Fourth Edition - THE TRUE AMERICAN HEALTH INSURANCE FINANCE

THE TRUE COMPARISON OF THE ANNUAL ACA PREMIUM & TAX SUBSIDIES

AND MEDICARE ADVANATGE PREMIUM PAYMENTS FOR YEARS 2015 AND 2016

Obamacare care annual per capita costs are significantly more expensive than Medicare Advantage. In total, Obamacare cost us even more that our Medicare Fee-for-Service Program. It is the most expensive federal health insurance program on the planet Earth. Medicare-Advantage-For-All.Com has completed a ground breaking Cost Comparison study below comparing the annual per person cost of Obamacare side-by-side with some of our other

federally sponsored health insurance programs. The results are logical, however by displaying Obamacare, Medicare Advantage, Commercial Individual Insurance and Medicare fee-for service all together on the same page allows you can really appreciate the dramatic differences in cost.

The conclusions that can be drawn from this study and the Cost Comparison include:

- THE AFFORDABLE CARE ACT IS THE MOST EXPENSIVE HEALTH INSURANCE PROGRAM ON THE PLANET, MORE EXPENSIVE THAN THE MEDICARE FOR ALL AND IS THEREFORE LESS LIKELY TO OFFER THE AMERICAN PEAOPLE AFFORDABLE HEALTH INSURANCE.
- THE MEDICARE FEE-FOR-SERVICE FOR ALL IS THE SECOND MOST EXPENSIVE HEALTH PLAN ("LESS" EXPENSIVE THAN OBAMACARE) AND THEREFORE ALSO LESS LIKELY TO OFFER AFFORDABLE HEALTH INSURANCE.
- MEDICARE ADVANTAGE IS THE LEAST COSTLY PLAN (IN IT'S PRESENT FORM), LESS COSTLY THAN OBAMACARE AND MEDICARE FOR ALL AND THERFORE FOR IS THE MOST AFFORDABLE PLATFORM AVAILABLE FOR MEANINGFUL HEALTH INSURANCE REFORM FOR THE AMERICAN PEOPLE.
- COMMERCIAL INDIVIDUAL HEALTH INSURANCE WAS FAR LESS EXPENSIVE THAN THE COST OF AFFORDABLE CARE ACT WHEN THE PROGRAM FIRST STARTED.

Because Obamacare has turned out to be so expensive, the third bullet (3rd.) above is the most important thing we verified from this study. We thought it was logical, but we were not sure which program was most affordable. Now we know our Medicare Advantage program (MA) is far LESS expensive than Obamacare and also the Medicare fee-for-service program. This finding should inform Congress and the public at large.

In 2015, if we had extended the current Medicare Advantage programs (MA) to everybody (which is not what we are proposing), participants and our government would have spent 26% LESS per person over the cost of Obamacare. This study makes clear that even the current Medicare Advantage programs offer the most affordable health insurance reform opportunity that we have available to us in the U.S. And, there is no reason MAA cannot be offered right alongside Obamacare, giving everybody an opportunity to choose the program that is best suited to them.

The ACA programs are prospectively rated and as a result, they tend to be more expensive. The Obamacare programs were originally designed to minimize health insurance carrier risk, while Medicare Advantage capitation rated programs are designed to contain health insurance carrier costs by capping the government's risk. This Comparison shows that if the Obama Administration had simply bought a Commercial Individual Health Insurance Market policy for each and every single ACA participant and paid 100% of the premiums, literally just gave each ACA participant a paid-up CIIM policy, the federal government and "We the People" would have saved over 60 Billion Dollars in 2015.

You may remember that when President Obama first introduced the ACA to the American people, he promised it would," lower premiums by up to $2,500 for the typical family per year …". Many of us were skeptical of that claim. Even so, our government backed him up. Prior to ACA enactment in 2009, in a Report to Congress, the Congressional Budget Office (CBO) and Joint Commission on Taxation (JCT) estimated that the total cost of the ACA would be *more than offset* by reductions in Medicare spending, increases in revenues, and other changes – such that enacting the ACA legislation would reduce the federal budget deficit over the next decade. After enactment of the program in July 2012, President Obama doubled down on his original promise, assuring small business owners that, "your premiums will go down." This was wishful thinking at best. The planned cuts to Medicare and Medicare Advantage were never made. The CBO estimates were wrong and between 2014 and 2017 ACA premiums increased by an average of 105%. And, Not-To-Be-Outdone, we have revealed, for the first time, a way for our governement to make good on President Obama's promises to the American people by 2020? And, that is to offer a Medicare-Advantage-Program (That Works)-For-All!

Unfortunately, Obamacare has dramatically increased the cost of health care since its implementation. Tax payers originally supported approximately 35% in ACA premium subsidies in 2015 to make health insurance more affordable for those of us that can least afford it. This subsidy was almost entirely (wasted) eaten up by the increases in insurance premiums caused by the ACA legislation itself. This study shows that even if we had extended the current Medicare Advantage programs (which is NOT our proposal) to All, the federal government would not only have saved Billions (26%), it would have effectively made high quality health insurance programs available to everybody with no out of pocket premium payments. Our proposal is to skillfully re-engineer the current Medicare Advantage Programs to make them more cost effective and cover the uninsured.

I. THE AFFORDABLE CARE ACT (IS NOT AFFORDABLE)

The Cost Comparison Table below displays figures from the work done by the best health care actuaries in the country. One should appreciate that isolating the budgetary effects of the ACA (or of any such complex federal legislation) is difficult because they are often embedded in the spending for existing programs and broad categories of federal tax revenues. Our Cost Comparison study incorporated data from a myriad of isolated sources, including specific reports from HHS, CMS, IRS, CCIIO "MLR" Data, "MLR" insurance company filings, NAIC State Supplemental Health Care Exhibit forms, insurance company filings and the Annual Medicare Trust Fund Actuarial Reports to Congress. Much of our findings are sourced from a Landmark study entitled, "Commercial Health Insurance: Overview of Financial Results" produced by Milliman (March 2017). The sources for most of the data are referenced in the Table Foot Notes. If we have NOT nailed these final figures exactly, we are embarrassingly, too close for comfort and whatever minor discrepancies, they are immaterial to the basic calculations (in the Billions of Dollars) and the general assumptions that we are clearly able to make from this

comparison. The shocking reality of this comparison should bring every True American up short! How can we let this kind of thing happen in the twentieth century, with all our technology, experience and all our skills and talents? Think of it. We pass a bill that is supposed to do something important and we promise it will be successful and do so in a cost-effective manner. We lie to ourselves about it. When the ACA fails miserably, especially in comparison with our other federal health insurance programs, we can't agree on its failure and we can't agree on how to fix it. Travesty is not too strong a term.

