Doctors Without State Borders
More doctors can now practice in states that recognize licenses from other states, allowing patients to get care faster.

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Off-Label Drugs
To save lives, regulators have given the green light for use of drugs approved for other diseases, and President Donald Trump signed on personally.

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COVID-19 Tests
Once the U.S. Food and Drug Administration got out of the way, the market responded in force with new COVID tests.

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Surprise Bills
Studies show the marketplace can solve the problem of surprise medical bills.

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Big Deregulation Push
Patients can now have virtual consultations, pre-tax money for 24/7 primary care, and portable health insurance.

Page 19

The Pulse

Personal, Portable Health Insurance Hits Workplace Just in Time

By Ashley Bateman
With millions of people losing jobs or dealing with pay cuts from the pandemic shutdowns, a workplace health care option recently expanded by the Trump administration is getting renewed attention because of its flexibility and portability.

Health reimbursement arrangements (HRAs) are employer-funded accounts that set aside pre-tax money for employees to use for out-of-pocket medical expenses and personal health insurance premiums. The new rules for HRAs went into effect on January 1, just weeks before many businesses

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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:
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Free to Choose Medicine Campaign
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The Heartland Institute Welcomes the Goodman Institute as Co-Publisher of Health Care News

The Goodman Institute for Public Policy Research has joined The Heartland Institute as co-publisher of Health Care News. Health Care News is the nation’s premier newspaper on health care issues, mailed to more than 8,000 legislators, policymakers, and thought leaders throughout the United States. Health Care News is one of several issue-centered newspapers published for two decades by The Heartland Institute, a nonprofit, nonpartisan public policy organization based in Arlington Heights, Illinois. The Goodman Institute, likewise a think tank on policy issues, is led by founder John Goodman, whom the Wall Street Journal called the father of health savings accounts (HSAs).

The partnership comes at a time when health care policy dominates the headlines nearly every day, with the COVID-19 pandemic and a general election in November many voters view as a referendum on sharply different approaches to the problems in the nation’s health care system. “Health care topics are at the forefront of attention throughout the 50 states as we address the coronavirus pandemic,” said James Taylor, president of The Heartland Institute. “The decisions we make today during these very challenging times will impact American society for generations to come. It is very important that we make wise decisions and safeguard freedom in the health care marketplace.”

Taylor says the Heartland Institute’s partnership with the highly respected Goodman Institute gives Health Care News an exceptional talent pool. “Readers will continue to receive the same high-quality news and information our newspapers have always delivered, and the participation of the Goodman Institute will provide additional insight and perspective,” Taylor said.

—The Editors

A New Chapter for Health Care News

By John C. Goodman

This is a critical time for Health Care News. The Heartland Institute suspended publication of the paper in March because of budget considerations. Fortunately, the Goodman Institute for Public Policy has agreed to partner with Heartland to ensure the newspaper’s survival going forward.

This new partnership could not have come at a better time. Polls consistently show that health care is the number one issue for American voters. So, the need to inform candidates and the public about health care policy choices in this election year has never been greater. HCN is ideally positioned to do that.

The newspaper goes out to more than 8,000 people every month, reaching every state officeholder in the country, and every member of Congress. Independent marketing surveys show HCN has a big impact on state legislators. More than 50 percent of state legislators say they always or sometimes read Health Care News. More than one-third say the newspaper has influenced their opinion on a health care issue or caused them to change their position on a vote.

As candidates throughout the country prepare for the election this fall, each and every one of them will need reliable information about health care policy alternatives.

The Goodman Institute is generally credited as the source of the idea of health savings accounts, along with other innovative ideas. It brings an important national perspective to HCN at a time when the health care policy space has already been nationalized. Our two organizations look forward to working together to continue to bring sound policy news to the nation’s lawmakers, policymakers, and opinion leaders.

John C. Goodman, Ph.D. (johngoodman@goodmaninstitute.org) is founder of The Goodman Institute for Public Policy and co-publisher of Health Care News with The Heartland Institute.
New Federal Rules Liberate Virtual Medicine

Continued from page 1

more than 80 telehealth services and cover visits in all settings, including a patient’s home.

Congress had prohibited full reimbursement for virtual doctor visits, except in underserved areas, and in those cases, the patient had to log on at a hospital or clinic for the service. CMS made the changes under President Donald Trump’s emergency declaration.

Telehealth, which allows patients to connect remotely with medical professionals, is an area where deregulation has empowered patients during the crisis and provided public health benefits. The remote nature of telehealth allows physicians to keep their practices open during the shutdowns while protecting themselves and others from those who may be contagious with the coronavirus or other illnesses.

Telehealth has also reduced the burden on hospital emergency rooms by enabling providers to screen patients safely to determine whether they need such extensive care, before they come to the ER. Telehealth is particularly advantageous for elderly individuals, who are more susceptible to COVID-19. Virtual visits have also allowed private physician practices to stay open during state shutdowns.

“We are glad CMS heard our concerns about physician practices,” said Robert McLean, M.D., American College of Physicians president, in a news release. “The changes by CMS will help practices by providing them with revenue to keep their practices open as they move away from in-person to virtual ones.”

Removal of Billing Obstacles
Providers are required to use an interactive audio and video telecommunications system so real-time communication can occur between the provider and patient at home.

Although the billing change provided some clarity to health care providers, it overlooked the fact that patients may not have video capability at home. That meant providers would be unable to bill CMS for helping those patients through remote audio consultation. Recognizing this obstacle, CMS on May 1 changed the rules to allow billing for telephone and other audio-only telehealth visits.

The May 1 reforms also expanded the categories of providers allowed to provide telehealth services to patients. Before this reform, only doctors, nurse practitioners, physician assistants, and certain other individuals could provide telehealth services. Now, physical therapists, occupational therapists, and speech language pathologists also can bill for telehealth visits.

AMA Supported Change
The change was so well-received that after years of remaining neutral on telehealth, the American Medical Association (AMA) endorsed the idea, announced initially by CMS on March 11.

In the run-up to those changes, the AMA on April 10 sent letters to the National Governors Association, the National Association of Insurance Commissioners, and the National Council of Insurance Commissioners to support policies encouraging telehealth and other innovations that improve patients’ access to doctors.

“The AMA strongly encourages all states to adopt telehealth policies that reflect those now being required under Medicare,” states one of the letters.

‘Ahead of the Game’
The suspension of regulations in a variety of areas during the coronavirus pandemic has been good public policy, says John Goodman, Ph.D., president and chief executive officer of the Goodman Institute for Public Policy Research and co-publisher of Health Care News.

“Governmental bodies are repealing laws, suspending regulations, and ignoring previous restrictions that impeded the ability of the private sector to act,” Goodman said. “They are liberating doctors, nurses, drug manufacturers, test makers, makers of personal protective equipment, etc. to do things that were illegal only a few months ago. Fortunately, the Trump administration was ahead of the game, making many needed changes before the COVID-19 virus hit. Once in crisis mode, Congress and state governments also responded, apparently in sheer desperation.”

‘Should Do More’
The changes are welcome, and Congress and the states should implement further reforms, says Marie Fishpaw, director of domestic policy studies at The Heritage Foundation.

“President Trump reiterated his commitment to clearing away barriers inhibiting the use of telehealth,” Fishpaw said. “Lawmakers have already moved to clear some away, but they can and should do more.”

There are still some important government-made barriers to telehealth, Fishpaw says.

“Among them are wide variations in the description of telemedicine among the states, with different definitions, regulations, and reimbursement arrangements,” Fishpaw said. “Only nine states have issued licenses related to telehealth that allow an out-of-state licensed medical professional to render services using telehealth.”

Great strides have been made in the increased use and acceptance of telehealth, and this should continue after the national emergency caused by COVID-19 ends, Fishpaw says.

“Absolutely, policymakers should build on the regulatory relief that the administration, Congress, and some states have done,” Fishpaw said. “This will help patients to access this care going forward and create an environment where innovators can develop new telehealth tools that we can’t even begin to imagine today. In addition, we not only need to make access to telemedicine permanent, but lawmakers should remove additional barriers that prevent patients from receiving timely and affordable care.”

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

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INTERNET INFO

With Regulators at Bay, Virtual Doctor Visits Soar

By Jesse Hathaway and AnneMarie Schieber

As shutdowns have forced physician practices to close their doors, doctors are increasingly turning to virtual visits and the private market is responding with new technologies and service platforms.

Moving to virtual visits, or telehealth, has become easier since the Centers for Medicare & Medicaid Services removed federal payment barriers to virtual and telephone visits in an effort to support those practices and protect patients and health care workers from infection (see article on page 1).

Benefitting Public Health

Telemedicine provides public health benefits, says Darcy Bryan, M.D., an obstetrician and gynecologist at Women’s Care Florida in Tampa, Florida and a senior affiliated scholar with the Mercatus Center at George Mason University.

“In the face of a highly contagious disease, limiting the potential for the disease to spread by keeping the infected but mildly ill at home has obvious benefits,” Bryan said. “Telemedicine gives the patient access to a provider while limiting the spread of the virus by keeping the patient in the confines of their own home.”

Telemedicine is not just live video conferencing but also a conduit for transmitting medical images and data. It can be diagnostic as well as prescriptive, says Samant Virk, M.D., chief executive officer and founder of MediSprout, a telehealth platform for physicians and their established patients.

