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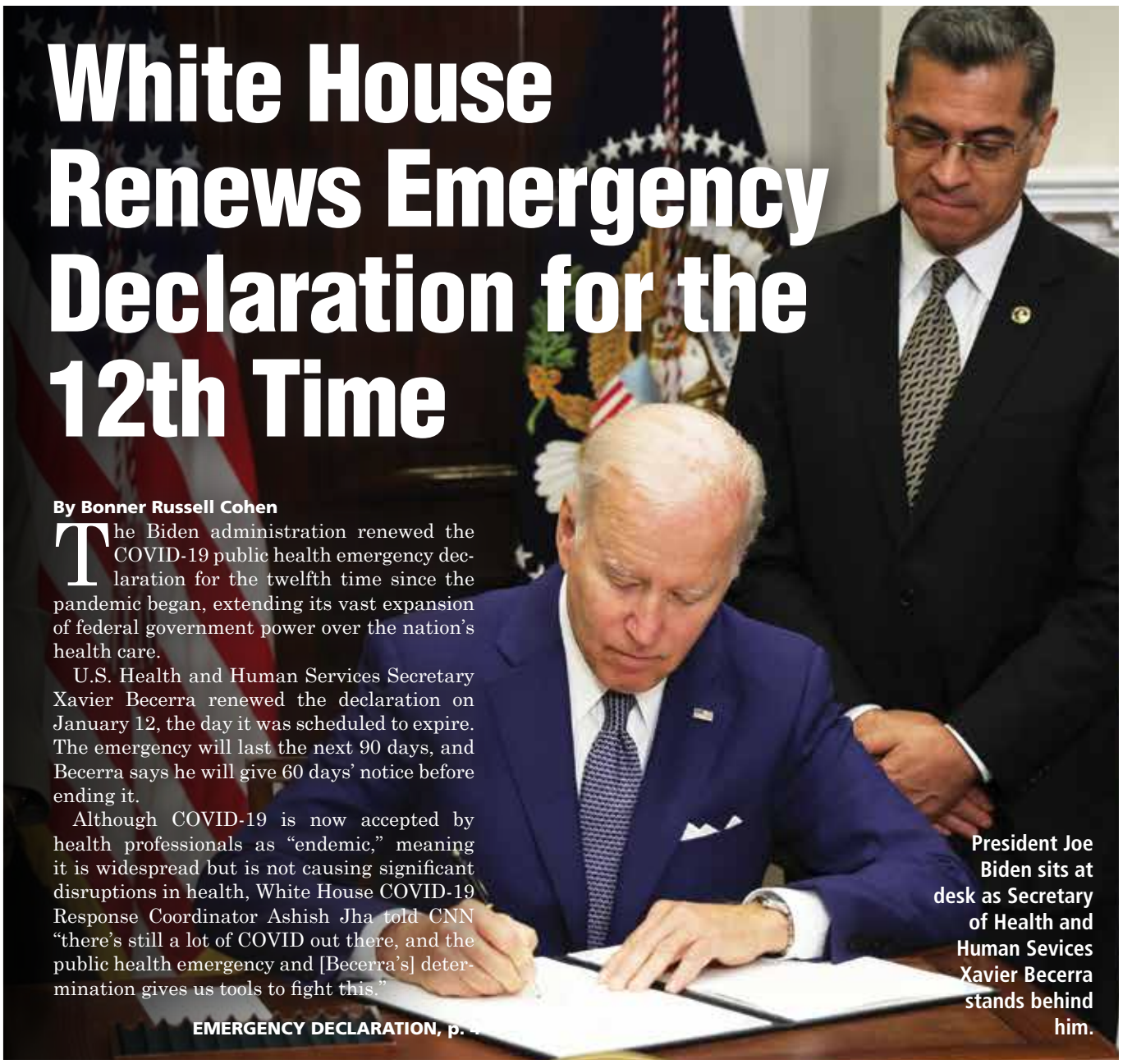
The Pulse

White House Renews Emergency Declaration for the 12th Time



President Joe Biden sits at desk as Secretary of Health and Human Sevices Xavier Becerra stands behind him.

PHOTO COURTESY ALEX WONG/STAFF/GETTYIMAGES

By Bonner Russell Cohen

The Biden administration renewed the COVID-19 public health emergency declaration for the twelfth time since the pandemic began, extending its vast expansion of federal government power over the nation's health care.

U.S. Health and Human Services Secretary Xavier Becerra renewed the declaration on January 12, the day it was scheduled to expire. The emergency will last the next 90 days, and Becerra says he will give 60 days' notice before ending it.

Although COVID-19 is now accepted by health professionals as "endemic," meaning it is widespread but is not causing significant disruptions in health, White House COVID-19 Response Coordinator Ashish Jha told CNN "there's still a lot of COVID out there, and the public health emergency and [Becerra's] determination gives us tools to fight this."

EMERGENCY DECLARATION, p. 4

Military Ends COVID-19 Shot Mandate

By AnneMarie Schieber

The U.S. Department of Defense (DoD) has stopped requiring all service members to get COVID-19 shots.

Secretary of Defense (SoD) Lloyd Austin made the policy official in a memo released on January 10. The 2023 National Defense Authorization Act (NDAA) required Austin to rescind the mandate, which was issued on August 24, 2021.

The memo states no military members will be discharged "solely" for refusing the shots "if they sought an accommodation on religious, administrative, or medical grounds."

Although the military will remove any disciplinary actions taken against

MILITARY ENDS MANDATE, p. 6

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SURVEY

Cigarette Smoking Decreases to Lowest Level on Record

By Kevin Stone

Cigarette smoking among Americans has fallen to the lowest level on record.

The Gallup survey of adults released in November returned its lowest result in the history of the poll, which has been conducted regularly since 1944. Gallup found just 11 percent of U.S. adults are cigarette smokers. That is down from 16 percent in 2021, 20 percent a decade ago, and the all-time high of 45 percent recorded in 1954.

Gallup asked, "Have you, yourself, smoked any cigarettes in the past week?"

Individuals 18 to 29 showed the sharpest decline in smoking rates, with positive responses dropping from 35 percent in 2001 to 12 percent in 2022. Smoking rates among those aged 50 to 64 dropped from 23 percent to 18 percent, and those aged 65 and older from 14 percent to 8 percent.

The percentage of U.S. adults aged 18 or older who smoke cigarettes is 12.5 percent, "the lowest prevalence since data became available starting in 1965," reports the Centers for Disease Control and Prevention (CDC).

Changing Public Perceptions

The decline in smoking rates may be due to several factors, including federal actions severely limiting advertising and requiring warnings on tobacco products, state and local smoking bans, and high taxes.

In addition, there is continuing public education on the health risks of smoking, and an advertising campaign that portrays smoking in a negative light, funded by the 1998 Master Settlement Agreement between tobacco companies and state attorneys general.

That campaign has turned the public perception of smoking and tobacco negative, says Jeffrey Singer, M.D., a surgeon and senior fellow at the Cato Institute's Department of Health Policy Studies.

"The biggest factor has been cultural: cigarette smoking has become 'uncool,' largely due to an effective advertising campaign," said Singer. "Secondarily, a public education campaign has made most people concerned about the harmful health effects of smoking."

"It may also be that vaping has played a role. There is impressive evidence that teens who take up vaping are the ones who are more likely to have otherwise taken up tobacco smoking. And vaping is a more modern phenomenon."

JEFFREY SINGER, M.D.
SENIOR FELLOW
CATO INSTITUTE

Vaping Alternative

Public perception helps explain the age differences in smoking rates, says Singer.

"I think it is multifactorial: the older age groups contain people who were more likely to have started smoking—and become addicted—before the education and public relations campaigns became very effective," said Singer.

The popularity among the young of alternative products that are less harmful than cigarettes is another possible factor, says Singer.

"It may also be that vaping has played a role," said Singer. "There is impressive evidence that teens who take up vaping are the ones who are more likely to have otherwise taken up tobacco smoking. And vaping is a more modern phenomenon."

Government's Role

There are different views on the government's proper role in regulating smoking, says Singer.

"I think the only legitimate role for the government to play is for public health agencies to inform people of the harmful effects of smoking and to provide a court system to adjudicate product liability cases, where people can sue tobacco companies if they do not adequately inform people of the potential dangers associated with their products," said Singer.

It is not the role of the government to ban harmful products such as alcohol and drugs, says Singer.

"A free people still must be allowed to make their own choices about what they want to ingest or otherwise put into their bodies," said Singer. "And while smoking is harmful, it also brings pleasure to many people. Each person should be free to make their own risk/benefit assessment, and the government should not be allowed to make that assessment for them."

Tax Effects

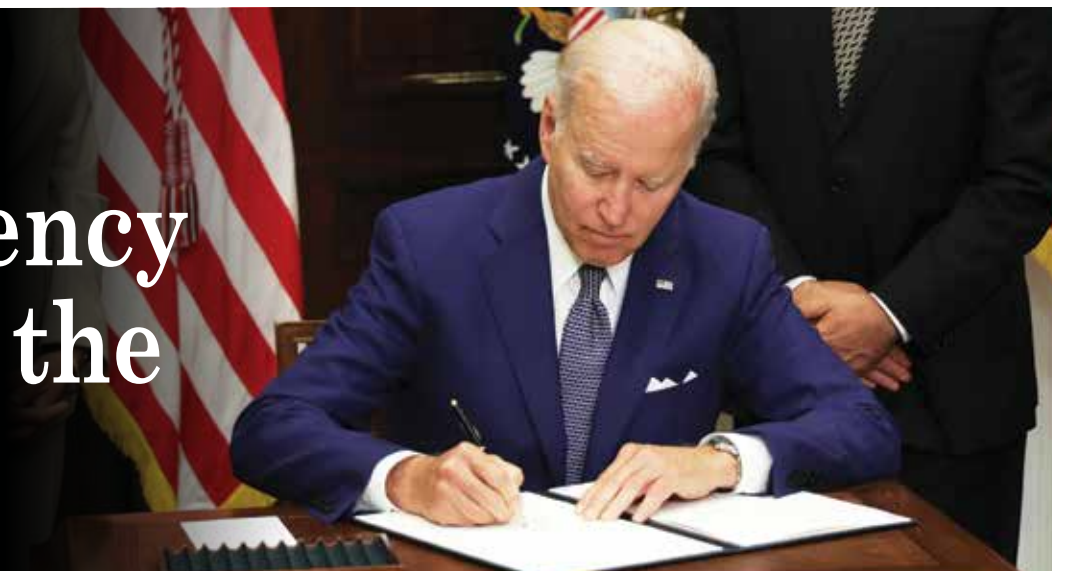
State and municipal governments have increased taxes on cigarettes to influence behavior, but that has done little except raise more money for governments, says Michael LaFaive, senior director of the Morey Fiscal Policy Initiative at the Mackinac Center for Public Policy.

"Those who are left smoking today have such a strong preference to do so that additional taxes will have little impact on their decision to quit," said LaFaive.

LaFaive coauthored a report in 2017, "Cross-Border Effects of Cigarette Tax Increases," which found smokers will drive miles to buy cigarettes in low-tax states rather than give up their habit.

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

White House Renews Emergency Declaration for the 12th Time



Continued from page 1

Priorities for Congress

The Biden administration's handling of COVID-19 will dominate much of the debate on health care in the new Congress as Republicans lead the House and Democrats control the Senate. Health care reform will be high on the priority list, but passage of major health care legislation is unlikely with the two chambers controlled by opposing parties.

Congress could advance smaller measures for less-controversial reforms and investigate agencies' COVID-19 actions, says Paragon Health Institute (PHI) President Brian Blase, Ph.D.

