Why Capitalism, If We Only Legalized It, Would Save Lives and Lower Prices

YOUR FACEBOOK FRIENDS ARE WRONG ABOUT HEALTH CARE

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Introduction
(Do Not Skip This!)

You probably want children to die.

That's about what you can expect from folks on Facebook when you express opposition to the idea of politicizing health, and removing it from the private, voluntary sector.

You will then have to endure fact-free tirades until the end of time, about how the dysfunctional American health care system is obviously a product of capitalism, and that we therefore need more coercion and more politics.

These are the same people, by and large, who cling to the dubious belief that the financial crisis of 2008 was caused by capitalism and "deregulation," even though (1) the banking sector is the most heavily regulated in the entire economy; (2) on the eve of the financial crisis there were 115 state and federal agencies overseeing the financial sector; (3) virtually all of the regulators themselves, in whom we are urged to repose our confidence, saw nothing wrong with the housing market throughout the bubble years; and (4) there is no repealed regulation, including the partial repeal of Glass-Steagall, that would have prevented the crisis.

The diagnosis is always: too much capitalism, too little regulation.

Meanwhile, Canada's much less heavily regulated banking system, which didn't have the crippling unit-banking laws that American states began imposing in the nineteenth century, avoided the bank panics that occurred here.

It's almost as if life is more complicated than the comic-book version of government good, selfish private sector bad, that we hear among fashionable opinion.

It's been especially melodramatic in the debate over health care. We've been told that the Affordable Care Act (ACA, or Obamacare) saves 36,000 lives per year, and that favoring its repeal therefore amounts to signing 36,000 death warrants.

As usual with the left and its melodrama, this figure has zero basis in reality.

Oren Cass of the Manhattan Institute actually bothered to examine the numbers. His conclusion: "The best statistical estimate of the number of lives saved each year by the ACA is zero."[1]

It's true that some studied find that health insurance does indeed save lives. But those studies are dealing with private insurance, or the expansion of private coverage in Massachusetts. Obamacare, by contrast, has by and large been an expansion of Medicaid, with the share of Americans holding private insurance actually declining. In fact, researchers find that Medicaid patients' results are unimpressive to nonexistent when compared to people with no

[1]For the analysis that follows I am indebted to Oren Cass, "No, Obamacare Has Not Saved American Lives," available at http://www.nationalreview.com/article/445260/obamacare-no-lives-saved.

insurance at all.

Data available from the Centers for Disease Control shows that in 2015, for the first time in 20 years, age-adjusted death rates increased. Does that mean the ACA is killing people? Not necessarily, of course. But it does mean it's not "saving lives."

In fact, Cass points out, a helpful control group exists. Some states refused to expand Medicaid under the ACA. Those states must have had worse health outcomes, right? Wrong. The 26 states with the Medicaid expansion saw mortality rise more than 50 percent faster.

Again, reality is more complicated than a comic book.

What you'll find in this book are the testimonies of physicians and other experts who don't believe the standard story that the American health care system is suffering from too much capitalism, or that only government can bring costs down. The exact opposite is the truth.

Chapter 1 begins with a brief overview of my own about the history of government and health care. The remaining chapters are transcripts from episodes of the Tom Woods Show, my libertarian podcast, which is approaching one thousand episodes as I write this.

If you enjoy what you find in this book, you'll want to join the tens of thousands who have made the Tom Woods Show a part of their daily routine:

http://www.tomwoods.com/episodes

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Chapter 1

How American Health Care Became Dysfunctional
(Hint: It's Not Because of "Capitalism")

For all the good things we can say about health care in the United States – and there are indeed plenty – we are all too aware of the perverse outcomes and the exorbitant prices.

Few people bother to seek out the causes of those high prices. They've already moved on to the solution: why, government can keep prices down!

I think it's better to start by figuring out why prices are high in the first place, and also to find out if we're attacking the right culprit.

We don't have a free market in health care when the federal government accounts for nearly 50 percent of all American health-care expenditures. Various government regulations, in turn, have interfered with the system and contributed to increasing demand for medical services while decreasing their supply. The shift to third-party payers (insurance companies) has made Americans largely insensitive to price, thereby pushing prices ever higher. A staggering regulatory apparatus, as well as significant barriers to entry into the medical field, keeps supply down and cost up.

Before we get started, let's clear away a common objection. Critics of the American health-care system say that, for all its high costs, it can't even deliver the same life expectancy or infant mortality rates of countries that spend less on health, and that these failings prove the free market has not worked. This criticism is untrue, even if we overlook the false claim that the United States has a free-market health-care system. Homicides and car accidents, which are higher in the United States than in most Western countries, are not the fault of the health-care system. In fact, Americans who don't die in homicides or car accidents have a longer life expectancy than people in any other Western country.[1]

As for infant mortality, the United States counts every baby who shows any signs of life as having been born alive. Other countries are not so generous – in France and Belgium, for example, a baby born at less than twenty-six weeks is registered as dead. In Switzerland, a baby has to be at least thirty centimeters long to be classified as living.[2] In this way, babies with an unusually high chance of death are simply removed from the statistics entirely, which makes countries that manipulate their statistics this way appear to be doing better in terms of infant mortality than the United States.

In the early twentieth century, health insurance was hardly used. Treatments available to patients were at times limited or even nonexistent, so the market for insurance was largely undeveloped. Some people did acquire sickness insurance, but that was an income maintenance program during times of illness, not a program aimed at providing for one's medical costs. Programs comparable to modern health insurance policies gained some steam during the 1930s, but really began to pick up in the next two decades, when government

policies made them artificially attractive.

Once the United States entered World War II, businesses on the home front found it difficult to attract the labor they needed because the draft had taken 11 million Americans out of the workforce, and the federal government had imposed wage and price controls. Those controls made it illegal for businesses to attract additional labor by offering higher wages. Businesses found a way around this restriction in the form of employer-supplied medical insurance. The wage control authorities did not consider this benefit to be a wage increase, and thus it was not subject to taxation like regular wages. This is the origin of what became the tax exemption for employer-provided medical care.

After the war ended, labor unions began to make employer-financed medical insurance part of their contract demands. Nonunion employers likewise felt compelled to provide it, in the hope that they could thereby avoid the unionization of their workplaces.[3] Here again we see the role of non-market forces in bringing about the present reliance on employer-supplied medical insurance: the special legal privileges labor unions enjoy, and the lengths to which employers are willing to go in trying to preserve a free labor market in their corner of the economy, derive from statutory interventions into the free market and are not part of the market itself.[4]

The establishment of health care as a company-offered benefit may seem innocuous enough. But as a result, medical care gradually became an expense Americans paid for only minimally out of pocket. People became accustomed to having most costs covered by a third party, and so slowly but surely they came to disregard price altogether when evaluating medical products and services. If employers are paying health costs (beyond the employee's deductible) for their employees through an insurance company, those employees will be less mindful of cost than if they bore it themselves. Likewise, suppliers of health care have an incentive to offer high-cost treatments with marginal benefits because someone else is picking up the bill. The predictable result, since neither suppliers nor consumers have an incentive to keep costs down, has been ongoing price increases. Naturally businesses tend to push back when their costs rise, but for privacy reasons they find it more difficult to pry into the merits of a particular medical procedure performed on an employee than, say, to uncover why that employee purchased a first-class plane ticket on the company credit card.[5]

Vijay Boyapati, a former Google engineer, tells a story that could be multiplied millions of times over, regarding the effects on price when perverse incentives, and then normal ones, are in place. He wanted to have a small epidermoid cyst removed from his back. This is what happened:

> The first practice I visited was a dermatologist's office, which deals primarily with insured customers and can afford to charge exorbitant rates. I explained to the assistant on my first consulting visit that I didn't have health insurance—I choose not to—and asked how much the procedure would cost if I paid cash. She quoted me $700 for a riskless procedure that takes about 15 to 20 minutes to perform, and would not in this instance be performed by the dermatologist, but by the assistant herself.…The fact that there are very basic procedures that cost the equivalent of $2,100 an hour is a glaring sign that the market's normal price mechanism has been broken.

> On the recommendation of a friend, I decided to visit another medical practice, Country Doctor, which deals mostly with lower-income patients who do not have health insurance. Because its customers pay out of pocket, Country Doctor has a much stronger incentive to charge prices that its customers are willing to pay up front. When I had the procedure to remove the cyst done at Country Doctor, it was performed by an actual doctor, and it cost less than $50.[6]

Medicare and Medicaid, created in 1965, are also examples of third-party payment. Medicaid, the means-tested program for the poor, and Medicare, a program to provide for the medical needs of American seniors regardless of income, artificially stimulated demand for medical services on the part of consumers who were not themselves bearing the cost. In 1960, government covered 21 percent of total medical expenditures, with consumers bearing 55 percent. In 2000, government covered 43 percent and consumers only 17 percent.[7] Naturally, costs rose dramatically under these conditions.

The federal government tried to push some of the costs it was bearing onto others. Doctors and hospitals, receiving only partial reimbursement from Medicare and Medicaid, began to compensate for their losses by charging private insurers more. Private insurance costs, in turn, began to skyrocket, a phenomenon that subsequently gave rise to so-called "managed care," the bureaucratic mess that everyone dislikes for its efforts to drive down costs by denying certain kinds of care.[8]

While some forms of government intervention, such as the ones we have examined thus far, produce an artificial stimulus to demand, others lead to higher medical costs as a result of artificial restrictions on supply. The American Medical Association, for example, restricts the number of medical candidates by means of its accreditation process for medical schools, with its decisions ratified by state governments. Nineteen states are limited to having *a single medical school*. We're supposed to believe this restrictive policy was developed with only the public good in mind?

The supply of medical services is also kept down by "certificate-of-need" (CON) regulation. Such regulation allows existing hospitals themselves to decide whether a "need" exists for additional hospitals in a particular area. Were such a privilege granted to existing firms in any other industry, its anti-competitive nature would be evident. Not surprisingly, CON regulation, which has also been used to block competition in related health professions like home health care and nursing, has been found to increase medical costs.

Additional restrictions on market competition contribute still further to rising costs. For example, Americans are prohibited from purchasing medical insurance originating in states other than their own. Mandates that states impose on insurance companies put upward pressure on policy prices. Each of these mandates requires that insurance companies in a particular state provide coverage for a particular disorder or kind of treatment. Each mandate results in higher premiums and less consumer choice. People have no way to choose policies that suit them and must instead "insure" against the need for hair implants or massage therapy—two examples of state mandates—whether they want to or not. As of 2009, when Barack Obama began his second term, Rhode Island led the nation in mandates with 70.

Idaho, with 13, had the fewest. That year there were a total of 2,133 mandates across the states, up from just 252 in 1979. These mandates make it difficult for people to find low-cost, high-deductible policies that can insure them against medical catastrophes. That's one of the reasons so many people have chosen to forego insurance coverage in the first place. A young person finds it silly to spend $300 per month on medical services he won't need or use, just so he can save 80 percent on routine doctor visits.[9]

The Obama plan establishes state-based exchanges where small businesses and uninsured individuals can purchase insurance. Not one of the plans offered at these exchanges provides only catastrophic coverage, the sensible option that would be available to consumers on the free market. Instead, they all cover even routine health expenses, thereby causing individuals to be as heedless of cost as ever, and continuing the perversion of the concept of "insurance" whereby people are to be "insured" against events like checkups that are certain to occur. High-deductible, catastrophic plans are also penalized by the establishment of deductible caps and the prohibition of co-payments for preventative care, which will make such policies more expensive. Meanwhile, research finds that high-deductible, catastrophic plans put strong downward pressure on health-care costs, lead consumers to be much more cost conscious, and still deliver the same amount of necessary care that people who hold more standard insurance policies receive.[10]

Given the ongoing rise in medical costs and the countless stories of personal hardship to which those costs have given rise, critics of the present system have claimed that additional government involvement is necessary. But if earlier government interventions have tended to push prices up, additional interventions in the same direction are likely to intensify the problem. The Austrian economist Ludwig von Mises once described how government intervention tends to feed on itself: the first intervention causes problems that still further interventions are enacted to resolve, and so on, until the economy becomes a maze of regulation and control. Never considered is the mere repeal of the initial interventions.

