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The Pulse

U.S. Senate Bill Would Expand HSAs to Direct Primary Care

Sen. Bill Cassidy

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

By Bonner Russell Cohen

A bipartisan U.S. Senate bill would expand the use of Health Savings Accounts (HSAs) to allow payments for direct primary care (DPC).

DPC offers primary care services for a flat monthly fee. The Internal Revenue Service (IRS) currently views DPC payments as insurance premiums, which are not an allowable expense for tax-advantaged HSAs.

The bill would make a small change to the federal tax code to clarify a DPC agreement between

DPC, p. 6

Continuous Medicaid Enrollment Ends

By AnneMarie Schieber

States have begun removing from the Medicaid rolls beneficiaries who no longer qualify but were continuously enrolled during the COVID-19 pandemic.

Under the Families First Coronavirus Response Act, enacted in 2020, states were prohibited from removing anyone from Medicaid while the public health emergency was in place. In exchange, states received enhanced federal matching funds.

The omnibus bill signed into law on December 29, 2022 delinked enrollment from the public health emergency, effective March 31. The bill phases out enhanced federal matching funds

MEDICAID ENROLLMENT, p. 4

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Supreme Court to Decide Abortion Pill Legality

By Harry Painter

The future of chemical abortion is in the hands of the U.S. Supreme Court after federal courts in two separate cases handed down conflicting rulings about the legality of mifepristone.

Mifepristone is the first of two drugs used to induce a chemical abortion during the initial weeks of pregnancy. Chemical abortions make up more than half of all abortions in the United States, according to the Guttmacher Institute.

On April 21, the Court said it would allow full access to mifepristone while the case works its way through the lower courts. Justices Samuel Alito and Clarence Thomas dissented from the decision to extend the stay.

Dueling Court Decisions

The U.S. Food and Drug Administration (FDA) overstepped its authority in 2000 when it approved mifepristone, U.S. District Court Judge Matthew J. Kacsmaryk of the Northern District of Texas ruled on April 7.

Kacsmaryk suspended the drug's approval while the lawsuit proceeds.

Less than an hour after Kacsmaryk handed down his decision, U.S. District Court Judge Thomas O. Rice of the Eastern District of Washington ordered the FDA not to interfere with the availability of the abortifacient in the states involved in a lawsuit before his court.

The Biden administration quickly appealed the Texas decision to the U.S. Court of Appeals for the Fifth Circuit, which stayed Kacsmaryk's preliminary injunction but upheld parts of his ruling. Without invalidating mifepristone's approval, the Fifth Circuit ruling rolled back some guidelines the FDA has changed over the past two decades.

FDA vs. Courts

The FDA has periodically loosened restrictions on mifepristone—most recently during the pandemic when it allowed doctors to prescribe the abortion pill without seeing a patient in person.

The Fifth Circuit's ruling disallowed that practice and prohibited sending mifepristone through the mail, which the FDA had authorized in 2021.

One week after Kacsmaryk's ruling, the U.S. Justice Department and Danco Laboratories, which manufactures mifepristone, applied for emergency relief from the Fifth Circuit ruling, which led to the April 21 Supreme Court stay. The Fifth Circuit is set to hear more arguments on the Kacsmaryk ruling in mid-May and expected to give a more detailed ruling.

FDA 'Completely Political'

From the start, the FDA has made decisions about mifepristone that went far beyond the agency's scope, says Katie Daniel, an attorney and state policy director at Susan B. Anthony Pro-Life America.

"This is completely political; it's not science- or data-driven at all, and that's really the crux of this lawsuit," said Daniel. "Bill Clinton came into office and said, 'A goal of my administration is to put this drug on the U.S. market,' and he got it done on the way out the door."

'They Don't Want to Know'

The FDA uses flawed reasoning to justify its rules, such as removing complicated reporting requirements, says Daniel.

"The reasoning is that they don't want to know," said Daniel. "They stopped collecting data about complications and then said, 'Look, there are no complications. No one's telling us about them.' They know how many root canals have happened, but not how many abortions."

To get the original approval, the FDA "reclassified a normal pregnancy into a life-threatening illness," said Daniel.

The FDA also dodged the Pediatric Research Equity Act, which requires a drug be studied on minors before it is approved for that population, says Daniel.

"The FDA issued itself a waiver from the requirements of that law," said Daniel.

'Total Malpractice'

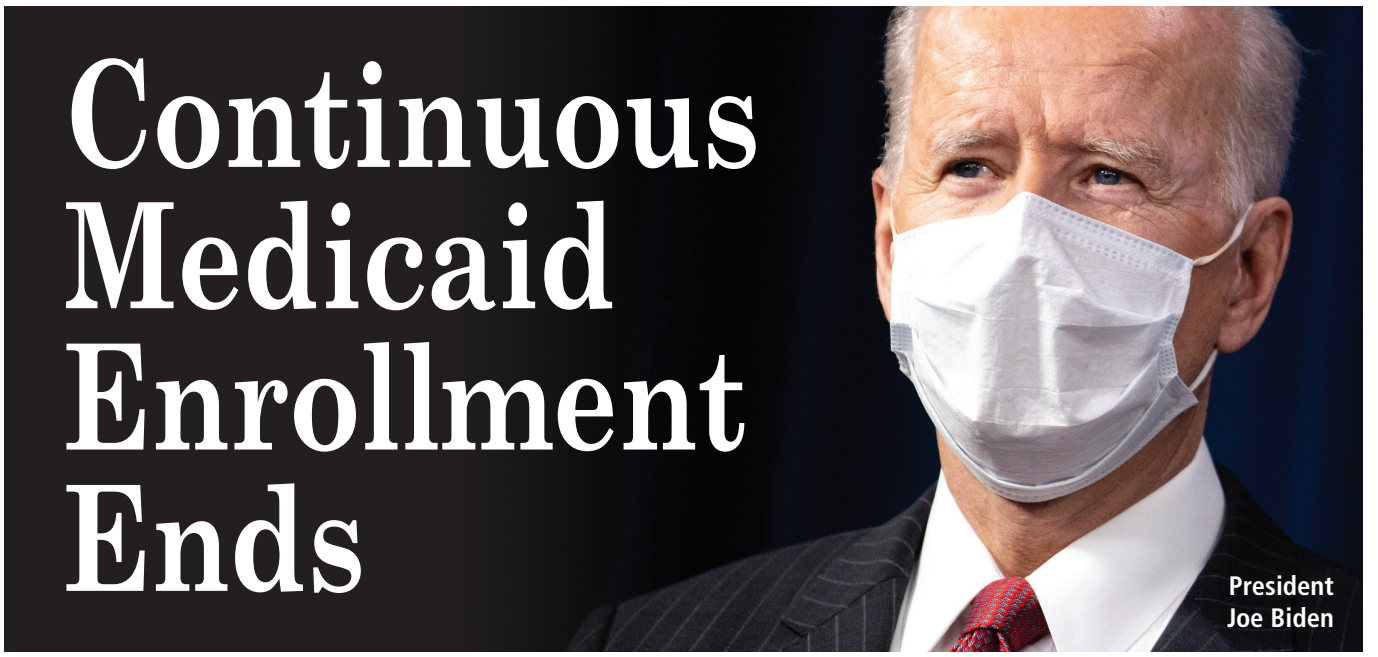
The FDA has repeatedly cut corners for mifepristone, wrote David Gortler, Pharm.D., a scholar at the Ethics and Public Policy Center and former senior advisor to the FDA commissioner, in an article published by the Brownstone Institute on March 25.

"The FDA is now not just approving—but promoting—Big Pharma's proposal to permit mailed, at-home use of mifepristone for 'do-it-yourself' abortion," wrote Gortler. "No more doctor or staff present. No more ultrasounds to confirm gestational age or any in-house monitoring for internal bleeding—for a drug well known to cause life-threatening bleeding."

As to what will happen next, Gortler told *Health Care News*, "What the FDA did is total malpractice. Nobody cares anymore, and I have no faith the right thing will occur."

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

Continuous Medicaid Enrollment Ends



President Joe Biden

PHOTO COURTESY U.S. SECRETARY OF DEFENSE/FLICKR.COM

President Joe Biden ended the national emergency on April 10, and the public health emergency is expected to expire on May 11. The Kaiser Family Foundation estimates five million to 14 million people will lose Medicaid coverage as continuous enrollment unwinds.

Continued from page 1

through December 2023. States can continue Medicaid coverage without checking enrollees' eligibility beyond April 1, but they must meet certain requirements or risk losing additional federal funding.

Emergency Officially Ending

President Joe Biden ended the national emergency on April 10, and the public health emergency is expected to expire on May 11. The Kaiser Family Foundation (KFF) estimates five million to 14 million people will lose Medicaid coverage as continuous enrollment unwinds.

The Paragon Health Institute estimates 15 million to 20 million people in Medicaid do not meet eligibility guidelines and are costing taxpayers more than $100 billion a year. Enrollment in Medicaid and the Children's Health Insurance Program grew by about 25 percent during the pandemic, to 95 million people, according to the KFF.

Obamacare Expansion Hiked Costs

Continuous enrollment during the pandemic isn't the only driver of Medicaid's massive expansion, which began in earnest after the Affordable Health Care (ACA) went into effect and the legislation was affirmed by a U.S. Supreme Court decision in June 2012.

For the first time, states had the option of expanding their Medicaid programs to nondisabled people with incomes up to 138 percent of the federal poverty level. To entice states to sign on, the federal government initially paid 90 percent of the bill.

Today, all but 10 states have chosen to expand their programs, according to the KFF. The states that have not expanded eligibility are Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.

Those states made the right decision, says Linda Gorman, director of the Independence Institute Health Care Policy Center and a senior fellow with the Goodman Institute for Public Policy Research, which co-publishes *Health Care News* and released a new report by Gorman on Medicaid expansion on March 1.

"States that have expanded Medicaid to cover able-bodied low-income people have faced much higher than predicted costs," said Gorman. "There is surprisingly little evidence to show that overall health has improved. There is a substantial amount of evidence suggesting that the bureaucracies running Medicaid expansion degrade the quality and quantity of medical care in their efforts to reduce spending."

Healthy Crowding Out Sick

Gorman's report, "Medicaid Expansion: Expensive, Ineffective, and Damaging to Existing Healthcare Infrastructure," cites alarming developments in expansion states.

"Spending on Medicaid has always been difficult to limit," wrote Gorman. "As its enrollment expands, it reduces available funding for other pressing public needs like schools, infrastructure improvements, law enforcement, and higher education."

In Colorado, for example, one in four people is now enrolled in Medicaid, up from one in 12 before expansion. As a result, Medicaid consumes 37.9 percent of the state's budget.

Additionally, Medicaid now covers people who entered the nation illegally. Illegal aliens over age 50 can qualify in California and those over age 65 in New York.

The Biden administration is now trying to extend Medicaid and Obamacare to all those in the Deferred Action for Childhood Arrivals (DACA) program for so-called "Dreamers." This could add 580,000 new people to these programs. Obamacare is heavily subsidized by federal taxpayers.

Medicaid Waste Keeps Expanding

Often, no cost sharing is required for able-bodied Medicaid enrollees, which raises spending further, Gorman told *Health Care News*.

"Wasteful spending has increased because Medicaid provides few incentives to use medical care wisely," Gorman said. "To make matters worse, the federal government has blocked expansion states' efforts to monitor Medicaid for ineligible enrollment and other frauds."

