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HEALTH CARE NEWS

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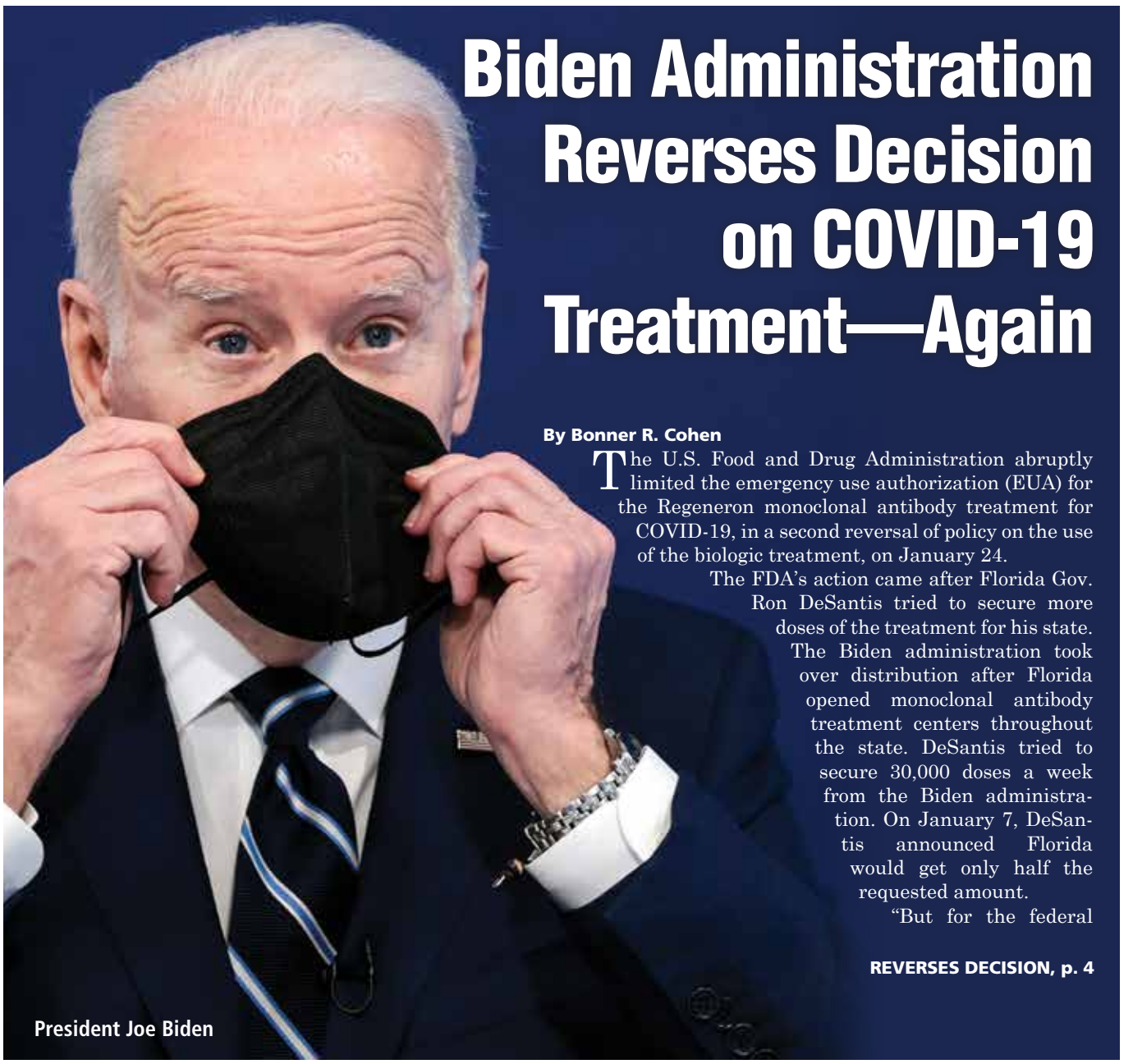

President Joe Biden

PHOTO COURTESY ANNA MONEYMAKER/STAFF/GETTY IMAGES NEWS

Biden Administration Reverses Decision on COVID-19 Treatment—Again

By Bonner R. Cohen

The U.S. Food and Drug Administration abruptly limited the emergency use authorization (EUA) for the Regeneron monoclonal antibody treatment for COVID-19, in a second reversal of policy on the use of the biologic treatment, on January 24.

The FDA's action came after Florida Gov. Ron DeSantis tried to secure more doses of the treatment for his state. The Biden administration took over distribution after Florida opened monoclonal antibody treatment centers throughout the state. DeSantis tried to secure 30,000 doses a week from the Biden administration. On January 7, DeSantis announced Florida would get only half the requested amount.

"But for the federal

REVERSES DECISION, p. 4

Lockdowns Had Near-Zero Impact on COVID-19 Deaths

By AnneMarie Schieber

A study published by the Johns Hopkins Institute for Applied Economics found a variety of restrictions to stop deaths from COVID-19 had little to no effect and instead caused more damage by imposing "enormous economic and social costs."

Economists Jonas Herby, Lars Jonung, and Steve H. Hanke, a policy advisor to *Health Care News* co-publisher The Heartland Institute, per-

LOCKDOWNS, p. 6

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Biden Administration Challenges Health Workers' Religious Freedom

By Harry Painter

The U.S. Department of Health and Human Services (HHS) has undone religious liberty protections put in place by the Trump administration.

The HHS Office for Civil Rights (OCR) under President Donald Trump authorized faith-based waivers for health care workers under the First Amendment and the Religious Freedom Restoration Act (RFRA), a law enacted during the Clinton administration that strengthened religious liberty protections against federal infringements. Under President Joe Biden, HHS Secretary Xavier Becerra revoked the OCR's authority to enforce such exemptions and to ensure compliance with RFRA.

Faith-based organizations affected by Becerra's action include foster care agencies that have declined to work with same-sex couples. In a press release announcing the move, HHS stated it was overturning "inappropriate and unnecessary" waivers issued to Michigan, South Carolina, and Texas and said its action was intended to "prevent discrimination and strengthen civil rights."

The HHS action applies to groups that receive funding from the federal government.

HHS Secretary Xavier Becerra

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"[W]e are witnessing the emergence of a government largely run by unelected officials who see themselves as rulers, not public servants."

MARK B. BLOCHER
PRESIDENT AND CEO
CHRISTIAN HEALTHCARE CENTERS

Protection Flip-Flop

During his confirmation hearing, Becerra promised to protect religious liberty. His policy direction since then has been criticized by religious liberty advocates, including Roger Severino, OCR director in the Trump administration and now a senior fellow of the Ethics and Public Policy Center, who accused Becerra of breaking his pledge.

The OCR under Severino twice found California was in violation of federal conscience laws when Becerra was attorney general there. During his time in that position, Becerra sued the Little Sisters of the Poor, a religious order of nuns that runs homes for the elderly, for failure to comply with the Obamacare contraception mandate.

"Since day one, the Biden-Becerra HHS has been systematically rolling back health care conscience and religious freedom protections and refusing to enforce the law," Rachel N. Morrison, an HHS accountability fellow at the Ethics and Public Policy Center, told *Health Care News*.

"In the last year, Becerra undermined HHS's Conscience and Religious Freedom Division, 'redetermined' multiple violations of federal conscience laws, revoked several states' religious exemptions, and removed the authority of the expert career professionals in OCR to enforce RFRA," Morrison said. "Becerra claims HHS will enforce laws protecting conscience and religious freedom, but actions speak louder than words."

'Cannot Be Taken Lightly'

The consequences of infringing on religious liberty have already become apparent, says Mark B. Blocher, president and CEO of Christian Healthcare Centers.

"People are already being forced to quit, and this has created its own set of adverse consequences for individuals and the organizations that imposed the HHS rules on them," Blocher said.

Blocher says there will be legal challenges to the HHS policy.

"Religious freedom is not a right that can be taken lightly," Blocher said.

Although religious liberty advocates are often thought of as Christian conservatives, the issue affects everyone, says Blocher.

"The free exercise clause of the First Amendment does not privilege Christians over other religions," said Blocher. "It applies to all faiths and is intended to protect the liberty of religious individuals by placing a high burden on the state when it believes it has a compelling reason to do so."

'Founders Warned Us'

The loss of the religious freedom enshrined in the First Amendment is a consequence of "big government that has lost its mission to 'serve' the public, to govern by consent of the governed," said Blocher.

"Rather, we are witnessing the emergence of a government largely run by unelected officials who see themselves as rulers, not public servants," said Blocher. "This is the government our Founders warned us about."

The government we have today is dangerous and out of control, says Blocher.

"When a government can impose mandates, rules, etc., that strip citizens of their basic civil rights, their right to work in a profession for which they have been trained, and can unilaterally suspend explicit rights found in the Bill of Rights and Constitution as we have seen with COVID-19, that government is itself a threat to the free market and a threat to freedom itself," said Blocher.

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

Biden Administration Reverses Decision on COVID-19 Treatment—Again

President Joe Biden

PHOTO COURTESY ANNA MONEYMAKER/STAFF/GETTY IMAGES NEWS

Continued from page 1

government's decision to restrict the supply of monoclonal antibody treatments to Florida, my administration would have already opened additional monoclonal antibody treatment sites throughout the state," said DeSantis in his January 7 statement. "Before the Biden administration seized control of the monoclonal supply after Florida pioneered its widespread use and demonstrated its efficacy, approximately 30,000 doses per week were being administered to Floridians, saving countless lives."

There are four antibody treatments for COVID-19. The FDA no longer authorizes emergency use for three of them: the one made by Regeneron known as casirivimab or imdevimab, and the two made by Eli Lilly, bamlanivimab and etesevimab, which are administered together. Sotrovimab, made by GlaxoSmithKline, is a laboratory-made monoclonal antibody treatment and is still available for treatment.

Treatment Centers Closed

At the request of DeSantis and other officials, in early January the U.S. Department of Health and Human Services (HHS) reversed its earlier policy and began preparations to send 30,000 more doses of Regeneron to Florida.

The FDA then switched course again and pulled its EUA for Regeneron and a monoclonal antibody from Eli Lilly without advance notice, putting Florida's plans to use the treatments for COVID-19 patients on hold indefinitely.

"Unfortunately, as a result of this abrupt decision by the federal government, all monoclonal antibody state sites will be closed until further notice," the Florida Department of Health stated on January 24. "Florida disagrees with this decision that blocks access to any available treatments in the absence of clinical evidence. To date, such clinical evidence has not been provided by the United States Food and Drug Administration."

"I just think they don't have enough treatments to go around, and I think they realize that," said DeSantis at a January 25 press conference. "And I think it would look very bad to be able to admit that, so instead they're saying this is revoked."

Takeover Spreading

The government's handling of Regeneron is typical of what can happen when the health bureaucracy gets between the doctor and the patient, says Marilyn M. Singleton, M.D., J.D., former president of the Association of American Physicians and Surgeons.

"Unfortunately, the government's takeover of Regeneron's product set the precedent for the government to do likewise with GlaxoSmithKline's monoclonal antibody preparation, Sotrovimab," said Singleton. "Unlike the EUA for the mRNA vaccines, U.S. government control over the distribution of Sotrovimab is a condition of the authorization."

This can cause a big problem because of the rise of Omicron, says Singleton.

"Sotrovimab appears to be the only monoclonal antibody preparation that is effective against the more dominant Omicron variant," said Singleton. "According to CDC estimates, Omicron makes up 99 percent of new COVID-19 cases.

