

White Paper on Repeal/Replacement of the Affordable Care Act

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800 Tons of Lead Brick Counterweights Prevent Collapse of Leaning Tower of Pisa. [Image from Wikimedia commons.
https://en.wikipedia.org/wiki/File:Pisa_schiefer_turm_gewichte_1998_01.jpg]

Executive Summary

Repealing the Affordable Care Act (ACA), known as “ObamaCare,” after it has been in effect for 7 years is rather like trying to uproot kudzu. It is deeply entwined in American medicine, and despite soaring premiums and deductibles combined with difficulties accessing actual medical care, many people are dependent on it. One needs to avoid collateral damage.

ACA is also integrated into the structure of the “healthcare delivery system,” which is built on an unsound foundation: forcible redistribution of wealth and the concept of “comprehensive coverage” as the most favored way to pay for medical care. This structure will inevitably collapse. The first priority is to save the people who are trapped in it.

Medical institutions built on liberty and sound financing will arise if allowed to do so. They cannot be built by congressional or bureaucratic diktat. America must not waste this opportunity for genuine reform, and instead try to replace one tottering structure with another centrally planned disaster that resembles it.

The ACA structure must be allowed to wither and die as a result of administrative actions that deprive it of its nourishment: mandates and coercive redistribution. The same actions will relieve the chokehold that government has on innovation and financing mechanisms, and allow excellence to flourish.

Introduction

The problem with the ironically named Affordable Care Act (ACA or “ObamaCare”)—is with the foundation. Like a building on an unsound foundation, it cannot be fixed by “tweaking” or patching up the cracks. ACA has so many complex, interdependent parts that attempts to alter parts of it will upset the balance with unpredictable, likely disastrous effects.

Worse, ACA is inextricably tied to the rest of the American “healthcare delivery system.” Besides the radical changes in health insurance and medical institutions, ACA makes many changes in Medicare and Medicaid and heavily depends on them. About half of the “healthcare dollar” passes through these federal programs, and 90 percent passes through some third party. As

with the Leaning Tower of Pisa, there is a legacy to be preserved: the legacy of Barack Obama, and also of Franklin Roosevelt, Lyndon Johnson, Richard Nixon—and Marx and Lenin.

However much expense and ingenuity is lavished on shoring up the edifice, gravity eventually wins. One can keep piling on lead counterweights, but the masonry will someday crumble because of the abnormal stresses. When it falls, building inhabitants and bystanders are in grave peril. The laws of economics are just as inexorable.

At the root of ACA is a requirement that people buy a product from a government-favored private company—health insurance—that they do not want, or at least do not want on the terms government forces on them. This in turn is based on the fallacy that the way to an equitable state of “universal healthcare” is through comprehensive third-party payment. When that fundamental economic fallacy is uprooted and people are allowed to spend money in more efficient ways, then the inherent waste in the current system would be avoided, to the benefit of the entire economy.

Political & Timing Considerations

ACA is now “status quo,” and its supporters will do everything they can to perpetuate it. Outgoing President Obama himself has reportedly been meeting with leaders of the Democratic Party to develop strategies for preserving ACA. Congressional Republicans may also be unnecessarily reluctant to repeal the massive legislation, now that it has been in effect for many years with millions who believe they are dependent on it.

If the incoming President Donald Trump waits for Congress to act on ACA, then it appears likely that nothing—or nothing good—will be achieved in the foreseeable future. Worse, the Republican-controlled Congress could increasingly blame the Republican President Trump for inaction, and vice-versa. Democrats might then win big in the midterm elections, retaking control of the House or Senate, and ACA could subsequently be perpetuated by the incoming Democrats in Congress.

The better strategy, accordingly, is to adopt approaches that can be taken unilaterally by the Trump Administration, without requiring congressional approval. If Congress wants to concur or expand on action taken by the Administration, then that would be welcome. But if Congress instead wants to delay until after the midterm elections, ACA could and should be deconstructed without waiting for congressional action that may never happen, or that might only perpetuate the worst flaws, with a Republican imprimatur.

ACA as constructed is inherently unstable and would have inflicted intolerable pain on many already, including the special interest groups that got it passed, had Obama not made dozens of unilateral changes. These included exemptions for some employers and the illegal spending of money that Congress did not appropriate to shore up insurers. Many provisions, including tax increases and a harsher individual mandate, are timed to go into effect after Obama leaves office. Their ill effects, and the effects of congressional alterations, can conveniently be blamed on Republicans.

