

# Healthcare Reform

## Proposals for Restructuring the U.S. Medical System

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Many people are dissatisfied with our current healthcare system — and with Obamacare in particular — and are asking,

*How can we improve the existing system?*

or

*How can we overhaul the system and come up with a new and better alternative?*

In this paper, we go back to first principles and take a fresh look at these questions. Then based on our analysis, we provide a collection of concrete proposals to improve, reform, and reorganize the U.S. healthcare system.

## Fundamental Goals

Let's state our objectives first. There are five fundamental goals we'd like any reform to accomplish.

- We want to **lower the cost** of medical care, both to individuals and to the national economy overall.
- We want the system to **provide more and better medical care** to people. That is, we want to improve the quality and, at the same time, increase the quantity of medical care.
- Government should **provide some level of low-cost or subsidized healthcare** to people who are both unhealthy and unable to afford it themselves.
- We want to **avoid increasing taxes** or expanding the government deficit.
- We'd all like to **reduce the complexity of government rules** and reduce the interference of the government in our own personal medical decisions.

Ideally, we'd like to achieve all these goals at the same time, but *these goals are in conflict*.

How can we provide more healthcare and yet spend less at the same time? How can we provide subsidized healthcare to our poorest citizens while not increasing the welfare state and breaking the government budget?

## A Proposal Based on Economic Principles

By understanding modern economic theory, and by accepting the difficulty of the problem and the realities of human nature, and by thinking rationally and clearly about the issues involved, our country can at least do better than we're doing now.

This paper makes a number of concrete, specific proposals that address our conflicting healthcare goals. Taken together, they constitute a radical reorganization of our healthcare system.

The proposals here constitute a complete and total reorganization of the entire U.S. health insurance and medical care systems. The plan proposed here is complex and is made up of many individual proposals. This paper, which describes and motivates these proposals, is long, detailed, and full of technical arguments and is meant for people with a serious and deep interest in public policy.

We begin our quest with a fundamental belief that the free-market economic system can most efficiently provide the high-quality medical care that most people demand and expect. But we also recognize that a government-funded healthcare safety net must exist for people who cannot, on their own, afford the costs of a private for-profit medical marketplace.

## [A Two-Tiered System](#)

Thus, we propose a two-tier system. We start with the first-tier and describe the operation of **a free-market private system**. Then we move on to describing the second-tier, which provides **a safety net at the bottom**.

It is critical to promote freedom of choice for patients concerning their personal medical decisions. The federal government must not try to pick winners and losers through tax policy or specialized funding programs, or dictate to people which procedures they can or cannot have. We have a **healthy respect for the free-market** as well as for **the wisdom of individual Americans**.

The government must not try to pick and choose which medical procedures, products, suppliers, treatments, and behaviors are most effective. For example, scientific research tells us that the healthiest diet does not include meat, butter, or dairy products, alcohol, or sugars such as candy, sodas or desserts. However, Americans have “unalienable rights, including the pursuit of happiness”, even if this includes doing something that bureaucrats in the federal government do not approve of. We must preserve our right to eat beef or candy or drink sugary sodas, not because these are healthy choices, but because the government should not make any of our medical choices.

With the right to make our own choices comes the responsibility for taking care of ourselves and this includes making our personal medical decisions, even if our decisions are poor ones.

Since we aim to protect and promote individual rights, our proposals must prevent government policy makers from making our medical decisions for us. To achieve this goal, our proposals dramatically simplify and minimize the role of the federal government in healthcare.

At the same time, we recognize that the government needs to step in and help people with no insurance, especially people with grave health issues as well as people at the lower-levels of income who are not in a position to afford private medical care.

Our plan achieves these goals, but it is rather complicated. We begin with an easy piece.

## Mandatory Price Disclosure

Our first proposal is for mandatory price disclosure. The first step in controlling costs in any domain is to learn what those costs actually are. So our first proposal is to enact a law that requires all doctors, hospitals, clinics, and other providers to **tell patients the cost of their services ahead of time.**

Ultimately, it should be doctors and patients who make individual healthcare decisions, not bureaucrats working for corporations or the government. But to get there, we must first make sure that doctors and patients have cost information in advance so they can make good decisions about whether or not to perform various procedures.

For example, doctors need to tell patients how much an MRI is going to cost before it is performed for the same reason a restaurant should tell its customers how much a hamburger will cost before the restaurant delivers it.

## Prohibit Price Discrimination and Price-Fixing

Our second proposal is concerns the current practice in which the exact same service is billed at different rates. The amount received by the medical provider depends not only on what service was performed, but also which insurance program is paying for it. For example, Medicare and Medicaid pay at below-market rates and, to make up the difference, medical providers must bill private patients at over-market rates to compensate.

This practice introduces distortions and inefficiencies. The price of a MRI ought to depend on the cost of performing that MRI and not be influenced or distorted by interference from insurance companies or government rules.

To fix this, we need a simple mandate that ends this practice and **requires each medical provider to charge all patients the same price for the same service.**

Of course, some doctors may charge more than others for essentially the same service, but this is an issue that must be resolved by the free market, not the government. The government must stop engaging in price-fixing and must also prevent large health insurance corporations from using their market power to gain unfair competitive advantage through price-setting. This is basic, common-sense economics.

## Eliminating the Role of Employers

Our next proposal is much more radical. It is to eliminate employer-provided insurance.

*We propose to completely remove employers from participation in the U.S. healthcare system.*

After all, what business is it of your employer to be involved in any aspect of your medical care?

Of course, we all want someone else to pay for our expensive healthcare, and corporate employers sure seem like a good source of money, but this is muddled

thinking. It makes no sense to involve employers in healthcare decisions, for the same reason that we don't want employers making decisions about who we marry or what color we paint our kitchens.

Healthcare decisions should not involve unnecessary parties and the existing system, in which a profit-oriented corporation is involved in a person's healthcare — in decisions about your medical care — makes no sense. Among other problems, it adds inefficiency which increases costs.

As an example of one inefficiency of the present system, consider the **discrimination that now occurs against elderly workers and employees with health issues**. Our current system makes elderly or unhealthy workers more costly to employers, and they are definitely being discriminated against today. But if such people are willing and able to perform the work, why should they be arbitrarily locked out of the workforce? They have an equal right to employment and our country needs their contribution. Forcing employers to be involved in healthcare introduces inefficiencies, such as this.

As another example, consider the large number of young people who only seem able to find part-time jobs.

One reason is simple: Many employers are limiting the number of hours their employees can work, because increasing an employee's hours would require the employer to provide health insurance, thereby adding an additional cost to the employer. The government wanted people to have health insurance so they made a law requiring employers to provide it in certain circumstances. The employers responded by reducing the hours an employee can work. This is an example of the "law of unintended consequences," which has made part-time workers less expensive than full-time workers. Instead of fully achieving the goal, the government's rules are reducing the number of hours that some employees can work. Obviously, we don't want to create an environment where companies, acting in their own self-interest, reduce a given worker's hours when they would otherwise prefer that the employee worked more hours. Any economist knows this: if the government wants to increase employment, it needs to reduce labor regulations.

Any law suddenly ending the involvement of corporations in healthcare would be a blunt-force blow and cause significant disruption. So our proposal is to eliminate the deductibility of any and all healthcare costs as a business deduction for employers

and — at the same time — to tax all healthcare benefits in any form as normal income to employees. The economic incentive of this “double taxation” will encourage businesses to compensate their employees with wages instead of benefits, removing the employer from the healthcare complex.

You might react by saying that this is a terrible idea! It would result in ending a lot of people’s healthcare. Most employees cannot afford to pay for their own health insurance, and they would suddenly have their health insurance terminated.

Keep in mind that the money doesn’t just disappear. The employers can, if they choose, simply give the money they were paying for health insurance directly to their employees in the form of higher wages. But, some people will say, “Employers wouldn’t do that, they would just keep the money.” Yes, they could do this. But in a free-market system, the players must be free to make their own decisions, and this includes the negotiations between employer and employee. In a truly free marketplace, employees are free to demand higher wages and to quit and find work elsewhere if an employer doesn’t compensate them well enough.

Some people will respond by saying, “We’d have to protect the workers and force the employers to pay them more.”

If this is your opinion, then it is stated very clearly: Your goal is to force employers to pay their workers more. In general, such policies are in opposition to free-market economics. The goal of getting employers to be nicer to their employees is unrelated to whether employers should be allowed to interfere in the medical decisions of their employees. Whether or not you want the government to force employers to pay their employees more, it is critical that it is done directly, and through federal mandates that keep employers involved in healthcare, which is not their business.

We must remove employers from the healthcare system. Employers will be encouraged — through this new tax — to shift their current healthcare expenses directly to their employees in the form of increased wages. They will want to do this to avoid the double taxation. Note that if an employer simply shifts their healthcare expenses to their employees, there is no consequence to their profit-and-loss statements.

Of course removing the link between employment and healthcare will take some time since employment contracts will have to re-negotiated, wages will have to

readjust, and individuals will have to get used finding their own health insurance and medical care. But, in the long term, it is the right thing to do.

To make great leaps of progress, we all need to focus on our ultimate goal, the place we'd like to get to. Once we can see where we are going, getting there becomes possible.

## On Capitalism and Free Market Economics

Our fourth proposal is more complex, difficult to understand, and even more radical.

It is based on **a fundamental confidence in capitalism** — the private, free-market system which America holds as a core value. There is really no question: The capitalist economic system works better than all known alternatives. It encourages innovation, greater production, and increased efficiency. Capitalism works better than socialism in delivering a higher quality of life to citizens, on average and overall. Let us not forget that, in the 19th and 20th centuries, capitalism turned the U.S. economy from almost nothing into the strongest in the world and raised the standard of living of Americans well above all other countries.

We must accept capitalism, and understand how to harness it.

*Any solution must embrace the free-market and allow it to function if we have any hope in improving our healthcare system and getting more better medical care for less money.*

## Oppression, Exploitation, and Redistribution of Wealth

Some people associate capitalism with oppression of the poor. Oppression of the poor definitely occurs, but don't become confused. **Oppression is not unique to capitalism and the poor always need protection**. In a modern capitalist economy, government charity and redistribution of wealth can exist comfortably and operate effectively.



