Health Care News *is sent to every national and state elected official and thousands of opinion leaders.*

THE HEARTLAND INSTITUTE
IS ONE OF THE WORLD'S LEADING FREE-MARKET THINK TANKS. IT IS A NATIONAL NONPROFIT RESEARCH AND EDUCATION ORGANIZATION.

THE GOODMAN INSTITUTE
WORKS WITH THE BEST SCHOLARS FROM AROUND THE COUNTRY ON THE NATION'S MOST DIFFICULT PUBLIC POLICY PROBLEMS.

HEALTH CARE NEWS

Vol. 24 No. 08 September 2023

HealthCareNewsOnline.com

The Pulse

Unresolved Issue: When Are You Dead?

By Kevin Stone

A nonprofit organization that drafts model legislation for state legislatures is considering changing the definition of clinical death.

During its annual meeting in Honolulu, Hawaii, in July, the Uniform Law Commission (ULC) discussed a revision of the Uniform Determination of Death Act (UDDA). The group was unable to reach a consensus. The discussion will continue at a later date.

Dead or Alive?

Commissioners considered two options.

The first option was to keep the current definition, which states an individual is clinically dead if there is an irreversible cessation of circu-

UNRESOLVED ISSUE, p. 6

New Science Policy: No Apologies for COVID Mistakes

By Dvorah Richman

The White House Office of Science and Technology Policy (OSTP) published a Scientific Integrity Policy (SIP) for federal agencies on June 22.

The purpose of the SIP is "to provide instruction and guidance to enhance and promote a continuing culture of scientific integrity" at the OSTP and other Executive Branch agencies.

Congress established the OSTP in 1976. It resides in the Executive Office of the President, has specific advisory duties, and is a source of scientific and

COVID MISTAKES, p. 4

NON PROFIT
ORGANIZATION
US POSTAGE PAID
BEAVER DAM, WI
PERMIT NO. 412

The Heartland Institute
3939 North Wilke Road
Arlington Heights, IL 60004

Health Care News

The Heartland Institute
3939 North Wilke Road
Arlington Heights, IL 60004
312/377-4000 voice • 312/277-4122 fax

Goodman Institute
6335 W Northwest Hwy - #2111
Dallas, TX 75225

Health Care News is available on the internet. Point your web browser to **HeartlandDailyNews.com**

PUBLISHED BY
James Taylor, The Heartland Institute
John C. Goodman, Goodman Institute

EXECUTIVE EDITOR
S.T. Karnick

MANAGING EDITOR
AnneMarie Schieber

SENIOR EDITOR
Joe Barnett

PUBLISHER
Jim Lakely

DESIGN AND PRODUCTION
Donald Kendal

ADVERTISING MANAGER
Jim Lakely

CIRCULATION MANAGER
Keely Drukala

CONTRIBUTING EDITORS
Brian Blase, Dean Clancy
Twila Brase, R.N.
Matt Dean, John Goodman
Devon Herrick, Phil Kerpen
Jane Orient, M.D., Chad Savage, M.D.
Marilyn Singleton, M.D.

ADVERTISING: *Health Care News* accepts display advertising and advertising inserts. For an advertising kit with rate card, contact Associate Publisher Jim Lakely at 312/377-4000, e-mail **jlakely@heartland.org**.

Health Care News is published by The Heartland Institute and The Goodman Institute—nonprofit and nonpartisan public policy research organizations serving the nation's federal and state elected officials, journalists, and other opinion leaders. Their activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

U.S. Drug Patents Put at Risk by WHO COVID Policy

By Kevin Stone

The U.S. International Trade Commission (USITC) has launched an investigation into the proposed expansion of a trade agreement waiver on intellectual property (IP).

The Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), which establishes regulatory standards for intellectual property among members of the World Trade Organization (WTO), was waived during the COVID-19 pandemic.

In October 2020, South Africa and India proposed setting aside IP rights to expedite the manufacture of COVID-19 vaccines. After agreeing to the waiver, the WTO proposed expanding it to include COVID-19 diagnostics and therapeutics. Opposition was swift. The U.S. Chamber of Commerce's Global Innovation Policy Center pleaded with the Biden administration to oppose the change.

The expansion was opposed by major pharmaceutical manufacturers, patent rights advocacy groups, and analysts who say it is a threat to continued U.S. investment in the development of patentable medical technologies.

A report on the proposed TRIPS waiver expansion is due to the U.S. Trade Representative on October 17.

Waiver 'Not Limited to Vaccines'

Opponents of the expanded waiver note demand for COVID-19 vaccines has plummeted.

Currently, the global vaccine supply vastly outstrips demand. Nonprofit organizations, such as the International Vaccine Alliance, called Gavi, stopped supplying COVID shots to most nations by December 2022.

In May 2021, 16 U.S senators sent a letter to Commerce Secretary Gina Raimondo and U.S. Trade Representative Katherine Tai, urging the administration to withdraw support of the original TRIPS waiver. Signers included Tom Cotton (R-AR), Mike Lee (R-UT), and Ben Sasse (R-NE).

"The waiver, which is not limited to vaccines, will do nothing to end this global pandemic," wrote the senators. "Instead, it will undermine the extraordinary global response that has achieved historically remarkable results in record time and our nation's global leadership in the technologies, medicines, and treatments of the future."

'Unconscionable to Remove Protections'

The waiver is unjustified, says Walter G. Copan, Ph.D., vice president for research and technology transfer at the Colorado School of Mines.

"It is particularly unconscionable to remove protections afforded to innovations in diagnostics and therapeutics after the World Health Organization has formally declared that the COVID-19 pandemic phase is over," said Copan. "Hence, no credible justification for the waiver exists."

There is no reason to waive IP rights when major drug makers already provide doses to developing nations in sufficient volume and at a discount, says Devon Herrick, a health economist and former senior fellow at the National Center for Policy Analysis.

"The United States is the world leader in the development of new drugs and drug therapies," said Herrick. "With the worst of the pandemic over, there is no reason to extend the TRIPS waiver and deny protection for intellectual property. Furthermore, drug makers have been willing to sell to poor nations at drastically reduced costs. It makes little sense, then, to allow poor countries to buy unlicensed generic drugs made abroad."

'Set a Devastating Precedent'

The waiver also poses national security risks because it allows competitor nations such as China to pilfer U.S. intellectual property by claiming "developing nation" status, Copan says.

"Expanding the TRIPS waiver to COVID-19 diagnostics and therapeutics would set a devastating precedent for government nullification of constitutionally guaranteed IP rights in the future," said Copan.

"IP-intensive industries support over 60 million U.S. jobs, and further eroding the reliability of America's IP protections would clearly threaten many of them," said Copan. "However, the threat goes well beyond future returns on R&D investment. Globally waiving the rights of U.S. inventers risks handing hard-earned innovations to America's economic competitors, including China."

'Disregard' for Innovators' Rights

The expansion of the waiver endangers all IP rights, says Copan.

"The WTO's vaccine IP waiver merely 'encouraged' China, as a 'developing nation,' not to seize U.S. innovations, and the proposed expansion of the TRIPS waiver opens the door to a disregard for the rights of innovators everywhere," said Copan.

In addition to being unnecessary, the waivers pose a risk to ongoing investment in medical research and development, says the Center for Innovation and Free Enterprise (CIFE), a project of Americans for a Balanced Budget, Inc., which opposed the expanded waiver in a press release in April.

"Intellectual property rights are essential for promoting innovation, investment, and economic growth," the CIFE stated. "The TRIPS agreement already provides adequate flexibilities to ensure access to medicines in times of public health emergencies."

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

New Science Policy: No Apologies for COVID Mistakes

Dr. Anthony Fauci

PHOTO COURTESY NIAID/FLICKR.COM

Continued from page 1

technological analysis and judgment for the president.

The policy applies to the "whole of government," covering "all staff, including career employees, contractors, and political appointees."

'Science Benefits from Dissent'

OSTP's policy "provide[s] instruction and guidance to enhance and promote a continuing culture of scientific integrity," the document states.

The SIP defines scientific integrity as "adherence to professional practices, ethical behavior, and the principles of honesty, objectivity and transparency when conducting, managing, using the results of, and communicating about science, and scientific activities. Inclusivity and protection from inappropriate influence are hallmarks of scientific integrity."

The SIP section on policy "requirements" reflects prior guidance about scientific integrity issued during the administrations of President Joe Biden and President Barack Obama.

A bullet-pointed section of "guiding principles" states, in part, "Science benefits from dissent within the scientific community to sharpen ideas and thinking. Scientists' ability to freely voice the legitimate disagreement that improves science should not be constrained. … Transparency underpins the robust generation of knowledge and promotes accountability to the American public."

'Free of Misinformation'

Other SIP principles relate to the public availability of scientific findings and investigating possible lapses of integrity in research.

"Violations of scientific integrity should be taken as seriously as violations of government ethics, with comparable consequences," states the SIP.

One goal of the policy is to "[r]eflect scientific information appropriately and accurately and ensure that it is free of misinformation." The SIP does not define misinformation, but the Surgeon General's 2021 advisory titled "Confronting Health Misinformation" states it is information "that is false, inaccurate, or misleading according to the best available evidence at the time."

Dubious Government Practices

The policy has raised questions about whether it is a product of politics or science after the federal government worked to suppress opinions with which it disagreed during the COVID-19 pandemic.

Attorneys general from Louisiana and Missouri, along with several individuals, argued in *Missouri v. Biden* that U.S. government officials coerced many social media companies, including Google and Facebook, to suppress and censor what the government called "misinformation," "disinformation," or "malinformation" about COVID and other significant issues.

On July 4, U.S. District Judge Terry A. Doughty granted a preliminary injunction barring eight federal agencies and many government officials from meeting or communicating with various social media companies "for the purpose of urging, encouraging, pressuring or inducing in any manner … removal, deletion, suppression, or reduction of content containing protected free speech."

The judge's 155-page ruling extensively documented circumstances where government officials significantly encouraged and coerced social media companies to censor and remove information—"almost exclusively conservative"—that questioned or was contrary to government policies, effectively making the companies government agents.

Doughty wrote that the "seemingly unrelenting pressure by [the government] had the intended result of suppressing millions of protected free speech postings by American citizens" and the government had assumed a role "similar to an Orwellian 'Ministry of Truth.'"

Protecting Government Censorship

The government opposed Judge Doughty's preliminary injunction, which was stayed by the Fifth Circuit Court of Appeals, allowing the government to continue pressuring social media companies.

The stay is being challenged by the plaintiffs. The case will eventually be heard on its merits in the Fifth Circuit.

John Vecchione, a senior litigation counsel for the New Civil Liberties Alliance, which represents individuals in *Missouri v. Biden*, said the government doesn't want transparency, it hasn't rebutted "compelling facts" about the government's tactics, and government agencies are "fighting like maniacs" to continue suppressing free speech.

In addition to overlooking the current political climate, there are questions about enforcement of the SIP. OSTP serves only in an advisory capacity, and although OSTP uses mandatory language like "must adhere to," "requirements," and "ensure compliance," a policy is not a law or regulation and cannot be enforced.

Calls for Action

Jay Bhattacharya, M.D, Ph.D., a coauthor of the Great Barrington Declaration and a private plaintiff in *Missouri v. Biden*, said OSTP's position on scientific integrity "presents laudable goals of transparency and honesty."

During the pandemic, "the government disastrously failed in achieving these goals," said Bhattacharya. Top scientific bureaucrats "abused their power by smearing outside scientists who were critical of their policy stances," and they organized "public, devastating takedowns of their positions," said Bhattacharya.

In many cases, according to Bhattacharya, government demands included suppression of inconvenient but valid scientific findings such as that the COVID shot does not prevent disease transmission.

Scott Atlas, M.D., who served as Trump's COVID-19 advisor, said the "government itself has violated public trust and harmed the public by directly censoring information" and adds the media are also responsible for permitting the free flow of information that is "critical to a free society."

Bhattacharya urges the government to abide by OSTP's scientific integrity principles, stop fighting the temporary injunction in *Missouri v. Biden,* and dismantle its censorship efforts.

Dvorah Richman, J.D. (**dvorahrichman@gmail.com**) *writes from Fairfax, Virginia.*

Is It Time to Stop Worrying About COVID?