ACA can only be enforced, if at all, by the incoming Trump Administration. Executive agencies controlled by the President have enormous discretionary authority. The linchpin of ACA is the individual mandate, which compels people to buy health insurance under threat of penalty by the IRS, which is part of the executive branch. The definition of acceptable coverage is determined by the Department of Health and Human Services (HHS), which did

not, for example, have to mandate contraceptive coverage.

Actions that could be taken by the Trump Administration include adopting a policy of non-enforcement of any penalties for not purchasing health insurance, refusing to bail out insurers, and abiding by the district court decision in *U.S. House of Representatives v. Burwell*, which declared the taxpayer subsidies on the health insurance exchanges to be illegal. Supporters of ACA attempted to intervene in the *U.S. House of Representatives v. Burwell* case, but the judiciary is no more than a co-equal branch of government. Incoming President Trump was elected to dismantle ACA, and he should make clear that the judiciary lacks “the power of the purse” and the enforcement authority that are properly conferred only on the other two branches of government.

There is not as much time as may first appear to dismantle such complex and far-reaching legislation as ACA. Early voting for the midterm elections begins a mere 21 months after the November election, with campaigning beginning far earlier than that, and there are many issues that will compete for politicians’ time between now and then. If the Trump Administration waits on a decision by the D.C. Circuit in *U.S. House of Representatives v. Burwell*, and then review by the U.S. Supreme Court after that, no time will be left for Congress to act before the midterm elections, and the opportunity for reform may then be lost forever.

Accordingly, reform that can be implemented administratively has inherent advantages over legislative options. Fortunately, ACA can and should be repealed in practice through administrative actions, without awaiting approval by Congress or the judiciary. ***The same executive actions that allow ACA to self-destruct would at the same time make it possible for the free market to develop better, actually affordable options.***

The Legacy and the Foundations

Prosperity depends on free enterprise, which absolutely requires protection of private property and freedom to spend one’s resources as one chooses. Centralized government planning, which is what ACA essentially imposes, creates enormous inefficiencies and hinders prosperity under the guise of reducing inequalities. The seductive goal of egalitarianism is not new, but has been around for centuries. It is based on the fundamental axiom of socialism: from each according to his means, and to each according to his need.

The economic principles and the morality of socialism were decisively, irrefutably debunked in the early 19th century by Frédéric Bastiat in *The Law*¹ and *Economic Sophisms*. Attempts to implement them in practice, outside of monastic communities, have had a failure rate of 100 percent. Early American settlers at Jamestown and Plymouth were dying of starvation and disease until they privatized property. Every single utopian community in America failed.² Attempts to implement socialism worldwide, with or without retention of nominal “private” ownership of the means of production (national socialism or fascism vs. communism) have always resulted in misery and violence, and caused at least 100 million deaths.³ The social welfare states in Western Europe or Canada are often touted as shining counterexamples, but it must be remembered that these are “mixed economies,” whose prosperity comes from free enterprise. Moreover, the final outcome is not yet known. These nations, like the U.S., are consuming their capital from the past and mortgaging their future, accumulating huge, unpayable debts.

So proposals to “modernize” our system are really attempts to tweak a very old, consistently disastrous, idea. We must remember that whatever the government “gives,” it first takes—

from the “forgotten man.”⁴ The taking may be outright and visible through taxation, confiscation, and monetary penalties, or hidden through debasement of the currency (“inflation”), capital controls, suppressing market interest rates, or regulations preventing productive activity.

Once a building is occupied—or once people have become dependent on a bankrupt system—one cannot simply demolish it without causing enormous immediate harm. So the first priority is to let the people out. Some suggest that a new “Pisa Tower” has to be complete before the doomed one is demolished, and they even propose the equivalent of piling up more lead bricks. But the evacuation needs to start immediately. As noted above, the Trump Administration can and should do that under its existing statutory and constitutional authority.

The rotting structure comprises Medicare and Medicaid as well as ACA. All are based on the concept of legal plunder, or forcible redistribution of wealth from those who own it to those to whom it does not belong. None of them are insurance products. Their acceptance depends on deceit. Social Security recipients (Medicare is Title 18 of Social Security) were told and believe that they funded their own retirement, including medical insurance. In fact, the Supreme Court held, in *Helvering v. Davis*, early in the New Deal, that Social Security is constitutional only as a tax, not a pension plan. The rationale reminds one of the Court’s upholding ACA. Benefits are an entitlement—a privilege—dependent on Congress. There is NO contractual right to anything, no matter how much a “beneficiary” paid in.⁵ Workers’ “contributions” are immediately spent on benefits to persons already retired, and any surplus is spent on other things, thereby reducing the apparent size of the federal deficit. “We owe it to ourselves” means we promised it to our descendants, some yet unborn. The financing system was unsustainable from the start, being dependent on continuous population growth or unlimited economic growth. The U.S. population is not replacing itself, a substantial part of the working-age population is claiming disability or simply not working, people are living much longer, and economic growth is stagnant at best.

