program. The provider payment rates for MA for America would be set at 95 percent of the average Medicare for America cost in each

county, and the payment rate for prescription drugs under MA for America would not exceed the amount set for prescription drugs under the Medicare for America plan.⁴¹

In addition to a variety of other health-related initiatives,⁴² the act would establish a new services and support program for federal, home, and community-based, long-term care. Any individual who is eligible for Medicare for America and is unable to perform at least one activity as defined under IRS rules would be eligible for services and support under this new program. State entities responsible for administering such services under Medicaid would be legally responsible for administering services under this new federal program.⁴³

New Taxes. Title II of the act outlines a sundry list of new tax increases for taxpayers.⁴⁴ It would sunset the entire Tax Cuts and Jobs Act, add a 5 percent surtax on incomes that exceed \$500,000, revise tax treatment related to inheritance property, increase the Medicare payroll tax from 2.9 percent to 4 percent, increase the net investment tax from 3.8 percent to 6.9 percent, terminate deduction for contributions to health savings accounts (HSAs), increase the excise tax on various tobacco products, increase the excise tax on alcohol, add a tax on sugared drinks, and repeal the ACA's excise tax on high-cost employer-sponsored health coverage.

Choose Medicare Act (S. 1261/H.R. 2463). Senator Jeff Merkley (D-OR) and Representative Cedric Richmond (D-LA) are sponsoring the Choose Medicare Act.⁴⁵ The bill has 15 Democratic co-sponsors in the Senate and seven Democratic co-sponsors in the House of Representatives. Neither have Republican co-sponsors.⁴⁶ The bill would establish a government-run plan (Medicare Part E) that would be in the individual, small group, and large group markets. Although not explicit, this proposal would put in place the regulatory infrastructure from which a single payer model could evolve from in the future.

An individual would be eligible for the new public option if he is a resident of the U.S., as defined by the Secretary of HHS, and is not eligible for, or enrolled in, Medicare; is not eligible for Medicaid; and is not enrolled in CHIP.⁴⁷

The Part E plans would be required to offer ACA gold-level coverage and meet the requirements of a “qualified” health plan as defined in the ACA, including ACA essential benefits, Medicare benefits, and all reproductive services, including abortion.⁴⁸

The act would extend the ACA health insurance rating rules to the large-group market,⁴⁹ and would permit new federal rules and restrictions on insurance rates that the Secretary deems “excessive, unjustified, or

unfairly discriminatory.”⁵⁰ The bill would also pre-empt any state actions prohibiting the Part E plan from being offered in the state or prohibiting the outlined benefits.⁵¹

These plans would be available to employers on a voluntary basis one year after enactment. An individual who is enrolled in a Part E plan through her employer and later separates from her employer would be able to maintain her enrollment in the Part E plan, regardless of whether that individual has access to new coverage through a new employer.⁵² It would also require employers who do not provide “qualified” coverage, meaning the employer coverage is deemed “unaffordable” or does not meet minimum actuarial value, to refer employees to an ACA Navigator and authorizes appropriations for “such sums as may be necessary” for the Navigator program to carry out related tasks.⁵³

The Secretary would set premiums for the Part E plans based on its offering in the individual, small-group markets, or large-group markets, and their rating areas. The plan’s premiums would be required to be sufficient to fully finance the benefits and administrative costs of the plans and to comply with the requirements under the ACA.⁵⁴

The act would change the benchmark for ACA premium tax credits from the second-lowest silver-level plan to the second-lowest gold-level plan, and would expand eligibility for the subsidy for persons with incomes from 400 percent to 600 percent of the FPL. The act would change the ACA cost-sharing subsidy from silver-level coverage to gold-level coverage, and would further reduce cost sharing by income level.⁵⁵

The Secretary would set reimbursement for services at levels that are not lower than Medicare rates and not higher than the average rates in the ACA exchanges.⁵⁶ The bill would also require the Secretary to negotiate rates for prescription drugs in Medicare Part D, Medicare Advantage Prescription Drug plans, and for the new Medicare Part E plans.⁵⁷ If the Secretary is unable to reach an agreement with a drug manufacturer after one year of negotiations, reimbursement rates will be set at the price paid by the Veterans Administration or as set by the federal government through the Federal Supply Schedule.

A health professional who is a participating provider under Medicare would be assigned as participating provider under the new Medicare Part E plan and a process would be established to accept providers who do not participate in Medicare.⁵⁸ The bill would also impose the same Medicare balance-billing limitations—the prohibition on medical professionals to charge any amount above the Medicare payment—on participating providers in Part E.⁵⁹

The bill would appropriate \$2,000,000,000 out of funds not otherwise obligated for fiscal year (FY) 2020 for purposes of establishing the Part E program, and “such sums as may be necessary” for the first year to fund initial claims. The bill would establish a reinsurance fund and appropriates \$30,000,000,000 out of funds not otherwise obligated for two years for the states to provide reinsurance payments to insurers or to provide assistance to reduce out-of-pocket costs for individuals enrolled in plans through the exchanges.⁶⁰

The proposal would remove any federal funding restriction for reproductive health services, including abortion.⁶¹ In a similar vein, the bill includes a Sense of Congress supporting open access to reproductive services.⁶²

Medicare-X Choice Act of 2019 (S. 981/ H.R. 2000). Senator Michael Bennett (D-CO) and Representative Brian Higgins (D-NY) are sponsoring the Medicare-X Choice Act.⁶³ The bill has 11 Democratic co-sponsors in the Senate and 25 Democratic co-sponsors in the House of Representatives. Neither has a Republican co-sponsor.⁶⁴ Similar to the Choose Medicare Act, the bill would establish a new government-run health plan (Medicare-X) that would be available in the individual and small group markets. This proposal, although not explicit, would put in place a regulatory framework for a single payer model to evolve from in the future.