Medicaid offers extensive coverage and will pay for a wide variety of goods and services such as "transportation, extended nursing home care, prescription drugs, over-the-counter medications, physical and occupational therapy, inpatient psychiatric care, home care, eyeglasses, hearing aids, and dental care," wrote Gorman.

California Gov. Gavin Newsom on March 20 announced a plan to get Medicaid to pay six months' rent for homeless enrollees. Meanwhile, 3,501 people in Colorado with intellectual and developmental disabilities are on waiting lists for residential care, one of the "crueler aspects" of expansion, wrote Gorman.

Nationally, more than 707,000 people with such disabilities were on waiting lists for Medicaid home- and community-based services in 2017, up 8 percent from the previous year, according to Gorman's report.

Single-Payer Bonanza

Lax enrollment policies have been a big problem for Medicaid, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"You can make too much money, live in a state other than the one on your Medicaid card, or be dead, and still be on Medicaid," said Dean.

COVID-19 was an opportunity to enroll more people in a government health care program, says Dean.

"Expanding Medicaid to middle-class, healthy individuals during the pandemic provided the one-way door single-payer activists had long been looking for," said Dean. "Politicians, terrified of the potential price paid when these folks are 'kicked off' health care as the pandemic rules are lifted, are crying uncle.

"The 10 states who held out on expanding Medicaid will now be squeezed ever-tighter as millions of dollars flow in to expand Medicaid in those other states," said Dean.

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

INTERNET INFO

Linda Gorman, "Medicaid Expansion: Expensive, Ineffective, and Damaging to Existing Healthcare Infrastructure," Goodman Institute for Public Policy Research, March 1, 2023: **https://www.goodmaninstitute.org/wp-content/uploads/2023/03/GI-Medicaid-Expansion-3-6-23.pdf**

U.S. Senate Bill Offers Insurers More Flexibility in Chronic Illness Treatments

By Kevin Stone

A bipartisan U.S. Senate bill would allow health insurers to provide first-dollar coverage for chronic disease treatments.

The Chronic Disease Management Act of 2023 (S.655), introduced by Sens. Tom Carper (D-DE) and John Thune (R-SD), would let high-deductible health plans (HDHPs) linked to health savings accounts (HSAs) cover low-cost drugs and treatments shown to delay or reduce the onset of more-serious or secondary conditions arising from chronic illness, with no deductible.

The bill codifies and expands a 2019 guidance from the Internal Revenue Service (IRS) and U.S. Treasury in response to an executive order by then-President Donald Trump that permitted coverage of certain treatments as "preventive" and not subject to a deductible.

The guidance listed 14 specific items and services falling into that category, including insulin, beta blockers, and statins. Treatments would have to be "low-cost," backed by "medical evidence" supporting "high-cost efficiency," and have a "strong likelihood" of cost-saving.


Senator Tom Carper (D-DE)

"It looks to me like the Carper/Thune legislation builds on Trump's executive order and gives employers the kind of flexibility that once existed in South Africa. Employers aren't going to make benefits below the deductible gratis unless that satisfies a cost/benefit test."

JOHN C. GOODMAN
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'Gives Consumers ... Greater Flexibility'

The Carper-Thune bill addresses several important issues, says Daniel Perrin, president of the HSA Coalition, a group that defends HSAs against legislative, judicial, and regulatory restrictions.

"In general, any bill that gives consumers and employers greater flexibility in HSA-qualified plan design will expand the number of people who can take advantage of the triple tax break the HSA provides," said Perrin.

Payroll deductions or employer contributions to qualified HSAs are tax-free, as is any interest earned by the accounts (balances accumulate year-to-year), and withdrawals for medical expenses are tax-free, says Perrin.

"[It is] the best tax break on the books [because] they can use tax-free funds to cut their out-of-pocket costs when spending to meet their health plan deductibles," said Perrin. "The Carper/Thune bill does just that by allowing more medical goods and services to be covered below the deductible while still being an HSA-qualified health plan."

'Once Existed in South Africa'

The HSA bill closely parallels a model used to great success in South Africa before it was compromised by government interference, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"In South Africa, under [Nelson] Mandela, medical savings accounts (MSAs) emerged in a virtually free health insurance marketplace," said Goodman. "Discovery Health, the largest South African insurer at the time, sold plans that had no deductible for hospital care, on the theory that patients exercise little [spending] discretion within hospitals. Patients did have a deductible for outpatient care, where discretion is often both possible and desirable."

There was a deductible for most drugs, but the system allowed first-dollar coverage for maintenance drugs such as insulin, says Goodman.

"It makes no sense to discourage patients from taking drugs that prevent emergency room visits, hospital admissions, and more-expensive care when there is noncompliance," said Goodman.

"It looks to me like the Carper/Thune legislation builds on Trump's executive order and gives employers the kind of flexibility that once existed in South Africa," said Goodman. "Employers aren't going to make benefits below the deductible gratis unless that satisfies a cost/benefit test."

'Ideologues Will Push'

The bill doesn't have enough specifics to deter mission creep, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

"People who favor limited government tend to analyze policy and proposed laws under the presumption that once a law or policy is enacted people will try to abide by the law and carry out the law in the spirit in which it was written," said Gorman. "If we have learned anything from the last decade, it should be that this is not the case at all. Ideologues will push laws and policies to the absolute limit and beyond if they think such actions will help them achieve their ends."

Gorman says HSAs have never been a favorite of promoters of big-government health care.

"The Left has long disliked HSAs because they remove government from health care decisions," said Gorman. "One of the arguments it uses to push expanding coverage and ending individual payment is that individuals make poor health care choices and therefore 'experts' should control the amount and direction of health spending."

'Where's the Dollar Figure?'

Ambiguity in the bill's terms could lead to the inclusion of ongoing medical care for a chronic disease, a huge chunk of modern medical practice, under the umbrella of preventive care, allowing expansion and abuse of coverage without deductibles, says Gorman.

"I have no idea what 'low-cost' means," said Gorman. "Some of the drugs apparently allowed under the current rules cost thousands of dollars a year. Is that 'low-cost?' Where's the dollar figure for reference? I have absolutely no idea what 'high-cost efficiency' means. If it is something along the lines of 'bang for the buck,' the average sick person is going to have very different views of high-cost efficiency than the average university public health professor. I have no idea what 'strong likelihood' means: 65/35 chance of success? 70/30? 95/5?"

The clinical basis for deciding which chronic treatments are covered is also vague, says Gorman.

"I'm not even sure what 'medical evidence' means," said Gorman. "Rat studies? Theoretical COVID incidence models? One questionable paper? A likelihood function value of X for an unknown parameter? Randomized controlled trials, clinical observation? I guess we'll know what it is when a handpicked group tells us what it is."

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

U.S. Senate Bill Would Expand HSAs to Direct Primary Care

Sen. Bill Cassidy

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

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a physician and patient does not make the individual ineligible to contribute to an HSA, and pre-tax HSA funds may be used to pay DPC fees.

As of July 2022, there were 1,762 DPC practices in the United States, in 48 states and the District of Columbia, according to elationhealth.com. The number of DPC practices tripled during the pandemic, DPC groups report.

The Primary Care Enhancement Act (S. 628) was introduced by Sens. Bill Cassidy (R-LA), Jeanne Shaheen (D-NH), Tim Scott (R-SC), and Mark Kelly (D-AZ) on March 2. Similar legislation is expected to be introduced in the U.S. House of Representatives by Rep. Pete Sessions (R-TX).

'This Bill Empowers Patients'

HSAs were designed to allow health care consumers to choose their providers and save money in the process, said Cassidy, a medical doctor, in a press release about the bill.

"With direct primary care, patients have control over their families' health care decisions," said Cassidy. "That was the intent when creating health saving accounts. This bill empowers patients to see the doctor they trust."

The bill is a practical step toward better medical care, says Kelly.

"This is the kind of commonsense change we have to push if we want to make our health system work better for families," said Kelly.

'More Time [for] Medicine'

The bill is welcome and needed, especially given its relatively broad political support, says Phil Eskew, D.O., J.D., a family medicine physician and founder of DPC Frontier.

> **"The bill looks to level the playing field regarding the use of tax-advantaged saving modalities, such as HSAs, FSAs [flexible spending accounts], and MSAs [medical savings accounts], and could further accelerate the growth of high-quality, accessible DPC practices."**
>
> **CHAD SAVAGE, M.D.**
> **FOUNDER, YOUR CHOICE DIRECT CARE**

"I am encouraged that the Primary Care Enhancement Act has bipartisan support," said Eskew. "Earlier versions of the Act have received bipartisan support in prior legislative sessions. In fact, direct primary care is one item on a short list of health care topics that routinely does receive bipartisan support."

Lack of legislative clarity over what DPC is has affected care, says Eskew.

"Direct primary care physicians would like to be able to spend time practicing medicine," said Eskew. "At present, many DPC practices have made adjustments to our model of care that make no clinical sense, merely to reduce an IRS audit risk.

"Updating an outdated tax code so that DPC patients with health savings accounts do not face discrimination will allow all of us to spend more time talking about medicine," said Eskew.

'Level the Playing Field'

The bill would increase competition in medical markets by giving cash payments by patients the same tax advantages as health insurance, says Chad Savage, M.D., founder of Your Choice Direct Care, president of DPC Action, and a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"S. 628 is a major leap forward for direct primary care," said Savage. "DPC is already thriving despite a massively skewed playing field under which traditional insurance-based practices enjoy the advantage of indirect subsidy through insurance companies. The bill looks to level the playing field regarding the use of tax-advantaged saving modalities, such as HSAs, FSAs [flexible spending accounts], and MSAs [medical savings accounts], and could further accelerate the growth of high-quality, accessible DPC practices."

States Have Acted

More than 30 states have passed laws or regulations to clarify that DPC is not insurance but a medical service, and that shows this clarification is needed, says Mark B. Blocher, president and CEO of Christian Healthcare Centers.

"The IRS interpretation of the HSA rule which treats a DPC agreement as 'insurance' is refuted by the number of states whose legislative bodies expressly say DPC is not insurance," said Blocher. "The IRS has not treated the DPC option in good faith, choosing rather to retain rules in the tax code that prevent patients with HSAs from accessing the exceptional quality of care provided by DPC practices [that is] one reason DPCs grew by 300 percent last year."

The bill would make a big difference by clarifying that individuals with HSAs can use those funds to pay DPC fees, says Blocher.

"The HSA/DPC dilemma can easily be resolved by passing the Primary Care Enhancement Act to treat a DPC agreement as a 'qualified medical expense,' thereby directing the IRS to cease describing a DPC arrangement as a 'second health plan,'" said Blocher.

"The goal of an HSA is to incentivize individuals to seek timely preventative and acute medical care by allowing patients to use pre-tax dollars," said Blocher. "DPC is a perfect way to achieve that goal."

'I'll Drop Everything'

Republicans hold a narrow majority in the House, where the bill is likely to pass. Bipartisan support will be needed in the Senate, where Democrats are in the majority.

Cassidy's measure has two Democrat cosponsors in the Senate, and prospects for obtaining a majority look promising, as Shaheen says the bill is a priority.

"I'm glad to join this bipartisan bill that would break down barriers that patients face when seeking care," said Shaheen.

"I'll drop everything I can to reform health policies that best support patients and families," said Shaheen.

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

COMMENTARY

How Congress Can Save Medicare

By Chad Savage, M.D.

During his 2023 State of the Union address, President Joe Biden and congressional Republicans had an entertaining back-and-forth about the president's claim that Republicans wanted to "sunset" Medicare. The raucous exchange ended with both parties applauding their apparent agreement not to touch the popular program.

