Reader-friendly examination of American Founders' principles. Analytical applications to problems in: health care, taxation, education, immigration, national security, energy, and world development. Practical solutions to the health care crisis. Appropriate for policy-makers, concerned citizens, and serious students who love America.

Save America, Save the World

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Salvador, Guatemala, Honduras, Japan, Mexico, Nicaragua, Puerto Rico and the United Kingdom.

Some grocery stores also have labs of available at limited times throughout the month. Patients can have anything from basic blood work that their doctor could tell them they need to screening tests for heart disease, mammograms, bone density tests, and allergy testing. The prices charged for those tests are typically substantially (around 25 percent or more) less than what is available through one's doctor or a lab if you have no insurance.

Many doctors have been fed up with the poor treatment they typically receive from insurance companies (low and slow pay and a lot of dictating of how they are to practice medicine). They open up "surgi-centers" where some surgeries can be offered, similar to a hospital's out-patient surgery centers. When enough physicians have decided that they have had enough of getting the smallest part of the pie at the hands of the insurers, they will find other ways to present cost-effective services to patients. As it is physicians, not insurers, who provide the service patients need, the patients will go with the physicians. We simply need to hasten the inevitable before more people are permanently maimed, dead, or bankrupted courtesy of the current rigged system.

Proposed New System

We can all agree that the present system is broken. After looking realistically at universal health care we can see it

fails to work—otherwise those other countries would not need "supplemental" insurance, their governments would not be trying to foist more off on to private insurance, and the government programs would be solvent, not in distress. We can also see the physicians in the system are not happy and ill patients have major problems. Universal health care simply does not work. People need to provide for themselves with genuine insurance—which is to say catastrophic-coverage—and in a genuine free market where prices can be kept reasonable and workers can have more freedom to run their practices. So let's talk about how to make this a reality.

Logically, we should put an end to entitlement spending of all sorts as it is not Constitutional and is counterproductive. (Read about the AMT in "Taxation" and see how the politicians set time bombs for us. The AMT was supposed to affect only the very rich when instituted, but because of government-caused inflation, the Congress' failure to adjust the stated sums that trigger it for inflation, we now have millions who are hit by it. Some of those same millions are now supposed to be able to get "government-provided" health care via SCHIP. A mess always results when foolishness is engaged in.) However, in the real world, as our Founders well knew, compromise is required. It would be even more unfair than the present system to suddenly cut off the disabled, aged, and truly poor from all governmental help with health care—but our **goal** should be to return to a Constitutional-sized government where that is not the concern of the government. To get there, we will need to

keep the ultimate goal—more freedom—in mind, but use the government in a different way for probably 30 more years.

Because not all people are insurable, the government will see to it that catastrophic-coverage is available to all on a sliding fee scale (based on ability to pay) so that all Americans can have the protections that insurance was originally designed for: preventing bankruptcy and sharing extraordinary costs. It would also be best to offer one full physical, one follow up visit, and one ER visit per year—all with co-pays—to everyone in the catastrophic-coverage program. The rationale for this is that it is always less expensive and the outcome better to find and treat serious illness in the early stages. For those who are healthy, making sure they have their vaccinations, and know important baseline information such as their BP, lipids, blood sugar level, etc. is worth doing. It's also a good time for their physician to advise them on any lifestyle changes they need to make. Because "things" happen in life, having the possibility of visiting the ER once a year without breaking the budget should be available. As we are going to stop seeing people in the ER for things which don't require an ER visit, that one visit (with co-pay) should not be abused.

States should run these programs, as they do Medicaid, SCHIP (children), and in some cases, "high risk" insurance pools and **the programs should pay for themselves** which will make them less of a burden on the taxpayer. We will have them administer Medicare within their state, though Medicare will follow federal guidelines. With one such

department per state we can then refer to this as something such as "State Government Insurance" and they can streamline paperwork and communication, which will help when the residents of one state need treatment while in another.

These state programs may well set their definitions for "catastrophic." Essential pharmaceuticals would be covered. Therefore, if a person has cancer, his chemotherapy and ancillary medications should be covered. Medications frequently improve the quality and quantity of life and prevent emergencies. Also, just as the VA logically gets to use its bulk power in purchasing drugs, so will the state government systems.

