COVID-19 Lockdown is Costing Money, Lives

By Devon Herrick and AnneMarie Schieber

Studies analyzing data from the COVID-19 pandemic show stay-in-place orders and social distancing have been costing the economy and individual health several times the value of lives saved.

The months of shutdowns have reduced gross domestic product by 5 percent, or $1.1 trillion, translating to 65,000 lives lost, note economists Scott Atlas, John Birge, Ralph Keeney, and Alexander Lipton in an article for The Hill. The authors estimate we are losing another 7,200 lives a month because of the increase in unemployment and 8,000 lives because people with health problems other than COVID aren’t getting needed medical care.

COVID-19, p. 4
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.

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Data Analysis Refutes COVID Projections That Led to Shutdowns

By Bonner Cohen

A mericans have a less than 3 per-cent chance of contracting COVID-19, an analysis by Professor Anne Marie Knott of Washington University in St. Louis found.

Knott, a professor of business with a strong background in mathematics, presented her findings to faculty and staff at the Olin Business School in an online town hall on May 13, 2020, “Why You Haven’t Caught Covid-19.”

Anti-COVID-19 policies in the United States (and the United Kingdom) began in earnest on March 15, 2020, when the Imperial College of London promoted a model forecasting 265 million Americans would contract the virus and 2.2 million people would die from it if no preventative measures were taken, Knott told the group.

It was primarily on the basis of these projections that government at the federal, state, and local levels intervened to stem the spread of the virus, recommending or requiring social distancing, the imposition of widespread lockdowns of the economy, and the reordering of treatment priorities in hospitals to favor COVID-19 patients.

These projections were off by a factor of 20, Knott says. The number of COVID-19 deaths is likely to be approximately 120,000, not 2.2 million, Knott found.

Knott dismisses the notion government intervention is responsible for the lower infection and death rates, pointing out that, in contrast, deaths from the flu increased this year.

To understand how an error of this magnitude could be made, Knott says, it is important to look at the non-cases—the people who did not get sick.

Measuring Disease Spread

Knott and others note the potential of an infectious disease to spread depends on what is called the R (reproduction) number, with “1” being the threshold between an infectious disease’s rise and fall.

The Imperial College of London forecast, by contrast, used an R “naught,” or R0, model, which measures the basic reproduction rate of a disease based on a worst-case scenario. It projects the number of people one person will infect if you assume everyone is susceptible to the virus.

“R,” however, measures the effective reproduction number and is crucial to understanding the trajectory of an epidemic. It takes into consideration the proportion of people who are immune to a pathogen, for example, or how a population reacts by protecting itself through voluntary means.

“An R of 1.5 would see 100 people infect 150, who would in turn infect 225, who would infect 338. In three rounds of infection, the number of people with the virus will have quadrupled to 438,” the World Economic Forum (WEF) points out in an analysis by writer Peter Beech. “Conversely, an R of less than 1 means the virus will eventually peter out—the lower the R, the more quickly this will happen.

“An R of 0.5 means that 100 people would infect only 50 people, who would infect 25, who would infect 13. As the number of cases drop and the ill people either die or recover, the virus will be brought under control—as long as the R remains low,” Beech writes.

An R significantly higher than 1 indicates explosive growth, and an R of 1 or lower suggests the end of an outbreak. Beech states.

The R0 for this year’s seasonal flu is 1.3, and the projected R0 for COVID-19 was 2.4.

Seaborne ‘Petri Dishes’

Knott says two prominent instances of “petri dishes” where outbreaks occurred show how COVID-19 spreads: the U.S.S. Roosevelt, a naval aircraft carrier, and the Diamond Princess, a cruise ship. In both cases, shipmates and cruise passengers were in tight, confined spaces and the outbreak could “fully propagate,” meaning no one had a chance to disembark, and hence avoid exposure, once the disease was identified.

On the Roosevelt, sailors slept in berths stacked three bunks high, with no space for social distancing. The population density on the carrier was 943,835 per square mile, yet nearly 77 percent proved resistant to COVID. The population density on the Diamond Princess was 883,571 per square mile, and 81 percent of passengers avoided infection.

The average population density in the United States is 92.9 residents per square mile, according to Statista.

Knott determined the R0 for the Roosevelt to be 1.14 and 1.11 for the Princess. The average age on the Roosevelt was 19, with one fatality, and 69 on the Diamond Princess, where nine people succumbed to the virus. (See accom-panying figures; courtesy Anne Marie Knott.)

Checking the Data

Comparing forecasts to real-world data is the essence of reliable estimation, says Knott.

“An alternative to my approach when you don’t have a completed outbreak, is to divide the daily data, use the first set of days to estimate R0, then use the second set to test how well you forecast what happens next,” Knott told the town hall. “Researchers did this for the Diamond Princess, and we knew by February 26 they were off by over 100 percent. That should have raised alarms.

“Spending $3 trillion and shutting down society to save lives from COVID-19 seemed unfair to the 2.8 million people who die each year from other causes,” Knott said. “We are now spending 50 times more per COVID death than per heart death, and 80 times more per COVID death than influenza death. This seems backwards, since heart disease and flu are with us for the foreseeable future, whereas COVID looks like it may disappear after this year.”

Knott says it is important for policymakers to look at data with a critical eye.

“I think the big lesson for policymakers is to get a second—at least—opinion before committing the largest increase in federal spending since World War II,” Knott said. “Michael Levi at Stanford was posting daily analysis of COVID data beginning February 2, with different conclusions than Imperial College. Why did their forecast prevail?”

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

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“We put a lot of weight on saving lives. But it is not the only consideration. That’s why we don’t shut down the economy every flu season. They’re ignoring the costs of what they’re doing. They also have very little clue how many lives they are saving.”

CASEY MULLIGAN, ECONOMIST, UNIVERSITY OF CHICAGO

The reason for the additional deaths is because mortality and income are related, the authors note. The less well-off Americans are, the less healthy they tend to be. For every $10 million to $24 million in lost economic output, the overall death rate increases by one, the article states. The death rate from COVID alone was 120,542 as of June 16, 2020, according to Worldometer.

The stay-at-home orders disrupted lives, added financial and mental stress, and precluded people from seeking medical care for non-COVID health problems, the article notes. The health ramifications of the shutdown could extend beyond reopening, because 40 percent of those who have temporarily lost jobs may not regain them soon, if at all, the authors note.

High Cost of Restrictions

COVID-19 is serious, but the government restrictions came at a high cost, says Atlas, the Robert Wesson Senior Fellow at the Hoover Institution. “The bottom line is what’s been done is catastrophic,” Atlas told Health Care News. “The total destruction from the lockdown is far more than from COVID.”

Many deaths from COVID-19 would have been avoided if better policies had been in place, Atlas says.

“The loss of lives from the pandemic has been tragic,” Atlas said. “Sadly, much of that was an egregious failure of our governors to protect our elderly nursing home residents, while instead they confined healthy people out of fear.”

Confining the Healthy

When cases of COVID-19 began to emerge in January, cities and state governments were unsure how to respond to a virus with little history. Governments imposed stay-at-home orders to prevent patients from overwhelming hospitals, but they soon set a broader goal of containing the spread of COVID.

“We put a lot of weight on saving lives,” University of Chicago economist Casey Mulligan stated in the New York Times on April 13. “But it is not the only consideration. That’s why we don’t shut down the economy every flu season. They’re ignoring the costs of what they’re doing. They also have very little clue how many lives they are saving.”

Mulligan created a “pandemic cost tracker” in which he calculates the cumulative costs of the pandemic in the United States from mortality and all other economic variables (see accompanying figure). As of June 14, the cost per household was $14,390, six times the loss-of-life cost based on the “value of a statistical life,” or VSL, how much a lost life is worth in terms of its economic input.

Writing in The Wall Street Journal on June 15, economists David Henderson and Jonathan Lipow highlight a University of California, Berkeley study that found the lockdown measures saved 74,000 lives and $250 billion. Given that 80 percent of COVID-19 deaths are among the elderly, the VSL is $250 million, the economists note.

A conservative estimate of the cost of the lockdowns is $1 trillion, four times the amount of benefit derived by lives saved, Henderson and Lipow note.

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“The finding casts major doubt on the value of lockdowns and even social distancing as a method of reducing the spread of COVID-19,” write Henderson and Lipow.

COVID vs. Other Threats

Much of the cost of the lockdown has been from mental and health conditions left untreated while physician practices were shut down, Atlas says.

“The policy itself is killing people,” Atlas told Fox News on May 23.

Analyzing claims data from March and April, the California-based health data analytics company Komodo Health found the numbers of colonoscopies and biopsies were nearly 90 percent below those for the same period last year. As a result, new colon cancer diagnoses fell by 32 percent and colorectal cancer surgeries were down by 53 percent. Chemotherapy visits were cut by one-half.