"[In the House,] Republicans will chair the committees, and … they will be setting the priorities and conducting oversight," said Blase on the *Heartland Daily Podcast* on December 23. "I think there will be some areas—hospital consolidation and price transparency—where there will be serious conversations."

House committees could examine the actions taken by the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), and the National Institutes of Health (NIH) during the national health emergency, says Blase.

"I expect them to carry out investigations into the origin of COVID and the failure of the CDC, FDA, and NIH during the pandemic," said Blase.

Pandemic Emergency Review

Congress should begin by focusing on pandemic policy oversight, write Blase and PHI Senior Policy Analyst Drew Keyes in a policy brief, "A Health Care Agenda for the 118th Congress."

A first step would be for Congress to end the COVID-19 emergency declaration, which has led to an "enormous federal role in health care, particularly a massively expanded Medicaid program," write Blase and Keyes.

"The federal government's response to the COVID-19 pandemic failed in multiple respects, including the promulgation of policies not based on science, poor communication, and an unprecedented expansion of government authority like the [CDC] eviction moratorium. School lockdowns, based in part on guidance from the CDC, had disastrous results. And social isolation, mental health problems, and drug overdoses have all soared as negative consequences of government-driven lockdowns."

BRIAN BLASE, PH.D.
DREW KEYES
PARAGON HEALTH INSTITUTE

"The federal government's response to the COVID-19 pandemic failed in multiple respects, including the promulgation of policies not based on science, poor communication, and an unprecedented expansion of government authority like the [CDC] eviction moratorium," write Blase and Keyes. "School lockdowns, based in part on guidance from the CDC, had disastrous results. And social isolation, mental health problems, and drug overdoses have all soared as negative consequences of government-driven lockdowns."

Scientific Groupthink Problem

Congress should also reform the CDC and return power to the states, say Blase and Keyes.

"Congress should lay out a center-by-center authorization of the agency, reform its emergency powers, cut redundant activities, and reassign functions that may be carried out better by other agencies," write Blase and Keyes. "Activities that state and local governments are better equipped to do should not be crowded out by federal actions."

Officials from the CDC, FDA, and NIH have "spoken out about the politicization occurring within the federal public health bureaucracy," and the size of the bureaucracy has become a problem in its own right, with the NIH providing a prime example, say Blase and Keyes.

"What once began as a single institute has proliferated into 27," write Blase and Keyes. "While the NIH has garnered much public support for much of its existence, scientific groupthink has led to growing frustration and a centralization of public funding. Dissenting views are cast aside, which is unsurprising given that most taxpayer dollars are granted to a small subset of educational institutions."

IRS Obamacare Subsidies

Another potential target for House Republicans is the Biden administration's rule that "used the Internal Revenue Service to unlawfully expand ACA subsidies to close the so-called 'family glitch,'" write Blase and Keyes.

Congress authorized subsidies based on keeping the cost of individual coverage to no more than 9.83 percent of personal income. The Biden rule allows the cost of a more expensive family plan to be factored into the subsidy calculation.

"The next Congress should conduct oversight of the illegal IRS rule and the White House pressure on the IRS to change its implementation of the tax code to further expand government control of health care," write Blase and Keyes.

Drug Price Controls

Congress should ensure the rebates and drug price controls in the 2022 Inflation Reduction Act (IRA) are implemented in such a way that they don't reduce access to drugs, say Blase and Keyes.

"The law appropriated $3 billion to CMS, largely to establish a massive bureaucracy to set pharmaceutical prices," write Blase and Keyes. "The IRA's price controls and inflation rebates begin in 2024. Congress should ensure the rebates and price controls do not have unintended consequences, beyond the ill-effects of the policies themselves, on the ability of Americans to access innovative cures."

Leverage for Reform

The public's loss of trust in the public health community in the COVID era could ultimately lead to important reforms, says Keyes.

"Even in the public health community, there is awareness that the public has lost faith in federal health agencies," Keyes told the *Heartland Daily Podcast*. "I would be surprised if the CDC did not undergo reform."

Bonner Russell Cohen, Ph.D. (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research.* Health Care News *Managing Editor AnneMarie Schieber* (**amschieber@heartland.org**) *contributed to this article.*

Portable Health Insurance Could Advance in Congress

By Bonner Russell Cohen

Health insurance portability could be enshrined in federal law with Republican control of the U.S. House of Representatives and Sen. Bill Cassidy (R-LA) as ranking member of the Senate Health, Education, Labor, and Pensions Committee.

"Portability" means each employee owns their insurance plan and can take it with them if they leave their job.

Rules implemented by President Donald Trump in 2019 expanded a type of portable insurance known formally as Individual Coverage Health Reimbursement Arrangements (ICHRAs). ICHRAs give employers an alternative to manage the rising cost of health coverage for employees.

"IRAs and 401(k)s were strange and unfamiliar concepts when Congress created them in the 1970s. By 2019, people held $20.2 trillion in these accounts, more than 60 percent of Americans' retirement assets, according to the Congressional Research Service. [Individual Coverage Health Reimbursement Arrangements] seem as strange to many people today as personal retirement accounts once did, but they will grow in popularity as workers benefit."

DOUG BADGER
SENIOR RESEARCH FELLOW
THE HERITAGE FOUNDATION

Enjoys Bipartisan Support

Cassidy and U.S. Rep. Pete Sessions (R-TX) in 2016 introduced a bill to codify portable insurance in federal law and replace Obamacare. Sessions could reintroduce the "Health Care Equality and Modernization Act of 2022," a version of the earlier legislation.

There is support in both parties for portable health insurance, says Paragon Health Institute President Brian Blase.

"ICHRAs permit employers a simpler and likely more cost-effective way to offer health insurance to their employees while expanding employees' coverage options," said Blase. "Many entrepreneurial and innovative companies are working to make this option as attractive as possible for employers and employees. The bipartisan nature of ICHRAs means that the policy is likely enduring."

The 21st Century Cures Act in 2016 had the support of then-Vice President Joe Biden. The bill established qualified small-employer HRAs, the precurser to the ICHRAs. The Biden administration has rolled back several Trump executive orders but has left ICHRAs alone, despite the urging of left-leaning health care activists.

Benefits Employees, Employers

An ICHRA allows employers to reimburse the cost of plans employees choose, with certain restrictions, and relieves employers of the paperwork burdens and annual negotiations with health insurers typical of traditional employer-provided group coverage.

ICHRAs are a nontaxed benefit, like traditional employer-sponsored group health plans, and can be offered on the Obamacare marketplace, according to the U.S. Department of Health and Human Services (HHS) website, healthcare.gov.

"It's a specific account-based health plan that allows employers to provide defined non-taxed reimbursements to employees for qualified medical expenses, including monthly premiums and out-of-pocket costs, like copayments and deductibles," states the HHS.

People with ICHRAs must have a health insurance plan that complies with the Affordable Care Act (ACA), or Obamacare, like the policies offered through the federal health insurance exchange, according to the HHS.

"Employees must be enrolled in individual health insurance coverage (like a plan they bought through the Marketplace) to use the funds," states the HHS.

Employees choose among plans offered by a qualified ICHRA administrator. Plans can differ in premium cost, deductibles, copayments, and the network of doctors offered.

Popularity Increasing

A survey of 455 U.S. employers by insurance consultants Willis Towers Watson (WTW) found 67 percent plan to prioritize controlling health care costs over the next three years.

Health care consultancy Avalere projects uptake of ICHRAs will increase throughout 2023, including 10 percent of firms that don't currently offer benefits (up from 7 percent in 2021) and 7 percent of firms that do (up from 4 percent).

Given the advantages ICHRAs offer both employers and employees, it might surprise some people that the plans haven't caught on faster, wrote small business analyst Gene Marks on *Medium* on November 8.

"Many small businesses are still unaware of their existence and let's face it: it's not as if the insurance companies or their brokers are breaking down the doors to get the word out, given that many will wind up paying so much less," wrote Marks.

Inflation Could Be Catalyst

In 2019, the U.S. Department of the Treasury projected 800,000 businesses would offer ICHRAs to more than 11 million employees during the next five to 10 years.

As employers, particularly owners of small businesses, try to cope with the pressures of inflation and labor shortages that escalated in 2020, they may give ICHRAs a serious second look.

One threat to ICHRAs could come from the Biden administration, which is reversing many Trump-era policies through the administrative rulemaking process. The Trump administration favored patient choice, whereas the Biden White House wants a larger role for the government in health care coverage. Undoing the rule or sharply limiting ICHRAs would require joint rulemaking by HHS, the Labor Department, and the Treasury Department.

It is only a matter of time before ICHRAs achieve widespread acceptance, as with Individual Retirement Accounts (IRAs) and investment-based, employer-sponsored retirement plans, says Doug Badger, a senior research fellow at The Heritage Foundation Center for Health and Welfare Policy.

"IRAs and 401(k)s were strange and unfamiliar concepts when Congress created them in the 1970s," said Badger. "By 2019, people held $20.2 trillion in these accounts, more than 60 percent of Americans' retirement assets, according to the Congressional Research Service. ICHRAs seem as strange to many people today as personal retirement accounts once did, but they will grow in popularity as workers benefit."

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

Military Ends COVID-19 Shot Mandate

Continued from page 1

individuals currently in the armed forces, such as letters of reprimand, vaccination status can still affect service members' careers.

"Other standing Departmental policies, procedures, and processes regarding immunizations remain in effect," states Austin's memo. "These include the ability of commanders to consider, as appropriate, the individual immunization status of personnel in making deployment, assignment, and other operational decisions, including when vaccination is required for travel to, or entry into, a foreign nation."

"Even allowing for initial caution and uncertainty about COVID and the vaccines, this mandate, and certainly the exemption denial practice, should clearly have been seen to be unjustified more than a year ago."

DOUG SEATON
PRESIDENT AND GENERAL COUNSEL, UPPER MIDWEST LAW CENTER

'Fusillade of Challenges'

Austin's memo states individuals who were discharged must petition their former service to change their discharge record. The defense secretary must do more than that, says Sen. Ron Johnson (R-WI), who led the charge against the military's COVID-19 vaccine policy.

"Now @SecDef needs to take every step necessary to undo the harm done to service members and their families when they were forcibly discharged," tweeted Johnson.

Austin did not want to rescind the mandate, says Doug Seaton, president and general counsel of Upper Midwest Law Center, a firm that has represented employees facing COVID-19 vaccine orders.

"The SoD's rescission of the DoD's Armed Forces' COVID vaccination mandate, along with the reprehensible practice of ignoring and denying legitimate exemption applications, is very welcome," said Seaton. "But it is also long overdue and only comes after a fusillade of challenges from service members, veterans' organizations, and political leaders, among whom Sen. Ron Johnson deserves particular mention, and court cases."

'Deserve to Know the Truth'

Johnson says his investigation into vaccine injuries of military members will continue.

Johnson released a copy of a letter he sent to Lt. Gen. Ronald Place, director of the Defense Health Agency, on December 22 requesting detailed information on claims filed by active-duty service members for a wide range of health diagnoses, including COVID-19.

"The brave men and women who serve our country deserve to know the truth about the short and long-term health effects these mandated vaccines will have on the rest of their lives," wrote Johnson.

'Make Them Whole'

Seaton says the government should investigate why the mandate was put in place and why the military refused requests for exceptions.

"Even allowing for initial caution and uncertainty about COVID and the vaccines, this mandate, and certainly the exemption denial practice, should clearly have been seen to be unjustified more than a year ago," said Seaton.

The NDAA does not require the military to accept back those who were discharged, says Seaton.

