Updated as of 5/15/2019

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress

	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
	Sanders	**Jayapal**	**DeLauro and Schakowsky**	**Cardin**	**Merkley/ Richmond**	**Bennet and Kaine/Delgado**	**Schakowsky/ Whitehouse**	**Stabenow**	**Higgins**	**Schatz/ Luján**
Title & Bill Number	S.1129, Medicare for All Act of 2019	H.R. 1384, Medicare for All Act of 2019	H.R. 2452, Medicare for America Act of 2019	S. 3, Keeping Health Insurance Affordable Act of 2019	S. 1261 / H.R. 2463, Choose Medicare Act	S. 981 / H.R. 2000, Medicare-X Choice Act of 2019	H.R. 2085 / S. 1033 The CHOICE Act	S. 470, Medicare at 50 Act	H.R. 1346, Medicare Buy-In and Health Care Stabilization Act of 2019	S. 489 / H.R. 1277, State Public Option Act
OVERVIEW										
Role of Public Plan	Single federal program with comprehensive benefits for all US residents Tax financed (no premiums, limited cost sharing) Replaces all private insurance, Medicaid, Medicare and CHIP for covered benefits	Single federal program with comprehensive benefits for all US residents Tax financed (no premiums or cost sharing) Replaces all private insurance, Medicaid, Medicare and CHIP for covered benefits	Federal public program with comprehensive benefits for all US residents. Individuals can opt out for qualified employer-sponsored health plans and certain other coverage No premiums or cost-sharing below 200% FPL, with income-related premium and cost sharing for public program above 200% FPL Replaces marketplaces, individual health insurance, current Medicare, Medicaid, and CHIP. Employers can continue to offer qualified group plan coverage, or pay 8% of payroll for employee coverage in Medicare for America; Individuals eligible for qualified coverage can opt for Medicare for America. Public program also provides private Medicare Advantage for America plan option	Federal public plan option offered to individuals eligible to participate in marketplace Marketplace subsidies unchanged Retains current sources of private and public coverage	Federal public plan option offered to individuals eligible to participate in marketplace, and to large and small employers Marketplace subsidies enhanced for all participants Retains current sources of private and public coverage	Federal public plan option offered to individuals eligible to participate in marketplace Marketplace subsidies enhanced for all participants Retains current sources of private and public coverage	Federal public plan option offered to individuals eligible to participate in marketplace Marketplace subsidies unchanged	Option for individuals 50 and over to buy into Medicare Marketplace subsidies unchanged; and comparable subsidies apply to Medicare Buy-in enrollees can also buy Medicare Advantage plans Current sources of private and public coverage continue	Option for individuals 50 and over to buy into Medicare Marketplace cost sharing subsidies enhanced for all participants; and comparable subsidies apply to Medicare Buy-in enrollees can also buy Medicare Advantage plans Current sources of private and public coverage continue	State option to offer public plan option based on Medicaid Marketplace subsidies unchanged; state flexibility to further reduce premiums and cost sharing for Medicaid buy-in Current sources of private and public coverage continue
ELIGIBILITY										
Individuals	All US residents, as defined by the Secretary	All US residents, as defined by the Secretary	All US residents, as defined by the Secretary; must include lawfully present immigrants and immigrants eligible for emergency services under Medicaid	All individuals eligible to participate in the marketplace	All US residents who are not eligible for Medicaid, not entitled to the current Medicare program, or not enrolled in CHIP are eligible to enroll in public plan called Medicare Part E	All individuals eligible to participate in the marketplace (citizens, lawfully admitted permanent residents, not incarcerated) and not otherwise eligible for Medicare	All individuals eligible to participate in the marketplace (citizens, lawfully admitted permanent residents, individuals who are not incarcerated)	Individuals ages 50 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	Individuals ages 50 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	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

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						Medicare-X offered to individuals in the marketplace beginning in 2021 in areas with one issuer or high costs due to provider shortages, then in all areas by 2024		under Medicare Parts A or B States are prohibited from purchasing Medicare buy-in coverage on behalf of full-benefit Medicaid enrollees ages 50-64	under Medicare Parts A or B States are prohibited from purchasing Medicare buy-in coverage on behalf of full-benefit Medicaid enrollees ages 50-64	enrolled in other health coverage
Employers	Not applicable	Not applicable	Small employers (fewer than 100 workers or payroll less than $2 million) may participate beginning in 2023; large employers may participate beginning in 2027 Individuals whose employers offer qualified coverage can choose to enroll in that coverage or in Medicare for America Secretary shall set standards to prevent employers from inducing sicker individuals to elect Medicare for America Beginning in 2027, large employers must offer qualified coverage to their full-time employees or pay 8% of annual payroll to the Medicare Trust Fund Qualified employer coverage includes: (1) any plan established by a governmental employer (2) any other employer plan that includes vision, dental and hearing benefits, with an actuarial value equivalent to at least 80% of	No provision	Employers (large and small firms) can offer Medicare Part E option to their employees. Secretary also authorized to act as third party administrator for self-insured group plans Individuals enrolled in Medicare Part E through employer-sponsored plans may remain enrolled after termination of employment relationship	Small employers and their employees and dependents have access through the SHOP Exchange Medicare-X offered to small groups beginning in 2025	No provision	No provision	No provision	No provision