Policymakers often make decisions that pit one group of people against another, says Robert Graboyes, a scholar at the Mercatus Center at George Mason University.

“Open your town’s businesses, and five to 10 nursing home patients will die of COVID-19,” Graboyes said. “Keep the businesses closed, and five to 10 financially devastated residents will die from suicide, substance abuse, stress-induced heart attacks, and failure to seek timely medical care.”

Atlas says the lesson is simple.

“The most important point is not to implement a single-minded, myopic policy without understanding the impact that policy has,” Atlas said.

Devon Herrick, Ph.D. (devonherrick@sbcglobal.net) is a health economist and policy advisor to The Heartland Institute. AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
COVID Response Fails to Protect Nursing Home Residents

By Kelsey E. Hackem

ew data indicates policies responding to the COVID-19 pandemic failed to protect one of the groups most vulnerable to the disease: the 2.1 million people in the United States who live in nursing homes.

After COVID-19 struck the Life Care Center in Kirkland, Washington, resulting in at least 30 deaths, nursing homes and residential care facilities became a focal point of the COVID-19 response. COVID-19 affects the elderly more severely, on average, than younger individuals, and statistics show deaths are more concentrated among those who live in nursing homes or residential care facilities than those who do not.

Approximately 42 percent of all COVID-19 deaths have occurred in nursing homes and assisted living facilities, as of June 2, reports the Foundation for Research on Equal Opportunity (FREOPP), based on its monitoring of infection and death rates among the nursing home population.

Big Variations

The percentage of COVID-19 deaths in nursing homes or residential care facilities varies widely by state, according to the report. Minnesota, New Hampshire, and Rhode Island report 81 percent of COVID-19 deaths were in these facilities, and Nevada and Wyoming report under 28 percent of COVID-19 deaths occurred in those places. Some states, such as Michigan, Missouri, and South Dakota, have not reported COVID death rates at nursing homes.

New York has been an outlier, says FREOPP. Despite ordering nursing homes to accept COVID patients, the state reports less than 14 percent of its COVID deaths happened at nursing homes. It appears New York has not included deaths of residents who eventually die at hospitals. Michigan, New Jersey, and Pennsylvania also ordered nursing homes to accept COVID patients.

Mismanaged Confinement

These orders were a deadly misstep, says Gregg Girvan, a health care research fellow at FREOPP. “States should never have ordered nursing homes to accept actively infected COVID-19 patients,” Girvan said. “While states like New York have since rescinded such orders, others like Michigan have kept them in place, despite the fact that declining COVID-19 hospitalizations mean nursing home residents do not need to be hastily discharged to free up an ICU bed. Therefore, any orders to send patients back to nursing homes before they are no longer infectious should be rescinded immediately.”

COVID-19 has a greater effect in nursing homes because of their congregate nature and the resident population served, according to the Centers for Disease Control and Prevention. “Given emerging evidence that COVID-19 disproportionately affects the elderly with preexisting conditions, long-term care facilities, like hospitals, should have been prioritized for both personal protective equipment and testing for every worker and resident for infection,” Girvan said.

Girvan said states should focus on this population as they reopen their economies. “Beyond ensuring adequate PPE and universally testing, we must continue to restrict access by family and friends to nursing homes and to limit long-term care workers to working at just one facility, so as to prevent transfer of the virus from one facility to another,” Girvan said. “Finally, all levels of government should work with facilities to accurately report cases and fatalities so that resources can be mobilized to prevent further outbreaks and loss of life.”

Kelsey Hackem, J.D. (khackem@gmail.com) writes from Washington State.

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CDC’s COVID Reopening Projections Were Off by 900 Percent, Data Shows

A n early-May projection by the Centers for Disease Control and Prevention that reopening states’ economies would radically raise the number of COVID-19 cases and deaths was off by 900 percent, an analysis by a University of Virginia economist found.

The CDC predicted the number of COVID-19 cases would rise to 200,000 a day and deaths would increase by 3,000 per day by June 1. When June 1 arrived, Edwin Burton reviewed the numbers and found cases had declined by 46 percent over the course of the month, and the death rate was reduced by 62 percent. (See accompanying figures.)

“The media, of course, is now radio silent on these predictions that were completely absurd in the first place,” wrote Burton in an email to friends, colleagues, and former students, which he shared with Health Care News.


“The ‘reopening too early’ narrative was stoked by these CDC predictions,” Burton writes.

—Staff reports
Government in the Exam Room

HHS Secretary Alex Azar, along with then-Labor Secretary Alexander Acosta and Treasury Secretary Steven Mnuchin, mentioned government health care obstacles when they presented the plan to the President.

“Health care bills are too complex, choices are too restrained, and insurance premiums and out-of-pocket costs are climbing faster than wages and tax revenue,” the secretaries wrote. “Health care markets could work more efficiently, and Americans could receive more effective high-value care if we remove and revise certain federal and state regulations and policies that inhibit choice and competition.”

The plan is in stark contrast to the “public option” and Medicare for All proposals put forward by the Democrat Party, says Brian Blase, who helped draft the Trump plan while serving as a special assistant to the president at the National Economic Council.

“The Democrats tend to support empowering government and bureaucracies to limit the choices of consum-

“Although the president never talks about it and his administration has done little to advertise it, there really is a Donald Trump plan for health reform, and it’s radical,” says health economist John C. Goodman, president of The Goodman Center for Public Policy, which co-publishes Health Care News.

“This is the first time an administration has ever said that in health care, government is the problem, not the solution,” Goodman said. “The Trump vision for health care reform calls for deregulation on a massive scale.”

Continued from Page 1

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JOHN C. GOODMAN
PRESIDENT, THE GOODMAN CENTER FOR PUBLIC POLICY

Putting Consumers in Control

The plan involves five general categories of reform aimed at empowering the private sector and keeping government regulation at bay.

Suggested reforms include giving employees access to portable health insurance they can take with them when they leave their employer (see related article, opposite page); making it easier for patients to get round-the-clock medical care from providers who are available at nights and on weekends; reimbursing for virtual consultations that allow patients to be examined and treated in their own homes; allowing health plans to specialize and become “centers of excellence” for the treatment of various chronic diseases; and giving patients the opportunity to manage and control more of their own health care dollars.

Blase says there have been notable successes supporting those general areas to date: the elimination in 2017 of the Obamacare individual mandate penalty “which mostly harmed lower-income families who couldn’t afford the expensive government-approved plans”; new rules “that allow consumers to know real health care prices”; a decrease in prescription drug prices “resulting from deregulation and expanded competition”; and health insurance reform through the expanded use of association health plans and lower-cost short-term plans that are renewable in case of illness.

The pandemic opened the door for expansion of virtual health care and telemedicine as the Trump administration began reimbursing such visits under Medicare, Blase says.

“The Trump administration’s focus was empowering patients with expanded choices and information to be better consumers and ensuring robust competition between providers and insurers to offer the highest-quality care at the lowest possible cost,” Blase said.

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

INTERNET INFO


Make COVID-19 Health Care Reforms Permanent, Congress Urged

Three-dozen organizations are urging congressional leaders to make permanent the reforms the Centers for Medicare and Medicaid Services (CMS) made to expedite health care during the COVID-19 pandemic crisis.

Drafted by Americans for Prosperity and signed by The Heartland Institute and the Goodman Institute for Public Policy, co-publishers of Health Care News, the May 12 letter singles out four policy areas: telehealth, professional licensing, physician supervision, and patient privacy.

“These waivers are saving people’s lives right now and they will save people’s lives in the next crisis, too,” the letter states.

In telehealth, CMS has begun reimbursing providers for virtual visits, whether done in real time or in a practice known as “store and forward” in which videos and images can be shared with other physicians.

The number of virtual visits in the United States grew from 10,000 to 300,000 a week by the end of March.

The CMS also relaxed restrictions on physicians, nurse practitioners, and occupational therapists to allow them to practice across state lines and at the full capacity of their licenses. In addition, the agency eliminated the requirement for a physician’s signoff on home health services and plans of care, and it eased up on privacy protections under HIPAA that prevented provider-patient communication in Web platforms such as Skype and FaceTime.

—Staff reports
First to Reopen, Georgia Keeps COVID Numbers at Bay

By Ashley Bateman

Georgia became the first state in the nation to reopen its economy after a statewide closure due to COVID-19, and five weeks later there has been no reported surge.

Gov. Brian Kemp issued a statewide shelter-in-place order on April 2, authorizing enforced social distancing and closure mandates to slow the spread of COVID-19. Kemp lifted the order on April 24 when Georgia’s COVID-19 numbers began to decline. The governor’s action allowed the opening of hair salons, gyms, bowling alleys, and barber shops, with dine-in restaurants and theaters to resume business a few days later. Some restrictions remained in place until May 20 for at-risk people, and the state is encouraging voluntary protective measures.

