A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

The following is a suggested alternative to "Medicare for All", or even lowering the age of eligibility for Medicare that has been proposed by many progressive presidential candidates during our most recent federal election process. This proposed plan will provide health insurance for all U.S. Citizens and Legal Residents without significantly increasing our income taxes or our national debt, In addition, it will, with the exception of required subsidies, remove federal and state governments from the health care administration business and eliminate the ticking time bomb looming for Medicare in the not-to-distant future. It creates the equivalent of a single payer system that is not the government, simplifying the collection process for both insurers and health care providers.

It is not intended that significant changes be made to the benefits or qualification for coverage under the Affordable Care Act (Obamacare). However, it **is** intended to suggest methods to totally revamp the funding; the system of collection and payments; and the administration of the health care system under the Act in order to provide health care protection for **all** U.S. citizens and legal residents.

However, to accomplish all this, it is necessary to **"THINK OUTSIDE THE BOX"**.

THIS PROPOSAL THAT WILL PROVIDE HEALTH CARE INSURANCE FOR ALL AMERICANS WILL BE EXPLAINED IN 5 PARTS:

PART A – FUNDING

- Two primary funding sources for "Obamacare" still in existence
- An explanation of large group health care plans
- Breaking the ties of large group health care plans away from our places of employment
- How it would work - Proposed sources of funding
- Coverage for dependents
- Covering former dependents, laid off workers and early retirees
- Part time employees
- Combining current & future health care costs
- Deductibles and maximum out of pocket costs under the plan
- The General Pool – Coverage for those with little or no sources of income
- Those with Significant Medical and other Care Expenses

PART B – THE PROPOSED SYSTEM OF COLLECTION AND PAYMENTS

- Medical clearing corporation(s) providing the equivalent of a single payer system

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"
(continued)

- Fine-tuning group health care insurers' requirements, specifications and incentives

PART C –BENEFITS AND OTHER NOTABLE ITEMS BY GROUP

- The benefits of this proposal for –
  - Wage earning individuals
  - Employers
  - The Self-employed
  - Wealthy Individuals
  - Laid off employees
  - Early retirees
  - Those already retired and currently in the Medicare system
  - Unemployed former dependent children
  - Health care providers
  - Health care insurers
  - The U.S. and State Governments

PART D – THE NUMBERS: HOW IT WILL ALL WORK

- U.S. Statistical Information Used
  - A note regarding currently computed per capita U.S. health care expenditures
  - A note regarding the cost of prescription medicine and other drugs

PART E – LOOKING DOWN THE ROAD FOR A COMPLETE LIFETIME OF HEALTH CARE, RETIREMENT AND OTHER BENEFITS

- Implementation of this proposal on a national level
- Combining health care benefits with future retirement and other benefits

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

PART A – FUNDING

TWO PRIMARY FUNDING SOURCES FOR OBAMACARE STILL IN EXISTENCE

The most significant and irksome funding sources of the Affordable Care Act are:

- An additional Medicare tax of .9% on individual incomes over a specified amount *($200,000 for individuals and $250,000 for joint tax return filers); and*
- A tax on the lesser of net investment income *(interest, dividends, capital gains, rental and royalty income, etc.)* or modified adjusted gross income over a specified amount *($200,000 for individuals and $250,000 for joint tax return filers)* of 3.8%.

THESE FUNDING SOURCES WOULD BE ELIMINATED

LARGE GROUP HEALTH GROUP PLANS – AN EXPLANATION

Before going forward with this proposal, it will be necessary to establish an understanding of **LARGE GROUP HEALTH CARE PLANS** and question why most plans are generally only obtainable through one's place of employment.

It is common knowledge that **LARGE GROUP HEALTH CARE PLANS** provide the best means to protect both insurers and the insured. They **PROTECT THE INSURER** because they spread the cost of significant medical expenses incurred by some over a large group that consists primarily of healthy individuals. They also **PROTECT THE INSURED** because if the insurer wants to raise premiums, they must raise the premiums of all those participating in the plan with similar coverage by the same amount. As they say, "there's safety in numbers".

SO WHY ARE LARGE GROUP PLANS ASSOCIATED PRIMARILY WITH PLACES OF EMPLOYMENT?

If we want to enable everyone to belong to a large group plan we must **take the focal point of the group plan away from our places of employment**. In the past it was extremely cumbersome for insurers to deal with a significant number of people individually instead of dealing with a few individuals in a human resources department, which employer plans afforded. Today, in the computer/internet age, the inconveniences an insurer would encounter in dealing with a large number of people individually have been significantly reduced.

BREAKING THE TIES OF LARGE GROUP PLANS AWAY FROM OUR PLACES OF EMPLOYMENT

What if a replacement to the remnants of the Affordable Care Act (Obamacare) were established with guidelines for the introduction of large group health care plans that are not associated with any specific employer? To repeat, with the exception of monetary elements (co-pays, deductibles, etc.) and a few other modifications, which will be covered later, most of the benefit provisions of Obamacare would all be retained.

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

Once an individual selects a specific group plan, that plan stays with them until they elect otherwise, no matter where he or she is employed. When they begin working with a new employer, they will provide the code for their group insurer to the new employer, or provide their own insured account number *(possibly the individual's social security number)*, which, would point toward the applicable insurer when the employer's HR person enters that account number into the system.

Insurers desiring to participate in this plan would need to form health insurance groups; would need to have certain minimum financial resources; provide specified health care benefits to all members of the group and their dependents insured under the plan for a pre-determined fee; and be insured themselves in the event they encounter financial difficulties.

Insurers that currently provide health care insurance for employer based plans, provided they make certain changes to the plan *(if necessary)* to conform with federal guidelines, would be able to continue offering those plans, but they would now expand those plans to cover those not employed by the company(ies) that they currently insure.

HOW IT WOULD WORK – PROPOSED SOURCES OF THE FUNDING

Note: It is extremely important to note that, in the sources of funding that follow, the first two sources - Waged Employees and Self Employed Individuals, are already taxed/assessed for future health care costs by paying a 2.9% Medicare tax. In the case of Waged Employees, half of that tax (1.45%) is withheld from an employee's pay and the other half (1.45%) is contributed by their employer.

In the case of Self-Employed Individuals, they pay the entire 2.9% tax. They pay 1.45% as their own employee; and another 1.45% as employer (since they are their own employer). The 2.9% that is paid by the self-employed is contained in the 15.3% tax that is referred to as a "self-employment tax".

The assessment for this health care proposal (which may be characterized by some as a tax as well), is for current, as well as future health care costs. However, , until the Medicare program is no longer necessary, both waged employees, their employers and the self employed will find themselves subject to both the Medicare Tax and the assessment for this health care proposal (3.95% for waged employees and the same for their employers). This will occur because, under this proposal, those about to, or currently eligible (and using) Medicare to pay for their health care needs, will be allowed to continue using that program if they wish. Therefore, based upon current mortality rates, the need for the Medicare tax (at least a diminishing portion of it) should persist for approximately 20 years after the enactment of this proposed health care plan.

Consequently, many will complain that they are paying two taxes simultaneously: 1) the existing Medicare tax(es); and 2) the assessment (tax) under this proposal. However, it is extremely important to note that, when paying the assessment under this proposal, all individuals will receive current health care insurance, whereas, when paying Medicare taxes, individuals are making payments for future health care benefits only. In other words,

those currently being taxed for Medicare, still need to obtain, and pay for, health care insurance (either they will, their employer will on their behalf, or both).

Thus, the only group that should experience an increase in cost (and that cost should be nominal, as explained later), if this proposal is accepted, will be employers that do not provide health care insurance for their employees. Virtually all others will be paying, in the form of this plan's proposed assessment, health care insurance premiums which they are already paying (and will find that their costs will be generally less than what they currently pay).

WAGED EMPLOYEES

Ordinarily, at the end of each payroll period, when wages are to be paid, the employer's payroll department *(or a payroll service that is used by the employer)* makes deductions from each employee's gross wages for state withholding taxes, federal withholding taxes, Social Security and Medicare taxes and also makes additional charges to the employer for the employer's portion of Social Security and Medicare taxes as well as charges for unemployment insurance, both state and federal. These amounts withheld are forwarded to various federal and state agencies. Other voluntary deductions such as payments to retirement accounts (IRAs, 401(k)s, etc.) are also deducted and forwarded to the appropriate retirement plan or organization. *(Employers may also have agreed to match the employee's contribution*). In addition, if the employer provides health care insurance to its employees, there may also be an additional amount withheld from the employee's pay to provide the same health care insurance for an employee's dependents.

What this proposal suggests is that, in addition to all of the foregoing amounts being withheld and forwarded to various agencies and organizations, an additional amount is withheld from the employee's pay that will also be matched by their employer and forwarded to the employee's designated insurer. Our suggested percentage is 3.95% of the employee's pay that will be matched by an additional 3.95% from the employer up to a maximum of $500,000 in wages.

While the amount to be withheld subject to this proposal will be an additional amount to be borne by both the employee and the employer, after a transitional period, the number of those enrolled in the Medicare system should diminish *(to be explained later)*. Once there are no longer any Medicare recipients, .95% that is included in the 1.45 % that is withheld from an employee's pay and .95% that is included in the additional 1.45% that is matched by the employer[1] should become unnecessary, further reducing the total amount to be paid by the employee and employer for health care.

ALL ASSESSMENT PAYMENTS WOULD BE PRE-TAX

Since all U.S. citizens and legal residents would be required to belong to this national health care program, including federal and state legislators and all those employed by federal and

[1] The other .5% of wages from the employee and .5% of wages from the employer (a total of 1%) that is currently being charged for Medicare will be paid to insurers to help cover those with greater medical care costs. However, unlike the Medicare tax, this 1% assessment will stop at $500,000.

state governments, **ALL** income would be subject to the assessment. *(This would exclude the wages withheld and contributed directly to retirement plans, and income earned in retirement plans that hasn't been withdrawn from the plan(s).)* However, all payments of the assessment would be pre-tax *(reduce taxable income)*. In other words, if an employed person claiming no dependents earns $100,000 *(therefore paying an assessment of 3.95% thereof or $3.950)* their taxable income before other adjustments would be $96,050 ($100,000 - $3,950).

SELF EMPLOYED INDIVIDUALS

Just as with Social Security and Medicare, self-employed individuals would be responsible for their portion of the assessment as employees (3.95%) and their portion of the assessment as their own employer (an additional 3.95%), for a total of 7.9% (3.95% + 3.95%) of their earnings, up to $150,000. Thereafter they would be assessed 3.25%[2] on their earnings from $150,001 up to $500,000.[3] If they were covering any dependents, additional amounts would be necessary. But just as with those earning regular wages, the total assessment would be pretax *(reducing taxable income)*.

It is important to keep in mind that while this assessment would be an additional cost *(in addition to numerous other taxes and fees)* and therefore increase the burden a self-employed individual must bear; they will also receive their group insurance in consideration for this payment and the cost of their current medical insurance might be greater than the amount of the proposed assessment. For example: An individual with self-employment income of $80,000 and covering no dependents would be assessed $6,320 [(3.95% + 3.95%) x $80,000]. This would result in a monthly payment of $527, which might possibly be less than the amount they are currently paying for medical insurance.

In addition, as previously mentioned, after a certain transitional period for those already on Medicare and electing to stay with that program *(to be explained later)*, 1.9% of the Medicare tax included in the 2.9 %[4] that is currently paid by the self-employed individual *(as part of self-employment tax)* should be eliminated. And, unlike the cap under this proposal, the current additional amount for Medicare has no ceiling – it is assessed on all self-employment income, no matter how great that amount may be.[5]

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[2] However, legislators may decide to increase this 3.25% rate to 3.95% (1/2 of the 7.9% rate), especially when Medicare is totally phased out. If this were decided, monthly premiums per person paid to insurers would increase in the example in the foregoing paragraph by $47. This rate increase should only apply to the self-employed and not to others with non-wage income, such as the wealthy and employees earning wages with additional other earnings from investments, etc. Their rate on income over $150,000 should not be subject to change.

[3] This cap on earnings of $150,000 that is subject to the full 7.9% assessment is to mitigate the fact that, until the Medicare tax is eliminated, the self-employed individual will actually be paying two health care assessments (taxes) even though they'll get health care insurance for paying the assessment for this proposal. However, once Medicare phases out, the ceiling might be removed, rendering all earnings up to $500,000 subject to the 7.9% assessment.

[4] See Note 1.

