Journal of American Physicians and Surgeons
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Copy Editor
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Cover Design
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Typesetting and Printing
Skyline Printing Co., Inc.
Tucson, AZ

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www.jpands.org

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Tucson, AZ 85716

Journal of American Physicians and Surgeons (ISSN 1543-4826)
is published quarterly.

Correspondence

Memorandum to Incoming Congressmen on Health Solutions

Health-related costs account for about 8 percent of the average household's annual spending, up from 5 percent in 1984, according to the Bureau of Labor Statistics,[1] and are a concern for Republicans and Democrats alike. Thus, the focus of healthcare reform must shift from merely providing insurance coverage to providing affordable options and increasing access to medical care.

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. A good medical "system" requires voluntariness, price transparency, multiple medical practice models, and a variety of insurance products in order to lower costs. True indemnity insurance (not pre-paid medical care) is a necessary evil for the big expenses.

Subsidies such as cost-sharing reductions (CSRs) and "stability funds" (state reinsurance) shift the insurance premium costs to taxpayers, and both are purported to lower costs to enrollees. However, as of 2017 amounts in excess of $100 billion in Affordable Care Act (ACA) funds have been spent subsidizing "the individual market," and premiums have only soared. If absolutely necessary to gain congressional support for regulatory rollback, appropriating federal funds for a fixed period of one to two years may force states to act quickly.

Ensuring that any "fixes" do not further burden the federal budget is vital to the success of a new program.

Lowering Prices

Prices could be lowered substantially through increased competition, and care improved through direct, unencumbered patient-physician relationships.

Congress needs to remove federal barriers to these free-market mechanisms, including:

- Lack of price transparency
- Certificate-of-need laws, and Affordable Care Act (ACA) restrictions on physician-owned hospitals
- The linkage of Social Security to Medicare Part A, which destroys the potential for a true insurance market for the over-65 population, as opposed to supplements tied to Medicare, while burdening the Treasury with costs people are willing and able to pay for themselves
- Lax interpretation of anti-trust laws that allows hospital and insurance carrier consolidation as well as vertical consolidation such as the Cigna/Express-Scripts and Aetna/CVS mergers
- Difficulties in opting out of Medicare by physicians
- Medicaid rules that decrease Medicaid patients' access to independent physicians, such as ACA Section 6401(b), which requires physicians who order or prescribe for Medicaid patients to be enrolled in Medicaid
- Failure to explicitly define direct patient care (DPC) as medical care (instead of insurance) to avoid any conflict with state laws protecting DPC and to allow patients to use their Health Reimbursement Accounts (HRAs) and Flexible Spending Arrangements (FSAs) for DPC
- Safe harbor rules created by the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. §1320a–7b (b)(3)(c)) and implemented by 42 C.F.R. §1001.952(j), which protect Group Purchasing Organizations (GPOs) and by extension, pharmacy benefits managers (PBMs), from the Medicare Anti-kickback Statute and contribute to the excessive cost of medications.
- Clinical Laboratory Improvement Amendments (CLIA) requirements for physicians' in-office laboratories

Empowering Patients

Congress also needs to help patients afford their medical bills by improving Health Savings Accounts (HSAs). The Employee Benefits Institute estimates that a person saving in an HSA for 40 years, assuming a 2.5% return, could accumulate up to $360,000.[2]

HSAs are not just for high-income earners. "An often-assumed data point is that HSAs are primarily utilized by highly paid employees. Our data supports the conclusion that this assumption is incorrect," stated Jody L. Dietel, ACFCI, CAS Chief Compliance Officer for WageWorks, Inc. According to her congressional testimony, the median household income for an HSA accountholder is $57,060.[3]

Several bills were proposed; two passed the House in July 2018 and are in the Senate, H.R. 6311 and H.R. 6199. Salient provisions include allowing working seniors to contribute to an HSA; not

disqualifying persons with a DPC arrangement from contributing to an HSA; and increasing contribution limits.

Another idea that Congress might consider, without the complicated restrictions of current HSAs, is to allow everyone to earn a certain amount of money free of income or payroll taxes[4] that would go into a medical expense account. The funds could be used for paying for anything reasonably related to healthcare as determined by the states, e.g., insurance premiums, deductibles and co-pays, DPC monthly fees, and health-sharing ministries' costs. The funds would be taxed if they were used for any other purpose. The funds could be passed to heirs or rolled into an IRA upon death (thus, withdrawn funds could be taxed providing revenue for the government). Less IRS-intrusive would be an HSA modeled after Roth IRAs, where after-tax dollars are deposited into an account, but the earnings are tax-free.

