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HEALTH CARE NEWS

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The Pulse

Government Targets 10 Drugs for 'Price Negotiation'

By AnneMarie Schieber

The Biden administration announced the first 10 drugs covered by Medicare that will be subjected to "price negotiation" under the so-called Inflation Reduction Act (IRA).

Makers of the drugs on the list must sign an agreement to enter negotiation. If drug makers refuse, they will be subject to a tax of up to 95 percent on all their U.S. drug sales. Drug makers could instead agree not to participate in Medicare or Medicaid.

Drug makers and the U.S. Chamber of Commerce have filed separate lawsuits

PRICE NEGOTIATION, p. 6

Maternity Wards Closing in Rural Areas

By Harry Painter

Rural hospitals across the nation are shuttering their maternity wards.

By the end of the year, hospitals in Ashland, Ohio; Baker City, Oregon; Troy, New York; and Pontiac, Illinois will no longer deliver babies, *The Wall Street Journal* reports. The closings are part of a trend throughout the country of small or older communities being left without access to maternity care.

OSF HealthCare Saint James-John W. Albrecht Medical Center in Illinois delivered 120 babies last year, down from 184 in 2019, according to the *Journal*. Although it provides OB/GYN services, it is now routing labor and delivery patients to another hospital.

In a statement, OSF HealthCare said, "Many hospitals and health care

MATERNITY WARDS, p. 4

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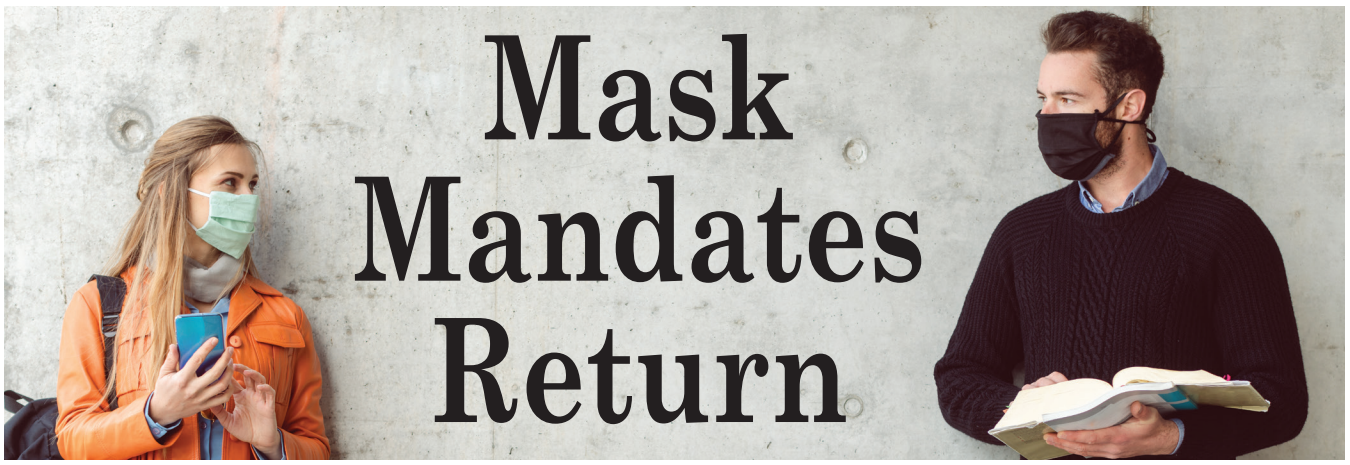

Mask Mandates Return

By Bonner Russell Cohen

Mask mandates returned at various institutions across the country in September, despite the evidence facial coverings are ineffective at protecting against the coronavirus.

The emergence over the summer of new strains of COVID-19, including the BA.2.86 variant, triggered the reimposition of mask mandates in some places.

Mask mandates were reinstated at two hospitals in New York City, one in San Francisco, and at Morris Brown College in Atlanta and Dillard University in New Orleans, as well as for about half the staff at Hollywood's Lionsgate Film Studios in Santa Monica.

"Multiple studies in the mask literature, including randomized clinical trials, combined with a January 2023 Cornell University meta-analysis, found masks had no effect. Simply put, masks are not effective in stopping an airborne virus."

STANLEY YOUNG, PH.D.
SHIFTING SANDS PROJECT DIRECTOR
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Effectiveness Questioned

The effectiveness of masks in preventing COVID-19 infections has been questioned from the pandemic's beginning.

Citing more than 170 studies and articles on mask effectiveness and harms in a December 20, 2021 article for the Brownstone Institute, Paul Alexander, M.D., an epidemiologist and former senior adviser to the U.S. Department of Health and Human Services for the COVID-19 response in 2020, wrote, "To date, the evidence has been stable and clear that masks do not work to control the virus and they can be harmful and especially to children."

A research review by the Cochrane Collaboration, a nonprofit organization that provides comprehensive summaries of evidence on various medical topics, found "there is no statistically significant difference in infection rates between the masked and unmasked group in any of the [clinical] trials."

A study shared on the National Institutes of Health (NIH) website in 2023 found tight-fitting N95 masks could expose wearers to dangerous levels of total volatile organic compounds (TVOCs), at eight times the safe level of TVOCs.

"Extreme fears about the lethality of Covid may have led to decisions that were counterproductive," Stuart Fisher, M.D., an internist in New York, told the *Daily Mail*. "Covid won't be going away for a long time, if ever. We desperately need policies that do not fracture our society while providing minimum protection."

Fauci Is Back

Former White House chief medical advisor Anthony Fauci, M.D. supported resuming the use of masks.

On an "individual basis," many studies "show there is an advantage," Fauci said in a CNN interview on September 2.

Alexander said in 2021 masks were of doubtful benefit without additional personal protective equipment (PPE) or other measures.

"It is not unreasonable to conclude that surgical and cloth masks, used as they currently are being used (without other forms of PPE protection), have no impact on controlling the transmission of COVID-19 virus," Alexander wrote.

In an August 24 post on X, Florida Surgeon General Joseph A. Ladapo, M.D, Ph.D., responded to calls for masks during the current uptick in COVID-19 infections by saying, "These terrible policies only work with your cooperation. How about refusing to cooperate."

Particle Size Matters

Masks can't stop viruses, says Stanley Young, Ph.D., a statistician and Shifting Sands Project Director for the National Association of Scholars who has worked with Eli Lilly, GlaxoSmithKline, and the National Institute of Statistical Sciences.

"COVIDs, like influenzas, are a small, airborne virus, much smaller than the pore size of a medical mask," said Young. "Multiple studies in the mask literature, including randomized clinical trials, combined with a January 2023 Cornell University meta-analysis, found masks had no effect. Simply put, masks are not effective in stopping an airborne virus."

'Symbolize the Power of the State'

Masking orders aren't meant to protect the public, says Craig Rucker, president of the Committee for a Constructive Tomorrow.

"During the pandemic, mask mandates came to symbolize the power of the state and its political allies over the populace at large," said Rucker. "With the waning of the pandemic, that power diminished. The emergence of new COVID variants might be welcomed by certain segments of society eager to recapture the power they wielded with such authority only a short time ago."

Mask mandates do not indicate sincere concern, says Chris Talgo, editorial director of The Heartland Institute, which publishes *Health Care News*.

"This is especially true for children, who were forced to wear masks for years on end, which studies show had a detrimental impact on their learning and development of social skills," said Talgo. "We are witnessing a disturbing trend as mask mandates creep back into society."

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

Maternity Wards Closing in Rural Areas

Continued from page 1

systems, especially in rural areas, are struggling to care for expectant mothers right now. This is due to several factors, including physician shortages, staffing challenges, regulatory requirements, and financial hardships."

Closing maternity units causes risks to infant health and increases in maternal death rates, among other problems.

Poor Medicaid Pay

Medicaid's poor payment rates are an important reason rural maternity wards are struggling to stay afloat, says Gary Alexander, director of the Medicaid and Health Safety Net Reform Initiative at the Paragon Health Institute.

"Medicaid doesn't pay adequately," said Alexander. "Even though Medicaid is the largest payer—let's say typically 50 percent [of revenue for rural hospitals]—add to that fact that Medicaid is often the lowest payer."

Medicaid's reimbursement rates are only one-third to one-half of what private health insurers pay, and they often do not cover a hospital's costs.

Safety Net Jeopardy

Medicaid is no longer the program it was intended to be, suffering from mission creep as politicians try to use it to increase access to housing and food and to stop climate change, says Alexander.

"Medicaid has a place as a safety net for a very targeted smaller population: the populations as defined in the original law," said Alexander.

The program originally targeted the intellectually disabled, poor, elderly, and pregnant women.

"It absolutely has a place, and it should be a payer, but it shouldn't [pay only] 50 percent or 75 percent," said Alexander.

Money Over Health

Data from the Kaiser Family Foundation indicating Medicaid expansion helps rural hospitals is not compelling, says Alexander.

"Even in the expansion states, rural hospitals are struggling," said Alexander. "Medicaid is not adequate. It's not an adequate funder. It's not a fixer for government. States need to be incentivized to do more free-market solutions for health care and to come up with different models."

Alexander says politicians want to expand Medicaid because of perceived general economic benefits, not necessarily for any health improvements.

"Governors will say that Medicaid is [an economic] stimulus," said Alexander. "They don't want to cut Medicaid because they feel it's free federal money. The feds are paying most of the tab."

Rural Population Declining

Rural hospital maternity ward closures reflect a larger problem of hospitals closing down in rural areas, says Devon Herrick, a health economist and advisor to The Heartland Institute, which publishes *Health Care News*.

"As rural hospitals struggle financially, they begin to cut those services that are not profitable," said Herrick.

One problem for rural areas is lower demand for maternity services, says Herrick.

"One thing state and local governments can do is free midwives and nurse midwives to practice in small towns. For that matter, states could even train nurse midwives specifically to work in areas lacking maternity services."

DEVON HERRICK
HEALTH ECONOMIST

"What makes maternity wards unprofitable is partly the depopulation of rural areas," said Herrick. "Rural residents tend to be older, as younger people leave for jobs in the city. Demand for maternity wards is not as great as in years past."

Country people are also less affluent, says Herrick.

"Rural residents tend to be poorer than residents in metropolitan areas," said Herrick. "Lower-income people may have no insurance coverage or Medicaid coverage."

Outdated Business Models

Alexander sees additional problems inherent in rural hospitals.

"For the most part they're a legacy system," said Alexander. "They've been around for a long time, and a lot of them really haven't looked at changing or altering their business model."

With fewer patients, rural hospitals struggle for efficiency, says Alexander.

"So, there are fewer cases to spread fixed costs, and there's a minimum of specialty staff and equipment that must be there, whether it's optimally used or not," said Alexander.

Less Experience, Higher Risk

Rural hospitals also offer their employees lower salaries with fewer opportunities for job advancement and have lower visibility than urban hospitals, all of which makes it harder to hire high-quality doctors, says Alexander.

"Rural obstetricians don't often have the broadest experience with challenging cases," said Alexander.

The potential for lawsuits might also be a factor, says Herrick.

"Because babies are young and sympathetic patients, there is also significant malpractice liability to delivering babies," said Herrick. "Doctors not specifically trained in OB/GYN may not want to be the county obstetrician like was common decades ago."

Government Reform Role

Alexander's proposed solutions include more surgery centers, specialty care, short-term facilities, rehabilitation centers, and telemedicine.

"Rural hospitals are important; however, I think that government's role should be allowing them to have new business models," said Alexander. "Sometimes you have winners and losers in that, like in any industry. It's still going to be a struggle for rural hospitals to exist. I think the only way really around it is we have to incentivize these hospitals to start to look at different models.

"The state needs to create that atmosphere or that incentive so that they don't just continue to operate under the same model and then go out of business," said Alexander.

