POINTS OF RESOLUTION: REFORMS

GENERAL THOUGHTS

In my opinion cost cannot be reduced without a close examination of price, practice, process and consumption. While price is the common denominator in most issues, it is process that ultimately determines overall cost. It should be noted that adding 28 million people into the plan when will increase aggregate spending, but overall , my perceived demographics of that group, when combined with Expanded Medicaid will reduce per person cost. Until now, there has not been a focused discussion of the effects of price in terms of overall spending, and the impact of cost shifting on the private sector. However, Price is a function of cost, on which there has never been any competent focus.

"US.US" seeks to mediate lower pricing through direct efforts to reduce provider cost, in part by implementing the following reforms. It is believed by myself, and others, that there is at least $500Billion in administrative and other waste in the current system. PNHP believes this as well, but they propose keeping the savings for themselves by offering consumers more services rather than reduced "premiums". "US.US" seeks to put those dollars directly in the pocket of American households.

Provider pricing can differ 500% between networks, even with the same provider, leaving considerable latitude for savings, as just one example. This is also a well-defined ADVERSE BEHAVIOR built into the current system. IF THE OBJECTIVE IS TO MAKE HEALTHCARE AFFORDABLE, NO COMPETENT PROPOSAL CAN BE SUCCESSFUL WITHOUT FIRST ADDRESSING PRICE AND BEHAVIOR!!!!! THE FAILURE TO DO SO, WOULD SUGGEST THAT WE STOP ALL THE NOISE, AND MERELY CONTINUE ON AS WE HAVE FOR THE PAST 30 YEARS!!!! Price will go up and access will go down, as access is determined by PRICE!! "US.US" is the only system that seeks to effect specific reforms that will in turn produce specific changes in attitudes and behaviors over both the short and long term.

1. CHANGING THE ROLE OF INSURANCE COMPANIES:

Insurance companies typically have little interest in controlling cost, unless hired to do so. Their interest is solely on charging more than cost. Even at the same margin, higher premium, equals higher overall profit potential. 'UNITED STATESUNIVERSAL SYSTEM" eliminates insurance dollars from the system and reduces their participation to Administrative Services Only (ASO) capacity, consistent with all SELF-FUNDED PLANS. The number of active insurers WILL BE reduced. There will be ONE Administrator for each State or region in each State. The Administrative Corridor will be reduced from 20% to 10 or 12%, as miscellaneous expenses such as advertising, etc. will become unnecessary. Therefore the Claims Corridor increase to 88-90% and further equates to a direct, IMMEDIATE 8-10% COST DECREASE. It is

my intent for insurers to reinsure the stop loss provisions of the trust funds in declining fashion over 3 yrs. to allow for an experience rating period. It is estimated that profits will remain in line with current. Insurers will be released from claims liability (LOSSES) in return for:

- ✓ BENEFITS COMMUNICATION & CUSTOMER SERVICE
- ✓ CLAIMS PROCESSING & ADJUDICATION
- ✓ CLAIMS REMITTANCE
- ✓ CASE MANAGEMENT SERVICES
- ✓ ACTUARIAL ANALYSIS & PROJECTIONS
- ✓ WEBSITE MAINTAINANCE
- ✓ ALL OTHER DAILY ADMINISTRATIVE FUNCTIONS

Claims processing costs have been in the 1-2% range. Increasing that component in return for a greater range of services would essentially cost the same, however these companies now have a vested interest in responsibly managing cost. I would further suggest a bonus type arrangement for companies successful in doing so. Insurance companies who ARE NOT a regional administrator would be allowed to engage in the administration of ancillary benefits such as; community rated life, accident, disability, dental, vision, programs, etc. for that region with a particular focus on small business and the self-employed.

MANY JOBS ARE SAVED. The current expertise, claims processing capacity, databases, actuaries, provider relationships, system knowledge, etc. of insurance companies are maintained. CMS made $100Billion in incorrect payments to providers in 2016. And once again…NOTHING SUBSTANTIALLY CHANGES FOR CONSUMERS OR PROVIDERS.

2. EXPANDED EMPLOYER MANDATE

Expanding the Employer Mandate to ALL employers will bring incredible predictability and stability to the Plan. It maintains the most prominent source of funding for private insurance and the most STABLE risk population. It is perceived that smaller companies represent a high percentage of younger employees, including part-time workers. The relatively low risk presented by this group means that dollars contributed on their behalf will average down per capita costs under Part A. Is it fair?? All employer based plans represent the average premium of all participants based on age and sex. So there really isn't any significant change. Younger employees are already subsidizing older employees. Healthcare is an inclining curve. One may pay more now, but a lot less as the years accumulate.

