A Modest Proposal on Health Care

Health care is a major issue in the United States this year. The biggest questions looming over health care revolve around how to insure the large uninsured segment of the population. Many groups, politicians, and others have offered their proposals. As an American citizen, I now wish to offer mine.

First, health insurers need to ensure that the people whom they are insuring are actually trying to be healthy. Towards these ends, some level of government (whether it be state or federal) needs to require that anyone who subscribes to any health insurance plan will need to have a physical once every two years. In the off-years, the insured will be required to have a check-up. The times between check-up and physical should not be less than nine months and more than one year three months. If an insured is unable to comply with these requirements without reasonable excuse, they can be summarily dropped by their insurer. To assure the insured, the insurance company will be required to fully pay for these physicals and check-ups.

The benefits to these requirements are simple: prevention and early detection of problems. People who go to their doctors more often will find problems earlier. Prevention and early detection will save the insurers, since they will not have to pay for otherwise undetected problems further on down the line.

Second, insurers need to be given the ability to deter unhealthy behaviors. Dropping an insured person from coverage should only be in the most extreme cases as a last resort. I'm focusing on allowing insurers to charge higher rates for specifically unhealthy behaviors, namely obesity, smoking, excessive drinking, drug use, and other risky behaviors. These behaviors and their standards for application would be delineated in law rather than company policy to ensure consistency and fairness to people who lead varying, occasionally unhealthy lifestyles as compared to those who lead morbidly unhealthy lifestyles.

The benefits here are that Americans are given a financial motivation to stay reasonably healthy. Healthy people generally do not require the same level of medical care as the consciously unhealthy. This should not be construed as to say that people with conditions out of their control should be affected, because that is not at all what I am saying.

Third, individuals and families need to be given more choice in health insurers. The state lines need to vanish with respect to what health insurer people may choose. This will also allow insurers to spread their risks over larger geographical areas, where healthy states can help offset costs and keep premiums down in unhealthy states.

Fourth, the insured need the security of knowing their insurance will be accepted anywhere. Either at a government level or through an industry organization, health insurers will be required to meet minimum standards of transparency, accountability, and other criteria to receive a qualification of universal acceptance. Upon meeting the minimum standards, an insurer can guarantee that the people it insures will be able to go anywhere in the country and have their insurance accepted.

Fifth, costs need to be managed at the supply side by improving and streamlining the methods and procedures by which medical facilities are compensated by Medicare. Forms are so laborious and tedious that many of them are rejected, with a significant amount never being resubmitted. This is what Medicare sees as saving money. This means that Medicare makes it hard for health care providers to get the money for the services they provided. The health care providers then need to pass the costs on to everyone that does pay, resulting in higher overall costs for

everyone. While this may not be the costliest portion of medical costs, it certainly is the easiest to resolve.

Sixth, the focus needs to shift away from employer-provided insurance to individual and family insurance plans. Employer-provided plans receive tax benefits that individual and family plans do not, meaning that the employees of the smallest businesses and the self-employed are burdened more heavily than those who receive health insurance through large employers. This field should be leveled, meaning that the same tax breaks should be provided to employer-provided plans as to individual and family plans. By focusing and encouraging more individual and family insurance, employees are guaranteed portability in their health care benefits when moving between employers and when employing themselves in the activities of small business.

Seventh, access to health care facilities needs to be widened. Hospitals are currently filling roles that are not the most appropriate, and which lead to crowding issues. A widespread system of small clinics offering basic medical care, even up to the level of the check-up mentioned above, needs to be deployed to take the load off of the hospitals, and to provide more localized points of access to health care. Government should partner with business to meet this need, and a perfect candidate for partnership would be the pharmacy chains so prevalent across the nation. Offering subsidies and assistance to these businesses to include small health clinics inside of their already health-centric facilities would provide sufficient numbers of locations, penetration into all areas, and focus on healthy lifestyles.

There are further, more ambitious components that would follow if these seven points were implemented, such as limitation on noneconomic damages in lawsuits and investment in health information technologies to streamline health care processes. These pieces would only be built upon a more stable base of a medical industry.