By Bonner Russell Cohen

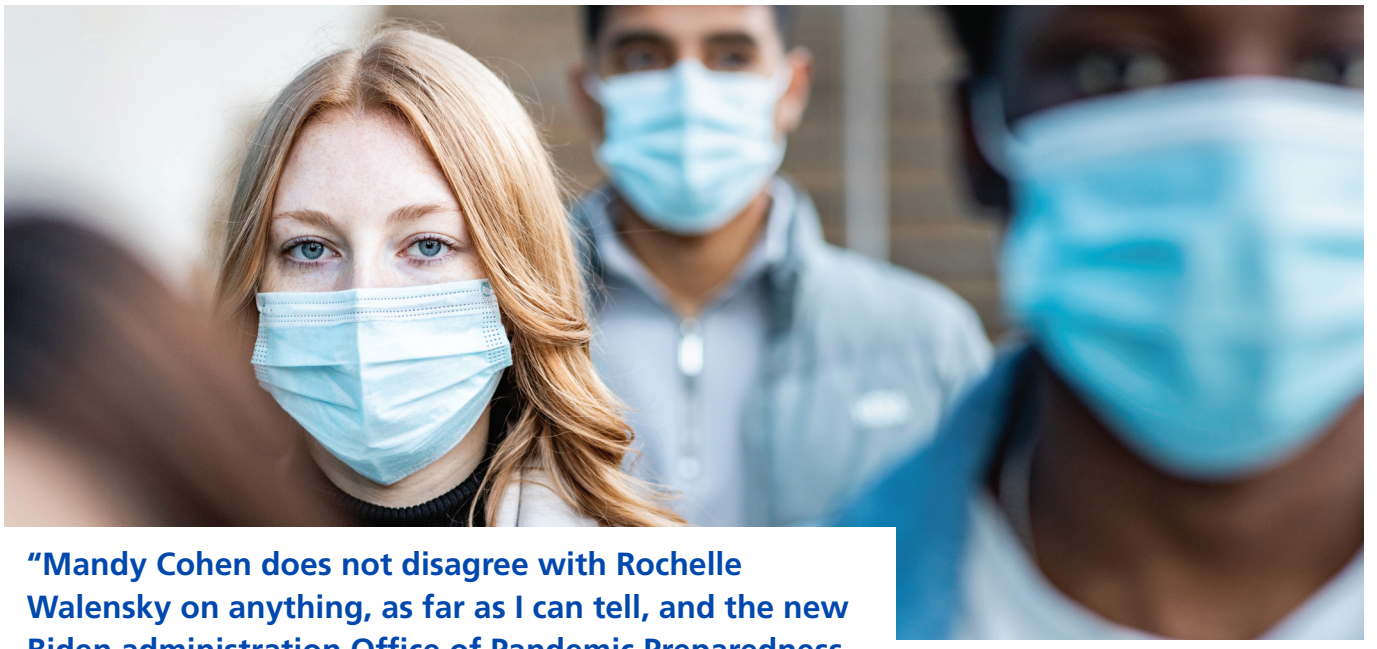
The coronavirus is finally losing its grip on the American public, the news media, and the Biden administration.

Packed airports over the summer, after the White House formally lifted the COVID-19 public health emergency in May, signaled the end of the pandemic. *NBC News* reported the number of excess deaths in the United States had plummeted to pre-pandemic levels and free COVID tests are harder to come by, on July 17.

The New York Times (NYT) described the development as "A Positive Covid Milestone."

"After three horrific years, in which Covid has killed more than one million Americans and transformed parts of daily life, the virus has turned into an ordinary illness," the *NYT* reported.

The Washington Post reported on June 25 the University of Pittsburgh Medical Center cared for less than 20 patients with coronavirus across its entire system in mid-June, compared with 1,200 at the height of the Omicron wave in early 2022.



"Mandy Cohen does not disagree with Rochelle Walensky on anything, as far as I can tell, and the new Biden administration Office of Pandemic Preparedness and Response Policy represents an institutionalization of failure. Some of the personnel have changed, but there has been no official acknowledgment that lockdowns were a catastrophic error, and the refusal of the public health establishment to admit error puts America at risk of lockdown relapse every respiratory season."

PHIL KERPEN
PRESIDENT, AMERICAN COMMITMENT

No More U.S. Funding

The Biden administration appears to be taking a new approach to COVID-19, with get-tough initiatives on censorship and China.

In addition to a "scientific integrity" panel announced by the White House Office of Science and Technology Policy (see related article, opposite page), the U.S. Department of Health and Human Services (HHS) said it would stop funding the Wuhan Institute of Virology (WIV).

The WIV lab has been suspected as the source of the coronavirus since the pandemic reached the United States in 2020. HHS says the step is needed because Chinese authorities refused to turn over documents relating to lab safety and security.

"This action will ensure that [WIV] does not receive another dollar of federal funding," a spokesman for HHS told *Bloomberg News*.

Departure of Lightning Rods

No one embodied the federal government's response to COVID-19 more than Anthony Fauci, M.D., the now-retired former director of the National Institute of Allergy and Infectious Diseases.

Fauci, who also served as President Biden's chief medical adviser in 2021 and 2022, was criticized for his contradictory statements on masks and other aspects of the federal response to the pandemic, and his less-than-candid statements on his agency's funding of the WIV, where gain-of-function research was taking place.

Rochelle Walensky, M.D., has stepped down as director of the Centers for Disease Control and Prevention (CDC). Walensky, who acknowledged the CDC "did not reliably meet expectations" during the pandemic, will be replaced by Mandy Cohen, M.D., former head of the North Carolina Department of Health and Human Services.

Also departing the scene is Ashish Jha, the White House COVID-19 response coordinator from April 2022 to June 15, 2023. A staunch advocate of the Biden administration's vaccine campaign, Jha recommended people get the latest booster to protect them against the virus's mutating variants.

New White House Pandemic Office

Although some familiar faces associated with COVID-19 will be gone, a newly created office in the White House could provide a certain degree of policy continuity.

The Office of Pandemic Preparedness and Response Policy (OPPR), established by law in 2022, will be headed by retired Air Force Maj. Gen. Paul Friedrichs. Friedrichs previously served as joint staff surgeon at the Pentagon, where he oversaw all health services, including the military's COVID-19 response.

"During the height of the pandemic, the Biden-Harris Administration made historic progress in COVID-19 vaccines, tests, and treatments that were made widely available," the White House said in a July 21 statement. "OPPR will continue to leverage these investments as it drives future progress in combatting COVID-19 and other public health threats."

'An Institutionalization of Failure'

Phil Kerpen, president of American Commitment, a free-market advocacy group, sees nothing encouraging in the steps taken by the Biden White House.

"Mandy Cohen does not disagree with Rochelle Walensky on anything, as far as I can tell, and the new Biden administration Office of Pandemic Preparedness and Response Policy represents an institutionalization of failure," said Kerpen. "Some of the personnel have changed, but there has been no official acknowledgment that lockdowns were a catastrophic error, and the refusal of the public health establishment to admit error puts America at risk of lockdown relapse every respiratory season."

'Not a Substitute for Accountability'

The administration's publication of a "guidance" on scientific integrity is more telling than the White House realizes, says Jeff Stier, a senior fellow at the Consumer Choice Center.

"This situation evokes thoughts of those ubiquitous warning signs such as 'Do not attempt to open the train's doors, even if the train is not on a bridge,'" Stier said. "It makes me wonder what happened to necessitate such a strange warning. Similarly, here the utterly toothless 'Scientific Integrity' guidance is just as obvious as the train warning, but it raises real questions about what happened to prompt such a guidance.

"Unfortunately, the Biden administration refuses to acknowledge that many of its own [agencies] did the equivalent of opening the door of a moving train," said Stier. "These guidelines are not a substitute for accountability."

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

Unresolved Issue: When Are You Dead?

Continued from page 1

latory and respiratory functions or an irreversible cessation of all functions of the entire brain, including the brain stem.

The second option would change the word "irreversible" to "permanent," and instead of "all functions of the entire brain," would state, "permanent coma, cessation of spontaneous respiratory functions, and loss of brainstem reflexes."

Heidi Klessig, M.D., a retired anesthesiologist writing at respectforhumanlife.com, presented a summary of the meeting after watching it on a livestream.

"During the meeting, Professor Nita Farahany described the RUDDA [revised UDDA] language change this way: 'irreversible' means 'cannot be reversed'; 'permanent' means 'will not be reversed,'" wrote Klessig. "In short, this means that you can be declared legally dead because your doctors are unwilling to intervene on your behalf. This would allow the same person, with the same brain function, to be declared either dead or alive based entirely on their doctors' intentions."

"Now they are pushing to declare people who have significant cognitive injuries or disabilities as being dead."

ALEX SCHANDENBERG, CHAIRMAN, EUTHANASIA PREVENTION COALITION

Fierce Opposition

Before the meeting, several dozen individuals and organizations, including the Association of American Physicians and Surgeons, the Catholic Medical Association, the Christian Medical and Dental Association, National Right to Life, and The Arc, an advocacy group for the disabled, objected to the revised definition.

The National Catholic Bioethics Center and the U.S. Conference of Catholic Bishops expressed their opposition in a joint statement.

"Nothing in Catholic teaching provides support for lowering the criterion to something less than 'irreversible cessation of all functions of the entire brain,'" stated the Catholic groups. "We are opposed to lowering that standard in the absence of compelling scientific evidence."

The statement also referenced a controversial new procedure that maintains oxygenation and blood flow to harvestable organs while shutting off blood flow to, and effectively killing, the brain.

"Under this controversial protocol, the transplant team could directly cause the death of the donor," the organizations stated.

Legal Cover for Diagnosis

The push to change the death definition was prompted by a group of specialists, Klessig told *Health Care News* on February 24.

"According to the American Academy of Neurology, the reason that these revisions are being proposed in the first place is to make it more difficult to challenge a brain death diagnosis in a court of law," said Klessig. "Clearly, the revisions to the UDDA will stack the deck against families and will only promote the interests of the transplant industry."

Canada Broadened Definition

Canada now defines death as "permanent" cessation of brain function and has broadened laws regarding euthanasia to allow doctors to assist in the suicide of mentally ill patients.

The Euthanasia Prevention Coalition (EPC), a Canada-based organization, notes 50 percent to 84 percent of brain deaths are misdiagnosed under the current standard.

"Remember Damar Hamlin, the football player who collapsed during a game when his heart stopped?" wrote Sara Buscher on the EPC blog, on June 19. "His heart was restarted several times on the field, but he was unconscious (i.e., in a coma) and ended up in the hospital on a ventilator."

Hamlin could have been declared brain-dead under the revised definition, Buscher writes: "What if the doctors decided to stop restarting his heart?"

Damar was treated, recovered, and is playing football again.

What Is Next?

"In a sense, the future is already here," Klessig told *Health Care News* before the July meeting.

"The proposal before the ULC is about changing the legal definition of death in America to reflect what doctors are already doing, ... diagnosing death by neurological criteria according to looser standards than what the law stipulates," said Klessig. "And this has led to lawsuits because families have recognized that doctors did not fulfill the requirements of current law when diagnosing their children or family members as brain-dead."

The new definition is all about providing more latitude to human-organ harvesters, says Alex Schadenberg, international chair of EPC.

"The organ harvesting industry wants greater access to healthy organs," said Schadenberg. "When a person is not dead yet, their organs are healthier because they have not experienced the deterioration that occurs soon after death ensues."

'Who Is Next?'

The revisions to the definition of death represent an incremental step toward more broadly defining death in a manner that marginalizes the cognitively disabled, says Schadenberg.

"All of these changes happen in steps," said Schadenberg. "Now they are pushing to declare people who have significant cognitive injuries or disabilities as being dead. Soon they will define those with permanent but less severe cognitive disabilities as being dead. The question is, who is next?"

Nancy Valko, R.N., a spokesperson for the National Association of Prolife Nurses, says the redefinition represents a risky move toward euthanasia and limiting informed consent.

"Another potential problem is 'presumed consent,' which is the assumption that everyone is willing to donate his or her organs unless there is evidence that they would not want to donate," said Valko.

"Illinois narrowly avoided a 'presumed consent' statute a few years ago where people who didn't want to donate [would have] had to file an opt-out document with the Secretary of State," said Valko. "Even more horrifying, there have also been proposals to link organ donation and assisted suicide as a potential solution to the organ-scarcity problem. Countries like Belgium and the Netherlands already allow this."

