Episode 1,351: Medicare for All, and Other Disasters

Guest: Jane Orient

WOODS: I have several things I want to ask you about that I think you're the best person to answer. And in particular, I want to get to Medicare for All. I want to talk about preexisting conditions, because I remember you gave me a very interesting answer I'd never heard before, and now for the life of me, I can't remember what it was. And then after that — well, then after that, we'll kind of look at what your wish list would be, if you could have health delivery the way you like it.

So let's start with the proposal for Medicare for All, which we see a number of Democratic candidates advancing, and which seems to be very popular in the polls, when nothing about it is actually spelled out to the people being surveyed. What exactly would this proposal look like?

ORIENT: I guess to see what it would look like, you'd have to see the bill, and I don't think that has been forthcoming in its final form. One thing that's in it is that it would outlaw, disallow any private insurance that would duplicate the Medicare for All coverage, which means you couldn't buy catastrophic hospital insurance or insurance for life-saving things. You might be able to buy private insurance for tummy tucks or unnecessary procedures, but not for the things that would save your life. And I think a lot of the support for this proposal really drops significantly when people find out that they would have no choice about it. And when it says "for all," it means for all, and that means everybody and nobody out. No matter how bad it is, no matter how often they send people who could recover to hospice prematurely, no matter how many long waiting lines there are, you would not be allowed to buy your own medical care or your own insurance that would supposedly duplicate what Medicare covers but you can can't get.

WOODS: What kind of a price tag do you think this carries? Again, it's hard to know at this point, but that is a problem with it, is it not?

ORIENT: Oh, yeah, I think I've heard like $30 trillion over 10 years or something like that, or maybe even more. It sort of depends on what the thing is supposed to do. But it really makes a lot of sense, doesn't it, to take a program that is scheduled to go bankrupt — which means not only is the income less than the outgo already, but the so-called trust fund is being devoured, and there are $40 trillion at least in unfunded liabilities — that means promises made to the elderly Medicare population for which there is no source of revenue — doesn't that make a lot of sense to throw everybody in this program that's bankrupt as it is?

WOODS: Yeah, no doubt. What is the difference then between Medicare for All and so-called single-payer? Or are they the same thing?

ORIENT: I think it sounds like the same thing. Single-payer means that you're not allowed to pay, that if the "single payer" doesn't pay, you can't have it, and the "single payer" is the government, which means the taxpayers. I mean, government doesn't have a money tree that it can shake and come up with unlimited funds. If your outlawing private insurance, well, then that really means it's a single payer, except I guess you have a choice of how to administer it. You can either have quasi private carriers like Medicare does, or you can have a VA equivalent.

WOODS: What's it like on the physician end dealing with Medicare?

ORIENT: Well, I haven't done it for a long, long time, because back when this resource-based relative value scale came into effect, and I looked at what I had to sign to send in a claim so that I was doing everything accurately, and I looked at the requirements for the AMA's coding system, I said I can't figure this out. I was a math major, but I can't figure out how you calculate all the bullet points and stuff that you're supposed to have to document the service that you offered. And so I just quit accepting money from Medicare on that very day. But I do know that doctors are being prosecuted, they're being fined draconian fines, their offices are being turned upside down by audits, by recovery audit contractors who get a bounty for the amount of fines they can do. For a single mistake, you could be charged more than $13,000. It really is very intimidating, and I think the only way to escape from these massive headaches and threats to your livelihood and your freedom are to get out of Medicare.

WOODS: Now, let's look at this from the point of view of somebody who is just an ordinary citizen, hasn't read anything about the history of American medical care, has no idea what the various government interventions are. Just what the person sees are medical bills that just seem completely untethered to reality and that legitimately fears that one major medical emergency could lead to bankruptcy for that person. I mean, that's not an illegitimate concern. But what's the source of this? We get people saying that, look, all around the world, people are happy with their medical care, and here in America, wicked capitalism is jacking up the prices. What's the reality of the situation?

ORIENT: I think the crony capitalism and government interference and the reliance on third-party payment is the cause of this. These medical bills that you may get are so high, that virtually no one could afford to pay them, and they virtually are not paid. The insurance company, who really should be called a third-party payer, makes a deal with the hospital to cover some fraction of it. And it's very much to the hospital's advantage and the insurer's advantage for these bills to be very, very high, because the insurer can say, "Hey, look, if you don't pay us these outrageous premiums, you'll get a bill that you can't possibly pay." I mean, they never tell the person that that's not what the service actually costs, and that's not what the insurer is going to pay. And the hospital has these chargemaster prices that it bills the insurance company for. It doesn't get paid, but it can claim on uninsured patients that this is the loss that they took and get the government to give them money to help defray this totally fictitious price.

