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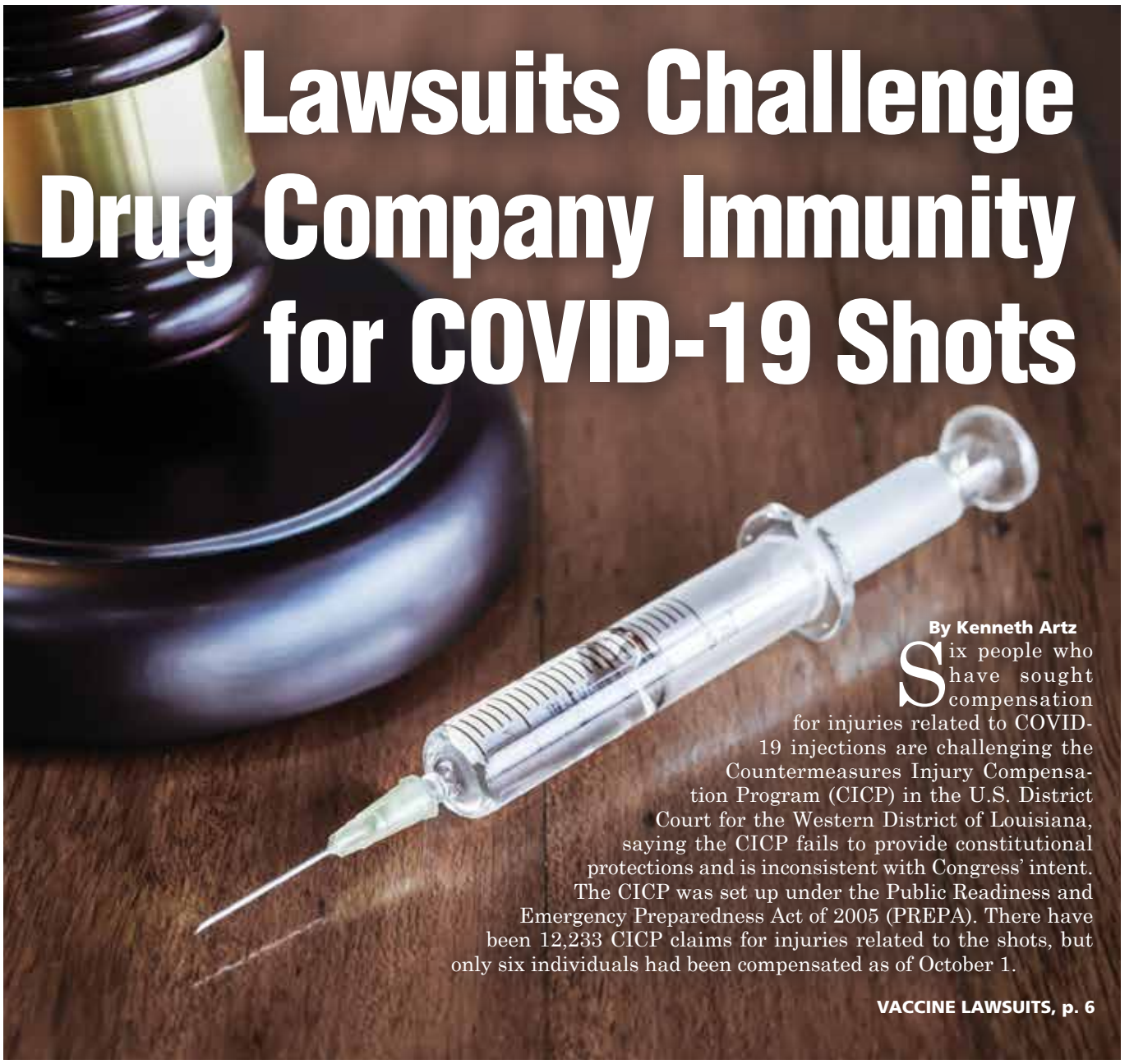

Lawsuits Challenge Drug Company Immunity for COVID-19 Shots

By Kenneth Artz

Six people who have sought compensation for injuries related to COVID-19 injections are challenging the Countermeasures Injury Compensation Program (CICP) in the U.S. District Court for the Western District of Louisiana, saying the CICP fails to provide constitutional protections and is inconsistent with Congress' intent. The CICP was set up under the Public Readiness and Emergency Preparedness Act of 2005 (PREPA). There have been 12,233 CICP claims for injuries related to the shots, but only six individuals had been compensated as of October 1.

VACCINE LAWSUITS, p. 6

AMA Reconsiders Doctor-Assisted Suicide

By Ashley Bateman

An interim meeting of the American Medical Association's (AMA) House of Delegates rejected two resolutions that would have softened its opposition to doctor-assisted suicide.

AMA delegates in November voted on 50 draft resolutions, two of which dealt directly with assisted suicide and euthanasia.

Resolution 4 proposed to strike language prohibiting physicians from

AMA DEBATES, p. 4

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Congress: Mask Mandates on Planes Will Face a Much Higher Bar

By Ashley Bateman

The U.S. Senate passed an amendment prohibiting the use of federal funds to enforce mask mandates on passenger airlines, commuter rail, rapid transit, buses, and any other form of transportation through the end of fiscal year 2024.

Sen. J. D. Vance (R-OH) introduced the amendment to a three-bill Senate "minibus" appropriations bill. To take effect, similar language would have to be included in either an omnibus appropriations bill, funding for the U.S. Department of Transportation, or a standalone measure passed by Congress and signed into law by President Joe Biden.

The federal government was working under a temporary spending measure that expires in January and February, as of press time.

Vance's legislation gained the support of 10 Democrats in a 59-to-38 vote on October 25: Tammy Baldwin (WI), Michael Bennet (CO), Sherrod Brown (OH), Tim Kaine (VA), Mark Kelly (AZ), Amy Klobuchar (MN), Joe Manchin (WV), Jacky Rosen (NV), Jean Shaheen (NH), and Jon Tester (MT).

'Cycle of Public Health Panic'

Speaking on the Senate floor on October 25, Vance said "the never-ending cycle of public health panic that greets the rise of a respiratory virus, that there is very little we can do to stop or control" is unacceptable.

"We know, of course, that the era of mask mandates caused a lot of problems," said Vance. "It caused problems for our kids, it caused developmental delays for schoolchildren, it caused a lot of rancor and a lot of division within our common American family. If people want to wear masks, of course they should be able to. But if people don't want to wear masks on airplanes, on transit, they should have that option as well, and that's all that my amendment does."

Vance said the amendment is more "narrowly scoped" than the Freedom to Breathe Act he introduced in September. That bill would permanently ban mask mandates in transportation, federal bureaucracies, and schools.

Commenting on the violence that emerged on airlines over the enforcement of masking, the Air Marshal Association (AMA) stated its support in a September 6 letter Vance received from AMA President John Casaretti.

"Even the CDC has now admitted that masks alone do not stop the spread of COVID. Masking advice always includes handwashing and respiratory etiquette, … and people are always free to wear masks if they so choose."

MARILYN SINGLETON, M.D., J.D.
SENIOR FELLOW
DO NO HARM

"We support a permanent ban on masking requirements in public transportation," Casaretti wrote.

'Welcome News'

"The passage of Vance's amendment is welcome news," said Gregg Girvan, a resident fellow at the Foundation for Research on Equal Opportunity. "The evidence on the effectiveness of masks is quite thin and often involves retrospective studies rather than randomized trials to minimize bias.

"The bipartisan support shows that many on both sides of the aisle want to move on from the pandemic," Girvan said. "But more importantly, it's an acknowledgment of what many of us have known for a while: that COVID is widespread and that measures that were ostensibly pushed on the public to protect the vulnerable are not effective. ... Data proves conclusively that there is no point in public health interventions like masking. Since January 2023, excess mortality in the United States is nonexistent."

That happened even though mask use and participation in getting COVID boosters were low, says Girvan.

'Science on Their Side'

"These senators have science on their side," said Marilyn Singleton, M.D., J.D., a senior fellow at Do No Harm.

"Medical freedom for health care professionals and patients is a key component of trust in one's clinician," said Singleton. "Freedom and trust breed adherence to medical treatment and wellness suggestions, keeping our patients healthier. Even the CDC has now admitted that masks alone do not stop the spread of COVID. Masking advice always includes handwashing and respiratory etiquette, … and people are always free to wear masks if they so choose."

Vance's bill is a rare reversal of Congress's repeated failure to maintain constitutional authority over federal agencies, says Girvan.

"Sadly, Congress has ceded significant decision-making authority to the executive branch over several decades, and the trend is unlikely to reverse itself any time soon," said Girvan. "The notable instances of push-back against executive overreach have instead come from the Supreme Court, whether it be the Biden administration's eviction moratorium, vaccine mandates, or EPA regulations under the Clean Air Act."

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

AMA Reconsiders Doctor-Assisted Suicide

Continued from page 1
performing euthanasia and assisted suicide from the current code of ethics, which states "the societal risks of involving physicians in medical interventions to cause patients' deaths is too great to condone euthanasia or physician assisted suicide at this time."

Resolution 5 proposed a "neutral" stance on the topic.

Both resolutions would have altered the terminology from "euthanasia" or "physician assisted suicide" (PAS), to "medical assistance in dying" (MAiD).

"Very few people address how physician-assisted suicide changes the nature of medicine as a social institution. As [journalist] Jonah Goldberg said, 'The Hippocratic Oath … represents not a triumph of science but a triumph of moral absolutism.' Changing the definition of the absolute changes the nature of the community built upon that absolute."

SHAWN WHATLEY, M.D.
AUTHOR, *WHEN POLITICS COMES BEFORE PATIENTS*

Cross-Border Expansion

As of 2020, 18 jurisdictions around the world had legalized PAS, resulting in access for more than 200 million people. In the United States, nine states and the District of Columbia had passed laws legalizing PAS as of August 2023. In Montana, a state court ruling held the practice legal.

In June, Gov. Josh Green of Hawaii signed a bill altering the state's 2019 Our Care, Our Choice Act to allow advanced practice registered nurses (APRNs) in addition to physicians to prescribe life-ending drugs.

Telehealth expansion during the pandemic further complicated the legal status of PAS. In May, Vermont Gov. Phil Scott signed a law permitting doctors in the state to prescribe life-ending drugs to nonresidents, 10 years after legalization.

Vermont's law, the most permissive in the country, may serve as a gateway for "suicide tourism." Two groups opposed to the law, Vermont Right to Life and True Dignity Vermont, say the legislation includes no tracking system for lethal prescriptions and no provisions to prevent abuse.

The state of Oregon reached a legal settlement to allow for similar nonresident access in March 2022.

'Medical Murder'

The AMA debate distracts the public's attention from an ongoing nationwide movement toward institutionalization of assisted suicide, says health care industry researcher Scott Schara.

"The AMA is using a dialectic discussion that encourages a debate about something that's already in practice," said Schara. "It's deceitful, a trick. They are just trying to distract people. We are already assisting people in dying, euthanizing, and hastening their death."

Since the death of his daughter, Grace, a patient with Down Syndrome who was refused resuscitative care in a hospital during the pandemic, Schara has amassed an extensive amount of material on what he calls "medical murder."

Medical murder is catching up to cancer and heart disease as America's leading killer, Schara says. Schara describes the trend as a "degree of negligence and recklessness which can only be identified as intentional."

Obamacare Effect

"The health care culture has been supporting physician-assisted suicide much longer than people think," said Schara. "We've been pointing our fingers at the Canadians, but all the while we've been [allowing] it. The U.S. was the first to the table with assisted suicide, under section 1553 of Obamacare."

