Extended Medicare For All
Financial Approach

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Health financing drives equitable health care.
Caroline Heider, World Bank Group (2014)

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Introduction

The best health insurance plan ensures that everyone has equal access to health care. Health insurance is a natural monopoly. Competition among health insurers fragments the financing which increases the costs of health insurance for everyone. This segmentation of the population is the cause for the wasteful complexity of the health care system.

Extending Medicare to those under 65 years of age and improving the current Medicare program requires the replacement of private health insurance premiums and out-of-pocket spending with income related Medicare insurance premiums. The individual income tax and corporate income tax should be used to increase general revenue. These are the appropriate funding sources for social health insurance.

Twenty-first century technology provides an opportunity for the United States to provide the most equitable, efficient, and effective health care system in the world. Income related health insurance premiums which simplify health financing is the means to realize this opportunity. It's just good business.

EXTENDED MEDICARE FRAMEWORK

Universal Health Care

Equal Access

National Social Health Insurance

Current Medicare (65y/o +) [1]

Part A-Hospital Insurance	Federal Insurance Contributions* (FICA)
Part B-Medical Services Insurance	Premiums + General Revenue
Part D-Prescription Drug Coverage	Private Plan Premiums Medicare Premium Surcharge + General Revenue

*Actuarial Principles + Mortality Table = Premiums (aka Payroll Taxes including Social Security)

ADD

Under 65y/o Medicare [2]

Hospital Insurance	Premiums + General Revenue
Medical Services Insurance	Premiums + General Revenue
Prescription Drug Coverage (Under 65 & 65+)	No Private Plan Premiums Medicare Premiums + General Revenue [3]

Elimination of Private Health Insurers

Losses in the Economy

Financial Crisis of 2007–2008	$613 billion default
Enterprise Value of Private Health Insurers*	$714 billion default [4]

*Enterprise Value = market value of common stock + market value of preferred equity + market value of debt + minority interest - cash and investments = Liquidation Value

Remedy

Governmental Proprietary Capacity*	Acquire Private Health Insurers at Enterprise Value [5]

*Example: U.S. government becoming the majority shareholder of the new GM.

What is insurance? Insurance is risk management. It uses actuarial methods to predict future costs to ensure that there are enough funds to cover those costs.

CMS Office of the Actuary calculates premiums and appropriations from general revenue based on their projections of the following year's medical claims and administrative costs for risk pools of individuals.

All premiums/contributions and appropriations are mandatory by law.

Notes

1. Improved Medicare. No private Medicare supplement plans. Income-related premiums and general revenue cover all benefit costs. Reconciled on the annual federal income tax return. No cost sharing except for drug coverage.

2. Affordable Care Act. Premiums based on federal poverty level (FPL) income and family size. General revenue covers premiums for those with lower incomes. Premiums and general revenue cover all benefit costs. Reconciled on the annual federal income tax return. No cost sharing except for drug coverage.

3. Coinsurance for brand drugs with multiple generic equivalents.

4. The estimate is in the high range since detailed information is not publicly available. The estimated investment of $714 billion to acquire the private health insurers is offset by the estimated annual administrative cost savings of $405B. This results in a payback period of two years.

5. The private health insurers are acquired well in advance to facilitate a smooth transition to social health insurance. Private health insurers continue until all pending claims are resolved.

U. S. Healthcare Financing Reform:
The Consolidation of the Health Insurance Industry

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Abstract
Equitable distribution of healthcare services and administrative efficiency are lacking in the current American healthcare system. A high concentration and a lack of competition in the health insurance industry suggests the feasibility of a single government health insurer, which could be achieved using a mergers and acquisition strategy, thus removing the wasteful complexity in healthcare financing. In this study, the enterprise value, market share, and financial characteristics of commercial health insurers are used to estimate that an investment of $714 billion would be needed to consolidate the health insurance industry. We estimate that, with an annual administrative cost savings of $405B, there would be a payback period of two years. Merging state medical assistance programs and acquiring the private health insurers to reform the Medicare program would be the most effective method of achieving affordability, equitable access, and cost savings in healthcare.

Introduction
Mergers and acquisitions (M&A) are common business practices used to acquire customers, achieve economies of scale, and reduce expenses. The Federal Government, the largest health insurer in the country and the largest customer of private health insurance, has a financial incentive to use an M&A strategy to merge state medical assistance programs and acquire private health insurers to reform the Medicare program.

The purpose of this study is to analyze the synergy that could be achieved by federalizing the cost of state medical assistance programs and consolidating the health insurance industry into a single government health insurer. Economists have extensively studied the savings in administrative costs that can be achieved by replacing the multi-insurer system with a single government health insurer.[1] In the present study, the financial characteristics and market share of private health insurers are examined to determine the feasibility and expected cost to the Federal Government of acquiring the entire private health insurance industry. The payback period method, which measures the number of years it takes to return the initial investment, is used to value the M&A strategy.

The estimated payback period shows that the Federal Government has the opportunity to invest and consolidate the industry, and thus reduce the wasteful complexity of health insurance. The Medicare program that we propose would simplify billing and health insurance-related (BIR) activities, resulting in a more efficient healthcare financing system.[2] Using income-related

actuarial premiums and family size in reforming the Medicare program would make health insurance affordable while adding social value.[3]

Background

The Centers for Medicare & Medicaid Services (CMS) manages both the Medicare and Medicaid programs, each of which provides health services in different ways to different groups of people.

The CMS describes the Medicare program as the largest health insurer in the United States.[4] Medicare provides health insurance to over 56 million people, and is available to those who are aged 65 and over or have permanent disabilities or End-Stage Renal Disease.[5]

Medicaid consists of three medical assistance programs including Medicaid, Expanded Medicaid, and the Children's Health Insurance Program (CHIP) that provide health insurance coverage to about 73 million low-income individuals.[6] Hospital care, medical services, and prescription drugs account for 75 percent of Medicaid spending.[7] Medicaid programs are jointly funded by federal and state governments, and administered by states according to federal requirements. Under the original Medicaid, the federal government pays, on average, 59 percent of costs for children, pregnant women, parents, seniors and individuals with disabilities, and 93.8 percent of the CHIP costs.[8, 9] The federal share of Expanded Medicaid for adults aged under 65 is 100 percent in 2016 with the federal contribution to be phased down to 90 percent by 2020.[10]

Medicare and Medicaid therefore together provide health insurance coverage to 129 million individuals, approaching 40 percent of the population, with the majority of the funding provided by the Federal Government.[11]

The Federal Government is also the largest purchaser of private health insurance. The 2015 Health Insurance Industry Analysis Report shows Medicaid with 25.2 percent of direct premiums written followed by Medicare at 24.8 percent. The Federal Employees Health Benefits (FEHB) Program is the largest employer-sponsored group health insurance program in the United States, covering over 9 million individuals.[12] The government's share of FEHB premiums is equal to 72 percent of the weighted average premium of all plans, not to exceed 75 percent of any given plan's premium.[13] FEHB accounts for 6.2 percent of direct premiums written, as illustrated in Table 1.

