Physicians' Proposal for National Health Program (Single Payer)		Medicare Extra for All (ME)
Everyone living in the U.S. is automatically covered.	**COVERAGE**	Only seniors, newborns and the uninsured automatically enrolled, as well as those in military and federal employee plans. Coverage limited to citizens and legal residents. It is not clear if services can be denied for nonpayment of patient cost sharing.
Coverage for all medically necessary care, including inpatient and outpatient services, prescription drugs, dental, vision, hearing, and long-term care.	**RANGE OF BENEFITS**	Includes benefits currently covered by Medicare, plus prescription drugs, dental, vision, and hearing care. Long-term care would be covered under a separate program run by states.
Covers 100% of health care costs. Premiums and copays are replaced with progressive income and wealth taxes, so that 95% of American households will pay less for care than they do now.	**PATIENT COST SHARING**	Significant cost sharing. Depending on income, ME covers only 80% of health care costs. Households earning more than 150% of poverty line ($36,900 for a family of four in 2018) must pay premiums, capped at 10% of income. Deductibles and copays would vary by income and have not been determined.
Free choice of any provider or hospital.	**PROVIDER CHOICE**	Public ME plan includes all Medicare providers. Those in private employer or Medicare "Choice" plans will be restricted to narrow networks of providers, which may change from year to year.
Saves an estimated $617 billion annually by slashing administrative waste of the private insurance industry ($504 billion) and bargaining down drug prices ($113 billion), freeing up enough money for universal, first-dollar coverage without any net increase in U.S. health spending. Improved health planning assures that expensive health facilities are available where needed and not duplicated where they are wasteful. Control of drug industry profiteering ensures the system's long-term sustainability.	**COST CONTROL & SUSTAIN-ABILITY**	ME maintains most of the wasteful bureaucracy of our multi-payer system, achieving only a fraction (about 1/6th) of the administrative savings of a single-payer system. While ME will negotiate prices for drugs and devices, and set uniform fees for services, it could not globally budget hospitals or implement regional health planning.
No role for private insurance. Everyone is in the same risk pool.	**ROLE OF FOR-PROFIT PRIVATE INSURANCE**	Maintains a major role for profit-based insurers, who can continue to sell private employer group plans and also sell ME "Choice" plans (similar to the wasteful Medicare Advantage plans) to all enrollees, plus additional services for even higher premiums. Private insurers would continue to restrict provider choice and deny payment for care; they could market plans to healthier individuals and employee groups, while pushing sicker people into the public ME program, which would become a defacto high risk pool.
Coverage is lifelong and portable, no longer tied to employment.	**ROLE OF EMPLOYER COVERAGE**	Firms with 100+ workers can either provide private coverage, enroll employees in ME and pay part of their ME premiums, or pay a fee for not providing coverage. Smaller employers are not required to provide any coverage or ME premium reimbursement.
Year one coverage for everyone, with funds set aside to provide income support and job training for displaced administrative workers.	**TRANSITION**	8-year rollout. Year 1: ME "public option" for counties with no ACA exchange plan. Year 4: Enrollment for seniors, newborns, and uninsured. Year 6: Enrollment for Medicaid and CHIP recipients. Year 8: Enrollment available for large employers.

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