

UNSUSTAINABLE



HOW BIG GOVERNMENT, TAXES AND
DEBT ARE WRECKING AMERICA

James E. MacDougald

*“We cannot allow ourselves to be in a situation where the debt continues to rise,” Federal Reserve Board chairman Ben Bernanke told Congress. “That means more and more interest payments, which swell the deficit, which leads to an **unsustainable** situation.”*

— Newark Star-Ledger.
June 28, 2009

_____ Chapter Seven _____

The Health Care “Reform” Debacle

With the passage of the recent health care reform legislation, the United States Congress passed legislation that is both unconstitutional and financially unsustainable. There is an ongoing and significant effort to either get the Supreme Court to declare the new law unconstitutional or to get Congress to repeal it. We believe that there is a distinct possibility that The Patient Protection and Affordable Care Act will be repealed in the next session of Congress, or that the Supreme Court will find the act unconstitutional. If either should occur, the debate will start again as to what should be done by Congress, if anything, to solve the national health insurance problems. This chapter contains a brief history of how we got to this point in our current health care/health insurance debacle.

Government has had a lot to do with creating many of the problems that confront us today. It will be impossible to solve the enormous problems through legislation without an understanding of what government has done to get us here in the first place. We must understand what should be undone in order to move forward in a way to benefit all Americans.

There is historical precedent in both the passage and the repeal of an act that mandates health care. Congress passed the Medicare

Catastrophic Care Act of 1988, intending to mandate a solution to the problems faced by some seniors with very large claims. It provided prescription drug coverage and a large array of new benefits. What was significant, however, is that a majority of seniors had their own private insurance and therefore did not need more Medicare coverage, and they certainly didn't like the fact that they would face an increase in Medicare premiums to pay for it. The national furor among seniors led to the passage of the Medicare Catastrophic Coverage **Repeal** Act of 1989.

If repeal efforts on the current health care reform act fail, there will undoubtedly be continuing efforts to make significant modifications before it is fully implemented in 2014. Health care reform, and the taxes required to support it, will serve as pivotal issues in Congressional elections in 2010 and 2012 and in the Presidential election in 2012.

There will likely be challenges as to the constitutionality of its provisions brought before the Supreme Court. Twenty states have joined together to file a suit against the federal government on the premise that Congress has exceeded its constitutional authority. Their complaint begins:

“The Act represents an unprecedented encroachment on the liberty of individuals living in the Plaintiff’s respective states, by mandating that all citizens and legal residents have qualifying health care coverage or pay a tax penalty. The Constitution nowhere authorizes the United States to mandate, either directly or under threat of penalty, that all citizens and legal residents have qualifying health care coverage. By imposing such a mandate, the Act exceeds the powers of the United States under Article 1 of the Constitution and violates the Tenth Amendment to the Constitution.” It adds, “The Act also represents an unprecedented encroachment on the sovereignty of the States...”

At the root of health care reform legislation are significant legitimate problems with health care costs, health insurance and the massive deficits that exist in order to fund previously passed

government programs, Medicare and Medicaid. The debate and resulting legislation has involved a confusing array of facts (and fallacies) that were used to support its passage. The cry that "50 million Americans don't have health care" was inaccurate, but effective.

Claims of the flaws in our current health care system revolved around the argument that the U.S. "has the highest costs but ranks 38th in life expectancy," appearing to prove the ineffectiveness and wastefulness of our current system. Receiving scant publicity were those who pointed out that **if you removed deaths caused by homicide and auto accidents, the U.S. has the highest life expectancy in the world.**

But comparing national mortality statistics can be misleading for other reasons, as well. The U.S. leads the world in teen pregnancies and in the resultant low birth weight babies. These "preemies" are provided with huge and expensive medical resources. Some other countries' infant mortality statistics don't include births of less than a specified weight or body length. While in the U.S. hundreds of thousands or even millions of dollars might be spent on a very low birth weight child, other countries wouldn't even consider them, statistically, as live births.

Shouldn't we factor in that U.S. teens have the highest pregnancy rate in the world and teens have by far the highest rate of low-birth weight (under 5 pounds 8 ounces) and very low-birth weight (under 3 pounds 5 ounces) babies? One in three teenage girls in the U.S. gets pregnant before she reaches the age of 20, of which 81% are unmarried. In 2008, there were 750,000 teen pregnancies, with 215,000 ending in abortion and 535,000 resulting in live births, a huge number of which were low birth weight and required significant health care costs. Shouldn't we factor in both the health care costs and the effect on mortality rates that are caused by a societal problem that is virtually unique to the United States? It seems fair to say that there appears to be no scientific basis for comparing the effectiveness of one country's entire health care system against another's in a way that its impact on overall mortality can be accurately assessed.

When specific diagnosis mortality results measure U.S. outcomes against those of other countries, the U.S. health care system is the clear winner. For example, the U.S. leads the world in survival rates for breast cancer at 84%, and prostate cancer at 92%. Meanwhile, in the national health care environment, figures can be frightening. In the United Kingdom, the survival rate for breast cancer is 70% and for prostate cancer it is 51%. We're talking about survival. Life itself.

If we are to compare the U.S. medical care delivery system with other countries using life expectancy as a measure, shouldn't we take into consideration that we save tens of thousands of low birth weight babies (at huge cost) and that large numbers of gunshot wounds, homicides and traffic accidents just don't happen in other countries? To what extent does all this both increase medical costs and increase the rate of mortality? Should we be examining the overall statistics that compare U.S. life expectancy with other countries that have virtually no homicides, few traffic accidents and low rates of teen pregnancies and "preemies?" Of course we shouldn't.

Is the Problem "Health Care" or "Health Insurance"?

Congress really misled the American people when it started saying that "50 million have no health care," when it was referring to statistics concerning health insurance coverage. Is "health care" the same as "health insurance?" One might think so, if you listen to some members of Congress. The two terms have been used loosely and interchangeably in Congress over the past few years. We are also often told by some of the leaders in Congress that we have a "right" to "health care." According to Speaker of the House Nancy Pelosi:

"...the American people have been exploited by the insurance industry. We can't walk away from this. So I have faith in them that they value what this is—health care as a right, not a privilege."

Was she talking about health care or health insurance? Does the insurance industry provide health care? She actually said that the health insurance industry has "exploited the American people." She damned an entire industry and got away with it. No one said, "Wait a minute! That is untrue and unfair! How do you DARE to make such an unsupported and prejudicial statement?" Where does it say in our Constitution that we have a right to health care or health insurance? Do we have a right to car insurance, homeowners insurance and life insurance? Do we have a right to credit cards? Savings accounts? Speaker Pelosi, what ARE you talking about?

Further, is she saying that there is ANY American who cannot get health care? Hospitals must treat, for free, anyone who seeks care, whether they can pay or not. That is the law. Medicaid provides for the indigent. That's another law. Any American is free to call a doctor of his own choosing, make an appointment and go see him. Who, exactly, is denied health care?

