

Review of Medicare for All Act of 2019, HR 1384

Kip Sullivan, March 7, 2019

I. Overview

Rep. Pramila Jayapal introduced HR 1384, the new version of HR 676, on February 27, 2019.

<https://www.scribd.com/document/400662193/Medicare-for-All-Act-of-2019-Jayapal> It is 120 pages long, 90 pages longer than HR 676, which was entitled “Expanded and Improved Medicare for All Act.” <https://www.congress.gov/115/bills/hr676/BILLS-115hr676ih.pdf>.

HR 1384 is a very good bill. It is a slight improvement over the old HR 676, and a vast improvement over Bernie Sanders’ bill, S 1804.

The new bill has a few minuses compared with the old HR 676, notably:

- * allowing clinics to affiliate with hospitals and receive their funding through the hospital's budget, a provision which will encourage hospitals to continue buying up clinics;
- * sections that threaten patient privacy in the name of “assessing quality”; and
- * the removal of the four taxes HR 676 listed (it contains no description of the new taxes that will be needed in addition to existing funding for public programs like Medicare).

But it has several pluses that are very important. The most important of the improvements is the explicit repeal of all the toxic “value-based payment” (VBP) programs authorized by the Affordable Care Act of 2010 and the MACRA law of 2015 (Medicare Access and Chip Reauthorization Act). Much of the additional detail about how the bill will be implemented is useful (for example, closing down the Obamacare exchanges at the end of the two-year phase-in period, and authorizing the federal government to compel the production of certain drugs if drug companies refuse to negotiate in good faith on price).

HR 1384 has 11 titles. I will not comment on each one. Rather, I'll divide my comments into comments about cost containment, coverage, and quality evaluation. These features of a bill, along with financing, are the most important. Ordinarily I would have added a section on financing, but as I mentioned above, this bill, like S 1804, offers no information on how it will be financed.

II. Cost containment

A. Main components of a single-payer system; no risk-bearing entities

The ideal single-payer bill has four components:

- * one payer that pays providers directly (not through risk-bearing middlemen), plus authority for the one payer to set:
 - * a uniform fee schedule for doctors (“individual providers”),
 - * budgets for hospitals and nursing homes (“institutional providers”), and
 - * price limits on drugs and equipment.

Like HR 676, HR 1384 contains all four components. The “single payer” under HR 1384 is the Department of Health and Human Services (HHS). (S 1804 is missing the first three components.) Budgets for

institutional providers are not split into operating and capital budgets. Rather, regional directors are instructed to negotiate operating budgets with hospitals; *all* providers (institutional and individual) are permitted to apply for permission to spend money on capital projects; and hospitals that receive money for capital expenditures are prohibited from commingling capital with operating funds.

Although Representative Jayapal remained ambivalent well into the fall of 2018 about whether to import into HR 1384 Section 611(b) from S 1804 (the section that authorizes risk-bearing “accountable care organizations” and dozens of other VBP programs), HR 1384 not only does not mention ACOs etc., it prohibits them. The bill does this three ways.

* First, it declares in Section 302 (p. 32) that a “provider is considered to be qualified to furnish covered items and services” only if the provider “delivers items and services directly to individuals.” This would exclude an entity like an HMO or ACO that “arranges” for the delivery of medical care by contracting with clinics and hospitals, but does not itself deliver services.

* Second, as I mentioned above, the bill repeals a long list of VBP programs, including Medicare's ACO programs; the MACRA legislation of 2015; the expensive and burdensome “meaningful use” program that forced doctors to buy clunky electronic medical records; and the Hospital Readmissions Reduction Program, which has been shown to worsen mortality rates (see Section 903, pp. 98-100, entitled “Sunset of Provisions Related to Pay for Performance Programs,”).

* Third, the bill does not use the red-flag words that appear in both HR 676 and S 1804 – “enroll” and “capitation.” Those are red-flag words because they signify risk has been shifted off the single-payer and onto some other entity.

