HCQ Success
Efforts to discredit hydroxychloroquine continue, despite studies showing promise for its use in early treatment and its potential to help prevent COVID-19.

Page 8

FDA Testing Debacle
The U.S. Food and Drug Administration’s delay in releasing diagnostic tests for COVID-19 made the pandemic worse.

Page 9

Medicaid Pandemic Risk
Interview: Stephen Moses, president of the Center for Long Term Care Reform, explains how Medicaid may be making nursing homes riskier.

Page 13

Colleges Reopening
Colleges are finding different ways to open their doors safely.

Page 17

MI Governor Rebuked
A judge says there is “no rational basis” for Gov. Gretchen Whitmer’s decision to keep Michigan’s gyms closed as COVID cases decline.

Pages 20

Congress Pressured to Free Telehealth

By Bonner Cohen
The U.S. Congress is facing pressure to ensure the Trump administration’s telehealth reforms remain in place after the national pandemic emergency ends, providing more options for patients and providers.

“Telemicine program has reduced the burden of travel for Virginians by more than 21 million miles, saved many lives, and fostered innovative models of care delivery and workforce development,” testified Karen Rheuban, M.D., a professor of pediatrics at the University of Virginia and director of the university’s Center for Telehealth, before the U.S. Senate Committee on Health, Education, Labor, and Pensions (HELP) on June 17. “The simplest and most important

TELEHEALTH, p. 4

Court Upholds Short-Term Insurance Plans

By AnneMarie Schieber
Short-term health insurance plans do not run contrary to federal law, the U.S. District Court of Appeals for the District of Columbia ruled. The ruling arrived on July 17, weeks after House Democrats released a 197-page report attacking short-term, limited duration health insurance (STLDI) as “junk insurance.”

The Trump administration expanded access to STLDI in August 2018, allowing the plans to be sold for one year and renewable for three years beyond that. The Association for Community Health Plans challenged the rule, saying the plans run contrary to the Affordable Care Act, popularly known as Obamacare.

SHORT-TERM INSURANCE, p. 6

40% OF STATE LEGISLATORS HAVE USED OUR INFORMATION TO FORM AN OPINION OR TO CHANGE THE OPINION OF A COLLEAGUE OR CONSTITUTE.

34% OF STATE LEGISLATORS SAY READING HEALTH CARE NEWS HAS INFLUENCED THEIR OPINIONS OR CHANGED THEIR PUBLIC POLICIES.
Your Promise:
Work for the good of your patients.
Treat your patients according to the best of your ability and judgment.
Do no harm.

Your oath, your solemn obligation to your patients, is under constant assault by the government. Antiquated FDA rules prohibit you from using promising new drugs to treat your terminally and seriously ill patients.

There is a way to fight back. Free to Choose Medicine is a groundbreaking plan to reform the FDA and speed cures and therapies to patients.

It is time to re-empower physicians, protect patients and take government out of the doctor-patient relationship.

For more information on Free to Choose Medicine, go to freetochosemedicine.com, where you can also order a copy of the third edition of Bartley Madden’s book, Free to Choose Medicine.

For more information contact:
Christina Herrin, Manager
Free to Choose Medicine Campaign
The Heartland Institute
EMAIL: cherrin@heartland.org
PHONE: 312/377-4000
COVID Will Worsen M.D. Residency Shortage, Study Finds

By Kelsey E. Hackem

The COVID-19 pandemic is putting additional stress on the program that matches medical school graduates to residency programs, further straining the supply of trained physicians, a new study finds.

The pandemic has caused a great deal of disruption in medical school training, the study found. Students have been unable to take timely medical licensing exams, which has caused additional delays for students in foreign medical schools. Medical schools cut back on clerkships, rotations, and other opportunities for students to bolster their applications.

The JAMA Network article, published on June 3, offers several ideas for reforms.

Study authors Maya M. Hammoud, M.D., M.B.A.; Taylor Standiford, B.S.; and J. Bryan Carmody, M.D., M.P.H., suggest adjusting the residency application timeline, modifying application requirements, using a more holistic review of applicants, limiting the number of applications, expanding information to applicants to help them make better application choices, capping the number of interviews a student can accept, and allowing graduates to find residencies outside the National Residency Matching Program.

More Graduates, Fewer Residencies

This year, 40,084 medical school graduates applied for 37,256 residencies, according to the National Resident Matching Program. Applicants from U.S. medical schools apply to an average of 65 programs, and international students more than double that number.

The federal government, through Medicare, funds residencies under a cap set by Congress in 1997. Under the Resident Physician Shortage Reduction Act of 2019, Congress proposes to fund 15,000 new residency positions over five years beginning in 2021.

In its annual report released on June 26, the Association of American Medical Colleges (AAMC) predicts the United States will have 139,000 too few physicians in 2033, and primary care physicians will constitute up to one-third of that shortage.

Funding Freeze

Ending the cap on residency funding is a key to eliminating the shortage, says Rebekah Bernard, M.D., a board member of Physicians for Patient Protection.

“One of the biggest issues is that there has been a freeze on residency funding, and therefore spots, since 1997,” said Bernard. “The ACA [Affordable Care Act] of 2010 did nothing to expand physician training while increasing funding for the training of non-physicians such as nurse practitioners and physician assistants. We have thousands of graduating medical students, both U.S.- and foreign-trained, who are unable to match every year because of the lack of spots. The only way residency spots grow is through funding, which has traditionally been through Medicare funding of hospitals.”

Temporary Measures

The shortage of residency spaces means medical school graduates cannot satisfy states’ licensure requirements. Allowing these graduates to work while waiting for the next residency cycle could help alleviate some of the pressure, says Bernard.

“Some states have incorporated an ‘assistant physician’ program that allows unmatched medical school graduates to work under physician supervision while they await the next year of residency applications,” said Bernard. “Missouri has led the way in this. It’s been controversial among physician leadership, with some seeing it as a way to get unmatched graduates an opportunity to get some experience, while others fear that it will create a sort of lower-level physician.”

Missouri offers an assistant physician program allowing unmatched medical school graduates to practice under the supervision of licensed physicians.

Virtual Options

Trent Schmale, D.O. was finishing his third year as a family medicine resident when the coronavirus pandemic hit. His training changed dramatically.

“During the start of the COVID outbreak, my residency severely cut who we were seeing in the clinic,” said Schmale. “We only saw obstetric patients, kids that needed vaccines, and acute problems in non-high-risk groups of people that didn’t have COVID symptoms.”

Numerous patients were transitioned to virtual visits or to home visits. Those methods could be expanded to residency programs, says Schmale.

“It would be great to see telemedicine playing a larger role during training,” said Schmale. “This is going to continue to become a larger part of health care in the future, and it already was big in certain areas of private health care like direct primary care clinics. I also foresee home visits becoming a larger part of training again, due to COVID not going away anytime soon and not wanting to expose high-risk patients who don’t have the access to a computer, smartphone, or other devices.”

Kelsey Hackem, J.D. (khackem@gmail.com) writes from the state of Washington.
Once Medicare removed reimburse-vices for the same episode."

Chairman Lamar Alexander (R-TN) acknowledged the explosion of tele-health services during the public emergency.

“We have crammed 10 years’ worth of telehealth experience into three months,” Alexander stated at the meeting.

Outdated Rules
One of the emerging legacies of the COVID-19 outbreak has been the transformative effect it has had on telehealth. Before March 13, when President Donald Trump issued his emergency declaration and the Centers for Medicare & Medicaid Service (CMS) removed rules restricting telehealth, consumers and doctors never had a chance to give telehealth a full-fledged try.

Before the declaration, CMS was operating under rules put in place by Congress 20 years ago, which prohibited reimbursement for telehealth services except in areas with an established doctor shortage. Additionally, all telehealth visits had to occur in an approved medical facility. There were also privacy protections in place that restricted doctors from using platforms such as Facetime to communicate with their patients. Under the emergency, these restrictions have been lifted.

Before the emergency, two concerns lawmakers had regarding permanently lifting restrictions were a possible increase in health care spending and fraudulent billing. In a May 16, 2019 report, The Commonwealth Fund stated the higher-cost concern is unfounded, having been based on faulty assumptions by the Congressional Budget Office “that providers would deliver telehealth in addition to in-person services for the same episode.”

Telehealth Boom
Once Medicare removed reimburse-

“Patient care and revenue opportunities afforded by telehealth functionality will continue to play a significant role within the U.S. healthcare system and care delivery models, even after the [public health emergency] is lifted.”

JACQUELINE FINCHER
PRESIDENT, AMERICAN COLLEGE OF PHYSICIANS

Continued from page 1

ment restrictions in response to the emergency, states and private insurers followed suit and a telehealth boom quickly followed. Ballard Health, a health care system that serves parts of North Carolina, Tennessee, and Virginia, reported 15,000 telehealth visits from April to May, up from 2,400 for the same period in 2019.

A recently released survey by FAIR Health found the number of telehealth-related insurance claims submitted to private payers increased by more than 4,300 percent from March 2019 to March of this year. In the hard-hit Northeast, such claims rose by 15,500 percent.

A survey by consulting firm McKinsey & Co. found growth in telehealth services by consumers rose from 11 percent in 2019 to 46 percent in 2020. McKinsey estimates telehealth, which had pre-COVID-19 revenues of about $3 billion a year, now has the potential to reach $250 billion annually, with 20 percent of all Medicare, Medicaid, and private care being done virtually.

Telehealth Boom
Once Medicare removed reimburse-

Broad-Based Support
The fast-rising popularity of telehealth has prompted organizations to speak out in favor of making the emergency rules permanent.

The American College of Physicians (ACP) asked the CMS to keep telehealth reimbursement rules in place at least until a treatment or vaccine for COVID-19 is available.

“Patient care and revenue opportunities afforded by telehealth functional-

Protecting Privacy
Even if Congress removes regulatory hurdles to telehealth, the industry will still face challenges over security of records and data,workflow integration, reimbursement, and patient outcomes, McKinsey states.

Despite these hurdles, telehealth has entered a new era, says Robert F. Graboyes, a senior research fellow with the Mercatus Center at George Mason University.