The Medicare-X Choice Act would offer a government plan (Medicare-X) through the ACA exchange. An individual would be eligible to enroll in the Medicare-X plan if the individual is qualified to purchase coverage through the ACA exchanges and is not eligible for Medicare.⁶⁵

Starting in 2021, the plan would be available in priority areas, as determined by the Secretary, where no more than one health plan is offering coverage in the ACA exchange or where there is a shortage of health care providers or a lack of competition. Availability of the Medicare-X plan would increase so that the plan is available to all residents in all rating areas by year 2024 and to the entire small-group market by 2025.⁶⁶

The Medicare-X plan would have to comply with the same requirements as those of the ACA, as well as other federal health insurance requirements.⁶⁷ The Medicare-X plan would offer ACA silver-level and gold-level coverage, and may offer no more than two versions of the plan for each of the four ACA coverage levels. After 2021, all enrollees in a state would be in a single risk pool, unless the Secretary establishes, or the state has established, a separate risk pool for the individual and small-group markets.⁶⁸

The Secretary would set premiums to cover the plan’s full actuarial costs and administrative costs. The premiums would vary by geographical region and between the small-group and individual markets.⁶⁹ The bill would require

that, if premiums collected are in excess of costs, the funds will remain available to the Secretary for administration in subsequent years. The bill would also expand availability of the ACA premium tax credit for those individuals earning below 100 percent of the FPL and for those earning above 600 percent of the FPL, and make it more generous for certain groups.⁷⁰

The Secretary would set reimbursement for health care providers at Medicare fee-for-service rates.⁷¹ The Secretary would be able to increase reimbursement rates by 25 percent for services in rural areas. The proposal would require the Secretary to “negotiate” prescription drug payment rates for Medicare-X, and would remove the existing prohibition forbidding government intervention in setting prices for in Medicare Part D.⁷²

The proposal would set as a requirement that a provider must participate in Medicare-X if he is also participating in Medicare or Medicaid.⁷³ The Secretary would establish a process for providers who wish to opt out of Medicare-X, and to accept new providers who are not participating in Medicare or Medicaid.

The Treasury Department would establish a Plan Reserve Fund, and the Secretary of HHS would administer the fund.⁷⁴ The bill would appropriate \$1,000,000,000 out of funds not otherwise obligated for FY 2020. There would also be a fund established at the Treasury, also administered by the Secretary of HHS, for updating technology and data collection for purposes of establishing appropriate premiums.

The bill would also direct the Secretary to establish a national reinsurance mechanism to pool the cost of the highest-cost patients with individual coverage (on and off the ACA exchange). The bill would authorize the appropriation of \$10,000,000,000 each fiscal year for 2021, 2022, and 2023.⁷⁵

Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act (S. 1033/H.R. 2085). Senator Sheldon Whitehouse (D-RI) and Representative Jan Schakowsky (D-IL) have sponsored this bill.⁷⁶ It has eight Democratic co-sponsors in the Senate and 20 Democratic co-sponsors in the House. Neither has Republican co-sponsors.⁷⁷ Like others, the CHOICE Act would establish a new government-run health plan and would put in place the regulatory framework needed for a single payer model in the future.

The CHOICE Act would make a government plan available through the ACA exchanges at the silver and gold levels, and may also offer coverage at the bronze level. The government plan would comply with the ACA’s various insurance requirements and would be required to offer “comprehensive” benefits, including ACA essential health benefits.⁷⁸ The bill would pre-empt any state laws that would prohibit a public option.

The Secretary would establish geographically adjusted premium rates for the public option based on ACA premium-rate requirements and other data collected, at levels sufficient to fully finance benefit and administrative costs.⁷⁹ A state could establish a state advisory council to provide recommendations to the Secretary on policies to integrate quality improvement and cost-containment mechanisms, mechanisms to facilitate public awareness of the public option, and an alternative payment mechanism. The Secretary would be able to apply those recommendations to that state, in any other state, or all states.⁸⁰

The Secretary would negotiate the plan's payment rates with providers. If the Secretary and providers are unable to reach an agreement, the Secretary would set provider reimbursement rates at Medicare fee-for-service rates and set payment rates for services not covered under Medicare. Similarly, the Secretary would negotiate payment rates for prescription drugs as well. If the Secretary were unable to reach an agreement, the Secretary would use Medicare fee-for-service rates, and would set payment rates for drugs not covered under fee for service.⁸¹

An account would be established at the Treasury for the administration of the public option. The bill authorizes "such sums as necessary" for start-up funding with the Secretary required to repay those start-up funds over a 10-year period, and authorizes additional appropriations as necessary. The bill also states that there would be no prohibitions on federal funding for "any reproductive health service," presumably including abortion.⁸²

Health care professionals who are participating providers under Medicare or Medicaid would automatically be participating providers under the public option, unless the medical professional opts out of participating in the public option through a process determined by the Secretary. The Secretary would also establish a process to allow non-Medicare and non-Medicaid providers to participate in the new public plan. Participating providers would have to be licensed and certified under state law, and a provider could not be excluded for reasons other than his or her ability to provide covered services.⁸³

Medicare at 50 Act of 2019 (S. 470). Senator Debbie Stabenow (D-MI) is sponsoring the Medicare at 50 Act, to expand the Medicare program.⁸⁴ The bill has 20 Democratic Senate co-sponsors and no Republican co-sponsors.⁸⁵ This bill would expand the Medicare program to individuals ages 50 to 64, and, although not explicit, its regulatory design, would put in place an infrastructure for a single payer model to emerge from in the future.