WOODS: I've talked to people who have managed to maneuver within this crazy system in one of two ways that have led to satisfactory results for them, given that no individual can change the system, but individuals want to figure out some way they can navigate it. And one way

has been with these health-sharing plans, like Liberty HealthShare, for example. And another has been through cash-only practices that somehow, by not interacting with either Medicare or traditional insurance, they've managed to keep costs to a level that actually seems reasonable to people. What other things do you recommend?

ORIENT: Well, I think that's it. You need a free market with transparent pricing. We need to get rid of impediments to free markets, like certificate-of-need laws in many states that keep independent facilities that compete with hospitals from opening up. But if you doubt that these prices are achievable, look at SurgeryCenterOK.com. That's the Surgery Center of Oklahoma. You click on a body part, and it lists the procedures that they make available and the cash price, that includes the facility, the surgeon, the anesthesiologist. And if you pay that amount, cash up front, that is the cost. And it may be even one-tenth the amount that Medicaid may pay at so-called nonprofit hospitals. In fact, that Keith Smith, the director of there, told me that he saved one guy $40,000 on a prostate operation, and they didn't even do the surgery. All the man had to do was to take the quoted price for the surgery to his local hospital, and they quoted him a price that was the same as that, plus the amount that it would cost him to fly to Oklahoma City.

WOODS: Wow. I've talked to — I know Dr. Lantier, who's been partnered with Dr. Smith, and I do know Dr. Smith. I probably should talk to one of them as well. But before I forget, you mentioned a certificate of need, which, it's interesting that the acronym is CON. But I wonder if you could explain what that is, because my recollection is that hospitals get to determine whether there's need for additional medical facilities. It seems like they may have a vested interest in this question.

ORIENT: Well, I think you're right, and they do have a vested interest, and a lot of independent centers, you can get a quote for an MRI, if you tell them you're uninsured, and it may be a tenth of what the hospital will charge or half — anyway, much, much less than what the hospital would charge. And so the hospital naturally has an interest in stamping out this kind of competition.

WOODS: Let's talk about one of the main concerns on people's minds in addition to the high prices, and that is the related question of preexisting conditions. Because even the president says, whatever health plan we ultimately decide on, naturally, we have to make provision for preexisting conditions, that if somebody has some preexisting condition, a private insurer is very unlikely to cover them for that condition, and that means they're on the hook for these crazy prices that, as you say, basically nobody could pay. So what is the correct way to think about that, and how would you want to proceed on that issue specifically?

ORIENT: I think that the president and the Republicans are really ignorant of the economics of the situation, and it's pretty obvious that you can't insure your house when it's burning down. You can't buy insurance for your car after you've just had a crash. In that situation, yeah, you've got a big bill, but you can't really have voluntary insurance, because who is going to agree to share the price of your house burning down? They're just not going to do that. I mean, insurance is a voluntary contract that you agree to share the risk of a foreseeable but unlikely catastrophe. And the way health insurance would work, I would say, "Okay, I'm going to pay in advance in premiums more than I ever expect to get, just in case. I would rather help pay for your heart attack than have you help pay for mine." So it's just like when I buy car insurance. I send the premium to the insurance company; I hope to have no more

communication with them. It's reasonable. It's there if I have an unanticipated accident. Otherwise, I understand that that's going to somebody else's accident, and that's okay.

But if you already know that you're sick, and the insurer is forced to give you coverage at the same price as everybody else, that insurer is going to go bankrupt. It's an incentive to wait until you're sick to buy the product, and that's why there was the individual mandate. We're going to force you to buy this product at an elevated price and maybe five times the price that would be charged in a free market, because your risk is that low, but you're going to have to pay it, because we want to protect these people who don't buy insurance.

Now, of course, what happened with Obamacare was a lot of people who were responsibly paying their insurance all along suddenly lost it. And maybe they lost it three or four times. So instead of having this guaranteed renewable coverage that covered them for themselves even if they got sick, after they bought the initial plan, they had to reapply over and over again. And so every time they reapplied, there was an increased chance that they had a preexisting condition. So Obamacare really made the problem a whole lot worse.

And there are ways to deal with the problem. There are state high-risk pools. There are limited policies that limit the exposure. In the old days, when I was able to get catastrophic insurance, it would ask about preexisting conditions, say it's not going to check if you don't file a claim for a year or two. They could only deny your coverage if you lied to them and they find out about it. So there are ways to deal with it, but abolishing insurance, which means price according to risk, it just drives the cost way, way up and defeats the whole purpose. It means that nobody can get true insurance, and everybody's going to pay a whole lot more.