Defining the "Uninsured"

Congress's definition of uninsured includes nearly 18 million Americans with a household income of \$50,000 or more per year but who have no health insurance. It also defines the indigent (many of whom are eligible for Medicaid) as uninsured. Even worse, it defined those as uninsured (and thus needing government help) all those who chose NOT to enroll in their own employer's highly subsidized health insurance plans. I have personal experience with this. When I was president of a company with 1,000 employees, we paid 80% of the employee health insurance premium. About 15% chose not to participate because they didn't feel they needed it. Congress defined these people as uninsured and in need of government help.

This disingenuous approach of defining those who had no health care was clearly intended to dramatize and justify an emergency approach to pass legislation without fully exploring all of the specific problem areas and seeking solutions on a selective basis.

We all have basic needs for food, clothing and shelter. Certainly without these, health care becomes less significant. Are these rights, too? Does that require our government to provide them to us? If

The new Patient Protection and Affordable Care Act represents one of the most serious abridgments of human rights that the U.S. government has ever attempted.

so, how does it decide who gets how much food, clothing or shelter? Who pays for it? Do we follow Lenin's advice and let the government decide for each of us, following the axiom, "From each according to his ability, and to each according to his needs?"

What, exactly, is the role of government in providing us with health care, or health insurance, or food, clothing and shelter?

Most would agree that society (all of us) should help those who are in dire need and who cannot help themselves. Thousands of organizations provide such assistance every day. What role should the government play? When did we decide that government should step in to help us even when we don't want or need its help? Who is in charge here, anyway?

The Constitutionality Issue

Congress clearly does NOT have the right to dictate what and how much insurance Americans must buy, and to fine them or tax them if they fail to comply. Congress also does NOT have the right to force employers to purchase insurance for their employees. And Congress does NOT have the right to force states to pay to provide health insurance to those the Congress tells them to provide it to.

The new legislation also seriously abridges the right of individual free choice of physicians. It limits the treatment that a doctor or hospital may provide, and what equipment the hospital may

maintain. It eliminates the fundamental rights we all have, of liberty, free choice and self-determination. It also eliminates personal responsibility. It will fine employers for failing to pay for health insurance in addition to the compensation they provide to employees, thus limiting the creation of jobs, limiting resources available for the compensation of employees and limiting employees' rights to use compensation as they feel is in their best personal interest or the interests of their own family members.

The new Patient Protection and Affordable Care Act represents one of the most serious abridgments of human rights that the U.S. government has ever attempted.

If the American voter allows Congress to dictate that insurance must be purchased and the coverage that must be provided, one of the most fundamental of all American rights will be taken away: **personal freedom**.

Congress Needs to Get Its Priorities Straight

Current financial problems in the United States are staggering. Moody's bond rating service has a "negative outlook" on every municipality in the nation. The federal debt now approaches our gross domestic product (GDP), and it is projected to increase for the next decade. Because of federal bookkeeping madness, the unfunded liability of current entitlement programs is not included as debt. This liability is estimated to exceed \$100 trillion! We are at war in two faraway countries, and our armed forces are stretched to the breaking point. Unemployment is at historic levels, and is predicted to remain high for years to come. Medicare and Medicaid are financially unsustainable. Social Security is financially unsustainable. The Postal Service is financially unsustainable. Fannie Mae and Freddie Mac have been taken over by the government and are incurring enormous losses and accruing staggering new and irresponsible levels of debt.

During the long months that the 111th Congress has been in session, it has paid scant attention to these staggering problems. Instead,

Congress has concentrated on health care reform, including scandalous deal-making with every major special-interest group imaginable and with very special appropriations given to recalcitrant politicians. The taxpayer will pay dearly for those votes for decades to come.

Congress developed its health care reform package without input from the American people. Leaders of the majority party in Congress met with representatives of various special interest groups, including the pharmaceutical industry, the insurance industry, the American Medical Association, unions, the AARP and various other special interest players. But just whom were these groups representing? The AMA represents only 15% of physicians and earns \$70 million to \$100 million a year selling medical treatment coding **to the federal government**. AARP purports to represent 40 million Americans over the age of 50, but earns about \$1 billion a year selling supplemental health insurance . . . a business certain to grow as government takes over the health “care” industry. And what about the “coincidence” that the pharmaceutical industry increased prices 10% to all of us, then promised the government rebates on Medicare prescriptions, and then supported the health care “reform” legislation? And Senators unabashedly and openly “sold” their votes to get pork to bring home in return for supporting “health reform.” The unions got a special tax exemption so that their members wouldn’t have to pay taxes on their own gold-plated health plans, but everyone else would pay taxes on theirs, and they, too, supported the “reform” measures.

Each of these special interests was apparently more concerned with their own survival and prosperity in the event of a federal government takeover of our health care system than it was with the plight of the vast majority of private businesses and employees—in other words, our economy and nation. These private sector businesses and employees will bear the brunt of the costs of this government plundering, and they weren’t even invited to participate. In upper social circles there’s a saying, “If you aren’t invited to the dinner, you’re on the menu.” We provided quite a feast!

Simply put, they carved up the turf just like Roosevelt, Stalin and Churchill carved-up Europe after WWII. We were supposed to be viewing this live on TV, remember? Perhaps they thought we were dumb enough to take it lying down. As a friend of mine asked when Congress passed the health care "reform" bill, "Do they think we are THAT stupid?" Of course they do.

Health care reform legislation could be the harbinger of many more intrusions into the life of the average American citizen than the U.S. Constitution permits. Should our government be determining exactly what level of health care benefits will be provided to those who cannot or will not pay or the appropriate levels of the rationing of medical treatment? What additional steps will Congress deem necessary to keep health care costs under control? What other individual rights will be abridged by Congress in the name of serving the people?

Under the new law, the government will dictate what medical treatments will be provided and what the appropriate payment level is. Most experts agree that this will result in a severe shortage of physicians who will be willing to treat elderly patients. Currently, those over the age of 50 represent nearly one-third of the United States population. As this segment of the population ages, the government will be faced with a vastly increased number of Americans entering the years during which their health care needs are the greatest. Government will now determine the scope and quality of health care, while facing enormous self-inflicted debt and deficits in other areas. It is likely that government will say it has no choice but to further curtail payment levels and treatment methods in order to keep costs under control. The combination of fewer physicians, more patients, lower payments and rationing of health care treatment will have a devastating impact on Americans over the age of fifty, all 100 million of them!

Health care reform legislation could be the harbinger of many more intrusions into the life of the average American citizen than the U.S. Constitution permits.

Government Meddling Caused the Problem in the First Place

Why has government interfered for so many years in the field of health care and health insurance? And in doing so, did it create a problem so big that it cannot be fixed?

