HEALTH CARE REFORM 2015

The Family Managed Health Care System

Developed By:

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1.0 Introduction

The Family Managed Health Care Financing System is designed to address the current situation regarding inadequacies identified in universal access to health care primarily among middle and lower income citizens, but covering all American citizens. For any new system to take hold it must promote free market concepts and diminish the role of government in the operation of the system. While all levels of government will need to participate by modifying the decision-making process involving health care services and availability, the shift must leave these decisions in the hands of the citizens, their families and their providers. Each level of government will be expected to adopt new legislative initiatives that remove obstacles that will allow for the system to function and to enroll the public employee population as initial participants in the system.

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Every option, currently being debated to reform health care in the United States requires sacrificing some element of quality of medical services or some degree of universal access. Each of these options places the burden of bringing down the costs on the providers of these services. The proposals on the table do not address individual responsibility, corruption and waste. These proposals call for greater government intervention and regulatory controls. This translates into additional burdens being placed on the medical providers' time or finances to meet these requirements.

Under the current system, medical providers spend upwards of 40% of their work time writing up justifications for patients in order to get the insurance company or government to approve the procedure. This burden impacts the supply side of the equation and detracts from the time the provider can be spending with their patients. Additional regulations and government mandates will increase the time demand on providers and reduce the supply of patient time.

This is significant since the goal is to add nearly 47 million new participants into the health care system. The numbers simply do not add up. The current system is already squeezing medical providers and there is a 1% annual decline in the number of medical providers. Implementation of a new more burdensome system will increase that rate of decline to 5% per year or greater. This will aggravate the shortages in the patient time supply. Under free market principles this would cause the cost to increase as supply shrinks and demand increases. But, under the ObamaCare plan the government will intervene to force prices down by limiting reimbursements. The effect will be an exodus of trained medical professionals and forced rationing of health care will be necessary.

The Family Managed Health Care System is the solution to everything that all parties express they want except for government control over the health care system.

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The Family Managed Health Care System provides the following advantages:

- ***Access To Health Care will be Universally Available (including outside the US)***
- ***No one can be Denied Participation in the System based on Pre-Existing Conditions***
- ***No one will lose Participation in the System based on loss of Employment***
- ***No one will be denied a Medical Procedure by any Government/Insurance Company administrator***
- ***Protects Medical Providers from Skyrocketing Malpractice Costs***
- ***Provides for Controls on Medical Malpractice Awards Through Local Arbitration Boards***
- ***Reduces the Cost of Medical Malpractice Coverage for all Medical Providers to 1% of Revenues***
- ***Reduces the Administrative Cost of Payment on Services to 3.5% from over the current 34% to 60%***
- ***Provides all Medical Providers (Payment at the Moment of Service) PATMOS.***
- ***Eliminates all Medical Billing to Insurance Companies, Unions, Federal and State Governments.***
- ***Eliminates all Collection Costs (Collections Attorneys, Court Costs, etc)***
- ***Protects Employers from Catastrophic Impact arising from Employees with Severe Health Issues***
- ***Levels the Playing Field for all Employers in the Cost of Providing Employees Contributions***
- ***Protects Employers from Employees that Abuse the system by fixing the employer's Cost.***
- ***Eliminates all Medical Bankruptcies and their Long Term Economic Consequences***
- ***Reduces National Health Care costs a minimum of 34% and as much as 66%***
- ***Increase Earnings of Medical Providers by minimum of 10% and as much as 30%***
- ***Increase National Patient Visit Capacity by a minimum of 40% and as much as 60%***
- ***Guarantees Families and Physicians Maintain Control over Health Care decisions***
- ***Increases Competition among Medical Providers***
- ***Reduces the Projected Federal Deficit by $4.9 Trillion over the next 10 years***
- ***Reduces the Size and Scope of the Federal Government***
- ***Reduces the Cost to State Governments by $1.023 Trillion over the next 10 years***
- ***Makes All Employees (Full and Part Time) Eligible for Employer Contributions***
- ***Eliminates the Bureaucratic Costs of Medicare and Medicaid.***
- ***Incentivizes Elimination of High-Risk Health Behaviors such as Obesity, Smoking, Drinking, Drugs, etc.***
- ***Creates Disincentives for Violence against others that lead to Medical Costs.***
- ***Utilizes Existing Advanced Technology to manage the Accounting (ACH, EFT, Internet, etc)***
- ***Can Be Expanded Internationally To Provide Access to Facilities and Providers in Any other Country.***
- ***Can Be Expanded Internationally To Citizens of Any Nation.***

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Under the current system, medical providers spend upwards of 40% of their work time writing up justifications for insurance companies and government bureaucrats. This translates into cost. The Family Managed Health Care System will alter the distribution of coverage to increase private participation and begin to eliminate the role of government in health care.

The next three figures provide visual representations of the role government will play in the Family Managed Health Care System, the proposed ObamaCare plan and the current system.

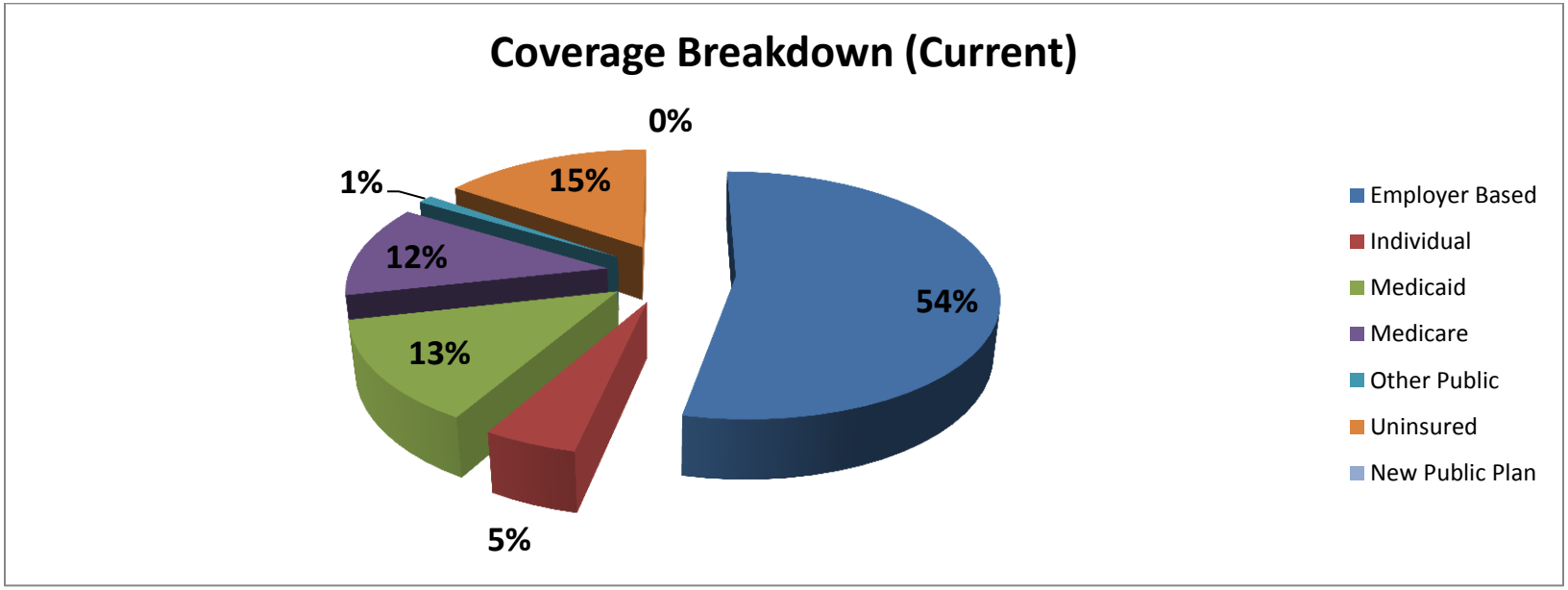

Figure 1: Coverage Breakdown (Current 2010)

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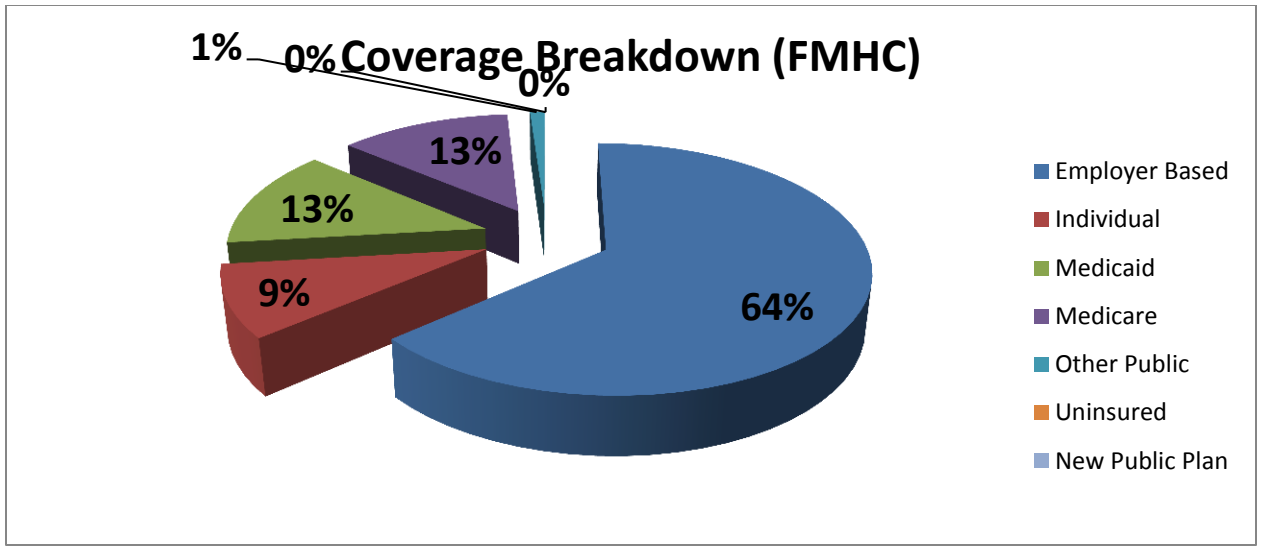

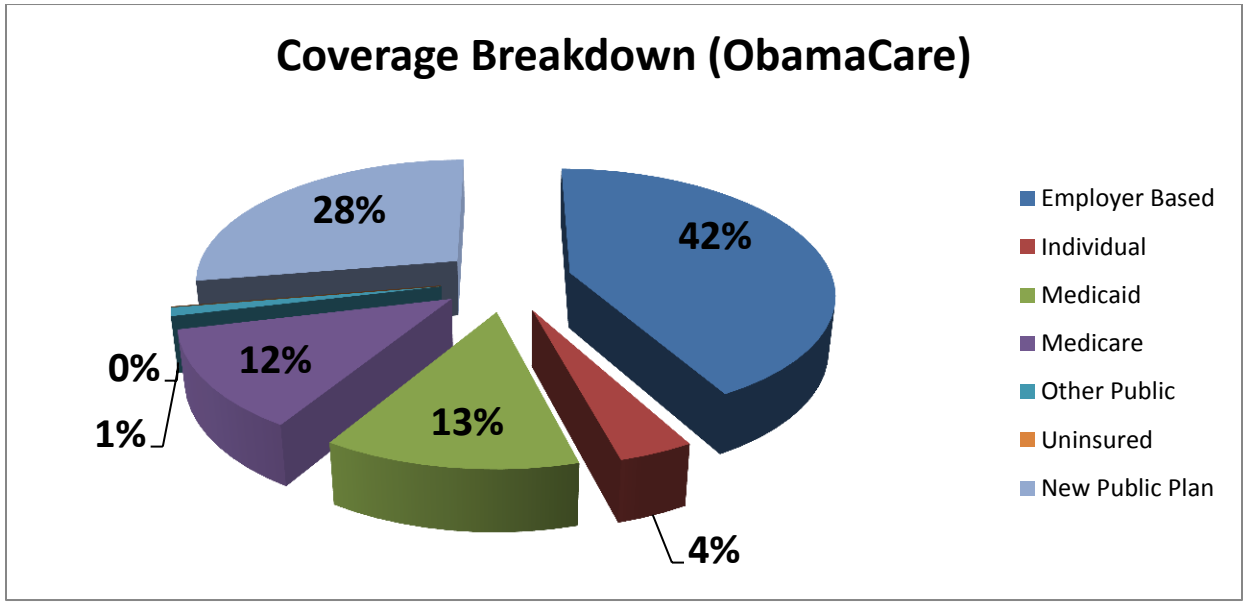

Figure 2: Coverage Breakdown Comparison (FMHC/ObamaCare)

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2.0 Risk Mitigation versus Defined Pool Financing

The ultimate goal of any healthcare system is to guarantee that health care services are available to everyone at the time these services are needed at an affordable price.

One of the key concepts behind the Family Managed Health Care System is to shift the paradigm from a risk mitigation mechanism to a Defined Pool Financing mechanism. This will assure American citizens have access to affordable health service when needed. It will trim the administrative and bureaucratic excesses currently hampering the efficient function of the health care system. Historically, insurance has been purchased to protect citizens against potential losses resulting from medical emergencies. The function of insurance is to hedge against the risk of financial loss. This risk-mitigation function is obsolete and misapplied in the area of health care.

Fundamentally, health care has evolved from a condition involving catastrophic incidents to one of on-going preventative medical services. Overhead associated with the numerous low-cost, doctor encounters increases the administrative burden on billing staffs, insurance companies and collection services.

All these costs are redundant and consume a high percentage of the health care dollar. Therefore, this system offers a plan to eliminate these costs.

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The Family Managed Health Care System is based around a desire to have the ultimate decision-making power in the hands of the members of an extended family and out of the reach of the government and third party insurers. The system is designed to utilize the forces of a free and open health care market place by establishing a standard transaction processing system that is enhanced by a direct financing mechanism that provides for immediate payment to medical professionals for services rendered. The system invalidates the concept of using the function of insurance to perform the tasks of transaction payment processing and financing in the health care marketplace.

The Family Managed Health Care System addresses the ongoing dilemma of health care costs for employers and the governments where national and state funded health costs and employee health insurance costs are skyrocketing and fewer and fewer people are able to afford the cost of the insurance.

The initial reaction of most people is that health care access and health insurance are synonymous. This engrained vision has led most to try to address the problem through the insurance paradigm.