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			Medicare for America coverage, and for which employer contributes at least 70% of the premium Bill does not specify that qualified employer plans cover benefits identical to those under Medicare for America							
ENROLLMENT										
Duration	Lifetime enrollment	Lifetime enrollment	Enrollment in Medicare for America begins in 2023 and is for lifetime, except that individuals may opt out for a program year when they have other qualified coverage	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 generally for one year at a time	Enrollment generally for one year at a time. The Secretary shall establish enrollment and coverage periods in coordination with the marketplace and with Medicare Advantage and Medicare Part D plans	Enrollment generally for one year at a time	Enrollment generally for one year at a time
Enrollment Process	Auto-enrollment of newborns at birth; Secretary shall provide for enrollment of others Benefits begin 4th year after enactment, children have option to begin enrollment in year one	Auto-enrollment at birth or upon establishment of US residency Enrollment at site-of-service for other individuals Enrollment for all individuals begins two years after date of enactment. Children under age 19 and adults age 55 and older have option to enroll earlier, beginning one year after date of enactment	Auto-enrollment of newborns at birth; Secretary shall establish process for auto-enrollment of others beginning in 2023 Medicare for America participating providers shall facilitate enrollment and States shall serve as enrollment entities Auto-enrollment process must include ability for individuals to opt out of Medicare for America if they enroll in qualified coverage under an employer-sponsored plan, Veterans health care, Indian Health Service, or FEHBP for a program year From 2023-2026, ability to opt-out applies, and phases out, for dual eligibles and those	Public health insurance option offered exclusively through the marketplaces Follows ACA marketplace 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	Medicare-X offered through the individual and SHOP marketplaces Follows ACA marketplace and SHOP enrollment procedures and rules	Public plan offered only through the marketplace Follows ACA marketplace enrollment procedures and rules	Enrollment will be coordinated with marketplace and Medicare enrollment periods. Secretary may expand enrollment period, if appropriate Eligible individuals can enroll in Medicare buy-in option for people 50-64 (Parts A, B and D, similar to traditional Medicare) or in Medicare Advantage plans Eligible individuals continue to have option to enroll in private coverage and could do so during the marketplace open enrollment period	ACA enrollment periods, marketplace procedures and rules apply for Medicare buy-in option Eligible individuals can enroll in Medicare buy-in option for people 50-64 (Parts A, B and D, similar to traditional Medicare) or in Medicare Advantage Prescription Drug plans (MA-PD) The Medicare buy-in plan and Medigap policies for the Medicare buy-in population would be offered on the marketplace website 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

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			enrolled in Medicaid and CHIP							
BENEFITS AND COST SHARING										
Benefits	All medically necessary services in 13 benefit categories, including home and community-based long-term services and supports (LTSS), dental, hearing, vision, comprehensive reproductive services (Hyde limits repealed), EPSDT, and transportation to health services for individuals with disabilities and low-income individuals Institutional long-term services and supports (LTSS) covered under Medicaid Secretary makes national coverage determinations for experimental items, services and drugs Items and services not provided in accordance with practice guidelines will be deemed to be in accordance if the health care provider exercised appropriate professional discretion to deviate from the guideline States may provide additional benefits at state expense	All medically necessary or appropriate services in 14 benefit categories including institutional and community-based long-term services and supports, dental, hearing, vision, comprehensive reproductive services (Hyde limits repealed), EPSDT, and transportation to receive health care services for people with low incomes and people with disabilities Secretary reviews benefits at least annually and makes recommendations to Congress regarding improvements Secretary makes national coverage determinations for experimental items, services and drugs Items and services not provided in accordance with practice guidelines will be deemed to be in accordance if the health care provider demonstrates appropriate professional judgement, provided in the best interest of patients, and consistent with patient wishes States may provide additional benefits at state expense	Comprehensive benefit package including ACA 10 essential health benefits, dental, hearing, vision, abortion (no Hyde limitations), infertility services, gender-confirming procedures, home and community based LTSS, nursing facility care, EPSDT for children, non-emergency medical transportation, and any other service covered by any state Medicaid program on the date of enactment No lifetime or annual limits apply Prior authorization and step therapy is prohibited under Medicare for America, Medicare Advantage for America plans, and qualified employer plans States may provide additional benefits at state expense	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. Hyde limitations do not apply and state laws restricting coverage of abortion and reproductive health services under QHPs and Medicare Part E are preempted	ACA 10 essential health benefits	Comprehensive benefit package that meets the health care needs of patients and includes ACA 10 essential health benefits State laws prohibiting qualified health plans from covering abortion are preempted for the public health insurance option Any provision of law restricting use of Federal funds with respect to any reproductive health service shall not apply to public health insurance option	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