Under the act, individuals who are between 50 and 64 would be eligible for the new buy-in program.⁸⁶ Individuals who are eligible for Medicaid would not be eligible for the Medicare buy-in program, and states would

be prohibited from buying-in their Medicaid enrollees between 50 and 64 to Medicare, unless their Medicaid coverage does not meet “minimum essential coverage” under government-sponsored-plan requirements.⁸⁷

Eligible individuals enrolled in the program would be entitled to the same benefits available in Medicare Parts A, B, C, and D. Individuals who enroll in the Medicare buy-in program would also be eligible to purchase Medigap coverage on a guaranteed-issue basis when they first enroll.⁸⁸

The Secretary would determine a monthly premium based on an estimated combined per capita average for benefits and administrative expenses. Nothing would preclude an individual from choosing a Medicare Advantage or Part D plan that requires a higher premium, understanding the individual would be responsible for the premium difference.⁸⁹

Medicare buy-in enrollees would not be eligible for traditional Medicare cost-sharing assistance, but enrollees would be eligible to receive assistance that is “substantially similar to the assistance the individual would have received” if obtaining coverage through the exchange.⁹⁰ The Secretary, with certification from Centers for Medicare and Medicaid Services (CMS) Actuaries and in consultation with the Department of the Treasury, would determine amounts that would be transferred from what otherwise would have been allocated to individuals in the exchange.

While not explicit in the text, the bill would presumably depend on participating Medicare providers and reimbursement rates for new enrollees. Section 3 of the bill would strike the current legal prohibition that forbids the Secretary to intervene in setting prices for Medicare prescription drugs.⁹¹ In short, the bill would eliminate existing private market negotiations between health insurers and drug manufacturers.

The Secretary would award grants to entities, either states or nonprofit community-based organizations,⁹² to carry out outreach, public education, and enrollment activities “to raise awareness of the availability of, and encourage enrollment” in this program, as well as the availability of premium assistance and cost-sharing reductions.⁹³ The bill would appropriate \$500,000,000 out of funds not otherwise obligated for each year and prioritizes grants to those geographic areas with no qualified health plans available in the individual market.

Finally, the bill would establish a Medicare Buy In Oversight Board to oversee implementation and make periodic recommendations,⁹⁴ as well as a Medicare Buy In Trust Fund that would collect premiums and follow the same rules as applied to Medicare Part B.⁹⁵

State Public Option Act of 2019 (S. 489/H.R. 1277). Senator Brian Schatz (D–HI) and Representative Ben Ray Lujan (D–NM) re-introduced

the State Public Option Act.⁹⁶ The bill has 22 Democratic co-sponsors in the Senate and 51 Democratic co-sponsors in the House of Representatives. Neither has Republican co-sponsors.⁹⁷ This proposal would allow states to open the Medicaid program as a government-run option for those individuals not currently eligible for Medicaid. Here, too, the regulatory design sets in place a framework for a single payer model in the future.

The bill would create, at state option, a new category of individuals eligible for Medicaid benefits who are residents of the state and who are not enrolled in another health plan.⁹⁸ It would require states to provide coverage that meets minimum “benchmark” coverage as defined in Medicaid,⁹⁹ and would require coverage of comprehensive reproductive health care services, including abortion services, as a condition of state Medicaid plan approval.¹⁰⁰ A state could also require an individual who obtains coverage through the Medicaid buy-in program to enroll in a managed care plan as a condition of receiving such services.¹⁰¹

A state would be able to impose premiums, deductibles, cost sharing, and other charges, but may only vary the premium based on those factors described in the ACA.¹⁰² Premiums would not exceed 9.5 percent of household income, and cost-sharing requirements would be limited as set in the ACA.¹⁰³ An individual who qualifies for a premium tax credit and cost-sharing reductions under the ACA would also be eligible for a premium tax credit under the Medicaid buy-in program.¹⁰⁴

With regard to reimbursement rates, while not explicit in the text, presumably state Medicaid payment rates would generally apply, with certain exceptions. For example, Section 4 of the act would set a federal floor for primary care services at the 100 percent of Medicare, and not less than the rate that was set in Medicaid for 2013 and 2014 or on the first day after enactment of this proposal.¹⁰⁵ Section 5 of the act would allow states that adopt the ACA Medicaid expansion to receive the full, enhanced match rate.¹⁰⁶ Additionally, it would extend an enhanced federal match rate of 90 percent for expenses related to the administration of the Medicaid buy-in program.¹⁰⁷ Finally, the bill would direct the Agency for Healthcare Research and Quality to develop standardized, state-level metrics on Medicaid enrollee access and satisfaction.¹⁰⁸

How Public Option Schemes Expand Government Control and Weaken Access to Care

Though seemingly less radical than the leading House and Senate “Medicare for All” bills, the public option proposals nonetheless lay a firm foundation for a single payer, government-run health care system to take

hold in the future. All these proposals—whether they create a new government plan or broaden the scope of existing government programs (Medicare and Medicaid)—would erode and eventually eliminate private alternatives to the government health plan, compel provider participation, consolidate enrollment in the government plan, and shift costs to taxpayers and health care providers.