“It’s mostly diagnosis, but there can be treatment, too,” Virk said. “When you get connected to a doctor who knows you, they generally will know what your health condition is, whether it’s blood pressure, or a rash, or diabetes. If you connect with them remotely over the video and say, ‘Hey, this is happening; this is what I’m feeling; here’s what my blood sugar has been,’ the doctor can recommend treatment options for you, as well.”

Exploring New Avenues

Telemedicine can perform many services in addition to conversations between patients and their doctors, Virk says. “Telehealth and telemedicine are words for remote health care,” Virk said. “When you say the word ‘telehealth’ and ask people what it is, you get ten different answers. It can be everything from virtual devices to a video call with a doctor.”

Virk says telemedicine can and should take new forms.

“It could be, like when you go to an Apple store and they have that whole section of healthy-living devices, those devices are considered telehealth devices as well,” Virk said. “Patients go home, they use them, their information gets pulled into a cloud account, and that information can be utilized for a variety of purposes.”

Making Reforms Permanent

Bryan says one of the biggest obstacles to telehealth until this point has been lawmakers’ and insurance companies’ use of outdated models and incorrect assumptions.

“The main barrier [had been] coming up with a good payment model,” Bryan said. “Primary care is already struggling with thin margins of profitability. Will insurance companies take the work performed by the provider remotely via telemedicine and heavily discount reimbursement? Probably, with the argument that a physical exam wasn’t performed so somehow the job was ‘easier.”

However, as a working clinician, I can testify that the cognitive and administrative workload is not less just because it is performed by video-conferencing.

“Payment models such as direct primary care should make integrating this technology possible and profitable,” Bryan said.

Bryan says there are other barriers governments could remove to bring down costs and improve access, such as rules requiring a third party be in the room during a video conference, restricting prescribing abilities of telemedicine providers, and requiring that the patient and doctor meet in person before a telemedicine visit.

Comparing to Online Banking

Virk compares the future of telemedicine to past consumer-friendly innovations by banks.

“The analogy I love to give is online banking,” Virk said. “Everyone used to go to the bank to do everything: cash checks, look at the bank statement, whatever. What the banks did was figure out which services people came in for that they don’t need to come in for, and they virtualized those so the services became more valuable and they could spend more time with their clients.”

Like online banking, telemedicine is consumer-friendly, Bryan says.

“It is flexible, mobile, and responsive to patient needs,” Bryan said. “A lot of health care is cognitive and procedural. You can come to some solid decisions without requiring an in-person physical exam, by taking a good history and knowing the right questions to ask to differentiate between a life-threatening problem versus a garden-variety problem and asking the patient to take their own temperature or blood pressure or count their pulse, if needed.”

Getting the Vitals

An innovation receiving renewed attention as telehealth expands is MedWand, a palm-sized recording device created in 2014 to help patients give physicians their vital statistics from home.

MedWand, which costs $399, can listen to the heart, measure heart rate and conduct an EKG, listen to the lungs and measure respiratory rate, measure blood oxygen levels, take the patient’s temperature, listen to the abdomen, look inside the nose, throat, mouth, and ears, and inspect skin for abnormalities, the company says.

In an April 8 interview, MedWand founder and CEO M. Samir Qamar, M.D., told Startup TV the coronavirus has made telemedicine much more important.

“We were forecasting that telemedicine for consumers may be adopted on a wider scale three to five years from now. Well, it’s been adopted. Everyone wants telemedicine; nobody wants to be exposed to this dreadful virus. And so, we have moved up our timeframe to consumers.”

M. SAMIR QAMAR
FOUNDER AND CEO, MEDWAND

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FOUNDER AND CEO, MEDWAND
Personal, Portable Health Insurance Hits Workplace Just in Time

Continued from Page 1

shut down in response to the pandemic crisis.

In some cases, laid-off employees with an “excepted benefit HRA” would be able to tap into these accounts to continue their health insurance while out of the workforce. Without an HRA, the employee would probably have to go without, enroll in Medicaid, or opt to continue employer health insurance under COBRA at a cost of hundreds of dollars each month (see article, page 8).

An HRA can provide an employee with funds to purchase a short-term, limited duration health insurance plan. Those plans are generally much cheaper than COBRA or what can be purchased on the individual insurance exchanges, because they don’t have to include expensive Obamacare-mandated items.

‘Potential to Revolutionize’

On January 29, Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma addressed participants at a CMS Health Care Innovation event in which she stated a common thread of health care challenges is cost and affordability.

“HRAs hold the potential to revolutionize the health insurance market,” Verma told the group. HRAs could double the size of the individual market and create stability for years to come, Verma said.

By 2029, 8,000 employers will cover 11 million employees with HRAs, according to the Trump administration, increasing by 800,000 the number of Americans insured. HRAs were created in 2002, but the Obama administration discouraged their use by imposing a $100 per day fine for each employee, according to the Goodman Institute for Public Policy Research, which co-publishes Health Care News.

“With Obamacare came regulations and threats of steep employer fines that effectively deep-sixed this option,” wrote Goodman Institute President John Goodman and Marie Fishpaw, director of domestic-policy studies at The Heritage Foundation, in their August 15, 2019 paper, “A Health Plan for President Trump.”

Catching On

According to a discussion at an industry panel at the CMS event, a recent survey showed 70 percent of small businesses didn’t know what an HRA was. Just 29 days after the new HRA rules went into effect, some 200 employers had begun using them.

“We always said that small businesses would find the most value in offering the individual coverage health reimbursement arrangement (ICHRA),” said William Sweetnam, legislative and technical director for the Employers Council on Flexible Compensation. “By offering an ICHRA, they would be providing a benefit that would help them attract and retain a better workforce.”

Before the pandemic shutdowns caused a rapid spike in unemployment, HRAs were a recruitment tool for employers hiring temporary, part-time, or seasonal workers, Sweetnam says. “ICHRA will remain a valuable option for employers in attracting and retaining employees.”

The interest in HRAs is here to stay, Sweetnam says.

“The pandemic has shown the value of having health care coverage and the perils of having employer-provided coverage, if you lose your job,” Sweetnam said. “The pandemic will cause people to see the value of health insurance, and the ICHRA is another method of getting coverage.”

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

Prescription for Better Healthcare Choices

A Better Choice

Healthcare Solutions for America
John C. Goodman

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

—Bill Cassidy, M.D., U.S. Senator

Priceless

Curing the Healthcare Crisis
John C. Goodman

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

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

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

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Doctors, Nurses Cross State Lines to Care for Pandemic Patients

By Bonner Cohen

The nationwide effort to deal with the coronavirus has brought new attention to the idea of removing government barriers to the employment of medical expertise across state lines.

Reforming state occupational licensing requirements to allow newly arrived licensed workers to ply their trade in their new state streamlines the workforce and increases access to health care by allowing providers to reach consumers more quickly. The overall share of workers required to obtain an occupational license to do their job has soared from about one in 20 to about one in four over the past 60 years, according to a 2017 report by the Institute for Justice.

Workers, including those in the medical profession, frequently find they must apply for a new license upon relocating to a different state. The resulting red tape and expense carry an especially heavy price when health-care professionals are needed to combat a deadly pandemic.

“Licensing recognition makes it easier for people to provide their services across state lines,” said Michael Slabinski, director of the commerce, insurance, and economic development task force at the American Legislative Exchange (ALEC). “It is especially important during COVID-19, as health care workers are needed more in some states than others.”

Model Legislation Available

Model legislation developed by ALEC provides a blueprint states can follow to lift restrictions on cross-border licensing. ALEC’s Model Interstate Mobility and Universal-Recognition Occupational-Licensing Act (the Freedom to Travel and Work Act; see sidebar) is designed to apply to a wide range of professions and could cover physicians and nurses who relocate to a new state.

“States should allow access to trained professionals even if their licenses did not originate within the state,” Slabinski said. “Just because someone crosses state lines does not negate their training and experience. Universal recognition lets workers apply their certification, work experience, and occupational license in good standing towards applying for a license in a new state.”

Calls for Regulatory Review

States should make sure their licensing rules are truly needed, Slabinski says. “As the number of licensed professionals increases, states should consider a system of licensing review that requires legislatures to periodically review occupational licensing requirements to determine if other forms of regulation, like registration or inspections, are less burdensome and more effective at protecting health and safety.”

Medical professionals and the public at large could benefit from occupational licensing reform, says Rea Hederman, vice president for policy at the Buckeye Institute.

“ALEC’s [model] is meant to apply to a wide range of professions but could also cover physicians and nurses who relocate to a new state,” Hederman said.

Springboard to Telemedicine

Streamlining occupational licensing laws would have a direct effect on the growing field of telemedicine. The COVID-19 crisis created a need to reduce human contact, and for many people this has meant foregoing a trip to the doctor or to a hospital, especially when dealing with illnesses unrelated to COVID-19. Telemedicine can alleviate that problem.

“Technology and the internet have made treating patients remotely a possibility no matter where the provider is located,” said Brooklyn Roberts, director of ALEC’s health and human services task force. “The current pandemic reminds us how important it is to have access to great care in many different forms. Telemedicine can be especially helpful in treating mental health or substance abuse issues, and the importance of allowing access to trained providers regardless of their location should not be overlooked.”

Telemedicine, which already has 20 million users, can help fill that gap, but telehealth providers still face barriers to cross-border licensing. Some states make it difficult for telemedicine by requiring providers to connect patients to licensed physicians within their states, making it more expensive and reducing choice and access. In addition, many people in rural areas still have internet access problems that hinder their ability to use telemedicine.

