



## **Analysis of the Medicare for All Act of 2022 (Senate Bill 4204)**

*Developed by the PNHP Policy and Legislative Committees*

PNHP welcomes the U.S. Senate's new Medicare for All Act of 2022, introduced by Sen. Bernie Sanders and 14 co-sponsors. We applaud several significant improvements beyond what was proposed three years ago in S. 1129 and highlight some areas for additional attention.

The list of features in common between S. 4204, and the most recent House Bill (H.R. 1976) is substantial and beyond the scope of this summary. In short, each of these bills provides all residents of the United States and its territories with a nationally consistent comprehensive benefit design, eliminates nearly all copays and deductibles, is funded through an equitable tax model, protects current benefits and services for veterans and Native Americans while also including them in Medicare for All, and dedicates expanded resources towards improving equity and justice in health care.

A major step forward in the new Senate bill is the addition of a provision for global budgeting of hospitals and other institutional providers of care, matching the language in H.R. 1976. The most critical area for improvement is allowing institutional long-term care to remain within state-based Medicaid.

### **Major Areas of Improvement from the 2019 Senate Bill**

- **Global budgeting of hospitals and other institutional providers:** The most important improvement is the funding of institutional providers through global budgets, with separate funding for capital projects in Title VI. This is key to resolving disparities in health care and is essential to controlling long-term cost growth.
  - A “global budget” is a lump sum paid to hospitals and similar institutions to cover operating expenses, eliminating wasteful per-patient billing. Global budgeting minimizes hospitals’ incentives to avoid (or seek out) particular patients or services, inflate volumes, or upcode.
  - In section 601(a)(2), the national budget is divided into multiple components. This means that the operating budget cannot be diverted into capital projects like expansion or modernization (which are funded separately), advertising, profit, or bonuses.

- Divorcing the funding of capital projects from the operating budget ensures that new hospitals and facilities are built where they are needed—not simply where profits are highest.
  - 611(b)(2)(G)(iii) determines that payment factors for global budgets include a specific factor to decrease health disparities or medically underserved areas.
  - 614(b)(2) now matches H.R. 1976 in prioritizing the allocation of capital funding to projects that propose improvements in service to medically underserved areas.
  - 601(v)(1) removes language allowing the use of capital budget funds for return on equity capital (which was part of the 2019 bill).
  - 615(e) newly matches H.R. 1976 in prohibiting the use of quality metrics or standards for provider payment determinations.
- **Payments to individual providers through fee-for-service (Sec. 612):** Medicare establishes a national fee-for-service schedule for individual and group providers, similar to language in H.R. 1976 and absent from the 2019 Senate bill.
- **Establishes a new Office of Health Equity (Sec. 616):** This matches language in H.R. 1976.
- **Broadens definitions of non-discrimination:** Several important categories are protected in section 104(a) in the same manner as in H.R. 1976.
- **Expands benefits:** Some important benefits that had been identified in H.R. 1976 had but were not in the previous Senate bill are newly included in S. 4202, including transportation for older individuals with functional limitations, and services provided by a licensed marriage and family therapist or a licensed mental health counselor, in section 201(a)(12) and 201(a)(13).
- **Increases funding for temporary worker assistance:** Section 602(a) increases to “at least 1% of the national health budget” instead of “1%”.
- **Increases income threshold for prescription drug copayments:** Copayments are withheld for households below 250% of the federal poverty level, a higher threshold than the 200% FPL applied in the 2019 Senate bill. (Note that PNHP prefers the full elimination of these copayments but recognizes the value of increasing the threshold in this manner.)
- **Improves access to data:** As in H.R. 1976, the new Senate bill grants the Comptroller General unrestricted access to *all* deliberations, records, and data, as does H.R. 1976. (New bill deletes the qualifier “non-proprietary” in front of the word “data.”)