- THE TRUE AMERICAN -

COST COMPARISON - ANNUAL AFFORDABLE CARE ACT (ACA) PREMIUM & TAX SUBSIDY PAYMENTS AND MEDICARE ADVANTAGE (MA) PREMIUM PAYMENTS FOR YEARS 2015 AND 2016

	AFFORDABLE CARE ACT			MEDICARE ADVANTAGE	
YEARS	2015	2016		2015	2016
A M EARNED PREMIUM (Billions) 1.	70.9	80.1	Part A	86.5	94.2
A P TAX CREDIT SUBSIDY (Billions) 2.	25	29.8	Part B (A M E P)	86.5	96.8
TOTAL COST (Billions) 1.+ 2.	95.9	109.9		173	191
TOTAL ENROLLMENT (Millions) 3.	9.1	11.1		17.8	18.7
ANNUAL PM COST (Total Cost 1+2.divided by Total Enrollment)	$10,538	$9,900		$9,719	$10,214

COMPARISON OF “INDIVIDUAL MARKET" COMMERICIAL BENEFITS PAID WITH MEDICARE-FEE-FOR-SERVICE BENEFITS PAID

	COMMERCIAL "INDIVIDUAL INSURANCE" MARKET			MEDICARE FEE-FOR-SERVICE	
YEARS	2014	2015		2015	2016
TOTAL CLAIMS PAID (Billions) 4.	45.4	63.8	Total (Parts A & B)	549.3	570
TOTAL ENROLLMENT (Millions) 5.	15	17.5		55.3	56.8
ANNUAL BENEFIT PM (Dollars) 6.	$3,794	$4,410		$10,419	$10,526

COMPARISON OF TOTAL OBAMACARE (ACA) COST
WITH MEDICARE ADVANTAGE (MA) AND MEDICARE (MFFS) EXPENSES

	ACA	MA	MFFS
YEARS	2015	2015	2015
A M EARNED TOTAL COST (Billions) ACA & MA 1.+ 2. & MFFS 4.	95.9	173	549.3
CSR PAYMENTS (Billions) 1. Milliman	5.7	0	0
REINSURANCE (Billions) 7. Harvard	7.8	0	0
RISK ADJUSTMENT (Billions) 1. Milliman	4.8	0	0
RISK CORRIDOR (Billions) 1. Milliman	5.9	0	0
TOTAL COST/BENEFIT (Billions - Sum)	120.1	173	549.3
TOTAL ENROLLMENT (Millions) ACA & MA 3. & MFFS 5.	9.1	17.8	55.3
ANNUAL COST/BENEFIT PM 6.	$13,198	$9,719	$10,419

Notes: Arthur Jackson Wheeler - May 25, 2018

1.ACA Aggregate Market Earned Premium - Milliman (March 2017) 2015 Commercial Health Insurance: overview of financial results.

Medicare Advantage Annual Market Earned Premium - 31% and 33% of Part A - AMEP per Medicare Actuary Trust Fund Reports to Congress.

2.ACA Advanced Premium Tax Credit Subsidy values from CMS and IRS data and publicly available Reports, Milliman methodology (March 2017).

Medicare Advantage Aggregate Market Earned Premium - 31% and 33% of Part B - AMEP per Medicare Actuary Trust Fund Reports to Congress.

3. The 2015 Effectuated Marketplace enrollment from HHS and 2016 CMS Enrollment Report, 2016 March 31.

Medicare Advantage enrollment from CMS Medicare Advantage Monthly Summary Contract Reports, December 2015 and 2016.

4.Total Claims Paid for Commercial Individual Insurance Market - Part 1, Line 5, NAIC Supplemental Health Care Exhibit forms, Per Member/Per Month X 12 x Total Enrollment.

Medicare Fee-For-Service Total Claims Expenditures - Table 11.B1, 2016 and 2017 per Medicare Actuary Trust Fund Reports to Congress.
5.Commercial Individual Insurance Market average covered life years monthly enrollment per Milliman (March 2017).
Medicare Fee-For-Service Total Enrollment - Table 11.B1, 2016 and 2017 per Medicare Actuary Trust Reports to Congress.
6.Commercial Individual Insurance Market Annual Benefit Per Member from Part 1 of NAIC Supplemental Health Care Exhibit forms, Per Member/Per Month x 12.
Medicare Fee-For-Service Average Annual Benefit Per Member - Table 11.B1, 2016 and 2017 per Medicare Actuary Trust Reports to Congress.
7.Feldscher K. Reinsurance Program Critical to Shoring up the ACA. Harvard T.H. Chan School of Public Health. 2017 Aug 14.
8. General: Isolating budget effects of the ACA (as with any complex legislation) is difficult because Expenses are often imbedded in other program spending as with the CSR payments, 3R programs, Medicare and other broad categories of federal spending.

The True American Cost Comparison Table above displays the two biggest federal expenses for the Affordable Care Act (ACA) i.e. the ACA's Annual Market Earned Premiums and the Advanced Premium Tax Credit Subsidies, representing the direct expenses. Together, these direct expenses are essentially the same as the Total Cost of the Medicare Advantage Annual Market Earned premium (AMEP) for Part A and Part B, which the Medicare actuaries account for in their Trust Reports to Congress, as a percentage of the AMEP for Medicare for calendar years 2015 and 2016. This table shows that the ACA and the MA trading places being the higher cost plan.

The Comparison of the Total Obamacare Cost (ACA) with Medicare Advantage (MA) and Medicare fee-for-service (MFFS) for 2015 however, adds in some of the following additional risk adjustment programs (3R's), which have also been part of the ACA program. This is where the rubber hits the road in terms of the ACA's Total expenses as compared to Medicare Advantage and other programs, including MA and MFFS. These added expenses put the ACA in a class-by-itself as the most expensive health insurance plans on the planet.

The Total ACA Cost includes unauthorized Cost-Sharing Reduction Subsidies (CSRs) which accounted for 4.9 Billion and 5.7 Billion Dollars respectively in 2014 and 2015. These costs are now generally loaded into regular premiums for the Silver plans. The ACA Reinsurance Program cost tax payers 7.9 Billion in 2014, and 7.8 Billion in 2015, with some monies maybe left owing. Reinsurance phases out in 2016. There is also the Risk Adjustment Program with carrier transfers totaling 4.6 Billion in 2014, increasing four percent (4%) to about 4.8 Billion in 2015. CMS is currently trying to figure out how to modify the Risk Adjustment program to make it more effective? The most famous of the 3R's, is the Risk Corridor program worth 2.4 Billion and 5.9 Billion in 2014 and 2015. This program was an early attempt to reduce or eliminate carrier risk (removing the incentive to adequately price their products) and ACA carriers are suing the Administration for 2.87 Billion in unpaid claims from 2014. In addition, the federal government spent over 5 Billion Dollars supporting and operating the (now 51 - 2019) State and Federal

Marketplace exchanges. The federal exchange adds on three and half percent (3.5%) of premium as fees to the cost of the products sold on the Exchange and the state marketplace premium fees add on an average of one and a four tenths percent (1.4%) to premiums. These fees which are not included in the A M Earned Premium Dollars summarized in the Cost Comparison above.

Our claim of Sixty (60) Billion Dollars in savings in 2015, if Obama had just given everyone a paid up CIIM, is in fact Billions of Dollars less than the actual savings that would be derived from these figures. Consequently, we can say with some certainty that the ACA is substantially more expensive than Medicare Advantage and traditional Medicare fee-for-service. A dubious distinction and No mean feat. THE ACA IS THE MOST EXPENSIVE HEALTH INSURANCE PROGRAM ON THE PLANET.

Now with all these expenses displayed side-by-side you can appreciate, perhaps for the first time, the magnitude of the true total cost of ACA and how badly it compares to all of our other government-sponsored insurance programs. Exacerbating this consciousness is the fact that the federal government still owes much of the Reinsurance and Risk Corridor reduction payments to the insurance carriers under court order and these remain unpaid to this very day! This realization should ROCK your world. The "Affordable" Care Act is actually "Unaffordable" and unsustainable in it's present form.

The CSR payments that ACA carriers are required to make (and for which money was never properly authorized by Congress) are still being paid today. The ACA Law requires all the ACA carriers to pay these CSR benefits but we DO NOT pay the carriers directly for the cost of these benefits. Instead HHS has allowed the ACA carriers to load the CSR costs into their Silver Plan rates which have disproportionately increased federal subsidies paid to the carriers as well as Sliver plan premiums paid by all participants.