"There should be an effort to reinstate service members who suffered under this mandate and make them whole," said Seaton. "There should also be an inquiry into the sources of this mandate, because I am afraid we will then find not a sober assessment of medical issues by the DoD, but something akin to the strongarming and lobbying we saw in the Department of Justice's infamous directive on parents as terrorists or the Twitter emails exposé of the censoring of critical voices on vaccine policy by White House officials."

'Win Redress'

Health care professionals who worked for private organizations and were denied exemptions from vaccine mandates reached a $10 million-plus settlement with a health care system in August.

Other private sector workers should receive similar restitution, says Seaton.

"At the Upper Midwest Law Center, we are litigating numerous cases of unlawful religious vaccine exemption denials against several employers, including a number of cases against the Minneapolis Federal Reserve, which also recently rescinded its vaccine mandate without offering reinstatement to those adversely affected," said Seaton. "We hope the DoD's action will reinforce our efforts to win redress for these clients and others similarly affected."

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

Hospitals Reap Huge Profits from Drug Discount Program

By Bonner Russell Cohen

A federal program requiring drug manufacturers to give big discounts to providers that serve low-income patients is profitable for hospitals but has little accountability, an independent study has found.

The 340B Drug Pricing Program requires drug manufacturers to sell medications at steeply discounted prices to hospitals, contract pharmacies, and other covered entities serving Medicaid and uninsured patients.

"The 340B program is growing unsustainably and isn't improving health outcomes for at-risk patients," said study author Wayne Winegarden, Ph.D., director of the Center for Medical Economics and Innovation at the Pacific Research Institute (PRI), in a news release.

Lucrative Rebates

Hospitals profit lavishly from the 340B program by getting drugs at discounted prices and then charging insurance companies and Medicare the full price, which is sometimes nine or 10 times higher, according to a PRI study by Winegarden titled "Good Intentions Gone Awry: The Case of the 340B Program."

From 2015 to 2021, purchases of drugs under the 340B program increased by an average of 23.8 percent each year, or four to five times faster than the overall growth in pharmaceutical spending, Winegarden found. Over the six years, 340B discounts totaled $208.3 billion.

The program allows hospitals to dispense discounted drugs to any patient, not just the needy, and doesn't require providers to improve people's health, says Winegarden.

"[A] core problem with the 340B program is that covered entities do not need to demonstrate that at-risk patients' outcomes are improving," wrote Winegarden. "And, while many covered entities do important work, many entities, particularly too many 340B hospitals, are providing less charitable care than the average institution but are reaping the higher revenues 340B enables."

Debatable Benefits

Former U.S. Rep. Henry Waxman (D-CA), a consultant to 340B Health, an advocacy organization representing more than 1,400 participating hospitals, defended the 340B program in *Health Affairs* on December 7.

"In the three decades since the enactment of 340B, it has proven to be a durable and successful government health program," wrote Waxman. "More than 700 drug manufacturers have participated in 340B, and they deserve tremendous credit for their contributions to a secure health care safety net."

The government-mandated discounts are paid for by others and don't necessarily help patients, says Doug Badger, senior analyst for health and welfare policy at The Heritage Foundation.

"It isn't surprising that someone who advocates for hospital conglomerates that pocket billions from the 340B program and [give] none of that money to their patients would consider it a success," said Badger. "There is zero evidence that hospitals use government-mandated 'contributions' from pharmaceutical manufacturers to benefit anything other than their operating margins."

Limited Options for Patients

The 340B program benefits health care systems but limits competition, to the detriment of patient care, says Linda Gorman, director of the Independence Institute's Health Care Policy Center.

"Over time, federal fecklessness distorts the incentives for providers of private care," said Gorman. "It also increases private sector health care costs. Thanks to 340B, oncology practices cannot compete against hospitals. They either join hospital staff or are frozen out of providing certain treatments. This is enormously inconvenient for patients because they are denied the convenience of getting many oncology treatments in less-expensive physicians' offices or surgery center equivalents."

Increasing concentration among providers reduces patients' access to specialists, says Gorman.

"Patients are hampered in their quest for truly independent opinions on the best care for their case," said Gorman. "Limiting treatment to hospital staff means limiting treatment to certain clinical pathways approved by a hospital."

'Lax and Ineffective Oversight'

Hospitals participating in the 340B program are supposed to serve Medicaid patients, but many do not, says Winegarden.

"Another problem is the program's lax and ineffective oversight that is enabling entities that do not qualify for 340B status to become 340B institutions," wrote Winegarden. "Further, the program's lack of transparency means that there is insufficient information regarding the profits covered entities generate from the program."

Contract Pharmacy Expansion

Among the participating entities benefitting from the 340B program are contract pharmacies, says Winegarden.

"The number of contract pharmacies has grown by more than 4,000 percent between 2010 and 2020," wrote Winegarden. "Contract pharmacies earn significantly higher margins (an estimated 72 percent profit margin) when dispensing 340B medicines. Unfortunately, contract pharmacies do a poor job of ensuring that the 340B discounts are only provided to the eligible population."

There is also no correlation between where contract pharmacies operate and the population they're intended to serve, says Winegarden.

"[T]he expansion of contract pharmacies is mostly occurring in rich neighborhoods, not lower-income areas," wrote Winegarden.

"Another problem is the program's lax and ineffective oversight that is enabling entities that do not qualify for 340B status to become 340B institutions. Further, the program's lack of transparency means that there is insufficient information regarding the profits covered entities generate from the program."

WAYNE WINEGARDEN, PH.D.
DIRECTOR, CENTER FOR MEDICAL ECONOMICS AND INNOVATION
PACIFIC RESEARCH INSTITUTE

Not Meeting Goals

Winegarden recommends requiring improved patient outcomes, increasing program oversight, closing contract pharmacy loopholes, and fixing market distortions that increase patient costs.

"They should also include transparent reporting requirements that detail the profit that covered entities, particularly the disproportionate share hospitals, receive and how much charity care the hospitals provide both at the main hospital and all satellite clinics that are also allowed to participate in 340B," wrote Winegarden. "In those cases where the transparency requirements reveal that the covered entities are not meeting the programs' goals, those entities should be ineligible for 340B discounts."

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

INTERNET INFO

Wayne Winegarden, Ph.D., "Good Intentions Gone Awry: The Case of the 340B Program," Issue Brief, Center for Medical Economics and Innovation, Pacific Research Institute, November 2022: **https://www.pacificresearch.org/wp-content/uploads/2022/11/340B-Policy2022_F.pdf**

Montana Moves to Stop Medicaid for Ineligible Recipients

By Bonner Russell Cohen

The state of Montana is using a provision in the federal omnibus bill passed on December 23 to remove ineligible people from its Medicaid rolls, a move that could save the state millions of dollars.

Under the public health emergency declared by the federal government in response to COVID-19, states have been required to wait 12 months before removing anyone found to be ineligible for the program, regardless of how much the person's income may have increased.

"That has led to, in all states including Montana, strong growth in Medicaid enrollment," said Josh Poulette, the legislature's senior fiscal analyst, in a budget hearing January 11, as reported by the *Independent Record*. "There's a door in, but there is no door out."

The omnibus bill allows states to begin the "redetermination process" to remove people whose incomes no longer qualify them for Medicaid, after an earnest attempt to contact them.

Ineligibility Explosion

The Affordable Care Act (ACA) and COVID-19 pandemic policies vastly expanded Medicaid and enrolled millions of ineligible people, a new study found.

More than 90 million individuals are enrolled in Medicaid, the joint federal-state health care program for the poor, including millions who don't qualify, says Brian Blase, president of the Paragon Health Institute. Total Medicaid spending increased from $445 billion in 2013 to an estimated $783 billion in 2022, says Blase.

"There are 15 to 20 million people enrolled in Medicaid who are not eligible for the program, and the true amount of improper payments exceeds $100 billion annually," Blase told *Health Care News*. "By ensuring that Medicaid is preserved for those who are truly eligible, states will preserve resources for those who need them, save taxpayers a tremendous amount of money, and increase the number of people with private coverage."

"[T]he Centers for Medicare and Medicaid Services (CMS) does not know how hundreds of billions in Medicaid money is being spent by insurers nor how much value recipients and taxpayers are getting for the massive amount of spending through Medicaid," wrote Blase in a Paragon study titled "Managed Care in Medicaid: Need for Oversight, Accountability, and Reform," published in October. "CMS has prioritized maximizing enrollment over ensuring that federal dollars are being effectively allocated and has not even responded to congressional oversight letters from [last] spring on the high improper payment rates."

Lack of Accountability

Medicaid's growing problems are rooted in the program's structure, which has failed to adapt to the demands placed on it, Blase says.

"States lack incentive to ensure value from Medicaid," wrote Blase. "The federal government typically pays about 65 percent of Medicaid's costs, with no cap on federal expenditures. Because of COVID-related Medicaid policies, the federal government now reimburses about 70 percent of program expenditures. Meanwhile, CMS has never prioritized program integrity."

In June 2022, says Blase, 82.3 million people were enrolled in Medicaid, up from 55.0 million in 2013 before the ACA expansion of the program, and enrollment has continued to grow. About half of that growth was due to the expansion of Medicaid to able-bodied, working-age adults, with the other half the result of increased federal spending during COVID, according to Blase.

Skyrocketing costs have gone hand in hand with the surge in enrollees who are not eligible for the program, says Blase.

"The Urban Institute estimated that 15.8 million ineligible people were on Medicaid as of September 30, 2022—a number that will increase as long as the public health emergency is extended," wrote Blase.

No Eligibility Audits

States and the CMS have not carefully monitored, much less enforced, eligibility status, opening the floodgates to more enrollees, says Blase.

"[S]tates still have large incentives to misclassify recipients as eligible under the expansion," wrote Blase. "The lack of incentives for states to implement program integrity measures benefits the health care industry, including insurers, who persistently lobby for greater subsidies from the government."

More than 50 million Medicaid recipients are in managed care organizations (MCOs) run by private insurers under contracts with the various states. Thus, private insurers have benefited from Medicaid expansion.

The Families First Coronavirus Response Act of March 2020 increased the federal reimbursement rate for state Medicaid spending by 6.2 percentage points for the remainder of the official public health emergency, but only for states that did not remove ineligible recipients or change eligibility rules. As a result, states have not removed ineligible people from Medicaid since early 2020. The spending plan approved by Congress as part of the omnibus and signed by President Biden on December 29 phases out the 6.2 percent increase in funding starting in 2023 for all states.

Pandemic Penalties

A November 2021 CMS report estimated improper federal Medicaid spending at nearly $100 billion, says Blase.

"This estimate is actually too low, since CMS halted the eligibility component of audits for one-third of states because of COVID," wrote Blase.

The ballooning number of ineligible Medicaid recipients is due to federal policy, says Doug Badger, a senior research fellow at The Heritage Foundation's Center for Health and Welfare Policy.

"Since the spring of 2020, the federal government has financially penalized states that removed ineligible recipients from Medicaid," said Badger. "This misguided policy incentivizes states to improperly keep millions of people on the government dole and cost taxpayers billions."

The omnibus bill will bring some relief, says Badger.

"Beginning in April, states can review whether recipients remain eligible for benefits," said Blase. "While this won't eliminate the waste and fraud the Paragon report identifies, it will at least allow states to undo some of the damage that the unfortunate pandemic policies of the Trump and Biden administrations produced."

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

"There are 15 to 20 million people enrolled in Medicaid who are not eligible for the program, and the true amount of improper payments exceeds $100 billion annually. By ensuring that Medicaid is preserved for those who are truly eligible, states will preserve resources for those who need them, save taxpayers a tremendous amount of money, and increase the number of people with private coverage."

BRIAN BLASE
PRESIDENT
PARAGON HEALTH INSTITUTE

REPORT

Medicaid Expansion Shifts Care Away from Children

By AnneMarie Schieber

Medicaid spending on children shifted sharply away from children in states that expanded the program under the Affordable Care Act to include able-bodied adults, a new study finds.

