THE BEST BI-PARTISAN ANSWER TO REPEAL AND REPLACE OBAMACARE

Medicare Part C – Medicare Advantage

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EXECUTIVE SUMMARY

Presidential Candidate Hillary Clinton, who owns the health policy mantel of the Democratic party, campaigned for a "Medicare-Buy-In" plan, the so-called public option in 2016. Bernie Sanders campaigned for "Medicare for All." They were both on the right track. Hillary more so because she had originally proposed Medicare Part C - Twenty-Five (25) years ago when her husband, Bill Clinton was President.

In fact, the so-called Public Option - Medicare Part C was included in the House version of the Affordable Care Act (aka ACA - Obamacare) and it was only stripped out of the bill at the last minute by Senator Joe Lieberman. Otherwise, it would have become law and been one of the programs upon which this Congress could have successfully built the "Best Bipartisan Answer to Repeal and Replace Obamacare." Medicare Part C is an idea born of the Democratic Party, whose time has come Today! Medicare Part C – Medicare Advantage (MA) has many elements that both Democrats and Republicans want in a bill, including flexible benefit programs, premium subsidies and tax credits that make the health plans more affordable, the ability to extend health insurance to all Americans once and for all and to quote James Hacker, known as the father of public opinion and an effective early proponent of Obamacare, " Medicare, or another Government Plan is in the best position to lower overall costs because the Government can best negotiate lower payments for doctor's visits, tests and medications." (1.)

Bernie's plan to give everyone "Original Medicare", unfortunately died with his candidacy. Hillary's plan, which she called Medicare C back in the day, was taken out of ACA because proponents said lost its resemblance to a Medicare plan in the amendment process. (2.) It lacked the flexibility and structure of the current Medicare Part C – Medicare Advantage plans. This health insurance program is the answer to uniting Democrats and Republicans by bringing back Hillary's Medicare Part C plan without the dysfunctional elements that caused it to be stripped out of ACA - Obamacare.

This Bi-Partisan Answer to Repeal and Replace Obamacare proposes to marry many of the elements of the Senate bills, extending the subsidies and the co-payments for the people, wedded to the current Medicare Part C structure and administration, of which Hillary Clinton would approve. The current Medicare Part C – Medicare Advantage plans have been working successfully to cover retirees over age 65 for Twenty (20) years and can be extended to all those under the age of 65, as Hillary Clinton (and Bernie Sanders) had hoped to accomplish.

Medicare Part C has many of the elements that the Republicans value most. It is a proper insurance plan in the traditional sense and it eliminates the need for market stabilization and extraordinary loss funds. It eliminates the need for special state funding. It makes use of the

capitation financing, which is the basis of their Medicaid reforms. I think it will save One Hundred (100) billion dollars in 2018 and at the same time eliminate the need for selective taxes by establishing a more equitable funding base.

The United States has made great strides toward the goal of making affordable health insurance available to everybody, but our current Congressional efforts to continue that effort are detracting from this progress. ACA did not do the job. The Congressional Budget Office (CBO) has confirmed that both House and Senate Repeal bills, the American Health Care Act (AHCA) and the Better Care Reconciliation Act of 2017 (BCRA) respectively will not do the job either. *Medicare Part C, which has been successful for twenty years WILL DO what both political Parties are striving to achieve.*

We must force our Congress to put aside their partisan politics and take care of the health and well-being of "We the People" (to whom they represent) if we are going to be the successful beacon of freedom and democracy around the World. We the People do not have to accept the defeat of socialized medicine. Whether the Democrats and the Republicans get it right this time, as explained here-in, Medicare Part C is the "BEST ANSWER TO THE REPEAL AND REPLACE OBAMCARE" and all the members of both political Parties should read my White Paper entitled "Medicare C – The Advantaged Replacement for Obamacare" (3.) and this more detailed document explaining how this "public option", extending our beautiful and successful Medicare Part C - Medicare Advantage plans would work, understand and accept the Truth of what BCS is advocating and make it happen!

Medicare Part C was good enough for Hillary Clinton, and it is good now, enjoyed by 17 million retirees currently covered by it. How much better will it be for the 9 million ACA members struggling to find and keep an Obamacare health plan and the 28 million uninsured Americans that are not covered under any health insurance plan at all? The time for us to Act is Now!

OVERVIEW

The Congressional Budget Offices' (CBO) Cost Estimate Report on Senate Bill H.R. 1628 – entitled "Better Care Reconciliation Act of 2017", released on June 26, 2017, estimates that enacting this legislation will increase the number of people without health insurance by Twenty-Two (22) million, raising the total number of uninsured in the U.S. to roughly Forty-Nine (49) million by the year 2026. This is Un-American and a disgrace. The CBO Report compares this result to the Twenty-Eight (28) million currently uninsured and predicts an equal number of people will lack health insurance in 2026 under the current ACA law, if Congress makes no changes. Now what do we do?

If we do nothing, we will spend hundreds-of-billions of dollars on ACA, Obamacare will still collapse and at least Twenty-Eight (28) million people will still be without health insurance. If we try to fix this problem the way Republicans have proposed, we will spend hundreds-of-billions of dollars and end up with almost twice the number of uninsured Americans in Ten (10) years. Neither of these alternatives are acceptable choices for the American people! I estimate that a Medicare Part C Extension to under age 65, in place of Obamacare, would *save the federal government 100 Billion dollars in 2018.* The CBO estimates Obamacare cost 110 billion in 2016. (4.) If Medicare Part C could be extended to cover the under age 65 population, retaining the Senate Bill's (H.R. 1628) premium subsidies, eliminating the need for state and insurance company stabilization and loss recovery funds, leaving the state health insurance exchanges alone, 100 billion dollars would be saved in 2018. This savings could be used to increase the number of Americans covered by health insurance.

The solution to this dilemma can be found in the White Paper on my web site: www.bcsconsultants.net. BCS Consultants (BCS) mailed this White Paper entitled, "Medicare C – The Advantaged Replacement for Obamacare", to all the members of Congress in April, 2017 and we have been promoting it right along. This document is the "follow-up" and explains in greater detail how BCS thinks this Medicare Public Option program should be made to work, why it will work and why YOU should be in favor of it. This is a national challenge and a national priority and we must devise one national solution as one people and one political party, working together.

The functioning of our health care entitlement programs relies on Public-Private Partnerships. These partnerships have thus far failed to make healthcare affordable and accessible for every American citizen. Obamacare (ACA) was an attempt to fix that and it has unfortunately failed to deliver. Medicare Part C - is the Right answer and right now you and ONLY YOU can change the course of our health-care history! Go to my Facebook site BCS Consultants and Like It! Go to: www.bcsconsultants.net, download this and other documents for more information. You can help make it happen by contacting your Senator and Congressional Representative Today! You can easily reach them all with One phone number: 1-202-224-3121. Tell them to check out Medicare Part C - Medicare Advantage Programs as the Answer. Refer them to my website tell them if the current bills fail, Medicare Part C is the bipartisan solution to the problem.

THE PLAYERS AND THE NUMBERS

Congress should continue to do what we have been doing correctly with health care and health insurance in the United States. According to the Kaiser Family Foundation (KFF) in 2015, Our health insurance carriers and health maintenance organizations (HMO's) cover One Hundred and Seventy-Eight (178) million citizens in the group and non-group markets. The federal government successfully supervised health insurance programs for at least another One Hundred and Six (106) million U.S. citizens. After the ACA's Medicaid Expansion, the states have Seventy-Four (74) million enrolled in Medicaid. We have Twenty-Eight (28) million citizens still uninsured because it is not available, they can't afford it, or they don't care to be insured. (5.) And, bringing up the rear, we have Obamacare (ACA) which covers only Nine (9) million citizens, and make us, as a country and a people, look ridiculous in our struggles to fix it. (6.)

These numbers make clear several important facts:

- Most powerful elephants in the room are health insurance carriers, HMO's and health care providers and they are having an impact on the agenda.
- Federal government does (or should) know what it is doing. With 106 Million people under management, there is really no excuse for this debacle.
- The Real problems are the Medicaid programs, uninsured low-income workers and the unemployed, uncompensated care and the fact that our system is so expensive.
- The small number of people covered by Obamacare makes the program relatively insignificant in the broad scheme of things.

The successful federally supervised programs covering 106 Million include Medicaid, Medicare, CHIP, Tricare, Veterans Health (VA) and the Federal Employee Health Benefits plan (FEHB). These programs dwarf the size of ACA and cover over One-Third of all Americans. Our federal government knows how to do health insurance. For the most part, they don't operate these programs. They largely just pay for them. The best programs are run by the health insurance industry, Health Maintenance Organizations (HMO's) and their computer systems in what is, in its entirety, the largest and most successful Public-Private Partnership on the Planet Earth.

Given only Nine (9) million people covered, why is Obamacare such a lightning-rod between the Democrats and the Republicans and the American people? The answer is certainly the cost of the program and the taxes levied to pay for it. It is also the failure of ACA to cover the Twenty-Eight (28) million uninsured residents (which has been a goal in the U.S. for 50 years). But, it is also the Medicaid Program, which covered Sixty-Two (62) million of our low income, needy and disabled citizens in 2015. With the ACA - Medicaid expansion (90% of which is being paid for by the federal government) Medicaid enrollment has increased to Seventy-Four (74) million in the last Three years. (7.) The Republican mantra of "Repeal and Replace" was really all about the money, the one thing which Congress is all too familiar!

Medicaid is the biggest part of this battle. The fortunate thing is that the failure of Obamacare has presented us with another Golden opportunity to do the right thing. We have the added knowledge of the reasons Obamacare failed, we know the way to fix the system and for the first time in a long time, we can almost grasp the dream of covering ALL of the American people once and for all!

THE MYTHS OF SINGLE-PAYER AND HEALTH INSURANCE

A prominent Chicago physician, Dr. Donald McCanne's blogged "Quote of the Day", on the PNHP website (Physicians for a National Health Program, located on Madison Avenue) in May 2016, commenting on Hillary's Medicare Buy-In proposal, as follows: "No, a Medicare Buy-In or Public Option is not a step towards single payer." Medicare is not a "single-payer" system. Our government contracts with a Public-Private Partnership for all federally sponsored entitlement insurance programs, except for Medicaid. The federal government partners with each of the 50 states and the states run their own Medicaid administrations with a shared purse-string responsibility. All the other federally sponsored health insurance programs are principally supervised by federal government but administered by the Private Partnership.

Since 1966, the Public/Private Partnership that runs the Medicare program has used about 30 – 50 private health insurance companies across the United States under contract for the administration. (8.) We commonly refer to Medicare as a "single- payer" system, however this is a false narrative description of the administration. Medicare is a "multiple-payer" system. It seems to us like a "single-payer" system because there is a single manager. Medicare is managed by the Centers for Medicare and Medicaid (CMS), under the Department of Health and Human Services, currently under the leadership of Secretary Tom Price, M.D, a former congressman and Trump Administration appointee.

Originally passed in 1956, Medicare was created to cover the civilian families of individuals serving in the military. In 1965, under President Lyndon Johnson, Congress re-enacted Medicare under Title XVIII of the Social Security Act to provide for the payment of health services for every citizen age 65 and older, regardless of income or medical history. (9.)

CMS calls almost all the shots on Medicare. CMS determines exactly what health care services are to be covered, exactly how they are to be paid, and most importantly, they determine (through various means) exactly how much is to be paid for each covered health service, in every county in the U. S. They generally do not get involved in a person's health or life-style. This is one of the major reasons Medicare is so expensive. Although Medicare is often criticized for costing too much money, the government has been successful in reducing the rate of the programs medical inflation to less than the private health insurance market. The Medicare single-payers in this Public/Private Partnership include companies like Anthem, Electronic Data Systems (EDS), BlueCross BlueShield (BCBS), Humana and United Health Care (UHC). They are useful to CMS because they generally have favorable medical and hospital provider contracts which reduce the health care cost and inflation. These favorable provider contracts may save more money than it costs to administer of the benefit program. A PBS Documentary on Medicare Part C Plans uncovered the fact that some carriers could save more money through their administration of the programs than it cost them.

These health insurance carriers are paying Medicare claims by programing CMS instructions into their computer systems. Therefore, Medicare "single-payer" is just the working of the "computer systems" of the Public/Private Partnership. There is not a lot of fragmentation in this

infrastructure that would cause un-necessary expense. Even with only "one" computer system, software is software, and the complications would be great and the savings would be negligible with further consolidation. The most beautiful thing about this decentralized system is that it should be more flexible and responsive to changing conditions. It will have the centralization necessary to launch a national health and fitness program and maintain the adaptability to the implement different aspects of the program in different parts of the country.

The second most beautiful aspect of this system is the effectiveness with which CMS can be, for us, a "single-payer", and use the health insurance carriers to pay the claims and do its bid in the Public-Private Partnership that exists. These carriers will do exactly what CMS tells them to do and they have been doing so for the last 25 years. The federal government and CMS have, in fact, acted as a "single payer" for us. CMS is our Single-Payer health care system, but Congressional reforms of the ACA are about the permanently change all of that.

We remember the fake appointment fulfillment reports and gross negligence and mismanagement uncovered at every level of the Veterans Administration (VA). Executive Orders and repeated firing of top management has been required to fix the system. This is the kind of thing that can be expected with a government run health care system. The VA is the closest the U.S. has come to a Government run health system, yet no one wants "The VA for everybody". But, you often hear public avocation for Single-payer. Some part of their Single-payer will look like the VA. We greatly value the service of our veterans. And, when the back-log veterans waiting for appointments were too unmanageable we authorized them go to any private health care provider they chose at the VA's expense. Where would the government refer veterans or anybody else too that need of health care and can't get it, if there is No private health care system? We can't let that happen in the United States.