These public option schemes would:

1. **Drive Out Private Competition and Coverage.** According to the U.S. Census, approximately 213 million Americans have private health insurance, primarily through their place of work.¹⁰⁹ These public option proposals would undermine and erode private coverage in favor of government-run health care.

All the public option proposals either create or expand a government-run health program. The Medicare for America Act extends a public option as a transition to a robust government-run model. The Choose Medicare Act, the Medicare-X Act, and the CHOICE Act create a new government plan to be available in the private market. The Medicare at 50 Act and the State Public Option Act expand existing government programs—Medicare and Medicaid—as the base for the public option.

An analysis of a plan broadly similar to the Medicare for America proposal found that job-based coverage would drop by 33 million, and that coverage in the individual market would drop by 12 million.¹¹⁰ Similarly, analysis of the Medicare-X proposal found that job-based coverage would drop by 22.6 million persons and coverage in the individual market would drop by 12.6 million.¹¹¹ An Urban Institute analysis of various public option concepts found similar outcomes, with the number of persons enrolled in employer coverage dropping between 3 million and 16 million, depending on the scenario.¹¹²

As Hoover Institute economist Scott Atlas points out, “[G]overnment insurance options erode, or ‘crowd out,’ private insurance, rather than provide coverage to the uninsured.”¹¹³ He also points out that Jonathan Gruber, a key architect of the ACA, found that public insurance expansions “clearly show that crowd-out is significant,” with a crowd-out rate of about 60 percent.¹¹⁴

Reducing the un-insurance gap is important. However, the magnitude of the problem is less dramatic than proponents claim. The reason: Many of the uninsured are, in fact, eligible for coverage either with generous federal subsidies or coverage under other government health programs, such as Medicaid.¹¹⁵ And yet, these public option proposals would undermine the existing coverage arrangements that the majority of Americans have today.

- 2. Compel Provider Participation in the Government Plan.** In an attempt to prevent an exodus of health care providers unwilling to accept government payment rates, all the public option proposals, either explicitly or implicitly, would compel providers in existing government programs to also participate in the new government plan.

The Medicare for America Act,¹¹⁶ the Medicare-X Act,¹¹⁷ and the CHOICE Act¹¹⁸ would compel existing providers in Medicare and Medicaid to participate in the new government health plan. The Choose Medicare Act (Part E)¹¹⁹ and the Medicare at 50 Act¹²⁰ would depend on existing Medicare providers, and the State Public Option Act¹²¹ would depend on existing Medicaid providers.

While the Medicare X Act¹²² and CHOICE Act¹²³ would theoretically provide an opt-out for providers, the HHS Secretary would be in charge of establishing such an opt-out process for physicians who might prefer to not participate.¹²⁴ The Secretary, in other words, would be given the legal right to act like judge in his or her own cause, whether or not a physician or class of physicians can opt out of the Secretary's administered program.

Armed with the power to determine conditions of participation, the federal government would obviously not be operating on anything resembling a level playing field. By force of law, the public option would have an inherent and unfair competitive advantage in securing provider participation and undermining private provider alternatives for consumers.

- 3. Consolidate Enrollment in the Government Plan.** Despite what supporters purport, the public option would not expand choice. By design, the public option would drive out private competition and provide government privileges to the public option over private plans.

There are a variety of ways public option proposals would accomplish this objective. As directed under the Medicare for America Act, the government would simply auto-enroll groups into the government plan over time.¹²⁵ Other proposals would boost taxpayer-financed organizations. The Choose Medicare Act would use ACA's Navigators to expand enrollment in the public option,¹²⁶ while the Medicare at 50 Act would use "outreach" entities to promote the public option.¹²⁷ This, of course, is intended to drive consumers away from private alternatives and toward the public option; in short, deploy additional government resources to tilt the playing field in favor of the government plan. As explicitly noted in the Medicare at 50 Act, these entities are directed "to carry out outreach, public education activities, and enrollment activities to raise awareness of the availability of, and encourage, enrollment" related to this program.¹²⁸

Other proposals would expand the availability of the government option through the exchanges.¹²⁹ Others, as outlined in the Medicare for America Act¹³⁰ and the Choose Medicare Act,¹³¹ would expand availability of the public option to employers outside the exchanges. The Medicare at 50 Act and the State Public Options Act would offer new groups access through existing government programs.

Fueled by its unfair advantages, the public option will not increase competition nor increase choice. As private alternatives are driven out by the appearance of lower premiums and generous benefits in the government plan, those left in a rapidly shrinking individual private health insurance market are likely to experience even higher premiums and even fewer health plan choices.¹³² Ultimately, it will drive competitors out of the market and enrollees into the government plan.

4. **Shift New Costs to the Federal Taxpayers.** There are a variety of ways the public option proposals would shift costs on to the federal taxpayer. While many of the proposals assume that the government premiums would cover benefits and administrative costs, it is unclear exactly how these proposals would be financially sustained over the long term.