Most Ponzi schemes are stopped at the stage in which benefits are paid by new “investors,” rather than by investment income, and the perpetrators imprisoned. Social Security and Medicare are past that stage, being dependent on deficit financing, as outgo has already exceeded revenue for several years.

Medicare, Medicaid, and ACA are all “pay as you go.” They do not have insurance reserves. Increasingly, they are managed-care programs, not insurance at all. Premiums are not risk-based, and benefits are determined by the discretion of the managers, not an indemnity table agreed to by contract. The payment and delivery systems are co-mingled. The system benefits by restricting service. With the passage of MACRA (the Medicare Access and CHIP Reauthorization Act), our single payer system for seniors—Medicare—is being turned into the equivalent of a giant, capitation-based HMO. Physicians are gatekeepers who profit by rationing care and are punished for providing too much.

Medicare and Medicaid are supposed to be “safety net” programs. Of course, one can’t go anywhere when enmeshed in a safety net, and the safety-net programs are serving as a poverty trap.

Letting People Out

People who want to be out of the supposedly voluntary Medicare program can simply be released immediately. Such action could be taken by the Trump Administration or Congress,

or both.

The Centers for Medicare and Medicaid Services (CMS), a division of the Department of Health & Human Services (HHS), should issue new regulations permitting patients and physicians alike to opt out of Medicare and Medicaid *on a per-service basis*, just as participants in other entitlement programs can. By analogy, in many states families are allowed to participate in public school activities and sports without enrolling as public school students, and that system works well without imposing a “take it or leave it” basis.

Additionally, CMS could issue a new regulation directing carriers to reimburse Medicare beneficiaries (*patients*, not “providers”) who receive services from a nonenrolled or disenrolled physician and submit their own claim with an itemized bill, without imposing any claims submission requirement on the physician.⁶ This would inject a much-needed dose of free enterprise into the system, reduce costs by eliminating bureaucratic paperwork, and cause Medicare patients to become more cost-conscious since they would be paying directly for the costs of the services. Many patients would choose not to submit claims. The economic savings would be immense and grow over time. Yet patients who have become dependent on Medicare would not be deprived of benefits simply because they choose a physician not in the system.

Congress, for its part, could easily:

- Repeal the rule that people can’t leave Part A without losing their Social Security benefits.
- Repeal the requirement that enrolled “providers” file claims for all covered services rendered to Part B beneficiaries.
- Expand the current “opt out” provision to allow physicians to work outside the system on a patient-by-patient basis without an all-or-none opt-out.
- Institute a *patient-value-based* system by repealing the Byzantine Medicare price control system, the Resource-Based Relative Value Scale, which is based on the Marxist Labor Theory of Value,⁷ for nonparticipating physicians.
- Exempt nonparticipating physicians from MACRA. Medicare can determine reimbursement based on its concept of value to the system, and patients in cooperation with their physician determine the fee based on their values, without the costly, privacy-destroying MACRA reporting systems.

People who like their Medicare could keep their Medicare and stick with Medicare “participating” physicians (more than 90 percent of all physicians at this time). They would be better off if the system is unburdened by people leaving it. But people are going to like their Medicare less and less, thanks to Obama’s cuts, the increase in Part B premiums, and MACRA, which turns doctors into rationing and government surveillance agents.

States set Medicaid requirements. The ACA Medicaid expansion increased enrollment much more than anticipated, but 60 percent of the new enrollees were previously eligible—the “woodwork” effect, attributable at least in part to the individual mandate. Medicaid is estimated to deliver 20-40 cents worth of medical value per dollar spent. Many do not consider it worth the bother of signing up, or the loss of access to physicians who are unwilling to participate. Those who don’t like their Medicaid would not have to keep it, and each state could decide whether to continue to accept all who do like it. Block grants to the states would make it possible for states to allocate funds more efficiently, without counterproductive federal requirements.

Those who like their ACA plan could keep it, if still available, but the government could no longer require young, healthy

persons to pay premiums many-fold higher than actuarially fair, nor could it illegally take money from current and future taxpayers to subsidize unaffordable plans. Because of high premiums and narrow networks, more people would choose to leave ACA if they were not financially punished for doing so.