Reopening was the right call, says Kyle Wingfield, president and CEO of the Georgia Public Policy Foundation. “Gov. Kemp made it clear from the beginning that he didn’t want to keep businesses closed any longer than was necessary,” Wingfield said. “In announcing the end of the shelter-in-place order, the state achieved a sufficient downward trend in the infection rate and sufficient capacity in hospitals.”

Monitoring Progress

As of June 5, the Peach State had conducted more than half a million COVID-19 tests and found 31 new cases, a new low comparable to the number reported in February. Georgia’s health department notes reporting delays may skew preliminary data, and there may be cases of delayed testing or people who are sick and never had a confirmed diagnosis.

Cases of the novel coronavirus trended downward in the first half of May, followed by an uptick in the second half of the month after the reopening of most businesses in the state.

“It’s hard to know [if the increase] is because the virus is resurgent or because testing has increased dramatically,” Wingfield said. “It would appear to be the latter, as the percentage of positive tests remains lower than the 14 percent rate we were seeing in past weeks.

“It’s also noteworthy that hospital capacity remains sufficient for now,” Wingfield said. “We always knew there would be an increase in infections after some of the restrictions were lifted. At the moment, that increase appears to be manageable.”

Benefits of Work

Allowing Georgia residents to get back to work improves people’s well-being, says Buzz Brockway, vice president of the Georgia Center for Opportunity.

“It’s also noteworthy that hospital capacity remains sufficient for now. We always knew there would be an increase in infections after some of the restrictions were lifted. At the moment, that increase appears to be manageable.”

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PRESIDENT AND CEO
GEORGIA PUBLIC POLICY FOUNDATION

Five Ways Trump Health Plan Puts Consumers in Charge of Health Care

Numerous surveys indicate the American public broadly supports moving the nation’s health care system to a more consumer-oriented model, says John C. Goodman, a health economist and co-publisher of Health Care News, and Marie Fishpaw, director of domestic-policy studies at The Heritage Foundation.

In an August 15, 2019 analysis, Goodman and Fishpaw describe five areas where President Donald Trump’s plan, “Reforming America’s Healthcare System Through Choice and Competition,” would do that. (See related article, opposite page.)

Personal, Portable Health Insurance

The Trump reform not only allows employees to have insurance they own individually, it encourages it. As of January 1, employers are now able to put pretax money into accounts called Health Reimbursement Arrangements (HRAs) so employees can buy the insurance that best meets their needs. The insurance can travel with them from job to job and in and out of the labor market, instead of being tied to their current employer.

Round-the-Clock Care

Direct primary care (DPC) is an arrangement under which patients pay a flat fee, often as little as $50 a month, for 24/7 access to a doctor. Communication by phone and email is common and is especially important as an alternative to visiting hospital emergency rooms at night and on weekends. The Trump administration has been working on allowing Medicare to pay for DPC. The use of pre-tax accounts for a broader population to pay for DPC will require an act of Congress.

Teledicine

The coronavirus pandemic kicked open the door to virtual health care. Previously, federal law prevented Medicare from paying for telemedicine except under rare circumstances. Under President Trump’s emergency declaration order of March 13, 2020, Medicare now allows doctors to provide care by means of phone, Skype, Zoom, and other devices without physically being in the same room with patients.

Care from the Best

Under current law, health plans are required to be all things to all patients. Plans are not allowed to offer specialized coverage such as care for cancer. Last year, the Trump administration took steps to change that. Under the new rules, Medicare Advantage plans may specialize in conditions such as diabetes and heart and lung disease. Such plans should be available to all consumers under equal tax treatment.

Savings Accounts for Chronically Ill

With moderate training, patients with chronic conditions can manage their own care as well as or better than under traditional care approaches, studies show. It follows that they should be allowed to manage the dollars that pay for that care. The Trump administration is making it easier for this to happen, such as by loosening the across-the-board deductible rule to allow HSAs to be more flexible with respect to chronic care in general and COVID-19 testing and treatment in particular.

—Staff reports
Kids Are Much More at Risk from Flu Than COVID-19, A New Study Finds

By Emma Kaden

Children are at far greater risk of death from influenza than from COVID-19, a new report states.

The report, published on May 18 by the Foundation for Research on Equal Opportunity (FREOPP), says school-aged children between the ages of five and 14 have a one in 200,000 chance of dying from influenza but a one in 2.5 million chance of dying from COVID-19. Children aged from one to four have an even lower chance of fatality from COVID-19: they are 20 times more likely to die of the flu than of COVID-19.

Those statistics make a solid case for reopening schools, especially pre-K through junior high, the report states. Reopening schools could also make it easier to reopen certain parts of the economy, as workers will not have to worry about childcare or leaving their children at home during school hours.

As seen in the accompanying figures, school-aged children are much less at risk from COVID-19 than their adult counterparts. Coronavirus would not even make the list of the top 10 leading causes of death for people aged 24 or younger, the study notes. The leading cause of death for ages one to 44 is unintentional injury.

The adult population faces a much more significant risk from COVID-19, especially those over the age of 75, the report states. Those above the age of 85 are 314 times more likely to die of COVID-19 than those aged 25-34. Death rates from COVID-19 skyrocket as age increases, making it important to prioritize safety in nursing homes and assisted-living units, the report states.

Measuring the Risks

As states across the country consider the safest ways to begin reopening businesses, schools, and transportation, information about the potential risks of COVID-19 compared to the other risks Americans face on a daily basis provide a crucial understanding of what can safely be opened first, FREOPP states.

Although it is important to calculate and understand the potential risks of reopening, it is also critical to recognize the potential harm imposed by keeping states in lockdown, writes FREOPP President Avik Roy in the report.

“Our caution should include an understanding that while the risks of COVID-19 are serious, they appear to be in the range of other lethal diseases that are all too common in the United States and other industrialized countries,” Roy writes. “There is growing evidence that complete economic lockdowns cause more harm than good, and that it is possible to prudently reopen the economy today. Reopening is especially important to lower-income Americans, whose economic prospects have been most durably and significantly harmed by shelter-in-place orders.”

Emma Kaden (EKaden@heartland.org) is an assistant editor at The Heartland Institute.
Pandemic Lockdown Put Children at Risk, New Data Shows

By Ashley Bateman

The inability to see a doctor and the fear of contracting COVID-19 in a hospital led to life-threatening delayed diagnoses of Type 1 diabetes in children, a new study states.

The study, published in The Journal of Pediatrics on May 4, describes cases of children who could have received lifesaving treatment early on but delayed visits to the hospital because of coronavirus fears and restrictions.

In one case the study cites, an eight-year-old California boy with no significant past medical history showed up in the emergency room in pain from severe diabetic ketoacidosis (DKA), a condition of out-of-control blood sugar levels. The family tried to see a provider three days earlier but never received a response.

In another case cited, a 17-year-old Indiana girl had a history of health problems and developed breathing difficulties, but a respiratory clinic failed to investigate her symptoms beyond COVID-19, for which she tested negative. The girl was suffering from DKA and required treatment three days later in a hospital intensive care unit.

“Appropriate measures to prevent the spread of COVID-19 are vitally important,” the study’s authors write. “But we must not let the fear of COVID-19, from health professionals and the general population, delay the diagnosis and prompt treatment.”

The authors point out urine dipsticks for glucose and ketones and fingerstick tests for blood glucose can avert potentially deadly delays in diabetes diagnosis.

Concerns Beyond Diabetes

The concerns go beyond missed diabetes diagnoses, says Meg Edison, M.D., a Michigan pediatrician and policy advisor to The Heartland Institute, which publishes Health Care News.

“As pediatricians, many of us are concerned about the health consequences of social isolation for children. The concern is that the morbidity and mortality of isolation will start to eclipse the morbidity and mortality of coronavirus in this population.”

MEG EDISON, M.D., PEDIATRICIAN

“Nothing and no one can replace parents and family relationships; however, the unprecedented long-term closure of schools has been disruptive and destabilizing for many youths who thrive on routine and socialization,” said Cretella.

“Our greatest fear has been for the children silently suffering abuse at home, now separated from all mandatory reporters, such as teachers, doctors, and pastors, who could help,” Edison said. “The combination of family financial stressors, close quarters, and increased substance use by adults creates a riskier environment for vulnerable children.”

Mental Health Impact

Isolation caused by the COVID-19 lockdowns has raised concerns about pediatric mental health.

A survey of 2,111 participants up to 25 years old with a history of mental illness found 83 percent experienced worsening conditions because of the pandemic. More than a quarter of those surveyed for the study, published on April 14 in The Lancet, found mental health and peer support groups and in-person services had been canceled or inaccessible.

