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HEALTH CARE NEWS

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President Joe Biden

Democrats' Spending Deal Will Extend Obamacare Subsidies

By Bonner Russell Cohen

By a one-vote margin, Senate Democrats passed a \$740 billion federal budget reconciliation plan that, among other things, extends enhanced subsidies for Obamacare health insurance premiums and imposes price controls on Medicare prescription drugs.

The Inflation Reduction Act of 2022 replaces the Build Back Better proposal Sen. Joe Manchin (D-WV) scuttled in December. Manchin changed his mind after reaching a deal in late July with Majority Leader Chuck Schumer (D-NY). The plan extends subsidies for Affordable Care Act (ACA) policies for three years.

The legislation would also remove the income eligibility limit for subsidies, which was originally 150 percent of the poverty level and was temporarily lifted by the COVID pandemic relief bill enacted in 2021.

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PHOTO COURTESY GAGE SKIDMORE/Flickr.COM

Democrats Target Medicare Drug Spending to Pay for More Obamacare

By Kevin Stone

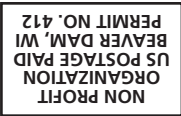
Congressional Democrats are targeting Medicare drug spending to finance the extension of expiring pandemic subsidies for Obamacare.

The drug price provisions are included in the Inflation Reduction Act agreed to by Sen. Joe Manchin (D-WV)

and Senate Majority Leader Chuck Schumer (D-NY) and passed by the U.S. Senate.

The drug price plan would allow the Centers for Medicare and Medicaid Services (CMS) to decide what prices

MEDICARE DRUG, p. 4



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'Family Glitch Fix' Could Extend Obamacare Subsidies to Millions

By Bonner Russell Cohen

The Internal Revenue Service (IRS) has proposed a rule that could extend Obamacare health insurance subsidies to millions more people.

The IRS regulation would remove the so-called "family glitch" in the Affordable Care Act (ACA), according to the Biden administration. The glitch refers to an ACA provision that determines who qualifies for subsidized coverage on the Obamacare exchanges.

Obamacare defines "affordable" as individual coverage that costs no more than 9.83 percent of a person's annual income. An employee could have affordable employer-based health insurance as an individual, but not affordable family coverage. Under the ACA, the employee's family does not qualify for subsidies. The rule change would allow such employees and their families to receive subsidized Obamacare coverage.

Big Potential Expansion

An estimated 200,000 people without health insurance would gain coverage and nearly one million Americans would "see their coverage become more affordable," a White House Fact Sheet states.

The rule change could extend exchange subsidies to more than five million additional Americans, according to Kaiser Family Foundation (KFF) figures, wrote Sally Pipes, president and CEO of the Pacific Research Institute, in RealClearPolicy on May 11.

More than 9.7 million Americans received exchange subsidies in 2021, the KFF states.

Lawmakers Cry Foul

The ACA does not allow eligibility expansion by rulemaking, say U.S. Rep. Kevin Brady (R-TX), ranking member of the House Committee on Ways and Means, and U.S. Sen. Mike Crapo (R-ID), ranking member of the Senate Finance Committee, in a letter to Treasury Secretary Janet Yellen.

"As the Obama administration ultimately acknowledged, the applicable statutory language does not allow for the revisionist reinterpretation advanced by the Treasury and the Internal Revenue Service through this new regulation," the letter states.

"Moreover, unilaterally redefining the ACA's insurance affordability standard could result in substantial disruption



"This stealth Obamacare expansion will incentivize employers to spend less on health insurance for workers' families, leaving many Americans worse off."

BRIAN BLASE, PH.D.

CEO

PARAGON HEALTH INSTITUTE

tions of workers and job creators alike, in addition to exacerbating 40-year-high inflation through tens of billions of new taxpayer spending," Brady and Crapo wrote. "Unfortunately, the proposed rule contains little discussion or analysis of either the coverage or the economic effects, including the estimated cost of the regulations."

'Tool of the White House'

The Biden administration is overstepping its authority, says Brian Blase, Ph.D., CEO of Paragon Health Institute and a senior research fellow at the Galen Institute.

"During the Obama administration and after an exhaustive review, the IRS and Treasury correctly determined that Obamacare defines affordability of employer coverage with respect to the price of the plan offered the worker for self-only coverage," said Blase. "The White House has a political desire to expand Obamacare, but the IRS must not allow itself to become a tool of the White House, changing its enforcement of the tax code based on the party in power."

One consequence of what the administration is proposing is that employers

will drop their health plans or increase employee premium costs, says Doug Badger, a senior research fellow at The Heritage Foundation's Center for Health and Welfare Policy.

"This stealth Obamacare expansion will incentivize employers to spend less on health insurance for workers' families, leaving many Americans worse off," said Badger.

Potential Court Challenge

If the Biden administration finalizes the rule, it will almost certainly face a court challenge. The U.S. Supreme Court's June 30, 2022 ruling in *West Virginia v. EPA* reined in federal agencies' power to act beyond what Congress specifically authorizes them to do, especially in matters involving major questions.

"A decision of such magnitude and consequence rests with Congress itself, or an agency acting with clear delegation from that representative body," Chief Justice John Roberts wrote.

That Supreme Court precedent could also be applied to the Biden administration's efforts to expand subsidized ACA coverage without congressional authority.

The proposed rule, "Affordability of Employer Coverage for Family Members of Employees," is expected to be finalized before the end of 2022 and would go into effect on January 1, 2023.

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

Democrats Target Medicare Drug Spending to Pay for More Obamacare

Continued from page 1

pharmaceutical manufacturers may charge for drugs paid for by Medicare. Drug manufacturers would be hit with a 95 percent tax on their total sales if they fail to lower drug prices to the satisfaction of federal regulators.

The plan could cut Medicare prescription drug spending by \$288 billion over the next 10 years, according to the Congressional Budget Office (CBO).

The projected savings would be used to pay for a three-year extension of Obamacare subsidies.

'Exact Same Mistake'

Drug price negotiation is a euphemism for drug price controls, said Phil Kerpen, president of American Commitment, on the *Heartland Daily Podcast* on July 28.

"A classic mob-style 'offer you can't refuse,'" said Kerpen.

The plan will rightly be viewed as taking from Medicare to finance Obamacare, wrote Kerpen in a blog post.

"There were a lot of ingredients in the 2010 Republican electoral landslide, but perhaps the most significant was that by raiding hundreds of billions of dollars from Medicare to pay for Obamacare, Democrats gave the 'Medicare cuts' club they had used to beat Republicans over the head for decades to their opponents, who then hammered away at them," wrote Kerpen. "Remarkably, 12 years later they may—in a last-ditch attempt to salvage something from the wreckage of Build Back Better—repeat the exact same mistake again."

Drug Access Crash

The proposal is not drug pricing reform, wrote Kerpen.

"Proponents pretend this is a free lunch, that seniors will have access to the same drugs at steeply lower prices," wrote Kerpen. "Reality doesn't work that way. Imposing price controls to siphon hundreds of billions of dollars out of Medicare prescription drug spending will clearly result in few new cures and treatments available to seniors."

Drug Innovation Gap

The proposed legislation would stifle the development of new drugs, says the Pharmaceutical Research and Manufacturers of America (PhRMA), a trade group representing drug makers, in a statement on the version of the drug price plan released on July 6.

"The prescription drug bill released today went from bad to worse for patients," states PhRMA. "Democrats weakened protections for patient costs included in previous versions, while doubling down on sweeping government price-setting policies that will threaten patient access and future innovations."

Sen. Joe Manchin (D-WV) talking with Senate Majority Leader Charles Schumer (D-NY)

PHOTO COURTESY CHIP SOMODEVILLA/STAFF

University of Chicago researchers Tomas J. Philipson and Troy Durie stated a previous version of the drug price plan would have reduced patient access to prescription drugs, in an issue brief published in November 2021.

Pharmaceutical companies would lose an average of 12 percent of their revenue through 2039, according to Philipson and Durie. This would reduce research and development spending by about 18.5 percent, or \$663 billion, resulting in the development of 135 fewer new drugs and the potential loss of 331.5 million life years.

Prescription drug prices rose by an average of 2.5 percent in the past year, far below the 9.1 percent overall annual inflation rate for the United States, and the prices fell between 2009 and 2018, according to the CBO.

'Fewer Cures'

This plan could create drug shortages, says Ryan Ellis, president of the Center for a Free Economy.

"The drug manufacturer may choose to avoid the 95 percent tax and live under the government-dictated price control," said Ellis. "In that scenario, the manufacturer will sell only as much as they absolutely have to, since they will be forced to sell at a loss. That easily can turn into a scarcity situation, much as we have seen with baby formula this year."

Consumers will lose in other ways as well, says Ellis.

"Studies show that government price-fixing of prescription drugs—in the manner contemplated in Congress right now—will discourage the production of new drugs," said Ellis. "That means fewer cures for life-threatening diseases and shorter life expectancy for the population as a whole."

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



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COMMENTARY

A Better Way to Address Medicare Drug Price Complaints

By John C. Goodman

The Democrats' reconciliation bill imposes price controls on prescription drugs for Medicare beneficiaries.

Critics note the measure would lead to fewer new drugs, fewer cures, more avoidable deaths, and higher drug prices for the private sector.

Still, public opinion polls show high approval for the proposal. Why is that? Likely, it is because voters realize there are problems that need solving.

The solution to this is to give Medicare enrollees access to rational insurance.

Medicare's Part D Problem

In a proper insurance arrangement, people self-insure for small expenses they can easily afford while relying on third-party insurers for very large expenses.

Medicare drug coverage does the reverse. After a deductible, Medicare enrollees pay 25 cents of the next dollar of cost until the patient's out-of-pocket expenses reach a "catastrophic" limit of \$7,050. Above that amount, the patient is responsible for 5 percent of any additional costs.

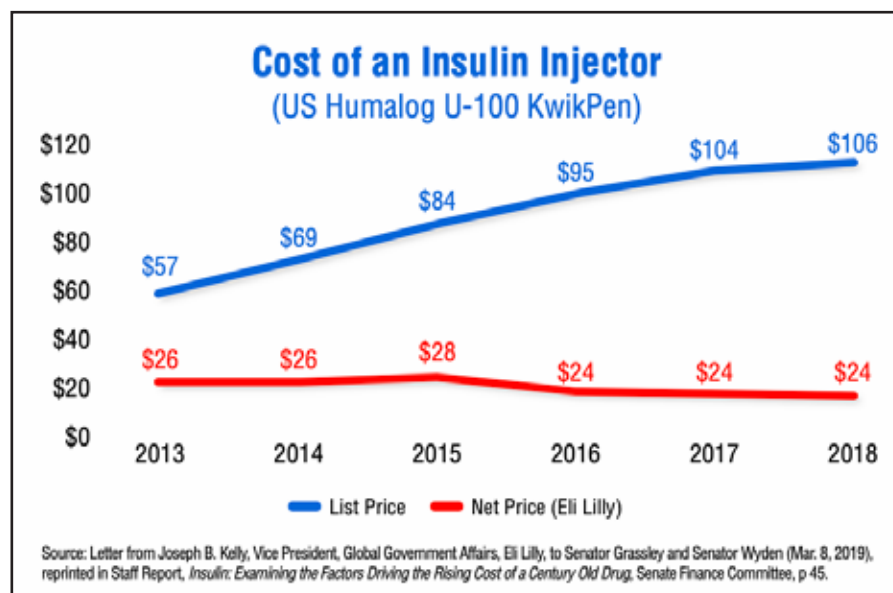
A study of 28 expensive specialty drugs found that even among Medicare enrollees covered by Part D drug insurance, out-of-pocket patient spending ranged from \$2,622 to \$16,551, annually. More than half (61 percent) of these drugs would require out-of-pocket spending averaging \$5,444 in the catastrophic phase alone.

The reconciliation bill caps the annual out-of-pocket costs for all Medicare Part D enrollees at \$2,000 and imposes price controls to boot. University of Chicago economist Tomas Philipson estimates that because of the price controls there will be 135 fewer new drugs in the next two decades—causing a loss of 331.5 million life-years in the United States. That is a reduction in life spans about 31 times as large as from COVID-19 to date!

Combined Catastrophic Coverage

Medicare could be redesigned to cover all catastrophic costs, leaving patients with the responsibility to pay for smaller expenses.

