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The Pulse

Rep. Pete Sessions Introduces Sweeping Health Care Bill in Congress

By Bonner Russell Cohen

U.S. Rep. Pete Sessions (R-TX) introduced a comprehensive reform bill titled the Health Care Fairness for All Act, on May 9.

The bill provides for a universal tax credit and individual accounts for after-tax savings for medical expenses that would be invested and never taxed again (called Roth taxation), states Sessions' press release on the bill.

"This legislation would create a new option for Americans to obtain health care coverage via a health insurance tax credit that is portable, fair, and available to all Americans," Sessions' press release states. "The bill would also reduce health care costs, promote price transparency and competition, and would allow all Americans to save and pay for health care with a tax-advantaged Roth Health Savings Account (HSA)."

SESSIONS BILL, p. 4

Rep. Pete Sessions

PHOTO COURTESY ALEX WONG/STAFF/GETTYIMAGES

State Legislatures Expand Competition in Health Care Markets

By AnneMarie Schieber

Several state legislatures are considering or have passed health care reforms lowering government barriers to competition and increasing patients' access to drugs and treatments.

With federal action unlikely, state lawmakers are advancing bills to repeal Certificate of Need (CON) laws, remove hurdles for direct primary care (DPC), and work around federal health agencies' regulatory roadblocks to life-saving treatments.

CON laws were put into place nearly

STATE LEGISLATURES, p. 6

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Views Clash Over Value of Life Metrics

By Ashley Bateman

A bill to ban metrics used to evaluate medical interventions is advancing in the U.S. House of Representatives.

The Protecting Health Care for All Patients Act (H.R. 485), introduced by House Energy and Commerce Committee Chair Cathy McMorris Rodgers (R-WA), was approved by the committee on a vote of 27 to 20 on March 24. The bill would prohibit Medicare, Medicaid, and other federal health programs from using Quality Adjusted Life Years (QALYs) and similar measurements in coverage and payment determinations.

The QALYs metric "is used to discriminate against people with chronic illnesses and disabilities, like cystic fibrosis, ALS, or Down's syndrome, putting them at the back of the line for treatment," McMorris said in a press release.

Cathy McMorris Rodgers (R-WA)

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

'Risks Life-Enhancing Advances'

Sens. Ron Johnson (R-WI), Mike Crapo (R-ID), and other Republican members of the Senate Finance Committee stated concerns like Rodgers' in a letter to Health and Human Services (HHS) Secretary Xavier Becerra and Centers for Medicare and Medicaid Services (CMS) Administrator Chiquita Brooks-LaSure on March 1.

"While recent decades have seen countless life-saving and life-enhancing advances in treatments and cures for conditions affecting vulnerable communities and seniors, the rise in QALYs risks reversing these trends, particularly as the government bureaucracy plays an increasing role in cost-effectiveness analyses for new medications under the partisan Inflation Reduction Act (IRA)," the senators wrote.

Eliminating QALY metrics in determining the value of a drug would ensure the United States remains a global leader in biomedical research and development while preventing "bureaucratic price controls from constraining patient access to new treatments," the letter states.

Assigning Value to Life

Calculation of the cost-effectiveness of a medical intervention depends on the value placed on the lives saved, says Linda Gorman, director of health care policy at The Independence Institute.

"In the 1990s, the average from 'willingness to pay' studies put the value of a life year at a median of $265,345, more than enough to make screening mammograms cost-effective," said Gorman. "But a National Institutes of Health [NIH] panel recommended against screening mammography for women aged 40 to 49 years, while conventional government estimates of the value of a life year by various federal agencies ranged from $21,000 to $50,000. This decision ignored other estimates from surveys and panel studies with significantly higher values for a life year."

New cost-effectiveness calculations will differ from judgments made in the past, says Gorman.

"The value attached to various kinds of treatments will vary radically when a system changes from traditional assessments of value developed when medical pricing operated with much less government intervention to the assessments provided when academics and bureaucrats make them," said Gorman.

'Pseudoscientific and Inhumane'

After decades of government intervention in the health insurance market, it is important to consider how QALYs can be misused, says Gorman.

"Measures [like QALYs] are only necessary when individuals no longer purchase and pay for their own medical care," said Gorman. "When people are paying for themselves, they determine what is worthwhile and what isn't, by the amount of money they spend on medical care and how they want to finance it."

In an analysis published in 2009, Gorman reviewed a reordering of health care priorities by the state of Oregon based on metrics. Many lifesaving surgeries were deprioritized in favor of elective surgeries.

Metrics undervalue the lives of the elderly, the disabled, and patients with chronic diseases, Sally Pipes, president of the Pacific Research Institute, wrote in *Forbes* on April 10.

"QALYs are a pseudoscientific and inhumane way to make decisions about medical treatment," wrote Pipes. "In countries where regulators rely on these metrics to determine patient access to drugs, they almost exclusively lead to the denial of lifesaving treatments."

'Essential in Cost-Benefit Analysis'

QALYs can make sense in pricing drugs, especially when taxpayers are footing the bill, says John Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"Quality-adjusted life years are used by all federal regulatory agencies," said Goodman. "They are essential in cost-benefit analysis, which is how we stop bad regulations."

The metric is used in medicine to determine the value of drugs, not patients, says Goodman.

"QALYs are never used to determine how much a particular individual's life is worth," said Goodman. "They are used to establish rules that everyone lives under, and health insurance coverage should be no exception."

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

Rep. Pete Sessions Introduces Sweeping Health Care Bill in Congress

Rep. Pete Sessions

PHOTO COURTESY ALEX WONG/STAFF/GETTYIMAGES

Continued from page 1

'Proud to Endorse This Bill'

Americans for Prosperity (AFP), a free-market advocacy group, supports Sessions' bill because it offers individuals and families a choice of options, Sessions' press release quotes AFP Senior Health Policy Fellow Dean Clancy as saying.

"We are proud to endorse this bill because it offers American families a personal option in health care—sensible reforms that ensure lower prices, less hassle, and more personal choice and control without new taxes," said Clancy. "The Health Care Fairness for All Act will make health care dramatically fairer by giving every American access to a generous new subsidy that lets you tailor your health care benefits to fit your individual needs—and then take them with you when you change jobs."

AFP defines "personal option" as "a commonsense alternative to plans like the public option that put government in key control." Alternatives to a public option include affordable health insurance, reasonably priced drugs, and price transparency.

'Will Free the Health Care Marketplace'

Under Sessions' plan, individuals and families would use the tax credit—which is refundable and advanceable for low-income people—to purchase health insurance, said John Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*, in Sessions' press release.

"For millions of Americans, health insurance is unaffordable and inaccessible," said Goodman. "The Health Care Fairness for All Act will give each American citizen access to a refundable, advanceable, and assignable health tax credit to be used to purchase health insurance, buy medical care, and make deposits to a Health Savings Account," said Goodman. "This bill will free the health care marketplace to meet the different needs of different families, and provide health care financial support to every individual, including the uninsured."

"With Obamacare, people were promised if they liked their health care, they could keep it. This bill actually does that and more. It preserves existing safety-net programs and protects people with preexisting conditions. If you want lower prices, more freedom, and fairness for all—this bill is for you, too."

DEAN CLANCY
SENIOR HEALTH POLICY FELLOW
AMERICANS FOR PROSPERITY

'Health Care Parity'

Sessions and Goodman discussed why health insurance, including Obamacare (ACA) plans, is not affordable for many people, in a Goodman Institute podcast recorded on May 3.

"The average deductible for a family is $8,500," said Goodman. "Only hospitalization can reach this in high-deductible policies."

Democrats' push for Medicare for All would make the situation worse, said Sessions.

"Medicare is not designed for children or young people," said Sessions.

The ACA's subsidy structure discourages lower-income people from working, said Goodman.

"We need people to go out and work without losing benefits," said Goodman.

The current system discriminates against the self-employed and increases government dependency among lower-income people, said Goodman.

"Taking an entirely different approach, the Sessions bill aims to create health care parity" for the self-employed by providing $12,000 in tax credits for a family of four, said Goodman.

'Patient-Friendly, Cost-Effective'

The Sessions legislation is a welcome change of course in health care policy, says Robert A. Koshnick, M.D., chair of the policy committee of the Minnesota Medical Association. Koshnick has proposed what he calls Empower-Patient Accounts (see related article, page 19).

"This bill could be a legislatively disruptive innovation that could recreate a patient-friendly, cost-effective medical care market that will reduce health care costs, improve quality, and raise patient and physician satisfaction," said Koshnick.

Congress will be forced to address health care because of time limits in current tax law, says Koshnick.

"Health care will be front and center in the 2024 election because tax credits for health insurance premiums are set to expire in 2025," said Koshnick. "It is vital that any bill be 'forward-looking.' Elections are decided by what people expect a political party will give them in the future."

'Removes Needless Barriers'

The Sessions bill would make health care affordable in three key ways, Clancy says in an AFP statement.

"First, it funds patients rather than insurance companies, said Clancy. "Second, it empowers every American to shop for value with a tax-advantaged health savings account. And third, it removes needless barriers between patients and innovative, lifesaving care delivered by the medical professionals they trust."

The bill can appeal to Democrats and independents, Clancy told *Health Care News*.

"With Obamacare, people were promised if they liked their health care, they could keep it," said Clancy. "This bill actually does that and more. It preserves existing safety-net programs and protects people with preexisting conditions. If you want lower prices, more freedom, and fairness for all—this bill is for you, too."

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

INTERNET INFO

"The Health Care Fairness for All Act," H.R. 3129, May 9, 2023: **https://www.congress.gov/bill/118th-congress/house-bill/3129?s=1&r=2**

"Dr. John C. Goodman and Congressman Pete Sessions, Texas 17th," Goodman Institute, May 3, 2023: **https://www.youtube.com/watch?v=ggDX6tm5Qsk**

‘Plan for America’ Promotes Private Accounts to Fix Entitlement Programs

By AnneMarie Schieber

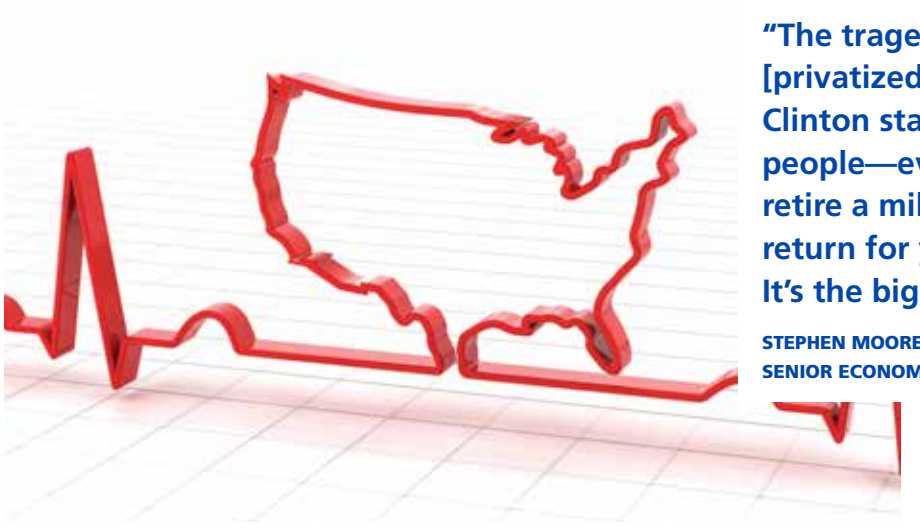
A voluntary savings plan could avert Social Security and Medicare insolvency and reduce health care costs, public policy experts told a national conference.