"The Affordable Care Act's Medicaid Expansion Is Shifting Resources Away from Low-Income Children," published by the Mercatus Center at George Mason University, also notes less than robust enrollment growth for the aged and the disabled in the expansion states.

"The expansion of Medicaid had the good intention of promoting health," write study authors Charles Blahous and Liam Sigaud. "But well-intended policies can have unintended side effects."

The study analyzed per capita expenditures for children and adults during fiscal years 2013 to 2019. The authors found Medicaid spending on low-income children in expansion states increased by 5.9 percent over the period, whereas in states that chose not to expand, the growth in spending on children was nearly three times higher, at 22.7 percent.

"When contemplating future Medicaid policy adjustments, they must consider how the opening of services to new enrollees affects the resources available to previously eligible enrollees. This is especially important in the case of low-income children, who are inherently vulnerable and for whom access to health services can have pronounced long-term effects."

CHARLES BLAHOUS AND LIAM SIGAUD
STUDY; "THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION IS SHIFTING RESOURCES AWAY FROM LOW-INCOME CHILDREN"

Expanded Demand

The Affordable Care Act, which went into effect on March 23, 2010, expanded health insurance coverage and required states to expand their Medicaid programs to include able-bodied adults with incomes up to 138 percent of the poverty level.

The U.S. Supreme Court later ruled the federal government could not force states to expand Medicaid, making the increases optional. According to the Kaiser Family Foundation, 39 states and the District of Columbia had expanded their programs as of November 9. In expansion states, nearly all adults earning up to $17,774 annually (for individuals) qualify for health care coverage at no cost to them.

Under expansion, Medicaid enrollment increased by 22 percent without an equal increase in health care providers. In addition, Medicaid pays physicians 54 percent of what they are reimbursed under private insurance, and hospitals receive 62 percent less than private insurers pay, which makes it less attractive to providers, write Blahous and Sigaud.

Unintended Consequences

As a result, families with low-income children in expansion states have more difficulty in finding physicians and getting timely appointments, Blahous told *The Heartland Daily Podcast* on January 9.

"A lot of children's health is preventative: wellness checks, you do things to keep children on track; whereas spending for the disabled, the aged, a lot of that probably occurs on an emergency basis, and those people may wind up closer to the front of the pipeline more often," said Blahous.

"Policymakers must understand how Medicaid's financial resources are being shifted away from children as a byproduct of program expansion," write Blahous and Sigaud. "When contemplating future Medicaid policy adjustments, they must consider how the opening of services to new enrollees affects the resources available to previously eligible enrollees. This is especially important in the case of low-income children, who are inherently vulnerable and for whom access to health services can have pronounced long-term effects."

Unaffordable vs. Free

Medicaid expansion has created a host of distortions in the health care system, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*. Dean saw the unintended consequences of expansion first-hand while serving seven terms in the Minnesota House of Representatives.

"While Minnesotans were paying more and more to get less and less health insurance, others were paying less and less to get more and more—a lot more," said Dean.

Private health insurance is unaffordable for many working families in Minnesota, yet people from any state can get the best health care in Minnesota for free, says Dean.

"A farmer was paying $40,000 a year for family health insurance and was unable to obtain a policy at any price that would allow his family to go to the Mayo Clinic, which was a priority for him," said Dean. "Meanwhile, anyone without income from any state can appear at Mayo and be treated for free, if they simply declare the intent to move to Minnesota, as they will be retroactively enrolled onto Medicaid."

Free Riders

Another problem is ineligible people have been enrolled in Medicaid, says Dean.

"Minnesotans are asked to pay for folks who do not qualify for Medicaid because they may live in another state, make too much money, or are dead," said Dean.

Medicaid-managed care plans do not check whether enrollees qualify, says Dean.

"I sponsored legislation that would ask Medicaid plans to directly contact the patient before they received payment for a Medicaid enrollee," said Dean. "The 'I'm Not a Robot' bill would simply ask insurance companies to receive confirmation that a patient is alive, lives at an identified address, and wants coverage, before tax dollars are sent to the insurance company. Some patients no longer qualify, while others are covered by Medicaid with multiple plans, each receiving a check from the government to cover the patient."

Individuals in need have been shoved aside, says Dean.

"States were given a financial incentive to essentially move newly eligible enrollees—who may have had private insurance—ahead of poor or disabled folks who may have no insurance," said Dean.

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

House Tackles 'Weaponization of the Federal Government'

By Kenneth Artz

The new Republican majority in the U.S. House of Representatives has formed a Select Subcommittee on the Weaponization of the Federal Government in the wake of Elon Musk's release of the "Twitter Files" revealing the Biden administration's collusion with the private company to censor opposition voices.

The committee is likely to dive into a wide range of government collusion issues, including suppression of dissenting views on COVID-19 pandemic policies. Judiciary Committee Chairman Jim Jordan (R-OH) chairs the 13-member committee.

An investigation of the use of private corporations to pursue government policies is long overdue, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"The people who should be standing up for the free exchange of ideas and open scientific debate—doctors, medical schools, and elected officials—are subject to the same threats of censorship, funding cuts, and intimidation," said Dean. "We can restore public trust when these groups can be faithful to the oaths they took to protect the public they serve, above the legitimate fear they feel being imposed by Big Tech authoritarians."

Twitter Users Blacklisted

From 2020 to 2022, the giant social media platform Twitter Inc. blacklisted users, did the bidding of the FBI, and allowed company executives to rewrite policies to control information about the COVID-19 pandemic, according to evidence revealed in the "Twitter Files," a cache of internal screenshots, emails, and chat logs from the company's executives released by new CEO Musk to reporters in December.

During the COVID-19 pandemic, Twitter suppressed information from doctors and public health professionals and information about how other countries responded to the virus that called into question the Biden administration's approach, the files reveal.

'Do Exactly What We Say'

The files show the Trump administration pressured Twitter to suppress certain tweets in the beginning stages of the pandemic, mostly to discourage panic buying in grocery stores, according to David Zweig, one of the journalists who received early access to the files.

When the Biden administration stepped in, the strategy changed, says Zweig.

"Its agenda for the American people can be summed up as: Be very afraid of COVID and do exactly what we say to stay safe," wrote Zweig.

By the summer of 2021, President Joe Biden announced social media companies were "killing people" by allowing misinformation about vaccines. Hours later, Twitter locked Alex Berenson, a popular journalist skeptical of lockdowns and mRNA vaccines, out of his account. Twitter permanently banned him the following month.

Twitter also began suppressing the tweets of medical and public health professionals who expressed opinions and cited research that contradicted official policy. Consequently, legitimate findings and questions regarding COVID-19 policies, and their consequences, were unavailable to the public.

'Failed Them and Us'

Doctors and scientists should be able to express their viewpoints freely, like anybody else, says Dean.

"Their academic institutions and professional organizations have failed them and us by looking the other way or participating in censorship and electioneering," said Dean. "But our elected officials are charged with defending our ability to engage in free speech despite the risks to them or their partners in private industry."

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

Airline Pilot Dies in Midair

By Harry Painter

A passenger jet pilot who died after collapsing just after takeoff from Chicago's O'Hare International Airport is one of a growing number of "sudden deaths" making news.

Sudden deaths among young athletes and celebrities have alarmed journalists, health professionals, and the public.

Among numerous examples, U.S. soccer journalist Grant Wahl, age 49, died of an aortic aneurysm while covering the World Cup on December 9, his wife, Celine Grounder, M.D., told CBS. On January 2, 24-year-old Buffalo Bills safety Damar Hamlin suffered cardiac arrest during a game, was resuscitated on the field, and was breathing on his own three days later. Victoria Lee, a ONE Championship mixed martial arts "rising star" aged 18, died on December 26 with no cause of death stated.

"In cases of myocarditis, more than 50 percent of people have subclinical cases, meaning they have no symptoms. The very first symptom could be sudden death. We potentially have thousands of pilots that are flying with myocarditis that have no idea. It will not be found on their normal physicals."

JOSHUA YODER
PILOT AND MEDICAL FREEDOM ADVOCATE

'Extremely Dangerous'

Captain Patrick Ford, 54, who had been hired by American Airlines' regional carrier Envoy Air just two months earlier, was incapacitated midflight. His first officer then safely landed the aircraft, carrying 57 passengers, back in Chicago.

Ford was pronounced dead upon arrival at a Chicago hospital on November 19, according to Envoy Air.

It is extremely unusual for an airline pilot to die in flight, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and president of Doctors for Disaster Preparedness.

"Pilots becoming incapacitated in flight is of course extremely dangerous," said Orient. "I've never heard of it happening before."

The Federal Aviation Administration (FAA) announced it would investigate the incident but had not revealed Ford's cause of death as of press time. Neither American Airlines nor Envoy Air has revealed any details about Ford's medical history or cause of death.

'Near Miss'

Ford's collapse could have resulted in disaster, says Joshua Yoder, a pilot and medical freedom advocate.

"From a time perspective, that was a near miss," said Yoder. "We know they were probably between 2,000 and 4,000 feet in altitude, because the tower cleared them to climb and maintain 5,000 feet. So, they were certainly under 5,000 feet when the incapacitation occurred."

If Ford had been stricken 45 seconds earlier, says Yoder, the airplane could have been in mid-rotation or just above the ground, causing a disaster.

Luckily, the copilot on Flight 3356 was a "check airman": an experienced pilot who monitors the competency of new crew members during training, says Yoder.

"Everyone is very fortunate there was a senior check airman in the right seat, and not a brand new first officer," said Yoder. "Had that happened three trips later, there is a high probability there would have been a very junior and inexperienced first officer in the right seat."

Copilot Brandon Hendrickson knew how to respond to Ford's incapacitation, says Yoder.

"He did a phenomenal job," said Yoder. "It was perfect execution."

COVID Shot Mandates

Yoder started a nonprofit group called US Freedom Flyers to oppose pilot and passenger vaccine mandates after President Joe Biden announced a COVID-19 vaccine mandate for federal contractors, including major airlines.

US Freedom Flyers successfully sued to overturn the government mandate, though airlines were free to continue to impose their own. Yoder says the private mandates broke the law because they required vaccinations with unapproved shots that are allowed only under an Emergency Use Authorization from the U.S. Food and Drug Administration.

The FAA website states the agency "requires at least one year of post-marketing experience with a new drug before consideration for aeromedical certification purposes."

Young Pilots' Risk

Yoder says 80 percent of airline pilots have been injected with at least one round of shots (boosters are not required), and this puts pilots, particularly at regional carriers such as Envoy Air, at higher risk of heart problems.

"The largest percentage of the regional airline population is males between the age of 23 and 39; that's by far the largest age group," said Yoder.

Florida Surgeon General Joseph A. Ladapo recommends people between the ages of 18 and 39 not get an mRNA vaccination, based on research showing they have a heightened risk of cardiac-related death.

'Flying with Myocarditis'

The FAA does not require heart tests for younger pilots, says Yoder.

"There's no cardiac testing among pilots unless requested, until the age of 35," said Yoder.

After pilots reach age 40, they get one cardiac test per year, but a standard electrocardiogram (EKG) is not designed to detect cardiac inflammation, says Yoder.

"The only cardiac testing that the FAA currently does is an EKG, and an EKG essentially does nothing more than take a snapshot of the heart's electrical rhythm," said Yoder. "It doesn't test for inflammation.

"That's very concerning," said Yoder. "In cases of myocarditis, more than 50 percent of people have subclinical cases, meaning they have no symptoms. The very first symptom could be sudden death. We potentially have thousands of pilots that are flying with myocarditis that have no idea. It will not be found on their normal physicals."