The most obvious problem with the recently enacted health-care legislation is the incentive structure it creates for the uninsured, and indeed even for many of the presently insured. Individuals are subject to financial penalties for not purchasing health insurance policies that meet government standards. But the penalties are far lower than the cost of purchasing such policies. That means it is less expensive for people to remain (or become) uninsured and simply pay the corresponding penalty. They can get away with doing so because under the new law, insurers are required to (1) enroll everyone who applies ("guaranteed issue"), (2) cover pre-existing conditions, and (3) adopt a policy known as "community rating," in which they must charge the same premium to all, with minor exceptions for geographical area, age, and whether the plan covers an individual or a family. (And insurance companies are regulated in how large the differential can be between, say, very young and very old customers; the elderly, whose medical bills are far higher and of greater quantity than those of the young, may be charged a premium only twice as high.) It therefore makes sense for people not to purchase health insurance, wait until they become ill, and then purchase an insurance plan—their current illness being a "pre-existing condition" that insurance companies would be required to cover.

This is a suicidal business model—or perhaps homicidal, since the insurance companies did

not elect to impose it on themselves. No insurance company can survive without being allowed to pool risks appropriately and charge premiums based on relevant actuarial estimates. Profit-seeking insurance cannot operate according to a business model designed for a social-welfare agency funded by taxation. Requiring insurance companies to cover "pre-existing conditions," moreover, is like demanding that homeowners be able to take out fire insurance on a burning building. Cynics suspect that advocates of this plan understand perfectly well the impossible burden it will place on insurance companies (the bogeymen we are supposed to hate, who are in fact earning a mere 2.2 cents on the dollar in profit), and must be intelligent enough to foresee the coming collapse—and, as night follows day, nationalization—of the insurance industry.

In 2006, Massachusetts instituted an individual mandate along with guaranteed issue and community rating. The result was major losses among insurers, which led to lower payments to hospitals and large group practices. Insurers and hospitals found themselves on the verge of going out of business. Residents, meanwhile, faced an ongoing rise in premiums. State Treasurer Timothy Cahill said the program had been a "fiscal train wreck," costing more than $4 billion—over 11 times the initial projection.[11]

Now the whole country gets to try out this approach.

On top of this, insurance companies will not be allowed to impose lifetime limits on coverage—e.g., $2 million or $6 million, as in many popular plans. The insured must be allowed to consume as much as they need, forever. Insurance companies will also be forced to cover the children of the insured until age twenty-six. Some "children"! All of this means higher premiums, naturally, and less consumer choice. By October 2010 some health insurance premium rates in Connecticut had already risen 47 percent in response to the new law, and Well-Point, the country's largest insurer, found the average premium for a 25-year-old man likely to rise by 155 percent in Richmond, Virginia, and by 300 percent in Louisville, Kentucky.[12] But that hardly seems the point, which is how juvenile all these provisions are: why, if we want a particular outcome, let's have our congressman demand it! Resources are unlimited! Demand your share!

Meanwhile, the Obama plan will add another 18 million people to Medicaid, a jointly run federal-state medical care program for those with low incomes. In other words, states drowning in red ink are about to be thrown an anchor.

Other anchors are being thrown to taxpayers and businesses. The so-called "rich"—who have no rights and exist only to be plundered—will find their Medicare taxes jump by 60 percent, and will be hit with a new tax on "unearned income," based on the Marxist view that income not derived from physical labor is not really "earned." Health insurance companies and pharmaceutical manufacturers will also be hit with higher taxes, and a new tax on medical devices will be imposed. "Cadillac" health-care plans, which offer consumers more than the federal government thinks they ought to have, will be subject to a new 40 percent tax. And the annual tax deduction for medical expenses—a deduction half of whose beneficiaries earn under $50,000 per year—is being reduced.[13]

In 2014, firms with fifty or more employees will be fined if they do not offer workers a health

insurance plan that meets with the federal government's approval. (Smaller firms are exempted, but skeptics say the exemptions will be short lived: the federal government, facing rising costs and revenue shortfalls, could very well lower the threshold to twenty-five or even ten employees.) As *Barron's* puts it, if you want to expand your business under these conditions, you might follow one of these strategies: "a) asking your full-timers, at say 35 hours, to work 40 or 45; b) firing a few workers and outsourcing their services to another firm; c) hiring more workers off the books; d) not expanding at all."[14]

What about all the "savings" the program is supposed to yield us? The alleged savings are the product of accounting tricks. They result from the fact that the program begins taxing people in 2011 but doesn't begin paying out benefits until 2014. If we start our measurement of costs in 2014, we find the program's alleged savings are nowhere to be found, and that in fact—although estimates range from several hundred billion to several trillion—it promises to be enormously expensive over the following ten years.[15]

The Obama plan also suffers from critical omissions. It does nothing to reduce the regulatory burden that reduces both the supply and the efficiency of health-care services. It does not promote competition between states. It does nothing at all to reduce costs. It does not address the cost implications of low deductibles and co-payments and of excessive reliance on third-party payment in general. If anything, it accentuates this reliance by imposing penalties on employers who do not provide health coverage to their employees. It is precisely the employer provision of health care and its tax deductibility that has encouraged the system of third-party payment. It seems significant that in Switzerland, whose health-care system is so often praised, the percentage of medical costs that people bear out of pocket is two and a half times as great as it is in the United States. And in the United States, those sectors of the industry whose services are not typically covered under standard insurance plans—including LASIK surgery and most plastic surgery—have seen costs come down, even as technological innovation has increased.[16] With consumers bearing the costs of these services themselves, they have been much more conscious of price differentials, thereby forcing providers to become competitive on price.

Medicare, meanwhile, which is supposed to provide medical care for the elderly, is itself in serious need of reform, underfunded to the tune of tens of trillions of dollars. And yet with the program's unsustainable trajectory becoming clearer every year, a Republican Congress under President George W. Bush pushed through so-called Medicare Part D, which established a prescription drug benefit for seniors that added tens of trillions more to the total. Most Americans, seeing such a program proposed, can be forgiven for assuming it must have been addressing a pervasive problem, since why else would the federal government get involved? In fact, a 2002 government survey of seniors found 86.4 percent saying that getting the prescription drug they needed over the past six months had been "not a problem," 9.4 percent "a small problem," and a mere 4.2 percent "a big problem." Three-quarters of American seniors already had prescription drug coverage through various private and other outlets.[17]

We now know that the estimated cost of the program was deliberately understated; the program, moreover, was structured in such a way that future expansions of coverage were inevitable. But even in the absence of any modification, Pete Peterson warns that "by the year

2030, incredibly, the federal government will be spending as much on prescription drugs for Medicare enrollees (as a share of GDP) as everything it now spends on non-health benefits for needy working-age Americans—including means-tested cash welfare, food stamps, unemployment compensation, child nutrition, foster care, and the refundable portions of the earned income tax credit and child tax credit."[18] It has been estimated that nearly $20 trillion of the staggering unfunded liabilities facing the U.S. government is attributable to Medicare Part D.

What did people do before these programs existed? Historian David Beito has documented the previously neglected role of fraternal organizations in providing discounted health care to their members. Such organizations were able to secure group discounts from physicians, which meant their members were able to enjoy affordable medical care. One of the reasons for the decline in and eventual disappearance of the fraternal associations' role in providing medical care and other services that we associate with the modern welfare state is the growth of the welfare state itself. As Beito argues, when the state begins providing services and performing functions that had previously belonged to the care of civil society, it crowds out these private institutions, which tend to atrophy in proportion to the growth of the state.[19]

The year prior to the establishment of Medicaid, poor families had higher hospital admission rates than did those in wealthier brackets. And while higher income individuals had an average of 5.1 doctor visits a year, low-income individuals had 4.3—hardly a dramatic difference. What Medicaid did result in was a dramatic decline in the reduced-cost or pro bono services that doctors had once provided the poor as a matter of routine. According to historian Allan Matusow, "Most of the government's medical payments on behalf of the poor compensated doctors and hospitals for services once rendered free of charge or at reduced prices.…Medicare-Medicaid, then, primarily transferred income from middle-class taxpayers to middle-class health-care professionals."[20]

Author Jacob Hornberger recalls growing up in Laredo, Texas, in the 1950s, at a time when the Census Bureau had labeled that city the poorest in the country on a per-capita income basis. Yet according to Hornberger, "I never knew of one single doctor who turned people away. They treated everyone who came into their office. I never heard of a doctor complaining about having to provide free services to the poor."[21]

And how were doctors doing in those days?

"They were among the wealthiest people in town," Hornberger says. "The money they made from the middle class and the wealthy and the poor who could pay subsidized the patients who couldn't pay." Those who received free care were grateful to receive it, and typically brought the doctor in-kind gifts.

When government got involved, an impossible regulatory thicket invaded and complicated medicine to the point that physicians began retiring early, having come to despise a profession they had once loved. Meanwhile, among patients a sense of entitlement began to supplant the normal human instinct of gratitude. What had once been a harmonious and mutually satisfying relationship became frustrating for everyone.

The very fact that people today, so long accustomed to government-provided medical care, would actually wonder what would happen to the poor under a system without government coercion shows, as Hornberger says, "what America's welfare state has done to people's faith in themselves, in others, and in a free society."

To be sure, there *are* measures that can be taken to rein in health-care costs. Employers should be free to offer their workers a choice between continuing to receive employer-provided medical insurance or instead receiving the tax-free cash equivalent of the present average cost of such insurance (say, $10,000 to $15,000, indexed for inflation). This change would make clear to employees that the money an employer pays for their medical insurance comes out of their own pockets in the form of lower salaries. (Right now, most workers doubtless consider their fringe benefits to be "free.") If the employee chooses the tax-free income, he would then have a much greater incentive to carry only a high-deductible policy. That is, since he can pocket any money he doesn't spend on his policy, he has an incentive to keep that policy inexpensive. High-deductible policies, in turn, make people more cost conscious, since more of their medical expenses come out of their own pockets. And under this arrangement, the typical worker would save more than enough to pay the full deductible on whatever insurance policy he may choose to purchase (should he even need that much medical attention in a year), with money to spare.[22]

If a free market in medical care is not politically feasible as a policy option for the whole country, economist Fred Foldvary of Santa Clara University proposes that individuals be allowed to choose it for themselves. He calls it the Complete Private Medical Option (CPMO). People opting for it would forfeit all forms of government medical assistance, but they would also enjoy exemption from all forms of government medical restriction. Foldvary makes an exception for emergency services, but says that anyone choosing his plan would be ineligible for any other government medical benefit. On the other hand, they would pay no taxes for medical services, including the Medicare portion of payroll taxes and the sales taxes on medical products. They would be exempt from licensing laws and drug restrictions, such that they could purchase medical services from anyone they wished according to their own good judgment, and obtain any drug, dietary supplement, or medical service. They could purchase any kind of medical plan from any willing provider anywhere. That, excepting a few technical details, is Foldvary's plan, which he contends would establish a free market in medicine alongside the government-controlled alternative.

