

White Paper: After the Affordable Care Act: Freedom for All vs. Medicare for All

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Introduction

In 2017, the Association of American Physicians and Surgeons (AAPS) produced and circulated a White Paper on repealing and replacing the Affordable Care Act (ACA), known as “ObamaCare.”¹ Republicans were elected based on campaign promises to repeal that unipartisan Democrat law, but as our White Paper predicted, this proved to be as difficult as uprooting kudzu. Limited congressional efforts, which fell far short of full repeal, were finally killed by the late Sen. John McCain’s (R-Ariz.) dramatic thumbs-down gesture, while he himself was dying of brain cancer. The Trump Administration promulgated rules that liberalized ACA policies and thereby permitted more Americans to choose to buy affordable health insurance. This was called “sabotage” by ACA defenders. In the 2018 midterm election, “healthcare” was a leading campaign issue, as “healthcare voters” increasingly aligned with the Democratic Socialists of America, who are proposing “Medicare for All.”

Medicare itself, as AAPS noted, is largely responsible for the unsound foundation of the medical system, which was further undermined by ACA.¹

President Trump may have proclaimed in the 2019 State of the Union address that “America will never be a socialist country,” but the U.S. has been enacting parts of the Communist Manifesto since at least 1913, when the 16th Amendment with the progressive income tax was ratified, and a “Great Leap Forward” was taken in the New Deal of President Franklin D. Roosevelt. President Barack Obama’s promise to “fundamentally transform” America was not mere oratory. Rep. Alexandria Ocasio-Cortez’s (D-N.Y.) “Green New Deal,” so extreme that the original version was pulled from her website soon after being widely distributed, is evidence that the Left does indeed intend a fundamental—and socialist—transformation.² Incrementalism, so far, always seems to progress in one direction.

Taking benefits away from a population that has become dependent on them—and from the medical-industrial complex that is enriched by skimming the revenue—may be impossible. Those who hold power rarely surrender it voluntarily. Nations that have succumbed to socialism (or communism, its extreme form), including formerly prosperous nations such as Cuba, Argentina, and Venezuela, have yet to cast off their poverty, misery, and oppression, and become thriving, free societies. China and Russia are still tightly controlled by authoritarian rulers. Does the U.S., which has a tradition of freedom and a remnant of constitutional protections and independence-minded citizens, have a chance to escape the vortex of socialism?

“Medicine is the keystone in the arch of socialism” is a proposition generally attributed to V.I. Lenin (1870-1924), who headed the Soviet government from the revolution until his death. The importance of making people dependent on the Kaiser for life-saving treatment or pain relief was clearly recognized by Prussian “Iron Chancellor” Otto von Bismarck. If medicine can pull the nation down and cement the grip of socialism, can it also lead the way to recovery and a new golden age of freedom?

Redistribution creates winners and losers. The winners may be relatively few, but their winnings are substantial. The losers may be many, but readily forgotten, and with losses spread among so many, the effort of fighting may not seem worthwhile. Hence the political difficulty of undoing an entitlement.

Might it be possible to upend this calculus by creating a new type of winner: one who gains freedom, while not taking from others? Consider a variant of the Obama promise: If you like your ObamaCare, you can keep your ObamaCare. If you like your Medicare, you can keep your Medicare. But if you don’t like it, you have a choice.

The Problem of the Pre-Existings

A pre-existing condition is one a patient develops while not enrolled in a guaranteed-renewable medical insurance plan. Years ago, when I was able to buy real medical insurance, I read the contracts. Some would accept your word about your medical history but could cancel your policy for fraud if it was later determined that you had lied. Some would agree not to search for pre-existings if no claim was filed for a certain period of time, for example a year. Buying a policy that contractually agreed not to cancel or raise individual premiums in the event of illness, and then keeping it in force continuously, was the prudent, economically reasonable course.

Pre-existing conditions are simply not insurable. An insurance company that permitted a customer to buy insurance after incurring a catastrophic loss could not remain solvent. Denying or limiting coverage for pre-existings protects already-enrolled subscribers from loss of coverage as the insurer goes bankrupt or from enormous premium increases.

If one is short of lunch money, one cannot expect to put a nickel into a slot machine and win the jackpot to cover the bill, as in an old episode of *Laurel and Hardy*.

With a fair premium, one pays in, over the lifetime of the policy, a little more than the actuarial expectation of a payout. Under guaranteed issue/community rating, high-risk

beneficiaries get an entitlement to a winning lottery ticket after the winning numbers have been announced.