Effective Heart Tests

Other tests, such as Magnetic Resonance Imaging (MRI), could detect heart inflammation, says Orient.

"They should arguably be adding a cardiac MRI to the fitness exams," said Orient.

Yoder says many pilots are worried that adding cardiac testing to the fitness exam increases the likelihood of detecting a career-ending condition.

"Our goal is not to ground pilots who have these issues and destroy their careers," said Yoder. "The goal is to find the problem, treat the problem, and get the pilot back on the flight deck."

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

INTERNET INFO

"FAA Pilots Letter," Children's Health Defense, December 15, 2021: **https://childrenshealthdefense.org/wp-content/uploads/FAA-pilots-letter.pdf**

"The U.S. Department of Defense Covered Up Airline Pilot's mRNA Deadly Shot Data," The Pete Santilli Show, Episode #3235, December 9, 2022: **https://rumble.com/v200rqm-the-u.s.-department-of-defense-covered-up-the-pilots-data-regarding-the-mrn.html**

TESTIMONY

Governments Blocked Informed Consent for COVID-19 Shots

By Harry Painter

Governments and the medical establishment prevented informed consent in the push for mRNA inoculations, experts at a COVID-19 roundtable sponsored by Sen. Ron Johnson (R-WI) said.

Johnson's fifth such panel since the virus emerged in early 2020, on December 7, was titled "COVID-19 Vaccines: What They Are, How They Work, and Possible Causes of Injuries." The panel brought together a dozen policy experts and medical professionals.

Inserts 'Completely Blank'

Panelist Renata Moon, M.D., a pediatrician and Washington State University professor, displayed the package insert of an mRNA injection, showing the entire page was blank.

That means the product she received did not come with a list of side effects or risks, said Moon.

"I have a government that's telling me that I have to say, 'safe and effective,' and if I don't, my license is threatened," said Moon. "How am I to give informed consent to patients?"

Although the mRNA vaccine inserts are no longer blank, the lack of information for providers and patients was unprecedented, Del Bigtree, founder of the Informed Consent Action Network and another panelist at the roundtable, told *Health Care News*.

"Prior to the COVID vaccine, every vaccine administered in America arrived in a box that contains the glass vial of the product and a folded information insert," said Bigtree. "The tiny font that fills every inch of the insert includes the list of ingredients in the product and all of the known and suspected potential adverse side effects. However, the inserts delivered with the millions of COVID vaccines that were administered during the pandemic were completely blank."

'Deadly Side Effects'

The inserts were blank because "safety trials for the vaccines were not completed when the vaccines were granted Emergency Use Authorization (EUA)," said Bigtree.

The FDA granted an EUA instead of full approvals to the Johnson & Johnson, Pfizer, and Moderna vaccines during the pandemic so they could distribute the vaccines widely and quickly, says Bigtree.

"This means manufacturers had no idea whether the product was safe or effective at the time that their product was being given to hundreds of millions of people around the world," said Bigtree. "We now know these products have been causally related to incidents of myocarditis, blood clotting, and anaphylaxis, to name but a few of the potentially deadly side effects now being witnessed worldwide."

'Immunity from Liability'

AstraZeneca executive Ruud Dobber told Reuters in 2020 the company could "simply not take the risk" of liability claims if "in four years the vaccine is showing side effects."

Belgium eventually exempted the company from liability for the product. The United States granted manufacturers immunity through the Public Readiness and Emergency Preparedness Act. Other countries also granted immunity.

Responsibility for any problems with the vaccines was shifted from manufacturers to governments and taxpayers, says Bigtree.

"Of all the industries to be granted immunity from liability, it is hard to imagine any more worrisome than the pharmaceutical industry," said Bigtree. "All fault related to poor testing standards, false advertising, and any harm caused by the products must be blamed on the government and its regulatory agencies."

'Incorporated into DNA'

The mRNA shots should not even be referred to as vaccines but as gene therapy, said David Gortler, Pharm.D., a scholar at the Ethics and Public Policy Center and former senior advisor to the FDA commissioner, on the panel.

"They should have gone through a gene therapy review process at the FDA and should have been advertised as gene therapy to the public from the very beginning," said Gortler.

The mRNA could be incorporated into the human genome, said Jane Orient, M.D., executive director of the American Association of Physicians and Surgeons.

"The vaccines contain engineered genetic material (mRNA or DNA) that uses the cell's protein factory to make viral spike protein," said Orient. "The material is widely distributed in tissues. It was claimed not to be incorporated into DNA, but there is evidence that it is."

'Nobody Should Be Getting These'

The safety profile for the COVID-19 mRNA shots is "unacceptable," and nobody should get them at this point, Gortler told *Health Care News*.

"Now that the original [Wuhan] strain of COVID-19 has been shown to be extinct and the adverse event and safety profile monumentally is unacceptable, nobody should be getting these mRNA shots either in the form of the original or in multivariate forms," Gortler said.

The shots now being offered are mismatched to the current strains of the coronavirus, says Gortler.

"Today's multivalent shots inexplicably contain mRNA from the original, long-mutated-away and extinct COVID-19 disease," said Gortler.

Bipartisan Concerns

More research is needed to find out whether the shots do more good than harm, says Gortler.

"Multivariate epidemiology studies comparing safety need to be heeded to answer who, if anyone, would have benefited from mRNA shots for COVID-19, before they were mandated by the Biden White House," said Gortler. "At the very least, these COVID mRNA shots do not need to be given to any individual who expresses antibodies via acquired natural immunity."

Johnson's website lists 11 government and industry leaders who declined to participate in the roundtable. The media mostly ignored the discussion, says Gortler.

"There were several people on Sen. Johnson's panel who are liberal and/or left-wing, with at least two Bernie Sanders supporters that I know of," said Gortler. "That fact should destroy any regurgitated mainstream media narrative stating that it is just a bunch of right-wingers complaining and wrong."

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

"Of all the industries to be granted immunity from liability, it is hard to imagine any more worrisome than the pharmaceutical industry. All fault related to poor testing standards, false advertising, and any harm caused by the products must be blamed on the government and its regulatory agencies."

DEL BIGTREE
FOUNDER
INFORMED CONSENT ACTION NETWORK

Florida Grand Jury to Investigate COVID-19 Shots

Florida Governor Ron DeSantis

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

By AnneMarie Schieber

The Florida Supreme Court gave Gov. Ron DeSantis the green light to impanel a statewide grand jury to investigate the safety and efficacy of COVID-19 shots over a 12-month term, on December 23.

The "pharmaceutical industry has a notorious history of misleading the public for financial gain," states the governor's petition to the high court. "[There are] good and sufficient reasons to deem it to be in the public interest to impanel a statewide grand jury to investigate criminal or wrongful activity in Florida relating to the development, promotion, and distribution of vaccines purported to prevent COVID-19 infection, symptoms, and transmission."

"Gov. DeSantis' bold and courageous leadership at the state level is showing all of us how each state in the United States of America can exercise its investigative, legal, and judicial authority to investigate threats to the public safety of the citizens of that state and hold wrongdoers accountable."

ELIZABETH LEE VLIET, M.D.
PRESIDENT AND CEO, TRUTH FOR HEALTH

Misinformation Effect

People were pushed or coerced to get vaccinated based on inaccurate information, DeSantis' petition argues.

"[T]he federal government, medical associations and others have created an expectation that receiving a COVID-19 vaccine is an ethical or civic duty and that choosing not to get vaccination against COVID-19 is selfish and harmful to others," states the petition.

Although the state of Florida rejected vaccine mandates, many people chose to receive the shots "because they believed that receiving the vaccine would prevent them from spreading COVID-19 to others," the petition states.

The closed-door inquiry does not require specific allegations of crimes, says Drew Keyes, a senior policy analyst at the Paragon Health Institute.

"It is unclear exactly what the grand jury is investigating or what it will find," said Keyes. "It all leads back to the same fundamental problem plaguing public health: a lack of trust."

Call for Consequences

Other states should follow DeSantis' lead, says Elizabeth Lee Vliet, M.D., president and CEO of Truth for Health, a patient advocacy organization, in a press release.

"*This*, America, is how our Constitution Republic is *supposed* to work, with states controlling all powers not specifically enumerated in the Constitution as belonging to the federal government," stated Vliet (emphasis in original). "Gov. DeSantis' bold and courageous leadership at the state level is showing all of us how each state in the United States of America can exercise its investigative, legal, and judicial authority to investigate threats to the public safety of the citizens of that state and hold wrongdoers accountable."

States' Primacy

States are in the best position to hold federal health agencies such as the Centers for Disease Control and Prevention (CDC) accountable, says Keyes.

"The CDC's original mission was to support state public health efforts," said Keyes. "What we've seen since the pandemic shows just how much that relationship has changed, as more and more power has been concentrated in Washington."

States are the proper center of authority in these matters, says Robert E. Moffitt, a senior research fellow at the Center for Health and Welfare Policy at The Heritage Foundation and coauthor of a policy brief, "COVID-19 and Federalism: Public Officials' Accountability and Comparative Performance."

"As a constitutional matter, the states—not the federal government—are granted broad police powers to protect public health and safety," said Moffit. "On the ground, the primary responsibility for protecting the public in a pandemic rests with the states, and the federal government's role is secondary, providing scientifically valid information, data, and guidance, as well as financial and technical support."

Investigation of Unexpected Deaths

DeSantis also directed Florida Surgeon General Joseph Ladapo to put together a surveillance program to investigate cases of sudden deaths of people who received the mRNA shots made by Moderna and Pfizer BioNTech.

The program will be modeled on a German autopsy study that found "final diagnoses consistent with vaccine injury syndrome," wrote Peter McCullough, M.D., MPH, on Substack.

Ladapo will also oversee the Florida Public Health Integrity Committee, appointed by DeSantis, which will review data and make recommendations for further action. Panel members include Jay Bhattacharya, M.D., Ph.D. and Martin Kuldorff, Ph.D., two of the signers of the Great Barrington Declaration, which urged a more focused approach to deal with the pandemic during its early stages.

Other panelists include Tracy Beth Hoeg, M.D., Ph.D.; Joseph Fraiman, M.D.; Christine Stabell Benn, M.D., Ph.D.; Bret Weinstein, Ph.D.; and Steven Templeton, Ph.D.

Chance to Restore Confidence

Florida's actions could inspire similar efforts in other states, says Keyes.

"I think we will see a renewed focus on public health throughout the country, which is no surprise as Americans begin to take stock of the failures of our federal response to the pandemic," said Keyes. "Whether such actions take the same form remains to be seen, but there will be a strong interest in assessing the state and federal role, and hopefully more states will take a strong leading role in that relationship."

Open discussion of issues and locally determined policies would help reestablish confidence in public health agencies, says Keyes.

"An open and honest local conversation about the poor information coming out of federal public health agencies and how they interact with private industry should be a positive step in restoring that trust," said Keyes. "The way to reach that goal is through an inclusive process that listens to people and tailors a public health approach to their needs, rather than the centrally dictated, one-size-fits-all approach we've seen fail.

"Given Washington's meat-axe attempt to impose a vaccine mandate, it is appropriate for more prudent state public health officials to address the problem," said Keyes.

'An Epic Policy Failure'

Restoring trust in public institutions will be difficult, says Moffit.

"Unfortunately, the federal government's performance, ranging from mixed messaging on masks and mandates to ill-conceived recommendations for social, economic, and educational lockdowns, has been an epic policy failure," said Moffit.

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

Negative COVID Test Required for Travelers from China

By AnneMarie Schieber

Federal health officials are requiring visitors from China to submit a negative COVID-19 test before entering the United States.

