Skidaway Island Republican Club
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2014 BEER & BRATS RALLY - October 20
The Beer, Brats and Politics Rally is on Monday, October 20 at 5:30pm at Plantation Club Ballroom. Local Republican candidates will be available to answer questions.

Members pay $15 per person; non-members $25. Beer, brats, hot dogs and soft drinks are included; other alcoholic drinks available from a member bar.

Invite Non-members as well and introduce them to the SIRC family as possible future members. New members can join now and dues will cover all of 2015. Regular memberships are $40 a year, Sustaining Memberships $100 a year.

For reservations or more information, please contact Mary Ann Senkowski at masenkowski @ gmail.com or 598-0493. Drop checks in advance (made out to SIRC) at SIRC Treasurer Courtney Neely's mail tube at 30 Tidewater Way.

FALL ELECTION DAY NOVEMBER 4; EARLY VOTING STARTS OCTOBER 13
Vote early in person at 1117 Eisenhower Drive, up until October 31. You can also get an absentee ballot from that same Chatham County election office.

TRUE PERSPECTIVES SEMINAR Aug. 19 - Sharia Law's Effect on Women
Sharia Law's insidious inroads in the U.S. have been under the radar for most Americans. David Bores presented a shocking profile of what problems this forbodes to our country's culture and law enforcement. See article on page 2.

TEA PARTY SEMINAR September 15 - Common Core
Common Core standards have been pushed by the federal government without much public input. There are some adverse consequences. See article on page 3.

TRUE PERSPECTIVES SEMINAR September 23 - Immigration
Michael Cutler, formerly of INS, gave a riveting seminar on why most politicians have it wrong on the need for Immigration Reform. See article on pages 4-5 on why securing the border is not nearly enough and why enforcing the existing Immigration Laws are really the answer instead of Comprehensive Reform or the Dream Act.

HEALTHCARE INSURANCE REFORM
A replacement to the Affordable Care Act, based on free market principles, can be passed by Congress. It can achieve ACA's goals without a draconian federal takeover of our health care system. The details are covered on pages 6 - 11. Your comments on this proposal are welcome. Email the author at mawalters@me.com.

In this issue…

SIRC Seminar on Sharia Law – August 19

The basic theme of David Bores' riveting expose of radical Islam was that a sizable number of fanatic Muslims are committed to the destruction of Western Civilization. They have made significant inroads into the fabric of most European Countries as well as in U.S. And their insistence on implementing Sharia Law everywhere proves their unwavering intent to replace traditional Western values.

A major problem in the U.S. is that there is little general awareness of this threat. Is there willful blindness and/or willful deception by the Media and the White House? They must be aware of the findings of the 9/11 Commission: "What motivated the attackers was a seductive Jihadist Ideology rooted in Islamic law. That has been lying dormant during the decline of the Ottoman Empire, but has been revived and renewed in the Twentieth Century."

Islam's Second Jihad mandates imposing Sharia Law and the destruction of non-Muslim cultures.

The Muslim Brotherhood is a major player in their achieving this goal.

While the majority of modern Muslims are peaceful, the way to discern the radicals is their genuine goal to establish Sharia Law and their view of women's roles. Strict Sharia Law is inimical to women's rights.

What modern societal code would allow child brides, honor killings of women who are raped ("it's their fault"), beatings if women are disobedient, and general unequal application of due process for women? How can anyone espouse Sharia Law to replace U.S. law in any jurisdiction in America?

Key Slides From David Bores Presentation

GRAND JIHAD or "The Third Jihad" - Impose Shar'ia Law via Two Methods:

1. EXTREME/RADICAL JIHAD
- Overt Violence
- Foreign Terrorists—al-Qaida
- Domestic "Lone Wolves"
- Jamaat al-Fuqra in US
- Follow Jihadi-Salafisim & Wahhabism
- DIRECT ATTACK

2. PRACTICAL /STEALTH JIHAD
- Non-Violence
- "Mainstream" Front Groups Promote Islamization by Deceit & Disinformation
- Saudi Financial Backing
- Muslim Brotherhood
- Follow Salafism & Wahhabism
- INDIRECT ATTACK

Women, Honor, & Chastity

- Man's Honor = Woman's Chastity; Not Based on Personal Character of Honesty & Fidelity
- Family Honor Depends on It
- Men Considered Weak Until Honor Restored
- If Raped, Female Charged for Adultery Unless Four Male Witnesses
- Reestablishing Honor Is Man's Responsibility
  - To Save Face & Restore Social Standing
  - Murder is Legal to Protect Honor
- "…honor killing falls into perfect harmony with Muslim views of women and their sexual repression."
- Shar'ia Law: "The following are not subject to retaliation—a father or mother…for killing their offspring, or offspring's offspring."

