A Health Care Funding Plan Alternative

During the last 30 years I have witnessed several efforts by various states and our federal government to provide affordable health care coverage for many, if not all U.S. citizens and legal residents. For the most part, these valiant efforts have met with limited success.

What **we'd** like to offer is a health care **funding** system that will cover all U.S. citizens and legal residents and eliminate the projected future financial shortfalls for Medicare, as well as Medicaid and the CHIP programs. There is no medical advice in this proposal. We merely suggests a different method for **funding** health care expenses. This proposal also contains the mechanics for creating the equivalent of a single payer system other than our federal government to eliminate confusion that may be encountered by health care providers and insurers.

It is important to note that what is proposed is a funding system for health care, not just for our retirement years, but for our entire lifetimes.

My associates and I have prepared two videos: the first describes the plan and is divided into sections containing basic information regarding the plan that is primarily for the general public and employers; the second video provides additional information for employers, health care providers and health care insurers *(including an explanation of our suggested "single payer" system)*. This written document is designed to cover most, if not all, other details not contained in the videos.

Finally, I'd like to respond to two comments I frequently encounter when discussing health care with various members of the general public:

1) Healthy, generally younger individuals, say, "Why pay $xxx monthly for health care insurance? I will probably never encounter medical bills anywhere near that amount. I'm healthy and haven't been to the doctor for years. I'm just throwing away my money."; and

2) "I pay $xxx per month for medical insurance, but the deductible is so high that I probably will never be able to use that insurance, even if I encounter substantial medical bills."

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In our proposed plan we suggest there are no deductibles for lower income individuals, but as income increases, and. therefore our ability to pay a portion of our medical expenses increases, our deductible will increase.

In addition, when we are young and healthy *(the majority of us at least)*, our medical expenses will be minimal, but as we age, our medical cost will increase significantly. So please keep in mind two thoughts:

1) **THE PURPOSE OF MEDICAL INSURANCE IS NOT TO PAY EVERY MEDICAL BILL WE GET, BUT TO PROVIDE FOR THE CATASTROPHE.** If you or one of your family members break an arm or a leg, you may encounter an inconvenient financial burden. But what if you or one of your family members is suddenly diagnosed with cancer or another life threatening and/or debilitating disease and you are unexpectedly overwhelmed by significant and quite possibly continual medical bills?

2) Since, in this proposal, your medical insurer would usually stay with you from birth until the day you die, think of the medical insurance premiums you are now paying, but that are not currently being used, as being put away for your future medical costs. These future costs will most likely be significant and continual when you are older and will be at the time when you are most likely paying lower insurance premiums.

We hope that you find some merit in what we have proposed. If you are in favor of what we suggest *(or in favor of its basic elements)*, please contact your U.S. Congressional representatives and U.S. Senators, as well as your state and local legislative leaders. Please also pass our website or the information contained in it to your friends and relatives.

Thank you for your time.

Thomas P. Dunleavy
Certified Public Accountant (Retired)

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The supplemental information hereafter is presented for each video section as indicated.

VIDEO 1

First Section - the Introduction:

Most funding sources for the Affordable Care Act (Obamacare, "The Act") have been removed by subsequent legislation, or executive directives since the establishment of The Act. Any individual, company, or governmental support is all but non-existent at this time. Therefore, going forward, additional taxes will be necessary to fund any medical expenses incurred under the Act.

In addition, many governmental agencies, both federal and state, have provided their own health *(as well as other)* insurance to their employees at significant cost to taxpayers. This includes the executives of both federal and state governments, their legislative members as well as federal and state employees.

Under this proposal **ALL** U.S. citizens and legal residents will be covered. However, what is being proposed is lifetime health care insurance from cradle to grave. Therefore, what the insured individual is paying for is current, as well as future health care insurance, not just future health care insurance *(like Medicare)*.

The comment that people currently enrolled in the Medicare program and those about to enter the Medicare system will be allowed to stay within that system and to retain the benefits of that program may not be tenable after an allotted period of time and certainly not forever. The economics of keeping our current system and our proposed system may prove to be quite unsustainable after a certain time period.

Part 1A – How it will all work:

It is essential to emphasize that the individual and/or their employer will still need to pay an assessment of 3.95% to the Medical Clearing Corporation (MCC)[1] even after Medicare is terminated. The health care assessments are separate from the 1.45% Medicare fee. After Medicare is eliminated, the required assessment that individuals and employers must pay to the MCC for health care of 3.95% will continue. But, by eliminating the 1.45% fee that both the employee and their employer must currently pay for Medicare, the final result will be a **net cost** of 2.5% Nevertheless, we wish to emphasize that both these charges are separate charges.