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

Patients Lose Life to Donate Organs

By AnneMarie Schieber

Recent news articles about deaths in tragic circumstances indicate patients with impaired consciousness are being allowed to die so their organs can be harvested.

Patients must exhibit signs of life for hospitals to harvest viable hearts, lungs, entire livers, and both kidneys.

Life Support After Death

Recent reports include that of 38-year-old Aimee Sachs, who died after suffering two strokes within a matter of weeks.

On June 2, the *Tallahassee Democrat,* where Sachs worked as a reporter, reported the family was told Sachs had "locked-in" syndrome. Through blinking, Sachs reportedly indicated she wanted to become an organ donor after being told by her father, "You'll always have the ability to think and feel things, but you're trapped in your body."

On June 15, the *New York Post* reported Mia Kanu, a 23-year-old college student from Michigan, became a live organ donor by being put back on life support after being pronounced dead. Police are investigating Kanu's death as a homicide after she was found lying on a road after being ejected from a car.

On August 3, the *New York Post* published an article reporting on how Ashley Summers, a 35-year-old wife and mother of two children donated her heart, liver, lungs, kidneys, and long bone tissue, "ultimately saving five other lives," according to her family. Summers suffered from water toxicity after consuming too much water in a short period of time.

"Since the concept of brain death was enacted into the Uniform Determination of Death Act (UDDA) and brain death was declared as equivalent to human death (National Conference of Commissioners on Uniform State Laws, 1981), this act has been a driving force to permit organ procurement in heart-beating donors."

PAPER PUBLISHED ON THE NATIONAL LIBRARY OF MEDCINE WEBSITE

Locked-in Author

Conscious patients and distraught families are asked to make these choices at the worst time, says Heidi Klessig, M.D., a retired anesthesiologist who writes and speaks on the ethics of live organ transplantation.

"The sad part is that disabled people are so often given bad information and rushed into a life-ending decision," said Klessig.

"Jean-Dominique Bauby was an editor for the French *ELLE* magazine when he suffered a brainstem stroke and developed locked-in syndrome," said Klessig. "He wrote an amazing book, *The Diving Bell and the Butterfly,* about his incredible life of the mind while his body was immobile. The book was also made into a movie. Was the reporter or her family given this information?"

'Concealed Practice'

Klessig says a paper published in 2009 on the National Library of Medicine website may provide context for the recent cases.

"Since the concept of brain death was enacted into the Uniform Determination of Death Act (UDDA) and brain death was declared as equivalent to human death (National Conference of Commissioners on Uniform State Laws, 1981), this act has been a driving force to permit organ procurement in heart-beating donors," the authors wrote.

The authors concluded, in part, "Heart-beating or non-heart-beating organ procurement from patients with impaired consciousness is de facto a concealed practice of physician-assisted death, and therefore, violates both criminal law and the central tenet of medicine not to do harm to patients."

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

'Do Not Resuscitate' Case Goes to Trial

A Wisconsin judge has set a date for a three-week jury trial in a wrongful death case against doctors and a hospital for placing a "do not resuscitate" (DNR) order for a Down syndrome patient without the knowledge or permission of her family.

Family Sues for Wrongful Death

Grace Schara, a 19-year-old, was admitted to St. Elizabeth's Hospital in Appleton, Wisconsin in October 2021 for COVID-19. Seven days later she died after hospital staff refused to intervene when her vital signs plummeted.

Grace's family later learned about the DNR order and claimed medical personnel administered a combination of lethal and unnecessary drugs, hastening her death.

The family filed a lawsuit against Ascension Health, five medical doctors, and others, on April 11, 2023. On July 18, an Outagamie County judge heard motions from the defense to dismiss the case and give a declaratory judgment, arguing the case was moot and not about wrongful death but malpractice.

In a courtroom packed with Schara supporters, according to news reports, Circuit Court Judge Mark McGinnis rejected both motions and set a "fast track" trial date for November 4, 2024.

Consent Issue Seen As Critical

In a news release, Grace's father, Scott Schara, said the suit is a "bellwether case" much bigger than simple malpractice.

"Our goal is simple: save lives," said Schara. "That's why this case is first about the lack of informed consent—a battery—leading to negligence and malpractice, which then resulted in wrongful death.

"Moreover, this case is about protecting the public from doctors unilaterally placing DNR orders on patients," Schara said. "If we would have had informed consent, Grace would be with us today."

Grace's family is funding the lawsuit themselves.

"We had originally budgeted $250,000 for the trial, not knowing how long it would be, but since the trial has now been scheduled for three weeks, it looks like the cost will be closer to $350,000," Schara told *Health Care News*.

The family has set up a page on the fundraising platform Give Send Go for members of the public who want to support their effort.

—Staff reports

COMMENTARY

States Buckle Down to Remove Ineligible People from Medicaid

By Matt Dean

Skyrocketing Medicaid costs were already threatening to overpower every other priority in state budgets before the pandemic. As COVID-19 spread, national Medicaid enrollment ballooned from 23 million people to 95 million under relaxed eligibility requirements.

States were given enhanced funding from the federal government to load more people onto Medicaid while simultaneously being barred from disenrolling anyone who didn't request it.

Now that the COVID-19 emergency is over, states must unwind the Medicaid COVID-19 expansion and transition nonqualifying enrollees back to private health insurance and taxpayer-supported exchanges. The Urban Institute predicts as many as 15 million Americans will "lose" insurance as pandemic-era emergency declarations expire and states can resume disenrolling people who do not qualify for Medicaid.

However, the Urban Institute acknowledges "almost all" are eligible for state-supported insurance exchanges, employer-sponsored health insurance, or Medicaid itself through redetermination. As COVID-19 relief funds dry up and hospitals scramble to balance their books, those who no longer qualify for Medicaid should have to transition to private insurance.

Medicaid Explosion

To provide care to those who truly need it and make health care insurance premiums more affordable for businesses and families who pay for private health insurance, states must stop paying for people who do not qualify for social service programs, whether it is because they make too much money, live in another state, or are dead.

In January 2023, more than 93 million Americans were enrolled in Medicaid. According to Centers for Medicare and Medicaid Services (CMS) data, $80.6 billion was improperly spent in 2022, and a staggering $98 billion was misspent in 2021.

The vast majority of these improper payments (66.4 percent for Medicaid) went to payments deemed improper because of eligibility problems.

Texas Takes Action

In Texas, state Sen. Lois Kolkhorst (R-Brenham) introduced legislation to stop some of the improper payments flowing through pandemic-related social service programs. SB 745, which makes simple changes to expand the investigations of the Office of the Attorney General (OAG), was signed into law by Gov. Greg Abbott on May 29.

The OAG investigates dozens of these cases of fraud each year. Since 2000, the OAG has recovered more than $2.5 billion for taxpayers under the Texas Medicaid Fraud Prevention Act. The OAG can now expand its scope to include associated social services such as the Children's Health Insurance Program and the Healthy Texas Women program, along with many others administered by the Department of State Health Services.

Eligibility Checks

Texas Medicaid enrollment grew from 3.99 million in April 2020 to 5.12 million in December 2021. Much of that growth was forced by the presumption of continuous eligibility. Under SB 745, enrollees will be checked for eligibility and disenrolled if they no longer qualify.

State officials aim to minimize disruption by giving priority to those who are most likely to continue benefits. For example, a mother who became eligible when she became pregnant two years ago is more likely to transfer off Medicaid than her fully disabled neighbor and so will have eligibility redetermined first.

Texas has increased staff for the extra services required to unwind pandemic-era eligibility standards. Since April 2022, the Texas Health and Human Services Commission has added 1,000 eligibility staff to its workforce.

Recession-Ready Rules

Other states are using vendors to help locate vulnerable enrollees and manage their redetermination while recapturing costs by eliminating waste, fraud, and abuse.

In Iowa, SF 494, signed into law by Gov. Kim Reynolds on June 1, tackles redetermination with the help of contracted consultants.

States should continue to find meaningful ways to communicate with program enrollees to help determine their eligibility for scarce health care resources. The Paragon Health Institute has published a list of specific steps states can take and published a paper on the cost of delaying disenrollment.

As unemployment increases, so do the size and cost of Medicaid. A future recession may give state legislators little choice but to stop paying for the health care of people who don't qualify for Medicaid and to consider prosecuting those who are stealing health care resources from those who need it the most.

Matt Dean (**dean@heartland.org**) *is senior fellow for health care policy outreach at The Heartland Institute. An earlier version of this article was published at heartland.org.*

"States should continue to find meaningful ways to communicate with program enrollees to help determine their eligibility for scarce health care resources. The Paragon Health Institute has published a list of specific steps states can take and published a paper on the cost of delaying disenrollment."

MATT DEAN
SENIOR FELLOW
THE HEARTLAND INSTITUTE

Texas Reforms Health Care to Lower Prices, Broaden Choices

By Bonner Russell Cohen

In a bid to control the rising cost of health care, the state of Texas has enacted legislation that offers patients and providers more options and recoups losses from Medicaid fraud.

One of the new laws targets rising prescription drug prices by allowing Texans to import cheaper pharmaceuticals from Canada as of September 1.

The Wholesale Prescription Drug Importation Program, HB 25, introduced by Rep. James Talarico (D-Austin), was signed into law by Gov. Greg Abbott on June 12.

Expecting Lower Drug Prices

"The program would allow Texas to import low-cost drugs from Canada with 'tight regulatory safeguards from the FDA,' according to a press release from Talarico's office," KUVE-TV reported on its website when the bill was passed unanimously by the Texas Senate. The House of Representatives had approved the bill by 144 to 1.

Talarico cites estimates his bill will save Texans 60 percent to 70 percent on items such as EpiPens, blood pressure medicine, and cancer drugs. Six states have adopted similar policies.

"Texans are choosing between their medications and their groceries—and many of them are choosing to go without their medications," KUVE reported Talarico as saying.

Questions About Quality

Merrill Matthews, Ph.D., a resident scholar at the Texas-based Institute for Policy Innovation, says he doubts the drug importation law will have the desired effect.

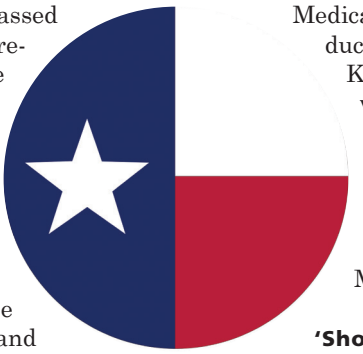
"No state representative can ensure that the drugs come from Canada, even if they are shipped from Canada," said Matthews. "And the FDA has no authority to police Canadian drugs and has said so many times."

"Ironically, Texas's own [businessman] Mark Cuban has established the nonprofit Cost Plus Drug Company, which is essentially bypassing the pharmacy benefit management companies and selling directly to customers at very low prices," said Matthews. "Cuban's pharmacy is a much better option than another failed importation scheme, and it's available now."

Physician Assistant Licensure Compact

Licensed physician assistants (PAs) from other states could help serve Texas' rapidly growing population under new legislation.

The PA Licensure Compact (HB 2544) overwhelmingly passed the state House of Representatives, though the Senate took no action in the regular legislative session.



PAs from states that join the compact will be allowed to practice in Texas without having to go through the license approval process again, and Texas PAs will be able to practice in states that honor Texas licenses.

"Expanding access to physician assistants, especially through interstate compacts, is a much-needed step," said Matthews. "PAs, working under physician oversight, can address most medical needs, saving the more difficult cases for the physicians. PAs can also fill a gap by providing care to lower-income, uninsured families, often at lower cost."

Addressing Medicaid Fraud

Texas Medicaid enrollment ballooned during the pandemic, from 3.99 million people in April 2020 to 5.12 million by December 2021, while lax federal oversight reportedly led to billions of dollars in Medicaid fraud nationwide.

Now that the COVID-19 emergency is over, Texas is cracking down on Medicaid fraud. SB 745, introduced by state Sen. Lois Kolkhorst (R-Brenham) was signed into law by Gov. Greg Abbott on May 29. The law expands the Office of the Attorney General's investigations into Medicaid fraud.

'Should Not ... Subsidize Cheaters'

Medicaid fraud in Texas largely involves exploitation of lax enforcement of eligibility rules, says Matthews.