States could take an innovative step by encouraging midwifery, Herrick says.

"One thing state and local governments can do is free midwives and nurse midwives to practice in small towns," said Herrick. "For that matter, states could even train nurse midwives specifically to work in areas lacking maternity services."

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

Court Orders FDA to Restore Abortion Pill Safety Measures

By AnneMarie Schieber

A three-judge panel of the Fifth Circuit Court of Appeals unanimously ruled the abortion drug mifepristone can stay on the market but the Food and Drug Administration (FDA) must restore safety protections removed over the years.

The August 16 decision in the case, *Alliance for Hippocratic Medicine v. FDA*, came after U.S. District Court Judge Matthew Kacsmaryk of the Northern District of Texas stayed the FDA's initial approval of mifepristone in 2000 entirely on April 7. The Biden administration quickly appealed Kacsmaryk's order and the U.S. Supreme Court intervened, allowing the drug to stay on the market as the case advanced through the judicial system.

The plaintiffs or the Biden administration could appeal to the U.S. Supreme Court. The White House indicated in a statement it will ask the Supreme Court to review the decision, stating the ruling "undermines FDA's scientific, independent judgment and reimposes onerous restrictions on access to safe and effective abortion."

"The FDA approved mifepristone under its Subpart H regulations. But Subpart H only authorizes the FDA to approve drugs that 'treat serious or life-threatening illnesses.' And pregnancy is plainly not an illness."

JUDGE JAMES C. HO
FIFTH CIRCUIT COURT OF APPEALS

'Restore … Safeguards for Women'

If the appeals court decision stands, it will be illegal to send mifepristone through the mail or prescribe it after seven weeks of pregnancy. It will have to be prescribed by a physician after a face-to-face visit, and adverse effects will have to be reported.

The appeals court ruling is a victory, says Alliance Defending Freedom (ADF) Senior Counsel and Vice President Erin Hawley.

"The 5th Circuit rightly required the FDA to do its job and restore crucial safeguards for women and girls, including ending illegal mail-order abortions," said Hawley in a press release. "The FDA will finally be made to account for the damage it has caused to the health of countless women and girls and the rule of law by unlawfully removing every meaningful safeguard … without regard to women's health or the rule of law."

Mifepristone will be available by mail in some states under a decision in another case, *Washington v. FDA*. Within an hour of the Kacsmaryk decision, a federal district judge for the Eastern District of Washington ordered the FDA not to interfere with the availability of mifepristone in 17 states and the District of Columbia.

Judge Wanted Approval Voided

The appellate decision was unanimous. Judge James C. Ho said in a separate opinion the court should void the FDA's approval of the drug 23 years ago.

"The FDA approved mifepristone under its Subpart H regulations," wrote Ho. "But Subpart H only authorizes the FDA to approve drugs that 'treat serious or life-threatening illnesses.' 21 C.F.R. § 314.500. And pregnancy is plainly not an illness."

The government argued it is too late to challenge a drug approval made in 2000, but Ho noted the clock restarts when the FDA changes regulations, as it did in removing safety precautions in 2016 and in 2021.

'Aesthetic Injury'

Ho also addressed conscience and "aesthetic injury," which refers to someone being forced to witness an activity that interferes with the joy of viewing something, similar to the Sierra Club objecting to the destruction of trees or wildlife.

"The FDA's approval of mifepristone creates a substantial risk that Plaintiffs will be forced to participate in the abortion process," Ho wrote. "The FDA has approved the use of a drug that threatens to destroy the unborn children in whom Plaintiffs have an interest. And this injury is likewise redressable by a court order holding unlawful and setting aside approval of that abortifacient drug. I see no basis for allowing Article III standing based on aesthetic injury when it comes to animals and plants—but not unborn human life."

Judge's Arguments 'Spot-On'

It is unfortunate that mifepristone will remain available while the case is under appeal, says Genevieve Marnon, legislative director for Right to Life Michigan.

"I do believe the Supreme Court will hear this case, but unfortunately, the status quo continues," said Marnon. "Until then, abortion providers will still have an opportunity to expand their mail-order abortion business and leave women in harm's way. Women will still be able to receive abortion pills via telemedicine with no physical exam, no follow-up, and nowhere to turn if there are complications except to the emergency room."

Marnon was encouraged by Judge Ho's concurring opinion.

"It was excellent!" said Marnon. "I hope and pray that the SCOTUS will give it deference, as his legal arguments were spot-on, in my opinion. The original approval of Mifeprex (mifepristone) was unlawful and should be reviewed, and hopefully the Supreme Court will agree that the abortion pill should be removed from the market.

"That said, I would have preferred if the sentiments expressed by Judge Ho had been affirmed by the rest of the panel of judges," said Marnon.

'Politically Charged'

The Supreme Court will undoubtedly need amicus briefs and more pointed oral arguments to help it decide whether mifepristone should be pulled from the market, says Marnon.

"This is such a politically charged issue, and the SCOTUS has recently been through such a rough time over *Dobbs* [abortion decision]—including the Biden administration allowing a sitting Justice to be hassled, threatened, and picketed at his home," said Marnon. "I wonder if there is enough willpower to actually pull the abortion pill off the market now that there have been 23 years of reliance on it."

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

Government Targets 10 Drugs for 'Price Negotiation'

Continued from page 1

challenging the new law, which was signed by President Joe Biden in August 2022.

Negotiation or Price Controls?

The IRA gives the federal government the authority to control the prices it pays for drugs covered by Medicare (Part D), which it never had before. Over the next four years, up to 60 drugs covered under Part D and Part B will be targeted for "price negotiation," and every year thereafter up to 20 more drugs will be added.

Seniors paid $3.4 billion in out-of-pocket costs for the drugs in 2022, according to a White House "fact sheet" released on August 29, 2023. Many seniors have supplemental insurance. For those who do not, the average annual out-of-pocket cost for drugs was up to $6,497 per enrollee, the fact sheet states.

"It is important to note that the IRA isn't an intrusion into the free market for prescription drugs any more than the myriad laws and regulations that allow drug companies to sell at monopoly prices," said Gregg Girvan, a scholar at the Foundation for Research on Equal Opportunity.

'Potentially Devastating Consequences'

The government created the need for price controls, says Girvan.

"Government policy has made the prescription drug market less free," said Girvan. "Making the patent system fair, paying for drugs based on value, and removing barriers to generic and biosimilar market entry would restore a competitive drug market that is freer and affordable for American patients."

Drug maker Merck, whose diabetes drug Januvia is on the list, said the negotiation program is a "bad policy, that will stifle the U.S. biopharmaceutical sector's research and development and have potentially devastating consequences for the millions of patients who need new therapeutic options."

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

Medicare Drugs Targeted for Price Negotiation

Drug Name	Commonly Treated Conditions	Total Part D Gross Covered Prescription Drug Costs, June 2022-May 2023	Number of Medicare Part D Enrollees Who Used the Drug, June 2022-May 2023	Average Part D Covered Prescription Drug Costs Per Enrollee
Eliquis	Prevention and treatment of blood clots	$16,482,621,000	3,706,000	$4,448
Jardiance	Diabetes; Heart failure	$7,057,707,000	1,573,000	$4,487
Xarelto	Prevention and treatment of blood clots; Reduction of risk for patients with coronary or peripheral artery disease	$6,031,393,000	1,337,000	$4,511
Januvia	Diabetes	$4,087,081,000	869,000	$4,703
Farxiga	Diabetes; Heart failure; Chronic kidney disease	$3,268,329,000	799,000	$4,091
Entresto	Heart failure	$2,884,877,000	587,000	$4,915
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	$2,791,105,000	48,000	$58,148
Imbruvica	Blood cancers	$2,663,560,000	20,000	$133,178
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis	$2,638,929,000	22,000	$119,951
Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill	Diabetes	$2,576,586,000	777,000	$3,316

Source: "Fact Sheet: Biden-Harris Administration Announces First Ten Drugs Selected for Medicare Price Negotiation," August 29, 2023: https://www.whitehouse.gov/briefing-room/statements-releases/2023/08/29/fact-sheet-biden-harris-administration-announces-first-ten-drugs-selected-for-medicare-price-negotiation/

COMMENTARY

Medicare Drugs on the Chopping Block

By Grace-Marie Turner and Nina Owcharenko Schaefer

The Biden administration announced the first 10 prescription drugs it will target in its newly authorized drug price "negotiation" regime, on August 29.

Under the Inflation Reduction Act (IRA)—more properly dubbed the Innovation Reduction Act—the Centers for Medicare and Medicaid Services (CMS) announced the 10 drugs under Medicare Part D the agency will subject to its Drug Price Negotiation Program.

These drugs are "single-source drugs with the highest Medicare spending," with some exemptions.

However, the IRA, passed by Congress and signed by President Joe Biden a year ago, threatens to impose an enormous excise tax on the selected drugs to force pharmaceutical developers to participate.

Boehringer Ingelheim is the seventh company to file a lawsuit against the U.S. Department of Health and Human Services (HHS) over the issue. The suits claim the drug price program is unconstitutional on several grounds, including that it violates the First Amendment (compelled speech), Fifth Amendment (due process and unlawful taking), and the Eighth Amendment (excessive fines) as well as other constitutional harms.

Two plaintiffs have filed motions seeking injunctive relief to stop HHS from implementing the program through the CMS.

President Joe Biden

"Each year, the CMS will add more and more drugs to its target list. Americans can expect to see fewer new cures and treatments along with the same restrictions and rationing patients face in countries that have government-run, price-controlled health systems."

Benefits Few Seniors

Douglas Holtz-Eakin, an economist who heads the American Action Forum, details the impact of the misguided program which, he says, "features price controls and draconian taxes."

Holtz-Eakin argues that although Biden and other Democrats advertised the IRA as "substantially" reducing drug costs for a wide swath of Medicare beneficiaries, in fact, fewer than 10 percent of seniors will benefit at all. For those who do see savings, he argues, they will be modest. Fully 69 percent of those who see any savings will pocket less than $300.

University of Chicago economist Tomas Philipson has extensively studied the law's expected impact. He estimates that because of the price control regime, 135 fewer drugs will be brought to market, amounting to $18 trillion in health-related losses through 2039.

Cost in Lives

The impact on patients will be significant, decimating drug development as pharmaceutical companies pull funding for promising drugs from the research pipeline, Philipson predicts.

"This drop in new drugs is predicted to generate a loss of 331.5 million life years in the U.S., 31 times as large as the 10.7 million life years lost from COVID-19 in the U.S. to date," Philipson wrote.

Each year, the CMS will add more and more drugs to its target list. Americans can expect to see fewer new cures and treatments along with the same restrictions and rationing patients face in countries that have government-run, price-controlled health systems.

"Of all drugs launched worldwide between 2011 and 2018, 89% were available in the U.S. while only 48% were available in France. Bureaucrats may be well-intentioned, but markets are always better at setting prices," wrote Philipson.

Freezing Innovation

And all of this is being done so the Biden administration can "save" an estimated $238 billion over a decade—money that it does not plan to reinvest in Medicare to stave off the program's pending bankruptcy, but rather to fund its radical agenda, especially its climate change initiatives.

The drug price control scheme will freeze today's innovation in place because it punishes companies that continue to improve a drug and find new disease applications—applications that are the source of the majority of cancer drugs.

Erica York, senior economist with the Tax Foundation, explains that it currently takes an average of 10 years and more than $2 billion to develop and bring a new drug to market. The industry invested more than $100 billion in research and development in 2021, but leaders already are pulling funding for new drugs. Peter Thompson, private equity partner at OrbiMed Advisors LLC, said during a recent BIO Investor Forum that the 2022 law already is "directly hampering science."

Involuntary 'Negotiations'

Drug companies are in the crosshairs of the IRA, no matter what they do. The law forces them to state they "agree voluntarily" to whatever price the government offers for their drugs—with no minimum price.