Titled "Prohibition Against Discrimination on Assisted Suicide," the Affordable Care Act provision prevents the government from discriminating against any doctor who "does not provide any health care item or service furnished for the purpose of causing, or the purpose of assisting in causing, the death of any individual, such as by assisted suicide, euthanasia, or mercy killing."

"Why would we need a law preventing discrimination for doctors who do not want to murder patients by government protocols?" Schara said.

The AMA's guidelines on informed consent are also misleading, says Schara.

"Any legislative or administrative attempts to define informed consent always take away our natural, God-given rights," said Schara. "You cannot legislate morality. COVID showed how far people will go outside the rule of law. More legislation is another dialectic trap."

Rapid Expansion in Canada

Canada has had MAiD since 2015, when in *Carter v. Canada* the country's Supreme Court approved ending a patient's life as "lawful and warranted, in specific situations with proper safeguards."

"The philosophical debate lasted decades," said Shawn Whatley, M.D., author of the book *When Politics Comes Before Patients*. "But once the Supreme Court struck down the ban on physician-assisted suicide and euthanasia in 2015, implementation of access to physician-assisted suicide and voluntary active euthanasia proceeded quickly.

"The slippery slope, which many denied during debates before 2015, has been far more slippery and steep than anyone ever imagined," Whatley said.

Canada enacted MAiD into law in 2016 and has since expanded it to minors, infants, those with dementia, and the mentally ill. Since 2016, 31,664 Canadians have lost their lives to PAS. More than 80 percent of MAiD requests are approved, and the number of organ donations from the program accounted for 6 percent of the nation's transplants in 2021.

Physician-assisted suicide advocates have successfully lobbied to extend and expand access, says Whatley.

"Modern liberalism, progressivism, seems to be the primary influence on health policy decisions in Canada right now," said Whatley. "The MAiD advocates want us to believe it is widely accepted, but the Canadian public expresses far more uncertainty than euthanasia advocates admit."

Transformative Power

Whatley says traditionally a right to say "no" protected both patient and physicians, but that has changed as doctors serve as 'vending machines' to dispense whatever consumers now seem to want.

"Very few people address how physician-assisted suicide changes the nature of medicine as a social institution," said Whatley. "As [journalist] Jonah Goldberg said, 'The Hippocratic Oath … represents not a triumph of science but a triumph of moral absolutism.' Changing the definition of the absolute changes the nature of the community built upon that absolute."

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

Hospital Forces Family Not to Talk About Covid Ordeal

By Bonner Russell Cohen

A nondisclosure agreement (NDA) an Ohio hospital insisted a COVID-19 patient's husband and daughters sign before she could be given the drug ivermectin was ruled invalid by Franklin County Court of Common Pleas Judge Carl A. Aveni, on October 6.

After returning to Ohio from a family trip, Brenda Downs, 64, contracted COVID-19, and within days her health deteriorated to the point that she was admitted to OhioHealth in Columbus. Despite a federally recommended treatment that included remdesivir, Downs' condition worsened.

On the day she was put on a ventilator, her family requested doctors at OhioHealth administer ivermectin, an antimalarial drug that had shown success in combatting COVID-19.

The hospital refused, saying ivermectin had not been approved by the U.S. Food and Drug Administration (FDA) for use against COVID-19. The family sued the hospital to administer the drug or allow an outside physician to do so.

"The court criticized FDA's 'you are not a horse' campaign and emphasized that the FDA is not a physician. Nor is the hospital. The patient and her physician had the right to try the ivermectin. This reeks of a power play rather than a patient safety concern. The lawsuit by the hospital is not only cruel; it telegraphs that the hospital was wrong in fighting the patient and now it is doubling down."

MARILYN SINGLETON, M.D., J.D.
SENIOR FELLOW
DO NO HARM

$100,000 Penalty NDA

OhioHealth relented, but only after insisting the Downs family sign an NDA. That agreement, a copy of which was obtained by *Health Care News*, states the following:

"Mr. Downs has been fully apprised and informed of OhioHealth's position that the administration of Ivermectin to Mrs. Downs in these circumstances is unlikely to provide her with a medical benefit, is an off-label use not approved for emergency or other use and that he voluntarily consents to proceed with the treatment described in Paragraph 1 as a compassionate use, with full knowledge of OhioHealth's position; and

"Mr. Downs has voluntarily agreed to proceed with the treatment described in paragraph 1 because he believes, based on his independent research, that it has the realistic probability of benefit equal to or greater than standard care and that the risks of using such treatment are reasonable compared to the risks associated with not proceeding with the same."

The NDA further states, "upon proof by OhioHealth of such breach [of the NDA], OhioHealth shall be entitled to recover liquidated damages, without proof of actual damages, in the amount of one hundred thousand dollars ($100,000.00) from the Downs' Releasors, who shall be jointly and severally liable for the same, except that the Downs lawyers and law firms shall not have liability unless that lawyer or that law firm is proven to be the violator."

Forced Compliance

Under pressure from the hospital and desperate to save Downs' life, the family signed the confidentiality agreement on August 18, 2021. Franklin County Court of Common Pleas Judge Mark Serrott then insisted the NDA be signed by the family's attorney, Ralph Lorigo, who refused.

Even after Downs' husband obtained a new attorney, the ivermectin was never administered. Downs died on September 2, 2021.

Dueling Lawsuits

Wanting to tell their story without each of them being held liable for a $100,000 fine, the Downs family on October 22, 2022 asked the Franklin County court to declare the agreement void. The Downses argued, among other things, the hospital never intended to administer the ivermectin or allow it to be given by a third party, and that the family signed the NDA under duress.

OhioHealth countersued, saying the Downses' suit was frivolous, and demanded the family be held responsible for the hospital's legal fees.

Cara Bookman, one of the Downses who signed the confidentiality agreement, said in an email to *Health Care News*, "We did not sue for malpractice or wrongful death and our current case was filed under seal."

"The reason we did not seek an against medical advice discharge of my mother was due to her unstable condition," said Bookman. "The doctors told us she would most likely die in transport, and we agreed with that assessment at the time."

As for the hospital not administering ivermectin, Bookman wrote, "Someone from OhioHealth lied to the judge, and told him my mother was doing significantly better and due to this lie, the judge did not force the hospital to uphold their agreement."

'A Dictatorial Institution'

"The hospital's behavior is both outrageous and hard to believe," said Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons. "An NDA with a $100,000 fine might be appropriate to protect against disclosure of proprietary information causing financial loss.

"But what is the hospital afraid of?" asked Orient. "That people might find out that an outside physician saved the life of a patient they refused to help? That they allowed an 'off-label' use of a long-approved drug—which is routine and extremely common in almost all other circumstances? That a dying patient went on to die after getting ivermectin instead of not getting it? That a family had to sue them to get a drug billions of people have received, often over the counter? That they are a dictatorial institution without regard for patients' views or common compassion?"

'Fighting the Patient'

Marilyn Singleton, M.D., J.D., a California-based physician, says the decision of the U.S. Court of Appeals for the Fifth Circuit in *Apter et al. v. Department of Health & Human Services et al.,* centering on whether the FDA interferes with doctors' ability to prescribe ivermectin for COVID-19, is instructive.

"The court criticized FDA's 'you are not a horse' campaign and emphasized that the FDA is not a physician," said Singleton. "Nor is the hospital. The patient and her physician had the right to try the ivermectin.

"This reeks of a power play rather than a patient safety concern," said Singleton. "The lawsuit by the hospital is not only cruel; it telegraphs that the hospital was wrong in fighting the patient and now it is doubling down."

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

Lawsuits Challenge Drug Company Immunity for COVID-19 Shots

Continued from page 1

Plaintiffs are seeking to stop the government from forcing their claims into the CICP until due process safeguards are added, including the right to an adequate statute of limitations and the ability to review evidence, obtain discovery, present expert witnesses, and appeal adverse decisions, among other things, says Elizabeth A. Brehm, a partner at Siri & Glimstad LLP, the firm that filed the Louisiana lawsuit.

"Until that happens, the vaccine manufacturers' immunity protections cannot stand as these provisions violate procedural and substantive due process," said Brehm. "Should the plaintiffs prevail, those injured by a COVID-19 vaccine would have the right to a fair and constitutional procedure to seek redress for their injuries."

"I have assiduously followed the news on mRNA shot injuries and deaths, and the problem is not a figment of the imagination. This is an international medical scandal. The U.S. government and the international public health officials were culpable for civil and criminal misconduct—I say criminal not to downplay the civil misconduct but to emphasize that reckless production of products that are harmful is criminal and civil legal misconduct."

JOHN DALE DUNN, M.D., J.D.
POLICY ADVISOR
THE HEARTLAND INSTITUTE

Childhood Vaccine Injuries

In a potentially related development, the Torts Branch of the U.S. Department of Justice (DOJ) is hiring eight new attorneys to handle vaccine injury cases, according to a job ad it posted.

The ad on the USAJOBS website states, "The office is currently expanding to address workload created by an increase in cases filed under the Vaccine Act." These compensation claims do not include any for injuries from the COVID-19 shots, which are managed by the CICP.

The timing of the government's announcement is interesting given its claimed justification of the workload for cases filed under the National Childhood Vaccine Injury Act of 1986, says Brehm.

"Since 2021 the filings in the Vaccine Injury Compensation Program (VICP) have decreased from 2,057 petitions filed in 2021 to only 1,029 filed in 2022 and 1,167 filed in 2023," said Brehm. "It would have made more sense for the government to have taken action any time from 2016 through 2021, when the numbers of petitions filed were generally and significantly increasing each year, with the high of 2,057 petitions filed in 2021."

The new hires might, instead, be in anticipation of COVID-19 vaccine-related claims being moved into the VICP, says Brehm.

"In order for that to occur, Congress would first need to add an excise tax on COVID-19 vaccines, which it has not yet done," said Brehm. The tax would be imposed to support payment of claims.

Political Theater?

The hiring of additional attorneys by the DOJ reeks of political theater, says Marilyn Singleton, M.D., J.D., an anesthesiologist in California and visiting fellow at Do No Harm.

"When it was clear the injections had serious side effects and did not stop transmission of COVID, the government should have suspended the injections program, as [it did] in 1976 with the H1N1 vaccine," said Singleton. "Importantly, mandates to take a drug that was not effective as a vaccine should have been prohibited. … There was no informed consent. There was coercion. These cases deserve to be in a medical malpractice civil court."

Fraud Cancels Immunity

The situation is far worse than it initially appears, says John Dale Dunn, M.D., J.D., a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"I have assiduously followed the news on mRNA shot injuries and deaths, and the problem is not a figment of the imagination," said Dunn. "This is an international medical scandal.

"The U.S. government and the international public health officials were culpable for civil and criminal misconduct—I say criminal not to downplay the civil misconduct but to emphasize that reckless production of products that are harmful is criminal and civil legal misconduct. … [F]ailure to halt the distribution and administration of the mRNA shot was culpable, and failure to restrict the vaccine to only populations that were at risk from the disease when the risks were found is malfeasance of a terrible magnitude, resulting in deaths and harm."

The pharmaceutical industry can be held responsible for its conduct, says Dunn.

"Immunity was only available for good-faith production and distribution of the mRNA shot, and when the harm was identified and deaths counted, continuing the promotion and not warning the public, covering up the negative reports, is a civil and criminal offense and extinguishes the immunity under the Emergency Use Authorization," said Dunn.