People leaving their current unsatisfactory arrangements are potential customers for new products—if the government doesn't block them—including affordable policies for catastrophic, unpredictable contingencies, which is true insurance.

The Replacement

Many assume that we need one big, centrally planned federal replacement plan for everyone, which will allow all to “keep” their ACA benefits. The “winners” might choose to do so. The “losers” (far larger in number) likely would not. Remember that many “Exchange” enrollees have lost plans repeatedly already.

In a free market, many different structures are built, without governments, think tanks, or advocacy groups dictating the plans. Innovation of course cannot be predicted or forced to happen. The government's job is to make and enforce fair, reasonable, predictable rules that foster innovation and competition.

“There is no return to the status quo ante,” say opponents of immediate ACA repeal. But maybe that situation was not so great either.

It is true that many insurance plans that people liked were wiped out by ACA requirements. It's déjà vu for Lyndon Johnson's cancelling seniors' private insurance plans, to assure that “his” Medicare program would succeed. The market for insurance for persons age 65 and older (and needed actuarial information) has been gone for 50 years—but reviving a market for younger people should be much less difficult.

A vibrant competitive market could develop rapidly if permitted. Some of the needed conditions are listed below. Some would require federal or state legislation, but many could be achieved or facilitated through executive action at the regulatory level:

- **Honest pricing.** All facilities should be encouraged to post their prices—it should be clear that there are NO antitrust constraints for doing this. Facilities and managed-care plans that want to keep their pricing and reimbursements secret would face a massive exodus of patients who prefer to know their costs.
- **Honesty in reimbursement.** Patients should demand access to information about what insurers reimburse for specific procedures before buying the policy and before undergoing elective procedures. Government agencies should not contract with insurers who refuse to provide this information accurately.
- **Tax fairness.** Individually owned policies should receive the same tax treatment as employer-owned policies—including exclusion from payroll tax, the biggest or only tax low-income workers pay. Out-of-pocket payments should receive the same treatment as insurance premiums (a greatly expanded Health Savings Account concept). This is especially important for low-income workers, from whom the payroll tax takes 15 percent off the top of their earnings, and who benefit little if at all from an income-tax deduction.
- **Removal of barriers to competition.** This includes certificate-of-need laws, attempts to regulate direct primary care practices or health sharing organizations as if they were insurance companies, or regulations and payment policies that only large or already existing entities can meet (a form

of “economic credentialing”). ACA restrictions on physician-owned hospitals should be eliminated to spur competition and competitive pricing.

- **Group plans available through associations, not just employers.**
- **Repeal of insurance mandates** that require all to pay for costly coverage they do not need or want.
- **Repeal of antitrust exemptions** for the “business of insurance” (McCarran-Ferguson).
- **Enforcement of antitrust law** against hospital systems that are driving out competitors.
- **Repeal of all laws and regulations such as the HMO Act that protect or favor managed-care** over casualty insurance, including laws that require or enable the “enrollee hold harmless clause” in provider agreements. This clause protects fiscally unsound plans against bankruptcy, and enables them to ration care through “providers” they control in order to protect plans against accusations that the plan practices medicine.⁸
- **Fair trade and nondiscrimination.** Insurance collusion with physicians/hospitals for a patient population is a restriction of trade and prevents any price negotiations. Reimbursement policy should not discriminate against independent facilities in favor of those owned or controlled by hospitals, insurers, or other favored customers.
- **Streamlining regulatory procedures that unreasonably delay licensing of insurance plans or medical facilities.**
- **Streamlining licensure** of physicians through reciprocity, and reject requirements such as costly, proprietary Maintenance of Certification that reduce physician supply.
- **Removal of barriers to self-funded plans.** Their access to re-insurance needs to be protected.

The Pre-Existing Conditions Problem

Guaranteed *renewable* insurance should be purchased when a person is young and healthy, and maintained continuously. Many responsible people have been unable to do this because of government policy, especially that which ties insurance to employment. Laws can be changed to prevent this problem in the future, but at the moment many people are stranded through no fault of their own. But regardless of fault, they are uninsurable.⁹ As demonstrated by the current escalation in prices, requiring coverage leads to a “death spiral” in voluntary insurance when low-risk people refuse to be overcharged to cover those at high risk. If people are exempted from the consequences of not buying insurance when healthy, moral hazard will ultimately destroy the concept of health insurance.

