



May 7, 2022

Sen. Jim Abeler  
Sen. Paul Utke  
Sen. Michelle Benson  
Sen. Mark Koran  
Sen. John Hoffman

Rep. Tina Liebling  
Rep. Jennifer Schultz  
Rep. Aisha Gomez  
Rep. Dave Pinto  
Rep. Tony Albright

RE: Omnibus HHS Bill – SF 4410

Dear Chair Abeler, Chair Liebling, and Members of the HHS Conference Committee,

Citizens' Council for Health Freedom (CCHF) is a Minnesota-based, patient-centered, privacy-focused organization that supports patient and doctor freedom. We've been following several issues that will be discussed in the HHS Conference Committee, which begins on May 9, 2022.

I am writing to share our support for the provision on the **hospital construction moratorium**, although, as we've testified, we believe it should go much farther by eliminating the state's moratorium altogether.

I'm also writing to share **our concerns** with several sections in both the proposed Senate and House HHS omnibus bills, SF 4410. While there are many items in the bills that we could speak to, we believe the items highlighted in this letter will be the most detrimental to patient privacy rights and health freedom if passed into law—and thus we ask you to reject them.

## **Protect Privacy Rights — Reject Government Surveillance**

- **REQUEST: Reject HOUSE Nationwide Sharing of Patient-Identifiable Cancer Data** (*Article 2, Section 14, lines 122.18-123.8*)

The proposed changes to the Minnesota Cancer Surveillance System would eliminate the physician consent requirement for MDH contacts with cancer patients or their family members for research purposes. The bill would also permit sharing of MN cancer patients' personally identifiable data nationwide. Because of our privacy laws, Minnesota cancer patients are the only cancer patients protected from this national cancer registry and it should stay that way.

Supporters of the legislation claim Minnesota will lose federal funding for cancer research if we do not join the national database. However, the requirements for funding cited in the MDH summary of HF 3871 (the original bill) say that Minnesota is only required to have its own state cancer registry, not that it must share patient data with other states, to receive funding. Thus, Minnesota has long received federal funding.

If the proposed changes pass, personally identifiable information will be shared without the patient's consent to other states. Once their data has been placed into a nationwide cancer registry, Minnesota cancer patients become ongoing research subjects – whether they wish to or not. There is no indication in the language as to how long data may be retained, making cancer patients potentially life-long participants in studies they never consented to be part of.

- **REQUEST: Reject HOUSE Long Covid Surveillance Program** (*Article 1, Section 33, lines 47.1-48.7*)

This HOUSE language will fund a new government registry to track individuals with long Covid, which is defined in the bill as symptoms lasting longer than four weeks post infection. MDH would partner with health care professionals and community members – including schools and employers – to identify those with long Covid and determine methods to monitor them. These individuals would become part of a statewide medical study whether they want to or not.

If people wish to participate in a study on long Covid, it should be their choice. Those with lingering struggles from the virus should not be used to justify government surveillance. They should not be automatically placed into a government research project just because they have a disease of interest. Nor should physicians be required to report their patient's illness and treatment without the patient's explicit consent.

- **REQUEST: Reject HOUSE Health Disparities “Surveillance and Tracking Plan”** (*Article 12, Section 44, lines 58.20 – 58-22.*)

To our knowledge, this would be a new surveillance system established by MDH. While it may begin for people with disabilities, we believe it would expand to cover the other groups often mentioned in documents related to “health equity” such as race, ethnicity, sex, gender identity, comorbidity, and ability. It will be used to advance one-size-fits-all socialized medicine.

The divisive “health equity” initiative: 1) claims that the health care system is treating certain people poorly because of their group status; and 2) is being used to drive America's health care system toward restrictive one-size-fits-all treatment protocols. Despite unique patient needs, doctors will use these protocols for all patients to avoid being charged with civil rights violations. As the *AMA Journal of Ethics* makes clear, “to achieve health equity, governments can use a variety of tools, including civil rights legislation and constitutional jurisprudence.”

## **Protect Rights of Parents with Newborns**

- **REQUEST: Reject HOUSE Funding for Newborn Screening House Visits—or Require Written and Verbal Tennessee Warning, Opt-Out Notice and Consent Process** (*Article 3, Section 39, Paragraph (i), lines 234.17-234.*)

If this section becomes law, it will fund “metabolic disorder testing” (newborn genetic screening) for medical assistance families and who opt to have their child outside a hospital.