“Not only are youth having anxiety precipitated by a constant barrage of unbalanced COVID-19 news with seemingly no hope in sight, but they have also essentially been imprisoned within the four walls of their homes,” Michelle Cretella, M.D., executive director of the American College of Pediatricians, told Health Care News.

“Nothing and no one can replace parents and family relationships; however, the unprecedented long-term closure of schools has been disruptive and destabilizing for many youths who thrive on routine and socialization,” Cretella said. “For children already dealing with mental illness and/or special education needs, school closures have meant lack of access to services they received from school counselors, psychologists, and therapists. While remote interaction is better than no contact at all, it is not as effective as face-to-face interactions with family, friends, teachers, and therapists. Human beings, especially children, need face-to-face warmth and human touch.”

‘Life on Hold’

Edison says the lockdowns have put greater pressure on children.

“Anxiety and depression in older kids is spiking, as many teenagers put their life on hold and all the social activities and sports that bring joy and build community are cancelled,” Edison said.

“Religious services are also a source of comfort to many children and adults,” Cretella said. “Here, in Rhode Island, where strip clubs are now reopened for business, houses of worship [have been] forbidden from holding public services.”

WHERE POLICYMAKERS FAILED

Data shows COVID-19 has had little direct effect on teens and children, Edison and Cretella say.

“Children appear to do well with COVID-19,” Edison said. “Michigan has been in the news as a hotspot state, and out of 4,714 deaths, we’ve had one pediatric death, a tragic case of a five-year-old with a rare form of COVID-19 meningocencephalitis. The pediatric risk is not zero, so we remain vigilant, but this should be reassuring to parents.”

“COVID-19 illness in those under age 21 is overwhelmingly mild, with a mortality rate close to zero,” Cretella said. “As of the end of April, the CDC had reported only three pediatric deaths due to COVID-19, but 166 pediatric deaths due to seasonal influenza. There is emerging evidence from multiple countries around the world that children may not be COVID-19 super-spreaders, which means communities should be free to consider reopening schools depending on their local situation. There is no one-size-fits-all solution.”

“Hopefully, data in the next few weeks from states and other countries who have opened up will allow us to open up more broadly for all children,” Edison said.

It’s important for policymakers to consider all aspects of health when making rules about coronavirus and other issues, Cretella says.

“In short, there is a growing chorus of physicians reminding folks that there is more to health than avoiding COVID-19,” Cretella said.

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

INTERNET INFO


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.
Pandemic Opens Door for Pro-Patient Reforms

By Jesse Hathaway

As lawmakers and regulators in many states begin to ease public health orders enacted in March and April to mitigate the spread of COVID-19 to manageable levels, free-market organizations are working together to suggest how emergency rules that liberated patient care can become permanent reforms.

President Donald Trump authorized federal government action to control the spread of COVID-19, commonly referred to as coronavirus, on March 13, declaring a national emergency. Forty-eight governors declared their respective states to be in states of emergency in March, expediting state government assistance and temporarily bypassing regulations for government health care payment programs such as Medicare.

As infection rates have declined across the country, states have started to reopen their economies by gradually rolling back emergency restrictions on commerce and removing stay-at-home orders and other measures.

Problems of Government Control

The COVID-19 crisis demonstrated how government micromanagement of health care harms patients instead of helping them, says Charlie Katebi, a health care policy analyst with Americans for Prosperity.

“There are many laws and regulations intended to promote patient health that lead to less access to high-quality tests, services, and health care providers,” Katebi said. “The result is that the United States had no idea how quickly COVID was spreading through our communities, and health care facilities lacked the capacity to care for large numbers of patients that needed acute health care services.”

Government micromanaging continued throughout the crisis, blocking access to care beyond COVID-19, says Twila Brase, president of the Citizens’ Council for Health Freedom, a national organization based in St. Paul, Minnesota supporting health care choice, and a policy advisor for The Heartland Institute, which publishes Health Care News.

“Very clearly, mandating that nonessential services not take place has put a huge barrier between patients and the care that they need,” Brase said. “I think that a lot of doctors and hospitals weren’t sure how to classify nonessential and essential, and so a lot of hospitals closed their doors to anything that wasn’t COVID-19-related. A lot of clinics closed their doors and weren’t accessible to patients.”

“I’ve heard of patients who’ve called the clinic because they needed something, and no one answered the phone, and no one called them back,” Brase said.

Patients were refused vital care such as hormone replacement therapy, pain relief, cancer treatment, orthopedic care, and elective surgery, Brase says.

Regulatory Overdose

Katebi says government regulations and bureaucratic delays at the U.S. Food & Drug Administration and Centers for Disease Control and Prevention hamstrung the ability of doctors and medical researchers to identify and stop the spread of COVID-19 before it could establish a beachhead in the United States.

“The FDA’s and CDC’s testing process is one of the major reasons why the United States failed to respond fast enough to the COVID outbreak,” Katebi said. “Prior to the crisis, CDC rules prohibited universities and researchers from developing their own tests for COVID unless the FDA determined that they meet Medicare’s guidelines as a certified laboratory. This process can take months.”

Katebi says medical researchers’ decisions to ignore government rules and prioritize the people’s well-being were instrumental in the development of tests for COVID-19.

“We only discovered COVID-19 had reached the United States once researchers from the University of Washington [bypassed] the law and developed their own test,” Katebi said. “Lawmakers can ensure this fiasco doesn’t happen again by allowing researchers and patients to freely use any test that has been approved in other advanced countries.”

Do No Harm

Now that the threat from the pandemic has diminished, lawmakers should use this opportunity to access what health care policies work and which ones stand in the way of patient care, Katebi says.

“What lawmakers and regulators should learn from this crisis is that any regulation that imposes delays on the ability of a provider or researcher to test or treat an individual could potentially threaten their lives,” Katebi said. “Going forward, these barriers should be permanently lifted at the state and federal level.”

Brase says reducing government meddling in the relationship between patients and their doctors and promoting competition are keys to curing what ails the nation’s health care system.

“The only way we will continue to have excellence in medical care in America is if we get the government out of the way and let hospitals and doctors and competition rule the day,” Brase said. “The ancillary thing lawmakers should learn is how much government gets in the way of medical care being given quickly, efficiently, and with excellence.”

Jesse Hathaway (think@heartland.org) is a policy advisor for The Heartland Institute.
Obamacare Gets Mixed Reviews on Its Tenth Anniversary

By Bonner Cohen

As the Affordable Care Act (ACA) reaches the tenth year since enactment, there is renewed interest in questions about whether it has delivered on its promise of universal health care to all Americans.

During the original congressional debate over whether the ACA should be implemented, proponents argued that it would ensure all Americans, regardless of income, would have access to affordable health insurance. Proponents said low-income people would receive generous subsidies that would enable them to purchase plans on newly created federal and state exchanges. States would be allowed to cover additional low-income people by expanding Medicaid, and people with preexisting conditions would not be denied coverage under the ACA.

To help cover the cost of the program, all Americans would be required to have health insurance or pay a penalty to the IRS. This individual mandate went into effect in 2014 after a 2012 Supreme Court ruling declared the penalty constitutional as a tax under the IRS. This individual mandate was subsequently repealed in the December 2017 tax reform.

Now: 29 Million Without Insurance

The health insurance coverage numbers have not borne out the promise of Obamacare, says Linda Gorman, a senior fellow at the Goodman Center for Public Policy Research and director of the Health Care Policy Center at the Independence Institute.

“Although private individual coverage grew by 5.3 million from 2014 through 2016, private coverage in the employer market fell by 3.6 million,” Gorman wrote in a 2018 analysis. “As a result, Obamacare witnessed a net increase of a mere 1.7 million people—slightly less than half of the natural increase in the civilian labor force.”

In September 2019, the U.S. Census Bureau reported the number of Americans without health insurance had risen for the first time in a decade in 2018, by about two million people. The Bureau found 8.5 percent of Americans went without medical insurance at some point in 2018, up from 7.9 percent in 2017. It was the first year-to-year increase in the percentage of the uninsured since Obamacare went into effect. Although the number is still below the 13.3 percent uninsured rate in 2013 prior to Obamacare taking effect, the increase means about 29 million Americans are still without health insurance.

Disabled on Waiting Lists

Medicaid expansion to able-bodied adults, which proponents said would ultimately benefit those with disabilities and chronic illnesses, was one of the cornerstones of Obamacare. It turned out to be far more expensive than predicted and may have actually harmed those with disabilities.

The Centers for Medicare & Medicaid Services (CMS) Office of the Actuary estimates the federal government spent $148.2 billion on Medicaid expansion from 2014 through 2016. Originally expected to cost just $3,500 per enrollee, the price taxpayers were footing rose to nearly $6,000 per enrollee by the end of 2016.

