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The Freedom Plan for Health Care Finance Reform – The Medical Credit Card

Summary

Our humanitarian desire to provide medical treatment regardless of ability to pay has resulted in a large amount of “free care” being given. ***A major problem with health care in the United States today is that we pay for this “free care” through higher prices.*** Prices charged to those who pay are higher by an amount to cover the cost of providing care to those who do not pay. This causes health insurance premiums to be higher as well as expenditures for Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP).

Health care prices have been increasing at a greater rate than general inflation because “paying for ‘free care’ through higher prices” has added a second component to the inflationary spiral that further boosts health care prices. General inflation leads to rising health insurance premiums. Rising health insurance premiums lead to more people being uninsured, which results in more “free care” being given. The additional “free care” further increases health care prices, which further increase health insurance premiums, and which further increase the number of people uninsured.

The problem is not health care, health insurance, or overall spending on health care. We have the best health care system in the world; health insurance companies are managing their businesses to meet their obligations to owners, regulators, and those insured (the demonization of insurance companies is simply Marxist propaganda); and we expect to spend more on health care for an aging population. It does not matter whether we employ people in the health care industry or another industry as long as the health care industry is efficient – jobs are jobs. The problem is how to finance “free care” and make the health care industry more efficient.

The *Freedom Plan for Health Care Finance Reform* shifts the payment of “free care” from prices to “those who receive the benefit” and taxes by creating a medical credit card program. “Those who receive the benefit” will be responsible for payment with taxpayers funding only the bad debt upon the death of the individual. The resulting lower prices will lead to reduced spending by health insurance companies, Medicare, and Medicaid, which will lead to lower premiums and lower taxes.

Table of Contents

Summary	1
The Freedom Plan for Health Care Finance Reform	2
The Medical Credit Card	3
Tort Reform – Reduce the Cost of Litigation	6
“Those Who Receive the Benefit Pay More of the Cost”	7
Pre-Existing Conditions – The High-Risk Pool	8
Portability	8
Non-U.S. Citizens	9
The Health Insurance Market	9
Overall Impact on the Economy	9
More on Cost	10
Conclusion	11

The medical credit card program will replace Medicaid and SCHIP, except for Medicaid’s long-term-care program, and can provide 110 million people access to health insurance at a lower cost to taxpayers than currently spent on Medicaid and SCHIP.

This medical credit card program will replace Medicaid and SCHIP, except for Medicaid's long-term-care program. Those currently on Medicaid can work without losing health insurance coverage. ***Medicare is not affected by this plan other than benefiting from lower prices.***

Those currently on Medicaid and SCHIP and those without health insurance will be able to purchase health insurance with the medical credit card. Individuals may choose to self-insure, that is, to not buy health insurance; however, they will be responsible to pay the full bill. They may be refused treatment if they cannot pay and may not discharge medical debt in bankruptcy. This is necessary to control the "free rider" problem and reduce the amount of "free care."

The medical credit card program can provide 110 million people access to health insurance at a lower cost to taxpayers than currently spent on Medicaid and SCHIP. By providing a helping hand rather than a handout, we can cover more people for less taxpayer money. The *Freedom Plan for Health Care Finance Reform* includes other measures that will lead to lower prices, lower premiums, and lower taxes, too. ***We have the best health care system in the world and do not want to change the supply side other than to make it more efficient.***

The Freedom Plan for Health Care Finance Reform

1. Create a medical credit card program for individuals to finance health care expenditures, including health insurance, to reduce the amount of "free care."
2. Require patients to pay upon receipt of service using a credit card or cash. Insurance companies will reimburse the patient. This will reduce the administrative cost of medical providers in dealing with insurance companies and financing costs incurred in waiting for insurance company payments. Medical

Impact on Medical Service Providers

1. Medical providers will no longer have to deal with insurance companies, reducing administrative cost and improving productivity of medical personnel.
2. Medical providers will be paid upon delivery of service, reducing finance costs incurred in waiting for payment from insurance companies.
3. Medical providers will determine their prices, not insurance companies or the government.

3. Require that Medicare reimburse medical providers at the published market price to prevent cost-shifting.
4. Reduce the cost of litigation and malpractice insurance premiums by incorporating a "loser pays" provision into tort laws; eliminating financial punitive damage awards; and capping "pain and suffering" awards.
5. Increase co-pays and deductibles on health

insurance policies, shifting cost from health insurance premiums to those who receive the service. This also will help reduce unnecessary, or frivolous, demand.

