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The Pulse

UK Rejects WHO Pandemic Treaty, Biden Eager to Sign

By Bonner Russell Cohen

The United Kingdom (UK) has indicated it will not sign the World Health Organization's (WHO) new pandemic treaty, based on the draft being negotiated as of mid-May.

"We will only support the adoption of the accord and accept it on behalf of the UK, if it is firmly in the UK national interest and respects national sovereignty," a spokesperson from Britain's Department of Health and Social Care told Reuters on May 8. One stumbling block has been drug patents the UK may have to surrender at the WHO's command in the event of a public health emergency.

The Biden administration has signaled it will support the WHO pandemic treaty expected to be finalized at its World Health Assembly in Geneva, Switzerland between May 21 and May 30.

Pamela Hamamoto, the State Department official

PANDEMIC TREATY, p. 4

Washington State Voters Could Nix Long-Term Care Tax

By Ashley Bateman

The state of Washington's mandatory long-term care (LTC) insurance program, WA Cares, and the payroll tax that funds it will become optional if voters approve a citizen's initiative this November.

WA Cares was authorized by a law enacted in 2019, and the state began collecting a 0.58 percent payroll tax on all wage income on July 1, 2023. More than 475,000 Washingtonians who were able to opt out of the program did so during a limited initial period.

NIX CARE, p. 6

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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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After Three Years, NYT Discovers Injuries from COVID-19 Shots

By AnneMarie Schieber

The COVID-19 shots can and have caused multiple, serious injuries, *The New York Times* now acknowledges.

The un-paywalled article is the first admission by the so-called newspaper of record since the massive inoculation campaign went into full swing in January 2021.

The May 4 article profiled about a half-dozen health professionals with advanced degrees who suffered debilitating injuries including neurological disorders, shingles, hearing loss, tinnitus, Guillain-Barre Syndrome, and racing heartbeats within weeks or months of receiving COVID-19 shots.

'Told I'm Not Real'

The patients, all familiar with the workings of the health care system, described their utter frustration with their complaints not being taken seriously.

"I can't get the government to help me," Shaun Barcavage, a 54-year-old nurse practitioner from New York City, told the *Times*. Barcavage now suffers from tinnitus after suffering from stinging in his eyes, mouth, and genitals upon getting his first COVID shot. "I'm told I'm not real. I'm told I'm [a] coincidence."

The *Times* found a similar case with Gregory Poland, editor-in-chief of the scientific journal *Vaccine*. Poland has urged his contacts at the Centers for Disease Control and Prevention to examine the connection between the shots and tinnitus, which has afflicted him.

"I just don't get any sense of movement," Poland told the *Times*. "If they have done studies, those studies should be published."

Stories Dismissed

The 3,244-word article, which the *Times* says was months in the making, highlights reports of COVID shot injuries that were reported by patients, conservative media outlets, and courageous doctors almost immediately after the vaccine campaign got underway but were dismissed by the *Times* and other mainstream media outlets.

"That it took *The New York Times* more than three years to report on COVID side effects is just the latest indictment against our corrupt corporate legacy media," said Jim Lakely, vice president and communications director at The Heartland Institute, which publishes *Health Care News*.

"Back when such reporting would have been just as true and actually mattered, the likes of *The New York Times* characterized all talk of negative side effects of a rushed COVID treatment as 'disinformation' and unproven 'conspiracy theories,'" said Lakely.

Previously Unfit to Print

In contrast with journalism's tradition of remaining neutral and being skeptical of power, the pandemic showed corporate media outlets can no longer be trusted in reporting the news, says Lakely.

"The same legacy media that led the charge to deplatform and shame any free-thinking American who dared to question government narratives and mandates during the pandemic—the efficacy of the vaccines, shuttering businesses, closing schools, creating mask mandates, dismissing military veterans and nurses for not getting the jab, forcing the arbitrary six feet of social distancing, treating everyone as if they had an equally high chance of death if they got COVID, overcounting COVID deaths, and more—does not get points for now starting to gently report what has been true since the spring of 2020," said Lakely.

Deaths Ignored

"This is a promising start, but what about the dead?" wrote journalist Jeff Childers in his *Coffee and COVID* Substack on May 4. Childers has been meticulously documenting "sudden deaths" of young, healthy people who received the COVID shots.

"The *Times* avoided this difficult issue, only briefly referring to possible deaths," wrote Childers. "But maybe it was too much to expect in this cautious, tentative first step toward officially acknowledging that 'Houston, we may have a problem.'"

Sudden deaths began receiving serious attention late in 2022 after insurance executives began noticing a rise in death claims for young, working age people. Pilots, whose health is closely monitored, oddly began dying mid-flight.

Also missing from the coverage is any mention of Peter McCullough, M.D., who has become one of the most recognizable names around the globe warning people about the mRNA shots.

"No, I was not contacted," McCullough told *Health Care News*.

Political Motives Indicated

Childers says the timing of the *Times* article is suspicious, noting former CNN anchor Chris Cuomo, who championed pandemic mitigation measures, went on national television recently discussing his COVID shot injuries.

"I'm speculating, a lot, but cynically I sense politics at play," wrote Childers. "We're six months out from the election. Who does admitting even partial failure of the vaccine program help, politically, and who does it hurt? The acknowledgement of the reality of widespread, unaddressed vaccine injuries would seem to hurt President Trump the most."

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

UK Rejects WHO Pandemic Treaty, Biden Eager to Sign

Continued from page 1

representing the United States at the meeting, stated, "America is committed to signing the treaty that will 'build a stronger global health structure,'" wrote Manhattan Institute Senior Fellow John Tierney in *City Journal*.

Permanent Pandemic Playbook

Adoption of a legally binding pact governing how countries around the world respond to future disease outbreaks has been the goal of WHO-directed negotiations since 2021.

Reconciling the conflicting interests of WHO's 194 member countries has been a challenge for the organization, especially given the sharp criticism directed at the WHO worldwide for its handling of the coronavirus.

On May 8, attorneys general from 22 states sent President Joe Biden a letter saying they oppose the accords, which they say will turn the WHO into the "world's governor of public health."

Giving the WHO such authority would violate the U.S. Constitution and could lead to censorship of dissenting opinions, undermine constitutional freedoms, and give the WHO power to declare other situations as emergencies, such as climate change, gun violence, and immigration, the letter says.

WHO COVID Missteps

In a post on *Twitter* (now *X*) on January 14, 2020, the WHO stated, "Preliminary investigations conducted by the Chinese authorities have found no clear evidence of human-to-human transmission of the novel #coronavirus (2019-nCoV) identified in #Wuhan, #China."

Just over two weeks later, on January 30, 2020, the WHO's Emergency Committee reversed course, issuing a Public Health Emergency of International Concern (PHEIC). "The Committee emphasized that the declaration of a PHEIC should be seen in the spirit of support and appreciation of China, its people, and the actions China has taken on the front lines of this outbreak, with transparency and, it is to be hoped, success," the WHO stated.

The WHO's initial investigation into the origins of COVID-19 concluded it was improbable the virus resulted from experiments at the Wuhan Institute of Virology. The WHO later acknowledged the virus could have come from a lab leak there.

The WHO's investigation, which was thwarted by Chinese officials, ultimately reached no conclusion. President Donald Trump announced the United States' withdrawal from the WHO, a decision reversed by Biden on January 20, 2021.

Dubious Associations

Further undermining the WHO's credibility in setting policies for managing future pandemics was the organization's decision to include Peter Daszak, president of the New York-based EcoHealth Alliance, in its initial investigation into the origins of COVID-19.

Daszak and EcoHealth Alliance featured prominently in an investigation by the U.S. House of Representatives Select Subcommittee on the Coronavirus Pandemic into the U.S. government's funding and lack of oversight of gain-of-function research at the Wuhan lab, for which EcoHealth received grants from the National Institute of Allergy and Infectious Diseases and the National Institutes of Health.

"WHO's performance during COVID-19 was a lethal combination of incompetence and dishonesty. The organization failed to protect public health and went to extraordinary lengths to cover up China's role in fostering gain-of-function research at the Wuhan lab. Ratification of any WHO pandemic treaty would be nothing short of a travesty."

CRAIG RUCKER
PRESIDENT, COMMITTEE FOR A CONSTRUCTIVE TOMORROW

In an interim report released on May 1, 2024, the subcommittee stated there is "significant evidence that Daszak violated the terms of the NIH grant awarded to EcoHealth. Given Dr. Daszak's apparent contempt for the American people and disregard for legal reporting requirements, the Select Subcommittee recommends the formal debarment of and a criminal investigation into EcoHealth and its President."

On May 15, the U.S. Department of Health and Human Services suspended funding to EcoHealth for failing to monitor its virus experiments with the Wuhan lab, *The Washington Post* reported.

After the release of the report, U.S. Rep. Tom Emmer (R-MN) told the *Washington Examiner*, "The World Health Organization covered up the Chinese Communist Party's role in developing and spreading COVID-19 and has since failed to hold them accountable for the global pandemic that killed millions, upended our daily lives, and destroyed thousands of small businesses."

Public Distrust

The WHO's shaky record on COVID and its close ties to China and Peter Daszak have taken a toll on the American people's trust in the organization.

A poll conducted by McLaughlin & Associates for the Center for Security Policy, released on April 17, found 54.6 percent of likely U.S. voters oppose tying the United States to a WHO pandemic treaty, and just 29.0 percent favor such a move.

Bypassing Congress

The "treaty" the Biden administration is eager to sign will likely be an executive agreement, like the 2015 Paris Climate Agreement, which was not presented to the U.S. Senate for ratification though it contained "commitments" President Barack Obama pledged to honor.

Also in the works in Geneva are amendments to the organization's International Health Regulations, which Congress would not have an opportunity to approve or disapprove.

WHO's Power Grab

Sen. Ron Johnson (R-WI) on May 2 sent a letter to Biden signed by all 49 Republican senators, expressing their concerns about the powers the administration plans to hand over to the WHO.

"Some of the over 300 proposals for amendments made by member states would substantially increase the WHO's emergency powers and constitute intolerable infringements upon U.S. sovereignty," the letter states.

Craig Rucker, president of the Committee for a Constructive Tomorrow, says the WHO is a destructive force.

"WHO's performance during COVID-19 was a lethal combination of incompetence and dishonesty," said Rucker. "The organization failed to protect public health and went to extraordinary lengths to cover up China's role in fostering gain-of-function research at the Wuhan lab.

"Ratification of any WHO pandemic treaty would be nothing short of a travesty," said Rucker.

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

Biden Administration Probes Anticompetitive Practices in Health Care

By Bonner Russell Cohen

The federal government, which regulates much of the nation's health care, is taking steps to investigate why the industry is so uncompetitive.

Teaming up with the Federal Trade Commission (FTC) and the U.S. Department of Health and Human Services (HHS), the U.S. Department of Justice launched an online portal, HealthyCompetition.gov, the agencies say will allow "the public to report potentially unfair and anticompetitive health care practices to the FTC and the Justice Department's Antitrust Division," on April 24.

