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# HEALTH CARE NEWS

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# Project 2025 Faces Backlash

**By Ashley Bateman**

The national Democratic Party is focusing attention on a conservative plan for America's future developed by The Heritage Foundation.

Project 2025 involves policy recommendations and recruitment and training of personnel for a potential Republican presidential administration. The project includes the latest edition of a policy document, *Mandate for Leadership*, which The Heritage Foundation

**PROJECT 2025, p. 6**

Minnesota Gov. Tim Waltz at an anti-Project 2025 event, July 17, 2024

PHOTO COURTESY JIM VONDRUSKA/GETTY IMAGES NEWS

# Physicians Have Right to Question Vaccines, Court Rules

**By Ashley Bateman**

A federal appeals court ruled physicians may sue specialty boards that threaten their constitutionally protected speech, in one of several cases alleging censorship against health care workers.

The U.S. Court of Appeals for the Fifth Circuit remanded to a district court a lawsuit by the Association of American Physicians and Surgeons (AAPS) that alleges federal agencies

**VACCINES, p. 4**

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# Is Bloomberg's $1 Billion Gift DEI in Disguise?

**By Kenneth Artz**

Businessman Michael Bloomberg's $1billion donation to Johns Hopkins University in July will cover the full cost of attendance for most medical students, including tuition and living expenses such as rent, according to a report from the university.

In writing about the announcement, the Associated Press reported, "School officials said they hoped free tuition would attract a diverse pool of applicants."

"Of course, there will be strings attached," said Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons. "It is naive to think that admissions criteria will not be influenced."

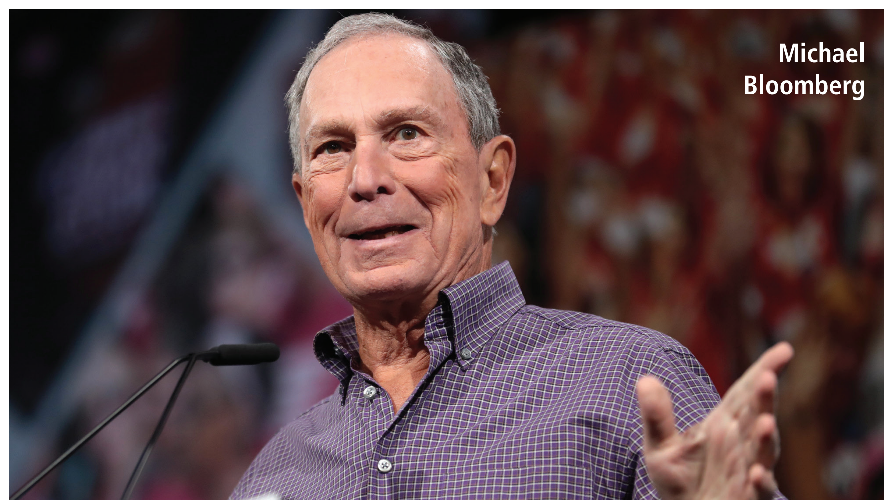

Michael Bloomberg

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

> **"I don't just mean indoctrination on DEI [diversity, equity, inclusion] types of issues. Although modern medicine presents itself as a knowledge tradition based in science, too much of modern medicine is actually built on truth claims, methodologies, theories, and alleged facts that students are expected to accept to become a doctor. Modern medicine is as much a belief system as any religion."**
>
> MARK BLOCHER, PRESIDENT AND CEO, CHRISTIAN HEALTHCARE CENTERS

### Forced Conformity

Bloomberg's donation means huge numbers of students will now apply to Johns Hopkins, giving the university much greater power to sift out applicants it does not like, which means conservatives, says Mark Blocher, president and CEO of Christian Healthcare Centers, a direct primary care organization based in Michigan, and the author of *Missional Medicine* (see related article, page 19).

"I fear that medical education in the United States is becoming less about education and more about indoctrination," said Blocher.

"I don't just mean indoctrination on DEI [diversity, equity, inclusion] types of issues," said Blocher. "Although modern medicine presents itself as a knowledge tradition based in science, too much of modern medicine is actually built on truth claims, methodologies, theories, and alleged facts that students are expected to accept to become a doctor. Modern medicine is as much a belief system as any religion."

Medical school education is expensive, requiring most students to take out massive loans. Offering education for free will give Johns Hopkins even greater power over its medical students, says Blocher.

"In exchange, the school will have even more leverage over what the student learns," said Blocher. "Anything that makes medical education cheaper for the student will give a school a competitive advantage."

### Attitude Exams

Indoctrination starts with the medical school application process and the Medical College Admission Test® (MCAT®), says Blocher. "The medical school accreditation entity I reference in *Missional Medicine* has revised the MCAT to make it easier to weed out applicants who are not the kind of people the elites want as doctors."

Medical schools also require a personal essay to accompany the application, said Blocher. This essay often reveals the student's religious background, personal values, and other information the school can use to decide whether the applicant is a good fit with the school's culture.

In addition to the personal essay, some schools require an interview in which the applicant will be presented with hypothetical clinical situations to which to respond with a course of counsel or action they deem appropriate, to gauge students' adherence to politically correct attitudes, says Blocher.

### Radical Philanthropy

Bloomberg is using his financial power to change people's attitudes, says Texas physician John Dale Dunn, M.D., J.D., a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"He's been doing this now for 20 years with his international news network, called Bloomberg News, that colors the news based on their political positions on everything," said Dunn.

Bloomberg uses philanthropic donations to force social change, like the leftist international financier George Soros, says Dunn.

"Bloomberg is just another Soros, and the word 'oligarch' certainly fits or describes these people," said Dunn. "You could also call them 'plutocrats,' but they're basically people with a lot of money and highly positioned in society, and they use this to try and control people. Bloomberg uses his money that way."

### Political Strings

Great wealth allows these individuals to pursue all kinds of leftist ideological agendas, such as the imposition of environmental, social, and governance (ESG) criteria, says Dunn.

"What do you think some of the strings attached to the money are going to be?" Dunn said. "One will be that Johns Hopkins will continue to pursue the tranny [trangender] project. Second, Bloomberg will want to make sure that Johns Hopkins is pursuing the DEI project. Third, he will want them to pursue the ESG project.

"Just go down the list of the woke agenda, and you know that Michael Bloomberg is on board for all of those things," said Dunn.

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

# Physicians Have Right to Question Vaccines, Court Rules

Continued from page 1

and professional medical credentialing boards coordinated attempts to censor physicians who spoke critically against pandemic lockdown policies, Anthony Fauci, abortion, and vaccination.

The American Board of Internal Medicine (ABIM), the American Board of Obstetrics and Gynecology, the American Board of Family Medicine, and the Secretary of the U.S. Department of Homeland Security are defendants in the AAPS complaint. The district court, by dismissing all claims with prejudice and denying AAPS the opportunity to amend its complaint, violated the Federal Rules of Civil Procedure, the appellate court stated in an opinion published on June 3.

The ruling sends the case back to the U.S. District Court for the Southern District of Texas for discovery and potentially a full trial.

#### 'Not Moot'

The district court had dismissed the lawsuit on the grounds the issue was "moot" after Homeland Security dissolved an advisory board that influenced the credentialing boards.

Judge James Ho dissented in part from the appeals court ruling, arguing that the court should have gone further and "remand[ed] this case for further proceedings on all of the association's claims—including those against the government officials sued here, which the majority dismisses as moot."

"[W]hen government officials voluntarily cease some action in response to litigation, courts are supposed to be skeptical," wrote Ho. "[An official] could engage in unlawful conduct, stop when sued to have the case declared moot, then pick up where he left off, repeating this cycle until he achieves all his unlawful ends."

**"These First Amendment cases, including ours, are enormously and increasingly important today. Many of the most important legal and political struggles now are on the First Amendment issue. If the worsening liberal censorship prevails, then many of our freedoms will disappear as a result."**

**ANDREW SCHLAFLY**
**ATTORNEY**

The remand to the district court will allow the case to proceed on claims of infringement of freedom of speech.

"We agree with the separate opinion by Judge James Ho on this point of how our claim against the Biden administration for its censorship is not moot," said Andrew Schlafly, the attorney representing the AAPS.

#### A Physician's Ordeal

In another First Amendment case, the ABIM instituted a COVID-19 misinformation policy in 2021.

The board then retroactively accused Peter McCullough, M.D., a professor of medicine and academic physician with more than 30 years' experience, of misinformation based on his March 2021 testimony before the Texas Senate, where he publicly questioned the safety, efficacy, and longevity of the vaccines. The board provided McCullough no type of due process. McCullough was then released from two jobs at a major medical center.

McCullough says he was targeted because he spoke out.

"I was brought into peril because I answered questions honestly under oath," McCullough said. "I then provided documentation and evidence [to the board] supporting all of my points. The board had a closed meeting and said that nothing I put in my response document had convinced them."

McCullough was given 10 days to appeal the process, which he did. The case has been on appeal since the fall of 2022. "As a doctor, I have a right to present and publish data and offer my analysis and comments under oath and in the press," said McCullough. "There are procedural errors to what [these boards are] doing, with a lack of due process, following no rules of evidence."

#### Silencing Dissent

In a free speech case that has been resolved, Scott Jensen, M.D., a former Minnesota state senator and candidate for governor, was investigated six times by the state Board of Medical Practice. Jensen was an outspoken critic of pandemic policies, especially payments by the federal government to hospitals for COVID-19 diagnoses, initiating intubation, and declaring COVID-19 as a cause of death.

The board dismissed all charges and ended its investigations against Jensen in March 2023.

"During my run for governor, the incumbent used the accusations of these investigations to discredit me," said Jensen. "They hung like a gray cloud over my campaign."

A ruling against these all-powerful boards in the AAPS case "would emphasize that while they have jurisdiction over professional conduct, they do not have jurisdiction over political speech," said Jensen. "The AAPS win at the appellate court … is a clear directive saying that [boards] cannot do this. There is a line between political speech and professional conduct."

#### First Amendment vs. Censorship

Now that the AAPS case will move forward in discovery, it could reveal the involvement of the federal government in the specialty board's actions, says McCullough.

"The genesis of the ABIM misinformation policy needs to be examined," said McCullough. "Questions to ask include, where did this policy come from? Did it come from a federal agency? Did it come from an intelligence service? Was there a flow of money?"

The push by government officials and licensing boards to silence dissent is a critical issue today, says Schlafly.

"These First Amendment cases, including ours, are enormously and increasingly important today," said Schlafly. "Many of the most important legal and political struggles now are on the First Amendment issue. If the worsening liberal censorship prevails, then many of our freedoms will disappear as a result."

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

# Study: Widespread Obamacare Fraud

By Bonner Russell Cohen

A report examining misstatements of income by individuals applying for Obamacare to qualify for bigger federal subsidies has garnered congressional interest.

Fraudulent enrollment in Affordable Care Act (ACA) plans by individuals falsely claiming they are in the appropriate income range have increased dramatically in 2024, according to "The Great Obamacare Enrollment Fraud," written by Brian Blase and Drew Gonshorowski and published by the Paragon Health Institute.

"In nine states (Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee, Texas, and Utah), the number of sign-ups reporting income between 100 percent and 150 percent of FPL [Federal Poverty Level] exceeds the number of potential enrollees," the report states.

The report traces the problem to the Inflation Reduction Act (IRA), which increased payments to ACA plans through 2025 and fully subsidizes the premiums of enrollees with incomes between 100 percent and 150 percent of the FPL.