## **Areas that need improvement**

---

- **Institutional long-term care remains within Medicaid** (Sec. 204), preserving the state-based variations that contribute to inequities, injustice, and complexity.
- **The four-year transition to Medicare for All is needlessly complex:** The four-year transition creates three simultaneous implementation paths: 1) Immediate improvements in the benefit design (dental, hearing, and vision) for people in traditional Medicare; 2) Optional “buy in” to Medicare for All phased in by age, which alarmingly also *includes commercial Medicare Advantage plans* as an alternative; 3) A new temporary public program available to all age groups, sold on the ACA Marketplace, priced for a 90% actuarial value.
  - The four-year transition delays access to care for the most vulnerable and disenfranchised, exacerbating inequities that could be more rapidly mitigated.
  - The four-year transition prolongs the diversion of provider time into non-productive interactions with the insurance industry and away from direct patient care. A more rapid transition would more quickly allow providers to align their time with the health care needs of patients, improving the practice of medicine, and reducing the provider burnout that drives early retirement.
  - The four-year transition makes it more difficult to account for shifts in the political landscape. Delaying the time before most Americans reap many of the benefits of Medicare for All increases the political vulnerability of the bill once it is enacted.
- **Fails to use all levers to control prescription drug costs for Medicare and patients:** (Sec 614) are *missing many of the key elements* seen in Sec 617 of H.R. 1976, for example:
  - The bill eliminates most, *but not all*, prescription drug copayments. Even with the important constraints in the bill, copayments are most burdensome on people of lower income.
  - The bill fails to eliminate managed-care pharmacy tools such as “prior authorization” that are proved to delay needed care.
  - The bill fails to explicitly allow the use of comparative clinical effectiveness and cost effectiveness analyses in formulary design.
  - The bill fails to authorize competitive drug licensing if price negotiations fail.
  - The bill fails to authorize the direct procurement of drugs if price negotiations fail.
  - The bill fails to authorize the Secretary of HHS to prioritize FDA reviews of new drug applications.
  - The bill fails to provide interim authorization to default to a variety of industry prices, including an average of ten large OECD nations.
- **Treats value-based models ambiguously:** The new bill fails to adopt H.R. 1976’s clear language terminating what are often called “alternative payment models.”

- H.R. 1976, section 614(a)(3) explicitly prohibits value-based payments.
- H.R. 1976, section 903 explicitly terminates programs related to pay-for-performance and value-based purchasing, which are absent in the Senate Bill, for example:
  - Merit-based Incentive Payment System
  - Adoption and Meaningful Use of Electronic Health Record technology
  - Alternative payment models
  - Value-based payments for physician fee schedules, ambulatory surgical centers, hospitals, skilled nursing facilities, and home health agencies
  - Medicare shared savings program
  - Hospital readmissions reduction
- However, some sections that seem to accomplish a similar goal:
  - 611(c)(3) and 611(c)(4) broadly exclude value-based payment adjustments from baseline and annual updates to the global budgets.
  - 612(c) authorizes the continuation of payment reform activities only to the extent necessary to ensure a smooth and fair transition.
- **Fails to ban or buyout for-profit and investor-owned health facilities:** For-profit health care facilities and agencies provide lower-quality care at higher costs than nonprofits, resulting in worse outcomes and higher costs compared to not-for-profit providers. Medicare for All should provide a path for the orderly conversion of investor-owned, for-profit health care providers to not-for-profit status.

## **Observations of unclear impact**

---

- S. 4204 Matches H.R. 1976 by dropping the previous Senate Bill's section 601(a)(2)(D) that dedicated funds to Section 1315a of the Social Security Act that established the Center for Medicare and Medicaid Innovation. It is unclear what this means for ongoing funding of CMMI.

## **Important typos (apparently) in the early draft**

---

- 303(b)(1)(B) Page 38 line 16: The word "not" was omitted from the equivalent language in H.R. 1976 (page 38 line 6) requiring that private contracts *not* be entered into during emergency situations.
- 201(a)(4) removed "biological products" from the list of prescription drugs and medical devices, a phrase that is included in H.R. 1976 and in the previous Senate bill.