“COVID-19 is forcing the medical community to reckon with several revolutions,” Graboyes said. “First, requiring patients to seek in-person treatment inconveniences them, exposes them to contagion, causes them to delay treatment, and dissuades others from seeking care altogether. Second, a high percentage of medical encounters can be safely, effectively delivered remotely; in some cases, telemedicine can be superior to in-person care, thanks to better compliance or lower stress,” Graboyes said. “Third, telemedicine can be convenient and pleasant for doctors, too, by allowing them to reduce commute times, deliver care from vacation homes, and reduce exposure to patients’ infections. My guess is that we’ll never return again to care pre-2020. And that’s a good thing.”

Bonner R. Cohen, Ph.D., (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow (CFACT).
Company Offers Doctor House Calls at Affordable Rates

By Leo Pusateri

In response to growing demand, a Minnesota-based company called Nice Healthcare is offering affordable “concierge”-style primary care by visiting patients in their homes.

The company offers its direct primary care (DPC) services to employers as a supplement to company health insurance for $30 per employee per month. There are no employee co-pays for the home visits, and the service includes care for dependents. Since opening in 2017, Nice Healthcare has gained 3,000 members.

Cofounder and CEO Thompson Aderinkomi says market research shows there is a demand for affordable, convenient primary care.

“We knew that with the rapid increase in the size of health insurance deductibles, many families in the middle class were avoiding medical care due to the cost,” Aderinkomi told Health Care News. “So we set out to create a primary care offering that was affordable enough for employers to pay 100 percent of the fees without passing any of the costs on to their already-struggling employees.”

No Real Estate Overhead

Nice Healthcare has no physical locations, which helps keep down overhead costs associated with leasing or owning office space.

Additionally, by being “on the road,” health care providers can attend to patients more quickly.

“We provide full-service primary care completely via same-day house calls, video visits, and chat visits,” Aderinkomi said. “We even do labs, tests, and x-rays in the patient’s home. We also offer about 30 different prescriptions at no cost to the patient and deliver the prescriptions to the patient at home the same day at no additional cost.”

Employers Saving Money

A St. Cloud, Minnesota nonprofit organization called Wacosa, which hires employees with disabilities, is one of Nice Healthcare’s biggest customers, says Sandi Westergren, Wacosa’s human resources manager.

“It is absolutely fabulous,” Westergren said. “When we first started, I was thinking it was for [employees with children] and rather than taking them to the doctor to get throat cultures or other things done they come to you; but it’s so much more than that.”

Managing chronic conditions is a particular strength, Westergren says.

“So, if you’ve got high blood pressure, instead of having to go into a doctor’s office for regular visits, they [Nice Healthcare] can do it,” Westergren said. “And they carry many of the medications.”

This is Wacosa’s first year with Nice Healthcare, and Westergren says it could save the organization $1,000 per employee each year. One way it does so is by keeping a lid on rising insurance premiums.

“As we’re doing this, we have seen our [insurance] claims go down; we should see our insurance rates drop too,” Westergren said. “And with Covid, people are doing telemedicine and home medical visits that they otherwise may put off because they’re afraid to go out.”

Government Barriers

Government obstacles at the federal and state level are holding back operations like Nice healthcare, Aderinkomi says.

“[The IRS [Internal Revenue Service] prohibition on direct primary care being compatible with high-deductible health plans is a significant impediment to the spread of our innovative, affordable, and accessible primary care,” Aderinkomi said.

At the state level, there are two main hurdles, Aderinkomi says.

“The fact that not all states have passed legislation that exempts DPC from insurance regulation is a major impediment to our model of care,” Aderinkomi said. “Our country also needs to standardize the licensing of advanced practice nurse practitioners, physician assistants, and physicians across all states. The state-by-state approach is a significant barrier to getting affordable health care to families. Solving these three policy issues would greatly expand access to our affordable care for most middle-class families.”

“This is the sort of entrepreneurial development that we expect from a free market for medical care. This kind of activity has been suppressed for way too long by the government and by organized medicine.”

JOHN GOODMAN, THE GOODMAN INSTITUTE FOR PUBLIC POLICY

‘Suppressed for Way Too Long’

Services provided by companies like Nice Healthcare are long overdue, says John Goodman, co-publisher of Health Care News and founder of The Goodman Institute for Public Policy.

“I think this is very exciting,” Goodman said. “This is the sort of entrepreneurial development that we expect from a free market for medical care. This kind of activity has been suppressed for way too long by the government and by organized medicine.”

Goodman says the Trump administration has aggressively sought this type of access to health care and wants to lift restrictions to make such access as easy as possible.

“There’s a law of Congress that prevents HSAs from being used for this purpose,” Goodman said. “But the Trump administration has indicated it wants to make it as easy as possible, not only for employers to empower their employees in this kind of market but to allow the employers to choose the service the employees want.”

Leo Pusateri (paymeisstr@fastmail.fm) writes from St. Cloud, Minnesota.

FCC Funds Boost for Rural Telehealth

The Federal Communications Commission (FCC) is carrying forward $198 million in unused funds from prior years to improve broadband service in rural areas so patients can get better virtual access to doctors.

In addition, the FCC has been given $200 million in funding under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, of which it has allocated $105 million so far.

In response to the pandemic, the Trump administration has lowered regulatory hurdles for telehealth so doctors and nurses can get paid for consulting with patients across state lines. Broadband service is weak in some rural areas, and the CARES funding is intended to help improve signals and update telecommunication infrastructure in order to expand access to telehealth.

The FCC has devoted more funding to the Rural Health Care Program by increasing annual spending caps and allowing unused funds to be carried over into future spending. As a result, the program now has $802.7 million, the largest amount in its history. Before the change, funding was capped at $604.76 million for 2020.

“In 2018, the FCC took swift action to ensure that the Rural Health Care Program better reflected the needs of and advances in connected care,” said FCC Chairman Ajit Pai in a statement. The carryover funding and the CARES money ensure “that rural health care providers can continue to serve their communities during this difficult time and well into the future,” Pai said.

—Staff reports
Court Upholds Short-Term Insurance Plans

Continued from page 1

Low-Cost, Specialized
STLDI plans are bare-bones, low-cost health insurance for healthy people. They have been available for many years in virtually every state to meet the temporary need for insurance by people who are transitioning from home to school, school to work, or job to job.

Traditionally, this type of bridge insurance has lasted for up to 12 months. Because the product meets the needs of a niche market, Obamacare regulations do not apply, including the prohibition against discrimination based on health status. Many state insurance regulations don’t apply either.

The plans often exclude coverage for mental health, alcohol and drug abuse, and even prescription drugs, making them undesirable for patients with chronic conditions who require expensive drug therapy.

Growing Popularity, Pols’ Opposition
Short-term plans are an increasingly attractive option for those who qualify. Premiums are typically one-third the price of plans on the Obamacare exchanges, and the insurance covers doctors and hospitals that Obamacare plans often exclude. Enrollees are free to leave at any time and sign up for an Obamacare plan if they want more expansive coverage.

According to the Democrats’ June 25 report, STLDI plans are growing in popularity. Three million individuals are enrolled in STLDI plans, up by 600,000 in 2019 alone.

The Obama administration clamped down on short-term plans, with the president bypassing Congress and using executive action to restrict the plans to three months with no renewals. The Trump administration has been more favorable, allowing plans to offer 12-month coverage and an option to renew for two more years if state governments approve.

STLDI plans are an attractive option for, says John Goodman, co-publisher of Health Care News. “They create the possibility for the closest thing we have ever seen to free-market health insurance,” said Goodman (see related article, page 7).

Denounced as ‘Junk’
The House Democrats’ report refers to STLDI plans as “junk” insurance and uses the word in its title.

“Because premiums have doubled since 2013 in the individual market, people have limited choices for something affordable, so short-term plans offer a way for consumers to protect themselves from being uninsured during a transition.”

GREG GEORGE
SENIOR RESEARCH FELLOW
FOUNDATION FOR GOVERNMENT ACCOUNTABILITY

These plans are simply a bad deal for consumers,” the executive summary states.

The report claims STLDI plan brokers “engage in misleading and fraudulent marketing practices,” and it states the plans are “highly profitable for insurers and brokers.”

Dispute Over Denials
In one case cited in the report, an insurer denied coverage for a $280,000 bill to treat an infection because the enrollee did not reveal a previous diagnosis of diabetes.

Denials occur when enrollees have been dishonest, and they are standard practice in the insurance industry, says Goodman.

Supplying a Need
STLDI plans are not the problem but a solution, says Greg George, a senior research fellow at the Foundation for Government Accountability and co-author of “Short-Term Plans: Affordable Options for America’s Uninsured.”

“People are buying short-term plans typically during a life transition such as following a job change or loss, transitioning to Medicare, or they are in between enrollment periods for employer or Obamacare coverage,” says George. “Because premiums have doubled since 2013 in the individual market, people have limited choices for something affordable, so short-term plans offer a way for consumers to protect themselves from being uninsured during a transition.”

There may be a good reason people are buying this “junk” insurance, says Chris Pope, a senior fellow at the Manhattan Institute and author of “Renewable Term Health Insurance: Better Coverage than Obamacare.”

“There may be some cases in which state regulators are allowing plans to be sold that shouldn’t be, but in many cases STLDI plans offer better value than is available through the ACA market,” said Pope.

Protecting Obamacare
Pope and George say congressional Democrats oppose STLDI because they want to protect Obamacare at all costs.

“Democrats in Congress think that Obamacare coverage is the only kind of ‘real’ health insurance,” says George. “What they are ignoring is that for millions of Americans, these flexible short-term plans are the difference between them having health coverage or being uninsured.

“Pallone’s committee has been opposed to STLDI from the outset,” said Pope. “They initially claimed STLDI deregulation was designed to sabotage Obamacare, but Obamacare is actually more stable since STLDI deregulation went into effect.”

Media on the Attack
Media coverage of STLDI has been consistently inaccurate, says George, citing as an example a June 26 article in Health Affairs which failed to present any views in support of the plans.

“The media has done a very poor job of telling the stories of patients that have been saved by short-term plans when they have gotten very sick or had a major medical event, as the alternative is often that that patient would have been uninsured,” said George.

“The report appears to say that at least three million Americans utilized short-term plans in 2019,” said Pope.

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

INTERNET INFO


Study: Public Option Could Uprock the Insurance Market

By Bonner Cohen

Allowing a government-sponsored “public option” health care plan on the individual insurance market could push up the price of private plans while not substantially decreasing the number of uninsured people, a new study finds.

The analysis by the RAND Corporation found premiums for public plans could be 10 percent to 27 percent lower than private insurance plans because of lower provider payment rates in the public option.