Inadequate Compensation for Victims

It is telling that the government is hiring lawyers now, instead of funding research to investigate the safety signals that soon began to emerge, or ways to alleviate the effects, or hiring prosecutors to investigate wrongdoing by drug companies, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Unfortunately, there are probably plenty of unethical lawyers willing to help deny people some compensation for their devastated lives," said Orient.

The program set up to compensate individuals injured by childhood vaccines is also problematic, says Orient.

"The VICP was set up to compensate people quickly for the inevitable adverse effects of childhood vaccines, financed by a small tax on each dose," said Orient. "The program has paid out billions but avoided paying for most of the damage. The statute of limitations is very short, many parents do not learn about it in time, and the government fights most claims strenuously except possibly if the injury is clearly on the very limited table of injuries. The only theoretically available compensation for Covid vaccines is even less adequate."

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

Younger Adult Death Rates Up 20 Percent

By Harry Painter

Excess mortality, anticipated during the pandemic, remains a concern in the United States, particularly rising death rates among young adults.

The life insurance industry has been monitoring death rate trends, and a report published at insurancenewsnet.com on October 26 notes "life insurance executives and actuaries believe the numbers are alarming and could continue to drag earnings and surge death claims for years to come."

The report mentions provisional data from the U.S. Centers for Disease Control and Prevention (CDC) that show excess deaths among young adults ages 15 to 45 are up more than 20 percent compared to the baseline of 2019. Excess deaths for all ages are down over the past two years but have not returned to pre-COVID rates despite the pandemic being considered over.

Excess mortality refers to the difference between the number of deaths in a given period and the number that would have been expected under normal conditions.

Although some excess deaths were to be expected because of the COVID-19 pandemic—life insurers paid out record levels of claims in 2021—cause-of-death data show COVID-related deaths are not driving the continued surge. COVID deaths are down, and the data show increased cardiac mortality in all ages, as well as deaths by stroke, diabetes, and kidney and liver diseases.

CDC 'Reluctant to Investigate'

"Excess mortality occurring as a result of COVID-19 vaccine deaths will impact the labor force, insurance claims, and sadly will leave many children without parents as they grow into early adulthood," said Peter A. McCullough, M.D., a cardiologist and epidemiologist who has gained global attention for concerns he raised about the safety of the COVID mRNA jabs.

McCullough cites a paper that reviewed published autopsies of people who died after COVID-19 vaccinations.

"Hulscher et al. have independently adjudicated all published autopsies after COVID-19 vaccination and found that 73.9 percent of all deaths were either directly caused by the vaccine or the injection contributed significantly to the demise of the patient," said McCullough.

The government has incentives to avoid investigating concerns about the mRNA injections, says McCullough.

"The CDC believes it is in their best interest as an agency to promote the vaccines and has willfully ignored harms to Americans," McCullough said.

"The CDC and the FDA are the government sponsors of the COVID-19 vaccine campaign," said McCullough. "As such, they are in the business of promoting vaccines and are reluctant to investigate safety concerns, since by doing so, rates of vaccination could drop."

'They're Spread Thin'

The CDC has lost its focus, says Drew Keyes, who coauthored a report advocating CDC reform when he was a senior policy analyst at Paragon Health Institute (PHI). Keyes spoke to *Health Care News* before leaving PHI for another position.

"They can't focus on their core mission anymore," said Keyes. "I think part of it is that mission creep. They're spread thin. They're doing things in climate change; they're doing things in all these other areas—gun violence."

The dramatic change in the scope of the CDC's mission "has hindered its ability to focus on fighting infectious diseases," Keyes said.

'Put in Guardrails'

Keyes contrasts the CDC's performance with that of Johns Hopkins University, which created a real-time pandemic data tracker.

"One university student at Johns Hopkins was able to put together something that outshined and outcompeted [the CDC]," Keyes said.

"Congress needs to step in," Keyes said. "A lot of the reason the CDC's failing is because Congress hasn't put in guardrails. It hasn't directed the government's role in this more directly and has allowed the agency to grow by fiat over the last 50 to 60 years."

Keyes said too much of the CDC's power lies in the lack of congressional oversight of the executive branch.

"To a certain extent I think it's about restoring [CDC] to what it's supposed to be doing," said Keyes.

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

"Hulscher et al. have independently adjudicated all published autopsies after COVID-19 vaccination and found that 73.9 percent of all deaths were either directly caused by the vaccine or the injection contributed significantly to the demise of the patient."

PETER A. MCCULLOUGH, M.D.
CARDIOLOGIST AND EPIDEMIOLOGIST

INTERNET INFO

Nicolas Hulscher *et al.*, "A Systematic Review of Autopsy Findings in Deaths After Covid-19 Vaccination," Zenodo, July 6, 2023: **https://zenodo.org/records/8120771**

Disability Claims Have Skyrocketed

Disability claims in the civilian labor force among workers aged 16 or older have soared 33 percent since January 2020, data from the U.S. Bureau of Labor Statistics shows.

Growing Backlog of Claims

The increases have aggravated the existing backlog of Social Security Administration (SSA) disability claims. According to the U.S. House Ways and Means Committee, applicants now wait 220 days for an initial decision and 213 for an initial appeal. The SSA's standard is a 58-day wait for first claims, a standard that has not been met in 40 years, according to the Committee.

"Worse yet, the SSA is exacerbating the problem by spending more than $100 million on outreach efforts to increase initial disability claims instead of prioritizing clearing the existing backlog," states a news release from the committee.

Obsolete Technology

At a Social Security Subcommittee hearing on October 29, committee members grilled administrators about the use of outdated occupational data to determine whether a disability claimant can work. The SSA still relies on snail mail and fax machines, members noted.

Mark Warshawsky, a former Social Security Deputy Commissioner, testified the agency was ready to launch massive, expensive processing reforms at the end of 2020 but the Biden administration put them on hold.

"My very rough estimate is that it cost $100 million in terms of people-time to do that, in addition to the expenditure of $300 million for the data," said Warshawsky. "And it stopped. It's sort of inexplicable. … It would definitely speed things up because it would be automated. And it would be relying on current data."

Labor Force Crisis

The increase in disability claims and reports of post-pandemic excess deaths among young people (see article on page 15) have raised concerns about the impact on the workforce.

"These shocking developments are surely contributing to ongoing labor shortages," wrote Pierre Kory, M.D., and Mary Beth Pfeiffer in *Newsweek* on October 26.

"People are leaving work at younger ages, in greater numbers, and from diseases seen mostly in later life," wrote Kory and Pfeiffer. "We need an unbiased, nonpartisan investigation into this troubling trend. Record-high rates of incapacitation threaten our economy and signal continuing waves of early death."

—Staff reports

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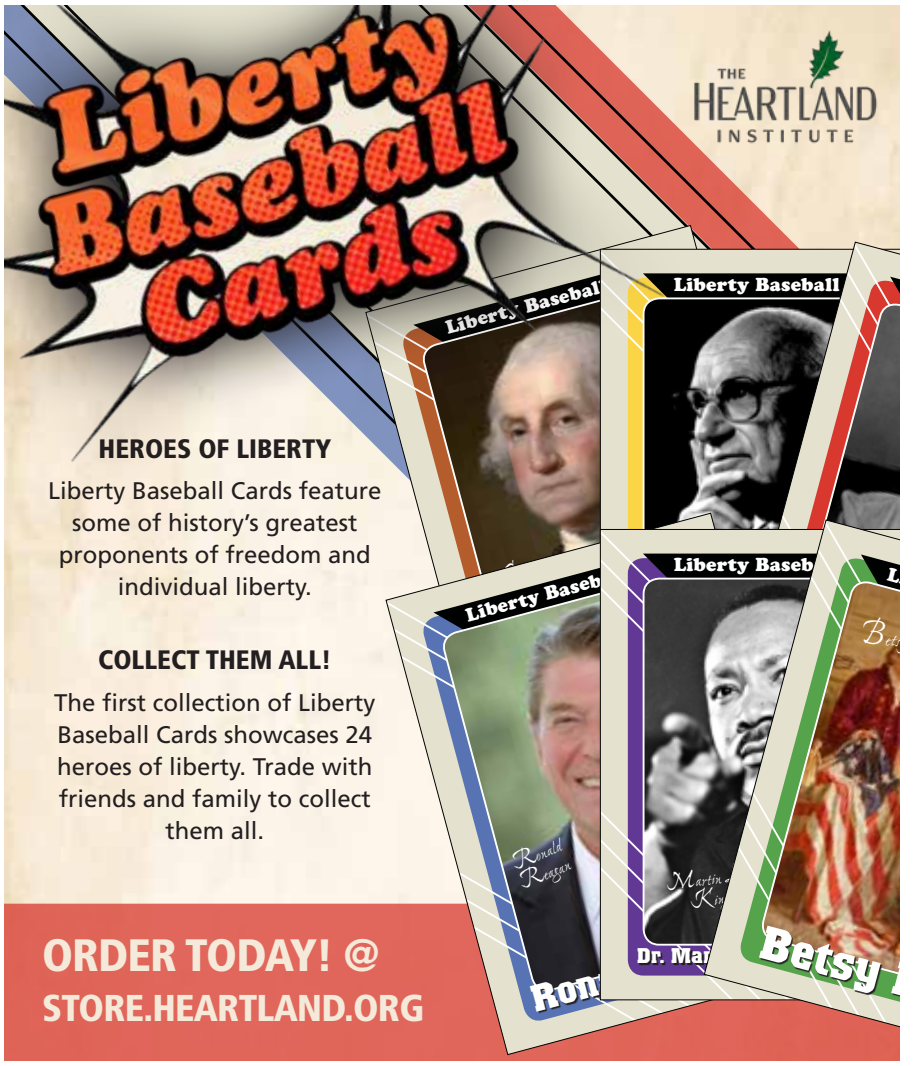


Medical Students Engage in Anti-Israel Activism

By Kevin Stone

The woke activist group White Coats for Black Lives (WC4BL) is spearheading an effort to embroil medical students in the Israeli-Palestinian conflict.

Protests on college campuses began after Israel's response to the attack on Israeli civilians in Gaza by the Palestinian political and military faction Hamas. WC4BL published a letter titled "Regarding the Increasing Harassment and Punishment of Pro-Palestine Healthcare Workers" on November 19.

The letter demands American medical institutions "reinstate all healthcare providers who have been fired or placed on leave for demanding a ceasefire, the end of the siege on occupied Gaza, and the end of Israeli occupation, or have affirmed Palestinians' right to resist in the face of 75 years of relentless oppression."

The letter makes no mention of the October 7 attack, which involved a range of atrocities including rapes, hostage taking, and beheadings of men, women, and children. Hamas has been classified as a terrorist organization by the U.S. government since 1995 and by the European Union since 2003.

"As physicians, we should be taught to care for people regardless of their nationality, ethnicity, religion, or political views. The Hippocratic Oath demands that we treat our patients equally 'whether they are free men or slaves.' Any time I hear medical students standing so firmly in hate against a country, be it Russia or Israel, I question their ability to uphold this oath to treat every patient with dignity."
ANONYMOUS MEDICAL SCHOOL STUDENT

Activist Physicians

The medical profession's guiding principles, embodied in the Hippocratic Oath and the 1864 Geneva Convention, direct practitioners to ply their trade impartially and outside the bounds of politics, race, and other biases.

Radicalized medical students today are abandoning those principles and actively engaging in advocacy for one side of the Israel-Palestine conflict, denouncing what they characterize as "mass murder" and "genocide" allegedly directed by Israelis against Palestinian Arabs.

An internet search shows no notable anti-Israel protests on medical school campuses after the Gaza attack. However, medical schools and associations have treated the Israeli-Hamas conflict differently from how they responded to the Russia-Ukraine war, argued Ian Kingsbury and Jay P. Greene on November 21 in *Tablet*.