Table 1
2015 Direct Premiums Written

Line of business	Amount ($ B)	Percent
Medicaid	$148.4	25.2%
Medicare	$146.1	24.9%
FEHB	$36.5	6.2%
Medicare Supplement	$9.4	1.6%
Individual and Group	$216.2	36.7%
Other Health	$31.9	5.4%
TOTAL	**$588.5**	**100.0%**

Source: National Association of Insurance Commissioners & the Center for Insurance Policy and Research. 2015 Health Insurance Industry Analysis Report [Internet]. 2015. Available at: http://www.naic.org/documents/topic_insurance_industry_snapshots_2015_ann_health_ins_ind_report.pdf

In addition, the Federal Government subsidizes private health insurance coverage. Subsidies include tax exclusions, deductions, and credits. The Congressional Budget Office estimates the cost for these subsidies at $300 billion in fiscal year 2016.[14]

Private Health Insurers' Concentration

Private health insurers are highly concentrated. An American Medical Association (AMA) study found 14 states had a single health insurer with at least a 50 percent share of the commercial health insurance market. Forty-six states had two health insurers with at least a 50 percent share. In nearly 40 percent of the metropolitan areas studied, a single health insurer had at least a 50 percent share of the commercial health insurance market.[15]

The AMA study further reported that 70 percent of 388 metropolitan areas had a Herfindahl-Hirschman Index (HHI) greater than 2,500. The HHI is calculated by summing the squares of the

market shares of individual firms. HHI scores in excess of 2,500 indicate a highly concentrated market and low level of competition.[16]

A Blue Cross Blue Shield (BCBS) licensee is the largest insurer in 44 states in the individual market, 38 states in the small group market, and 40 states in the large group market.[17] BCBS companies cover more than 107 million people, which represents nearly one-in-three Americans.[18] Nationally, nonprofit BCBS affiliates, treated as a single firm, have a 37 percent market share including the number of privately insured lives in fully and self-insured plans. The publicly-traded Anthem BCBS has a 15 percent market share. The next three largest publicly-traded insurers include United Healthcare with 13 percent, Aetna with 11 percent and Cigna with 6 percent. The remaining 17 percent is comprised of multiple smaller for-profit and nonprofit health insurers.[19]

Health Insurance Consolidation and Valuation

Currently, publicly-traded and nonprofit health insurers are pursuing growth and synergy through mergers and acquisitions in an already highly concentrated industry.[20, 21] As the largest health insurer and a major customer of private health insurance, the Federal Government can follow the same mergers and acquisitions strategy. By acquiring the private health insurers and merging the state Medicaid medical assistance programs into Medicare, the Federal Government can achieve the optimal cost reduction synergy. The cost of acquiring a publicly-traded health insurer is the enterprise value.

> Enterprise Value = market value of common stock (market capitalization) + debt at market value + minority interest at market value + preferred equity at market value + unfunded pension liabilities – value of associate companies – cash and cash equivalents.

Non-profit health insurers are valued by comparison with a publicly-traded insurer having similar financial characteristics. The total enterprise value for the four largest publicly-traded health insurers is $238.4B with a direct premium written market share of 33.4 percent. Dividing the enterprise value by the market share, results in an estimated $714B enterprise value for all private health insurers, both for-profit and not-for-profit, as shown in Table 2.

Table 2
Private Health Insurance Enterprise Value

HEALTH INSURER	ENTERPRISE VALUE JUNE 2016 ($ B)	2015 DIRECT PREMIUMS WRITTEN MARKET SHARE
UnitedHealth Group (UNH)	$147.80	11.35%
Anthem (ANTM)	$30.37	9.23%
Humana (HUM)	$19.5	8.67%
Aetna (AET)	$40.72	4.12%
TOTAL	$238.41	33.37%
Adjusted total	**$714.44 (238.41/0.3337)**	**100%**

Source: YAHOO! FINANCE. Key Statistics. Valuation measures. Enterprise Value. Accessed 1 June 2016 at: https://finance.yahoo.com/quote/UNH/key-statistics?p=UNH
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https://finance.yahoo.com/quote/HUM/key-statistics?p=HUM%20https://finance.yahoo.com/quote/AET/key-statistics?p=AET
U.S. Department of the Treasury and Federal Insurance Office. Annual Report on the Insurance Industry (September 2016) [Internet]. Figure 7: Health Insurance Groups by 2015 U.S. Health Lines Direct Premiums Written, page 16. https://www.treasury.gov/initiatives/fio/reports-and-notices/Documents/2016_Annual_Report.pdf

When the current multi-insurer system is replaced with a single government health insurer with no cost sharing, an estimated $375B in BIR administrative costs savings would be realized.[1] This figure excludes BIR spending by individuals and employers, and the total cost associated with government regulation of private health insurance. By eliminating the $30B BIR administrative cost caused by the Affordable Care Act (ACA), the total BIR cost savings becomes $405B.[22] Dividing the enterprise value for all private health insurers by the BIR administrative cost savings, the payback period for the investment is just under two years ($714/$405B=1.77 years). By comparison, this payback period far outstrips that realized by the Troubled Asset Relief Program (TARP), which disbursed $429.7B with a six year payback period.[23]

Medicare Reform and Financing Simplification

Medicare consists of Part A Hospital Insurance, Part B Medical Insurance, and Part D Prescription Drug Coverage. Medicare is funded primarily from three sources: general revenues (42%), payroll taxes (37%), and beneficiary premiums (13%).[24]

In simplifying healthcare financing, the current Medicare program for ages 65 and older could be modified to eliminate the need for Medicare Supplement Insurance (Medigap) policies and Prescription Drug Plans (Part D). A single income-related actuarial premium would cover Part B medical services, Part D prescription drugs and deductibles, copayments, and coinsurance, including Part A hospital inpatient cost sharing.[25] Payroll taxes would remain the primary source for Part A Hospital Insurance. Appropriations from general revenues would remain the primary source for Parts B and D.

The cost for those beneficiaries currently enrolled in both Medicaid and Medicare (with dual eligibility) would be federalized to cover Parts A, B, and D premiums. Public financing and the lead role of state governments in long-term care services and supports would remain unchanged. The annual federal general revenue appropriations would continue for the federalized dual eligible medical assistance program and long-term services and support.

A new no cost-sharing Medicare Part E would expand the current Medicare program to include those aged under 65. Part E would provide hospital, medical services, and prescription drug coverage. The funds would come from annual actuarially determined health premiums and a reallocation of appropriations from general revenues that currently go to Medicaid medical assistance programs. The premium for Part E would be collected as an earmarked graduated income tax based on the federal poverty level, family size, and income. The tax would be refunded or owed on the annual federal individual income tax return.

Discussion and Conclusion

Equitable distribution of healthcare services and administrative efficiency are lacking in the current American healthcare system. The ACA healthcare reform is focused on preserving a highly concentrated health insurance industry whose business model is based on avoiding high-risk consumers in the individual market and transferring risk in the group market. The ACA healthcare reform has failed to recognize the need for healthcare financing reform.

Multiple health insurers; cost shifting between employers and employees, and insurers and consumers; provider cost shifting between health insurers; and state healthcare provider taxes for additional federal Medicaid funds are together driving the wasteful complexity in today's healthcare financing system. The fragmentation of healthcare financing has also led to a delivery system that lacks coordination and efficiency in the allocation of resources.

It is the responsibility of government to act when the private sector fails to achieve equity and efficiency. The fact that there is only a two year payback period for a $714 billion investment suggests that there is an opportunity for the Federal Government to develop a new financing

scheme that would remove wasteful complexity in healthcare financing and make the allocation of healthcare resources equitable and efficient. The expansion of health insurance coverage with income-related actuarial premiums, and hence the reallocation of the current mandatory appropriations from general revenues to the proposed Medicare program, would be the most effective method to achieve affordability, equitable access, and cost savings.

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Public Takings of Private Health Insurance

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Facts

The Medicare for All Act of 2019 (SB 1129) was introduced in the US Senate on April 10, 2019.[1] The Bill provides national public health insurance, ultimately ending private health insurance coverage. Effective January 1 of the first year of enactment, Medicare would lower age of coverage to 55 years of age; the second-year coverage would begin at 45 years of age; and the third year at 35 years of age. Effective January 1 of the fourth year after the date of enactment, Medicare would cover all individuals and it would be unlawful for a private health insurer to sell health insurance coverage that duplicates the benefits provided under the Act.

Issue

Is Senate Bill 1129 subject to the last clause of the Fifth Amendment of the Constitution of United States which states "nor shall private property be taken for public use, without just compensation"?