Stepping back and redefining the problem in its lowest level state makes identifying a solution that will be much more practical and less oppressive in nature. The real problem with making sure everyone has access to quality, affordable health care is one of how it is paid for. Insurance companies take money from many insured parties and pools the funds, when a covered participant incurs a fee from a medical provider; the insurance company makes payment to the provider. With the insurance company gaining profits based on the difference between how much it can charge and how little it has to pay out, assumes the role of gatekeeper to deny treatments and slow payments for services.

The Family Managed Health Care System employs a similar pooling process. Each individual has an individual account where contributions can be made by employers, state or federal governments or the individual

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themselves. The balance in this account is then pooled into a Family Pool account with other members of an individual's extended family. The Family Pool is part of a regional pool which is part of the national pool. Each account is established at the individual's private banking institution of choice or online through a cloud based payment system. When the individual receives medical treatment and a fee is charged, the provider charges the patient's FMHC Health account and payment is made within 48 hours. The FMHC makes immediate payment using the same process that the credit card companies use.

The Family Managed Health Care System is a transaction processing system and not an insurance company. The system uses existing banking technology to provide individuals with immediate payment for services, even when no funds are available at the time of service. The overhead for the payment system is funded by the transaction fees paid by medical providers to have this payment method available.

There is no economic value or profit potential in delaying or denying medical services under this system. The economic value is to promptly pay service providers and provide accurate and timely accounting to the individual and family pool members. This flow of accounting information will allow families to determine the impact of medical services and monitor costs.

The impact on the US economy will be dramatic. Under current government run proposals the taxpayers can expect to see an increase in taxes and/or national debt of $6.8 trillion over the next ten years. Under the Family Managed Health Care System, the cost savings will be $4.9 trillion over the next ten years. The economic impact of reducing the federal deficit by nearly $5 trillion dollars will stimulate the economic growth in all other sectors. State governments will save $1.023 trillion over the same ten year period. This will help alleviate the budget shortfalls caused by the recent real estate tax and sales tax collapse.

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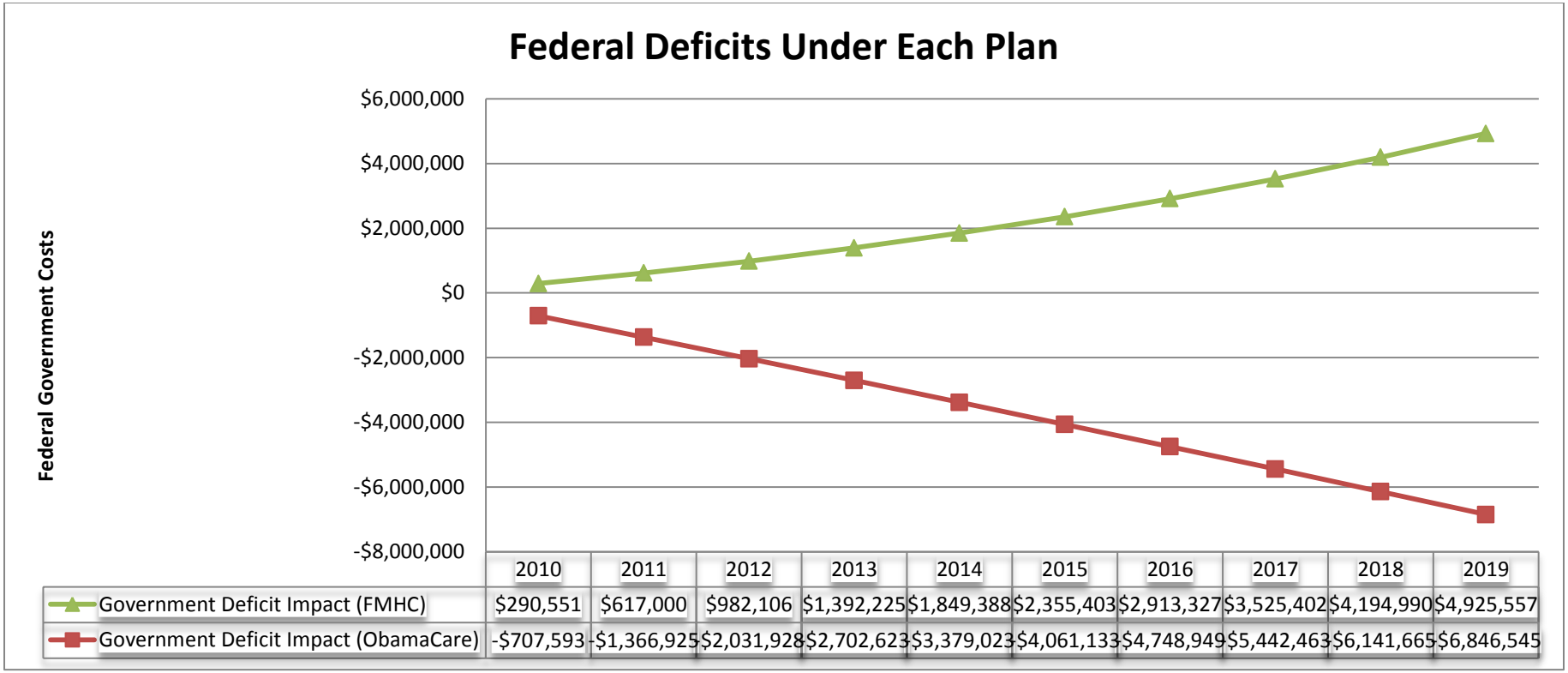

Figure 3: Federal Deficits by Plan (millions)

This plan will allow any individual to walk into any medical provider and receive immediate care or service and the medical provider will be compensated upon completion of care or delivery of services. This is referred to as PATMOS (Payment at the moment of Service). Dr. Robert Berry formed the PATMOS Medical Association[1] that educates and promotes the PATMOS methodology because of its dramatic cost saving and improved quality of service. Medical billing, as it is known today, will no longer exist. Medical transactions will be handled much like

[1] PATMOS www.patmos.com

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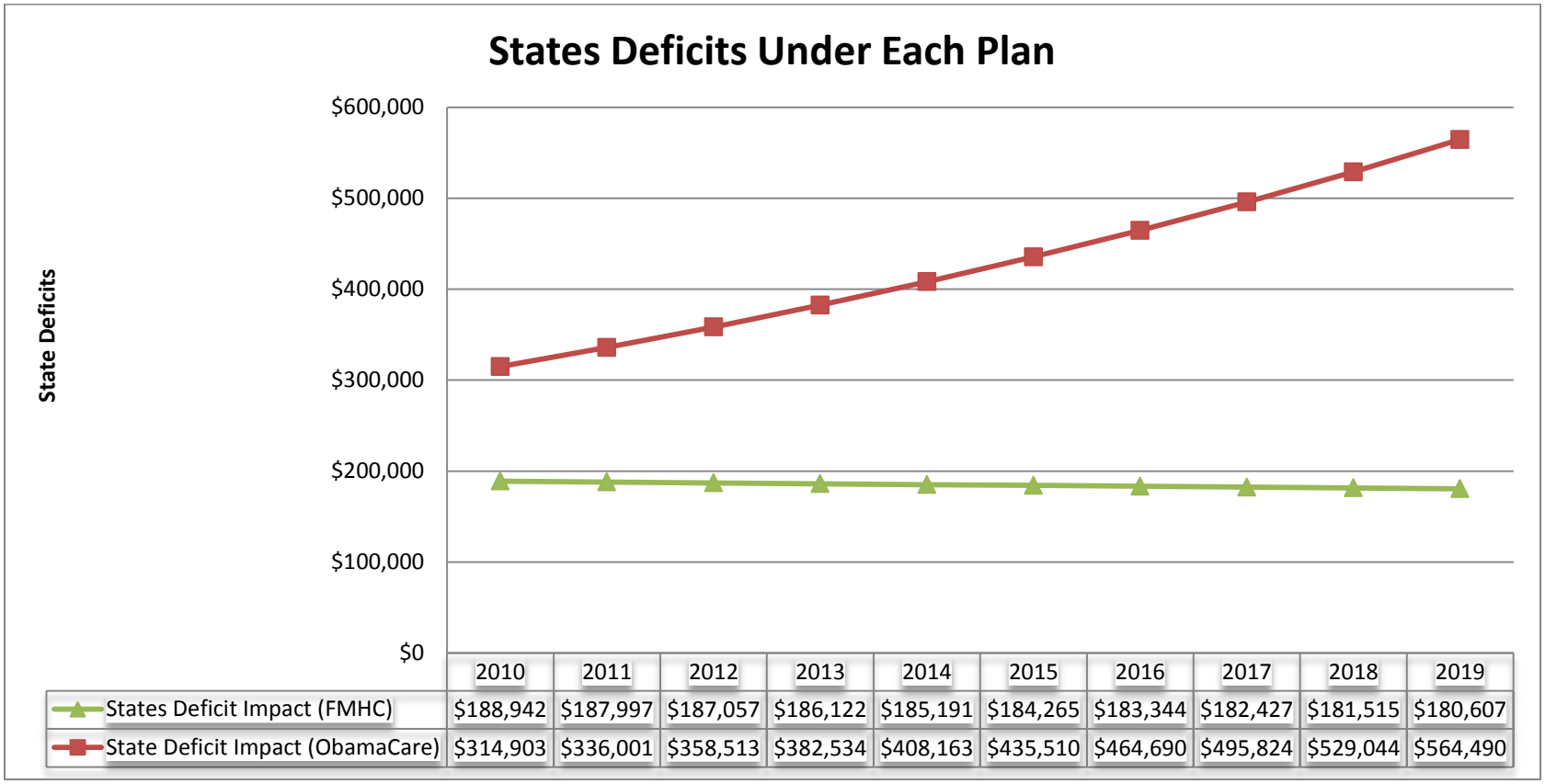
the millions of transactions people conduct every day using credit cards. The difference comes about in how the charges are paid for by the individual. Repayment is the unique and essential aspect of the plan.



	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
States Deficit Impact (FMHC)	$188,942	$187,997	$187,057	$186,122	$185,191	$184,265	$183,344	$182,427	$181,515	$180,607
State Deficit Impact (ObamaCare)	$314,903	$336,001	$358,513	$382,534	$408,163	$435,510	$464,690	$495,824	$529,044	$564,490

Figure 4: State Health Deficits Under Each Plan

To assure the system is not under the control of a single entity, participating private banking institutions are used to handle family accounts. Any private banking institution or credit union can offer the Family Managed

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Medical Account service to their customers. The accounts will be accessible through the internet and provide detailed medical billing for family members to review.

Health care providers can enroll as participating members with their current private banking institutions. It will be the responsibility of the banking institution to certify the provider as an approved health care provider in accordance with the system's qualifications, as well as, national and state regulations.

Banks will be compensated based on the volume of business that flows through these accounts. Banks will be authorized to provide additional services to account holders and collect fees for some services.

The central concept of this system is that the raw costs are paid for directly by the individual and indirectly by the family of the recipient of services. The raw cost will be substantially lower than the fees being charged through the current system because the overhead costs of all services will be reduced. Common sense would dictate that the costs related to multiple levels of management and shareholder dividends, that must be paid out of the fees collected by health care insurance companies, will also find their way into the fees paid by consumers and employers.

Likewise the costs of facilities, computers, claim handlers, management, officers and shareholders of these health care insurance companies must be drawn from those same fees. These fees are paid by employers, government and citizens. As an example several years ago, Thomas Frist of Hospital Corporation of America received an annual compensation of $160,000,000.

For that amount of money, a hospital could hire 1,600 physicians at $100,000/year, or 4,571 nurses at $35,000/year. A good deal of the

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money paid for medical care flows from the patient to these private sector bureaucrats, instead of to the physicians and hospitals. While the physicians may or may not deserve excessive compensation, depending on their competence, it is certain that those CEOs that are not essential to function of the health care system do not deserve excessive compensation. If there is any relationship between the value of something and what is paid for it, it is difficult to understand how anyone is worth that kind of money in an industry that is rapidly pricing itself out of the reach of so many people.

Free market principles dictate that when the delivery of a service becomes more expensive than alternative options, the consumers will switch to the less costly option. The government reform effort is moving to institutionalize the insurance paradigm for the eventually absorption into the government. The FMHC plan offers a methodology to meet all the stated objectives of reform without the government taking over the system.

It is estimated that 1 in 10 employees in the United States works in the health care or a related industry. This translates into approximately 16% of the annual gross domestic product and is estimated to be $1.55 trillion annually[2]. While the raw cost of health care is much less than the aggregate GDP generated by the industry, a majority of the capital expended in the health care industry is provided by governments and health insurance companies that derive their capital from health insurance premiums paid by governments, private employers and individuals or, in the case of governments, from taxes. In addition, billions of dollars are spent by all levels of government directly and these expenditures include very high and excessively redundant, overhead and administrative costs.

Separating the raw cost of health care from the loaded cost of health care will allow us to create a layer of availability to all citizens, while maintaining the opportunities for medical investment and research. Currently all

[2] Henry J Kaiser Family Foundation, statehealthfacts.org, Does not include construction related portion

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costs are included in the individual charges and fees for all patients. Medical service companies absorb the cost for unpaid medical care as hospitals and providers include those losses into their pricing structure.

At the time of this writing, legislation is being discussed that will increase the minimum wage by $2.10 per hour. It is expected to place a burden on many small to medium size businesses as FICA and Medicare contributions increase. Under this new plan, employers can be given the option of paying the increase to the individual health accounts of employees and forgoing any FICA or Medicare contributions on the increase. This incentive will make part-time employees eligible for contributions to cover their national minimum rates. Employers and employees benefit from the change in designation.

The total national cost of health care will change depending on which plan the government chooses to move forward on.

The following figures represent the impact of the Family Managed Health Care System versus the Obama Care plan. Over the next ten years, health care costs under the Obama Care plan the costs will increase by $2.4 trillion. The Family Managed Health Care System will actually reduce the national health care costs. This will impact everything from state, federal and business budgets by stabilizing what is now projected to be a 6.7% annual rate increase.

By 2019, total health care spending under the Obama Care plan will be nearly 100% higher than under the Family Managed Health Care System.

