Why Is Health Care So Damned Expensive, and Is There A Solution?

A Doctor's Essay on Free Market Health Care Solutions

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As a physician, still relatively new to private practice (about 6 years), I have found my greatest challenge has not been in the practice of medicine, in providing patients with safe anesthetic experiences throughout their surgeries, or in keeping up with the pace of medical advancements, but in working my way through non-medical bureaucracies and their endless streams of complicating consequences. Some of those bureaucracies include the third party payors that "reimburse" doctors for their services. These payors may be private insurance companies, like Aetna, Blue Cross and United, for example. Increasingly, payors are government entitities: Medicare, Medicaid, State Children's Health Insurance Programs (CHIPS), Tricare (for the present and former military personnel), etc. In addition to the dictates of the payment intermediaries, there are innumerable layers of rules, regulations and advisories heaped upon the medical community primarily by government-related agencies such as the federal Center for Medicare and Medicaid Services (CMS), Health and Human Services (HHS), the Drug Enforcement Agency (DEA), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the state Department of Health, and the state Department of Public Safety, to name those that quickly come to mind.

As a result of all of this interference between a doctor and the patient, and one of the surprising realizations for which I received no real preparation neither in medical school nor in my four year anesthesiology residency, is that I have no idea how much you pay me when I keep you asleep and alive for your appendectomy, or your elective knee replacement, or the emergent 2:00 AM ruptured abdominal aneurysm repair. I don't know how much I will be paid for my service to you. I couldn't tell you how much you would owe to me or to the hospital or to the surgeon. They probably don't know either, at least not readily. Sure, I have a rough idea of what I will average in income over the course of a month, but what you personally will pay is a mystery to both of us. How could that possibly be? Is there another industry in which costs are hidden from both the provider and the recipient of the service, in which some non-present third party that lies outside of the interaction governs its financing and influences its specifics? How did this system come to exist?

It has taken a good deal of investigation, personal experience and not an inconsequential degree of angst, to begin to piece together how medical payments and economics work. While it is still beyond my complete comprehension, I would like to share some of the points that I've learned. I invite others to follow the references that I provide. I hope they can verify for themselves how this perverse system developed and identify the best solutions. Certainly, just as in politics or foreign relations, we cannot move to repair a situation without first understanding its history. Like mine, your view will be influenced by your personal ideologies, moralities and politics, e.g. your concept of individual rights, of the appropriate role of government in our lives, of your impression of man's ability for self-sufficiency versus a need for significant external assistance, etc.

For myself, one of the most significant insights into the history of medical financing was gained when I came across a short book by William C. Waters, III, MD entitled *2 Days That Ruined Your Health Care (And How You Can Provide the Cure).* I highly recommend the book to any interested in the topic. You can buy a cheap, used one at amazon.com.

In Dr. Waters' book, he references two specific dates: Oct 2, 1942, and April 10, 1965. These days brought new, sweeping, federal legislation and would come to alter healthcare forever. On the first date, Congress passed the Stabilization Act of 1942.[1] During WWII, in an effort to "stabilize the economy" lawmakers thought it would be helpful to freeze wages so people would stay in their current jobs. It seems that Congress believed the "stability" would help tamp down the effects of wartime inflation, essentially another form of price fixing that was common in that era. Hence, without the ability to lure new workers with a higher wage, employers began to offer fringe benefits, among them employer-sponsored health insurance.[2] Therein began the coupling of your insurance to your job. Within a few decades it would no longer be common place to simply carry an affordable, individual health insurance policy for unforeseen events. What has evolved in its stead is a massive, corporate-government pre-paid health system whereby the employers get tax deductions for paying for their employees' insurance – deductions that the IRS does not extend to you when you carry your own policy.[3] (Despite the tax discrimination against individual policies, I do carry an individual policy for my family for reasons that I'll describe below.) After that insurance-employment coupling, forever more would you lose your insurance every time you switched jobs. From that point forward, changing jobs meant changing insurance, which also introduced the problem of "pre-existing conditions" as a new insurance carrier is cautious in taking on a new liability without knowing your personal risk to them.