The Real Problem: Female Sexuality & Social Order

- Males Taught to Disdain Women
  - Power of Enticement Promotes Male Lust/Weakness
  - Women Must be Dehumanized to be Tolerated
- The "Disruptive power of female sexuality" Feared --Must be Controlled or Attacked

- Fear Stems From Tribal Culture When Female Gratitude Expressed Openly & Sexually to Male Warriors
- Non-Muslim Women Viewed as Spoils of War
  - Because They Refuse Shar'ia Law
  - Punish Through Sexual Violence

Female Apartheid

- CONTROL OF WOMEN ESSENTIAL
  - Commingling with Males=Temptation & Sin
  - Leads to Fitna or "Social Disorder"
- The Fundamentalist Message that Women Are Not Valued Starts at Birth
  - Girls Considered "the fountainhead of shame"
  - Only Value is to Give Birth to Male Baby
  - Mothers Blamed for Baby's Gender

To the Fundamentalists, Love Must be Eliminated!
  - Love Between a Man and Woman Considered an Idol
  - And Detracts from True Submission to Allah
- The "Love Idol" is Removed by:
  - Forced Marriages
  - No Dating or Courtship
  - Total Isolation Until Marriage
  - Female Genital Mutilation
  - Polygamy
  - No Celebration of Valentine's Day
  - Easy Divorce

Shar'ia Law & Women - Summary

1. Personal Freedom & Liberty Limited
2. Unequal Due Process for Females
3. Physical Punishment in Marriage Sanctioned
4. Dishonor to Family Can Result in Death
5. Family Disharmony with Multiple Wives
6. Marriages Pre-Arranged
7. No Fault Rape
8. Forced Circumcision & Pedophilia.

Be Wary of Common Core - Sept. 15 Seminar

The guest speaker was Rob Cunningham who has started a group called AboutCommonCore.com. He is a former Air Force pilot and Delta pilot who is founder and EVP of the Freedom Motion Picture Group developing a soon-to-be released movie called *Washington's Axe,* based on the book *Smeared*. He also worked in the financial services industry and is a conservative commentator.

He has only recently gotten involved in the controversy surrounding Common Core and is astonished at how little the American public knows about Common Core. His judgment is that its supporters wanted it that way, i.e., a stealthy introduction of its tenets. The origin of Common Core was hidden in a little known section of the Congressional stimulus Bill in 2009 to fund the beginning of a federal takeover of our education system. What did education have to do with the Stimulus Bill's purpose? Nothing. Common Core was inserted at an opportune time without debate and without Congressional members knowing much about it. Who reads two thousand page bills that are submitted for a vote?

It began with enticing waivers to President Bush's bill – No Child Left Behind. It also now has added science and history to the math and English language alleged goals and standards. Why did the Obama Administration push it? Their progressive ideologues love the chance to indoctrinate future citizens in their worldview and shaping behavior by controlling money to schools.

David Coleman is considered the "architect" of Common Core. He is currently the president of the College Board that administers the SAT exams for college entrants. He founded a consulting company acquired by the big textbook company McGraw-Hill. His firm Student Achievement Partners, with funding from the Bill and Melinda Gates Foundation, has been developing these new standards in common Core. He is also renowned for his goal of rewriting America's history with an internationalist view and by degrading American patriotism. His method would be by controlling the testing of students and testing of teachers. If non-progressive teachers are in the system, there are ways of disqualifying them.

A stealthy introduction of this was decided by its proponents after a devastating rejection of their goals when they tried a more direct approach in California in the 1990s. Even members of the teachers unions couldn't stomach the overt anti-patriotism in its suggested curriculum. This caused the progressives to map out an entirely different approach, almost a total reversal of the one they chose in pushing ObamaCare where partisan Democrats simply ramrodded the health insurance reform through because they could. They Temporarily had control of the White House and both branches of Congress. Yet those aggressive actions were known to Americans who now are reviled over the unsavory tactics of "bribing" some hesitant congress members in some states with extra benefits to push the total vote over the top.

For Common Core, it was viewed as much better to cloak the reform in terms of a state led movement – even soliciting some Republican governors to adopt it. The approach was to entice support by tying extra federal funding to its implementation.

They also lobbied hard to get the support of the U.S. Chamber of Commerce heralding the potential job training aspects of a new curriculum and set of standards. There are some Republican notables who have drunk the "Kool-Aid" as well., e.g. Jeb Bush, Chris Christie, Nathan Deal, and possibly even Mike Huckabee. How much do they really know about the potential downsides and how much was as appeal to their sense of hope that there are potential gains from the new system

Some of the real criticisms of Common Core:

1. It's never been tested.
2. It was sold as a solution to a minor problem – children who move from state to state (very few)
3. The U.S. has fallen behind some much smaller countries such as Finland, Norway and South Korea in math proficiency. Yet the new Math standards are nowhere near what those countries use, and especially the Math standards are very new, controversial and untested.

What can be done to combat this new phenomenon before it gets too far?

Individuals can get involved in local education decisions. Nowhere is it written that school districts are compelled to use the new standards. Parent teacher organizations will become a non-entity in the future unless they wield current power they have over school districts.

Even teacher union members are opposed to what this new movement stands for, so they can be relied on as a bipartisan opponent to its adverse features.

Louisiana Governor Bobby Jindal has taken a strong stand against the new standards and he is an outspoken and likely future aspirant on the national scene.

Individual Colleges can also reject the complicity of the college entrance exam testers (ACT and SAT) in their attempts to climb on board the Common Core bandwagon in their hopes to retain relevance with the federal proponents for funding money.

Bill Gates has committed heavily to Common Core. And he is very testy when his motive is impugned because Microsoft appears to be a big winner when the new standards are adopted. Similarly, Pearson Publishing will be a big winner, as they are heavily involved in developing testing questions for the new textbooks they will likely win the bid for.

Seminar on Immigration – September 23

On Tuesday September 23, SIRC held its last True Perspectives seminar of the year at the Plantation Club using our new Skype technology. The speaker was David Cutler who gave his remarks from his office in Brooklyn, New York. It was broadcast over the internet to our audience in Savannah, with opportunities for the live audience to ask questions back to him.

