THE STATE OF HEALTHCARE 2014

A Special Report Prepared by The Washington Times Advocacy Department

Bad Policy Doesn't Have To Last Forever

New Health Care Options Can Lead To A Better Quality Of Life

Senator Mike Enzi
(R-WY)
Member of the Healthcare Subcommittee on Finance

New Coke, the Edsel, Betamax. Potential customers were excited about their arrival. Company executives proclaimed them the products of the future. Yet when they hit the shelves and showrooms and people tried them they found they didn't get what was advertised. No amount of marketing or promises could save these products because what was advertised just wasn't what was under the hood. We see something similar with Obamacare.

Those blinded by the flash and splash of Obamacare marketing missed the boat for true health care reform and it will take a lot of hard work to bring America back from the damage being inflicted by the law. The key is common ground. I believe that we can agree on 80 percent of an issue 100 percent of the time. It's the basis of my 80 percent rule and how I believe we should go about improving our health care system. My 80 percent rule isn't about compromise. When you compromise, both sides give up something they believe in and we end up with something no one believes in. It's about agreeing on common ground that doesn't compromise either side's principles by leaving out part of it for a later solution. Instead of focusing on what divides us, we need to turn to where there are areas of agreement.

President Obama and the party in charge of Congress at the time unfortunately took a go-it-alone approach to health care reform, but opportunities existed for a different path. Now, four years after the Affordable Care Act, we see headlines every day that show the effects of the health care law. Health insurance rates are skyrocketing. Employees are losing coverage through their employers. Families are struggling to cope with higher costs and less choice. Businesses aren't hiring full-time employees. Obamacare is the policy version of an over-marketed, rushed, poorly planned and failed product.

The real tragedy of the health care law is the opportunity that was missed. There are clear differences between what Republicans and Democrats envision for a health care system that lowers costs, expands choice, and doesn't bankrupt each of us or our country. Fixing our health care system doesn't have to be the divisive and partisan issue it became in 2009.

Long before President Obama was elected to the United States Senate, fundamental changes to America's health care system were already being developed. In fact, there was even agreement between Republicans and Democrats that changes were needed. I developed my Ten Steps to Transform Health Care back in 2007 after traveling across Wyoming and the country looking for solutions. A step-by-step approach would have been more politically feasible and sensible policy, because Congress could have responded to the concerns and consequences of the law as we moved forward. It would also have been a lot easier for people to read and understand!

Many of my ideas from 2007 are still viable options today if Congress has the will to pursue a new path. Some of these ideas include: increasing consumer choice in health insurance through the tax code, helping businesses pool together to get better rates, and putting the individual, not the government, in charge of care. We need to admit a level of humility and acknowledge that Congress and the Administration do not do well with massive bills that attempt to remake one-sixth of our nation's economy. Instead, we should move forward with discrete, common sense reforms to address specific problems.

But I'm not claiming to have a monopoly on solutions. There are a number of additional ideas that other Republicans and I have introduced and support.

We need to support policies that reverse the unfair tax treatment of non-employer based health insurance plans and improve affordable options for low-income and working families. We need to provide greater support for interstate health insurance compacts, portability in the individual insurance market, and other ways to make health insurance more accessible and transferable for individuals and small businesses.

We need to move past the current funding model for Medicaid and the Children's Health Insurance Program. The current funding model for Medicaid is unsustainable for the federal government, while states are held hostage by changes in federal rules and providers refuse to accept the low payment rates. All of these factors have produced a program that has not improved access to care or the quality of care itself. We should consider ways to align Medicaid spending with a model based on per-person costs or allowing Medicaid recipients the option to purchase private insurance with a tax credit. Let's create a defined contribution model for Medicaid.

We can reduce the regulatory burdens on health care professionals to allow them to practice to the full extent of state scope of practice laws. Wyoming has been a leader in this effort, but health professionals in the state are often hampered by federal requirements.

We can revamp the funding model for medical education to direct more money into primary care training and in-state programs. We need to move away from a funding model that is centered on teaching hospitals and strict residency slots. We need to look at the possibility of realigning the scholarship money given by the National Health Service Corps to support more primary care and more non-physician health professionals and to incentivize professionals to remain in a locality after their loans are paid.

We need to restore reliability in our medical liability model by expanding opportunities for alternative dispute resolution, physician-patient communication, health courts, and other reform models.

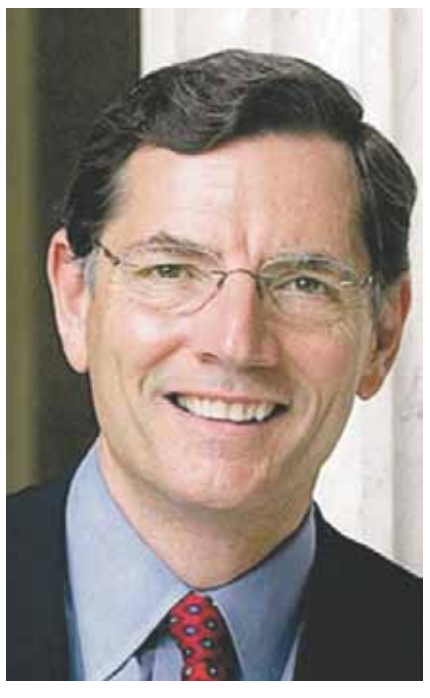
We need to increase parity between home- and community-based care models and institutional care in Medicare and Medicaid.

I continue to believe that there is a better way to improve our health care system that doesn't involve top-down management from Washington, doesn't undermine individual choice, and relies on market-based solutions. The solutions to fix our nation's problems are not developed behind closed doors by a few people and presented as the only option. It has to be a national conversation where everyone involved is onboard with finding a solution, no matter who gets the credit. That was true before Obamacare became the law of the land and it's still true today. We can move forward with step by step, common sense reforms that will make care more efficient and more patient focused – without driving us further into debt and bankrupting our country.

Having alternatives and options is key. We still enjoy soft drinks. We can find nice cars. Our favorite movies and TV shows are more accessible than ever. The difference is that we were not forced to buy New Coke, the Edsel or the Betamax. We had other choices. One-size-fits-all federal government health care options aren't really options.

By working together, we can make sure that each of us is able to find health care that not only works for our own best interest, but moves the country forward in a responsible way.

Four Questions About Those Obamacare Numbers



Senator John Barrasso, M.D.
(R-WY)
Member of the Budget Committee

Next Monday, we will hit the deadline for Americans to sign up for insurance under President Obama's health care law. The Obama administration repeatedly declared that seven million people would have to sign up by March 31 in order for this enrollment period to be a success. With five days to go, they are two million short of their goal.