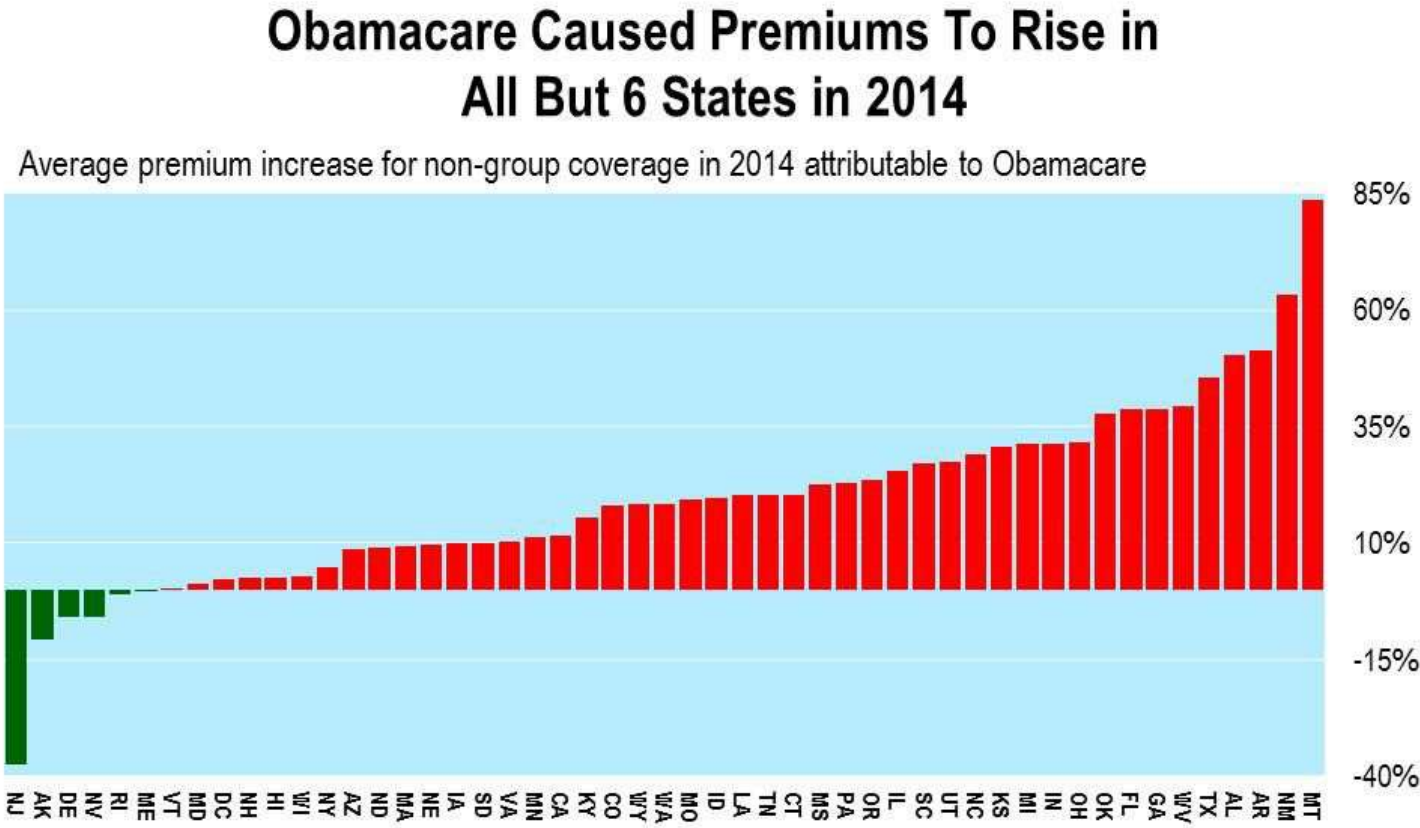
This ACA Law is so convoluted that while a taxpayer would assume that when the government stops paying for something, our ACA payments and the taxes to support them would go down. In this case, stopping the CSR's caused the total required ACA government subsidies to increase, benefiting the participants and costing the federal government several Billion more and no subsidized ACA participants were disadvantaged. The non-subsidized ACA participants were disadvantaged with higher premiums, the taxpayers were disadvantaged with higher costs and of course, the insurance carriers, who are required to pay the benefits were satisfied. This is a shame and a perfect example of the ACA's legal and structural flaws.

It is easy to understand why some of the larger health insurance carriers dropped out of the ACA program. There can be no question that the federal government's non-payment of Billions in claims and their subsequent losses exasperated the insurance carrier's withdrawal from the market and fueled the remaining ACA carrier requests for premium rate increases. As mentioned above, ACA rates increased One Hundred and Five Percent (105%) over the four years ending 2017 and the cost of CSR's probably represents at least ten percent (10%) of annual premiums today. Of course, nobody has any idea how much money the carriers have actually paid out for the CSR benefits, as there have not been any audits of these payments. We

are skeptical that these payments are even being separately tracked by carriers, given the way their enrollments are often structured. If so, carrier pleas for needed CSR funding are based on premium calculations and not actual claims payments. Is this any way to run an insurance program? We don't think so.

II. INSURANCE PREMIUM REDUCTIONS

The ACA caused dramatic increases in Commercial Individual Health Insurance rates. One popular myth that persists about the ACA program is the claim that ACA lowered the cost of individual health insurance. Nothing could be further from the truth. A definitive study from the well-respected non-partisan National Bureau of Economic Research found that premiums in the 2014 non-group market grew by 24.4% *compared to* ***what they would have been*** **without Obamacare**. The state-by-state assessment graph below shows that premiums rose in all but six (6) states (including Washington DC). NJ and CA averages are probably distorted here due to anomalous data.



All figures calculated by author using data reported in Table 1 from Amanda E. Kowalski. *The Early Impact of the Affordable Care Act State-by-State*. Working Paper 20597. http://www.nber.org/papers/w20597. National Bureau of Economic Research, October 2014.

Further, this 2014 study shows that premiums for individual market's Qualified Health Plans (QHPs), which were the ACA-compliant plans certified to be sold on the Marketplace Exchanges, carried **MUCH HIGHER** premiums than the Individual Non-QHPs Plans, which consisted mostly of Commercial Individual Health Insurance Market (CIIM) plans in existence. Health insurers collected on average more than $1,000 in higher premiums per individual enrollee and more than $2,300 in higher premiums per family for QHP's in 2014 (after accounting for the large premium subsidies). Another study reported in Forbes Magazine (Roy, 2014) concluded that (non-enrollment weighted) Non-QHP premiums increased an average of forty nine percent (49%).

The bottom line is the ACA was inflationary, not just for the subsidized plan but also the non-subsidized plans. If you were not getting a government subsidy, you were paying more money for Commercial Individual Health Insurance. If you were unfortunate enough not to be able to afford health insurance, it was now financially out of your reach. The Kaiser Family Foundation (KFF) studies indicated that the ACA increased the number of people with health insurance by 4.2 Million. The ACA total enrollment in 2015 was 9.1 Million and if 4.2 Million of those had previously been uninsured, then 4.9 Million dropped their Commercial Individual Health Insurance, probably for governement subsidies. So we created a program to spread health insurance to those True Americans that can't afford it. We end up attracting more than half of the participants away from Commercial Individual Health Insurance plans that they were paying for on their own and put another 4.2 Million more people on the dole, while increasing the cost of health insurance, so that those that did not qualify for a subsidy were permanently priced out of the market.

We basically created another governement entitlement program pure and simple, the effects of which worked against the goals of the program itself. We should have creating a program that would add people to the health insurance rolls with affordable coverage that did not reduce the number of people that already had their own coverage and used our resources to bring people into the system that could Not afford to buy their own health insurance. Millions of Americans were already getting a benefit from their private health insurance and paying their own way in the private market. The ACA tried, and is still trying, to crush that market. We hear lowd complaints from politicians and experts alike to this very day that the Republicans are diluting the ACA pool with Temporary Insurance Plans and Association Plans, when all they are trying to do is create affordably health insurance options that are Not tied to government subsidies for their success. In this economic environment where our governement is faced with limited resources, a massive deficit and the need to refinance the most important entitlement programs our citizens enjoy, we cannot afford to be increasing the cost of health insurance and using are limited resources to cover people that can afford health insurance on their own!