In addition, the Obama administration’s decision to reimburse states for 90 percent of the cost of able-bodied, working-age adults in Medicaid caused an unexpectedly rapid rise in enrollment. The federal government reimburses traditional Medicaid enrollees at a lower rate, and because of that, states limit enrollment.

“Expanding Medicaid to this group cost $148 billion from 2014 through 2016, money that could have been used to reduce the waiting lists for care for the disabled,” Gorman said.

Red Tape Entangling Patients

Largely hidden from public view are Obamacare’s reporting requirements for what are called “quality measures,” which have increasingly taken up the valuable time of physicians and hospitals.

“Virtually all published studies on the value of Obamacare quality measures ignore whether the quality gains would have occurred anyway,” Gorman writes.

Physicians have also had to spend a growing amount of time on electronic health records (EHRs). A 2009 statute, the Health Information Technology for Economic and Clinical Health Act (HIThE), has added to the Obamacare record-keeping requirements.

The U.S. health care system was already using electronic medical records where it made sense. HIThE’s meaningful-use requirements have made data entry a time-consuming task for physicians. A September 2017 Annals of Family Medicine study by Brian Arndt et al. found physicians spend two hours on EHRs for every hour of direct patient care.

Cost Increases for the Unsubsidized

Families looking for insurance in the individual market who don’t qualify for federal subsidies have found their premiums have increased significantly, says John Goodman, co-publisher of Health Care News and cofounder of The Goodman Institute.

“What we were promised was access to the type of insurance people used to get at work. What we got instead was something that increasingly looks like Medicaid with a ridiculously high deductible.”

JOHN GOODMAN
THE GOODMAN INSTITUTE FOR
PUBLIC POLICY
HRAs Provide New Opportunity for Employer Health Insurance

Employers can now offer employees an alternative to traditional group health insurance plans. Individual Coverage Health Reimbursement Accounts (ICHRA), re-established by the Trump administration on January 1, allow individuals to pick their own health plan. The rollout has been overshadowed by the pandemic crisis. Health Care News talked with Bill Sweetnam, technical and legislative director at the Employers Council on Flexible Compensation, about the prospects for ICHRAs and their potential as a positive disrupter in the health insurance market.

**Health Care News**: How do ICHRAs work, and what is their potential for improving the health insurance market?

**Sweetnam**: If an employer puts money into an ICHRA, the employee can use that money and go out into the marketplace and buy health insurance on the individual market. This has the potential for making this market more competitive because employers are now providing financial assistance to employees purchasing insurance in the individual market.

This is a big change from what existed under the Affordable Care Act. HRAs existed before the ACA, but under ACA, employer plans could not have annualized or lifetime limits on employer coverage, and preventive care had to be provided at no cost to the employee. That struck at the heart of a traditional HRA because these were fixed accounts and once you used them up, no further reimbursements for medical care were available, regardless of whether the expense was for preventive care. Traditional HRAs that were integrated with employer-provided health insurance coverage and retiree-only HRAs continued to be allowed under the ACA.

**Health Care News**: When it announced new rules for ICHRAs last year, the Trump administration projected ICHRAs would ultimately cover 11 million workers, including new coverage for 800,000 working Americans who do not have employer insurance. Who are these employers?

**Sweetnam**: An employer could decide it was going to stop offering individual health insurance altogether and offer these ICHRAs so that employees could purchase individual health coverage with the funds the employer provided through the ICHRA. That is a big change in how employers provide health insurance. There are also employers who don’t currently offer insurance to certain groups, like part-time or seasonal workers. While an employer may not be required to offer health insurance to these groups, they may want to offer the ICHRA to become a more attractive employer.

I’m not sure if employers who are currently offering health insurance will drop insurance coverage and switch over to ICHRAs. Employers could have done this under ACA because there was now an exchange where people could get subsidized insurance, and we didn’t see that happen.

This is giving some new impetus to employers to offer something to workers who don’t have any coverage.

**Health Care News**: HRAs became effective on January 1. What has the response been so far?

**Sweetnam**: We don’t have a lot of data yet. The unfortunate thing is the rollout happened during a time when employers are dealing with the issues related to COVID-19. Examining the types of coverage you’re going to provide is not on top of most employers’ radar screens right now.

The other thing, as with any employee benefit program focused on small employers, these programs are sold, rather than bought. There are lots of incentives for small employers to take advantage of ICHRAs, but when it comes down to it, it is up to brokers and actuaries to sell it. We saw this at first with 401ks as a retirement benefit: there were incentives for small employers to offer these plans, but there has been slow take-up. The same thing needs to happen in the health care market. Small businesses are busy running their business, not worrying about health insurance. Small business organizations will need to push the idea as well, so that small businesses understand the opportunity available with ICHRAs.

One problem may be compensation. With an ICHRA, the major challenge is administering the accounts and reimbursing the premiums paid by participants. Not all brokers are equipped to do that, and not all HRA administrators are brokers. The marketing pipeline is different for this than traditional health insurance.

**Health Care News**: Will employees balk? Are there enough affordable and attractive plans on the individual market to make this a good benefit? Unlike Health Savings Accounts or Flexible Savings Arrangements, HRAs must be spent on an ACA-compliant health insurance plan. Employers don’t get to keep the money if they decide to pass, right? How will that affect uptake?

**Sweetnam**: Yes, the employee can only use the money on health insurance, and once they have insurance, they can only use that money to be reimbursed for qualified health expenses.

I’m not sure about the insurance options available now, but the individual market could change as more people get health insurance this way. The Trump administration has been very proactive on short-term limited disability plans, but they would not work in this situation.

For the money to be spent for anything other than health insurance and qualified health expenses, there would need to be a legislative change for that. In this legislative environment, it may be difficult to get a majority to push for a change like this to the employer-provided health care system.

Is it fair to call an ICHRA a 401k plan for health insurance? In some ways it is, since the employees have to learn what is out there in the insurance market and pick it themselves, much like they invest the funds they contribute to their 401(k) plan. And that is not always easy.

**BILL SWEETNAM**
**TECHNICAL AND LEGISLATIVE DIRECTOR**
**EMPLOYERS COUNCIL ON FLEXIBLE COMPENSATION**
By Kelsey Hackem

Medicaid expansion produced negligible average effects on health and increased mortality rates across numerous age groups, a new report states.

“Is Medicaid Expansion Worth It?” published on April 23 by the Texas Public Policy Foundation, analyzes a variety of studies on Medicaid expansion outcomes. Authors Brian Blase and David Balat suggest targeted programs, including those particularly geared toward the young, provide more benefit to overall health than massive Medicaid expansion.

More than $300 billion, mostly from the federal government, was spent on Medicaid expansion between 2014 and 2018. In 2019, the federal government spent approximately $120 billion subsidizing health care coverage through Medicaid expansion and subsidies for coverage on the health insurance exchange.

“Ultimately, the enormous outlays of economic resources plowed into Medicaid expansion likely could have been used in a variety of ways to better improve the economic well-being and health of Americans.”

BRIAN BLASE AND DAVID BALAT, TEXAS PUBLIC POLICY FOUNDATION

Mortality Effects

Since 2013, when the Affordable Care Act (ACA) was enacted, there has been a significant increase in Medicaid enrollment. As enrollment increased, average life expectancy decreased more rapidly in states that expanded their Medicaid coverage than in non-expansion states.

“The ACA significantly expanded health insurance coverage between 2013 and 2017, but Americans’ health worsened during this period as life expectancy declined for three consecutive years from 2014 to 2017,” Blase and Balat write.

Specifically, expansion states experienced a 1.5 percentage point greater increase in mortality than non-expansion states, when measured in 2014. Mortality trends for nonelderly adults were also worse in Medicaid expansion states from 2014 to 2017.

Blase and Balat analyze three economic studies released since 2018 assessing the effect of Medicaid expansion on mortality.

“One paper found that near-elderly individuals who had low income in the five-year period before the expansion took effect had lower mortality rates after 2013 in expansion states,” Blase and Balat write. “A second paper found broader mortality reductions in Medicaid expansion states, but with the largest effect also concentrated among 55- to 64-year-olds. However, a third paper found no discernible effect of Medicaid expansion on mortality for the same age group and stresses the difficulty of drawing definitive conclusions from this type of research.”

Blase and Balat state Medicaid expansion led to increases in preventive health services, access to primary care services, and fewer skipped medications due to cost. Medicaid expansion was also associated with improvements in self-reported health and greater financial peace of mind. The evidence on physical health benefits has been mixed.

Better Options

Blase and Balat conclude “programs that focus aid on providers that care for lower-income populations are almost certainly a better public investment than programs aimed at boosting coverage.”