Even if the White House claims that it's come close to the seven million target, there will be many unanswered questions about the numbers and what they really mean.

First, how many of the people signing up actually have insurance? The Obama administration has released numbers showing how many people went through the sign-up process on its website or through state exchanges. Those people don't actually have insurance until they pay their premiums.

Secretary of Health and Human Services Kathleen Sebelius testified before the House of Representatives recently that she has no idea how many people have not paid. The point of Obamacare was to get people insurance, not just register them on a website.

A recent survey by McKinsey & Company found that only 53 percent of previously uninsured people who selected a plan actually paid their first month's premium. Someone may not realize the difference between signing up and having insurance until he or she shows up at a hospital needing care.

Second, how many people are newly insured? This was the other major goal of Obamacare. Washington Democrats said that we needed a massive overhaul of America's health care system in order to cover the uninsured.

Many of the people signing up are doing so because the insurance they had, and liked, was cancelled. The President's health care law forced them to switch. How many people? We don't know that either.

An HHS official admitted, "That's not a data point that we are really collecting in any sort of systematic way." The paper application for Obamacare included a question about whether the person already had insurance. The bureaucrats and contractors who created the Healthcare.gov website dropped that important question.

The best estimate we have is from the McKinsey survey. They figured that only 27 percent of people who signed up for Obamacare insurance by early February were newly insured. If that number holds, the exchanges might end up covering fewer than two million previously uninsured Americans this year. Think of how much simpler, and more cost-effective, health care reform could have been while still covering the same number of people.

Third, who is signing up? The administration is pushing young adults between the ages of 18 and 34 to sign up. That's not happening. Through February, less than 10 percent of the young adults who potentially could enroll had done so.

Insurers need lots of young, healthy people to pay premiums and not ask for much care in return. Premiums are likely to jump unless more of them sign up by the beginning of next week.

Fourth, what kind of care will Obamacare insurance provide? For some people, having a doctor won't mean they can actually see the doctor. According to the Association of American Medical Colleges, we're facing a shortage of 90,000 physicians by the end of the decade. Instead of training more doctors and nurses to deliver care, Obamacare focused on hiring IRS agents to force Americans to buy expensive coverage.

Some patients will get to see a doctor, though maybe not the one they need. Only four of 19 leading cancer hospitals in an Associated Press survey said they accept plans from all of the insurance companies in their states' exchanges.

For many other patients, their doctor will be spending more time looking at the computer instead of looking at them. That's because of burdensome new rules and record keeping requirements in the law.

Patients may get less care, but they soon will be paying even more. Secretary Sebelius finally conceded in her testimony that rates will continue to rise in 2015.

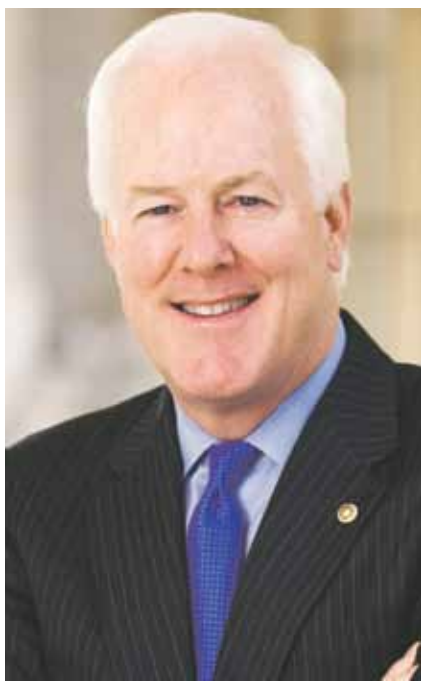
The President said recently that the law "is working the way it should." I believe he actually has no idea if his law is working, or what will happen next.

Our health care system needed reform; and needs it now more than ever. What Americans got with the Obama health care law was a monstrous new bureaucracy. It is raising costs for millions of people and leading to worse care and other unintended consequences.

As these four questions are answered, it will become even more clear that the health care law has failed patients, health care providers, and taxpayers.

The President should admit his law is not working and accept Republican ideas to replace it. Americans need better access to quality, affordable health care, not just broken promises, tired excuses, and unanswered questions.

Why — And How — We Should Replace Obamacare



Senator John Cornyn
(R-TX)
Member of the Finance Committee

When the debate over Obamacare began five years ago, America's health care system was facing three major problems: a coverage problem, a cost problem, and an access problem. Democrats' efforts focused largely on trying to solve the coverage problem. Unfortunately, they passed a law that has made all three problems worse and created a major drag on the U.S. economy.

Because of Obamacare, millions of Americans have lost their preferred health insurance, and millions are facing higher premiums and deductibles. Obamacare's dramatic expansion of Medicaid is making an already weak safety-net program weaker, and its more than $700 billion in Medicare cuts to pay for a new entitlement is jeopardizing patient access.

The President promised his law would provide "universal coverage." Instead, the Congressional Budget Office (CBO) estimates that Obamacare will leave upwards of 30 million people uninsured a decade from now. As if that isn't bad enough, CBO also recently announced that the law will effectively shrink our labor force by 2.5 million full-time workers by 2024.

Health-care reform didn't have to turn out this way. There are plenty of ways we can expand coverage without kicking millions off their preferred insurance plans, without raising millions of premiums, without imposing a massive tax increase and thousands of pages of new regulations, without weakening Medicare and Medicaid, and without triggering a huge drop in labor-force participation.

Simply put, the government should not dictate the type of plan you must purchase. Americans should be able to choose what works best for them. This might include selecting a Health Savings Account (HSA) that allows Americans to set aside money for health-care costs without being taxed by Uncle Sam. In fact, it turns out Americans like having control over their own health-care dollars: According to one estimate, "HSA growth averaged nearly 70 percent" between 2005 and 2008. By expanding the availability of HSAs, we could empower patients and expand coverage in one fell swoop.

Furthermore, we should create more competition in the market to drive health care costs down. Individuals should be able to buy cheaper plans across state lines. We should let people and businesses form risk pools in the individual market. We should take steps to improve the transparency of price and quality information. We should eliminate unnecessary government mandates that drive costs up and force people to pay for coverage they don't want and don't need. And we should embrace serious medical-liability reform, which will bend the cost curve downward.

And while we're at it, let's make it easier for individuals to purchase insurance on their own. People should not be at a disadvantage because they do not receive health coverage from their employers.

Now, some folks might say: "Sure, the reforms you just mentioned would be good for healthy people, but what about sick people? What about people with preexisting health conditions who still couldn't afford insurance?" The simplest answer is: We can—and we should—create a system that provides these Americans with affordable, high-quality care on par with that available to everyone else; but we can do this without spending billions of dollars under Obamacare.

