COVERAGE FOR ALL
A Realistic Middle Path to Universal Coverage and Reform

The United States is the only advanced industrialized country in the world without some form of universal coverage. Numerous proposals have been put forth to transform U.S. healthcare and provide universal coverage, the most recent and high profile being the Medicare for All proposal offered by Sen. Bernie Sanders. Medicare for All would radically transform our healthcare system and end our private insurance industry, among other significant changes.

Coverage for All takes a different approach. Instead of ending our current healthcare system, it works within the system. It changes one key element, who collects funds for healthcare, but leaves the rest of our healthcare economy generally in place. Because it is designed to work within the healthcare system we have, it has a legitimate chance of being implemented and working. Coverage for All is by far our best chance to finally achieve universal healthcare coverage in the U.S.

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A VIABLE PATH TO UNIVERSAL COVERAGE

What follows may be the only realistic approach to achieving universal health coverage in the United States.

To summarize: The federal government collects a tax from individuals and businesses sufficient to provide on average $5,000 for healthcare for every person not on Social Security or in the VA system. The $5,000 credit, paid through the ACA system, can be supplemented to purchase broader healthcare coverage. Each person decides which organization spends their credit.

This approach to universal coverage has a chance of working because:

- It sidesteps what, for many people, is the most concerning part of healthcare reform, putting the federal government in charge of people's care, and by extension, who lives and who dies. The federal government is in charge of collecting the funds for healthcare, which are distributed through the Affordable Care Act portal, but not spending them.

- It doesn't end the existing health insurance industry that tens of millions of Americans currently rely upon. It shaves off a part of the process, collecting funds for healthcare, and gives that responsibility to the Federal Government, however leaves in place our existing system for spending healthcare dollars.

- It allows employers and unions to supplement the credit to provide the better health insurance that their employees and members have sacrificed for and expect.

- It doesn't force the end of our existing fee for service care provider system. While it supports capitation and Independent Care Networks, it doesn't force a change in how and how much doctors and hospitals are currently compensated.

- While it leaves in place the existing system, the funding mechanism also enables the use or development of alternative approaches to providing and paying for healthcare that can be tailored to the many different realities facing different communities and populations.

- With a defined revenue stream, communities, populations and care providers can re-imagine how healthcare is provided to increase access, reduce bureaucratization and re-establish the relationship between patients and care providers.

- It doesn't try to create a system where everyone gets the same level of care. Rich people will continue to get better care than poor people, and the responsible will continue to get better care than the irresponsible. But it will ensure that every person has access to basic healthcare, free of direct cost. It will ensure the universal coverage we currently lack.

- It will change how people think about their healthcare spending and the tradeoffs necessary for lower costs, and will create tens of millions of new healthcare consumers interested in low cost healthcare solutions. It enables insurers, HMOs and other healthcare payors to offer lower-cost plans with defined rationing and limitations on liability, to meet the demand for lower cost coverage.

HOW THE CREDIT WORKS

The Federal Government collects taxes, from individuals based on their income and from businesses based on their US revenue, sufficient to provide a credit of, on average, $5,000 for every person not on Social Security or in the Veterans Administration system. The credit amount is adjusted up or down using CMS' formula for regional weighting. Residents of higher cost states will receive slightly more, with residents of lower cost states receiving slightly less than $5,000.

Medicare continues to provide coverage to Seniors, paid for by the existing Medicare tax, and veterans continue to receive care from the Veterans Administration, paid for through the Department of Defense budget. Veterans may choose to transition off of VA care onto the credits.

There are approximately 340 million people in America, including minors, less 70 million on Social Security and 16 million in the VA system, leaving 254 million Americans to be covered. At $5,000 each, that's $1.27 trillion. Our current annual non-Medicare, non-VA spending on healthcare is approximately $3.8 trillion.

The credit can only be paid to qualified entities in our healthcare system, through the existing Affordable Care Act portal for distributing credits. They can be paid to health insurers, Taft-Hartley plans, a health maintenance organization, an integrated care network, an association health plan, a health payment cooperative or a state or community-managed health plan. The credit can NOT be used to fund a health savings account – every dollar has to go towards insurance or a care network.

How the $5,000 credit is spent:

- People have the option of contributing a part of their credit to the Emergency Care Fund
- A portion of everyone's credit goes to a High Risk Fund for hemophilia, etc.
- The balance is used for hospital and primary care
- The credit is paid directly by the government to the designated insurer or care provider
- Parents or guardians designate the insurer or care provider for their children
- If a person chooses insurance, to the person's insurer of record
- If a person chooses capitation, to the person's care network of record
    - All can go to a network providing primary and hospital care
    - Or divided between the person's hospital care and primary care provider
- If no insurer or care provider network is selected, 100% goes to emergency care fund

The $5,000 credit can be supplemented with additional funds. Employers could offer additional payment for employees that choose to use the employer's designated insurance or care approach. Unions could also supplement for its members that choose to participate in the Union's Taft-Hartley plan. Individuals may choose to supplement the credit to be able to afford more expensive health insurance, or to purchase additional coverage if they choose capitation.

Maintaining the coverage of an existing employer-funded healthcare plan will require approximately $4,000 in additional funding. The government credit provides a level of care equivalent to Medicaid, ensuring basic medical coverage. If an individual's credit is not supplemented, the credit will provide that individual funds sufficient for basic coverage for primary care and hospitalization, however will be unlikely to cover more expensive treatments.

HOW CREDITS ARE USED BY EXISTING POPULATIONS

As noted, the goal of Coverage for All is to fit seamlessly into our existing healthcare system, to address one specific issue, universal coverage, while also providing a foundation for innovations in our healthcare system. Following is a summary of how the credit works with different populations.

POPULATION	USE OF CREDITS
Medicare	No change, remain on existing Medicare, funded by existing Medicare tax. Continue existing fee for service care, administered by CMMS
Medicaid	Credit replaces existing federal funding to state-administered Medicaid programs. Medicaid recipients can choose to remain in their existing state Medicaid program, with credit paid to the program, or can seek coverage elsewhere. If they remain in state Medicaid program, their credit is supplemented by the State's spending on Medicaid. If they leave program, lose access to the state's supplemental program.
Veterans	Can choose to remain in the existing VA care system, or can opt into the credits. If they chose credits, they are subject to the individual taxes that fund the credit, and will need to select a different care approach/provider.
Employees receiving Health Insurance through their Employer	Can choose to remain in their existing employer-funded health insurance or can leave their employer insurance and select a different care approach/provider. If they leave, they likely lose the employer's supplement to their healthcare costs. Maintaining existing employee coverage will require supplemental funding of approximately $4,000 on average. Currently employers pay 74% to 80% of their employees' premiums. Employers can elect to require employees to pay a pro rata portion of any required supplemental funding, or employer can contribute the necessary funds. Potentially, employers could end their employer insurance programs, providing no additional supplement or a cash supplement that employees can use with their new plan.
Union Members receiving Health Insurance through their Union Taft-Hartley Plan	Can choose to remain in their existing union-funded Taft-Hartley health insurance or can leave their union insurance and select a different care approach/provider. If they leave, they likely lose the union's supplement to their healthcare costs. Currently unions usually require member contribution towards the member's healthcare premium. Unions can elect to require members to pay a portion of any required supplemental funding, or union can contribute the necessary funds.
People with individual Insurance Policies	Can choose to remain on their current individual insurance plan, whether purchased directly from insurer or through healthcare exchange. If current plan premiums higher that credit, can supplement credit or move to less expensive insurance. Depending on their state, may be able to join the state's Medicaid program, though depending on income likely won't receive the state's Medicaid supplement funding.
Currently Uninsured	Can use credit to secure traditional insurance, potentially secure coverage under their state's Medicaid program, or choose alternative coverage through a provider network. Can choose to supplement credit to receive broader healthcare coverage.

