From the President

The Restoration of American Medicine, Part II

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At this writing the U.S. House of Representatives has just narrowly passed the bill called the American Health Care Act (AHCA). Now it proceeds to the U.S. Senate for modification or rewriting. At the state level, Texas has just passed an anti-MOC bill that is headed to the governor's desk. Several other states are fighting Maintenance of Certification/ Maintenance of Licensure (MOC/MOL) effectively with the help of AAPS.

The Association of American Physicians and Surgeons believes in repeal and in several important logistical items that could benefit the patient-physician relationship. Now is the time to inform your senators of the importance of the details of the AAPS white paper on repeal/replacement of the Affordable Care Act.[1] Phase 2 and Phase 3, promised by Republicans, may also offer opportunities for reform.

Physicians who decide to switch to non-participation status with Medicare ("non-par") should be exempt from MACRA (the Medicare Access and CHIP Reauthorization Act of 2015), including MIPS (Merit-based Incentive Payment System) and APMs (Advanced Alternative Payment Models). We have asked HHS Secretary Tom Price, M.D., to consider this change in the rules.[2] Imagine the patient paying the physician at the time of service in cash, check, credit, or health savings account card, and then submitting a claim to Medicare or other third party for potential partial or full reimbursement depending on deductibles. The physician who is not beholden to MIPS and APMs could spend more quality time with the patient, offering even more value by focusing on the most pertinent issues. Patients, not "administroids," determine quality.

A good physician does not need to increase the risk of carpal tunnel syndrome and/or tension headache while wasting time clicking and following a checklist. There is no guarantee that the said checklist represents quality. The skilled physician will already be providing care that meets or exceeds standard quality expectations without having a government mandate or penalty threatening the practice and the doctor's autonomy. Recall that MACRA in operation is a malignant attempt to curb and restrain autonomy or a malicious act to coerce and regulate attending physicians. As such, it is likely to crash and burn by design and will not improve quality or lower the cost of medical care. Healthcare is not synonymous with medical care. Patients are responsible for their health; physicians and surgeons render medical care.

Ultimately, AAPS desires the practice of private medicine to thrive and not just survive. Third party "gorillas" are not tolerated in our members' clinics. Several strategies are in place to reclaim physician autonomy and preserve the sanctity of the patient-physician relationship. Three outpatient clinic models that are working well are: officially opting out of Medicare; direct-pay primary care; and "non-par" (nonparticipating) status for physicians enrolled in Medicare. Since opting out is impractical for many hospital-based physicians and surgeons, the next best strategy will be to pass legislation that exempts "non-par" physicians from MACRA and does not require MOC for licensure, hospital privileges, or payment.

AAPS will continue to fight for the right of patients to have and pay a private physician outside the system. Also, physicians know that many of their patients would willingly pay their full fee, but Medicare bars such a mutual transaction to the detriment of helping the next poor patient in need of charity, discounts, or payment plans. The price controls affect both those who are "par" (have an agreement with Medicare to accept assignment on all covered services to Medicare Part B beneficiaries) or "non-par" (do not have such an agreement, but are still enrolled and not officially "opted-out"). If a physician could opt out of Medicare on a case-by-case basis, a patient who desires to pay the physician a mutually agreed upon fee for medical or surgical services could then do so. This is called an exchange of goods and services in a free market, and it works. It works so well that the uninsured, or the indigent, or those with suboptimal Medicaid plans can still be cared for because the clinic is viable, due to some partial restoration of a free market. Any attempt to extricate the practice from the chains and ownership of a price-controlled system is worthwhile if it results in the daily infusion of some free-market economics.

In 1992, AAPS past-president Lois Copeland, M.D., and five of her patients sued to establish the right to opt out on a case-by-case basis (*Stewart v. Sullivan*). The outcome of the case left the issue murky: what the plaintiffs wanted to do was not clearly illegal, but intimidating assertions by Medicare carriers made physicians unwilling to exercise this right. The opt-out provision of the Balanced Budget Act of 1997 complicated the issue further, as explained by Pavey et al. in the inaugural issue of this Journal.[3]

The legal situation may still be ambiguous, but the government's hostility to private arrangements that circumvent its control is very clear. The truth is that American medicine cannot be restored without a free market.

When patients are in control of their own money, and own true catastrophic insurance with reasonable premiums and deductibles, cash, catastrophic insurance, and charity

will be allowed to flourish in medicine again. It is not too late to return to such wise practices. All three of these concepts were proven to work before Medicare was passed in 1965.

The poor will always be with us, and charity is the true safety net. Most will willingly help the poor. Christians see it as commanded by Jesus Christ (Matthew 6:19-20). Saint Teresa of Calcutta said that "we receive much more from the poor than we give them."[4] Shakespeare wrote in *The Merchant of Venice* (Act IV, scene 1) that "[mercy] is twice blest;/ It blesseth him that gives and him that takes."

Caring for the poor should be simple. However, programs that are supposed to help them can make it formidably difficult. Most of the generalists and specialists I know do not take Medicaid, despite the Medicaid expansion of 14 million enrollees nationwide, including 1.5 million in Arizona. Even more physicians, capable of helping the poor involved in accidents sustained on the job, do not take workers' compensation insurance. Even fewer help the sick involved in personal-injury litigation. Thus, the poor are in need, but third-party red tape, prior authorization, delays, denials, billing/coding, and claims filing hassles otherwise restrict access and prohibit much of their needed medical care.

Universal coverage does not equal quality and cost-effective care. Very short visits, poly-pharmacy, and difficulty seeing specialists or even any doctor are all happening in the PPO ("preferred provider organization") managed-care model. How much more do we observe these consequences within the HMO ("health maintenance organization") or Medicaid model? And "universal" does not mean the same for everybody. Employees inside the Washington, D.C., beltway enjoy the federal health plan by Blue Cross Blue Shield, which many say is the best PPO plan available, while the private citizens have to use grandfathered PPOs, HMOs, or the misnamed Medicare Advantage plans, which have more disadvantages than actual advantages.

The vast gap in quality between private and public medical care results largely from hassle factors in third-party government payment schemes including the enforcement of price controls. Physicians' ability to work in those programs, or to offer charity, is constrained by their high expenses: for example, front office and mid-level staffing, professional liability insurance premiums, MACRA, electronic health records, billing and coding requirements, prior authorizations, various taxes on time and talent, as well as direct costs of MOC requirements. The bureaucratic requirements that originated in Medicare and Medicaid are increasingly migrating into private insurance as well. AAPS is committed to fighting these metastasizing intrusions, including MACRA and MOC.

The expansion of government schemes is increasingly supplanting the private market through the process called "crowding out." Would-be reformers still obsessed with the idea of "single payer," despite the failures of socialized medicine throughout the world, seem pleased with the growing dependency of Americans on the government insurance card and the expansion of the inefficient Medicaid culture in which a mere 20 to 40 cents on the dollar goes to actual medical care.[5]

AAPS members reject increasing governmental control of medicine and support individual responsibility and freedom within the sanctified patient-physician relationship. We strive daily to leave a legacy of freedom in medicine that is right and good for all Americans in the long run.

Voluntary exchanges with fair and transparent pricing, genuine charity, and catastrophic insurance rather than pre-paid "health care" ensure innovation and prosperity, and restore physicians' joy in the practice of private medicine and surgery.

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