Seniors could be given better access to plans that integrate pharmaceutical and medical coverage. Medicare is the only place in our health care sys-



“Virtually all our problems in the market for prescription drugs are created by unwise public policies. The reconciliation bill will create more harm without correcting a single one of them.”

JOHN C. GOODMAN

PRESIDENT

GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

tem where plans that sell drug coverage are separate from plans for medical expenses. So, if a diabetic neglects to purchase insulin or a cancer patient neglects to pay for cancer drugs, the drug plan would profit. But the health plan that covers the patient's medical procedures will likely incur costs much greater than any savings from the failure to purchase those drugs.

That is why the typical Medicare Advantage (MA) plan and many employer plans make insulin (and many other chronic medications) free for enrollees. Yet no Part D insurer is doing that.

Perverse Plan Incentives

We should eliminate perverse incentives for drug plans.

Health plans are forced to community rate (that is, charge the same premium, regardless of health status), giving them strong incentives to attract the healthy and avoid the sick. That happens in the Obamacare exchanges: health plans discourage the sick with high deductibles and narrow provider networks and use the

savings to attract the healthy with lower premiums.

Bad as things are in Obamacare, the effects are ameliorated by imperfect risk adjustment—giving extra compensation to plans with disproportionately sicker enrollment populations. In Medicare Part D, however, the risk adjustment is even less adequate, because the risk adjusters only have access to pharmaceutical information, not underlying medical data.

This gives Part D plans a perverse incentive to overcharge the users of expensive drugs and use the surplus funds to lower premiums for healthy enrollees. The entire rebate system (discussed below) is a prime example of how this works.

Real Price Competition

Give buyers access to genuinely competitive prices.

One of the most frustrating aspects of the market for Medicare-covered drugs is the practice of basing the patient's (25 percent) copayment on the list price, even though the insurer pays a much lower net price, courtesy of a

rebate from the drug company.

In some cases, the patient's copayment is higher than the cost of the same drug purchased from GoodRX or Mark Cuban's Cost Plus Drugs (at 15 percent over the manufacturer's cost). These discount outlets are able to offer low-priced drugs because they operate outside of the Medicare Part D system and its distorted incentives.

Where Does The Fault Lie?

Why is this happening? It is tempting to search for a scapegoat.

Take the market for insulin. Critics of drug manufacturers claim the price is so high because only three companies produce insulin for the U.S. market and that smacks of monopoly. But as the graph shows, the manufacturer's (net) price in recent years hasn't even kept up with inflation.

Other critics blame pharmacy benefit managers (PBMs), the “middlemen” who contract with insurers to lower drug costs. Are they ripping everyone off by paying rock-bottom prices to the drug companies, overcharging the patient, and pocketing the difference? On the contrary, a General Accounting Office (GAO) study finds 99.6 percent of profits PBMs make from the rebate system are returned to patients in the form of lower premiums.

Perverse outcomes in the market for insulin are the result of vigorous competition in the face of perverse incentives. Antitrust law makes the outcomes worse.

In the 1990s, drug companies could give upfront discounts to large institutional buyers, and these discounts could be passed along directly to patients. But upfront discounts were replaced by after-the-sale rebates due to antitrust concerns.

Virtually all our problems in the market for prescription drugs are created by unwise public policies. The reconciliation bill will create more harm without correcting a single one of them.

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

Democrats' Spending Deal Will Extend Obamacare Subsidies

President
Joe Biden

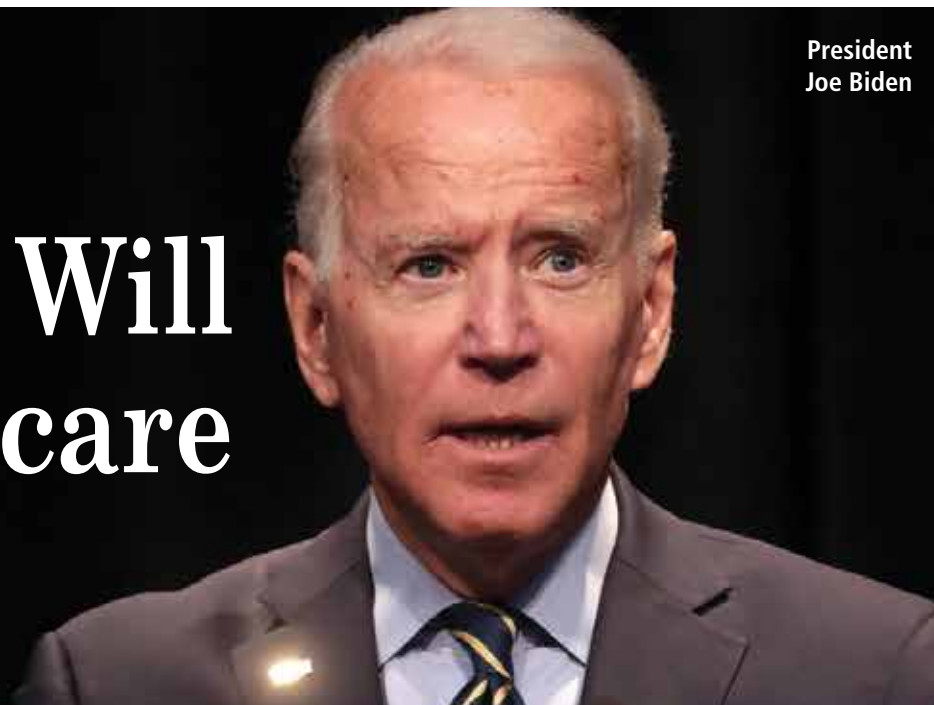


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Continued from page 1

The measure is expected to be approved by the House.

Cuts Medicare Drug Spending

The Schumer-Manchin agreement announced on July 27 pays for the subsidy extension by imposing price controls on certain Medicare prescription drugs (see related article, page 1).

Under the plan, the U.S. Department of Health and Human Services (HHS) would “negotiate” Medicare Part D drug prices with pharmaceutical companies. Drug makers that refuse to agree to the government’s price would be slapped with a 95 percent excise tax on their sales. The tax revenue would be used to pay for the Obamacare subsidies. The HHS Secretary would designate 10 drugs for price negotiations in the first year, and at least 20 drugs by the end of the decade.

Having HHS negotiate Medicare prescription drug prices as a funding mechanism for extending enhanced Obamacare subsidies could create other problems, says the Academy of Managed Care Pharmacy (AMCP) in a statement.

“The negative consequences of government intervention in the pharmaceutical marketplace have been illustrated by the best price provisions of the Medicaid prescription drug rebate program, which required manufacturers to provide large rebates to state Medicaid programs,” said the AMCP. “In response to the legislation, drug manufacturers attempted to recoup their lost profits in the government-regulated markets by charging more to consumers in other unregulated mar-

“Are buyers willing to spend their own money to cover the cost of the product being offered? A Kaiser Foundation study estimates there are almost 11 million people who have elected to remain uninsured even though they qualify for subsidies in the exchanges. Meanwhile, the unsubsidized part of the ACA market—consumers who pay full price—has been in a death spiral, losing almost half of its enrollment, 45 percent, between 2016 and 2019.”

JOHN C. GOODMAN

PRESIDENT, GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

kets and gradually raising prices to all markets over time.”

Big Long-Term Costs

The Schumer-Manchin plan to extend enhanced Obamacare subsidies will cost an estimated \$64 billion over three years.

If Congress extends the subsidies again, the cost will balloon, according to an analysis by the Kaiser Family Foundation (KFF).

“The Congressional Budget Office (CBO) expects the enhanced subsidies to cost about \$248 billion over the course of ten years if extended permanently,” states the KFF. “A large part of the estimated cost is due to the CBO’s expectation that 4.8 million more people would enroll in the ACA Marketplaces than would if the ACA enhanced subsidies are not extended.”

Poor Track Record

The COVID pandemic policy of subsidizing insurance regardless of income was ill-considered, states Doug Badger,

a senior research fellow in the Center for Health and Welfare Policy at The Heritage Foundation, in a published analysis.

“It was based on the false premise that millions of workers and their dependents had lost coverage during the government lockdowns,” wrote Badger. “It poured almost all resources into subsidizing the premiums of people who already had insurance. It made the nation’s highest earners eligible for government premium insurance.”

The Schumer-Manchin deal is a step in the wrong direction for health care, says Brian Blase, Ph.D., CEO of Blase Strategies LLC and a senior research fellow at the Galen Institute.

“Extending the enhanced Obamacare subsidies will exacerbate inflation, increase wasteful spending, lead employers to drop coverage, and provide disproportionate benefits to the health insurance companies and wealthy households,” said Blase.

“If congressional Democrats are worried about the political fallout from peo-

ple losing their subsidies, they should extend the enhanced subsidies to those who already have them,” said Blase.

Bad Deal

At present, the deductible in the Obamacare exchanges can reach \$8,700 for an individual and \$17,400 for a family of four. Adding that to the premiums makes for very costly insurance, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

“If you combine the average premium that people without subsidies paid last year with the average deductible they faced, a family of four potentially had to pay \$25,000 for their health insurance plan before receiving any benefits,” said Goodman. “This is like forcing people to buy a Volkswagen Jetta every year before their insurance kicks in. For families living paycheck-to-paycheck, this is like not having insurance at all.”

The best way to evaluate the worth of a product is to see if it can survive the market test, says Goodman.

“Are buyers willing to spend their own money to cover the cost of the product being offered?” said Goodman. “A Kaiser Foundation study estimates there are almost 11 million people who have elected to remain uninsured even though they qualify for subsidies in the exchanges. Meanwhile, the unsubsidized part of the ACA market—consumers who pay full price—has been in a death spiral, losing almost half of its enrollment, 45 percent, between 2016 and 2019.”

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

Lawmakers Press for Doctor Right to Treat

By Harry Painter

State and federal legislators are moving to ensure the rights of physicians and patients to decide what drugs to use.

Thirty-one states have either proposed or passed legislation to ensure off-label prescribing rights, with some states specifically mentioning the anti-parasitic drug ivermectin or hydroxychloroquine, the antimalarial drug with which President Donald Trump was famously treated off-label.

Tennessee made ivermectin available as an over-the-counter drug upon consultation with a pharmacist, in June. In most states, only physicians can prescribe ivermectin, and they must do so in a heavily politicized environment in which public pressure by governments and medical boards discourages use of the antiparasitic drug.

In February, Sen. Ron Johnson (R-WI) introduced the Right to Treat Act to prevent federal health agencies from interfering with doctors' and patients' treatment decisions.

Feds Suppressed Meds

During the pandemic, regulatory authorities suppressed medications that could work as therapeutics for COVID-19, such as ivermectin. A page on the U.S. Food and Drug Administration's website falsely claimed ivermectin is "not an anti-viral" and suggested off-label use of the drug is dangerous.

Raising the pressure on doctors, the Federation of State Medical Boards followed the feds' lead by warning physicians risk losing their licenses for spreading misinformation as the organization defines it (see related article, page 15).