"The most striking thing about the response of medical schools to the wars in Ukraine and Israel is how nearly half have something to say about Ukraine while almost none say anything about Israel," wrote Kingsbury and Greene. "If we combined the 42 medical associations and 152 medical schools, we find that 100 out of 194 of them posted responses to the conflict in Ukraine, while 15 of those 194 issued statements regarding the war in Israel."

No Room for Politics

In an article for *Commentary* magazine, Sally Satel, M.D., a senior fellow at the American Enterprise Institute, detailed her receipt of an October 17 email from WC4BL imploring "physicians and physicians-in-training to use our power to amplify Palestinian people's demands for freedom, safety, and dignity," and asking recipients to "participate in in-person protests and sit-ins," with the University of Minnesota chapter reposting messages on X calling for "Palestinian resistance to free themselves from their oppressors by any means necessary."

Satel said the email was inappropriate and medical schools should not allow their students to be distracted from the study of medicine.

"There should be no place in any medical school for interest groups that engage so aggressively in political campaigns bearing no relationship to medicine or that impose limits on scholarly endeavors for the good of patients everywhere," wrote Satel. "The WC4BL episode is representative of the growing trend among medical trainees to claim social justice as part of their mission that calls for immigration reform, ending the electoral college, changing housing policy, confronting capitalism, and 'dismantling racism.'"

Marxism and Medicine

Although groups like WC4BL claim to focus on racial injustice, their rhetoric reveals destructive neo-Marxist roots, says Marilyn Singleton, M.D., J.D., a senior fellow at Do No Harm.

"White Coats for Black Lives, a purportedly grassroots medical student-led organization, had the opportunity to gather support from all corners of the political spectrum," said Singleton. "Who could argue with the concept of improving health for people of color?

"Unfortunately, based on its 'Vision and Values' statement, WC4BL turned out to be another group of Marxist marionettes," said Singleton. "Its vision is to dismantle 'exploitative systems in the United States which are largely reliant on anti-Black racism, colonialism, CIS heteropatriarchy, white supremacy, and capitalism.'"

On the role of physicians, Singleton said, "Our calling is not to take sides, but to take care of patients."

Expectation of Impartiality

The "Balkanization" of health care is a real concern, says Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"Just as black patients would be justified in not trusting a doctor who marched with the Ku Klux Klan, Jews are justified in not trusting a doctor, other medical professional, or a medical center that implies or publicly supports Hamas or any other antisemitic group," said Matthews. "As various medical groups and health care providers rally for Hamas, or just in opposition to Israel, they are alienating a large segment of the population and undermining public trust."

Not all medical students embrace the politics of medicine. A medical school student in Oklahoma who asked to speak anonymously said she is concerned about such blatant activism from students in a field that requires impartiality.

"As physicians, we should be taught to care for people regardless of their nationality, ethnicity, religion, or political views," said the student. "The Hippocratic Oath demands that we treat our patients equally 'whether they are free men or slaves.' Any time I hear medical students standing so firmly in hate against a country, be it Russia or Israel, I question their ability to uphold this oath to treat every patient with dignity."

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

Violent Attacks Prompt Reassessment of Mental Health Care

By Bonner Russell Cohen

The murder of an 18-year-old college student while taking a walk near her campus in Nashville, Tennessee by a man with a long history of mental disorders has renewed discussion of whether the chronically mentally ill, especially those with violent tendencies, should be involuntarily institutionalized.

Jillian Ludwig, an 18-year-old freshman at Belmont University, was struck in the head on November 9 by a stray bullet allegedly fired by a career criminal who had been released from custody earlier in the year because he had been deemed mentally incompetent to stand trial, the *New York Post* reported.

The young woman's death happened two weeks after a man opened fire at two locations in Lewiston, Maine, killing 18 people. Like the suspect in Nashville, the shooter in Maine had mental health problems that included "hearing voices and threats to shoot up the National Guard Base in Saco, ME," a law enforcement bulletin stated.

"[The shooter] was also reported to have been committed to a mental health facility for two weeks during summer 2023 and subsequently released," *The Daily Wire* reported.

'Failed Mental Health Policy'

The perceived rise of random violence reflects serious inadequacies in the nation's mental health system, says the Arlington, Virginia-based Treatment Advocacy Center (TAC).

"Fifty years of failed mental health policy have placed law enforcement on the front lines of mental health crisis response and turned jails and prisons into new asylums," the TAC states on its website.

"Deinstitutionalization, outdated treatment laws demanding a person become violent before intervention, discriminatory federal Medicaid funding practices and the prolonged failure by states to adequately fund their mental health systems drive those in need of care into the criminal justice and corrections systems, rather than into public health systems where they belong," the TAC site states.

The failure to treat mental health problems is creating big problems, the TAC says.

"Most individuals with serious mental illness are not dangerous, most acts of violence are committed by individuals who are not mentally ill, and people with mental illness are more likely to be victims than perpetrators of violent acts," states the TAC website. "It is also true, however, that violence is more common in people with serious mental illness, especially when psychosis with paranoia and 'command hallucinations' are present."

"The human, social, and economic impacts of not treating serious mental illness are beyond calculation," states the TAC.

Need for Consistent Treatment

TAC Executive Director Lisa Daily says consistent treatment is the key factor in neutralizing the risk of violence for those with severe mental illness.

"You should not equate mental illness with violence, though failure to treat psychosis can increase the potential for harm," Daily told *Health Care News*. "The focus must be on ensuring that those who need it are receiving the treatment they require, both to prevent violence and to protect against victimization."

Link to Homelessness

Widespread homelessness in urban areas across the country has been linked to the growing number of mentally ill people living in tent cities.

"Recent random attacks by homeless people have left many people concerned about their safety on the streets of Southern California," KTLA5 in Los Angeles reported in October 2022.

The TV station reported "the City of Long Beach closed the Billie Jean King Main Library due to ongoing threats and attacks on library staff by mentally unstable homeless individuals."

The following month, New York City Mayor Eric Adams directed the police and emergency medical workers to hospitalize severely mentally ill people unable to care for themselves, *The New York Times* reported.

Former President Donald Trump said he would bring back institutional care for dealing with the "deeply disturbed" if he is elected to a second term.

Involuntary Treatment Debate

In their 2016 book, *Committed: The Battle over Involuntary Psychiatric Care*, psychiatrists Dinah Miller, M.D., and Annette Hanson, M.D., explored the potential of involuntary treatment in preventing violence, suicide, and mass murder.

> **"For one thing, we don't have a good definition of mental illness, there is no specific mental illness associated with violence, [and] lots of people have mental disorders—one in five in any given six-month period and one in two in the course of a lifetime."**
>
> **DINAH MILLER, M.D.**
> **PSYCHIATRIST**

The authors looked at options such as court-ordered outpatient treatment, mental health courts, crisis intervention training, and pretrial diversion, all of which are intended to keep the mentally ill from falling into repeated cycles of hospitalization and incarceration and possibly prevent violent acts from occurring.

Miller cautions against increasing forced institutional care as a means of preventing mass murder or violence by people with mental illness.

"For one thing, we don't have a good definition of mental illness, there is no specific mental illness associated with violence, [and] lots of people have mental disorders—one in five in any given six-month period and one in two in the course of a lifetime," Miller, an assistant professor at Johns Hopkins University, told *Health Care News*.

Multiple Factors

Policymakers should not overemphasize mental illness as a causative factor in serious crimes, Miller says.

"Half of mass murderers have had mental illnesses, but most are able to buy their guns legally," said Miller. "Substance abuse is likely a higher predictor of violence. Many people who commit violent crimes have had no history of violence, so the idea of institutionalizing people because they might commit a crime seems misguided.

"Our book is on civil commitment; the issues for forensic commitment are much different," said Miller. "And while the average length of stay in a psychiatric unit is seven to 10 days, the average length of stay in a forensic hospital is three years."

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

Will the Supreme Court Stop the Abortion Pill?

By Harry Painter

"Medical malpractice" is how a panelist described the failure of the U.S. Food and Drug Administration (FDA) to monitor the removal of abortion pill safeguards, 11 in total, since 2016.

The panel discussion, titled "Abortion Pills: What's Next?" was livestreamed by The Heritage Foundation on November 13, as a case before the U.S. Supreme Court could determine the regulation and mailing of abortion pills.

The panel featured Christina Francis, M.D.; Erik Baptist, an attorney for the public interest law firm Alliance Defending Freedom; and U.S. Rep. Bob Good (R-VA), and was moderated by Sarah Parshall Perry, a Heritage senior legal fellow. The panel members explored different aspects of the fight to regulate abortion pills in a post-*Dobbs*-decision environment.

The availability of abortion pills by mail effectively makes abortion legal even in the states with the most pro-life laws.

U.S. Supreme Court

"If you read the *Dobbs* decision, it turned it over to the people and the states, which means their elected representatives in Washington and in their respective states. So, it doesn't require Congress to regulate abortion, but it does give Congress again the rightful ability to do that."

U.S. REP. BOD GOOD (R-VA)

Safety Questioned

Chemical abortions typically consist of a two-pill series of mifepristone and misoprostol. Pro-life advocates say that allowing the drugs to be prescribed in advance to women who are not pregnant, and the mailing of the drugs, removes important safeguards that protect women's health.

Perry asked Francis, CEO of the American Association of Pro-Life Obstetricians and Gynecologists and a member of Abortion Pill Rescue Network, whether the abortion industry's claim the pill is as safe as Tylenol is accurate.

"Absolutely not," said Perry. "I can confidently say that I've never been called to the emergency room to take care of a Tylenol complication, and I have been called to the emergency room many, many times to take care of complications of these drugs."

"The FDA does not do a good job of capturing these complications. They're very difficult to report to the FDA," said Francis, who made the "medical malpractice" comment.

Perry said high-quality studies show "emergency room visits may be as high as 35 percent of women who take these drugs," and that isn't comparable to the effects of Tylenol.

Safeguards Removed

"When FDA approved the drug in 2000, the agency recognized that there were some dangers inherent with mifepristone," said Baptist, a counsel for the Alliance for Hippocratic Medicine in its lawsuit against the FDA, which is now before the U.S. Supreme Court.

Baptist walked the panel through how the safeguards the FDA had included upon mifepristone's approval have slowly been "stripped away."

For example, patients used to need three in-person doctor visits, in which the expectant mothers were screened for life-threatening conditions and other complications. The doctor would also "make sure the woman takes the drug at the appropriate time and in the appropriate manner," said Baptist.

"The FDA got rid of two of those three doctor's appointments," said Baptist, in addition to allowing abortion pills to be ordered by mail. "That's dangerous, again, because now you're going to have no doctor involved. You're not going to have any medical professional screening the woman before receiving these drugs," said Baptist.

FDA Sued

In August, a federal appeals court ruled the protections must be restored as a condition of keeping mifepristone on the market.

Ultimately, the Supreme Court may rule on whether mifepristone must be pulled from the market completely. Oral arguments are scheduled for early 2024.

Meanwhile, three red states are also suing the FDA, building on precedent from that lawsuit.

Congressional Power Noted

Good told the panel *Dobbs* did not leave the question of abortion legality to the states.

"If you read the *Dobbs* decision, it turned it over to the people and the states, which means their elected representatives in Washington and in their respective states," said Good. "So, it doesn't require Congress to regulate abortion, but it does give Congress again the rightful ability to do that."

Sen. Rand Paul (R-KY) introduced the Life at Conception Act, which would extend 14th Amendment right-to-life protections to the unborn, in 2021.

