Face the Facts: Obamacare Means Mass Murder

by Marcia Merry Baker

Oct. 21—The United States was suffering from a crisis in health care when President Barack Obama came into office. As a result of the deindustrialization of the U.S. economy, the privatization of health care into profit-making ventures, and deregulation, both the health-care system and the health of the American population were rapidly deteriorating.

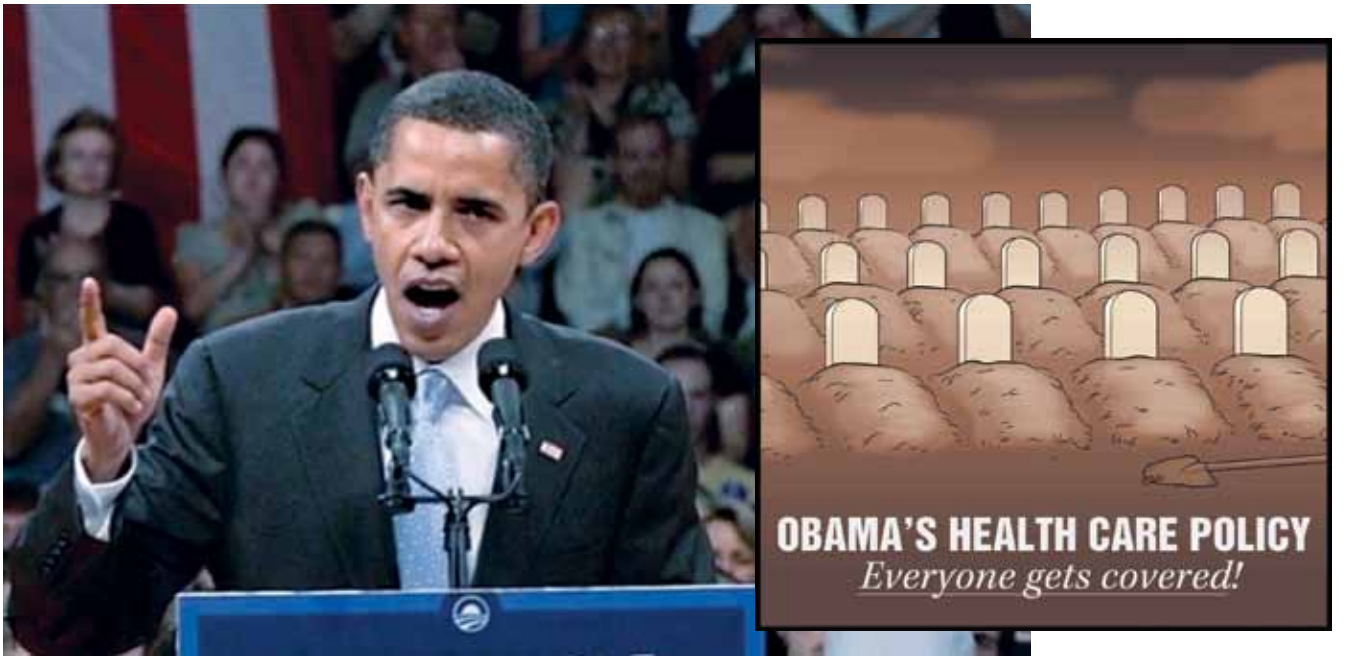
Obama's health-care program, however, has made the situation much worse. If allowed to continue, it will turn the U.S. government into the enforcer of a worse-than-Hitler genocide machine.

In other locations, *EIR* has provided in-depth examination of the Nazi premises behind what is called Obamacare. Here we restrict ourselves to a presentation of crucial facts which show that such Nazi measures are already underway and leading toward mass death.

I. Provenance: Hitler's T4

1. Hitler T4 Health Care. In October 1939, Adolf Hitler issued his official directive on selectively putting people to death, which was already underway in Germany against handicapped children and concentration camp inmates. It was titled, "The Destruction of Lives Unworthy of Life." It arose from a prior meeting he held with medical professionals, to review "criteria" for practical and cheap methods of removing people deemed to be "unrehabilitable," and thus burdens on the nation.

Hitler's directive was administered from Berlin headquarters at No. 4 Tiergarten Strasse, where the Reich Work Group of Sanatoria and Nursing Homes began by conducting surveys of patients nationwide, designating who was not worthy to continue to live. They were put to death; the principle came to be applied



President Obama's Nazi health-care plan is designed to cut costs and lives. It was never intended to provide medical care, as advertised.

on a mass scale through the gas ovens at concentration camps.

2. Tony Blair's T4 Health Care. In Britain, on April 1, 1999, the first initiative was taken by the Blair government (1997-2007) in the name of health-care "reform," to institute an updated version of the Hitler T4 program: The **National Institute for Health and Clinical Excellence (NICE)** was formed, to dictate what treatments would, and would not, be given to designated groups of patients in the British **National Health Services (NHS),** which had served the nation since the 1940s.