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[1] *The Medical Clearing Corporation (MCC) is explained in Video # 2 and later in this written explanation.*

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Part 1B – Payroll and Other Expenses:

In some examples for health care costs in Part 1B of the video, the claim that the ultimate elimination of Medicare fees will also reduce the net cost that an employee, employer or other taxpayer will be assessed for health care has been omitted. However, that factor is still valid even though it has not been referenced in the example(s).

As in the first example cited, for employees making $30,000 annually, it is stated that the assessment of 3.95% would result in a monthly assessment of $98.75 ($1,185 annually/12 months = $98.75 **[A]** per month), as stated in the video. However, although not expressly stated in the video, the net effect of the monthly fee would be further reduced after the ultimate elimination of Medicare ($30,000 x 1.45% Medicare fee = $435 annually /12 months = $36.25 **[B]** per month.) The resulting monthly net cost would therefore be **[A]** $98.75 - **[B]** $36.25 = $62.50 per month, or 2.5%.

Regarding dependents: for married individuals filing jointly and for all other couples that have entered into an agreement to report and to file as one entity [2]; for both such of the foregoing couples - the total of the two individuals' combined income up to $200,000 will be used to determine what the assessment will be for each dependent.

For example: two married individuals or two individuals that have entered into a legal *(and filed)* agreement to pay for the health care expenses of certain dependents, both partners, will be assessed up to $200,000 of their combined adjusted gross income.

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[2] *It is believed by the principal author of this suggested plan that marriage should be regarded as either a religious agreement between two individuals, possibly solemnized by a religious ceremony, or a personal commitment between the two individuals. This latter group represents many couples in our modern era that live and form a family together, and have not solemnized their union to each other religiously, but have merely made a personal commitment to each other. It is suggested that the actual commitment should not be a legal affair whether it is religious or otherwise – justice of the peace marriages or other civil marriages should be discontinued. However, any type of such commitment, religious or otherwise, should be recorded in an agreement containing: the two individuals' names; and other specific information (including dependents claimed), as well as other items, such as the right to render decisions regarding their partner's health issues and even death issues. The essentials of the agreement might be situated in a QR code, most ideally located on each partner's driver's license or identity card. Naturally the health and death issues would also apply to any dependents that they have designated in an agreement and in the QR code.*

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Part 1B – Payroll and Other Expenses *(continued)*

Any individual(s) or group of individuals may pay the health care assessment for any juvenile under the age of 26 years old that is (are) not a direct lineal descendent, or possibly not related in any way to the payer(s). They must notify their own MCC[3] and then, if necessary, notify the MCC of the dependent(s) if the MCC of the intended dependent(s) is different from their own MCC, by a written statement specifying the arrangement. The amount they must pay will be computed based upon the required assessment of the juvenile(s) they wish to assist. If the young person(s) they wish to assist has little or no income, the paying party will be assessed the minimum amount that the dependent(s) would be required to pay if no assistance was to be provided.

As stated in the video, the wealthy, those not needing to work, or just not earning wages, the self-employed, early retirees, and regular retirees, will be assessed, as stated in the video at 7.9% (3.95% + 3.95%) up to $150,000 and 6.5% (3.25% + 3.25%) from $150,001 to $500,000.

The reason the self-employed are assessed twice at 3.95% rate is that they are their own employer and, therefore, must pay the employer's assessment as well. The others previously mentioned have no employer and therefore they will be required to pay the employer's contribution as well. However, the authors of this plan have given some relief to all of the aforementioned by not assessing any of them at 7.9% on income over $150,000 to $500,000. That amount has been arbitrarily reduced to 6.5% (3.25% + 3.25%) of their remaining income. However, that rate reduction may not prevail with legislators adopting this plan.

Part 1C – Those Retired, Former Dependents 26 Years of Age and Older, Unemployed Workers, Part Time Workers, the General Pool and an End to Medicare

For retirees, the amounts reflected in the video are estimated and, based upon the current state of affairs in Washington, these estimates may be extremely tenuous.

Former dependents 26 years of age and older, still unemployed, and laid off workers will be assessed as if they were working self-employed at the minimum wage. The federal minimum wage is $15,080. Therefore, they will be assessed

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[3] *See note 1.*

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Part 1C – Those Retired, Former Dependents 26 Years of Age and Older, Unemployed Workers, Part Time Workers, the General Pool and an End to Medicare
(continued)

$99.28 per month. ($15,080 x 7.9% [3.95% + 3.95 = 7.9%] = $1,191.32 / 12 months = $99.28 per month. If they are unable to pay the assessment, the General Pool is available.

However, a parent or other individual(s) may also pay the required assessment for any former dependent(s) that is (are) 26 years of age or older, but still unemployed, or minimally employed. Nevertheless, they must notify their MCC(s) of the intended arrangement.