There is now a large pool of people with pre-existing conditions, and a free market is likely to develop appropriate products. Most could be covered at a higher price. Previously existing state high-risk pools could be re-established, as Alaska recently did. As market reforms—and restoring insurance to its role of reimbursing people for catastrophic losses—result in drastic reductions in price, the burden will be much less. For people who need care but can't afford it, charity is the moral answer. If taxpayers wish to fund a safety net, it is far more equitable to spread the costs over all taxpayers than to impose it on the sick or those who care for them, and far cheaper to pay for the care directly rather than to funnel the money through a middleman.

What to Do If You Are Uninsured

There are many possibilities:

- Join a health-sharing ministry.

- Join a direct primary care or membership-model practice.
- Join a “Wedge of Health Freedom” practice (jointhewedge.com) or other independent practice that receives direct pay from patients and is free to negotiate terms without third-party interference.
- Increase medical coverage on your auto insurance.
- Check into critical illness coverage.
- Deposit the premiums you would have paid into a dedicated savings instrument.
- Look into medical tourism for elective procedures, many of them within the U.S. (one idea is Medi-Bid.com). Research prices. The website www.surgerycenterok.com is a model; there may soon be many imitators. SmartChoice MRI, for example, advertises “no MRI for more than \$600.”
- Ask for a cash price quote ahead of time—even if you have insurance, as you may be better off not using your insurance plan (and your pharmacist may be forbidden to tell you that).
- Look for a self-funded plan (or start one for your business).

Many who are uninsured choose to live that way, using emergency rooms as their point of access when they have a real medical crisis. Requiring people to purchase health insurance, as ACA does, is an economically inefficient way to address the problem of uncompensated care. (Many uninsured patients do pay for care, and insurers sometimes don’t.) The use of savings and credit to pay unanticipated bills is rational, prudent, and responsible. Medical bills can be reasonable, as many facilities are demonstrating. Outrageously high “chargemaster” rates may result from hospital/insurer collusion that makes insurance look more necessary and valuable than it is, and allows some brokers to profit from “re-pricing” or arbitrage schemes.

Expand Opportunities for Charity Care

Medical care is traditionally an act of charity, and there was no “health care crisis” when a greater percentage of hospitals were true charities staffed with many volunteers, instead of the highly profitable but tax-exempt businesses that many are today. While no one is going to turn the clock back 100 years, and perhaps no one would want to, a partial restoration of the essential role played by charity in medical care would be immensely helpful.

Under legislation submitted in New Jersey and other states, physicians could qualify for protection from vast malpractice liability if they provide a certain amount of charity care in qualified clinics. One charity clinic in New Jersey has been so successful that some patients are even referred to it by the Medicaid program. Charity care is far more efficient than care covered by health insurance, because there is less paperwork and no issues as to what will or will not be covered for reimbursement. Participating physicians, benefiting from some limited protection against malpractice claims, are freed from having to practice defensive medicine and can provide timely, sensible care that they might otherwise avoid doing due to fear of an overzealous lawsuit.

HHS could adopt a pilot program to provide greater protection from malpractice for physicians who generously donate significant amounts of their time to charity care in federally qualified charity clinics. This would alleviate the growing financial crisis in the Medicaid program while extending greater access to care for needy patients, and this innovation could help the Medicare program also.

Both the federal government and states might explore the tax credit model used by Arizona for supporting charities and tuition for students attending private (including parochial) schools: a dollar-for-dollar state income tax reduction up to a certain limit. Georgia has enacted a similar program¹⁰ for donations to rural hospitals.

Key False Assumptions

The language of egalitarianism and “fairness” frequently cloaks socialist concepts. False crises are created to promote big-government schemes. These are some of the false premises that reform advocates tend to accept without question:

- **We need “universal coverage.”** No, we need optimal availability of actual medical care. We need a free market, not mandatory third-party payment.
- **We need to “contain costs.”** No, costs are far too high, mostly because of comprehensive third-party payment. They can and should be greatly reduced.
- **“We” are all responsible for everybody else’s health care.** No, we are responsible for caring for our own health and for paying for the necessities of life, including medical care when appropriate. Comprehensive third-party payment is the most expensive and least efficient way of doing that.
- **Charity is demeaning; people have a right to help.** No, charity is a blessing both to those who give and those who receive. Being dependent on government-forced redistribution is both demeaning and debilitating.
- **The federal government can “assure” health care for all.** No, the government can only take. Each lead brick piled on to stabilize a tottering structure is taken from another, better use, and can at most only delay the day of reckoning.

The legacy we want to preserve is the one of freedom, which brought us prosperity and wonderful advances in medicine. Piling on more lead blocks to try to salvage the icon of socialism is suppressing a return to greatness in America.

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