On the topic of health insurance, I would like to insert here a review of that concept. The idea of insurance is that a group of people gets together and pays into a large pool of money, hoping never to need to dip into it, but having a safety net which would cover the costs of an unforeseen catastrophe. This is how fire insurance works for our homes. I don't think I'll ever need to use it, but in the unlikely event of its occurrence, at least I know that I will not be destroyed financially. There is a backstop to my potential loss. Similarly, our car insurance covers unforeseen losses like collisions and theft, rather than oil changes, new tires, wiper fluid, brakes, etc.

As you will likely note, health insurance is no longer an affordable policy that covers the unforeseen catastrophe, but has morphed into a many thousand dollar, pre-paid health plan that covers almost anything that could be linked to health: routine doctor visits, lab work, chiropractics, in vitro fertilization, planned childbirth, mental health therapists, sexual dysfunction, massage and spa stress management, a wide variety of elective surgeries, and other lobbyist-driven and government-mandated coverages. People rarely carry individual policy health insurance these days. Instead, they are members of expensive, pre-paid health care clubs. It has become a buffet, of sorts. You (primarily your employer, really) pay your entrance fee, then you enter the health buffet and consume your preferred amount with minimal attention to any costs other than your deductible for the current year. Being that every economic incentive has been either removed or perverted in this system, it is not altogether difficult to comprehend why healthcare costs keep rising.

As for the second day "that ruined your health care", on April 10, 1965, "… President Lyndon Baynes Johnson signed into law a bill to provide health care benefits for anyone who had passed his or her 65th birthday. It was the Mills Bill, HR 6675, popularly called Medicare."[4] That same year, Medicaid, health coverage for the indigent, was created. Medicaid is a state-run program and regulated by the same federal agency that oversees Medicare – CMS, the Center for Medicare and Medicaid Services.

When these programs were created, they were intended as "safety net" programs, or at least sold to the public as such. These programs appealed to the human desire to help the down-trodden and to care for that small segment of society's lesser fortunate: the elderly, disabled and the poor. The initial costs of these programs were low and were projected to stay low.

Like most government programs, initial intentions and projections are typically far from realistic. At its inception, Medicare supporters projected the program would cost $12 Billion annually by 1990. By that year, however, costs equaled $90 Billion – a 750% miscalculation.[5] Jumping forward, for 2011, the Bureau of Economic Analysis calculated Medicare and Medicaid expenditures alone to be $992 Billion, just under a trillion dollars.[6] Medicaid has become the states'second biggest budget outlay after education, consuming approximately 17% of revenue.[7] Looking towards the future, a recent Medicare trustees' report estimated Medicare's unfunded liability to be $89 trillion.[8] In other words, these are gigantic obligations for future Medicare recipients for which there is no viable plan to provide for the funding shortfall.

Over the ensuing decades since their initiation, these and similar government programs have come to encompass 50% of health care dollars.[9] Health insurance companies have followed government payors leads to enact similar reimbursement schemes and rules over health care providers and facilities.[10] These payors are able to impose compliances by law, regulation and, in what could be considered an extortion tactic, the denial of payment, despite the service having been rendered. As a result of the intertwining of corporations (pharmaceutical, insurance, large medical groups, biomedical device makers, hospital conglomerates, etc), unelected government officials and agencies, lobbyists and politicians, these entities have become the dominant forces in medicine. You and your doctor do not control your health care. The medical-industrial-government complex does. The major decisions about your health are made far away from you, and those costs are elusive to both the provider and consumer of health services.

So, if my assertion is true that health care decisions are made primarily by third parties outside of the doctor-patient relationship as a result of these two days of legislation (and obviously an untold number of additional days), why would that drive up health costs? Wouldn't it make sense to turn it over to the "experts", and to have highly intellectual people take control of the health care system? First, I argue that no one can be smarter about your health decisions or about the use of your health dollars than you. I also argue that few, if any, individuals or groups in state and national capitols are smarter than the average physician when offering you counsel, options and treatment regarding your health. I would encourage you to reject the false premise of intellectual and capable beings as your Authority. They are people with agenda, faults, and often misguided ideas, even if well-intentioned. When error-prone, power-seeking individuals get put in charge of others' outcome, their poor decisions don't just affect themselves, but are amplified throughout society. Please, stop giving them that power.