However, that's not possible. Medicare's coffers are running dry, and the program's trustees predict the system will run out of money by 2031. With the aging Baby Boomer demographic, the cost of Medicare continues to grow significantly, crowding out other governmental priorities. Despite the spectacle of apparent bipartisanship, reality will soon come calling.

U.S. Capitol Building

MSAs to the Rescue

Thankfully, there is a way for Congress to avert this looming disaster while upholding its promise to save Medicare. The solution lies buried in a little-used Medicare plan known as medical savings accounts (MSA).

These accounts would be like a health savings account (HSA) in that the government funds would be controlled by Medicare recipients to spend as they see fit on their own health care instead of asking permission from Medicare bureaucrats. This allows patients to engage in the 90 percent of outpatient medical care that is "shoppable" on price and quality outside of artificially restrictive insurance networks.

MSAs also functionally make normally costly "first dollar coverage" achievable. They do so by combining Medicare-funded MSAs to pay low-cost expenses with high-deductible Medicare insurance to cover high-cost medical expenses such as hospitalization. If made more widely available, MSAs would allow Medicare recipients to use their immense clout to introduce cost-constraining free-market forces into the out-of-control centrally priced health care system.

Further, with a slight revision to IRS tax code 213(d), Congress could ensure MSAs can be used for more affordable direct primary care (DPC), surgical centers, and other market-based medical providers. Like HSAs, MSAs cannot currently be used for some of these options because the IRS doesn't consider them "medical care." For example, the IRS considers DPC an insurance plan, even though it is not insurance at all. Members pay a monthly fee like a gym membership.

Revealing Hidden Prices

One of the primary reasons for the monumental cost of health care is that patients are disconnected from prices and do not believe the cost of care affects them. It affects us all—it is simply buried within a mountain of taxes, deferred wages, copayments, and premiums. This labyrinthine payment complex hides the inflated price, making high prices possible and confirming that the only way to perpetuate a falsely priced system is to obscure it and subsidize it.

The solution to false pricing is transparency combined with knowing what the prices are and having the power to do something about them. By putting power in the hands of the patient, MSAs do exactly this, empowering patients to know prices, reject mispriced services, and replace them with better, more cost-efficient service providers.

The ensuing competition will incentivize cutting administrative waste, as overly wasteful service providers will not be able to price their services profitably against more-efficient, less-bureaucratic competitors.

Freeing Medical Personnel

Ironically, streamlining is good for doctors and nurses, too, as they will be able to do more of what they love—caring for patients.

This is because financially empowered patients would rather pay for quality care instead of wasteful activities that do not contribute to their well-being. As things that are inefficient go away, patients' unwillingness to pay for bureaucracy can make providers more productive and save them from the burnout-inducing processes currently causing an exodus of professionals from health care.

Many wasteful insurer-mandated processes exist because the patient is not the payer. Insurers require massive amounts of data to justify payment and assess quality, something a consumerized patient does innately without having to charge for it. To meet this demand, staff are diverted from patient care to data entry, worsening care.

Putting Patients at the Center

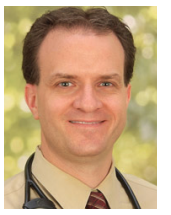
Despite appearances, medical services are designed to satisfy payers and only superficially the patient. MSAs reestablish the patient as the all-important payer instead of simply functioning as the substrate between doctors and insurers through which the financial transaction occurs.

MSAs place the patient at the center of health care, take decision-making away from administrators, and restore it to its most ethical location: between doctor and patient.

Medicare accounts for 21 percent of U.S. health care spending. Modifying who controls Medicare payments may seem inconsequential. However, what happens in Medicare spills out into the rest of the health care system. Thus, expanding Medicare MSAs would go well beyond that 21 percent and fundamentally transform American health care.

Congress has the power to enact these simple but profound changes. It should act urgently to save Medicare.

Chad Savage, M.D. (**info@d4pcfoundation.org**) *is the founder of YourChoice Direct Care in Brighton, Michigan, and president of DPC Action.* A version of this article appeared in the Washington Examiner *on March 17, 2023. Reprinted with permission.*



"Medicare accounts for 21 percent of U.S. health care spending. Modifying who controls Medicare payments may seem inconsequential. However, what happens in Medicare spills out into the rest of the health care system. Thus, expanding Medicare MSAs would go well beyond that 21 percent and fundamentally transform American health care. Congress has the power to enact these simple but profound changes. It should act urgently to save Medicare."

CHAD SAVAGE, M.D.

Medicare Will Require a Payroll Tax Hike, Trustees Report

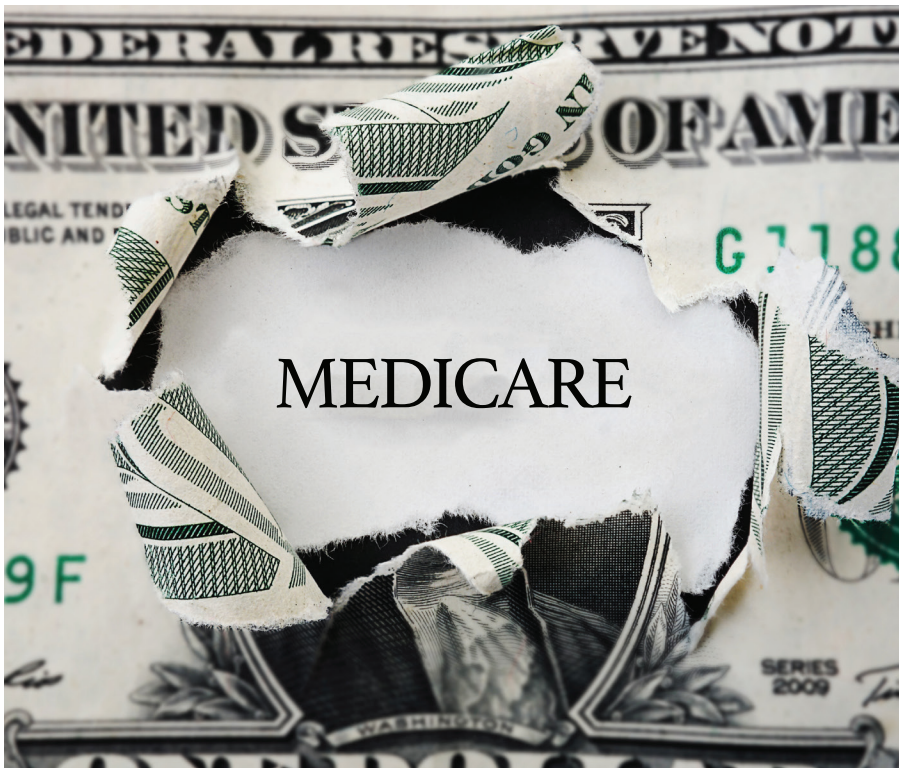
By Bonner Russell Cohen

Rising health care costs and an aging population will require Medicare benefit cuts or tax increases within a decade, the program's trustees report.

The 2023 annual report from the Board of Trustees of the Federal Hospital Insurance (HI) and Supplemental Insurance Trust Funds projects the HI Trust Fund (Medicare Part A) will be insolvent in 2031, three years later than last year's report forecast. The trustees project a 75-year shortfall in the HI Trust Fund of 0.62 to 1.46 percent of the taxes needed to fund the program.

The Trustees project total Medicare spending will grow from 3.7 percent to 6.0 percent of gross domestic product (GDP) by 2046 and remain at that level thereafter.

An alternative scenario, developed by the Medicare Chief Actuary and included in the report, projects total Medicare spending will rise to 8.3 percent of GDP by 2097, which is considerably higher than the 6.0 percent to 6.3 percent increase by 2097 forecast by the Trustees.



Tough Choices Ahead

If the HI Trust Fund is emptied in 2031, seniors will be in serious trouble, according to an analysis of the trustees' report by the Committee for a Responsible Federal Budget (CRFB).

"At that point, the law requires spending to be cut 11 percent to match revenue, with the cut growing to 19 percent by 2047," states the CRFB. "The result would likely be a reduction in health services."

Both the Trustees and the Chief Actuary conclude the shortfall in HI will require tax hikes, says the CRFB.

"Restoring solvency to the HI trust fund over the next 75 years would require the equivalent of immediately raising the HI payroll tax by 21 percent (0.6 percentage points) or reducing spending by 13 percent," states the CRFB. "Under the Chief Actuary's alternative scenario, the shortfall and necessary adjustments would require immediately raising the HI payroll tax by 50 percent (1.5 percentage points) or reducing expenditures by 26 percent."

Spending Up, Up, Up

Total Medicare spending has risen from 2.2 percent of GDP in 2000 to 3.9 percent in 2023 and will continue to grow, according to the Trustees' projections, says the CRFB.

"Specifically, the Trustees project that costs will grow further to 5.5 percent by 2035 and 6.0 percent by 2050," states the CRFB analysis. "Beyond 2050, cost growth will moderate to about the pace of GDP growth, with costs reaching a high of 6.3 percent in 2076 before gradually dipping to 6.1 percent in 2097."

Much of the growth in expenditures will come from the rising cost of Medicare Part B (outpatient care), which is expected to increase from 1.9 percent of GDP in 2023 to 3.5 percent in 2097, the Trustees state. The cost of Medicare Part A (HI) is projected to rise from 1.5 percent of GDP in 2023 to a high of 2.2 percent in 2045 before gradually leveling off to 2.0 percent in 2097.

The Inflation Reduction Act (IRA) of 2022, which allows Medicare and pharmaceutical manufacturers to negotiate prices on certain drugs, will hold down the costs of Medicare Part D (drug benefits) by limiting the rise from 0.5 percent of GDP in 2023 to 0.7 percent by 2097, according to the Trustees.

Advantage Plans Increasingly Popular

The Trustees project a growing number of seniors will enroll in Medicare Advantage (MA), or private insurance plans.

"The private Medicare health plan enrollment projections for the 2023 Trustees Report are higher than those in the 2022 report," said the Trustees. "[T]he share of Medicare enrollees in private health plans is projected to increase from 45.9 percent in 2022 to 55.9 percent in 2032."

These increases "are partly due to higher relative rebates that are used to lower premiums and expand coverage," the Trustees said.

'Budget Gimmicks'

The Biden administration on March 7 proposed extending the solvency of Medicare into the 2050s by increasing the payroll tax rate from 3.8 percent to 5 percent for households making more than $400,000 a year.

U.S. Rep. Jason Smith (R-MO), chairman of the House Ways and Means Committee, favored a different approach in an April 1 statement responding to the Trustees report.

"We need to protect and strengthen Social Security and Medicare, and the first step to accomplishing that is growing the economy—not budget gimmicks or tax increases that hold back economic growth," said Smith. "In fact, that's precisely what Americans are telling the Ways and Means Committee during our hearings throughout the country."

"Biden's proposal to raise taxes to address Medicare's future financial problem ignores how progressive Medicare taxes already are. Besides Medicare's payroll taxes—2.9 percent split between the employer and the employee and an additional 0.9 percent for those making $200,000 or more—the government forces Medicare recipients to pay higher Part B and Part D premiums based on their income."

MERRILL MATTHEWS
RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

Highly Progressive

Medicare taxes are already highly progressive, says Merrill Matthews, a resident scholar at the Institute for Policy Innovation.

"Biden's proposal to raise taxes to address Medicare's future financial problem ignores how progressive Medicare taxes already are," said Matthews. "Besides Medicare's payroll taxes—2.9 percent split between the employer and the employee and an additional 0.9 percent for those making $200,000 or more—the government forces Medicare recipients to pay higher Part B and Part D premiums based on their income."