The General Pool –

We believe that a few further comments regarding the General Pool should be noted. One method to determine what percentage of a health insurer group's assets should be allocated to those unable to pay insurance premiums might be based upon how premium rich the group's revenues are. This might be calculated by taking the total amount of assets *(premiums received)* in the group, divided by the number of the insured in that group that have actually paid insurance premiums. A higher average premium per insured might determine a greater potential commitment to those unable to pay insurance premiums. However, that determination is better left to actuaries.

As of June 2025 there were approximately 70.5 million people enrolled in Medicaid in the U.S. When children registered in the CHIP program are added to this figure the total increases to 77.7 million people.[4]

However, in "Understanding the Intersection of Medicaid and Work: An Update" [5] the authors indicated that in 2023 *(updated in 2025)*, 44% of Medicaid recipients were fully employed and another 20% were employed part time. Some of those working part time were only able to do so, because of caregiving responsibilities, illness or disability, or school attendance. However, it is believed that a majority of those working part time pursue full time work, but have only been provided work part time because their employers were unwilling to pay for their health care.

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[4] *Pew Research Center, "What the Data Says About Medicaid", June 24, 2025*

[5] *Taken from "Understanding the Intersection of Medicaid and Work: An Update", Published: May 30, 2025, by Jennifer Tolbert, Sammy Cervantes, Robin Rudowitz and Alice Burns, on behalf of the Kaiser Family Foundation.*

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The General Pool *(continued)* –

According to the foregoing information, if we add those currently using Medicaid that are working full time - the 44%, and let's assume that the 10% included in the 20% (one half of the total) that are working part time are only doing so because their *(usually)* small employer does not wish to provide health care benefits for them due to the additional cost. The total of 54% (44% + 10% = 54%) are fully capable of working full time according to the reasons provided in the video. If all of the 54% are now, because of the plan we suggest, receiving employer health care benefits, that leaves only 10% that are still without health care insurance.

Based upon the foregoing information, we would suggest that the General Pool participants that group insurers must provide coverage for gratis should be in the 7 – 10% range.

Two additional caveats regarding those entering the General Pool should be noted: 1) If those entering the General Pool have some income, but not sufficient income to avoid entering the General Pool, that income will be assessed by the applicable group insurer, just as all other insured in that group are assessed; and 2) Once General Pool recipients no longer need the free services of the "Pool", they may encounter some difficulty finding coverage outside the Pool, experience a waiting period before being able to enter another insurance group, or encounter difficulty reentering the insurance group they were formerly with before entering the General Pool. This would be primarily due to many insurance groups not being able accept new applicants because of the fact that they *(the insurance group)* is completely full of potential insured in that applicant's category. What is meant by "category" is that insurance groups will all need to stay balanced with different types of insured in each type to keep the composition of its insured sufficiently balanced, such as: insured types with minimal services generally needed; insured types with moderate services, drugs and equipment needed; and the most costly insured types with multiple and continual services, equipment and drugs needed.

Part 1D – Deductibles, Co-Pays and Out-of-Pocket Expenses

It is believed that all of the above have been adequately described in the video. The only item that should be re-emphasized is that those insured will be allowed to contribute to an account similar to a Health Savings Account (HSA) up to the maximum amount of the out of pocket costs of their plan. This amount, if deducted from wages, would be pre-tax.

The appendix to this document contains a list of Deductibles and Maximum Out-of-Pocket Amounts for Various Income Levels.

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Part 1E – Advantages for Workers

We believe that advantages for workers is fairly explained in the video.

Part 1F – Advantages for Employers

We also believe that the video aptly explains the reasonableness of costs for small employers and the fact that taxpayers will be relieved of the burden of providing health care for their employees, especially when the charge of 1.45% for employers as well as employees is eliminated. In addition, the cost of providing health care benefits, both current health care and future health care will be significantly reduced for employers that already provide health care insurance for their employees.

Part 1G – Advantages for the Self-Employed

A self-employed person must pay for their health care with both their assessment of 3.95% and for the employer assessment of 3.95% (3.95% + 3.95% = 7.9%), since they are their own employer. In addition, until the Medicare Tax is removed, they must also pay for the employer's portion of the Medicare Tax of 1.45% and for their own portion of the Medicare Tax of 1.45% (a total of 2.9%). The latter is paid when a self-employed person pays 2.9% (1.45% + 1.45%) in tax with their income tax return on a form entitled "Form SE" that is filed with their form 1040. It may therefore be assumed that the new assessment for health care insurance (3.95% + 3.95%) of 7.9% assessment will be paid on the Form SE as well. However, both assessments will likely require periodic payments during the taxable year.