Blair's health advisor to set up NICE, Simon Stevens, then moved to take down the NHS system, by privatizing key functions, in particular, through the private insurer **UnitedHealth Group UK,** which Stevens joined.

The record shows how the death rate has climbed for whole classes of Britons, especially the elderly and cancer patients, as a result of both NICE barring treatments, and the NHS being dismantled. For example, as of 10 years after NICE went into effect, only 40-48% of British men diagnosed with cancer survived, and 48-54% of British women; in stark contrast to Sweden, for example, where 60% of men and 61% of women survived after a cancer diagnosis.

The particular program put into effect to speed up death rates was called the **Liverpool Care Pathway for the Dying Patient (LCP)**. According to extensive exposés in the British press during the 2000s, participating NHS hospitals were offered financial inducements to put patients deemed to be at the end of life, on the LCP list, under which all treatment is discontinued, and even water and hygiene removed. The LCP started for cancer patients in Liverpool in the 1990s, with royal patronage; by 2012, it involved 178 NHS hospitals throughout Britain, and included patients with any illness. On average, 130,000 persons a year were put under LCP, based on the claim of saving medical resources, which, as of 2012, had rewarded hospitals with at least $40 million. An estimated 60,000 people on LCP died yearly, without having given their consent to discontinue care. After storms of protest, the U.K. government, in July 2013, ordered the LCP to be phased out over the next 12 months.

3. Obama's T4 Health Care. In 2009, the Blair/Hitler health concept was launched in the United States by the new Obama Presidency, as a campaign under the euphemism of care "reform," just as Blair had done in Britain. The Obama drive culminated in the March 23, 2010 **Patient Protection and Affordable Care Act (ACA).** Leading up to this were 18 months of intense propaganda, including 30 hearings and roundtables, under the cynical slogan that, under Obamacare, all Americans will get "access to care" through access to insurance.

In reality, the ACA law is made up of measures to cut care, destroy the means to deliver it, and to perpetrate death. At the same time, private Wall Street insurers get Federal subsidies.

Key figures in bringing about the ACA—including several with direct involvement in the British health system—have explicitly expressed the T4 principle, that there are "lives not worthy" to continue.

Dr. Ezekiel Emanuel, a longtime advocate for this Hitler health view, was appointed by Obama in early 2009, as the health advisor to the Office of Management and Budget (OMB). In April 2009, he was put on the new Federal **Coordinating Council on Comparative Effectiveness Research,** to devise rationalizations for cutting medical treatment. In particular, Emanuel stressed that the Hippocratic Oath caused "over-use" of medical resources, which must stop.

Peter Orszag, Obama's first head of OMB, promoted the panoply of Hitler health arguments and mechanisms. He is considered the leading architect of the **Independent Payment Advisory Board (IPAB)**—the analog to NICE, which was quickly dubbed Obama's "death panel." Orzag advocates cost-benefit analysis to determine whether medical treatment is warranted for a person. He backs the statistical **"Quality Adjusted Life Years" (QALY)** metric for whether it is worth it for a person to continue to live. Orszag's London collaborator, **Sir Michael Rawlins,** head of NICE, pumped the QALY formula in a *Time* interview March 27, 2009, saying, "A QALY scores your health on a scale from zero to one: zero if you're dead, and one if you're in perfect health. You found out, as a result of a treatment, where a patient would move up the scale," and you decided, based on how much a year of life is worth in dollar terms, whether to permit it or not, based on whether it takes too much away from society's scarce resources.

Moreover, Orszag holds that, even if you are not sick, but are living "excessively long," he advises that you should have your Social Security "adjusted" (i.e., reduced), according to a statistical formula he backs, called the "Longevity Index."

EIRNS/Joanne McAndrews

Obama's OMB director Peter Orszag was the architect of the "death panels," known offically as the Independent Payment Advisory Board (IPAB). Shown: LaRouchePAC organizing in Philadelphia, May 2009.

Simon Stevens, Blair's Hitler health operative, who re-located from the U.K. to the United States in 2007, personally advised the Obama White House on how to shape the new health law. In May 2009, he presented a report titled "Reducing Avoidable and Inappropriate Care," saying that $520 billion can be "saved" in the first 10 years of a new reform act, by cutting services to non-worthy people, especially the old. Stevens is the Medicare expert at **UnitedHealth Group,** the largest HMO in the United States (70 million policies).

Sir Donald M. Berwick, knighted by Queen Elizabeth for his work on NICE and on "reforming" the British NHS, was given a recess-appointment by Obama on July 7, 2010, to be administrator of the **Centers for Medicare and Medicaid Services (CMS).** As such, he was responsible for initiating T4 policies in programs affecting 49 million older Americans on Medicare, and 48 million poor, disabled, and dependent, on Medicaid. He stayed in office as long as his recess-appointment tenure would allow, leaving in December 2011, to avoid the scrutiny that would ensue in a Senate confirmation hearing.