The researchers estimate 13.9 million people in the individual market would switch to the public option and 4.1 million would stay with the private plans on the exchange. That would raise prices on the exchange plans by changing the composition of the group, the study states.

“A relatively smaller pool of sicker and more expensive people would remain enrolled on private plans because of assumptions that higher spenders would have lower preferences for public plans because of real or perceived access barriers to lower payments to providers,” the study states.

The researchers modeled four scenarios for adding a public option nationwide and assumed varying rates of payments to providers and whether the public option plan would be offered on the Obamacare exchanges. Under three of the scenarios, the number of uninsured people would fall by 3 to 8 percent, and the number of uninsured would decline marginally under the fourth scenario.

Tax credits for lower-income individuals who switch to a public option would probably be reduced because the premiums would be lower, the study states.

The study, “Public Options for Individual Health Insurance: Assessing the Effects of Four Public Option Alternatives,” was released on May 28.

Not Much Improvement Found

The researchers modeled four scenarios for adding a public option nationwide and assumed varying rates of payments to providers and whether the public option plan would be offered on the Obamacare exchanges. Under three of the scenarios, the number of uninsured people would fall by 3 to 8 percent, and the number of uninsured would decline marginally under the fourth scenario.

Tax credits for lower-income individuals who switch to a public option would probably be reduced because the premiums would be lower, the study states.

The study, “Public Options for Individual Health Insurance: Assessing the Effects of Four Public Option Alternatives,” was released on May 28.

Says It’s Not Competition

Policymakers should reject claims that a public option will increase competition, says Robert Moffitt, a senior fellow at The Heritage Foundation.

“The government health plan is superficially attractive, like the proverbial wolf in sheep’s clothing, because the government will set artificially low premiums for its health plan and force, either directly or indirectly, doctors, nurses, and other medical professionals to accept artificially low payments for the medical services,” said Moffit.

At first, public option plans will have government-imposed advantages to make them more attractive to a broader swath of consumers, but that will create big problems, says Moffit.

“It will encourage employers to dump workers and their families out of their existing coverage, as well as drive other private health plans out of the market,” said Moffit.

If the public option plans run into financial trouble, the federal government will force taxpayers to pony up more money for subsidies because the system will be “too big to fail,” says Moffit.

“The likely result of a public option will be the use of general taxpayer dollars to subsidize premiums. This is what happens in existing programs like Medicare. People pay in far less money than they receive in benefits, and the difference is covered by taxpayer dollars.”

CHARLES SILVER, PROFESSOR, UNIVERSITY OF TEXAS SCHOOL OF LAW

With the market heavily concentrated, it is only a matter of time for the program to evolve into the single payer system—the intention all along,” said Moffit.

Doubts It Would Happen

The assumptions in the Rand report are unrealistic, says Charles Silver, a professor at the University of Texas School of Law, adjunct scholar at the Cato Institute, and coauthor of Overcharged: Why Americans Pay Too Much for Health Care.

“The likely result of a public option will be the use of general taxpayer dollars to subsidize premiums,” said Silver. “This is what happens in existing programs like Medicare. People pay in far less money than they receive in benefits, and the difference is covered by taxpayer dollars.”

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

COMMENTARY

Short Term Plans Are Free-Market Health Insurance

Editor’s note: Short-term, limited duration plans are health insurance plans for healthy people and resemble policies that used to be offered before Obamacare. The plans are a low-cost way to cover high-cost but unlikely health events, such as a catastrophic accident. The Trump administration removed restrictions on the plans, and except for several states where they are banned, the policies can last from three to 12 months before deductibles reset and can be renewable for the same premium for up to three years.

By John Goodman

1. Short-term plans have a long history.

2. Short-term plans can last up to 12 months and are designed as bridge insurance: from home to school, from school to work, and from job to job.

3. Far from being junk insurance, short-term plans have served a niche market and have done so without serious complaint for decades.

4. Obamacare regulations do not apply, including the prohibition on basing enrollment and premiums on the applicant’s health condition. Most state regulations don’t apply either.

5. Short-term plans are designed for the healthy. They typically do not cover mental health or alcohol and drug abuse and often do not cover prescription drugs.

6. President Barack Obama feared these plans would attract enrollees away from the Obamacare exchanges. To prevent that, Obama issued an executive order (without any act of Congress) limiting them to three months with no option of renewal.

7. President Donald Trump, likewise by executive order, reversed the Obama order and now allows renewals for up to three years.

8. Trump also allows a second type of insurance to bridge the gap between three-year periods. The Trump rule allows short-term insurance to be renewable indefinitely by stringing these two types of insurance together.

9. This means states can allow insurance that looks very much like pre-Obamacare insurance.

10. The fact that there is very little state regulation on short-term plans creates the possibility for the closest thing we have ever seen to free-market health insurance.

John Goodman (johngoodman@goodmaninstitute.org) is co-publisher of Health Care News. This article is excerpted from an article in Forbes on June 29, 2020. Reprinted with permission.
Hydroxychloroquine Can Save Lives, Study Finds

By AnneMarie Schieber

A study of 2,500 patients in a COVID-19 hotspot found treatment with the antimalarial drug hydroxychloroquine (HCQ) significantly reduced deaths from the disease.

The peer-reviewed scientific study published in the International Journal of Infectious Diseases reviewed cases of COVID-19 patients from March 10 to May 2 at six hospitals in the Detroit, Michigan area. Of those treated with HCQ alone, 13 percent died from COVID-19, compared to 26.4 percent who were not given the drug. Of those given HCQ with the antibiotic azithromycin, 20.1 percent died. In patients given azithromycin alone, the mortality rate was 22.4 percent.

“Considered in the context of current studies on the use of HCQ for COVID-19, our results suggest that the drug may have an important role to play in reducing COVID-19 mortality,” stated study coauthor Marcus Zervoc, M.D., in a news release.

“Currently, the drug should be used only in hospitalized patients with appropriate monitoring, and as part of study protocols, in accordance with all relevant federal regulations,” Zervoc stated.

The study was released on July 1 by the Henry Ford Hospital System.

Campaign to Discredit HCQ

Despite the promising results, the study has not received much attention, says Meryl Nass, M.D., a biological warfare expert who is on the board of the Alliance for Human Research Protection. Nass is documenting efforts to discredit HCQ and publishes the results online.

“You are certainly not hearing as much about the Henry Ford study as you are the Lancet paper that came out April 22,” Nass told Health Care News.

The Lancet article reported hydroxychloroquine is an unsafe and ineffective treatment for COVID-19. The medical journal pulled the article after 200 researchers and physicians complained about inconsistencies in the data used in the study and the original researchers’ failure to provide more information, but the damage was done, says Nass.

“It was blared over all major media and halted a number of ongoing trials around the world,” said Nass. “The World Health Organization (WHO) contacted governments, advising them to get doctors to stop using the drug. Doctors could no longer prescribe it. Two manufacturers said they would no longer supply it for COVID and stopped their own trials.”

Nass’s list, “How a False Hydroxychloroquine Narrative Was Created,” cited 28 examples as of June 28. Item five is one that has gotten particular attention, says Nass.

“You design clinical trials to give much too high a dose, ensuring the drug will cause harm in some subjects, sufficient to mask any possible beneficial effect. You make sure that dozens of trials in dozens of countries around the world use these dangerous doses,” the item states.

HCQ’s Long, Safe History

The U.S. Food and Drug Administration approved hydroxychloroquine as safe and effective in 1955. It is commonly prescribed to treat malaria, arthritis, and lupus and other autoimmune diseases.

“It was an over-the-counter drug in France and many other countries until the pandemic started,” said Nass. “It was considered so safe that in parts of Asia it had been added to table salt in areas with a lot of malaria. It has also been on WHO’s list of essential medications.”

Liability Concerns

Nass has used the drug in her practice for years to treat Lyme disease. Now, because of the negative attention on HCQ, her patients are reluctant to use the drug. Physicians are reluctant to prescribe it, for fear of lawsuits.

“Liability is always an issue for doctors, and as of June 15 the FDA has told doctors [HCQ] should only be used in clinical trials for COVID, and if you’re going to use it, you need to monitor for electrolytes, do EKGs [electrocardiograms], order a number of lab tests,” said Nass.

Petition Asks FDA to Green-Light Early Hydroxychloroquine Treatment

Clinicians, medical researchers, statisticians, and ethicists are urging the U.S. Food and Drug Administration (FDA) to expand the use of hydroxychloroquine (HCQ) in early outpatient treatment settings.

A consortium of physicians led by Peter McCullough, M.D. and Kevin Wheelan, M.D., at Baylor University Medical Center is circulating a petition stating the current protocol for the drug’s use is a “failure.” Treatment protocols based on FDA guidance require COVID-infected patients to wait at home until they experience shortness of breath and are admitted to a hospital before getting HCQ.

“It is unrealistic to believe that a continuation of this doctrine will have any practical effect in halting the epidemiological spread and significantly reducing the mortality rate of COVID-19,” the petition states.

The signees are asking the FDA to grant emergency use authorization for HCQ allowing physicians to prescribe the drug based on their clinical judgement; a continuation of studies that include measuring the effect of HCQ before infection or symptoms appear; the establishment of a prophylactic HCQ program for healthcare workers, first responders, and other high risk groups; and allowing health care professionals to administer the drug during case-contact tracing.

“What we need is for the FDA to announce that the drug is safe and recommended for specific COVID situations,” says Meryl Nass, M.D., a board member of the Alliance for Human Research Protection. Nass says such an acknowledgement by the FDA would eliminate liability problems physicians would still face even under a new EUA.

“Thousands of patients might die needlessly because government is obstructing treatments that might work if given early, while doctors tell patients to take Tylenol, self-isolate, and go to the ER if they can’t breathe,” said Orient.

AnneMarie Schieber (anschieber@heartland.org) is managing editor of Health Care News.
FDA Obstacles to COVID Testing Cost Lives, Study Finds

By Jesse Hathaway

A n analysis by Columbia University epidemiologists finds more than 36,000 Americans died unnecessarily because government regulators reacted too slowly to the building coronavirus global pandemic in March and April 2020.

“Early in the COVID-19 epidemic, the FDA’s barriers for laboratories that wanted to deploy LDTs resulted in a critical testing gap. This experience validated one of the key arguments against FDA regulation of laboratory-developed tests: that labs would be unable to respond quickly to increased medical knowledge and changing conditions such as epidemics.”

