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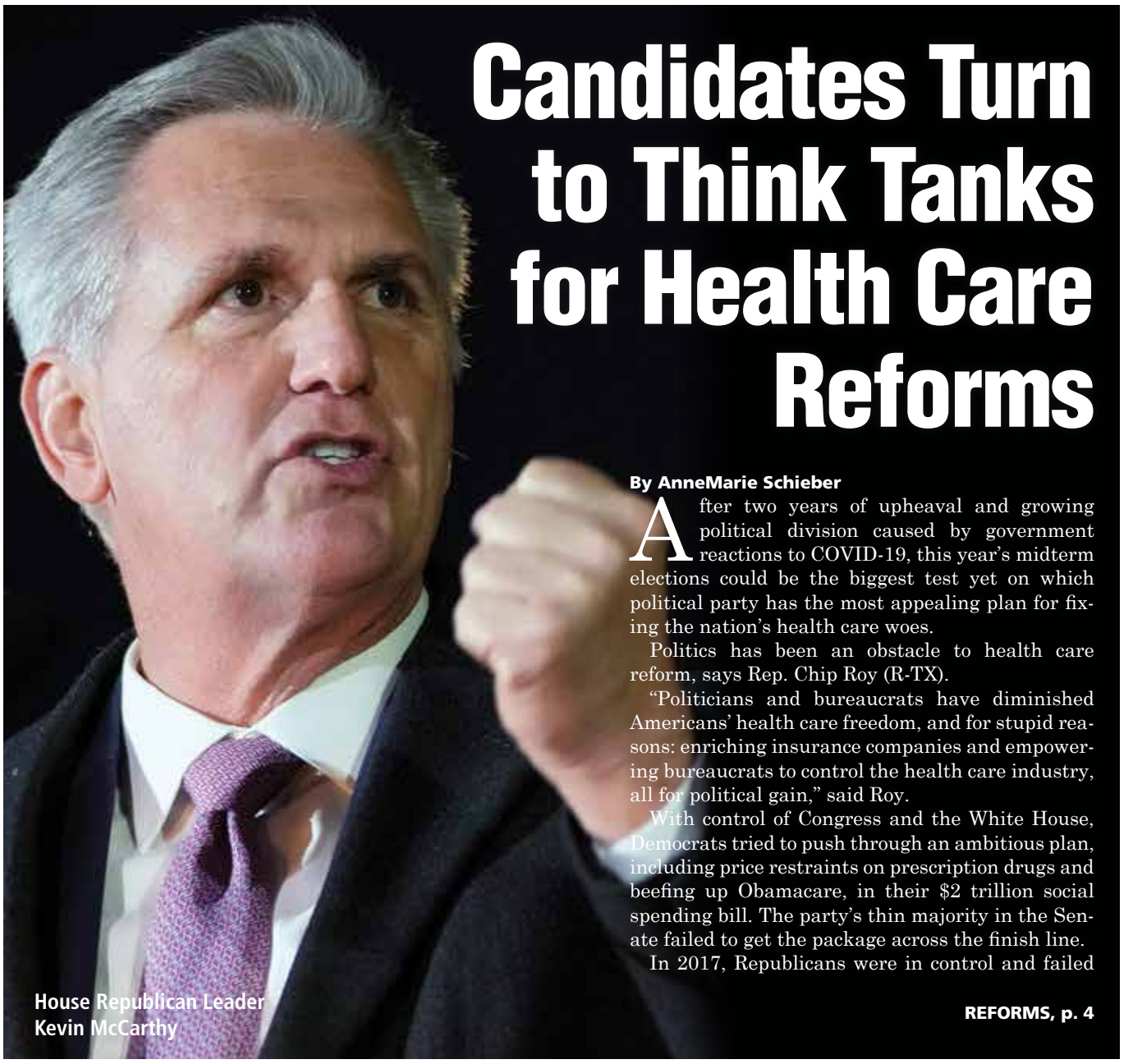
The Pulse



House Republican Leader Kevin McCarthy

PHOTO COURTESY DREW ANGERER/STAFF/GETTY IMAGES NEWS

Candidates Turn to Think Tanks for Health Care Reforms

By AnneMarie Schieber

After two years of upheaval and growing political division caused by government reactions to COVID-19, this year's midterm elections could be the biggest test yet on which political party has the most appealing plan for fixing the nation's health care woes.

Politics has been an obstacle to health care reform, says Rep. Chip Roy (R-TX).

"Politicians and bureaucrats have diminished Americans' health care freedom, and for stupid reasons: enriching insurance companies and empowering bureaucrats to control the health care industry, all for political gain," said Roy.

With control of Congress and the White House, Democrats tried to push through an ambitious plan, including price restraints on prescription drugs and beefing up Obamacare, in their $2 trillion social spending bill. The party's thin majority in the Senate failed to get the package across the finish line.

In 2017, Republicans were in control and failed

REFORMS, p. 4

Medicaid Expansion Could Jeopardize Reform Opportunities

By AnneMarie Schieber

As states come under heavy pressure to expand their Medicaid programs with the lure of billions of dollars under the American Rescue Plan Act (ARPA), concern grows that no place in the nation will be left to try innovative health care reforms that could improve health care coverage and lower prices.

"It is important to remain independent because by expanding their Medicaid programs, these states will lose the flexibility to innovate," said Matt Dean, a senior fellow for health care

MEDICAID EXPANSION, p. 6

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Mark Cuban Launches Online Generic Drug Pharmacy

By Kevin Stone

Mark Cuban

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Billionaire entrepreneur Mark Cuban has launched an online pharmacy with the goal of selling steeply discounted generic drugs to patients who have no insurance coverage for prescription medicines.

The company will build an $11 million, 22,000 square-foot warehouse and office facility in Dallas, Texas, where products will be packaged and shipped.

The Mark Cuban Cost Plus Drug Company says it will publicly reveal the cost to purchase and distribute medicine that is not packaged in its facility. It will add 15 percent to the wholesale price it pays to manufacturers and disclose the sales price to everyone involved. It will not accept insurance for payment.

The founder and CEO of the company is Alex Oshmyansky, M.D., Ph.D., a radiologist.

Patients 'Spending Crazy Amounts'

Americans spent $348.4 billion on retail prescription drugs in 2020, Centers for Medicare and Medicaid Services data shows.

Much of that spending is for cutting-edge specialty drugs and biosimilars. Ninety percent of all prescriptions are written for generic drugs, which account for 20 percent of total drug costs, says the Association for Accessible Medicines, a trade group of generic drug manufacturers and distributors.

The company aims to drive down generic drug costs for patients, says Cuban in a mission statement on the corporation's website.

"We started Mark Cuban Cost Plus Drug Company because every American should have access to safe, affordable medicines," wrote Cuban. "If you don't have insurance or have a high deductible plan, you know that even the most basic medications can cost a fortune. Many people are spending crazy amounts of money each month just to stay healthy. No American should have to suffer or worse—because they can't afford basic prescription medications."

Bypasses Third-Party Payers

Most prescription drugs in the United States are paid for by third parties, not patients, states a September 2020 report by Bloomberg based on 2014 spending: 13.9 percent were paid for directly by patients, 35.1 percent by private insurers, 30.5 percent by Medicare, 15.6 percent by Medicaid, and 5 percent by other public programs and community clinics.

The Cuban venture will sell only generic drugs, and how it approaches the market is distinctive, says John Goodman, president of the Goodman Institute and co-publisher of *Health Care News*.

"Cuban is doing what any insurance company could have done but didn't," said Goodman. "He is buying generic drugs at cost and passing on the savings to patients. This is yet another example of the tendency for real innovation to occur outside the third-party payer system. The insurance companies only sign on after the innovation is well-established."

'Great for Uninsured People'

There are more savings to be realized in the generic market, says health economist Devon Herrick, Ph.D., a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"Mark Cuban is entering an area of the market that is underserved," said Herrick. "He's focusing on approximately 100 generic drugs that are pricy because they are on the U.S. Food and Drug Administration's shortage list. His firm is buying directly from manufacturers, and it may manufacture some drugs in-house. His venture is cash-only, so it will be great for uninsured people and those with high deductible plans."

The effect of Cuban's model and his promise to publish prices on overall retail costs remains to be seen, says Herrick.

"It's hard to say whether price transparency will affect retail chain drug store prices," said Herrick. "Their business model is heavily predicated on insurance coverage. Chain drug stores purchase the bulk of their drugs from three pharmacy benefit managers (PBMs) who control 80 percent of the drug business."

Offers Big Savings

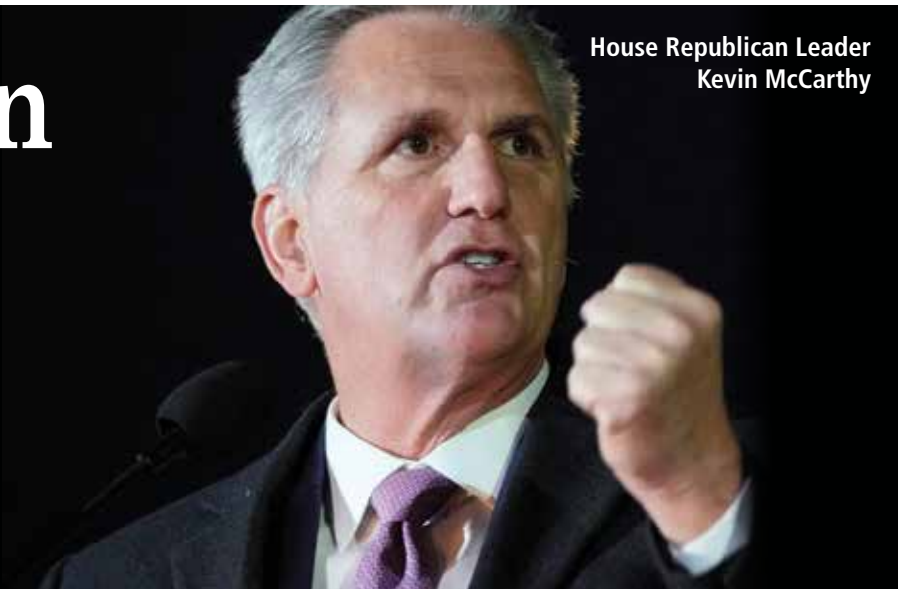
A review of the prices on the CostPlus website shows the company offering drugs for $100 or more off the retail price.

For example, the company offers a 90-day supply of 5 mg Montelukast (Singulair) tablets for $6.60. The website states the retail price at other pharmacies is $510.30. GoodRX shows prices for a 90-day supply of 10mg tablets from $14.40 to $63.97.

CostPlus offers a 90-day supply of 100mg tablets of Imatinib (Gleevec) for $45.30. GoodRX shows a price range for the same quantity and dose between $107.77 and $6,608. CostPlus will charge $5 for regular shipping.

Kevin Stone (**kevin.s.stone@gmail.com**) *writes from Arlington, Texas.*

Candidates Turn to Think Tanks for Health Care Reforms



House Republican Leader Kevin McCarthy

PHOTO COURTESY DREW ANGERER/STAFF/GETTY IMAGES NEWS

Continued from page 1

to come up with an Obamacare replacement. Gearing up for a possible takeover of Congress, House Republican Leader Kevin McCarthy has set up a "Healthy Future" task force in hopes of avoiding a repeat of that washout.

Health Care Choices Plan

A centerpiece of the McCarthy task force is the Health Care Choices plan, the culmination of two years of work on reform measures by 81 think tanks and grassroots organizations under the direction of the Galen Institute.

The plan was a "huge accomplishment" but needs better marketing than what it received in 2020, says John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News*, in his email newsletter.

"We should begin by saying Obamacare has made health insurance unaffordable and the best doctors and hospitals inaccessible," wrote Goodman on February 19. "In other words, we should go right to the heart of what the other side promised and didn't deliver; and then pledge to do what they didn't do by empowering individuals and letting markets work."

Big Leap or Baby Steps?

A package of specific reforms, not an all-out revamp, is the prudent approach, says Grace-Marie Turner, president of the Galen Institute.

"Opinion polling consistently shows people do not have an appetite for another massive revamp of our health care system," said Turner. "They want it fixed in a way that won't be as disruptive as Obamacare was."

The Health Care Choices plan has 35 specific recommendations organized around key concepts such as personalized health care, lower costs, better coverage, and safety nets, says Turner.

"Republicans' message to the American people should be simple: Americans should have personalized care, should be able to choose the doctor or plan of their choice, and we should get the insurance bureaucrats, government bureaucrats, and 'big health care' out of the way. We should fight for policies that will bring down costs through competition and innovation, not through the crony capitalism that has only fueled our health care system's problems. This is a message everyone ought to be able to get behind."

REP. CHIP ROY (R-TX)

"It's organized around a central theme but also offers a menu of policy proposals," said Turner. "If someone is concerned about hospital consolidation, we have some ideas for you. Or, if you're more focused on affordability or the vulnerable not having access to quality health care, we have recommendations there."

Reaching Across the Aisle

Given the struggles both parties have had regarding health care when they had full control in Washington, this could be the year for an earnest effort to reach across the aisle.

There was a sign of that during a hearing before the House Education and Labor Subcommittee titled "Exploring Pathways to Affordable, Universal Health Coverage," on February 17. Reps. Pramila Jayapal (D-WA) and Mark DeSaulnier (D-CA) expressed an interest in learning more about pro-market reforms Paragon Health CEO Brian Blase proposed in his testimony (see article, page 21).

Jayapal asked questions about hospital consolidation, and DeSaulnier wanted to explore ways to help small businesses find affordable plans for their employees.

Turner says she was encouraged by that because there is a common ground where both parties can win.

"Every congressional district has a small-business coalition they need to please, and a reform proposal like association health plans could help a great deal in lowering premiums and offering more choices," said Turner.

Selling Reforms to Voters

One of the biggest challenges will be selling reforms to voters on something as complicated as health care.

Goodman and Marie Fishpaw of The Heritage Foundation pulled 10 key benefits out of the Health Care Choices plan they say a candidate could easily sell voters. These include letting Obamacare insurers compete by receiving premium income that reflects the patients' expected cost of care; allowing families to purchase insurance that meets their financial and medical needs; and letting employees "own" their employer insurance so it travels with them when they leave.