"Medicaid eligibility changes as people move in or out of state, die, or get employer-provided coverage," said Matthews. "Eligibility is also changing because pandemic regulations allowed people to remain on the Medicaid rolls who were no longer eligible for coverage. It's critical that the state examine its rolls and remove those who are no longer eligible."

Matt Dean, a senior fellow for health care outreach at The Heartland Institute, says fraud hurts individuals who are eligible for Medicaid.

"Expanding access to physician assistants, especially through interstate compacts, is a much-needed step. [Physician assistants (PAs)], working under physician oversight, can address most medical needs, saving the more difficult cases for the physicians. PAs can also fill a gap by providing care to lower-income, uninsured families, often at lower cost."

MERRILL MATTHEWS
RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

"People who pay for their own health insurance or receive it as a benefit through their employer should not have to subsidize cheaters who help themselves to public health care they do not qualify for," said Dean. "Fraud takes scarce health care away from the needy and gives it to the greedy."

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

Texas Reforms Required 'Fortitude,' Advocacy Group Says

Texas enacted seven laws that will improve health care, despite heavy resistance from Big Pharma, hospitals, and the health insurance industry, say reform advocates.

"Our success in this session came from bringing the stories of Texans to legislators who were focused on getting something done and having the fortitude to take the fight to the finish line," said Genevieve Collins, state director of Americans for Prosperity-Texas (AFP-TX), a grassroots group.

AFP-TX supported the reform bills during the legislative process. Gov. Greg Abbott signed into law all the bills that required his signature.

HB 25 allows drug imports from Canada (see related article, this page). The group also lobbied for HB 290, which authorizes Multiple Employer Welfare Arrangements that allow small businesses to negotiate collectively for better health insurance deals.

HB 2002 allows a broader range of medically necessary out-of-pocket expenses to meet insurance deductibles.

SB 490 and HB 1973 require greater detail on patients' bills. SB 622 requires health plans to disclose certain information about prescription drugs.

HB 711 amends the insurance code to prohibit insurance companies and providers from entering provider network contracts with anticompetitive clauses. SB 2193 and HB 3317 create a pilot program for Federally Qualified Health Centers to provide direct primary care arrangements.

—Staff reports

COMMENTARY

Medicare Cuts Loom—Time to Modernize

By John C. Goodman

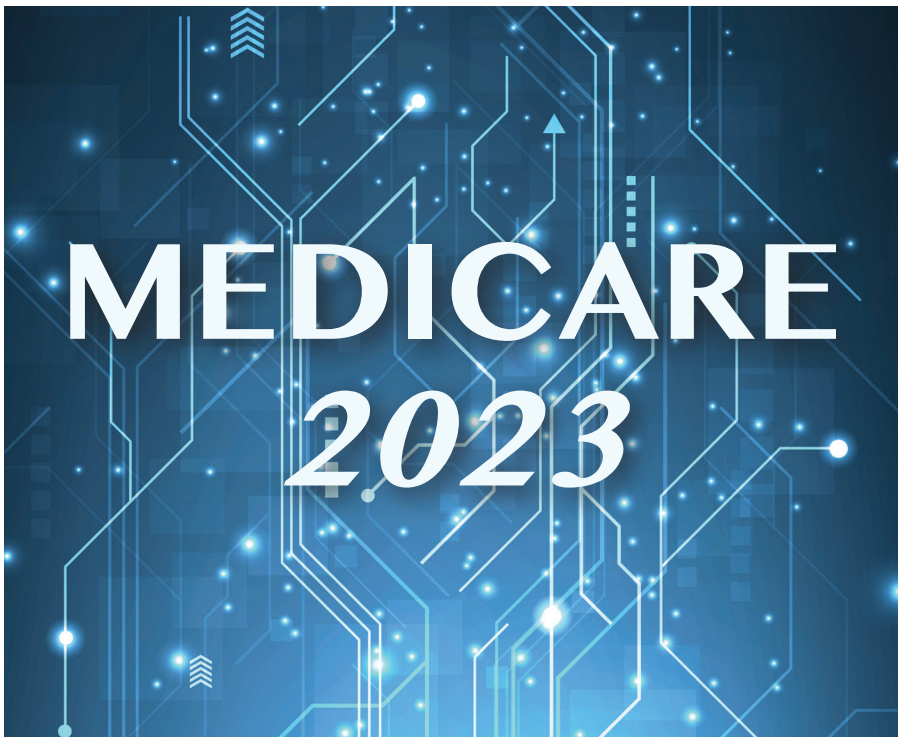
President Joe Biden and former President Donald Trump have made the same promise to voters: they won't touch Social Security or Medicare.

That's not merely disappointing. It's irresponsible. According to the latest Social Security and Medicare Trustees Report, in the very near future the trust funds supporting these two programs will be depleted. If the president and Congress do nothing in the interim, the law requires automatic cuts in benefits.

In just eight years, nearly 78 million Medicare beneficiaries will face an automatic 11 percent payment cut in their hospital insurance benefits, and these cuts could come sooner and strike even deeper if America is hit by a recession. In 10 years, 66 million Social Security beneficiaries will see their monthly benefit checks cut by 23 percent.

That is just the short-term problem. Looking further into the future, the trustees' report reminds us we have made promises to millions of workers who are paying payroll taxes today, and the future cost of those promises far exceeds the expected revenues dedicated to supporting them. Further, the gap between promises and future revenues keeps getting larger over time.

Looking into the indefinite future, the trustees tell us the combined promises in both programs exceed expected revenues by $163 trillion. That number is in current dollars, and that unfunded liability is almost seven times the size of today's entire economy.



"Is it possible the value seniors place on Medicare is similarly much below what Medicare actually costs? If so, there would be an opportunity to spend less on medical benefits, give seniors a cash rebate, and lower the taxpayers' burden—all at the same time."

JOHN C. GOODMAN
PRESIDENT AND FOUNDER
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

No Money, No Plan

In a sound retirement system, we would have $163 trillion in the bank earning interest—so the funds would be there to pay the bills as they arise. In fact, we have no money in the bank for future expenses and there is no serious proposal to change that.

So, what can be done?

Hoover Institution economist David Henderson argues Medicare is the easier program to reform. The reason? Social Security benefits come in the form of cash. Medicare benefits are in-kind services. Henderson cites a well-regarded academic finding that Medicaid beneficiaries value enrollment in Medicaid at as little as 20 cents on the dollar, which means if you offered the enrollees membership in Medicaid or a sum of money equal to a little more than one-fifth the cost of Medicaid, a great many enrollees would take the money.

Is it possible the value seniors place on Medicare is similarly much below what Medicare actually costs? If so, there would be an opportunity to spend less on medical benefits, give seniors a cash rebate, and lower the taxpayers' burden—all at the same time.

A mechanism for accomplishing that would be a Health Savings Account, which allows younger people to make choices between medical care and other uses of money. A similar account for seniors, but with after-tax deposits and tax-free withdrawals (like a Roth IRA), would avoid the charge the deposits are a tax dodge. But it would allow seniors to conveniently avoid unneeded care and bank the savings for other purposes.

Modernizing Medicare

This is one of a number of ideas proposed in *Modernizing Medicare*, a multiauthor Johns Hopkins University publication edited by Heritage Foundation scholar Robert Moffitt and former Heritage vice president Marie Fishpaw.

Of course, to give Medicare enrollees the full freedom to choose between health care and other uses of money, seniors would have to have a wider choice of plans and insurers would need greater freedom to offer innovative alternatives.

In one chapter, former Congressional Budget Office Director Douglas Holtz-Eakin envisions putting Medicare on a budget. Seniors would be given "premium support," allowing them to buy private insurance of their own choosing. The government's contribution would grow through time but somewhat more slowly than spending under the current system. Holtz-Eakin estimates such a reform would save taxpayers $1.8 trillion over 10 years and save beneficiaries $333 billion.

Building on Medicare Advantage

Contributing authors point to Medicare Advantage (MA), which already enrolls half of all beneficiaries, as the vehicle for change. In this program, seniors enroll in private plans similar to the employer-provided plans they had while working. Medicare pays a large share of the cost of the premiums.

American Enterprise Institute economist Joe Antos points out that in MA, seniors pay one premium to one plan. In traditional Medicare, by contrast, they pay three premiums to three plans: Part B, Part D, and Medigap coverage. Antos says traditional Medicare must become more like MA, which saves seniors money and allows for integrated care, such as combining medical and drug coverage in the same plan.

Medicare Advantage Reform

In a chapter by yours truly, I argue for several reforms to make MA work better—including continuous open enrollment and the right to return to traditional Medicare.

If the enrollees' medical conditions change, they should be able to switch to plans more appropriate for their care. If diabetes emerges, enrollees should be able to switch to a special needs plan specializing in diabetic care. Enrollees who develop heart disease should be able to switch to a special needs plan for congestive heart failure. No one should have to wait 12 months to enroll in the plan that best meets his or her medical needs.

Currently, if a senior stays in an MA plan for more than a year and then chooses to return to traditional Medicare, there can be financial penalties. If people knew they could easily return to traditional Medicare when needed, enrollment in MA plans would be more desirable.

John C. Goodman, Ph.D. (**johngoodman@goodmaninstitute.org**) *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *A version of this article appeared on The Goodman Institute website on June 3, 2023.*

Market Solutions to Fix Medicare Insolvency Gain Attention

By Kevin Stone

A range of plans and studies proposing ways to stave off the insolvency of Medicare, the nation's primary health care program for seniors and disabled adults, have been published.

Hospital Insurance (HI) trust fund reserves are projected to be exhausted by 2028, according to the 2022 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. By 2028, payroll taxes and other revenues will cover only 90 percent of Medicare HI costs.

Top scholars and policy experts have come together with solutions to Medicare's biggest challenges from a free-market approach, culminating in a book titled *Modernizing Medicare: Harnessing the Power of Consumer Choice and Market Competition,* published by Johns Hopkins University Press in April.

In addition, new papers from the Mercatus Center at George Mason University and the *Journal of the American Medical Association* (JAMA) discuss fixing Medicare by addressing payments to doctors.

"The general answer to the problem is to transform the entire Medicare program—hospitalization, outpatient, and physicians' services, as well as drug coverage—into a fully competitive program"

ROBERT E. MOFFIT, PH.D.
SENIOR FELLOW
THE HERITAGE FOUNDATION

Making Medicare Competitive

Medicare's biggest issue is lack of competition, says Robert E. Moffit, Ph.D., a senior research fellow at the Center for Health and Welfare Policy at The Heritage Foundation and coeditor, with colleague Marie Fishpaw, of *Modernizing Medicare*.

"We have eight years before the hospitalization program—Part A—falls into insolvency," said Moffit. "We have time, but we do not have time to waste.

"Hospitalization insolvency is only part of a much larger problem: the rapid growth of Medicare spending—doubling from $1 trillion to $2 trillion in just 10 years for Parts A and B—will impose ever-larger financial burdens on beneficiaries and taxpayers alike," said Mofffit.

The Medicare trustees have warned the current Medicare payment systems for Parts A and B threaten seniors' access to high-quality care, says Moffit.

"The general answer to the problem is to transform the entire Medicare program—hospitalization, outpatient, and physicians' services, as well as drug coverage—into a fully competitive program," said Moffit. "Such a program would compel all health plans, including traditional Medicare fee-for-service (FFS), to compete on a level playing field in an environment of price and performance transparency."

Medicare Advantage Example

Medicare Advantage (MA) shows how the government can offer traditional Medicare benefits for less, says Moffit.

"Congress and the White House should build on the best features of the MA program of competitive private health plans, while fixing the program's flawed plan payment and risk adjustment systems," said Moffit.

To start, Congress should make enrollment in MA the default enrollment, instead of Medicare fee for service (FFS), for new beneficiaries, says Moffit.

"A senior would have the right to reenroll in Medicare FFS if they wish," said Moffit. Congress should "transform Medicare FFS into a single comprehensive plan rather than a disjointed set of entitlements, by combining Parts A and B into one package, with a simplified system of cost-sharing and the crucial addition of financial protection from the costs of catastrophic illness," said Moffit.

Medicare beneficiaries should also be allowed to contribute to health savings accounts (HSAs) if they desire, Moffit says. Right now, those on Medicare are prohibited from setting up or contributing to an HSA.

"Their medical needs are far more diverse, costly, and complex than those of younger and healthier persons," said Moffit. "They should also be permitted to use such accounts for direct primary care if they wish to do so, and health plans should be permitted to offer direct primary care programs as a component of their health care benefits package."

