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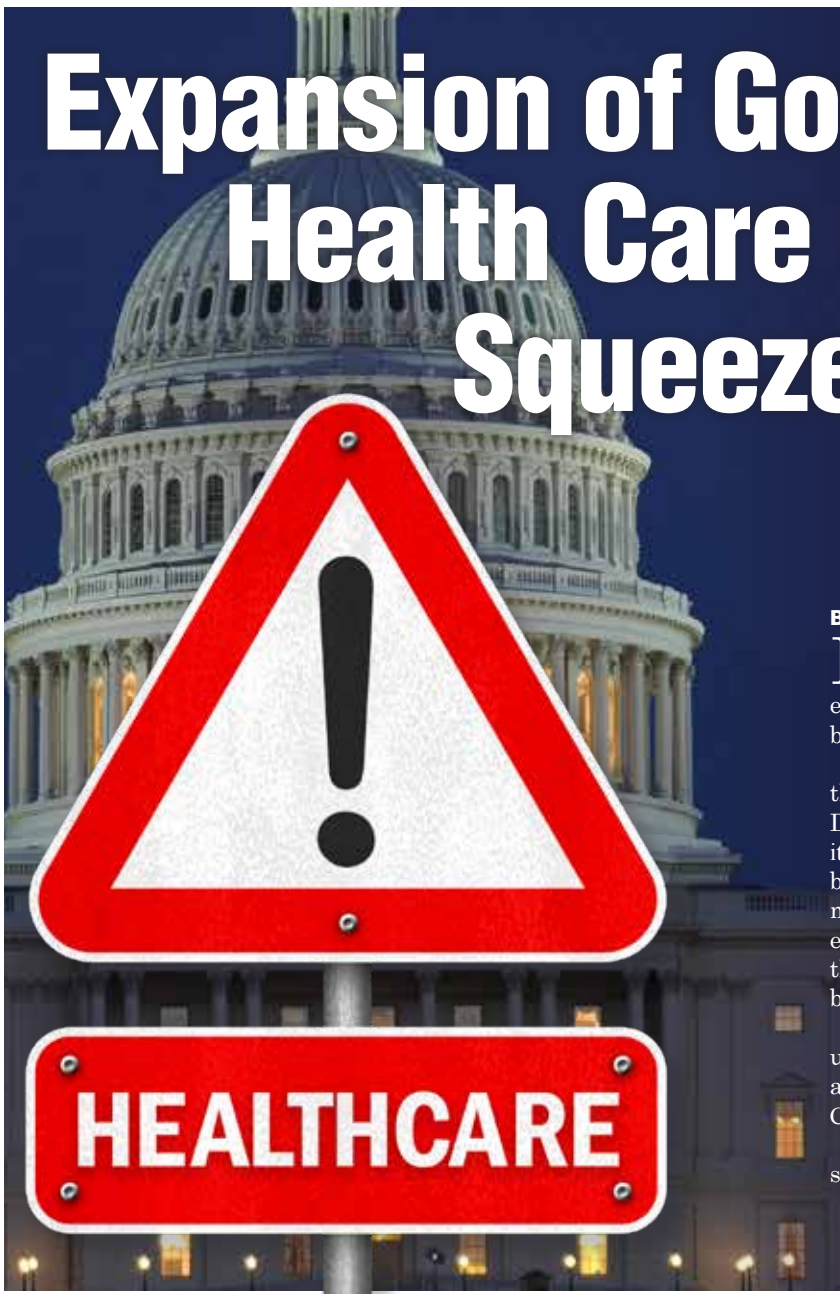
The Pulse

Expansion of Government Health Care Coverage Squeezes Private Insurers



By Bonner Russell Cohen

Private insurance plans are being crowded out of the market as subsidized government programs scoop up growing numbers of enrollees.

Citing data released in September by the U.S. Census Bureau, the Washington, D.C.-based Committee to Unleash Prosperity reported the number of people covered by private insurance plans declined by 1.2 million from 2020 to 2021, the population enrolled in Medicaid rose by 3.2 million, and the number of Medicare recipients increased by 1.7 million.

"In 2021, private health insurance continued to be more prevalent than public coverage, at 66.0% and 35.7%, respectively," the Census Bureau reported.

The Affordable Care Act's (ACA) expansion of Medicaid, the Biden administration's

GOVERNMENT INSURANCE, p. 6

Biden Issues Executive Order to Harness 'Power of Biology'

By AnneMarie Schieber

President Joe Biden signed a sweeping 6,100-word executive order (EO) mandating a "whole-of- government" approach using "the power of biology" as a massive problem solver on a variety of fronts.

"For biotechnology and biomanufacturing to help us achieve our societal goals, the United States needs to invest in foundational scientific capabilities," states the EO.

The order, numbered 14081 and signed on September 12, refers to this

'POWER OF BIOLOGY', p. 4

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Fauci, NIH Under Fire for Private Royalty Payments

By AnneMarie Schieber

Anthony Fauci, M.D., director of the National Institute of Allergy and Infectious Diseases (NIAID) and chief medical advisor to President Joe Biden, faced tough questioning from Sen. Rand Paul (R-KY) once again over third-party royalty payments from pharmaceutical companies to government scientists at the National Institutes of Health (NIH).

"We've been asking you, and you refuse to answer, whether anybody on the vaccine committees gets royalties from the pharmaceutical companies," said Paul at a U.S. Senate hearing on September 14. "I asked you last time, and what was your response? 'We don't have to tell you.' When we get in charge, we're going to change the rules, and you will have to divulge where you get your royalties from, from what companies, and if anybody on the committee has a conflict of interest, we are going to learn about it. I promise you that."


Dr. Anthony Fauci

Continuing Investigation

The grilling followed similar questioning in June when Paul asked Fauci about $194 million given to 18,000 NIH employees between 2010 and 2016.

The royalty payments were also the subject of questioning on May 13 by Rep. John Moolenaar (R-MI). NIH Acting Director Lawrence Tabak admitted the payments appear to be a conflict of interest.

"It's the sort of thing that maybe we work together on so we can explain to you the firewalls we do have in place," said Tabak.

Federal law allows scientists at universities and government institutions to receive royalty payments from private companies for federally funded research under the Bayh-Dole Act of 1980.

FOIA Watchdogs

The questioning on Capitol Hill began after the watchdog group Open the Books obtained documents revealing NIH scientists received $134 million in royalty payments between 2009 and 2014. Open the Books says Fauci, Francis Collins (NIH director from 2009 to 2021), and Clifford Lane (Fauci's deputy director) are among those who have received payments. The information was received under a Freedom of Information Act (FOIA) request.

"They [the NIH] were going to give us nothing [at first]," Adam Andrzejewski, CEO and founder of Open the Books, told the *Heartland Daily Podcast* on September 21. "They finally gave us heavily redacted documents, and they're blanking out the names of the third-party payers—think pharmaceutical companies."

Based on the $134 million, Andrzejewski believes more than $350 million in royalties were paid to NIH scientists between 2010 and 2020.

On June 1, Paul and Sens. Rick Scott (R-FL), Ron Johnson (R-WI), Josh Hawley (R-MO), and James Lankford (R-OK) sent Tabak a letter demanding the number of individual royalty payments between 2009 and 2021, the names of the recipients, and the payers. The lawmakers also asked how much money NIH received for COVID-19 testing, research treatment, and vaccination efforts.

Fauci Off the Hook?

When asked by Paul at the September 14 hearing whether the payments influenced government policy and guidance on COVID-19, particularly as regards statements about natural immunity, Fauci denied responsibility for the decisions.

"You keep saying, 'You approve, you do this, you do that,'" Fauci testified. "The committees that give the approval are FDA, through their advisory committee. The committees that recommend are CDC, through their advisory, and you keep saying I'm the one that's approving a vaccine."

Andrzejewski says he does not believe that argument will get Fauci off the hook.

"NIH is hiding the royalty string, and this at its nexus, at its core, is what Dr. Rand Paul is objecting to: the secrecy," said Andrzejewski.

Another Pay Increase?

Although Fauci announced this summer he will be leaving the NIH at the end of the year, he can still be subpoenaed by Congress. Andrzejewski says he believes Fauci's next role will be as director of the National Institutes of Health Foundation.

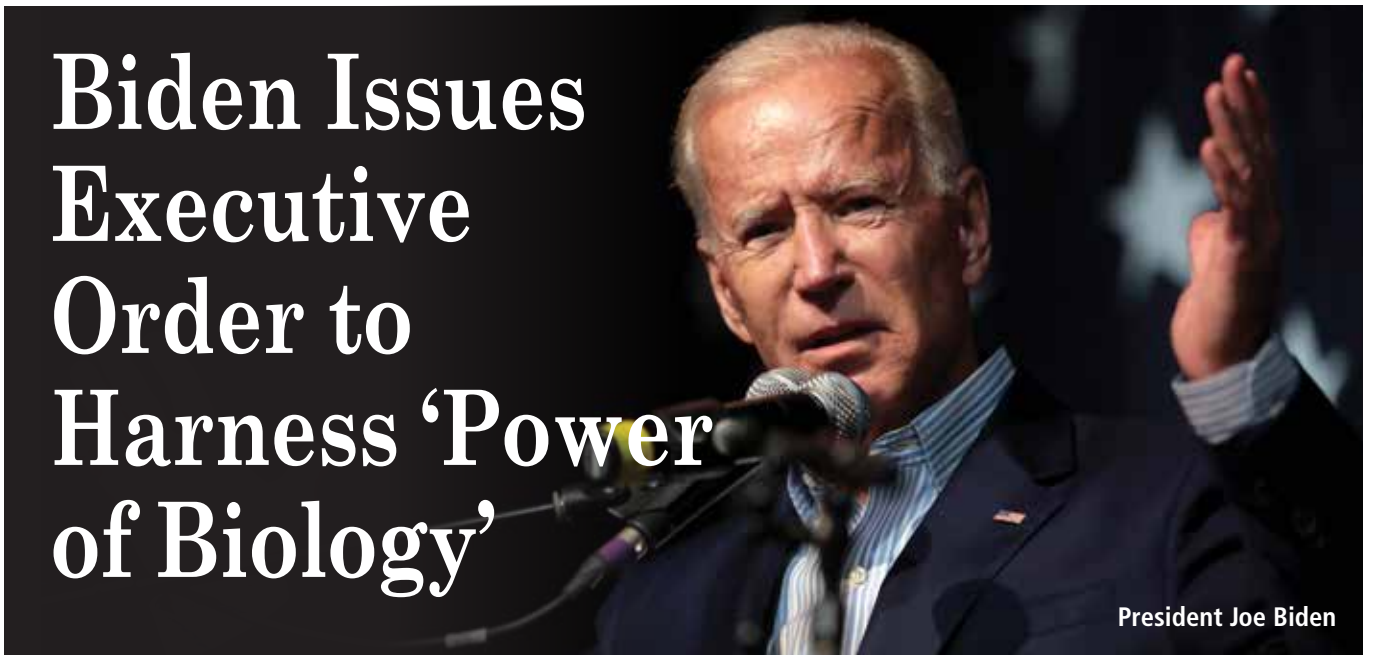
"Incredibly, he'll get a pay increase, and because it's a 501(c)(3) public charity, it is not subject to FOIA, so he is just going to shift from the director of NIAID to the foundation, an entity which is probably funded by pharmaceutical companies, so he'll still have his finger on the scale," said Andrzejewski.

Although the royalty payments have caught the attention of Republican legislators, Andrzejewski says this should be a bipartisan concern.

"Transparency used to be a transparty issue," said Andrzejewski. "Democrats and some Republicans run on transparency during the election and once they get elected they run away from the issue."

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

Biden Issues Executive Order to Harness 'Power of Biology'



President Joe Biden

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Continued from page 1

activity as "the bioeconomy" and states the COVID-19 pandemic demonstrated how it could be used for social improvement in an ambitious variety of areas.

"Although the power of these technologies is most vivid at the moment in the context of human health, biotechnology and biomanufacturing can also be used to achieve our climate and energy goals, improve food security and sustainability, secure our supply chains, and grow the economy across all of America."

'Jurassic Park' Unleashed

Some elements of the EO align with traditional initiatives such as promoting biosecurity, securing strategic supply chains, and protecting the nation from foreign adversaries. Other sections ring alarm bells with people knowledgeable about the dangers of mixing government and science, says Matt Dean, senior health care policy outreach fellow at The Heartland Institute, which co-publishes *Health Care News*.

Dean cites the fourth paragraph of Biden's order as an example.

INTERNET INFO

"Executive Order on Advancing Biotechnology and Biomanufacturing Innovation for a Sustainable, Safe, and Secure American Bioeconomy," The White House, September 12, 2022: **https://www.whitehouse.gov/briefing-room/presidential-actions/2022/09/12/executive-order-on-advancing-biotechnology-and-biomanufacturing-innovation-for-a-sustainable-safe-and-secure-american-bioeconomy/**

The paragraph states, "We need to develop genetic engineering technologies and techniques to be able to write circuitry for cells and predictably program biology in the same way in which we write software and program computers; unlock the power of biological data, including through computing tools and artificial intelligence; and advance the science of scale-up production while reducing the obstacles for commercialization so that innovative technologies and products can reach markets faster."