ACA and bills recently proposed by congressional Republicans have “consumer protection” for pre-existings, i.e. guaranteed issue/community rating. This outlaws the incentive to voluntarily purchase continuous coverage, replacing it with an incentive to game the system and purchase coverage only after becoming ill. It “protects” potential subscribers at the expense of the current subscribers who would have to cover the certain spike in costs. An attempt to counter that moral hazard, proposed by the Heritage Foundation and first enacted in Massachusetts (“RomneyCare”), is the individual mandate, forcing people to purchase a policy even if they are being charged far more than their risk would justify.

Many prudent, responsible Americans now have a pre-existing condition through no fault of their own. One reason is losing a job or changing jobs and thus losing employer-based health benefits. This is the predominant form of coverage because of federal tax policy. After ACA went into effect, millions of Americans in the individual insurance market, which covered about 5 percent of the population in 2007,³ had their insurance plan terminated because of failure to meet federal requirements such as “minimum essential benefits.” Some got replacement policies on the ACA Exchanges, but for those not qualifying for taxpayer subsidies, the cost may have been unaffordable. One young person who was paying \$40/month pre-ACA now must pay \$400.⁴

A prior occasion on which millions of Americans lost their long-time private coverage was the passage of Medicare in 1965, when President Lyndon Johnson persuaded private insurers to cancel policies on all Americans over age 65. Most of them have a pre-existing condition by now that might preclude buying a substitute for Medicare—if one were available. Medicare supplemental policies are tied to Medicare coverage.

Having created a problem, the federal government proposes coercive means to get Americans to pay for it. Both parties have taken a position in favor of abolishing affordable, voluntary insurance as a means of paying medical bills, the inevitable consequence of forbidding insurers to underwrite and price according to risk. What is now called insurance is basically corporate socialism (from each according to means, and to each according to need, administered by quasi-private entities). The difference between ACA-compliant private policies and Medicare is that ACA premiums, without the individual mandate, are voluntary; one has the option of being uninsured. Medicare Part A premiums are mandatory—taxes paid by everyone who has employment income. Once Medicare-eligible, a person has the option of being uninsured under Part A only by forgoing all Social Security payments. Parts B and D are voluntary, but there is no private substitute. Unlike with ACA there are steep penalties for not enrolling when first eligible if one later decides to sign up.

By destroying the existing private market, which offered

longstanding, guaranteed renewable coverage, first for Medicare beneficiaries, then for younger persons insured in the individual market, federal government policy also created a huge obstacle to the way back.

Constitutionality

Although AAPS has always held that Medicare and Medicaid are unconstitutional, because providing insurance or paying medical bills is not among the defined powers of Congress, the constitutionality has never been directly challenged in court. Social Security, however, has been, and Medicare and Medicaid are Title 18 and Title 19, respectively, of the Social Security Act. As decided in *Helvering v. Davis* (1937) at the time of the New Deal,⁵ in reasoning strikingly similar to that of Chief Justice John Roberts in the *NFIB* case upholding ACA,¹ Social Security is constitutional as a tax, not as a pension plan. The decision was arguably made under duress, an act of self-preservation to thwart President Franklin D. Roosevelt’s court-packing threat. Why Chief Justice Roberts made his unexpected last-minute “switch in time” to save ACA is a subject of much speculation.⁶

The late John Attarian, author of the 2002 book *Social Security: False Consciousness and Crisis*, states that the *Helvering* opinion was “laughably weak,” and that “the issue of Social Security’s constitutionality, far from being settled, remains wide open.” He writes that: “The purported constitutionality of Social Security rests on sloppy argument, willful evasions of reality, and, ultimately, frightened submission to one of the worst acts of tyrannical bullying in the federal government’s history.”⁷

For example, the government’s brief argued that the Social Security taxes were “true taxes, their purpose being simply to raise revenue...available for the general support of Government,” even though “in 1935 the Administration had told Congress and the public that the purpose of the taxes was to build up a fund to pay old-age annuities.” The Justices ignored the plaintiff’s argument that it was an odd tax for raising general revenue: It taxed the smallest wage earners and exempted income above \$3,000 a year and some workers (at the time, federal government employees, including Veterans Administration physicians, who had their own retirement fund until the 1980s).

