Lockdowns and Suicide
Young adults report lockdowns are making them suicidal. New reports show a threefold increase over 2018.

Bullied into Silence
A new poll shows people are afraid to express political views—except those who describe themselves as “strongly liberal.”

2.4 Million False Positives?
Confirmed cases of COVID-19 may be significantly overstated because health agencies are not correctly factoring in “false positives.”

COVID Cash Incentive
Governors are under fire for exposing nursing home residents to COVID, including a $5,000 incentive for each COVID patient accepted.

T-Cells Show Promise
Researchers are learning more about the role of T-cells and how they account for why some people exposed to COVID-19 don’t get sick.

Cheap, Rapid Strip Test Shows Promise in Curbing COVID-19

By AnneMarie Schieber

A n inexpensive, self-administered antigen strip test could rapidly curb the spread of COVID-19 if government regulators would get out of the way, a Harvard infectious disease expert says.

Michael Mina, M.D., Ph.D., an epidemiologist at Harvard University, and Laurence Kotlikoff, Ph.D., an economist at Boston University, wrote about the idea in a July 3 New York Times op-ed.

Drug Prices

By Kenneth Artz

P resident Donald Trump signed four executive orders intended to lower drug prices and boost U.S. production of medicines and medical equipment.

The orders allow Americans to import drugs from pharmacies in Canada and other countries, tie prices paid for drugs under Medicare Part B to the prices paid in other countries, require discounts given to pharmacy benefit managers (PBMs) to be passed on directly to patients, and require community health centers to pass on drug price discounts for insulin and epinephrine to low-income patients.

On drug imports, importation must be “safe” and drugs will have to be approved by the U.S. Food and Drug Administration before being brought into the country. States and pharmacies would import drugs through waivers and would have to show the purchase results in lower cost. The order would allow wholesalers and pharmacies to “reimport” biologic drugs and insulin made in the United States but sold to other countries.
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 freetochoosemedicine.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
Employees Can Use Pre-Tax Money for 24/7 Direct Care

By AnneMarie Schieber

The Internal Revenue Service (IRS) is moving forward with a new rule allowing employees to use tax-advantaged health reimbursement accounts (HRAs) to pay for direct primary care (DPC).

For the first time, employees will be able to use HRAs to pay for DPC and health care sharing ministry memberships (HCSM).

In addition, taxpayers without employer-provided health care plans will be allowed to deduct DPC and HCSM fees as a medical expense from their tax returns if those expenses exceed 7.5 percent of adjusted gross income. The rules still classify DPC as a “health plan,” thus blocking consumers from paying for such arrangements through health savings accounts (HSAs).

The agency announced on June 8 it was proposing new regulations based on section 213d of the Internal Revenue Code, and the comment period ended August 11.

Increasing Employee Control

HRAs are funded by employers for health care, but the employee, not the employer, decides how to spend the money. The Trump administration has taken steps to expand the use of HRAs in the workplace.

DPC is an arrangement in which consumers pay an affordable, flat fee, usually under $100 a month per person, for what is often 24/7 primary care. Members can get discounted prescription drugs and lab and imaging services. DPC practices keep their prices low by not accepting third-party payers, thus cutting administrative overhead.

The new rule is a big first step, says John Goodman, president of The Heartland Institute, which publishes Health Care News.

“The reality is that the IRS is a rigged system that works against the public,” said Goodman. “Millions of employees have contributed to employee HSAs, but the IRS still views them as ‘gap plans.’ HSAs are accounts funded by consumers using pre-tax dollars to pay for medical expenses and must be linked to a high-deductible insurance plan. Taxpayers cannot use HSAs to pay for health plans.

“Congress has so far failed to clarify this innovation, so the IRS is forced to view it through an outdated regulatory lens,” Habig said. “All levels of government—local, state, and national—need to encourage innovation in health care delivery, since the inefficient government-dominated, insurance-based system is bankrupting the nation and delivering mediocre results.”

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

Continued from page 1

The international pricing index would apply to drugs used under Medicare Part B, such as those administered in a clinical setting, Trump said he will decide by August 24, after meeting with pharmaceutical industry leaders, whether he plans to implement this provision of the executive orders he announced on July 24.

The transfer of discounts given to PBMs, health plan sponsors, or pharmacies would apply to drugs sold to patients under Medicare Part D. One obstacle has been the federal anti-kickback statute which has prevented discounts from being passed on to consumers at point of sale. The new rule would create a “safe harbor” protection.

Discounts on insulin and epinephrine would apply only to low-income patients who have high cost-sharing requirements for the drugs.

Subsidizing Other Countries
Being able to buy less-expensive drugs from other countries is important, and the United States should be able to do that without restriction, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of Health Care News.

One consideration is price discrimination: the practice of charging a customer what a seller expects they will pay. Trump has publicly complained many inexpensive drugs Canada can purchase to resell to the United States. Canada manufactures generic drugs, but they are generally more expensive than elsewhere.

“What we really ought to have is free trade,” Goodman said. “They [Canada] don’t manufacture any branded drugs, and further, they tell companies like Pfizer that if you don’t sell us your drug at the price we want to pay, we will ignore your patent.”

Violating patents is not free trade, Goodman says.

“We’re already doing a lot of bad things when it comes to drugs,” Goodman said. “We ought to tell Canada to abide by our patents, and we ought to tell Americans they can buy from a Canadian pharmacy and that’s fine.”

Unleashing the Market
The rules address a longstanding complaint in the United States that prescription drug prices are too high, says Christina Herrin, a policy analyst at The Heartland Institute, which co-publishes Health Care News.

“According to the U.S. House Ways and Means Committee, the U.S. consumer pays nearly four times the amount for the same drug when compared to other countries, and in some cases 67 times as much,” Herrin said. “President Trump is right: Americans are getting the short end of the stick, and it is costing us billions, but the solution is to unleash the market.”

Herrin is not so confident that tying Medicare pharmaceutical prices to the International Pricing Index (IPI), a policy proposed by the Trump administration in 2018 with bipartisan support, is the answer. The policy could have “negative side effects to the production of new, innovative treatments, wait times, and even possible drug shortages,” Herrin said.

“Price discrimination is a normal thing and encouraged in many markets,” Goodman said. “Wherever there is a price discrimination, buyers being charged a higher price have an incentive to find buyers being charged a lower price to contract with them. To put it differently, buyers that buy at a lower price have an incentive to resell to the buyers that are being gouged. And we can allow both things to happen, but what our current law does is try to protect the industry that wants to price-discriminate.”

Preventing Patent Violations
Goodman says there is a limit to how much pharmaceutical companies can do to cut health care costs when they think outside the box, says Adam Habig, president and co-founder of Freedom Healthworks and a policy advisor to The Heartland Institute, which publishes Health Care News.

“Too often, employers have tunnel vision for high-cost centers like surgical procedures and medications,” said Habig. “While it’s easy to trim fat from those areas, primary care is where deep, sustainable savings are generated. Using employer clinics to procure DPC is really only feasible for the largest employers like Amazon, but all companies can emulate Amazon by using affiliated communities of independent direct care practices like Freedom Healthworks.”

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

Amazon Offers Employees Round-the-Clock Direct Health Care

By AnneMarie Schieber

Amazon is providing direct primary care (DPC) to its workforce through 20 new health centers, in a partnership with national medical group Crossover Health.

Centers are opening in five regions of the United States where Amazon operates fulfillment facilities. The first is expected to open in Las Colinas, Texas, and if the centers prove successful, the company will open more. Amazon employs one million workers, making it the nation’s second-largest employer, behind Walmart.

“Across the U.S., an increasing number of patients do not have easy access to a primary care physician and instead utilize emergency or urgent care options, which is not only more expensive for patients but also overlooks important preventative care opportunities,” said Darci Henry, Amazon’s vice president of human resources, in a statement.

The clinics will provide primary care, vaccines, physical therapy, chiropractic care, behavioral health care, health coaching, and specialist referrals. Clinics will accommodate Amazon’s round-the-clock workforce and their families by expanding hours and offering virtual care.

DPC on the Rise
The announcement is welcome news, says Mark Blocher, CEO and president of Christian Healthcare Centers, a direct primary care provider based in Michigan.

“Amazon doesn’t launch into new lines of business unless it is convinced of their viability,” said Blocher. “Therefore, the announcement is a validation of the DPC movement that is spreading throughout the United States. More and more companies want to contract directly with health care providers rather than through third-party payers such as insurance companies.”

“A number of big companies who self-fund their health insurance have been going in this direction for some time,” says Russ Carpel, CEO of LevelFund Health. “The one concern I would have is patient privacy, especially now under COIVD when a number of protections have been put on hold. Will Amazon have access to employee medical records?”

Carpel says the partnership is an improvement over the third-party payer system, where preferred provider organizations determine prices with providers.

“This setup eliminates those back-room deals,” Carpel said. “If done correctly, it can save money and keep quality care intact.”

Says Others Can Follow
The Amazon move shows what big companies can do to cut health care costs when they think outside the box, says Adam Habig, president and co-founder of Freedom Healthworks and a policy advisor to The Heartland Institute, which publishes Health Care News.
Employers Turn to Direct Care to Save Money, Provide 24/7 Care

By Ashley Bateman

In the wake of COVID-19 lockdowns, more employers are exploring direct primary care (DPC) and unconventional setups such as health sharing networks to provide lower-cost healthcare for employees without sacrificing quality.

Although exact numbers are difficult to track down, platforms that match employers with DPC, such as Accresa, have been promoting new DPC partnerships with reinsurers for employers of all sizes who want to self-fund health care.

“DPC is an amazing opportunity for employer groups to get better access to care at a much more affordable price, and we want to encourage the expansion of models like DPC by offering preferred pricing through our underwriting for groups that implement a DPC benefit,” an Accresa press release states.

DPC practices are membership-based and do not accept insurance, which allow them to keep prices low, generally under $100 a month per person. Members pay a flat fee for what is typically round-the-clock care.