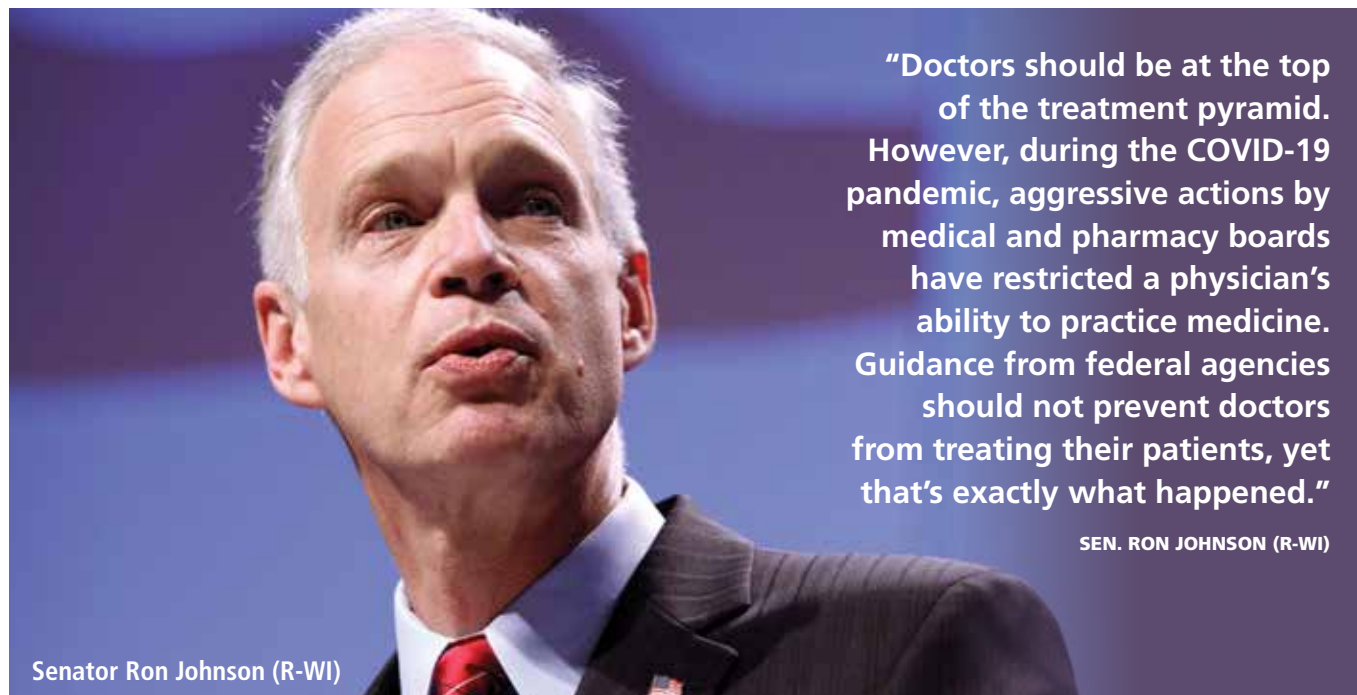
'Right to Treat' Offered

Johnson's Right to Treat Act would prevent the federal government from influencing such decisions.

"Numerous physicians have had their licenses revoked or threatened to be revoked because they prescribed off-label treatments for COVID-19," Johnson said.

The proposed law would prevent federal agencies from regulating the practice of medicine and would ensure no federal law, rule, regulation, or policy interferes with the distribution of FDA-approved drugs or Right to Try drugs.

Although guidance from public health agencies regarding off-label use of FDA-approved drugs has been technically nonbinding, the reality has been far different, says Johnson.



Senator Ron Johnson (R-WI)

"This 'guidance' from federal health agencies essentially serves as de facto regulation for states and state boards to implement," said Johnson. "Federal health agencies have used tweets, media appearances, and other guidance to influence state policies regarding the practice of medicine."

Boards, Governments Muscling In

Several medical associations, the Federation of State Medical Boards, and individual state medical and pharmacy boards responded to this guidance "by issuing statements in opposition to certain off-label treatments or by sending letters threatening the licenses of physicians and pharmacists that order, prescribe, or dispense certain off-label treatments," said Johnson.

"Doctors should be at the top of the treatment pyramid," said Johnson. "However, during the COVID-19 pandemic, aggressive actions by medical and pharmacy boards have restricted a physician's ability to practice medicine. Guidance from federal agencies should not prevent doctors from treating their patients, yet that's exactly what happened."

The use of an emergency to clamp down on the rights of patients and physicians is the opposite of what should happen, says Johnson.

"Allowing doctors to practice medicine and use their full 'off label' prescription rights is particularly important during a pandemic caused by a novel disease for which there are limited or no known treatment options," said Johnson.

Off-Label Treatment Hindered

The Congressional Research Service finds 12 to 38 percent of all doctor-office prescriptions are off-label. One downside of making off-label prescriptions harder to obtain during the pandemic was the increased difficulty of treating patients with non-COVID problems, says Johnson.

"Hydroxychloroquine is used in an off-label capacity to treat lupus," said Johnson. "During COVID-19, many of these patients had a hard time filling their prescriptions due to government and medical board barriers to treatment."

Naomi Lopez, vice president for health care policy at the Goldwater Institute, says laws should always serve the needs of patients, not just during a pandemic.

"Laws that respect the important principle of patient autonomy serve to get us closer to the goal of getting the right treatment to the right patient at the right time," Lopez said.

"Regardless of the timing—during a public health emergency or not—a patient's autonomy should never be compromised or limited by arbitrary federal rules and red tape that keep them from seeking needed care," said Lopez.

Popular Legal Solution

The Right to Treat Act is one of several medicine policy reforms offered since Trump signed the Right to Try law in 2018. Lopez says 41 state and federal Right to Try laws have been enacted to allow patients access to "investigation-

al treatments that have passed basic safety evaluation and remain in clinical trials, without first having to beg the federal government for permission."

"The original Right to Try law is saving lives, accelerating clinical development, and restoring the practice of medicine where it rightfully belongs: between doctor and patient, not federal bureaucrats," said Lopez.

Press for Prescribing Rights

The Goldwater Institute is backing an extension of Right to Try, called Right to Try 2.0.

"The Right to Try for Individualized Treatments, also known as Right to Try 2.0, allows patients, under their doctors' care, to seek personalized treatments that are tailor-made for them, often based on their unique genetic makeup," said Lopez.

With Right to Try laws defending patient rights, Right to Treat is focused on the other side of the coin: doctors' prescribing rights. Lopez says the federal government does not have the constitutional authority to intervene in doctors' decisions.

"The Goldwater Institute affirms that the practice of medicine is an authority granted to state governments," said Lopez. "No federal agency or rule should restrict the lawful practice of medicine—including but not limited to the prescribing of FDA-approved treatments and, where legal, investigational treatments."

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

Republican Bills Promote Hospital Competition

By Ashley Bateman and
AnneMarie Schieber

The Republican Study Committee's Health Care Task Force has proposed a set of bills in the U.S. House of Representatives to improve hospital competition.

U.S. Reps. Kevin Hern (R-OK), Rick Allen (R-GA), and Victoria Spartz (R-IN) of the Task Force's Affordability Subcommittee introduced several bills that would repeal Obamacare prohibitions on physician-owned hospitals, increase oversight of anticompetitive behavior, improve transparency in hospital billing practices, and review clauses in health care contracts that restrict competition.

The legislation would reduce the cost of health care, said Joel White, president of the Council for Affordable Health Coverage (CAHC), in a statement.

"To further promote competition, Congress should adopt these bills to set the right conditions for market rivalries," said White. "The result could be electric, reducing the price of medical services and lowering premiums significantly."

Bills introduced on June 16 include the Flexibility in Hospital Ownership Act (H.R. 8132), the Oversight of Anti-Competitive Behavior of Non-Profit Hospitals Act (H.R. 8129), the Transparency of Hospital Billing Act (H.R. 8133), the Consumer Choice of Care Act (H.R. 8134), and the Competition in State Healthcare Markets Act (H.R. 8130).

Private Coverage Preferred

Regardless of political affiliation, people do not want their health care arrangements fundamentally changed, instead favoring smaller improvements that would lead to better access, expanded coverage, and lower costs, a CAHC voters poll reports.

The survey found 82 percent of all respondents were satisfied with their health care coverage, regardless of type. Though respondents said they were generally satisfied, 51 percent want to "keep the basics of the current health care system in place but make improvements where we can."

Forty-six percent of those polled had job-based insurance. The poll found strong support for employment-based coverage. Forty-eight percent strongly supported making out-of-pocket costs tax-deductible.

Respondents were in favor of price controls on prescription drugs (40



"People with serious health problems should be able to buy insurance that gives them access to the doctors they need, as an alternative to the narrow provider networks in the Democrat-created health insurance exchange plans."

JOHN GOODMAN

PRESIDENT, GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

percent strongly support) until they learned controls would lead to fewer treatments (23 percent strongly support).

Voters Support HSAs

The poll found voters support HSAs, regardless of party, White told *Health Care News*.

"One idea with stratospheric bipartisan support is lowering out-of-pocket costs, like expanded use of health savings accounts," said White. "Congress could easily make this a reality by updating HSA rules to allow more Americans access and expand how those accounts can be used."

Incremental Reforms Favored

The survey results suggest voters do not want radical changes in the health care system, says Gregg Girvan, a research fellow at the Foundation for Research on Equal Opportunity.

"The polling results overall show there is an opening for health reform, but it is most likely to succeed if reform is incremental rather than replacing the existing system; for example, expanding coverage while leaving the employer-sponsored insurance system intact," said Girvan.

Interpretations Differ

Support for changes could indicate people's underlying dissatisfaction with current coverage, says Girvan.

"The pollster seems to conclude the

high level of satisfaction with insurance coverage is the main reason voters do not want fundamental changes to the system," said Girvan. "That is certainly one plausible interpretation and lines up with other polling that indicates support for proposals like Medicare for All drops when people realize how their employer-sponsored plans are likely to be affected. ... [However,] it signals underlying discontent with existing coverage that isn't immediately obvious with polling that asks about general satisfaction with health coverage."

The poll missed an opportunity to explore satisfaction further, says Girvan.

"The polling results don't necessarily mean people think their coverage could not be better," said Girvan. "Other polling suggests people are still worried about unexpected medical bills, the amount of their deductibles and other cost-sharing, and rising prescription drug costs, especially in light of recent concerns over inflation."

"These concerns signal possible discontent with available coverage options," said Girvan.

Dissatisfied with Congress

Forty-two percent of the respondents trust Democrats on health care, 34 percent trust Republicans, and 25 percent are not sure, says White.

"CAHC polling shows Americans do not believe Congress is addressing

their health care priorities," said White. "While lawmakers focus on government takeover of health care, they are ignoring that most Americans have coverage and like it a lot. Most get coverage through their employer and are concerned about rising health costs and want Congress to do something about it."

John Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*, says the solution is straightforward.

"People should be able to buy insurance that meets their financial and health care needs, as an alternative to the outrageous deductibles and unaffordable premiums in the Democrat-created health insurance exchange plans," said Goodman. "People with serious health problems should be able to buy insurance that gives them access to the doctors they need, as an alternative to the narrow provider networks in the Democrat-created health insurance exchange plans."

Multiple Polls Conducted

The CAHC conducted three separate polls, with the first one done in a focus-group setting of 100 Virginia voters who voted for Democrat Joe Biden for president and Republican Glenn Youngkin for governor. All participants were voters from outside northern Virginia.

Based on those results, CAHC polled 34 voters from around the country among not-so-strong Republicans and independents who had health insurance and insurance coverage. The third poll, based on the previous results, surveyed 100 respondents matched to the DataTrust voter file. The poll reports a margin of error of plus or minus 3.1 percent.

Ashley Bateman (bateman.ae@googlemail.com) writes from Virginia. AnneMarie Schieber (amschieber@heartland.org) is the managing editor of *Health Care News*.

INTERNET INFO

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<https://static1.squarespace.com/static/58bf2243d482e99321a69178/t/628699e7b60cd62112/102c42/1652988392332/CAHC%2BPolling+2022.pdf>

Illinois Clamps Down on Surprise Medical Billing

By Kevin Stone

An Illinois state law extending consumer protections created by the federal No Surprises Act will become fully effective on January 1, 2023.

The federal law protects consumers from surprise bills—also called balance billing—for emergency services delivered by out-of-network physicians or facilities, and for nonemergency services provided by out-of-network physicians in network facilities when patients do not consent.

Costs for the insured will be limited to cost-sharing amounts that apply to in-network services, and providers are banned from billing for any higher amounts. The federal law complements and defers to state laws that afford such protections.

Surprise medical bills often arise when the patient needs immediate care and can't review the coverage status of every medical professional involved in their care but seeks an in-network medical facility with the expectation the medical providers at the facility will also be in-network.

Cap, Dispute Resolution

The Illinois law requires insurers to hold enrollees harmless for amounts beyond the in-network level of cost sharing and prohibits out-of-network providers from billing enrollees for any amount beyond the in-network cost.