States considering further expansion should assess the balance between medical services and social services. Blase and Balat note Medicaid expansion increased the demand for medical services, including emergency room utilization, while there were not any corresponding measures or initiatives in the ACA for health care and other services that could provide greater benefits to low-income individuals.

“Ultimately, the enormous outlays of economic resources plowed into Medicaid expansion likely could have been used in a variety of ways to better improve the economic well-being and health of Americans,” Blase and Balat write.

Kelsey Hackem, J.D. (khackem@gmail.com) writes from Washington State.

States May Need to Brace for Medicaid ‘Tidal Wave’

Enrollment in Medicaid could soar by 73 percent, to nearly 55 million people, a new study states.

The increase results not only from the economic downturn caused by the pandemic crisis but also from recent “congressional hand-tying” restricting states from moving ineligible enrollees off Medicaid, the study states.

“States will need to fund nearly $128 billion of those costs with state revenues, while federal tax payers will be on the hook for the rest,” write authors Nicholas Horton and Johnathan Ingram in the study released on June 10 by the Foundation for Government Accountability.

Hardest-hit will be states that expanded Medicaid under Obamacare to able-bodied adults based on income, not disability, write the authors. The pandemic will cause enrollees to move in and out of income eligibility as they return to work, but under the CARES Act and the Families First Coronavirus Response Act, Congress is restricting states from moving enrollees off the rolls.

The increased funding for Medicaid (6.2 percent) will not apply to expansion costs but to traditional Medicaid only, the authors note.

“So, as expansion states enroll more and more able-bodied adults, they will bear more of the brunt of those costs,” Horton and Ingram write.

Nearly a Half-Trillion Dollars

Medicaid spending could soar by more than $440 billion, of which states will have to pick up varying amounts, the report states. The authors calculate how much states will have to pay out of their own budgets based on anticipated Medicaid growth as a result of the recession and congressional restrictions on removal of enrollees. California has the highest prospective payout, at $20.1 billion, and Wyoming will have the lowest burden, at $159.1 million.

Lawmakers must act now to give states relief by allowing them more control over their Medicaid programs, the authors write.

“Congress should be giving states more tools to manage and preserve Medicaid for those who need it most,” Horton and Ingram write. “Unfortunately, they have done the exact opposite, but they still have time to get it right.”

—Staff reports

Nicholas Horton and Jonathan Ingram, “States Are About to be Hit by a Medicaid Tidal Wave,” Foundation for Government Accountability, June 10, 2020: https://www.heartland.org/publications-resources/publications/states-are-about-to-be-hit-by-a-medicaid-tidal-wave
Oklahoma Medicaid Block Grant Put
on Hold Due to Budget Headwinds

By Bonner Cohen

Oklahoma Gov. Kevin Stitt cancelled his state’s planned Medicaid expansion, citing a lack of funding caused by the economic impact of COVID-19.

Before the pandemic struck, Oklahoma was on track to become the first state in the nation to finance Medicaid expansion for low-income people via Trump administration-approved federal block grants.

The governor vetoed a bill that would have funded Medicaid expansion starting July 1, noting the record-high unemployment caused by the COVID-19 shutdowns greatly increased the number of people who would be eligible for the program.

Block Grant to Manage Expansion

Stitt’s Medicaid expansion plan, SoonerCare 2.0, would apply capped funding to an estimated 220,000 adults with income less than 133 percent of the federal poverty level, allowing them to become newly eligible for Medicaid.

The governor’s plan would move people away from a “fee-for-service” model by adopting block grant funding and requiring able-bodied Medicaid enrollees to work, attend school, or attend a certification program in order to stay in the program.

Oklahoma is one of 14 states that have not expanded Medicaid coverage under the Affordable Care Act, also known as Obamacare. Other states that have expressed an interest in funding Medicaid through block grants include Alaska, Georgia, and Tennessee.

One of the nation’s leading producers of oil and natural gas, Oklahoma has been hit hard by the recent collapse in oil and gas prices and global demand for fossil fuels. The sudden economic downturn and Stitt’s decision to put a hold on Medicaid expansion come at a time when voters will be deciding State Question 802, a June 30 ballot initiative that would expand Medicaid without block grants or work requirements for recipients.

Constitutionally Protected Costs

State Question 802 would cover about 200,000 people under the age of 65—about 5 percent of the state’s population. Estimates of the potential cost of the ballot initiative-driven Medicaid expansion range from $175 million to $375 million per year.

Costs are hard to predict, however, because the initiative would enshrine expansion in the state’s constitution, says Samantha Fillmore, a government relations coordinator for The Heartland Institute which publishes Health Care News.

“It would leave elected officials in Oklahoma to have to find a substantial source of funding for this large and permanent expansion,” Fillmore said. “With states’ revenues across the nation suffering a serious blow from the stay-at-home order, this is the worst time to commit to that level of expansion and spending. Voters should decide if they are prepared to permanently alter their Constitution and commit to exponential spending for generations. Furthermore, massive state expansions, at their very core, do not help and protect the most vulnerable citizens.”

Getting Hospitals to Help Pay

Taking account of the new situation, the governor vetoed a bill on May 21 that would have increased hospital fees to help pay for SoonerCare 2.0, stating it did not include enough long-term funding for his planned expansion of Medicaid.

Senate Bill 1046 would have generated $134 million a year—a significant portion of Oklahoma’s share of financing Medicaid expansion, expected to be about $164 million in the coming fiscal year—and would have applied regardless of which plan the state ultimately implemented.

Faced with a deteriorating financial situation, Stitt said he had little choice but to veto the bill.

“Due to the current COVID-19 pandemic and uncertainties within the energy markets and commodity prices, unemployment rates are expected to be as high as 14 percent. This will not only increase the number of individuals currently enrolled in Medicaid but will also increase the number of potential enrollees in the expanded population.”

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

KEVIN STITT
OKLAHOMA GOVERNOR
Biosensor Patch Opens the Door for Virtual Care

By Ashley Herzog

The U.S. Food and Drug Administration granted emergency use authorization for a wearable biosensor patch that helps solve many of the challenges doctors, nurses, and therapists face when treating COVID-19 patients in intensive care units (ICUs).

“The VitalPatch allows clinicians to monitor 11 vital signs continuously and remotely, freeing staff to attend to more patients. It also protects staff from being exposed to infectious diseases. The device and its software were developed by Vital Connect, a biotechnology company based in Silicon Valley.

“The [software] interface shows patients in easy-to-interpret tiles, displaying vital signs to clinicians,” said Natalie Schoen, a senior account executive for VitalConnect. “This allows them to review historical data for each patient, to understand trends and inform treatment decisions.”

Checking Signs

VitalPatch can measure vital signs such as blood oxygen levels, blood pressure, respiratory rate, heart rate, and body temperature.

“Clinicians can set customized thresholds and be alerted in real time if a patient crosses a threshold,” Schoen said.

Schoen says physicians and researchers are using VitalPatch to monitor COVID-19 ambulatory patients in an isolation unit at Oxford University Hospital in the United Kingdom.

“Its use reduces risk to caregivers during the pandemic and may lead to improved care of patients,” Schoen said.

Cutting Costs

The patch can also reduce treatment costs, Schoen says.

“A one-day stay in a New York City hospital costs, on average, $2,013 a day,” Schoen said. “The virus typically takes fourteen days to run its course, so that’s almost $30,000 in cost to the health care system. VitalPatch costs a fraction of this—roughly $1,000—for the same time period.”

Schoen says monitoring health metrics is particularly important in treating COVID-19 patients because reaching certain thresholds can mean death. Patients can wear the patches when they are removed from critical care and return home to recover.

“Physicians have the ability to set and receive text notifications for patients that are outside their current threshold for any of their vitala,” Schoen said. “Clinicians also have the ability to immediately connect with patients through the [computer] tablet to visit the patient virtually and determine next steps in their course of treatment.”

Expanding Access

Remote technology and telemedicine are important in addressing the pandemic, especially in underserved areas, says Sally Pipes, president of the Pacific Research Institute.

“Telemedicine can address health disparities by allowing physicians to remotely deliver care,” Pipes said. “A recent survey found that one-quarter of rural Americans say they’re unable to get care when they need it. It takes people living in rural parts of the country almost twice as long as urban residents to get to the nearest hospital. Telehealth allows these patients to get the care they need, even if they live in an area with a shortage of providers.”

Reducing Mortality

Virtual technology that allows doctors to monitor patients remotely can greatly reduce death rates, Pipes says.

“Take the case of a Utah-based tele-intensive care unit, where providers monitor patients by video and can modify treatment and order tests remotely,” Pipes said. “A study of 3,000 patients found that the program cut mortality by 33 percent.”