"Having the federal government take charge of supplies of medications is a larger issue than COVID-19," said Singleton. "This further widens the already-opened door to the federal government dictating medical care through treatment pre-authorizations, government drug formularies, and the like. Recall that when Medicare was passed in 1965, the law [42 U.S. Code § 1395] specifically prohibited the federal government from 'exercis[ing] any supervision or control over the practice of medicine or the manner in which medical services are provided.'"

Doctors Overruled

Governments should not outlaw potentially useful treatments, says Florida Surgeon General Joseph Lapado, M.D.

"In our field of medicine, when someone comes to you seeking a treatment that could save their life, it is essential to have treatment options to ensure health care providers can make the best decisions for their patients," said Lapado in a January 24 press release.

Doctors have to stand up for their rights, says Singleton.

"Physicians must tell the federal government to keep its promise," said Singleton. "Make the drugs available for direct purchase by the states."

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

"I just think they don't have enough treatments to go around, and I think they realize that. And I think it would look very bad to be able to admit that, so instead they're saying this is revoked."

RON DESANTIS
GOVERNOR OF FLORIDA

Monoclonal Antibodies Save Woman with COVID-19, End-Stage Lung Disease

By AnneMarie Schieber

An 88-year-old woman on oxygen with advanced-stage chronic obstructive pulmonary disease (COPD) recovered so rapidly and robustly from COVID-19 that within days of being treated with monoclonal antibodies she became the caregiver for her family when they got sick.

"She was running around the house trying to cook and help us," said Dana Hale, an attorney from Virginia. "I know my story is anecdotal, but why wouldn't we make this antibody treatment more available so that doctors can use their own discretion to treat their patients?"

"Even if the effectiveness [of monoclonal antibodies] goes down from 80 percent to 20 percent, what other tools do we have? Why would we pull it? Why wouldn't we just make it available? It's nonsensical to me. It almost sounds to me—and honestly, I'm not a conspiracy theorist—but it sounds like a conspiracy."

DANA HALE
ATTORNEY

Boosted but Sick

Hale and her husband were caring for her mother in their home when one of their adult children came to visit in November after travels where the individual probably picked up the virus and was still contagious weeks after mild symptoms.

Hale's mother was vaccinated and received one booster shot, but within days of the visit she rapidly became debilitated with fever and diarrhea.

"We were hopeful because she had the vaccine, but she was really, really sick," said Hale. "She was shaking and couldn't walk."

Navigated Treatment

Hale opted to take her mother to an urgent care center, where she was told her mother was a candidate for the monoclonal antibody treatments. The center told her to call the local hospital to sign up for the outpatient treatment.

"I had to really navigate that myself, calling the hospital, getting rerouted to other people," said Hale. "Some of the people at the hospital didn't even know what the treatment was. Eventually, I reached someone who seemed to be the only, single point of contact for this, and I managed to get her in the next day."

The treatment lasted 30 minutes.

"Two days later, she made what seemed like an instant recovery," said Hale. "It was amazing."

Made It Just in Time

Soon after, Hale and her husband got sick with COVID-19, probably the Delta variant, and Hale was hospitalized for five days. Both recovered.

On January 24, the U.S. Food and Drug Administration announced it was pulling the emergency authorization of two COVID-19 monoclonal antibody treatments, one from Regeneron and one from Eli Lilly, "because data show these treatments are highly unlikely to be active against the Omicron variant, which is circulating at a very high frequency throughout the United States."

Hale says she doesn't understand why the government would ban the treatment after the positive results she saw firsthand.

"Even if the effectiveness [of monoclonal antibodies] goes down from 80 percent to 20 percent, what other tools do we have?" said Hale. "Why would we pull it? Why wouldn't we just make it available?

"It's nonsensical to me," said Hale. "It almost sounds to me—and honestly, I'm not a conspiracy theorist—but it sounds like a conspiracy."

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

Obstacles Expected as U.S. Gov Distributes Free Rapid Tests

With the nation apparently past the most dangerous variants of the COVID-19 virus, the federal government is making available up to four rapid antigen at-home COVID-19 tests for every U.S. household at no direct cost.

Households can get access to the tests through the mail, at a local pharmacy, or at one of at least 20,000 free testing sites, states the COVIDtests.gov website. The Biden administration has ordered private insurers and group health plans to cover up to 32 rapid tests each month for a family of four. Government insurance programs such as Medicare and Medicaid are exempt from the order.

President Joe Biden has promised to make up to one billion tests available for distribution. Congress has set aside $53 billion for COVID-19 testing, of which $29 billion is unspent so far.

'Parallel Distribution Chain'

The rollout's success and its impact on stopping the coronavirus are not exactly clear, says Doug Badger, a senior fellow at the Galen Institute and The Heritage Foundation (see related article, page 19).

"We have insurance mandates and the U.S. mail—what could go wrong?" said Badger.

One concern is what effect the government's stockpiling of the tests will have on the supply chain, says Badger.

"If the government plans to mail out one billion tests, what does that do to the supply at your local Walgreens?" said Badger. "Already, the tests are in short supply. I don't think this parallel distribution chain is going to be the best way to do it."

Demand Could Outstrip Supply

Additionally, some 200 million people receive health insurance through private plans, meaning they could request up to 6.4 billion tests per month, says Badger.

"Obviously, if everyone were to use this benefit, you would never be able to get any of these tests," said Badger.

Private insurance enrollees will buy the test and request reimbursement from their insurers. Some insurers may have arrangements with certain drug stores. In any case, reimbursements will be limited to $12 a test, and if a shortage occurs, tests could cost enrollees far more out of pocket, as with any product in short supply.

—Staff reports

REPORT

Lockdowns Had Near-Zero Impact on COVID-19 Deaths

Continued from page 1

formed a meta-analysis reviewing the empirical evidence on the effectiveness of lockdown measures. The researchers defined a lockdown as a government mandate restricting activity, such as travel bans, school and public facility closures, face mask requirements, and limits on crowds.

Using a "systematic search and screening" process, the authors sifted through 18,590 studies that could "support the belief that 'lockdowns reduce COVID-19 mortality.'" The team selected 24 studies and put them in three topical groups: lockdown stringency indices, shelter-in-place orders, and specific nonpharmaceutical interventions.

"An analysis of each of these three groups supports the conclusion that lockdowns have had little to no effect on COVID-19 mortality," write the authors.

The analysis determined strict lockdowns in Europe and the United States reduced mortality by a mere 0.2 percent compared to similar virus control measures that were recommended but not mandated.

"Lockdown policies are ill-founded and should be rejected as a pandemic policy instrument," concludes the report.

Other Measures Not Much Better

Shelter-in-place orders were not much more effective than compulsory nonpharmaceutical interventions, reducing mortality by 2.9 percent. Closing nonessential businesses reduced COVID-19 deaths by 10.6 percent, but the effect was likely due to the closure of bars. Border closures had a 0.1 percent impact, school closures a negative 4.4 percent effect, and limiting gatherings reduced deaths by 1.6 percent. The authors state there wasn't enough evidence to examine the impact of universal mask mandates.

One reason lockdown measures are fairly useless is the natural behavioral response of people when faced with risk, state the authors.

"[P]eople respond to dangers outside their door," the researchers write. "When a pandemic rages, people believe in social distancing regardless of what the government mandates."

The authors also note the limitations of enforcement.

"[M]andates only regulate a fraction of our potential contagious contacts and can hardly regulate nor enforce handwashing, coughing etiquette, distancing in supermarkets, etc.," the authors write.

Didn't 'Follow the Science'

The Johns Hopkins research is consistent with other reports, says Jeffrey Tucker, founder and president of the Brownstone Institute.

"This meta-analysis is very compelling and only the latest of perhaps 150 or [so] studies of particular cases that have shown no relationship between restrictions and virus outcomes," said Tucker. "This has been the persistent result of every quality study for some 20 months now, and true in every country. It's remarkable how a series of unprecedented policies enacted in the name of science could so thoroughly fail to pass a scientific examination of their efficacy.

"When these studies started coming out in late spring 2020, I had assumed that governments would follow the science," said Tucker. "Instead, they adhered to their failed paradigm, with enormous social, cultural, economic, and public health costs."

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

INTERNET INFO

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STUDY

Natural Immunity Is Stronger than Immunity from COVID-19 Shots

By AnneMarie Schieber

After months of denial, the Centers for Disease Control and Prevention (CDC) published a report showing that, compared to getting the experimental vaccine shots, natural immunity to COVID-19 is 2.8 times as effective in keeping people out of the hospital and 3.3 percent to 4.7 percent more effective in preventing reinfection.

The study, "COVID-19 Cases and Hospitalizations by COVID-19 Vaccination Status and Previous COVID-19 Diagnosis—California and New York, May-November 2021," was published in the CDC's *Morbidity and Mortality Weekly Report* on January 19.

The analysis proves what many suspected throughout the pandemic, says Joel Hirschhorn, author of *Pandemic Blunder* and editor of the *Pandemic Blunder Newsletter*.

"The refusal by U.S. government public health agencies to formally give credit to people with natural immunity obtained from prior COVID infection made no sense," said Hirschhorn.

"The only apparent motivation was to *not* give those people a way out of getting experimental COVID vaccines and to *not* give them a way out of obeying all kinds of mandates," said Hirschhorn. "It has nothing to do with 'following the science.'"

Shots 'Safest Strategy'

The study's authors looked at COVID-19 cases in California and New York, two states with high mortality rates from COVID, where one in six COVID-19 deaths in the United States occurred. The researchers found vaccination was less effective than natural immunity in preventing reinfection with the virus.

Despite the findings, the authors say it is important for people to get the shots.

"Although the epidemiology of COVID-19 might change as new variants emerge, vaccination remains the safest strategy for averting future SARS-CoV-2 infections, hospitalizations, long-term sequalae, and death," states the report.

'Hybrid Immunity' Slightly Better

The study authors spins the results to push the agency's persistent narrative, says Marty Makary, M.D., a surgeon at the Johns Hopkins University School of Medicine, professor, and public policy researcher, in a commentary in *The Wall Street Journal* on January 26.

"It based this conclusion on the finding that hybrid immunity—the combination of prior infection and vaccination—was associated with a slightly lower risk of testing positive for COVID," wrote Makary.

"But those with hybrid immunity had a similar low rate of hospitalization (3 per 10,000) to those with natural immunity alone," wrote Makary. "In other words, vaccinating people who had already had COVID didn't significantly reduce the risk of hospitalization."

Natural immunity is superior, says Hirschhorn.

"The science has always been crystal-clear: natural immunity is more effective, longer-lasting, and safer than vaccine immunity," said Hirschhorn.

Natural Immunity Persists

A new report by Johns Hopkins researchers published in the *Journal of the American Medical Association* on February 3 found natural immunity persists over time, writes Hirschhorn in his newsletter on Substack.

"The results are spectacular," wrote Hirschhorn.

"It shows that people with natural immunity have the same level of antibodies no matter when they were infected," wrote Hirschhorn. "The study proves that people who have recovered from Covid have far better protection from future infection than vaccinated people."

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

COVID-19 Not Primary Cause of Death in 75 Percent of Cases, CDC Director Admits

By Kenneth Artz

Most vaccinated people no longer need fear imminent death from COVID-19 or its variants, says Dr. Rochelle Walensky, head of the Centers for Disease Control and Prevention (CDC).

Remarking on a CDC study showing vaccines targeting COVID-19 and its variants have successfully prevented serious illness, Walensky said most deaths from COVID in vaccinated people occurred in individuals diagnosed with several other conditions or diseases, during an appearance on ABC's *Good Morning America* on January 7.