While in office, he moved to strike certain cancer drugs from approved Medicare reimbursement; to set up ways to financially penalize hospitals for "over-treating" patients; and to limit physicians by imposing financial penalties and pushing top-down "evidence-based" medical practice dictates. He was followed in office by **Marilyn Tavenner,** a technocrat for Obamacare with a pedigree as top executive at **HCA,** the mega-for-profit hospital chain, benefitting from the takedown of the traditional community hospital system.

II. Context: Poverty, Illness, Degraded Hospital System

The ACA measures are being imposed as the final health-care "solution" to the poverty, illness, and suffering already underway as of 2010, and now far worse.

1. Impoverishment. Of the U.S. population of 314 million, roughly 135 million are working, but 20 million of those are working only part-time, and more than 50 million (inclusive of most of the 20 million) have work defined as low-wage (twice the poverty line or lower). Fifty-two million people are in households defined as poor ($22,000 or less income for a family of four); this is the highest number of people ever. The number of people living in "deep poverty," represented by an impossible $11,000 annual income for that family of four, has jumped to 20 million—1 in 15 Americans.

Some 50 million are forced to use food stamps to feed themselves and their families; and 50-80% of public school students in 20 Southern and Western states are poor, and rely on discount and free meals through the school-lunch programs of the Agriculture Department.

In the official, understated jobless picture: 11.8 million Americans are unemployed; 8.8 million are forced to work part-time; 4.5 million eligible workers have left the labor force or, coming of age, never entered it. This is 25 million eligible workers who need, but do not have, full-time work.

Due to actual inflation as defined by major catego-

ries of the market basket of living, in government statistics, the lower-income 60% of the population has experienced a drop of 10-15% in its real income since 1999. The fourth quintile has somewhat more than broken even, and the top 20%'s real income has doubled. Another measure of this for the lower 60%: Their actual average income is $500 more per household than in 1999; their actual expenses of living are $5,000 more.

The ratio of the total population employed is at a four-decade low, 52.4%. For young people aged 18-34, the ratio of employed has fallen from 84% in 2000 to 72% in 2012.

But if one subtracts self-employment, and takes Americans employed full-time by an employer not themselves, that ratio is down to 43.4%. According to a Gallup survey, it has fallen by 5% since 2010.

As to "saved" wealth (mainly houses), more than 90% of the households in the country have less wealth than they had in 2008.

2. Desperation: Suicide Rate. The U.S. suicide rate has skyrocketed. The rate at which Americans between 50 and 64 years of age kill themselves rose 45% between 1999 and 2010, according to the **Centers for Disease Control and Prevention (CDC)**. Women aged 60 to 64 had a rise of 60%; and men in their 50s had a rise of 48%. The CDC researchers point out that these citizens are being squeezed under impossible pressures of lack of means to care for themselves, their elderly parents, and their own children, also hit by economic crisis.

3. Disease, Death Rates Rising. Sickness and mortality rates are increasing for cohorts of the population who are poor, jobless, and with no future. Many illnesses are associated with increased accident rates, obesity, malnutrition, parasites, drug and alcohol abuse, and other factors of despair, plus lack of medical treatment.

Add to this, the increased diseases associated with globalization and decline in public health services.

The CDC, in September, sounded the alarm about the increase in drug-resistant bacteria, in a 114-page report, **Antibiotic Resistance Threats in the United States 2013**, giving particulars for 18 microbes. Two million Americans—at the very least—are affected by one or more of the prevalent microbes each year, with at least 23,000 deaths from the infection.

Consider food-associated illnesses. Forty-eight million Americans—one in six—are each year get food-borne illnesses; 128,000 are hospitalized and 3,000 die, as reported by the CDC. A high percentage of the microbes come in food imports, which now supply 15% of U.S. food consumption overall, and much higher percentages for particular types, e.g., seafood (85%).

Even crude vital statistics for the county level, show that U.S. life expectancy is declining for millions of Americans. The July 10 issue of the **Journal of the American Medical Association** ran coverage titled, **"The State of U.S. Health,"** showing that in 1,405 counties (mostly in the South, Western tribal lands, and Appalachia)—which is 45% of the total number of 3,014 counties in all 50 states—female life expectancy remained static or declined from 1985 to 2010. In 72 of these counties, the decline was very significant—over two years or more. The same for men in poor counties. If you were born a male in McDowell County, West Virginia, in 2010, your life expectancy is 63.9 years. (The analysis covers all counties; and a set of 291 diseases. See healthmetricsandevaluation.org)

4. Safety Nets Fail: Medicaid. There are now more than 51.5 million Americans on Medicaid, the Federal program—run in conjunction with states—enacted in 1965, as a safety net to see that people who lack means for necessities—temporarily, or for reasons beyond their control—have medical care. Moreover, this roster of one in six Americans who are so poor as to qualify for Medicaid, does *not* represent the extent of low-income persons who need help, because in recent years, most state governments have imposed ever-stricter enrollment requirements, to try to keep down the numbers. Over the last 10 years, Medicaid expenditures overall grew 90%, and became, in many states, the foremost budget category.