3. NEGOTIATED BILLINGS/SIMPLIFIED ADMINISTRATIVE PROCESS FOR ALL PROVIDERS

After exhaustive review of all hospital administrative processes and expenses, in/out network analysis and billings, I believe these expenses can be negotiated down by more than 20%. Where will the savings come from??

- ✓ ELIMINATION OF ACA TAXES
- ✓ PAYMENT GUARANTEE (6-8% of cost is unpaid billings)

- ✓ STREAMLINED, SIMPLIFIED ADMINISTRATION AND ASSOCIATED COST

The rules and regulations manual for Medicare is 130,000 pages. The Physician fee schedule 1,250 pages. There are 40 government agencies associated with Medicare, each with their own compliance requirements. It is acknowledged that hospital compliance with Medicare and associated agencies consumes 25% or more of revenue. The average Physician spends 20 uncompensated hours/week dealing with Medicare issues. "US.US" will streamline this convoluted system by creating a simplified payment structure and process that is ACCEPTABLE to Providers. Medicare claims to have a 2-3% overhead, which is not entirely true, as the majority of cost is on the Provider side which is reflected in PRICE. Total Medicare overhead is closer to 8% when ALL agencies are considered. In addition all advertising and marketing expenses have been passed on to the providers of supplemental policies.

4. REGULATED REIMBURSEMENT

The objective is to find the true median price point between all networks and providers that will establish the terms of Guideline Reimbursement for each region. A re-evaluation of CMS RVU system seems a logical place to start. All providers will be reimbursed at the same rate for the same service in the same region. No more unlimited supply of premium dollars. This will give Providers a fair, equitable, dependable and organized format from which to operate. Low Medicare and Medicaid reimbursements often cause providers to charge other consumers wildly more for the same service. The illustration below is the actual reimbursement rates for my PCP including co-pays;

MEDICAID VISIT	$ 48	($45+$3)
MEDICARE VISIT	$ 71	($56+$15)
REGULAR VISIT	$180	($145+$25)
CASH PRICE	$ 91	

So in this illustration $90 to $100 represents the "sweet spot" and therefore the objective. The average patient mix is approximately 60/40 Public vs. Private as the incident rate is higher in the Public programs (Medicare/Medicaid). So if we assume 1 Medicaid patient, 2 Medicare patients and 2 Private patients, the resulting average is $90/person without co-pays, $100/person with co-pays, and $56 under S1804 and HR676. No provider can run an office and support staff on $56/patient. However, if cost is lessened for the provider, the new resulting "sweet spot" might become $80. "US.US" is based on a uniform payment structure using the new Medicare rate as the basis with a STANDARDIZED deviation up or down Medicaid vs. Private. A revised reimbursement schedule might look similar to this;

MEDICAID VISIT	$ 60	($55+$5) 20% Down deviation
EXPANDED MEDICAID	$ 75	(1/2 $60 + 1/2 $90+ 0)
MEDICARE VISIT	$ 75	($65+$10)
EPANDED MEDICARE	$ 83	(1/2 $75 + 1/2 $90 +0)

PRIVATE VISIT $100 ($90+$10) 33% Up deviation

The new average becomes greater than $80 and can be adjusted to any number necessary using the same format. So we can see by this example that the combination of cutting costs and raising substandard payments in Public Plans by an average of 20%, Reduces PRICE in the Private sector by 45%.

It is clear to me that we CANNOT force any Provider to accept an arrangement of this type. They MUST be willing and further be provided the economic incentives to do so. I envision the potential for Providers to be split into two categories; CERTIFIED PROVIDER & NON-CERTIFIED PROVIDER. Among other requirements, certified providers are those willing to accept the terms of the new structure. Non-certified would be those who do not. S1804 forces those Providers out which totally eliminates access for many people. "US.US" proposes keeping these Providers in the system but reimbursing them at the Medicaid rate (default rate). It will be become their responsibility to collect additional funds directly from the consumer. The transparency requirements will clearly define them as certified or not and what their additional charges would be. There has to be some degree of forced compliance. If the system were designed to define what the "PLAN" will pay and Providers could charge any amount they desired beyond that, no competition would result and prices would not come down.

Consumers who choose higher priced providers will ultimately pay more. Conversely most consumers will seek certified providers or those closest to the regulated price point. This will create competition within the provider marketplace. Since "US.US" reimburses all providers the same, non- premium supported pricing will come down significantly over time.