One of my favorite stories involves a spring training baseball game. The coach sends a rookie out to play left field. A long fly ball is hit directly at the rookie. The rookie gets under the ball, and the ball hits the heel of the glove and bounces out. The coach yells encouragement, “That’s OK, rookie, we all make mistakes. Just keep your eye on the ball . . . you’ll be fine.” Another sharp hit to left field lines toward the rookie. The ball takes a bounce over the head of the rookie. The manager becomes a bit more impatient, “Aw, for cryin’ out loud, rookie! You can do better than that. Concentrate!” Another towering ball flies out to left field. The rookie moves under it. The ball hits the webbing of the glove and glances off. Now the manager is fed up. “That’s it! I’ve had enough. I’ll SHOW you how this position should be played!” He storms out to left field, sending the rookie back to the dugout. The manager waits out in left field. A fly ball heads his way. He confidently lopes under the ball, and nonchalantly holds up his glove. The ball hits the heel and bounces out. The manager runs, screaming, into the dugout, throwing his glove at the ground in front of the rookie. “ROOKIE,” he yells, “YOU’VE GOT LEFT FIELD SO FOULED UP, NO ONE CAN PLAY IT!”

Government has health care and health insurance so fouled up that it may be true that “no one can play it.” Its solution, in the health care reform legislation, has been to say, “It’s so bad, that we need to do more of it.” Say, what?

Health care and health insurance began to get completely screwed up when the government decided to allow a tax deduction to companies to provide health insurance for their employees who

would receive these benefits on a tax-free basis. No taxes were paid by employees on the compensation they received if it was in the form of health insurance. This was a double win. Employers could get tax-free compensation to their employees and the employer didn't need to pay payroll taxes on the amount of the premiums they paid on behalf of employees.

Nonsensically, Congress did not allow a self-employed person to purchase his or her own health insurance on a tax-favored basis. The tax deductibility and tax-free benefit to employees encouraged employers to extol the value of these fringe benefits to their employees and to look for ways to increase the things that would be covered under health insurance plans. It was a no brainer to provide as many of these benefits as possible, in lieu of compensation. Unions negotiated for these benefits to be enriched and to be provided to employees after retirement, even if retirement was at age 40 or 45 or 50. To most employers, there was no requirement to recognize the current liabilities involved with promising these future benefits. It was free on a short-term basis.

Because these employee benefits were tax-deductible to the employer and tax-free to the employee, it was smart tax practice to provide as much under health insurance as possible. **Health insurance morphed from something intended to protect against a future unforeseeable loss, to something that could provide immediate short-term benefits, i.e. reimbursement of relatively small and routine health care expenses.**

Because of tax policy, and the resulting practice of employers and insurers to expand the definition of covered expenses, what we define as health insurance today is not really insurance at all. True insurance is intended to cover unforeseen and catastrophic losses. But health insurance today is usually defined by most of us by its coverage, meaning which medical expenses will be paid for by someone else. And it seems that almost everyone wants ALL medical expenses paid by someone else.

What if Homeowner's Insurance Worked Like Health Insurance?

Imagine that homeowners insurance worked the way health insurance works today. The homeowner's policy would cover lawn mowing, tree trimming, house painting, roof replacement, appliance repairs and every other expense that might be faced by a property owner. And, oh yes, by the way, it would also pay for catastrophic losses in the event of fire, hurricanes, floods and the like.

How might this play out if homeowners insurance worked like health insurance? Let's live in a dream world of such insurance. You notice that your air conditioning unit is squeaking. You call the AC people who immediately send a repairman. The repairman looks it over and reports, "It looks like the main bearings are going, so we're replacing the unit with a new one. And, while we were here, we noticed that the other AC unit was about the same age, and probably will go soon, too, so we're replacing that. Please give me \$20 for your "co-pay" for the visit. The insurance company will take care of the rest." Similarly, when the roof leaks, or the dishwasher breaks, or the garbage disposal goes on the blink, you call the vendor, the vendor charges you a pittance, and the insurer pays the rest. You wouldn't care if you really needed a new AC unit, or what it cost. Someone else was paying the bill. The insurer, if they tried to deny or reduce a claim, would be demonized for it. Legislators would "fix" the problem by saying insurers couldn't deny a claim.

The insurance company would obviously have to charge more and more over the years. New replacement AC units would be much better and at far higher cost than the originals. If you bought a new house in disrepair, you'd call the vendors and say, "Fix it. Here's your \$20. The insurance company will pick up the rest." Every time you called a vendor, they'd have a new AC or other appliance, at higher and higher costs. Who cares? You're not paying for it.

Insurers would, of course, raise prices to cover claims. Once again, legislators would stop the outrage of insurers raising their prices, by preventing the insurer from raising prices. They'd pass laws

setting premium limitations. They'd tell insurers, "You have to buy 50 year roofs," or "You have to pay for foliage replacement when bad weather causes a loss." Predictably, most insurers would go broke, or stop selling homeowners insurance. Those who remained in business would find another way to reduce claims. What they'd have to do is change their policies to require you to use vendors with whom they have special heavily discounted pricing arrangements and strict rules as to when the vendor could replace an old AC unit with a new one. Eventually, the insurer's rules would say, "Even if the AC unit is a rusting hulk, you can't replace it if you can find any way to keep it running." The AC repairman would have a big problem. If you REALLY needed a new unit, he'd be unable to provide it. The insurer is now in charge of what you can, and cannot, have. The AC repairman would have another problem. His contract with the insurance company pays him so much less than his real "costs" of providing services, that he has to charge his other customers, who are not insured by that carrier, more and more to make up the difference. He would hate the system but if he said that he would only serve the people who don't have deals with insurance companies, he'd lose half of his customers and go out of business. He'd have no choice but to take what the insurance company paid, and charge everyone else a lot more. Now compare that with health insurance today.

Health insurance is the most difficult of all forms of insurance to underwrite. In addition to being expected to pay for expenses that do not fit the true definition of "insurable events" (unpredictable and catastrophic), it operates in a world of rapidly changing treatments, technologies and pharmaceuticals. And the worst part of health insurance is that if the insurer pays a bundle to keep you alive, you live to have another claim on another day. Death is cheap to health insurance carriers. Life is expensive. Think about that when you contemplate what government will do with the health insurance coverage it provides when it has budget problems. We can all see it coming: "We're sorry, we just can't afford to place all these elderly people in intensive care facilities and provide expensive surgical procedures. They are going to die soon, anyway."

Health insurance is different, not only because it is expected to pay for predictable and/or non-catastrophic events, but because it has no defined maximum claim. Life insurance has a set amount. Car insurance is based on the depreciated value of the car at time of loss, with a maximum set amount. The same is true for homeowners and virtually every other kind of insurance. But with health insurance, the total potential risk is unknown. The amount and cost of each treatment is unknown, and the total claim that might be incurred is also unknown. If a person gets cancer, no one knows what the treatment costs will be.

