"US.US"

UNITED STATES UNIVERSAL SYSTEM

"US.US" Prototype Model is the most comprehensive reform of the American Healthcare System that will reduce spending 30-35% over a 3 year experience period. It is the result of statistical analysis of claim specific data acquired from employers across New York State, during the highest period of growth in the cost of medical services (provider pricing). It is based on many years' analysis of millions of healthcare claims within employer sponsored plans to specifically define how the premium dollar is spent in terms of; utilization, provider practice patterns and pricing, network allocation and fraud among others. The thesis resulting from said analysis, "National Healthcare Initiatives & Cost Management 1989" clearly proved that healthcare had become a system of socio-economic behaviors in which each entity; consumer, provider and insurer would all simultaneously seek their own "economic best interests" and is the basis for all aspects of the prototype. The demonstrated results of the ACA are clear proof of that the original thesis was entirely valid, as the ACA has PERFORMED EXACTLY AS IT WAS DESIGNED, by producing the exact opposite of intended results for a great many reasons.

"US.US" represents a contemporary upgrade to the original MedicareforAll prototype of 1989. "Medicare for ALL" would have been most effective if implemented in 1973, rather than the HMO ACT, which triggered an immediate, rapid increase in demand and pricing, allowed for the formation of For-Profit healthcare entities and most importantly, forever changed the basis of health "insurance" by adding maintenance to normal risk. The cost of preventative care has been 10X the outcome.

The time for "Medicare for All" in its' present form have long passed, and both Medicare and Medicaid have been principle factors in rising healthcare cost within the private sector since 1990, as the indirect costs of these programs have been essentially "shifted" to this domain.

To properly understand the healthcare delivery system, one must first acknowledge that it is comprised of a series of well-defined socio-economic behaviors, in which each component; insurer, provider, government and consumer seek their own economic "best interests", that further, can be expressed in simplified (non-actuarial) mathematical terms.

This is not an insurance issue, but rather, a social issue engineered by this generation, to evolve into a fiscal crisis. Congressional counter-proposals to the ACA reflect the same flawed perceptions, by focusing on premiums rather than, the social behaviors resulting in premium. However, the thesis suggests that if we write a National Plan of lesser proportions, that lesser consumer spending and lower provider pricing will result (i.e. social behavior).

"Premium" derivatives can now be determined as 1/3 risk, 1/3 unfunded accrued liability (previously unaccounted for pre-existing conditions for the past 30 yrs.) and 1/3 adverse socio-economic activity highlighted by over consumption, excessive pricing and fraud. To influence cost, one must influence behavior. THE "US.US" model easily accomplishes that and unlike all other proposals can be PRICE PROVEN on a per person basis in any market. Thesis principles are maintained throughout the model.

WHAT IT IS NOT:

- Government Insurance as oversight will ultimately fall to the States
- Another Entitlement Program but supports both Medicare & Medicaid
- Socialism but rather Social Insurance not unlike any other Group Plan
- Liberal as it is the most CONSERVATIVE means to address all concerns relating to an unmitigated problem that has been developing for at least 40 years

My analysis of claims data has shown that as premiums increase, claims activity increases by a greater amount as does provider pricing. Premium is an obsolete term that can now be defined as cost, or in many cases, less than cost. Since premiums are based entirely on the cost of claims, this is evidenced by consistent losses in the insurance marketplace over the past 30 yrs. High premiums equate to high social activity, as consumers, seek to recover premium outlay in the form of greater, and quite often, unnecessary services.

- LOW CLAIMS ACTIVITY=HIGH RESERVE=PROFIT=LOW PREMIUM
- HIGH CLAIMS ACTIVITY=LOW RESERVE=LOSS=HIGH PREMIUM

This has resulted in a form of prepaid (no risk) by insuring known (guaranteed) losses (claims) for the most basic services. To lessen overall current spending, it becomes necessary to reduce consumer activity and provider pricing, by introducing CHOICE into the plan model. "US.US" will give Americans that choice.

Resolving these effects, CAN ONLY BE ACHIEVED by development of ONE statutory plan model for risk/cost evaluation, as opposed to, the overwhelming number of splinter plans presented in the private sector. "UNITEDSTATESUNIVERSALSYSTEM represents the only model to date.

- ONE DEFINABLE POPULATION (by census)
- ONE DEFINABLE RISK (by age/sex)
- ONE DEFINABLE COST (benefits)
- ONE WELL DEFINED and MANAGEABLE SOLUTION

Universal Healthcare is the only viable model that can have an immediate short and long term impact on the attitudes, behaviors and pricing necessary to effectively "REBALANCE" the system and further, reverse all the negative aspects of the "Affordable Care Act". That model is contained herein and provides:

- UNIFORM BENEFITS
- GUARANTEED ACCESS
- AFFORDABLE COST STRUCTURE

And further, represent the stated objectives of the Republican Party. This revised, expanded concept of Medicare, was first presented by myself to Hillary Clinton in 1991, and again to President Obama and Bernie Sanders in 2013.