Everyone should be eligible for the new government insurance system. Everyone who can pay for his own insurance or find a private plan should do so and be allowed to have what the government would "pay" for his premium sent to the private plan. This is no different than Medicare allowing private industry HMO and such plans to exist which the government sends money to when a Medicare beneficiary enrolls. This will mean that private insurance will exist, though in a radically different form than it does now, because it will have to become truly competitive and transparent.

What will also happen as a result of instituting such a plan is that people will be paying something for their medical care that they use. If someone fails to get the catastrophic-coverage and suffers a heart attack, we're not going to let

him die, but there is no reason why responsible taxpayers should get stuck with the whole bill either. The person should be treated under the State Government Insurance program. When it is determined what his level of premium payment is, he will have to pay for three years' worth of premiums as well as whatever his co-pay would be for the treatment he receives if he can't pay for the care on his own. (If he doesn't pay some manner of penalty too many people will irresponsibly choose not to be insured until after the need and that means policies will cost more than if people are responsible and self-insured. It's time to stop rewarding selfishness.) If somehow an uninsured illegal has come in for treatment, the federal government, whose business it is to keep illegals out, will have to reimburse the State Government Insurance fund if the illegal doesn't have sufficient assets to cover his bill. (The federal government needs to secure our borders and many issues of illegal immigration are covered in "Immigration.")

Because of the special circumstances of American Indians, the IHS will remain. If Indians wish to purchase the catastrophic-coverage insurance, they are welcome to do so. Veterans also have special needs and the VA should remain intact at this point at least and full care needs to be provided to those veterans (and their system needs a substantial upgrade. As the military is one of the few things the Constitution authorizes and charges to the federal government, we need to make them a top priority. We have the best military in the world and it's wrong that they frequently don't get what they need while in service or when

retired out. That must change.) VA care should be raised to such a level where veterans don't feel the need for another insurance plan, but they certainly wouldn't be denied coverage.

Funding

Funding is always a key issue. Remember the idea is to ultimately make these government-programs at the least self-sufficient (no general tax revenues going into the State Government Insurance pool) and even better, get them all moved into the private market. Until that time, however, we're going to more sensibly use available resources. Private insurers will have to have price transparency, be allowed to sell to anyone in the U.S., and truly follow contract law principles.

Given the problems with determining if a hospital is doing "enough" for a charity designation, it seems there is a better solution: eliminate the charity designation and make other key changes. Charity facilities do not pay federal or state income tax, property taxes, or sales taxes. A few changes in how that collected money is allocated will be far superior to the current system. First, eliminate **all "**provider discounts": a procedure costs what it costs and that is what will be billed no matter the kind of insurance or lack of insurance. Second, hospitals need to have price transparency and their rates need to be posted publicly, on their web site and available at their facility for public review. When the person enters, a print out of costs needs to be run for him—for scheduled procedures,

that is not a problem (remember we're simplifying coding instead of letting private insurers dictate it). For the insured, they will also receive a statement of what the insurance is paying and what the patient's responsibility is for that visit.

For ER visits, there is a cost to be seen and that basic cost can be posted. Essential testing and treatment will be done as needed in the view of the doctor. In some places, it is of little consequence what the basic costs are, because that hospital will be the only one for miles and the person can not shop around if he genuinely needs an ER. In other areas, however, there may be several hospitals within a few miles of one another and sensible people will have checked ER prices in their locality so they know what to expect if they need those services. Third, refuse ER treatment to everyone who does not have a potentially life-threatening condition and can not pay the bill himself: people are not dying from stubbed toes and poison ivy. Those are treatable at medi-clinics, urgent care, and doctors' offices—even with a 49 hour wait. Those places want payment at the time service is rendered, which is why some abuse the ER. That must be stopped. If a rich man wants to go to the ER for a stubbed toe, he may do so. Triage principles will still apply and those who have a genuine need of the ER services will take precedence over his non-emergency condition so he may be there for 12 hours. It will cost him more than the appropriate place to go, such as to his doctor's office or an urgent care clinic. The rich, however, can waste their money so long as they're not taking time away from those with a genuine need for the ER.

As to the revenues now collected, let's consider this. The sales taxes should remain in the locality (some of those funds support 911, the fire department, and police, all valid uses of such tax money and of benefit to the community, the hospital, and patients). As to the property and state income taxes, that should go into a state medical pool. People's premiums should be based on a sliding-fee scale and the coverage should be catastrophic-care coverage plus one physical per year with a follow-up visit and one ER visit per year, all of which would have small co-pays which will reduce abuse and costs.