SALLY PIPES
PRESIDENT, PACIFIC RESEARCH INSTITUTE

Bill Would Allow Individuals to Buy Group Health Insurance

Recognizing that many Americans have lost jobs and the health insurance that goes with them during the coronavirus pandemic, Sen. Rand Paul (R-KY) introduced a bill to allow organizations to offer portable insurance that can stay with an individual in and out of the workforce and across state lines.

The Healthshare Plans Act of 2020, introduced on May 5, would amend the Employee Retirement Income Security Act of 1974 (ERISA) to allow membership organizations such as Costco and Sam’s Club and associations such as the National Restaurant Association to offer health insurance to their members. Eligible organizations would also include small-business platforms for gig workers, such as Uber, Etsy, eBay, and Amazon, plus trade associations and other large groups.

Large-group policies typically offer lower premiums, but under current law they are not available to people who do not work for companies with 51 or more workers.

An added feature of the proposed plans is their portability from job to job. Coverage would continue as long as the enrollee continues to pay premiums. Membership organizations can design plans that best suit members’ needs. They would be prohibited from refusing insurance based on health status or preexisting conditions.

A companion bill is under consideration in the U.S. House. Neither bill has bipartisan support.

“Innovation has given us more options in many areas than ever before, and it’s long past time to bring it to a health insurance system that leaves too many on the outside looking in,” stated Paul in a news release. “The American Healthshare Plans Act will help remove one of the heaviest burdens from off Americans’ backs, putting more power in the people’s hands and using pure numbers to drive down insurance costs and expand opportunities.”

The Healthshare Plans Act is a step in the right direction, says John C. Goodman, co-publisher of Health Care News.

“The individual market has been destroyed by Obamacare, with soaring premiums, outrageously high deductibles, and skinny provider networks that omit the best doctors and the best hospitals,” Goodman said. “That’s why Sen. Paul’s proposal to give more people access to group insurance is so important.”

—Staff reports
FDA Allows Pathologists to Work Offsite

By Jesse Hathaway

The U.S. Food & Drug Administration (FDA) is allowing pathologists to work from home while reviewing cases during the coronavirus pandemic.

Before the publication of the emergency guidance document in April, FDA regulators had not approved remote viewing, requiring pathologists to be physically present while working at clinical laboratories and hospitals.

The guidance remains in effect throughout the national public health emergency, first declared by President Donald Trump in March.

Regulatory guidance documents are generally not legally binding or enforceable, but they describe the agency’s suggestions and recommendations for governed entities.

The new rule is one of several deregulatory moves by the Trump administration in response to the COVID-19 crisis, intended to save money and reduce the risk of accidental exposure to COVID-19 among pathologists and laboratory technicians.

Says Streamlining Is Safe

The FDA’s relaxation of overly strict rules on clinic technicians proves government barriers to medical innovation can be lowered without sacrificing patients’ safety, says Jeff Stier, a senior fellow with the Taxpayers Protection Alliance and a policy advisor at The Heartland Institute, which publishes Health Care News.

“I’m pleased to see that the FDA is relaxing regulations to provide better access to care during the pandemic,” Stier said. “Critics of such moves often justify burdensome regulations by alleging that the rules are necessary for various technical reasons. But the FDA, by attaching strict technical requirements before permitting remote reading of scans, proves that deregulation can be implemented nationally. The only problem with the agency’s move is the temporary nature of it.”

Hidden Costs, Forgotten Lives

Government rules are often enacted and then forgotten by bureaucrats, just like the people who pay the costs of overregulation, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

“Once regulations are imposed, there is little incentive to lift them, examine how they interact with one another, or question whether the pile that has built up over the years makes much sense,” Gorman said. “People killed by too much regulation are not as visible as people killed by too little regulation. Plus, health care regulation is an easy sell: we have to keep people safe, after all, and even if it would save only one life, never mind that everything is a tradeoff.”

Calls for More Deregulation

Gorman says it’s too easy for lawmakers and agency officials to overlook the costs of their edicts.

“They don’t think in terms of tradeoffs,” Gorman said. “Health care policy people, especially if they are academics or in government public health agencies, often have an overweening belief in the beneficial effects of government central planning when applied to health care. [The free-market economist Friedrich] Hayek is not required reading for a public health degree.”

Congress plays a vital role in getting government out of the way of health care innovation, Gorman says.

“Lawmakers can reduce regulation by passing laws that repeal it,” Gorman said. “They can reduce the need for regulation by giving patients more control over how health care money is spent. Quality of care, like everything else, is subject to tradeoffs. Optimal quality for you will differ from optimal quality for me.

“The role of government, if anything, might be to certify that people are doing what they say they are doing—the test works, the harms of the drugs are disclosed, and what is in the package is what the seller says is in the package,” Gorman said.

Costs ‘Not Just Economic’

Stier says the FDA should take the opportunity to cement the changes to rules governing remote pathology and look for more red tape to cut once the pandemic ends.

“I encourage the FDA to work with providers and device manufacturers to study the benefits of the increased access, together with any unintended consequences, so that the deregulatory move could become permanent if supported by the data,” Stier said. “The costs of unnecessary regulation are not just economic.”

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

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Doctors Question Treatment Protocols

By Ashley Herzog

As the battle against COVID-19 continues, physicians and a patient advocacy group say it’s time to rethink evidence-based medicine protocols (EBMs).

EBMs were designed to help physicians make treatment decisions based on rapidly growing data and studies in medical literature. Instead, a growing number of doctors are finding EBMs to be a bureaucratic straitjacket that promotes a one-size-fits-all approach, often requiring them to go against their better judgment.

Twila Brase, president and cofounder of Citizens’ Council for Health Freedom, cites an example.

“To save his patients from EBM protocols, New York City physician Dr. Cameron Kyle-Sidell, made a public plea online for every hospital to change ventilator protocols because they were damaging lungs,” Brase said. “But why did he, a physician, even have to ask for permission? Evidence-based medicine protocols can act like handcuffs, preventing the proper care of patients.”

Mandated Treatment

EBMs can be unnecessarily restrictive to medical professionals, says Chad Savage, M.D., an internist who founded a direct primary care practice in Brighton, Michigan and is a policy advisor to The Heartland Institute, which publishes Health Care News.

“It’s not that evidence-based protocols used as tools to assist with complex decision-making are wrong; it’s that they are mandated,” Savage said.

“I trained in the ‘90s, and protocols and treatment algorithms were just coming into common practice,” Savage said. “At that time, they were covered in disclaimers that indicated these should never replace clinical judgment. However, over time, that has inverted. Now they supersede clinical judgment. So this may work for the majority of patients, but it places at risk the minority of patients whose needs deviate from these protocols.”

Hydroxychloroquine Lawsuit

Doctors treating COVID-19 patients are especially adamant about the need to use their professional judgment first and foremost, which may require care much different from the hospital’s EBM protocol.

On June 5, the Association of American Physicians and Surgeons (AAPS) sued the Food and Drug Administration (FDA) in the U.S. District Court for the Western District of Michigan for limiting the use of hydroxychloroquine, a controversial anti-malaria drug that some doctors were using to treat coronavirus patients.

“The FDA has no right to regulate the practice of medicine,” said Jane Orient, M.D., AAPS executive director and a policy advisor to The Heartland Institute. “Once a drug is approved, doctors may prescribe for additional indications.”

The practice is known as “off-label” prescriptions, and it can be a vital tool for medical professionals to provide early and efficient care to patients, especially when it comes to treating a new disease such as COVID-19, Orient says.

“About 20 percent of prescriptions and most pediatric prescriptions are ‘off

“The [evidence-based medicine protocols] issue is a matter of control and the desire to have objective standards by which to judge physicians. However, the standard by which we should be judged is, by definition, subjective.”

DEANE WALDMAN
AUTHOR, CURING THE CANCER IN U.S. HEALTHCARE

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Retractions Suggest Politics at Play at Medical Journals

By AnneMarie Schieber

A mid concern about data flaws, The Lancet and The New England Journal of Medicine (NEJM) retracted reports discrediting off-label drugs being used to treat and prevent COVID-19.

On June 4, 2020, The Lancet pulled a study it had published stating hydroxychloroquine (HCQ)—a possible COVID-19 treatment touted by President Donald Trump—and another anti-malarial drug, chloroquine, were ineffective treatments for COVID-19 and increased the risk of heart problems and death. Hours later, NEJM retracted a study discrediting a blood pressure medication being used for COVID-19 treatment. The studies were done by the same company, Surgisphere, and used retrospective data, not data from a randomized, controlled study.

Outside experts raised red flags about the Lancet study when they noticed inconsistencies in the data. Surgisphere failed to provide its raw data for peer review, stating contractual obligations prohibited it from doing so.