Rule

The last clause of the Fifth Amendment is known as the “Takings Clause.” Constitutional takings refer to the government depriving owners of their interest in private property. The takings require payment of compensation based on the value of the property.

Analysis

In 1965, the United States Congress enacted Medicare under Title XVIII of the Social Security Act to provide health insurance to people age 65 and older. In 1972, Congress passed legislation extending Medicare eligibility to individuals under age 65 with long-term disabilities or end-stage renal disease. These individuals found it nearly impossible to get private health insurance coverage due to the high cost and risk to the private health insurers.

Senate Bill 1129 extends Medicare coverage to everyone under age 65 who is a resident of the United States. Private health insurance providers currently issue policies to the majority of those under age 65. Medicaid provides coverage for lower-income individuals in this age group.

The enactment of Senate Bill 1129 without compensation would result in financial losses to owners of private health insurance companies. Under prior Medicare legislation, no compensation was required under the Takings Clause since there were no losses.[2] The Takings Clause requires that financial losses caused by public action be compensated by the government.

Per Se Takings

A health insurance policy is a contract written between a private health insurer or a government program and an individual. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national health policy for public insurance.

Private health insurance companies have a contract interest in health insurance policies. Interests in intangible property are subject to protection under the Takings Clause. The Supreme Court has ruled that private contract rights are "property" for the purposes of the Takings Clause. A taking occurs when the government directly appropriates contract interests for itself.[3] In Brooks-Scanlon Corp. v. United States, the Court ruled that an appropriation of a contract had occurred when the government had "put itself in the shoes" of one of the contracting parties.[4]

Monongahela Nav. Co. V. U S is an example of the taking of contracts rights. An Act of Congress authorized the government to acquire and operate a lock and dam of a private navigation company. The company was a publicly traded corporation that was collecting tolls under a franchise granted by a state government. The Act provided "that in estimating the sum to be paid by the United States the franchise of said corporation to collect tolls shall not be considered or estimated." The Court ruled that the franchise was as much a vested right of property as the ownership of the tangible property and just compensation requires payment for the franchise to take tolls. The Court recognized that the stockholders are entitled to a reasonable compensation for the present and prospective earnings which the franchise would otherwise receive without the taking. The Decision stated that "the value, therefore, is not determined by the mere cost of construction, but more by what the completed structure brings in the way of earnings to its owner."[5]

Further, Mr. Justice Black delivering the opinion of the Court in Armstrong v. United States stated that "the Fifth Amendment's guarantee that private property shall not be taken for a public use without just compensation was designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." [6]

Thus, the facts of Senate Bill 1129 support a finding of per se takings. The Fifth Amendment of the United States Constitution requires just compensation to the owners of private health insurance companies that suffer financial losses.

Just Compensation

The Supreme Court has stated that the purpose of paying just compensation is to make "whole"

the injured parties, to be accomplished by paying fair market value.[7] Since the government would dissolve the commercial health insurers, the fair market value is the enterprise value, not the going concern equity value. The difference is the debt which includes bonds, loans, unfunded pension liabilities and other financing or leasing obligations.

> Enterprise Value = market value of common stock (market capitalization) + debt at market value + minority interest at market value + preferred equity at market value + unfunded pension liabilities – value of associate companies – cash and cash equivalents.

Nonprofit health insurers are valued by comparison with a publicly traded insurer having similar financial characteristics. The proceeds from the government to the discontinued nonprofit health insurers would go into newly formed charitable foundations with a new mission.

Economic Impact

The Takings Clause requires that economic losses caused by public action be compensated by the government. The economic impact on the property owners is one of the regulatory takings tests found in Penn Central Transportation Co. v. New York City.[2] Regulatory takings is a governmental action that significantly restricts uses of private property to such a degree that the action effectively deprives the property owners of the economic benefits or productive uses of their property.[8] This test is similar to the facts that support per se takings. However, the magnitudes of the losses and types of ownership of the health insurance companies requires not only an analysis of the economic impact on the property owners but the entire economy.

Health insurance companies are some of the largest publicly traded companies listed on the American stock exchanges. The revenue ranking in the 2017 Fortune 500 includes the largest health insurance companies. Six of the health insurance companies are in the top 70 with two more added for the top 195. Compared with other companies, UnitedHealth Group is ranked 6th with General Motors ranked 8th, Ford Motor ranked 10th, Fannie Mae ranked 20th, Wells Fargo ranked 25th, and Bank of America Corp. ranked 26th.[9] The nonprofit health insurance organizations are not included in this ranking, however three of the nonprofit health insurers are in the top 10 of health insurers by enrollment.[10]

The top publicly traded health insurers' ownership must also be examined. The breakdown of the shareholders for UnitedHealth Group shows 1.57% of shares held by all insider, 89.15% of shares held by institutions, 90.57% of float held by institutions, and 1,981 institutions holding shares.[11, 12] The institutional holders are investment management firms and mutual funds. These financial institutions manage funds for governments, companies, foundations, educational institution, pension plans, life insurance policies and educational savings accounts for children. The next three largest health insurers are Anthem, Humana, and Aetna. Individually, they each have less percentage of shares held by all insiders and a higher percentage of institutions holding shares.[13, 14, 15]

The enterprise value for all of the private health insurance companies has been estimated to be $714 billion.[16] Consequently, due to the required large compensation and types of ownership, the

failure to pay the enterprise value for the health insurers would result in financial market instability and a government caused financial crisis.

Transition

Senate Bill 1129's Transitional Medicare Buy-in Option and Transitional Public Option program phases-in Medicare over a 4-year period for those under age 65. This incremental approach does not take into account the Federal Government's liability to pay a just compensation for the takings of private health insurance. Partial constitutional takings valuations cannot be determined with the transition proposed in Senate Bill 1129. There are no market values and debt obligations associated with age that can be used to measure a just compensation.

In per se takings or regulatory takings, the Federal Government can acquire private health insurers by paying the enterprise value. Once in control, the government can dissolve the companies after properly dealing with the assets and liabilities. Thus, everyone under 65 years of age will be in a newly created single public insurance risk pools with their own Trust Funds starting January 1st of the effective year.

Conclusion

The Medicare for All Act of 2019 (SB1129) is subjected to the last clause of the Fifth Amendment of the United States Constitution which states "nor shall private property be taken for public use, without just compensation." In per se takings or regulatory takings, the Federal Government pays the enterprise value which is the just compensation for owners and debtholders in the dissolution of health insurance companies.

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Expanding and Improving Medicare

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Medicare is a social insurance program that provides health insurance coverage. And like private health insurance, premiums are calculated by actuarial methods. The purpose of this paper is to show how Medicare can be expanded and improved without changing its administrative and funding structure.

Background

Medicare consists of four parts: Hospital Insurance for the Aged and Disabled (Part A), Supplementary Medical Insurance for the Aged and Disabled (Part B), Medicare Advantage Programs (Part C), and the Voluntary Prescription Drug Benefit Program (Part D).

Medicare has two separate trust funds. The Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund consisting of Part B and Part D accounts. The Medicare Advantage Programs (Part C) receive capitated payments for enrolled beneficiaries from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The four Medicare parts, two trust funds, and administration by the Centers for Medicare & Medicaid Services are authorized by Title XVIII of the Social Security Act.

Hospital Insurance

The primary source of funding for the Hospital Insurance Trust Fund is payroll taxes. Other sources consist of Part A premiums from people who do not qualify for premium-free Part A, a portion of the dedicated income taxes paid on Social Security benefits, and interest earned on the trust fund investments. The Hospital Insurance Trust Fund does not receive funding from congressional appropriations.