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Cost Sharing	No cost sharing, except Secretary has authority to require cost sharing for prescription drugs and biologics, not to exceed $200/year, indexed for inflation; cost sharing must encourage use of generic drugs, cannot apply to preventive drugs, and cannot be imposed on individuals with household income at or below 200% FPL. Secretary may exclude the cost of brand drugs from calculating the out-of-pocket limit, if a generic version of that brand is available	No cost sharing	Income-related cost sharing generally applies No cost sharing for people with income below 200% FPL 20% coinsurance applies up to annual out-of-pocket (OOP) limit of $3,500/individual or $5,000/family. OOP limit for individuals with household income between 200% and 600% FPL increases on a linear sliding scale OOP limit indexed annually to CPI-medical No cost sharing for preventive services, maternity care, pediatric services, long-term care, or services for individuals who are frail or have special needs No deductible Secretary shall establish a default monthly payment plan to ensure cost sharing owed by enrollees can be spread out evenly throughout the year	Cost sharing follows ACA marketplace rules Annual out-of-pocket limit applies ($7,900 in 2019) Public health insurance option shall be offered at Bronze, Silver and Gold levels; may also be offered at Platinum level	Public plan offered at Gold level Annual out-of-pocket limit applies ($7,900 in 2019) Sets benchmark plan at Gold level for all marketplace participants	Cost sharing follows ACA marketplace rules Annual out-of-pocket limit applies ($7,900 in 2019) Medicare-X offered at ACA Silver and Gold 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 follows ACA marketplace rules Annual out-of-pocket limit applies ($7,900 in 2019) Public plan offered at the Silver and Gold levels; Secretary may offer at Bronze level	Cost sharing same as under current Medicare for covered benefits No annual limit on out-of-pocket cost sharing, unless enrolled in Medicare Advantage plan, or if ACA cost-sharing subsidies apply (see below) Individuals who voluntarily enroll in Medigap would have limited exposure to out-of-pocket costs for covered benefits	Cost sharing same as under current Medicare for covered benefits No annual limit on out-of-pocket cost sharing, unless enrolled in Medicare Advantage plan, or if ACA cost-sharing subsidies apply (see below) Individuals who voluntarily enroll in Medigap would have limited exposure to out-of-pocket costs for covered benefits	Cost sharing set by state to be actuarially fair Annual out-of-pocket limit cannot exceed the ACA limit ($7,900 in 2019)
PREMIUMS AND PREMIUM SUBSIDIES/TAX CREDITS										
Premiums	No premiums	No premiums	No premiums for people below 200% of poverty Premium for individuals with household income between 200% and 600% FPL increase on a linear sliding scale up to 8% of income Individuals with income above 600% FPL pay lower of 8% of income or	Premium for public health insurance option set by Secretary to cover 100% of benefits and administrative costs plus contingency margin Premium can vary only by factors allowed by ACA rating rules (age up to 3:1, geography, family size, and tobacco use)	Premiums for Medicare Part E would be set by the 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, geography, family size, and tobacco use) and whether plan is offered in the individual,	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) Single risk pool requirement is specified	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	Single, national premium set at average annual per capita amount for benefits and administrative costs for the buy-in population, based on average per capita costs for expenses under Parts A, B and D	Premium set to cover 100% of benefits and administrative costs for the buy-in population, based on average per capita costs for expenses under Parts A, B and D No adjustment for family status or tobacco use	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)

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			full premium amount. Secretary will determine full premium amount, adjusted by family size Current Medicare beneficiaries as of date of enactment pay the lesser of the current Part B premium or the applicable Medicare for America premium Individuals who opt in to Medicare for America from qualified employer coverage pay the lesser of the income-related premium, or the full Medicare for America premium reduced by the dollar amount their employer would have contributed toward their qualified coverage		small group, or large group market Extends ACA rating rules to large group market Gives Secretary of HHS authority to deny unreasonable rate increases in states where state regulators do not take action to correct unreasonable rate increases Extends ACA rate review to grandfathered health plans		up to 3:1, geography, family size, tobacco use) Public plan exempt from state premium taxes	No adjustment for age, geography, family status or tobacco use Buy-in enrollees who select Medicare Advantage or Part D prescription drug plans with premiums above the average would be required to pay additional amount	Premium for buy-in plan shall be adjusted for geography. Secretary may adjust premiums by age Buy-in enrollees who select Medicare Advantage or Part D prescription drug plans with premiums above the average would be required to pay additional amount	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	Not applicable	ACA premium subsidies apply	ACA premium subsidies apply	ACA premium subsidies apply	ACA premium subsidies apply	ACA premium subsidies generally apply to the Medicare buy-in plan Secretary shall determine amount of marketplace subsidies that would have been made on behalf of an individual Amounts will be transferred to a new Medicare Buy-In Trust Fund, and used to provide financial assistance that is substantially similar to what enrollees would have received in the marketplace Secretary shall determine the applicable second-lowest-cost Silver plan for purposes of determining premium tax credit amounts for	ACA premium subsidies generally apply to the Medicare buy-in plan Secretary shall determine amount of marketplace subsidies that would have been made on behalf of an individual Amounts will be transferred to a new Medicare Buy-In Trust Fund, and used to provide financial assistance that is substantially similar to what enrollees would have received in the marketplace	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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								buy-in individuals. Coverage under the Medicare buy-in shall not be taken into account as a Silver marketplace plan in determining the applicable second-lowest-cost Silver plan		
Changes to ACA Premium Subsidies	Not applicable During transition, marketplace subsidies enhanced (see below)	Not applicable During transition, marketplace subsidies enhanced (see below)	Not applicable During transition, marketplace subsidies enhanced (see below)	Expands premium tax credit eligibility to income 100%-600% FPL and extends cap on tax credit reconciliation/repayment to all income levels	Enhances tax credits for all marketplace plans by changing benchmark plan from second-lowest cost Silver to second-lowest cost Gold plan Expands premium tax credit eligibility to income 100%-600% FPL and increases income threshold for cap on tax credit reconciliation/ repayment to 600% FPL	Expands premium tax credit eligibility to people with income above 400% FPL by capping their required contribution for the benchmark plan to 13% of income; also enhances tax credit amount for people at lower income levels Caps tax credit reconciliation/repayment amount for people with income above 400% FPL to no more than $5,000	No provision	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	Not applicable	CSR subsidies apply to Silver-level plan options	CSR subsidies apply to Gold-level plan options	CSR subsidies apply to Silver-level plan options	CSR subsidies apply to Silver-level plan options	CSR subsidies generally apply to Medicare buy-in plan Secretary shall determine amount of marketplace subsidies that would have been provided to each buy-in enrollee (see applicability of APTC subsidies, above) and provide financial assistance that is substantially similar to what enrollees would have received in the marketplace	CSR subsidies generally apply to Medicare buy-in plan Secretary shall determine amount of marketplace subsidies that would have been provided to each buy-in enrollee (see applicability of APTC subsidies, above) and provide financial assistance that is substantially similar to what enrollees would have received in the marketplace	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 Marketplace CSRs enhanced during transition period, see below	Not applicable CSRs enhanced for a public plan option during transition period, see below	Not applicable Marketplace CSRs enhanced during transition period, see below	No provision	Effective 1/1/2020, enhances CSR subsidies for marketplace participants by applying them to Gold-level plans and changes actuarial	No provision	No provision	No provision	Enhances CSR subsidies for all marketplace participants by increasing actuarial values for CSR Silver plans as follows:	No provision