Under Obamacare and the Reform bills (Obamacare Dark), the responsibility for our national insurance programs is being transferred to the states. There is no question that CMS must improve its performance and do more, if we are ever going to arrest the cost of our health care at a more reasonable level. However, the best and clearest path to that success is through the private health insurance carriers, HMO's and the medical and hospital provider communities, not through the federal and state governments. And, Medicare Part C can help facilitate this process.

In 2015, CMS under Medicare arranged for the payment of health services for Fifty-Five (55) million beneficiaries, 46 million of which were retirees over the age of 65 and 9 million citizens on disability. On average, Medicare pays for about half of the health care expenses for those enrolled. (9.) In addition to the Myth that Medicare is a "single payer", is the Myth that Medicare is health insurance. Medicare, and most of the other programs primarily supervised by the federal government, are "NOT" Health Insurance. ACA - Obamacare is "NOT" health insurance.

Medicare Part C - Medicare Advantage and FEHB, "ARE" the only federal programs that are actuarially underwritten ("Real") health insurance, where risks are quantified and rates are

developed to cover those risks. All the rest of the federal entitlement health programs are pay-as-you-go contracts for health care services. BCS is advocating “real” health insurance for the replacement of ACA – Obamacare.

Under a real health insurance contract, the insurance company takes the risk. They implement programs that are actuarially underwritten to cover certain risks. If they miscalculate the risk, and the cost is more than they projected, they will lose money. If they manage the program efficiently and deliver all the benefits for less, they make more money. Their goal should be to at least break even. Under most government entitlement programs, the government generally takes the risk and the health insurance carriers are relegated to the position of administrator. The government is going to pay, no matter what. Is this any way for us to run a health insurance plan?

THE VA FOR EVERYBODY

I don't know why there is so much mistrust between the public and the health insurance companies. All health insurance carriers generally respect and honor their obligations. This Obamacare mess is partially due to the Obama Administration's mistrust and bad attitude toward health insurance companies. Health insurance companies are not the bad guys. Obama sappropriated billions of dollars for the creation of brand new Non-profit health companies and introduced health insurance (Marketplace) Exchanges, which was and absurd waste of resources. Half these new health carriers are gone and almost all the Exchanges are struggling because the insurance companies are supposed to pay for them and they don't, for good reason. Bernie Sanders and his supporter's think of single payer is a panacea for something? It is a computer system. We have essentially had single payer for years. We just haven't expanded it to everyone yet.

The truth is paying claims for health insurance is not an easy job, especially when everyone is on their case about the high cost of health care and everyone thinks they are the cause of the problem. Those companies that know how to do it, and do it well, are constantly innovating to be more successful, profitable and productive. We have come so far from the old fee-for-service system that this very nomenclature seems antiquated. Insurance carriers can make money under a capitation reimbursement system. There is nothing new about paying for health care with capitation. There is nothing new about alternative financial arrangements. There should not be anything new about the need to cover all of our people with a health insurance plan efficiently, cost-effectively and in such a manner as to allow the free markets to control the cost of health care and allow our healthy self-interest to improve the system.

Our Government wants to take the risk and responsibility for all of this stuff and we generally think this is a good idea. Our Representatives in Washington argue about how to pay for it, who is going to be taxed to pay for it and how it is going to be paid. But, this approach is just like Communism. How is it different from the communist Russia or even socialist England? Their government takes care of everything that has to do with health care, including rationing it, budgeting for it and managing and mismanaging it. The British are proud of their health system, but there are lots of problems with it. We are Americans and we can do it better.

BCS doesn't want to cast aspirations on the Veteran administration by analogy, because it is a vital system on the mend and we have heard a lot of good things about it. But, we do remember the veterans, who died while on the waiting list for a doctor's appointment. We remember the fake appointment fulfillment reports and gross negligence and mismanagement uncovered at every level. It has taken an Executive Order and repeated firing the top management to begin the improvement process. This is the kind of thing that happens and this is what can be expected with a government run health care system. When they discovered that the back-log of veterans was not manageable, they authorized letting them go to any private health care provider at the VA's expense. Where would the government refer veterans or

anybody else too that need of health care and can't get it from the national system, if there is No private health care system? We can't let that happen in the United States.

How many Americans would vote to have all their health care handled through the VA? President Trump has done a lot to fix the problems, but the VA is exactly where we are headed if we cannot figure out how to come up with a formula to use the public-private partnership to administer a Medicare Part C Buy-in program based on capitation financing. Our veterans are the most important segments of our population. Without their sacrifice, we would not be free. The VA is a valiant service created to provide necessary health care to those veterans that cannot afford the private system. Veterans that can afford to go to the private system, usually do, but will also use the VA for specialty care.

Maybe some of our citizens want single payer because they are frustrated with the rising cost of health insurance and health care. At BCS we do not hear the call for the "VA for Everyone", but we will consider making this our next battle cry. We wonder how much support we can get for the single payer universal health care idea if they think it is going to work like the VA did in the past.

GIVE THE PEOPLE WHAT THEY WANT

If Congress does not come up with a successful repeal and replace program "We the People" are going to *come up with a New Congress*. The details of health care and health insurance are for the most part lost on the public and the press. No one likes to read their insurance policies. That is why we have insurance agents. But when elected Representatives fail to live up to their promises and continue support for programs that do not do the job, these things are not lost on us. Read this proposal. Tell us why this proposal is NOT a good idea. And, if they believe it is not a good idea, tell us what they are going to do as an alternative?

The New York Times Op-Ed contributor David Leonhardt is running Opinion Pages on the dishevelment in our congressional health care reform efforts. He has illuminated the fact that every person involved in this messy process wants affordable health insurance and lower health care costs. The Democrats as well as the Republicans, did most of the drafting of their health care bills behind closed doors. The complexity of the issues and the powerful interests involved almost require it.

In 1995, health care in the United States was 13% of GDP. In 2014, it was 17% of GDP. (11.) We spend more than any other nation in the World on health care. This is "Big" business. President Trump recently got the Senators together at the White House told them (and us) that he expected the Senate bill to be, "a phenomenal Bill for the people of our Country." He was hoping it would be a bill that is, "generous, kind and with heart." President Trump said the Senate is going to, "come out with a, "Real bill – not Obamacare!" The Democrats continue to resist any changes to Obamacare. Fortunately for them, the actual Senate draft bill was an adjustment to ACA – Obamacare, and it's later version that I call the "Obamacare Dark". As CBO reported, it is not an answer to providing affordable health insurance to the low-income and uninsured Americans. But, because Republicans are not making substantial changes to ACA, one would hope the Democrats would be more conciliatory with their participation in the reconciliation amendment process.

In fact, I hope the Democrats will embrace the idea of promoting Medicare Part C - as the Medicare Buy-In program that Hillary Clinton has been promoting and come to a compromise that will give Republicans some tax relief on and greater control over future health care costs. Democrats can take credit for coming up with the Medicare Part C Plan, that will include competitive benefit plans to attract new members, adequate premium subsidies and tax credits, more affordable plans for the needy, protection for pre-existing conditions, more uninsured voters signing up for coverage and more influence over the programs design. The Democrats need to do absolutely everything they can to shore up their base right now. Congress is at an all-time low approval rating and The Republicans seem to have all the answers. So, isn't it about time for the Democrats to stand FOR SOMETHING, as opposed to standing AGAINST EVERYTHING?

I fully recognize the reasons that Obamacare failed and I judge the Republicans with knowing how to correct the situation. I also recognize that the Democrats know what went wrong. And,

consequently, the real reason the Republicans are proposing these harmful solutions has not gone unnoticed. It is the ugly word "Reconciliation." Since here-to-for the Democrats have not had a good reason to participate in this process and are threatening to filibuster, I am sincerely hoping that this proposal will give the Democrats enough reason to come back to the table. No amount of money approved by the Republicans or the continuation of Medicaid expansion would have saved ACA - Obamacare program. Republicans are trying to fix it and at the same time, get the tax relief and cost controls they want. Democrats need to step up for their party to protect the interests of the people they represent and insist on the elements of the plan that will appeal to their base and participate in this solution. Medicare Part C is a start!

Everybody knows the Democrats and Republicans do not generally cooperate with one another. Each party selfishly acts to favor its own constituencies and that generally takes priority over everything else. I support the way the parties respectively act and think about each other and talk about each other on the floor. But, when it comes to serious national priorities that effect the health and well-being of "We the People", we must draw the line.

I have been privileged to gain and share the knowledge of why Obamacare failed. We cannot continue the out of control government spending and the out of control health care system. I have made it abundantly clear in this document as well as in my White Paper entitled, "Medicare C – The Advantaged Replacement for Obamacare" dated April 15, 2017 (and available on my web site at: www.bcsconsultrants.net) that the federal government knows how to successfully structure health insurance programs. They are supervising several of them and they cover tens of thousands of people. The Senators and Representatives are all very smart, many of them millionaires, many of them know how to fix problems like this, but they can't fix this problem purely because of politics. If you are as frustrated as I am with this situation, we can truthfully lay the blame squarely on many of our Congressional Representatives of both parties in Washington, D.C. They are "NOT" acting like Statesmen and Stateswomen and they are "Not" acting in our BEST interest. Those of our Representatives that are, need our full support!

As stated above, every member of Congress and the Trump Administration is, or should be, aware that the federal government is already doing a great job providing essentially the things that everybody wants, for over One-Third of Americans, Right Now! I am obviously "NOT" talking about Obamacare! However, there are 2.75 million federal employees (who polled overwhelmingly against ACA). What about their program? Ask former President Barack and Michele Obama about their health care plan? Ask the more than 55 million Americans covered by Medicare A and B or the 17 million Americans covered by Medicare Part C – Medicare Advantage Plans how they feel about their health plans? They will ALL tell you they are happy to have them. Without them, they would be worried about how they were going to pay their bills, if they get sick.

HOW MUCH DOES IT COST?

Republicans and Democrats, health care providers, insurers and "We the People" all want - more - than just affordable health insurance, *we all want more people to have it*. The CBO and Kaiser Family Foundation (KFF) both estimate that we have Twenty-Eight (28) million people without health insurance. To help you understand why this is such a difficult problem and why it is so hard to fix, consider the following facts:

Except for brief periods over the last 50 years, the rate of health care inflation and the concomitant cost of health insurance has risen at double digit rates of increase. According to the CBO, healthcare is the fastest growing category of national spending. The U.S. health expenditures in 2015 accounted for over 25% of the federal budget, up from just 7% in 1976. A comparative reference on this level of health care spending, is the comparison to what we spend on our national defense. Our "entire" National Defense and Security Budget is 16% of the federal budget. Our healthcare expenditure is 1.56 times as much as we spend on our military. Just think of the enormous size and omnipresence of the military/industrial complex in our country. And, just think how important is our national security to the future health and well-being of our nation? Our military budget is also, by far, the largest in the World. It exceeds the spending of All the other industrialized nations "combined" including Russia and China. The military/industrial complex does not get nearly as much of our tax dollars, as our government spends health care!

From one perspective, our national priorities are Right, but it is just mind boggling to realize the humongous amount of money we spend on health care. In 2008, the CBO wrote that, "future spending … on the federal government's major health care programs – will be the most important determinant of long-term trends in federal spending. Changing those programs in ways that reduce the growth of costs will be difficult, in part because of the complexity of health policy choices– is ultimately the nation's central long-term challenge in setting federal fiscal policy." (12.) As a nation, we might not be able to afford National Security, if we do not get this health care program right! The Republicans are trying to do something about this huge problem for the sake of the nation. For the Democrats, it is perhaps more a question of priorities and who should pay for them.

From the democratic perspective, consider what we are spending all this money on. This is our Butter, not Guns! We are compassionately spending these tax dollars to sustain and improve the very health of our citizens, including our indigent mothers with children, many of our low wage workers, our retirees, our veterans, the unemployed, our poor men and women and our disabled. How much of your own family budget is spent on health insurance? If it is just 25% (like our national budget), you would probably feel pretty good about it. But what if your spending only covered 90% of your family? What if you couldn't afford to cover your children for that amount of money? How would you feel about it then? Ten percent of our citizens are not covered by health insurance. The question is, do we have to spend even more money to cover them or is there another way to do it?

The National Priorities Project, quoting from numerous reputable Research Polls and Reports, found that most Americans name controlling healthcare costs as a top priority (64%). An equally large number of Americans strongly value Medicare, but only 22% say they support reducing health spending. As Senator Rand Paul said recently, "we all want more health care benefits, but we are unwilling (or unable) to pay for them," especially at the state level. We cannot blame the Republicans for trying to reduce the cost of health care. And, we cannot fault the Democrats for trying to increase the number of our citizens, who have health insurance at the same time.

HOW DO WE FIX THESE PROBLEMS?

Because our government manages the largest, most successful "Public-Private" Partnership, providing access to quality health care in the World, Congress is between a rock and a hard place. They know how to fix the problem but they don't want to just throw money at it. Everyone wants lower cost health care and because it is so expensive, too expensive for many of us to afford, we must have health insurance to pay for it. The challenge for the federal government is to curb the tremendous increases in the cost of health care and at the same time give those people, who are not insured, access to affordable health insurance. This is what Obamacare is supposed to do and that is not happening.