"The overwhelming number of deaths, over 75 percent, occurred in people who had at least four comorbidities," said Walensky. "So, really, these are people who were unwell to begin with. And yes, really encouraging news in the context of Omicron. This means not only just to get your primary series but to get your booster series. And yes, we're really encouraged by these results."

The CDC study found among 1,228,664 people who completed primary vaccinations during the period from December 2020 to October 2021, severe COVID-19-associated outcomes (0.015 percent) and deaths (0.0033 percent) were rare.

Risk factors for severe outcomes identified in the study included being 65 years or older, immunosuppressed, and having one or more of six other underlying conditions. All people with severe outcomes had at least one risk factor, and 78 percent of those who died had at least four.

Dr. Rochelle Walensky
Director, CDC

PHOTO COURTESY CDC.GOV

"The overwhelming number of deaths, over 75 percent, occurred in people who had at least four comorbidities. So, really, these are people who were unwell to begin with. And yes, really encouraging news in the context of Omicron. This means not only just to get your primary series but to get your booster series. And yes, we're really encouraged by these results."

DR. ROCHELLE WALENSKY
DIRECTOR
CENTERS FOR DISEASE CONTROL AND PREVENTION

'Commissar of Health'

Mission creep has diminished the value of the CDC, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute, a think tank in Denver, Colorado.

"The only reason to have a CDC is to help individuals assess their risk of disease and to present accurate information about the steps that can be taken to modify the risk of bad outcomes if individuals think it makes sense to do so," said Gorman.

"Unfortunately, the CDC long ago redefined its mission," said Gorman. "It now acts as a Commissar of Health, claiming unlimited power to make individuals conform to whatever it defines as healthy behavior for the entire U.S. population. It defines behaviors that will reduce suicide, obesity, firearms violence, general violence, adolescent and school [ill] health, smoking, perinatal care, [poor] reproductive health—both U.S. and global, and only for women—depression, 'disparities,' dental problems, drinking, [harmful] sexual behavior, [poor] childrearing, and lack of sleep.

"These are not diseases, and the CDC's solutions mostly involve spending a lot of money on programs that deny human agency, rearrange the same public health nostrums that have already failed, and waste a lot of effort," said Gorman.

Confounding Causes of Death

There are problems in reporting the cause of death of patients who tested positive for COVID-19, says Erwin Hass, M.D., M.B.A, an infectious disease expert and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"The legal/medical cause of death on a death certificate is usually the last event that entrained the final chain of events that led to death," said Haas. "I found another formulation: the most important, immediate, direct or actual cause, or last event or act that occurred before the chain of events leading to death. As such, the folks with four comorbidities who develop COVID-19 clinically and die after a few weeks [are said to have] died of COVID-19, not of their obesity or lung diseases.

"There is a confounding problem when everyone who comes to a hospital is cultured, has false positives or actually truly positive tests but no real symptoms, but die from their underlying auto accident or from a complication of one of the infirmities of old age, but who arguably develop a few symptoms that could be ascribed to COVID-19 and are labeled as dying from the virus—especially when there might be a $35,000 bonus for that diagnosis," said Haas, referring to extraordinary government reimbursements implemented during the pandemic.

Leader of a Pack

In dealing with COVID-19, authorities have misled the public, says John Dale Dunn, M.D., J.D., a physician whose background is in emergency medicine.

"Tony Fauci, M.D., director of the National Institute of Allergy and Infectious Diseases (NIAID), was and is the lead 'noble' liar, but he had help from the WHO [World Health Organization], pharma[ceutical companies], and, of course, the complicit health care industry poohbahs in and out of government," said Dunn.

"The most devastating blow Fauci struck was his successful effort to censor physicians advocating early treatment, to include condemnation of ivermectin and hydroxychloroquine, combined with his push for unprecedented and ineffective, harmful masking, social distancing, lockdown, and school closing mitigations, all the while ignoring the importance of special precautions for the at-risk and the absolutely low risk for the healthy and children," said Dunn.

Pharma Benefactor?

Fauci has a history of suppressing inexpensive cures and promoting treatments under patent to drug companies, says Dunn.

"Fauci is and has been a shill for vaccine makers and has a history of bad medical science and policymaking dating back to the 1980s HIV/AIDS matter," said Dunn. "I know; I have been watching him for more than 30 years.

"Tony Fauci is a megalomaniac, authoritarian dissembler who has blood, particularly the blood of the old and vulnerable, on his hands," Dunn said.

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

INTERNET INFO

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Judge Orders FDA to Speed Up Release of Vaccine Data

By Kevin Stone

The U.S. Food and Drug Administration (FDA) must disclose 55,000 pages each month of the documents it relied on to license the Pfizer COVID-19 vaccine, beginning March 1.

U.S. District Judge Mark Pittman of the Northern District of Texas ordered the FDA to produce 12,000 pages by the end of January and the rest of the 450,000 pages of documents within months, instead of the 500 pages per month the FDA requested—which could have taken 75 years to complete—on January 6.

The nonprofit Public Health and Medical Professionals for Transparency filed the Freedom of Information Act (FOIA) lawsuit on September 16.

In his ruling, Pittman wrote, "this FOIA request is of paramount public importance."

Pittman cited the decision in *Payne Enterprises, Inc. v. United States*, in which a three-judge panel of the D.C. Circuit Court of Appeals ruled "stale information is of little value."

"The Court, agreeing with this truism, therefore concludes that the expeditious completion of Plaintiff's request is not only practicable, but necessary," wrote Pittman.

"No person should ever be coerced to engage in an unwanted medical procedure. And while it is bad enough the government violated this basic liberty right by mandating the COVID-19 vaccine, the government also wanted to hide the data by waiting to fully produce what it relied upon to license this product until almost every American alive today is dead. That form of governance is destructive to liberty and antithetical to the openness required in a democratic society."

ADAM SIRI
MANAGING PARTNER, SIRI & GLIMSTAD LLP

'Access to the Data'

Pittman's ruling comports with standards of transparency and accountability, says Adam Siri, managing partner of Siri & Glimstad LLP, who represented Public Health and Medical Professionals for Transparency in the case.

"We are very pleased with the decision, which came down on the side of transparency and accountability," said Siri.

"Americans are mandated to receive this product and cannot sue Pfizer for harm it may cause, so we are pleased that at least the public and independent scientists will have access to the data underlying its licensure," said Siri. "This is a great win for transparency and removes one of the strangleholds federal health authorities have had on the data needed for independent scientists to offer solutions and address serious issues with the current vaccine program."

'Experiment on an Unsuspecting Public'

The FDA issued an emergency use authorization (EUA) for the Pfizer vaccine in 2020 and formally approved the shots on August 23, 2021, in a process that was truncated, says Elizabeth Lee Vliet, M.D., president and CEO of the Truth for Health Foundation.

"Never in the history of the FDA has a brand-new technology for a novel medical intervention been approved with only three months of safety data when known long-term risks of this technology have been reported for more than a decade in the pharmaceutical research," said Vliet.

Vaccine approval usually requires years of clinical trials, says Vliet.

"Traditional vaccines, which the COVID shots are not, have always had a minimum two years' safety data and up to seven years' safety testing before release," said Vliet. "In addition, the mRNA- and DNA-based experimental shots for COVID are correctly classified under FDA regulations as 'gene therapy agents,' [for] which FDA regulations require five to 15 years [of] ongoing safety trials."

"This unconscionable rapid approval has unleashed a vast human experiment on an unsuspecting public," Vliet said. "Practicing physicians are seeing major complications and deaths in patients of all age groups as a result of these premature approvals."

'Violated This Basic Liberty'

COVID-19 vaccine mandates violate individual rights, says Siri. In addition, the FDA's attempt to withhold the data on which it based its approval denies the full disclosure necessary for informed consent, says Siri.

"No person should ever be coerced to engage in an unwanted medical procedure," Siri said. "And while it is bad enough the government violated this basic liberty right by mandating the COVID-19 vaccine, the government also wanted to hide the data by waiting to fully produce what it relied upon to license this product until almost every American alive today is dead. That form of governance is destructive to liberty and antithetical to the openness required in a democratic society."

Troubling FDA Appointment

President Joe Biden nominated Robert Califf, who previously held the post in the Obama administration, as commissioner of the FDA in November.

Califf's appointment was approved by the Senate Committee on Health, Education, Labor, and Pensions on January 13, but he faces bipartisan opposition in the U.S. Senate.

Suspicions of collusion between the pharmaceutical industry and regulatory agencies to suppress alternative opinions on COVID have raised concerns about Califf's nomination, states Vliet in a press release.

"It is beyond alarming that private tech behemoths like Google, where Dr. Califf served as a senior executive at its Verily life sciences arm, are censoring the free flow of medical information from world-class academic physicians and scientists, as well as practicing physicians who have a legal and ethical duty to inform patients of risks of therapies they prescribe," said Vliet. "It is entirely another matter for government to actively violate First Amendment free speech guarantees in censoring discourse and dissent, the cornerstone of scientific inquiry."

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

INTERNET INFO

Judge Mark T. Pittman, *Public Health and Medical Professionals for Transparency v. Food and Drug Administration*, U.S. District Court for the Northern District of Texas, Fort Worth Division, order, January 6, 2022: **https://www.fdanews.com/ext/resources/files/2022/01-07-22-PittmanFOIAOrder.pdf?1641590012**

Likely Democrat Voters Favor Most-Draconian COVID-19 Policies

A poll by The Heartland Institute and Rasmussen Reports shows majorities of Democrats endorse some of the most heavy-handed policies against people who have chosen not to get COVID-19 shots (see figures to the right).

"The 'otherizing' of the un-vaxed by our government and bureaucrats has really settled into the minds of Democrats," said Jim Lakely, vice president of The Heartland Institute. "These are likely Democratic voters, not people selected to be more radical.

"It goes to show how radicalized the Democratic party has become," said Lakely. "Bernie and the Squad are no longer the outliers. Radical, hateful leftism is now the heart and soul of the party."

The poll, completed on January 5, surveyed 1,016 likely voters and has a plus/minus error rate of three percentage points and a 95 percent level of confidence.

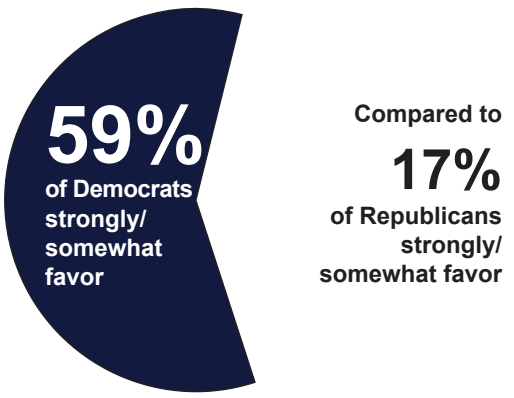
Lakely says the response to the poll has been like none other The Heartland Institute, which co-publishes *Health Care News*, has done.

"I think this poll has hit such a nerve because it verifies, with data, what regular Americans have experienced in their everyday lives over the past two years," said Lakely. "It was their left-leaning family members who insisted no visits unless you are vaccinated. It was their left-leaning friends who declined invitations to get together for fear of catching COVID. And it was the left-leaning media outlets that pumped up the volume of panic over COVID.

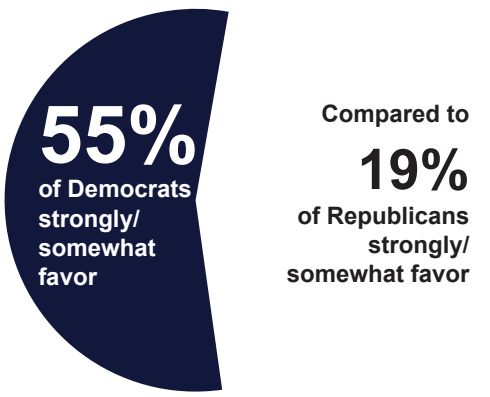
"The plural of anecdotes is not data, but this polling data proves their personal anecdotes were widely true across the population," said Lakely.