The nonprofit group Plan for America (PFA) says the purpose of the April 28 meeting at Principia College in Elsah, Illinois was to introduce others to its savings plan and raise awareness of the shortfalls facing the nation’s entitlement programs. The livestreamed and recorded confab featured panel discussions on Social Security, the national debt and federal budget deficit, and health care.

PFA proposes Congress and the states contractually create a trust into which individuals could direct their payroll taxes and other earnings in accounts that would guarantee lifetime health care and retirement income. By providing health care, the plan could relieve states of their Medicaid obligations. The trust could pay off the programs’ more than $100 trillion in estimated unfunded liabilities between 2059 and 2079, PFA says.

The panelists included Terry Nager and Eric Nager, two of the three authors of the plan; John Goodman, an economist and co-publisher of *Health Care News*; Stephen Moore, a senior economist with FreedomWorks; Daniel Smith, a professor of economics at Middle Tennessee State University; and AnneMarie Schieber, managing editor of *Health Care News*.

Social Security and Medicare will be insolvent in a few years, requiring higher taxes or benefit cuts, officials and analysts report.



“The tragedy is if we had done this [privatized entitlements] when Bill Clinton started talking about it, young people—every millennial—would retire a millionaire. You’re getting no return for your Social Security money. It’s the biggest rip-off in your life.”

STEPHEN MOORE
SENIOR ECONOMIST, FREEDOMWORKS

Flawed Current System

The federal programs for retirees have a basic flaw, Goodman told the audience.

“What we have is a pay-as-you-go (PAYGO) system,” said Goodman. “Nothing is saved, nothing is invested. If you are receiving Social Security, it’s being paid for by younger workers because there is no other source of funds.”

PAYGO financing means that succeeding generations of workers must agree to pay taxes for the benefit of retirees, Smith told the audience.

“We’re relying on a politician’s promise that a future politician that we don’t even know is going to tax other people to fund that promise,” said Smith. “That’s insane, and people take that to the bank.”

A funded retirement system could have been implemented a generation ago, Moore told the audience.

“The tragedy is if we had done this [privatized entitlements] when Bill Clinton started talking about it, young people—every millennial—would retire a millionaire,” said Moore. “You’re getting no return for your Social Security money. It’s the biggest rip-off in your life.”

Guaranteed Benefits

The PFA proposal, which is described on the organization’s website and detailed in a book, would give workers the option to divert their payroll taxes into a For American Security Trust (FAST) the proposed program would create.

The FAST would administer and invest in a total market index fund of U.S.-domiciled companies and use the power of compound interest to provide benefits and retirement income. Participants would own their accounts, which could be passed on to heirs. The FAST would guarantee, at a minimum, the Social Security benefits promised today.

Today’s retirees could participate in the plan and, if they choose to remain in Social Security, could create an account as an alternative to Medicare.

Lifetime Health Coverage

Workers would use their FAST accounts to purchase health insurance that would offer a comprehensive plan for a standard individual premium of $11,200 that would include a $1,200 health savings account.

Low-income people could pay for their health insurance with interest-free loans tied to a life insurance policy and later paid back from the account.

Eric Nager presented an example to the audience: a single mother over 40 years old who earned only $25,000 in her entire lifetime would get at least the amount currently promised her ($14,676 per year) by Social Security. If the stock market averages an annual rate of return of 10.2 percent over the 40 years, she could get a payout of $45,363 a year when she retires, and she would still be better off financially after paying off the interest-free loans for health care than if she had stayed in Social Security.

“The choice [to participate] should be a no-brainer,” said Nager.

Health Insurance Option

Terry Nager told the audience it is important to include health care in the plan, but participation would be voluntary.

Private insurers could charge less than the standard premium to compete against one another, but they would not be allowed to turn down anyone for coverage for any reason, said Nager.

“What we want is a standard of care; how they package it is up to them,” said Nager.

FAST account holders could opt out of the health care but would have to place $100,000 in escrow to cover an unforeseen health event.

“Nobody pays for someone else’s care,” said Nager.

Game Changer

Jim Stock, a small-business owner, traveled from Jacksonville, Florida to attend the conference in person.

“I had read part of the book and understood the basic concept, but [it wasn’t] until they drilled it down at the conference that I realized, ‘Wow, there is no reason why this can’t work,’” said Stock.

People will have to band together to push the plan forward, says Stock.

“I’m an optimist by nature,” said Stock. “I believe even with this debt culture that people do have the ability to self-correct. Politicians need to be honest about these programs, and voters have to support them even if they say something no one wants to hear.”

Livestream viewer Jeff Scott says he has shared information about PFA with close friends and found the support heartening.

“I’ve heard a lot of people talk about health care over the years, and this is the first plan that has started to make sense,” said Scott.

PFA is planning future conferences and is recruiting actuaries to review its projections.

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

INTERNET INFO

Plan for America Conference, Principia College, April 28, 2023: **https://www.youtube.com/watch?v=MDmBfgyXqIY, https://www.youtube.com/watch?v=4TGOmPtlSXk**

State Legislatures Expand Competition in Health Care Markets

Continued from page 1

50 years ago to restrict competition in health care markets in the belief they would contain costs and promote excellence, but they have stifled innovation, reduced supply, and increased costs.

The Heartland Institute, which publishes *Health Care News*, has long advocated the repeal of CON laws and other regulations which limit patients' medical choices.

South Carolina 'Opening the Doors'

After years of trying, lawmakers in South Carolina have enacted a law that almost entirely repeals the state's CON regulations.

The South Carolina House of Representatives unanimously passed a CON repeal bill the state Senate previously approved. Gov. Henry McMaster signed the bill into law on May 17.

The bill phases out CON completely for new hospitals starting in January 2027. Long-term care facilities will still require approval from the state's Department of Health and Environmental Control.

The bill includes a provision banning hospitals from "economic credentialing," a practice that denies privileges to physicians who have economic ties to possible hospital competitors.

Marcelo Hochman, M.D., president of Independent Doctors of South Carolina, says South Carolina's new law will be a game changer.

"The South Carolina legislature unanimously passed a bill that sweeps away decades of protectionism, opening the doors for true innovation and disruption of health care delivery," said Hochman. "This is very good news and a huge step toward providing patients more options for higher-quality, competitively priced care. We are intent on continuing to pursue measures that put control back in patients' and doctors' hands."

By allowing [Direct Primary Care] to function as a service, and declaring it is not insurance, which it is not, patients will have access not just to affordable but excellent primary care."

ADAM HABIG
PRESIDENT AND COFOUNDER, FREEDOM HEALTHWORKS

'Turf Wars' in North Carolina

The North Carolina General Assembly is taking a more circuitous route to banning CON as part of a budget deal to fund Medicaid expansion, after passing authorizing legislation in March.

The reforms will end CON for ambulatory surgery centers (ASCs) and imaging centers such as MRI providers in counties with fewer than 125,000 people, drug treatment and behavioral health centers, and other diagnostic facilities. Some restrictions would remain, such as requiring approval for hospital imaging equipment costing more than $3,000,000, and ASCs would be required to devote 4 percent of their incomes to charity care.

The dealmaking is no surprise, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute.

"Turf wars are notoriously difficult to resolve," said Dean. "Any protection for a group based on licensure or geography will be defended vigorously. Lobbyists on both sides dig in, at times with a perverse incentive to continue the battle for another session—and another contract."

Budget negotiations in North Carolina are complicated because Democrats control the office of governor while Republicans have supermajorities in both chambers of the General Assembly.

Right to Try, Treat

The Texas Senate unanimously passed a bill that would expand patients' "right to try" experimental treatments that have not received final Food and Drug Administration approval, on April 30.

The state's current "right to try" law, in effect since 2015, is limited to the terminally ill. Senate Bill 773 would expand access to patients with chronic diseases. Patients and their doctors would be allowed to get experimental products directly from manufacturers.

The bill has protections against misuse, says Dean.

"There is always a concern that there could be bad actors who might want to experiment in dangerous ways on vulnerable people," said Dean. "This will take some vigilance. Investigational treatment should only be used as a last resort when standard proven treatments have failed. What is important is protecting the relationship between the doctor and the patient, without the government interfering."

The Nevada Assembly passed a similar right to try expansion on April 25. A.B. 188 was read in the state Senate for the first time on April 26. The bill is expected to pass the Senate, and Gov. Joe Lombardo was expected to sign the legislation into law, as of press time.

Alaska Expanding Direct Primary Care

Alaska is making headway on opening the door for direct primary care (DPC) by recognizing it is a "membership" service and not health insurance, which is subject to costly regulation.

The Alaska Legislature is considering two bills, S.B. 45 and H.B. 47, which would clarify the definition of DPC in a way that makes it easier for physicians to open practices. Without legal specificity, physicians are reluctant to open direct care practices because they could face costly and onerous regulation.

DPC practices charge individual consumers a monthly fee, usually under $100, for unlimited primary care, rather than accepting payment from an insurance company. DPC is already operating in 49 states, with 26 states having laws that explicitly state DPC is not insurance.

Alaska could benefit from the bills, says Adam Habig, president and cofounder of Freedom Healthworks and a policy advisor to The Heartland Institute.

"Alaskans pay more for health care than almost any other state," said Habig. "One study estimates average care costs $11,000 per patient. Unexpected health care bills have led people into bankruptcy. By allowing DPC to function as a service, and declaring it is not insurance, which it is not, patients will have access not just to affordable but excellent primary care. There will be no surprise bills, because patients will know up front how much their care will cost."

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

DEA Extends Telehealth Rule for Controlled Substances

By Kevin Stone

Telehealth providers can keep writing prescriptions for controlled substances without an office visit, the U.S. Drug Enforcement Agency (DEA) announced on May 3.

The DEA extended for an additional six months the permissive telehealth rules enacted during the COVID-19 pandemic that allow patients to receive prescriptions for controlled medical substances through telehealth providers.

Before the extension, patients receiving opioid painkillers, stimulants, and tranquilizers through telehealth faced a potential cutoff of access to their medications until they could schedule an office visit with a primary care physician (PCP). This could have created a serious backlog of medical appointments, resulting in some patients' prescriptions running out before they could obtain an appointment with a provider.