Obamacare was successful in increasing the number of people signing up for Medicaid by Eleven (11) million. The way ACA did that was easy. The federal government agreed to pay the states 100% (gradually reducing to 90% in 2020) of the cost of raising the eligibility for qualified citizens to sign up for the program. It was like signing people up for a free lunch. Even more shocking is the fact that the sharing between the federal government and the state governments is open ended. In other words, whatever the state decided to spend, the federal government would have to match it. This is like saying to your kid, I am going to give you an allowance equal to half of what you spend every month. And, if you spend more than you expected, no matter how much more, don't worry. I've got you covered 50%/ 50%.

If your kid was your state representatives they would only be half as worried as they should be about the amount of money they spend. If you are your federal representatives, you are naturally going to want to establish some limits to your kid's spending.

Our focus on health insurance may cause us to forget that the federal government does have other national priorities, not the least of which are a crushing trillion-dollar national debt load and a multiple billion dollar annual budget deficit. We can't keep throwing money at every problem we have, without having some rational plan to handle the risks. How do we fix ACA – Obamacare, so that this time we get it right, without having to pay for a government take over of the entire health care system, a move that will certainly and severely damage our quality of health care?

We have approximately 43 million citizens that need help from the government. These include the ACA enrollees (9 Million), the low-wage uninsured and unemployed workers (28 million) and segments (more or less) of the Medicaid eligible population (5 million). In order to "fix" the problems, we must figure out an economical way to help about 10% -13% of our total population. The problem is manageable.

HEALTH INSURANCE IS THE SMART WAY TO START

The FIRST thing that Congress needs to understand is that the ONLY way they can lower the cost of health insurance, without doing anything about the health of the population, is to use the power of leverage in a REAL insurance plan! President Trump told the Senators, he wants, "a REAL bill – NOT Obamacare." Congress must stop throwing good money after bad and make it possible to use the power of leverage in a "REAL" actuarially underwritten insurance contract. The power of leverage in health insurance, is the ability for health insurance carriers and HMOs to charge a low premium rate (less than one would normally have to pay on their own) to a large number of people and when the little premiums are all added together, the total amounts to enough money to pay for the health care expenses of those few in the group that actually get sick.

In 2015, our health insurance carriers privately underwrote health insurance for approximately 22 million of our citizens with Non-Group contracts in the "REAL" insurance World. (13.) Our free insurance market is still alive and well. Insurers and HMOs still design and evaluate insurance programs to determine the risk of loss and set premium rates based on the assumed cost of paying for those losses. This is called actuarial-underwriting. This process allows insurance carriers to determine the prospective cost of a health insurance program. All the Trump Administration employees and all our Congressional Representatives and all the other 2.75 million federal employees are covered by FEHB programs. These programs are ALL actuarially-underwritten and designed to be annually self-supporting.

At some point, at the beginning of this decade, before ACA was passed, Congress polled the federal employees on whether they wanted to maintain their FEHB health plans or go with the ACA - Obamacare plans. They voted overwhelmingly to keep their current programs. Congress then exempted itself and all federal employees from Obamacare and that is why very few, if any of the House Representatives and Senators trying to Repeal and Replace the ACA program, have any first-hand knowledge of what it is like to be covered by the program. I am reasonably sure even President Obama's family is not covered by an ACA - Obamacare plan. The House of Representatives may have included a provision in AHCA which requires them to be subject to their proposed plan.

Why didn't Congress just make it simple and pass a law that required the AHCA to work exactly like the FEHB program? They have never proposed anything like giving "We the People" the SAME benefits that we all pay for them to enjoy. If they had done so, it would have made very good sense and been a great success. The only one that would cry about that law would be the Exchequer! FEHB was seriously considered to be a Model for how health care would be delivered in the U.S. What BCS is proposing with Medicare Part C, is very similar to FEHB, using capitation rating and some reverse engineering.

It was very thoughtful of the House to agree to subject themselves to the same health insurance menagerie that "We the People" have to put up with under AHCA, but that doesn't change the fact that the programs they are proposing, on the ACA platform, are flawed. We

hear Congressman talk about risk pools like they are a magic carpet. If you have this or that, it will be OK, seemingly ignoring the fact that the industry knows exactly how to create successful risk pools. It is an art and not a science, but they have been doing it for a very long time. The problem is Congress wants to tell the carriers what they can and cannot do. And, when they do that, they ruin the one thing that BCS thinks will save them. If we are going to allow the creation of a risk pool, the insurance carriers, and not the federal government, should take the risk. That is what Medicare Part C is so good at doing.

MEDICARE PART C - IS "REAL" HEALTH INSURANCE

The only other "Real" actuarially underwritten federally sponsored health insurance program (besides FEHB) that covers "We the People" is our Medicare Part C – Medicare Advantage. This is the program that BCS advocates as "The Best Bi-Partisan Answer to Repeal and Replace Obamacare." About 5 years after Hillary's - Health Security Act was briefly referred to as Medicare Part C, the national health care inflation rate surprisingly fell into single digits, due in part to the impact of HMOs. This took some of the steam out of health reform.

Congress, perhaps hopeful of enacting more far reaching legislation, passed Balanced Budget Act of 1997, allowing capitated health insurance programs to be the Part C of our Medicare. These plans were initially referred to as "Medicare + Choice". They were very successful in lowering the rate of inflation and the cost of traditional Medicare, in part because of the creative techniques used to manage the delivery of health care in the "Choice" programs. Later, the Medicare Modernization Act of 2003 re-branded most of the Medicare Part C programs as "Medicare Advantage" (MA) in which Medicare beneficiaries are given the choice of receiving their Medicare benefits through capitated Part C health plans. (14.) A person making this choice joins a Medicare Part C Plan and suspends their participation in an Original Medicare - fee for service plan. Medicare Part C has also included some fee for service plans in the past, which may be used again for people who live in an area not covered by a Medicare Part C plan.

The Medicare Part C operates under the principals of "REAL" insurance. Medicare Part C - Medicare Advantage programs cover approximately 17 million of our most vulnerable elderly citizens. The program's popularity has increased due to ACA. For the participants in Medicare Part C, the federal government does an annual evaluation on the actuarial equivalency of cost for Original Medicare. This means that they determine how much the government would have to pay an insurance carrier if they were going to produce an insurance program that was actuarially-equivalent to the traditional Medicare program in a particular county. Therefore, CMS annually determines what capitation fee the federal government is willing to pay for health insurance in each county in the United States. The health insurance carriers and health maintenance organizations take these rates and design health insurance benefits programs, with CMS approval, to cover the participants within the margin of the prospectively determined capitation (per person dollar amount) rate. The federal government agrees to pay that rate and the insurers (insurers and/or health care providers) take the risk and assume the responsibility of administering the programs. There is no confusion about how much the carriers are to be paid. There are certain requirements that the insurers must meet to satisfy the Centers for Medicare and Medicaid Services and these are met in strict but collaborative and rational interactions characteristic of this successful Public-Private Partnership. This is the way it should be done, and is unlike the turmoil that ACA has created in some markets.

As stated above, Original Medicare is not a capitation rated plan. It is a "pay-as-you-go" fee for service plan, meaning the federal government takes the risk and is going to pay for all the expenses, using various revenue streams, plus any general revenues required, no matter what

the cost. This guarantee is backed by the full faith and credit of the federal government. The providers that make application to CMS to participate in Medicare Part C assume all the risk for the programs administration and financial viability. And, they have demonstrated agility in controlling the cost of health care for the government and participants at the same time. Any savings they are able to generate goes directly to their bottom lines.

According to the latest estimate by the Medicare Trustees (2016) Medicare trust funds will become insolvent in 11 years (2028), give or take a few years. Medicare was designed to be funded from payroll taxes, paid by the active healthy workers and employers, enrollee's out-of-pocket premiums and surtaxes and if necessary, general revenues. It works a little like a socially acceptable well-intentioned government Ponzi scheme, where our workers pay into the Medicare Trust for the promise of future health benefits and their money is used to pay for the retired and disabled enrollees that are presently using their benefits. Medicare enrollment is set to increase from 55 million to 79 million by 2020 and the ratio of workers to enrollees will decrease from 3.7 to 2.4. The good news about is this ratio has declined for many years and yet our social insurance systems have remained sustainable due to increases in worker productivity. (16.)

However, the biggest difference between Original Medicare and Medicare C is the risk assumption. We don't have the expectation that Original Medicare (Medicare A,B & D) is going to pay for itself, as there would be if Original Medicare was an actuarially-underwritten insurance plan. Pay-as-you-go is the only way for us to go on Original Medicare, because you can't get a balanced risk pool when all the participants are "restricted" to retired Americans over age 65 and the disabled. The older we are, the more likely our need for healthcare.

OBAMACARE IS "NOT" HEALTH INSURANCE

The Obama Administration tried to design Obamacare, as a market basket of actuarially underwritten insurance programs but ended up a collection of "pay as you go" plans. The original idea was to get a lot of healthy people to participate and pay premiums, that in total would be enough to cover the older, sicker enrollees. This would normally have resulted in actuarially sound health insurance contracts. Real health insurance is the least expensive, most cost-effective way, to finance health care, using insurance leverage and the law of large numbers. To make health insurance financially viable, you must create a balanced risk pool, which includes as many healthy people as possible. Unfortunately, crippling regulations that "restricted" the underwriting and enrollment and the benefits and rating and the marketing, etc. combined to make ACA plans too expensive. This resulted in a fair amount of documented anti-selection and more people applying for ACA waivers than for the health insurance plans themselves.

The Obama Administration requires the insurance carriers to cover a loaded set of health benefits *(essential benefits).* They also dictate how the insurance companies are to calculate their rates and how they had to distribute their plans to the public. In addition, they require the insurance companies to abandon several critical health insurance underwriting practices. Obama and Congress allows the federal government to pay most of the premiums AND the deductibles and coinsurance for anybody earning less than 400% of the federal poverty level. This eliminates any reservation (moral hazard) people should feel when they seek health care services. No cost means no caution. It re-enforces the incentive for enrollees to charge up to the emergency rooms for care and other expensive procedures without any sense of responsibility. The health insurance carriers were the same way. They sought and received no cost, no caution Risk Corridor loss recovery contracts, that allowed them to charge any rate they wanted.

The federal government had the short sightedness to agree to pay the insurance carriers, even if they lost money. A lot of them lost money and "We the People" may yet be required by law to pay more of their losses. It already cost us 2.4 billion to create 23 non-profit insurance plans, presumably because the insurers we already had were not sufficiently acceptable to the Obama Administration. Most of these plans declared bankruptcy and are out of business. But, the ACA straw that broke the camel's back was allowing anyone that didn't want to join the plan, to get away with <u>not</u> signing up for it, by paying a low "Shared Responsibility Tax" (equal to less than one month's average premium in many cases) and/or apply for waivers. This is euphemistically referred to as the Individual Mandate which the Republicans our falling all over themselves to repeal, despite the fact that such mandates tend to increase the viability of the risk pools. Congress also requires the insurance carriers to accept anybody without any waiting period or preexisting condition exclusion. Most of these flaws are still in the Republican reform bills.

The Obama Administration agreed to "bail-out" the insurance companies with market stabilization funds and billions of dollars for the so-called risk corridor program. Senator Marco

Rubio (R-FL) led a group of Senate and House Republicans in blocking the Obama Administration from funding these financial agreements. They claim they saved 2.5 billion in HHS discretionary funds. These regulations were in abrogation of traditional insurance underwriting guidelines. At the same time, the carriers were asked (but were never fully paid and are suing) to artificially lower the deductibles and co-payments, creating moral hazard for those enrolled. They required the carriers to accept pre-existing conditions, incorporate adverse selection into risk the pool, end any possibility for lower costs due to actuarially sound underwriting and kill the program's chances for success.

Although the fate of ACA was sealed by design, the most common explanation for its failure is the miscalculation in projecting just how many of the enrollees would be young and healthy – and thus unlikely to make big demands on their coverage – and how many would be older and sicker enrollees who would require more medical attention and drugs. Contributing to this failure was the community rating requirement of the program, where apparently age was not a factor in the plans rating. Consequently, many believe that the young people could get a better deal elsewhere. More than likely, young people did not feel obligated to sign up for the program and went without health insurance altogether.

Community rating was an invention of BlueCross BlueShield (BCBS) plans back in the days when they were organized as state chartered non-profit organizations with the principal responsibility for providing low cost comprehensive health insurance for the people of their states. It was considered the fairest rating system because everyone, businesses and individuals were all in the same risk pool. The problem was periodically the rates for some groups and businesses would be lower if they were rated on their own. To remain competitive and viable with commercial health insurance carriers, BCBS plans started breaking up the pools and the remaining community pool was the non-group market. One of the last hold outs was the BCBS plan in Rochester, New York. This was because of Kodak and their insistence that their rating be reflective of the community risk. I explain this to illustrate that community rating is almost by definition non-competitive. If you want to be competitive in the health insurance market, you must rate for the risk that you intend to cover. That is the level playing field. Anything else is fictitious, as Obamacare has so aptly demonstrated.

Mr. Rivlin, who is a policy expert at the Brookings Institution recalled that without the bail-out Risk Corridor program, which the Obama Administration desperately agreed to, insurance companies "were a little reluctant (to participate in ACA), because they weren't familiar with this population of people, who hadn't previously had insurance." (17.) We have also learned from recent research that low-income adults do not make the expected risk and reward calculus when it comes to health insurance, that underlies the basic assumptions of these subsidized programs, that are designed to encourage them to buy health insurance.