—*Staff reports*

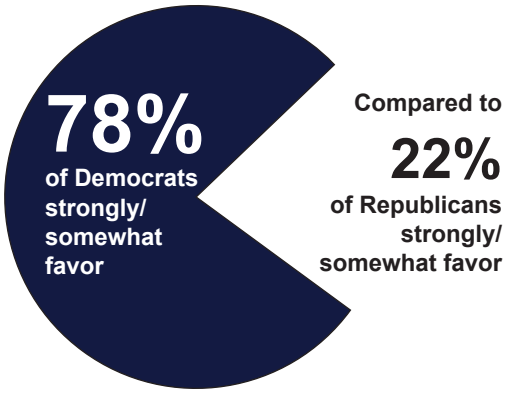
Federal/state government order to confine unvaccinated individuals to their homes to limit the coronavirus



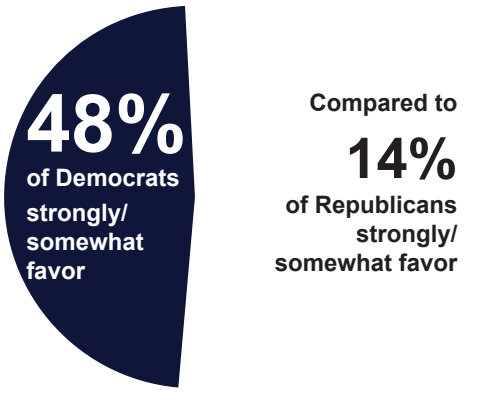
Fine Americans who choose not to get COVID-19 shots



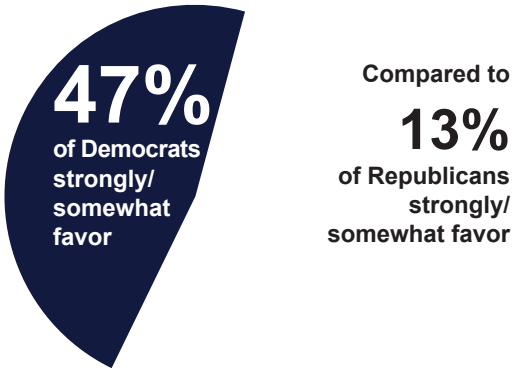
Require vaccine mandates for private businesses with 100 or more employees



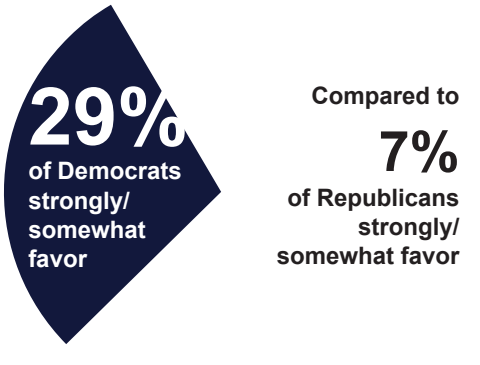
Fine or imprison individuals who publicly question the efficacy of COVID-19 shots



Track the unvaccinated to ensure they are quarantined or socially distant



Remove custody of children from parents who refuse COVID-19 shots



INTERNET INFO

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Despite Adverse Reactions, Government Pushes Booster Shots on Teenagers

By Ashley Bateman

Despite mounting evidence of dangerous side effects of COVID-19 boosters for younger populations, public institutions continue to implement mandates requiring multiple jabs.

The under-30 population has been particularly affected, with one study indicating seven times the normal rate of myocarditis in 16- to 24-year-old young men after their second dose of the Pfizer vaccine.

The increase in inflammation of the heart muscle among the vaccinated is unprecedented, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and an advisor to The Heartland Institute, which co-publishes *Health Care News*.

"Everyone who gets the vaccine incurs the risk of myocarditis," said Orient. "We were never seeing this many cases of myocarditis before the rollout of COVID-19 vaccines."

No Explanations

The U.S. Food and Drug Administration (FDA) and the Centers for Disease Control and Prevention (CDC) have promoted boosters for young people, with the FDA expanding emergency use authorization of the Pfizer shots for children as young as five.

Given the rise in myocarditis associated with the vaccines and the lower risks of COVID among the young, no one has explained why it is necessary to vaccinate them, says Paul Elias Alexander, Ph.D., an epidemiologist, former World Health Organization consultant, and senior advisor to the U.S. Department of Health and Human Services in 2020 for COVID-19 response.

"This is the data and science," said Alexander. "No public health official has yet made the case as to why these vaccines are needed in children and young people," said Alexander.

'Data Is Being Cherry-Picked'

Science is not currently driving most COVID policies, says Marty Makary, M.D., a professor at Johns Hopkins University, who testified before Congress in December and spoke out against the government's approach to the pandemic in a Wall Street Journal commentary published on December 21.

"Data is being cherry-picked to support predetermined agendas, while the roles of natural immunity and life-saving therapeutics are being sidelined," wrote Makary.

The push for boosters "came over the objections of the agencies' own experts," wrote Makary. "The last vote by FDA advisers, in September, rejected the proposal 16-2. FDA leaders revisited the proposal in November and simply bypassed the experts. So did the CDC, whose advisers had rejected boosters for people not at high risk," wrote Makary.

'A Massive Human Experiment'

Lack of data gathered after COVID vaccinations is preventing doctors from properly treating those who experience adverse reactions, says Orient.

"We have done no studies on the asymptomatic cases of myocarditis, and we aren't measuring cardiac enzymes or heart ultrasounds [after vaccinations]," said Orient. "In one case, myocarditis was discovered in a young woman after a vaccination—incidentally on an ultrasound machine—and was treated. How many people are going undiscovered and untreated and may go on to do some exertion when they should be resting for several months?"

Policymakers are ignoring the evidence, says Orient.

"It is incredible that we aren't taking a cold, hard look at these results," said Orient. "We have a massive human experiment, and we're not even collecting good data. We don't have any stopping point.

"It's completely unethical," said Orient. "It is reckless and irresponsible."

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

Was FDA Rationing Treatment by Race?

By Bonner R. Cohen

Encouraged by the Biden administration, several states and municipalities are adopting policies giving preference to nonwhite patients in receiving potentially lifesaving treatments for COVID-19, including scarce monoclonal antibody infusions.

Health officials, first in Minnesota and then in New York City and Utah, developed race-based ranking systems after a key federal agency issued guidance documents citing race and ethnicity as factors in allocating therapies.

The U.S. Food and Drug Administration (FDA) "fact sheet" for emergency use authorization (EUA) of GlaxoSmithKline's Sotrovimab, currently the only monoclonal antibody treatment effective against the Omicron variant, states "race or ethnicity" can "place individual patients at high risk for progression to severe COVID-19."

The document limits "authorized use" for a large group of patients but creates "race or ethnicity" as an exception.

Legal Challenges

Some of those that embraced racial formulas for dispensing coronavirus treatments are now facing serious legal challenges.

On January 17, Minnesota, which had specifically cited the FDA fact sheet language on race and ethnicity in determining eligibility for monoclonal antibodies, removed race as a preferential factor in receiving treatment. The move came after the state was threatened by a lawsuit from the America First Legal Foundation, which said Minnesota's policies violated several federal statutes.

Similarly, SSM Health, a Catholic hospital chain with 23 hospitals spread across Illinois, Missouri, Oklahoma, and Wisconsin, abandoned its race-based ranking system after the Wisconsin Institute for Law & Liberty threatened a lawsuit.

Determining Intent

Some medical conditions are more prevalent among certain minorities, and that deserves consideration, but it is unlikely this is what motivated the Biden administration's push for preferential treatment, says Merrill Matthews, Ph.D., a resident scholar at the Texas-based Institute for Policy Innovation.

"The FDA's statement highlights medical conditions that 'may place adults and pediatric patients … at higher risk for progression to severe COVID-19,' said Matthews. "Among those conditions is sickle cell disease, which primarily affects blacks. But some racial minorities also tend to have a higher incidence of obesity, diabetes, and hypertension, all of which are on the FDA list. If the FDA is saying that certain races and ethnicities are more likely to have those comorbidities and so should be given higher priority in receiving Sotrovimab, that may well represent appropriate medical rationing.

"But the Biden administration may not deserve a generous interpretation," said Matthews. "For example, Biden's American Rescue Plan included $4 billion in debt relief for 'farmers of color,' as a form of restitution for past discriminatory lending practices. The courts blocked that effort. If the FDA's underlying motive in its guidance is a form of restitution for what we might call 'patients of color,' then it not only violates the Constitution, it violates good medical practice."

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

"If the FDA's underlying motive in its guidance is a form of restitution for what we might call 'patients of color,' then it not only violates the Constitution, it violates good medical practice."

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

NJ Governor Lifts School Mask Order

By Kenneth Artz

Gov. Phil Murphy of New Jersey is lifting the mask mandate for students and staff in the state's schools and day care centers, effective March 7.

Murphy is also extending his executive order declaring a public health emergency for 30 days, to give the public time to adjust to the new policy, he stated in a February 7 briefing and press release from his office.

Local school officials and businesses may still implement their own mask mandates, Murphy stated.

"We are not removing the ability of individual district leaders to maintain and enforce such a policy," said Murphy. "We will not tolerate anyone being put down by exercising their choice to mask up."

Murphy's announcement came weeks after he reinstated a 30-day public health emergency starting January 11 in response to escalating cases of the Omicron variant. On January 10, Murphy stated mask requirements for students and staff would continue "for the foreseeable future." The statement caught members of Murphy's own party by surprise and was severely criticized by Republicans.

Legislation Introduced, Lapsed

Republican lawmakers in the state have expressed deep concerns about the aggregation of power by Murphy through emergency authority, says Adrienne Zimmermann, director of constituent services for New Jersey state Assemblyman Brian Bergen (R-Denville).

Bergen introduced Assembly Bill 4147, which would limit the governor's executive order power to two weeks, after which any such order would require a vote by the legislature, on May 5, 2020.

"He recognized that Gov. Murphy was abusing the power of executive orders," Zimmermann said. "It was obvious that unless the Assembly and Senate took back the power granted by the New Jersey Constitution, Gov. Murphy would not give it back."

Bergen's bill had 22 cosponsors in the Assembly, and the Senate version of the bill was sponsored by every Republican senator, says Zimmermann.

A new legislative session began on January 12. Bergen's bill had not been reintroduced as of press time.

Governors 'Can't Let Go'

Acting unilaterally against the pandemic is not a good look for Murphy, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"Gov. Murphy has obviously not learned from the many Democratic Party governors across the country who regret not including their legislatures in the pandemic response," said Dean.

"The lure of autonomy is almost irresistible for many governors, who can't let go of emergency powers, but the cold splash of electoral accountability is strong enough to snap them back into their senses," said Dean.

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

Doctors Face Disciplinary Action for COVID-19 Treatments

By Bonner R. Cohen

Physicians prescribing ivermectin and other off-label treatments to patients with COVID-19 are under investigation and facing disciplinary action in several states, including Arkansas, Minnesota, and Virginia.

The U.S. Food and Drug Administration, since March 2021, and the Centers for Disease Control and Prevention, since August 2021, have warned against the use of the anti-parasitic drug ivermectin in treating patients for COVID-19. This led hospitals and other health care systems to ban ivermectin for use in COVID-19 patients. Doctors who persist in prescribing ivermectin face serious repercussions.