WOODS: I think now I have to ask the question that comes up constantly, and that is what's going on and other countries, because what we hear all the time is the United States is backward because it doesn't have the kind of healthcare delivery that we have in other countries, where the state is really at the center of the system. And they say, in these countries, they have great life expectancy, they have good health results. If you poll people, people say they're very happy with the system. Yes, we admit that in some cases there are long waits, but you balance that against the benefits that people get and that they're not worried about bankruptcy because of one bad thing. And I've even had libertarians say, you know, given the mix of crony capitalism and government that we have in our system now, the results are so bad, I don't see how much worse single-payer could be. So how do you answer that?

ORIENT: Well, I think it could be a whole lot worse, because if there's no out, there's no incentive for things to get better. And all these other countries, you know, polls are going to — if you look at the population as a whole, most of the people are not sick, so they don't have to worry about being bankrupt if they get a medical condition, but what they do have to worry about is getting any kind of medical service. And people who have had experience with being sick will give you a different story, maybe with some exceptions. But keep in mind that there are very few of these countries that actually have a single-payer system. Switzerland, Germany, and France, they all have a parallel private insurance system. You can buy private insurance. You can get private treatment. It's just places like Canada, where, if you want private treatment, you want to jump the queue, so to speak, you have to come to the United States or to some other offshore location. Or you have to be a cat or dog. They can keep the

MRI center open later and charge cash for your pet, even though it can't do it for you, who might have a brain tumor.

WOODS: I don't know. I don't know. It's just overwhelming that we see this kind of response everywhere, though, that everywhere where there's more state involvement, they say: look, these people pay less money. They pay less money.

ORIENT: Well, they don't.

WOODS: And yes, it's state money.

ORIENT: They don't. The amount that they may pay for their insurance coverage through their taxes is very high. And they may pay with their lives. I mean, the UK's NHS is going bankrupt. The hospitals are shabby. They have old equipment. People circle the ER in ambulances for hours. They wait for hours in the ER to then be treated in a corrido. It is not so rosy. And these horror stories come from British newspapers. I'm not making them up. Or look at our own VA. We have a single payer with the VA, and everyone seems to agree that our veterans should be getting the best in care, but they're obviously not. They're dying on the waiting list. The officials at the hospital may be lying about their statistics to make it look as though people are getting care. We see Medicare is already cutting back on services. You talk to Medicare patients here. They go to the provider; they may not see the doctor; they may get ten minutes with the provider behind a computer screen. They really don't have the doctor's professional time or access to his best judgment, because Medicare doesn't pay for that.

WOODS: One response that I get also is that, in these different countries — let's take a Canada — they'll say: look at countries that have a setup like Canada. None of them have abolished their system. So that shows that people must be content with it. Now, I'm pretty sure I can refute that one, but I'm curious about your thoughts about that. I mean, of course once a program gets started, the interest groups involved are so entrenched, that it can never, ever be gotten rid of, almost, no matter how unhappy the population is. Do you have a further kind of response to that?

ORIENT: Well, I think that that's a good response, but what the people do — and a lot of them are indoctrinated. They think, *Oh, isn't that wonderful here? I am willing to wait in line in pain at risk of death for years, because that's just fair.* But there are others who will come to the United States. And if you ask doctors in Seattle or Detroit or Buffalo how many Canadians they're seeing, who come here — you know, assuming that they can travel and they're not just not able to get into the emergency room for their ruptured aneurysm. And then the government has a lot of control of the news media and of the information that gets out. Doctors who complain are at risk of losing their job or their position on the insurance panel. I mean, that was one of the provisos that I had when I was working at the VA that I discovered after I'd been there for several years, is that employees are not allowed to speak publicly with criticisms about the government. So it's really hard to get the truth out. Once they get to control of your medical care, they have control over your life.

WOODS: How about this? If we could talk about politically feasible reforms that could be made, as opposed to what we might want, which is just a complete separation of state and medicine — let's say maybe that's the direction we want to go in, but right now, what do you think is the most politically feasible kind of reform that would have, let's say, the least resistance and would do the most good?

ORIENT: I think you're going to run into resistance from the vested special interests no matter what you do, but the idea that I like best is to say: okay, let's imitate Obama only, let's tell the truth — that if you'd like your Medicare, you can keep your Medicare. If you like your Obamacare plan, you can keep your Obamacare plan. But let people out. One first thing we could do is make it possible for people to get their social security benefits and opt out of Medicare Part A, opt out of their entitlement for Medicare Part A. And some people wanted to do that, and they failed in court to get that, because they could get a substitute plan from their employer only if they were ineligible for Medicare.