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

Proposed Legislation Would Expand Health Care Access, Jobs

Editor’s note: The Freedom to Travel and Work Act model legislation from the American Legislative Exchange Council offers a state-level reform that can broaden work opportunities and consumer access to services by ensuring licenses are recognized across state lines. Under the model legislation, the appropriate state board or other state license-issuing entity would be required to issue an occupational license or government certificate to a person upon application, if the following stated conditions apply.

1. The person holds a current and valid occupational license or government certificate in another state in a lawful occupation with a similar scope of practice, as determined by the board in this state;

2. The person has held the occupational license or government certification in the other state for at least one year;

3. The board in the other state required the person to pass an examination, or to meet educational, training or experience standards;

4. The board in the other state holds the person in good standing;

5. The person does not have a disqualifying criminal record as determined by the board in this state under state law;

6. No board in another state revoked the person’s occupational license or government certification because of negligence or intentional misconduct related to the person’s work in the occupation;

7. The person did not surrender the occupational license of government certification because of negligence or personal misconduct related to the person’s work in another state;

8. The person does not have a complaint, allegation, or investigation pending before a board in another state which relates to unprofessional conduct or an alleged crime. If the person has a complaint, allegation, or investigation pending, the board in this state shall not issue or deny an occupational license or government certification to the person until the complaint, allegation, or investigation is resolved or the person otherwise meets the criteria for an occupational license or government certification in this state to the satisfaction of the board in this state; and

9. The person pays all applicable fees in this state.

President Trump Uses Off-Label Drug to Protect Against Virus

President Donald Trump said he is using hydroxychloroquine and zinc to protect himself against the coronavirus.

The president said he had been taking the drug for one week under the advice of White House physician Sean Conley, M.D., speaking to a group of restaurant executives on May 18.

“I’m still here,” Trump told the group.

“We concluded the potential benefit from treatment outweighed the relative risk,” Conley stated in a memo he released to reporters.

A survey by staffing firm Jackson & Coker published on April 8 showed physicians widely support the use of hydroxychloroquine to treat or prevent COVID-19. Of 1,271 physicians surveyed across the United States, 65 percent said they would prescribe it to a family member.

Patient Choice, Control

The science is not settled on the efficacy of hydroxychloroquine as a prophylaxis for COVID-19, but it shows promise, says Chad Savage, M.D., an internist and policy advisor to The Heartland Institute, which co-publishes Health Care News.

“Many countries are using it prophylactically with anecdotal good results,” Savage said. “The president’s decision to use this medication off-label for this purpose is a time-honored right and decision reserved for a patient and their physician.”

The announcement speaks to a larger issue, Savage says.

“In recent years, we have seen the health care system move away from personal health care liberty and toward a totalitarian, top-down model,” Savage said. “I feel this is counter to American ideals and has slowly robbed Americans of their ultimate liberty: control over their own bodies.”

—Staff reports

Off-Label Drugs Are Saving Lives in COVID-19 Fight

By Bonner Cohen

The U.S. Food and Drug Administration (FDA) on May 1 granted emergency use authorization for Remdesivir, an anti-viral drug developed by Gilead Science already being used to treat Ebola.

With hospitals expressing concerns they won’t receive enough Remdesivir to handle their caseload, Gilead has pledged to donate 1.5 million doses, enough to treat 190,000 cases, by the end of May, The Wall Street Journal reported on May 8. Gilead expects to produce enough doses to treat one million patients by the end of the year, the Journal reports.

New Look at Old Drugs

While awaiting results from long-term efforts to come up with an effective vaccine, health care professionals have been combating the deadly novel coronavirus by using existing drugs developed for other purposes, known as off-label use.

Any new vaccine must clear the FDA’s rigorous testing protocols, a process that can take years and cost millions of dollars. This is why some existing pharmaceuticals, while not providing immunity to COVID-19, are gaining consideration as ways to shorten the illness of patients stricken by the pandemic.

The off-label drugs with antiviral properties that have received the most attention—from supporters and critics alike—are chloroquine (CQ) and, particularly, hydroxychloroquine (HCQ). Commonly used in Africa and on the Indian subcontinent to treat people with malaria, HCQ also serves as a prophylaxis in India to protect medical workers, first responders, household contacts, and others at risk of exposure.

The Association of American Physicians and Surgeons (AAPS) notes the COVID-19 mortality rate in India is only two per million, compared with more than 200 per million in the United States. HCQ has also been used in treating autoimmune disorders such as lupus and rheumatoid arthritis.

“Governors Say No

Some Governors in several states, including Michigan, New York and Nevada, have issued executive orders restricting how doctors can prescribe CQ and HCQ to treat COVID-19.

The AAPS sent a letter to Arizona Gov. Doug Ducey on April 27 expressing concerns about his order forbidding prophylactic use of CQ and HCQ until peer-reviewed evidence becomes available.

“To date, the total number of patients treated with HCQ with or without zinc and the widely used antibiotic azithromycin is 2,333 in observational data from China, France, South Korea, Algeria, and the U.S.,” AAPS wrote. “Of those, 2,137 or 91.6 percent improved clinically. There were 63 deaths, all but 11 in a single retrospective report from the Veterans Administration where the patients were severely ill.”

AAPS further points out pharmaceutical companies have donated tens of millions of doses of HCQ to federal and state health agencies. At least 14.4 million doses of HCQ have been distributed to 14 city governments, according to the Federal Emergency Management Agency (FEMA). Yet New York (the state hit hardest by COVID-19 by far), Arizona, and Nevada are stockpiling HCQ, arguing more clinical trials to determine its efficacy are necessary.

Common Practice

Claims that off-label drugs are “unproven” miss the point, says John Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of Health Care News.

“[FDA]-approved drugs work for you only about half the time and in some cases only 20 percent of the time,” Goodman said. “Almost all drugs have side effects, and these side effects, by law, are stated when the patient purchases a drug.”

Goodman says as many as one in five drugs sold in the United States are used off-label, and for cancer drugs the figure is one in two.

Addressing concerns that HCQ can have side effects in people with cardiac problems, Dr. Michael Robb, M.D., physician at the Phoenix-based Robb Oto Neurology Center, says doctors can screen out such patients while administering the drug safely to other COVID-19 patients. Robb says there are 148 studies on HCQ posted on clinicaltrials.gov.

Jane Orient, M.D., president of the AAPS, says HCQ “was approved for use against malaria decades ago, and its use today is perfectly legal.” By issuing an advisory against using the drug except in hospital settings, Orient says the FDA “is trying to squelch its use.”

Use of the drug “could drastically reduce the carnage,” Orient said. “Why is the government restricting the use of medicine?” (See related story, page 13.)

Bonner R. Cohen, Ph.D. (bcohen@nationalcenter.org) is a senior fellow at the National Center for Public Policy Research and a senior policy analyst with the Committee for a Constructive Tomorrow (CFACT).
FDA Allows Production of COVID-19 Test

By Jesse Hathaway

A s the number of individuals diagnosed with COVID-19 in the United States surpassed 1.3 million in May, demand for accurate and fast diagnostic test kits played a vital role in determining the scope of the public health crisis.

A first-of-its-kind test developed by Rutgers University researchers in April was approved weeks later by the U.S. Food & Drug Administration (FDA) on May 6, for home use. Developed by RUCDR Infinite Biologics, the test uses saliva collection instead of a nasal swab and can more easily be performed by the patient while in self-quarantine. Test samples can be mailed to a laboratory for analysis, and because samples are not collected at physical collection sites, it reduces the number of health care workers who could be exposed to the virus.

Section 564 of the Federal Food, Drug, and Cosmetic Act permits the FDA commissioner to allow otherwise unapproved medical products to be used in an emergency to diagnose, treat, or prevent serious or life-threatening diseases or conditions when no adequate, approved, and available alternatives exist.

The FDA published regulatory guidance for Emergency Use Authorizations (EUAs) in the March 6, 2020 edition of the Federal Register, to speed up testing capacity in response to the COVID-19 public health emergency.

Process ‘Ought to Be Revised’
The approval process for diagnostic tests is even more Byzantine than the one for drugs, involving multiple regulatory agencies, says Edmund Haislmaier, a senior research fellow with The Heritage Foundation’s Center for Health Policy Studies.

“The Centers for Disease Control and Prevention (CDC) is responsible for standards and methods, the FDA is for the actual approval of the tests and components themselves, and the Centers for Medicare and Medicaid Services is for the oversight of the sufficiency and quality of the labs,” Haislmaier said.

“Right off the bat, this is a more fused arrangement [and something] that ought to be revised in light of what’s happened,” Haislmaier said. “[Approval involves] three different agencies within the U.S. Department of Health and Human Services, and that alone is what makes it different from drugs and devices.”

Process Had Been Tightened
Soon after the first U.S. case of COVID-19 was identified on January 19, problems with the diagnostic testing approval process became apparent. Regulatory hurdles cost precious time, says Roger Klein, M.D., J.D., a former advisor to health care regulatory agencies and a policy advisor to The Heritage Institute, which co-publishes Health Care News.

“In contrast to the H1N1 epidemic (2009), when hospital laboratories quickly set up testing without interference, for coronavirus, FDA prevented them from doing so, instead placing the CDC in charge of all testing,” Klein said. “This strategy cost us weeks of testing that may have alerted us to the extent of community spread.”