[5] Those with net losses from self-employment would still be required to make a minimum assessment payment amount. However, if the individual could not afford to make the payment, they would be assigned to the "General Pool". Later in the proposal both the minimum assessment and the "General Pool" will be described.

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

THE WEALTHY – THOSE NOT NEEDING TO WORK

Just as with self-employed individuals, the wealthy *(or those not receiving wages)* would pay the assessment on all their sources of income (interest, dividends, royalties, etc.) – at a total rate of 7.9% (3.95% + 3.95%) of that income up to $150,000. Thereafter they would be assessed 3.25%[6] on their earnings from $150,001 up to $500,000. *(Again, if they were also covering any dependents, that amount would be slightly greater.)* And, just as with those employed and those self-employed, the amounts paid would reduce gross income.

While this assessment may seem onerous to wealthy individuals, it is important to keep in mind two factors: 1) Under the current funding system for the Affordable Care Act *(Obamacare)* the lesser of net investment income *(interest, dividends, capital gains, rental and royalty income, etc.)* or modified adjusted gross income over a specified amount *($200,000 for individuals and $250,000 for joint tax return filers)* is subject to a 3.8% tax – and that amount is not capped at $500,000! Under the proposed new plan, this tax will be eliminated.; and 2) the individual or family's health care insurance premiums to their selected provider will be paid out of the health insurance assessment, eliminating the need for those individuals or families to pay additional health care insurance premiums.

ALL INCOME IS SUBJECT TO THE ASSESSMENT- NOT JUST WAGES

TOTAL INCOME FROM WAGES AND OTHER SOURCES

Just as the wealthy must pay the assessment on **all** their sources of income, those earning wages *(as well as those self-employed)* would also be required to pay 7.9% of their earnings from other sources *(interest, dividends, royalties, etc.)* up to $150,000 *(or slightly more if they were claiming any dependents)* and 3.25% of those earnings from $150,001 up to $500,000.

Example 1 – If Mike claims no dependents and earns W-2 income as an employee of $80,000 and has interest income of $3,000 *(both totaling $83,000)*, he must pay an assessment of 3.95% of his $80,000 in wages ($3,160) and 7.9% of his $3,000 in interest ($237) for a total annual assessment of $3,397, or $283 per month. And, just as with all assessment payments, the $3,397 would reduce his gross taxable income.

Example 2 – If Patricia claims no dependents and earns W-2 income as an employee of $140,000 and has interest and dividend income of $25,000 *(both totaling $165,000)*, she must pay an assessment of 3.95% on her $140,000 in wages ($5,530); 7.9% on $10,000 of her interest and dividend income *(bringing the assessment on income from wages + income from other sources up to the cap of $150,000)*, or $790 *(7.9% x $10,000)*; and 3.25% on her remaining interest and dividend income of $15,000 *($165,000 total income - $150,000 cap for the 7.9% rate)*, or $488 *(3.25% x $15,000)*. This would bring her total assessment to $6,808, or $568 per month *[($5,530 + $790 + $488)/12]*. And, just as with all assessment payments, the $6,808 would reduce her gross taxable income.

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[6] See footnote 2.

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

JOINT INCOME TAX FILERS

Married couples or domestic partners would be subject to the full assessment of 3.95% each on all earned (W-2) income up to $500,000 **each**. This means that they might be subject to a health care assessment of up to $1,000,000 on their combined W-2 income when filing jointly *(just as they would if they filed as single individuals)*. However, if filing jointly, their combined income would be capped at $750,000 (150% of $500,000) for any remaining health care assessment on their income from other sources.

The simplest way to explain the assessment to be paid by joint income tax filers is that the income earned from W-2 wages of both spouses or domestic partners would be capped at $500,000 **each**. However, when filing their joint income tax return, income from sources other than W-2 wages would be capped at $750,000 for both, not $500,000 for each. And, with the exception of their wages, any other income earned over $225,000 (150% of $150,000) jointly by both, would be assessed at a rate of 3.25%. To explain the nuances of the joint filing rule(s) the following examples have been provided[7]:

Example 1 – Dave and Lisa *(husband and wife)* each earn W-2 wages. Dave earns $50,000 in W-2 wages and Lisa earns $60,000 in W-2 wages. Dave will be assessed 3.95% of $50,000 ($1,975) and Lisa will be assessed 3.95% of $60,000 ($2,370). If, when filing their joint federal income tax return, they also have earned $13,000 in interest and dividend income, they must also pay 7.9% of $13,000 ($1,027). Therefore, their annual assessment for health care insurance will be $1,975 + $2,370 + $1,027 = $5,372 annually, or $448 per month.

Example 2 – John and Sue *(husband and wife)* each earn W-2 wages. John earns $360,000 in W-2 wages and Sue earns $290,000 in W-2 wages. John will be assessed 3.95% of $360,000 ($14,220) and Sue will be assessed 3.95% of $290,000 ($11,455). They also have realized $145,000 in other income *(interest and dividend income, and capital gains)*. However, since they have already paid an assessment on combined wages of $650,000 ($360,000 + $290,000), if they file a joint federal income tax return, they will pay an additional health care assessment on only $100,000 of that $145,000 of their other income. This is because their combined joint income is capped at $750,000 for purposes of computing any health care assessment on income earned from other sources *(income from wages $650,000 + income from other sources $100,000 = $750,000)*. This would render $45,000 of their income from other sources ($145,000 - $100,000) not subject to any health care insurance assessment whatsoever. And, since their total income from other sources, when added to their combined wages is in excess of the cap on the 7.9% rate *(that cap being $225,000)*, they will pay $3,250 *(3.25% of the $100,000 that is subject to the additional assessment)*. Therefore their total assessment on all their income would be $28,925 *($14,220 + $11,455 + 3,250)*, or $2,411 monthly.

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[7] Naturally, in all the examples below, if the couples or partners had dependent children, they would be assessed additional amounts for each.

Example 3 – Larry and Jane *(domestic partners)* each earn W-2 wages. Larry earns $750,000 in W-2 wages and Jane earns $825,000 in W-2 wages. Larry will be assessed 3.95% of the maximum amount of his assessable wages, $500,000 ($19,750) and Jane will also be assessed 3.95% of the maximum amount of her assessable wages, $500,000 ($19,750). They also have realized $540,000 in interest, dividend and other investment income for the year. However, since they have already paid an assessment on combined wages of $1.000,000 ($500,000 for Larry + $500,000 for Jane), if they file a joint federal income tax return, they will pay no additional health care assessment on any of their other income because their combined income is capped at $750,000 for purposes of computing any health care assessment on joint income earned from other sources and they have already been assessed on $1,000,000 on their joint income from wages. Therefore their total health care assessment for the year would be $19,750 + $19,750 = $39,500 or $3,292 monthly.

Note: In example 3, while it may appear onerous that Larry and Jane will pay $39,500 annually ($3,292 monthly) for their health care assessment, let's look at what they will pay on the same income to support the provisions of the Affordable Care Act *(Obamacare)* as conditions currently exist. To fund Obamacare, they will pay an additional Medicare tax of .9% of their combined income from wages in excess of $250,000, or $11,925 [($750,000 + $825,000) - $250,000 = $1,325,000 x .9%] and a 3.8% tax on the lesser of their net investment income, or modified adjusted gross income, in excess of $250,000 *(in these circumstances the lesser of the two is their net investment income of $540,000)* or $11,020 [($540,000 - $250,000) x 3.8%]. This is a total of $22,945 ($11,925 + $11,020) that is currently being charged for the same income – and this total still doesn't pay for their current health care insurance! **Larry and Jane would still need to pay insurance premiums for their current health care and/or they and their employers would jointly pay the premiums**.

As an additional note, Larry will pay $10,875 *(1.45% x $750,000)* and Jane will pay $ *(1.45% x $825,000)* in regular Medicare taxes. However, as mentioned earlier, .95% of this amount will be eliminated after the need for Medicare is phased out, resulting in further savings of 7,125 *(.95% x $750,000)* for Larry and 7,837 *(.95% x $825,000) for Jane, eventually resulting in further savings of $14,962.*

COVERAGE FOR DEPENDENTS

For those with dependent children, for every child carried on the parents' plan, each spouse or domestic partner would pay an additional 1% of their income up to $200,000. If both husband and wife, or both domestic partners earn W-2 wages, each will have an additional 1% of their wages deducted *(withheld)* for each child/dependent from their pay until their total wages earned is in excess of $200,000[8]. **The employer will not be required to match any additional**

[8] Under the payroll system, each spouse or partner would have the additional 1% per dependent/child withheld from their wages. At year end, if their combined wages exceeded the $200,000, any excess in assessments paid could either be refunded to them or credited toward their next year's assessments. However, since their assessment would be paid to the same insurance group, the group would be able to notify employers when the thresholds were reached in order that the withholding for dependent health care may cease. **It is absolutely necessary that both spouses/partners wages be subject to assessment. If spouses/partners are allowed to choose whose wages will**

amounts for dependent children. The employer would be required to match only the 3.95% of each employee's wages.

The remainder of the health insurance assessment due for the dependent children *(if any)* would be determined when the parent(s)' federal income tax returns are filed. *[Remember that the health care insurance premium is assessed on all income – earned, or otherwise.]* However, there will be no additional amounts to be paid to cover an employer's matching amount on any unearned income *(as with self-employed and wealthy individuals)* because an employer is not required to match the assessment amount for dependents. Naturally, those with unearned income beyond a certain amount would be required to make quarterly assessment payments to be included with their other estimated tax payments.

If a spouse or domestic partner living with the taxpayer is not employed and/or has no other sources of income in excess of $15,079[9] *(and is an adult beyond the age of 21)*, the working spouse or partner will be assessed on an additional 2% of their wages up to $200,000. This additional amount will not be matched by the employer. *[In all instances, the employer never pays a health care assessment in excess of 3.95% of the employee's wages.]*

For example: an employee with a non-working spouse or domestic partner above the age of 21 years old *(with no other income)*, that has two dependent children will be assessed an additional 4% of their wages (1% each for the 2 dependents = 2% + 2% for the non-working spouse[10]) up to $200,000. This is in addition to the 3.95% of their wages for their own health care assessment. For example: if the working employee with a non-working spouse earns $80,000 annually and has no income from other sources, they will pay an annual assessment of $6,360 *[$3,160 for the employee + $1,600 for the non-working spouse or domestic partner + $1,600 for the two dependent children (1 % for each)]*, or $530 per month. And, to repeat, the employer would be required to match only the 3.95% of the employee's wages.

COVERING FORMER DEPENDENTS THAT ARE UNEMPLOYED, LAID OFF WORKERS AND EARLY RETIREES

WHEN DEPENDANT CHILDREN REACH THE AGE OF 22 YEARS, ARE UNEMPLOYED AND MAY NO LONGER BE COVERED BY THEIR PARENT'S POLICY

Unemployed dependents of taxpayers reaching a certain age that are no longer eligible for coverage under their parent's plan might adopt the same insurer as that of their parent(s) and pay the premiums on their own *[or their parent(s) may make the payments for them]* until they become employed. Then they may decide to continue with that same group plan as that of their parents, or select another.

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be assessed for dependent care, the spouse with the lower wages will most commonly be selected for obvious reasons.

[9] Even if the non-working spouse has less than $15,080 in other income, that income from other sources would still be assessable at the 7.9% rate up to $225,000 on the couple's joint income tax return + the additional amounts for a non-working spouse and dependent children.

[10] If the non-working spouse had income from other sources equal to or greater than $15,080, the couple would be assessed on that amount earned. However, they would not be charged the non-working spouse assessment of 2%.

If a former dependent is still not employed and/or not generating any other sources of income[11] at age 22, they would have the option to pay 3.95% of the annual salary an individual would receive if they were employed at the federal minimum wage *(currently $7.25 per hour)* for 2,080 hours annually + an additional amount representing the employer's contribution for the same amount. Therefore, the total they would need to pay is $1,191 annually or $99.28 monthly [$7.25 per hour x 2,080 hours = $15,080; 7.9% (3.95% employee portion + 3.95% employer's portion) x $15,080 = $1,191 in annual premiums, or $99.28 per month]. If a former dependent has their own dependent child, they would be required to pay an additional 1% of the $15,080 for each dependent child (approximately $12.57 monthly).

An unemployed individual's parent, by having the amount withheld from their (the parent's) wages or otherwise making a periodic payment to the insurer, may make the monthly payment explained above for the former dependent in lieu of the unemployed former dependent making the payment. The unemployed individual may also have their monthly assessment deducted from their unemployment compensation *[and their parent(s) possibly make up any difference]*.