> "Investigators should be asking whether bureaucrats are knowingly looking the other way in the face of rampant fraud, as a tactic to expand 'free health care for all' who are willing to lie about their income."
>
> JEFF STIER
> SENIOR FELLOW, CONSUMER CHOICE CENTER

### Call for Review

In response to the Paragon report, the chairmen of three House committees—Energy and Commerce, Judiciary, and Ways and Means—sent letters to the Government Accountability Office and the Office of Inspector General (OIG) at the U.S. Department of Health and Human Services requesting information on the "astonishing level of improper, and possibility fraudulent, behavior, in Obamacare markets" (see sidebar).

In another letter, the committee chairs asked the OIG to "conduct a systemic review of enrollment in 'zero-premium' plans to estimate the scope of potential improper enrollment in such plans as well as improperly paid federal subsidies provided to insurance companies on behalf of such individuals."

### Questions About Brokers

The cost to taxpayers of people understating their income to qualify for subsidized plans is $15 billion to $20 billion in 2024, the Paragon report estimates.

"In all states, there is an incentive for all people who have an income between 200 and 400 percent of the FPL to report an income of 100 to 150 percent of FPL," states the report. "They qualify for a larger advanced subsidy and a plan with much lower cost-sharing, and the Internal Revenue Service only recaptures a portion of the excess subsidy when they file their taxes."

ACA premium subsidies are paid directly to insurers, but individuals sign up for plans through the marketplace, often with the aid of independent brokers.

During the COVID-19 emergency, HealthCare.gov inadequately policed fraudulent sign-ups on the Obamacare exchanges by people who were eligible for Medicaid, according to the report.

"Unscrupulous brokers are certainly contributing to fraudulent enrollment and the enhanced direct enrollment feature of HealthCare.gov appears to be a problem," states the report. "Brokers just need a person's name, date of birth, and address to enroll them in coverage, and reports indicate that many people have been recently removed from their plan and enrolled in another plan by brokers who earn commissions for doing so."

### Double Dipping

In addition to the understating of income, Medicaid-eligible individuals in North Carolina, including current enrollees, are also signed up for ACA plans, says the report.

"The data indicates that many North Carolinians were (and still are) simultaneously enrolled in Medicaid and the exchanges," states the report. "Because North Carolina transitioned its Medicaid program to managed care in 2021, this suggests that insurers are potentially reaping windfall profits from dual enrollment."

Fraud plaguing Obamacare is not surprising, says Devon Herrick, Ph.D., a health economist.

"Government programs that rely on self-reported data certainly run the risk of fraud," said Herrick. "The Biden administration wants to make Obamacare appear to be to be a success. That makes me wonder if the administration will ever try to track down those who intentionally underestimated their income to boost subsidies."

### 'Looking the Other Way'

The principal reason for enrollment crime is a lack of accountability for government officials supervising the ACA program, says Jeff Stier, a senior fellow at the Consumer Choice Center.

"The question I'd like to have answered, given the widespread and systemic fraud, has less to do with dishonest applicants and shady brokers, and has more to do with those charged with overseeing Obamacare," said Stier.

"Investigators should be asking whether bureaucrats are knowingly looking the other way in the face of rampant fraud, as a tactic to expand 'free health care for all' who are willing to lie about their income," said Stier.

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

## Obamacare Enrollment Practices Under Fire

In a June 28 letter to the Government Accountability Office, three congressional committee chairs requested the agency conduct an investigation and analysis including the following:

- a systematic review of the practices employed by healthcare.gov and state-based exchanges and recommendations to improve eligibility integrity;
- a systematic review of changes enacted by the Biden administration, such as those affecting eligibility verification and special enrollment periods, that are contributing to improper enrollments;
- a survey of individuals enrolled in "zero-premium" plans to determine which portion of these individuals use or even know they are enrolled in in their health plan, and
- a survey of brokers in targeted states to review enrollment practices with respect to "zero-premium" plans and recommendations to protect against the misstatement of income and enrollment without enrollees' consent.

**Source**: Reps. Jim Jordan, Cathy McMorris Rodgers, and Jason Smith, Letter to the Hon. Gene Dodaro, Comptroller General of the United States, June 28, 2024: https://www.documentcloud.org/documents/24784444-gao-aca-fraud-letter

# Project 2025 Faces Backlash

Minnesota Gov. Tim Walz

PHOTO COURTESY JIM VONDRUSKA/GETTY IMAGES NEWS

**Continued from page 1**

began publishing in 1980. The new edition, published in 2023, addresses the border crisis, inflation, the economy, crime, education, and health care, along with numerous other policy and cultural topics affecting America today. More than 50 conservative think tanks and groups contributed to building out the plan.

The health care portion of the paper was written by Roger Severino, who was the head of the Office of Civil Rights at the U.S. Department of Health and Human Services (HHS) during the Trump administration.

> **"Project 2025 has become a political football, which is too bad because at least as far as health care goes, there are very stark differences between what the Trump administration has done and where Joe Biden and Kamala Harris have taken it. We are marching toward socialized medicine, and we should not allow ourselves to be distracted by fear-mongering taking place on both sides of the fence if we want to return health care back to patients."**
>
> MATT DEAN
> SENIOR FELLOW, THE HEARTLAND INSTITUTE

### Trump, Media Unimpressed

Former President Donald Trump has distanced himself from the project, issuing a statement in July disavowing involvement with the plan.

"Reports of Project 2025's demise would be greatly welcomed and should serve as notice to anyone or any group trying to misrepresent their influence with President Trump and his campaign, …" said Susie Wiles, campaign senior advisor, and Chris LaCivita, top advisor, in a statement.

Republican National Committee (RNC) cochair Lara Trump called the plan an "absurd vision," in a *Washington Times* opinion piece.

Mainstream media responded quickly and vigorously, predicting the imminent collapse of the effort. An article in *The Wall Street Journal* pointed out that abortion is mentioned 200 times in the document. *The Hill* published an article on August 4 titled "Trump campaign's Project 2025 bashing irks conservative loyalists."

### Health Care Vision

Despite the negative media attention, there is little dispute that Project 2025 is comprehensive, at 823 pages, and focuses on near-term political problems and social issues. The section on health care covers 54 pages and outlines the failures, corruption, and shortsighted actions of U.S. regulatory agencies over the past several years, particularly during the COVID-19 pandemic. The section offers detailed policy remedies.

In a chapter addressing HHS, Severino described protecting life, conscience, and bodily integrity "from day one until natural death" as a necessary foundation for reform.

"Health care reform should be patient-centered and market-based and should empower individuals to control their health care-related dollars and decisions," Severino wrote. Most health care regulation should be done by the individual states, and the federal government should reform "irrational Medicare and Medicaid reimbursement schemes," Severino recommended.

The section argues federal health care agencies should be free from biopharmaceutical funding and regulators should be banned for 15 years from working for any company they have regulated. Scientific data-gathering and public health recommendations should function under separate branches at the Centers for Disease Control and Prevention. The Food and Drug Administration should concentrate on the generic drug market and reverse its approvals regarding chemical abortion pills, the health care section states.

The document recommends curbing the influence of gender ideology in federal health policy.

Regarding Medicare and Medicaid, the section recommends more vigilance to prevent waste, fraud, and abuse.

### Trump Executive Orders Ignored

Though Heritage facilitated Health Care Choices, a document published during the Trump administration endorsed by more than 80 right-of-center organizations and distributed to members of Congress and candidates for office, most of the reforms in that document do not appear, or get little attention, in Project 2025.

Project 2025 favors telemedicine, but not necessarily across state lines. Although the document addresses price transparency, reference pricing is generally absent. Direct primary care is lauded as a health care solution, but the document does not expand on extending DPCs and Health Savings Accounts (HSA) to Medicare, Medicaid, and those purchasing insurance on the Obamacare exchanges.

"Surprisingly, there is no mention of Trump's executive orders allowing many things that could move the health care market in the right direction," said John Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*. "Those include HSAs for the chronically ill, personal and portable employer health care insurance, and removing barriers to short-term insurance, basically a free-market alternative to Obamacare."

A full alternative to Obamacare, drawing on bipartisan ideas, would be "to model the exchange to Medicare Advantage, to allow providers to compete for the sickest enrollees," said Goodman.

### 'Distracted by Fear-Mongering'

Although reformers such as Goodman are disappointed by the absence of some preferred recommendations in *Mandate for Leadership*, that does not mean the plan should be rejected, especially by the Trump campaign, argues Mollie Hemingway, editor-in-chief of *The Federalist*, in a discussion on X.

"Trumpworld bows down to left-wing media lies, and keeps signaling he doesn't want his most loyal foot soldiers—who kept with him even when very few others did—or their conservative ideas in his next administration. Interesting," wrote Hemingway.

The dispute over Project 2025 should not distract policymakers from the need for serious reform, says Matt Dean, senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*.

"Project 2025 has become a political football, which is too bad because at least as far as health care goes, there are very stark differences between what the Trump administration has done and where Joe Biden and Kamala Harris have taken it," said Dean.

"We are marching toward socialized medicine, and we should not allow ourselves to be distracted by fear-mongering taking place on both sides of the fence if we want to return health care back to patients," said Dean.

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

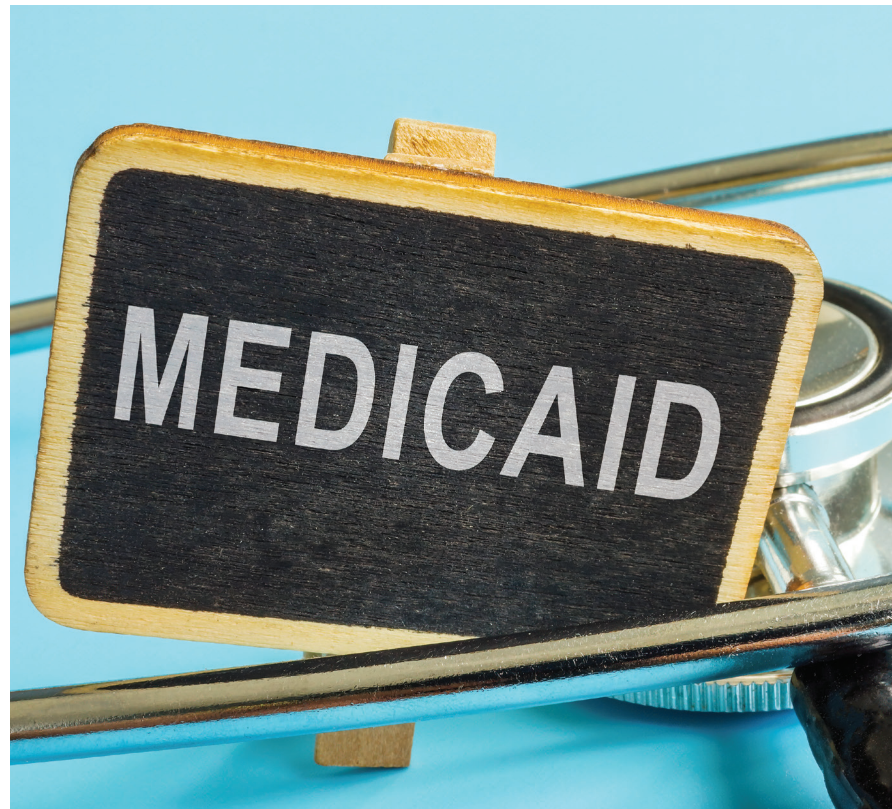
# Georgia Medicaid Work Program Stays Afloat, One Year Out

By Kevin Stone

Georgia is the only state that requires some able-bodied adults to work to qualify for Medicaid, under a program that has reached its one-year anniversary despite opposition from the Biden administration.