We should help people with preexisting conditions by increasing support for the state-run high-risk pools that were established long before Obamacare. And we should amend the Health Insurance Portability and Accountability Act (widely known as HIPAA) to safeguard their coverage if they move from the employer health care market to purchase insurance on their own.

As for Medicare and Medicaid, we should focus on strengthening these programs for current enrollees and ensuring they remain strong for the next generation.

Obamacare tries to curb Medicare spending by slashing provider-payment rates. This approach hasn't solved our problems in the past, and it won't work in the future. Rather than double-down on failed policies, we should increase provider competition and patient choice. A few other commonsense reforms, such as asking wealthy beneficiaries to pay more for their coverage, would reduce costs even further.

Finally, turning to Medicaid: This program, with its rigid structure and low payment rates, is failing the neediest and most vulnerable among us. In my home state of Texas, a majority of established primary-care physicians aren't accepting any new Medicaid patients. The answer is not to add millions of individuals to an already fragile program, but rather to give states much greater freedom to reform and improve Medicaid so that it becomes more dependable for patients and providers alike.

Taken together, these reforms would help America solve all three of the health-care problems I mentioned above: the coverage problem, the cost problem, and the access problem. Regrettably, the architects of Obamacare decided to go in a different direction, and the results speak for themselves. That's why I remain committed to repealing Obamacare and replacing it with patient-centered alternatives.

Sen. John Cornyn (R., Texas) is the Republican Whip.

Unleashing Medical Innovation For The Benefit Of America's Patients

Senator Richard Burr
(R-NC)
Member of the Finance Committee

In 1997, after years of fits and starts, Congress passed the FDA Modernization Act of 1997 (FDAMA), the first significant reforms of the agency in a generation. FDAMA's objective was straight forward—to ensure that the agency charged with reviewing life-saving drugs and medical devices had the tools it needed to keep pace with modern scientific advances. FDAMA modernized the agency in a way that supported regulating in the least burdensome manner, while ensuring that the innovative products that meet the agency's rigorous standards would reach patients in as timely a manner as possible. These reforms were adopted at a critical point in fight against the HIV/AIDS epidemic, and helped to pave the way for life-saving medicines that have since changed the trajectory of the epidemic and vastly improved the quality of life for millions of patients.

Seventeen years after enactment of FDAMA, patients, researchers, and health professionals continue to face the challenge of ensuring that the FDA is equipped with, and is consistently and appropriately applying, the tools necessary to regulate innovative products. This challenge will only increase as our understanding of diseases improves, and we learn how to better target and customize individualized therapies. Unfortunately, FDA's risk aversion is only likely to increase as new products outpace FDA's understanding of them and overwhelm the agency's ability to review applications in a timely manner. This risk aversion will have a chilling effect on innovation. We have seen how regulatory burden and uncertainty results in innovation going overseas, while America's patients wait for FDA to catch up. This is neither the way for FDA to preserve its gold standard nor ensure that American patients have access to the most innovative and cutting-edge drugs and medical devices.

Most importantly, the day-to-day actions—and, in many cases, inaction—at the agency has a profound effect on our nation's patients. It also directly impacts our economy, as FDA-regulated products account for about 25 cents of every dollar spent by American consumers each year. In the years since enactment of FDAMA, the FDA's responsibilities have only expanded. This presents an increasing challenge for the agency in fulfilling its mission. The growth of the agency and its responsibilities also present serious management challenges. The importance of holding the agency accountable for its actions and inactions—all the way from front-line reviewers to the Commissioner—has never been more important.

While the current drug and device user fees are not set to expire until 2017, discussions surrounding priorities for the reauthorization of the prescription drug and medical device user fee programs will occur well in advance of the actual negotiations with the FDA. This is an important opportunity for all stakeholders—researchers, patients, taxpayers, legislators, and others—to look at the results and data surrounding the current drug and device agreements and ask hard questions to inform how to improve regulatory certainty, timely and predictable decisions by the agency, and agency wide accountability for performance goals. It will be critically important to take complete stock of how well the agency is performing, what the data from the performance metrics say, as well as where more metrics are necessary to help support and hold the agency accountable. For example, is the agency applying guidance in a predictable and consistent manner at all levels of the agency? Have the actions by the agency resulted in achieving greater regulatory certainty? After all, as my colleague Doctor Tom Coburn and I have said many times, you don't know what you don't measure.

While these hard questions need to be asked and the latest user fee agreement results examined, the Agency should be held accountable for taking the action they can now on behalf of patients. FDA already has the preliminary priority recommendations from the independent management review provided for by the last medical device user fee agreement. While the final recommendations remain forthcoming, FDA should not wait to take steps to address the shortcomings, which have already been identified and are contributing to regulatory uncertainty and increasing times for the clearance and approval of medical devices.

We should look carefully at the lessons learned from the fight against HIV/AIDS and apply them in the fight to find the next generation of treatments and, ultimately, cures. Such innovation is central to addressing our nation's unsustainable health care costs. Fully leveraging and embracing the tools FDA has been empowered with—including tools that date back to FDAMA—will reduce the time it takes for novel products to reach patients, help the Agency keep pace with medical advances, and unleash the next generation of innovation on behalf of America's patients. In so doing, we will also help ensure America's continued standing as the world's leading innovator.

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ObamaCare Cronyism Persists While Millions Left Out In The Cold

Senator John Thune
(R-SD)
Member of the Finance Committee

Another day, another ObamaCare carveout ... or so it seems. It's getting tough to keep track of all the ObamaCare delays, exemptions, and political payoffs.

The administration's latest carveout – released the same week as a new delay to prevent another wave of canceled plans right before the elections – is an exemption for one of the administration's most favored constituencies: unions.

Unions, of course, are traditionally strong supporters of the Democrat Party. They were instrumental in President Obama's election and reelection, and they strongly supported passage of ObamaCare. Once the law passed, however, unions started to realize what millions of Americans were finding out: ObamaCare was going to make their health care plans more expensive.

Last summer, the heads of three of the country's most powerful unions wrote a letter to Nancy Pelosi and Harry Reid making it clear that they had a problem with ObamaCare and that they expected Democrats in Congress to fix it: "[We] voted for you. We have a problem; you need to fix it," they told the Democrat leaders.

Among their demands was a request that union members be given taxpayer subsidies for their health care premiums, which would have ultimately forced taxpayers to double-subsidize union members' health plans because union plans already benefit from the employer tax exclusion.

When the White House simply could not publicly justify giving hard-earned taxpayer money out to unions, the administration turned its attention to unions' other demands, like relief from ObamaCare's reinsurance tax.