Some people point out that **capitalism requires government regulation** and intervention, or else crimes and exploitation will occur. This is absolutely true; there is no question that government will still be needed to insure that everyone plays fair. But there is nothing to suggest that medical care is different from any other industry. Medical care can be delivered efficiently and fairly in a purely free-market system.

In the opinion of many people, the federal government has **a legitimate responsibility in redistributing wealth to halt the widening income gap.** Whether or not you support this responsibility, wealth redistribution is a distinct policy objective, very different from the goal of improving our healthcare system, of lowering costs, and improving care.

To make progress with healthcare reform, we must separate out the goal of wealth redistribution. Any attempts to redistribute wealth must be dealt with in other programs, and we won't discuss them here. We must be careful of people who want to sneak other policy objectives, such as wealth redistribution, into healthcare reform, lest we end up creating a messy, inefficient system that achieves neither goal very well.

It is important to understand that the goal of “supporting and helping our poorest citizens” is different from the goal of “wealth redistribution”. The U.S. government already takes a very active role in supporting our poorest citizens. Regardless of whether you agree or disagree with the degree to which the government should do this, we take it as a given fact that it will continue. Instead, the problem we must address is **how can we allow capitalism to work properly — and deliver its benefits in the medical sector — while, at the same time, providing some sort of medical safety net for all citizens.**

## **The Free Market is Not For Everyone**

There are many Americans who are doing well and our first-tier system is for them. But **there are also many people for whom a capitalist will not work.** There are many reasons. Some people don't have much money. Some people have low cognitive ability, or are emotionally challenged. And many people have very costly medical conditions. In short, there is a large group of people who are, in some way or another, unable to pay for the medical care they need.

But before turning to our proposals for the second-tier medical safety net for those who need government assistance, let's discuss the first-tier and ask how we can structure the healthcare industry to maximize capitalist competition and free-market economics.

## Trusting the Individual Patient

We begin by expressing our great faith in the individual. This too, is a core American value. In particular, we believe that all healthcare **decisions should be made by patients and doctors**. Not the central government, and Not profit-oriented insurance corporations. We trust patients to act rationally in their own best interests; after all, who cares more about the outcome than patients and their loved ones? And we believe that the majority of doctors really care about the welfare and health of their patients and will work to achieve what they feel are the best medical outcomes, given the patients' conditions and the available — but limited — resources.

Capitalism is based on a simple idea, which is many people have forgotten or misunderstood. The idea is this: Two parties should have the freedom to interact and conduct business whenever they both want to, under whatever terms they both agree to. But they also have the freedom to avoid a transaction whenever they choose. Of course there are caveats to be made. No one questions that there is a role for government in regulating things such as monopolies, externalities like pollution, fraud and other crimes, and so forth. But the essential idea is that every transaction involves two parties who are free to act in whatever ways they each think are in their own best interests.

## Eliminating Unnecessary Parties

Unfortunately in healthcare today, there are not just two parties, but five parties: Patient, doctor, insurance company, employer, and government.

Our proposal is to **eliminate insurance company, employer, and government from the decision-making process**. We trust doctors and patients above all to

make the most rational decisions since they are directly involved, they have a real stake in the outcome, and they have the greatest amount of knowledge about the particulars of the case.

## Seven Mandates to Create the Medical Marketplace

To implement the first-tier in our proposed system, we impose the following seven mandates. Together they create a purely free-market medical healthcare system, vastly different than today's system.

1. All health insurance payments must go directly to the patient, and not to the doctor or other service provider.
2. All interaction between insurance companies and medical care providers is eliminated. A wall between insurance companies and medical providers must be erected.
3. Doctors and other healthcare providers serve their patients, and no one else. They contract directly with the patients, billing them directly for any services rendered.
4. Insurers must interact with patients directly. Patients must be trusted to interact with insurers. The patient becomes the one and only customer of the health insurance company.
5. Doctors and patients must be trusted to make good decisions about medical treatments without any government or insurance oversight and control. The insurance companies and the government shall not interfere with or influence medical decisions. Neither the government nor insurance companies can dictate to doctors or patients what prices to charge or which procedures are allowed. Patients and medical care providers are always free to choose not to do business together. The choices that patients make will not always be good and will sometimes be really bad, but — on average — their decisions will be more rational, and more economically efficient than decisions made by government or by corporate fiat.

6. All doctors and healthcare providers operating in the free-market first-tier system are free to set prices as they wish. There shall be no government-regulated or fixed prices. Doctors can charge whatever prices they want.
7. Health insurance companies shall provide their services directly to patients. We must trust patients to spend their money on health insurance when — and in such ways as — they feel it benefits them.

## The Basic Scenario

A patient goes to a doctor, or other medical provider, and decides to purchase some medical service. After the service is performed, the doctor bills the patient. The patient is responsible for paying the doctor. The patient may or may not have health insurance. And that insurance company may or may not reimburse the patient.

But the key is that the second transaction — the reimbursement — remains an issue between the patient and the insurance company.

What was previously a complex interaction involving patient, doctor, and insurance company is split into two separate and independent transactions. There is a free-market for medical care and there is a free-market for health insurance, and they are isolated from each other.

## How will this work in practice?

- For a typical low-cost procedure, the patient will pay the doctor immediately. Simultaneously the patient will ask their insurance company for reimbursement, perhaps by forwarding them a copy of the bill. The insurance company will then send a check to the patient.
- For a high-cost procedure, the patient would probably contact the insurance company for pre-approval or to find out how much the insurance company will pay. The patient might elect to negotiate the price with the doctor. In some cases, a patient might shop around for lower cost providers or choose a less

costly procedure. In other cases, a patient might choose to forego some costly uncovered procedure altogether.

- Some patients do not have excess cash and they won't be able to pay the doctor until after the insurance company has sent them the reimbursement. A reasonable standard for paying all medical bills is 30 days. A reasonable standard for insurance companies is that they will reimburse patients promptly within 2 weeks. If insurance companies are going to pay, they need to do it promptly, within 2 weeks.
- Doctors might require pre-payment for some procedures, as happens in other industries already. This will always be their choice.
- Instead of obtaining preauthorization from an insurance company (as might happen today), the patient can ask the doctor or medical provider to generate a price-quote in advance of the procedure. It is then up to the patient to negotiate with the insurance company.
- Insurance industry groups are free to promote standardized billing procedures and formats for doctors and medical providers to use, in order to make their reimbursement procedure more efficient and reduce the burden on patients.

## Potential Problems

Obviously, there will be disputes between patients and insurance companies, particularly when an insurance company fails to reimburse a patient.

Today, there is a large, existing body of contract law that deals with corporate malfeasance. Insurance companies will be fined and/or sued for breach of contract when they fail to reimburse patients as they had promised. There is a legitimate role for government in regulating insurance companies and making sure they behave and live up to their promises, just as there is for other industries. Also insurance companies that continually cheat their customers will eventually be pushed out of business.

## Insurance Companies will Serve Patients

The radical suggestion we are making here — forbidding the insurance company to interact directly with doctors and healthcare providers — **forces the insurance companies to recognize and cater to their ultimate customers, the patients.** This is where capitalism will show its creative force.

## Incentivizing Doctors and Patients

In today's system, there is a lack of motivation for doctors and patients to avoid expensive, unnecessary procedures. We assume most doctors and patients are honest and responsible. But human nature is what it is. Whether we like it or not, we must accept that people act on their on self-interest.

Today, **doctors and patients are quick to order expensive procedures.** Patients want the most care they can get and doctors want to give the most care they can.

Our plan will incentivize doctors and patients to become cost-conscious. As a result, **lower-cost options will be considered and myriad efficiencies will be discovered and adopted, out of the self-interest of doctors and patients.**

With our proposal, insurers may still pay for some expensive and unnecessary tests, but at least patients will now see the bills and be responsible for paying them. Under our proposal, doctors and patients will be encouraged to make rational, economically sensible decisions about medical care. Pressure will be applied to the people making the medical decisions: patients and providers of medical care.

## The Patient is the Customer

Our proposal will **force the insurance companies to treat patients as customers.** We believe that this pressure on insurance companies will force them to provide a useful, cost-effective service to patients. We trust consumers to make sound, economically rational decisions about health insurance.

Of course many people make foolish choices, such as failing to purchase any health insurance. Then, when they need medical care, such people are in serious trouble. We discuss this later, when we discuss the second-tier system.

But first, let us recognize that doctors and medical caregivers will not like having to deal with patients.

- Patients can be uninformed and uneducated about medical procedures.
- Patients can be sick, elderly, or mentally incompetent.
- Patients can be financially irresponsible or poor.
- Patients can be unreliable when it comes to paying their bills.

Nevertheless, the responsibility for making all medical decisions must fall to the patients and medical caregivers, even if this puts additional burdens on the doctors and caregivers to educate their customers and to spend more effort on bill collection.

**The patient is ultimately the consumer.** Medical caregivers must cater to their customers, however difficult this may be. This is capitalism. In a free-market economy, participants are always free to avoid a transaction and this means that every doctor is always free to turn away customers who do not pay.

## **What Exactly is Insurance?**

Insurance companies provide a useful service, but it is critical to distinguish between insurance companies and healthcare providers. Insurance companies reduce risk, while healthcare companies provide medical services for a fee. Today, these functions are often mixed together. To make progress, we need to discuss the separate function of insurance.

Insurance is useful when there is a small possibility of something very bad happening in the future. This bad event is called a “**threat**”: A threat is statistically improbable, which just means “highly unlikely.” But if the bad thing happens, it will be very bad and will cost a lot of money.

Examples of health threats include: contracting a rare contagious disease or getting a diagnosis of brain cancer. These tragic events are very unlikely, but if they occur,

they will be very costly. Insurance against these “health threats” is a good idea, unless you are wealthy enough to pay for your care directly.

Avoiding insurance and electing to take on the risk yourself, paying all costs out-of-pocket, is called “self-insurance.” It appeals to wealthy people and those who prefer to gamble and take risks.

Let’s review the basic ideas of insurance, using **home insurance as an example**. Every year, a few people are unlucky and their homes are destroyed by fire, hurricane, etc. In the case of home insurance, a very large number of people pay a small yearly premium, while a very small number of people receive a huge payment to rebuild their homes.