There are two important things to keep in mind regarding former dependents above 21 years of age that are unemployed: 1) If former dependents have other unearned income (interest, dividends, rents, royalties, etc.), that income would be subject to the health insurance assessment; and 2) If the former dependent, and/or their parent(s) are not able to pay the $1,191 amount annually ($99.28 monthly), they would fall into the classification of the "general pool" that others that are unemployed or otherwise unable to pay health insurance premiums are grouped. *The general pool will be described later.*

LAID OFF WORKERS

Similarly, workers laid off would pay the same amount as that delineated above for former dependents 22 years of age and older and still not employed. They would be able to do so until they were either called back by their employer, or able to find other employment. If they are able to make the payments, they will be able to stay with their current group insurance provider. However, if they are unable to make the premium payments, they will still be covered in the "general pool".

The assessments for laid off workers may be deducted from the individual's unemployment compensation. If the amount of unemployment compensation received for the year is greater than $15,080, then the larger amount will be used to determine the amount to be assessed for health care insurance. However, if this is the case, the consolation is that the individual would avoid being placed in the "general pool".

MINIMUM ASSESSABLE WAGES/INCOME

With the exception of those over 65 years of age, the lowest amount of wages that must be used to compute the amount of the assessment due is $15,080 *(the amount used in the prior examples for unemployed former dependents of taxpayers and laid off workers)*. However, if

[11] Naturally, if the unemployed dependent had income from other sources *(including unemployment compensation)*, they would be assessed at 7.9% of that income.

this minimum amount to be used is less than $15,080, an individual would be able to make up the assessment difference out of their own funds to avoid being assigned to the "general pool".

Those over 65 years of age have no minimum assessable amount. They will just be required to make assessment payments based upon their income.

The minimum assessable amount also applies to net losses reported by unincorporated individuals, or individuals incurring losses in partnerships or S Corporations. Even though they have incurred net losses, their minimum assessment remains 7.9% of $15,080. Naturally, if they are unable to pay the assessment, they could still be covered by health insurance under the terms of the "general pool".

EARLY RETIREES

Since, according to this proposed plan, there is no distinction between current and future health care insurance costs, those retiring before they would ordinarily be eligible for Medicare benefits would be assessed in the same manner as those retiring after they are eligible for Medicare benefits. (See "Combining Current & Future Health Care Costs".) However, unlike those 65 and older, early retirees would be subject to the minimum assessment amount until they reached their 65th birthday.

PART TIME EMPLOYEES

Since the health insurance assessment will be assessed from the first dollar earned, the amount of those only able to work part time should diminish because an employer will have no incentive to limit an employee's hours to avoid paying health care insurance premiums. However, if an individual is still unable to work full time after this plan is enacted, they would be able to avoid being assigned to the general pool by working other job(s) part time so that the total amount of their wages equaled or exceeded $15,080.[12]

COMBINING CURRENT & FUTURE HEALTH CARE COSTS *

Since the health care assessment will be based upon all earnings and not just wages on earned income, there is no reason why the suggested system cannot continue on after retirement and replace the function that Medicare currently performs.

Retirees would be assessed based upon their income, which, in addition to Social Security benefits, would also include interest, dividends, rents, royalties, etc. up to $500,000. While this may seem onerous to retirees with significant income, it is important to note that if this plan is adopted the 3.8% tax on net investment income *(or modified adjusted gross income, if less)* that was imposed to support Obamacare *(and which has no income limit)* will be eliminated.

Retirees, like all others, would be assessed at 7.9% of their retirement income *(pension payments and distributions from retirement accounts, etc.)* as well as other sources of income *(interest,*

[12] However, if the individual is unable to work a minimum of 40 hours from two or more jobs, or to earn more than $15,080 annually and is placed in the general pool, their wages, as they are, will still be subject to the health care assessment of 3.95% and the employer(s) that provides their part time employment must still match this amount to the extent of their wages – even though they are assigned to the general pool.

dividends, royalties, etc.) up to $150,000 and 3.25% on income from $150,001 up to $500,000, just as are wealthy individuals not needing to work. For example: A retiree with $55,000 in earnings would pay 7.9% x $55,000 = $4,345 annually, or $362 monthly. The retiree in this example will most likely discover that this $362 monthly payment is less than the Medicare Part B, Medicare Part D and Supplemental Medicare Insurance *(Medigap)* premiums that he or she is currently paying.

Those whose **only retirement income is their Social Security benefit** will find that they will generally pay less than they currently pay for their Part B Medicare benefits since that cost usually ranges from 7% to 11% *(and possibly higher)* of the amount they receive from Social Security. Taking into consideration what that same individual would pay for Part D and a Medicare Supplement insurance, the premiums under this proposal would be far less.

* **The combination of Medicare payments and benefits with current health care payments and benefits would not apply to those currently receiving *(and paying for)* Medicare benefits. This new proposed rule would apply only to those below a certain age (to be actuarily determined), such as 63 years of age and younger. Those currently under the Medicare umbrella would be able to remain with Medicare, should they elect to do so. However, those desiring to switch to this proposed plan would have the option to do so as well.**

Since it is believed that most of those currently receiving Medicare benefits will pay less under this proposed plan, although skepticism will make many hesitate, eventually, most will switch from Medicare to the new plan. The eventual switching to this proposed plan and the termination of life by others refusing to leave the Medicare umbrella, will ultimately cause the Medicare program to terminate within approximately the next 20 years. And, as those collecting Medicare benefits diminish, more and more of the 2.9% Medicare tax withheld from wages may be gradually reduced over a period of years.

DEDUCTIBLES AND MAXIMUM OUT OF POCKET COSTS UNDER THE PLAN

It is essential that there be a deductible to the proposed plan. Keeping in mind that the primary purpose of health insurance is to guard against the catastrophe and not to pay every medical bill presented to the insured, a mandatory deductible and maximum out of pocket amount should be established based upon the modified adjusted gross income of the individual or family unit. The reason for basing the deductible and maximum out of pocket amounts upon modified adjusted gross income is that a deductible of even $500 for a minimum wage earner may prevent that individual or family from seeking medical care, while a $3,000 deductible amount for an individual or family unit earning $200,000, although it may cause some financial disruption, would not prove to be unduly burdensome or prevent that individual or family unit from seeking medical attention.

Therefore, it is suggested that there be no deductible or co-pays for single individuals earning $15,080 or less (2,080 hours annually x federal minimum wage of $7.25 per hour) and joint

return filers earning $30,160 or less (total minimum wages earned by two individuals – 2 x $15,080 = $30,160). For individuals with income above $15,080 and joint tax return filers with income above $30,160 the deductible amount would be 1½% of their adjusted gross income + tax exempt income *(i.e., modified adjusted gross income)*. After the deductible is met, the insured would then pay coinsurance of 20% of the total medical costs incurred until they reached their maximum out of pocket costs of 3% of their modified adjusted gross income (2 x the amount of the deductible). For two working or separate income producing spouses, the same maximum out of pocket costs would apply to each. ***[See the chart in Appendix B containing a determination of deductibles and maximum out of pocket amounts for various income levels.]***

All insured would be able to contribute to a pre-tax account *(not subject to taxable income - similar to an HSA account)* up to the amount of their maximum out of pocket costs. The amounts contributed would accumulate until the maximum out of pocket amount was achieved. Thereafter, they would only be able to contribute pre-tax amounts to replenish the account balance up to the full maximum out of pocket amount.

THE GENERAL POOL– COVERAGE FOR THOSE WITH LITTLE OR NO SOURCES OF INCOME

Regarding those receiving governmental assistance *(welfare recipients, etc.)*, as well as others unemployed or otherwise unable to pay insurance premiums, each group medical health insurer would be required to assume responsibility to provide health insurance to a specified number of those unable to pay health insurance premiums.[13] The amount of general pool members assigned to group plans would be actuarially determined.

To explain further, let's assume that the actuarially determined number is 18%. That 18% determines the number of general pool members that must be insured by each health insurance group.

For example: If there are 800,000 members of our sample health insurance group that have fully paid their insurance premiums *(Employee wages have been effectively assessed and/or premiums have been otherwise paid)* then 144,000 general pool members (800,000 x 18%) must be covered by our sample health insurance group. Therefore, the total number of insured within our sample group would be 944,000 *(800,000 of those having fully paid their premiums + 144,000 members of the general pool)*.

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[13] By those unable to pay health insurance premiums is meant all those not able to pay at least the amount designated for those unemployed ($1,191 annually or $99.28 monthly). Should the individual have some earnings and, therefore, have been assessed some insurance premiums, but not an amount sufficient to meet the $1,191 annual amount required, they would be assigned to the general pool. However, the insurance group would still be entitled to those premiums, however insufficient, that were paid by the general pool member.

Both federal and state governments would still be required to contribute their designated amount *(to be explained later in this proposal)* for all 944,000 members of the group, both those paying premiums and those allocated from the general pool per this example group.[14]

Naturally, there would be no deductibles or co-pays for the general pool members.

The primary disadvantage of being placed in the "general pool" is that those in this group would not be able to select the group insurer they ish to use. In addition, group insurers may have the option of requiring that general pool insured use only a select network of medical care providers restricted to the area surrounding their legal residence, except in emergencies - similar to the limitations required by most Health Maintenance Organizations (HMOs).

An additional disadvantage to belonging to the general pool is that, if a medical condition occurs while the individual is in the general pool, even if that individual later becomes able to pay sufficient premiums to exit the general pool, there may be a waiting period before that individual will be able to join the plan of their choice, based upon openings available in that particular group(s).

While it would be necessary for the federal and state governments to subsidize group insurers, for the most part, the establishment of the "general pool" should eliminate the need for federal and state governments to make Medicaid and certain Medicare payments. However, more will be said about federal and state assistance later in this proposal.

THOSE WITH SIGNIFICANT MEDICAL & OTHER HEALTH CARE EXPENSES

For those, such as the aged and those requiring weighty and continual medical costs outlays for insurers, an additional 1% of all employee wages will be paid to insurers as Medicare is phased out. That 1% will come from .5% included in the 1.45% currently withheld from employee wages *(but only up to $500,000)* and .5% included in the 1.45% of employee wages contributed by employers *(but only up the $500,000 of each employee's wages)*.

The 1% total from Medicare taxes will only become available gradually, as the number of Medicare recipients slowly diminish. Once Medicare has been completely phased out, all of the 1% will become available, but unlike Medicare, the 1% will only apply to income up to $500,000 – not indefinitely.

When will Medicare be phased out? After those currently in Medicare decide to switch to this proposed plan and after the deaths of those deciding not to accept the insurance offered in this proposal, but to continue under the Medicare system. For the most part, this should occur within the next 15 – 20 years.

Some of those requiring continual and significant cash outlays from insurers may belong to the general pool, but others may be among those regularly making insurance premium payments.

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[14] Appendix A reflects the estimated average annual and monthly per capita premiums available. These computed averages are after government subsidies. However, these premium amounts are not guaranteed. It is essential that the profit motive remain present. Otherwise customer service would be drastically impaired.

However, even if they are making premium payments, they may need to be apportioned among health insurance groups and not necessarily be able to obtain the first insurance group they choose. Nevertheless, they will not experience the other restrictions imposed upon general pool participants.

PART B – THE PROPOSED SYSTEM OF COLLECTION AND PAYMENTS

MEDICAL CLEARING CORPORATION(S) - PROVIDING THE EQUIVALENT OF A SINGLE PAYER SYSTEM

To reduce confusion and streamline the collection and payment process for all parties, insurer, insured, employers and medical care providers it is proposed to establish (a) **Medical Clearing Corporation(s) *(MCC)***.[15] An MCC(s) **would not be a governmental bureau**, but a medical clearing organization(s) that is owned and operated jointly by insurers, employers and medical care providers.[16] [17] For various reasons more than one MCC is suggested. However, for the time being, in order to simplify the foregoing example(s) we'll just assume that there is only one MCC.

An MCC would make the payment and collection system similar to a single party payer system. Employer, insured employees, non-employee insureds[18], insurers and medical care providers would each have an account with the MCC. All the foregoing would have their own unique code or symbol and part of that code would indicate whether the member was an employer, insured employee, non-employee insured, insurer, or medical care provider. The following sections will explain how each facet of the "clearing" process would work.