Despite the extension, there is an ongoing concern that a massive backlog in PCP appointment slots is unlikely to be resolved during the six-month period.

Easing the Shortage

The eventual end of the temporary telehealth rule will create serious access problems, says Jeffrey A. Singer, M.D., a senior fellow at the Cato Institute.

"The nation already has a significant shortage of health care practitioners, particularly in primary care, and with patients poised to no longer get ready access to telehealth services from out of state, health care access—particularly for people in rural and underserved areas—will only get worse," said Singer.

Lack of a PCP varies widely by state, ranging from a low of 16 percent of Massachusetts patients to a high of 42.6 percent in Tennessee, over the 2016 to 2022 period, according to a study published by FAIR Health on March 15. Another study found the ratio of people to each primary care practice location ranged from a low of 115 for Rochester, Minnesota to 2,760 for Zapata, Texas.

Arizona's Telehealth Solution

When the DEA's telehealth rule expires, state professional licensing regulations will reduce patients' access to telehealth providers, says Singer.

"With the emergency over, obstacles to telehealth services posed by state licensing laws [will] prevent people from getting telehealth services from providers who are not licensed in the state in which the patient lives," said Singer. "Since 2021, Arizona state law has allowed Arizonans to get telehealth services from any type of health care provider licensed in any of the 50 states and the District of Columbia," said Singer. "But efforts to replicate the Arizona reform in other states have been met with strong opposition from entrenched incumbents who fear out-of-state competition."

"The nation already has a significant shortage of health care practitioners, particularly in primary care, and with patients poised to no longer get ready access to telehealth services from out of state, health care access—particularly for people in rural and underserved areas—will only get worse."

JEFFREY A. SINGER, M.D.
SENIOR FELLOW, CATO INSTITUTE

State medical market protectionism can be overcome, says Singer.

"There is, however, a federal fix," said Singer. "Congress can define, for the sake of interstate telehealth services, the 'locus of care' as the state in which the provider is licensed, not the state in which the patient purchasing the service resides."

Assistant Physician Access

The obvious solution to the shortage of physicians is to increase the supply, says Singer.

That could be done by giving patients nationwide access to assistant physicians (APs) through telehealth. Unlike physician assistants (PAs), APs are medical doctors (M.D.) and doctors of osteopathy (D.O.) who have not completed a residency program. Singer says expanded AP access, which could be done at the state level, would greatly ease shortfalls.

"States that pass AP laws should not require that APs work only within the premises of a supervising physician, as some have done," said Singer. "They should follow the example of Missouri and permit them to practice in their own clinics, providing they have a 'collaborating' or supervising physician nearby and available 24/7. This will allow people to access primary care at more locations. In Missouri, the supply of primary physicians has increased by 3 percent just since the AP law was implemented in 2017."

Texas is one state that could benefit from more flexibility, says Singer.

"If Texas were to pass an AP law—which the legislature is now considering—it would certainly help," said Singer. "However, Texas needs to also allow allied health care practitioners to provide primary care services. For example, Texas is now among the minority of states that don't grant full practice authority to advanced nurse practitioners such as board-certified family nurse practitioners. FNPs have proven, over the decades, to provide excellent primary care services."

Non-Physician Alternatives

APs receive two years more clinical training than do PAs. Nurse practitioners (NPs), another option to ease shortages, receive less clinical training than physicians.

Replacing physicians with nonphysicians could present some problems, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

"We lack clear data about physician assistant abilities relative to physician abilities," said Gorman. "Their training differs. The question is whether it matters for patients. There are also liability issues that would have to be resolved."

Although there is no clear consensus on how to address the prescription issue moving forward or what post-emergency permanent rules will look like, Gorman said there may be a simpler solution.

"A bigger question is why we have prescription requirements at all, with the exception of those for drugs such as antibiotics or addictive drugs which generate severe externalities if they are improperly prescribed," Gorman said.

The current DEA rule extension runs through November 11.

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

INTERNET INFO

Jeffrey A. Singer and Spencer Pratt, "Expand Access to Primary Care: Remove Barriers to Assistant Physicians," Cato Institute, April 24, 2023: **https://www.cato.org/briefing-paper/expand-access-primary-care-remove-barriers-assistant-physicians**

Physician to Sue Medical Board, Attorney General for License Attacks

By AnneMarie Schieber

Scott Jensen, M.D., announced he is suing Minnesota officials for multiple attacks on his medical license.

Jensen, a family physician, will file a lawsuit against state Attorney General Keith Ellison and members of the state Board of Medical Practice in federal court, he said in a press release.

Jensen said the defendants violated his First and Fourteenth Amendment rights.

"My rights were violated, as were the rights of so many, to speak freely during the COVID-19 pandemic and afterward," said Jensen. "We are going to take this lawsuit as far as we need to in order to protect the rights of physicians and all other professionals who have dissenting voices."

Jensen says he expects to file suit before mid-June. His legal team is reviewing the state's Data Practices Act in preparation for the case.

"We are gathering potential background information which may be helpful to understand the breadth of the lawsuit in regard to freedom of speech," Jensen told *Health Care News*.

State Attorney General Keith Ellison

PHOTO COURTESY LORIE SHAULL/WIKICOMMONS

'Intimidation of Political Adversaries'

Jensen spoke out publicly against COVID-19 death-reporting guidelines and reimbursements to hospitals for diagnosing COVID-19 and putting patients on ventilators.

In the past three years he has defended his medical license five times against complaints to the board that were eventually rejected. Jensen, a Republican, was a state senator from 2017 to 2021, and ran unsuccessfully for governor in 2020.

Jensen says Ellison, a Democrat, was a "political actor" in representing the Board's review committee in the fifth complaint hearing.

"The silencing and intimidation of political adversaries cannot become the norm in America," said Jensen.

Boards, Not Weapons

The lawsuit is intended to draw a line between speech and professional conduct and will stop government agencies, such as regulatory boards, from being used as political weapons, says Jensen.

"Government regulatory boards should not be used as political weapons," said Jensen. "I'm hoping legal action will not just vindicate me but also protect doctors or anyone else who must be licensed by a regulatory board to work. What happened to me could happen to anyone."

Physicians throughout the country have faced censorship, legal threats, and termination of employment for speaking against COVID-19 pandemic policies such as masks, mandatory COVID-19 shots, and lockdowns.

California's medical boards now have the authority to discipline physicians for "false or misleading information regarding the nature and risks of the virus, its prevention, and treatment; and the development, safety, and effectiveness of COVID-19 vaccines." The law, which went into effect on January 1, is being challenged in court. In Florida, John Littell, M.D. claims he was fired from a Sarasota hospital for saying ivermectin was effective in treating COVID-19.

Jensen is raising money for his legal expenses on a crowdsourcing platform and had not yet filed his lawsuit at press time.

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

Why Do Doctors Ignore Patient Feedback? Because They Can.

By Kevin Stone

Physicians given the opportunity to read their patients' feedback on the effectiveness of treatment don't review it, current research finds.

Patient-reported outcome measures (PROMs) are the unfiltered responses of individuals regarding a clinical health encounter on a questionnaire.

The use of PROMs is promoted by the Centers for Medicare and Medicaid Services and the U.S. Food and Drug Administration, and PROMs are being implemented by many health systems.

A study on the use of PROMs in a major health care system in Minnesota found although about 60 percent of patients complete the forms, and they are available in the patients' electronic health records, clinicians accessed only 1 percent of the questionnaires.

"Medicine today is dictated by corporate- and government-imposed protocols, not by individualized and personalized care. Corporate treatment protocols restrict treatment options and prohibit personalized care. Thus, if the patient reports good outcomes or bad outcomes, it's likely because of the corporate protocol, not the physician who complied with it."

TWILA BRASE
PRESIDENT AND COFOUNDER
CITIZENS' COUNCIL FOR HEALTH FREEDOM

'Nothing to Gain'

Health care providers' failure to use the PROMs could be an outcome of our third-party payment system, wrote Elise Amez-Droz, manager of the Open Health Project of the Mercatus Center at George Mason University, on April 7.

"Why don't doctors care about these metrics?" wrote Amez-Droz. "Probably because they have nothing to gain from using them. Patients can't reward or penalize doctors for performance. … The real customer is insurance companies."

Other potential factors cited are the growing shortage of primary doctors (see related article, page 7) and doctors being overburdened with paperwork.

'Stick to the Script'

It is not surprising to see Minnesota doctors bypassing government-recommended patient reports that aren't used in their employer's performance evaluations, says Matt Dean, a senior fellow for health care policy outreach for The Heartland Institute, which publishes *Health Care News*.

"Doctors are under increasing pressure to see more patients and stay within the contours of best practices," said Dean. "Minnesota, which brought HMOs [health maintenance organizations] to the rest of the country, is more integrated, systematized, and compliant than nearly any other state. So it isn't surprising that docs stick to the script in the Gopher State."

The Minnesota Legislature is considering a bill that would give patients a wider choice of physicians if they don't want to entrust their care to those employed by a hospital system. The bill would compel hospitals to allow patients to be treated by their "trusted" physician regardless of hospital privileges, *Health Care News* reported.

The issue of patient choice moved front and center during the COVID-19 pandemic as patients and families had to go to court to allow family physicians to enter hospitals and to prescribe treatments such as ivermectin that were not part of hospital protocols.

Cookie-cutter Medicine

The Minnesota study results reflect doctors' awareness that today's health care system severely limits their decision-making, says Twila Brase, president and cofounder of the Citizens' Council for Health Freedom,

"Medicine today is dictated by corporate- and government-imposed protocols, not by individualized and personalized care," said Brase. "Corporate treatment protocols restrict treatment options and prohibit personalized care. Thus, if the patient reports good outcomes or bad outcomes, it's likely because of the corporate protocol, not the physician who complied with it.

"If physicians can't use their skills and critical thinking to treat a patient, why should physicians care about outcomes that are the result of a treatment protocol that the doctor is forced to use?" said Brase.

'An Elaborate Façade'

Brase questions the value of PROMs and other mandated busy work that distract doctors from their primary purpose of providing care to patients, because they increase the doctor-patient disconnect.

"First, looking at and evaluating PROMs data takes more time away from patient care than the government and health plans have already taken away with their myriad reporting requirements, which can amount to death by 10,000 clicks," Brase said. "Second, when CMS created PROMs, it was never meant to improve patient care. It was meant to make it look like the government cares about patients, but it doesn't.

"If government officials truly cared about patients and patient outcomes, they would get out of the way, eliminate bureaucratic processes and reporting systems, … and they would let doctors be doctors that answer to patients and their own conscience, not bureaucrats and their corporate collaborators," said Brase.

Doctors may be justified in viewing the reading of patients' reports as a waste of effort, Brase says.

"Given the imposition of standardized corporate treatment protocols, doctors may not be able to do anything differently if they want to get paid and stay in practice," said Brase. "So, doctors could see the entire enterprise as an elaborate façade which does not deserve their time or attention."