Secondly, I would encourage you to consider some economic principles, specifically the incentives of free-market versus collectivized economics. There was an insightful article written in 1995 by Russell Roberts which ran in the Wall Street Journal and was reprinted in the Libertarian Reader: "If You're Paying, I'll Have Top Sirloin."[11] Mr Roberts illustrates: if you and a friend go to lunch and each

pays for his own meal, you consider your financial situation, and you order accordingly. If your budget is tight, you'll likely opt for something on the average or lower end of the lunch menu. However, if your friend is buying (and especially if he's buying for a large group wherein your individual order would make little difference in the overall outcome of the bill), maybe you'll opt for the steak or other higher end item. Clearly, incentives change as we shift cost responsibilities from ourselves to others, or as we collectivize (socialize) the costs. The further the payment lies from the individual consumer, the less the individual must weigh that cost or the impact of his personal choice. Stated differently, separating the payer of a service from the recipient of the service has the consequence of distorting value and cost.

In addition to consumers, doctors have been marginalized from costs and pricing as a result of the growth of this system of legislated consequences. As I pointed out initially, I have little information on the costs or financial responsibility that my patients are incurring, although I do make a concerted effort to acquire drug prices and make that best selection for the cost that someone somewhere is paying. Do you ever wonder why you can't just ask for a menu price at your doctor's office? Why can't he (the generic, non-sexist "he") just post a chart: a well-child check costs $45, a new initial visit $75, a suture of a simple laceration $125, an x-ray for a suspected broken arm $90, a simple follow-up and prescription refill $40, etc? Why don't you see those prices posted? For one, it doesn't really matter what your doctor would charge, because he is going to get paid whatever the insurance company or government decide. When there are many different payors and prices, a single price list becomes impossible. If you paid the bill, you could get a transparent price. You could also choose to receive the service, or you could shop around for a better deal.

Insurance companies all separately determine what they will reimburse for each and every visit, procedure and intervention. These payments differ among the carriers and also depend on the individual contracts with doctors and facilities. Additionally, contracts typically change from year to year as they must be renewed. Keeping up with this, negotiating contracts, billing all the separate payors, re-submitting the denied claims, complying with all of the appropriate documentation, trying to avoid the ever-present accusation of Medicare fraud, etc. all takes time, employees and overhead expense. Your doctor cannot keep up with what Aetna pays for a specific service versus Blue Cross/Blue Shield versus United Healthcare versus any number of other private and government third-party payors. These are some of the reasons that you are unlikely to find transparent menu pricing.

In addition, and mostly unrecognized by the public, is that this system incentivizes doctors and hospitals to keep their official rates for cash paying customers very high. In exchange for their contract with a doctor or facility, insurance companies demand a reduction in prices for their customers – a special deal. Therefore, if a doctor wants to offer a low cash price for services, the third party payors will want to reimburse at a percentage of that, say 80% of "usual and customary". In my specialty, government payors tend to pay between 20%-30% of usual and customary. As a consequence, if providers were to offer low, competitive prices as usual and customary charges, these prices would lower the starting point from which insurance and government payors would then calculate their demanded contract concessions.

Of course, few can keep up with the 132,000 pages of complex Medicare law and regulation. The job of medical billing now requires extensive training and full-time personnel. Whatever the actual Medicare payment, I understand that it is a violation of federal law to provide a service at a price beneath the level of Medicare reimbursement.[12] The government demands the best price. I cannot charge less for a service than what Medicare pays for its recipients. That would be considered one of the many forms of Medicare fraud. If I wanted to offer a significant discount to an indigent patient, for example, I may not do that. The complexities of the associated rules and law can be overwhelming.