ROGER KLEIN, M.D., J.D.

The only tests that typically are required to go through FDA approval are manufactured tests that are sold and distributed to clinical laboratories,” said Klein. “The other type of tests is laboratory-developed tests, which are tests developed and validated by laboratories for use with their own patients. These include tests created and designed de novo, purchased tests that have been FDA-authorized for sale but are modified or deviate from the label or manufacturer’s exact instructions, and other tests such as tests in Europe that laboratory professionals adapt and validate for use within their laboratories.”

Klein says the process is lengthy when taking into account the time spent on preparation for submission and is much more intense for tests that are approved under the highest standard of pre-market approval as opposed to being cleared for use.

“The process is document-heavy and involves not only submission but also quality systems regulations—good manufacturing practices—that are poorly suited for laboratory-developed tests,” Klein said.

Patients Pay the Price

Regulatory delay is immoral and unethical and undermines people’s health, says Jessica Flanagan, the Richard L. Morrill Chair in Ethics and Democratic Values at the University of Richmond.

“First, people are prevented from accessing information about their health status, and that’s harmful because that information may inform their decisions about treatment or resuming work,” Flanagan said. “Second, delays in approval delay public health interventions and prevent officials from learning about the spread of a disease, and that uncertainty also harms everyday people who are trying to manage their risk.”

Delayed Adjustments, Knowledge

The FDA is responsible for the causalities inflicted by its failure to approve tests quickly as the pandemic hit, Klein says.

“Early in the COVID-19 epidemic, the FDA’s barriers for laboratories that wanted to deploy LDTs resulted in a critical testing gap,” Klein said. “This experience validated one of the key arguments against FDA regulation of laboratory-developed tests: that labs would be unable to respond quickly to increased medical knowledge and changing conditions such as epidemics.”

Klein says the “testing gap” prevented public health officials and lawmakers from making decisions based on real-world data, and that led to bad policy decisions and unnecessary human suffering.

“Because so few tests were performed, we underestimated the extent of community spread and did not take measures to contain the virus,” said Klein. “We failed to identify infected patients and their contacts, who spread the disease to others. In addition, there was an unrecognized outbreak in a nursing home in Seattle associated with almost 40 deaths that perhaps could have been abated with earlier recognition of the situation.”

Recommend Single Regulator

Klein says Congress should enact the Verified Innovative Testing in America Laboratories (VITAL) Act of 2020, introduced by Sen. Rand Paul (R-KY) in March.

“Sen. Paul is a physician who had coronavirus,” said Klein. “The VITAL Act clarifies that the FDA does not have authority to regulate laboratory-developed tests, which are already regulated by the Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Amendments of 1988 and accompanying regulations,” said Klein. “This would benefit patients and preserve innovation and dynamism in the field and ensure that laboratories can effectively respond to changing conditions or emergencies.”

Calls for Extensive Reform

Flanagan says the federal government should reform the regulatory system for normal times as well as emergencies.

“As a first step, if there is a health emergency, expedited approval should be automatic,” said Flanagan. “By this I mean that declaring a public health emergency should automatically lower regulatory barriers. Every day of delay sets back public health efforts, so these decisions shouldn’t return to lawmakers and regulators every time there’s a crisis.

“The barriers should not exist in the first place, because everyday, nonemergency illnesses can be health emergencies for patients and their families,” Flanagan said. “The same reasons for promoting innovative treatment and fast access during pandemics are more generally reasons for these policies.”

Jesse Hathaway (think@heartland.org) is a policy advisor for The Heartland Institute.

INTERNET INFO

COVERING IMPORTANT NEWS OTHER MEDIA IGNORE

The very fabric of America is under attack—our freedoms, our republic, and our constitutional rights have become contested terrain. The Epoch Times, a media committed to truthful and responsible journalism, is a rare bastion of hope and stability in these testing times.

SUBSCRIBE TODAY ReadEpoch.com
Medicaid Has Become a Cash Cow for Wealthy States

By Ashley Herzog

The federal government’s Medicaid reimbursement formula gives a huge funding advantage to wealthy states that lean Democrat, a new analysis finds.

“Federal law sets a state’s Medicaid matching rate based on that state’s [per capita] wealth compared to the national average,” Chris Jacobs, founder and CEO of Juniper Research Group, told Health Care News. “But that same funding formula guarantees every state a 50 percent match, meaning that a wealthy state like Connecticut—which would have a matching rate of 11.69 percent in Fiscal Year 2020—gets a far greater match.”

Section 1905(b) of the Social Security Act establishes Federal Medical Assistance Percentages, the matching rate each state receives from the federal government to support its Medicaid program. The match has a ceiling of 83 percent and a floor of 50 percent.

Advantage: Blue States

As of 2018, the average per capita income in the United States was $51,000, according to the U.S. Bureau of Economic Analysis. Income is significantly higher in several East Coast states: $83,242 in Maryland (the wealthiest state, behind the District of Columbia), $81,740 in New Jersey, $79,835 in Massachusetts, and $76,348 in Connecticut.

At those very high income levels, the federal government should match only about 10 percent of Medicaid spending, says Jacobs.

“This disproportionately high match rate encourages wealthy blue states to overspend on their Medicaid programs, raising federal costs for taxpayers in red and blue states alike,” said Jacobs.

“It also explains why New York had a budget deficit well before coronavirus hit: the state has had a bloated Medicaid program for years because of the higher federal match,” said Jacobs.

“New York would have a match rate of 34.49 percent absent the 50 percent floor [which] encourages overspending.”

The annual per capita income in the two poorest states—Mississippi and West Virginia—is below $45,000. Poor states rarely hit the 83 percent ceiling, Jacobs notes in an analysis published on May 8 in The Federalist.

Cuomo: ‘Unsustainable’

The state budget troubles caused by Medicaid spending have become so large that even free-spending blue state governors are finding the price is too high, says Jacobs.

 “[New York] Gov. Andrew Cuomo in January called the state’s fiscal situation ‘unsustainable’ after the state announced a $6 billion budget deficit, most of which came from Medicaid,” writes Jacobs in his Federalist analysis.

“To his credit, Cuomo proposed changes to crack down on Medicaid fraud and enact other program reforms. He also criticized Congress when it passed legislation to block New York and other states from changing their Medicaid programs during the pandemic. But he has not acknowledged the underlying flaws in federal law that, by encouraging profligate state spending, created the problem in the first place.”

Congress should remove this funding disparity, says Jacobs.

“Congress should begin a process of phasing out the 50 percent minimum floor on the federal Medicaid match and stop the process of poorer red states bailing out wealthier blue ones,” said Jacobs.

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.

INTERNET INFO


Prescription for Better Healthcare Choices

A Better Choice
Healthcare Solutions for America
John C. Goodman

“John Goodman understands the real life effects of the Affordable Care Act and the proposed alternatives. John also writes extremely well, making complicated concepts clear. All this makes A Better Choice a highly recommended read for those who wish to understand the current health policy debate.”

—Bill Cassidy, M.D., U.S. Senator

Priceless
Curing the Healthcare Crisis
John C. Goodman

“There’s no question that today’s healthcare system is littered with distorted incentives and what John Goodman calls dysfunctionality. Priceless is a call to arms to do something about it. . . . You should read this book if you want to be an informed participant in the debate over the future of healthcare in this country.”

—Peter R. Orszag, former Director, Congressional Budget Office

Polls show that by a large margin Americans remain opposed to Obamacare and seek to “repeal and replace” it. However, the question is: Replace it with what? In A Better Choice, John C. Goodman clearly and concisely provides the compelling answer. For anyone who wants to learn about some of the boldest prescriptions designed to remedy our healthcare system, Goodman’s book is a must-read.

Priceless cuts through the politics and proposes dozens of bold reforms to free patients and caregivers to be empowered to chart their own lives with low-cost, high-quality healthcare.
By Bonner Cohen

The U.S. Department of Health and Human Services (HHS) rolled back the Obama administration’s broad interpretation of the Affordable Care Act’s (ACA) language on sexual orientation and gender identity.

Section 1557 of the ACA specified that covered health care programs and activities, such as hospitals and insurance, could not deny access to health care services or facilities based on sex and certain other conditions. Two years after the Affordable Care Act (ACA) went into effect in 2014, the Obama administration issued a regulation implementing Section 1557 “that redefined sex discrimination to include termination of pregnancy and gender identity, which it defined as ‘one’s internal sense of gender, which may be male, female, neither, or a combination of male and female,’” states the U.S. Department of Health and Human Services in a press communication.

After a federal court blocked and then later threw out the Obama rule’s gender-identity provisions (along with provisions dealing with termination of pregnancy), the Trump HHS set about rewriting the rule in order to be able to enforce it. The new rule restores providers’ conscience rights and decision-making “by returning to the government’s interpretation of sex discrimination according to the plain meaning of the word ‘sex’ as male or female and as determined by biology,” HHS states. “The 2016 Rule declined to recognize sexual orientation as a protected category under the ACA, and HHS will leave that judgment undisturbed.”

HHS says the new rule will save taxpayers $2.9 billion in “undue and ineffective regulatory burdens over five years.”

‘Eminently Reasonable’

Attorneys general from 23 states filed a complaint on July 20 in the U.S. District Court for the Southern District of New York seeking declaratory and injunctive relief from the rule. The complaint cites the June 15, 2020, U.S. Supreme Court decision in Bostock v. Clayton County which redefined biological “sex” in the 1964 Civil Rights Act as encompassing gender identity and sexual orientation. The Bostock ruling applies to discrimination in the workplace.

The new HHS rule should be upheld, says Ryan Anderson, a senior research fellow at The Heritage Foundation.

“It is eminently reasonable, and even under the Bostock logic, it is lawful,” said Anderson.

Discrimination or Disagreement?

Anderson says the new rule acknowledges the realities of health care decision-making.

“Suppose the argument is the doctor, hospital, or insurance covers double mastectomies in the case of cancer but not in the case of gender dysphoria,” said Anderson. “For a discrimination claim to be successful, you have to argue that a patient with cancerous breast tissue is comparable—similarly situated to—a patient with healthy breast tissue.