Candidates could pitch creating Medicare Roth-style health savings accounts to reward enrollees for lower utilization (see article, page 20); allowing direct primary care (24/7 access to a doctor) to be used in all health care arrangements; requiring more price transparency; and eliminating competition killers such as certificate-of-need approval and scope-of-practice restrictions.

'Should Have Personalized Care'

One challenge candidates face is explaining to voters how "free" Medicaid or government-subsidized health insurance comes at the price of encouraging small businesses to drop or not offer health care, says Turner.

"The employer health system in this country has been the bedrock," said Turner. "But we are at risk of eroding it to the point that a government plan or program will be the only choice for millions of people."

Roy says it is important for Republicans to emphasize consumer benefits.

"Republicans' message to the American people should be simple: Americans should have personalized care, should be able to choose the doctor or plan of their choice, and we should get the insurance bureaucrats, government bureaucrats, and 'big health care' out of the way," said Roy.

"We should fight for policies that will bring down costs through competition and innovation, not through the crony capitalism that has only fueled our health care system's problems," said Roy. "This is a message everyone ought to be able to get behind."

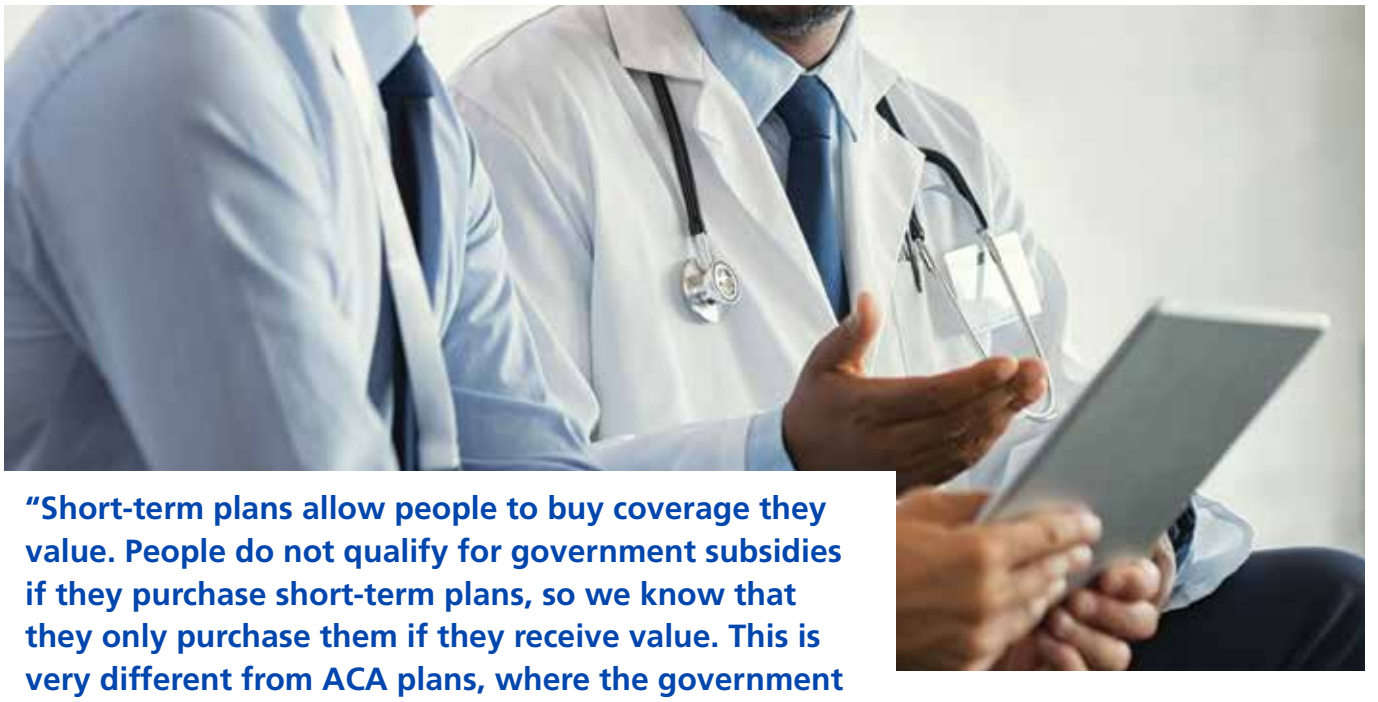
AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

Democrats Push to Limit Short-Term Health Care Plans

By AnneMarie Schieber

Democrat members of the U.S. Senate are urging the U.S. Department of Health and Human Services (HHS) to move quickly to restrict short-term health insurance.

Short Term Limited Duration Insurance (STLDI) plans "sow confusion and cause harm to patients," wrote Sens. Tammy Baldwin (D-WI), Chris Murphy (D-CT), and Jeanne Shaheen (D-NH) in a letter to HHS Secretary Xavier Becerra on February 14. The letter was signed by 35 of their Democrat colleagues and independents Sens. Angus King (ME) and Bernie Sanders (VT).



"Short-term plans allow people to buy coverage they value. People do not qualify for government subsidies if they purchase short-term plans, so we know that they only purchase them if they receive value. This is very different from ACA plans, where the government typically pays 80 percent or more of the premium. If HHS restricts short-term plans, more people will be uninsured, and the market will even further tilt in the direction of government control [rather] than consumer choice."

BRIAN BLASE
FOUNDER AND PRESIDENT, PARAGON HEALTH INSTITUTE

'Undo the Sabotage'

A record 14.5 million Americans signed up for Affordable Care Act (ACA) plans during the most recent Open Enrollment period but could be misled to choose STLDI plans, say the senators.

"STLDI plans undermine the integrity of the ACA and put those with pre-existing conditions at risk," wrote the senators. "HHS must act quickly to limit the proliferation and promotion of STLDI plans, and undo the sabotage caused by the previous administration."

The senators want HHS to restrict the plans to three months with no renewal option upon expiration and to prevent people from immediately buying a different STLDI plan after one expires. In addition, they call on HHS to ban sales of STLDI plans during the ACA open enrollment period, limit their sales online and by phone, prohibit retroactive coverage rescissions, and require insurers to disclose more details of the plans.

'Coverage They Value'

STLDI, sometimes called "plans for healthy people," allows consumers to bridge gaps in health insurance coverage.

STLDI premiums are lower than for ACA plans because STLDI is not subject to the coverage requirements of Obamacare. Consumers buy them to protect themselves against a catastrophic health event, and they can purchase them easily, often online.

STLDI plans became more accessible when the Trump administration increased their duration to 12 months and allowed them to be renewed three times for a total coverage period of 36 months, says Brian Blase, founder and president of the Paragon Health Institute, who served as an economic advisor in the Trump White House.

"The Trump administration's actions increased consumer options and consumer protections, as people could keep the coverage longer, without having to go through health underwriting," said Blase.

The plans offer another benefit, says Blase.

"Short-term plans allow people to buy coverage they value," said Blase. "People do not qualify for government subsidies if they purchase short-term plans, so we know that they only purchase them if they receive value. This is very different from ACA plans, where the government typically pays 80 percent or more of the premium.

"If HHS restricts short-term plans, more people will be uninsured, and the market will even further tilt in the direction of government control [rather] than consumer choice," said Blase.

Insurance Against Bankruptcy

It would be a mistake to restrict an option for people who don't have an employer plan and find Obamacare plans unaffordable, says Kansas state Sen. Beverly Gossage (R-Eudora), president of HSA Benefits Consulting.

"This is a small subset of the population," said Gossage. "For example, fewer than 1,800 Kansans have an STLDI, but without these plans, many of them would be forced to go uninsured.

"These buyers are informed at application that most of these plans do not cover preexisting conditions, but they are often less than 50 percent [of the cost] of ACA plans and do cover new standard medical claims after a deductible, reducing an eligible buyer's risk for bankruptcy due to medical bills," said Gossage.

'Price They Can Afford'

Uninsured Americans were initially required to buy ACA plans, which have lots of benefits and high premiums, says John Goodman, president of the Goodman Institute and co-publisher of *Health Care News*.

"In the Obamacare exchanges, people are not allowed to buy health insurance that meets their medical and financial needs," said Goodman. "Instead, they are forced to buy plans that very few families would purchase by choice.

"Initially, an Obamacare mandate tried to force people to buy the insurance," said Goodman. "When the mandate went away, Obamacare supporters reverted to more-generous subsidies, with buyers paying 20 cents on the dollar," said Goodman. "The short-term market avoids all this. It allows people to buy insurance that meets their needs for a price they can afford, without government subsidies. We should welcome this option, instead of trying to outlaw it."

Uncertain Timeline

The Biden administration plans to publish new STLDI regulations in August, as stated in the unified agenda of planned regulatory actions published in fall 2021, but when the changes will take place is not clear, says Blase.

"Presumably, the Biden administration can change the definitions [of STLDI plans] once again, although doing so would harm people with this coverage as well as people who would benefit from this coverage in the future," said Blase.

"The timelines listed in the unified agenda are always a bit nebulous," said Blase. "In my experience, the action is more likely to occur later than the time they list than it is before the time they list. And sometimes the proposed action on the unified agenda never comes to fruition."

If the proposed rule for STLDI plans is published on August 1, there would be a 60-day comment period and revisions after that, says Blase.

"A final rule could be released on January 1, 2023, [and] the new guidelines could go into effect March 1, 2023," said Blase.

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

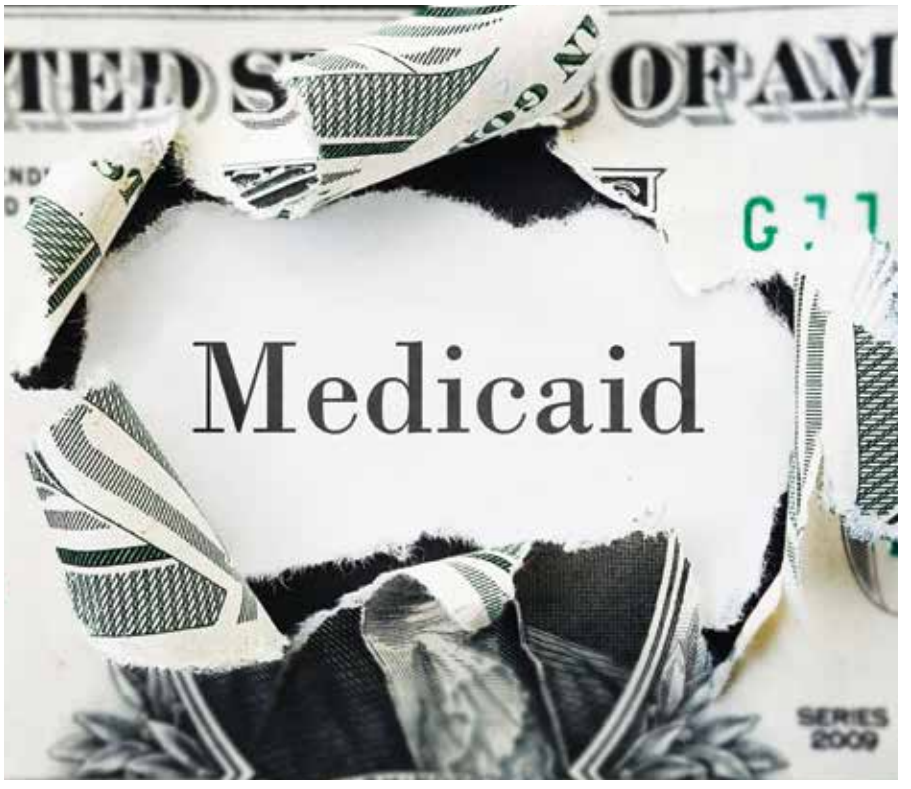
Medicaid Expansion Could Jeopardize Reform Opportunities

Continued from page 1

policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

Currently, 12 states have not expanded Medicaid under the Affordable Care Act. Expansion covers able-bodied adults with incomes below 138 percent of the federal poverty level. There is no deadline for states to implement expansion.

The 12 holdout states are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin, and Wyoming, according to the Kaiser Family Foundation.



Lure of Federal Money

North Carolina is the latest state to come under heavy pressure to expand Medicaid. The administration of Gov. Roy Cooper, a Democrat, made an expansion pitch on March 1 to a Republican-led House-Senate committee created to study the issue. Senate President Pro Tem Phil Berger is now open to the idea, according to a report by WRAL.com.

North Carolina Medicaid Director Dave Richard told lawmakers the state could reap $1.5 billion in additional revenue under the COVID-19 relief package. A nonpartisan analysis by the General Assembly said expansion could be a "fiscal net positive" in the first two years but after that the state would be on the hook for $500 million to $600 million per year.

"This is a program that is financially self-sustaining," said Richard, despite those numbers.

Split Decisions

Kansas and Wisconsin are two other states where Democrat governors are tangling with Republican-led legislatures to expand Medicaid. Kansas Gov. Laura Kelly included Medicaid expansion in her 2023 budget, reflecting the additional money from ARPA.

Republican legislators in Wisconsin put up a tough fight against Democrat Gov. Tony Evers, who called a special session last year to include expansion in the 2022-2023 budget with new incentives from ARPA. The legislature adjourned the special session with no action.

'Free,' Not Free

Wisconsin and other expansion holdout states would be smart to resist the lure of additional federal money, says Dean, who has been working closely with legislators in those states.

"Wisconsin should instead provide targeted help to expand coverage without harming the care or breaking the bank of middle-class folks who pay premiums individually or through their employer," wrote Dean in a document he is drafting to help legislators decide.

Dean, who served six terms in the Minnesota legislature, says Medicaid expansion damages the health care market.

"Wisconsin need only look to her neighbor, Minnesota, to find that the costs are high and that not all those costs are financial," wrote Dean. "Private insurers fled. Premiums jumped as much as 56.7 percent, and networks shrank."

More, Not Merrier

Medicaid expansion consistently leads to huge cost overruns and consequent pressure on state budgets, says Dean Clancy, a senior health policy fellow at Americans for Prosperity.

"We've seen it in state after state," said Clancy. "Whatever number of people you expect to sign up, multiply it by 150 or 200 percent.

"People always come out of the woodwork for free health care, including people who were eligible for regular Medicaid but didn't bother to show up before hearing about the expansion," said Clancy. "And P.S.: Don't be surprised when Congress pulls the funding rug out from under you."