Cutler spent 30 years as an agent with the Immigration and Naturalization Service (INS), now known as I.C.E. (Immigration and Customs Enforcement). As background, his mother emigrated to the United States just ahead of the Holocaust. His maternal grandmother wasn't quite so fortunate and fell victim to genocide at the hands of the Nazi's.

Immigration Laws are Systematically Ignored

In retirement he is now devoted to raising awareness of the dangers he witnessed first hand while investigating and enforcing our nation's immigration and customs laws. His overall concern is the blatant ignorance of our Constitution and existing Immigration Laws which were crafted in wisdom to protect our nation.

He was appalled, for example, when our own U.S. Justice Department (headed by Eric Holder) sued governor Jan Brewer in Arizona who was trying to uphold our immigration laws.

He is also concerned that the problem is not just securing the Mexican Border, a good idea, but the other threats that exist even after that Border were secured.

Enforce Our Original Laws on Immigration

He outlined the major and original purposes of our immigration laws enacted to keep out persons who:

1. Have dangerous diseases
2. Are violent and have major mental illnesses
3. Are terrorist threats
4. Are poor financial risks, who will be a drain on our treasury

He is therefore appalled to hear politicians (who supposedly know what Immigration regulation is designed to do) articulate arguments like "they paid taxes for the past few years, so they should be given consideration in expediting amnesty and a path to citizenship." How does that square with the whole purpose of protecting our country from inappropriate immigration?

He therefore equated the term "Comprehensive Immigration Reform" as the "Terrorist Enabling Act." How can you possibly have such sweeping new rules and still adhere to the fundamentals involved in our existing Immigration Legislation designed to protect America?

He is also appalled at the idea of "sanctuary cities" like New York and San Francisco who openly declare that they will not enforce our Immigration Laws. He is even critical of the U.S. Chamber of Commerce which appears to set its priorities narrowly on economic issues of allowing low cost labor in, while choosing to ignore the security aspects of our Immigration Laws.

Then there is the actual history of terrorist violence in the U.S. that has been enabled by lax enforcement of our Immigration Laws – from the original bombing of the World Trade Center in 1993 to the planes crashing into the World Trade Center and the Pentagon on September 11, 2001. The Clinton Administration after the first WTC bombing did virtually nothing to re-secure our country from lax deportation practices.

Follow the 9/11 Commission Report

After the 2001 disaster, the 9/11 Commission Report clearly outlined the steps needed to reassert our protective steps in the future. The ensuing Republican and Democratic administrations appeared to do very little on rooting out the terrorists who had already infiltrated our borders.

This happened not just through a porous border with Mexico, but also from inadequate procedures on "student" visas and "farming" visas. There are outright examples of immigration fraud perpetrated by immigration lawyers who know how to game the system. There are countless thousands of "student" visas given to foreigners who have no intention of adding to the economic base of the U.S. but who clearly intended to gain entry by any means for whatever purpose they intended. And many of them are under 31 years of age (the limit for allowing student entry). Virtually all of the 9/11 terrorists were under age 31.

It is clear that there is not a priority concern by Congress on this continuing threat. Or else they would do something about the woefully inadequate staff with INS dealing with these problems (fewer than 4,000 agents).

Even the Hawks Have it Wrong

Some of the supposed hawks on Immigration reform talk about putting the illegal aliens at the "back of the line". Cutler's position is that those who are in major violation of our existing Immigration Laws need to be deported quickly at a minimum, or incarcerated for other crimes and security threats. Putting others in a mythical line would imply they have a right to stay here indefinitely for years without the threat of deportation. Having paid a few taxes while here illegally is a rhetorical trick by amnesty advocates to try to get the illegals some status and frankly gives some opportunity for illegal voting using "motor voter" tactics at local polls.

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Too many politicians are worried about perceptions and pandering to groups like the "Latino vote". Why would existing Latino descent citizens object to rooting out the terrorist who got in illegally and are seemingly impervious to detection?

Forget the Dream Act

Similarly the Dream Act proponents are also pandering, by assuming that a "student" age 29 deserves citizenship by serving in the military. It was evident from the Fort Hood" terrorist shooting other military people means that putting enemies of the U.S. in the military is not such a good idea either.

In summary, controlled immigration is an excellent national strategy. But recognize the U.S. is the most desirable destination country in the world. Even our legal immigration system allows more people into our country than all the other countries in the world combined. Our current immigration practices are analogous to opening your front door to strangers and letting them in temporarily instead of looking through the peephole first to see if they are a threat.

Ponder the following statistic. We have evidence that foreigners – legal and illegal – now wire U.S. dollars earned here to the staggering amount of $120 billion a year. What if that money stayed here and was used to support our economy?

New Legislation Is Not Needed

It was clear from Cutler's talk that we need to take a strategic look at our immigration policy and reassert and really enforce the crucial parts of the original laws which still have tremendous validity. And it is also clear that 4,000 INS agents are woefully inadequate to deal with the problems that have evolved today – with some 12 million illegals and more chicanery such as the "children" influx perpetrated in the past year via unintended loopholes in laws already passed.

A worse situation could not be imagined than a current administration that does not even believe in the principles of our existing laws and openly attempts to thwart enforcement of them.

Governor Nathan Deal Remarks - September 9

On September 9, Governor Deal visited Savannah and hosted a luncheon among Republican supporters at the Savannah Harbor Golf Club.

In his prepared remarks, he highlighted his track record of growing job opportunities in Georgia since he became governor. He pointed out that several sources have recently named Georgia as the Number 1 state in which to do business.