“Perhaps some physicians will argue that the noncancerous breasts are in fact unhealthy because they are the cause of the gender dysphoria,” said Anderson. “That will only further highlight that what we really have here is a disagreement about the diagnosis and treatment of gender dysphoria. And policies like the Trump administration’s recent regulation on Section 1557 of the ACA are entirely defensible for refusing to treat a disagreement on medical care as if it were discrimination based on identity.”

Bonner R. Cohen, Ph.D., (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research.
Medicaid Makes Nursing Homes a Target for Pandemics

As of mid-June, one quarter of all COVID-19 deaths, 30,784, had occurred among people living in nursing homes. Stephen Moses, president of the Center for Long Term Care Reform, says he is not surprised by this outcome, as Medicaid now pays the bill for more than 62 percent of nursing home residents. An estimated 1.3 million people reside in America’s 15,600 nursing homes. The full interview with Stephen Jones can be heard on The Heartland Daily Podcast.

Health Care News: Is it accurate to describe care in nursing homes as substandard?

Moses: I’d say that statement is accurate and recognized by most economists and other analysts. Medicaid reimburses nursing homes only about 80 percent of the private-pay rate and often less than the cost of providing the care, according to the American Health Care Association. Consequently, nursing homes heavily dependent on Medicaid have difficulty hiring and retaining enough quality caregivers at the very low salaries they can afford to pay. Having inadequate caregiving staff is closely associated with lower care quality ratings.

Health Care News: How much does Medicaid pay for long-term care, and what should it reasonably cost?

Moses: According to Genworth’s 2019 cost of care survey, the average private-pay monthly nursing home cost for a semi-private room is $7,751, and $8,517 for a private room. Costs in expensive urban areas can easily be half again as much or even double.

As Medicaid pays about 80 percent of the private-pay rate, it would pay about $6,010 on average for a semi-private room. Medicaid would rarely if ever pay for a private room.

Health Care News: Who qualifies for Medicaid?

Moses: Medicaid long-term care eligibility was originally available to almost anyone who applied. Transferring assets to qualify was explicitly permitted until 1980. Since then, elastic income and asset eligibility rules have allowed the middle class and affluent to qualify for what was originally intended to be a poverty program. There is literally no limit on income if your medical and long-term care costs are high enough.

Assets are also practically unlimited, with home equity exempt between $595,000 and $893,000. Many other resources are exempt with no dollar limit, such as a car, term life insurance, individual retirement accounts, one business including the capital and cash flow, and personal belongings and home furnishings, including heirlooms. Generous matching funds from the federal government encouraged state Medicaid programs to maximize their grants almost without limit. Naturally, Medicaid expenditures exploded.

Health Care News: Does Medicaid require any co-pay for long-term care?

Moses: Most people on Medicaid have some sources of personal income, nearly always Social Security at least. Medicaid requires that all income except for a tiny personal-needs allowance must be used to offset the program’s cost for their care.

For example, a person with several thousands of dollars’ worth of income from Social Security, a private pension, an exempt business, etc. qualifies for Medicaid nursing home benefits because their income is less than the cost of the nursing home. But once on Medicaid, they must pay most of that income back to the nursing home, reducing Medicaid’s liability.

There are even cases where the Medicaid recipient’s income covers the entire cost of the care at the Medicaid rate. This is very important because it shows, one, that Medicaid recipients get a substantial discount on the cost of their care; two, nursing homes end up with more low-pay Medicaid recipients and fewer higher-pay private patients, which impairs their ability to provide quality care; and, three, state and federal Medicaid programs subsidize welfare dependency at the expense of nursing home providers’ financial viability.

Health Care News: Given that nursing homes are under financial pressure to provide good care, why do families find it acceptable to use Medicaid to pay for it?

Moses: Few people plan to rely on Medicaid, but most end up there if and when they need high-cost care for an extended period. The dynamic works like this. People don’t worry or plan for long-term care because Medicaid has always been there as the safety net for poor, rich, and in-between. Once they need expensive care, the path of least resistance is to qualify for Medicaid. That’s the only way to preserve wealth and heirs’ inheritances, which makes the program’s access and quality downsides more tolerable.

Thousands of elder-law attorneys across the country use sophisticated legal techniques to qualify affluent clients while preserving enough “key money” to buy their way into the higher-quality, lower-Medicaid-census facilities.

This key money buys access to the best nursing homes with the fewest Medicaid beds. After a few months, the attorney flips the switch, and voila, Medicaid picks up the tab going forward. Tragically, poor people don’t have key money, so they end up in the 100 percent Medicaid hellholes.

Health Care News: What impact has this system had on the private market? What about long-term care insurance?

Moses: You can’t sell apples on one side of the street when they’re giving them away on the other. Easy access to Medicaid after the insurable event has occurred was the biggest obstacle to private long-term care insurance. The federal government added insult to injury by artificially forcing interest rates to nearly zero, making it impossible for insurance carriers to get adequate returns on their reserves. That forced the carriers to raise premiums, which enraged policyholders and repelled future prospects.

Congress should remove the perverse incentives in public policy that discourage responsible long-term care planning. Individuals should wake up to the reality that to avoid Medicaid and its nursing home trap, they must plan early and save, invest, or insure so if and when they need extended, expensive long-term care, they can pay privately for it.”

STEPHEN MOSES
PRESIDENT, CENTER FOR LONG TERM CARE REFORM

INTERNET INFO

States Impose Fines for Not Wearing Masks

By Kelsey Hackem

States are toughening up measures to control COVID-19 by imposing fines on people who do not wear masks in public.

Michigan Gov. Gretchen Whitmer issued an executive order on July 10 making it a misdemeanor not to wear a facial covering in public indoor and crowded outdoor spaces. Violators are subject to a $500 fine. Businesses are required to enforce the order or risk license suspension.

On July 1, New Mexico began imposing a $100 fine for not wearing a face covering in public. Hawaii has required masks for customers of essential businesses and employees who have contact with customers since April 17. Violations could result in a fine of not more than $5,000 or imprisonment for not more than one year, or both.

Some states have left it up to local governments to determine whether and how to enforce face-covering mandates. In California, Gov. Gavin Newsom ordered face coverings in public weeks ago but did not authorize fines or jail time. Some California cities, such as Los Angeles, Monterey, Santa Monica, and West Hollywood, are fining individuals for not wearing face coverings. Santa Monica imposes fines on an increasing scale starting at $100 for not wearing a face covering or complying with social distancing.

Enforcement Quandary

Gov. Whitmer’s order requires businesses to refuse service and deny entry to any customer without a face covering and to post signs informing customers of their obligation to wear masks. Businesses that fail to comply can have their licenses suspended.

Michigan Senate Majority Leader Mike Shirkey (R-Clarklake) says he is concerned about the financial burden the order puts on people and businesses struggling in the current economic climate.

“If businesses fail to comply, their license to operate will be temporarily suspended. Shifting the burden of mask enforcement to local businesses and police departments creates even more of a burden on businesses and public services that have suffered during the COVID-19 lockdowns.”

MIKE SHIRKEY
MICHIGAN SENATE MAJORITY LEADER

Questions Value of Masks

Public health experts have changed guidance over the months regarding masks. There is still debate over the effectiveness of masks in slowing down the progress of the virus, says Singleton.

“Studies show nonmedical masks do not stop aerosolized droplets of less than 2.5 microns,” said Singleton. “An impressive number of scientists from multiple disciplines have recently agreed that SARS-CoV-2 is spread by such small droplets. They recommend improving indoor ventilation infection controls as the key protective measure. Handwashing and social distancing, but not masks, were advised.”

Kelsey Hackem, J.D. (khackem@gmail.com) writes from the state of Washington.
Health Care Groups Enter Politics, Race Debates

By Madeline Peltzer

Science and medicine have long been considered off-limits for political debate, but with increasing tensions over pandemic lockdown measures, race relations, and the presidential election, health care professionals and their organizations have visibly joined the fray.

During the pandemic, doctors and nurses joined a campaign called “Stay Home: Stay Safe,” in which they publicly showed themselves on the streets and in social media campaigns. In some cases, health care professionals confronted people for protesting lockdown orders.

When racial tensions heated up in the wake of George Floyd’s death at the hands of a police officer, governments and health care professionals set aside pandemic concerns and social distancing for this one purpose. Instead of “stay home, stay safe,” health care workers clad in scrubs high-fived protestors making their way past hospitals.

Others, such as the group White Coats for Black Lives, paused for “unity breaks” on hospital grounds to show solidarity with protesters. Still others held “die-ins” where staff laid on their chests for 8 minutes and 46 seconds, the length of time the Minnesota police officer pinned Floyd to the ground.

An open letter signed by more than 1,200 medical professionals stated the BLM protests require a “wholly different” response from those against lockdowns and urged that protests for George Floyd not be disbanded “under the guise” of COVID-19 concerns.

Cause and Effect

In Michigan, the Genesee County Board of Commissioners voted to declare disparities in health care as “racism” and called for a review of health department policies on “racial equity.” Two commissioners complained the resolution was rushed through with no time for questions.

The American Hospital Association expressed a similar sentiment, stating minorities had been “disproportionately affected” by the pandemic and resolving to address “racial, ethnic, and cultural inequities, including those in health care, that are everyday realities for far too many individuals.”

The exam room is an attractive platform for political activism, says Sally Pipes, president and CEO of the Pacific Research Institute.

“Health care is the one public policy issue that affects every single American,” said Pipes. “As a result, it’s also the easiest issue to politicize.”

Question of Expertise

It is admirable that doctors and nurses are fighting for a cause, says Anthony Fappiano, a third-year medical student at the New England School of Osteopathic Medicine.

“My criticism is, in my experience they aren’t fully educated on all the factors involved,” said Fappiano. “We can see this with the lockdowns, as an example. The doctor and nursing groups are all in favor of shutting everything down because they don’t want to be overwhelmed. But that is a narrow-minded viewpoint because it ignores the economic impact, the psychological impact, etc.

“Tentative viewpoint is shrouded by the fact that they are the ones dealing with these patients, Fappiano said. “That’s understandable, but that’s also what they signed up for.”

Racism or Disparities?

Not all health care professionals agree disparities in health care are the result of “systemic racism,” the notion that institutions put some groups at a disadvantage because of race. The notion that bigotry, hatred, and racism run rampant in health care is an insult to the millions of health care workers who do their best to help all people, says Fappiano.

“I have worked in the health care field since I was 15, in different locations and positions, and have never seen a single incident of systemic racism,” said Fappiano. “There are individuals who are racist, including patients who make racist comments towards medical staff, but I have never seen a patient treated differently because of their race or ethnicity.”