"It's very concerning, quite frankly, that some of my friends in Congress who were signing onto the Life at Conception Act with me pre-*Dobbs* decision, many of them became hyper-federalists all of a sudden after *Dobbs*," said Good. "We ought to continue to unashamedly, unapologetically fight for that."

Good also argued for the Teleabortion Prevention Act which he said would require "that the patient, the mother, would have to have an in-person visit, the physician would have to be present or the medical practitioner during the process, and there would have to be a follow-up," out of concern for the mother's health.

State-Level Bans

The abortion pill is effectively banned in 13 states. In some other states, such as Wyoming, lawsuits have prevented enforcement of bans. In still others, such as Indiana, pressure has led to restrictions on the pill's distribution despite the drug remaining legal.

Some states, such as Michigan and Ohio, have enshrined abortion rights in law. In Michigan, "There isn't much that can be done with regard to abortion in general and the abortion pill specifically other than to try to educate people about the humanity of the unborn and the dangers of abortion," said Genevieve Marnon, legislative director of Right to Life Michigan, in an email to *Health Care News*.

"We are anxiously awaiting the decision of the Fifth Circuit regarding the lawful/unlawful FDA approval of the abortion pill and the subsequent changes in the [risk evaluation and mitigation strategy, or REMS]," said Marnon. REMS restricts how an approved drug may be used.

"We are hopeful that the case will eventually make its way to the Supreme Court, where they will see that the abortion pill was unlawfully approved in 2000 and will order the removal of the pill from the FDA's list of approved drugs," said Marnon.

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

COMMENTARY

Over-the-Counter Decongestant Doesn't Work—Now What?

"Lawmakers should admit [Combat Meth-amphetamine Epidemic Act] was a mistake and get rid of it. The CMEA isn't working, and in fact it helped to increase meth-related deaths. Congress should repeal it. Then drugs like Sudafed, Claritin-D, and others can return to the shelves and make America breathe again."

JEFFREY SINGER, M.D.
SENIOR FELLOW
CATO INSTITUTE

By Jeffrey Singer, M.D.

Just as cold and flu season was set to kick off in the fall, the Food and Drug Administration's (FDA) advisory panel reported an oral decongestant Americans have relied on for nearly 20 years is no better than a placebo.

This ingredient—found in popular versions of Sudafed, Dayquil, and other medications—has gained popularity since Congress made it difficult for people to obtain an effective oral decongestant. Lawmakers should correct that mistake before the winter cold and flu season arrives in full force.

Meth Connection

In an effort to shut down homegrown meth labs in which people converted oral decongestants containing pseudoephedrine into methamphetamine, Congress 18 years ago passed the Combat Methamphetamine Epidemic Act. Under the CMEA, the Drug Enforcement Administration ordered all pseudoephedrine-containing products moved "behind the counter" and required pharmacists to register and track people who purchased them.

The DEA placed strict limits on the number and dosage of pseudoephedrine-containing products patients may obtain in any 30-day period. Until last year, Oregon and Mississippi required residents to get a doctor's prescription.

As often happened to the meth lab "cooks," the methamphetamine law has become a spectacular failure, backfiring on its creators and harming innocent bystanders.

When the CMEA took effect in 2006, there were only two over-the-counter oral decongestants on the market: phenylephrine and pseudoephedrine. A third, phenylpropanolamine, was fading from the market after studies associated it with hemorrhagic strokes.

The CMEA effectively narrowed patients' choices to one: phenylephrine.

Marketing Dilemma

Many drug makers substituted phenylephrine for pseudoephedrine so their customers could continue buying their products over the counter and avoid the stigma of registering to purchase pseudoephedrine.

Sudafed, which manufactured pseudoephedrine, came out with Sudafed PE (for phenylephrine). Phenylephrine replaced pseudoephedrine in Nyquil Sinex Nighttime Sinus Relief.

The makers of Claritin-D, a nonsedating antihistamine combined with pseudoephedrine, chose not to switch to phenylephrine. Their chemists ran tests on phenylephrine and found it ineffective when taken orally. The drug maker decided to stay behind the counter. Competitors Zyrtec and Allegra made the same decision.

In 2007, two academic pharmacists from the University of Florida looked at the studies the FDA relied on to declare oral phenylephrine safe and effective in the 1970s. The researchers concluded phenylephrine was no better than a placebo.

A year had passed since the DEA moved pseudoephedrine, an effective oral decongestant, behind the counter. This was not a good time to tell millions of cold and allergy sufferers the drugs they buy over the counter probably won't work.

Pharmacists' Study

By 2015, when the University of Florida pharmacists saw the results of studies by Merck and other drug companies showing oral phenylephrine doesn't work, even at high doses, they asked the FDA to take oral phenylephrine off the shelves.

After the American Pharmacists Association and other groups joined the petitioners, the FDA convened another advisory panel eight years later, in April.

On September 12, 2023, decades after the FDA proclaimed oral phenylephrine safe and effective, the panel concluded oral phenylephrine is no better than a placebo.

Unlike pseudoephedrine, digestive juices break down the phenylephrine before it can be absorbed into the system and work.

It doesn't take a conspiracy theorist to wonder whether the FDA didn't want to undermine the newly minted CMEA by telling cold and allergy sufferers they would all be facing limits on their access to oral decongestants. It wouldn't be the first time politics influenced the FDA.

Drug Prevention Failure

Meanwhile, how's the CMEA working to combat the methamphetamine epidemic?

The Mexican drug cartels soon took advantage of the new hole the law created in black market meth and figured out other ways to make methamphetamine more efficiently. One way is by using phenyl-2-propanone, also called phenylacetone or P2P.

Meth-related drug deaths per 100,000 thus increased nationally by 1,400 percent between 2006 and 2020.

More than half of American households trust and use oral phenylephrine, accounting for an estimated $1.76 billion in sales last year. The FDA hasn't yet decided to officially inform them they are wasting their money on phenylephrine or to order it off the shelves.

If it does, expect cold and allergy sufferers to be very upset when they learn how inconvenient the government will make it for them to get relief from pseudoephedrine. Last week, CVS announced that it will begin voluntarily pulling oral phenylephrine decongestants off its store shelves.

Need for Action

Lawmakers should admit CMEA was a mistake and get rid of it. The CMEA isn't working, and in fact it helped to increase meth-related deaths. Congress should repeal it.

Then drugs like Sudafed, Claritin-D, and others can return to the shelves and make America breathe again.

Jeffrey A. Singer, M.D. (**jsinger@cato.org**) *practices general surgery in Phoenix and is a senior fellow at the* Cato Institute. *An earlier version of this article appeared in* USA Today. *Reprinted with permission.*

Americans Born Today Will Use Prescription Drugs for Half Their Lives, Study Finds

By Dvorah Richman

Americans are taking prescription drugs over longer periods of their lives, and the trend is raising new questions about the costs' impact on the economy, society, and health care in general.

Using data from the Medical Expenditure Panel Survey, the Human Mortality Database, and the National Center for Health Statistics, Jessica Y. Ho of Penn State University found prescription drug use is spreading and high levels of use begin early. Babies born in 2019 could take prescription drugs for roughly half their lives, Yo writes.

The article, "Life Course Patterns of Prescription Drug Use in the United States," was published in the latest issue of the population journal *Demography*. The study states prescription drug use is a recent phenomenon that started in the mid-twentieth century, and the use of the most frequently prescribed drugs spread quickly.

Prescription drugs are now the most common therapeutic intervention, with 6.3 billion prescriptions in 2020, approximately 19 for each American.

Multiple Causes

The article identifies a substantial increase in the number of years Americans can expect to take five or more drugs simultaneously. There has been a "particularly dramatic" increase in years spent taking statins, antihypertensives, and antidepressants. It also finds significant gender, racial, and ethnic differences in prescription drug use.

Several factors have contributed to the rising use of prescription drugs, including population aging, the culture of modern medicine, time constraints in health care, and payments tied to "patient satisfaction."

With longer lives and the rising incidence of chronic diseases, large quantities of several drugs are taken simultaneously for long durations and a widening array of conditions, such as menopause and depression. Drugs, including antibiotics for urinary tract infections and psychotherapeutics, may be overprescribed.

Increasingly sedentary lifestyles contribute to health conditions frequently treated with prescription drugs. This includes the "skyrocketing" incidence of fatty liver disease in children and teens. Aspects of daily living like weight gain, hyperactivity, substance use, loneliness, and even so-called "climate-grief" are increasingly "medicalized" and treated with prescription drugs.

Industry marketing (such as direct-to-consumer advertising and medical conferences) also factors into the increase.

Entangling Alliances

John Abramson, M.D., a family physician, retired lecturer in the Harvard Medical School's Department of Healthcare Policy, and author of *Sickening: How Big Pharma Broke American Healthcare and How We Can Repair It*, says "visible issues" pale compared to critical, "invisible issues" resulting from the industry's powerful, bipartisan political influence and an "unholy alliance" between pharmaceutical companies and medical journals. Abramson says agreements between industry and research centers can restrict investigators' control over clinical trials.

"Many doctors think they are sophisticated enough to cut through all these layers, but they can't because they don't have access to the real data," said Abramson.

Abramson says there are "layers of lack of transparency," including pharma's latitude in interpreting research data, peer reviewers' inability to access underlying data, relationships between industry and medical journals, journal articles "that are really marketing pieces," and medical opinion leaders with financial ties to companies.

"Such factors greatly impact research accuracy, medical journal content, and physicians' ability to practice evidence-based medicine, including the ability to knowledgeably prescribe drugs," said Abramson.

High Costs

Prescription drugs have contributed tremendously to improved health and life expectancy, but there are downsides, says Gregg Girvan, a health care policy specialist at the Foundation for Research on Equal Opportunity. One of those is costs.

"U.S. prescription drug expenditures are higher than in other high-income countries, with Medicare and Medicaid among the largest payers," said Girvan. "Government policy allows drug companies to manipulate patents and [Food and Drug Administration] exclusivities to have monopolies on branded drugs far longer than policymakers intended. This allows companies to continually raise prices on drugs that have been on the market for several years yet still have no generic or biosimilar competition."

Expanded prescription drug use can also lead to drug dependency and abuse, harmful interactions between drugs, antibiotic resistance, adverse drug events, drug shortages, and damage to the environment.

Alternative Options

"The increase in drug prescriptions is not necessarily a good or bad thing," said Girvan. "What we really need to do is determine the value of the approved drug being prescribed."

"Lifestyle changes work to prevent and treat many diseases," said Abramson. A 2002 study "shows unequivocally that lifestyle interventions can significantly reduce the rate of developing Type II diabetes for people at increased risk," Abramson said. Another study found 22 minutes of brisk walking per day can offset harmful effects associated with a sedentary lifestyle.

Physical activity can also help control pain, says Amy Driessen, a physical therapist who practices in Fairfax, Virginia.

"Exercise and increased heart rate produce opioid-like, natural pain-mitigating mechanisms," said Driessen.

Recent research shows Medicare beneficiaries who received physical therapy after a fall were 39 percent less likely to use opioids in the following six months, says Driessen.

Education on "inappropriate" prescribing, as suggested in a May 2021 article published in *Lancet* could change the "pill for every ill" mindset, says Girvan.

"Greater use of cognitive therapy, telemedicine, and 'wellness' products like mental health apps may also be beneficial," said Girvan.

Independent Advice

Abramson says he supports the idea of establishing a "Health Technology Assessment Board," as is common in other countries, to analyze new versus old drugs and to recommend the most effective therapies.