Unlike a car or a house insurer that has a total loss maximum, the health insurer can't just total you and send your next of kin a pre-defined and fixed market value of what it insured. With health insurance there is an unknown risk for the insurer and a fixed premium to provide for it. Health insurance claims are unpredictable for many reasons. New drugs and treatments are unveiled almost every day. Each time one of these new drugs or procedures is introduced, totally unforeseen costs appear as if by magic.

In the 1980s, AIDS appeared. Those expenses weren't in anyone's forecasts. New illnesses and conditions have been discovered, requiring treatment. Who had ever heard of ADD or ADHD? Is dyslexia an illness requiring treatment? To make it even more complex, pharmaceutical companies are now advertising widely, telling us to "ask your doctor" for a prescription if your leg falls asleep too often, or if you have a ringing in your ears, or if you want to prevent plaque build-up in your arteries, or if you want to experience the unlikely possibility of a 4 hour erection. Prescription claims are now driven by television advertising as often as they are by a person going to the doctor with a complaint. If you have a problem you don't consider serious enough to take to the doctor, the ads tell you, "Go see your doctor. Incur a visit charge. Get a prescription." If the doctor prescribes the medication (often forever) the insurance company will be expected to pay for it, forever.

Health insurers must undertake the most complex guesswork in order to arrive at adequate premium rate estimates. In the early days

of health insurance, they used morbidity tables that told them what percent of any given age group would have what kind of illness in a given year. Other data included the cost of treating that illness in that locale. By considering the demographics of a group, these morbidity and cost statistics allowed insurers to estimate what their claims would be and to price their insurance accordingly. In the cases of individuals seeking health insurance, they would underwrite the health history of the individual. If there was no ongoing illness that pre-existed the onset of insurance, they'd establish a premium, take the risk and cross their fingers that they got it right. Almost no one ever got it right!

As a health insurance underwriter told me many years ago, "When you set a health insurance premium to insure someone for \$200 a month, it can only be \$200 to the good, but it can be infinitely bad."

An inherent problem with health insurance is that there are many potential treatments and providers and many different philosophies concerning treatment methods and the extent to which experimental, unproven or questionable treatments should be utilized. If a physician recommends a potential life-saving surgery or treatment that has never been done before, or has been done with mixed results, should the insurer have to pay for it? If so, to what limit?

Who Should "Ration" Health Care?

Emotion and politics always play a great part in dealing with health insurance. If an experimental procedure, costing \$1,000,000 might save your life or the life of your child, should the insurer pay for it? If they don't, you or your child might, and probably will, die. Providers won't undertake the treatment for free. They want to get paid. If the insurer does pay for it, where is the line drawn the next time another new procedure might be utilized on another person? And how is the insurer supposed to pay for this? Should they charge everyone else, to the point that insurance becomes unaffordable for most people? Who should set the outer limits of what an insurer must pay for? Where does it end?

That gets to the question of rationing. **Do you think health care should be rationed?** Before you answer, consider this scenario: A 101-year-old person is dying. He can be kept alive for 10 more minutes if we provide a treatment that will cost \$1 million. Should we do it? Of course not. So we can agree that we now both believe in rationing.

The next question is a lot tougher: **What should be rationed and who should make the rationing decisions?** We'll never agree on that one, because we each want to maintain our right to determine for ourselves what the appropriate course of treatment should be for ourselves. Some people will willingly pay more for health insurance coverage that will apply virtually unlimited resources to preserve their own life, or the life of their child, even at very high cost. Others might be a bit more fatalistic and be inclined to select an insurance policy with limitations. That is a choice that each of us should be free to make. Actually, according to our Constitution, that is a choice that each of us IS free to make.

Many of us have living wills, but not many of us would say "let the insurance company decide when to pull the plug" or "let the government decide when to pull the plug." We want to make those decisions for ourselves or let a loved and trusted next-of-kin make that decision. Certainly not someone who has to pay to keep us plugged in and who saves a bundle if the plug is pulled!

How Government Created the Health Insurance/Health Care Mess

How did we get into this health insurance mess? It all started so innocently! **In the early years, group health insurance was sold based on the concepts of cost savings, tax advantages and as an employee benefit, never thinking that it would become an absolute entitlement and that every employee would expect an employer to provide payment for virtually every medical bill of every kind.**

I entered the group health insurance business just as Medicare was passed. At the time, Dr. Edward Annis, president of the

American Medical Association (AMA), had fought as an eloquent spokesman against the passage of Medicare. The AMA wasn't against providing health care for the needy or elderly. It was against making it a forced and totally unfunded entitlement program, transferring medical costs from those over age 65 to current workers. He said that government would ultimately determine the scope and quality of treatment for everyone over 65, taking away the right of self-determination from patients as well as the right of the doctor to treat his or her patient as he or she saw fit. He also opposed the concept of transferring the obligation to pay for health insurance from those who were over age 65 to those in the workforce. **He argued that such a system was unsustainable**, and that costs would be far higher than Congress predicted it would be. He argued that it made no sense to "solve" a problem that wasn't there.

Most people over age 65 had health insurance and were willing to pay for it. He asked, in one example of what Medicare could do, "Why should the government tax the little guy to provide health insurance for a millionaire?" He lost. Congress passed Medicare. In the following decade, by 1975, the cost of Medicare was TEN TIMES higher than the government had estimated it would be—as predicted by Dr. Annis and the AMA. And during that decade, "cost shifting" became a way of life in health care.

Medicare had massive problems almost immediately. It was never funded. Instead, it was a transfer of payments from workers, via payroll taxes, to provide benefits for retirees. As more and more people over the age of 65 began using more and more services, costs escalated alarmingly. As had been predicted, the tax burden being placed on workers to fund for the costs for those over 65 became increasingly difficult to bear. Medicare had to cut its costs. But it couldn't take away benefits. It was now seen as an entitlement.

And this is when the great departure took place—a departure that would doom the health care and health insurance industries. The federal government did something it had never done before, and hasn't done since,

except in health care. It demanded (commanded) that it would pay arbitrary amounts that were well below the actual charges made by providers.

Usually, when governments buy things, bids are requested and received, and the government (supposedly) attempts to select the most cost-effective proposal. Inherent in federal government contracts is the premise that the provider of services must be paid fairly. These days, the government will require accounting to show that profit isn't more than 17% of the contract. But Medicare behaved quite differently. It said to health care providers, "You will accept my fees. You must agree to accept them if you want to treat anyone over 65."

Hospitals and doctors went along grudgingly with the new government policy. No one said, "You can't do that. It's unconstitutional. I have equal rights." Medicare used their awesome power to control costs. It was now firmly established as the major player in the cost shifting game. Medicare would pay less, and everyone else would pay more.

Over the years, Medicare started to dictate which procedures it would or would not pay for, as well as how much it would pay. The more Medicare reduced what it would pay, the more would have to be charged to everyone else. But that was not Medicare's problem. It was "saving money."