"All too often, we hear how unfair methods of competition and monopolistic practices may be depriving Americans of access to affordable, high-quality healthcare," said FTC chair Lina M. Khan, in a statement. "This joint initiative between FTC, DOJ, and HHS will provide a crucial channel for the agencies to hear from the public, bolstering our work to check illegal business practices that harm consumers and workers alike."

President Joe Biden

"Anticompetitive practices are destroying American medicine. So far, the federal government has done nothing to contain them but instead encourages them through regulations that only enormous enterprises can comply with."

JANE ORIENT, M.D.
EXECUTIVE DIRECTOR
AAPS

PHOTO COURTESY LDJ LIBRARY/FLICKR.COM

Call for Informants

Khan's statement and her agency leave little doubt that a complaint submitted to the portal is the first step in a process that could lead to a full-scale investigation of the alleged anticompetitive practice.

"Complaints will undergo preliminary review by staff at the FTC and Justice Department, Antitrust Division," the FTC states. "If a complaint raises sufficient concern under the antitrust laws and is related to HHS authorities, it will be selected for further investigation by the appropriate agency. This action may lead to the opening of a formal investigation."

The DOJ Antitrust Division cites four federal statutes it says "ensure healthy competition." These include the Sherman Antitrust Act, "which prohibits certain agreements between companies that harm competition. It also prohibits companies from unlawfully gaining or maintaining monopoly power." The other statutes are the Clayton Act, which regulates mergers; the Federal Trade Commission Act, which bans unfair competition and deception; and the Robinson-Patman Act, which forbids price discrimination by sellers.

Examples of Complaints

The DOJ Antitrust Division gives examples of complaints it would be interested in reviewing. These include "consolidation, joint ventures, and 'roll-ups,'" the limitation of choice and fair wages to health care workers, collusion and or price fixing among competitors, the prevention of transparency, contracts that restrict competition, "anticompetitive" uses of health care data, and "Unnecessary Healthcare Provider Recertification or Accreditation Requirements."

Alerting its members to the opportunity for input into federal enforcement actions, the Arizona-based Association of American Physicians and Surgeons (AAPS) urged them to "expose the onerous, counterproductive, and harmful mandates and policies imposed by entities, like the American Board of Medical Specialties (ABMS), and their member boards, that control specialty board certification and recertification for physicians."

Anticompetitive Pandemic Actions

During the COVID-19 pandemic, doctors who questioned government-ordered lockdowns, school closures, mask and vaccine mandates, and suppression of readily available treatments such as ivermectin, were threatened with loss of certification in their medical specialty.

For example, renowned cardiologist Peter McCullough, M.D., was stripped of his medical credentials in 2022 after speaking out against policies imposed during the pandemic.

The FTC may have engaged in anticompetitive practices itself during the pandemic. On October 28, 2021, the FTC sued Xlear, a Utah-based company, for claiming its over-the-counter xylitol-based nasal sprays could help prevent and treat COVID-19.

The FTC has sought to stop the company from making such claims and has imposed monetary penalties on the company. Yet, in September 2023, nearly two years after the FTC's action, Xlear's attorney, Rob Housman, told *Health Care News*, "The FTC has produced no studies to rebut the studies Xlear has provided the government."

Government Favoritism

Government policies are behind much that stifles competition in the healthcare sector, says AAPS Executive Director Jane Orient, M.D.

"Anticompetitive practices are destroying American medicine," said Orient. "So far, the federal government has done nothing to contain them but instead encourages them through regulations that only enormous enterprises can comply with. It is trying to force people into managed care. It exempts big actors, such as pharmacy benefits managers, from anti-kickback laws that cripple small practices."

Enforcement of government policies is often delegated to unaccountable groups, says Orient.

"Supposedly private entities like specialties boards with quasi-government powers crush independent practitioners with demanding, costly requirements that do nothing to improve patient care," said Orient.

Numbers Over Consumers

The U.S. health care system needs a radical overhaul, and the Biden administration's antitrust policies are making the situation worse, says Jeff Stier, a senior fellow at the Consumer Choice Center.

"Short of a complete repeal of Obamacare, tort reform, and an end to the war against profitable, innovative pharmaceutical and medical devices companies, one of the few options to rein in health care costs is consolidation" of providers, said Stier. "Unfortunately, FTC chair Lina Khan has made it clear that she does not respect the longstanding antitrust litmus test: the consumer welfare standard."

Khan is focused on the size and number of competitors instead of how well a market serves consumers, says Stier.

"In practice, this means that rather than allowing a large but struggling company to be bought by a competitor and preserve customer choice, the Biden administration would rather see the [struggling] company shut down," said Stier.

"That's why Khan blocked the Jet Blue-Spirit Airlines merger, among others," said Stier. "If you want your future health care experiences to be as competitive as Spirit Airlines, you have got this Biden administration move to thank."

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

Washington State Voters Could Nix Long-Term Care Tax

Washington Governor Jay Inslee

PHOTO COURTESY GOV. JAY INSLEE/FLICKR.COM

Continued from page 1

Washington Gov. Jay Inslee (D) signed bills on March 15 that add portability to WA Cares, allowing employees to receive benefits out of state and continue their eligibility by making further payments to the program.

Initiative 2124, which will appear on the November ballot due to a petition effort, could drastically reduce payroll revenues by requiring individual employees be given a choice as to whether to join the program and pay the tax and allowing them to opt out at any time.

Leaders of the Democrat-controlled legislature announced in February they would take no legislative action to derail the ballot initiative, which is supported by Republicans, who say the tax is unpopular, unfair, uncertain, inadequate, and should be repealed.

Washington is the first state to implement a payroll tax for state-based long-term care. Other states are considering implementing similar programs.

"Unlike private insurance, which spreads price risk, social insurance does not price risk. If you want life insurance and you smoke, you pay a higher premium [in private plans]. Social insurance charges everyone the same. It punishes responsible behavior and rewards irresponsible behavior."

STEPHEN MOSES
PRESIDENT
CENTER FOR LONG-TERM CARE REFORM

'The Math Doesn't Work'

WA Cares promises total lifetime benefits that would cover less than three months in a Seattle-based nursing home at today's prices; in-home care now costs more than $7,100 per month.

Compared to current and projected LTC costs, the limited lifetime benefits promised by the Washington program are negligible, says Devon Herrick, a health care economist who is a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"Probably one of the biggest problems with the Washington Cares Act will be the political pressure to expand benefits to cover more situations than initially planned," said Herrick. "The average income worker paying in for 30 years will contribute $8,716 in withholding but be eligible for a maximum benefit of $36,500."

The payroll taxes collected for WA Cares are put in a trust fund that will begin paying benefits to certain employees, such as individuals near retirement, in 2026. Most workers will have to pay into the program for a decade before they are eligible, though the state says 35 percent of individuals requiring LTC are under 65 years of age.

"All the while, the state claims 70 percent of residents will need long-term care and benefits will be available in as little as 10 working years," said Herrick. "The math doesn't work."

Medicaid Is LTC for All

Most Americans rely on Medicaid for LTC. Less than 8 percent of Americans age 55 or older have LTC plans, *Insurance News* reports.

Qualifying for Medicaid is easy, says Stephen Moses, president of the Center for Long-Term Care Reform.

"That's the fundamental problem: we have everyone relying on Medicaid, and we end up with people needing long-term care, usually from old age, frailty, or cognitive impairment," said Moses. "Income can be virtually unlimited, because [the government] deducts your medical and long-term care from your income before determining your income, and assets are exempt."

Safety-net programs are on the verge of collapse, says Moses.

"We are approaching a perfect storm in the fourth decade of the current century when the Social Security and Medicare trust funds run out," said Moses. "Most importantly it's the beginning of the aging of the Baby Boom generation, who now need medical and long-term care at much faster and higher rates."

'Basically Ponzi Schemes'

"The easy way out, to most policymakers or politicians, is to just give people access to long-term care and to fund it through payroll deductions similar to Medicare and Social Security," said Moses.

These entitlement programs will become insolvent in the 2030s and are unlikely to exist in the future as they have in the past, says Moses.

"These big, payroll-funded, pay-as-you-go programs are basically Ponzi schemes," said Moses.

The claim that people are "dying broke" and are being "forced into long-term care" is a lie, says Moses.

"The vast majority of people who need catastrophic care qualify for Medicaid," said Moses. "In [Washington,] the state will just capture all the money."

'Punishes Responsible Behavior'

"It's just a shame that objective analysis of the real problem with long-term care is not carried out," said Moses. "Analysts, especially those on the left—and most of them are so-called progressives—will recount all the problems with long-term care, institutional bias, shortage of caregivers, excessive dependency on friends, family, and loved ones, but not one of them ever asks, 'How did we get into this mess?'"

Most LTC is government-financed, which discourages individual long-term planning, says Moses.

"Medicaid has the effect of discouraging responsible planning early in life when you have the chance to prepare by buying insurance or saving," said Moses. "These [government plans] exacerbate the problem and create a false sense of security. People have been totally irresponsible in how they represent [government-funded] LTC.

"Unlike private insurance, which spreads price risk, social insurance does not price risk," said Moses. "If you want life insurance and you smoke, you pay a higher premium [in private plans]. Social insurance charges everyone the same. It punishes responsible behavior and rewards irresponsible behavior."

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

Old Laws Can Force Children to Pay Parents' Medical Debts

By Ashley Bateman

A Pennsylvania state legislator is trying to amend the state's filial responsibility law, which currently compels adult children or family members to pay medical bills when a patient passes away or can't afford their long-term care.

State Rep. Kristine Howard (D-Malvern) introduced H.B. 2094, which would restrict corporate nursing homes' legal right to sue the children of patients for outstanding medical bills.

In enforcing that law, Pennsylvania's "outlier status is shameful," Howard wrote in a March memo.

"While [filial laws] have generally fallen out of favor elsewhere, Pennsylvania stands as the only state to have enforced its filial responsibility law in the past 25 years," Howard wrote. "Given that Pennsylvania nursing homes average a cost of nearly $400 per day, this can quickly lead to bankruptcies."

'Scarecrow' Laws Resurrected

Filial laws are modeled after the Elizabethan Poor Laws of 1601 in Britain, which obligated adult children to care for vulnerable parents to the best of their ability.

"Clearly, there is a societal good that comes from caring for one's parents in much the same way there is a good emanating from marriage and care for children," said Matt Dean, a senior fellow in health care policy at The Heartland Institute, which publishes *Health Care News*.

"The duty to care is imposed upon parents not just as a moral tradition and perceived virtue, but as a legal obligation, enforceable by the courts," said Dean. "Both parents are legally bound to care for their child until adulthood. The concept of reciprocity holds that the debt owed to parents for raising them from a baby is due to them when they, like the child they raised, become vulnerable and no longer able to care for themselves."

Today, filial laws enacted in approximately half the states are rarely used and exist mainly as "scarecrow" legislation to deter parents from transferring money to children to shield it from their financial obligations to a care facility, said Dean.

States' Revenue Quest

In 2012, in *Health Care & Retirement Corporation of America v. Pittas*, the Pennsylvania Superior Court ruled in favor of corporate nursing homes holding children accountable for their parents' unpaid bills.

