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MEMORANDUM May 29, 2019

To: Senator John Barrasso
Attention: Jay Eberle

Subject: **Effect of S. 1129 on Certain Federally Funded Health Programs and Private Health Insurance**

Pursuant to your request,[1] this memorandum discusses the legal effect of S. 1129, the Medicare for All Act of 2019 (MFAA or Act) on various public and private health care programs or plans.[2] Specifically, the memorandum analyzes whether the MFAA would authorize the following programs or plans to continue in their current form:

- Medicare (including Medicare Advantage and Part D);
- Medicaid (including the Children's Health Insurance Program);
- TRICARE;
- Plans under the Employee Retirement Income Security Act; and
- Individual, Small and Large Group Market Coverage.

For reasons discussed in greater detail below, the Program created by the MFAA would, following a phase-in period and with some limited exceptions, largely displace these existing federally funded health programs as well as private health insurance. This memorandum begins with a description of the key provisions of the MFAA before turning to its legal effect on the programs and plans that are the subject of your request.

Medicare for All Act of 2019

The MFAA aims to establish a national health insurance program (Program) that would "provide comprehensive protection against the cost of health care and health-related services" in accordance with the standards set forth under the Act.[3] Specifically, under the Program, every resident of the United

[1] Information in this memorandum is drawn from publicly available sources and is of general interest to Congress. As such, all or part of this information may be provided by CRS in memoranda or reports for general distribution to Congress. Your confidentiality as a requester will be preserved in any case.

[2] S.1129, 116th Cong. (2019). All citations in this memorandum refer to the version of the bill as of May 29, 2019.

[3] *Id.* § 101.

States,[4] after a four-year phase-in period following the MFAA's enactment,[5] would be entitled to have the Secretary of Health and Human Services (Secretary) make payments on their behalf to an eligible provider for services and items in 13 benefits categories, provided they are "medically necessary or appropriate for the maintenance of health or diagnosis, treatment or rehabilitation of a health condition."[6] Except for prescription drugs and biological products, for which the Secretary may set a cost-sharing schedule that would not exceed $200 annually per enrollee and meet other statutory criteria, no enrollee would be responsible for any cost-sharing for any other covered benefits under the Program.[7] The bill would direct the Secretary to develop both a mechanism for enrolling existing eligible individuals by the end of the phase-in period and a mechanism for automatically enrolling newly eligible individuals at birth or upon establishing residency in the United States.[8]

All state-licensed health care providers who meet the applicable state and federal provider standards may participate in the Program,[9] provided they file a participation agreement with the Secretary that meets specified statutory requirements.[10] The Secretary would pay participating providers pursuant to a fee schedule that would be set in a manner consistent with the processes for determining payments under the existing Medicare program.[11] Participating providers would be prohibited from balance billing enrollees for any covered services paid under the Program,[12] but providers would be free to enter into private contracts with enrollees to provide any item or service if no claims for payment are submitted to the Secretary and the contracts meet certain statutory requirements.[13]

With respect to payment for covered pharmaceuticals, medical supplies, and medically necessary assistive equipment, the Secretary would negotiate their payment rate annually with the relevant manufacturers.[14] The bill would further direct the Secretary to establish a prescription drug formulary system that would encourage best practices in prescribing; discourage the use of ineffective, dangerous, or excessively costly medications; and promote the use of generic medications to the greatest extent possible.[15] Off-formulary

[4] *Id.* § 102(a). The bill would direct the Secretary to promulgate a rule setting forth the criteria for determining residency for eligibility purposes. *Id.*

[5] *Id.* § 106(a).

[6] *Id.* § 201(a). The 13 benefits categories include (1) inpatient and outpatient hospital care; (2) ambulatory patient services; (3) primary and preventive services; (4) prescription drugs, medical devices, and biological products; (5) mental health and substance abuse treatment services; (6) laboratory and diagnostic services; (7) comprehensive reproductive, maternity, and newborn care; (8) pediatrics services; (9) oral health, audiology, and vision services; (10) short-term rehabilitative and habilitative services and devices; emergency services and transportation; (11) emergency services and transportation; (12) necessary transportation to receive health care services for individuals with disabilities and low-income individuals; and (13) home and community-based long-term services and supports. *Id.*

[7] *Id.* § 202(a), (b).

[8] *Id.* § 105

[9] *Id.* § 302(a). The bill would direct the Secretary to develop and establish national minimum standards to ensure quality of services provided under the Program. *Id.* § 302(b).

[10] *Id.* § 301(a), (b).

[11] *Id.* § 611. The bill would also direct the Secretary to establish a standardized process for reviewing and updating the relative values of physicians' services under the fee schedule. *Id.* § 612.