In 2019, if a person has maintained a grand-fathered CIIM product, and does not qualify for a government subsidy, insurance consultants advise them to keep their plans. After several failed federal attempts to terminating Grand-fathered plans, these plans may now be renewed indefinitely. Other Non-QHP health plans which pre-date 2014, maybe grand-mothered. HHS has issued yet another extension of grand-mothered plans in 2018 — again at each state's

discretion — allowing grand-mothered plans to renew this time until October 1, 2019, as long as they terminate by the end of 2019. The details of this extension are the same as all the previous extensions, but with the deadlines pushed out another year. The people that have these plans want to keep them and the people that don't, are stuck with the ACA plans and the misery that may go along with them.

This CIIM premium differences are reflected in the True American Cost Comparison Table above, that the Milliman Study mirrored, and are the basis of our 60 Billion Dollar Savings claim. This is very important because the typical American family does not require a full-blown QHP to have financial security from financial loss due to the unexpected onset of an illness or injury. ACA *did not* invent the comprehensive health insurance contract and not all Non-QHP's are bad.

Safe and economical Medicare Advantage For All programs can be re-engineered to be affordable for more people, in many ways and the ACA QHP's can go on, just as they are, with no changes. What are we afraid off? Does anyone really think we can't do this better than the ACA? Simply creating a massive ACA program that subsidizes 8 Million participants to buy health insurance and at the same time, pricing 10.1 Million Americans that we also need to protect, out of the market, is NOT the best way to run a health insurance Plan. Congress knows better than to do it this way, but this knowledge is purposely being hidden by influential interest groups that do not have the interests of the common American citizen at heart.

III. REDUCTION OF FEDERAL REGULATION

One of the biggest causes of the huge difference in cost between the Commercial Individual Insurance Markets (CIIM) and ACA is federal regulation. Everyone is under the misapprehension that before ACA, health insurance companies did not offer adequate non-group health insurance for sale to the general public. This is NOT true. The CIIM values recorded in the Cost Comparison Table above are generally for comprehensive Non-QHP health insurance contracts that provided more than adequate protection against the financial risk of unexpected personal illness and injury. For instance, after the ACA required Minimum Loss Ratios, studies found that over seventy percent (70%) of the Individual Health Insurance policies were voluntarily in compliance with the ACA's new MLR regulations, meaning that the majority of health insurance companies were returning value to their customers consistent with ACA requirements before the federal regulations were introduced.

One size does not fit All. Federal regulations increase the cost for everyone. For instance, the average inpatient hospital stay is six (6) days. Yet the most prevalent QHP inpatient benefit provides for 365 days. Consequently, even though few people will ever exceed the average length of stay, all the ACA carriers charge a premium consistent with the risk that the participants may have above average lengths of stay. Prior to the ACA, a woman could generally add maternity coverage to her health plan within 60 days of becoming pregnant. After the ACA, maternity coverage was required in all QHP's. Comprehensive health insurance contracts were standard before the ACA invented the required "Essential Health Benefits". Milliman studies reveal that essential health benefits increase premiums by an average of 3 percent to 17

percent depending upon the state. The ACA also requires a "Minimum Actuarial Value" of 60% on all plans, which Milliman believe increases premiums by 8.5%. There is a "Prohibition of Age/Sex Rating" imposing rules that artificially increase premiums for younger adults, making it harder to attract those who are more likely to be uninsured and would be most helpful to the risk pool. ACA also requires insurance companies to put enrollees suffering from pre-existing conditions into the same risk pool as other health risks, thereby ensuring adverse selection and unnecessarily driving up the cost of everybody's health insurance. Milliman predicts that what they term "Risk Pool Composition Changes/Adverse Selection" caused individual premiums to increase 20 percent to 45 percent in 2014. In addition, ACA Regulations increase premiums by encouraging high-risk enrollment, including early shifts from COBRAs continuation of coverage, early retirement shifts and other so-called gaming techniques with SEPs, etc. There are a cluster of other regulations prohibiting medical underwriting, requiring the issuance of coverage, and banning pre-existing condition exclusions under any circumstances. Collectively these have had the largest effect on arbitrary increases in health insurance premiums.

All this regulation makes health insurance less affordable by requiring health insurance carriers in the public/private partnership to do things that are not in the best interests of their customers. And, this prevents them from designing contracts on which they are willing to accept the risk of loss. The result is an abrogation of the normal insurance underwriting and risk-taking processes, potentially resulting in ever higher rates, the requirement for more government subsidization and an inability for insurance carriers to compete with one another to improve their individual insurance market shares. This stifles innovation, restricts free trade and further drives up the cost of health insurance and ultimately may lead to a complete government take-over of our Truly American healthcare system. This is what is happening today with the ACA. Medical socialism has failed in countries as diverse as socialist Great Britain and communist Russia. No one is electing to travel to either of these countries to avail themselves of quality health care. Free enterprise is the only system that will successfully survive a changing environment because it is the only system that enhances our basic human nature to survive, improve our performance and achieve greater success. Socialized medicine will extinguish the benefits of our flourishing free enterprise health care system that produces the many medical miracles that are now well known all over the globe.

This is not to say that our Medicare Advantage (MA) is in any way shape or form un-regulated by the federal government. On the contrary, it is one of the most regulated insurance plans sponsored by our federal government. However, there is a big difference between the CMS's Medicare Advantage regulation and that of the punitive HHS's ACA regulations.

The mission of HHS is the promotion of the general welfare and it is taken most seriously when it comes to the protection of our most vulnerable retired, elderly and disabled population. The purpose of our Medicare program is to provide financial security to the aging. CMS's MA regulations support this vital interest by making sure the carriers correctly deliver an equivalent level of Medicare benefits and that beneficiaries are protected from any coercion and manipulation. No enterprise in any business can be completely unfettered without regulation and expected to do the right thing all the time. Checks and Balances are required. We learned

that with our government and we see the need for it in our businesses as well. But, there is constructive regulation and destructive regulation. CMS's Medicare Advantage regulation is, for the most part, a sterling example of the former, just as ACA regulations are a disastrous example of the later in action.

No one should be too surprised that, in the absence of government subsidies, the ACA programs are NOT generally affordable. ACA enrollment has declined in each of the last four years. The Congressional leaders are frustrated with the high cost of out-of-pocket expenses and sky rocketing premiums, and the many other "serious problems" that they mistakenly believe are part and parcel with a health care system dependent on private health insurance plans. On the contrary, their Federal Regulations are largely to blame.

IV. HEALTH RISK MANAGEMENT

A. CAPITATION REIMBURSEMENT

The Republican Graham-Cassidy health reform bill attempted to use capitation reimbursement to limit the federal cost of Medicaid. CMS uses it to cap the cost of Medicare Advantage Plans. Capitation Reimbursement is one of the most effective health risk management tools. Capitation is the main reason Medicare Advantage (MA) plans *costs less* than the Medicare fee-for-service (MFFS) program and Obamacare (ACA) program costs. Federal Capitation Reimbursement acts exactly as it sounds. It caps the amount of money the federal governement has to spend on a program. A capitation is a pre-set amount of money paid by the federal governement for each participant in an MA or Medicaid program.

The Centers for Medicare and Medicaid (CMS) have an extensive data base of U.S. health costs by jurisdictional county. CMS uses this data base to set the capitation rates for the MA carriers each year. The health plans use the capitation amounts to determine what benefits they can provide and what amount, if anything, they need to charge prospective beneficiaries. Unlike MFFS and the ACA, CMS caps the full amount that federal governement is willing to pay the MA carriers and therefore places the risk for any excess loss onto the health plans. Consequently, the federal governement does not have to carry any future lability on it's books and MA plans do not add anything to the Trillion Dollar federal debt level.