The income-based premiums double or triple the cost of Part B for some seniors, says Matthews.

"For example, a senior with an income between $123,000 and $153,000 will pay an additional $164.80 for their monthly Part B premium, on top of the $164.90 base Part B premium," said Matthews. "If that person's income is between $183,000 and $500,000, that individual will pay $362.60 a month above the base Part B premium. Those increased premiums, based on income, are a tax, and a very progressive tax at that."

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

Can Health Care Providers Deny Care for Refusing to Sign Privacy Notice?

By AnneMarie Schieber

An advocacy group that says patients are being misinformed about their privacy rights is calling for an official clarification from the federal government.

The Citizens' Council for Health Freedom (CCHF) sent a Freedom of Information Act (FOIA) request to the Office of Civil Rights (OCR) in the U.S. Department of Health and Human Services (HHS) asking whether the OCR has ever authorized a provider to deny care to a patient for refusing to sign the form known as the "acknowledgment of receipt of the Notice of Privacy Practices."

HIPAA's 'No Privacy Rule'

Congress added privacy provisions to the Health Insurance Portability and Accountability Act (HIPAA) in 2003 designed to protect private health information. Patients are asked to sign HIPAA forms before receiving treatment.

The notices are deceptive and should be called the "no privacy rule," said Twila Brase, R.N., founder and president of CCHF, in a press release.

"Most people wrongly think signing the HIPAA form, the acknowledgment, means their medical data is held confidential, just between them and their doctor," said Brase. "But signing the acknowledgment means they have read, understood, or received a form that notifies them that they have no privacy rights over their data."

'Right to Refuse'

Signing the form allows health care practices to share private medical records with anyone. The rule requires health care practices to document a patient's refusal to sign, but the law does not require or allow the provider to deny treatment if the patient refuses to sign the document.

"Ultimately, we want HHS to issue an official statement acknowledging that patients have a right to refuse to sign the HIPAA acknowledgment statement and providers still have to treat them," said Brase.

CCHF is responding to the 20th anniversary of the HIPAA privacy rule with an informational campaign directed at patients, called "Exposing HIPAA, the Deliberate Deception," Brase told the *Heartland Daily Podcast* on March 30. "It is our intent to undo HIPAA and bring back real privacy, whether at the state or federal level," Brase said.

"We must do this because this is the only way we gain control in the exam room," Brase said. "Privacy is the foundation of freedom, and while HIPAA exists all sorts of outsiders can control what happens in the exam room."

Brase says CCHF released a video, *The Truth About HIPAA*, showing how misinformed patients are about HIPAA.

"Most people wrongly think signing the HIPAA form, the acknowledgment, means their medical data is held confidential, just between them and their doctor. But signing the acknowledgment means they have read, understood, or received a form that notifies them that they have no privacy rights over their data."

TWILA BRASE, R.N.
FOUNDER AND PRESIDENT
CITIZENS' COUNCIL FOR HEALTH FREEDOM

"You'll see people have no idea what HIPAA is and what they thought when we told them what it actually is," said Brase on the podcast.

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

Justice Dept. Charges Rite Aid with Filling Illegal Opioid Prescriptions

By Bonner Russell Cohen

The U.S. Department of Justice (DOJ) has charged the pharmacy chain Rite Aid with filling illegal prescriptions for opioids.

Rite Aid drug stores filled "hundreds of thousands" of illegal prescriptions between May 2014 and June 2019, said Associate Attorney General Vanita Gupta in a press release on March 13.

"We allege that Rite Aid filled hundreds of thousands of prescriptions that did not meet legal requirements," said Gupta. "Rite Aid's pharmacists repeatedly filled prescriptions for controlled substances with obvious red flags, and Rite Aid intentionally deleted internal notes about suspicious prescribers. These practices opened the floodgates for millions of opioid pills and other controlled substances to flow illegally out of Rite Aid's stores."

'Looking for Scapegoats'

The press release describes the prescriptions as having "no legitimate medical purpose" and as not being issued "in the usual course of professional practice."

The DOJ claims the chain was

alerted to the illegal prescriptions by distributors, pharmacists, and its own data and deleted those notes from its internal system. The department says Rite Aid's actions violated the Controlled Substances Act and, by billing Medicare and Medicaid for the drugs, the False Claims Act.

The government is blaming others for the failure of U.S. drug policies, says Jeffrey A. Singer, M.D., a senior fellow at the Cato Institute.

"The DOJ is still looking for scapegoats for the futile and failed war on drugs," said Singer. "When overdoses in the 1980s and early 1990s were associated with minority or marginalized groups, the drug warriors blamed it on them: they made bad choices. When overdoses grew to include white, middle-class people, they blamed it on pharmaceutical companies, pharmacies, and doctors. Now, they are blaming it on the border.

"They refuse to put the blame where it belongs: on drug prohibition," said Singer.

'Lure of Easy Money'

Drug users have increasingly turned to riskier street drugs as the federal government doubled down on prohibition, Singer wrote in an analysis published by the Cato Institute on November 29, 2022.

"Doctors, pharmacists, and drug makers did not create a generation of zombie-like drug addicts," wrote Singer. "There has been a growing population of non-medical drug users—recreationally or otherwise—and when doctors were prescribing opioids more liberally, [those users] preferred to use diverted prescription pain pills, a wiser choice than street drugs. When the sources of prescription pain pills dried up, they moved first to heroin and now to fentanyl."

Television series like *Dopesick* paint an unrealistic picture of the illegal drug market, Singer told *Health Care News*.

"While there were undoubtedly nefarious doctors and pharmacists who used their practices as a cover for drug-dealing operations—aka 'pill mills'—they were exceptions to the rule," said Singer. "And they were incentivized to do so by the lure of easy money that the drug prohibition created for them."

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

FDA Considers 'Gender-Inclusive' Blood Donor Rule

By Ashley Bateman

The Food and Drug Administration (FDA) proposes changing blood donor eligibility guidelines to include more gay men.

The new FDA guidance to donation centers would use "gender-inclusive, individual risk-based questions" to replace the waiting period before a man who has had sex with a man, or a woman has had sex with a gay man, can give blood.

The current donor history questionnaire would be revised to ask all prospective donors if they have had sex with new or multiple partners in the past three months and if so, whether that included anal sex. Blood donations from individuals who answer those questions affirmatively would be deferred for three months.

"I strongly object to 'inclusivity' statements. Inclusivity is not an analysis. The analysis should be strictly scientific and empirically based on the need for blood and the risk. Blood is red; it doesn't matter who it's coming from. It's strictly a question of the risk and need for the blood. The vast majority of people who are recipients of blood or blood products don't want to run the risk of HIV."

ROGER KLEIN M.D., J.D.
EXPERT ON MOLECULAR PATHOLOGY

'Deferred Permanently'

In the 1980s, during the AIDS (Acquired Immune Deficiency Syndrome) epidemic, the FDA banned any man who had ever had sex with a man from donating, to reduce transfusion-transmitted infections with the Human Immunodeficiency Virus (HIV).

In 2015, the ban was replaced by a one-year waiting period, and during the COVID-19 pandemic the deferral was reduced to three months.

The new guidance would not change other HIV-related waiting periods or bans, the FDA stated in a press release on January 27.

"No change in the donor deferral time periods for other HIV risk factors, including for individuals who have exchanged sex for money or drugs or have a history of non-prescription injection drug use," states the FDA press release. "Any individual who has ever had a positive test for HIV or who has taken any medication to treat HIV infection would continue to be deferred permanently."

Most developed countries defer donors at high risk for carrying HIV and developing AIDS, which is highly fatal despite the availability of therapies.

Prepping for Unsafe Sex

Blood donations from those taking oral medications to prevent HIV infection—pre-exposure prophylaxis (PrEP) or post-exposure prophylaxis (PEP)—would be deferred for three months from their most recent dose, under the guidance.

Blood banks would still be required to test all blood donations for certain transfusion-transmitted infections, including HIV, hepatitis B, and hepatitis C.

"Maintaining a safe and adequate supply of blood and blood products in the U.S. is paramount for the FDA, and this proposal for an individual risk assessment, regardless of gender or sexual orientation, will enable us to continue using the best science to do so," stated FDA Commissioner Robert Califf in the news release.

The American Red Cross, the Association for the Advancement of Blood and Biotherapies, the American Medical Association, and gay rights activists have stated their support for the rule change.

Risk v. Inclusion

The new FDA guidance appears to prioritize expanding the pool of blood donors over the safety of the blood supply, says Roger Klein M.D., J.D, an expert in molecular pathology and medical and legal advisor to various organizations including The Heartland Institute, which publishes *Health Care News*.

"I strongly object to 'inclusivity' statements," said Klein. "Inclusivity is not an analysis. The analysis should be strictly scientific and empirically based on the need for blood and the risk. Blood is red; it doesn't matter who it's coming from. It's strictly a question of the risk and need for the blood. The vast majority of people who are recipients of blood or blood products don't want to run the risk of HIV."

'Donated Anyway'

Current tests for HIV cannot overcome the nine-day period during which the infection can be undetectable but be transmitted to a recipient, wrote Richard Kaufman in the journal *Blood* in September 2020.

"In these rare cases, an individual donates soon after getting infected with HIV, when the viral RNA load is still very low and before specific antibody is detectable," wrote Kaufman. "The screening tests result as negative, and the donated unit may infect a transfusion recipient."

In addition, antiretroviral therapy (ART) may suppress HIV to undetectable levels, a study found, says Kaufman.

"What they found was sobering," wrote Kaufman. "The investigators obtained blood samples from 299 HIV-positive donors and 300 control donors with nonreactive screening tests. ... Evidence for ART was found in 46 samples from the HIV-positive donors (15.4%), but in zero control samples. It would appear that a number of blood donors knew that they had HIV but donated anyway."

'Higher Risk Group'

Blood testing can give a false sense of safety, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and a Heartland Institute policy advisor.

"Like all diagnostic tests, HIV tests have false negatives," said Orient. "Plus, it takes time for an infected person to seroconvert. Thus, FDA is willing to put patients' lives at risk to avoid hurting people's feelings. It's a simple fact that gay men are at higher risk of STDs [sexually transmitted diseases]."

Safety protocols should not be changed for social reasons, says Klein.

"What's most important is that such decisions not be made on a political basis," said Klein. "We need to worry about the patient and recipient. There's no question that men having sex with men would be a higher risk group of donors."

The 60-day comment period for the proposed rule change ended March 31. After reviewing the comments, the FDA could issue the new guidance at any time.

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

‘Stark’ Decline in Female Students’ Mental Health Reported

By Ashley Bateman

Mental health declined and harmful behaviors rose during the COVID-19 pandemic, especially among female high school students, a federal government report states.

The nationwide “Youth Risk Behavior Study” from the Centers for Disease Control and Prevention (CDC) found 60 percent of female students suffer from mental health problems and many experience sexual violence, substance abuse, and suicidal tendencies at higher rates than their male peers.

“Across almost all measures of substance use, experiences of violence, mental health, and suicidal thoughts and behaviors, female students are faring more poorly than male students,” states the report. “These differences, and the rates at which female students are reporting such negative experiences, are stark.”

“I resonate with the results of the survey because in the past three years I have seen high levels of emotional distress in the young adults in my clinical practice, and they tell me their peers are highly stressed nowadays.”

ROBERT S. EMMONS, M.D.

