The future of patient privacy is at a pivotal moment. At the end of July, Health and Human Services Secretary Alex Azar announced impending changes to the HIPAA Privacy Rule. The federal rule, resulting from the Health Insurance Portability and Accountability Act of 1996 (HIPAA), became effective in April 2003. CCHF will be watching for these proposed changes because this rule has been modified numerous times, often expanding outsider access to patient health information. We’ll let you know when you need to take action.

How do you define privacy? The Vice President and Chief Privacy Officer for Allina Health Systems defined privacy at a June 2018 hearing of the Minnesota Legislative Commission on Data Practices like this: “Often people are confused and think that privacy means locking down data, but that is not actually what we typically do . . . Instead, privacy is a broader and more complex concept – one that addresses the appropriate collection, handling, and use of information.”

Her explanation is revealing. It makes privacy completely dependent on the one holding the data—and their subjective definition of ‘appropriate.’ It degrades the term ‘privacy’ by not taking into consideration the patient’s wishes or the sanctity of the confidential patient-doctor relationship.

Today’s HIPAA rule permits broad use and disclosure of individually-identifiable ‘protected health information’ (PHI) without patient consent. For example, according to this “privacy” rule, whoever holds patient data can choose to share it with over 2.2 million entities, plus government agencies. Fortunately, the rule permits state
The most important change to the HIPAA rule should be to re-establish the privacy and consent rights the rule took away.

Legislatures to enact more protective (actual) state medical privacy laws.

Right now, CCHF is fighting to save Minnesota’s strongest-in-the-nation medical privacy law. The Minnesota Health Records Act (MHRA) grants patients a private right of action (to sue) and requires patient consent for sharing of information for treatment, payment, health care operations (TPO), research and more. But Big Business and the health care industry want consent removed. They claim MN is an “outlier” on privacy. Yet, other states also protect privacy. For example, Florida requires consent to share information for payment, health care operations, and research.

In the near future, HHS will release proposed changes to HIPAA, but it’s unclear if these will be better or worse because conflicting statements have emerged. Azar described the need to reduce the paperwork burden on physicians, but he also declared the importance of reimbursing doctors based on the “quality” or “outcomes” of care (likely requiring data reporting through the electronic health record).

Likewise, Seema Verma, Administrator of the Centers for Medicare and Medicaid (CMS), claims personal health information belongs to the patient and the patient should control it. However, she also says, “Imagine if our health records weren’t just used by our doctors in their workflow, but rather if EHRs allowed third-party applications to access and leverage that data…”

Because protecting your privacy protects your freedom, CCHF is at the forefront of this battle. Thanks to your support, we are continuing to bring these important privacy issues to the Trump Administration—we recently brought it directly to HHS Deputy Secretary Eric Hargen during a conference call held by the White House. The most important change to HIPAA should be re-establishing privacy and consent rights that the rule took away from American patients.

Our new book, Big Brother in the Exam Room, has a section dedicated to unveiling the HIPAA privacy deception and lists specific action items for patients, doctors, and lawmakers to restore patient privacy rights.
Good news! Many have thrown in the towel on health care—but not CCHF. Some think this is not a winnable issue. But Americans cannot afford to lose. We cannot give up on patient freedom, physician autonomy, affordable prices, and medical excellence. We must win. Socialized medicine would be the beginning of the end of freedom.

The opposition is fierce. The fans of a government-controlled, health plan-run system are well-funded (e.g. government, liberals, health plans, hospital systems, big employers, technocrats). And progress seems slow. But CCHF is implementing strategies (e.g. The WEDGE) that allow patients and doctors to exit from today’s costly and controlling third-party-payment health care system. That’s the root of the trouble we’re in: third parties are paying our medical bills—as I make clear in our new book: Big Brother in the Exam Room.

We won’t win every battle, but we must successfully open pathways back to affordability and freedom, even small ones that can later grow into huge off-ramps when the conditions are right. That time is coming. Doctors are retiring early, Medicare is going broke, and middle-class Americans who want health insurance are choosing to go uninsured.