6. Establish high-risk insurance pools, state-subsidized if necessary, in each state to insure those who are denied coverage due to pre-existing conditions. Kentucky Access (www.kentuckyaccess.com) is one example of a high-risk insurance pool.
7. Make health insurance premiums on individual policies directly tax deductible and encourage businesses to reimburse employees for health insurance premiums paid on individual policies instead of paying on group policies. This will spread the risk over a wider population; reduce overall administrative costs; and eliminate the portability problem. The insurance policy will move with the individual.
8. Repeal all federal laws that act to restrict the selling of health insurance across state lines.
9. Make medical credit card debt and any other medical care debts non-dischargeable in bankruptcy and permit medical providers to refuse treatment, except for life-saving emergency treatment, to those without health

Impact on Individuals

1. Individual applies for a medical credit card with a lending institution for use until he transfers into Medicare.
2. Individual pays for health insurance with medical credit card or cash. Those with employer-paid health insurance skip steps 2 and 3.
3. Individual pays off credit card account when due. If full payment is not made, then he will agree to an affordable payment schedule with issuing lender.
4. Patient pays for health care service^a upon receipt with medical credit card or cash and receives detailed, itemized receipt for presentation to insurance company.
5. Patient presents receipt to insurance company; insurance company makes payment to patient's medical credit card account; and patient pays the remaining balance when due. If full payment is not made, then he will agree to an affordable payment schedule with issuing lender.
6. If patient fails to pay account in full prior to death, then lending institution will have first claim on deceased's assets up to the amount of the outstanding balance plus interest and collection costs. Medical credit card debt is not dischargeable in bankruptcy.

Notes:

^a Service includes doctors, hospitals, test labs, drug purchases, etc.

^b Note that the demand side of the health care market must become more cost conscious, or price sensitive, in order to reduce excessive use and pressure medical providers to be efficient and constrain prices. Having the patient pay more of the cost and invest time to deal with his insurance company and lender will tend to make him more conscious of his health and use of the health care system.

insurance who cannot pay. This is necessary to control the "free rider" problem and reduce the amount of "free care."

10. Reduce capital requirements on insurance companies and eliminate taxes on their profits. Rising claims costs drive even higher premium increases because of the need to increase after-tax profit to maintain the insurance company's risk rating. Profit taxes cause even greater increases in premiums to get the required after-tax profit. Allowing more operating risk will result in lower premiums.
11. Eliminate profit taxes on medical providers and on all other businesses in the medical industry; fund the unemployment insurance program from general revenues rather than from businesses; and fund the employers' portion of Social Security and Medicare from general revenues rather than from businesses to significantly reduce the cost to deliver health care services and, by extension, health insurance premiums.
12. Repeal Medicaid and SCHIP, except for Medicaid's long-term-care program.

The Medical Credit Card

Description of the Program

Medical credit cards can be offered through banks and other lending institutions to any individual not already on Medicare who wants to buy health insurance. The line of credit amount will be sufficient to meet the medical needs of the individual up to \$250,000. The credit card can be used to pay for health insurance premiums, basic and reconstructive medical care provided by doctors and hospitals, rehabilitation, drugs, etc. Some medical costs (cosmetic surgery, sex-change operations, etc.) may not be paid with this credit card.

The lending institution will manage the account until the account holder's death or transfer to another lending institution. At death, the lending institution will sell the account to the government for the amount of the remaining principal balance up to \$250,000. Interest or other account charges will not be guaranteed by the government. The lender may charge a credit fee to medical service providers, as is currently done with credit cards, and interest on overdue balances. Lenders may not charge late payment fees to account holders; but may

charge, on a case by case basis, to recover time and other costs incurred in managing accounts with an accumulating balance.

Impact on Lenders

1. Lender issues medical credit card to those who apply and manages the account until account holder death or transfer to another lender^a.
2. Lender collects a credit fee from medical service providers and interest from account holders^b.
3. Lender works with account holder to establish an affordable payment plan on accounts with an accumulating balance^c.
4. Upon death of account holder, lender collects from account holder's estate and sells remaining principal balance to the government at full value^d.

Notes:

^a Credit line will be sufficient to meet the medical needs of the account holder up to \$250,000, enough to cover reasonable health insurance premiums for 50 years until individual qualifies for Medicare or Medicaid's long-term-care program.