And companies will face enormous and punitive fines if they don't comply. New Jersey-based Merck states in its lawsuit that manufacturers who don't participate in negotiations "must pay an escalating excise tax that starts at 186% and eventually reaches 1,900% of a drug's daily revenues."

The company estimates that refusal to negotiate for even just one drug could incur fines of tens of millions of dollars on the first day—increasing to hundreds of millions of dollars per day thereafter.

Lives at Risk

This exposes the falsehood of the "negotiation." In a private negotiation, the playing field is level. Under this scheme, though, the government sets the terms and enforces the penalty.

It's as if the government fielded a baseball team and also acted as umpire. The playing field here is not equal. It's important for Americans to know these facts before the CMS decimates drug development in the United States.

Congress has held numerous hearings to investigate the expected impact of the new law. It must continue its oversight and use its authority where possible to curtail the Biden administration's plans as the law makes its way through the courts.

With fewer cures and treatments, lives are at risk.

Grace-Marie Turner (**gracemarie@galen.org**) *is president of the Galen Institute. Nina Owcharenko Schaefer* (**nina.schaefer@heritage.org**) *is the director of the Center for Health and Welfare Policy at The Heritage Foundation.* *This article appeared in* The Daily Signal *on August 29, 2023. Reprinted with permission.*

Ailing Canadian Transgender Patient Denied Assisted Suicide

By Kevin Stone

A transgender patient was rejected by Canada's Medical Assistance in Dying (MAiD) program.

Lois Cardinal says debilitating pain following a 2009 vaginoplasty surgery for a male-to-female (MTF) transition led to the euthanasia request. Cardinal was rejected from MAiD for not meeting the program's current criteria, the *Daily Mail* reported.

Cardinal reports experiencing constant pressure, pain, and discomfort from the procedure, which inverts penile tissue into a created cavity to form a "neovagina." Other recipients of MTF vaginoplasty have reported similar postoperative symptoms.

"The story about Lois Cardinal is particularly distressing since Lois is seeking to be killed, not because of a terrible terminal condition but rather because Lois feels that the medical community has abandoned her condition."

ALEX SCHADENBERG
EXECUTIVE DIRECTOR
EUTHANASIA PREVENTION COALITION

Pain, Regret, and Rhetoric

A preliminary report from a yet-to-be-published study by researchers at the University of Florida and Brooks Rehabilitation found 81 percent of the participating recipients of one or more gender-affirming surgeries experienced regular pain and discomfort in the five years after the surgery. Another 57 percent found sexual intercourse painful, and 29 percent suffered urinary incontinence or a frequent and urgent need to go to the bathroom, the researchers found.

Cardinal has stated regret for the surgery in social media posts and does not "agree with the current rhetoric of the trans community." Cardinal stated young people are at risk of "falling prey to a trend that is medicalized."

'Abandoned' by Caregivers

Cardinal, who was prescribed a topical anesthetic "numbing cream" that did not reduce the pain, has identified an inability to receive effective care for the problematic surgery as the primary cause for seeking medically assisted death.

Cardinal's story is symptomatic of a greater health care problem in Canada, says Alex Schadenberg, executive director of the Euthanasia Prevention Coalition.

"The story about Lois Cardinal is particularly distressing since Lois is seeking to be killed, not because of a terrible terminal condition but rather because Lois feels that the medical community has abandoned her condition," said Schadenberg. "Further to that, it is possible that Lois may be approved to be killed in the future based on the meaning of the phrase 'irremediable medical condition' which is essentially what is required to be approved for death by lethal drugs."

Schadenberg says Cardinal may meet expanded criteria in March 2024 when Canada's euthanasia law will include people with mental health problems.

Coming to America?

While Canada has embraced medically assisted death and continues to expand its scope, euthanasia is meeting more resistance in the United States.

The American College of Physicians (ACP), the second-largest U.S. network of physicians, stated its official opposition to euthanasia in a 2017 position paper.

"The ACP and its members, including those who might lawfully participate in the practice, should ensure that all persons can rely on high-quality care through to the end of life, with prevention or relief of suffering insofar as possible, a commitment to human dignity and the management of pain and other symptoms, and support for family," the paper states.

Ten states and the District of Columbia currently permit medically assisted suicide. Vermont became the first state to allow doctor-assisted suicide for non-residents, in May.

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

Canadian Mental Health Patient Offered Suicide Option

By Kevin Stone

A patient in Canada says her clinician asked if she might consider assisted suicide, the *Globe and Mail* reports.

A 37-year-old British Columbia resident, Kathrin Mentler, sought treatment for depression and suicidal thoughts at Vancouver General Hospital, the *Globe and Mail* reported on August 9. A clinician told Mentler there were no available beds and access to treatment would be difficult because Canada's socialist medical system is "broken."

The clinician then asked Mentler whether she had considered suicide under Canada's Medical Assistance in Dying Act (MAiD). Mentler said she was shocked the country's medical system would suggest someone seeking help for suicidal ideation should kill herself with medical assistance.

'Killing People Is Not Caring'

Unavailability of beds and treatment has been a growing problem in Canada. Hundreds of Canadians died in 2018 and 2019 while waiting for surgery, according to a report published by SecondStreet.org.

Alex Schadenberg, executive director of the Euthanasia Prevention Coalition, says replacing medical care with assisted death is dangerous for patients.

"In Canada, there was the story of a 51-year-old woman with multiple chemical sensitivities who needed a clean place to live," Schadenberg said. "Instead, she was provided death. There was the story of the Canadian veteran who was living with PTSD who was told by the Veterans Affairs worker to consider euthanasia.

"Killing people is not caring, and it changes our cultural attitudes towards the person in need of help," Schadenberg said.

Spreading Assisted Suicide

Canada began permitting medically assisted suicide under the MAiD law in June 2016, allowing physicians to help terminally ill patients die.

Legal eligibility for MAiD was expanded in 2021 to additional groups, including patients with chronic diseases or disabilities.

The 2021 law also removed safeguards from the original bill, such as eliminating the 10-day waiting period and the requirement to offer palliative care and reducing the required number of independent witnesses to one. The revised statute also allowed a new class of eligibles to be phased in, including those with severe refractory mental illnesses, in March 2024.

Medical practitioners are now legally obligated to inform patients who might fall under one of the permitted classes of the option. Clinicians who object to euthanasia must make a referral to nonobjecting providers under guidelines formulated by the Canadian Association of MAiD Assessors and Providers.

'Suicide Booth' Invented

Expansion of medically assisted suicide has led to the invention of a "suicide booth," a "coffin-like pod" that fills with nitrogen and causes a quick death from oxygen and carbon dioxide deprivation, *The U.S. Sun* reported on August 27.

Expansion of medical suicide could threaten vulnerable populations, says Matt Dean, a senior fellow for health care policy outreach for The Heartland Institute, which publishes *Health Care News*.

"MAiD was sold as a means to legally end the suffering of a person dying from an insidious and painful disease," said Dean. "However, critics pointed out that soon not just the terminally ill would be seeking to end their life."

Dean recalled the story last year of 54-year-old Amir Farsoud.

"Farsoud was approved for MAiD by one doctor, even though he had no reasonably foreseeable death, and his main complaint was a loss of housing subsidy," said Dean. "He publicly stated that he did not want to die but felt he could not afford to live. After his story attracted attention, a go-fund-me page raised $60,000 and Farsoud withdrew his request for MAiD."

'Duty to Die'

Patients could be pressured to accept MAiD, says Dean.

"Government-sanctioned death-inducing drugs prescribed for principally economic reasons creates a 'duty to die' expectation for those deemed to be a drain on the system," said Dean. "What kind of country can tolerate the killing of a patient—in this case a nonterminal 54-year-old—to save $60,000?"

'Mature Minors' Eligible

Adolescents, already a high suicide-risk group, are particularly vulnerable to the suicide push, says Dean.

"The most basic role of the government is to protect its most vulnerable," said Dean. "Unbelievably, Canada is not stopping at allowing the mentally ill to be essentially put to death. Children, or as the recommendations of the Report of the Special Joint Committee on Medical Assistance in Dying calls them, "mature minors," deserve barely any extra care when the state approves their death."

Although the parliamentary report perfunctorily acknowledges teenagers are vulnerable, it gives short shrift to the need for additional measures to protect them, says Dean.

"The report states that mature minors make up a potentially vulnerable group, calling for heightened societal protection, but concludes, 'While acknowledging that MAID for mature minors should therefore involve special safeguards, a number of witnesses emphasized that these should not create onerous barriers to access," said Dean.

"The most basic role of the government is to protect its most vulnerable. Unbelievably, Canada is not stopping at allowing the mentally ill to be essentially put to death. Children, or as the recommendations of the Report of the Special Joint Committee on Medical Assistance in Dying calls them, 'mature minors,' deserve barely any extra care when the state approves their death."

MATT DEAN
SENIOR FELLOW
THE HEARTLAND INSTITUTE

'Killing Is Cheaper Than Caring'

Schadenberg says he's concerned about the acceptance of euthanasia as a panacea driven by dollars and cents rather than societal costs.

"As for the issue of medical cost, it is clear that killing is cheaper than caring or providing treatment, but the expense related to killing is how it changes society," said Schadenberg. "When someone is killed rather than cared for, society comes to accept that some lives are not worth fighting for or caring for. This is a very sad statement because it results in a hardened society, one that lacks true empathy. As death becomes a treatment, society eliminates people who may be difficult to care for."

"I oppose killing people," Schadenberg said. "There are many difficult human circumstances that require a highly intensive form of care. Some situations do not offer easy answers, but once killing becomes an acceptable solution to human suffering, it cannot be controlled because there are many types of human suffering."

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

Medical School Dean Cancelled for Liking Tweets

By Kenneth Artz

The president of Thomas Jefferson University, who was also the medical school dean, resigned under pressure for liking politically incorrect tweets, *The Philadelphia Inquirer* reported.

Molecular immunologist Mark L. Tykocinski, M.D., age 70, who has been with the university for about 15 years and was president for a few months, will continue to teach.

Tykocinski left his leadership positions under controversy over some tweets he "liked" from his official presidential Twitter account. The tweets were about COVID-19 vaccines, gender reassignment surgery for children, and a letter in *The Wall Street Journal* titled "Diversity Czars Always Need to Find New Oppression."

In an email, Tykocinski told the *Inquirer* he "liked" tweets to bookmark them to "learn more about the subject matter or the particular viewpoint," and he did not endorse the tweets or the person tweeting those thoughts.

Doctor-Patient Trust Strained

Doctors should be able to communicate with their patients without fear of retaliation, says Marilyn Singleton, M.D., an anesthesiologist in California and visiting fellow at Do No Harm, a national association of medical professionals.

"Physicians now are hesitant to have honest conversations with their patients about fears and questions the patients brought to them," said Singleton. "Hippocrates felt that the patient-physician relationship was sacred. Part of informed consent and good medicine, in general, is explaining all sides of an issue to patients."

In California, sharing what the state Medical Board deems to be COVID-19 misinformation—anything inconsistent with what it designates as the "scientific consensus"—is grounds for severe disciplinary action against physicians, says Singleton.

"While the proponents of the law say it only applies to COVID, once the politicians have their feet in the door of the confidential exam room, patients will lose trust in their physicians if they believe they are not going to receive all the available facts surrounding their condition," said Singleton.