Another red-flag word – and a word that could easily be misunderstood – that appeared in the old HR 676 but does not appear in HR 1384 is “HMO.” The HMO loophole in HR 676 was so small it referred to a clinic or small groups of clinics. No existing HMO or insurance company could have gotten through the HR 676 HMO loophole. But its existence, and HR 676's vague description of “HMO” and other risk-bearing entities (“group practices, and other institutions”), was an unnecessary invitation to HMO/ACO proponents to widen the loophole to let every insurer and hospital-clinic chain that claims to “integrate” or “coordinate” care walk through it.

HR 1384 explicitly forbids insurers that participate in the Medicare Advantage program from participating.

HR 1384 does not attempt to define how much providers will be paid. It instructs the Secretary of HHS to do that. It does say that in setting new rates under the new systems, HHS should treat Medicare's current payment rates for hospitals as a “comparative payment rate system,” and HHS should “take into account” Medicare's payment rates for doctors. Obviously, this is not equivalent to instructing HHS to reduce provider rates to Medicare levels.

B. Shared hospital-clinic budgets; regulation of for-profits

Section 611(a)(3) allows clinics to receive budgets as part of a nearby hospital's budget (ordinarily clinics would be paid fee-for-service). The relevant sentence reads: “Certain group practices and other health care providers, as determined by the Secretary, with agreements to provide items and services at a

specified institutional provider paid a global budget under this subsection, may elect to be paid through such institutional provider's global budget...." (pp. 63-64)

Representative Jayapal might have seen this provision as a replacement of, or substitute for, HR 676's HMO loophole. Whether that's the case or not, Section 611(a)(3) is a substantial improvement over HR 676's HMO loophole. Unlike the tiny HMOs authorized by HR 676, the clinics that share budgets with hospitals in HR 1384 will not enroll "members," and, therefore, they won't be paid a premium (capitation payment) per member. That's an improvement over HR 676's HMO loophole because paying a per-member fee shifts risk; it requires risk-adjustment of the fee, which is administratively expensive and difficult; and because it's difficult and cannot be done accurately, it winds up underpaying clinics with sicker patients. (See my two-part series on how pay per-enrollee harms the poor and the sick entitled "Practicing medicine while black", <http://thehealthcareblog.com/blog/2017/11/09/practicing-medicine-while-black>, and <http://thehealthcareblog.com/blog/2017/11/27/practicing-medicine-while-black-part-ii/>.)

Moreover, Section 611(a)(3) requires HHS to determine what the salaries of the doctors in the clinics that share budgets with hospitals are paid; the CEO of the hospital will not be doing that.

Although Section 611(a)(3) is an improvement over the HMO loophole in HR 676, it creates a risk of two adverse outcomes. The first is that by permitting hospitals and clinics to share one budget, this provision may encourage hospitals to buy up clinics. Second, permitting hospitals and clinics to share budgets might be interpreted by regional directors to permit budgets for chains of hospitals and clinics (not just one hospital sharing a budget with one clinic). The vagueness of the phrase "certain group practices and other health care providers" is not helpful. A more precise definition of which providers can share a budget with a hospital, and an additional sentence stating that regional directors cannot negotiate budgets with corporations that own more than one hospital, would reduce the risk that this section will be misinterpreted to permit budgets for hospital-clinic chains consisting of more than one hospital and one clinic.

HR 1384 does not retain HR 676's requirement that HHS buy out for-profit providers. Rather, in Section 614, HHS is told that "payment to providers ... may not take into account ... profit or net revenue of the provider" (p. 77).

III. Eligibility

The bill mandates universal coverage two years after the date of its enactment (the phase-in period under HR 676 was one year; under S 1804, the phase-in was four years). On that date (two years after enactment), insurance companies are prohibited from selling insurance that duplicates the benefits provided under the Act, and employers are prohibited from "providing" duplicative health insurance to their employees. Insurance companies are allowed to sell coverage for services not covered by the Act.

People under 19 and over 54 are eligible *one* year after the date of enactment, but they're free to continue with their private coverage for the remaining year of the two-year phase-in if they want to.

The bill creates a very complex "Medicare transition buy-in" program that will be available to all residents during the second year of the phase-in period (Section 1002, p. 102). The buy-in policy must cover the benefits required of a "qualified plan" under the Affordable Care Act, and it must have an

actuarial value of 90 percent of “the plan,” which I interpret to mean the Medicare for all benefits package. The buy-in policies will be sold only on the Obamacare exchanges (which will be terminated on the date universal coverage begins, which is to say one year after the buy-in policies go on sale).