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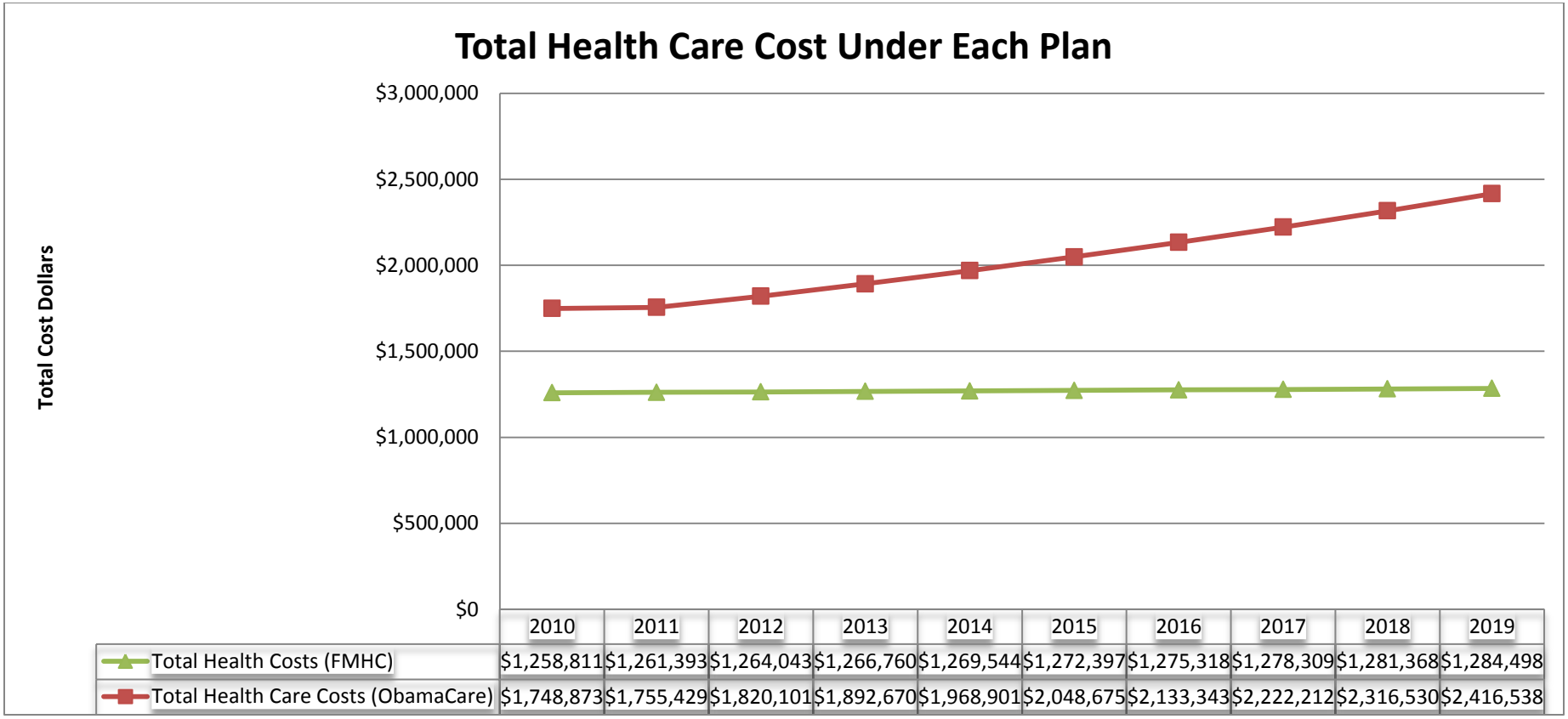

Figure 5: Total Health Care Costs Under Each Plan

2.0 Congressional Action Needed

Important actions are required by Congressional leaders to establish a legal framework that will enable the growth of a Global Family Managed Health Care System. It is necessary to incorporate these actions into legislation expected to be debated over the next 12 months.

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Minimum Wage Modifier

With each increase in minimum wage, businesses are negatively impacted by the increase in the wage, as well as, increases in matching payroll taxes. If Congress would allow employers the option to meet minimum wage requirements by paying up to $2.25 per hour direct to individual health accounts without having to pay matching payroll taxes, this would create incentives for employers to switch part of the income of employees to direct health accounts.

Immigration Reform

Immigration affects the costs of medical services where illegal immigrants incur costs without paying. The ability to require immigrants to be attached to a family pool before receiving health services would reduce the losses by health care providers. Any illegals that fail to be attached to a family pool would be assigned to an immigrant pool for the nation of origin. All immigrant pools will be recouped by a levee against the imports from the nation of origin.

Tax Incentives for Health Care Service Centers

Changes need to me made in the tax law that will allow investors and providers incentives to build 24 hour Diagnostic Centers so that providers can schedule services 24 hours a day.

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Tax Incentives for Mobile Health Care Treatment Centers

Changes in the tax law are needed that will allow investors and providers to purchase mobile medical vehicles so that providers will be able to relocate a medical treatment facility for use during national emergencies and into areas lacking easy access to health care providers.

Estate Tax Changes for Pool Contributions

Changes in the tax law that will allow family members to leave contributions to their family health pools that will be exempt from estate taxes.

Bankruptcy Laws for Pool Contributions

Changes in the bankruptcy law are needed that will prevent the relief of liability from a family pool for any charges applied to any pool member. Since the value of a health account is tracked by individual just as a standard bank debit account, the system needs to have the pool protected from family members attempting to be relieved of liabilities charged to the family pool. Any negative account balance would be restored by the pool in the event of a bankruptcy filing.

Civil Judgments Laws for Pools

Changes in the Civil law that will allow family members collect medical damages judgments from the family pool of the liable individual. These costs are actual costs related to the injuries incurred.

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3.0 Incentives

It is important to understand that the benefits and resulting savings created by this system for health care providers, families, employers and the government greatly outweigh the costs of altering the role of the health insurance industry, claims processing industry, medical billing industry and government health related bureaucracies. Under the Family Managed Health Care System employers enjoy a level playing field in the cost of providing health care coverage for their employees.

Families gain control over decisions for treatment and other health related issues. The government is relieved of the responsibility for assuring all citizens are covered by a health plan, yet, it retains the ability to provide catastrophic support to families that have unique and quantifiable economic hardships.

The government is provided a mechanism for emergency medical treatment during disasters, epidemics or terrorist attacks. The health care providers cost of doing business is dramatically reduced and the guarantee of payment reduces interest and write-offs. Universal health care access can be established without government bureaucratic control over the system. This addresses the concerns of those that fear the impact of government funded health care and those that are demanding universal access.

While health insurance companies have been the primary form of health care financing in this country for the last 50 years, the cost of providing that financing is too high and the very structure of the industry prohibits it from bringing the cost down to a reasonable level.

The Family Health Care System will utilize a tested and fully functional system of payment processing that is already in place; the Federal Reserve and EFT systems. The banking industry is already providing internet banking services to their customers for individual accounts and many credit card companies are already doing the same.

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The software and technology are already functioning. The incentive to utilize a tried and true payment processing system to process payments over a mish-mash of insurance rules and variations is clear; it will facilitate payments and participation in this new system.

3.1. Impact on Health Care Providers

Many of the benefits of this system provide advantages to those that provide the health care services, supplies and equipment. The most important benefit being immediate payment for services, supplies and equipment. Elimination of claims processing provides additional cost savings that will allow health care providers to reduce their costs. Competition will drive down raw costs as these savings are passed on to the consumers. The list of incentives to adopt this system is extensive.

3.1.1. Immediate Payment for Services

The system provides for each patient to present a debit card whenever medical services are provided. This card is processed in the same manner as a credit card transaction utilizing the Federal Reserve System for processing the transaction. Providers receive immediate availability of funds

3.1.2 Elimination of Non-Payment for Services

The ability to receive immediate payment for services eliminates the problem within the industry for non-payment. Changes in the laws that involve providing emergency services can be repealed, since all participants will be able to receive care.

3.1.3. Reduction of Write Offs

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Immediate payment eliminates the millions of dollars in write-offs that hospitals and medical providers have to take each year. These savings will again find their way to the consumer and bring down costs.

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3.1.4. Reduction of Interest Costs

Many health providers are forced to maintain credit lines with their banks to even out cash flow due to delays in payments from insurance companies or government agencies. This system eliminates delays and allows providers immediate access to their funds. This reduces the cost of doing business and will filter to the end cost to consumers.

3.1.5. Reduction of Administrative/Management Costs

The variety and complexity of insurance rules and claims processing, billing and collections efforts has forced many health care providers to purchase costly billing and claims systems and employ expensive business management staffs, claim processing professionals and billing and collection services. These costs increase the cost of raw medical services. Reduction and in some cases elimination of these costs will allow health care providers to reduce the cost of services and consumers will benefit.

3.1.5.1 Elimination of Collection Services

Almost every physician, hospital and health care provider contracts with a collection service to attempt to collect unpaid medical bills from consumers and this constitutes a major added unnecessary cost to the actual cost of health services. But one other cost is not considered; the economic impact of destroyed credit ratings and garnishments against middle and lower income families that restrict the opportunities for these families in other areas of their lives.

3.1.5.2 Elimination of Billing Staff

Billing is one of the most critical elements in any health business. Hospitals, clinics, physicians' offices and pharmacies find that without skilled and dedicated billing and claims processing staffs they are unable to

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function. The cost of these personnel in wages, benefits and office space for them to work in, and computers and equipment to do their jobs will be eliminated in this plan. This reduction in cost will impact the raw cost of health care that will benefit the consumer.

3.1.5.3 Elimination of Claim Processing

Approximately 21% of claims are rejected on initial submission to carriers for hospitals doing $400 million in billing annually. This dramatically increases the cost of processing these claims. Under this plan, the need and costs for reprocessing are eliminated.

3.1.6. Reduction in the Need for Free Clinics

The universal availability of health care financing mechanism of the Family Health Care System eliminates the need to establish free clinics since ever individual is eligible to enroll and participate in the plan.

3.1.7. Reduction in the Need to Consolidate

Many physicians and medical practitioners have been consolidating into larger and larger groups in order to gain more clout when negotiating with insurance providers. This trend has restricted availability of services as these larger groups provide exclusive or restrictive services to carriers. Under this plan the factors driving this trend are eliminated

3.1.8. Increased role of Family Practitioners

The design of the Family Health Care System is to promote the role of physicians that provide care to families on a generational basis. The ability of a physician to negotiate family wide service plans at fixed rate per month per family member will allow many families to have basic health services and physicians will even be able

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to schedule appointments at the home of the patients. For procedures that require equipment, the physician will have access to facilities that physicians can reserve time to conduct the procedures. This will maximize the utilization of equipment and streamline the market path for new medical equipment.

3.1.9. New Career Path

Under the current proposal on health care reform, the number of medical providers will decline as incomes and profitability of the medical profession are squeeze. Providers have been dealing with the squeezing reimbursements by Medicare, Medicaid and insurance companies for the last decade. The flattening of growth in medical providers has direct impact on the supply element in the equation. The new reforms being debated in Washington will discourage new entrants into the medical profession.

Under the Family Managed Health Care System many new career paths for health care providers will emerge. The role of family physician will become the center of all health care services, but, other roles will become just as vital.

The family health care advisor is a new medical services role that will be critical in helping families make decisions related to procedures and treatment options and selection of specialists.

Physicians with extensive equipment investments will have the option of offering their facilities to the family physicians at negotiated fees. Medical investment will begin to flow to establishing 24 hours diagnostic and treatment centers that physicians can use on an hourly basis. This will reduce the cost of new equipment by increasing the utilization level of the equipment.

An example can be seen in today's system where each provider's office makes a substantial investment in an ultrasound machine. In order to pay for that machine, a minimum number of scans must be performed each

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month; the motivation for the physician is to order an ultrasound in as many cases as possible. Under the Family Health Care System, a family physician may visit the patient and conclude it is not necessary or if it is necessary, he can schedule a time at the diagnostic center to have the scan done. The physician has specific hours at the center that he has reserved in a contracted agreement with the center's management. The patient is now being charged based on a prorated value that is much less than the individual physician's office. This is because the numbers of scans at the diagnostic center is much higher than at the physician's office. Since the facility is being utilized 24 hours a day it also will have a lower per hour operating cost.

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3.1.9.1. Family Health Care Advisors

The Family Health Care Advisor is a new role that offers physicians an opportunity to move for direct care to providing advice to family members on health care related issues. Former physicians can assist in finding a family practitioner for the family, assist finding family practitioners for members in other cities, deciding on which hospitals to use for in-patient services, determining the most cost effective and safest means to receive treatment and care and even in how to address issues of long-term care and elderly care.

Preventative health measures can often save a family considerable cost in the long term. Physicians advising families on health issues can often identify areas which can be improved on.

3.1.9.2. On-Line Health Care Providers

The world of on-line health advice and consultation and even treatment is just beginning to see the light of day. The Family Health Care System will open the door for families to utilize on-line professional health services for many of the most routine care issues that were often the most time consuming. Family members can be directed to diagnostic and treatment centers to provide blood or urine samples, for x-rays and ultrasounds by on-line physicians and the result can be forwarded to the physician for analysis. The family has the option to use this option and cost saving will always be a factor.

With the proliferation of video cameras and online communications it is only a matter of time before basic medical examination equipment will be in every house. Thermometers, blood pressure cuffs, close-up eye, nose and throat cameras will soon be available with computer interfaces so a physician can conduct basic examinations remotely.

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Many ophthalmologists can detect heart disease, arterial blockages and other life threatening diseases by examining the eyes. The future use of remote diagnosis and treatment will help bring down the cost of health care for all families.

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3.1.9.3. House Call Health Care Providers

By restructuring the mechanism for financing health care we establish incentives within the free market environment to alter the way business is conducted. The use of hospitals, medical diagnostic and treatment centers, physicians' offices, pharmacies and medical supply facilities will be optimized to address the primary concern of the families that are paying for the services. This optimization will extend to the ability to have physicians that do not have their own offices. These physicians will contract with entire family pools to be their family physicians. They will be able to call the physician and he will visit the family at home and address any medical issues with him. He can prescribe medicines or arrange further testing. The cost to the family is less than taking time from work and visiting a physician's office. The family pays a per member fee to the family physician. The physicians that tailor their services to meet the needs of the family will be successful. This includes the manner in which they concern themselves with promoting preventative health measures that, quite often, can only be viewed from within the home.

3.2. Families

Families are the key building block of any society. They serve as the incubator of the individual. If the foundation of a society is weak and fails to adapt and grow in strength and unity, then the society will also fail to remain strong and united.

In the last half century, the government has taken on greater responsibility in areas once the domain of the family. This trend serves to produce impersonal results and the individuals evolving from this system become more distant and detached. The family unit must be promoted and re-instilled with responsibility for health care decisions and responsibility. The value with be a better system of health care than we have today.