At the beginning of the year (before the fires, hurricanes, etc.), all homeowners face a threat. A few homes will be destroyed, but we cannot know ahead of time which homes it will be. The important point is that all homeowners face a probability that their home will be destroyed in the future. The threat itself is a real cost of owning a home and every homeowner has this cost, although the cost is small.

*It is important to understand that the threat of future disaster is a real (although small) cost to all homeowners in the present, since all homeowners face a possibility of disaster. Similarly, the possibility of future medical costs is a real cost in the present to every one of us.*

“Risk” has a specific meaning in economics and statistics. The “threat” of home destruction is pretty much the same for all houses, but different homeowners can choose different levels of risk. High risk implies that a statistically unlikely event may occur, but if it happens the costs will be very high. Low risk means that there is much less variability; the costs and their likelihoods are predictable.

Without insurance, all homeowners face a high risk. “High risk” means that a few homeowners will face a huge out-of-pocket expense while most homeowners will have no expense. With insurance, the risk is reduced. Even if the home is destroyed, the out-of-pocket costs are still small and predictable.

*The function of insurance is to reduce risk, not reduce the cost of the threat itself.*



The purpose of insurance is to spread the risk around, thereby reducing the risk. Instead of a very unlikely but very large cost in the case of a destroyed house, every homeowner pays a small but highly predictable amount every month. Those people who understand statistics and probability will know that the insurance company does not change the “expected cost” of the threat of a home being destroyed. The small probability of a very large expense is equal to a small, highly predictable expense.

Likewise, in the medical area, insurance does not somehow reduce the cost of healthcare; insurance only reduces the unpredictability of the expected payments. We must all understand that insurance companies can never be expected to reduce our costs; only to make our payments more predictable.

The service provided by an insurance company is to change a high risk gamble into a low risk predictable monthly cost. The insurance company doesn’t reduce the cost of the threat itself. Many homeowners are willing to pay for this reduction in risk and this allows the insurance companies to make a profit.

*Insurance never reduces cost. In fact, the cost of reducing the risk is an additional expense, on top of the cost of the threat itself.*

If you own a home, there is a threat that your home will be suddenly destroyed by a fire or hurricane and the cost of this threat is a real cost. The cost of the threat cannot be avoided. The homeowner has only the choice of whether to gamble or not. A risk-loving gambler will not buy insurance, while a more conservative homeowner will buy insurance to reduce the risk. But either way, there is no question that homeowners ultimately pay the expenses associated with fires, hurricanes, etc.

*In the same way, health insurance can never reduce the cost of medical problems. All health insurance can do is reduce the risk associated with unpredictable, random future bad luck.*

The practical consequence of this is that insurance can never pay for expected medical costs. In the final analysis, **the costs associated with your health must either be paid by you directly, or by some other group which will be forced to subsidize your medical care.**

All health insurance can do is reduce the variability and smooth out the random unpredictable events. People in poor health have high expected medical costs and insurance is powerless to change that fact.

## Buying Insurance After the Fire

Here is a key question. It seems silly, but thinking about it will help clarify things.

***Why don't people just wait until after their house is destroyed by fire and then buy home insurance?***

This is a crazy idea. An insurance company would never agree to this; it would mean certain losses for the insurance company. To make this possible, the government would have to enact a law requiring insurance companies to sell home insurance, even after the house has already burned down. And with such a law, only a fool would buy home insurance before their home burned down; it would be a waste of money.

Obviously this scenario is completely unworkable.

With this crazy policy, insurance companies will either go bankrupt or will have to charge a premium that is so large it equals the entire cost of the home. In other words, the law mandating that insurance companies must sell insurance, even after houses have already burned down, would effectively destroy the purpose and function of insurance.

Insurance is a useful function. But in order to have a functional insurance system, there has to be a statistical risk that some events may or may not happen in the future. Selling insurance after the outcome is known makes no sense. Risk no longer exists, so the concept of insurance becomes meaningless.

## **Obamacare Ignores Preexisting Conditions**

*“All Marketplace plans must cover treatment for pre-existing medical conditions. No insurance plan can reject you, charge you more, or refuse to pay for essential health benefits for any condition you had before your coverage started.”*

— [www.healthcare.gov](http://www.healthcare.gov)

Obamacare includes a mandate that health insurance companies must sell insurance to people without regard to their existing health. In other words, the insurance company must insure a person who has already been diagnosed with an expensive disease and cannot adjust the premium rate accordingly.

By this logic, insurance companies must sell home insurance, even after the house has burned down.

Of course something is wrong here. Whatever Obamacare is doing here, it is not insurance. Let's back up, slow down, and sort things out.

## **Preexisting Conditions: Insurance is Too Late**

Many Americans today have preexisting medical conditions. A preexisting medical condition is not something that may happen; it is a condition that already exists.

Here are some common preexisting conditions:

- Arteriosclerosis and Cardiovascular Disease
- Cancer
- Stroke
- Respiratory Disease
- Diabetes
- Alzheimer's Disease
- Kidney Disease

For people with these conditions, **there is no longer any function for insurance**, as it is properly defined. Statistics, probability, and risk are no longer issues. There

is not a future threat; the future has already arrived for them and the medical condition exists.

Unfortunately, for people with diagnosed medical problems like these, **it is now too late for insurance**. The time to buy home insurance is before your house burns down. Likewise, the time to buy health insurance is while you are healthy, before the medical need arises.

After the medical need arises, there is nothing but cost. And for many medical conditions, the cost is very, very large. Without insurance, you take a gamble and you may lose.

## **Expected Future Healthcare Costs**

Many Americans have conditions which make future health problems likely. These include: being overweight, smoking, drug and alcohol abuse, poor nutrition, various genetic issues, and the presence of secondary health conditions. There are also many elderly people who, while still healthy, will inevitably have health problems in the future as they get closer to the end of life.

**All of us face the threat of future medical expenses. It is correct to think of that future threat as a real cost that can be measured today.**

Some people who are now healthy have a high probability of large medical expenses in the near future. Others, such as a healthy young person, are very likely to remain healthy for many years. They have a low probability of high costs. But all of us will grow old, with the inevitable decline in health as we age.

Each American has a different medical history, different genes, different existing conditions, different health behaviors, and different risk factors for future problems.

To move forward, we need to talk about how much a person's medical care is going to cost. It's going to take a different amount of money to provide the medical care for each person, since each person has a different health profile.

The cost of caring for a person consists of the money needed for existing medical problems, plus the money needed for medical problems that arise in the future.

*A person's net medical cost is the sum of **current medical expenses** (to treat existing conditions) and **expected future costs** (to treat conditional threats for medical problems that might arise in the future).*

Let us define a person's "**health liability**" as that person's the expected cost for future medical care plus the known costs for treating existing medical conditions. The health liability is the amount of money that is required for the medical care of a particular person. We prefer the term "health liability" since it combines both existing costs and expected future costs.

**Each person's "health liability" (the net expected health care cost) is different.**

Some people are healthier and face a lower health threat for future problems. Their "health liability" is low, since they have low expected future costs. Other people are less fortunate and have many more health threats, including those of currently existing medical conditions. These people have a larger "health liability".

*It is irrefutably true that different people have widely different "health liabilities." The medical care of some people will be much costlier than others.*

Unfortunately, **insurance cannot change this underlying reality**. Some people have greater medical needs than others, and in many cases the differences are huge. A healthy young person has almost no medical need, while other people are undergoing extremely expensive treatments for serious medical conditions, with enormous costs.

The difficult question is: *What shall society do for those people that have very high "health liabilities"?*

We have discussed the first-tier medical market place. For people who are able to afford their own medical costs (both existing and expected future costs), there is no problem. These people can and should pay for their own care in the free-market medical sector. The difficult question has a simple answer: this group of people will pay for their own care.

As a society, we want to get to a place where the majority of citizens plan for their own medical costs, where most people take responsibility for both their current and future medical costs. For many, this involves buying insurance to reduce the risk of

unlikely high cost medical conditions. For many people, it involves saving for future medical expenses.

But there are **many people who cannot afford to pay for their health liability.** This may mean that they are unable to pay for the treatment that they need today. But it may also mean that their expected future health costs are great. They may be healthy today but they may be unable to afford their future medical costs. Their health may be so poor that they cannot afford to purchase adequate health insurance.

For people like this who are unable to afford insurance to cover future medical costs, there is a problem. They need someone else to pay for their medical costs. For people with preexisting medical conditions that exceed their ability to pay, **someone else must pay their medical expenses,** if they are to have the care they need.

We must confront the following reality.

*People who cannot afford insurance against future health threats are dependent on the subsidies provided by another group. A person whose "health liability" exceeds their ability to pay, must rely on someone else to pay.*

It is an indisputable fact that there are many people who cannot afford to pay for the medical care related to their current condition. And there are many people whose future health is so problematic that no insurance company will offer them insurance in a free market, at least at a price they can afford.

We will discuss this group of people later, when we discuss the second-tier government safety net. For now, we stay focused on the majority of people with the most money, who can afford to pay for their own medical care, current medical expense and expected future costs.

## Reorganizing the Insurance Industry

Next, we turn to the insurance industry, as it will be reconstituted.

*Insurance companies provide a useful service, namely to reduce the risk of future unknown bad events.*

In the case of health insurance, there are many bad things that may happen but probably will not. Health insurance against future, unlikely medical problems makes great sense for most people.

### **We want this service and we need this service.**

For example, the likelihood of a diagnosis of brain cancer is very low, but the cost of brain cancer treatment is very high. Therefore, it makes sense to purchase health insurance that covers a diagnosis of brain cancer.

We believe in the power of free-markets and we believe that individuals and insurance companies should be free to engage in such transactions that are mutually agreeable to both parties. They should not be forced to participate in transactions that are disagreeable.

### **Therefore, the following mandates shall apply to the health insurance industry:**

- No person is forced to buy health insurance.
- Health insurance companies make payments directly to their customers, not to doctors, hospitals, or other medical providers.
- Health insurance companies are free to screen their customers and charge premiums based on whatever information they choose. They can base premium rates on age, gender, race, preexisting medical conditions, health-related behaviors, etc.
- Health insurance companies are free to set premium rates as they choose and to enact whatever deductibles they want.