Such laws could make a comeback in other states, says Stephen Moses, president of the Center for Long-Term Care Reform and a visiting fellow at the Paragon Health Institute.

"It could be that states will get so desperate, they may start using their filial responsibility rules to close [financial] gaps," said Moses. "As it is harder for state and federal governments to close their budgetary gaps, we may see more filial responsibility."

Long-Term-Care Tax

Some state governments use the concept of filial responsibility to promote imposing payroll taxes for state-run long-term care (LTC) plans.

"It becomes a way to sow discord and confusion and convince people to give up their personal freedom and compel them through the government to pay into a system," said Moses.

In November, Washington state voters will decide whether to repeal a mandatory payroll tax for LTC. (See related article, page 1.)

Entitlements Under Pressure

Medicaid has been a primary source of funding for LTC. Legal professionals counsel families on how to shelter assets to qualify for Medicaid. As state Medicaid budgets crack at the seams, states might turn to filial laws to help keep those programs afloat.

Medicare is also under a great deal of financial pressure, says Terry Nager, founder of Plan for America, a proposal to privatize entitlement programs.

"In about 10 years, the [government] trust funds [for Medicare] will be empty, but the reality is they are already empty," said Nager.

"The one thing we won't see as much of [in the future] is the government being able to borrow and spend and throw money at problems," said Moses. "We're already seeing the excessive government spending and consumers having to pay not through honest, upfront taxes but through inflation."

Middle-Income Burden

"When courts can decide who should pay, there is a hefty and unfair burden placed on the middle class," said Dean. "Wealthy families have the ability to shield income and wealth as well as pay for LTC with insurance or self-insurance.

"Low-income folks depend on Medicaid and rarely have the resources to pay, and what little they have is not worth the time of the legal folks at the state or the care center," said Dean. "Middle-income families, however, do pay at least a portion of the costs and can have assets attractive to their dead or indigent parent's bill collectors."

Surprise medical bills from nursing homes can be financially devastating, Dean said.

"The duty to care is imposed upon parents not just as a moral tradition and perceived virtue, but as a legal obligation, enforceable by the courts. Both parents are legally bound to care for their child until adulthood. The concept of reciprocity holds that the debt owed to parents for raising them from a baby is due to them when they, like the child they raised, become vulnerable and no longer able to care for themselves."

MATT DEAN
SENIOR FELLOW
THE HEARTLAND INSTITUTE

"While we all have an obligation to cover our expenses, including skilled-care expenses, the cost burden should not fall disproportionately on middle-income families trying to raise children of their own," Dean said.

Case for Privatization

Plan for America is a proposed contractual trust that would be created by the federal government and the states, into which individual payroll taxes and other earnings could be placed, guaranteeing lifetime health care and retirement income. The plan would reduce the need for filial laws.

According to the plan's authors, the trust could eliminate more than $100 trillion in estimated unfunded liabilities of the entitlement programs between 2059 and 2079.

"The ideal solution is a constitutional amendment, but that could take 30 years, so that's not practical," said Nager. "We believe the hybrid solution is a contract, among the federal government, the 50 states, and a trust, which we call the For America and Security Trust, representing the interest of the people."

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

States Using Tax Dollars to Pay Off Consumers' Medical Debt

By AnneMarie Schieber

Seventeen states are working on reducing or eliminating consumers' medical debt, according to reports.

The average medical debt owed by U.S. households was $18,660 in 2021, says David Kendall of Third Way, a center-left think tank.

"Unfortunately, having health insurance is no guarantee of financial protection," Kendall wrote in *Governing* magazine. "Two-thirds of adults under 65 with health coverage have problems paying off medical bills or medical debt."

States are partnering with third-party debt collectors to help pay off the unpaid medical bills.

Michigan is one of the most recent to jump on board. The state appropriated $4.5 million in its current budget to pay off about $450 million in consumer medical debt for 180,000 residents. Michigan is one of several states working with RIP Medical Debt, a nonprofit debt collection agency.

Other actions by states include capping the amount hospitals can collect from low-income patients and giving homestead exemptions for liens from medical debt.

"Medical-debt relief is merely government subsidizing high medical prices. It is yet another way that government, having intervened in countless ways to increase medical prices, then subsidizes the resulting harm rather than dealing with the root cause."

MICHAEL CANNON, DIRECTOR OF HEALTH POLICY STUDIES, CATO INSTITUTE

'Medical Debts Being Erased'

"These are the kind of public-private 'feel good' initiatives that are easy to praise, but deep down they don't do much more than provide good public relations for hospitals and local governments," said Devon Herrick, Ph.D., a health care economist who is a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"The medical debts being erased most likely have already been deemed uncollectible by the hospitals," said Herrick. "At that point, the local government likely pays less than 1 percent of the face value to erase the debt. It is better to work out a deal with the hospitals to erase the debt than for hospitals to sell the debt to private debt collectors who harass the debtors for years to come."

Phil Kerpen, president of American Commitment, agrees.

"These programs are buying bad debts that will never be paid, and for pennies on the dollar," said Kerpen. "The hospitals get some money when they would otherwise get nothing, and the debtors get to avoid stress and potential bankruptcy. The only losers are the taxpayers, who are forced to pay."

Subsidizes High Prices

The debt relief initiatives are another symptom of a dysfunctional health care system, says Michael Cannon, director of health policy studies at the Cato Institute.

"Medical-debt relief is merely government subsidizing high medical prices," said Cannon. "It is yet another way that government, having intervened in countless ways to increase medical prices, then subsidizes the resulting harm rather than dealing with the root cause."

Cannon and Herrick both say rising medical debt shows the need for real health care reform.

"If state and federal governments continue to block cost-reducing innovations and to subsidize high prices, health care will continue to grow more unaffordable," said Cannon.

"I could imagine an alternative scenario where it cost taxpayers nothing," said Herrick. "If hospitals were more eager to work with patients, patients themselves might be able to pay their debts if they were given a similar deal."

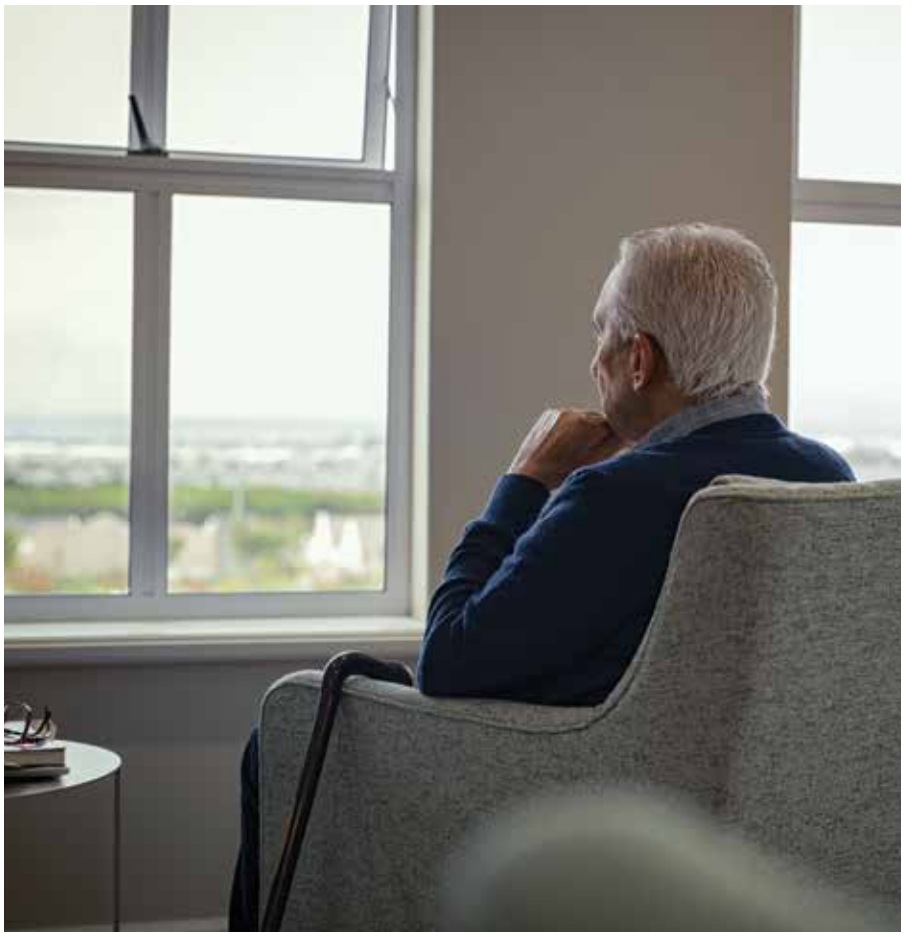
AnneMarie Schieber (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

Biden CMS Imposes 'Unachievable' Nursing Home Staffing Standards

By Bonner Russell Cohen

The Biden administration issued final rules setting minimum staffing levels and national waiting times for medical care in the nation's 15,000 nursing homes certified for Medicare and Medicaid long-term care.

The new regulations "fulfill President Biden's commitment to support family caregivers, boost compensation and job quality for care workers, expand and improve care options, and improve the safety and quality of care in federally-funded nursing homes," the Centers for Medicare and Medicaid Services (CMS) stated in a press release announcing the final rules on April 22.



"Not only will this drive up the cost of care and reduce the supply of nursing home beds, but residents want quality care, not 'hours.' Their family members want to know that their loved ones have needs met and are not needlessly having to have direct care staff checking a box because the government thinks they know better."

CHRIS JONES
VICE PRESIDENT FOR HEALTH CARE
CICERO INSTITUTE

Federal Standards, Secret Shoppers

The new rules bring significantly tighter federal management to the operation of nursing homes, which care for 1.2 million individuals daily, according to CMS figures.

Under the first-of-their-kind federal staffing requirements, every nursing home must have a registered nurse (RN) on site 24 hours a day, seven days a week, and provide residents with a minimum of 3.48 hours of nursing care per day, of which a little more than a half-hour must be from an RN.

Each facility must conduct a "stronger annual facility assessment of resources and support," including feedback from direct care workers, and develop a staffing plan to "maximize recruitment and retention."

In addition, "for the first time ever, states will be required to have national wait time appointment standards," the CMS press release says. "States will enforce the wait time standards by introducing 'secret shopper' surveys, which can help verify compliance with appointment wait time rules and correct provider directory inaccuracies. States will also be required for the first time to disclose provider payment rates publicly."

States will also be required to collect and report on what percentage of Medicaid payments are spent on staff compensation, and post the data publicly.

'We Don't Have the Nurses'

The Biden administration's call for increased staffing levels at nursing homes coincides with a growing shortage of nurses nationwide, according to a January 2024 report by the U.S. Chamber of Commerce.

"The United States is currently grappling with a nursing shortage that is causing a ripple effect of rising health care costs and lower quality of life across the country," the Chamber's report states. "By the year 2030, it is expected that 42 of the 50 states in the United States will experience shortages in nursing staff."

The nationwide nursing shortage played a prominent role at a March 21 hearing before the House Ways and Means Committee, at which Health and Human Services Secretary Xavier Becerra was forced to defend the administration's proposed nursing home rule.