The government can levy taxes to support the general welfare, but the Court stated that the concept of “general welfare” is not static, but “adapts itself to the crises and necessities of the times.”⁵ We might ask whether a program that imposes the largest and perhaps only federal tax that low-income workers pay, for the benefit of retirees, some quite wealthy, and which is imposing enormous debt on future generations, serves the general welfare. There are also constitutional restrictions on the types of taxes that can be imposed. These are direct taxes, which must be apportioned based on the census; excise, which must be uniform; or income, which must be triggered by net income.⁶

Constitutional challenges to Medicare⁸ have accepted the basic premise of the program, while focusing on particular

features. *AAPS v. Weinberger* challenged the Professional Standards Review Organizations (PSROs). *Whitney v. Heckler* challenged the physician fee freeze. In *Stewart v. Sullivan*, patients and physicians sued to establish the right to privately contract on a case-by-case basis. *United Seniors Association v. Shalala* concerned whether the Balanced Budget Act (BBA) of 1997, which established opting-out provisions for physicians, precluded private payment for certain services from non-opted-out physicians.

The courts did not find any basic constitutional right for patients to privately contract with physicians, nor did they find an explicit and clear statutory provision denying that right. In *United Seniors Association*, the D.C. Circuit Court of Appeals found that BBA restrictions did not apply to services not covered by Medicare.⁹ My impression was, as an observer at the oral argument, that the judges were visibly relieved when the plaintiff's attorney declined to press the issue of whether a Medicare beneficiary had the right to pay privately for a necessary, life-saving service that is covered by Medicare but is unavailable under Medicare's conditions, as opposed to an unnecessary service like an extra diagnostic test or a cosmetic procedure.

The right to private contract appears to be gray area in the law, but physicians have been unwilling to risk severe Medicare sanctions or an expensive, prolonged court battle to assert that right—even though Judge Nicholas Politan of the U.S. District Court for the District of New Jersey could find no authoritative policy forbidding *Stewart* plaintiffs to act as they wished. Today's Americans have apparently internalized the need to have federal government permission for acts the Founders would have considered to be outside federal jurisdiction.

Medicare beneficiaries sued, in *Hall v. Sebelius*, to establish the right to decline Medicare Part A without forfeiting all past and future Medicare benefits. They wished to decline Part A because they preferred private insurance, and the insurer refused to accept them as long as they were entitled to Part A. The U.S. Court of Appeals for the District of Columbia Circuit, in an opinion by Judge Brett Kavanaugh with concurrence by Judge Douglas Ginsburg, ruled against them.¹⁰

Judge Karen Henderson wrote an interesting dissent in that case, citing the story "Silver Blaze" by Sir Arthur Conan Doyle, in which the dog did not bark in the nighttime. She noted that the massive Social Security Administration (SSA) Program Operations Manual System (POMS), which had been produced without notice-and-comment rulemaking, gives the SSA power that Congress did not provide. In footnote 10, she suggests that a comparable situation would be requiring a person who declines food stamps to repay all the Medicaid benefits he had received.¹⁰

Proposed legislation, called Medicare for All, would clarify these issues by explicitly outlawing coverage that duplicates Medicare coverage.¹¹ Then, U.S. citizens might have the same issue litigated by Dr. Jacques Chaoulli¹² in Canada: Patients were denied the possibility of purchasing life-saving services that are "covered" by the government plan but unavailable within the system.

The fundamental constitutional issue is whether Americans have the liberty to use their own property to preserve and enhance their own lives. This was recognized by the Clinton Health Care Task Force as a potential obstacle. In a memorandum to White House Health Care Task Force member Walter Zelman, Douglas Letter, appellate litigation counsel for the Civil Division of the Department of Justice, wrote:

This is an uncharted area of the law. The right to medical treatment has been given constitutional protection in the area of abortion; but that is for reasons that are not generally applicable to other types of treatment. Where the treatment sought is medically necessary—and particularly where a life-threatening condition is involved—it is entirely possible that the courts would impose some constitutional limits on the Government's ability to impose, for economic reasons, restrictions on a patient's ability to obtain treatment for which he or she is willing to pay.¹³

The memorandum also noted that one justification for previous government actions such as price controls has been doctors' ability to opt out of the system:

Where all or virtually all medical services were required to be provided within the government regulated system, a very limited "escape hatch" would not necessarily carry the day. But if there is some reality to the escape opportunity, we believe it would contribute substantially to a legal defense of the system.¹³