"Who wrote this?" said Dean. "Are they too young to remember the end of the movie *Jurassic Park*? Set aside all the immediate data-security nightmares associated with this. This proposal seeks to redress societal inequities by rewriting biology, using AI with fewer roadblocks to speed solutions to market."

"Biden's executive order represents a great leap forward in hubris when humility is called for," said Dean.

Big Step Beyond

Biden's order goes far beyond anything government has authority to do, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons, president of Doctors for Disaster Preparedness, and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"This is astonishing hubris," said Orient. "I suspect that the World Economic Forum wrote it or collaborated.

"Who is Joe Biden or any other president to define our 'societal goals,' to transform and direct the economy, to 'unlock' biological data, such as your genome, possibly from samples you gave without permission to be stored by government?" said Orient.

Biden is running roughshod over people's natural and constitutional rights, says Twila Brase, president and cofounder of the Citizens' Council for Health Freedom and author of *Big Brother in the Exam Room*.

"In pursuit of intruding in American lives at the cellular and genomic level, President Biden pushes a program that will almost certainly lead to the violation of basic human rights, constitutional protections, genetic privacy, and national security," said Brase.

"This program does not match our 'societal goals,'" said Brase. "Americans were not asked. This executive order matches his goals and the goals of those who are pushing for federal permission to exploit and intrude at the deepest level."

"In pursuit of intruding in American lives at the cellular and genomic level, President Biden pushes a program that will almost certainly lead to the violation of basic human rights, constitutional protections, genetic privacy, and national security. This program does not match our 'societal goals.' Americans were not asked. This executive order matches his goals and the goals of those who are pushing for federal permission to exploit and intrude at the deepest level."

TWILA BRASE
PRESIDENT AND COFOUNDER
CITIZENS' COUNCIL FOR HEALTH FREEDOM

Climate Change Change

Biden's executive order is meant to bind biotech development to the climate change agenda and social issues, says Dean.

"One might think that this is merely a way to promote Biden's key initiatives on climate change and equity, and that's where he starts off, but as is the case with so many of his initiatives, it quickly blows by that," said Dean.

COVID-19 was a test run for what Biden is attempting, say Brase and Orient.

"The president who doesn't care a whit about the safety of COVID shots, the lives of the vaccine-injured, or actual scientific facts about the vaccine or early treatment for COVID, has issued an executive order to advance broad-scale genetic manipulation, deep-dive dissection at the cellular and genomic level, and nationwide biosurveillance," said Brase.

"What the pandemic should have proved is the extreme danger of the technology our government was funding without accountability and oversight, and the disastrous results of their emergency measures, which are only beginning to manifest," said Orient. "This agenda must be exposed and stopped."

Brave New Biology

Since 1986, the United States has had a framework to guide the development of biotech, and President Barack Obama and President Donald Trump each worked to update and modernize it. Biden's EO is the first to take detailed steps on advancing biotech into manufacturing and economic development.

"The initiatives and federal actions announced in EO 14081 constitute the most comprehensive, coordinated, and committed action plan ever devised by a U.S. administration to promote the development of the U.S. biotech economy and manufacturing base," write Keith A. Matthews and Nur Ibrahim, attorneys with Wiley Rein LLP, a Washington, D.C. law firm, on their website. "Of particular importance will be the development of new regulatory policies that will facilitate agricultural biotech and chemicals manufacturing."

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

Pressure Mounts to End COVID-19 National Emergency Declaration

"Currently the dominant variant, Omicron, is very mild for most people, even those in high-risk categories. It is appearing to be less severe than the seasonal flu in general, with effective therapeutic treatments available. [A state of emergency] cannot be justified by fears of a hypothetical recurrence of some more severe infection at some unknown hypothetical point in the future. We just cannot operate public health policy this way."

PAUL ALEXANDER, PH.D.

By Ashley Bateman

Congressional Republicans are calling on the Biden administration to end the nation's emergency health declaration after President Joe Biden said on television the COVID-19 pandemic is over.

Sen. Roger Marshall, M.D. (R-KS) introduced a resolution on September 22 to end the declaration after Biden told *60 Minutes* the pandemic had come to an end but the government would continue to deal with the disease. "We still have a problem with COVID. We're still doing a lot of work on it," said Biden.

"It was jaw-dropping," Marshall told *The Wall Street Journal*, referring to the billions of dollars the White House continues to request in the name of fighting the pandemic. "Here's Joe Biden talking out of both sides of his mouth, saying that the COVID pandemic is over with and yet he wants to continue these emergencies."

Marshall's bill was referred to the Senate Finance Committee. Committee chairman Sen. Ron Wyden (D-OR) pledged to block the resolution.

Marshall had attempted to end the state of emergency on March 3, and a resolution passed the Senate by a vote of 49-48. The White House threatened a veto, and the measure was never picked up in the U.S. House.

In March 2020, President Donald Trump invoked the declaration under the National Emergencies Act. It has been extended several times and was most recently set to expire on October 13.

Moment of Truth

"President Biden said what we've all known is true for months," said Twila Brase, president and cofounder of the Citizens' Council for Health Freedom, in a press release published the day after Biden's television interview aired. "Government officials must take him at his word and end the emergency declarations."

The declarations are far from harmless, says Brase.

"Taxpayer dollars continue to be spent on unnecessary programs that are harmful to the American people and to American business," said Brase. "Under these declarations, the emergency use authorizations for COVID shots, including untested booster shots, have continued to advance injection mandates in places of employment. People are forced to choose between a job they want and a jab that could harm them, potentially for life."

Fear Factor

Though thousands of Omicron cases continue to be registered daily, symptoms and death rates have significantly decreased and treatment options continue to improve.

"Currently the dominant variant, Omicron, is very mild for most people, even those in high-risk categories," said Paul Alexander, Ph.D., a consulting researcher in evidence-based medicine, research methodology, and clinical epidemiology. "It is appearing to be less severe than the seasonal flu in general, with effective therapeutic treatments available."

Alexander says there is no case for a state of emergency at this point.

"It cannot be justified by fears of a hypothetical recurrence of some more severe infection at some unknown hypothetical point in the future," said Alexander. "We just cannot operate public health policy this way. If a novel severe strain or variant were to occur, and it seems unlikely from Omicron, then that would be the time we discuss a declaration of emergency. Not now. It is done, it is over, and it is time we let Americans go back to normal life."

Health Worker Crisis

With so many resources still directed at the waning threat of COVID, several immediate health crises loom, not the least of which has been a shortage of health care workers.

During the emergency, hospitals laid off nurses and health care workers who chose not to receive COVID-19 inoculations. The vaccine mandates were a mistake, says Alexander.

"The data clearly showed very early on after COVID vaccine rollout that there was no difference in terms of viral load between a vaccinated and an unvaccinated person," said Alexander. "Thus, the policy was punitive and nonsensical, and not just for nurses but for all employees subjected to it, without any scientific basis. Hospitals and workplaces should take these employees back and pay them all lost wages."

The U.S Bureau of Labor Statistics says the nation will need 275,000 more nurses by 2030.

Pandemic Pivot

While many continue to argue for an end to the national public health emergency declaration, the pandemic seems to have created two new crises, says Joel Hirschhorn, editor of the *Pandemic Blunder* newsletter and author of the book by the same title.

"The pandemic has shifted gears in that we have millions of people now with what we call 'long COVID.' That is a very serious medical condition with 20 to 30 common symptoms, and few doctors know how to deal with it," said Hirschhorn on the *Heartland Daily Podcast* on October 4.

Long COVID can show up weeks or months after infection and may affect as many as 20 percent of patients, says Hirschhorn.

The other big problem is the effect of the vaccines, which can harm the immune system and damage the blood, says Hirschhorn.

"Those factors explain why some people have died within days of the shots, but the data also show people are dying on average about five months after their last shot," said Hirschhorn.

Ashley Bateman (**bateman.ae@googlemail.com**) *writes from Virginia.* Health Care News *managing editor AnneMarie Schieber also contributed to this article.*

Expansion of Government Health Care Coverage Squeezes Private Insurers

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elimination of almost all work requirements for Medicaid recipients, and the Inflation Reduction Act's extension of increased subsidies for insurance premiums on the Obamacare exchanges have combined to move millions of people into government-provided health insurance.

Workplace Dropouts

If current trends continue, increasing numbers of Americans will be enrolled in government insurance plans. That may be detrimental to those who have swelled the Medicaid rolls in recent years, according to the Buckeye Institute. The organization's research shows separating Medicaid recipients from work radically reduces their earning potential.

"Medicaid expansion has had the unintended consequence of causing healthy, single adults to leave the labor force or reduce their work hours to maintain or qualify for Medicaid benefits," said Rea S. Hederman Jr. in a statement issued upon release of the 2018 Buckeye Institute study "Healthy and Working: Benefits of Work Requirements for Medicaid Recipients." Hederman is vice president of policy for the institute and executive director of its Economic Research Center. "And by exiting the workforce, workers have risked reducing their lifetime earnings," Hederman said.

Four years before the Biden administration all but eliminated work requirements for Medicaid recipients, the Buckeye Institute found implementing such requirements can increase total lifetime earnings to close to $1 million for individuals who transition off Medicaid.

Wealth-Building Work

Work requirements can increase a recipient's lifetime earnings by more than $212,000 for women and more than $323,000 for men who remain on Medicaid for their entire working life, and it can increase weekly work time by 22 hours for women (from 12 hours to 34 hours per week) and by 25 hours for men (from 13 hours to 38 hours per week), the study found.

"Government insurance often replaces or crowds out private insurance," Hederman told *Health Care News*. "During the COVID crisis, Medicaid enrollment spiked, and people have remained on government health insurance even as they have returned to work. The federal government has restricted the ability of states to audit Medicaid programs to remove ineligible recipients.

"Taxpayer-funded insurance programs have replaced private insurance as federal programs are highly subsidizing insurance for millions of Americans," Hederman said.

The Biden administration's elimination of work requirements has contributed to the current labor shortage by reducing incentives for low-income people to seek employment.

"Government insurance often replaces or crowds out private insurance. During the COVID crisis, Medicaid enrollment spiked, and people have remained on government health insurance even as they have returned to work. The federal government has restricted the ability of states to audit Medicaid programs to remove ineligible recipients. Taxpayer-funded insurance programs have replaced private insurance as federal programs are highly subsidizing insurance for millions of Americans."

REA S. HEDERMAN JR., VICE PRESIDENT, THE BUCKEYE INSTITUTE

Medicaid Boom

As Medicaid expansion under the ACA took its toll on private insurance plans, two provisions of the law aimed at increasing the availability of employer-sponsored health insurance (ESI) among workers at small firms missed their mark, according to a November 2021 study published in the *Southern Economic Journal*.

Study author Conor Lennon, an associate professor of economics at Rensselaer Polytechnic Institute, compared changes in ESI availability among workers at small and large firms before and after the ACA came into effect in 2013. Lennon's review of Medical Expenditure Panel Survey data found a slight increase in ESI availability and a big increase in working adults being covered by Medicaid.

"I find no evidence that greater ESI availability led to increases in ESI coverage rates," Lennon wrote. "Instead, descriptive estimates suggest that gains in health insurance coverage after 2013 consist of significant increases in the number of working adults who report having Medicaid coverage, including among workers who are offered ESI."

Lennon found "limited evidence to suggest that the ACA's provisions improved access to care or measures of health status for workers."

Government Dominance

Brian Blase, Ph.D., president of the Paragon Health Institute, says the government's ever-increasing role in health care will place an undue burden on taxpayers.

"The majority of money that health insurers now receive comes from government as opposed to people paying for private coverage," Blase said. "With Congress enacting policies to dramatically expand Obamacare subsidies and substantially grow Medicaid managed care, private spending and coverage are being replaced by government spending and coverage. Although these policies have boosted profits for big health insurance companies, they have resulted in an explosion of taxpayer cost and poured fuel on the nation's inflationary fire."

Government money is corrupting the private sector, says Doug Badger, a senior analyst for health and welfare policy at The Heritage Foundation.

"Private insurance companies are becoming increasingly reliant on government payments to fatten their bottom lines," said Badger.

"Since Obamacare, companies selling individual policies have begun to operate like government-funded enterprises, with premium subsidies accounting for nearly 75 percent of their revenue," said Badger. "States contract with low-bid HMOs to cover most of their Medicaid receipts. Medicaid HMOs collected $154 billion from the government during the second quarter of this year alone. Apart from the group markets, taxpayers are making the health insurance industry profitable."

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

INTERNET INFO

Rea S. Hederman Jr. *et al*., "Healthy and Working: Benefits of Work Requirements for Medicaid Recipients," The Buckeye Institute, December 3, 2018: **https://www.buckeyeinstitute.org/library/docLib/2018-12-03-Healthy-Working-Benefits-of-Work-Requirements-for-Medicaid-Recipients-policy-report.pdf**

Obamacare Premiums to Rise After Subsidy Hikes

By Bonner Russell Cohen

Affordable Care Act (ACA) health insurance plans are about to get a lot less affordable, with some plans proposing premium increases of 10 percent or more for the coming year.