ObamaCare requires all self-insured health care plans – including Taft-Hartley plans used by many unions – to pay a so-called reinsurance tax for the next three years for each person covered under the plan. The tax was designed to help absorb the cost of care for people with pre-existing conditions in the exchanges.

Unions were not happy about having to pay the tax, so in October the administration announced that it intended to propose a regulation that would exempt unions. Earlier this month, the administration followed through and formally exempted Taft-Hartley health plans from the reinsurance tax for 2015 and 2016, ensuring that a number of unions will no longer be subject to the tax.

Other health plans, however, are not so lucky.

The tax still exists, and the administration still has to collect the amount of money that the law decrees -- $8 billion in 2015 and $5 billion in 2016. The only difference is that now the administration will be collecting it from fewer health plans, so each non-exempt health plan will have to pay a greater share.

In other words, by carving out an exemption for some favored union health plans, the president has raised taxes on the remaining health plans that are still subject to the tax. So much for equality under the law.

The president's decision to exempt his political allies from this tax is just the latest example from an administration that has elevated cronyism to an art form. It's become clear over the past five years that if you're a political ally or donor, you'll be treated better than the average American. It's no coincidence that union protests were listened to while those of other Americans were not.

I am working with Senate Republicans on options to stop this latest political carveout and, in the meantime, have sent a letter with 25 of my colleagues demanding the administration rescind the exemption before it takes effect in 2015.

Delays and carveouts may provide temporary political cover, but they can't change the fundamental reality that this law is hurting Americans. It's driving up health costs, it's costing Americans their health plans and doctors, it's harming small businesses, and it's damaging our economy. It's time to get rid of this law and pass real health care reform that will provide relief to all Americans – not just the president's political allies.

The Future Of Obamacare: More Of The Same Broken Promises

Representative Joe Pitts
(R-PA)
Health Subcommittee Chairman, House Energy and Commerce Committee

In 1980, as Ronald Reagan delivered his closing remarks during the lone debate against President Carter, he posed a simple question to the American people: "Are you better off now that you were four years ago?" Fast-forward to today, and the question is just as meaningful as we are less than a week removed from the Obamacare's fourth anniversary.

Sadly, because of the health law, many Americans find themselves worse off than they were when it was signed four years ago. The law has upended the entire health system, and the last four years have been plagued by broken promises, delays, and missed deadlines. Premiums have skyrocketed, millions of Americans have lost their health plans, and countless others have lost access to their trusted doctors.

The president sold his health care law on a number of promises including: "If you like your health care plan, you will be able to keep your health care plan;" "If you like your doctor, you will be able to keep your doctor;" and "We'll lower premiums by up to $2,500 for a typical family per year." Promises that the president and the administration have failed to keep.

The administration seemingly cannot run away fast enough from its broken promises. The lack of accountability throughout this law's passage and implementation is cause for significant alarm. Dozens of delays and missed deadlines have defined the last year. What is notable is that as the president assailed Congress for voting to protect all Americans from the disastrous law, the administration acted unilaterally dozens of times over the last year to delay or change the law because it was not ready for prime time. Individual mandate for Americans with cancelled plans? Delayed. Individual mandate deadline for purchasing coverage? Delayed. Employer mandate? Delayed. Twice. Employer reporting? Delayed. Medical loss ratio requirement? Delayed. The list goes on and on.

But after dozens of delays and countless regulatory rewrites of the law, the administration's metrics for success remain unclear. Administration officials have repeatedly moved the goal posts and failed to disclose accurate figures to the American people. With or without the accurate figures, we do know the law's broken promises have ensured that this law has failed to deliver, disrupting the peace of mind of millions of folks in my home state of Pennsylvania and across the country.

For months, administration officials have boasted about so-called enrollment figures, but refused to tell the American people how many individuals actually have paid for their plans and received coverage. After several attempts at asking the administration the basic question: "Who's paid?," we've decided to ask the insurance providers directly.

What's more, the administration is not even collecting data so that it can report how many previously uninsured Americans are actually receiving coverage. Was that not the goal?

As the law continues to take effect, these broken promises will worsen. Once the administration's many delays finally are exhausted – most after the president is no longer living at 1600 Pennsylvania Avenue – businesses will be left with massive bills, employees will see their private health care coverage change, and all those with health care coverage will be forced to deal with disruptions to their care as the entire health care market is turned upside down.

This weekend, we will mark another milestone as Obamacare's first open enrollment period is scheduled to draw to an end at the stroke of midnight on March 31.

We may have reached the end of the first open enrollment period, but the full affects of this law loom large over the next several years. If history is any guide, the administration will continue to do its best to paint a rosy picture, but we have learned over the past several months that there's no escaping the expensive and harsh realities of this law.

Great Strides In Closing Health Gaps, More To Be Done

Representative Barbara Lee
(D-CA)
Member of Budget Committee

As we celebrate the 4th anniversary of the Affordable Care Act this year, we must recognize the strides we have made toward making the United States a healthier nation, particularly in working on eliminating health disparities for communities of color. But we must do more.

In the last century, tremendous progress has been made in how we detect and treat illnesses. Diagnoses that were once a death sentence are now manageable, treatable, and curable. We can look at advances in HIV/AIDS, cancer, and hepatitis C and see incredible developments.

These advances have saved millions of lives, but many have been excluded from our nation's progress in medicine, particularly communities of color, and women.

Compared to white women, black women have higher rates of obesity, have almost two times the risk of stroke, develop high blood pressure earlier in life, and suffer from more chronic diseases. Even with what we've learned about how to detect and treat breast cancer in the last few decades, black women die an average of three years earlier than white women with similar diagnoses.

But why? Not just the obvious reasons of lower rates of health insurance for communities of color, but even persistent poverty play a big part in overall health. What we need is a set of comprehensive solutions that help to close those gaps and ensure that in the richest and most powerful nation on earth, everyone can live healthy lives and pursue the American dream. That includes strengthening Medicaid, supporting the Affordable Care Act, protecting safety net programs, and expanding access to preventative health care through community health centers.

Started out of President Johnson's 1964 War on Poverty, Medicaid has been changing lives for 50 years and is a vital lifeline for low-income families that would otherwise lack health care.

With the Affordable Care Act's expansion of Medicaid, Medicaid now covers roughly 63 million Americans who are living in or near poverty, including 1 in 3 of our nation's children. However, some states have refused to expand Medicaid and have created a gap for families that don't earn enough to qualify for subsidies in the health care exchanges, but earn enough to not qualify for Medicaid. Five million people are falling into the coverage gap and are once again being left behind. We must fight to close that gap and expand Medicaid across the country.