Instead of seeing this as the reflection of the economic collapse, many Congressional delegations express their version of Hitler's health care, by opposing not only Obamacare, but also demanding cuts to Medicaid, in order to "cut the deficit" by cutting lives.

5. Hospital System Dismantled. Over the past 40 years of worsening economic conditions, the nationwide system of hospitals, which had been built up since the **1946 Hill-Burton Act (Hospital Survey and Construction Law),** has been drastically dismantled. The advent of HMOs after the enabling act of 1973, and further deregulation allowing the predation by for-profit Wall Street hospital chains to take over or shut down non-profit local hospitals, drove the takedown.

EIRNS/Steven Carr

Starting with the creation of HMOS in 1973, thousands of non-profit medical institutions, like this health clinic in St. Louis, were shut down.

As of 1980, when the ratios of standard care (hospital beds and physicians per 100,000 persons) was the best, there were 5,810 community hospitals, spread over 3,000 counties, which provided 987,000 beds for 226 million people. But by 2011, the number of hospitals dropped 15%, down by 837 to below 5,000. The number of beds dropped by 20%, down by 189,000, to 798,000. Yet there were 85 million more people to care for. The national average bed-to-population ratio fell from 4.4 per 1,000 people in 1980, down to 2.6 per 1,000 in 2011, a 41% drop.

In the course of this, local, non-profit community hospitals have been taken over, scaled down, or shut, as a few mega-chains—many of them for-profit—are coming to dominate hospital care. This is another aspect of Wall Street crime. The hospital chains—six of the biggest are publicly traded—are positioning on how to profiteer, in the new corporatist ACA world.

6. Public-Health Takedown. Vital public-health services by the Federal government, states, and localities—from pest-eradication, to food-safety monitoring—have been cut back drastically in the last few years to try to "balance the budget" on Wall Street's terms.

For example, Federal aid has dropped for the CDC divsion, **Epidemiology and Laboratory Capacity for Infectious Disease,** down from around $35 million yearly in the early 2000s, to $10 million by 2012. Among many other things, this is the agency supplying resources for fighting mosquito-borne diseases, such as West Nile Fever, which surged back this Summer.

III. Obamacare Killer Measures

1. Shut Down Hospitals. The U.S. hospital-centered health-care system, already contracting, is now under assault from multiple Obamacare measures.

Overall, Obamacare identifies cuts of $716 billion over 10 years in cuts to Medicare, as well as cuts in other programs. Much of this directly and indirectly hits hospitals.

• *Penalize readmissions.* Financial penalties against hospitals are in effect for their too-frequent re-admission of sick patients. Since October 2012, hospital rates of re-admission are reported quarterly and evaluated. A rate considered too high results in docking Medicare payments to the hospital. The cut is up to 1% in FY 2013; up to 2% the next year; and 3% thereafter.

On Sept. 30, 2013, the end of the first year of the ACA **Hospital Readmissions Reduction Program (HRRP),** 2,225 hospitals were penalized a total of $227 million, according to Kaiser Health news.

The intent was clear right from the start. As of the first quarter of the program, of the 3,282 hospitals in the HRRP, fully 66.7%, or 2,189 facilities, suffered a cut in Medicare payments. Teaching hospitals, which tend to have complex cases of elderly patients, and safety-net hospitals serving the poor, predictably have the most need for re-admissions: they are reeling from the cuts. HRRP will cut Medicare spending by $8.2 billion from 2013 to 2019, say Obamacare statisticians.

• *Cut charity care.* Obamacare specifies cuts in Federal aid to hospitals, which has defrayed costs of treating the uninsured poor. Starting in 2014, Obamacare will cut what are called **Disproportionate Share Payments (DSP).** The hospitals are to get $22 billion

less over the current 10-year period, according to the American Association of Medical Colleges and the Commonwealth Fund.

• *Sequester cuts.* Some $95 billion in other cuts in Medicare programs are underway, including the impact of the sequester, all of which are slamming hospitals, according to Caroline Steinberg, vice president for analysis at the **American Hospital Association.** In fact, a specific automatic sequestration cut has taken away $45 billion from hospitals—more than double what the Obamacare DSP charity cut was.

• *Mass threat to rural hospitals.* In August 2013, the Obama Administration proposed a rule change to the **Critical Access Hospital (CAH)** program, which would shut down hospitals in rural areas en masse. There are currently 1,332 CAH hospitals nationwide, with potentially two-thirds in line for shutdown. The CAH system was set up in 1997 to curb closures of rural hospitals.