THE FINANCIAL IMPACT

Coverage for All is designed to be financially neutral, not significantly changing how much or how money is spent on healthcare, or who spends that money. Realistically, any time there is a policy change such as this, there are winners and losers. Again, the approach is designed to minimize the financial impact, and thus winners and losers. For most participants, Coverage for All won't change how much they spend on healthcare, it will just re-route that spending, with part of if going to the government in taxes before being returned to them in the form of the credit. However different populations and participants in our system will likely see increases or decreases in what they are currently spending on their own healthcare coverage or the contributions they are making for their employees of clients. The final financial impact will be dependent upon the calculated tax rate necessary to fund the credit, however below is a summary of the likely impact on different participants in our healthcare system.

PARTICIPANT	LIKELY FINANCIAL IMPACT
Medicare	No impact, not included in credit plan
State Medicaid Agencies	All states currently receive federal funds for their Medicaid and associated health plans. Generally, the credit will replace what is currently being paid by the federal government. Potentially Medicaid agencies could open up their plan to people who are above the income threshold; State Medicaid agencies would operate as the equivalent of the Public Option.
Veterans Administration	No direct impact, not included in credit plan. May see some veterans transition to the credit plan
Employers that provide health insurance to their employees	Employer-funded healthcare is a significant expense for those companies that offer health insurance plans. Under Coverage for All, the amount they spend in aggregate on healthcare should be approximately the same. However the spending will be redirected, with a portion of it paid as a tax on their U.S. revenue, used to fund the credit.
Employers that DO NOT provide employee health insurance	Companies that **do not** currently provide health insurance will see an increase in their expenses; they will pay a tax on their U.S. revenue to help fund the credit. Many of these companies benefit from society subsidizing the cost of their employee's healthcare. Under Coverage for All, they will have to contribute their share towards U.S. healthcare costs. They will receive an added benefit from being able to recruit from a larger pool of potential employees; many workers currently won't apply to companies that do not provide health plans.
Employees with Employer-Funded Healthcare	Employees with employer funded plans should see nominal changes in their healthcare spending. They will pay the tax to support the credit, however the credit will replace the money they currently spend on their portion of the premiums for their employer funded plan.
People with Private Insurance	For people that are currently purchasing individual policies through the Healthcare Exchanges or directly from insurers, the financial impact will depend on the coverage they have. If they are currently paying for full coverage, the impact on their spending will be nominal; again, a part will

	be paid as a tax to the government, however the credit they receive will offset the increased tax. If a person has a weak, low-priced plan with minimal coverage, they will likely see their costs increase. However they should also receive broader, better health coverage.
The Uninsured	For the uninsured, the financial impact of Coverage for All will depend on their healthcare situation. If they are heavy users of healthcare and paying out of pocket, their overall spending will likely go down. If they manage to avoid health challenges or visiting the doctor, their spending on healthcare will likely increase. However they will have the peace of mind of knowing that they have healthcare available if they need it.
People on Medicaid	Their spending will likely go up, even if nominally. Currently Medicaid requires no premiums from recipients. Under Coverage for All they will also pay the tax to support the credit. However they will have far more certainty with their healthcare, and will no longer be penalized if their income increases.
Veterans	No change to current VA healthcare, no financial impact. If they choose to exit the VA system and instead receive the credits, they will pay the tax in support of the credit.
People on Medicare	No change to current Medicare, no financial impact

Why Base the Company Tax on US Revenue instead of US Payroll

Under Coverage for All, the company tax in support of the credits would be based on the company's U.S. revenue, not it's U.S. payroll. Yes, companies that hire U.S. workers benefit from having healthy workers. However every company that sells its products or services to U.S. consumers benefits from broader healthcare coverage for Americans, whether they produce domestically or not. U.S. consumers will have more certainty around their healthcare spending, allowing them to use their discretionary income for other purposes. And decoupling healthcare from employment will increase the dynamism vibrancy of our economy, allowing greater economic growth.

Why everyone, even Medicaid recipients, should pay

Ideally, under Coverage for All, every person should pay the healthcare tax, even if they are on public assistance. People receiving a benefit from government should understand the cost of that benefit, and make their contribution. Cost awareness is a key principal of cost control for Coverage for All, and should apply to everyone in our country. Even if the federal government needs to marginally increase public assistance to allow recipients to pay the tax. People need to see money coming out of their pockets for healthcare, even if it is money they first received from the government.

THE IMPORTANCE OF SEPARATING COLLECTOR FROM PAYOR

Coverage for All has a chance of succeeding because it works within the existing healthcare system, instead of ripping it out by the roots. The other critical design decision that increases its

chances of succeeding is something else it doesn't do: put the federal government in charge of individual healthcare spending. It changes one critical element, putting government in charge of collecting the funds to ensure everyone has basic healthcare. However, it sidesteps what, for many people, is the most concerning part of healthcare reform, putting the federal government in charge of people's care.

We tend to view our healthcare system as having two distinct components: payors and providers. However the payor role more accurately includes two distinct function: collecting the funds for healthcare and paying the collected funds for healthcare.

"Who pays" for the healthcare we receive is one of the most contentious questions in healthcare reform. The payor, ultimately, is responsible for rationing care. Inevitably some of these spending decisions result in people being denied care that might improve their health, and in some situations dying from lack of care. The Left demonizes health insurers as payors, suggesting they are denying care to protect their profit at the expense of people's health and wellbeing. For many on the Left, care decisions should never be impacted by profit. The Right demonizes the government as payor. They suggest giving the government the power to decide who receives care and who doesn't, and in extreme cases who lives and who dies, is a radical expansion of the government's control over our lives and our liberties. Government as payor would undermine personal freedom and allow government vendettas to cause people harm. It would lead to a vast expansion of the power of government, something many people are temperamentally against.