REQUESTS FOR PAYMENT SUBMITTED BY HEALTH CARE PROVIDERS

The chief problem facing providers of medical services (doctors, etc.), drugs and medical products and equipment *(Hereafter all the foregoing will be referred to as medical care providers.)* is that they must often deal with a myriad of insurers and the insurers' differing and often conflicting requirements and restrictions in order to receive payment for the medical care they have already provided. This necessitates the hiring of individuals with significant expertise in the medical billing process. Since these billing "experts" are few *(as well as being expensive)*, most small medical practices have been forced to join hospital affiliated organizations *(increasing their costs)*, or simply go out of business and get a job in a hospital.

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[15] Actually, what is recommended is not one, but several Medical Clearing Corporations for the primary reason that, if there is only one MCC, after a certain period of time, the size of the MCC would be such that significant inefficiencies would ensue and one might as well be dealing with the U.S. government. Each MCC would be required to follow one established set of rules and, as part of their charter, be required, to transfer funds to, accept funds from, as well as transmit information – documentary or otherwise – to other MCCs, when necessary. However, in order to simplify this explanation, only one MCC will be used as an example.

[16] If it were decided that the MCC were to be owned solely by insurers, or other parties that do not represent medical care providers, employers, or even insurers; representatives from each of the foregoing groups would be required on the MCC's board of directors.

[17] An MCC(s) would be required to be insured against errors and financial misappropriations or other irregularities. They would also be required to be insured against the inability to pay funds to those entitled to those funds.

[18] Non-employee insureds would be: the wealthy *(those not needing to work)*; early retirees; laid off workers; former dependents over 21 years old that are not yet employed; those belonging to the general pool; etc.

For this reason, fewer and fewer physicians are inclined to operate on their own, requiring those seeking medical care to go directly to hospitals for even the most trivial medical issues.

Now let's digress for a moment and look at the operations of another industry; the securities brokerage industry: In this industry all brokerage houses that accept and receive customer funds and securities belong to a clearing corporation(s), the largest and most pervasive of which is Depository Trust & Clearing Corporation (DTCC).

Prior to the advent of DTCC, stock brokerage firms had to deal with a myriad of other stock brokerage houses with which they had executed securities transactions.

DTCC is a user-owned and directed entity (not government owned and directed) that clears securities transactions, pays sellers and collects from buyers of securities as well as performing custodial functions for hundreds of stock brokerage firms.

DTCC settles the vast majority of securities transactions in the United States and in 2018 processed worldwide a total volume of 389 million securities transactions with an over-all value of 1.85 quadrillion dollars.

And DTCC accomplishes this feat for a fraction of what it would cost our federal government to perform the same tasks.

In a typical transaction, a brokerage firm's customer may buy a certain stock and then, if there is a significant price increase (or decrease) in that stock, the customer may sell the stock at a profit (or loss). Often the purchase and sale of the stock might occur during the same business day. The customer's stock brokerage firm (BF-1) may have acquired the stock for its customer from one brokerage house (BF-2) and then sold the same stock later to a different brokerage house (BF-3). If all three brokerage houses belong to the same clearing corporation (clearing corp.), such as DTCC, they all reported the applicable trade(s) to that entity. The clearing corp. will then net the transactions and so, will treat both the buy and sell transaction as occurring through it (the clearing corp.) and not through BF-2 or BF-3. The clearing corp. then adjusts all broker accounts (BF-1, BF-2, BF-3, etc.) for the amounts owed for purchase of the stock, amounts due for sale of the stock, transfers of ownership of stock (if requested), charges for dividends and interest due or payable (if applicable), stock borrowed or loaned (for short sales), etc. The clearing corp. may also initiate settlements of trading errors between brokerage houses.

Although the clearing corp. is owned by bankers and/or brokerage houses, it follows a certain protocol and an established set of rules. The clearing corp.'s members' accounts are credited or charged based upon these rules. In other words, it "calls the shots". For example: if BF-3 claims a dividend is due on the stock it has purchased from BF-1, it initiates the claim with the clearing corp. and not with BF-1. In essence, the clearing corp. steps in to function as the contra-broker[19] for all securities transactions – to a seller it is the buyer; to a buyer it is the seller. Operationally, from a securities clearing point of

[19] The "contra-broker" is the brokerage house on the opposite side of a securities transaction. If the brokerage house, BF-1 is selling a stock, the brokerage house buying the stock is the contra-broker. If BF-1 is buying a stock, the contra-broker is the brokerage house selling the stock.

view, this creates the impression that every securities broker-dealer is only dealing with one contra-broker and not with hundreds or thousands.

Now let's look at how medical care providers are compensated for the services, drugs and/or medical goods and equipment they have furnished to their patients. Medical revenue and payment management exchanges (medical exchanges) exist, such as Change Healthcare (formerly, Emdeon Inc.). These medical exchanges provide software to providers that allows them to enter what are referred to as **cpt** codes (**C**urrent **P**rocedural **T**erminology codes) into their medical exchange's system. These codes indicate which services and/or what type of services or products the health care providers have performed or supplied for a particular patient. However, one visit to a doctor's office may involve numerous procedures *(a doctor's examination, blood testing, X-rays, etc.)* for that patient's visit. And since, as medical technology continually increases, the amount of medical procedures alone are increasing almost exponentially, more and more cpt codes are required. At the time this proposal was originally written, a book was produced annually containing all current cpt codes. *(The book for 2015 consisted of 545 pages, not including a 223 page index[20].)* Hopefully, these codes are now within the system and don't require a "book" to consult. However, a problem still exists.

The primary difference between a securities clearing corp. in the securities brokerage industry and a medical revenue and payment exchange, is that the latter *(the Medical exchange)* merely transmits to the insurer specified or to the U.S. and/or state governments (Medicare, Medicaid and Chip)[21] the information that the medical care provider's staff has input into its system and the amount being claimed by the provider. Then each insurer responds individually to the information it has received from the exchange. Some, but very few, promptly transmit payment to the provider, most ask for additional information and some, less reputable insurers, attempt to delay the claim as long as possible until the provider's time period for making the claim has been exhausted. The bottom line is that, although the provider's staff enters all of its claims to the various insurers in a uniform basis due to the cpt codes, the responses and subsequent demands from insurers vary significantly, creating a lot of additional work for the provider's staff and delaying the provider's receipt of payment. So a medical exchange doesn't "call the shots". It merely transmits detailed information to numerous insurers and governmental agencies.

Under the proposed MCC system, all group insurers would be required to pay fees established for each medical good and service currently being offered in the medical profession. [22] [23] This

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[20] It is difficult to believe that, at the time this proposal was originally developed, all of these codes are contained in a lengthy written manual and not within the computer software system itself. We must assume that this is no longer to be the case. However, for purposes of this proposal, the manner in which codes are entered is irrelevant.

[21] Since one of the goals of this proposal is to eliminate the need for Medicaid, Chip and Medicare, only the mechanics of transmitting claims and other information to private insurers will be addressed.

[22] The board and staff of the MCC, or a subgroup of that board, will establish *(with the input, or even legislation provided by the federal and/or state governments)* the amount for each medical good and service that each health insurance group must cover.

[23] Naturally the listing would require continual updating since new services and products are continually débuted in the medical profession. For all new medical equipment and services, the best group to make any pricing decisions would be the same group mentioned in note 24 – the board of the MCC, or a sub-group of the board (containing

information would be made public and readily available, especially to medical care providers beforehand – allowing the provider ready access to the insurer's coverage and payment data before discussing with the patient what that patient's options for treatment are[24]. In addition, since this information will be public through the MCC, it would be possible for independent rating services *(or even the MCC itself)* to rank/rate each insurer based upon the quality of the services they offer, such as customer service, accessibility, etc., as well as the amount paid for each medical good or service. This information from both rating types would be available to those attempting to select a group insurer or change group insurers.

Based upon the foregoing, the MCC will need to develop more interactive software *(possibly based upon the cpt code system, but it is recommended that this system be discontinued [25])* whereby the medical care provider's staff would enter *(in code or otherwise)* the goods and services provided and the amount that the provider was claiming. If the medical care provider were claiming an amount not determined to be in line with the procedures performed[26] and the appropriate payment amount(s) *(which would be available within the MCC software)*, the MCC software would prompt the provider for more information until both the provider and the MCC would be in sync.

The required documentation and other information required to be submitted to the MCC(s) for each type of medical good and/or service performed would be standardized nationally. Once the required information received by the MCC was determined by the MCC system *(staff)* to be sufficient, the MCC would debit the group insurer's account based upon the insurer's established rates and credit the health care provider for the same amount[27]. Additional amounts might be due from the patient, depending upon the patient's deductible and coinsurance amounts[28]. If the insurer disagreed with payment of the health care provider's claim its only recourse would be against the MCC. The MCC would "call the shots".

To support the MCC organization(s), medical care providers would pay a percentage of the dollar amount of the claims submitted *(such as .25% - .5% of the claim)* to the MCC and insurers would pay a percentage of the premiums it receives *(from employers and otherwise)* through the MCC *(perhaps .25% - .5% of the premiums)*.

Rather than "reinventing the wheel" it may be decided to use existing Medical revenue and payment management exchanges *(medical exchanges)*, such as Change Healthcare – provided

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members from the insurance and health care industry and possibly employers.) *[If this appears to be a daunting task, keep in mind that this process is continually done currently by health care insurers.]*

[24] For sales of medical equipment, pre-approval from the MCC might be required.

[25] Rather than the provider's staff looking up and entering cpt codes, it is strongly recommended that the software provided by the MCC be more user friendly and accept information entered in suggested wording that the system will sort out (with the provider staff's participation) and arrive at the intended procedure being billed.

[26] Those in the general pool may also have certain restrictions to be met by the medical care provider that may require additional claim information to be input into the MCC's system.

[27] However, just as there is with Depository Trust and Clearing Corporation (DTCC) in the securities industry, there will be a one day delay in the charge *(as well as credits for premiums)* to the insurer's account, allowing a review by insurer personnel for bona fide errors and/or omissions), before the insurer's account will be debited or credited.

[28] The patient may be able to transmit any deductible or coinsurance payments directly to the MCC from its HSA type account. This amount may be then transmitted to the applicable health care provider.

they are willing to adapt their software to the new requirements and comply with the mandated ownership and governance stipulations. *(Federal financial assistance in the form of low cost loans or grants may be offered to assist the exchange(s) in effecting the required software and other system modifications.)* There would be several advantages in using existing exchanges. One advantage would be that the existing exchange(s) and their staff are already familiar with industry, their system and the software currently being used. Therefore modifications to that software would be less onerous to them. Another advantage would be that, since the MCC entry software would be a modification of that which is currently being used and not a completely new system, there would be a reduced learning curve for those currently employed by medical care providers to input claim information into the system after the modifications are effected.

TRANSMISSION OF ASSESSMENT PAYMENTS TO THE MCC

Payment of wages –

To repeat from a prior explanation: Ordinarily, at the end of each payroll period, when wages are to be paid, the employer's payroll department *(or a payroll service that is used by the employer)* makes deductions from each employee's gross wages for state withholding taxes, federal withholding taxes, Social Security and Medicare taxes and also makes additional charges to the employer for the employer's portion of Social Security and Medicare taxes as well as charges for unemployment insurance, both state and federal. These amounts withheld are forwarded to various federal and state agencies. Other voluntary deductions might also be made, such as payments to retirement accounts (IRAs, 401(k)s, etc.) to be forwarded to the appropriate party.

In addition to the above, 3.95% of the employee's wages would be withheld from their pay[29] *(plus extra amounts if the employee were covering any dependents)* and the employer's assessment of 3.95% of the employee's pay would be forwarded to the Medical Clearing Corporation (MCC). The account of the health care insurance group selected by each employee would be credited for both the employee's assessment and the employer's assessment.

However, it is important to note that, when the employee filed their annual federal income tax return, an assessment might also be due on income from other sources *(interest, dividends, royalties, etc.)*. This additional assessment would be included with any tax payment due to the IRS, or deducted from any income tax refund the taxpayer was due. Since most, if not all, tax returns in the future will most likely be filed electronically; the amount of any additional

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[29] Although this might be interpreted as "just one more tax" imposed upon workers, it is important to realize that after a predetermined transitional period, all U.S. citizens and residents, including retirees, would fall under this proposed health care plan. Therefore, after a transitional period, Medicare taxes of 1.45% for the worker and 1.45% for the employer would be reduced to .5% for each **AND** premiums currently being paid for health care insurance *(often being a much larger % of a worker's pay)* would not be necessary. However, see footnote 1 and **"THOSE WITH SIGNIFICANT MEDICAL & OTHER HEALTH CARE EXPENSES"** in part A of this proposal.

assessment due by the taxpayer would be forwarded directly to the MCC then and credited to the appropriate insurer's account.