Tax Considerations

Employees must pay for DPC out of pocket, but the expense is sometimes lower than meeting a deductible. Currently, employees are prohibited from using health savings accounts to pay for DPC. DPC plans, like traditional insurance, are not exempt from payroll tax if an employer chooses to pick up the tab.

Despite these government rules, DPC can save employers money if they can scale it, says Russ Carpel, CEO of Level Funded Health.

“For employers with several-hundred employees, the cost savings may not be all that significant because the biggest cost driver is not routine care,” Carpel said. “Five to 10 percent of claimants drive 50 to 90 percent of claim dollars, the majority of which is prescription drugs and hospital and facility fees. A large employer, with thousands of workers could really see significant savings because they can scale the small savings of routine care and save, perhaps, millions of dollars.”

Interest in Health Share Plans

Some employers are turning to health care sharing programs. Such programs, sometimes faith-based, agree to cover health care expenses for a flat fee, and they are not insurance. Members “share” costs with other members in the group, and fees may be adjusted from time to time to cover expenses.

Christian Healthcare Centers (CHC), a nonprofit DPC based in Grand Rapids, Michigan, works directly with employers working under such arrangements. CHC recently created a subsidiary to provide multispecialty in-office procedures and minor surgeries at substantially reduced cost to employers and employees.

“A colonoscopy that typically costs $2,800 in a hospital-owned facility can be provided in our office for $850,” said Mark Blocher, executive director at CHC. “Inserting a chemotherapy port at a hospital-owned facility or surgery center costs around $2,500 but is $500-700 in our office. There are many more common procedures that can be provided that save employers on their health care spending.”

Last year the program saved one group approximately $184,000 on medical expenses, says Blocher.

Blocher says third-party benefit administrators for self-funded companies are also recommending health care sharing to their clients.

“Third-party administrators love this because they don’t have as many separate claims to manage and it reduces the employers’ health care spend,” Blocher said. “During the COVID shutdown when patients could not get in to see primary care doctors because insurers companies would not reimburse doctors for nonurgent visits, our office continued to care for patients through in-office urgent needs and through tele-medicine.”

Regulatory Uncertainty

The use of health sharing plans for employer health care can be complicated, says Philip Eskew, D.O, J.D., a policy advisor to The Heartland Institute, which co-publishes Health Care News, and founder of DPC Frontier, an organization that monitors the DPC industry.

“Both DPC practices and health share plans had to have clarifying laws passed in many states to make sure that they were not labeled as an insurance product,” Eskew said. “The debate on the health share side was more difficult in that regard than on the DPC side.”

Historically, employers have not taken advantage of health share and DPC memberships for employees, Eskew says.

Some of the newer health shares that were not grandfathered by the Affordable Care Act seem to be attempting to build a business model around this idea, but the legal footing is unsteady, and I have not seen any large employers or any health benefits advisors, brokers, promoting health shares as a solution,” Eskew said.

No Mandate, More Options

Rising unemployment is also increasing interest in health share plans and DPC, says Cliff Porter, M.D., a physician at Texas Direct Medical Care in Austin, Texas.

“People suddenly faced with the loss of employer-sponsored insurance have far better options than the high expense of COBRA or Obamacare plans, by adopting a DPC plan with a cost-sharing or other catastrophic-type health insurance option. The ending of the individual mandate has opened the door for better options. There are religious- and nonreligious-based [share] plans less than half the cost of insurance, with better access to care. Cost-sharing plans often offer discounts when combined with DPC clinics, because of the dramatic reduction in unnecessary medical costs and improved actual medical care.”

Cliff Porter, M.D., Physician

“People suddenly faced with the loss of employer-sponsored insurance have far better options than the high expense of COBRA or Obamacare plans, by adopting a DPC plan with a cost-sharing or other catastrophic-type health insurance option. The ending of the individual mandate has opened the door for better options. There are religious- and nonreligious-based [share] plans less than half the cost of insurance, with better access to care. Cost-sharing plans often offer discounts when combined with DPC clinics, because of the dramatic reduction in unnecessary medical costs and improved actual medical care.”

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
Cheap, Rapid Strip Test Shows Promise in Curbing COVID-19

Continued from Page 1

Mina has been promoting the idea in journals and in a one-hour discussion on August 6 with Med-Cram. Rapid testing shows much more promise than spending billions of dollars on development of therapeutics or a vaccine, Mina stated in Harvard Magazine on August 3.

“It’s a crapshoot that may or may not work,” Mina writes. “We have solutions, sitting in front of us right now, that are cheaper, would be much quicker to build, and much less risky to actually introduce and roll out.

“The only thing standing in the way is that there just doesn’t seem to be the will to bring a public health tool to market,” Mina writes.

The public health tool is a $1 to $2 self-administered paper strip test, similar to at-home pregnancy tests, that can indicate in a matter of minutes whether an individual is infectious with SARS-CoV2, the virus that causes COVID-19.

The tests are saliva-based and look for antigens to the virus. The tests are half as sensitive as the PCR (polymerase chain reaction) nasal swab tests being used around the country, but what matters is capturing the “threshold of transmissibility,” Mina says.

Concentrating on Transmissibility
A highly sensitive test will pick up particles of the virus when an individual is contagious and a threat to others, but it will also detect evidence of the virus several months after a victim has recovered and is no longer contagious.

The rapid test, in contrast, picks up the virus only during the period when an individual is likely to transmit it to other people.

Mina gives the hypothetical example of a fire department with an extremely sensitive monitoring system, one that can detect even the smallest fire anywhere in a city. In such a system, the fire trucks would be out on the street, headed toward a new destination every time someone struck a match.

“Is that what we want in a fire department?” Mina asked.

Identifying Transmitters on the Spot
To understand how the strip test works, it is helpful to know what a “Ct” value is, says Robert Seheult, M.D.

“It is a way of measuring viral load,” Seheult explained in a MedCram video on July 20. “To be infectious, you have to carry a high viral load.”

Seheult refers in the video to a March 19 article in the New England Journal of Medicine which describes the detectable viral load or “Ct value” of infected patients measured against days since the onset of symptoms. Ct values can range from a low of 40 to a high of 15.

“If you’re missing people with higher CT values, who cares?” Mina asks in a clip in Seheult’s presentation. “They are not infecting people.”

“It is not important for a supersensitive test to be given on everyone,” Mina says. “The less-sensitive test [the strip test], one that detects virus at lower Ct values, is fine because it captures the window of transmissibility.”

If someone gets a positive on a strip test, he or she can stay home, which could help control the spread of the virus. Frequency in conducting the tests is much more important than sensitivity, says Mina.

The PCR test, by contrast, requires some effort on the part of the medical professional, costs $25 to $200, and can take up to seven days to deliver results, by which time the diagnosis is likely to be of limited value.

Holdup at FDA
Regulatory hurdles at the U.S. Food and Drug Administration (FDA) are the main reason rapid strip tests are not widely available, Mina says.

“What they are expecting is an at-home test that meets all the metrics and milestones of a lab test,” Mina said in the video.

Regulators also want tests to have a system for reporting all results to health departments, but this would require some effort on the part of the people being tested, says Mina.

“So then the companies have to develop some kind of software on the internet for reporting, and we can’t realistically create a test where people are going to report their results each and every time, and this will make the test more expensive,” Mina said.

Mina says the technology is available for a strip test, but few companies want to launch if they will run a high risk of being shut down by regulators or held liable for outcomes of incorrect results.

“We’re seeing some lack of urgency [at the FDA],” Mina said. “Part of it is, who wants to be liable?”

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

Socialism Is Evil
The Moral Case Against Marx’s Radical Dream

“Immunize your kids and grandkids early and often - send them to StoppingSocialism.com”

- Michelle Malkin

INTERNET INFO

“How to Fix COVID-19 Testing; Q/A with Dr. Michael Mina: Cheap, At Home, Rapid Antigen Tests,” August 5, 2020: https://www.youtube.com/watch?v=3seIAs-73GB

“Coronavirus Pandemic Update 98: At Home COVID-19 Testing—a Possible Breakthrough,” July 20, 2020: https://www.youtube.com/watch?v=h7Sv...
Rapid COVID Test Could Present Complications in Practice

A rapid, frequent, and more widespread test for COVID-19 could present complications in practice, says Roger Klein, M.D., J.D., an expert in molecular diagnostics and regulatory issues and a policy advisor to The Heartland Institute, which co-publishes Health Care News. Klein spoke with Health Care News about the hurdles a strip test would have to overcome for it to be a realistic tool in curbing the pandemic.

Health Care News: The public is frustrated with how little the lockdowns seem to have controlled the virus. The idea of an inexpensive, easy, and rapid test seems like an obvious solution, but is it?

Klein: The notion that one can reliably separate people into two groups—those who are infectious and those who are not—based upon nearly divisible viral levels, is more complex in practice. If the test performs as we hope and assumptions about viral transmissibility prove correct, we then need to ask what proportion of the population could or would properly test themselves on a daily basis. Participation would likely be far less than needed to control a pandemic. Those at risk of spreading the disease are probably least able or willing to engage in daily self-testing. We then need to assume people will act on the results. Would people with no symptoms stay home?

Health Care News: Should the U.S. Food and Drug Administration (FDA) do more to maximize the potential of these tests?

Klein: FDA has to ensure the tests are safe for individuals to use. Home tests all have to meet a set of standards. First, tests have to employ methodologies so simple and accurate as to render the likelihood of erroneous results by the user negligible. Second, the Secretary of Health and Human Services has to determine the tests pose no unreasonable risk of harm to the patient if performed incorrectly.

Even under emergency use authorization, FDA will want to ensure tests do not pose risks to individuals. For example, if a test has poor sensitivity, it could mislead people into taking unsafe and risky actions with respect to themselves or others in which they may otherwise not engage; for example, visiting grandma at her nursing home. FDA would need to have standards and base the standards and adherence to them, on data.