3.2.1. Guaranteed Universal Access to Health Care

The universal availability of health care can only be achieved if the cost that is currently being applied to the processing of payments and placing controls on the system is converted into a system that provides a financing mechanism to every family. It must also apply this access equitably and allow businesses a mechanism to provide this benefit in an equitable manner. Currently, competition between businesses and the number of wide ranging health programs and employee health benefit structures places employee access out of the reach for many employers. This plan allows all employers to meet a minimum level of payment regardless of the size of the company. Companies are also not affected by catastrophic losses experienced by an employee or employee family.

The system is focuses around the super-extended family. Every member of this plan is pooled with other members of their family regardless of the geographic location of the members. The family pools span multiple generations and include uncles, aunts, cousins, siblings, nieces, nephews, etc. The issues related to health services become a private family matter and are no longer left to the corporate for-profit decision process of the current system.

3.2.2. Guaranteed Financing Structure for payment for services

The Family Health Care System is designed to replace the current method of health care financing. Since insurance currently provides the financing for health care, it has a vested interest in controlling access and eliminates the incentives to control cost, by the consumers. Consumers view participation in a health plan as a ticket to health care regardless of the cost. These two positions run counter to each other. The result is a system that has to restrict who can have what health care. The cost of the current health care financing system is over 34% of the total cost of health care. Some estimates put it as high as 60%

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Under this plan, the financing cost of health care will be reduced to three and half percent (3 ½%) and every member of every family will be eligible to participate. Every employer will be eligible to participate and every health care provider will be eligible to participate.

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3.2.3. Increased Decision-Making Authority on Medical Procedures

Placing responsibility for health decisions at the family level and having the option to have a family health care advisor assist in those decisions mean the decisions will be more acceptable to the consumers. The current system of a for-profit entity deciding the treatment or whether treatment will be allowed creates a financial conflict of interest. Since the family will responsible for payment, it will be the family that will make the decision.

This shift in responsibility and decision making may actual reduce the overall costs since family members will decide based on the effects their treatment will have on the family overall.

3.2.4. Awareness of All Costs for Health Care

The ability to review proposed charges for services and to shop for better rates will make health care more competitive and this awareness will allow consumers to have an impact on the overall cost of receiving care.

The on-line health care account will define every charge to the account and the account can be reviewed by the consumer for accuracy. These account will be scrutinized much more closely that the current billing notices filed by physicians with insurance companies.

3.2.5. Role in Keeping Costs Down- Power to Negotiate

The power to negotiate for health care services will allow families to hire a family physician that meets their desired level of service. This will serve to open up health care provider roles that the current system does not allow for. A physician may provide a level of service to include home visits on a quarterly visit and emergency on-call. Another may have evening hours for patient out-patient visits. Still another may have week-

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end only hours for out-patient visits. The role on keeping costs down is based on negotiating for the service level that is best for the family and meets the desire level of spending the family opts to commit to health care.

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3.2.6. Elimination of Economic Catastrophe for Families

The universal availability of health care financing mechanism of the Family Health provides a framework from which general health care services can be provided to all citizens and remain within the free market environment to optimize the care and cost of care.

As with any system, the possibility of catastrophic events impacting a single family pool always exists. For example, in the case of a family involved in car accident with multiple serious injuries, or multiple cases of cancer afflicting a single family pool, these are viewed as catastrophic economic events that the system can handle only to a point. When the total cost of treatment for all these events drives up the family pool rate to a level that creates financial hardship on every member of the pool, a mechanism is provided that triggers financial assistance to adjust the rate of the repayment to control this condition. The adjustment is accomplished by extending the period for repayment in the family pool account to reduce the payments or transferring credits to the family pool account from a catastrophic pool paid into by health care providers.

Another option also exists for individual members of family pools to purchase an insurance policy to cover the outstanding balance of their account should they die with a balance owing in their account. This is a legitimate role for insurance and can be seen in credit card life insurance policies that the industry currently provides credit card holders.

Three methods for handling catastrophic medical crisis are outlined here. The government has the option of adopting additional programs to assist in terrorist acts, natural disasters and national emergencies.

3.2.7. Reduction of Health Care Bankruptcies

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The current system is plagued by write-offs of losses from non-payment for service. The Family Health Care System has a unique structure that does not allow for write-offs. While this must be addressed in the law by the government, the structure of assigning responsibility for health care costs to the individual and to the pool to which they belong precludes the ability of the individual to include health costs in a bankruptcy and not have to ever pay the bill. Since the pools have no ability to file bankruptcy the charges to the pool are perpetually serviceable by the members of the pool and since the individual will remain a member once the bankruptcy process is complete, the cost will still be borne by the individual.

3.2.8. Greater Influence over High Risk Behaviors

Shifting the responsibility for health cost to the individual and their family will have some significant sociological influences. The first is the influence of the family on high risk behaviors. Alcohol and drug abuse, promiscuous behavior, smoking, wearing seat belts, driving habits, etc. can all be influenced by family members that have a view of the cost they will all incur if a family member requires treatment for these behaviors.

Another aspect involves the family pressures that can be employed to reduce obesity, and improve unhealthy living conditions. Preventative healthy life styles begin at an early age in life and the incentives will be in place to promote such life styles when the cost of not doing so can be very high and negatively impact the family in the future.

The current system uses the employer to pool members. This creates a group of people that may have not more connection than the place of employment. Any attempts to influence or mandate behavior will be resisted and people will resent the intrusion. But, the family, in spite of the substantial influence it possesses, has been on the opposite side of the argument and left without a legitimate economic position to expect family members to conform to healthy behaviors.

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The argument within the current family is that what one member does has no impact on the other so they have no right to say anything about their behavior. This argument dissolves in this family plan.

3.2.9. Improved Health Care (family history)

The value of having a physician that has treated your father, his father and your uncles and aunts can be invaluable in times where medical conditions are hereditary. The knowledge of conditions within the family has long been a value tool to physicians. This plan promotes the concept of family practitioners and family health care advisors.

The knowledge of medical issues existing within a family tree can often reduce the time it takes to diagnose a condition and prescribe a treatment. The trusted physician that visits the family can also recognize unhealthy conditions in the home that can be corrected long before health deteriorates for other members of the household, thereby, saving the family on future health care costs.

Diagnosis of a condition that is contagious or hereditary can allow the visiting physician to examine other members of the household for symptoms and begin preventative treatments.

What is described is a substantially improved health care system that reverses the trend toward centralized and impersonal treatment for families and focuses on a more decentralized personal family oriented system of treatment. This decentralized layer of providers will have access to diagnostic and treatment centers to assist and to specialists in the numerous fields of medicine, but the ability to have care when it is needed is what people want and need and this plan provides that.

3.3. Impact on Employers

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Employers have the most to gain from this new and innovative approach to universal access to health care. Employers are burdened with the responsibility of meeting the need of employees to have health coverage. Unfortunately, smaller companies cannot afford the cost of providing health coverage to their employees.

These same employers are competing for qualified personnel and have to find a way to meet the competition. Bigger companies are given bigger breaks by insurance companies. Meanwhile, the costs are made up on the backs of the smaller companies. Even the big companies get locked into programs that cost them market advantage by driving up their labor costs in comparison to other competitors.

The Family Health Care System levels the playing field for all employers. It offers a means to offset increases in minimum wage laws and reduce the cost of employer related taxes. Since social security will be relieved the medical coverage entitlement the cost of social security taxes should decline over the first decade the system is in place.

3.3.1. Level Playing Field

Under this plan every employer that provides health benefits to their employees does so at the same rate. The system is designed to work on a bi-rate level for the family pools. The key rate is the national minimum rate (NMR). This is effectively the rate calculated by the system to be the minimum rate necessary to pay for services for all participants. Under this plan the rate is set and employers can prorate the NMR based on a 40 hour workweek and apply it to all employees; full and part time. This allows part time workers to earn the full NMR if they are working more than one job.

The contribution is not considered part of the wage of the employee and is not taxed, not subject to FICA, FUTA or SUTA. It is also not considered in the overtime calculation.

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This means that Ford Motor Company or Microsoft Corporation pay the same and Sam Auto Shop or Main Street Computer store. The contribution by employers is not mandatory, but the option should exist to replace minimum wage increases in favor of providing health benefits to all employees. The value to industry of replacing minimum wage with health benefits is it lowers the taxes on the employers yet increases the benefits to the employees and keeps the burden for national health care off the government.

3.3.2. Simple Direct Deposit as payroll contribution and deduction

The processing of payments is handled electronically. Each employer can establish a relationship with their bank to process the payments. The employer simply provides the employer with a account number and the contribution is transferred to the account using EFT just like any other direct deposit of pay.

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3.3.3. Reduced Administrative Costs

The administrative costs of processing EFT transfers are much less than the processes employed by insurance companies today. -The infrastructure that currently exists in the bank processing system is already in place and requires not initial capital investment to employ. The use of on-line banking technology and having banks competing for the accounts of businesses, providers and families transfers the administrative costs of registering accounts in the system to the banks and competition between the banks will keep that cost down.

3.3.4. Eliminates Unpredictable Annual Health Care Cost Increases

The annual increase in health care costs are normally determined post annum or after the fact. This system provides a mechanism to determine sudden changes in costs on a real time basis. While the forces of supply and demand may have legitimate justification for such fluctuations, the possibility remains that collusion or market manipulation may also be a factor. This plan provides the ability to monitor and assist in correcting out of balance supply and demand conditions to keep costs at their optimum.

3.3.5. Mechanism for Providing Retirement Health Care

One of the most valuable aspects of this plan is the role of retirement health care. Currently the burden of health care costs for the elderly falls on Social Security (Medicare). Many families rely on this overburdened bureaucracy to address the health care needs of their elderly members.

Under this plan, the costs that are currently being provided to any Social Security recipient are converted to a contribution at the NMR rate by the Social Security Administration. The same level of service that the family received over their lifetime continues throughout their life. The government is no longer responsible for administering or monitoring the services the elderly receive. The responsibility for caring for the health of the

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elderly returns to the family. Another aspect of this is decisions made by the elderly person will be transformed into family decisions and not simply individual decisions.

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3.3.6. Reduction in Retiree Health Costs

The redefinition of the way health services are paid for and how decisions are reached on receiving care will bring down the cost of health services to the elderly. Over a generation the influence of family on health related behaviors and preventative care will provide for better quality of life among the elderly.

Having family physicians that can visit the elderly at their home and make recommendations to the families on how to avoid injuries or illnesses among the elderly will serve to prevent many costly procedures and hospital stays. The Family Health Care advisor can provide assistance in getting the best level of professional care for elderly members needing in home assistance or full-time hospitalization. The competition among providers will improve the quality and bring down the cost. It will not be a case of a provider meeting state minimums and getting the maximum payout from insurance carriers to house elderly patients. The family will be in on the decision and scrutinize the facilities much more than the Social Security Administration or the insurance carrier.

3.4. Impact on the Government

One of the most controversial issues related to providing universal access to health care in the United States relates to whether the government should be in charge of administering all health care.

Clearly, government has not demonstrated an ability to manage, in a cost-efficient high quality manner, any agency throughout its 230 year history. By centralizing health care, decisions are made on how they will affect the cost of the overall bureaucratic operation and not on what is in the best interest of the individual. Many other governments that have opted to provide national health care have experienced long delays in treatment and elimination of economic incentives for professional health care providers. This equates to a flight of skill professionals and a reduced quality of service.

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It is important to understand that these national health care systems do not operate in a void. Their current level of service is enhanced by the fact that the United States still has a private health care system. Innovation and technological advances in medical science that originate in the United States are exported to these countries to improve their quality of service. If these incentives to develop new technologies are eliminated in the United States, then the quality of services in all countries would begin to diminish as technological advances began to wane.

Yet, in spite of this, the need, in the United States, for a universal system of access is clear and apparent. This is where the Family Health Care System fits in.

It functions entirely within the private sector and over time relieves the government of health care management for the elderly under Social Security, Welfare, the military and government employees and all government retirees.

The system employs proven technology that is already processing billions of payment transactions from around the world. It maintains the invisible hand of free market forces to control costs far better than the current system and at a fraction of the cost. The Family Health Care System transfers health care decisions to the family and away from the government and the for-profit insurance companies.

3.4.1. Mechanism for providing health care to all citizens

The universal availability of health care financing mechanism called the Family Health Care System allows every citizen to open a health care account at any participating bank. For a bank to participate it must be a participant of the FDIC, the Federal Reserve System and capable of conducting EFT transfers and it cannot be in debt under the TARP program to the Federal Government and have no government stock ownership in the bank.

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It must also allow health care providers, individuals and employers to establish accounts through their banks. The bank will be permitted to charge specific service fees to employers and health care providers for transactions. The banks will also be allowed to offer services to individual account holders such as health account life insurance and other forms of protection for individual accounts.

For a health care provider to be eligible to participate and receive immediate payment for services, they must open a health provider account at any participating bank. The system provides a fee structure for providing the payment service to the provider much like MasterCard or VISA charge for vendors for payments through their service.

For an employer to be eligible to participate and provide health benefits to their employees, they must open a health employer account at any participating bank. Banks can offer employers on-line services and direct deposit services to process contributions to individual accounts.

3.4.2. Elimination of Outdated Public Health Insurance Programs

The current methods for making payments to health care providers is based on a complex set of rules and approval processes that delay and often deny payment. The delays cost providers millions of dollars in interest expenses and billing and collection costs. This plan eliminates all the downside impact of the current system by replacing it with an immediate payment system.

3.4.3. Reduction of Medical Claims Abuses in Public Assisted Care

The eliminations of medical claims also eliminate the cost of fraud and abuse. With every family monitoring their own health care charges, the ability for providers to abuse the payment system is reduced.

3.4.4. Mechanism to Fund Health Care in National Emergencies

The possibility for national health emergencies increases with the threats from terrorist attacks use chemical, biological and nuclear weapons. The effects of natural disasters creating mass casualties and overwhelming the current system can be mitigated by employing a system in which the government can inject economic countermeasures into a region to ward off economic catastrophe. This plan will enable a state or federal government to provide an immediate injection of emergency funds and treatment capabilities into a region to assist in limiting the impact on the economy of the region and inducing private health care providers to mobilize into the area with mobile clinic and physicians to assist and still be eligible for compensation to justify the cost.

3.4.5. Allows for International Medical Treatment

By interlacing the system with the Federal Reserve System, the ability to make payment for medical treatment received anywhere in the world will be possible. This means providers in other parts of the world can establish health provider accounts and be eligible for payment should a participant of the plan require medical treatment in that part of the world.

Since all payments are processed like VISA or MasterCard payments, the system already exists to handle the transfer of payments.