What else can be done? Upon reaching age sixty-five, Americans should be given the option of giving up federal entitlement benefits in exchange for complete exemption from income tax for the rest of their productive lives. Likewise, such individuals should be exempt from taxation of any interest and dividend income that accrues from money they save from their tax-exempt income, and anything they hand on to their heirs from that income should likewise be exempt from estate and gift taxes. The incentives thus created would doubtless make a substantial dent in the Medicare and Social Security crises by dramatically lowering the number of people demanding payments from those programs.[23]

Medical licensure is unlikely to be going anywhere, so deeply entrenched is the spurious public-good justification for this barrier to entry. Short of removing that requirement, some measures might be taken that would painlessly increase the supply of physician services and

thereby reduce costs. Every physician might be granted the right to select, say, six individuals whom he might train and supervise, and who would serve as "associate physicians." Thus the physician could extend the benefits of his own license to six individuals of his choosing. Those individuals might be drawn from a pool of candidates consisting of people who have attained some degree of distinction within the medical field. The physician could delegate to them whatever tasks his good judgment and their qualifications justified.[24] Such a liberalization of licensing requirements would mean, in practice, that someone with strep throat, if his pharmacist were an associate physician, could be examined and granted a prescription on the spot, rather than having to make an expensive office visit. A registered nurse or paramedic might set a broken limb and put it in a cast. Obviously, the efficiency and cost gains would be significant. According to some estimates, nurses could provide as much as 80 percent of the medical care that primary physicians currently deliver, and at only 40 percent of the cost.[25]

There seem to be two major perils of health-care reform. One is intensifying the very factors contributing to the increase in medical costs, which is precisely what the Obama plan does. The other is implementing piecemeal reforms in the right direction at a time when nothing short of radical surgery will do. The Medicare crisis, to say nothing of the health-care crisis as a whole, is much too severe to be dealt with by anything short of a complete revolution in our expectations and philosophy of government. It is not an ideological statement, but a practical one, to conclude that the system can be fixed only if we return to individuals, families, doctors, and communities full control over decisions pertaining to their own health and well-being.

Chapter 2

The World's Most Affordable Health Care – Here in the U.S.? (with Dr. Josh Umbehr)

Dr. Josh Umbehr is a physician and the owner of AtlasMD, a direct care practice. This was episode 481 of the Tom Woods Show.

WOODS: I'd like to talk about your practice first of all, which is highly unusual from the point of view of the average consumer of health care, and the average deliverer of health care. I want people to know exactly what it is you do, and then I want to talk about the more general question of government and health care. So tell me about Atlas.MD and how it's different from my neighborhood physician's office.

UMBEHR: Well, in a lot of ways nothing's different, and in some ways everything's different. It's Marcus Welby medicine with an iPhone, because it's going back to what a lot of people remember from their doctor in the old days, where they worked directly with their doctor, there was no insurance, you paid with cash or chickens, and the doctor took care of you. But in our system, we started with the idea of having insurance for the wrong things. We don't have car insurance for gasoline or homeowner's insurance for lawn care; why have health insurance for family medicine, the bulk of what most people need?

And we were able to remove that middleman, the third-party payer; we structured it a little differently on the billing side, so it's a flat rate per month based on age, just like a gym membership. For that membership, you get unlimited home visits, work visits, office visits, technology visits – like email, cell phone, texting, Twitter, Facebook, Skype – basically whatever we want, because now we're not limited to what insurance will allow or pay for. Then we have no copays in our office. Any procedure we can do in the office is included free of charge, because that's what the membership is covering, just like any equipment in the gym is included at the base membership price – so stitches, biopsies, joint injections, ultrasounds, bone scans, lung scans, urine testing, strep throat testing, minor surgical procedures – all included for free.

Then something else we do that makes us very unique and valuable is wholesale medications, labs, imaging, and pathology. We had a perfect example recently. We ordered some blood work – we have our negotiated cash discounts of usually 95 percent – and a patient's blood work was accidentally billed through the insurance rate, because of a computer mistake at the lab. The price they were quoted was $1,028. We ran that back through our system, and it cost $39 – a 97 percent savings just by cutting out the middleman. And it's an amazing opportunity; it's far past the 10x improvement that most entrepreneurs are looking for.

We can do the same things with medications. We outcompete the Walmarts, the CVSs, the Targets of the world, because we have a different business model. We can dispense medications in Kansas just like a pharmacist. Forty-four states allow physicians to function like this, and so I can order the medications wholesale from the same places the pharmacies

do, but I can get 1,000 blood pressure pills for $8.33. Even after my 10 percent markup, they're under a penny a pill. Walmart would literally have to give them away to out-compete us, and if they do, great; we still win. It's not a value that's a revenue generator for us; we're adding to the value of the membership, very Costco-esque.

So we could drastically reduce the costs of people's health care by 80 to 90 percent. We can take all of the value; we can go to your employer; we can restructure their insurance plan, decrease the premiums by 30 to 60 percent, year one. We had an example of a company here in Wichita, Kansas, 18 employees. Long story short: from 2013 to the end of 2014, they decreased their out-of-pocket costs for insurance from $98,000 to $47,000, year one. Now, employees had unlimited access 24/7 to their doctor – call, text, email, visits, hour-long appointments if necessary, free stitches instead of going to the ER – but none of that was claimed toward the insurance. Even the insurance company loves us now, because they realize they're in the business of insuring rare, catastrophic events, not the daily things.

So in a lot of ways, we haven't done anything different – this is regular medicine, regular blood pressure, regular stitches, regular doctors – but then in other ways, we've done everything different. The exciting part – but maybe the sad part, too – is that all these pieces were in place for the last 20 years. Any doctor could be doing this going back a long ways. We didn't create a new way of dispensing medications, of dispensing labs. Those discounts were already available inside the system. It just took doctors who were willing to say: the system's broken, and I'm going to take a very logical business approach to this.

But that's not medicine. My med school, we were taught that business is bad, it's beneath us, it's unbecoming and unprofessional of physicians to dirty their hands with it. Of course, I didn't buy that. Business is the most ethical of things, because it forces you to ask the question: what is value, what is right? And I can go to a patient and say, you're getting your migraine medicine for $200 a month at the pharmacy; I can get it for $6. That is a better value for you. If I take my oath of "do no harm" seriously, it has to include "do no financial harm." That means I should be the constant advocate in an open and free and efficient market for my patients, looking for the best prices, the best quality, guiding them and bringing high value to them, just like Amazon, just like Walmart, just like any other industry. And so as doctors take that responsibility on, their patients are the beneficiaries of that.

WOODS: After listening to everything you just said, I can't help wondering how we can possibly account for the staggering scope of the savings you're talking about. I could see a little bit of savings here and there, but the scope of the savings you're talking about basically solves the health-care problem. So what could possibly be going on here?

UMBEHR: Well, I think we all understand the health care system is bloated and expensive and bureaucratic and cumbersome, and everyone complains about the red tape. So if we just associate that red tape and bloat of the system and equate that to dollar signs, it makes perfect sense why everything is so expensive and why the health care system is broken. But on that same message would be the proof that we can lower the fees. Actually, doing a blood test isn't expensive. We've done that for so long, and the cost of doing that has been driven down to pennies on the dollar. It's the delivery of care, it's the payment system that is expensive.

So when we're insuring the equivalent of gasoline for cars, oil changes, tires, windshield-wiper fluid, then we're going to get a very bloated system. It's not that insurance is bad; it's that we've been using it wrong. So actually I blame doctors more than I blame the insurance company – not that they're blameless, but the real fault lies in the fact that we're using it inappropriately. Einstein said that if you judge a fish by its ability to climb a tree, he'll forever think he's unable. And if we think that we're going to pinch the cost curve by adding more red tape to the system, then we're fools.

What we need is a free-market system, and I think we can all agree that there's probably never been a mechanism in history that will find efficiencies and drive down the cost of a product and drive up the quality quite like the free market. So when doctors have to compete with other doctors, when hospitals have to be transparent in their prices, when the provider of care, the deliverer, is taking their oath to the next level and saying good business results in good medicine, when done appropriately – this idea that medicine is above business is ridiculous.

The reason health care is broken is that we don't have a Walmart or an Amazon, a Sam Walton or a Jeff Bezos who have a pathologic desire to drive down the cost of their goods and services because they understand what it means to be valuable. Einstein also said, don't aim to be a man of success; aim to be a man of value. I love that quotation. We're constantly telling that to other doctors looking to start with this model. How do you want to be successful? Be valuable to your patients, and they will come to a model like this.

Doctors will tell me, well, I can't get my patients to pay $20 for their copay; how am I going to get them to pay $50 a month? Well, a $20 copay for a seven-minute visit that you're an hour late to is not a value. Fifty dollars a month for unlimited access is. Netflix to Blockbuster. Blockbuster had an unpredictable fee-for-service type revenue model, very analogous to our current health-care system. Netflix found out how to give me 10,000 videos for $7 when Blockbuster could give me only one for $7. So if we apply that same innovation to health care, it only stands to reason that we can drastically reduce the cost curve.

The innovator's description or the standard Silicon Valley bar is a 10x improvement; you have to be that much better before the barrier to change is overcome. We're at 20x better. If you go back to the last year that I have data for – I think it was 2011 – the total cost for all prescription medications in the U.S. was $263 billion. The cost for all cancer care was $157 billion. And we can get cancer medicines cheaper. Not all of it; not everything's cheap. Some stuff is just expensive. But if you get that lower, and we have an example where we had a breast cancer chemotherapy pill that was $600 for every two refills at the pharmacy and $7 with us – a literal 99 percent savings. We gave it to her for free, just so we could say we were now providing chemotherapy. So let's just be minimalists and say we save only $157 billion out of that $263 billion in prescriptions for all the things that are expensive. Well, then we've paid for all cancer care.

Go a little bit further and take out all the administrative burden of that, the duplication of cost, the waste and inefficiency. So when we talk to an insurance company, they'll say family medicine as a total cost isn't enough for us to change if you take that one small piece. I say great, look at the full value proposition under the umbrella of direct primary care, and you

will see a value that will incentivize you to change, because that is all the copays, all the procedures, all the family medicine bills wiped away, but then extend that out to the laboratory, the pharmacy, the imaging center.

No one goes to the ER for $1500 in stitches when I'll do them for free. Why do I do them for free? Same reason Costco does things for low cost, low profit: to protect their membership. So my stitches cost me a dollar each. They're going to expire in a year if I don't use them anyway. I might as well at least get some value with my patient. And my job, just like Jeff Bezos and just like Sam Walton, is to save you money, and make you healthy. So if I saved you $1500 on your stitches, you're going to come back with me, you're going to stay with this membership. I've become valuable to you, and that's how I become successful.

And in the process of appropriately aligning the incentives from doctor to patient to insurance, or to employer and to insurance, we changed the system. Just something as simple as that transparency in price. I have it on my desktop as something I need to post for social media, an example of what's broken with our health-care system: name-brand price for 30 pills of a medication, $268. My generic, $5.39. So when you align the incentives appropriately, no employee wants to pay $268 out of their dollars for a name-brand medication that's no better than the $5 equivalent. So you saved the system $263 just by appropriately aligning the incentives. What patient wants to submit a bill to their insurance to wash their car? It makes no sense. Why would you submit a bill to your insurance for a $5 medication? So we start removing administrative costs, we start putting the true cost of care directly in the hands of the patient, and they can decide to be as aggressive or conservative as they want. And that makes a very free and efficient market.