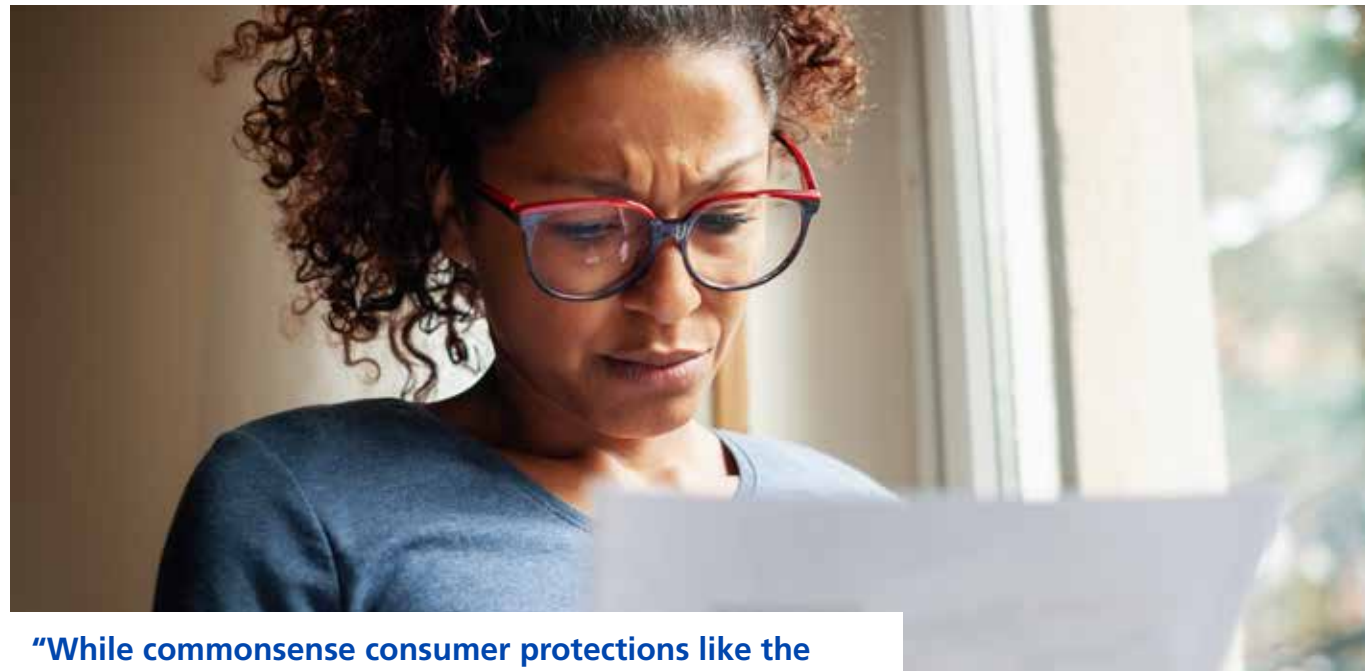
It also provides a dispute resolution process whereby the insurer can pay the billed amount or attempt to negotiate reimbursement with the out-of-network provider. If attempts to negotiate the amount are not resolved, the insurer or the physician may initiate binding arbitration by filing a request with the Illinois Department of Insurance.

The law does not cover ground ambulance services, services received at out-of-network facilities, enrollees who consent to nonemergency out-of-network services, or enrollees in employer self-funded health plans.

Transparency and Advertising

Although most analysts agree reform was necessary to avoid excessive billing, there is considerable disagreement on whether binding arbitration is the best approach to the problem. Requiring transparency and truth in advertising would be more effective, says John C. Goodman, president and CEO of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"This is a command-and-control



"While commonsense consumer protections like the No Surprises Act and complementary bills like Illinois' make sense, it is simply treating a symptom. Only more choices and a return to a freer market system will help alleviate the root cause of this problem."

MATT DEAN
SENIOR FELLOW
THE HEARTLAND INSTITUTE

approach which could lead to lack of access to care," said Goodman. "The better approach is to prohibit false advertising. Insurers should not be allowed to advertise that a hospital is in their network if some medical services delivered there are by nonnetwork doctors charging nonnetwork fees. Similarly, hospitals should not be able to advertise they are in an insurer's network if some services they provide are not in the network."

Costs of Control

Mandatory arbitration of billing disputes and rate benchmarking create additional problems, says health economist Devon Herrick, Ph.D., a contributor to the Goodman Institute Health Blog and policy advisor to The Heartland Institute, co-publisher of *Health Care News*.

"Many states and the federal government have passed laws trying to reduce surprise medical bills," said Herrick. "Some state laws are better than others, but none are perfect. The problem is that none really follow free-market principles. States that use an arbitration board are not free-market, as no other industry allows a vendor to sup-

ply a service and have a third party negotiate fee disputes after-the-fact."

Instead of being subjected to more regulations and arbitration, hospitals could solve the problem easily by coordinating with insurance companies, says Herrick.

"Benchmarking out-of-network fees to in-network rates is also problematic," said Herrick. "Hospitals are the owner of the emergency room but make no effort to align those allowed to staff emergency rooms with the networks the hospital affiliates with."

'Massive Overregulation'

Past governmental intrusion into the health care market, and particularly the Affordable Care Act (ACA), may have contributed to the problems surprise billing laws are intended to correct, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute.

"First, the ACA made middle-income folks eligible for Medicaid, who should have private health insurance," said Dean. "Medicaid reimburses hospitals and physicians below cost, and many rural and big city hospitals see their patient mix changing so that the

majority of patients are on Medicaid, Medicare, or both."

As millions of people dropped their private insurance for Medicaid coverage, hospitals were forced to form billing alliances and narrow networks to stay in business, says Dean.

"It also drove insurance agents and plans out of business through massive overregulation of the private health care system, and its complicated publicly funded subsidies," said Dean.

"Policyholders now pay more and get less, so that those on public programs can pay less and get more," said Dean.

'Treating a Symptom'

Obamacare did not live up to its advocates' claims, says Dean.

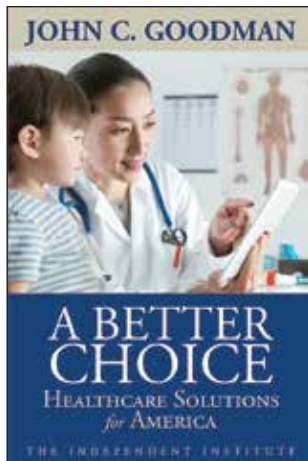
"The promise was, 'If you like your plan, you can keep your plan, and if you like your doctor, you can keep your doctor,' but what if your plan has been declared illegal and your doctor is now out of network?" said Dean. "President Obama's promise turned out to be a lie for most people on private health insurance."

The ACA put doctors and hospitals in a vise, says Dean.

"While commonsense consumer protections like the No Surprises Act and complementary bills like Illinois' make sense, it is simply treating a symptom," said Dean. "Only more choices and a return to a freer market system will help alleviate the root cause of this problem."

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

Prescription for Better Healthcare Choices

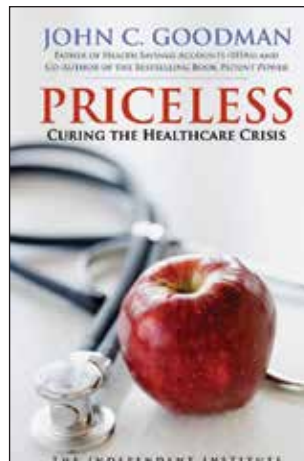


A Better Choice Healthcare Solutions for America John C. Goodman

"John Goodman understands the real life effects of the Affordable Care Act and the proposed alternatives. John also writes extremely well, making complicated concepts clear. All this makes *A Better Choice* a highly recommended read for those who wish to understand the current health policy debate."

—Bill Cassidy, M.D., U.S. Senator

Polls show that by a large margin Americans remain opposed to Obamacare and seek to "repeal and replace" it. However, the question is: Replace it with what? In *A Better Choice*, John C. Goodman clearly and concisely provides the compelling answer. For anyone who wants to learn about some of the boldest prescriptions designed to remedy our healthcare system, Goodman's book is a must-read.



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COMMENTARY

Tomorrow's Doctors Already Practice 'Cancel Culture'

By Charles Hilu

Incoming University of Michigan Medical School students staged a walkout of the school's White Coat Ceremony to protest the choice of a pro-life doctor as the ceremony's keynote speaker.

Students previously attempted to pressure the administration to cancel the July 24 speech of Kristin Collier, M.D., a pro-life assistant professor of medicine at the university. They submitted a petition claiming the choice of Collier as a speaker made them "doubt whether the school will continue to advocate for reproductive rights."

The school's dean, Marschall Runge, M.D., refused to disinvite her, citing the "critical importance of diversity of personal thought and ideas, which is foundational to academic freedom and excellence."

Speaker Extends Olive Branch

"I want to acknowledge the deep wounds our community has suffered over the past several weeks," said Collier as she began her speech, which was not about abortion, apparently referencing the controversy.

"We have a great deal of work to do for healing to occur," said Collier. "And I hope that for today, for this time, we can focus on what matters most: coming together to support our newly accepted students and their families with the goal of welcoming them into one of the greatest vocations that exist on this Earth."

Some students were apparently not ready to do that, and they walked out of Hill Auditorium, the ceremony's venue, as soon as Collier was introduced.

Academic Freedom Damaged

On its face, this collective decision by



many of the incoming students is inappropriate for civil society and academia.

Whenever one of these incidents occurs, we rightly lament the damage it does to academic freedom.

Collier's speech was not political at all, nor was it planned to be. She did not talk about abortion or praise the overturning of *Roe v. Wade*. She simply gave advice to the students as they entered their profession.

Students wanted to cancel her simply because she publicly holds pro-life beliefs. They could not stand to hear from a speaker with whom they disagreed, even when she was not espousing those views to them.

Cancel Patients, Next?

We should certainly be concerned about the state of our universities and campus cancel culture, but this incident should mean a lot more.

The White Coat Ceremony is a rite of passage for new medical students. The giving of the coat symbolizes their entry into the medical profession and their readiness to take on the duties that come with it.

One of those duties is to care for patients who may have different political views. If a patient says or believes something with which doctors disagree, they still must care for that person. One cannot be confident doctors will properly serve this patient if they cannot tolerate beliefs that contradict their own.

No one is asking these med-school students to agree with Collier's beliefs. They simply have a duty as future physicians, university students, and citizens of a civil society to respect her right to hold them. They should be ashamed of their actions, and they need to take a moment to reflect seriously on whether they will be able to discharge their obligations properly when they finish medical school.

Otherwise, they contribute to the rot in the academy and degrade the profession of medicine.

Charles Hilu (@charleshilu73) is a rising senior studying political science at the University of Michigan and a summer editorial intern at National Review. A version of this article appeared in National Review on July 24. Reprinted with permission.

"One of those duties is to care for patients who may have different political views. If a patient says or believes something with which doctors disagree, they still must care for that person. One cannot be confident doctors will properly serve this patient if they cannot tolerate beliefs that contradict their own."

CHARLES HILU
UNIVERSITY OF MICHIGAN

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Correction

In "VA Secretary Hints at Limiting Community Health Care" in our August 2022 issue, we inadvertently attributed a FOIA request as being made by Concerned Veterans of America. The FOIA request was made by the Americans for Prosperity Foundation. We regret the error.

State AGs Warn Google Not to Censor Pregnancy Aid Centers

By Kenneth Artz

Virginia Attorney General (AG) Jason Miyares and 16 other Republican AGs warned Google it could face legal consequences for viewpoint discrimination after 21 Democrat members of Congress urged the company to censor search results for “abortion services” by excluding crisis pregnancy centers.

The AGs advised Alphabet Inc. (Google) CEO Sundar Pichai they will investigate potential violations of state antitrust laws and religious discrimination and sue the company if it does so, in a letter on July 21.

“Suppressing pro-life and pro-mother voices at the urging of government officials would violate the most fundamental tenet of the American marketplace of ideas,” states the AGs’ letter.

Congressional Pressure

U.S. Sen. Mark Warner (D-VA) and 20 other Democratic lawmakers previously wrote to Pichai urging action to change search results for Google and Google Maps.

“Google should not be displaying anti-abortion fake clinics or crisis pregnancy centers in search results for users that are searching for an ‘abortion clinic’ or ‘abortion pill,’” the letter states.

U.S. Sen. Elizabeth Warren (D-MA), who signed the legislators’ letter and later called for crisis pregnancy centers to be shut down, introduced the Stop Anti-Abortion Disinformation Act, which would give authority to the Federal Trade Commission to prohibit “deceptive or misleading advertising” about the provision of abortion services, on June 23, before the U.S. Supreme Court overturned *Roe v. Wade*.