Under the Trump administration, the Centers for Medicare and Medicaid Services (CMS) approved waivers allowing states to condition Medicaid benefits for nondisabled adults on work efforts and payment of minimal premiums. The Biden administration began withdrawing federal approval of the waivers, although 13 states had received them, and nine other states' waiver requests were pending.

Georgia was one of the states that moved to implement work requirements and challenged the recission of its waiver by CMS. A federal judge ruled the agency's action was arbitrary and capricious, in August 2023. CMS did not challenge the ruling. As a result, Georgia is currently the only state with a work requirement for any Medicaid beneficiaries.



**"Work requirements are not an end goal for this Medicaid reform but are instead a way to encourage enrollees to work, earn more money, and become better off. With a solid labor market, some potential enrollees in Georgia's program may have started working in excess of 80 hours a month and finding alternative health coverage to Medicaid. It is too early to make a final decision on how effective that program is."**

REA S. HEDERMAN JR.
EXECUTIVE DIRECTOR
THE BUCKEYE INSTITUTE

### Alternative to Medicaid Expansion

Medicaid is a state-run program that was originally envisioned as a means of providing health care to low-income Americans, including the destitute and individuals with debilitating chronic illness and disability.

Medicaid was expanded by the Affordable Care Act in 2010 to cover able-bodied single adults and families with incomes up to 138 percent of the federal poverty level. Coverage of the expansion population became voluntary for each state following a lengthy court battle. In 2024, there remain only 10 states that have not fully expanded Medicaid, including Georgia, according to KFF. The other nine states are Alabama, Florida, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming.

These states, and others that eventually expanded Medicaid, applied for federal permission to implement alternative health plans for various Medicaid-eligible populations, with such features as managed care, financial contributions by enrollees, and work or training requirements.

### Pathways Plan

Georgia's program, Pathways to Coverage, is designed for individuals who are not otherwise eligible for Medicaid. It requires these able-bodied adults to work 80 hours a month in a job, volunteer opportunity, training, or education. To qualify, an individual can earn no more than $15,600 per year, or $31,200 for a family of four.

While a full expansion of Medicaid in Georgia would have made an estimated 430,000 additional individuals eligible for Medicaid, the Pathways program was projected to enroll 25,000. Only 4,300 individuals have signed up for the program, according to an Associated Press (AP) article published on July 13.

Critics say the low enrollment proves requiring Medicaid recipients to work has been a failure.

"First year of Georgia experiment is not promising," reported AP, citing "barriers to employment," including drug addiction, lack of transportation, and difficulty documenting hours.

### Not Worth the Effort

Low enrollment is a sign of the success of work requirements, not a failure, says Devon Herrick, a health economist and policy advisor to The Heartland Institute and editor at the Goodman Institute Health Blog.

"It's pretty clear that many low-income people in Georgia do not consider Medicaid enrollment worth the effort of documenting their employment," said Herrick. "Perhaps they don't consider it enough of an incentive even to get a job.

"The purpose of work requirements is twofold: not subsidize sloth, and to reward people for working, or at least encourage them to look for a job. It's not clear that low enrollment represents a failure of the work requirement program."

### Seeking Better Life Outcomes

Reporting requirements for a Medicaid work program should not be so burdensome that they discourage people from working, says Rea S. Hederman Jr., executive director of the Economic Research Center and vice president of policy at The Buckeye Institute.

"State governments need to continue to make the administrative burden of work requirements as light as possible so the program is effective and Medicaid enrollees can complete the paperwork," said Hederman.

However, increasing Medicaid enrollment is not the principal reason for programs like Georgia's Pathways, says Hederman.

"Work requirements are not an end goal for this Medicaid reform but are instead a way to encourage enrollees to work, earn more money, and become better off," said Hederman. "With a solid labor market, some potential enrollees in Georgia's program may have started working in excess of 80 hours a month and finding alternative health coverage to Medicaid. It is too early to make a final decision on how effective that program is."

### Contribute What You Can

Work requirements for the able-bodied are common sense, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*, and a former seven-term member of the Minnesota House of Representatives.

"It is reasonable to limit access for those who can afford to contribute something to their care but do not," said Dean. "Recipients should be willing to contribute as much as they can, even if it's only a dollar. People making enough money to support themselves is a good thing."

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

# Presidential Race Shake-Up Opens Debate on Medicaid Reform

By Jesse Hathaway

A new analysis predicts health care could be a campaign weapon for Democrats in a tight presidential race, with the news media stressing stark differences between Donald Trump and Kamala Harris on the issue.

The two candidates have sparred over health insurance. Trump said Harris wants to outlaw private health insurance, and Harris responded by accusing Trump of wanting to end Obamacare, CNN reported on July 31.

KFF said in its analysis Harris may use health care as a counteroffensive against discussion of inflation and immigration, pushing the idea of abortion as health care and Obamacare as the only way to protect people with preexisting conditions.

"The Democratic advantage on health is about the same size as the Republican advantage on immigration," stated the July 25 KFF analysis. "We won't know for some time what the picture looks like with Vice President Harris at the top of the ticket. Voter trust in the Democratic candidate to handle health care issues could grow or shrink."

Vice President Kamala Harris

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

### Contrasting Histories

As a U.S. senator, Harris supported single-payer health care to replace private health insurance. Harris softened that position when she ran with Joe Biden in 2020.

Trump established a strong record on opening the health care market to more competition, by expanding short-term health insurance, association health plans, and portable health insurance for employees during his term as president.

### Restoring Medicaid's Mission

The candidates can distinguish themselves on Medicaid reform, says Linda Gorman, director of heath care policy at the Independence Institute and a policy advisor to The Heartland Institute, which publishes *Health Care News*. Medicaid provides poor-quality health care, says Gorman.

"Medicaid was designed to care for people who were too frail and compromised to work," said Gorman. "It makes sense to reserve Medicaid funding for those people. Their conditions are expensive, but they are relatively few in number.

"Huge waiting lists, appointment shortages, specialists not included in networks, poor drug coverage, poor-quality hospitals, and decrepit facilities are some of the problems people encounter when trying to use Medicaid for health care."

The Democrats' Affordable Care Act (ACA) made Medicaid, and health care in general, unaffordable, says Gorman.

"The Affordable Care Act eliminated all of the financial controls private insurers had to control spending and ensure that incentives were properly aligned to reduce fraud," said Gorman. "As a result, Medicaid costs are uncontrollable, its quality is declining, and it is taking the private health care system down as well."

### Reconsidering Alien Lawbreakers

The candidates should discuss reforming Medicaid spending by reducing red tape and revising expensive policies like the Emergency Medical Treatment and Labor Act (EMTALA), says Gorman.

EMTALA requires hospitals to provide health care to people in the country illegally, who often cannot pay for the services they use.

"It is essential to keep the interplay between illegal immigration and EMTALA in mind," said Gorman. "Under EMTALA, hospitals must treat illegals no matter what, and Medicaid coverage just pays [the providers] a bit toward the cost of care. Medicaid does not pay the full cost.

"When hospitals are overwhelmed by people who do not pay, they try to reduce their attractiveness by closing emergency rooms and maternity centers," said Gorman. "When the nonpaying population gets too big, hospitals cannot pay market wages."

An excess of nonpaying patients causes hospital quality to decline and deprive paying, legal citizens of good health care, says Gorman.

"Public money should be reserved for people who are sick," said Gorman. "The regulatory thicket needs to be cleared. Government needs to stop shifting the cost of government programs to the private sector through programs like EMTALA and federal price controls."

### Eliminating Cost Shifting

The shortcomings of Medicaid and Obamacare provide candidates an opportunity to appeal to a large group of voters, says Lauren Stewart, a senior legislative affairs liaison with Americans for Prosperity (AFP).

"Enrollees in both Medicaid and Obamacare plans have learned the hard way that access to health insurance does not equal access to health care," said Stewart. "These enrollees experience their already limited networks continuing to shrink; boxing out options, which can include a doctor you've been seeing for years but simply and suddenly is no longer in-network,

> **"The Affordable Care Act eliminated all of the financial controls private insurers had to control spending and ensure that incentives were properly aligned to reduce fraud. As a result, Medicaid costs are uncontrollable, its quality is declining, and it is taking the private health care system down as well."**
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> **LINDA GORMAN**
> **DIRECTOR OF HEALTH CARE POLICY**
> **INDEPENDENCE INSTITUTE**

delaying care with long wait times, or even due to the exorbitant costs of the premiums."

Frustration is growing over inconsistent and unreliable health care coverage, says Stewart.

"The plans offered change frequently, and in some instances in a very untimely manner, as it was for my friend Mary Katharine Ham, who was recently widowed and seven months pregnant when she was informed that her ACA plan was simply not going to exist anymore," said Stewart.

### Enjoying Bipartisan Support

Polls conducted by AFP show bipartisan support for some reforms, including site-neutral payment under Medicare. Currently, Medicare reimburses hospitals more than independent practices for the same service.

"There are a number of Democrat lawmakers on [Capitol] Hill that are on board with enacting site-neutral payments across the board or even for certain services," said Stewart.

The current payment system incentivizes hospitals to buy up independent practices, which reduces competition, lowers access to care, and raises prices, says Stewart.

"Rampant hospital monopolies drive up the cost for patients across the board," said Stewart. "Democrats and Republicans support this idea, but one reason particularly exclusive to Democrats is their desire to keep Medicare solvent."

*Jesse Hathaway* (**think@heartland.org**)*, a policy advisor to The Heartland Institute, writes from Columbus, Ohio.*

INTERVIEW

# What Are the Major Presidential Candidates' Plans for Health Care?

*Politics may overshadow the issues in the November presidential election, but health care is on most voters' minds. Twila Brase, president and cofounder of the Citizens' Council for Health Freedom, spoke with* Health Care News *Managing Editor AnneMarie Schieber about the crucial health care issues for a new administration and what health policy could look like under whichever candidate wins the White House.*

**Health Care News:** As we speak, Vice President Kamala Harris appears to be the Democratic Party nominee. If she wins, what impact could this have on the biggest complaints in health care: unaffordability, fewer choices, and longer wait times?

**Brase:** Americans don't realize we are moving in lockstep to socialized medicine. All you need to do is look at the fact of longer wait times, increasing requirements for prior authorizations from insurance companies, and limiting doctor choice and treatment. This is now being run in the United States through health plans. If we are looking at Harris and what she wanted during her first run [for president in 2020], we are likely looking at Medicare for All, but with health plans that operate like public utilities. The idea is something like Medicare Advantage for All, where private health plans and corporations will be used to ration care.

This is where Democrats *and* Republicans have taken health care coverage over the past 30-some years, moving away from real insurance—major medical indemnity insurance—something affordable and only for insurable events.

Vice President Kamala Harris

Former President Donald Trump

PHOTOS COURTESY GAGE SKIDMORE/FLICKR.COM

**Health Care News:** Leaving aside Robert F. Kennedy Jr. on an independent ticket, we have Donald Trump, whose track record on health care is known. The wild card might be his VP choice, J. D. Vance. Vance is new to politics and seems to have the backing of party elites. He has a Yale law degree and was a venture capitalist. Should this be a concern for voters looking for meaningful reform?