- Health insurance companies are free to write policies that exclude various conditions, including preexisting conditions.
- Health insurance companies contract with and interact with patients only, and not with medical care providers.
- The insurance industry is a financial industry and, as such, it will be regulated and policed by the government.
- All insurance coverage shall occur within two years after the collection of the associated premium. Immediate lump-sum payouts are encouraged, where appropriate.
- State laws restricting the insurance industry shall be eliminated. Insurance companies shall be free to do business where they choose under a single set of federal laws.

The first condition — that no one is forced to buy insurance — is a fundamental condition for a free-market. Today many people complain about Obamacare because they are forced to enter into a transaction against their choice. When people are free to choose, then they are more likely to accept their choices. Generally, people are unhappy whenever the government forces them to act and they will be more agreeable when they only purchase the insurance they want.

The second condition — that insurance companies make their payments directly to their customers and not to doctors, hospitals, and other medical caregivers — puts the patient in the center of the decision making. In our plan, patients will have full responsibility in contracting with their medical care providers. Patients will now have a dramatically increased role in decision making. Increased efficiency in medical care becomes possible once we stop hiding the money from the primary decision maker, the patient.



## Age, Gender, and Race Affect Health Expectations

Premium differentiation based on age, gender, and race is justified because these factors have real and unquestionable consequences for health outcomes.

*Different demographic groups have different “health liabilities.”*

Some groups have greater average expected medical costs than others. There is certainly the philosophical question of whether this is fair or just. However, that question is not addressed here, since it does not affect our analysis. Instead, we simply **respect scientific reality that age, gender, and race affect a person’s expected future medical liability.**

Since age, gender, and race matter, different demographic groups will cost the insurance companies more. Insurance companies provide the service of reducing the uncertainty of future costs, not reducing those costs.

While we may wish that everyone was created equal and that everyone had equally good health, this is not reality. Some types of people have greater expected health costs than other types. We must avoid asking the insurance industry to address issues of fairness or justness. We only ask the insurance industry to reduce the uncertainty that each individual faces in his or her situation.

Clearly, people with certain preexisting medical conditions are going to cost a lot more than healthy people. For these people, insurance is too late. They already have a known medical condition and there is no longer uncertainty or risk. A hypothetical cost for a possible future condition has become a real medical cost for a now-diagnosed condition.

(Of course, insurance may still serve a function when uncertainties remain, such as the exact nature of the condition, or the effectiveness and prognosis for various treatments. But this is a minor caveat which should not distract us.)

## Don't Force Insurance Companies to Subsidize Groups

Some people have greater health costs than others and, in some cases, much larger costs. In the insurance marketplace, we specifically avoid anything that allows or forces one group to subsidize another group. We are being careful here to guarantee that a more healthy group (with lower expected “health liability”) does not end up subsidizing the costs of a less healthy group (those people with a greater “health liability”).

In other words, by allowing the insurance companies the freedom to discriminate and set their rates accordingly, we avoid creating a charity system within the insurance industry.

*Charity has a place in our society, but hiding it within the insurance industry is misguided and will not work as well as making it explicit.*

Insurance companies are allowed to discriminate based on health and set premiums freely.

By allowing insurance companies to set their own terms, we allow them to sell their service directly. Insurance companies mitigate risk and lower the uncertainty for their customers. Insurance companies have the function of determining or estimating a person’s actual “health liability” and then taking the uncertainty out and presenting the customer with a single predictable cost.

Healthy people will have lower premiums than unhealthy people, in exact proportion to their expected future health costs.

*Insurance companies are not responsible for keeping people healthy.*

The insurance industry does not exist to solve the problem of the high cost of medical care or to provide medical care directly. The only function of insurance is to reduce uncertainty. People with poor health still have poor health; their expenses will be high.

**The purpose of insurance is not to reduce the cost of poor health.** Insurance cannot do that and it is irrational to ask that of the insurance industry.

## Deductibles to be Set by the Market

Concerning deductibles, we allow insurance companies to structure their policies with whatever deductibles they and their customers want. Many people have a number of small medical expenses every year. For example, things like minor scrapes, bruises, the occasional cold, and minor infections can be expected to occur every year, so it makes sense not to insure against these.

Small expenses like these are predictable and to be expected. There is no need to mitigate the risk associated with them; they can safely remain uninsured. The purpose of a deductible is to effectively exempt small predictable expenses from coverage. This is something that many people will want to do, since it will naturally reduce their insurance premiums.

## Policing Insurance Company Misbehavior

Insurance companies can be expected to behave poorly from time to time. This happens in many other industries, too. Capitalism embraces the profit motive, although we all understand that government has a role in making sure that companies do not make their profits through unscrupulous or illegal behavior.

Health insurance companies are essentially financial institutions: they collect money in advance from customers and use that money to pay their customers back later. There will always be an incentive for them to renege on their promises and, as such, they need the level of oversight that banks require.

For example, consider an insurance company that offers a lifetime policy with a one-time fixed premium, protecting the customer against a collection of rare diseases. Imagine what might happen if the person happens to contract one of these rare diseases later in life. The customer has the expectation that the insurance company will pay a large lump sum of money to cover medical expenses for this unexpected disease.

Effectively, this customer is depositing money in one year for a financial benefit that may come decades later.

For such companies there is a tremendous incentive for the company to collect the money up front but fail to meet their commitments several decades later. It is a familiar pattern: The original executives are long gone and the company goes bankrupt. Any financial company offering a long-term plan must be highly regulated by the federal government. In general, people should be very careful when making any fixed, irrevocable long-term investment. A high level of trust and faith is required.

For example, it may seem reasonable to purchase insurance against, say, T-cell lymphoma when you are young and healthy. But decades later, it may be impossible to collect the payment when you are unexpectedly disabled with this disease and learn that the company is unwilling or unable to meet their responsibility. Perhaps the contract contains some fine-print buried deep in a lengthy contract or the amount to be paid out for this condition is unreasonably meager. But at this point, the poor patient is helpless.

Because of such concerns, we forbid insurance in which the premiums are paid more than two years in advance of the period of insurance coverage. Of course, many medical conditions persist over many years and decades. However, the purpose of insurance is to mitigate and reduce the risk of contracting an expensive medical condition. The insurance company must provide insurance against the occurrence of disease. Disease appears relatively quickly — you are healthy at one time and then you become unwell — although the disease or condition itself may persist for years or decades.

*The insurance company's work is done after the disease onset since the uncertainty they were addressing is no longer present.*

For example, it makes sense to purchase insurance against a diagnosis of T-cell lymphoma, a rare and expensive disease. A person might reasonably purchase insurance against such a unwelcome diagnosis. When that diagnosis is confirmed, the insurance company will then pay out a lump sum, according to the terms of the insurance policy. The patient can then use that money to pay the costs associated with treatment over several years.

What about the problem of purchasing insurance against T-cell lymphoma occurring at any time during your long life? Simple: You would want to purchase a year's worth of coverage every year. If you remain healthy this year, you will want to purchase the same coverage again next year. Most likely, the coverage for T-cell

lymphoma would be included in a larger policy that covered many other diseases and conditions as well.

You might be concerned that the cost of the treatment is highly variable and depends on many things. This is correct, but do not underestimate the power of free markets. For example, some insurance companies might offer special plans for those initially diagnosed with T-cell lymphoma, in order to mitigate the uncertainties associated with this particular disease.

There is another concern about insurance company misbehavior. Human biology is complex and most people have very little information about medical conditions which they might acquire in the future. The insurance companies have much more information and can be expected to use that information to bamboozle customers. Imagine purchasing health insurance in one year and learning in the next year that you are very ill. Imagine that you learn you have an obscure and very expensive disease, but the fine print of your insurance policy does not cover this particular disease! Or imagine that they pay, but the amount they pay is much too little to cover the treatment you now need!

In a very real sense, you have been scammed by the insurance company. This is a real possibility since any insurance company can be expected to have much greater knowledge about medical conditions, their costs, and their likelihoods than any consumer.

*Unfortunately, we can find no other way to protect consumers other than through constant and pervasive government regulation, oversight, and auditing.*

In addition the market place itself will find novel solutions. With our plan, insurance companies are forced to cater to their customers and, just as in other industries, some companies will provide better service than others. Those companies with better reputations will be favored by consumers. We can expect a secondary industry to arise, in which insurance companies are rated and reviewed, just as happens in other industries.

It makes sense for the government to formulate various standardized insurance policies — perhaps similar to the bronze, silver, and gold plans we have today — in which the payout rates for various diagnoses are predetermined, fixed, and standardized. Then insurance companies can offer these standard products, while

retaining the freedom to set premiums as they wish. In this way, consumers would have some guarantee that they are purchasing the product they think they are getting.

Free market competition works most effectively when the goods involved are identical and substitutable. The government has a role in making this happen.

Finally, we remove state-by-state barriers to competition. The profusion of different state laws only creates a more complex environment for insurance companies to operate in. We want to encourage competition and the benefits it brings. The best way to encourage competition among insurance companies is to create a single large uniform market.

## Patients Will Seek Cost-Effective Medical Care

An important aspect of our proposal for a free-market in health insurance is that patients will receive the proceeds from the insurance company immediately and the money will go straight to the patient, not their healthcare providers. For example, when a patient finds they have contracted some particular disease or condition, they may receive a large lump-sum payout from the insurance company, meant to cover the cost associated with that disease.

*After receiving an insurance payout, the patient is free to negotiate with their medical care providers.*

With our plan, there is full incentive for each patient to choose the most cost-effective treatments. Any money wasted on unnecessary procedures is money that could be spent elsewhere by the patient. The patient is highly motivated to avoid unnecessary or costly tests, treatments, and procedures.

**There can be no doubt that this will bring medical expenditures in the U.S. way down.**

Requiring the insurance company to give the money directly to the patient and allowing the patient the freedom in choosing how to spend it will result in achieving

greater efficiency in the medical and health industries.

*Giving patients the insurance money directly and allowing them to choose how to spend it will reduce U.S. medical expenditures dramatically.*

## Why Make Young People Pay for Older People?

Some policy-makers have suggested that we should jury-rig the insurance system in such a way that the premiums paid by young and healthy people are available to the insurance companies to pay the medical expenses incurred by older or less healthy people. This is one of the core ideas behind Obamacare.

Any such scheme will face a never-ending head-wind of non-compliance: **By-and-large young, healthy workers simply don't want to pay for other people's medical care** and they'll try all kinds of clever tricks to avoid any such payments. We must accept this reality.

