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UFCW LOCAL 1994
Municipal & County Government Employees Organization

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Testimony of Gino Renne, President of UFCW Local 1994 MCGEO on SB431 – Home of the Brave Act (Long Covid Occupational Disease Workers' Compensation Presumption)

My name is Gino Renne, President of UFCW Local 1994 MCGEO and I am here today representing the members of UFCW Local 1994 MCGEO. I am speaking in support of SB 431, also known as the HOME OF THE BRAVE ACT, which establishes a Long COVID workers' compensation presumption for essential workers in our state.

During the unprecedented COVID-19 pandemic, Governor Hogan rightly declared a "State of Emergency" from March 2020, through July 2021. Throughout this period, a significant number of Local 1994's members were deemed essential. They heroically reported to work despite the heightened risk of infection and related conditions.

These workers spanned various sectors. Our members in public safety and public health and social services, transit operations, and park services reported to work as necessary and ensured the continuity of critical government operations for well over a year. They showed unprecedented dedication to the citizens of Montgomery and Prince Georges' Counties and to the City of Cumberland and to the government agencies employing them. Unfortunately, some of them did not survive. We lost quite a few to this dreadful disease. Others, like our member Kenneth Jenkins who is here to testify today, have to deal with the aftermath of having Long Covid.

SB 431 recognizes the occupational risks faced by these essential workers by establishing a Long COVID workers' compensation presumption. This is crucial legislation that acknowledges how workers who contract COVID-19 on the job may also face other risks like the risk of experiencing prolonged symptoms that impact their ability to work and lead fulfilling lives.

Long COVID presents a myriad of devastating symptoms that persist for months to years after the acute phase of COVID-19 has resolved. From respiratory and heart disorders to neurological and digestive issues, the list of chronic illnesses and conditions linked to Long COVID is extensive and severe. Moreover, affected individuals, including those in the workforce, may experience prolonged periods of disability or reduced productivity, posing significant challenges to their livelihoods.

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SB 431 is not just about recognizing the plight of affected workers; it is about providing them with the support and assistance they urgently need. By establishing a workers' compensation presumption for Long COVID, this bill ensures affected individuals have access to medical treatment, wage replacement, and vocational rehabilitation if necessary. It removes barriers that workers might otherwise face in accessing benefits and proving the connection between their illness and work-related exposure to COVID-19.

Furthermore, SB 431 incentivizes employers to prioritize workplace safety measures and adhere to public health guidelines to mitigate the risk of COVID-19 transmission. By promoting safe working environments, we can prevent future cases of COVID-19 and reduce the prevalence of Long COVID among workers, thereby safeguarding public health and ensuring the well-being of our workforce.

I urge you to support SB 431 and take decisive action to protect the essential workers who selflessly served our communities throughout the pandemic. By prioritizing the health and well-being of workers, we can create safer workplaces, promote economic stability, and ensure that individuals with Long COVID receive the care and assistance they need to recover and return to work.

2024 SB 431 -Workers Compensation-Occupational Dis

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TREASURER

March 4, 2024

SB 431 - Workers' Compensation -Occupational Disease Presumption- Long COVID (Home of the Brave Act of 2024)

Dear Chairman Smith and Distinguished Members of the Judicial Proceedings Committee,

The Maryland State Fraternal Order of Police **SUPPORTS** Senate Bill 431 - **Workers' Compensation - Occupational Disease Presumption- Long COVID (Home of the Brave Act of 2024).**

Public Safety Personnel were placed in harm's way daily during the worldwide COVID-19 pandemic. While many citizens remained secure in their houses and were able to work remotely or have their workplaces completely shut down, Public Safety Personnel came to work and risked their lives taking calls for service and regularly interacting with the public during critical incidents and necessary interactions and calls for service. As a result, many members of Public Safety agencies contracted COVID-19 because of their workplace contacts. The result for our Public Safety Community was that many members paid the ultimate sacrifice and died because of this terrible disease, and many did recover; However, there have also been those that are still suffering from the long-term side effects which have become known as "Long COVID". **SB 431**, if passed, will recognize, and create a presumption for Long COVID as a workplace exposure, for those brave men and women that now suffer from the disease.

SB 431 defines the "Governmental Essential Worker", which includes Public Safety Personnel, and further defines COVID-19 and Long COVID. **SB431** then establishes that the "Governmental Essential Worker is presumed to be suffering from an occupational disease that was suffered in the course of employment and is compensable" under the Worker's Compensation Statutes of Maryland if the member was diagnosed with COVID-19 on or after March 5, 2020, but before July 1, 2021. **SB 431** further mandates that the diagnoses of COVID-19 must be within 14 days after a day that the member was at work and performing labor or services and not at their residence. The diagnosis made or test performed as well as the subsequent diagnosis of Long COVID must be by a person authorized, licensed, or certified to do so under the Health Occupations Article. **SB431** also makes this presumption rebuttable with substantial evidence that the disease was contracted outside of the workplace.

SB 431 would have a limited set of members that would be eligible for this presumption. This would go a long way to show those that sacrificed their health for the safety and wellbeing of others during the height of the COVID-19 pandemic that their Government appreciates their service and commitment and desires to properly compensate them for the costs that they will incur due to contracting Long COVID.

On behalf of the more than 20,000 Courageous Men and Women of the Maryland Fraternal Order of Police we thank you for your support and ask for your **FAVORABLE** vote on **Workers' Compensation - Occupational Disease Presumption- Long COVID (Home of the Brave Act of 2024).**

Angelo L. Consoli Jr,
2nd Vice President, FOP, Maryland State Lodge
President, FOP Lodge 89, Prince George's County

3.4.2024 MSEA Senate Bill 431 Testimony_FAV.pdf

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FAVORABLE
Senate Bill 431
Workers' Compensation – Occupational Disease Presumption – Long Covid
(Home of the Brave Act of 2024)

Senate Finance Committee
March 5, 2024

Christian Gobel
Government Relations

The Maryland State Education Association supports Senate Bill 431. Senate Bill 431 provides that a governmental essential worker is presumed to be suffering from a compensable occupational disease that was suffered in the course of employment if: i) the individual tested positive for Covid 19 within a specified timeframe after the individual performed labor or services at the individual's primary workplace or another assigned workplace; ii) the test was performed or the diagnosis was made by a licensed or certified health care practitioner; and iii) the individual has subsequently been diagnosed with long covid by a licensed or certified health care practitioner.

MSEA represents 75,000 educators and school employees who work in Maryland's public schools, teaching and preparing our almost 900,000 students so they can pursue their dreams. MSEA also represents 39 local affiliates in every county across the state of Maryland, and our parent affiliate is the 3 million-member National Education Association (NEA).

Individuals suffering from long covid may experience a range of health symptoms including fatigue, fever, respiratory and heart symptoms, neurological symptoms, digestive symptoms that can last weeks, months, or years.[1] Essential government workers who risked their health and safety for the public during the height of the Covid-19 pandemic and now have health related issues from long covid should be eligible for compensable claims under workers' compensation.

We urge the committee to issue a Favorable Report on Senate Bill 431.

[1] Centers for Disease Control and Prevention, *Long COVID or Post-COVID Conditions*, https://www.cdc.gov/coronavirus/2019-ncov/long-term-effects/index.html#:~:text=People%20with%20Long%20COVID%20can,can%20sometimes%20result%20in%20disability. (last updated July 20, 2023).

MacAlister Article from Trial Reporter Special 202

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Position: FAV

A Medical View of COVID-19 and Workers' Compensation

By James K. MacAlister and Atiq Rahman, MD

"May you live in interesting times," an age-worn axiom forewarns. During the preceding year of 2020, a global pandemic made its way to the United States, infecting millions of Americans. This virus, COVID-19, quickly overwhelmed hospital emergency rooms/ intensive care units with highly contagious patients gasping for breath – in addition to other life-threatening symptoms. Worse still, it has claimed the lives of over 400,000, and the daily death counts at the time of this writing are on the uptick. Not since the Spanish Influenza of 1918-1919, which killed more people than the total number of soldiers who perished in World War I, has the nation had to cope with such a virulent, lethal virus.

Among the victims of the pandemic are workers who attribute their COVID-19 infection to an occupational exposure. Common sense suggests that, if someone gets sick at work, the illness and the financial consequences of that illness should be covered by Maryland Workers' Compensation. Proving the axiom that the only "common" aspect of "common sense" is that it is "uncommon," the legal and evidentiary hurdles COVID claimants must clear are substantial.

COVID-19 spreads by people-to-people contact. The contagion is exhaled, coughed, and sneezed, wherever and whenever it is "shed" (quits) the body of a "host" (infected person). The contagion remains there, aerosolized or on contact surfaces, until it in can find a new host (infect). Notably, nothing in this process is unique to the workplace. Given that claimants have the burden of proving compensability, it is vital that COVID Claimants' counsel understand the legal and factual issues associated with meeting this burden of proof.

In this article, we will analyze the legal issues of whether/when a workplace infection is a cognizable occupational disease and/or accidental injury, and strategies to assist with meeting the burden linking infection to the workplace. Then we will turn to the medical issues, offering insight into the types of information experts rely upon when called upon to attribute where and when a patient contracted the virus. To assist practitioner screening potential COVID claims[1] we will suggest areas of inquiries counsel should explore during initial consultations with would-be COVID claimants.

Compensability: Different Roads, Same Destination?

Understanding how and why viral infection can be both an "occupational disease" and "accidental injury" claim requires a brief history lesson.[2] When first adopted, Maryland's Workers' Compensation Act covered only accidental injuries. During the ensuing years, the Court of Appeals of Maryland recognized that, under certain circumstances, an employee sickened as a result of workplace exposure to a contagion suffered a compensable "accidental injury."

A 1939 amendment entitled employees disabled or killed by specific enumerated occupational diseases to compensation "as if such disablement or death were an injury by accident."[3] In the early 1950's, the General Assembly repealed the list of enumerated ailments as a path to accidental injury, replacing it with a stand-alone compensable claim, titled "occupational disease." The effect of this change was to expand coverage to include unspecified ailments, but to limit the scope of compensability by requiring an "occupational" qualifier.

Though the Maryland General Assembly expressly decided to cover occupational diseases, there is no suggestion that this legislation repealed or limited the accidental injury/contamination caselaw that preceded its adoption. As a result, COVID-19 infection is not only a likely "occupational disease," but it may be an "accidental injury" as well.

1 Also contributing to this article is John Keskula, a retired workers' compensation insurance supervisor with decades of experience adjusting these claims.

2 Maryland Workers' compensation encompasses two main categories of compensable events: accidental injury and occupational disease." Montgomery Cty. v. Cochran, 471 Md. 186 (2020).

3 Polomski v. Mayor & City Council of Baltimore, 344 Md. 70, 77-78 (1996)

Occupational Disease: Importance of "Post-If" Occupational Nexus

The Act covers employees diagnosed with an "occupational disease,"[4] an ailment "contracted" by a worker: **(1)** as the result of and in the course of employment; and **(2)** that causes the covered employee to become temporarily or permanently, partially or totally incapacitated."[5] Compensability of an "occupational disease" that meets this definition, must "cause death or disability," only "IF" - and it is this statutory mandate referred to herein as the "post-if" occupational nexus - the alleged disease:

> (i) is due to the nature of an employment in which hazards of the occupational disease exist and the covered employee was employed before the date of disablement; or
> (ii) has manifestations that are consistent with those known to result from exposure to a biological, chemical, or physical agent that is attributable to the type of employment in which the covered employee was employed before the date of disablement; and
> (iii) on the weight of the evidence, it reasonably may be concluded that the occupational disease was incurred as a result of the employment of the covered employee.

Over the years, much appellate ink has been spilled defining precisely when an employee's job duties are sufficiently rigorous to establish the requisite causal linkage between employment and ailment.[6] The following discussion appears in a 1994 decision, *Davis v. Dynacorp*:

> *"Simply because a disease falls within § 9-101(g)'s definition of occupational disease, however, does not mean it is compensable. Section 9-101(g) must be read in conjunction with § 9-502(d), which limits an employer's and insurer's liability to those cases where the occupational disease that causes the disablement is either "due to the nature of an employment in which hazards of the occupational disease exist" or the disease "has manifestations that are consistent with those known to result from exposure to a biological, chemical, or physical agent that is attributable to the [employee's] type of employment."*[7]

In dictum, worthy of note, the opinion says "it should be borne in mind that the Act is designed to provide compensation to workers injured by the *effects of industry*," and therefore, "the definition of occupational disease should not be read too loosely… while a claimant might prove that a common cold was contracted in the workplace and that lost time resulted, compensation for that occurrence would far exceed the scope of remedy contemplated by the General Assembly."[8]

Davis did not involve "a common cold" or an "uncommon" lethal influenza virus, so it is difficult to know what to make of this dictum, standing alone.

Balt. Cty. v. Quinlan,[9] a 2019 decision, may hold the answer. There, an EMT claimed an occupational disease related to overuse of his knees, as he knelt and lifted patients in the course of his employment. Summarizing out-of-state authority, then deeming it "consistent" with Maryland law, the Court explains that, for a disease to be "occupational" – rendering it "post-if" compensable - there must be evidence that the "employment exposed him to greater risk than the public generally."[10] Dismissing the County's claim that Quinlan was required to point to rigors "unique" to his personal duties, the Court reasoned:

> *"The County, too, points to the commonality of knee injuries among other professions as disqualifying here. Assuming, without deciding, that such a characterization is accurate, 'uniqueness' is not a required element of LE § 9-502(d)(1)—being within the "nature" of the employment is the precise statutory language. See also Victory Sparkler, 147 Md. at 379 (occupational disease must have 'its origin in the inherent nature or mode of work of the profession or industry, and it is the usual result or concomitant)'. As Judge Andrea Leahy wrote for the court below, 'the Act*

4 *Davis v. Dynacorp*, 336 Md. 226, 235-236 (1994) (explaining legislative history).

5 Md. Lab. & Empl. Art. §9-101(g).

6 *Balt. Cty. v. Quinlan*, 466 Md. 1 (2019) summarizes "post-if" occupational nexus caselaw

7 336 Md. 226, 235-236 (1994)

8 336 Md. at 235-36 (emphasis original). In light of this restrictive standard, a computer operator's "mental stress," owing to bullying by co-workers, though a cognizable "disease," failed to satisfy the statutory "post-if" occupational/causal nexus required by Section 9-502, because alleged injurious forces (hazing) bore no relationship to the demands of the data entry work he had been commissioned by the employer to perform.

9 466 Md. 1 (2019).

10 *Harvey v. Raleigh Police Dep't*, 85 N.C. App. 540, 355 S.E.2d 147, 150 (N.C. Ct. App. 1987)

does not limit occupational diseases to rare diseases or those exclusive to a specific profession.'"[11]

In light of these cases, how does one prove "post-if" nexus between working and contracting COVID-19? *Quinlan* requires proof that, by virtue of having to do his or her job, a claimant was exposed to a greater physical demands/ risk of infection than the public at large. With this in mind, COVID-19 claimants, assuming they can prove workplace infection, were undeniably sickened because they left the safety of their home and went to work. For many types of work, "phoning it in" is not an option. Grocery store cashiers and those stocking shelves cannot work remotely. Accordingly, those who contracted the virus because they showed up for work establish an occupational "post-if" nexus between their vocation and risk of infection that is undeniably greater than the stay-at-home general public.

For certain classes of workers, the risk of occupation exposure is considerably higher than it is for other classes of employees who must report for work. Public safety employees, such as police officers, fire fighters and correctional officers, for example, cannot socially distance, because their work requires otherwise. The same argument can be made for teachers and childcare workers, whose duties necessitate close personal interactions.

Analysis of "post-if" occupational versus general risk must also consider the degree of danger associated with occupational exposure to COVID-19, when contrasted with the risk of catching the common cold at work. Few, if any, public or private institutions enforce demanding protocols to prevent workers from catching colds, so, workers and their counterparts in the general public are exposed to an equal degree to the likelihood of infection. In contrast, given the catastrophic risks of medical complications and death associated with contracting COVID-19, public and private institutions have instituted rigorous preventative measures, including social distancing, mask mandates, contact tracing, and lockdowns. Employers' adoption of these safeguards is a recognition that workers who have to go to work are exposed to a higher demand or risk of harm than are their counterparts who can work remotely. Additionally, because employers are uniquely empowered to implement and enforce COVID-19 "best practices" safety protocols, an expansive reading of "post-if" occupational nexus will incentivize them to adopt these protective measures - if for no other reason that than to rebut any suggestion that any of its employees could have been infected at work.

11 466 Md. at 17

Accidental Injury

The Act states "an accidental injury that arises out of and in the course of employment… or… a disease or infection that naturally results from an accidental injury that arises out of and in the course of employment, including: (i) an occupational disease; and (ii) frostbite or sunstroke caused by a weather condition."[12]

Not long after Maryland first adopted workers' compensation, the Court of Appeals ruled that being sickened by a workplace exposure constituted an "accident," without proof that the "bacillus" or toxic agent entered the body as a result of trauma.[13] Construing the term accidental to mean "unusual," the claimant was required to point to actions by the employer that resulted in a hazard that was different than the perils of a given line of work.[14] For example, if an employer imported well water that contained typhoid, then the claim of a sickened worker compassable; the opposite would be true if the plant was connected to the same city water available to the general public.[15]

Notably, in *Montgomery v. Athey*, a 1962 decision, the Court of Appeals found that a police officer could state a claim for accidental injury, provided he was able to prove that he contracted tuberculosis due to exposure to infected persons.[16] This holding, coming two decades after Maryland adopted statutory coverage for occupational diseases, signals that COVID-19 patients can still make accidental injury claims.

The Court of Appeals in *Harris v. Bd. of Educ*,[17] held that the legislative use of adjective "accidental," did not require proof of an "accident" – a slip, twist or fall. Post-Harris, the mere happening of an injury, unless it was expected or intended by the claimant, constituted a compensable "accidental injury."[18]

Regarding the application of this standard to workers sickened on the job, recall that, prior to the adopting of coverage for occupational diseases, on the job contamination/infection was only deemed an accidental injury if there was proof of an "unusual" risk, owing to the employer having created a danger that is not associated with doing that type of work. *Harris* references

12 Md. Lab. & Empl. Art. §9-101(b).

13 Victory Sparkler & Specialty Co. v. Francks, 147 Md. 368, 380 (1025).

14 147 Md 379-80

15 Union Mining Co. v. Blank, 181 Md. 62, 78-79 (1942).

16 227 Md. 312, 314 (1962).

17 375 Md. 21 (2003)

18 375 Md. at 53.

these cases, noting that contamination and infection are no less injurious physical injuries. Then, in the last sentence of the opinion, *Harris* expressly overrules three prior cases and "similar holdings."