No one at the time took great issue with the fact that the government was paying less than the actual costs that were required, and therefore it was transferring the real underlying cost to everybody that wasn't covered by Medicare. It was also rationing health care treatment. Its refusal to pay actual costs was actually a "tax," charged to all other payers, but nobody recognized it, and nobody complained about it. As the years went by, Medicare paid less and less, forcing the providers to charge more and more to those who did not have Medicare coverage. Medicaid, established to provide money to states for treatment of the poor, followed suit.

Cost shifting from Medicare and Medicaid pushed up charges for everyone else. Insurance premiums began to skyrocket.

Insurers were being faced with increasing costs and their premiums jumped to cover them. Insurers began to behave very stupidly, because competition required it. They began offering unlimited maximum major medical coverage and they'd pay a lot of up-front costs and then 100% of all charges after the insured had paid \$500 to \$1,000 out of pocket. Deductibles of \$100 per year were standard. A \$100 deductible had been significant in 1965, but it was an ever-easier threshold to pass as inflation and health care costs increased. Insurers were paying more and more each year as "nickel and dime" claims became payable under major medical plans. Insurance policies that had been designed to protect against unforeseen and catastrophic risk were now paying for almost everything. Even worse, they were paying 80% and 100% of rapidly escalating charges.

A key and seminal event was taking place in the 1970s, and no one really noticed. Health insurance was no longer insurance...it had become an obligation for someone else to pay virtually all of one's health care costs.

Of course premiums began to go through the roof. Insurers were facing cost shifting from Medicare and Medicaid, and providers were increasing charges to everyone else. Why not? Someone else was going to pay the costs, whatever they were. A crisis in health insurance costs ensued, and the industry moved to find a way to reduce unnecessary claims. Cost containment became the buzzwords of the health insurance field. Insurers began to implement requirements that a second surgical opinion be sought before surgery would be paid for. They began to require advanced determination before hospital admission would be permitted. They began to eliminate Friday or weekend admissions unless it was a case of a dire emergency. They had some small impact, but nothing seemed to stem the gusher of red ink hitting insurance companies.

Of course Congress felt it should step in and fix things again. Its premise? "If we can keep people healthy, we'll save money later because they won't have those huge claims." It sounded logical... of

course if you encouraged people to get annual physicals and routine tests, you could prevent or intervene earlier to forestall the big claims later on. The idea had sex appeal.

But pros in the insurance industry asked the big question: “How can we pay what we’re paying now, plus the built-in increases, PLUS all the “nickel and dime” preventive/diagnostic claims? It would cost more. How could we do that?”

Congress Strikes Again

Congress’s answer to containing health care costs was the coercion of businesses to employ a relatively new concept called a Health Maintenance Organization (HMO). There had been a few, like Kaiser Permanente in California, that were not experiencing the same huge premium rate escalations. Maybe that concept could be employed nationally? The theory was that if an organization were formed that would provide ALL medical treatment needed by a patient, that organization would have a vested interest in keeping people healthy so that they wouldn’t have bigger costs later on.

Some people asked, “How can you treat all the people that are sick, and will get sick, and then also pay for well baby care, annual physicals, shots and routine visits, too?” Some even asked, “Should we be doing this? Isn’t there some level of individual responsibility involved here?” But their voices were lost in the noise. The accepted rationale was that the HMO would manage the treatment of each patient, and it would provide virtually every service needed. HMOs would be owned and operated mostly by physicians. The business models often didn’t include any need for people who understood health insurance.

To those in the insurance industry it was clear that an HMO could not do both. It could not pay the same amount of money that other carriers were paying for medical claims and also include well baby care, full payment for maternity expenses, etc. They argued that it didn’t make sense. How could you pay for more things and charge less? But Congress didn’t know anything at all about health

insurance. Knowing anything has never been a prerequisite for being elected to Congress, it seems.

HMOs sounded like such a great idea that Congress decided to make sure that many were started and that everyone had access to one. They passed the HMO Act of 1973, providing federal money including tax advantages and provisions mandating that every employer had to offer HMOs to their employees.

Almost overnight, HMOs were formed by the thousands. HMOs began springing up everywhere. There was one on nearly every corner. It was a gold rush for federal subsidies and mandated access to employers. What could be better? The government gives me money, I start an HMO, and then employers HAVE to let me pitch their employees in groups, during normal business hours.

It would be like "taking candy from a baby." The concept was simple—Create a panel of doctors and link up with a clinic or hospital. Design plans that pay for routine physicals, well baby care and full 100% coverage for maternity. Include provisions that if anything really serious happens, you must use our hospital and our physicians. We have contracts with the hospital and physicians that control their treatment practices and their fees. If we don't have a hospital of our own, we'll establish a discount arrangement with a nearby hospital and send our people there when needed. Our coverage will say, "If you want to go outside our HMO, we will provide very limited coverage," forcing our insured parties to stay within our system for all of their treatment. Then hire good-looking young gals to present these plans to groups of employees. Send a letter to the employers mandating that they allow us to pitch their employees. Give the "HMO girls" a nice slide show presentation and turn them loose.

Employers with more than 25 employees, if they had a group health insurance plan, had to allow an HMO to come in and solicit their employees to drop out of the group insurance plan provided by the employer and participate in the HMO instead. And that became the death-knell for health insurance as we knew it. The basic concept of underwriting the risk of a group became impossible.

Health insurance underwriting is based on a spread of the risk, with insurance companies basing rates on group demographics and actuarial tables. Over time, the group's own claims history would be used to predict next year's claims and the premium rates necessary to support them. Smaller groups would be pooled with other small groups to create a larger group with statistical reliability. It was very difficult to do, but they got rather close to it most of the time.

When the HMO Act was passed, local HMOs were allowed to selectively remove a certain portion of employees from the group plan and switch them to HMO coverage instead. This wrecked any chance that the group insurance carrier had of predicting claims. The insurance carrier had based their rates on the demographics and claims history of the ENTIRE group. They knew they had some young people and some old people, and some healthy people and some sick people. But they knew they had them all, and the insurer had some degree of predictability of claims costs by spreading the risk among the entire employee population. As HMOs siphoned off the youngest employees, the group insurer was left with an older and sicker group.

Here's how it usually worked:

A typical employer of, say, 100 employees would be approached by an HMO and told that there was a government mandate that allowed the HMO to solicit employees. The employer was compelled to pay the HMO the same portion of the premium that the employer was paying towards their selected health insurance plan.

HMOs relished the idea that they could seek enrollment from only the youngest and healthiest employees of the group, and not the oldest and most likely to incur significant claims. So they designed their plans to have a lot of free "nickel and dime" benefits for routine care, physicals, maternity expenses and for well-baby care. That's what younger employees cared about.