When the outbreak began, the University of Washington, located near the first identified case, had the ability to perform 4,000 tests a day, dwarfing the capacity of public health labs, but federal regulations prevented their use, Klein says.

“The FDA stopped them from doing so,” Klein said. “It is a sad example of how overregulation may have contributed to the worsening of the outbreak and deaths from the disease.”

The FDA eventually recognized the problem and changed course, Haislmaier says.

“Clearly, there was a big breakdown at the CDC,” Haislmaier said. “The FDA has [now] issued over forty EUAs, for everything from a handful of academic medical centers with sophisticated labs doing specialized tests, like Yale New Haven or Children’s in Philadelphia, all the way to huge companies working on developing and mass-producing tests that can be used at the point of care.”

Not Just for Emergencies?
Regulatory agencies should look at this experience and consider using the expedited approval process in emergency situations on the individual level and not just for nationwide crises, says Christina Herrin, manager of The Heritage Institute’s Free to Choose Medicine project.

“The EUA process is important as it gives authority for the FDA to expedite approval or allow access to unapproved treatments in times of emergency,” Herrin said. “I push this idea further: those suffering with debilitating diseases, day in and day out, need emergency help under normal circumstances as well. If you were diagnosed with amyotrophic lateral sclerosis, cancer, or Alzheimer’s, your number-one priority would be getting a safe and effective treatment as soon as possible.”

Who Decides?
Herrin says the cost and complexity of health care regulations have given power to bureaucrats who have no accountability to the people they supposedly serve.

“I don’t want to point only to regulatory capture,” Herrin said. “The current process has allowed the federal government to grow so large that unelected officials are making regulations that are equivalent to laws.”

At-Home COVID-19 Test Gets Green Light

The U.S. Food and Drug Administration (FDA) granted approval for the first rapid test for the coronavirus that causes COVID-19.

The new test is cheaper than the more conventional diagnostic test and can be offered on a larger scale. The agency gave the approval under its emergency use authority on May 9.

The new test, the Sofia 2 SARS Antigen FIA, developed by the Quidel Corporation, requires the use of nasal cavity swabs like the conventional test, but it can deliver results in minutes. The conventional test, known as a polymerase chain reaction diagnostic test, can be “incredibly inaccurate,” according to the FDA, but can take days to process.

Diagnostic tests look for active virus and are different from serological, or antibody tests, which identify the immune system’s response to the virus. Antibody tests are in development, but none have been authorized for use outside certified labs.

—Staff reports

“I don’t want to point only to regulatory capture. The current process has allowed the federal government to grow so large that unelected officials are making regulations that are equivalent to laws.”

CHRISTINA HERRIN
MANAGER
FREE TO CHOOSE MEDICINE PROJECT
THE HERITAGE INSTITUTE

The bureaucracy slows down medical responses, to the detriment of patients, Herrin says.

“Currently, it takes on average twelve years and $2.9 billion to bring a drug from lab to market,” Herrin said. “There is a better solution: Free to Choose Medicine. After a drug passes safety testing, the free market should have more input and access.”

Patients should be more in the driver’s seat because they are closest to the problem, Herrin says.

“The government doesn’t know what is best for me. I know what is best for me,” Herrin said.

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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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Massive Losses of Employer Health Insurance Highlight Need for New Options

By AnneMarie Schieber

With millions of people having lost their jobs and their employer-provided health insurance during the pandemic shutdowns, Congress is considering a plan to pay employer health insurance companies directly so furloughed workers can keep their health coverage.

Insurance companies, labor unions, and big businesses are lobbying heavily for the proposed subsidy to pay for health insurance under the Continuation of Health Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, employers with 20 or more workers must offer a continuation of health care benefits for a limited time.

Many departing employees decline COBRA because they must pay the entire premium out of their own pockets, which can cost as much as $600 a month for individual coverage.

Congress approved COBRA subsidies during the 2008 recession under the American Recovery and Reinvestment Act. A new bill proposed by House Democrats, the Worker Health Coverage Protection Act, would expand the COBRA subsidy to cover 100 percent of premiums for laid-off workers and those who are furloughed.

Recommends HSAs Instead

Instead of paying insurance companies directly, Congress would be wiser to use the situation as an opportunity to make the health insurance market more responsive to consumers, says Brian Blase, a senior fellow at The Galen Institute and president of Blase Policy Strategies.

“If [Congress] wants to provide health care to people, they should just put money in a health savings account and allow people to choose the coverage and care that works best for them,” Blase said.

Consumer Options Abound

Consumers already have a variety of health care options outside of employer insurance, Blase says. Individual health insurance plans are available on the Obamacare health insurance exchanges, and several states have reopened the enrollment period for the plans in response to rising unemployment caused by the shutdowns.

The unemployed can also enroll in Medicaid. The $600 employment subsidy is not considered income for Medicaid eligibility, and many would qualify for the program, Blase says.

A third option is short-term, limited duration insurance policies. In 2018, the Trump administration expanded the legally allowed length of the plans to one year, with the option of staying on a plan for three years if the individual gets sick.

“They are perfect for this situation because they are designed for short-term gaps in coverage and they’re very affordable, some for as low as $30 a week,” Blase said.

HSA, DPC Reforms in Play

Interest in maintaining employer health care coverage has put renewed focus on expanding health savings accounts (HSAs) and direct primary care (DPC) arrangements.

Sen. Ted Cruz (R-TX) has proposed waiving high-deductible health plan requirements for HSAs during the coronavirus emergency period. In addition, the Primary Care Enhancement Act, introduced in 2019, awaits action in Congress. The legislation would define DPC arrangements as qualified medical expenses for use of HSA dollars.

DPC is a membership plan in which consumers pay a flat fee for round-the-clock access to health care. DPC models can keep prices below $100 a month because they do not accept third-party payers and thus can limit the significant administrative expense of coding and handling claims.

Late action on the CARES Act included primary care enhancement language that was pulled out at the last minute, says Philip Eskew, D.O., J.D., founder of DPC Frontier and a policy advisor to The Heartland Institute.

“It was there briefly, and it was gone,” Eskew told a group of physicians on a webinar hosted by the Association of American Physicians and Surgeons.

AnneMarie Schieber (amschieber@heartland.org) is managing editor of Health Care News.
Congress May Award Wuhan Whistleblower

Congress is considering a bill that would posthumously award a Congressional Gold Medal to Dr. Li Wenliang for his lifesaving efforts to draw attention to COVID-19 and advocate for government transparency in China.

H.R. 6471, introduced by Rep. Chip Roy (R-TX), would recognize Wenliang’s contributions in reducing the spread of COVID-19 in the early stages of the pandemic.

Wenliang was the Wuhan doctor who first sounded the alarm about the virus and continued to spread the word about the potential impact of the disease, despite censorship by the Chinese government. For his efforts to share information about COVID-19, Wenliang was detained by the communist Chinese government, interrogated, and forced to sign a document “confessing” he had spread illegal rumors.

Although he knew the risks associated with COVID-19, Wenliang continued to treat patients. Tragically, while working on the front lines to help save lives, Wenliang contracted the virus and succumbed to it shortly thereafter.

Criticized Government Cover-Up

In a statement made to *The New York Times* shortly before his death, Wenliang said honesty by the Chinese Communist government could have saved many more lives.

“If the officials had disclosed information about the epidemic earlier, I think it would have been a lot better,” Wenliang stated. “There should be more openness and transparency.”

In addition to recognizing the doctor’s bravery and hard work, awarding Wenliang with the Congressional Gold Medal would shine a light on the censorship in communist China that amplified the COVID-19 crisis, Roy said in an April 9 press release.

“I am proud to author legislation to honor Dr. Wenliang—a truly courageous doctor who saved countless lives by telling the world about the dangers of coronavirus,” Roy stated. “Awarding Congress’s highest civilian award to Dr. Li would not only honor his brave action to warn others about the spread of COVID-19 but also call global attention to China’s lack of transparency and censorship of speech.”

—Staff reports

Consumer Group: Minnesota Governor Misleads with COVID Graph

A graph Gov. Tim Walz of Minnesota used at a press conference showed a far more dramatic spike of COVID-19 cases than what actually happened, a review by the Citizens Council for Health Freedom (CCHF) reveals.

The graph, created by the Minnesota Department of Health (MDH), used extremely uneven increments on the vertical Y axis representing the number of cases, which suggested Minnesota was on a path similar to the number of COVID-19 cases confirmed in 16 other states. Specifically, the space between 1 and 2 on the graph is the same as the space between 200 and 500.

The uneven increments might not be immediately obvious to the average viewer, potentially misleading the public into believing the virus was spreading much more rapidly than it was, says Twila Brase, president and cofounder of CCHF.

“These are already uncertain times for Minnesota families, business owners, and health professionals,” Brase said. “Data that is poorly presented creates false narratives about the facts on the ground, potentially leading to coercive actions and expanded government intrusions. When properly informed, the American public can be trusted to make the right decisions for themselves, their families, and their communities.”

Brase says the data represented in the graph is accurate. CCHF created another graph with the same data but with an evenly spaced Y axis. It shows a much flatter curve (see accompanying graphs).

“Now, more than ever, in a time when Minnesotans are looking to their leaders for guidance and security, state officials need to make a concerted effort to provide transparent, accurate information,” Brase said. “Minnesotans deserve reliable facts and clear presentations, not diagrams that could potentially scare the public into believing things are worse than they are, as this will harm the public’s trust.”