Given that *Harris* removes the term "unusual" from accidental injury analysis, it appears COVID-19 claimants need only prove an "accidental" infection, one that was neither expected nor intended by the claimant. In other words, absent proof that the claimant wanted to get sick, viral infection traceable of a workplace exposure should be sufficient to prove a compensable accidental injury.

Proof: Expert Required?

Proving that a worker has tested positive for COVID-19 simple: the test result speaks for itself. Whether the virus was contracted at work poses a greater challenge.

"When a complicated issue of medical causation arises, expert testimony is almost always required." [19] Because "a physician need not be a specialist in order to be competent to testify on medical matters,"[20] the easiest way to meet this burden is to secure the opinion from one of the treating health care providers – even though he or she does not treat infectious diseases on a regular basis.

Can a claimant meet the burden of proof without an expert? The answer to this question begins with the rules of evidence that govern Commission hearings. A "commissioner may admit evidence that reasonable and prudent individuals commonly accept in the conduct of their affairs, and give probative effect to that evidence."[21] Next, Maryland's judiciary recognizes that an expert's opinion is not required if when there is "an obvious cause-and-effect relationship that is within the common knowledge of laymen."[22] *S.B Thomas v. Thomas*, involved an argument by the defense that it should be allowed to admit proof of a prior injury, to question the extent to which a workers' compensation claimant's accidental injury was in fact related to the earlier injury.[23] This was deemed a complicated medical issue, requiring an expert, because the linkage, if any, between the residual effects of trauma to a body part and a reinjury to that same body part is one lay people are unlikely to understand – without an explanation from a medical expert.

Applying this standard to COVID-19 infection, it is unclear whether determining the probable infection site, where a claimant "got sick," requires an expert to explain what happened. My co-authors outline sources of this evidence below, infected co-workers/uninfected family members; the availability of protective equipment and its adequacy; CDC protocols that define exposure, to name a few. None of these factual issues require an expert to explain how exposure to a highly contagious virus at work, and the absence of similar exposure at home, support a probable workplace infection.

But there is *Montgomery v. Athey*,[24] the previously alluded-to decision that holds that mere exposure to people infected with tuberculosis fails to meet the burden of proving a police officer contract the ailment at work. *Montgomery* can be distinguished because there was no evidence that mere exposure to tuberculosis can infect. In contrast, CDC guidelines establish state that anyone who come "into close" contact with someone who has the virus should quarantine.[25] For those claimants who can demonstrate they were in "close contact" with someone infected, shouldn't a commissioner accept that as sufficiently linking infection to the workplace, without an expert? Such a finding would not only meet the Commission's relaxed evidentiary rules, but it would effectuate the command that the workers' compensation laws be interpreted to protect the workers from the consequences of workplace hazards.[26]

Virology 101: COVID-19 - An Influenza Virus on Steroids

A virus, unlike a germ, is not a living organism, but, in the realm of infectious medicine, it functions in a similar manner. It requires a host, a body where it can "set up shop." Inside that body, it attaches itself to a cell and breaches the cell's outer wall. There, the virus highjacks the cell's DNA, and turns it into a factory that replicates copies of the virus. These newly-minted viruses infect other cells, causing each of them to replicate even more copies of the virus, which, in turn infect more cells.

Cells, once commandeered, may no longer perform the function the host's body requires of them, and, in some

19 *Giant Food, Inc. v. Booker*, 152 Md. App. 166, 178, cert. denied, 378 Md. 614 (2003).

20 *Ungar v. Handelsman*, 325 Md. 135, 146 (1992).

21 COMAR 14.09.03.09(c)(4)

22 *S.B. Thomas, Inc. v. Thompson*, 114 Md. App. 357, 382-383 (1997).

23 114 Md. App. 357 (1997).

24 227 Md 312 (1962).

25 https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html

26 Md. Lab. & Empl. Art. §9-102(a)

cases, the replication process creates toxic byproducts. The body responds by creating antibodies to attack the infection and its temperature may rise to a feverish level that is less hospitable to the virus. In some, but not all, victims, the cumulative effect of commandeered cells, toxins, detritus of antibody-virus combat can cause symptoms generally associated with having the flu. God willing, in most cases, the host's body prevails, vanquishing the pathogen.

To perpetuate itself, a virus must find a new host before its current host's body eradicates it. Newly replicated viruses look for opportunities to "jump" to a new host – someone not previously infected. This process begins early in the infection timeline, often before the host begins to experience symptoms. In other words, asymptomatic hosts, unaware they are infected/contagious, go about their normal daily routines, all the while shedding the viruses their bodies are expelling. The same is true for those infected, but asymptomatic.

And it is here the replicated influenza and respiratory viruses have a built-in escape mechanism that can make them super spreaders. Namely, they infect the respiratory system in a manner that causes the host to cough and sneeze them into the air. Additionally, each exhalation breathes them out. The new host inhales the aerosolized particles or rubs his or her eyes, after touching a contaminated surface - beginning the process anew.

With this knowledge of viral pathology in mind, the COVID-19 virus is uniquely equipped to spread. It owes its virulence to its ability to infect, and to shed replicated viruses in hosts who do not know they are infected, let alone contagious. In additional to a higher than average asymptomatic infection rate, COVID-19 takes longer than average flu viruses to produce symptoms. As a result, on any given day, there is an ever expending population of asymptomatic and pre-symptomatic hosts unwittingly shedding virus.

Screening Covid Cases: Is the Juice Worth the Squeeze?

Garden variety claims for accidental injury follow a common timeline. For compensable claims, a year or two after the claim is filed, the claimant may seek an award for permanent disability benefits. Due to the novel nature of COVID-19, there may be claims where patient recovers with no residual impairment. This means that no monetary/indemnity benefits awarded to a claimant, other than perhaps a couple of weeks of temporary total disability.

Given these financial dynamics, counsel conducting an initial consultation for a prospective COVID-19 claim needs to answer two important questions: 1) Can I prove occupational exposure – with or without an expert, and 2) is there a sufficient likelihood of permanent disability from which to pay the legal fees and expenses needed to prove the occupational exposure?

Exposure and Compensability

Turning to the application of this virology to tracing infection to the workplace, the starting point is proving "exposure." The CDC advises that anyone with "close contact" with someone who has the virus should quarantine.[27]

With these principles in mind, the following facts may assist in proving an occupational infection:

1. Co-workers Infected: If there are other co-workers who have symptoms, it is likely they were shedding the virus for at least 10 days prior to contracting the virus, even though they did not exhibit symptoms for some of that time period. Additionally, many employers collect information regarding employees who have reported test results.

2. Family Infection: It is not uncommon for workers who contract the virus to infect members of their household. But household members can contract the virus, perhaps without symptoms, from other sources. If household members do in fact test positive, it is important to determine if the testing occurred before or after the worker got sick. Obviously, if the family member was positive prior to the workplace exposure, it will be harder to attribute the infection to the workplace.
3. Exposure: The CDC generally requires people who have had "close contact" -defined as "within 6 feet of someone who has COVID-19 for a total of 15 minutes or more."[28] The same guideline cites hugging, kissing, and working with a COVID-19 patient as close contact. With these standards in mind, the would-be client should be questioned about, not only his or her proximity to the infected workers, but to those who were had "close contact" with that person.
4. Medical Records: For much of 2020, patients

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28 https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/quarantine.html

reported symptoms to health care providers, who may not have realized they were treating someone infected with COVID-19. Subsequent doctors who see this patient often parrot the same incorrect diagnosis. A proper diagnosis, as of the date of this writing is generally confirmed by two tests: rapid test and PCR. The former generates immediate results but is only approximately 60% accurate. The latter is 90% accurate but requires three days for a lab to generate results. It is important to correlate examination findings with the test result because some tests results are wrong.

5. Blood Testing: COVID-19 leaves immunoglobins that can confirm diagnosis, and perhaps shed light on when an infection might have taken place. The immunoglobins (IgM) appears 2-4 weeks after contracting the virus and is then replaced by IgG. Accordingly, the presence of IgM suggests a relatively recent infectious exposure.

6. Employer Precautions: Any employer adopted plan to safeguard workers from infection must include the "Three W's" – wash hands, watch distance, wear a mask. To what degree did the employer adopt/enforce a Covid-19 protocol? Inquire as well about the types of personal protective gear provided, in light of the probable risk. A paper mask might be appropriate in one setting, while front line health care workers may require the additional protections of an N-95. With respect to the N-95 mask, its effectiveness is compromised substantially if it does not fit snugly over the mouth and nose.

7. Contact Tracing: In the initial intake, while it is still fresh in the client's mind, it is important to create a list of persons the client came into contact with, during the period of likely exposure. Employers may be reluctant to share this information, citing confidentiality. The information may be sought by a Commission subpoena to the employer. A failure to respond to this subpoena arguably gives rise to an inference that the employer is hiding information that, if disclosed, would be favorable to the claimant. Alternatively, it wise to ask the claimant for the names of co-workers, or to have the claimant canvass co-workers regarding employees who have tested positive. This type of news travels fast, but it is time-specific. Precisely how many co-workers were infected at the time the claimant was infected is information that co-workers will likely know, early on. As time passes, the clarity and accuracy of co-worker testimony regarding the workplace exposure of a given claimant diminishes, as new infections, occurring after the claimants are incorporated into workplace gossip.

Permanency: Complete Recovery Means No Recovery for Counsel

During the preceding year, infectious disease specialists thought that those who survive COVID-19 would be no worse off than those who recover from the flu, with a few exceptions. During the ensuing months, now almost a year, doctors report ongoing a significant number of complaints stemming from the viral infection. Over the course of 2020, it became apparent to the Doctor that this optimistic prognosis was premature. Patient after patient got "better," but continued to experience lingering health issues. Medical literature, as studies of the novel virus are completed, is increasingly finding long-term impact from having been sickened with the virus.

Note at the outset, determining whether a patient might have permanent impairment from a COVID-19 infection, is complicated by comorbidities, unrelated health problems/genetic predispositions that, cause patients infected with COVID-19 to experience the most severe, life threatening, symptoms. Gaining an early understanding of these pre-existing conditions helps medical experts rating impairment to demarcate the extent to which the virus impacted the health of a patient who may not have been in good health at the time he or she contracted the virus.

As a general rule, the most permanent impairment can be diagnosed with a high degree to confidence approximately 6 months post-COVID. By that time, most people who are lucky enough to recover without any residuals are "out of the woods" – they have no impairment and they are not likely to contract the virus again. Prior to six months, the likelihood of permanent as **probable, possible and unlikely**, with regard to the following:

Probable:

- Blood Clots (newly acquired or exasperation of previous condition)
- Organ damage due to blood clots
- Loss of limbs due to blood clots
- Lung and/or heart damage due to intubation
- Loss of vision
- Loss of hearing
- COPD (newly acquired or exasperation of previous condition)
- Chronic fatigue Syndrome

Possible:

- Uncontrolled blood pressure
- Memory loss, dizziness confusion
- Difficulty breathing
- Tiredness
- Muscular aches and pains

Unlikely:

- Loss of senses (taste and smell)
- Restless Leg(s)
- Fever
- Hair loss
- Memory loss, dizziness (with resolution)
- Confusion (with resolution)
- Difficulty breathing, (with resolution)
- Tiredness (with resolution)
- Muscular aches and pains (with resolution)
- Loss of vision (with resolution)
- Loss of hearing (with resolution)

Additionally, experts offer the following screening criteria:

1. Hospitalization: An admission, as opposed to being seen in the ER and released to home, suggests the patient's symptoms were severe, and a complete recovery is less likely. It is important to inquire about what medical procedures accompanied the admission. Was someone hospitalized for observation or were they placed on oxygen or a respirator?
2. Medical History: Because many COVID-19 patients have co-morbidities, it is vital to inquire extensively into the patient's medical history – the goal being to establish that the viral infection was dramatic departure from the pre-infection baseline medical condition. Another term for "dramatic departure," is "permanent impairment" attributable to having contracted COVID-19.
3. Current Medical History: Everyone knows the virus attacks the lungs. But it can also damage the heart and other organs. For example, someone who tested positive, and complains of residual abdominal pain, may not be aware that COVID-19, as with all viruses, can damage the liver. We also believe that a significant number of COVID patients continue to suffer from chronic fatigue syndrome, after their traditional symptoms abate. Given that the medical science is evolving, obtaining a detailed post-COVID history may turn up residual complaints that might be later linked to having contracted the virus.
4. Testing: Certain medical tests, pulmonary function tests and echocardiograms/EKG's are inexpensive, and can establish that a patient's functional capacity has been compromised as a result of contracting the virus. More expensive testing, such as a CAT scan of the chest, can also prove an objective change in condition. Before commissioning an expert to perform a full analysis of permanent impairment, it may be prudent to see if any of these tests confirm residual deficits.

Conclusion

Our goal in writhing this article is to inform practitioners about the legal and factual hurdles to anticipate, before deciding to invest the time and money needed to prove a COVID-19 workers' compensation claim. The law governing such claims is evolving, as is the medical science relating to diagnosing and treating the virus. Asking the right questions before signing up a prospective COVID workers' compensation claim, avoids the unfortunate plight of the practitioners who didn't: in the words of Yogi Berra: "I wish I had an answer to that because I'm tired of answering that question."

Biographies

James K. MacAlister is an attorney at Cohen, Snyder, Eisenberg & Katzenberg, PA in Baltimore focusing on personal injury and workers' compensation cases. In practice for nearly 40 years, he is a recipient of numerous awards including MAJ's *Trial Lawyer of the Year* in 2015 and the *Robert J. Zarbin Memorial Legislative Advocacy Award* in 2018. He is also a current member of the MAJ Board of Governors and co-chair of the Workers' Compensation Section. He was also a recipient of the *Leadership in the Law* Award from *The Daily Record* in 2013.

Atiq Rahman, MD is a Board Certified physician who specializes in the outpatient treatment of Infectious Diseases and he performs IMES at his office in Glen Burnie, Maryland. Dr. Rahman is a graduate of the Fellowship in Infectious Disease Program at Johns Hopkins and previously graduated from King Edward Medical College, Lahore, Punjab University in Pakistan. He has spent his entire medical career specializing in infectious disease care and diagnostic medicine. His resume includes serving as the chairman of Infection Control Committee, chief of teaching service for the Infectious Diseases Department of Medicine and as an instructor of infectious diseases to medical residents & students at Medstar Harbor Hospital. He also currently serves as a consultant at Baltimore Washington Medical Center.

covid.pdf
Uploaded by: Joseph Norton
Position: FAV

All during the Covid pandemic I was working for Montgomery County Police as a patrol officer on a mid-night shift performing all functions of a patrol officer. I was responding to calls for service, traffic stops, going to court, checking business, talking to business owners and training. When calls needed, I had to go to the hospital and station when brought higher risk with the amounts of people at these locations. Just days prior to coming down sick I was Inservice training with officers from across the county, fire rescue from across the county and civilians. While out in the public we were doing what we could to be safe following all CDC, county, state, and federal mandates. While the masking was lifted and reinstated several times, I personally was still wearing a face covering while indoors trying to reduce my risk of exposer. At home we were doing all we could to be safe. We got out groceries delivered and disinfected them when they arrived. The Kids were doing online school and were only went out for necessary things and while out in public were once again following local, state and federal guidelines.

In Aug 2021 I came down with covid and ended up in Fredrick Hospital. All I remember is getting into the ambulance at home then waking up in the hospital with a tube in my throat could barely move and a family member by my bed side. After three hospitals and considerable time, learning to walk again and regaining some strength I was home after 79 days. The only reason i was released as early as I was because I worked hard to be able to at least stand on my own and finished my physical rehab at home. Since then, I have been to numerous doctors for the aftereffects of covid. With having no pervious health issues now I'm dealing with memory issues, tinnitus and loss of hearing, loss of smell, neuropathy in both of my hands and feet, nerve pain in right elbow which causes pain and loss of control of my right hand, weak lung function, over all loss of strength and an enlarged aorta from my heart. I have been out of work since going to the hospital, Luckly I had saved up my sick leave over the last 20 years on the job and that has afforded me the ability to be on live while trying to figure out what's next and focusing on getting back to how I was before.

My future is unsure at this point. I am in the appeal process with the workers comp for my case because the burden of proof is on the injured to prove that you came down with Covid on the job. After all contact tracing the only way we can come up with is that I did get it on the job, but since we can't point to known person whom I delt with the works comp will not cover me. The toll on my family has been untold.

SB 431 testimony.pdf
Uploaded by: Robert Phillips
Position: FAV

MARYLAND STATE FIREMEN'S ASSOCIATION
REPRESENTING THE VOLUNTEER FIRE, RESCUE, AND EMS PERSONNEL OF MARYLAND.

Robert P. Phillips
Chairman
Legislative Committee
17 State Circle
Annapolis, MD 21401
email: rfcchief48@gmail.com
cell: 443-205-5030
Office: 410-974-2222

SB431: Workers' Compensation – Occupational Disease Presumption – Long COVID

My name is Robert Phillips, I am the Legislative Committee Chair for the Maryland State Firefighters Association (MSFA). The MSFA represents the 25,000 plus volunteer Fire/EMS and Rescue first responders across the state.

I wish to present testimony in favor of Senate Bill 431: Workers' Compensation – Occupational Disease Presumption – Long COVID

The MSFA fully supports the adoption of this bill. We have seen first hand the effects that COVID 19 had on our first responders. Many had long term issues with it when they were first affected. Now two years or so finished with the original virus, they are still seeing effects from it with lingering issues. The virus is passed but the effects are still here and causing ongoing health issues. These issues need to be addressed with the same care and concern as before and should be treated as a work related injury with the appropriate benefits.

I thank the committee for their time and attention to this important bill and ask that you vote favorable on Senate Bill 431.

I will now be glad to answer any questions, or my contact information is listed above and welcome any further inquiries you might have.

Kenneth Jenkins Testimony SB431 Favorable.pdf
Uploaded by: Ryan Conlon
Position: FAV

Testimony of Kenneth Jenkins in Support of SB431 – Home of the Brave Act (Long Covid Occupational Disease Workers' Compensation Presumption)- Favorable

My name is Kenneth Jenkins, and I am here today to share my experience with long COVID and to voice my support for the SB431 – Long Covid Occupational Disease Workers' Compensation Presumption – that addresses this condition for workers like me. As someone who has experienced the debilitating effects of Long COVID firsthand, I believe it is crucial to provide adequate support and protection for individuals like myself who are struggling with this illness.

Covid changed my life. I came down with Covid in late March 2020. It started with a fever, body aches, headaches, and other gruesome symptoms. I took a Covid test, but back then you didn't get your results right away. It took a couple of days. When I got my diagnosis, I called my wife and broke down crying. All I could think about was all the people dying from this disease.