First Covid-Era Stats

The study by the CDC’s Division of Adolescent and School Health (DASH), conducted every two years, presents risk behavior data from a nationally representative sample of U.S. high school students.

Tracking 10 years from 2010 to fall 2021, this is the first report of the series that includes data since the onset of the COVID-19 pandemic and school shutdowns.

Rates of most mental health markers in the report—including unprotected sexual behaviors, violence, and suicidal thoughts—significantly increased in recent years. Nearly 25 percent of female students made suicide plans in the year leading up to 2021. That same year, 57 percent of female high school students reportedly “felt so sad or hopeless almost every day for at least two weeks in a row that they stopped doing their usual activities,” a nearly 20 percent increase since 2011.

More females than males made a suicide plan, attempted suicide, or were injured in a suicide attempt in 2021, the report states. More female students than males avoided school because of fear of violence or reported being bullied, raped, or sexually violated. In 2021, nearly 20 percent of female high schoolers experienced sexual violence.

Females also used alcohol, marijuana, and illicit drugs more than their male peers and misused opioids at a higher rate.

Isolation, Stress Factors

A psychiatrist in private practice, Robert S. Emmons, M.D., a policy advisor to The Heartland Institute, which co-publishes *Health Care News*, says he has had a historically high influx of young adult patients in recent years.

“I resonate with the results of the survey because in the past three years I have seen high levels of emotional distress in the young adults in my clinical practice, and they tell me their peers are highly stressed nowadays,” said Emmons.

Social isolation made worse by some public health interventions can lead to despair, Emmons told *Health Care News*. Emmons says he encourages his patients to avoid social media and political news and meet with people face to face.

“My young female patients can contemplate their relationships with men in ways that are more nuanced and complex than the caricatures of what men and women think about each other that appear in media,” said Emmons. “Media reporting makes people appear more ideological and intolerant than they actually are in their private minds.”

Loss of Key Connections

School closures over the past two years exacerbated challenges many teenagers face, says Virginia Gentles, director of the Education Freedom Center at the Independent Women’s Forum.

“The report indicates that school connectedness, or feeling close to people at school, provides a protective impact for adolescents, yet public schools in the country closed for months during the COVID era and shut students out of the athletic and artistic programs and extracurricular activities that connect students to each other and their schools,” said Gentles. “School closures, including extended labor union strikes, must never happen again.”

Gentles says the report misses the mark when it recommends classroom-style activities such as safe places and the “Gender-Sexuality Alliance” instead of encouraging students to develop hobbies, skills, and relationships.

“The report authors do not consider the possibility that a student’s mood and connectedness to peers and school could increase more while learning to dance, sing, and act in a school musical, for example, than while sitting in a classroom discussing gender and sexual identities week after week,” said Gentles.

Concerns About Social Media

Emmons says social media have a pervasive, negative influence on his patients.

“As a clinician, I can only intervene one mind or one family system at a time, and these methods have worked for my patients to promote personal wellness,” said Emmons. “In all my years of publicly advocating for the best interests of my patients, I have found that I cannot move systems [social media] that are not aligned with those interests.”

There is plenty of evidence the overuse of technology is dangerous, says Gentles.

“The nation should start taking the investigative reports into how social media harms young women seriously,” said Gentles. “It is irresponsible of policymakers to not investigate further the harms of social media.”

Creation of ‘Cognitive Distortions’

Reflecting on the CDC report in Substack on March 9, Jonathan Haidt, author of *The Happiness Hypothesis*, wrote “cognitive distortions” in today’s political discourse are harming young women.

“Many young people had suddenly—around 2013—embraced three great untruths,” wrote Haidt. “They came to believe that they were fragile and would be harmed by books, speakers, and words, which they learned were forms of violence (Great Untruth #1). They came to believe that their emotions—especially their anxieties—were reliable guides to reality (Great Untruth #2). They came to see society as comprised of victims and oppressors—good people and bad people (Great Untruth #3).”

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

INTERVIEW

Pandemic Policy Critic Fights Multiple Attacks on His Medical License

Scott Jensen, M.D., is a family physician who has practiced medicine for nearly 40 years and served as a Minnesota state senator from 2017 to 2021. Jensen ran unsuccessfully for governor in 2022. In the last three years, Jensen has had to defend his medical license five times before the Minnesota Board of Medical Practice against complaints that were eventually rejected, most recently on January 30. Jensen was a vocal critic of COVID-19 death reporting guidelines, financial incentives to hospitals for diagnosing COVID-19, and putting patients on ventilators.

***Health Care News*:** Can you give us some background on your medical career and how you ended up getting into politics?

Jensen: I grew up in a small town in southern Minnesota, was valedictorian, went to the University of Minnesota, and took a roundabout way to become a physician. I first went to dental school, then the seminary, then medicine.

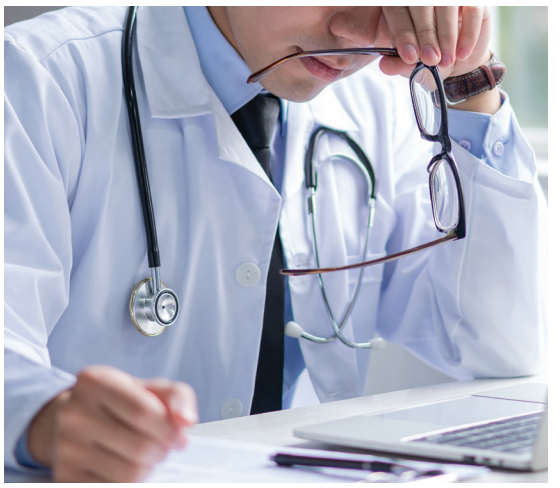
My wife is a veterinarian. I'm a family doc. Our two daughters are physicians, and my son is a lawyer. Twenty years ago, I opened my own clinic and now we have two, [with] seven providers, and one of my daughters practices with me.

In 2015, someone asked me if I wanted to run for the state Senate. I was flattered and said, "No, thank you." But we talked to more folks, thought more about it, and I decided to make a run for it. I ended up getting more votes than any other Republican senator in the state of Minnesota in the 2016 election, and I served for four years.

***Health Care News*:** What had been your experience in the legislature, which coincided with the start of the pandemic in 2020?

Jensen: I had no idea that I'd be playing a role as a whistleblower. I was alerted to the death certificates because I got a notification, as a doctor, telling me if I thought COVID was a contributing cause of death, to use it as the cause of death. I thought this was wrong because it may not be the precipitating event to someone's demise.

We had never done this before. It would also corrupt the data because it creates the impression, for example, that heart disease was dropping because now a large percentage of the deaths were being attributed to COVID.



I made a comment about the death reporting on a news program, and then it got picked up nationally. I also started looking into the CARES Act [the Coronavirus Aid, Relief, and Economic Security Act, enacted in March 2020], and did some checking, started calling hospitals and asking what they were getting for various diagnoses—standard pneumonia, pneumonia with COVID, and COVID [with] pneumonia on a ventilator—and reported the numbers, $5,000, $13,500, $39,000.

I never felt like I was doing anything renegade, but the information just kept getting picked up.

***Health Care News*:** This seems to coincide with the attacks on your medical license.

Jensen: Two months after speaking publicly about the COVID reporting policies, I was informed my medical license was being investigated, for the first time in my career.

They told me two allegations were submitted, alleging I was promoting conspiracy theories and providing reckless medical advice. Apparently, I compared influenza to COVID, which even [Anthony] Fauci was doing. I responded, and a month later I was told the allegations had been dismissed.

A month later, I was informed of another investigation. Same thing. There was a third investigation, and this time, they didn't even bother contacting me. I just got a letter informing me the Board [had] dismissed the allegations. There was a fourth investigation and a fifth one. By this time, I made the decision to run for governor because I was so frustrated with what the country was doing and Minnesota with the lockdowns.

The fifth time, my response wasn't good enough, and they asked for patient charts. I got the charts, redacted them, and sent them in. I got a letter in January 2022 saying they received the data, and then that was it. For the next 12 months, there was no communication.

Normally they would take care of this in a few months. I emailed them and said I hadn't heard anything and wondered if I was going to get myself in more hot water if I treat with ivermectin or hydroxychloroquine or recommended Vitamin D, quercetin, anything. The Board said it had no standard of care but if there was another complaint, they'd investigate.

We finished up the campaign for governor and lost in November, but two months passed and lo and behold, the fifth complaint was resurrected. The board told me there were more allegations. So now I'm facing the sixth investigation. This time they wanted a face-to-face conference. I realized I needed a lawyer. We had a hearing for 90 minutes. The board dismissed all the allegations, and I was gratified.

"Activists are weaponizing regulatory agencies to control the narrative. If this could happen to me, it could happen to anyone with a license. I've been very lucky. I've had a Marcus Welby kind of career, and for me to be investigated six times simply because I questioned public policies that didn't work, is astounding."

SCOTT JENSEN, M.D.

***Health Care News*:** How did this weigh on you professionally and financially, and do you think this will be the last of it?

Jensen: It's been a tremendous amount of time. I tabulated it, and it is probably 2,000 [hours] over the last three years. It cost me time away from patients, and now I have legal fees.

I think they'll come back. I will probably now have to have a lawyer working with me on a regular basis.

Activists are weaponizing regulatory agencies to control the narrative. If this could happen to me, it could happen to anyone with a license. I've been very lucky. I've had a Marcus Welby kind of career, and for me to be investigated six times simply because I questioned public policies that didn't work, is astounding.

COMMENTARY

Why Are There Drug Shortages?

By John C. Goodman

Jenny Morrill, a Kingston, New York mother and former arts administrator, had battled ovarian cancer since 2007 when she went for her chemotherapy treatment in June 2011 and the nurse greeted her with good news and bad news.

The good news: she was responding well to the drug Doxil. The bad news: the hospital had no more Doxil to give her.

Morrill was not alone. By November 2011, the plant that produced the drug shut down, leaving 7,000 U.S. patients without access to its lifesaving properties.

Doxil is not the only drug patients have faced trouble getting. The problem has been escalating for many years. Some patients have died as a result. Others are trying to get by on inferior substitute therapies.

Nearly all the 30 most frequently used emergency department drugs experienced shortages from 2006 to 2019, exacerbating patient harm due to the time-sensitive nature of acute care.

Regulations not only slow production at particular facilities but also make it difficult for competitors to take up the slack. If a shortage develops because the FDA shuts down a competitor's plant, for example, a manufacturer must seek FDA approval to increase output and alter its production timetable. This slows down adjustments in production.

Generic Drugs in Short Supply

Today, there are shortages of 186 to 308 drugs.

Shortages in 2022 included saline solutions potentially needed by almost every patient admitted to a hospital. Almost all the drugs in short supply, by the way, are generics.

The American Hospital Association reported in 2011 virtually every community hospital it surveyed had experienced a drug shortage in the previous six months. Two-thirds of hospitals had experienced a shortage of cancer drugs, 88 percent were short on pain medications, and 95 percent lacked anesthesia drugs needed for surgery.

Hospitals respond in a variety of ways, including delaying treatment, giving patients less-effective drugs, and providing a different course of treatment than the one recommended. About 82 percent of hospitals surveyed reported at least occasionally delaying treatment because a drug was in short supply.

Regulations Limit Production

According to Ezekiel Emanuel (who in addition to being a White House adviser was also an oncologist), only about 10 percent of shortages in 2011 were caused by a lack of raw materials needed to manufacture the drugs. A more important source of the problem is government policy.