But we cannot believe that only health policy affects health outcomes in America. Another assault on the health and well-being of communities of color and people living in poverty comes with cuts to safety net programs. Every time Congressional Republicans move to slash the social safety net and cut programs like the Supplemental Nutrition Assistance Program (SNAP), they impact the health of our nation. Food insecurity, which SNAP works towards eliminating, is leading to poor health outcomes, like anemia and hypoglycemia. What's more, researchers have found that people living in poverty go into the hospital for low blood sugar complaints especially at the end of the month, when benefits run low and food becomes scarce. We can't separate health policies and social policies when it comes to tackling poverty and closing health gaps; we need to include the social determinants of health care.

Beyond pushing back against cuts to Medicaid, SNAP, and other assaults against our nation's poor, what can we do to improve the state of our country and close health gaps? One way to do this is to invest in community health centers. As a member of both the House Budget and Appropriations Committees, I have been fighting to increase funding for community health centers. In communities with persistent poverty, these health centers are crucial for families on the edge. By expanding access to community health centers and ensuring robust funding, we can improve the health of people living in underserved communities through quality primary and preventative health care.

We have made incredible strides, but much remains to be done. It may surprise people that until very recently, our national institutions that help keep track of our nation's health and well-being had no offices for communities of color. With the creation of the Office of Minority Health at the Department of Health and Human Services to the Offices of Minority Health and Health Equity at the Centers for Disease Control, we are ensuring that the United States government prioritizes everyone's health equally. When we do that, we will close health gaps and help to ensure that everyone can lead a healthy life.

Seniors Need A Doctor They Know And Trust

Representative Kevin Brady (R-TX)
Chairman of the House Ways & Means Health Subcommittee

"The doctor won't see you now."

This is a statement too many of America's seniors are hearing as fewer and fewer doctors can afford to treat patients in Medicare. In my home state of Texas, less than half of primary care doctors are accepting new Medicare patients.

The unfair way Medicare pays local doctors is a problem that's been growing over the past decade. Now it's heading into a full blown crisis.

Due to poor reimbursements many doctors are being chased out of Medicare and out of private practice.

That's terrible news for the 10,000 new seniors who sign up for Medicare each day – a trend that will continue for the next 17 years. Congress has already spent over $150 billion in short term fit-and-start patches over the years, but enough is enough. Congress must act now – both parties, both chambers and the White House.

When I took over the leadership of the House Ways & Means Health Subcommittee last year, one of my top priorities was to solve this growing problem once and for all. After 14 months of hard work, the U.S. House of Representatives recently passed legislation which creates a fairer way to reimburse local doctors when they treat Medicare patients.

Developed with the help of local doctors across America, Republicans and Democrats in the House and the Senate – along with key members of the Doctors Caucus – have agreed on a bipartisan, reliable, affordable 21st Century solution.

The legislation permanently ends the yearly threat of massive cuts to local doctors, provides long-sought stability, rewards doctors for high quality care and begins to streamline the massive amount of Washington red tape our local physicians face.

Gradually moving from a volume-based system to a value-based system directed not by Washington but by local doctors will ensure our seniors have the care they need from the doctor they trust.

The bill focuses on paying for high quality care, improving the coordination of care for seniors who have multiple physicians treating specific medical concerns, and creating the right financial incentive so doctors – whether in cities or rural areas - want to participate in Medicare.

Recognizing that innovation is occurring in the free-market today, this solution encourages alternative models that put doctors in the driver's seat, reduces paperwork and increases quality care for seniors. Unlike the President's Affordable Care Act, this bi-partisan approach rejects the "one size fits all" approach.

In the end, this is about creating an even better Medicare system that can be sustained. It's about making sure my mom and yours can see a doctor they know – and who knows them.

Now is the time to act. In the past the high cost of replacing the unfair Sustainable Growth Rate formula that drives doctor reimbursement has been the largest hurdle. But the latest estimate by the Congressional Budget Office has lowered the cost considerably.

I have been very clear that reform must not increase our deficit while strengthening Medicare for the long haul. In truth we can't truly save Medicare until we first solve how we reimburse our local doctors.

Our seniors deserve a Medicare system modeled after what works in the private sector. Their doctors deserve payment rates they can count on. Doctors know that high quality, efficient care is better than a system that encourages more tests and unnecessary spending.

The U.S. House of Representatives has acted. But we have more work to do. The Senate now needs to act and we must pay for it in a way that doesn't add to the deficit.

The clock is ticking, but I'm optimistic we can finish the job. Our seniors and our local doctors can't afford to wait any longer.

Replacing the Affordable Care Act With Affordable Cures

Representative Marsha Blackburn (R-TN)
Member of the Budget Committee

There are aspects of healthcare on which everyone can agree. Healthcare can be expensive and chronic and debilitating diseases contribute to its skyrocketing cost.

Take Alzheimer's disease (AD), as just one example of a chronic and debilitating disease. A recent study published in The New England Journal of Medicine reports that AD is costing the nation as much as $215 billion a year, a sum growing toward a trillion dollars annually by 2050. In other words, today the cost of caring for each patient with dementia--typically requiring 24/7 care--is roughly the same as the median household income of Americans, or a little over $50,000 per year.

But these are not the only costs. AD is a terrible disease that first robs people of their memory and ultimately their lives. It also places a tremendous toll on the patient's family and caregivers.

We can't simply sit idly by and accept the status quo. We need to embrace a national vision of improving lives--and, thereby saving money--through medical cures—a Cure Strategy.

How is a Cure Strategy different from the Affordable Care Act? Most importantly, it's an "all in effort". It means not simply waiting for the federal government to do it all. It focuses on cures and improving lives rather than relying on a centrally based system that's solely focused on cost controls.

A Cure Strategy includes a nationwide network of private-public partnerships. We have incredible resources in the U.S., both intellectual and financial, at our disposal. We have brilliant medical researchers, the best laboratory infrastructure, and a myriad of inventors and investors who are eager to be part of a big and bold national project.

Yet, we need to mobilize these resources, rallying the nation and its creative minds around an unwavering commitment to finding cures. I strongly believe that we first need to improve the regulatory environment in order for this discovery to happen. Simply put, we need an environment in which we can find cures.

I have introduced two pieces of legislation that will help our nation take the first steps needed to operationalize a Cure Strategy. A third step is one that was introduced in recently enacted legislation which I supported.

Step one: H.R. 3303, the Sensible Oversight for Technology which Advances Regulatory Efficiency (SOFTWARE) Act will provide regulatory clarity to the FDA regarding the development of health care software, including mobile medical applications (apps). The goal of this legislation is to get these tools in the hands of doctors and nurses in order for them to provide first class care to patients.