At first, I was home, but I wasn't getting any better. Less than two weeks after my diagnosis, I went into the hospital and then into the critical care unit. I was in critical care for three weeks, under heavy sedation. My sedation medication had to be increased because I broke my restraints and removed my life-support equipment twice. The first time, my heart stopped, and I had to be resuscitated. The second time, I aspirated and I got a huge hematoma on my forehead that I still have a scar from. I was finally able to breathe on my own on May 4, five weeks after I started having symptoms.

I have been recovering ever since. I had to re-learn to walk. I have pulmonary rehab twice a week. My wife helps me at home with physical therapy. I have issues with swallowing because I was on oxygen for so long.

I'm back at work, but not in the same position. I've been with Ride On in Montgomery County for 16 years. Before Covid, I was a transit coordinator with Ride On at the Silver Spring Depot. But I can't do that job anymore. I am now a transit analyst. And while I am full-time, I am disabled from Covid. Luckily, I can telework a couple of days a week so I can continue to get some of the care that I need.

I incurred substantial medical expenses for ongoing treatment and management of my symptoms. Unfortunately, the current workers' compensation system does not adequately address the needs of individuals with long Covid. Many workers are left without the support and assistance they desperately need to cope with this debilitating condition and navigate its long-term effects on their ability to work and provide for their families.

The proposed long covid presumption workers' compensation bill is a critical step towards fixing this injustice. By explicitly recognizing long COVID as a compensable occupational disease

and providing coverage for medical expenses, lost wages, and disability benefits, this bill would offer much-needed relief to workers grappling with the long-term consequences of COVID-19.

Furthermore, enacting this legislation would send a powerful message of support and solidarity to workers across our state who have been impacted by this devastating illness. It would demonstrate our commitment to protecting the health and well-being of our workforce and ensuring that no worker is left behind in their time of need.

I urge you to support the long COVID workers' compensation bill and take decisive action to provide essential assistance to workers like me who struggle with this debilitating illness. Together, we can ensure that no worker is forced to bear the financial and emotional burden of long COVID alone.

Donnay 2024 support for SB0431 with amendments.pdf
Uploaded by: Albert Donnay
Position: FWA

Testimony in Support of Maryland SB 0431 with Amendments
The Home of the Brave Act of 2024

4/4/24

Albert Donnay, MS, MHS
Donnay Detoxicology LLC
Hyattsville MD
albert@donnaydetox.com

posted at www.tinyurl.com/SB431

Maryland Resident 1958-1970 and 1980-2024

Maryland Business Owner

Master's degrees from Maryland Schools

- Environmental Health Engineering from Johns Hopkins in 1982
- Toxicology in 2015 from UM Graduate School

Golden ID non-degree student since 2018 at UM College Park

UMCP required all students to get COVID vaccine
to register for classes in 2022

Got Moderna vaccine
- No reaction to 1st dose
- Bedridden for 5 days with fever after 2nd dose
- Lost ability to multi-task
- Lost ability to recover short-term memories
- Injection site is still sore and arm muscle is still weak

Got COVID anyway
Much less severe illness than reaction to vaccine

In contrast, my wife,
then teaching at Prince George's Community College,
got much sicker within 1 day of her first mRNA vaccination

Overnight, her normally low level of exhaled carbon monoxide,
a biomarker of stress, went up from 1 part per million to 19 ppm.
She woke up with a fever of 101F, headache, and flu-like symptoms.
Her exhaled CO continued rising to 24 ppm the next day
before gradually coming down over the next week with no after-effects

Her carbon monoxide increase was not caused by inhaling any CO,
but just from making more in response to the stress of vaccination.

When she later got COVID, her exhaled CO only went up to 6 ppm,
showing actual infection was less stressful than the mRNA vaccine.

Our anecdotal experience shows mRNA vaccines made some Marylanders sicker than COVID infection!

Large peer-reviewed study of 284,592 published in December 2022 found most common post Vax diagnoses were ***myocarditis, dysautonomia, and POTS = Postural Orthostatic Tachycardia Syndrome***

nature cardiovascular research

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nature › nature cardiovascular research › articles › article

Article | Published: 12 December 2022

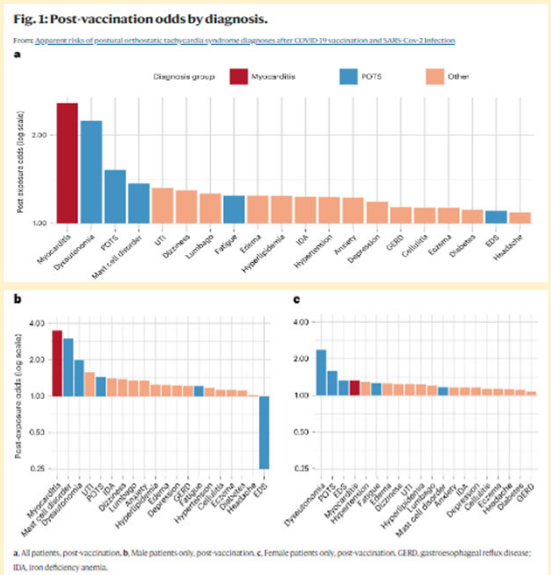
Apparent risks of postural orthostatic tachycardia syndrome diagnoses after COVID-19 vaccination and SARS-Cov-2 Infection

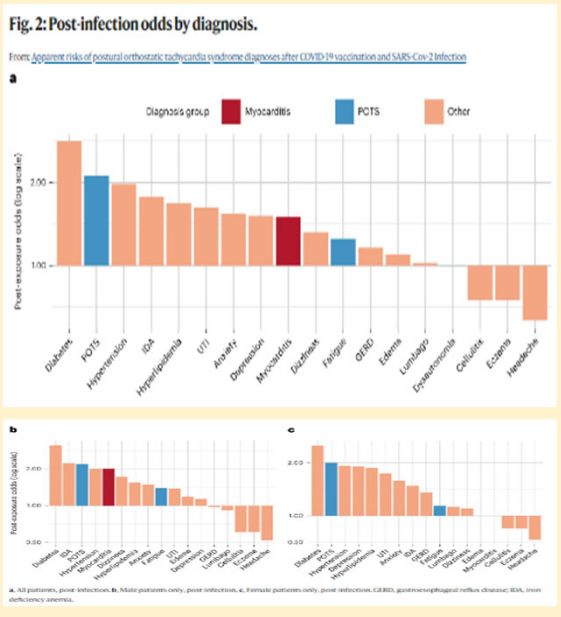
Alan C. Kwan ✉, Joseph E. Ebinger, Janet Wei, Catherine N. Le, Jillian R. Oft, Rachel Zabner, Debbie Teodorescu, Patrick G. Botting, Jesse Navarrette, David Ouyang, Matthew Driver, Brian Claggett, Brittany N. Weber, Peng-Sheng Chen & Susan Cheng

Nature Cardiovascular Research **1**, 1187–1194 (2022) | Cite this article

108k Accesses | **26** Citations | **3315** Altmetric | Metrics

Diagnoses seen at higher rates in 90 days after Vaccination (left) or COVID Infection (right) compared to in 90 days before, with totals above and male vs female results below





Requested Amendment

Given that some workers in Maryland developed disabling illnesses after getting employer-mandated COVID vaccines and boosters,

If this committee can find the compassion and funds needed to expand worker's compensation to authorize payment of suitably documented claims for Long-COVID-related illnesses that government workers developed after contracting COVID-19 while doing an essential job,

I ask the committee to amend SB0431 to authorize payment of suitably documented claims for vaccine-related illnesses that government workers developed after getting an employer-mandated COVID vaccine or booster.

Maryland SB 0431 Written Testimony.pdf
Uploaded by: Andre Cherry
Position: FWA

SB 0431 FWA
Andre Cherry
164 West Maplewood Avenue, Philadelphia, 19144

To the Chair and members of the Senate Finance Committee,

My name is Andre Cherry. Last year, I gave testimony in favor of the amended Vaccination by Choice Act to protect government employees and college students from the draconian and scientifically unfounded COVID-19 vaccination mandates. Now, I come to you as a concerned citizen in favor of the 2024 Home of the Brave Act as amended by Senator Ready.

For almost a thousand days, I have been battling my own adverse reaction to the shots, dealing with debilitating and constantly evolving symptoms that erode my quality of life and rob me of my independence. These symptoms include ballismus, flaccid paralysis, tremors, vocalizations, lethargy, and tactile sensitivity (see Figures 1-3). My condition affects every muscle of my body, afflicts me at random, and my symptoms can be triggered by repetitive motion or labor, among other things. My disability poses a great deal of danger to myself and my loved ones, and because of this, I require constant at-home care and supervision.

I reported my case to VAERS twice because my doctors would not, despite my worsening symptoms, and I have yet to hear from the CICP even though I reported my case within a year of the onset of my injury. One could say the same of the majority of the vaccine-injured, many of whom lost their health and even their lives because they complied with mandates imposed on them by their employers and their government, forcing them to choose between their health and their ability to provide for themselves and their families.

As someone who is totally disabled as a result of COVID vaccine injury, I can attest to this fact: Injuries inflicted by the COVID shot, once recognized - if at all - are serious, often debilitating, and always difficult and costly to treat. Medicines, treatments, and other care protocols used by the injured at the recommendation of organizations such as the FLCCC can cost hundreds of dollars per month; emergency room visits, long-term hospitalizations, appointments with specialists, and acquiring scans, bloodwork, or naturopathic treatments combine into a hefty sum, which is financially devastating for those who are vaccine-injured and can no longer work. The continual insistence by our government leaders that the COVID vaccine is safe and effective has also cost many of the COVID vaccine-injured the trust and support of their families and loved ones, compounding their physical affliction with deep emotional damage and even greater financial burden as they seek advocacy, acknowledgment, and treatment alone.

In a tenth of VAERS' three-decade history, reports of deaths resulting from the COVID shots have surpassed all other deaths reported from all other types of vaccines combined since the implementation of the system (see Figure 4). Despite these staggering numbers, censorship and lack of public or professional awareness suggest that COVID vaccine-induced fatalities and injuries are underreported, as many doctors and public figures dismiss any association between the shots and the maladies that afflict many who have taken them. This has also been detrimental to the efforts of the injured and bereaved in pursuit of compensation.

This was made clear on February 15th, 2024, when Congresswoman Marjorie Taylor Greene, a member of the Select Subcommittee on the Coronavirus Pandemic, using information from the Congressional Research Service, stated that as of January 1st, 2024, only 11 people

have been compensated by CICP, and of the over 10,000 injured that applied for compensation from the program, only 40 claims were determined eligible. Even more damning is the fact that the 11 who were compensated received an average of $3,700, whereas recipients of VICP compensation have received an average of $490,000 over the past 35 years.

The pursuit of compensation by the COVID vaccine-injured is further upset by the strict deadline of 12 months to file a claim with the CICP. While an entire year may seem reasonable on paper, the aforementioned censorship and general unawareness of COVID vaccine injury can cause many who have been injured to be led to believe their new, strange, and debilitating symptoms may have a different origin than the shots, which would naturally delay their ability to file for CICP compensation, in some cases, until it is too late.

I mention VAERS, CICP, and VICP data because it has become abundantly clear that the federal government is failing American citizens who are suffering from adverse reactions to the COVID-19 shots or have lost loved ones who took the shots. In October of 2023, I worked with the organization React19 to convince the House of Representatives to reform and modernize the compensation programs available to American citizens (See Figure 5), but unfortunately, our efforts were largely unsuccessful.

So, I turn to this committee in hopes that you will do for your local constituents what D.C will not: show compassion for the COVID vaccine-injured and bereaved and compensate them for the damages they have endured under the directives and/or mandates of their government and employers. Please vote for the Home of the Brave Act favorably with the amendment, and live up to the name of the bill, and the lyrics of our nation’s anthem.

Appendix

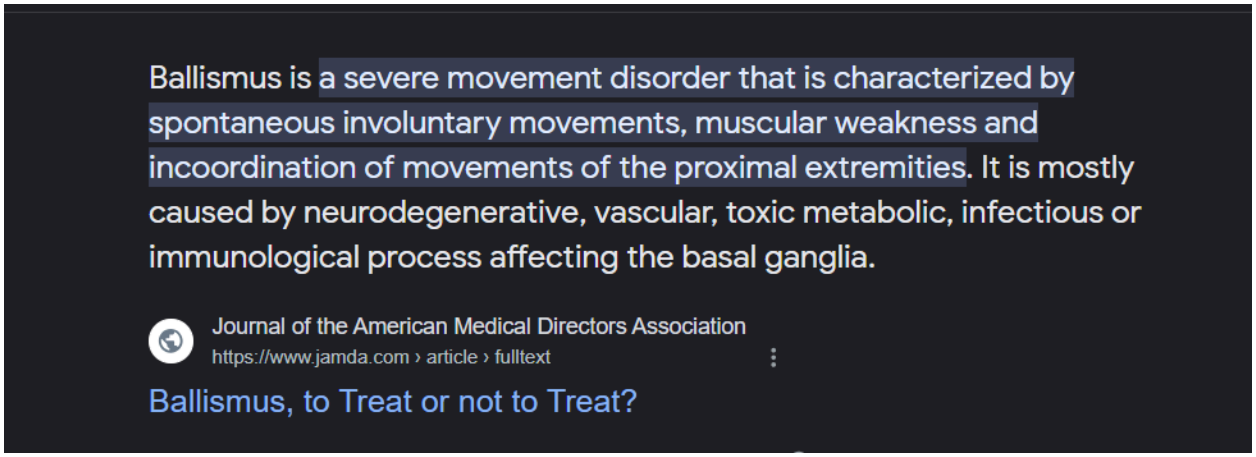


Figure 1

J Pediatr Neurosci. 2015 Jul-Sep; 10(3): 280–281.
doi: 10.4103/1817-1745.165716
PMCID: PMC4611905
PMID: 26557177

A rare cause of acute flaccid paralysis: Human coronaviruses

Cokyaman Turgay, Tekin Emine, Koken Ozlem,[1] S. Paksu Muhammet,[1] and A. Tasdemir Haydar

▸ Author information ▸ Copyright and License information PMC Disclaimer

Abstract

Go to: ▸

Acute flaccid paralysis (AFP) is a life-threatening clinical entity characterized by weakness in the whole body muscles often accompanied by respiratory and bulbar paralysis. The most common cause is Gullian–Barre syndrome, but infections, spinal cord diseases, neuromuscular diseases such as myasthenia gravis, drugs and toxins, periodic hypokalemic paralysis, electrolyte disturbances, and botulism should be considered as in the differential diagnosis. Human coronaviruses (HCoVs) cause common cold, upper and lower respiratory tract disease, but in the literature presentation with the lower respiratory tract infection and AFP has not been reported previously. In this study, pediatric case admitted with lower respiratory tract infection and AFP, who detected for HCoV 229E and OC43 co-infection by the real-time polymerase chain reaction, has been reported for the first time.

Figure 2

Overview

Essential tremor is a nervous system condition, also known as a neurological condition, that causes involuntary and rhythmic shaking. It can affect almost any part of the body, but the trembling occurs most often in the hands, especially when doing simple tasks, such as drinking from a glass or tying shoelaces.

Essential tremor is usually not a dangerous condition, but it typically worsens over time and can be severe in some people. Other conditions don't cause essential tremor, although essential tremor is sometimes confused with Parkinson's disease.

Essential tremor can occur at any age but is most common in people age 40 and older.

Figure 3

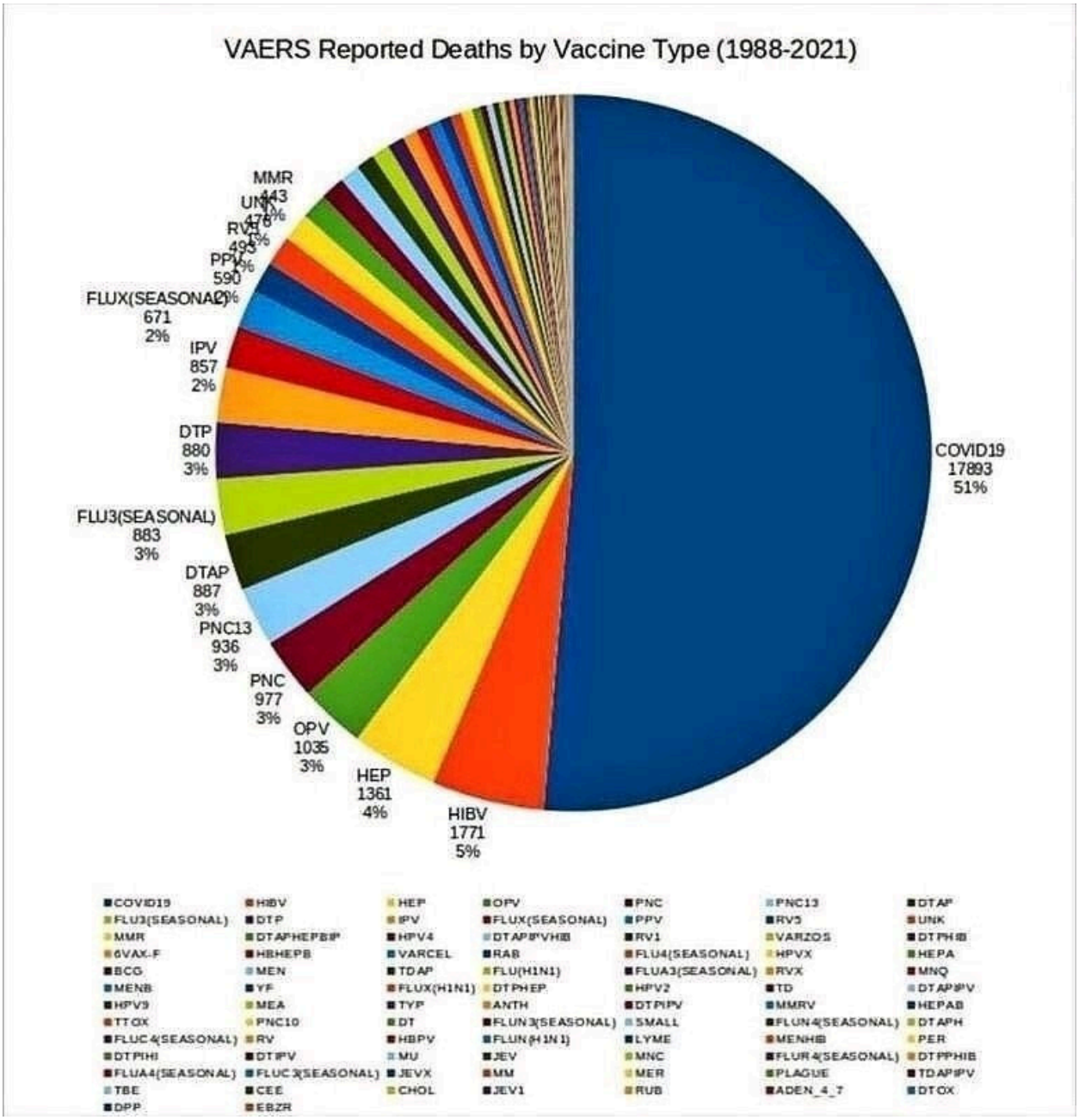

VAERS Reported Deaths by Vaccine Type (1988-2021)
COVID19 17893 51%
HIBV 1771 5%
HEP 1361 4%
OPV 1035 3%
PNC 977 3%
PNC13 936 3%
DTAP 887 3%
FLU3(SEASONAL) 883 3%
DTP 880 3%
IPV 857 2%
FLUX(SEASONAL) 671 2%
PPV 590
MMR 443
COVID19
HIBV
HEP
OPV
PNC
PNC13
DTAP
FLU3(SEASONAL)
DTP
IPV
FLUX(SEASONAL)
PPV
RV5
UNK
MMR
DTAPHEPBIP
HPV4
DTAPIPVHIB
RV1
VARZOS
DTPHIB
6VAX-F
HBHEPB
VARCEL
RAB
FLU4(SEASONAL)
HPVX
HEPA
BCG
MEN
TDAP
FLU(H1N1)
FLUA3(SEASONAL)
RVX
MNQ
MENB
YF
FLUX(H1N1)
DTPHEP
HPV2
TD
DTAPIPV
HPV9
MEA
TYP
ANTH
DTPIPV
MMRV
HEPAB
TTOX
PNC10
DT
FLUN3(SEASONAL)
SMALL
FLUN4(SEASONAL)
DTAPH
FLUC4(SEASONAL)
RV
HBPV
FLUN(H1N1)
LYME
MENHIB
PER
DTPIHI
DTIPV
MU
JEV
MNC
FLUR4(SEASONAL)
DTPPHIB
FLUA4(SEASONAL)
FLUC3(SEASONAL)
JEVX
MM
MER
PLAGUE
TDAPIPV
TBE
CEE
CHOL
JEV1
RUB
ADEN_4_7
DTOX
DPP
EBZR

Figure 4

Did You Know... the drug companies CANNOT be sued for vaccine injuries?