The Food and Drug Administration (FDA) attempts to ensure drug manufacturing processes and facilities meet its quality standards, by enforcing a zero-tolerance policy with fines and by requiring manufacturers to retool both domestic and foreign facilities.

The FDA uses a pass-fail system that does not reward companies that exceed minimum required standards nor account for whether a facility is using best practices to anticipate and minimize the occurrence of production problems.

Regulations not only slow production at particular facilities but also make it difficult for competitors to take up the slack. If a shortage develops because the FDA shuts down a competitor's plant, for example, a manufacturer must seek FDA approval to increase output and alter its production timetable. This slows down adjustments in production.

Medicare Part B Price Controls

Some drugs administered by physicians—such as chemotherapy drugs or anesthesia during surgery—are paid for through Medicare Part B.

Government price controls prevent the prices of these drugs from adjusting in response to shortages, increases in manufacturing costs, or rises in demand. Normally, the market price of a product rises when it is in short supply, attracting competing manufacturers. However, Medicare discourages this response.

Medicare Part B allows health care providers, such as doctors and hospitals, to charge a small percentage of the drug's "average selling price" to cover the cost of administering the drug. However, that "average selling price" is calculated across all manufacturers and is based on historical prices.

So if one manufacturer sees a shortage developing, that manufacturer can legally raise the price of its drug. But since the health care providers that buy it will purchase it at a loss, they won't want to buy it. As a result, the shortage won't be averted.

Competing Only on Price

Regulations also limit the ability of drug makers to communicate improvements in safety, reliability, or efficacy to potential customers. These regulations remove the economic incentives to solve problems the way they would be solved in any normal market. As a result of these and other regulations, firms cannot recoup investments.

At the same time, the pharmacists who fill the prescriptions are implicitly or explicitly required to fill them with the lowest-price generic. The result: there is no competition on any other product feature other than price.

When buyers and sellers are forced to compete on price alone, there will be a race to the bottom on every other product dimension.

Contrast what happens in the market for regulated generics with what happens in the largely unregulated market for aspirin. Because aspirin is sold directly to consumers (rather than through a pharmacist middleman), there can be different prices for different brands and producer reputation matters to many consumers.

I can't remember when there has been a shortage of aspirin or any other over-the-counter pain-relief drug.

340B Price Controls

The federal 340B drug rebate program also contributes to shortages. This program allows hospitals and clinics treating low-income and uninsured patients to dispense drugs purchased at a discount from drug manufacturers but still receive reimbursement from the federal government at full prices.

Hospitals and clinics have gained from these discounts: $6 billion in 2015 alone. But there appears to be no gain for either patients or taxpayers.

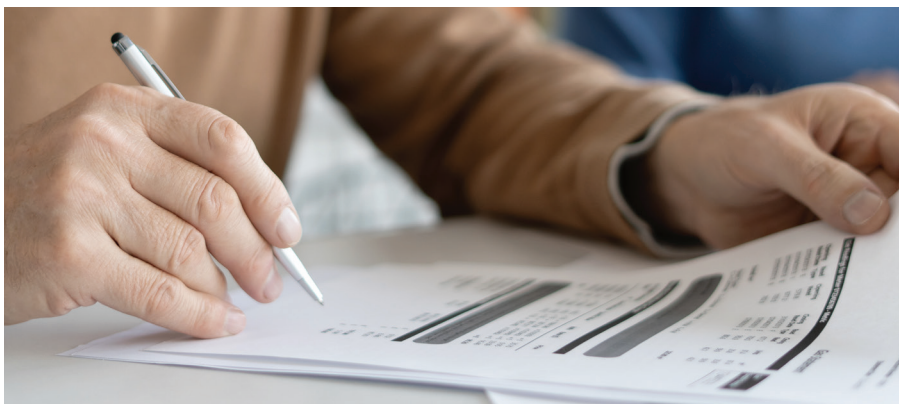
John C. Goodman, Ph.D. (**johngoodman@goodmaninstitute.org**) *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *This article is adapted from Goodman's testimony before the U.S. Senate Committee on Homeland Security and Government Affairs on March 22, 2023.*

Tax Exclusion for Employer-Sponsored Health Insurance Questioned

By Bonner Russell Cohen

Health care policy experts criticized the federal tax exclusion for employee health benefits from a variety of perspectives at a national policy conference.

Panelists addressed the question, "Should Congress End the Tax Exclusion for Employer-Sponsored Health Insurance?" at a Cato Institute policy forum in Washington, D.C., on March 31.



Employers in Charge

The exclusion of employer-provided health insurance from federal income and payroll taxes saved workers $352 billion in additional taxes in 2022, said Michael F. Cannon, director of Health Policy Studies at the Cato Institute, at the conference.

Including employee contributions, these health plans control $1.3 trillion in workers' income, said Cannon.

"If we got rid of the exclusion, what would happen to the $1.3 trillion [currently] denied [to] workers? They would make their own health care decisions," said Cannon. "They would have more control over their incomes, transferring control from employers to employees and allowing them to purchase health insurance tax-free. They could still stay in employer-provided plans if they choose to do so."

The tax exclusion for health benefits is the source of multiple problems in health care, including rising prices and coverage gaps, Cannon told the audience.

"It has caused or contributed to every problem in the health care system. … It is the most damaging thing the federal government has done in health care," said Cannon.

'Leads to Job Lock'

Employment-based health coverage reduces workers' job mobility, said Brian Blase, president of the Paragon Health Institute, who moderated the panel discussion.

"The federal government does not tax health coverage," said Blase. "About half of all Americans receive their health care through their employer. … This leads to job lock, in which people stay in their jobs because they fear they will lose their health care."

Employees do not benefit equally from the tax exclusion, said Cannon.

"The exclusion is regressive, with people of higher incomes benefitting more from the tax break than low-income wage-earners," said Cannon.

Options for Reform Offered

Blase said the options for reforming the tax exclusion or eliminating it altogether include replacing it with a standard deduction, for which premiums up to a certain amount wouldn't be subject to taxation, or a uniform refundable tax credit for health insurance which could be adjusted based on age and/or income and offered as a rebate to lower-income households.

The third option, favored by Cannon, is a "large" health savings account (HSA) in which the employer would put the money it would otherwise spend on health insurance. This would be a tax-advantaged account that the employee would control. The employee could purchase the employer plan or seek other health coverage options.

A May 2022 study by Cannon suggests the tax-advantaged amount would have to be capped to be revenue-neutral and should remove the insurance requirement currently in place for HSAs "so that taxpayers can pair an HSA with any type of coverage."

HSAs have broad political support and the average amount spent by employers on health premiums each year is $16,253, Cannon notes in his study.

'Gold-Plated Plans'

The tax exclusion as it stands now encourages overly generous coverage, says Amy Finkelstein, an economics professor at the Massachusetts Institute of Technology.

"[W]orkers are getting health insurance at less than cost," said Finkelstein. "People on the margins would rather have the extra cash. If the exclusion were eliminated, there would be fewer gold-plated plans."

Separating the issue of eliminating the tax exclusion from that of employer-provided health insurance is critical, Finkelstein told the audience.

"You can support employer-provided health insurance, which I do, and still oppose the exclusion," said Finkelstein.

Employer Inertia

Many employers continue to support the exclusion because it gives them more power, said Richard Hinz, a senior advisor to the American Benefits Council, a group representing corporate employers.

"Employers support it for reasons of inertia," said Hinz. "There is a benefit from the standpoint of the business. Employers want to bind the employees to the firm. They are benefitting from their workers' ties to the firm. If the exclusion went away, where would employees go for their health insurance? It would be the Wild West."

Employees also benefit from the purchasing power employer-provided health care gives them, said Hinz. "Acting as agents, businesses have real leverage in the marketplace to negotiate better coverage," said Hinz.

'Somebody Will Have to Pay'

The Affordable Care Act (ACA) is another alternative, said Jason Furman, chairman of the Council of Economic Advisers during the administration of President Barack Obama and an economics professor at Harvard University.

"The ACA provides an affordable option," said Furman. There was less "employer drop"—employers terminating health coverage after enactment of the ACA—than the Congressional Budget Office (CBO) had projected, said Furman.

As for allowing people to buy health insurance with pre-tax dollars, Finkelstein says there must be a limit.

"I don't think we should be privileging health insurance on the margin," said Finkelstein.

"You have to close the budget somewhere, because if we're making health insurance tax-free, that is going to come out of somebody's wages," said Finkelstein.

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

"If we got rid of the exclusion, what would happen to the $1.3 trillion [currently] denied [to] workers? They would make their own health care decisions. They would have more control over their incomes, transferring control from employers to employees and allowing them to purchase health insurance tax-free. They could still stay in employer-provided plans if they choose to do so."

MICHAEL F. CANNON
DIRECTOR OF HEALTH POLICY STUDIES
CATO INSTITUTE

INTERNET INFO

"Should Congress End the Tax Exclusion for Employer-Sponsored Health Insurance?" Cato Institute Policy Forum, March 31, 2023: **https://www.cato.org/events/should-congress-end-tax-exclusion-employer-sponsored-health-insurance**

Children Face Life-Long Costs for School Shutdowns

Prolonged school closures during the COVID-19 pandemic will have long-term costs for students, a new study says.

The children who lost years of learning during COVID-19 shutdowns face a 16.6 percent loss of the wealth they were projected to accumulate by 2040, and 10.9 percent of the labor income they otherwise would have earned, according to an analysis published by the Committee to Unleash Prosperity (CTUP) on April 2. The estimated costs will rise throughout their work life and amount to trillions of dollars in losses, the study states. (See table.)

The losses aren't just financial, CTUP President Phil Kerpen told *Health Care News*.

"After three years it's clear school closures had literally zero health benefit—nearly 100 percent of kids got COVID anyway—but massive educational, social, developmental, mental health, and economic harms," said Kerpen. "All of this was not just predictable but predicted, and the mistake of extended school closures should never be allowed to happen again."

Despite calls from federal health officials in 2020 to reopen schools, teachers unions demanded prolonged shutdowns, Kerpen and CTUP cofounder Stephen Moore wrote in the *New York Post* on April 2.

"The teachers unions played a major and inexcusable role in keeping schools locked down," wrote Kerpen and Moore. "What is maddening is that closing public schools was entirely unnecessary from a health standpoint. After relatively brief closures, almost all private schools reopened with no negative health impact."

—*Staff reports*

Mandates Had No Impact on COVID-19 Deaths, *Lancet* Study Finds

By AnneMarie Schieber

COVID-19 policy measures had no significant effect in reducing deaths from the virus, a new study reports.

The authors of the study, published in *The Lancet* on March 23, examined the impact of a variety of factors on infection and death rates. The researchers considered mask and vaccine mandates for schools and state employees, stay-at-home orders, gathering restrictions, and the closure of gyms, pools, bars, restaurants, schools, colleges, and universities.

"Mandate propensity (a summary measure that captures a state's use of physical distancing and mask mandates) was associated with a statistically significant and meaningfully large reduction in the cumulative infection rate, but not the cumulative death rate," write a team of scientists and analysts in "Assessing COVID-19 pandemic policies and behaviours and their economic and educational trade-offs across US states from Jan 1, 2020, to July 31, 2022: an observational analysis."

Missing the Point

The study seems to bury its most significant finding, says Robert E. Moffit, Ph.D., a senior research fellow in the Center for Health and Welfare Policy at The Heritage Foundation.

"Perhaps the most intriguing finding in the latest *Lancet* study is that a state's propensity to mandate physical distancing and masks was associated with a reduction in 'the cumulative infection rate' but not 'the cumulative death rate,'" said Moffit. "That finding is broadly consistent with previous academic research."