Health Care News: Wouldn’t this be a good time for the FDA to lower those standards, as we seem to be in a race against time?

Klein: The issue is whether FDA’s standards are too high and whether lowering them provides benefit in some settings. This is undoubtedly true. We use rapid, less sensitive tests for influenza in order to rapidly administer antiviral agents but have only limited access to such tests at this time for SARS-CoV-2. There is nothing preventing use of rapid testing up front, supplemented by more accurate PCR testing, either for patients in whom the disease is suspected or who are at high risk for it, or in conjunction with rapid testing on a sampling basis in a surveillance program.

I think rapid testing, even with lower sensitivity, has definite and important uses in certain settings. Those would include workplaces and nursing homes, as part of surveillance programs intended to curtail local outbreaks. FDA needs to be aware of and open about other uses and avoid rigidity as it balances benefits versus harms.

Health Care News: Let’s say there could be widespread voluntary compliance. Could it get COVID-19 to a point where we wouldn’t have to worry about it any more than the flu in a reasonable period of time?

Klein: This is unlikely. The epidemic is unlikely to burn out unless and until enough people have some level of immunity gained through infection or a vaccine. Right now, we are in a race between viral infections and vaccine development, the latter of which, if successful, will save lives and avoid substantial morbidity.

For most people, SARS-CoV-2 presents a very small risk and the virus already is in the vein of a bad flu, a novel strain that we haven’t seen before that will not cause serious illness for most infected people. The virus’s pernicious effects are primarily from the large numbers it has infected and will infect, and the vulnerability of particular populations such as the sick elderly.

Health Care News: I think rapid testing, even with lower sensitivity, has definite and important uses in certain settings. Those would include workplaces and nursing homes, as part of surveillance programs intended to curtail local outbreaks. FDA needs to be aware of and open about other uses and avoid rigidity as it balances benefits versus harms.”

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

Unfortunately, some people are going to get seriously ill and even die from this virus, as they do from other diseases, and we cannot know with certainty who those individuals will be. We can, however, play the odds in order to save as many lives as possible. This means devoting our resources and efforts toward protecting vulnerable populations, such as nursing home residents and other sick elderly people, who are most likely to be harmed by the infection.

Health Care News: Given that we have little history with the SARS CoV-2, aren’t we better off trying anything?

Klein: We would still be prolonging the inevitable. It is preferable to develop immunity through a vaccine, and the Trump administration’s Operation Warp Speed has been a brilliant and, thus far, unbelievably successful attempt to save thousands of lives at a miniscule cost relative to other expenditures during this epidemic.

In my view, President Trump and his administration have done an outstanding job in a difficult situation over which we unfortunately—and people don’t want to believe this—have limited control.
Two-Million-Plus COVID-19 Cases Could Be False, Physicians Report

By AnneMarie Schieber

U.S. health agencies have failed to factor in false positive results among confirmed cases of COVID-19 and could be overstating the number of positive cases by as much as 100 percent, say physicians in recent published articles.

Of the 65.7 million COVID tests reported by the Centers for Disease Control and Prevention (CDC) as of August 10, 5.9 million Americans, or 9 percent of those tested, showed positive results. Infectious disease expert Erwin Haas, M.D., says the data reported by health agencies does not acknowledge the possibility a percentage of the positive results are false.

“It is a well-known principle in statistics that all tests will have some biologic false positives that unfortunately label individuals as being diseased but who are not afflicted,” Haas wrote in the American Thinker on July 21.

Haas says he found only one published study, by the Foundation for Innovative New Diagnostics, that found a 100 percent sensitivity (the measure of positive accuracy), and the study had 96 percent specificity (the measure of negative accuracy), suggesting 4 percent of all results are false. Four percent of 65.7 million is 2.6 million, nearly half the number of all confirmed cases. (See related article, this page).

“That is being charitable,” Haas said August 4 on The Heartland Daily Podcast. “I think most tests would say a 4 percent false positive rate would be a very, very good test.”

Barbara Yaffe, M.D., Canada’s associate chief medical officer of health, made similar remarks to The Scoop on August 1.

“If you’re testing in a population that doesn’t have very much COVID, you’ll get false positives almost half the time,” Yaffe told The Scoop.

Too Many Tests

Haas says much of the problem derives from trying to test a broad population, which makes false positive rates more probable.

“Targeted testing is a well-established practice for any disease,” Haas told Health Care News.

Bayesian inference, a statistical procedure that adjusts the probability of a hypothesis as more information becomes available, is a good way to look at the problem, Haas says. Assuming the actual number of cases to be constant at any moment in time, the more you test, the higher the number of false positives. The fewer you test, the lower the number of false positives relative to number of people who are truly sick.

“One million Americans develop cancer every year,” Haas said. “It’s a terrible disease, and we should try to diagnose it earlier to try to get a better cure rate. Let’s say there is a test which has a 10 percent false negative rate and a 10 percent false positive rate. We do the test on all 330 million Americans. Of (each) one million new cases of cancer, we pick up 900,000, and they are very grateful.”

The 33 million false positives, however, create a problem, Haas said.

“These 33 million Americans will be very upset and will require much more diagnostic workup,” Haas said. “The 900,000 who have been told correctly of their cancer diagnosis will be mixed in with this group. It is fairly easy to see testing everyone is a very bad idea and will create huge numbers of false positives, which is what is basically happening today.”

Pyramid of False Diagnoses

Haas says although COVID-19 doesn’t require the same confirmation workup as cancer, the false positive results are being used to contract-trace others, who will be given tests regardless of whether they symptoms, increasing the number of false positives.

“Being ‘safe’ by overcalling or tolerating a high false positive rate encourages one faction of our political blowhards to exaggerate the seriousness of the ‘pandemic,’ so as to ramp up spending, borrowing and intruding into American life,” Haas said.

False Second Surge?

Haas says the testing problems call into question the assumption the nation is undergoing a second surge of COVID-19 cases.

“For one thing, we are sampling a totally different population [now],” Haas said. “We are testing people for whom we don’t even have a suspicion that they may even have the illness.”

Testing the general population in this way violates standard screening protocol, Haas says.

“You don’t do screening tests on people you think will have a low incidence of positives,” Haas said.

Hordes of Testers Unleashed

Early in the pandemic, the CDC prevented other agencies from developing a COVID-19 diagnostic test and then, weeks later, as the virus gained a foothold, produced an unreliable test.

What followed was a “wild west” of health care, Haas says.

“The CDC’s next brilliant move was to allow anyone to develop his own test after ‘internal validation,’ which meant that any backwater could set up their own proprietary test and charge for doing it as many times as customer could attract paying customers,” Haas said.

“I saw yet another ‘test site’ sign this morning on my daily rounds,” Haas said. “The owners of what are licenses to print money have no incentives to challenge the validation of their early retirement modalities.”

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

How 2.4 Million Positive COVID-19 Results Could be False

Infectious disease expert Erwin Haas, M.D., says the rate of false positive test results can be easy to misunderstand because most people want to apply the false positive rate only to the total number of positive results, not the total number of tests, which dramatically lowers the number of false positives calculated.

“Technically, the [reported rate of] 4 percent applies to the folks who are negatives, who do not actually harbor the virus, and excludes the real positives and the false negatives,” Haas explained. “But the magnitude of having an extremely low actual disease prevalence makes it mathematically irrelevant.”

The August 10 numbers from the CDC report 65.7 million total tests, of which 5.9 million showed positive results.

“You would subtract 5.9 from 65.7, to equal 59.8,” Haas said. “Next, you multiply that by 4 percent, which gives you 2.4 million, subtracted from the new 5.9 million.”

“This is where it can get tricky,” Haas says.

“So 3.5 million actual positives would have to be reinserted into the original 65.7, of which you subtract 3.5, which equals 62.2, the actual negatives,” Haas said.

Because it is not clear who among the positives are really infected, simply saying 5.9 million have the virus can be confusing, Haas says.

“Positive tests and number of ‘cases’ found because of symptoms don’t anywhere match, and trying to explain it makes it a nightmare,” Haas said. “I’ll stand by the original 4 percent of the 65 million. Oh, sancta simplicitas!”

—Staff reports

“The CDC’s next brilliant move was to allow anyone to develop his own test after ‘internal validation,’ which meant that any backwater could set up their own proprietary test and charge for doing it as many times as the advertising budget could attract paying customers.”

Erwin Haas, M.D.
Tyson Foods Uses Algorithm Testing to Beat COVID

By AnneMarie Schieber

Tyson Foods, one of the world’s largest food processors, has launched a first-of-its-kind program using algorithms to ramp up testing on workers who show no symptoms for COVID-19.

Tyson did a trial run of the “testing as a tool” program at three plants in the summer. The trial was such a success that the company will expand it to all its facilities in the coming weeks.

Using data science, the program selects which employees and how many employees will be tested each week. The number and the population will be adjusted based on results from Tyson’s facilities and the number of new cases in surrounding communities.

Testing employees without symptoms is one step the company is taking to keep its workers safe and its doors open. Tyson will continue to screen workers for COVID symptoms and perform diagnostic tests on employees who’ve been in contact with people infected with the virus. The company also monitors its floors to make sure workers are keeping safe distances and wearing masks properly.

Tyson is also expanding its health staff. The company has a new chief medical officer and has added 200 nurses and administrative support staff to its existing health team.

Workers will receive extra counseling on healthy living. Tyson employs 120,000 people at 140 facilities throughout the United States.

Efficiency Factor

Tyson developed its “testing as a tool” program with health care management provider Matrix Medical Network. Using data science to determine who and when to test makes complete sense for a large company, says Tyson spokesperson Gary Mickelson.

“It is virtually impossible to test everyone, every day,” Mickelson told Health Care News. “We have been testing employees probably more than any other company. We have tested about one-third of our workforce, most of it through onetime facility-wide testing, which provides only a snapshot.”

With the new system, Tyson can conduct thousands of tests each week, Mickelson says.