The COVID-19 vaccine injured are currently forced to lodge claims for financial recovery with the inefficient and inadequate ***Countermeasures Injury Compensation Program (CICP) rather than the Vaccine Injury Compensation Program (VICP)*** – the program available for those injured by vaccines such as MMR and flu.

Astonishingly, the ***current rejection rate for CICP claims is 97%***. As such, the CICP has ***only compensated four injured individuals*** in the entire United States - with combined **awards totaling less than $10,000**. To be blunt, these statistics are simply unacceptable.

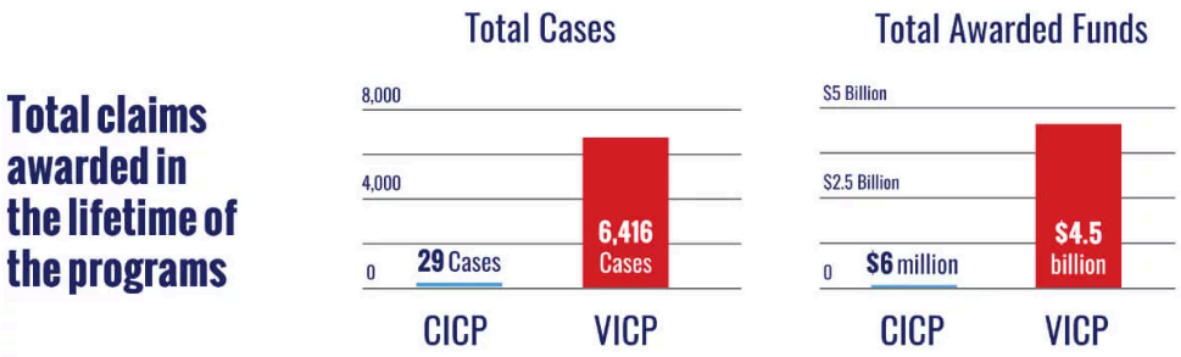


Figure 5

03438973_Email.pdf
Uploaded by: Brent Fuller
Position: FWA

Janssen Scientific Affairs, LLC

1125 Trenton-Harbourton Road
PO Box 200
Titusville, NJ 08560
800.526.7736 tel
609.730.3138 fax

November 15, 2022

Brent Fuller
445 Hand Ct
Hampstead, MD 21074
USA

Dear Mr. Fuller,

Thank you for contacting the Medical Information Center. The enclosed information has been supplied in response to your unsolicited request.

Response(s):

- Janssen COVID-19 Vaccine - What are the risks of the Janssen COVID-19 Vaccine?
- Janssen COVID-19 Vaccine - Can you provide me with medical advice?

Information contained in this response is not intended as an endorsement of any usage of this product outside of the Fact Sheet. Janssen COVID-19 Vaccine is not approved by the Food and Drug Administration (FDA) and has been authorized by the FDA in the United States for emergency use only. For information on ongoing clinical trials for our products, please visit www.clinicaltrials.gov.

If you would like additional information or to report a possible adverse event or product quality complaint, please contact the Janssen Medical Information Center at 1-800-JANSSEN (1-800-526-7736).

Sincerely,

Marchella A Robinson

Marchelle Robinson, RPh
Medical Information Specialist
Janssen Scientific Affairs, LLC

Inquiry #:03438973

Enclosure(s)/Electronic Link(s):

Need Help? If you have any additional questions, please contact us via:

1-800-JANSSEN Monday - Friday, 9 am - 8 pm EST	**24x7 Access to Medical Information** www.janssenmd.com
Email Medical Information	**Locate Medical Science Liaison** www.janssenmsl.com

To report a possible adverse event or product quality complaint, please call the Medical Information Center immediately, at 1-800-JANSSEN (1-800-526-7736).

Janssen COVID-19 Vaccine
What Are the Risks of the Janssen COVID-19 Vaccine?

SUMMARY

- The Janssen COVID-19 Vaccine has not been approved or licensed by the U.S. Food and Drug Administration (FDA), but has been authorized by the FDA through an Emergency Use Authorization (EUA) for active immunization to prevent Coronavirus Disease 2019 (COVID-19) in individuals 18 years of age and older for whom other FDA-authorized or approved COVID-19 vaccines are not accessible or clinically appropriate, and in individuals 18 years of age and older who elect to receive the Janssen COVID-19 Vaccine because they would otherwise not receive a COVID-19 vaccine as: a single dose primary vaccination; a single booster dose after completing primary vaccination with the Janssen COVID-19 Vaccine; a single booster dose after completing primary vaccination with a different authorized or approved COVID-19 vaccine.
- Talk to the vaccination provider if you have questions. Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away. Report vaccine side effects to Food and Drug Administration (FDA)/Centers for Disease Control and Prevention (CDC) Vaccine Adverse Event Reporting System (VAERS) at 1-800-822-7967 or call Janssen Biotech, Inc. at 1-800-565-4008 (United States [US] Toll Free). Please read the Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers available at www.JanssenCOVID19vaccine.com.[1, 2]

Who should NOT get the Janssen COVID-19 Vaccine?

You should not get the Janssen COVID-19 Vaccine if you[2]:

- Had a severe allergic reaction after a previous dose of this vaccine
- Had a severe allergic reaction to any ingredient of this vaccine
    - The Janssen COVID-19 Vaccine includes the following ingredients: recombinant, replication-incompetent adenovirus type 26 expressing the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) spike protein, citric acid monohydrate, trisodium citrate dihydrate, ethanol, 2-hydroxypropyl-β-cyclodextrin (HBCD), polysorbate-80, sodium chloride.
- Had a blood clot along with a low level of platelets (blood cells that help your body stop bleeding) following the Janssen COVID-19 Vaccine or following AstraZeneca's Coronavirus Disease 2019 (COVID-19) vaccine (not authorized or approved in the US)

What are the risks of the Janssen COVID-19 Vaccine?

Side effects that have been reported with the Janssen COVID-19 Vaccine include[2]:

- Injection site reactions: pain, redness of the skin and swelling
- General side effects: headache, feeling very tired, muscle aches, nausea, and fever
- Swollen lymph nodes
- Blood clots
- Unusual feeling in the skin (such as tingling or a crawling feeling) (paresthesia), decreased feeling or sensitivity, especially in the skin (hypoesthesia)
- Persistent ringing in the ears (tinnitus)
- Diarrhea, vomiting

Severe Allergic Reactions

There is a remote chance that the Janssen COVID-19 Vaccine could cause a severe allergic reaction. A severe allergic reaction would usually occur within a few minutes to one hour after getting a dose of the Janssen COVID-19 Vaccine. For this reason, your vaccination provider may ask you to stay at the place where you received your vaccine for monitoring after vaccination. Signs of a severe allergic reaction can include[2]:

- Difficulty breathing
- Swelling of your face and throat
- A fast heartbeat
- A bad rash all over your body
- Dizziness and weakness

Blood Clots with Low Levels of Platelets

Blood clots involving blood vessels in the brain, lungs, abdomen, and legs along with low levels of platelets (blood cells that help your body stop bleeding), have occurred in some people who have received the Janssen COVID-19 Vaccine. In people who developed these blood clots and low levels of platelets, symptoms began approximately one to two weeks after vaccination. Blood clots with low levels of platelets following the Janssen COVID-19 Vaccine have been reported in males and females, across a wide age range of individuals 18 years and older; reporting has been highest in females ages 30 through 49 years (about 8 cases for every 1,000,000 vaccine doses administered), and about 1 out of every 7 cases has been fatal. You should seek medical attention right away if you have any of the following symptoms after receiving the Janssen COVID-19 Vaccine[2]:

- Shortness of breath
- Chest pain
- Leg swelling
- Persistent abdominal pain
- Severe or persistent headaches or blurred vision
- Easy bruising or tiny blood spots under the skin beyond the site of the injection

Immune Thrombocytopenia (ITP)

Immune Thrombocytopenia (ITP) is a disorder that can cause easy or excessive bruising and bleeding due to very low levels of platelets. ITP has occurred in some people who have received the Janssen COVID-19 Vaccine. In most of these people, symptoms began within 42 days following receipt of the Janssen COVID-19 Vaccine. The chance of having this occur is very low. If you have ever had a diagnosis of ITP, talk to your vaccination provider before you get the Janssen COVID-19 Vaccine. You should seek medical attention right away if you develop any of the following symptoms after receiving the Janssen COVID-19 Vaccine[2]:

- Easy or excessive bruising or tiny blood spots under the skin beyond the site of the injection
- Unusual or excessive bleeding

Guillain Barré Syndrome

Guillain Barré syndrome (a neurological disorder in which the body's immune system damages nerve cells, causing muscle weakness and sometimes paralysis) has occurred in some people who have received the Janssen COVID-19 Vaccine. In most of these people, symptoms began within 42 days following receipt of the Janssen COVID-19 Vaccine. The chance of having this occur is very low. You should seek medical attention right away if you develop any of the following symptoms after receiving the Janssen COVID-19 Vaccine[2]:

- Weakness or tingling sensations, especially in the legs or arms, that's worsening and spreading to other parts of the body
- Difficulty walking
- Difficulty with facial movements, including speaking, chewing, or swallowing
- Double vision or inability to move eyes
- Difficulty with bladder control or bowel function

These may not be all the possible side effects of the Janssen COVID-19 Vaccine. Serious and unexpected effects may occur. The Janssen COVID-19 Vaccine is still being studied in clinical trials.

What should I do about side effects?

If you experience a severe allergic reaction, call 9-1-1, or go to the nearest hospital.

Call the vaccination provider or your healthcare provider if you have any side effects that bother you or do not go away.

Report vaccine side effects to **FDA/CDC (VAERS)**. The VAERS toll-free number is 1-800-822-7967 or report online to https://vaers.hhs.gov/reportevent.html. Please include "Janssen COVID-19 Vaccine EUA" in the first line of box #18 of the report form.

In addition, you can report side effects to Janssen Biotech, Inc. at the contact information provided below.

E-mail	Fax number	Telephone numbers
JNJvaccineAE@its.jnj.com	215-293-9955	US Toll Free: 1-800-565-4008 US Toll: (908) 455-9922

You may also be given an option to enroll in **v-safe**. **V-safe** is a new voluntary smartphone-based tool that uses text messaging and web surveys to check in with people who have been vaccinated to identify potential side effects after COVID-19 vaccination. **V-safe** asks questions that help CDC monitor the safety of COVID-19 vaccines. **V-safe** also provides live telephone follow-up by CDC if participants report a significant health impact following COVID-19 vaccination. For more information on how to sign up, visit: www.cdc.gov/vsafe.[2]

ADDITIONAL INFORMATION

How can I learn more?

- Ask your vaccination provider.
- Visit CDC at https://www.cdc.gov/coronavirus/2019-ncov/index.html.
- Visit FDA at https://www.fda.gov/emergency-preparedness-and-response/mcm-legal-regulatory-and-policy-framework/emergency-use-authorization.
- Contact your local or state public health department.[2]

This information is provided ONLY in response to your request and is not intended as medical advice, to promote the use of our product, or suggest using it in any manner other than as described in the Fact Sheet for Recipients and Caregivers. All decisions regarding your medical treatment should be made with your healthcare professional(s). Please contact your healthcare professional(s) to discuss the information in this response.

Please refer to the attached full Fact Sheet for Recipients and Caregivers for the Janssen COVID-19 Vaccine.[2]

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2. Janssen COVID-19 Vaccine. Emergency Use Authorization (EUA) Fact Sheet for Recipients and Caregivers. Janssen Biotech, Inc. https://www.janssenlabels.com/emergency-use-authorization/Janssen+COVID-19+Vaccine-Recipient-fact-sheet.pdf.

CAN YOU PROVIDE ME WITH MEDICAL ADVICE?

We are not able to provide you with medical advice. Only your healthcare provider can do that. Each person has a unique medical history that is best interpreted by his or her treating healthcare provider. Because the risks and benefits of any prescription medications or vaccine must be evaluated in relation to this history, your healthcare provider is the person most qualified to determine the appropriate treatment for you and to discuss your questions and concerns. Our policy strives to maintain the integrity of this healthcare provider-patient relationship.

Testimony of Brent Fuller Covid Shots.pdf
Uploaded by: Brent Fuller
Position: FWA

Testimony of Brent Fuller

I received the JNJ shot for covid on 10/15/2021. The night of the day after my shot I abruptly awoke in the middle of the night with a racing heart and a whooshing noise in my ears, kind of like a white noise. I over the next days and weeks developled a numbness from my elbows to pinky and ring finger on both sides, had strange headaches – more like numb spots that would come then pass, and the wooshing noise developed into a rather sever tinnitus. (I also at this time developed blind spots in my eyes from aneurysms in my retina but this is not directly tied to the covid shots like these other symptoms are)

All this faded away over the next months except for the tinnitus, which I have sought treatment for at Johns Hopkins, Mercy Medical and UMMS.

The tinnitus has been life changing for the worse, especially at the beginning before I was able to get special hearing aids to help manage the noise my brain/ nerves were generating. Beyond thousands in medical expenses and thousands more I will have to spend over my lifetime the suffering was awful and continues to affect my life. I no longer have peaceful silence in my life. At first I could barely sleep, I would be constantly interrupted from focusing when the ringing would start. The ringing gets to be incredibly loud, imagine a smoke alarm, (always on not on and off) being held right next to your ears like ear muffs. Now imagine you cant turn it off, and that it wakes you up at night while sleeping… or sometimes chirping noises in your ears that are just being imagined by your brain. It is a real challenge to cope with these things. Fortunately for me, with these hearing aids I am able to better manage the severe noises and live closer to a regular life.

In calls with JNJ they confirmed these symptoms are associated with there vaccine (which has now lost EUA, never got approved and millions of doses destroyed due to safety issues). JNJ stated that side effects are why it is critical to consult with your doctor and weigh the risks vs benefits. I did not have this choice, I was subject to the executive order mandating these shots. As I was working for a company (ServiceNow) not the government directly, workers comp turns out to be my only path to recover losses and damages from the shot.

Please consider extending the coverage of workers compensation to include Vaccine injuries, especially related to COVID where mandates were in place. Also please consider adding to the time to file a workers compensation claim based on these damages, sometimes they take longer to manifest, or like me, you think they might go away and don't want to be a person filing a workers comp claim…. And then the problems do not resolve and you have no recourse.

Regards,

Brent Lange Fuller

Testimony FWA SB 431 Bell 2024.pdf
Uploaded by: Charlie Bell
Position: FWA

Testimony for Charlie Bell

charlesbell171@gmail.com

FWA for SB 431

Compensation for eligible workers who suffer long COVID
Asking to be amended to include eligible workers who also suffer from COVID vaccination

Dear Senators, My name is Charlie Bell. I am a 54 yer old US Navy veteran and worked in a US Navy shipyard. I was vaccinated with the required Covid 19 vaccine on April 1, 2021 and with the second shot on April 30, 2021.

After the second shot, I got excruciating pain starting with my back and neck and a hardened stomach. I went to the ER in June 2021 and they referred me to a primary care doctor who did a lot of tests. That doctor did not tell me the results of the test and she seemed to me to be hiding something. When I later saw another doctor, he told me the tests showed inflammation in my neck and lower back. This all started after the second Covid shot.

We were all told that the lipid nanoparticles stayed at the injection site, but now we know that they travel all over the body. I began to think that this was happening to me and was the start of causing my pain. My legs started with internal vibrations and pins and needles sensations. I couldn't lift my legs to walk and had shooting pains down my arms.

I searched around for help and after two years found a doctor who seemed to understand what was happening to me. He diagnosed me with myositis, an autoimmune disorder of the muscles and also Anti-Jo1 which is an autoimmune connective tissue disorder. He also said due to the stress my body experienced there was a reemergence of Epstein Barr virus.

I asked the doctor if the vaccine caused my condition or was it from long Covid. The doctor confirmed that I was vaccine injured. He said that the testing showed a very high level of antibodies which were due to the Covid shots. He said that doesn't happen with long Covid. He said that my body was still making high levels of antibodies and these were causing an autoimmune response and my continuing inflammation.

I felt gaslighted by the primary care doctor who tried to hide the inflammation detected after the shots and who didn't provide early treatment to try and calm my immune system. I am disabled and barely treading water financially. I am on disability and medicaid. I couldn't apply to the CICP program because the year to apply had passed. And the average compensation has been only $3,000 to $4,000. They do not compensate for pain and suffering.