It is unscientific to assume disparate outcomes are caused by racism, says Chad Savage, M.D., founder of Your Choice Direct Care and a policy advisor to The Heartland Institute, which publishes Health Care News.

“Though racism and discrimination could play a role in racially based differences in diseases such as susceptibility to COVID-19, basing all conclusions on this presumption may blind researchers to other possible attributions of these differences,” said Savage.

Freedom to Reform

A better way to address disparities in health care is to give people more freedom, says Fappiano.

“Whether you believe in systemic racism in our health care system or not, the best way to fix it is to release health care from the grip of the government and large accreditation agencies,” said Fappiano.

Removing barriers to allow providers to offer different levels of services at different price points would help solve health care access problems, says Fappiano.

“We could get effective health care into the low-income neighborhoods that desperately need them,” said Fappiano.

Madeline Peltzer (mpeltzer@hillsdale.edu) writes from Hillsdale, Michigan.

CDC: 94 Percent of COVID-19 Deaths Involved Comorbidity

The Centers for Disease Control and Prevention released its provisional death counts for COVID-19 for February 1 to July 4.

The accompanying figure shows the death count peaked between April 18 and April 25 for most age groups. The report states 6 percent of all COVID-19-related deaths in the United States during the period were caused by the coronavirus alone. Ninety-four percent of COVID-19 deaths involved comorbidities, with an average of 2.6 conditions per case.

—Staff reports
WHO Releases Mixed Messages on Asymptomatic COVID Spread

By Kelsey Hackem

The World Health Organization (WHO) issued mixed messages about the spread of COVID-19 in June.

On June 8, Dr. Maria Van Kerkhova, head of the WHO’s emerging diseases and zoonosis unit, said, “it still seems to be rare that an asymptomatic person actually transmits onward to a secondary individual.” On June 10, 2020, WHO officials moved away from that statement, instead saying asymptomatic spread is a complex question and there is very much still unknown about it.

“Since early February, we have said that asymptomatic people can transmit COVID-19, but that we need more research to establish the extent of asymptomatic transmission,” said WHO Director General Tedros Adhanom Ghebreyesus at a media briefing.

Initial evidence from early outbreaks led to the conclusion asymptomatic individuals, those with COVID-19 but who do not show symptoms of illness, could spread the virus through person-to-person contact. This conclusion drove policy decisions at all levels of government, including severe restrictions such as lockdowns.

“If policy were guided by science, what should have happened from the beginning is complete articulation of the epidemic model driving policy, including its assumptions. That should have led to efforts to disprove the forecast and/or its assumptions. That never took place, for some reason.”

ANNE MARIE KNOTT, ECONOMICS PROFESSOR, WASHINGTON UNIVERSITY

Models with One Viewpoint

Scientists failed to engage a variety of analyses and instead chose to adopt one interpretation, says Anne Marie Knott, an economics professor at Washington University who did an analysis of COVID outbreaks in two confined environments: the USS Roosevelt and the Diamond Princess cruise ship.

“At the outset, there was huge uncertainty about COVID, but the data from China was widely available beginning in January,” Knott said. “Not only was Imperial College analyzing the data, but so too was Michael Levitt, the Nobel chemist at Stanford’s medical school. Levitt’s forecasts were ver different from [those of ] Imperial College. If Imperial College were behaving as scientists, they would have tried to reconcile their forecasts with Levitt’s—and of course Levitt’s turned out to be much closer to the underlying truth.”

Ultimately, public policy was driven by one area of study, epidemiology, rather than biology and chemistry, Knott says. “There was lots of science taking place in infectious disease, that permitted to design of tests for COVID itself as well as its antibodies, development of vaccines, and basic understanding of the virus itself, including the means by which it spreads,” Knott said.

Divergence of Opinion

As more data and information about COVID-19 emerge, scientists and policy officials should take a more reasoned approach in analyzing the disease and releasing information to the public, Knott says.

“If policy were guided by science, what should have happened from the beginning is complete articulation of the epidemic model driving policy, including its assumptions,” Knott said. “That should have led to efforts to disprove the forecast and/or its assumptions. That never took place, for some reason.”

Ideally, scientific conclusions should reflect all publicly available data, Knott says. Instead, statements by the WHO were viewed as conclusive.

“If we were following a scientific process, nothing WHO says should come as news,” Knott said. “All epidemiologists should be working from the same information as the WHO. This is equivalent to what we refer to as an ‘efficient market’ in finance. Stock prices are supposed to reflect all publicly available information at all times. The only news should be how the policymakers react to it—which was to have them walk it back.”

Kelsey Hackem, J.D. (khackem@gmail.com) writes from the state of Washington.

Pandemic Lockdowns Could Impede Cancer Survival

Social distancing and other measures to control the spread of coronavirus infection have disrupted clinical visits, lab tests, and tumor imaging to such a degree that it could set back progress in lowering cancer deaths among Americans, the National Cancer Institute warns.

“We know that delayed diagnosis and delayed therapy lead to worse outcomes for patients with cancer,” said NCI Director Ned Sharpless during a May 31 virtual meeting of the American Society of Clinical Oncology.

Data from cancer studies was less than half the normal amount in March and April, Sharpless told the group.

“Clinical trials are how we make progress for patients with cancer, and these decreases in accrual will translate into reduced new approaches for patients,” said Sharpless.

For several weeks, nearly all states banned “nonessential” activities, which included physician office visits, out of fear that hospitals would be overwhelmed by COVID-19 cases.

Testing for the virus, which might have expedited cancer visits, got off to a slow start. In early March, the Centers for Disease Control and Prevention was the only agency granted Emergency Use Authorization by the U.S. Food and Drug Administration to distribute COVID-19 testing kits. The tests contained defective reagents and had to be sent back, delaying testing nationwide.

—Staff reports

U.S. Withdraws from WHO

By Bonner Cohen

A fter months of harshly criticizing the World Health Organization’s (WHO) response to the outbreak and spread of the COVID-19 pandemic, President Donald Trump has formally notified Congress and the United Nations the United States will withdraw from the U.N.-affiliated body.

Under a 1948 act of Congress, withdrawal requires a year’s notice, so it won’t take effect until July 6, 2021. The United States is by far the world’s biggest funder of WHO, contributing about $450 million a year.

Costly Errors, China Ties

Tensions between Washington and the Switzerland-based WHO had increased after a series of missteps by the U.N. health organization that raised questions about the WHO’s close ties to China, the source of the new coronavirus, COVID-19.

The WHO came under attack from the White House and members of Congress after its initial assertion in January the virus could not be spread by human-to-human transmission. In addition to its early praise of China for its handling of the virus, the WHO was quick to condemn the travel ban the White House imposed on China at the end of January.

‘A Year to Reform and Redeem’

The Trump administration is giving the WHO a year to reform itself, says Horace Cooper, co-chairman of Project 21, the black leadership network of the National Center for Public Policy Research.

“Using the power of the purse, the Trump administration has the WHO right where it needs to be,” Cooper told Health Care News. “WHO’s mishandling of the H1N1, Ebola, and coronavirus pandemics, and its loyalty to the Chinese government, must be addressed.”

Bonner R. Cohen, Ph.D. (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research.
Higher Ed Rethinking Fall Reopening Plans

By Madeline Peltzer

Colleges and universities are grappling with how to bring back students for the fall semester after campuses were abruptly shut down in March in response to the coronavirus pandemic.

Reopening policies run the gamut. The University of Alabama announced it will put $30 million in federal COVID funding toward testing and recommends universities test every returning student. Bob Jones University in South Carolina has opted to start the semester a week earlier, cancel fall break, and wrap up final exams before Thanksgiving, to cut down on cross-country travel. The University of California state system will keep campuses closed and continue to hold classes online.

Cornell University, expecting students to return to off-campus living arrangements regardless of whether the campus reopens, will open its doors this fall, hoping “pooled testing” will give it more control over the spread of the virus. Pooled testing involves combining test samples from groups of students to gauge virus spread. Hillsdale College, with a smaller student body, is reopening its campus with safety measures in place, such as fumigating buildings, checking temperatures, and quarantining those with symptoms.

Weighing the Risks

Parents and students agree with Hillsdale’s plan, says Matthew Spalding, dean of the college’s Van Andel Graduate School of Government.

“They want to come back, and they’re excited to come back,” said Spalding. “At a certain point, life goes on and you assume certain risks.”

Colleges and universities have weathered pandemics in the past. When the swine flu swept the country in 2009, the Centers for Disease Control and Prevention (CDC) actually advised colleges not to close. During the bird flu outbreak the year before, the CDC recommended basic precautions and self-isolation for infected individuals but never broached the idea of shutting down schools. Harvard University had continually kept its doors open dating back to the Spanish Flu of 1918. Five students and one instructor died on campus within weeks of the quarantine going into effect.

Studies have found those under the age of 25 are at significantly lower risk of death from COVID-19 than of the flu. According to data from the CDC, school-age children have a one in 2.5 million chance of dying of COVID-19. For those aged 15-24, coronavirus is more than halfway down the mortality list, with unintentional injury, suicide, and homicide taking the top spots.

Cornell’s approach to dealing with the virus is good because it recognizes the differing risk levels of various options, says Michael Urbinato, a rising junior at the university.

“I think the limited reopening gives us as much traditional class time as possible while emphasizing mass testing and eliminating large social events and lectures, which would pose a major infection risk to the student body and surrounding area,” said Urbinato.

Rethinking the College Experience

The pandemic is giving colleges and universities an opportunity to rethink the college experience.

“A lot of schools want things to go back to normal,” says Spalding. “That, I think, is the wrong way to think about it. Higher education is not a free market right now, and it hasn’t been for a long time. This is the kind of situation where we should allow higher education to rethink their models like a business.”

A key way to encourage that would be to direct federal emergency funds, such as the CARES Act, to students instead of institutions, says Andrew Gillen, a senior public policy analyst at the Texas Public Policy Foundation.

“It’s more flexible in terms of letting student choices determine which institutions are funded,” Gillen said.

Such flexibility is particularly important when future enrollment numbers are unknown and some institutions may no longer be viable, Gillen says.

“It avoids squandering scarce resources to prop up obsolete institutions if we end up needing a new normal for which existing institutions are ill-equipped,” Gillen said.