Walmart, Target, Amazon all know they're constantly competing against each other for similar products. TVX, I can go on and find out the price and compare, and it's going to be within a marginal difference from each store, because they know what the other stores are selling it for. But medications? I can pull you up one, using a free-market tool, GoodRx.com, and one of my favorite examples is Imitrex, a migraine medicine that at the pharmacy, for the name brand, as I pull it up now, is $565 cash price, anywhere from $447 to $486 with a coupon. The generic is $260 cash price, as low as $101 – that I get for $5, my patient gets for $5, because I don't need to make revenue off the medication. I'm trying to make them healthier; I'm trying to save them money; I'm trying to show the value of my membership.

So every month they refill that medicine, I'm saving them at least $100. Their membership's $50, their medicine's $5. I'm giving them $45 of their life back – that's life, that's time, that's energy. So when someone says, well, this only works well for the rich, for the healthy, that's ridiculous. This works out best for the sick and the poor. Just like any market, I'm reaching the people most likely to benefit from a food service or a phone service or a car service. So the people who want to save money on their medicines and are sick enough to need medicines benefit the most from this system.

So the government is paying $101 for that migraine medicine instead of the $5 that they should be. Walmart doesn't want a free market in medication, because they're competing against a very inefficient system. CVS gets to charge that much; Target gets to charge that much. And 65 percent of all prescriptions are controlled by now four large companies. But it

only takes one spot of innovation, one doctor like us to say: I'll do it different; I'll be the little company that eats the big company, because I'll offer value that you can't compare to, because I'm looking out for my patient. If physicians had been doing that the whole time, we'd have a completely different health care system.

WOODS: If I listen to somebody like Bernie Sanders, or indeed any typical politician, I'll be told that what we have in health care now is capitalism, and that's what's given us all these problems. What do you say to that? Secondly, since I'm sure you don't believe that, where did it all go wrong, so that we have all these perverse outcomes?

UMBEHR: I think we have capitalistic components to our health care system, but when I believe the statistic is that 52 or 53 percent of all health care dollars are paid for by the government, between Medicare, Medicaid, state agencies, you don't have a free market. Doctors have to opt out of their contract with Medicare and the government penalizes them for two years, that they can't come back in. That's not a free market, that's not free flow of providers to services to people in need. The restrictive contracts that we have with insurance companies isn't a free market.

If you want to compare Medicaid to Lasik eye surgery – and again, yes, this is apples to oranges – but broad terms, most states can show that Medicaid patients, in a pure government system, have worse health outcomes than uninsured, because at least I can charge a fair price to an uninsured patient and make money. Medicaid, I am told what I can charge – that's not capitalism – and I lose money on that – that's not capitalism – and so I don't take those patients because they're not a value, and I can only lose so much money and keep my doors open. So they end up getting worse health outcomes. That is a badge of recognition that does not serve them well, which is to say: I have a Medicaid card. Now, it covers some things, great, but it still doesn't result in great outcomes.

Compare that to something like Lasik surgery for eyes, where the cost continues to go down and the quality continues to go up, because there's little to no government regulation on that end. So the market is free to move forward as quickly as possible.
Another great analogy would be the iPhone to most medical technology. Most medical technology is a decade behind where we are with anything else. But the iPhone, with limited government restriction, can create the best software that they know how to make and meet the needs of their clients in whatever way they see fit, to the point now that a billion apps have been made. Okay, fantastic. But that's without regulation and everybody's free to create a unique product.

Government dictates how we create health-care software and says: to get paid by us, and we're the 800-pound gorilla, it has to do meaningful use or it has to do ICD-10, which is coming down October 1, and we're going to go from a mandatory 15,000 different billing codes to 155,000 different billing codes. They are continually pulling out components of the free market and complicating it with their bureaucracy. So I think we're going to get all the love and attention of the DMV, with all the efficiency of the post office.

WOODS: But what about all these examples of countries that have single-payer systems, and if you poll the people there, they say they love their health care system?

UMBEHR: Oh, they do – if they don't use it. And there's plenty of data to show – and of course people will disagree on this – but if you actually look at the data, a great example, the World Health Organization says that we rank 38th in total health care, right below Cuba. Well, when they can't blind you with their brilliance, they're going to baffle you with their data, and lies, damned lies, and statistics. What we know is that study was horribly flawed. They were supposed to repeat that every so often like a census; they never repeated it again because the data was so bad. Cuba just self-reported data, and their self-reported data says they're better than the U.S.'s data. But we actually submitted information.

Part of that is the grading criteria: you pre-weight the scales so that the people you want to win, win. So part of that is the grading scale for how points are awarded to rank health-care systems is based on egalitarian distribution of health care. Well, Cuba has a very egalitarian distribution of health care. Everybody gets the same awful health care. And countries like Canada won't diagnose cancer after 75.

Infant mortality is a great example, because there are very few countries that strictly follow the WHO's definition of what is considered an infant death. Basically, if it comes out breathing and with a beating heart, it was a live infant. Anything after that is an infant mortality. Some countries will change that data and give it a month before they'll consider it a live baby and any death in the first month of life is considered a stillborn. So we're not comparing fair data to fair data. But I think you can say, well yes, us compared to Second or Third World countries, of course we have better infant mortality rates, but we're actually being more honest with the data than other countries.

So those are the things that don't get reported. Maybe we have worse health care outcomes and we spend twice as much. Again, it's a bit of a straw-man argument. We already know we spend too much because of a bloated, bureaucratic system, most of which the government has created. In our system, we have no red tape. If a patient wants a medicine and it's appropriate, we give them the medicine. There's no administrative cost involved. The average physician would have seven employees per doctor to run a practice. We have half of a full-time equivalent per physician, because of less regulation, less red tape, less bureaucracy. That would drive down the cost of care.

So yes, America may be more expensive, but we get better outcomes, but we also buy what we want. If I want to go to the ER because I'm worried about something, I can. Not every country can do that. If I want to have an eye surgery that may be more elective, I can. In Canada, you can't. If I want an MRI because I'm concerned about my back, I can go out and purchase that on the open market. In Canada, you can't. So just because we spend more and we get different outcomes doesn't necessarily mean that those are better or worse. Those are consumer decisions made based on what people want for their health care dollars. And I'll be the first to agree that there's a lot of bloat, but at the end of the day, we still have more options, more choice to decide what we want to do.

I think Malcolm Gladwell said it best recently when he was interviewed for a physician website. He said that he's occupied every position on the bell curve from socialist health care, Canadian health care to free market, and now he's on the free-market side, where we

probably need less insurance, less government, less bureaucracy, because those things aren't adding value, but are adding a cost. So the fact that we can remove all that cost and still give our consumer, our patient, high choice, is a bedrock of American capitalism.

WOODS: The whole insurance system that we are stuck with – as you note, there's something odd about the fact that you have insurance to get an ordinary check-up, but you don't have insurance for all the other things you *know* you're going to do.

UMBEHR: Right.

WOODS: Insurance is traditionally for things you don't expect to happen. And this seems to have gotten started as a result of a peculiar feature of the tax code – that during World War II, when the wage and price controls were in effect, you couldn't attract additional labor by raising wages because it was illegal to do so, but you could offer fringe benefits, which in some cases amounted to having your health care paid for pre-tax, and then this became a demand that labor unions had for the future, and it wound up embedded in the whole system.

I do want to ask you before we wrap up: how is Obamacare going to affect the kind of practice you have?

UMBEHR: Well, slightly tongue-in-cheek, I'm probably one of the few physicians excited about the Affordable Care Act, because – and this is less Obama; Bush was no friend of the free market at the end of his eight years. Every politician raises the cost of government and health care and bureaucracy and regulation, so it was broken before Obama; it'll be broken after him. But he is speeding it up. The Affordable Care Act is complicating the delivery of care so much that it's driving doctors out of practice. It's making insurance go up 40 percent a year. In Kansas, Blue Cross has quoted that their average increase will be 37 percent going into 2016, because we're insuring too much. So as insurance continues to go up based in large part because of government reform – and we haven't raised our prices in five years: $10 for kids, $50 per month for all the access that we offer – the delta continually looks better in our favor.

In fact, I don't know if our model would succeed in an economic high point, because as incomes are high, there's no need to change. People are comfortable with the status quo as long as they can afford the status quo. We almost need some turbulence in the market for people to see the value of innovation. And if I tried to sell you car insurance that's structured like health insurance now, you wouldn't take it. It wouldn't make any sense. But we stay in the status quo of health care because that's the way we've always done it.

So the Affordable Care Act is providing some amount of pressure to incentivize people to look for more logical, more affordable, more commonsense options for insuring their high-risk health care and for paying for the rest of their health care from doctors who practice insurance-free models like ourselves – so that now, instead of paying a $25 or $30 copay for a $50 blood test, they pay the doctor directly $1.64 for that same blood test and don't insure that and pocket the savings. So a down economy, increasing government regulation, increasing business stress – because of compliance with a bloated, bureaucratic regulatory system – all of

that drives doctors, patients, employers, and even the insurance to a model like this. That pain point has now hit every key player in the health care system to the point that they are actively seeking out innovative solutions to survive.

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Chapter 3

Where to Find Extremely Affordable Health Coverage – and It Isn't Obamacare (with Dale Bellis)

Dale Bellis is executive director of Liberty HealthShare. This was episode 165 of the Tom Woods Show.

WOODS: Tell us about Liberty HealthShare.

BELLIS: Liberty HealthShare is a national, non-profit community of like-minded Americans who simply have chosen to share each other's medical costs. So without the help of an insurance company or the government we mutually share our costs together, and it's a systematic method that's dependable and transparent and very cost effective.

WOODS: And also exempt from the Affordable Care Act – so-called Obamacare.

BELLIS: Yes, thankfully built into the Affordable Care Act is an exemption for what it calls a healthcare sharing ministry. And so based upon certain religious perspectives and exemptions we're able to do this within the confines of the Affordable Care Act and not be subject to any fines or penalties for not having insurance, because we're all self-paid patients. It's not an insurance program. It's just mutual assistance to one another, and it works beautifully.

WOODS: So even before Obamacare came along, you guys were exempt from whatever regulations, whatever bureaucratic structure exists to oversee the insurance industry.

BELLIS: Yes, we are a group of health-conscious Americans who have practiced time-tested principles Christians have been observing for over 30 years about their healthcare, and we've been in existence and actively sharing expenses together since before 1990.

WOODS: How does this work? Suppose I join, and I have some medical procedure. I submit it to you, and then – what? Have you done the actuarial estimates, so you can anticipate what everybody's monthly payment ought to be, or does everybody's monthly payment fluctuate on the basis of how many people are having procedures that month?

BELLIS: We calculate on an annual basis what our monthly share amount is going to be, so it doesn't change month to month. So each month everyone's share is matched to another member's medical expenses. With our secure, online technology you send that predetermined share amount directly to another member who has the medical expenses. Depending on whether you are single or a couple or a family, we have set share amounts for those different categories. Should ever you have medical costs, a sufficient number of singles, couples, or families are directed to contribute their monthly share amount directly to you equal to your expenses.

WOODS: How do your monthly rates compare to the monthly premium somebody would pay with traditional insurance?