"Doctors know more about the needs of their patients than bureaucrats ever will, but that accounts for little when the government runs the show. The media often has lent a helping hand in demonizing contrarian voices. An open and informed exchange of medical views is not something we want to suppress. Yet this is exactly what has happened under COVID. This is the same pattern we have seen in the debate over climate change. Those who question the reigning orthodoxy are branded 'climate deniers.' Ike was right."

CRAIG RUCKER
PRESIDENT, COMMITTEE FOR A CONSTRUCTIVE TOMORROW

Physicians Under Fire

Physicians have been penalized in a variety of ways for treating COVID-19 patients with ivermectin.

Paul Marik, M.D., who served as professor of medicine and chief pulmonary and critical care medicine at Eastern Virginia Medical School (EVMS), was suspended from his privileges at Sentara Norfolk General Hospital for 14 days in December for advocating use of ivermectin to treat COVID-19. On January 4, Marik resigned his position at EVMS to devote more attention to the Front-Line Critical Care Alliance, a group he helped found.

The Arkansas Medical Board in August launched an investigation of Robert Karas, M.D., who provides services to the Madison County Jail, after it was revealed he had prescribed ivermectin to 531 high-risk inmates over 40. Karas is being sued by four of the inmates he treated.

Scott Jensen, M.D. is undergoing his fifth investigation by the Minnesota Board of Medical Practice, which is seeking the medical records of the patients to whom he has prescribed ivermectin.

One state is providing legal protection to doctors whose treatment of COVID-19 patients strays from federal guidance. In October, Nebraska Attorney General Doug Peterson issued a legal opinion saying his office will not seek disciplinary action against physicians who prescribe ivermectin or hydroxychloroquine as off-label medicines to treat or prevent COVID-19 if they are not engaging in any misconduct.

'One of the Safest Drugs in History'

The government's hostility to ivermectin is astounding, says Jane Orient, M.D., executive director of the American Association of Physicians and Surgeons and a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"It is shocking to see physicians threatened for prescribing one of the safest drugs in history, available over the counter in many countries, which has been used by hundreds of millions of people and saved millions of lives," said Orient.

"Although its primary use has been as an antiparasitic, it also has antiviral properties plus other mechanisms of action that likely benefit COVID patients at later stages of the disease," said Orient. "Like all drugs, it has potential side effects, particularly in overdose. But unlike with Tylenol and other common drugs that generate thousands of calls to poison control centers, every single call about ivermectin probably generated a news article even if the patient was unharmed, as in most cases."

Crony Medicine?

What has happened with ivermectin, with its potential benefit and record of safety, raises suspicion about the conduct of government health agencies, says Orient.

"Is it because much more expensive drugs—Pfizer's Paxlovid and Merck's molnupiravir—are becoming available?" asked Orient. "And because [ivermectin] might be preferred to the extremely profitable genetically engineered vaccines or might have kept them from getting an emergency use authorization (EUA)?"

Under the Federal Food, Drug, and Cosmetic Act, an EUA can be issued for a new drug or treatment when "there are no adequate, approved, and available alternatives." Ivermectin could have stood in the way of an EUA.

"How can anyone justify paying hospitals $7,000 to give remdesivir, or bullying patients into taking it, when there is scant evidence of benefit and very serious adverse effects, especially renal failure?" said Orient. "Medical ethics are being turned on their head."

Concerns About Speech Rights

Because many physicians have not only prescribed ivermectin but have also spoken out in favor of its use, the effort to discipline them raises serious issues about freedom of speech, says Craig Rucker, president of the Committee for a Constructive Tomorrow.

"In his Farewell Address in January 1961, President Dwight Eisenhower warned of the dangers of giving the government too much power in determining science policy," said Rucker. "Once government officials had adopted certain views on science policy and disbursed research funds accordingly, the federal bureaucracy had a stake in those policies, irrespective of their merit. Dissenting opinions were not welcome and were liable to be suppressed."

This has been the case with COVID-19, says Rucker.

"Vaccines and boosters are preferred to readily available, and often cheaper, treatments," said Rucker. "Doctors know more about the needs of their patients than bureaucrats ever will, but that accounts for little when the government runs the show.

"The media often has lent a helping hand in demonizing contrarian voices," said Rucker. "An open and informed exchange of medical views is not something we want to suppress. Yet this is exactly what has happened under COVID. This is the same pattern we have seen in the debate over climate change. Those who question the reigning orthodoxy are branded 'climate deniers.' Ike was right."

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

Med School Goes Full Woke

By Kevin Stone

A top-ranked medical school has gone "full woke" with revised guidelines for appointment, reappointment, and promotion of faculty that include diversity, equity, and inclusion (DEI) training and making a "positive contribution to DEI efforts."

The University of North Carolina (UNC) at Chapel Hill School of Medicine policy change, in effect since May 2021, means the staff has to accept subjective indoctrination in DEI and materially demonstrate acceptance of that doctrine through active participation in promoting it, such as through materials provided to students.

Proof of Indoctrination

The university provides a nonexclusive list of activities an applicant could use on his or her curriculum vitae (C.V.) to demonstrate what it calls a "positive contribution" to the promotion of the DEI doctrine. Examples include lectures on the subject and DEI-themed CME courses.

The program means a candidate or applicant must demonstrate overt acceptance of an approved doctrine promoting concepts of innate racial bias and social justice in order to be eligible for appointment, reappointment, or promotion.

These stated concepts are part and parcel of the "critical race theory" doctrine promoted by the Left as scientific fact. Among the related concepts of this doctrine is "implicit bias," which presumes whites are prejudiced against people of color. Other buzzwords associated with CRT are inclusion, diversity, equity, and social justice, all of which are echoed in the UNC guidelines.

U.S. News ranks the UNC medical school number 24 in research and number 3 in primary care. The school has 1,819 full-time faculty members.

'An Inclusive Approach'

The UNC's move is part of a bigger trend, with many insurers, including Blue Cross Blue Shield, and the medical boards of some states now requiring so-called "cultural competency training."

The Oregon Medical Board's website, for example, states the organization "considers continuing medical education (CME) in cultural competency to be relevant to the current practice of all licensees, and licensees may use this type of continuing education toward satisfying the required CME hours for license renewal."

The website states "inequities in access to quality health care are apparent," and it claims "racial and ethnic populations, lesbian, gay, bisexual, and transgender communities, low literacy level individuals, and rural Oregonians experience severe health disparities according to the Oregon Health Authority's Office of Equity and Inclusion."

The site identifies cultural competency training as one tool to bridge this gap, improve health outcomes, and enhance patient safety, and it indicates the training will never end, describing cultural competency continuing education as "a life-long process of examining values and beliefs while developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient interactions and preserves the dignity of individuals, families, and communities."

'Stereotypes a Patient'

DEI policies are bad for patients and providers alike, says Diana Blum, M.D., a fellow at FAIR in Medicine, a nonpartisan professional group sponsored by the Foundation Against Intolerance & Racism.

"Anytime a physician stereotypes a patient based on immutable characteristics, inevitable harm may arise," said Blum. "Teaching physicians that people of color are perpetual victims trapped in a rigged system they have no control over robs them of personal agency, thus promoting a learned helplessness, which only increases both mental and physical health morbidity.

"[S]ystematically dismissing alternative explanations for health care disparities limits a physician's ability to formulate an accurate differential diagnosis, thus increasing the likelihood of delayed or inappropriate medical care," said Blum.

Other Factors in Disparities

Woke policies fail to address real problems, says Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Information.

"There have long been disparities in the U.S. health care system, but in recent decades those are mostly related to low incomes and lack of health insurance, language barriers, jobs that aren't conducive to taking time off to see a physician, and living in medically underserved areas, rural and urban," said Matthews.

"Infusing political ideology into medical education for the pursuit of 'equity' in medical outcomes assumes that all individuals of a certain color are the same," said Blum. "This punishes individual human beings today for societal wrongs of the past and erodes trust in the doctor-patient relationship."

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DIANA BLUM, M.D.
FELLOW, FAIR IN MEDICINE

'Why Burden Themselves?'

Diversity and equity issues are already being resolved without mandatory indoctrination, says Matthews.

"The good news is that the number of women and minorities in medical school has been increasing," said Matthews. "Interestingly, during the pandemic health care professionals have been actively seeking ways, some of which have been very creative, to identify and reach out to minority and low-income populations to expand vaccinations."

UNC's actions could discourage some of the best physicians from taking jobs there, says Matthews.

"Why burden themselves with additional meetings and bureaucratic oversight and scolding when they can continue to help patients on a daily basis [elsewhere]?" said Matthews.

DEI doctrines could have negative effects on health care, says Blum.

"The medical profession must be founded on scientific excellence and integrity based on the principles of the scientific method, where collective truth is achieved through open and honest discourse evolved from data and diversity of thought for the betterment of humanity," said Blum.

"Instead of cultivating the art and science of healing by developing critical thinking skills, students are pressured into becoming social justice warriors afraid to speak up for fear of ruining their future medical careers," said Blum. "Patients are the ones who ultimately suffer."

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

Auditor: Michigan Governor Whitmer Undercounted COVID Nursing Home Deaths

By Ashley Bateman

The Michigan Auditor General found 29.6 percent more COVID-19 nursing home deaths than Gov. Gretchen Whitmer's health department reported.

The investigation requested by state Rep. Steve Johnson (R-Wayland), chair of the Michigan House Oversight Committee, reviewed long-term facility deaths from January 1, 2020 through July 2, 2021. The state's Department of Health and Human Services (MDHHS) reported 5,675 COVID-19 deaths for that period. The audit found 8,061 residents died of the virus, Auditor General Doug Ringler wrote in a January 12 letter to Johnson.

The administration disagreed with the auditor's finding of an uncounted 1,511 deaths, questioning the reliability of the Michigan Disease Surveillance System's address field.

"[W]e contend the address field is reliable," wrote Ringler.

'Discrepancy in the Reporting'

Publicity about the undercounting of deaths in New York State led legislators in Michigan to request the auditor's probe, says Steve Delie, J.D., director of labor policy and the Workers for Opportunity program at the Mackinac Center for Public Policy in Michigan.

"The legislature recognized that there could be a discrepancy in the reporting of nursing home deaths, so they took appropriate action by asking the auditor general to do what MDHHS should have been doing all along," said Delie. "The auditor general's report accurately tracks the number of COVID deaths that are associated with long-term-care facilities, giving a more complete picture of the impact of our state's COVID-19 response."

A Freedom of Information Act (FOIA) lawsuit against the MDHHS in February 2021 by the Mackinac Center Legal Foundation revealed widely varying counting practices. Deaths in long-term care facilities serving 12 or fewer residents, accounting for 76 percent of such facilities in the state, were not included in MDHHS death counts.

'Flawed Processes'

At an Oversight Committee hearing, MDHHS Director Elizabeth Hertel accused Ringler of politicizing the findings and intentionally providing misleading information.

Ringler testified his office deliberately used the word "difference" instead of "underreport" to describe the administration's tally of deaths because the audit used additional data sources MDHHS did not include.

"For the long-term-care facility-related deaths or linked deaths, we knew the department wasn't tracking all of the ones that we reflected in our letter, so we didn't feel the word underreport was fair. We cited it as a difference," said Ringler at the hearing, the *Detroit Free Press* reported on January 20.