**Brase:** When I look at Vance—who seems to have everything but health care on his Senate website; you have to Google it to find what he has said on the topic—I don't think we really know what he will do. We know he doesn't like Medicare for illegal immigrants; he doesn't like lockdowns, masks, or vaccine mandates; but he has much concern about Medicare and Social Security. He once commented that the Republicans are the party of the elderly, and because of that Medicare is untouchable in terms of making it more fiscally sound.

Now, from my organization's perspective, we got an executive order in 2019 from President Trump allowing seniors to opt out of Medicare voluntarily and not lose their Social Security benefits. The two were tied together unlawfully by the Clinton administration. COVID derailed the decoupling, and Biden rescinded it altogether. We're hopeful this will happen again, and quickly. This might open the door to promoting alternatives like cheaper indemnity plans, and Vance would be open to that because it could be the solution to putting Medicare on a better fiscal footing.

**Health Care News:** Trump did a lot of good things in the interest of reform: removing barriers to short-term health insurance and association health plans; allowing states to have better control over Medicaid; and expanding access to generic drugs. Some things were not so good, such as putting too much trust in Fauci, Birx, and the CDC on COVID. Could we expect more regulatory reform and better accountability from our health care agencies under Trump?

**Brase:** I'm encouraged by his last executive order, which was supposed to go into effect in January 2021 and would have created a Schedule F for some federal employees. Schedule F would have put many bureaucrats on the chopping block, able to be fired in an instant, and that indicated his seriousness about reining in the deep state.

It was planned for his first day in office had he been reelected [in 2020], and this is why I think so many in government are worried about another Trump presidency.

**Health Care News:** Patient privacy has been an issue you've long championed, notably with your book *Big Brother in the Exam Room*. Do you find it any accident that HIPAA (the Health Insurance Portability and Accountability Act), which we assume protects patient privacy, is now being weaponized, as in the case of the doctor who blew the whistle on Texas Children's Hospital in Houston for performing trans procedures on children?

> **"If we are looking at Harris and what she wanted during her first run [for president in 2020], we are likely looking at Medicare for All, but with health plans that operate like public utilities. The idea is something like Medicare Advantage for All, where private health plans and corporations will be used to ration care."**
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> TWILA BRASE
> PRESIDENT AND COFOUNDER
> CITIZENS' COUNCIL FOR HEALTH FREEDOM

**Brase:** So many people don't understand what HIPAA is, or the power of the bureaucracies and corporations that are allowed to do all sorts of things with data when they want to. HIPAA was a deliberate deception to get people to think it protects privacy when it doesn't. It is no accident that this doctor is now being accused of violating the privacy of patient records, but it is all right for them to pass out these records to others. HIPAA is all about an agenda and access to data.

It is unconstitutional that the government can get your personal medical information without your consent. One thing a new administration could do is write a rule requiring expressed consent.

Additionally, a new administration should allow hospitalized patients the right to be seen and treated by their private physician. Hospitals are tax-funded, and they have started restricting care to their own hospitalists. Hospitals are there for the benefit of the public. We need to protect independence in health care. Medicine has been taken over by the business of health care.

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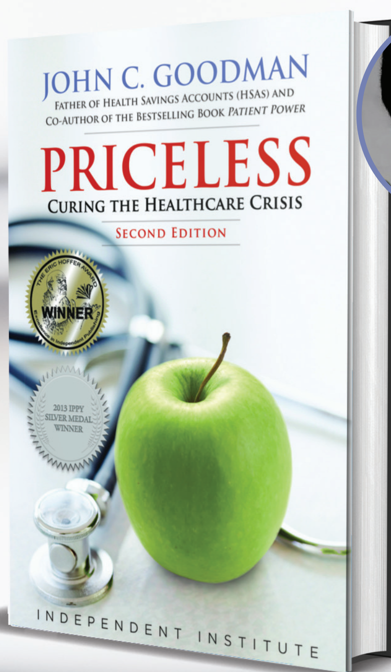

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# PRICELESS
## CURING THE HEALTHCARE CRISIS
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In this long-awaited **updated edition** of his groundbreaking work ***Priceless: Curing the Healthcare Crisis***, renowned healthcare economist **John C. Goodman** ("father" of Health Savings Accounts) analyzes America's ongoing healthcare fiasco—including, for this edition, the extra damage Obamacare has inflicted on America's healthcare system.

Goodman then provides what many critics of our healthcare system neglect: *solutions*.

If you read even one book about healthcare policy in America, this—once again—is the one to read.

# Biden, Trump Concur on Alternative to Employer Health Plans

PHOTOS COURTESY GAGE SKIDMORE/FLICKR.COM

By Jesse Hathaway

As Vice President Kamala Harris and former president Donald Trump square off for the November elections, the candidates' support for an important health care reform could become an issue.

Although President Joe Biden rolled back many Trump reforms, his administration left Trump's creation of Individual Coverage Health Care Arrangements (ICHRAs) alone. The common ground was recently noted by *Politico,* in an article titled "The Trump policy Biden won't kill."

Harris might reverse that beneficial policy, in accordance with her stated preference for higher subsidies and government spending, says Brian Blase, president of the Paragon Health Institute.

"ICHRAs have bipartisan appeal," said Blase. "Republicans like that they give greater flexibility and control to employers and employees, and Democrats like that people can use them toward the purchase of Affordable Care Act (ACA)-compliant plans," Blase said. "Thus, ICHRAs have increased the number of people with ACA individual market coverage."

### Expanding Options

Although ICHRAs are not for everyone, they expand the availability of health care, says Joshua Archambault, a senior fellow in health care policy at the Pioneer Institute.

"The need that it's filling is allowing employers more certainty in their budget for health insurance, but also allowing them to offer insurance to employees that maybe they historically have never offered them," said Archambault. "They're not for everybody, but they do serve the purposes of some people in some kinds of situations. They're not short-term health insurance plans: this is just another arrangement. It could be a mom-and-pop restaurant that has never offered health insurance but are now able to offer it."

ICHRAs benefit workers in industries such as tourism and are good for employees who work part-time, says Archambault.

"An example of this would be an industry in a state where tourism is really big, and they have a lot of seasonal or part-time workers," said Archambault. "Historically, they don't get offered any assistance with health insurance. This would allow restaurants, hotels, and others, for the first time, to offer some assistance to their employees to purchase health insurance."

> **"[Individual Coverage Health Care Arrangements] give employees greater choice over their health insurance coverage, as many employees only receive options of one or two plans that are selected by their employer," said Blase. "Employees have different needs and preferences and should have more options for their health insurance than they currently receive."**
>
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> PRESIDENT AND COFOUNDER
> CITIZENS' COUNCIL FOR HEALTH FREEDOM

### Giving Employees More Choices

Currently, the choices in the individual market for employees with ICHRAs are limited mostly to ACA-compliant plans. ICHRAs might have broader appeal than an employer health plan, says Blase.

"ICHRAs give employees greater choice over their health insurance coverage, as many employees only receive options of one or two plans that are selected by their employer," said Blase. "Employees have different needs and preferences and should have more options for their health insurance than they currently receive."

### Saving Cost, Trouble

Such arrangements are also less costly for businesses and easier to administer, says Blase.

"ICHRAs also make it much easier for employers to offer coverage," said Blase. "Rather than having to deal with annual renewals, rate increases, participation requirements, and stress about picking the best plan, an employer offering ICHRAs simply sets the contribution requirements and hires a vendor to deal with the ICHRA implementation."

ICHRAs can also help hold down costs in the overall insurance market, says Archambault.

"They increase the number of enrollees in the individual market, which can spread insurance risk, which stabilizes the market and can potentially keep premiums in line," said Archambault.

### Contrasting Approaches

Blase says he expects ICHRAs to expand if Trump is elected, and subsidies and government spending to grow under Harris.

"ICHRAs will be better positioned if the enhancements made to the ACA subsidies are permitted to expire after 2025," said Blase. "This is because the enhanced subsidies make it much less likely that small employers [will] decide to offer health insurance. If employees receive health insurance through work, they are generally not eligible for the subsidies. The enhanced subsidies are much less likely to expire if Harris is elected president than if Trump is elected president.

"Thus, the future of ICHRAs would likely be brighter under a second Trump term," said Blase. "I can envision a follow-up ICHRA rule that would remedy some of the operational challenges employers face in offering ICHRAs."

A Trump win would bring back regulatory changes made under his previous administration.

"A lot of what President Trump would probably do, if he is back in office, is codifying what he did previously, because his health reforms were in regulation," said Archambault. "They weren't in law. I think there would be efforts to codify price transparency and association health plans, putting them into law."

### Backing Off from Single Payer?

If Harris wins the presidency, she is likely to continue Biden's approach to health care, instead of implementing policies she advocated when running for the Democratic Party's nomination in 2020, says Archambault.

"When Harris ran in the primary, she supported single payer and ending private health insurance," said Archambault. "I don't think she's going to return to those positions. It's a radical departure from where President Biden has been, even though he's been sympathetic to greater government involvement and is certainly different from what former President Trump has been talking about."

*Jesse Hathaway* (**think@heartland.org**) *a policy advisor to The Heartland Institute, writes from Columbus, Ohio.*

# Family Estrangement Therapy Emerges as New Trend

By Ashley Bateman

A mental health crisis in adolescents and young adults that has been growing since the COVID-19 pandemic is leading to estrangement from family members on the recommendation of licensed mental health professionals.

Online therapists are particularly prominent in encouraging this social response to mental distress. *The New York Times* profiled a college student who disengaged from her parents after being encouraged by an online social worker to do so, on July 17, 2024.

### Recent Development

The promotion of family separation appears to be a recent development in the field of mental health treatment, says Michelle Cretella, M.D., spokesperson for Doctors Protecting Children at the American College of Pediatricians.

"Possibly [within] the last two or three decades this blaming of parents has grown into … therapists saying you have to cut them," said Cretella. "Whether it originates from the young adult or client, this narrative is not challenged or investigated."

Historically considered the strongest social structure, families are increasingly affected by the trend, and some health care professionals are weighing in on its damage to clients and their families.

"The culture, over the last several decades, has become so focused on autonomy, the individual, and client-directed goals in therapy, that you can go to the extreme," said Cretella. "Especially when we're dealing with children and young adults, the family is the most pro-child and pro-young adult institution we have."

### Standard of Neutrality

Robert Emmons, M.D., a practicing family and individual therapist and clinical associate professor of psychiatry, says therapeutic neutrality is the standard practice in psychotherapy.

"When intense conflict occurs in a family, generally I find the best practice is to not take sides toward any specific outcome, reconciliation, or breaking contact," said Emmons.

The role of the therapist is to "facilitate exploration of thoughts and feelings in an emotionally safe environment," said Emmons. "In service of modifying problematic dynamics of communication and behavior … therapists promote change, but usually do not prescribe the specifics of change.

"A family system is extraordinarily complex, and too much cannot be fully known, so therapists are well advised to avoid the role of omniscient prescriber of reconciliation or separation," said Emmons.

### Counselors Taking Sides

"Counselors can unintentionally minimize, maximize, or [alter our perceptions of] our emotional wounds for good or bad," said Cretella. "[In this way, there may be] some social contagion, perhaps even unintentional manipulation of memory."

Recollections of individual relationships vary by family member, notes Devon Herrick, a health care economist, in a post on the Goodman Health Blog. Herrick notes a "trend of TikTok therapists and sociology gurus on YouTube counseling young adults on becoming estranged from family members."