Capitation reimbursement simultaneously eliminates the need for the ACA's "3R" program costs and all of the other bizarre reimbursement, market stabilization and risk adjustment schemes mandated by the Affordable Care Act. At Medicare-Advantage-For-All.Com we believe the federal governement should be able to get the Health plans to re-design MA contracts for under age 65 participants and use properly targeted capitation reimbursement rates that will dramatically lower the federal cost of health insurance and maximize the possibility of enrolling up to 27.3 Million insured and uninsured Americans, 17.2 Million of which already have coverage and 5.3 Million uninsured American that are eligible for ACA Plan subsidies. Please see New Member Enrollment below for details. A complete explanation of capitation for Medicare

Advantage Plans starts on page 38 of, "The Best Bi-Partisan Answer to Repeal And Replace Obamacare", a Key Document in our library.

B. HEALTH PLAN COMPETITION

Medicare Advantage (MA) is the ONLY federally sponsored health plan, besides the Federal Employee Health Plan, that creates a functioning health insurance market with incentives for the insurance companies to compete with one another. The average Medicare Advantage Plan beneficiary has 21 Medicare Advantage plans to choose from. The health plans get paid on capitation and actually assume the health insurance risks. Therefore it is in their self-interest to reduce the cost of their programs for all of their participants and they do so in a regulatory environment that supports competition and encourages innovation.

MA carriers in a competitive market can make more money by getting more customers and since Medicare-Advantage-For-All carriers would be required provide all of their benefits within the prescribed capitation reimbursement amount, they would naturally find ways to reduce the cost of health care, without having to charge their customers any additional premium. MA enrollment has increased by 2.5 Million in the last three years. *Medicare Advantage is the fastest growing government-sponsored health insurance program in the United States.*

The Affordable Care Act (ACA) is the exact opposite. ACA enrollment has dropped by over 4 Million participants in the last three years. ACA regulations have left Millions of Americans stranded with just One (1) health insurance carrier (and, in some cases none) in over 50% of the jurisdictional counties in the U.S. With many health insurance carriers dropping out of the program, the remaining health plans have almost exclusive possession of ACA products in their markets with no remarkable competition, which is the text book definition of monopolistic restraint of trade.

The American people created Anti-Trust Laws and the Federal Trade Commission to protect the general public from industries that possess exclusive possession of a service, because businesses without any competition tend to become usurious. For most jurisdictional counties, this is what has happened with the ACA. The structure and delivery of the ACA are flawed. Businesses in a competitive market realize that they can make more money by getting more customers. They naturally lower their rates or find other ways to reduce the cost of health care. With the ACA, the incentive to do this is limited:

1. Monopolistic conditions exist in over 50% of the ACA markets, so there is NO market incentive to lower premiums.
2. If you need to increase salaries and grow your companies' administrative expenses (with MLR's at 80%- 85%) you simply raise the base rates.
3. There is also no incentive to charge lower rates because governement marketing regulations limit their ability to attract new customers.
4. The easiest way to make more money is simply to get the governement and consumers to pay more money.
5. To get more money you raise your rates and lobby HHS to approve them.

6. Since your administrative expenses are fixed and in order to justify raising the rates, it helps to pay the health care providers more money.

   And (without capitation) so it goes …. higher health care charges, higher reimbursements, higher administrative expenses and higher rates.

Since the health plans get paid by federal subsidies and participant premiums, and eighty-five percent (85%) of the ACA participants get a tax payer paid premium subsidy (based on the Silver plan benchmark premium), the higher the Silver plan premiums, the more the governement and the participants must pay to the ACA carrier. Since, there is no competition in most instances, and little opportunity for gaining new customers; a lower the Silver plan premium is just going to reduce the amount being paid to the ACA carrier. Therefore, there is no incentive for the health plans to reduce their rates. In fact, the only way the ACA carrier can make more money is by raising the rates. The incentive to lower their cost is purely altruistic because they are required to pay out at least 80%- 85% of every dollar they collect.

On the other hand, Medicare Advantage has demonstrated success delivering high-quality health insurance to all the participants. The health insurance carriers can save their customers more money than it costs them to administer their benefit programs. A PBS Documentary on Medicare Advantage Plans uncovered the fact that some Medicare Part C (MA) carriers could almost save more money through favorable provider contracts than they had to charge the governement for their administration.

The challenge for the government is to share the risk with the insurance carriers as much as possible, pay the lowest and most reasonable capitation fees possible, but pay them enough money to be enable them to make a profit. And, if they get creative, find a way to motivate the carriers to factor their profit back into the cost that they charge the government for administration. The non-profit BlueCross BlueShield “system” did this voluntarily (and may still) for many years before the federal governement taxed them (forty years ago) as profit making commercial insurers. HHS invented a very successful STAR rating system for improving carrier performance and it may be adaptable to maximizing the government’s return on investment.

C. NEW MEMBER ENROLLMENT

Competitive health insurance carriers naturally seek to attract new member enrollment. The more people they can enroll, the more successful their business will be. This drive to succeed creates the incentive to innovate, find ways to improve efficiencies and lower their rates, so that they can be in a better market position than their competition, to attract more members. When the Obama Administration was negotiating with Karen Ignagni, CEO of the American Health Insurance Plans (AHIP), she was excited by the prospect of her industry gaining access to a large uninsured population with the help of the federal governement. In 2009, with her skillful use of the AHIP partnership, Karen advanced the best interests of the industry. In return, her health plan membership largely gave up the ability to seek new members directly.

Instead of the traditional business marketing model used by most other health plans, the ACA could create state non-profit health insurance Marketplace exchanges, 51 of which still exist. These Marketplaces have cost the federal governement in excess of $5 Billion Dollars and had at best, a checkered performance blackened by disfunction and insolvency. The most famous failure was that of the federal Marketplace Exchange which Bloomberg Governement News reported cost us and additional $2.5 Billion to fix. Some major ACA carriers have so completely abandoned individual health insurance marketing that all telephone calls to their offices are referred to the federal Marketplace Exchange directly, indicative of a Zero interest in the market or even maintaining their particular market share.

Consequently, the governement removed a major incentive for ACA health plans to be competitive and hold rates down. In this environment the ACA becomes a cash cow giving the health plans very little incentive to invest any money or effort to add new members, improve their products or lower their rates. The Commercial individual Health insurance Market (CIIM) has never been the darling of the industry to begin with. To many of the larger carriers, the market was more trouble than it was worth, requiring high administrative expenses and generally higher levels of risk. BlueCross BlueShield considered non-group business as more of a public service to the community. It was an important service for people who were in transition, between jobs, loss of a bread winner or working for an employer that did not offer health insurance. When the Obama Administration approached AHIP offering to subsidize premiums and protect their health plans from financial losses in a market with which they had very little experience, they were interested! Karen Ignagni appreciated the opportunity. She realized that by cooperating with the Obama Administration, her industry would reap Billions of Dollars in new income and she was right.

The design of the ACA is built upon the pervasive assumption that if you get enough people to sign up for the program, it will support itself. This is what they originally thought would be the case with the National Flood insurance Program (NFIP). The guiding principle was to insure as many people as possible and eventually earned premiums and fee income would cover the claims and program expenses. Over the last decade the NFIP is Billions of Dollars in Debt because *the level of risk assumed by the program can NOT be adequately covered by affordable premiums.* Who said the ACA's health risks are any different?

The problems with the NFIP are the like those of the ACA. And, Congress would do well to learn from the NFIP experience. To make the program successful, NFIP partnered with Property & Casualty insurance companies to administer the program and share the risk. They made a concerted effort to get as many people as possible to enroll in the program. The National Flood Insurance program's solution is essentially what Medicare-Advantage-For-All.Com is proposing for health care in addition to the ACA. *Use the Medicare Advantage Program as a platform to design programs that share the risk of losses with the health insurance companies and with the participants in order to avoid complete reliance on the treasury and the tax payers.* Congress should authorize HHS to expand the Medicare Advantage program using capitation reimbursement to share the prospective health risks with the carriers and then enroll as many people as possible in the program.