The way it has worked prior to the Obama proposed change, is that, under the CAH system, since 2006, state health officials designate which of their community hospitals—often in low-population-density areas—are critical to remain open and viable, to provide residents, in particular the Medicare-age bracket, the physical means to receive care. The criteria include that the facility not have more than 25 beds, that it be at least 35 miles distant from other hospitals, and other rubrics. These CAH facilities then get reimbursed by the Federal **Center for Medicare and Medicaid Services (CMS)** at 101% for their Medicare-related expenses, not at any lower Medicare reimbursement rates.

But in August, **Inspector General Daniel Levinson,** for the **Health and Human Services Department (HHS),** issued a report declaring that hundreds of these CAH hospitals no longer meet the criteria. So states should no longer have the right to designate CAH facilities; the HHS/CMS should henceforth do so, and they will disqualify many such hospitals from adequate reimbursement. This will financially ruin hundreds of rural hospitals, and cut access to care for millions of people, whether or not they may have health "insurance." Particularly vulnerable are Iowa with 82, and Kansas with 83 CAH hospitals.

2. Drive Out Doctors. Under various Obamacare measures, physicians are under financial pressure and subjective coercion to acquiesce to the intent of the ACA to cut care and lives. To begin with, two-thirds of the doctors in the United States no longer practice medicine independently, but are now in the employ of other entities—groups and hospital systems—to the point that the American Medical Association, in November 2012, issued guidelines on how to cope with the "conflict of interest" involved—namely, where the physician wants to treat his patient according to the Hippocratic Oath, and the Obamacare system does not.

Only 36% of all U.S. practicing physicians own their own practice (in whole or in part), which is way down from 57% in 2000; and way below the 85% or higher in the 1960s.

Rural areas are desperate for physicians, and the threat to shut down Critical Access Hospitals is a threat to cut off all advanced care in these localities, in particular in the farm states, where counties have a high percentage of elderly.

The **Physician Value Based Modifier** program mandates that all doctors who see Medicare patients, as of 2017, will be paid by the CMS on a new basis of Federal judgment of the "quality" of their "performance," instead of being paid according to the traditional reimbursement for actual treatment administered to patients. Physicians who are classified as "over-treating" will be financially penalized. There is a "bonus" system for doctors considered compliant. Obamacare foresees having 500,000 doctors now working in group practice, under this program by 2017.

The system is being implemented in phases, according to what the Obama Administration announced in July 2013:

Starting in 2015, group practices of 100 or more health professionals (doctors, nurses, technicians, social workers, etc.) will gain or lose up to 1% of their pay, depending on their rating. This will rise to 2% the following year.

Starting in 2016, mid-size physician groups (10 to 99 health professionals) will be offered 2% bonuses, and the first year free of penalties, to ease into the system.

Starting in 2017, the remaining physicians, in practices of 9 or fewer health professionals, will be phased in. The CMS estimates this will bring in 350,000.

A whole system of "quality" measures to rate doctors is pending, with differing factors for each specialty. All physicians and health staff will have to file reports on every case, which, in itself, will be an impossible burden for all but the large-scale practices

now taking over what's left of doctoring.

There is already an acute shortage of primary physicians everywhere, and certain specialties (such as obstetrics and orthopedics) from region to region. In the District of Columbia, out of 8,000 physicians licensed to work in the capital, only 453 are primary-care doctors who see patients more than 20 hours a week, according to a September 2013 report by the D.C. Board of Medicine.

Walter Reed Army Medical Center/John Chew

Under Obamacare, high-quality medical care, such as that provided in the past by Walter Reed Army Medical Center (shown here in 2002), will be out of reach for millions of Americans.

3. Cut Diagnostics. Screenings and diagnostics for diseases and conditions, and the staff and facilities to conduct them, are being denied and reduced under Obamacare. One of the methods is the issuance of guidelines to cut back on preventive screening, by the **U.S. Preventive Services Task Force (USPSTF),** a preexisting agency in the Department of Health and Human Services. Private insurers, accordingly, move to implement the new restrictions. Just two examples show the thinking.

• *Breast cancer.* Within three months of the enactment of Obamacare, new guidelines were that women should get less frequent mammograms. This decree was made, despite the national concern for the fact that *mammography use was already declining* in the 2000s, the numbers of mammography facilities was decreasing, and doctors feared a rise of breast cancer mortality rates. As of 2009, 27% of U.S. counties had no mammography facilities at all, a pattern associated with poor and rural areas.

In May 2010, the USPSTF stated that screening mammography for women aged 50 to 74 should be every two years, not yearly; and for younger and older women, such screening should be less often, and decided on an "individual" basis only.

This went directly against the modern standard, recommended by cancer specialists, for women to have annual screenings at age 50 and above; and every two years for those 40 to 49.

Since the USPSTF decree, preventive mammography rates in women in their 40s have dropped nearly 6%, as of 2012 (Mayo Clinic study).