Payroll taxes (aka FICA) are imposed under the Federal Insurance Contributions Act found in the Internal Revenue Code. FICA is levied on employees, employers, and self-employed for Medicare Hospital Insurance and Old-Age, Survivors, and Disability Insurance (aka Social Security). The U.S. Supreme Court ruling on the constitutionality of the Social Security Act of 1935 quotes from the Act that these payments are “annual premiums to be determined on a reserve basis in accordance with accepted actuarial principles and based upon such tables of mortality as the Secretary of the Treasury shall from time to time adopt.”[1]

The Office of the Actuary at the Centers for Medicare & Medicaid Services prepares an annual report for Congress which includes short-range and long-range tests of financial adequacy for the

Hospital Insurance Trust Fund. This allows Congress to close any projected funding gap by raising the Medicare portion of FICA or an equivalent mix of program cuts and contributions increases.

The Medicare portion of FICA pays for Hospital Insurance benefits for individuals having at least 40 quarters of covered employment. Individuals not meeting this requirement must pay an insurance premium while receiving Part A benefits. The premium is set each year by the Office of the Actuary. The premium rate is calculated by projecting the number of Part A enrollees without 40 quarters of covered employment along with the benefits and administrative costs that will be incurred on their behalf.

Supplementary Medical Insurance Trust Fund

An annual budget request is sent to Congress in the "Justification of Estimates for Appropriations Committees" report.[2] Part B and Part D accounts of the Supplementary Medical Insurance Trust Fund receive funding from beneficiary premiums and general revenue. The Office of the Actuary sets the actuarial income-related premium rate for Part B and Part D at levels that cover approximately 25 percent of estimated benefits and related administrative costs. Congressional mandatory appropriations from general revenues pay the remaining 75 percent.[3] Both accounts remain in financial balance for all future years because beneficiary premiums and general revenue transfers are annually set at a level to meet expected costs for the following year.

Medicare Administration

The Centers for Medicare & Medicaid Services has ten regional offices. The regional field staff work closely with beneficiaries, health care providers, state governments, Medicare contractors, community groups and others to provide education and address questions. The regional offices put into practice the protective regulations, policy and program guidance developed in the central office.

The fee-for-service claims are sent to Medicare and processed by a Medicare Administrative Contractor (MAC). There are 12 A/B MACs with a defined geographic area that process Part A and Part B claims for institutional providers, physicians, practitioners, and suppliers. Four A/B MACs also process home health and hospice claims in addition to their typical Medicare Part A and Part B claims. There are four DME MACs, each with a defined geographic area that processes Medicare durable medical equipment, orthotics, and prosthetics claims.

The Centers for Medicare & Medicaid Services pays a monthly capitation rate to Part C Medicare Advantage plans and Part D prescription drug plans. In addition to the fee-for-service and capitation payment models, the Medicare & Medicaid Innovation Center is developing and testing innovative health care payment and service delivery models including global budgeting.

The Centers for Medicare & Medicaid Services relies on quality improvement organizations to improve the quality of health care for all Medicare beneficiaries. These organizations are composed of a group of health quality experts, clinicians, and consumers whose mission is to

improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries.

The Centers for Medicare & Medicaid Services has contractors that perform specific functions. These contractors include fee-for-service recovery auditors and contractors who combat fraud, waste and abuse. Other contractors monitor the accuracy of claim payments in the fee-for-service program. A/B MACs and DME MACs are responsible for handling redeterminations, the first level of appeals for a fee-for-service claim. The first level of appeals in a Medicare Advantage plan claim is reconsideration by the plan. The second level of appeals is conducted by Medicare appeals contractors.

Expanding and Improving Medicare

Using the current Medicare law, expanding Medicare clearly means extending coverage to those under 65 years of age and eliminating the medical assistance programs in Medicaid. Improving Medicare means eliminating Medicare supplement plans and limiting cost sharing.

The new under age 65 coverage is funded by beneficiary premiums and appropriations from general revenue. Instead of the Affordable Care Act premium tax credits, sliding scale premium rates are based on the poverty level of each taxpayer. The full premium is paid if the taxpayer's modified adjusted gross income is above a set federal poverty level. The premiums are collected as an earmarked income tax under the Internal Revenue Code and reconciled on the U.S. Individual Income Tax Return. In the Social Security Act of 1935, the worker's portion of Social Security is collected as an income tax. The amount collected is not deducted from the taxpayer's income.[4]

The current Hospital Insurance Trust Fund (Part A) and the Supplementary Medical Insurance Trust Fund with medical services (Part B) and prescription drug coverage (Part D) accounts are kept separate from a new trust fund for those under 65 years of age. The new trust fund is composed of hospital, medical services, and prescription drug coverage accounts.

Hospital stays and medical services in all three trust funds are provided without copays, deductibles, and coinsurance. Outpatient prescription drug coverage for all Medicare beneficiaries is provided with nominal copays and coinsurance only for those who choose more expensive drugs over their generic equivalents. Beneficiary premiums and appropriations are set to cover these costs.

Changes to Federal and State Revenue

Expanding Medicare increases individual income tax revenue and FICA for the Social Security and Medicare Hospital Insurance trust funds. It also eliminates spending on government subsidized health coverage programs.

Based on fiscal year 2017 data, the increase in federal revenue due to the elimination of federal tax allowances for work-related health coverage is about $284 billion. Included are the small

business health care tax credits of $1B and the self-employed income tax deduction for health insurance of $7B. Health insurance coverage for workers that is paid by the employer is currently treated as non-taxable wages. Employee contributions to a cafeteria plan or various health plans are also excluded from taxation. Removing these tax exclusions results in additional federal income tax revenue and FICA of $279B.[5] Utilizing the average effective federal tax rates, the $279B can be separated into individual income taxes of $163B and FICA of $116B.[6] The removed tax allowances are offset by the Affordable Care Act penalty payments of $3B for those who fail to acquire health insurance coverage.[5] These estimated amounts apply only if people do not adjust their behavior to reduce the new tax liability created by these changes.

Federal spending in 2017 for Medicaid medical assistance programs for people under age 65 and the Children's Health Insurance Program is estimated to be $296B. The Affordable Care Act premium tax credits, cost-sharing reduction subsidies, spending and revenues related to risk adjustment and reinsurance, and the Basic Health Program payments total $45B.[5]

State funding for Medicaid medical assistance programs for people under age 65 and the Children's Health Insurance Program is roughly $148B.[5] The states paid $17B for Medicare Part A and Part B insurance premiums for those who qualify for both Medicare & Medicaid.[7] The states also made Part D transfers of $10B to Medicare.[3] Federal law requires that state Medicaid programs make Disproportionate Share Hospital payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. The states paid $9B and the Federal Government paid $12B for this program.[8]

In summary, federal general revenue is increased by $494B. The Social Security Trust Fund and Medicare Hospital Trust Fund have a combined increase of $116B. The states see an increase in general revenue of $184B, (see Exhibit 1). Note: The states with an income tax have an even larger increase in revenue due to the increase in adjusted gross income.

Exhibit 1

Revenue Changes (Billions of Dollars)			
	Federal General Revenue	**SS/HI Trust Fund**	**State General Revenue**
Elimination of Federal Tax Allowance for Work-Related Coverage			
Federal Income Tax	163		
FICA		116	
Self-Employment Tax Deduction	7		
Small Business Tax Credits	1		
Federal Spending			
Medicaid/CHIP	296		148
ACA	45		
Transfer from States			
Part A / Part B	(17)		17
Part D	(10)		10
Disproportionate Share Hospital	12		9
Coverage Penalties	(3)		
TOTAL	**494**	**116**	**184**

Discussion and Conclusion

Expanding and improving Medicare as a social health insurance program creates equity in the finance and delivery of health care. The current Medicare law is expanded to include those under 65 years of age. It is improved and made more efficient by incorporating health insurance cost sharing as part of the beneficiary premiums which are based on income and family size.

Extending coverage to those under age 65 requires a new trust fund consisting of hospital, medical services, and prescription drug coverage accounts. The new trust fund accounts become part of the annual budget request sent to Congress in the “Justification of Estimates for Appropriations Committees" report. The Office of the Actuary sets a single sliding scale premium rate based on the poverty level of each family by combining the premium rates of the three accounts. The full premium is paid if the taxpayer’s modified adjusted gross income is above a set federal poverty level.