—Staff reports

Covid-19 State Comparison Through April 4 (Consistent 0-600 Y-Axis Scale)

Epidemiologic Data

Cases per 100k People After First 100 Confirmed Cases, MN and Select States (Based on MDH Report Date, Cumulative)

Source: Data collected from National Safety Council (NSC);
[NSC analysis of Johns Hopkins Center for System Science and Engineering COVID-19 data and US Census population data;](https://systems.jhu.edu/research/public-health/covid/)
[Note: Access date 4/14/2020, includes reported data through 4/4/2020.]
States have likely been nursing home half the COVID-19 cases in the United States since the healthcare system has paid hospitals by the diagnosis for COVID-19 without confirmation, because hospitals get paid more for as COVID-19 than for other medical conditions that have been untreated.

Perhaps to some extent, but we don’t know the final cost yet. If the country reopens for business, there will be more cases of COVID-19 reported, and more deaths. And the more tests we do, the more cases we will find. If the country remains locked down, [likewise] there will be more cases of COVID-19 reported and more deaths. There will also be increasing economic devastation, which itself causes deaths, and many more deaths from other medical conditions that have been untreated.

What if the number of cases starts to increase again?

If an epidemic starts in one or a few locations and is promptly identified, it can be contained. But COVID-19 was probably circulating worldwide for at least a month before it was recognized. That’s how as many as half the people in certain places got antibodies.

The idea of “flattening the curve” was to prevent hospitals from being overwhelmed. It was a delaying tactic, with no prospect of ending the disease. In a few places, especially in New York City, hospitals are struggling. In most places, they are nearly empty and going bankrupt for lack of patients. The “expert” models that predicted two million deaths in the United States were wildly wrong.

It is hard to say what is going on now. Many deaths are coded as COVID-19 without confirmation, because hospitals get paid more for that diagnosis. (See sidebar.) Medicare has paid hospitals by the diagnosis for decades.

Half the COVID-19 cases in the United States have likely been nursing home residents. Did some die of “failure to thrive” because of neglect? We don’t know, because no visitors have been allowed in.

To what extent should we count on the development of a vaccine?

Should we let economies collapse until we have a vaccine? Does that mean until or unless everybody is vaccinated with a safe and effective vaccine? There is no vaccine for most viruses. The influenza vaccine may be only 30 percent effective, and many serious side effects are reported to the Vaccine Adverse Event Reporting System (VAERS).

Stay home if you are sick. Wear a mask in public is a “precaution” backed by little evidence. It probably does not protect you but may help protect others. [The mask] has germs all over it, outside and inside, so do not touch it. If it is cloth, wash it with soap and water. Don’t wear it while driving. At least one crash may have resulted due to a driver wearing one.

Take your vitamins. Some doctors recommend 5,000 IU (international units)/day of vitamin D3, or even more if exposed to a respiratory virus. In an Indonesian study, 96 percent of patients who died of COVID-19 were vitamin D deficient, and only 7 percent of survivors had low or deficient vitamin D. Vitamin C, selenium, zinc, and other nutrients help build resistance.

Ask your doctor about early treatment with hydroxychloroquine, azithromycin, and zinc. It’s a new indication for long-established drugs being used with great success in Brazil, India, France, Israel, Morocco, Algeria, and many other nations, and in some places in the United States. Use is discouraged by the U.S. Food and Drug Administration and the American Medical Association, who state there is not enough evidence.

Pay Bump for Covid-19 Diagnoses Casts New Doubt on Corona Numbers

Deep within the Coronavirus Aid, Relief, and Economic Security Act, or CARES Act, Congress approved a 20 percent add-on payment for in-patient Medicare beneficiaries diagnosed with COVID-19.

The COVID-19 ICD-10 code must be present on claims to receive the higher payment.

Physician and Minnesota state senator Scott Jensen, M.D. (R-Chaska) on April 9 told Fox News physicians and hospitals might be influenced to classify more diagnoses and deaths as COVID-19 because of the higher payment.

“Right now, Medicare has determined that if you have a COVID-19 admission to the hospital, you’ll get paid $13,000,” Jensen said. “If that COVID-19 patient goes on a ventilator, you get $39,000—three times as much. Nobody can tell me, after 35 years in the world of medicine, that sometimes those kinds of things [don’t have an] impact on what you do.”

Guidance by the Centers for Disease Control states “if the circumstances are compelling within a reasonable degree of certainty the patient had COVID-19, it can be listed as cause on the death certificate, even in the absence of a positive test.”

—Staff reports
Study Offers Lawmakers Guidance in Getting People Back to Work

By Bonner Cohen

A growing understanding of the unique features of COVID-19 is making it possible for policymakers to develop strategies that safeguard public health while allowing people to get back to work, concludes a study-in-progress by a group of prominent physicians and researchers.

The study, “A New Strategy for Bringing People Back to Work During Covid-19,” initially published on April 14 by the Foundation for Research on Equal Opportunity (FREOPP), is regularly updated to account for new data and posted at freopp.org. Its five authors and contributors are experts in medicine and public policy.

First and foremost, the authors point out, is COVID-19’s “heavy skew toward bad outcomes in the elderly and near-elderly who also have other chronic diseases. With the proper precautions and tools like contact tracing, self-quarantines, and telemedicine, we can continue to protect the most vulnerable, while returning as many Americans as possible to work.”

Tailoring Orders

Much of the pushback against reopening has been the idea another surge in COVID-19 cases could occur and a second shutdown would be more economically devastating than the first. Targeting protection for the vulnerable would solve that problem, says Avik Roy, cofounder and president of FREOPP and one of the study’s authors.

“States should be thinking about a tailored approach to stay-at-home orders rather than a shutdown for everyone,” Roy told Health Care News. “The purpose of the lockdown was not to prevent every American from contracting the virus, but instead to prevent our health care system from becoming overwhelmed.”

That has been accomplished, Roy says.

“It’s now time to reopen businesses, schools, and workplaces,” Roy said. “Individuals who are most at risk based on their age or underlying health conditions, as well as any family members who live with them, should continue to take extra precautions to avoid getting sick. The economy should reopen for everyone else.”

‘Exacerbated the Outbreak’

Forty percent of COVID-19 deaths occurred in nursing homes and assisted living facilities, according to FREOPP, which suggests the broad-based shutdowns may have come at the expense of vulnerable populations.

“Rather than using blanket shutdowns, much more attention should be paid to the risk of infection in nursing homes, especially through nursing home staff who work at multiple facilities,” Roy said. “Employees should be limited to working at one facility to avoid spread.

“A big problem is that some states have forced nursing homes to accept patients who had been discharged from hospitals after being infected, which has exacerbated the outbreak by bringing the infection back to the most at-risk population,” Roy said. “States should instead contract with empty hotels to house COVID-19 patients until they are no longer contagious.”

Huge Economic, Health Effects

The study notes the mass shutdowns have had major economic and public health consequences.

An analysis by Moody’s Analytics found the stay-at-home orders have reduced U.S. economic output by 29 percent in just a few weeks. The study quotes research by the University of Illinois, Harvard University, and the University of Chicago estimating 100,000 small businesses have already closed permanently, with more closures to come.

On the public health side, much care has been ignored or neglected. The study notes organ donations and transplantsations have declined precipitously during the outbreak, harming those with serious health problems such as end-stage liver disease.

“The public health impact of a shutdown, including fewer vaccinations, diagnostic screenings, and doctors’ visits for treatment of other diseases, is yet another reason why we can’t afford to stay shut down,” Roy said.

Putting Off Cancer Screenings

The study’s concerns about people foregoing examinations in the midst of the pandemic are supported by findings just released by the IQVIA Institute for Human Data Science. As a result of a sharp decline in cancer screenings nationwide, the report projects more than 80,000 diagnoses of five common cancers will be lost from March through early June.

Citing data from the study, the Washington Times reported on May 15 the number of mammograms has dropped by 87 percent since February. Colonoscopies declined by 90 percent, and pap smears decreased by 83 percent. Testing for prostate cancer is down by 60 percent, and the number of CT scans for lung cancer has been reduced by 39 percent.

Sense of Urgency

The FREOPP blueprint for reopening the economy is an evidence-based work-in-progress, incorporating refinements as more information about COVID-19 becomes available.

“It has been updated many times, and revisions are noted at the end of the document,” Roy said. “We have learned a lot in the past couple of months about how the virus is transmitted and who it affects most severely, which informs the FREOPP guidelines for a strategic reopening of the economy.”

Proposals to sustain government restrictions until a vaccine is developed are unrealistic, Roy says.

“We can’t wait until [that happens],” Roy said. “In fact, we’ve never developed vaccines for other coronaviruses like SARS and MERS. The fastest vaccine prequalification process that the World Health Organization has ever conducted was for the Ebola vaccine, which took five years.

“We don’t have that kind of time to wait,” Roy said.

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

INTERNET INFO

Heartland Connects Lawmakers with Physicians to Help States Reopen Safely

By Ashley Bateman

With unemployment reaching historic levels, state lawmakers have been eager to reopen their economies from the unprecedented shutdowns created by the coronavirus pandemic. But media hype and misinformation, unrealistic goal setting, and political opportunism have made reopening unnecessarily difficult, said members of The Heartland Institute’s Legislative Forum, who reached out to the institute for guidance. In just over a week, Heartland, which co-publishes Health Care News, delivered a paper titled “COVID-19 Response/Return to Normal: Getting Our States Back to Work Quickly and Safely.”