“By using data science to test a statistically sound sample of team members, we have a better chance of staying ahead of any potential virus spread and protecting our teams and communities,” Mickelson said.

As of mid-August, less than 1 percent of Tyson’s U.S. workforce had active disease, Mickelson says.

“The objective is to stay ahead of the virus, to be on the offensive,” Mickelson said.

Tyson will test asymptomatic employees until COVID-19 is no longer a public health threat, Mickelson says.

FDA OKs COVID ‘Batch Tests’

By AnneMarie Schieber

In a move that could ramp up testing for COVID-19, the U.S. Food and Drug Administration (FDA) gave the green light to the first diagnostic test to be used on pools of samples.

So-called pool or “batch” testing allows labs to run fewer tests by combining multiple samples.

The FDA authorized Quest Diagnostics to start experimenting with pool testing in March. Validation data proved successful, and the FDA approved pool testing on July 18. The agency says pool sampling works best in areas with low prevalence of the disease.

FDA officials say pool testing is a first-of-its-kind program using algorithms to ramp up testing on workers who show no symptoms for COVID-19.

By using data science to test a statistically sound sample of team members, we have a better chance of staying ahead of any potential virus spread and protecting our teams and communities,” said Daniel Castillo, M.D., chief medical officer for Matrix Medical Network. “You’ll likely see many others adopt a similar approach in the coming months because it’s a process that looks both at people showing symptoms as well as those who do not.”

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

Promise for Economic Reopening

Pool testing could allow the reopening of the economy in as little as a month, says Laurence Kotlikoff, an economist at Brown University.

“We are doing extremely stupid testing,” said Kotlikoff. “We are focused on testing the sick rather than the healthy, and we’re missing people, with no idea who is spreading the virus.”

Kotlikoff wrote an open letter to National Institute for Allergy and Infectious Diseases Director Anthony Fauci and White House Coronavirus Response Coordinator Deborah Birx, published in Forbes on May 3, in which he urged the use of PCR-based household-group testing, a protocol developed by Cornell University Research Professor Peter Frazier.

Using this approach, authorities could test every household in the country for COVID-19 in one month by doing six million PCR “group” tests a week. Testing would be done using a combined saliva sample of all members in a household. The combined sample would be mixed with those of dozens of other households, perhaps in one neighborhood. If the result comes back negative, each member of the group could be given a green wristband to wear in public until a second test is conducted a week later. Groups that test negative could be quarantined for two weeks, and those who are sick could be treated at home.

Kotlikoff says such group testing worked during World War II in controlling syphilis among army recruits.

“This would have to be done in a nationally coordinated way and involve heavy-duty quarantining, but essentially it would be similar to a cure for COVID,” Laurence Kotlikoff Economist, Brown University

Coercion, Effectiveness Concerns

Conducting a nationwide testing operation in which everyone would be compelled to participate raises a number of problems in addition to the cost, who would pay for it, and what agency or business would process the millions of bio-samples, says Twila Brase, president of the Citizens’ Council for Health Freedom and a policy advisor to The Heartland Institute, which co-publishes Health Care News.

“This wouldn’t be voluntary; it would be coercive,” said Brase. “Being forced to wear green bracelets as a license to live, work, eat, move, or play in America is totally unconstitutional and wholly un-American.”

Brase says she also has questions about the effectiveness of such a system.

“The study has not been peer-reviewed or evaluated,” said Brase. Kotlikoff says no policy will be perfect, but economists are trained to think in terms of the big picture, things not being done now.

“What we’re doing is chaotic, inefficient, and grossly incompetent,” said Kotlikoff.

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Americans Are Bullied into Silence on Political Issues

By Kelsey Hackem

A national poll found 62 percent of Americans are afraid to share their political views, a four percentage point increase from a similar survey conducted in 2017. The survey, released by the Cato Institute on July 22, found self-censorship ran the political spectrum. Only respondents who described themselves as “strongly liberal” stated they felt free to express their viewpoints.

When presented with the statement “the political climate these days prevents me from saying things I believe because others might find them offensive,” 58 percent of strong liberals disagreed. Seventy-seven percent of conservatives and strong conservatives agreed with the statement, as did 64 percent of moderates and 52 percent of liberals.

Particularly striking is that those with moderate viewpoints are now afraid to speak up, says Emily Ekins, Ph.D., a research fellow and director of polling at Cato.

“This is about the majority of liberals, the majority of moderates, and the majority of conservatives who feel like they can’t share their views, which indicates it’s not just some wacky fringe or racist views that people aren’t sharing but rather perhaps more mundane views,” Ekins said.

Consequences of Silence

Restraining oneself from expressing political viewpoints goes beyond politeness, Ekins says.

“There has been such a chilling effect on speech, it has effectively raised the transaction cost of expressing yourself politically,” Ekins said.

The climate of silence has also undermined political engagement, Ekins says. Poll respondents said they were afraid of making political contributions because it could hurt them in the workplace.

“We think, why would they want to risk losing friends, losing their job, or suffer economic punishment just by weighing in on political matters, so they just disengage,” Ekins said. “That is going to have ramifications for the political process.”

Free speech is still protected at the voting booth, where votes are cast privately, Ekins says.

“That is a core component of democracy,” Ekins said. “But there are all sorts of other aspects to the democratic process that are not done in private, whether that be contributing your time, talents, and resources to a cause or candidate that you believe in.”

One particular concern recently has been the pandemic, Ekins says.

“We just don’t have all the facts and all the information, and so a lot of the guidance that was given is often changing,” Ekins said. “Then, people are frustrated about those changes, and so I would suspect that many people have just decided to disengage from that topic as well.”

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

Mask Mandates Worry Workers’ Comp Underwriters

By Ashley Herzog

Insurance underwriters are scrutinizing whether mask use could lead to an increase in workers’ compensation claims.

PN Medical, which calls itself “the nation’s leader in specialty network management services for the workers’ compensation industry,” published a press release saying masks can create workplace respiratory complications.

An employee who suffers an injury in the workplace may be eligible to file a workers’ compensation claim to cover medical bills, rehabilitation, and wage loss.

The consulting firm stated it has been investigating the effects of mask wearing for eight to 10-hour days and what affects the practice could have on employee health.

“Improper breathing while wearing surgical or cloth masks has been shown to cause anxiety, headaches, increased heart rate, dizziness and fatigue,” the release stated.

“We are not condemning masks,” said PN Medical CEO Mark Carbone in a statement. “We realize they are necessary tools given the current environment we live in. That said, it’s critical to educate people on how to breathe effectively while wearing them.”

PN Medical offers several steps employees can take to assure safe breathing with masks. Steps include taking five deep breaths before and after the mask is on the face; longer, slower breaths while wearing the mask; and learning how to control a virus may be to wait for herd immunity and the development of effective treatments.

“Of course, this means folks will continue to become ill,” Singleton said.

Mask Training

PN Medical offers several steps employees can take to assure safe breathing with masks. Steps include taking five deep breaths before and after the mask is on the face; longer, slower breaths while wearing the mask; and learning how to control a virus may be to wait for herd immunity and the development of effective treatments.

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.
Lockdowns Are Making More Adults Suicidal, Vulnerable to Non-COVID Death, CDC Figures Show

By Kelsey Hackem

As public health officials and other government officials continue COVID-19 pandemic lockdowns and strict public health measures, new data from the Centers for Disease Control and Prevention (CDC) shows deaths from opioid overdoses and Alzheimer’s disease have risen and more young adults are suffering from mental health problems and contemplating suicide.

The latest numbers, released on August 14 and reflecting data gathered between June 24 and June 30, show 10.7 percent of U.S. adults contemplated suicide in the last 12 months. Among adults aged 18-24, 25 percent reported suicide ideation in the last 30 days. In 2018, 4.3 percent of adults considered suicide at some time in the year.

Comparing the two periods in 2020 and 2019, anxiety disorder among all adults is three times as common this year (25.5 percent vs. 8.1 percent) and depressive disorder is four times as common (24.3 percent vs. 6.5 percent).

Suicides Outpacing Infection Deaths

“We’re seeing, sadly, far greater suicides now than we are deaths from COVID,” said CDC Director Robert Redfield on July 14 at a Buck Institute webinar. “We’re seeing far greater deaths from drug overdose that are above excess.”

One in 10 U.S. adults reported starting or increasing substance abuse in 2019, and there were 70,980 fatal drug overdoses in the United States in that year, according to the CDC, which is still compiling numbers for the year.

Alzheimer’s deaths have also increased during the lockdowns. The CDC reports nearly 100,000 people died from Alzheimer’s and dementia from February through May, 18 percent higher than the average incidence for those disorders. Not all of the increase is attributable to deaths from COVID-19 infections, the CDC reports.

Lockdown Collateral Damage

Individuals who suffer from mental illness or dementia-related conditions bear a higher burden from COVID-19 restrictions, to the detriment of their overall health, says Robert Emmons, M.D., a psychiatrist and policy advisor to The Heartland Institute, which publishes Health Care News.

“Quarantine policies during the COVID-19 pandemic have created a burden of social isolation, a burden which falls most heavily on patients of limited economic means, cognitive impairment, and chronic psychotic illness,” said Emmons. “Social isolation exacerbates preexisting symptoms.”

Public health officials must focus more on these populations and their mental health needs, instead of prioritizing COVID-19 over all other serious illnesses, says Emmons.

“Finding ways to increase social contact for these populations is a low-tech intervention with the potential to employ able-bodied individuals currently sidelined from work,” said Emmons. “Finding ways to target quarantine policies more precisely, in order to permit visits between patients and low-risk family members, is another potentially powerful, no-cost intervention that has the potential to dramatically improve clinical outcomes.”

Tradeoffs Ignored

As the lockdowns and restrictions continue, individuals with life-threatening conditions or whose treatment and diagnoses are delayed are suffering serious and often fatal harm, says Jeffrey Singer, M.D., a surgeon and senior fellow with the Cato Institute.