State Innovations

The Trump administration encouraged states to redesign their Medicaid programs under federal Section 1115 waivers. Some states took advantage and introduced work requirements to help enrollees earn more money and have a springboard to private insurance from an employer.

A "Medicaid Waiver Toolkit" published by the State Policy Network gives states a list of measures that can bolster their health insurance markets, such as allowing more direct primary care, lower-cost surgical options, health savings accounts, and "skin in the game" requirements for able-bodied enrollees.

"The Trump administration recognized states are far better positioned to design health care programs that meet the needs of their residents and worked closely with states to develop innovative waivers from both Medicaid and Obamacare requirements," said Peter Nelson, a senior policy fellow at the Center of the American Experiment who previously served as a senior advisor to Seema Verma, administrator of the Centers for Medicare and Medicaid Services (CMS) during the Trump administration.

"Though the Biden administration is less receptive to these waivers, states should continue pursuing waivers that can pass muster today, as well as developing blueprints for bigger waiver ideas that can be achieved in a new administration," said Nelson.

Waiver Blockage

States were making big progress when CMS was more open to waivers, says Clancy.

"Texas had creative ways of providing benefits," said Clancy. "Indiana experimented with personal health savings accounts for enrollees. Rhode Island had something similar to a block grant.

"Unfortunately, expansion has created budgetary pressures that tend to suppress creativity," said Clancy. "And the Left's Medicaid expansion obsession has caused CMS to become actively anti-state-flexibility. It's sad."

AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

"We've seen it in state after state. Whatever number of people you expect to sign up, multiply it by 150 or 200 percent. People always come out of the woodwork for free health care, including people who were eligible for regular Medicaid but didn't bother to show up before hearing about the expansion. And P.S.: Don't be surprised when Congress pulls the funding rug out from under you."

DEAN CLANCY
SENIOR HEALTH POLICY FELLOW
AMERICANS FOR PROSPERITY

Single-Payer Health Care Stalls in California

By Kenneth Artz

A bill to establish a state-run, single-payer health care system in California was stopped without a vote in the state Assembly after supporters realized they didn't have enough votes to pass it.

A.B.1400 would have begun a state takeover of private insurance, Medicare, and Medi-Cal at a cost of $391 billion a year, says Sally C. Pipes, president and chief executive officer of the Pacific Research Institute.

"Rather than risk the bill not passing, Assembly Member Ash Kalra (D-San Jose), the main sponsor, let it expire before a vote was held," said Pipes. "There was even a funding mechanism attached: ACA11. [ACA11] would have raised $163 billion in new taxes if it had passed the legislature and an initiative by the voters, whereby only a simple majority would be needed to raise taxes rather than the two-thirds majority under current law."

'Single-Payer Will Be Back'

Assembly Speaker Anthony Rendon (D-Lakewood), who shelved a single-payer bill in 2017 because it did not include the tax hikes necessary to fund it, expressed his support for AB 1400.

"The shortage of votes needed to pass this bill out of the Assembly indicates the immense difficulty of implementing single-payer health care in California," said Rendon in a statement. "Nevertheless, I'm deeply disappointed that the author did not bring this bill up for a vote today. I support single-payer and fully intended to vote yes on this bill."

This is not the end of single-payer efforts in California, says Pipes.

"The nurses' union, Democratic Assembly Speaker Rendon, and members of the Progressive Caucus were furious that the bill did not come to a vote," Pipes said. "California's progressives say they are not giving up and that single-payer will be back. Stay tuned."

'Leads to Rationing'

Supporters of single-payer health care have an unrealistic view of the system and often overlook its obvious flaws, says Roger Stark, M.D., a health care policy analyst at the Washington Policy Center, a retired physician, and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"The fundamental problem with any single-payer health care system is it puts unseen government bureaucrats in charge of a patient's medical care," said Stark. "These bureaucrats then decide what kind of health care and how much each patient receives.

"Another fundamental problem is demand for health care far outweighs supply," said Stark. "Financing a single-payer system is impossible, which leads to rationing by the government. Plus, health care financing must then compete with every other budget item, which makes medical care very political."

'Huge Increase in Taxpayer Burden'

A sharp rise in taxes is the hallmark of every single-payer health care system, says John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News*.

"Single-payer health insurance generally means replacing the money already being spent with taxpayer dollars," said Goodman.

"Rarely is anything done to increase the number of doctors, nurses, or medical procedures," said Goodman. "So, in return for a huge increase in taxpayer burden, you get virtually no improvement in health outcomes."

'Doctors Will Flee'

The money for single-payer health care must come from somewhere, and one bureaucratic trick is to shortchange health care providers, says health economist Devon M. Herrick, Ph.D., a policy advisor to the Heartland Institute.

"The idea behind single-payer is with only one payer for medical care, the state can ratchet down what it pays doctors, hospitals, and drug makers," said Herrick. "Proponents must realize doctors will flee to other states when their fees are cut to Medicaid levels. Indeed, rationing access to care is a feature of single-payer, not a bug.

"In the states that still think they can enact single-payer health care, it's either a political ploy or a pipedream," said Herrick. "Federal regulations and federal programs make it difficult if not impossible. Furthermore, voters with employee plans will not give up their higher-quality coverage easily. Nor will Medicare beneficiaries want to compete for access to care with millions of other new beneficiaries."

'Like a Bad Penny'

Even though the California effort failed, other states are considering single-payer schemes, says Pipes.

"Despite the best efforts of progressives like Sen Bernie Sanders (I-VT) and Rep. Pramila Jayapal (D-WA), single payer is off the table in Congress, at least for now," said Pipes. "However, that does not mean single payer is dead. Like a bad penny, it keeps coming back at the national level and in many blue states.

"Lawmakers in Oregon, New York, and a dozen states are pursuing their own form of single-payer health care," said Pipes. "They would be wise to look at what just happened in California and in Vermont in 2014 and Colorado in 2016."

The Vermont Legislature approved a single-payer system in 2011 but abandoned the plan when there was no clear path to fund the program. Colorado voters rejected a single-payer system in 2016, 79 percent to 21 percent. In March 2021, Colorado Democrats introduced a bill calling for the state to request a 1332 waiver from the federal government to help create a state-offered health insurance option. The waiver request was submitted on November 30, 2021.

"The fundamental problem with any single-payer health care system is it puts unseen government bureaucrats in charge of a patient's medical care. These bureaucrats then decide what kind of health care and how much each patient receives. Another fundamental problem is demand for health care far outweighs supply. Financing a single-payer system is impossible, which leads to rationing by the government. Plus, health care financing must then compete with every other budget item, which makes medical care very political."

ROGER STARK, M.D.
HEALTH CARE POLICY ANALYST
WASHINGTON POLICY CENTER

Kenneth Artz (**KApublishing@gmx.com**) *writes from Dallas, Texas.*

INTERNET INFO

California Assembly Bill 1400:
https://leginfo.legislature.ca.gov/faces/billVotesClient.xhtml?bill_id=202120220AB1400

CDC Lowers Standards for Childhood Development

By Harry Painter

Two years into the pandemic, the Centers for Disease Control and Prevention (CDC) has changed its early childhood development milestones, the guidelines for identifying delayed development.

The milestones were previously based on the developmental progress 50 percent of children would achieve at a given age. In February, the CDC updated the milestones to reflect the abilities of 75 percent of children.

The change indicates parents and doctors should refrain from investigating possible developmental problems unless a child is in the bottom 25 percent. Previously, performing in the bottom half of all children would have called for closer observation.

The milestones previously stated, for example, a 24-month-old child should be able to say approximately 50 words. The new milestone raises that age to 30 months. Although some milestones were eliminated or moved to younger ages, 67.7 percent of retained milestones were moved to older ages.

"Changing the standard does not account for the exponential rise in the number of spoken words once a child starts speaking. Isolation and masking during flawed COVID policies have left their mark on children."

MARILYN M. SINGLETON, M.D., J.D.
ANESTHESIOLOGIST

CDC Says It's Better

The CDC says focusing on the 25 percent of children who are farthest behind will improve detection of developmental delays. An article in *Pediatrics*, which the CDC says prompted the change in milestones, found the 50 percent standard might have been encouraging a "wait-and-see" approach that led to late detection of abnormalities.

The CDC says the milestone changes are not intended to lower the bar in measuring child development. Studies have found negative effects on infant and child development from environmental changes imposed during the pandemic, which the change in standards might obscure.

Wearing masks around infants and small children could have a "long-term impact on neonatal development," concluded a discussion paper published on the National Library of Medicine website on October 29, 2020.

"COVID-19 has changed the way that newborn babies are cared for within the neonatal setting due to the introduction of social distancing and wearing of face masks to limit the spread of infection," the researchers wrote. "Potential implications exist related to the normal development of bonding and connections to others."

Not So Sure

Robert Emmons, M.D., a Vermont psychiatrist and clinical ethics advocate, says uncertainty about public health guidance is here to stay.

"Public health officials would dearly like to believe that the guidance is effective in saving lives and reducing morbidity," Emmons said. "The way it goes with science, though, we won't really know the answers for years."

Suspects a Hidden Agenda

The new milestones appear to be meant to cover up recent problems caused by government lockdowns, says Marilyn M. Singleton, M.D., J.D., a board-certified anesthesiologist and member of the Association of American Physicians and Surgeons who has written extensively on pandemic policies.

"Is this like not giving students Ds or Fs or eliminating SAT testing for college admission?" said Singleton. "Changing the childhood developmental milestones is another example of lowering the bar to accommodate a problem rather than working on the root of the problem. It is also an example of changing a parameter in a way that creates confusion.

"The previous milestone was 50 percent of children can say 50 words at 24 months; the revised milestone is 75 percent of children can say 50 words at 30 months," said Singleton. "I'm only a mother, not a speech pathologist. Changing the standard does not account for the exponential rise in the number of spoken words once a child starts speaking. Isolation and masking during flawed COVID policies have left their mark on children. The government should assist parents in fixing the problem, not covering it up."

Harry Painter (**harry@harrypainter.com**) *writes from Tulsa, Oklahoma.*

INTERNET INFO

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Ten Worst Actors in U.S. Health Care Named

By Kevin Stone

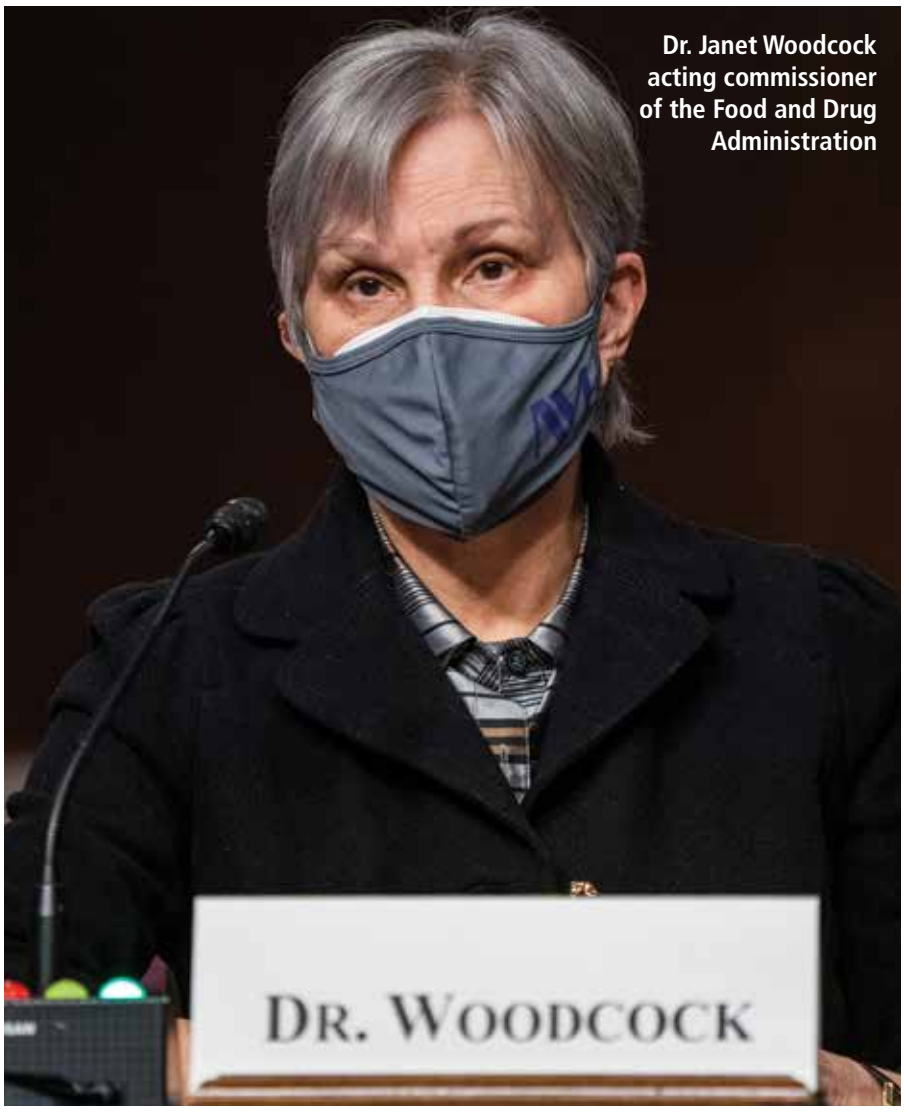
The U.S. Food and Drug Administration (FDA) was responsible for the worst example of profiteering and dysfunction in the U.S. health care system in 2021, a health policy reform group says.

The FDA, various hospitals, and several drug companies have been given Shkreli Awards for dubious actions, states the Lown Institute, a nonprofit group in Massachusetts, in a press release on January 11.

The awards are named after Martin Shkreli, whose company, Turing Pharmaceuticals, hiked the price of a generic drug that is the only treatment for parasitic infections in infants and HIV patients by 5,000 percent in 2015.

The annual honors recognize the 10 worst actors in health care.

Judges for the awards include scholars, physicians, and health care research fellows and writers, states the Lown Institute website.



Dr. Janet Woodcock acting commissioner of the Food and Drug Administration

PHOTO COURTESY POOL/GETTY IMAGES NORTH AMERICA

FDA Approval of Unproven Drug

The FDA was named the worst of the bad actors identified by the judges, for its approval of an ineffective and potentially harmful Alzheimer's drug, states the Lown Institute website.