On Fox News, Senator Rand Paul asked, "why would any smart citizen on a tight budget pay health insurance premiums for twelve months, for a high deductible health plan, if they can get away with a small dollar penalty at tax time and sign up for the health plan without penalty

anytime they get sick?" (18.) Apparently, the American people are even smarter than Senator Paul was giving them credit for, because more people apply for an Exemption/Waiver to the "Shared Responsibility Tax" than pay the penalty. Also, more people applied for the Waiver that applied for the ACA – Obamacare. This is a text book failure. The American people are voting against ACA with their feet.

Think of it. These are the uninsured people that the Obamacare was supposed to help! More of these Americans chose NOT to enroll and save their money. A lot of people who did sign up needed the health insurance benefits and they also qualified for a subsidy. H&R Block learned that when they helped a sizable number of people to pay the tax penalty, they found that most of those people would have qualified one of the more than 30 tax penalty waivers or for premium subsidies. CPA's and accountants say ACA is now the most frustrating and time-consuming section of the 1040 individual tax return to complete. I am sure CPAs would support the Repeal of Obamacare based on Tax simplification alone. I personally hated the Marketplace's intrusion into my tax records. They solicited authorization over the phone for unlimited access to my tax records on a recorded line.

WHY DIDN'T THEY SIGN UP?

"Some (low-income) individuals may remain uninsured because they are not aware of the coverage option or face barriers to enrollment, even though they may be eligible for financial assistance under ACA." "Cost still poses a major barrier to coverage for the uninsured", making it the most common reason given, when they are asked, "what is the primary reason you are uninsured?" (19.) A new study just published entitled, "Subsidizing Health Insurance for Low-income Adults: Evidence from Massachusetts" takes this inquiry much deeper. The study concludes that even a modest enrollee premium can be a major deterrent to universal coverage among individuals with a low-income. This is one of the reasons the Medicaid expansion was so successful. Understanding the reason enrollments in ACA were so comparatively disappointing is more complicated than one would think. It is not simply because of adverse selection but because low-income people are NOT willing to pay the (gross) cost of coverage. Senator Rand Paul could have saved these Ivy league researchers a lot of time. (20.)

They found that health insurance leads individuals to consume more health care (as much as 25% more) than they would have consumed if they were uninsured. This is normally considered a good thing, as the value of providing the coverage is to get people to take advantage of it. A KFF Study found that uninsured adults are far more likely to postpone health care or forgo it altogether, with potentially severe consequences, particularly when preventable conditions or chronic diseases go undetected. However, low-income people are smarter than some researchers give them credit. They know that they are more likely to get providers to forgive them for uncompensated care if they are NOT insured. Some research indicates that they can often settle their health care bills for 20% to 35% of the cost of care, but not if they have any kind of health insurance. I know some people, who purposely tell their health care providers that they do not have health insurance, even though they have it, for this very reason.

This study of the mature programs in Massachusetts, shows the existence of a significant degree of resistance to sign-up for health insurance, even with very generous premium subsidies. They found that premium rates at 25% of carrier cost will at most get only Half or less (<50%) of the potential uninsured enrollees. And, even if subsidies lower the premiums to 10% of average health carrier cost, Twenty (20%) percent of the uninsured would remain uninsured under normal circumstances.

As a nation, after we add the Eleven (11) million Medicaid expansion, we only have about Ten (10%) of our population without health insurance. Premium subsidies would have to increase dramatically to close the gap between the cost of insurance and their willingness to pay. (20.) Unless we decide to give all of the uninsured individuals health insurance for FREE, we will never ever reach universal health insurance coverage in this Country. However, on the bright side, the uncompensated care situation can be delimited.

The Massachusetts Study reveals that low-income adults may have become strongly accustomed to the lack of health insurance, just as adults with higher incomes cannot imagine being without health insurance. It is mind boggling for each to seriously consider the others

position. To some degree, it is easier for low-income people because they usually have less to lose. Anyone, who has taken a trip to the ER sees that the uneducated, unemployed and working poor use it as their primary care physician. Many of our needier citizens learn from experience that EMT's respond immediately with an ambulance and have not the slightest reluctance to using the emergency room or calling 911 whenever necessary. Since they generally never pay the bill, the service is free to them and hopefully a life saver, when it is necessary. People do not often die or go without health care in acute situations, but we certainly can develop a less expensive and more effective way to treat their minor ailments.

ACA failed and BCS believes we have learned more about the character of the uninsured individuals in our health insurance market. The effort to replace ACA should incorporate how best to spend our limited national treasure addressing the need to deliver cost effective health care to the low-income uninsured population in the United States. BCS Consultants will address this issue in the next White Paper, presumably after the dust has settled on the current repeal and replace contretemps.

It is no wonder Representative Nancy Pelosi told the House of Representatives they had to vote on ACA before they could read it. To sum up, the ACA insurance carriers did not get too involved in any REAL risk underwriting, because the Obama Administration agreed to establish risk corridors through which to pay the insurance carriers for their losses. Promising to pay an health insurance company to cover their unexpected losses is like throwing the fox into the hen house. There was No incentive for the insurance company to charge reasonable rates because if they low balled the rates, they would attract more members and after they got their market share, when the loses developed, the federal tax payers will make them whole again. And, we almost did that and still may be forced by the courts to thus pay up. In this way, the Obama Administration collaborated with the insurance companies in a perfect storm mantra of "the lower the rates - the better." They both wanted to attract as many participants into ACA as possible and deliberately created a situation that contributed significantly to the underfunding of the programs, leaving the federal and state tax payers hanging out to dry.

Karen Ignagni, the former top lobbyist powerhouse for the American Health Insurance Plans in Washington D. C. was the one person, in the beginning, considered to have the influence to stop Obamacare. "Some conservatives regarded her as the enabler of Obamacare, willingly submitting the industry to vast government oversight in exchange for new customers receiving millions in federal subsidies. At the other end of the spectrum, progressives saw her as defender of the for-profit insurers that made out like gangbusters under the flawed health law that could have done so much more for consumers." Wendell Potter, a former insurance official turned consumer watchdog with the Center for Public Integrity, was quoted speaking about Karen Ignagni informatively, to Politico in 2015, "She knew that the industry would do better under the law. She was able to envision, even with the new consumer protections, that the industry would get many billions of dollars in new revenue that can be converted into profits, and that is exactly what happened,"(21.)

In sum, ACA had NO limitation on uninsured enrollees with pre-existing conditions, NO medical or personal qualifications for participation, NO deductibles and NO coinsurance for some people and NO risk of loss for anyone that did NOT sign up for the program. Consequently, insurance companies did not really compete with one another for the business. They appear to have been in a race for the lowest premium in a risk-free proposition, which guaranteed protection against losses. The insurers obviously led their programs with teaser rates. And, as anybody would expect, some of them lost a lot of money and were subsequently motivated to drop out of the program, creating more chaos. Others raised their rates to the point of ridiculousness. And here we are Today. What a mess!

UN-RECONCILABLE DIFFERENCES

Instead of continuing to collaborate with the federal government the way the insurance carriers do under Medicare Part C, some of the ACA health carriers are suing the federal government which, thanks to the Republicans, has refused to pay them some of what they were promised. The only reason that Republicans are proposing to build on this failed program is reconciliation. The reason reconciliation is necessary is the Democrats don't want to take responsibility for ACA crashing down around our ears. After all, Republicans also voted for ACA. Former President Obama has admitted on Facebook that reversing this signature piece of his legislation will be a "massive transfer of wealth". He is not claiming a loss of health care. Since this transfer would be from the reverse of ACA taxation, it is obviously his true intention was that ACA be a massive transfer of wealth from the rich to the poor. And, here I naively thought the focus of ACA was health care insurance. The Democrats are now hinting that the only way they would support the Senate Republican bill is if they keep the tax on investment earnings.

The false narratives on the impact of the Republican health care reform bills include the fantastic claims on the number uninsured people that are going to die. Nancy Pelosi, Al Franken and Bernie Sanders facetiously told the American people that Hundreds (of) Thousands of Americans will die, if a Republican bill passes. Is that why wealthy Americans should support a failed health care plan?

No one will be deprived the lifesaving care needed to save their life. Neither were the wealthy responsible for ACAs creation and they had nothing to do with its failure. A fairer way to fund this program would be to tax the people and institutions that benefit from it! I guess this is already happening to some degree.

Obama is a community organizer at heart. He continues to champion the transfer of wealth from the rich to the poor. Obamacare was altruistic, but at heart, ACA appears to have been another way for his Administration to exercise it's "Robin Hood" tendencies. Why does anybody think that taxing the rich is the answer? The rich in this world, which includes almost all of our representatives in Washington D. C. and former Presidents, are the ones that have the money to invest in our economy. Retaining those taxes on the richest citizens of our country is <u>NOT</u> going to stimulate their investment in our economy, nor should they be responsible to pay for health insurance for those that are not willing to buy it for themselves! A rising tide lifts all boats. If we can lower taxes and improve our economy, we will be able to motivate more people to buy health insurance on their own.

I hope that the hold-outs, hold the line, including Republican Senators Rand Paul, Ted Cruz, Mike Lee, Ron Johnson, Shelley Capito, Jerry Moran, Rob Portman, Dean Heller, Susan Collins and everybody else, who knows that the House and Senate bills are not in the best interests of the American people. For President Trump's sake, I hope we can escape a Reconciliation based compromise and get the necessary support for some basic ways to hold the line on expenditures. I hope the Republicans begin to talk to the Democratic leadership and find a way for them all to save-face and help each other do the right thing. Both Republicans and

Democrats created this mess and they should be working together to fix it. This would be the right thing to do. Hillary's Medicare Part C should be a good start, especially if they can't move forward any other way.

What the representatives of both parties are NOT talking about is the fact that a successful resolution of the health care matter would accomplish everybody's goals and save a ton of money. This money can be put back into the pockets of our citizens and back into our economy to get America moving again. I figure that our BEST Bi-Partisan Answer to Repeal and Replace Obamacare will save 100 Billion Dollars. This money can be used to support the substantial tax cuts that the Trump Administration needs to get our economy going. The President and Congress cannot do this without Democratic support. If the YOU and the Democrats do not get on board, we are going to miss this opportunity for everyone. And, if that happens, I hope that "We the People" will never forget, or fail to remind these politicians in Washington, D.C. of their abject failure, at the ballot box.

In lieu of what Hillary Clinton's Team called her Medicare Part C plan, I do support the Republican proposals for changing Obamacare, perhaps splitting the one bill into two bills, one to Repeal of ACA and one to Replace it. At least we will be doing something to stem the tide of losses and debt. As Americans, we must look at the big picture. Medicare is a "pay-as-you-go" proposition. We normally don't worry about it too much when the Medicare Trust Funds are solvent, as they are now. In January 2006, the Pew Research Center found that Sixty-Two (62%) percent of the public thought that Medicare's problems should be a high priority. We are still obligated by law to assess the future cost of the program over at least a 75-year period. As of January 1, 2016, the Medicare actuaries determined the unfunded liability of Part A was 3.8 Trillion Dollars (that is Trillion with a "T") and 28.6 Trillion Dollars for Part B. That total future unfunded liability is 34.4 Trillion Dollars, and the Medicare Trustees say, "that actual long-range present values for (Part A) expenditures and (Parts B/D) expenditures and revenues could exceed the amounts estimated by a substantial margin." (23.)

Two things are critical for your consideration of the actuarially determined status of the unfunded liability of the Medicare Trusts reported here above:

- First, if revenues are better than expected, i.e. if Trump gets the GDP up to 5%, we can better sustain these programs.

- Second, you notice the Trustees did not mention Medicare Part C in their description of the unfunded liability. They only noted Medicare Part A and Parts B/D. Medicare Part C - is a capitated program that does not have any unfunded liability. It is a self-supporting actuarially-underwritten capitated insurance plan.

It is also critical for you to remember the reason Congress added Part C to the Medicare program in the first place. It was to save money! And, it worked. The program has lower health care costs, lower utilization rates and lower inflation than Original Medicare. Think of Medicare Part C – Medicare Advantage (MA) as a Cost Containment program. I figure we can save 100 billion next year. That will put a sizable dent in the future liability of all our health insurance plans.

THE BEST Bi-PARTISAN ANSWER TO REPEAL AND REPLACE THE AFFORDABLE CARE ACT

If this Congress wants their brand of health insurance to be more affordable for the average American tax payer, they must restore the leverage of insurance and the law of large numbers into the equation. They must be willing to negotiate with insurance carriers, not just dictate terms to them. The carriers will do whatever the federal government wants them to do, but they are going to want the government to pay for it. And, this time around, they are also going to want to actually get paid. ACA is NOT insurance and that is one of the foremost reasons it is falling apart. The BEST Answer to the Repeal and Replacement of Obamacare is to move entirely away from the failed Obamacare model and start fresh. Too much water has gone under the bridge.