Part 1H – Laid Off Employees and Former Dependents 26 Years of Age and Older, Still Unemployed or Minimally Employed

This section is fairly redundant. It is merely restated to emphasize an important factor in this plan, but also to explain the rationale behind the $12.57 assessment for the dependents of the unemployed. If they are not employed, they must pay both the employer's assessment *(since they are theoretically their own employer)* and their own assessment. It is assumed that they will be at the minimum annual wage of $15,080 *(the lowest level of full employment)*. Therefore, their assessment of 7.9% x $15,080 annually will equal $1,191.32. That amount divided by 12 months = $99.28 per month. This has already been explained in Part 1C. However, that same amount of $15,080 x 1% *(the assessment for dependents)* will equal an annual payment for dependents of $150.80 and a monthly assessment of $12.57 *($150.80/12 months)*.

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Part 1I – Those About to and Those Currently Collecting Medicare

We only wish to restate what we already have stated in the initial explanation of the video:

> The comment that "people currently enrolled in the Medicare program and those about to enter the Medicare system" will be allowed to stay within that system and to retain the benefits of that program may not be tenable after a certain period of time and certainly not forever. The economics of the current system and our proposed system may prove this fact to be unsustainable after a certain period of time.

Part 1J – So How Do We Accomplish This?

We believe that this point is adequately explained in the video.

VIDEO 2

1) Before we get into the explanation of the Medical Clearing Corporation, an explanation of the payroll process may be necessary for those not familiar with that process:

   Most large companies will have a payroll department and smaller companies may use a payroll service. Both perform the same function.

   For hourly workers, the number of hours worked would be submitted to the payroll department, or payroll service and that service would have records of what each employee's hourly pay is and the total due would be computed.

   For employees earning commissions, their gross commissions earned less any applicable charges would be determined based upon their agreement with their employer.

   For salaried employees their gross pay would be registered and included with the gross pay of the commissioned employees and hourly employees.

   Once the gross pay of each group is computed, their federal withholding taxes, social security and Medicare taxes + the employer's contribution for the latter two would be determined for each employee and sent to the IRS. Then the state or states' withholding taxes would be determined and sent to the applicable state(s). In certain instances a city and/or county tax would also be determined and sent to the applicable state or municipal authority. If an employee indicated that a certain amount of their pay should also be deducted from their wages for

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1) An explanation of the payroll process *(continued)*

   retirement, that amount would be withheld and sent to the designated retirement fiduciary. Other items might also be deducted, such as periodic contributions to charitable organizations.

   Therefore there should be no difficulty in also withholding the employee's health care insurance contribution of 3.95%, adding the employer's matching contribution of 3.95% and forwarding both to the applicable Medical Clearing Corporation.

2) It is suggested that those waged employees that also have some investment or other income not earned through their employer and others not employed, such as the wealthy and early retirees earning income from other sources would fall into three categories: a) Those regularly employed, but having made some nominal investment income; b) those regularly employed, but having also been more successful with their other non-employer related investments; and c) those having earned income not derived from an employer.

   a) For those regularly employed having earned some nominal non-employer derived income, there would most likely be a certain threshold where a de minimis amount of income would permit taxpayers to avoid making periodic tax payments until they filed their annual income tax return;

   b) Those regularly employed having been more successful with their non-employer derived investments; and

   c) all others having earned income, none of which has been earned through an employer, *(such as the wealthy, retirees and the self-employed)* would most likely be required to open a bank account or designate a bank account from which payments would be automatically withdrawn to fund their health care payments. Other estimated tax payments might also be withdrawn from this account as well. All of the foregoing would probably have estimated payments withdrawn from the account based upon the taxpayer's last year's required amounts determined on their federal and state income tax returns.

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3) The Medical Clearing Corporation (MCC) - Providing the Equivalent of a Single Payer System

To streamline the collection and payment process for all parties, insurer, insured, employers and medical care providers it is proposed to establish a Medical Clearing Corporation(s) (MCC).[6] An MCC(s) would not be a governmental bureau, but a medical clearing organization(s) that is owned and operated jointly by insurers, employers and medical care providers. [7] [8] However, for various reasons, more than one MCC is suggested. Nevertheless, for the time being, in order to simplify the foregoing and subsequent examples, we'll just assume that there is only one MCC.

An MCC(s) would make the payment and collection system similar to a single payer system. Employer, insured employees, non-employee insureds [9], insurers and medical care providers would each have their unique code or symbol and part of that code would indicate whether the member was an employer, insured employee, non-employee insured, insurer, or medical care provider. The following sections will explain how each facet of the "clearing" process would work.