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					values for CSR Gold plans as follows: • 100-133% FPL: 94% AV • 133-150% FPL: 92% AV • 150-200% FPL: 90% AV • 200-300% FPL: 85% AV • Above 300% FPL: AV remains at 80% (Current law sets AV for CSR 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)				• 100-200% FPL: 95% AV • 200-300% FPL: 90% AV • 300-400% FPL: 85% AV • Above 400% FPL: AV remains at 70% (Current law sets AV for CSR 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 and certified providers who meet applicable provider standards and file a participation agreement can participate Federal standards that apply under the current Medicare program and those pertaining to non-discrimination and quality, and requirements to submit data and other information also apply Private contracting between institutions or individual providers for covered services is permitted, subject to specified requirements and limitations States may set additional standards	All state-licensed and certified providers who meet applicable provider standards and file a participation agreement can participate Federal standards that apply under the current Medicare program and those pertaining to non-discrimination, quality, and ethics, and requirements to submit data and other information also apply Entities or providers that do not provide items and services directly to individuals may not participate Private contracting between participating providers and individuals only permitted for non-covered services or for ineligible individuals	Medicare and Medicaid participating providers shall participate in Medicare for America Secretary shall establish process for other providers to participate Student loan forgiveness program established for participating providers New federal minimum nursing staffing requirements apply to all hospitals Private contracting between health care providers or institutions and individuals enrolled in Medicare for America for covered services is prohibited	Medicare participating providers and facilities also participate in the public health insurance option; Secretary shall establish a process to allow health care providers to opt out of the public plan Secretary shall develop process to allow additional providers to participate in public health insurance option	Medicare participating providers and facilities shall also participate in Medicare Part E Secretary shall allow additional providers to participate in Medicare Part E	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 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; providers must be licensed or certified under state law	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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		Private contracting between non-participating institutions or individual providers for covered services is permitted, subject to specified requirements and limitations States may set additional standards								
Balance Billing	Balance billing is prohibited	Balance billing is prohibited	Balance billing is prohibited in Medicare for America (including in Medicare Advantage for America plans) and in qualified employer plans that use Medicare for America provider rates Surprise medical bills prohibited in all private plans	Medicare balance billing limits apply	Medicare balance billing limits apply to Medicare Part E	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	To the extent proposal adopts same protections as are applied to current Medicare program with respect to benefits and payment rules, Medicare limits on balance billing would apply	To the extent proposal adopts same protections as are applied to current Medicare program with respect to benefits and 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	Payments established through global budget process and negotiations Hospitals/facilities paid quarterly lump sum to cover operating expenses under a global budget; amount of payments determined by annual negotiation between institutions and regional office director, taking into account multiple factors, including historical expenditures, data on costs, changes in volume, other factors Physicians/clinicians in general paid fee-for-service based on a fee schedule determined by the Secretary, taking into account current Medicare fee schedule, expertise of providers, information from national data/tracking program	Secretary establishes payment rates based on rates that would have applied under current Medicare or Medicaid (whichever is higher) and are necessary to maintain network adequacy, except: Hospital payment rates shall be at least 110% of the higher of current Medicare or Medicaid rates and further increased in underserved areas Secretary shall provide for site-neutral payment for services furnished in hospital outpatient and physician offices Payment rates for primary care and behavioral health services shall be	For years 2020-2022, Medicare payment rates for services covered under Parts A and B will be used in public health insurance option Secretary may make adjustments for new providers/services not currently in Medicare, and for graduate medical education and disproportionate share hospital (DSH) payments Starting in 2023 and subsequently, Secretary shall set payment rates, and can establish process to adjust rates to ensure payment accuracy, efficiency, access to care, and affordability; subject to limit that overall payments should not exceed what would have	Secretary establishes 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 other insurers offering health insurance through the marketplaces; rates established at level necessary to maintain network adequacy Use of alternative payment models is encouraged	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, such as value-based payments, patient-centered medical home arrangements, that improve quality and reduce costs	Secretary negotiates provider payment rates for the public plan. If the Secretary is unable to reach a negotiated agreement with health care providers, Medicare payment rates will be used. Medicare rates modified to accommodate payment for pediatric and other services not otherwise covered under Medicare Parts A and B	Medicare payment rates used in the buy-in plan	Medicare payment rates used in the buy-in plan	All states required to pay primary care providers at least Medicare rates for the buy-in plan and the current Medicaid program Medicaid rate used for other providers