‘Politicians’ Sneering Insults’

Google should not bow to political pressure, the AGs say.

“That Members of the United States Congress would openly call for the full weight and power of the federal government to shut down private charitable organizations that have shown compassion and love to so many vulnerable women over the years is unconscionable,” wrote the AGs. “Left-wing politicians’ sneering insults toward crisis pregnancy centers and their important work is all the more disturbing because it comes at a time when pro-life pregnancy centers are literally under attack



by violent pro-abortion activists.”

Google must be unbiased or face legal action, said Miyares in a press statement.

“American consumers expect diversity of opinion and thought,” said Miyares. “The idea that elected officials are both advocating for the removal of private charities and encouraging Google to outwardly discriminate against crisis pregnancy centers and silence voices different than their own is appalling.”

Growing Demand

The nonprofits that offer women abortion alternatives perform valuable services, the AGs say.

“According to a 2020 study, crisis pregnancy centers served over 1.8 million clients in 2019, providing services valued at \$266 million at little or no cost to their patients,” wrote the AGs. “These services included free ultrasounds, pregnancy tests, testing for sexually transmitted diseases, parenting and prenatal education classes, post-abortive care and recovery counseling, and free or reduced-cost diapers, baby clothes, car seats, and strollers.”

Demand for the services has grown so much that it prompted HELP Pregnancy Aid, a Michigan charity, to expand, says Executive Director Paula Veneklas.

“Pregnancy center services go far beyond the immediate problems a woman might be facing in an unexpected pregnancy to the resources she needs to look at her situation long-term,” said Veneklas.

Pregnant women are overwhelmingly likely to have their children if they get the right help, says Veneklas.

“What we experience when working with women vulnerable to thinking abortion is their only option is that usually it is not the baby that is the problem,” said Veneklas. “If we can alleviate the circumstances with information, community support, and resources, women will 92 percent of the time make a choice that will bring her pregnancy to term.”

‘Google Is the Nanny Company’

Google has revised its official code of conduct, removing the goal of “providing our users unbiased access to information,” stated the AGs.

What Google does and should do could be two different things, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

“Google should be an open forum, a free market for ideas,” said Goodman. “If it’s not functioning that way, then it should warn people that when they search on Google it’s not a real search



“American consumers expect diversity of opinion and thought. The

idea that elected officials are both advocating for the removal of private charities and encouraging Google to outwardly discriminate against crisis pregnancy centers and silence voices different than their own is appalling.”

JASON MIYARES
VIRGINIA ATTORNEY GENERAL

and there’s nanny regulation because they decide what you should see and what you shouldn’t see. You’ve heard of the nanny state; well, Google is the nanny company.”

Tech companies like Google may downplay information about crisis pregnancy centers because they want to keep women from having options, says Goodman.

“I can understand why there would be limits on what people would put online,” said Goodman. “But they’ve gone way beyond that. These highly educated young people want to impose their woke ideology on other people, not because the ideas they’re against are a dangerous threat against anybody or because they’re criminal. They do it because they just don’t like them.”

‘Aware of All Options’

Censoring pregnancy support services interferes with a woman’s right to choose, says Veneklas.

“To make a choice about something this important would mean she should be aware of all options before her,” said Veneklas. “Included in the options should be the right to explore what it would be like to parent or make an adoption plan for her baby.

“To offer abortion as her only way out of a difficult situation is to say that there are no resources available to her, and that is simply not the case,” said Veneklas. “If she is being told that, she is being lied to.”

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

Biden Administration Uses Executive Actions to Overrule State Abortion Laws

By Harry Painter

The U.S. Department of Health and Human Services (HHS) issued guidance letters telling health care providers and pharmacists nationwide they must give access to emergency abortions and abortion drugs.

HHS Secretary Xavier Becerra wrote to hospitals stating the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 preempts state laws that conflict with it and requires providers to give unlimited forms of treatment in emergency cases involving pregnancy, on July 11.

“Stabilizing treatment could include medical and/or surgical interventions (e.g., abortion ...), irrespective of any state laws or mandates that apply to specific procedures,” wrote Becerra.

The HHS rule overrides any state abortion laws, Becerra states in the letter.

“Any state laws or mandates that employ a more restrictive definition of an emergency medical condition are preempted by the EMTALA statute,” wrote Becerra.

Pharmacy Discrimination Angle

The HHS Office for Civil Rights (OCR) issued guidance telling pharmacies they are obligated under federal law to fill orders for abortifacient drugs and contraceptives, on July 13.

Doing otherwise would constitute discrimination against “women and pregnant people,” states the OCR guidance.

“Under federal civil rights law, pregnancy discrimination includes discrimination based on current pregnancy, past pregnancy, potential or intended pregnancy, and medical conditions related to pregnancy or childbirth,” states the OCR.

Both documents warn that hospitals and pharmacies violating HHS’s interpretation of federal law could lose eligibility for Medicare and Medicaid reimbursement.

‘Attempt to Coerce Doctors’

The U.S. Supreme Court overturned *Roe v. Wade* and returned jurisdiction over abortion to the states in its June 24 decision in *Dobbs v. Jackson Women’s Health*. Invoking EMTALA in response to the decision is deliberately misleading, says Rachel N. Morrison, J.D., who focuses on HHS policy



President Joe Biden

at the Ethics and Public Policy Center (EPPC).

“No state abortion law prohibits medical professionals from treating miscarriage, ectopic pregnancy, or other life-threatening situations a pregnant woman may face,” said Morrison. “The suggestion by the Biden administration to the contrary in its EMTALA guidance is misinformation and dangerous to women who wrongly believe they cannot receive necessary medical care.”

On the contrary, EMTALA is supposed to ensure women and their babies receive needed emergency care, says Morrison.

“EMTALA is a pro-life statute, and its text explicitly recognizes the life and health of a pregnant mother and her unborn child,” said Morrison. “HHS’s EMTALA guidance is a thinly veiled attempt to coerce doctors to perform abortions contrary to their consciences.”

In addition, the letter encourages physicians to violate state laws, says Morrison.

“[The guidance intends to] give cover to pro-abortion doctors to perform abortions in states that protect life, when EMTALA requires no such thing,” said Morrison.

Pill Push

The HHS guidance to pharmacists is unethical, says Morrison.

“Pharmacists are not vending machines; they are medical professionals that exercise autonomous medical judgment and expertise on over 20,000 FDA-approved drugs,” said Morrison. “Just as no doctor should be forced to perform an abortion, no pharmacist

should be forced to provide drugs to intentionally end a child’s life in the womb, nondiscrimination laws notwithstanding.”

Texas Legal Challenge

Texas Attorney General Ken Paxton filed a lawsuit in federal district court to challenge Becerra’s guidance.

“The Biden Administration’s response to *Dobbs v. Jackson Women’s Health* ... is [an] attempt to use federal law to transform every emergency room in the country into a walk-in abortion clinic,” states Paxton’s complaint. “President Biden is flagrantly disregarding the legislative and democratic process—and flouting the Supreme Court’s ruling before the ink is dry—by having his appointed bureaucrats mandate that hospitals and emergency medicine physicians must perform abortions. But Defendants’ Abortion Mandate forces hospitals and doctors to commit crimes and risk their licensure under Texas law.”

States’ Role

Texas should be commended for resisting improper federal interference with state abortion laws, says Andy Schlafly, general counsel for the Association of American Physicians and Surgeons.

“The Biden administration should not be attempting to dictate to states, such as Texas, what should be done concerning abortion within their states,” Schlafly said. “I expect Texas to prevail, and that should help bolster state autonomy nationwide to protect religious liberty and the unborn.”

State governments are the proper

“The Biden administration should not be attempting to dictate to states, such as Texas, what should be done concerning abortion within their states.”

ANDY SCHLAFLY

GENERAL COUNSEL

ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

domain for abortion law, from legal and democratic perspectives alike, says Schlafly.

“The state level is far better,” said Schlafly. “There is more political accountability there, and less influence by a handful of elites in the liberal media and a few law schools.”

Dobbs is a win for the U.S. Constitution and representative government, says Morrison.

“The Supreme Court corrected its deadly error in *Roe* and rightly recognized that the Constitution does not contain any right to abortion,” Morrison said. “There is no federal compelling government interest in abortion. The Court sent the issue back to the people’s elected representatives, which will allow laws that reflect the values in the community.”

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

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INTERVIEW

Was the COVID-19 Mass Vaccination Campaign a Deadly Mistake?

In 2020, cardiologist and epidemiologist Peter McCullough, M.D. became one of the most vocal proponents of using safe, existing drugs to treat COVID-19. That approach was ignored or derided by governments and mass media in favor of a mass vaccine campaign using a genetic product with no more than two months of trial data. *Health Care News* spoke with McCullough at a recent health care summit in Michigan, discussing the last two years and how to use what we have learned going forward.

Health Care News: A few months into the pandemic, you described how troubled you were that government health agencies were so resistant to an early treatment approach in protecting people from the COVID-19 virus. You wondered if there was going to be a massive effort to push vaccines. You were right. Do you feel vindicated?

McCullough: The idea of a mass vaccine campaign seemed preposterous because we never mass vaccinate for illnesses, particularly during a prevalent pandemic. If we had an outbreak of staph, we would never put [every uninfected person] on antibiotics because it would invite resistant strains.

By the end of February 2021, 27 million people had taken the vaccine—far too many for a brand-new genetic product with no assurances they were safe. About 2.7 million people—nursing home patients and staff—should have received these new products, not millions, and very carefully. For genetic products such as these, we should have five years of safety data. Instead, we had two months.

Health Care News: People have certainly grown weary of the pandemic. At least one poll shows COVID-19 is at the bottom of the list of voter concerns. Fewer people are wearing masks, and those who declined the shots don't seem inclined to change their minds now, especially when shot proponents like Anthony Fauci and President Joe Biden have been infected. Can we declare COVID-19 over?

McCullough: If you go on social media and type in “#Covid is not over,” the people who use this hashtag are the



same people who use “#vaccines work,” and “#get vaccinated.” So, there is this mindset out there that COVID is not over and it's all about vaccines.

If vaccines worked, we wouldn't need a hashtag that says vaccines work. Do we have a hashtag that says cars work? There are people out there who think COVID is not over or don't want COVID to be over. They believe vaccines work and they want everyone to get vaccinated. But COVID has mutated to a point where it has basically become the common cold.

Health Care News: You had a close relationship with Dr. Vladimir “Zev” Zelenko, one of the biggest champions of early COVID treatment, who spoke out forcefully against the mass vaccine approach before he lost a long battle with cancer. Many people called him a freedom fighter. Do you agree?

McCullough: We did lose a freedom fighter. He lost his life early, and it was expected. He was also, in many of his statements, going for broke. He knew he had little time. He warned the world not to mass-vaccinate with a brand-new genetic product that codes for the lethal Wuhan spike protein.

We are seeing record rates of life insurance claims among working people, largely working for employers who mandated COVID-19 vaccines. Record numbers! We have seen celebrity after celebrity become injured or die after getting the vaccine.

What has been interesting is the psychology. When people die, there is typically some kind of reaction, some kind of outrage, or some type of explanation. For instance, these deaths that occur in young people [are] now called “sudden adult death syndrome.” There is a death, there is no explanation behind it, typically. It's like natural causes, like they were found dead in their sleep.

People don't naturally die in their sleep, and we've seen this over and over again. The first one was Hank Aaron, and within a few weeks after getting the vaccine before cameras, he died. The press disconnects the two events, and that should tell you something.

Health Care News: How worried should the public be about censorship in medicine?

McCullough: There has been censorship in COVID-19 and the concern is this could spread to other diseases. In my book, *Courage to Face COVID-19*, [I discuss] the censorship in COVID applied by a group of stakeholders I call the biopharmaceutical complex. They include the Centers for Disease Control and Prevention, the National Institutes of Health, the U.S. Food and Drug Administration, the World Health Organization, the Coalition for Epidemic Preparedness Innovations, the Global Alliance for Vaccines and Immunization, the Gates Foundation, Wellcome Trust, and the vaccine manufacturers.



“It's basically a syndicate that has the mission of mass vaccinating

the world with no exceptions, and it is in the open that that is what they want to do. There is no discussion about whether the vaccines can be safe or are working; that is censored. The false narrative is coming through that syndicate mechanism down through the medical literature, medical colleges, hospitals, health systems, doctors, and the media.”