"We should also reestablish independent oversight of the trustworthiness of clinical practice guidelines," said Abramson. "Ultimately, to curtail inappropriate prescribing, we need a powerful coalition of medical professionals, payers, including businesses that purchase health insurance for their employees, and the public, to diminish industry influence and demand transparency and integrity of medical knowledge."

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

Taxpayers Pay Millions of Dollars for Child Sex-Change Surgeries

By Kenneth Artz

Massachusetts taxpayers reimbursed Boston Children's Hospital (BCH) $1.4 million for "gender transition services"—including physician's services, inpatient and outpatient care, hospital services, surgical services, prescribed drugs, therapies, and other services—to minors from January 2015 to May 2023, according to documents obtained by *The Daily Caller*.

BCH is one of the top medical centers in the United States encouraging life-altering gender procedures for minors, according to *The Daily Caller*.

"The hospital, which boasts of having the first pediatric transgender surgery center in the country, has performed hundreds of gender surgeries on children since 2017 and has offered phalloplasties for 18-year-old boys and vaginoplasties for girls as young as 17, according to scrubbed pages of its website," the *Daily Caller* reports.

Obamacare Stimulus

Taxpayer dollars are now paying for dangerous, life-altering operations on minors because of the fine print in President Barack Obama's signature health care law, the Affordable Care Act (ACA), said Chris Moritz, a policy expert and documentarian, in an interview by independent journalist Tucker Carlson in October.

The ACA, known as Obamacare, was enacted in March 2010 and resulted in 20,000 pages of rules and regulations.

Moritz told Carlson insurance companies were required to provide coverage for what is deemed to be "medically necessary gender-affirming care." As a result, there was a 50 percent increase in sex reassignment surgeries and a 25 percent increase in insurance coverage for transgender individuals between 2010 and 2016.

In addition, at the very end of the Obama administration, the ACA was amended so private insurance companies could not deny coverage for gender identity treatment.

These provisions led to a 150 percent increase in sex reassignment surgeries in the United States from 2016 to 2017, Moritz told Carlson.

Schools Replace Parents

"Peer contagion" has been an additional catalyst for the skyrocketing rise in the number of minors undergoing gender modification surgeries, says Larry Sand, president of the California Teachers Empowerment Network.

"Now, why wouldn't a teen want to be LGBT?" asks Sand. "These days, it's cool! In reality, the leap in numbers is largely due to social contagion. It's the 'in' thing, like owning a hula hoop, lava lamp, or mood ring. These things may have cost a few bucks at one time but would not potentially damage anyone's life."

Schools have greatly expanded their control over children's values, says Sand.

"Many school districts have decided to take over the traditional role of parents, and this is a very important factor in the alienation of the young," said Sand. "It's happening all over the country."

Hiding from Parents

The Escondido Union School District in California is all too typical of this intrusion and the use of subterfuge to carry it out, says Sand.

Under current policy, "teachers must refer to students by their preferred pronouns or gender-specific names during school hours but revert to biological pronouns and legal names when speaking with parents," said Sand.

After a teacher learns of a child's social transitioning, he or she is obliged to ensure parents do not discover it, says Sand.

'Dangerous Experimentation'

No one should be funding this type of dangerous experimentation on healthy children, says Kallie Fell, a registered nurse and executive director of the Center for Bioethics and Culture Network.

"During production of each of our documentary films on the gender industry, we interview many de-transitioners and medical experts, who all echo the same message: once a person decides to medically transition, they are lifelong patients, no matter what," said Fell.

"Can a minor really understand and consent to this medicalization and the lifelong consequences of these decisions?" asked Fell. "We would argue that they cannot. They cannot know as a child what they are doing to their healthy bodies and what kind of regret, especially reproductive regret, they might face in the future."

Public policy should protect children from the gender-transition industry, says Fell.

"We hope taxpayers wake up and realize no one should be funding this type of dangerous experimentation on healthy children," said Fell. "What these children really need is to be provided evidence-based counseling and therapy and an opportunity to grow up protected from the dangerous ideology of gender 'medicine.'

"No child is born in the wrong body, and no child should have a perfectly healthy body permanently scarred and damaged in the name of 'gender medicine,'" said Fell.

Second Thoughts and Lawsuits

The rise in transgender surgeries on minors has spurred a new trend of de-transitioners bringing lawsuits against the practitioners, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"Numerous physicians and health care centers are boasting about how many transgender surgeries they are performing on minors, but a small and growing number of people who were children when they received hormone treatment or surgery are now de-transitioning and asserting that what they really needed was mental health care," said Matthews.

"During production of each of our documentary films on the gender industry, we interview many de-transitioners and medical experts, who all echo the same message: once a person decides to medically transition, they are lifelong patients, no matter what. Can a minor really understand and consent to this medicalization and the lifelong consequences of these decisions? We would argue that they cannot. They cannot know as a child what they are doing to their healthy bodies and what kind of regret, especially reproductive regret, they might face in the future."

KATIE FELL
EXECUTIVE DIRECTOR
CENTER FOR BIOETHICS AND CULTURE NETWORK

"Their lives and their bodies have been changed forever, and they are seeking out law firms that will hold these doctors and health care facilities financially and professionally accountable for their actions," said Matthews. "Juries hearing their horrific stories and seeing the lasting physical and mental scars are likely to conclude that doctors broke their very first vow, 'to do no harm.'"

Florida has banned the spending of tax dollars on sex change procedures on any person, not just minors. Last summer, after new laws were passed, the state fined five Medicaid providers, sanctioning one after an audit revealed it had used Medicaid dollars to fund treatments.

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

COMMENTARY

Get Ready for a Tsunami of Lawsuits Against Adolescent Trans Medicine

By Robert Koshnick, M.D.

The adolescent transgender medicalization movement will arrive soon in your state and medical society, if it has not already.

Transgender medicine is not based on science but on ideology. The Society for Evidence Based Gender Medicine points out six methodological errors and several untoward ramifications of gender ideology in medicine in an article titled "The Dutch Studies and the Myth of Reliable Research in Pediatric Gender Medicine."

Gender refers to the norms, behaviors, and roles associated with women, men, girls, and boys that are socially constructed and culture-specific. One way of dealing with variations is to accept whatever behavior an individual has as part of the bell curve of behaviors of their natal sex. A gender-nonconforming person would then not require sexual transition.

The other way is to believe in rigid sex roles, medicalize gender variations, and offer sexual transition early in adolescence to those who "feel they are in the wrong body." Gender identity is very fluid in adolescence (as opposed to sexual orientation). Gender ideologists believe adolescents have the right to match their physical sexual appearance with their perceived gender to conform to gender norms, behaviors, and roles.

"On the legal front, nine lawsuits have already been filed in the United States by de-transitioners. One significant lawsuit is against the American Academy of Pediatrics (AAP) and Jason Rafferty, M.D., author of the 2018 AAP policy statement and one of the biggest advocates of gender-affirming hormone treatments."

ROBERT KOSHNICK, M.D.
RETIRED PRIMARY CARE PHYSICIAN

Dutch Model

The adolescent sex transition movement accelerated after the publication of the "Dutch Studies" in 2011 and 2014. The experiment was funded by the pharmaceutical company Ferring, which markets the puberty blocker Triptorelin.

The study started with a sample of 196 adolescents. This was cut down to 70 in the 2011 paper. It was further cherry-picked to 55 transitioners in the 2014 paper. There was no explanation of what happened to the dropouts, one of whom we know died of surgical complications.

This was not a random, controlled trial. There were no controls. The effects of mental health counseling and support were not separated from the sex transition component. There were only 18 months of follow-up.

The thesis was that sexual transition through hormonal manipulation by puberty blockers, hormone reversal, and surgery could benefit adolescents. This was then codified by an organization called the World Professional Association for Transgender Health (WPATH) into what they called standards of care (SOC). The latest edition (SOC-8) is the bible for gender ideologists.

Gender Ideology

Gender ideologists start by manipulating language. Their chosen term is "gender affirming care." This is an example of what Herbert Marcuse, the father of critical race theory, called "liberating tolerance."

Liberating tolerance means that only views supporting liberation are tolerated and censorship, repression, and, when necessary, violence are justified against anyone who opposes them. This is the theoretical justification of the cancel culture. Anyone opposed to sexual adolescent transition must be silenced, canceled, shunned, and humiliated for their views.

Barrier Removal

The policy goal of the transgender movement is to remove all barriers to medical gender transition. SOC-8 advocates the elimination of age minimums for sexual transition if "The adolescent has reached Tanner stage 2 of puberty for pubertal suppression to be initiated."

This normally occurs between eight and 13 years in girls and six to 12 months later in boys. The only other SOC-8 exception is that "Given the complexity of phalloplasty, and current high rates of complications in comparison to other gender-affirming surgical treatments, it is not recommended this surgery be considered in youth under 18 at this time."

SOC-8 recommends chemical or surgical castration and sex transition as early as Tanner stage 2. That has irreversible lifelong physical and social implications. Ethical considerations such as "first, do no harm" should be at the forefront of this discussion.

Yet, SOC-8 eliminated the chapter on ethics. SOC-8 mentions the word "ethics" only twice in its chapter on adolescents, in both cases referring to a right to self-determination. This is despite our understanding that the prefrontal cortex, where cause-and-effect reasoning occurs, does not complete development until age 23 in females and 25 in males.

Turning Point?

The major organization opposing WPATH is Genspect. On November 4 and 5 of 2023, Genspect held a conference called "The Big Picture" in Denver, Colorado, at which it released a 334-page "Gender Framework." The Gender Framework does not recommend medical sex transition before adulthood (age 18). That document may represent a turning point for the adolescent sexual transition movement.

Genspect points out there is no quality evidence supporting the use of puberty blockers for children, and no studies showing sexual transition in adolescents leads to long-term positive mental, physical, social, or romantic outcomes compared to "watchful waiting" or counseling and psychotherapy.

Genspect recommends these conservative approaches for adolescent gender confusion, instead of sexual transitioning.

Litigation Explosion

On the legal front, nine lawsuits have already been filed in the United States by de-transitioners. One significant lawsuit is against the American Academy of Pediatrics (AAP) and Jason Rafferty, M.D., author of the 2018 AAP policy statement and one of the biggest advocates of gender-affirming hormone treatments.

This is the opening volley of what is likely to be a tsunami of de-transitioner lawsuits from the 51,000 people on the Reddit website r/detrans.

European countries, which have already abandoned gender transition in adolescents, may or may not have laws that protect state-run gender clinics from lawsuits. In the United States, it will be open season on gender clinics in America, whether private or public.

It is likely that this will be the greatest medical litigation explosion ever seen, and one of the greatest medical scandals of all time.

RobertKoshnick,M.D. **(bob.koshnick@gmail.com)** *is a retired primary care physician from Detroit Lakes, Minnesota. Koshnick was chair of the policy committee of the Minnesota Medical Association in 2023 and author of* Empower-Patient Accounts Empower Patients!

Site-Neutral Medicare Payments Could Save Thousands of Dollars Per Patient

By AnneMarie Schieber

A breast cancer patient could save $1,500 per year in out-of-pocket costs if Medicare reimbursed hospitals and independent health care providers equally for the same service, and taxpayers would spend $7,750 less, a study conducted by Avalere Health for the American Cancer Society Action Network (ACSAN) reports.

The study looked at the Medicare practice of paying health care providers by setting. Hospital out-patient departments are paid significantly more money than independent providers for the same services, to compensate hospitals for higher overhead and equipment costs.

The report found hospital outpatient departments were reimbursed at a rate three times higher than what an independent practice would charge. In some cases, the reimbursement rates were five to six times higher.