Another market-skewing effect of Medicare legislation is the prohibition of "balance billing", which is essentially price fixing.[13,14] A provider or facility is prohibited from billing the Medicare patient anything above the amount of Medicare's fixed payment, regardless of the provider's charge or costs. That difference must be absorbed by the doctor or hospital, accepting as full payment whatever amount the unelected regulators have determined to be appropriate. The only other option as a doctor is to withdraw from the Medicare program entirely, which is a growing trend, albeit unfortunate for both our seniors and the physicians who would prefer to maintain a relationship with them if the economics and regulatory intrusions were not detrimental to the doctor-patient relationship. The end result of this perverse system of third party payor domination is that the prices that are billed for services tend to be inflated in order to compensate for the reduced, negotiated reimbursements of third party payors. This is known as "cost shifting." The cash paying customers get the worst pricing and wind up subsidizing the providers' losses from the poorest reimbursements.[15]

I've outlined some of the problems that I and many others, more informed than I, have found with health care economics in America. My opinion is that most of the cost distortions are related to government and third party intervention. My recommendations center on extracting those parties from the doctor-patient relationship (including the innumerable and faceless layers of paid bureaucrats, administrators and paper pushers that your insurance premiums and/or taxes support), placing the consumer back in charge of the money that he is paying in insurance premiums (and that his boss is diverting to pay the larger share of premiums that would otherwise belong to the employee as wages), and allowing the economics of a free market between a service provider and a selective consumer to drive down costs and incentivize improvements. In contrast to the solutions offered up by the political class today, I do not believe that these goals can be achieved by more of the same interventions that distorted the market in the first place. If a 50% (at least) government takeover of health financing and regulation hasn't provided any improvement in escalating costs or led to improved healthcare delivery, then an almost total takeover is not likely to reach the desired results. The most likely development is a continued stream of far reaching, unintended consequences along with the empowerment of politicians and unelected officials, the politicization of the minutest aspects of medicine that a politician could possibly exploit among an electorate in order to create anxiety and drive them to the polls, a great transfer of wealth from the American taxpayer to the System, your loss of control over your healthcare choices, and your doctors' surrender of profession and livelihood to the medical-industrial-government complex and the national medical boards' pseudo-evidence based, mandated standards of care and reimbursement.[16]

Many before me have recommended the following **free-market health care solutions** to counteract this trend of increasing costs and centralized control. Even so, these ideas seem to be scarcely mentioned in the public arena.[17-21] The first and foremost recommendation to improve health care costs and efficiency is the expansion of **health savings accounts (HSAs).** HSAs are coupled to personal, catastrophic, **high deductible health plans (HDHPs).** My family has had such a policy with Assurant Health/Aetna since 2006. The total premium is approximately $250/month, paid solely by me, and completely dissociated from my employment. If I change my job, I take the plan with me; the insurance company has no idea my employment has changed and couldn't care less as long as I make my premium payment. In addition to the premium, I also monthly auto-draft an amount of my choice into our personal HSA, which is tax-deductible up to about $5500 per year. I can then use my HSA debit card for routine medical costs, like doctor visits and prescriptions, and the remainder is carried over year after year. I have the option of rolling the residual into an investment, like an approved mutual fund, for potential growth of that health care dollar. As we have built up our HSA over the years, we can easily cover the high deductible (about $5000) for any unplanned event or catastrophe that might occur, then the insurance company picks up a standard 80/20 split of the rest. This is closer to true insurance, as opposed to the expensive, pre-paid health plans that are common today.

You may think that the premiums or deductible seem high for this type of plan, but I would encourage you to consider what your insurance plan costs in personal premiums paid by you and your employer (which would have been your wages), in addition to your own plan's deductible (often $2500). I suspect that you are paying (at least indirectly) between $7,000 and $12,000 annually out of your productivity, and you will keep none of that money. My HSA dollars are mine to save and spend as I choose, as opposed to being forever lost to support those innumerable layers of bureaucracy, shareholders and CEO salaries, not to mention the black hole that is government mismanagement. On analysis, the HDHPs with HSAs are a vast improvement for personal cost and control.

Also, please consider the sweeping economic incentives and implications of everyone spending his own money on his own care. When I write the check or swipe my debit card from my HSA, I demand to know the cost, I seek out the best deal, I have bargaining power with the service providers (in this case the doctor and hospital) who seek my business. As I have described above, in the current system, those incentives have been obstructed and perverted, if not entirely removed. A free market system would encourage lower and transparent menu pricing to attract consumers, much like we see in the field of elective surgeries such as LASIK vision correction. No third party will pay for these surgeries, but prices keep falling even as the technology and techniques advance in complexity.[22]

One of the legislative changes that must occur for HSAs and HDHPs to be widely acceptable (and which should be infinitely easier to pass Congress than the 2,700 pages of labyrinthine national health care takeover which, years after narrow passage, is still debated and unclear) is to remove **the IRS tax code's** preference for employers (and discrimination against individuals) to pay for your insurance.[23] Currently, businesses may tax-deduct the insurance premiums paid in your name. This must be extended to individuals so that you can receive the same tax benefits for carrying your own policy, and thus de-couple that policy from your employment. That concept is known as **portability** – you can keep your policy regardless of where you happen to be employed.