PETER MCCULLOUGH, M.D.

It's basically a syndicate that has the mission of mass vaccinating the world with no exceptions, and it is in the open that that is what they want to do. There is no discussion about whether the vaccines can be safe or are working; that is censored. The false narrative is coming through that syndicate mechanism down through the medical literature, medical colleges, hospitals, health systems, doctors, and the media.

Health Care News: What can the public do to speak out against this?

McCullough: I think it can start in the physician's office. If a doctor recommends the COVID-19 vaccine, the patient should say they researched the topic and they just don't feel safe taking it.

I want that doctor to hear it from a patient, because the vast majority of doctors took these [shots]. Once someone takes the vaccine, they figure, if I took a risk, the next person needs to do the same. It is up to the patient to break that cycle.

Physicians Sue Specialty Boards for Threatening Certifications

By Bonner Russell Cohen

A doctors' group is suing three medical specialty boards for threatening physicians with loss of professional credentials for criticizing COVID-19 pandemic policies.

The Association of American Physicians and Surgeons Educational Foundation (AAPS) filed a lawsuit against the American Board of Internal Medicine (ABIM), the American Board of Obstetrics & Gynecology (ABOG), and the American Board of Family Medicine (ABFM) in the U.S. District Court for the Southern District of Texas on July 12.

"Defendants wrongly misuse their authority in a politically partisan manner to chill speech critical of positions taken by Dr. Anthony Fauci, lockdowns, mask mandates, COVID vaccines, and even abortion," states the AAPS complaint.

'Defendants Improperly Chill Speech'

These government-influencing organizations control the ability of doctors to practice medicine, says the AAPS.

"Although only official state medical boards have the authority to regulate the practice of medicine, certification by the Board Defendants constitutes a *de facto* essential credential for practicing in most hospitals or participating in most networks," states the AAPS complaint. "By threatening to revoke board certification of physicians, the Board Defendants improperly chill speech by physicians without the political accountability of state medical boards."

Actions by these credentialing groups directly affect doctors' livelihoods and patients' access to care, states the AAPS on its website.

"Losing certification often results in the loss of a physician's hospital privileges and insurers frequently make board certification a requirement to pay for care," states the AAPS. "In other words, when a specialty board takes away a physician's board certification, they may be taking away patients' access to that doctor."

'Partisan Retaliation'

The three organizations have taken specific actions that threaten physicians' livelihoods for expressing views different from those of the certification entities, states the AAPS complaint.

"The Board Defendants have announced their campaign to take



action against certifications earned by physicians who make public statements with which the Board Defendants disagree," states the complaint. "Defendants ABIM and ABFM have already sent the letters to physicians threatening them with revocation of their earned board certification based on the exercise by those physicians of their First Amendment Rights on matters of public policy."

The boards have cautioned doctors against voicing disagreement with them on COVID-19 and reproductive issues, states the complaint.

"Defendant ABOG has publicly warned physicians against making statements against abortion and contraception, lest they have their board certification revoked by ABOG if it disagrees with such statements," the complaint states. "The partisan retaliation by Board Defendants has been based in part on statements by physicians warning pregnant women against receiving the Covid vaccine, even though the World Health Organization issued a similar warning in 2021."

'Experimental Products'

ABIM sent a letter threatening disciplinary action to Peter A. McCullough, M.D., an internist, cardiologist, and epidemiologist in Dallas, Texas, who was one of the first to question the efficacy of the vaccines (see related article, page 14).

"They went back and cited public statements I made and said basically that they disagreed with them," said

McCullough. "They pulled out statements—many of which I made under oath—to the U.S. Senate twice and the Texas Senate twice. They said the statements could lead someone to think the vaccines weren't effective. They presume the vaccines are safe and effective and that people should take them."

The ABIM is violating principles of ethical research adopted after World War II to prevent atrocities like those committed by the Nazis, says McCullough.

"The vaccines are under EUA (Emergency Use Authorization), and no board, no doctor, can ever encourage or discourage people from taking them because they're experimental," said McCullough. "The ABIM is violating the Nuremberg Code. You can't pressure people to take experimental products."

Medical License Threatened

State medical licenses are also at stake for physicians like Scott Jensen, M.D., who practices family medicine in Chaska, Minnesota.

Jensen questioned the COVID-19 death count, promoted off-label treatment with ivermectin, and called for banning private-sector vaccine mandates. He was one of the first to call attention to the fact hospitals received more money by diagnosing patients with COVID-19.

Jensen's views put him in the crosshairs of the Minnesota Board of Medical Practice, which is investigating him for the fifth time.

"Medical boards are there to protect public safety through high standards of training and public practice. They are not there to chill speech or define 'misinformation' or 'disinformation.' These terms have been used as political weapons against adversaries both to the Right and the Left."

MATT DEAN
SENIOR FELLOW
THE HEARTLAND INSTITUTE

'Political Weapons'

The AAPS complaint also names Homeland Security Secretary Alejandro Mayorkas, who proposed a Disinformation Governance Board designed to pressure social media and professional groups to censor speech with which the Biden administration disagrees, states the complaint.

Licensing and certification groups are undermining their credibility by caving to political pressure and amplifying abuses of power, says Matt Dean, senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"Medical boards are there to protect public safety through high standards of training and public practice," said Dean. "They are not there to chill speech or define 'misinformation' or 'disinformation.' These terms have been used as political weapons against adversaries both to the Right and the Left."

"It is very sad to see these terms coming from boards themselves as they are badgered by political groups to engage in broader political disputes," said Dean. "Science by its very nature is never settled, and declaring it so has seldom ended well for science."

The ABIM will consider disciplinary action against McCullough at a closed meeting later this summer.

"I have no idea who will attend, what rules they will be using to adjudicate," said McCullough. "It's basically a kangaroo court."

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

FTC Launches Probe of Pharmacy Benefit Manager Practices

By Kevin Stone

The Federal Trade Commission (FTC) is investigating the practices of pharmacy benefit managers (PBMs).

The FTC voted 5-0 to conduct a study under Section 6(b) orders, which authorize special reports on the competitive impact of supply chain disruptions in consumer goods, on June 7.

The FTC stated it will order the six largest PBMs to submit records and answer questions. The six companies are CVS Caremark; Express Scripts, Inc.; Humana Inc.; MedImpact Healthcare Systems, Inc.; OptumRx, Inc.; and Prime Therapeutics LLC.

The inquiry will shed light on several practices that have drawn scrutiny in recent years, including fees charged to unaffiliated pharmacies, an FTC press release states.

The FTC is also looking at how patients are steered to PBM-owned pharmacies; potentially unfair audits of independent pharmacies; complicated and opaque methods to determine pharmacy reimbursement; the prevalence of prior authorizations and other administrative restrictions; policies on



“Currently, it is difficult for new entrants with different business models to break into the PBM market. Any efforts to limit the influence of major PBMs and encourage competition will inevitably result in lower costs for patients and a sustainable, fairer marketplace.”

ALLEN GOLDBERG
VICE PRESIDENT OF COMMUNICATIONS
ASSOCIATION FOR ACCESSIBLE MEDICINES

the use of specialty drugs and lists; the impact of rebates from drug manufacturers on formulary design; and the cost of prescription drugs to payers and patients.

‘PBMs Restrict Patient Access’

PBMs restrict access and increase costs to consumers, says Allen Goldberg, vice president of communications at the

Association for Accessible Medicines (AAM), which advocates policies supporting access to biosimilar drugs.

“PBMs restrict patient access to lower-cost generic and biosimilar alternatives by requiring insurance companies to deploy blatantly anti-competitive business practices which keep costs high for patients and Medicare,” said Goldberg.

PBMs use formularies that increase the cost of drugs to patients, including seniors with drug plans, says Goldberg.

“PBMs frequently place generic drugs on non-generic formulary tiers with higher copays, meaning patients are overpaying for their prescriptions,” said Goldberg. “PBMs frequently prefer higher-cost, brand-name drugs over lower-priced alternatives.”

“Avalere Health studied formulary placement in Medicare Part D and found that the number of generic drugs placed on the lowest tier, where seniors pay the least for their drugs, declined by 53 percentage points between 2011 and 2015,” said Goldberg. “This resulted in a 93 percent, or \$6.2 billion, increase in patient out-of-pocket costs.”

‘Fear of Retaliation’

Supporters of the FTC probe are calling for a broad range of PBM reforms, says Goldberg.

“First and foremost, we have urged the FTC to clamp down on the anti-competitive practices we’ve outlined, to ensure that fair market competition can be restored to the prescription drug market,” said Goldberg. “Generics and biosimilars should be placed on the correct, lower-cost formulary tier, and insurance plans should [be able to] cover them without fear of retaliation from PBMs.”

Drug benefit management has

become too concentrated in a few dominant firms, says Goldberg.

“Consolidation and monopolization in the PBM industry have gotten out of hand, exacerbated by over 80 percent of prescriptions flowing through three vertically integrated companies,” said Goldberg. “Currently, it is difficult for new entrants with different business models to break into the PBM market. Any efforts to limit the influence of major PBMs and encourage competition will inevitably result in lower costs for patients and a sustainable, fairer marketplace.”

‘Black Box’ Operations

Scrutiny of PBM practices is long overdue, said Greg Reybold, director of health care policy and general counsel at American Pharmacy Cooperative Inc. (APCI), a group representing independent pharmacies, in a press release on June 7.

“We are extremely pleased with the depth and scope of the information the FTC is requesting from these middlemen,” said Reybold. “For years, PBMs have operated in a black box and FTC scrutiny of PBM practices that restrict patient access to care and raise prescription drug costs falls squarely within the commission’s twin missions of protecting consumers and competition.”

APCI supports ending these anti-competitive practices, stated CEO Greg Hamrick in the press release.

“As an organization, APCI and its members have advocated aggressively for the federal government to investigate anticompetitive PBM practices,” said Hamrick. “We very much look forward to working with the FTC, Congress, and other stakeholders to rein in these problematic issues that are detrimental to patients, taxpayers, and small businesses.”

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

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California Government to Produce and Distribute Insulin

By Kevin Stone

Gov. Gavin Newsom of California announced his approval of a budget that provides \$100 million for the state to begin manufacturing insulin.

The budget allocates \$50 million for construction of manufacturing facilities and \$50 million for development of low-cost insulin products. Newsom did not provide an estimated date for the products to reach the market.

The July 7 announcement responds to claims many diabetic Americans face monthly out-of-pocket costs of \$300 to \$500 for the drug.

In a program unveiled in April 2020, Eli Lilly, one of the three largest manufacturers of the drug, capped monthly copays at \$35 for people with private insurance or uninsured.

Although the program does not cover users of Medicare, Medicaid, and some other government-backed plans, its availability calls into question how many diabetes patients are subjected to high out-of-pocket costs.

Warns Against Government Overreach

Linda Gorman, director of health care policy at the Independence Institute, says the government has no business going into manufacturing.

“Government production is dangerous to both one’s health and one’s wallet,” said Gorman. “It is generally inefficient and expensive, and it produces poorer-quality goods than private production because it does not have to make a profit or please customers who are free to go elsewhere.”

Government entities are privileged, says Gorman.

“It is exempt from third-party oversight, loses focus by incorporating electoral politics into every decision, and doesn’t have to face a disinterested third-party regulator ensuring that it plays by the rules,” said Gorman. “There is little accountability for poor decisions, and few rewards for good ones. Government officials tend to discount the importance of having a wide range of product quality, price, and features. Government also does a poor, poor, job of cost accounting and almost always fails to adequately replace capital.”

Poor Track Record Cited

The state government moved to produce generic drugs several years ago and has failed, says Gorman.

“The *Los Angeles Times* reported it was still looking for a generic firm to ‘play ball’ as of March 3, 2022,” said Gorman. “California is still trying



California Governor
Gavin Newsom

“I don’t really see it as a state’s job to manufacture a specific drug. That’s not their expertise, and I would expect them to do it badly. If there is a major need and it would save money, I would expect the state to be able to find a private manufacturer willing to contract to manufacture the drug and supply it to the state. The U.S. Food and Drug Administration has been approving generic versions of the popular, fast-acting insulin Humalog, and I don’t see how the state can do it cheaper.”