The state-run catastrophic coverage policy needs to be available for **al**l residents regardless of income. This way, all residents have the opportunity to have basic, essential coverage. Costs for these programs, the "State Medical Insurance," will be supplemented by the state income tax and property taxes now collected from the hospitals to help make premiums as reasonable as possible but still allow the beneficiaries to cover the cost of the program to the greatest extent possible with their sliding-fee scale premiums. What is supplemented is the federal government funds for Medicaid and SCHIP as well as "high-risk insurance" pools, though all states don't take the funds or offer that program. Some additional state funding may also be decided on. (Again, people who forego any manner of insurance and present themselves at the ER for treatment with a life-threatening condition will be treated. The basic tab will be picked up by the state fund, but the patient will need to pay three year's premiums to the fund. He will also owe the

hospital any co-pays he would owe as an insured patient. We will have changed rules on immigration, so the person should not be an illegal. If he is, the immigration system needs to deal with him and the federal government needs to cover the cost of the essential treatment at the ER.)

The federal income tax collected from hospitals needs to go into a pool as well. Each of the federal health programs: Medicare, VA, IHS, and the now combined Medicaid, SCHIP, high-risk insurance pool groups will receive those income taxes. It will be allocated as follows. First, each program's beneficiaries will be tallied up nationally (for "high-risk" the assumption will be 5 percent of the population—arbitrary but reasonable). Assume that the VA is 10 percent of the population of this pool, then 10 percent of each state's hospitals' income taxes will go in to the VA program to **supplement** it. Let's stress supplement because those programs will require more federal funds in all likelihood than the federal income tax can cover, but that additional (compared with now) funding along with a shift away from private insurance dictating prices and coding methods, will result in cost-savings. That will mean better service for the covered populations.

This will remove the burdens—including costs—of any added regulation to see if a hospital is "doing enough" for its charity status. There simply will no longer be such a category. With the demand for price transparency (posted prices) and the refusal of all "provider discounts," hospitals will have to become as efficient and competitive as possible

because they will no longer have any protected status, nor will certain patients be funneled into their facilities because of which insurance they have. For that ER visit, the price that will be paid to the facility by the insurance is whatever the lowest price is which is available within a 25-mile radius of the facility. If a person has a choice of three hospitals and decides he wants to go to the most expensive, his State Medical Insurance will pay that selected ER the money it would pay the least expensive of the local ERs. The difference between the lowest cost facility charges and the one selected will be paid by the patient. If the person had no coverage (his bad decision) then his bill is also covered at that lowest possible price and he is responsible for the difference. He will reimburse the state fund for his three years' worth of premiums.

For people who exceed one ER visit per year, it depends on why they do so. If a person has a bad heart and has two heart attacks and two ER visits, he should be under the catastrophic coverage provision of the insurance. If a person has a clumsy child who ends up in the ER twice in a year for broken bones, he will probably have to pay for the second visit. Because ERs are going to turn away people who do not need their services, there should be no abuse of them.

Catastrophic coverage plans would cover the medication costs of major illnesses—the chemotherapy for a cancer patient would be covered. The heart medications for a cardiac patient are covered. Additional prescription insurance plans would be available for the medications not essential to

deal with life-threatening conditions. Let's have one such governmental program available as a separate policy that people could purchase—but the premiums collected need to pay for the cost of that program so the program would need to be able to buy in bulk for savings and would want to exclude non-essential drugs such as for fertility or erectile dysfunction. The drugs would still be on the market and if a private insurer wants to offer coverage, that's an option as well, but there has to be a way to focus on what most people need and provide it at the most reasonable cost.

Long-Term Care

There are potential solutions to the long-term care crisis that **is** coming to us. There are many people, who for whatever reasons (mental deficiencies, physical inabilities) need some degree of assistance. When the problem is a disability that does not require extensive coverage, family can frequently provide necessary caretaking. However, in most homes, kids are in school and both parents work, so during that work time, there is no one at home to care for a person. If we were to have more adult "day care" provisions, this could work for those folks. Those in need of supervision could get that care.

For those whose problems are more serious, perhaps they need actual medical care throughout the day, that is a different level of care which naturally costs more. However, when people have great physical needs, it soon becomes too much for the average family to handle, so care facilities, which already exist, are frequently turned to. The problem

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