Medicare Part C - Medicare Advantage is a very similar program. It is tremendously popular with seniors, covering now over 39% of our elderly and disabled (16.8 Million). Despite the concern that ACA would lead to reductions in Medicare Advantage plan enrollment, since the ACA was enacted, Medicare Part C members increased by 5.6 million, which is a testament to the Program's affordability and popularity. Medicare Advantage Plans are running like a top, right now, under the Centers for Medicare and Medicaid (CMS), HHS and Secretary Tom Price, M.D. All the insurance carriers understand the program. The government knows the cost of the various Plans by geographic area. And, there is an administration in place to handle the expansion of the program. The insurers are pulling out of Obamacare. The health care providers at large, including the American Medical Association (AMA) and the American Hospital Association (AHA) are against House AHCA and the Senate repeal programs. In sum, the key players of the health care system, including all the Democrats and even the President of the United States do NOT whole heartedly support AHCA. So, why isn't Congress willing to look at the Medicare Part C Program, which they created back in the early 80's? The Medicare Part C Program is almost ready and certainly able to fill the gap for Obamacare people and probably also many of the Twenty-eight (28) million uninsured citizens. The answer must be Reconciliation. They can't make any "REAL" changes in the ACA without the Democrats. If Reconciliation fails, we need to be ready to forcefully recommend a "REAL" solution.

Medicare Part C is a "REAL" insurance program. There are currently no exclusions or waiting periods for coverage for anybody with a pre-existing condition. As previously mentioned, the design and funding of Medicare Advantage Plans is a collaborative process between the insurance companies and The Centers for Medicare and Medicaid Services (CMS). If Congress would authorize the necessary changes to make it work for under age 65 citizens, like it does for over age 65 retirees, we would have solvent and affordable health insurance contracts and a system that will work day in and day out for everybody.

CMS can translate any legislative funding goals into regulations, and the health insurance carriers can develop the programs accordingly, with certain adjustments for the benefit of the participants. The rates for Bronze, Silver and Gold benefit plans should be self-supporting and subsidies and tax credits or other assistance funding can be whatever we are willing to spend

on it. There will be financial rewards to the carriers for better healthcare management. But, there WILL NOT BE any loss reimbursements, no payments to stabilize markets, no adjustments for unanticipated conditions and hopefully no law suits. If Congress agrees to design a program to effectively extend Medicare Part C to the uninsured under age 65 (go to visit my web-site at: www.bcsconsultants.net) the federal government would know in advance exactly how much the Program is going to cost and accurately determine how much "We the People", and the participants in the program are going to have to pay for it. The federal government would allow insurance carriers the necessary latitudes to do whatever is necessary to prevent adverse selection and make the program work. Managing the programs, keeping the risk pools vibrant, reaching the maximum possible number of uninsured and creating the necessary incentive to adapt the program to changing conditions will be required. And, the government will find a way to stop meddling in participants tax records and violating our privacy. Our word on projected income should be acceptable. If we are wrong, we will then pay more when we pay our taxes.

President Trump told Senators that, the more money they are willing to put into their plan, the greater the number of Americans that can take advantage of it. He wants it to be a fantastic program. I think he "gets" it! And, I hope "his desires" are not lost on the Senators.

WE THE PEOPLE AND CONGRESS ARE NOT GETTING THE TRUTH

The CBO says AHCA and the Senate Repeal bill would leave to 22 - 23 million more people uninsured by 2026. (24.) Their claims are either purposely misguided or unintentionally misleading. The Kaiser Family Foundation estimated that we had 29 million uninsured in 2015. We can then assume that our uninsured population could swell to as much as 52 Million people without health insurance by 2026? On the face of it, this is an odd claim because this level of uninsured people would be way more than all the Obamacare subscribers (9.2 million) and all the uninsured (28.9 million) persons in this country. So, that is like CBO saying to us, look if Congress enacts this awful program to provide health insurance to the public, and spends 44 billion annually, it would cause more people to lose health insurance than the law itself is trying to get insured in the first place.

But, as you may have discerned, this analysis naively does not include the estimated shrinkage in the Medicaid program. CBO does of course include Medicaid, but hopefully you can still see their assumption of additional uninsured is a stretch. Since Medicaid is a free program and all anyone must do to get it, is sign up for it; dropping it would have to be because one gets cut off due to inadequate state funding. All we know for sure at this point is that funding level will be less under the reform bills. I don't know how CBO could possibly know that the funding will be inadequate to cover everyone that is being covered now? And, the funding may certainly be adequate to keep everyone enrolled, if the states (have budgetary limitations that would cause them to) lower the cost of their programs so they may cover even more people. Several states have not adopted the managed care model for their Medicaid program administration. Doing so will save money.

Even more of a stretch is when the CBO predicts that the number of uninsured would "NOT" increase over the period thru 2026, if ACA were to continue unchanged. (25.) Common sense says that if we cut the subsidies, a lot of the ACA people are going to drop. Without doing anything, some 400,000 ACA people dropped the coverage in 2017. In the real world, HHS just completed an analysis which identified 24 out of the 39 States in which ACA plans average premium increases exceeded 100% over 4 years. Presumably CBO considers some of these states stable markets? Half of the non-profit exchanges ACA created have gone bankrupt. Carriers including Aetna, BlueCross BlueShield and United Healthcare have dramatically increased rates and the commercial carriers have pulled out of several exchanges and geographic markets. In some counties, there is only one carrier to choose from and others there is none. Every day, we hear about more ACA premium increases and programs cancelled and insurers abandoning markets. Just today, Secretary Tom Price told us that 40% of the counties in the country have only one carrier and that there are 40 more counties that have "NO" carrier at all. And, CBO tells the Senators of the United States that there would be NO change in the number of uninsured residents under the age 65 if Obamacare subsidies are continued? Perhaps the CBO is not be fully aware that cost of health insurance poses THE major

barrier to coverage for the uninsured. If they do know this, they would presumably have a harder time claiming these double digit rate increases would not cause a decline in ACA enrollment, government subsidies or not?

We the People and Congress are geared to believe CBO numbers and I don't think we are getting the whole truth. No question CBO has a very difficult job. No one seems willing to admit the fact that CBO has an impossible job because without the CBO, nothing could be done in a mandated deficit reduction environment. But, don't expect We the People or Congress to believe that Obamacare participation will not be reduced by these carrier shenanigans and premium increases. CBO should not have the power to limit our chances for meaningful legislation that will improve the health care system. BCS has the biased opinion that sometimes CBO pronouncements are more political commentary than truth.

In the same report, CBO says that there are unstable markets in some areas of the country (covering only 17% of the population) which might cause people to drop insurance if they don't get what they want, their ACA subsidies. When insurance premiums double, people are more likely to drop it, subsidy or no subsidy. The premiums more than doubled in most of states surveyed by HHS. In a report issued by the CMS in February 2017, "Premiums for the (ACA) Marketplace have increased 25% while the number of insurers has declined 28% over the past year" presumably referring to the bankruptcies of the non-profits. Under these conditions, enrollment is going to decline no matter what. *Rather than just giving ACA members more money to help pay for this failed program, we need to focus on designing a health care plan that doesn't cause this kind of gross instability! Congress needs to wake up and smell the Roses.*

And, what about the rest of us, who don't qualify for any premium subsidies? Is ACA doing anything for us? We are certainly more likely to drop these programs when the premiums increase. Obamacare has failed. CBO estimated ACA would cover 13 Million in 2016. Remeber, we still had and now have, almost 29 Million uninsured, even with Obamacare. Healthcare.gov actually enrolled 9.6 Million in 2016 and that enrollment declined to 9.2 Million in 2017. *We are not addressing the basic problems with Obamacare Care.*

We the People want a program that is stable, that covers us when we are sick, that is affordable and makes us healthier. ACA is NOT that program, no matter what the CBO predicts, and neither is the AHCA or the Senate bill. Medicare Part C- WILL DO THE JOB. Medicare C is the BEST platform for health care reform right now. Go to www.bcsconsultants.net/ Like the BCS Facebook page. Send it to your Congress person. Call your Senator at: 202-224-3121, send them an email, and tell him/her to look at Medicare Part C – Medicare Advantage. CBO is not the guardian of the truth. Medicare Part C (and not Republican reform bills), is the answer. Maybe we can get some Democrats to agree with us when they seriously consider the alternative, like losing their jobs?

If I were a Congress person right now, I would be worried about my job. We have Network worthy news commentators seriously discussing the idea of putting up a full slate of new candidates for Congress, like in a complete house cleaning and a total fresh start. How many people would vote for that right now after reading this commentary on the failure of Obamacare and our Congress, a midst unlimited resources, not being able to fix a minor health care program, especially after one political party promises “We the People” that they would fix the failed program for Seven (7) years. And, the other political party, considered to be most responsible for the mess in the first place, acting like a spoiled child, and refusing to help clean up their part of the mess? You just can’t make this stuff up!

HOW WOULD MEDICARE PART C – MEDICARE ADVANTAGE WORK

The Senate has proposed continuing the subsidies for almost as many low-income citizens as ACA. The problem BCS has with this, is their willingness to put more money into this failed Program. We think the money will be better spent going into a program that will work. CBO claimed that the only way we are going to maintain the number of insured citizens is to keep up the ACA premium subsidies. CBO is under-estimating the detrimental impact of the implosion of Obamacare on enrollment. They are right about that fact that AHCA and the Senate bill will increase the number of uninsured by reducing the number of people covered by ACA and Medicaid. Pouring money into AHCA or the Senate version of the reform, is like beating a dead horse. It is just another way for Congress to waste money. Reducing Medicaid has its own set of problems. AHCA is better than nothing but we can do better. Here is how Medicare Part C plans would work for the American people:

A.) **MEDICARE PART C** - Medicare Advantage (MA) health plans for uninsured under age 65, would function like they do for over age 65 retirees. The focus would be on contracting with health insurance carriers and HMO's to deliver Medicare Part C plans using per capita financing. Medicare Part C programs would be required to offer coverage that meets certain standards but would be flexible enough to allow broad differences in benefit levels to accomplish certain goals for affordability. For continuity coverage, we will continue to allocate the Plans to the three valuation titles of Bronze, Silver and Gold. CMS will determine basic but flexible parameters that will insure a consistent level of benefit uniformity throughout the states, not quantitatively as high Medicare Plans A, B and the Medicare Part C - Advantage Plans for Over Age 65, but certainly a highly consistent level non-the-less. Health insurance carriers will <u>not</u> be required to provide the Ten (10) Essential ACA Benefits. A sub-set of those benefits would be negotiated between CMS and the health insurance carriers such that <u>Core</u> benefits will include those necessary for the treatment of illness or injury. Lifetime and other benefit limits will be allowed. Additional benefit riders can be added to plans. These riders will be permitted to cover Mental & Nervous, Maternity, Alcohol and Drug Addiction, Dental Care, Prescription Drugs, Rehabilitation and Therapies. Basic benefit plans will be designed to have the lowest possible rates. The CMS rules will permit health insurance carriers to go back to the comprehensive major medical contracts they had been selling prior to ACA.

However, a new addition to the Core benefit package will be specifically designed for the promotion of improved health and well-being. This Health and Wellness package of benefits will include at a minimum, Health Club and other active Sport and Exercise Club Dues and Gym memberships, personal trainers, dietitians, weight loss and smoking cessation programs and other professional and practical coverages that have the proven

potential for improving the insured's health and lowering their utilization of health services, excluding exercise equipment. The future of reducing the national cost of health care is improving the health of our citizens to lower their need for health care services. This will become a national priority and be promoted by CMS and the carriers in a big way.

Copayments and deductibles will be encouraged and all insured members will be required to pay them, regardless of their income. Benefit designs will be cost effective, with limited Emergency Room accessibility, Emergency Ambulance transportation and no unnecessary health procedures. Primary care visits and a limited amount of first dollar coverage for annual physicals and related lab work and examinations will be encouraged.

Medical necessity will be required, however a special new classification of benefit for Experimental Procedures will be required as part of the Core benefit. This coverage will be under CMS management. The review will work the way the FDA handles new pharmaceutical products. All experimental procedures, like ground breaking cancer treatments such as Ablation-Radio Frequency, Cryo-Ablation, Microwave-Ablation and other treatments that have shown promise in curing illness, especially those that are less costly than the more common medical and surgical practices. HMO and carriers may offer programs that provide full coverage for all services, however deductibles and coinsurance will be recognized as tools to influence the behavior of people seeking health care. If everything is paid for, no one will ever think twice about where they go for treatment or how much it costs. Special reimbursement for health insurance carrier cost sharing reimbursements should end for everyone immediately.

The best and most expensive plans will include many of these options. There would be many choices. Health Insurance carriers would be precluded from making changes to any benefit programs without prior CMS authorization and required notifications to the insured. Programs will be specifically design to reduce medical risks, promote healthy behaviors and physical exercise and reduce the waist lines of all Americans. We need to make our people want to be the healthiest people on the planet Earth, rather than the most rotund and well fed. We need to encourage our elderly to walk. If you have been to an amusement park lately, you can't help but see the number of obese people getting around with scooters that are paid for by Medicare. Ninety (90%) percent of those adults would be walking if Medicare refused to buy their scooters. I was catching a flight out of Florida and a dozen or more passengers showed up at the gate in wheel chairs. The stewardess very smartly suggested that the departure would be significantly delayed if everyone in a wheel chair required special boarding and invited anyone that could do so, to walk onto the plane themselves. After a few minutes, there was a sea of empty wheel chairs at the gate and the plane departed on time.