"The main contributor to premium growth is health cost trend, which reflects rising prices paid to providers and pharmaceutical companies as well as a rebound in utilization," reports a Kaiser Family Foundation review of proposals made by 72 insurers in 13 states. "While our analysis focuses on the ACA markets, the main premium drivers we identified (prices and utilization) are systemic and not specific to the ACA markets."

Crowd-Out Increase

Fear of a political backlash over soaring Obamacare costs prompted congressional Democrats to increase premium subsidies for plans sold on the ACA exchanges. The Inflation Reduction Act passed in August extends the subsidy increases for another three years, through 2025. The bill was passed without a single Republican vote in either chamber of Congress.

With inflation increasing premium costs, the subsidies will cushion the price hikes for many of the roughly 13.8 million people enrolled in Obamacare. Taxpayers will have to pick up the difference.

Small businesses and their millions of employees will face hard choices because of cost inflation.

Under the ACA, small employers are not required to offer health insurance, though many of them do and had done so before Obamacare was enacted. These employer plans are not eligible for the increased subsidies, and being smaller they lack the heft to negotiate favorable premium rates with insurers. As the country flirts with a recession and the threat of stagflation, some small businesses may be forced to drop coverage for their employees.

Subsidy Persistence

Health care premiums are not immune to the inflation that has buffeted other sectors of the economy since the beginning of 2021, and the increased subsidies for ACA premiums may be a sign Obamacare insurance will have to be subsidized indefinitely if the program is to continue to attract enrollees.

Doug Badger, a senior research fellow at The Heritage Foundation's Center for Health and Welfare Policy, says he has been warning about the real cost and perverse incentives of the ACA for years.

"Obamacare premium subsidies rise dollar-for-dollar with premiums," Badger said. "Insurers know that taxpayers, not their customers, will pay for the premium increases.

"Nearly one-third of the people who are enrolled in Obamacare pay premiums of less than $10 a month," Badger said. "Taxpayers pick up the rest, an average of $524 a month. If insurers raise their premiums for next year, these customers still will pay less than $10 per month. Taxpayers will be saddled with 100 percent of the premium hike."

Insurers are taking advantage of this mismatch, Badger says.

"Given these perverse incentives, it's no surprise that insurers have raised their rates," Badger said.

COVID Inflation

Devon Herrick, Ph.D., a health economist and advisor to The Heartland Institute, says higher ACA premiums are a result of inflationary pressures brought on by profligate government spending during the pandemic.

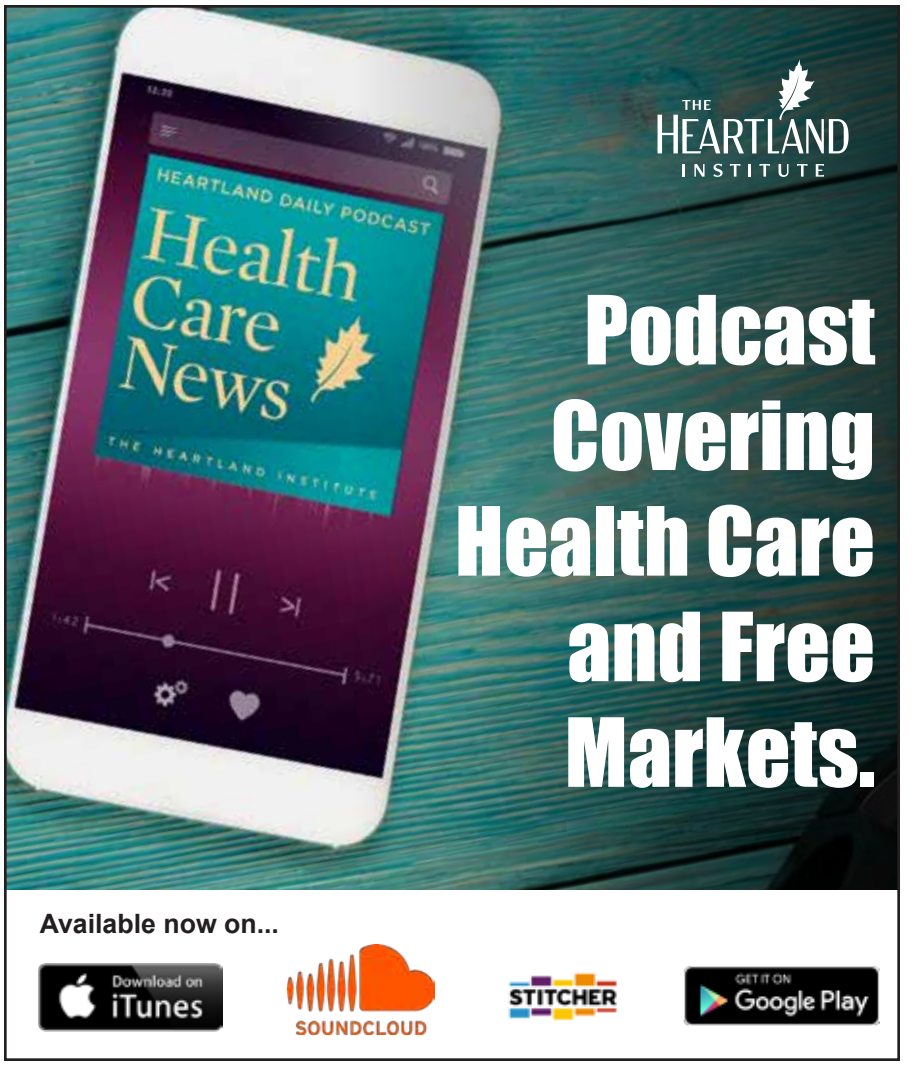
"Premiums are rising due to government overspending," Herrick said. "Inflation was caused by excessive COVID spending. Premiums were further given a boost by enhanced Obamacare premium subsidies."

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

Marketplace Average Benchmark Premiums

2014	$273
2015	$276
2016	$299
2017	$359
2018	$481
2019	$478
2020	$462
2021	$452
2022	$438
2023	Up 10 percent

Source: Kaiser Family Foundation (KFF)
https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D



Euthanasia Now a Leading 'Manner' of Death in Canada

By Bonner Russell Cohen

The preoccupation with COVID-19 since early 2020 has diverted attention from many other serious medical problems, including the startling rise of euthanasia in neighboring Canada, whose health care system many Americans praise.

Euthanasia, in which doctors use drugs to kill consenting patients, has been legal in Canada since 2016. To be eligible for the procedure, the law first stated a person must be at least 18 years old, be able to prove he or she is suffering from severe physical pain with a reasonable expectation of a foreseeable death, and have two doctors sign off on the decision to terminate life.

Since going into effect, the law has been amended to allow people who are not terminally ill to choose to be put to death.

Euthanasia accounted for more than 10,000 deaths in Canada in 2021, up by about one-third from the previous year, the Associated Press reported on August 11.

"Canada is rapidly becoming the world's leading manufacturer of death. Even Catholic nursing homes dedicated to palliative care, such as British Columbia's Delta Hospice, have narrowly escaped being coerced into becoming killing fields under the federal 'Medical Assistance in Dying Act,' so fittingly acronymized as 'MAID'—'call us to clean up your mess.'"

HARVEY PRICE, PH.D.

Confusion About Numbers

In 2019, suicide was listed as the ninth leading cause of death in Canada, according to Statistics Canada. It is unclear whether euthanasia is included in that number.

The number of people dying by euthanasia in Canada is unclear because euthanasia is recognized as a "manner" of death, not an underlying cause. Two Canadian provinces—Ontario and Quebec—explicitly instruct doctors not to indicate on death certificates that people died from euthanasia, and Canada's national statistical agency says the statistics enumerate the "underlying cause of death," not euthanasia.

Currently, seven U.S. states have "right-to-die" laws on the books: California, Colorado, Hawaii, New Jersey, Oregon, Vermont, and Washington, plus the District of Columbia. Although these laws are broader than traditional end-of-life decisions such as "do not resuscitate," they are distinct from euthanasia. Euthanasia, a broader category than "right-to-die" laws, is legal in Belgium, Canada, Colombia, Luxembourg, Netherlands, New Zealand, Spain, and several states in Australia.

World's Most Permissive

Even among the few nations that allow euthanasia, Canada's law is unusually permissive in allowing nurse practitioners, not just doctors, to administer the lethal drugs.

Such is the permissiveness of Canada's euthanasia law that last year three experts with the United Nations Human Rights Commission voiced their "grave concerns" the law violates the agency's Universal Declaration of Human Rights.

The practice is garnering critics in Canada, who express concerns about the ethical implications of the law. Harvey Price, Ph.D., a lecturer at the University of Toronto School of Continuing Studies, says the embrace of euthanasia is part of a larger, disturbing trend in Canada.

"Canada is rapidly becoming the world's leading manufacturer of death," Price said. "Even Catholic nursing homes dedicated to palliative care, such as British Columbia's Delta Hospice, have narrowly escaped being coerced into becoming killing fields under the federal 'Medical Assistance in Dying Act,' so fittingly acronymized as 'MAID'—'call us to clean up your mess.'

"In Canada of late there are more-stringent restrictions on the disposal of household waste at the local rubbish tip than the killing of the burdensome elderly, mentally ill, or babies in the womb," Price said.

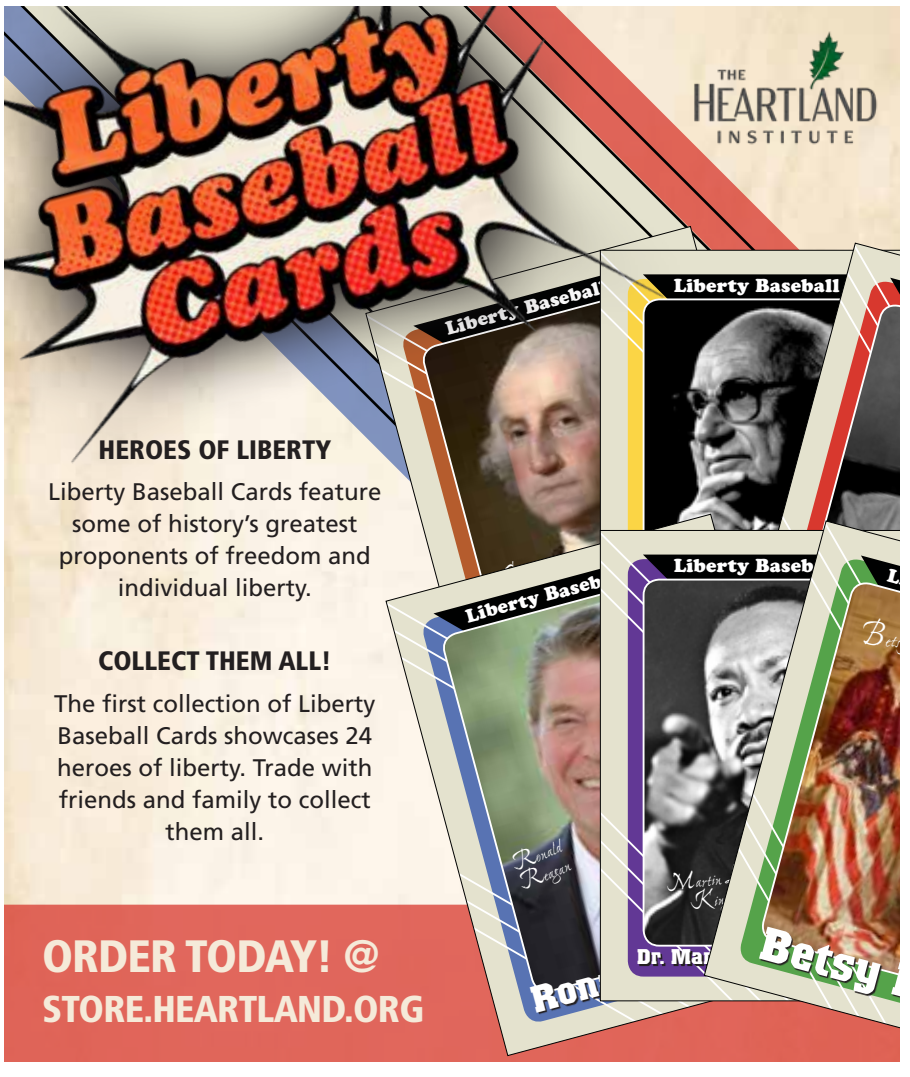
'Healers, Not Killers'

Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and a policy advisor to The Heartland Institute, which co-publishes *Health Care News*, says the expansion of euthanasia is part of a downward spiral of ethics in the medical profession.

"People often talk about doctors taking the Oath of Hippocrates, but these days they generally don't, substituting a bastardized version or making up one of their own," Orient said. "The original oath explicitly forbids euthanasia and abortion: 'To please no one will I prescribe a deadly drug or give advice which may cause his death.'

"Doctors are healers, not killers," Orient said. "Worse still, doctors or facilities may be punished for refusing to provide or arrange for this 'medical service.' At least at first, Nazi doctors rationalized the killing of the insane or disabled as a merciful service."