The new trust fund accounts remain in financial balance for all future years because beneficiary premiums and general revenue transfers are annually set at a level to meet expected costs for the following year. The premium is collected as an earmarked income tax under the Internal Revenue Code and reconciled on the U.S. Individual Income Tax Return.

Medicare currently provides reinsurance to Part D plan sponsors in addition to capitation payments. Most Part D plans change their premiums, deductibles, copays, the drugs they cover and whether they offer any coverage in the doughnut hole on a yearly basis. This is wasteful complexity for both the Federal Government and Medicare beneficiaries. Part D is improved by

Medicare becoming the sole provider of outpatient prescription drug coverage with nominal copays and coinsurance only for those who choose more expensive drugs over their generic equivalents. And by eliminating Medicare supplement plans and Medicaid medical assistance programs, hospital stays and medical services are covered with no deductions, copays, and coinsurance for all Medicare beneficiaries.

With the expansion of Medicare, federal general revenue increases by $494B. The Social Security Trust Fund and Medicare Hospital Trust Fund have a combined revenue increase of $116B. The new federal general revenue and the FICA Medicare contributions for hospital insurance can help pay for the expansion and improvement of Medicare. In addition, the new FICA Social Security contributions increase the Social Security fund.

The states see an increase in general revenue of $184B. States that have an income tax have an even larger increase in revenue due to the increase in adjusted gross income. The increase helps pay for the state portion of Medicaid long-term services and supports needs of those with low-income and other state budgetary items.

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Pricing and Payment
Drug Pricing and Payment: National Outpatient Prescription Drug Plan

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The United States holds the largest share of the global pharmaceutical market. However, federal policies have failed to take advantage of this position to improve economic efficiency and increase welfare. This study aims to describe how market mechanisms when combined with efficient financing can lower the prices of outpatient prescription drugs and provide coverage to the entire population.

Overview

Medicaid and private drug benefit plans both utilize a complex drug pricing and pharmacy payment methodology. A national outpatient prescription drug plan simplifies pricing and payment by maintaining a database of actual acquisition cost between the wholesaler and the pharmacy. The National Average Drug Acquisition Cost (NADAC) along with a fixed dollar spread or dispensing fee becomes the basis for payments to pharmacies.

A single source brand name drug refers to a drug sold by one manufacturer and has patent protection. The high price for such a drug is caused by the lack of a centralized volume rebate negotiation with the manufacturer. A national outpatient prescription drug plan centralizes the negotiation by covering the entire population which lowers the price for brand name drugs.

A multiple source generic drug is equivalent to a brand name drug and available through several manufacturers. The lack of price transparency for multiple source generic drugs inflates the pharmacy acquisition cost. Relying on the actual price lowers the cost of generic drugs.

Multiple prescription drug insurers fragment the financing and cause inequitable access to prescription drugs. A national outpatient prescription drug plan makes efficient use of funds and removes the financial barriers between patients and prescription drugs.

Medicaid

State Medicaid outpatient prescription drug programs are required to meet federal requirements concerning the federal rebate program and allowable payments to pharmacies. Manufacturers sign an agreement with the Secretary of Health and Human Services stating that they will rebate a specified portion of the Medicaid payment for the drug to the states. The states then share the rebates with the federal government. Medicaid covers almost all FDA-approved drugs that manufacturers produce. The federal Medicaid drug rebates are calculated as shown in Exhibit 1.[1]

Exhibit 1: Federal Medicaid Drug Rebates

Single Source Brand	Multiple Source Generic	Pediatric Clotting Factors

Greater of 23.1% AMP or AMP minus Best Price	13% of AMP	Greater of 17.1% AMP or AMP minus Best Price

plus Consumer Price Index-Urban (CPI-U) Component

AMP: Average Manufacturer Price is the average price paid by the wholesaler to manufacturers after volume discount.

Best Price: The lowest price available to any wholesaler, retailer, or prescription drug provider.

Besides the federal rebates, many states negotiate supplemental volume rebate agreements with drug manufacturers. State Medicaid outpatient prescription drug programs use the rebates to maintain a preferred drug list of outpatient prescription drugs. A state may require prior authorization for a drug not on a preferred drug list.

Medicaid does not purchase drugs directly from manufacturers or wholesalers. Instead, state Medicaid Programs reimburse the pharmacy for the ingredient cost of the drugs. A state has flexibility in selecting which price benchmark to use in determining ingredient cost (see Exhibit 2).

Exhibit 2: Medicaid Ingredient Cost

Single Source Brand	Multiple Source Generic
AAC	AAC
Usual and Customary	FUL
NADAC	Usual and Customary
	NADAC

AAC: Actual Acquisition Cost refers to the actual price that pharmacies pay to acquire drugs from manufacturers based on Average Manufacturer Price (**AMP**) or a state survey of pharmacies. AMP is the average price paid by the wholesaler to manufacturers after volume discount.

FUL: The Federal Upper Limit is no less than 175% of the weighted average of the most recently reported monthly AMP for drugs that are available for purchase by pharmacies on a nationwide basis.

State MAC: State Maximum Allowable Cost is a payment limit using state AAC.

Usual and Customary Charge: This refers to pharmacy calculation of the current charge to the public.

NADAC: The National Average Drug Acquisition Cost is the actual acquisition cost between wholesalers and pharmacies based on a sampling of independent and chain pharmacies' invoice prices.

The state payment to the pharmacy is the lowest of the following:

- AAC or NADAC plus dispensing fee;
- FUL plus dispensing fee;
- State MAC plus dispensing fee; or
- Pharmacy's usual and customary charge.[2]

Private Drug Benefit Plan

Private insurer outpatient prescription drug benefit plans develop and maintain formularies, negotiate volume rebates with drug manufacturers, process pharmacy claims, and reimburse network pharmacies.

A formulary is a list of drugs approved for coverage under a benefit plan. The preferred tier placement for single source brand name drugs is determined by a volume rebate negotiation with the manufacturer. Price concessions from manufacturers determine preferred tier placement for multiple source generic drugs. The formulary can have as many as six tiers:

- Tier 1 — Preferred generic drugs, lowest cost-sharing
- Tier 2 — Non-preferred generic drugs
- Tier 3 — Preferred brand name drugs
- Tier 4 — Non-preferred brand name drugs
- Tier 5 — Preferred Specialty drugs
- Tier 6 — Non-preferred Specialty drugs, highest cost-sharing

The higher tiers may require prior authorization, fail-first/step therapy, and quantity limits. The plan determines which drugs are therapeutically similar. Some drugs are not covered, and patients pay full retail cost out-of-pocket. Each drug benefit plan has its own formulary with different preferred drugs, premiums, and cost-sharing.

Pharmacies negotiate volume discounts with wholesalers for the drugs that they prefer to stock. The private drug benefit plan reimburses the pharmacy the ingredient cost of the drugs plus a dispensing fee. Depending on the drug, a plan may select among several price benchmarks to determine the ingredient cost for payment to pharmacies (see Exhibit 3).

Exhibit 3: Private Drug Benefit Plan Ingredient Cost

Single Source Brand	Multiple Source Generic
WAC	MAC
AWP	WAC
NADAC	AWP
	NADAC

WAC: Wholesale Acquisition Cost refers to the manufacturers' published list price for sales of drugs to wholesalers.

AWP: Average Wholesale Price is the average list price for drugs sold by wholesalers to pharmacies before discounts.

MAC: Maximum Allowable Cost is the upper limit that drug benefit plans will pay a pharmacy.

NADAC: The National Average Drug Acquisition Cost is the actual acquisition cost between wholesalers and pharmacies based on a sampling of independent and chain pharmacies' invoice prices.

