

Opinions of a Practicing Physician  
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Updated May 31, 2011

It has now become apparent to anyone who is paying attention that America cannot afford ObamaCare. The economic and personal liberty costs are too high. The Patient Protection and Affordability Act has very little to do with actual care of the sick. It utilizes the false promise of government run healthcare insurance as the vehicle to usurp control over 1/6<sup>th</sup> of the private sector economy. Robert Moffitt, PhD, Senior Fellow and healthcare expert for the Heritage Foundation, exposes the myths of ACA. Rather than bending the cost curve downward, the CBO estimate is now at \$1.4 trillion in increased government expenditures over the first decade. People cannot necessarily keep the health insurance they currently enjoy. Punitive taxes are levied against “Cadillac” plans (except for unions), as well as health savings accounts and Medicare Advantage plans. People will not see a decline in their premiums. The WSJ ran an editorial on the “dry run” in Massachusetts where the healthcare overhaul is identical to ObamaCare. They now have the highest premiums in the country and a 7% increase in visits to the emergency room. Furthermore, 56 % of primary care doctors will not accept Commonwealth Care making access difficult. The CBO estimates that across America the cost of premiums will go up 10 to 15% in the private sector the first five years. With taxes on drugs, medical devices, and insurance, the middle class will indeed see a tax increase. The biggest myth is the \$500 billion cut to Medicare will not cut Medicare benefits. The CMS actuary stated that the payment cuts to providers would end participation of an unknown number of physicians and make 15% of hospitals unprofitable.

All would agree that reform is necessary, but the dismantling of the private sector practice of medicine to be replaced by the failed socialist models of Great Britain and Canada is not reform, it is destruction. Any doubt that ObamaCare is based on the Great Britain model of socialized medicine should have been erased with the recess appointment of Dr. Donald Berwick to head Medicaid and Medicare Services. He is a Harvard trained pediatrician who stated, “In the United States, competition is a major reason for our duplicative, supply driven fragmented care system.” He goes on to salute Britain’s socialized medicine bureaucracy, the National Health Service, for rejecting the “immoral American system and the darkness of private enterprise. The holy grail of universal coverage cannot be achieved with consumer-centered healthcare, but only through the collective action overriding some individual interests.” Dr. Ezekial Emmanuel, Rham Emmanuel’s brother and a physician at NIH, is one of President Obama’s chief healthcare advisors. He wrote a chilling article in the medical journal, *Lancet*, entitled, “Principles for Allocation of Scarce Resources.” In it he discusses the system of

“disability adjusted life years”. The allocation system ranks each life year, already adjusted for disability and co-morbidities, with an age modifier. These rubrics decide if an individual gets a specific treatment or not. He pontificates, “The well being of some age groups is instrumental in making society flourish. We may be more concerned with improving health status for individuals in these age groups... Priority for young adults is better justified on the grounds of distributive justice.” He actually has a care curve revealing that before the age of 10 and after the age of 59 you are not worth much in terms of healthcare allocations for the collective good and social justice of society. We don’t know who the authors of ObamaCare actually are, but the IPAB and Council for Effectiveness Research reflect Dr. Emmanuel’s thinking, and there are comparable entities in the NHS British system. A comparison of the two systems, ObamaCare and the NHS System, is useful.

The IBAB, the Independent Payment Advisory Board, is in ObamaCare and it is comparable to the NICE board in Great Britain. It stands for the National Institute for Health and Clinical Excellence. Its stated function was to ensure that every treatment, operation or medicine used was the PROVEN best and that underperforming doctors and useless treatments would be rooted out. Government determined “best practices” would be nationally mandated. It has evolved into a rationing board utilizing “quality adjusted life years” to determine if an individual receives treatment and when via waiting lists. NICE limits Lucentis treatments, a major vision saving breakthrough in the treatment of macular degeneration. It limits treatment to specified individuals, and then allows only one eye to be treated. The other is left to go blind. The Council for Comparative Effectiveness Research is the ObamaCare equivalent of the Quality Adjusted Life Years panel. The Council will utilize the mandated centrally connected electronic medical records to establish compliance of the physician with the established treatment rubrics, as well as the allotment of healthcare monies to individuals based on mining the records for co-morbidities and age. Both of these systems have literal life and death, sight and blindness decision making capabilities. Ironically, Britain is moving towards a fee for service system after trying electronic medical records, centralized data collection, best practices, squeezing out waste and fraud, and flat out rationing of care. After twenty years even the government admits that in their system, the only way to decrease cost is centrally determined rationing of care. Why would we choose such a system over ours? The answer is we did not choose it. It was passed by overt bribery (Cornhusker Kickback and Louisiana Purchase), covert heavy handed coercion, and suspension of the usual rules of conduct when passing sweeping legislation such as ObamaCare. The hysterical convening of the Congress on Christmas Eve to pass a bill that no one had read with the infantile admonishment by then Speaker Pelosi that it must be passed so that it could be read was an insult to every citizen, regardless of political persuasion.