All the bills foresee new federal spending for the public option. For example, the Medicare for America plan would allocate "such sums as may be necessary" from Treasury funds not otherwise obligated to operate the temporary public option and would authorize future

appropriations “as needed to maintain maximum quality, efficiency and access.”¹³³ The Medicare for America Act would also create an assortment of tax increases borne by federal taxpayers.¹³⁴

The Choose Medicare Act would appropriate \$2 million out of Treasury funds not otherwise obligated for initial operations and \$30,000,000,000 for its reinsurance program, and would authorize “such sums as may be necessary” for its Navigator program.¹³⁵ The Medicare-X Act would appropriate \$1,000,000,000 out of funds not otherwise obligated and authorize funding for its reinsurance program.¹³⁶ The CHOICE Act would authorize “such sums as may be necessary” for start-up funding, which in theory would be repaid by the Secretary, as well as other funds as may be necessary.¹³⁷ The Medicare at 50 Act would appropriate \$500,000,000 in grants for outreach entities. The State Public Option Act would have the federal government assume a larger share of the cost to administer the Medicaid program.¹³⁸

In the end, the political dynamics of such an arrangement are predictable: As private competitors leave the market, the public option absorbs more enrollees. Then, the resources to provide the promised benefits become scarce, and demand for more taxpayer dollars will intensify likely through the proverbial back door to keep the government plan afloat.¹³⁹

5. **Shift Other Costs to Providers of Care and Treatments.** These public option proposals create the illusion that the government plan offers a lower cost option. In reality, the true costs are shifted not only to taxpayer but also to providers. All the public option proposals impose non-market, government payment rates as a way to shift costs to providers; and they put patient access to private care and medical treatments at risk.

Some of the public option proposals would rely exclusively on Medicare payment rates to pay providers or reduce costs. This is the case with the Medicare-X Choice Act,¹⁴⁰ the CHOICE Act,¹⁴¹ and the Medicare at 50 Act.¹⁴² The Medicare for America Act¹⁴³ and the Choose Medicare Act¹⁴⁴ would use a hybrid system based on Medicare, Medicaid, or commercial plans in the ACA exchanges. The State Public Option Act assumes Medicaid payment rates, which are historically even lower than the relatively low Medicare payment rates.¹⁴⁵ In some

cases, the negative impact of these artificial government payment rates would be compounded by the prohibition of private contracting between patients and their physicians, outside of the government program. This restriction on personal freedom and privacy is an explicit feature of the Medicare for America Act¹⁴⁶ and the Choose Medicare Act,¹⁴⁷ and in the Medicare at 50 Act and State Public Option Act.

These public option proposals would also impose non-market, government pricing for prescription drugs. Virtually all of these bills would authorize the Secretary to “negotiate” directly with drug manufacturers and establish a government payment rate for prescription drugs. Some of the proposals go even further by creating a government fallback rate, as outlined in the Medicare for America Act, the Choose Medicare Act, and the CHOICE Act. Such triggers only make the “negotiations” even more one-sided, with the government threatening the power of a fallback payment.

Government “negotiation” over payment rates or prices does not normally resemble the kind of “give and take” negotiations that regularly take place between buyers and sellers within the private sector. Indeed, such government “negotiations” mean little when the main, or sole, purchaser of medical benefits and services *is* the government.

Government payment setting or price fixing, moreover, can also weaken patient access to care. The Veterans Administration’s government pricing model for pharmaceuticals offers an example of how government rate setting affects patient access. A recent report by Avalere, a national research firm, found that “24 of the top 50 non-vaccine [Medicare] Part B drugs are not on the U.S. Department of Veterans Affairs’ National Formulary.”¹⁴⁸

The government payment setting in Medicare also raises access concerns. The CMS Office of the Actuary and Medicare Trustees have repeatedly stressed that keeping even the current Medicare payment rates is on track to undermine access to care and the quality of care that would be available to senior citizens. As the 2019 Medicare Trustees report states:

By 2040, simulations suggest approximately 40 percent of hospitals, roughly two thirds of skilled nursing facilities, and nearly 80 percent of home health agencies would have negative total facility margins, raising the possibility of access and quality of care issues for Medicare beneficiaries.¹⁴⁹

Government-set payment rates have also led to access issues for patients in the Medicaid program. A 2019 study by MACPAC found that health care providers were less likely to accept new Medicaid patients than those privately insured.¹⁵⁰ Specifically, only 68 percent of general practice physicians accept new Medicaid patients, while 91 percent of general practice physicians accept new privately insured patients; only 37 percent of psychiatrists accept new Medicaid patients, while 62 percent accept new, privately insured patients; and 78 percent of pediatricians accept new Medicaid patients compared to 91 percent who accept new, privately insured patients.

Adopting a universal government price-setting model might make the public option plans appear less costly than private plans, but similar experience shows that it would undoubtedly have a negative effect on patient access to, and quality of, care.

The End Game: Government-Controlled Health Care for All

The original architects of the “public option” were clear in their objective: to deploy a government health plan in competition with private health plans in order to ultimately secure a single payer system of government-controlled health care.¹⁵¹

These proposals use measures that would drive out private competition, reduce choice, and increase costs for taxpayers.

As the government plan, with its statutory and regulatory advantages, consolidates enrollment and pushes out private competitors, the demand to keep the public option afloat will intensify. Rather than recognizing the failure of the public option to increase choice and competition, champions of more government control would likely pursue an even more robust, government-run a single payer model.

Public option proposals are gaining interest in Congress, and they are often presented as a less radical approach to single payer. While these proposals are sold as merely a government “option,” in reality, these public option proposals lay the groundwork for a single payer system on the installment plan.

