# UNITED STATES UNIVERSAL SYSTEM

# AND

# THE AMERICAN HOUSEHOLD

In this section we attempt to look at how "US.US" differs from the ACA rather than Medicare. The ACA is based entirely on HOUSEHOLD income. Medicare is not and "US.US" is not. They are based on INDIVIDUAL income which substantially changes things. The subsidies offered under the ACA are based on household income. Subsidies under "US.US" are based on individual income. As a result there are numerous possibilities that exist.

The payroll obligation extends to the first $60,000 and overall cost to the individual is capped at 10.9% including the benefit tax. This IS very similar to the guidelines of the ACA. I will use our household of 2 as an example. I am disabled, on Medicare, work and have no need for insurance. My wife works as a waitress earning about $20,000 but has no insurance. Under the ACA we are entitled to about $600/mo. in subsidy if we BOTH need insurance or $30/mo. if we don't, which is the case. She gets $30 alone or we get$ 600 together. She would have to pay $330/mo. for a policy that has a $5500 Deductible OR WE could pay $225/mo. for a policy that covers BOTH of us and I can never use, and further has an $11,000 Deductible. If either policy were FREE we could not afford the Deductible expense. Under "US.US" she would receive Expanded Medicaid and I Expanded Medicare.

Under the terms of "US.US" you are entitled to benefits based on personal income. You, Your spouse, or You & Your spouse could max out if you are in the higher income range. If not, one could max out while another receives a partial subsidy. Parameters that are fair to the system (others), need to be established for students who also work and are also dependents. The only components that are fully subsidized are Medicaid, Expanded Medicaid and CHIP. All others will be presumed to spend 10% of income. Whether we have to mandate that is a matter for consideration that should be addressed. Enrollment is quite easy. You merely have to calculate a tier based on individual income.

Equitably financing dependents is a hurdle I have yet to overcome. What is fair to the system (others) and what is AFFORDABLE are two different matters. In any event, these determinations WILL BE based on HOUSEHOLD INCOME and perhaps exceed the $60K threshold per person. I suggest 2% per child to a max of 6% of household income. The employer who pays 50% of healthcare premiums pays 2 ½ times more for the employee with a family than the one that doesn't. Dollar wise does not seem fair. I spoke to a woman recently whose sister had quadruplets…then went on to have 5 more (9). That's not fair either in my opinion.

# ABOUT SUBSIDIES

Subsidies provided under "US.US" are for CARE not premiums. Subsidies are generated by the system itself (benefit tax). One of the big arguments is that the Federal Government helps finance healthcare by making both employer and employee contributions tax deductible. Further, employees who work for employers who do not provide such a benefit receive nothing at all. The benefit tax splits this issue. Employees are taxed on the economic benefit received in terms of dollars but not the benefit itself. You may pay $300 in benefit tax but receive $10,000 in actual benefits. No different than raising the minimum wage. This reduces the cost to the Federal Government which I am sure they would be in favor of. Another obstacle met in a straightforward manner.

These subsidies accrue to a subsidy pool in each state for CARE. If 10% of your income only allows you to buy level seven in the tiered, community rated, supplemental portion (Public Option), you are then subsidized for the BENEFITS provided within the lower tiers. However, if you have no MEDICALLY NECESSARY reason for care with the limits of the subsidized tiers, the money will stay in the pool. You are effectively covered but the money stays with the system until actually needed for YOU. Keep in mind that the tiered structure is already 50% subsidized with employer dollars for rate stabilization purposes.

THE POTENTIAL FOR SUBSIDY BEGINS WHERE EXPANDED MEDICAID ENDS. The subsidies are designed to provide coverage for the tiers your income cap determines to be UNAFFORDABLE which would be 4% additional unber Parts B & D. Based on an annual income of $30,000

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| Part A Employee Cost | $ 900 |
| Employer Match Part A | $ 900 |
| Part B Employee Cost | $ 900 |
| Employer Match Part B | $ 900 |
| Benefit Tax | $ 162 |
| HSA Received | $2000 |
| Balance of Cap (4%) | $1200 ($100/mo.) |

Let's assume $100/month will only buy to level (4) in the tiered structure. At that point you become SUBSIDIZED for the benefits that would have been provided in the lower tiers (100% coverage). The subsidies are for CARE. They will be collected from the benefit tax imposed thru payroll and remitted to a fund in each State. If you have no need for MEDICALLY NECESSARY CARE, or do not exceed certain tiers covered by subsidy, the money will stay with the State for future use. So even though this example pays the modest benefit tax, it is also the beneficiary of that benefit. Part B expenses are 50%

subsidized by employer participation to begin with.  Four sources of revenue; employee contributions (2 Base + Excess), Employer and Subsidy (Benefit Tax).

As stated, I can see a strong potential to garner addition revenues from other insurances that are based in part on medical related issues such as auto, workman's comp. and homeowners.  It would further remove these issues from court settlements subject to attorney fees.  These monies could potentially go to the subsidy pool, as I believe the risk occurrence is low enough that the system can absorb those costs as normal risk.  I remain undecided as I have no data to support that opinion.

# EMPLOYER MANDATE

The employer mandate is key to the success of the system as it;

MAINTAINS THE MAJOR SOURCE OF CURRENT PRIVATE FUNDING LOST IN OTHER PROPOSALS

PROVIDES THE HIGHEST STABLE RISK POPULATION

MAINTAINS THE STABILITY & INTEGRITY OF COMMUNITY RATING

SIMPLEST MEANS OF COLLECTING "PREMIUMS"

EASIEST MEANS OF COMMUNICATION & ENROLLMENT

IMPROVES CLINTON PROPOSAL of 1993 (EASY SELL)

The employer mandate represents about 50% of the cost just as it does now. However, the mandate extends the mandate to include ALL employers, not just some and All wages, not just some. The ACA did not do that and contributed to its' own failure. The mandate is set lower than what most employers currently spend to accommodate the smaller business owners. That said employers can pay more if they wish by grossing up wages. Those costs over the 6% base will continue to be tax deductible to both parties and further avoid the both the benefit tax and payroll taxes. SAME AS KNOW. SIMPLE. NO RADICAL CHANGE. However, in my opinion, unlike the Single/Family issue is SHOULD be even handed. Currently, if an employer opts to pay 50% of employee premiums, they pay 50% of Single, Spousal & Family coverage. The employee with the family receives 2 ½ the dollar value of a Single employee. My example is an employer may opt to pay EVERY employee $100/mo. more for benefit purposes. If the money is not used for that purpose it becomes fully taxable to the employee. In that sense you have a simplified benefit program…Cash or Benefit and all employees are treated equal in dollar terms. But admittedly, it is a minor issue. Finally, this eliminates the administrative burden and administrative cost of employer provided healthcare. It becomes merely a payroll exercise like a 401K. They will LIKE it.