“Our hope was to have a document that aggregated the best ideas for how state lawmakers could pursue free-market ideas during and after the pandemic,” said Cameron Sholty, director of government relations at Heartland.

“Lawmakers have been interested in safety, but not at the cost of austerity,” said report author AnneMarie Schieber, managing editor of Health Care News. “We wanted to provide guidelines because benchmarks may or may not be based on complete data.”

‘Define What Is Essential’
The Heartland Institute relied on advice from several of its policy advisors who are physicians, some with law degrees, who have served in advisory capacities on health care policy. The panel then participated in a one-hour webinar “town hall” discussing the guidelines in the paper and fielding questions from lawmakers.

A prominent line of inquiry pertained to the length of the shutdowns and their scope.

“One of the things that seems to have been ignored is this definition of ‘essential,’” said Marilyn Singleton, M.D., J.D., in the webinar. “We have to define what is essential to life, and one of these things is the negative effect of unemployment and the negative effect of keeping people in their homes. Domestic violence and child abuse are up; alcohol sales are up. Were these things even considered?”

Singleton says a well-documented statistic shows every 10 percent increase in unemployment results in a 1.2 percent increase in mortality, on average. Children in unstable homes are missing the support they get in school and from neighbors, and people with substance abuse disorders are missing assistance from support efforts such as group recovery sessions that have been cancelled, Singleton told the audience.

Non-COVID Patients Suffer
Jeffrey Singer, M.D., a surgeon on the panel and a senior fellow with the Cato Institute, said the shutdowns have caused much harm to people in need of elective surgery.

“Elective surgery is oftentimes thought by people as unnecessary,” Singer said. “But what it means it that it has to be planned.”

Delays in diagnosis of possible cancers, surgical intervention, and treating hernias and gall bladders and other nonmalignant disorders are certainly serious, Singer told the audience.

“Very important health care issues are not being addressed,” Singer said.

Panelists said it has been common practice for hospitals to ask surgeons to be judicious about scheduling procedures during deadly flu seasons, instead of having the government decide for them.

“We were able to make our decisions on what can wait a few weeks and what can be done sooner,” Singer said.

Chad Savage, M.D., an internist on the panel, said medical professionals have expressed concerns about heart patients not getting in to see a physician.

“There is a belief that there have been people sitting at home who could be having mild heart attacks,” Savage said. “Those instances could lead to heart failure later on.”

Smart Testing
Panelist Roger Klein, M.D., J.D., who has a background in molecular diagnostics, said it is important for states to recognize the limitations of testing. Klein told the audience there is plenty of capacity for diagnostic testing even though there have been supply chain disruptions for swabs and the chemical agents used to process tests.

Until more testing is available, testing requirements should be limited to health care workers and individuals exhibiting symptoms of COVID-19, Klein said. Other panelists agreed, also saying it is important to remember diagnostic testing is only a snapshot in time.

“The notion that we will test everyone in the United States is completely unrealistic and unnecessary,” Klein told the audience.

Revision with Real Data
The response to the paper and webinar has been positive, says Sholty. Lawmakers from states such as New Hampshire, Tennessee, Wyoming, and North Dakota thanked The Heartland Institute for the study and asked for the link to the recorded webinar.

“We are going to update our paper against parameters many of the states have outlined for reopening and tailoring specific ‘next steps’ for states still closed,” Sholty said.

Ashley Bateman (bateman.ae@googlemail.com) writes from Alexandria, Virginia.
CARES Act Gets Medical Volunteers to Front Lines with Lawsuit Protection

A provision in the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) is encouraging more health care professionals to volunteer to respond to COVID-19 hotspots by giving them more protection from lawsuits.

Section 4126 of the CARES Act mirrors the Volunteer Protection Act of 1997, which protects volunteers in nonprofit agencies and government entities from civil lawsuits for their actions while offering free service to help others. U.S. Sens. Bill Cassidy, M.D. (R-LA) and Angus King (I-ME) introduced the measure to extend legal protection to those who help others during federally declared disasters. The law, signed on March 27 by President Trump, applies only to licensed medical professionals and does not protect against litigation over damage done deliberately or in a criminal manner.

“This will encourage volunteers and facilitate the rapid deployment of needed medical personnel nationwide in response to the coronavirus pandemic,” wrote King in a March 17 letter to the Senate Appropriations Committee.

“In the wake of a disaster or crisis, it’s often doctors, nurses, and health care professionals who are among the first on the scene and who stay the longest to help people and communities heal,” King stated. “They’re folks who come from all across the country—putting their own lives on hold—to volunteer their time and talent to save lives. Cutting out the patchwork of government policies that inadvertently discourage their work is common sense because providing responsible and quality care should always come first, especially during a time of emergency when they’re needed the most,” King stated later in a news release.

“Doctors and hospital workers are putting their lives on the line every day, yet some in Congress want to see their pay slashed overnights,” wrote TPA President David Williams on the organization’s website. “Patients need choices, not another failed federal foray into healthcare.”

Trying to use benchmark rate setting to control surprise bills would further hamper the nation’s ability to fight the coronavirus pandemic, Williams says.

“Lawmakers and the Trump administration must continue to do everything they can to help health care providers help patients,” Williams wrote.

—Staff reports

Let States Protect Medicaid for the Neediest, Trump Administration Says

A major coronavirus response law could undermine the Trump administration’s initiatives to give states more cost and quality control over their Medicaid programs.

The Families First Coronavirus Response Act, signed into law by President Donald Trump on March 18, restricts states from controlling improper enrollments in order to preserve the funds for the neediest (see related story, page 17).

Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma had unveiled the “Healthy Adult Opportunity” policy on January 30, describing it as “a vital backstop” for Americans when “life can be turned upside down.”

The policy would give states more flexibility to administer and design their programs as they see fit, Verma told the press at the time.

“It provides rigorous protections for all Medicaid beneficiaries, and for the first time, it aligns financial incentives to improve quality of care and health outcomes,” Verma said.

In exchange for flexibility, states would have more accountability for managing their programs, Verma stated.

“I’ve come to appreciate that it’s not enough to enroll individuals in our programs and call it a day; instead, we must strive to provide high-value, high quality care to our beneficiaries,” Verma said. “That care must help beneficiaries achieve the best quality of life as possible and realize their fullest potential.”

Since 2014, Medicaid has added 15 million working-age adults to the program, according to Verma.

“The program was not originally designed for this group,” Verma said.

State practices for verifying eligibility “are far too lax,” and “we shouldn’t have to tell someone with a disability to get on a waitlist for services because we’re diverting precious resources to cover someone who potentially doesn’t qualify,” Verma stated.

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

Economists: Leave Surprise Medical Bill Problem to Marketplace

A letter to Congress and President Donald Trump signed by 160 economists warns the imposition of health care rate-setting as a way to fix surprise billing could ultimately hurt patients by leading to provider shortages.

In early May, Sen. Lamar Alexander (R-TN) and Rep. Frank Pallone (D-NJ) pushed to include health care price-setting in a fourth phase of coronavirus relief legislation. Consumers receive surprise bills when they unknowingly are treated by providers outside their insurance networks.

The letter, signed by the Coalition Against Rate-Setting and dated April 28, states price controls, such as pegging provider reimbursement to some kind of benchmark, “would hurt access to care, especially for patients in rural areas.”

The Taxpayers Protection Alliance (TPA) praised the economists for coming forward as the nation struggles to protect critical health care workers treating an infectious virus.

“The program was not originally designed for this group,” Verma said.

State practices for verifying eligibility “are far too lax,” and “we shouldn’t have to tell someone with a disability to get on a waitlist for services because we’re diverting precious resources to cover someone who potentially doesn’t qualify,” Verma stated.

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

—Staff reports
Congress Expands Medicaid, Restricts State Cost-Cutting Measures

By Kelsey Hackem

Responding to the coronavirus pandemic, Congress passed legislation increasing Medicaid funding and placing restrictions on states’ ability to apply cost-containing measures.

The Families First Coronavirus Response Act (FFCRA), signed into law on March 18, addresses paid sick leave, insurance coverage of coronavirus testing, nutrition assistance, and unemployment benefits.

The new law includes a temporary 6.2 percentage point increase in the Federal Medical Assistance Percentage (FMAP), which is the amount the federal government pays to states for Medicaid costs. The increase was driven by concern that more people would enroll in Medicaid in the wake of rising unemployment and put states under budget pressure during and beyond the coronavirus pandemic.

The FMAP increase is expected to provide the states an additional $9 billion to $10 billion per month in Medicaid funding, according to the Foundation for Government Accountability (FGA).

Strings Attached

The increase in federal money arrives with multiple provisions that may encourage prolonging enrollment of people once they are no longer eligible for the program, a new report states.

“Going to Spend Carelessly”

Those provisions are more restrictive than those attached to any previous increase in the FMAP and will cause a lasting increase in health care spending, Scott Centorino, an FGA senior fellow and coauthor of the report, told Health Care News.

“Congress has created a perfect storm for not only Medicaid and state budgets but also hospitals and health care more broadly,” Centorino said. “By barring states that accept COVID-19 aid from removing anyone on Medicaid even if they’re ineligible or commit fraud, Congress has created a slow-motion, single-payer machine, forcing states to choose between short-term aid or long-term program solvency.”