The repeal of ObamaCare must be a top priority for anyone who is concerned about the fiscal future of America and a sustainable healthcare system. The Congress, which was charged with overseeing Medicare, Medicaid, and Social Security have not done their job as evidenced by their projected bankruptcy dates. It defies logic to entrust them with further healthcare insurance oversight. Representative Paul Ryan's budget plan begins a conversation about beginning the "fix" for these involuntary benefit programs as well as the repeal of ObamaCare. I believe that his plan for future Medicare recipients has merit, but it lacks one crucial element: In order for a voucher system to work by the time today's fifty-five year olds are ready for Medicare, we must have reformed the private sector healthcare system to receive them. And how does this come about? In my opinion the sustainable solutions will come about state by state and the first step is State healthcare summits. Of necessity, the physician and patient must be at the core of private sector solutions, with insurance, hospitals, pharmaceuticals, lawyers, and medical device representative collaborating as well. Beginning with a template for reform, each group could elucidate their concerns, what they can contribute to cost savings and increased value, and how each group must change certain ways of thinking and behaving that have led us to this pivotal point in our nation's healthcare debate. Through this or similar processes which have occurred in Utah and Indiana, I believe we can rescue our healthcare system.

In closing, I have one such reform template that I have developed over the past three years. My plan and ideas on healthcare reform are on the "United with Solutions for American Healthcare" website, [www.usaHealthalert.org](http://www.usaHealthalert.org). Every American deserves to know what is at stake if ObamaCare is not repealed. In order for repeal to happen, people must know that there are much better alternatives that do not cut private sector jobs, run up the deficit, place a bureaucrat between their doctor and them, and potentially degenerate into a system of cruel rationing. Once they understand, they must act by putting pressure on elected officials of both parties. I have included my twelve point template for reform here.

1. Shift tax advantages to individuals, allowing health insurance as a tax deductible item. Promote health savings accounts.
2. Get employers out of the health insurance business. Have them add the healthcare money they would have spent to the paycheck (with proof of insurance) so that individuals and families can buy their own insurance that is portable. Patients would no longer be handed over in bulk to an insurance company. The insurance industry would respond with a robust offering of menu priced individual policies that would pool risk based on real actuarial considerations rather than volume based contracts with third parties.

3. Medicaid could temporarily serve as the stop-gap for those between jobs who could not afford to continue their insurance, much like unemployment. It would continue to be the safety net for all ages, and could serve as a one year rider for pre-existing conditions.
4. Encourage states to eliminate insurance mandates for non-essential non-medical coverage (acupuncture, therapeutic massage, etc.) to lower costs.
5. Return to a major medical model with no first dollar coverage. Insurance is for unanticipated medical expenses after a certain deductible is met. Routine care is not covered in return for coverage of a major medical or surgical event.
6. Allow purchase and portability across state lines. This would increase competition and spawn the type of innovative insurance solutions that are seen today in Utah and Indiana.
7. Encourage states to hold healthcare summits to include all segments of the healthcare industry to elucidate what the problems are, possible solutions, and what each part of the system can contribute to decrease cost, promote transparency in pricing, and promote personal responsibility within the framework of the traditional doctor and patient centered system.
8. Allow 65 year and older individuals to opt out of Medicare in return for a stipend check and selection of a private healthcare policy like the rest of the population.
9. Each physician should develop one fee schedule for all of his or her patients, including Medicare, Medicaid, and any other insurance. This could be available through a designated state official website. Patients could compare. No contracts between insurance companies and physicians would be made unless discounts were disclosed on the website. Allow balance billing to the Medicare patient, i.e. Medicare would list what they will pay but not what the physician may charge.
10. Apply the same transparent public fee list requirement to hospitals, laboratories, pharmaceuticals, and medical device companies. This would eliminate cost shifting, burdensome and dollar wasting administrative requirements, and would allow physicians and patients to make informed choices.
11. Enact tort reform to reduce the estimated 30% healthcare and drug costs related to fear of litigation. Texas is a model state where tort reform has reduced costs of malpractice premiums and allowed scarce specialties back to areas that drove them away with bogus litigation.
12. Finally, allow the cost of charitable care, up to a certain limit, to be deducted by the physician from their personal income tax. The Medicare fees could be used. This would greatly enhance the assimilation of the truly needy into the healthcare system.