Let's assume for the moment that Congress authorizes HHS to arrange for the MA health plans to re-engineer their programs and they develop a market basket of products that are affordable and potentially popular with American people. Exactly how many people are in this market and what is their potential for new enrollment? The non-group market churns a lot because people always looking for the best deal. If MAA is offered alongside Obamacare in 2020, the health plans will have a total market with 27.3 Million Americans.

Insured Market:

- 8.4 Million -ACA Subscribers (ACA 2019)
- 4.3 Million -ACA Drop Outs (down from 13 Million)
- 4.5 Million -Grand mothered & Grand fathered Policies (Norris-acasignups.net,04-16)
-
- 17.2 Million - Total Insured Market Potential

Uninsured Market:

- 27.4 Million -Uninsured (KFF 2017)
- - 5.4 Million -Undocumented Immigrants
- -6.4 Million -Medicaid Eligible
- -5.5 Million -Chronic Uninsured(20%)
-
- 10.1 Million - Total Uninsured Market Potential

27.3 Million Total Market x $7,500. = $20,475,000,000.

One hundred percent successful enrollment of this market would cover 27.3 Million people worth $20.5 Billion in annual premiums. More than half of these people already have coverage, so there is no question they can afford health insurance if governement subsidies are maintained at their current levels. The Kaiser Family Foundation (KFF) has determined that 8.4 Million of the uninsured population are between jobs or working for employers that do not offer group insurance, so they earn an income. KFF also estimates that an additional 5.3 Million uninsured in this market are eligible for federal tax credits but have failed to buy health coverage. Only about 45% of the uninsured market said they tried to buy health insurance and could not afford the coverage.

The bottom line is that if we were to make health insurance more affordable and open up health insurance carriers to compete with one another for new enrollment, there is a viable and lucrative market for them to go after. If we don't make health insurance more affordable, we will be stuck with the most expensive health insurance plan on the planet. Most True Americans are not going to be able to afford it unless the tax payers pay most of the cost. A re-engineered Medicare-Advantage-For-All program offered by our health insurance carriers in a more traditional capitated financial arrangement will solve these problems and save the tax payers a ton of money.

D. MINIMUM LOSS RATIOS

The Obama Administration tried to guarantee consumer value by requiring all carriers to adhere to a myriad of consumer regulations, including minimum Maximum Loss Ratio's (MLR's). Since over 70% of all health insurance carriers in the CIIM Market were voluntarily in compliance with MLR regulations before the ACA, the net effect of MRL's was to increase some health insurance premiums. MLR regulations incentivize health insurance carriers to increase premiums in order to increase their administrative expenses and profits and grow their companies. Such premium increases are either caused by, or result in, higher provider reimbursement rates that materially contribute to the over-all health care inflation. This is one of the reasons the Commercial Individual Insurance Market rates increased so precipitously after the ACA's enactment. The governement was trying to be insure the insurance company's didn't make too much money. No reasonable politician would propose limiting the cost of governement to 15% of the tax revenues to effectively reduce governement spending? The Democrats focus on MLR's is another way of indicating their preference for a tax payer financed governement run burocracy.

Why is it that we never seem to get anybody who understands health insurance legislating our health insurance reform? These MLR Regulations have a most important favored status. In fact, Elizabeth Warren has just introduced a Senate bill in Congress to raise the MLR's to 85% of premium. Senator Warren's Senate Bill has been co-signed by several democrat presidential hopefuls, including Senators Baldwin, Sanders, Harris and Gillibrand.

E. PRE-EXISTING CONDTIONS

The ACA carriers are increasing rates by an average of 20% to 45% simply to cover this Pre-X regulation. Medicare-Advantage-For-All.Com believes health plans should NOT be required to prospectively insure pre-existing conditions for all health insurance plans. Pre-existing conditions should be covered by special risk pools under state Medicaid Plans (which many states already have) regardless of a person's income. These plans are generally "pay as you go - cost plus" plans and 50% to 90% of the cost is paid by the federal governement. The problem is if we allow everyone to avoid buying health insurance until they suffer a serious illness, many people would never get the health insurance until they need it. Accepting them into the same risk pools of the ACA plans is like allowing them to burn their house down and then requiring a private property casualty insurance company to enroll them in an insurance program and pay for their fire damages. This practice is not fair. It is just not fair to force people who are responsibly insuring their health risks, who are already in the program to pay for those people who drop in to take care of a particular health issue and then may just as easily drop out once they have gotten their treatment.

This practice of thinking that prospective insurance plans can cover health insurance plans with anti-selection is just praying on the tax payers. We know this from the National Flood Insurance Program (NFIP). This program provides full coverage for properties in high risk flood zones. This not only encourages people to build and re-build in these areas, the program losses are perpetuated by the likelihood that flood prone properties are occupied by people that can least

afford to recover from a flood on their own. A resident in a flood prone zone is like someone with a pre-existing health condition. There is no imperative for them to move or take care of their condition if the insurance will always take care of it. Both programs refer to this as adverse selection. The NFIP covers acts of nature. The ACA covers acts of man. NFIP is Billions in debt and Congress has accepted the fact that NFIP can NOT charge adequate and affordable premiums to support the risks covered by the program. Although the True American public has come to this conclusion on the ACA, Congress is not yet there.

To manage this health risk, our recommendation, from Page 40 of the Bi-Partisan Answer Document, is to accept any uninsured applicant with a pre-existing condition, who has been able to qualify for health insurance, provided the coverage has been active no less than 60 days from the effective date of the MAA plan. If they have NOT been able to obtain health insurance for more than 60 days at the time of eligibility, the special State Fund for High-Risks under Medicaid will enroll them. Coverage will be available anytime under this Special Risk Pool (SRP). The federal and state governments will share the cost of SRP using a 1332 state waiver in the Medicaid program as necessary.

Medicare-Advantage-For-All.Com believes that Medicare Part C plans should not be required to take anyone with a serious and costly pre-existing condition that has not had coverage for that condition for more than 60 days. This at least helps the MAA plan by maximizing the possibility that the new enrollees have their Pre-existing condition under control, i.e. had a successful surgery, arrested cancer with chemotherapy, on maintenance drugs, etc. A lot of people have pre-existing conditions that don't cost any money because there is no medical treatment for them.

CMS and the states will agree to accept and pay for any and all pre-existing conditions under a "pay as you go" Medicaid plan. If they have a break in coverage of more than 60 days, no one with a pre-existing condition will be turned away. However, they will only (and immediately) be eligible for Medicaid, regardless of their level of income. After a period in which they may have been able to bring their condition under control, they will be able to participate in periodic Open Enrollments in the MAA Plans, in the same fashion as Original Medicare has open enrollments.

All citizens of the United States that want health insurance, should be able to get it. Hose people that do not income-qualify for the Medicaid coverage, will have to pay some premiums. But they will NOT be turned away! This will create an incentive for them to get and keep health insurance coverage and get the condition under control so that they may qualify for one of the Medicare Part C – Medicare-Advantage-For-All Plans in the future.

F. RE-INSURANCE PROGRAMS

I addition to these Special Risk Pools for Pre-X, the Robert Wood Johnson Foundation has recommended that HHS facilitate the creation of health plan reinsurance programs. This recommendation is the result of their Actuarial Challenge in 2017 which highlighted the

consensus among actuaries that re-insurance is a necessary component of stable health risk underwriting. The use of re-insurance with ACA programs in Alaska has recently resulted in lower premium increases. This may prove helpful in managing the cost of pre-existing health conditions in the Special Risk Pools as well.