B.) **CAPITATED PREMIUM REQUIRED** – Capitation rates are a method of cost containment developed by insurance companies and CMS as an alternative to fee-for-service payments. The idea is simple. The carrier pays a medical provider (like primary care physician - PCP) a set dollar amount each month. The provider agrees to provide a subscriber medical services in return for the capitation payment. The theory is that only a few of the subscribers will need to see the PCP, and the fees for everyone will more than cover the cost of those few patients that avail themselves of the PCP's service. The Chinese apparently only pay their doctor when they are well. A PCP makes more money taking good care of their patients without requiring any unnecessary service. In addition, there is a built-in incentive for the PCP to keep everyone healthy. Usually an annual physical is part of the package. Eventually this practice was used between payers of health insurance, like CMS and their health insurance carriers and HMO's. This method of reimbursement has many utilities, the most obvious of which is its predictability of future costs.

Under the expansion of Medicare Part C, under age 65 members will typically pay a monthly premium for the cost of their Plan, plus any additional benefit riders like maternity and mental and nervous benefits. Whoever and whatever Congress doesn't choose to pay for, will be charged as premiums to the members. CMS will do the same thing for under age 65 participants' in the Medicare Part C expansion that they currently do for the Over ager 65 retirees. They will calculate a reimbursement level that is equivalent to what Congress is willing to spend and whatever balance that may be necessary to cover the full cost of benefit plan will be paid by the subscriber.

This is exactly the way Obamacare works. The members are responsible for paying the premiums for their ACA health plan. In the case that their annual income qualifies them for a government subsidy, the premiums that they would otherwise be required to pay are reduced by the subsidy, which together pays the full cost of the plan to the health insurance carrier. This same level of funding can conceivably be achieved using tax credits, which may also be permitted for higher income earners. Whatever tax credits we estimate the members will qualify for at the end of the year, is the level of additional funding Congress can make available to the program, along with the application of other dedicated revenues from taxation.

Most of the ACA participants are receiving a premium subsidy now. That may be the principal reason they remain on the plans. In 2016, CBO estimates the ACA premium subsidies will cost the federal government 27 billion dollars with an additional 7 billion dollars in cost sharing for a total of 34 billion dollars. This is expected to rise to 67 billion dollars by 2020. I think the CBO has purposely underestimated these costs and the Senate has proposed keeping a good deal of that funding intact. (26.)

C.) **NEW BUSINESS – THE UNINSURED** - Several of the Medicare Advantage programs would be specifically designed to attract a majority of the uninsured. No one will be required to sign up for the program, but there needs to be a mandate even though the most recent studies indicate that the mandate is of limited value to the low-income consumer and is not sufficient to prevent adverse selection. The goal is to get everybody to have health insurance. To get as close as we can to this goal, we must create an incentive to buy it. Unfortunately, the effect a mandate has on the willingness of a low-income adult to pay for health insurance is difficult to measure. Mitigating factors include, waivers, as we have seen with ACA. Moreover, individuals may discount the mandate penalty because it is difficult to determine and normally incurred when they pay their following year's taxes, if they are aware of it at all. The goal is best achieved by having a vague but conceptually very real consequence to not buying the insurance, like the One (1%) percent mandate used for Medicare Part D plans.

If an otherwise eligible uninsured person DOES NOT SELECT the MA program when it is first offered to them, they will begin to accrue a deleterious sounding surcharge that will be applied to future premiums on any MA program they subsequently buy in the future, in the same way that Medicare Part D handles those citizens that do not enroll in a Part D Prescription Drug Plan.

If we want people to buy car insurance when they drive a car, we require it by law. We don't say, "If you don't want to, you can drive a car without paying for it." We know that when an uninsured driver has an accident, which is more likely when they cannot arrange for insurance in the first place, the driver may injure someone else and no one has the right to do that. If the people that don't buy health insurance have an accident, and require health care that ends up being partially paid, or not paid at all, there is supposedly upward pressure on everyone's cost of health care. No one should have the right to do that either.

Even with subsidies, only half of low-income eligible will buy health insurance, so we have to get creative. We will establish the requirement for people to have health insurance. We don't let anyone anywhere drive a car without car insurance. That is because they can injure themselves or others with their car and society needs to require them to have a way to pay for it. Accidents will happen. People will get sick and require health care. Health care, in a healthy free market economy, costs money. Society requires them to pay for it. If they don't have car insurance, they must go to court and they may have to go to jail. If they don't have health insurance, they will suffer all the credit and debtor problems we have in the system today, in addition to a higher cost of health insurance in the future. If we are successful in getting most of the uninsured covered, the uncompensated care problem will be minimized.

D.) **PRE-EXISTING CONDITIONS** - Any uninsured applicant with a pre-existing condition, which they have not been able to insure for more than 60 days in the past, will qualify for a special State Fund for High-Risks under Medicaid. Coverage will be available anytime under this Special Risk Pool (SRP). The federal and state governments will share the cost of SRP under the Medicaid program.

Everyone, who has been diagnosed with a pre-existing condition, that has been able to qualify for health insurance, or because they were insured when the condition developed, will be able to walk up to any Medicare Part C carrier and get full benefits for that condition under any Medicare Advantage program, provided the coverage has been active no less than 60 days from the effective date of the new MA plan.

Most people think that a pre-existing condition is something someone was born with or contracted by accident. Pre-existing refers to the onset of an illness "before" a person had health insurance. To have a preexisting condition, a person has to have been diagnosed with illness, like lung cancer or a tumor that developed before they were covered for it by a health insurance plan. Accepting them into a health insurance plan is like allowing them to burn their house down and then go to a property-casualty insurer expect them to pay for it. These conditions are not anybody's fault. They happen and people sometimes go long periods of time without health insurance. There is generally little that a person could have done to avoid the illness. But if they did not have health insurance at the time the condition was diagnosed, it is their fault that they did not have health insurance.

We must come from the premise that all citizens of the United States should have health insurance. If they can't afford it on their own, they should get it from the government, just as they would if they were insuring their house or their car. And, how much more important should it be for them to cover their bodies? There are too many people who have gotten too used to being without health insurance. If we allowed everyone to avoid health insurance until they get a serious illness, no one would ever get insurance until they seriously needed medical treatment.

The problems with that include:

a.) They haven't paid anything into the Plan to help defray the cost of their treatments.
b.) The cost of their treatments to get the condition cured or arrested are usually very expensive.
c.) The Risk Pool is tainted by a predominance of people, who only require the payment of benefits, commonly referred to as "adverse selection".

Letting these people join a health insurance plan abrogates the principles of a sound actuarially underwritten health insurance contract. The healthy people join a plan to be protected from unexpected medical expenses from a future illness. But, they hope they will never have to use the plan and their premiums pay for people that do. If too many people sign up for coverage because of an illness, the premiums for the plan will eventually have to increase to cover the cost. The plan is then required to pay out more than it takes in. This naturally migrates into the so called "death spiral" of a non-group risk pool, which eventually causes the plan to collapse. The healthy people find better deals with a new company. They drop out of the plan, leaving the sick people, who can't afford to leave the plan or find alternative coverage.

Something like this is happening to Obamacare. The collapse of the plan leaves everyone uninsured and having to start over. The difficulty for many of the people starting over, is qualifying for coverage now that they have a pre-existing condition. Hence the urgency of finding an alternative plan that will accept them within 60 days. What many people tend to forget is that this is the way health insurance worked in the U.S. since the turn of the century. The exception is with employer group insurance. After an employee qualifies for group insurance, they are accepted for all medical conditions, no questions asked. An obvious problem exists is with people, who can't find a job that offers health insurance or cannot work due to their illness.

BCS 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 MA plan by maximizing the possibility that the new enrollee has 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 treatment for them.

CMS and the states will agree to accept and pay for all pre-existing conditions under a "pay as you go" Medicaid plan. No one with a pre-existing condition will be turned away. However, they will only and immediately be eligible for Medicaid, regardless of their income level, if they have a break in coverage over the 60 days. A period after which they may have the condition under control, they will also be included in periodic Open Enrollments in the MA Plans, in the same fashion as Original Medicare.

Carriers will conduct periodic Open Enrollments and allow all citizens to join a plan of their choice without any medical qualifications. And, the insurance carriers will

not be prevented from reasonable underwriting that protects their risk pools and does not result in the denial of coverage for anyone that wants to sign up. The insurance carriers would be required to work with the capitation rates developed by CMS and to determine the risk of their benefit plans, underwrite them and live with the results. This should eliminate the need for rate and market stabilization and large loss recovery funds that are currently crippling the cost of Obamacare.

A major problem with Obamacare is that the people with pre-existing conditions can join the insurance pool. They generally have not maintained health insurance or they have been dropped (which should be illegal) and their condition in some cases has gone untreated and is not under control. Medicare Part C Plans should accept anyone with a pre-existing condition that has maintained insurance coverage for that condition. The "Pre" in pre-existing is "before any health insurance", not just Obamacare. The Senate repeal and replace bill and the AHCA proposes to sur-charge an extra arbitrary 30% in premium and also for Congress to pay more money to compensate health insurance carriers for accepting these risks.

To avoid these charges, we must keep these risks out of the insurance pool, as has historically been the case. What we can do instead, is give them coverage under a "pay-as-you-go" Medicaid plan. The coverage will be limited and they will have to pay some premiums just like everybody else. But they will NOT be turned away. Rather than penalizing them, 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 C plans in the future.

E.) **CMS and not THE STATES** – This is <u>the most important</u> reason you should vote to scrap Obamacare. Medicare is a national program. Obamacare was trying to be a national program. If we replace ACA with a program that gives the states options to change the nature of the plan in their state, we will have a plan for each of the fifty states. But, we will NOT have a national plan. If we do eventually have State plans, the federal government will eventually require the States to pay for their plans.

I don't think an insurance plan of this importance should vary by state. A plan on this scale would <u>not</u> be more successful being organized under the state governments. Obamacare and the Medicaid programs are good examples of that truth. Congressional Reform Proposals have already shifted some of the ACA responsibilities for this national health insurance program to the states, like the Marketplace Exchanges. Whenever, the federal government runs into financial challenges, Congress tends to propose block grant financing and other similar enticements to shift federal responsibilities onto the state governments.

This is what the states seem to want for Medicaid. Senator Linsey Graham, SC is now promoting a plan to whole sale block grant the entire health care program to the states. In the healthcare arena, states have been challenged enough to provide adequate funding for their Medicaid programs, even with an unlimited 50% match funding from the federal government. Medicaid plan eligibility, administration and benefits vary widely among the states. Gaps in the programs require local resources to fill and increase the level of uncompensated care for our major institutional providers in many areas. Although this may be appropriate due to the uniqueness of each state environment, states should be alarmed when the federal government is proposing caps to the Medicaid program and relinquishing decision making and granting waiver authority for the market based insurance programs. The natural progression of this activity will be the increasing demand for state financing associated with public-private market programs and greater reliance on the state property tax base of which very few are in favor.

In this Medicare Part C – Medicare Advantage plan, health insurance carriers will be primarily responsible to CMS for the Medicare Part C Plans. The carriers will be given broad authority to develop cost effective plans and manage program benefits and the treatment of health conditions. Serious attention will be devoted to promoting the health and well-being of the insured, using specific benefits designed for that purpose. Carriers will have incentives and funding to develop innovative cost containment programs and rewarded for programs that can be shown to reduce the cost of health care for their members.

State authority will be limited to the normal regulatory functions associated with their health insurance companies and the running their Medicaid programs. There should be coordination between the states' Medicaid programs and CMS Medicare Part C Plans, such that eligibility and movement between programs is seamless, as Secretary Tom Price, M.D. has suggested it should be.

F.) **THE PRIMARY RESPONSIBILITY FOR MARKETING** –

Health insurance carriers and states will NOT be required to financially support the Marketplace Exchanges. They were supposed to be self-supporting by this time anyway. The health insurance carriers and HMO's will be required to handle enrollment and billing as well as the marketing and full customer service for all plans. They will be required to provide all the information and product support, answer all questions and solve any and all problems. Health insurance carriers routinely handle these functions for Medicare Part C – Medicare Advantage for <u>over</u> age 65 retirees and their own private market products and they are the best source of the necessary information and administration to handle these issues. The marketplace exchanges are redundant and

the cost of running them should NOT be financed by the health insurance carriers or the states.

Who do Obamacare enrollees call when they have a problem? Do you call your federal or state Congressional Representative or administrators? Obamacare has practically no accountability built into its structure. If there is a successful Marketplace Exchange, it is in CA. California has merged their state-wide health insurance program with ACA. Private insurance agents are activity involved in enrolling new members and some very positive things have been written about the system. But, there are still big problems and they seem to revolve around the issue of accountability. Who's in charge? If you want more information on this, please visit my friend Kevin Knauf's blog. Kevin is an extremely knowledgeable agent for both Covered California (ACA) and Medicare Advantage Plans. His perspective on Medicare Part C – Medicare Advantage and the efficacy of expanding the program to include the under age 65 population is in parallel to BCS and yet we are on opposite coasts in very different insurance markets. Reading his blog is both edifying and illuminating. You can find Kevin's Blog at: https://insuremekevin.com/medicare-advantage-health-plans-as-blueprint-for-replacing-affordable-care-act/#disgus_thread/ If you are wondering how CA is doing, check it out.