The change drastically compromises Medicaid’s integrity, says Brian Blase, a senior fellow at the Galen Institute and president of Blase Policy Strategies.

“The [new rule] is going to lead to the federal government reimbursing almost all Medicaid spending for the rest of the year,” said Blase on The Heartland Daily Podcast on May 7, 2020. “If a state is spending on the program recognizing that their state taxpayers are going to bear none of the costs or little, they are going to spend carelessly. There is going to be a lot of waste, fraud, and abuse, and it’s going to be a recipe for massive government health care.”

Temporary Could Become Permanent

Blase says a mechanism in a proposal introduced by House Democrats would allow the changes to become permanent, which would greatly increase the cost of Medicaid. The program cost $597.4 billion in 2018, according to the Centers for Medicare & Medicaid Services.

“[Congress] wants Medicaid to be a source of state aid whenever there is an economic downturn,” Blase said. “States are going to become more dependent on this program, and it will weaken incentives for states to be fiscally responsible in managing taxpayer dollars.”

The rule changes put states in a no-win situation, the FGA report states.

“These restrictions and misguided requirements will force states into making impossible choices of accepting COVID-19 aid and putting their Medicaid programs at immediate risk of insolvency or attempting to make their way through the crisis without any of the additional federal funds,” the report states.

Eroding Medicaid’s Integrity

Blase says the changes to Medicaid in response to COVID-19 could jeopardize some of the reforms the Trump administration has taken to maintain the program’s integrity and eliminate accounting gimmicks.

In an April 7, 2020 article in Health Affairs, Blase described a tactic known as "supplemental payments," in which a state charges a tax to a health care provider, submits the expense to Medicaid, and gives the tax back to the provider in the form of a rebate, developing a “revolving door between consulting groups that create these schemes and state governments and Medicaid agencies.”

“These arrangements lead to high salaries for executives at hospitals, nursing homes, insurance companies, and consulting groups,” Blase wrote. “Many providers, particularly those with less political clout, are harmed by these financing gimmicks and suffer from Medicaid’s generally low payment rates.”

Kelsey Hackem, J.D. (khackem@gmail.com) writes from the state of Washington.
Past Pandemics Were Seen as Threats but No Apocalypse

By Jeffrey A. Tucker

In my lifetime, there was a deadly flu epidemic in the United States. The flu spread from Hong Kong to the United States, arriving in December 1968 and peaking a year later. It killed 100,000 people in the United States, mostly over the age of 65, and one million worldwide.

The average lifespan in the United States in those days was 70 years, whereas it is 78 today. The nation’s population was 200 million, and it is 328 million today. It was also a healthier population with low obesity. Extrapolating the death data based on population and demographics, we might be looking at a quarter-million deaths today. That flu was as deadly and scary as COVID-19, if not more so, though we shall have to wait to see.

H1N2 happened in the lifetime of every American over 52 years of age. I was five years old and have no memory of it at all. My mother vaguely remembers being careful and washing surfaces and encouraging her mom and dad to be careful. Otherwise, it’s mostly forgotten today. Why is that?

Life Went On

Nothing closed. Schools stayed open. All businesses did, too. You could go to the movies. You could go to bars and restaurants. The columnist John Fund has a friend who reports having attended a Grateful Dead concert in August 1969—planned in January during the worse period of deaths—occurred during a deadly American flu pandemic that only peaked globally six months later.

“Nothing closed. Schools stayed open. All businesses did, too. You could go to the movies. You could go to bars and restaurants. The columnist John Fund has a friend who reports having attended a Grateful Dead concert in August 1969—planned in January during the worse period of deaths—occurred during a deadly American flu pandemic that only peaked globally six months later.”

“In 1968-70, news outlets devoted cursory attention to the virus while training their lenses on other events such as the moon landing and the Vietnam War, and the cultural upheaval of the civil-rights movements, student protests and the sexual revolution,” Bojan Pancevski noted in The Wall Street Journal on April 24, 2020.

A Medical, Not Political, Problem

The only actions governments took were to collect data, watch and wait, encourage testing and vaccines, and so on. The medical community took the primary responsibility for disease mitigation, as one might expect. It was widely assumed that diseases require medical, not political responses.

It’s not as if our governments were unwilling to intervene in other matters. We had the Vietnam War, social welfare, public housing, urban renewal, and the rise of Medicare and Medicaid. We had a president swearing to cure all poverty, illiteracy, and disease. Government was as intrusive as it had ever been in history. But for some reason, there was no thought given to shutting down.

Which raises the question: Why was this different? We will be trying to figure this one out for decades.

Was the difference that we have mass media invading our lives with endless notifications blowing up in our pockets? Was there some change in philosophy such that we now think government has authority over all aspects of life? Was there a political element here in that the media blew this wildly out of proportion as revenge against President Donald Trump and his “deploables”? Did our excessive adoration of predictive modelling get out of control to the point that we let a physicist with ridiculous models frighten the world’s governments into violating the human rights of billions of people?

Maybe all of these were factors. Or maybe there is something darker and nefarious at work, as the conspiracy theorists would have it. Regardless, they all have some explaining to do.

Immunity Through Illness

By way of personal recollection, my own mother and father were part of a generation that believed they had developed sophisticated views of viruses. They understood that less-vulnerable people getting them not only strengthened those individuals’ immune systems but also contributed to disease mitigation by reaching “herd immunity.” They had a whole protocol to make a child feel better about being sick. I got a “sick toy,” unlimited ice cream, Vicks rub on my chest, a humidifier in my room, and so on.

My parents congratulated me on building immunity and encouraged me to take my illnesses in stride while doing their best to get me through them.

If we used government lockdowns then like we use them now, Woodstock (which changed music forever and still resonates today) would never have occurred. How much prosperity, culture, and tech has the nation lost in this calamity?

What happened between then and now? Was there some kind of lost knowledge, as happened with scurvy, which we understood how to beat when it was necessary but lost sight of when it was no longer a threat? For COVID-19, we reverted to medieval-style understandings and policies, here in the 21st century. It’s all very strange.

The contrast between 1968 and 2020 couldn’t be more striking. They were smart. We are idiots. Or at least our governments are.

Jeffrey A. Tucker (jeffrey.a.tucker@gmail.com) is editorial director of the American Institute for Economic Research. An earlier version of this article was published at AIER.org.

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COMMENTARY

Pandemic Proves Health Care Deregulation Saves Lives

By John C. Goodman

Our most important weapon in the war against COVID-19 is getting government out of the way and letting the private sector act.

Governments at all levels have been repealing laws, suspending regulations, and ignoring previous restrictions. As a result, we have been liberating doctors, nurses, drug manufacturers, test makers, makers of personal protective equipment, etc. to do things that were illegal only a few months ago.

Americans for Tax Reform calculates 500 regulations have been waived in order to fight COVID-19. That count is probably way too low. The federal Food and Drug Administration (FDA) has eliminated so many restrictions it would be hard to count them all.

In part, the goal has been to free up a modern-day Manhattan Project to produce a vaccine in six months instead of the normal regulatory process that would take years.

Suffocating Regulations

Fortunately, the Trump Administration was ahead of the game when it made needed changes before the COVID-19 virus hit. Once in crisis mode, Congress and state governments also responded—apparently in sheer desperation.

Consider that, up until a few months ago, the only coronavirus tests that were approved for use in the United States were produced by the Centers for Disease Control (CDC), and half of those tests turned out to be defective.

Until COVID-19, it was illegal to produce, sell, or distribute ventilators, respirators, and other medical equipment without complicated and burdensome government regulatory permission. The same was true for personal protective equipment such as masks, gowns, and gloves.

Medicare dictated how many beds a hospital could have, and no one could create additional beds anywhere without government permission. In most cases, it was illegal for doctors to practice across state lines. Physicians who wanted to consult with patients needed to have a license in the state where they lived.

Before the crisis, it was illegal for employers and insurers to waive deductibles and copayments for the 26 million families with health savings accounts (HSAs). Medicare refused to pay for doctor consultations by means of phone, email, or Skype, except under special circumstances.

Until 2019, Medicare refused to pay for 24/7 access to physicians in the form of direct primary care services and concierge care. Patients in these practices can often reach a physician at night and on weekends by phone, email, text, or video chat. Employers were unable to put money into an employee’s HSA to pay for such service.

In January of this year, the Trump administration began allowing employers to fund health reimbursement accounts (HRAs) so their workers can buy individually owned insurance that stays with them when they leave for another job or exit the workforce.

Under traditional group coverage, a departing employee could stay on the company plan via another federal rule, COBRA, but only for a short period of time and by paying the full price of the policy. Many go without (see related articles, pages 1, 11).

Government-Induced Coma

Meanwhile, the current approach to coronavirus mitigation may be making things worse. A nationwide lockdown has put the economy into a financial coma. Although the purpose of those measures was to keep people healthy, it may be having the opposite effect.

Between people’s fear of going to emergency rooms and government orders to cease all elective surgery, patients with non-coronavirus conditions are not getting health care.

These developments have also been bad for doctors, nurses, and other medical personnel who are not dealing directly with the coronavirus. Across the country, plunging revenues from canceled nonemergency medical procedures have forced hospitals to furlough or cut the pay of doctors, nurses, and other staff.

Medical practices other than hospitals have also been adversely affected.

In a Dallas-area survey conducted on April 7 and 8, almost half the medical practices said they had furloughed workers and almost a quarter had laid off staff. Respondents projected the numbers would be even higher in May.