"Though not one member of its advisory committee supported approval of Biogen's drug for Alzheimer's Disease, the [FDA] gave it the green light anyway, using a regulatory shortcut to accelerate the process," states the group. "The drug, Aduhelm, has not been shown to significantly reduce memory loss or cognitive decline."

As an FDA-approved drug for Alzheimer's treatment, Aduhelm could be prescribed to many seniors, says the group.

"The high price of the drug and large eligible population means Medicare could spend hundreds of billions each year just on Aduhelm," states the website. "An independent group of Alzheimer's experts and advocates recently called for the FDA to take the drug off the market."

Opioid Drug Deal

The Sackler family, owners of Purdue Pharma, were named the second-worst actors for a $4.3 billion bankruptcy deal a judge approved in September 2021 that granted them immunity from future lawsuits and any requirement to admit wrongdoing for their promotion of pain medications.

Purdue Pharma sought bankruptcy protection after it was sued by several states for its aggressive marketing of opioids.

'Classic Case of Price Gouging'

Another group on the list is the owners of Indocin, an arthritis suppository treatment. They raised the price of the drug from less than $200 for a box of 30 suppositories in 2008 to $10,350 as of October 1, 2021.

Physicians could help patients avoid paying such exorbitant prices, says Devon M. Herrick, a health economist and policy advisor to the Heartland Institute, which co-publishes *Health Care News*.

"The Indocin (indomethacin) suppositories are a classic case of price gouging doctors could put a stop to but won't," said Herrick. "Patients can take up to four 100mg suppositories a day at discounted prices of $231 to $282 apiece. Yet, Costco sells 60 generic indomethacin 50mg capsules for $11.98. That suggests doctors and patients willing to get creative could save $1,000 a day."

The drug maker Merck received an "award" for charging $712 for a five-day course of its COVID-19 early treatment drug. The judges note the drug costs $18 to make and was developed using millions of dollars in government funding.

Companies Covering Copays

The pharmaceutical industry received an award for setting up charitable funds to help consumers cover insurance copays for expensive treatments.

The U.S. Department of Justice has sued at least one such company, Teva, charging the charitable assistance is a kickback scheme.

Covering patients' copays increases sales of overpriced drugs, says Herrick.

"Drug makers donating to their own fake charities to offset drug copays so they can charge inflated prices is already illegal in public programs like Medicare and Medicaid," said Herrick. "It should be illegal in all plans."

Hospitals Behaving Badly

Hospitals on the list include Lennox Hill Hospital in New York, for charging $3,000 to administer a $100 COVID-19 swab test, and Emory Decatur Hospital in Atlanta for charging $700 to an emergency room patient with head trauma who was left untreated after a seven-hour wait.

Community Health Systems, Inc., a hospital chain, was recognized for filing at least 19,000 lawsuits against patients for nonpayment of bills in 2021 despite receiving more than $700 million in federal COVID-19 bailout funds. Parkview Regional Medical Center in Fort Wayne, Indiana was cited for raiding a Medicaid patient's accident settlement fund to cover lower government reimbursement rates.

The pandemic magnified preexisting problems with pricing and billing, says Herrick.

"COVID-19 is an area where Congress should aggressively act to stop price gouging," said Herrick. "Nobody should pay emergency room prices for a COVID-19 test after hospitals received huge bailouts."

Ascension, the nation's largest Catholic nonprofit health care system, made the list for straying beyond its mission to serve the "poor and vulnerable" by creating a $1 billion private equity operation that invested in a debt collection company.

Missing Ingredient

The nation's health care system is broken, and the Shkreli Awards illustrate the fallout, says John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News*.

"In our health care system, the patient is not the real customer," said Goodman. "Third-party payers are the customers. Providers view patients as an excuse to get money out of insurers, including Medicare and Medicaid. Providers don't compete for patients on price or on quality, the way they do in a normal market.

"Bad things happen because normal market incentives to meet consumer needs have been dismantled," said Goodman.

Kevin Stone (**kevin.s.stone@gmail.com**) *writes from Arlington, Texas.*

INTERNET INFO

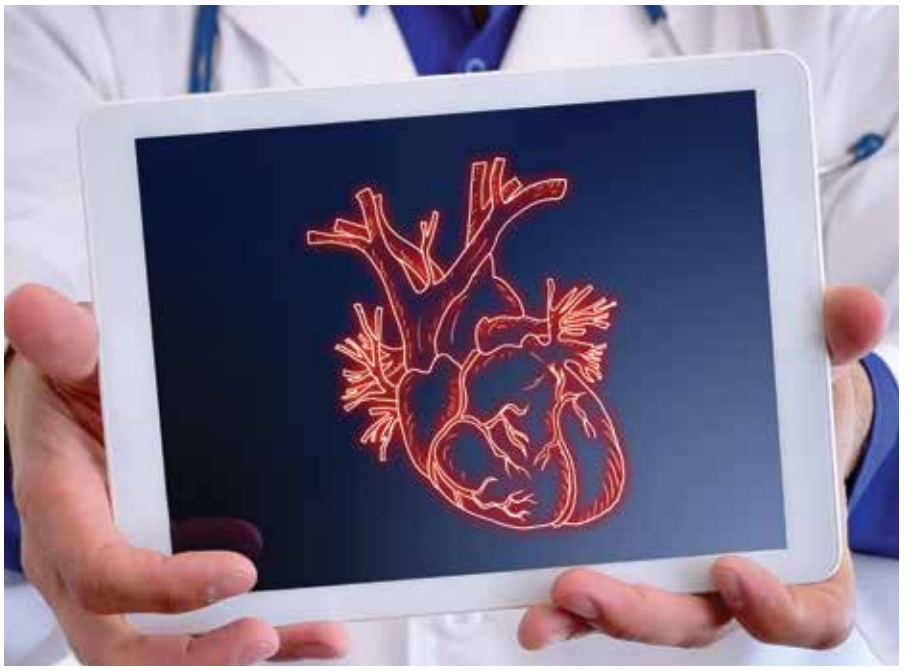
2021 Shkreli Awards, Lown Institute, January 11, 2022: **https://lowninstitute.org/projects/shkreli-awards/2021-shkreli-awards/**

Congress Considers Outlawing Denial of Transplants to Unvaccinated Patients

By Harry Painter

The U.S. House of Representatives is considering legislation that would make it unlawful for health care providers to deny organ transplants to patients who have declined to get COVID-19 shots.

H.R. 6534, the Stop Arduous Vaccine Enforcement (SAVE) Act of 2022, would amend the Public Health Service Act to prohibit transplant centers from denying organs to patients based on whether they have received a COVID-19 shot, including treating individuals as ineligible or lowering their priority on the transplant list.



'Denied an Organ Transplant'

The SAVE Act is a response to reports of unvaccinated Americans being removed from the organ transplant list, says bill sponsor Rep. Ben Cline (R-VA).

"It is unimaginable that organ transplant centers would deny American citizens life-saving medical procedures solely for being unvaccinated against COVID-19," said Cline, in a press release on the bill. "The SAVE Act ensures that no one is denied an organ transplant or donation based on their vaccination status.

"Getting vaccinated is a personal choice and should not be mandated," said Cline "This legislation is not anti-vaccine, it's about making sure individuals get the treatment they need."

The bill was introduced on February 1 by Cline and cosponsors Reps. Rodney Davis (R-IL), Jeff Duncan (R-SC), Bob Good (R-VA), Morgan Griffith (R-VA), Chip Roy (R-TX), and Rob Wittman (R-VA). It was referred to the House Committee on Energy and Commerce.

Patient Denied Transplant

In a widely reported case, a Boston man was refused a place on the heart transplant list at Brigham and Women's Hospital because of his vaccination status.

The transplant center acted ethically and was not discriminatory, states an article titled "Should Patients Who Refuse COVID Vaccination Be Denied Transplantation Eligibility?" by scholars at New York University and George Washington University, published in the *Journal of Cardiac Failure* on February 8.

The authors state organ transplant centers already require that candidates receive other vaccines and demonstrate a commitment to avoid unhealthy activities such as drinking, smoking, and using illegal drugs. The article also states the patient was given a left ventricular assist device instead of a donor's heart.

Who Is Fully Vaccinated?

Refusing transplants to individuals who decline COVID-19 shots isn't based on medical research, says Jane Orient, M.D., a policy advisor to The Heartland Institute, which co-publishes *Health Care News,* and executive director of the Association of American Physicians and Surgeons, which endorsed the SAVE Act.

"What would be needed is a study of transplant outcomes in vaccinated versus unvaccinated—likely impossible to do," said Orient. "There are also no studies on desperately sick people, who would have been excluded from [vaccine] clinical trials. Immunosuppressed people, as all recipients will be, probably won't respond."

Vaccination requirements change as the recommendations change, says Orient.

"So maybe they'll require 'full vaccination' sometime before surgery," said Orient. "But the vaccines apparently expire, so what good would a booster be? As for donors, the vaccine doesn't prevent transmission, so what you want is an uninfected donor; you need to test [for virus infection], whether the donor is vaccinated or not."

Potential for Harm

COVID-19 shots could be harmful to a patient undergoing an organ transplant, says Orient.

"Does the vaccine damage the organ?" said Orient. "There is reason to think it might, say by microthrombi. There are few and highly inadequate studies of vaccine-damaged patients, especially autopsies on patients who died post-vaccination."

Simone Scott, a 19-year-old Northwestern University student, died in June after receiving a heart transplant one month after receiving her second dose of the Moderna vaccine. In the Boston case, the heart patient had been diagnosed with atrial fibrillation and was concerned about the possible medical side effects from the vaccine.

Requiring vaccines for organ transplants is a medical and scientific issue rather than a question of discrimination, says Orient.

"It certainly violates the Oath of Hippocrates to give a patient any treatment more likely to harm than benefit," said Orient.

Better Before Transplant

There is a rationale for requiring vaccinations for transplant patients, says Jeff Singer, M.D., a surgeon and senior fellow at the Cato Institute.

"Organ transplant recipients will need to be on immunosuppressants, in order to prevent rejection of the transplanted organ," said Singer. "If they get infected by the COVID-19 virus after the transplant while they are immunosuppressed, they are at significantly greater risk of having a bad outcome, perhaps a fatal outcome, because they are unable to mount a strong immune response to the virus."

It makes sense for patients to be fully immunized before a transplant, says Singer.

"There is a lot of evidence that suggests the vaccine is much less effective if taken after the transplant, when the immunosuppressants that transplant recipients must take suppress a good immune response to the vaccine. In fact, many immunologists think that it is people on immunosuppressants who might need a fourth or even more vaccinations to get a decent response," said Singer.

"What would be needed is a study of transplant outcomes in vaccinated versus unvaccinated—likely impossible to do. There are also no studies on desperately sick people, who would have been excluded from [vaccine] clinical trials. Immunosuppressed people, as all recipients will be, probably won't respond. So maybe they'll require 'full vaccination' sometime before surgery. But the vaccines apparently expire, so what good would a booster be? As for donors, the vaccine doesn't prevent transmission, so what you want is an uninfected donor; you need to test [for virus infection], whether the donor is vaccinated or not."

JANE ORIENT, M.D.
POLICY ADVISOR
THE HEARTLAND INSTITUTE

Harry Painter (**harry@harrypainter.com**) *writes from Tulsa, Oklahoma.*

Health Insurers Must Pay for Gender Reassignments, HHS Rules

By Bonner R. Cohen

Insurance companies will soon be required to offer the same coverage of transgender transition treatment and surgery for children and adults as they do for other surgeries or mental health therapy, under a proposal rapidly pushed through the federal rulemaking process by the Biden administration.

The period for submission of public comments on the new rule was limited to an unusually short 22 days, much less than the customary 60 days or more.

The anti-discrimination provisions in the Notice of Benefit and Payment Parameters for 2023, the Biden administration's proposed rule for the government health insurance exchanges under the Affordable Care Act (ACA), were published in the *Federal Register* by the U.S. Department of Health and Human Services (HHS) on January 5 and would be effective for insurance plans for 2023.

Essentially, the rule reinstates Obama-era language under the ACA's section 1557, which deals with discrimination. The Trump administration removed sexual orientation and gender identity from the anti-discrimination language. Biden's HHS is putting them back in.

"We believe such amendments are warranted in light of the existing trends in health care discrimination and are necessary to address the barriers to health equity for LGBTQI+ individuals," the proposed rule states.

'Circumvents the Law'

The language in the rule is vague and could have unintended consequences, says Matthew Eyles, president and chief executive officer of AHIP, an insurance company trade group, in a letter of comment on January 27.

"The Department's proposed nondiscrimination framework is overly broad and could create a slippery slope of eliminating benefit limits that are based on clinical evidence, support value-based care, and ensure affordable premiums," wrote Eyles.

The rule is legally suspect and not founded on science, Heritage Foundation Senior Fellow Jay W. Richards, Ph.D. and Research Assistant Jared Eckert wrote in an analysis of the proposed rule.

"In fact, the department's proposed rule circumvents the law and treats dubious treatments as essential health benefits in qualified health plans," wrote Richards and Eckert. "This not only contradicts the best science and medicine, it's a disaster for insurers, for medical providers, and, most of all, for those struggling with gender dysphoria."

Child Protection

Controversy over gender reassignment of children is an issue in Texas and other states.

Texas Attorney General Ken Paxton issued an opinion, which is binding on state employees, that such therapies and surgeries constitute child abuse under current Texas law, on February 18.

Texas Gov. Greg Abbott (R) directed the Texas Department of Family and Protective Services to investigate instances of children undergoing sex-change procedures as possible child abuse, in a letter on February 22.

"As OAG Opinion No. KP-0401 makes clear, it is already against the law to subject Texas children to a wide variety of elective procedures for gender transitioning, including reassignment surgeries that can cause sterilization, mastectomies, removals of otherwise healthy body parts, and administration of puberty-blocking drugs or supraphysiologic doses of testosterone or estrogen," said Abbott.

Paxton's opinion is being challenged by district attorneys representing five of Texas's most populous counties. They say they will not enforce Abbott's order.

"In recent days, elected leaders in Texas have launched a cynical and dangerous campaign targeting transgender children and their parents," said President Joe Biden in a statement published on March 2.