The Coverage for All approach largely sidesteps this question. It puts the government in charge of collecting the funds necessary for basic healthcare for every American, but not in charge of spending the collected funds. Instead, each person decides for themselves who actually pays the bills. For many Americans, this will continue to be their existing health insurer, just with part of the money coming from the government. Others, however, will not trust for profit-health insurers. The Coverage for All approach enables a wide range of options for payors. While there won't be a public insurance option overseen by the federal government, some states will offer their own plans, and potentially even some municipalities. As an example, Oregon already offers the Oregan Health Plan, now just limited to Medicaid recipients. With Coverage for All, any person could potentially join the Oregan Health plan, even people above the Medicaid income threshold. Or potentially a person could join a faith-based insurer, such as REDEEM HealthShare Ministry. Or they could join a non-profit healthcare system such as Geisinger Health.

AN EVOLUTION, NOT A REVOLUTION

For some proponents, the attractiveness of Medicare for All is that it rips the existing insurance system out by the roots. It would undo bad healthcare choices made by our country going back to the beginning of employer funded healthcare during World War II and allow us to do it right. For other people, the idea of tearing out our existing system by the roots, while also allowing the federal government to create a new system from the ground up, is terrifying. They might have complaints about the insurance coverage they have now, but it generally works, and for people that have chosen large employers or joined unions, they have made sacrifices to secure good health insurance. Again, seeing the insurance they have taken away for the very large, vague promises that Medicare for All will be even better, is a truly frightening thought.

The advantage of the Coverage for All approach is it wouldn't rip our existing system by the roots. The people that have good insurance, that costs more money, would continue to have good insurance. The for-profit health insurers would continue to operate as they currently do, as would our fee for service healthcare system. Coverage for All wouldn't force people who are reasonably happy with their insurance to change.

This isn't to say, though, that Coverage for All won't result in significant changes to our healthcare system. The defined revenue stream of the Coverage for All approach will also enable new participants and new approaches to healthcare. By changing the dynamic of this one critical part of our healthcare system, collecting the funds for care, the people providing and receiving the care will have the resources and opportunities to re-imagine care delivery in the United States. They will be able to create a new model which addresses their concerns, increasing access, reducing bureaucratization and allowing the relationship between patients and care providers to be re-established. Instead of one answer for everyone, dictated by the government, different communities and populations will be able to use their resources to design a system that addresses their needs and their situation. It won't be perfect, and yes, some groups will make choices that in retrospect were misguided or inefficient, but the choices, and the outcomes, will be theirs. Coverage will all won't revolutionize our healthcare, however it will enable an evolution of our healthcare system.

A MORE HONEST CONVERSATION ABOUT HEALTHCARE COSTS

Coverage for All will not directly impact the other challenge facing our country, rising healthcare costs. It does, however, provide tools and possible structural evolutions that will allow our healthcare system to begin controlling and possibly even decreasing healthcare costs. The starting point for controlling costs has to be a more honest conversation about what is actually driving healthcare costs, why we have the most expensive healthcare system in the world, with only middling health outcomes.

Proponents of single payer healthcare regularly suggest that insurance companies are reason healthcare keeps getting more expensive. They suggest that the insurers create bureaucratic barriers to make it harder for patients to receive the care they need and arbitrarily deny care, all in an effort to increase their profit. This is a recurring refrain: insurers put profit above people, increasing costs and causing worse outcomes. If we eliminate insurers, we will reduce healthcare costs and improve outcomes.

In reality, the insurance providers are the least of the causes driving up healthcare costs. We spend approximately $4 trillion on healthcare every year; the $90 billion in profit for insurance companies is about 2% of our healthcare spending. It's not this 2% that is making healthcare unaffordable. And yes, the need to file insurance claims increases bureaucracy and costs for care providers and insurers, however it wasn't the insurance industry that chose our fee for service model. It was us, the patients, and the care providers themselves. We shouldn't blame insurers for the approach that we consumers, in conjunction with our doctors, selected.

WHAT'S ACTUALLY DRIVING HEALTHCARE COSTS?

More than anything else, it is our **For Profit, Fee for Service Provider Model** that is driving up our healthcare costs, in many different ways:

- Doctors make more money when they recommend more care. In every other profession, the profit motive causes the people selling a product or service to try to sell more of that product or service. If you get an oil change, they suggest a filter replacement. If you have your lawn seeded, they suggest aerating it also. If you buy an easy chair, they suggest buying an end table as well. We naturally assume that the person selling us a product or service has an interest in selling us more, and so we protect ourselves against their pressure to purchase more. However healthcare is a unique field, because the vast majority of us lack the knowledge to evaluate what our doctors tell us. We can remember the last time we replaced the oil filter, or decide if we actually need a new end table. We have virtually no ability to evaluate our doctor's recommendations. We have to trust our doctors, and have no real way of knowing if they are suggesting extra tests, procedures or treatments.

- Pharma Companies and Medical Technology companies have an incentive to introduce new or improved drugs and procedures. Because there is so much money to be made in providing care to people, we have literally thousands of companies working on new ways to spend healthcare dollars. Drugs to address previously unsolved problems, or to improve on current drugs. New ways to fix the things we are already fixing, and to fix things that we used to live with. Ever more tests to diagnose potential issues and maladies. Increasingly, gene therapies that can be targeted to a person's specific genetic makeup. Every year doctors and healthcare companies come up with new procedures to improve on existing treatments, fix maladies we used to have to live with and new technologies to save people that once would have died.

- We as consumers want to try these new drugs and procedures. In comparison to every other health system in the world, the U.S. health system introduces far more new treatments and drugs, and spends far more on these new treatments and drugs. Part of this is driven by the profit motive of the companies offering the new drugs or treatments. But a part of it is our view of healthcare as a consumer good, and our desire to have the latest treatments and drugs promising new, better outcomes. It's not just doctors and care providers recommending more – it's us as consumers asking for more. We have a vast and increasing range of health care services available, and these services are getting used by more and more people.

- Because of the vast number of ways to spend money on healthcare, and our approach of paying doctors and care providers by service, we have a vast, complex coding and billing system. There are over 10,000 separate billing codes, for everything from aspirin to open heart surgery. Adding complexity is that there is no universal price list for private insurers. Instead each insurer negotiates with care providers to set prices. And finally, different insurance plans have different coverages. These three facts – 10,000 different billing codes, prices that vary by provider and differences in coverage by insurance plan – result in an extremely complex and bureaucratic billing process that impacts care in many different

ways. Doctors have to keep detailed notes of everything they plan to bill for, instead of the information necessary for future care. Billing departments have to document all of the different procedures and codes and correlate them to the coverage and authorized payment for each specific insurer. Insurers have to check submitted bills to ensure they are covered and billed at the correct rate. To control costs, insurers require pre-approvals for many procedures, which adds even more complexity to billing. By some estimates, doctors offices spend an estimated 12% of their revenue on billing, with insurance companies spending a matching amount on the bureaucracy on their side. By any measure, the significantly higher level of bureaucracy required by our fragmented, for profit, fee for service approach to healthcare significantly increases healthcare costs.

