HB624 Proponent Testimony

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Representing Equal Protection for Posterity

House State and Local Government Committee

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Chairman Wiggam, Vice-Chair Stephens, Ranking Member Kelly, and Members of the House State and Local Government Committee,

Thank you so much for this opportunity to provide written testimony regarding HB624. In my role as a citizen activist, I am the Ohio Chairperson for Equal Protection for Posterity. However, my full-time position and career is as an infectious disease epidemiologist. I have a tenured faculty position at a well-respected university in Ohio, have studied infectious diseases since 2000, and I have a PhD in epidemiology. I teach an undergraduate course in epidemiology. My views are my own. I hope you will find this expertise valuable in my written testimony.

I am a **proponent of HB624** because the response to COVID-19 has been driven by flawed models and inaccurate data reporting, and perhaps if the legislature and public had the details of the models and accurate data at their disposal, this state may have avoided the economic and psychosocial hardships that have ensued in the response to this "pandemic". Both of these areas have been detailed by a recent white paper released by Health Freedom Ohio[1], which I helped prepare.

First, I would like to elaborate a bit about the models used to drive policy. Besides the fact that the assumptions were flawed and potentially based on little if any actual data, there are other important concerns. One concern, which is specifically addressed by HB624, is that the details of these models were cloaked in secrecy. I was only able to obtain them through other people

[1] https://healthfreedomohio.org/News-Views/8962174?fbclid=IwAR1AvhIrOwHEWjy_nObbRGedr2b3-XSFmDby5-kHUzM0hOJBaF44yVihQ7s

combing through the internet. By contrast, the models produced by the University of Washington (IHME) were published on medRxiv and was continually updated based on actual data. The online seminar that presented the Ohio State model showed a variety of different projections, but only the most dire was presented by Dr. Acton in the press conferences. This is important because the speaker actually said it was "too early to tell" how the epidemic would unfold, and yet, dire projections of "10,000 cases per day" were announced by Dr. Acton, and the actual numbers didn't come remotely close to that. A second concern is that there were other mysterious aspects to these models as well. The paper describing the model claimed that parameter estimates for the model, specifically regarding projecting hospital bed usage, cannot be shown because hospital bed numbers are considered a "trade secret" according to the Ohio Revised Code. This seems strange, considering a simple internet search reveals a cleveland.com article with the number of beds in the state of Ohio, and moreover, the IHME model explicitly modeled anticipated hospital bed usage. These are just two aspects that could have been identified if the public had general access to these papers. Additional critique of these models are provided in the Health Freedom Ohio white paper.

Second, the ODH has only presented cumulative numbers of cases, hospitalizations, and deaths. This makes the outbreak seem worse and worse, when we could in fact be on the "other side of the curve". If the new cases per day, hospitalizations per day, and deaths per day are actually declining, this is a good thing, and this is the parameter that infectious disease physicians are actually looking for. Information about length of hospital stay is important to understand the true severity of the disease. If relatively few cases are hospitalized, and if many have a short hospital stay, that is not reflective of a significant burden on the health care system. A major issue in these reports has been the inclusion of "presumptive cases" in the total case count. While the public is told that all cases of COVID-19 cannot be confirmed because of lack of available tests, it is also not fair to include these cases among the counts, because that could lead to inflated estimates of the public health burden. To be transparent, they should be clearly tabulated separately. It is also well-established that the CDC guidance has explicitly stated that reporting cause of death due to COVID-19 includes cases "with" the infection, not "of" the infection. However, there are many instances of death certificates citing COVID-19 as cause of death, when not only was the infection not confirmed, the individual may have died of an

accident and was totally healthy otherwise. We are aware of an instance of a child dying in an accident with farm equipment, but it deemed a "COVID-19 death" because the child was home from school! This has been happening in many states, not just Ohio. Again, given the importance of fatality statistics in understanding the true public health burden of disease, accurate reporting is essential.

The data displayed on the COVID-19 website maintained by the ODH has been inaccurate, inconsistent, and confusing. Even Dr. Acton's reports in press conferences do not match what can be delineated from the online database, and members of the media have caught these issues.

A paper by an internationally renowned epidemiologist recently elaborated on all the implications of poor data reporting regarding COVID-19 [2]. It closes by saying, "Unpredictable evolutions may ensue**, including financial crisis, unrest, civil strife, war, and a meltdown of the social fabric**. At a minimum, we need unbiased prevalence and incidence data for the evolving infectious load to guide decision-making." (emphasis mine.) This is why HB624 is such an important bill and why I urge you to vote in support of it. I encourage you to read the Health Freedom Ohio white paper (endnote [1]) for further elaboration on the issues with the models, data, and other aspects of the response to COVID-19 in Ohio.

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[2] https://www.statnews.com/2020/03/17/a-fiasco-in-the-making-as-the-coronavirus-pandemic-takes-hold-we-are-making-decisions-without-reliable-data/