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		and subject to annual review	increased by at least 30% As a condition of participation in Medicare for America, providers must accept Medicare for America payment rates paid by employer plans and by Medicare Advantage for America plans	been spent under current law payments Secretary may use innovative payment mechanisms to determine payments for services covered under the public health insurance option to promote care that is integrated, efficient and affordable among other outcomes						
PAYMENTS TO PLANS										
Payments to Plans	Not applicable	Not applicable	Secretary pays Medicare Advantage for America (MAA) plans a capitated amount equal to 95% of average Medicare for America costs in a county. MAA plans may charge individuals a separate premium for supplemental benefits or if the MAA plan is more expensive Bonus payments prohibited for MAA plans	No provision	No provision	No provision	No provision	No provision	No provision	No provision
PRESCRIPTION DRUG PRICES AND OTHER COST CONTAINMENT MEASURES										
Prescription Drug Prices	Secretary negotiates drug prices annually, and establishes a formulary for the Medicare for All program that discourages the use of ineffective, dangerous or excessively costly medications when better alternatives are available and promotes use of generic drugs. Off-formulary drugs covered subject to rules established by Secretary	Secretary negotiates prices with drug manufacturers for covered drugs taking into account comparative clinical effectiveness, budgetary impact, number of similar or alternative treatments, total revenue from global sales for such drug, and associated investment in research and development If negotiations are not successful, the Secretary shall authorize the use of any patents, data or	Secretary negotiates drug prices for Medicare for America and Medicare Advantage for America plans. If unsuccessful, Secretary has authority to license another company to offer that drug at a lower price A Prescription Drug and Medical Device Review Board is established to determine and prohibit excessive charges by any manufacturer. Board has authority to collect data and enforce against violations,	Secretary is authorized to negotiate drug prices for the Medicare program and the public health insurance option, but is prohibited from requiring a particular formulary or price structure Medicare beneficiaries would be guaranteed at least three Part D plans, including a national prescription drug plan sponsored by the Secretary and at least two qualifying plans (one	Secretary is authorized to negotiate drug prices for Medicare Part E and current Medicare program, with fall back to the lesser of prices paid by the VA or federal supply schedule if negotiations are not successful in obtaining an appropriate price as determined by the Secretary The Secretary determines which Part D drugs are appropriate for negotiation based on a number of factors, such	Secretary negotiates drug prices for Medicare-X and current Medicare program	Secretary negotiates drug prices for the public plan	Secretary is authorized to negotiate drug prices, by striking the "non-interference clause" in Title XVIII, for Medicare and the buy-in plan	Secretary shall negotiate drug prices for Medicare and the buy-in plan Part D sponsors would be permitted to obtain discounts or price reductions below the rate negotiated by the Secretary No authorization for the Secretary to establish a formulary, and no change in current law provisions that assure appropriate and	No provision

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress

	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
	Sanders	**Jayapal**	**DeLauro and Schakowsky**	**Cardin**	**Merkley/ Richmond**	**Bennet and Kaine/Delgado**	**Schakowsky/ Whitehouse**	**Stabenow**	**Higgins**	**Schatz/ Luján**
		exclusivity granted by the federal government for the manufacture of the drug, providing reasonable compensation to manufacturer holding the license Secretary is authorized to procure drugs directly During an interim period, the Program shall not pay more than the average of prices from the manufacturer to any wholesaler, retailer, provider, and others, including government entities in the 10 OECD countries that meet GDP and per capita income threshold levels Drug manufacturers are prohibited from engaging in anti-competitive behaviors	including with civil monetary penalties, excise taxes, and reduction in patent terms Direct-to-consumer advertising is prohibited for at least 3 years for drugs approved by FDA, and may be extended by Secretary in certain circumstances. Manufacturers may apply for waivers	of which must be a PDP) offered by at least two different entities. Establishes a base premium of $37 in 2021 for the national plan, indexed to growth in per capita Medicare drug spending Payments from qualified retiree health plans would count toward the true out-of-pocket limit (TrOOP) on Medicare enrollee drug spending, with conforming subsidy payments to sponsors of qualified health plans Requires drug manufacturers to provide rebates for drugs dispensed to Medicare beneficiaries also covered under Medicaid (dual eligible) and individuals eligible for Part D low-income subsidies. Rebate amounts would be excluded from Medicaid best price determination and AMP determination. Changes definition of covered Part D drug to include only those drugs from a manufacturer that enters into a rebate agreement	as spending on a per beneficiary basis, total spending on a given drug, initial launch price and other criteria				adequate access to drugs	
Other Cost Containment	Secretary annually establishes a global budget for all health expenditures, consisting of 7 components including operations, capital expenditures, quality assessment activities, health professional education, administrative costs, innovation, and prevention and public	Secretary annually establishes a global budget for all health expenditures, consisting of 8 components: program operations; capital expenditures; capital expenditures for rural/underserved areas; quality assessment activities; health professions education; administrative costs;	No provision	No provision	No provision	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	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	No provision	No provision	No provision

