A wrong has been made right.

On October 3, 2019, President Trump signed an executive order (EO) allowing Americans to opt out of Medicare without losing their Social Security retirement benefits. The U.S. Department of Health and Human Services (HHS) and the Social Security Administration must make that option possible by March 31, 2020.

We have achieved a great success. Former White House staffer Dean Clancy tweeted, “This is a strategic masterstroke for health care freedom.”

For nearly three years, we have been working to get this executive order.

In 1993, the Clinton Administration inserted language into the Social Security Administration’s procedural operations manual system that did two things:

- Required citizens to enroll in Medicare or lose access to their rightful Social Security retirement benefits (SSRB)
- Required citizens who chose to disenroll from Medicare to repay all Medicare and Social Security benefits they had received

These restrictions were not approved by Congress. No law required either, but for the past 26 years, seniors who refused Medicare have lost their Social Security benefits. In 2008, a lawsuit was filed by individuals who wanted to opt out of Medicare and keep their private insurance (Hall vs. Sebellius). In 2013, the U.S. Supreme Court refused the case and that appeared to be the end of the story.

But CCHF wanted a different ending. When President Trump was inaugurated in 2017, we began meeting with officials at HHS and

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Within 180 days of the date of this order, the Secretary, in coordination with the Commissioner of Social Security, shall revise current rules or policies to preserve the Social Security retirement insurance benefits of seniors who choose not to receive benefits under Medicare Part A, and propose other administrative improvements to Medicare enrollment processes for beneficiaries.” [Emphasis added]

No longer will senior citizens be forced to enroll in Medicare or forfeit their Social Security benefits.

This executive order couldn’t be more timely. It creates an escape hatch from Medicare as rationing strategies expand. Medicare is expected to be insolvent in 2026. Significant increases in the payroll tax or drastic cuts to physicians and hospitals are expected, leading to less care for the elderly.

Already, Medicare Advantage plans are denying access to medically necessary care, according to two reports from the HHS Office of Inspector General.

NOTE: Those who want to stay in Medicare won’t be affected. Opting out is a voluntary decision.

Begin thinking now about your choices. The first individuals to benefit will be enrollees in the Federal Employee Health Benefits Program and members of Samaritan Ministries, the only health sharing organization that does not require members to enroll in Medicare at age 65. Samaritan members will now be able to opt out of Medicare and use SSRB to pay their monthly shares.

This is good news for seniors. It’s good news for freedom. It’s good news for America. Please share the news. Major media ignored it, so let everyone know.

HHS Deputy Secretary Eric Hargan invited me to participate in the HHS Quality Summit. More than 300 health care leaders applied and I was selected to be one of 18 participants. HHS must provide a “Health Quality Roadmap” to President Trump by December 21. Hargan used the Summit to get outside input. Interestingly, we all agreed that the federal quality measurement enterprise (QME) needs reform (or repeal).

When I first met Mr. Hargan in July, I told him “quality” and “value” in health care can’t be quantified. I had studies to prove it. Plus, it’s obvious: we each judge quality and value differently. The real purpose of QME and its associated ACA “value-based payment” system is outside control of treatment decisions.

Nevertheless, I applied and to my surprise, an invitation arrived! Starting in September, we met three times at HHS in view of the U.S. Capitol. Mr. Hargan, the second highest person at HHS, attended every all-day meeting as co-chair. He rarely left the table.

In various ways and statements, I shared my main point: quality measurement has caused the real quality of care to be diminished as physicians and nurses are pushed to focus on the computer, not the patient.

The incessant checking of boxes to prove compliance with third-party “quality of care” metrics has interfered with care, reduced time with patients, and is the primary cause of physician burnout.

I shared statistics, such as the $15.4 billion it costs physicians each year to comply with QME. I also shared stories from patients, doctors and nurses. For example, one nurse who recently retired told me she spent 85-90% of her time on the computer.

My suggestion that HHS require each of us to list our top 10 quality measures (there are 2,300) was surprisingly agreeable to the group. While it didn’t happen, it would have shown how summit participants defined the amorphous term “quality.”

HHS’s final question was whether to let doctors opt out. I alone said yes, reminding Hargan that 48% of America’s physicians are making plans to leave the practice of medicine (17,200 surveyed). HHS can either measure physicians and lose them, or stop measuring to make sure patients have doctors in their future. It’s that simple.

By December 21, we’ll know if Mr. Hargan has taken my concerns and admonitions to heart.

Merry Christmas and Happy New Year!

Twila Brase, RN, PHN
President and Co-founder
With nearly 300 people filling a Minneapolis ballroom, CCHF had a fantastic fundraising dinner on September 19. Guests gave keynote speaker, Richard Baker, their undivided attention as he described Canada’s single-payer system and how it harms patients and the practice of medicine. Baker is the founder of Timely Medical Alternatives in Vancouver, Canada.

Baker founded the organization to bring sick and injured Canadians to the U.S. for timely, and often lifesaving, medical care. “Over the last 12 years, we have facilitated over $20 million worth of private surgeries for Canadians who are on interminably long waiting lists and had no other choice.” He shared stories of Canadians experiencing long waits, repeated delays, limited options, and direct harm.

Care is rationed for Canadians considered too young, too old, too sick, or not sick enough to qualify for medical care. Their options are also restricted. Baker noted 27 potential medications recognized for treating cancer, but Canada’s government-run health care system won’t pay for all of them. British Columbia, Alberta and Ontario only offer nine of the drugs. Manitoba covers just five. Baker explained, “If you have the misfortune of living on Prince Edward Island, they only cover one of the 27.”