Moffit notes a report making just that point was released by the Johns Hopkins Institute for Applied Economics in January 2022.

"Undertaking a comprehensive literature review, an international research team found that government mandates, including lockdowns and shelter-in-place orders, had little or no effect on COVID-19 mortality," said Moffit.

Focus on Pandemic Politics

The Lancet study, supported in part by the Bill & Melinda Gates Foundation, attempts to connect COVID deaths to socioeconomic factors such as education, poverty, and politics.

"The USA struggled in responding to the COVID-19 pandemic, but not all states struggled equally," write the authors. A "larger proportion of the population who voted for the 2020 Republican presidential candidate was significantly associated with a higher cumulative death rate," the study states.

Death Rates and Demographics

The differences between states' COVID-19 death rates can be explained by demographics, says Moffitt.

"While the study found states that voted Republican in the 2020 election had, on average, higher mortality, it is worth noting that red states are far more rural, and rural America is older."

The study shows how the discussion of COVID-19 has been contaminated by politics, says Moffitt.

"Unfortunately, America's response to the pandemic has been poisoned by overt politicization," said Moffitt. "Unfortunately, the *Lancet* study is unlikely to provide an antidote."

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

Percent Change in Labor Income and Wealth for Current Primary and Secondary School Students Due to Learning Loss from School Closures

Group	Labor Income			Wealth		
	2030	2040	2050	2030	2040	2050
Disadvantaged primary schoolers	-	-10.6	-10.9	-	-16.6	-15.2
Disadvantaged secondary schoolers	-8.2	-7.6	-8.2	-12.2	-11.2	-11.2
Non-disadvantaged primary schoolers	-	-10.0	-10.7	-	-15.8	-14.4
Non-disadvantaged secondary schoolers	-7.3	-7.3	-8.1	-11.3	-10.4	-10.7

Source: Committee to Unleash Prosperity, April 4, 2023.

COMMENTARY

Bill Gates' Pandemic Playbook: Wash, Rinse, Repeat

By Jeffrey A. Tucker

An epic disaster like the COVID-19 response, one might suppose, should inspire some humility and rethinking about how the public health establishment could have gone so wrong. They had their run at it, but created a global disaster for the ages.

This is more than obvious to any competent observer. The next step might be to see if there are any places where matters went rather well, and Sweden comes first to mind. The educational losses were nonexistent because they didn't close schools. In general, life went on as normal and with very good results.

One might suppose the Swedish way would be vindicated. Sadly, our leaders care nothing for evidence, apparently. Their concern is for power and money at any cost. As a result, we are witnessing a concerted effort not only to double down on errors the next time but make them even worse.

Two exhibits emerged in mainstream media publications recently. The first is an opinion article in *The Wall Street Journal* on March 17, 2023, by Tom Frieden, former head of the Centers for Disease Control and Prevention, titled "What Worked Against Covid: Masks, Closures and Vaccines."

The commentary by Frieden is so infuriating it is frustrating to write a response. His conclusion is baked into the prose, peppered with a flurry of links to other studies in case you doubt his veracity, but he carefully avoids the huge numbers of studies on masks, lockdowns, and vaccines that show otherwise.

Bill Gates

PHOTO COURTESY KUHLMANN/MSC/WIKICOMMONS

Gates deploys his privileged place at *The New York Times* to agitate once again for a Global Health Emergency Corps, ensconced at the World Health Organization (WHO) and managed by the same people who created the pandemic response this time around. Keep in mind that Gates isn't just another bloke writing an op ed; he is de facto owner of the WHO, so his push for a permanent pandemic bureaucracy carries a lot of weight.

Putting WHO in Charge

The second is a column in *The New York Times* on March 19, 2021 by Bill Gates, titled "I Worry We're Making the Same Mistakes Again."

Gates deploys his privileged place at *The New York Times* to agitate once again for a Global Health Emergency Corps, ensconced at the World Health Organization (WHO) and managed by the same people who created the pandemic response this time around. Keep in mind that Gates isn't just another bloke writing an op ed; he is de facto owner of the WHO, so his push for a permanent pandemic bureaucracy carries a lot of weight.

Gates' dream bureaucracy would override national sovereignty to make sure that never again would there be another Sweden.

"It's difficult for any one country to stop a disease from spreading on its own," wrote Gates. "Many of the most meaningful actions require coordination from the highest levels of government."

Learning Nothing

Gates has learned nothing from the last mess he created, and he is completely shameless about it.

In his view, the only problem is that we didn't lock down fast enough, get vaccines out fast enough, and conduct enough research ahead of time to craft the perfect vaccine. And yes, this necessarily requires gain-of-function research.

In Gates's view, we need to have researchers continue to fiddle around in labs with tricks that anticipate pathogens of the future, again raising the risk of lab leaks that then necessitate fixes that can only be produced and distributed by the pharmaceutical companies in which Gates has such heavy investments.

As a result, we have this hellish loop in play: gain-of-function research to anticipate the next pathogen by creating it—thus risking a lab leak that has to be fixed by the vaccines themselves. But the world has to lock down until the shots can be put into billions of arms.

Wiping Disks, People

The model is always the same, and it is taken from the world of computer science.

There is a clean hard drive, analogized to the human body or whole societies. They are working fine, but then an exogenous threat comes along in the form of malware. To defeat it, we need software that is updated. You clearly should not turn on your computer until you can get the hard drive cleaned up.

Gates's understanding of viruses is no more sophisticated than that. He is repeating ridiculous lines from his TED Talks of years ago. Gates finds it inconceivable the best strategy for healthy people is to meet the virus and train the immune system.

Lost on Gates is the natural epidemiological dynamics of pathogenic spread. The more deadly they are, the less likely they are to spread. And the reverse is also true: the more prevalent they are, like COVID-19, the less severe they are. The reason is simple: a pathogen needs a living host.

Speaking for Power

The reason Gates has so much influence over pandemic policy is, simply, his money. It is shocking how his money alone managed to buy the silence of scientists the world over. Scientists have shown themselves to be appallingly obsequious and deferential to the crankism Gates has peddled for decades.

There is a reason to be deeply alarmed by these two articles. The authors speak for some of the world's most powerful people. They are explaining exactly what they want to do. They are completely impervious to evidence. And they reveal every ambition to override, reverse, and effectively abolish everything once known as freedom.

Jeffrey A. Tucker (**jeffrey.a.tucker@gmail.com**) *is the founder and president of the Brownstone Institute. A version of this article was published by* The Epoch Times *on March 21, 2023. Reprinted with permission.*

More Pilots Require Urgent Care in the Cockpit

By Harry Painter

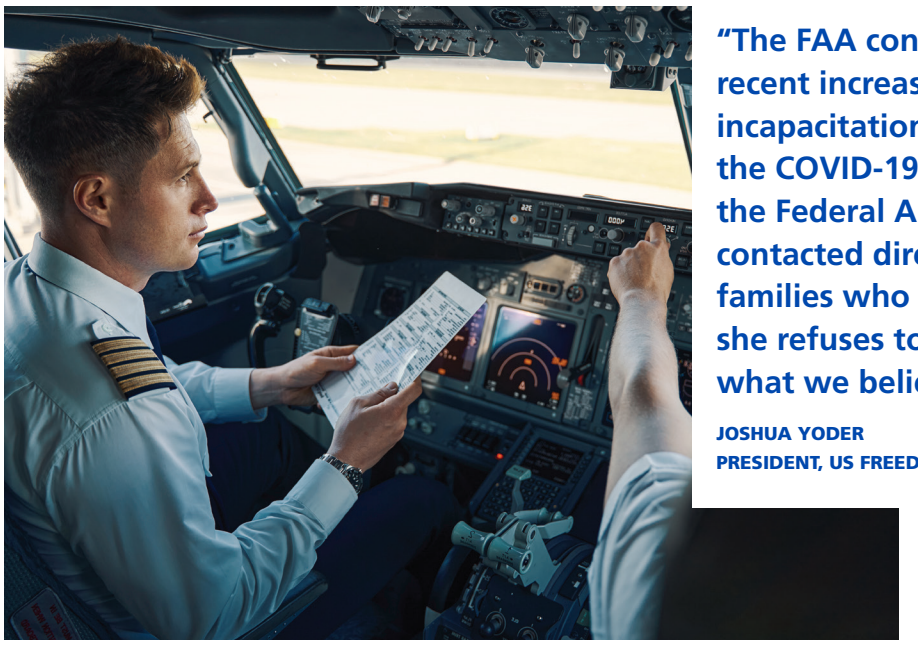
Several incidents of airline pilots becoming incapacitated during flights have occurred over a period of weeks.

A United Airlines flight from Guatemala City to Chicago in March was diverted to Houston after the pilot reported chest pain.

A Southwest Airlines flight was similarly rerouted because of pilot incapacitation. Radio communications from the Las Vegas to Columbus, Ohio flight indicated the captain reported stomach pain before he "fainted or became incapacitated." The pilot received medical attention at the rear of the aircraft as the copilot flew it back to Las Vegas.

Similar incidents occurred on British Airways, Emirates, and Virgin Australia flights in March. During the Australia incident, the pilot suffered a heart attack 30 minutes into the flight, forcing an emergency landing.

Health Care News earlier reported an American Airlines pilot collapsed mid-flight in November and was pronounced dead on arrival at a Chicago hospital.



"The FAA continues to deny that the recent increase in pilot death and incapacitations may be directly related to the COVID-19 vaccines. Susan Northrup, the Federal Air Surgeon, has been contacted directly by pilots and their families who have been affected, and yet she refuses to open an investigation into what we believe is a clear safety signal."

JOSHUA YODER
PRESIDENT, US FREEDOM FLYERS

'Seeking Out Unvaccinated Pilots'

Wealthy people and companies are increasingly looking for flight crew members who have not received COVID-19 shots, says Joshua Yoder, a passenger airline pilot and president of US Freedom Flyers, a nonprofit group opposed to air travel vaccine mandates.

"I first started receiving calls from wealthy individuals seeking unvaccinated pilots in the fall of 2021," said Yoder. "With more information becoming available daily regarding the dangers of the shot, we have also noticed an increase in aircraft owners seeking out unvaccinated pilots. US Freedom Flyers is not an employment agency, but we do utilize our network to assist as able."

Airline passengers do not have the luxury of being able to choose their pilots, says Yoder.

"Many airlines still have vaccine mandates in place; however, most are accepting religious and medical exemptions for current and new employees who are opposed to the vaccine," Yoder said. "Unfortunately, the majority of airline employees succumbed to the threats and intimidation that we experienced following President Biden's illegal vaccine mandates."

'A Clear Safety Signal'

President Joe Biden implemented a vaccine mandate for federal contractors, including major airlines, in the fall of 2021, which has been struck down by two federal courts.

The Federal Aviation Administration (FAA) has not investigated connections between the pilot incidents and the COVID-19 shots, which have been linked to increased risk of myocarditis. Last fall the FAA quietly loosened EKG standards for pilots, making it easier to approve pilots for flight duty.

"The FAA continues to deny that the recent increase in pilot death and incapacitations may be directly related to the COVID-19 vaccines," said Yoder. "Susan Northrup, the Federal Air Surgeon, has been contacted directly by pilots and their families who have been affected, and yet she refuses to open an investigation into what we believe is a clear safety signal."

Yoder said US Freedom Flyers is preparing to file litigation against the FAA "seeking accountability for their malicious and reckless behavior, which has created a negative impact on aviation safety."