DEVON HERRICK
HEALTH ECONOMIST

to produce high-speed rail, too. If I needed insulin, I don’t think I’d rely on Newsom’s project.”

Devon Herrick, a health economist and policy advisor to The Heartland Institute, which co-publishes *Health Care News*, says government should stick to governing.

“I don’t really see it as a state’s job to manufacture a specific drug,” said Herrick. “That’s not their expertise, and I would expect them to do it badly.”

“If there is a major need and it would save money, I would expect the state to be able to find a private manufacturer willing to contract to manufacture the drug and supply it to the state,” said Herrick. “The U.S. Food and Drug Administration has been approving generic versions of the popular, fast-

acting insulin Humalog, and I don’t see how the state can do it cheaper.”

Responsible for Price Hikes

Gorman points out government programs like Medicaid already create high artificial price points.

“It is important to understand that U.S. pricing for pharmaceuticals is distorted by extensive federal intervention,” said Gorman. “In general, the federal interventions encourage high prices for drug buyers other than government. The Medicaid best-price requirement limits discounts in the private market. It creates an impenetrable mess in pricing and a big difference between list prices and what people actually pay, often called the net price. It also limits the discounts that might

be offered in the commercial market.”

Beyond the effects of the Medicaid best-price requirement, subsidized purchasing decisions, whether through private insurers or government plans, discourage insulin users from purchasing cost-effective versions of drugs.

Better Drugs Cost More

Gorman says there is no “generic” version of insulin because it is a small-molecule, biologic drug that can’t be duplicated exactly like a large-molecule, chemical drug. Biosimilar is the name for a product that tries to act like a biologic.

“There are currently four approved biosimilars, and more are in the pipeline,” said Gorman. “The first insulin was extracted from cows and pigs. The problem is that while they kept people alive, many patients developed anti-insulin antibodies.”

Biosynthetic insulin is much more adaptable to patients’ needs and thus can be worth more than the biosimilars, says Gorman.

“The first biosynthetic insulin, Lilly’s Humulin, was approved in 1982,” said Gorman. “Several others followed. Since then, insulins have been designed with different time-action profiles to meet different clinical requirements and better mimic the body’s natural insulin production.”

High demand for specialized insulin raises prices, says Gorman.

“There are ultra-fast-acting, intermediate, and ultra-lasting insulins,” said Gorman. “Some manufacturers sell standardized mixes to produce time profiles. Some are more concentrated, because obese patients need more of the drug but would prefer not to have more injections to get it. Unsurprisingly, the newer insulins are also more expensive worldwide. But as they have a better therapeutic profile, more people use them, and costs increase.”

Private-Sector Head Start

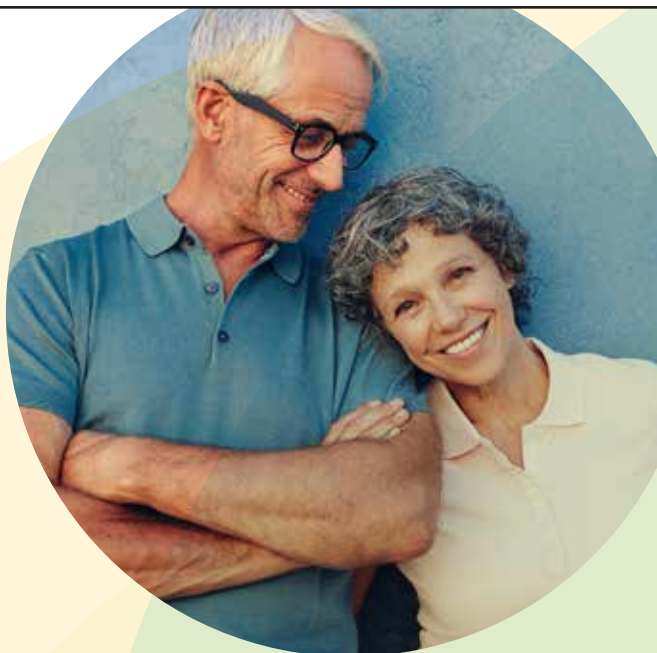
It is unclear how quickly California can build plants and deliver a safe insulin solution. Some private-sector companies may beat the state to the punch.

Civica Rx, a nonprofit generic drug maker, announced in March it plans to make and sell an insulin product for no more than \$30 a vial.

The company’s product is expected to hit the market in 2024, pending completion of its 140,000-square-foot manufacturing plant in Petersburg, Virginia and federal approval.

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

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JANIS S. SLEETER
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House Passes Medicare Telehealth Extension

The U.S. House of Representatives approved a bill to extend Medicare telehealth reimbursement until 2024, about two years longer than scheduled previously.

The omnibus spending package Congress approved in March granted pandemic reimbursement flexibility for 151 days after the end of the public health emergency.

The expiration of the public health emergency, however, has been pushed back several times this year: first to April, then July, and now to October 13.

Bipartisan Support

The House approved the Advancing Telehealth Beyond COVID-19 Act of 2021 (H.R. 4040) in a 416 to 12 vote on July 27.

The bill would allow Medicare beneficiaries to receive telehealth services from any location, including their homes, and expands the types of medical professionals and facilities that can be reimbursed for telehealth. It would also allow audio-only technology for behavioral health, substance use disorder services, and health care management and evaluation.

The bill would allow Medicare to reimburse telehealth services until December 2024. The legislation is expected to be approved by the U.S. Senate and signed by President Joe Biden.

Waste, Fraud, Abuse Concerns

Congress should not extend telehealth reimbursement until its utilization is more fully understood, says Joshua Gordon, director of health policy at the Committee for a Responsible Federal Budget, a fiscal policy group.

"Telehealth will appropriately remain an important part of the health care system going forward," said Gordon. "However, current law already allows for telehealth extensions 151 days beyond the end of the just-extended public health emergency, and there is little need to rush into a broad two-year extension."

Congress has not yet received required reports on virtual medical services, says Gordon.

"Prior congressional legislation mandated multiple studies on telehealth utilization and costs, and on preventing waste, fraud, and abuse—all due within the next year," said Gordon. "Legis-

"We are very concerned about reports that some are pushing Congress to extend the current policy of exempting telehealth visits from deductibles for those in high-deductible plans tied to Health Savings Accounts."

JOSHUA GORDON
DIRECTOR OF HEALTH POLICY
COMMITTEE FOR A RESPONSIBLE
FEDERAL BUDGET

lators should wait for this information before blanket extension, especially given that coverage in Medicare would cost at least \$25 billion over a decade, and likely more than that when looking at overall national health expenditures."

'Perverse Incentives'

An additional regulation under consideration would be especially troublesome, says Gordon.

"We are very concerned about reports that some are pushing Congress to extend the current policy of exempting telehealth visits from deductibles for those in high-deductible plans tied to Health Savings Accounts," said Gordon. "This creates perverse incentives that increase health care spending, drive higher utilization, unjustifiably advantage telehealth over in-person care, and counteract the core purpose of high-deductible health plans."

—Staff reports

INTERNET INFO

"Fiscal Considerations for the Future of Telehealth," Committee for a Responsible Federal Budget, April 21, 2022: <https://www.crfb.org/papers/fiscal-considerations-future-telehealth>

COMMENTARY

Can We Trust Telehealth to Be Fast, Easy, and Correct?

By Wayne Liebhard, M.D.

Consumers desire health care like everything else in America—fast and easy—and they want it delivered by competent and empathetic professionals.

However, timely, accessible, and affordable health care is useless, and potentially dangerous, if the diagnosis or the treatment is incorrect. “Fast and easy” is never supposed to imply “risky and unpredictable.” We trust that hamburger from McDonald’s because there is always someone in America looking out for the welfare of the consumer for everything commercially branded.

This, of course, brings up the obvious question: How do you know the diagnosis is correct and/or the treatment is correct when you engage the medical system? Answer: you don’t know, at least not until you get better or the medicine you are taking makes your eyelashes fall out.

Why, then, would you engage with the medical system at all, given the lack of certainty? There are two reasons, and they both relate to a risk/benefit ratio.

First, you wouldn’t engage the medical system at all if you felt that there was more risk than potential benefit in doing so. Second, you’ve developed enough trust in Western medicine or in your “provider” of choice. In any case, your level of trust allows you to engage with a system where potential risks are always present in its use.

Telehealth Beckons

With that in mind, who wouldn’t trust their care to a large medical conglomerate that owns hospitals, and all sorts of shiny new multiple-story buildings, when they advertise their telemedicine services with the following: “Get the same great care as an office visit!”

Certainly, in a rush to capitalize on the “new age” of telemedicine, a large medical conglomerate would *never* attempt to direct as many patients as possible, regardless of their presenting complaint, to a video visit. Right?

What about a slick online medical “provider” with an attractive clinician pictured front and center in an advertisement? The clinician will note how easy it is to book an online appointment and how almost any health concern can be handled through a phone visit: “prescriptions, antibiotics, diabetes, refills, birth control, gout, hypertension, PrEP, pneumonia, hypothyroidism, lipid reg-



“Undeniably, telemedicine has an important place in the current delivery of medical care. In fact, in some instances, and some circumstances, virtual health care is the best available way to access certain kinds of care. There is no doubt that, in remote areas, or in small hospitals without immediate access to specialty care, telemedicine can be a Godsend as a conduit to that specialty care. There are also certain services (such as diabetic consults or mental health visits) that can be reasonably achieved through telemedicine consults when circumstances demand.”

WAYNE LIEBHARD, M.D.
EMERGENCY AND FAMILY MEDICINE DOCTOR

ulators, IBS, asthma, depression, ear infection, acne, anxiety, STDs, sinus infection, erectile dysfunction, cough, flu, UTI... and almost anything else!”

Why stop there? Surely, the home appendix removal kit is right around the corner.

Or perhaps an ad might entice a consumer this way: “The last thing you want to do is trek across town to see a doctor.” This sounds like, “The last thing you want to do is drive another two miles up the road to where the bungee jumping is safety monitored.”

Roles Changing

By now it should be obvious that Western medicine has, in fact, been lying to everyone for decades, in fact for centuries. No one ever really needed to be examined in person by a doctor. It just took until now, when technology would allow, for us to admit that interaction on a screen is in fact better than an interaction in person.

Undeniably, telemedicine has an important place in the current delivery of medical care. In fact, in some

instances, and some circumstances, virtual health care is the best available way to access certain kinds of care.

There is no doubt that, in remote areas, or in small hospitals without immediate access to specialty care, telemedicine can be a Godsend as a conduit to that specialty care. There are also certain services (such as diabetic consults or mental health visits) that can be reasonably achieved through telemedicine consults when circumstances demand.

Doctors Pushed Aside

In early 2020, as we all know, circumstances regarding medical care changed drastically, and the Centers for Medicare and Medicaid Services decided the rules previously governing the delivery of and remuneration for telemedicine services would also be changed drastically, to provide medical care during the COVID-19 pandemic.

Large health care systems took notice—immediately. Certainly, their doctors bought into the provision of urgent care by telemedicine for just

about any condition imaginable, right?

Certainly, their doctors were consulted about how the telemedicine process would be set up, how it would work, and what conditions, as presented by patients, would be routed through for a telemedicine visit, right?

Certainly, their doctors were trained in the intricacies of providing care by telemedicine, more so than just the nuts and bolts of getting connected and instructing patients on how to stick their iPhones down their throats to get a peek at their tonsils, right?

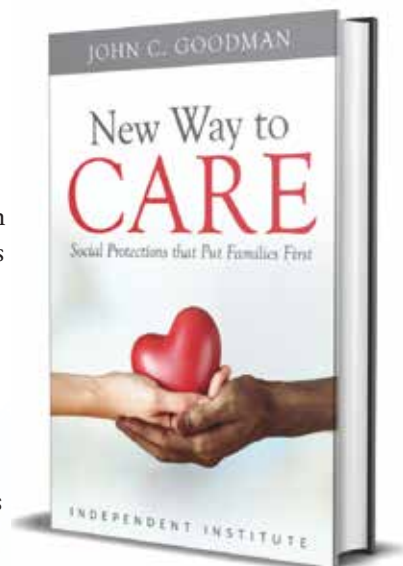
Certainly, the control of the narrative, and therefore the control of the delivery of medical care in the United States, is in the hands of your trusted clinician, right?