Step two: H.R. 762, the Health Care Choice Act will allow consumers to shop for health insurance just like they do for home or auto insurance – online, by mail, over the phone, or in consultation with an insurance agent in their hometown. New ways of financing health care are part of the Cure Strategy.

Step three: The Food and Drug Administration Safety and Innovation Act (FDASIA) was enacted in 2012. One part of this law provides for a breakthrough therapy designation and is intended to expedite the development of treatments for some times of illnesses.

A half-century ago, a charismatic young president put forth a bold vision of American greatness, based on scientific achievement and a common national purpose; crucially, he included a time-target. On September 12, 1962, John F. Kennedy declared, "We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills." President Kennedy was exactly right; great undertakings can, indeed, organize the best of our energies and skills. After Kennedy's tragic assassination, two more presidents, one of each party, carried on his mission and put those first Americans on the moon--within the decade.

History tells us that it's the goal that drives the policy. In 1961, Kennedy didn't say that he was going to increase NASA's budget; he said that we were going to the moon. And so that's what we need today: A national conversation about setting up an entrepreneurial vision to cure tragic and costly diseases and improve lives.

We can call it the Cure Strategy or some other name. But the goal is the same, offering hope for better days, and greater savings, for all Americans.

Why Obamacare Will Fail

Representative John Fleming, M.D. (R-IN)
Member of the Doctor's Caucus

Obamacare is falling short of the president's goals but living up to the low expectations of those who knew it would be a train wreck. When the president's signature law was enacted in 2010, I had a host of objections that could be boiled down to this: Obamacare was far too grandiose of an undertaking for our government, or any government. It was clear from the start that Obamacare would drive up the cost of health care, take away good-paying, full-time jobs, adversely impact the doctor-patient relationship, and, worst of all, impinge on the personal liberty of Americans by eliminating common health care choices they had made in the past.

The employer mandate was an obvious job-killer from the start. By imposing new regulations on small businesses that were already struggling to survive in the Obama economy, Obamacare forced them to cut employees and hours to get below the mandate's threshold. The individual mandate was an equally severe attack on individual choice, causing people to lose the health insurance they had and requiring that they purchase expensive new Obamacare plans with coverage for procedures they didn't need or want. Public opposition to both mandates left Obama no choice but to postpone their implementation.

There's an irony to Obama's scheming manipulation of his own law: despite finding that its centerpiece – the individual mandate – is unworkable, the president continues to act like a fast-talking used car salesman, pleading for people to enroll in Obamacare. While he's trying to take the pressure off Democrats by letting them say that people are not required to buy expensive Obamacare coverage (for now), his administration is employing every available gimmick, celebrity, and social media platform to push, cajole, and even scold young people into buying health insurance.

Without a large chunk of healthy young enrollees, Obamacare continues rushing toward an actuarial cliff. A solvent mandatory system cannot survive on a foundation that is comprised overwhelmingly of older and sicker enrollees. That's why the individual mandate threatened Americans with a penalty – even those who were satisfied with health coverage centered around major medical insurance and a health savings account. Obamacare destroyed that option. Instead, the president wants you to pay sky-high premiums for insurance that has higher out-of-pocket costs.

Despite all of the president's efforts to sell Obamacare, fully one-third of uninsured Americans say they still won't buy health insurance, and the largest part of that group say it's because the insurance is too expensive. Unfortunately, they've found out the hard way that the president wasn't telling the truth when he promised that households would see a $2,500 annual decrease in the cost of health insurance. For most, the cost has gone up dramatically. Of course, this is also the president who said you could keep your insurance and keep your doctor, two other Obamacare promises that were broken.

At the heart of the broken promises, the implementation games, and the $2 trillion taxpayer price tag for Obamacare is the simple reality that I and other Republicans have argued since the Obamacare debate began in 2009: our government was never designed to control one-sixth of the American economy. The framers of the U.S. Constitution enumerated limited powers, trusting that if the government preserved a free and safe nation, its citizens and their entrepreneurial spirit would ensure a land of opportunity. There is, however, no place for a limited government in the Obama agenda. By creating a new entitlement and a massive new bureaucracy, Obama has done everything in his power to expand government overreach into one of the most personal dimensions of our lives. Only now, it may collapse under the weight of its own failed mandates and regulations. That's why he's already effectively repealing the law piecemeal.

With Obamacare imploding, what can we expect? Through countless exemptions and delays, it is obvious that Obamacare will not be substantially implemented by the end of the president's second term. Mr. Obama's plan, either tacitly or deliberately, is to abandon our health care system to a state of suspension until his last day of office; leaving a huge overhaul, or a repeal and replace job for the next president, depending on whether he or she is a Democrat or Republican.

Should congress have the opportunity to wipe the slate clean and start over, there are many good ideas to lower health care costs and protect access to health care. One proposal, already in the House, is the American Health Care Reform Act, which I co-authored. It would end Obamacare, spur competition to lower the cost of health care, safeguard individuals with pre-existing conditions, and bring about common sense medical malpractice reform. I am convinced, now more than ever, that this kind of real health care reform is still possible as the American people continue to reject Obamacare.

Congressman John Fleming, M.D., represents the 4th district of Louisiana. He is a family physician and small business owner.

Obamacare Rhetoric vs. Reality

Representative Phil Roe, M.D. (R-TN)
Chair, Subctte. on Health, Employment, Labor and Pensions

When the president and his allies pushed Obamacare through Congress, a lot of promises were made. Now that we're experiencing the harmful effects of President Obama's flawed, unworkable law, it's become clear that many of the administration's promises were just empty rhetoric. Because of these empty promises, Americans are losing their health plans, being forced to change their doctors and paying more for their insurance.

Perhaps the most infamous false promise was the claim that if you like your current health care plan, you can keep it. We now know that the administration knew in 2010 that tens of millions of Americans in the private market could lose their health care plan under the president's health care law. According to the Associated Press, as of December of last year, at least 4.7 million Americans received cancelation notices. Nevertheless, the president knowingly misled the American people to believe that no hardworking family or individual would see disruption in their current coverage. After it became apparent this was untrue, President Obama delayed the provision in the law that would cause millions to lose their insurance plans—not once, but twice—and passed the buck until after the next election.

We were told that we'd all be able to keep our doctors. While this is true for many Americans, it's not true for everyone. Many plans offered on the Obamacare exchanges have very limited provider networks. The president himself now admits that this promise isn't true. He altered his promise by saying you can keep your doctor – if you can pay more.