^b Since the government guarantees the principal, the interest rate should be prime $\pm 2\%$ or so. Lender will provide a grace period of sufficient length to allow time for insurance company to make payment. Insurance company will be liable for interest on its payments made outside the grace period.

^c No late payment fees will be permitted; but lender may charge, on a case by case basis, for consulting time and to recover costs incurred in managing accounts with an accumulating balance.

^d The government guarantee covers the principal amount up to \$250,000 per person but not interest or other account charges.

Individuals can use the medical credit card to pay health insurance premiums and medical service providers at the time the service is rendered. The patient will receive a detailed, itemized receipt from the medical service provider for presentation to the insurance company. The insurance company will pay reimbursements directly into the insured's medical credit card account. The individual then pays the remaining balance on the account when due.

Lenders must provide a minimum grace period to allow time for the insurance company to make payment and to prevent excessive interest charges. Insurance companies will be liable for interest charges from the lender for payments made later than the grace period to ensure prompt processing. The interest rate on the account should be prime $\pm 2\%$ or so since the government guarantees the principal balance.

Those who do not have the means to pay the account in full when due will agree to an affordable payment schedule worked out with the lender. The payments should be as high as possible, but the credit account will remain

active as long as any payment is made. If no payment schedule is worked out or no payment made, then the account will be frozen at the current outstanding balance until payment arrangements are made or the account holder dies. The lender will have first claim on the assets of the estate of deceased account holders up to the amount of the outstanding principal balance plus interest and collection costs to keep the cost to taxpayers lower. Medical credit card debt will not be dischargeable in bankruptcy to reduce the burden on the rest of us.

Overview

With this medical credit card program, anyone who wants health insurance has a \$250,000 line of credit to manage his health care until he qualifies for Medicare or Medicaid's long-term-care program. This provides financing for 50 years' of premiums at \$5,000 per year.

The funds will be created and managed within the financial system, just like home loans, auto loans, etc. This program will not lead to another sub-prime mortgage crisis because principal losses are guaranteed by the government; and lenders will have the means to collect interest, fees, and other charges to cover their costs. The risk to the financial system is limited to interest and account management costs; and the means to manage this risk is provided in the program.

Impact on Government

1. The government initializes the program by offering guarantees for the principal balance remaining at death on specially designated medical credit cards; specifying that account holder must obtain health insurance to qualify for the government guarantee; prohibiting the discharge of medical debt in bankruptcy; prohibiting late payment fees on individuals; specifying a minimum grace period; and charging insurance companies with the responsibility to make payments within the grace period.
2. The government purchases the unpaid balances when presented by lender after settlement of the estate of the account holder.

*Note that the government stays out until the very end. Government leaders can help control the ultimate cost to taxpayers by implementing measures that help to reduce unemployment, the cost of living, and the cost of delivering health care services.

Medical service providers will receive payment upon delivery of service and will not have to deal with insurance companies. They will know with certainty how much they will receive and when they will receive it. This will reduce their administration and financing costs, leading to increased productivity and lower charged prices.

The medical credit card program will replace Medicaid and SCHIP, except for Medicaid's long-term-care program. Taxpayers only will pay for the bad debt, the amount that is not recovered prior to and at the account holder's death. The maximum taxpayer exposure for 110 million people with a \$250,000 limit is \$27.5 trillion. About 1% of our population dies every year, so the maximum annual exposure will be around \$275 billion, less than we spend on Medicaid and SCHIP now.

The cost to taxpayers is back-loaded, rising ramp-like over time. This maximum annual exposure will not be incurred for about 25 years at an average debt accumulation of \$10,000 per person per year; and, in the early years, taxpayers will pay **much less** than we currently spend on Medicaid and SCHIP. The actual cost

to taxpayers can be reduced by (1) reducing the cost to provide health care; (2) promoting competition among health insurance companies; (3) promoting economic policies to create more jobs (reduce unemployment); and (4) promoting economic policies to reduce the cost of living in the United States to help those who struggle to make ends meet.

The "Free Rider" Problem

With the medical credit card, anyone who wants health insurance will have access to funds to pay premiums. Some, however, may choose to self-insure, that is, to not buy health insurance. This introduces a "free rider" problem. A "free rider" is one who does not buy health insurance; then incurs larger medical bills than he can pay; and then files bankruptcy to discharge the debt. The rest of us would wind up paying his medical bills through higher health insurance premiums and/or higher taxes.