[12] *Id.* § 202(c).

[13] *Id.* § 303(a)-(c).

[14] *Id.* § 614(a).

[15] *Id.* § 614(b)(1)-(2).

medications would be permitted under the Program, but their use would be subject to further regulations the Secretary issues.[16]

With respect to the Program's administration, the bill would authorize the Secretary to develop the relevant policies, procedures, guidelines, and requirements necessary to carry out the Program.[17] The Secretary would also establish and maintain regional offices—by incorporating existing regional offices of the Centers for Medicare & Medicaid Services where possible—to assess annual state health care needs, recommend changes in provider reimbursement, and establish a quality assurance mechanism in the state aimed at optimizing utilization and maintaining certain standards of care.[18]

To fund the Program, the bill would create a Universal Medicare Trust Fund.[19] Funds currently appropriated to Medicare, Medicaid, the Federal Employees Health Benefits Program (FEHBP), TRICARE, and a number of other federally funded health programs would be appropriated to the new fund.[20]

The MFAA also includes a number of other provisions related to the administration of the Program, including an enforcement provision aimed at preventing fraud and abuse,[21] provisions relating to quality assessment,[22] and provisions concerning budget and cost containment.[23]

Effect of the MFAA on Certain Federally Funded Health Programs and Private Health Insurance

Federally Funded Health Programs

The federal government currently funds a number of health programs, including (1) Medicare, which generally provides health insurance coverage to elderly and disabled enrollees,[24] (2) Medicaid, which is a federal-state cooperative program wherein states receive federal funds to generally provide health benefits to low-income enrollees,[25] (3) the Children's Health Insurance Program (CHIP), which is a federal-state cooperative program that provides health benefits to certain low-income children whose families earn too much to qualify for Medicaid but cannot afford private insurance;[26] (4) the FEHBP, which generally

[16] *Id.* § 614(b).

[17] *Id.* § 401.

[18] *Id.* § 403(a)-(c).

[19] *Id.* § 701(a).

[20] *Id.* § 701(b). Other relevant federally funded health programs whose funding would be redirected to the new Trust Fund include the maternal and child health program under title V of the Social Security Act; vocational rehabilitation programs, programs for drug abuse and mental health services under the Public Health Service Act; programs providing general hospital or medical assistance; and any other federal programs identified by the Secretary as providing for payment for health services that may be covered by the new national Program. *Id.* § 701(b)(2)(E).

[21] *Id.* § 411.

[22] *Id.* §§ 501-502.

[23] *Id.* § 601.

[24] *See* 42 U.S.C. § 1395 *et seq.* The existing Medicare program has four parts: Part A provides coverage for inpatient hospital services (§ 1395c *et seq.*), Part B provides coverage for outpatient medical services (§ 1395j *et seq.*), Part C provides Medicare Advantage plans offered by private insurers (§ 1395w-21 *et seq.*), and Part D provides prescription drug coverage (§ 1395w-101 *et seq.*). Under the MFAA, all existing Medicare benefits would be terminated upon the effective date of the Program. *See* S. 1129, § 901(a)(1).

[25] *See* 42 U.S.C. § 1396b, *et seq.*

[26] 42 U.S.C. § 2101 *et seq.*

provides health insurance coverage to civilian federal employees,[27] and (5) TRICARE, which provides civilian health insurance coverage to dependents of active military personnel and retirees of the military (and their dependents).[28] Following an initial phase-in period,[29] the MFAA would prohibit benefits from being made available under Medicare, FEHBP, and TRICARE while also prohibiting payments to the states for CHIP.[30] These payment prohibitions would effectively terminate these programs in their current form.[31] This reading is confirmed by § 701(b)(2) of the MFAA, which redirects funding for these programs to the national Program.

With respect to Medicaid, the MFAA would significantly limit its scope. After the MFAA's effective date, Medicaid would only continue to cover services that the new national Program would not otherwise cover.[32] Thus, Medicaid benefits for institutional long-term care services (which are not among the 13 categories of covered services under the MFAA) and any other services furnished by a state that the Program would not cover, would continue to be administered by the states.[33] The bill would direct the Secretary to coordinate with the relevant state agencies to identify the services for which Medicaid benefits would be preserved and to ensure their continued availability under the applicable state plans.[34]

Private Health Insurance

Currently, private health insurance in the United States consists of (1) private sector employer-sponsored group plans, which can be self-insured (i.e., funded directly by the employer) or fully insured (i.e., purchased from insurers), and (2) group or individual health plans sold directly by insurers to the insured (both inside and outside of health insurance exchanges established under Section 1311 of the Affordable Care Act).[35] The MFAA would prohibit employers from providing, and insurers from selling, any health plans that would "duplicate[]the benefits provided under [the MFAA]."[36] Given that the benefits offered under many existing private health plans would likely overlap with—i.e., be the same as—at least some

[27] *See* 5 U.S.C. § 8901 *et seq.*

[28] *See* 10 U.S.C. §§ 1079, 1086.