Edie Littlefield Sundby described her experience in the Wall Street Journal in November. Ms. Sundby has fought stage-4 gallbladder cancer for seven years and carried a preferred provider organization (PPO) plan. PPOs typically cost a little more than health-maintenance organizations, but you have more doctors and hospitals to choose from for covered care. Ms. Sundby's PPO plan allowed her to visit many different hospitals and specialists around the country to receive the care she needs. In July, UnitedHealthcare withdrew from California's individual market, meaning Ms. Sundby's plan ended last December. At the time she wrote the piece, Ms. Sundby was weighing the cost of going on the exchange and losing her oncologist or paying more for insurance outside of the exchange. I believe patients, especially those with existing care plans, should be able to keep their insurance and see the doctors they feel most comfortable with. Ms. Sundby should be able to focus on getting healthy and continue the treatments that have been working for her the last seven years without worry of losing the doctors that have treated her throughout her fight with cancer.

The president wants people to believe that losing your insurance and your doctor is okay an acceptable trade-off to save money under Obamacare. But this is flawed logic also. Despite the president's claim that Obamacare would bring down insurance costs by $2,500, many are seeing their insurance premiums and out-of-pocket costs skyrocket. The Manhattan Institute examined the impact of the law on 27, 40 and 60 year olds, as well as the contrast between men and women. In my home state of Tennessee, a 27-year-old woman will see her premiums rise 21 percent, while a 27-year-old man's premiums will increase by a staggering 69 percent.

The administration promised you can keep your insurance if you liked it, that you could continue seeing your doctor and that your premiums would be lower. We know these claims were nothing more than rhetoric. I hear from people in Tennessee all the time about these broken promises.

Barbara is 58 years old and has a catastrophic plan with a $5,000 deductible. She is angry that she's being forced to purchase insurance that requires her to carry coverage she doesn't need, like maternity, pediatric dental and substance abuse treatment.

Kelly is a single mother who works hard to provide for her family and is trying to pay to go back to school. Kelly said, "I felt it was important to have health care coverage. I had purchased what I could afford. The policy wasn't ideal but reasonable." Kelly was notified that her policy would be canceled because of Obamacare. She added, "I have been on the health insurance marketplace. I was floored to find either with my premiums or out of pocket cost would be almost three-quarters of my income."

Both Kelly and Barbara are prime examples of the flaws with this law. When faced with stories like Kelly's and Barbara's, the administration relented and agreed to allow states to approve grandfathered policies like their for the time being. But not every problem with this law can be solved with an "administrative fix" – eventually, the fact that the individual market has been replaced with much more expensive health insurance and the fact that grandfathered plans aren't being allowed to keep up with consumer demand will result in significantly more expensive insurance for everyone.

No one is talking about returning to the status quo before Obamacare. The health care system in this country was broken before Obamacare, and it still is. As long as I continue to hear from Americans who are struggling because of this law, I will continue to fight against it. There is an answer to our country's health care problems, but Obamacare isn't it.

Access To Healthcare Critical For Rural America

Representative Larry Bucshon, M.D. (R-IN)
Member of Education and the Workforce

Before serving Southern Indiana in Congress, I spent my adult life caring for patients of all walks of life, regardless of their circumstances. I practiced under the fundamental philosophy that everyone should have access to quality, affordable healthcare. Unfortunately, many Americans face a variety of obstacles to receiving the care they need. The over 60 million Americans who live in rural communities know this all too well as they face unique challenges that are putting even access to basic healthcare at risk.

I, too, know these challenges well. I grew up in a small coal-mining town. My dad was a union coal miner and mom was a nurse. Over the course of my life, I have seen firsthand what the statistics tell us about healthcare in rural communities.

Rural hospitals are closing, areas are without robust trauma systems and access to critical care, and physician shortages have become endemic. At the same time, rural Americans face a unique set of health challenges compared to many of their urban counterparts – they are traditionally more Medicare dependent, low income, and at a higher risk of chronic disease or traumatic injury.

As rural facilities close, residents are required to travel greater distances to see their doctors. At the same time, many local EMS responders serve the community on a volunteer basis. Both increase the risk of mortality following a traumatic accident or serious complication, like a heart attack.

The data is clear: an inverse relationship exists between the time it takes a trauma or heart attack victim to reach care and that victim's probability of survival. In fact, a recent study by Cornell University demonstrates that every five-minute increase in travel decreases the patient's probability of survival by 1.25 percent. Additionally, the risk of a trauma death increases at a rate of 3.4 percent for every ten-minute increase in travel time, according to the University of Pennsylvania.

Access to a doctor or hospital is not just about severe cases; it is about access to basic health care needs for everyone. Expecting moms need prenatal care, families need childcare, and seniors need regular access to their physician.

Unfortunately, the gap between the number of required physicians and the number of Americans pursuing a career in medicine is growing. This phenomenon is particularly acute in rural America. In fact, while nearly one-fourth of the U.S. population is rural-based, fewer than ten percent of physicians serve the same geographic area, according to a Stanford University study. Furthermore, data from the National Association of Community Health Centers shows that 62 million Americans are without adequate access to primary care due to physician shortages.

While we do face these challenges to our nation's primary care infrastructure, there are programs that are helping rural communities. For instance, the Critical Access Hospital (CAH) designation helps equip at-risk rural facilities that serve Medicaid patients with the resources to serve their beneficiaries. These small facilities have become the backbone of the rural health care safety net that is critical to states like Indiana.

According to the Richard G. Lugar Center for Rural Health, Indiana is currently home to 35 CAHs, while 1,327 are located across rural America. In 2012 alone, 370,000 emergency room visits and nearly 4,000 births occurred at CAHs in Indiana, while the cost of care was 3.7 percent less expensive than in urban settings. We need to ensure that these facilities can continue serving the community.

One of the biggest challenges to rural healthcare is the financial instability of Medicare and Medicaid. The Medicare Trustees predict that if we continue on the current pathway, the program will be bankrupt by 2024. In states with vast budget issues, like Illinois, there is much uncertainty about whether or not Medicaid payments will actually reach providers, like physicians and pharmacists. In my own medical practice, I have personal experience with the Illinois Medicaid program running out of money before the end of the year.

To achieve savings, Washington has relied on reimbursement cuts to hospitals and other providers in an attempt to prop up these programs. However, the data shows that these cuts significantly hurt physician access, particularly in rural areas. The current uncertainty about future reimbursement along with high levels of educational debt make it difficult for medical students to choose primary care fields and particularly difficult economically to choose to practice in rural communities.

Our health care challenges are many, but they are not unsolvable. Politicians need to have an open an honest discussion with the American people based on the facts, and make the tough decisions necessary to get us on the correct pathway to ensure access to quality, affordable health care for every American. I am honored that as a legislator, I have the unique ability to continue caring for patients by advancing policies that will increase patient access and the quality of care delivered.