'Make Care Patient-centered'

Although patient-driven health care data can provide a path for improvement, it can also be used against them, says Dean.

"Individualized medicine offers, and the technology surrounding it creates, unbelievable opportunities to make care truly patient-centered," said Dean. "But the devil is in the data. Right now, data is the most valuable commodity on the planet. Your health data is worth more than gold. As patients track their steps, heart rate, calorie intake, locations, and purchases, this data is being captured and sold, mostly without the knowledge of the target."

Unlike consumer data, such as purchasing history or internet searches, health data can be used against someone, says Dean.

"Insurance companies can use it to decide what, if any, care I get," said Dean. "Machine learning applications might predict I am not going to be worth treating, for medical or nonmedical reasons. Health data might be shared with third-party apps on my phone because I desperately clicked 'accept all safety recommendations' without reading the legal disclaimer on a picture editing app."

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

CDC's Walensky Quits After Unprecedented Era of Overreach

Former CDC Director Rochelle Walensky, M.D.

PHOTO COURTESY DREW ANGERER/STAFF/GETTYIMAGES

By Kevin Stone

Centers for Disease Control and Prevention (CDC) Director Rochelle Walensky, M.D. announced her resignation, effective June 30, in a press release.

Walensky announced her departure on May 5 after House Judiciary Committee Chairman Jim Jordan (R-OH) sent a subpoena and letter requiring the CDC to provide his committee with communications between the agency and private companies and third-party groups.

"The Twitter Files and other public reporting have exposed how the federal government has pressured and colluded with Big Tech and other intermediaries to censor certain viewpoints on social and other media in ways that undermine First Amendment principles," wrote Jordan in the cover letter to the subpoena. "It is necessary for Congress to gauge the extent to which the CDC coerced, pressured, worked with, or relied upon social media and other tech companies in order to censor speech."

'Made COVID a Crisis'

During her three-year tenure, Walensky became the face of the Biden administration's response to COVID-19 and was widely criticized.

In the case of the COVID shots, Walensky stated in early 2021 "vaccinated people do not carry the virus, don't get sick." A CDC spokesperson quickly walked back that claim, admitting vaccinated persons could be infected and transmit the disease. Similarly, Walensky's mask guidance came under scrutiny when the mandate was lifted for vaccinated persons a day after she testified to Congress that masks were necessary.

Walensky's CDC repeatedly exceeded its authority in its response to COVID-19, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

"The government made COVID a crisis by forgetting that it was bound by law," said Gorman. "It closed businesses due to a virus infection that was about as lethal as the standard flu. When people lost their jobs and stopped paying rent, it arrogated to itself the power to tell landlords they couldn't evict people who were using their property without paying. No one who thinks that these kinds of measures are constitutional should be allowed anywhere near public office."

'Kids Were Locked at Home'

Under Walensky, the CDC gave unusual access to special interest groups, including big pharma, teachers unions, and woke ideologues, in their rulemaking.

The American Federation of Teachers played a major role in drafting school reopening guidelines. Walensky appears to have met with parental representatives only once, for a 30-minute session.

Allowing teachers' unions to dictate school closures under the guise of health guidance was unacceptable, says Matthew Dean, a senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*.

"After teachers got used to remote learning, they didn't want to go back to school, and they wanted a permission slip from the new president's CDC to Zoom it in from home," said Dean. "This is the part where Walensky was supposed to say, 'It's our job to tell you what the science says, not the other way around. I'll quit before I let the CDC get turned into a political press shop!'

"But that's not what happened," said Dean. "Instead, the permission slip was signed. Kids were locked at home, where they fell further behind and became more isolated, mentally ill, and chemically dependent. Their risk from COVID was always small."

'Embarrassingly Ignorant'

Gorman says Walensky undermined the CDC's scientific credibility.

"Another thing the CDC did under Walensky's tenure was destroy its reputation as an impartial assessor of existing scientific knowledge," said Gorman. "Anyone with a modicum of scholarly knowledge observing CDC COVID communications and data production will be careful about taking any CDC data at face value."

The CDC now gives unscientific guidance in the service of woke progressivism, says Gorman.

"Its definitions of health equity and disparities are embarrassingly ignorant," said Gorman. "They fail to take into account that people are independent actors and that differences in health outcomes are often caused by the patients themselves."

Jordan gave Walensky a May 22 deadline to respond to his subpoena. The CDC had not complied as of press time.

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

"Another thing the CDC did under Walensky's tenure was destroy its reputation as an impartial assessor of existing scientific knowledge."

LINDA GORMAN
DIRECTOR OF THE HEALTH CARE POLICY CENTER
INDEPENDENCE INSTITUTE

Nonprofit Hospitals Under Fire for Skimping on Charity Care

By Bonner Russell Cohen

A congressional hearing examined whether nonprofit hospitals are providing enough charitable services to justify the tax breaks and subsidies they receive.

The Subcommittee on Oversight of the House Ways and Means Committee received testimony on whether nonprofits provide charity care and community benefits commensurate with the tax benefits they get, at an April 26 hearing.

Subcommittee Chairman David Schweikert (R-AZ) said nonprofit hospitals are required to provide services for the subsidies they receive.

"Hospitals must meet certain standards to obtain and maintain tax-exempt status, including organizational and operational requirements, community benefits, and Patient Protection and Affordable Care Act (ACA) requirements," said Schweikert.

The value of the tax exemptions for nonprofit hospitals rose from about $19 billion in 2011 to around $28 billion in 2020, with half of that amount coming from the federal tax exemption, according to the Kaiser Family Foundation (KFF).

"The level of executive compensation is particularly alarming. The top 10 nonprofit hospital CEOs average more than $7 million annually, some as high as $14 million. This further questions whether these facilities are living up to their mission statements."

U.S. REP. JASON SMITH (R-MO)

Lax Oversight

Disparities in the amount of free or discounted health care individual hospitals provide are unrelated to their size or revenues, said Schweikert.

"KFF has also found that the value of charity care provided by hospitals varies substantially across facilities, ranging from 0.1 percent of operating expenses for a hospital to 7 percent or more for other hospitals," said Schweikert.

This range is likely the result of the failure to spell out the service obligations of nonprofit hospitals in federal law and regulations, said Schweikert.

"The wide variation here appears to come from the lack of clear guidance from Congress and the IRS about what constitutes community benefit," said Schweikert.

Net Worth Rising

Auditors at the transparency group OpenTheBooks.com found the cumulative net assets of the 20 largest nonprofit hospital systems grew from $200.6 billion in 2018 to $324.4 billion in 2021.

The hospitals received $23 billion in COVID pandemic bailouts, and only two providers have paid the money back, OpentheBooks CEO Adam Andrezejewski told *Health Care News*.

"For every $1 in COVID bailout money, the net assets of the top 20 largest nonprofits jumped $5," said Andrezejewski. "Nonprofit hospitals need to explain if they are serving the public's interests or their own."

CEO Compensation

The salaries of CEOs at nonprofit hospitals are a concern, Ways and Means Committee Chairman Jason Smith (R-MO) said at the hearing.

"The level of executive compensation is particularly alarming," said Smith. "The top 10 nonprofit hospital CEOs average more than $7 million annually, some as high as $14 million. This further questions whether these facilities are living up to their mission statements."

OpenTheBooks estimates the top executives at the 20 largest nonprofit hospitals in the United States receive a total of $148.8 million in annual compensation, based on these hospitals' latest publicly available tax filings. For example, the CEO at Ascension Healthcare, based in St. Louis, Missouri, made $13 million in 2021.

Profits from Mandated Discounts

The discounted drug prices nonprofit hospitals receive from drug makers through the federal 340B Drug Pricing Program are also a concern, said Smith.

The mandatory discounts are meant to reimburse providers that serve low-income patients, including hospitals serving Medicaid and uninsured patients.

Hospitals profit from the 340B program by getting drugs at discounted prices and then charging insurance companies and Medicare the full price, Ge Bai, Ph.D., a professor of accounting at Johns Hopkins Carey Business School and a witness at the hearing, told *Health Care News*.

"This 'buy-low-sell-low' 340B program for safety-net hospitals has evolved into a 'buy-low-sell-high' program for eligible tax-exempt hospitals, who can generate substantial profits by providing these drugs to well-insured patients," Bai said.

"To take advantage of the 340B program, many tax-exempt hospitals have acquired or affiliated with clinics located in wealthy communities and then shifted care away from outpatient physician offices to more expensive hospital outpatient centers," said Bai.

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

20 LARGEST U.S. NON-PROFIT HOSPITALS

HOSPITAL SYSTEM NAME	HEADQUARTERS	COVID AID	TOP EXEC. SALARY	SALARY YEAR	NET ASSETS	YEAR ENDING	NET ASSETS AS OF 2021
KAISER PERMANENTE	OAKLAND, CA	$500 MILLION*	$6.2 MILLION	2019	$32.2 BILLION	2018	$52.9 BILLION
ASCENSION HEALTHCARE	ST. LOUIS, MO	$2.7 BILLION	$13 MILLION	2021	$23.5 BILLION	2019	$29.3 BILLION
COMMONSPIRIT HEALTH (Formerly Dignity Health)	SAN FRANCISCO , CA	$3.6 BILLION	$17.4 MILLION	2020	$8.4 BILLION	2018	$21.9 BILLION
TRINITY HEALTH	LIVONIA, MI	$2.3 BILLION	$2.9 MILLION	2019	$13.3 BILLION	2018	$18.5 BILLION
PROVIDENCE ST. JOSEPH HEALTH	RENTON, WA	$3 BILLION	$10.9 MILLION	2019	$14.4 BILLION	2018	$17.8 BILLION
MAYO CLINIC HEALTH SYSTEM	ROCHESTER, MN	$350,000*	$2.8 MILLION	2019	$9.2BILLION	2018	$17.7 BILLION
MASS GENERAL BRIGHAM	SOMERVILLE, MA	$1.7 BILLION	$4.1 MILLION	2020	$9.7 BILLION	2019	$16.2 BILLION
CLEVELAND CLINIC HEALTH SYSTEM	INDEPENDENCE, OH	$118 MILLION	$3.3 MILLION	2019	$9.8 BILLION	2018	$15.7 BILLION
ADVOCATE HEALTH (Advocate Aurora Health/Atrium Health)	MILWAUKEE, WI	$662 MILLION	$13.4 MILLION	2019	$11.7 BILLION	2019	$14.3 BILLION
ADVENT HEALTH (Formerly Adventist Health System)	ALTAMONTE SPRINGS, FL	$747 MILLION	$4.7 MILLION	2019	$4.1 BILLION	2018	$14.3 BILLION
NORTHWESTERN MEDICINE (Formerly Northwestern Memorial Healthcare)	CHICAGO, IL	$419 MILLION	$7.3 MILLION	2020	$8.3 BILLION	2019	$11.9 BILLION
INTERMOUNTAIN HEALTHCARE (IHC HEALTH SERVICES)	SALT LAKE CITY, UT	$518 MILLION	$4.9 MILLION	2019	$7.1 BILLION	2018	$11.7 BILLION
SUTTER HEALTH	SACRAMENTO, CA	$1.8 BILLION	$5.5 MILLION	2019	$9.1 BILLION	2018	$11.4 BILLION
UPMC - UNIVERSITY OF PITTSBURGH MEDICAL CENTER GROUP	PITTSBURGH, PA	$1.4 BILLION	$9.5 MILLION	2020	$5.7 BILLION	2018	$11.3 BILLION
NEW YORK-PRESBYTERIAN HEALTHCARE SYSTEM	NEW YORK, NY	$124 MILLION	$12.4 MILLION	2019	$8.3 BILLION	2018	$11.1 BILLION
INDIANA UNIVERSITY HEALTH (IU HEALTH)	INDIANAPOLIS, IN	$726 MILLION	$3.7 MILLION	2020	$7 BILLION	2018	$10.3 BILLION
HOUSTON METHODIST	HOUSTON, TX	$580 MILLION	$3.5 MILLION	2020	$5 BILLION	2018	$10.2 BILLION
BON SECOURS MERCY HEALTH	CINCINNATI, OH	$1.1 BILLION	$15.8 MILLION	2019	$1.8 BILLION	2018	$9.9 BILLION
TEXAS HEALTH RESOURCES	ARLINGTON, TX	$283 MILLION	$3 MILLION	2019	$6 BILLION	2018	$9.5 BILLION
BAYLOR SCOTT & WHITE HEALTH	DALLAS, TX	$1 BILLION	$4.5 MILLION	2019	$6 BILLION	2018	$8.6 BILLION
TOTALS		$23.6 BILLION	$148.8 MILLION		$200.6 BILLION		$324.3 BILLION