Liability has an impact. Another factor driving up costs is our legal systems. Doctors and care providers in the U.S. are subject to our tort system, which makes it very easy to be sued for almost any reason. As a result, doctors and care providers in the U.S. face far more lawsuits than doctors in the rest of the world. They pay far more for liability insurance, and this exposure helps drive up healthcare costs. In addition to making more money when ordering more tests and procedures, doctors also have better liability protection when they order more tests and procedures.

We don't evaluate Cost. Adding to the impact of our for profit system is how we evaluate new medical procedures and drugs. While it's starting to change, we do not evaluate cost in deciding whether or not to approve new drugs or procedures. The foundation of our billing system is a Current Procedure Terminology (CPT) code, assigned by the American Medical Association for each new procedure. The AMA does NOT look at the cost of a procedure. Instead, it evaluates if the procedure achieves a medical outcome, and if the procedure is different enough from currently coded procedures to justify a separate code. Medical technology companies apply for new procedure codes because doing so allows them to then ask for a new, and usually higher price. Once a new procedure has a new code, the procedure provider can then apply to Medicare for coverage. Again, while it's starting to change, Medicare does not explicitly base its evaluation on costs. Instead, the provider submits its cost based on its expenses. Medicare has the ability to set a price for Medicare patients to receive the procedure. It is often lower than what the provider has asked for. However once the procedure is approved by Medicare as "medically necessary", the providers are able to negotiate with the private insurance companies for their pricing.

It's about to get worse. As expensive as procedures are now, we are starting to see the approval of a new generation of targeted gene therapies that are exponentially more expensive, costing hundreds of thousands or even millions of dollars. According to a paper by the National Center for Biotechnology Information, prices ".. are now cresting above $3 million dollars". The paper goes on to note that "85 new gene therapies across more than 12 therapeutic areas are expected to receive regulatory approval by 2032, with an estimated ten-year list price spend of $35 to $40 billion". The gene therapies are revolutionary, and again, allow us to save people that otherwise would have died. As an example, children born with spinal muscular atrophy typically do not live beyond the age of two. A new therapy Zolgensma helps correct the disease and gives them a chance to grow up to lead normal lives. The cost of the gene therapy is $2 million per dose. According to Bloomberg News, Lenmeldy, a gene therapy approved in 2024 for treatment of a hereditary condition called early-onset metachromatic leukodystrophy, or MLD, will have a wholesale cost of $4.25 million, which doesn't include the care provider's markup or facility cost.

The Disconnect because of the Insurance Pool. Sometimes in the national conversation it seems as if "society" or "government" are entities separate from the population that pay for healthcare so we don't have to. But health insurance is a risk pool that we all pay into. We all pay to keep ourselves and our neighbors healthy. Each person pays money into the pool and hopes they don't get sick and have to receive care. In any healthcare pool, the majority of people only have nominal spending every year, far less than their contribution. A smaller group requires care that is approximate to their annual contribution, and a small number of the people in the group require care and spending far, far greater than their annual contribution. The average premium cost of a private insurance plan is around $9,000 per person. Treating cancer cost tens of thousands of dollars, and often the costs exceed $100,000. Keeping a premature baby alive can cost more than $1 million just in the first year of a baby's life, and often several million dollars more while they are still infants. As a result, if we need treatment, it's not our money we are spending – it's everyone else's. This structure affects whatever financial calculation there might be. Cost is less of an issue if it isn't costing your money.

The Demonization of the Insurance Industry. When we get sick, we aren't spending our money, we are spending the money of our co-workers and employees, of the other people in the risk pool. However a part of our society distorts this relationship, suggesting we are actually spending the insurance company's money, or if we are on Medicare, the government's money. This further changes the dynamic. The people asking for more care don't see themselves as taking care away from their co-workers or other policy holders. They see themselves as taking the money away from the insurance company. It's not a choice between one's health and everyone else's healthcare, it's a choice between my health and the insurance company's profit. The constant misrepresentation of the role of insurance providers – and their demonization – further undercuts any argument about healthcare costs.

This false demonization of health insurers is one of the reasons reforming healthcare in the United States is so challenging. As a rule of thumb, real reform can only come from real facts, and the fact is that health insurance companies are the least to blame for increasing healthcare costs.

THE HARD TRUTHS OF HEALTHCARE

There are four immutable truths about healthcare, regardless of the system or country:

- No society can afford to spend an unlimited amount of money on healthcare
- No system can afford to spend an unlimited amount of money to keep any one person alive
- The rich will always get better care than the poor
- The responsible will always get better care than the irresponsible

For many people, their concern about Medicare for All is that it seems to deny or ignore these truths. The bill, as written, places no limits on the amount of money to be spent on healthcare, and no limits on the amount that can be spent keeping any one person alive. And it seems particularly intent on ensuring the rich do not get better care for the poor, and that the irresponsible get just as good of care as the rich.

The Coverage for All approach accepts all of these realities. It effectively puts a cap on how much society as a whole will pay for the care of any one person, $5,000, which will force whichever payor approach is utilized to, yes, limit its overall spending and the amount spent on any one person. This will also tend to limit the amount of money spent on care in response to people's irresponsibility. Finally, by allowing the credit to be supplemented, the Coverage for All approach will allow the rich to continue to purchase better healthcare than the rest of us, and will allow those people who have joined a union or made the sacrifice to work for a large corporation to secure better coverage to continue to have that better coverage.

THE REALITY OF RATIONING

This, ultimately, is why the Coverage for All approach will eventually transform healthcare and yes, rein in costs: it forces us to confront the hard question: how do we ration care?

Sometimes it seems as of proponents of the different approaches to healthcare believe their preferred approach doesn't ration care. However, EVERY healthcare system rations care in one form or another.

Under traditional insurance and fee for service care, the insurers often won't pay for whole categories of procedures, or require pre-approvals for expensive treatments and sometimes even well-established treatments. They financially advantage using in-network providers, or require people to go through less ideal, but less expensive options before trying more expensive options. Higher-priced plans cover more care and options. Lower cost plans, for example state Medicaid plans, cover fewer treatments and care.

Capitation systems, in which the care provider or care network gets a flat fee for person, ration care by not making every treatment or procedure available, or only providing a limited number of treatments each year for the group as a whole. Even traditional Medicare, as close as any nation comes to unlimited healthcare for a given population, includes some rationing. Some treatments aren't covered, others have limits on utilization, for example physical therapy, and individuals still have coinsurance or co-pays. It's not a question of WHETHER a health plan rations, only of HOW it rations.