HMO benefits (and usually the "HMO girls" who presented them) were extremely attractive to the younger employees. Young employees generally weren't concerned with heart disease,

cancer or other serious illnesses. They were concerned with what they would get for free. Full maternity! Full payment for routine care! Sign me up!

The expected and predictable happened, of course. The HMOs enrolled the youngest members of the group, who withdrew from the group health insurance plan that was sponsored by the employer and enrolled instead in the HMO to get their preventive care, well baby care and routine bills paid. The older employees of the group elected to stay with their health insurance carrier because they really didn't need full maternity or well baby coverage. They knew that in the event they had a serious illness (likely at their age), they wanted to be afforded the opportunity to seek treatment with any doctor or any hospital that they felt was most competent to serve their needs.

The HMO Act wrecked any real hope of survival by health insurance carriers. The health insurance carrier who had started the year with 100 employees covered and a reasonable spread of risk found itself at the end of the year having lost the 25 youngest employees of the group to an HMO, or to several HMOs, and now was left with the older and sicker portion of the group. In a textbook case of adverse selection, young members of the group who had significant illnesses stayed in the insured plan, while the young healthy ones went to an HMO. The insurer got to keep the old and the sick. The claims results, relative to premiums paid, were a disaster. Rates had to go up... way up. As rates went up for the insured plans because they had the older employees and the larger claims, HMO rates stayed lower. Employers began paying the lower of the costs between the HMO and the insured plan. More and more people elected the free or cheaper HMO, leaving only the oldest and sickest remaining covered by insurance carriers. Few recognized that the 'death spiral' for health insurance carriers had begun. Insurers began to lose astronomical amounts of money, and had to look for other ways to stay in business. Meanwhile, Medicare was solving its own problems by paying even less, shifting more and more to the health insurance providers.

Insurance Carriers Adapt

The next move by the insurance industry (those remaining few who were trying to stay alive), was to invent a new concept called managed care. They decided that if an HMO can manage the care of an insured, they could, too. This was a revolutionary approach wherein the health insurance carrier would actually take over the management of the scope, quality and amount of treatment that would be afforded to their insured parties. They also realized that they couldn't survive if Medicare, Medicaid, HMOs and Blue Cross plans (who also had huge discount arrangements with hospitals) were allowed to obtain discounts from hospitals and doctors while they weren't. They wanted the discounts, too!

It was typical for a hospital or doctor to make a charge for a service that wasn't really the amount they expected to be paid by Medicare, Medicaid, Blue Cross or an HMO. They knew that the charge was a mythical one, paid only by someone who didn't have a special discount arrangement. Perhaps they would show a charge of \$120, knowing that they would actually only be paid \$60 by Medicare, and perhaps only \$65 by Blue Cross. The insurance carriers and the uninsured would pay full list prices, and these prices were much higher than they should be, because the costs were being shifted to them. The larger the discounts, or the lower the pre-arranged set fees that doctors and hospitals made to some payers, the more they had to increase their billed charges to those who had no special payment arrangement.

Insurers and many physicians started forming Preferred Provider Organizations (PPO). Doctors, or groups of doctors, would agree that if Insurer X sent them patients, they would adhere to certain treatment limitations and would charge less. The insurer would steer patients to PPOs by telling their insureds that the plan would pay much less if the insured did NOT go to the preferred provider. The AMA fought this idea, recognizing that this could lead to the formation of monopolies, but the Federal Trade Commission (FTC) said that this arrangement was not in restraint of

trade, because it was reducing health insurance costs. It was doing nothing of the sort. It was legalizing a practice that was patently illegal (for very good reasons) in every other industry, and would lead to the formation of the very monopolies that the AMA had warned about. That would become justification for Congress to meddle again in the health care/health insurance industries when it decided to pass health care reform legislation in 2010.

Monopolies, Market Power and Restraint of Trade

Restraint of trade laws are designed to prevent illegal monopolies from forming. They follow a rule of reason that says if a firm has "market power," they cannot use this power to decrease competition. But large insurers began to obtain "most favored nation" contracts from hospitals, which did give them a cost advantage over their competitors. The contracts between insurers, who used their "market power" to obtain them, and hospitals that had no choice but to accept them, created discount arrangements or discounted fee schedules to be charged by the hospital. Only the largest insurers had a population large enough to command these discount arrangements. The FTC, on the premise of reducing health insurance costs, was permitting contractual arrangements that were clearly in restraint of trade. This was illegal in every other industry in America, and would undoubtedly create monopolies. Years later, Congress would decry that there were not enough insurance providers to provide a choice to the insured. No kidding.

Hospitals in an Untenable and Unthinkable Position

Typically, an insurance company with a large insured population in a city would approach each hospital and say, for example, "I am Ajax Insurance Company, and I have X of insured in this city. You

can be a member hospital, or a non-member hospital. If you are a member hospital, my insureds will receive nearly full benefits should they choose to use your facility. If you are a non-member hospital, my members will only receive a portion of the benefits that would otherwise be payable. In effect I will “steer” my insured population to you if you accept my fee schedule. In order to be a member hospital, you have to agree to accept my preferred schedule of payments for virtually every procedure you perform. You also have to accept my rules regarding which procedures you may perform, and under what circumstances.” The large insurer was now obtaining effectively the same deal that Medicare, Medicaid, Blue Cross and the HMO’s had. Who would be left to pay the real costs?

The hospitals found themselves in an untenable position. They could either allow this large insurer a substantial discount, or they could lose a significant portion of the population as potential patients. Most took the offer.

The hospitals and doctors faced an increasingly serious accounting problem. If it cost \$100 to perform a certain procedure (with overhead, salaries, expenses and profit built in), and Medicare and Medicaid and HMOs and Blue Cross, and now Ajax Insurance Company pay less than \$100, they had to charge everyone else more than \$100. **That’s the reason that doctor and hospital bills today are complete fiction.** Few, if any, pay the charges that appear on the bill. The \$30 aspirin doesn’t really cost \$30 and virtually no one actually pays \$30. What, then, are health care costs?

The unlucky person who came to the hospital who did not have Medicare, Medicaid, Blue Cross, an HMO, Ajax Insurance or another insurer who had a “deal” is billed enough to cover the entire shortfall between actual costs and those that are paid by insurers. The result is that billed costs have increased ridiculously. The procedure that actually costs \$200 is now billed at \$1,000 or more.

The hospital billed charges that are and were a complete fiction. It is at best misleading and, at worst, fraudulent. And small health insurers and those without health

insurance who don't have a special deal have to pay charges. The result was that the largest insurers paid less on claims, and put the smaller insurers (who lacked the power to get those discounts) out of business. The large insurers became virtual monopolies or "oligopolies" in most areas.