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



HHS Dumps Conscience Protections

By Kevin Stone

The U.S. Department of Health and Human Services (HHS) has proposed a rule implementing Section 1557 of the Affordable Care Act (ACA) that will force health care professionals to perform procedures that go against their consciences and religious beliefs.

The rule would roll back limitations on the application of the ACA provision put in place under the Trump administration. The 60-day public comment period ended on October 3.

HHS says the rule will "prohibit discrimination on the basis of race, color, national origin, sex, age, and disability in certain health programs and activities."

Expansive Definition

According to an informational bulletin by Alexandra Sumner, J.D., published by GoodRx Health on September 12, the proposed rule would expand the category of "sex" protected from discrimination to include intersex traits, sexual orientation, gender identity, and pregnancy, and related conditions, including its termination by abortion.

These changes are highlighted as bullet points in a press release from HHS announcing the rule proposed in August. HHS states that the proposed rule "Aligns regulatory requirements with Federal court opinions to prohibit discrimination on the basis of sex including sexual orientation and gender identity."

Compliance Nightmare

The rule would implement major changes to training and paperwork requirements and could invalidate existing standard of care guidelines, the GoodRx Health bulletin reports.

"If successfully passed, the rule would require covered entities to effectively train employees on resources for individuals with disabilities," Sumner writes. "They would also need to hand out Notices of Nondiscrimination. And they will also have to use clinical decision-making tools with caution."

The term "clinical decision-making tools" refers to existing clinical algorithms "that may unintentionally discriminate against people of color and those with disabilities," Sumner writes.

"[C]overed entities should revisit the algorithms behind them," Sumner writes. "They should also figure out if any patient populations are being discriminated against and/or if the algorithm leads to any implicit biases. If found, the algorithm should be changed to remove the discriminatory effect. But it should be revisited on an as-needed basis."

'Transgender Mandate'

The rule represents an unscientific intrusion of a political agenda into critical health care decision-making and treatment, says Rachel N. Morrison, a fellow at the Ethics and Public Policy Center's HHS Accountability Project.

"The proposed rule continues to push the Biden administration's radical health equity, gender ideology, and pro-abortion policies," said Morrison. "HHS is using nondiscrimination regulations to establish a medical standard of care even though there is no medical consensus over the proper standard of care for patients who have gender dysphoria or identify as transgender. The proposed rule imposes a transgender mandate by requiring doctors and hospitals to provide harmful and irreversible medical 'gender transition' interventions, including for children, in violation of doctors' medical judgments, consciences, and oaths to 'do no harm.'

"No medical professional should be forced to chemically sterilize or surgically remove healthy body parts from a patient, regardless of the patient's subjective self-identification," said Morrison. "The proposed rule ignores the legal requirement for abortion neutrality and purports to preempt conflicting state abortion laws."

Conscience Cancellation

The Biden administration intends to use this rule to force out medical professionals who refuse to perform these controversial forms of surgery, says Morrison.

"The proposed rule provides a sham process for those who have conscience or religious objections to its transgender and abortion mandates," said Morrison. "HHS, under Biden and Becerra, has gratuitously disregarded the conscience and religious freedom rights of medical professionals, even refusing in federal court to disavow that it would use 1557 to require doctors to perform 'gender transition' surgeries or abortions in violation of their sincerely held religious beliefs.

"These mandates will drive up medical costs and drive out many qualified and caring students and professionals from certain fields of medicine or from the medical professional overall," said Morrison.

Swift Pushback

Constitutional rights advocacy groups were quick to push back against the rule, including pro-life organizations and groups defending religious freedom.

The United States Conference of Catholic Bishops issued a July 27 press release stating, "Catholic health care ministries serve everyone, no matter their race, sex, belief system, or any other characteristic. The same excellent care will be provided in a Catholic hospital to all patients, including patients who identify as transgender, whether it be for a broken bone or for cancer, but we cannot do what our faith forbids. We object to harmful procedures, not to patients.

"Sadly, Monday's proposed regulations threaten our ability to carry out our healing ministries, and others to practice medicine," the statement said. "They mandate health care workers to perform life-altering surgeries to remove perfectly healthy body parts. Assurances that HHS will honor religious freedom laws offer little comfort when HHS is actively fighting court rulings that declared HHS violated religious freedom laws the last time they tried to impose such a mandate. This is a violation of religious freedom and bad medicine."

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

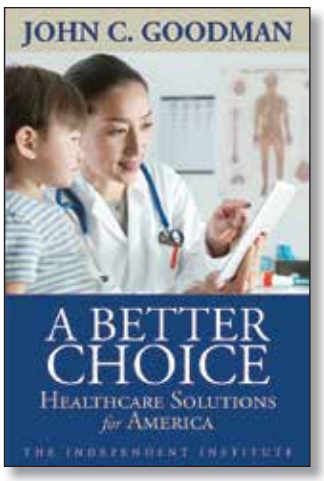
"The proposed rule provides a sham process for those who have conscience or religious objections to its transgender and abortion mandates. HHS, under Biden and Becerra, has gratuitously disregarded the conscience and religious freedom rights of medical professionals, even refusing in federal court to disavow that it would use 1557 to require doctors to perform 'gender transition' surgeries or abortions in violation of their sincerely held religious beliefs. These mandates will drive up medical costs and drive out many qualified and caring students and professionals from certain fields of medicine or from the medical professional overall."

RACHEL N. MORRISON
ETHICS AND PUBLIC POLICY CENTER

INTERNET INFO

Centers for Medicare & Medicaid Services, "Nondiscrimination in Health Programs and Activities," Federal Register, August 4, 2022: **https://www.federalregister.gov/documents/2022/08/04/2022-16217/nondiscrimination-in-health-programs-and-activities**

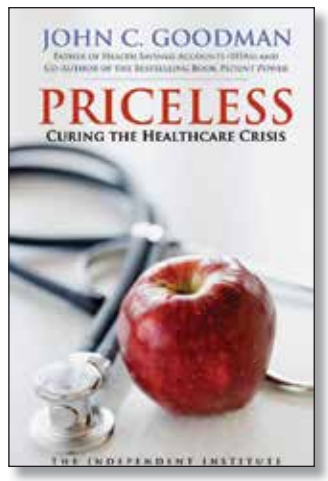
Prescription for Better Healthcare Choices



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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U.S. Life Expectancy Decreased by Three Years in the Past Two Years

By Harry Painter

Life expectancy in the United States declined at the most rapid rate since World War II in the past two years.

According to estimates from the Centers for Disease Control and Prevention, a June preprint study, and other research on the topic, the average life expectancy for Americans declined from 79 years in 2019 to about 76 in 2021.

It is wrong to assume the decline was caused by the COVID-19 pandemic, says Merrill Matthews, a resident scholar at the Institute for Policy Innovation.

"The pandemic certainly had an impact on life expectancy, but apparently not that much," said Matthews. "Life expectancy was declining sharply before COVID-19 hit, and only declined slightly in 2020. Asian life expectancy even improved a bit. The real question is why life expectancy was declining before COVID."

Non-COVID Causes

Causes other than COVID-19 are definitely part of the problem, says Gregg Girvan, a resident fellow at the Foundation for Research on Equal Opportunity (FREEOP).

"Clearly, the pandemic continued to take a toll on the U.S., so the decline in life expectancy is a reflection of that," said Girvan. "But it certainly didn't help that over the course of the pandemic, the United States has also seen increases in deaths due to drug overdose, homicides, traffic accidents, and chronic disease that has gone undetected and untreated.

"Many of these causes of death occur among younger age groups, which will have a disproportionate impact on overall life expectancy," said Girvan.

Chronic diseases have historically contributed heavily to lagging life expectancy in the United States, says Girvan.

"Over the coming years, these rates will only continue and perhaps get worse, because more cases of such diseases have gone untreated or were not caught early enough," said Girvan. "This is a negative consequence of lockdown policies and practices that did little to nothing to prevent COVID-19's spread but will have lasting consequences on public health."

Behavior Factors

The United States has a unique set of problems not found in other countries, including high rates of traffic accidents, drug overdoses, and homicide, says Girvan. The homicide rate "disproportionately affects younger ages and therefore has a greater effect on bringing down U.S. life expectancy," said Girvan.

"To improve life expectancy, the United States has to address aspects of longevity that often have little to do with the health care system directly," Girvan said. "America suffers from poor eating and lifestyle habits that contribute greatly to mortality."

Substance abuse, homelessness, and crime are major factors in the life expectancy decline, says Matthews.

"One of the most notable changes in the past several years is the increase in homelessness and crime, both of which have a strong correlation with substance abuse," Matthews said. "The government-imposed pandemic lockdowns exacerbated substance abuse."

Another important factor is automobile use, says Girvan.

"The U.S. is more auto-centric culturally, as well as out of necessity because of the country's suburban landscape," said Girvan. "Again, many people of younger ages die from accidents, having a greater downward effect on life expectancy."

Drug Abuse Problem

Drug overdose mortality disproportionately affects the young and thus has an outsized effect on life expectancy, says Girvan.

"Nearly half of [U.S.] overdose deaths in 2020 occurred among those ages 25 to 44," said Girvan.

"While the number of overdose deaths of people older than 55 is growing, 72 percent of the opioid deaths occur in people between the ages of 25 and 54, with ages 25-34 experiencing the most deaths," said Matthews.

Matthews says Americans should pay more attention to drug policy.

"Drug enforcement policies have been dramatically relaxed or ignored, especially in blue cities and states, even to the point of making it easy to access and use drugs openly," Matthews said. "Drug-involved deaths nearly doubled from 2015 to 2020, to 91,799."

A 2021 study by the National Institute on Drug Abuse found a steady increase in drug overdose deaths in the years 1999 to 2020.

Preventable opioid deaths increased by 41 percent in 2020 over the previous year. More than 17,000 people in the 25 to 34 age group died, a 38 percent increase from the year before.

"Averaging in those growing numbers of younger deaths has a disproportionate impact on the decline in the average lifespan," said Matthews.

"Clearly, the pandemic continued to take a toll on the U.S., so the decline in life expectancy is a reflection of that. But it certainly didn't help that over the course of the pandemic, the United States has also seen increases in deaths due to drug overdose, homicides, traffic accidents, and chronic disease that has gone undetected and untreated. Many of these causes of death occur among younger age groups, which will have a disproportionate impact on overall life expectancy."

GREGG GIRVAN
RESIDENT FELLOW
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

Bad Yardstick?

As a broad metric that does not distinguish between different types of mortality, life expectancy may be the wrong way to measure a health care system, says Girvan.

"Much of the improvement to life expectancy in the U.S. will come about with societal improvements that are not ameliorated by the health care system," said Girvan.

FREOPP publishes a yearly country-by-country comparison of health care systems, the World Index of Healthcare Innovation. The index provides additional evidence the increasing U.S. mortality rate is not being caused by poor health care.

"The U.S. has access to the best treatments and methods to extend lifespan," said Girvan. "We have room for improvement for greater health insurance coverage and certainly on affordability. But overall, the quality of available care suggests other interventions outside the health care system would deliver greater gains in longevity and quality of life."

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

INTERNET INFO

"Provisional Life Expectancy Estimates for 2021," NCHS National Vital Statistics System, August 22, 2022: **https://www.cdc.gov/nchs/data/vsrr/vsrr023.pdf**

"Changes in Life Expectancy Between 2019 and 2021 in the United States and 21 Peer Countries," *MedRxiv*, June 1, 2022: **https://www.medrxiv.org/content/10.1101/2022.04.05.22273393v4.full.pdf**

"Overdose Death Rates," *Advancing Addiction Science*, National Institute on Drug Abuse, January 20, 2022: **https://nida.nih.gov/research-topics/trends-statistics/overdose-death-rates**

REPORT

New York Times Blames White People, Vaccine Hesitancy for Longevity Decline

The New York Times was caught misrepresenting data and mischaracterizing the opinion of an expert source in an article purporting to explain the decline in average life expectancy in the United States.

Just Facts found several false claims in an August 31 *New York Times* article by Roni Caryn Rabin that blames the 2021 drop in U.S longevity on the lack of COVID-19 vaccinations, particularly among whites, and the failure to comply fully with pandemic mandates.

The article quotes Steven Woolf, M.D., director emeritus of the Center on Society and Health at Virginia Commonwealth University, blaming whites' supposed mask resistance and vaccine hesitancy for the falling U.S. life expectancy.

Rabin writes, "'The white population did worse in 2021 than communities of color, besides Native American and Alaska Natives,' Dr. Woolf said. 'I think that's very telling: It reflects the greater efforts by Black and Hispanics to get vaccinated, to wear masks and take other measures to protect themselves, and the greater tendency in white populations to push back on those behaviors.'"

PHOTO COURTESY AJAY_SURESH/FLICKR.COM

Sorry, Wrong Numbers

Writing in response, *Just Facts* President James D. Agresti noted vaccine compliance was greater in the United States throughout much of 2021 than in Europe and the European Union. Agresti also presented statistics showing U.S. whites had higher vaccine compliance than blacks and Hispanics and evidence that masking was less common in Europe than in the United States.