"The Michigan Department of Health and Human Services' response to the auditor general's report is alarming," said Delie. "Rather than acknowledging the errors that led to the undercount, and then fixing them, MDHHS has doubled down on its flawed processes, refusing to make the changes that would result in more accurate data. Whitmer and the Legislature should work together to require the Michigan Department of Health and Human Services to track deaths at all long-term care facilities moving forward."

Michigan Governor Gretchen Whitmer

PHOTO COURTESY GERALD R. FORD SCHOOL/FLICKR.COM

'Arbitrary Decisions'

In the early days of the COVID-19 pandemic, Whitmer paid nursing homes $5,000 per each COVID-19 positive patient they admitted.

By the summer of 2020, the Legislature passed a bill to stop the bounties and require COVID-positive nursing home residents to be housed in separate facilities, but Whitmer vetoed it. Later, Whitmer offered a $155,000 severance alongside a nondisclosure agreement (NDA) to her former health director, who resigned on January 22, 2021. After public pressure characterizing the payment as hush money, Whitmer withdrew the NDA on March 18, 2021.

Delie says these actions exemplify numerous mistakes by the state government in dealing with the pandemic.

"We knew early on that COVID-19 was disproportionately impacting the elderly, but the policy decisions being made didn't reflect that," said Delie. "Rather than prioritizing protecting the elderly, arbitrary decisions were being made about what someone could purchase or where they could travel."

Lack of Transparency

Whitmer is seeking a second term as governor in 2022. Voters appear to be split over her performance.

Whitmer has kept a lower profile since her lockdown policies during the pandemic gained national attention, but she should take responsibility for her actions, says Delie.

"The governor has claimed throughout the pandemic that the best science and data were being used to make these decisions," said Delie. "We now know that this was not the case.

"Despite recent revelations in the Auditor General's report, there is still much that hasn't been released about what was being used to make decisions impacting the lives of 10 million people. The governor should commit to being fully transparent and opening her office up to FOIA," said Delie. "This would help the public get answers and would restore trust."

'Must Be Held Accountable'

Accountability and transparency are reasons why Robert Regan, an unsuccessful candidate for the Michigan House in 2020, has decided to seek election again. Regan raised a red flag on Whitmer's nursing home policies after reviewing the evidence.

"In the summer of 2020, state Rep. Beau LaFave [R-Iron Mountain] sent me official State of Michigan documents proving Gov. Whitmer issued orders intended to populate nursing homes with patients [who had] tested positive for COVID," said Regan. "Not only did she issue the order but encouraged the practice by financially incentivizing the nursing homes."

Regan produced a video on the documents that received over 500,000 views.

"Not one media outlet reported on it," said Regan.

Regan says if he wins the seat he will demand an Oversight Committee investigation. And as a Republican Party Committeeman, he will oppose any attorney general candidate who will not investigate potential criminal culpability, he says.

"Gov. Whitmer's official orders amount to third degree murder, and she must be held accountable," said Regan.

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

REPORT

Telehealth Lowers Health Care Costs

By AnneMarie Schieber

Patients who used telehealth services during the COVID-19 pandemic spent more in the early months but less over time, and they accessed fewer health services overall compared to those relying on in-person care, a bipartisan report concludes.

"Between January 2020 and February 2021, the average telehealth patient's health care expenses fell 61 percent, from $1,099 per month to $425 per month," states "Telehealth Saves Money and Lives—Lessons from the COVID-19 Pandemic," published by Americans for Prosperity (AFP) and the Progressive Policy Institute (PPI).

"Additionally, people who used telehealth had lower overall health care utilization compared with people who used only in-person care, except during the early months of the pandemic, March to May 2020," write coauthors Charlie Katebi, a health policy analyst with AFP, and Arielle Kane, director of health care at PPI.

The "findings contradict assumptions made by the nonpartisan Congressional Budget Office (CBO) that unnecessary health care utilization (i.e., overuse) would increase if telehealth services were made easier to access," AFP's press release states.

Researchers examined private insurance claims data for 8.1 million patients who used telehealth and 15.8 million patients who used in-person care compiled by the nonprofit FAIR Health, Inc.

"There are so many benefits that come with telehealth and so many harmful regulations imposed on telehealth. The most important thing is helping consumers and patients. The fact that we disagree on a whole lot of other things simply doesn't matter because there is this real opportunity to advance something that benefits everybody."

CHARLIE KATEBI
HEALTH POLICY ANALYST, AMERICANS FOR PROSPERITY

Telehealth Parity

Before the pandemic, Medicare, which often sets the standard for all insurance, covered telehealth only in rural areas and only when delivered in a health care setting, not at home. Regulators assumed enrollees would overutilize health services if they were too accessible, and clinicians were concerned telehealth could disrupt payment models.

During the pandemic, President Donald Trump declared a public health emergency and the U.S. Department of Health of Human Services (HHS) lifted regulations prohibiting people from using telehealth.

HHS allowed reimbursement for 240 new telehealth services and payment parity for telehealth visits, to get clinicians on board. Additionally, states waived rules to allow other health care providers besides doctors and nurses to offer telehealth and to expand allowable platforms to include emails, texts, and online video streaming.

Consumer Migration

As a result of the regulatory relief, telehealth use increased from 134,000 to 10.1 million people in the first six months of 2020.

When the virus threat subsided, telehealth patient costs fell faster than those for in-person patients. In January 2020, in-person patients spent $910, while telemedicine patients spent $1,099, but by February 2021, in-person patients spent $578, or 36 percent less, and telemedicine patients spent $425, or 59 percent less.

One explanation for these differences is that virtual care reduced exposure to the virus and easy access improved health outcomes, Katebi told *Health Care News*.

"It delivered a lot of lifesaving care that would not have happened if the Trump administration did not end those restrictions," Katebi said.

More Efficient, Accessible Care

Kane says telehealth can benefit many people.

"Not every type of care will be appropriate for virtual care," said Kane. "However, many services can be comparable: think the opportunity to renew prescriptions, ask questions, and do talk therapy. All of this can be done remotely without sacrificing quality."

"There are so many health care services that can be delivered through telehealth and at a fraction of the cost," said Katebi. "The average primary care visit averages between $100 and $150. A telehealth visit costs about $40."

Additionally, telehealth can offer services a face-to-face visit can't always provide, says Katebi.

"Consultation is easier, and people with chronic conditions can wear medical devices that allow doctors to monitor 24-7," said Katebi. "That is a level of care that you didn't have before telehealth services."

'Benefits Everybody'

Telehealth has support across the political spectrum for several reasons, the authors say.

"There are so many benefits that come with telehealth and so many harmful regulations imposed on telehealth," said Katebi. "The most important thing is helping consumers and patients. The fact that we disagree on a whole lot of other things simply doesn't matter because there is this real opportunity to advance something that benefits everybody."

"This is an issue that transcends underserved urban communities and rural areas where doctors may be in scarce supply," said Kane.

Proposals for Permanence

If Congress does not act before the Biden administration lifts the emergency health declaration, the telehealth reforms will vanish.

Three bills in the U.S. Senate would change that by allowing telehealth anywhere in the country and multiplatform access from a patient's home: the Protecting Rural Telehealth Access Act, introduced by Sen. Joe Manchin (D-WV); the Telehealth Modernization Act, introduced by Sen. Tim Scott (R-SC); and the CONNECT for Health Care Act, introduced by Sen. Brian Schatz (D-HI) with 59 cosponsors.

"I don't think I've seen any other bill with that level of support in the Senate for anything," said Katebi.

States are also taking action to expand access to telehealth, says Katebi.

"Florida allows an out-of-state provider to practice in their state," said Katebi. "They just ask that they register and demonstrate that they have all of the qualifications to practice medicine. Arizona just passed a carbon copy of that reform, and we're working with Kansas and West Virginia to implement similar reforms. This, along with action at the congressional level, would really open up access."

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

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‘Build Back Better’ Ignored Need to Expand Self-Directed Health Care

By Bonner R. Cohen

The U.S. Senate’s rejection of the Build Back Better (BBB) tax and spending bill spelled defeat for the measure’s health care provisions, many of which built on existing programs riddled with fraud and waste.

The bill’s provisions on Medicaid Home and Community-Based Services (HCBS) included a permanent 6 percent increase in federal Medicaid matching funds. To qualify for these funds, states would have had to maintain existing HCBS eligibility, benefits, and payment rates and have an approved plan for expanding HCBS access, adding to the program’s red tape.

Another section of BBB would have provided $1 billion in grants to states, community-based organizations, educational institutions, and other entities by the U.S. Department of Labor to develop and implement strategies to recruit, train, and retain the HCBS workforce, without reforming the system that led to the shortage.

The Biden administration and congressional Democrats are considering several options to implement the health care provisions in the failed BBB legislation, including a scaled-back version of BBB and/or executive orders, regulatory action, and inserting relevant language into budget and spending bills. This piecemeal approach could get some of the agenda realized while Democrats still have control over Congress.

Missed Opportunity

There was a shortage of home caregivers before the outbreak of COVID-19 that has worsened as the pandemic has dragged on. BBB would not have expanded Medicaid waivers allowing states to provide more direct-pay “cash and counseling” programs in which money goes straight to patients instead of third-party caregivers.

“If instead of throwing good money after bad, we focused on rational reform of existing programs, we might find that the ‘unmet needs’ the Democrats have targeted could be adequately met—without spending any additional taxpayer dollars,” wrote John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News,* in The Daily Signal.

Cash and Counseling

An option for home care that has worked successfully at the state level for many years is Cash and Counseling. Originally a pilot Medicaid program in 15 states, these financial and care assistance programs are usually, but not always, part of state Medicaid programs.

“Under that program, money goes to the patient, not the caregivers,” wrote Goodman. “Patients can hire and fire their service providers, and the type of person who can be a provider also has been expanded. Some states even allow spouses to be caregivers.”

Acceptance of Cash and Counseling and the number of states in which it is available have expanded considerably since its inception. Today the program is sometimes referred to as Consumer Direction, Participant Direction, Self-Directed Care, and a variety of other state-specific names such as Services My Way (Pennsylvania), In-Home Supportive Services (California), and Choice Waiver (Michigan).

Consumer-Directed Care

Although the rules and regulations of self-directed care vary by state, medicaidassistanceplanning.org says all state programs allow the person receiving care “to choose, hire, train, and even fire, their own caregivers to assist with the activities of daily living (bathing, dressing, mobility, toiletry, transferring, and eating).”

The website says “49 states offer consumer direction in their Medicaid programs, 29 states have consumer direction in their non-Medicaid or nonprofit assistance programs, 42 states allow for some veterans’ care services to be self-directed, and life and long-term care insurance policy conversion programs are available in all 50 states.”

Appetite for Expansion

Governments’ top-down approaches take the long road to assisting with personal needs, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute in Colorado (see article, opposite page).

“The problem is that government never knows when to quit,” Gorman told *Health Care News.* “And as the COVID policy debacle has shown, those who make health policy are often unable or unwilling to properly assess risks and benefits for the various parties involved.

“For example, the home care benefit the Biden administration wants to add would give the 20 percent of Medicare patients being discharged from the hospital to a skilled nursing facility the right to duplicate skilled nursing care services at home,” said Gorman.

“The problem is that government never knows when to quit. And as the COVID policy debacle has shown, those who make health policy are often unable or unwilling to properly assess risks and benefits for the various parties involved.”

LINDA GORMAN
DIRECTOR OF HEALTH CARE POLICY
INDEPENDENCE INSTITUTE

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

INTERVIEW

Bureaucrats Attack Colorado's 'Cash and Counseling' Program

Colorado has had a successful "cash and counseling" program for years, called Colorado Consumer Directed Attendant Support Services (CDASS). Linda Gorman, director of the Health Care Policy Center at the Independence Institute, says CDASS has been attacked frequently by the state's health care bureaucracy. Gorman talked with AnneMarie Schieber, managing editor of Health Care News, *about why such programs are worth defending.*

Health Care News: How did you become acquainted with this cash and counseling program?