Canada’s waiting lists are long, too. It takes about two years for Canadians to receive hip or knee replacement surgery. In another example, Baker said 1,500 people are on the waiting list to have ankle replacements in Alberta, but the system only pays for 100 each year – so the wait is 15 years!

He shocked the audience with a story of an eight-year old girl whose wait for a simple procedure to insert ear tubes to treat a chronic ear infection was repeatedly delayed. After Health Canada postponed the September procedure until Easter, her father opted to pay cash.

Once Baker got her to America, the treating physician said the infection had moved into her brain and he was no longer “tasked with simply draining her ears – but saving her life.” She survived, but the damage was done, permanently losing hearing in one ear and partial hearing in the other.

CCHF supporters and guests also heard from Matt Flanders, CCHF’s state legislative and policy director. Flanders highlighted three major victories in Minnesota. During the 2019 legislative session, CCHF saved Minnesota’s strongest-in-the-nation patient privacy and consent law from repeal. We also secured the repeal of Minnesota’s electronic health record mandate.

Flanders also highlighted our landmark transparency law for Minnesota’s prescription monitoring program database. This first-in-
the-nation state law requires an audit, and appropriate and timely termination of access to the database - and it allows patients to see who accesses their private prescription data.

These successes, in the only split legislature currently in the country, resulted from CCHF working with both Democrats and Republicans.

Twila Brase, CCHF’s president and co-founder, introduced members of the CCHF staff, thanked the “Wedge physicians” in the audience (JointheWedge.com), and shared her vision for the future: medical care and coverage free from government or third-party control and intrusion. She declared, “CCHF is the only organization whose sole purpose is stopping a government takeover of the health care system.”

Brase also shared the good news that she was selected from more than 300 applicants to be one of just 18 members of HHS Deputy Secretary Eric Hargan’s Quality Summit, which met three times in Washington, D.C. (see page 3). Of her presence at these meetings, she said, “I am the lone voice for freedom, for patients and against quality measurements, and [Hargan] apparently wanted that voice in the room.”

Thank you for helping CCHF stay on the front lines as we enter 2020!
CCHF Offers Trump “Made-in-America Healthcare Act”

October 18, 2019

Our organization, Citizens’ Council for Health Freedom, has sent President Trump a 10-point plan for medical care and coverage. It’s called the “Made in America Healthcare Act,” or MAHA. This plan is an alternative to Medicare for All, the public option and the Affordable Care Act, or Obamacare. Our plan will restore affordability and freedom to patients and doctors. It will protect the charitable mission of medicine.

Our plan includes restoring real medical insurance, the kind that pays the patient. It includes steps to end the pre-existing condition problem altogether. It includes tax deductions for individuals rather than employers. And it allows individuals to buy affordable customized insurance policies. Check it out online at cchfreedom.org.

CCHF is excited to announce its new Patient Toolbox. This online resource provides patients and families with 24/7 assistance at the hospital, in the exam room, or when they’re having a baby.

Patient Toolbox is a real-time guide to help patients navigate the complex, difficult-to-understand, and often high-pressure situations that too many Americans experience in the exam room, including coercive consent forms and questionnaires. Check it out at PatientToolbox.org!
‘Tis the Season for Giving!

The health care issue may seem DENSE, but CCHF specializes in SEEING the forest despite all the trees!

We need to raise $125,000 to expand our staff and grow a “FOREST OF FREEDOM” for America’s future!

Please give generously before Dec. 31!

Merry Christmas!

YES, I WANT TO DONATE TO CCHF!

You have options! You may use the donation envelope you’ll find in this newsletter. Or if you prefer to make an online donation, please go to www.cchfreedom.org and click on “DONATE TODAY.” To make a donation of STOCK, please call us for instructions at (651) 646-8935. Thank you for supporting CCHF!

Please make your check payable to/mail to:

CCHF
161 St. Anthony Ave., Suite 923
Saint Paul, MN 55103

Special Option: If you are age 70 ½ or older, you may instruct your Individual Retirement Account (IRA) to transfer any amount, up to $100,000, directly to Citizens’ Council for Health Freedom.

Note: This gift would not produce a charitable contribution deduction, but it would fulfill some or all of your required minimum distribution (RMD) without increasing your taxable income.

For more information, including a sample letter for your IRA custodian, please contact us:

(651) 646-8935
info@cchfreedom.org
bit.ly/IRAforCCHF

*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.
“Health insurance companies have seized too much power in the health care process. They should be in the business of funding care, not determining what type of care you will get.”

– Elizabeth O’Connor, Texas Public Policy Foundation, September 7, 2019

“After about four-and-a-half years of dealing with some of the insanity of the system, I was like, ‘You know what? It is not ethical, in my opinion, to be a part of a system that was failing.’ I felt emotionally and physically drained.”

– Dr. Timothy Wong, iHealth Clinic, October 8, 2019

“‘The hottest word in health care today: Value.’

– Martin A. Makary, MD, November 13, 2017

“The word ‘provider’ encourages us to consider health care as a commodity and the physician-patient encounter as more business transaction than relationship, which must be grounded in trust and mutual respect. Physicians must not surrender professionalism to commercialism.”

– Niran Al-Agba, MD, pediatrician in Washington State, February 8, 2019

“Single-payer systems save money by squeezing health care providers — doctors, hospitals, and ultimately everyone who works for them...”