*Note: Net assets taken from the organization's audited financial statements, salary data taken from most recent reported 990 tax filings, 2019/20. Covid-aid amounts from covidstimulaswatch.org. | * Hospital system returned some of its Covid aid*

SOURCE: OPENTHEBOOKS.COM

INTERVIEW

Medical Residents Are Unionizing

Medical residents in many hospitals are unionizing. On May 8, a group of resident and interning physicians at the University of Pennsylvania Health System (Penn Medicine) announced an 892-110 vote in favor of forming a union. The decision followed organizing efforts at major hospitals in Boston (Mass General Brigham), the District of Columbia (George Washington University Hospital), and New York City (Montefiore Medical Center).

The Committee of Interns and Residents, part of Service Employees International Union Healthcare, claims it represents more than 25,000 resident physicians in the United States. *Health Care News* talked to a recent medical school graduate in Oklahoma about the prospects of being asked to join a union. The student asked to remain anonymous.

Health Care News: It is well-known that medical residents can work up to 80 hours a week for often less than $75,000 a year, and they may do this for several years. Did that factor into your decision about where to apply for residencies?

Medical Resident: In Oklahoma, the cost of living is lower than in many big cities. My residency salary will not be that much lower than what recent college graduates will earn. The residency salaries in the more expensive cities are not that much higher. There is a limit on how many hours residents work, but I've heard hospitals can exceed that.

Health Care News: You come from a conservative state, and I imagine unionization does not have the same appeal as in more left-leaning areas. How do you reconcile the long hours for what might amount to being paid less than $20 an hour?

Medical Resident: Residents are truly running the hospital. I saw it when I was doing rounds, and residents just expected to be alerted at any time when a new patient came in. If it wasn't for the residents, a lot of these hospitals really wouldn't be able to run the way they do. They basically get free labor from the residents, because I know they get funds from Congress, for Medicaid and such.

Health Care News: Aren't there limits on how many hours a resident can work?

Medical Resident: The standard is 80 hours a week, but hospitals do exceed that, and there is pressure on residents not to report on that. And if they do, the ACGME [Accreditation Council for Graduate Medical Education] could pull your program's accreditation, which could harm your ability to finish your residency and get fully board-certified to work independently after that. Congress, the hospital, and the American Medical Association control it, and the residents have no say.

Health Care News: Are you open to joining a union?

Medical Resident: Personally, no. The fact this issue is even coming up in hospitals is a signal that the market is not functioning like a free one. There are the employees—the residents—and the hospital, and these two groups can't seem to come to the table to negotiate resolutions to these problems.

Residents, individually, are unable to weigh competing offers like any other employee who might shop the market for better pay and work conditions. My issue with unions is they force everyone to toe the line of the union. They don't get you to the free-market position where you as an individual can advocate what is best in your case.

Health Care News: Could and should hospitals be doing anything more to supplement residents' salaries?

Medical Resident: Some hospitals in the more-expensive cities do try to add living stipends. I have been told this extra pay could amount to $10,000 to $20,000 extra a year, which is not insignificant, but that may not be enough in some places. Some hospitals kick in free meals.

These are all nice, but hospitals need to realize it does benefit them to make sure their residents are compensated fairly or [aren't] working to the point of exhaustion. After all, residents are caring for patients and need to be in peak shape.

Health Care News: Congress controls the number of residencies in the country and has a lot of say on how hospitals are run. So does the American Medical Association (AMA), in determining physician compensation, which influences residency choice. What would you like them to know about this trend toward residents organizing?

Medical Resident: Lawmakers need a more long-term vision. If they want doctors to last 30 to 40 years, they need to start on day one. It serves no one to have residents burned out by the time they're ready to practice independently. It takes a long time to become a doctor, sometimes several decades, which is half the typical working life of many people.

The AMA is more a business than a professional group representing the interests of doctors. They make a lot of money from the [Current Procedural Terminology] code system they own that Medicare uses to pay doctors. They haven't spoken loudly enough about resident pay and work conditions.

A big issue is morale. Seeing from the AMA and Congress a desire to invest in us and our well-being would go a long way to garner the support of current residents and medical students. This is all about investing in the future of physicians who are going to be caring for the population for the next few decades and creating an environment that makes us want to show up for work every day.

"Lawmakers need a more long-term vision. If they want doctors to last 30 to 40 years, they need to start on day one. It serves no one to have residents burned out by the time they're ready to practice independently. It takes a long time to become a doctor, sometimes several decades, which is half the typical working life of many people. The AMA is more a business than a professional group representing the interests of doctors. They make a lot of money from the [Current Procedural Terminology] code system they own that Medicare uses to pay doctors. They haven't spoken loudly enough about resident pay and work conditions."

MEDICAL RESIDENT

Top Medical Journal Article Calls for Race Segregation in Medical Schools

By Harry Painter

An article in *The New England Journal of Medicine* (NEJM) recommends racially separate "caucusing" of students at medical schools.

"Used as part of a broader antiracism and antioppression curriculum, racial affinity group caucusing (RAGC) engages participants in critical introspection through the lens of their own racialized experience," states the NEJM opinion piece.

"RAGCs are facilitated sessions involving participants grouped according to self-identified racial or ethnic identity to support integration of antiracism curricula into clinical practice," the authors of the article state.

The article, "Racial Affinity Group Caucusing in Medical Education—A Key Supplement to Antiracism Curricula," was written by academics and administrators at the University of California, San Francisco (UCSF) and the University of California, Berkeley.

A UCSF pilot RAGC program that supplements "antiracist curricula" and works to "eliminate health inequities" is one model for medical schools to follow, state the authors.

'Addressing Structural Racism'

The NEJM article claims medical education "has historically centered White learners" and is "founded on legacies of colonialism and racism."

Students who are black, indigenous, or of color (BIPOC) endure "personal experiences of racism that are nuanced" and therefore can find the medical education system "retraumatizing," the article states.

The authors cite the Critical Race Theory claim that minorities have been conditioned to defer to whites' defensiveness about their racism as a reason for separation.

"Some BIPOC people have been socialized to care for the egos of White people, to express their emotions only in ways that are palatable to White audiences, and to tread lightly around 'white fragility,'" state the authors. "In a space without White people, BIPOC participants can bring their whole selves, heal from racial trauma together, and identify strategies for addressing structural racism."

'A Tool to Control Us'

Minority students do not need racial "caucuses" to speak openly, says Marilyn Singleton, M.D., J.D., a black graduate of the UCSF School of Medicine.

"If students need someone to whom they can speak freely, they can confide in a friend," said Singleton. "They should not be subjected to university-sponsored segregation.

"To promote racial harmony, we need more open discussion between different individuals, not subjecting white people to struggle sessions and having black or brown people bare their souls to strangers who just happen to be black or brown," said Singleton.

Singleton says the mindset of the UCSF academics is characteristic of elites, not regular people.

"Society itself was evolving to Martin Luther King Jr.'s dream of judging people by the content of their character," said Singleton. "It seems those in power like division and strife as a tool to control us.

"Except for outliers on both sides of the political spectrum, everyday people are getting along fine and do not racialize every word, thought, or action," said Singleton.

'Profound' Segregation Consequences

Separating students by race is counterproductive, says Stanley Goldfarb, M.D., a former University of Pennsylvania medical professor and chairman of Do No Harm.

"It is distressing that such a prestigious medical journal can believe that race segregation is acceptable," Goldfarb said. "This flies in the face of the experience of most Americans, who work with and socialize with many different racial groups. Our society is healthier than our elites' academic institutions would like us to believe.

"The consequences of perpetuating racial segregation are profound and include further dividing an already divided nation," said Goldfarb.

'Start at the Beginning'

There is no evidence to support the claim health care disparities are caused by discrimination, says Goldfarb.

"The principal reason for poor health outcomes is delayed interaction with the health care system, leading to delays in receiving proper care," said Goldfarb. "Increased access is then the way to improve health care outcomes for minority patients."

The best way to improve minorities' health is to prepare low-income students for successful lives overall, says Singleton.

"We have to start at the beginning by improving the schools, including after-school programs, in low-income neighborhoods, to get children started on a path to success," said Singleton. "The current focus on painting people of color as victims compounds the problem. People internalize the political rhetoric and lose hope in their future."

Journal 'Has Become Politicized'

The NEJM has elevated ideology above science, says Goldfarb.

"*The New England Journal of Medicine* has become politicized," said Goldfarb. "The editors and the editorial board have decided that the political ideology of the Left is the only proper approach to dealing with health care for minority populations."

Goldfarb says that damages the journal's credibility, and the way to fix it is for think tanks and research centers in academic medicine to "rigorously study the culture and the scholarship of medical care to identify the real engines of poor health care outcomes."

"It is distressing that such a prestigious medical journal can believe that race segregation is acceptable. This flies in the face of the experience of most Americans, who work with and socialize with many different racial groups. Our society is healthier than our elites' academic institutions would like us to believe. The consequences of perpetuating racial segregation are profound and include further dividing an already divided nation."