Gorman: John Anderson, founder of the Independence Institute, and Julie Reiskin, currently executive director of the Colorado Cross Disability Coalition, introduced me to CDASS. In the mid-1990s, Colorado was fortunate to have had an exceptional group of officials interested in market-oriented health reform. They began working on a new attendant care model for Medicaid in 1995. Medicaid approved a pilot program limited to 150 people in 2001.

Medicaid case managers determine how much, and what types, of home care a disabled individual needs. Before CDASS, the state would simply pay an agency to send people to provide it. Sometimes they showed up, sometimes they didn't. Sometimes they stole. The people getting the care could not fire them.

The CDASS pilot gave people a choice after they had spent a year in regular Medicaid. CDASS clients take courses in managing their own care and in accounting for their funding. Each year, the state case managers determine a care plan for everyone enrolled in the program. The amount regular Medicaid would pay for the plan is deposited in an account overseen by a financial manager. After the manager collects its fee, participants use the remaining money to pay for their care.

In the pilot program, CDASS clients could use half of their savings to purchase things that Medicaid did not cover, such as voice-activated telephones for quadriplegics. The other half reverted to the state.

Health Care News: What were the results of the pilot program?

Gorman: The pilot program's monthly spending was about 20 percent under budget. Patient satisfaction was high.

When the incentives are right, people can get more health care for less. Patients in the program are much more selective in how they spend their money and who they hire. Rather than pay the high wages commanded by trained nurses, some CDASS participants prefer to hire less-expensive unskilled people and train them to do the tasks that the state would send nurses to perform.

Health Care News: What seems to be driving the resistance by the government health care apparatus?

Gorman: Interest group politics and government's unquenchable desire to control everything. Government agencies sympathetic to the claims of existing businesses and those who would unionize home care workers have steadily added unnecessary regulations to the CDASS program.

The first CDASS participants were essentially running small businesses. The wage flexibility and shared savings made it worth their while to work hard to keep their spending under budget. They also had lower overhead than the agencies that had previously provided them with home care workers.

When Colorado Medicaid applied to make CDASS a permanent part of its plan, federal Medicaid officials made limiting a family member, who might be providing the care, to a 40-hour workweek a condition of approval. This requirement made no sense. CDASS clients received an annual amount to pay for their care. If husbands, wives, parents, or children were willing to work more than 40 hours a week, and many were, it was no business of the government.

When clients compensated for the 40-hour limit by adjusting the hourly rates paid, state government responded by setting a maximum wage. Flexibility was further reduced when the state also began setting minimum wages even though some attendants accepted lower pay because working for a CDASS participant had other benefits like flexible hours, more training, or permission to bring their children to work. Home care agencies and those seeking to unionize home care workers pushed for wage limits in order to make CDASS less competitive.

Losing flexibility created other problems. A CDASS participant might offer someone $100 a month to be on call every evening for a month. If the timesheets approved for the program did not have a category for that kind of arrangement, the reimbursement might be recorded as $100 for one hour of work. When state officials saw those payments, they complained that wages were too high. The Colorado state auditor even concluded that CDASS clients were being given too much money for their care just because CDASS clients paid skilled attendants an average of $16.68 an hour when the standard state rate was $28.36.

Health Care News: It appears the sentiment on home health care is changing. Are you encouraged?

Gorman: Cash and counseling-type programs of varying quality are now common in state Medicaid plans. This is an undoubted improvement.

Unlike CDASS payments, Medicare payments go [directly] to home care providers. Counseling is nonexistent. Fraud, theft from patients, and other elder abuse are rampant in Medicare home care. Unlike Medicaid, Medicare does not cover long-term care or personal services. Its patients often have little experience directing their care. An estimated 50 percent of Medicare patients currently prescribed home care at hospital discharge actually receive it.

Perhaps new care structures will develop if Medicare ever gets serious about giving patients real power. Until then, at hospital discharge a short-term admission to a nursing home or rehab facility may cost less, and be better for patients, than poorly organized home care.

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COMMENTARY

It's Time for Separation of Science and State

By Peter Yim

The U.S. government's medical authorities have betrayed the country.

They have misled Americans on COVID-19 treatments and vaccines: suppressing the use of safe generic drugs for early treatment while endlessly promoting novel vaccines with horrific safety profiles. We don't know the impact of these acts, but it has likely been devastating.

The question is: What was all this about? Was this garden-variety corruption?

Yes, the behavior by the medical authorities likely resulted from the corruption of individuals. But there is more going on here. Namely, science is too closely associated with the state.

This is unnatural. Science is the search for truth in the natural world, and it is unavoidably in conflict with the state. The state seeks to control, and science is intrinsically uncontrollable.

Enduring Tension

The tension between church and the state has been at the core of Western liberal democracy since the signing of the U. S. Constitution.

The first clause of the First Amendment to the Constitution states, "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof." This is the doctrine behind the separation of church and state. The founders of the nation understood the relationship between the state and religion is fraught with potential conflict and sought to protect the church from the state.

In contrast, the relationship between the government and science was ill-defined in the Constitution except that the government should protect "writings and discoveries."

Deprived of Early Treatment

On issue after issue in the pandemic, federal medical authorities have lied and deceived. The most deadly were the U.S. Food and Drug Administration's (FDA) lies that hydroxychloroquine and ivermectin are dangerous. Hydroxychloroquine is used chronically by hundreds of thousands of people in the United States. Billions of doses of ivermectin have been dispensed worldwide since its discovery.

The National Institutes of Health (NIH) issued a statement with a similar impact. NIH was more circumspect on the use of ivermectin for COVID-19: "There is insufficient evidence for the COVID-19 Treatment Guidelines Panel (the Panel) to recommend either for or against the use of ivermectin for the treatment of COVID-19."

That statement is certainly false.

The "Panel" never considered the issue. My investigations have revealed as much. The chair of the panel implicitly acknowledged no vote was held on the ivermectin recommendation, in an exchange at the *Annals of Internal Medicine* (comments section).

The NIH statement on ivermectin is simply the view of the Panel Chairs. Litigation is ongoing to force the NIH to confirm this deception explicitly. The case will turn on a motion for summary judgment that is currently in the hands of the presiding judge.

Another fraud was the refusal to acknowledge natural immunity from prior COVID-19 infection. The assertion that vaccination is superior to natural immunity has a certain totalitarian brazenness: a newly minted theory based on an outlier study authored by federal employees and published without peer review.

COVID-19 Shot Safety Deception

The Centers for Disease Control and Prevention (CDC) has betrayed the country by its refusal to acknowledge uncertainty about the safety of the COVID-19 shots. The safety of the shots is unknown to the public because of the totalitarian secrecy of the U.S. pharmacovigilance system.

Anyone can report a vaccine adverse event through VAERS (the Vaccine Adverse Effects Reporting System), and the number of reported adverse events is publicly available. However, the CDC fact sheet states, "Once adverse events are identified using VAERS, they may be monitored in other immunization safety systems to confirm if a particular adverse event is related to a vaccination and identify any specific risk factors."

The events *may* be monitored. We don't know if they *are* monitored because that information is not publicly disclosed.

As a result, we don't know the number of cases in which the shot was ruled out as a cause of the adverse event. Those supportive of the COVID-19 vaccination campaign make their assumptions; those against make theirs. In truth, zero information is available on how many of the reported adverse events were not caused by the shot.

Mysterious Origins

Then there's the question of where the virus came from. On that issue, the NIH director released a statement: "The scientific evidence to date indicates that the virus is likely the result of viral evolution in nature. …"

At the same time, however, the NIH is defending itself against the charge it funded the development of SARS-CoV-2. This is surely the mother of all conflicts of interest.

On this critical issue, we are left to the mercies of the World Health Organization and the Chinese government to get to the bottom of this mystery.

Fear of People, Truth

Democracy functions properly only when the people are fully informed. In the words of John F. Kennedy, "A nation that is afraid to let its people judge the truth and falsehood in an open market is a nation that is afraid of its people."

In the United States, we would not tolerate a federal agency of religion, and the time has come to unplug federal medical authorities. The government is currently borrowing the mantle of "truth" by association with science without a *bona fide* dedication to truth and discovery. The U.S. government has clearly become the adversary of science.

There is no reason to expect more from the NIH, the FDA, or the CDC. These agencies are not much more than drug companies masquerading as public institutions.

Peter Yim, Ph.D. (**https://www.linkedin.com/in/peterjyim/**) *is a computer scientist and educator.* *A version of this article was originally published on Substack on December 26, 2021. Reprinted with permission.*

COMMENTARY

Biden's COVID-19 Home Test Plan: Too Little, Too Late

By Doug Badger

President Joe Biden has a new plan for rapid, at-home COVID-19 testing, but as with much of his administration's pandemic policy, the plan is convoluted, costly, and late.

Making affordable, rapid at-home tests widely available empowers people to learn their COVID-19 status. Instead of relying on mandates and compulsion, this approach equips people to make informed decisions for themselves and their families.

It's a good idea and would have been better if launched 18 months ago, or at least a year ago, before the steepest spikes in infections. Rapid tests got tangled in the Food and Drug Administration bureaucracy during the Trump administration, and the Biden administration wove a web of czars, task forces, working groups, and advisory councils that snarled decision-making and garbled messaging.

"As the national public health emergency enters its third year, it's long past time for the administration to adapt its approach to the pandemic's changing nature. More shots, more masks, and more mandates have proven ineffective. More normal is a strategy worth pursuing."

DOUG BADGER, SENIOR FELLOW, GALEN INSTITUTE

What Could Go Wrong?

Despite two presidents who sang the virtues of at-home testing and congressional authorization of $53 billion for COVID-19 testing—of which $29 billion remains unspent—their subordinates never found a way to get rapid tests into the hands of consumers.

Now that the Omicron variant appears to be receding, the Biden administration has a plan at last. It involves more insurance mandates and the U.S. mail. What could go wrong?

Biden on December 21 announced his plan to mail 500 million tests free of charge. He doubled down and promised another 500 million on January 14. Don't expect them to arrive anytime soon. The administration hopes your tests will leave the warehouse within seven to 12 days after you place your order. From there, it will be up to the U.S. Postal Service.

"There are households where there has been no mail delivered for days," congressional Del. Eleanor Holmes Norton, a nonvoting Democrat representing Washington, D.C. in the U.S. House of Representatives, noted in a letter to the Postal Service. "If we can't get the mail, how are we going to get these COVID tests?"

New Insurance Mandate

Those who hate to wait and have private health insurance (but not Medicare or Medicaid) can choose Plan B. The administration has mandated that your insurer provide you with up to eight free tests every month. Well, sort of.

Insurers can meet those requirements by establishing a "direct coverage" option—an arrangement with select retailers to provide enrollees with their free tests. There's no need for the enrollee to front the money when they pick up tests from those preferred outlets.

What if your insurer's "select retailer" is out of tests? You can purchase them elsewhere and send the receipt to your insurance company. They will send you a check for $12. Since at-home tests generally cost at least twice that, leaving you to cover the difference, your "free" test could get pricey.

According to a study by the Kaiser Family Foundation, about half of insurers had established the direct coverage option as of January 20, five days after the mandate took effect. Others likely will follow. If your health plan doesn't offer direct coverage, you can buy a test, submit a claim, and wait for your check to arrive in the mail.