Other people like me like it that way, because I want to be able to choose my doctor. And I signed up with Samaritan Ministries, one of these health-sharing plans, that will accept you even if you're eligible for Medicare if you decline Medicare, and hoped that if I did have a big emergency that my car insurance didn't cover — you know, there is some medical coverage on that — that the health-sharing ministry would help. Plus, I would have every incentive to tell the hospital: "Look, this bill is outrageous. I will pay you up front in cash what you would have gotten from Medicare ,and then leave me alone." And sometimes that works. I mean, sometimes just by asking, you can get a 40% discount from this fictitious bill.

There are a lot of things that you can do to keep the costs down. And you know, you don't want your doctor to have an incentive to kill you. You do not want to be dependent on the really lousy Medicare hospital coverage, which does not cover prolonged stays anyway, and puts you under the jurisdiction of an army of clerks who are continually trying to get you out of the hospital no matter what, to deny you things that might be expensive, and, worst of all, to ship you off to hospice before you really should go there.

WOODS: Can you take a minute to tell us about the Association of American Physicians and Surgeons, where you are the executive director? I have some physicians who listen who may not be members, and I'd like you to make the case to them.

ORIENT: Well, you can learn all about us at AAPSOnline.org. We have some articles in our journal, which is available through our website also at JPANDS.org, about our history from our 75th anniversary. We were founded in 1943 to fight socialized medicine. Basically, there were attempts back then to pass what was called the Wagner-Murray-Dingell Bill, which would have initiated socialized medicine in the US, and we've been fighting the idea ever since because it really does destroy private medicine. It destroys the patient-physician relationship. It turns the patient into livestock on the government ranch. It turns physicians into serfs, who are servants of the state, who are risking their own well-being if they really stick up for their patients and deviate from the protocol and the cost constraints. So we are the voice of private physicians since 1943, APSOnline.org.

WOODS: So what then was the attitude of the American Medical Association?

ORIENT: Well, at first in 1943, they were just not getting their hands dirty, getting involved in government. When they started fighting the Wagner-Murray-Dingell Bill after we did, they sort of took credit for that. They fought against Medicare until it looked like they would lose, and then they advocated for Part B, which they wanted to — *well, if the government's going to do it anyway, we want to get ours*, so they got this program that Medicare would also cover physicians' fees, which a lot of insurance didn't cover, because that was really much less significant than the hospital charges. And then they got the sweet deal with the government that gave them sort of a monopoly on the CPT, the current procedural

terminology codes that are the basis for the Medicare price controls, that are used by private insurers, that really — I mean, this brings in a huge proportion of their income, from their business interests, selling or licensing those codes. So they don't dare speak out too much against the government, lest they lose their monopoly, and certainly it's very lucrative for them. But if a procedure doesn't have a code, Medicare will not cover it, and insurance companies will not cover it either. So it really does constrain innovation. It constraints your freedom. It constrains your ability to get what might be the best medical care, and you're stuck with what the AMA decides to approve of.

WOODS: Wow. Well, how long has AAPS been going on?

ORIENT: We had our 75th anniversary meeting in 2018.

WOODS: So yeah, 1943, holy cow. I actually spoke at an event in Utah in 2010, and it was a wonderful time. And they put a misprint on my name badge; they had me as Tom Woods, MD. Now, I am a mere PhD, so to have that MD badge gave me a certain special feeling of superiority that was totally unearned.

ORIENT: Oh, I don't know; these days doctors are public enemy number one, so you might not want to put it on your bulletin board, after all.

WOODS: [laughing] Well, all the same, it was amazing to meet a group of physicians who were so, so committed to freedom and to the doctor-patient relationship. Amazing people.

ORIENT: The patient-physician relationship really is endangered, and you really do need an independent doctor, because the others are really punished if they do too much for you.

WOODS: Well, pretty terrible situation. And yet, the thing is, nobody knows this. Almost nobody knows the real story from the physician side, right? I mean, I find out about it because I talk to people like you, but the average person I don't think has any idea this is happening.

ORIENT: Yeah, they do complain a lot, though, about the treatment that they're getting.

WOODS: Oh, that's true. Yeah, but they think it's just because the doctor's a bad person and won't spend time with me. And maybe that is the case, but it could be that the doctor is just overwhelmed constantly and can barely cope.

ORIENT: Well, at least something like half the doctors suffer from burnout, supposedly. We lose a medical-school-class-full to suicide every year, and a lot of doctors are retiring early, or they're going to work for the hospital and just kind of becoming a good, docile employee.

WOODS: Well, I'm sorry to hear it, but I am glad that there is an AAPS out there. So AAPSOnline.org is definitely the website to check out, and Dr. Orient, thanks so much for your time today.

ORIENT: Thank you so much.