Anecdotally he mentioned the Baxter International Labs decision to build a $1 billion facility in Georgia near Interstate 20.

Since January 2011, Georgia has seen over 12,000 new businesses created, with almost 300,000 new jobs and over $17 billion in new investment in business opportunities.

The port of Savannah now exports over $37 billion in goods.

His policies that have encouraged this type of expansion include:

- Lower sales tax for energy used in manufacturing
- Hope Scholarship Grants for technical colleges, where there are seven categories for 100% tuition reimbursement, including: welding, medical technology and diesel machinery.

The impetus for choosing the different fields in which to offer programs was an analysis of job openings for which employers could not find enough qualified applicants here in Georgia.

The Hope scholarship funding is now at a level of over $900 million a year.

He is currently pushing more apprenticeship programs at the high school level, as well as computer programming language being considered a foreign language with respect to qualifying for an academic subject. Georgia Tech University now considers computer programming as a leading major in producing job offers at graduation with the highest starting salaries.

On replacing The Affordable Care Act, he strongly supports the states leading the way instead of federal government mandates. He defended his rejection of Medicaid expansion and building a state exchange. He acknowledged that there are plenty of GOP recommended replacement programs, possible four of which have emanated from Georgia sources.

Replacing the Affordable Care Act

By Michael A. Walters,
Fellow and Past President, Casualty Actuarial Society

The Patient Protection and Affordable Care Act of 2010 (ACA) is clearly undergoing much current scrutiny as its rollout and apparent provisions seem to be less than optimal versus its purported goals. The Supreme Court found its mandate to fail constitutional standards under the perceived authority of the federal government to use interstate commerce as a ruse to impose federal control. So it allowed ACA to continue using the mild threat of a tax on young, healthier people if they don't volunteer to buy overpriced insurance coverage to help subsidize older and less healthy citizens.

ACA's proponents sometimes argue that, despite its shortcomings, ACA appears to be the only alternative to a supposedly failed former system of health insurance in the U.S. This paper will outline ways to improve the old system without such draconian measures as forcing severe mispricing of some insureds in order to subsidize others.

The solution outlined herein actually draws upon time tested measures in other lines of insurance that do not require massive federal intrusion into one sixth of the American economy. Instead it relies on a regulated but stil competitive market to offer a long-term sustainable system that reinforces what has worked well in the past.

Origins of ACA

ACA has many elements of an auto insurance system that Massachusetts introduced some thirty years ago which has now been abandoned. Similar auto insurance experiments of disdaining cost-based pricing and making suppliers ignore real costs with a system of hidden subsidies had been tried elsewhere beyond Massachusetts (e.g. NJ and Michigan). However, they all failed when trying to work within a private-enterprise insurance system.

The Massachusetts crafters of its healthcare insurance experiment (the prototype of ACA) used some of the same fallacies as in their failed auto insurance system. They have not yet abandoned that health insurance system (as they did for their failed auto insurance mispricing system).

Basic Goals of a New System

For real sustainable reform, follow some basic goals:

- Achieve some overall healthcare cost containment
- Offer coverage to those who can't get health insurance today it at a reasonably affordable price.
- Maintain the benefits of a competitive market system which a government-run system threatens—namely lower costs, more innovation, increased supply of needed practitioners and more insurers that compete for business by offering low profit margin policies.

Subsidiary goals include:

- Keep your current coverage if changing employers or even being unemployed for a time.
- Handle the problem of pre-existing conditions.
- Use incentives rather than mandates.
- Recognize that insurance is not a universal solution to all healthcare access problems; suggest alternatives.

Why Are Medical Costs High and Growing Fast?

A. Demand is great and growing

- Everyone wants maximum healthcare – what's more important than your health and your life?
- U.S. is aging; older people need more healthcare.
- Doctors are motivated to do all they can – with more techniques available and the threat of being sued.
- Increased affluence allows more inclination to spend on the crucial service of healthcare.
- Lifestyles today are often not so conducive to good health (little exercise, obesity, alcohol, drugs)
- Knowledge/awareness programs promote more usage.

B. Supply is not unlimited

- New technologies are very expensive.
- Training new doctors is time consuming and expensive
- Many uninsured just use emergency rooms in a crisis, which is more expensive than alternatives, and unrecompensed costs are passed along to others by the hospitals.
- Medicare fee controls discourage new entrants.

C. Usual price mechanisms to deal with demand/supply issues are not being applied

- Someone else usually pays the bill – the insurer hired by your employer or the government - so customers have no ability or incentive to shop for value.
- Workplace insurance tax deductibility pushes routine procedures into insurance premiums versus allowing large deductibles to keep customer involved in price decisions.
- Not all the expensive procedures are equally valuable; shopping for value is not very common.
- There is a complex trade-off between early sure costs of annual checkups and expensive diagnostics versus cost of treating more advanced problems later.

D. The tort system creates special problems on costs

- Defensive medicine to reduce the risk of tort claims is a wasteful add-on to overall costs.
- Medical malpractice liability insurance for some specialties can far exceed $100,000 a year in premiums, driving up doctor and hospital bills.
- These extra costs often deter practicing in some specialties (e.g. obstetrics) and in some locales.

The Other Problem – Uninsured Population Is Large (But Not Uniform)

There are four very different categories of uninsured:

- Higher Cost/Hard to Price – including those with pre-existing conditions or other life-style problems that could lead to much more need for treatment in the future
- Rejecting Insurance as Not Worth the Price – The young who have other needs to pay for and think their risk is low as well as the wealthy who can self-insure and use other preventive methods to keep real costs down.
- Chronically Ill and/or Poor – including homeless.
- Non-Citizens – in the shadow economy.