Wealth and Health

Then there are the economic effects of the lockdown. University of Chicago economist Casey Mulligan has prepared a daily updated chart showing the cumulative cost of the reaction to COVID-19, including the loss-of-life costs and the economic costs of shutting down the economy. The latter are completely swamping the former.

What is not generally understood is that the economy has its own effect on health. Health economists have long known that “wealthier is healthier” and vice versa. Put simply, having no job and no income is bad for your health.

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REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA
Physicians Consider Direct Care After COVID-19 Disruption

By Bonner Cohen

The shutdowns from the novel coronavirus have forced many physicians to rethink their payment models to serve their patients better and protect their cashflows.

Although there are no official numbers, physicians are increasingly reporting they are exploring direct primary care (DPC), a practice model that replaces fee-for-service reimbursement with a system based on monthly membership fees.

Inquiries and call volume have been up, says Adam Habig, president of Freedom Healthworks, a private firm that helps physicians make the switch to direct care.

“Some insurance-based practices are reporting decreased patient demand, as people shy away from crowded waiting rooms in favor of telemedicine, private visits, and other attributes of direct care,” said Habig, who is also a policy advisor to The Heartland Institute, which publishes Health Care News.

“Treating patients at a time when human contact is discouraged, adapting to new and rapidly changing mandates handed down by governments and federal health agencies, and navigating new billing codes are big challenges for traditional medical practitioners confronting the COVID-19 outbreak, whereas direct care practices have already solved those problems.

Direct Care Flexibility

In effect, DPC physicians work directly for their patients, eliminating the red tape that comes with third-party payers such as Medicare, Medicaid, and insurance companies.

When the COVID-19 pandemic hit, many primary care physicians had to scramble to learn how to provide virtual office visits through telephone and video consults and deal with patients through emails and texts. Such practices are built into the direct practice business model, which has given DPC physicians a flexibility in coping with the coronavirus world that their fee-for-service colleagues lacked.

That flexibility has been long-established in DPC providers’ use of telemedicine (see related article, page 1). It was only after states ordered physician practices closed that the Centers for Medicare and Medicaid Services (CMS) issued new rules which now allow payment for telemedicine services in conventional fee-for-service practices. Although the ban was removed, physicians who want to bill Medicare for telemedicine services still face a mountain of paperwork if they want to be paid. One particularly onerous CMS rule requires that virtual visits have both audio and video components, notes medicaledconomics.com, which means fee-for-practice physicians cannot get reimbursed for conventional phone consultations and other audio-only interactions.

Free of Medicare billing requirements, DPC doctors continue doing what they have always done: communicate freely via telephone, email, text, and web-based video consults. Many DPC doctors regularly communicate with their patients via email alerts, a practice that is particularly valuable to people complying with shelter-in-place orders or engaging in self-isolation during the current pandemic. Internet communication by DCP physicians also extends to social media.

Personal Safety, Financial Security

Widespread use of telemedicine by DPC physicians provides an additional layer of protection to both patients and doctors and leads to less-crowded doctors’ offices when visits are necessary during a disease outbreak.

DPC has also been able to weather the financial fallout from the COVID-19 outbreak more easily than conventional practices. Operating with a smaller staff, overhead is lower in DPC, and the fact DPC patients pay a monthly fee reduces the pressure on cash flow.

Patients participating in a DPC program can terminate the arrangement whenever they wish and opt for a fee-for-service physician. But Rebekah Bernard, M.D., a family medicine specialist in Fort Myers, Florida, reports she and most of her direct care colleagues have not suffered a net loss of business during the COVID-19 outbreak.

“My practice has normal patient attrition of about 1 percent a month: patients moving away or getting health insurance, for example,” Bernard told Health Care News. “During the last several months, I’ve lost less than the usual number of patients and received many phone calls from patients seeking to join the practice.”

Sustaining and Growing

Bernard says the popularity of DPC has withstood the problems caused by the coronavirus.

“I attribute this to a regular newsletter I send to patients to keep them informed, which many really appreciate, as well as patient anxiety about the future,” Bernard said. “They want to be sure they have a doctor they can call on if they develop symptoms or have medical needs.

“Since DPC practices are priced to be very affordable, most patients are able to retain their membership even with a decrease in income, especially since they see the value. Patients who have lost their health insurance due to job loss particularly value the model as an affordable means of care.”

Innovation, ‘Old-Fashioned Comfort’

Although DPC is not new, this is the first time it has been tested in a healthcare crisis, and it has come through with flying colors, Habig says.

“DPC is the tech-enabled, consumer-driven future of health care, and the pandemic is magnifying its natural advantages,” Habig said. “When people are sick or frightened, they value prompt access to a trusted doctor at an affordable price. This is what direct care delivers, along with the clear prices and mobile convenience that today’s customers expect, wrapped within the old-fashioned comfort of doctors who truly get to know their patients.”

Habig says the coronavirus crisis has raised attention for DPC.

“The pandemic has accelerated DPC’s expansion as more doctors and patients alike recognize its appeal,” Habig said.

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

By Kelsey Hackem

In response to the COVID-19 pandemic, many states and hospitals have banned or delayed elective surgeries and procedures, to conserve hospital resources for an expected influx of COVID-19 cases.

The move has frustrated patients, physicians, and surgeons alike. Elective surgeries are thought of by people as unnecessary, but that is not accurate, says Jeffrey Singer, M.D., a surgeon and a senior fellow at the Cato Institute.

“It’s not unnecessary. It just means that it doesn’t have to be done this moment,” Singer said in an April 27 webinar hosted by The Heartland Institute, which publishes Health Care News (see related story, page 14).

The category of elected surgeries includes urgently needed procedures such as organ transplants and surgeries for cancer treatment.

“Just because it’s elective doesn’t mean a lot of very important health care issues are not being addressed,” said Singer.

Blanket Bans Issued

After the Centers for Disease Control and Prevention (CDC) issued its recommendation that hospitals cease elective surgeries, many hospitals and at least 35 states issued blanket bans on the procedures.

Egregiously, governors issued statewide bans in places where hospital capacity for COVID-19 was not at stake, says Christina Herrin, campaign manager for Free to Choose Medicine at The Heartland Institute, which co-publishes Health Care News.

“I think because of the timing situation, many policymakers or bureaucrats felt that they needed to do something, even if it was too extreme,” Herrin said. “It left lots of people with no answers.”

Herrin says this happened where she lives.

“In Scott County, Iowa, we had zero patients hospitalized, yet we had all of the hospitals and surgery centers in the county postponing surgeries,” said Herrin.

“I think it’s just very crucial to note that we live in a country with communities that differ from sea to sea,” Herrin said. “New York, Iowa, North Dakota, Wyoming, and California are vastly different from one another.”

Judgment Denied

Singer says it is not unusual for hospitals to reach peak capacity during virulent flu seasons and ask surgeons and physicians to postpone elective procedures.

“We do that because obviously we don’t want the hospitals to be overwhelmed, but when we’ve given it that way by the hospitals as a suggestion as opposed to a blanket ban, then we’re able to make our decision as to what can wait a few weeks and what has to be done sooner,” Singer said in the webinar. “[We can also] witness on the ground that the surge has started to abate. We then don’t have to get permission to start doing more elective procedures, because we can see that we can start doing that as opposed to when you have this rigid imposition of a mandate.”

Critical Care Delayed

Patients dealing with serious medical problems have had to wait weeks for necessary care, Singer says.

“There are a lot of patients in my practice and other surgical practices who are getting delays in, for example, diagnosis of possible cancers because they need biopsies done or further investigations which require surgical intervention.”

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Another concern is the backlog the shutdowns have created, which will lead to big problems once the bans are lifted.

“It’s going to be significant, and few policymakers have considered it,” Herrin said.

Kelsey Hackem, J.D. (khackem@gmail.com) writes from the state of Washington.
In big cities and small towns throughout America, bullying, teen suicides, sexual harassment, school shootings, and other violence targeting students have become far too common. In the wake of these tragedies, we need to ask: Why should any child be forced to remain in an unsafe school?

The Heartland Institute has published a new book that holds the key to answering that question and liberating children from failing and dangerous schools. *Child Safety Accounts: Combating Student Bullying and School Violence by Empowering Parents*, by Heartland’s Vicki Alger, Tim Benson, and Lennie Jarratt, is a revolutionary school reform idea that is being picked up in states across the country – and even in Congress.

Many people don’t realize the issues students face daily, including:

- Roughly four out of five public schools report violent criminal incidents.
- About 20 percent of all students aged 12 to 18 report being bullied.
- More than 30 percent of sixth grade students have been bullied.
- Bullying rates at public schools are 28 percent higher than private schools.
- The U.S. Department of Education estimates about 10 percent of students experience some form of sexual misconduct by a school employee.
- The suicide rate for adolescents aged 13 to 18 increased by nearly 31 percent from 2010 to 2015.

No child should be forced to stay in a school if he or she has been or is currently being victimized. Being trapped in unsafe conditions on a daily basis creates mental health trauma, decreases learning, and sometimes causes students to lose all hope and attempt suicide. Child Safety Accounts can help reduce student bullying and improve the education prospects of any child.

LEARN MORE about this vital reform, get your copy of the book, or request one of the authors as a speaker here ChildSafetyAccounts.com.
Health Savings Accounts
More than 30 million people are managing some of their own health care dollars in accounts they own and control

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

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

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

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