To control the "free rider" problem and keep health insurance premiums and taxes lower for everyone else, those who choose to self-insure (1) will not qualify for a medical credit card; (2) may be denied treatment if they cannot pay, except for life-saving emergency treatment; and (3) will not be able to have medical debts discharged in bankruptcy. The medical debt will last until paid off or death. These conditions are necessary to preserve choice and control the "free rider" problem to reduce the amount of "free care."

Insurance Companies and Profit

Independent companies, such as A.M. Best Company, provide ratings of an insurance company's ability to pay its claims. These ratings reflect the rater's estimate of the insurance company's financial strength, or risk of failure – the higher the rating, the stronger the company, and the lower the risk of failure. These ratings are important to an insurance company in competing for customers *because no one wants to pay premiums to a company that is at risk of failing and not paying its claims.*

While the rating procedure is very complex, the rating fundamentally reflects the relationship between the insurance company's liabilities (claims and other underwriting costs) and its "capital reserve" – the smaller the liabilities-to-capital ratio, the stronger the company, and the better the rating. When an insurance company's claims increase, due to higher medical prices for example, its requirement for capital to maintain its risk rating also increases.

The capital reserve is increased through after-tax profit. After-tax profit increases capital surplus which is a part of the capital reserve. When an insurance company's claims increase, it must raise premiums to cover not only the higher claims but also the increase in after-tax profit needed to increase the capital reserve to maintain its risk rating. Since profit is taxed, premiums must be increased even more to provide the needed after-tax profit. Increasing claims require more after-tax profit to maintain risk rating, which is why insurance company profits are increasing with rising premiums. ***It also helps explain why insurance premiums increase at a greater rate than general inflation.***

Health insurance companies and medical malpractice insurance providers are rated; so when we reduce the cost of medical malpractice litigation, for example, we also reduce the requirement for additional after-tax profit to maintain risk rating. The savings in claims will produce a magnified reduction in premium requirements. Reducing the number of frivolous lawsuits, eliminating financial punitive damage awards, and capping "pain and suffering" awards will significantly reduce the underwriting cost of malpractice insurance providers and after-tax profit requirement, leading to significantly lower medical malpractice insurance premiums. This, in turn, will reduce the cost of providing medical services. *(continued)*

Tort Reform – Reduce the Cost of Litigation

Medical providers in the United States face an extreme legal environment marked by very high legal costs and judgment awards. High litigation costs have produced very high medical malpractice insurance premiums and brought about the practice of "defensive medicine." Defensive medicine refers to proactive actions taken by medical personnel in preparation for defending a possible lawsuit. These actions can take the form of ordering tests "just to be sure" or performing surgical or other procedures "to eliminate any doubt." Many so-called "unnecessary tests and procedures" are the result of the practice of defensive medicine. If medical providers try to rely upon their experience and use their judgment, they risk losing a very expensive lawsuit.

The risk-reward relationship in medical malpractice litigation is way out-of-line. The risk to plaintiffs is relatively low – they pay court costs and expenses with legal fees contingent upon winning – but the reward is potentially great because of high punitive damage awards. This low-risk, high-reward condition leads to an extremely high number of lawsuits. The cost of this litigation and the defensive medicine it causes is passed along to the rest of us through higher health insurance premiums, higher taxes, and higher prices on

other goods and services, since many businesses pay for their employees' health insurance.

The number of lawsuits and, by extension, the cost of health care and cost of living in general can be reduced by increasing the risk of litigation to the plaintiff and/or reducing the return. The risk of filing a lawsuit can be increased by instituting a "loser pays" provision in litigation in which the losing party pays the other party's litigation costs. The reward can be reduced by (1) eliminating financial punitive damage awards; and (2) capping "pain and suffering" awards at a reasonable level.

Punitive damages are intended to punish the defendant and send a message to others to not engage in similar activity. The problem with financial punitive damages, though, is that consumers are the ones who are

punished. The cost of the award is passed along to the rest of us through higher medical malpractice insurance premiums, which are passed along by medical providers as higher charges to patients, which are passed along by health insurance companies, government, and businesses as higher health insurance premiums, higher taxes, and higher prices for goods and services. Non-financial punishment would not have this negative impact on consumers. Non-financial punishment could take the form of suspension or termination of license, mandatory re-training, etc.