The public-private partnership was also discussed as a possible work-around by "outsourcing" due-process violations,¹⁴ since private entities are not restricted by the Constitution. This is already happening. As managed-care giants increasingly dominate in federally funded care,¹⁵ such as Medicaid and Medicare Part C, the rationing function has been delegated to these corporate entities, which in turn delegate it to gatekeeper physicians. Contractual provisions keep physicians who participate in these plans from offering self-paid covered services to plan enrollees.¹⁶ Managed-care executives played a prominent role in the Clinton Health Care Task Force and in the design of ACA.¹⁷

The ACA individual mandate was found to be an unconstitutional expansion of the U.S. Constitution's Article 1 Commerce Clause, which gives Congress the power to regulate commerce among states and with foreign nations and Native American tribes, by requiring people to engage in commerce (buying an insurance product they did not want). But then it was ruled constitutional as a tax, in *NFIB v. Sebelius*.¹⁸ Still, a point not litigated is whether ACA's outlawing of alternative insurance products that do not include the federally defined "minimum essential benefits" is a violation of the 10th Amendment. The only specific exception to the individual mandate was health-sharing ministries, which are not insurance products. Whether ACA forbids true insurance (discussed below), or simply led to insurers' withdrawing policies not meeting the mandated requirements from the market, may be a moot point. Proposed legislation would prohibit the Trump Administration's revised

definition of short-term, limited duration insurance, so that it could last for only one year (H.R. 458, the Affordable Limited Health Coverage Act), and would require guaranteed issue and community rating (H.R. 692, the Pre-existing Conditions Protections Act of 2019).¹⁹

It has been said that “if ACA is unconstitutional, so are Medicare and Medicaid.” Some of the same constitutional issues apply. Proposed legislation from both parties would further expand the role of the federal government in medicine, with more compulsion, more restrictions, more taxation, and more redistribution, resembling those in Medicare and Medicaid.

“Healthcare Reform”

The discussion about “healthcare reform” is confused by the terminology. The term “healthcare” is often taken to mean medical care when it actually refers to the financing mechanism and the much broader context of economic and social factors affecting health. It conveys the deceptive impression that coverage equals care, and that loss of (or rejection of) coverage means that one cannot receive care. Medicaid is now being “leveraged” to address needs for healthy food, affordable housing, safe neighborhoods, etc.²⁰

The financing mechanism is closely intertwined with medical care. Collectivist financing is associated with the emphasis on population health and protocol-driven factory medicine. Quality and value measures do not concern patient values, but value to the “system.”

Innovations in care are stifled by the need to get AMA approval. If there is no AMA Current Procedural Terminology (CPT) code, and hence no Medicare Relative Value Unit (RVU) assigned, there can be no Medicare reimbursement, and commercial insurers generally follow Medicare. Additionally, the Food and Drug Administration (FDA) aggressively suppresses therapy that does not and usually cannot meet research demands most suitable for drugs (randomized, double-blind controlled trials) or do not offer enough profit potential to justify the billion-dollar investment in seeking approval.

A reformation should involve a return to sound principles and freedom of choice—not a revolution that overturns ethical principles, the free-enterprise economic system, constitutional government, and the patient-physician relationship.

Restoring a Sound Foundation

It is first necessary to use accurate language. Medicare, Medicaid, managed care, and ACA-compliant plans are *not insurance*. Beneficiaries of government programs have no enforceable contractual rights. Pay-as-you-go plans like Medicare, Medicaid, and managed care have no insurance reserves of marketable assets to cover future claims. There are no guarantees of benefits. Funding decisions are political, and governmental appropriations for medical services must compete with education, policing, roads, defense, other welfare programs, and so on.

“Healthcare” is not an insurable risk.²¹ Insurable risks, according to the 1989 book *Principles of Insurance* by George E. Rejda, have the following characteristics: (1) there must be a large number of homogeneous exposure units; (2) the loss must be accidental and unintentional; (3) the loss must be determinable and measurable; (4) the loss must not be catastrophic (e.g. an “act of God”); (5) the chance of loss must be calculable; and (6) the premium must be economically feasible.²² Most “health plans,” including the government programs, have open-ended coverage. They are basically third-party pre-payment plans with a large component of wealth redistribution to the extent that the amount paid in is not proportionate to expected loss.