Agresti reports Woolf said the quotes in the *New York Times* story do not accurately reflect his thoughts.

"When reporters ask me to explain why the U.S. losses were so large, my custom is to say that more research is needed to definitively answer the question and to mention a range of potential contributing factors," Agresti quotes Woolf as saying. "Among them is how people responded to vaccination and pandemic control measures, but I usually mention a number of other factors and in all cases [try to] use conditional language such as 'may have.'"

'Never Corrected Any'

Woolf did not respond when *Just Facts* asked whether he would seek clarification from the *Times*.

> **"I've documented dozens of other cases where *The New York Times* has published demonstrable falsehoods that have the potential to harm or kill people, and they have never corrected any of them."**
>
> **JAMES D. AGRESTI**
> ***JUST FACTS***

Agresti also emailed the paper about its claims in the article and requested a correction.

"Other than an automated email from the *Times* acknowledging receipt of my message, I have not heard back from them," Agresti told *Health Care News*. "As of 10/4/2022, 4:09 PM, the article has not been corrected.

"I've documented dozens of other cases where *The New York Times* has published demonstrable falsehoods that have the potential to harm or kill people, and they have never corrected any of them," Agresti said.

—Staff reports

Sudden Deaths Among Notables Raise Questions

By Harry Painter

In the past year, a string of notable deaths has raised interest among the public because of common factors and ambiguities reported in the obituaries.

The death of 54-year-old comedian David A. Arnold on September 8 is a recent example. "David passed away peacefully today in his home and doctors have ruled the cause of death due to natural causes," Arnold's family announced.

On July 14, Ivana Trump, the 73-year-old ex-wife of former president Donald Trump, was found dead in her home. A medical examiner's report stated Ivana Trump died from "blunt impact injuries" after accidentally falling down a set of stairs in the home where she had lived for years. Trump was planning to leave on a vacation to France the next day, her friend Nikki Haskell told *The New York Post*. Haskell said Trump was looking forward to the trip after having been "totally locked down" during the pandemic because of a fear of COVID-19.

> **"The website GoodSciencing.com lists more than 1,300 cases of young and healthy athletes experiencing cardiac arrest after receiving COVID-19 injections, more than 900 of which resulted in death."**

Another surprising death was that of Bob Saget, the 65-year-old comedian who died from blunt force trauma, according to his family. Saget was found unresponsive in his hotel room in January after having tweeted about a public performance just hours before.

Young, Healthy, Deceased

The website GoodSciencing.com lists more than 1,300 cases of young and healthy athletes experiencing cardiac arrest after receiving COVID-19 injections, more than 900 of which resulted in death.

In addition, musical artist GI Joe OMG died at 33 with no reported cause, wrote New York University professor Mark Crispen Miller on his Substack site *News from Underground* in September. In the same week, a 24-year-old aide to Vice President Kamala Harris "died unexpectedly of natural causes," according to his family.

Also in September, the 22-year-old daughter of Rahway, New Jersey Mayor Raymond Giacobbe "died suddenly … following a recent medical procedure," according to the *New Jersey Globe*.

On June 16, Rep. Sean Casten (D-IL) broke the news his teen daughter had been found dead in her room, apparently having died in her sleep.

"An exact cause has not been determined," reported WLS-TV.

Miller says the corporate media go out of their way to find explanations other than the COVID-19 injections, such as Sudden Adult Death Syndrome, for unexpected, sudden deaths, even when the victim's injection status is public knowledge (see related article, opposite page).

"They are very pointedly denying it, always blacking out the fact that this or that dead person had been vaccinated," Miller said.

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

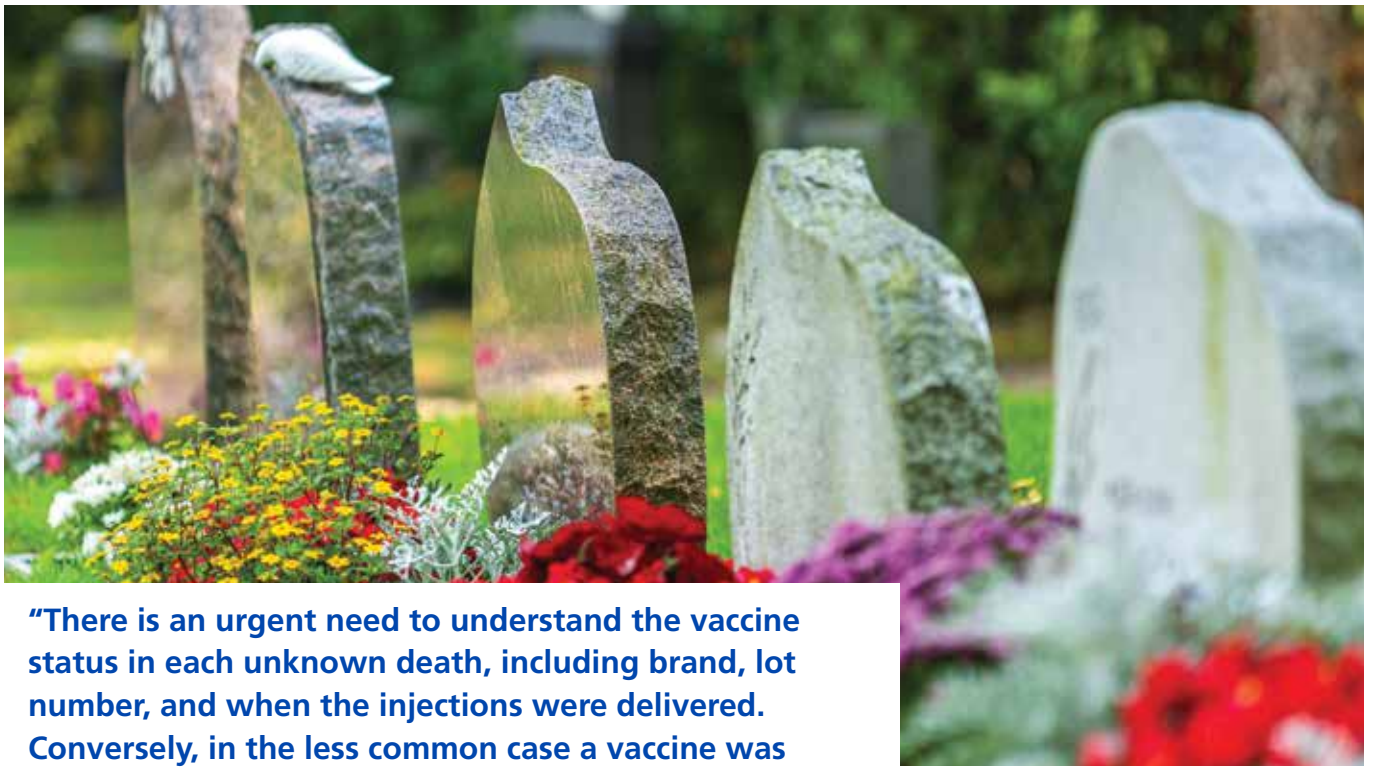
Websites Track 'Died Suddenly' Obituaries

by Harry Painter

Concerned citizens across the United States are tracking reports of people dying suddenly and unexpectedly.

For want of better explanations from official channels, people have created alternative networks to explore the phenomenon of news reports and obituaries for those described as having "died suddenly."

One such site is New York University Professor Mark Crispin Miller's Substack page, *News from Underground*. Another is the Facebook group "Died Suddenly News," in which members share stories of their loved ones they think were victims of COVID-19 vaccine side effects.



"There is an urgent need to understand the vaccine status in each unknown death, including brand, lot number, and when the injections were delivered. Conversely, in the less common case a vaccine was never taken, then the public would be reassured if family members come out and specifically rule out COVID-19 vaccination in the case. Autopsies and federally funded epidemiological research into this disturbing mortality trend for Americans are urgently needed."

PETER A. MCCULLOUGH, M.D.

More than a Statistic

"Since February, I've been tracking the reports of people 'dying suddenly' from all around the world, a task that's grown so huge that I now need the help of a whole team of researchers all over," Miller told *Health Care News*. Miller's compilations "put names—and, sometimes, faces—to the dead" and are hard to dismiss because they make more of an impression than abstract statistical observations, Miller says.

"My aim is to dissuade as many people as I can from getting jabbed or getting any further jabs, and to give those who are already fighting back against this 'vaccination' drive strong ammunition for that effort," Miller said.

Tiago Henriques, a computer programmer from Nova Scotia and the creator and administrator of *Died Suddenly News*, says he is planning to develop a platform for the group outside of Facebook. He wrote of that plan on a dedicated GoFundMe page which appears to have been taken down.

"My mission is to have our very own platform free from censorship and judgment," Henriques wrote. "A place where caring people can come share their stories free from harassment and feeling safe in a community that truly listens to them. The need for the new platform is important as it would allow us to compile statistics and evidence on what's really going on in the world. It will give us autonomy and not have to fear being turned off at any time by the powers that be."

Descriptions Have Changed

Miller says he has noticed a pattern in the attribution of unexplained and sudden deaths reported in the news or obituaries (see related article, opposite page).

"They either give no 'cause of death,' which is unprecedented in the history of obituaries in America—'died suddenly' was formerly obituary code for suicide or drug overdose—or they note some cardiological mishap: heart attack, stroke, blood clot, or cardiac arrest," Miller said.

The latter is unprecedented in descriptions of children's deaths, Miller says.

"Or they mention some rare, aggressive cancer which was diagnosed since early 2021," Miller said. "Also notable is the startlingly high and ever-growing number of fatal car, plane, and motorcycle accidents—we call them 'vaxxidents'—reported every week, and the bizarre rate of mysterious drownings, or seeming drownings, as well as deaths near the water.

"In Italy, for example, we keep seeing all these reports of people who either drowned in calm waters or who dropped dead just walking on the shore or along rivers," Miller said. "It's my hope that the recurrence of such deaths will move some scientists to come up with an explanation of why this should be happening."

Rise in All-Cause Mortality

Peter A. McCullough, M.D., a cardiologist and epidemiologist and the former vice chief of internal medicine at Baylor University Medical Center, says the rise in deaths since the release of COVID-19 vaccines should raise concerns about the safety of the injections.

"There is a disturbing trend since release of the COVID-19 vaccines: all-cause mortality is rising in the general population," McCullough said. "Before the COVID-19 crisis, in general the cause of death is usually known and falls into the following categories for adults: 40 percent cancer, 40 percent heart disease, and 20 percent other causes."

The Centers for Disease Control and Prevention (CDC) estimates the number of excess deaths since the pandemic began is more than 1.1 million, about 250,000 of which have been designated as non-COVID deaths.

"What we are seeing now is a rapid rise among working-age persons in death due to 'unknown cause,'" McCullough said. "These observations have been reported by many life insurance companies and actuary associations."

Calls for Investigation

Scott Davison, CEO of the insurance firm OneAmerica, estimates U.S. death rates were up 40 percent in early 2022 compared with before the pandemic. Former BlackRock portfolio manager Edward Dowd said in a September interview there was an 84 percent rise in excess deaths among millennials, which he attributed to the COVID vaccinations, through fall 2021.

"There is an urgent need to understand the vaccine status in each unknown death, including brand, lot number, and when the injections were delivered," McCullough said.

"Conversely, in the less common case a vaccine was never taken, then the public would be reassured if family members come out and specifically rule out COVID-19 vaccination in the case," McCullough said.

McCullough calls for more investigation into the causes of the excess deaths.

"Autopsies and federally funded epidemiological research into this disturbing mortality trend for Americans are urgently needed," McCullough said.

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

COMMENTARY

How to Win Back the Public's Trust on Health and Science

Academy for Science and Freedom, Hillsdale College

Editors Note
On August 23, the Academy for Science and Freedom at Hillsdale College released 10 principles to restore the public's trust in science and public health. The COVID-19 pandemic exposed a vast system where the government and private interests colluded to weaponize a virus, create fear, censor dissent, and obliterate informed dissent and civil liberties. People have been harmed, and an increasing number are dying unexpectedly. Excess deaths not related to COVID-19 are up, and life expectancy has had its steepest drop since World War II.

Statement on the Ethical Principles of Public Health, on behalf of Hillsdale College's Academy for Science and Freedom, Washington, D.C., August 23, 2022

During the SARS-CoV-2 pandemic, fundamental principles of public health were ignored and, as a result, trust in public health has been damaged. As experts in public health, medical science, ethics, and health policy, we propose the following ten principles

to guide public health officials and scientists, in order to ensure the credibility of public health recommendations and to help restore public trust.

1. All public health advice should consider the impact on overall health, rather than solely be concerned with a single disease. It should always consider both benefits and harms from public health measures and weigh short-term gains against long-term harms.

2. Public health is about everyone. Any public health policy must first and foremost protect society's most vulnerable, including children, low-income families, persons with disabilities and the elderly. It should never shift the burden of disease from the affluent to the less affluent.

3. Public health advice should be adapted to the needs of each population, within cultural, religious, geographic, and other contexts.

4. Public health is about comparative risk evaluations, risk reduction, and reducing uncertainties using the best available evidence, since risk usually cannot be entirely eliminated.