The FAA has "failed to adhere to the checks and balances which have been set in place for years to ensure public trust," said Yoder.

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

Minnesota Legislature Considers 'Trusted Doctor' Bill

The Minnesota Legislature is considering a measure to allow physicians without hospital privileges to admit and treat their patients.

Identical bills Senate File 2388 and House File 2735 were introduced in the Minnesota Senate and House of Representatives, respectively, by a bipartisan group of lawmakers on March 8.

Doctors Not Allowed

The proposal would allow a patient to be treated by a "trusted doctor," addressing the growing trend of physicians being assigned by the hospitals that employ them, rather than chosen by their patients.

In 2018, Naples Community Hospitals (NCH), part of the nonprofit NCH Healthcare System in Florida, announced physicians not employed by NCH could not admit, treat, or request records of patients. The announcement resulted in a public protest.

New Specialty: 'Hospitalist'

The Affordable Care Act allows hospitals to receive more federal money for meeting certain metrics and cost-saving measures, including employing "hospitalists," Twila Brase, R.N., president and cofounder of the Citizens Council for Health Freedom and a policy advisor to The Heartland Institute, which co-publishes *Health Care News*, told the *Heartland Daily Podcast* on April 4.

"The hospitals are looking for a kickback from the government," said Brase. "A hospital that allows any doctor to come in and take care of their own patients cannot control that doctor as they might a doctor they employ."

Hospitals place more restrictions on outside internists and primary care physicians than specialists, whom hospitals cannot easily replace with hospitalists.

Brase is not optimistic the bill will pass in Minnesota, because of the partisan makeup of the legislature.

"We do hope this kind of legislation will move forward where it has a better chance of passing," said Brase. "Legislators have heard from their constituents about their frustrations on this."

The issue came to the forefront during the COVID-19 pandemic, when patients and their families had to go to court to force hospitals to allow doctor-approved COVID-19 treatments such as ivermectin.

—Staff reports

INTERNET INFO

"Can You Trust Your Hospital Doctor? (Guest: Twila Brase)," *Heartland Daily Podcast*, April 4, 2023: **https://heartland.org/podcasts/can-you-trust-your-hospital-doctor-guest-twila-brase/**

Polio Outbreak in Africa Linked to Oral Vaccines

By Kevin Stone

An outbreak of poliomyelitis in Africa is linked to the use of live vaccines.

The East African nation of Burundi is experiencing its first outbreak of polio in 30 years, the Associated Press reports.

The World Health Organization (WHO) says eight cases of the illness have been identified, and five samples taken from wastewater showed the presence of poliovirus type 2.

"Circulating poliovirus type 2 is the most prevalent form of polio in Africa and outbreaks of this type of poliovirus are the highest reported in the region, with more than 400 cases reported in 14 countries in 2022," stated the WHO. "Circulating poliovirus type 2 infection can occur when the weakened strain of the virus contained in the oral polio vaccine circulates among underimmunized populations for long periods."

"We know full well that the live vaccine can cause paralytic polio, both in people who receive it and [in] their contacts. Very young children tolerate polio very well: just a mild illness that makes them immune. It is the older contacts who are severely hurt. Therefore, only killed vaccine is used in the United States. Oral live vaccine is used deliberately in Africa, Pakistan, etc."

JANE ORIENT, M.D.
EXECUTIVE DIRECTOR
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Live Oral Vaccines Used

Unlike the dead-virus vaccines administered in developed nations, oral polio vaccines use a live, attenuated virus and are generally distributed to developing nations because they are cheaper to produce, do not require refrigeration, and are easier to administer.

Viruses in live, attenuated vaccines occasionally regain full virulence in vaccinated subjects, who can then transmit the illness to others.

The vaccine-derived poliovirus (cVDPV) can spread by viral shedding and through wastewater from the stools of vaccinated children.

There have been multiple outbreaks of cVDPV across Africa in recent years, and Pakistan and Afghanistan now report more cases of paralysis from vaccine-derived viruses than from the wild virus.

UN Pushing Vaccines

There is a strong push for the use of polio vaccines on the continent, Matshidiso Rebecca Moeti, WHO Regional Director for Africa, told *UN News*, a United Nations agency.

"Polio is highly infectious, and timely action is critical in protecting children through effective vaccination," said Moeti. "We are supporting the national efforts to ramp up polio vaccination to ensure that no child is missed and faces no risk of polio's debilitating impact."

Goal Is Global Polio Eradication

Eliminating the disease globally is the goal of the vaccination programs that are introducing vaccine-derived variants into areas free of the wild variant, says Martin Kulldorff, a Swedish biostatistician, former professor of medicine at Harvard Medical School, and a fellow at The Academy for Science and Freedom at Hillsdale College.

"The goal is to eradicate polio worldwide, and until it has been, polio vaccinations should continue," said Kulldorff. "If not, the disease will reappear."

The oral vaccine has additional health benefits, says Kulldorff.

"The live vaccine also has nonspecific effects, protecting children against other infectious diseases—see research by Dr. Christine Stabell Benn," said Kulldorff. "That is especially important in the developing world, where children commonly die from other infectious diseases."

Polio Severity Age-Related

Widespread use of live, attenuated vaccines isn't the safest way to eradicate polio, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and president of Doctors for Disaster Preparedness.

"We know full well that the live vaccine can cause paralytic polio, both in people who receive it and [in] their contacts," said Orient. "Very young children tolerate polio very well: just a mild illness that makes them immune. It is the older contacts who are severely hurt. Therefore, only killed vaccine is used in the United States. Oral live vaccine is used deliberately in Africa, Pakistan, etc."

'Collateral Damage Doesn't Count'

It is important to understand what the underlying motives might be for a vaccine campaign when a disease like polio has been under the radar for decades, says Orient.

"There is the desire to claim credit for eradicating a disease through universal vaccination—or something more sinister," said Orient. "Note that even where polio is supposedly gone, there is acute flaccid myelitis, which clinically looks like polio and may also be caused by a [presumably different] enterovirus."

Agencies supporting use of oral polio vaccines are downplaying the outbreak.

"While detection of these outbreaks is a tragedy for the families and communities affected, it is not unexpected with wider use of the vaccine," the Global Polio Eradication Initiative stated on its website.

This seeming indifference to the outbreak is contrary to medical ethics, says Orient.

"It's a product of substituting public health for medicine," said Orient. "The collateral damage doesn't count, especially if it is mostly in Africa or Pakistan. Is that not outrageous?

"I read somewhere that parents were assaulting vaccinators, even when they had police escorts," said Orient.

Is Total Eradication Possible?

In the United States, where the last previous transmission of the disease was recorded in 1979, a case was detected in Rockland County, New York in the summer of 2022.

The case was linked to the oral vaccine-derived strain. The virus also turned up in New York City wastewater, according to the city's Department of Health and Mental Hygiene in August, after it was detected in Orange County and Rockland County, north of the city, in May, June, and July.

Vaccine-derived rogue variants from Pakistan and Afghanistan turned up in sub-Saharan Africa, Yemen, Malaysia, and the Philippines in 2020. While the wild variant may be in retreat, the vaccine-derived variant is proliferating.

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

States, Biden Administration Scrap over Childhood Transgender Treatments

By Harry Painter

As a growing number of states and medical professionals push back against the Biden administration's advocacy of transgender treatment for children, the president and his team are pressing the fight.

President Joe Biden criticized Florida's ban on transgender treatments for minors as "close to sinful," in an interview.

"It's just terrible what they're doing," Biden said. "It's not like, you know, a kid wakes up one morning and says, you know, I decided I wanted to become a man, or I want to become a woman."

> **"Activists urge children who express distress as they enter puberty [to] enter into a potentially irreversible medical and surgical regimen despite overwhelming evidence that many of these children suffer from serious psychiatric disorders."**
>
> **STANLEY GOLDFARB, M.D., CHAIRMAN, DO NO HARM**

'Wheels Will Turn on This'

Admiral Rachel Levine, M.D., assistant secretary for health at the U.S. Department of Health and Human Services, a biological male who identifies as a woman, said child gender reassignment treatment has the "highest support" of the Biden administration.

Levine spoke at the Connecticut Children's Medical Center in Hartford, which offers "gender-affirming" plastic surgery, hormone treatments, and puberty blockers to minors.

"Wheels will turn on this," said Levine, referring to normalization and acceptance of "gender-affirming care" for minors.

Under his birth name Richard, Levine fathered and raised two children before transitioning in 2011 at age 53. In 2019, Levine said, "I can't imagine a life without my children." Critics called out the contradiction between that sentiment and Levine's support for irreversible gender transitions in young people that leave them sterile.

'Gives Credibility to Activists'

Levine's position as a senior government health official "gives credibility to activists" pushing the agenda of normalizing child gender transition, says Stanley Goldfarb, M.D., chairman of Do No Harm, an organization opposed to radical ideological agendas in health care.

Whereas adults can make reasoned decisions about their health, children "cannot assess the risks and benefits" of treatments such as gender-affirming care, says Goldfarb.

In addition, "The preponderance of medical evidence does not support the efficacy of gender transition to ameliorate psychological dysfunction experienced by these children," said Goldfarb.

"A number of European nations have opted to pause or even ban 'gender-affirming care' after conducting careful reviews of the medical literature regarding the lack of benefit of the treatment of gender dysphoria," said Goldfarb.

'That Decision Is Final'

Trying to change one's sex with drugs and surgery is dangerous and delusional, says David Gortler, Pharm.D., a former Food and Drug Administration official and a fellow at the Ethics and Public Policy Center.

"Using pharmacology to fight against 100 trillion cells in one's body isn't going to be safe or ever work out, no matter what Levine, the Biden White House, or any other government official says," said Gortler.

"I can tell you that the adult human body has around 100 trillion cells in it, and all of those nucleated cells contain an XX or XY chromosome sequence, according to any high-school biology education," said Gortler.

An individual's sex is unalterable, not "assigned at birth," says Gortler.

"That is determined at the moment of egg fertilization by either an X or Y sperm cell, and that decision is final," said Gortler. "No matter how many gallons of estrogen Levine injects himself with, and no matter how many surgeries he undergoes, he will always be a male with an XY sequence according to a genetic blood test, period."

'Tainting the Field'

Transgender activism is "tainting the field" of medicine, says Goldfarb.

"There is the presumption that gender-affirming care is the only proper treatment," said Goldfarb. "That is just not so. The medical literature does not support its efficacy.

"Activists urge children who express distress as they enter puberty [to] enter into a potentially irreversible medical and surgical regimen despite overwhelming evidence that many of these children suffer from serious psychiatric disorders," said Goldfarb.

Most of these children would go on to become comfortable with their sex were it not for the medical interventions, says Goldfarb.

"Watchful waiting and psychotherapy result in the vast majority of such children opting to live in a gender that corresponds to their natal sex," Goldfarb said.

States Enact Bans

Fourteen states have restricted or outlawed "gender-affirming care" for individuals under 18 years of age, and more are expected to follow, according to CatholicVote.

The states that have acted include Alabama, Arizona, Arkansas, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Mississippi, Tennessee, South Dakota, Utah, and West Virginia. In Kentucky, a bill banning puberty blockers for minors was enacted over a veto by Gov. Andy Beshear.

Around 150 activists occupied the Oklahoma State Capitol after Republicans introduced bills to limit reassignment procedures.

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

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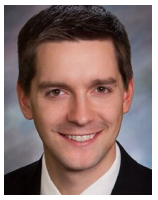

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REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA

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1

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2

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3

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4

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