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Endnotes

1. Medicare for All Act of 2019, S. 1129, 116th Cong., 1st Sess. <https://www.congress.gov/bill/116th-congress/senate-bill/1129/text> (accessed December 4, 2019). The bill has 14 Senate co-sponsors.
2. Medicare for All Act of 2019, H.R. 1384, 116th Cong., 1st Sess., <https://www.congress.gov/bill/116th-congress/house-bill/1384/text> (accessed December 4, 2019). The bill has 118 House sponsors, roughly half the entire Democratic membership of the U.S. House of Representatives.
3. Soon after, Professor Jacob Hacker, a Yale University political science professor, released another variation on the public option, and the general public option concept was adopted by candidate Senator John Edwards during the 2008 Democratic presidential primary. Helen A. Halpin and Peter Harbage, "The Origins and Demise of the Public Option," *Health Affairs*, Vol. 29, No. 6, (2010), pp. 1117–1124, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0363> (accessed December 4, 2019).
4. Helen Anne Halpin, "Getting to a Single Payer System Using Market Forces: The CHOICE Program," Robert Wood Johnson Foundation *Covering America Series*, 2003, <http://research.policyarchive.org/21872.pdf> (accessed December 4, 2019).
5. See Nina Owcharenko Schaefer and Robert E. Moffit, "The Obama Health Care Plan: More Power to Washington," Heritage Foundation *Backgrounders* No. 2197, October 15, 2008, <https://www.heritage.org/health-care-reform/report/the-obama-health-care-plan-more-power-washington>.
6. Quoted in Conn Carroll, "Still Not Convinced the Public Option Is a Trojan Horse for Single Payer?" *The Daily Signal*, August 3, 2009, <https://www.dailysignal.com/2009/08/03/still-not-convinced-the-public-option-is-a-trojan-horse-for-single-payer/>.
7. Even former Vice President Joseph Biden and House Speaker Nancy Pelosi (D-CA) endorsed this approach, although generally speaking, the public option would undermine employer-based health insurance, as well as the few private options available in the non-group market under the ACA. See Joseph Antos and James C. Capretta, "The Heavy Hand of the Public Option," *RealClearPolicy*, June 18, 2019, https://www.realclearpolicy.com/articles/2019/06/18/the_heavy_hand_of_the_public_option_111222.html (accessed December 4, 2019), and James C. Capretta, "A Public Option Would Cause More Problems for Obamacare's Private Insurers, and That's Probably the Point," *National Review*, August 25, 2016, <https://www.nationalreview.com/2016/08/obamacare-public-option-fix-will-further-undermine-private-insurance/> (accessed December 4, 2019).
8. The Medicare for America Act of 2019, H.R. 2452, 116th Cong., 1st Sess.
9. Co-sponsors as of this writing.
10. *Ibid.*, Title I, Subtitle A, § 101, and § 102.
11. *Ibid.*, Title I, Subtitle A, Sec. 103.
12. The Medicare for America Act of 2019, H.R. 2452, 116th Congress, 1st Sess., Title I, Subtitle A, § 104.
13. *Ibid.*, § 105 (a).
14. *Ibid.*, § 105.
15. *Ibid.*, § 105 (b)(3). In short, the government would compel doctors and other medical professionals to provide medical procedures that many, if not most, Americans would consider unethical or immoral.
16. *Ibid.*, § 106.
17. *Ibid.*, § 106 (d).
18. As defined in CFR Title 45, § 152.2.
19. The Medicare for America Act of 2019, H.R. 2452, 116th Cong., 1st Sess., Title I, Subtitle B, Part A, § 2202 (a).
20. In 2025, individuals enrolled in both Medicare and Medicaid would also be transferred to the government plan. *Ibid.*, § 2202 (b)(2).
21. *Ibid.*, § 2202 (b)(3).
22. Medicare Advantage for America plans would be available under new rules. See *ibid.*, Title I, Subtitle B, Part C.
23. *Ibid.*, Title I, Subtitle B, Part C, § 112 (b)(4). See also, Title I, Subtitle B, Part C, § 112.
24. For example, new rules on defining "qualified" employer-based coverage include requiring that the plan cover 80 percent of the actuarial value of Medicare, provide at least a 70 percent premium contribution, and cover dental, vision, and hearing benefits. For new rules on qualified employer coverage, see Targeted Reforms, *ibid.*, Title I, Subtitle C, § 126.
25. *Ibid.*, Title I, Subtitle B, Part C, § 112 (b)(4).
26. *Ibid.*, § 2202 (b)(3).
27. *Ibid.* § 2202(b)(1).
28. *Ibid.*, Title I, Subtitle B, Part A, § 2203 (a).
29. *Ibid.*, Title I, Subtitle B, Part A, § 2203 (d).
30. *Ibid.*, Title I, Subtitle B, Part A, § 2204.