As a Florida resident, I personally enrolled in ACA through the federal Marketplace Exchange, because Florida declined the Medicaid Expansion program and rejected the creation of an Exchange. I first established an on-line account and then forgot my User name. There was No mechanism to find out what my user name was, to change it or to set up a new account. Although my enrollment was easy, in some states almost 20% of the enrollments in the program have problems. ACA does the reverse of what most health insurance carriers do. Everything starts with the Marketplace Exchange and then flows to the carrier. Whereas with Medicare Part C – Medicare Advantage an applicant first contacts the insurance carrier and they get their enrollment records directly from the applicant. This makes for a smoother and more accountable enrollment. An applicant usually has a point of contact (a person or company name) and issues can be more easily be resolved. More importantly, CMS is so protective of their retirees that MA carriers literally shudder to think that a complaint may be logged against them for any reason. They train their agents exhaustively on all aspects of the program and they do an excellent job of enrolling new members and adhering to CMS guidelines. And, the carrier's telephone Representatives are licensed insurance agents in the states in which they enroll. They are also compensated based on their enrollment and they are crack agents at their jobs. Federal marketplace agents are not licensed, and the do a very good job, but they are not qualified to enroll anybody in anything other than ACA and that is a draw back. Under Obamacare, you just don't know who to call. Can you call your Congressional Representative for many things, like provider non-compliance,

incorrect tax forms, claims and billing problems, etc? Otherwise – who you gonna call (GB)? -

G). **MEDICARE PART C FUNDING** (Under Age 65) -

Medicare Part C (for under age 65) will be funded separately from the Medicare Advantage Plans for over age 65 and the disabled. There will be no overlap, mixing of risk pools or dual eligibility. In the event of dual eligibility with Medicaid, etc., the enrollee will be required to select which program they want to use. Over age 65 programs and procedures would remain the same. Like the over age 65, all private market participants will be required to pay premiums for the programs. These premiums will be self-supporting, provided the program is successful in attracting most of those lacking health coverages.

The primary purpose of the Medicare Part C plans for Under age 65 is to increase the number of people covered by health insurance, enabling them to have easier access to health care services and to lead more productive and healthier lives. The result of establishing this program will be a much lower incidence of uncompensated care, especially for our hospitals. This program will increase the overall demand for health care and related services, improving the earnings for providers. Health insurance company's and HMO's will benefit from increased enrollments and all businesses, including those <u>not</u> providing health insurance, will tangentially benefit from a higher worker productivity.

Every institution, organization and individual in the health care business that will benefit from the success of this program should contribute financially to its success. Taxes should continue to be levied on hospitals, doctors, insurance companies, HMOs and all the other health care related institutions that benefit from this health insurance program. In addition, all employers with more than 20 employees, that do not have a health insurance program for their employees should be required to contribute something and offer automatic payroll deduction services for anyone enrolling in Medicare Part C. We need to do more than just levy a temporary investment earnings tax on the rich. This healthcare related tax base from combined sources will stabilize funding for the program. It will create a revenue stream, like payroll taxes that support Original Medicare and eventually become part of the fabric of our everyday lives, like Medicare A and B. AHCA repeals investment taxes but BCRA retains them, according to some, to have money to give away for votes.

H.) **MEDICARE PART C - PROGRAM CREATIVITY AND FLEXIBILITY**.

If we don't have creativity and flexibility in this program, we will have socialized medicine by mid-century. The only thing that is going to lower the cost of health care in the United States is creative benefit administration, cost containment, health promotion

and well-being behaviors. We need to have a health plan that we can adjust to accomplish our changing needs, like covering more of the remaining uninsured population. The Medicare Modernization Act of 2003 payment formulas for Part C plans were increased by 12 percent or more on average, to increase the availability of Part C plans in rural areas and inner-city neighborhoods to increase the percentage of rural and inner-city poor retirees that could take advantage of the program. Although questionable Congressional wisdom, has cut this program, (in part to provide more money to fund Obamacare) the program was a success. Now, almost all Medicare beneficiaries have access to at least two Medicare Advantage Plans; most have access to three or more. Medicare Part C programs have historically cost the government the same as, or upwards of 5% less on average, than it cost to cover the medical needs of comparable beneficiaries on Original fee-for-service Medicare. (28.) This is an example of what a rational national policy can do to deliver a successful health care program for the American people. It is hard to see how this could have been accomplished in each of the 50 states.

The health insurance carriers for the Medicare Part C programs generally develop favorable contracts with health care providers that may save them more money than it costs them to administer their benefit programs. A PBS Documentary on Medicare Part C Plans uncovered the fact that some Part C carriers could almost save more money through provider contracts than they had to charge for their administration. This is one of the ways health insurance carriers make money. The challenges for the government include making sure the insurance companies are paid enough money to have profits and to motivate the carriers to factor the profit back into their cost of administration.

Astute publicly oriented health insurance carriers would generally not expect to earn much more than their reasonable cost of administration from a government funded entitlement program. They would naturally pass on most of their profits to the government to keep the business. This is how the non-profit BlueCross BlueShield Plan System worked before Congress made the questionable decision to tax the non-profit BCBS Plans like commercial health insurance carriers. Most of the Plans lost money annually by passing back more of their income to their customers than they earned. The short sighted politically motivated change in taxation removed the impetus for the BCBS plans to remain non-profit. This resulted in consolidation and privatization of the BCBS businesses and the loss of their non-profit health insurance orientation.

We need this non-profit altruistic flexibility when it comes to dealing with the uninsured population. The idea that insurance carriers should be allowed to apply to the states for waivers in a national program that could potentially cover over 40 Million citizens is ludicrous. This idea will make it very difficult, if not impossible, to change the program to respond to changing conditions nationally. More importantly, to bring the cost of health care under greater control, the U.S. will be required to change consumer

behavior. A national plan will give CMS and HHS the flexibility needed to accomplish this goal. This effort, albeit not undertaken as yet, is critical to our future viability as a nation. There is no compelling reason for us to make it more difficult to accomplish.

Congress is creating a 50- state program monster I call “Obamacare Dark”. Rand Paul rails against the repeal and replace bills as “Obamacare Light”. When the Senate came out with an even worse bill, I called it Obamacare Dark. For the moment, this option appears to be dead. However, if it rises like a phoenix, the federal government will eventually seek to dump the substantial cost of these programs onto the states, in the same way as with Medicaid. Nineteen (19) states did not believe the federal government would continue to fund the Medicaid expansion created by ACA. In this climate, who would believe that the federal government will continue to fund any state run obligations for an extended period?

One of the beautiful things about “ALL” the Medicare Part C programs for Over age 65 is that they are designed to be equivalent to the Original Medicare program. Retirees moving from one state to another don’t have to worry about being able to obtain a certain level of Medicare Part C – Medicare Advantage health insurance coverage in their new home.

That is the security they paid for with their payroll taxes and that is what CMS delivers for those over age 65. And, CMS will be able to do it for a Medicare Part C expansion. But they will not be able to do it if Congress is successful in giving every state the right to create their own “national” health care insurance plan, one state program without necessarily a consistent level of coverage with the next state. The number of uninsured is a national problem and it requires a national solution. State tax payers have enough challenge paying for and improving their Medicaid programs for the most needy of their residents. Making Medicaid programs consistent from one state to another is also a worthy goal. How else are we to know where one program is supposed to end and the next one to begin?

In some states, health care for the poor just doesn’t rise to a high enough priority level to warrant any special attention and resources. However, Politico recently reported that some of the push back against the ACA reform bill in the Senate is coming from unexpected political support for Medicaid. According to Diane Rowland of the Kaiser Family Foundation said, “We are finding that Medicaid has a constituency that may have been underestimated.” On the other hand, there are states that devote an overwhelming amount of attention to their Medicaid programs.

Florida Governor Rick Scott is a proponent of CMS helping the states innovate and improve their Medicaid programs with what he refers to as a 50 state incubator

experiment for Medicaid program development. Even though CMS professes flexibility, some states have been frustrated by the required federal approvals to change their Medicaid programs and the rigorous process for waivers and permits that delayed and prevented some states from making improvements in their programs. My guess is that one of the goals of this approval process was to use the federal purse strings to force the states to deliver a certain level of benefit and eligibility uniformity in the programs. While I like the idea of uniformity, whether this is a necessary or a worthy goal is debatable. I believe Governor Scott has successfully lobbied for Congressional approval of state Block Grant funding, to give states the financial flexibility they may need to improve their Medicaid programs. The survival of this idea in any subsequent legislation remains to be seen.

State budgetary challenges are a huge issue. The ink isn't even dry on the proposed ACA repeal efforts that will cap the federal spending on the Medicaid program and the State Legislators in Florida felt it necessary to approve a reduction in the Medicaid payments to hospitals by 521 million dollars next year. This is half of the One (1) billion-dollar reduction in the Medicaid budget that Governor Rick Scott requested, due presumably in part to punitive federal cuts in the Florida Low Income pool funding, in retaliation for not accepting the Medicaid Expansion Program.

Many experts believe the states are financially incapable of handling the "Marketplace" ACA reforms, on top of the state Medicaid budgets caps. If YOU don't want your state to end up footing the bill for the "Obamacare Dark", you had better get Congress to change the state sponsored aspects of the proposed Republican health reform bills, before it is too late!

MEDICAID

In 2015, CMS says the Medicaid program costs the federal government 545.1 billion dollars which was Seventeen (17%) percent of the total national healthcare spending. BCS advocates for a Medicaid Reform package that includes the following:

1. Provide essential coverage for low income citizens who may not otherwise have ready access to health care services.
2. Reduce the Long Term Federal expenditures for the program to pay for health care for this target population.
3. Increase the number of qualified people that can be enrolled in the Medicaid program.
4. Reduce the impact of uncompensated health care incurred by our health care providers and reduce its effect on the overall cost of health care and health insurance.

The proposed reforms are taking a few concrete steps toward being able to achieve these goals. Medicaid was originally intended to cover low income families with children, pregnant woman disabilities and long-term care. Twenty-five percent of the budget currently pays for nursing home care. It is an essential program for assisting low income families but it has a lot of problems and there are a lot of gaps in it. This program currently covers 74 million people and will costs 790 billion dollars next year. (29.x2) Obamacare has 9 million members and its cost of 124 billion which is one-sixth the cost of Medicaid. Obamacare is the tail wagging the dog. The real purpose behind AHCA and BCRA may be Medicaid reform. BCS advocates fixing the problems with the cost of both programs in the same way.

The federal government shares the cost of the program with the States on a $1 for $1 basis with exceptions, including the cost of the ACA Medicaid expansion. This expansion increased Medicaid enrollment by 11 million people in 31 States. The Obama Administration agreed to pay 100% at first, gradually reducing to 90%. The 19 States that didn't accept this offer, perhaps because they didn't trust Obama's Trojan horse, do not now face budget cuts. Although coverage in the expansion states successfully added millions of people. Senator Jim Beraso, M.D., WY says, "Obama made Medicaid the dumping ground for low-wage employees in his state, making it more difficult for those people that really need the program to get the health care they need."

The federal government, being more than an equal partner in the Medicaid program, insisted on dictating most of the regulations (like Obamacare -ACA- does to the health insurers), preventing states from making basic changes in the program without approval and basically slowing down the efforts of the states to organize their programs and make cost effective changes. Prominent Governors, included Florida's Governor Rick Scott, have successfully lobbied the Trump Administration for greater freedom to opt out of harmful Title I regulations,

determine the fate of their own Medicaid programs and even get all the money for the programs in a block grant, which the states can determine how best to spend. (30.)

Some states have done better jobs than others in organizing and developing their Medicaid programs. In a June 20th letter, Ten (10) prominent health insurance executives sent to the Majority and Minority leaders of the Senate, it was noted that," Most states have turned to Medicaid managed care plans to leverage their experience and expertise to deliver coverage that coordinates and manages care, and improves health outcomes, and build partnerships with providers to curb fraud, waste and abuse for the efficient use of public funds." (31.) Massachusetts and Ohio have implemented public and private sector programs that saved billions of dollars for Medicaid.

The irony of this ACA and Medicaid Repeal and Replace effort is that the means chosen in the bill to accomplish the proposed Medicaid reform goals are essentially the same (per capita funding) means that are being used successfully to keep the costs of the Medicare Part C – Medicare Advantage plans (for the Over age 65 retirees) under control. BCS Consultants has been advocating for Medicare Part C – Medicare Advantage private health insurance plans using capitation funding to solve the problems with Obamacare!

ACA and Medicaid programs suffer from similar circumstances. In the reform bills proposed by the House and the Senate, the federal government is planning to cap the Medicaid program with the same tools and techniques the government uses with the Medicare Advantage (MA) insurance carriers, i.e. the Senate is proposing to convert federal reimbursement to the states for Medicaid to a *"per capita"* system. This is the same funding mechanism used by CMS for the MA plans.

Here is a quotation from pages 28 - 29, of the CBO's most recent Report to Congress on the Senate bill (H.R. 1628), June 26, 2017 to repeal and replace ACA: (In the following quotations, I have purposely substituted the word "Medicare Advantage" in place of the word "Medicaid" and the words "health insurance company(ies)" has been substituted in place of the word "states" for the purpose of elucidating the irony of the BCS recommendation for the expansion of Medicare Part C. Hopefully, this transposition will make clear that these same paragraphs could, for the most part, be used to describe exactly what we want Congress to enact in the relationship between the federal government and the insurance companies for the expansion of Medicare Part C to enrollees under age 65.

Beginning of CBO Quotations - from the Report to Congress, June 26, 2017, p. 28 – 29.