In the *New York Times* article, some of the people who are estranged from their parents appeared to "dredge up false memories of childhood trauma and poor treatment that siblings and parents don't recall," wrote Herrick.

"It's hard to know what to make of the estrangement therapy movement," wrote Herrick. "In 30 years, it may be remembered like the Recovered Memory Movement, or it may have evolved into a more nuanced therapy about setting health boundaries."

### PTSD Connection

Estrangement therapy has coincided with a rise of diagnoses of post-traumatic stress syndrome (PTSD). The rate of PTSD diagnoses among college students more than doubled between 2017 and 2022, to 7.5 percent, according to a study published by *JAMA Network* on May 31.

"Since the 1970s, psychologists have steadily increased the scope of PTSD, at first changing what counts as trauma, then making the symptoms more and more vague until just about every person on the planet has it," wrote James Halley for The James G. Martin Center for Academic Renewal.

### Institutional Influence

Health care institutions and education establishments promote the separation of family members. In some states, minor-consent laws now separate patients as young as 12 years of age from their parents in the exam room.

"Leaving the parent out of the exam room [allows] the physician to talk to younger and younger children about birth control—part of the culture of death—putting them at risk for becoming sexually active at younger and younger [ages]," said Cretella. "[Becoming sexually active at younger ages] increases their risk of STDs, which can cause sterility, and unwanted pregnancies and abortion."

In California, Gov. Gavin Newsom (D) signed into law Assembly Bill 1955 on July 16, prohibiting public schools from requiring parental notification about their child's claimed gender identity or gender expression unless the child consents.

"Counselors and therapists are integral to the move to disempower parents, whether it's about restorative justice or the radical gender agenda," said Larry Sand, president of the California Teachers Empowerment Network. "Schools are now taking over the traditional role of moms and dads, with teachers and counselors in charge."

### 'Culture of Death'

The estrangement trend appears to be an extension of "death culture," which goes beyond assisted suicide, abortion, and euthanasia, says Cretella.

"The culture of death is much more insidious," said Cretella. "I don't know if it's a political or cultural goal, but I do think it's a eugenics goal of the people involved in undermining the family and cutting young people off from the family."

Health care professionals openly oppose parents and the family, says Cretella.

"What's really frightening and so diabolical is … we're seeing that medicine and psychiatry have imbibed that anti-family bias, anti-parent bias which is in our culture, and they are damaging nuclear families, actively encouraging and justifying estrangement," said Cretella. "[Estrangement] heals no emotional deficits."

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

# Judge Denies Gag Order on Wrongful Death Depositions

**By AnneMarie Schieber**

A judge is allowing the release of deposition transcripts and audio files in the wrongful death case of a young woman who died in a hospital during the COVID-19 pandemic because of an unauthorized do-not-resuscitate (DNR) order.

Grace Schara, a 19-year-old with Down's Syndrome, died at St. Elizabeth's (Ascension) Hospital in Appleton, Wisconsin several days after being admitted on October 7, 2021 for COVID-19. The hospital asked for consent to put Grace on a ventilator. At the time, the federal government was giving hospitals extra reimbursement for COVID-19 diagnosis and certain treatments.

"The staff acted as if Grace was DNR because we refused the ventilator, which has a 90 percent kill rate," wrote Scott Schara in an email update to supporters. "It is clear to me Grace was written off because we disagreed with the $300,000 ventilator payday."

Scott Schara filed a wrongful death claim in Wisconsin Superior Court on April 11, 2023, against the hospital, five physicians, two nurses, unnamed medical providers, and the Wisconsin Injured Patients and Families Compensation Fund. After depositions, Schara added a sixth doctor, the supervisor of the intensive care unit, to his complaint.

The case is scheduled for a three-week jury trial later this year. Ascension made two attempts to have the case dismissed and sought a gag order.

Grace Schara
*Photo taken October 7, 2021, courtesy – Scott Schara*

**"I had attorneys already flown in from Ohio when they brought up the gag order as 'normal.' This was a hostage tactic. The alternative was to call their bluff at that time and reschedule. These depositions were of the utmost importance in the discovery process. The route we chose was to spell out we are not agreeing unless the defense brought the issue to the judge, which resulted in hearings."**

**SCOTT SCHARA**

### Keeping Secrets

"[The defendants] seek a Protective Order because of their concern that the plaintiffs will misuse discovery obtained in the case for purposes that are unrelated to the lawsuit itself," the defendants stated in their brief. "They also fear for their personal safety."

The defendants' request claims Schara launched his lawsuit in 2023 to build a social media "crusade" against euthanasia and "medical murder." The brief notes the extensive promotion of the suit by Schara, including on a website called Our Amazing Grace.

Two defendants said they have been singled out for "more aggressive treatment" by Schara and his supporters. Their images have been widely disseminated on the Internet. The brief describes Schara's religious faith and cites as an example a post by Schara stating, "It depends on what doors God has been opening up."

The brief also criticizes Schara's sources of information, characterizing them as "self-directed internet research conducted almost entirely through alternative media sources on the internet, as he concededly avoids 'mainstream media' information sources of every type." The brief points out Schara has no medical expertise or training.

### 'Hostage Tactic'

Schara claims the defendants sought the gag order ultimately to ban the media from the jury trial scheduled for later this year. In his response to the brief, Schara stated they did not seek the gag order until May 20, 2024, days before key witnesses were to be deposed.

"I had attorneys already flown in from Ohio when they brought up the gag order as 'normal,'" Schara told *Health Care News*. "This was a hostage tactic. The alternative was to call their bluff at that time and reschedule. These depositions were of the utmost importance in the discovery process. The route we chose was to spell out we are not agreeing unless the defense brought the issue to the judge, which resulted in hearings."

On July 29, the judge ruled Schara could share the transcript and audio of the depositions, but not the video.

"We felt the law was on our side because there has to be 'good cause' for someone to restrict another person's First Amendment rights," said Schara. "'Fear' is not 'good cause.'"

### Higher Standard of Proof

Schara filed a wrongful death claim, which is more difficult to prove than a claim of medical malpractice. Courts accept medical records as prima facie evidence, unless a plaintiff can prove the information in them is false.

Another hurdle for the plaintiff has been the defendants' claims of an "Alt Privilege," based on another Wisconsin case, that would allow them to avoid answering questions.

"Our medical-profession-supported legislators codified the idea into law via State Statute 907.06 in 2013," wrote Schara in an email update to supporters. "The Statute has to do with Court Appointed Experts. As is typical, the slippery slope has mutated the idea that medical staff cannot testify against their colleagues."

Schara told *Health Care News* his experience over the past year has convinced him his lawsuit will not be in vain.

"Ultimately, what we are seeking is repentance—stop the behavior," Schara said. "We want to shed light on the evil in both the medical and legal systems. We've said publicly many times, we are not taking [any] money awarded. Money is not justice."

### 'Trusted Doctor' Laws

The Schara case might also raise awareness of proposed state "trusted doctor" laws that would allow patients to have access to physicians not employed by the hospital where they are being treated. Hospitals have limited independent physicians from admitting, treating, or requesting records of patients.

"Hospitals receive tax dollars," said Twila Brase, president and cofounder of the Citizens' Council for Health Freedom. "Patients are taxpayers, and they should have the right to bring in their 'trusted physician' as an advocate."

Brase says the need for trusted doctors increased after the enactment of the Affordable Care Act, which rewards hospitals for acting in certain ways.

"There is a conflict of interest between the 'hospitalists'—the doctors who work for the hospital—and the patient," said Brase.

There has been another death pointing to the need for trusted doctors, says Brase, that of former U.S. Rep. Eddie Bernice Johnson (D-TX), who died in January due to medical negligence, according to her family.

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

INTERVIEW

# How to Spend Billions of Dollars and Get Nothing in Return

Priceless: Curing the Healthcare Crisis *(Updated Second Edition), by John C. Goodman, Independent Institute, 392 pages, ISBN-13: 978-1-59-813395-0, $28.95, amazon.com (Hardcover)*
*John C. Goodman, co-publisher of* Health Care News*, known as the "father of health savings accounts," is releasing a second edition of his groundbreaking 2012 book,* Priceless: Curing the Healthcare Crisis*. Goodman sat down with Kenneth Artz of* Health Care News *to discuss why the new version was necessary.*

**"Going back to my book, *Patient Power*, I have always argued that we should all get the same tax credits and have a free market for health insurance. That was adopted by John McCain in his presidential campaign. There have been several bills to do that introduced in Congress, one by Paul Ryan, and most recently by Pete Sessions."**

JOHN C. GOODMAN
PRESIDENT AND CEO
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

**Health Care News:** What changes in the health care marketplace are reflected in the new edition of your book?

**Goodman**: The first edition of *Priceless* was published on the eve of the rollout of Obamacare. So, that edition focused a lot on what to expect from Obamacare. In the decade that has passed, a lot of things that were in the original legislation were rescinded, so it turned out to be much less harmful than it could have been. The new edition focuses a lot more on what is wrong with the market as a whole and gives somewhat less attention to Obamacare than in the first edition.

**Health Care News:** What is the most important thing that *Priceless* adds to the discussion of health care policy?

**Goodman:** This book is different than any other book you will find in health economics. What all the other books on health economics do is try to force health care into the supply and demand models you see in microeconomics, and it just doesn't fit.

The title, *Priceless*, is a double entendre: your health is priceless, but also the health care you get has no real price. So, normal supply and demand diagrams cannot explain why you pay $100 for an aspirin tablet at a hospital.

**Health Care News:** How did Obamacare affect the supply side of the market for health care?

**Goodman:** Although the individual mandate in Obamacare was repealed, there is still a mandate on the supply side of the market, in the sense that if insurers want to sell in the individual market, they can only sell Obamacare-

compliant plans. They can't sell any other kinds of plans. The only thing you can buy, with some minor exceptions, is Obamacare insurance.

**Health Care News:** How do Obamacare Exchange plans compare with insurance plans in the private market?

**Goodman**: The most obvious comparison is with the short-term market, which offers insurance that looks pretty much like insurance did before Obamacare. Short-term, as the name implies, is there to meet short-term needs like going from home to college, college to work, or job to job, and it's been there forever. Terms are typically up to 12 months. Obama restricted it to three months by an executive order. Trump said you can have it for a year and can renew for two more years. Now, Biden came back this spring and said, "No, you can only have these plans for three months with a one-month renewal."

This is the most obvious alternative to Obamacare. I think three million people have this right now because of Trump's liberalization of the rules. The premiums are half what they are in the Obamacare market, the networks are usually better, deductibles are smaller, and out-of-pocket exposure is less.

**Health Care News:** What are the major differences between President Trump's approach and that of President Biden?

**Goodman:** Trump wanted to open up alternatives to Obamacare, giving people choice, with plans that had lower premiums, broader networks, and less out-of-pocket exposure. Biden reversed this by closing off opportunities and forcing everyone into the Obamacare exchanges.

**Health Care News:** What are the best ideas in the new edition of *Priceless*?

**Goodman:** This is probably the only book where you're going to discover that when we created Medicare, Medicaid, and Obamacare, we spent billions of new dollars with no increase in health care. That is a rather remarkable fact. Under Obamacare, we insured a whole bunch of new people and the average number of doctor visits per capita went down, from the time they passed the law up until the pandemic.

Another fact: we have made Obamacare virtually free for most people. If you have an average income, you're probably not paying any premium at all when you go into the Exchange. So, one reason the insurance numbers look so good, why there are a lot more people with insurance, is because they're giving it away. That's great if you're healthy, but if you get sick, the out-of-pocket exposure is really higher than anywhere else in our health care system. It can be $9,400 for an individual and almost $19,000 for a family.