The second major free market health care solution is to open **interstate competition** among health plans. Currently, state insurance boards mandate their own state's insurance requirements for their population such that a policy in Texas, for example, cannot be offered in California or New York or New Jersey. This freezes competition between companies and decreases options for consumers. Those barriers must be removed so that people may choose the plan and coverage that they want among competing plans and pricing options.

Other options to bring about freer markets and more patient-physician control are to remove the **government mandates for covered health plan items** in order to allow more personalized and streamlined policies, address **medical malpractice** abuses and **tort reform** (for example, a "loser pays" provision to address frivolous suits) which would decrease the incentive to practice defensive medicine, and **reform Medicare and Medicaid programs**. The stated goal of these government health programs is the coverage of the elderly, disabled and impoverished. Clearly, with government payors now providing 50% of health expenditures, those groups are not accurately identified. The population at large is not composed of mostly elderly, disabled and poor, nor is it likely that the true members of those groups consume that much health care. The entitlement rolls have swollen with little restraint on whom receives those funds. The extension of these entitlement programs outside of the indigent and into the middle class may please the recipients who receive free benefits, but to do so has placed all of the programs at risk of failure through funding crisis.[24] (A topic for another discussion is the societal and politico-economic consequences of supporting the majority of a democratic population with entitlements paid for by the tax-providing minority.) Those with the capacity to care for themselves must do so in order to maintain a viable system. The free market solutions that are suggested here would facilitate that transition to self-care by the vast majority. While a difficult situation, an option for the elderly and needy could include **vouchers** for their own catastrophic HDHPs. **Block grants** to the states are another possibility. These grants would send federal health care tax funds back to the states (whose citizens paid them in the first place) so that each state may define its own programs and eligibility qualifications.

In a true free market, we would also entertain the removal of licensing requirements for providers and institutions, the deregulation of health-related industries, the elimination of the FDA, the phasing out of government-funded entitlements in exchange for private sources of charity as occurred prior to the domination by third party payors (family, churches, charitable organizations, physicians, and hospitals), and other industry-freeing moves that would shift power and responsibility onto the individual and away from government.[25-27] From where we stand today in a mixed economy, there are two divergent paths for the direction of healthcare: government-controlled, centrally-planned financing and delivery, or a movement towards putting the patient back in charge of his healthcare dollar, the patient's control of the doctor-patient relationship, responsibility for one's own health and the use of free-market economic incentives to put downward pressure on expenditures and increased incentive for high-quality, competitive services. As described from the beginning of this paper, there has not been a free market in health care since at least the 1940s. Given the expansive governmental power consolidation and voting tendencies observed in recent years, the nation does not appear ready for a

real free market, but a few major moves in that direction are feasible and could remedy much of the destructive effects initiated decades ago through the "2 days that ruined your health care".

Update May 3, 2015: I made some grammatical corrections and a few minor edits as I read through his essay today – almost three years after having written it. Much remains the same on the health care policy front today. National legislation has advanced to take greater control of Medicine, and insurance corporations in collusion with government are stronger than ever. I finally had to drop my individual plan with Assurant Health about six months ago. The premiums kept rising as the plan was altered to cover all of the minimal coverage items demanded in the Affordable Care Act (ACA). The plan became unaffordable as it morphed into the typical insurance product. I found and joined Liberty Healthshare, which is a group of individuals that pays for care out of pocket but also pays a monthly premium into the healthshare's coffers to cover medical services of its members – similar to a traditional insurance plan. There are four healthshare groups in existence, and they are specifically written into the ACA as exceptions such that there is no tax penalty for not carrying one of the typical overpriced, low-value insurance plans foisted on the rest of the country. They all require a commitment to healthy living and most have a religious affiliation.