31. Ibid., Title I, Subtitle C, § 134.
32. Ibid., Title I, Subtitle B, Part A, § 2205.
33. Ibid., Title I, Subtitle B, Part A, § 2206 (b).
34. Ibid., Title I, Subtitle B, Part A, § 2205 (e) and (f).
35. Ibid., Title I, Subtitle B, Part A, § 2206 (c).
36. Ibid., Title I, Subtitle B, Part A, § 2206 (d).
37. Ibid., Title III.
38. A maintenance of effort requirement would be set by the states. See *ibid.*, Title I, Subtitle B, Part A, § 2209.
39. Ibid., Title I, Subtitle B, Part A, § 2207.
40. Ibid., Title I, Subtitle B, Part A, § 2208.
41. Ibid., Title I, Subtitle B, Part C.
42. Ibid., Title I, Subtitle C.
43. Ibid., Title I, Subtitle B, Part B.
44. Ibid., Title II.
45. Choose Medicare Act, S. 1261, 116th Cong., 1st Sess., and Choose Medicare Act, H.R. 2463, 116th Cong., 1st Sess.
46. Co-sponsors as of this writing.
47. Ibid., § 2 (c)(2).
48. Ibid., § 2 (b).
49. Ibid., § 9.
50. Ibid., § 10.
51. Ibid., § 2 (b).
52. Ibid., § 2 (c)(3).
53. Ibid., § 3.
54. Ibid., § 2 (d).
55. Ibid., § 6 and § 7.
56. Ibid., § 2 (e)(2). The bill also places emphasis on alternative payment models. See § 2 (f).
57. Ibid., § 5 and § 2 (g).
58. Ibid., § 2 (e)(3).
59. Ibid., § 2 (e)(4).
60. Ibid., § 8.
61. Ibid., § 2 (h).
62. Ibid., § 11.
63. Medicare-X Choice Act of 2019, S. 981, 116th Cong., 1st Sess., also Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess.
64. Co-sponsors at the time of this writing.
65. Ibid., § 2202.
66. Ibid., § 2201 (a)(2).
67. Ibid., § 2203. The Secretary would also set rates for additional services not covered by Medicare, and the Secretary may adopt innovative payment models for services provided under Medicare-X.
68. Ibid., § 2206.
69. Ibid., § 2206.
70. Ibid., § 4.
71. Ibid., § 2207. The bill also puts emphasis on “innovative payment models.” See § 2209.
72. See Sec. 5 for new Medicare Part D authority.
73. Ibid., § 2208.

74. *Ibid.*, § 2201.
75. *Ibid.*, § 3.
76. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., and Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, H.R. 2085, 116th Cong., 1st Sess.
77. Co-sponsors at the time of this writing.
78. *Ibid.*, § 2795 (b)(1).
79. *Ibid.*, § 2795 (c)(1).
80. *Ibid.*, § 2795 (b)(3).
81. *Ibid.*, § 2795 (c)(2).
82. *Ibid.*, § 2795 (c)(3).
83. *Ibid.*, § 2795 (d)(1).
84. Medicare at 50 Act, S. 470, 116th Cong. H.R. 1346 establishes a similar Medicare buy-in program as well as other provisions related to reinsurance, risk corridors, and cost-sharing enhancements.
85. Co-sponsors at the time of this writing.
86. *Ibid.*, § 1899C (a).
87. *Ibid.*, § 1899C (g)(4).
88. *Ibid.*, § 1899C (h).
89. *Ibid.*, § 1899C (c).
90. *Ibid.*, § 1899C (f).
91. *Ibid.*, § 3.
92. Explicitly excludes health insurance issuers and any entity that directly or indirectly receives consideration from an insurance issuer.
93. *Ibid.*, § 1899C (j).
94. *Ibid.*, § 1899C (i).
95. *Ibid.*, § 1899C (d).
96. State Public Option Act, S. 489, 116th Congress, 1st. Sess., and State Public Option Act, H.R. 1277, 116th Cong., 1st Sess.
97. Co-sponsors as of this writing.
98. *Ibid.*, § 2 (a).
99. *Ibid.*, § 2 (b).
100. *Ibid.*, § 6.
101. *Ibid.*, § 2 (e).
102. *Ibid.*, § 2 (d)(1). See also, Patient Protection and Affordable Care Act of 2010, Public Law No. 111-148, Title I, Subtitle C, Part I, § 2701.
103. If an individual is enrolled in the Medicaid buy-in program but is eligible through another route, the state may only impose premiums or cost sharing based on traditional Medicaid requirements. See *Ibid.*, § 2(d)(3).
104. *Ibid.*, § 2 (d)(4).
105. *Ibid.*, § 4.
106. *Ibid.*, § 5.
107. *Ibid.*, § 2 (c)(1).
108. *Ibid.*, § 3.
109. This number represents 178,350 with employer based coverage and 34,846 with direct purchase coverage. See U.S. Census Bureau, "Health Insurance Coverage in the United States: 2018," November 2019, Table 1, <https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf>.
110. "Medicare Extra: Universal Coverage for Less Than \$3 Trillion and Lower Health Care Costs for All," Center for American Progress, July 23, 2019, <https://www.americanprogress.org/issues/healthcare/reports/2019/07/23/472520/medicare-extra/>.
111. Lane Koenig et al., "The Impact of Medicare-X on Coverage Healthcare Use and Hospitals," KNG Health Consulting, March 12, 2019, p. ii, <https://www.aha.org/guidesreports/2019-03-11-impact-medicare-x-choice-coverage-healthcare-use-and-hospitals> (accessed December 5, 2019).