Right now, we’re working on a critical exit strategy. We want to give senior citizens the freedom to keep private insurance, which is the freedom to choose or refuse Medicare (which will be bankrupt in 2026). Unless Congress raises payroll taxes to very painful levels, which will significantly reduce wages, you can expect unethical, potentially explicit, rationing of care to the elderly. You can expect the advance of physician-assisted suicide and euthanasia for Americans in their sunset years.

We must get this done with Trump in office. In 1993, the Clinton administration forced senior citizens into Medicare, and locked the door. It inserted an executive instruction into the Social Security Procedure Operations Manual (POMS) that says seniors who refuse to enroll in Medicare Part A (hospitalization) will lose access to their social security retirement benefits. It’s not a law. It’s not a rule. It’s an administrative decision. And as easily as Clinton added it to the POMS, Trump can take it out.

This is where you come in.

Our petition to President Trump asks him to strip the Clinton language from the POMS so seniors can voluntarily opt out of Medicare.

We’re talking with the Trump administration but it’s clear that we must raise the heat on this issue, and we need your help to do so. A lawsuit won’t work. Former House Majority Leader Dick Armey (R-TX) was a plaintiff in a 2008 case against this POMS instruction, but the U.S. Supreme Court refused to hear it in 2013. So we must act while President Trump is in office.

Imagine the new market of indemnity insurance options that would emerge if Americans were allowed to keep private health insurance for a lifetime. Imagine how this would make it difficult to advance “Medicare for All” or any other socialized medicine scheme.

Please act now. To sign our “Freedom to NOT CHOOSE Medicare” petition, go to: www.bit.ly/MedFreedom

Twila Brase, RN, PHN
President and Co-founder
Big Brother in the Exam Room: The Dangerous Truth About Electronic Health Records made its debut on July 11 in Las Vegas, Nevada during FreedomFest.

This book is an exposé of the government-mandated, government-certified electronic health record technology (CEHRT)—I call it the government EHR. The EHRs before Congress mandated them in 2009 worked well for doctors and nurses. Their purpose was patient care. But today’s EHR is built for data collection, data analytics, profiling, reporting, and control of physicians. Its purpose is the federal takeover of medical decision-making and the entire health care system. As I make clear in the book, the government EHR was in HillaryCare, and it became law four weeks after Obama’s inauguration—as the foundation for the Affordable Care Act.

Health IT expert, Scot Silverstein MD, says EHRs are “enterprise-wide command and control systems through which all medical transactions have to pass, controlling clinicians and clinical resources. They are beyond just a medical device. They’re really command and control systems.”

I wrote the book to tell Americans the dangerous truth about the government EHR. The “Clinical Chaos” section shows how today’s EHRs are dangerous to patients, pose ethical challenges to doctors, and allow a multitude of government agencies and corporations to conduct surveillance and impose third-party control over medical treatment decisions. Today’s EHR is not what most people think it is. It is not a computerized version of a paper medical record.

Here are a few comments we’ve received so far:

“Every patient should read this book. It mirrors what’s happening.” (hospital nurse)

The government EHR is built for data collection, data analytics, profiling, reporting and control of physicians. Its purpose is the federal takeover of medical decision-making and the entire health care system.
“This is truly a fine piece of work—and a good read. My wife thought the writing clear, concise, and easily understandable—high praise from an English major!” (retired physician)

“Reading the book was unsettling. It put on stark exhibition how Medical Informatics has been hijacked by government and commercial interests . . . severely damaging the medical profession itself.” (practicing physician)

“We’ve been lied to about HIPAA.” (patient)

 Shortly after its debut, Big Brother in the Exam Room was rated “#1 New Release” in the privacy and surveillance category for books on Amazon. Some people say they’re buying more than one book and giving one away to state legislators, Congress or their own doctor.