New Way to Pay Doctors

"How Medicare Part B's Physician Fee Schedule Drives Up Spending and Influences the Provision of Care," is the title and subject of a policy paper published by the Mercatus Center on June 13.

Authors John O'Shea, Kofi Ampaabeng, and Elise Amez-Droz argue for rebalancing the way Medicare reimburses doctors for care, with pricing weighted toward low-price, high-value service. The authors also favor default enrollment in MA for new beneficiaries.

A *JAMA Health Forum* article titled "Medicare Modernization—The Urgent Need for Fiscal Solvency," by Brian J. Miller, M.D., Lisa M. Grabert, MPH, and Eric D. Hargan, J.D., published on June 16, likewise recommends more value-based care, rewarding "value over volume," a bigger shift toward MA, and "orientating Medicare toward health rather than sickness."

Getting Serious About Privatization

The solution is to privatize the federal entitlement programs and their unfunded mandates, says Terry Nager, the principal author and founder of Plan For America, an organization advocating health care and retirement policy reform.

"Our Medicare solution within Plan For America is one cog in a larger entitlement plan designed to replace payroll taxes with a contractual trust into which employees pay, designed to eliminate federal deficits, debt, and unfunded liability," said Nager.

"In our plan, the 15.3 percent that is currently paid in payroll taxes is instead remitted to an account administered by the private For America Security Trust (FAST), which invests funds in a program similar to a total market index fund," said Nager. "In addition, participants would pay an annual $1,200 health care premium toward a fully comprehensive medical coverage plan and would be the standard that is 100 percent tax-deductible, with any unused amount being eligible for withdrawal by a participant, tax-free."

The plan would offer interest-free loans to help lower-income earners pay for health care, and the loans could be paid off with the growth from the FAST account, says Nager. Participation would reduce the government's entitlement bill, and the savings could then go toward paying off state and national debts.

"That combination should provide the political will to push the plan through," said Nager.

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

Amazon Tries Again to Transform Health Care Industry

By Ashley Bateman

Amazon's latest attempt to force change in the health care industry is getting mixed reviews several months out of the gate.

The retail giant quietly rolled out Amazon Clinic in November. In February, Amazon upped the ante by acquiring One Medical, a large, membership-based primary care company that offers on-demand virtual care, "appointments that start on time," and easy-to-book in-person visits to physicians and labs where it has offices. Membership costs $199 a year, and One Medical accepts most insurance plans.

Online reviews have not been encouraging. Consumers have expressed concerns about data privacy and hidden costs. Trust Pilot gave One Medical two stars based on 53 reviews as of July 8. One Medical lost $255 million in 2021 and $89 million in the prior year.

"The status quo is really standing in the way of changing our system, and if you don't have the math then you don't have the power to drive down prices. You can't drive down the cost, because you don't have purchasing power. Just because Amazon is a big, cool technology company with a lot of money doesn't mean they've invested the time and money to understand the problem."

PETER PITTS
COFOUNDER, CENTER FOR MEDICINE IN THE PUBLIC INTEREST

Prior Failures

In 2018, Amazon joined J.P. Morgan and Berkshire Hathaway to form a venture called Haven, with the goal of positively disrupting U.S. health care and providing high-quality, transparent care at a "reasonable" cost.

Boasting 1.2 million employees and a famous author/surgeon as CEO, the venture fell apart in less than three years. Amazon then launched Next Amazon Care in 2019 but shut it down in less than three years. The One Medical acquisition gives Amazon a shot at the primary care market.

Industry Resistance

Devon Herrick, a health care economist who writes for the Goodman Institute Health Blog, says the Amazon model, which sells and delivers some 353 million different products to doorsteps quickly and more cheaply than others, may be difficult to translate into health care.

"Health care has historically been very difficult to disrupt due to regulations, licensure and the way health care is purchased," Herrick wrote shortly after Amazon purchased One Medical. "Indeed, health care has only been disrupted a few times in the past 120 years."

The first major change in U.S. health care was the Flexner Report in 1910, which led to the closure of 60 percent of the nation's medical schools, says Herrick. The next was when Congress made employee health benefits nontaxable, in 1954. The third upheaval was the creation of Medicare and Medicaid in 1965.

"Consumers complain about our health care system, but entrenched stakeholders won't give up their coveted positions without a fight," wrote Herrick. "Despite Amazon's market power, it is unclear how its fleet of trucks and warehouses will make a dent in the medical marketplace."

No Midas Touch, Yet

The Amazon Clinic website lists 34 non-urgent conditions third-party physicians can treat via telehealth with prescriptions that can be filled at any pharmacy.

"Essentially, it is the conditions that are common and easy to diagnose over email," Herrick told *Health Care News*. "I would almost say they are things you can self-diagnose, and Amazon can have a provider quickly and systematically provide a common therapy. Many of the conditions have over-the-counter remedies, and probably all of them should.

"It appears very convenient, but it's also an indication of how convoluted and inaccessible our health care system is," said Herrick.

As for the addition of a primary care system, "it is difficult to tell whether One Medical is truly innovative or just hype on a website devoid of specific examples," wrote Herrick on the Goodan blog.

Telehealth, the Gamechanger

After choosing a listed health condition, an Amazon Clinic client fills out a basic intake form, receives a treatment plan from a U.S.-licensed clinician, and pays a flat fee.

Prescriptions can be sent to any pharmacy the patient chooses, and follow-up questions can be referred to the treating physician at no cost for up to 14 days. The program does not currently accept insurance, but patients can pay for treatment with a Flexible Spending Account or Health Savings Account.

"One of the things that changed in health care [since Amazon's 2018 attempt] was the forced acceleration of telemedicine," said Peter Pitts, cofounder of the Center for Medicine in the Public Interest. "I think telemedicine is good, and I think accelerating it is also good. Since so much of the Amazon Clinic is telemedicine, you would think they would be able to take advantage of that."

Despite the advances in the virtual side of the market, it is difficult for major corporations to understand health care, says Pitts.

"All of these large tech companies, whether it's Google, Amazon, or Apple, don't understand a few basic core issues with health care in the U.S.," said Pitts. "First, it is predominantly regulated on the state level, so they can't maximize the economy of scale."

Fifty State Markets

Dealing with 50 different subsidiaries and very entrenched interests, including insurance companies and professional licensing boards, are complications large tech companies don't understand, says Pitts.

"The status quo is really standing in the way of changing our system, and if you don't have the math then you don't have the power to drive down prices," said Pitts. "You can't drive down the cost, because you don't have purchasing power."

Amazon's past failures indicate the company doesn't know how health care differs from the single national retail market it operates in, says Pitts.

"Just because Amazon is a big, cool technology company with a lot of money doesn't mean they've invested the time and money to understand the problem," said Pitts.

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

Independent Physicians Judged 'Best' in Atlanta

By AnneMarie Schieber

A medical practice not connected with any university, hospital system, or private equity group dominates Atlanta, Georgia's list of "top doctors."

Each year, *Atlanta* magazine conducts a survey of physicians in the Atlanta metropolitan area. Physicians are asked to choose whom they deem best in their fields.

"Our list is based on professional assessment of medical expertise," states the publication, "qualified to judge clinical effectiveness."

"The 'secret sauce' is having an organization where doctors can practice medicine unencumbered by outside regulation and where we can respect and create an environment where everyone can thrive."

HAL SCHERZ, M.D.
PRESIDENT AND MANAGING DIRECTOR
GEORGIA UROLOGY

Physician Survey Results

Area physicians cast 10,000 votes in the survey, judging 24 of the 43 "best" urologists to be staff members at Georgia Urology, a physician-owned and physician-operated medical practice based in Atlanta.

"The 'secret sauce' is having an organization where doctors can practice medicine unencumbered by outside regulation and where we can respect and create an environment where everyone can thrive," said Hal Scherz, M.D., president and managing director of Georgia Urology and one of the doctors selected as best in his field.

Atlanta used an outside polling firm to conduct its survey. The magazine said advertising had no bearing on the results.

Resisting Big Offers

Scherz told the *Heartland Daily Podcast* on July 25 a week doesn't go by without a private equity group making an offer to buy the 50-year-old practice, which has 25 locations, seven ambulatory surgery centers, and a staff of 500, including 50 urologists.

"Our goal has been to build a thriving practice that will survive our careers and be successful past the point of retirement," said Scherz. "The goal of a private equity group or an outside owner is to increase the value of the practice and sell it. Some allow practices to operate freely, and they may even pump money into the practice, but by and large, as a physician you're accountable to an outside entity."

Staying independent has been good for patients too, says Scherz.

"Everything you do may not necessarily generate income, but sometimes it's the right thing to do because you need it to offer a full slate of care options to patients," said Scherz.

Attracting Top Talent

Despite the honor of having the most "top doctors," Georgia Urology realizes today's doctors may prefer working for a large organization or university.

"Medical students today are taught a more 'progressive' way of looking at health care, but not all doctors buy into that," said Scherz. "When we recruit, we ask them if they're willing to take a chance on themselves, bet on their own future, and have the opportunity to be their own boss."

Doctors at Georgia Urology can decide for themselves how many patients they want to see or the kind of patients they want to see. That is not often guaranteed when working in a large group practice or hospital system.

Independence has also been an asset in hiring and retaining support staff, says Scherz.

"During the pandemic, many hospitals turned their back on their employees," said Scherz. "They furloughed them or fired them because they didn't want to lose money. Many of these workers never came back to the hospital, which is why there has been a profound shortage of people working in hospitals today.

"At Georgia Urology, we did not let one single person go," said Scherz. "We have over 500 employees. We kept them all on, despite the fact we were all not collecting money."

Not for 'Lone Wolves'

Like other health care providers, Georgia Urology is faced with doctors retiring faster than they can be replaced.

Carl Capelouto, M.D., another "best" physician from the practice, says it is critical to recruit new doctors who will fit within the culture.

The firm evaluates whether a candidate has "a burning desired to be successful," is a "team player," is "united in staying independent," and prioritizes "sharing expertise, knowledge and mentoring," Capelouto told *Becker's Hospital Review* for an article published on July 14.

Capelouto told *Becker's* he avoids "lone wolves" and "[our] practice is constantly evolving, but we always remain committed to providing the best possible care for our patients, while also providing the best working environment for our providers and staff."

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

STUDY

Obamacare Hasn't Cut Risk of Losing Health Insurance

Obamacare has done little to prevent people from losing health insurance, a study has found.

The risk of losing insurance is about the same as it was before the 2010 Affordable Care Act (ACA) went into effect, according to a study by Liran Einav, an economics professor at Stanford University, and Amy Finkelstein, a professor of economics at the Massachusetts Institute of Technology, published in the *Proceedings of the National Academy of Sciences* in April.

"We estimate that although only 12.5% of under-65 Americans were uninsured at any given point in time, twice as many—one in four—were uninsured at some point over a 2-y[ear] period," Einav and Finkelstein wrote. "Moreover, the risk of an insured individual losing coverage barely declined after the passage of the landmark 2010 Affordable Care Act."

The risk of losing insurance is more pronounced for those on Medicaid or who get insurance through the health care exchanges, state Einav and Finkelstein. Of those who lose insurance, half remain uninsured beyond six months, with 25 percent uninsured for two years or more.

"These facts suggest that research and policy attention should focus not only on the 'headline number' of the share of the population uninsured at a point in time, but also on the stability and certainty (or lack thereof) of being insured," the authors wrote.

—Staff reports

Health Care Reform Plan Provides Blueprint for GOP Candidates

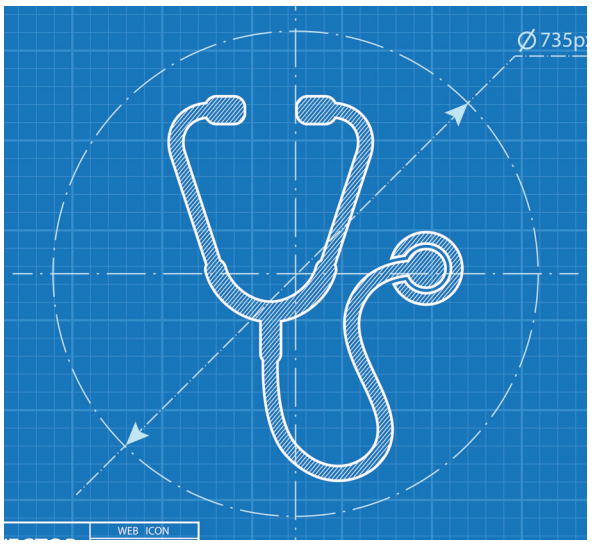
By Kenneth Artz

A new health care reform plan titled "Choices for All," published by the Hoover Institution at Stanford University, recommends several key changes to federal programs.