A private drug benefit plan's negotiation with pharmacies for reimbursement is confidential and proprietary.

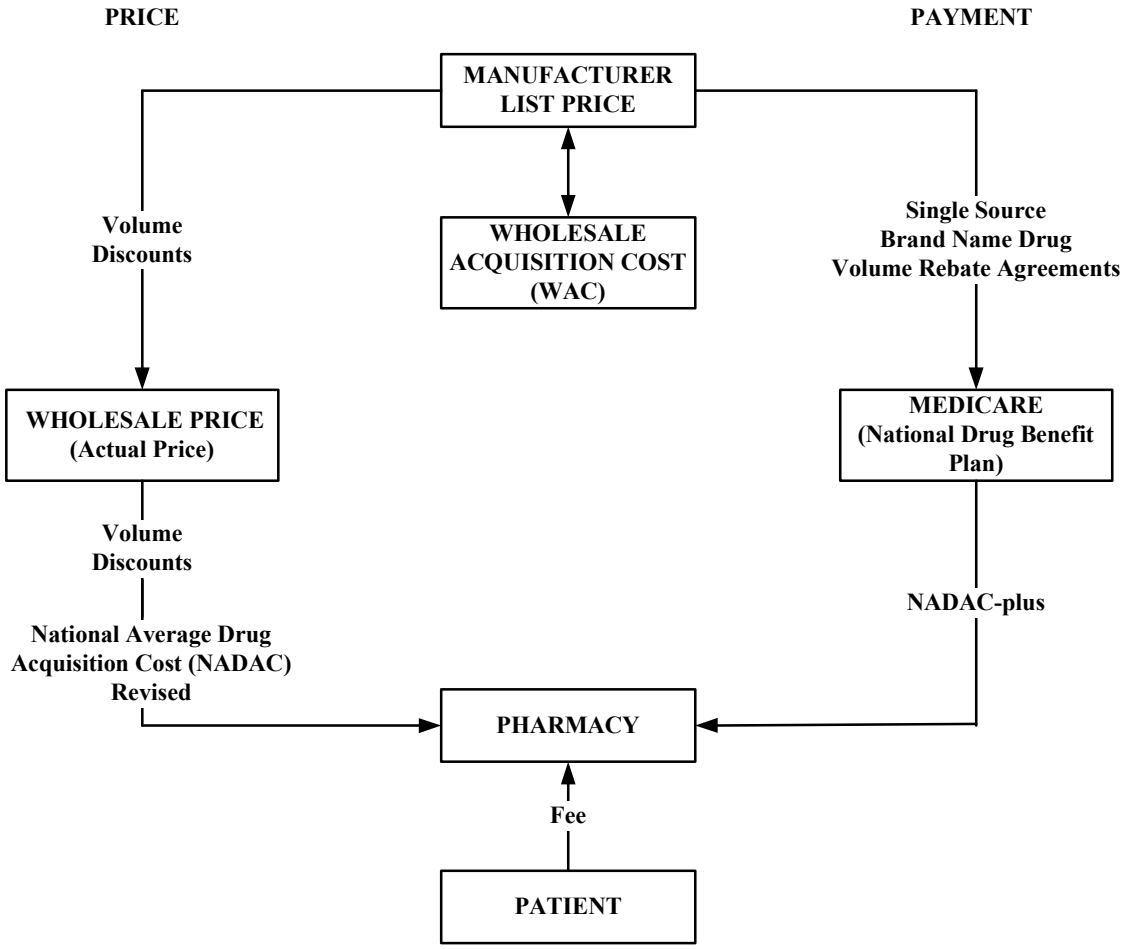
National Drug Benefit Plan

The national outpatient prescription drug plan extends Medicare prescription drug coverage to those under 65 years of age. State Medicaid outpatient prescription drug programs are no longer required, private drug benefit plans are discontinued, and Medicare becomes the prescription drug insurer.

Wholesale Acquisition Cost (WAC) and Average Wholesale Price (AWP) are commonly used as benchmarks to determine the ingredient costs paid by pharmacies. Neither WAC nor AWP are based on actual sales data. Both are publicly available price lists that approximate what pharmacies pay wholesalers for prescription drugs. WAC benchmarks, AWP benchmarks, fixed percentage rebates, maximum allowable cost lists, formularies, preferred drug lists, and cost containment strategies distort the market. The Medicare national drug benefit plan removes these market distortions.

The Medicare national drug benefit plan simplifies the drug pricing and payment methodology. The wholesale price is based on the actual sale transactions between the manufacturer and wholesaler. Subtracting volume discounts from the manufacturer list price and adding cost-plus markups determines the actual wholesale price. The NADAC is calculated after subtracting the volume discounts that wholesalers give to pharmacies from the wholesale price. Exhibit 4 shows the wholesale price and the average acquisition cost on the left and the brand name drug rebates and pharmacy payments on the right.

Exhibit 4



WAC-Wholesale Acquisition Cost is the manufacturers' published list price for sales of drugs to wholesalers.

Wholesale Price-The actual price paid by pharmacies to wholesalers before volume discounts.

NADAC- Revised -The National Average Drug Acquisition Cost is the actual acquisition cost between wholesalers and pharmacies based on the reporting by wholesalers of the pharmacy ingredient cost on all sales including the off-invoice discounts for multiple source drugs.

NADAC-plus-The national average drug acquisition cost plus a fixed dollar spread or dispensing fee paid to the pharmacy.

Volume Rebate Agreement-Single source brand name drug volume rebate agreements result in manufacturer rebates being paid to Medicare.

Fee-Nominal payment to record the transaction.

Brand Name Drug Rebates

The 2017 retail prescription drug expenditure in the United States was $333.4 billion.[3] Generic prescription drugs accounted for 83% of total prescriptions filled, but only 21% of total prescription drug spending. Brand name drugs accounted for 17% of prescriptions filled and 79% of the spending.[4]

Brand name drugs are the cost driver for high prescription drug spending. Multiple manufacturers sell the same generic drug which leads to price competition in the U.S. market and lowers the cost for pharmacies. A single source brand name drug is sold by one manufacturer and has patent protection. Competition among brand name drugs that treat the same condition does not lower the list prices.[5]

The United States had the largest prescription drug market in the world valued at $337b in 2018. This represented 39% of the global market.[6] It also has the largest population among high-income countries.[7] This, combined with the highest per capita consumption of brand name drugs relative to other countries, results in the United States holding the largest share of the global market for brand name drugs in terms of volume.[8] Other high-income countries optimize the cost reduction for brand name drugs by centralizing the volume rebate negotiation with the manufacturer.[9] The United States centralizing the negotiation would result in it having the lowest net price for brand name drugs than any other high-income country.

In the Medicare national drug benefit plan, the United States Secretary of Health and Human Services negotiates single source brand name drug volume rebate agreements with manufacturers. A retrospective rebate may be utilized based on quantity. This specifies a rebate factor percentage based on the defined purchase threshold levels during the rebate agreement life. Increases in purchased amounts can reach a higher threshold level, which changes the rebate factor for additional purchases as well as all the purchases to date within the rebate agreement life.[10]

National Average Drug Acquisition Cost (NADAC) Revised

The Centers for Medicare & Medicaid Services developed and maintains the NADAC database. NADAC estimates the actual average acquisition cost between wholesalers and pharmacies based on a monthly nationwide survey sampling of independent and chain pharmacies' invoice prices. Pharmacy reporting is voluntary and the sample size of the survey is small relative to the total number of pharmacies. The NADAC data set does not include all drugs. It excludes specialty and mail order pharmacies and does not reflect off-invoice discounts.

Manufacturer rebates for single source brand name drugs are provided directly to Medicare. There are no off-invoice discounts for these drugs. The pharmacy invoice price reflects the actual pharmacy acquisition cost.

