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President Donald J. Trump
The White House
1600 Pennsylvania Avenue, NW
Washington, D.C. 20500

Dear Mr. President:

Thank you very much for **Section 11, Maximizing Freedom for Medicare Patients and Providers**, of your Executive Order on Protecting and Improving Medicare for Our Nation's Seniors. Allowing seniors to opt out of Medicare Part A without losing their Social Security benefits is a huge step toward protecting and ensuring the right of Americans to choose their medical treatment and their means of arranging payment for medical care. The freedom to choose is critical to preserve access to care and quality, for seniors as well as for veterans. Additionally, all Medicare beneficiaries who use their own hard-earned, after-tax dollars to purchase medical care, without burdening the already overstressed system, free up resources for other beneficiaries. It is hardly fair for middle-class or low-income workers to be shouldering all the medical costs of wealthy retirees.

As rules are developed for other parts of the order, we respectfully request that you consider the following:

Sec. 3 Providing More Plan Choices to Seniors assumes that managed care is preferable to fee for service, and that the latter is responsible for cost inflation. In fact, cost inflation is the result of disconnecting the free-market regulatory mechanism in which the person receiving the services is responsible for payment. The moral hazard of third-party payment cannot be overcome by managed-care methods such as narrow networks, price controls, global budgets, pre-authorizations, formularies, drop-down menus of allowable treatments or tests, and denials.

Sec. 4 Improving Access Through Network Adequacy assumes that bureaucratic determinations, rather than the free market, can bring supply and demand into equilibrium.

Sec. 5 Enabling Providers to Spend More Time with Patients needs to acknowledge that it is critical to eliminate nonproductive bureaucratic demands, whether to determine “value-based” payments, to meet “Maintenance of Certification” (MOC) requirements, or to document “bullet points” to justify charges. However, time will not be available if price controls force physicians to “churn” large numbers of patients to make ends meet. Thus, physicians need the ability to balance bill. All of the pointless administrative overhead is completely eliminated in private fee-for-service or direct-patient-care models.

Sec. 5 also proposes expanded use of mid-level “providers.” Please consider the following:

- Nurse practitioners and physician assistants are not necessarily more likely than physicians to want to practice in remote areas—perhaps less likely because of lack of backup and lack of ability to treat difficult cases.
- Notwithstanding the use of the same billing code, the work done by a minimally trained person is not equivalent to that done by a highly trained and experienced person.
- The incentive to acquire additional training will be destroyed if a person cannot earn enough to pay for it.

Sec. 6 Encouraging Innovation for Patients recognizes the enormous costs and delays imposed by bureaucracy. An expansion of right-to-try legislation is needed, with voluntary (market) mechanisms to monitor safety and quality.

Sec. 7 Rewarding Care Through Site Neutrality recognizes the enormous disparity in payments allowed for identical services based on ownership of the facility, with independent physicians strongly disadvantaged compared with hospitals, resulting in greatly inflated costs both to beneficiaries and taxpayers.

Sec. 8 Empowering Patients, Caregivers, and Health Providers seems to be mostly about data collection, in service of what is commonly called “transparency.” There is an imperative need for honest price signals. Patients have the right to know what services cost and what their insurance pays. But much data collection concerns accumulating and disseminating non-validated “quality” metrics of unproven relationship to correct diagnosis or effective treatment, at the sacrifice of patient privacy. Of special concern is the emphasis on “outliers,” with the effect of exerting pressure to conform to bureaucratic dictates, regardless of the special characteristics of patients and individual practices. Transparency must include the qualifications of “providers,” and the identity of persons responsible for both care and coverage decisions.

Sec. 9 Eliminating Waste, Fraud, and Abuse to Protect Beneficiaries and Taxpayers Part (a) addresses the inevitable moral hazard in a system that pays out enormous sums of money based on easily gamed computerized claims. Fraud would be self-revealing, like credit-

card fraud, if payments were made to beneficiaries, by dual-payee check if necessary, instead of to “providers” that might be headquartered in a post-office box.

Sec. 9 (b) recommends transitioning to market-based pricing. Such pricing is based on voluntary transactions with prices set by agreement between buyer and seller, not on a set of codes and “resource-based relative values” determined in collaboration with a stakeholder committee (e.g. the AMA RUC Committee). There is no valid way to determine “reference” or “usual and customary” fees without a free market, with value determined by persons who personally benefit from economizing.

Sec. 10 Removing Obstacles to Improved Patient Care recognizes the need to reduce barriers to care, for which purpose Sec. 11 is absolutely essential.

Again we thank you for your attention to the need to improve medical care for Americans, especially our senior citizens, and for your appreciation of the blessings of freedom.

Most respectfully,

A handwritten signature in black ink that reads "Jane M. Orient". The signature is written in a cursive, flowing style.

Jane M. Orient. M.D.
Executive Director

CC Sen. Mitch McConnell, Rep. Kevin McCarthy