Insurance, or third-party prepayment, is not the only way to pay for medical care, as proponents of universal coverage implicitly assume. It is the most expensive way, fraught with moral hazard, and is the main driver of the outrageous price escalations in medicine. Without a drastic reduction in costs, excellent medical care will not be accessible to most, with or without an insurance card.

Spending and costs accelerated after the enactment of Medicare and Medicaid in 1965, just as AAPS had predicted.²³ Inflation-adjusted spending on prescription drugs was also fueled by government payment. In 1960, inflation-adjusted per capita retail spending on prescription drugs was \$90. In 1975, it was \$138. In 2003, when Medicare Part D was passed, it was \$784, and in 2006, when Part D went into effect, \$895. It stabilized for a time, possibly because of competition and the “doughnut hole,” but began a steep climb after 2012, when ACA increased the Part D benefit and increased payment for drugs, reaching \$1,046 by 2016.²⁴ Annual lobbying expense for Express Scripts was \$200,000 in 2003, \$750,000 in 2006, and \$3.24 million in 2018.²⁵ While the safe harbor protecting pharmacy benefits managers from the Medicare Anti-Kickback Statute²⁶ may have contributed, the availability of federal funding is a potent attractant for lobbyists.

An absolute requirement for a sound foundation is insistence on free-market principles: honest price signals, voluntary decision-making by buyers (the persons receiving the product, not a third party) and sellers, and the removal of barriers to competition. This precludes central planning, or the offering of a single, comprehensive Plan. Many innovative ideas have been proposed (see AAPS white paper on medical financing²⁷), but neither the government nor a private entity should be picking winners and losers. In a free market, there should be hundreds of insurers, charitable mechanisms, and financing methods, the best of which may not have been imagined yet.

Unlock the Medicare/Medicaid Trap

Politicians are proposing the idea that Americans over age 50 should be permitted to buy into Medicare, thus expanding government influence in medicine and further crowding out the private sector. Americans should keep in mind that Ponzi schemes are kept afloat only by constantly attracting new “investors.” It is becoming increasingly difficult to deny the

insolvency of Medicare as the program itself passes age 50 and Baby Boomers retire.²⁸

Instead, Congress should be letting people, both patients and physicians, opt out of the system. Since all workers have had to pay in, the government should instead be offering to buy them out. Or perhaps someday the equivalent of a bankruptcy court will need to settle with them. If Americans received a monthly deposit into a medical savings account, perhaps a fraction of the actuarial value of Medicare Part A, this could help fund a post-payment plan for medical expenses, or a means to pay premiums on catastrophic insurance if it became available. Another incentive might be exemption from the capital gains tax if people had to sell assets to pay medical bills, and exemption from payroll taxes if they continued to work.

Why should Americans want to escape from a “free” entitlement? Plaintiffs in *Hall v. Sebelius* wanted better insurance, from their employer. Under the Social Security Act (SSA), “It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title...a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX.”²⁹ While Medigap is regulated by the states, SSA requires that policies meet or exceed National Association of Insurance Commissioners (NAIC) Model Standards. These stipulate: “No Medicare supplement policy or certificate in force in the state shall contain benefits that duplicate benefits provided by Medicare.”²⁹

Most retired Americans do not have the option of employer-provided insurance if they become ineligible for Medicare. Why would they choose to be uninsured—or self-insured?

As George Gilder explains concerning Google’s model of offering everything for “free,” nothing is ever free. The price may be your privacy or your time—which is your life.³⁰ Medicare beneficiaries lose their choice of physician. Unless their physician is completely opted out, private treatment, at least for covered services, is not explicitly allowed, and the physician is generally not willing to risk becoming a test case. If the physician accepts government money, he is effectively agreeing to government rules and cannot offer services for which he can’t recover the cost. The most important loss to the patient is access to the physician’s time and best judgment. The physician and staff are laboring under a costly and onerous compliance and reporting burden, with draconian penalties for deviations such as providing “unnecessary” service.

In *Hall v. Sebelius*, the U.S. District Court for the District of Columbia opined that patients are not required to “use” their Part A entitlement, but can or will hospitals bill Medicare Part A-enrolled patients outside the prospective payment system, or circumvent the Medicare regulatory regime?

Many young Americans do not know that the Berlin Wall was built by the Soviet Union to keep people from escaping from the Eastern bloc into the West. Those who did not leave soon enough were trapped; later, many were shot as they

tried to flee. The Iron Curtain also attempted to keep out information from the West so that people in the oppressed and impoverished Communist bloc could not learn about the freedom and prosperity in the Free World.