“Public health officials and policymakers are not giving enough consideration to the tradeoffs involved in pandemic policy,” said Singer. “Many people with life-threatening conditions, acute or chronic, that have significant fatality rates, are ignored or neglected when public health policy focuses almost exclusively on controlling a virus that has an infection fatality rate somewhere below 1 percent.”

Government mandates have kept people from seeking medical attention when they need it, says Singer.

“We are already seeing increases in stroke, heart attack, and advanced cancer patients as their evaluation and treatment have been delayed or cancelled by statewide lockdowns and blanket bans on elective procedures,” said Singer.

Patients have held off seeking medical attention until they couldn’t avoid it, says Singer.

“In my surgical practice, we are seeing patients present to emergency rooms in critical condition from acute surgical emergencies, such as a ruptured appendix or strangulated hernia, because they waited far too long to seek attention, out of fear of COVID-19,” said Singer.

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

#INTERNET INFO


Lockdowns Don’t Work, Study Finds

Travel restrictions and containment measures have “no observed association” with the number of critical cases of COVID-19 or death rates for the virus, a new study has found.

Increasing caseloads were associated most strongly with other health conditions and social factors, says the study published by The Lancet. Researchers examined data in 50 countries through May 1 for the study.

Travel restrictions and containment measures put into place through May 1 “may have an impact on the total number of COVID-19 cases in a given country, but there was no observed association between public health policies and the number of critical cases or mortality,” the authors write. “Most importantly, low levels of national preparedness in early detection and reporting, limited health care capacity, and population characteristics such as advanced age, obesity and higher unemployment rates were key factors associated with increased viral spread and overall mortality.”

—Staff reports

Lockdowns Benefited Leading Cigarette Manufacturer

One of the world’s largest makers of cigarettes says the coronavirus pandemic is having a positive impact on sales.

U.S cigarette unit sales will fall much less than expected this year, because of people being confined to their homes during the pandemic, Altria executives told stock analysts on July 28. Sales are expected to fall by 2 percent to 3.5 percent instead of the previously anticipated 4 to 6 percent. Increasing government restrictions on vaping products have also slowed the slide.

“Fewer social engagements allow for more tobacco-use occasions,” said Altria CEO Billy Gifford in the call.

Unemployment is also keeping more Americans at home, where they are free to smoke, says Gifford, and stimulus checks have helped people afford to buy products such as cigarettes.

In addition, adult vapers are switching back to cigarettes as regulators Clamp down on the use of vaping products, said Gifford in the call. The U.S. Food and Drug Administration is requiring e-cigarette makers to submit their products for review.

“Consumers are faced with choices,” said Gifford. “It benefited the entire category.”

—Staff reports
Researchers Examine T-Cell Immunity from COVID-19

By Ashley Herzog

Researchers suspect T-cells have such a large role in protecting the public from COVID-19 that herd immunity could be achieved at a 20 percent rate rather than the 60 percent to 80 percent assumed for other infectious diseases.

T-cells are a type of white blood cell that help individuals fight bacteria or viruses and may explain why some people who have been exposed to COVID-19 have never gotten sick. Researchers believe some individuals have acquired these cellular warriors by being exposed to coronaviruses in the past.

According to the U.S. Health and Human Services Public Data Hub, there have been more than 5.3 million confirmed cases of COVID-19 in the United States—1.6 percent of the population—and 168,696 deaths, as of August 17.

Targeting the Intruder

T-cells work in a targeted way, says Yorgo Modis, Ph.D., a Wellcome Trust Senior Research Fellow at the Molecular Immunity Unit in the University of Cambridge Department of Medicine.

“Once they have learned to recognize a certain pathogen, the T-cells become able to trigger an immune response against the pathogen, essentially by ringing the alarm bells of the immune system and recruiting all sorts of different types of immune cells that can kill the pathogen,” Modis told Health Care News.

For that reason, some of these T-cells are called killer cells, Modis says.

“It takes about two weeks for the T-cells to learn to recognize a new pathogen the first time we are exposed to it—sometimes longer, depending on the pathogen,” Modis said. “So without previous exposure, people are generally most vulnerable to new infections during the first two to three weeks. But once T-cells have learned to recognize a pathogen, they will remember the pathogen for a long time—often for a lifetime.”

Mystery of Herd Immunity

Preexisting immunity may help the United States reach “herd immunity,” says Anne Marie Knott, a professor at Washington University.

“New COVID cases have peaked in most European nations and U.S. states, implying we’ve reached herd immunity,” Knott said. “We wouldn’t reach herd immunity until 58.3 percent of the population is immune. To date, only 1.6 percent of the U.S. population has contracted COVID-19, and we don’t have a vaccine, so we can’t have reached herd immunity through COVID itself.”

This could mean many people already have some degree of immunity to coronaviruses, including COVID-19, Knott says.

“A recent paper in Cell documents that 40 to 60 percent of unexposed subjects exhibited immune responses to past antigens that appear to protect against COVID-19,” Knott said. “Another more recent paper, in Nature, detected T-cells that protect against COVID in 35 percent of healthy donors.”

Knott says the authors used a key phrase, stating immunity was “probably generated during past encounters with endemic coronaviruses.”

Vaccine Booster

Until a vaccine is developed, T-cell research could help doctors treat COVID patients with T-cell therapy.

“Drugs that can control T-cell activity might help in treatment,” Modis said. “Sometimes, T-cells can cause the immune system to overreact and cause more damage than the virus itself. We don’t know what determines when this happens, but if we had ways to control or fine-tune T-cell activity, that should help us treat certain COVID-19 patients.”

The best bet is a vaccine, because it would help protect those who are vulnerable to COVID-19 while posing little to no risk to people with some degree of immunity, Modis says.

“Herd immunity is when enough people within a population are immune that the virus can no longer spread exponentially,” Modis said. “Typically, this requires more than 60 percent of the population to be immune to the virus.

There is no obvious reason why we can’t attain herd immunity against coronavirus, but it will require at least two-thirds of the population to either receive an effective vaccine or get infected by the virus and make a full recovery. So it is likely that we can get to herd immunity, but it will require people to get vaccinated.”

Fight May Never End

While T-cell immunity is being discussed in scientific journals, it is getting limited exposure in the general public.

In an August 15 article on the Marginal Revolution website, “The T-Cell Immune Response That Didn’t Bark,” Tyler Cowen, an economist at George Mason University, states one reason could be political incentives at work.

“If you do public health, your status incentives are to deliver warnings, not potential good news,” Cowen writes. “Your status incentives are always to hedge your bets, and to be reluctant to introduce new hypotheses. … Your status incentives are to discourage individuals from thinking that they might have some pre-existing level of protection. That might lead them to behave more irresponsibly, and then you in turn would look less responsible.”

Ashley Herzog (aebristow85@gmail.com) writes from Avon Lake, Ohio.
Governors Under Fire for Exposing Nursing Home Patients to COVID-19

By Bonner Cohen

The decision of the governors of five states to order patients with COVID-19 to be put in nursing homes is coming under intense scrutiny for potentially putting patients at risk.

The U.S. Department of Justice announced on August 26 it is requesting data from the governors of Michigan, New Jersey, New York, and Pennsylvania regarding government orders that “may have resulted in deaths of elderly nursing home residents.” The department’s Civil Rights Division will examine the data to determine if state actions warrant further investigation.

More than 6,400 residents of nursing homes or long-term care facilities in the Empire State have died during the pandemic, according to the New York Post. A July report by the New York Department of Health said Cuomo’s March 25 decision requiring nursing homes to accept coronavirus patients discharged from hospitals was not responsible for spreading the virus among residents, claiming instead that nursing home visitors and staff were the source. For his part, Cuomo acknowledged in late July that the state made “a lot of mistakes” in its fight against the virus.

Cuomo’s nursing home order remained in effect for 46 days before it was rescinded in early May amid growing criticism. More than 32,000 New Yorkers have died from the disease, the highest death toll in the country.

Most Vulnerable at Risk

In addition to calling for Cuomo’s impeachment, Paul, a physician who tested positive for COVID-19, has blasted lockdowns and other measures imposed to stem the spread of the virus.

“Terrible public health policy decisions were made and I think in the end, none of these policies have probably been good for the economy or actually good in containing the virus,” Paul told the Fox News “Bundown” podcast, as reported by several news outlets.

Cuomo is not the only governor catching heat over nursing homes. In June, Rep. Steve Scalise (R-LA), ranking member on the House Select Committee on the Coronavirus Crisis, led a group of GOP lawmakers in sending letters to five governors, all Democrats, asking for detailed information about their COVID-19 policies in nursing homes.

“The ongoing COVID-19 pandemic has disproportionately affected the elderly, especially those living in nursing homes and other long-term care facilities,” the lawmakers wrote in their June 15 letters to the governors. “We write seeking information, on a granular level, about the science and information used to inform your decision to mandate nursing homes and long-term care facilities to admit untested and contagious COVID-19 patients from hospitals.”

Targeted governors were also requested to supply a chronological list of all hospital discharges to nursing homes and other senior living facilities; data on nursing home deaths due to COVID-19; communications among the governors’ offices, state health departments, and operators of long-term care facilities; and communications between nursing home administrators and government officials.

In addition to Cuomo, the letters were sent to Govs. Gavin Newsom (California), Gretchen Whitmer (Michigan), Phil Murphy (New Jersey), Gretchen Whitmer (Michigan), and Tom Wolf (Pennsylvania).

One co-signer, Rep. Jackie Walorski (R-IN), made a scathing assessment of the governors’ action:

“Just about the worst possible thing to do is knowingly introduce the coronavirus to the most vulnerable populations, yet that’s exactly what several states did by mandating nursing homes accept infected patients.”

JACKIE WALORSKI, U.S. REPRESENTATIVE (R-IN)

“Just about the worst possible thing to do is knowingly introduce the coronavirus to the most vulnerable populations, yet that’s exactly what several states did by mandating nursing homes accept infected patients,” Walorski said in a statement. “These misguided policies deserve close scrutiny and the leaders who put them in place have a lot of tough questions to answer.”