3.4.6. Market Forces at Play

In a free market system competition forces prices to their optimum level based on the availability of services and the demand for those services. This plan provides a mechanism to monitor the costs for services in any region of the country. This allows for non-intrusive steps to be taken to correct the imbalance between supply and demand before the costs get out of hand.

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For example, in coal mining regions where black lung is prevalent, incentives can be provided by local governments to entice health care providers to build facilities equipped to diagnose and treat this particular illness. In areas with aging populations, providers may recognize the investment value of locating facilities for the elderly.

These efforts have the effect of influencing the free market forces of the system; they are a far cry from government mandates and restrictive policies.

3.4.6.1. Competition among Medical Service Providers

Medical Service Providers will evolve into a new breed of physician offices. Much like the corporate world has adopted a modular style by utilizing executive office spaces in a shared office environment. This is where multiple businesses are located in the same office space. The space is equipped with individual offices, but shared overhead services and equipment. This allows the management of the space to prorate the cost of copiers, networks, phone systems, cleaning services, receptionists and other shared services among all tenants.

Medical Service Providers will invest, build and manage medical diagnosis and treatment centers that are open 24 hours a day, 7 days a week. Physicians will schedule times to see patients based on the needs of the patient. This increases the utilization of technologically advanced equipment and reduce the per use cost.

Family practitioners will contract with these sites to schedule appointments to bring in out-patients for exams. This will mean these physicians will not even have to have offices and can conduct most of their visits at the home of the patient.

3.4.6.2. Competition among Hospitals

With the introduction of the Family Health Care Advisor, hospitals will be evaluated by these health care professionals based on quality of service, safety records, attention to details, cost of itemized items and skill of their staff. These professionals will advise families on which hospitals to use or avoid. In such an environment competitive considerations will drive the hospitals to provide the best possible services for the optimal cost. This will benefit the consumer and increase the overall quality of care across the board.

3.4.6.3. Competition among Medical Equipment Providers

The emergence of shared facilities to support family practitioners will open a new customer path for medical equipment providers. This system will also have far reaching international implications for health care across international borders. The competition for shared facilities equipment sales will be met with professional business managers evaluating the viability and cost-effectiveness of equipment vice a physician with limited business acumen. Making better decisions on equipment purchases will lead to increased cost savings on a per use basis. This translates into reduced costs to the consumers.

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3.4.6.4. Competition among Physicians

The natural evolution of competition in the technological age will lead to more information on physicians and the quality of service they provide. Blogs and internet sites dedicated to the quality of services of physicians will help families gain insight into the professionals that provide the most intimate services to their family members.

Physicians that are good with people and provide quality care will be in greater demand. Under the laws of diminishing returns, such a physician can only service a given number of patients before quality is affected. Therefore, when he reaches that patient load he will have to turn away patients. The cost will clearly be determined by the balance between the quality of service and what a family is willing to pay for the service. But, office based physicians will compete for the patients with family practitioners and other physicians and specialists in their field to get patients. Most families will tell you cost is not the single most important factor and having the doctor that finished number 1 in his class is not either, especially if he has no bed-side manner.

3.4.6.5. Reemerging Role of Family Practitioners

The ability of a family to secure the services of a family practitioner to give health care services to every member of a family pool opens the door for physicians to operate independent of the investment in an office and staff. The ability to receive direct payment on a monthly basis from each member of the pool at a fixed rate each will allow a physician to spend his time visiting the homes of the family members and addressing specific health issues. When he finds he needs to conduct tests or perform out-patient treatments or diagnostic tests, he can schedule these at a shared facility and charge the family for the cost directly or allow the facility to charge directly.

3.4.6.6. Newly Emerging Role of Family Health Care Advisors

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The role of family health care advisor is new to the health industry but is critical in bridging the gap between the highly technical and scientific field of medicine and the average individual. Understanding of the cost structures and the availability of services and how these services will address the needs of the family pool members becomes the responsibility of these professionals. Many retired physicians will find this type of consulting to families a welcome second career.

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4. Financial Structure of the System

The financial structure of the Family Managed Health Care system is not extremely complex but takes some understanding of how things work now in order to understand the benefits of the new system.

Currently, the cost of health care in the United States is paid for each year through a variety of mechanisms that get payments to the providers. Health and workmen's compensation insurance, direct social security payments, state and federal government budgeted benefits programs, government funded facilities paid for with tax revenues, direct patient payments, etc. are some of the methods health providers get paid.

The Family Managed Health Care System provides immediate payment to providers for services rendered. Immediate means the time it takes for the EFT transaction to hit the account of the provider. The timing is the same as for a MasterCard or VISA payment, normally overnight.

This payment for raw cost is where all health care costs begin. Under the current system additional layers of applied cost; whether it is government bureaucratic costs or insurance companies overhead, marketing, general and administrative costs, or providers billing, claims processing, collections, legal costs, write-offs and staffing costs they account for a major applied cost to the health care of every individual.

These costs are not a necessary component in providing health care access to everyone. They are the result of an obsolete system that has been adapted and modified and placed under government scrutiny. The government has attempted to control the system, but only succeeded in driving up the costs.

Each year the total cost of providing care to the citizens of the country is paid by the combination of all these sources. This means that the public is already paying for everyone's health care through insurance or taxes.

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CURRENT ($ in millions)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Common Projections										
US Population	308,935,581	311,600,880	314,281,098	316,971,485	319,667,598	322,365,787	325,062,633	327,755,597	330,443,861	333,127,039
Current Track Participation in Health Care System										
Medicaid Participants	40,709,048	41,060,260	41,413,437	41,767,955	42,123,227	42,478,773	42,834,141	43,188,999	43,543,236	43,896,804
Medicare Participants	39,481,666	40,243,713	41,121,053	42,551,388	43,972,925	45,340,117	46,790,727	48,202,339	49,694,108	51,256,025
Other Public Program Participants	3,370,065	3,399,140	3,428,377	3,457,726	3,487,137	3,516,570	3,545,989	3,575,366	3,604,691	3,633,961
Total Government Participants	**83,560,779**	**84,703,113**	**85,962,868**	**87,777,069**	**89,583,289**	**91,335,460**	**93,170,858**	**94,966,703**	**96,842,035**	**98,786,790**
Private Employer Insurance Participants	165,038,299	166,462,144	167,893,959	169,331,206	170,771,513	172,212,928	173,653,626	175,092,250	176,528,364	177,961,760
Individual Insurance Participants	15,064,529	15,194,496	15,325,191	15,456,381	15,587,851	15,719,422	15,850,927	15,982,244	16,113,330	16,244,169
Uninsured Individuals	47,298,475	47,706,536	48,116,881	48,528,783	48,941,562	49,354,658	49,767,549	50,179,846	50,591,423	51,002,221
Total Non-Government Individuals	**227,401,302**	**229,363,175**	**231,336,030**	**233,316,370**	**235,300,925**	**237,287,008**	**239,272,103**	**241,254,340**	**243,233,117**	**245,208,151**
Current Track Cost of Services										
Federal Expenditures on Health Care	$726,377	$760,096	$796,585	$839,441	$884,337	$931,055	$980,837	$1,032,874	$1,088,283	$1,147,168
Medicare Costs	$313,382	$319,431	$326,395	$337,748	$349,031	$359,883	$371,397	$382,602	$394,443	$406,840
Medicaid Costs	$412,995	$440,665	$470,190	$501,693	$535,306	$571,172	$609,440	$650,273	$693,841	$740,328
State Expenditures on Health Care										
Medicaid Matching Costs	$314,903	$336,001	$358,513	$382,534	$408,163	$435,510	$464,690	$495,824	$529,044	$564,490
Total Government Costs	**$1,041,280**	**$1,096,097**	**$1,155,098**	**$1,221,974**	**$1,292,501**	**$1,366,565**	**$1,445,527**	**$1,528,698**	**$1,617,327**	**$1,711,658**
Private Employers Expenditures on Health Care	$614,572	$661,650	$712,334	$766,901	$825,648	$888,895	$956,987	$1,030,295	$1,109,219	$1,194,188
Individual Expenditures on Health Care	$67,041	$67,644	$68,253	$68,867	$69,487	$70,113	$70,744	$71,380	$72,023	$72,671
Total Non-Government Costs	**$681,612**	**$729,294**	**$780,587**	**$835,768**	**$895,135**	**$959,007**	**$1,027,730**	**$1,101,675**	**$1,181,241**	**$1,266,859**
Total All Health Care Cost (current)	**$1,722,892**	**$1,825,391**	**$1,935,685**	**$2,057,742**	**$2,187,636**	**$2,325,572**	**$2,473,257**	**$2,630,373**	**$2,798,569**	**$2,978,517**

Figure 6: Current 10 Year Track For Health Care

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This leaves two ways of looking at the cost of providing universal access. If RC equals all raw cost for health care and AC = the applied cost of health care and the population is P then (RC+AC)/P = cost per person. If AC% = AC/(RC+AC) = 34% represents the percentage of applied cost that exists in the current health care financing system, then the most important element in the system is the AC. If MasterCard and VISA can process payments for less than 4%, then redesigning the system can equate to a 30% reduction in the cost of health care. By increasing the competition and making individuals more accountable for the health care decisions, the RC can also be reduced. As free market forces drive changes in the methods health care is delivered, the industry will further reduce the per person RC.

The Family Health Care System will drive down the raw cost (RC) and dramatically reduce the applied cost (AC) and the per person cost will decline accordingly.

4.1. National Pool Account (NPA)

The National Pool account is simply an account that is used to total all raw health care costs being charged to individuals in the system. Every charge from a health provider is applied to the pool account. The system also maintains the number of participating accounts in the system. The NPA account balance represents the sum of all family pool accounts in the system.

4.1.1. Family Pool Account (FPA)

The each family pool establishes a FPA at any participating bank. This account balance will represent the sum of the each member account. Each member account will have a complete history of all credits and debits to the account with details of the charge and provider filing the charge. The family pool will have two separate Minimum Rates, the National Minimum Rate (NMR) and the Family Pool Rate (FPR). It is the responsibility of each member of the pool to contribute to their account each period the equivalent of the higher of the two rates.

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OBAMA CARE ($ in millions)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Common Projections										
US Population	308,935,581	311,600,880	314,281,098	316,971,485	319,667,598	322,365,787	325,062,633	327,755,597	330,443,861	333,127,039
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Medicare Participants	39,481,666	40,243,713	41,121,053	42,551,388	43,972,925	45,340,117	46,790,727	48,202,339	49,694,108	51,256,025
Other Public Program Participants	3,370,065	3,399,140	3,428,377	3,457,726	3,487,137	3,516,570	3,545,989	3,575,366	3,604,691	3,633,961
New Public Plan	86,927,921	80,998,964	81,695,673	82,395,024	83,095,864	83,797,244	84,498,274	85,198,296	85,897,095	86,594,573
Total Government Participants	**170,488,700**	**165,702,077**	**167,658,540**	**170,172,093**	**172,679,153**	**175,132,704**	**177,669,132**	**180,164,999**	**182,739,131**	**185,381,363**
Private Employer Insurance Participants	132,030,639	133,169,715	134,315,167	135,464,965	136,617,210	137,770,343	138,922,901	140,073,800	141,222,691	142,369,408
Individual Insurance Participants	12,051,623	15,194,496	15,325,191	15,456,381	15,587,851	15,719,422	15,850,927	15,982,244	16,113,330	16,244,169
Uninsured Individuals	0	0	0	0	0	0	0	0	0	0
Total Non-Government Individuals	**144,082,262**	**148,364,211**	**149,640,358**	**150,921,346**	**152,205,061**	**153,489,764**	**154,773,828**	**156,056,044**	**157,336,021**	**158,613,578**
Current Track Cost of Services										
Federal Expenditures on Health Care	$1,433,970	$1,419,428	$1,461,587	$1,510,136	$1,560,738	$1,613,164	$1,668,653	$1,726,389	$1,787,486	$1,852,048
Medicare Costs	$313,382	$319,431	$326,395	$337,748	$349,031	$359,883	$371,397	$382,602	$394,443	$406,840
Medicaid Costs	$412,995	$440,665	$470,190	$501,693	$535,306	$571,172	$609,440	$650,273	$693,841	$740,328
New Public Plan	$707,593	$659,332	$665,003	$670,695	$676,400	$682,110	$687,816	$693,514	$699,202	$704,880
State Expenditures on Health Care										
Medicaid Matching Costs	$314,903	$336,001	$358,513	$382,534	$408,163	$435,510	$464,690	$495,824	$529,044	$564,490
Total Government Costs	**$1,748,873**	**$1,755,429**	**$1,820,101**	**$1,892,670**	**$1,968,901**	**$2,048,675**	**$2,133,343**	**$2,222,212**	**$2,316,530**	**$2,416,538**
Private Employers Expenditures on Health Care	$491,657	$529,320	$569,867	$613,521	$660,518	$711,116	$765,589	$824,236	$887,375	$955,350
Individual Expenditures on Health Care	$67,041	$67,644	$68,253	$68,867	$69,487	$70,113	$70,744	$71,380	$72,023	$72,671
Total Non-Government Costs	**$558,698**	**$596,964**	**$638,120**	**$682,388**	**$730,005**	**$781,228**	**$836,333**	**$895,616**	**$959,397**	**$1,028,021**
Total All Health Care Cost (current)	**$2,307,571**	**$2,352,393**	**$2,458,221**	**$2,575,058**	**$2,698,906**	**$2,829,903**	**$2,969,676**	**$3,117,828**	**$3,275,927**	**$3,444,559**
	133.9359%	**128.8706%**	**126.9949%**	**125.1399%**	**123.3709%**	**121.6863%**	**120.0715%**	**118.5318%**	**117.0572%**	**115.6468%**
Savings on Federal Budget	-$707,593	-$659,332	-$665,003	-$670,695	-$676,400	-$682,110	-$687,816	-$693,514	-$699,202	-$704,880
Savings on State Budgets	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

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Cumulative Deficit	-$707,593	-$1,366,925	-$2,031,928	-$2,702,623	-$3,379,023	-$4,061,133	-$4,748,949	-$5,442,463	-$6,141,665	-$6,846,545

Figure 7: Obama Care 10 Year Track

4.1.2. National Minimum Rate (NMR) and Family Pool Rate (FPR)

This rate is calculated using an algorithm that calculates the projected cost over the next twelve month period for health care expenditures by all participants in the system. It uses historical data for previous periods taking into consideration times of the year to make the projections. This projected cost value is divided by the number of participating members in the system and then divided by 2080 to determine the hourly rate for the national hourly minimum. The NMR is also expressed in monthly terms by multiplying the hourly rate time 2080 and dividing by twelve.