Even these four broad categories can be broken down further so that the answer can vary greatly from the one-size-fits all solution adopted by ACA which says that every person must buy a government-specified policy.

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General Principles and Features of the Solution

A replacement insurance system, one based on sound insurance principles, can help solve a number of the overall cost and availability problems. Avoid the controversial ACA approach of overpricing insurance for some to subsidize underpriced coverage for others. Also do not hide the true insurance cost in some "community rating" system that ignores relevant information that can identify where cost controls are better than just paying total claims.

Before crafting a solution for more insurance availability, it is important to follow some principles that can ensure a lasting system and that don't create a new crisis because of unintended consequences:

1. Free market works better:
   a. Avoid government control as much as possible
   b. Don't require heavy oversight for the system to work
   c. Use private sector efficiencies and innovation
   d. Competition keeps prices down.
2. No price controls on Healthcare suppliers and Insurers who offer coverage.
3. Model market assistance after successful state plans in auto and homeowners insurance:
   a. Assigned risk plans for hard to quantify risks and hard to place coverage
   b. Catastrophe plans for preexisting conditions.
4. Eliminate workplace special tax advantage
   a. Experiment of tax-advantaged employer-supplied health insurance is outmoded
   b. Level the playing field to allow portable, individual policies to flourish.
5. Discourage overutilization
   a. Current system encourages non-crucial usage as "somebody else is paying for it"
   b. Higher deductibles make insureds more involved in service selection and evaluation.
6. Use Premium support - like food stamps (but fixed for bureaucracy).
7. No new federal laws, if possible – Federal mandates are questionable under the U.S. Constitution. Instead use incentives to encourage states to do in health insurance what they already do in auto and homeowners insurance.
8. Customize solution by type of uninsured.
9. Encourage tort reform
   a. Several states already do it well
   b. No federal mandate
   c. Use Medicaid block grant extra funds as incentives.

Solution Using These Principles

1. The Free Market Works – Use It

Any sustainable solution must abandon the notion of intrusive front-end heavy government control that thwarts the efficiency of the competitive market.

Successful state programs can be encouraged in other states, but not mandated. The flexibility of Medicaid dollars collected by the federal government can be used as extra block grants to stimulate states to do the right thing.

Another solution is to encourage a low cost policy in every state that would be popular for young people – namely a very high deductible catastrophe type policy. This might only cost $300 or $400 a year, and only kick in for very serious accidents or illnesses. This way hospitals would not be stuck for large bills when a heretofore young "invincible" shows up after a serious accident.

In general, high deductible health insurance policies, such as in Health Savings Accounts (HSAs), promoted in 2003 Federal legislation, were a good idea that may have been discouraged in the ACA.

Having consumers responsible for first dollar spending by year is a good strategy in keeping some costs down. The incentive is that HSA owners can roll over the long-term residual savings into an IRA if they are quite judicious in their overall approach to medical spending.

It is recognized that some health planners decry the absence of promoted annual spending on preventive medicine. However, it is possible to structure even high deductible policies to allow some low cost procedures that have demonstrated prevention qualities.

2. Price Controls Don't Work

Whenever there have been heavy government price controls (either federal, state or local), the supply of products and services drops and innovations cease. Government tries to make draconian decisions it is ill equipped to make, under the mistaken impression that all customers want is the lowest possible price, or sometimes the broadest coverage, without regard to quality or availability.

The mandates, or now taxes, in ACA, for example, would not really have worked in the marketplace, as young, low-cost insureds will simply not accept the overpriced product that its advocates desire.

One option is to pay the tax and self-insure. When, or if, an expensive hospital procedure looms in the near future, they may trust that they can opt in to an insurer that is not allowed to use a pre-existing condition to deny coverage.

Another way is for them to simply gravitate to much lower-priced insurers who don't have a lot of high-cost and underpriced insureds that need this hidden subsidy. Those lower cost insurers may market selectively via the Internet and will usually not be very visible to the higher-cost insureds such as those with risky conditions or prior illnesses. So the hidden subsidies would not likely have been achieved to try to flatten the premiums across the whole population.

Also trying to require a common coverage that government deems to be the desired product usually means many insureds overpay for some coverages that they don't want or need.

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3. Copy Successes from State Auto/ Homeowners/Catastrophe Insurance Programs

For risks hard-to-place because of uncertainties and a higher expected loss, but not a catastrophic one, an assigned risk plan works well. Each of these unplaced risks goes into a system that assigns them randomly to voluntary carriers for that coverage in each state. The assigned carrier collects the right premium for the assessed risk and investigates and pays the claims under the policy.

For all such assigned risks for that insurer, if the premiums collected in total are insufficient, that insurer is entitled to pass the expected loss onto its voluntary insureds in future premiums if it is likely the shortfall will continue in the future. Other voluntary insurers are free to do the same, so losses (translate "subsidies") on the assigned business will not disadvantage insurers competitively. Auto insurance generally works well this way, as the subsidy (maybe an underpricing of say 20% on the 5% or 10% of the population that needs an assigned risk plan translates to only about a 1% or 2% rise in voluntary market rates to pay for the needs of the assigned risks, and the small surcharge falls rather uniformly on all voluntary insurers and voluntary insureds.