Here’s our suggestion for physicians and clinicians: Put a copy in the waiting room or several exam rooms and let patients look while they wait. Let them know the danger they’re in and the pressure you’re under to collect and report their data.

The book is both an exposé and an ‘evergreen’ resource. Most of the information will never become outdated. It tells the tale of deception, documents the history, shows both parties at fault, includes more than 1500 endnotes and a timeline of laws that led to third-party control. It quotes about 250 experts in medicine, technology and government. It also gives **four separate lists of action steps** to restore privacy, patient safety and freedom—one for Congress, state legislators, practitioners, and citizens. And best of all, we made it easy on the eyes!

Please buy the book, share it, and give it away. For the sake of patients, medical excellence and ethics, and freedom in America, Big Brother must be banished from the exam room. Order it by going to BigBrotherInTheExamRoom.com.
Congress Approves Theft by Insurers
June 15, 2018

What would your barber do if you refused to fully pay him because you didn’t think the cut was valuable? Or try telling the plumber that YOU’LL decide how much he gets paid depending on how much value you think he provided. Expect your plumbing problem to continue until you agree to pay exactly what the plumber tells you to pay.

But Obamacare lets insurers pay doctors based on “value,” not services. One insurer, UnitedHealthcare, expects 150 million patients to be under value-based payment in seven years compared to only 15 million today. This is legalized theft. And what kind of care will you receive if doctors are only paid for value not services?

“UnitedHealth Expects 150M Members to Be in Value-Based Programs by 2025,” (Evan Sweeney, FierceHealthcare, May 31, 2018)
please join us to hear KEITH SMITH, M.D., give an inspiring presentation

Showcasing Free-Market Medicine in Action

with emcee BOB DAVIS

Thursday, September 27, 2018

Keith Smith, M.D., is a pioneer in free-market medicine, the founder of the Free-Market Medical Association, and the nationally-recognized co-founder, CEO and medical director of the cash-based Surgery Center of Oklahoma.

Dr. Smith has appeared on CNBC, The O’Reilly Factor, NBC Nightly News, and his revolutionary approach to health care pricing has been featured in ABC News, The New York Times, and TIME magazine. Join us for an amazing evening!

To register online: bit.ly/cchfdinner2018

* CCHF is registered with the IRS as a 501(c)3 nonprofit organization. Your donation to CCHF is fully tax-deductible with the exception of the market-value of goods received at the event.

YES, I WANT FREE-MARKET MEDICINE IN AMERICA!

Use my donation* to restore freedom to patients and doctors! Enclosed is:

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Thank you for your support! Your tax-deductible gift supports health freedom, medical and genetic privacy rights, health care choices, physician freedom, and the protection and preservation of individualized patient care.

* CCHF has received 501(c)3 non-profit status from the IRS. CCHF has received permission to solicit charitable donations in all states except California. In August 2016, we withdrew our registration in CA to avoid the AG’s demand that we share the confidential names of certain donors. The full disclosure regarding solicitation is found on page 2 of this newsletter.
“Recent evidence suggests that small, physician-owned practices, while providing a greater level of personalization and responsiveness to patient needs, have lower average cost per patient, fewer preventable hospital admissions, and lower readmission rates than larger independent and hospital-owned practices.”
– Farzad Mostashari, MD, Former National Coordinator for Health IT, Ann Fam Med, 2016

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“It is virtually impossible to undo the harm and sense of violation individuals feel when the intimate details of their personal health information are breached. I find that the harm from these breaches is significant.” – Catherine Tully, Privacy Commissioner, Health Department of Nova Scotia, Cape Breton Post, August 8, 2018

“Our son went into the hospital. It was a scary time for us...We got shares from all over the U.S. and notes of encouragement.”
– Russell Anderson
Fox17 Nashville: Midstate family turns their backs on health insurance, resorts to ‘health care sharing,’ August 3, 2018

“I didn’t become a physician to do data entry.” – Jaya Mallidi, MD, KevinMD.com, August 18, 2018