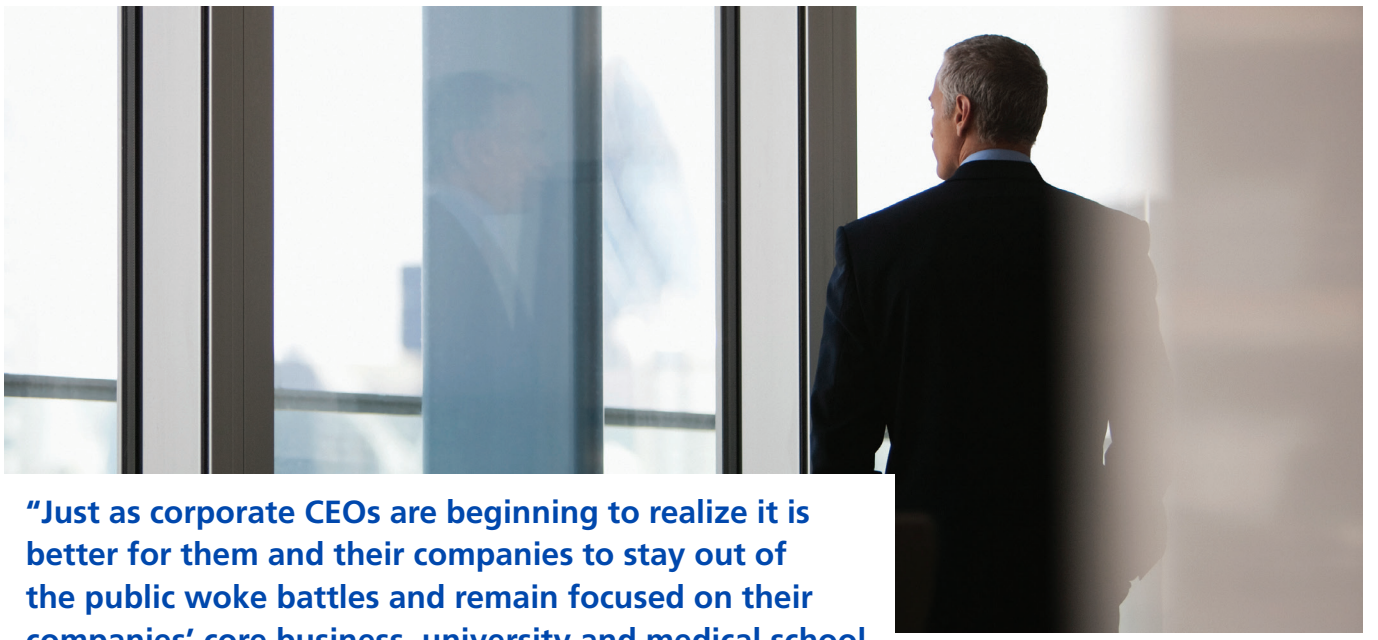
'Questioning the Party Line'

Doctors have First Amendment rights like every other American, says Singleton.

"Outside of the patient-physician relationship, a physician should be free to speak his or her mind," said Singleton. "Absent some contractual terms about specific unacceptable behavior, the physician-employee should be able to have open discussions about medical topics, even if contrary to the current 'consensus.' Science progresses by questioning the party line."

Sharing politically incorrect thoughts has become dangerous for physicians, says Singleton.

"In this new age of the thought police, our every word is scrutinized to determine if we are on the socially acceptable side of the cause célèbre of the week," Singleton said. "Engaging in social media or even cocktail party conversation has become a minefield."



"Just as corporate CEOs are beginning to realize it is better for them and their companies to stay out of the public woke battles and remain focused on their companies' core business, university and medical school presidents and deans should be doing the same.

MERRILL MATTHEWS, PH.D.
RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

'Undermining the Public's Confidence'

The kerfuffle over Tykocinski's "likes" highlights two problems, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"First, as the now former president and interim medical school dean, he should have known better," said Matthews. "Just as corporate CEOs are beginning to realize it is better for them and their companies to stay out of the public woke battles and remain focused on their companies' core business, university and medical school presidents and deans should be doing the same."

The second problem is that institutional leaders are being pushed by leftists, says Matthews.

"Woke activists, students, professors, and aligned associations—e.g., the American Medical Association—are spending less time on their primary mission of providing outstanding medical care and are instead pushing political agendas that are undermining the public's confidence in medicine," said Matthews. "Patients go to a doctor or hospital because they want competent health care providers treating them, not social warriors who focus more on curing perceived social injustices than real diseases."

'Complete Clean-Up Required'

These are dark times for medicine, says Texas physician John Dale Dunn, M.D., J.D., a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"Organized medicine and academic medicine have been highjacked by leftist ideologues with crazy and unethical, harmful ideas … that are nothing more than the wish list of socialist cranks and criminals," said Dunn. "The best word to use is criminals, because what they advocate, they know is not just junk science, but their agenda is harmful in demonstrable ways."

The health care establishment requires a thorough house cleaning, says Dunn.

"The misconduct of the organized medicine organizations, the medical specialty societies, and the state and federal medical licensure agencies that adhere to the unethical and harmful medical policy positions being advocated are now involved in actionable and criminally malevolent activities," said Dunn. "Only a major teardown and rebuilding of the medical institutions, medical societies, and professional organizations and their government enforcement colluders at the state and federal regulatory level will accomplish the complete clean-up required."

'Defending Science and Reality'

Medical careers are now being put at risk and, in some instances, ruined because a person said or thought the wrong thing, says Seton Motley, president of Less Government, a Washington, D.C-based nonprofit organization dedicated to reducing the power of government and protecting the First Amendment from governmental assault.

"It's 2023; there is now nothing 'controversial' about questioning the China Virus vaccines," said Motley. "Quite the contrary: if you're still a vaccine promoter—it is you who are anti-science. And it is quite obvious that surgically removing perfectly healthy sexual organs from minors is child mutilation.

"Tykocinski was dispatched for defending science and reality," said Motley. "In 2023, that means he has no business in the woke wastelands that are today's alleged medical schools."

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

Health Care Provider Bans Patient for 'Transphobic' Views

By Kenneth Artz

A woman was dropped by her health care provider for "hurtful remarks" about a trans pride flag in the waiting room.

Marlene Barbera, a breast cancer patient at the Richmond Family Medicine Clinic in Portland, Oregon, was scheduled for a mastectomy in late August. In 2022, she wrote her doctor a note objecting to the trans pride flag in the clinic's reception area, using MyChart—a computer application that lets patients access and manage their personal health information and communicate with physicians.

Barbera thought the online communication with her doctor was private but was later told other staff saw her remarks.

"What happened to this lady is no surprise considering that the medical profession and their bosses in the corporate medical organizations are tools of the Left and will use medical care availability as a weapon to suppress freedom of speech. We are now in the thrall of a police state. It's not complicated: the people in power are going to crush any opposing voices."

JOHN DALE DUNN, M.D., J.D.
EMERGENCY ROOM PHYSICIAN

Comments 'Harmful to Our Staff'

This summer, while trying to schedule blood tests via phone, Barbera was informed by Oregon Health Science University (OHSU) Practice Manager Stein Berger via MyChart that "Richmond is an all-inclusive clinic, and we value and advocate for diversity." Berger said Barbera had made "transphobic remarks" that were "harmful to our staff."

Berger followed up and received an email back from the clinic.

"Effective immediately, you are discharged from receiving medical care at the Richmond Family Medicine Clinic," said the email. "This action is being taken because of ongoing disrespectful and hurtful remarks about our LGBTQ community and staff. … Please note that you are also now dismissed from all OHSU Family Medicine clinics, including Immediate Care clinics."

'Like a Worthless Nothing'

The notice said the clinic would end all services to Barbera on July 29, giving her 30 days to find a new health care provider. In an interview with Reduxx, an online platform, Barbera said the ordeal has been traumatizing.

"I have severe chronic agitated depression since my teen years," said Barbera. "Now I have no primary care doctor and nowhere else to go. I have been made to feel like a worthless nothing."

'Put the Patient First'

Barbera's experience reflects the current social climate, says Roger Stark, M.D., a health care policy analyst at the Washington Policy Center and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"I had a number of gay associates when I was in clinical practice," said Stark. "They were all caring providers and always put the patient first. Plus, none of them made an issue out of their sexual orientation."

The first problem, says Stark, is the fact a medical office would hang a controversial flag in the reception area.

"Again, I think this reflects the current way priorities are set," said Stark. "For example, many medical schools now have a course on diversity in their curriculums."

'Responsibility to Treat'

Stark says it is notable Barbera had a 12-year history with the clinic, which has her medical records.

"If she was truly offended by the flag, she had the option of seeking care at a different office and avoiding further confrontation," said Stark. "I'm not sure what she could have said that was so offensive, but it seems to me that a physician has a certain responsibility to a patient regardless of what was said. Obviously, this is a complex issue, but from my standpoint as a practicing doctor, the clinic has the responsibility to treat the patient."

'Tools of the Left'

Many health care practices are owned by hospitals and big corporations, and they may be pressured into promoting LGBT+ advocacy. Corporations, for example, push policies to boost their Environment and Social Governance (ESG) scores to curry favor with certain investors and the government. Mass General Brigham recently implemented a 'patient code of conduct" that put patients on notice certain speech could cost them care.

There have been other free speech attacks, censorship, and cancellation of individuals who don't toe the federal government's line on medical matters, says John Dale Dunn, M.D., J.D., an emergency room physician and attorney.

"What happened to this lady is no surprise considering that the medical profession and their bosses in the corporate medical organizations are tools of the Left and will use medical care availability as a weapon to suppress freedom of speech," said Dunn.

"We are now in the thrall of a police state," said Dunn. "It's not complicated: the people in power are going to crush any opposing voices."

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

Health 'Misinformation' Still in Crosshairs

By Bonner Russell Cohen

The nonprofit Kaiser Family Foundation (KFF) has begun a program of tracking and combating communications the organization characterizes as "health misinformation," using political positions as a dominant factor.

KFF surveyed a sample of individuals in response to "the pervasiveness of false and inaccurate information about COVID-19 and vaccines" for a report released on August 23.

Public health officials have expressed concern over a new, highly mutated variant of the coronavirus, known as BA.2.86, renewing debate over how best to handle potential threats, though controversies surrounding policies adopted during the COVID-19 pandemic are far from resolved.

The tracking poll results are the first of several KFF plans to release that "will explore other health topics for which misinformation has been found to be circulating." The report says erroneous claims are easily accessible and widely disseminated among certain groups.

"With this understanding, KFF is designing a new program that will identify and track the rise and prevalence of health-related misinformation in the United States, with a special focus on communities that are most adversely affected by health misinformation," states the report, titled "KFF Health Misinformation Tracking Poll Pilot."

"The 'misinformation' tag is now being used to squelch healthy debate and censor dissenting views. And perhaps most troubling, as the KFF survey shockingly admits, the term 'misinformation' is now being used to target racial and ideological groups—African Americans and Republicans—that authorities deem incapable of forming fact-based opinions."

JEFF STIER
SENIOR FELLOW, CONSUMER CHOICE CENTER

Media Sources Matter

The survey examines what it says are "false claims" in four areas: COVID-19 and vaccines, reproductive health, gun violence, and the Affordable Care Act.

"Some groups seem to be more susceptible to misinformation than others, with large numbers of Black and Hispanic adults, those with lower levels of educational attainment, and those who identify politically as Republicans or lean that way saying many of the misinformation items examined in the poll are 'probably true' or 'definitely true,'" KFF states.

Those who trust conservative media sources are more likely to agree with false statements, says KFF.

"News sources also matter as sources as those who say they regularly consume news from One America News Network (OANN), Newsmax, and to a smaller extent Fox News, are likely to believe most of the misinformation items asked about in the survey," the report states.

Racial Minorities Distrust Vaccines

Regarding COVID-19 and vaccines, the individuals surveyed were asked to identify as true or false certain statements, such as "The COVID-19 vaccines have caused thousands of deaths in otherwise healthy people," and "Ivermectin is an effective treatment against COVID-19."

Some racial and ethnic minorities are especially vulnerable to misinformation about the vaccines for COVID-19 and measles, mumps, and rubella (MMR), says the report.