Authors Lanhee Chen, Tom Church, and Daniel Heil suggest Congress include a new type of tax-advantaged savings account; expand tax deductibility to include out-of-pocket medical expenses; increase flexibility for state innovation waivers which could allow the Affordable Care Act (ACA) exchanges to offer a greater variety of plans; roll back rules limiting association health plans; and enable the creation of more plans participating in direct primary care programs.

The authors say the problem with health care today is "missing prices," writing, "centralized healthcare suffers from the same issues as all other centralized economic activity: it distorts prices so that they no longer convey useful information about value or cost. In the process, it takes choices away from patients and limits them to government-approved coverage."

Republican candidates and officeholders who want to reform health care have many proposals to choose from, and the Hoover proposal builds on previous policy plans while providing some new wrinkles.



Concerns About Costs, Access

Americans are concerned about health care costs and access, says Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"With some 28 million people still uninsured—remember, Obamacare was supposed to essentially eliminate the uninsured—and millions of Americans losing their pandemic-related, expanded Medicaid coverage, and with the cost of health insurance skyrocketing, health care is likely to be a major topic of discussion in 2024," Matthews said (see article, opposite page).

"Democrats will want to spend more on government-run health care," Matthews said. "Republicans need an alternative, and the Hoover plan provides a very wide-ranging discussion of the existing problems with a number of reasonable options that build on the current system."

Calls for Price Transparency

There is much to like about the Hoover plan, but it should be refined further before being used in 2024 election campaigns, says Devon Herrick, a policy advisor to The Heartland Institute, which publishes *Health Care News*, and a contributor to the Goodman Institute's Health Care Blog.

"Rather than create a new individual health account, why not just reform health savings accounts?" said Herrick. "Allowing states more flexibility to create health plans that meet consumers' needs is a good idea."

Herrick says he likes the plan's proposal to expand scope of practice to allow patients to see a wider variety of providers.

"Expanding residency programs to train more physicians is a good idea, as is making it easier for foreign-trained doctors to practice in the United States," said Herrick. "Ending certificate of need laws that block competition is a good idea. Allowing Americans to deduct medical expenses would put individual insurance on a level playing field with employer insurance."

Hospitals Forming Regional Cartels

What the Hoover plan is missing is a tangible way to boost price transparency and price competition, says Herrick.

"Hospitals are consolidating into regional cartels," said Herrick. "They are snapping up physician practices and boosting costs by claiming services are now provided through the hospital."

Herrick says "perverse incentives" are driving out competition.

"Increasingly, patients are afraid to see a doctor because they can't ascertain prices in advance and they're afraid of being ambushed from bills they didn't expect," said Herrick.

Lots of Ideas

There are many plans for Republicans to choose from, says Roger Stark, M.D., a health care policy analyst at the Washington Policy Center, retired physician, and policy advisor to The Heartland Institute.

"Hoover's plan is one of several that Republicans and conservative think tanks are promoting, and Grace-Marie Turner of the Galen Institute recently published a list," said Stark.

"There is a consistent vision in the new Choices for All Project, the Consensus Group's Health Care Choices proposal, FREOPP's Fair Care Act, the Goodman Institute/Rep. Pete Session's Health Care Fairness for All Act, the Heartland Institute's American Health Care Plan, countless ideas from the American Enterprise Institute, Heritage, Paragon Health Institute, and many state-based think tanks, in addition to the dozens of individual bills making their way through the legislative process in Congress," said Stark.

All of these plans attempt to give patients more choices while working within the existing health care framework, says Stark.

Stark Contrasts to Obamacare

The Hoover plan introduces incremental changes that potentially could pass in a bipartisan fashion and gives Republicans health care talking points to counter the Left's single-payer proposals, says Stark.

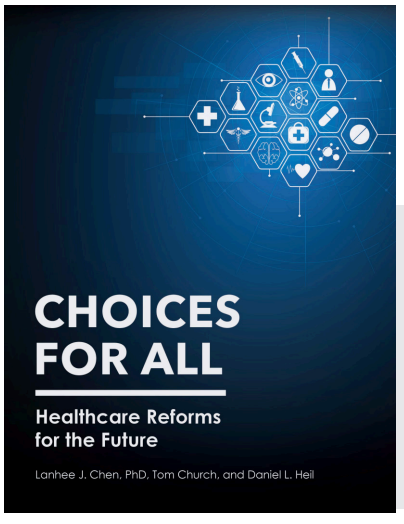
"As we have discussed before, the fundamental problem with health care in the United States is that almost 90 percent of care is paid for by a third party, either employers since 1943 or the government since 1965," said Stark.

"Until patients can control their own health care dollars and make their own care decisions, costs will continue to escalate and choices will be limited," said Stark. "Repealing the ACA would have helped, but Medicare and Medicaid are not viable in the long term and must be reformed. Unfortunately, no politician who wants to be elected can advocate for a complete overhaul of our health care system."

Kenneth Artz (**kennethcharlesartz@gmx.com**) *writes from Tyler, Texas.*

"As we have discussed before, the fundamental problem with health care in the United States is that almost 90 percent of care is paid for by a third party, either employers since 1943 or the government since 1965. Until patients can control their own health care dollars and make their own care decisions, costs will continue to escalate and choices will be limited."

ROGER STARK, M.D.
HEALTH CARE POLICY ANALYST
WASHINGTON POLICY CENTER



INTERNET INFO

Lanhee Chen, Tom Church, and Daniel Heil, "Choices for All," Hoover Institution, July 2023:
https://www.hoover.org/sites/default/files/2023-07/Choices%20for%20All.pdf

Health Care Price Transparency Pushed in Bills Before Congress

By Bonner Russell Cohen

A deeply divided Congress is scrambling to pass bills addressing health care price transparency before the end of the federal fiscal year on September 30.

Measures dealing with price transparency risk being caught up in other health care priorities, however, including legislation targeting pandemic preparedness, opioid addiction, and funding for health care centers.

Among the bills awaiting final congressional action is the Clinical Laboratory Price Transparency Act, introduced by Rep. Carol Miller (R-WV) on July 25. The bill would require clinical labs to publish their health care prices and the Centers for Medicare and Medicaid Services (CMS) to monitor compliance.

"Unknown health care prices should not be a factor patients are worried about when making health care decisions," Miller said in a press release. "Patients should know their health care treatment prices upfront and not be surprised by sky-high bills they didn't know they were getting charged for. This legislation provides price transparency for patients when considering basic lab tests and ensures that the patient is in control of their health care decisions and wellbeing."

Rep. Carol Miller (R-WV)

Not Just Labs

Miller's bill would require labs providing services to Medicare patients to publish their health care prices, starting January 1, 2025; require CMS to provide standard reporting formats for providers; and ensure CMS specifies the services to which transparency will apply.

The bill was included in a larger price transparency package that was marked up by the House Ways and Means Committee on July 26 and passed the same day.

Another area of concern is price transparency in imaging services. The same day Miller introduced her lab price transparency bill, Rep. Mike Carey (R-OH) unveiled his Imaging Services Price Transparency Act. His legislation would require hospitals and other medical providers to make public the cost of imaging services such as X-ray, MRI, and CT scans.

'Blindsided by Medical Costs'

"Health care costs are skyrocketing across America," Carey said in a statement. "Our legislation makes it easier for consumers to know in advance the cost of an x-ray or CT scan. This will go a long way to ensuring that hardworking Americans are not blindsided by medical costs."

Like Miller's bill, Carey's measure was included in the larger Health Care Price Transparency Act (H.R. 4822), which was approved by the full Ways and Means Committee before Congress adjourned for its August vacation.

"As America's medical system becomes increasingly consolidated, the legislation takes meaningful steps to ensure vertically integrated health insurers are directing care that benefits the patient—not their bottom line," states the committee's press release on the bill.

The committee also approved the Providers and Payers COMPETE Act (H.R. 3284), which requires the U.S. Department of Health and Human Services to examine how Medicare payment rules may affect health care consolidation.

The package approved by the committee could be passed by the full House in September, probably with some bipartisan support. Challenges will arise in reconciling House bills with whatever health care legislation the Democrat-controlled Senate passes.

Anti-Corporate Edge

Supporters of the legislative package made little secret of their distrust of the corporate health care world. Ways and Means Chairman Jason Smith (R-MO) was one.

"The Health Care Price Transparency Act of 2023 is a win for patients who deserve to know the actual price they will pay before they go see a doctor, fill a prescription, or get an x-ray," Smith said in a statement. "Families should not have to live at the mercy of large medical corporations who are too ashamed to list their prices publicly. This bill is about bringing honesty and clarity to the cost of health care."

Approval of the bills by Ways and Means came just as a study titled "Health Care Price Transparency: Achievements, Challenges, and Next Steps," by Theo Merkel, director of the Private Health Reform Initiative at the Paragon Health Institute, was published. The study reinforces arguments for the price transparency bills.

"It is gratifying seeing Congress taking up the urgent problem of secret health care prices. No other industry gets to hide prices from customers and bill them whatever they want months later. There's nothing special about lab tests, imaging procedures, or any other health care service that should shield them from market forces and accountability to the patients, employers, unions, and taxpayers who actually foot the bills."

KATY TALENTO
CEO, ALLBETTER HEALTH

PHOTO COURTESY STILL TAKEN FROM CSPAN

'Puts Customers First'

Katy Talento, CEO of AllBetter Health and a former top health care adviser to President Donald Trump, welcomes the congressional moves on price transparency.

"It is gratifying seeing Congress taking up the urgent problem of secret health care prices," Talento said. "No other industry gets to hide prices from customers and bill them whatever they want months later. There's nothing special about lab tests, imaging procedures, or any other health care service that should shield them from market forces and accountability to the patients, employers, unions, and taxpayers who actually foot the bills."

Requiring providers to list prices is essential for comparison shopping, says Talento.

"Ending secret prices will do to health care what it does to the rest of the economy: it will drive price and quality competition that puts customers first instead of giant hospital conglomerates and everyone else in the Health Care Swamp," said Talento.

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

Abortion Drug Used to End Pregnancy in Seventh Month

By Ashley Bateman

A Nebraska state court sentenced a woman to jail after she pled guilty to using the abortion drug Mifepristone to end her pregnancy at 29 weeks and then burning the remains of the unborn child and burying him.

On July 20, a district court judge sentenced Celeste Burgess, age 18, to 90 days in jail and two years' probation. Her mother, Jessica Burgess, age 42, will be sentenced in September for supplying the abortion drug without a medical license and helping to conceal the baby's remains.

At the time of the crime, abortion was illegal in Nebraska after the 20th week; it is now illegal after 12 weeks. Prosecutors say Jessica Burgess ordered the abortion pills online and gave them to her daughter, age 17 at the time.

"Chemical abortions are not safe. They have four times as many complications as surgical abortions. We don't know exactly how unsafe because we don't collect the needed data. The FDA ignores its own rules for products that further a political agenda such as abortion or transgender ideology."

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

'FDA Ignores Its Own Rules'

The case demonstrates how accessible and easily abused abortion drugs became after the Food and Drug Administration (FDA) approved Mifepristone as a mail-order drug in December 2021, removing the in-person dispensing requirement put into place during the Trump administration.

A lawsuit is working its way through the courts challenging the legality of the original approval of Mifepristone. The lawsuit, filed by the Alliance for Hippocratic Medicine, claims the FDA ignored safety concerns when it approved the drug in 2000.

Although half of all abortions are now performed chemically, there are no reasonable safety measures or standards in place, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Chemical abortions are not safe," said Orient. "They have four times as many complications as surgical abortions. We don't know exactly how unsafe because we don't collect the needed data. The FDA ignores its own rules for products that further a political agenda such as abortion or transgender ideology."

'Women Face Increased Risk'

Mifepristone ends the pregnancy by causing the mother to hemorrhage, a condition deemed a medical emergency, according to an article from the National Library of Medicine posted at the National Institutes of Health website on February 15, 2023.