The NFIP experience with re-insurance is instructive. Since they seek to maintain a meaningful level of private premiums coming into the program by those that are required to maintain the coverage (inadequate as they may be to cover the potential loss) they made the U.S. Treasury their reinsurer. This is like the way the Obama Administration provided such coverage in the ACA's early years. It permits the NFIP and their risk bearing (property & casualty insurance) partners to exclude the estimated cost of catastrophic claim losses in their regular program premiums. This practice allows them to reduce the regular premiums for everrybody, making their programs more affordable and keeping program participation as high as possible.

G. COMMUNITY HEALTH CENTER PRIMARY CARE INSURANCE PROGRAM

If we extend MAA to the under age 65 population, congress can build in fair sliding scale premiums and tax credit subsidies that will continue to make the programs affordable for those that are below the poverty lines and the unemployed. The ideal condition would be for Medicare Advantage Health plans to compete with one another in such a way as to attract as many uninsured Americans as possible. The over-all cost of the programs would be reduced over time by CMS negotiaitons over capitation reimbursement levels and the improvement of health outcomes.

Medicare-Advantage-For-All.Com will soon define and propose a special Public Option Health Plan that will appeal to the low wage workers, who make up approximately 20% of the target population that make too much money to qualify for ACA federal premium subsidies. This Public Option will rely on the Community Health Clinics for primary care and provide tertiary care through a third-party insurance mechanism. The federal government hasn't been able to offer a program that attracts most of the low wage workers, who make up 5.2 Million people, a significant proportion of the uninsured population. These special programs will require the participants to receive all their primary care from the Community Health Center network (CHC). The CHC can be the source of primary care for the 45% of the uninsured Americans, who say that the ACA coverage is too expensive. Many of these workers are NEVER going to be able to afford health insurance if we do not buy it for them. This program will make it affordable, even for them.

The Community Health Center network (CHC) employs over 51,000 health care workers in 1,400 communities and is primarily supported by the federal governement. However, the health centers accept all forms of health insurance including Medicare and Medicaid. Congress just re-authorized CHC funding for another two years. Special expertise, support, and direction for the CHC insurance program will be provided by HHS. The Community Health Center network is a

True American Jewel in our health care system, a wonderful thing for which every American citizen should be proud. True Americans believe in the value of our healthcare system and our need to care for one another. We should all be proud to deliver essential health care services to "We the People" in the United States of America through this network. Please see the upcoming Fifth Edition - The True American, for more information.

IV. COST CONTAINMENT AND WELL BEING

Would you be surprised to learn *every* major piece of health care legislation, passed by Congress since the enactment of Medicare in 1965 has been an attempt to contain the cost of the Medicare program in one way or another? And, these laws have been somewhat successful in at least slowing the escalating cost of the program.

The HMO Act was passed in 1973 to enable Medicare to contract with managed care providers because they were considered to be the key to reducing the cost of Medicare. TEFRA was passed in 1982 creating the Medicare + Choice programs because there was widespread recognition that *competing* health plans were our best bet to lower the cost of Medicare. In 1997, the re-branding these + Choice Health Plans became the Medicare Advantage (MA) Plans we know today. After another decade of MA program success, the financial guru, Peter Orsag, the Director the Congressional Budget Office (CBO) and later became President Obama's Budget Director, made the following statement before a Senate Budget Committee in 2007:

"The nations long-term fiscal balance will be determined primarily by the future rate of health care cost growth. And, a Medicare Advantage program that is able to thread the policy needle and offer high-quality health plans while saving money has the potential to improve the performance and sustainability of the Medicare program overall."

No truer words were ever spoken before the Senate. This statement was made two (2) years before the enactment of Obamacare, which was passed because both the CBO and President Obama said that it would lower the cost of health insurance and reduce the federal budget deficit. The ACA did exactly the opposite. It substantially raised the cost of health insurance, increased the budget deficit and Peter Orszag was one of the key architects of the program.

As you can see, Medicare Advantage programs were created and promoted to lower the cost of Medicare Parts A & B. This experiment was started 20 years ago and is still working successfully today. How many "Medicare Parts" do you think it takes to reduce the cost of health insurance in this country and cover All Americans? Hopefully, not any more than the number of Americans it takes to change a light bulb? We already have Medicare Parts A, B, C and D. Why is four Parts NOT enough to provide for the general welfare of our people, especially since all of these programs are "working".

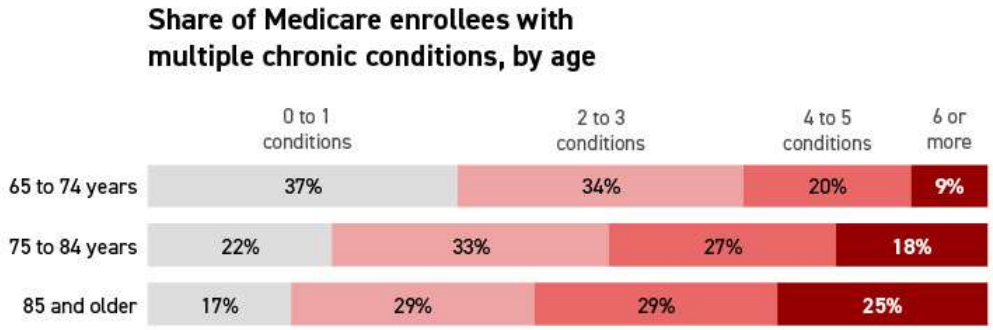
As a nation, we have successfully experimented with managed care programs for almost 50 years. We know what we are doing. We are the world-wide experts at it and people come from all over the globe to study how we do it. But, we can always "do it better." Just as we are going

to have to re-finance SSI and Medicare fee-for-service to make them sustainable, we are also going to have to change the SSI benefits and Medicare program administration, in order to save SSI and the Medicare Trust Funds. The First and most meaningful thing we can do make health insurance more affordable is to promote Medicare Advantage Plans For All Americans. Re-engineering Medicare Advantage for under age 65 participants will be make a constructive down payment on the Medicare reform and the most feasible approach to lowering the cost of health care for everyone in our nation, without threatening the viability of our healthcare system.

The Second most meaningful thing we can do is recognize the ELEPHANT in the room. We all should know that there is ultimately only one real solution to effectively lowering the cost of health care in the United States. WE MUST IMPROVE THE HEALTH OF OUR PEOPLE. This concept is not new but our pursuing it diligently as a nation is unknown!

Currently our consumer health care system is euphemistically re-branding "improving our health" with the improvement of health outcomes. However, it is more than that. What we really need to do is reduce the severity of our illnesses and decrease the incidence of the necessary health care to treat these illnesses on a national basis. This is THE ONLY WAY we are ever going to reduce the cost of health care and ensure the future commercial success of our nation-state on this planet. We must make our people the healthiest people in the world if we are going to successfully continue to provide leadership to the rest of the world. To accomplish this daunting and quintessential goal, we must improve our diets, increase our level of exercise and increase our public awareness of healthy (lifestyle) living. We are gradually becoming the most overfed, obese nation of spoiled and privileged children and adults in the world. We drink too much. We smoke too much, and we eat too much. We suffer from loneliness and mental illness and over 50% of our medical treatments are for preventable conditions that our people should not be suffering from in the first place. Learn More under the Wellness and Well Being.

The chart below shows, by age, the incidence of Medicare beneficiaries that suffer from chronic illness. Did you know that forty-eight percent (48%) of All Americans suffer from one or more chronic illnesses? Just look at the obesity all around you. In 2016, we had 57 Million Americans covered by Medicare. We spent 1.1 trillion Dollars on chronic illnesses, and our GDP was 17.9%. In 2030, CMS predicts Medicare will cover 77 Million Americans. In 2030, the National Health Council expects the annual cost of chronic illness, for more than 157 Million Americans (81 Million with multiple chronic conditions) will exceed 4.2 Trillion Dollars. If we continue the way we are going, employers will eventually abandon the private health care financial system, and the only alternative will be to nationalize the health care system, the way that many Democrats want to do.