And really, who can blame them?

Asking one group of people to pay the costs of another group of people is essentially asking them to be charitable. The government can always ask people to give money, but unfortunately voluntary contributions never seem to generate quite enough money. This is a simple fact of human nature. Instead, the government must forcibly compel people to contribute.

We need to steer away from any such interference in the insurance marketplace, and keep the first-tier marketplace free.

*The Obamacare policy of making young healthy people — who do not need insurance or much insurance — purchase insurance, is really a form of "forced charity," mandated by the federal government.*

When described in these terms, we can see that **Obamacare is trying to achieve a policy objective of charity** but is essentially sneaking it in under the rug.

We will address the charity objective — that it, asking young, healthy workers to pay the medical expenses of older, less healthy Americans — later on, when we describe our second-tier safety net.

## The Problem of Malpractice Awards and Tort Reform

Unfortunately problems will occasionally arise during medical procedures, and doctors or other caregivers make mistakes. These mistakes can result in very bad outcomes for the patients.

For example, a patient may elect to have some surgery with a high likelihood of success. They expect a full recovery, but end up being paralyzed and in terrible pain — or even dead — perhaps because the doctor made a poor decision or failed to respond appropriately to some information.

As another example, perhaps some patient has a rare, fatal reaction to a medication. This is just random, bad luck, even though the death might have been prevented if the caregivers had been more closely monitoring the patient.

What happens today after such a disaster? The lawyers are called in, there is a malpractice lawsuit, and the doctor is forced to pay a huge sum of money to compensate the patient.

In today's system, doctors and medical caregivers fear malpractice lawsuits and buy insurance to protect themselves. Malpractice insurance is exceedingly expensive and is a major contributor to the high cost of medical care today.

In today's system, doctors or other caregivers make mistakes or, for other reasons, the outcome is less than expected. In some cases, minor errors can result in truly awful outcomes. The patients and their loved ones are quite upset and the judge or jury feels that they have been somehow wronged. In attempt to compensate the victim, a large amount of money is awarded.

In medicine, accidents are inevitable and oftentimes the outcomes are much worse than hoped for. But the problem is that **these huge malpractice awards are hurting the system as a whole.**



We begin by making these observations:

- Medical care is full of uncertainty and random variation.
- Doctors and other medical caregivers are generally doing their best.
- Innocent accidents will happen often. Medical care that ought to work will often fail.
- There is no guarantee that medical problems can be fixed or cured. We cannot always avoid pain and suffering. We can never avoid death.
- Most people have trouble reasoning with probability and statistics. When things go wrong, they see nothing more than a mistake that is to blame.
- Malpractice lawsuits must be limited if we are to reduce the cost of medical care.

Each of these is self-evidently true.

**Medicine is full of uncertainty.** There is often incomplete knowledge about a patient's condition or what exactly the problem is. Sometimes caregivers have to act with incomplete information. Medicine and human biology are very complex subjects and we know only a small part about how the human body works and how various diseases and conditions function.

One thing is very clear: there is a tremendous amount of random, statistical variation between different patients, different pathologies, different drugs, and how they all interact. **The practice of medicine is imprecise, unpredictable, and reliable only in a statistical way.** Medical caregivers are trained to act confident and certain, but they are often doing little more than guessing and betting on the odds with incomplete understanding and information.

However, we believe that doctors and other caregivers are, for the most part, trying their hardest to help their patients. Unlike some other less savory professions, medical workers are almost always well-meaning and doing whatever they think is best for the patient. In some professions, workers are simply out to make money and cannot be trusted, but **medical workers are, on average, ethically good**

**people** who are working to make the lives of their patients better. The field tends to attract this sort of caring people.

We cannot deny that **accidents happen**. People are human and make mistakes. Medical care is very challenging and, in spite of everyone's best efforts, there will be many stupid, preventable mistakes that have very bad results.

Unfortunately, there is no guarantee of health. **You do not have a right to be healthy or free of pain.**

Government laws can guarantee some rights, but health is not among them. Sadly, many people will contract horrible, painful, fatal diseases. This is an unpleasant reality to confront, but necessary. We must all accept that unalterable truth that the health outcome for some individuals will be very bad.

Naturally, patients and their loved ones will look for someone to blame. Accepting disease and inevitable death is not easy. But in many, many cases, no one is "at fault." There is simply nothing that can be done and **suffering is often in the nature of life.** In the end, we will all die.

When people elect to have a medical procedure performed, they must accept that there is some probability that it will fail or that bad things can happen. When judges or juries are confronted with an instance of some error or mistake leading to a horrible outcome, they must accept that only bad luck is to blame. **Bad luck is not a reasonable excuse for damage awards.** But most judges, juries, and laypeople cannot simply accept that "accidents happen and no one is to blame."

So we must recognize that suffering usually doesn't imply malpractice. People naturally seek to blame someone and to seek compensation for the suffering.

As a society we must come to grips with the reality that bad outcomes will happen. We must stop blaming medical caregivers for bad outcomes. We must stop compensating the victims at the expense of the doctors for suffering that occurs as a result of medical problems.

Instead, we must protect doctors and medical caregivers from egregious malpractice awards.

To alter the malpractice litigation landscape of today, we offer **three simple laws**:

- *Doctors may not be blamed for incompetence, random accidents, unintentional errors, innocent mistakes, or minor negligence they make when providing care, even if they result in extremely poor medical outcomes or death.*
- *Patients cannot be compensated for suffering as a result of medical care they receive, as long the suffering is not the result of malicious or intentional acts, egregious carelessness, or gross negligence.*
- *A patient may only be compensated when criminal malpractice is proved, which is defined as harm caused by intentionally malicious acts or gross negligence.*

We have carefully worded these laws, keeping them simple so as to get across the main idea: **the doctor or other caregiver can not be asked to pay for a bad outcome just because he or she could or should have done better.**

A lawsuit is only reasonable when the caregiver behaved up in a criminal way. In other words, the malpractice must rise to the level of a crime.

Here are some illustrative examples:

**No malpractice:**

A surgeon accidentally cuts a nerve during a simple operation, resulting in lifelong insufferable pain.

**Malpractice:**

The surgeon was intoxicated while operating.

**No malpractice:**

A nurse accidentally switches medicines and a patient getting treated for a minor condition dies.

**Malpractice:**

A nurse unilaterally decides to prematurely end a suffering person's life and secretly administers a lethal drug. This is also murder.

What we propose may seem extreme at first glance, but these new laws are necessary to reduce the malpractice burden encumbering our current system.

Our proposals place great responsibility on the patient. Patients must choose their medical providers with care. Reputation among doctors will become more important: good doctors will command higher prices in the first-tier medical market place.

We get back to our fundamental principle: trust the doctors and patients to make good choices.

One thing to note is that bad outcomes are a constant risk, although they are statistically rare. This is exactly what insurance is for.

There is nothing in our proposals to prevent insurance companies from mitigating the risk to patients. For example, if you are going into the hospital for a surgery, it might make sense to purchase an insurance policy, just as some people elect to purchase flight insurance in case their plane crashes. Or more likely, a hospital might automatically buy insurance on behalf of their patients, so that an especially poor medical outcome will result in some meaningful compensation to the patient.

## What About Health Saving Accounts?

Some have proposed various programs whereby the government encourages people to save for their future medical expenses, for example, by providing incentives for people to put money into some sort of a special healthcare-related savings account.

The choice of whether to save, and how much to save, should be a free-market decision made by individuals based on their particular situations and particular choices. Government should not interfere in these decisions by creating programs that encourage saving over consumption, any more than they should encourage consumption over saving.

When the government creates programs such as specialized savings programs, it distorts the decisions that people would otherwise make. The resulting small inefficiencies cost individuals directly and add up to a large financial burden on the economy as a whole.

Furthermore, government programs like health savings accounts add to the growing “**complexity burden.**” Government rules and regulations are wearing out smart people and crippling people with lower intelligence.

## [Allow Natural Consequences to Encourage Saving](#)

The strongest and best incentive for people to save for their own future medical costs is to require them to pay for those same future medical costs. Furthermore, this is really the only reason to save: If people hope to obtain first-tier free-market medical care, they will need to have the money available. **The need to pay for their own care is exactly the right incentive for saving.** By unnaturally incentivizing saving through various government programs or mandates, the government only encourages people to make economically inefficient decisions.

We trust most citizens to make good choices, and one choice we believe that individuals should make is to determine how much to save for their future medical needs. After all, they have the information about their own medical conditions and likely outcomes, as well as determining how important their own health and medical care is to them.

**The government needs to let people make their own choices and the proper incentive is to face the natural consequences of their poor choices.**

But, of course, many people are foolish and will make choices they later regret. For example, many people will fail to save or buy insurance when they are young and healthy. Then, later, when they have medical problems, they’ll be in trouble.

*The price of freedom is that some people will fail. Paying that price allows the majority of us the freedom to choose our own destinies.*

## [The Second-Tier Provides a Safety Net](#)

There remains the question of what happens to people who can not pay for their own care in the first-tier medical marketplace.

## **How can we make sure everyone gets at least some medical care?**

We've just described the first-tier of our system. It is well-designed for intelligent, educated, responsible individuals who are competent to make sound decisions and who are financially capable of taking care of themselves. Most Americans are like this and a system based on free-market capitalist principles will work well for such people.

Most Americans do not need the government to take care of them. They will, on average, make pretty good decisions and, as a result of millions of reasonably good decisions every day, the first-tier free-market system will deliver the medical care that people want at economically efficient prices, just as in many other industries.

But there are some people for whom the free-market capitalist approach to medical care will not work, and we now turn to the second-tier.

## **Healthcare Need and Inability to Pay**

The fundamental problem that any federal healthcare program must address is an issue of charity.

### **How can one group of people pay for the medical expenses of another group who cannot afford to pay themselves?**

We begin by asking which people need financial help and which people will be required to provide that help.

Society's primary concern is with individuals who are elderly or are otherwise in poor health, and who are unable to afford to pay for the medical care they need.

We refer to people with lower incomes as "poor".

It is not always politically correct to use the term "poor", but we use this word anyway. It means the same thing as "people in the lower income brackets", and is more straightforward. In this paper, we make no value judgments about people in this group. They are simply referred to as "poor" since they have less money than richer people and that is the meaning of the word "poor". We don't differentiate

between “income levels” and “accumulated assets”, since poor people don’t have much of either.