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress										
	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
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	health activities; Secretary shall also establish a reserve fund for epidemics, pandemics, natural disasters, and other health emergencies Allows for continuation of payment and delivery system reforms	reserve fund for disasters, epidemics; and prevention/public health activities				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 Authorizes funding for new grant program to permit experimentation with accountable communities for health models that integrate social needs in the delivery of health care				
CONSUMER ASSISTANCE										
Consumer Assistance	Establishes Office of Beneficiary Ombudsman to receive complaints, grievances, provide help filing appeals, submit recommendations on improvements to administration of program	Establishes Office of Beneficiary Ombudsman to receive complaints, grievances, provide help filing appeals, submit recommendations on improvements to administration of program	No provision	Secretary shall establish Office of the Ombudsman for the public health insurance option. Duties similar to Office of Medicare Ombudsman	Authorizes such sums as necessary 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	No provision	Appropriates $500 million per calendar year 2019 through 2021 for enrollment assistance for buy-in eligible individuals. Grants can also be used to help individuals apply for tax credits and CSR through the marketplace Buy-in enrollees also have access to the Medicare Beneficiary Ombudsman	Appropriates $500 million per calendar year 2019 through 2021 for enrollment assistance for buy-in eligible individuals Grants can also be used to help individuals apply for tax credits and CSR through the marketplace Buy-in enrollees also have access to the Medicare Beneficiary Ombudsman	No provision
CHANGES TO OTHER COVERAGE (MEDICARE, MEDIGAP, MARKETPLACE, MEDICAID AND VA/IHS)										
Changes to Current Medicare Program	Replaces current Medicare program Before full implementation of Universal Medicare, adds annual OOP cost-sharing limit to Medicare Parts A and B ($1,500), eliminates Parts A and B deductibles, and	Replaces current Medicare program. No benefits furnished under current Medicare program two years after the date of enactment, with provisions for continuation of benefits for persons receiving	Current Medicare is replaced by Medicare for America in 2023, except continues for individuals dually enrolled in Medicaid until 2025 Eliminates 24-month waiting period for Medicare coverage for	Authorizes Secretary to negotiate drug prices for Medicare Establishes a national prescription drug plan under Medicare Part D Applies Medicaid drug rebates for dual eligible and Medicare Part D	Secretary negotiates drug prices for Medicare Part D program; if negotiations are not successful in obtaining an appropriate price, The Secretary shall establish a price that is the lessor of the price paid by the	Authorizes Secretary to negotiate drug prices for Medicare Medicare-X will not affect benefits under the current Medicare program, or impact the Medicare trust funds	No provision Establishes a separate account in Treasury for public plan option	Authorizes Secretary to negotiate drug prices for Medicare 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 shall negotiate drug prices for Medicare, with no authorization to establish a formulary. Part D plans permitted to obtain discounts below negotiated price Nothing in this proposal would adversely affect eligibility or benefits for	No provision

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress

	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
	Sanders	**Jayapal**	**DeLauro and Schakowsky**	**Cardin**	**Merkley/ Richmond**	**Bennet and Kaine/Delgado**	**Schakowsky/ Whitehouse**	**Stabenow**	**Higgins**	**Schatz/ Luján**
	reduces Part D out-of-pocket threshold and eliminates cost sharing under Medicare Part D above the threshold. Also adds vision, hearing aids and exams, and dental benefits to Medicare Part B. Eliminates the 24-month waiting period for Medicare for people receiving SSDI payments Prohibits Medigap insurers from denying a policy, or discriminating in the pricing of a policy to an individual based on pre-existing conditions During transition, premiums paid for Medicare buy-in (see Transitional Coverage Program) would be deposited into the Medicare Hospital Insurance and Supplementary Medical Insurance Trust Funds. The Secretary would implement these provisions in a manner to have no effect on benefits for beneficiaries covered under the current Medicare program, and no negative effect on the Trust Funds	inpatient and other services Eliminates 24-month waiting period for Medicare coverage for individuals with disabilities (see below)	individuals with disabilities Makes changes to current Medicare Advantage plans: new network adequacy standards; prohibition on removing an in-network provider except for cause; prohibition on broker commissions; requirement to publish annual bid information online; repeal of bonus payments	low-income subsidy recipients	VA or under the Federal supply schedule. Adds annual OOP limit on cost sharing for benefits under Parts A and B at $6,700 in 2021 and indexed thereafter In calculating the OOP limit, the Secretary will consider expenses to be incurred by the individual without regard to whether the individual or another person, a state program, employer, Medigap policy, or a third party payer has paid the expenses				the current Medicare program, or the Medicare HI Trust Fund. The Secretary may adjust premiums for the buy-in population so that expenditures under Medicare do not rise due to the new buy-in option A new voluntary public Medigap option is established for beneficiaries in current Medicare program (and new Medicare buy-in program), to be administered by the Secretary (see Changes to Medigap and Supplemental Insurance)	
Changes to Medigap and Supplemental Insurance	No restrictions on the sale of health insurance for any non-covered benefits Before full implementation of Universal Medicare, prohibits Medigap issuers from denying	No restrictions on the sale of health insurance for any non-covered benefits	Not applicable	No provision	No provision	Not applicable	Not applicable	Eligible individuals can buy Medigap on a guaranteed issue basis each time they enroll in the Medicare buy-in plan	Eligible individuals can buy Medigap on a guaranteed issue basis each time they enroll in the Medicare buy-in plan A new public Medigap option is established for Medicare buy-in	No provision