"Payment policies should not create incentives that push patients into higher cost settings when the same care can be provided in a lower cost, often preferable, site of care," the report states.

The House Budget Committee Health Care Task Force is examining "site-neutral" reimbursement and held a roundtable discussion on the issue after ACSAN released its report on October 23.

Price Inflation Effect

The policy of allowing hospitals to charge more and collect more money from Medicare than other health care providers increases prices across the board, says Richard A. Kube, M.D., founder of Prairie Spine & Pain Institute, an independent orthopedic practice in Illinois.

"If I want to pay cash for an MRI or a scan in Peoria, I don't have an independent option," Kube told the *Heartland Daily Podcast*. "I must go to one of the two major hospitals, and I'm going to pay a couple of thousand dollars for that. And maybe the insurance company won't approve it. I know that I can go to another clinic in Bloomington and for $600 get the exact same MRI."

The costs really add up for major surgeries done in hospitals, says Kobe.

"It is not so much the site-of-service differential but the amount of added costs that goes into keeping these giant administrative superstructures in place," said Kube.

In other markets, consumers can save more when they deal with a large distributor that has the advantage of economies of scale, says Kobe.

"Hospitals should have that same opportunity," said Kube. "It's the only industry where you go to the mass producer and you pay more."

Elimination of Competition

The higher reimbursements give hospitals an advantage when dealing with rising administrative costs created by government regulations. Independent practices have a hard time competing and may be inclined to merge with large hospital groups. The extra money hospitals collect from Medicare puts them in a better position to buy out practices. What results is a monopoly.

"The price will go up and value is going to go down because the hospitals no longer have to worry about competition," says Kube. "Years ago, when we had an independent imaging center in Peoria, I could get same-week, sometimes same-day MRIs all the time. Now it takes a month."

Hospitals' Power

Whether Congress will implement a site-neutral reimbursement system is a big "if," says Kube, because hospitals have become big business and are in a position to protect their turf.

"It's based on a monopoly," said Kube. "The site-of-service differential can start unraveling the whole thing. All of a sudden, their margins would change drastically. They would no longer have that subsidy to poach all the private practices."

Kube says he has personally experienced threats and pressure to use hospital imaging services.

"I'm a sub-specialist," said Kube. "I read probably thousands of MRIs a year, and for someone like me who knows the kinds of questions to ask and how [things work], it is inappropriate. If they're willing to do those kinds of things, I'd expect them to spread as many lobby dollars as they can to push. And frankly, the insurance industry would be aligned with them."

'Intense Lobbying'

Though Congress is making some headway on establishing site-neutral reimbursements, and the Trump administration made progress through executive orders, permanent reforms have never been enacted.

"The fundamental problem with all provider reimbursements in government health care programs is the fact that bureaucrats or elected officials are setting the payments," said Roger Stark, M.D., a senior fellow at the Washington Policy Center. "These government officials are subject to intense lobbying by special interest groups. The hospital associations in the U.S. are well-organized and pretty well-funded, and overall [they] command more attention than physician groups. Hence, hospitals and their clinics continue to get higher reimbursements."

"The fundamental problem with all provider reimbursements in government health care programs is the fact that bureaucrats or elected officials are setting the payments. These government officials are subject to intense lobbying by special interest groups. The hospital associations in the U.S. are well-organized and pretty well-funded, and overall [they] command more attention than physician groups. Hence, hospitals and their clinics continue to get higher reimbursements."

ROGER STARK, M.D.
SENIOR FELLOW
WASHINGTON POLICY CENTER

"In a truly free-market health care system, all providers would compete on both quality and pricing," Stark said. "Physician offices, with less overhead, would have a definite advantage over high-overhead hospitals for many patient services."

Congressional Support for Reform

Site-neutral reimbursement has bipartisan support in Congress, Kube wrote in a *Newsweek* op-ed.

"Several congressional committees are now debating a health reform package that includes provisions to establish site neutrality in limited circumstances," wrote Kube. "That would be a vital first step, one which physicians across the country hope will soon expand to other services.

"After all, what could be more fair than reimbursing providers the same amount for the same service?" wrote Kube.

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

STUDY

Easy Medicaid Access Discourages Long-Term Care Planning

By Kevin Stone

To resolve persistent problems in the nation's long-term care (LTC) system, the government must eliminate loopholes that allow people to qualify easily for Medicaid payment, a new study concludes.

Generous Medicaid eligibility coupled with estate recovery has failed to promote adequate planning for LTC, whether through savings or insurance, and that has left the LTC safety net in danger of financial collapse, says study author Stephen Moses, president of the Center for Long-Term Care Reform (CLTCR). The report, titled "Long-Term Care: The Solution," was published by the Paragon Health Institute in November.

"Too many people end up on Medicaid, which pays too little to ensure access to quality home care and causes excessive reliance on institutionalization and unpaid help from families and friends," wrote Brian Blase, president of Paragon, in an announcement of the report's release.

The report identifies ways lawmakers could empower younger and middle-aged Americans to plan responsibly using wealth held in home equity, individual retirement accounts, life insurance, and estates, and to serve seniors' desire to see their medical needs met in the home rather than in institutions.

"Central planning, public funding, heavy regulation, and easy access to welfare benefits have caused most of LTC's problems, such as nursing home bias, poor access and quality, inadequate revenue for care providers, caregiver shortages, and the terrible emotional and financial distress for caregiving families."

STEPHEN MOSES
PRESIDENT
CETNER FOR LONG-TERM CARE REFORM

Welfare for the Wealthy

Moses says he identified key issues threatening the viability of government-funded LTC in "Long-Term Care: The Problem," a study published by CLTCR in 2022.

"Central planning, public funding, heavy regulation, and easy access to welfare benefits have caused most of LTC's problems, such as nursing home bias, poor access and quality, inadequate revenue for care providers, caregiver shortages, and the terrible emotional and financial distress for caregiving families," said Moses.

Today, Medicaid LTC is not just a program for the poor, says Moses.

"Medicaid especially is responsible because, despite the conventional wisdom that it requires impoverishment, the program's LTC benefits are routinely available not only to the poor but to the middle class and affluent as well," said Moses.

The CLTCR report included real-life examples of how affluent people have received LTC under Medicaid, such as a couple sheltering $700,000 in liquid assets by purchasing a more expensive house, car, and annuity, all exempt from Medicaid's eligibility calculation. Another example is an able-bodied wife who received an $89,000-a-month annuity while Medicaid paid for LTC for her husband.

Ready to Reform

Moses says lawmakers might embrace the solutions outlined in the report "when politicians have to make budget ends meet again," said Moses.

"Historically, we made progress with measures to constrain Medicaid LTC and aim it to the needy during and after recessions forced attention to expenditures," said Moses. "That stopped since the Great Recession because of wide-open spending, deficits, debt, and artificially low interest rates. The result is inflation now and [the] inability to service the national debt [in the future]."

"Something will have to be done, and we're ready with the solution," Moses said.

In the Paragon report, Moses identifies the biggest loopholes that discourage early LTC planning, such as the purchase of exempt assets, the home equity exemption, Medicaid asset protection trusts, Medicaid-compliant annuities, and the "five-year asset transfer lookback," which is the timeframe Medicaid uses to ensure someone hasn't given away money or resources to qualify.

Close Asset Loopholes

Medicaid requires LTC recipients to spend down personal assets to $2,000 but doesn't state how, and the program allows many exceptions, says Moses in the Paragon report.

"Such exempt items include an expensive home and—without any dollar limit—the following: one automobile, prepaid burial plans, one business including the capital and cash flow, term life insurance, household goods, personal belongings, and even individual retirement accounts in many cases," wrote Moses. "Medicaid planners routinely advise clients to maximize this path to eligibility."

The report proposes "a phase-in schedule" for reform of the home equity exemption, which can exceed $1,000,000 in some states. The schedule should provide enough warning to incentivize early LTC planning "without unduly affecting people already too old to prepare."

Other recommendations include eliminating Medicaid Asset Protection Trusts (MAPT), which allow people to shelter assets for five years before applying to Medicaid, and Medicaid-compliant annuities. The "lookback" window for asset transfers should be expanded to 20 years, not five, the report states.

Additionally, LTC risk and cost should be widely publicized so once Medicaid is preserved for the truly needy, people will have far greater incentives to engage in proper planning and will find the LTC challenge less intimidating, the report says.

Eliminate Moral Hazard

"If people could not ignore LTC until they need it and get Medicaid to pay while preserving wealth, they would save, invest, or insure for the risk and be private payers when the time comes, with access to the best private LTC in the home instead of a nursing home," Moses said.

The current system creates a "moral hazard" that discourages consumers from making sound choices, says Blase.

"Most Americans possess enough wealth to fund their average LTC needs, which is about two years of home-based services," wrote Blase. "If the average 65-year-old had $70,000 set aside for LTC, it would grow to meet that need after age 85, when LTC commonly occurs. Positive incentives to plan early and pay privately avoid the loss of freedom and high economic cost from compulsory, payroll-funded policies."

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

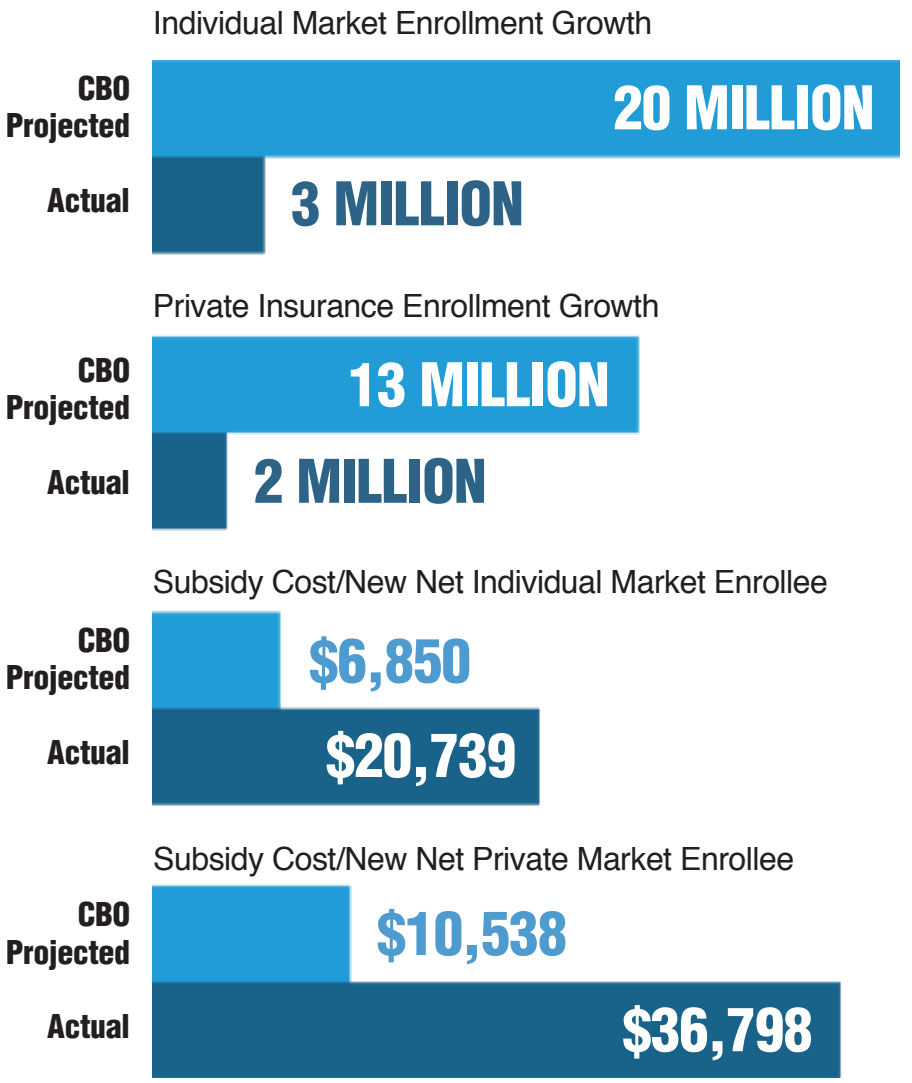
INTERNET INFO

Stephen Moses, "Long-Term Care: The Solution," Paragon Health Institute, November 2023: **https://paragoninstitute.org/research-paper-page-moses-ltc-solution-20231002/**

Obamacare: Half as Many People at Three Times the Cost

The average subsidy for Obamacare is at least 45 percent above Congressional Budget Office projections, yet fewer people are signing up for the coverage (see article, opposite page). Analysts expect Congress to address the subsidy expansions over the next few years.