Don’t bet on it.

Wayne Liebhard, M.D. (wdliebhard@yahoo.com) is an emergency and family medicine doctor in Minneapolis-St. Paul, Minnesota. His newest book is *Walking the Tightrope—Trusting Your Life to Telemedicine* (Alethos Press, 2022).

New Way to Care!

With the COVID-19 pandemic and shutdowns, federal debt has reached \$22.8 trillion with a 2020 deficit of \$3.3 trillion, more than triple the deficit for 2019. Not including Obamacare, the unfunded liability in Social Security and Medicare alone is \$120 trillion, 6 times the entire U.S. economy. If such spending continues, average people will be paying two-thirds of their income to the federal government by mid-century, destroying families, businesses, and communities. And with entitlements the largest component of federal spending, politicians have failed at reining in one of the most troubling issues facing Americans.



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—**Scott W. Atlas**, M.D., Member, White House Coronavirus Task Force

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John C. Goodman is Senior Fellow at the Independent Institute, President of the Goodman Institute, and author of the acclaimed, Independent books, *A Better Choice: Healthcare Solutions for America*, and the award-winning, *Priceless: Curing the Healthcare Crisis*. *The Wall Street Journal* has called him the "Father of Health Savings Accounts."

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Health Care System Agrees to Pay \$10 Million for Forcing COVID-19 Shots

Health care workers who were forced to take COVID-19 shots or lose their job will soon be eligible to tap into a \$10 million settlement.

About a dozen workers sued NorthShore University HealthSystem in Illinois in October 2021 for not accepting religious exemptions to the vaccine mandate. The settlement memorandum requests U.S. Judge John Kness approve the July 29 agreement for \$10,337,500 in compensation and legal fees.

Liberty Counsel, a public-interest pro bono law firm, said the settlement is the first of its kind involving private employers and vaccine mandates.

"The drastic policy change and substantial monetary relief required by the settlement will bring a strong measure of justice to NorthShore's employees who were callously forced to choose between their conscience and their jobs," Horatio Mihet, vice president of legal affairs at the group, said in a statement.

'The Tide Is Turning'

The settlement is encouraging, says Douglas Seaton, an attorney at the Upper Midwest Law Center, which

focuses on government overreach and protection of the rule of law.

"We have several cases in progress, at the mandatory agency charge stage and in the unemployment compensation system, where terminations or forced resignations have occurred under equivalent circumstances," said Seaton. "One repeat offender is the Minneapolis Federal Reserve Bank."

"The legal system takes a long time to work through these cases, but this is a sign that the tide is turning and that employers cannot ignore the legal requirements to recognize religious and medical/disability exemptions from these mandates," said Seaton.

Workers will be able to apply for money in the fund once it is approved by the court.

Workers who took the vaccine to keep their jobs would be eligible to receive \$3,000. Those who lost their jobs could collect up to \$25,000 each. Named plaintiffs will receive \$260,000 each, and the law firm is expected to get 20 percent of the total settlement amount.

—Staff reports

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Union Pushes California Ballot Proposition Raising Dialysis Staffing Costs

By Kevin Stone

A California ballot proposition would increase the cost of kidney dialysis and reduce patients' access in the Golden State, says a coalition of opponents.

Proposition 29 would require the presence of a doctor, nurse practitioner, or physician's assistant during outpatient kidney dialysis clinics' treatment hours. California's Secretary of State announced on June 20 it is eligible for the November 8 election ballot.

The Service Employees International Union-United Healthcare Workers (SEIU-UHW) spent millions of dollars on the successful petition effort for the measure, which is much like ballot initiatives the union backed in 2018 and 2020 that voters rejected.

'Endangering Dialysis Patients' Lives'

No on Prop 29, a self-described "coalition representing dialysis patients, doctors, nurses, social justice advocates, and dialysis providers," says the mandate would increase the cost of dialysis and cause many clinics to close, spokesperson Kathy Fairbanks told *Health Care News*.

"Prop 29 would cause dialysis clinics to cut back or close, endangering dialysis patients' lives," said Fairbanks.

The SEIU-UHW is trying to harm the clinics financially through the outlays required to fight the measure, and the members of these unions are likewise victimized, says Fairbanks.

"Wasting their members' dues money every election cycle on failed dialysis measures does impact their members, because they will likely have their dues raised to cover these worthless exercises," said Fairbanks. "Both the previous measures failed by margins of 20 percent or more. Voters clearly are not buying what UHW is selling and reject putting vulnerable dialysis patients in harm's way."

SEIU-UHW members have paid for many ballot measures over a decade, states a No on 29 press release.

"Since 2012, SEIU-UHW has wasted \$82 million of its members' dues money on 60 ballot initiatives across the country either directly or through its 501c4," states the release. "In California alone, UHW has filed 23 state and local initiatives at a cost of \$58 million or about \$600 per member."

'Costlier Forms of Treatment'

The cost of caring for dialysis patients would rise as clinics added the required



personnel, states an analysis of the measure by the Berkeley Research Group (BRG) conducted for opponents of the proposal.

"The initiative's clinician at-all-times requirement would increase costs statewide for all clinics, collectively, by between \$229 and \$445 million annually, depending on the type of clinician used," states the BRG report.

Many nonprofit and for-profit clinics treating the more than 80,000 dialysis patients in the state would be forced to operate at a loss, and up to half of them could close, says BRG.

"Out of the 622 dialysis clinics in California used in this analysis, this represents between 39 and 56 percent of dialysis clinics treating approximately 16,000 to 27,000 patients," wrote BRG.

California taxpayers would probably be stuck with the tab for patients who lose access, says BRG.

"By reducing clinics operating and forcing some dialysis patients into costlier forms of treatment, the initiative will increase costs to the State of California between \$19 million and \$1.7 billion to continue treatment for only those patients insured through three partially state-funded programs: CalPERS, Medi-Cal managed care and Medi-Cal fee-for-service, depending on the type of practitioner used," wrote BRG.

'Patients' Only Option'

Currently, the federal government picks up most of the cost of dialysis, says health economist Devon Herrick, a policy advisor to The Heartland Institute and analyst at the Goodman Center for Public Policy Research, which co-publishes *Health Care News*.

"A law requiring physician coverage at dialysis clinics would drastically increase the cost of dialysis, which taxpayers mostly pay for," said Herrick.

"End-stage renal disease is the only disease that is covered by Medicare for patients of any age, which has resulted in little change in the care of people with kidney failure in 50 years."

Because kidney dialysis is a federal entitlement and essentially managed by the government, treatment remains cumbersome and inconvenient, says Herrick.

"There are portable dialysis units that could be used at home for longer

periods—such as at night while sleeping for, example—but Medicare won't pay for them," said Herrick. "Instead, patients have to visit dialysis centers anywhere from once a week to about every day of the week, depending on their condition."

"A better way would be for patients to take home a small, portable dialysis

"A law requiring physician coverage at dialysis clinics would drastically increase the cost of dialysis, which taxpayers mostly pay for. End-stage renal disease is the only disease that is covered by Medicare for patients of any age, which has resulted in little change in the care of people with kidney failure in 50 years."

DEVON HERRICK
HEALTH ECONOMIST

machine that runs while they sleep, but for now, dialysis clinics are many patients' only option," said Herrick.

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



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Public Schools Order Masking Again

By Harry Painter

Some school districts across the nation are reimposing mask mandates for children, although the prevalent strains of the virus are presenting as bad colds.

Public schools in Louisville, Kentucky, and possibly Los Angeles could join the San Diego Unified School District (SDUSD) in requiring children and adults to wear masks indoors. San Diego's policy requires mask-wearing at all district schools and offices. The mandate went into effect on July 18.

"We will continue to monitor the COVID-19 community level according to the CDC and County data and we will communicate if there are any changes in two weeks," said the SDUSD in an update sent to parents.

The district says the decision was based on criteria the SDUSD board adopted in May.

"This week, one of those criteria was reached, with San Diego County entering the 'high' COVID-19 community [transmission] level," said the statement.



'The Entire Policy Is Political'

Public policy recommendations to bring back mask mandates are not justified by the science, says Patrick Wood, director of Citizens for Free Speech.

"The entire policy is political and not based on any legitimate scientific studies," said Wood.

The Centers for Disease Control and Prevention admitted in January, about two years into the pandemic, the widely worn cloth masks are ineffective at preventing the spread of the SARS-CoV-2 virus. Studies have shown cloth and surgical masks are far less efficient than N95 and KN95 masks at filtering

out aerosols.

Anthony Fauci, M.D., director of the National Institute of Allergy and Infectious Diseases and President Joe Biden's chief medical advisor, said people "should wear a mask in a congregate indoor setting," on CNN's *New Day* program on July 13 when discussing his recommendations about the new BA.5 variant of the Omicron strain of COVID-19.

Mask Nostalgia

Some officials are eager to resume pandemic powers, says Wood.

"There is both public and private pressure to return to wearing face masks," said Wood. "San Diego and Los Angeles are two civic entities that have reinstituted face masks."

Most businesses and events have stopped requiring masks.

One outlier was the recent Comic-Con 2022 gathering in San Diego, which required proof of vaccination in addition to mandatory face masks for

all attendees. A New York City subway mask mandate is still in effect, long after other restrictions in the state have been lifted.

'It's All Bad'

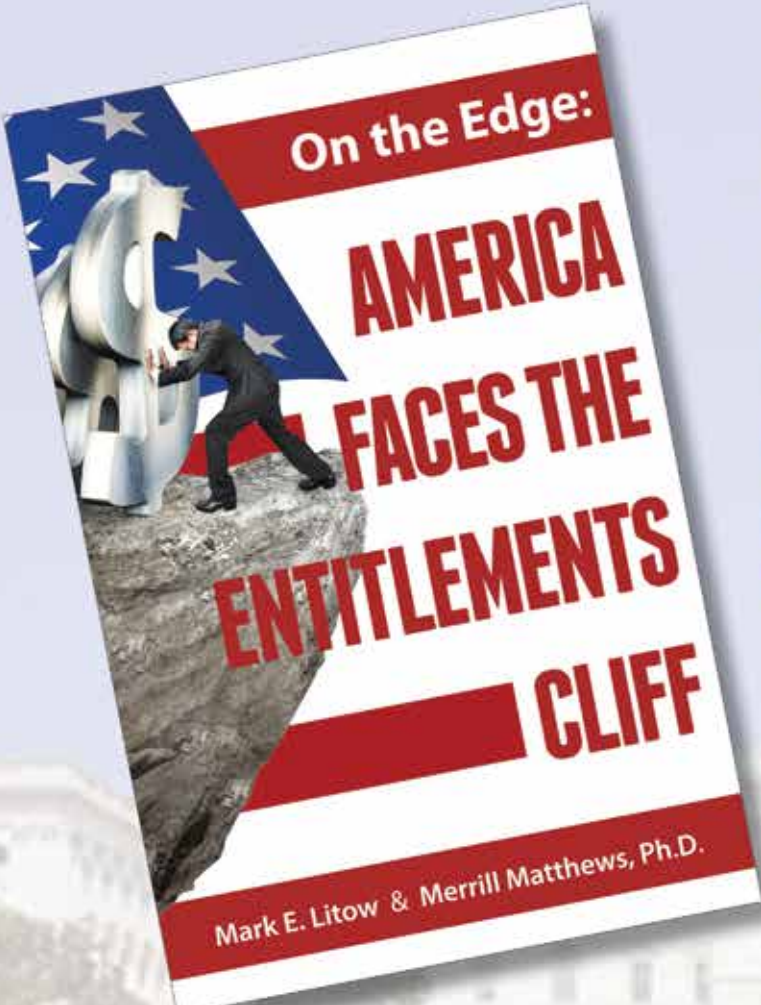
Throughout the pandemic, Citizens for Free Speech collected testimony from parents, teachers, and students on how the masks affected their health, education, and socialization.

The public found mask mandates to be physically and psychologically damaging, particularly when directed at schoolchildren, says Wood.

"Pediatricians have reported skin bacterial and fungal face infections, pneumonia, fainting, and breathing problems," said Wood. "Psychologists have reported regression in language skills, depression, loneliness, social isolation, and thoughts of suicide."

"It's all bad, and there is no upside to any child wearing a face mask to protect against the virus," said Wood.


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



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