“Public option” proposals (which is what the Medicare buy-in program is) present very difficult implementation issues. The Medicare buy-in will not only face those issues, HHS will have only one year to address them. I’m not optimistic about the buy-in.

Section 102 says “residents” of the US are eligible to enroll in Medicare for all and leaves it to the Secretary of HHS to define “residency.” HR 676 contained the same provisions.

IV. Coverage

The benefits provided under HR 1384 are very similar to those provided under HR 676. There is no cost sharing under HR 1384, as was the case under HR 676.

There are some odd differences that I assume are not significant. HR 676 specifically mentioned palliative, chiropractic, and podiatric care, while HR 1384 does not. Similarly, HR 1384 refers only to “oral health services” while HR 676 specified “[t]he full scope of dental services, including periodontics, oral surgery, and endodontics....” On the other hand, HR 1384 spells out “emergency services and transportation” while HR 676 listed only “emergency care.”

The two most important differences in the benefits lists are:

* HR 1384 authorizes the Secretary to add “complementary and integrative” services to the benefits list “that are appropriate to include” (p. 12), whereas the only words used by HR 676 that resemble “alternative medicine” were “dietary and nutritional therapies” (the latter phrase does not appear in HR 1384); and

* HR 1384 appears to authorize coverage of abortion.

I say “appears” because that word is not in the bill. Rather, the benefits section (Section 201) specifically mentions “*comprehensive* reproductive, maternity, and newborn care” (p. 10) (whereas these services minus abortion services would have been covered under several other categories listed in HR 676), and HR 1384 states that any other law on the books at the date of enactment “restricting the use of Federal funds for *any reproductive health service* shall not apply to monies in the Trust Fund.” (p. 91) The italicized words (my italics, not the bill's) presumably refer to abortion services.

HR 1384 lists the same categories of long-term care that HR 676 lists, but HR 1384's description of the long-term care services is much more detailed than that in HR 676.

V. Quality assessment

Section 302 authorizes HHS to set “minimum standards” for providers, and Title V (which begins at p. 55) authorizes the Secretary to develop “national practice guidelines” and to use them to measure the quality of providers. These parts of the bill do not use the phrase “medical records”; they refer instead

to “data.” But it is clear that “data” includes data in medical records. (HR 676 gave the Secretary broad authority to “address quality improvement” but no specific authority to collect medical records.)

The authority to collect medical records is most clearly implied by Section 302 of HR 1384, which authorizes HHS to measure “outcome in palliation, improvement of health, stabilization, cure, or rehabilitation” (p. 34), not merely health *services or processes* (for example, the percent of a doctor's diabetic patients who received an annual eye exam). *Outcome* measures, that is, measures that depict change in patient health, require medical records; *process* measures can be calculated using only claims data.

Title V does require HHS to “consider” patient privacy and “administrative burdens of data collection ... on providers” (p. 55) in quality measurement. But that instruction is in conflict with the instruction to measure health outcomes. In order to measure health outcomes, HHS will have to invade patient privacy and collect medical records, and that in turn will add to providers’ administrative burden.

Whereas HR 676 stated “patients shall have the option of keeping any portion of their medical records separate from their electronic medical record” (Section 304), HR 1384 contains no such provision.

Final comments

In this review of HR 1384, I have discussed only what I consider to be the sections of the bill that address the first-order or highest priority issues – namely, whether the bill contains costs in a manner that ameliorates rather than aggravates current problems (including high cost, physician burnout, and loss of patient privacy), and whether the bill mandates comprehensive, universal coverage. I have not discussed numerous other sections that are essential, either on moral grounds (for example, financial assistance for workers displaced by HR 1384) or to ensure the smooth functioning of the new system (for example, the anti-fraud section and the requirement that regional directors consult with public health officials, doctors and patients).

I would have discussed HR 1384's financing section if the bill had one, but it does not. Progressive funding of universal coverage is another important standard by which we should evaluate any universal coverage bill. We know HR 676's financing would have been progressive. We can't say that about HR 1384.

HR 1384 meets the most important, first-order criteria – it authorizes the four cost-containment features of an ideal single-payer system, and it mandates comprehensive, universal coverage.