"Black adults are at least ten percentage points more likely than White adults to believe some items of vaccine misinformation, including that COVID-19 vaccines have caused thousands of sudden deaths in otherwise healthy people, and that the MMR vaccines have been proven to cause autism in children," the report states. "Black (29%) and Hispanic (24%) are both more likely than White adults (17%) to say the false claim that 'more people have died from COVID-19 vaccine than have died from the COVID-19 virus' is definitely or probably true."

'Biased Polling System'

KFF's survey of misinformation circulating during the pandemic does not address policies and supporting statements by public health agencies and officials, such as the Centers for Disease Control and Prevention, the Food and Drug Administration (FDA), and former National Institute of Allergy and Infectious Diseases Director Anthony Fauci, that were contradictory and sowed confusion about the efficacy of masks, vaccines, and lockdowns.

KFF "has a biased polling system aimed at showing satisfaction and benefit of mass vaccination and other family issues," Peter A. McCullough, M.D., MPH, a cardiologist and former vice chief of internal medicine at Baylor University Medical Center, wrote on his *Courageous Discourse Substack* on August 23.

"I wonder what the actual sentiment is on vaccines if KFF had asked the questions in a more unbiased manner and did not load up their survey with charged words such as 'false' and 'misinformation,'" wrote McCullough.

The release of KFF's survey coincides with the FDA's launch of a "Rumor Control" section of its website on "the growing spread of rumors, misinformation, and disinformation about science, medicine, and the FDA." The webpage debuted nearly a year after FDA Administrator Robert Califf said controlling misinformation would be a top priority at the agency.

'Right to Question'

The term "misinformation" really means a view "not held by the regime in power," says Jeff Stier, a senior fellow at the Consumer Choice Center.

"The 'misinformation' tag is now being used to squelch healthy debate and censor dissenting views," Stier said. "And perhaps most troubling, as the KFF survey shockingly admits, the term 'misinformation' is now being used to target racial and ideological groups—African Americans and Republicans—that authorities deem incapable of forming fact-based opinions. Obviously, one group especially vulnerable to misinformation has been left out of the discussion: federal health officials."

Minorities are right to be skeptical of the medical establishment, says Donna Jackson, director of membership development for the Project 21 black leadership network.

"Based on the medical profession's recent history with these communities, black and brown people have the right to question their data and conclusions," Jackson said. "What's clear about this new poll tracker is that it appears to have started out with conclusions in search of supporting data.

"Scientific method and reasoning are being trumped by political biases and agendas pushed by the Biden administration in partnership with public and private entities to suppress information," Jackson said.

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

New CDC Director Wants More Money Despite Agency Failures

By Bonner Russell Cohen

Budget cuts will affect the national security functions of the Centers for Disease Control and Prevention (CDC), says CDC Director Mandy Cohen.

The CDC's spending was cut to pre-pandemic levels in the debt-ceiling deal signed in June by President Joe Biden. The CDC had a budget of $9 billion and a workforce of 15,000 employees in 2020.

The agency needs more funding, Cohen told National Public Radio in an interview on August 1.

"The CDC is an important national security asset," Cohen. "I think we understand that in a different way than ever before. We need to have a strong asset that can identify threats and respond to them quickly so that we can protect everyone's health. … Cuts are not going to allow us to do it. In fact, we need the right investments to make sure we have the data infrastructure and the workforce needed to be that national security asset that the country deserves."

The cuts to the CDC's budget were made after widespread criticism of the agency for its response to the COVID-19 pandemic.

CDC Failures

- **"CDC impeded testing capabilities from the outset of the pandemic by distributing a faulty test and prohibiting use of other effective tests, causing efforts to combat the outbreak to fall hopelessly behind."**
- **"CDC was repeatedly slow to update its guidelines and public information based on evolving scientific information showing, for instance, that deep cleaning and surface disinfection provided no real benefit, that disease could be spread by airborne transmission, and that natural immunity resulting from infection was real and provided protection that is as good or better as vaccine protection."**
- **"The agency relied on faulty science in advancing damaging guidance on social distancing, masking, and school closures that led communities that trusted its authority to impose mandates that did more damage than good."**
- **"The agency communicated incomplete and inconclusive data as scientific fact and excluded people with opinions that challenged its preferred narrative."**

Source: Joel M. Zinberg, M.D., J.D., and Drew Keyes, "Unauthorized and Unprepared: Refocusing the CDC after COVID-19," Paragon Health Institute, August 2023

Mission Creep

The CDC has strayed from its primary function, says a report titled "Unauthorized and Unprepared: Refocusing the CDC after COVID-19," by Joel M. Zinberg, M.D., J.D., director of the Public Health and American Well-Being Initiative at the Paragon Health Institute (PHI) and a senior fellow at the Competitive Enterprise Institute, and Drew Keyes, a senior policy analyst with PHI.

"The CDC's failures during the pandemic undermined public trust," the report states. "Unless the CDC is reformed and refocused on its core mission it will be unprepared to act effectively in future pandemics which will surely come."

The CDC has expanded far beyond its basic purpose, Zinberg and Keyes state.

"After reviewing the history, organization, and pandemic performance of the CDC, we identify the basic problem as mission creep, abetted by the lack of congressional authorization for the agency," Zinberg and Keyes write. "The CDC has grown into a large, diffuse agency with priorities that are far afield from its core mission of controlling and preventing communicable disease outbreaks. The profusion of programs left the agency unprepared for the pandemic and distracted it from an effective response."

The Communicable Disease Center, as the CDC was originally known, was created on July 1, 1946, through executive action rather than legislation, and started with a budget of $10 million and fewer than 400 employees.

Success and Expansion

The CDC's original mission was "to diagnose and control communicable diseases through the application of epidemiological science and, with that goal in mind, to serve the states with 'training, investigations, and control technology' and surveillance of disease-related threats," the report states.

Successes in responding to malaria, polio, and several pandemics, along with the CDC's role in the eradication of smallpox, boosted the agency's reputation.

The agency's expansion beyond its original mission was made possible by the absence of statutory guardrails from Congress, say Zinberg and Keyes.

"The lack of direct congressional authorization, aggressive efforts by the CDC's early directors to expand the agency's purview, and the willingness of executive branch officials to delegate authority to CDC led to a rapid expansion of the agency's responsibilities beyond its original mission of dealing with communicable diseases," Zinberg and Keyes write.

Social Priorities

Unfettered by congressional restraints, the CDC "grew by acquisition," adding programs in communicable and non-communicable diseases alike, Zinberg and Keyes write.

"CDC priorities now include addressing 'the public health consequences of the climate crisis,' 'reducing racial disparities in public health,' addressing 'the social determinants of health conditions in the places where people live, learn, work, and play' and 'increases in injury and violence prevention programs that will help to address the growing crisis of domestic, sexual, and gun violence,'" states the report.

The overextended agency made numerous missteps during the pandemic, but money wasn't the reason, the report states.

"We cannot rely on the CDC to reform itself," write Zinberg and Keyes. "[L]ack of focus and incompetent performance, not inadequate funding, were the causes of the CDC's pandemic failures."

Calls for Congressional Action

The remedy for the CDC's failures is legislative, the report says.

"Congress must engage in the hard work of outlining exactly what activities the CDC should and should not undertake," Zinberg and Keyes write. "It should undertake a comprehensive, center-by-center authorization of the CDC."

> **"The CDC has failed America in every way. Its core competency was supposed to be infectious disease, and it has irreversibly lost the faith of the American people, who refuse to take its recommendations seriously anymore."**
>
> **KATY TALENTO**
> **CEO**
> **ALLBETTER HEALTH**

The CDC has pursued an ever-widening agenda, while public health has declined, says Katy Talento, CEO of AllBetter Health and a former health adviser to President Donald Trump.

"The CDC has failed America in every way," said Talento. "Its core competency was supposed to be infectious disease, and it has irreversibly lost the faith of the American people, who refuse to take its recommendations seriously anymore.

"Rather than focusing on doing that one job well, the CDC has expanded into unaccountable grantmaking and programs for chronic conditions," said Talento. "On that front, Americans—especially children—have grown exponentially sicker on its watch, including from Type II diabetes, obesity, autism, and allergies."

Overbearing policies during the pandemic raised public awareness of the CDC's influence, says Marilyn Singleton, M.D, J.D.

"I like to point out that there were good things that came out of the COVID debacle," said Singleton. "It opened everyone's eyes to the consequences of a sprawling government with unbridled power and passive acceptance of incompetence with no accountability. The CDC has become, as the adage goes, a jack-of-all-trades and a master of none."

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

Biden Administration Stalls on COVID Origin

By Bonner Russell Cohen

U.S. intelligence agencies and the Biden administration are not cooperating in providing legally required information about the origin of COVID-19, members of Congress say.

The COVID Origin Act of 2023, which Congress passed unanimously and President Joe Biden signed into law, requires the Director of National Intelligence (DNI) to declassify all information pertaining to potential links between the Wuhan Institute of Virology (WIV) and the virus.

The information the DNI is supposed to report to Congress includes activities performed by the Wuhan lab and the People's Liberation Army, coronavirus research or other related activities prior to the outbreak of COVID-19, and the names of researchers at the WIV who fell ill in the autumn of 2019.

"As evidence grows that the Wuhan lab was at fault, either through an accidental leak—a sign of gross negligence—or a deliberate release—something approaching an act of war—the efforts by the administration and the public-health establishment to suppress the truth will only encourage the future release of a manmade pandemic by China or some other hostile power."

CRAIG RUCKER
PRESIDENT
COMMITTEE FOR A CONSTRUCTIVE TOMORROW

'Half-Baked Effort'

The Biden administration's 10-page report contains numerous redactions and fell well short of the law's requirements, according to lawmakers.

Bill sponsors Sens. Josh Hawley (R-MO) and Mike Braun (R-IN) sent a letter to Biden complaining about the report's inadequacies.

"The act does not allow redactions based on your administration's view of 'national security' broadly defined, as you claimed in your signing statement," the letter states. "Rather, the act only provides for much narrower redactions to protect intelligence sources and methods. Your administration should comply with the law as written and not undermine clear congressional intent to provide as much transparency to the American people as possible."

Hawley and Braun followed up with a letter to DNI Avril Haines, who is primarily responsible for complying with the law.

Citing the report's "paltry" content, Hawley and Braun wrote, "Obviously, the U.S. government is in possession of more information than that. This half-baked effort falls woefully short of the statutory requirements and undermines congressional intent."

Lab Leak 'Most Likely Cause'

The intelligence agencies differ on the origins of the coronavirus, the report says.

"The National Intelligence Council and four other IC [intelligence community] agencies assess that the initial human infection with SARS-CoV-2 most likely was caused by natural exposure to an infected animal that carried SARS-CoV-2 or a close progenitor, a virus that would probably be more than 99 percent similar to SARS-CoV-2," the report states.

"The Department of Energy and the Federal Bureau of Investigation assess that a laboratory-associated incident was the most likely cause of the first human infection with SARS-CoV-2, although for different reasons," the report states.

The report added, "The Central Intelligence Agency and another agency remain unable to determine the precise origin of the COVID-19 pandemic, as both hypotheses rely on significant assumptions or face challenges with conflicting reporting."

No Names Provided

The report does confirm widely known biosafety concerns surrounding the Wuhan lab.

"Some WIV researchers probably did not use adequate biosafety precautions at least some of the time prior to the pandemic in handling SARS-like coronaviruses, increasing the risk of accidental exposure to viruses," the report states.

The report failed to identify the Chinese researchers at the Wuhan lab who became ill prior to the onset of the coronavirus pademic, although their names have already been published by journalists Michael Schellenberger, Matt Taibbi, and Alex Gutentag, *The Daily Signal* reported on July 12.