What was the main argument for Obamacare? It wasn't that we wanted to do something for people who are healthy; it was that we wanted to do something for people with preexisting conditions. What we now have is a system that's really good for healthy people and really bad if you're sick.

Going back to my book, *Patient Power*, I have always argued that we should all get the same tax credits and have a free market for health insurance. That was adopted by John McCain in his presidential campaign. There have been several bills to do that introduced in Congress, one by Paul Ryan, and most recently by Pete Sessions.

**Health Care News:** What will a layperson get from reading *Priceless*?

**Goodman:** We would like to believe that our system is really different from Canada's—Bernie Sanders said it was really different; but, in fact, they're 80 percent the same because in both countries we're paying with time, and not with money. We need a price system, a free market for health insurance, doctor care, and hospital care.

# Do 'Social Determinants of Health' Really Affect Health?

By Harry Painter

Research supporting the Biden administration's favored "social determinants of health" theory of "health equity" is flimsy, a new study has found.

The White House is pushing the controversial theory that spending more taxpayer money on housing, early childhood education, support services for homeless people, nutrition, and other social services directly improves public health.

Most of the research cited in support of the administration's claims about social determinants of health (SDOH) is substandard and confuses causation and correlation, writes Manhattan Institute Senior Fellow Chris Pope in a report published by the think tank on July 11.

Randomized controlled trials reveal SDOH expenditures "have weak effects on health and few offsetting savings," Pope found.

### White House Enthusiasm

The doctrine is being pushed through Medicaid. In February, *Vox* reported six states will be part of a pilot program providing six months of rental assistance to Medicaid enrollees. On May 15, the Centers for Disease Control and Prevention posted an article on "Social Determinants of Health" on the CDC website. On July 1, KFF released a report titled "Medicaid Efforts to Address Racial Health Disparities."

A November 2023 White House policy guide titled "The U.S. Playbook to Address Social Determinants of Health" made the case for government spending to improve Americans' health by addressing "social circumstances and related environmental hazards" allegedly pertinent to health outcomes.

The document argues Americans suffering from social disparities are more likely to have chronic diseases and disabilities and other adverse health situations such as exposure to pollution or hazardous waste.

### Scholarship Questions

In addition to being tainted by political advocacy, SDOH research suffers from financial conflicts of interest and basic logical errors, Pope told *Health Care News*.

> **"The main problem with most studies is they take correlation to mean causation and fail to eliminate possible confounding factors. For instance, poorer people are sicker, but poor people also smoke more. The correlation between income and health does not prove whether the poor are sicker due to lack of money or higher rates of smoking."**
>
> CHRIS POPE
> SENIOR FELLOW, MANHATTAN INSTITUTE

"The main problem with most studies is they take correlation to mean causation and fail to eliminate possible confounding factors," said Pope. "For instance, poorer people are sicker, but poor people also smoke more. The correlation between income and health does not prove whether the poor are sicker due to lack of money or higher rates of smoking."

SDOH spending is tied to multiple financial conflicts of interest, says Pope.

"Private entities, such as insurers, are nudged to undertake SDOH expenditures by government subsidies, taxes, and regulations," said Pope.

### Carrots for States

The Biden administration's plan incentivizes states to raise social spending.

"States can get $1 to $3 in federal funding for every $1 they spend on Medicaid," said Pope. "So, by classifying spending on social services as influencing health care, they can claim Medicaid matching funds from the federal government."

In an op-ed for *The Wall Street Journal*, Pope said reclassifying social service funding as health care funding gives states, nonprofits, and policy advocates access to the "much larger pool of federal funding that is allocated to healthcare."

The mechanism for SDOH spending is less accountable than typical social programs, says Pope.

"We have dedicated social welfare programs and an appropriations process for them," wrote Pope. "Steering funds through the healthcare system certainly reduces accountability."

### Government Expansion Plan

"SDOH tends to place the real need for improvements in health measures—such as obesity, heart disease, substance abuse disorder, etc.—within subjective preconceptions about race, age, religion, and familial status," said Matt Dean, senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*. "Many of the measurements buried within the conclusions are themselves biased."

Dean says the Biden administration guide twists the facts to argue that disparities lead to poor health outcomes.

"Our betters determine that if it can be shown that people who are actively engaged with government are healthier, then the government needs to step in to help [some] people vote to improve their health," said Dean. "Of course, it begs the question of 'Who needs more help voting?'"

Dean agrees with Pope that SDOH is boosted by financial interests.

"The medical economy tends to bill for what gets paid for," said Dean. "Once states began measuring outcomes that showed correlation for SDOH, it didn't take long for payment models to be developed to pay for outcomes along subjectively drawn SDOH lines."

### Social Engineering Camouflage

Associating unrelated programs with SDOH allows politicians to get funding for programs that would not be approved on their own, says Dean.

"Health care is a $5 trillion source of funding for everything from housing to get-out-the-vote," Dean said. "The Green New Deal could not be passed with appropriations on its own, but if Medicaid starts paying for green roofs, solar panels, and electric buses, the Green New Deal is funded. But there might not be a pacemaker for you when you need it."

Current payment models for health care are too easily manipulated, says Dean.

For example, "value-based purchasing models promote some providers by scoring them higher for whatever metric is chosen," said Dean. "If doctors primarily see Medicaid patients, their patients will be sicker as a group and more complex—and expensive—than their fellow patients in the individual insurance market.

"The more subjective the payment model, the more the measurement and associated reimbursements will be tweakable for the purposes of remuneration," Dean said.

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

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# Texas Squares Off with CMS on Medicaid Funding

**By Bonner Russell Cohen**

Texas and the Centers for Medicare and Medicaid Services (CMS) are locking horns over what Lone Star State officials say is CMS's unfair treatment of states that have not participated in Medicaid expansion.

Along with Florida and Missouri, Texas was targeted by CMS last year for audits and other enforcement actions as part of what officials in the three states say is a concerted effort by the agency to crack down on states that have chosen to forgo Medicaid expansion.

In a complaint filed on April 5 in the U.S. District Court for the Eastern District of Texas, Tyler Division, Texas alleges CMS is selectively enforcing an Informational Bulletin it issued last year governing the financing of Medicaid and has "wielded its oversight role as a cudgel to force Texas to adopt its policy preferences. It has shaken the structural foundations of Medicaid's operation in Texas."

As the case continues to play out in a Texas court, CMS upped the ante by announcing that enforcement of provisions related to the financing of state Medicaid programs will begin on January 1, 2028, with corrective actions to follow.

> **"The Biden administration would prefer the state adopt Obamacare's Medicaid expansion. But that action would raise the cost to the state and federal government and give the feds more control over the Texas health care system, something Texas has been unwilling to do."**
>
> MERRILL MATTHEWS, PH.D., RESIDENT SCHOLAR, INSTITUTE FOR POLICY INNOVATION

### Localized Expansion

As in other states, Texas's Medicaid program is funded jointly by the federal and state governments. Local governments in Texas may also participate in the program by providing funding to the state to give additional residents greater access to health care, regardless of income level.

Since 2013, with CMS authorization, Texas has allowed local governments to administer Local Provider Participation Funds (LPPFs). In 2021, CMS attempted to rescind Texas Medicaid's authorization to use LPPFs. A federal court issued a preliminary injunction against that effort.

"LPPFs involve local governments collecting a mandatory assessment from healthcare providers and then transferring that money to the state to help finance Texas's share of Medicaid. Such arrangements are expressly permitted by federal law," states a press release from Texas Attorney General Ken Paxton.

### Definition Dispute

Texas alleges the February 23, 2023, Informational Bulletin "is a retroactive change in CMS's definition of a hold harmless arrangement," states an article on the website of the global law firm Norton Rose Fulbright.

"Federal law, however, outlaws hold harmless arrangements, which are agreements between a government and a health care provider through which the government guarantees that the provider will receive its total tax payment back through Medicaid payments," Paxton's press release states. "CMS recently issued an unlawful informational bulletin that would arbitrarily categorize purely private contracts involving entities paying taxes into an LPPF as prohibited hold harmless arrangements. Nothing in federal law prohibits purely private contracts of this sort."

By unilaterally redefining hold harmless arrangements to invalidate LPPFs, Texas says CMS violated the Administrative Procedure Act by failing to give notice and initiate a public comment process before issuing the Informational Bulletin.

The Texas lawsuit and one filed by Florida were launched before the June U.S. Supreme Court ruling that overturned the doctrine of "Chevron deference," which had given federal agencies wide latitude in interpreting federal statutes, in the case of *Loper Bright Enterprises v. Raimondo*. CMS's interpretation of its powers over Medicaid could be in violation of the Court's decision in the case.

### Enforcement Deadline

In an analysis of the Texas-CMS dispute, Norton Rose Fulbright states the outcome "could significantly reduce the amount of Medicaid funding in Texas and in every other state that uses the same or similar Loan Provider Payment Fund (LPPF) measures to help pay for its Medicaid program."

"In those states that have had these arrangements formally approved by CMS, including Texas, the hospital system and physician groups rely heavily on funding provided by these programs to help to make such entities fiscally whole as they treat larger percentages of Medicaid patients at a significant financial loss," Norton Rose Fulbright states.

### 'Strongarm Methods'

Merrill Matthews, Ph.D., a resident scholar at the Texas-based Institute for Policy Innovation, says Texas uses its LPPF program to help it qualify for the 1115 Medicaid waiver, which helps hospitals cover the cost of the state's roughly five million uninsured.

"The Biden administration would prefer the state adopt Obamacare's Medicaid expansion," said Matthews. "But that action would raise the cost to the state and federal government and give the feds more control over the Texas health care system, something Texas has been unwilling to do. It's the same old game of using strongarm methods to achieve liberal goals."

The CMS decision is part of a concerted effort by the Biden administration to increase the power of the central government, says Craig Rucker, president of the Committee for a Constructive Tomorrow.

"The less control states have over their health care systems, the more power CMS can concentrate in Washington," said Rucker. "We see the same thing in the Biden administration's efforts to cripple Medicare Advantage for seniors, curtail individual choice in coverage, and erase state health care programs that operate independently of the feds."

At a hearing before the House Energy and Commerce Committee Subcommittee on Health, Rep. Dan Crenshaw (R-TX) said Texas's approach to funding its share of Medicaid "focuses on making sure that the health infrastructure is funded so that people who need care actually have a place to go, not just a piece of paper that says they have a place to go."

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

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# Optometrists Go After Online Vision Tests

**By Kevin Stone**

Under pressure from optometrist associations, some of the 37 states that currently allow online eye examinations are moving to limit or ban them.

For instance, under heavy pressure from the Kentucky Optometric Association (KOA), the state attorney general (AG) alleged online eyeglass retailer Warby Parker violated the state's KOA-backed Consumer Protection in Eye Care Act.

Specifically, the AG argued 69 Kentucky residents were "improperly given" the company's online eye exam. Warby Parker agreed to pay a hefty fine and remove the test from its website.

### Telemedicine Not for Eyes

KOA President Leslie Cecil, O.D., defends the organization's advocacy of limits on access to eye exams.

"We were met with a lot of pressure from outside companies and public concerns that we were thwarting technology," an article on the Amerian Optometric Association's (AOA) website quotes Cecil as saying. "The KOA had to educate our legislative leaders about the concerns of patient safety, while also making sure that Kentuckians had appropriate access to technological advancements."