When proponents of socialized medicine deplore a two-tiered system, there does not seem to be any doubt about which tier delivers better care. Thus, like LBJ, they want a universal “everybody-in-nobody-out” system to prevent leakage into the private sector—something like a virtual Berlin Wall.

Medicare and Medicaid are increasingly dominated by managed-care gatekeepers, tighter restrictions, and “fail first” policies. Early hospice admission and refusal of treatment, including feeding and hydration, are encouraged. “Burned-out” physicians are being replaced with minimally trained surrogates or robots. If private medicine is permitted to survive, patients may increasingly seek out independent physicians.

Physicians must recognize that price controls, massive data collection, and tightened constraints are not an optional component that can be fixed by more enlightened legislation or regulation. They are inevitable in the structure of the program. Hiring more compliance staff will not reliably protect a practice from penalties. The only relative safety is in not being under the jurisdiction of government or insurance bureaucrats, because of refusing their money. Real, total non-participation (not as in Medicare “nonpar” status) might be the only way to assert constitutional protection, under the 10th Amendment, which reserves powers to the States and to the people; the 5th Amendment’s Takings Clause, which bars taking private property for public use without just compensation; or the 13th Amendment, which bars involuntary servitude. Courts have upheld what once seemed unacceptable by claiming that participation is, after all, voluntary. Physicians have unwittingly surrendered their rights, for “consideration” (tax-funded payment).

In the U.S., why should patients and physicians not be allowed to move back and forth between the two sectors? Restoring the ability for Medicare “nonparticipating” (nonpar) physicians and their patients to opt out of filing claims on a case-by-case basis would enable patients to retain some of their Medicare benefits.¹ Medicaid enrollees should be allowed to seek private care on a self-pay or charitable basis without reporting or triggering penalties for doctors or patients. Managed-care plans should not be allowed to impose their constraints on physicians who do not sign contracts with them (i.e. physicians who are “out of network”).

The Right to Try

Congress recently passed very limited right-to-try legislation for the benefit of terminally ill patients to obtain access to drugs that were still in clinical trials and not yet approved by the FDA. This raises the question of why patients who are not terminally ill do not have the right to choose their treatment, if they wish to forgo federal government

protection. Does the FDA really assure safety? Consider the number of drugs and devices that have had to be recalled. Are there no private mechanisms for testing drug purity, or verifying claims of efficacy, or providing after-market surveillance? What about potentially safer treatments that do not offer enough profit potential to justify investing more than \$1 billion in the approval process? Do physicians have no First Amendment rights when giving professional advice, and do patients have no right to hear advice that is not supervised by a government agency?

How can patients have the right to obtain an abortion, or, increasingly, to smoke marijuana, or to obtain a lethal prescription, but have no right to try non-government-approved treatments or advice for the purpose of extending life or enhancing health and function?

Why do patients not have the right to choose catastrophic medical coverage, or a physician-owned hospital, or some innovative means of medical financing?

The government has a constitutional role in medicine as in other areas of the economy by enforcing laws against the use of force or fraud. State and local governments may provide services that benefit the public, such as medical treatment for emergent conditions, or public health measures. Their proper function is to protect life and health, not to redistribute wealth.

Numerous measures have been suggested to the incoming Congress³¹ to help lower prices, empower patients, increase insurance choices, and encourage charity. "At bottom, good medical care requires freedom for physicians to do the best for their patients and for patients to choose what is best for their circumstances," writes AAPS president Marilyn M. Singleton, M.D., J.D.³¹

Reform Must Start with the "False Consciousness"

Almost all reformers and politicians promise to "save" and even improve Medicare. Together with its mother Social Security, it is the "third rail" of American politics. Proponents of privatizing Social Security also generally assert their commitment to keep promises to current beneficiaries, i.e. to continue current eligibility rules and levels of benefits. Of course, many Americans are completely dependent on these benefits and could not survive without them.

Still, the fiscal crisis cannot be avoided. In 2015, "mandatory" spending constituted two-thirds of the federal budget. That is spending that Congress legislates outside of the annual appropriations process, usually less than once a year, dominated by the "well-known earned-benefit programs Social Security [about 33 percent] and Medicare [about 15%]."³² These programs are doomed by demographics.

The idea of the earned benefit is what Joseph Attarian calls the "false consciousness" created in the design of Social Security and its funding through a tax on labor income.