The Financial Constraints of the Healthcare Pool. Health systems have these limits, do this rationing, because of the reality of the healthcare pool. Each person pays money into the pool and hopes they don't get sick and have to receive care. In any healthcare pool, the majority of people only have nominal spending every year, far less than their contribution, a smaller group requires care that is approximate to their annual contribution, and a small number of the people in the group require care and spending far, far greater than their annual contribution. The average premium cost of a private insurance plan is around $9,000 per person. Treating cancer cost tens of thousands of dollars, and often the costs exceed $100,000. Keeping a premature baby alive can cost more than $1 million just in the first year of a baby's life, and often several million dollars more while they are still infants. The harsh reality is that the money spent on extremely expensive care is paid by everyone else in the healthcare pool and causes the manager of the healthcare pool to either cut back on the care available to other members or the pool or increase premiums for everybody in the pool to pay.

Forcing the Hard Decisions. Under the Coverage for All, people on good employer or union Taft-Hartley plans can avoid, for now, the hard conversations. However people who are not currently on good insurance will have no choice but to be aware of the costs and compromises of healthcare. They will either need to find a way to supplement the $5,000 credit to purchase broader, better care, whether through an employer or union or out of their pocket, or they will have to accept a lesser level of care. And if they accept a lesser level of care, they will be forced to make compromises. They will have to decide what is important to them, what they can live with and live without, and yes, how best to ration the available healthcare dollars.

THE HARD QUESTIONS AND REDUCING HEALTHCARE COSTS

Coverage for All will change how Americans think about their healthcare and its costs. The $5,000 credit will help make people more aware of healthcare costs, and the possibilities of reducing their healthcare costs by accepting explicit rationing and liability protection. It will also create tens of millions of new healthcare consumers interested in lower-cost healthcare solutions.

Coverage for All would enable insurers, HMO's and other healthcare payors to offer lower-cost plans with defined rationing and limitations on liability. Below is a summary of the reforms. All of these are tradeoffs. All of these will impact the care of patients, and particularly patients with the worst health situations. However all have a chance to bring down healthcare costs.

- **Annual limits on costs.** Allow insurers and other providers to put an annual cap on the amount of money they will spend on the care of any one person. A blunt rationing tool, but one of the most effective at limiting costs.
- **Alternative resolution of Liability claims.** Allow insurers and care providers to offer plans in which participants have to agree to specific processes and parameters for handling claims of medical negligence or malpractice. Participants could be required to waive most of their right to a jury trial and agree to adjudication by an independent panel, and to specific definitions of expected care, negligence and malpractice, or to agree to limitations on pain and suffering, or a cap on awards.
- **Consider cost of new drugs and procedures.** Allow insurers to offer plans which explicitly will not include new technologies or treatments that are above a defined price, or which have been judged by an independent organization to be not cost-effective.
- **Negotiating Leverage for Payors.** For any provider group that has more than 30% of a market, allow insurers, HMOs and other payers to form a buying collective to negotiate with the providers. Potentially collectives from across the country could combine to negotiate with Pharma companies.

The Inherent Advantages of Integrated Care Network and Capitation. An integrated care network (ICN), in many different ways, is the most logical approach to controlling healthcare costs. Instead of fee for services, the ICN receives a flat payment per person in the system, called "capitation". With an ICN, the doctors and care providers work for the care network as employees, and don't make more money if they order more procedures. Their bureaucratic burden is significantly reduced, since they don't have to keep notes to justify billings. The ICNs are able to

take a more wholistic approach to health and wellness, can often coordinate care more effectively (since the providers are competing for billings). The ICN's also have an easier time rationing care – it is only obligated to provide the care options already in the system, and only as available. These factors give ICNs a better chance of controlling healthcare spending.

The credits will create a financial awareness on the part of consumers that will help highlight the advantages ICNs. A person trying to limit their healthcare spending to the $5,000 credit will have limited options: private insurance or HMOs with limited coverage, possibly joining their state's existing Medicaid program, if allowed, or choosing an Integrated Care Network.

Coverage for All does not mandate ICNs. However it provides a steady revenue stream that will allow existing ICNs to more easily expand and support the formation of new ICNs. Coverage for All will also include reforms that will make it easier for ICN's to control costs and stay within budget. Following is a summary of the reforms.

- **Care Gap Coverage.** If an ICN has a gap in its coverage, obligate fee for service providers to allow the ICNs to purchase those services from the providers at the Medicare rate.
- **Alternative resolution of Liability claims.** As with insurers, allow ICN's to require participants to agree to specific processes and parameters for handling claims of medical negligence or malpractice

SUMMARY OF CAPITATION AND FEE FOR SERVICE APPROACHES

Generally speaking, there are two approaches for healthcare: capitation and fee for service. Under capitation, a primary care doctor or health system gets a flat fee per person, regardless of how much or how little care that person requires in a given year. Generally, there are two kinds of capitation approaches: the Independent Provider Model and the Staff model. Under the fee for services approach, doctors and care providers only get paid when they actually provide a healthcare service or treatment. Many systems have a blend of both. A capitation system might also pay for fee for service care for necessary testing or procedures not available within the capitation system. A fee for service insurer might also work out flat rate pricing for lab services. And many insurers negotiate prices with preferred providers, guaranteeing more business in exchange for a reduced per-service fee. With the complexity and continual evolution of healthcare, it's hard for a system to be only one or the other; most have, and will continue to have, a blend.

Coverage for All is approach-agnostic. The $5,000 credit can be paid to a traditional health insurer, which will use it for its traditional fee for service approach to providing care. The $5,000 can also be directed to an integrated care network which uses capitation, which requires the individual to only use care providers that are part of the capitation system. Again, the Federal government doesn't decide how best to provide care to any one individual. Instead each individual has the buying power to select an insurer or a provider that uses the approach they are most comfortable with, or provides the coverage most consistent with their personal situation and beliefs.

Fee For Service Strengths and Weaknesses

Strengths:

- Tends to introduce new treatments and procedures more quickly
- As a result, gives patients access to the latest advances in treatments and drugs
- Individuals able to receive care from a wider network of providers
- Because more providers can be accessed, shorter wait times for treatments
- Doctors and care providers have an incentive` to work longer hours
- Doctors and care providers can make more money by providing more care

Weaknesses:

- Because payment is based on procedures, Doctors and care providers have to document the care to justify the billing, increasing their paperwork and bureaucracy
- Because claims must be filed to receive payment, staff must be devoted to understanding and managing the claims submission process
- Creates pressure for doctors to spend less time with each patient to maximize billings
- Creates pressure for doctors to recommend more treatments and procedures, which can lead to over-utilization and inefficient healthcare spending
- Can fragment the care a person receives, as each doctor or care provider facility only get paid for the care they directly provide
- Less of an incentive to encourage wellness and prevention, as doctors and care providers only get paid when someone gets sick.
- Can sometimes slow down innovations, if the innovation isn't yet approved by payors
- Can effectively reward doctors and providers for poor outcomes that require additional follow up care or procedures which generate additional billings

Approaches to Capitation:

- The "Independent Provider" model. The doctors and care providers continue as independent providers, however, are paid by the capitation entity to provide their service or specialty to its members. Often an Independent Provider Association serves as an intermediary between the doctors or care providers and the capitation entity. Usually doctors and providers receive a flat fee per HMO member, though some HMOs also have fee for service arrangements with select care providers. Doctors and care providers generally continue to take fee for service patients as well.
- The "Staff" model. The care providers work for the capitation entity, sometimes called an Integrated Care Network (ICN). As an example, Geisinger Health/Risant hires as employees most of the doctors that provide care through the network. The doctors receive a competitive salary, and have no financial incentive to provide more care.