This contemplates that the assigned risk rates are higher than the voluntary rates. States that tried to make all rates the same have failed in their utopian dream that everyone should be treated "equally" and ignored cost-based pricing systems and individual risk rating mechanisms.

For catastrophic type risks, e.g. those with a pre-existing condition that make extraordinarily high future health costs likely, a separate involuntary market mechanism may be needed, similar to a catastrophe wind pool on homeowners insurance. In states with a very high coastal wind exposure to hurricane, there are usually state wind pools to write that coverage alone, so that the voluntary market writes the more vanilla ex-wind coverage.

Pre-existing condition policies could be available to supplement the regular market. Allow them to be rated at actuarially sound levels (covering all the expected costs.) Those who can afford them should pay the market rate. If there is an affordability problem, use a premium support system outlined below. However, do not use price controls on the insurance provider, or there will be no market.

The proliferation of true actuarial pricing for pre-existing condition policies in the free market can help identify where loss control and prevention are the answer, instead of just risk transfer. The result is that society will ultimately benefit by encouraging the free use of information.

There is another way to handle pre-existing conditions, even within an assigned risk system that has features of a premium support system. Allow the assigned risk insurer of a "catastrophe risk" to apply for the premium support instead of issuing the check to the individual insured. This lessen the bureaucratic risk when a citizen directly solicits support from a government agency. It also will force the insurer to confront its insured with the news that they owe more on their premium because they are not so destitute.

State Regulation in a Competitive Market

The current auto insurance systems in place in most states uses a combined regulatory/competitive market system that could be emulated for health insurance.

Public Law 15 (the McCarran-Ferguson Act of 1945) allows states to regulate insurance prices to allow some collective features to encourage competition from smaller insurers who benefit from information published on all insurance. States can regulate rates by monitoring competitive market results or reviewing the rates before they are put in place. States also monitor the financial condition of insurers licensed in their state as insurance is considered a complex service which needs help to evaluate.

Selling freely across state lines is a measure already proposed by some, but state regulators would be quick to point out that their state insolvency funds would not be available to pay the claims of an insolvent unlicensed insurer. This is true already in the excess and surplus lines market today for complex coverages not readily available in a state. Also, if the solutions espoused in this article were adopted, there would be less need for out-of state access. However, some version of out of state access might be an incentive for state legislatures to be more reasonable in allowing innovation.

4. Level the Tax Playing Field: Workplace Versus Individual Policies

Employer-based health insurance expanded during World War II when wage controls spawned tax deductibility to attract workers by this added benefit. Now the model of working for the same company one's whole career is an anachronism. Furthermore health issues may be an impediment to a person even getting a new job if it is viewed as raising the cost of the employer-supplied health plan.

Clearly employer-supplied health insurance should not have exclusive tax deductibility. One solution is to add tax deductibility for individual policies. Individual deductions mostly affect those who are in higher tax brackets using itemized tax returns. Lower economic bracket consumers would have to be handled with some assumptions on insurance purchased and expanded standard deductions. For example, give a higher standard deductible for those who actually purchase a health insurance policy.

This would allow individual policies to better compete with group policies. This would also promote many more insurers to compete in market place versus the handful now doing group policies.

Yet tax deductibility still has some perverse incentive to cover trivial medical procedures because of the "35% discount" from corporate tax liability. By lowering overall tax rates and eliminating so called "tax deductions", it would encourage higher deductible policies and have insureds with more of a stake in the outcome on smaller losses. This avoids the "somebody else is paying for it" syndrome that insulates the consumers from deciding whether each medical procedure is worth it.

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Another solution would be to limit the tax deductibility to only the portion of coverage that is basic insurance, i.e., very high deductible coverage.

Employer-supplied coverage is also very limited as to portability. The three-year window of COBRA benefits (mandated by The Consolidated Omnibus Budget Reconciliation Act of 1985) is not even a solution if the employer goes bankrupt or withdraws from the market.

Individual insurance policies (like those in auto and homeowners insurance) have a huge advantage in solving problems of limited consumer choice and isolation from key procedure selection. Individual policies are inherently portable and even can carry guaranteed renewability in the future. If someone develops a subsequent condition after initial underwriting, that can be priced for in the original policy so no extra premium is warranted at renewal. Larger deductibles mean more cost control by insureds paying small bills directly and restoring the buyer/supplier perspective.

For auto insurance, the existence of vigorous competition among auto insurers by state (usually some 100 licensed carriers by state) has produced an average overall gross profit margin before tax of under 4% over the past few decades. This reflects all sources of profit including investment earnings on the prepaid premiums.

Also, have you ever tried to fire your group insurer for poor service? There aren't very many of them and it is major step to replace one for the whole sponsoring organization.

6. Curtail Overutilization

With more traditional individual policy insurance, higher deductibles, co-pays and coinsurance can usually deal better with the problem of overutilization. Costs tend to be higher when the patient is insulated from payment participation decisions and the costs are paid by somebody else - the employer's insurer or the government. The latter is also where fraud is a greater potential, because the profit motive is not present.

7. Use Premium Support (Not Price Controls) to Solve Affordability Problems

Other needs in life do not require massive federal government intrusions and price controls in the market place. Periodic government attempts to provide affordable shelter (e.g. housing projects and rent controls) have usually resulted in failures. Milk programs similarly contain a lot of waste and bureaucracy with little real success.

Food stamps, on the other hand, have been a partial aid to affordability without the government trying to control prices. Price controls invariably lead to supply problems (shortages) when competitive markets are short-circuited. Food stamps in theory only go to those who need them without price controls on suppliers.