112. See scenarios 4–6 in Linda Blumberg et al., “From Incremental to Comprehensive Health Insurance Reforms: How Various Reform Options Compare on Coverage and Cost,” Urban Institute, October 2019, https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf (accessed December 5, 2019).
113. Scott Atlas, “Public Option Kills Private Insurance,” *The Wall Street Journal*, July 16, 2019, <https://www.wsj.com/articles/public-option-kills-private-insurance-11563309118> (accessed December 5, 2019).
114. Jonathan Gruber and Kosali Simon, “Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?” National Bureau of Economic Research *Working Paper* No. 12858, January 2007, <https://www.nber.org/papers/w12858.pdf> (accessed December 5, 2019).
115. Doug Badger and Jamie Bryan Hall, “Why Millions Are Still Uninsured Despite Government Intervention,” *The Daily Signal*, October 28, 2019, <https://www.dailysignal.com/2019/10/28/why-millions-are-still-uninsured-despite-government-intervention/>.
116. Medicare for America Act, H.R. 2452, 116th Cong., 1st Sess., Title I, Subtitle B, § 2206 (c)(1).
117. Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2208 (a) and (b).
118. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (d).
119. Choose Medicare Act, S. 1261, 116th Cong., 1st Sess., § 2201 (e)(3).
120. Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (a)(2).
121. State Public Option Act, S. 489, 116th Cong., 1st Sess., § 2 (a)(1)(A).
122. Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2208.
123. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (d).
124. Other proposals offer no explicit opt-out.
125. Medicare for America Act, H.R. 2452, Title I, Subtitle B, § 2202 (b)(2)(B) and (C).
126. The “navigator” described in the Choose Medicare Act, H.R. 6117, 115th Cong., 1st Sess., § 3 refers to navigators from the ACA, or individuals who “conduct public education activities to raise awareness of the availability of qualified health plans,” from the Patient Protection and Affordable Care Act 42 U.S. Code 18031 § 1311 (i)(3)(A).
127. The Medicare at 50 Act seeks to “carry out outreach, public education activities, and enrollment activities to raise awareness of, and encourage, enrollment under this section.” Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (j)(1)(A).
128. *Ibid.*
129. For example, the Medicare-X Choice Act of 2019, H.R. 2000, 116th Cong., 1st Sess., § 2203, and Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, 116th Cong., 1st Sess., § 2795 (b)(1)(D) would require the government plans to operate at both silver and gold levels.
130. Medicare for America Act of 2019, H.R. 2452, Title I, Subtitle B, § 2202 (b)(3)(C).
131. Choose Medicare Act, S. 1261, § 2201 (a).
132. Says CMS Administrator Seema Verma, “Access will be compromised for patients, and reimbursement cuts in the public plan will shift more pressure to employer sponsored plans to make up the difference, driving up costs for 180 million Americans with private insurance.” Cited in Nathaniel Weixel, “Trump Health Officials Bash Public Option as No Better than Medicare for All,” *The Hill*, July 22, 2019, <https://thehill.com/policy/healthcare/454145-verma-bashes-public-option-as-no-better-than-medicare-for-all> (accessed December 5, 2019). Also see Seema Verma, “I’m the Administrator of Medicare and Medicaid. A Public Option Is a Bad Idea,” *The Washington Post*, July 24, 2019, https://www.washingtonpost.com/opinions/a-public-option-for-health-insurance-is-a-terrible-idea/2019/07/24/fb651c1a-ae2e-11e9-8e77-03b30bc29f64_story.html (accessed December 4, 2019).
133. Medicare for America Act of 2019, H.R. 2452, Title I § 106, and Subtitle B, § 2207.
134. *Ibid.*, Title II.
135. Choose Medicare Act, S. 1261, § 2(h).
136. Medicare-X Choice Act of 2019, H.R. 2000, § 2201(b).
137. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, H.R. 2085, 116th Cong., 1st Sess., § 2(c)(3).
138. For example, the bill would create a 90 percent enhanced match rate for administration costs of the new Medicaid buy-in program and extend the ACA enhanced match rate for expansion states. See State Public Option Act, S. 489, 116th Cong., 1st Sess., § 4 and § 5. See also Medicare at 50 Act, S. 470, 116th Cong., 1st Sess., § 1899C (j)(4).
139. “Unlike a private Insurance plan, there’s no particular reason why a publicly run product couldn’t experience ongoing losses, so long as the law provided for direct or indirect taxpayer subsidization.” Capretta, “A Public Option Would Cause More Problems for Obamacare’s Private Insurers, and That’s Probably the Point.”
140. Medicare-X Choice Act of 2019, S. 981, 116th Cong., 1st Sess., § 2207 (b).

141. Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act, S. 1033, § 2795 (c)(2).
142. Medicare at 50 Act, S. 470, 116th Cong., 1st Sess. § 1899C (2).
143. Medicare for America Act, H.R. 2452, Title I, Subtitle B, § 2206 (b).
144. Choose Medicare Act, S. 1261, § 2201 (e)(2).
145. In 2016, Medicaid reimbursement rates were an average of 72 percent of Medicare payment rates. See Kaiser Family Foundation, “Medicaid-to-Medicare Fee Index,” <https://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> (accessed December 13, 2019).
146. Medicare for America Act of 2019, H.R. 2452, Title I, Subtitle B, § 2205.
147. Choose Medicare Act of 2019, S. 1261, Sec. 2 (e)(4).
148. Milena Sullivan and Ekemini Isaiah, “The VA National Formulary for Top Medical Benefit Drugs Is Narrower than Current Medicare Part B Drug Coverage,” Avalere, August 13, 2019, <https://avalere.com/insights/the-va-national-formulary-for-top-medical-benefit-drugs-is-narrower-than-current-medicare-part-b-drug-coverage> (accessed December 5, 2019).
149. *The 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medicare Insurance Trust Funds*, April 22, 2019, p. 180, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2019.pdf> (accessed December 5, 2019).
150. Kayla Holgash and Martha Heberlein, “Physician Acceptance of New Medicaid Patients,” Medicaid and CHIP Payment and Access Commission, January 2019, <https://www.macpac.gov/wp-content/uploads/2019/01/Physician-Acceptance-of-New-Medicaid-Patients.pdf> (accessed December 5, 2019).
151. Halpin, “Getting to a Single Payer System Using Market Forces: The CHOICE Program.”