5. Public health requires public trust. Public health recommendations should present facts as the basis for guidance, and never employ fear or shame to sway or manipulate the public.

6. Medical interventions should not be forced or coerced upon a population, but rather should be voluntary and based on informed consent. Public health officials are advisors, not rule setters, and provide information and resources for individuals to make informed decisions.

7. Public health authorities must be honest and transparent, both with what is known and what is not known. Advice should be evidence-based and explained by data, and authorities must acknowledge errors or changes in evidence as soon as they are made aware of them.

8. Public health scientists and practitioners should avoid conflicts of interest, and any unavoidable conflicts of interest must be clearly stated.

9. In public health, open civilized debate is profoundly important. It is unacceptable for public health professionals to censor, silence, or intimidate members of the public or other public health scientists or practitioners.

10. It is critical for public health scientists and practitioners always to listen to the public, who are living the public health consequences of public health decisions, and to adapt appropriately.

Statement authored by Ryan T. Anderson, Ph.D.; Scott W. Atlas, M.D.; David Bell, Ph.D.; Jay Bhattacharya, M.D., Ph.D.; David Doat, Ph.D.; Carl Heneghan, D. Phil.; Aaron Kheriaty, M.D.; Martin Kulldorff, Ph.D.; Robert W. Malone, M.D.; Peter A. McCullough, M.D.; Elisabeth Paul, Ph.D.; Roger Severino; and Ellen Townsend, Ph.D. An earlier version of this article was published on the Hillsdale College, Washington, D.C., campus website.

Oklahoma Uses Power of the Purse to Stop Child Sex Transitions

By Harry Painter

Oklahoma Children's Hospital announced it would cease "certain gender medicine services" as a bill before the state legislature prepared to withhold millions of dollars in federal funds.

In advance of the bill's passing, the pediatric care provider, part of the University of Oklahoma health system OU Health, said it would stop its Roy G. Biv services so it could receive funding for a new mental health facility.

On October 4, Gov. Kevin Stitt signed Senate Bill 3. The law blocks American Rescue Plan Act (ARPA) funding from being used for permanent gender transition treatments for minors at OU medical facilities.

The new law provides, among other things, $39.4 million in ARPA funding for the mental health hospital, on the condition OU Health does not provide gender reassignment surgeries, puberty blockers, or "gender-affirming" hormone therapy for minors.

Power of the Purse

"I worked on this bill from the beginning because of my long career as a licensed psychologist who has worked in schools for years," state Rep. Randy Randleman (R-Eufuala) told *Health Care News*.

While developing the bill, Randleman and his colleagues discovered the Oklahoma Children's Hospital was providing gender reassignment services through the Roy G. Biv program.

"I was concerned about funding being potentially used for this program, as I and many of my constituents believe these irreversible medical procedures can do irreparable mental and physical damage to children and teens," said Randleman.

"These are not simple cosmetic procedures that can be easily reversed in a few years," said Randleman. "These surgeries are permanent, and there is no way to undo the damage done if someone regrets their decision."

Call for Ban

S.B. 3 addressed only the ARPA funds. Stitt has called on the state legislature to ban "irreversible gender transition surgeries and hormone therapies on minors" when lawmakers reconvene in 2023.

"Last week's session was called specifically to address federal ARPA funds, so Senate Bill 3 was the only way we could address this deeply concerning issue constitutionally," said Randleman. "I think one thing some legislators were concerned about was that there was nothing in Senate Bill 3 that would prevent another hospital in the state from beginning a similar program."

The new law is only the beginning of the discussion, says Randleman.

"I know many of my colleagues in the legislature are interested in pursuing a more extensive end to these surgeries on children in the state, so I have no doubt that this conversation will continue throughout the interim and into our regular session in February," said Randleman.

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

INTERNET INFO

"Oklahoma SB3: University Hospitals Authority; making an appropriation. Emergency." *TrackBill*, accessed October 5, 2022: **https://trackbill.com/bill/oklahoma-senate-bill-3-university-hospitals-authority-making-an-appropriation-emergency/2263380/**

California to Penalize Doctors for Alleged COVID-19 Misinformation

By AnneMarie Schieber

California physicians and surgeons may lose their medical licenses if they are found to be disseminating "misinformation or disinformation" about COVID-19.

Gov. Gavin Newsom signed into law AB 2098, which expands the definition of "unprofessional conduct" to include going off message on COVID-19, on September 30.

Offenses defined in the bill include giving out false or misleading information on the nature of COVID-19, the "risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines."

The state's Medical Board and Osteopathic Board have the authority to act against licensed physicians charged with unprofessional conduct. Boards can discipline doctors in a variety of ways, including suspension, mandatory retraining, and license revocation.

The bill says the board must consider the intent, scope, and nature of the information in determining action.

Defining Misinformation

"They defined it in the law, but it is still

vague," said Marilyn Singleton, M.D., J.D., a board- certified anesthesiologist who has practiced in California, on the *Heartland Daily Podcast* on September 13.

"Disinformation still has to have so-called 'malicious intent,' but that is not fully described," said Singleton. "The worst is the [definition of] misinformation, in that they call it false information that is contradicted by scientific consensus. Medicine has never been driven by consensus."

Singleton says two well-known examples of debate in health care history prove this point: handwashing in health care practice, which was long ignored and even denounced, and ulcers being caused by a bacterium instead of worry or spicy foods.

Whether the law will drive physicians out of California is hard to predict, says Singleton, as it is unlikely patients will "rat out" a doctor if they have a good relationship.

"If in the case of COVID, you wrote your patient a prescription for ivermectin, you might have some activist pharmacist that might turn the doctor in," said Singleton. "But this is the problem with laws like this: they can upend a person's life.

"It's sad they don't take these things into account, but they don't care," said Singleton. "That is the bottom line: they don't care."

And Fauci?

Under California's new standard, presidential health care advisor Anthony Fauci could end up in the crosshairs.

"No wonder he's retiring," wrote columnist Roger L. Simon in *The Epoch Times*.

"And where will the line be drawn?" wrote Simon. "Will it be no masks necessary, one mask necessary, two masks necessary, one week to break the curve, two weeks, six months, one booster, two boosters, boosters until we're dead and buried? What constitutes misleading the public? Dr. Fauci, at one time or another, recommended all of the above in less than two years, and that's barely getting started."

"If in the case of COVID, you wrote your patient a prescription for ivermectin, you might have some activist pharmacist that might turn the doctor in. But this is the problem with laws like this: they can upend a person's life. It's sad they don't take these things into account, but they don't care. That is the bottom line: they don't care."

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

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

POLL

Democrats, Liberals Still Fear COVID-19

By Kevin Stone

People identifying as liberal or Democrat are twice as afraid of COVID-19 as people in other political groups, according to the most recent polling by Morning Consult.

In a September poll of 2,200 U.S. adults, 18 percent of those who identified as Democrats viewed COVID-19 as a "severe" health risk in their community, whereas 8 percent of Republicans had that view. The average for all U.S. adults was 12 percent.

The poll result follows an established trend, with the Morning Consult results on the same question for the same period in the previous two years showing a Democrat-Republican split of 43-21 for 2021 and 39-19 in 2020.

The poll has an unweighted margin of error of plus or minus two percentage points.

Morning Consult has been surveying Americans weekly on the subject since the start of the pandemic.

Fear of Virus?

A poll conducted by The Heartland Institute and Rasmussen in January 2022 found Democrats support draconian policies in response to the virus.

The poll of 1,016 likely voters found 59 percent of Democrats favored forcibly confining the unvaccinated to their homes, with only 17 percent of Republicans agreeing with that idea. Seventy-eight percent of Democrats were in favor of President Joe Biden's government-enforced vaccine mandate for private businesses with more than 100 employees, compared to 34 percent of voters overall.

While claiming to be more fearful of COVID-19, those on the Left do not appear to be acting on their stated opinions. According to recent data from the Centers for Disease Control and Prevention, only 1.5 percent of those with access to the new "bivalent" COVID booster shot designed for the newest Omicron subvariants have taken it.

Authoritarian Dreams?

The disparity in stated opinions may reflect a preexisting political agenda more than a sincere concern about the virus, says Jim Lakely, vice president of The Heartland Institute, which co-publishes *Health Care News*.

"I think the response reflects a desire by those on the Left to impose authoritarianism on America," said Lakely.

Those who crave power often use fear to spur people to action, says Lakely.

"Authoritarians gain power from fear," said Lakely. "Our government and their propagandists in the corporate media exploited COVID to stoke maximum fear, knowing that half the country or more would find it impossible to not live in fear. That fear was unfounded, but it still did the trick for the authoritarians in elected positions and in the bureaucracy that serves them.

"From Marx to the Bolsheviks to America's leftist intellectuals, the Left has long held to this dream of perfecting humanity," said Lakely. "We are flawed only because individuals have the freedom to do as they wish. If only we all got behind this unachievable goal—ending poverty, stopping climate change, stopping a super-infectious virus—it would happen. But it never happens. Only misery follows, every time."

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

COMMENTARY

Medicare Prescription Drugs: A Case Study in Government Failure

By John C. Goodman

Sen. Bernie Sanders and other socialists think the government should provide health care, and their latest version of that idea is "Medicare for all."

How does Medicare stand up against private, free-market coverage with similar benefits? Let's examine drug coverage, since Congress just acted on Medicare's prescription drug benefits.

Pursuing Votes

Drug coverage lowers the overall cost of health care and improves patient outcomes. As a result, by 2003 virtually every major health plan in the country was covering prescription drugs and had been doing so for quite some time. Medicare, by contrast, was well into its fourth decade with no drug coverage, and it took a major effort in Congress to get coverage even then.

Why the difference? Private businesses always tend to make changes when there are opportunities to lower costs and serve their customers better. In the political arena, however, nothing changes unless special interest pressures change.

Medicare has traditionally paid many small expenses that seniors could easily afford on their own, while leaving them exposed for tens of thousands of dollars of catastrophic costs. The reason why has to do with the nature of insurance.

In any scheme, a small percent of the insured will make up a very large percentage of the claims in any given year. In health insurance, for example, about half the money is spent on 5 percent of the insured. When the insurer is the government that means half the money will be spent on 5 percent of the voters—people who may be too sick to vote at all.

Favoring the Healthy

Politics is the art of taking from Peter and giving to Paul. That will always be tempting to do if there are a lot more Pauls than there are Peters.

Take Medicare's "donut hole." After a certain point, Medicare pays less for drugs than it has been paying, until a patient's catastrophic coverage kicks in.

The reason is to create a benefit for the many seniors below the donut hole, with small drug costs. That's also the reason why a very small percentage of seniors pay $10,000 or more every year for specialty drugs while the typical senior pays only 25 percent of the cost of inexpensive drugs.

Conflicting Financial Interests

Seniors in traditional Medicare are usually paying separate premiums to three different insurers: one for Part B coverage for doctor care, a second for Part D coverage for drugs, and a third for Medigap insurance to plug the holes in Part A (hospital care) and Part B.

The suppliers of these three plans have differing financial interests, and the results are waste, inefficiency, and inferior patient care.

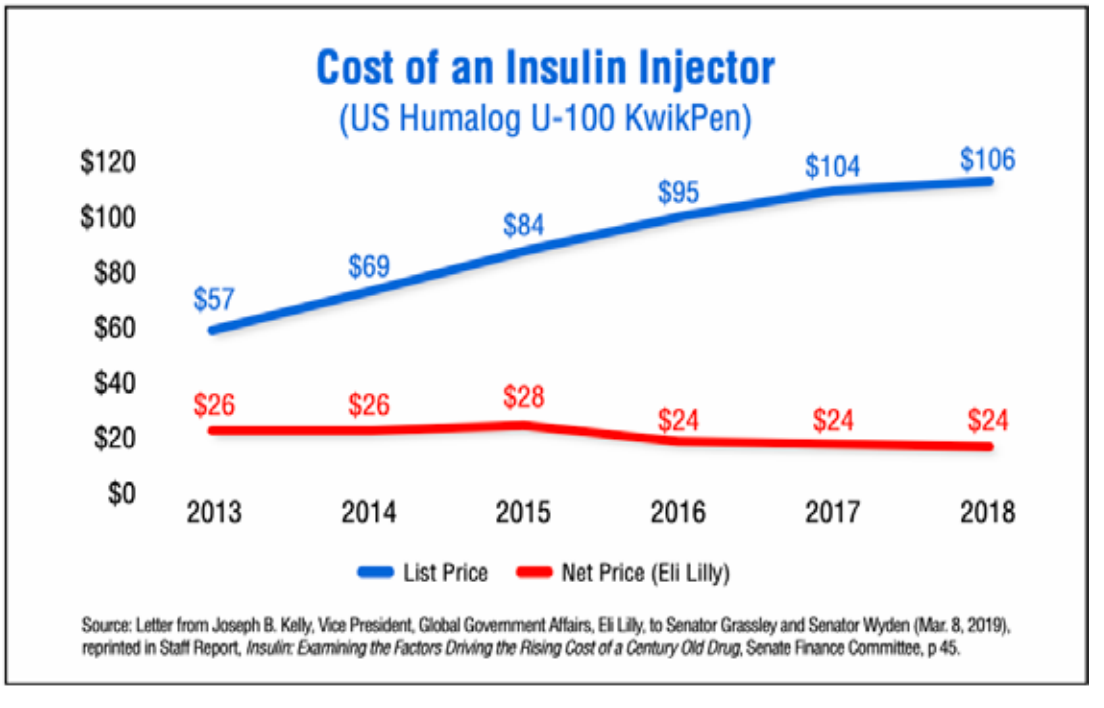
If a diabetic skips his insulin and other medications, that increases the profit for the drug insurer because it doesn't have to cover those expenses. However, if such nonadherence to a drug regimen leads to emergency room visits and hospitalization, the other two insurers will have to bear the costs.