(Insurance Companies and Profit, continued)

Reducing the number of frivolous malpractice lawsuits and the amount of the awards also will reduce the need for “defensive medicine” tests and procedures, further reducing the cost of providing health care. This will lead to reduced claims placed upon health insurance companies and a reduced need for after-tax profit to maintain *their* risk rating. The cost of litigation is buried deep within our health care system, and its impact is significant.

We also can see significant reductions in premiums if we reduce the capital requirements for insurance companies and ***eliminate profit taxes on them***. Allowing more operating risk (larger liabilities-to-capital ratios) will result in lower premiums. Also, the value of the capital reserve itself is uncertain because the money is invested in risky securities. This uncertainty requires an additional safety margin in the size of the reserve, requiring higher premiums.

Insurance companies and rating organizations should re-examine their capital guidelines and investment policies with an eye on reducing capital requirements. Less investment risk may permit a greater operating risk and lower premiums.

Compensatory damages compensate the plaintiff for his injury with the intent to make him “whole.” Most compensatory damages reimburse the plaintiff for economic costs actually incurred, including lost pay; however, the plaintiff also is compensated for the “nuisance” of having been injured through an award for

“pain and suffering.” “Pain and suffering” is not an actual economic cost; and the amount of the award is arbitrary and highly subjective, being left to the judge or jury to determine. This can lead to very high judgment awards just as with punitive damage awards, with the rest of us paying the cost through higher prices and higher taxes. Therefore, it is reasonable for us to want to set limits to protect ourselves. Limiting “pain and suffering” awards protects all of us from higher prices.

We can no longer afford our current attitudes toward litigation. They produce higher health care costs, higher health insurance premiums, higher taxes, and a higher cost of living in general, putting increased financial pressure on individuals and families already struggling to make ends meet. Increasing the risk of litigation to the plaintiff by incorporating a “loser pays” provision into tort laws and reducing the potential return by eliminating financial punitive damage awards and capping “pain and suffering” awards will lead to fewer lawsuits and lower health insurance premiums.

“Those Who Receive the Benefit Pay More of the Cost”

Generally, the lower the price of a desired good or service, the greater the demand will be for that good or service. Programs that provide low-cost or free health care coverage, such as Medicaid and SCHIP, and insurance policies that have low co-pays and deductibles promote increased use of the health care system because they reduce the marginal cost to the patient of each use. This increased use results in higher insurance premiums, higher spending on government health care programs, and higher taxes.

Such low-marginal-cost programs and insurance policies also make the patient less sensitive to cost, or price; billing accuracy; and waste, fraud, and abuse. Normally, the consumer's sensitivity to price and inclination to switch to lower-cost alternatives puts pressure on producers to be efficient and to constrain prices. We lose this pressure with low-marginal-cost programs and insurance policies. They essentially remove the consumer from the transaction. Why would anyone care whether his doctor receives \$100 for each visit or \$50 if he only has to pay \$10 for that visit? Why would he care if his doctor presents an inaccurate bill to the insurance company if he only has to pay \$10?

The consumer's sensitivity to price plays a vital role in promoting efficiency and lower prices in any market; and we must re-establish this role in the market for health care. We can accomplish this by making "those who receive the benefit pay more of the cost," that is, by increasing the marginal cost of each use of the health care system. This means higher co-pays and higher deductibles. The higher payments can be funded by using the medical credit card. This will shift payment from insurance companies to patients, resulting in lower premiums. The patient will be more sensitive to price and the cost of overbilling, waste, fraud, and abuse; putting pressure on medical providers to be more efficient, that is, to reduce cost and price. Patients also will have more incentive to control usage, eliminating unnecessary visits to the doctor or hospital emergency room, and to maintain and manage their health (prevention).

We have over-socialized our health care system; and this has contributed to the high cost of health care and health insurance premiums. Making "those who receive the benefit pay more of the cost" will reduce this socialization. We must bring the patient back into the health care transaction to the point at which enough become sensitive to price and put pressure on medical providers to be more efficient and cost conscious.

Pre-Existing Conditions – The High-Risk Pool

Private-sector insurance companies must be able to refuse coverage in order to manage their costs and keep premiums lower for everyone else. To accommodate those with pre-existing conditions, each state can establish a high-risk pool to sell health insurance to those who are denied coverage by private-sector insurance companies or who must pay a premium that is too high to be reasonably paid off on the medical credit card. This pool may be subsidized by the state to keep the premiums more affordable if necessary. Kentucky Access is one such high-risk pool (www.kentuckyaccess.com).