If the employee had annual earnings other than wages in excess of a certain amount, they might be required to make periodic estimated assessment payments, just as they are required to do for their federal and state income taxes. Those payments would be forwarded to the MCC. Alternately, to cover the additional assessment from income derived from other sources, the employee might elect to have an additional amount withheld from his or her paycheck or set up a monthly amount to be deducted electronically from his or her bank account to make estimated assessment payments to the MCC. The MCC would then credit the employee's health care insurer's account for the employee's additional assessments on non-wage income, to reduce any actual amounts due when his or her income tax return is filed. The estimated amount to be deducted could be based upon the information reported on the taxpayer's tax return filed the previous year, or based upon a current determination of their estimated non-wage income. This latter method of paying additional assessments due by having additional amounts withheld from an employee's wages or through electronic withdrawals from one's bank account on a monthly basis is strongly recommended and, in our electronic age, should prove to be the method of payment required in the future[30].

Those self-employed, early retirees and the wealthy –

As previously stated, self-employed individuals, early retirees and the wealthy would be responsible for their portion of the assessment as employees *(3.95%)* and their portion of the assessment that an employer would ordinarily pay *(an additional 3.95%)* - a total of 7.9% of their earnings, up to $150,000. From $150,001 to $500,000, they would pay 3.25%[31] of their earnings. If they were covering any dependents *(including nonworking spouses or domestic partners)*, additional amounts would be necessary.

As those self-employed, early retirees and the wealthy are required to make quarterly estimated tax payments, they would also be required to make quarterly estimated health insurance assessment payments *(included with their estimated tax payments)*, based upon the amount of their assessment paid during the prior year, or based upon a current determination of their estimated income. The amount paid for the assessment would be broken out from the estimated taxes being paid and forwarded electronically to the MCC. Alternately, just as stated previously, self-employed individuals, early retirees and the wealthy might establish a monthly amount to be deducted electronically from his or her bank account to make estimated assessment payments to the MCC. These amounts will be credited to his or her health care insurer's account. The payments would make up for any actual amounts due when his or her income tax return is filed. Once again, the estimated amount to be deducted monthly would be based upon the information reported on the taxpayer's tax return filed the previous year and adjusted when significant differences in the current year's income have occurred. And again,

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[30] Any overpayment of amounts withheld in excess of what is due at the end of the year may be refunded to the insured wage earner in the same manner as any tax refund would be received or credited against their next year's assessment.

[31] See footnote 2.

this electronic monthly deduction method is strongly recommended and, in our electronic age, should prove to be the method of payment required in the future.

Former dependents no longer eligible to be included on their parent's plan –

Once again, if a former dependent is still not employed at age 22, they would be required to pay 3.95% of the annual salary an individual would receive if they were employed at the federal minimum wage *(currently $7.25 per hour)* for 2,080 hours annually + an additional amount representing the employer's contribution for the same amount.[32] Since this annual amount is fixed until the federal minimum wage is changed, the monthly amount due ($99.28) should be deducted electronically from his or her bank balance if they had sufficient funds to be able to make the payment and forwarded to their insurer through the MCC. Alternately, parents may agree to have this monthly payment deducted from their own bank balances or their wages.

Laid off employees –

Since the annual insurance assessment is the same for laid off employees as for unemployed former dependents no longer eligible to be included on their parent's plan, laid off employees would be required to have the same electronic monthly payment ($99.28) deducted electronically from their bank balance, *(provided they had sufficient funds to be able to make the payment)*, or deducted from their unemployment benefits and then transmitted to the MCC. The assessment would then be transmitted to their insurer through the MCC. Naturally, if the laid off employee were covering any dependents, the monthly amount would need to be adjusted accordingly.

DISTRIBUTION OF GOVERNMENT SUBSIDIES

Another very important function of the MCC is the "allocation" of government subsidies.

As will be described later in this proposal, both the federal and state governments will pay per capita subsidies for every insured in each group. Those subsidies will be paid to the MCC(s) and then distributed to each insurance group based upon the number that it insures. The payment will include subsidies for those insured gratis in the general pool.

MORE THAN ONE MCC???

This point has already been stated, but we believe that is important enough to be reiterated. It is strongly recommended that there be more than one MCC. The primary reason that more than one should exist is the inefficiencies that would ensue if one organization would be permitted to grow beyond a certain point where productivity would significantly suffer. Many governmental bureaus, as well as other extremely large organizations have demonstrated this quite aptly.

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[32] However, see the provisions described earlier for former dependents still not employed that have their own dependent children.

The main concern that would most likely be posed if more than one MCC were established is that the collection and payment system would lose the effect of being a single payer system. However, this is not necessarily correct. To make the system work and still simulate the effect of a single party payer: 1) standards would need to be established providing a listing of the documentation and other evidence required for each type of medical service and/or product and those standards would be agreed to and be uniform among all MCCs; 2) each MCC would be required to freely transmit documentation and funds received by it, if not allocable to one if its members, to the appropriate MCC whose member the documentation pertained to or who was entitled to any payment; and 3) each MCC whose member was required to render payment to an employer, employee, other insured, or medical care provider belonging to another MCC would be required to freely transfer the payment to the MCC.in which the intended recipient belonged.

Employers, medical care providers and insurers would be able to elect which MCC they wished to belong. However, employees would be required to belong to the same MCC as that of their employer. Therefore, although an individual would be able to retain their insurer when switching jobs, they would be required, if applicable, to switch to their new employer's MCC.

FINE–TUNING GROUP INSURERS' REQUIREMENTS, SPECIFICATIONS AND INCENTIVES

Insurers that currently provide health care insurance for employer based plans, provided that they make the necessary modifications to their existing plans to conform with the requirements established by Congress *(regarding benefits to those it insures)*, will be able to continue offering those plans. However, they will now be able to expand those plans to cover those not employed by the company(ies) that they currently insure; and they must allow those currently insured in their existing employer based plan to leave their plans and join other health insurance plans, if they so wish and are able to do so.

Insurers desiring to form new group insurance plans that conform with the requirements established by Congress *(regarding benefits to those it insures)* as well as those that have adapted their existing employer based plans to conform with the newly established requirements *(mentioned above)*:

- Would need to have *(and prove that they have)* certain minimum financial resources;
- Be insured and/or bonded themselves in the event they encounter financial difficulties;
- Be required to accept a specified amount of general pool (GP) members. The amount of GP members should be apportioned among insurance groups based upon a specified formula, such as the average amount of the premiums received in the group. In other words, those groups receiving premiums primarily from higher income individuals might be required to accept a greater number of general pool participants. *[This is just a suggested method for determining the amount of GP participants a group should accept.]*
- Initially would be allocated a portion of high risk individuals and those with pre-existing medical issues. *(Possibly in a manner similar to the method employed for their acceptance of members classified as general pool participants. However, once all U.S. citizens and*

legal residents are within a health insurance group, that allocation method would become unnecessary.[33]

- Might be required to vary the composition of their groups *(the insured within each group)* by certain factors, such as: geographic location *(since medical costs vary in different regions of the country)*; by age, by those having higher risks of *(susceptibility to)* illness, etc. in order to effectively manage costs for their group(s). Therefore, it is strongly recommended that Congress establish guidelines *(with actuarial assistance and input from insurers as well)* regarding the mix of insured participants that each insurer should actively seek to comprise the "portfolio" of their group(s).

- Be required to maintain a certain minimum amount of insured individuals actuarially determined to approach specified probability norms (50,000 insured?)

- Be limited to providing health care insurance for a maximum amount of insured actuarially determined to prevent undue influence upon the industry[34] (1,000,000?)

  Based upon the foregoing, the size of each health care insurance group should be limited as to the number of insureds. For example: The minimum and maximum permissible amount of insureds that one group might accommodate might be 50,000 and 1,000,000 respectively.

Economic incentives???

There are two obvious factors that should be sufficient incentive for insurers to back this proposal: 1) If "Medicare for All" is adopted *(with no deductibles, as certain socialists have suggested)*, then group health care insurance plans will no longer have any business; and 2) The approximate 47% of Americans insured under group health care plans will expand to 100% of all Americans and legal U.S. residents, dramatically increasing insurance premium revenues.

Other incentives may be provided to health care insurers, such as a maximum federal income tax rates of 10% (?), little or no state income taxes, and low cost financing for newcomers entering the health care insurance industry.

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[33] This would mean that, not only general pool participants, but those with pre-existing medical issues may be also be restricted in selecting their group insurer. However, the latter may apply to their preferred group(s) and when a vacancy occurs in the group so selected, that group would be required to accept that applicant.

[34] One insurer may form more than one health care insurance group. However, the number of health care insurance groups formed by one insurer may be limited by law to prevent any undue influence on the industry as stated above. For example: One insurer, such as United Health Care might be limited to owning and operating three health care insurance groups.

PART C – BENEFITS AND OTHER NOTABLE ITEMS BY GROUP

WAGE EARNING INDIVIDUALS

For those whose insurance is paid through their wages:

- All those employed will be covered with medical insurance.
- Since health care insurance will be assessed from the very first dollar earned, there will be less incentive for employers to limit the working hours of employees and many part time workers may become full time workers. However, those still limited to part time work would nevertheless be able to obtain full coverage without going into the general pool by working more than one part time job and/or earning wages equal to, or in excess of $15,080 annually.
- Employees need not worry about losing health insurance by switching, losing or quitting their jobs. Their insurer stays with them unless they elect to switch insurers, or are unable to pay the required insurance assessment due to their new situation. However, if the latter is the case, they may still obtain coverage in the general pool.
- Examples of premiums paid by employees at various wage levels are:
  - Employees with annual wages of $30,000 would pay a monthly insurance premium (withheld from their wages) of $98.75. If the employee were also covering two dependent children, they would pay an additional $50 per month *($25 for each dependent child)* [35] for a total monthly premium of $148.75;
  - Employees with annual wages of $50,000 would pay a monthly insurance premium (withheld from their wages) of $164.58. If the employee were also covering two dependent children, they would pay an additional $83.33 per month *($41.67 for each dependent child)* for a total monthly premium of $247.91;
  - Employees with annual wages of $80,000 would pay a monthly insurance premium (withheld from their wages) of $263.33. If the employee were also covering two dependent children, they would pay an additional $133.33 per month *($66.67 for each dependent child)* for a total monthly premium of $396.66.
  - Employees with annual wages of $100,000 would pay a monthly insurance premium (withheld from their wages) of $329.17. If the employee were also covering two dependent children, they would pay an additional $166.67 per month *($83.33 for each dependent child)* for a total monthly premium of $495.84.
  - Employees with annual wages of $200,000 would pay a monthly insurance premium (withheld from their wages) of $658.33. If the employee were also covering two

[35] Those also with working spouses would need to add 3.95% of the spouse's income and also 2% for the two dependents. For those with non-working **spouses, 2% of the gross amount reflected in each example above would also need to be added to the total** presented.

dependent children, they would pay an additional $333.34 per month *($166.67 for each dependent child)* for a total monthly premium of $991.67.

- Employees with annual wages of $500,000 and higher would pay a monthly insurance premium *(withheld from their wages)* of $1,645.83. If the employee were also covering two dependent children, they would pay an additional $333.34 per month *($166.67 for each dependent child, but only up to $200,000 in wages)* for a total monthly premium of $1,979.17.

  If the amount to be paid for those falling within the last example (annual wages of $500,000 and higher) appears to be excessive, let's look at what those within this group currently must pay on the same income to support the provisions of the Affordable Care Act (Obamacare). To fund Obamacare, assuming the taxpayer is filing jointly, they must pay an additional Medicare tax of .9% on their income from wages in excess of $250,000. If they also have net investment income, they must pay a 3.8% tax on the lesser of their net investment income, or modified adjusted gross income, in excess of $250,000. AND, unlike the assessment suggested in this proposal, both the additional Medicare tax of .9% and the 3.8% tax on the lesser of net investment income, or modified adjusted gross income have no cap. The tax continues to be accessed as income increases. AND the taxpayer will still need to obtain and pay for health care insurance after paying these taxes.

EMPLOYERS

Benefits and other information for employers:

- For employers not previously offering health care insurance benefits
  - Under the current rule(s), employers not wishing to provide health care benefits must keep employee working hours under 30 hours per week – relegating these employees to part time work. Therefore, employers must deal with many more employees, some of which invariably prove to be the "not so reliable" type.