Cost of Expanding Obamacare Enrollment, 2009-2021



Source: "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Price," Paragon Health Institute

STUDY

What Is an Increase in Obamacare Enrollment Costing Taxpayers?

By Bonner Russell Cohen

Obamacare has badly failed to meet its proponents' lofty promises, a new study concludes.

A study released by the Paragon Health Institute reports the health insurance marketplaces established under the Affordable Care Act (ACA) attract half as many people as projected by the Congressional Budget Office (CBO), at three times the projected cost to taxpayers.

"The ACA's individual market policies have produced far less enrollment at a much higher unit cost than projected, write Daniel Cruz and Greg Fann, authors of the Paragon report, titled "The Shortcomings of the ACA Exchanges: Far Less Enrollment at a Much Higher Price."

In a post on X, formerly Twitter, President Joe Biden said 301,000 "new customers" had signed up in the first week of the open enrollment period that began on November 1.

"To improve government, it is vital that we analyze how public programs actually work. A fair analysis of the ACA finds that it has largely been an expansion of the Medicaid welfare program and that the individual market is in poor condition, with most enrollees needing to receive giant subsidies to purchase coverage."

BRIAN BLASE
PRESIDENT, PARAGON HEALTH INSTITUTE

Health Insurance Goal

Cruz and Fann, actuaries with extensive backgrounds in health care, note a major goal of Obamacare was to get more people covered by health insurance.

"The passage of the Patient Protection and Affordable Care Act (ACA) in 2010 represented one of the most significant changes in federal health policy since the Social Security Amendments of 1965, which established Medicare and Medicaid," Cruz and Fann write. "The principal goal of the multifaceted law was to reduce the number of uninsured Americans. The primary barrier to insurance coverage was presumed to be cost, and the intent of the law was to appropriate financial resources to provide coverage incentives for lower-income people.

"The means of accomplishing this goal were two-fold: (1) enhanced federal funding for states to expand eligibility for Medicaid and (2) restructuring the individual market into federally regulated exchanges with large subsidies linked to both premiums and household income."

Huge Medicaid Expansion

The Paragon study shows nearly all the people newly "insured" under Obamacare ended up on Medicaid.

"While ACA advocates focused on the private market reforms when selling the legislation to the public, the vast majority of individuals who gained coverage following the implementation of the law have done so through Medicaid," write Cruz and Fann. "Of the 19 million Americans with health coverage after the ACA was implemented, 17.4 million were covered under the newly eligible Medicaid expansion group."

These figures are in sharp contrast to projections made by the CBO in 2013, the year before the ACA went into effect. The CBO projected a health coverage increase of approximately 25 million Americans, evenly split between new ACA exchanges and Medicaid.

This lopsided result occurred even though ACA subsidies have increased by more than 45 percent since 2014, the study says.

Lack of Concern About Efficiency

There has not been much research on the efficiency of the ACA, say Cruz and Fann.

"Health coverage policy efficiency is defined in terms of the increase in overall coverage relative to the taxpayer cost of achieving that increase," write Cruz and Fann. "While ACA enrollment figures have been reported—and sometimes singularly celebrated—on growth alone, without regard to underlying cost, assessments of efficiency have been lacking and have resulted in a poor understanding of policy efficiency.

"ACA exchange spending of $60 billion in 2021 cost taxpayers $36,798 per additional private insurance enrollee ($20,739 per additional non-group enrollee), more than triple CBO's original projections of $10,538 and $6,850, respectively. Overall, employer coverage dropped by 1.3 million, and non-group coverage increased by 2.9 million."

Employer Insurance Cancelations

Since the enactment of the ACA, employer-sponsored coverage has declined significantly, particularly among small businesses, the study shows.

"According to the most recent (2022) KFF Employer Health Benefit Survey, small employers (3-199 employees) are increasingly not offering health benefits to their employees, with 51 percent offering coverage in 2022, down from 69 percent in 2010," write Cruz and Fann. "The cost of insurance is cited as the primary reason employers are not offering coverage. Many of the ACA provisions—including benefit minimums, essential health benefit requirements, and the small group market single risk pool—have driven costs higher for these employers."

Post-Adoption Cost Hikes

Obamacare's original stated goals have been further undermined by changes to the program since 2014, including the federal government's decision to stop reimbursing insurers for cost-sharing reduction (CSR) payments, which prompted insurers to raise the price of premiums for ACA silver plans to reflect the actuarial value of those plans.

In addition, the 2021 American Recovery Plan Act "reduced required income-based premium contributions for subsidized enrollees and expanded the population eligible for subsidies," write Cruz and Fann.

"Meanwhile, unsubsidized middle- and upper-class families are forced to pay the full cost of plans and have limited options outside of the individual ACA market, resulting in minimal overall non-group enrollment gains due to the ACA," write Cruz and Fann.

Failure All Around

"This study should silence all claims that the ACA has been a success," said Dean Clancy, a senior health policy fellow at Americans for Prosperity. "The law has failed to deliver more affordable care to people and transferred hundreds of billions of dollars from taxpayers to insurance companies—all while, remarkably, making it harder to access quality care."

"To improve government, it is vital that we analyze how public programs actually work," said Brian Blase, president of the Paragon Health Institute. "A fair analysis of the ACA finds that it has largely been an expansion of the Medicaid welfare program and that the individual market is in poor condition, with most enrollees needing to receive giant subsidies to purchase coverage."

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

COMMENTARY

Price Transparency Is a Fraud in a Fake Market

By Deane Waldman, M.D.

A recent report by the Patient Rights Advocate (PRA) group claims health care price transparency could save as much as $1 trillion a year—but the PRA has things backward.

Not only will savings fail to materialize, a federal mandate for transparency will increase federal expenditures on health care and cost American lives.

Health care, unlike every other commercial activity, has three parties. The first party is the buyer: the patient, who does not decide the payment. The second party is the seller—a nurse, doctor, pharmacist, hospital, any provider of clinical care.

In contrast to other markets, the health care seller's price is not what is paid, because there is a third party, the payer, who will ultimately make financial and medical decisions. Payers are the insurer or the government, and the price they pay is often based on guidelines called allowable reimbursements.

"A mandate to make health care prices transparent is a fraud. It will not save $1 trillion. It will, in fact, cost billions of dollars. It will produce a false impression in the public's mind of what is being paid for their care. Worst of all, federally mandated price transparency will cost American lives."

DEANE WALDMAN, M.D., MBA
PROFESSOR EMERITUS OF PEDIATRICS
UNIVERSITY OF NEW MEXICO

Market Participants Disconnected

The health care market is "disconnected." The buyer is disconnected from the seller. The buyer is also disconnected from his or her money. The third party, not the patient, decides how the patient's money is spent. The seller is disconnected from his cost basis by fixed-price payment schedules.

Most important, the buyer (the patient) is disconnected from their constitutionally guaranteed medical autonomy. Not only are financial decisions made for the patient by the third party, so are medical choices, thus taking away medical freedom.

Price Signals Distorted

Making prices transparent in the disconnected health care *market* will not save money because the usual free-market forces are absent. Price variability is a signal that balances supply and demand. In health care, however, the price is fixed arbitrarily by the payer. What will be made public in the interest of transparency is the charge, which bears no relation to the payment or the seller's cost of doing business (CODB).

Publishing fixed prices cannot function as a signal that balances supply and demand. It will also give the public a grossly inflated picture of what providers are paid. This author's average charge for a cardiac catheterization in a critically ill newborn baby averaged $2,500. That is what the public would see, not the payment from Medicaid of $367 ("maximum allowable reimbursement").

Health care is both a monopsony—a market with effectively one buyer, the federal government—and a monopoly, a market where one party controls the supply—again Washington, by mandating insurance benefits. Market forces do not function when there is either a monopsony or a monopoly. When both are present, that is by definition central economic control, as in the Soviet Union.

Price Transparency Raises Prices

Third-party disconnection removes patients' incentive to economize. Without that incentive, spending continues to rise without surcease, as history proves. Third-party disconnection also discourages sellers (providers) from competing for patients' business. Sellers have no incentive to provide timely service, especially when their compensation is below CODB.

Mandating price transparency will not save money. In fact, it will increase spending.

Regulation Increases Spending

Many people assume regulations are free, but they cost money. Any government order, whether it is called an advisory, guideline, law, regulation, or rule, invariably creates bureaucracy, administration, rules, regulations, compliance, oversight, mandates, and enforcement (BARRCOME).

When Washington passes a law such as price transparency, people must write and vet the law. Then, federal agencies such as the Centers for Medicare and Medicaid Services, the Food and Drug Administration, and others must establish rules that personnel and institutions will use to implement price transparency.

These rules must be made consistent with each other and with state and local laws they affect. Conflicts must be resolved. Then, the rules, which are general, must be turned into highly specific regulations. The first set of Affordable Care Act regulations comprises more than 10 million words.

After establishing timelines for completion and compliance, an oversight process with necessary personnel and structure must be created. Finally, an enforcement system must be developed, including penalties for noncompliance. Officers are hired to oversee compliance, investigate fraud, and apply penalties.

Mandating price transparency generates BARRCOME, which triggers massive federal spending.

Price Transparency Costs Lives

In 2022, the United States spent $4.3 trillion on health care—18.3 percent of GDP. At a minimum, 31 percent and more likely 50 percent of all U.S. "health care" spending went to BARRCOME. That amount, approximately $2 trillion, reflects the care Americans were denied when Washington diverted funds from nurses, doctors, and hospitals to pay its minions.

President Joe Biden has hailed job growth as an indicator of the success of his economic plan. Many of those new jobs are for health care BARRCOME. These people do not provide care. They do require compensation paid by taxpayer dollars expended as "health care" spending. By diverting funds from care, bureaucratic job growth produces medically dangerous wait times for care that result in death by queue.

A mandate to make health care prices transparent is a fraud. It will not save $1 trillion. It will, in fact, cost billions of dollars. It will produce a false impression in the public's mind of what is being paid for their care. Worst of all, federally mandated price transparency will cost American lives.

Deane Waldman, M.D., MBA (**dw@deanewaldman.com**) *is a professor emeritus of pediatrics, pathology, and decision science at the University of New Mexico; former director of the Center for Healthcare Policy at Texas Public Policy Foundation; and former director of the New Mexico Health Insurance Exchange. An earlier version of this article appeared in* RealClearHealth *on October 24, 2023. Reprinted with permission.*

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Dr. Goodman addressing The Economic Club of Indiana

What We Have Accomplished

Health Savings Accounts

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

1

Roth IRAs

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

2

Social Security

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

3

401 (k) Plans

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

4

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