REQUESTS FOR PAYMENT SUBMITTED BY HEALTH CARE PROVIDERS

The chief problem facing providers of medical services *(doctors, etc.)*, drugs, medical products and equipment *(Hereafter all of the foregoing will be referred to as medical care providers.)* is that they must often deal with a myriad of insurers

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[6] **Actually, what is recommended is not one, but several Medical Clearing Corporations for the primary reason that if there were only one MCC, after a certain period of time the size of the MCC would be such that significant inefficiencies would ensue and one might as well be dealing with the U.S. Government. Each MCC would be required to follow one established set of rules and, as part of their charter, be required to transfer funds to, accept funds from, as well as transmit information – documentary or otherwise – to other MCCs when necessary. How many MCCs do we suggest? How about 12 regional MCCs – just as there are 12 Federal Reserve Banks? However, nothing is etched in stone.**

[7] If it were decided that the MCC were to be owned solely by insurers, or other parties that do not represent medical care providers, employers, or even insurers; representatives from each of the foregoing groups would be required on the MCC's board of directors.

[8] An MCC would be required to be insured against errors and financial misappropriations or other irregularities. They would also be required to be insured against the potential inability to pay funds to those entitled to those funds.

[9] Non-employee insureds would be: the wealthy *(those not needing to work)*; early retirees and regular retirees; laid off workers; former dependents over 25 years old that are not yet employed; those belonging to the general pool; etc.

A Health Care Funding Plan Alternative

3) The Medical Clearing Corporation (MCC) *(continued)*

and the insurers' differing and often conflicting requirements and restrictions in order to receive payment for the medical care they have already provided. This necessitates the hiring of individuals with significant expertise in the medical billing process. Since these billing "experts" are few *(as well as being expensive),* most small medical practices have been forced to join hospital affiliated organizations *(increasing their costs),* or simply go out of business and get a job in a hospital. For this reason, fewer and fewer physicians are inclined to operate on their own, requiring those seeking medical care to go directly to hospitals for even the most trivial medical issues.

Now let's digress for a moment and look at the operations of another industry, the securities brokerage industry: In this industry virtually all brokerage houses that accept and receive customer funds and securities belong to a clearing organization(s), the largest and most pervasive of which is Depository Trust & Clearing Corporation (DTCC). DTCC was not the first clearing organization to net securities transactions and then clear those transactions. DTCC was formed in the late 1990's. However, several clearing organizations had been springing up since the 1970's. Midwest Clearing had been netting securities transactions since the 1970's. However, after a period of time DTCC had grown to operate a significant amount (if not virtually all) *of the securities brokerage industry.*

Prior to the advent of clearing houses (exchanges), stock brokerage firms had to deal with a myriad of other stock brokerage houses with which they had executed securities transactions.

In a typical transaction, a brokerage firm's customer might buy a certain stock and then, if there was a significant price increase (or decrease) in that stock, the customer might sell the stock at a profit (or loss). Often the purchase and sale of the stock might occur during the same business day. A customer's stock brokerage firm (BF-1) may have acquired the stock for its customer from another brokerage house (BF-2) and then sold the same stock later in the day to a different brokerage house (BF-3). Prior to the establishment of clearing houses such as DTCC, the initiating brokerage house BF-1 would need to pick up the stock purchased from BF-2 and make payment for the stock, or provide a draft as payment. Then that same house (BF-1) would go to brokerage house BF-3 and deliver the stock that it had just received from BF-2 to BF-3 and receive payment, or a draft. Prior to clearing houses there would be multiple employees from BF-1 pushing carts (or something similar to shopping baskets) loaded with

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3) The Medical Clearing Corporation (MCC) *(continued)*

stock certificates going up and down Wall Street taking receipts of securities and issuing payment for them, usually in the form of drafts (a form of a check) and then delivering the securities to the brokerage house, BF-3, that purchased them and receiving payment for them (again, usually in the form of a draft.).

Naturally, those securities brokerage houses not located in Manhattan would operate differently. But it will not be worth going into their operations further for purposes of this explanation.

If all three brokerage houses belong to the same clearing corporation (clearing corp.), such as DTCC, they all would report the applicable trade(s) to that entity. The clearing corp. will then net the transactions and so, will treat both the buy and sell transaction as occurring through it (the clearing corp. - in this situation, DTCC) and not through BF-2 or BF-3. The clearing corp. then adjusts all broker accounts (BF-1, BF-2, BF-3, etc.) for the amounts owed for the purchase of the stock, amounts due for sale of the stock, transfers of ownership of stock (if requested), charges for dividends and interest due or payable (if applicable), stock borrowed or loaned (for short sales), etc. The clearing corp. may also initiate settlements of trading errors between brokerage houses.