Unsettled Science

The results of medical studies on the effects of gender transition are contradictory or ambiguous, says Linda Gorman, director of the Health Policy Center at the Independence Institute.

"The science is most definitely unsettled with respect to whether transgender surgery helps or harms individuals with gender dysphoria," said Gorman. "A federal mandate requiring coverage would short-circuit the normal discovery process that occurs when the truth is unknown. In this case, the federal government should refrain from telling insurers what to do until the truth of the matter becomes clearer."

'Social Policy Tool'

The Biden transgender initiative is part of a broader effort to force health insurers to pay for government social policies, says Merrill Matthews, Ph.D., a resident scholar at the Texas-based Institute for Policy Innovation.

"Liberals have long viewed health insurance as a social policy tool, not just a health care tool," said Matthews. "That is, they want health insurers to pay for whatever social policy liberals need someone to pay for. So, they keep broadening whatever is considered health care, so they can force health insurers to pay for it.

"Mandating health insurers to pay for certain transgender-transitioning costs is just the latest example," said Matthews. "If the proposed rule change is allowed to stand, the initial cost impact on health insurance will likely be minimal, primarily because the number of people seeking gender-affirming surgery and other related medical care is still relatively small. But it would grow more quickly once people realize there would be little to no financial barrier to transitioning."

"Liberals have long viewed health insurance as a social policy tool, not just a health care tool. That is, they want health insurers to pay for whatever social policy liberals need someone to pay for. So, they keep broadening whatever is considered health care, so they can force health insurers to pay for it. Mandating health insurers to pay for certain transgender-transitioning costs is just the latest example."

MERRILL MATTHEWS, PH.D.
RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

'Inhibits Appropriate Therapy'

Many insurers cover treatments specific to transgendered individuals, says health economist Devon Herrick, a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"Dozens of health plans already provide a range of services for gender dysphoria," said Herrick. "It is not entirely clear what the Biden administration's goal is. My guess is political posturing.

"A risk of politicizing gender dysphoria treatment is the potential for politics to inhibit the appropriate therapy," said Herrick. "I've seen no estimates, but many other mandates over the years increased premiums between 1 and 5 percent."

Bonner R. Cohen, Ph.D. (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

COMMENTARY

Dr. David Gortler: FDA Is Ignoring COVID Shot Adverse Effects

By David Gortler

From day one, the U.S. Food and Drug Administration (FDA) knew the COVID-19 vaccine was linked to serious heart trouble in recipients.

The FDA medical officer review of Pfizer's original COVID-19 application notes "clinically important serious adverse reactions [included] anaphylaxis and myocarditis/pericarditis"—severe allergic reactions and inflammation of the heart and/or the sac containing the heart, respectively.

Adverse Reactions

The Vaccine Adverse Event Reporting System (VAERS), jointly run by the FDA and the Centers for Disease Control and Prevention, lists a long number of cardiovascular-related events in healthy young people. Without the underlying narratives submitted with the reports, it's hard to establish the precise causes of these adverse events. Still, there are thousands of reports of heart attacks, myocarditis, and pericarditis in the United States alone, which should have spurred manufacturers and the FDA to investigate fully.

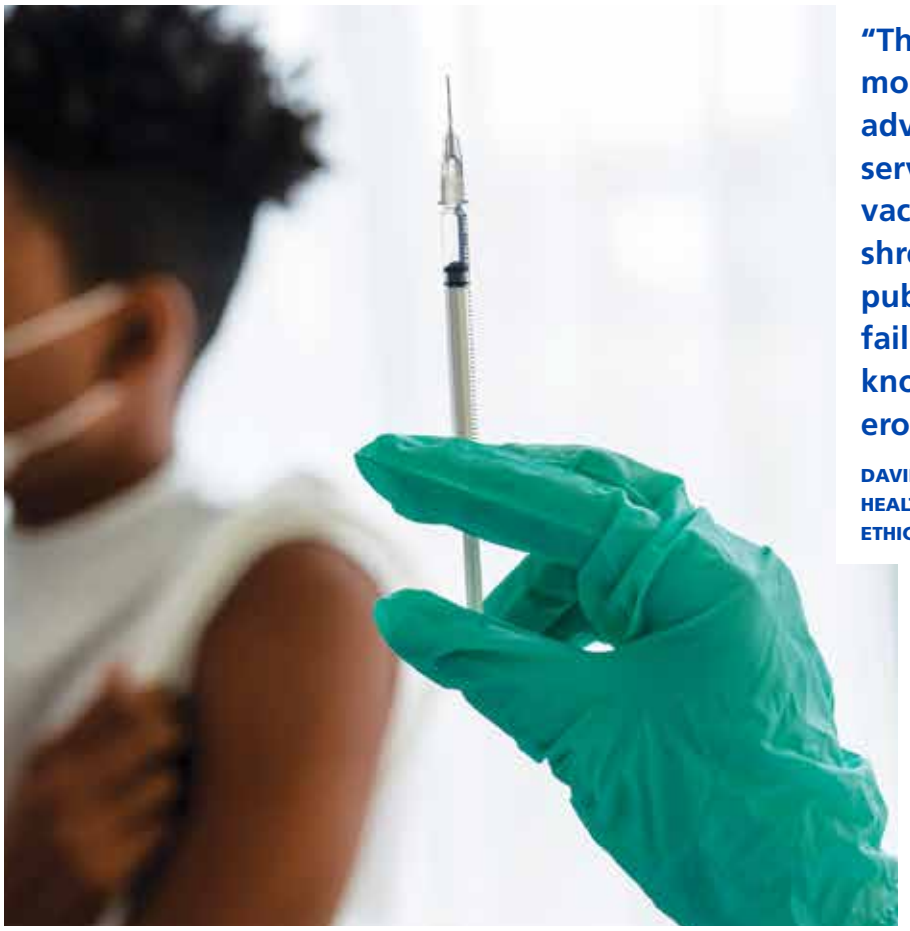
FDA officials acknowledge studies show the agency's various safety databases collect only an estimated 1 to 13 percent of all adverse events that occur. Multiple FDA drug safety epidemiologists have stated during official FDA presentations that it takes only a single well-documented adverse event to justify a safety signal investigation and warning to the American public of the potential risk.

Unusual Leeway

Historically, the FDA has sought safety warnings on labels, up to and including a "black box warning" and a prescribing restriction, or Risk Evaluation and Mitigation Strategy (REMS), for much less.

For instance, in 2008, after fewer than 200 spontaneous VAERS reports of tendon rupture following administration of antibiotics known as fluoroquinolones, FDA added a "black box warning" and REMS prescribing restrictions.

Yet thousands of serious, debilitating, and deadly VAERS reports following COVID-19 vaccines and boosters are not held to the same regulatory standards. If approximately 1 to 13 percent of adverse events are reported, the actual number could easily be in the hundreds of thousands in the United States and many millions worldwide.



"The failure to adequately monitor and warn about adverse events has not only served to harden COVID vaccine hesitancy but has shredded the credibility of public health authorities. The failure to openly talk about known adverse reactions erodes trust."

DAVID GORTLER, PHARM.D., FCCP
HEALTH POLICY FELLOW
ETHICS AND PUBLIC POLICY CENTER

In addition to VAERS, the CDC's Vaccine Safety Datalink indicates an excess risk of myocarditis and pericarditis following Pfizer and Moderna vaccinations. The cardiovascular risk after any mRNA vaccine is high, but with Moderna it's approximately four times higher than Pfizer's.

Scandinavian Ban

Public health agencies in other countries took action against these cardiac risks months ago. In October, Denmark, Finland, Norway, and Sweden suspended use of the Moderna vaccine for young people, but it's still full speed ahead here in the United States.

Since then, more data has been released: a CDC and FDA study published in the *Journal of the American Medical Association* on January 25 shows the risk of myocarditis following any kind of mRNA COVID vaccination is greater than normal, with the largest proportion of cases among white males.

A comprehensive British study examining data from more than 42 million people who received a COVID-19 shot, published in December 2021, found a noteworthy increase in myocarditis with mRNA vaccines that persisted and increased with every dose and booster.

"An association between COVID-19 infection and myocarditis was observed in all ages for both sexes," the study's abstract states. "These findings have important implications for public health and vaccination policy."

Indeed, they do, especially in light of the questionable way the FDA approved vaccines in kids five to 13 years old and the pending FDA applications to approve vaccination in babies as young as six months.

Presidential Pressure

The FDA, CDC, and manufacturers have access to VAERS and additional high-quality vaccine safety systems, including the Biologics Effectiveness and Safety Initiative (BEST) and the Vaccine Safety Datalink (VSD).

Have manufacturers and health agencies used these tools and others to fully investigate the cardiovascular health risks of the vaccine? There is reason to doubt, given the political pressure the Biden administration has put on the agencies to advocate taking the vaccine, while almost never mentioning safety.

Credibility Gap

Historically, myocarditis and pericarditis have been rare. Both conditions cause easily recognizable ECG changes and have ambiguous symptoms that include shortness of breath and chest pain. Myocarditis and pericarditis can easily be diagnosed and treated, but for that to happen, people need to know to seek medical diagnosis and care.

Therein is the problem: providers and patients are not adequately warned to monitor for cardiovascular symptoms despite the increased incidence. Since manufacturers and the FDA have failed to address this and other untoward effects of mRNA utility and mandates, outside drug safety experts need to publicly address mRNA COVID vaccine safety immediately.

The failure to adequately monitor and warn about adverse events has not only served to harden COVID vaccine hesitancy but has shredded the credibility of public health authorities. The failure to openly talk about known adverse reactions erodes trust.

David Gortler, Pharm.D., FCCP (**dgortler@eppc.org**) *is a pharmacologist, pharmacist, and health policy fellow at the Ethics and Public Policy Center. Gortler was a professor at the Yale University School of Medicine, where he also served at Yale's Bioethicist Center and was an FDA medical officer. He was later appointed by the White House as a senior advisor to the FDA commissioner. He is a columnist at Forbes and a policy advisor to The Heartland Institute. A version of this article appeared in The Federalist on February 10. Reprinted with permission.*

INTERVIEW

Restore Open Dialogue in Science, Says Great Barrington Declaration Author

On October 4, 2020, Jay Bhattacharya, Sunetra Gupta, and Martin Kulldorff posted the Great Barrington Declaration online. "As infectious disease epidemiologists and public health scientists, we have grave concerns about the damaging physical and mental health impacts of the prevailing COVID-19 policies, and recommend an approach we call Focused Protection," the authors stated. More than 925,000 individuals have signed the declaration, including 60,000-plus medical and public health scientists and medical practitioners.

In a February 24 interview on The Heartland Daily Podcast *with AnneMarie Schieber, managing editor of* Health Care News*, Bhattacharya—a physician and epidemiologist at the Stanford University Medical School—discussed why it took 16 months for countries, states, and cities to lift their mandates and talked about the proper role of science in a free society. Questions and answers have been edited for space and clarity.*

Health Care News: Mandate supporters now say the science regarding COVID-19 has changed, and that is why they are pulling back on their orders. Has the science changed?

Bhattacharya: The fundamental thing hasn't changed. There's this big age gradient in the risk, so we still should be focusing on protecting the vulnerable. This mainly means older people and some folks with chronic conditions. And I think the other part of science that hasn't changed is that the lockdowns are ineffective and are harmful themselves.

Even back as far as March or April of 2020, it was a fool's errand to think that we could control and stop this virus from spreading everywhere. We don't have the technology to stop the spread of the virus. The vaccine doesn't stop the spread of the virus. The lockdowns don't stop the spread of the virus.

Coming to terms with that [has] taken two years. I wish that it had happened much earlier, because the harms from the lockdowns have been devastating. They've hurt the poor, the vulnerable, and they've failed to protect people from the virus itself, as they inevitably couldn't have.

The lockdowns are essentially a luxury of a certain class of people who can afford to lock down without losing their jobs. Not true for most of the rest of the population. And so I am really pleased to see that the policy is finally turning.

Health Care News: You are now involved with a new organization at Hillsdale College with Scott Atlas, M.D. and Martin Kulldorff, Ph.D., the Academy of Science and Freedom. How did the idea come about, and what do you hope to accomplish?

Bhattacharya: It was a joint idea with Scott and Martin and some others. The way science has functioned during the pandemic, there have been some great advances. We've had a vaccine essentially in record time that does protect against severe disease.

At the same time, we've had a lot of weaknesses in science. The main weakness has been the capacity for scientists who disagree to talk to each other in good faith without facing enormous headwinds from other scientists and from the media. And it's made it very difficult for people who disagreed with the dominant consensus to speak up. But you can't have science where people are afraid.

For example, Francis Collins [former director of the National Institutes of Health (NIH)] and Tony Fauci [director of the National Institute of Allergy and Infectious Diseases] essentially involved themselves in the health policy discussions about what to do with COVID. They control billions of dollars in funding, and not just the funding. If scientists can't get funding from the NIH, their careers stagnate. [These organizations] control the careers of countless numbers of scientists. And when they say that our ideas are fringe, a lot of scientists who agree with us will be afraid to speak up (see related article, page 14).

It creates a situation where science can't be science. It can't function. And so that's one of the activities of [the Academy of Science and Freedom]. Our goal is to restore free discussion within science itself.

Health Care News: Do you have any other objective?

Bhattacharya: The second aim is to restore the proper place of science within a free society. A lot of times during the pandemic, you've heard, "Well, you're not an epidemiologist, so therefore you can't tell us what the right thing to do is in this circumstance. Don't you know there's a pandemic on?"

Well, you know, epidemiologists do not have a monopoly on wisdom. They do not have a monopoly on understanding the values of the people. Discussion about what the right policy is should be expanded far beyond scientists themselves.

"The proper place of science in a free society is to help inform people about what science shows and tells people: 'Well, if you do A, here are the range of likely outcomes. If you do B, here are the other range of likely outcomes.' But science itself is a morally neutral activity. It doesn't say, 'Choose A or B.' That is the proper domain of public discussion, of politics. For that, scientists have no special expertise."