As for the opposite group, the term “rich” works well. These people have both “high income” and “high net worth”. Again, there is no need to distinguish between income levels and asset levels because these are highly correlated among the rich.

*Discussing healthcare reform without talking directly about “rich people helping poor people through government-run charity programs” is a certain sign that politically-correct thinking is interfering with common sense.*

Without talking openly about what we are doing, we can’t hope to find good solutions.

## [What is a Government Provided Safety Net?](#)

The second-tier system is designed to help people who are both **unhealthy** and **poor**. This is because people who are not sick or elderly are healthy, and so they don’t need medical care. Likewise, people who are not poor have money so they can afford to buy medical care in the free-market system we described earlier. They don’t need the second-tier safety net.

Our society has decided to provide some level of medical care to people who are unhealthy and poor, and we do not question that decision here. Instead, we focus on the best mechanisms to achieve this objective.

Of course there is a spectrum of health and wealth, so the first question is where shall we draw the line concerning who is to be considered “unhealthy and poor.” In the spirit of a liberal democracy, we feel the government should not draw lines or segregate people into classes such as “poor” or “unhealthy.”

Instead, the myriad small choices that people make determine how much they rely on the first-tier free-market system and how much they rely on the second-tier safety net. The choice is left to the individual.

Society is divided into a spectrum, with self-reliant people needing no assistance on one end, people with serious health issues beyond their ability to afford on the other end, and a full spectrum of people in between.

*Our proposal is for a two-tiered system, with the one tier for one end of the spectrum and the other tier for the other end. The first tier free-market medical marketplace serves the majority of Americans who are healthy or at least not poor. The second tier safety net provides government-funded medical care for the people falling at the other end of the spectrum, who are both unhealthy and poor.*

## Funding the Safety Net

We decided to remove employers from the healthcare system, so the first question is: Where shall we get the money to pay for the government-funded second tier?

To provide care for the unhealthy and poor, we must obviously take the money from the opposite group. Of course, this is just the rest of society, everyone else.

Recall that one of our initial fundamental goals was to simplify government. The simplest approach to funding the safety net is to tax everyone, more-or-less equally, in order to provide care for those who are unhealthy and poor, the users of the safety net.

Our proposal is to impose no new funding mechanisms. There will be no new tax programs, no changes to the federal income tax regulations, and no new budget financing schemes.

**Our proposal is simply to fund the second-tier safety net out of the general government budget.**

Any government-funded safety net is going to be costly and everyone is going to have to pay for it. In this case, “everyone” means the federal government as a whole.

There is no point in borrowing the money, issuing debt, or hiding the cost as future obligations. The cost of running the second-tier system is a current and real cost.



The only rational approach is to fund it in the present, not through any multi-year schemes.

Some people propose various funding mechanisms, such as “get employers to pay,” or “get the young people to pay,” or “get the rich to pay.” Medical-related tax structures or complex government funding programs distort the operation of a free market economy. Regardless of how creative and well-meaning these funding ideas may be, they must be avoided.

Our proposal gets the money from everyone equally to pay for the medical care of the people who are the beneficiaries of the second-tier safety net system.

*By taking the money straight from the general fund, the plan is being paid for, in the end, by taxing every American.*

Of course, this means that poor people will also be contributing and paying for the safety net to some extent. However, since they are poor, their contributions will be small or zero, according to their levels of income.

**The rich will pay for more than they get, and the poor will get more than they pay for.**

People who are richer will naturally contribute more, since they typically pay more in taxes. This seems appropriate for any government mandated charity program. Our proposal effectively taxes the rich to pay for the medical care of the poor, as we intend.

Also note that, by taking money from the government’s general fund, the money is ultimately coming from the people who pay taxes. The money is coming from the employed and the wealthy people, who we are more healthy on average. So, roughly speaking, we are requiring healthy people to subsidize the elderly and unhealthy population.

Concerning any proposal for a comprehensive safety net, some people will immediately say, “This is going to be expensive!” This is obviously true. Providing subsidized medical care to millions of people is, by its nature, very expensive, and there is no way around this hard fact. But keep in mind that our economy is already spending a huge amount of money providing subsidized or free medical care — though one program or another — to tens of millions of people.

So this proposal only impacts the national economy or government budget only if we increase or decrease the amount of medical care being provided to the people who need assistance. We are not proposing a major increase or decrease in the amount of overall assistance being provided by the government.

## What About a Tax on Medical Care?

Some have proposed that the government **impose a tax on all private medical expenditures** and use the funds raised to pay for subsidized care for the poor.

This is a bad idea for the following reasons:

- (1) This is effectively a **sales tax** and would require a **new, large federal bureaucracy** to administer.
- (2) The presence of a medical tax will **distort free market decisions**. As every economist knows, a tax on any behavior will discourage that behavior. We do not want to discourage people from buying medical care in the first-tier private medical marketplace.
- (3) Most importantly, such a medical tax would require one segment of the population to subsidize another segment but it **would ask the wrong group of people to pay**. This tax would force non-poor people with medical problems to subsidize poor people with medical problems. Obviously, to subsidize the medical care for poor unhealthy people, we must make someone pay. But **asking other unhealthy people to pay is wrong**. To pay for the medical care of the unhealthy and poor people, the government needs to collect the funds from all other people, as our plan proposes.

This idea is rejected.

## Subsidized Medical Care – Core Issues

There are really three separate policy questions:

1. *How much money shall society provide to subsidize medical care for the elderly, unhealthy people who cannot themselves afford it?*
2. *How shall we get the money to pay for this?*
3. *How shall we provide care for this group?*

The first question — how much to spend — is a question which society as a whole must find a consensus on.

The second question — how to fund it — is a question we answer here: The money for the second-tier system shall be taken out of the overall federal budget.

There is a larger discussion about the overall size of government and how we should pay for our government. There are exactly three mechanisms for funding any government:

- Taxation
- Debt
- Monetary growth, i.e., printing money

Any government is always funded through some combination of these, and there are really no alternatives. The proper proportion of these is a macroeconomic question and is extremely important, but it is not relevant to a discussion of healthcare. We will not say anything more about this issue here.

The third question — how we can provide medical care for the elderly or unhealthy segment who cannot afford private care — is what we turn to next.

## The Moral Hazard of Government Programs

Before going on, we all need to acknowledge and accept that there is a so-called “moral hazard” of providing a government-funded safety net — whether for healthcare or any other form of welfare.

What does “moral hazard” mean? The more government promises to take care of people — for example, with a healthcare safety net or with income assistance — the more people will rely on the government and not bother to take care of themselves.

**By-and-large, people tend to make rational decisions in their own self-interest.**

If the government guarantees excellent healthcare for all people, then only a fool would save or purchase insurance for a medical emergency in the future. In the same way, the more money government provides to poor people in any form of welfare, the less incentive there is to work.

We may not like this unpleasant reality, but this is how humans behave. We must acknowledge the moral hazard involved here.

*The more assistance that our government provides, the more America will become a country where people depend on the government to take care of them, and relinquish control of their destinies to bureaucrats and politicians.*

Many people are suffering horribly and need help right now. Unfortunately, being kinder today will result in problems in future years. Over time, people will work less vigorously and not bother to plan or save. As a result, our economy will fail to thrive, and our average standard of living will fall. On the other hand, being tough today, letting people fail and suffer, will lead to a stronger, more responsible society in the distant future. Finding a proper balance, a middle pathway between cruelty and shortsightedness, is a challenge society must face consciously.

## Resources will Always be Limited

And there is another reality: Our society simply cannot afford a perfect safety net that provides first class medical care for everyone, even if we choose to ignore the moral hazard altogether. There will never be enough money for charity.

Many people contract horrible diseases and terminal medical conditions, which cannot be cured no matter how much we spend. And of course, no amount of money is enough to keep people alive forever. As each of us faces the inevitable decline of our health in old age, the demand for medical care often becomes infinite, and will always outrun whatever resources we can throw at it.

Instead, our society can only afford, at best, a safety net that provides limited medical care for a fraction of the population.

The larger the safety net, the more people will turn over responsibility to the government. The smaller the safety net, the more a free-market, private system will operate, putting pressure on people to take care of themselves.

We must strike a balance between having no safety net at all, and having a government that guarantees excellent medical care for everyone. ***The first is cruel, but the second is impossible.***

## Personal Responsibility: Expected and Respected

Our proposal is to place full responsibility on the majority of citizens to save and plan for their future medical costs. Requiring people to take responsibility for the own outcomes is the American way.

Of course, not everyone will act responsibly, however you might define “responsible”. But the constant pressure on each of us to take care of ourselves must, over time, result in a society of mostly responsible people. This is the future America we want: a society of independent, self-reliant individuals.

## Many People Require Government Assistance

Today, the majority of people can afford to pay for their own medical care. In other words, the end of the wealth spectrum providing medical charity is larger than the end of the spectrum receiving medical charity. Most Americans are not poor.

Of course many people will make poor decisions when young and fail to save for the medical costs that occur at the end of life. And unfortunately, some people are born with genetically-caused health problems. And some people will unexpectedly contract random or rare diseases or encounter unexpected insults to their health.

*For the group of people who cannot afford to purchase adequate medical care in the first-tier private medical market place, the government must provide for their medical care.*

The question is: How can the government most effectively provide that medical care?

## The Federal Government Does Not Need Insurance

Concerning the second-tier, our first proposal is to eliminate any and all participation by insurance companies.

The government is large and does not itself require insurance, so there is simply no insurance function required here. People have medical needs and the government needs to provide medical care for them, one way or another. But in the second-tier system, there is no need or function for the participation of insurance companies, which can only act as corporate middlemen, striving to make a profit on the enormous amounts of money that will be involved.

The mandate of Obamacare that forces everyone to have health insurance is essentially trying to force people and insurance companies to interact in transactions that are designed and controlled by bureaucratic fiat, in opposition to the basic principles of free-market economics.

The result is a system that refuses to function.

It seems that what is really happening is that our government is trying to out-source the job of managing medical care to a few large healthcare corporations. Obamacare has managed to create a system in which large corporations — rather than doctors, patients, or even the government — are making medical decisions. Profit-oriented companies have gotten into the business of being paid to provide medical care; their income streams are forced and often neither doctor nor patient is a happy participant. The government is furiously making myriad policy decisions about which medical procedures are to be performed in which situations. I think we all recognize that this is a dysfunctional, expensive, inflexible, and inefficient system.