The fact that the insurers have competing and opposing financial interests means there is no possibility of alignment with the goal of cost-effective, well-managed care.

Overcharging the Sick

When insurers are forced to charge a community rate (charging everyone the same premium regardless of each individual's health status) and there is no adequate risk adjustment, they will have an incentive to overcharge the sick (to discourage their enrollment) and undercharge the healthy (to encourage their enrollment).

In Medicare Part D, this perverse incentive leads to distorting effects in the "rebate" system. Suppose a diabetic goes to a pharmacy where the list price of insulin is $100. Her 25 percent copayment amounts to $25. However, unbeknownst to her, the insurer is getting a $76 rebate from the drug company that produces the insulin. That means that the real cost of the insulin to the insurer was only $24. So, a fair out-of-pocket charge to the patient would be only $6, not $25.



Source: Letter from Joseph B. Kelly, Vice President, Global Government Affairs, Eli Lilly, to Senator Grassley and Senator Wyden (Mar. 8, 2019), reprinted in Staff Report, *Insulin: Examining the Factors Driving the Rising Cost of a Century Old Drug*, Senate Finance Committee, p 45.

"Consider the effect of having one insurer cover drugs while the other two are covering medical care. If a diabetic skips his insulin and other medications, that increases the profit for the drug insurer because it doesn't have to cover those expenses. However, if such nonadherence to a drug regimen leads to emergency room visits and hospitalization, the other two insurers will have to bear the costs. The fact that the insurers have competing and opposing financial interests means there is no possibility of alignment with the goal of cost-effective, well-managed care."

What happens to that additional profit the insurer makes but doesn't share with the patient? It gets competed away by charging lower premiums for buyers of Part D drug insurance.

In this way, the system causes the sick who need drugs to be overcharged while the relatively healthy premium payers are undercharged.

Private Sector Alternatives

Instead of a rebate system, private plans in the Medicare Advantage program tend to pass along any discounts from drug producers to the patients.

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 September 13, 2022. Reprinted with permission.*

STUDY

Medicare Advantage Plans Deliver Better Value

By AnneMarie Schieber

Medicare Advantage (MA) plans cost enrollees 7 percent less than traditional fee-for-service (FFS) plans, show higher rates of consumer satisfaction, and can save money for the Centers for Medicare and Medicaid Services (CMS), a new study finds.

MA is the private option in Medicare. Enrollees sign up with a private company for Medicare coverage, and the private company manages the care for a reimbursement fee based on the enrollee's risk profile.

Apples to Apples

The study, released September 21 by America's Health Insurance Plans (AHIP), the trade group for health insurance providers, was conducted in response to a March 2022 report by MedPAC that said MA plans cost 2 percent more than FFS plans. The Medicare Payment Advisory Commission (MedPAC) report failed to factor in the mandatory maximum out-of-pocket (MOOP) requirement for MA plans, according to AHIP.

The study found if FFS plans were required to implement a MOOP, those plans would cost CMS 3.5 percent more. Accounting for the extra benefits and services MA plans offer, such as grocery delivery, vision, dental care, and zero-premium prescription coverage, MA costs 7 percent less than FFS plans, the report states.

"These savings are one more demonstration of how MA delivers better services, better access to care, and better value," AHIP stated in a news release.

The study also found 94 percent of seniors in MA expressed satisfaction with their plan, compared with 84 percent in FFS, and that MA outperforms traditional Medicare on 16 different clinical quality measures.

Attractive to Those in Need

AHIP's comparison shows the superiority of MA, says John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News*.

"In addition to the cost comparison, it is worth noting that seniors save $2,000 or so by not having to buy Medigap insurance," said Goodman. "And they get much better drug coverage."

MA has been a positive outlier in health care, says Goodman.

"Medicare Advantage is the only place in the entire health care system where health plans specialize in various chronic conditions and advertise to attract patients with those conditions," Goodman wrote in a *Forbes* commentary on July 13. "By contrast, there is no employer in the entire country that seeks to attract employees who have diabetes, heart disease, or cancer. Plans in the Obamacare exchanges also appear to have no interest in high-cost enrollees. To the contrary, these plans, along with most employer plans, seem designed to attract the healthy and avoid the sick."

Interest in Success

The MA model also avoids some of the drug cost pitfalls in Medicare Part D, the drug plan FFS Medicare enrollees must purchase separately for drug coverage, says Goodman. The separate plan can work against sick enrollees with big drug bills.

"In Medicare Advantage, people are paying one premium to only one insurer, who is responsible for all costs," wrote Goodman in a September 22 article posted on the Goodman Institute's webpage. "That means the insurer has a non-conflicted, integrated interest in keeping patients healthy and in minimizing costs.

"Because of a highly sophisticated risk adjustment system, these plans have just as much economic incentive to attract the sick as they have to attract the healthy," wrote Goodman.

Attention to Real Costs

The study tries to make a fair cost comparison in a market known for distortions, not the least of which is the third-party payment system in which the consumer is abstracted from the cost and providers shift costs.

"Charges—billed prices—do not reflect actual costs," said Linda Gorman, director of health care policy at the Independence Institute. "Reimbursement rates from the government programs do not reflect actual costs, either. One needs to focus on transaction prices to the extent that they are available."

The controversy over which approach is more expensive is partly driven by a desire to control care, says Gorman.

"A lot of it presumably derives from the absolute determination that some groups have to prove that organizationally integrated care is better," said Gorman. "No one likes to be wrong."

The study may overestimate the advantages of MA, says Gorman.

"Like so many studies of Medicare Advantage versus fee-for-service Medicare, it does not consider whether there are group differences in the people who choose to enroll in each type of plan," says Gorman. "Nor does it discuss the known incentives to inflate the health risk of Medicare Advantage patients. Without adjustment for risk, we really cannot say much about relative cost."

Back to Cash

Although having two Medicare models can be a good way to create checks and balances, ihe best approach would be to get back to a free-market health care system, not just for seniors but for everybody, says Gorman.

"A good start would be going back to encouraging cash payment for routine expenses and revamping coverage so that true insurance policies are again available," said Gorman. "This would allow families to better control their financial losses if they are hit with a serious disease.

"Government programs should stop wasting money on healthy people," said Gorman. "Subsidies should be transparent. They should be in cash and focused on medically indigent patients who have seriously expensive diseases or on the hospitals that treat them."

Having the government hire private plans to organize care is a further waste of money, says Gorman.

"In traditional private practice, competent physicians developed informal networks of specialists they trusted to do right by their patients," said Gorman. "The informal networks functioned pretty well and didn't have all the administrative overhead."

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

INTERNET INFO

"Value of Medicare Advantage Compared with Original Medicare," America's Health Insurance Plans, September 21, 2022: **https://www.ahip.org/resources/value-of-medicare-advantage-compared-with-original-medicare**

COMMENTARY

Private Equity Is Buying Up Health Care Providers

By Devon Herrick

Private equity investors are scooping up thousands of health care businesses across the nation.

If you present at an emergency room, there is a good chance you will be treated by a physician employed by a firm backed by private equity investors. In some cases, entire hospitals are being purchased or managed by firms backed by private equity. Increasingly, physician practices are being bought up by private equity investors.

Private equity typically refers to a partnership or group of investors who seek out struggling businesses to purchase to make a quick turnaround on the investment. The profit motive is worrying many stakeholders in health care, fearing higher prices and lower quality.

"To the degree that private equity is seeking to standardize business models and buy struggling health care businesses to make them more efficient, the investment is beneficial. To the degree private equity is taking advantage of health care market dysfunction, it's a concern."

Patient Payoff

Kaiser Health News has been reporting on how private equity is investing in health care. An article on May 27 noted investors are tapping into the growing demand for colonoscopies.

"We are in the Golden Age of older rectums," the article quotes an investment manager as saying.

An article on June 15 reports on investors buying rural hospitals only to dump them when there isn't a quick buck to be made. The practice can devastate a community when people suddenly find the doors to a local hospital are slammed shut.

A *Kaiser* article on July 29 reports hospices are becoming a hot investment where financial considerations could interfere during a sensitive time for patients and families if profit, not end-of-life care, is the driving force.

"Private equity sees a huge opportunity to take smaller businesses that lack sophistication, lack the ability to grow, lack the capital investment, and private equity says, 'We can come in there, cobble these things together, get standardization, get visibility, and be able to create a better footprint, better access, and more opportunities,'" the article states, quoting Steve Larkin, CEO of Charter Healthcare, which is owned by the private equity firm Pharos Capital Group.

"It is a little scary," Larkin told *Kaiser Health News*. "There are people that have no business being in health care" looking to invest in hospice.

Nursing homes are another investment target that is causing worry for families. I recently helped locate a facility for a family member, and there is intense competition for those seniors with enough money to pay privately.

Not a Typical Investment

This is what worries me about private equity investing in health care. Our health care system is dysfunctional. It consumes nearly 20 percent of our economy, and 90 percent of the resources are paid for by parties other than the patient.

This is a recipe for waste, fraud, and abuse. From what I've seen, there is very little interest in innovative business models that compete for cash-paying patients. Most of what I've seen are schemes seeking ways to maximize reimbursements against third-party payers' formulas.

There has been significant investment in air ambulances by private equity in recent years. Why air ambulances? Because if you need air transport, as my father did a few years ago, you are in no position to negotiate.

In addition, states are not able to regulate the huge fees that air ambulances charge (often more than a new luxury car). The airline industry was deregulated in the late 1970s, and federal law preempts states' laws. Thus, private equity investors in air ambulance services take advantage of two unusual market characteristics: the consumer (patients) cannot refuse the service when their life is on the line, and states cannot prevent price gouging.

Death a Growth Industry

To the degree that private equity is seeking to standardize business models and buy struggling health care businesses to make them more efficient, the investment is beneficial. To the degree private equity is taking advantage of health care market dysfunction, it's a concern.

Interestingly, the latest private equity target is the $23 billion funeral home industry, according to *Kaiser*. With a vast cohort of boomers slipping into old age, death is becoming a growth industry.

Devon Herrick (**devonherrick@sbcglobal.net**) *is a health care economist and a policy advisor to the Heartland Institute. A version of this article appeared on the Goodman Health Blog on September 15.*

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COMMENTARY

Private Medicine Trumps Corporate Medicine

By Marilyn M. Singleton, M.D., J.D.

Over the last couple of years, we've been living in a frenzied political atmosphere of inflation worries, unaddressed crime, COVID, monkeypox, and a variety of social problems. These are distractions from thinking about the big picture: the march toward government and corporate control over our lives, including the absorption of medical practice into the statist-corporate complex.

While many say COVID-19 brought out flaws in public health, it has also highlighted the joys and advantages of private-practice medicine. People who are disappointed in governments' ofttimes unscientific public health recommendations and mandates have benefitted from the advice of private practitioners. Sadly, we are on the road to losing private practice, the heart of good medicine.

A recent article about a private equity group's purchase of a small rural hospital chronicled in great detail how the firm ran the hospital into the ground. The residents were left with no hospital in their area. That was but one example among many in recent years.

Until the past 10 or 15 years, most hospitals were owned either by nonprofit entities, mainly religious, or by states and cities, with ties to medical schools. Private equity ventures have quadrupled over the last 10 years, and they have spent approximately $750 billion on health provider purchases during that time. As Bain Capital put it, 2021 was a "banner year" for equity purchases, fueled by an aging population and increase in chronic illnesses.

Private equity firms now control a large swath of hospitals, physician practices, ERs, nursing homes, and hospice centers.

"Why is all this so concerning? Consolidation is decreasing choice and competition. CVS began its expansion by purchasing multiple drugstore chains—its competitors. In 2006 it added 'Minute Clinics' to its stores. In 2007, CVS Corporation and Caremark Rx, Inc. merged, creating CVS Caremark, CVS' own pharmacy benefits manager. In 2018, CVS merged with the health insurance company Aetna. An antitrust judge ruled that as a condition of approval Aetna had to sell its Medicare prescription insurance operation to WellCare Health Plans. What is happening is vertical consolidation: one company controls all levels of the stream of commerce in its business sector."

Profits over Patients

For years, health care policy experts have been warning about the dangers of private equity and consolidation in medical services. The focus on return on investment by private equity owners puts profits over patients. A study found hospitals increased their prices after being acquired by private equity firms. Studies on nursing homes and dialysis centers have found private equity ownership is associated with higher prices and a decrease in quality of care.