Lab Leak Dismissed

The possibility COVID leaked from the WIV was dismissed early in the pandemic, in a paper by five scientists titled "The Proximal Origin of SARS-CoV-2," published in *Nature Medicine* on March 17, 2020.

Matt Ridley and Alina Chan, the authors of *Viral: The Search for the Origin of Covid-19*, note the paper's findings were hailed by Francis Collins, director of the National Institutes of Health (NIH), who wrote on the NIH website that "this study leaves little room to refute a natural origin for COVID-19."

Writing in *The Wall Street Journal* on July 27, Ridley and Chan note emails released this summer show some of the study's authors ruled out a laboratory origin in private messages at the time because it was politically expedient to deflect attention away from the lab, with one of the authors writing in an email, "I hate when politics is injected into science—but it's impossible not to."

"If experts hadn't shut down the rational possibility of a laboratory origin of Covid-19, a credible investigation might have taken place (it still has not), the World Health Organization might not have taken Chinese government assurances at face value, and governments might have done more to detect and deter laboratory-based outbreaks in the future," Ridley and Chan write.

Hostile Intent?

Finding the origin of SARS-v2 is necessary to avoid future outbreaks, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"It is vitally important to find out what happened to prevent recurrence," said Orient. "Already, mandates are being geared up for a new outbreak of something.

"Besides the possibility of a natural event or lab leak, there is a third possibility: a deliberate release," said Orient. "There are biowarfare labs around the world, which have the stated purpose of defense—otherwise, their creation of dangerous pathogens would be illegal. Why isn't the [Biden] administration concerned about that?"

Craig Rucker, president of the Committee for a Constructive Tomorrow, says American national security is at risk.

"There are sound geopolitical reasons for the Biden administration to level with the American people about the origin of COVID-19," said Rucker. "As evidence grows that the Wuhan lab was at fault, either through an accidental leak—a sign of gross negligence—or a deliberate release—something approaching an act of war—the efforts by the administration and the public-health establishment to suppress the truth will only encourage the future release of a manmade pandemic by China or some other hostile power."

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

INTERVIEW

Database Tracks Problem Studies

Since 2010, the Retraction Watch website has tracked scientific and medical studies that were pulled for flaws or needed corrections. Scientific data and research statistics rose to prominence with the onset of the COVID-19 pandemic. Adam Marcus, one of the founders of Retraction Watch, talked with Ashley Bateman of Health Care News *about what the database reveals about the scientific process and the increase in transparency about problematic studies since the pandemic.*

Health Care News: What is Retraction Watch? How is it different from other whistleblower websites?

Marcus: Retraction Watch is a blog that Ivan [Moransky] and I started 13 years ago to track retractions and other events in scientific literature. That includes things like corrections and expressions of concern across all the sciences, and we do some humanities too, on occasion.

Some years after we started, thanks to some generous grant funding we were able to start a database of retractions. We know we have the largest database of retractions of any place on Earth. We now have 42,000 retractions.

We have an excellent researcher who has a Ph.D. in retractions, and we have a couple of excellent editors and a couple of freelancers. [Ivan and I] are volunteers.

Health Care News: What prompted you to start the site?

Marcus: At the time [we launched the blog], I was editing a publication, *Anesthesiology News*, and we broke a story about Scott Reuben, an anesthesiologist who had fabricated a bunch of papers and … went to jail for health care fraud. Ivan was editing *Scientific American* online. We had been friends. He did a story on [Reuben] as a follow-up and much bigger piece. One day he called me up and said we should do a blog about retractions because he had done a blog about embargoes [on releasing the data underlying studies].

At that time there were about 40 papers a year being retracted, then 400, now thousands. Data sleuths are pointing out problems in journals. There's a lot more scrutiny [of] scientific publications.

Health Care News: Are you tracking site traffic? What metrics are you using to determine success?

Marcus: I don't think site metrics are all that important to us. We have a daily newsletter and weekend newsletter, and those have grown exponentially. We have lots of people in this space. We track our impact by looking at how often stories we cover get picked up by the mainstream media and citations of our work in the scientific fields that we cover.

We have certainly influenced lots and lots of coverage of retractions and how they're covered by mainstream publications, and I think it's fair to say we're pretty well-known and respected.

Health Care News: Is there a goal to expand to publish more retractions? Do you have a general idea of how many you are currently capturing—that is, what percentage do you think you're likely getting on the site out of total retractions, if that's even quantifiable?

Marcus: We're less concerned now about covering every retraction as a news item on Retraction Watch, the blog—to be honest, many are not all that interesting, journalistically—than we are in making sure our database (retractiondatabase.org) continues to be the most comprehensive repository of retracted papers available to scholars, journalists, and anyone else who might want to look at the information.

Based on research by others, we're confident we capture well over 95 percent of retractions going back as far as our first entry, for a paper published in 1753. That is three or more times what other leading repositories have.

Health Care News: Has COVID-19 broken down a barrier to publicizing them? (The site has 37 pages of retracted studies on COVID-19.)

Marcus: I don't think the pandemic broke any barriers in terms of retractions, but I would say I'm glad the event happened when it did and not, say, 10 or 20 years prior, when journals were much less likely to retract problematic work and much less likely to inform readers about the reasons for the retractions. The relative state of transparency, which is by no means total, has been refreshing.

Health Care News: What does your work say about the institution of medicine in our country?

Marcus: I would say, nothing particularly revelatory. Certainly, some of what major institutions recommend—but also what some self-styled mavericks sell—is based on shakier foundations than we'd perhaps like. But what it does speak to is how the scientific publishing process works and, at times, doesn't work. Retractions are part of science in the way a fever can be part of an infection: a sign of both a problem and a solution at the same time.

People are tempted to point to a retraction and say, "Look, doctors/scientists/researchers are corrupt, and science is fatally flawed." But that's a mistake. What a retraction means—with some rare exceptions for overzealous editors—is that the scientific process worked. Sometimes it works more slowly than it should, and it's clear that there should be far more retractions than there are.

Health Care News: What has surprised you in your work on this project?

Marcus: We were initially quite surprised by how opaque journals and publishers were when it came to retractions. We'd assumed that they wanted to keep their pages—and the scientific literature—as clean as possible, while also notifying their audience and the public when things went awry. For much of the early years of this effort, many journals behaved as if they did not share those goals.

"We were initially quite surprised by how opaque journals and publishers were when it came to retractions. We'd assumed that they wanted to keep their pages—and the scientific literature—as clean as possible, while also notifying their audience and the public when things went awry. For much of the early years of this effort, many journals behaved as if they did not share those goals."

ADAM MARCUS
RETRACTION WATCH

COMMENTARY

Ohio Bill Would Reform Drug Preauthorization

By Matt Dean

Two people who are suffering from the same curable condition may need the same drug.

One will get it, while the other may be prescribed something less effective. The insurance you have determines which drug you are prescribed, because your insurer may require prior authorization (PA) for certain treatments (see article, opposite page).

PA is a process currently used by insurance companies which requires doctors to obtain insurer approval before prescribing a treatment, diagnostic test, or other medical service.

PA reform is taking shape in several states to allow patients faster access to treatments currently held up by bureaucratic gatekeepers. Insurance companies and payers stress the need for PA as a means of providing the right care at the right price, acting as hoops to jump through to lower the cost of health care and drive standardization.

Ohio Statehouse

"Legislatures should adopt commonsense [preauthorization] reforms to improve patient safety and redirect valuable physician time away from insurance companies and back to the patient."

MATT DEAN, SENIOR FELLOW, THE HEARTLAND INSTITUTE

States should reduce regulatory burdens on sick patients and their doctors. PA reform must balance the needs of the patient with the need to reduce costs. Reforms should include transparency regarding PA requirements from insurance companies and streamlining the process to expedite approvals and cut red tape.

'Gold Card' Solution

In Ohio, state Rep. Kevin Miller (R-Newark) recently introduced House Bill 130, which would accomplish both reforms.

House Bill 130 would create a Prior Authorization Gold Card for some providers, who would be exempted from certain prior authorization requirements. Physicians who are consistently (80 percent or more) approved will be granted presumptive exemptions (known as a "Gold Card").

The legislation would also require each insurance company to "make prior authorization data available on its public website in readily accessible format" outlining which services are PA required and the process for denial and appeal.

Delayed Care

Gold Card legislation first passed in Texas (HB 3459) in 2021, with similar requirements. The Texas Medical Association had reported providers making an average of "31 prior authorization requests a week, taking time away from patient care. Four-fifths (85 percent) reported prior authorizations delayed patient care, and 78% said this can lead patients to abandon needed treatment altogether."

The Ohio State Medical Association (OSMA) and more than 30 other medical societies support HB 130.

"As physicians, we know prior authorization impacts the way we practice medicine, and our patients, every day," said Brian Santin, M.D., OSMA president, chief medical officer at Clinton Memorial Hospital, and a vascular surgeon with Ohio Vein & Vascular, Inc.

"Prior authorization is frequently cited as not only a major contributor to administrative burden but also a cause for delay and roadblocks to patients receiving critical treatment and care," said Santin.

Harm to Patients

A 2022 American Medical Association (AMA) survey shows PA reform is needed to address patient safety concerns. Approximately 94 percent of physicians report the burdensome PA process causes care delays. Roughly 33 percent of physicians say PA has led to a serious adverse event for a patient.

Twenty-five percent of doctors report a hospitalization due to delays caused by the PA process, and 9 percent confirm PA led to a patient's disability, permanent bodily damage, congenital anomaly, birth defect, or death.

Federal vs. State Action

The Biden/Harris administration is seeking to streamline PA through mandates on payers. The Centers for Medicare and Medicaid Services proposed reforms to implement an electronic prior authorization process, shorten timeframes for certain payers to respond to PA requests, and make information more readily available through enhanced transparency requirements. The policy focuses on public plans and oversight.

States should recognize that although those changes would be helpful, more is needed to improve the PA system. Legislatures should adopt commonsense PA reforms to improve patient safety and redirect valuable physician time away from insurance companies and back to the patient.

Matt Dean (**mdean@heartland.org**) *is senior fellow for health care policy outreach at The Heartland Institute. A version of this article was published on June 7, 2023 at heartland.org. Reprinted with permission.*

COMMENTARY

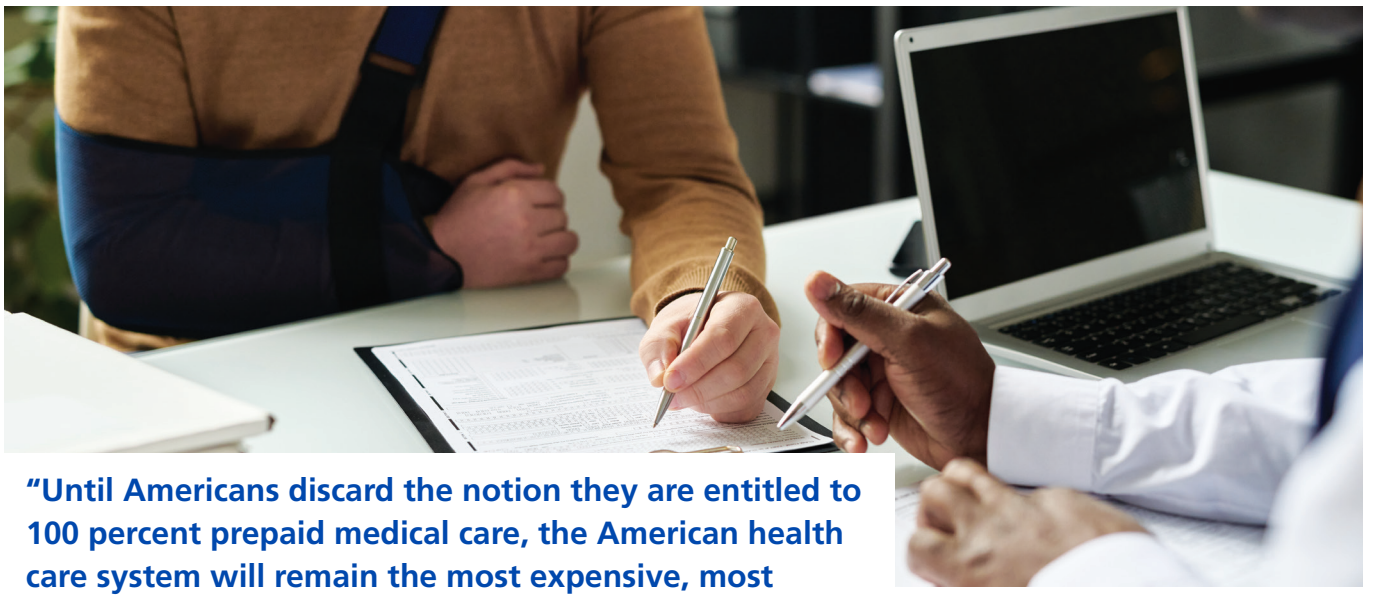
Health Insurance Can Be Hazardous to Your Health

By Mark B. Blocher

Most Americans rely on some form of medical insurance to give them peace of mind when facing health needs.

