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September 23, 2016

To the Committee Members:

This letter is intended for the members of the Working Group on Healthcare Alternatives for Citizens below 100% of Poverty Level. It is written to address several issues that arose during the discussion after my presentation on August 29th. Several members of the committee were concerned about how specialty care would be addressed, including what they called "high ticket" imaging needs. I was not talking just about direct-pay primary care. I was advocating attracting a direct-pay imaging center also. That would bring the high-ticket MRI or CT scan down to the low-ticket price range. As far as other specialists go, there is no reason to stop with surgery and radiology. Rheumatologists, dermatologists, and other specialists could also run direct-pay practices once they got the idea that these practices work.

There is also much less of a need for specialty care when the primary care doctor does his job right. As an example, I saw a patient who had severe muscle weakness. He saw a typical family practice doctor who found a high ANA titer, pointing to the rheumatology realm, as the cause of his weakness. Instead of looking deeper, he simply referred to a rheumatologist. The first appointment was months away. So the patient came to me. I evaluated him, noting a particular type of rash. I hit the books and found his presentation to be typical of dermatomyositis, confirmed it with a lab test, and got him on the proper treatment. He did not need a rheumatologist because he went to a thorough doctor. That sort of thing has happened many times.

Simply expanding Medicaid or creating some other state program does not actually provide health care. There is nothing the state government can do to provide health care. Only doctors can do that. With over half of doctors refusing to take Medicaid patients, it will not provide health care just by expanding Medicaid. Coverage is not the same thing as health care. Just ask Canadians that are stuck on waiting lists. They have first-rate coverage. They flee their country to find health care. What we need to do is work at bringing the cost of health care down, not just work at redistributing the costs of it.

One way the state could help would be to reduce the regulations that prevent people from buying true catastrophic coverage policies. State insurance laws, and the regulatory barriers of the state insurance commission, need to be reduced. There are plenty of people, including me, who would buy catastrophic coverage policies even if they did not avoid Obamacare penalties, if they were available for reasonable premiums. Those policies do not exist now in Idaho. There are too many coverage specifications that are forced onto the insurance industry by the state.

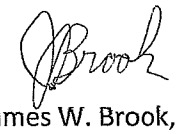
Another concern was that the amount of patients I see is less than that of most family practice doctors. That is simply because I choose to be more thorough. I could choose to be just as quick as a doctor who takes insurance. I would then make more mistakes. I would need repeat visits to treat the same thing that I could have gotten right the first time. If I provided the same level of care as other doctors, I would be even quicker than they are, because I would not be wasting time in insurance-related documentation and coding that are not relevant to the patient's health issues. I saw a patient who had seen an otolaryngologist 4 times for the same issue over the past year and did not improve. In one visit, I was able to provide relief. She had been seeing a specialist.

Representative Chew attempted to disparage the affordable care that I, and others like me, provide, by painting it as slipshod and substandard. She claimed that it takes 5 medicines to properly control a hypertensive or diabetic patient. The consensus expert medical opinion disagrees fundamentally with her, as you can find in the report of the 8th Joint National Committee hypertension guidelines. They recommend the very medications that I use, generally 1 or 2 medications, sometimes needing a third. Rep. Chew claimed that lisinopril costs $90 per month. I called 5 pharmacies in the Boise area, and the highest price I was able to find for 3 months, not just 1 month, of lisinopril was $53. As a pharmacist, she is in a position to know these things. I provide it to my patients profitably for $30 for over 6 months worth. Many patients come to doctors like me not for the affordability, but for the higher level of care that they cannot find with a typical insurance doctor.

The way for Idahoans from across the income spectrum to find good health care is not to simply tax the working people to create another government program. The way is to get the government, including the state insurance commission, out of the way as much as possible, and promote a free market in health care. Then the "poor" could afford quality health care just like they can afford quality electronics.

For a person without dependents to rise financially above the "gap," all that would be needed is to work 39 hours per week at minimum wage. Potato packing plants in Idaho Falls pay $9 - 12.50 per hour. Even McDonalds had a sign up a couple of weeks ago advertising for employees at $8 per hour. People in the "gap" are nondisabled adults under the age of 65. 61% are childless, according to the Millman report. Please do not tax us workers even more, in order to pay for people who will not even work full time at minimum wage. It is estimated that there are 86 million full-time private sector workers in America now, and about 148 million non-veterans receiving government entitlements. We are getting tired from carrying all those people on our shoulders. Please do not add to that weight. Governments, like doctors, should also follow the dictum "first do no harm."

Sincerely,



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