Strategic Implementation Plan

A Long-Term Blueprint for Healthcare Funding Transition

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1. Implementation Overview

In order for this plan to serve as a replacement for Medicare—whose ultimate demise is imminent (within the next 8 to 12 years)—it will be necessary to enlist the aid of healthcare insurance groups on a massive scale. The entire implementation process is neither quick nor easy; if executed properly, it should take 5 to 8 years. Nevertheless, once completed, the system should endure throughout the 21st century and possibly longer.

As expressed in our introductory video, it is not necessary to initiate this plan across the entire U.S. all at once. Instead of mass national integration, we strongly suggest selecting a hand-picked region or state(s) to test and develop the model. After a specified period, the results from the trial area would be analyzed, any operational difficulties or problems encountered would be tweaked, and additional states or regions would be phased in until the plan is ubiquitous throughout the U.S. and its territories.

2. Phase I Pilot Region

The region we suggest for the initial trial encompasses Idaho, Montana, Wyoming, North Dakota, and South Dakota. The authors of this program believe this five-state region serves as the ideal starting point for several key reasons:

- **1.** Contiguity: The states are contiguous, keeping travel and geographical logistics between them minimal.
- **2.** Political Alignment: They are all currently under Republican administrations, which should minimize structural disputes over implementation methods.
- **3.** Manageable Population: The combined estimated population of these five states (as of May 7, 2026) is only slightly over 5.4 million.

Executing the plan within this region will involve soliciting group health insurers to develop plans within these states. Because the populations of most states in this area are under 1 million—with the exceptions of Idaho (2.2 million) and Montana (1.1 million)—we project that 11 group plans of approximately 500,000 insured individuals each would be effective initially. Furthermore, since no single state has an exact population of 500,000, there will be geographic overlap, meaning some insurance groups will operate across state lines.

We suggest that each region appoint a coordinator and/or department to oversee all transitioning states during the implementation process. This individual or department would likely also monitor and assist the process in the next selected state or region. Because the Depository Trust & Clearing Corporation (DTCC) was used as the conceptual model for the Medical Clearing Corporation (MCC), hiring personnel familiar with the DTCC system would be highly beneficial.

> ** See "Additional Notes for Videos 1 and 2" on the homepage of this website. Under Video 2, Number 3 (page 2), a description of the DTCC is offered.*

3. The Payroll Process & Group Classifications

The payroll process is the critical mechanism for transitioning from the Centers for Medicare & Medicaid Services (CMS) and federal, state, and regional taxing authorities to private healthcare groups and the Medical Clearing Corporation (MCC).

First, employee wages will be determined either by an in-house payroll department or an external payroll service. Regardless of the method used, the operational results should be identical. When the payroll process is completed, funds and deductions will be categorized into three distinct groups: [A], [B], and [C].

- **[A] Employee-Paid Taxes:** Deducted directly from employee wages, including federal withholding (W/H) taxes, FICA taxes (the employee portion of Social Security and Medicare), and state or regional W/H taxes.**
- **[B] Employer-Paid Taxes:** Paid by employers based on employee wages. Employers must continue to pay these to federal, state, and local taxing authorities until implementation is fully completed and approved. This includes the employer's matching FICA payments, FUTA (federal unemployment insurance), and state or regional unemployment insurance. **
- **[C] General Deductions:** Various other deductions computed by the payroll department or service that reduce net wages. Examples include workers' compensation insurance, alimony, child support, wage garnishments, and deferred compensation (IRAs, SIMPLE plans, pensions, and employer matching). It also includes employee-directed charitable donations, voluntary payments, and existing group healthcare plans (which will be eliminated once full implementation is achieved, but may be adjusted proportionally sooner).

These Group [C] amounts will remain on the employer's books until paid out to the respective entities (not to government taxing authorities). Eventually, these workflows will be redirected to the MCC for central recording and disbursement.

> *** It may be possible to apply to federal, state, and regional taxing authorities (before an insurance group is fully populated) to relieve a significant portion of payroll tax obligations for individuals who are already fully integrated into a group plan.*

4. Fund Transfers and Diversification

Groups [A] & [B]

Once an insurance group is completely filled (reaching 500,000 insured individuals***), regional coordinators will notify CMS and other applicable federal, state, and regional taxing authorities. From that point forward, only the tax amounts not covered by the insurance group will be forwarded to the MCC and subsequently routed to government taxing authorities. All other funds transferred to the MCC that fall under the scope of the insurance group will be routed directly to the healthcare insurers.

Group [C]

Because Group [C] deductions are not owed to government taxing authorities, their payment processing can be immediately transitioned to the MCC at the discretion of the group management.

Diversification of Insured Locations Within Each Group

Because medical costs vary dramatically by state and region, insurance groups will be encouraged (and potentially mandated later) to acquire clients from various parts of the country once the system is fully implemented. This strategy will help insurers achieve a financially favorable expense and risk mix.

This diversification will be managed by specialized software capable of optimizing selection. The software will not select isolated individuals; rather, it will group insured clients from a balanced mix of 5 to 10 distinct states or regions to ensure the collection process does not become overly complex.

> **** Later, as states with larger populations are integrated, the capacity of each group may be progressively scaled to 1,000,000–1,500,000 insured individuals.*

5. Multiple Medical Clearing Corporations (MCCs)

Even if most insurance groups scale to 1.5 million individuals, regional population variances will create exceptions. However, assuming an average of 1.5 million insured per group, America's current estimated population of 349 million means the system would require more than 232 separate insurance groups.

To manage this volume, the individual MCCs receiving initial data and funds from these groups will act as Sub-MCCs. These entities will transmit data up to Regional MCCs, which will in turn report to a single Central/National MCC.

Every tier of this hierarchy—whether a Sub-MCC, Regional MCC, or the Central/National MCC—will possess the capability to aggregate and report financial and statistical data periodically (daily, monthly, and/or annually):

- **Sub-MCC:** Will aggregate reporting for all insurance groups under its immediate purview.
- **Regional MCC:** Will aggregate reporting for all Sub-MCCs within its territory.
- **Central/National MCC:** Will provide comprehensive national reporting by aggregating data from all Regional MCCs.

6. Conclusion

Even though the population of the initial trial region is relatively small, Murphy's Law dictates that unforeseen complications will arise. Consequently, launching the program across this five-state area will likely consume an inordinate amount of time relative to its population size. However, once these initial issues are resolved and the system is refined, a second region will be selected for implementation. This iterative cycle of testing, troubleshooting, and expansion will continue until all states and U.S. territories are fully covered.

Executing this program will require all the aforementioned procedures, alongside others not yet anticipated. Reaching the finish line will be exceptionally labor-intensive and time-consuming. Furthermore, given the current political focus of our federal legislative bodies, this proposed program will likely face significant political resistance; as many lawmakers favor short-term fixes designed primarily to secure their reelection.

However, we must ask ourselves: what is our long-term alternative?

Once this massive undertaking is successfully and carefully established, the MCC infrastructure will also possess the capability to collect and manage retirement contributions. This opens the door to replacing or supplementing Social Security payments to the very same MCCs, utilizing the very same established insurance group frameworks.