"We don't have the nurses," Rep. Greg Murphy (R-NC), a practicing physician, told Becerra. "We have closed beds at my institution, at my medical center, because—guess what—we don't have the nurses."

Boosting Union Membership

The new rules are aimed at increasing union membership among nursing home employees, not improving quality, says Chris Jones, vice president for health care policy at the Texas-based Cicero Institute.

"The Biden administration is less interested in the well-being of nursing home residents and more interested in protecting a unionized workforce," said Jones. "The administration focuses on inputs, not resident satisfaction.

"Not only will this drive up the cost of care and reduce the supply of nursing home beds, but residents want quality care, not 'hours,'" said Jones. "Their family members want to know that their loved ones have needs met and are not needlessly having to have direct care staff checking a box because the government thinks they know better."

'This Is Unachievable'

CMS did not estimate the cost of the regulations to nursing homes, which will receive the same standard payments as before, says Jones.

"Finally, and most troubling, the administration did not even do the math to see that this is unachievable and will only drive the cost of health care up in skilled nursing, home- and community-based services, and general medical care," said Jones.

Biden has even more cost-increasing regulations in store for nursing homes, says Jones.

"As another example of the 'nanny state,' CMS/CDC [Centers for Disease Control and Prevention] just promulgated new rules to enhance barrier protections in skilled nursing facilities," said Jones. "It is clear this administration cannot do math or understand supply chains, much less the dignity of residents."

'Regulatory Knots'

The CMS rules do nothing to improve long-term care, says Stephen Moses, president of the Center for Long-Term Care Reform and a visiting fellow at the Paragon Health Institute.

"CMS demands Ritz-Carlton care at Motel 6 rates," said Moses. "Ever since [the Omnibus Budget Reconciliation Act of 1987] required nursing homes to hire more staff, provide better training, and improve quality, … without increasing reimbursement, the federal government has tried to get something for nothing from long-term care providers.

"Medicaid dominates long-term care financing, does too little to ensure quality care, and ties providers in regulatory knots," said Moses. "These new rules pretend to provide long-term care, but they are more about virtue signaling for political advantage than about genuinely beneficial reform."

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

COMMENTARY

Noncompete Ban Is Good for Health Care Though Legal Challenges Loom

By Devon Herrick

Noncompete agreements have always been common in high-tech industries with significant intellectual property. The FTC says it is increasingly alarmed that more employers are using noncompete agreements to restrain competition for workers who have no access to trade secrets.

The Federal Trade Commission's (FTC) announcement that it plans to ban noncompete agreements in all industries is a welcome relief to many professionals in health care.

Two physicians in my family relocated to small towns after they were recruited to join other practices. Both uprooted their families to move hundreds of miles away. Ultimately, neither move worked out.

One of the physicians was my uncle. Once settled into the new practice, my uncle's schedule was quickly inundated by Medicare patients. Many of his elderly patients had multiple chronic conditions requiring 30-minute or longer office visits to address their health problems.

My uncle soon realized he would have to work twice as many hours or accept an income only about half the norm for his level of training. He resigned from the practice and found a job a few miles away in a nearby town.

That was years ago, when noncompete agreements in health care were uncommon.

Loss of Independence

Nowadays, nearly three-quarters of physicians are hospital employees or employed by investor-owned group practices. Many are bound by employment agreements that limit their ability to leave a job for a new one.

An underappreciated problem with noncompete agreements between doctors and hospitals is the additional strain they place on the doctor/patient relationship.

Dr. Jacqui O'Kane had an experience similar to my uncle's. Dr. O'Kane took a job working for a hospital in a small Georgia town. Her patient roster quickly shot up to 3,000 patients, about the maximum a doctor can treat in a full-time practice without working overtime.

When physicians can no longer squeeze more patient exams into a workday, many close their practice to new patients. O'Kane's hospital employer would not allow that. The hospital wanted her to expand her office hours to work evenings and weekends if needed.

O'Kane wanted to quit, but she had signed a three-year contract that included a noncompete agreement. She was not allowed to work as a doctor within 50 miles for two years after the end of her contract.

Not Just Doctors

Doctors are not the only health care professionals who face noncompete agreements while working for hospitals. Hospitals often require nurses to sign training repayment agreement provisions (aptly called TRAPs) which lock nurses into jobs.

Nurses leaving within two years are expected to repay hospitals for training that amounts to little more than job orientation. These supposed training fees can reach $20,000.

The FTC's planned ban will apply to most employees other than senior executives. The U.S. Chamber of Commerce is suing to block the ban.

About 18 percent of the total U.S. workforce is covered by noncompete clauses, reports *Becker's Hospital Review*.

"The American Medical Association estimates that between 35% and 45% of physicians are bound by noncompete clauses," *Becker's* notes. "Existing noncompetes for most workers will no longer be enforceable once the rule takes effect, but there are exemptions."

Health Care Alarm Bell

Noncompete agreements have always been common in high-tech industries with significant intellectual property. The FTC says it is increasingly alarmed that more employers are using noncompete agreements to restrain competition for workers who have no access to trade secrets.

For instance, a cosmetologist working in a salon reported being asked to sign a noncompete agreement restricting her right to change jobs.

Nonprofit hospitals may not be under the FTC's authority and may still be able to compel nurses and doctors to sign noncompete agreements as a condition of employment, *Becker's* notes.

"Though the FTC recognized that it does not have jurisdiction over nonprofit entities, it reserved the right to evaluate an entity's nonprofit status, which would include a significant portion of the 6,120 hospitals in the U.S.," *Becker's* reports.

"Specifically, the agency said that 'some portion of the 58% of hospitals that claim tax-exempt status as nonprofits and the 19% of hospitals that are identified as state or local government hospitals in the data cited by [the American Hospital Association] likely fall under the commission's jurisdiction and the final rule's purview.'"

The FTC decision came down to a 3-2 approval for a ban and is expected to result in lawsuits that may take years to resolve.

Devin Herrick, Ph.D. (**devonherrick@sbcglobal.net**) *is a health care economist. An earlier version of this article was published on the Goodman Institute Health Blog. Reprinted with permission.*

FTC Ban on Noncompetes Seen as a Plus for Doctors, Patients

By Kevin Stone

The Federal Trade Commission (FTC) announced a nationwide ban on non-competition agreements (NCA) that limit employee mobility, effective September 4.

NCAs prevent physicians, nurses, and therapists employed by large health care providers and hospitals from moving to a competitor or establishing independent practices in the same market. FTC Chair Lina M. Khan said in an April 23 press release the new rule seeks to protect a fundamental right of employee mobility.

"By design, noncompetes often close off a worker's most natural alternative employment options: jobs in the same geographic area and professional field," said Khan. "These restrictions can undermine core economic liberties, burdening Americans' ability to freely switch jobs."

The press release also states employers retain viable alternatives to NCAs.

"The Commission found that employers have several alternatives to noncompetes that still enable firms to protect their investments without having to enforce a noncompete," the release said. "Trade secret laws and non-disclosure agreements (NDAs) both provide employers with well-established means to protect proprietary and other sensitive information. Researchers estimate that over 95% of workers with a noncompete already have an NDA."

"The legal profession essentially bans noncompete clauses for lawyers, recognizing that the lawyer/client relationship outweighs the business interests of the law firm. However, in health care, noncompetes are widely abused to handcuff key personnel, especially doctors, into employment simply because they are valuable or difficult to replace."

ADAM HABIG
PRESIDENT AND COFOUNDER, FREEDOM HEALTHWORKS

Medical Industry Impact

The FTC press release says the new rule is expected to lower health care costs by up to $194 billion over the next decade by increasing competition throughout the industry.

Adam Habig, president and cofounder of Freedom Healthworks, says the new rule will be a boon to doctors and patients.

"There is a clear benefit to the rule, especially with regard to doctors," said Habig. "Innovative practice models are emerging, but many doctors find themselves locked into hospital employment by a noncompete clause, contributing to record levels of physician burnout and stifling [of] consumer choice.

"Eliminating noncompetes and restoring doctors' professional mobility should accelerate innovation in healthcare delivery, leading to falling prices and increased access," said Habig. "Does anyone believe the prevailing health-care system delivers good value? Americans deserve an array of better options, which are only possible if doctors are free to innovate."

Patients' Interests

The end of NCAs in health care will benefit patients, says Marcelo Hochman, M.D., president of IndeDocs.

"I very much welcome the FTC's recent rule announcement regarding noncompete agreements specifically as it relates to health care," Hochman said. "This contractual arrangement between the doctor and the practice they are exiting fails to consider the impact on a critical third party: the patients."

Hochman attempted to get NCAs for physicians banned in his home state of South Carolina.

"The geographic restrictions of medical NCAs result in hardships for patients which can make it impossible for them to continue receiving care from their chosen physician," said Hochman. "Not only does this cause injury to the doctor and also to a potentially uprooted patient whose rights are abridged, it also deprives the public of services and choices in health-care matters. These all constitute more than a mere 'contractual' problem: it is unethical."

Legal Challenges

Ryan LLC, a Dallas-based tax service, the U.S. Chamber of Commerce, and other business groups filed lawsuits in federal courts to block the FTC rule, saying the commission exceeded its legal authority.

"The FTC's ban on noncompete agreements is another attempt at aggressive regulatory proliferation, said the chamber, in a statement. "That's why we're suing the FTC to block this unnecessary and unlawful rule and put other agencies on notice that such overreach will not go unchecked."

"Since its inception over 100 years ago, the FTC has never been granted the constitutional and statutory authority to write its own competition rules. This decision sets a dangerous precedent for government micromanagement of business."

The chamber joined the Ryan lawsuit in the U.S. District Court for the Northern District of Texas, in May. Legal challenges could result in delay or modification of the rule, says Habig.

"Confronted with a potentially seismic shift in regulation, especially in an election year, I expect the courts to pump the brakes," said Habig. "Although abuse is rampant, noncompete clauses do have a legitimate purpose when used properly. The 'goldilocks' solution is somewhere between the status quo and a blanket noncompete ban: ending the widespread abuse while permitting legitimate usage."

Legal Precedent

If the general application of the FTC rule to all employment contracts is struck down by the judiciary, an exception could be carved out for health care practitioners, says Habig.

"With respect to treating the healthcare industry different from businesses at large, there's a clear precedent in the legal profession," said Habig. "Both involve highly personal relationships—lawyer/client vs. doctor/patient—and professional services delivered confidentially to customers.

"The legal profession essentially bans noncompete clauses for lawyers, recognizing that the lawyer/client relationship outweighs the business interests of the law firm," said Habig. "However, in health care, noncompetes are widely abused to handcuff key personnel, especially doctors, into employment simply because they are valuable or difficult to replace."

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

DEA to Reclassify Marijuana as Less Dangerous

By AnneMarie Schieber

The Biden administration intends to reclassify marijuana as a less dangerous drug with fewer restrictions on its use under the 1970 Controlled Substances Act.

The Drug and Enforcement Administration (DEA) on April 30 recommended the White House change the status of marijuana from Schedule I to Schedule III, the Associated Press reported.