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress										
	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
	Sanders	Jayapal	DeLauro and Schakowsky	Cardin	Merkley/ Richmond	Bennet and Kaine/Delgado	Schakowsky/ Whitehouse	Stabenow	Higgins	Schatz/ Luján
	policies, or discriminating in the pricing of policies, to individuals covered by Medicare due to pre-existing conditions								enrollees and for current Medicare beneficiaries Current Medicare beneficiaries would have a one-time initial enrollment period; individuals who subsequently become eligible for Medicare would have an individual enrollment period during their first 6 months of Medicare eligibility Enrollment in the public Medigap plan would be permitted at other times, subject to a late enrollment premium penalty. Penalty does not apply to periods of time covered under a retiree health benefit plan, a Medicare Advantage plan, or a PACE program Benefits shall not be medically underwritten or subject to pre-existing condition exclusion period Premiums for the public Medigap option will be set to cover costs, and community rated (not adjusted by age, geography or any other factor, other than a late enrollment penalty, if applicable)	
Changes to Other Marketplace Plans/Private Plans	Replaces private insurance (marketplace, employer, FEHB, TRICARE) Insurers may not sell policies, and employers may not provide benefits that duplicate covered benefits	Replaces private insurance (marketplace, employer, FEHBP, TRICARE) Insurers may not sell policies, and employers may not provide benefits that duplicate covered benefits	Surprise medical bill protections apply to all private plans, effective January 1, 2020 All group health plans are prohibited from using prior authorization for covered services or step therapy for covered prescription drugs,	No provision	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	Authorizes Secretary to establish a reinsurance mechanism to pool costs of highest cost patients on a nationwide basis Authorizes funding of $10 billion per year for each of fiscal years 2021, 2022, and 2023	No provision ACA “level playing field” requirement applies to public plan (must follow market rules applicable to other qualified health plans)	No provision	Enhances cost-sharing subsidies for marketplace plans Establishes reinsurance program for entire individual market The temporary ACA risk corridor program is reestablished for	No provision

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress

	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
	Sanders	**Jayapal**	**DeLauro and Schakowsky**	**Cardin**	**Merkley/ Richmond**	**Bennet and Kaine/Delgado**	**Schakowsky/ Whitehouse**	**Stabenow**	**Higgins**	**Schatz/ Luján**
	For first 5 years, up to 1% of global budget amount set aside to offset economic dislocation of workers in private health insurance system	For first 5 years, 1% of global budget amount set aside to offset economic dislocation of workers in private health insurance system	effective for plan years following date of enactment Marketplaces sunset January 1, 2023 Beginning in 2023, private insurers and plans – other than qualified employer health plans - are prohibited from selling coverage for Medicare for America benefits Private insurers can contract with Medicare for America to offer Medicare Advantage for America (MAA) plans to individuals Covered benefits and cost sharing for MAA plans must be identical to Medicare for America MAA plans are subject to the following requirements: network adequacy standards, removing participating providers except for cause prohibited, broker commission prohibited, use of prior authorization and step therapy prohibited		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 $30 billion to establish and administer reinsurance and affordability fund for the individual market for 3 fiscal years (2020-2022) Fund enables states to provide reinsurance to insurers to reduce individual market premiums or to provide other assistance to individuals in the marketplace to reduce out-of-pocket costs				calendar years 2019-2021	
Changes to Medicaid	Replaces Medicaid for most services. Retains Medicaid coverage for institutional LTSS, and any other benefits furnished by a state Medicaid program as of January 1, 2019 that are not covered by Universal Medicare, with a state maintenance of effort requirement for these services	Replaces Medicaid No state maintenance of effort specified	Within 90 days of date of enactment, all individuals on State waiting lists for Medicaid home and community-based services must be enrolled. Federal government appropriates such sums as necessary to facilitate enrollment Medicaid and CHIP are gradually replaced by	No provision	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 Requires the development of state-level metrics of access to and satisfaction with Medicaid providers and appropriates $200 million to support state

Side-by-Side Comparison of Medicare-for-all and Public Plan Proposals Introduced in the 116th Congress										
	Single Payer (Medicare-for-all)		**Public Program with Opt Out**	**Public Plan Option**				**Medicare Buy-In for Older Adults**		**Medicaid Buy-In**
	Sanders	**Jayapal**	**DeLauro and Schakowsky**	**Cardin**	**Merkley/ Richmond**	**Bennet and Kaine/Delgado**	**Schakowsky/ Whitehouse**	**Stabenow**	**Higgins**	**Schatz/ Luján**
	Increases the resource limit for eligibility for Supplemental Security Income (SSI), which expands eligibility for full Medicaid during the transition period as well as eligibility for Medicaid institutional LTSS under Universal Medicare		Medicare for America from 2025-2027 Federal matching payments for state Medicaid and CHIP programs are increased to pay the difference between Medicare for America provider payment rates and Medicaid and CHIP rates from January 1, 2023 to December 31, 2027 Beginning in 2028, State Maintenance of Effort (MOE) applies and must be satisfied for states to continue receiving other federal health funding, including maternal and child health grants, Ryan White grants, and others MOE payment set to reflect state's Medicaid and CHIP spending for the plan year before the date of enactment For 2029-2033, a state's MOE amount is indexed annually at rate of: • GDP per capita growth plus 0.4% for states that adopted ACA Medicaid expansion • GDP growth plus 0.7% for non-expansion states Beginning in 2033, index rate for all state MOE amounts is GDP per capita growth plus 0.7%							implementation of the metrics Extends 100% federal matching funds for three years to any state newly adopting the Medicaid expansion Adds comprehensive reproductive health services, including abortion services, as a mandatory Medicaid benefit
Changes to VA and Indian Health Service	Retains VA and the IHS	Retains VA and the IHS	No change	No provision	No provision	No provision	No provision	No provision	No provision	No provision