Although the clearing corp. is owned by numerous financial institutions, including bankers and/or brokerage houses, it follows a certain protocol and an established set of rules. The clearing corp. 's *members' accounts are credited or charged based upon these rules. In other words, DTCC* (the clearing house) *"calls the shots". For example: if BF-3 claims a dividend is due on the stock it has purchased from BF-1, it initiates the claim with the clearing corp. and not with BF-1. In essence, the clearing corp. steps in to function as the contra-broker for all securities transactions - to a seller it is the buyer; to a buyer it is the seller. Operationally, from a securities clearing point of view, this creates the impression that every securities broker-dealer is only dealing with one contra-broker and not with hundreds or thousands of brokerage houses.*

DTCC is a user-owned and directed entity (not government owned and directed) that clears securities transactions, pays sellers and collects from buyers of securities, as well as performing custodial functions. It performs the vast majority of securities transactions in the U.S. and trillions of other transactions outside the U.S. And DTCC accomplishes this feat for a fraction of what it would cost our federal government to perform the same functions.

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3) The Medical Clearing Corporation (MCC) *(continued)*

Now, let's look at how medical care providers are compensated for the services, drugs and/or medical goods and equipment they have furnished to their patients. Medical revenue and payment management exchanges *(medical exchanges)* exist, such as Change Healthcare *(formerly, Emdeon Inc.)*. These medical exchanges provide software to providers that allows them to enter what are referred to as cpt codes *(Current Procedural Terminology Codes)*. They are standardized codes used in medical billing to describe medical services, procedures and diagnostic tests performed by health care providers. These codes indicate which services and/or what type of services or products the health care providers have performed or supplied for a particular patient. However, one visit to a doctor's office may involve numerous procedures *(a doctor's examination, blood testing, X-rays, etc.)* for that patient's visit. And since, as medical technology continually increases, the amount of medical procedures alone are increasing almost exponentially, more and more cpt codes are required. Nevertheless, this system is updated continuously and maintained by the American Medical Association (AMA)

The primary difference between a securities clearing corp. in the securities industry and a medical revenue and payment exchange, is that the latter *(the Medical exchange)* merely transmits to the insurer specified or to the U.S. and/or state governments (Medicare, Medicaid and Chip) [10] the information that the medical care provider's staff have input into its system and the amount being claimed by the provider. Then, each insurer responds individually to the information it has received from the exchange. Some, but very few, promptly transmit payment to the provider; most ask for additional information and some, less reputable insurers, continually ask numerous questions attempting to delay the claim as long as possible until the provider's time period for making the claim has been exhausted. The bottom line is that, although the provider's staff enters all of its claims to the various insurers in a uniform basis due to the cpt codes, the responses and subsequent demands from insurers vary significantly, creating a lot of additional work for the provider's staff and delaying the provider's receipt of payment. So a medical exchange doesn't "call the shots". It merely transmits detailed information to numerous insurers and governmental agencies.

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[10] Since one of the goals of this proposal is to eliminate the need for Medicaid, Chip and Medicare, only the mechanics of transmitting claims and other information to private insurers are addressed.

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3) The Medical Clearing Corporation (MCC) *(continued)*

Under the proposed MCC system, each group insurer belonging to the MCC would be required to establish what medical goods and services they will cover and the amount that they will pay for each of those goods and/or services. For the most part, this information is already in existence. However, now this information would be more public and readily available.[11] This information will be especially helpful to medical care providers beforehand - allowing the provider ready access to the insurer's coverage and payment data before discussing with the patient what that patient's options for treatment are. In addition, since this information will be public through the MCC, it would be possible for independent rating services *(or even the MCC itself)* to rank/rate each insurer based upon their overall coverage *(what coverage they provide and how much they will pay for each good or service)*. This rating process should have the effect of coercing all group insurers to match the coverage of their compatriots. The MCC and/or independent rating services may also offer an additional rating of group insurers that ranks/rates the quality of the services they offer, such as customer service, accessibility, etc. This information from both rating types would be available to those attempting to select a group insurer or change group insurers.

The required documentation and other information required to be submitted to the MCC(s) for each type of medical good and/or service performed would be standardized nationally. Once the required information received by the MCC was determined by the MCC system to be sufficient, the MCC would debit the group insurer's account based upon the insurer's established rates and credit the health care provider for the same amount. Additional amounts might be due from the patient, depending upon the patient's deductible and coinsurance amounts. If the insurer disagreed with payment of the health care provider's claim, its only recourse would be against the MCC. The MCC would "call the shots".

To support the MCC organization(s), medical care providers would pay a percentage of the dollar amount of the claims submitted *(such as .25% - .5% of the claim)* to the MCC and insurers would pay a percentage of the premiums it

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[11] The board and staff of the MCC(s) will establish *(with the input, or even legislation, provided by the federal and/or state governments)* the minimum amount for medical goods and services that each health insurance group must cover and the minimum amount that every insurer must pay for each good or service. However, it is tempting to think that the amount and the cost of all medical services provided would be standardized for all insurers. The foregoing suggestion would make it significantly easier for the amount due for services to be determined & realized.