BELLIS: Well, it is far less costly. We're able to share our medical expenses together for several reasons, and I can go through those, but for several reasons we're far lower than the ordinary health-care costs out there. We share medical bills after a modest amount we agree to be responsible for; once that (quite low) threshold is met, sharing commences. Up to a million dollars per incident is $199 monthly for a single person, $299 for a couple, $449 for a family.

We find that one of the side benefits of choosing our own way in terms of managing and directing our own health care is that we cut out a lot of the overhead costs, and the middleman expense, and minimize the expenses of health care significantly.

WOODS: Explain further how you're able to keep costs down.

BELLIS: One reason is that we share the actual medical expenses of our members. That is, we do not do actuarial projections (which are typically an inflated number) as traditional insurance companies do. So whenever a member has an expense, we share the actual cost as opposed to some projected amount in the future. And secondly, our members access a very rigorous medical discount system. We enjoy about a 50 to 60 percent discount on our medical bills. So we end up sharing the true cost of health care, not an inflated retail cost. And we keep our costs down by attracting health-conscious people. Now, you notice I didn't say healthy people but health-conscious people – people who take responsibility for their health. So our costs are just a whole lot lower.

WOODS: I still can't help thinking about my own situation, though. For instance, we just had a baby, and the baby had to be in neonatal intensive care for 11 days. In our view, by the way, she didn't need to be there. They claimed they needed to watch to make sure she could gain weight. My wife, who has a lot of experience with children, said, "I'm pretty sure if I bring her home, she'll gain weight." Well, of course, she has flourished and gained far more weight at home than she did in the hospital, just as my wife predicted.

BELLIS: Well, that's exciting to hear.

WOODS: But apparently, all things considered, we racked up a bill of $42,000. Now when I get the Blue Cross statement and I look at the breakdown, some of it is paid for by insurance, but there's another very, very substantial section: contractual provider write-off. In other words, there's an agreement between the insurance company and the provider that we're a big insurance company, so you're just going to lower that fee way, way down, and then we'll pay the remainder. As a result, our out-of-pocket expense wound up being a little over $3,000 – when the original bill had been $42,000. How could you guys save so much money in this way that you could comparably reduce a bill like that?

BELLIS: We have created a reimbursement system to our providers, doctors, hospitals, ancillaries that our medical doctors readily and quickly and gratefully accept that basically creates a value for every medical procedure known to mankind. There are thousands of those medical procedures. We've assigned a value to them, and we communicate in advance

to our provider: here is our reimbursement schedule. We're a group of individuals who are all self-paid patients but we're sharing our bills, and here's how we reimburse. And they readily, happily accept it. It eliminates the overhead cost of having to argue with an insurance company.

Every doctor and hospital runs a report every month as to the reimbursements they are not going to receive from the insurance company because they submitted the claims in some way that fell outside the contract. They get stuck with the bill in those cases. None of that stuff with us. We don't require administrative overhead with a group of people calling up a gatekeeper trying to get permission on stuff. It just eliminates their costs. It helps us maintain the efficiency and cost-effectiveness so that we're accessing the true cost of health care and our providers readily participate and accept it.

WOODS: How many people would you estimate are pursuing this, let's say, non-traditional approach to medical provision?

BELLIS: In the United States today there are about 150,000 households who are sharing their medical bills together on a voluntary, cooperative basis. There are a number of cost-sharing ministry groups out there. We are somewhat different from the others in that we have a much more robust online technology that we use as opposed to the mail. So your share amount's going online to another member's online account. That's number one. But number two, while we are spiritually based, we do not impose a specific faith requirement on our members because we want to make it as broad based and as open to as many as we can.

WOODS: That was going to be one of my questions, whether members have to be religious in general, Christian in particular, or neither?

BELLIS: Well, they do need to be religious in general. Anyone can participate with us who joins in with agreeing with our shared beliefs. I can run through those quickly in a moment. But one of our most fundamental is that our rights, our liberties, our freedoms as individuals come from God. They don't come from an agency of man or from the government. So it would be somewhat difficult to be an atheist and join our group. But it is a shared belief on which our entire nation was founded. It's a fundamental, core belief both with our group and those who were our Founding Fathers, who believed our rights came from God.

WOODS: The reason you're able to do what you're doing is that there is a religious, I don't know if exemption is quite the right word, but—

BELLIS: It is. Yes, that's the correct word, Tom.

WOODS: Okay, so there is a religious exemption in Obamacare and from general regulation pertaining to insurance because, as you say, it's not strictly an insurance program. It doesn't follow the principles of insurance. It's a sharing program. But if you had just said, we want to have a program where we share medical expenses and we're a bunch of healthy people, and we want to share medical expenses, they would not allow you to do that. Is that what you're telling me?

BELLIS: That's correct. The Affordable Care Act requires that there be a set of shared religious or ethical beliefs. And our belief system is basically the following five points. One, that our rights rather come from God. Two, that we have the right to worship as we choose. Three, that we have the right and spiritual obligation to help our fellow man when he is in need. Four, we have the right – and again, the obligation – to maintain a healthy lifestyle and treat our bodies in ways that don't produce sickness or disease. And five, that we have the right to administer and direct our own health care free from government intervention and oversight. Those are our religious and ethical beliefs.

WOODS: Do you make any effort to get testimonials from people or documentation that they are registered with a church, or anything of that nature? Or do you more or less take them at their word?

BELLIS: We take them at their word. It's an honor system, and they just simply sign off on those shared beliefs, and we welcome anyone who wishes to join.

WOODS: Has there been an increase in interest in what you're doing since Obamacare came onto the scene?

BELLIS: Oh, there's been a dramatic increase of interest.

WOODS: Are you concerned that this dramatic increase in interest in what you're doing, and, I am sure, to some extent also an increase in public awareness of what you're doing and exposure to what you're doing may be a double-edged sword? On the one hand, it's wonderful to have more members, and it makes the program work better the more members there are. But on the other hand, the more visible you become the more the totalitarians in our midst realize, wait a minute, there's one small sliver of mankind that hasn't been subjected to our stultifying rules. Are you concerned about that?

BELLIS: Well, while it's true that the Affordable Care Act gives us this basis or this platform on which to operate, and we are open to anyone who will join in with us on our shared beliefs, frankly, Tom, it's not for everybody because it is a change of mindset regarding health care and how health care is paid for. It's really a paradigm shift. We believe that one must change from simply having someone else take care of us, and instead take responsibility and be focused on caring for ourselves. And as self-paid patients, we direct and manage our own health care. So rather than receiving from a third party out there, with someone else taking care of the bill, we focus on our own costs, our own treatments, our own expenses, and we share them together. That's an entirely different mindset. It's frankly not for everybody – not everyone identifies with that approach to health care and the way in which we should meet those expenses.

WOODS: That's true. On the other hand, I would say my audience, vastly out of proportion to its numbers –

BELLIS: Well, then we welcome them all.

WOODS: Exactly; it's going to have a lot of people who think about their entire lives in exactly that way, not just medical care. Before we wrap up, what have I left out that we should talk about about this?

BELLIS: Well, just the fact that we exist for health-conscious Americans, and when you join, number one, your costs will remain low because that's our primary objective, to do it in a cost-efficient way. Number two, you'll know where your money is going because we have a very transparent online sharing system, and every month you see exactly where your share amount is going – to a fellow member whom you can message with encouragement, with cheer, with prayer. So not only do we take care of each other's medical costs, but we also give each other a hug in the middle of life's most incredibly difficult crises. What's more, you'll be able to make your own health care decisions, and you can choose any doctor or hospital you please. Check us out at LibertyHealthShare.org, or give us a call at 855-58-LIBERTY.

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Chapter 4

Obamacare and Medicare: A Physician's View
(with Jane Orient)

Dr. Jane Orient received her M.D. from the Columbia University College of Physicians and Surgeons, and has served as executive director of the Association of American Physicians and Surgeons. This is drawn from episode 147 of the Tom Woods Show.

WOODS: Some people are concerned about those with pre-existing conditions, and the difficulties they would have getting health coverage without something like Obamacare. How do you answer that?

ORIENT: Well, it is a problem that was created by the government, by having a system of insurance that is exempt from taxation, if and only if it's bought by your employer. So every time you change jobs, you have to be underwritten again. So at any time during your life you could develop a pre-existing condition. What we really need is a sort of insurance that is non-cancelable. You buy the insurance, and you keep it in force continually. We don't cancel it just because you develop a condition. So there's only the pre-existing condition once. And if you're responsible you pay insurance when you're young and healthy, and then you keep it in force all the time. But there's no incentive to do that under Obama's plan or under the ill-advised plans in states like New York and New Jersey that say, oh, we can't charge you for pre-existing conditions. That would be mean. We'll charge everybody the same thing for the policy with maybe some age bands or something. This means that it's stupid to buy insurance before you're sick because you can buy it at the same price once you get sick.

WOODS: Haven't they tried to cope with that problem by saying there's a limited range of sign-up periods during the year, thereby limiting people trying this strategy?

ORIENT: Yes, that's called the open enrollment policy, and in fact, that's what companies are doing under Obama's plan, so they can't charge extra for people who are sicker. They are saying the market is now closed until November to get coverage in 2015 unless you've changed jobs, or you've gotten married or had a child, or had some other life-changing event. So they have restricted signups to a very narrow range of time.

WOODS: Now, I can understand how the general public is affected by Obamacare. I can see what it's going to do to insurance companies. I can see all the incentives that are created there. But what's it like on the other side of things? What's it like being a physician and having the prospect of Obamacare, but then also all the other various interventions by government? How does that affect the practice of medicine by a physician?

ORIENT: If a physician participates in insurance panels – most of them do, although more and more of them are wising up – it means that their ability to do their job is increasingly constrained. They are constantly filling out forms, looking at changes in a little bit of

regulation, trying to comply with just really intrusive and meaningless, and onerous, and costly documentation requirements. They don't have time to listen to their patients. They can be punished for offering what the bureaucrats consider to be too much treatment or the wrong treatment for their patients. So many of them are quitting their independent practice. They can't afford to keep them open. And they are going with a big institution and just following orders just so they can get their paycheck until the time comes when they can retire. So we're going to have patients, maybe some of them will realize what's happening and some of them won't. But they are going to be getting care that might as well be rendered by a robot. But it's worse than that. It's rendered by someone who has a conflict of interest and who may be sacrificing his own financial stability, or maybe his own career, if he does what he believes is right for a patient.

WOODS: What would be an example of a physician who would be conflicted between doing what's right for a patient and abiding by government regulations?

ORIENT: Well, he will be considered an outlier if the codes he submits, the number of treatments that he does, are more than average, and that means that either he will be penalized by having a so-called bonus withheld, or he might just be stricken off the panel, saying, you know, you're just not a team player. You're costing us too much money. We're not getting any savings, which can only come about by restricting care, so you're out of here. Once that happens, he could find his ability to work for anybody else diminished or canceled. Physicians are very well aware of this, and it gets incorporated into their own thinking that if they do something that will be considered a little too much or a little above average, they could suffer.

WOODS: I had been under the impression that because of third-party payments, because almost everybody has medical insurance, and the cost of procedures gets submitted to these third-party payers – that the problem was not one of physicians who were ordering too many tests or offering too many treatments getting into trouble for doing so. I thought the problem was that they ordered too many of these things in the first place because they knew that there's some third-party payer that'll pick up the tab.