This rate is published and updated quarterly by the system and all participating employers are required to meet this cost figure in applying health benefits to an employee's account. The employer can offer incentives to cover family members at the same rate per member. This will be competition driven element of level of employer health services.

Employers should have the option of substituting minimum wage increases with national minimum rate contributions.

The Family Pool Rate is calculated using an algorithm that focuses on the sum balances of all individual member accounts. The sum of the accounts is divided by the number of family members in the pool and the number of months the system designates as the payback period. For instance, with an 84 month pay back period

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for a family pool of 200 members having and average of $5,000.00 each on account or $1,000,000 in total health care costs, they would have a monthly family pool rate of $59.52 or an hourly FMR of $0.34. If the monthly national minimum rate is $100.00 then each member would be responsible for the higher or $100.00 each. The participating employers would be contributing the NMR to each employee.

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FMHC ($ in millions)	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Common Projections										
US Population	308,935,581	311,600,880	314,281,098	316,971,485	319,667,598	322,365,787	325,062,633	327,755,597	330,443,861	333,127,039
Current Track Participation in Health Care System										
Medicaid Participants	40,709,048	41,060,260	41,413,437	41,767,955	42,123,227	42,478,773	42,834,141	43,188,999	43,543,236	43,896,804
Medicare Participants	39,481,666	40,243,713	41,121,053	42,551,388	43,972,925	45,340,117	46,790,727	48,202,339	49,694,108	51,256,025
Other Public Program Participants	3,370,065	3,399,140	3,428,377	3,457,726	3,487,137	3,516,570	3,545,989	3,575,366	3,604,691	3,633,961
New Public Run Program	0	0	0	0	0	0	0	0	0	0
Total Government Participants	**83,560,779**	**84,703,113**	**85,962,868**	**87,777,069**	**89,583,289**	**91,335,460**	**93,170,858**	**94,966,703**	**96,842,035**	**98,786,790**
Private Employer Insurance Participants	198,147,231	166,462,144	167,893,959	169,331,206	170,771,513	172,212,928	173,653,626	175,092,250	176,528,364	177,961,760
Individual Insurance Participants	29,254,071	15,194,496	15,325,191	15,456,381	15,587,851	15,719,422	15,850,927	15,982,244	16,113,330	16,244,169
Uninsured Individuals	0	0	0	0	0	0	0	0	0	0
Total Non-Government Individuals	**227,401,302**	**181,656,640**	**183,219,150**	**184,787,588**	**186,359,364**	**187,932,350**	**189,504,554**	**191,074,494**	**192,641,694**	**194,205,930**
Current Track Cost of Services										
Federal Expenditures on Health Care	$435,826	$433,647	$431,479	$429,321	$427,175	$425,039	$422,914	$420,799	$418,695	$416,602
Medicare Costs	$188,029	$187,089	$186,154	$185,223	$184,297	$183,375	$182,459	$181,546	$180,639	$179,735
Medicaid Costs	$247,797	$246,558	$245,325	$244,098	$242,878	$241,664	$240,455	$239,253	$238,057	$236,866
State Expenditures on Health Care										
Medicaid Matching Costs	$188,942	$187,997	$187,057	$186,122	$185,191	$184,265	$183,344	$182,427	$181,515	$180,607
Total Government Costs	**$624,768**	**$621,644**	**$618,536**	**$615,443**	**$612,366**	**$609,304**	**$606,257**	**$603,226**	**$600,210**	**$597,209**
Private Employers Expenditures on Health Care	$593,818	$599,163	$604,555	$609,996	$615,486	$621,026	$626,615	$632,254	$637,945	$643,686
Individual Expenditures on Health Care	$40,225	$40,587	$40,952	$41,320	$41,692	$42,068	$42,446	$42,828	$43,214	$43,603
Total Non-Government Costs	**$634,043**	**$639,749**	**$645,507**	**$651,317**	**$657,179**	**$663,093**	**$669,061**	**$675,083**	**$681,158**	**$687,289**
Total All Health Care Cost (current)	**$1,258,811**	**$1,261,393**	**$1,264,043**	**$1,266,760**	**$1,269,544**	**$1,272,397**	**$1,275,318**	**$1,278,309**	**$1,281,368**	**$1,284,498**
	73.0638%	**69.1026%**	**65.3021%**	**61.5607%**	**58.0327%**	**54.7133%**	**51.5643%**	**48.5980%**	**45.7866%**	**43.1254%**
Savings on Federal Budget	$290,551	$326,449	$365,106	$410,119	$457,162	$506,016	$557,924	$612,075	$669,588	$730,567

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Savings on State Budgets	$125,961	$148,004	$171,456	$196,412	$222,972	$251,245	$281,346	$313,397	$347,529	$383,883
Cumulative Deficit	$290,551	$617,000	$982,106	$1,392,225	$1,849,388	$2,355,403	$2,913,327	$3,525,402	$4,194,990	$4,925,557

Figure 8: Family Managed Health Care 10 Year Track

4.1.3. Tax Deductibility and Labor law exemption

The contribution made by employers to their employees' accounts should be fully tax deductible and not subject to overtime rules for compensation. The hourly based contribution is designed to open the door for part-time employees to receive sufficient health benefits to cover their basic health care.

Since these benefits serve dual purposes in providing a mechanism for financing health care for the individual and supporting the financial viability of the overall system, the individual should not be taxed on this portion of their compensation. These contributions are in a closed system and are not available to be spent on anything other than health related costs.

4.1.3.1. Families

Families are the centerpiece of this system. This reverses a trend toward government assumption of the role of caregiver. It restores the family as decision-maker in private matters relating to health and care of family members. The system is designed to provide all families with employment options to satisfy the requirements of the system. This includes working multiple jobs, the ability to change jobs without losing benefits, the guaranteed support of family members in a medical crisis and the ability to influence the behavior of family members to improve their health.

4.1.3.2. Employers

Universal access to health care has not been a top priority for most employers in the United States and the overwhelming cost of making it available to employees has hindered progress in achieving it.

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The Family Health Care System offers a consistent and equitable mechanism to all employers enabling them to provide health care access to their employees. It reduces the disparities between employers and eliminates competitive disadvantages based on smaller numbers of employees. The system eliminates the administrative and overhead costs of administering an insurance based system.

The ease of application to participate in the system makes it possible for companies of all sizes to participate.

The government has the ability to influence (not mandate) employers to offer such access by categorizing the contributions as not subject to withholding, non-taxable, not subject to overtime and not subject to FICA, FUTA or SUTA. The government can also create incentives by allowing companies to offset minimum wage increases with health benefit contributions through this system.

4.1.3.3. Providers

The greatest financial step in improving health care is to provide for direct payment for services and eliminating the layers of applied costs that providers are forced to pay to simply receive payment for services rendered. Providers will be allowed to focus on their areas of expertise and avoid being inundated with issues related to insurance companies, claims, collections, billing, legal services, and write-offs. The provider benefits dramatically through this system and as a result the consumers get better service.

4.1.3.4. Banking Institutions

Banks are a key component of the economic engine of the United States. Technology has delivered more and more services to the individual in their homes and opportunities to expand those services are always being looked at by this industry. The massive size the health care industry and the potential earning value for providing

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those services should have banks rushing to participate or fear losing employers and individuals to other banks that do participate.

4.1.3.5. Bond Holders

Individuals that purchase Solvency bonds can have their interest payments contributed to individual health accounts. This allows for tax-free contributions to be made to the accounts at rates designated by the bond holder. If a member of a family invests $100,000.00 in a solvency bond and the interest rate on that bond is 2.5% annually. The bondholder would gain 2500.00 each year for the life of the bond. This amount could then be designated to be paid to both his and his wife's account equally.

That would allow for $1250.00 a year in contributions and if the family pool and national minimum rates are less than that the bondholder would not have to make a contribution for the entire year or term of the bond.

4.1.4. Private Employer Participation

The importance of getting employers to participate voluntarily will be based on the incentives government is willing to offer. The use of offset medical wages that allow employers to designate a portion of pay as health benefits to the system and have those payments exempt from employer taxes and FICA, FUTA and SUTA will go a long way in getting employers on board.

The recent increase in the minimum wage could be used to allow employers to offset medical wages for direct wages in meeting the required increase. The system allows part-time employees to receive medical wages from multiple employers. The benefit to such an approach is the burden is reduced on the government for health care and entitlement programs will see a reduction in cost and in many cases elimination of substantial bureaucracy.

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4.1.4.1. Level Playing Field

Leveling the playing field among employers consists of providing a simple and easy to use mechanism for giving employees access to health care. It also eliminates on the difficulties in attracting highly skilled labor. Currently, insurance plans vary in benefits provided and costs. Often, potential employees will not fully understand the advantages or disadvantages of a given plan and it may result in losing out on a key prospect. This eliminates the question of the plan only deals with the level of contribution the employers is will to provide; whether the employee and 3 family members will be covered or the employee only.

For smaller companies the level playing field allows them to compete for the same employees as the bigger companies.

4.1.4.2. Free Market Forces Affecting Labor Force

In a free market system employees have the option of moving from employer to employer. This ebb and flow among employees will drive the cost of labor. This will cause it to fluctuate based on many factors. Among those factors is the cost of health benefits. Employees will recognize the cost and advantages of having employment that includes health benefits and can negotiate a split of hourly pay and health benefits based medical wages. Since it advantageous for the employer to pay health benefits over direct pay, the employer may place the offer on the table for the employee to consider.

4.1.4.3. Employee Enrollment Process

A new employee will be required to provide his Individual Health Account number and his family pool account number. The employer will go on-line with his bank and register the employee in the employer's employee data base. Each pay period the employer will designate a contribution amount and the bank will

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transfer that amount to the Family Health System National Account with the Family Pool and Individual Account identifiers.

4.1.4.4. Union Employee Health Care

Unions have traditionally negotiated with employers on behalf of employees to secure health benefits. Some unions have assumed responsibility for providing health insurance coverage for their memberships directly. This new system will allow the unions to distribute contributions or allow employers to handle this directly. Regardless of which organization handles the contributions, the costs of administering the system will be dramatically reduced from current costs.

4.1.4.5. Part-Time Employee Health Care

One the innovations of this system is providing a mechanism for part-time employees to receive contributions for health care access from multiple employers. This will open the door for many employers of part-time employees to offer a level of health benefits commensurate with the hours worked. For employees holding multiple jobs this means they can get coverage. Previously they were not eligible.

4.1.4.6. Multiple Employers

Employers that offer health benefits through this system benefit by not having to pay employer taxes on the wages that are for medical benefits. This encourages employers to offer a portion of pay as health benefits. It also means that an individual can work multiple jobs and accumulate larger contributions to his individual and family accounts.

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4.1.4.7. Overtime Adjustments

Employers will not be obligated to pay time and half on health benefit medical wages since they are calculated on a fixed 2080 hour work year. The national minimum rate (NMR) is met at the 40 hour level. This is not a prohibition and employers can offer to pay on overtime if they wish to use it as an enticement.

4.1.5. Government Participation

The government is the largest employer in the United States. Aside from employees, the government also provides benefits to retirees, social security recipients, survivors, and disabled individuals. Through welfare and aid to dependent children recipients also receive health benefits. The cost in terms of health care is substantial for these segments of the population. Every member of these groups of citizens would be expected to participate in this system.

The initial start-up period will require the government to fund benefits for a period of time since many are in non-income producing statuses. The system is designed to allow younger participants to accumulate positive balances in their accounts before retirement. These accumulated accounts can then be used during retirement

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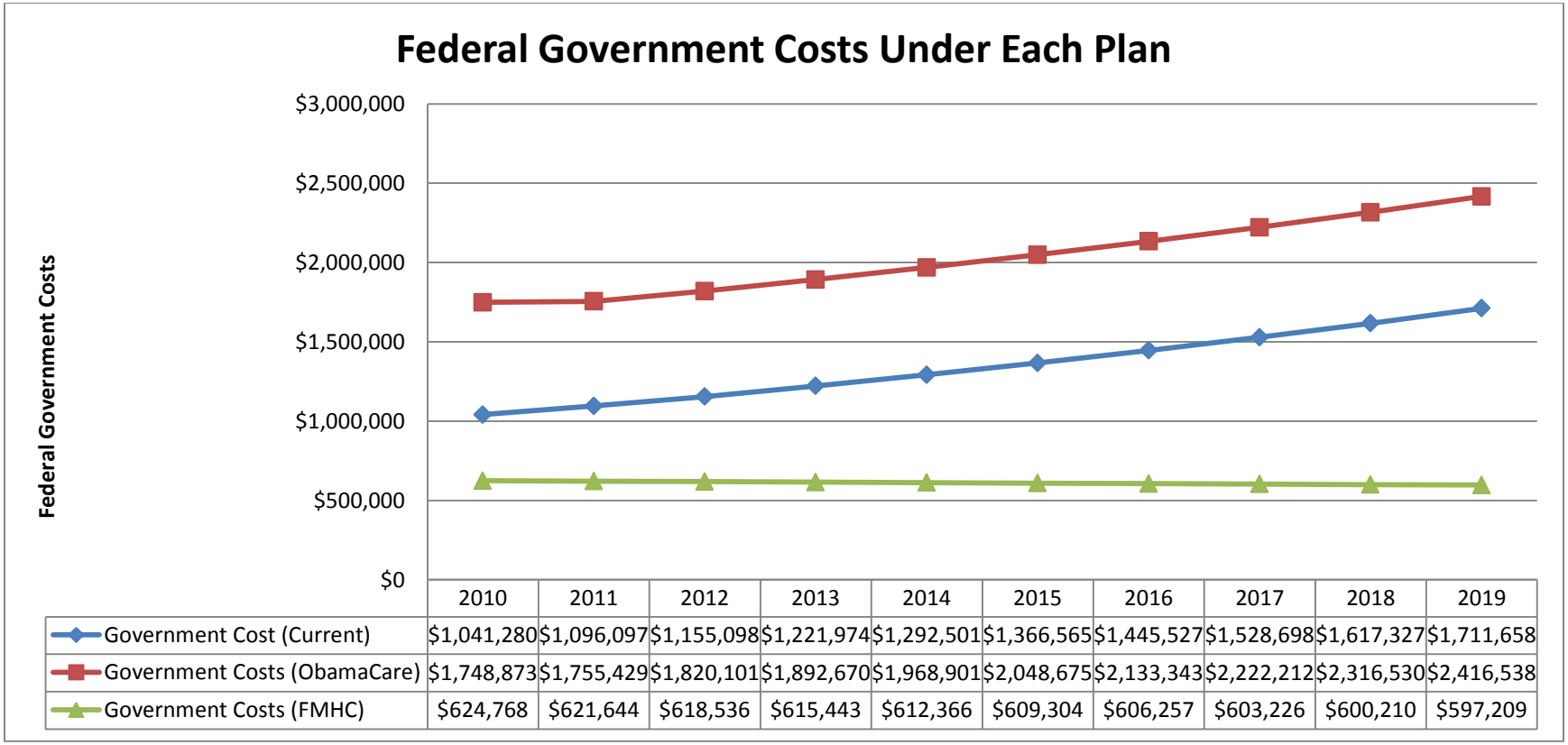

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Government Cost (Current)	$1,041,280	$1,096,097	$1,155,098	$1,221,974	$1,292,501	$1,366,565	$1,445,527	$1,528,698	$1,617,327	$1,711,658
Government Costs (ObamaCare)	$1,748,873	$1,755,429	$1,820,101	$1,892,670	$1,968,901	$2,048,675	$2,133,343	$2,222,212	$2,316,530	$2,416,538
Government Costs (FMHC)	$624,768	$621,644	$618,536	$615,443	$612,366	$609,304	$606,257	$603,226	$600,210	$597,209

Figure 9: Federal Government Costs Comparison

without dramatically impacting the family pool account. This will also promote healthy lifestyles and reduced high risk behaviors.