A high-risk pool will provide insurance to high-cost individuals so that they may maintain their eligibility for the medical credit card. A high-cost individual will be able to change insurance companies, because of a job change for example, without losing his medical credit card. Note that if all employers reimbursed employees for premiums paid on individual policies, then high-cost individuals would not be forced to change insurance companies when they change their job. The policy would follow the individual.

Portability

Portability would not be an issue if all health insurance policies were individual policies because the policy would follow the individual. Employers could reimburse employees for health insurance premiums paid up to a certain amount, limiting the reimbursement at any desired level to control cost. Employers could save administration costs, too. The reimbursement could be made with the same system that processes and reimburses business travel costs.

Employees will get health insurance that better fits their needs; and insurance companies will reduce administration costs, only having to manage a portfolio of individual policies rather than many different group policies and individual policies. In addition, individual health insurance premiums should be deductible on personal income tax returns without having to itemize deductions to put individual policies on par with business-provided group policies.

Absent the above, COBRA provides an opportunity to transition to another policy in the event of job loss. Individuals can use their medical credit card to pay premiums. Their options after COBRA coverage expires will be to get insurance from another employer, a private-sector insurance company, or a state-backed high-risk pool, using their medical credit card to pay the premiums. Employees may be better off with individual policies, with premiums reimbursed by employers, than with employer-provided insurance because they can choose their own policy and will not have to worry about portability issues.

Non-U.S. Citizens

Americans cannot afford to take care of the health needs of the world, so we must draw a line somewhere. The medical credit card will be available only to U.S. citizens. Non-U.S. citizens will have to buy their own insurance, get insurance from their employer or some other organization, or self-insure. They may be denied treatment, except for life-saving emergency treatment, if they do not have health insurance and cannot afford to pay for their treatment.

The Health Insurance Market

Private-sector health insurance companies cannot successfully compete against government because their costs are significantly higher. The government does not have to maintain a capital base; pay federal, state, and local taxes; comply with state and federal insurance regulations; and pay the cost of litigation. The government also can use its natural taxpayer subsidy to further under-price the private-sector competition and drive them out of business with predatory pricing.

The only way that private-sector insurance companies can exist in a market with government-backed insurance programs is if the government-backed programs only insure those risks that the private-sector insurance companies do not want to insure. The *Freedom Plan for Health Care Finance Reform* maintains this market separation. The government-backed programs, Medicare and the state high-risk pools, only insure high-cost individuals. Medicare insures seniors; and the state high-risk pools insure those not on Medicare who have been refused coverage by the private-sector insurance companies.

Overall Impact on the Economy

Rapidly rising health insurance premiums increase the cost of doing business because many businesses provide health insurance benefits to their employees. This promotes higher unemployment because the higher cost of doing business drives jobs to lower-cost foreign countries and increases the risk of starting new businesses and expanding existing businesses in our country. Also, these higher costs are passed along to consumers as higher prices, increasing the cost of living and the financial pressure on those who struggle to make ends meet.

Reducing the cost of health insurance, therefore, will promote job creation and lower prices and will produce more tax revenue to reduce government budget deficits (job creation expands the tax base). It will help us win back jobs that have been lost to lower-cost foreign countries. The medical credit card program also will cost taxpayers less than we currently spend on Medicaid and SCHIP (on the order of \$4 trillion over 25 years), further reducing the budget deficit.

More on Cost

Table 1 shows a listing of some of the costs incurred by doctors in their practices. Hospitals and other medical providers incur similar costs. Note the feedback effect that helps promote spiraling health care costs. As the cost of health care and health insurance premiums increase, the cost of employee health insurance, Medicare payroll taxes, and workers' compensation insurance incurred by medical providers also will increase. These cost increases are passed along as higher prices, which helps fuel the next round of inflation in health care.

Note also the effect that litigation and government policies have on the cost of delivering health care services. The need for malpractice, general liability, and property liability insurance and some of the legal fees is the direct result of the litigious nature of our society. Social Security and Medicare payroll taxes, business license taxes, profit taxes, unemployment insurance, some legal fees, and tax preparation fees are the direct result of Marxist government policies that tax businesses. The cost of health care and health insurance premiums would be significantly lower if we did not tax businesses and "charge" them for unemployment.