Wholesalers negotiate generic drug manufacturer rebates for pharmacies. The rebates are provided to pharmacies in the distribution chain as off-invoice discounts. Requiring wholesalers to report all sales including the off-invoice discounts on a weekly basis makes the pharmacy ingredient cost for multiple source generic drugs comprehensive, timely, and accurate. The

resulting transparency of generic drug prices lowers the cost for the Medicare national drug benefit plan.[11]

NADAC is revised to reflect the actual acquisition cost between wholesalers and pharmacies based on wholesalers' reporting of the pharmacy ingredient cost on all sales including the off-invoice discounts for multiple source generic drugs. Thus, NADAC plus a fixed dollar spread or dispensing fee becomes an accurate payment for pharmacy reimbursement.[12] The patient pays a nominal fee to record the transaction.

Financing of a National Drug Benefit Plan

Population segmentation into different outpatient prescription drug benefit plans fragments the financing and causes inequitable access to prescription drugs. A Medicare prescription drug benefit plan for the entire population with income-related premiums and appropriations from general revenues results in efficient use of funds and removes financial barriers between patients and prescription drugs.

The Office of the Actuary at the Centers for Medicare & Medicaid Services determines annual mandatory premiums and appropriations from general revenue to fund an Outpatient Prescription Drug Insurance Trust Fund. The amount of the premium is based on federal poverty level income and family size. The premiums cover the cost-sharing except for a brand name drug with generic alternatives unless specified by the prescriber. The premium is collected as a dedicated income tax and reconciled on the annual U.S. Individual Income Tax Return.

Conclusion

Market mechanisms combined with efficient financing lower the cost of outpatient prescription drugs while providing coverage to the entire population. Centralized volume rebate negotiations between Medicare and manufacturers lower the price for single source brand name drugs. The Center for Medicaid and Medicare Services requiring drug manufactures to report the actual price paid by pharmacies lowers the cost for multiple source generic drugs. The calculated national average drug acquisition cost plus an explicit spread or dispensing fee is used to reimburse pharmacies.

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Financing
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Fragmentation in health financing is the cause of the wasteful complexity of US health care spending. Centralized financing under Medicare is critical in providing equitable, efficient, and effective health care for all. Replacing the multiple private health insurers, government reinsurance, premium subsidies, and the Medicaid medical assistance programs with income related premiums simplifies the financing.

Consistent with the Affordable Care Act, the new Extended Medicare premiums are calculated based on poverty level income and family size. Appropriations from general revenue covers the cost of premiums for low income families.

The Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) uses actuarial methods to predict future costs to ensure that there are enough funds to cover those costs. Each year, estimates are made of financial and actuarial status of the Part A Hospital Insurance trust fund. The Part A Medicare tax rate may be changed periodically to meet financial adequacy. The Part B Medical Insurance and the new Extended Medicare premiums and appropriations are reset each year to cover expected costs and ensure reserve contingencies. Each trust fund account consists of its own separate risk pool.

See the following exhibits:

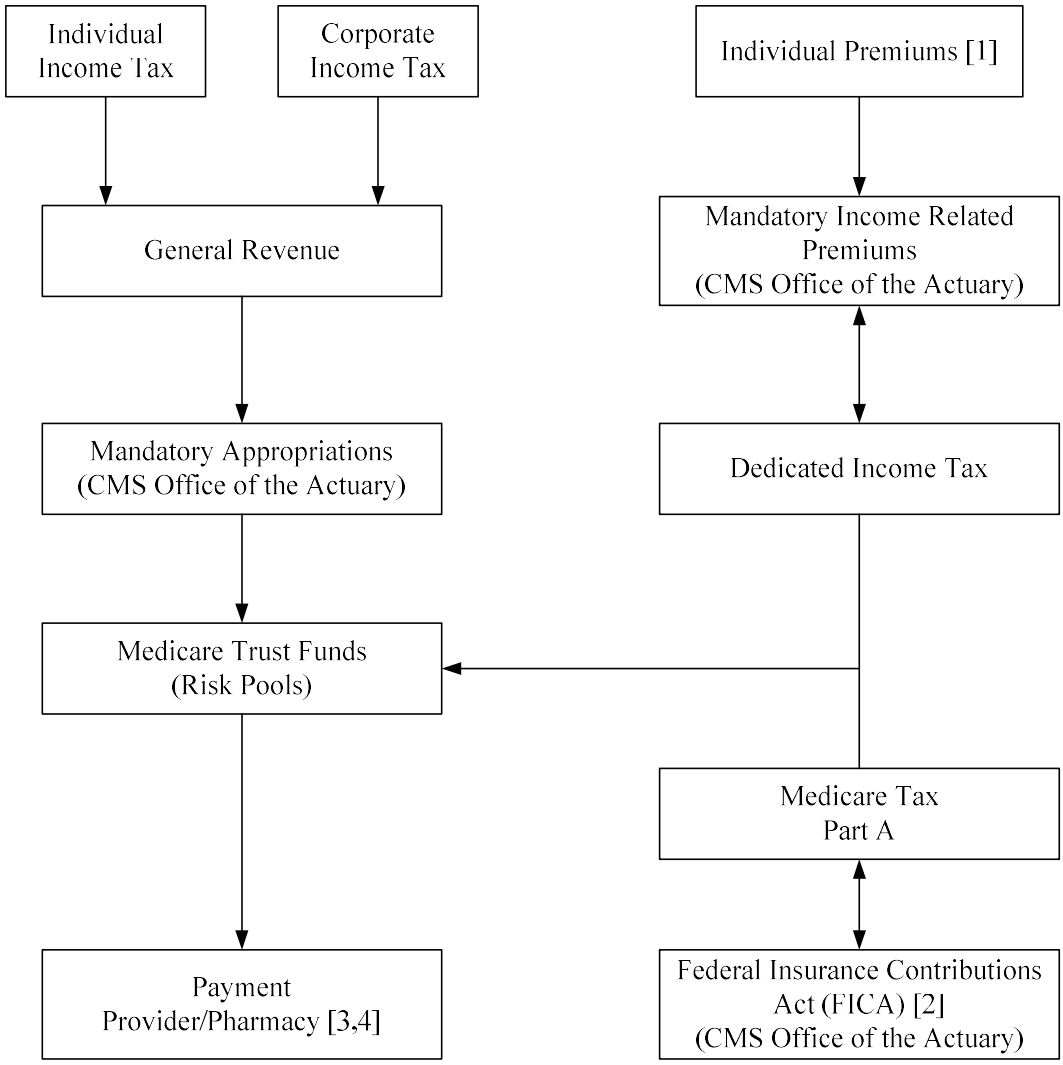
Exhibit 1 shows the source and payment of funds for Extended Medicare.

Exhibit 2 compares 2020 Medicare with Extended Medicare financing for those age 65 and older.

Exhibit 3 compares 2020 Medicare with Extended Medicare financing for those under age 65.

Exhibit 4 compares the current prescription drug coverage financing with the prescription drug coverage for entire population.

Exhibit 1- Extended Medicare-Source of Funds/Payments



1. Premiums are included in taxable income on individual tax returns.
2. Employer contributions for FICA only.
3. Payment methods and levels are negotiated between providers and the Centers for Medicare & Medicaid Services (CMS).
4. Payment to pharmacy based on the national average drug acquisition cost plus a fixed dollar spread or dispensing fee.