In the case of those that have not had the opportunity to establish these foundations, the government will be expected to provide assistance. The advantage to all is the overall cost of health services will decline and these recipients will get better care at a less expensive price. This will equate to a substantial savings to the government by reducing the actual cost of entitlement programs and the bureaucracies that operate them.

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The government will be able to transfer, or sell, public hospitals and government clinics and facilities to the private sector to support the private providers. This will also provide additional cost saving for government in the area of entitlement programs.

4.1.5.1. No Employee Enrollment Deadline

Employees will have the option of registering with an employer and designating a specific amount of his pay to be directed to his health account, at any time. This places the obligation on the employer to make the deposit even if the employer does not provide health benefits to his other employees.

This is designed to influence the employer to establish an employer account and begin offering to provide the service to all. Since he can derive employer tax savings by having a plan in place, it is in his best interest to do so.

4.1.5.2. Medical System Solvency Bonds

Medical System Solvency Bonds are government backed tax exempt bonds that can be purchased at a market based interest rate. The funds from these bonds are designed to address catastrophic conditions in the system. A major health crisis can drive up the cost of everyone's health care. These bonds can buy down the immediate impact and spread it over a longer period and reduce the current period costs. Interest costs are included in the calculation for the NMR and escrowed prorated principle payments are also included in the NMR. Individuals can invest in these bonds to offset payments of the national minimum rate during retirement.

4.1.5.3. Public Assistance Programs

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Public assistance programs are operated by state and federal agencies and have seen dramatic increases in costs for health services. Many of the higher-than-normal costs can be traced to abuses by those participating in the programs.

Under this plan, the agencies in charge of these programs can restrict their roles to approving a payment of the NMR for each member of the program. If the individual drives up their individual and family account, the family and the individual share in paying the difference. If the individual must pay a higher family pool rate – the amount can be deducted from the other benefits they receive.

Another advantage of the Family Managed Health Care System is the ability of government to prorate the level of medical support they wish to provide. One of the dynamics affecting people moving off the public assistance rolls is the dramatic spike in getting health insurance coverage once the public assistance ends. Under this plan, the government can offer a declining contribution to individuals attempting to return to self-sufficiency.

4.1.5.4. Military Health Care

One area of health care is critical to the national security of the United States and quite often lags behind the advances in the private health care sector. Military health care can be included in this plan. The cost structure of health services received while on active or reserve duty or once retired from the service will be included in the NMR. The only distinction is the US government will reimburse the individual accounts of military service members at 100% of costs. This will negate the impact on the overall NMR and FPR. While legislators will be tempted to restrict what services will be reimbursed the result will be a reduction in the overall cost of providing the health services.

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This methodology will allow military to receive treatment at any facility and remain covered under the military plan. The value in improved quality of care, wider availability of care, and reduced cost of care will save the military millions of dollars in health care expense.

Private health care providers can be paid in accordance with rates in the market place and contracted to provide care for groups or elements under negotiated rates.

4.1.5.5. Civilian Government Employee Health Care

Civilian employees of local, state and federal governments will lead the way in establishing the foundation for the national pool. These employees represent the nearly 25% of all employees. Each government will be required to contribute the National Minimum Rate (NMR) vice providing health insurance. The reduction in the cost of health services will assist all levels of government in reducing cost and streamlining the bureaucracies associated with providing these benefits.

4.1.5.6. Government Contractors Employee Health Care

All levels of government will require contractors to utilize this system for employees. This will not preclude them from offering other health care benefits or programs. But, once the impact of the overall system takes affect these companies will see a reduction in providing these benefits to employees.

4.1.6. National Health Emergencies

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National health emergencies can result from epidemics to pandemics to outbreaks of deadly or debilitating viruses, to widespread environment calamities, floods, riots, hurricanes, tsunamis, earthquakes and terror attacks with biological, chemical or nuclear contaminants.

This system is designed to have the greatest positive impact on medical emergencies. Since the system places a premium on expanding the number of the family practitioners, it will allow many people to be treated at home; it will reduce the immediate impact on hospitals. More physicians will choose to be trained and prepared to provide care from a mobile base. The hospitals will be relieved of the massive administrative burden associated with current insurance payment system. This will streamline the in-processing of patients.

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4.1.6.1. Criminal/Terrorist Attacks

The threat of attack by terrorist against water supplies, nuclear power plants, mass transit systems or the introduction of biological agents or nuclear radiation can result in mass casualties. This system will allow for emergency medical responses from mobile treatment and diagnostic centers and professional medical staffs that have been contracted and are prepared to provide the services. These centers will charge the individual accounts of the injured. The government will decide on the appropriate level of compensation for those injured and make payment to their individual accounts.

The civil or criminal courts can order payment to the individual's accounts for any criminal act that results in medical treatment. If the perpetrator has an account the charges can be transferred to the perpetrators account. This will impact the criminal and place a burden on the family pool that it would normally not have had. The incentives in these cases become one of choosing to harm someone else and risk imposing a burden on your own family or not causing harm.

Families will have legal recourse to sue criminals that cause them medical losses and have these losses transferred against the criminals account.

4.1.6.2. Natural/Man-Made Disasters

Homeland security can employ this system for identifying mobile health care providers that can be relocated or dispatched to disaster areas. This emergency response will allow health care professionals and national disaster planning agencies to coordinate a response and get medical services to those in need. Each patient will be able to receive treatment and the provider can be paid. Issues arising from these catastrophic events can be address in disaster relief aid programs each of the government bodies decide to offer.

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The Homeland security staff can have pre-qualified and contracted staffs and mobile facilities ready to move immediately on word of a disaster.

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4.1.6.3. War Casualties

When soldiers are wounded in combat and transferred to the United States for treatment, they can be sent to any hospital and their individual accounts will charged for all services. This includes rehabilitation or long-term care facilities. The government will be responsible for reimbursing the individual account of the soldier for all charges. This will require public policies to address these issues.

4.1.6.4. Civil Unrest

When riots and civil unrest result in numerous casualties and medical professionals in the area are overwhelmed, this system will streamline the process of administratively in-processing the injured and assures the hospital of being compensated for the services they provide.

The possibility for transferring medical costs to the perpetrators of violence against individuals and indirectly against their families should serve as a deterrent for many contemplating violence.

4.1.6.5. Epidemics/Pandemics

In the case of epidemics and pandemics it will be necessary to isolate the infected from others in the population. Allowing physicians to isolate people in their homes to reduce the chance of infecting others is made possible for physicians that make house calls.

Many infectious diseases are spread in hospitals, waiting rooms and emergency rooms. If people do not have to go to these places they reduce their risk. With the increased cases of antibiotic resistant bacterial infections in health care facilities, home care can reduce the individual's risk of infection or death.

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4.2. State or Regional Pool Account

Each state and region can maintain a pool account to monitor the level of health care cost being incurred in their region or state. The initial purpose of this account is to provide comparative information on how an area compares to another area. Competition between jurisdictions for business and for employees will drive local leaders to assist in keeping health care cost under control with incentives to employers and healthy life style programs. Viewing the impact of out of control health care costs on the future viability of industry in a locality can serve to improve the quality of life for all in the area.

4.2.1. Calculation of Rate

The rate calculation is the same as for the NMR, except the pool is limited to the geographic boundaries of the pool. For instance, New York State would include all individual accounts based in New York. This means that an individual that is part of a family pool based in New Jersey would still have his costs calculated in New York. Likewise, a resident of New York City would be calculated in New York City even if his family pool was based in Buffalo, NY.

The calculation would break the rate down to the hourly and monthly rates using the same algorithms as the national minimum rate based on 2080 hours.

4.2.2. Regional Minimum Rate

The minimum rate is used to compare the cost in a given region to the cost in a different region. During the first ten years of the system the rate is for comparisons. After that period state government will have the option to impose the rate on employers in the region for employees in the region.

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4.3. Family Pool Account

The family pool account is the center piece of the entire system. It serves to join the interests of the family with the power of the individual. Each and every individual has an individual account that is linked to their own family pool account.

4.3.1. Calculation of Rate

The rate is calculated by dividing the total pool costs by the number of family members in the pool. This provides the pro-rata cost to each member. This pro-rata amount is further divided by the number of years the system will allow for repayment. The financing period can be adjusted but should initially be 3 years. The result is the Family Pool Rate. If this number is greater than the National Minimum Rate then each family member must increase their contribution to cover the difference.

While that may seem drastic, let me explain. If you have 200 members of your family pool and the total outstanding balance of health care services is negative $200,000.00 for the year. This will equate to a Family Pool Rate of $200,000.00 divided by 200 members divided by (2080 times 1 year financing period) is $0.48 per hour or $19.23 a week per member. If the National Minimum Rate is $1.93 per hour or $77.38 per week per member, then the members will have no increase in their contribution.

Based on these assumptions it would require that a family have over $1,000,000 in annual medical services to drive up their minimum rate. In the case of families with large percentages of non-contributors the family rates will rise faster. Non-contributors are unemployed children and adults that receive no contributions from social security or pension programs or any other contributing source.

4.3.2. Family Member Minimum Rate

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For most individuals this is the most important number in the entire system. This number adjusts based on the total cost of health services all members of a family pool incurs. This means that if your uncle has bypass surgery your pool rate could adjust.

The design of the FMHC system would require a substantial increase in health costs in order to drive up the family pool rate.

As long as the Family Member Minimum Rate is less than the national minimum rate (NMR) then family members only contribute the NMR rate. If the Family Rate exceeds the NMR the family will contribute the higher rate.

4.3.3. Extended Family Structure

The extended family refers to the organization of the family. A family will begin with a man and a woman bearing offspring. Each offspring will subsequently meet someone and bear another generation of offspring and then they will repeat the process. With each generation more members of the family pool are created. This means a family pool can be anyone related by law or blood. A premium is place on members that are contributing members.

4.3.4. Marriage

Marriage provides a mechanism to join two individuals together produce offspring to expand the family pool. In most cases, at the outset the two individuals belong to separate family pools. Marriage will allow the couple to choose which family pool their children with become a part of. They will most likely choose to be part of the least expensive pool. The impact of adding an individual account with a large balance can impact every

member of the family pool it is joining. This makes the decision an important one and can be influenced by the family.

The subliminal value of this is for people to take care of themselves and be aware that their lifestyles could impact their options in marriage.

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4.3.5. Children

With the birth of offspring the child immediate joins the family pool of one of his parents. This allows for all costs of natal care and early childhood immunizations to be paid for from the child's own account. The parents are responsible making the appropriate rate contribution to the account or allow the account to go into a negative balance and be paid from the Family pool.

Children born out of wedlock will have their individual accounts linked to their mother's family pool in cases where paternity is undetermined. All contributions for the minimum rate will be the responsibility of both parents until the child reaches 18 years of age. The paternal father's and maternal mother's individual accounts will be charged equal shares of the national minimum rate each period.

This places a primary burden on the parents and a minimal but noticeable burden on the families. Within a generation, this will eliminate the governments need for health care for children through entitlement programs.

4.3.6. Divorce

Divorce creates a fracture in the system by breaking the family structure. Upon divorce, each partner is allowed to return their individual account to their respective family pools. The court can approve requests to have the child included in either family pool but both parents will be required to share equally in the minimum rate payment. The system will automatically deduct the appropriate rate from each parent's account to contribute to the child account.

4.3.7. Elderly

The elderly have multiple options in providing for their health care future. One option is to have successful healthy offspring that can offset any health care cost that might be incurred later in life. It also will help to keep a

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healthy lifestyle and avoid medical expenses. This will allow the account for the elderly member to grow and be available for the later years.

Another option is to invest in a Solvency bond to protect the payments. The last option is to purchase account life and disability insurance to protect the family pool from sudden death or incapacitation.

The influence on families to improve their lifestyles and avoid injurious behavior will help reduce the cost of health care and provide for the elderly. The essential element remains, the families will have control over treatments and care and have a means to provide what is necessary.

4.3.8. Family Influences

The influence of the family is considered to be one of most important influences affecting the lives of individuals in any culture. Establishing a system which highlights the value of this influence and providing incentives to employ that influence in positive ways will be far more effective than attempting to accomplish the same goals politicians have been trying achieve through legislative initiatives or corporate mandates.

The implied value of maintaining healthy lifestyles, diminishing high-risk behavior, avoiding causing injury to others and caring for one another will result in reduced need for medical expenses and reduce the cost for all. It will also lead to a healthier society overall.

4.3.9. Medical Account Life Insurance (MALI)

Medical Account Life Insurance functions the same as credit life insurance on a credit card. It is an optional expense that an individual can incur that protects the family pool in the event of a sudden death. Sudden death by accident or unexpected illness could cause an individual to exhaust any positive balance in the health care account and incur addition costs for treatment. Patients that pass away with balances owing in their

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individual accounts will leave these balances for all members of the family to pay. By purchasing MALI, any outstanding balance in the account is paid by the insurer. This changes the role of insurance in health care from financing every health expense to protecting against death and can be rated based on actuarial tables.