"CAPS ON FEDERAL "MEDICARE ADVANTAGE" SPENDING. Under current law, the federal government and the "health insurance companies" share in the financing and administration of "Medicare Advantage". In general, the "health insurance companies" pay health care providers for services to enrollees, and the federal government reimburses the "health insurance companies" for a percentage of their expenditures. All federal reimbursement for medical

services is open-ended, meaning that if a "health insurance company" spends more because enrollment increases or costs per enrollee rise, additional federal payments are automatically generated. This bill would establish per capita "cap" on most spending for medical services and offers the "health insurance companies" an option for a block grant to provide medical services for certain adults. In addition to affecting total spending, the caps would have a variety of other effects on the "health insurance companies" and enrollees, including an interaction with the effects of work requirements, in the near and longer term.

"Per Capita Cap for – "Health Insurance Companies" - Under this legislation, beginning in fiscal year 2020, the federal government would limit the amount of reimbursement it provides to the "health insurance companies". That limit would be set for a "health insurance company" by calculating the average per-enrollee cost of medical services…"

(This is exactly what CMS does for Medicare Part C Plans with the health insurance companies.)

"If a "health insurance company" spent more than the amount eligible for federal reimbursement, the federal government would provide no reimbursement for spending over the limit." (28.)

End of CBO Quotations –

That is exactly what we have been advocating. This is how the federal government does it now for Medicare Part C – Medicare Advantage – Over age 65. *If Congress is willing to authorize doing it with the states for all the Medicaid enrollees, how much more willing should they be to do it with the "health insurance companies" insuring all the Obamacare- ACA enrollees and the millions more uninsured Americans that would join such a plan?*

Congress obviously thinks this is the answer for saving money with the Medicaid programs. We think they should be willing to consider the same approach for saving money with a public/private partnership programs taking care of everybody else. It would be hard for Congressional Representatives to claim this is not a workable idea, while proposing to handle the problems with much larger health care spending program covering seven (7) times more people. BCS believes the viability of the Medicare Part C expansion, as the Best Bipartisan Answer to Repeal and Replace Obamacare is self-evident.

I have been clear all along about the fact that the federal government knows how to solve the problems we have with our health insurance system. The above quotations from the CBO Report to Congress make this crystal clear. The federal government spends Six (6) times LESS on Obamacare than it spends on Medicaid. Both programs are in financial trouble and need a haircut. In the same bill Congress wants to give the smaller program a careful trim, while giving the larger program a crew cut. I think we ought to give BOTH programs the SAME haircut and avoid another trip to the barber.

I suggest that the Democrats and Republicans get together on the fact that “We the People” must lower the cost of health insurance for both programs and they need to seriously consider doing it in the same way. What works for one program will work for the other. The costs may vary. The level of coverage may vary. And the people to be covered may vary, but both programs have the same problems, and the solution for both programs is essentially the same. We need Capitated programs for everybody, and that means Per Capita rates for the Medicare Part C expansion program for Obamacare and Per Capita rates of reimbursement for the Medicaid programs.

THE COST OF SENATE OBAMACARE REPEAL (SAVE 100 BILLION DOLLARS)

The CBO estimated Obamacare would cost 110 billion in 2016. The Senate bill proposes to continue the ACA tax credits, premium assistance and cost-sharing payments until 2020. In addition, it adds about 11 billion annually in funds paid to the states and to the health insurance carriers for stabilization funds. The annual composite cost trend in hospital and medical care is 6%. (2., 17.) Since ACA enrollees are largely insulated from premium increases (32.), the trended federal subsidies should approximate a 124 billion next year under the Senate's H.R. 1628 BCRA. If Congress will agree to extend Medicare Part C in 2018 to the Under age 65 population and maintain the Senate Bills proposed premium subsidies, we should save over ***100 billion dollars*** next year, with no special state and insurer stabilization funds and no federal money for marketplace exchanges. (33.)

This savings does not include the cost of the state Medicaid Special Risk Fund for Pre-existing Conditions. This is a type of fund to which several states have previously received funding from CMS. It is hard to verify this BCS savings estimate using the CBO reports for reconciliation and deficit reduction. They don't tell Congress or the public the annual expense of a program, the expenses associated with various elements of a plan or the total cost of a program. The CBO Reports to Congress on the financial impact of congressional bills on the national deficit. BCS can only access CBO's gross estimates of deficit and revenue changes over a ten-year period, to which Congress has become accustomed. Consequently, my estimated of a 100 billion-dollar savings surely means that we can "Save Many Billions of Dollars", give or take a few billion, and get a lot more people insured under a Medicare Part C extension.

As Rand Paul has questioned, how much better is it to have a savings like that, then throwing a Hundred (100) billion dollars away on a program we know is a fatally flawed, especially when most of the money is going to insurance companies that have already made many billions of dollars off Obamacare, while covering only 9.2 million Americans? CBO should tackle calculating the comparative cost effectiveness of complimentary health care entitlement programs. If they were to figure out what the tax payers have spent on each Obamacare enrollee (per capita) and compare it to Medicaid or any other federal health care spending program, you would be shocked!

At the risk of being redundant, if Congress does nothing, we will still have 28 million uninsured in 2026. In CBO's June 26th Report on the Senate BCRA, the number of people uninsured will increase by 22 million people in 2026. (34.) In their June 8th Report in the House of Representatives AHCA bill, the number was even higher. However, CBO claims the number of uninsured will remain about the same as it is now under the current law.

If we try to fix the problem the way the Republicans wants to fix it, we will spend a whole lot of money and end up much worse off than we are now. However, if we just cap Medicaid (having

added 11 million insured) and let ACA continue to fall down around our ears, CBO says we will NOT be much worse off in 2026, then we are now with only 28 million uninsured.

When in doubt, do nothing? The problems with the do-nothing approach include the following:

- The ACA death spiral.
- The suffering of ACA participants who lose coverage.
- The continuing uncompensated care with the 28 Million or more uninsured.
- Taxing the rich to give to the poor.
- An out of control federal budget deficit.
- Unlimited Medicaid funding (which needs a cap).
- The 32.4 Trillion-dollar unfunded Medicare obligation.

Many Republicans are now saying we must fix the system for the people. But, this reconciliation process, which the Democrats are placing around our necks like an albatross, is not the helping!

Please tell Congress that the sooner they accept the fact that, as Senator John McCain so aptly stated on his last address on the senate on the Senate floor, “We aren’t getting anywhere …”, worth going, doing what they are doing (creating Obamacare Dark), the sooner they can give serious consideration to a fresh compromise with a Medicare Part C – Medicare Advantage plan! Go to www.bcsconsultants.net/ follow the leads on the website and contact your Representatives.

THE BARE BOTTOM BLUES

The Senate does not have the votes to Repeal and Replace Obamacare, Repeal Only or the Skinny Repeal, Thank God! As Rand Paul stated in a recent CNN interview, "the Senate is currently proposing to put money into ACA which will support its ultimate death spiral." They should be trying to come up with an affordable solution to finance the cost of providing everyone in our Country with a better way to stay healthy. Prior to this coming summer recess, at the time of this writing, it appears the Administration may turn back to the House of Representatives to generate another bill to again attempt to address the issues. Whatever the next step happens to be, now is the time for us to get all of our Congressional Representatives focused on a Real Solution to Real Problems! And, that Solution is Medicare Part C. Please contact your Congressperson 1-202-224-3121. Tell them to visit my website and challenge them to tell you why they think Medicare Part C for everybody is NOT a good idea and if they do, ask them what they are going to do about the problems in its stead. It is Time for us to Rock and Roll!

This document has not even touched on the critical subject of our collective Health Condition from the stand point of improving it. Congress has been too busy just trying to pay it. The federal government is not doing anything remarkable to improve our health, which is one of the more effective ways to lower the cost of health care in America. Unfortunately, there is no potent industry or lobby group devoted to health promotion. Alternatively, the food industry is a massive force in Washington D.C. as our waist lines so visibly well demonstrate. Is there a fatter national population on Earth? To name one may be politically incorrect but I don't think there is one to name. If Congress would only spend as much time on the question of how to improve our actual physical health as they do on our health insurance, controlling the cost of health care would be a problem half solved.

In my life time, we have gone down this road of health insurance reform with Congress several times. First with Hillary Clinton, who originally had the wisdom to pursue a Medicare Part C back in the 70's? As a young health care executive, I used to shutter at the thought. Then we had the Balanced Budget Acts, which supposedly favored Big Pharma and the hospitals, but also brought us Medicare Part C - Medicare Advantage and Medicare Part D (Managed care and Drug coverage for seniors). Then we had ACA - Obamacare in 2010 which again attempted to improve the everybody's health coverage level, expand eligibility and streamline health insurance delivery but ended up creating unworkable overly expensive programs that only attracted most people when they were heavily subsidized or free. Now the Obamacare "Light" or maybe Obamacare "Dark" in 2017, which is attempting to cut money devoted to both the individual health insurance market and the federal cost of Medicaid. Now the Republicans are trying to cut the money first (Repeal) and figure out how to fix it later (Replace). I wish I was not bearing witness to all this stuff. You can't make this stuff up!

Medicare Part C was enacted as a demonstration project twenty (20) years ago. It is a program based on the use of (per capita) capitation rates in a strong relationship with health insurers. Given the fact that the federal government recommends this financial mechanism as the way to fix Medicaid, it is time to tell Congress to STOP fooling around. We have seen enough of these demonstrations, protestations and delays. Everyone wants to know, "Where is the Beef?!" We need Congress to act boldly, do the next right thing and make it better for everyone.

Christy Chapin Ford, in her recent New York Times Op-Ed piece on health care noted that pre-paid physician groups were successful in holding down health care costs, much to the consternation of many independent practitioners and hospitals. "Physicians established a particularly elegant Model: the pre-paid doctor group. Unlike Today's physician practices, these groups usually staffed a variety of specialists, including general practitioners, surgeons and obstetricians. Patients received integrated care in one location, with group physicians from across specialties meeting to review treatment options for chronically ill or hard-to-treat patients." (35.) Facility based HMO's and other practice models can also work in this manner. "This system held down costs. Physicians typically earned a base salary plus a percentage of the group's quarterly profits, so they lacked the incentive to either ration care, which would lose them paying patients or provide unnecessary care." (35.) Rationed care is a constant complaint in the British Health Service and our VA. Unnecessary care is more of a Tort Reform issue.

Group Practice organizations are not exactly the darlings of the AMA, the AHA or Congress for that matter. It was Health Maintenance Organizations and Independent Practice Associations that were successful in reducing medical inflation to single digits when they were first introduced in the 70's and staving off the political pressure for national health. Multidisciplinary Medical Practices such as the Lahey Clinic in Massachusetts, Loma Linda Health in California and the Mayo Clinic in New York have achieved worldwide recognition for their medical excellence, while dramatically lowering their cost of care for their patients. The credibility of these Clinics and their medical excellence is due in no small part to the commitment that their physicians have to these institutions, which enjoy illustrious histories of superlative medical excellence. Another example of what we do Right!

It is important for us all to remember why the federal government finally created Medicare Part C. It was to save money! It was for this very reason that we created Medicare Advantage (MA). Group Practices and HMO's are now responsible to taking care of Thirty-Nine (39%) percent of all the Medicare eligibles enrolled. Their systems are not for everybody, but it beats the pants off not having any health insurance at all. Other participating MA providers include Independent Practice Associations and carriers like BlueCross BlueShield, Humana and United Healthcare that have built their own physician networks, created specifically to take care of Medicare Part C- enrollees. Insurance companies are not always the bad guys. They are an important and integral part of the system.

We are the most successful advanced industrialized nation in this World. Our health care providers deliver the highest quality health care, which is the envy of all nations and is the preferred provider of the most privileged people on Earth. I hope we are not going to ruin our

health care system because we can't figure out how to make these great services available to our own people!

Aaron Copland and Leonard Bernstein were great composer's, who wrote beautiful American symphonies. Dr.'s Frank Lahey and Sara Jordan, and Dr.'s William(s) and Charles Mayo (and many others) developed very successful health care systems in the U.S. We can build on their expertise by creating a health insurance system that relies on our strong and independent Public-Private partnership that makes their health care available, affordable and accessible for every American citizen. We have made great strides toward this goal but our current efforts are detracting from this progress. ACA didn't do the job. AHCA and BCRA will not do what we must do to make the system play like a symphony. Medicare Part C has been successful for Twenty (20) years making a great symphonic resound. You must convince our Congress to put aside their partisan politics and take care of the health and well-being of the "We the People", to whom they are responsible.

If we are going to be a successful beacon of freedom and democracy around the World we need to be the nation that finds a free market solution to health care for all. We do not have to accept the defeat of socialized medicine. The closest thing we have to socialized medicine is the Veterans Administration (VA). Need I say more? We don't have to accept anything less than what we want and what will make our healthcare better for everybody. Whether the Democrats and the Republicans get it done right this time or not, BCS and our many Friends and Followers are certain that Medicare Part C is the Right answer.

I hope after reading this document, you will join with us. If you do, ONLY YOU can change the course of our health-care history! And, the time to do it is RIGHT NOW! Go to: www.bcsconsultants.net for more information. You can help make it happen by calling your Senator and Congressional Representative Today! You can reach them by calling just one phone number: 202-224-3121. Send them an email. Refer them to go to the BCS website. Share some of the BCS Facebook Posts from my personal (Jay Wheeler) and BCS Consultants FB pages with all your friends and acquaintances. Urge all your friends to help. Tweet everyone you know. If the Egyptians can create an "Arab-Spring" on-line, we can create a "Medicare-Spring" right here in the USA, where we can all take the next big step toward a health plan that works and of which we can ALL be proud. Time, Time, Time has come "Today". We can make it happen. It is our blessed time to Rock and Roll Today!

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