It is understandable why people fear for their health and financial well-being, considering how expensive modern medicine has become. Medical debt is a leading cause of personal bankruptcy. Consequently, medical insurance has become for millions of patients the warm blanket we wrap around ourselves to provide peace of mind should a medical disaster arrive at our doorstep.

The truth is: sometimes health insurance can be hazardous to your health. Medical insurance should be a bridge to needed medical care for patients, not a barrier to it.



"Until Americans discard the notion they are entitled to 100 percent prepaid medical care, the American health care system will remain the most expensive, most overused, and least efficient in the world."

MARK B. BLOCHER
PRESIDENT AND CEO, CHRISTIAN HEALTHCARE CENTERS

Harm No. 1: Uncovered

A recent study by the Kaiser Family Foundation reported most insured patients do not know what their health plan covers or doesn't cover. They might know their copays and deductibles, and those with employer-provided coverage might pay attention to how much is deducted from their paycheck to cover their portion of the premium, but most do not know much more than this.

Consider that annual premiums for employer-sponsored family health coverage reached $21,342 in 2020, up 4 percent from 2019, with workers on average paying $5,588 toward the cost of their coverage and employers paying the remaining $15,754 (2020 Employer Health Benefits Survey).

Now think about this: 87 percent of insured households do not satisfy their annual deductible, resulting in insured individuals paying all or part of their insurance premium *and* out-of-pocket for any medical care they receive.

If households do reach their deductible, insurance plans use language that reduces transparency, making it harder to know when or if a plan will cover certain medical expenses.

Harm No. 2: Untimely Care

Studies published in several major medical journals indicate a large percentage of insured patients with high-deductible health plans delay or forgo seeking timely medical care.

In one major study, 38 percent of adults with deductibles of $1,000 or more reported not filling a prescription, not getting needed specialist care, skipping a recommended test or follow-up, or not visiting a doctor or clinic when experiencing a health problem.

Fifty-two percent reported carrying medical debt on credit cards. If their insurance is so good, why are insured patients taking on medical debt? Why would people with "good" insurance be so hesitant to seek timely medical care?

Harm No. 3: Prior Authorization

According to a study conducted for the American Hospital Association, 62 percent of insured patients say their household experienced an insurance-related barrier to treatment over a two-year period. Many of these patients reported becoming sicker as a result.

Doctors spend a lot of time arguing with insurance companies to get authorization for evidence-based medical tests and treatments that benefit patients.

Denial decisions are based entirely on the insurance company's own guidelines, which are mostly designed to control their costs, not to do what is best for patients. With insurers reporting record profits, it appears some of the profiteering is on the backs of patients.

Harm No. 4: Waiting in Line

In 2022, the average wait time to secure a doctor appointment was 26 days. There are two principal reasons why: a declining number of primary care doctors and closed provider networks that lock insured patients into seeing a doctor preselected by the insurance company.

When an insured individual calls the typical insurance-based, in-network practice that is still accepting new patients (many are not), they often encounter a phone tree that guides them through several prompts before they reach a live human being.

It is common for doctors' offices to double- and triple-book patients for the same appointment time slot.

Since the average time patients spend with their doctor is 10 to 12 minutes, they frequently sit in the waiting room longer than they are in the exam room with their physician. Many patients give up in frustration, choosing instead to use an urgent care center or hospital ER for primary care needs.

Harm No. 5: Rx Formularies

Insurance plans have a "formulary," which is the list of medications a particular health plan includes. As new medications become available and the patents of older ones expire, insurers tend to change their formularies.

The same thing happens when the manufacturer reduces the pharmacy benefit manager's discounts and rebates. This often results in medications being removed from a health plan, but the patient doesn't find out until they try to (re)fill a prescription. This can be hazardous to a patient's health.

Harm No. 6: Specialists

The fear hurried primary care providers have of "missing something" triggers quick referrals to specialists. This practice of "defensive medicine" typically means more screening, testing, x-rays, MRIs/CTs because specialists are also afraid of missing something. When the patient is insured, the less they will complain when insurance is presumably paying.

Harm No. 7: Poor Individual Stewardship

The concept of personal stewardship is often the elephant in the exam room. Doctors see a lot of patients with conditions that could be avoided if they took personal responsibility for their own health.

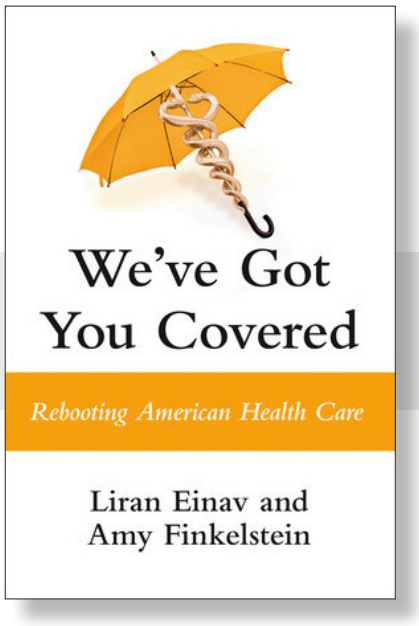
Numerous studies confirm both doctors and insured patients are insufficiently concerned about the cost of expensive medical services. Patients think they can live carelessly, expecting doctors to help them avoid the natural consequences of their carelessness, and insurance will pay for it.

Until Americans discard the notion they are entitled to 100 percent prepaid medical care, the American health care system will remain the most expensive, most overused, and least efficient in the world.

Mark B. Blocher (**mblocher@chcenters.org**) *is the president and CEO of Christian Healthcare Centers (CHC), a direct primary care organization based in Michigan. CHC published a version of this article in its August/September newsletter.*

BOOK REVIEW

A Flawed Case for Centrally Planned Health Insurance



Review of *We've Got You Covered*, Liran Einav and Amy Finkelstein, (Portfolio/Penguin, 2023), 304 pages, ISBN 978059342239 (Hardcover), 9780593421246 (ebook)

By David R. Henderson

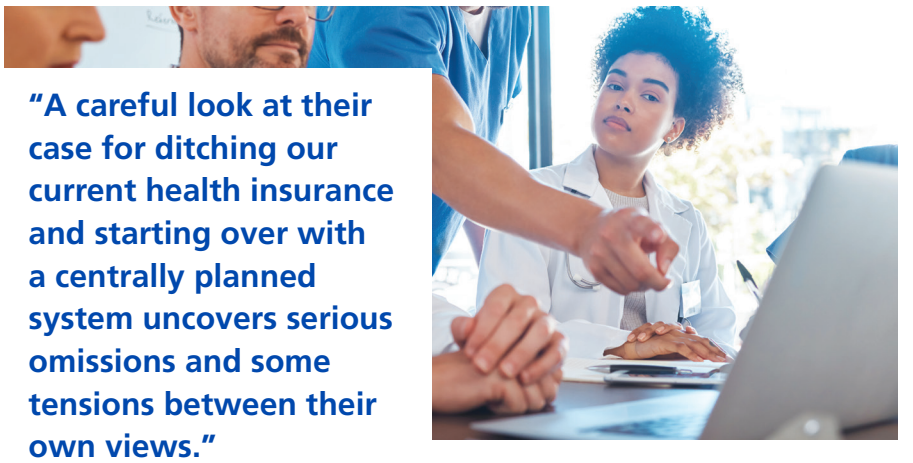
In their recent book, *We've Got You Covered*, two health economists make their case for ditching the current system of health insurance in favor of government-financed, zero-premium insurance for basic coverage.

The two economists, Stanford University's Liran Einav and Massachusetts Institute of Technology's Amy Finkelstein, well-known contributors to the literature on health insurance, propose a plan to allow people to buy supplementary insurance to expand their coverage.

With their breezy and humorous writing style, Einav and Finkelstein make what seems at first like a compelling case. They may sway many readers, especially those who don't know the literature on health economics.

But a careful look at their case for ditching our current health insurance and starting over with a centrally planned system uncovers serious omissions and some tensions between their own views. Two omissions are: any mention at all of health savings accounts, and any mention—except for one sentence—of possible reforms on the supply side that would increase supply and reduce the price of health care.

One major tension is in their view of the importance of copayments and deductibles. Moreover, they seem to misunderstand the way to measure the impact of copayments.



"A careful look at their case for ditching our current health insurance and starting over with a centrally planned system uncovers serious omissions and some tensions between their own views."

DAVID R. HENDERSON
RESEARCH FELLOW
HOOVER INSTITUTION

What About HSAs?

It's slightly ironic that in a book titled *We've Got You Covered*, there are important issues in health economics the authors don't cover at all. These are issues that matter for an overall evaluation of the health care system.

For example, one increasingly popular innovation in health care purchase in the past few years is health savings accounts (HSAs). With HSAs, people save before-tax money the way they do with Individual Retirement Accounts and can then spend those dollars tax-free on health insurance, copayments, and deductibles.

Many people have used HSAs to cover expenses that otherwise would have been difficult to cover. Would HSAs solve all the problems that Einav and Finkelstein point to? Of course not. But they would help. It is disappointing, therefore, that the authors don't even mention HSAs.

Opening the Market?

After reading every page, including every one of the authors' extensive (and impressive) footnotes, I could find no mention, other than one sentence, of government restrictions that make the supply of health care less than otherwise and prices higher than otherwise.

Three such regulations are certificate of need (CON) laws at the state level, federal restrictions on the immigration of doctors, and constraints preventing nondoctors from doing things now done only by doctors. Restraining supply limits competition and raises prices.

CON laws require permission from a state government agency to build a hospital or a surgical facility, to name only two. Existing providers often show up to contest their application, and often succeed.

Similarly, immigration restrictions prevent tens of thousands of doctors from moving to the United States, making doctors' fees higher than otherwise.

Also, pharmacists, who usually know much more about drugs than doctors do, are typically prevented from prescribing drugs. If they were able to do so legally, as they are in many countries, people could often skip an expensive trip to the doctor, saving time and money.

Copays and Deductibles

As recently as the 1970s, we didn't have good empirical evidence that requiring patients to pay a copay would influence the amount of medical care people demanded.

Einav and Finkelstein point out we now have scads of such evidence. One might think, therefore, that they would advocate having at least modest copays as part of their basic coverage. That would cause people to spend less money, presumably cutting out the marginal uses. Surprisingly, though, the authors oppose copays.

In countries that have modest copayments, the restraint on spending is modest, the authors argue. Yet in their later discussion of Medicare, they note that because Medicare will pay for whatever doctors and hospitals provide, "Why not run a few extra tests and scans to be on the safe side, or send the patient to a specialist when in doubt?"