4.3.10. Medical Account Disability Insurance (MADI)

Medical Account Disability Insurance functions the same as credit disability insurance. It is an optional expense that an individual can incur that protects the individual account from being unable to pay the minimum payment should the accountholder become disabled.

4.3.11. Catastrophic Genetic Disorders

Some families may have genetic disorders that strike multiple members of the family. The treatments for these disorders may be expensive and drive up the cost to the family pool. Catastrophic costs can be addressed through special governmental programs, tax incentives and private foundations and research groups.

4.3.12. High-Risk Behaviors

The ability of the family to influence family members away from high risk behaviors is enhanced in the new system. It provides every family member with the right to address concerns over these behaviors with other family members. Since the financial impact of future medical care affects everyone in the pool, pressures can be applied to eliminate these types of behaviors.

Alcohol abuse, drug abuse, smoking, physical abuse of family members are just a few of the obvious behaviors that can become subject to family pressures to eliminate.

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The value to society created by structuring the influencing of behaviors within the family will be substantial. The need will rise to introduce how this health system works and how family members can maximize the value to the family.

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4.3.13 Elective Medical Procedures

Decisions related to elective medical procedures are currently made by insurance carriers. This system transfers these decisions to the family.

4.3.14. Decision Process

Another key factors that improves the quality of care individual will receive is the ability to decide what, when and where to have medical treatments performed. This can be expanded to decisions on whether to have a procedure or not. The economic impact on the family becomes an essential element of the decision process. The cost and risk factors of creating economic burdens on the other family members will be elements in the process. Today, social security or an insurer might deny a family member treatment due to their age. Under this system, that family member may opt not to have the treatment because of the risk of leaving a burden to other family members. This places the risk and decision in the hands of the family.

4.3.18. Inheritance Changes

Family members that opt to leave assets to the family pool to provide protections to survivors should have the assets transfer free of inheritance tax. By creating incentives to individuals to assign some portion of their estates to the family health pool will assure the long term solvency of the system.

4.4. Non-Family Pool Account

The Family Health Care System provides for non-family Pool Accounts for the purpose of addressing those which fall outside the criteria for participating in a Family Pool Account. Some examples are those with too few living family members to be able to maintain a cost effective Family Minimum Rate, Individuals with catastrophic Genetic Disorders that participate in research studies, Illegal residents of the host nation. These allow for costs to

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be tracked until such time as an appropriate Family Account can be identified or in the case of the sponsored Accounts participant can receive care.

4.4.1. Too Few Family Members

One of the issues that will impact the family pool structure is the matter of pool size. Large families with many descendants will enjoy continued protections from the system. But family pools that contract will see their protections diminished. The system provides the ability to merge pool accounts by family pool minimum rates. If two families that have dropped below the effective pool size agree, they can be merged into a new pool provided they understand the impact on their respective pools by merging. If the two families have the same family pool rate the impact is minimal. So like pools will be allowed to merge.

4.5. Medical Provider Accounts

Every medical provider in the system will establish a Medical Provider Account (MPA) to receive payments and pay transaction and malpractice fees from. These are established at the private banking institution of the choice.

4.5.1. Medical Arbitration

One of the most expensive costs a health care provider confronts is for malpractice insurance. In an effort to reduce this cost all participants are expected to agree to submit any claims to a medical arbitration board.

The medical arbitration board is comprised of physicians, dentists, pharmacists, community members and attorneys. The board is 24 individuals that review all malpractice or negligence claims. The board will have access to all complaints filed by members through the electronic services complaint system. These complaints are filed by family medical advisors or family pool administrators on behalf of the family.

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The family medical advisor can submit a claim on behalf of a family. The claim must address the issues of the claim and what negligence occurred and how the individual has been economically damaged and physically harmed. The board will be empowered to reject the claim or offer compensation to the family member in several forms. One form would be reimbursement for the procedure and all related medical care deemed to be related to the negligence. Another would be compensation for losses related to loss of income due to the negligence and finally direct compensation to the individual's health care account for a given period of time. Compensation for settlements will be paid from the Malpractice Pool by electronic transfer.

If a member believes the arbitration is unsatisfactory they have the option to pursue the matter in a court having jurisdiction. The medical arbitration board in that region will provide all documentation and justifications to the court for initial review.

The court can rule on procedural correctness of the arbitration and sufficiency in law and settlement and as a result can make a bench ruling on the acceptability of the settlement or adjust the settlement. If either party is dissatisfied with the ruling, a trial date can be set and a jury will hear the case.

A special note should be taken of the fact that every individual on the jury will be a participant of the system and large settlements will have a direct affect on the cost of health care to each of them. This will make finding an impartial jury difficult.

This method of handling medical errors or negligence provides individuals with multiple opportunities to secure compensation without having to resort to legal fees.

4.5.2. Malpractice Pool

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Every health care provider will contribute to the malpractice pool based on a formula that combines all malpractice payments and divides it into the total of all medical services.

The rate is adjusted quarterly. The fee is collected on each transaction for payment by including it in the transaction processing fees. This means a charge of $100.00 could be charged $2.00 in bank fees, $2.50 in system fees and $0.50 in provider protection fees. The provider would net $95.00 on the charge and be protected

If an individual files a malpractice claim against a medical provider, the provider is represented before the Medical Arbitration Board by an attorney paid for by the Malpractice Pool.

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4.5.3. Incompetence and negligent providers

In cases where health care providers are deemed to be repeatedly negligent or proved to be incompetent, the Medical Arbitration board can revoke the medical provider number which will preclude any further billing in the system. The board can also require specialized training and criteria to be met before the medical provider can apply for a new number. Since this a global system, this provider will be unable to relocate to another jurisdiction and resume providing medical services.

Once a provider is de-listed for incompetence or severe negligence, any legal fees and expenses will become the responsibility of the provider.

4.6. Medical Account Insurance (life/disability)

The Family Health Care System exposes the misdirected use of insurance in financing health care, but a role for insurance remains. Individuals will still want to cover the outstanding balance of their accounts with insurance styled after the credit life policies offered by credit card companies.

The availability of credit life policies to cover the outstanding balance in the event of death would allow members to pay a nominal fee to protect the other members of their family pool should they die leaving a negative balance.

Disability insurance can also be offered to protect against short or long term disability that would prevent the member from meeting their obligation to make the family pool rate payment.

4.7. Bankruptcy Process

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Bankruptcy is designed to provide relief for individuals or companies that have incurred too much debt to continue to function effectively. Within the Family Health Care System, health care services are not strictly an individual issue. Families play a major role in the lifestyle and health patterns of the individual members. It is this principal that links the health requirements of the individual to the responsibility of the family.

If an individual member of a pool files for bankruptcy, his health care account could be eliminated, but, the balance of the account would remain intact at that pool level and once the bankruptcy procedures are concluded, the family pool minimum rate would not be reduced. This means the individual does not get out of paying his health costs.

4.8. Government Backed Solvency Bonds

Solvency bonds are government backed bonds to assist in assuring the solvency of the system. As participation increase during the enrollment period, the national minimum rate can fluctuate dramatically. These bonds can be used to level out the rate. During times of national emergencies cost may jump and these bonds can be employed to even out the impact over longer periods.

4.9. Catastrophic Event Assistance Program

In the event of a catastrophe, the government can offer assistance to the injured or families of those killed that will relieve them of the burden of carrying massive medical expenses on their pool. These would be legislative decisions that would involve substantial negotiation and decision making in determine what assistance will be provided, but this system provides a mechanism to distribute that assistance as defined by the governing body.

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Private charitable groups can offer to give specific assistance to those affected to help offset the costs to families in these types of events. An example would be the 911 fund. If the fund offered to pay medical expenses, then those expenses could be easily identified and paid by transfer from the CEAP assistance pool to the individuals account.

ASSUMPTIONS USED IN PROJECTIONS AND ANALYSIS

Number of Providers	991066	
Visits Per Person	8.9	
Providers Hours Per Week	40	
Patient Load Per Day	14.4	
Time Per Patient (mins)	20	
Current Cost Per Visit	75	Practice $
Time Spent Writing Justifications	40%	Hours Available
Hours Worked Per Annum	2000	Patients
Annual Population Growth Rate	0.9000%	
Beginning Year	2010	
Ending Year	2019	
Annual Rate of Health Care Costs Growth	6.70%	
PATMOS Cost Savings	40%	
Percentage Employers Providing Health Care	56%	
FMHC National Minimum Rate (NMR)	$2.11	
Health Spending Per Capita (Current)	$5,238.00	
Health Spending Per Capita (FMHC)		

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Employment Level	301,306,800	
Employed	139,649,000	46.35%
Unemployed	14,928,000	4.95%
Not In Work Force	81,509,000	27.05%
Under 16	65,220,800	21.65%
Unemployment Rate	9.657%	
FMHC Rate of Health Care Costs Growth	-0.50%	
Man-hours Generating FMHC NMR		
NMR Per Annum From Labor Hours		
Government NMR Hour Equivalents		
Government NMR Reimbursements		

Total NMR

Percentage of Employer Converts to Public	20.00%
Percentage Decline in Providers	5.00%

Source: Henry J Kaiser Family Foundation, statehealthfacts.org

Facts		**2003**
Starting Population	298,215,356	
Seed Population Year	2007	
Non-Citizens	7%	20,875,075
Seed Medicaid Expenditures	$ 319,676,945,585.00	
Seed Medicare Expenditures		
Medicare Cost Per Member	$ 7,439.00	
Medicaid Cost Per Member	$ 8,841.00	
Seed Annual Health Care Costs	$	

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	1,551,255,000,000.00	
Seed Cost Year	2004	
Seed Annual Health Costs for Corrections	$ 4,333,800.00	$ 4,333,800.00
Seed Corrections Costs Year	2003	
Seed Prisoners	1,598,316	
Seed Prisoners Year	2007	

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Population	299,105,000	**Death Rates**
Under 5 years	20,902,000	0.20%
5 to 9 years	20,018,000	0.30%
10 to 14 years	20,038,000	0.30%
15 to 19 years	21,314,000	1.30%
20 to 24 years	20,529,000	1.30%
25 to 29 years	21,057,000	1.70%
30 to 34 years	19,089,000	1.70%
35 to 39 years	20,733,000	3.70%
40 to 44 years	21,399,000	3.70%
45 to 49 years	22,701,000	6.70%
50 to 54 years	21,234,000	6.70%
55 to 59 years	18,371,000	10.00%
60 to 64 years	14,931,000	10.00%
65 to 69 years	11,165,000	18.40%
70 to 74 years	8,423,000	18.40%
75 to 79 years	7,353,000	29.10%
80 to 84 years	5,559,000	29.10%
85 years and over	4,289,000	27.40%
Births Per Year	4,265,555	
Infant Deaths	29,327	
Annual Deaths	2,403,351	2,424,981
Net Population Gain	1,862,204	0.6226%

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Coverage Breakdown		
Employer Based	159,311,384	53.42159%
Individual	14,541,782	4.87627%
Medicaid	39,296,423	13.17720%
Medicare	36,155,452	12.12394%
Other Public	3,253,122	1.09086%
Uninsured	45,657,193	15.31014%
New Public Plan	0	0.00000%
Total Population	298,215,356	100.00000%

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	Federal	State
Alabama	$2,836,955,928.00	$1,280,541,790.00
Alaska	$549,313,441.30	$404,686,977.70
Arizona	$4,400,540,993.00	$2,216,813,883.00
Arkansas	$2,273,259,070.00	$823,824,131.50
California	$17,983,986,904.00	$17,983,986,904.00
Colorado	$1,463,996,535.00	$1,463,996,535.00
Connecticut	$2,175,548,923.00	$2,175,548,923.00
Delaware	$495,458,675.00	$495,458,675.00
District of Columbia	$971,278,287.70	$416,262,123.30
Florida	$7,987,348,199.00	$5,596,577,310.00
Georgia	$4,345,505,650.00	$2,663,374,430.00
Hawaii	$632,387,058.60	$465,507,140.40
Idaho	$771,962,241.60	$324,575,033.40
Illinois	$6,331,158,741.00	$6,331,158,741.00
Indiana	$3,205,253,308.00	$1,914,959,644.00
Iowa	$1,572,761,792.00	$964,769,334.10
Kansas	$1,287,631,537.00	$849,516,242.60
Kentucky	$3,195,571,777.00	$1,397,086,713.00
Louisiana	$3,751,056,385.00	$1,631,432,330.00
Maine	$1,259,987,863.00	$731,458,103.70
Maryland	$2,717,817,693.00	$2,717,817,693.00
Massachusetts	$5,147,513,389.00	$5,147,513,389.00
Michigan	$5,225,932,788.00	$4,043,192,413.00
Minnesota	$3,095,792,465.00	$3,095,792,465.00
Mississippi	$2,494,036,254.00	$792,347,003.50
Missouri	$4,061,075,936.00	$2,531,579,805.00
Montana	$506,314,533.40	$226,306,698.60

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Nebraska	$890,186,616.60	$646,472,483.40
Nevada	$670,860,620.90	$573,086,386.10
New Hampshire	$582,613,801.50	$582,613,801.50
New Jersey	$4,458,623,504.00	$4,458,623,504.00
New Mexico	$1,894,796,845.00	$739,426,490.10
New York	$22,169,701,109.00	$22,169,701,109.00
North Carolina	$6,340,035,508.00	$3,489,476,907.00
North Dakota	$328,780,189.40	$179,223,811.60
Ohio	$7,788,933,096.00	$5,266,603,437.00
Oklahoma	$2,298,649,078.00	$1,074,771,935.00
Oregon	$1,767,734,573.00	$1,126,869,280.00
Pennsylvania	$8,664,203,312.00	$7,265,569,278.00
Rhode Island	$904,351,382.40	$823,158,421.60
South Carolina	$2,895,640,134.00	$1,268,352,006.00
South Dakota	$389,921,851.60	$229,788,656.40
Tennessee	$4,537,938,472.00	$2,591,579,945.00
Texas	$12,514,880,738.00	$8,075,577,863.00
United States	$181,378,422,620.00	$138,298,522,965.00
Utah	$975,363,155.50	$415,231,591.50
Vermont	$532,922,723.80	$371,409,066.20
Virginia	$2,481,443,130.00	$2,481,443,130.00
Washington	$2,902,326,773.00	$2,888,428,960.00
West Virginia	$1,582,466,406.00	$591,251,184.80
Wisconsin	$2,837,377,596.00	$2,099,768,038.00
Wyoming	$229,225,635.90	$204,011,249.10
Total Medicaid Expenditures	$362,756,845,239.20	$276,597,045,931.10

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