Congress should also remove federal barriers to health-sharing ministries. Health Care Sharing Ministries (HCSMs), defined in 26 U.S.C. § 5000A(d)(2)(B) (2012) for purposes of ACA, engage in voluntary sharing and not a contractual transfer of risk. Despite being sold by commissioned brokers, they are not insurance. HCSMs are under the oversight and general regulation of both the Internal Revenue Service and the states' attorneys general since they are 501(c)(3) charities. No states regulate them as insurers. From 1994 to 2016, legislation has been passed in 30 states recognizing that HCSMs are not insurers under the state's insurance code (AK, AL, AR, AZ, FL, GA, IA, ID, IL, IN, KS, KY, LA, MD, ME, MI, MO, MS, NC, NE, NH, OK, PA, SD, TX, UT, VA, WA, WI, and WY).

Typically, members contribute periodically (usually monthly) to cover the medical expenses of other members. HCSMs either match paying members with other members who need funding for medical bills, or pay covered medical expenses directly from the pool of contributions. Most have features like traditional insurance, such as payments resembling deductibles, monthly premiums, co-payments, a defined benefits package, use of provider networks, and levels of coverage.

Health-sharing groups should not have to be religiously exempted by the ACA, opening the door for secular charitable health sharing.

Increasing Insurance Choices

Congress needs to eliminate barriers to portable individual insurance. Currently, employer-sponsored coverage is given a tremendous tax advantage as it is free of both income and payroll tax. Individually owned policies, which are not tied to employment, do not enjoy this tax exclusion. U.S. state and federal governments yearly lose roughly $260 billion in tax revenues from the employer-sponsored insurance tax exclusion.[5]

Americans seldom if ever have the option of choosing true indemnity insurance. The individual market is moving toward HMOs and narrower networks. The number of ACA plans offering any out-of-network coverage declined to 29 percent in 2018 from 58 percent in 2015. Even in the ACA Marketplace consumers must buy a new insurance plan when relocating to another state. It is rare for plans to offer coverage in multiple states. With true indemnity health insurance, this would not be a problem—just as if the consumer were involved in an auto accident in another state.

Pre-existing Conditions

The Kaiser Family Foundation estimates these bad insurance risks to be about 5 million persons. In any given year, the healthiest 50% of the population accounts for less than 3% of total healthcare expenditures, while the sickest 10% account for nearly two-thirds of population health spending. On average, state high-risk pool membership was about 2% of the non-group health insurance market participants.

A troubling thought is that most of our nation now has a "pre-existing condition": More than 30 percent of Americans are obese, and the American Medical Association is defining obesity to be an illness.

Two House measures were introduced by congressmen who were not re-elected: H. Res. 1089 by Rep. Pete Sessions (R-Tex.) and H.R. 6898 by Rep. Steve Knight (R-Calif.). One idea was amending the Health Insurance Portability and Accountability Act (HIPAA) to duplicate ACA's pre-existing conditions provisions in case ACA is struck down in court. A similar bill, S. 3388, was introduced by Sen. Thom Tillis (R-N.C.).

In a free market, insurers would not have to "take everyone" at a pre-set price—with the result of soaring premiums for everyone. Standard insurance industry reinsurance options would better serve patients and taxpayers. Also known as insurance for insurers or stop-loss insurance, reinsurance is the practice of insurers transferring portions of risk portfolios to other parties by some form of agreement to reduce the likelihood of paying a large obligation. Two types of products would add minimally to the overall premium and rarely be used: With proportional reinsurance, the reinsurer receives a prorated share of all policy premiums sold by the insurer. When claims are made, the reinsurer bears a portion of the losses based on a pre-negotiated percentage. Excess loss reinsurance is non-proportional coverage in which the reinsurer covers the losses exceeding the insurer's retained limit. This contract is typically applied to catastrophic events, covering the insurer either on a per-occurrence basis or for the cumulative losses within a set time period.

Charity Care

The voluntary way to help patients pay unaffordable costs is through charity. Charitable deductions or tax credits for donations to organizations that pay medical costs for others prevent IRS invasion into physician records and eliminates having to place a price on the care rendered. Individual physicians should be able to treat patients free of charge without running afoul of federal fraud laws.

H.R. 3976, proposed by Rep. Kevin Cramer (R-N.D.), would amend ACA and would allow charities to pay premiums for others.

In Kansas, some physicians gathered together to pay patients' bills.[6]

St. Luke's Family Practice in Modesto, California, is a DPC non-profit organization. Here, "benefactors" pay the fees for the "recipients"—those who cannot afford the fees. Despite the novelty of nonprofit status for a private practice medical office, St. Luke's prevailed in its IRS battles and received 501(c)3 status.

A New Jersey physician, Alieta Eck, M.D., is pioneering a volunteer charity model for patients who cannot find care "in the system." It costs Zarephath Health Center (her volunteer-run and funded facility) $15 to see a patient, versus $160-$280 at the Federally Qualified Health Center down the street

[A more detailed version of this memo was sent to two incoming congresspersons at their request.]

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