DR. JAY BHATTACHARYA
PHYSICIAN AND EPIDEMIOLOGIST
STANFORD UNIVERSITY MEDICAL SCHOOL

The proper place of science in a free society is to help inform people about what science shows and tells people: "Well, if you do A, here are the range of likely outcomes. If you do B, here are the other range of likely outcomes." But science itself is a morally neutral activity. It doesn't say, "Choose A or B." That is the proper domain of public discussion, of politics. For that, scientists have no special expertise.

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Pandemic Response: What the CDC Got Wrong

By Bonner R. Cohen

The federal government's handling of the COVID-19 pandemic highlights the urgency of reforming federal health research agencies, say House Republicans and prominent health care analysts.

The Centers for Disease Control and Prevention (CDC); the CDC's parent agency, the National Institutes of Health (NIH); and the U.S. Food and Drug Administration (FDA) are not serving the country well, says Jay Bhattacharya, a physician and epidemiologist at the Stanford University Medical School and coauthor of The Great Barrington Declaration (see article, page 13).

"The CDC has failed in deep ways during the pandemic," said Bhattacharya on *The Heartland Daily Podcast*. "I think we're going to need reform of all three agencies."

'Obvious Blunders'

In the latest skirmish involving the CDC, House Republicans want to investigate the CDC's withholding of certain COVID-19 data, *The New York Times* reported on February 20.

Days after the report, House Minority Whip Steve Scalise (R-LA) and Rep. James Comer (R-KY) sent a letter to CDC Director Rochelle Walensky demanding release of the information by March 11, the *Washington Examiner* reported on February 25.

The lack of data from the CDC is not surprising, says Doug Badger, a senior fellow for domestic policy at The Heritage Foundation.

"Among the CDC's most obvious blunders is its failure to collect and disseminate data," said Badger. "Since 2006, Congress has passed multiple bills requiring the agency to implement real-time data collection. They still have not complied. The CDC has been a disservice to public health agencies, the medical profession, and the American people."

CDC Weighs Public Health, Politics

The CDC has divided loyalties to the worlds of science and politics, says Vinay Prasad, a hematologist-oncologist and associate professor of epidemiology and biostatistics at the University of California-San Francisco, in an essay titled "How the CDC Abandoned Science," published at tabletmag.com on February 14.

"The CDC is, in part, a scientific agency—they use facts and principles of science to guide policy—but they are also fundamentally a political agency: The director is appointed by the president of the United States, and the CDC's guidance often balances public health and welfare with other priorities of the executive branch."

VINAY PRASAD
ASSOCIATE PROFESSOR OF EPIDEMIOLOGY AND BIOSTATISTICS
UNIVERSITY OF CALIFORNIA-SAN FRANCISCO

"The CDC is, in part, a scientific agency—they use facts and principles of science to guide policy—but they are also fundamentally a political agency: The director is appointed by the president of the United States, and the CDC's guidance often balances public health and welfare with other priorities of the executive branch," wrote Prasad.

There are numerous examples of flawed, politically driven CDC research on COVID-related policy, says Prasad.

A CDC study published in November 2020 that attempted to prove mask mandates slowed the spread of the coronavirus found counties in Kansas that implemented mask mandates had COVID case rates start to fall, and counties that did not mandate masks had rates continue to climb, says Prasad. However, the CDC's findings narrowly focused on trends from July and August 2020 and ignored trends over the following months that showed practically no difference in COVID case rates in counties with and without mask mandates.

"In short, the CDC's study was not capable of proving anything and was highly misleading, but it served the policy goal of encouraging cloth mask mandates," wrote Prasad.

'Science As Political Propaganda'

The CDC's goal of vaccination regardless of age or medical condition has led it to promote vaccination of children between the ages of 12 and 15. The FDA granted emergency use authorization (EUA) for this cohort to receive the Pfizer vaccine on May 10, 2021. On June 11, 2021, the CDC published a study in the *Morbidity and Mortality Weekly Report* claiming to demonstrate rising hospitalizations among this age group, which received widespread coverage in the media.

"But the absolute rates for this age group were, in reality, amazingly low: less than 1.5 per 100,000, which was lower than it had been the previous December," wrote Prasad.

"The CDC was undeterred, and in recent weeks the agency's director has started to push for more doses at these ages," wrote Prasad. "Against the advice of an FDA advisory committee, Rochelle Walensky has moved forward with recommending boosters for 12- to 15-year-olds. … This is not science as such, but science as political propaganda."

Bonner R. Cohen, Ph.D. (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.*

Fauci Was Warned of COVID-19 Origins in 2020, Emails Reveal

White House Chief Medical Advisor Anthony Fauci suppressed crucial evidence when he and a small group of scientists tried to dispel reports the COVID-19 virus leaked from the Wuhan Institute of Virology, members of Congress say.

The emails, which have not been publicly released other than through hand-transcribed excerpts, reveal Fauci was warned of the possibility of a leak and the likelihood the virus was genetically manipulated, state U.S. Reps. James Comer (R-KY), ranking member of the House Committee on Oversight and Reform, and Jim Jordan (R-OH), ranking member of the House Committee on the Judiciary, in a letter to U.S. Department of Health and Human Services Secretary Xavier Becerra on January 11.

In the emails, a scientist warned Fauci it was highly unlikely the virus naturally spilled over from bats to humans. The emails also indicate Fauci knew of U.S. government funding of research at the Wuhan lab.

In another case of Fauci apparently promoting a narrative, emails obtained by the American Institute for Economic Research through a Freedom of Information Act request included an October 8, 2020 exchange between Fauci and National Institutes of Health Director Francis Collins in which the two discuss efforts to discredit the "fringe epidemiologists" who had recently published the Great Barrington Declaration (see article, page 13).

"There needs to be a quick and devastating published take down of its premises," Collins wrote.

Sen. Rand Paul (R-KY) says he will issue a subpoena for Fauci's records if Republicans win the Senate this fall and he is named chair of a committee.

—Staff reports

Homeland Security Labels Vaccine Skeptics Terrorists

By Kenneth Artz

The Biden administration says vaccine dissenters may cause acts of violence, in a new terrorism advisory from the U.S. Department of Homeland Security (DHS).

The DHS's National Terrorism Advisory System Bulletin says false information online heightens the threat of violence. The bulletin was published on February 7 and expires on June 7.

Surgeon General Set Stage

U.S. Surgeon General Vivek H. Murthy released a 22-page report titled "Confronting Health Misinformation: The U.S. Surgeon General's Advisory on Building a Healthy Information Environment," on July 15, 2021.

Murthy's report tells Americans how to identify misinformation and gives examples of what the public can do to stop it.

Misinformation differs from disinformation promoted for financial gain or political advantage, says Murthy's report. Health misinformation, however, could do damage by making people less willing to seek effective treatment, the report states.

Some of the tactics identified in the report include presenting unqualified people as experts, misleading consumers with logical fallacies, setting impossible expectations for scientific research, cherry-picking data or anecdotes, and spreading conspiracy theories.

Motives Questioned

The report and terrorism advisory are part of a federal government effort to fine-tune its tools for censuring dissent, says Marilyn M. Singleton, M.D., J.D., a board-certified anesthesiologist and member of the Association of American Physicians and Surgeons (AAPS).

"Interestingly, the government comes out with a global policy months after the surgeon general comes out with his report," said Singleton. "I'm assuming the surgeon general's report didn't hit hard enough or scare enough people. And now we have the government's global policy, with an acronym, MDM, [for] mis-, dis-, and mal-information."

The government itself is undermining public trust, says Singleton.

"As far as I'm concerned, their misinformation is more [dangerous] than ours," said Singleton. "Look at what the government has done to mislead, calling COVID an emergency two years later. It's not an emergency anymore. It is not unexpected. It doesn't need immediate action anymore, yet they are continually calling it an emergency just so they can keep these police powers in force."

Calls Feds Terrorists

We are in the age of doublethink, says Twila Brase, R.N., president and cofounder of the Citizens' Council for Health Freedom.

"There is no such thing as misinformation, and there are no crimes or laws against misinformation," said Brase. "America was founded on freedom of speech, whether anyone likes that speech or believes that speech or thinks that speech misinformed."

"The Biden administration is pursuing thought crimes," said Brase. "Homeland Security officials want to shut down citizen speech that doesn't fit their narrative. They want to unleash the government forces against law-abiding people who disagree with the Biden administration's version of truth."

The Biden administration is trying to terrorize dissenters, says Brase.

"The Biden administration should be pointing their fingers at themselves, not the law-abiding citizens that have the right to speak freely without being deemed a criminal or a terrorist," said Brase. "The only terrorist in the room, given this national terrorism advisory, is the Biden administration itself."

Kenneth Artz (**KApublishing@gmx.com**) *writes from Dallas, Texas.*

INTERNET INFO

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Sweden's Approach to Virus Wins Accolades

By Harry Painter

Sweden has had a drop in cases and hospitalizations since it abolished its remaining pandemic restrictions.

Scientists criticized the move on February 9 as premature, but the policy has been a success, say Swedish government officials.

"There are no indications that the opening increased spread, so we assess that it was relevant and correct," Karin Tegmark Wisell, director general of the Public Health Agency of Sweden, said at a press conference on March 3.

Famously, Sweden was one of just a few countries that chose not to lock down their citizens and economy in 2020.

'Persuasion, Not Coercion'

Sweden took a different approach to the pandemic than other countries, says Twila Brase, president of the Citizens' Council for Health Freedom (CCHF).

"Not locking down was a controversial position at the time, but Swedish health officials held to it," said Brase. "Anders Tegnell, [Sweden's] chief epidemiologist, was instrumental in that decision. Officials used persuasion, not coercion."

Sweden has had one of the lowest COVID-19 mortality rates in Europe, at 1,757 deaths per million people. The rate in lockdown-heavy Britain is 2,366 per million. Sweden also took on a smaller debt burden than lockdown countries such as Britain.

Sweden's measured approach to the pandemic protected the nation's economy, says the Committee to Unleash Prosperity, a free-market advocacy group.

"This year it's projected to be 5 percent larger than before the pandemic, versus a two percent gain for Germany and one percent for Britain," stated the organization's newsletter on February 15. "The level of extra debt Sweden has had to take on is a fraction of that in lockdown countries."

Hands-Off Approach

Sweden's Public Health Agency in 2020 touted its focus on clear, consistent messaging and personal responsibility instead of lockdowns.

Tegnell defended his nuanced approach to the pandemic, saying in a September 2021 interview Sweden's legal system forced the government to "focus on areas where we really can see that there is a high level of threat."

Sweden's COVID-19 deaths exceeded neighboring countries' in the early stages of the pandemic because the government was not sufficiently vigorous in protecting nursing home residents, says Joel S. Hirschhorn, founder of the *Pandemic Blunder Newsletter*.

"Like the U.S. and some other nations, nearly half the COVID deaths were in nursing homes and nearly 90 percent of deaths were in people 70 years or older, again similar to the U.S. and other nations," said Hirschhorn.

"It is also important to note that generally, the Swedish population is healthier than Americans, with fewer chronic comorbidities, especially obesity," said Hirschhorn.

Early Treatment Successes

The verdict is in on other approaches taken to protect people from the virus, and not just from Sweden, says Brase.

"Various Indian and South African countries, as well as South American countries, likely did better than the U.S. because they used early treatment," said Brase. "Many of them were already on hydroxychloroquine to prevent malaria," she said. "And in Uttar Pradesh, a state of India with more than 240 million people, the government distributed early treatment kits including ivermectin—and the cases and deaths plummeted."

Other public health measures have not worked as expected, says Brase.

"Scrubbing surfaces was mostly stopped after it was recognized that the virus spread through the air, and at some point in 2021 it was acknowledged that the plexiglass barriers in schools did virtually nothing," said Brase.

Vaccine Disappointment

Another measure that failed to live up to its promise has been vaccines, says Brase.

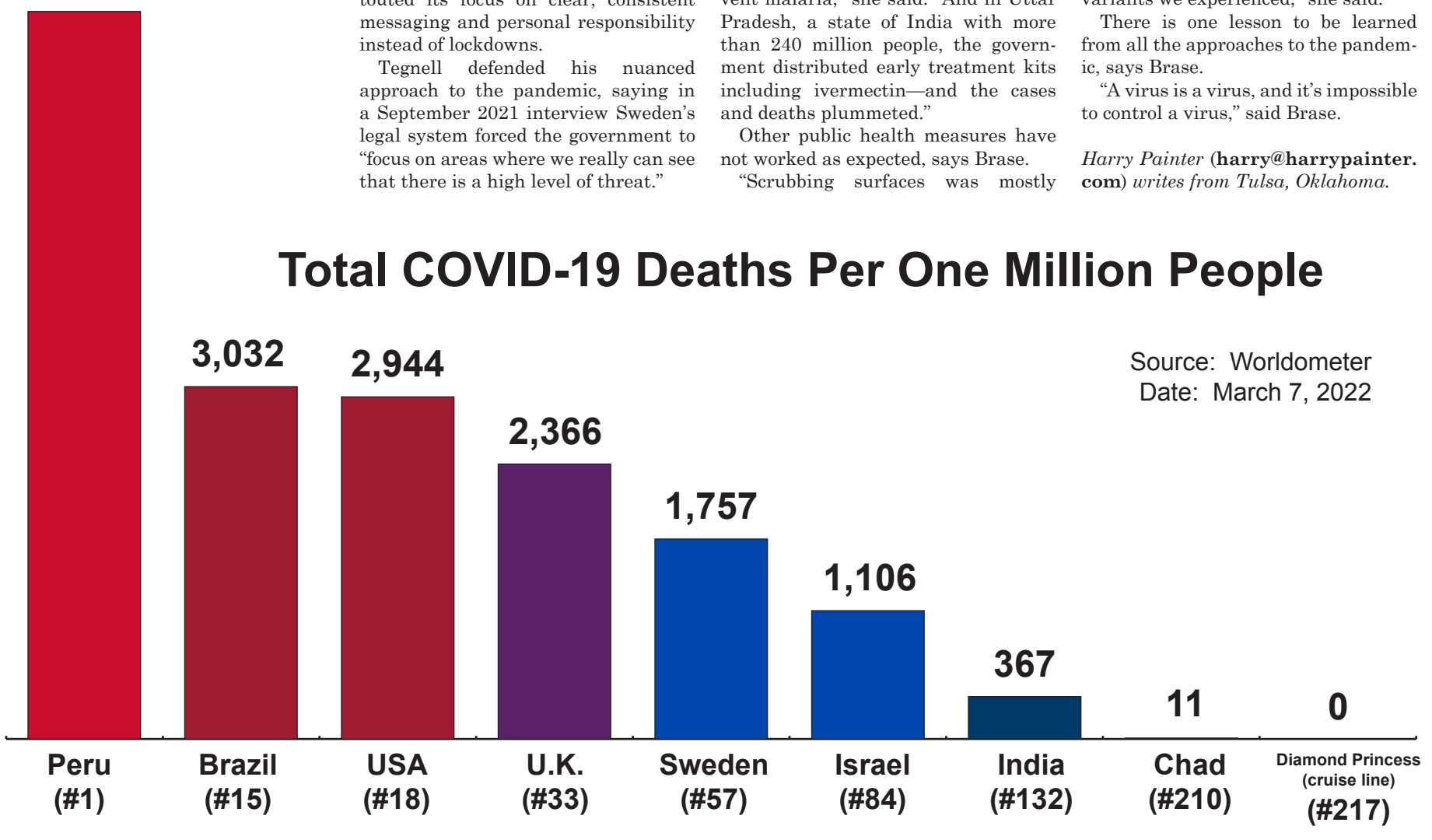
"The vaccines didn't work to stop COVID, stop transmission, [or] decrease viral load," said Brase. "They provided no sterilizing immunity, so they really are not vaccines. In some countries, the vaccinated are suffering higher rates of hospitalization, such as in Scotland and Israel.