Here's how we can fix this problem.

An informed consensus of medical opinion categorically believes that 80% of the chronic diseases we suffer from in this country are preventable or almost completely reversible with the right combination of health and wellness promotion and medical intervention. The magnitude of this revelation is enormous. For instance, if as a nation, we had eliminated 80% of the cost of treating chronic illnesses in 2016, the U. S. Health Care GDP would have been 13%; which is a full five percentage points (-5%) less than our actual GDP and just equal to our nearest international competitor, Switzerland.

The correct path forward to lowering the U.S. health care GDP is to expand the eligibility of Medicare-Advantage-For-All Americans and require the health plans to implement the New Paradigm for patient care. We must require carriers to accept the full risk for quality and cost outcomes under new CMS approved value-based payment initiatives, that provides sufficient funding for a meaningful re-allocation of medical resources to the implementation of this new methodology. Based on the cost of chronic illness and the professional estimates of the potential reductions in health care utilization, a reduction of eight percent (8%) or more in the U.S. health care GDP is a practical reality. Anything less than this path forward will continue to represent a misallocation of limited national resources, encourage the wrong incentives and perpetuate the epidemic (and the cost) of chronic illness, to the point where nationalization of the U.S. health care system will become inevitable.

Theoretically, if we had a ZAR for health care, CMS would then be able to get health plans to re-engineer their programs for people under age 65. The health plans could be compelled to implement comprehensive Wellness and Well-Being programs and monitor their performance, reward the health plans for good performance, and get the same positive results they get now under the STAR system. We are cautiously optimistic that the Administration is moving us in the right direction.

Medicare-Advantage-For-All.Com is skeptical that our States can achieve the kind of savings and effectively lower the Health Care GDP in a Block Grant type federal program like the one favored by Lindsey Graham and the President. It is laudable that they want to get the money

out of Washington, D.C. and give more power and innovation to the states. Unfortunately, CMS will have a tremendous challenge achieving the necessary level of savings under a Wellness and Well-Being program. They have not had a particularly good track record in this area under any program.

However, HHS could be up to the challenge. Did you know that since 1984, HHS has had the world renown Preventative Services Task Force as part of their team? After ten long years, HHS has also recently released new guidelines for physical activity, which is a step in the right direction. Their Center for Medicare and Medicaid Innovation has done some ground-breaking work, but so far Warren Buffet is right to caution us that we are a "rich country and we can get along doing the Wrong thing for some time, but we can't get along doing the Wrong thing indefinitely." Now is the time for All of us to do the next Right thing.

VI. THIS IS A FINANCIAL EMERGENCY (NOT)

As U.S. citizens, you would think we would have an EMERGENCY. We have over 29 Million Americans living and working in our nation that do not have and cannot afford health insurance. The Democrats are certainly concerned about it and generally want to throw money at the problem. The Republicans are rightly concerned about the money and they do not have the same sense of urgency. This is because it is NOT a financial crisis for most Americans. Everybody in the health care system is making money. Hospitals and most medical providers are enjoying some of the best years they have ever had. Hospital bad debt write-offs are at an all-time low. Metropolitan Community Hospital profit margins are up. The rural hospitals are struggling in some areas but Merger and Acquisition activity in the medical provider community is approaching an all-time high. Thirteen healthcare M&A deals made headlines in 2017, with eighty-seven (87) Hospital mergers recorded through the third quarter of 2017. Eight (8) of these hospital deals each involved over a Billion Dollars in annual revenues, twice as many of these big deals as there were in 2016. These are major health care providers that are strategically positioning themselves for greater future control of their markets, improving their consumer health care operations and increasing their profitability. The Affordable Care Act is partially responsible for this abundance.

The Council of Economic Advisors reported in their March 2018 Report, "… health insurer profitability in the individual market has risen due to substantial premium increases, government premium tax credits that pay for the premium increases and the large government-funded Medicaid expansion. Since ACA implementation…, health insurance stocks out-performed the S&P 500 by 106%." Some of the largest health insurance carriers expect their earnings to increase between 9 and 20 percent in 2018. (Reference) A.M. Best is projecting that health insurance payers will have a positive year in 2018 as they continue to engage in profitable health plan markets. They further predict that health insurance carriers will continue to be profitable in years to come; if they can successfully work around," the political challenges that We put in front of them." Nobody in the industry want to upset the apple chart.

We are also seeing major non-healthcare market innovation deals, including Amazon, Berkshire Hathaway and J.P. Morgan forming an independent company (ABJ) to try and improve the nation's health care system by putting the brakes on the spiraling cost of medical treatment. CVS recently purchased Aetna to gain the ability to better serve their 44.7 Million customers and manage their health care more efficiently. And, Humana and Walmart are looking to combine services to create a "One Stop Shop" where Humana can offer Medicare Advantage and Pharmaceutical Benefit Plans and Walmart can use its massive investment in primary health care clinics to serve both its employees and customers from all their strategic geographic locations.

The "Emergency" that the 116th Congress faces is the high cost of inaction. There is no end in sight for the rising cost of health insurance which is also driving up the cost of health care and making it less and less likely that our low wage and middle-class citizens will be able to take advantage of the innovation, creativity and financial health we are enjoying in the healthcare sector. Congress is bankrupting the nation, and the cost of our healthcare and our government sponsored health insurance programs are, as Warren Buffet says," the tapeworm of our American economy."

This is an Emergency and the taxpayers are the real losers. Congress has NOT been able to agree on a way to fix or repeal Obamacare, and the Administration never put forward a viable alternative. Out of the frustration, Congress almost passed an ACA bail-out, as a part of the bipartisan Omnibus Budget Bill that had the Republicans running for cover ever since it passed. The ACA insurance companies are threatening to raise rates at an even greater pace if they don't get more money. And, our Congressional Representatives are increasingly willing to throw more money at the ACA, rather than face the serious problems head-on.

In addition to the democratic opposition to changing the Affordable Care Act, there is another huge influence working against any change. While the general public is concerned about health care and the Democrats have made it an important issue; most voters don't want to pay higher taxes for more health insurance reform. And, most Americans don't want any changes to the health insurance that they have already. Bernie Sander's Medicare for All idea is a Non-starter and most everybody knows it. There is little or no incentive for either the provider community or the health insurance carriers to support any changes. Most of our health care is paid by employers, insurance companies and the governement. As has been pointed out, the public/private partnership carriers, with the support of the federal government, currently manage health insurance programs that cover 74 Million Medicaid, 57 Million Medicare Fee for Service and 21 Million Medicare Advantage subscribers as well as the 8.5 Million ACA participants. While some Medicaid programs are still administered by the states, most are now managed by health insurance carriers. As we learned from the whole-sale withdrawal of political support for the Republican Graham-Cassidy Reform Bill, there is almost no provider community support for changes in the Medicaid program, or any other program for that matter, while some idealistic physicians think single payer is the answer. Consequently, the two most powerful interests in the system, the health insurance plans and the providers are not generally in favor of the change, because they have their markets pretty much under control.

That leaves We the American People. If we do not get behind the Medicare-Advantage-For-All solutions to this problem, we are going to suffer from the consequences of the solution that is forced upon us. The Democrat's interest in health care reform and in Medicare for All and the Republican's interest in doing away with Obamacare, the state block grants and the necessary re-financing of the SSI and Medicare entitlement programs are the positive influences that we have going for us.

With your help, Medicare-Advantage-For-All can become the bipartisan solution for both political parties, because it is successful, less costly and our best shot at successfully reforming the system.

January 22, 2019

Medicare-Advantage-For-All.Com

Arthur Jackson Wheeler, CHC