While the concept is much older, the capitation model in U.S. healthcare was formalized by the Health Maintenance Organization Act of 1973. HMOs were seen as a tool to control increasing healthcare costs. However HMOs, while they have often achieved lower costs, have also faced backlash from both patients and providers. To succeed in cost control, HMO's limit the care network and often require primary care referrals before allowing specialized care. This approach to rationing care can be frustrating to members, limiting the doctors they can see and often the treatments that are available. Doctors and care providers are put in the position of deciding which

patients should qualify for treatment, and with the flat fee approach have a financial incentive to limit the number of procedures for the HMO population. Again, in both situations there is pressure on doctors to ration care, though in different ways. It's worth noting that the last time the U.S. tried capitation as an approach, there was significant pushback on its limitations. As a result, insurers and employer plan providers shifted more to preferred provider networks, which allow access to more doctors, even out of network.

Capitation Strengths and Weaknesses

Strengths:

- Much less bureaucracy – doctors only need to note what's important to care, instead of what is needed to justify a procedure billing
- Significantly less staff time devoted to billing – no need to submit claims to get paid
- Less bureaucracy allows reduced overhead for doctors and care providers
- Doctors able to spend more time with patients, have a more traditional relationship
- Allows more coordination across doctors and care providers
- Predictable revenue stream for doctors and care providers
- No financial pressure to prescribe more treatments or care
- Easier for doctors and care providers to encourage wellness and prevention
- Incentive to get the care right the first time, since no additional funding for poor outcomes that require additional follow up care or treatments
- Sometimes flexibility to introduce innovations that improve care and outcomes

Weaknesses:

- No incentive for doctors to work extra hours
- Financial risk for providers if care costs more than projected
- Sometimes pressure to not recommend care that's over budget
- Quality concerns if budget considerations outweigh patient needs
- Reduces patient choice - limits patients to doctors and facilities that are in the network
- Can result in rationing and longer wait times for procedures
- Slower to introduce new treatments and drugs

ANNUAL DOLLAR LIMITS ON PAYMENT FOR CARE

Under Coverage for All, health insurers and payors would have the option of re-introducing annual caps on payments for care, as a tool to help control healthcare spending.

Virtually every kind of insurance offered includes some kind of cap on liability. For risk pools to work, boundaries have to be drawn around what is paid for by the risk pool. For many auto insurance policies, the insurer's exposure for any one accident is capped at $300,000. Undoubtedly this results in victims of accidents not getting as much from the insurance company as they might deserve. However this cap also protects the insurer from claims that would force the insurer to raise rates on all policy holders.

A significant contributor of increasing healthcare costs is a change introduced as part of the Affordable Care Act: insurers were no longer allowed to set annual and lifetime caps on spending for any one person. The motivation behind the ban is commendable – no person should be denied care that might save their life, regardless of the cost. However the reality is that healthcare is paid for as a pool, and spending too much for any one person either reduces the care available for the other people in the pool, or forces everyone in the pool to pay higher premiums. As noted, health insurers have a number of means of rationing care. An annual cap on spending was a fairly blunt tool, but also effective. It gave insurers an important tool to push back against high cost procedures, and also had the effect of making patients more aware of their healthcare spending and the need to self-ration to ensure they have coverage available if they need it.

Coverage for All would allow health insurers to re-introduce annual caps on spending. Insurers would be able to set the caps at different levels. For some plans, the cap might just be $250,000 per year. For others it might be $1 million, with a higher premium. Insurers could still offer high premium plans without annual caps. Again allowing the caps would give insurers an important tool to offer different levels of care. If a person wants insurance and fee for services care, the $5,000 credit will only cover a basic plan, with primary care, hospitalization and few additional services. Re-introducing the annual cap would give insurers to option to offer a plan with just the $5,000 annual premium, and potentially even no co-pays or co-insurance. Again, Coverage for All won't give every person the best possible healthcare regardless of cost, however will ensure that every American has access to the basic care they need.

MEDICAL LIABILITY FOR PAYOR PLANS

Coverage for All will plans in with specific processes and parameters for handling claims of medical negligence or malpractice that participants have to agree to. This could include waiving their right to a jury trial in all but the most egregious cases. Instead, cases would be adjudicated by an independent panel using specific definitions of expected care, negligence and malpractice. Plan participants could also have to agree to limitations on pain and suffering, or a cap on awards.

One of the starkest differences in healthcare between the United States and the rest of the world is how we handle bad outcomes. Medicine, for all we've learned, is still an imprecise science. Sometimes doctors can do everything right, and a person still has a bad outcome, or even dies. Sometimes the doctors make care plans based on what they currently know, but other information might have produced a different care plan and better outcomes. And yes, sometimes doctors mess up, they do a surgery wrong, or misdiagnose something. In theory, if a doctor does everything right, or recommended for a given diagnosis, and there's a bad outcome, the doctor should not be financially liable. Liability isn't for bad outcomes, it's for bad treatment. But functionally, we have reached a point where for all practical purposes liability doesn't pay for mistakes, it pays for bad outcomes. Doctors get sued in the United States far more than any other nation. Most advanced nations have processes to evaluate cases. As an example, in Canada, any claim goes to a review board to decide if the doctor or facility actually did something wrong.

Any effort to control or reduce healthcare spending is going to require a re-examination of liability insurance. Again, the purpose isn't to force reforms on every plan and every person. It's to give insurers and providers the ability to offer options, and let people choose what they want and what they can afford. Insurers could offer higher prices policies with no cap on liability. However they

could also offer lower priced plans which require a medicate arbitration board similar to Canada's to adjudicate claims. Specifically, it will determine if there was an actual mistake on the part of the doctor:

- Did the doctor perform the treatment incorrectly, resulting in the bad outcome?
- Was there information the doctor missed or should have known which would have led to a different treatment course and better outcome?
- Did the doctor do the current procedure correctly, and still have a bad outcome.

Again, if the doctor did everything that was reasonably expected, and did it correctly, and still had a bad outcome, it would not be classified as medical negligence or malpractice. Essentially the plan would using the liability definitions that existed before the explosion of medical lawsuits.