Optometric associations in other states are also trying to get governments to shut down online tests. Indiana took similar action against Chicago-based Visibly. Visibly sued the state and sought Food and Drug Administration approval of its online vision test.

On August 12, 2022, the company became the first online test provider to gain "510(k) Clearance" from the FDA for its Visibly Digital Acuity Product, after successfully arguing it is intended to augment in-person exams, not replace them.

### Claims of Health Risk

The Health Policy Institute (HPI) of the AOA posted a statement in 2019 warning of alleged risks of the Visibly (at the time called Opternative) online exam. The claimed health risks centered mainly on the idea that a quick and easy home test would enable patients to avoid a comprehensive eye exam in-clinic.

"Ultimately, the AOA HPI found there is a high and unacceptable likelihood that doctors relying on data self-generated by consumers using the Opternative device will misdiagnose the user's refractive correction and

importantly, the patient misses professional in-person eye care that could identify serious ocular and systemic disease requiring treatment before eyesight is permanently impaired or lost," said the statement.

### Consumers Without Glasses

The statement does not address the fact that these same conditions also apply to the large number of Americans who do not use vision correction at all or who use only off-the-shelf reading glasses, nor does HPI suggest the government should intervene against people for not obtaining regular eye exams with an optometrist as it does regarding online eye exams.

The value of full in-clinic exams should not preclude the existence of less comprehensive services, says Matt Dean, senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*, and a former state legislator.

"Optometrists look for melanoma, glaucoma, and other issues," said Dean. "They do catch certain conditions that can be referred to specialists, but the question is, should this preclude people from getting eyeglasses? The answer to that question is 'probably not.'"

### Industry Interests

Health care regulations are often designed for the benefit of existing providers, says Dean.

"Professional associations heavily influence state laws," said Dean. "Specialists do have an interest in protecting public health, but providers in competing specialties often use state laws to 'fence' other professions by mandating such things as how often patients must be examined, and who can perform which procedures,"

Medical boards tend to serve providers' interests more than those of the patients, says Devon Herrick, a health care economist.

"Rulings like [the one in Kentucky] accomplish little more than protectionism," said Herrick. "Over time, professional medical boards become captured by the interests of their profession. They begin to view their mission as one to protect their profession, protect the status quo, and they do so in the name of patient protection.

"Claims that convenient, in-home vision tests are not comprehensive enough are making the perfect the enemy of the good," said Herrick. "The result is fewer patients getting vision tests of any kind. Although in-home vision tests may not be as comprehensive as in-office optometrist visits, they expand access to vision care for many who would never set foot in an optometrist's office."

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

**"Claims that convenient, in-home vision tests are not comprehensive enough are making the perfect the enemy of the good. The result is fewer patients getting vision tests of any kind. Although in-home vision tests may not be as comprehensive as in-office optometrist visits, they expand access to vision care for many who would never set foot in an optometrist's office."**

**DEVON HERRICK**
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COMMENTARY

# The Latest Surprise Charge on Medical Bills: Facility Fees

By Devon Herrick

**Congress should require greater price transparency, to ensure patients are never caught off guard by faux hospital services. In years past, many states had laws banning the corporate practice of medicine, which is when corporations employ doctors to work on their behalf. It may be time to revisit that doctrine.**

DEVON HERRICK, PH.D., HEALTH CARE ECONOMIST

"Surprise, surprise, surprise!"—as TV's Gomer Pyle was fond of saying.

There's yet another surprise medical bill scam that most patients probably do not know about. It is hospital-affiliated urgent care centers that are billed as hospital outpatient departments.

I often tell the story of the time my wife almost got a CT scan at a hospital outpatient clinic. My wife's share of the bill after her deductible was met was going to be $2,700. I quickly found a freestanding radiology clinic that accepted her insurance and charged $403.

My wife hadn't realized prices vary and hospitals charge the highest price.

I explained to her you never want to seek care at a hospital if you can avoid doing so.

### Urgent Care at Hospital Prices

A physician writing in *The New York Times* found this out the hard way.

Danielle Ofri's daughter was still limping a week after a bike accident. Ofri took her child to an urgent care center for ankle and wrist X-rays. She chose an urgent care center because they are usually good values. When care is needed in a hurry but the condition is not serious enough for an emergency room, urgent care centers are the place to go.

Then, Ofri got the bill.

"The radiology charge from NorthShore University HealthSystem for the ankle and wrist X-rays was $1,168, a price that seemed way out of range for something that usually costs around $100 for each X-ray," wrote Ofri. "When I examined the bill more closely, I saw that the radiology portion came not from the urgent care center but from a hospital, so we were billed for hospital-based X-rays. When I inquired about the bill, I was told that the center was hospital-affiliated and as such, is allowed to charge hospital prices."

### Outpatient Clinics = Moneymakers

Just as hospitals began buying physicians' offices so they could control the physician's pen and charge facility fees for physician visits, they also saw money to be made in urgent-care centers.

Let's say you sprain your ankle but don't really need treatment in an emergency room. You seek out a freestanding urgent care center, only to receive a bill that's three, five, or maybe 10 times what you expected because a hospital owns the facility and bills like you went to a hospital.

Did the hospital warn you ahead of time? Probably not. As crooked as this sounds, it's not illegal. Hospitals have enough lobbying clout that Congress won't stand up to them.

Ofri said she discovered the same billing practices happen when patients undergo outpatient procedures that are associated with a hospital, such as colonoscopies.

"One study of pricing revealed that HOPDs [hospital outpatient departments] charged an average of $1,383 for a colonoscopy, compared with the $625 average price at a doctor's office or other non-HOPD settings," wrote Ofri.

### Health Care Cartels Forming

As a doctor, Ofri knew she should avoid hospitals when seeking nonemergency care. However, she was unaware of hospital-affiliated urgent care centers that charge hospital prices. How is the average patient supposed to know that?

There is a policy debate about site-neutral payments, which would require Medicare to pay the same fee regardless of where a service is performed. Whether that would help non-Medicare patients avoid surprise medical bills is debatable.

Hospitals have been allowed to consolidate in recent years such that all major metropolitan areas are now dominated by several health care systems that function like cartels. They are buying physician practices and are now buying urgent care centers and other office-based facilities and raising prices.

Congress should require greater price transparency, to ensure patients are never caught off guard by faux hospital services. In years past, many states had laws banning the corporate practice of medicine, which is when corporations employ doctors to work on their behalf. It may be time to revisit that doctrine.

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

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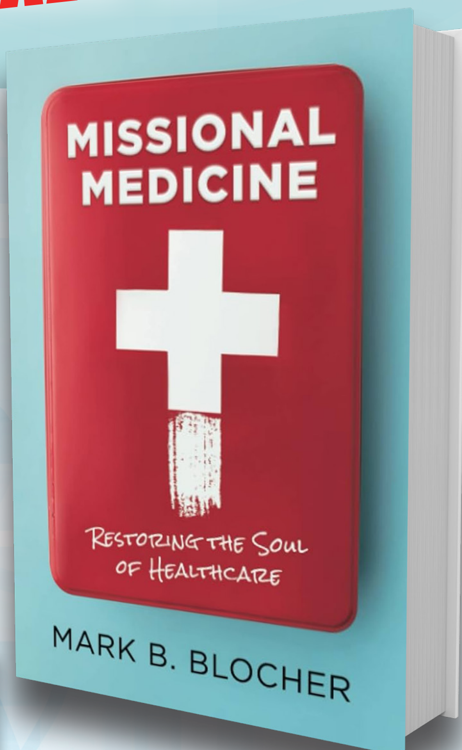

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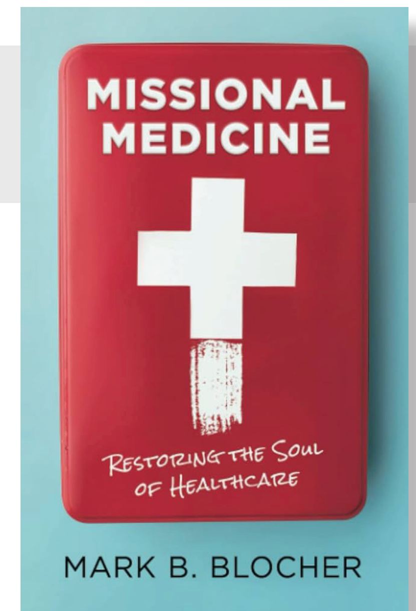
BOOK REVIEW

# Secularized Medicine Harms Doctors, Patients

By AnneMarie Schieber

*Review of* Missional Medicine: Restoring the Soul of Medicine, *Mark B. Blocher, M.D., 2022, 175 pages, ISBN 9781792383069, $20, amazon.com (Paperback)*




Imagine you are about to undergo a major surgical procedure, and your surgeon comes in and asks if you want to pray first or have a serious conversation about the state of your soul.

Today's patient would probably bolt out of the room. We expect physicians to perform miracles but forget that doctors are not the final arbiters of life and death. Having that discussion would not be out of line, but it rarely happens in today's hospitals and exam rooms, if ever. The most patients might get is "are your affairs in order?"

Such is the premise of *Missional Medicine—Restoring the Soul of Medicine*, Mark B. Blocher's insightful, commonsense, engaging, and must-read treatise on the state of modern medicine and how abstracted it has become from the genesis of health care.

The removal of the spiritual component from health care is behind much of what is dysfunctional in the system, Blocher argues: the insurance-payer morass, volumes of government regulation, physician and health care professional burnout, and the always escalating costs and wait times for care.

### Missional Medicine in Practice

Assembly-line medicine has no room for compassion, let alone prayer. When you ask health care professionals why they chose medicine as a career, or patients what they are really seeking from the health care system, it is more than a means to make money or relief from a physical ailment. Medical science forces everyone to think about fundamental questions: Why am I here? What is my purpose? Why do I suffer? Where am I going? It does not make sense that any discussion about God in the exam room is off-limits.

Blocher is a medical ethicist and cofounder of Christian Healthcare Centers (CHC), an amazing nonprofit direct primary care (DPC) practice that has revolutionized health care in Michigan. I can testify to this, having been a member of CHC since it first opened its doors in 2018. I have never seen my physician for less than 30 minutes. I can get medical attention within 24 hours, and my physician knows most things about my life because *he has time to talk to me*.

DPC works outside the third-party insurance system, and because of that it saves time and bundles of money by skipping insurance pre-authorization and processing of claims.

CHC charges less than $90 a month and offers discounted imaging, labs, and drugs. I can give countless examples of how CHC has made me a better medical consumer. For example, my doctor has given me $20 cortisone injections when most specialists wanted to march me straight to the surgical suite, uncertain my condition was chronic.

### Health Insurance Addiction

Health care has lost its soul, and Blocher places much blame on the public's addiction to health insurance. The author devotes an entire chapter to the harms of having "others" pay one's health care bills. One effect is the behind-closed-door deals insurers make with providers, which have more to do with driving up profits than taking care of people.

"Since Obamacare went into effect, many large hospital systems and insurance companies have seen their profits rise substantially, leaving little incentive to reform how we pay for healthcare," writes Blocher.

Even employer-provided insurance is not beyond reproach, since employees have little say in what their health plan covers. "Since employees bear an increasing amount of the health plan cost, why should anyone other than the employee decide what their health plan will be?" Blocher writes. "What other major purchase does the employer make on behalf of the employees? Does an employer decide what house an employee should buy, what car to purchase, or which college her children should attend?"