This has been a disaster. Our government forced us to get the shots and now they are ignoring the vaccine injured in the US. If my doctor wasn't paying for my prescriptions and visits, I wouldn't be here. Please don't abandon the Covid vaccine injured. Please amend the bill to include eligible workers who have been seriously injured by the Covid shots. Thank you.

Charlie Bell

MD 2024 SB 431 FwA.pdf
Uploaded by: Danielle Baker
Position: FWA

Testimony
SB431
Favorable with Amendment Danielle Baker RN

My name is Danielle Baker and I am a 44-year-old registered nurse. I am testifying today to hopefully help you understand why it is important to vote for this bill favorable with amendment.

I had worked for the same hospice for 17 years even during the Covid pandemic. In 2020, I contracted Covid and after that I had symptoms that had yet to be named, but ended up being Long Covid. I did not know I had long covid until 2021 after having a vaccine reaction when I took the COVID-19 vaccination due to workplace recommendations and eventually mandates.

I had not wanted to take the Covid vaccination and I felt that it had not yet been fully studied and we did not know the devastating, side effects or adverse events that it could have.

As stated above due to the workplace expectations, I did move forward with the vaccination. After my second dose of my only series of Covid vaccination, I became ill and over the next few weeks lost my ability to essentially walk, take care of myself and control of my bodily functions to name just a few things.

Three weeks after my second dose, extensive testing and procedures, I was diagnosed with a disease called Tranverse Myelitis. Essentially what had happened to me was my immune system was lowered from contracting workplace Covid that developed into unknown Long Covid setting me up to have a reaction to the vaccination that resulted in my body attacking my spinal cord, rendering me disabled for life. Not only that, but now I am dealing with heart and lung issues also as a result of long covid/vaccine injury, and it has been three years since my initial neurological vaccine injury.

Due to how the compensation systems are set up, I have not been able to secure financial compensation for my injuries that were a direct result of working as a nurse in the Covid environment as well as taking a vaccination for the benefit of my employer. For that very reason, I have had to take my former employer all the way through the court system, and I am now in civil court, attempting to Gain access for financial support for my workplace injury.

It has been a long drawn out process, and we are in financial ruins. I cannot get the medical assistance I need, and our life has plummeted into a living nightmare. I do not

wish anyone to have to go through this as it is devastating not only emotionally, but physically and it’s also some thing that my family should not have to endure.

The simple act of voting favorable with amendment and adding vaccine injury to the table for allowable compensation would save so many time, energy, effort, and heartache. When we become an employee for a company, we do so in good faith, assuming that we will be cared for just as much as we care for those that employ us sadly, that is not always the case.

As representatives, it is your duty to ensure that we have the protection that is needed and if anybody’s case shows that the protection isn’t taken place it’s mine. We should not have to have gone to this extent and financial devastation in order to be compensated for illness and injury that took place because of working as an RN. I know I am not the only example of a person that this has happened to.

This is not a political issue. This is a bipartisan issue. This is an issue about taking care of your constituents and ensuring that they have what they need and deserve.

Again, I urge you to vote favorable with amendment, and add vaccine injury onto the table as well .

Danielle Baker, RN

808 Caribou Court
Piqua Ohio 45356
9372143121

Officer Teichler_SB431_Testiomony_FAV.pdf
Uploaded by: Derek Teichler
Position: FWA

Good morning! I am Derek Teichler and am a 27 year veteran police officer with the Montgomery County Police Department here in MD. The beginning of 2020 was filled with uncertainty and fear. The members of my department as well as other agencies across the state and country were tasked with continuing to answer calls for service regardless of the still largely unknown COVID. What was COVID, how did you contract it, what were the symptoms, is it like the flu, but most importantly can it be treated? The department had officers meet at our academy on 3/16/2020 to fit test for the N95 mask, quite possibly and unintentionally creating the perfect super spreader event for the department. It is during this event that I believe I became infected with COVID.

On March 19, 2020, I became symptomatic with COVID symptoms to include trouble breathing, congestion, loss of smell/taste and coughing fits where I would almost blackout.

My primary care doctor advised me to get tested at Holy Cross hospital Germantown on March 25, 2020, due to the increased severity of my symptoms. At that time, I was admitted to “meet the criteria” for testing. I was

tested and released the next day on March 26,2020. On March 27 I was notified that I was positive for COVID. Due to a worsening of my breathing, I was advised to return to HCHG by my primary care doctor. I was seen in the ER and was discharged with a diagnosis of "asthma". How could it be asthma if I already tested positive for COVID? My condition continued to worsen and was advised to go to Shady Grove Hospital on April 1, 2020 were within the hour I was admitted to the Intensive Care Unit. This is an experience I don't wish on anybody! After being released from the ICU and sent home, it has and continues be a long road to recovery. The extreme weakness to where walking across the room without stopping was impossible and needing to stop 3 times while climbing a flight of stairs due to severe breathing difficulties was the norm for months after leaving the hospital. I also still tested positive for COVID for 2 months after being discharged.

It has been 3+ years and I still have lasting effects from COVID. I am under the care of a Cardiologist, Pulmonologist, and primary care doctor. The most limiting effects from having COVID has been my

diminished lung capacity and ability to process oxygen and high blood pressure. These limitations have prevented me from returning to full duty as a police officer assigned to a patrol shift, working overtime, part-time, or performing everyday tasks most people take for granted. Additionally, there is the brain fog, joint pain, and anger because you are no longer the man you once were and having a hard time coming to terms with this reality. My family unfortunately was the recipient of this anger. This bill is important as it would give all essential personnel suffering from long COVID much needed relief both financially and emotionally.

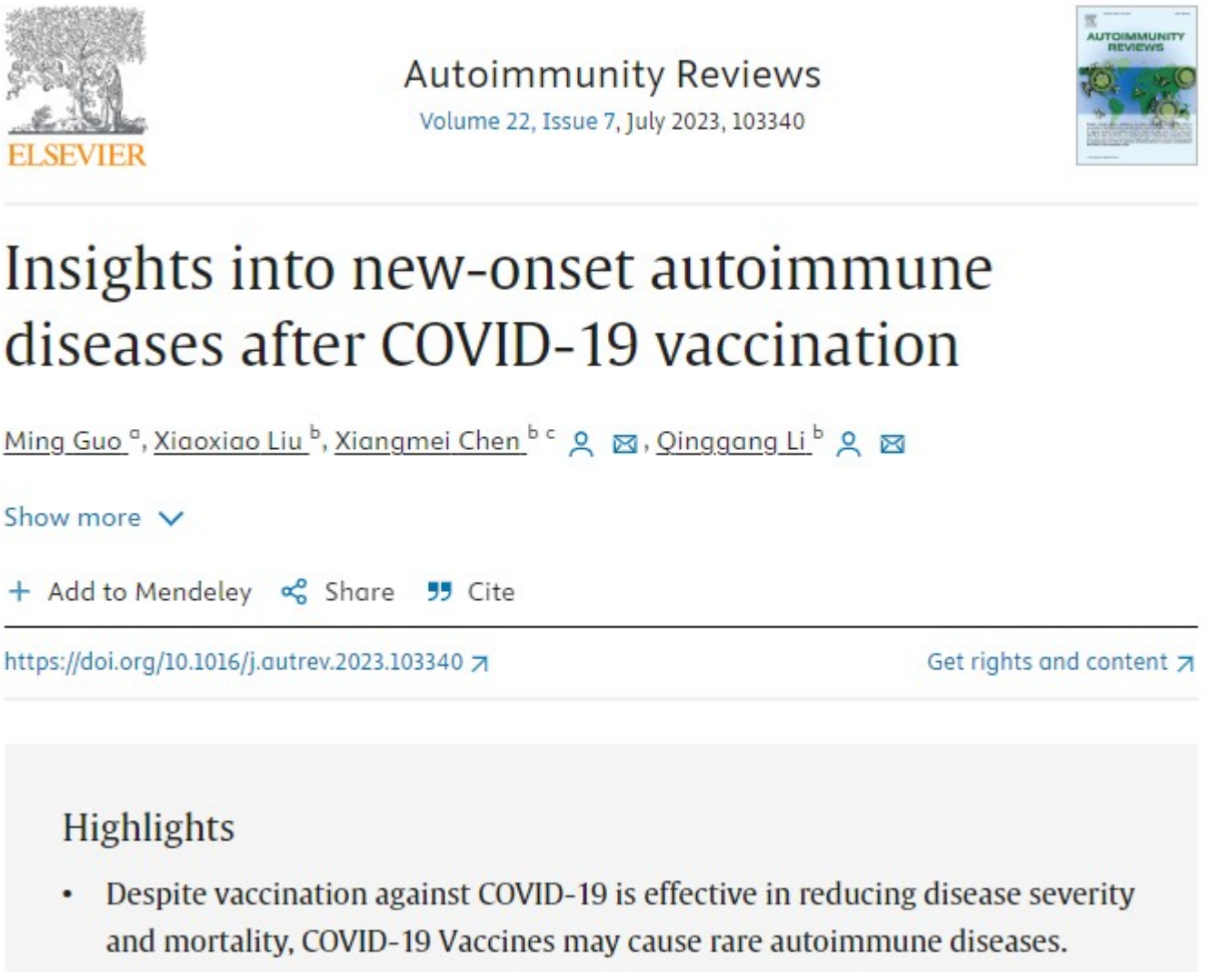
testimony FWA SB 431 supplement.pdf
Uploaded by: Emily Tarsel
Position: FWA

Moderna Scientists Warn mRNA Vaccines Carry Toxicity Risks

The technology used in Moderna's COVID-19 vaccine carries toxicity risks, scientists with the company said in a new paper.

"A major challenge now is how to efficiently de-risk potential toxicities associated with mRNA technology," the scientists wrote in the paper, which was published by Nature Reviews Drug Discovery on Jan. 23.

The mRNA vaccines have multiple known side effects, including heart inflammation and severe allergic shock. Those may stem from hypersensitivity reactions, which can be elicited by "any LNP-mRNA component" but are most likely triggered by PEGlyated lipid nanoparticles, which is "the most potentially reactogenic component," according to the scientists.



ELSEVIER

Autoimmunity Reviews

Volume 22, Issue 7, July 2023, 103340

Insights into new-onset autoimmune diseases after COVID-19 vaccination

Ming Guo [a], Xiaoxiao Liu [b], Xiangmei Chen [b c], Qinggang Li [b]

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Highlights

- Despite vaccination against COVID-19 is effective in reducing disease severity and mortality, COVID-19 Vaccines may cause rare autoimmune diseases.

Respiratory Medicine Case Reports
Available online 13 December 2023, 101959
In Press, Corrected Proof What's this?

Case Report

A Lethal Case of Acute Exacerbation of Rheumatoid Arthritis – Related Interstitial Lung Disease Induced by the COVID Vaccine.

Rayan Mohamad, Rami Hallak, Imad Bou Akl, Hisham Bou Fakhreddine

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https://doi.org/10.1016/j.rmcr.2023.101959

Abstract

Interstitial lung disease (ILD) exacerbation is a serious condition that can have a high morbidity and mortality. Identifying the triggers of ILD exacerbations is very challenging. Several case reports described COVID-19 vaccine-induced exacerbation of underlying interstitial lung disease, namely idiopathic interstitial pneumonias. The clinical implications of this adverse effect is underrecognized. We are reporting a case of fatal respiratory failure in a patient with rheumatoid arthritis Interstitial Lung disease few days following the second dose of COVID vaccine. Identifying risk factors of this complication is of utmost importance to aid in the rapid recognition and early initiation of treatment.

biomedicines

MDPI

Biomedicines. 2023 May; 11(5): 1469.
Published online 2023 May 17. doi: 10.3390/biomedicines11051469

PMCID: PMC10216497
PMID: 37239140

COVID-19 Vaccines and Myocarditis: An Overview of Current Evidence

Altijana Hromić-Jahjefendić,[1,*] Abas Sezer,[1] Alaa A. A. Aljabali,[2] Ángel Serrano-Aroca,[3] Murtaza M. Tambuwala,[4] Vladimir N. Uversky,[5] Elrashdy M. Redwan,[6,7] Debmalya Barh,[8,9] and Kenneth Lundstrom[10,*]

Willibald Wonisch, Academic Editor

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Abstract

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COVID-19 vaccines have been widely used to reduce the incidence and disease severity of COVID-19. Questions have lately been raised about the possibility of an association between COVID-19 vaccines and myocarditis, an inflammatory condition affecting the myocardium, or the middle layer of the heart. Myocarditis can be caused by infections, immune reactions, or toxic exposure. The incidence rate of myocarditis and pericarditis was calculated to be 5.98 instances per million COVID-19 vaccine doses delivered, which is less than half of the incidences after SARS-CoV-2 infection. Myocarditis rates in people aged 12 to 39 years are around 12.6 cases per million doses following the second dose of mRNA vaccination. Adolescent men are more likely than women to develop myocarditis after receiving mRNA vaccines. The objectives of this systematic review and meta-analysis are to find out how often myocarditis occurs after receiving the COVID-19 vaccine, as well as the risk factors and clinical repercussions of this condition. Nevertheless, the causal relationship between vaccination and myocarditis has been difficult to establish, and further research is required. It is also essential to distinguish between suggested cases of myocarditis and those confirmed by endomyocardial biopsy.

Myocarditis with **COVID**-19 mRNA **vaccines**

B Bozkurt, I Kamat, PJ Hotez - Circulation, 2021 - Am Heart Assoc

... **Myocarditis** has been recognized as a rare complication of **coronavirus** disease 2019 (**COVID**-19) mRNA **vaccinations**... Disease Control and Prevention, **myocarditis**/pericarditis rates are ...

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Myocarditis after BNT162b2 mRNA **vaccine** against **Covid**-19 in Israel

D Mevorach, E Anis, N Cedar... - ... England Journal of ..., 2021 - Mass Medical Soc

... To assess the incidence of **myocarditis** among **vaccine** recipients, we ... **vaccinated** and unvaccinated persons. To calculate the risk difference, we determined the risk of **myocarditis** per ...

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Article | Published: 12 December 2022

Apparent risks of postural orthostatic tachycardia syndrome diagnoses after COVID-19 vaccination and SARS-Cov-2 Infection

Alan C. Kwan ✉, Joseph E. Ebinger, Janet Wei, Catherine N. Le, Jillian R. Oft, Rachel Zabner, Debbie Teodorescu, Patrick G. Botting, Jesse Navarrette, David Ouyang, Matthew Driver, Brian Claggett, Brittany N. Weber, Peng-Sheng Chen & Susan Cheng

Nature Cardiovascular Research **1**, 1187–1194 (2022) | Cite this article

Abstract

Postural orthostatic tachycardia syndrome (POTS) was previously described after severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection; however, limited data are available on the relation of POTS with Coronavirus Disease 2019 (COVID-19) vaccination. Here we show, in a cohort of 284,592 COVID-19-vaccinated individuals, using a sequence–symmetry analysis, that the odds of POTS are higher 90 days after vaccine exposure than 90 days before exposure; we also show that the odds for POTS are higher than referent conventional primary care diagnoses but lower than the odds of new POTS diagnosis after SARS-CoV-2 infection. Our results identify a possible association between COVID-19 vaccination and incidence of POTS. Notwithstanding the probable low incidence of POTS after COVID-19 vaccination, particularly when compared to SARS-Cov-2 post-infection odds, our results suggest that further studies are needed to investigate the incidence and etiology of POTS occurring after COVID-19 vaccination.

Testimony FWA SB431 case study.pdf
Uploaded by: Emily Tarsel
Position: FWA

manuscript; H. Cetin report no disclosures relevant to the manuscript; M. Hülsmann reports no disclosures relevant to the manuscript; P. Wohlfarth reports no disclosures relevant to the manuscript.

DATA AVAILABILITY STATEMENT

Anonymized data not published within this article will be made available by request from any qualified investigator.

ETHICS STATEMENT

We confirm that we have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

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Post–COVID-19 vaccine small-fiber neuropathy and tinnitus treated with plasma exchange

Small-fiber neuropathy (SFN) is a known complication of vaccinations, including the coronavirus disease-2019 (COVID-19) mRNA vaccines.[1] A 52-year-old man received the BNT162b2 mRNA COVID-19 vaccine. After two doses, he had paresthesias as well as burning and stabbing pain in the arms, face, and eyes, accompanied by high-pitched right ear tinnitus. He subsequently developed orthostatic intolerance and was unable to stand and walk without syncope. These symptoms progressed for 5 months and cardiac monitoring revealed significant postural tachycardia with heart rate varying from 50 beats per minute (bpm) supine to 180 bpm standing with episodes of supraventricular tachycardia. Neurological examination was normal except diminished sensation to temperature in the feet.

The following laboratory tests were normal or negative: comprehensive metabolic profile, complete blood count, vitamin B12 and B6 levels, thyroid-stimulating hormone, homocysteine, methylmalonic acid, serum protein electrophoresis with immunofixation, paraneoplastic antibody profile, antinuclear antibody, double-stranded DNA, Lyme antibody, C-reactive protein, and erythrocyte sedimentation rate. Hemoglobin A1C was mildly elevated at 5.7%. Electromyography and nerve conduction studies were normal in the upper and lower extremities. Skin biopsy revealed decreased epidermal nerve fiber density of 2.2/mm^2 (normal 13.8) at the distal leg and 7.5/mm^2 at the thigh (normal 21.1). MRI of the brain and internal auditory canals was unremarkable. Expanded antibody testing (CellTrend Laboratories, Luckenwalde, Germany) revealed elevated

Abbreviations: COVID-19, coronavirus disease-2019; PLEx, plasma exchange; POTS, postural orthostatic tachycardia syndrome; SARS-CoV-2, severe acute respiratory syndrome coronavirus-2; SFN, small-fiber neuropathy.

TABLE 1 Autoantibody titers pre- and post-PLEx

Antibody	Pre-PLEx titer (units/mL)	Post-PLEx titer (units/mL)	Reference range (units/mL)
Anti–α1-adrenergic antibodies	21.8	6.8	<7/0
Anti–β1-adrenergic antibodies	41.9	5.0	<15.0
Anti–β2-adrenergic antibodies	39.1	3.5	<8.0
Anti-muscarinic cholinergic receptor-1 antibodies	18.7	3.7	<9.0
Anti–muscarinic cholinergic receptor-2 antibodies	25.5	3.3	<9.0
Anti–ACE2 antibodies	41.5	15.7	<9.8
Anti-Mas antibodies	61.3	30.8	<25.0

ACE2, angiotensin-converting enzyme 2; PLEx, plasma exchange

titers of antibodies to multiple adrenergic receptors along with muscarinic cholinergic receptors and angiotensin-converting enzyme 2 (ACE2) (Table 1).