The straightforward reality is that the government needs to provide medical care to the people who would not otherwise be able to afford it.

## **Government Must Provide Medical Care**

Our proposal is simply that the government should provide the medical care directly, and cut out the insurance companies.

There is nothing inherently wrong with government-run clinics and hospitals, as long as we all understand any government run operation will be somewhat inefficient and will not tend to spark as much innovation as occurs in the free market. They will not have the same level of funding as the first-tier facilities. They may at times be crowded, the level of care will not always be first-class, and some medical procedures may not be available at all.

## Separating the Two Tiers

The crux of our proposal is that we have a two-tier system, and the tiers are completely isolated from each other. The first-tier is a private free-market system providing medical care for the majority of citizens. The second-tier is a system of government-run hospitals, clinics, and other programs providing a safety net by providing and paying for all medical costs directly.

First-Tier:

**Free-Market, Private Medical Marketplace**

Efficiency, Innovation, Competition

Second-Tier:

**Government-Run Clinics**

Safety Net, Free To All, Basic Level Care

As long as there is free-market medical care outside the government-operated clinics and hospitals, innovation and efficiency will flourish in the private sector. With a well-functioning, private sector medical system, operating under capitalist principles, there can be no doubt that the best medical care in the world will be available to some people, and high-quality, reasonably-priced care will be available to the majority of Americans.

The care provided for free in the government-run second-tier system will obviously not be as good as the first-tier care, but it will be free and available to anyone who wants to use it.

It is important to keep the government completely out of the free-sector medical industry, allowing capitalism and the free-market to foster as much efficiency and innovation as possible. Meanwhile, the government-run system will provide care for the poor, the elderly without adequate savings, and those few who are struck with unexpected, disastrous, and uninsured medical conditions. They may not get first-class care, but they will get something.



## Government Programs Tend to Grow Uncontrollably

In order to keep the government-run medical system from overrunning the private sector, we must have a mechanism to discourage the government-run system from growing ever larger. Government programs always tend to grow and we must design a foolproof way to prevent the second-tier system from ballooning to ever-larger proportions.

## A Novel Solution: The 25% Limit

To achieve this, we mandate that the government-run sector must always remain at 25% of the nation's overall medical expenditures. In other words, **the second-tier system will provide 25% of all medical care in the country**, as measured by overall money spent.

Conversely, the remaining 75% of all medical care will be provided through the private free-market first-tier system, paid for directly by the patients.

This national health-care program will provide government-run clinics and hospitals, as well as subsidized medical care provided through private sub-contractors, and reimbursement programs.

The fraction we propose will allow a capitalist-driven, free-market, private sector to flourish while, at the same time, providing a government-run, public, and free medical system to care for that fraction of the population which would otherwise suffer from a lack of medical care.

The actual budget of the second-tier system will be determined quarterly by government economists who statistically measure and estimate the amount of money spent in the first-tier free-market system.

**This is an adaptive funding system:** As the economy improves or the population grows, people will naturally spend more on medical care in the first-tier marketplace. The second-tier government-run system will automatically grow at the same rate. No political debate or consensus is required to determine the size of the second-tier system.

## A Huge New Government Bureaucracy?

Many people don't trust the government to run any complex activity efficiently or effectively, and I am one.

And I'm asking you to imagine a government-run system of public clinics and hospitals providing 25% of the nation's medical care!

We're talking about the government trying to manage *hundreds of hospitals*, employing *thousands of doctors*, and overseeing the medical care of *millions of people*.

How could this ever be implemented?

Or implemented in a reasonable time without vast bureaucratic confusion? Isn't this a recipe for a governmental disaster of epic proportions? Imagine the potential for government bungling, mismanagement, and bureaucratic waste!

## A Radical Proposal: County-Level Management

The solution is remarkably simple.

*The national healthcare safety net will be implemented at the county level, not the federal level.*

This is a very decentralized approach to government.

**The federal government will send all the money for the second-tier system straight to the individual counties and the counties will provide the second-tier medical care at the local level.**

Here's how it will work.

## Implementation Details

Every quarter, an appointed economist within the federal government will estimate the size of the first-tier marketplace, using standard econometric analysis and estimation techniques. This estimate will determine the total budget for the second-tier system, based on the 25% ratio.

Then, second, this total budget number will be converted into a “per capita” figure.

Then, third, the appointed economist will look at the population of each and every county in the U.S. and mail a check to each county in an amount that is proportional to that county’s population.

From then on, the counties take over and deliver the medical care to their citizens.

## Result: No New Federal Bureaucracy

Note that this will entail almost no new bureaucracy at the federal level.

The federal government will make no medical policy decisions, such as which conditions are covered, who is to receive care, or how our limited resources are to be allocated.

Every day there are millions of such decisions that must be made. The federal government simply cannot make all these decisions well and it is best to push these decisions down toward the people involved.

We would be wise to avoid letting the federal government make any medical policy decisions, or at least keep such controversial decision-making completely separated from funding issues and the healthcare system discussed here.

Our proposal makes it impossible for the federal government to implement medical policy directly through their control of your private medical decisions.

Controversial topics (such as abortion or birth control) must be dealt with separately, outside of healthcare funding, outside of our proposals. Perhaps

cigarettes should be taxed to discourage smoking, but that is a separate issue, not addressed here. Existing programs and departments that have health or medical impacts are not affected by our proposals. For example, the Food and Drug Administration will continue to regulate pharmaceuticals, the National Institutes of Health will continue to fund research, and so on.

## County-Run Health Clinics and Hospitals

Each county will receive its healthcare money from the federal government with the direction to provide medical care to its poorest residents, in whichever ways each county determines are best. The money comes from the federal government with no further conditions attached, allowing each county full freedom in implementing its public healthcare system.

Different counties will deliver medical care in different ways. Some counties will do a better job than others. Some counties will discover ways that work and it can be assumed that, over time, good practices in one county will be adopted in other counties.

How will a county implement second-tier medical care?

A large county like Manhattan will have a large allocation, allowing it to operate a number of publicly-run hospitals and clinics. Their public healthcare system will be complex and the result of much political activity.

A medium-sized county might choose to open a small clinic or even purchase an older hospital facility.

A small county might choose to contract with certain doctors to provide public care or contract with an existing clinic to provide public care. They might contract with a private contractor to provide hospital services or they might simply reimburse a private hospital for beds on an as-needed basis.

A sparsely populated county might have such a small allocation that they choose to just give it directly to a local doctor with the instruction that he or she is to decide how to allocate the funds. They are to treat, to the best of their ability, anyone unable to pay his or her own medical bills.

### **County-Level Options:**

- Operate free, walk-in clinics
- Out-source all care (e.g., to Kaiser)
- Create a healthcare system

*Other, innovative approaches will be tried.*

Some counties may choose to create new programs, enroll potential patients in them, and issue ID cards to all residents, documenting and approving each treatment in advance.

Other counties may simply choose to treat anyone who wanders into their clinics without any paperwork at all.

Some counties may choose to own, operate, and manage their own medical facilities, while other counties may choose to subcontract all their medical care obligations to private-sector corporations (perhaps like Kaiser), which then manage the clinics and hospitals.

Each county will independently determine out how to allocate its scarce public healthcare resources among the people who need — but cannot afford — medical care. Some counties may even choose to tax their residents to augment the federal dollars in order to provide even greater care for their poor residents.

## **Local Decision-Making**

The bottom line is that all decision-making will become local. Decisions about what medical care is provided will no longer be made by the federal government, but locally, closer to the actual patients, their communities, and their caregivers.

Many different approaches will be tried, some with more success and some with less success. Over time, counties will learn how best to provide public medical care to their populations.

## The Quality of Free Medical Care

We must all realize that **the second-tier system will be second class** in the medical care it delivers, and we make no attempt to disguise this fact.

There may be long waiting times at the county clinics; doctors may be rushed; some procedures will not be available; some treatments may not be as effective. The medical care provided by the second-tier system is, without any qualification, **a government-funded and government-run charity** and we acknowledge that it cannot be equal in quality to the medical care provided by the first-tier private medical marketplace.

First-class care is available for those who can afford it, but **society simply cannot afford to pay for first-class care for the poor**. Our proposals simply recognize these truisms.

Basically, our program gives counties a fixed budget and they do with it what they can.

## How Many People Will Get Free Care?

The hope is that counties will provide good care, but **the quality of care depends on how many people ask for free care**. If lots of people want free care, the county's limited budget for second-tier care will be stretched thin. So next, let's take a look at that aspect of our plan.

When individuals have medical problems, they will have a choice. They can contract with a doctor in the first-tier free-market system or they can walk into a county clinic and get the care for free in the second-tier. People will be free to make this choice. The government does not have to screen people or label some as poor and others as not-poor. In fact, there's nothing in our proposal to prevent a rich person from taking advantage of the free system. Generally, the free-market care will be superior, so the majority of the not-poor people can be expected to turn to the free-market system.

*People will, through countless small decisions, determine how many people the second-tier system will serve. If more people opt for the county clinic, wait times will increase and the free service will decline in quality. There is nothing in our plan that fixes how many people go to the free clinics. As more and more people show up to get free medical care, the quality of care will decline until an equilibrium is reached.*

## **Safety Net Utilization: Examples**

To see how our safety net program might work in practice, let's work through some different scenarios.

The total budget of the second-tier system is 25%. So, for every \$25 being spent in the second-tier, there will be \$75 spent in the first-tier. In other words, the second-tier will have  $\frac{1}{3}$  as much money as the first-tier system has.

### **Example #1:**

As our first example, suppose that **25% of all Americans** opt to get their medical care for free through the second-tier system, while the remaining 75% go to the free-market private system.

For example, consider 4 patients, each with the exact same medical problem. So one person goes to the second-tier system and the other 3 go to the first-tier medical market place. The county clinic has \$25 to spend on the one patient while the first-tier spends \$75 on 3 patients. In this scenario, the amount of money spent on each patient's care is equal. With  $\frac{1}{4}$  of Americans opting for second tier medical care, we would expect the quality of care to be about the same as for first-tier medical care.