Press Pushback Against President

HCQ is a generic and inexpensive drug that has been safely used to treat malaria and autoimmune diseases such as lupus. The drug has been in the spotlight since Trump tweeted on March 21 that for COVID-19, HCQ and the antibiotic azithromycin “have a real chance to be one of the biggest game changers in the history of medicine.” On May 18, Trump said he was taking the drug to protect himself from getting the disease, and his physician stated the benefit outweighed the risk.

Since then, there have been numerous media reports discrediting the drug. Several states, such as Michigan, threatened civil action against physicians who prescribed the drug for a use other than its approved purpose. Such use is known as “off label” and is a widely accepted practice.

Coverage by the media has been “consistently biased,” wrote Manhattan Institute Policy Analyst Connor Harris in City Journal on June 5, 2020. Harris says research into small datasets indicates HCQ shows promise in treating COVID-19 in its early stages, but the evidence “has gone almost entirely ignored by most media outlets.” Research on the drug’s efficacy and risks should continue, and “what is not warranted, though, is the portrayal of HCQ as deadly,” Harris writes.

Politics in Medical Science

The medical journals’ publication of these articles undermines confidence in scientists’ integrity, says Marilyn Singleton, M.D., J.D. and past president of the Association of American Physicians and Surgeons.

“The Lancet debacle illustrates the danger of injecting politics into medical science,” Singleton said. “Some media outlets perversely reported with glee that ‘Trump’s drug’ was useless. We all should be disappointed that multiple reports of clinical successes were not validated in a well-publicized study.”

Getting information to the public about a presumably unknown virus and one that has upended lives is key, Singleton says.

“Dodgy research methods neither advance our knowledge of COVID-19 nor give us confidence in the guidelines from the experts,” Singleton said.

Pandemic Book Nixed

Medical journals and media outlets are not the only institutions under fire for trying to control the discussion of COVID-19. The same week as the retractions, Tesla and SpaceX CEO Elon Musk called out Amazon founder Jeff Bezos for rejecting a book questioning the severity of the pandemic.

Author and former New York Times reporter Alex Berenson tweeted Kindle Direct Publishing would not make his book Unreported Truths about Covid-19 and Lockdowns available on its platform. After the tweets, Amazon announced the book would be available.

Singleton says it is important to let the public judge for itself.


“The Lancet debacle illustrates the danger of injecting politics into medical science. Some media outlets perversely reported with glee that ‘Trump’s drug’ was useless. We all should be disappointed that multiple reports of clinical successes were not validated in a well-publicized study. Dodgy research methods neither advance our knowledge of COVID-19 nor give us confidence in the guidelines from the experts.”

Marilyn Singleton, M.D., J.D.
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COVID-19 and ‘Deaths of Despair’ Make Weak Case for Socialized Medicine

By John Couretas

The American health care industry is undergoing a massive stress test from the coronavirus. For months and years to come, analysts will be issuing their opinions about just how well that industry performed under the incredible, sudden surge of the pandemic.

Given the massive influx of stimulus funding for health care and government programs such as Medicare, no one should be surprised about a barrage of new lobbying activity and a surge of activism for single-payer or “universal” health care. Getting just ahead of that surge are Angus Deaton and Anne Case, two distinguished economics scholars, with the publication in March of their book Deaths of Despair and the Future of Capitalism (Princeton University Press). The book explores rising death rates from suicide, drug overdose, and alcoholism, and more specifically, the health care sector’s role in the economy.

Rich Stealing from Poor?

American health care, the authors argue, is the most expensive in the world and delivers the worst outcomes of any advanced nation, making it “a cancer at the heart of the economy.”

In Case and Deaton’s view, discussed in the book and in a video interview, American health care is a Sheriff of Nottingham con game—the rich stealing from the poor—with no Robin Hood in sight. The industry, they claim, “is not very good at promoting health” but delivers vast riches to physicians, pharmaceutical companies, medical device manufacturers, health insurers, and hospitals. And all of it is protected by a potent lobbying effort in Washington, the writers argue.

Case and Deaton go into some detail on the deadly opioid crisis, and the culpability of pharmaceutical companies in that ongoing plague, but they say the problems in American health care go well beyond that.

Health insurance, Case and Deaton say, inordinately consumes personal income whether it is paid by the individual or through the shared cost of an employer plan. “It has often been noted that health insurance is less about protecting your health than protecting your wallet against the health care system,” the authors write. They look at the cost of health care as a form of reverse taxation where “squeezing even small amounts out of each of a large number of working people can provide enormous fortunes for the rich who are doing the squeezing. That is what is happening today, and we should stop it.”

Critical of Health Insurance

The authors are serious people. Deaton, author of The Great Escape: Health, Wealth, and the Origins of Inequality, won the economics Nobel Prize in 2015 for his work on poverty. Case is the Alexander Stewart 1886 Professor of Economics and Public Affairs Emeritus at Princeton University.

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Calling for Compulsion

To bolster their case, the authors cite the work of economist Kenneth Arrow, who they say concluded a “laissez-faire solution for medicine is intolerable.” The authors agree with that thought. “Certainly, as market fundamentalists argue, competitive free markets (together with antitrust enforcement) would almost certainly deliver lower prices than those we see today,” the authors write. “But health care is not like other services. Patients lack the information that providers possess, which puts us largely in their hands. We are in no position to resist provider-driven overprovision, which can also happen with a garage mechanic, but with less serious consequences.”

Like good progressives, Case and Deaton advocate imposing some form of universal health care. … They concede that ‘no viable scheme can work without compulsion to prevent those who do not need insurance from refusing to pay, nor without cost control, which will cut the incomes of providers, not all of whom are extremely rich.’”

“The American health care industry is undergoing a massive stress test from the coronavirus. For months and years to come, analysts will be issuing their opinions about just how well that industry performed under the incredible, sudden surge of the pandemic.”

“Like good progressives, Case and Deaton advocate imposing some form of universal health care. … They concede that ‘no viable scheme can work without compulsion to prevent those who do not need insurance from refusing to pay, nor without cost control, which will cut the incomes of providers, not all of whom are extremely rich.’”

Reluctant to Trust

Anyone who witnessed the debate over Obamacare, a thoroughly partisan project, should expect that Case and Deaton will get a lot of pushback on their claims. In an April 14 Washington Post column titled “Why this pandemic is an indictment of socialized medicine,” Marc Thiessen of the American Enterprise Institute says the coronavirus response calls into question “the dangerous idea that we should put the government bureaucrats who could not develop tests or stockpile masks, gowns and ventilators in charge of our entire health-care system.”

Deaths of Despair and the Future of Capitalism will find a receptive audience among progressives in an election year, for all sorts of reasons. The outcome of the race for the White House will have a huge bearing on whether another push for socialized medicine is ahead. Former Vice President Joe Biden, the current frontrunner for the Democrats’ presidential nomination, has promised a major expansion of government support for health care, including a Medicare-type public option.

But whoever wins in November, the 2,829 health care lobbyists in Washington—by Case and Deaton’s count—are sure to remain very busy.

John Couretas (jcouretas@acton.org) is editor-at-large for the Acton Institute. This article was excerpted from “COVID-19, socialized medicine and deaths of despair,” a post published on the Acton Institute PowerBlog on April 22, 2020. Reprinted with permission.
CDC Changes View on COVID Surface Contamination

In a surprise move, the Centers for Disease Control and Prevention stated surface contact is not the main way the coronavirus that causes COVID-19 spreads.

The information caused confusion because agencies such as the National Institutes of Health (NIH) said weeks earlier the virus could live up to 24 hours on cardboard surfaces and as long as three days on other materials. Store staff and members of the public across the nation began a campaign of sanitizing surfaces with bleach.

“Clean and disinfect frequently touched objects and surfaces using a regular household cleaning spray or wipe,” the NIH website recommended on March 17.

On May 11, with no public announcement, the CDC website stated COVID-19 “does not spread easily from touching surfaces,” under the headline “Spread from Contact with Contaminated Surfaces or Objects.”

The media picked up on the wording, which prompted the FDA to dial it back on May 22, stating the change “was intended to make it easier to read, and was not a result of any new science.”

Such confusion shows the need for more calm and common sense in government agencies’ messaging, says Marilyn Singleton, M.D., J.D.

“The new CDC information is a far cry from the scary news blasts that the coronavirus can last up to nine days on surfaces and tutorials on the hours-long process of disinfecting our homes, food, and phones,” Singleton said. “Where was this advice during the last [2018-2019] flu season when millions were infected and over 61,000 died? People shopped without giving a second thought to contracting the flu.”

Singleton says when the dust settles from the pandemic scare, a single, commonplace action will prove to be the best way to reduce the chance of illness.

“The advice for staying healthy is time-tested and the simplest: wash your hands and don’t touch your face,” Singleton said.

—Staff reports

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