Hands Off Endowments?

With the pandemic costing institutions tens of millions of dollars in lost tuition due to campus closures, the crisis provides a reason to rethink how the government treats college endowments, says Spalding.

“Creating an endowment is hard to do, generally, but there’s also no incentive when you can get government to cover 40 percent of expenses,” Spalding said. “We should make it easier to start an endowment. Endowments shouldn’t be taxed. Create incentives for private donors to give money to schools to help them fund it. Let the market decide, not the government.”

Despite the uncertainty, Gillen said some positive changes that restore free-market forces to higher education could emerge from the disruption.

“For universities, that means reassessing traditional approaches to determine if there are better methods of producing and disseminating knowledge,” said Gillen. “For policymakers, the budgetary pressure of the crisis should lead to tough questions about what, exactly, taxpayer money is funding and how much it is costing.”

MadelinePeltzer(mpeltzer@hillsdale.edu) writes from Hillsdale, Michigan.
Health Care Professionals Are Crossing State Lines

By Ashley Bateman

Patient demand created by the COVID-19 pandemic has pushed legislators to pass laws recognizing the professional licenses of out-of-state health care professionals.

Missouri Gov. Mike Parson (R) signed into law House Bill 2046, considered one of the most expansive licensing reciprocity measures in the nation. Bill sponsor Rep. Derek Grier (R-Chesterfield) says universal licensing recognition is something Missouri legislators have been discussing for some time.

“It’s going to set Missouri as the number one reformer in the entire country when it comes to occupational licensing recognition,” Grier said on June 22 on The Heartland Daily Podcast. “It takes Arizona’s law and goes one step further for other states to jump on the reciprocity wagon, says Michael Slabinski, legislative director at ALEC.

“There are two ways for states to reform licensing: liberalizing current laws and recognizing licenses from other states, Slabinski says. “It’s argued at ALEC that if you’re going to have an occupational license, it should be to protect the health and safety of the citizens of that state,” Slabinski said. “It shouldn’t be to ensure that there’s a minimum quality standard. It’s not the government’s job to protect people from bad haircuts.”

States have begun to consider universal recognition licenses, especially for military spouses. Slabinski says states should remove licensing barriers for all workers.

“One of the most important things in our model is recognizing work experience,” Slabinski said. “Not all states license the same occupation. If you’re coming from a state that didn’t license an occupation but you have a lot of experience, then you can apply that experience in a new state that you’re moving to or a new state you’d like to work in.”

Hoping for Domino Effect

Iowa and Mississippi are considering bills that emphasize work experience, which is important if workers come from a state that doesn’t license a particular occupation, Slabinski says.

“That’s where it seems a lot of these policies are going,” Slabinski said.

Grier says it is important for reformers to recognize pushback from competitors.

“What I did to overcome that opposition was early on, I created a coalition,” Grier said.

The bill received bipartisan support and passed unanimously in the state Senate.

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Pandemic Exposes Government Barriers to Ambulance Service

By Bonner Cohen

The state of Florida has temporarily suspended a Certificate of Need (CON) law that prevented ambulance companies from expanding services into neighboring counties.

Florida lifted most CON requirements in 2019 but left ambulance service subject to approval by local entities. Florida is one of five states that require a CON for ambulance services.

Shortly before the ambulance decision, Florida had permanently exempted intermediate care facilities for elderly persons from CON laws if they meet certain conditions. Gov. Ron DeSantis signed the bill into law on June 20.

Making the Case

In an open letter on April 16, attorneys Anastasia P. Boden and Mollie R. Williams of the Pacific Legal Foundation (PLF) had urged Florida to join 18 other states in suspending all CON laws for the duration of the pandemic. CON laws “prioritize the financial interests of incumbent operators over the public interest,” the letter stated. “These laws are anti-competitive and unfaired barriers to earning a living under any circumstances, but they are especially pernicious in the middle of a pandemic when health care providers must be free to adapt to changing circumstances.”

Boden and Williams were prompted by a case involving ambulance service in Florida’s Lee County.

Last year, the Lee County Board of Commissioners denied an out-of-county company from providing ambulance service within its jurisdiction. After the outbreak of COVID-19, the company, Brewster Ambulance Service, reapplied for a CON but was again turned down.

Shortly after the release of the PLF letter, the state suspended the CON requirement for ambulance service until the end of the pandemic. PLF is now calling on Florida to make the suspension permanent and repeal the state’s remaining CON laws.

“We’re pleased that the CON suspension in Florida has allowed health care entrepreneurs like Brewster to respond freely to facts on the ground,” PLF’s Anastasia Boden told Health Care News. “Even after the pandemic, Florida and other states should consider permanent CON repeal. Entrepreneurs are in the best position to judge when they should expand, not bureaucrats or potential competitors.”

Pursuing Emergency Reform

The coronavirus pandemic illustrates the need to end CON laws, says PLF Attorney Mollie Williams.

“Given the latest spike in COVID in Florida, it’s great that the government acted to suspend the CON requirement for ground ambulances when it did,” Williams said. “This move allowed providers like Brewster to adapt and meet the growing need for ambulance services. As a result, people are getting the care they need during this medical emergency.”

Restricting Competition

CON laws restrict competition in health care markets by limiting new diagnostic, surgical, and ambulatory care centers and even new equipment in local hospitals.

Rooted in the National Health Planning and Resource Act of 1974 (NHPRA), CON laws were intended to enable states to cut health care costs by reducing redundancy. The NHPRA was repealed during the Reagan administration after it failed to produce the desired cost savings, but most states have held on to their CON laws, bowing to the fierce resistance of established providers.

CON decisions are often made by local governments, which frequently allow existing providers—including health care conglomerates—to serve on review panels. In practice, CON laws put the burden of proof on new providers, who must prove to local officials and competitors there is a “need” for their facilities or services.

Questioning Constitutionality

In a paper released in February by the Regulatory Transparency Project of the Federalist Society, the Goldwater Institute’s Christina Sandefur states CON laws “violate a host of constitutional provisions, including anti-monopoly clauses found in several state constitutions. Enabling existing providers to use the law to bar others from entering an industry or offering a service is the very definition of a government-created monopoly.

“Few state courts so far have directly addressed whether CON laws violate state anti-monopoly clauses, but several have noted that they are inherently anti-competitive,” writes Sandefur.

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

Quick COVID-19 Vaccine Unlikely, Pharma Exec Warns

Government officials, politicians, and industry leaders are doing the public a “grave disservice” by suggesting a COVID-19 vaccine could be ready by the end this year, Merck CEO Kenneth Frazier said in an interview with the Harvard Business School.

“Ultimately, if you are going to use a vaccine in billions of people, you’d better know what that vaccine does,” said Frazier.

Vaccines typically take years of development before receiving government approval, said Frazier.

Merck’s vaccines against mumps and Ebola took at least four years of research and development, and there is still no vaccine against HIV, Frazier notes. In fact, only seven “new” vaccines have been developed in the last 25 years, said Frazier in the July 13 interview.

Two prominent governors have defended their stay-at-home orders by citing the lack of a vaccine, saying they will continue to restrain public activities until a cure is ready.

Illinois Gov. J. B. Pritzker said on May 5 he did not envision a return to normal until a vaccine became available. On May 7, California Gov. Gavin Newsom told reporters, “We’re not going back to normal. It’s a new normal with adaptations and modifications, until we get to immunity and a vaccine.”

—Staff reports

INTERNET INFO

Ohio Lawmakers May Limit Governor’s Emergency Powers

By Jesse Hathaway
Ohio legislators are proposing more oversight on the governor’s emergency powers in dealing with public health crises such as the Covid-19 pandemic.

The package of bills would require legislative approval and public testimony before the executive branch can enact any public health orders, restrict the duration of public health orders, and prohibit requiring Ohioans to wear face coverings or masks in public.

The bills—House Bill (H.B.) 618, H.B. 649, H.B. 671, Senate Bill 1, and S.B. 311—would also rescind any currently active public health orders and change them to recommendations.

On May 19, Gov. Mike DeWine (R) lifted his March 22 stay-at-home order, which had restricted travel to “essential” purposes such as grocery shopping and commuting to work. On July 7, DeWine ordered face coverings to be worn in public in counties designated as having higher risk of transmission.

Child-care providers and day camps reopened on May 31, and amusement parks, indoor and outdoor movie theaters, nursing homes, water parks, and zoos reopened to the public in June and July.

DeWine issued a public health order on July 7 requiring individuals in seven counties experiencing larger incidences of COVID-19 cases to wear face coverings in public for the duration of the elevated risk. The executive order does not include language providing for enforcement by government authorities.

Ohio Governor Mike DeWine

‘Epic Abuse of Power’
The pushback against the state’s emergency orders is about fighting tyrants and preserving liberty, says Ohio state Rep. John Becker (R-Cincinnati), sponsor of H.B. 618.

“Nobody ever envisioned such an epic abuse of power that we’ve had, hence the necessity of this legislation to rein in and prevent that abuse of power from happening again for the purposes of a pandemic,” Becker told Health Care News. “The General Assembly’s not on a witch hunt to solve problems before they occur. The problem’s already occurred. Now we need to step up and solve it.”

What the bill does is reverse all past, present, and future orders of the director of health and the governor on the topic of a pandemic, and it makes them advisory rather than mandatory, unless they are approved by the General Assembly,” said Becker.

Jesse Hathaway (think@heartland.org) is a policy advisor for The Heartland Institute.

Federal Judge Rebukes Michigan Governor for Keeping Gyms Closed

On June 19, U.S. District Judge Paul Maloney ruled Michigan had no scientific basis for keeping gyms closed under Gov. Gretchen Whitmer’s epidemic emergency lockdown. The following is an excerpt from the decision in “League of Independent Fitness Facilities and Trainers, Inc, et al., v. Gretchen Whitmer and Robert Gordon.” On June 24, a federal appeals court ordered gyms to remain closed until an appeal on the matter is heard.

“Defendants cited to the preambles of the Executive Orders and vaguely stated that indoor gyms are a ‘petri dish’ of infection, but Defendants could not point to any facts in the record to support that statement. Defendants emphasized the low bar: all that needed to be presented was a reasonably conceivable set of facts that connected the continued closure to protecting the public health. But when asked, even counsel was unable to state a rational basis to support the position that indoor gyms must still be closed...”