Blocher explains how employers or individuals can save money and get better care with insurance alternatives such as DPC, coupled with a health share ministry, for instance, which is not insurance but an example of an affordable option for individuals and families other than "the health plan."

### Decline of Ethics

A meaningful discussion on health care, however, must go beyond economics and examine the shocking ethical lapses taking place in our hospitals, which are under pressure to ration health care. Increasingly, they ration by death. As difficult as it is to believe, "death panels" exist, and readers will appreciate Blocher's learned perspective as a medical ethicist.

"We have witnessed the application of mostly secular ethics in healthcare long enough to see the inevitable clash of worldviews, especially conflicts between Christianity and secularism," writes Blocher. "In our mostly secular society, ethical relativism reigns."

A provider's worldview might mean the difference between life and death, Blocher argues.

Western medicine has always been grounded in Judeo-Christian "moral precepts," writes Blocher. "These are the moral pillars from which the 'do no harm" medical ethic flows, and it is this Judeo-Christian ethical formula that has contributed substantially to the development of the premiere healthcare system in the world."

### Role of Churches

Ultimately, churches must once again participate in health care, to "bear one another's burdens," Blocher concludes. If churches viewed health care as part of their mission, their members might be less inclined to depend on the government and health plans to pay the bills.

Blocher's book was published two years ago, but it was prescient and is possibly more relevant today. The author of *Missional Medicine* is on to something.

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

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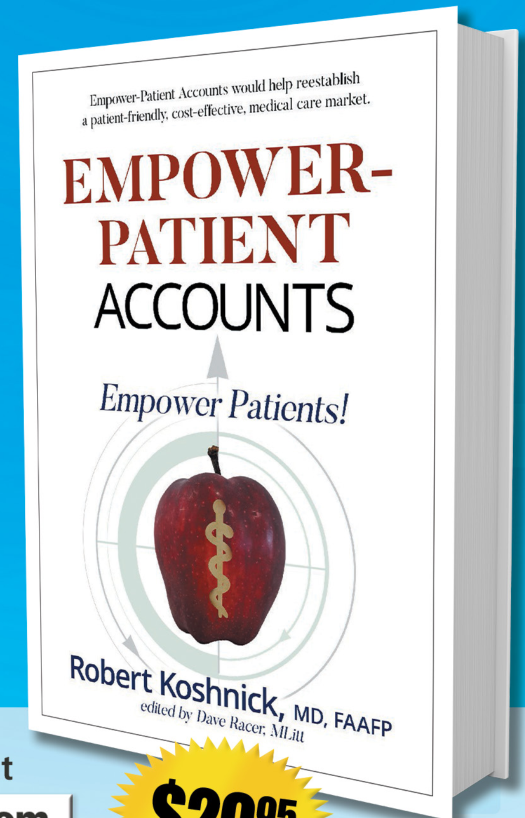


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# FDA Hid COVID Shot Side Effects: Congressional Report

By Bonner Russell Cohen

A congressional investigation has found evidence the Biden administration pressured drug regulators to cut corners in authorizing COVID-19 shots and boosters.

The Biden administration "pressured the Food and Drug Administration (FDA) to go beyond its regulatory authority to change its procedures, cut corners, and lower agency standards to approve the Pfizer COVID-19 vaccination and authorize boosters," states the U.S. House Judiciary Committee's Subcommittee on the Administrative State, Regulatory Reform, and Antitrust press release on the publication of its interim staff report, on June 24.

"This approval enabled the Biden administration to mandate the COVID-19 vaccine, despite concerns that the same vaccine was causing injury among otherwise healthy young Americans," the subcommittee states.

"The rush to approve the vaccine and mandate its use put otherwise healthy young people who have a virtually nonexistent risk of severe COVID-19 illness at risk, for little benefit. However, it is in stark contrast to what then-candidates Biden and Harris said in 2020 when they discouraged people from taking 'Trump's vaccines.'"

JOEL ZINBERG, M.D.
SENIOR FELLOW, COMPETITIVE ENTERPRISE INSTITUTE

### 'Politics Overruled Science'

"In August 2021, when the Pfizer shots received FDA licensure, and just before the booster received EUA [Emergency Use Authorization], FDA vaccine reviewers with decades of experience announced they were leaving the agency," said subcommittee Chairman Thomas Massie (R-KY), in a statement. "During the pandemic, politics overruled science at the government institutions entrusted with protecting public health."

The 29-page report, "Politics, Private Interests, and the Biden Administration's Deviation from Agency Regulations in the COVID-19 Pandemic," traces the FDA's approval process for COVID-19 vaccines and boosters from the last year of the Trump administration, 2020, through the Biden administration's implementation of its own policies in 2021-22.

Development of COVID-19 vaccines began in April 2020 under the Trump administration's Operation Warp Speed (OWS), which followed the FDA's standard EUA process.

### Emergency Factor

The report notes the FDA and manufacturers are supposed to monitor and communicate findings on effects related to the lower standard under an emergency declaration.

"The Biden administration, however, pivoted away from this important requirement and sought to ensure the EUA vaccine received full licensure as a way to support vaccine mandates," states the report. "While the vaccine approval process can be robust and lengthy, the Biden administration through Acting Commissioner Janet Woodcock sought to move on an arbitrary political timeline and pressed the FDA to ignore its regulations in the approval process.

"During this time," the report states, "the administration ignored or silenced voices that questioned the merits of universal vaccination and downplayed the serious injuries from the EUA vaccine," states the report.

### Dissent from Within

Subcommittee investigators also examined how the Centers for Disease Control and Prevention (CDC) characterized the efficacy of the vaccine, the FDA's active promotion of the vaccine in 2021 and 2022, and the CDC's conduct related to reporting on the safety and efficacy of the vaccine.

"The transcribed interviews and internal FDA documents revealed that, despite evidence of harms from the EUA vaccine, the Biden administration sought to fully approve the Pfizer vaccine through the Biologics Licensing Application (BLA) process," the report said. "The BLA approval occurred despite the objections of the FDA's experts in vaccine development who were concerned about risks for healthy young people caused by the Pfizer vaccine, particularly the risk of myocarditis."

Peter Marks, M.D., Ph.D., head of the FDA's Center for Biological Evaluation and Research, testified to the subcommittee that, in rushing approval of the Pfizer vaccine, "he was seeking to appease outsiders who wanted to have an approved vaccine that gave them 'more confidence' in a vaccine, even though it was the exact same vaccine already on the market under the EUA."

"Unless changes are made to improve the FDA's once-robust vaccine approval process," the report states, "future vaccines approved by the FDA may be met by an American public with increased skepticism and elevate the potential for higher vaccine hesitancy."

### Opened Pandora's Box

The report's findings were bolstered by pharmaceutical toxicologist Helmut Sterz, Ph.D., who served for eight years as CEO of global research and development at Pfizer's lab in Amboise, France. In a July 8 post on Substack by Peter McCullough, M.D., and John Leake, Leake recounted a recent conversation with Sterz.

"Dr. Sterz confirmed that Pfizer-BioNTech did not perform proper toxicology studies on its COVID-19 mRNA 'vaccine' prior to its injection into hundreds of millions of people," wrote Leake. "Those responsible for this undertaking created the Pharma Lab equivalent of a Pandora's Box that has released a host of sickness and death on mankind."

### Rush to Mandate

Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons, says she is not surprised by the report's findings.

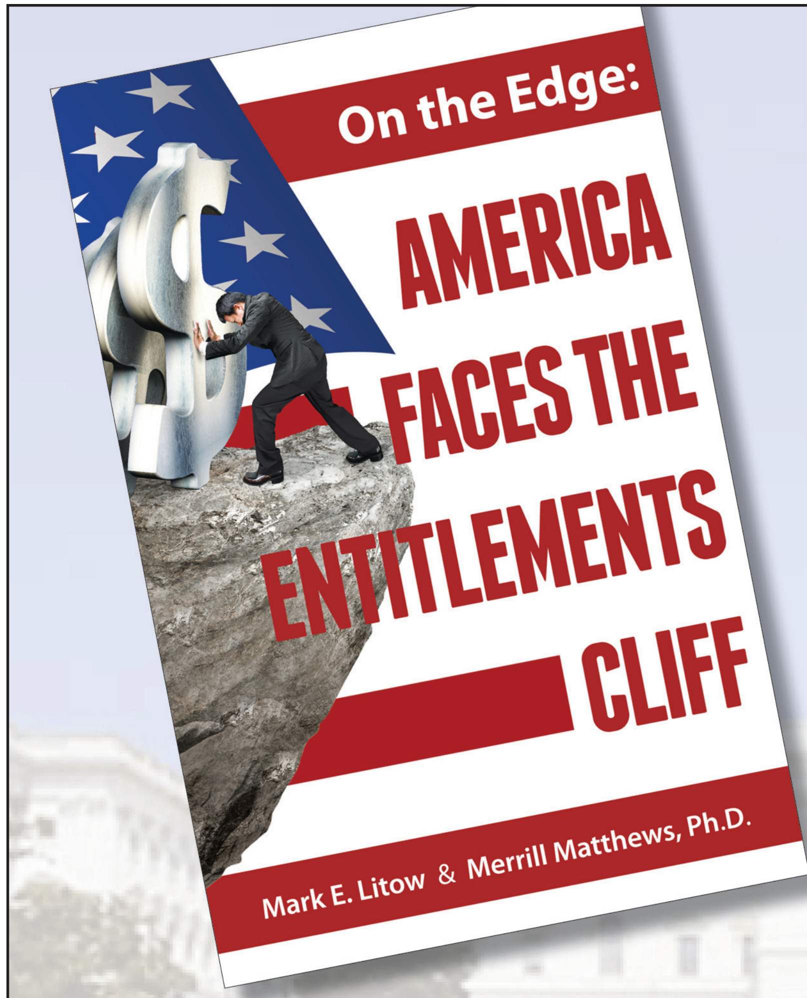
"The FDA's regulatory process was clearly short-circuited," said Orient. "Americans have cause to seriously distrust the agency. Many products, including [other] vaccines, have been pulled from the market because of serious adverse responses, while reports of thousands of adverse effects associated with COVID injections are downplayed or suppressed."

"The people in charge of the rushed approval, such as Janet Woodcock, were also responsible for suppressing early treatment with hydroxychloroquine, as shown in *AAPS v. FDA*," said Orient. "The FDA failed to note a change in the manufacturing process that introduced DNA contaminants, which remained in impermissible quantities. Long-term effects such as cancer, birth defects, and infertility cannot yet be known."

Joel Zinberg, M.D., a senior fellow at the Competitive Enterprise Institute and director of the Public Health and American Well-Being Initiative at the Paragon Health Institute, says the FDA's actions harmed the public's health.

"The rush to approve the vaccine and mandate its use put otherwise healthy young people who have a virtually nonexistent risk of severe COVID-19 illness at risk, for little benefit," said Zinberg. "However, it is in stark contrast to what then-candidates Biden and Harris said in 2020 when they discouraged people from taking 'Trump's vaccines.'"

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

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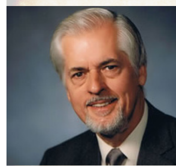

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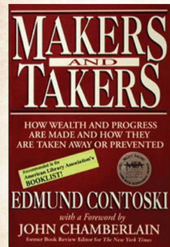


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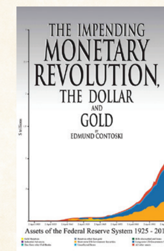


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