Exhibit 2-Age 65 and Older

2020 Medicare	Extended Medicare
Part A Hospital Insurance	
Premium free if you have at least 40 quarters of Medicare covered employment; for 30-39 quarters the monthly premium is $252; for less than 30 quarters the monthly premium is $458. Income taxes paid on Social Security benefits.	Same
Part B Medical Services Insurance	
Monthly premiums are $144.60 based on income. High income beneficiaries pay an income related monthly adjustment amount. *	Same
Cost Sharing – Medicare Supplement Insurance Plans – Dual Eligible	
Part A Deductible and Coinsurance Amounts: Inpatient hospital deductible- $1,408. Daily coinsurance for 61st-90th Day each benefit period -$352. Daily coinsurance for lifetime reserve days (additional 60 days of coverage)-$704. Skilled Nursing Facility coinsurance-$176. Part B deductible & coinsurance: $198 per year deductible. Pay 20% of the Medicare approved services after deductible is met. Medicare Supplement Insurance Plans Dual eligible beneficiaries eligible for both Medicare and Medicaid	Mandatory Income Related Premiums (Poverty Level Income & Family Size)
Part D Prescription Drug Coverage – See Prescription Drug Coverage for Entire Population	
*Filing Status and Yearly Income Table at https://www.medicare.gov/your-medicare-costs/part-b-costs.	

Exhibit 3-Under Age 65

2020 Medicare	Extended Medicare
Federal Insurance Contributions Act (FICA)	
Federal Insurance Contributions Act (aka Medicare Tax) pays for Part A Hospital Insurance at age 65 and older. The Medicare Tax is an actuarial insurance premium determined by the Centers for Medicare & Medicaid Services Office of the Actuary. Medicare Payroll Tax: Employees 1.45% and Employers 1.45% on all covered wages. Wages paid in excess of Individual Return-$200,000, Joint Return-$250,000 are subject to an extra 0.9% Medicare tax paid by employees not employers. The self-employment Medicare tax rate is 2.9%. A 0.9% additional Medicare tax applies when net earnings exceed Individual Return- $200,000, Joint Return-$250,000.	Same
Hospital and Medical Services	
Employer Sponsored Health Coverage Individual Market Health Insurance Cost Sharing-Deductible, Copay, Coinsurance Medicaid State Medical Assistance Programs Provider Cost Shifting Between Patients Health Insurance Exchange Premium Tax Credit Small Business Health Care Tax Credit Affordable Care Act Taxes and Fees Federal/State reinsurance programs for private health insurance companies. Medicaid Disproportionate Share Hospital (DSH) Payments	Mandatory Income Related Premiums (Poverty Level Income & Family Size)
See Prescription Drug Coverage for Entire Population	

Exhibit 4-Prescription Drug Coverage for Entire Population

Current Prescription Drug Coverage	Extended Medicare
Medicare Part D Private Insurance Companies Part D high income beneficiaries pay an income-related monthly adjustment amount in addition to private plan premiums. * Part D Extra Help Program for people with limited income and resources to pay premiums, deductibles, and coinsurance. Employer Sponsored Health Coverage Individual Market Health Insurance Cost Sharing-Deductible, Copay, Coinsurance Medicaid State Medical Assistance Programs Health Insurance Exchange Premium Tax Credit Small Business Health Care Tax Credit Affordable Care Act Taxes and Fees Federal/State reinsurance programs for private health insurance companies.	Mandatory Income Related Premiums (Poverty Level Income & Family Size)
*Filing Status and Yearly Income Table at https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.	

APPENDIX: Presentation

The Best Health Insurance Plan
February 2020

The best health insurance plan ensures that everyone has equal access to health care. The plan includes:

HEALTH BENEFITS

- ✓ Medical services same or better than your current coverage
- ✓ Choice of all accredited doctors, hospitals and other medical providers
- ✓ No change in health benefits, doctors, hospitals, and other medical providers if you change or lose your job
- ✓ Allows access to complementary and supplemental insurance

COST

- ✓ Premiums related to income level and family size
- ✓ No out-of-pocket costs such as co-pays, deductibles, and co-insurance when you use health care services.
- ✓ Includes prescription drug coverage with a small administration fee
- ✓ Overall cost the same or less than the current American health care system

FINANCE

- ✓ Collection of funds – Utilizes current Medicare law and Internal Revenue Code (IRC), an accepted and proven American system of health financing
- ✓ Distribution of funds – Provider payment methods and levels negotiated with doctors, hospitals, and other medical providers

SEE EXHIBIT - Extended Medicare-Source of Funds/Payments

FOR FURTHER DETAILS SEE:

Extended Medicare for All: Financial Approach
February 2020
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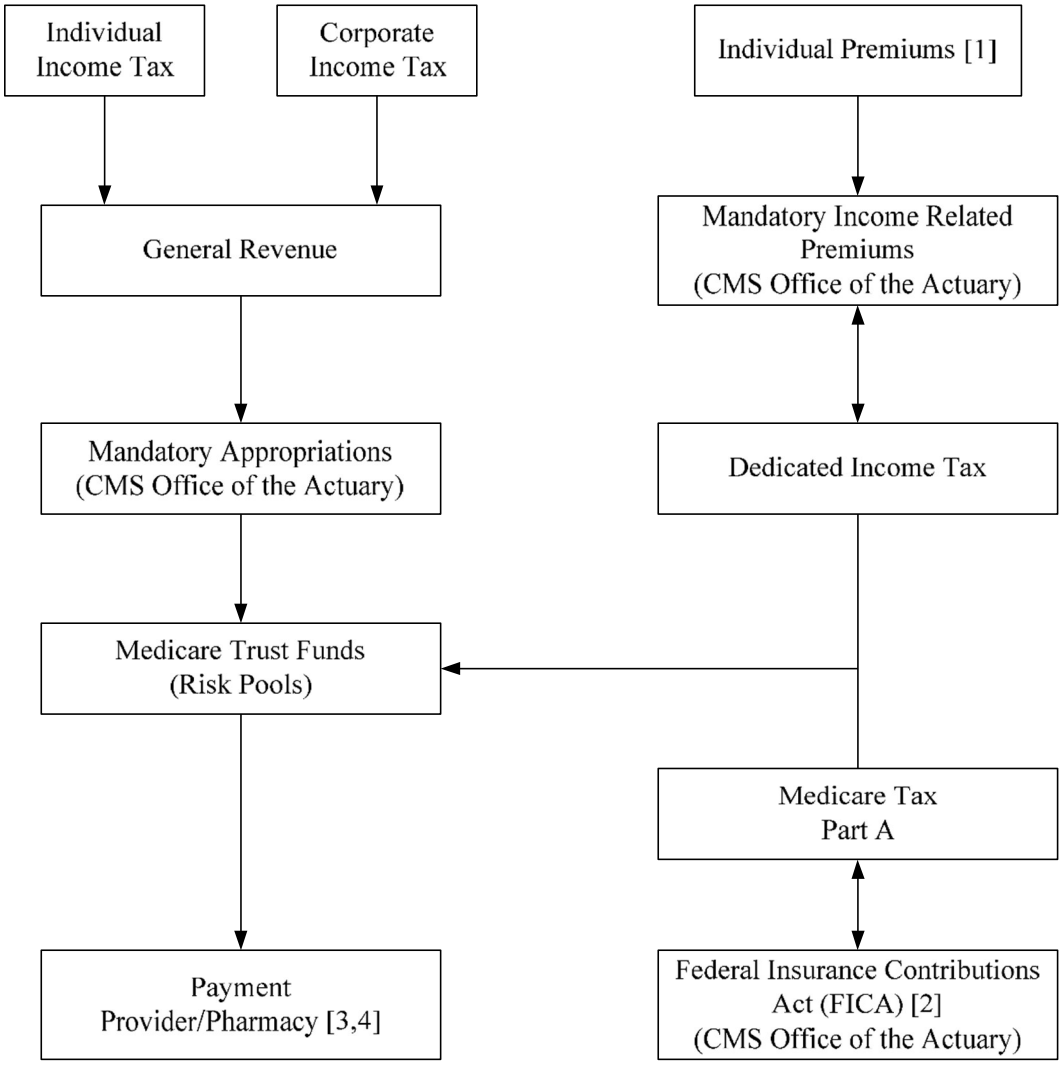
Thomas Billroth Gottlieb, MD

www.extendedmedicare.info

Exhibit - Extended Medicare-Source of Funds/Payments



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