But why would any person pay for private care when they can get roughly the same level of care for free. This situation is not a stable equilibrium.

*More than 25% of people can be expected to seek care through the second-tier system.*

We cannot know exactly what fraction of people will opt for free care at the county clinics, but it will exceed 25%.

### **Example #2**

In our next example, let's next suppose that the rate is **50% of the population**. So, half of Americans use the second-tier and half use the first-tier.

With a 50-50 split, for every 1 person using the first-tier private system, we have exactly 1 person using the second-tier government system. Recall that for every \$100 in available money, we have \$25 in the second-tier system and \$75 in the first-tier system. So the person getting free care will have \$25 being spent on their care, while the other person who is going to the first-tier marketplace will have \$75 being spent on their care.

Assuming a nice even split of 50-50, with half the population using the free county-based care and the other half paying for private medical care in the free-market first-tier system, the result is that, for the exact same medical procedure, second-tier patients will have only 1/3 as much money spent delivering their care as the same patient with the same medical issue in the first-tier would have to pay for that procedure.

To look at it another way, if a patient in the first tier pays X for some particular bit of medical care, another person could get the same bit of care in the second tier. Yes, they would get that care for free and, yes, the government would pay for the care, but there would only be 1/3 as much money spent on delivering that care.

So with a 50-50 split of the population between the tiers, the difference in the quality of the care would be roughly 3-to-1, at least as measured by the number of dollars spent. Furthermore, we can assume the free-market system will be more efficient than the government run system, so the actual difference in care will even be a little more than this.

### **Example #3**

Now imagine an extreme situation in which only 1 in 10 people opts to purchase medical care in the private marketplace, so **90% of people opt for free care.**



In this scenario, consider a procedure costing \$75 in the free market. In the second-tier, there is only \$25 in available funds for this procedure, and this has to be divided up between 9 people! This works out to only \$2.77 per person. So to provide this bit of care, there is about 27 times as much money in the first-tier as the second-tier.

With this many people opting for free care, the quality of care in the second-tier system will be very poor indeed, since there will be so little money for so many patients.

Since this example assumes that 90% of all people are opting for free care, it must be the case that many of these people will be in higher income brackets, and some in very high brackets. People with high incomes will surely abandon the second-tier system and return to the private marketplace to purchase their medical care directly, since they will get so much better care there.

*Clearly the free second-tier system will be used by fewer than 90% of the population, probably much fewer. Certainly the utilization rate will be higher than 25% and it seems reasonable to assume that it will be less than 50%.*

## [A Self-Adjusting Equilibrium Between Number Served and Quality of Care](#)

We cannot know exactly what fraction of the population would opt for free care and what fraction would opt to pay for private care. This would be determined by many countless small decisions made by individuals. Perhaps the number of people opting for free care would go even higher than 50%. But at some point, this would be self-limiting. As more and more people opt for free care, the available funds in the second-tier — on a per-person basis — will fall. As a result, the quality of the free care must necessarily decline.

*Our proposal is simple and self-adjusting. As more people opt for free care, the quality of the free care will decline, due to the fact that the budget of the second-tier free care is fixed by the 25% rule.*

At some point, the quality of the free care will decline to the point where **a natural balance will be found**, with some fraction of people opting to pay for their own medical care. They will do this in order to obtain superior medical care.

People in the middle of the income spectrum are always free to move between the tiers, using the free system for some medical needs and the private system for other medical needs.

In our scheme, there is nothing that defines a person as “poor” except their own choices to utilize the free system. We feel that it is important that any healthcare reform avoids creating fixed classes of people or placing certain groups of people into rigorously controlled categories, since such ideas run the risk of creating class-based, entrenched interest groups and introducing class divisions into our society.

## **People are Incentivized to Take Responsibility for Their Healthcare**

A most important feature of our proposal is that it incentivizes Americans to pay for the own medical care in order to receive a better level of care. If we want to stop our government from making our medical decisions, we have to get to a place where most people are in the habit of paying for their own medical care. Of course this will take time, but as our society’s wealth increases, and more and more people begin to take responsibility for paying for their own medical care, more and more will be spent in the free-market sector. *As a result, the quality of the medical care we deliver to our poorest citizens will also rise over time.*

This is the goal; this is the place we’d like to get to, with the majority of Americans taking care of their own medical care in a private free-market medical marketplace, while government-funded free care is available to those people unable to provide for their own medical care.

With better care being provided by the free-market system, people will naturally, over time begin to take responsibility for their medical care, by saving for future medical needs and by purchasing insurance against unexpected medical calamities. And with a healthy free-market in medical care, efficiency and innovation can be expected to flourish.

## The Cost of Free Care: No Attempt to Hide It

A publicly-funded free medical system sounds like a very expensive burden on our government and on the taxpayers who must eventually pay the bills. And, yes, of course it is. It already is: Currently, the costs of Medicare, Medicaid, subsidies to health insurers, and various other programs pose a looming financial catastrophe. Providing a healthcare safety net for people who cannot pay for it themselves, is necessarily expensive. There is no free lunch, and medical care today can be very costly.

We are not denying this reality, but we are neither making it better nor worse. It will cost a lot of money to subsidize the medical care of the poorest citizens, under this proposal or any other.

What we reject is the idea of hiding the costs or forcing the costs to be born by unwilling parties. Mandating that people buy health insurance against their will can only lead to financial inefficiency on a huge scale. Mandating that employers or insurers provide certain coverage interferes with the free-market and it is a mistake for government to try to control an industry that will function more efficiently if left alone.

We believe the way forward is to completely separate and isolate a free-market medical sector from a government-funded medical safety net. Then, the government simply needs to pay the bill for the second-tier safety net. No hiding the cost. No shifting the cost around to other entities. No shifting the cost into future budgets. Second-tier medical care delivered today must always be treated as a current expense of the government, with the cost borne by whoever pays for the government as a whole, namely the taxpaying citizens.

## Phasing In Our Proposals

The next big question is: How do we get there from here?

We propose to phase in the second-tier funding and do it fast, over a period of just a couple of years.

The first year will be funded at 5%. The second year will be funded at 20%. And after that, the system will be fully funded at the 25% level.

Here is the thinking: During the first year, the counties get a little money to get their systems set up and running. In the second year, patients will start arriving. We can assume the systems will be rocky and there will be many problems. Funding at this time will be almost full, but not quite.

Finally, after that, the funding level will increase a little more. This final increment is intended to be used to fix and smooth over initial problems and startup issues.

<u>Year 1:</u>	5%	Organization and planning at the county level
<u>Year 2:</u>	20%	Begin the implementation
<u>Year 3:</u>	25%	Complete system up and running

Simultaneously, we phase out Medicare, Medicaid and other government programs. During the second year, all patients whose medical care is currently paid for by the government will be transferred to the second-tier system.

We must honor previous commitments made to older Americans. A significant reorganization of the nation's healthcare system, such as the one proposed here, will be disruptive.

Medicare must be phased out slowly, with essentially no change for older and retired people. These people have been promised healthcare in their retirement years and it is now too late for them to save to pay for their own care.

People 10 or 20 years away from retirement will go directly into second-tier care upon retirement. Of course, any money they have managed to save in their last years

of employment can be used to augment the second-tier care provided by the government.

Young people are instructed to plan and begin saving for their future medical care. However, we prohibit any government incentives to force them to save.

## **Who Loses? Who Will Fight These Proposals?**

In any sweeping proposal like this, there are losers.

**Health Policymakers** Many people have strong beliefs about how the medical industry should function differently. For example, they may think that there should be a greater emphasis on preventive exams, or on dietary changes, or on new technology, or on caring for the elderly, or on naturopathic remedies, or on any of a thousand different things.

Our proposals allow no room for anyone in the federal government to impose such arbitrary medical mandates on citizens. All medical decisions are left either to individual citizens and their doctors in the private sector, or to local county governments which provide a basic, minimum level of medical care and which may, through this, implement particular healthcare policies.

**Medical Administrators** Some doctors will appreciate that they no longer have to deal with insurance company rules and are free to make medical decisions without corporate oversight. But other doctors will bemoan the necessity of having to deal directly with patients, of allowing the patients to participate in medical decisions, and of having to deal with billing patients directly and all the problems associated with bill collection from an elderly or sick clientele.

**Malpractice Lawyers** Our laws will reduce malpractice awards and, ideally, eliminate this industry.

**Insurance Companies** The health insurance industry may object to our proposals. Having a government mandate (such as Obamacare) that requires people to buy a product is certainly a good thing for the industry providing the product. But with our proposals, insurance becomes entirely free-market, and no one is forced to do business with an insurance company.

The multi-way medical decisions that benefited the health insurance companies so much in the past, are entirely eliminated. The ability of the insurance companies to get between the patient and his or her medical care (by contracting with employers and with medical providers) will be eliminated.

The result will be that insurance companies must switch their focus to satisfying patients in order to survive. How they do this is up to them, but the patients will benefit from this competition. Companies never like increased competition, so there may be push-back from insurance companies.

**Government Bureaucrats and Politicians** Finally government bureaucrats will also be unhappy since there is almost no role for the federal government here. The redistribution from the federal budget to the counties — while huge in dollar amounts — can easily be handled by a small office with a dozen competent workers, who issue routine quarterly checks to the counties. No reports are required. No oversight is required. No policy decisions are required. No studies are required.

## **Why Adopt These Proposals?**

Overall, we think the winners in the long-term will be us, the consumers of healthcare, the patients. We think that — over time — the first-tier free-market system will encourage most of us to take more responsibility for ourselves and our own medical care. We believe that this is consistent with American principles of independence, self-determination, and individual responsibility.

We also believe that a free-market system will deliver better medical care more efficiently than any government program can ever do.

In the end, this will be good for the overall health of all Americans.

If you feel these proposals are promising or this presentation contains useful ideas, then please: Forward it to others who are interested in healthcare policy reform.

## **About the Author**

Harry H. Porter is a professor of Computer Science whose main research areas are technical and unrelated to public policy. However, he has a longstanding interest in economic theory and public policy. He is also an engineer by temperament and drawn to real-world problems with mutually exclusive constraints and working with complex systems for which no optimal solution exists. Reforming and improving America's healthcare system is just the sort seemingly insurmountable challenge that is worthy of deeper consideration.