President Joe Biden directed the U.S. Department of Health and Human Services (HHS) to review the classification of cannabis in 2022. HHS recommended switching marijuana to a Schedule III drug, which is defined as having "a moderate to low potential for physical and psychological dependence."

The proposed reclassification would move marijuana from the same category as heroin to the same list as ketamine and some anabolic steroids. After the reclassification is reviewed by the White House Office of Management and Budget, it must undergo a public comment period.

"It will still be federally illegal to buy, sell, or use marijuana for recreational purposes in the U.S. I don't need a prescription to buy my recreational drug of choice, bourbon, from my local liquor store. And alcohol has a 'high potential for abuse' and is much more physically harmful than marijuana."

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

Not 'for Recreational Purposes'

The reclassification "changes nothing," says Jeffrey Singer, M.D., a surgeon and senior fellow at the Cato Institute.

"It will still be federally illegal to buy, sell, or use marijuana for recreational purposes in the U.S.," said Singer. "I don't need a prescription to buy my recreational drug of choice, bourbon, from my local liquor store. And alcohol has a 'high potential for abuse' and is much more physically harmful than marijuana."

'Cannabis Has Medicinal Uses'

The downgrade will benefit patients and taxpayers, says Singer.

"The good news is that the federal cops practicing medicine—the DEA—finally recognize that cannabis has medicinal uses," Singer wrote in a blog post on the DEA decision. "Rescheduling should make it easier for patients to obtain the drug with a prescription in the states that have not yet legalized medicinal cannabis."

Though 38 states and the District of Columbia have legalized medicinal cannabis, research on the drug has been limited by its Schedule I status, says Singer.

"It will also make it easier for researchers to perform high-quality studies on the plant's medicinal uses," wrote Singer. "And it will make it easier for cannabis retailers to take federal tax deductions from which the law has barred them."

Bad Move, Say Congressmen

Downgrading marijuana to a Schedule III drug is a cause for alarm, argued Rep. Pete Sessions (R-TX) in a bicameral letter last year urging the DEA not to change the marijuana classification. Sessions also led a bipartisan, bicameral letter this year signed by 49 lawmakers to Attorney General Merrick Garland on illicit marijuana operations linked to drug cartels and China.

We don't know enough about the dangers of marijuana, particularly with the concentrations of tetrahydrocannabinol (THC) in cannabis today, says Sessions.

"Marijuana with high levels of THC is not only more addictive, but also more dangerous, especially for children and young adults," said Sessions in a May 1 news release. "The rescheduling of marijuana will lead to more illicit marijuana farms to produce dangerous strains of marijuana that will be then sold to children and adults alike throughout the United States."

Sessions says the proposed reclassification ignores science and public safety.

"The Centers for Disease Control (CDC) has linked marijuana use to thoughts or feelings of anxiety and paranoia and higher THC levels make it more likely to develop temporary psychosis and long-lasting mental disorders, including schizophrenia, suicidal thoughts, suicidal attempts, and suicide," said Sessions.

Promises vs. Reality

"I actually understood the initial libertarian reasoning for legalizing many currently illegal drugs," said Chad Savage, M.D., founder of YourChoice Direct Care and president of DPC Action.

"Their general contention was that people were going to use them regardless of their legality, [and] by legalizing them we would minimize excess incarceration and reduce the violent and dangerous drug trade, thus making our borders and streets safer," said Savage. "By making them legal, we could ensure the purity of what was being used and minimize other toxins from being incorporated and use the tax receipts to fund treatment and public outreach programs with the intention of actually decreasing use."

The experience after years of legalization has been different, says Savage.

"The tax receipts have largely not gone to prevention or treatment programs as promised, and what has been accomplished is the destigmatization and easing of access to these mind-altering substances and the deleterious effects they have had on the youth who predominantly engage in recreational use," said Savage.

Not for Kids

Singer says many of the arguments Sessions makes against reclassification are based on poorly performed studies that are "observational and correlative."

"In other words, it is bad science, like a lot of the 'science' that influenced COVID policy," said Singer. "And making the drug Schedule III means it still requires a doctor's prescription. By what logic does Rep. Sessions conclude that this will lead to more children using marijuana? You need a prescription for Ambien—does this mean kids are getting access to Ambien?

"Nobody is calling for legalizing marijuana for kids—just like we don't advocate the legalization of tobacco or alcohol for kids," said Singer. "Legalizing the drugs makes it more difficult for kids to obtain them from retailers than leaving them to the black market to provide them."

It is clear more studies on the effects of marijuana are needed before making any changes, says Savage.

"I personally would call for a nonpartisan, thorough review of all states that have legalized marijuana and compare pre- and post-legalization outcomes related to marijuana," said Savage.

"I think it would be irresponsible to expand access until we better know if doing so is unsafe," said Savage.

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

Harvard Psychiatrist Advocates Allowing OTC Sale of Antidepressants

By Harry Painter

Psychiatrist and Harvard Medical School professor Roy Perlis, M.D., argues for changing the status of some antidepressants from prescription to over-the-counter (OTC), in a commentary published by *Stat News*.

Like the OTC oral contraceptive Opill, selective serotonin reuptake inhibitors (SSRIs) such as Prozac and Zoloft are safe and meet a "massive public health need," thereby justifying Food and Drug Administration (FDA) approval of OTC status, Perlis argues.

Perlis says access to psychiatrists is "extremely limited" in many states, despite high levels of anxiety and depression among the population.

"We Americans have developed a taste for pharmaceutical quick fixes. While SSRIs have been around for years and have been found safe when appropriately prescribed, leaving the decision to use mind-altering drugs up to the patient could be disastrous."

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

GPs Prescribing

Perlis, a researcher at Massachusetts General Hospital in Boston, says antidepressants are overwhelmingly prescribed by non-psychiatrists, especially general practitioners.

Nonprescription medications must meet three FDA criteria, writes Perlis: "they can be used for self-diagnosed conditions; there's no need for a clinician's involvement to be used safely; and they have a low potential for misuse and abuse."

Perlis writes that OTC antidepressants are "not a panacea" but can provide a "safe, effective, and inexpensive treatment for many who need it."

Bar Will Be High

In his commentary, Perlis advocates setting an age limit on who can purchase OTC SSRIs, requiring younger customers to talk with a pharmacist.

SSRIs have been used for three decades in the United States and "have a record of safety and effectiveness for treating depression and anxiety," said health economist Devon Herrick, who writes for the Goodman Institute Health Blog.

However, Herrick says, "the FDA has a high bar" for approving the change from prescription to OTC. "Meeting the FDA's criteria is all or nothing," said Herrick.

Regulatory Hurdles

In addition to meeting strict FDA conditions, there are other roadblocks, says Herrick.

"Manufacturers must apply to switch their approved prescription drug to OTC," said Herrick. "The application process is long and drawn-out. The manufacturer must include studies proving it's possible for patients to self-diagnose and self-medicate their condition with the drug under consideration. Regulations also require manufacturers to include self-medicating information on the drug label."

Manufacturers also must persuade two separate FDA panels, a tall order since no SSRI has been approved for OTC sale.

Faster Access, Lower Costs

"Millions of Americans would benefit from easier access to SSRIs," said Herrick.

It will take an SSRI manufacturer with "the courage to engage with the FDA and invest the necessary resources" to get approval, writes Perlis. Other drugs have been taken down this path, including medicines for allergies, acid reflux, and emergency contraception ("Plan B" pills), Perlis writes.

Gregg Girvan, a research fellow at the Foundation for Research on Equal Opportunity, says the FDA should reduce barriers whenever possible.

"A big reason prescription drugs are so expensive in the United States is because our regulatory system drives up the cost of R&D," said Girvan. "Granted, SSRIs have been available as generics for a long time, so a switch to OTC will likely deliver modest savings for the drugs themselves."

There are, however, other benefits to expansion of access, says Girvan.

"The real upside of delivering SSRIs over the counter is twofold: first, patients save time and money since they no longer have to schedule appointments with a psychiatrist, and second, patients get access to treatment much faster," said Girvan.

Safety Questions

A drug could be safe in one context and dangerous in another, says Marilyn M. Singleton, M.D., J.D., a board-certified anesthesiologist and senior fellow at Do No Harm.

"We Americans have developed a taste for pharmaceutical quick fixes," said Singleton. "While SSRIs have been around for years and have been found safe when appropriately prescribed, leaving the decision to use mind-altering drugs up to the patient could be disastrous. We just have to look at the fentanyl crisis. Fentanyl in the right hands and the right circumstances is safe."

A major downside of SSRIs is their association with violent behavior, with some people blaming the drugs for mass shootings and murder-suicides.

Singleton says just as fentanyl can be safe, even something as commonplace as Tylenol can be unsafe.

"Any drug can be unsafe when not used properly," said Singleton. "Even acetaminophen can cause liver problems in higher, chronic doses."

Calls for Additional Reforms

Additional steps are needed to address the mental health crisis, says Girvan.

"The access issue can be addressed in part by solving our physician shortage," said Girvan. "We should reform our immigration laws to allow for a greater number of highly trained foreign doctors to practice here, reform scope-of-practice laws, and expand medical school and residency slots."

Singleton says improving patients' access to physicians is important.

"Expansion of telehealth would appeal to many patients, particularly those in rural areas," said Singleton. "Perhaps starting urgent care centers with mental health counselors available at convenient hours [would help]. We have to deal with the shortage of mental health professionals by making it an attractive career choice with reasonable payment for their skills."

Costly Paperwork

Psychiatrist Robert Emmons, M.D., offers another policy solution.

"At the top of my list would be abolishing Prescription Drug Monitoring Programs, which bring requirements that chew up time for patients, doctors, and pharmacies," said Emmons. "Medical board officials and experts in the field have already admitted years ago that 'doctor shopping' is a very small part of the problem of substance use disorders and misuse of prescription drugs."

Emmons says reducing red tape would improve care.

"Any policy intervention that reduces the time spent by doctors on documentation will improve access to care in all medical specialties," said Emmons. "I suppose that's why we're talking about OTC antidepressants, because for some reason that kind of policy change seems easier to get through than reductions in documentation."