[29] All individuals who would be eligible for the Program—whether they are currently covered under a federally funded program or a private health plan—would have four years after the MFAA's enactment to transition into the Program. S. 1129, § 106(a). During that interim period, the eligible individuals would have two transitional options. First, all eligible individuals would have the option to purchase through the health insurance exchanges a public health plan that the Secretary establishes for transitional purposes. *Id.* § 1002. Additionally, eligible individuals who are U.S. citizens or legal permanent residents, and who meet certain age requirements, would have the option to buy into the existing Medicare program, which would be expanded by lowering the qualifying age. *Id.* § 1001.

[30] *Id.* § 901(a)(1) (terminating benefits under Medicare); § 901(a)(1)(C) (terminating benefits under the State Children's Health Insurance Program); § 901(b) (terminating benefits under the FEHBP); § 901(c) (terminating benefits under TRICARE).

[31] *Cf.* Guadamuz v. Ash, 368 F. Supp. 1233, 1241 (D.D.C. 1973) (noting that "Congress . . . may . . . decide to terminate a program before its authorization has expired, either indirectly by failing to supply funds through a continuing resolution or appropriation, or by explicitly forbidding the further use of funds for the programs").

[32] *See* S. 1129, § 901(a)(1)(B), § 901(a)(3)(A).

[33] *Id.* § 901(a)(3)(A).

[34] *Id.* § 901(a)(3)(B). In addition to these Medicaid benefits, the MFAA would also maintain the medical benefits and services provided to veterans under Title 38 of the U.S. Code and the medical benefits and services that the Indian Health Service currently administers. *Id.* § 901(d).

[35] *See* CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, coordinated by Bernadette Fernandez, at 1-2; *see also* CRS In Focus IF10830, *U.S. Health Care Coverage and Spending*, by Ryan J. Rosso (noting that private insurance, comprised of the group market (including employer-sponsored insurance) and the individual market, is the predominant source of health insurance coverage in the United States that, together, cover approximately 68.5% of the U.S. population based on data from 2008-2017).

[36] *See* S. 1129, § 107(a).

of the benefits within the Program's 13 categories of covered benefits,[37] those existing health plans would likely "duplicate" the benefits provided under the MFAA.[38] Thus, this prohibition of duplicate coverage would effectively eliminate those existing private health plans.[39] Employers and insurers, however, would be allowed to offer as benefits or for sale supplemental insurance coverage for any *additional* benefits not covered by the Program.[40] As a result, employers and insurers could offer, for instance, coverage for institutional long-term care services, which are not among the 13 categories of covered services.

[37] *See, e.g.*, 42 U.S.C. § 18022 (requiring small group and individual health plans to provide 10 categories of "essential health benefits" that overlap with the 13 categories of covered services under the MFAA).

[38] *See, e.g.*, MERRIAM-WESTER.COM, https://www.merriam-webster.com/dictionary/duplicate (defining "duplicate" as "being the same as another").

[39] To the extent the word "duplicate" also means "to make an exact copy of something," it is conceivable that one could argue that the prohibition on duplicative coverage under § 107(a) of the MFAA only prohibits employers and insurers from offering plans that exactly replicate the same 13 categories of covered benefits. *See, e.g.*, CAMBRIDGE DICTIONARY, https://dictionary.cambridge.org/us/dictionary/english/duplicate. Under this construction, it is likely that a relatively small number of plans would be affected, given the coverage that would be provided by the national Program is more comprehensive than that provided under many existing health plans. *See, e.g.*, 42 U.S.C. § 18022 (covering only 10 categories of "essential health benefits").This reading of the law, by allowing those health plans to survive, would be difficult to reconcile with the exception carved out under § 107(b), which would permit "the sale of health insurance coverage for any additional benefits not covered by [the MFAA]." Accordingly, this explicit allowance for only *additional* benefits not covered by the Program suggests that the prohibition under subsection (a) is intended to extend to all plans that cover any of the same benefits that the Program would cover. *Cf.* FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 133 (2000) ("A court must . . . interpret the statute as a symmetrical and coherent regulatory scheme, and fit, if possible, all parts into an harmonious whole." (internal quotations and citations omitted)).

[40] *Id.* § 107(b).