As Roosevelt admitted, the payroll tax is "politics all the way through." Its true purpose was and is to create a mentality of entitlement to benefits and give the insurance analogy an apparent basis in reality.³³

Attarian's "Modest Proposal" for action on Social Security begins with "Looking Reality in the Face." Social Security (and Medicare) are not insurance, an earned right, or a contract. His proposal is beyond the scope of this paper, but any reforms should aim for these goals: (1) restore truthfulness to public policy; (2) reduce the burden on taxpayers; (3) avert fiscal crisis and serious damage to the economy; (4) avert intergenerational warfare; (5) acknowledge the necessity of sacrifice and suffering, and spread it widely and fairly (so far the burden has fallen primarily on the young); (6) encourage personal responsibility and freedom; (7) keep government involvement minimal; and (7) do not promise the moon.³³

The first step, beyond truth-telling, is building up private medicine and expanding the exits from the government and third-party-managed system. Without a Free World to show the contrast, most have no reason to question the government system. We need to tear down the equivalent of a Berlin Wall—and preserve and expand the world beyond it.

Conclusions

American medicine is at a crossroads. It can continue on the path that leads from Medicare to ACA to a fully closed, coercive system, or it can allow freedom-loving Americans to build a private sphere with government confined to its constitutional role. Our current path will only lead to a worsening of the enormous cost, deteriorating quality, and demoralization we are now experiencing, as inevitable insolvency looms. Allowing freedom could bring a replay of the unprecedented prosperity of America's earlier history, or of the postwar German economic miracle. It is also the just and moral course, and the one that allows physicians to serve their patients rather than the system or the state.

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REFERENCES

1. Orient JM, Association of American Physicians and Surgeons. White Paper on Repeal/Replacement of the Affordable Care Act. *J Am Phys Surg* 2017;22:25-29.
2. Thomas C. Green New Deal more proof Left Intends to "fundamentally transform" U.S. *Daily Signal*, Feb 12, 2019, Available at: <https://tinyurl.com/yyj22suf>. Accessed Feb 12, 2019,
3. Schiff J. Individual market explained. *Kaiser Health News*, Oct 6, 2009. Available at: <https://khn.org/news/npr-individual-market-explainer/>. Accessed Mar 6, 2019.
4. Robinson AB. Medical costs. *Access to Energy*, July 2018.
5. Anon. *Helvering v Davis* upholds Social Security program: historical. *Constitutional Law Reporter*, Jan 9, 2019. Available at: <https://constitutionallawreporter.com/2018/01/09/helvering-v-davis-1937/>. Accessed Feb 13, 2019.
6. Bandow D. John Roberts: rarely has such a smart judge written such a bad opinion. *Forbes*, Jul 2, 2012. Available at: <https://www.forbes.com/sites/dougbandow/2012/07/02/john-roberts-rarely-has-such-a-smart-judge-written-such-a-bad-opinion/#6cb8b1484fee>. Accessed Mar 3, 2019.
7. Attarian J. Is Social Security constitutional? *LewRockwell.com*, May 23, 2003. Available at: <https://www.lewrockwell.com/2003/05/john-attarian/is-social-security-constitutional/>. Accessed Feb 14, 2019.