It seems to this health economist (for two years I was the senior economist for health policy with President Ronald Reagan's Council of Economic Advisers) that copays could restrain Medicare spending a fair amount.

Basic Coverage, Global Budget

In a chapter titled "A Shack, Not a Chateau," the authors advocate "very basic" coverage. That way, government spending wouldn't be as large as otherwise. Later, they state basic coverage "should include primary and preventive care, specialist, outpatient, emergency room, and hospital care."

The hard part, they write, is choosing what more to cover. To avoid tackling the issue directly, they advocate an overall health care budget to pay for basic coverage, and they call for making tradeoffs within that budget.

I wonder if the authors worry about whether the same kind of political forces that ended copays in other countries or added patchwork coverages in this country would lobby successfully to have various coverages included under "basic," with the effect being higher spending, possibly even higher than it would be under the current system.

What if we combined three things: (1) the reforms I suggest above that would reduce health care prices, (2) health savings accounts, and (3) an expanded role for private, voluntary charity? It would be interesting to see how that would compare.

David R. Henderson (**davidrhenderson1950@gmail.com**) *is a research fellow with the Hoover Institution and emeritus professor of economics at the Naval Postgraduate School in Monterey, California.* *A version of this article was published at hoover.org on August 24, 2023. Reprinted with permission.*

COMMENTARY

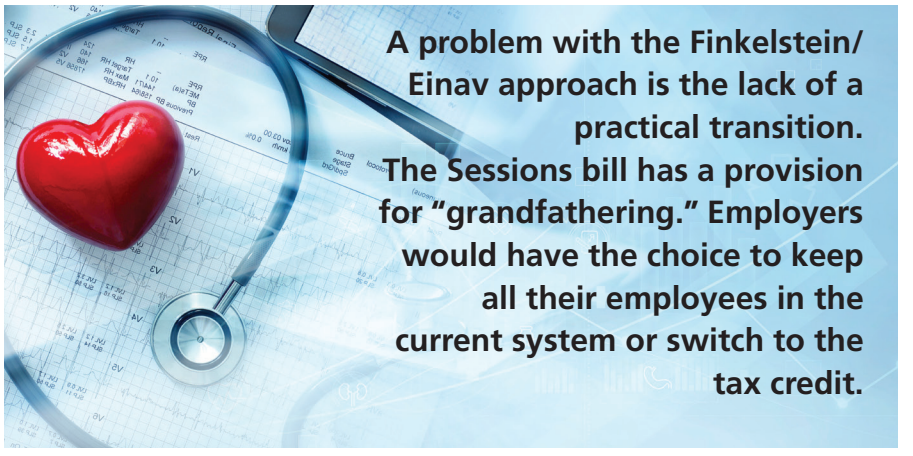
Can the Left and Right Agree on Health Care Reform?

By John C. Goodman

In their book, *We've Got You Covered*, Liran Einav and Amy Finkelstein call for universal health insurance coverage, with no increase in government spending.

It's getting a lot of attention in progressive circles. Yet, Massachusetts Institute of Technology economist and coauthor Finkelstein says she doesn't regard the proposal as left-wing. In a recent podcast, she said the best health care systems in the world are in Australia, Israel, Singapore, and Switzerland. These are all market-based systems.

Surprisingly, a bill that would go a long way toward implementing Finkelstein's proposal has been introduced in Congress by a conservative Republican.



A problem with the Finkelstein/Einav approach is the lack of a practical transition. The Sessions bill has a provision for "grandfathering." Employers would have the choice to keep all their employees in the current system or switch to the tax credit.

The Problem

Einav and Finkelstein say U.S. health insurance has three flaws.

First, it is hard to access. Six in 10 people who are uninsured are eligible for free or highly subsidized insurance but can't manage to enroll. Second, health insurance doesn't last. One in five people under age 65 will become uninsured over a two-year period.

Third, health insurance is inadequate. The amount of unpaid medical debt is more than the debt for all other consumer expenditures combined, and three-fifths is incurred by insured households.

So, what can be done? Finkelstein and Einav note half of health care spending is by government. That's enough, they say, to provide every American with "universal coverage that is automatic, free and basic."

"Automatic" means people are auto-enrolled into a plan. "Free" means the premium for basic coverage is paid by the government, and "basic" would be care most of us would regard as medically necessary. People could upgrade beyond that.

Solution Already in Congress

A bill embodying much of this idea is the Health Care Fairness for All Act, introduced by U.S. Rep. Pete Sessions (R-TX). The bill would replace all federal tax and spending subsidies for private insurance with a tax credit—giving every American an equal amount.

Because it would be refundable, even those who pay no tax would receive it. Health plans would compete to provide "basic" coverage at a price equal to the tax credit. People could add their own money for "non-basic" coverage.

For anyone who turns down the credit and elects to be uninsured, the subsidy would fund coverage through a safety net.

An important argument by Finkelstein and Einav is that Americans are paying about twice as much as we should for medically necessary health care. So, if we gave the government's share to people directly, they would be able to buy essential coverage with that money alone.

Making health care "free" does not mean there would be no role for price-conscious consumers. Under Medicaid's Cash and Counseling program, for example, homebound disabled patients manage their own budgets and can hire and fire their attendants.

Similarly, under the Sessions bill, health insurers could make deposits to health savings accounts to allow patients to manage their own budgets for diabetes and other chronic conditions.

Making the Transition

A problem with the Finkelstein/Einav approach is the lack of a practical transition. The Sessions bill has a provision for "grandfathering." Employers would have the choice to keep all their employees in the current system or switch to the tax credit. Sessions believes it wouldn't take long for both employers and employees to decide that tax credits are better.

Take an executive facing a 50 percent marginal tax rate, choosing a health plan for employees. If family coverage costs $24,000 a year, the current ability to substitute tax-free health insurance for taxable wages is worth $12,000 to her in reduced taxes.

If the executive chooses a more economical plan (resulting in less insurance and more wages), 50 cents of every dollar saved would go to Uncle Sam.

By contrast, with a tax credit approach, the first $12,000 of spending is subsidized dollar-for-dollar by the government. Beyond that, every additional dollar reduces take-home pay by a dollar.

Potentially, the employee now has an opportunity to convert $12,000 of health care spending into take-home pay by being a more economical buyer of health insurance and receiving higher wages instead.

The same principle applies to all employees, regardless of their tax bracket. Sensible ways to reform health care have now been around for almost two decades. It's time for politicians to pay attention.

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 at* Forbes *on August 6, 2023. Reprinted with permission.*

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Lab-Grown Chicken Tastes Like … Environmental Problems

By Kenneth Artz

With lab-grown, cultivated, or cell-cultured meat having been cleared for sale by the U.S. Department of Agriculture, suppliers face hurdles in marketing the new products: high costs, scalability, overcoming consumers' "ick" reaction, and environmental impact.

Companies like Upside Foods and Good Meat can grow cell-based proteins—such as chicken, beef, and seafood—in a lab, for restaurants and supermarkets.

Worse for Environment

A recent study from the University of California, Davis (UCD) suggests lab-grown meat cultured from animal cells is likely to have an environmental impact "orders of magnitude" worse than beef produced through traditional cattle ranching.

"Because of the purification needed to produce meat in the lab and receive certification for sale, the UCD scientists found that the carbon dioxide equivalent emitted for each kilogram of lab-grown meat is four to 25 times greater than the average for retail beef," said H. Sterling Burnett, Ph.D., director of the Arthur B. Robinson Center on Climate and Environmental Policy at The Heartland Institute, which publishes *Health Care News*.

"I see no reason for believing that what is true for lab-grown beef wouldn't also be true for lab-grown chicken," said Burnett. "The level of purification needed is the same. As a result, lab-grown chicken produces no net carbon-dioxide reduction."

'Consumers Should Decide'

Companies producing cell-based proteins are looking to government to make natural meats more expensive, says Jeff Stier, a senior fellow at the Consumer Choice Center.

"I'm a big fan of private-sector innovation, but the key is, it has to be truly private-sector," said Stier. "Regulators need to regulate with a light touch to get the potential real or even imagined benefits."

In the case of Impossible Foods, which advocated governments impose sin taxes on traditional meat, the innovative company revealed a lack of confidence in consumer demand for their product by rent-seeking, trying to get a market advantage by taxes on their competitors.

Similarly, so-called green energy is great until the government interferes in the market with subsidies, sin taxes, and other sorts of central planning, says Stier.

"Will cell-based proteins have advantages? Only consumers should decide," said Stier. "The innovators should be confident to compete on an even playing field. Otherwise, I'm afraid they're just sort of … chicken."

Where's the Beef?

Even if the scalability problem can be solved, there might not be a large market for lab-grown meat, says Devon Herrick, a health care economist and policy advisor to The Heartland Institute.

"I don't really see laboratory-grown chicken becoming anything more than a novelty in the near future," said Herrick. "Plant-based meat sales are declining. I don't see lab-grown meats being any different. Production methods for chicken are well-established and prices are lower compared to lab-grown products."

Consumers looking for food alternatives might not want animal protein at all, says Herrick.

"Something else that remains to be seen is whether vegetarians and those who abstain from meat for ethical reasons will embrace lab-grown meat," said Herrick. "It almost seems like firms pursuing lab-grown products are up against a limited market."

Nature Versus Nurture

Consumers are right to be skeptical of lab-grown meat, says Teresa Mull, an assistant editor at *The Spectator World* and author of *Woke-Proof Your Life*.

"Not only is the idea of 'cultivating' meat in steel tanks creepy and untenable financially, it's also unnatural and carries with it a host of risks that don't exist when meat is raised in a responsible way," said Mull.

Pushing cultivated animal protein on people will give the state more power, says Mull.

"The so-called 'fears' being mongered to force lab-grown meat to the market—that the traditional way of raising animals for food leads to pollution and climate change—are just another smokescreen to convince the public to fall for a foolish scheme that results in more government control of the population," said Mull. "If government were to eliminate agricultural regulation, farmers and ranchers would be free to innovate and refine their craft to everyone's benefit—no labs required."

'Eco-Posturing Techies'

Only environmental activists could propose such an unnatural project as lab-created fake foods, says John Dale Dunn, M.D., J.D., a physician, attorney, and policy advisor to The Heartland Institute.

"Don't fool with Mother Nature," said Dunn. "Eco-posturing techies are just trying to substitute lab products produced by genetic engineering—sci-fi horrors—for natural food, with all the uncertainties and potential risks of lab products, genetic and cancer risks, for futuristic nonsense that substitutes a chemical factory for farming."

"Farmers are the real nature lovers—they grow crops and animals for food, and it's proven safe and healthy," said Dunn. "It is stupid posturing and pretense to propose that lab-produced cell lines are somehow the food of the future. Pinheads are always trying to push crazy. As Orwell said so well, 'There are some ideas so absurd that only an intellectual will believe them.'"

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

"Because of the purification needed to produce meat in the lab and receive certification for sale, the UCD scientists found that the carbon dioxide equivalent emitted for each kilogram of lab-grown meat is four to 25 times greater than the average for retail beef."

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INTERNET INFO

Derrick Risner *et al.*, "Environmental impacts of cultured meat: A cradle-to-gate life cycle assessment," *bioRxiv*, April 21, 2023: **https://www.biorxiv.org/content/10.1101/2023.04.21.537778v1.full**

Amy Quinton, "Lab-Grown Meat's Carbon Footprint Potentially Worse Than Retail Beef: Study Finds Scaling Up Production Using Existing Processes Highly Energy-Intensive," University of California, Davis, May 22, 2023: **https://www.ucdavis.edu/food/news/lab-grown-meat-carbon-footprint-worse-beef**

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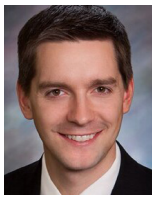

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4

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