WHAT "US.US" WILL ACCOMPLISH:

- Integrate All existing Public, Private and Employer Systems and FUNDING into ONE flexible, vertical, universal format, while simultaneously reducing cost per person, implementing a host of cost reforms and expanding Medicaid to a broader range of the lesser income sector.
- Mandate coverage for part-time workers and create a disincentive to hiring ONLY part-time workers to result in the potential for more full-time employment.
- Provide 100% Hospitalization and identical, uniform basic benefits to every single AMERICAN regardless of ability to pay in every region, and further the option to upgrade that coverage on equivalent (community rated) terms.
- Cover all and future Pre-Existing Conditions as NORMAL
- Eliminate High Deductibles
- Reduce Administrative Expense
- Eliminate Fraud and provide for Pricing Transparency which will encourage a more "Free Market" Environment where one does not currently exist (create provider competition)
- Increase payouts under Medicare & Medicaid mandating full participation by providers while simultaneously reducing price for all other Americans
- Expand Medicaid to 200% of FPL and integrate expanded Medicare for those working (Full or Part-time) while reducing that burden on both programs by 50%
- Create a fully integrated, flexible & vertical format between Medicaid, Traditional "Insurance", Pre-Medicare & Medicare Systems
- Increase consumer awareness of provider pricing and encourage direct involvement In the decision making process and associated costs
- Provide for complete portability
- Reform Malpractice
- Equitably decrease Hospitalization Expenses by an average of 20%
- Eliminate ACA Tax Structure
- Provide paid for subsidy pools for care rather than premium of lower income
- Change the role of insurer to daily administrator and cost manager of the regional Plan(s) within the same cost corridor
- Expand the role of 501C provided services (Clinical Resources)
- Create 2-5 million long and short term jobs
- Create nearly 1 trillion dollars in disposable income to be redirected in the economy

NON-MEDICAL BENEFITS of "UNITED STATES UNIVERSAL SYSTEM"

- ✓ 100% PARTICIPATION IN BASE PLAN INC. PART-TIME & SEF-EMPLOYED
- ✓ IDENTICLE, STATUTORY BASE BENEFITS FOR ALL AMERICANS
- ✓ SINGLE, IDENTIFIABLE RISK STRUCTURE FOR STABILIZATION & COST MANAGEMENT
- ✓ GEOGRAPHICAL PRICING
- ✓ LOCALIZED ADMINISTRATION
- ✓ UNLIMITED RESERVE PRICING IF REQUIRED
- ✓ LOWEST PREDICTABLE PER CAPITATED COST STRUCTURE
- ✓ LOWEST ADMINISTRATIVE COST FOR PROVIDERS
- ✓ ELIMINATION OF ADVERTISING & OTHER MISC. EXPENSES
- ✓ EXISTING NETWORKS AND CLAIMS PROCESSING CAPABILITY
- ✓ FAIR & EQUITABLE MANDATED FUNDING REPRESENTING MASSIVE CASH FLOW
- ✓ SIMPLE UNDERSTANDING & COMMUNICATION OF PLAN BENEFITS
- ✓ EASY ENROLLMENT PROCESS
- ✓ SIMPLIFIED EMPLOYER PROCESS & LOWER ADMINISTRATIVE COST
- ✓ NO DEFICIT SPENDING
- ✓ "KEEP YOUR OWN DOCTOR"

This updated model reintroduces Medicare as a defined contribution plan rather than a defined benefit plan consistent with other current benefit programs. The guidelines of the ACA were chosen as the approximate contributory rates. It revises the parameters of the base (threshold) plan relative to the supplemental (excess) portion of the program. It represents an ADMINISTRATIVE SERVICES ONLY, TARGET PREMIUM, SELF-FUNDED PLAN that can easily be "Targeted" to ANY given price poi

The concept is to begin moving back to the basics by calculated means, by effectively starting over from a median (known) point as opposed to a total restructuring from "ground zero". The community rating represented by the model is successful because it intends to underwrite only absolute (known) risk in the base model, and leave variable (excess) risk to the free market (supplemental portion). Using this format , the possible negative consequences (variable), represented by the currently uninsured can be accounted for in development of the base plan, without, having a negative effect on the currently insured. The numbers prove it IS POSSIBLE to provide for 100% of medically necessary hospitalization and catastrophic loss, as well as, guarded (capped) benefits for Basic Care and Prescription Drugs within the target cost basis.

Healthcare plans are a DESIGN/ENGINEER/BUILD process intent upon producing a predictable result after considerable analysis of systemic claims experience, price, access points, delivery cost and other administrative data, that will ultimately produce a model that can be accurately priced in the private sector. Actually it is quite easy to underwrite any plan to any given price as I have done. THE PRIMARY OBJECTIVE IS TO UNDERWRITE THE BEST UNIVERSAL BASE PLAN POSSIBLE AT; 50% OF CURRENT EXPENDITURES (17%) GDP, THAT IS ALSO 50% MANDATE AND 50% FREE MARKET SOLUTION (50/50/50). The secondary objective is to increase benefits payable per dollar by both reducing cost and raising the claims to premium ratio to 90% from 80%. "US.US" succeeds in accomplishing both of those objectives.

I AM PROPOSING INTRODUCTION OF A BILL THAT MANDATES FOR COLLECTION AND POSSIBLE AUDIT OF EVERY FACET OF THE HEALTHCARE SYSTEM TO DEFINE PATTERNS THAT EXIST BETWEEN INSURER, PATIENT, PROVIDER AND OTHERS TO IDENTIFY ALL POTENTIAL MEANS OF REDUCING COST PRIOR TO ANY OTHER DEFINITIVE ACTION IN CONGRESS. THAT INFORMATION IS READILY AVAILABLE.

If your intent is to REFORM THE SYSTEM, LOWER CURRENT COSTS and MANAGE FUTURE COST, then there can only be ONE FULLY INTEGRATED, FLEXIBLE, VERTICAL FORMAT FROM WHICH TO WORK.

All current conversations ignore the fact that the majority of cost, while motivated in part by behavior, is still generated at the point of service. It's time to change the conversation which is focused entirely on the politics rather than the solution. The healthcare system has been built on a "House of Cards" since the HMO Act of 1973. Suddenly, this has become a crisis that developed right in full view. Thanks to the poor work of the ACA "architects" the system is finally being exposed, but there is much, much more.

TIME TO EXPLORE THE POSSIBLE