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

VA Now Covering IVF for Gay Couples, Unmarried Vets

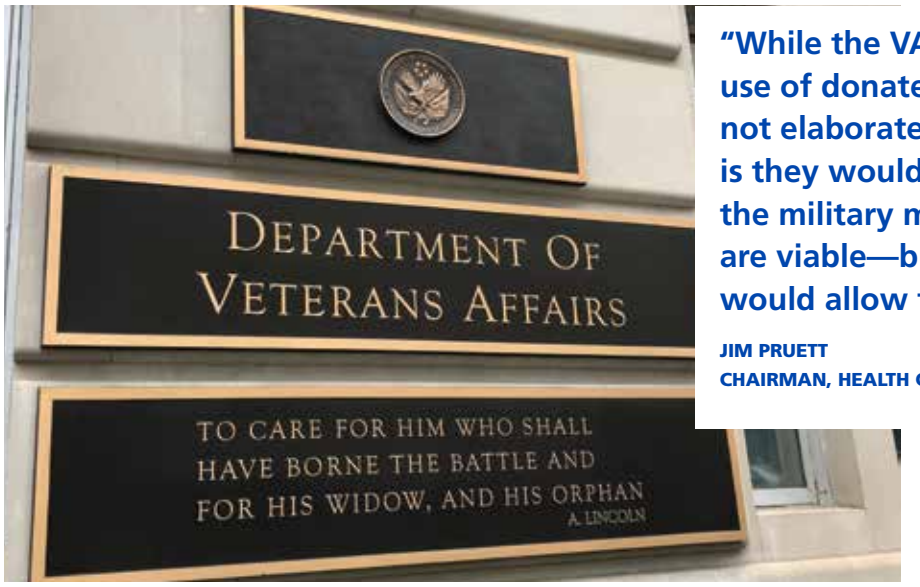
By Kenneth Artz

The U.S. Department of Veterans Affairs (VA) is expanding its coverage of in vitro fertilization (IVF) for service-connected infertility to include same-sex couples and unmarried vets.

The VA previously covered IVF only if the veteran was married and would have been able to conceive naturally if not for an injury or health condition resulting from military service.

The policy change requires the VA to cover IVF using donated ova, sperm, or embryos if the service member is unable to conceive.

IVF, also called assisted reproductive technology, can cost $30,000 or more for a single treatment. The procedure often leads to the destruction of human embryos, which many taxpayers find objectionable.



"While the VA's expansion does allow for use of donated sperm and ovum, it does not elaborate beyond that. My guess is they would use the ovum/sperm of the military member and spouse if they are viable—but if they aren't, then they would allow for donated sperm/ovum."

JIM PRUETT
CHAIRMAN, HEALTH COMMITTEE FOR VFW POST 7103

'Has Not Been Fully Vetted'

Sen. Patty Murray (D-WA), a former chair of the Senate Veterans Affairs Committee, introduced the Veteran Families Health Services Act in 2023. Murray's bill would "permanently authorize fertility treatment to more veterans and ensure that spouses, 'partners,' and gestational surrogates are included in the eligibility rules," ABC News reported.

Sen. James Lankford (R-OK) says he opposes Murray's bill for its expansion of services and lack of a cost estimate.

"So all of these issues, I look at and say this has not been fully vetted through what this actually is, and what it actually does, nor the cost of it," ABC News reported Lankford as saying on the Senate floor.

'Potential for Abuse'

The VA's policy is vague and raises eligibility questions, says Jim Pruett, chairman of the health committee for VFW Post 7103 in Athens, Texas.

"While the VA's expansion does allow for use of donated sperm and ovum, it does not elaborate beyond that," said Pruett. "My guess is they would use the ovum/sperm of the military member and spouse if they are viable—but if they aren't, then they would allow for donated sperm/ovum. I would assume there could be potential for abuse but cannot find enough info to ascertain what safeguards the VA will have in place to monitor and control that aspect."

'It's Not Health Care'

Like cosmetic surgery, IVF is not health care, says John C. Goodman, Ph.D., co-publisher of *Health Care News* and president of the Goodman Institute for Public Policy Research.

"It is not a medical condition that arises through an unpredictable event," said Goodman. "It is a choice people make in pursuit of goals of their own choosing."

There is nothing wrong with those goals or the procedures, says Goodman, but there is no reason why other people should be forced to bear the costs.

Any complicated, expensive medical care like IVF is likely to be contracted out by the VA, says John Dale Dunn, M.D., J.D., a physician and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"That's common; the VA doesn't have in-house specialty capability for some things," said Dunn.

'Committed, True-Believer Marxists'

The VA has been highjacked and will continue to modify its benefits package to include promoting sexual deviancy and family breakdown, says Dunn.

"That is the explanation for what has happened," said Dunn. "The next step in this logical progression is VA therapies catering to the many paraphilias—and there are a bunch of them."

Dunn says a push for continual expansion of what is considered acceptable has been at the forefront of Marxist-socialist agitation designed to break down the institution of the family and overall morality to make it easier for government to control people.

"The people who run the VA are advocates of this nihilist ideology that is the essence of Marxism," Dunn said. "They have been indoctrinated and are committed, true-believer Marxists."

'Service-Related Conditions—Period'

The VA has been widely criticized for long wait times for treatment at its hospitals and clinics, as a reader commented in an article on the VA's new IVF policy on the *CV News Feed*.

"I do not understand why the VA would provide this care at all, or any pregnancy care," wrote the reader. "VA services should be for service-related conditions—period. All other care should be sent to the community. Since it takes 6-9 months to assess a VA claim, continuing care for pregnancy is rarely service connected. Maybe if VA focused on actual veteran medical issues the care would improve."

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

Are New Cases of Measles Causing Undue Concern?

By Kenneth Artz

Outbreaks of measles and other diseases are causing alarm in the media and public health circles, though health officials disagree on the causes and the risks for the general population.

Washington Post columnist Leana Wen, M.D., a former Baltimore Health Commissioner and president of Planned Parenthood, criticized Florida Surgeon General Joseph Ladapo for his calm response to the "burgeoning measles outbreak" early this year in South Florida.

"Florida surgeon general Joseph A. Ladapo has done the unthinkable," Wen wrote. "He told parents they could defy health guidance and continue sending unvaccinated kids exposed to measles to school."

Twenty-nine of the 338 new cases of measles reported from 2020 to 2024 occurred in the first quarter of this year, according to the Centers for Disease Control and Prevention (CDC). That is slightly below the average number of cases for the previous four years.

The recent uptick in cases is putting renewed focus on compulsory measles vaccines. Critics of public health agencies say the concern is nothing but fearmongering and completely wiping out measles is unrealistic.

"The source of the outbreaks appears to be from unvaccinated or under-vaccinated individuals who have traveled overseas, but also migrants who have recently come into the country. Chicago is experiencing a measles outbreak, and the cramped migrant centers appear to be a major reason."

MERRILL MATTHEWS
RESIDENT SCHOLAR, INSTITUTE FOR POLICY INNOVATION

'Vaccine Is Not Great'

Measles shots are typically given in combination with inoculations for mumps and rubella (MMR). Parents should be aware of the possible serious adverse effects from the vaccines, as research has not ruled out brain damage and autism from the inoculation, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"It's possible that the rubella component, especially in combination, might be responsible," said Orient. "Single antigen measles [vaccination] has not been tested against MMR and is no longer available. Mumps [vaccine] doesn't work well, so why insist on the MMR combo?"

Most people recover from measles with lifetime immunity, though the disease can be serious for some, says Orient.

"One unfortunate consequence of mass vaccination is to shift incidence from school-age youngsters to age groups who do less well: infants and adults," said Orient. "Measles is treatable with vitamin A and vitamin C. The vaccine is not great: it doesn't always work, and patients get atypical measles. It wears off. Most transmission may come from vaccinated but no longer immune adults."

Unlikely to Be Eradicated

It is unlikely measles will ever be eradicated, says Orient.

"Can you name a single disease that has been eradicated, other than smallpox, which took 100 years, and might have been eradicated by intense public health measures, and disappeared for centuries at various times for no known reason?" said Orient.

"Most measles is now imported from visitors, and from the millions crossing our borders illegally—who also bring worse things like tuberculosis," said Orient.

Border Problem

Migration and travel are spreading diseases from other countries, says Merrill Matthews, a resident scholar with the Institute for Policy Innovation.

"The source of the outbreaks appears to be from unvaccinated or under-vaccinated individuals who have traveled overseas, but also migrants who have recently come into the country," said Matthews. "Chicago is experiencing a measles outbreak, and the cramped migrant centers appear to be a major reason."

The open U.S. border contributes to outbreaks of exotic diseases, says Matthews.

"Many of the home countries of the migrants crossing the border have very poor health systems, and many children likely lack the basic vaccination regimen," said Matthews. "So as long as the border is wide open, it's entirely possible that we will see sporadic outbreaks of various diseases we have largely eradicated in the United States."

Vaccine Skepticism

Matthews says he's generally supportive of the long-established vaccines, including for measles, that states require children to have when they enter public schools. The questionable performance of the COVID-19 shots has spurred some public skepticism toward other vaccines as well.

"All states provide exemptions for religious and medical reasons, which is appropriate," said Matthews. "However, the CDC recently reported that vaccine exemption rates are the highest on record: down from 95 percent vaccinated pre-pandemic to 93 percent. When you get below 95 percent on measles, you start getting outbreaks, and we've seen them in Philadelphia, Chicago, Florida, and other places."

Risk Aversion

The current measles concerns are based on an unrealistic view of risk, says John Dale Dunn, M.D., J.D., a physician and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"They're marching around, saying, 'We've got to do more things to be safe,'" said Dunn. "Here's what they suffer from: it's called the precautionary principle. It's the thing that guides the thinking of children. Of babies. Particularly of nannies.

"In fact, the nanny state is built on the precautionary principle, and it's not a good approach to risk, because it tolerates no risk," said Dunn. "In other words, if there are more cases of measles, then we have to have another mass vaccination program."

Public policy should be based on a dispassionate comparison of risks and benefits, says Dunn.

"What these people are saying is, 'Well, the hell with that; you've got to do everything you can, and it has to be done now because this is a risk and we can't tolerate it,'" said Dunn.

"People who can't tolerate risk are not adults," said Dunn. "They are still children looking for a perfect world where there are no risks."

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

Michigan Family Succeeds in Stopping Unwanted Organ Donation

By AnneMarie Schieber

A Michigan state judge halted the harvesting of organs from a patient declared "brain dead" who had reportedly said she changed her mind about the decision.

The family of 30-year-old Jaszmine Philips went to court to prevent Gift of Life Michigan, the organ procurement agency working with Trinity Health in Muskegon, Michigan, from harvesting her organs.

Philips suffered from type-1 diabetes and showed no brain activity when she was admitted to the hospital, according to news reports. Philips' driver's license indicated she was an organ donor, but her family said she reversed her decision and indicated that multiple times.

Organ donors must be kept alive for hospitals to remove vital organs, such as the heart, lungs, liver, and kidneys, to give to others.

"Most people do not understand that an organ donor registration is legally binding and irrevocable after the donor's death," said Heidi Klessig, M.D., cofounder of respectforhumanlife.org. "Family members, guardians, and health care surrogates are being left helpless."

Court Intervenes

Philips' family requested a temporary restraining order against the organ procurement. Gift of Life argued the Revised Uniform Anatomical Gift Law states only a donor can revoke an agreement to donate organs and the revocation must be clear and objective.

Muskegon County Probate Judge Kenneth Hoopes sided with the family. Philips died on February 25.

"Organ procurement organizations are becoming even more aggressive and are suing families for possession of their loved ones' organs," said Klessig.

"Jaszmine Philips' story is like many others: people are not being given the information they need to give fully informed consent when signing a donor card, and it's even worse when you consider that many of these decisions are being made by minors, sixteen-year-olds who are getting their first driver's license," said Klessig.

Ohio Family's Request Denied

In 2013 in Ohio, in a case similar to Philips', the family was unable to stop a forced organ donation. According to the *Columbus Dispatch*, Ohio law prohibits anyone other than the donor from revoking a donation decision.