Value in Question

The Biden administration is launching these rapid-testing programs just as some are questioning their value. A preprint study found the Quidel and BinaxNOW rapid antigen tests failed to register positive results in some people infected with the Omicron variant.

"Rapid antigen tests may not be as fit-for-purpose in routine workplace screening to prevent asymptomatic spread of Omicron, compared to prior variants," the study's authors concluded. The FDA continues to stand behind these tests.

Despite its flaws and complications, the administration's testing plan is notionally correct. Government policy on the pandemic should focus on giving people options, not imposing burdens and restrictions.

Emergency Drags On

Instead, the administration continues to advocate more restrictive approaches. Dr. Anthony Fauci, the president's chief medical adviser, backs mandated mask-wearing and vaccines. Such policies haven't proven effective in reducing the transmission of the coronavirus. France, which has long mandated masks and required vaccine passports, had a population-adjusted rate of daily confirmed cases nearly two and a half times that of the United States as of January 22.

And even as Rochelle Walensky, the director of the Centers for Disease Control and Prevention, calls for "pivoting the language" on the definition of "fully vaccinated" to require a third shot to be considered "up to date," the booster strategy appears to be failing in Israel, where it has been most aggressively pursued. As of January 22, Israel's rate of daily confirmed cases was more than triple that of the United States.

As the national public health emergency enters its third year, it's long past time for the administration to adapt its approach to the pandemic's changing nature. More shots, more masks, and more mandates have proven ineffective. More normal is a strategy worth pursuing.

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Fauci to Receive Record Retirement Benefit Payout

By Kevin Stone

Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, is set to receive a retirement benefit of $350,000 a year plus cost-of-living adjustments, the highest payout for any federal employee, reports OpenTheBooks.com.

U.S. government pensions are based on recent salaries and years of service. Fauci, who continues to work at age 81, has been on the federal payroll for 55 years.


Dr. Anthony Fauci

PHOTO COURTESY TRUMP WHITE HOUSE/FLICKR.COM

Pay Boost Hikes Pension

Fauci was paid $434,312 in 2020, the last year for which salary figures were provided to OpenTheBooks.com. That represented a 4 percent increase over the previous year. Fauci's current salary exceeds that of the U.S. president, who is paid $400,000 a year.

Pension payouts are 80 percent of the employee's highest salaries for three consecutive years, plus credit for sick leave. Fauci benefits each year he stays on the job because his compensation keeps getting higher.

In 2004, under the George W. Bush administration, Fauci got a 68 percent boost in pay to "appropriately compensate him for the level of responsibility … especially as it relates to his work on biodefense research activities," writes OpenTheBooks, quoting a document the transparency group obtained through legal action. Fauci's salary went from $200,000 to $335,000 a year that time.

Finances Raise Red Flags

In addition to Fauci's salary being a point of contention among his detractors, his level of financial transparency has raised concerns.

U.S. Sen. Roger Marshall (R-KS), whom Fauci famously dismissed as a "moron" during a Senate Health Committee hearing in January, has been particularly critical of Fauci's level of candor about his financial dealings. Marshall introduced the Financial Accountability for Uniquely Compensated Individuals (FAUCI) Act in response to it.

Although Fauci claimed in his testimony to the committee his finances were a matter of public record, Marshall obtained the records only through pressure after the fact.

Not 'Public Information'

Watchdog groups such as OpenTheBooks.com have been similarly stonewalled in trying to obtain financial disclosures and current salary information for Fauci. A lawsuit was necessary to obtain much of the information, says Adam Andrzejewski, CEO and founder of OpenTheBooks.com.

"Dr. Anthony Fauci testified under oath that his financial records were 'public information,'" said Andrzejewski. "It wasn't true. Our organization at OpenTheBooks.com has battled for 12 months to obtain Fauci's contract, confidentiality agreement, job description, ethics disclosures, and financial and conflict [of interest] disclosures.

"With Judicial Watch as our lawyers, last October we filed a federal lawsuit," said Andrzejewski. "Now the National Institutes of Health admit to holding 1,200 pages subject to our request. On February 1, NIH is supposed to start producing these documents at a rate of 300 pages per month."

Others are blunt in their criticism of Fauci, including John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News*.

"Clearly, we are not getting our money's worth," said Goodman. "And if Fauci was funding the gain-of-function research that created the coronavirus, he should pay us—a lot."

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

COMMENTARY

Government Dollars Come with a Stiff Price Tag: Liberty

By Chad Savage, M.D.

The U.S. Supreme Court's divergent rulings regarding the mandates for the COVID-19 vaccine shots offer a stark contrast with the constitutional limits of the government's power.

But there's another takeaway from the high court with far greater consequences to civil liberties, regardless of one's position on vaccines. In a much-ballyhooed win for the rule of law and the U.S. Constitution, the high court soundly rejected the Biden administration's vaccine mandate for large private employers. The 6-3 decision reaffirmed that the power to make law lies with Congress, not federal agencies, even during a pandemic.

That is, no matter how much the president desires a vaccine mandate, only Congress can make it happen.

Separation of Powers

Five justices overlooked the separation of powers in the other case, however, and upheld the vaccine requirement for workers at health care facilities that receive funding from the Centers for Medicare and Medicaid Services (CMS). The majority reasoned that the agency is authorized to impose conditions to support its fundamental function of ensuring that "providers who care for Medicare and Medicaid patients protect their patients' health and safety."

To be sure, the CMS ruling is not the first legal quibble over congressional intent versus executive authority, nor will it be the last. But buried deep within the decision concerning this vaccine mandate is a far more consequential depiction of government power: those who take federal funding are bound by the whims of the federal government, even at the expense of civil liberties.

Nowhere did the Supreme Court specifically articulate that health care providers do not have a choice to accept or reject CMS contracts and the accompanying arbitrary and capricious mandates. But the implications loom large. If your choice is to work with CMS or not work, do health care providers have a choice?

Socialization of Industry

The ruling fails to recognize that health care simply does not function like any other free-market industry. In health care, government contracting is near-universal and obligatory.

For example, if General Motors decides it does not like the stipulations of a contractor, it can simply contract with a different company. However, the government does not function in health care in the same way. The substantial socialization that has occurred within health care has afforded the government near-monopolistic power over the industry.

Nearly all hospitals accept Medicare and require participation in the program for doctors to care for patients. Thus, avoiding CMS contracts is near professional suicide for many specialists who, without it, can be denied access to the hospitals where they practice.

In other words, what is a surgeon without an operating room or obstetrician unable to deliver babies? Unemployed.

Roping Others In

CMS mandates are not limited to doctors and nurses. They cover all employees, including janitors, billers, and records staff. They encompass anyone working for or affiliated with the growing medical behemoths that control the health care landscape through consolidation.

Leaving the government's monopolistic power over a largely socialized health care system out of the equation, Justices Breyer, Kagan, Kavanaugh, Roberts, and Sotomayor cannot possibly recognize that the absence of true choices for health care workers undermines their ability to retain both their liberty and health care jobs. Doctors, medical assistants, reception staff, nurses, cafeteria workers, and others who value bodily autonomy face the brutal decision to forfeit their civil liberties or be excluded from the industry. Functionally, they must submit or get out.

More at Stake

Lest readers think this opinion argues against the vaccines, it does not. People can choose for themselves whether to vaccinate or not. This position instead argues against the overwhelming power of the increasing central control of the nation's medical industry and how, under the full socialization of a single-party payer, all residual freedoms will be removed from health care workers.

Under CMS control: today the requirement is the vaccine; tomorrow it could be anything else.

The Supreme Court's CMS ruling must be a clarion call to health care workers about the unanticipated perils of a centrally controlled health care system, and to encourage the pursuit of freer forms of medical practice such as direct primary care. We need a robust alternative option beyond government-controlled health care.

Though many have a naive belief that single-payer is simply "free" medical care, in reality single-payer gives the government control over medical practices, decision making, and, as with vaccines, our bodies.

Unfortunately, the Supreme Court has put Americans on notice: you can work in health care or have civil liberties—but not both.

Chad Savage, M.D. (**info@d4pcfoundation.org**) *is a policy advisor to The Heartland Institute, a policy fellow at the Docs 4 Patient Care Foundation, and president of DPC Action.* *A version of this article was published in Townhall on January 30, 2022. Reprinted with permission.*

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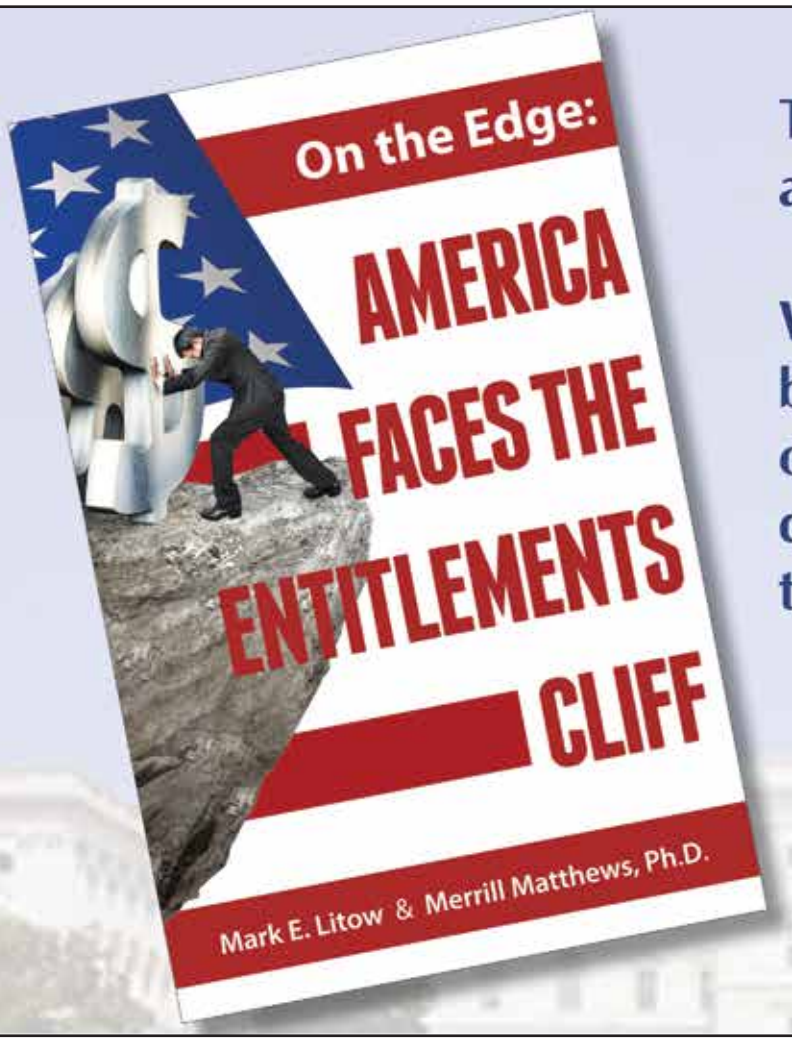
CHAD SAVAGE, M.D., POLICY FELLOW, DOCS 4 PATIENT CARE FOUNDATION



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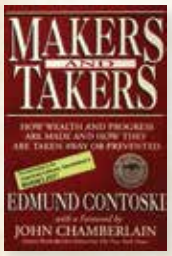

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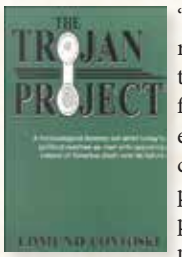

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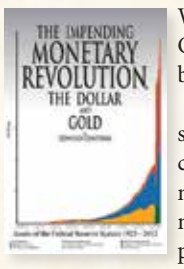

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