Concurrently, consolidation has been on a roll. Five for-profit insurers now control 43 percent of the market, more than 60 percent of community hospitals belong to a health system, and less than half of physicians own part of a private practice.

A large California study found consolidation of the hospital, physician, and insurance markets increased prices of services and Affordable Care Act (ACA) premiums. Research shows hospital mergers increase the average price of hospital services by 6 percent to 18 percent.

An industry group places some of the blame on the increase in government programs, with the 55 percent increase in consolidation correlating with the introduction of the ACA and the Medicare Access and CHIP Reauthorization Act.

Of course, consolidation reduces patient choice.

Vertical Consolidation

We need more choice, but is expansion of big companies into health service provision the answer? Amazon just made a $3.9 billion agreement to buy One Medical. This is ironic given that One Medical is a primary care service offering 24/7 personalized care. In addition, Amazon purchased the PillPack online pharmacy in 2018. Walgreens drug stores will now have in-store clinics staffed by VillageMD personnel and ultimately will own 30 percent of VillageMD.

CVS's new venture is downright scary. The drug store giant is seeking to purchase the managed-care company Signify Health or some other primary care provider group by the end of this year. Some even speculate CVS wants to buy Teledoc, a major telehealth service. Teledoc already is the exclusive telehealth provider for Aetna.

Why is all this so concerning? Consolidation is decreasing choice and competition. CVS began its expansion by purchasing multiple drugstore chains—its competitors. In 2006 it added "Minute Clinics" to its stores. In 2007, CVS Corporation and Caremark Rx, Inc. merged, creating CVS Caremark, CVS' own pharmacy benefits manager. In 2018, CVS merged with the health insurance company Aetna. An antitrust judge ruled that as a condition of approval Aetna had to sell its Medicare prescription insurance operation to WellCare Health Plans.

What is happening is vertical consolidation: one company controls all levels of the stream of commerce in its business sector.

Best Defense: Direct Pay

Legally, there is not much we can do about consolidation except protest with our feet: seek out private practices where you are treated as an individual human being and not just an income generator. The ideal practice is a cash-based practice or direct primary or specialty care practice.

With direct primary care, a monthly fee covers all doctor visits, drugs dispensed at the office at wholesale prices, and 24/7 access to your doctor. Odd as it may seem, paying cash to see the doctor or have outpatient surgery can be less expensive than buying insurance, with its co-pays and high deductibles.

All you really need to add to that is hospitalization insurance (unless you are a billionaire, in which case you don't even need that). If there is no such practice near you, find a second opinion via telehealth.

It is up to us to save the patient-physician relationship—and just maybe our republic!

Marilyn M. Singleton, M.D., J.D. (**marilynsingletonmd1@gmail.com**) *is a board-certified anesthesiologist, a member of the Association of American Physicians and Surgeons, and an attorney focusing on constitutional and administrative law. Her articles can be viewed at https://marilynsingletonmdjd.com.*

NC Solicitor General Asks Court to Halt Racetrack's Lockdown Lawsuit

By Victor Skinner

North Carolina Solicitor General Ryan Park wants the North Carolina Supreme Court to reverse a unanimous Appeals Court ruling that allows an Alamance County speedway to sue the state government over a 2020 COVID shutdown order.

Park filed a petition for discretionary review on September 6 that asks the high court to consider *Kinsley v. Ace Speedway Racing*, a lawsuit asserting the authority of the North Carolina Department of Health and Human Services (DHHS) to shut down Ace Speedway during the pandemic.

The original lawsuit involved former DHHS Secretary Mandy Cohen, who was replaced in her position and in the lawsuit by DHHS Secretary Kody Kinsley.

"This Court has held that there is sufficient evidence to show a constitutional violation when a deprivation of plaintiffs' freedom of speech was the moving force behind an injunction closing a business."

CHUCK KITCHEN
ATTORNEY FOR ACE SPEEDWAY RACING

Motion Denied

Three Republican judges on the Appeals Court upheld a lower court decision against a motion by DHHS attorneys to dismiss Ace's claims, which allege violations of a right to earn a living under the state constitution's fruits of labor clause, as well as selective enforcement of Gov. Roy Cooper's COVID-19 executive orders.

"This appeal concerns whether the State can be subject to claims for financial damages for taking steps to protect public health during the worst pandemic in a century," Park wrote in the September 6 filing on behalf of Kinsley.

The filing cites experts' predictions about COVID-19 in 2020 and the intent of Cooper's executive orders to prevent the spread as justification for attempting to limit spectators at the racetrack and alleged the Appeals Court ruling sets a dangerous precedent.

"The decision … marks a sharp departure from this Court's well-established precedent," Park wrote. "And if allowed to stand, the decision … would hamstring the government's ability to effectively address future public-health crises."

Decision Defied

DHHS secured abatement and temporary restraining orders to shut down Ace Speedway in June and July 2020 after owner Jason Turner openly defied Cooper's restrictions on gatherings to hold stock car races on three occasions in May and June 2020, hosting more than 1,000 spectators at each event.

Prior to the races, Turner consulted with county health officials to implement COVID precautions including contract tracing, temperature screenings, social distancing in common areas, and reduced and distanced audience seating arrangements.

Cooper called the events "reckless" and "dangerous," according to local media outlet Fox 8.

Selective Enforcement?

Chuck Kitchen, attorney for the speedway, responded to Park's petition on September 13, asking the Supreme Court to reject the appeal.

Kitchen noted the races took place only after consulting with Alamance County health officials and instituting recommended precautions, argued Cooper's executive order could not legally be enforced with abatement, and suggested Ace was singled out by the governor for enforcement.

"The Appellees spoke out in the press against the Executive Orders of the Governor," Kitchen wrote. "The Governor became personally involved and contacted the Alamance County Sheriff. The Sheriff had never had this happen in his 49 years in law enforcement. Further, the Sheriff had an investigation conducted by his office and determined that there were several other racetracks in the area which were conducting races. Since the State was not taking action against those tracks, the Sheriff refused to charge the Appellees with violating the Executive Order of the Governor."

"This Court has held that there is sufficient evidence to show a constitutional violation when a deprivation of plaintiffs' freedom of speech was the moving force behind an injunction closing a business," Kitchen wrote in Ace's response to the Supreme Court.

Because the Court of Appeals decision was unanimous, the Supreme Court is under no obligation to take up the case and is not bound by a timeline for a decision if it does, *The Carolina Journal* reports.

Victor Skinner (**info_tcs@thecentersquare.com**) *is a contributor to* The Center Square. *An earlier version of this article appeared at* The Center Square. *Reprinted with permission.*

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COMMENTARY

Social Scores Are Invading Health Care

By Matt Dean

When the Electronic Health Record (EHR) system replaced paper medical charts, critics worried about personal data privacy.

A dozen years later, doctors and nurses are recording nonmedical social codes as part of the EHR, and those extraordinarily subjective codes will probably have a decisive impact on how much of the $4 trillion the United States currently spends on health care will be diverted to government action on social and environmental causes.

"With $4 trillion in medical spending, there are four trillion great reasons to worry that the money for a pacemaker you thought you were getting might turn into a 'green' roof in a targeted congressional district."

Climate Equity Crusade

The Biden administration's newly formed Office of Climate Change and Health Equity (OCCHE) has introduced plans to "redress the disparities" in health outcomes across populations. OCCHE was created under Executive Order 14008 and led by Admiral Rachel Levine. The bureau is tasked to "protect the health of people throughout the US in the face of climate change, especially those experiencing a higher share of exposures and impacts."

In a recent interview, Acting Director John Balbus, M.D., said OCCHE is going even further.

The "equity lens says that we need to be incorporating climate resilience to our built environment to improve our built environment not just when the flood hits, but for the 99% of the time when people are working, playing, and going to school in their environments to redress the disparities, and we are working on that, we are working on the indicators," said Balbus.

Balbus went on to share the vision for exactly how to use health care money for infrastructure: "We are working on the data systems; we're working on getting it into the EHR, and ultimately we need to get it into the Z-codes and into reimbursement strategies," said Balbus.

Balbus proposes using health care money to change the physical environment to make it healthier for those "experiencing a higher share of exposure." OCCHE Senior Advisor Joe McCannon promises to "explore Incentives and Standards" for businesses to "improve resilience in service of vulnerable populations."

Government 'Help' Monitors

Z-codes were originally created as a medical-chart catchall for health care situations that are difficult to quantify. Providers now code "Social Determinants of Health" under Z-codes.

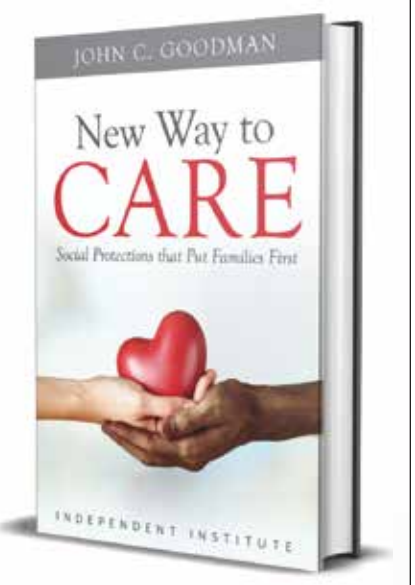
For example, code Z-59 includes "inadequate housing, housing instability, lodgers and landlord problems." Code Z-64 includes "unwanted pregnancy, multiparity and discord with counselors." If the nurse notices "stress on family due to return of a family member from military deployment," that falls under code Z-62.

Biased health care workers could easily prejudge a patient in a particular line of work, neighborhood, or political party and Z-code that person into needing "help" from the government. If you homeschool your kids, live near a river, and were the victim of a crime, you may get rung up for Z-65, Z-62, Z-57, and Z-55, even though you and your family are all healthy and presented no complaints.

Political bureaucrats have no business asking doctors and nurses to assign a subjective social score in a medical chart. With $4 trillion in medical spending, there are four trillion great reasons to worry that the money for a pacemaker you thought you were getting might turn into a "green" roof in a targeted congressional district.

Matt Dean (**mdean@heartland.org**) *is a senior fellow for health care policy outreach at The Heartland Institute. A version of this article was published at* The Center Square.

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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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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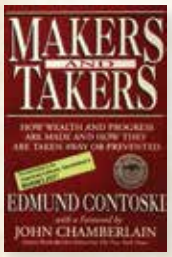

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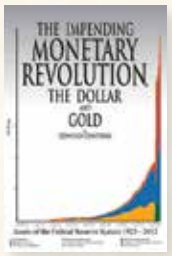

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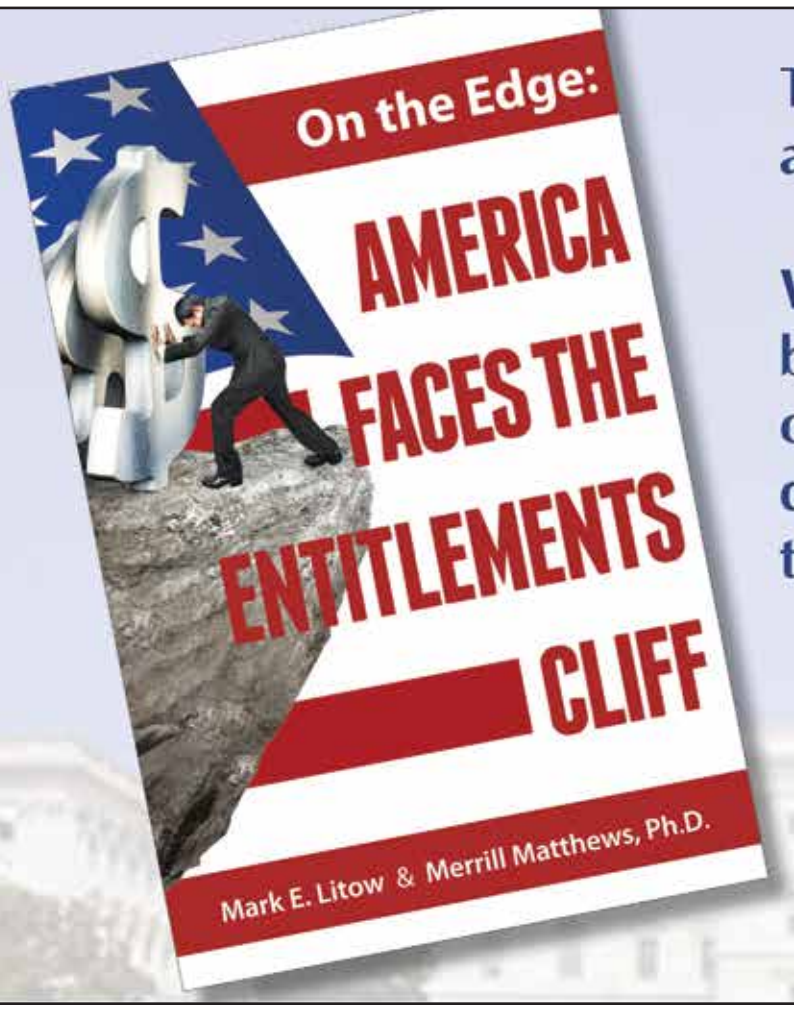

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