ORIENT: Oh, you're exactly right. This is a corrupting influence of nobody being responsible for his own bill. But the control mechanisms that are instituted to try to cope with that problem, managed care, puts all the incentives the other way.

WOODS: I see. Now what about the response though that for all the bureaucratic inconvenience that this causes, and for all the transformation of physicians into robots, this is still a small price to pay for getting medical care for all our poor and elderly?

ORIENT: Well, in the first place, it's not medical care, and the second place, it's not going to all our poor and elderly. It's restricting the total amount of care that can be delivered. It may be driving out of business the independent doctors who care the most, the most skillful, the most accomplished. It may be shutting down the institutions that really care about patients and just leading to generalized shortages, which means that there's less and less care available and of poorer and poorer quality. So how can you say that that's an advantage?

WOODS: Well, tell me about this. I read anecdotal pieces about physicians who have more or less dropped out of the mainstream system of accepting third-party payment, and they will just put a sign in the window and say, this is a cash-only practice and it's $35 a visit for a standard visit, and they've got some kind of price schedule that's easy to access. What are the benefits of doing that? And is there going to be an acceleration of this?

ORIENT: I hope so. These are real-life stories of real-life physicians, who instead of just caving in and going to work for a big institution or of hanging up the shingle altogether, decide to go back to the old-fashioned way of working for their patients. The advantages are that they can save so much in their overhead that they can keep their prices very low. They can spend all their time doing things that benefit a patient and don't spend their time doing mindless, stupid, repetitious, absurd, counterproductive busywork to satisfy the bean counters. They love their profession again. The patients love it because the doctors are looking at them and talking to them and spending more time with them, and the prices are quite reasonable, and they can figure out what's going on. The prices are known ahead of time, and it's just a really terrific deal.

WOODS: What about Medicare and Medicaid? There are a lot of people who say they favor a free- market approach to medicine, so we need to repeal Obamacare, but Medicare and Medicaid are the elephants in the living room that are not, of course, free market. They are government programs. But you very, very rarely, if ever, hear a prominent free-market person saying that this means we'll have to scrap or substantially modify those programs. Where do you stand on those programs? And how do you defend yourself against people who say that, of course, Medicare and Medicaid have kept countless people alive who would have had no access to anything otherwise?

ORIENT: Well, we were against Medicare and Medicaid to begin with. They are unconstitutional. The chairman of the House Ways and Means Committee at the time, a Democrat from Arkansas who had been chairman for decades, said he was never going to let it come to a vote because it would bankrupt the country. But then when Johnson came into power with his landslide vote, he said, "Okay, I can count." Medicare is going to crash and burn – it's just inevitable. It was unconstitutional. We are against it. We need to phase out of it so the fewest number of people get hurt, but as a matter of fact, if Obamacare is unconstitutional, so is Medicare.

WOODS: Well, then what are people supposed to do when they are elderly, and they don't have a lot of money? Now, it turns out that the wealthiest cohort in the United States happens to be the over-65s, but even if we leave that aside, think about an indigent 65-year-old man, let's say. He has got no hope of getting medical care. He doesn't care about your constitutional objection.

ORIENT: Well, back before 1965 people were not dying in the streets. Half of the elderly had good private insurance plans, and they were really angry when President Johnson got them canceled for them. The others had access to care through charitable institutions, through their state or county, or just through charity by doctors and hospitals. As soon as Medicare went into effect, the price of medical services doubled or tripled overnight, so it

was much more difficult for people to afford them, and as I say, all of the private insurance plans were gone. So immediately this had a bad effect on medical care for everybody. To say that we have to magically do away with poverty and illness and the need to be charitable to our fellow man, or else we're going to stuck with a miserable socialist system, is just accepting a terrible, terribly flawed assumption.

WOODS: What would you say to people who respond by pointing to the various government-run health programs around the world and who will say, yeah, yeah, you get some horror stories about rationing and wait lists, but if you ask these people, if you poll them, they are all basically pretty happy with those systems, so if anything, we should be more radical than Obamacare and try to adopt some of these successful systems from Europe.

ORIENT: Every time I give a talk there's somebody in the audience that says, "Oh, I know some Canadians. I was a Canadian. It's a wonderful system." And if you poll the people, yeah, a lot of them are in favor of it because they're not sick. They are not lying in a hospital bed or sick. The vast majority of people aren't sick. And they can say well, I don't have to worry about a medical bill because it will be paid for, assuming you can get any medical care, but in Canada there's even a lottery for people to get a primary physician, and without a primary physician you can't see a specialist at all, and even if you do there are long waiting periods, and there are people who die on the waiting list. In Britain there are people who are starved to death in the hospital because there is nobody to feed them or to even take reasonably decent care of them, and these things, they are just not well covered in the press. If you even quote the British press, people will say, oh, I don't know about that. That must just be the right-wing propagandists casting mud on the National Health Service. Everybody knows it's a beautiful, wonderful system that we ought to have. But I think if you have been sick, or you have been in one of those hospitals, or you have been the family member of somebody who's been in one of them, then you see a different picture, but people will say, oh, you're just telling us anecdotes.

WOODS: We learned not long ago about VA hospitals in the U.S. – I think there was one in Arizona, for instance, in which their publicly stated policy is that no veteran who goes in for care will have to wait more than X number of days to get it, something like 30 days. But then they realized that they can make those public policies all they want, but they are coming up against the limitations of resources. So they established a secret waiting list so they didn't have to admit they were violating their officially stated policy. These secret lists, they had hundreds of people who were on them for months and months who then died because they were waiting for treatment. So you can speak all you want to about your wonderful policy of seeing everybody promptly, but you know what they say about actions speaking louder than words.

ORIENT: Well, the government routinely lies. I mean how many times do they have to lie to us before we finally get the idea that that is just their modus operandi? I worked at the VA after I finished residency for about five years, and our job was to be the gatekeeper and to kick veterans out after they had waited all day if they were not seeking care for a service-connected disability. We violated it all the time, but it was against the

rules. That was our role as gatekeeper. These people did not get the treatment that they deserved.

WOODS: Dr. Orient, I'd like to know the story of the foundation of the Association of American Physicians and Surgeons because I think, if memory serves, it has something to do with the fact that the American Medical Association and the physicians that formed this new organization didn't see eye to eye on important matters of philosophy and ideology.

ORIENT: Yes, in 1943 the Wagner-Murray-Dingell bill was pending before Congress. (That was Dingell the elder, the father of Dingell the younger, who was the power behind Obamacare.) The AMA was not fighting it, so a number of AMA members set up this parallel organization maybe to be the conscience of the AMA and to do the political work opposing socialized medicine that the AMA was declining to do that point. The AMA did come around and did something to fight Medicare in 1965, but after Medicare passed, the AMA just continually moved leftward, so it endorsed Obamacare even though it lost a big chunk of its members when it decided to do so.

WOODS: Let me ask you a very frank question as we wrap up. Of course, you are in a beautiful profession, and we all admire what it is you do, but surveying the situation right now and taking into account what a young physician is likely to experience over the course of his career, do you advise young people to enter medicine anyway and just fight the SOBs from within the profession? Or do you advise them to do something else altogether?

ORIENT: Well, a lot of college career counselors are telling the young people – smart people don't go into pre-med. And many physicians have gone so far as to threaten to disinherit their children if they follow in their footsteps.

WOODS: Wow!

ORIENT: Many children are deciding they don't want to follow in daddy's footsteps because his life is so hard, and he's so frustrated, and it's becoming harder and harder for him to do his job. I tell medical students, frankly, if it's your vocation, if it's your calling, if you can't not do it, and you are doing it for love, don't let anybody stop you, but if you're going into it hoping that you'll be respected and make a good living and can always count on that, you've got to think twice about that, because doctors are the villains these days. They are the scapegoats.

WOODS: Are there any areas of medicine where the doctor is somewhat freer to practice the way a normal doctor would like to practice, or they all uniformly the same?

ORIENT: There are some that are worse. The ones that are the very worst are things like kidney disease and ophthalmology, because all in-stage renal failure is on Medicare. A high percentage of eye patients are elderly, and so almost all of the doctor's livelihood comes from these government programs. What doctors are doing more and more is going into more alternative, niche practices of medicine where they can still charge their patients what the service is worth – plastic surgery, or just plain alternative, more holistic medicine. A lot of psychiatrists are opted out of Medicare and Medicaid.

WOODS: So this might be information that somebody who does want to enter medicine might want to bear in mind. Now, I have a fairly diverse audience listening in. I am sure I have a cohort of physicians listening in. Why should they join the Association of American Physicians and Surgeons?

ORIENT: AAPS is the only medical organization that's really based on principle. We do not have any business interests. We are not on the take for selling materials to comply with government regulations or to promote managed care or pharmaceuticals. So we do truly represent the views of our members as they were based on principles of the old-fashioned, pre-revolutionary medicine, the sanctity of the patient/physician relationship. And we fight for our members. We fight against sham peer review. We fight against increasingly intrusive bureaucratic attempts like maintenance of certification. We fight against prosecution of physicians for acting in their own best judgment, which is happening more and more. We fight against threats to one's ability to opt out of Medicare or to opt out of insurance. We provide tools for physicians to maintain a truly independent practice. So if you are a private physician, you believe in the patient/physician relationship? AAPS is your organization.

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Chapter 5

Market Medicine
(with Charles Sauer)

Charles Sauer is executive director of the Free Market Medical Association. This was episode 191 of the Tom Woods Show.

WOODS: You have a brand new, free-market medical organization. How are you different from the Association of American Physicians and Surgeons?

SAUER: I am an economist, so I tend to look at things that way. We are definitely not competitors with the Association of American Physicians and Surgeons, and I work with them through another business. But the AAPS is focused on creating physicians that will opt out of the system and become third-party-free. And through the Free Market Medical Association what we're looking to do is bring in the physicians that are third-party-free and some that are looking to become third-party-free, or at least host their prices and link them up with also the buyers and purchasers and the other people that are looking to work in the health-care market. So we are working with doctors like Keith Smith, the co-founder of the Surgery Center of Oklahoma. We're also working with Jay Kempton, who is the head of the Kempton Group. They are a third-party administrator. So they work with a bunch of banks and self-insured businesses throughout Oklahoma and Texas, and they do the insurance administration. So they work with a lot of the Keith Smiths and the other free-market physicians in the area to give their businesses a better deal. So we are kind of the umbrella for the health-care free market.

WOODS: The website is marketmedicine.org. Is this an organization primarily for physicians, then? Or is it somewhere that just a layman who is interested in free-market medicine might get information?

SAUER: It's an all-of-the-above organization. I'm in Washington, D.C., and for the past 10 years I've been walking the halls of Congress trying to convince members and staff that free-market health care is the way to go. If you give the patient money, and they give that money to the physician, you end up getting more access to care and higher-quality care. And almost at every turn they keep saying that free markets just won't work in health care. I knew that to be untrue. I knew there were doctors who were out there doing it, and statisticians always talked about them. They were called islands of excellence.

So our goal here is to give up on Congress for the time being and build the free market. So that is the Joe Everybody on the street, the Main Street guy who is searching for health care by himself, or as Sean Parnell calls him, the self-pay patient. That's also working with the self-insured company, and then the service providers within that, and the doctors. So it's kind of everybody. Our focus right now is on self-insured business and health care providers.

WOODS: Now when you say third-party-free, of course, you're talking about physicians who want to get out from under the insurance companies and just deal directly with the patient. Am I understanding that correctly?

SAUER: Correct.