The policy issued by the U.S. Centers for Disease Control and Prevention (CDC) took effect on January 5 and requires travelers from mainland China, Hong Kong, and Macau who are at least two years of age to test negative within two days of arrival. Visitors from South Korea or Canada who were in China 10 days before their flight to the United States must also present a negative COVID-19 test.

"This public health policy is due to the surge in COVID-19 cases in the PRC (People's Republic of China) and the risk of the emergence of a new viral variant given the lack of adequate and transparent epidemiological and viral genomic sequence data being reported from the PRC," states the advisory on the U.S. State Department website.

"While the restriction on Chinese visitation to the United States is a sensible policy, absolutely nothing else about the Biden administration's COVID policies has ever made sense. I have little hope actual science and common sense will ever drive it, either, despite this policy."

JIM LAKELY
VICE PRESIDENT, THE HEARTLAND INSTITUTE

About Face

This is not the first U.S. attempt to restrict entry from China to protect the public health.

In January 2020, during the early stages of the pandemic, the Trump administration moved to bar entry to anyone who had been in China within the past 14 days. Joe Biden, then a candidate for president, lambasted the policy.

"We are in the midst of a crisis with the coronavirus," tweeted Biden, on February 1, 2020. "We need to lead the way with science—not Donald Trump's record of hysteria, xenophobia, and fear-mongering."

On February 24, 2020, then-Speaker of the House Nancy Pelosi walked through Chinatown in San Francisco with no mask, stating publicly there was no reason for fear.

No Apologies

The federal government's policies on travel abroad are judged on overtly partisan terms, says Jim Lakely, vice president and director of communications at The Heartland Institute, which co-publishes *Health Care News*.

"I wonder why the same people who called [Trump's] sensible policy racist think they can get away with imposing it without an apology to the last administration?" said Lakely. "Just one year ago, I traveled to Scotland and our ruling class required me to test negative for COVID to return home, as an American, to my own country. And now, only now, is there a restriction on admitting Chinese to the United States. And there is still a senseless restriction on people entering the United States if they are not current on the arbitrary vaccine regime of the CDC."

Little in the government response to the pandemic makes sense, says Lakely.

"While the restriction on Chinese visitation to the United States is a sensible policy, absolutely nothing else about the Biden administration's COVID policies has ever made sense," said Lakely. "I have little hope actual science and common sense will ever drive it, either, despite this policy."

In June 2022 the CDC lifted a 2021 requirement that all international travelers pass a COVID test for entry to the United States.

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

STUDY

Risks Outweigh Benefits for College Student COVID Shots

By Harry Painter

The risks of college and university COVID-19 vaccine mandates outweigh the benefits, a new study has found.

"Based on public data provided by the CDC (Centers for Disease Control and Prevention), we estimate that in the fall of 2022 at least 31,207–42,836 young adults aged 18-29 years must be boosted with an mRNA vaccine to prevent one Omicron-related COVID-19 hospitalization over 6 months," write University of Washington, Seattle public health professor Kevin Bardosh and others in "COVID-19 Vaccine Boosters for Young Adults: A Risk Benefit Assessment and Ethical Analysis of Mandate Policies at Universities," published in the *Journal of Medical Ethics* in December.

"Given the fact that this estimate does not take into account the protection conferred by prior infection or a risk adjustment for comorbidity status, this should be considered a conservative and optimistic assessment of benefit," write the authors.

Vaccine mandates are likely to result in "net expected harms to young healthy adults," write the authors. "For each hospitalization averted we estimate approximately 18.5 SAEs [serious adverse events] and 1,430–4,626 disruptions of daily activities—that is not outweighed by a proportionate public health benefit."

The mandates are "ethically unjustifiable" infringements of individual liberty, the authors conclude.

Boosting Boosters

More than 1,000 institutions of higher education still require enrolled students to provide proof of two doses of a COVID-19 vaccine, and about 300 colleges and universities had booster mandates as of spring 2022.

'All Mandates Violate' Ethics

Vaccine mandates violate the principle of informed consent as outlined in the Nuremberg Code, says Del Bigtree, founder of the Informed Consent Action Network.

"It is important to note that even if the potential benefits, adverse effects, and concerns are clearly described to the patient as required by informed consent, the right to consent or not to the administration of the medical product is the primary power granted to the patient," said Bigtree. "Therefore, all mandates violate this important tenet of modern medicine."

The CDC and the U.S. Food and Drug Administration recommended the mRNA vaccines for young people despite the risk profile, says Bigtree.

"They know the risk of being hospitalized for myocarditis caused by the vaccine is greater than the risk of being hospitalized for a natural COVID infection," said Bigtree.

'May Have Accepted Corruption'

Governments and other major institutions are undermining science and putting people's health in jeopardy, says Bigtree.

"As a society, we may have accepted corruption as an unavoidable byproduct of pharmaceutical industry tactics, but if we accept corruption by the regulatory agencies that have asserted their power to force pharmaceutical products upon us, we may find the very existence of our species in jeopardy," said Bigtree.

"We must demand protection from our political representatives for the fundamental right to control what goes into our bodies and our children's bodies," said Bigtree.

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

"It is important to note that even if the potential benefits, adverse effects, and concerns are clearly described to the patient as required by informed consent, the right to consent or not to the administration of the medical product is the primary power granted to the patient. Therefore, all mandates violate this important tenet of modern medicine."

DEL BIGTREE
FOUNDER
INFORMED CONSENT ACTION NETWORK

Travel Nurses Slam Pay Cuts After COVID-19

Travel nurses are suing staffing agencies for cutting their premium pay—by half, in some cases—in the wake of the COVID-19 pandemic.

Nurses who relocated for temporary assignments to cities with a high cost of living are finding it difficult to make ends meet under the pay cuts, Austin Moore, an attorney representing nurses in a class action lawsuit, told NBC News on December 28.

"To go take a travel assignment is a really big deal, and to get there to have the rug pulled out from under you, for someone to collapse your pay, I just think it's unconscionable," said Moore. "They're on the hook for a lease, and they're scrambling trying to find another job, and it's a really terrible set of circumstances."

Bait and Switch?

Four travel nurse agencies are facing lawsuits over the lower salaries, according to the NBC report.

Travel nurses were in high demand during the COVID-19 pandemic, as recently as January 2022, with some earning as much as $5,000 a week in addition to monthly living stipends. By spring 2022, when the companies renewed the assignments, pay dropped to starting rates of about $44 an hour.

Some nurses claim their pay was cut shortly after they accepted assignments and signed "at-will" employment contracts at higher rates. Travel nurse company Aya Healthcare told NBC News the nurses' allegations of "bait and switch" tactics "are demonstrably false."

Supply and Demand

Staffing hospitals with temporary workers is a reality in the current market, health economist Devon Herrick wrote in the Goodman Institute Health Blog, on December 28.

"Hospitals are loath to raise nurses' pay and often would rather hire temporary nursing staff at much higher rates than raise the standard pay to retain nurses already on staff," wrote Herrick. "Hospitals' unwillingness to compensate nurses for the heightened risk [of treating infected COVID-19 patients] caused many nurses to jump ship and join traveling nurse agencies."

Nurses now complaining the staffing companies lured them into relocating with deceptively higher pay are mistaken, wrote Herrick, who has worked in hospital accounting departments.

"No, people, it's called supply and demand," wrote Herrick. "In retrospect, many of the nurses made the decision to relocate their families assuming the gravy train would never end."

Aya Healthcare says travel nurses represent 2.34 percent of the total employment market of 3,047,540 registered nurses.

—*Staff reports*

COMMENTARY

Omnibus Funds 'High Risk' Health Innovation

By David Gortler and Roger Severino

The glut of pork and woke spending loaded into the lame-duck omnibus spending bill included $1.5 billion in taxpayer funding for something called the Advanced Research Projects Agency—Health (ARPA-H).

ARPA-H didn't exist before March 2022. But this obscure agency cannot be ignored. It was supercharged by the omnibus bill President Joe Biden signed into law on December 29, and it could have deadly consequences for public health.

By statute, ARPA-H's mission includes "promot[ing] high-risk, high-reward innovation for the development and translation of transformative health technologies" by "supporting … acceleration of transformational health technological advances in areas with limited technical certainty."

Most competent health authorities will agree the words "high risk" and "limited technical certainty" should never be considered *positive features* when discussing public health, but ARPA-H embraces them with gusto.

It is precisely this sort of reckless thinking that got us into funding "gain of function" experiments with deadly viruses—including, it appears, high-risk research that may have led to the creation and escape of the COVID-19 virus at the National Institutes of Health-supported Wuhan Institute of Virology.

New Runway

Under the omnibus bill, ARPA-H will be plucked out of the National Institutes of Health (NIH), where it currently resides, and established as "an independent operating division within the Department of Health and Human Services" (HHS).

This is clearly meant to allow ARPA-H to operate outside the purview of HHS's other operating divisions, including the NIH, the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the Indian Health Service (IHS), and the Centers for Medicare and Medicaid Services (CMS).

ARPA-H is designed to sidestep more than a dozen different agencies and almost 100,000 scientists, researchers, nurses, pharmacists, physicians, and support staff. ARPA-H is purposely hostile to existing structures, so much so that the omnibus all but bars it from hiring people from the NIH.

Additionally, the ARPA-H director will have a renewable, four-year term of office and, in a move of dubious constitutionality, would be insulated from any requirement to submit "for approval or review" any personal recommendations to Congress regarding ARPA-H's activities, even if they conflict with presidential policies.

Disrupting Science and Safety

To what end is all this independence?

It is to empower ARPA-H to mimic Silicon Valley "disruptors" and jam its risky ventures through or around existing public health safety structures. The bill sets up an advisory committee that includes the FDA, CDC, NIH, and others, but it clarifies the committee will have no authority whatsoever over ARPA-H's activities.

Although the law grants the FDA—America's premier agency in charge of drug approval and medical device safety—the ability to meet separately with ARPA-H, it specifies that it must be only to discuss "actions that may be taken to facilitate the development of medical products and projects that are the highest priorities to ARPA-H."

If that isn't enough pressure on the FDA to do ARPA-H's bidding, the law requires ARPA-H to "reimburse" the FDA for any activities it conducts as a result of these prioritization meetings. In short, the FDA is expected to regularly meet with ARPA-H to get its marching orders and then get paid every time it completes them.

This structure so erodes the independence of the FDA as to be laughable if it weren't so dangerous.

Risky Business

One can only imagine the deadly dangers to be unleashed when an ARPA-H director pushes for approvals of "high-risk" drugs or vaccines in an environment of "limited technical certainty," such as during a pandemic. Under the omnibus bill passed by Congress, ARPA-H will have a $1.5 billion budget to play with as a nonemergency *baseline*.

The FDA can and should improve its drug safety record and its speed of approvals, but injecting ARPA-H's gotta-break-some-eggs-to-make-an-omelet ethos into the mix is not a solution but a recipe for disaster—much like the rest of the omnibus bill.

David Gortler, Pharm.D. (**dgortler@eppc.org**) *is a pharmacologist, pharmacist, and health care policy scholar at the Ethics and Public Policy Center. Roger Severino is vice president of domestic policy and the Joseph C. and Elizabeth A. Anderlik Fellow at The Heritage Foundation.* *A version of this article appeared in* The Daily Signal *on December 21, 2022. Reprinted with permission.*

Live Organ Harvesting Procedure Raises Red Flags

By Kevin Stone and AnneMarie Schieber

A medical protocol that expands the pool of live donor organs is getting increased attention from doctors and patient advocates who say it skirts the legal definition of death.

The practice, known as normothermic regional perfusion with controlled donation after circulatory death (NRP-cDCD), involves inducing brain death in terminal patients by clamping the person's carotid artery and then restarting the heart to keep the organs viable. Three hospitals—in Arizona, Nebraska, and New York—are conducting clinical trials to expand the practice, Medpage reported in September.