In the ensuing two decades virtually all major health insurance carriers left the health insurance business. (Some just went out of business entirely.) We should have learned that government cannot create successful private sector businesses but it CAN destroy them. Some of the huge multi-billion dollar insurers who provided group health insurance in 1985 but no longer do include:

Allstate Life Insurance Company
American Family Life Insurance Company of Columbus
American General Group Insurance Company
Bankers Assurance Company
Subsidiary/Bankers Life-Nebraska
Business Men's Assurance Company
The CNA Insurance Companies
Colonial Life & Accident
Confederation Life Insurance Company
Connecticut General, a Cigna Company
Crown Life Insurance Company
Educators Mutual Life Insurance Company
Equitable Group & Health Insurance Company, a division of
The Equitable
First Continental Life & Accident Insurance Company
General American Life Insurance Company
The Great-West Life Assurance Company
Group Life & Health Insurance Company
GroupAmerica Insurance Company

The Hartford Insurance Group
Home Life Insurance Company of New York
John Alden Life Insurance Company
John Hancock Mutual Life Insurance Company
Life Insurance Company of North American, a Cigna Company
Life Insurance Company of The Southwest
Lincoln National Life Insurance Company
Massachusetts Mutual Life Insurance Company
Metropolitan Life Insurance Company
The Midland Mutual Life Insurance Company
MONY Financial Services
Mutual Benefit Life
Mutual of Omaha
The New England
New York Life Insurance Company
North Atlantic Life Insurance Company
Northwestern National Life Insurance Company
Pacific Mutual
The Paul Revere Life Insurance Company
Philadelphia American Life Insurance Company
Phoenix Mutual Life Insurance Company
Pilot Life Insurance Company
The Principal Financial Group
Protective Life Insurance Company
Provident Indemnity Life Insurance Company
Provident Life and Accident Insurance Company
Provident Mutual Life Insurance Company of Philadelphia
Prudential Insurance Company
Safeco Life

Security Life of Denver

Shenandoah Life Insurance Company

State Mutual Life Assurance Company

Transamerica Occidental Life Insurance Company

The Travelers Insurance Company

Union Labor Life Insurance Company

Unionmutual Life

United States Life Insurance Company

Congress Could Act, but Doesn't

While all of the cost shifting was going on, insurers had compliance problems with state laws. Insurers are regulated by the states, while the employers buying the insurance from them are regulated by the federal government. The two governments, federal and state, have created a bizarre world of overlapping and contradictory regulations that makes it almost impossible for any health insurer to survive.

It began in 1973 when the federal government passed the Employee Retirement Income Security Act (ERISA). (*Note: all public sector entities are exempt from compliance with ERISA and the associated penalties.*) Although primarily focused on pension plans, it described basic requirements concerning all employee benefits plans. It contained a provision saying that no state may regulate any employee benefits plan. That sounds pretty clear. But that isn't what happened.

States have the right and obligation to regulate insurance companies. The regulation of these companies is important. The foundation of most state insurance departments goes back to the Great Depression, when insurance companies went broke because they lacked the reserves to pay obligated claims. As a result, various states established rules and regulations governing the behavior of, and dealing with the financial solvency of, insurance companies doing business in their state.

States took on not only the right to determine if the insurance company was fiscally sound, but they actually assumed the right to determine what the insurance company would be allowed to sell and what they would be allowed to charge for services and products.

Although ERISA says that no state may regulate any employee benefit plan, the states took the position that their right to regulate insurance companies gave them the right to regulate the employee benefit plans sold by insurance companies. As a result, states began to dictate with great precision the exact coverage that must be offered, the conditions under which they must be offered and the premiums that could be charged. They didn't regulate what an employer could buy, they regulated what an insurer could sell!

Every state has different rules and different regulations. Often the rules and regulations will depend on the strength of special interest groups concerning coverage that is mandated. The result is 50 different and sometimes contradictory sets of rules and regulations, and ever-changing laws and mandates. This environment makes successful large-scale insurance company operations virtually impossible.

In an almost incomprehensible failure, Congress did NOT apply its Constitutional authority to "regulate commerce between the states." Unbelievably, while Congress has used the commerce clause to interfere in areas that are clearly prohibited by our Constitution, it chose NOT to involve itself in an area that clearly DID require Congressional involvement! Congress allowed barriers to be established in every single state of the union, preventing commerce between the states.

In the latest iteration of idiotic statements made by leaders of Congress, they have complained that health insurers impose limitations for pre-existing conditions. **They are really saying to insurers, "You are refusing to insure burning ships! That's outrageous!"** In what other form of insurance would Congress insist that insurers pay for a claim that is happening right now? Insure a car AFTER it has had an accident? Sell life insurance AFTER the guy is dead?

Insure a house AFTER it has burned down? How on earth can Congress (and the president) look at supposedly smart Americans and demonize health insurance carriers for refusing to insure a known claim? But they do, and they do it with a straight face.

With all of this interference into free markets of health care and health insurance, governments have "fouled up left field so bad, that no one can play it." Their solution of taking it over so that they can fix it themselves is being implemented at exactly the same time that they admit that Medicare, their 1965 creation, is TRILLIONS of dollars in the hole, and there is no way out unless they dramatically cut costs or reduce benefits. What planet have they been living on?

No One Knows What Health Care "Costs" Really Are

Isn't it remarkable that in the entire debate concerning health care costs, little or nothing has been said about hospital, medical or pharmaceutical costs, or excessive compensation being provided to those who run those sectors or work there? Or about pay and benefits provided to hospital workers? Only the insurance carrier is responsible for the entire health care/health insurance debacle. But the health care business must be pretty good. Hospitals have taken to advertising on television that their hospital is better than another one. Most are non-profits but they're acting like they're selling cars. There must be a reason!

Just for fun I went to www.Guidestar.org. They provide access to Form 990 that must be filed by non-profit organizations. The IRS requires non-profits to file Form 990 and to make them publicly available. **They always make interesting reading, especially when you consider that these organizations don't have profits and pay no income taxes.** They MUST spend everything they make in order to avoid the appearance of making a profit. There's an easy solution to that. You can always spend it on yourself!

These non-profits are, in effect, taxpayer-supported because they don't pay sales, property or income taxes and we do, and they

can directly or via their foundation receive tax-deductible contributions from people who ALSO avoid paying taxes. And... they can then pay the money to themselves! How cool!

Unscientific and Random Sampling—Yet Telling Examples

To do some random research, I considered names that I thought would lead me to random hospitals. I then looked at the Form 990 to see what their highest-paid people made. Certainly that is far from a scientific study, and all I could hope to learn was a glimpse of how much money was in the non-profit hospital business.

I first stumbled across Baptist St. Anthony’s Hospital in Amarillo, Texas.

- The CEO was paid \$945,000 plus \$237,000 to a special deferred compensation plan.
- They have two doctors who serve as “VP-Staff Rel.” One makes \$599,000 and the other \$562,000.
- The VP of Operations earns \$562,000.
- The 7th highest-paid earns \$436,000.

Then I found University Community Hospital in Tampa, FL.