WOODS: Isn't that going to become a dying breed in the age of Obama, in which people are going to be penalized if they as patients are third-party-free?

SAUER: There's a kind of a weird opt-out that I think is where we're going to see a lot of growth in the market, and where we're going to see a robust argument and defense against Obamacare grow. And that's the self-insured businesses. For a lot of people it makes economic sense to go ahead and pay the fine in Obamacare and insure themselves or become a self-pay patient. And that actually comes from the fact that it was believed politically expedient to just not raise the fine high enough to where it would make economic sense to not pay the fine and get an Obamacare plan that doesn't provide as much access to cheap care as just insuring yourself would. But since the economics of that are actually on the margins, there's not a lot of people that I see that are going to drive a free market in individual health care. However, there are a lot of self-insured companies out there, and those self-insured companies have a lot of employees, and just them alone, we can drive the numbers that we need to prove that free markets work. So for instance, one of my favorite stories recently is Oklahoma County, an actual government entity in Oklahoma – they are a self-insured county, and their third-party administrator talked to Dr. Smith, and so then he made an arrangement. It was about two months ago. And in the first three weeks of their contract Dr. Smith has saved Oklahoma County $140,000. So the key here is being able to get numbers like this and drive numbers. Jake Jason saved his small businesses that he worked for I believe $1.2 million in the first quarter of 2013. As these numbers start building, the federal government to local governments and individuals and business owners won't be able to stop the growth of the free market.

WOODS: I can understand why looking at society in general we might want to avoid the third-party system because it seems to impose fewer burdens on society, fewer misallocations, fewer distortions in our decision-making about the kind of health care we need. But why is it, from the point of view of the individual physician, that it would be a good thing to get out from under the system? In catering to people, or firms, or whatever, who aren't dealing in the whole third-party system, aren't I artificially limiting my market?

SAUER: It has to do with how do you want to practice medicine. Do you want to practice medicine for the patient, or do you want to practice medicine for a company or a third party? My favorite doctor on this is Dr. Juliette Madrigal Dersch. She's outside of Austin, Texas. And she gives discounts to patients if they come in with spurs. If you get cancer, she treats you and your family for free. She'll make house calls. And all of this is legal because she doesn't participate, or she doesn't bill CMS, which is what the actual law is on that. She calls it slavery. If she couldn't run her business the way she wanted to, or charge the price she wanted to, then it wouldn't work. And you see that going through the system. Third parties dictate how the doctors have to run their practices, how much they can charge their

patients – and how much they can charge their patients also means how long they can stay with them. So Dr. Madrigal gets to spend more time with her patients. She gets to really learn what their problems are, what their issues are, and take care of them.

And that money does other things, too. When you directly pay your doctor, they have a higher incentive not to have you wait. Dr. Smith has almost no waiting time. If you call him today, you can get in tomorrow for a surgery. That's starting to become untrue as he becomes more popular, but he's speaking then of raising his prices or expanding the practice. Both choices become a possibility. So yeah, in some ways in the current market – which is why economically they are called islands of excellence, because some of the decisions have to be outside of the economics. They have to be personal for a doctor to opt out now. But the joy that you see once a doctor has opted out that they actually get to take care of the patients and restore the patient-physician relationship is just something that almost no amount of money can buy. Doctors are not rationing by prices. They are rationing by lines. So no matter what, every doctor is just running circles if they have a third-party practice nowadays. They just don't get enough money. They are forced to run circles while they are at work.

WOODS: What is your sense of where the average physician stands on this? Has there been an evolution in thought among a lot of physicians? Are many of them too busy really to think about fundamental questions like this? Is there a slow but sure movement in your direction? What do you think the trend is?

SAUER: Oh, it's an interesting question. I think the people that are going third-party-free right now are the entrepreneurs. One of the newer groups, Atlas MD in Wichita, Kansas, is a concierge practice, but they are in the middle of Wichita, Kansas, so they are not catering to the rich. They charge $10 a month, I believe, if you're under 18, and for most adults it's $50 a month. This is a different type of care, but it's what they did when they came out. I don't know if entrepreneurs are 1% of the population or 3% of the population. It's a low percent of the population and the people that are willing to take a risk and get out there on the edge, and so that's the group that we're seeing doing it.

I think that as the argument builds, as they see that through Obamacare prices will continue to increase and access will continue to be limited, more physicians – who become physicians because they want to take care of people – will figure out ways to take care of their patients, and that will be through the free market.

WOODS: Can you tell us very quickly what a concierge service is?

SAUER: With a concierge service you pay a set price, and for that set price you get access to your doctor. It's often called direct pay. With Atlas MD you pay $50 a month, and now you have access to—one of their doctors is Dr. Doug Nunamaker. If your doctor is Dr. Doug Nunamaker, you can call him, Skype him, Twitter him, Facebook him, show up to his office. You can ask him to show up to your house as many times as you want in a month. With Atlas MD, they will give you different tests, EKGs, and whatever, in their office for free. I think they do some blood tests for free, and then they give severe discounts on medicine that can go down to like $2 a month, because they'd buy their medicine in bulk. So with a

concierge practice you pay a set fee, and you get almost unlimited access to your doctor's services. So there's no three-month wait, like in my plan.

WOODS: Charles, what do you say to people who say that before we got Obamacare, we had the kind of approach that you and the people at your institute are proposing, that we had a free market already and we saw that it didn't work? It yielded such high prices that anybody in the country, practically, would be ruined by one adverse health situation. So how can you favor going back to that?

SAUER: Well, if I talk to anybody who says we had a free market before Obamacare, I generally just move on, because they weren't paying attention to the health-care market. The health care system before Obamacare was just a little bit less socialist or a little bit less government-controlled than what Obamacare is. Obamacare is a big shift towards government-controlled health care, but it's just another step along the line. So there was no free market in health care. There were people, there were actors who were acting in a free market way within the health-care system, but the government is heavily subsidizing care and providing tax incentives to non-profit hospitals that create other incentives in the market, and the incentives are to raise your prices and negotiate down to the lowest amount for a hospital. For a doctor, there is no incentive to list their prices. For a doctor's office, there's no incentive to treat the patient as a client. The patient wasn't a client before Obamacare, and the patient is not a client now. The insurance company is the client, and the government is the client. So what we're looking to do is shift that.

One of the problems here is that this isn't a partisan issue. This is a bipartisan issue on Capitol Hill. Both parties have agreed that at least some level of government interference in the market is needed, and until we switch that and at least one party says the government is not needed, we're going to continue on this track towards more government health care. So our goal is to build the market so that Congress can eventually provide a robust argument. Of course, that's the secondary goal. Our first goal here is always going to be to provide more access in higher quality care to patients, and we see that across the board: where doctors start treating the patient as the client, we get higher quality care at lower prices almost every time.

WOODS: Now when we say "third-party-free," most people are thinking in terms of insurance companies. You're getting out from under that whole system. But another third party would be the government. So for example, when you have Medicare, Medicaid, the third party in that case is the government itself. Now, you're talking about being committed to increasing the quality of care, the availability of care, the affordability of care, and yet it would seem counterintuitive to many people that you could do that by ignoring the largest welfare state programs of them all, namely in medical care. How can this seeming paradox be resolved?

SAUER: If I am climbing a mountain and I can't reach the top until I take that last step on the top, but if I start up the mountain, you can say, well, he's probably going to try to climb the mountain. So I think that those programs are off in the distance. It's going to take the most arguments to take off Medicare, to take down Medicaid. My wife is actually on Social Security disability. She had a Medicare plan, and it gives her almost no access to any doctor.

We have still a Medicare Advantage plan for her, and that doesn't have much access to anybody, and that's supposed to be better than a normal Medicare plan. So once you get a robust free market in under 65 and above whatever poverty level that Obamacare set at this point, then we can take on the government plans.

Dr. Smith, whom I keep coming back to – he's actually a co-founder of the Free Market Medical Association – has the first surgery center to post its prices online. He does a lot of charity work, though. One of my favorite of those charities is cochlear implants. I think the price for a cochlear implant at a hospital is $20,000. It might actually be $100,000. Either way, he does it for about 20% of what the so-called non-profit hospital does it for. This is a non-profit hospital that is supposed to be given this tax incentive from the government to provide better, cheaper care to people, and yet they don't, and Keith does.

He buys the cochlear implant and does that at no cost, and then they do the surgery at a severe discount, and they are available to do I believe it's five to one at his center. So once we build a free market, I think Medicare and Medicaid will fall quickly. This government top-down – they force EMRs on the doctors. Now, electronic medical records, EMR, can be a good thing. They can help doctors out. But if you're forced with a one-size-fits-all, with a certain checklist that doesn't fit a patient, or doesn't fit your practice, and yet you have to check boxes every single patient, we see a lot of errors. So where we see a doctor, and their first priority is the client, which if you're a business owner, you understand that. The client's your goal. They don't just go out and buy a random EMR. They buy an electronic medical record that will help them treat their patients better and more effectively. We have to get out from under the government's control to have any of those market actions take place.

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Chapter 6

The Self-Pay Patient
(with Sean Parnell)

Sean Parnell is the author of* The Self-Pay Patient: Affordable Health Care Choices in the Age of Obamacare. *This was episode 193 of the Tom Woods Show.

WOODS: Give us the one-minute overview of what the "self-pay patient" is.

PARNELL: A self-pay patient is simply anyone who is paying directly for some or all of his health care. My book, *The Self-Pay Patient: Affordable Healthcare Choices in the Age of Obamacare,* as well as my blog, theselfpaypatient.com, are both intended to be resources for these self-pay patients, explaining how they can find affordable health care options by going to providers and facilities that cater to self-pay patients. A lot of facilities and providers in health care are so entangled in the health insurance system that it's difficult for them to actually just give a price, certainly a fair price, to a self-pay patient. But there are people and organizations out there that cater to self-pay patients, and my book discusses all of the places where people can go to get this information and to get the health care they need.

WOODS: But why would I want to be a self-pay patient if I can go through the insurance system? No matter how convoluted and bureaucratic it is, I can still get discounted care. What interest would I have in divorcing myself from that, or is this a strategy simply for people who don't have insurance?

PARNELL: It's a strategy for anybody who wants to be in control of their health care. You're right: people can, if they want to, be a part of the bureaucratic health-care system, but I don't think that they are going to actually get much in the way of a discount. In fact, being a self-pay patient is usually going to be a lot less expensive than going through the insurance system once you start to factor in your premiums, your co-pays, your deductibles, and all of those sorts of things.

One of the things I discovered over the years – this is one of the things that spurred me to write the book – was that once you step out of the bureaucratic health-care system of third-party payment, costs actually drop. Because for every doctor a practice has in the office, they have one person whose job it is simply to submit the billing requests to the insurance companies, to haggle with the insurance companies, to argue with the insurance companies. It costs a lot of money to send paperwork back and forth from a doctor's office to the insurance company for what ultimately is a $60 or a $70 or an $80 medical bill, and that just adds costs to it. So if you can step outside of that system and just pay directly, eliminate the overhead, then it's actually much less expensive in most cases to be a self-pay patient.

Plus you get to have control over your health care. You don't have to worry about an insurance bureaucrat or even a government bureaucrat saying, no, this is not an approved treatment, or we don't cover this. You step outside of that entirely, and the relationships that self-pay patients have are directly with their doctors. There is no third-party interfering with that.