Patient advocacy groups such as Respect for Human Life are warning the public about the ethical problems of NRP-cDCD. Heidi Klessig, M.D., wrote, "Don't become a victim of unethical organ harvesting practices. Don't sign that donor card!" in *American Thinker*.

"There have been efforts to develop animal transplants; none of them have been successful. There have also been efforts to develop mechanical organs, such as a permanently implanted pump that would act as an artificial heart. A wonderful physician, Harold Kletschka, M.D., developed a successful working model decades ago, but it never went to market due to several unsavory efforts to take control of the project."

JULIE GRIMSTAD
BOARD MEMBER
HEALTHCARE ADVOCACY AND LEADERSHIP ORGANIZATION

Potential Conflicts

Patients receiving critical care in hospitals and other medical facilities may not understand the processes by which clinical death is determined or organs may be harvested.

A 2006 revision of the Uniform Anatomical Gift Act allows hospital administrators to take organs from incapacitated patients determined to have irreversible brain function and whose family members are not reachable, Klessig told the *Heartland Daily Podcast* on November 28.

"[This] is terrifying when there is a person whose interest is how much money can be made from your organs, not what is in your best interests," said Klessig.

Live organ transplants can reap millions of dollars for hospitals that procure the organs and the centers that transplant them. According to a report by the consulting firm Milliman, the average billed charges for a heart transplant in 2020 amounted to $1,664,800. Lung transplants were billed at an average of $1,295,900, and intestines at $1,240,700.

Lack of Shelf Life

Unlike tissue from cadavers, vital organs such as the heart, lungs, liver, and kidneys cannot be harvested from a patient whose circulatory system has shut down, says Klessig.

"These organs rely on a continuous supply of oxygen and nutrition through the bloodstream to remain viable," said Klessig. "They are so complex that once the blood flow stops, they very quickly break down and become unsuitable for transplant."

This explains why around 100,000 patients remain on an organ waiting list despite the deaths of 1.5 million people registered organ donors each year, says Klessig.

"If a dead person could donate organs, that would work out to 15 organs per waiting recipient, which is a lot more than we need," said Klessig. "So, … we wouldn't have a waiting list at all but an organ surplus."

An exception to the rule is a kidney or a lobe of the liver, which can be donated by patients who remain alive.

Defining Death Down

The current clinical definition of death arises from the 1968 "Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death," which replaced previous standards for determining death based on the failure of the circulatory, respiratory, and neurological systems.

The Harvard report led to the federal Uniform Determination of Death Act (UDDA), which redefined death as either (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain, including the brain stem.

Allowing for a clinical diagnosis of "brain death" opened the door to certifying the death of a patient whose heart and lungs were still providing oxygenated blood to organs, and thereby created a convenient new avenue for live organ harvesting. The UDDA requires determinations of brain death to be rendered according to "accepted medical standards." There is no medical requirement beyond clinical observation.

"Irreversible cessation of heart and lung function or irreversible [loss of] function of the entire brain, including the stem, doesn't sound terribly controversial, but the devil is in the details," said Klessig. "The problem is that doctors are not always able to determine what is irreversible."

'Better Solutions'

In 2021, the American College of Physicians stated the NRP-cDCD procedure raises "profound ethical questions regarding the determination of death, respect for patients, and the ethical obligation to do what is best."

Medical practice should not condone taking the life of one person to save another, says Klessig.

"I really believe if we hadn't been pouring all our time, money, and research dollars into the current, unethical system, I think we would have found better solutions for people, such as augmenting the heart or providing an artificial one," said Klessig. "Those treatments need to be developed, and those scientific pursuits are not being funded."

'Unsavory Efforts'

Organ procurement is a big business with less and less concern for donors' welfare and lives, says Julie Grimstad, a board member and patient advocate at the Healthcare Advocacy and Leadership Organization.

"There have been efforts to develop animal transplants; none of them have been successful," said Grimstad. "There have also been efforts to develop mechanical organs, such as a permanently implanted pump that would act as an artificial heart. A wonderful physician, Harold Kletschka, M.D., developed a successful working model decades ago, but it never went to market due to several unsavory efforts to take control of the project."

Kevin Stone (**kevin.s.stone@gmail.com**) *writes from Arlington, Texas. AnneMarie Schieber* (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

Court Orders HHS to Restore 'Fertility Awareness' Language in Guidelines

By Ashley Bateman

A federal court has ordered the Biden administration to restore "fertility awareness" language to family planning guidelines used to determine benefits in Obamacare and most health insurance plans.

Cami Jo Tice-Harouff, DNP, a licensed nurse practitioner, filed suit against the Health Resources and Services Administration, the agency of the U.S. Department of Health and Human Services (HHS) that removed the language. Tice-Harouff argued the move was illegal, was arbitrary, and limited the instruction on fertility-based family planning she typically provides her patients.

After the Biden administration removed the language, the Catholic Medical Association (CMA), of which Tice-Harouff is a member, had released "public comments" calling for the language to be restored without change.

Language Barrier

Under the Affordable Care Act, insurance plans "must cover contraceptive methods and counseling for all women, as prescribed by a health care provider," states the HealthCare.gov website.

In 2016, the requirement was expanded to include "instruction in fertility awareness-based methods" of contraception.

The Biden administration removed the 'fertility awareness' language from the Women's Preventive Services (WPS) Guidelines in 2021, a move that affected 60 million women. There was no notice-and-comment period for the change as required under the Administrative Procedure Act (APA).

Judge Jeremy D. Kernodle of the U.S. District Court for the Eastern District of Texas, Tyler Division, ordered the Biden administration to restore the language, on December 6.

The restored WPS Guidelines now state, "Additionally, instruction in fertility awareness-based methods, including the lactation amenorrhea method, although less effective, should be provided for women desiring an alternative method."

'Back-Room Government Decisions'

The violation of the APA is typical of the implementation of the Affordable Care Act, says Matt Bowman, a senior counsel at the Alliance Defending Freedom, a public interest law firm, which represented Tice-Harouff.

"Under Presidents Obama and Biden, HHS has long implemented Obamacare without respect for basic values or the public comment process," said Bowman. "We are grateful that the court restored to tens of millions of women the right to access fertility-awareness-based methods that help them raise families in a manner consistent with their unique needs."

Kernodle's order is "a win for women and couples" that restores a health care practitioner's ability to instruct patients in multiple evidenced-based family planning and fertility awareness methods and to be a "preferred provider" for patients, says Tice-Harouff.

"Women should never have to fear losing their doctor and insurance coverage for fertility awareness instruction as a result of back-room government decisions," Tice-Harouff said. "I applaud the court's order for restoring fertility-awareness-based methods of family planning to health insurance plans."

"Women should never have to fear losing their doctor and insurance coverage for fertility awareness instruction as a result of back-room government decisions. I applaud the court's order for restoring fertility-awareness-based methods of family planning to health insurance plans."

CAMI JO TICE-HAROUFF
LICENSED NURSE PRACTITIONER

Family Planning Alternative

There are several advantages to fertility-awareness-based methods (FABM), according to the CMA.

"Women choose FABM for a variety of reasons, including the desire to avoid the use of hormones and devices, to avoid the ill side effects of other forms of birth control, and to understand one's natural body processes consistent with religious preferences," stated the CMA in its public comment on the Biden administration's decision.

The CMA says FABM can be used to avoid or achieve pregnancy and that "typical use failure" can be as low as 2 percent.

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

SATIRE

Canadian Health Care System Introduces Punch Card: Tenth Visit, Free Suicide

As Canada's Medical Assistance in Dying (MAID) system continues to alleviate the pain of patients and the financial strain on the nation's health care system, a recent innovation is expected to further improve results: Parliament just announced a punch card that allows patients to receive a free suicide after 10 doctor visits.

"From a small-scale maple syrup overdose to a full-blown moose attack, you receive a punch on your card every time you are admitted for an injury or sickness," states a blog published this week on the Canadian Health Care system's website outlining the new program. "Filling out your punch card is mandatory, for data tracking purposes. No one sick person can be allowed to drain more than their share of the taxpayer's dollars!"

Canadian Prime Minister Justin Trudeau praised the new initiative, positioning it as a way to better engage citizens and prevent any one citizen

from becoming a burden on the system.

"Canadians are team players," said Trudeau. "It's important for every citizen to make sure he's not wasting taxpayer money to sustain a life that's not worth living. And now with this punch card, they know that with each hospital visit they're one step closer to the end!"

Critics contend the new approach preys on disabled and impoverished Canadians who may see assisted suicide as their only option, but the criticism has already been quieted since Trudeau froze the bank accounts of anyone who spoke out against his regime's policies in the comments section of the health care website's blog, or on Twitter, or elsewhere.

The burden on Canada's health care system was further alleviated when Parliament announced the policy would retroactively apply to people who have already been admitted for 10 prior hospital visits.

A version of this article was published by The Babylon Bee *on December 12, 2022. Republished with permission. Photo courtesy of* The Babylon Bee. *See the related news article, "Doctor-Assisted Suicide Now a Leading 'Manner' of Death in Canada,"* Health Care News, *October 17, 2022.*

Canada Expands Doctor-Assisted Suicide to Mentally Ill

By AnneMarie Schieber

Starting in March, Canada is expanding the availability of doctor-assisted suicide to those with mental illness.

Previously, doctor-assisted suicide was only available to the terminally ill. Canada will now be one of five countries that allow the practice for the mentally ill. The others are Belgium, Luxembourg, the Netherlands, and Switzerland.

More than 30,000 Canadians have died by assisted suicide since it was legalized in 2016, reports Reuters. One-third of those deaths occurred in 2021 alone, comprising 3.3 percent of all deaths in Canada, making it a top ten leading "manner" of death there.

As with the terminally ill, two medical professionals will determine whether the person has an irreversible condition and is mentally fit to make the decision.

'Dishonest to the Core'

In practice, there is no oversight of assisted suicide, says Julie Grimstad, a patient advocate and board member of the Healthcare Advocacy and Leadership Organization (HALO).

> **"So-called 'safeguards' or 'restrictions' written into euthanasia and assisted-suicide proposals are merely window-dressing to gain approval, soon gone and forgotten after legalization. The pro-death lobby is dishonest to the core."**
>
> **JULIE GRIMSTAD**
> **BOARD MEMBER**
> **HEALTHCARE ADVOCACY AND LEADERSHIP ORGANIZATION**

"So-called 'safeguards' or 'restrictions' written into euthanasia and assisted-suicide proposals are merely window-dressing to gain approval, soon gone and forgotten after legalization," said Grimstad. "The pro-death lobby is dishonest to the core."

There has been a big push in Canada to promote doctor-assisted suicide. The Canadian government published an activity book to teach children how the process works and explain why adults choose to end their lives, the *National Post* reported on December 21. The book states illness or disability "hurts their body or their mind so much that it feels too hard to keep living."

In addition, the Quebec College of Physicians is lobbying to expand assisted death to allow the killing of severely disabled newborns.

'Suicide by Telemedicine'

Assisted suicide is legal in 10 U.S. states and the District of Columbia. Oregon took the practice a step further in 2022 by dropping its residency requirement.

"Since assisted suicide by telemedicine is also permitted, this probably means that people don't even have to see a doctor face-to-face or be examined by the prescribing physician but can meet via video chat and have the drugs mailed to them," said Grimstad.

HALO is a U.S. nonprofit founded in 2018 to defend "the lives and safety of persons facing the grave consequences of healthcare rationing and unethical practices, especially those at risk of euthanasia and assisted suicide," its website states. The organization has documented the denial of life-sustaining treatment to patients who want it.