The article states hemorrhage is a leading cause of death, second to trauma, among Americans ages 46 and under.

"Without doctor oversight, women face increased risk of hemorrhage, infection, death, incomplete abortion requiring surgery, and undiagnosed ectopic pregnancy with risk of death," said Michelle Cretella, M.D., cochair of the American College of Pediatrics Adolescent Sexuality Council.

'Legal Not the Same as Safe'

In an article titled "The FDA is Dead Wrong in its Review of Mailed Abortion Pill Safety," David Gortler, Pharm.D., a former senior advisor to the FDA commissioner, says studies referenced to affirm the safety of the drug by the FDA "were shamefully deceptive, and instead of referencing 'safety' used muddy, academically unacceptable language like 'unplanned clinical encounters.'"

"Unfortunately, it's just one more in a series of dozens of examples of FDA ignoring clear clinical data pointing in the opposite direction to force through unproven edicts," Gortler wrote. "In the meantime, the cumulative safety profile of mifepristone predicts that the FDA's decision to allow mailing of abortion drugs for at-home use will lead to preventable morbidity and mortality in America's women and children."

Orient cited the case of Kermit Gosnell, who was convicted of murder in the deaths of women he treated, as just one horrific example of the abortion industry's lax ethical standards.

"Regulation of abortion facilities for basic health and safety concerns is nonexistent to lax," said Orient. "'Legal' is not the same as safe. I can't ever recall hearing of a big malpractice award against an abortionist whose patient died of hemorrhage or [a] perforated uterus."

Evading State Laws

Abortion advocates have clamored for legal "protection" of abortion seekers and providers since the 2022 overturning of *Roe v. Wade* in the *Dobbs v. Jackson Women's Health Organization* case.

"After Dobbs, abortion advocates can no longer claim that the Constitution contains a mother's right to kill her baby," said Orient. "So, they are seeking to circumvent states' protection of developing babies, with blatant disregard for the health of mothers."

The evidence in the Nebraska case came from a search warrant for Facebook messages between Celeste Burgess and her mother, which led police officers to the field where the baby's remains were buried.

A proposed new federal rule would limit the information investigators will be able to access in abortion-related cases.

The Biden administration's new Health Insurance Portability and Accountability Act privacy rule will restrict access to medical records involving "reproductive health."

'Why Is Anyone Surprised?'

Legalized abortion unleashed numerous social ills in addition to the deaths of children in the womb, says Cretella.

"After decades of Americans being raised to accept the heinous act of killing an unborn baby not as a crime but as a 'woman's right,' why is anyone surprised by the heinous killing of a newborn by this mother and grandmother?" said Cretella. "These [abortion drugs] drive increased sexual promiscuity, increased STIs [sexually transmitted infections], increased sexual exploitation and abuse, and repeat unwanted pregnancies as well as negative psychological effects."

The women who fought for the right to vote recognized terminating a pregnancy meant killing a person, says Cretella.

"Deep down, everyone knows that abortion is murder of the worst kind," said Cretella. "No one is more innocent or vulnerable than an unborn child. Even the first-wave feminists decried abortion as prenatal infanticide."

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

More Teens, Young Adults Call Themselves 'Trans'

By Harry Painter

The percentage of young people identifying as transgender or nonbinary has skyrocketed over the past few years.

The latest figures on the trend come from New Jersey data and a student poll at Brown University in Rhode Island.

A 2023 survey of Brown students found 38 percent of the student body does not identify as "straight," double the percentage of students in 2010 and more than five times the national rate. In New Jersey, there has been a 4,000 percent increase in students identifying as nonbinary in just four years.

Seen As Social Contagion

The Centers for Disease Control and Prevention estimates the transgender population of high schoolers is 1.8 percent, though other studies have found the number to be up to 9.2 percent.

Abigail Shrier, the author of *Irreversible Damage*, attributes the spike in self-identifying transgender and nonbinary youth to the power of suggestion or "social contagion." Transgenderism advocates argue the number is rising because it is now safer for people to "come out."

London University political scientist Eric Kaufmann found an increase in the number of people who identify as bisexual has not been accompanied by an increase in corresponding sexual behavior. Kaufmann's studies show most women who identify as bisexual have sex exclusively with men, suggesting the phenomenon is social.

The spike in teenagers and young adults identifying as transgender may mean big profits for the pharmaceutical and medical industries. "Sex reassignment" surgery can cost patients thousands of dollars, and they will spend much more if they remain dependent on hormones or other drugs and therapy.

From Disorder to Affirmation

Gender identity is liable to change, sometimes multiple times, during a person's life, says Michelle Cretella, M.D., executive director of the American College of Pediatricians.

"Contrary to the insistence of gender activists that a sex-discordant gender identity is immutable, change of gender identity has been documented to occur during childhood, adolescence, and adulthood," said Cretella. "While it may be influenced by one's biology, gender identity is not solely determined by biology and is heavily influenced by psychological and cultural factors. Like all developmental processes, gender identity formation may be derailed by children's subjective perceptions, relationships, and adverse experiences from infancy forward."

Accepting someone's dysphoric perceptions as fact can worsen the problem, says Cretella.

"Social affirmation of children's professed sex-discordant gender identity is harmful," said Cretella. "Prior to 2013, [gender dysphoria] was classified as Gender Identity Disorder (GID), and parental affirmation of their children's opposite-sex identification was associated with persistence of the disorder; this fact remains recognized today."

'This Is Medical Child Abuse'

A large majority of transgender-identified youth experience serious emotional illness, says Cretella.

"When an otherwise healthy boy believes he is a girl, or an otherwise healthy girl believes she is a boy, an objective psychological problem exists that lies in the mind, not the body, and it should be treated as such," said Cretella.

Instead, some physicians are ignoring the problems of self-identifying transgender patients and encouraging their delusional thinking, says Cretella.

"Gender ideologues in pediatrics are being financially rewarded to chemically and surgically sterilize a class of deceived and emotionally troubled youth," said Cretella. "This is not health care. At best, this is medical child abuse; at worst it constitutes eugenics."

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

CDC Gives Advice on Male 'Chest' Feeding

By Harry Painter

Biological males who want to "chestfeed" their infants can get advice from the Centers for Disease Control and Prevention (CDC).

Multiple articles on the CDC website provide guidance. One article states, "an individual does not need to have given birth to breastfeed or chestfeed." The article encourages health care providers to "use terms that are inclusive of all gender identities such as 'pregnant person,' 'breastfeeding parent,' and 'lactating person.'"

'Maximizing Milk Production'

A section of the CDC's Q&A page addressed to individuals who have had breasts surgically removed or implanted asks, "Can transgender parents who have had breast surgery breastfeed or chestfeed their infants?"

The response reads, "Yes. Some transgender parents who have had breast/top surgery may wish to breastfeed, or chestfeed (a term used by some transgender and non-binary parents), their infants."

The CDC goes on to encourage health care providers to help these parents in "maximizing milk production," "supplementing with pasteurized donor human milk or formula," and "finding appropriate lactation management support, peer support, and/or emotional support." It also encourages them to help find medications that induce lactation and avoid those that inhibit milk production.

> **"The CDC, like so many other government bureaucracies—IRS, FBI, Border Patrol—operates on ideology rather than its stated mission."**
>
> **MARILYN SINGLETON, M.D.**
> **VISITING FELLOW, DO NO HARM**

For patients who don't want to chestfeed or breastfeed, the CDC encourages health care providers to help them suppress lactation. The articles include no warnings or cautions regarding health risks of transgender chestfeeding and breastfeeding to the parent or baby, or health risks of transgender surgery in general.

Safety Concerns

The *Daily Mail* reported men can take hormone medications to induce production of a substance similar to breast milk, but that can cause heart problems in infants.

"All persons have mammary glands and nipples," says Marilyn Singleton, M.D., an anesthesiologist and visiting fellow at Do No Harm. "What biological men do not have are the necessary hormones to produce lactation, so they must be given various drugs and hormones to actually produce milk."

Singleton says the study of transgender parents chestfeeding or breastfeeding their infants is an emerging area and "even the CDC doesn't know its immediate and long-term safety."

Bandwagon Effect

The CDC and major medical societies are in lockstep with the transgender craze, says Singleton.

"I've never seen medicine jump on a bandwagon with so little information on the psychological and long-term effects of trying to alter one's physical appearance and hormone production so dramatically," said Singleton.

"I sympathize with the CDC's attempt to treat everyone with respect, but the CDC is supposed to be a scientific organization," said Singleton. "As such, it should limit itself to information that clearly 'does no harm.' The CDC, like so many other government bureaucracies—IRS, FBI, Border Patrol—operates on ideology rather than its stated mission."

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

INTERNET INFO

"Breast Surgery," Centers for Disease Control and Prevention, updated July 9, 2023: **https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/breast-surgery.html**

"Health Equity Considerations," Centers for Disease Control and Prevention, updated July 9, 2023: **https://www.cdc.gov/nutrition/emergencies-infant-feeding/health-equity.html**

COMMENTARY

Health Care Fairness for All Act–Why It Works

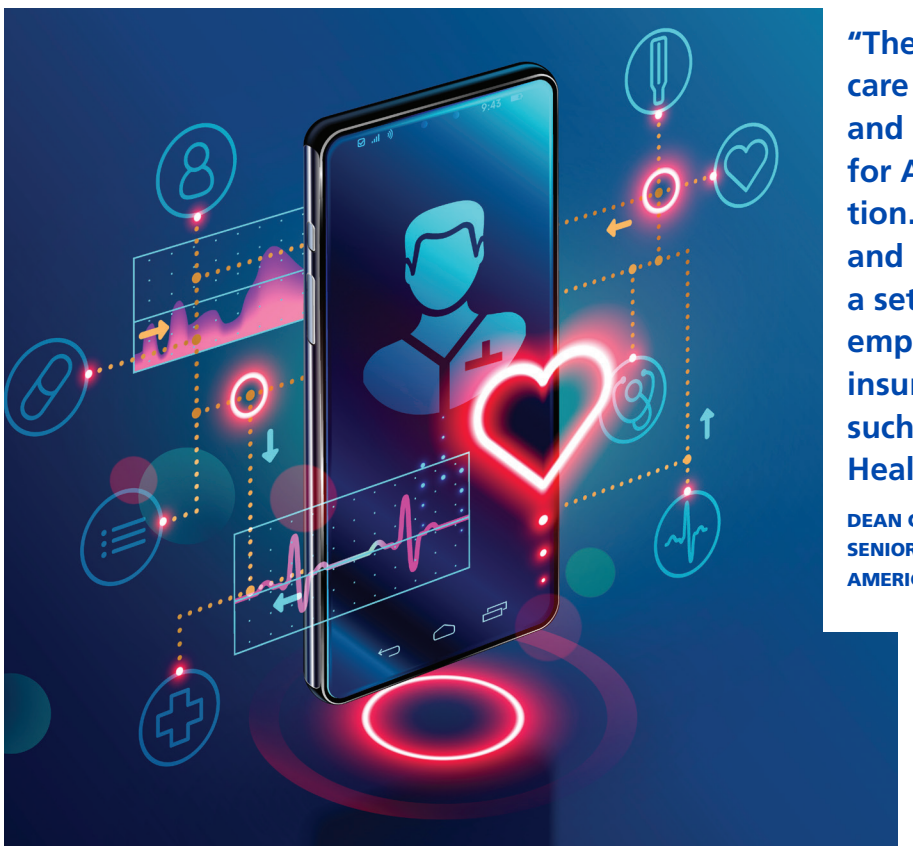
By Dean Clancy

Forty percent of U.S. voters say the high and rising cost of health care represents a "crisis," according to a recent poll.

A majority (56 percent) say they feel "helpless" when dealing with the U.S. health care system—that the system is in charge, not them.

Voters are right. Medical prices are rising faster than inflation. The share of the family budget devoted to health care has nearly doubled since 2000, from 13 percent to 25 percent of the median family's household income. It is getting hard for patients these days to find doctors and hospitals who will accept their insurance, and even harder to find doctors who will spend sufficient time with them.

Meanwhile, gaps in the safety net are leaving too many Americans, especially low-wage workers, without any affordable health insurance options.



"The voters are right. Health care has become too expensive and impersonal. But 'Medicare for All' is the wrong prescription. Instead, Americans want and deserve a Personal Option, a set of sensible reforms that empower patients instead of insurance companies—reforms such as those found in the Health Care Fairness for All Act."