"The injections may have decreased severity of disease for the especially vulnerable, but they also caused death and damage to some of the vaccinated, and we don't yet know the full impact of the genetic injections because there was insufficient study before injections," said Brase. "In addition, it appears the vaccines given in the midst of a pandemic may have led to the long line of variants we experienced," she said.

There is one lesson to be learned from all the approaches to the pandemic, says Brase.

"A virus is a virus, and it's impossible to control a virus," said Brase.

Harry Painter (**harry@harrypainter.com**) *writes from Tulsa, Oklahoma.*



Is the Military Hiding Disease Data From Before Vaccine Mandate?

By Bonner R Cohen

Data presented on Capitol Hill by an attorney representing three U.S. Department of Defense (DoD) whistleblowers show dramatic increases in a variety of medical diagnoses among military personnel, raising questions about possible links to COVID-19 vaccines members of the military were required to take.

During a January 24 roundtable hosted by Sen. Ron Johnson (R-WI) that was livestreamed on the Internet, medical experts shared their perspectives on COVID-19 vaccine efficacy and safety.

"Based on data from the Defense Medical Epidemiology Database (DMED), Renz reported that these whistleblowers found a significant increase in registered diagnoses on DMED for miscarriages, cancer, and many other medical conditions in 2021 compared to a five-year average from 2016-2020."

SEN. RON JOHNSON (R-WI)

Startling Testimony

Johnson, ranking member of the Permanent Subcommittee on Investigations of the Senate Committee on Homeland Security and Governmental Affairs, wrote to DoD Secretary Lloyd Austin stating he received testimony from Thomas Renz, an attorney representing the three Pentagon whistleblowers, all of whom are physicians, on February 1.

"Based on data from the Defense Medical Epidemiology Database (DMED), Renz reported that these whistleblowers found a significant increase in registered diagnoses on DMED for miscarriages, cancer, and many other medical conditions in 2021 compared to a five-year average from 2016-2020," wrote Johnson.

"For example, at the roundtable, Renz stated that registered diagnoses for neurological issues increased 10 times from a five-year average of 82,000 to 863,000 in 2021," wrote Johnson.

Johnson asked what Austin and the DoD knew about these allegations and what, if anything, they had done about the alleged problems.

"Is DoD aware of increases in registered diagnoses of miscarriages, cancer, or other medical conditions in DMED in 2021 compared to a five-year average from 2016-2020?" asked Johnson. "If so, please explain what actions DoD has taken to investigate the root cause for the increases in these diagnoses."

Missing Myocarditis Numbers

Johnson asked Austin to explain the discrepancies in the data and the alleged removal of data on myocarditis, an inflammation of the heart muscle reported in some young adults after COVID-19 shots.

"Renz also informed me that some DMED data showing registered diagnoses of myocarditis had been removed from the database," wrote Johnson.

"Have registered diagnoses of myocarditis in DMED been removed from the database from January 2021 to December 2021?" asked Johnson. "If so, please explain why and when this information was removed and identify who removed it."

Renz told *Health Care News* neither he nor Johnson had received a response from DoD as of March 8. Johnson's office had not responded to requests for comments from *Health Care News* as of press time.

PolitiFact: 'Faulty Data'

Video of Johnson's roundtable was widely circulated and reported. PolitiFact, a website owned by the nonprofit Poynter Institute for Media Studies, Inc., published an article "fact-checking" an Instagram post citing figures stated by Renz at the roundtable, on January 31.

The DoD said the numbers showing a dramatic increase in military medical diagnoses were wrong, states the PolitiFact post by Jeff Cercone.

"They resulted from a glitch in the database, a military spokesperson said," wrote Cercone.

"But Peter Graves, spokesperson for the Defense Health Agency's Armed Forces Surveillance Division, told PolitiFact by email that 'in response to concerns mentioned in news reports' the division reviewed data in the DMED 'and found that the data was incorrect for the years 2016-2020,'" wrote Cercone.

"The DMED system has been taken offline to 'identify and correct the root-cause of the data corruption,' Graves said," wrote Cercone.

Convenient Glitch?

To believe the "glitch narrative," you have to accept several absurd assertions, says Renz.

"The DoD said the numbers were wrong from 2016-2020 but then correct in 2021," said Renz. "The DMED database is monitored by an entire division of the military and numerous subagencies throughout [the Department of Health and Human Services] (including Fauci and the CDC). It is also cited in peer-reviewed articles and scientific literature.

"For an ongoing glitch to have occurred for those five years, we have to believe that none of these people noticed an error that, according to the updated numbers, was over 2,000 percent in some instances," said Renz. "That includes the year of COVID—2020—when Fauci and crew claimed to be following the science to keep us safe. This leaves us with only two conclusions: either Fauci and the others monitoring the database in 2020 were well beyond grossly negligent, or, more likely, they are corrupt and covering up the truth."

There is also a possible conflict of interest, says Renz.

"I can only speculate, but I do know that there are potential conflicts," said Renz. "For example, the Secretary of Defense earned nearly $300k in 2020 sitting on the board of a health care company that we believe is making quite a bit from COVID subsidies."

Search for Connections

The Renz data contain diagnoses that cannot currently be traced to COVID-19 shots and some that can, says Joel S. Hirschhorn, author of the book *Pandemic Blunder* and the *Pandemic Blunder Newsletter* on Substack.

"I would rather see the emphasis on those diseases and illnesses that do connect to the COVID vaccines, such as myocarditis and several neurological conditions," Hirschhorn told *Health Care News*. "In my research, I have tried to explain how the vaccines cause problems, such as intense micro blood clots that we know through blood testing are caused by the vaccines. These micro clots in small blood vessels throughout the body can greatly impede oxygen getting to all organs and the brain, thus leading to a host of impacts, including heart attacks and strokes."

It is also important to have mortality reports, says Hirschhorn.

"[C]ase data cannot be the full story; there should have been a lot of deaths from several of the vaccine-induced health impacts, even for young, healthy military people," said Hirschhorn. "Where are the mortality data?"

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INTERNET INFO

Sen. Ron Johnson's Letter to Defense Secretary Lloyd Austin, February 1, 2022: **https://www.ronjohnson.senate.gov/services/files/FB6DDD42-4755-4FDC-BEE9-50E402911E02**

SATIRE

Putin Receives Nobel Prize in Medicine for Ending COVID Pandemic

The Babylon Bee

Switzerland — After serious deliberations deep inside the super-secret Nobel Prize Compound in Switzerland or wherever, the Nobel committee of medicine deciders have awarded the coveted Nobel Prize in Medicine to Russia's President Vladimir Putin for singlehandedly ending the COVID pandemic practically overnight.

News of the swift and nearly miraculous end to a years-long pandemic came at a serendipitous moment for members of a certain American political party.

"While Putin should receive credit for ending this pandemic, President Biden also deserves praise for ending the pandemic and fulfilling yet another campaign promise like all of the other campaign promises he keeps fulfilling," said Jen Psaki to a journalist and future coworker at MSNBC. "Yes, Putin's magical ability to end this pandemic bodes well for any Democrat running for reelection this November, but that's just a happy, happy coincidence."

Originally published by The Babylon Bee. Reprinted with permission.

SURVEY

Teen Drug Use Declined During School Lockdowns

By Ashley Bateman

The pandemic lockdowns led to large increases in online play and gaming addiction, but drug use among American teenagers fell sharply, a survey reveals.

Eighth and tenth graders reported a 40 percent drop in cannabis use, and lower cocaine and LSD consumption, in the Monitoring the Future survey. The decrease in adolescent drug use from 2020 to 2021 was the largest ever recorded, the researchers found.

The annual survey by University of Michigan researchers is funded by the National Institute on Drug Abuse (NIDA). Responses were collected from 32,260 students in grades 8, 10, and 12 in more than 300 public and private schools across the country.

This year's data collection differed from previous years, with 60 percent of self-reporting surveys having been completed at home during virtual learning.

Students Bored, Anxious

Being forced to stay at home affected students' psychological well-being, says the NIDA.

"The study found that students across all age groups reported moderate increases in feelings of boredom, anxiety, depression, loneliness, worry, difficulty sleeping, and other negative mental health indicators," stated the NIDA in a December news release.

The survey did not come to conclusions about influences on drug use, says Jane Orient, executive director of the Association of American Physicians and Surgeons.

"[Researchers] checked for differences in reporting behavior if reporting from home, and mentioned peer pressure, but don't comment on [its] likely importance and do not mention drug dealers in schools," said Orient.

"Isolating kids is not a good idea, even if there is less drug use, as there are many other harms," said Orient.

'Fewer Chances ... to Partake'

Less access to drugs and other teens could be an explanation for the decrease in use, says Timothy Benson, a senior policy analyst at The Heartland Institute, which co-publishes *Health Care News*.

"It's certainly plausible, and probably likely, that limiting access to their peers in and out of school is a contributing factor in that decline," said Benson. "Kids certainly buy or sell drugs at school and do them with their friends from school, so it seems reasonable that the less time they spend there, the fewer chances for them to partake in recreational drug use.

"It's just where they spend the most time interacting with their peers, and these things are going to happen," said Benson.

Lockdown Lessons

Parents are looking for alternative education options, says Ben DeGrow, director of education policy at the Mackinac Center for Public Policy.

"There are a multitude of reasons that more parents are considering a different school for their child, including questionable or inappropriate curriculum and problems in school social settings, such as bullying or peer pressure," said DeGrow.

"The pandemic has made abundantly clear that one school or type of education does not fit everyone," said DeGrow. "Parents should be equipped with the information and resources to send their children to a school they find safe, suitable, and motivating for them to learn in."

Ashley Bateman (**bateman.ae@googlemail.com**) *writes from Virginia.*

INTERNET INFO

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Let Seniors Protect Themselves from High Drug Costs with HSAs

"This is a brilliant way to work around a dysfunctional system and meet people's needs. But as I wrote the last time I discussed this idea, what we need even more is deregulation. Seniors deserve real catastrophic coverage, and they deserve the opportunity to save and manage their own health care dollars for non-catastrophic expenses. The market can meet all these needs if we just let it work."

JOHN C. GOODMAN
PRESIDENT
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

By John C. Goodman

The federal government spends an enormous amount of money on the elderly—far more, for example, than it spends on children.

At the same time, rules, regulations, taxes, and penalties create enormous burdens for senior citizens when they do such ordinary things as work for wages, withdraw funds from an IRA, or even try to insure themselves for medical expenses.

Seniors who claim early retirement under Social Security face the highest tax rates in the nation when they earn more than a modest amount of wage income. These tax rates can exceed 90 percent, and they are far higher than the rates faced by Warren Buffett or Jeff Bezos. Some seniors face higher tax rates on capital gains and pension fund income than younger people at the same income level. Some are even taxed on their tax-exempt income!

Although accountants are aware of many pitfalls seniors face under the income tax law, even well-trained CPAs tend to be unaware of the problems seniors encounter when they try to insure against unexpected medical expenses.

HSAs Banned

Take Health Savings Accounts (HSAs). This is an extremely popular way non-seniors self-insure for medical expenses not paid for by third-party health insurance. People can put pretax dollars in their HSAs, and employers can contribute as well.

HSA funds can be invested at the owner's discretion, and the accounts are completely portable, traveling with an employee from job to job and in and out of the labor market.

A senior could contribute after-tax money to an HSA similar to a Roth Individual Retirement Account. The growth would be tax-free.

Here's the problem. Seniors can't have an HSA. Once you become eligible for Medicare, you can no longer open and contribute to an HSA. That's too bad, because seniors on Medicare have a lot of out-of-pocket costs.

Big Out-of-Pocket Bills

Take prescription drugs. A senior who enrolls in Medicare Part A (hospital services), Medicare Part B (doctor services), and Medicare Part D (drugs) can face considerable out-of-pocket costs for drugs, even after paying premiums. Supplemental insurance, often called Medigap, is supposed to fill the gaps in Medicare coverage, but it doesn't help in this case. For some strange reason, the law doesn't allow Medigap to pay for the patient's share of drug costs.

If you are wondering what that might mean, consider that a study of 28 expensive specialty drugs found that among Medicare enrollees covered by Part D drug insurance, the out-of-pocket spending by patients ranged from $2,622 to $16,551. And those are annual costs!

Here is how Medicare drug coverage is working in 2022. After a deductible of $445, Medicare pays 75 cents of the next dollar of cost. And it pays 75 cents of the dollar after that, until the patient's out-of-pocket expenses reach a limit of $6,550. Above that amount, in the "catastrophic phase," the patient is responsible for 5 percent of any additional costs. For the 28 drugs mentioned above, more than half (61 percent) would require an average of $5,444 a year in out-of-pocket spending in the catastrophic phase alone.

Private-Sector Aid

Other than changing federal law, is there a market-based alternative? As I explained in a previous post at *Forbes*, a Houston-based firm called Health Matching Account Services (HMA) has been offering young people an intriguing way of insuring out-of-pocket medical costs. In recent years it has been expanding to the senior market as well.