$5,000 Nursing Home Payment

Michigan’s State Budget office issued a directive April 22, offering to pay nursing homes $5,000 for each bed they could offer a sick or recovering COVID-19 patient. The directive states Whitmer’s Department of Health and Human Services will use up to $5 million of $50 million from the general fund appropriated for increased health care to make the payments.

“Under this plan, one or more facilities within a region will be designated as a hub for receiving COVID patients discharged from hospitals,” the directive states. “This ensures hospitals can continuously discharge recovering COVID patients and maintain surge capacity within their facilities.”

Robert Regan, a candidate running for the state’s 73rd legislative district, made the payments a focus of his campaign.

“There was a palpable sense of disbelief at first when I presented it to voters,” Regan said.

Regan says the directive has gotten little media attention, but a video about it that he posted to his website got 500,000 views.

“Hopefully, it will stimulate discussion and lead to a demand in accountability for the Governor’s actions,” Regan said.

Elderly Risk Was Known

It was common knowledge by spring that the virus was dangerous to people in nursing homes, says Gregg Girvan, health care fellow at the Foundation for Research on Equal Opportunity (FREOPP).

“We began to learn which age groups were at greatest risk by early March,” Girvan said. “By then, we had learned that all seven people who had died under quarantine aboard the Diamond Princess cruise ship were over the age of 70, as well as received studies from China showing the same skew of severe illness and death toward the elderly, especially those with preexisting conditions.”

Girvan says the nation is still learning more, but he would not be surprised if similar payments were made in other states.

“Though my initial impression was such states were using a ‘stick‘ rather than a ‘carrot‘ approach—they were basically ordering nursing homes to take recovering patients,” Girvan said.

Whether hospitals were exceeding surge capacity to justify the placement of patients in nursing homes, is another question, Girvan says.

“In hindsight, it appears the policy of sending recovering patients back to nursing homes was foolish, even if you were exceedingly generous with such policies, based on a worry of exceeding hospital capacity,” Girvan said.

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

INTERNET INFO

House Bill Would Get Treatments to Sick Patients Much Faster

By Kelsey Hackem

A group of Republican U.S. senators is sponsoring a bill to create a provisional pathway to get treatments to patients faster, especially those facing life-threatening illnesses.

“The Promising Pathway Act would require the U.S. Food and Drug Administration (FDA) to establish a rolling, real-time priority review pathway to evaluate provisional approval drug applications for drugs intended to treat, prevent, or diagnose serious or life-threatening diseases or conditions.

For patients suffering from serious, life-threatening, or terminal illnesses such as ALS, the bill would provide more efficient access to new treatments, eliminating years of waiting for promising new drug therapies. To receive provisional approval status from the FDA under the bill, a drug would have to demonstrate substantial evidence of safety and relevant early evidence of positive therapeutic outcomes.

“We know that ALS is a tragic disease, but with advances in research, treatment, and advances in clinical trials, my hope is that we are closer to a cure for ALS,” Murkowski stated in a news release. “Our legislative effort recognizes that patients suffering from life-threatening, fast-moving diseases may benefit from access to promising treatments earlier.”

Sens. Mike Braun (R-IN), Martha McSally (R-AZ), and Lisa Murkowski (R-AK) introduced the bill on June 4, 2020.

Encouraging Innovation

In addition to expediting beneficial outcomes for patients who cannot wait out the lengthy review process, the bill would encourage innovation in drug development and empower patients, says Peter J. Pitts, a former FDA associate commissioner and president and cofounder of the Center for Medicine in the Public Interest.

“It incentivizes innovators to pursue exciting new ideas through progressive and pragmatic 21st century science,” Pitts said. “Provisional approvals forge a partnership between patients, developers, and the FDA, sharing acceptable risks and promising benefits for serious and life-threatening diseases.”

Increasing Options

The FDA has some pathways for expedited drug approval, such as the accelerated approval protocol, but the provisional approval under the Promising Pathway Act would less limited than those methods. For example, the accelerated approval pathway only applies to drugs being reviewed in clinical trials, which can limit access, Pitts says.

“Many of the FDA’s expedited pathways overlap, but they are also additive in important ways,” Pitts says. “The Promising Pathways Act makes it possible to bring new products to market with a guarantee of robust post-market safety and pharmacovigilance. It allows patients to have the final say in how they want to address their own health conditions and work with developers and regulators to identify both unexpected problems as well as exciting outcomes.”

Peter J. Pitts
FORMER FDA ASSOCIATE COMMISSIONER

COVID Treatment Costs Exceed $12,000 Per Patient

By Kelsey Hackem

The average hospitalization bill for a COVID-19 patient is $12,489 and the total national cost for inpatient hospitalizations will range from $9.6 billion to $16.9 billion in 2020, a new study finds.

The analysis by health care consulting firm Avalere looked at three scenarios of hospitalization to develop its projections. Commercial payers will bear the largest portion of costs for hospitalization, with Medicare picking up the second-highest share, between $3.5 billion and $6.2 billion, Avalere found.

Avalere’s numbers differ markedly from those estimated by the insurance trade group America’s Health Insurance Plans. That analysis found the average cost for hospitalization to be $30,000 per patient.

Avoiding Hospitalization

The cost projections make a strong case for keeping COVID-19 patients out of the hospital as much as possible, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons (AAPS) and a policy advisor to The Heartland Institute, which co-publishes Health Care News.

One way to cut costs is to give physicians more freedom to use hydroxychloroquine (HCQ) in treating patients infected with the virus, says Orient.

“States have to stop obstructing it,” said Orient. “If widely used, hospitalizations and deaths might drop dramatically.”

Orient says the use of HCQ in other countries has shown encouraging results in keeping COVID at bay.

“In Vadodara, India, of more than 100,000 close contacts of COVID-19-positive patients who were given HCQ, only 0.2 percent became positive,” said Orient. “What is impressive.”

Doctors Asking Permission

In the United States, physicians have been petitioning states and the federal government to loosen restrictions on HCQ, which has been used safely for decades for malaria and some autoimmune disorders but is not approved for COVID-19.

On July 30 the Ohio Board of Pharmacy, at the urging of Gov. Mike DeWine and the medical and patient communities, withdrew its rule preventing HCQ from being sold in Ohio as a treatment for COVID-19.

DeWine said treatment decisions are best left between doctor and patient.

“The Board of Pharmacy and the State Medical Board of Ohio should revisit the issue, listen to the best medical science, and open the process up for comment and testimony from experts,” said DeWine in a statement.

Kelsey Hackem, J.D., (khackem@gmail.com) writes from the state of Washington.
The number of people that Americans believe have died from COVID-19 is 22 times as high as the real number, a new poll shows.

According to the Centers for Disease Control and Prevention (CDC), as of August 13, 163,651 Americans have died from COVID-19—about .05 percent of the nation’s population. The poll shows Americans believe the number is about 2,970,000, or 9 percent.

The poll, published July 27 by communications firm Kekst CNC, looks at a variety of perceptions of the pandemic around the world. U.S. respondents were asked to estimate the percentage of deaths and cases from and of COVID-19 in the United States.

Respondents overestimated the number of COVID deaths by a mean of 22.5 times.

Respondents also reported they believe 20 percent of the population has been infected with the virus. The CDC reports 5,119,711 confirmed cases, less than 2 percent of the population.

The poll surveyed 1,000 adults in the United States between July 10 and July 15 and has a margin of error of plus or minus 3.3 percent.

On its website, the Committee to Unleash Prosperity stated on August 12 the poll is an example of “just how unsuccessful the media has been in putting the coronavirus into perspective.”

—Staff reports

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.

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Hospitals, Insurers Must Reveal Prices, Discounts, Court Decides

By Bonner Cohen

The battle over price transparency between hospitals and the Trump administration entered a new phase with the American Hospital Association (AHA) appealing a federal judge’s decision upholding the administration’s mandate that hospitals disclose their negotiated rates with insurers.

Hospitals have long opposed rules requiring them to disclose privately negotiated rates, which they consider proprietary information. When the U.S. Department of Health and Human Services (HHS) issued a rule last year, based on a presidential executive order, interpreting the Affordable Care Act’s (ACA) call for disclosing “standard charges” for items and services to include negotiated rates, the AHA challenged the rule in court. The AHA provides a vague definition of standard charges, giving HHS the opportunity to fill in the blanks in a way that advances price transparency.

The Centers for Medicare and Medicaid Services (CMS), a division of HHS, said hospitals must publish list prices and post their negotiated rates with insurers, cash discount prices, and the minimum and maximum negotiated charges for 300 “shoppable” services.

In the appeal filed on July 17, the AHA and other plaintiffs argue the rule interferes with their First Amendment rights of free speech by forcing them to disclose proprietary information. Hospitals and insurers consider negotiated rates to be trade secrets, which they are reluctant to disclose. The plaintiffs also said the rule would undermine negotiations between providers and insurers.

Right to Price-Shop

U.S. District Judge Carl Nichols, a Trump appointee on the U.S. District Court for the District of Columbia, dismissed the AHA’s arguments in a June 23 summary judgement favoring HHS.

“All of the information required to be published by the Final Rule can allow patients to make pricing comparisons between hospitals,” Nichols wrote in his ruling.

Brushing aside the hospitals’ claims that the rule would undermine commercial speech, Nichols embraced the idea of transparency for patients.

“Plaintiffs are essentially attacking transparency measures generally, which are intended to enable consumers to make informed decisions; naturally, once consumers have certain information, their purchasing habits may change, and suppliers of items and services may have to adapt accordingly,” Nichols wrote.

Consumer Empowerment

Nichols also dismissed the hospitals’ argument that the rule would create additional paperwork burdens and lead to price increases.

“Traditional economic analysis suggested to the agency that informed customers would put pressure on providers to lower costs and increase the quality of care,” Nichols wrote.