5. REVISED MEDICAID AND MEDICARE REIMBURSEMENTS

A successful Single Payer System would, in my opinion, begin with bringing Medicare & Medicaid payments to at least a break even point. Many providers do not accept Medicare or Medicaid patients due to the lower reimbursements, but may still charge high fees. Even so, it therefore becomes necessary to consider raising these payments closer to the median level in order to save money. A simple concept illustrated above. Raise payments for 75 million, to lower them for 250 million. Providers will have less of an argument. "US.US" has reformed the contribution rate to account for this increase as well as reduce the cost to the government, beneficiaries and begin the upfunding process required for future sustainability of Medicare itself.

6. ESTABLISH REGIONALIZED COMMUNITY RATING SYSTEM UTILIZING EMPLOYER MANDATE

Every aspect of "US.US" is Community rated as it produces the lowest possible cost per person. This is explained in some detail in the Clinton proposal of 1993 previously sent.

7. ELIMINATE IN NETWORK AND OUT OF NETWORK PROVISIONS

"US.US" sets the same reimbursement rate for every provider and every area. Rescinding the law that allows for this pricing differential should be straightforward. Even without repeal this profit motive has been eliminated from the system.

8. IMPLEMENT CONCIERGE OR CO-OP SERVICES WHERE POSSIBLE

"US.US" provides the flexibility to encourage Concierge Services or DIRECT PRIMARY CARE which is popular with many Physicians. Whether this may or may not reduce cost of primary care is unknown but it will effectively put a stop loss on this expense which consumes 18% of current spending. This concept is currently used by Medicare Advantage Plans to some degree. Under this type of arrangement, PCP services are bought on a contractual or subscription basis. In Louisiana the current rate would equate to $50/month Traditional, $100/month Pre-Medicare and $150/month Medicare. This is a choice consumers can make on an individual basis and pay for from their self-directed HAS. They can "shop" and compare PCP services and pricing. It also takes physicians out of regulated reimbursement and may upon analysis, represent the method that will be both the most widely accepted and economically feasible means of paying for ALL PCP Services.

9. ADDRESS MALPRACTICE

Consider arbitration. Create uniformity in procedure, process and settlement guidelines. Limit attorney fees.

10. CERTIFIED PROVIDER STATUS, PRICING TRANSPARENCY & E-FILE VERIFICATION & ELIMINATING POTENTIAL FRAUD

Health visits are where you pay first and find out later what it actually cost and what you still owe. E-Filing will mean that a computer generated claim (bill) will be generated for your signed approval at the time of service. The bill will outline the services provided, associated costs and payment structure, and acknowledgement that you both understand and agree with the statement. There will be only ONE place to file the claim, saving providers both time and money. Scheduled normal procedures will require a cost estimate for both administrator and patient. Becoming a Certified Provider will require meeting with administrator reps annually to verify location, discuss operations and issues and verify pricing for posting on the regional website. You will not be selling wheelchairs from the back of your car or from the garage, the internet or Somalia. MOST IMPORTANTLY…BEING A CERTIFIED PROVIDER WILL REQUIRE THAT YOU ACCEPT A PERCENTAGE OF MEDICARE & MEDICAID PATIENTS, OR YOU WILL RECEIVE NO REIMBURSEMENT OF ANY KIND FROM THE PLAN!! PROVIDERS MUST BE PART OF THE SOLUTION.

All Provider information including pricing information for most services will be posted on a website or directory of information hosted by the Plan Administrator. This will make comparisons easy. What may not be easy is gaining access to those providers, which is why clinical medicine becomes so important.

11. MODESTLY EXPAND DRG'S & ADD LEVELS TO EXISTING ONES

Billing codes of all types can be very broad and non-specific encompassing many degrees of service. A $50 service can be lumped into a code that bills for $200. An improved system is needed.

12. CASE MANAGEMENT & REVIEWING THE PARAMETERS OF "MEDICALLY NECESSARY"

Case management has proven to reduce unnecessary services but also support Medically Necessary additional services as well. A good case manager is both the advocate for and liaison between patient, insurer and hospital.

13. PROVIDE INCENTIVES FOR GENERAL PRACTITIONERS/CLINICS TO INCREASE HRS. OF OPERATION

(Less Emergency Room Utilization}. Development of clinical medicine will help address this issue. However, my own Physician only works 4 days per week and only from 8-4:30. There are multiple Drs. In that group. I see no reason where there becannotis a rotating schedule of evening hrs. and Saturdays which would not only increase availability but make it easier for working people as well. PEP BOYS will fix your "sick" car at 8:00 p.m. May have to pay a little more to accomplish this.

14. SEEK BIDS FOR GENERIC EQUIVALENTS AT HOME OR ABROAD

It is my new position that this is probably not viable. We need to look at financing innovation as well as recapture costs and patent rights. I envision production cost and reasonable profit combined with a royalty in perpetuity to cover invention cost. Stephan Rosenthal suggests looking at the high innovation cost of many drugs that never come to market, fast tracking those that do, and a number of other innovative solutions as presented by Rosenthal2020 as means of reducing cost.