• *Upper age limits on screenings?* The Task Force is considering an upper age limit for screening mammography. In The Netherlands, women over 75 are not prohibited from mammograms, but they are no longer reminded to do it, despite the fact that breast cancer for elderly women is still a clinical concern, and treatment can extend their lives.

• *Prostate cancer.* In May 2012, the Task Force recommended against prostate-specific antigen (PSA)-based screening for prostate cancer.

4. **Make Medicines Scarce.** Obamacare, which empowers Big Pharma to effectively run part of the health system, has also given them virtual carte blanche over drugs. At present, they are presiding over a fast-worsening situation of medication shortages. This involves cancer drugs, sterile injectibles, certain antibiotics, and many other basics. For example, in recent months, the frontline drug for tuberculosis, INH (isoniazid), has been scarce.

This is the characteristic, not the exception, under the ACA. As of July 2013, supplies were short for 302 drugs, which is up from 211, at the same time in 2012.

5. **Cuts to Home Health Care.** CMS has issued plans to cut back many Medicare programs, for example, $100 billion in cuts over 10 years to home health care, from the combined impact of new CMS proposals and cuts already underway. Nationally, 3.5 million seniors are lined up for a 14% reduction in Medicare home health payments, potentially losing the skilled

services on which they depend to live at home. The entire nationwide system of home health agencies is jeopardized by what CMS Administrator Tavenner calls her new plan to "re-base" the rates used to calculate funding for payments for home health care.

6. Basic Research Starved. Funding for public medical research at the National Institutes of Health has fallen 20% in the last 10 years. This holds throughout the nation, at Federal, state, and private centers, such as those working with the CDC. In particular, the pipeline is running dry for ways to treat drug-resistant microbes.

Instead, the priorities and grants for studies are concentrated in the control of Wall Street networks, through the **Bill & Melinda Gates Foundation** and the like. For example, the **Weill Cornell School of Medicine,** named for its financial patron **Sandy Weill,** former CitiGroup executive, is focusing priority research on "precision medicine"—the polite name for individual gene-profiling and custom-treatment for the elite. If you can pay, you can live.

7. **IPAB: Cut Lives To Cut Costs, by Decree.** The Independent Payment Advisory Board (IPAB) was authorized in 2010 under the ACA, in sections 3403 and 10320. Its purpose is to formulate specific cuts to medical care, mostly for those on Medicare—the old—to save money. Because of its infamous mandate, its 15-member board, which must be approved by the Senate, has not even been appointed so far. Unprecedented power is designated for IPAB, which is scheduled to go into effect in 2014. While the law is written to say that IPAB will not cut care according to costs, it will simply accomplish the same objective through application of the criterion of statistical "effectiveness," and overall financial benchmarks for health spending. The Medicare program is under orders to implement whatever IPAB orders, unless those cuts are expressly overruled by a vote in Congress, which must be through a supermajority.

IPAB is modelled exactly on the 1999 agency created under the Blair government's NICE, which has ordered cuts in treatment by the National Health System of Britain, resulting in a record of increased death rates since then.

8. Sign-Up Pretense. Only two weeks into the operation of the new online ACA markets for obtaining insurance, the drastic malfunctioning of the system, the rate of non-signups, and most of all—the fact that 5-9 million people are known in advance to be *disqualified for coverage*—manifest how the process is a pretense.

The "disqualified" status hits those poor persons who make too little annual income to qualify for a Federal subsidy on an insurance policy from the exchange—specifically, less than 138% of the official poverty line; and too much money to qualify for Medicaid, relative to the poverty line rules in their state.

These people reside mostly in 26 states, 17 of which are in the South, where Medicaid has not been expanded under inducement of Federal financial incentives upfront, which are to be then cut back in three years. Both the White House and the respective state Congressional leaders have known all along about these categories of people.

Two national estimates have been done on how many people are in this category, based on census data, plus Obamacare and Medicaid rules:

A *New York Times* Oct. 2 report, titled, "Millions of Poor Are Left Uncovered by Health Law," estimates that nearly 9 million are in a "gap" preventing them from receiving any insurance coverage. Obamacare "will leave out two-thirds of the poor blacks and single mothers, and more than half of the low-wage workers who do not have insurance…" (by S. Tavernise and R. Gebeloff).