INCLUDING COST IN APPROVAL OF TREATMENTS AND DRUGS

Coverage for All would allow insurers to offer plans which have limits on the cost of covered procedures or drugs, and explicitly not approve procedure or drug, even when deemed medically necessary, if they are above the cost limit. This will serve as a significant protection against the skyrocketing cost of new treatments and drugs, including gene therapies. Again, this means accepting that every person will not get the most cutting edge, expensive care available.

Many people blame private insurance companies for our expensive healthcare system, but insurers actually have very little to do with rising costs. Instead advancing medical technology is a primary cause. Our for-profit medical technology industry has made amazing advances in treatment and care that have allowed us to save people that used to die. But its primary goal is still profit. Every year the industry comes up with new procedures or refinements. Most provide only incremental improvements in care but they all come with a higher price tag. Every year the industry spends billions of dollars – yes, billions – successfully encouraging doctors to recommend the new procedures and drugs, and marketing directly to consumers to encourage them to ask for the treatments or drugs. As noted, it's about to get much, much worse. There is a flood of new treatments and targeted drugs getting ready to hit the market. Some will undoubtedly be true advances, but all are likely to cost tens of thousands or even millions of dollars per treatment.

All new treatments and drugs must be approved by the Food and Drug Administration before they can be offered in the United States. The treatment or drug must have successfully gone through the required trials and is evaluated to confirm that it is safe and effective, its benefits outweigh its risks, and it aligns with current medical practices. The FDA does NOT make any financial determination that the added health benefit is worth the increase in cost over other, existing procedures and drugs.

Once it has been approved by the FDA, a doctor or care provider is legally able to prescribe that treatment or drug. Technically, insurers are supposed to pay for any treatment the care provider deems medically necessary for their patient. However in actual practice insurers use a number of tactics to avoid paying claims for expensive treatments. This can include questioning the medica necessity of the treatment, requiring an alternative, less expensive treatment or classifying the treatment as still "experimental", and so not covered by the policy.

We need to explicitly allow insurers and payors to refuse to cover treatments and drugs just because of the cost, whether they are approved by the FDA or not. Yes, in some cased this means individual will not get care from which they would benefit. However not paying for that individuals' care will help keep care available and affordable for the other participants in the plan. Again, this is the reality of healthcare – we have to balance the needs of individual patients against the needs of the group as a whole.

NEGOTIATING LEVERAGE FOR PAYORS

Coverage for All will allow insurers and payors to collectively negotiate with large care provider networks and pharma companies. If a provider group has more than 25% of a market, insurers, HMOs and other payers can form a buying collective to negotiate prices with that provider. If a pharma company is the only supplier of a specific drug, insurers in any market can form a buying collective to negotiate with the pharmaceutical company.

Proponents of Medicare for All note that one of its primary advantage is "monopsony" – as virtually the only payor, the federal government can essentially dictate prices to providers. This is the government's approach with the current Medicare system. It spends by far more money than any other single payor. Providers either accept its prices for treatment of Seniors or they lose access to a very large market. Medicare was originally forbidden from negotiating on drug prices when drug coverage was first added, leading to increases in its drug costs far greater than the rate of inflation (Congress is starting to correct this, allowing Medicare to negotiate prices on selected drugs).

We allow the government to use its monopoly market power to set price. However we make it very difficult for large insurers to work together to negotiate with care providers. We have seen significant consolidation of hospital systems and medical providers; often there is one dominant hospital group in an area that is large enough to dictate prices to insurers. Essentially, we have allowed near monopolies to form on the care giver side, but forbid large insurers from aggregating their market power to counteract the care givers monopoly. Allowing insurers to work together to negotiate with care providers and pharma companies will restore balance to the negotiations and give insurers better leverage to control pricing increases or even reduce cost of care. This would extend one of the primary advantages of Medicare for All, the ability of the federal government to use its market size to improve pricing, to private insurers and payors.

CAPITATION AND INTEGRATED CARE NETWORKS AS THE PRIMARY ALTERNATIVE

In many ways, "staff model" capitation, integrated care networks (ICNs) are the simplest, least bureaucratic approach to providing healthcare. The doctors and care providers work as employees of ICN. Instead of billing based on usage, the ICN receives a flat monthly or quarterly fee per person, whether they required healthcare that period or not. Doctors and care providers are under no pressure to increase billings, and aren't incentivized to do so. They also are required to do far less paperwork, and can again treat their notes as part of the care process instead of documentation for claims submissions. ICNs allow for a more traditional relationship between doctor and patient and a more wholistic approach to coordinating treatment and keeping people

healthy. Doctors on salary with the ICN often make less than if they were billing per service, however in many ways experience a better quality of life.

As noted, Coverage for All does not pull out the existing healthcare system by the roots or mandate any one approach. However the change in dynamics and increased market which will result from Coverage for All will likely lead to the growth of ICNs. People will be more financially aware of their healthcare and conscious of costs. A person trying to limit their spending to just the $5,000 credit will likely have limited options. Insurers or HMOs may offer low-cost policies, and the state Medicaid may serve as a public option. ICMs, with their built in cost advantages, will likely also be a lower cost option, and many consumers will appreciate their more wholistic approach to care.

Rationing. ICNs also have a built-in advantages on rationing and cost controls. As noted, doctors and the ICN have no financial incentive to provide additional care or order additional tests. Instead, they are aware of the limitations of their care network, and cautious to not order unnecessary care which would inefficiently use limited resources.

ICNs are also protected against the extreme cost of new technologies. Insurers are obligated to pay for whatever FDA-approved treatment their doctor deems “medically necessary”, regardless of the cost. Increasingly, this includes multi-million dollar gene therapies. Integrated Care Networks are only obligated to provide the care in the network they have. They can’t be forced to send patients to other providers, or to purchase and offer the new treatments. They are only obligated to provide the care available within their network, with technology and personnel they have on staff, or what they’ve contracted for with third party care providers. This model helps protects ICNs against the extreme cost of cutting edge technologies, allowing them to better keep costs down.

Separate Primary Care. An advantage of the Coverage for All approach is it shifts control to each person, to allow them to find a healthcare situation in alignment with their needs and budget. In some areas, the capitation may include both a hospital network and an independent primary care doctor. In this approach, doctors would be able to own their own practices, just as was done in the past. They would have to meet minimum capabilities, for example having an on-site x ray machine and ultrasound. They would also have to have relationships with medical testing companies for the tests they can’t do in-house. Doctors could again have their own practices, building long-term relationships with their community.

CARE GAP COVERAGE

Coverage for All will require fee for service doctors and care providers that accept Medicare patients to also provide services at Medicare pricing to Integrated Care Networks that lack that capability in-house.

One of the bigger challenges of establishing an Integrated Care Network is being able to provide the full range of services and specialties necessary to provide mandated basic primary care and hospital care. Particularly for ICNs in rural areas, there will be gaps in the care and testing that the ICN can provide. Under coverage for all, a registered ICN will have the right to fill these gaps by purchasing services from fee for service providers. Ideally, ICNs can reach a form of flat rate pricing with hospital systems, providing reasonably priced access to the services the ICN can’t provide.

