UNITED STATES UNIVERSAL SYSTEM

PROTOTYPE FORMAT & BENEFITS

While Buffalo, Rochester and Syracuse many be considered among the worst cities to live, they have one positive that most other cities don't have. Respectively they represent the 2nd, 4th and 19th lowest healthcare costs in the country, and not by accident, but by design. I would encourage anyone to ask Rep. Collins and Senators Schumer and Gillebrand what those elements are that support this fact, and why they haven't considered them as part of an overall solution. It is my opinion that neither have any idea or expressed interest in these facts as they are not political, although these elements define one-third of any potential solution. Community Rating, Clinical Medicine and Not-for-Profit Insurers are the correct answers, WHICH I believe to be more unique to this area than other parts of the country.

The PLAN PROTOTYPE is actually quite simple as it is formatted using Medicare as the basic template that further integrates ALL Public, Private and Employer formats into ONE, flexible, vertical, universal system comprised of five parts;

- MEDICAID, CHIP & EXPANDED MEDICAID
- TRADITIONAL
- PRE-MEDICARE (age 50)
- MEDICARE & EXPANDED MEDICARE
- PRESCRIPTION DRUGS

Utilization of these separate accounts makes it possible to monitor both activity in each account and the system as a whole, thereby maintaining the flexibility to make adjustments where and when necessary. It acknowledges that the needs and behaviors in each part can vary significantly from each other part, as well as between states and regions within states.

The Traditional Plan is exactly what has been asked for; A National Hospitalization Plan (Part A if you will), "wrapped" around a flexible, choice and free market driven Major Medical (Parts B & D) or "Public Option", offered in s fully Community-Rated format. Community Rating further implies that the plan will operate under uniform rules, on a regional basis, and final oversight responsibilities will fall to the States. Reinsurance features will be phased out over 3 years to accommodate a fair experience rating period. Final insurer participation will be limited to Administrative Services Only (ASO). It is projected that the mandates are sufficient to cover Part A expenses without additional support, and because it only represents "true risk", can to proven to a minimal margin of error.

PLAN BENEFITS

PART A HOSPITALIZATION & CATASTROPHIC RISK

Fully Self-Funded National Hospitalization Plan that allows for 100% of ADJUSTED COST BASIS for MEDICALLY NECESSARY process and procedures performed in the hospital. It also provides for an annual aggregate spending limit ($50,000 cap) under Parts B & D. Provided by mandate 3/3%

PARTS B & D PRIMARY, SECONDARY, PRESCRIPTION DRUGS & EXCESS (ASL)

These Parts are designed to address all non-hospital healthcare needs such as primary care, diagnostics and prescription drugs. This is a multilevel program providing for benefits at the top and bottom of the tiered plan structure. These benefits will ultimately be determined by what the mandate at both the top and bottom of the flexible vertical design can support. A free market solution requires some form of cash or other form of payment, rather than ever increasing premium dollars. Fifty per cent of Part B/D will be flexible choice (cash or benefit), "opening the door" to design of the "free market" components of the plan design. In addition, each participant will receive actual CASH in the form of a HEALTH SAVINGS ACCOUNT to pay for the first $2000 of medically necessary expense. This approach allows consumers the CHOICE of how to best design there overall plan based on INDIVIDUAL NEEDS AND PERCEPTIONS, without having a negative impact on the group as a whole. Additionally, the new rules for pricing transparency will allow consumers the first opportunity to directly determine how to spend "THEIR" dollars. The remaining objectives are to;

1. INCREASE CONSUMER AWARENESS OF PROVIDER PRICING
2. ENCOURAGE DIRECT INVOLVEMENT IN DECISION MAKING & ASSOCIATED COST
3. CAUSE PROVIDERS TO BEHAVE IN A MORE COMPETITIVE, FREE MARKET, SERVICE BASED FASHION, RATHER THAN MONOPOLISTIC MANNER
4. EXPAND RANGE & ACCESS OF 501C PROVIDED SERVICES (Clinical Medicine)
5. CREATE 3-5 MILLION LONG & SHORT TERM JOBS

The objective of the model is to average risk/cost within the tiered structure, in a manner that will diminish high deductible medicine. The high deductible is moved from first dollar to secondary tiers,

and further be divided proportionately among those tiers. The design of this vertical structure will additionally provide consumers with:

- ✓ EFFECTIVE "FIRST DOLLAR" COVERAGE
- ✓ ABILITY TO PURCHASE AFFORDABLE, SPECIFIC, ADDITIONAL LEVELS OF COVERAGE
- ✓ AN ANNUAL AGGREGATE STOP LOSS (ASL)
- ✓ PROTECTION OF COMMUNITY RATING
- ✓ EASY TO UNDERSTAND
- ✓ POTENTIAL FOR SUBSIDIES OR COST SUPPORT BASED ON INCOME

TIER STRUCTURE & COVERAGE LIMITS (included as portion of mandate 3/3%)

❖ LEVEL ONE	100% OF FIRST $2000 OF ADJUSTED COST (HAS)
❖ LEVEL TWO	50% of next $5,000
❖ LEVEL THREE	50% of next $5,000
❖ LEVEL FOUR	50% of next $5,000
❖ LEVEL FIVE	50% of next $5,000
❖ LEVEL SIX	50% of next $10,000
❖ LEVEL SEVEN	50% of next $10,000
❖ LEVEL EIGHT	50% of next $10,000
❖ FINAL TIER	$50,000 INDIVIDUAL SPECIFIC AGGREGATE STOP LOSS (Part A)

PUBLIC OPTION

The "Public Option" allows consumers the opportunity to reduce the $25K exposure by purchasing supplemental coverage under the protection of community rating, and further in incremental levels. Under this BASE PLUS plan format, the risk of each tier decreases and subsequently the price of each tier. The base tier is considered to be the "entitlement" tier covering any range of unspecified services. "US.US" does not provide benefits for specific medical issues, but rather, medically necessary spending. There are no specific benefits for Dental or Vision, however, HSA dollars can be used, in part, for these purposes. HSA dollars can be used to pay for these benefits in accordance with the Medicaid reimbursement rate for these services. Out-of-Pocket dollars are necessary for the balance of those specific benefits Consumers can purchase supplemental tiers for medically necessary benefits, including prescription drugs, at any level they choose. 100% coverage would constitute the sum of supplemental premiums for ALL tiers. For example, one could add personal monies to their HSA's and buy upwards in the tier structure at a lower cost. Accumulating unused HAS dollars also allows one to purchase lesser cost tiers over time and still approximate 100% coverage. This effectively allows younger and/or healthier people the opportunity to pre-fund future medical expenses. Risk is traded for cash and the employer mandate keeps the Community Rating intact. Since 65% of claim activity occurs in Parts B & D, and below the $5,000 threshold, some early volatility can be expected to occur in the lower tiers initially. This is the reason behind pursuing a 3 year experience rating strategy, and further, allowing time for the impact of cost reforms to be realized. It is important that consumers realize the

more claims THEY generate, the more likely it is that costs increase. It is difficult to determine at this point, if mandated participation to 4% of income in the tiered structure is required for optimum success. Those eligible for subsidies WILL be required to participate to the 4% Cap.

ENROLLMENT

Most annual enrollments will occur in the workplace and be initially processed and forwarded to the Plan Administrator by the Employer. They will be quite simplified consisting of an income worksheet to determine possible qualification for Medicaid, Expanded Medicaid, Subsidy and calculation of 4% of income for determining placement in the tiered structure. There are no specific benefits to be considered only dollars of potential spending.