A report Oct. 17 by the **Kaiser Commission on Medicaid and the Uninsured**, puts the national figure at 5.2 million Americans denied health insurance coverage. The study reports:

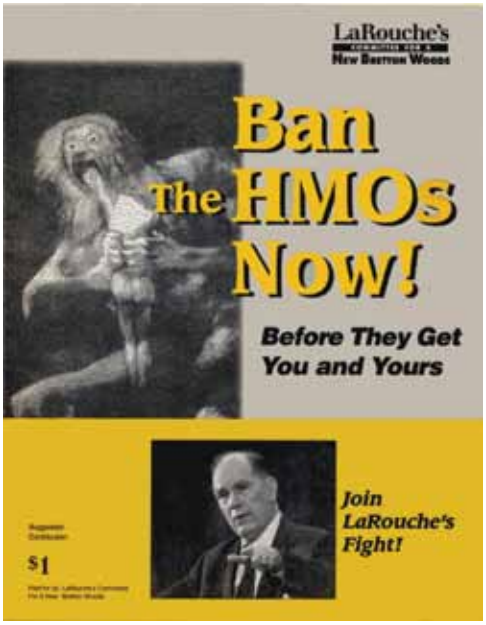
- *Texas.* More than 1 million people won't have access to insurance.
- *Florida.* 763,890 won't get insurance.

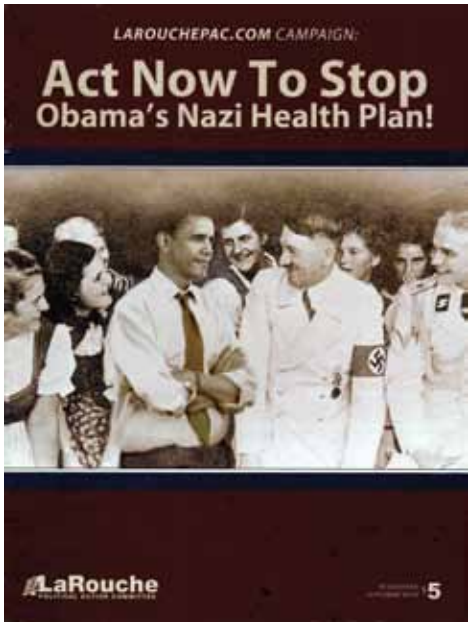
Also large numbers of uninsured under Obamacare are in Alabama, Louisiana, Mississippi, and South Carolina.

- *Tennessee.* Up to 220,000 won't get insurance.

On the technical dysfunction of the exchanges, details are provided in the Oct. 12 *New York Times* report titled, **"From the Start, Signs of Trouble at Health Portal."** A research team (R. Pear, S. LaFranier, and I. Austen) summarized the analyses of many IT experts. The conclusion: " 'These are not glitches,' said an insurance executive who has participated in many conference calls on the federal exchange.... Interviews with two dozen contractors, current and former government officials, insurance executives, and consumer advocates, as well as an examination of confidential administration documents, point to a series of missteps—fi-

nancial, technical and managerial—that led to the troubles." In other words, planned failure is the name of the game. As the *Times* noted, "just a trickle of the 14.6 million people who have visited the federal exchange so far, have managed to enroll in insurance plans…." The Obama Administration refuses to say how many.





The LaRouche movement's battle against Nazi-style denial of health care, goes back decades. The pamphlet "Ban HMOs" was issued in May 2000; LaRouchePAC's "Act Now To Stop Obama's Nazi Health Plan" is from May 2009.

9. Penalize Trade Union Insurance Plans. Trade union members covered by multi-employer plans—referred to as the Taft-Hartley plans—are considered by the ACA as high-end insurance-policy holders, and as a class ineligible for usage and benefit from the new exchanges. An estimated 26 million U.S. workers fall into this group, according to the **National Coordinating Committee for Multiemployer Plans**.

Additionally, in 2018, these types of insurance plans, among those dubbed "Cadillac plans," are subject to a large new Obamacare tax.

10. **Back Companies To Cut Workforce.** Many companies and local government entities are cutting hours of employees to below 30 per week, to avoid the ACA mandate for providing coverage for all "full-time" employees, and making other kinds of downshifts. For example, **Trader Joe's** and **Home Depot** are shifting part-time workers to the Obamacare exchanges.

Smaller companies are socked by the **"Employer Shared Responsibility Payment"** Obamacare mandate, which, under pressure, was postponed a year to 2015.

11. Cost Shock. Insurance premium prices on exchanges vary by state, but cost shock is hitting online shoppers for various types of policies. For example, in some states, rates for large and small companies, which already have gone up an average of over 20% a year for the last three years, will now jump as much as 40% the first year (2014). These costs will be passed on to their workers.