The patient was treated with nadolol 40 mg/day, with improvement in tachycardia. Gabapentin 600 mg three times daily for 1 month, amitriptyline 50 mg/day for 2 months, and trazodone 50 mg twice daily for 2 months resulted in no improvement in pain. He was then treated with intravenous immunoglobulin 2 g/kg one time, but he developed hemolytic anemia with the second treatment. He was started on subcutaneous immunoglobulin 200 mg/kg per week for three doses, with improvement of his neuropathic pain but significant worsening of tinnitus. A course of prednisone at 0.5 mg/kg per day for 1 month had no effect.

He underwent five plasma exchanges (PLEx) over 10 days without side effects. His neuropathic pain began to improve after the second exchange and resolved after five exchanges. In addition, after the fourth exchange his heart rate and blood pressure remainder stable upon standing, permitting him to ambulate normally. His tinnitus persisted but improved. Subsequent antibody testing showed reduction of all titers (Table 1).

We have identified a case of small-fiber and autonomic neuropathy with tinnitus after COVID-19 vaccination responding to PLEx. There are multiple reports of SFN after various vaccinations, including human papillomavirus, varicella zoster virus, Lyme and rabies,[2] and COVID-19.[1] Post-vaccine neuropathy is likely immune-mediated from either hypersensitivity to the vaccine solvent or to the active components of the vaccine itself. In our patient, the presence of the ACE2 antibody suggests an immune reaction to the vaccine itself as the vaccine mRNA encodes the spike protein that binds to ACE2 receptors. ACE2 antibodies have been described after infection with severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2).[3]

A distinctive feature of our case was dysautonomia and the postural orthostatic tachycardia syndrome (POTS). POTS has been described following both SARS-CoV-2 infection and COVID-19 vaccination.[4] A subset of patients with POTS have antibodies to beta-adrenergic and muscarinic cholinergic receptors[5]; the presence of these antibodies in our patient and the response to PLEx suggests that his POTS was an immune-mediated response to the COVID-19 vaccination, although the antibody titers may also have represented a monophasic response to the vaccination.

The patient's tinnitus responded partially to PLEx. Interestingly, his anti-ACE2 and anti-Mas antibodies (in the ACE pathway) were the only antibodies to remain elevated when tested after plasma exchange though the titers of both decreased. Recent studies examining tinnitus after infection with SARS-CoV-2 show that the human inner ear expresses the ACE2 receptors and that the virus directly infects inner ear hair and Schwann cells via entry through this receptor.[6] This suggests that the anti-ACE2 antibodies induced by vaccination may have cross-reacted with cochlear ACE2 receptors and contributed to the tinnitus.

To date, PLEx has been used successfully for treatment of thrombotic thrombocytopenia purpura after adenovirus-based COVID-19 vaccination,[7] but not for treatment of neuropathy. Our case indicates a need for further investigation of the immune response to COVID-19 vaccination and possible immunomodulatory treatments of adverse neurological events.

KEYWORDS

COVID-19, dysautonomia, plasma exchange, small-fiber neuropathy, vaccination

CONFLICTS OF INTEREST

T.H.B. has received consulting income from Pfizer, Akcea, Ionis, and Alnylam, and clinical trial funding from Ionis and Alnylam to his institution. The remaining authors have no disclosures.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request." cd_value_code="text

ETHICAL PUBLICATION STATEMENT

We confirm that we have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

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Diagnosing myasthenia gravis in older patients: Comments and observations

We read with great interest the excellent manuscript published in the latest issue of *Muscle & Nerve* entitled" Validation of myasthenia gravis diagnosis in the older Medicare population" by Lee et al.[1] This study concerns an extremely important issue of myasthenia gravis (MG) epidemiology in patients aged 65 y or older. The authors demonstrated algorithms that, based on the International Classification of Diseases (ICD) codes, enabled them to identify with high accuracy MG patients aged ≥65 y in administrative health data.[1] The issues raised by Lee and colleagues are of special interest as in recent decades a steady increase in MG incidence and prevalence rates has been observed, especially in the elderly.[1,2] Due to comorbidities and the aging process, the diagnostic approach to elderly patients remains a great challenge for clinicians.

Therefore, this study is appealing but raises several points that require discussion. Importantly, some MG symptoms in the elderly may be perceived as age-related, such as ptosis often misdiagnosed as senile ptosis or fatigue commonly attributed to other neurological disorders associated with aging. However, the diagnostic criteria used by the authors did not take into account clinical features of MG, such as fluctuating weakness of ocular and/or extraocular muscles. Noteworthy, the presence of these symptoms justifies further targeted diagnostics.

Interestingly, as many as 38% of patients were classified as ocular MG, despite having a median disease duration of 5 y in 2015, which exceeds the data from other reports. It is widely assumed that the majority of patients with ocular MG experience conversion to generalized disease within 2 y from onset, and up to 20% of them continue to manifest isolated ocular MG.[2,3] Sakai et al. showed that elderly individuals with late onset MG experienced transition to generalized symptoms at a higher frequency than non-elderly ones.[4]

We are surprised that only 19 patients had repetitive nerve stimulation (RNS) tests performed, and 17 patients had single fiber electromyography (SFEMG). Among them, 15 patients had confirmed postsynaptic neuromuscular junction dysfunction in RNS tests and 16 patients in SFEMG. The percentage of patients who underwent electrophysiological studies appears to be particularly low compared to the fact that results of serum antibody testing were available in all subjects. However, false positive acetylcholine receptor (AChR) antibodies results can occur in radioimmunoprecipitation assays in patients without clinical MG symptomatology, and such findings should be confirmed in a live cell-based assay.[5]

Therefore, questions arise as to why the electrophysiological tests and clinical symptomatology were scarcely reported in these patients? Did they complain about less specific symptoms or could electrodiagnostic techniques be too burdensome for them? We are also interested in which methods were used to detect the antibodies against antigens of the neuromuscular junction? Interestingly, despite such a high percentage of patients with ocular MG, only 7.2% of the study participants were seronegative.

When considering the increase in MG prevalence in the elderly, one cannot be certain that the proportion of seronegative patients in

Abbreviations: MG, myasthenia gravis; **ICD**, International Classification of Diseases; **AChR**, acetylcholine receptor; **RNS**, repetitive nerve stimulation; **SFEMG**, single fiber electromyography.

Testimony FWA- SB431 compensation -2024.pdf
Uploaded by: Emily Tarsel
Position: FWA

Emily Tarsell, LCPC

2314 Benson Mill Road

Sparks, Maryland 21152

March 5, 2024

FAVORABLE with AMENDMENT SB431

Madame Chair, Sponsors and Senate Finance Committee Members,

I am Emily Tarsell, a mom, a licensed therapist and President of Health Choice Maryland. We favor SB 431 with an amendment to include for compensation those eligible employees who were Covid vaccine injured.

All medical procedures and products come with risk. Such is the case with the COVID 19 vaccines. We now have documented studies and reports of serious adverse outcomes from COVID vaccines: blood clots, heart inflammation, seizures, autoimmune disorders, chronic fatigue, ringing in the ears, POTS and more.[1] The National Institute of Health (NIH) and Center for Disease Control (CDC) acknowledge a causal relationship between COVID 19 vaccination and myocarditis and other outcomes are pending.[2,3,4,5]

COVID vaccines were fast track approved with little testing. Pharma and the medical industry were given blanket immunity for adverse outcomes. So where do heroes who were COVID vaccinated to help others go when they become the Covid vaccine injured? There are heroes with us on Zoom. They suffer serious afflictions but feel abandoned by a system

- Where your voice is censored or silenced and no one is running a marathon or wearing a ribbon for you.
- Where there is no research for you and your case is called a “rare” event– as if being catastrophically harmed physically, emotionally and financially is irrelevant; you’re just a statistic.
- Where you have no legal recourse. You were mandated to accept 100% of the risk, while our government and the manufacturers have no liability or obligation to help you. They failed to put in place robust policies to protect those who would be harmed.
- Where you have little to no chance for any compensation. The Covid vaccine compensation program, the CICP, is broken, underfunded, lacks transparency and to date has paid only 11 claims for an average payment of $3,700.

These heroes were abandoned by the system and left to fend for themselves medically and financially. We ask that the bill be amended to honor and include these heroes.

Thank you.

Emily Tarsell

References:

[1] See attached list of references.
[2]https://www.nature.com/articles/s41598-022-10928-z
[3] National Library of Medicine https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10043280/
[4] National Institure of Health https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9905103/
[5] Vaccine and Immunization CDC https://www.cdc.gov/vaccines/covid-19/clinical-considerations/myocarditis.html

Support 2024 Senate Bill 0431.pdf
Uploaded by: Eszter Szabo
Position: FWA

Support with Amendment for 2024 Senate Bill 0431

Eszter Szabo
Bethesda, MD 20817
March 4, 2024

The original SB 431 is aiming to add Long-Covid as an occupational disease to be eligible under Workers' Compensation for those employed by a governmental unit in Maryland. I support this bill with an amendment which will include those employees of the government to be added to Workers' Compensation who are experiencing Covid-19 vaccine injuries.

The Covid-19 vaccine was developed in a couple of months which is a short period compared with the usual 5-10 year-long process of vaccine development. These vaccines went through a minimal clinical trial process and their manufacturing process development was also warp-speed. It is thus not surprising that today there are tens of thousands of people who are experiencing serious CV-19 vaccine injuries as a result.

The federal Covid Injury Compensation Program is supposed to carry out compensation for those who have been injured by the mRNA Covid vaccines. However, this program is lacking in administration and it has a long backlog. Therefore, additional compensation programs need to be established. Also, many government employees in the state were required to receive this vaccine to keep their job and they are now vaccine injured.

Please support this bill with an amendment that would also compensate Covid vaccine injured government employees along with those who have long Covid disease.

Thank you and sincerely,

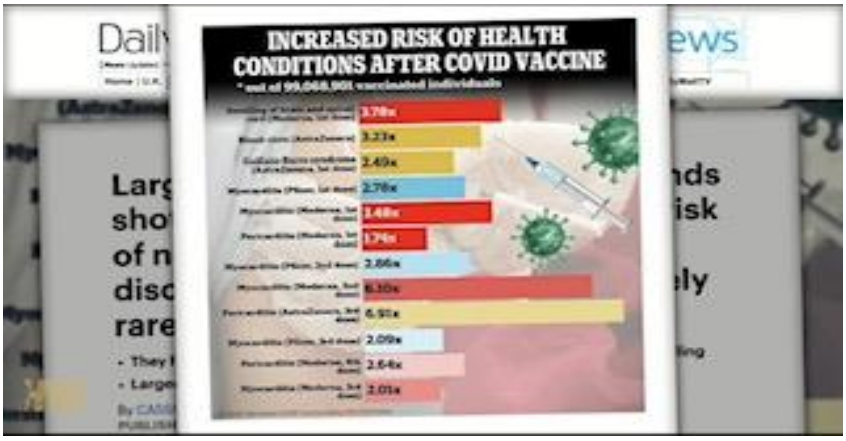
The following data is from The Global COVID Vaccine Safety (GCoVS) Project which aims, among other issues, at the following activities:

- "Conduct association studies for events that have been identified as likely associated with COVID-19 vaccines
    - Myocarditis and pericarditis and mRNA vaccines
    - Thrombosis with thrombocytopenia syndrome/vaccine-induced immune thrombotic thrombocytopenia (TTS/VITT) and viral vector vaccines
    - Guillain-Barré syndrome (GBS) and viral vector vaccines
- Assess risk of vaccine mediated enhanced disease"

Increased of risk of health conditions after Covid Vaccine

Swelling of brain and spinal cord (Moderna, 1st dose)	3.78x
Blood clots (AstraZeneca)	3.23x
Guillain-Barré syndrome (AstraZeneca, 1st dose)	2.49x
Myocarditis (Pfizer, 1st dose)	2.78x
Myocarditis (Moderna, 1st dose)	3.48x
Pericarditis (Moderna, 1st dose)	1.74x
Myocarditis (Pfizer, 2nd dose)	2.86x

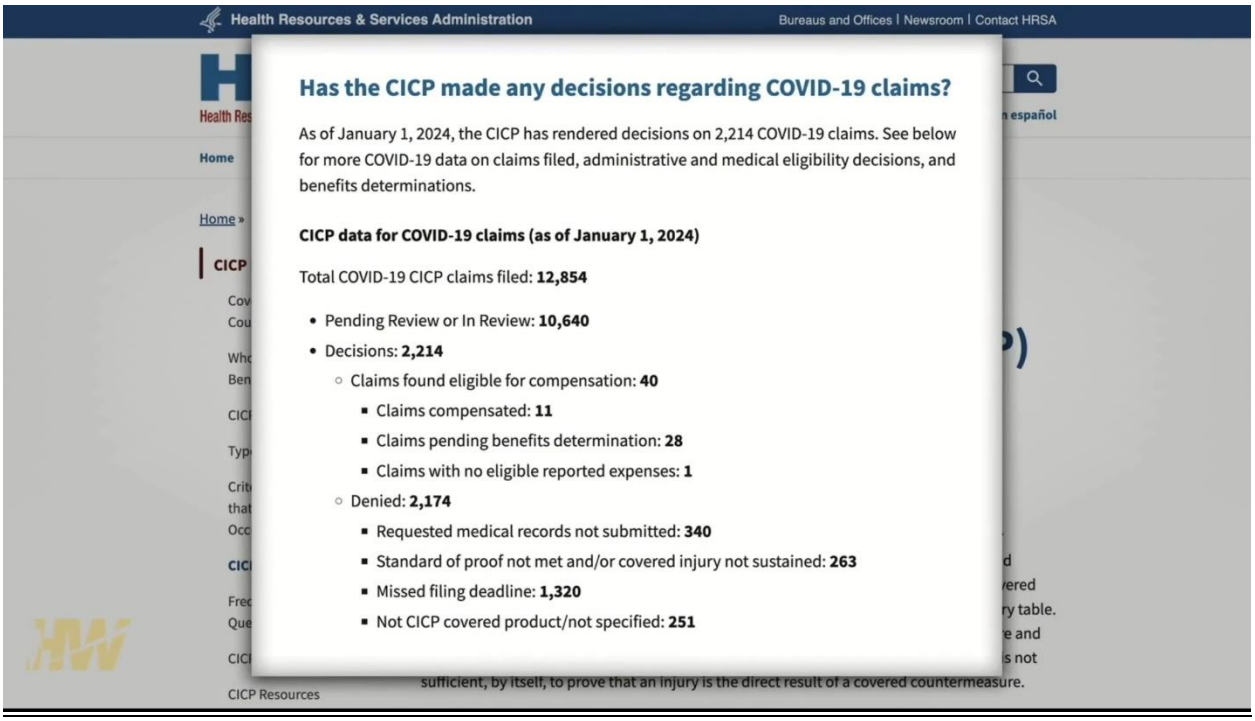
Myocarditis (Moderna, 2nd dose)	6.10x
Pricarditis (AstraZeneca, 3rd dose)	6.91x
Myocarditis (Pfizer, 3rd dose)	2.09x
Pericarditis (Moderna, 4th dose)	2.64x
Myocarditis (Moderna, 3rd dose)	2.01x



The following data is from the webpage of the Health Resources & Services Administration (HRSA).

"According to testimony given during a Feb. 15 hearing of the Select Subcommittee on the Coronavirus pandemic, there's a backlog of about 10,800 claims. With only 35 employees processing claims at a rate of 2.7 cases per employee per month, it will take about 10 years to process the remaining claims."


EPOCH HEALTH
US Vaccine Injury Compensation Program
According to testimony given during a Feb. 15 hearing of the Select Subcommittee on the Coronavirus Pandemic, there's a backlog of about 10,800 claims. With only 35 employees processing claims at a rate of 2.7 cases per employee per month, it will take about 10 years to process the remaining claims.
vaccine to receive a decision on whether their claim is eligible for compensation by the government's vaccine compensation program—if they receive a response at all.


Health Resources & Services Administration
Bureaus and Offices | Newsroom | Contact HRSA
Has the CICP made any decisions regarding COVID-19 claims?
As of January 1, 2024, the CICP has rendered decisions on 2,214 COVID-19 claims. See below for more COVID-19 data on claims filed, administrative and medical eligibility decisions, and benefits determinations.
CICP data for COVID-19 claims (as of January 1, 2024)
Total COVID-19 CICP claims filed: 12,854
Pending Review or In Review: 10,640
Decisions: 2,214
Claims found eligible for compensation: 40
Claims compensated: 11
Claims pending benefits determination: 28
Claims with no eligible reported expenses: 1
Denied: 2,174
Requested medical records not submitted: 340
Standard of proof not met and/or covered injury not sustained: 263
Missed filing deadline: 1,320
Not CICP covered product/not specified: 251
Home
CICP Resources
sufficient, by itself, to prove that an injury is the direct result of a covered countermeasure.

SB431.pdf
Uploaded by: Jill Kapper
Position: FWA

JIll Kapper
221 Owings Gate Court T2
Owings Mills MD 21117
SB431-Favorable W/Amendments

Good afternoon,

My name is Jill Kapper and I'm a lifelong resident of Maryland. I'm supporting this Bill with the amendment to compensate those mandated to take the covid injection and then injured by the vaccine. I don't believe the compensation should end with long covid. Why would those injured by covid receive compensation but Not those heroes that kept us all together. Many of these heroes experienced lifelong injuries and all from a vaccine they never wanted in the first place. Talk about brave right! Workers compensation is supposed to be cash benefits to anyone who is injured or becomes ill as a direct result of their job. It doesn't get any more direct than a mandate so I ask of you to only support this Bill if the amendment is to be included.

Thank you for listening

SB 431 (jmkelly).pdf
Uploaded by: John Kelly
Position: FWA

Support with Amendment SB 431

Before the Senate Finance Committee

of the

Maryland General Assembly

Hearing on SB 431

March 5, 2024

Written Testimony in Support with Amendment to Senate Bill 431

John M. Kelly

Bethesda, Maryland

I support Senate Bill 431 with an amendment that persons injured by Covid-19 vaccines be included in the bill. They are equally deserving of compensation as those with Long-Covid included in the bill. They also should be presumed to have an occupational injury that is compensable under workers' compensation law after being diagnosed as injured from a Covid-19 vaccine.

A January 2021 article (see: https://www.nejm.org/doi/full/10.1056/NEJMp2034438) published by the *New England Journal of Medicine* stated that "All potential vaccine recipients, and especially people in high-risk communities... face a dilemma" about whether to take the COVID-19 vaccine: "… Should they risk becoming infected or risk having a vaccine injury without sufficient access to compensation?"