An impressive development has been the work of Dr. Keith Smith of the Surgery Center of Oklahoma, physicians at several other surgery centers, and a growing host of primary care doctors that are increasingly opting out of third-party payment plans and operating under transparent, free-market pricing systems. In fact, Dr. Smith helped found the Free Market Medicine Association which held its inaugural conference in September, 2014, which I had the privilege of attending. I came away optimistic that free market medicine will be able to stand against centralized planning and increasingly offer value, control and quality medical services to patient-consumers in the coming years. I hope to participate in such a practice in the not-too-distant future.

The greatest contribution that the public can make towards free market medicine is to simply demand to know what medical services cost before the time of service. That type of pricing pressure and transparency requirement cannot be accommodated by the system, as it is now. Even if most of the cost of a medical service is supposedly being covered by an insurance plan, it is very likely that most services could be provided near the cost of the patient's deductible alone. The thousands of dollars of additional payment, in addition to the true cost of the service, is absorbed into an inefficient, price-gouging system that fleeces the consumer. Check Surgery Center of Oklahoma's price list and then compare that with the charges you'll be billed at the big medical center in town – if you can get them to release that price to you. Don't forget to add in all of the associated doctors' fees, radiology fees, pathology fees, etc. Medical care is not very expensive. The non-transparent insurance coverage racket, on the other hand, is a many trillion dollar a year industry.

Cited works:

1. Waters, W.C, III. 2 Days That Ruined Your Health Care (And How You Can Provide the Cure). Newnan, GA. Logikon Press, 2008. Pg 12
2. Schumann, R. E. “Compensation from World War II through the Great Society.” United States Dept of Labor, Bureau of Labor Statistics. 30 Jan 2003. 6 Jun 2012. http://www.bls.gov/opub/cwc/cm20030124ar04p1.htm
3. Boyapati, V. “What's Really Wrong with the Healthcare Industry.” 22 Jun 2010. 12 Jun 2012. http://www.lewrockwell.com/orig11/boyapati1.1.1.html
4. Waters, W.C, III. 2 Days That Ruined Your Health Care (And How You Can Provide the Cure). Pp 12-13.
5. “Health Costs and History: Government Programs Always Exceed Their Spending Estimates.” Wall Street Journal. 20 Oct 2009. http://online.wsj.com/article/SB10001424052748703746604574461610985243066.html
6. Cauchon, D. “Medicare, Medicaid Tab Keeps Growing.” USA Today. 3 Aug 2011. http://www.usatoday.com/news/health/healthcare/health/healthcare/story/2011/08/Medicare-Medicaid-tab-keeps-growing/49776998/1
7. “Medicaid and the Uninsured: State Fiscal Conditions and Medicaid”. The Kaiser Family Foundation. Feb 2012. http://www.kff.org/medicaid/upload/7580-08.pdf
8. Williams, W.E. “Gullible Americans.” 26 Dec 2011. 8 Jun 2012. http://lewrockwell.com/williams-w/w-williams108.html
9. Lilly, J. “Medicare Reform: It's the Price-Fixing, Stupid.” 16 Jun 2011. American Thinker. 10 Jun 2012. http://www.americanthinker.com/2011/06/medicare_reform_its_the_price_fixing_stupid.html
10. Cannon, M. Edwards, C. “Medicare Reforms.” Downsizing the Federal Government. Sep 2010. Cato Institute. 7 Jun 2012. http://www.downsizinggovernment.org/hhs/medicare-reforms
11. Roberts, R. “If You’re Paying, I’ll Have Top Sirloin.” Libertarian Reader. (Ed- Boaz, D.), New York, Free Press. 1997. Pp 312-14.
12. Huntoon, L. R. “Medicare Myths and Facts: What the Government Doesn’t Want You to Know.” 15 Dec 2011. American Association of Physicians and Surgeons. 10 Jun 2012. http://www.aapsonline.org/index.php/article/medicare_myths_and_facts/?newsletter=off
13. Waters, W.C, III. 2 Days That Ruined Your Health Care (And How You Can Provide the Cure). Pg 25.
14. Singer, J. “A Simple Way to Improve Medicare.” Cato Institute. 25 Nov 2010. http://www.cato.org/publications/commentary/simple-way-improve-medicare
15. Schlafly, A., Orient, J. M. “White Paper on Medical Financing.” Journ Am Phys Surg 11.3 (Fall 2006): 86-91. 7 Jun 2012. http://www.jpands.org/vol11no3/schlafly.pdf
16. Richman, Sheldon. “The Political Economy of Health Care.” The Future of Freedom Foundation. 2010. 7 Jun 2012. http://www.fff.org/freedom/fd1002b.pdf
17. Waters, W.C, III. 2 Days That Ruined Your Health Care (And How You Can Provide the Cure). Pp-86-93.
18. Paul, R. The Revolution: A Manifesto. New York. Grand Central Publishing, 2008. Pg 85-91.