8. Snavelly J. Federal health policy hall of shame and AAPS advocacy hall of fame. *J Am Phys Surg* 2018;23:72-80.
9. Bernstein DE. *Restoring Freedom of Contract between Doctor and Patient in Medicare Part B*. Mercatus Research; September 2015. Available at: <https://www.mercatus.org/system/files/Bernstein-Medicare-Freedom-of-Contract.pdf>. Accessed Feb 14, 2019.
10. *Hall v. Sebelius*, 667 F.3d 1293; Feb 7, 2012. Available at: <https://caselaw.findlaw.com/us-dc-circuit/1593485.html>. Accessed Feb 14, 2019.
11. Held KS. Do not be deceived! Medicare for all will crash the system. AAPS op-ed. Available at: <https://aapsonline.org/do-not-be-deceived-medicare-for-all-will-crash-the-system/>. Accessed Feb 14, 2019.
12. Chaoulli J. The long road to freedom in Canadian medicine. *J Am Phys Surg* 2005;10:91-92.
13. Letter D. Memorandum to Zelman W. Clinton Health Care Task Force documents. Available at: <http://aapsonline.org/judicial/zelman.txt>. Accessed Feb 14, 2019.
14. Orient JM. Court decides against Privacy Rule challenge. *AAPS News*, December 2005. Available at: <https://aapsonline.org/aaps-news-dec-2005/>. Accessed Feb 14, 2019.
15. Orient JM. LBJ-Nixon care. *AAPS News*, July 2018. Available at: <https://aapsonline.org/aaps-news-july-2018-lbj-nixon-care/>. Accessed Feb 14, 2019.
16. Lobb F. *The Great Health Care Fraud*. Kimkris Publishing; 2012.
17. Tillman K. Building the Infrastructure of the Affordable Care Act: Hillary Clinton, UnitedHealth Group/Optum, and the Center for American Progress. *J Am Phys Surg* 2015;20:110-115.
18. Orient JM. Obama tax. *AAPS News*, August 2012, Available at: <https://aapsonline.org/aaps-news-august-2012-obamatax/>. Accessed Feb 14, 2019.
19. Singleton MM. Legislative Update—116th Congress Convenes. *AAPS*; Feb 13, 2019. Available at: <https://aapsonline.org/legislative-update-116th-congress-is-in-session/>. Accessed Feb 14, 2019.
20. Brooks T, Whitener K. *Leveraging Medicaid to Address Social Determinants and Improve Child and Population Health*. Georgetown Health Policy Institute, Center for Children and Families; February 2018. Available at: <https://ccf.georgetown.edu/wp-content/uploads/2018/02/Leveraging-Medicaid.pdf>. Accessed Feb 15, 2019.
21. Butz RO. Healthcare is not an insurable risk. *J Am Phys Surg* 2013;18:120-121.
22. Butz RO. The medical insurance idea. *AAPS News*, February 1992, p 2. Available at: <http://aapsonline.org/newsletters/feb92.htm>. Accessed Feb 15, 2019.
23. Pavey C, Leithart PW, Quinlan D, et al. Fighting to preserve private medicine: the role of AAPS. *J Am Phys Surg* 2003;8:19-25.
24. Kamal R, Cox C, McDermott D. What are the recent and forecasted trends in prescription drug spending? Peterson-Kaiser Health System Tracker; Dec 10, 2018. Available at: <https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/#item-start>. Accessed Feb 16, 2019.
25. Center for Responsive Politics. Express Scripts. Available at: <https://www.opensecrets.org/lobby/clientsum.php?id=D000021977>. Accessed Feb 26, 2018.
26. Singleton MM. Group purchasing organizations: gaming the system. *J Am Phys Surg* 2018;23:38-42.
27. Schlafly A, Orient JM, AAPS. White paper on medical financing. *J Am Phys Surg* 2006;11:86-91.
28. Orient JM. Medicare at 50. *AAPS News*, July 2015. Available at: <https://aapsonline.org/aaps-news-july-2015-medicare-at-50/>. Accessed Feb 16, 2019.
29. Social Security. Certification of Medicare supplemental health insurance policies. Compilation of the Social Security Laws. Available at: https://www.ssa.gov/OP_Home/ssact/title18/1882.htm. Accessed Mar 3, 2019.
30. Gilder G. *Life after Google: the Fall of Big Data and the Rise of the Blockchain Economy*. Gateway Editions; 2018.
31. Singleton M. Memorandum to incoming congressmen on health solutions. *J Am Phys Surg* 2018;23:97-98.
32. National Priorities Project. Federal Spending: Where Does the Money Go. Available at: <https://www.nationalpriorities.org/budget-basics/federal-budget-101/spending/>. Accessed Mar 4, 2019.
33. Attarian J. *Social Security: False Consciousness and Crisis*. New Brunswick, N.J.: Transaction Publishers; 2002.

AAPS PRINCIPLES OF MEDICAL POLICY

Medical care is a professional service, not a right. Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

Physicians are professionals. Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government “guidelines,” which soon become mandates. Physicians’ decisions and procedures cannot be dictated by overseers without destroying their professionalism.

Third-party payment introduces conflicts of interest. Physicians are best paid directly by the recipients of their services. The insurer’s contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

Government regulations reduce access to care. Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians’ judgment, etc.

Honest, publicly accessible pricing and accounting (“transparency”) is essential to controlling costs and optimizing access. Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer’s willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

Confidentiality is essential to good medical care. Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

Physicians should be treated fairly in licensure, peer review, and other proceedings. Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors’ malice, hospitals’ attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

Medical insurance should be voluntary. While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

Coverage is not care. Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.