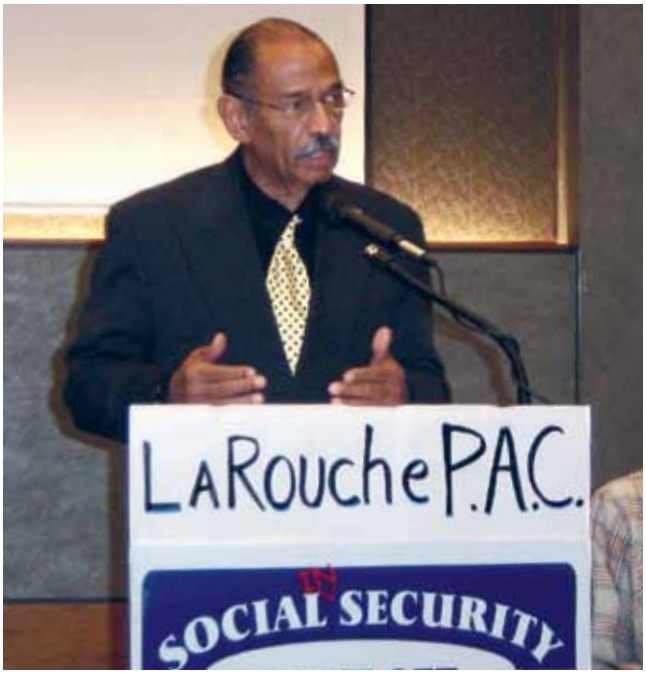
12. Insurance Subsidies to Wall Street. Under Obamacare, the insurance mandate constitutes unprecedented flows to the insurance wing of the Wall Street/London financial crowd. Dimensions of the matter were reported in *Forbes*, Oct. 1 by Robert Lenzer, who noted that the "value of the S&P health insurance index has gained 43% this year alone." Among the major companies, **CIGNA** is up 63%, **Wellpoint** 47%, and **United Healthcare** 28%. Since the passage of Obamacare in 2010, the stock values of these big firms have risen 200-300%.

IV. What Must Be Done

1. The first step is to repeal the 2010 Patient Protection and Affordable Care Act. This must be taken in the course of Congressional action to restore the **Glass-Steagall** law of 1933, as the gateway for stopping the Wall Street crash process, and issuance of credits to rebuild the economy.

Glass-Steagall re-instatement bills are in both Houses of Congress: In the House of Representatives, **H.R. 129 (The Return to Prudent Banking Act of 2013)**, with 75 co-sponsors, which is in the Senate as **S. 985 (Return to Prudent Banking Act of 2013)**, filed by Tom Harkin (D-Iowa); and **S. 1282 (21st Century Glass-Steagall Act of 2013)**, filed by Elizabeth Warren (D-Mass.), with 9 co-sponsors.

Bills to repeal the ACA have been passed repeatedly in the House of Representatives. With passage in the



EIRNS/Sharon Stevens

Rep. John Conyers (D-Mich.) has introduced a bill in Congress, H.R. 676, to provide Medicare for all, which now has 51 co-sponsors. He is shown here addressing a LaRouchePAC town hall meeting in March 2005.

Senate, the corollary measures outlined below can proceed.

2. Initiate impeachment proceedings to remove Barack Obama from office, for the crimes inherent and on record, from the ACA.

3. Declare a moratorium on closures of hospitals, clinics, radiology centers, doctors practices, public-health and research laboratories, and other vital parts of the health-care-delivery system, pending review, and initiation of a new program to build up health-care delivery capacity to modern standards for all Americans.

4. Affirm and implement the principles embodied in the Hill-Burton Act, 42 U.S.C. 291 et seq., as the governing principles for U.S. health-care policy.

5. Launch new research initiatives for advanced medical, biological, and chemical research, in conjunction with a renewed drive for a nuclear-fission-based economy, and soon, a thermonuclear-fusion economic platform.

6. Activate anti-trust action throughout the health-care sectors, in which facilities and services have been taken over and dominated by extensions of Wall Street operations in pharmaceuticals, hospital care, group practices of physicians, research, and other matters.

Cancel the 1973 Health Maintenance Organization authorization law, and nullify subsequent laws to the same effect. This means, repeal 42 U.S.C. Section 300c, et seq.

7. Examine and act on the best way to provide health care for all Americans, under the principle of the Preamble to the Constitution, "to promote the General Welfare."

The **"Medicare for All"** act in Congress is current the foremost proposal to cut Wall Street out of looting health care and dictating death. It calls for instituting an insurance coverage system (called "single payer")—different from that which worked in the pre-1970s/HMO period, but still aimed at seeing that everyone gets treated. Those under age 65 would be eligible for Medicare coverage; premiums and practices would be set accordingly.

In recent years, Medicare's overhead costs amount to only 3% of its expenditures, in contrast to the 30% overhead under the Wall Street HMO insurance system, and the fake mandate under Obamacare, which asks insurers to limit overhead to 20%.

Rep. John Conyers (D-Mich.) has a bill, **H.R. 676 (Expanded and Improved Medicare for All Act)** in the current session of Congress, with 51 co-sponsors.

Revive Glass-Steagall Now!

"The point is, we need Glass-Steagall immediately. We need it because that's our only insurance to save the nation.... Get Glass-Steagall in, and we can work our way to solve the other things that need to be cleaned up. If we don't get Glass-Steagall in first, we're in a mess!"

—Lyndon LaRouche, Feb. 11, 2013

WATCH the LaRouchePAC video:

'Glass-Steagall: Signing a Revolution'

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