Health insurance stamps could similarly be used as a partial solution to affordability problems for health insurance without intrusive price controls on healthcare service providers. But the analogy from food stamps must correct for abuses of that program where the number of recipients has doubled in the last ten years. Government bureaucracy in that program has led to expanded amounts of fraud by those attempting to qualify, with poor incentives to remove the unqualifieds.

One answer may be to outsource management of the program to the private sector, possibly varying by state. Another would be to have the assigned risk insurer have to apply to a state agency instead of individuals requesting checks to offset higher premiums. Those subsidy checks tend to keep coming long after the need exists.

8. Customize Solutions by Type of Uninsured

"One size fits all" solutions mostly don't work. There are many reasons people do not have health insurance today. It is useful to analyze why and craft solutions for each of those major segments, and not try to solve the whole problem en masse.

For the **temporarily unemployed**, after a short-term continuation of a policy at a high price, they have to shop around for an individual policy in a market that has essentially shriveled because the group health market dominates with the tax deductibility of employer-based plans.

If most policies in the future were individual ones, like in auto or homeowners insurance, then a temporary period of unemployment would not be a special problem, as the individual policy would simply continue in force. The premium payment would of course be under stress, but no more than other major expenditures that must be made without a job to fund them. Food and shelter have to be continued. The use of premium support could be extended to this group as well, depending on how much is left from Medicaid block grants.

The existence of individual policies may actually help in the unemployed getting a new job. When health insurance is automatically provided upon employment, then someone with a higher risk or a pre-existing condition may be shunned by a prospective employer for fear of driving up the group health policy's annual costs.

The **chronic unemployed** fall under the Medicaid block grant solution, as they likely never had a group insurance policy, and couldn't afford an individual policy either.

For the **young and voluntarily uninsured**, their choice is likely driven by allocating resources. If not already covered at a large employer, they view health insurance as an option they choose to defer for now, as they are making much less in the early stages of any career, and may prefer other spending options to health insurance.

With a vigorous individual policy market, the much lower expected losses for a young adult's health insurance mean much lower premiums. And in contrast to ACA, no one is trying to make them pay a huge subsidy to be with an insurer that is not allowed to recognize age as a rating criterion. (There should be no forced "community" rating under this new proposed system. It it must allow a robust set of risk assessment criteria.)

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Some young people may still defer getting an individual health policy, even one with guaranteed renewability and low cost catastrophe coverage. That's their choice. If they get sick, they will pay for medical services at the point of delivery – at doctor's offices or emergency rooms. A credit card could well be required before admission.

If a state is concerned that still too many people show up at a hospital demanding "free" health care, an alternative might be to enact mandatory financial responsibility (FR) for its citizens. A state could even legally "mandate" such a concept, even though the federal government cannot. States already mandate FR to car owners before allowing drivers on the highways that might do damage to others. FR can be established by proof of assets or else with a basic liability insurance policy. Car license plate applications help to enforce this by at least asking for FR proof. The result is about 80% to 85% compliance in the U.S.

States could similarly ask for FR proof of all (except for Medicare and Medicaid recipients). This is especially doable for young "invincibles" by using applications for credit cards from banks to require evidence of a catastrophe policy as security for paying back debt. Banks can now even sell such health insurance policies to customers and charge the premium in monthly installments. (Gramm-Leach-Bliley repealed the Glass-Steagall Act of 1933 which heretofore banned banks selling insurance.)

For **wealthy and self-insured**, similarly, they would not be required to buy a health policy, as they already qualify for FR. Moreover, a much larger individual policy health insurance market could well spur policy options that may appeal to this group – with much higher deductibles – essentially a catastrophe policy, with a continuation of the health savings accounts (HSAs). Funds put in an HSA can accumulate tax deferred, and those not used by age 65 can be rolled over to a regular IRA.

Hard-to-price risks would qualify for the new assigned risk plan (ARP). They may have to pay a surcharge over standard policies, but after a few years in an ARP they may provide enough information to return to the regular voluntary market. Before entering the ARP auction, however, a market placement facility may try to find a non-standard insurer that would issue a policy. If so, the insured would then apply for premium support via insurance stamps if affordability were the issue.

Premiums unaffordable today applies to those not covered at work. Like the young who opt out, this group might benefit from new catastrophe policies that are low cost, but don't cover regular doctor visits. State or local health clinics would benefit this group. Assigned risk plans would not help this group because those premiums are higher than basic policies which they cannot afford.

For those with **pre-existing conditions** (PEC), an individual policy excluding that condition is presumably easy to obtain. Then a separate policy is envisioned for pooling with other high-risk insurance conditions to be written by specialty carriers in that field at a much higher premium than the regular market. It is still insurance because a pre-existing condition doesn't usually mean automatic medical bills, just a much higher likelihood. Don't mix such policies with standard policies because it would raise the premium for everyone else.

For a high-rated PEC policy is written, the insured can apply for premium support (e.g. insurance stamps). The insurer should not have to subsidize those risks by charging less than the actuarially sound price for assuming the risk. Some of the extra premium may come from a state general revenue source such as a block grant from Medicaid. If the extra-condition is solved by new drugs or new procedures, then that insured could well return to the full standard market for all his health insurance needs.

If a subsequent illness is not clear as to the source, then the regular policy provider and the pre-existing condition policy provider will need to collaborate who is primary on the claim, just as flood and wind insurers do when a hurricane produces storm surge and wind damage both.