"It is extremely unjust that people are being asked to make what may be the most important medical decision of their lives at the [Department of Motor Vehicles] while being denied information about the medical and legal facts involved," said Klessig.

Driver's licenses are not the only place where people are asked to decide on being an organ donor. Gov. Gretchen Whitmer of Michigan signed legislation in 2023 allowing state taxpayers to check a box on their tax return to authorize organ donations.

Drivers' licenses are still the most common recruitment tool for live organ donation, and state websites like the one in Michigan give little to no information on the procurement process for someone declared brain dead.

Dignity of Dying Naturally

Right to Life of Michigan (RLM) has not taken a position on the individual's "autonomous choice to donate their organs," says Genevieve Marnon, the organization's legislative director.

"But RLM absolutely supports and defends the right of any person to live out their natural life and die a natural death free of any form of hastened death," said Marnon. "Michigan's Determination of Death Act, which was passed in 1992, was an attempt to provide patient protections from individual health care providers' or facilities' differing criteria for determining brain death. Unfortunately, brain death determinations have led to situations whereby the families have gone to court to prevent the withdrawing of life-sustaining treatment for their loved ones."

Marnon says there have been cases in Michigan where families seeking to keep their loved ones on life support ended up in court and lost.

"Though organ donation can save lives, it is unjust to sacrifice the life of one patient to save another," said Marnon. "All persons deserve proper time for their conditions to be monitored and, if recovery is not possible, the dignity of dying a natural death and then having their organs donated if that was their desire or the desire of their patient advocate or family."

"Patients may be very ill, and their prognosis may be death, but it is wrong to treat them as dead and plunder them for their organs while they are still sick and helpless. Doctors, scientists, scholars, and philosophers have been vigorously debating the veracity of 'brain death' for the last 60 years, but the public has been kept in the dark and fed propagandistic slogans such as 'give the gift of life.'"

HEIDI KLESSIG, M.D.
COFOUNDER
RESPECTFORHUMANLIFE.ORG

'Brain Death Fallacy'

Klessig, a retired anesthesiologist, now devotes her time to informing patients about "brain death" and published a book on the subject, *The Brain Death Fallacy*.

"'Brain dead' patients show every sign of life: their hearts beat, their cellular respiration continues, they digest food and excrete waste, they heal wounds, they can even deliver healthy babies," said Klessig.

"Patients may be very ill, and their prognosis may be death, but it is wrong to treat them as dead and plunder them for their organs while they are still sick and helpless," said Klessig. "Doctors, scientists, scholars, and philosophers have been vigorously debating the veracity of 'brain death' for the last 60 years, but the public has been kept in the dark and fed propagandistic slogans such as 'give the gift of life.'"

Organ transplantation is a growing industry. The consulting firm Milliman says the average billed charge for a heart transplant in 2020 was $1,664,800, for lung transplants $1,295,900, and for transplants of intestinal organs $1,240,700.

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

Congress Considers Prohibiting DEI at Medical Schools

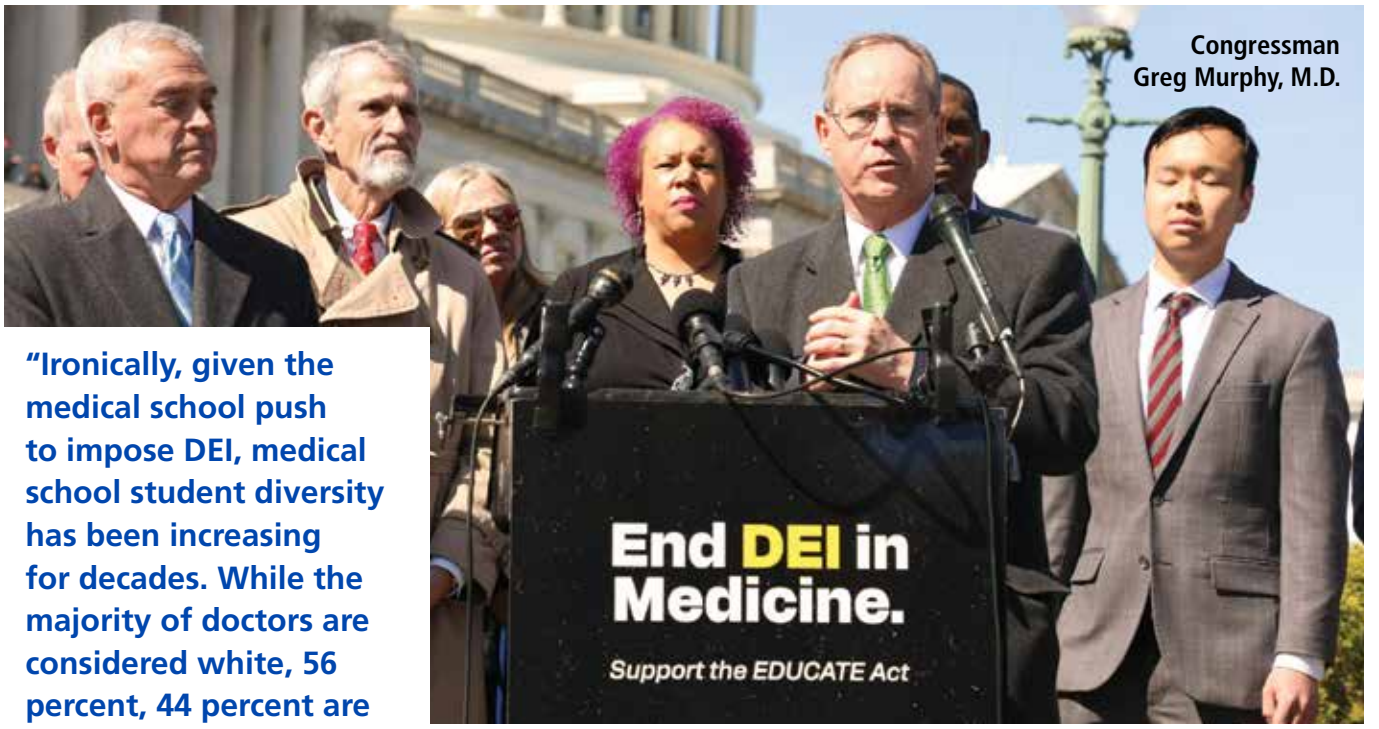
By Harry Painter

Legislation to ban race-based mandates in medical schools has been introduced in both houses of Congress.

U.S. Rep. Greg Murphy, M.D. (R-NC) and Sen. John Kennedy (R-LA) introduced identical versions of the Embracing Anti-Discrimination, Unbiased Curricula, and Advancing Truth in Education (EDUCATE) Act (H.R. 7725/S. 4115) in the House of Representatives and Senate, on March 19 and April 11, respectively.

The legislation would cut off federal funds, including student loans, to any medical schools that "force students or faculty to adopt specific beliefs, discriminate based on race or ethnicity, or have diversity, equity, and inclusion (DEI) offices or any functional equivalent," states Murphy's press release on the bill.

The EDUCATE Act would stem the "dangerous" DEI ideology in medical schools, Murphy and Stanley Goldfarb, M.D., chairman of the nonprofit policy organization Do No Harm and former associate dean at the University of Pennsylvania medical school, wrote in *The Wall Street Journal*.



Congressman Greg Murphy, M.D.

PHOTO COURTESY CONGRESSMAN GREG MURPHY, M.D./X.COM

"Ironically, given the medical school push to impose DEI, medical school student diversity has been increasing for decades. While the majority of doctors are considered white, 56 percent, 44 percent are minorities or unknown. Asians, who have been the subject of racist attacks, make up the second largest group, 17 percent. Importantly, women comprise the majority of first-year medical school students. In other words, things are changing."

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

Calls DEI 'Un-American'

There is "no valid scientific basis" for implementing DEI in health care, Goldfarb told *Health Care News*.

"In the past, medical schools provided education on patient communication, some of the social issues involved in health care, and resources available to patients that have difficulty in getting transport to the hospital or outpatient visits or other issues related to either frailty or to poverty," said Goldfarb. "This sufficed to prepare students to enter clinical practice."

DEI standards assume medical providers should mirror the characteristics of their patients, says Goldfarb.

"The fact that the country has had changing demographic characteristics does not require perfect representation of those demographic characteristics in the health care workforce," said Goldfarb. "Moreover, to try to match patients and physicians based on race or ethnicity is not only impossible but un-American."

Racism in Health Care?

While proponents of DEI argue color-blind policies overlook racism in society, Goldfarb says that claim is unfounded.

"There simply is no valid evidence that racism or prejudicial treatment is playing any role in health care outcomes," said Goldfarb. "DEI advocates ignore the complexity of the issue, attributing it all to bias on the part of white physicians."

It is "facile" to attribute health care disparities to racism, says Goldfarb, because that ignores many other causes of health problems, such as "health care access, health literacy, personal and cultural behavioral characteristics, and even genetic factors."

Advocates Merit Standard

"DEI is the tool of identity politics," said Goldfarb. His organization, Do No Harm, fights identity politics in health care, particularly the ideology of anti-racism.

"We need look no further than the outburst of anti-Semitism to see what happens when we start treating people as members of a group and not as individuals with their own characteristics, needs, and health care problems," said Goldfarb.

"It is certainly true that if one injects immutable characteristics like skin color or ethnic background into the formula for choosing America's health care workforce, there must be a sacrifice in the quality of those individuals who become the physicians, nurses, and other health care workers of the future," said Goldfarb. "Only merit should determine who can become a physician."

Ethnic Diversity Increasing

"The problem with DEI is it changes the fundamental goal of medicine, which is to provide patients with the best possible care regardless of their race, religion, sex, or national origin," said Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation. "DEI argues that the best possible care cannot occur unless there is an equitable distribution of doctors and other health care providers delivering that care."

Ethnic diversity in medical schools has been increasing for many years, calling into question the need for DEI policies, says Matthews.

"Ironically, given the medical school push to impose DEI, medical school student diversity has been increasing for decades," Matthews said. "While the majority of doctors are considered white, 56 percent, 44 percent are minorities or unknown," said Matthews. "Asians, who have been the subject of racist attacks, make up the second largest group, 17 percent. Importantly, women comprise the majority of first-year medical school students. In other words, things are changing."

Concerned About Quality

There is a difference between wanting to increase minority representation and implementing DEI standards, says Matthews.

"While there is nothing inherently wrong with a medical school desiring to increase its minority representation, DEI turns it into a necessity," said Matthews. "Thus, if a medical school can't get the share of black and Hispanic students it wants, it may begin relaxing standards—and justifying its actions by claiming the school is trying to achieve a higher goal."

The logic of proponents who claim DEI is needed to match physicians with the communities they serve is flawed, says Matthews.

"One of the biggest problems with this scheme is that doctors tend to move where they can develop their specialty," said Matthews. "There is no guarantee that black or Hispanic doctors will return to their former neighborhoods and practice there. Very few people think black and Hispanic doctors can't effectively treat white patients, nor should people think whites cannot effectively treat blacks and Hispanics."