Businesses do not pay taxes. Their customers do through higher prices. The cost of living would be significantly lower if we financed government spending through taxes rather than prices; and unemployment and the financial burden on those struggling to make ends meet would be much less.

The socialization of the United States, with its Karl-Marx-inspired anti-business bias, has made the cost of living and cost of doing business much higher than they would be otherwise through excessive taxation, regulation, and litigation. This high cost underlies our loss of manufacturing and other jobs to lower-cost foreign countries; many Americans' struggle to make ends meet; and many being trapped in poverty. Unemployment is higher than it would be otherwise; and government spending and taxes are higher than they would be otherwise.

People need jobs to pay their bills. Businesses create jobs, so why do we make it harder for them to create those jobs? Why not make it easier? Isn't this just common sense? Marxists demonize businesses and profit, but it is profit that finances new job creation. Taxing business profits takes investment capital from businesses, slowing job growth and promoting higher prices.

Why do our politicians not care about making the economy more efficient so that more Americans can live better lives? The answer to this question is that they care more about power, control, and domination. Our

Table 1. Doctors' Costs

- Doctors
- Nurses
- Administration staff
- Employee health insurance
- Other employee benefits
- Social Security and Medicare payroll taxes
- Workers' compensation insurance
- Unemployment insurance
- Malpractice insurance
- General liability insurance
- Property insurance
- Capital cost of equipment
- Legal fees
- Accounting fees
- Answering service
- Office "rent"
- Electric
- Phones
- Supplies
- Business license taxes
- Profit taxes

politicians are engaged in a political war for power, control, and domination; and the rest of us simply are casualties of that war. This war is being brought about by those who want to transform the United States into a socialist/communist state. (Communism is socialism with one-party-rule.) They follow the ideology and strategy developed by Karl Marx in *Das Kapital* and *The Communist Manifesto*. Their strategy is the age-old divide and conquer strategy – create divisions within the society to gain control.

One of those divisions is along economic class lines – the rich vs. the poor. The Marxists promote policies that hinder job growth and fuel inflation so that more and more people will suffer and respond to their class envy propaganda. Their policies create much of the poverty that they use as a power base to further their transformation movement. Life in America could be much better for many struggling to make ends meet or living in poverty if we would just “put the people first” and enact policies that will make our economy more efficient and promote job creation.

The *Freedom Plan for Health Care Finance Reform* is oriented toward making the health care system more efficient and less costly. The difference between this plan and our current system shows the magnitude of the influence of Karl Marx. It is time to relegate Karl Marx and his destructive ideas to the ash heap of history where they belong.

Conclusion

A major problem with health care in the United States today is that we pay for “free care” through higher prices. As general inflation increases health insurance premiums, the number of people without health insurance increases and so does the amount of “free care.” Increasing amounts of “free care” cause health insurance premiums to increase even more, making insurance unaffordable to even more people. Health insurance premiums increase further because insurance companies must increase after-tax profit to increase their capital reserve to maintain their risk rating when their claims costs increase.

The medical credit card shifts the payment of “free care” from prices to “those who receive the benefit” and taxes. This should significantly reduce health insurance premiums because the cost of health care will be spread among more people. We can further reduce health insurance premiums by reducing unnecessary demand and reducing the cost of providing health care.

Making “those who receive the benefit pay more of the cost” by increasing co-pays and deductibles will result in fewer visits to medical providers for minor care. Requiring patients to pay the medical provider upon receipt of service will reduce administration and financing costs for providers. Bringing the risk-reward relationship for malpractice litigation more into balance by instituting a “loser pays” provision, eliminating financial punitive damage awards, and limiting “pain and suffering” awards will significantly reduce the cost of litigation, leading to lower malpractice insurance premiums and less spent on “defensive medicine.” Loosening overly conservative capital requirements for insurance companies will reduce the need to increase after-tax profit to maintain risk rating when underwriting costs increase; and eliminating profit taxes on all businesses in the health care industry will further reduce the cost of health care and health insurance premiums.

We have the best health care system in the world; and we do not want to allow self-centered politicians with a greedy lust for power and control to ruin it for us. We do not need a massive overhaul of the system with more layers of control. We only need to make a few improvements that will make the industry operate more efficiently.