19. Mackey, J. "The Whole Foods Alternative to ObamaCare: Eight things we can do to improve health care without adding to the deficit." Wall Street Journal, 11 Aug 2009. http://online.wsj.com/article/SB10001424052970204251404574342170072865070.html
20. "A Free-Market Guide to Healthcare". 2 Oct 2009. Ludwig von Mises Institute. 10 Jun 2012. http://mises.org/daily/3737
21. Hornberger, J. G. "The Real Free-Market Approach to Health Care." Freedom Daily. Jan 1994. The Future of Freedom Foundation. http://www.fff.org/freedom/0194a.asp
22. Boyapati, V. "What's Really Wrong with the Healthcare Industry."
23. Lee, L. R. "ObamaCare: 'We Have to Pass the Bill So that You Can Find Out What Is in It'." 7 Aug 2011. Breitbart. 11 Jun 2012. http://www.breitbart.com/Big-Government/2011/08/07/ObamaCare--We-Have-to-Pass-the-Bill-So-that-You-Can-Find-Out-What-Is-in-It
24. Roff, P. "GOP Governors Point the Way Out of the Medicaid Mess." 1 Sep 2011. US News. 11 Jun 2012. http://www.usnews.com/opinion/blogs/peter-roff/2011/09/01/gop-governors-point-the-way-out-of-the-medicaid-mess
25. Hoppe, H. H. "A Four-Step Health Care Solution", The Free Market, April 1993, Volume 11, Number 4. http://mises.org/freemarket_detail.aspx?control=279
26. Paul, R. The Revolution: A Manifesto. Pp 85-91.
27. Hornberger, J. G. "Let's Admit It: Enacting Medicare Was a Mistake." 8 Jun 2011. Hornberger's Blog. The Future of Freedom Foundation. 6 Jun 2012. http://www.fff.org/blog/jghblog2011-06-08.asp

Other references:

Tanner, M. "Bankrupt: Entitlements and the Federal Budget." Cato Institute. 28 Mar 2011. http://www.cato.org/pubs/pas/pa673.pdf

"AAPS White Paper on Medicare Reform." Association of American Physicians and Surgeons. 1995. 7 Jun 2012. http://www.aapsonline.org/medicare/wpmedcar.htm

"Health Care Solutions". Americans for Tax Reform. 2009. 7 Jun 2012. http://www.atr.org/health-care-solutions-a3817

"People Without Health Insurance." Political Sunshine, Government Sunshine. 27 Mar 2008. 10 Jun 2012. http://www.politicalsunshine.com/health_care/uninsured_census/comments_our.html

Twight, C. "Medicare's Origin: The Economics and Politics of Dependency." The Cato Journal 16.3. 6 Jun 2012. http://www.cato.org/pubs/journal/cj16n3-3.html

McClellan, M. "Medicare and the Federal Budget: Past Experience, Current Policy, Future Prospects." Jan 2001. National Bureau of Economic Research. 6 Jun 2012. http://www.nber.org/chapters/c10858.pdf

Max, S. "The fuzzy math of health insurance: When an insurer's idea of usual, reasonable and customary comes up short, you're stuck paying." 30 Aug 2005. CNN Money. 10 Jun 2012. http://money.cnn.com/2005/05/26/pf/insurance/usual_and_customary/

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(Dr Rice is pictured on the Pacific coast of Costa Rica in 4/2012 on a fantastic trip with his wife and family to a friend's wedding)