This requirement will facilitate the formation of ICN, particularly in rural areas that often lack a full range of healthcare specialties or even primary care options.

MEDICAL LIABILITY FOR CAPITATION AND INTEGRATED CARE NETWORKS

Coverage for All will extend specific medical liability options for ICNs. This will include specific processes and parameters for handling claims of medical negligence or malpractice, potentially waiving their right to a jury trial in most cases, and having cased decided by an independent panel using specific definitions of expected care, negligence and malpractice. ICN participants could also have to agree to limitations on pain and suffering, or a cap on awards.

Because of how they operate, ICNs have different liability exposures than fee for service providers. An ICN has no legal liability for not providing care that's not available within its network. However an ICN that supplements its in-house services will have potential liability exposure if it chooses not to refer a patient for outside care. Further, ICNs have limited care available within their network. Even within network, patients will sometimes have to wait longer for tests or procedures, or are denied treatment because the ICN staff believes the available resources will produce better outcomes with other patients. ICN participants could potentially have to agree that if these occur they don't constitute negligence or malpractice on the part of the ICN.

Protection from unreasonable medical liability is critical for ICNs, particularly those in rural areas. It's not an abstract insurance company paying a jury settlement, or people they don't know. Lawsuits and extreme awards impact the care for everyone in their community. If an ICN has to pay more money in liability insurance, or pay out a pain and suffering award, everyone else in the community sees their healthcare suffer.

HOW THE CREDITS SUPPORT RURAL HEALTHCARE

Currently many rural areas are "healthcare deserts", with a very limited number of care providers and often no local hospital. Almost two hundred rural hospitals have closed or reduced services over the past fifteen years. The credits should have a significant impact on rural healthcare. The guaranteed revenue of the credits will ensure doctors and hospitals in rural areas have larger and steadier revenue stream. The credits also support the formation of Integrated Care Networks in rural areas. If the people living in an area agree to pool their credits, this funding may be sufficient to allow previously closed care facilities to be re-opened.

Rural areas will continue to have compete for doctors with urban areas able to pay higher salaries or higher fee for service reimbursements. However the rural Integrated Care Networks will be able to offer medical professionals a less bureaucratic working environment with better doctor-patient relationships and in many ways a better quality of life. Doctors who once dreamed of being a small town doctor would again have an opportunity to have actual relationships with their patients. In some cases, the ICN will be the only healthcare provider in the area. This will give it an opportunity to generate additional revenue by serving Medicare patients and potentially even people with traditional insurance.

The formation of rural Integrated Care Networks will be facilitated by other reforms included in Coverage for All. Care Gap Coverage will allow Integrated Care Networks to fill in gaps in coverage by using fee for service providers, under Medicare pricing. An alternative medical liability process will allow Integrated Care Networks to reduce their liability exposure and insurance costs. Using cost to evaluate new procedures and technologies will reduce pressure to add technologies that will consume too much of the limited budget. There is no one answer to the challenges of providing healthcare in rural areas. However the credits plus the reform of Coverage for All should create conditions which facilitate improving care options in rural areas. The care in rural areas is unlikely to match that available in urban areas with more hospitals and doctors. The ICNs are unlikely to have the latest technologies or access to the latest drugs or gene therapies. However for many rural residents it will give them closer, faster access to needed healthcare than what's currently available. Again having a hospital that's ten minutes away instead of two hours away will have a material impact on the health and wellbeing of rural Americans.

EMERGENCY ROOM OPERATION AND FUNDING

Coverage for All would establish a national Emergency Care Fund. If a person choses capitation coverage (as opposed to traditional fee for service insurance), a portion of their credit is paid to the Emergency Care Fund. Traditional insurers can also opt into the Emergency Care Fund. If they choose to do so, they remit a portion of the credits they receive to the Emergency Care Fund.

Hospitals, urgent care centers, even individual doctors, can choose to participate in the emergency care program. They can offer traditional 24 x 7 emergency room access, or more limited hours, or for rural areas to be on-call for emergencies. Each participating facility or doctor receives a flat fee for the coverage they provide, plus additional usage compensation based in the number of emergency visits. Emergency rooms are not allowed to add additional charges for treating the people that pay into the fund. The usage compensation is calculated by totaling all of the emergency room visits in the prior month and then giving each facility a portion of the usage fund based on their percentage of those utilizations.

As noted, if a person does not choose an insurer or Integrated Care Network, their entire credit is deposited in the Emergency Care fund. Care for the uninsured is calculated separately. A portion of their credit is added to the flat fee fund. The balance of their credit is paid to whichever emergency care providers provided care to them during the previous month. If an uninsured person receives care from more than one emergency care provider, the monthly portion of their credit is distributed pro rata between the different providers. The emergency care provider or providers continues to receive the monthly payment related to that person until they receive care at a different emergency care provider. Thus even if the uninsured person doesn't require care the next month, emergency care provider continues to receive the monthly portion of their credit. This will provide a consistent revenue stream for the emergency rooms and care providers that service large uninsured populations.

HEMOPHILIA AND HIGH RISK FUND

Maladies such as hemophilia pose unique challenges to healthcare systems. Being able to save hemophiliacs was one of the great advances of modern medicine. However treating the disease is uniquely expensive. Average cases can incur hundreds of thousands of dollars of expenses each year, for the life of the person. Harder cases can cost as much as $1 million annually to keep the person alive, driven by expensive clotting factor replacement therapies.

Under coverage for all, the cost of care for hemophilia and other high cost treatments is nationalized. A small part of every person's credit is directed to the High Risk fund. The High Risk fund ideally should be able to use its buying power to negotiate better prices on treatments. If the treatments are at a capitation care facility, the High Risk fund pays directly to the care facility. If through traditional insurance, to the person's insurance provider.

THE BACKGROUND OF THIS PROPOSAL

The idea of having the Federal government collect funds for healthcare and then provide them as a credit isn't new. Most recently, Sen. John McCain, in his 2008 presidential campaign, made the credits the centerpiece of his healthcare policy. Virtually everything referenced in the Coverage for All proposal already exists in our existing healthcare system. We already have all of these different forms of insurers and providers. We already have organizations that evaluate the cost-effectiveness of treatments. We already have a Medicare price list. We have medical review committees. Again, virtually everything in the Coverage for All proposal already exists in our existing healthcare system. This is why Coverage for All has a chance of succeeding. It's not forcing a revolution in healthcare. Instead, it's changing one key element, collection of the credit, and several other factors, to create an environment in which our current system can evolve. It solves for one problem, universal coverage, and assumes the system itself, and more importantly the people in the system, will figure out the other challenge, controlling healthcare costs. It puts Americans more firmly in control of their healthcare.