- The CEO made \$510,000 plus a \$300,000 contribution to a supplemental retirement plan.
- The medical director earns \$437,000.

Next, I found University Hospital in Cincinnati.

- The five highest-paid NON-officers were all nurses, averaging \$179,000 each.
- The top officer earned \$1,319,000 plus a \$576,000 contribution to his benefit plan.
- The COO earned \$961,000 and the SVPs averaged \$562,000.

- I have no idea how much their average workers earn, or what their benefits are. But I'll bet they are at, or in excess of, public sector levels.

Why am I bringing this up? I bring it up because health care non-profits are BIG BUSINESS but they are not generally seen as such by the U.S. taxpayer. There is a lot of MONEY being made in the health care business! Yet that money does not have to support what the private taxpayers must support. Something is wrong with this picture.

On April 20, 2010, the *Wall Street Journal* ran an article reporting that the prices for brand-name pharmaceuticals jumped 9.1% last year, the largest increase in more than a decade, and it was occurring during one of the worst economic downturns in U.S. history. Industry spokespersons said it was purely coincidental that they had (a) supported the health care reform legislation and (b) agreed in negotiations with those writing the new bill to give rebates to Medicaid beginning next year.

Since every major payer only has to pay a predetermined amount that has absolutely nothing to do with the charges that appear on the bill, we have no idea what anything really and truly costs. **In reality, no one in America knows what real health care costs are.** A hospital may present a \$10,000 bill for a two-day stay, showing aspirin at \$80 each, and a unit of blood at \$1,000, but it knows that nobody really pays that. Medicare doesn't pay that. Medicaid doesn't pay that. Ajax doesn't pay that. Blue Cross doesn't pay that. Nobody pays that, except for the poor sap that goes to the hospital with no insurance. He will get that full charge bill, and the hospital will chase him to the gates of hell to collect it. And if he can't or doesn't pay, those bogus billed charges will be written-off, either as uncollectable or as indigent care. The fact is that no one knows what health care costs really are, so how can we possibly attack or control them?

Maybe we'll be lucky enough to get a do-over. If the health care reform legislation is overturned by the Supreme Court or the next Congress, we'll have to take another hard look at the whole mess

we're in. Before Congress can really learn what it takes to undo the great harm it has already done, it needs to recognize that there is a difference between health care and health insurance. It needs

There is a difference between health care and health insurance. It needs to determine exactly what the proper role of government should be, and it needs to get out of areas in which it has never belonged.

to determine exactly what the proper role of government should be, and it needs to get out of areas in which it has never belonged.

Can all of these health care and health insurance problems be solved? Of course they can if our free market can be allowed to operate and our citizens can be

allowed to use their own judgment and determine their own risk tolerance. They are very smart consumers when they are permitted to make their own buying decisions.

Steps That We Must Take

There are a number of steps we must take.

FIRST, we must determine what health care costs actually are. We can do this by requiring that all payers must pay the same for any given procedure, and that the provider must charge the same amount for each procedure to every payer. The provider could charge whatever he or she wants to, but they would not be permitted to give discounts to third-party payers. That would end the false, misleading (and, in my opinion, fraudulent) practice of producing invoices that have no relationship to actual costs. We must say that the charge must be paid, whether by Medicare, Medicaid, any commercial carrier or anyone without insurance.

SECOND, we have to change tax policy. Benefits to employees should be considered compensation and taxed accordingly. Employers would have to pay payroll taxes on these amounts, and employees would have to pay income taxes on these

amounts. I GUARANTEE that employees would want REAL insurance plans that cost a lot less, with high deductibles, less "nickel and dime" coverage, and much less taxable income charged to them. Additionally, the new true insurance plans would require an insured to pay a portion of the charges. This coinsurance would result in the person who incurs the charge actually CARING how much it is.

THIRD, we would require health care providers to publish their charges, so that consumers could know in advance which provider they would want to use.

FOURTH, Congress can say, "We meant it when we said no state may regulate any employee benefits plan. You may not, under the guise of regulating insurance companies, dictate what the specific coverage offered by those insurance or employee benefits plans will be." That would make it possible for large national insurers to achieve economies of scale by having policies that were the same everywhere. It would be possible for large organizations to have one large consistent plan that would cost much less to administer, as they would not have to deal with the complexity of insurance law variations in every single state of the union.

FIFTH, to assure that basic protection was contained in all policies, the Federal government could come up with a standard minimum approved plan, in much the same way that they set minimum safety standards for automobiles.

SIXTH, the federal government would have to find a way (perhaps via tax policy) to assure that every public sector entity and union must follow the same rules.

SEVENTH, all of the above would apply to pre-age 65 retiree plans.

If Medicaid is not providing adequate protection to the truly needy, it should be reviewed and changed. But Medicaid should not be used as a substitute for those who could, but choose not to,

provide insurance for themselves. Medicaid would be required to pay the actual charges made by the provider. No discounts!

This doesn't solve the problem of the person who elects not to buy insurance, or who cannot obtain insurance. If the person decides to go without insurance, they should have to deal with the consequences, as they would if they did not insure their house or their automobile. For those truly uninsurable because of an ongoing claim or a pre-existing condition, a one-time window, allowing minimal catastrophic coverage to be obtained, could be afforded once, when the new world of health insurance is implemented. One-time, open enrollment, everyone can get in a plan. Then the window closes.

These are relatively easy things to do as compared with the trillion dollar costs associated with a federal government takeover of one-sixth of the economy and, more importantly, a takeover in which government decides what is best for us. These changes would revolutionize the health care industry in the United States.

Tough Medicine to Take, but the Alternative is Unthinkable

There would be many opponents, no doubt...particularly the unions who have secured unbelievably rich health insurance plans, tax-free, for their members. Recommended changes would have far-reaching impact in many ways. Income taxes would go up for those individuals who have group health plans. Employers would face increases in payroll taxes. The true costs of Medicare and Medicaid would be seen, as these plans began to pay actual costs, not hugely discounted rates. **Congress would have to focus on paying for what has already been promised, instead of creating more entitlement programs that no one can afford.**

The costs of obtaining insurance plans would go way down, as insurance became true insurance. Insurers would compete on

a level playing field, with not one of them getting lower prices than another. Claims would be reduced as "nickel and dime" claims were borne by those who incurred them, and the buyer of health services became knowledgeable about varying costs among different providers. Consumers would actually care what the costs were, and adjust their buying habits accordingly. Large insurers would establish nationwide plans and pools of insureds. Their compliance costs with 50 different state laws would be eliminated. Individuals would be able to buy the amount of protection they were willing to pay for. Riders allowing coverage for experimental procedures, or extremely high limits, could be purchased if the insured wanted to pay the appropriate price.

All this would be tough medicine to take. But the alternative is to cede to the government forever the right to control the scope, quality and amount of our medical care and treatment. It really shouldn't be a very tough choice to make.