A Health Care Funding Plan Alternative

3) The Medical Clearing Corporation (MCC) *(continued)*

receives from employers and otherwise, through the MCC *(perhaps .25% - .5% of the premiums).*

Rather than "reinventing the wheel" it may be decided to use existing Medical revenue and payment management exchanges *(medical exchanges),* such as Change Healthcare - provided they are willing to adapt their software to the new requirements and comply with the mandated ownership and governance stipulations. Federal financial assistance in the form of low cost loans or grants may be offered to assist the exchange in effecting the required software and other system modifications. There would be several advantages in using existing exchanges. One advantage would be that the existing exchange(s) and their staff are already familiar with the industry, their system and the software currently being used. Therefore modifications to that software would be less onerous to them. Another advantage would be that since the MCC entry software would be a modification of that which is currently being used and not a completely new system, there would be a reduced learning curve for those currently employed by medical care providers to input claim information into the system after the modifications are effected.

SOME ADDITIONAL NOTES FOR CONSIDERATIOIN REGARDING THE IMPLEMENTATION OF THE MCC

1) For sales of medical equipment pre-approval from the MCC *(and perhaps the insurer as well)* might be required for its acquisition.

2) Rather than the provider's staff looking up and entering cpt codes, it is strongly recommended that the software provided by the MCC be more user friendly and accept information entered in suggested wording that the system will sort out (with the provider staff's participation) and arrive at the intended procedure being billed.

3) Those in the general pool may also have certain restrictions to be met by the medical care provider that may require additional claim information to be input into the MCC's system.

4) However, just as with Depository Trust and Clearing Corporation (DTCC) in the securities industry, there will be a one day delay in the charge *(as well as credits for premiums)* to the insurer's account, allowing a review by insurer’s and the MCC’s personnel for bona fide errors and/or omissions, before the insurer's account will be debited or credited.

A Health Care Funding Plan Alternative

SOME ADDITIONAL NOTES FOR CONSIDERATION REGARDING THE IMPLEMENTATION OF THE MCC

(continued)

5) The patient may be able to transmit any deductible, coinsurance payments, or HSA funds in the patient insured's account directly to the MCC from its HSA type account. This amount may be then transmitted to the applicable health care provider. OR, once the account number *(see 6 below)* is acquired and/or provided, that might be easily obtained electronically.

6) The code for each insured might consist of 5 components: a) The first might consist of a 3 digit code indicating the specific regional MCC; b) the next might be the employer's code *(if possible),* a six or seven digit code; c) the next might be a three or four digit code specifying the specific insurance group; d) the next might be a six or seven digit code specifying the medical care provider (i.e., physician, chiropractor, dentist(?), or other health care professional, such as a physician's assistant or a nurse, etc., a drug manufacturer, a medical equipment provider, etc.); and e) the insured patient's social security number.

Note: All of the above in number 6 would entail each patient insured (as well as all others previously referenced as well) having code with a possible number of digits totaling: 3+7+4+7+9 =30 . At first glance this might appear to be extremely unwieldy. However, in this computer assisted age, that amount might not be so difficult. The entire account might be located on a QR code on an individual's driver's license or identification card, a business entity's ID (similar to a "to be developed" business ID number, or health care professional's MCC identification card).

THE NUMBERS: HOW IT WILL ALL WORK

To prove the monetary feasibility of our proposal, it became extremely difficult to determine the veracity of the numbers that were determined during our search since the results of our quests varied, often significantly, between various publications and other information scrutinized. One reason for these discrepancies could be the result of the Covid pandemic that preceded the year 2022. Another might be difficulties encountered with federal agencies during the current presidential administration.

Therefore, it decided to use the data provided in the IRS publication entitled "INDIVIDUAL INCOME TAX RETURNS [THE] COMPLETE REPORT 2022". Consequently, the determination of the following amounts are also presented as conservative as possible since we believe that the results of subsequent years (2023, 2024, 2025, etc.) will prove to be even greater after 2022.

	Total projected Assessments/Subsidies
7.9% of total employee wages for 2022 [i] (3.95% for employee and 3.95% for employer)	$ 632,952,840,000
6.5 % [ii] of other income (Employee, self-employed Income, those receiving non-employer based income, such as self-employment income	364,371,518,000
Estimate amounts to be paid for dependents [iii]	14,640,000,000
Total from non-governmental funding	$ 1,011,964,358,000
Federal and state government subsidies –	
Federal government (per capita subsidy of $3,600 for every insured in each insurance group) using 347 million in 2025	$ 1,249,200,000,000
State governments (per capita subsidy of $700 for every insured in each insurance group (paid based upon the number of insured in each state)	242,900,000,000
Total from government funding	$ 1,492,100,000,000[iv]
Total from all funding	$ 2,504,064,358,000[v] [vi] [vii]

THE NUMBERS: HOW IT WILL ALL WORK

*(continued)*Looking down the road.