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	Single Payer (Medicare-for-all)		Public Program with Opt Out	Public Plan Option				Medicare Buy-In for Older Adults		Medicaid Buy-In
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COVERAGE DURING TRANSITION										
Transitional Coverage Program	During implementation phase in, establishes several transitional programs: Children under 19 have option of enrolling in Universal Medicare beginning January 1 of year following date of enactment or can remain in current coverage Option to buy into Medicare (or enroll in Medicare Advantage) established for certain adults not otherwise eligible for Medicare on a phased in basis (age 55 and older, 1 year after date of enactment; age 45, 2 years after date of enactment; age 35, 3 years after date of enactment) Premium for Medicare buy-in plan established to cover costs of benefits and administrative costs for Medicare Parts A, B and D benefits; marketplace subsidies can be applied. Individuals would not be eligible for Medicare cost-sharing assistance provided under Medicaid Also during transition, a public plan option (the Medicare Transition Plan) will be established and offered in marketplace. National premium established to cover costs; essential health benefits covered with platinum plan level cost sharing. Enhanced	For the year beginning one year after the date of enactment, a transitional Medicare buy-in plan will be offered through the marketplaces Covered benefits will be the same benefits available under Medicare-for-all; cost sharing for covered benefits will be set to achieve an actuarial value of 90% (similar to Platinum marketplace plan) Secretary will determine a premium for the transitional program; can vary by age, family status, and tobacco use but not geographically During transition, marketplace premium and cost sharing subsidies available for transitional Medicare buy-in plan; premium tax credits for transitional buy-in plan would be more generous than otherwise applied in the marketplace and available to individuals with income above 400% FPL and to those with income below 100% FPL in states that have not expanded Medicaid	For 2021 and 2022, a transitional public plan option will be offered to individuals through the exchange Individuals eligible to participate in the exchange may enroll Public plan will cover EHB plus abortion and all reproductive health services (state laws prohibiting abortion are preempted and Hyde limits do not apply) Premiums for public plan set to fully finance costs and will be adjusted geographically Marketplace subsidies continue for other QHPs and are enhanced; benchmark plan that determines tax credit amount will be based on second-lowest-cost Gold plan Different premium subsidies apply to the temporary public plan. Public plan enrollees with income below 200% FPL pay no premium. Premium increases on sliding scale until income of 600% FPL; no individual or household above 600% FPL will pay more than 8% of income for the public plan Public plan will be offered at Silver- and Gold-level; cost-sharing subsidies (CSRs) apply to the Gold-level public	Not applicable	Not applicable	No provision	No provision	Not applicable	Not applicable	Not applicable

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	marketplace premium and cost sharing subsidies apply to the Medicare Transition plan, including for poor individuals in states that do not expand Medicaid. Current Medicare providers and payment rates will be used by Medicare Transition plan During transitional period, Secretary shall ensure that individuals enrolled in private coverage are protected from disruptions in their care		plan and to Gold-level QHPs CSR subsidies are further enhanced by changing actuarial values as follows: • 100-200% FPL: 95% AV • 200-300% FPL: 90% AV • 300-400% FPL: 85% AV Medicare and Medicaid participating providers shall participate in transitional public plan Secretary shall establish payment rates based on Medicare rates that are necessary to maintain network adequacy. Secretary shall negotiate Rx prices for public plan and for Medicare Such sums as necessary are appropriated to finance any additional costs							
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 Separate White Paper describes other financing options	Appropriates to new Universal Medicare Trust Fund current federal health spending offsets (e.g., for Medicare, Medicaid, FEHB, TRICARE, ACA marketplace subsidies, other federal health programs), with amounts indexed to inflation in future years No provision for other financing sources	Medicare for America is financed by premiums paid by individuals and by 8% payroll tax paid by large employers that do not provide qualified coverage. Net increases in federal revenues attributable to enactment of Medicare for America will be transferred to the Medicare for America trust fund on an ongoing basis Current program receipts for Medicare and	Premiums for public health insurance option set to cover benefit and administrative costs Appropriates $2 billion in start-up costs, to be repaid over 10 years No provision for other financing sources	Premiums for Medicare Part E plan 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 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, except in case of certain innovative payment models	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 startup costs and initial 90-day claims reserve; startup funds repaid to the Treasury over 10 years	Premium for the Medicare buy-in plan set to cover benefit and administrative costs, and deposited into the Medicare Buy-In Trust Fund No provision for other financing sources	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 No provision for other financing sources	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

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			Medicaid program will be transferred to the Trust Fund State MOE payments for Medicaid In addition, new revenue from: • Repeal of 2017 Tax Cut Act • 5% income tax surcharge on individuals with income above $500,000 • Estate tax increased • Supplemental Medicare tax on high earners increased from 0.9% to 4% • Net investment income tax increased from 3.8% to 6.9% • Health Savings Account tax preference repealed • Flexible spending account tax preference limited to benefits not covered by Medicare for America • Excise taxes on tobacco products and alcohol increased; new federal excise tax on sugar-sweetened beverages Also repeals Cadillac tax		No provision for other financing sources	Authorizes such sums as necessary to pay for contracting costs for third party to handle administrative functions			Administrative costs for the Medicaid buy-in receive 90% federal matching payments No provision for other financing sources