    Since the implementation of this proposal would assess health care insurance benefits from the very first dollar earned, there would be less incentive for employers to keep good employees as part time workers. Employers should be able to employ and retain fewer individuals, keeping those that are more reliable and increase the probability that those more reliable employees will continue in their current positions because they are now covered by health care insurance. This should reduce the frequency in which an employer must train new hires.

  - The "outcry" will most likely be that these proposed changes will make it too expensive for small employers to operate. However, let's look at what the monthly cost to

employers will be for employees at three income levels[36] if this proposal is accepted. Keep in mind that if the employee has dependents that doesn't affect the employer's assessment. The employer's assessment never exceeds 3.95% of the employee's wages.

- An employee earning the federal minimum wage annually ($7.25 x 2,080 hours = **$15,080 in yearly wages**) x 3.95% employer assessment) ÷ 12 months = $49.64 per month.

- An employee earning 1½ times the federal minimum wage annually ($7.25 x 2,080 hours x 1½ = **$22,620 in yearly wages**) x 3.95% employer assessment) ÷ 12 months = $74.46 per month.

- An employee earning 2 times the federal minimum wage annually ($7.25 x 2,080 hours x 2 = **$30,160 in yearly wages**) x 3.95% employer assessment) ÷ 12 months = $99.28 per month.

Are the foregoing monthly expenses that will be incurred to retain fewer, more reliable employees too cost prohibitive for small employers?

IT IS ALSO IMPORTANT TO ASK THOSE EMPLOYERS THAT DO NOT CURRENTLY PROVIDE HEALTH CARE BENEFITS TO THEIR EMPLOYEES, "WHO PAYS FOR THEIR EMPLOYEES' MEDICAL CARE?" – "THE TAXPAYER DOES!" "IS IT FAIR FOR THE TAXPAYER TO BEAR THESE COSTS?"

- For the most part, **employers that already provide health care insurance benefits** to their employees should experience a **significant decrease in their monthly employee medical insurance premium costs since the premiums that they currently pay for their employees' health care insurance will no longer be necessary**.

THE SELF-EMPLOYED

One of the primary benefits of the proposed plan for self-employed individuals is that they possess the ability to transition from a wage paying environment *(as an employee)* to starting their own business without needing to worry about being able to obtain and afford health care insurance when they "take the plunge" to be off on their own. Although, as a self-employed individual, they must pay both the employee and the employer's portion, they will still be able to retain their current group insurance when they make the transition.

They will also be able to pay the health insurance assessments pre-tax, lowering their taxable income from the very first dollar.

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[36] For purposes of this explanation, it is assumed that, for the most part, smaller employers that do not provide medical insurance for their workers employ individuals in the lower income levels. Therefore, the examples do not contain data for those in the upper income stratum.

Costs of the proposed insurance assessment in the following examples of net self-employment income *(gross income, less expenses and other adjustments)* for self-employed individuals are as follows:

- Those making net self-employment income of $80,000 will pay an assessment of $526.67 per month [$80,000 in net self-employment income[37] x (3.95% for the individual portion + 3.95% for the employer's portion = 7.9%) / 12 months]. If they also claim 2 dependents, he or she will pay an additional $133.33 per month for a total monthly premium of $660.

- Those making net self-employment income of $100,000 will pay an assessment of $658.33 per month [$100,000 in net self-employment income x *(3.95% for the individual portion + 3.95%* for the employer's portion = 7.9%) */ 12 months].* If they also claim 2 dependents, he or she will pay an additional $166.67 per month for a total monthly premium of $825.

- Those making net self-employment income of $150,000 will pay an assessment of $987.50 per month [$150,000 in net self-employment income x *(3.95% for the individual portion + 3.95%* for the employer's portion = 7.9%) */ 12 months].* If they also claim 2 dependents, he or she will pay an additional $250 per month for a total monthly premium of $1,237.50.

- Those making net self-employment income of $200,000 will pay an assessment of $1,122.92 per month [*((3.95% for the "employee" portion + 3.95%* for the "employer" portion = 7.9%) x the first $150,000 in self-employment income/12 months = $987.50) + (3.25% of the remaining $50,000 in self-employment income/ 12 months = $135.42)]. If they also claim 2 dependents, he or she will pay an additional $333.33 per month for a total monthly premium of $1,456.25.

However, there is a one additional item to note: There is a <u>minimum assessment amount for self-employed individuals</u>. If the self-employed individual reports a loss on their business activity for the year for federal income tax purposes, or any net self-employment income amount below what they would have earned on a job earning the federal minimum wage for the year *(currently $7.25 per hour x 2,080 hours worked annually = $15,080)*, they must pay, at a minimum, 3.95% of $15,080 + an additional amount representing the employer's contribution for the same amount. Therefore, the total they would need to pay, at a minimum would be $1,191.32 annually or $99.28 monthly. If they are able to make these payments, they will be able to stay with their current group insurance provider. However, if they are unable to make the premium payments, they will be assigned to the "general pool".

In addition, if the self-employed individual, reports less than $15,080 *(currently the total annual earnings for an individual earning the federal minimum wage for a year)* for four successive years, the individual will be assigned to the general pool until their employment situation changes.

It is very important to realize, that one additional benefit realized after making the required health care assessment payments, is that the self-employed individual will not need to go out and obtain <u>and pay for</u> a health insurance policy. That coverage is included in the assessment.

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[37] This is net taxable income prior to the reduction for the amounts paid for the health care assessment.

WEALTHY INDIVIDUALS

Under current rules for funding the Affordable Care Act (the Act) *(otherwise referred to as "Obamacare")* the wealthy pay an additional tax of 3.8% on the lesser of their net investment income *(interest, dividends, capital gains, rental and royalty income, etc.)* or modified adjusted gross income above a specified amount *($200,000 for individuals and $250,000 for joint tax return filers)*. However, after paying this tax, they must still pay premiums for their own health insurance. This proposal suggests that the 3.8% tax be eliminated. In lieu of that tax a single individual, will pay a health care insurance assessment of 7.9% *(3.95% for their portion + 3.95% for the employer's portion had they been a waged employee)* of their first $150,000 in income and 3.25%[38] on their income from $150,001 up to $500,000. And this assessment will pay their premiums for their health care insurance.

To demonstrate the difference between the current rule and the changes being proposed, let's look at the resulting tax/assessment under the current rule and under the one being suggested for a single wealthy individual with $1,200,000 of net investment income that has earned no wages.

- Under the current rule, a single wealthy individual will pay 3.8% in tax on $1,000,000 of net investment income ($1,200,000 - $200,000). That tax will amount to $38,000 (3.8% x $1,000,000). In addition, that single individual will need to pay for his or her own health care insurance. Let's assume that he or she will pay $300 per month for a total of $3,600 for the year. Therefore, that individual's total annual costs related to health care insurance will be $38,000 in tax + $3,600 in health care insurance premiums = $41,600.

- Under this proposal, a single individual will pay an annual assessment of $23,225 [(7.9% on the first $150,000 = $11,850) + (3.25% of the additional assessable amount of $350,000 ($500,000 cap on assessable income - $150,000) = $11,375)[39] and they will not need to pay any further premiums for health care insurance. This is difference of $18,375, which is nearly half (45%) of what they will pay under the current rules and the savings will only increase the greater the individual's net investment income.

LAID OFF EMPLOYEES

Under the proposed changes to the Act, a laid off employee will be able to retain his or her insurer provided they were able to pay *(or the employer that laid them off, a relative(s), or another individual or entity is willing to pay)* $99.28 per month [(the federal minimum wage of $15,080 x 7.9%) ÷12 months). If the laid off employee had dependents, they would also pay $12.57 additional monthly for each dependent. And, if it is not possible to make the required payment, the individual would be able to obtain health care coverage in the "general pool".

EARLY RETIREES

How many of us know an individual(s) that wants to retire early and is financially able to do so, but must continue to work to retain their health care benefits until they are eligible for

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[38] See footnote 2.
[39] See note 2.

Medicare. On their own, obtaining health care benefits would be either impossible or cost prohibitive. Now they will be able to stop working when they wish if they have worked hard and had the good fortune to accumulate sufficient monetary resources to do so.

Regarding their costs of obtaining health care insurance under the proposed change(s) those costs would be the same as those presented for wealthy or other non-waged individuals.

UNEMPLOYED FORMER DEPENDENT CHILDREN

What can best be said about the proposed changes to the Act regarding unemployed former dependents? If former dependents are still unemployed after age 21 when they must leave the security umbrella of their parents' health insurance plan, as long as they are able to pay *(or their parents are willing and able to pay)* $99.28 per month *[(the federal minimum wage of $15,080 x 7.9%) ÷12 months)]* they will be able to stay in that plan. And, even if they *(or their parents)* are unable to pay the stipulated monthly fee, they will still receive the coverage that is allotted to those in the general pool.

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

THOSE ALREADY RETIRED AND CURRENTLY IN THE MEDICARE SYSTEM

It is important to note that all those 65 and over that are currently on Medicare will have the option of staying with their current Medicare plan(s), or switching to this proposed plan. Examples of costs under the new plan versus existing costs follow:

First, let's note that the following are the estimated **costs of one individual on Medicare**. In most, **but not all cases**, these costs will not vary for middle class Medicare recipients under a certain threshold. .

Medicare Part A	$ 0
Medicare Part B	137 *(subject to change)*
Medicare Part D	55 *(estimated)*
Medicare Supplement	170 *(estimated)*
Total Estimated Medicare Monthly Costs	$ 362

Retiree's costs under this proposed plan:

	[A] Total Monthly Income	(7.9% of [A]) Total Monthly Insurance
If the retiree's sole income is from Social Security and they receive monthly -	$ 1,000	$ 79
-	1,500	119
-	2,000	158
Retiree's monthly Social Security payment is $1,500		
+ he or she has additional monthly income of $2,000	3,500	277
+ he or she has additional monthly income of $3,000	4,500	356
+ he or she has additional monthly income of $5,000	6,500	514

HEALTH CARE PROVIDERS

A Medical Clearing Corporation (MCC) system would simulate a single payer system for medical care providers. This is because an MCC will possess more interactive and user friendly input collection software, a uniform information collection system with standardized (uniform) documentation requirements, immediate access to insurer payment policies, the ability (of the MCC) to independently render decisions regarding payment and directly access health care and insurer accounts[40] as well as act as a buffer between Health Care Providers and Health Care Insurers.

Hospital costs would be reduced because all U.S. citizens and legal residents entering a hospital's doors would be insured.

In addition, the government, both federal and state, after a certain transitional period, will be completely taken out of the operational picture.

In a nutshell, health care providers will find the collection process greatly simplified and realize a considerably reduced collection period. These two factors should allow the providers significant savings in collection time and costs.

HEALTH CARE INSURERS

Besides the benefits *(tax cuts, low cost loans, etc.)* that may be provided by federal and state governments as incentives to form group health insurance plans, and the obvious benefit for existing insurers of not being put out of the health care insurance business as they would if "Medicare for All" is adopted, insurers will also realize the following benefits:

- Because all U.S. citizens and legal residents will be required to join large group health care plans, insurance premium revenues will increase dramatically. This may not be readily apparent since group insurers will be required to insure a certain amount of non-income producing individuals in the general pool for free *(but still receive government subsidies for them)*. However, the costs incurred for these individuals should be offset by larger income earners also participating in their group. The ultimate result will be a suitable average premium per insured, but, again, with a larger number of those insured. For the estimated average premiums to be received for all those in the group see Part D of this proposal.

- Medical Clearing Corporations (MCCs) will significantly increase the ease *(and therefore reduce the cost)* at which insurance premiums are received.

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[40] Direct access to insurer accounts would not be immediate. A daily report would be transmitted by the MCC to each insurance group with the premiums that it had received on the group's behalf for the day less any charges for claims against the group for medical services or goods provided that have been submitted by health care providers and approved for payment by the MCC. The group's designated bank account would be credited/charged for the daily net amount on the following business day.

- Since all individuals will need to select a group health care insurer, those insurers will find that they have a ready market for other insurance products marketed by affiliated insurance entities.[41] For example:
  - Worried about future layoffs? For an extra $XX per paycheck we will pay your health care insurance premiums for the first six months *(or year)* that you are laid off.
  - Want to retire early? For an extra $XXX each paycheck *(or per month)* you may receive a future payment of $XXX per month after age XX, etc.

Insurers would be able to distinguish their plans from others by the rating(s) that they receive from the MCC or other independent rating services, or by reducing the premiums they charge for coverage *(the cost of their insurance)*. For, although it would be quite difficult to reduce assessments of insurance premiums for individual health care insurance groups during the assessment collection process, premiums might be rebated at some point after the end of the tax period to those qualifying for them based upon the group insurer's criteria. For example, the rebates might come in the same format as an income tax refund.