Notes for previous page

[i] There were 128,388,000 returns filed involving wages yielding $9,738,951,000,000, which means that the average of these returns reported was $75,856 in adjusted gross income. Although some of those reporting wages will pay more in assessments, others will not make the average amount determined. Therefore, it will (must) be assumed that the average reported income for wages ($75,856) is a reasonable amount to determine the assessments to be received. ($75,856 x 6.5% = $4,930 estimated to be the average assessment. 128.388,000 returns reporting wages x $4,930 = $ 632,952,840,000 in projected potential assessments.

ii Even though the first $150,000 of earnings will be assessed at 7.9%%, to be conservative, the lower amount 6.5 % (3.25% + 3.25%) that is assessed on additional amounts up the $500,000 will be used for the entire amount listed. Since the average "other income" earned is $19,640, it should be safe to multiply the average of $19,640 x 6.5% = $1,277. Multiplying this amount by the total returns filed of 285,334,000 = $364,371,518,000, which is being used for the estimate.

iii The authors could not unearth any data to determine the number of dependents claimed as deductions/exemptions in any data prepared by the U.S. Bureau of Labor Statistics, or the Internal Revenue Service (IRS). However, the amount of youths 17 years of age and under in 2022 was cited in a schedule prepared by CHILDSTATS, a forum on child and family statistics, which is a collection of 23 Federal government agencies involved in research and activities related to children and families. In 2022 the total number of children 17 years of age and younger was 73.2 million. Being extremely conservative, it was assumed that only 2/3s of that amount would be used and that total of 48.8 million would be assessed at the nominal amount of $300 per dependent (48.8 x the $300 annual assessment), or $14.64 billion.

[iv] Should the total funds provided be determined not to be sufficient, an increase in the per person contributions paid by both federal and state governments be increased.

[v] Based upon the population estimate for 2025 of $347 million people in the U.S, the average annual premium for every man, woman and child, would be $7,216 and the monthly premium would be $601.36.

[vi] **The cost of drugs were not mentioned in our videos. However, drug costs would also be included in the required coverage provided by health care insurers.**

Notes for the previous two pages

[vii] Looking down the road – If this Health Care funding system is successful, insurance for dental services might also be added in the future. **And, a similar system may also be adopted for retirement funds (Social Security) and those amounts may be collected and paid out through existing MCC's.**

APPENDIX - Deductibles and Maximum Out-of-Pocket Amounts for Various Income Levels

[A] Modified Adjusted Gross Income	[BJ Deductible %	[C] Deductible Amount Per Person Isured	[D] Maximum out of Pocket Amount% Per Person Insured *	[EI Maximum $ Out of Pocket Amount _e_er Person Insured *
$ 50,000.00	1.50%	$ 750.00	3.00%	$ 1,500.00
$ 80,000.00	1.50%	$ 1,200.00	3.00%	$ 2,400.00
$ 100,000.00	1.50%	$ 1,500.00	3.00%	$ 3,000.00
$ 150,000.00	1.50%	$ 2,250.00	3.00%	$ 4,500.00
$ 200,000.00	1.50%	$ 3,000.00	3.00%	$ 6,000.00
$ 300,000.00	1.50%	$ 4,500.00	3.00%	$ 9,000.00
$ 400,000.00	1.50%	$ 6,000.00	3.00%	$ 12,000.00
$ 500,000.00	1.50%	$ 7,500.00	3.00%	$ 15,000.00

* This is 2 times the deductible amount per person insured (2 x [CI)

Maximum out of pocket costs at these income levels might be capped at lower amounts.

This deductible is the ~~per person covered~~ by the payer's withheld payments.

Example **[X]:** A father with adjusted gross income of $100,000 and two dependent children covered by his insurance would have a deductible amount of$1,500 per person insured. Therefore, if he and both his children required medical services, the deductible amount for all of them would be $4,500 ($1,500 for each insured person x 3 people). Thereafter he would pay 20% of medical expenses for each up to his maximum out of pocket amount.

This total out of pocket amount is per person covered by the premium payer. Using the same example [X] to the left: A father with adjusted gross income of $100,000 and two dependent children covered by his insurance would pay the deductible amount, for each insured person requiring medical services, of $1,500 each and then 20% of medical expenses until he had paid out his maximum out of pocket amount of $3,000 per person insured. If the father and both dependent children all incurred significant medical expenses, the maximum out of pocket amount for this family unit (father+ 2 children) would be $9,000 (3 x $3,000). Thereafter, all his medical expenses would be borne by the insurer.

The insured would be allowed to contribute pre-tax to an account similar to a Health Savings Account (HSA) up to the maximum amount of their out of pockets costs for all those that they have insured. Then they will only be able to replenish this account when the account balance falls below that amount.