Bucshon, a former cardiothoracic surgeon, is serving his second term representing Southern Indiana in Congress. He is also a member of the House GOP Doctors Caucus.

Protecting Medicare Advantage

Representative Renee Ellmers (R-NC)
Member, Energy & Commerce

Medicare Advantage is under siege. For the past three years, the Obama administration has carried out an orchestrated attack on the funding for Medicare Advantage and the cost-saving mechanisms that have allowed it to provide important care for our seniors. They are doing this in order to divert funding for the aptly-named Affordable Care Act (Obamacare) - a law which has already forced millions of Americans off their health plans and caused premiums to skyrocket.

This is no secret. Back when this terrible law was rushed through the Democrat-led Congress in 2009, the law mandated that there be a way to pay for it. After increasing taxes to unprecedented levels, there was still the need to find additional funding for the law that everyone knew would raise premiums, cost jobs and destroy the doctor-patient relationship. The Obama administration needed more money and they found it in Medicare Advantage - to the tune of $200 billion - and now they are looking for even more.

In February, the Centers for Medicare and Medicaid Services (CMS) proposed a new rule to cut Medicare Advantage funding in 2015 by at least 5.9 percent after gutting the program by 6.7 percent last year. As a result, our seniors are currently facing higher out-of-pocket-costs, limited access to providers, and reduced benefits. Because of these harmful cuts, 2013 saw an unprecedented exodus of Medicare Advantage plans from the market - the first market exit in nearly five years.

Through Medicare Advantage, medical professionals deliver higher quality care using tools that enhance patient-provider communications. This has reduced hospitalizations by over 20 percent and decreased individual patient health care costs by thousands of dollars each year. The heightened collaboration among participants also allows providers to identify treatment gaps and deliver much-needed follow-up care to beneficiaries, leading to a reduction of emergency room visits by 20 to 30 percent.

This program was designed to foster competition and use free-market mechanisms to drive down costs and provide greater options. It helps providers coordinate care for patients through innovative programs that manage complex chronic conditions, promote wellness and prevention, and deliver other benefits beyond those available under fee-for-service Medicare. Yet the cuts proposed by CMS will cripple our seniors' ability to make ends meet.

According to a recent report by Oliver Wyman, the 2015 cuts could lead to benefit reductions and premium increases of $35 to $75 per member per month, including plan exits from local markets. This means that many beneficiaries could lose access to Medicare Advantage plans. Nationwide, that number comes to 15 million. In my home state of North Carolina alone, nearly half-a-million seniors could see their plans cut due to this misguided and dangerous policy. Moreover, the 2015 cuts would also have a disproportionate effect on beneficiaries with low incomes, including the 41 percent of Medicare Advantage enrollees with annual incomes below $20,000.

This is completely unacceptable. That's why this month I sent a letter to CMS that was co-signed by eighteen of my colleagues on the House GOP Doctors' Caucus - calling on the Obama administration to account for this unnecessary intrusion. Because of CMS, our seniors will see a dramatic change in the program's funding this year, which includes the $200 billion that is scheduled to be removed over the next ten years to pay for Obamacare.

This fight will continue until our government realizes that we have a responsibility to maintain and support the promises we have made to our citizens. As a proud supporter of Medicare Advantage, I believe it is our duty to protect it for the sake of American seniors. Robbing our seniors of the benefits they earned to pay for a takeover of our health care system betrays that promise, and I for one will do everything I can to stop it.

Mrs. Ellmers is serving her second term as U.S. Congresswoman representing North Carolina's second district in the House of Representatives. She currently serves on the House Energy and Commerce Committee and is Chairman of the Republican Women's Policy Committee.

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About This Supplement

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A Reasonable Alternative To ObamaCare

L.R. Halsted

This is proposed as a reasonable alternative to ObamaCare in that **it completely avoids the very expensive and wasteful use of insurance as required in ObamaCare** and also that it completely avoids the income tax type of premiums required in ObamaCare. Instead it would be a part of the Public Services and Systems (PSAS) that the public wants and pays for by paying income tax and payroll taxes, and as such would **be more of a supplement to the health care plans that people had prior to the passage of the Affordable Care Act (ObamaCare).**

The Alternative System would be a nationwide system of clinics that would be designed to provide the following three types of health service:

(1) Emergency Care of all types where the care is needed urgently but **where the treatment would be limited to a few days duration.**

(2) Personal Health Evaluation of an individual, **as requested by that person's family doctor or health specialist.** The requestor would provide the medical and physical description of the individual and the tests to be performed. **The tests would be performed using the most up-to-date methods and facilities available and the results provided in a standard manner to the requestor.**

(3)Health Education and preventive care. **This service would be for the purpose of teaching an individual how to take good care of his body.** Subjects would be good nutrition, the use of alcohol and drugs, sexual behavior, care of one's eyes, ears and skin, boosting immunity to disease, dieting and weight control, and sports activities.

Consider what help the Alternative System would provide the family without health insurance. That family would certainly want to have a family doctor now as **the System would allow the doctor to simply request that the health of each family member be evaluated (without cost).** Also if the family had not been able to afford health insurance before they would have a better idea as to the type and amount of health insurance they could now afford. Further the free emergency treatment service would diminish the anxiety over not having any medical service in the event of a sudden need of such service.

The System would surely transform medical practice for doctors. **Doctors could use the System for free diagnostic services and be practically immune from malpractice suits for that usage.** Many doctors have given up private practice because of the cost of malpractice suits, working instead as hospital staff members. The Alternate System would make private practice much more attractive to doctors than ObamaCare would, as ObamaCare views doctors as rather subservient to the insurance companies. **The Alternative System would put doctors back in control of Medical Practice.**

The Health Education and Preventive Care service would be especially valuable for the young people. The personal and social health benefits of a good marriage would be detailed. Also the love and affection, both given and received, in raising children would be emphasized as to the health benefits for everyone involved. The value of establishing good nutritional and weight control habits at an early age so as to avoid common diseases such as type 2 diabetes, which frequently lead to other health problems, would be stressed.

The Alternative System would be the type of health system that the people would want as a basic service, such as our K-12 educational system. It would provide organized emergency care facilities that would be very useful in the event of a natural emergency and would both ease and supplement the use of hospital emergency rooms. The Personal Health Evaluation capability would be a very valuable public service for the individual and could revolutionize the way diagnostic services are obtained and put doctors in control of Medical Practice. It would not provide free non-emergency medical treatments. Those treatments would be up to the individual to manage.

ObamaCare is essentially a Socialistic Mandatory Entitlement that reduces our personal freedoms and burdens our businesses so that it harms our economy!!