This dilemma was especially difficult because the Covid-19 vaccine was rolled out in a matter of months rather than the usual ten years it takes for vaccine testing and approval. The article noted that such a short timeline does not provide opportunity to see long-term effects until a vaccine is distributed to a large population. It further noted that adverse vaccine effects are particularly hard on low-income persons who do not have insurance or financial means to deal with vaccine injuries.

Unfortunately, the article's concerns about the potential **risks** of adverse effects from Covid-19 vaccines and the lack of adequate **compensation** for those who might be injured have proven to be – to say the least – well-founded.

In regard to risks, adverse effects (injuries) from Covid-19 vaccines are not rare, not merely anecdotal. They can – without qualification – be described as disastrous. In recent Congressional testimony, Federal Drug Administration, Director, Dr. Peter Marks said the federal program that tracks adverse effects from vaccines (the "Vaccine Adverse Events Reporting System") was faced with an

avalanche of reported adverse reactions to Covid-19 vaccines. There were more adverse events reported for Covid-19 vaccines than for all other vaccines since the reporting system began in 1990.

As of January 2024, there were more than 37,000 reported deaths from the vaccine, 214,000 hospitalizations, thousands of reports of myocarditis, pericarditis, anaphylaxis, Bell's palsy and other serious injuries. It is important to note that these numbers reflect only a fraction of the actual injuries because of under-reporting. A recent conservative analysis estimates the official estimates could be increased by thirty times.

Further evidence of widespread injuries is a recent study of ninety-million vaccinated persons. It showed the persons were: (1) two to six times more likely (depending on which vaccine they took and which dose) to experience Myocarditis; (2) two to seven times more like to experience pericarditis (depending on which vaccine they took and which dose); (4) four times more likely to experience "swelling of the brain and spinal cord" (Moderna, first does); and (5) three times more likely to have "blood clots" (AstraZeneca).

The elevated risks of injury from Covid-19 vaccines are likely far worse than this CDC and FDA funded study found. It only focused on thirteen of hundreds of possible adverse effects after vaccinations, and – glaringly – excluded "deaths". It tracked people for only 47 days after vaccinations and did not include many adverse reactions considered worse than the 13 it studied. (For a critique of the study's limited analysis see: https://kirschsubstack.com/p/99-million-patient-records-and-they).

In addition, a well-documented study by the Society of Actuaries is consistent with the large number of reported Covid-19 vaccine injuries. In the second quarter of 2023, deaths were 26 percent higher than normal among insured 35-to-44-year-olds, and 19 percent higher among 25-to-34-year-olds. These high rates continued a death spike that peaked in the third quarter of 2021 at a staggering 101 percent and 79 percent above normal, respectively. (See: https://thehill.com/opinion/healthcare/4354004-this-is-bigger-than-covid-why-are-so-many-americans-dying-early/).

In regard to adequate compensation, the concern expressed in the NEJM's article was, again, well founded. Persons injured by Covid-19 vaccines cannot sue pharmaceutical companies that produced the vaccines. Instead, they have to go through a long and difficult process – with no "rebuttal presumption" provision like that proposed in SB 431.

They have to file claims with the federal "Countermeasures Injury Compensation Program" (CICP). Their chances of success are slim, and if successful, the amount of compensation paltry.

As of January 1, 2024, there were 12,854 Covid-19 injury claims of which only 11 have been approved and paid an average of just $3,700. Twenty-nine (29) have been approved and are awaiting payment determination. Over half of the 2,174 denied claims were dismissed because the claimants missed the one-year deadline for filing.

Over 10,000 cases are pending. It is reported that only 35 employees are working on the backlogged cases at a rate of 2.7 per month per employee. At this rate it will take about ten years to process pending claims. (See: https://thehighwire.com/ark-videos/world-leader-forced-to-face-failure-to-vaccine-injured/)

The tens of thousands of person injured by Covid-19 vaccines face hurdles equal to or even greater – in regard to compensation for injury– than those with Long Covid. It is clear from the number of people compensated by the CICP and the amount of compensation paid that the Covid-19 vaccine-injured have been abandoned. They are people who did what they were advised and urged to do by public health officials, and in many cases mandated to do by public agencies or lose their jobs.

FOP35_SB431_Testimony_FAV.pdf
Uploaded by: Lee Holland
Position: FWA

Fraternal Order of Police
Montgomery County Lodge 35

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Phone 301.948.4286 Fax 301.590.0317

TESTIMONY

SB431 - Workers' Compensation – Occupational Disease Presumption – Long COVID
(Home of the Brave Act of 2024)

FAVORABLE WITH AMENDMENTS

Dear Chairs Beidle and Wilson, and honorable members of the Senate Finance Committee and the House Economic Matters Committee:

As a current Montgomery County law enforcement officer and the current President of Montgomery County Fraternal Order of Police Lodge 35 (Lodge 35), on behalf of our lodge which proudly represents over 1500 active and retired Montgomery County law enforcement officer, I write in strong support of SB431, the Home of the Brave Act, and I ask for a favorable report.

Throughout the period encompassing Governor Hogan's declaration of a COVID-19 "State of Emergency" from March 5, 2020, to July 1, 2021, numerous frontline workers in the public sector were mandated to continue their duties, despite facing heightened risks of infection and related health challenges. These individuals were classified as "essential" due to the nature of their responsibilities, which necessitated their physical presence to ensure the uninterrupted continuity of critical governmental services. This indispensable group of workers include fire and rescue personnel, healthcare professionals, law enforcement officers, educators at various levels, park service personnel, and numerous others essential to maintaining governmental operations during the declared emergency.

While many of these dedicated individuals contracted COVID-19 and subsequently recovered, a significant portion fell victim to what is now recognized as Long COVID, a complex condition characterized by a myriad of persistent health issues following initial infection. According to the Centers for Disease Control (CDC), Long COVID encompasses a spectrum of symptoms ranging from respiratory and cardiovascular disorders to neurological complications, musculoskeletal ailments, and various other debilitating conditions. Regrettably, there remains no definitive cure for this affliction.

Tragically, a considerable number of frontline workers grappling with Long COVID have encountered hurdles in accessing workers' compensation benefits for their service-related disabilities. The proposed legislation under SB341 acknowledges the extraordinary sacrifices made by these individuals by establishing a presumption for Long COVID as an occupational disease, specifically for those who diligently fulfilled their duties throughout the duration of Governor Hogan's declared state of emergency.

We ask the committee to consider amending the period for testing positive for Covid-19 from July 15, 2021 to September 1, 2021. This amendment would cover essential workers who contacted Covid-19 during the Governor's declared state of emergency but didn't test positive until later. In rare cases, it has taken almost 30 days to test positive from Covid-19 from initial contact.

It is incumbent upon us to provide the necessary care and compensation to these courageous frontline workers who have selflessly dedicated themselves to safeguarding our communities, often at great personal risk. As such, I implore you to support this critical measure, and I ask for a favorable report.

With sincerest regards,

Lee Holland
President
Montgomery County Fraternal Order of Police Lodge 35

roswell-testimony-sb-431-seeking-injury-amendment.
Uploaded by: Marjorie Roswell
Position: FWA

Verbal Testimony

Article 25 of the Declaration of Human Rights notes that everyone has the right to security in the event of disability

My testimony is in the form of a song.

Well I got my vaccination, and then suddenly behold!
My face it felt a-fire and I went home and I told myself to not freak out.
Do some work.
Got some work done, yeah, I'm strong, but then the fever came, oh no.
Woah.

Well, I tried some meditation, opened up my sleeping app,
But my temperature was rising, and every day since then I've really felt like crap
Laying low, seeking out the bedroom quarters
But neuropathy prevails.
My brother says I'm crazy, tells my friends I'm off the rails

Well I tell my friends what happened to me, they don't seem to care
They just say: "misinformation…" "not causation," or "what happened to you is quite rare."
"Anti-vax! You're an antivax conspiracist, and definitely wrong"
(They think they're so much smarter and that's why I wrote this song.)
Lie, lie, lie, lie, lie lie

I tell them of the whistleblowers, people harmed in trials
Unreported, unsupported, and I cite the facts, and impacts. They won't read the files
Their eyes are closed. They just can not see the suffering. They will not lend an ear.
"It's safe and it's effective. Boost, or you're not welcome here."

The workers compensation law is just right for this case
Compassionate support will bring us to a better place
The injured in America have zero right to sue
Compensation for the injured? Well: It depends on you!
Lie, lie, lie, lie, lie lie lie lie lie lie lie lie… that's no lie.

Written Testimony

A Serious Subject

The song in my verbal testimony takes a light-hearted approach to a very serious subject. Those of us who find ourselves unlucky and injured start out alone. In my case, I suffer from post-vaccine neurological pain, tinnitus and other symptoms.

Over time, many of the injured find one other, and we naturally form support groups. While we find emotional support, we also find ourselves surrounded by profound human suffering. The situation honestly reminds me of the "Hell" panel of a painting by Bosche. While individual symptoms vary (cardiac, or gastric, or neurological, or menstrual or autoimmune, or some unfortunate blend) the experiences most have in common are disability, lost income and financial pressure. Many without support have been careening towards–or beyond– homelessness.

Last week I persuaded an injured friend–whose suffering is extreme–not to go to Switzerland to end her life. She had already paid her down payment, and was raising funds for the rest. There have been too many vaccine injury suicides; The intersection of physical suffering, targeted gaslighting, and poverty convene into unlivable lives.

I never lost my mobility. Despite profound impact, I have *never* had the degree of injury that would cause me to have suicidal ideation. But every single injured person experiencing such ideation credits the physical torture of their symptoms. They have a strong preference for their pain to stop vs. the alternative choice they are considering. But **I've noticed that many people are reaching this stage when the money runs out.**

Vaccine-injured people in the United States do not have the legal right to sue for compensation

There are several very important things to know about the COVID mRNA vaccines.

First, we were promised many things about the vaccines that proved not to be true. "Safe and effective" messaging is the start. For many of us in the injury community, the "safe" messaging is just a way of saying that we are collateral damage, and we are swept under the rug.

Most people do not know that what was studied and what was delivered were manufactured by two different processes.[1]

Further: the Nobel-prize-winning technology that enabled the vaccine (substituting pseudouridine for each uridine to increase mRNA stability) has been proven faulty. "Ribosomal frameshifting" doesn't "slip off the tongue" (and there has been little mainstream coverage) but it is a real phenomenon that was published in the respected journal *Nature*[2]. The result is that the vaccine mRNA yields both off-target proteins (i.e. not spike protein) and an off-target immune response. The impact is grossly-under-studied.

We have not properly studied many important issues. Standard testing protocols were given a pass with the Emergency Use Authorization. One of the issues missed by regulators in an epic way is that each vial contains billions to hundreds of billions

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[1]Guetzkow JA. Letters to the editor: Effect of mRNA Vaccine Manufacturing Processes on Efficacy and Safety Still an Open Question. BMJ 2023;378:o1731

[2] Mulroney, T.E., Pöyry, T., Yam-Puc, J.C. et al. N1-methylpseudouridylation of mRNA causes +1 ribosomal frameshifting. Nature 625, 189–194 (2024). https://doi.org/10.1038/s41586-023-06800-3

of molecules of DNA![3] This is not what we were initially told. The vaccines were purportedly safe precisely because there was no DNA.

The DNA finding is not pseudoscience, It has been confirmed by multiple molecular biology labs around the world in 2023 (long after regulators should've found it). We should be testing for incorporation of DNA into the human genome. I know how much that sounds like "conspiracy theory." News organizations are calling related claims "Misleading." But we must not let truth be shrouded by what we wish to be true. I can walk anyone on the committee who is interested through many levels of detail on this issue.

I was a science major who won the award for the highest GPA in my major (The Betty Flanders Thomson Prize for Excellence in Botany). I routinely read science. And now I read it for my advocacy work on behalf of the injured. Most people can not (on their own) get through the *Nature* article on *ribosomal slippage* or the molecular biology published about the *plasmid DNA in the vaccines*). I make it a point to read until I understand. And my new phrase is: the deeper the dive, the greater the concern. I realize that is often called a "rabbit hole." But I hold a deep, abiding concern for the role of valid science. **We should NOT be ignoring these findings.**

Other key findings of concern include the *persistence of mRNA*[4] (that we were promised would not happen) and the *biodistribution of the mRNA* (that we were also assured would not happen). The modified mRNA has been found in many tissues, including breast milk[5], and the mRNA remains in the body for a much longer period than originally promised).

Unexpected proteins yielding an immune response, plasmid DNA, mRNA persistence, mRNA biodistribution, genetic predisposition, may *all* be mechanisms for injury. The COVID vaccines are substantially different from prior vaccines.

In a database containing 1,833,754 reports recorded since 1990 in the Vaccine Adverse Event Reporting System (VAERS), a whopping 56% of the reports are from the COVID vaccines. (See chart below.)

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[3] https://osf.io/preprints/osf/mjc97

[4] Brogna C, Cristoni S, Marino G, Montano L, Viduto V, Fabrowski M, Lettieri G, Piscopo M. Detection of recombinant Spike protein in the blood of individuals vaccinated against SARS-CoV-2: Possible molecular mechanisms. Proteomics Clin Appl. 2023 Nov;17(6):e2300048. doi: 10.1002/prca.202300048. Epub 2023 Aug 31. PMID: 37650258.

[5] Hanna N, Heffes-Doon A, Lin X, et al.. Detection of messenger RNA COVID-19 vaccines in human breast milk. JAMA Pediatr. Published online September 26, 2022. doi: 10.1001/jamapediatrics.2022.3581

Safety Signals

I believe I have discovered why the federal government insists that there are so few "safety signals" (that signal cause for further research into causation) in the VAERS database. I'd like to work with epidemiologists and statisticians and pharmacovigilance experts to explore precisely if the Proportional Reporting Ratio *cancels out* safety signals.

Consider Guillain-Barre Syndrome (GBS), for instance (one of more than 14,700 reported adverse events). GBS is a very serious disease that often paralyzes people, and in some cases kills them. Ten percent of all the GBS reports in the VAERS database are from the Pfizer COVID-19 vaccine. In essence, if Pfizer were the only COVID vaccine: I believe there would be a glaring safety signal (triggering further research and potential for federal compensation). But when compared against ALL the rest of the vaccines (including the J&J and Moderna vaccines, which are also associated with GBS), **the Proportional Reporting Ratio places Pfizer adverse event (AE) incidence in the numerator while the other high-risk COVID vaccines AEs are in the denominator.** They cancel each other out. ***Voila, no safety signal!*** If there were only one COVID vaccine, that cancellation wouldn't be possible, and more neuro-injuries might land on the list of potentially compensable through the federal Countermeasures Injury Compensation Program (CICP). If anyone on the committee can put me in touch with experts to explore this, I'd be happy to work with them. I am a data analyst with a skillset in data visualization. I have a strong sense that what I'm saying is true, and deeply concerning. We should be looking at this, because it impacts the potential for profoundly injured people to get compensation.

Helping People with Compensation

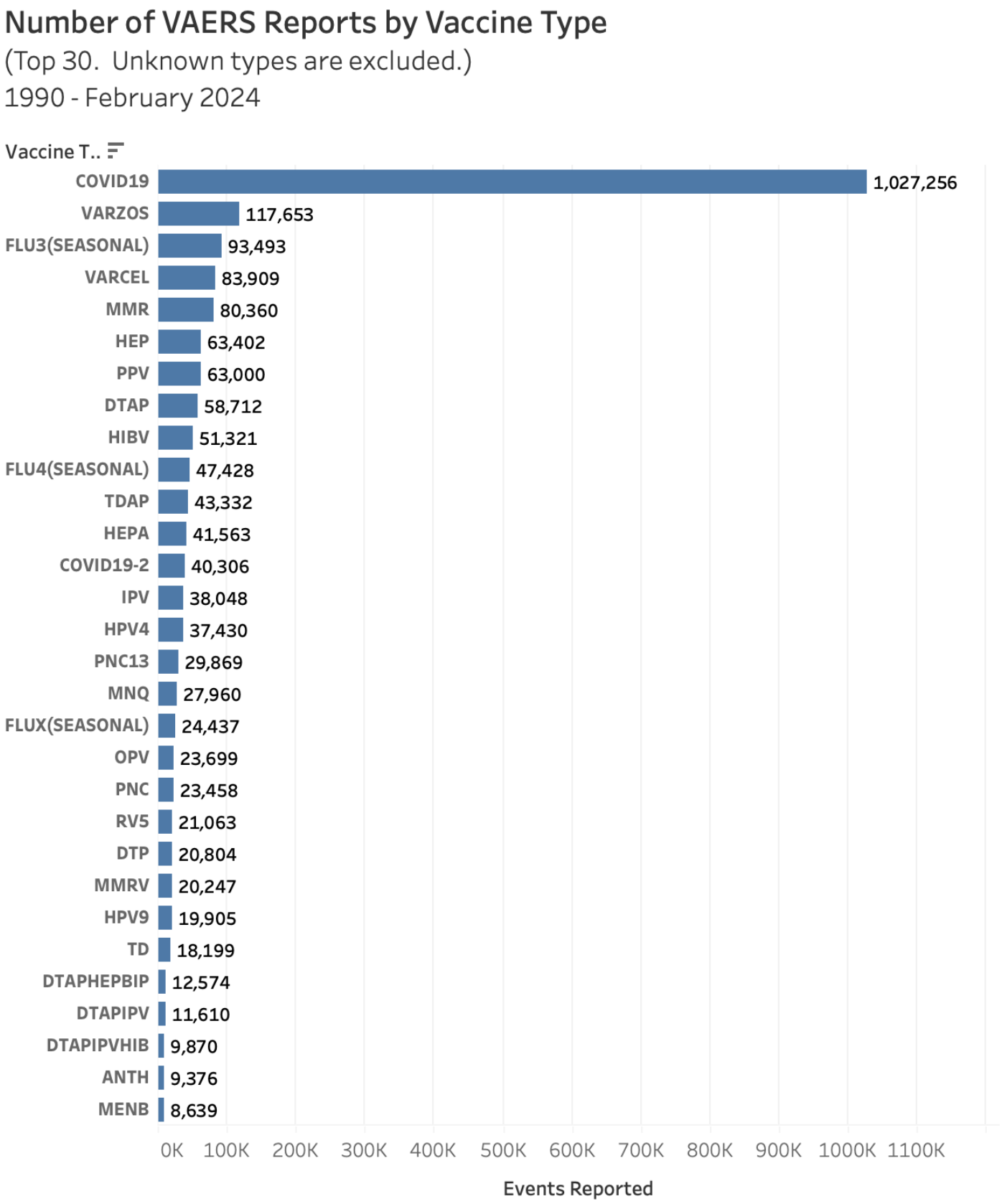
Article 25 of the Universal Declaration of Human Rights notes that everyone has the right to security in the event of disability.