DEAN CLANCY
SENIOR HEALTH POLICY FELLOW
AMERICANS FOR PROSPERITY

Trading Bureaucrats

Some say the solution is a government takeover, such as "Medicare for All." But that would be a remedy worse than the disease.

Why would we replace unresponsive insurance company bureaucrats with unresponsive government bureaucrats? And why would we give the leak-prone government even more power over our personal medical information?

To see what a centralized, government-run system would mean for Americans, just look at Great Britain, where supply shortages and wait times for emergency care have reached crisis levels.

Happily, there is a better way. We call it the "Personal Option."

This approach fixes what's broken in our system, keeps what works, and gives patients what they want—more control, lower prices, and less hassle—without more bureaucracy or red tape.

'Personal Option' Bill

The best vehicle for achieving a Personal Option is the Health Care Fairness for All Act, a brilliant new bill authored by Rep. Pete Sessions (R-TX). It does three significant things.

First, the bill would reform federal health tax subsidies to fund patients instead of insurance companies.

Second, it would let every American have a tax-advantaged health savings account (HSA).

Third, it would remove needless barriers between patients and the medical professionals they trust.

In short, the Health Care Fairness for All Act puts patients in charge to reduce prices and improve quality, without, as in Britain, limiting patients' access to the latest and best treatments.

Health Care Tax Credit

The heart of the bill is a new, universal voucher-like health care tax credit available to everyone under 65. It would be worth $4,000 a year for every adult and $2,000 for every child. The chronically ill would receive extra help. Using the credit would be optional: you could keep your current plan if you wanted.

For the first time, every single American would have access to the same generous amount of federal help for their medical costs. The health care safety net would have no holes.

An adult couple with two children would receive $12,000 every year, enough for a good health insurance plan tailored to their individual needs, which could be purchased through their workplace or an online marketplace. They could also use the credit to pay for out-of-pocket medical expenses.

If they have money left over at the end of the year, they could save or invest in an HSA for future needs. Anyone, including an employer, could put money directly into the HSA.

Employers could still sponsor health benefits for their workers, as they do today, but those benefits would now be portable from job to job and for times between jobs.

Roadblock Removal

To bring down insurance prices, the bill would make commonsense changes to federal regulations while maintaining guaranteed protections for people with preexisting conditions.

Importantly, people with preexisting conditions would have an extra layer of protection against discrimination: premiums would be risk-adjusted. Insurers could no longer make money by cherry-picking only the healthiest customers and avoiding paying claims when they get sick.

The bill also reduces insurance company meddling by removing barriers to "direct patient care," an exciting subscription-based model that offers patients unparalleled, round-the-clock access to their favorite doctors, lab tests, and imaging for one low monthly fee, with no hidden fees. DPC patients enjoy personalized service, often with same- or next-day appointments.

Finally, the bill removes needless barriers to competition. For example, it lifts a decades-old government ban on physician-owned hospitals. Barring a physician from owning a hospital makes as much sense as prohibiting a mechanic from owning a garage or a hairstylist from owning a salon.

The voters are right. Health care has become too expensive and impersonal. But "Medicare for All" is the wrong prescription. Instead, Americans want and deserve a Personal Option, a set of sensible reforms that empower patients instead of insurance companies—reforms such as those found in the Health Care Fairness for All Act.

Dean Clancy (**DClancy@afphq.org**) *is a senior health policy fellow at Americans for Prosperity.* *A version of this article was published in the* Washington Examiner. *Reprinted with permission.*

INTERNET INFO

U.S. Rep. Pete Sessions, H.R. 3129, Health Care Fairness for All Act, introduced May 9, 2023: **https://www.congress.gov/bill/118th-congress/house-bill/3129/text?s=1&r=9**

COMMENTARY

Biden Torpedoes Short-Term Health Insurance

By Chris Talgo

Campaigning for the presidency in 2019, Joe Biden assured voters he would not eliminate private health insurance plans.

Biden even told an audience in Iowa, "If you have private insurance, you can keep it"—a risky echo of President Barack Obama's 2013 "Lie of the Year."

But over the Independence Day weekend, the Biden administration announced a new rule that will severely restrict Americans from purchasing short-term, limited-duration insurance plans. The rule will basically eliminate the health insurance plans of more than 1.5 million Americans.


President Joe Biden

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Reverses Trump Reforms

In 2018, the Trump administration issued a rule that made it significantly easier for Americans to purchase such short-term plans, which had been limited to three months, for as long as 12 months, and to renew them for up to 36 months.

It is also important to note the Trump rule required issuers of short-term, limited-duration insurance to "display prominently in consumer materials one of two versions of a consumer notice explaining the policy that they are purchasing."

At the time, Health and Human Services Secretary Alex Azar said the goal was to bring "more affordable insurance options back to the market, including through allowing the renewal of short-term plans. These plans aren't for everyone, but they can provide a much more affordable option for millions of the forgotten men and women left out by the current system."

Trump's Centers for Medicare and Medicaid Services administrator, Seema Verma, correctly said the "rule opens the door to new, more affordable coverage options for millions of middle-class Americans who have been priced out of ACA (Affordable Care Act) plans."

Lifelines, Not 'Junk Plans'

For many Americans, short-term plans have been an excellent choice, with premiums and deductibles extremely affordable compared to their ACA counterparts. For those between jobs, in school, or unable to enroll in employer-provided insurance, the plans have been a health insurance lifeline.

Short-term insurance plans have their drawbacks. If you have a preexisting health condition, the insurers do not have to cover you. But unlike plans available under the ACA (aka Obamacare), they offer consumers extensive flexibility and catastrophic coverage at a low price.

Yet, even though more than 1.5 million Americans have chosen to enroll in these short-term plans, the Biden administration is determined to eliminate this popular health insurance option.

According to the Biden administration and Democrats in Congress, short-term plans are "junk plans" because, unlike ACA plans, they do not offer comprehensive coverage options. But that is the entire point of these plans. They are intended as a stopgap health insurance option for people between jobs or who do not need or want comprehensive coverage or cannot pay the attendant costs of such coverage.

Under the current rule, there is a wide range of short-term options, with some beginning as low as $55 per month for individuals. On the other hand, the least expensive Obamacare option, the Bronze plan, costs several times that, on average. Obamacare insurance can run more than $1,000 per month for a 40-year-old couple with one child. And even at that price, these plans can carry family deductibles of more than $18,000 per year.

"Biden's rule is an affront to federalism. As of this writing, 38 states offer short-term plans, with a range of renewal limits. Some states, such as California and New York, do not offer them at all. This, in the words of Supreme Court Justice Louis Brandeis, is a feature of 'the laboratories of democracy' at work."

CHRIS TALGO
EDITORIAL DIRECTOR
THE HEARTLAND INSTITUTE

Overriding the States

Biden's rule is an affront to federalism. As of this writing, 38 states offer short-term plans, with a range of renewal limits. Some states, such as California and New York, do not offer them at all. This, in the words of Supreme Court Justice Louis Brandeis, is a feature of "the laboratories of democracy" at work.

But under Biden's plan, no state would be allowed to offer such plans at all. This will further centralize power in Washington and strengthen D.C. bureaucrats' stranglehold.

As House Ways and Means Chairman Jason Smith (R-MO) said of Biden's new rule, "The American people, not Washington bureaucrats, should be the ones deciding what health care coverage is the best for themselves and their families."

The good news is that Biden's rule is not permanent: it can be changed by the next administration. But that rings hollow for the 1.5 million Americans who are about to be kicked off their private insurance despite Biden's pledge he would never do such a thing.

Chris Talgo **(ctalgo@heartland.org)** *is the editorial director at The Heartland Institute. An earlier version of this article appeared at* The Hill *on July 23, 3023. Reprinted with permission.*

Health Care Reform Bill Would Remove Obstacles to Direct Primary Care

By AnneMarie Schieber

Bills under consideration in the U.S. House and Senate would give individuals the same tax advantages employers have to make their own health care arrangements, such as direct primary care (DPC), and remove many restrictions on health savings accounts to do so.

The Personalized Care Act (PCA), HR 4803, introduced by Rep. Chip Roy (R-TX) on July 20, is a new version of legislation introduced in 2020. Sen. Ted Cruz (R-TX) introduced a companion bill in the Senate.

The PCA has provisions to appeal to consumers, employers, and physicians, says the advocacy group DPC Action in a news release.

"We firmly believe that the Personalized Care Act has the potential to revolutionize healthcare by placing the power back into the hands of patients, employers, and physicians alike," stated Lee Gross, M.D., chairman of DPC Action. "It is time for a patient-centric approach, and this Act offers the foundation for such a transformation."

PHOTO COURTESY STILL TAKEN FROM CSPAN

Putting Consumers in Charge

The PCA would raise the cap on contributions to HSAs and broaden their use.

Currently, a consumer must be covered by a high-deductible Obamacare-compliant plan to contribute to an HSA and is prohibited from using the funds for DPC.

The PCA also addresses the tax advantage employers get for providing health insurance to their employees. Currently, only health insurance premiums paid by employers are exempt from federal income and payroll taxes. The PCA would extend that tax advantage to individual employees to make their own health care arrangements.

"The Personalized Care Act liberates employers from the burden of serving as de facto healthcare providers," states DPC Action. "This freedom will allow businesses to redirect their focus toward their core operations and foster economic growth."

> **"The Personalized Care Act liberates employers from the burden of serving as de facto healthcare providers. This freedom will allow businesses to redirect their focus toward their core operations and foster economic growth."**
>
> **DPC ACTION**

Fostering Innovation, Price Cuts

Chad Savage, M.D., president of DPC Action, says the PCA would lead to innovation and reduce health care prices.

"The provisions would unleash a wave of new coverage products that could reduce purchase costs and break the government-sanctioned monopoly that traditional insurance has on HSAs," said Savage.

"Individuals could own their health plans themselves, which means they wouldn't have to lose their insurance between jobs," said Savage. "Also, with self-ownership of a plan, Americans could buy a policy at a young age, like a life insurance policy, and keep it for life. They wouldn't have to worry about losing coverage if they develop a pre-existing condition, which can happen between plans."

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

Legislators:

Make Us Your New Legislative Aide!

Join Heartland's Legislative Forum today and stay on top of the latest research and policy solutions.

Why Join?

Simply, The Heartland Institute delivers what elected officials need. Busy elected officials have little or no staff and need a reliable source of research and commentary on the most important public policy issues of the day. For decades Heartland has been that resource.

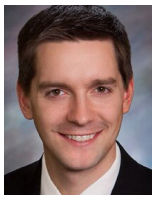
Benefits of membership include:

- Travel scholarships to Heartland's Emerging Issues Forum
- Priority access to your very own free-market think tank
- Bringing experts to your state
- Invitations to Legislative Forum members-only events
- Complimentary copies of *Heartland Policy Studies* and books

Membership is limited to current elected officials and costs just $99 for a lifetime membership. As a lifetime member, you will enjoy the great benefits the Legislative Forum offers for your entire time in office, as well as alumni benefits thereafter.

Visit **heartland.org/sign-forum** to sign up.

For more information, please call 312/377-4000 and ask for a member of the government relations team.



"Heartland's research and advocacy for science-based policies that improve people's lives have been very helpful to me and my colleagues."

REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA

THE HEARTLAND INSTITUTE

The Heartland Institute is a national nonprofit organization based in Arlington Heights, Illinois. Its mission is to discover, develop, and promote free-market solutions to social and economic problems. For more information, visit our Web site at heartland.org or call 312/377-4000.

Goodman Institute
FOR PUBLIC POLICY RESEARCH

Turning Healthcare Ideas Into Public Policy

Dr. Goodman book tour stop at Cato Institute in Washington, D.C.

Dr. Goodman addressing The Economic Club of Indiana

What We Have Accomplished

Health Savings Accounts

More than 30 million people are managing some of their own health care dollars in accounts they own and control

1

Roth IRAs

19.2 million people own $660 billion of retirement money that will never be taxed again

2

Social Security

78 million baby boomers are able to work beyond the retirement age without losing retirement benefits

3

401 (k) Plans

Because of automatic enrollment in diversified portfolios, 16 million employees are enjoying higher and safer returns

4

Visit us at online at **www.GoodmanInstitute.org**