“If Defendants can open or close any sector of the economy, at will, with nothing more than a vague reference that it is ‘dangerous,’ the potential for abuse is palpable. To be sure, the coronavirus pandemic has devastated parts of the country and the state and containing the transmission of the virus is crucial. Activities that are dangerous should be avoided, for the public health. But after more than 90 days of closure, the scientific knowledge of the virus has grown, and Michigan has made great gains in containing the pandemic. At this point, the bare assertion that gyms are dangerous is not enough to demonstrate a ‘real or substantial’ connection to public health, nor is it a set of facts establishing rational basis to justify their continued closure.”

—Staff reports
Pandemic Response Shows Failure of Administrative State

By Roger Klein, M.D., J.D.

In many ways, the election of President Donald Trump represented a challenge to, if not an outright repudiation of, the philosophy of governance by subject-matter experts that has characterized the administrative state.

Over time, government power has increasingly become centralized in administrative agencies, which have been called upon, or have taken it upon themselves, to make policy decisions impacting broad swaths of American society. Ostensibly, this was necessary because of supposedly unique bureaucrats’ competence to address arcane technical matters. It appears, however, to have been as much the result of conscious congressional abdication of responsibility for politically difficult policy choices.

At no time has the public’s skepticism toward expert rule seemed more justified than during the COVID-19 pandemic. We began the epidemic in the United States with our largest and most prestigious public health agency, the Centers for Disease Control and Prevention (CDC), reassuring the country that the coronavirus had barely reached our shores and was not disseminating here. We subsequently learned the opposite was true.

Central Planning Disaster

As the virus continued to spread undetected, precious weeks were lost before we could take measures that might have contained or slowed the burgeoning epidemic. Perhaps just as important, we relinquished the opportunity to gain knowledge about the characteristics of the disease—its severity, its lethality, and its level of transmission—because of a U.S. Food and Drug Administration (FDA) decision to place clinical diagnostic testing exclusively in the hands of the CDC (see related article, page 9).

In an outcome reminiscent of the failures of central planning in the former Soviet Union, socialized testing did not turn out well. Public health labs were unable to validate CDC’s contaminated reagents and could not deploy the agency’s tests. As a result, little testing took place in the United States until the FDA opened the field to private laboratories and in vitro diagnostic test vendors in late February and early March.

At this point, the clinical laboratory industry rapidly ramped up to perform millions of tests—an unprecedented and astounding feat that was a testament to the dedication and ingenuity of the skilled professionals in the industry and demonstrated the great heights to which Americans can soar when left to do their jobs unencumbered by the redundant and unnecessary “protections” of a largely ineffectual bureaucracy.

Radically Wrong Numbers

We were warned the SARS-CoV-2 virus kills 3 or 4 percent of those it infects, and that we could expect more than two million Americans to die from it. But even subsequent speculation of a 1 percent death rate never made sense. The estimates were derived from limited, faulty data, and the case and fatality numbers were obtained by testing mostly the sickest patients.

The CDC now estimates the infection fatality rate of SARS-CoV-2 at a more influenza-like level of less than 0.3 percent: less than three of every 1,000 infected people. Moreover, deaths are heavily concentrated among the sick elderly, with the overwhelming number of infected individuals experiencing mild illnesses or no symptoms.

Cuomo’s Deadly Decision

The “expert” mathematical modelers who projected millions of deaths also told us we would need thousands of ventilators and would run out of hospital beds and supplies as “doctor-gods” chose who would live and who would die through allocation of grossly insufficient health care resources. Despite admitted problems in uniquely populated-dense New York City—with its heavy reliance on public transportation and large numbers of low-income multigenerational households living in small quarters—the doomsday scenarios never came to pass.

Instead, nearly 60 percent of states still have fewer than 1,000 attributable fatalities. Residents of inadequately protected long-term care facilities account for about 40 percent of deaths nationally and much higher proportions in some states.

In epicenter New York, a gubernatorial executive order sent more than 4,500 recovering COVID-19 patients to vulnerable nursing homes to avoid discrimination against those infected and to preserve hospital beds that were never needed. This move almost certainly resulted in the unnecessary deaths of perhaps several thousand elderly residents.

Moving Goalposts

Politicians and public health officials imposed Draconian economic lockdowns, initially with the laudable short-term goal of avoiding overload of the health care system. But these restrictions were unjustifiably and indefinitely prolonged without supportive empirical data, to “save lives.”

Unemployment skyrocketed to Depression-era levels, not because of the virus but because of expert-directed action that confined people to their homes and left them unable to work as politically designated nonessential businesses were shuttered.

Lack of money and home confinement, at times with significant numbers of people crowded into small spaces, set the stage for mass protests, riots, and looting. These activities were defended by the same public health experts who had just warned us against leaving our houses and who had imposed and encouraged jailing of the dangerous rebels who dared open their businesses in order to feed their families. They did this while recommending the release of convicted criminals to prevent them from contracting what for most turned out to be a harmless disease.

The 180-degree turn from explicit instructions not to wear face masks to legal mandates to don them is but one of many examples of expert-directed authoritative pronouncements that were reversed without adequate explanation.

Is it any wonder ordinary Americans are confused and distrustful of the overconfident, smooth-talking experts who hold so much power over their personal destinies? Vigilance in guarding against arbitrary or unwarranted regulatory encroachments is essential to the preservation of a free society.

Roger D. Klein, M.D., J.D. (roger@rogerklein.com) is a faculty fellow at the Center for Law, Science, and Innovation at the Sandra Day O’Connor School of Law at Arizona State University, an expert in molecular oncology and regulatory policy, and a policy advisor to The Heartland Institute. This commentary is adapted from remarks delivered on June 12 before The Federalist Society.

“Politicians and public health officials imposed Draconian economic lockdowns, initially with the laudable short-term goal of avoiding overload of the health care system. But these restrictions were unjustifiably and indefinitely prolonged without supportive empirical data, to ‘save lives.’”

ROGER D. KLEIN, M.D., J.D.

HEALTH CARE NEWS | AUGUST 2020
Cancer Survival Depends on Treatment Center

By Ashley Herzog

Cancer patients are more likely to survive if they receive treatment at a top-ranked cancer center than at a hospital associated with the cancer center, a study finds.

Adjusted long-term survival at affiliate hospitals was 77 percent of that at cancer centers, and cancer centers beat affiliate hospitals by nearly 1.7-fold for 90-day survivability. The study reviewed the 90-day mortality and longer-term survival of 119,894 patients who underwent surgical treatment for five different kinds of cancer.

The study, published on May 26 in JAMA Network Open, also found cancer centers spent more time than affiliate hospitals staging patients and offering preoperative chemotherapy. Cancer centers were also more likely to be academic hospitals.

Open Letter Calls for End to Health Care Red Tape

Eighty-three health care leaders and participants in the Health Policy Consensus Group signed an open letter urging Congress and the Trump administration to make permanent the removal of hundreds of federal rules waived in response to the COVID-19 crisis.

The letter, signed by individuals from The Heartland Institute and The Goodman Institute, which publish Health Care News, recommends three areas for reform: making health insurance “portable,” making communication with providers easier, and giving consumers better control of how their health care dollars are spent.

“The COVID-19 pandemic has exposed how government red tape gets in the way of a rapid response and interferes with patients being able to quickly and efficiently get the care they need from those they trust,” the June 18 letter states.

Five Ways the President’s Health Plan Improves Health Care

In a 2019 analysis for the Goodman Institute, health care experts John Goodman and Marie Fishpaw describe five ways that President Donald Trump’s plan, “Reforming America’s Healthcare System Through Choice and Competition,” puts health care back into the hands of consumers instead of government bureaucrats.

Personal, Portable Health Insurance

Accounts called Health Reimbursement Arrangements, now available to employees, allow people to buy the insurance that best meets their individual and family needs. The insurance can travel with them from job to job and in and out of the labor market.

Round-the-Clock Care

Direct primary care (DPC) is an arrangement under which the patient pays a flat fee, often as little as $50 a month, for 24/7 access to a doctor. This type of care is popular with patients, but under previous regulations it was difficult for employers to pay for it.

Teledicine

Under President Trump’s emergency declaration order in March in response to the pandemic, Medicare now allows doctors to provide care by means of telephone, Skype, Zoom, and other devices without physically being in the same room with patients. Making virtual health reimbursement permanent for government programs will require an act of Congress.

Exchange Limitations

Ironically, the people hurt most by the ACA’s shrinking networks of providers are the same people the bill promised to help: people who do not receive health insurance from their employer.

“Top-rated cancer centers may not be in-network for health coverage sold on the exchange,” Herrick said. “By contrast, these centers are often in the networks of self-insured employee health plans. Individuals buying their own coverage may find they cannot get care at top cancer centers while those who have employee coverage can.”

The ACA, popularly known as Obamacare, was poorly designed in ways that encourage health plans to ration care, Herrick says.

“This should have been easy to anticipate,” Herrick said. “The overall impact of the ACA was to make health care less affordable. In the process, cost-sharing rose, making access to care worse for millions of Americans.”

President Proposes Choice

In 2017, the Trump administration put forth its own health care reform proposals that could restore consumer choice for treatment centers.

“Reforming America’s Healthcare System Through Choice and Competition” is the first-ever health care reform plan put forward by a modern-day president. The plan was drafted in response to the public’s frustration with rising health care prices and reduced access and choice, says John C. Goodman, a health economist and co-publisher of Health Care News.

Goodman and Marie Fishpaw, director of domestic-policy studies at The Heritage Foundation, highlighted five ways the Trump plan will make health care more affordable and consumer-friendly (see accompanying article). Improving access to “centers of excellence” is one way. Another way is to allow Medicare Advantage plans to specialize in certain conditions, such as cancer, where patients could get “care from the best.”

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.
Tired of Being LECTURED, MOCKED AND LIED TO by the Mainstream Media?

Join the more than 20 million readers who turn to The Washington Times.

Get 1 year of unlimited digital access to The Washington Times for just $49.95 and arm yourself with the facts.


Your subscription will also include our digital version of the daily paper delivered to your email, every weekday morning, with breaking news on the issues that affect the future of our nation.

The Washington Times

Reliable Reporting. The Right Opinion.

washingtontimes.com/heartland
What We Have Accomplished

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

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

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

401 (k) Plans
Because of automatic enrollment in diversified portfolios, 16 million employees are enjoying higher and safer returns

Visit us at online at www.GoodmanInstitute.org