There should be certain restriction on insurance companies, primarily to prevent undue influence by one insurer in the health care insurance market – restrictions such as: no one insurance company would be able to establish, own and run more than 3 health insurance group plans; and the size of those plans must be a minimum of 50,000 and a maximum of 1,000,000 insured individuals.

STATE AND FEDERAL GOVERNMENT

If this proposal is adopted, the federal government would be required to contribute to each health care insurance group $3,750 for every insured in the group. Based upon an estimated US population of 330,000,000[42] that would cost the federal government $1.24 trillion, which is far less than what they are projected to spend in the not-too-distant future. State governments would be required to contribute to group plans a per capita amount of $750 for every insured in their state. This would result in a total subsidy from all states of $247.5 billion, which is also not far from what they are projected to pay for Medicaid in the near future.[43] In fact, the only other costs that may increase if these changes are accepted and implemented would be transitional costs and the cost of regulating health care insurers. However, the latter may be completed by state agencies, which currently perform the lion's share of this effort. In addition, after a period of time, other US departments associated with the funding and operational functions of Medicare, Medicaid and Chip (CMS) may be slowly eliminated.

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[41] All insurance products offered to those insured in a group health care plan need not be from the same entity. Insurance products from other entities may be bundled when offered to those currently insured for health care.

[42] Even though the income data from 2014 is being used, the actual population was estimated to be slightly less than 330,000,000 at April 2020 . However, the per capita contributions would remain unchanged. Therefore, the numbers that are being used are more conservative than what the actual totals would be.

[43] The above estimated totals still do not include the amounts paid for federal and state employees, which would be covered under this plan.

PART D – THE NUMBERS: HOW IT WILL ALL WORK

U. S. STATISTICAL INFORMATION USED

To prove the monetary feasibility of this proposal it was necessary to use data from 2014, that being the last year in which the required information from both the Internal Revenue Service (IRS) and the Social Security Administration (SSA) was available at the time this proposal was written. However, since the purpose of this exercise is to determine that the provisions of this proposal will be sufficiently funded, the following amounts presented are conservative, as the results will only be greater for 2015 - 2019. All information summarized herein is presented in more detail in Appendix A.

Summary of funding information

	Total projected Assessments/Subsidies	% of Total
7.9% of wages per SSA for 2014 *(3.95% Employer + 3.95% Employee)*	$ 513,486,640,832	24.05%
3.25% of other income per IRS summary of tax return information filed for the year ended 2014	66,863,620,330	3.13%
Estimated premiums paid for dependents	69,584,362,916	3.26%
Totals from non-governmental funding	$ 649,934,624,078	30.44%
Federal and state government subsidies –		
Federal government *(per capita subsidy of $3,750 for every insured in each insurance group) (using 330,000,000 as U.S. Population in 2020)*	$ 1,237,500,000,000	57.97%
State Governments *(per capita subsidy of $750 for every insured in each insurance group) (to be paid based upon the number of insured in each state)*	247,500,000,000	11.59%
Totals from governmental funding	$ 1,485,000,000,000	69.56%
Totals from all funding	$ 2,134,934,624,078	100.00%

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

Potential per capita premiums for all U.S. Citizens

(based upon all the foregoing information)

U.S. Population Estimate April 2020 *(rounded upward)*	330,000,000
Estimated annual premium to be realized for every insured *(totals from all funding ÷ U.S. Population 2020)*	$ 6,469[44]
Estimated monthly premium *(annual premium ÷ 12)*	$ 539
Estimated annual premium to be realized for a family of four	$ 25,876[45]

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[44] This amount is less than the average annual premiums charged for employer-sponsored health care insurance in 2020 of $7,470 for single coverage. *(per the Kaiser Family Foundation "2020 Employer Health Benefits Survey")* That amount is $1,001 greater than the amount presented above. However, there are commissions included in those premiums *(and profits)* and, it is assumed that once insurers determine the increased number of insured that they may now gain in their groups *(possibly greater than double their current number of insured)* the commission average and average profit per capita (per insured) may decrease due to the increase in volume of their business.

However, if the above assumption is incorrect, the required $1,001 increase (or less) to the above stated estimated premiums may be still covered by increases in both federal and state subsidies that will still be less than what federal and state governments are projected to pay in the not-so-distant future.

Insurers might also consider that if the federal government expands Medicare to cover those not yet 65 years of age *(expanding Medicare to cover all, with no deductibles as certain progressives suggest)*, or lowering the age of eligibility for Medicare, which is currently being proposed by many, those insurers will have little, or no market whatsoever.. This possibility may make insurers more negotiable.

[45] This estimated monthly premium for a family of 4 stated above is actually $4,534 higher than that stated for family coverage *(per the Kaiser Family Foundation "2020 Employer Health Benefits Survey")* that is referred in note 46 above. This fact should also make insurers more negotiable.

A HEALTH CARE PLAN ALTERNATIVE TO "MEDICARE FOR ALL"

(continued)

In addition to the numbers on the previous pages, certain sources of funding mentioned in Part B of this proposal have not been presented in this section due to the difficulty of determining the total assessments to be realized from these sources. However, the amounts, although not as significant in relation to the sources of funds to be realized from the assessment of payrolls and other income, would still be an addition to the amounts presented and would therefore, only further increase the argument for the feasibility of this proposal.

Additional sources of funding not further explored and presented in this section:

- Assessments computed and received from laid off employees
- Assessments received from former dependents over the age of 21 and still not employed

Note: Regarding currently computed per capita U.S. health care expenditures presented in the news media, these annual totals are far in excess of the annual per capita premium computed on the prior page. However, 37% of the payments for these expenditures are made by Medicare and Medicaid and the abuses (such as provider fees paid to state governments, the inability to negotiate for the costs of prescription drugs, etc.) have inflated these costs significantly in the last two decades.

As an additional note regarding currently computed per capita U.S. health care expenditures presented by the media (above); employer provided health care insurance, which provides coverage for 157 million Americans (an estimated 47% of the U.S. population) have premiums significantly lower than the cost estimates presented by the media. If "for profit" insurers (whose premiums also contain built in commissions) are significantly less that what the media is touting, even taking into consideration deductibles, shouldn't that be a better indication of health care expenditures in the U.S.?

In addition, since health care providers have been made to negotiate with insurers for the equipment, goods and services they have provided, the standard practice of providers has been to inflate their fees in order to obtain a favorable result after negotiations with the insurer are concluded. The publication of fees that will be paid by health care insurers for each good or service must be made readily available to the health care provider prior to their rendering of any good or service; the fact that this information will be made more public and easily assessable; and the establishment of Medical Clearing Corporation(s) that will ultimately render payment decisions, should significantly reduce all per capita costs to be published in the future..

Note: Regarding the ever escalating cost of prescription drugs; at this point in time it is assumed that since drug importers and manufacturers would be dealing with insurance companies and not the federal government, these costs should diminish over time. However, if this assumption does not bear fruit within a reasonable period of time, the approach of the Canadian government in regulating the cost of drugs should be explored.

PART E – LOOKING DOWN THE ROAD FOR A COMPLETE LIFETIME OF HEALTH CARE, RETIREMENT AND OTHER BENEFITS

IMPLEMENTATION OF THIS PROPOSAL ON A NATIONAL LEVEL

It is not recommended that this proposal be immediately applied on a nationwide basis. Initially, a select group of insurers, health care providers, employers, employees and other insured may be given incentives to enter the program.

For example: One MCC may be established and updated with the software deemed necessary and supplied with the pre-established protocols and required procedures, standardized information and documentation needed to submit a claim for payment of designated medical goods and services, as well as procedures for applying premiums received from employers and other insured to the appropriate insurance group.[46] Several insurers willing to try the system may form insurance groups. Health care providers, employers, employees and other insured would be needed to participate in the initial program. This group may operate for a period of time, fine tuning the system and reporting results.

Alternately, a select region or state might be proposed as the designated group and that chosen region or state might perform the same beta testing as that suggested above.

Then others may be allowed to either join the initial existing group or form new groups, all the while honing the operations of the MCC(s) until, after a period of time, the system has proved itself successful, and, if successful, all others heretofore not participating may then be required to form and/or join new or existing groups.[47]

STANDARDIZED INSURANCE REINBURSEMENT RATES

Initially, when this proposal was first developed, it was decided *(subject to them meeting certain minimum coverage requirements)* to allow insurers discretion in the amount of medical and other health care fees that they reimbursed the health care provider(s). It was assumed that, by making insurers' reimbursement rates accessible to the public, the market would force more competition among insurance groups. However, many hospitals have "gamed" the system, negotiating higher reimbursement rates with insurers for themselves and medical care providers within their groups. They have entered into Non-Disclosure Agreements (NDAs) with insurers that are not made public, even to the U.S. and state governments. Many NDAs also require insurers to forward potential patients to those in their group and not necessarily to the best physician for that patient's needs. This has forced many, many health care practitioners not within the hospital's group out of private practice and/or into joining the hospital's group. In one instance *(hopefully an extreme one)* in which the author of this proposal is familiar, the hospital group mandated that a physician belonging to their group terminate the employment of his entire staff and accept their (the group's) replacement staff.

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[46] These protocols and other procedures may be jointly established by all members of the initial group, together with input from the executive and legislative branches of government.

[47] Naturally, those currently under the Medicare umbrella may elect to stay with that system.

For the foregoing reasons, and for purposes of greater transparency) this proposal has been amended to require all insurer reimbursement fees be standardized and strongly recommends that the hospitals' practice of entering into NDAs with insurers to be prohibited or extremely restricted as to their content.

COMBINING HEALTH CARE BENEFITS WITH FUTURE RETIREMENT AND OTHER BENEFITS

Note: What is being suggested hereafter is not a proposal in which immediate action is recommended. However, if this proposed health care system proves successful, perhaps further adjustments to our social services systems might be anticipated.

It was never intended that the proposed assessment for health care insurance be just one more assessment *(or tax)* to be borne by taxpayers. In the long run, what is foreseen is the displacement of our current Social Security and Medicare, Medicaid and Chip systems.

To further clarify, what if large group health plans promoted in this proposal *(or their affiliates)* also offer retirement and other benefits similar to those that are provided by Social Security? Currently, employers and employees each contribute 6.2% of the employee's wages *(a total of 12.4% on wages up to $137,700 for 2020)* in Social Security taxes. *(This amount is included with the previously mentioned 1.45% each that employers and employees – totaling 2.9% collectively - contribute in Medicare taxes – with no income ceiling.)*

Naturally, the above would only apply to: those earning wages, full and part time employees; those currently unemployed *(but intending to be employed as some point in the future)*; and self-employed individuals. It would not apply to retirees, early retirees and the wealthy. The amount to be assessed (12.4%?) would only apply to wages, the amounts previously designated for unemployed individuals and self-employment income - no other income.

Therefore, in essence, what it being suggested is: the replacement of the tax of 7.65% on every employee and self-employed individual for Social Security and Medicare benefits and the tax of 7.65% on every employer and self-employed individual for Social Security and Medicare benefits; with an assessment of less than 10% on each of the two parties for current and future health care benefits and benefits similar to those currently offered by Social Security.[48]

Collection of the above assessments could be forwarded through MCCs to the appropriate party, just as health care insurance assessments would be under this proposal.

The above suggestion is just something to keep in mind for the future, depending upon the success of this proposed universal health care plan.

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[48] We realize that the 6.2% for Social Security benefits and the suggested assessment of 3.95% for current and future health care benefits total 10.15%, but it is assumed that for-profit insurers would be able to provide the same benefits for 6% or less, thereby rendering an assessment of less than 10% on all wages for both benefits.

A FINAL NOTE

Will everyone be pleased with the effects of this proposal? Definitely not! But, at this point in time, what are our alternatives? The proposed method(s) will "hurt" the least and extricate our governments, both federal and state, from a future financial crisis while providing adequate health care for all.

Would there be abuses under a comprehensive non-governmental health care insurance system? Definitely! But compared to what we have now; compared to what will result if nothing is done; or compared to the abuses and gross inefficiencies that would result if a national health care plan were adopted that would be provided by federal and/or state governments, potential abuses under this proposed plan would pale in comparison.

And during the learning curve under this proposed system, legislation might be enacted or regulations established periodically to tweak and fine tune any perceived deficiencies.