The AHA is seeking an expedited review of the ruling. In a comment on the judge’s decision, the AHA alluded to the problems hospitals are facing as a result of COVID-19.

“We are disappointed in today’s decision in favor of the administration’s flawed proposal to mandate disclosure of privately negotiated rates,” AHA said in a statement. “The proposal does nothing to help patients understand their out-of-pocket costs. It also imposes significant burdens on hospitals at a time when resources are stretched thin and need to be devoted to patient care.”

HHS Secretary Alex Azar used the backdrop of COVID-19 in praising the judge’s decision.

“With today’s win, we will continue to deliver on the president’s promise to give patients easy access to health care prices,” said Azar in a statement. “Especially when patients are seeking needed care during a public health emergency, it is more important than ever that they have ready access to the actual prices of health care services.”

Doubts About Effects

Price transparency doesn’t always lead to the desired result, says Robert Graboyes, a senior research fellow and health care scholar at the Mercatus Center.

“Price transparency rules have their place, but they should be administered with a syringe, not with a firehose,” Graboyes said. “The inability to obtain prices before a medical procedure is a frustrating problem, but mandatory price transparency can be a cure worse than the disease. Counterintuitively, mandatory price transparency can reduce competition and push prices upward through a process called ‘tacit collusion.’”

Robert Graboyes
Senior Research Fellow
Mercatus Center

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Robert Graboyes
Senior Research Fellow
Mercatus Center
Arkansas, White House Petition Court to Allow Medicaid Work Requirement

By Ashley Bateman

The state of Arkansas is getting help from the Trump administration in petitioning the U.S. Supreme Court to reinstate its Medicaid work program.

The U.S. Department of Justice (DOJ) joined the state in asking the high court to review and uphold the Arkansas Works Medicaid Demonstration project, Arkansas Attorney General Leslie Rutledge announced on July 14.

In its filing, the Department of Justice says the lower court’s decision to strike down the Arkansas program “reflects a fundamental misreading of the statutory text and context.” The filing also says the decision should not be allowed to interfere with work requirement programs in 17 other states. If the decision stands, those programs could be in jeopardy, DOJ argues.

In February, the U.S. Court of Appeals, upheld a lower court’s decision to cancel the program. Rutledge said the decision was disappointing and forced the state to reinstate those who were removed from the program for failing to work or participate in a community program for three consecutive months.

**Encouraging Self-Reliance**

In 2018, Arkansas was one of the first states to implement a work requirement for its expanded Medicaid program, requiring able-bodied enrollees between ages 30 and 49 to work or participate in community engagement for 80 hours a month. Within six months of implementation, 18,000 beneficiaries failed to meet requirements and were disenrolled.

“Arkansas Works’ model was designed to encourage able-bodied Arkansans without dependents to transition into the workforce, building a stronger, more resilient connection with their communities,” Rutledge said in a statement.

Rutledge said the state reached out to U.S. Attorney General Bill Barr, and Barr’s agency soon agreed to file a writ of certiorari.

**Helping the Neediest**

The Trump administration has supported establishment of work programs for able-bodied Medicaid enrollees. In a November 12, 2019 speech, Centers for Medicare and Medicaid Services Administrator Seema Verma said there is a moral obligation to protect the program for those who need it most.

“Any vision for Medicaid that would trap beneficiaries in poverty instead of helping them reach their fullest potential, or drive the program into bankruptcy, fails the test miserably,” said Verma. “Our duty to protect the vulnerable means ensuring that the program is there for future generations, as well as the current one.”

Court challenges to Medicaid work programs have also been filed in Kentucky and New Hampshire. Arkansas is the only state that was able to launch its program before a court blocked it.

Ashley Bateman (bateman.ae@gmail.com) writes from Alexandria, Virginia.

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**A Better Choice**

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John C. Goodman

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Innovation, Choice Put U.S. at Top in Global Health Care Index

By Bonner Cohen

As COVID-19 continues to cast its shadow over the globe, a timely report sheds light on the performance of the world’s wealthiest countries in providing health care to their citizens.

In the World Index of Healthcare Innovation (WIHI), the Foundation for Research on Equal Opportunity (FREOPP) has compiled a first-of-its-kind ranking of the 31 highest-income countries in four categories of health care: quality, choice, science and technology, and fiscal sustainability.

FREOPP evaluated the strengths and weaknesses of the countries’ health-care systems in those four categories. The top five finishers received an overall score of “excellent.” Switzerland came in first with a score of 59.56, followed by Germany (59.28), the Netherlands (59.14), the United States (54.96), and Ireland (54.48). At the tail end of the list were countries rated “poor,” including Italy (37.29), Poland (34.44), and Japan (31.51).

Improving on Past Indexes

There have been previous attempts to compare health systems worldwide, but their results, FREOPP points out, “have been hard to square with reality.” An index published by the World Health Organization (WHO) implausibly ranked the United States 37th, behind Oman (8th), Colombia (22nd), Saudi Arabia (26th), Morocco (29th), Dominica (35th), and Costa Rica (36th).

Similarly, the Commonwealth Fund has been ranking the health care systems of a small number of high-income countries for two decades. In its latest ranking, published in 2017, the organization placed the United States last among 11 countries, behind the United Kingdom, Australia, the Netherlands, New Zealand, Norway, Sweden, Switzerland, Germany, Canada, and France. The Commonwealth Fund stated it derived its rankings by examining delivery of health care, affordability and timeliness of care, administrative efficiency, equality of care, and health care outcomes.

Seeking to avoid such dubious outcomes, the FREOPP index ranks countries “not only by traditional measures such as universal affordability and health outcomes, but also by features such as: the degree to which patients have the ability to choose their doctor and their insuror; health care-related patents; scientific impact and Nobel Prizes in Chemistry and Physiology or Medicine; access to new treatments, and health digitalization.”

“The Index also measures the fiscal sustainability of countries’ health care systems: that is, how much ability a given country has to sustain its public health care spending without punitive taxes or a debt crisis,” the FREOPP report states.

Measuring Potential

FREOPP’s report emphasizes the importance of going beyond the scope of earlier international rankings to get a more accurate picture of health care delivery.

“The Index not only examines the quality of each health care system, but also the ability of that system to improve over time through scientific and medical advances, and the degree to which patients can drive quality improvements by encouraging insurers and health care providers to compete for patients’ patronage,” FREOPP states.

Those market forces explain why several countries, including some relatively affluent ones, finished at or near the bottom. Poland placed last for quality and science and technology. Finland, a single-payer country, placed last for choice. Japan is affluent and technologically advanced but has the highest debt-to-GDP ratio in the industrialized world, putting it in last place for fiscal sustainability.

The United States easily captured the top spot in science and technology, with a score of 75.14, but its overall ranking was pulled down by a dismal 27.33 score in fiscal sustainability.

Key Role of Innovation

The viability of a nation’s health care system depends on innovation, FREOPP concludes.

Policymakers are increasingly recognizing the value of personal choice and digital technology in providing high-quality, patient-centered health care, and most have come to rely on American research and development for new treatments, the report states.

“These goals—sustainable costs, best-in-class therapies, personalized care—can best be achieved through innovation: innovation in the development of cures and vaccines, innovation in the delivery of health care services, and innovation that leads to the economic growth that can fund health care expenditures,” FREOPP states. “While universal health insurance is important, it is just as important to measure the role that innovation plays in improving health outcomes for all people.”

Fiscal Sustainability

The WIHI is an innovative way of analyzing health care freedom, says FREOPP President Avik Roy.

“At FREOPP, we support universal, market-based coverage that will be fiscally sustainable for generations to come,” Roy told Health Care News.

“At [Foundation for Research on Equal Opportunity], we support universal, market-based coverage that will be fiscally sustainable for generations to come. [World Index of Healthcare Innovation] is the first ranking system to incorporate patient choice and medical innovation in its evaluation of global health care systems. We trust that the report will be useful to U.S. policymakers who are considering changes to our health care system at home.”

AVIK ROY
PRESIDENT
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

“At FREOPP, we support universal, market-based coverage that will be fiscally sustainable for generations to come.”

FREOPP President Avik Roy.

New Rule Addresses RX Price Gaming in Government Programs

By Jesse Hathaway

The Centers for Medicare & Medicaid Services (CMS) is allowing more flexibility for state governments to create value-based drug purchasing agreements with pharmaceutical companies.

The new rule reduces the regulatory burden on drug manufacturers in publishing manufacturer prices. The rule allows average price calculations for brand-name drugs to exclude similar generic drugs manufactured by the company. According to CMS, the previously existing requirement to include generic drugs in the calculation of the average manufacturer price report shortchanged drug manufacturers by keeping rebate prices artificially low.

The rule was published in the Federal Register on June 19 and took effect on August 18.

Diagnosing the Real Culprit

The new rule is an attempt to fix a larger problem with Medicaid and Medicare, says Linda Gorman, director of health care policy at the Independence Institute.

“This rule is in reaction to the criticism of the existing Medicaid best-price rule,” Gorman said.

The rule has been in effect since the late 1980s and defines the “best price” as the lowest price charged to any U.S. purchaser.

“The best-price program discourages manufacturers from giving steep discounts to anyone other than Medicaid,” Gorman said. “It is also combined with required rebates to safety-net providers, mostly certain hospitals, and the Veterans’ Administration under the 340B program. As always when government doubles in price controls, enormous problems develop.”

Root Cause, Untreated

Gorman says the proposed rule still gives government a mechanism to control prices.

“This is likely a political obstacle that cannot be overcome, so the administration is seeking to address some existing problems by creating more price flexibility by allowing a variety of best prices,” Gorman said. “This gets rid of some of the rigidity created by the one best price control and may encourage the commercial health coverage market to come up with new drug payment models. While in theory this should be an improvement, it will massively increase program complexity.”

Gorman says the new rule may inhibit drug development.

“At present, a new drug creates a new best price, and companies tend to modify drugs more often if Medicaid patients are big users of it,” Gorman said.