15. ADDRESS FRAUD VIA SECTION 10 ABOVE

The E-FILE & PATIENT VERIFICATION SYSTEM will eliminate many opportunities for Providers to commit fraudulent acts or submit fraudulent billings. Under this format patients will either agree or disagree with each itemization on the bill. Should a patient disagree with an item on the bill they will enter a number in that box that relates to a short list of reasons why, including "other", sign the bill and automatically submit to plan administrator. The Provider will not know. Those payments will be withheld until the issue is resolved. Providers with frequent issues will be "red flagged" for review and it will be recorded in their profile.

16. LEGISLATE 501c's TO PROVIDE A RANGE OF BASIC CLINICAL , WELLNESS & PREVENTATIVE SERVICES IF TO RETAIN NOT-FOR-PROFIT STATUS. PROVIDE INVESTMENT FROM PLAN ASSETS

INVESTMENT IN THE EXPANSION OF ALL FORMS OF CLINICAL MEDICINE IS PRIMARY LONG TERM OBJECTIVE OF "UNITED STATES UNIVERSAL SYSTEM". It is vital to the future cost of healthcare to greatly expand clinical and/or co-operative options in all areas within the delivery system including hospitals. Not-for-Profit DOES NOT mean COSTS LESS. Clinical services cost less. As many as 500 new hospitals could be required over the next 10 years. This new delivery system should be specifically designed to operate at or below the Medicaid reimbursement levels provided by the plan. This will provide consumers with an economical choice on both a cash and insured basis. Consumers will have an option that requires no further out-of-pocket expense. This option should also lessen the burden on Medicaid and Medicare. Many basic and frequent services can be performed at a much lower cost in a clinical setting as opposed to individual practice. Medicare recipients will double over the next 10 years, and we as a nation are not ready. While many more doctors will be needed, a few well qualified physicians can effectively manage an efficiently organized system of PA's, RN's, LPN's, etc. University of Rochester is a model clinical operation for the country. However, basic services are still provided through Individual Practice Associations. The poor need some place to go without placing undue burden on the overall system to include emergency room services. I see the eventual creation of 5 million short and long term jobs. University of Rochester is the largest employer in this area and continues to grow. Most jobs are well paying, but not necessarily high paying.

I envision a system that is 70% Clinical and 30% Specialized over the next 10 yrs. This puts healthcare in a sustainable format and creates a reasonable timeframe for reversing back to a mostly Not-for-Profit System. You will not become like Canada overnight. Clinical medicine will be designed to compete directly against remaining For-Profit and higher priced entities. A wide range of facilities are needed that concentrate on; comprehensive physicals, & wellness, testing, bloodwork, basic & urgent care type issues, etc. I can see every abandoned WAL-MART becoming a clinical out patient resource.

17. THE FREE MARKET

The $2000 annual HAS provided the CASH equivalent to support a free market approach. It gives consumers the dollars and personal incentive to "SHOP" for services. There is no free market in healthcare or anywhere else for that matter. 36% Corporate tax rates do not constitute a "free market", but merely a cost that is passed on to "WE THE PEOPLE". Like banking, energy, communications, etc., healthcare is just one more unregulated (unsupervised) monopoly. The design of this proposal creates a free market by forcing competition among providers, converting up to $700Billion of premium dollars to choice driven cash, and making providers, in part, responsible for their own market share and revenues.

18. SUBSIDY POOL FOR CARE RATHER THAN "PREMIUM"

Subsidy dollars are to be directly spent on medically necessary services ONLY IF and WHEN they might be required.

CONCLUSION:

As the architect of this proposal, admittedly not perfect, there is an overwhelming need for the collection and analysis of a broad range of readily available support data necessary to make it perfect. That said, it does represent a wholly integrated, vertical and flexible system (Plan). Healthcare is not a complex issue once broken into all of its' various parts, and evaluate the significance of each individual part, on every other part, as I have done. It should be noted that this system will change NOTHING for consumers other than CHOICE and COST. Although it may be reformed, it is still the same system of providers and operates largely in the same manner. The failure to recognize Medicare as the largest and mostly successful Single Payer system in the world is gross negligence of fact… But, there ARE issues. This proposal integrates the interests of both Medicare and Medicaid into the whole for continued success. It is a model, not a piece of legislation. All databases, operating and administrative systems are in place to make this an easy transition. We have gone too long in the wrong direction as a nation to be in a position to simply "start over". This starts in the middle the and represents the only provable concept to date.