It works like this. Under a standard plan, seniors make a monthly contribution of $140 to an HMA. After 12 months, they will have paid $1,680. For that amount, they will have coverage for the first $1,980 of medical expenses.

In other words, the buyers are getting $1.17 of coverage for every $1.00 they contribute for the first year. You might regard that as not much better than putting the money in a bank account. But this low payoff reflects the fact that first-dollar coverage is very expensive, even for people who don't expect to file a claim.

Things get better in year two (where you get more than $2 of coverage for every $1 of contribution) and better still in year three (where you get almost $3 of coverage for every $1 of contribution). After 35 months of payments, people who have had no medical bills will have $10,000 of coverage in return for monthly payments that add up to less than half that amount.

Say you have a drug that costs $4,600 and you pay for it from the HMA. That reduces your coverage level from $10,000 to $6,400. You can replenish the account by reinstituting the $140 monthly payments, which will increase your coverage at a rate of about three to one.

This account, by the way, can be used to pay out-of-pocket deductibles, copayments, or coinsurance under all parts of Medicare. It can also be used to pay for medical expenses Medicare itself doesn't cover, including hearing, vision, and dental.

Need for Deregulation

This is a brilliant way to work around a dysfunctional system and meet people's needs. But as I wrote the last time I discussed this idea, what we need even more is deregulation. Seniors deserve real catastrophic coverage, and they deserve the opportunity to save and manage their own health care dollars for non-catastrophic expenses.

The market can meet all these needs if we just let it work.

John C. Goodman (**johngoodman@johngoodmaninstitute.org**) *is president of the Goodman Institute for Public Policy Research and co-publisher of* Health Care News. *An earlier version of this article appeared in* Forbes *on February 8, 2022. Reprinted with permission.*

COMMENTARY

Government Subsidies Make Health Care More Expensive

By Brian Blase

The goal of universal health coverage can be achieved only if both health care and health coverage are affordable, and for too many people today they are not.

We can achieve more-affordable and higher-quality health care, which will lead to millions more people having health coverage.

Getting Less, Spending More

In many areas of the economy, products and services have become higher in quality over time, while real prices, after accounting for inflation, have declined. Unfortunately, this has not been the case for most health care products and services.

Prices for hospital services—the largest component of health care expenditures—have increased more than three times faster than general inflation over the past two decades. As costs have risen, insurance premiums have soared correspondingly, even as plan deductibles have risen dramatically.

In 2020, health care spending was 19.7 percent of U.S. gross domestic product, a 6.4 percentage-point increase and 48 percent increase from the 13.3 percent of U.S. GDP spent on health care in 2000. Importantly, over the past few decades there have been some noticeable advances in health, such as a decline in cardiac mortality, improvement in cancer survival rates, a cure for Hepatitis C, and new AIDS treatments.

However, there is also significant waste in the health sector, and health outcomes have recently stagnated despite the Affordable Care Act's (ACA) new spending and the significant expansion of Medicaid. American life expectancy was lower in 2019 than it was in 2013, before the ACA's coverage and spending provisions took effect.

Inflationary Government

There are many policies—at both the federal and state levels—that raise health care prices and costs. Generally, high prices convey high value. But in health care, because of the government's involvement, excessive third-party payment, and generally consolidated markets, high prices are often not a reflection of high value.

A primary way government inflates health care prices and costs is through tax and spending policies. In 2020, government health care spending—including both state and local government spending—was half of total U.S. health care expenditures.

Federal policy also has a major influence on private-sector health care spending, particularly through the tax exclusion for employer-sponsored health insurance. The Tax Policy Center estimates this tax exclusion reduced federal revenue, both income and payroll tax collections, by $273 billion in 2019.

The key economic reality is that when government subsidizes something, it becomes more expensive. Subsidies increase demand and raise prices, thus increasing total spending.

Health Subsidy Design Flaws

Although the magnitude of government subsidies for health care increases prices and spending, the design of the subsidies is also problematic.

Historically, government programs and tax policy encouraged third-party payment for health services. Thus, for the vast majority of health care transactions, individuals do not directly spend their own money but instead rely on a government program or their insurance plan.

Insurance should play a significant role in financing catastrophic and expensive care, but having insurance pay for routine and shoppable services rather than relying on markets distorts decision-making and leads to overconsumption and waste.

While inflation in health care services has been substantial, health care services where third-party payment is limited—such as cosmetic surgery and Lasik eye surgery—have had real price declines as quality has significantly improved. Also, some physician practices and medical centers, such as the Oklahoma Surgery Center, do not accept insurance and have much lower average prices.

New Federal Spending Unneeded

There are ways to increase the availability of affordable health coverage without new federal spending. Many policies implemented by the Trump administration expanded affordable coverage options for families and workers without new federal spending.

These policies included Association Health Plans, limited-duration health plans, individual coverage health reimbursement arrangements, and price transparency policies.

Although access to affordable health coverage and care are important, it is vital for policymakers to recognize two key facts. First, a large amount of medical spending is wasteful—with some of it even harmful to patients. Second, health insurance expansions, particularly through government programs such as Medicaid, tend to have disappointing results in terms of health outcomes.

A significant concern with our high medical spending is that a large share of it—estimated by some researchers to be 25 percent of spending—does not provide Americans with any benefit.

In fact, some of that spending may instead harm our health. A 2016 study found medical errors are the third leading cause of death in the United States and as many as 250,000 people die each year from errors in hospitals and other health care facilities.

Obamacare Health Decline

The effect of health insurance on health is not as clear or positive as commonly believed. At a macro level, despite the significant increase in health coverage beginning in 2014 through the Affordable Care Act, American life expectancy declined for three straight years from 2014 through 2017.

A guiding principle for reforming government health financing would be to let people control more of their own money for health care and coverage rather than continue to have the government control how most of their money is spent.

Brian Blase **(https://paragoninstitute.org/contact/)** *is founder and president of the Paragon Health Institute, a senior research fellow at the Galen Institute and the Foundation for Government Accountability, and a former special assistant to President Donald Trump on economic policy. This article is adapted, with permission, from Blase's testimony before the House Committee on Education and Labor, Subcommittee on Health, Employment, Labor, and Pensions, on February 17, 2022.*

INTERNET INFO

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COMMENTARY

They Are Still Defending Lockdowns

By Jeffrey A. Tucker

"A guiding principle for reforming government health financing would be to let people control more of their own money for health care and coverage rather than continue to have the government control how most of their money is spent."

JEFFREY A. TUCKER
FOUNDER AND PRESIDENT
BROWNSTONE INSTITUTE

Fifteen years ago, writers schooled in computer science began to imagine various totalitarian schemes for pandemic control.

Experienced public health officials in 2006 warned this would lead to disaster. Donald A. Henderson et. al., for example, went through the whole list of possible restrictions, shooting them down one by one.

Still, a decade and a half later, governments all over the world tried lockdowns anyway. And sure enough, since April 2020, scholars have observed these lockdown policies haven't worked. The politicians preached, the cops enforced, citizens shamed each other, and businesses and schools did their best to comply with all the strictures. But the virus kept going, with seeming disregard for all these antics.

Neither oceans of sanitizer, nor towers of plexiglass, nor covered mouths and noses, nor crowd avoidance, nor the seeming magic of six feet of distance, nor even mandated injections caused the virus to go away or otherwise be suppressed.

Restrictions Were Disastrous

Restrictions aren't associated with any set of virus mitigation goals. Forty studies have shown no connection between the policy (egregious violations of human liberty) and the intended outcomes (diminishing the overall disease impact of the pathogen).

You can forget about "causal inference" here because there is an absence of correlation between policy and outcomes at all. You can do a deeper dive and find 400 studies showing that the impositions on basic freedoms didn't achieve the intended result but instead produced terrible public health outcomes.

The two years of the hell into which hundreds of governments simultaneously plunged the globe achieved nothing but economic, social, and cultural destruction. Very obviously, this realization is shocking and suggests a crying need for a reassessment of the power and influence of the people who did this.

This reassessment is happening now, all over the world.

Media Ignored Evidence

A major frustration for those of us who have denounced lockdowns (which go by many names and take many forms) is that these studies haven't exactly rocked the headlines. Indeed, they have been buried for the better part of two years.

Among the ignored studies was a December 2020 examination of light and voluntary measures (discouraging large gatherings, isolating the sick, generally being careful) versus heavy and forced measures. This article, by Eran Bendavid et al., observes some effects on the spread from light measures but nothing statistically significant from heavy measures such as stay-at-home (or shelter-in-place) orders.

The most recent meta-analysis from Johns Hopkins University (JHU), by Jonas Herby of the Center for Political Studies in Copenhagen, Denmark, Lars Jonung of Lund University, and Steve Hanke of JHU, seems to have achieved some measure of media attention. It focuses in particular on the effects of heavy interventions on mortality, finding little to no relationship between policies and severe disease outcomes.

Dismissed Questions

The attention given to this meta-analysis seems to have annoyed the small cabal of academics who still defend lockdowns.

Among the comments were those of the University of Oxford's Seth Flaxman, a major figure in this realm, who is trained not in biological science or medicine but in computer science, with a specialization in machine learning. And yet it has been his work that has most often been cited in defense of the idea that lockdowns achieved some good.

In opposition to the JHU study, Flaxman wrote: "Smoking causes cancer, the earth is round, and ordering people to stay at home (the correct definition of lockdown) decreases disease transmission. None of this is controversial among scientists. A study purporting to prove the opposite is almost certain to be fundamentally flawed."

See how this rhetoric works? If you question his claim, you are not a scientist; you are denying the science! To say that this isn't controversial is ridiculous since such policies had never before been attempted on this scale. Such a policy isn't at all like an established causal claim (smoking increases cancer risk) nor a mere empirical observation (the earth is round). It's subject to verification.

Created a Catastrophe

It isn't possible to order everyone to stay home, not even for a day or two. The groceries must get to the store or be delivered to homes and apartments. People must staff the hospitals. The electrical plants still need staff. Cops still must be on the beat. There is literally no option available to "shut down" society in real life versus in computer models.

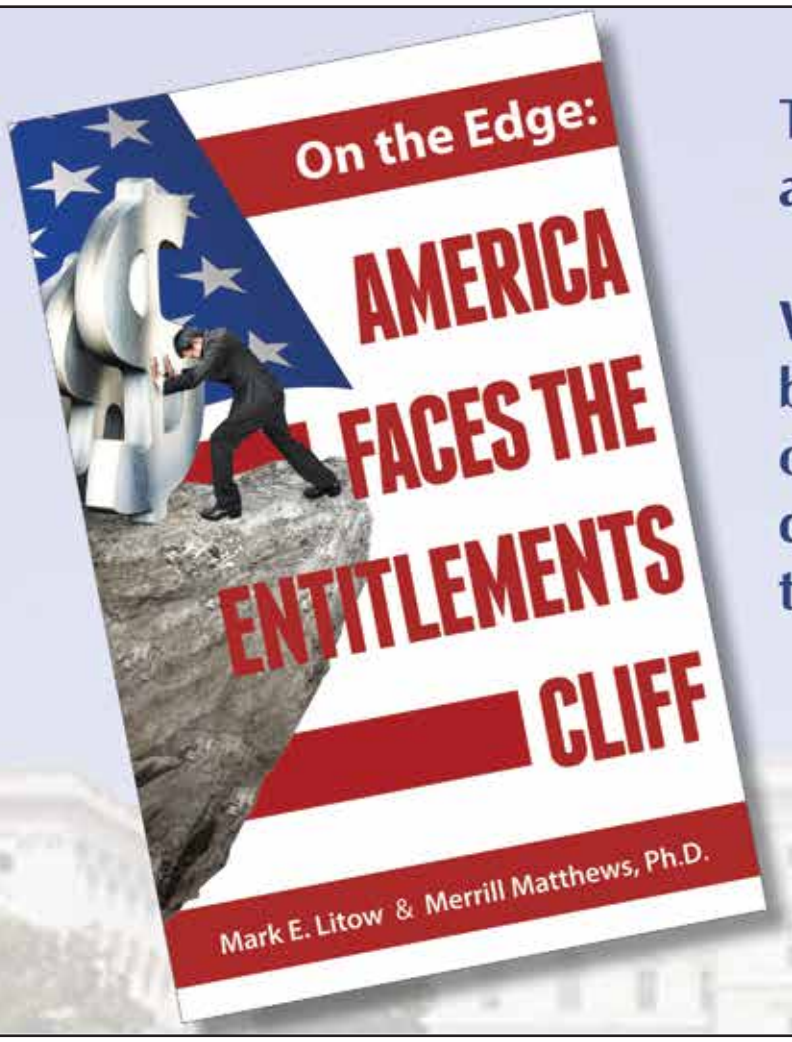
In the end, what is the point of the stay-home orders? For a widespread virus such as this one, everyone will eventually meet the virus anyway. Only once the winter wave of 2021 finally swept the Zoom class did we start to see a shift in media messaging that there is no shame in sickness and perhaps we need to start relaxing these restrictions.

The dogma that ordering people to stay home reduces the spread comes not from evidence but from Flaxman-style modeling plus a remarkable capacity to ignore reality.

Lockdown policies are easily marketed to political players who might get a power rush from the exercise. But, in the end, Henderson's prediction was correct: these interventions turned a manageable pandemic into a catastrophe.

It's a sure bet, however, that lockdown proponents will be in denial for at least another decade.

Jeffrey A. Tucker (**jeffrey.a.tucker@gmail.com**) *is founder and president of the Brownstone Institute.* *A version of this article was published by* The Epoch Times *and the Brownstone Institute. Reprinted with permission.*



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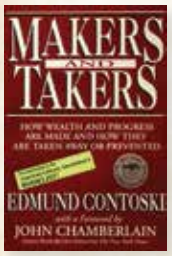

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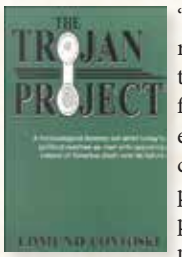

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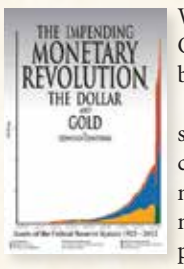

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