STANLEY GOLDFARB, M.D.
FORMER MEDICAL PROFESSOR
UNIVERSITY OF PENNSYLVANIA

A systemic problem with medical journals is centralized control, says Martin Kulldorff, a professor of medicine at the Harvard Medical School who spoke against the public health establishment during the pandemic and coauthored the Great Barrington Declaration.

"While extremely profitable for commercial publishers, the scientific publication system is broken," said Kulldorff. "Controlled by entrenched scientists in each field, scientific journals delay and restrict new important research. The solution is a decentralized system of open-access, open-peer-review journals, where a research article is judged by its content rather than the journal in which it is published."

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

INTERNET INFO

Leanna Lewis, M.S.W., et al., "Racial Affinity Group Caucusing in Medical Education—A Key Supplement to Antiracism Curricula," *The New England Journal of Medicine*, April 27, 2023: **https://www.nejm.org/doi/full/10.1056/NEJMp2212866**

House and Senate Republicans Demand Answers on Trans Youth Experiments

By Tyler O'Neil

Fifteen Republicans in the U.S. House and Senate sent a letter to the National Institutes of Health on May 9, demanding answers about a study on experimental medical interventions for youth who claim to identify as transgender.

Two of the study participants committed suicide, 11 experienced suicidal ideation and the drugs participants took will likely sterilize them, the Republicans noted.

"It is sickening that the federal government is preying on young people and using our taxpayer dollars to advance its radical gender ideology," Rep. Josh Brecheen (R-OK) told *The Daily Signal* in a statement on the letter, exclusively provided to *The Daily Signal*. "We are rightfully demanding answers from NIH, and we are committed to holding those responsible accountable for this tragic loss of life."

Study Participants Are Minors

The National Institutes of Health granted $477,444 in a five-year grant to the Boston Children's Hospital, the University of California at San Francisco, and the Lurie Children's Hospital of Chicago for the study, "Psychosocial Functioning in Transgender Youth after 2 Years of Hormones." Dr. Diane Chen at the Lurie Children's Hospital led the study, which the *New England Journal of Medicine* published in January.

The study analyzed 315 participants, identified as transgender and nonbinary, between the ages of 12 and 20, over the course of two years. These participants received "gender-affirming hormones," i.e. hormones to make their male or female bodies resemble bodies of the opposite sex.

"During the study period, appearance congruence, positive affect, and life satisfaction increased, and depression and anxiety symptoms decreased," Chen's article on the study claims. Eleven participants experienced suicidal ideation, and two committed suicide.

In the letter, the Republicans express "grave concerns" about the study, noting that 240 of the 315 participants were minors.

Study Continues After Suicides

The Republicans cite a report from the medical organization Do No Harm, which found the study "fatally flawed and borderline unscientific."

"Taxpayer dollars should not be used to fund studies that encourage gender transition interventions on young people. The NIH must be held accountable for using taxpayer dollars to study these highly questionable experiments."

SEN. TED BUDD (R-NC)

"Notably, the four clinics and some of the researchers who conducted this experiment are outspoken advocates for conducting gender transition interventions on children," the GOP letter notes. "In a video it later removed from its YouTube channel, Boston Children's Hospital, one of the clinics involved, went as far as to claim that children can know their gender identity 'from the womb.'

Johanna Olson, a coauthor of this paper, told CNN in 2014, 'We're definitely in the middle of a gender revolution and it's exciting.' This same researcher later received a federal grant for a study in which she altered protocol to allow children as young as 8 years old to receive cross-sex hormones."

The Republicans note the two suicides and 11 episodes of suicidal ideation. "Rather than shutting the study down after such serious adverse events, the researchers published their paper, concluding that the study was a success because cross-sex hormones had altered subjects' physical appearance and improved psychosocial functioning," the letter notes.

"However, the researchers admitted that they were not able to properly establish causality between the administration of cross-sex hormones and improved psychosocial functioning because their study lacked a control group," wrote the legislators.

"It is alarming that vulnerable young people died by suicide while participating in a taxpayer-funded study that will almost certainly inflict devastating physical harm on those who participated," the letter adds. "Twenty-four participants in this study received cross-sex hormones after puberty suppression or 'in early puberty' and are likely sterile as a result. Further, participants are now at increased risk for cardiovascular disease, blood clotting, and a list of other complications."

NIH to Fund More Experiments

The Republicans also cite research showing that "gender dysphoria in minors often resolves as they progress through puberty—completely undermining the idea that children should have their bodies permanently altered to match their changing identities."

"Despite overwhelming evidence that chemically transitioning children is not safe, the NIH plans to give more than $10.6 million to experiment on children and adolescents through 2026," the letter adds. "We are deeply concerned about your agency's use of taxpayer dollars to advance experiments on children who will be irreversibly harmed by radical gender ideology."

The letter ends with a request for responses to 14 questions by a deadline of June 9, 2023. The Republicans ask how old the two individuals who died by suicide were, where they received "treatment," and when the researchers at that site alerted other researchers of the suicides.

The legislators ask the NIH to "list the steps that were taken to halt and review the study after the first and second deaths," and whether other participants were notified of the suicides. They also ask whether other participants and their parents were given the opportunity to withdraw from the study following the suicides.

"Have study participants been evaluated to assess sterility or impaired fertility as a result of receiving cross-sex hormones?" the Republicans ask. "Will a follow-up occur to evaluate the long-term physiological state of the subjects?"

Misuse of Taxpayer Dollars

The letter notes that six participants withdrew from the study and asks for these participants' ages and their reasons for withdrawing. It also requests information on "ongoing or proposed NIH funding for studies involving transgender or nonbinary identified minors."

"Despite glaring shortfalls, this government-funded research is already being used to further the fallacy that chemically transitioning children is safe and effective," states the letter.

Sens. Ted Budd (R-NC), Marco Rubio (R-FL), Rand Paul (R-KY), James Lankford (R-OK), and Mike Lee (R-UT) signed the letter as well as Reps. Josh Brecheen (R-OK), Mary Miller (R-IL), Lauren Boebert (R-CO), Andy Biggs (R-AZ), Eli Crane (R-SC), Jeff Duncan (R-SC), Randy Weber (R-TX), Chip Roy (R-TX), Ronny Jackson (R-TX), and Michael Cloud (R-TX).

Budd, who led the effort in the Senate, declared that taxpayers should not have to foot the bill for studies on "gender-affirming care" for minors.

"Taxpayer dollars should not be used to fund studies that encourage gender transition interventions on young people," Budd told *The Daily Signal* in a statement. "The NIH must be held accountable for using taxpayer dollars to study these highly questionable experiments."

Tyler O'Neil (**@Tyler2ONeil**) *is the managing editor of* The Daily Signal.
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White House Touts Actions on Transgender Rights, 'Affirming Care'

By Harry Painter

President Joe Biden officially celebrated a "Transgender Day of Visibility" and released a fact sheet touting his administration's support of transgender children and youth.

"While transgender Americans have an unwavering champion in the President, conservative politicians have advanced hundreds of anti-transgender laws in states across the country so far this year, putting the fundamental rights and freedoms of trans Americans at risk," states the White House document.

The fact sheet lists steps the Biden administration has taken to promote "gender-affirming care" and protect the rights of transgendered persons with federal laws and regulations.

President Joe Biden

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"We will eventually see a tsunami of lawsuits brought by young adults against doctors and health care centers who coerced these patients into transgender procedures as teenagers using these very lies."

MICHELLE CRETELLA, M.D.

Gender Action

Biden administration actions on trans issues have included a new Office of Personnel Management guidance on "gender inclusion in the federal workplace" and the release of a report from the Substance Abuse and Mental Health Services Administration (SAMHSA) detailing "evidence-based practices to affirm and support transgender and LGBTQI+ youth and their families," according to the fact sheet.

"In spite of the overwhelming scientific evidence that affirming an LGBTQI+ child is in their best interest, LGBTQI+ children—especially transgender children—face a nationwide mental health crisis because of the harassment, rejection, bullying, and discrimination they face," states the fact sheet.

The fact sheet says the Biden administration has done "historic work" to support LGBTQI+ people, including the ending of "disparities" in the child welfare and foster care system, supporting trans rights in schools, and ensuring "accurate IDs" and access to government services.

The fact sheet states "gender-affirming care—which includes counseling and mental health supports" improves the well-being of "transgender children." The SAMHSA report states the treatment of dysphoria in trans children and youth may require "medically necessary care," meaning hormonal and surgical treatments. The White House document does not mention that.

Support or Pressure?

The entire fact sheet is "activist propaganda points" that will lead to pressure on patients to undergo transgender procedures, says Michelle Cretella, M.D., co-chair of the Adolescent Sexuality Council for the American College of Pediatricians, and member of the Advisory Board of Advocates Protecting Children.

"We will eventually see a tsunami of lawsuits brought by young adults against doctors and health care centers who coerced these patients into transgender procedures as teenagers using these very lies," said Cretella. "For reasons we can only speculate, this administration—the entire Democrat Party, for that matter—has decided to do all it can to increase the profits of the trans-bio-pharmaceutical complex at the expense of the health and lives of our most vulnerable citizens."

Message to Doctors

The fact sheet sends a message to health care professionals, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons and a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"Probably all providers will be bringing this up [in the exam room], especially if they participate in any government insurance program," said Orient. "Normal, non-confused children will be discriminated against and feel isolated but will get thousands of Facebook friends if they 'come out.' Parents who try to defend their children will not just be shut out but possibly lose custody of their children."

Culture at Stake

Biden's fact sheet is "delusional, harmful, unethical, just plain evil," and it is crucial to push back against the ideology it represents, says Orient.

"If people go along with this, our culture is destroyed," said Orient. "God is not mocked. And nature always wins. Cultures and species have gone extinct many times before. Maybe that is the purpose—the result is the intention."

Cretella says the long-term prognosis for resisting radical transgender ideology is positive, but the actions of the Biden administration will cause harm.

"In the short term, it will make it far more difficult for the silent majority of physicians and mental health professionals to heal these young people and promote optimal mental and physical health," said Cretella. "In the long term, I believe the transgender lies will collapse, in large part due to future lawsuits and ongoing education by those of us dedicated to 'first, do no harm.'"

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

Vermont Becomes Medical Tourism Site for Doctor-Assisted Suicide

By Ashley Bateman

Vermont is the first state to enact a statute permitting doctor-assisted suicide for nonresidents.

Gov. Phil Scott (R) signed Act 39 into law on May 2, making Vermont's measure the most permissive in the United States and opening the door to so-called "suicide tourism."

Vermont was the third state to enact doctor-assisted suicide, in 2013.

Oregon agreed to physician-assisted suicide for nonresidents in March 2022, but that was done through a legal settlement between state administrators and a plaintiff, not legislative action.

Firm Opposition

Vermont Right to Life and True Dignity Vermont staunchly opposed the bill, saying it fails to provide immunity for nurses and pharmacists who don't want to engage in the practice.