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

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COMMENTARY

Germany Allows Parents to Change Their Baby's Gender

By Sarah Holliday

When it comes to gender politics, many in the opposition acknowledge that adults can choose for themselves whether to pursue hormone therapy or body-mutilating operations, because adults can weigh the risks of their decisions.

Children, on the other hand, are quite different from adults. Opponents of gender ideology are steadfast in the fight to keep these ideological procedures away from children because they understand how vulnerable children are to the manipulative nature of so-called gender-affirming care. Far too many kids have already become victims of medical experiments as it is.

This is what makes a law recently passed in Germany even more infuriating.

Five-Year-Olds 'Choose' Gender

On April 12, the Bundestag, the German parliament, "passed one of the world's most far-reaching sex self-determination policies," Reduxx reported. This radical legislation, it added, "establishes 'gender identity' as a protected characteristic and allows parents to change the sex marker on their children's documents from birth."

Under the Self-Determination Act, citizens may be fined 10,000 euros ($10,719) for "deadnaming," a term LGBT activists use when someone, without his or her permission, is referred to by the name given at birth rather than the name he or she chose as part of this identity façade.

And just when it appears the situation can't get any more drastic, the Self-Determination Act also "permits parents to alter the recorded sex of children beginning from birth. From the age of 5 years old, it allows for name and sex changes if there is 'mutual consent' between the child and their parents."

Is America Next?

Physicians have emphasized that Europe is ahead of the United States in terms of how far gender ideology has gone. Some countries, though—such as the U.K., Sweden, Finland, and Norway—have begun backtracking as more evidence comes to light about the harmful nature of such procedures.

Thankfully, in America, those determined to keep children safe by preventing legislation such as the Self-Determination Act, known in Germany as SBGG, from happening in this country are fighting back strongly.

However, several questions come to mind when analyzing this recent development. What are the implications of a law such as Germany's for what is next in the gender politics wars? Will similar laws pass elsewhere in Europe? How will America respond?

Parental Rights, Radical Wrongs

Joseph Backholm, the Family Research Council's senior fellow for strategic engagement and biblical worldview, helped give insight into some of those questions in comments to *The Washington Stand*.

"If we describe 'radical' as something far outside the lines of decency, this is definitely a radical policy," Backholm said. "The idea that parents would be allowed to change the sex of their child from birth is outrageous. Any parent who wanted to treat their son as a girl from birth should lose their parental rights, not do so with the support and encouragement of the government."

Addressing the details of the law passed in Germany, Backholm noted, "The name is ironic but perfect, much like their flagship holiday: Pride. The Self-Determination Act reflects their desire to define their own reality, but reality will never stop pushing back and will never lose."

This, of course, is exhibited in the mountains of research and evidence that prove the biological reality of the two-sex binary, as well as the reality that biological sex cannot be altered by hormones and surgeries.

Choose Your Age … or Species?

"Why is a child's sex the only thing the parents can change?" Backholm asked. "Why can't they change their birth year to make them immediately eligible for retirement benefits? Why can't a child who feels like an old soul identify as a retiree?"

In answer to those questions, Backholm said, "If we allow this logic to prevail, there's simply no point in having identification documents. Germany should get rid of any attempt to describe someone's characteristics and simply give every life (we shouldn't assume their species) an identification number and let them make up the rest. That's the only way to be consistent."

However, Backholm said, "that would be insane." But the sad reality is that "it's not more insane than this law is."

"If we describe 'radical' as something far outside the lines of decency, this is definitely a radical policy. The idea that parents would be allowed to change the sex of their child from birth is outrageous. Any parent who wanted to treat their son as a girl from birth should lose their parental rights, not do so with the support and encouragement of the government."

JOSEPH BACKHOLM
SENIOR FELLOW
FAMILY RESEARCH COUNCIL

'These Ideas Cannot Prevail'

For Backholm, the irrational possibility that "the elites" might decide we can "choose our own birth year … may be coming."

As to how believers should respond, Backholm helpfully observed, "The correct response for Christians to madness like this is to say what we know to be true, without fear." Ultimately, he said, "The more people hear the truth spoken, the more likely they are to speak the truth."

"These ideas cannot prevail over time," he said, "but they can do a lot of damage before we come to our senses. Our job is to minimize that damage and encourage a return to reality as quickly as possible."

Sarah Holliday (**media@frc.org**) *writes for* The Washington Stand. *A version of this article previously appeared in* The Daily Signal. *Reprinted with permission.*

COMMENTARY

To Save Hospitals, States Should Resist Medicaid Expansion

By Hayden Dublois and Michael Greibrok

It's been 10 years since Obamacare went into effect, and 10 states still refuse to accept its Medicaid expansion.

Texas, Florida, Tennessee and the other holdouts face pressure to do so, especially after North Carolina folded last year, taking billions of dollars in federal taxpayer money in exchange for putting millions of people on subpar health insurance.

The holdouts have it right, because Medicaid expansion is crushing hospitals—and forcing some to close.

That's the conclusion of our new research. We looked at more than 4,000 hospitals nationwide, examining their federal filings to see how they fared financially. In 2013, the final year before Obamacare's implementation, hospitals in expansion states reported just over $10 billion in losses due to Medicaid.

The most recent data, from 2021, show the shortfalls ballooning more than 115 percent, to $22.3 billion. By comparison, the shortfalls in states that didn't expand Medicaid grew only 6 percent. When the data from 2022 and 2023 become available, they'll likely show even bigger losses in expansion states.

Pushed Out of Private Insurance

Such massive red ink is written into Medicaid's flawed design. The program reimburses hospitals a mere 78 percent of what Medicare pays for the same treatments and procedures, and 62 percent of what private health insurance pays.

Expansion pushes far more people off private insurance and onto Medicaid, meaning hospitals make less on the same patients they have been seeing.

And they're seeing far more Medicaid patients than expected. As of last year, nearly 20 million people received Medicaid through expansion nationwide, compared to initial state estimates of less than seven million. All of them are able-bodied adults. Total Medicaid enrollment is more than 90 million.

Hospitals must cover shortfalls, somehow, but they have no good options. They can lobby state lawmakers for more taxpayer funding, which is a challenge in an era of tight budgets. More likely, they're raising the costs they charge to private health insurance companies. In other words, they're forcing some patients to pay more because Medicaid expansion recipients pay less.

That necessarily drives up the cost of health insurance, which rose 4 percent between 2022 and 2023 and another 4 percent heading into 2024.

Death Spiral for Hospitals

The soaring costs persist because Medicaid expansion continually shrinks the number of people on private health insurance. Every year, there are fewer people to stick with higher prices and more people paying less than the cost of the care they receive.

There's a name for that: a death spiral, and it is already killing hospitals nationwide.

Arkansas's Crittenden Regional Hospital had a nearly $7 million surplus before Medicaid expansion. It closed in 2014 after profits turned to losses. Illinois's Westlake Hospital managed a surplus before expansion, but by 2019 a nearly $7 million loss pushed it out of business.

Rural hospitals appear to be hit the hardest. At least 12 have closed in expansion states despite promises from activists and experts that expansion would save rural hospitals and add hospital jobs.

The facts haven't stopped Obamacare advocates from demanding the 10 holdout states embrace this foolishness. The way they tell it, these states are heartless, leaving needy people out in the cold. Yet Medicaid expansion hurts the needy by forcing some of the most vulnerable patients to compete with able-bodied adults for the same care, making wait times and health outcomes worse.

Pushes Up Prices, Premiums

We estimate if those 10 states give in, at least 3.6 million people—mostly able-bodied adults—will be crowded out of private insurance and onto Medicaid. The resulting hospital shortfalls from these crowd-outs and the broader movement of Americans to Medicaid would be severe, jumping from $6.3 billion today to $13.2 billion after expansion.

That would mean even higher prices for private health insurance customers, even more pressure on hospitals, and in time, more hospitals closing.

The only way to prevent this is to steer clear of Medicaid expansion, putting patients and taxpayers ahead of political demands. Ten years after Obamacare introduced that failed policy, the 10 holdout states have been vindicated, and they shouldn't give in.

Hayden Dublois is the data and analytics director and Michael Griebrok (**adam@thefga.org**) *is a senior research fellow at the Foundation for Government Accountability. An earlier version of this article appeared in* The Wall Street Journal. *Reprinted with permission.*

POLL

Voters Support HSAs for Obamacare Enrollees

By AnneMarie Schieber

A substantial majority of American voters, regardless of party, support offering health savings accounts (HSA) to individuals and families with Obamacare policies, a new poll finds.

The poll by Americans for Prosperity (AFP) measured support for provisions of the ACCESS Act, H.R. 5608, introduced by Reps. Greg Steube (R-FL) and Kat Cammack (R-FL). The bill would allow Obamacare enrollees to use taxpayer subsidies that currently go to health insurers to fund an HSA they would own and control.

The poll found 82 percent of registered voters support the HSA proposal, including 78 percent of Republicans, 79 percent of independents, and 88 percent of Democrats. Fifty-four percent said lower-income Americans deserve the same health care options as others and agreed the bill could help accomplish that with HSAs.

"The core of the lesson here is that Americans want more options in their health care and more access to those options for themselves and their neighbors. They recognize the lack of parity in health care and that a one-size-fits-all model doesn't work."

LAUREN STEWART
SENIOR FEDERAL AFFAIRS LIAISON
AMERICANS FOR PROSPERITY

Desire for More Options

The poll indicates support for greater choice in health care, says Lauren Stewart, senior federal affairs liaison at AFP.

"The core of the lesson here is that Americans want more options in their health care and more access to those options for themselves and their neighbors," said Stewart. "They recognize the lack of parity in health care and that a one-size-fits-all model doesn't work.

"Lawmakers should tune in to their voters' openness towards expanding health care options and removing barriers to quality, affordable care for all Americans," said Stewart.

Political Opportunity

Polls showing Americans trust Democrats more than Republicans on health care indicate an opportunity for the GOP, says Stewart.

"Republicans should focus on the solutions they are driving and support in health care because, for the first time in a while, they have solutions that challenge the status quo that so many Americans are dissatisfied with," said Stewart. "[Those] solutions empower patients by giving them more control over their health care dollars, removing arbitrary barriers to physician-owned hospitals, and bringing generic drugs to market."

H.R. 5608 and other proposals to expand HSAs can give Republicans the advantage on health care, says Stewart.

"For many years, Democrats have been unchecked on their failed policies in health care simply because there was not an alternative, but that is no longer the case," said Stewart. "Republicans can say that their plan is to put American families and patients in the driver's seat of their health care, instead of insurance companies and the government. They should emphasize that all Americans deserve a personal option in health care."

Obamacare Ownership

Republican candidates should talk more about the problems with Obamacare and advocate options for health care reform, says Eric Hovde, a Republican primary candidate for the U.S. Senate in Wisconsin.

"I really want more Republicans to start talking about this issue," Hovde said on the *Clay & Buck* radio show on May 7. "The consequences of Obamacare, of what [the Democrats] passed, are all coming home to roost, with access to care and the cost of care."

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

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