HALO filed an amicus brief to save Tinslee Lewis, a baby in Texas who was being denied treatment because of a serious heart condition against her mother's wishes, says Grimstad.

"To make a long story short, Tinslee is now four years old, at home with her family, and doing quite well in spite of the doctors' prediction of her life expectancy," said Grimstad.

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

Texas Nurse Sues VA for Violating Religious Liberty

By Ashley Bateman

A Texas nurse is suing the U.S. Department of Veterans Affairs (VA) to stop it from requiring her to provide abortion services despite her religious convictions.

In response to the U.S. Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization* which overturned *Roe v. Wade* and state laws restricting abortions, the VA enacted a rule allowing abortion counseling and services for veterans and their beneficiaries in VA hospitals and clinics, in cases of rape, incest, or if the pregnancy would put the mother's life or health at risk.

Texas Nurse Practitioner Stephanie Carter

PHOTO COURTESY FIRST LIBERTY

No Religious Accommodation

The VA will "prepare to provide these services in as many locations as possible" with immediate action, states a September 2022 press release from the VA Office of Public and Intergovernmental Affairs.

Texas Nurse Practitioner Stephanie Carter, a devout Christian and Army veteran who has served the VA for 23 years, says the rule violates her religious beliefs and medical ethics.

Carter sought legal counsel after realizing she could lose her job or be sued, says Danielle Runyan, senior counsel at First Liberty and lead counsel in Carter's case.

"The Department of Veteran Affairs does not have a religious accommodation process for the rule," said Runyan. "There is no protection for those participating."

Carter requested a religious exemption from participating in abortion services twice in October. Her supervisor told her there was no process for religious accommodations, states the lawsuit filed on Carter's behalf in the U.S. District Court for the Western District of Texas, Waco Division by First Liberty Institute on December 13.

'Could Exceed State Law'

H.R. 1308, the Religious Freedom Restoration Act, passed by Congress in 1993 and signed into law by President Bill Clinton, prohibits government entities from "burdening" a person's exercise of religion.

"We are asking the VA to not enforce the rule, not apply the rule to Ms. Carter, but also not to apply the rule to the facility in which she works," said Runyan. "She not only has an objection to performing abortion services but [also to] working in a facility where those services are performed except in the case of saving the life of the mother."

In a state with very stringent abortion laws, Carter is also concerned she could be subjected to civil action or other liability and possibly lose her medical license, says Runyan.

"The rule talks about such a wide variety of what constitutes 'preserving' the life of the mother that it could exceed state law in Texas," Runyan said.

Texas law allows third parties to take civil court action against individuals and organizations that perform abortions in contravention of state law. Since the fall of 2021, First Liberty Institute, a nonprofit public interest law firm, has handled an increasing number of religious liberty filings for government contractors and civilians seeking representation after being denied religious exemptions to COVID-19 mandates.

'Devolution of Medical Ethics'

The issues of the past two years regarding informed consent, bodily autonomy, and right to conscience are all a result of a "devolution of medical ethics," says Chelsea Sheppard, M.D., an associate professor at the University of Virginia who was terminated in 2021 after her religious exemption to the COVID-19 vaccination was denied.

"In regard to these cases, there are two main issues," said Sheppard. "The first and most important involves the fact that the vocation of medicine should be reserved for people who are called to heal and cure."

Government entities are ignoring the Religious Freedom Restoration Act, says Sheppard.

"The second, more practical issue is in many of these instances the institutions appear to be obfuscating the law either overtly or covertly to deny people the right to participate in society while holding true to their religious convictions," said Sheppard. "Both are fatally detrimental to the health care system."

The VA had not responded to the lawsuit at press time.

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

> **"We are asking the VA to not enforce the rule, not apply the rule to Ms. Carter, but also not to apply the rule to the facility in which she works. She not only has an objection to performing abortion services but [also to] working in a facility where those services are performed except in the case of saving the life of the mother."**
>
> **DANIELLE RUNYAN**
> **PUBLIC INTEREST ATTORNEY**

INTERNET INFO

Stephanie Carter v. Denis Richard McDonough, U.S. Department of Veterans Affairs; U.S. District Court, Western District of Texas, Waco Division; December 13, 2022: **https://firstliberty.org/wp-content/uploads/2022/12/001-VA-Complaint_Redacted.pdf**

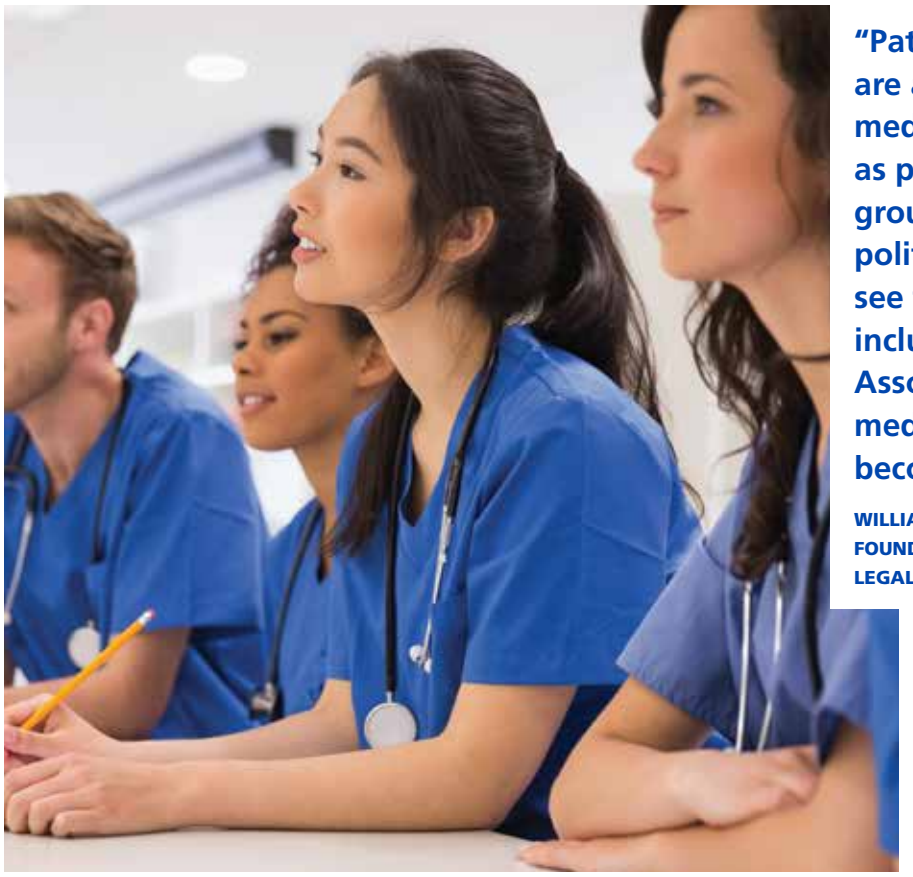
Critical Race Theory Mandatory for Medical Students

By Bonner Russell Cohen

More than half of the nation's top 100 medical schools now require prospective doctors to take classes in critical race theory (CRT).

"Medical school education is in crisis, with 'social justice' and race-focused activism being imposed on students, faculty, and staff," William Jacobson, founder of the CriticalRace.org website, a project of the Legal Insurrection Foundation (LIF), told Fox News.

Of the top 100 medical schools, based on *U.S. News* rankings, 58 have mandatory CRT training for faculty and staff, CriticalRace.org reports.



"Patient care and people's lives are at risk when doctors and medical providers view patients as proxies for racial and ethnic groups in sociological and political battles. We increasingly see the medical establishment, including the American Medical Association, demanding that medical students and physicians become race-focused activists."

WILLIAM JACOBSON
FOUNDER, CRITICALRACE.ORG
LEGAL INSURRECTION FOUNDATION

'Race-Focused Activists'

Jacobson, a clinical professor of law at Cornell Law School, founded the website and created a database that tracks CRT requirements for 500 undergraduate programs, private K-12 schools, and military service academies, in addition to medical schools.

"An outgrowth of the Marxist European school of critical theory, critical race theory is an academic movement which seeks to link racism, race, and power," states the website. "Critical race theorists argue that American social life, political structures, and economic systems are founded upon race, which (in their view) is a social construct."

CRT-related indoctrination can be especially harmful in medical schools, Jacobson says.

"Patient care and people's lives are at risk when doctors and medical providers view patients as proxies for racial and ethnic groups in sociological and political battles," Jacobson told Fox News. "We increasingly see the medical establishment, including the American Medical Association, demanding that medical students and physicians become race-focused activists."

Racism 'a Public Health Threat'

Among the institutions requiring some form of CRT-related instruction is the Department of Surgery at the Lewis Katz School of Medicine at Temple University, which pledges to "assess and improve upon the current state of surgical training evaluation to eliminate the impact of implicit and explicit bias," CriticalRace.org reports.

The David Geffen School of Medicine at the University of California at Los Angeles (UCLA) says it will "work together … to ensure a robust focus on anti-racism, structural and social determinants of health and health equity throughout all four years of the medical school curriculum."

The University of Colorado School of Medicine set aside April 2022 to encourage its "faculty, staff, and trainees to participate in a 30-Day Anti-Racism Challenge" to address "power, privilege, oppression, equity, and social justice" as part of "recognizing racism as a public health threat."

The University of Illinois School of Medicine states, "Education on racial inequities, microaggressions, caring for diverse patient populations, improving teaching techniques/content that is free of bias and encouraging engagement of active bystanders will be some of the content presented to faculty and staff in order to improve the environment for students and the college community."

'Ace Your CASPer'

Many medical schools require prospective students to pass a CASPer (Computer-based Assessment for Sampling Personal characteristics) test before they are admitted.

According to "BeMo's Ultimate Guide to CASPer Test Prep," published by BeMo Academic Consulting Inc., CASPer "is a web-based situational judgment test (SJT) claimed to assess how you approach and consider different real-life scenarios and the problems within them."

Originally designed by Canada's McMaster University to screen its medical school applicants, CASPer tests focus on applicants' personal characteristics.

A good CASPer score is more important than a high grade point average (GPA), the study guide states.

"[R]egardless of how well you do on your admissions test and how high your GPA score may be, without a competitive CASPer score you will not be invited for an interview and you will likely be rejected," states BeMo. "On the other hand, even if you have a below average GPA and admission test scores, you can still gain admission, if and only if, you ace your CASPer test."

'Choose a Different Profession'

Changes in medical schools' curriculum and admission standards will discourage qualified students from pursuing medical careers, says Merrill Mathews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"The more time medical schools spend indoctrinating medical students in critical race theory, the less time they spend teaching medicine, even as new advances require more learning time," said Matthews. "It creates just one more reason for the promising students to choose a different profession."

Most medical school students are racial and ethnic minorities, says Matthews.

"Ironically, this development comes at a time when medicine is no longer a bastion of white males and hasn't been for a while," said Matthews. "Medical school students are quite diverse, with only 42 percent of the 2022-23 medical school matriculants self-describing as white."

'Public Health Crisis'

The focus on CRT could damage the quality of health care, says Donna Jackson, director of membership development for Project 21, a nationwide network of black conservatives.

"This could lead to a real public health crisis," said Jackson. "Graduating ill-prepared medical professionals will lower the quality of care in the United States for all races. It sends exactly the wrong message at a time when schools are already experiencing a decline in academic performance."

The emphasis on race at the expense of medical knowledge will discourage the large percentage of U.S. medical students from foreign counties who have customarily been attracted by the high quality of American medical schools, says Jackson.

"As woke policies take root in more medical schools, we will no longer be able to attract high-quality international students," said Jackson. "They will choose to study in countries where the medical curriculum has not been corrupted."

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

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