Newborn (genetic) screening by the government has been a contentious issue as the law attempts to reconcile providing important screening for unseen issues while also respecting the privacy and DNA property rights of the child. The proposed language does not include a requirement for: 1) a Tennessean Warning, 2) parent consent before a home visit is attempted; 3) fully informing the parents that Minnesota law allows them to opt-out of newborn screening; or 4) notifying the parents that the left-over DNA, in the form of dried blood spots, is retained indefinitely by the Minnesota Department of Health, unless a parent specifically requests that their child’s DNA be destroyed.

- **REQUEST: Reject Universal Home Visiting Program and require Tennessean Warning for All Current Home Visiting** (*Article 1, Section 37, lines 49.28-51.17*)

The language in this section would expand government home visiting (and its vast array of data collection) to every family in the state that has or is expecting an infant. Currently the program is not universal, applying only to families that fall in a certain economic status. Although this program is voluntary, there is no specification as to how parents will be informed that they can decline. If a public health visitor arrives unannounced to a home, it makes it difficult for parents to decline the visit, but they should be given every opportunity to do so – before the visit.

Line 51.1 states that at a minimum the home visiting services must “include an assessment of the physical, social, and emotional factors affecting the family and provide information and referrals to address each family's identified needs.” Parents may not understand that public health workers (government) will be collecting data on their family and their home.

## **Support Physician-Based Care for Patients**

- **REQUEST: Reject SENATE Expanded Scope of Practice for Pharmacists** (*Article 14, Section 22, lines 411.13-414.13*)

This section expands the scope of practice for pharmacists, allowing them to take specimens for lab tests, interpret test results, refer patients for treatment, initiate, modify, and discontinue drug therapy. In short, it appears to move pharmacists from dispensers to prescribers.

Expanding scope of practice puts patient safety at risk. Pharmacists typically receive four to eight years of pharmaceutical education compared with at least 11 years of medical training for the average physician. This vast difference in education and experience is vitally important when it comes to making decisions such as diagnoses and treatment plans.

Many people see scope of practice expansion as the answer to staffing shortages in hospitals and clinics, however, this approach is not a sustainable or even a good solution. Staffing

shortages are largely happening because the regulations, mandates, and bureaucracy within health care is making the practice of medicine difficult and disheartening. Expanding scope of practice does not solve these underlying issues or bring patients any closer to the medical management they need.

## Reject Proposals that Make Government Bigger

### REQUESTS:

- **Reject HOUSE Balance Billing sections** (*Article 1, Section 1-4, lines 4.4 – 9.13*).
- **Reject HOUSE Health Care Affordability Board** (*Article 3, Section 1, lines 177.1 – 188.30*)
- **Reject HOUSE Expanded Use of All-Payer-Claims Database** (*Art. 1, Sec. 7-8, lines 11.8 - 12.31*)
- **Reject SENATE Establishment a New Department of Behavioral Health** (*Article 7, Section 5, lines 168.15-168.25 pf SF 4410*).

Growing government in health care means higher taxes, higher prices, less money to pay for higher costs and premiums, greater intrusion and outside control over medical decisions, more regulations, and less reasons for doctors to stay in practice. Therefore, we ask you to reject the four provisions listed above. Related to balanced billing, this is a price control provision. Price controls always lead to shortages. There are already **six lawsuits** against the “No Surprises Act”: <https://www.healthaffairs.org/doi/10.1377/forefront.20220216.824139/> (Feb 2022).

**Regarding the proposed new Department of Behavioral Health:** although supporters say the new department will not cost more than the current agency, we don’t believe this is possible. A new department will mean a new Commissioner and staff, higher taxpayer costs, more programs—and greater data collection on very sensitive issues. The newly created Department of Behavioral Health is responsible for mental health services, chemical dependency services, and “behavioral health quality, behavioral health analysis, behavioral health economics, and related data collection initiatives under chapters 62J, 62U, and 144.” (*lines 168.23 – 168.24*)

We appreciate the deliberation of this committee and ask you to work to limit the size (and power) of government and to protect patient privacy and patient consent rights.

Sincerely,



Twila Brase, RN, PHN  
President and Co-founder