The groups also say there is no system in place to track lethal prescriptions, and there are no provisions to prevent abuse, such as requiring a disinterested witness be present at the time of ingestion of a lethal drug to ensure the patient is capable of consent.

Safeguards Dismantled

Currently, 10 states and the District of Columbia permit medically assisted suicide.

After a state has legalized the practice, it is a simple matter for proponents to remove safeguards, says William Toffler, M.D., cofounder of Holy Family Clinic in Oregon and national director of the Physicians for Compassionate Care Education Foundation.

"Every single society that has passed assisted suicide laws has expanded [them] to include those with mental illness, disabled people, and those who have more than six months to live," said Toffler.

In Vermont, safeguards have been systematically removed since its assisted suicide law was first enacted. An amendment passed in 2022 removed the requirement of a face-to-face doctor visit and physical examination before receiving life-ending drugs. The state also dropped its 48-hour waiting requirement.

"Parents can end a child's life in the Netherlands [under certain circumstances]," said Toffler. "There's no stopping it. Once you believe the solution to a medical problem is to kill yourself, you've already accepted that any life is not worth living."

'Family Members ... Subtly Encourage'

When it comes to life-and-death decisions, there are many factors in play, says Marilyn Singleton, M.D., J.D., a visiting fellow at Do No Harm, which works to keep political ideology out of health care.

"The biggest fear of assisted suicide with doctors who do not know the family dynamic is being sure this is what the patient wants," said Singleton. "In many cases, family members cannot be trusted to do what the patient really wants. As cruel as it sounds, some family members see the debilitated person as a burden and subtly or not so subtly encourage assisted suicide."

'Degrades Trust in Doctors'

In Oregon, about 300 of the more than 10,000 registered medical doctors in the state practice assisted suicide, which is not a widely accepted standard of patient care, says Toffler.

"This degrades trust in doctors when a doctor's boundaries involve situational killing if someone is deemed terminal," said Toffler. "In reality, we are all terminal. A doctor's ability to make a determination of when someone will die is often horribly flawed, especially several months out. Doctors can easily kill [a person] prematurely."

Allowing "interstate" practice further degrades patient protections, says Toffler.

"We have state licensing boards for a reason," said Toffler. "Doctors in a state are subject to the state board of medical examiners. Now, individuals are coming from out of state, and next they will likely [administer life-ending drugs] by telemedicine. It's chaotic and breaks down the state board of medicine examiner system and control of doctors."

'Aid in Dying' by Telemedicine

The fact that Vermont's law requires patients to be "physically" in the state to receive the drugs is no assurance, says Singleton.

"We all know how things change," said Singleton. "What if there is another lockdown for a new pandemic or some other public health emergency? Telemedicine would be deemed appropriate."

Advocacy groups that promote doctor-assisted suicide refer to laws like Vermont's with a euphemism, says Singleton.

"Let's be clear, changing the name to 'Medical Aid in Dying' does not change the fact that the doctor is hastening someone's death," said Singleton. "Assisted suicide is for desperate people who would gladly go to another state, assuming they had the money to do so."

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

"The biggest fear of assisted suicide with doctors who do not know the family dynamic is being sure this is what the patient wants. In many cases, family members cannot be trusted to do what the patient really wants. As cruel as it sounds, some family members see the debilitated person as a burden and subtly or not so subtly encourage assisted suicide."

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

Social Isolation Is Epidemic, U.S. Surgeon General Advises

By Ashley Bateman

"Loneliness and isolation represent profound threats to our health and well-being," states U.S. Surgeon General Vivek H. Murthy, M.D., in a public health advisory.

In the cover letter to an 82-page report titled *Our Epidemic of Loneliness and Isolation*, released on May 3, Murthy, the nation's chief public health officer, warns increasing social isolation is harming Americans' health and costly to the economy.

Well-Being Trending Downward

Murthy's report presents surveys and studies from government agencies and private groups that show a growing trend of social isolation beginning in 2003 that was exacerbated by the COVID-19 pandemic lockdowns and school closures.

Social isolation is measured by the number of social relationships and roles, group memberships, and level of "social interaction" in which a person engages. Loneliness is measured by individuals' perceptions.

A study published in 2022 cited in the report found "only 39% of adults in the U.S. said that they felt very connected to others." In addition, the study states, "Recent surveys have found that approximately half of U.S. adults report experiencing loneliness, with some of the highest rates among young adults."

'Alone Time' Growing

Social networks built on participation and strong relationships have declined as social media use soared, according to Murthy's report.

Americans spend an average of six hours a day on social media, and 30 percent of U.S. adults report a "constant" online presence, according to survey data. Their in-person interactions with friends decreased by 20 hours per month, from 2003 to 2020, averaging only 20 minutes a day in 2020.

The greatest reduction in personal interactions was among young adults aged 15 to 24 years. Their time spent with friends declined by nearly 70 percent.

Lockdowns and stay-at-home orders during the COVID-19 pandemic accelerated the trend of declining social participation. A historically low 47 percent of Americans reported belonging to a church, synagogue, or mosque in 2020 during the pandemic.

Costs of Loneliness

Murthy's report states the risk of premature death increases by 26 percent for those experiencing loneliness, and 29 percent for those defined as socially isolated.

Indirectly, isolation and social disconnection result in lower academic achievement and decreased work performance, states the report. "Stress-related absenteeism" in the workforce associated with loneliness is costing employers nearly $154 billion per year.

Older Americans increasingly need services to care for them when they become sick or immobile, the report states. Those costs can be averted by people who have family or friends to help care for them, but 29 percent of households consisted of a single adult in 2022.

"Social isolation among older adults alone accounts for an estimated $6.7 billion in excess Medicare spending annually, largely due to increased hospital and nursing facility spending," states the report.

Pandemic Policies Piled On

Public-health measures imposed or encouraged by governments during the COVID-19 pandemic to slow the spread of the disease—such as masks, remote work, and school closures—have made social isolation worse, says Robert Emmons, M.D., a psychiatrist, clinical ethics advocate, and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"The Surgeon General's report identifies an 'epidemic' of loneliness, but 'iatrogenic' is the word that fits better," said Emmons, using the term for an illness caused by a medical activity such as a treatment or test.

"The advice to improve personal health by increasing social contact is sound and timely, but we can only wish that public health officials had taken a 'do no harm' approach during the pandemic," said Emmons. "Much of the universal risk management policies yielded little in the form of truly preventing serious illness and caused great harm by exacerbating social isolation."

Medicaid Expansion Factor

The Affordable Care Act's (ACA) expansion of Medicaid eligibility to able-bodied adults makes it more difficult to deal with the mental health aspects of social isolation, says Liam Sigaud, a fellow at the Open Health Project at the Mercatus Center at George Mason University.

"There's a lot of crossover between this concern of social disconnection and programs like Medicaid," said Sigaud. "Historically, Medicaid has focused on a few key groups of vulnerable Americans: children, the elderly, those with disabilities, pregnant women, … [but the ACA] threw a wrench in that. That led to a massive increase in Medicaid enrollment."

The newly eligible Medicaid populations compete with existing patients for access to mental health professionals such as psychologists, psychiatrists, and licensed mental health counselors, says Sigaud.

"The concern with this huge influx is that the vulnerable already in the program, specifically adolescents with a lot of social isolation, depression symptoms, and social media use, will have a tougher time finding the professional care they need, because there are so many more people demanding those services," said Sigaud.

"The advice to improve personal health by increasing social contact is sound and timely, but we can only wish that public health officials had taken a 'do no harm' approach during the pandemic. Much of the universal risk management policies yielded little in the form of truly preventing serious illness and caused great harm by exacerbating social isolation."

ROBERT EMMONS, M.D.
PSYCHIATRIST

Limited Access

There is evidence it is more difficult for vulnerable populations of Medicaid patients to access care, says Sigaud.

"Preliminary results show there has been this displacement of the traditional medical population most at risk for negative health outcomes, under Medicaid expansion, but policymakers simply aren't predisposed to think of unintended consequences," said Sigaud. "[These policies] haven't been scrutinized as they should. More than half the residents in the U.S. live in an area with an active mental health provider shortage. That's astonishing given the discussion of social isolation and mental health problems."

Big Band-Aid

Murthy's report recommends adding health care workers, improving infrastructure in the public sector, requiring more transparency from social media companies, and cultivating a "culture of connection."

A similarly ambitious approach to health care was tried and failed during the pandemic, says Emmons.

"What lessons have public health officials learned about making their interventions narrower, higher-yield, and less harmful?" said Emmons. "No reports yet on that topic."

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

COMMENTARY

Health Sharing, an Alternative to Obamacare, Should Be Protected

By Chad Savage, M.D.

After decades in the relative obscurity of small religious communities, health care sharing ministries have become practically a conventional, and much-needed, low-cost alternative to traditional health insurance.

The distinction is that these organizations function through the pooled resources of members based on a shared belief in the biblical principle of bearing one another's burdens.

Health-sharing ministries' popularity erupted after passage of the Affordable Care Act (ACA), which classified several of them as exempt from the ACA's Individual Mandate. By doing so, the federal government validated these organizations as adequate forms of medical coverage.

The repeal of the individual mandate further opened the health-sharing market. Many new organizations sprouted up, and membership skyrocketed from 100,000 in 2010 to one million by 2018.

Faces Growing Pains

Unfortunately, health care sharing's mainstream breakout could be its downfall. Though many were well-intended, bad actors also became attracted to this new market and began to undermine the credibility of honest health-sharing organizations. This led to health sharing's two greatest threats: misunderstanding and fraud.

Misunderstanding is common in all forms of health care coverage. The industry's unnecessarily labyrinthine reimbursement procedures frequently catch patients unaware of their coverage parameters, causing unexpected bills and great frustration if not despair.

Despite recent vocal reports of coverage gaps, however, health-sharing ministries are actually custom-built to cut through much of the coverage confusion inherent in the complex and byzantine coding and billing systems of American health care.

Sharing Is Simpler

Traditional health insurance companies use documents known as medical policies to explain what they won't cover. Each insurance company has its own unique and changing medical policies. United Health, for one example, has a whopping 259 medical policies regarding coverage.

These policies may also be inconsistently applied and based on the insurance company's determination of medical necessity, regardless of the health care provider's justification.

These medical policies can be in addition to the prohibitive prior-authorization programs of these same insurers. Insurance companies' payment refusals receive far less publicity than health-sharing shortfalls, but they're so common in "Big Insurance" that most medical offices require patient signatures acknowledging they will pay for everything insurers will not.

Health sharing ministries have similar criteria, but they're less restrictive and easier to understand. Their religious underpinning and discretion in covering preexisting conditions set them apart from traditional insurance.

Exclusions May Apply

To be sure, prospective members need to be aware of these differences to ensure a satisfactory experience with health sharing. Membership requirements are clearly listed: not using illegal drugs or smoking, for example.