Under the new rule, a new drug will be considered a “same drug” if it shares patients are big users of it,” Gorman says. “Most drug development occurs in small steps, as a particular active ingredient is better understood, targeted, or combined with other active ingredients. It is likely [now] to retard advances in new treatments, shifting significant costs to patients.”

“Businesses talked openly about arrangements where, if you were to separate someday through a layoff, the business would help you out with your health insurance through COBRA,” Mulligan said. “Now, the federal government says, ‘You know what, you don’t need to help your employee out anymore, the federal government has got all the help.’ That’s a perfect time to do your layoffs, because you don’t have any health insurance burden.”

Congress Holds the Line on COBRA Subsidies

By Jesse Hathaway

Congress stopped negotiations over whether to enact additional COVID-19 relief programs, including a proposal to use taxpayer funds to subsidize health insurance for individuals between jobs.

Senate Majority Leader Mitch McConnell (R-KY) adjourned the chamber until September 8, reducing the likelihood of additional government unemployment benefits in the near future. Congress passed the CARES Act in March and extended $600-per-week federal unemployment benefits through the end of September.

In a July 16 letter to President Donald Trump, McConnell, and House Speaker Nancy Pelosi (D-CA), Thomas Donohue, chief executive officer of the U.S. Chamber of Commerce, urged lawmakers to use taxpayer funds to pay for COBRA health insurance premiums of individuals laid off by businesses because of COVID-19 concerns.

The national COBRA insurance program, established in 1986, allows unemployed workers to remain covered on their employer-provided health insurance after being laid off. Currently, COBRA continuing-insurance premiums are paid by the individual, the employer, or a combination of the two.

‘You’re Subsidizing Layoffs’

Government economic relief packages actively encourage business owners to fire employees, says Casey Mulligan, an economics professor at the University of Chicago and a former chief economist for the president’s Council of Economic Advisers.

“When you subsidize unemployment, you get more unemployment because people don’t go back to work as quickly,” Mulligan said. “You also get more layoffs. Layoffs are a painful thing, but they happen all the time. In good economic times, there are millions of separations every month, and it’s often a sad situation. Businesses try to put off layoffs, but when you know if you make the separation now, there’s a bunch of cash coming your way, then you might as well do it now because it’s less painful than normal.”

Using taxpayer money to pay COBRA premiums will accelerate layoffs and increase unemployment rates, Mulligan says.

“If they make it a 100 percent subsidy, we can’t afford anything in that ballpark,” Mulligan said. “COBRA is something that happens when you separate from a job. What they did in the previous stimulus is the only ones who got COBRA were the ones who were laid off. You’re subsidizing layoffs, and you get more layoffs.”

Bailing Out Businesses

Paying for COBRA would encourage business owners to fire employees because it would reduce the cost of separation, Mulligan says.

“Businesses talked openly about arrangements where, if you were to separate someday through a layoff, the business would help you out with your health insurance through COBRA,” Mulligan said. “Now, the federal government says, ‘You know what, you don’t need to help your employee out anymore, the federal government has got all the help.’ That’s a perfect time to do your layoffs, because you don’t have any health insurance burden.”

Jesse Hathaway (think@heartland.org) is a policy advisor for The Heartland Institute.
Court Levels Playing Field for Medicare Reimbursements

By Bonner Cohen

In a decision that promises to level the playing field between hospitals and physician offices when it comes to Medicare reimbursements, a federal appeals court ruled the U.S. Department of Health and Human Services (HHS) has the authority to implement a Trump administration rule providing for site-neutral payments.

Crafted to address the Medicare reimbursement disparity between hospital-affiliated remote practices not located on hospital grounds, and independent physician practices, the HHS annual payment rule requires clinics to undergo a cut in their payments over the next two years to bring them into parity with reimbursements to physician offices. Currently, clinics are paid more than physician offices for providing the same Medicare services.

The July 17 ruling by the U.S. District Court of Appeals for the District of Columbia reverses a lower-court decision stating HHS lacked the authority to mandate site-neutral payments.

Hospitals Lose Argument

The American Hospital Association (AHA) bitterly opposes site-neutral Medicare payments and spearheaded the lawsuit against the HHS rule. AHA argued the site-neutral payment cuts violated the federal statute governing the annual payment rule. The appeals court dismissed this claim, noting federal law gives HHS latitude in changing the payment formula. In addition, the government has the authority to control unnecessary increases in the volume of outpatient services, the court found.

The AHA also argued HHS's change was not budget-neutral, a requirement under federal law. The court agreed with the Trump administration's view that overall reimbursement for such payments would remain the same and the volume would simply shift toward physician offices.

The court also rejected the AHA's argument that HHS's decision to reduce payments to off-campus clinics violates the Bipartisan Budget Act of 2015. That statute gave HHS the power to cut payments to clinics created after the law went into effect but not to pre-existing clinics. The court determined the rule does not violate the intent of Congress because the cuts in payments reflect only a shift in volume at remote hospital practices since enactment of the Bipartisan Budget Act.

Closing ‘a Loophole’

The site-neutrality issue arises from the fact health care does not function as a true market, says Devon Herrick, a health economist and policy advisor to The Heartland Institute, which co-publishes Health Care News.

“In competitive markets, prices can vary from one store to the next for a variety of reasons. These include competition and convenience. However, it makes little sense for taxpayers to pay more for physician visits just because a hospital has purchased physician practices. This is a loophole to raise reimbursements, not competition.”

DEVON HERRICK
HEALTH ECONOMIST

Bonner R. Cohen, Ph.D. (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research.
Congress Stalls on Surprise Medical Bill Legislation

By Kenneth Arzt

Despite an intense push by businesses, health care groups, and the Trump administration, Congress appears to have put on hold legislation to protect consumers from surprise medical bills.

Surprise bills occur when a consumer goes to an in-network hospital and discovers the treatment providers are not in the network. After receiving medical treatment, consumers are shocked when they receive an unexpected bill with an average amount of more than $2,000.

Congress has attempted to stop surprise billing on several occasions recently but has not been able to pass a law abolishing it. Three major bills surfaced late last year but stalled.

Perverse incentives in the health care market have led to the trend of surprise medical bills, and there has been a push for more government intervention, including government price controls, but that is no solution, say Sens. Bill Cassidy (R-LA) and Roger Wicker (R-MS). Recognizing insurance companies want to control prices and providers want no limits, Cassidy and Wickers have introduced bills that would allow the market to determine a fair price.

Tackling Specific Problems

Cassidy’s proposal (S 1531, the STOP Surprise Medical Bills Act), introduced on May 16, would prohibit surprise medical billing, also known as “balance billing,” in three areas.

For emergency services, a consumer would have to pay only the in-network cost-sharing amount required by their health plan, regardless of whether the facility or provider was in-network or not. The restriction would extend to nonemergency services following an emergency service at an out-of-network facility, and nonemergency services performed by an out-of-network provider at an in-network facility.

Wicker’s (R-MS) proposal (S 4185, the End Surprise Medical Bills for Air Ambulances Act), introduced on July 2, would establish an independent dispute resolution (IDR) process for surprise air ambulance bills between a health plan and an out-of-network air ambulance provider and calls for a list of qualified providers who could serve as IDR entities.

The Taxpayers Protection Alliance (TPA), a nonpartisan organization that educates the public on the government’s effects on the economy, commended the lawmakers for their bills in a letter of support signed by several organizations, including The Heartland Institute, which co-publishes Health Care News.

‘Truth in Advertising’

Surprise bills are unique to health care because governments do not allow it to function as a normal market, says John Goodman, president of the Goodman Institute for Public Policy, which co-publishes Health Care News.

“That’s false advertising,” Goodman said. “So the ideal solution is truth in advertising; They don’t get to say they’re in the network unless they guarantee there will be no surprise bills, and the hospital and insurer have to work out how to cover the cost of non-network doctors.”

Not Satisfied

Air ambulances have been particularly problematic for surprise bills because the service can be costly and easily overlooked by consumers when shopping for a health plan. Air ambulance providers say it is difficult to negotiate “in-network” compensation agreements with insurance companies.

Balance billing legislation under consideration in the Senate HELP Committee, House Energy and Commerce Committee, and House Education and Labor Committee would leave consumers “in the middle,” says Christina Kanmaz, a spokesperson for Save Our Air Medical Resources, a national campaign dedicated to preserving access to emergency air medical services.

“The proposed language in the committee’s draft would allow insurers to continue maintaining narrow networks and denying patients coverage after emergency transports and empower insurance companies to set one reimbursement rate for all air medical providers by negotiating with only a single provider. This would result in the closure of air medical bases, particularly in rural areas, and diminished access to the critical services air ambulances provide.”

Kanmaz says the Wicker bill establishes an arbitration process that creates more balance between health insurance plans and medical providers and incentivizes both parties to be in-network.

“Going in-network is the fastest and most efficient way to protect patients,” Kanmaz said. “Patients deserve the peace of mind to know that their premium dollars guarantee that they will be covered in-network for critical emergency services.”

Calls for Further Reforms

Lawmakers should not exploit the COVID-19 pandemic to push through institutional rate setting and price setting, says Ross Marchand, vice president of policy for TPA.

“We’re in the worst medical emergency we’ve had in a hundred years, and if you have price fixing, you will see an exodus away from the medical profession and patients with decreased choices having to deal with consolidation across the health care system, and this is the worst possible time for that,” Marchand said.

TPA supports a system of professional mediators to resolve billing disputes, Marchand says.

“The first step with arbitration is patients are taken out of the equation and will not be forced to foot the bill for an unwanted, unexpected surprise bill,” Marchand said.

Arbitration should be a stepping stone to greater reforms, Marchand says.

“Ultimately, there is a wide need for health care reform that nominally addresses surprise billing and other bizarre aspects of the medical system that increase costs and decrease options for patients and customers, so it can’t end at arbitration,” Marchand said.

Kenneth Arzt (kennethcharlesartz@gmx.com) writes from Dallas, Texas.
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