Some proposals have a high-risk pool set up by a state to cover PEC. That could work too, but is not as optimal as having specialty insurers doing the rating, because the later can spawn more research by the competitive market on how to reduce the risk by mitigating the conditions.

Chronically ill persons do not have traditional insurance today because medical expenses are not fortuitous but certain. Medicaid support is no doubt the source of available funds today and in any new system. No insurance system can handle this type of risk because claims are not a risk but a certainty.

Truly **indigent and homeless** populations are theoretically covered by Medicaid today, and may have to continue that method, supplemented by more available community clinics, perhaps funded by charities. This is a difficult problem because their whole lifestyles are not very conducive to promoting healthy conditions. Information on prevention does not translate readily into meaningful reform of their lifestyle. Some incentive system is needed to encourage them to go to these clinics, perhaps bonus food stamps or coupons for home assistance.

If **non-citizens**, including undocumented workers (UWs), don't have health insurance, they tend to use emergency rooms of hospitals as their primary healthcare backstop. Student visitors from another country should carry their own policies, but like young citizens may choose to self-insure. (If a state required FR of all who live there, the enforcement rules could apply here on credit cards.

Companies often rely on UWs when there is a current scarcity of workers, without giving them workplace insurance or checking on whether they have their own health insurance. There is no reason why UWs couldn't buy individual policies under a new health insurance system, but there would be no option use premium support from federally funded Medicaid block grant sources. The assigned risk plans might similarly be precluded from giving them access to extra-subsidized coverage. Under standard insurance policies they would have to pay deductibles and coinsurance just like other customers do.

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Hospitals admitting UWs to emergency rooms can and should ask to see their insurance card or FR proof before full admission to help pay for that hospital service. Otherwise they would fall into the indigent or homeless categories to rely on charity or other government programs to handle humanitarian needs.

9. Tort Reform to Limit Proliferation of Medical Liability Lawsuits

The fear of lawsuits has spawned the practice of defensive medicine increasing costs by as much as 10%, without really benefiting patients. Spurious lawsuits and outrageous allegations of "pain and suffering" have caused medical malpractice liability insurance (MML) premiums to exceed $100,000 a year for some specialties. This is ironic because the quality of medicine now is so much better than it was in the 1960s when that coverage was about a cheap as auto collision insurance coverage.

MML premiums began to jump in the 1970s (ironically right after no fault auto insurance was growing rapidly, and tort lawyers may have feared the loss of revenue from 10 million auto accidents a year). In response California enacted its Medical Injury Compensation Reform Act (MICRA) in 1975, limiting non-economic loss in medical malpractice cases to $250,000 with caps on attorney fees. The result was an actual lowering of medical malpractice liability premiums per capita adjusted for inflation over 25 years: 52% lower compared to an increase in Florida (with no tort reform) of almost 300%.

Other states have contemplated tort reform, but the presence of lawyers in state legislatures has not been conducive to many meaningful results. Not until costs are made known to the public and the deleterious effect on doctors not willing to practice in certain states will legislators begin to deal with this problem more seriously.

States can be encouraged to innovate with tort reform or adopt successful other state models by varying the amount of premium support from the federal government using block grants of Medicaid funds.

Transitioning to a New System

A replacement health insurance system described herein would no doubt take a few years to fully implement, as it depends on the pace at which individual state legislatures take the initiative to foment an aggressive set of assigned risk plans for health insurance. The National Association of Insurance Commissioners (NAIC) and the National Conference of Insurance Legislators (NCOIL) could help with supporting and crafting model legislation, but they would no doubt wait for U.S. Congress to take action on leveling the playing field on tax deductibility of employer-based group insurance versus individual policies.

There are proposals now to make U.S. corporations more competitive by lowering tax rates and eliminating certain exemptions. Group health insurance could fall in this category. One option short of eliminating it entirely would be to only allow tax deductions for a basic very high limit policy, covering say losses above $3000 (indexed of course). Then employers would not be incented to offer "Cadillac" policy provisions where employees are covered for even small dollar claims.

Realistically, after a change in the employer advantaged status, it will take time for the more than 1,000 insurers In this country to decide to crank up a capacity to handle individual health insurance policies and to rate them using new rating criteria allowed by free market principles. Fortunately this will be on a state-by-state basis, as the federal government no longer appears to have the ability to mandate massive changes here. Also states will need to review any current price controls such as "community rating" laws so that their removal is conducive to a vigorous competitive insurer market.

There may be a need for a step up in actuarial capacity to meet that demand in the U.S. as well. Pricing of individual health insurance policies for over 100 million households has not been needed in the past, as group policies sold through employers have so far met those needs with relatively few insurers supplying the pricing and using large commercial concepts such as experience rating. Having a robust individual risk rating system, such as exists in auto insurance, would be a major expansion of the health insurance pricing challenge, especially when removing the concept of "community rating" where rating variables were not allowed by government fiat. The actuarial profession is up to that challenge.

Final Perspective on Costs

In reality, with something as vital as one's health, it may be that 15% or 20% of GDP is the right portion to spend. Many would rather have another 20 years of higher quality of life than a 3D 80-inch TV. Most Americans would not trade our medical care facilities for those of other countries where rationing, waits for MRIs and earlier death from preventable outcomes are more accepted.

And health care might well deserve to be the third most costly item in one's annual budget behind shelter and food. The main problem then becomes the need for wider availability of insurance to spread out those costs over time, so that one-year variations don't break the bank. And if a new replacement healthcare insurance system can actually help to bend the cost curve down, even better.

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