So are coverage exclusions. A heath share member who contracts a sexually transmitted disease through an extramarital affair would not be covered by most groups and should not expect such coverage.

Thus, some media coverage of patient complaints about health sharing is falsely placed, as they really indicate a patient's *misunderstanding* of health sharing, not substantive coverage deficiencies.

> **"Health-sharing ministries must continue to look within themselves to help protect members from the biggest threats that they face: fraud and misunderstanding."**
>
> **CHAD SAVAGE, M.D.**

Fraud is another huge threat. Since the Individual Mandate was removed in 2017, a veritable explosion of start-up health sharing organizations entered the market. While most were well-intended and many are successful, some simply didn't attain a critical membership mass large enough to absorb catastrophic medical expenses, and others were flat-out fraudulent.

Accountability to Shareholders

As with any new or burgeoning industry, health sharing has some growing pains. But it must be preserved for the patient empowerment; the efficient, streamlined processes; and the financial benefits over traditional health insurance coverage, which are nothing less than staggering.

My family received better care and saved $86,000 over five years when health sharing was combined with the more cost-effective care provided by direct primary care.

Health-sharing ministries must continue to look within themselves to help protect members from the biggest threats that they face: fraud and misunderstanding.

The health-sharing industry, for its part, has responded to the need for further patient protection with the creation of a new, voluntary credentialing organization. Further, accountability for issues that have arisen from bad actors already exists in criminal and contract law. New regulations are not needed, but authorities must better police claims of fraud to ferret this out.

It's up to the rest of us to allow neither a few bad seeds nor misunderstanding to derail greater choice and autonomy in caring for ourselves, our families, and each other.

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 RealClearHealth on April 3, 2023. Reprinted with permission.*

COMMENTARY

Empower-Patient Accounts Would Expand Personal Health Options

By Robert Koshnick, M.D.

People could manage their health care spending if they had the means to directly pay for it. That could reestablish a consumer-friendly, cost-effective medical market without the added cost of third-party payers who limit patients' choices.

Prices would then be more in line with the real value of health care.

Journalist John Cassidy famously commented, "By allowing millions of decision-makers to respond individually to freely determined prices, the market allocates resources—labor, capital, and human ingenuity—in a manner that can't be mimicked by a central plan, however brilliant the central planner."

"Reestablishing a direct patient-physician relationship could attract more people into primary care vocations that provide incremental care that can make the biggest difference in people's health outcomes. Medicine might again become an enjoyable profession with lower burnout rates. U.S. health care could once more be the envy of the world."

ROBERT KOSHNICK, M.D.

Empower-Patient Accounts

I propose what I call Empower-Patient Accounts (E-PAs). E-PAs would be like health savings accounts (HSA) without the requirement of having a high-deductible health plan. People could access the money in their E-PA through a smart credit card. The associated financial institution would be responsible for limiting its use to qualified medical expenses.

Subsidies would be means-based. Lower-income people, those who earn no more than two-thirds of the average income, would receive, each year, a flat E-PA subsidy of $3,000, adjusted over time for inflation. People who earn between two-thirds and two times the average income would annually receive a $1,500 subsidy and a tax deduction for $1,500 they could contribute to the account directly. Individuals who earn twice the average income or more could contribute $3,000 into their account per year and receive a tax deduction for all of it.

The funding for E-PAs would be high enough to give people the means to sign up for unrestricted access to primary care through direct primary care and/or pay for such things as medical office visits, deductibles, copayments, coinsurance, and generic drugs. People paying directly for medical care would care about price transparency and would force medical care providers to adopt transparent pricing.

E-PA+HSA

People could have HSAs funded in the same way. The 2023 limits for contributions to an HSA are $3,850 per individual, $7,750 for family coverage. The government could fully fund HSAs for low-income people; half-fund them and make the other half tax-deductible, for middle-income people; and make the whole amount tax deductible for upper-income people.

People would then have two options to pay for health care. They could have individually controlled E-PA and HSA accounts that they own as financial assets to manage their medical care. Or they could continue to have third-party payer insurance that limits their choices and inflates costs.

Those choosing an E-PA and HSA would own their accounts. They would have a financial incentive to maintain healthy behaviors and habits and would determine health care spending as they see fit. Upon death, their heirs could inherit unspent funds that could build family wealth.

Reinsurance for Preexisting Conditions

Those with preexisting conditions might choose to stay on their current health insurance plan instead of choosing E-PA+HSA. However, a federal reinsurance program might make E-PA+HSA a favorable choice even for those with preexisting conditions.

Minnesota and some other states have shifted federal funds to offset the cost of the highest-risk individuals in the individual market. This had the effect of reducing premiums in the overall private insurance market. Private insurance coverage expanded to more than 80,000 individuals when Minnesota instituted reinsurance. Minnesota went from 37th place in health insurance affordability in 2017 to third place in 2021—a historic low, according to the state health department—after instituting the reinsurance program.

Congress could do nationally what Minnesota did. A national reinsurance program could pay part of individual claims disproportionately higher than average. E-PAs and HSAs supplemented by a federal reinsurance program could reduce the economic impact of preexisting conditions by reimbursing insurers for people with high medical care use.

Other safeguards, such as the Federally Qualified Health Centers, federal end-stage renal disease and ALS programs, the Children's Health Insurance Program (CHIP), and nonprofit programs such as Lend a Hand Up would still exist.

Forces of Resistance

A colleague told me this was the best solution he had heard but had words of caution. "It will be opposed by the managed care and insurance industry and by public advocates," he said.

It is possible, however, that the insurance industry and public advocates might like the idea of individually controlled accounts.

My colleague said, "I hope there will be enough forces for good to overcome the inevitable resistance to change." I hope so, too.

People empowered with E-PAs and HSAs would drive costs lower, force improved performance and quality, incentivize innovation, and demand a reduction in costly administrative inefficiencies. Medicine would have to be "patient-friendly" to retain patients and attract new ones.

Reestablishing a direct patient-physician relationship could attract more people into primary care vocations that provide incremental care that can make the biggest difference in people's health outcomes. Medicine might again become an enjoyable profession with lower burnout rates. U.S. health care could once more be the envy of the world.

Robert Koshnick, M.D. (**bob.koshnick@gmail.com**) *is a retired primary care physician from Detroit Lakes, Minnesota. He is chair of the policy committee of the Minnesota Medical Association and author of* Empower-Patient Accounts Empower Patients!

U.S. Senate Budget Committee Debates Health Costs of Climate Change

By Bonner Russell Cohen

The health costs of oil and gas use are rising, said Chairman Sheldon Whitehouse (D-RI) in his opening statement at a U.S. Senate Budget Committee hearing on climate change and health on April 26.

"Health care costs related to the combustion of fossil fuels are estimated to total nearly $820 billion in the U.S., annually," Whitehouse said. "Over the ten-year budget window, that's over $8 trillion."

In addition to the direct costs of medical care, there are indirect costs to the U.S. economy, said Whitehouse.

"The indirect economic costs—from lost work and school days, reduced productivity, and increased economic instability—all add to that $8 trillion burden," said Whitehouse. "If you care about [government] deficits and economic growth, you have to care about climate change and its costs and risks."

"The world's most vulnerable people are those who lack access to reliable and affordable energy. In the Global South, hundreds of millions of people still heat their homes and cook their food using dung or wood. The resulting air quality is terrible, and it shortens life expectancy."

CRAIG RUCKER
PRESIDENT
COMMITTEE FOR A CONSTRUCTIVE TOMORROW

'Little the CDC Can Do'

Testifying at the hearing, Syracuse University professor Carl J. Schramm, Ph.D., J.D. said it is unwise to add climate change to the agenda of public health agencies such as the Centers for Disease Control and Prevention (CDC).

"[E]ven if global warming presented a clear and present danger to the health of every American, there is little the CDC can do to mitigate such a threat," Schramm told the committee.

The nation's experience with the CDC during the recent pandemic shows we should be cautious before expanding the scope of public-health policy beyond what the government can reasonably manage, Schramm told the committee.

"[T]he CDC, the nation's principal agency charged with protecting public health, failed to effectively control the COVID pandemic," said Schramm. "I believe the principal reason is that both the CDC and the larger public health establishment, reflecting in part the initiatives of Congress and major philanthropies, have expanded the scope and definition of public health such that its boundaries are nearly meaningless to the public."

'Long List of "Epidemics"'

The CDC has already become involved in too many areas that have nothing to do with disease, said Schramm.

"The CDC currently deals with a wide range of problems that are not encompassed by the traditional definition of public health, which is 'the science and art of preventing disease, prolonging life, and promoting health,'" Schramm said. "Instead, it deals with a long list of 'epidemics' that are not related to communicable pathogens and cannot be corrected by traditional public health tools. Among these 'epidemics' are gun deaths, traffic fatalities, obesity, domestic violence, workplace violence, and a long list of issues distant from traditional public health threats."

'Threat Multiplier'

Climate change is making all sorts of weather events worse, stated witness Katelyn Moretti, M.D., an assistant professor of emergency medicine at Brown University, in written testimony she read at the hearing.

"Climate change is a *threat multiplier* with health impacts happening through a variety of mechanisms, including worsening temperature extremes, wildfires, coastal storms, spikes in air pollution, and vector-borne diseases, as well as disruptions to supply chains, safe housing, safe working conditions, safe water, nutrition, and health care," said Moretti (emphasis in original).

'Schemes Are Cooked Up'

There is a real threat to public health from ill-conceived policies designed to combat climate change, says Craig Rucker, president of the Committee for a Constructive Tomorrow.

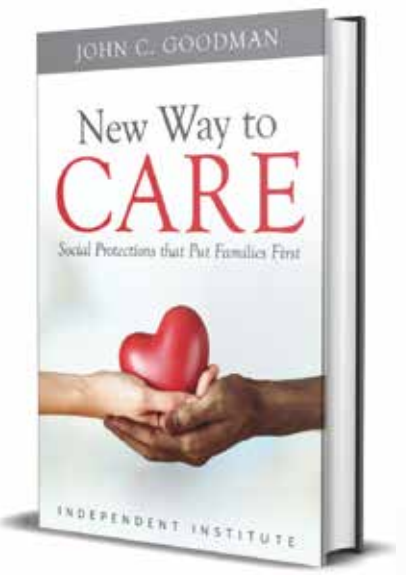
"Data from around the world show that far more people die from extreme cold than from extreme heat," said Rucker. "The world's most vulnerable people are those who lack access to reliable and affordable energy. In the Global South, hundreds of millions of people still heat their homes and cook their food using dung or wood. The resulting air quality is terrible, and it shortens life expectancy."

Policymakers from rich, developed countries ignore the plight of the poor, says Rucker.

"These people's concerns are rarely heard at highbrow global climate conferences where schemes are cooked up that lower agricultural productivity, deepen malnutrition, and perpetuate poverty," said Rucker.

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

New Way to Care!



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

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4

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