WOODS: I had a guy named Dale Bellis on the show talking about Liberty HealthShare as an example of a way that you could be more or less a self-pay patient. He is not really offering traditional insurance. He's just offering a system in which people share medical expenses together. There's an exemption for that in Obamacare. But apart from an approach like that, as Obamacare comes into effect and people are penalized for not having insurance, doesn't the role of the self-pay patient in medical care diminish or even disappear?

PARNELL: I don't think so. To be a self-pay patient means you are paying for some or all of your medical bills, and most of the policies that are being sold through Obamacare and also the direction that most employer-provided insurance is going have very high deductibles, $2,000, $3,000, $6,000. And what that means is that even though you have insurance, conventional health insurance for the catastrophic event (e.g., cancer or a serious car accident) you are still a self-pay patient when it comes to going to the emergency room with a $500 bill because you sprained your ankle, or going to the doctor because you have a cold or just the everyday, run-of-the-mill, relatively low-cost health-care events that people have. So my book is designed not just for people who are uninsured but also for people who have high-deductible plans who are going to be told by their insurance companies, hey, you want to have an MRI on your knee because it's kind of sore, well, that's on you. That's under the deductible. If patients in that type of situation simply were to go to, say, the local hospital for that MRI, they are probably going to wind up paying anywhere from three to five times – and this is for somebody who is insured – for that MRI what they might have to pay if they simply went to a stand-alone MRI clinic or one of the other facilities that I talk about in my book.

WOODS: I am sure you would be familiar with the Surgery Center of Oklahoma.

PARNELL: I am very familiar with the Surgery Center of Oklahoma. I probably mention them at least once or twice a month on my blog.

WOODS: Explain the significance of what they are doing. Do you think there's going to be more or less of this in the future?

PARNELL: What the Surgery Center of Oklahoma does is very simple. They offer what is essentially what I call all-inclusive pricing, meaning that if you need a hernia repair operation, you go to their website, and there are four or five different types of hernia repair operations, and you see a single, all-inclusive price. That means it includes the surgeon, facility fee, the anesthesiologist, everything.

This is in contrast to your local hospital, or really any other hospital in the country, where a hernia repair operation might literally generate hundreds of lines of codes that are pretty

much indecipherable and probably filled with a lot of errors, and it's probably inflated well beyond what you would pay for at the Surgery Center of Oklahoma. So what they've done at Surgery Center of Oklahoma is just offer a flat price. You come in, you get the treatment, you pay for it, and you're done. There's no having to figure out five months down the road, did the nurse really come in and deliver this medicine three times that day or four times that day, because I am getting charged for four times that day. You don't have to worry about any of that. Furthermore, because these are fairly simple cash prices that they are offering for people who are self-pay who don't have insurance, who don't have access to the pre-negotiated rates that a lot of insurance companies do, unfortunately what happens at most hospitals is they charge wildly inflated prices to the uninsured.

So a hernia repair surgery that might cost $3,5000 at Surgery Center of Oklahoma – if you go to a major hospital in Brooklyn, or Los Angeles, or Topeka, Kansas, they are probably going to charge you $15,000, maybe $20,000 for that because of their frankly bizarre pricing strategies. So what Surgery Center of Oklahoma has done is to say, okay, we're just going to charge people a fair price, a simple price. And they are doing very well by it.

I do think that it is going to grow. Again, when you get back to the issue of Obamacare and the high deductibles – and I am a fan of high deductibles, but they can be kind of startling to people at first – I think that as more and more people wind up in these high-deductible plans, they are going to be looking for places they can go like Surgery Center of Oklahoma where they can simply get a fair price, and know that they are not going to be haggling over 13 out of 28 line items on their bill five months after the surgery was done.

WOODS: You have a section here called "Options for Employers." What options do employers in fact have? Certainly their options have been diminished.

PARNELL: I'll preface this by saying that anybody who is an employer and who is looking for ways to sort of opt-out or at least limit the role of bureaucratic medicine and the health-care benefits they provide their employees really needs to talk with a professional benefits administrator or a health insurance broker. That said, I think I can offer a few thoughts on what I have seen being done that people can follow up with. One of the misunderstood aspects of the Affordable Care Act is that employers are required by law to offer a very rich benefits package. And while generally there is some benefit to doing that, there are some ways to get around it that basically allow employers to still design benefit plans that meet the needs of their employees but that don't conform with the very high (and expensive) standards that Obamacare would like to impose.

Basically, it's a matter of finding a benefit package that works and then accepting that maybe a few of your employees will then wind up going to the Affordable Care Act exchanges and getting the coverage, and that that might result in a small penalty. But that's probably going to be much less than (1) the decision for a large employer not to offer health insurance at all, or (2) the decision to offer a plan that does comply with all of the Affordable Care Act's requirements. So it's kind of convoluted, and as I said, you do need to talk to a benefits professional. I usually recommend that people talk with Ralph Weber of Route Three Benefits in Tennessee. He's pioneered a lot of the work that people are doing to

find creative ways to get out of the Affordable Care Act's supposed requirements on employers.

WOODS: So we can see, then, reasons that patients themselves as well as employers might favor the kind of alternative strategies that you are advocating, but how about the physicians themselves? What are the benefits to physicians of dealing with self-pay patients, and secondly, if such benefits do exist, why are such physicians so few and far between?

PARNELL: The main benefits, and I guess it's from talking to a number of physicians, but the main benefits to them in dealing with self-pay patients really are twofold. One is that they get payment immediately, and they don't have the overhead expense associated with having to go through an insurance company. There are no requirements that they document their patients in certain ways. They don't have to become experts in the billing codes that each company requires. They are able to simply accept payment for the services that they provide, and that's it.

The other benefit to doctors, and this is what I hear probably more even than the financial benefit, is they get to practice medicine. It's just them and their patient. They don't have an insurance company saying, no, we don't cover that. Or you need to get pre-authorization before we'll allow you to do this. It's restored the doctor-patient relationship and eliminated the third-party interference that doctors have been complaining about for a long time.

I used to work for the congressman who was the author of the Patient's Bill of Rights back in the late '90s and early 2000s, and while that bill had its issues, one of the things that was very, very clear is that doctors were extremely unhappy with the degree to which insurance companies were interfering in that doctor-patient relationship. That's sort of a necessary thing if you're going to have a third-party payer system, and it's why I tell people: if you don't want third-party interference in your health care, then move away from a third-party payer system.

WOODS: Any parting words of advice?

PARNELL: My biggest advice is that if you want to save money on health care, and if you don't want to be part of the bureaucratic health care system, I think people should really consider becoming a self-pay patient. It's not for everybody, but I think most people would benefit from this sort of system. I would really, strongly encourage people to consider their options and, most of all, just understand that they do have options. That's one of the biggest myths out there, which is another one of the things that spurred me to write this book. People think that since the Affordable Care Act passed, they're stuck with it. They have to be part of that system. They don't. They can opt out, and they can opt out in such a way, as my book describes and the blog expands on, that they still have protection against major medical expenses, which everybody should be concerned about, and also still be able to find affordable health care for the run-of-the-mill stuff that they have to pay for out of pocket.

If you enjoyed this chapter, you'll love the Tom Woods Show, where I release content like this every weekday. Check out the full list of episodes, along with links to subscribe to the show for free, at tomwoods.com/episodes.

Notes

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13. Pipes, *The Truth About Obamacare*, 183-84.
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18. Peterson, *Running on Empty*, 128.
19. David T. Beito, *From Mutual Aid to the Welfare State: Fraternal Societies and Social Services, 1890-1967* (Chapel Hill: University of North Carolina Press, 2000).
20. Allen J. Matusow, *The Unraveling of America: A History of Liberalism in the 1960s* (Athens, GA: University of Georgia Press, 2009 [1984]), 230, 231- 32.
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About Tom Woods

Tom Woods is a senior fellow of the Mises Institute and host of The Tom Woods Show, which releases a new episode every weekday. He holds a bachelor's degree in history from Harvard and his master's, M.Phil., and Ph.D. from Columbia University. Woods has appeared on CNBC, MSNBC, FOX News Channel, FOX Business Network, C-SPAN, and Bloomberg Television, among other outlets, and has been a guest on hundreds of radio programs, including National Public Radio, the Dennis Miller Show, the Michael Reagan Show, the Dennis Prager Show, and the Michael Medved Show.

Woods is the author of twelve books, most recently *Real Dissent: A Libertarian Sets Fire to the Index Card of Allowable Opinion*, *Rollback: Repealing Big Government Before the Coming Fiscal Collapse* and *Nullification: How to Resist Federal Tyranny in the 21st Century*. His other books include the *New York Times* bestsellers *Meltdown: A Free-Market Look at Why the Stock Market Collapsed, the Economy Tanked, and Government Bailouts Will Make Things Worse* (with a foreword by Ron Paul) and *The Politically Incorrect Guide to American History*, as well as *Who Killed the Constitution? The Fate of American Liberty From World War I to Barack Obama* (with Kevin R.C. Gutzman), *33 Questions About American History You're Not Supposed to Ask*, *How the Catholic Church Built Western Civilization*, *Sacred Then and Sacred Now: The Return of the Old Latin Mass*, and *The Church and the Market: A Catholic Defense of the Free Economy*. His critically acclaimed 2004 book *The Church Confronts Modernity* was recently released in paperback by Columbia University Press. Woods' books have been translated into Italian, Spanish, Polish, Lithuanian, German, Czech, Portuguese, Croatian, Slovak, Russian, Korean, Japanese, and Chinese.

Woods edited and wrote the introduction to five additional books: *Back on the Road to Serfdom: The Resurgence of Statism*, *We Who Dared to Say No to War: American Antiwar Writing from 1812 to Now* (with Murray Polner), Murray N. Rothbard's *The Betrayal of the American Right*, *The Political Writings of Rufus Choate*, and Orestes Brownson's 1875 classic *The American Republic*. He contributed the preface to *Choosing the Right College* and the foreword both to Ludwig von Mises' *Liberalism* and to Abel Upshur's *A Brief Enquiry into the True Nature and Character of Our Federal Government*. He is also the author of *Beyond Distributism*, part of the Acton Institute's Christian Social Thought Series.

Woods' writing has appeared in dozens of popular and scholarly periodicals, including the *American Historical Review*, the *Christian Science Monitor*, *Investor's Business Daily*, *Catholic Historical Review*, *Modern Age*, *American Studies*, *Intercollegiate Review*, *Catholic Social Science Review*, *Economic Affairs* (U.K.), *Quarterly Journal of Austrian Economics*, *Inside the Vatican*, *Human Events*, *University Bookman*, *Journal of Markets & Morality*, *New Oxford Review*, *Catholic World Report*, *Independent Review*, *Religion & Liberty*, *Journal of Libertarian Studies*, *Journal des Economistes et des Etudes Humaines*, *AD2000* (Australia), *Christian Order* (U.K.), and *Human Rights Review*.

Woods won the $50,000 first prize in the prestigious Templeton Enterprise Awards for 2006, given by the Intercollegiate Studies Institute and the Templeton Foundation, for his book *The Church and the Market*. He was the recipient of the 2004 O.P. Alford III Prize for Libertarian Scholarship and of an Olive W. Garvey Fellowship from the Independent Institute in 2003. He

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A contributor to six encyclopedias, Woods is co-editor of *Exploring American History: From Colonial Times to 1877*, an eleven-volume encyclopedia. He is also a contributing editor of *The American Conservative* magazine.

His primary website is TomWoods.com. He also operates a site dedicated to online entrepreneurship: HappyEarner.com.