APPENDIX A - DETERMINATION OF PER CAPITA PREMIUM FUNDING

IRS SOI Tax Stats - Individual Statistical Tables by Size of Adjusted Gross Income

Individual Income Tax Returns Filed and Sources of Income

Table 1.1. All Returns: Selected Income and Tax Items, by Size and Accumulated Size of Adjusted Gross Income, Tax Year 2014 (Filing Year 2015)

From IRS info from 2014 Form 1040						**From IRS 2014 Return Info**	
Adjusted Gross Income ≤ $500,000		$ 8,042,077,206,000	AGI	*(Excluded negative AGIs)*		All AGIs $500,000 or less ==>	$ 7,844,386,412,000.00
Add backs *(all under $500,000)* :						Negative AGIs **added back** ==>	197,690,794,000.00
Tax Exempt Interest		37,943,167,000					$ 8,042,077,206,000.00
Self employed health insurance deduction		24,224,761,000	<====	$23,544,516,000 + $680,245,000 (from returns reflecting losses)			
Adjusted AGI		$ 8,104,245,134,000					
Less Wages ≤ $500,000	[C]	$ (6,046,902,970,000)	<====	*This amount differs with the amount on page 2 by $452,927,926,606. The amount from the IRS data was used since the amounts above are taken from the IRS data. This is almost a 7% difference. (The IRS was using estimates.)*			
Other non-wage income		$ 2,057,342,164,000	[F]				
[F] x 3.25% *(Assessment rate)*		$ 66,863,620,330	[G]				
Total premiums from Wages	[E]	$ 513,486,640,832					
Total premiums from Other non-wage income	[G]	66,863,620,330					
Estimated Premiums paid for dependents	[T]	69,584,362,916	<====	See [T] on page three.			
		$ 649,934,624,078					

Governmental Assessments

The federal government contributes $3,750 per insured in each group	$ 1,237,500,000,000	57.97%
The state governments contribute $750 per capita to each group *(based upon the number of insured in their specific state)* The total assessment for all states will be ====>	247,500,000,000	11.59%
Non-governmental funding (wages, other income, etc.)	649,934,624,078	30.44%
Total governmental and non-governmental funding	$ 2,134,934,624,078	100.00%

Annually	$ 6,469	*These are the average annual and monthly per capita premiums available. However, they are not guaranteed. It is essential that the profit motive remain present. Otherwise customer service would be drastically impaired .*
Monthly	$ 539	
Population estimate April 2020 =	330,000,000	

APPENDIX A - DETERMINATION OF PER CAPITA PREMIUM FUNDING

FROM WAGE AND STATISTICS DATA FOR 2014
PUBLISHED BY THE SOCIAL SECURITY ADMINISTRATION JANUARY 24, 2017

Compensation Interval	Aggregate Amount	Times Employers' 3.95% & Employees' 3.95% Assessment *(Total Assessment = 7.9%)*	1% of 2.9% in Medicare Taxes
$ 0.01 ----> 4,999.99	$ 46,647,919,125.68	$ 3,685,185,610.93	$ 466,479,191.26
$ 5,000 ----> 9,999.99	102,586,913,092.61	8,104,366,134.32	1,025,869,130.93
$ 10,000 ----> 14,999.99	153,566,802,438.45	12,131,777,392.64	1,535,668,024.38
$ 15,000 ----> 19,999.99	200,878,198,035.07	15,869,377,644.77	2,008,781,980.35
$ 20,000 ----> 24,999.99	245,317,570,246.88	19,380,088,049.50	2,453,175,702.47
$ 25,000 ----> 29,999.99	279,865,461,187.05	22,109,371,433.78	2,798,654,611.87
$ 30,000 ----> 34,999.99	307,828,947,411.16	24,318,486,845.48	3,078,289,474.11
$ 35,000 ----> 39,999.99	321,200,755,103.44	25,374,859,653.17	3,212,007,551.03
$ 40,000 ----> 44,999.99	320,563,569,965.15	25,324,522,027.25	3,205,635,699.65
$ 45,000 ----> 49,999.99	310,391,706,424.23	24,520,944,807.51	3,103,917,064.24
$ 50,000 ----> 54,999.99	300,016,377,448.51	23,701,293,818.43	3,000,163,774.49
$ 55,000 ----> 59,999.99	278,354,367,841.41	21,989,995,059.47	2,783,543,678.41
$ 60,000 ----> 64,999.99	262,203,932,128.68	20,714,110,638.17	2,622,039,321.29
$ 65,000 ----> 69,999.99	240,948,179,180.40	19,034,906,155.25	2,409,481,791.80
$ 70,000 ----> 74,999.99	224,145,278,103.36	17,707,476,970.17	2,241,452,781.03
$ 75,000 ----> 79,999.99	207,853,372,824.62	16,420,416,453.15	2,078,533,728.25
$ 80,000 ----> 84,999.99	189,370,862,869.17	14,960,298,166.66	1,893,708,628.69
$ 85,000 ----> 89,999.99	172,719,042,418.70	13,644,804,351.08	1,727,190,424.19
$ 90,000 ----> 94,999.99	158,442,931,588.44	12,516,991,595.49	1,584,429,315.88
$ 95,000 ----> 99,999.99	144,858,203,365.61	11,443,798,065.88	1,448,582,033.66
$ 100,000 ----> 104,999.99	134,083,282,259.67	10,592,579,298.51	1,340,832,822.60
$ 105,000 ----> 109,999.99	120,020,513,136.11	9,481,620,537.75	1,200,205,131.36
$ 110,000 ----> 114,999.99	109,855,105,705.14	8,678,553,350.71	1,098,551,057.05
$ 115,000 ----> 119,999.99	101,693,061,676.62	8,033,751,872.45	1,016,930,616.77
$ 120,000 ----> 124,999.99	94,660,281,091.31	7,478,162,206.21	946,602,810.91
$ 125,000 ----> 129,999.99	85,886,152,964.93	6,785,006,084.23	858,861,529.65
$ 130,000 ----> 134,999.99	78,899,843,713.01	6,233,087,653.33	788,998,437.13
$ 135,000 ----> 139,999.99	72,476,546,845.30	5,725,647,200.78	724,765,468.45
$ 140,000 ----> 144,999.99	66,519,743,635.12	5,255,059,747.17	665,197,436.35
$ 145,000 ----> 149,999.99	61,787,674,520.19	4,881,226,287.10	617,876,745.20
$ 150,000 ----> 154,999.99	58,607,775,121.57	4,630,014,234.60	586,077,751.22
$ 155,000 ----> 159,999.99	52,801,735,517.69	4,171,337,105.90	528,017,355.18
$ 160,000 ----> 164,999.99	48,087,213,596.86	3,798,889,874.15	480,872,135.97
$ 165,000 ----> 169,999.99	44,426,198,104.69	3,509,669,650.27	444,261,981.05
$ 170,000 ----> 174,999.99	41,304,379,348.95	3,263,045,968.57	413,043,793.49
$ 175,000 ----> 179,999.99	38,370,042,895.27	3,031,233,388.73	383,700,428.95
$ 180,000 ----> 184,999.99	36,588,064,085.78	2,890,457,062.78	365,880,640.86
$ 185,000 ----> 189,999.99	33,554,727,208.93	2,650,823,449.51	335,547,272.09
$ 190,000 ----> 194,999.99	31,807,897,759.84	2,512,823,923.03	318,078,977.60
$ 195,000 ----> 199,999.99	30,425,466,536.83	2,403,611,856.41	304,254,665.37
$ 200,000 ----> 249,999.99	230,863,458,226.21	18,238,213,199.87	2,308,634,582.26
$ 250,000 ----> 299,999.99	153,945,762,663.99	12,161,715,250.46	1,539,457,626.64
$ 300,000 ----> 349,999.99	107,708,119,615.81	8,508,941,449.65	1,077,081,196.16
$ 350,000 ----> 399,999.99	82,117,070,706.61	6,487,248,585.82	821,170,707.07
$ 400,000 ----> 449,999.99	63,997,346,472.50	5,055,790,371.33	639,973,464.73
$ 450,000 ----> 499,999.99	51,583,042,398.64	4,075,060,349.49	515,830,423.99
	$ 6,499,830,896,606.19	$ 513,486,640,831.89	$ 64,998,308,966.06
	[C]	[E]	

APPENDIX A - DETERMINATION OF PER CAPITA PREMIUM FUNDING

IRS SOI Tax Stats - Individual Statistical Tables by Size of Adjusted Gross Income

Individual Income Tax Returns Filed and Sources of Income

Table 1.1. All Returns: Selected Income and Tax Items, by Size and Accumulated Size of Adjusted Gross Income, Tax Year 2014 (Filing Year 2015)

Income Interval	Average Income For Range [P]	Excess Exemptions Claimed [R]	
$ 0.01 ----> 4,999.99			
$ 5,000 ----> 9,999.99		*Ignore*	
$ 10,000 ----> 14,999.99			
$ 15,000 ----> 19,999.99	$ 17,453.59	6,142,533	$ 1,072,092,525
$ 20,000 ----> 24,999.99	22,465.53	6,257,174	1,405,707,302
$ 25,000 ----> 29,999.99	27,415.01	5,600,969	1,535,506,211
$ 30,000 ----> 39,999.99	34,760.09	10,308,716	3,583,318,959
$ 40,000 ----> 49,999.99	44,798.44	8,776,338	3,931,662,513
$ 50,000 ----> 74,999.99	61,458.02	17,431,086	10,712,800,320
$ 75,000 ----> 99,999.99	86,671.31	15,033,709	13,029,912,532
$ 100,000 ----> 199,999.99	134,947.85	25,427,128	34,313,362,553
$ 200,000 ----> 499,999.99	*No assessment on income over $200,000 for dependent coverage*		
			$ 69,584,362,916 [T]

[P] This amount was determined by taking the total adusted gross income listed for each group ÷ the number of tax returns listed for the same group. *(This amount will be off somewhat because it does not include the additions to Adjusted Gross Income that are used to determine the assessment on "Other non-wage income" that is on the preceeding page.)*

[R] These are the exemptions claimed on the IRS schedule, less 1.25 x the total number of returns for that income range. This assumes that a husband and wife are claiming themselves on a joint return on one out of every four tax returns. This procedure is intended to eliminate all exemptions except those of dependent children.

APPENDIX B -Deductibles and Maximum Out-of-Pocket Amounts for Various Income Levels

[A] Modified Adjusted Gross Income	[B] Deductible %	[C] Deductible Amount Per Person Isured	[D] Maximum out of Pocket Amount % Per Person Insured *	[E] Maximum $ Out of Pocket Amount per Person Insured *
$ 50,000.00	1.50%	$ 750.00	3.00%	$ 1,500.00
$ 80,000.00	1.50%	$ 1,200.00	3.00%	$ 2,400.00
$ 100,000.00	1.50%	$ 1,500.00	3.00%	$ 3,000.00
$ 150,000.00	1.50%	$ 2,250.00	3.00%	$ 4,500.00
$ 200,000.00	1.50%	$ 3,000.00	3.00%	$ 6,000.00
$ 300,000.00	1.50%	$ 4,500.00	3.00%	$ 9,000.00
$ 400,000.00	1.50%	$ 6,000.00	3.00%	$ 12,000.00
$ 500,000.00	1.50%	$ 7,500.00	3.00%	$ 15,000.00

* This is 2 times the deductible amount per person insured (2 x [C])

Maximum out of pocket costs at these income levels might be capped at lower amounts.

This deductible is **per person covered** by the payer's withheld payments. Example [X]: A father with adjusted gross income of $100,000 and two dependent children covered by his insurance would have a deductible amount of $1,500 per person insured. Therefore, if he and both his children required medical services, the deductible amount for all of them would be $4,500 ($1,500 for each insured person x 3 people). Thereafter he would pay 20% of medical expenses for each up to his maximum out of pocket amount.

This total out of pocket amount is per person covered by the premium payer. Using the same example [X] to the left: A father with adjusted gross income of $100,000 and two dependent children covered by his insurance would pay the deductible amount, for each insured person requiring medical services, of $1,500 each and then 20% of medical expenses until he had paid out his maximum out of pocket amount of $3,000 per person insured. If the father and both dependent children all incurred significant medical expenses, the maximum out of pocket amount for this family unit (father + 2 children) would be $9,000 (3 x $3,000). Thereafter, all his medical expenses would be borne by the insurer.

The insured would be allowed to contribute pre-tax to an account similar to an Health Savings Account (HSA) up to the maximum amount of their out of pockets costs for all those that they have insured. Then they will only be able to replentish this account when the account balance falls below that amount.