Unfortunately, none (zero) of my profoundly-injured friends who applied to the Countermeasures Injury Compensation Program (CICP) have received compensation.
CICP is currently the only option for compensation for COVID vaccine-injured, but it is a broken program. People's most basic needs are not being met.

One thing I appreciate about Senate Bill 431 is that it applies retroactively.

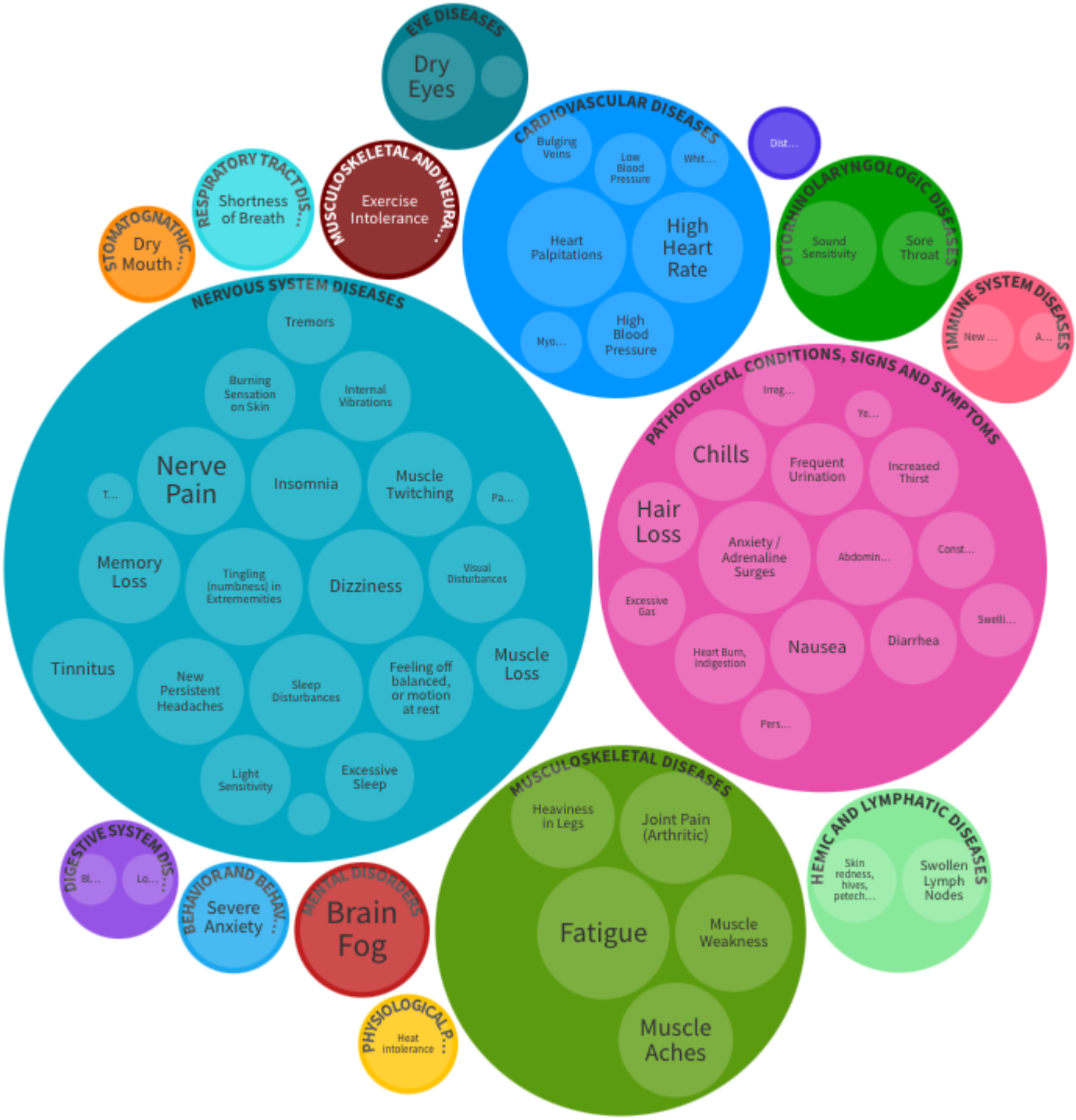
But the piece that is missing is that vaccine-mandated injured people were also injured on the job, and they are neglected in the bill. Please amend Senate Bill 431 to make vaccine-injury compensable, especially if the vaccine was mandated.

Appendix


Number of VAERS Reports by Vaccine Type
(Top 30. Unknown types are excluded.)
1990 - February 2024
Vaccine T..
COVID19 1,027,256
VARZOS 117,653
FLU3(SEASONAL) 93,493
VARCEL 83,909
MMR 80,360
HEP 63,402
PPV 63,000
DTAP 58,712
HIBV 51,321
FLU4(SEASONAL) 47,428
TDAP 43,332
HEPA 41,563
COVID19-2 40,306
IPV 38,048
HPV4 37,430
PNC13 29,869
MNQ 27,960
FLUX(SEASONAL) 24,437
OPV 23,699
PNC 23,458
RV5 21,063
DTP 20,804
MMRV 20,247
HPV9 19,905
TD 18,199
DTAPHEPBIP 12,574
DTAPIPV 11,610
DTAPIPVHIB 9,870
ANTH 9,376
MENB 8,639
0K 100K 200K 300K 400K 500K 600K 700K 800K 900K 1000K 1100K
Events Reported

React19 Survey 2: Persistent Symptoms

(React19 is a non-profit advocating for the injured.)



FWA SB 431.pdf
Uploaded by: Mark Meyerovich
Position: FWA

Favorable with Amendment SB 431

Difficult long term conditions, such as Long COVID, undoubtedly cause significant physical, emotional, and financial stress on those suffering.

There is some research that indicates that rare cases of COVID vaccine injury manifest and cause similar burdens as cases of Long COVID. Both may be related to spike protein toxicity present in both conditions.
https://www.science.org/content/article/rare-cases-coronavirus-vaccines-may-cause-long-covid-symptoms
https://www.nature.com/articles/s44161-022-00177-8
https://www.mdpi.com/2076-2607/11/5/1308
https://medicine.yale.edu/ycci/listen-study/

Please amend the bill to allow the same benefits to the essential workers who suffered COVID vaccine injuries.

Sincerely,
Mark Meyerovich
Gaithersburg, MD
District 15

2024 SB 431 Favorable with Amendment.pdf
Uploaded by: Melissa Burns
Position: FWA

SB 431 - Workers' Compensation – Occupational Disease Presumption – Long COVID (Home of the Brave Act of 2024)

Favorable with Amendment

I want to thank the sponsors for introducing a bill showing compassion for those struggling with the symptoms of Long COVID. I am a licensed counselor in Maryland. In 2021 I volunteered with people who suffered COVID vaccine injury. Many of whom were no longer able to work and lost health insurance, as a result of their injuries. I ask you to amend this bill to be all-inclusive by providing workers compensation benefits, not only to those with Long COVID under the presumption they got COVID by being an exposed essential worker, but also to those essential workers who are suffering life-long COVID vaccine injuries as a result of vaccine mandates enforced by their employers. You can visit the websites listed below to learn more about the vaccine-injured. Please vote "Favorable with Amendment" for SB431.

react19.org
realnotrare.com

Melissa Burns
Forest Hill, Maryland

favorably with Amendment for SB 431.pdf
Uploaded by: Peter DOrazio
Position: FWA

Hello Senate Finance Committee,

Please vote favorably with Amendment for SB 431– Amend the bill to include compensation for those eligible employees who were injured by their COVID-19 vaccination.

My husband got long COVID and severely struggled to work to provide for our family as a breadwinner. My son and I were terrified that he could die!

Then his job threatened him with loss of job if not covid vaccinated despite having the virus prior. He got the JJ COVID-19 vaccine and got very sick with a powerful headache, ptosis, fever, whole body pain, and symptoms like a stroke.. Again, my son and I were terrified that he could die! Only a few months before, two Maryland friends 50 years old died shortly after vaccination so my heart stopped because of fear that my husband could die just as our friends died or become paralyzed and unable to work to provide for us and have a healthy life.

We as a family went through serious mental trauma from losing young friends shortly after vaccination, from government tyrannical overreach over our bodily autonomy and freedoms, and suffered physical trauma from the COVID-19 virus and vaccine.

I am here today to speak up for Marylanders who are vaccine-injured and on behalf of those emotionally hurt by Covid restrictions. Please add those eligible employees who were Covid vaccinated and became seriously ill to the list of the heroes who should get financial support.

Thank you,

Daniela D’orazio

Muscle and Nerve - 2022 - Schelke - Post COVID-19
Uploaded by: Shaun Barcavage
Position: FWA

manuscript; H. Cetin report no disclosures relevant to the manuscript; M. Hülsmann reports no disclosures relevant to the manuscript; P. Wohlfarth reports no disclosures relevant to the manuscript.

DATA AVAILABILITY STATEMENT

Anonymized data not published within this article will be made available by request from any qualified investigator.

ETHICS STATEMENT

We confirm that we have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

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Post–COVID-19 vaccine small-fiber neuropathy and tinnitus treated with plasma exchange

Small-fiber neuropathy (SFN) is a known complication of vaccinations, including the coronavirus disease-2019 (COVID-19) mRNA vaccines.[1] A 52-year-old man received the BNT162b2 mRNA COVID-19 vaccine. After two doses, he had paresthesias as well as burning and stabbing pain in the arms, face, and eyes, accompanied by high-pitched right ear tinnitus. He subsequently developed orthostatic intolerance and was unable to stand and walk without syncope. These symptoms progressed for 5 months and cardiac monitoring revealed significant postural tachycardia with heart rate varying from 50 beats per minute (bpm) supine to 180 bpm standing with episodes of supraventricular tachycardia. Neurological examination was normal except diminished sensation to temperature in the feet.

The following laboratory tests were normal or negative: comprehensive metabolic profile, complete blood count, vitamin B12 and B6 levels, thyroid-stimulating hormone, homocysteine, methylmalonic acid, serum protein electrophoresis with immunofixation, paraneoplastic antibody profile, antinuclear antibody, double-stranded DNA, Lyme antibody, C-reactive protein, and erythrocyte sedimentation rate. Hemoglobin A1C was mildly elevated at 5.7%. Electromyography and nerve conduction studies were normal in the upper and lower extremities. Skin biopsy revealed decreased epidermal nerve fiber density of 2.2/mm^2 (normal 13.8) at the distal leg and 7.5/mm^2 at the thigh (normal 21.1). MRI of the brain and internal auditory canals was unremarkable. Expanded antibody testing (CellTrend Laboratories, Luckenwalde, Germany) revealed elevated

Abbreviations: COVID-19, coronavirus disease-2019; PLEx, plasma exchange; POTS, postural orthostatic tachycardia syndrome; SARS-CoV-2, severe acute respiratory syndrome coronavirus-2; SFN, small-fiber neuropathy.

TABLE 1 Autoantibody titers pre- and post-PLEx

Antibody	Pre-PLEx titer (units/mL)	Post-PLEx titer (units/mL)	Reference range (units/mL)
Anti–α1-adrenergic antibodies	21.8	6.8	<7/0
Anti–β1-adrenergic antibodies	41.9	5.0	<15.0
Anti–β2-adrenergic antibodies	39.1	3.5	<8.0
Anti-muscarinic cholinergic receptor-1 antibodies	18.7	3.7	<9.0
Anti–muscarinic cholinergic receptor-2 antibodies	25.5	3.3	<9.0
Anti–ACE2 antibodies	41.5	15.7	<9.8
Anti-Mas antibodies	61.3	30.8	<25.0

ACE2, angiotensin-converting enzyme 2; PLEx, plasma exchange

titers of antibodies to multiple adrenergic receptors along with muscarinic cholinergic receptors and angiotensin-converting enzyme 2 (ACE2) (Table 1).

The patient was treated with nadolol 40 mg/day, with improvement in tachycardia. Gabapentin 600 mg three times daily for 1 month, amitriptyline 50 mg/day for 2 months, and trazodone 50 mg twice daily for 2 months resulted in no improvement in pain. He was then treated with intravenous immunoglobulin 2 g/kg one time, but he developed hemolytic anemia with the second treatment. He was started on subcutaneous immunoglobulin 200 mg/kg per week for three doses, with improvement of his neuropathic pain but significant worsening of tinnitus. A course of prednisone at 0.5 mg/kg per day for 1 month had no effect.

He underwent five plasma exchanges (PLEx) over 10 days without side effects. His neuropathic pain began to improve after the second exchange and resolved after five exchanges. In addition, after the fourth exchange his heart rate and blood pressure remainder stable upon standing, permitting him to ambulate normally. His tinnitus persisted but improved. Subsequent antibody testing showed reduction of all titers (Table 1).

We have identified a case of small-fiber and autonomic neuropathy with tinnitus after COVID-19 vaccination responding to PLEx. There are multiple reports of SFN after various vaccinations, including human papillomavirus, varicella zoster virus, Lyme and rabies,[2] and COVID-19.[1] Post-vaccine neuropathy is likely immune-mediated from either hypersensitivity to the vaccine solvent or to the active components of the vaccine itself. In our patient, the presence of the ACE2 antibody suggests an immune reaction to the vaccine itself as the vaccine mRNA encodes the spike protein that binds to ACE2 receptors. ACE2 antibodies have been described after infection with severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2).[3]

A distinctive feature of our case was dysautonomia and the postural orthostatic tachycardia syndrome (POTS). POTS has been described following both SARS-CoV-2 infection and COVID-19 vaccination.[4] A subset of patients with POTS have antibodies to beta-adrenergic and muscarinic cholinergic receptors[5]; the presence of these antibodies in our patient and the response to PLEx suggests that his POTS was an immune-mediated response to the COVID-19 vaccination, although the antibody titers may also have represented a monophasic response to the vaccination.

The patient's tinnitus responded partially to PLEx. Interestingly, his anti-ACE2 and anti-Mas antibodies (in the ACE pathway) were the only antibodies to remain elevated when tested after plasma exchange though the titers of both decreased. Recent studies examining tinnitus after infection with SARS-CoV-2 show that the human inner ear expresses the ACE2 receptors and that the virus directly infects inner ear hair and Schwann cells via entry through this receptor.[6] This suggests that the anti-ACE2 antibodies induced by vaccination may have cross-reacted with cochlear ACE2 receptors and contributed to the tinnitus.

To date, PLEx has been used successfully for treatment of thrombotic thrombocytopenia purpura after adenovirus-based COVID-19 vaccination,[7] but not for treatment of neuropathy. Our case indicates a need for further investigation of the immune response to COVID-19 vaccination and possible immunomodulatory treatments of adverse neurological events.

KEYWORDS

COVID-19, dysautonomia, plasma exchange, small-fiber neuropathy, vaccination

CONFLICTS OF INTEREST

T.H.B. has received consulting income from Pfizer, Akcea, Ionis, and Alnylam, and clinical trial funding from Ionis and Alnylam to his institution. The remaining authors have no disclosures.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request." cd_value_code="text

ETHICAL PUBLICATION STATEMENT

We confirm that we have read the Journal's position on issues involved in ethical publication and affirm that this report is consistent with those guidelines.

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7. Major A, Carll T, Chan CW, et al. Refractory vaccine-induced immune thrombotic thrombocytopenia (VITT) managed with delayed therapeutic plasma exchange (TPE). *J Clin Apher*. 2022;37: 117-121.

Diagnosing myasthenia gravis in older patients: Comments and observations

We read with great interest the excellent manuscript published in the latest issue of *Muscle & Nerve* entitled" Validation of myasthenia gravis diagnosis in the older Medicare population" by Lee et al.[1] This study concerns an extremely important issue of myasthenia gravis (MG) epidemiology in patients aged 65 y or older. The authors demonstrated algorithms that, based on the International Classification of Diseases (ICD) codes, enabled them to identify with high accuracy MG patients aged ≥65 y in administrative health data.[1] The issues raised by Lee and colleagues are of special interest as in recent decades a steady increase in MG incidence and prevalence rates has been observed, especially in the elderly.[1,2] Due to comorbidities and the aging process, the diagnostic approach to elderly patients remains a great challenge for clinicians.

Therefore, this study is appealing but raises several points that require discussion. Importantly, some MG symptoms in the elderly may be perceived as age-related, such as ptosis often misdiagnosed as senile ptosis or fatigue commonly attributed to other neurological disorders associated with aging. However, the diagnostic criteria used by the authors did not take into account clinical features of MG, such as fluctuating weakness of ocular and/or extraocular muscles. Noteworthy, the presence of these symptoms justifies further targeted diagnostics.

Interestingly, as many as 38% of patients were classified as ocular MG, despite having a median disease duration of 5 y in 2015, which exceeds the data from other reports. It is widely assumed that the majority of patients with ocular MG experience conversion to generalized disease within 2 y from onset, and up to 20% of them continue to manifest isolated ocular MG.[2,3] Sakai et al. showed that elderly individuals with late onset MG experienced transition to generalized symptoms at a higher frequency than non-elderly ones.[4]

We are surprised that only 19 patients had repetitive nerve stimulation (RNS) tests performed, and 17 patients had single fiber electromyography (SFEMG). Among them, 15 patients had confirmed postsynaptic neuromuscular junction dysfunction in RNS tests and 16 patients in SFEMG. The percentage of patients who underwent electrophysiological studies appears to be particularly low compared to the fact that results of serum antibody testing were available in all subjects. However, false positive acetylcholine receptor (AChR) antibodies results can occur in radioimmunoprecipitation assays in patients without clinical MG symptomatology, and such findings should be confirmed in a live cell-based assay.[5]

Therefore, questions arise as to why the electrophysiological tests and clinical symptomatology were scarcely reported in these patients? Did they complain about less specific symptoms or could electrodiagnostic techniques be too burdensome for them? We are also interested in which methods were used to detect the antibodies against antigens of the neuromuscular junction? Interestingly, despite such a high percentage of patients with ocular MG, only 7.2% of the study participants were seronegative.

When considering the increase in MG prevalence in the elderly, one cannot be certain that the proportion of seronegative patients in

Abbreviations: MG, myasthenia gravis; **ICD**, International Classification of Diseases; **AChR**, acetylcholine receptor; **RNS**, repetitive nerve stimulation; **SFEMG**, single fiber electromyography.

Testimony FWA SB431 Shaun Barcavage.pdf
Uploaded by: Shaun Barcavage
Position: FWA

Shaun's Covid Vaccine Reaction Story FWA Maryland SB-431

My name is Shaun Barcavage, and I am a 54-year-old Research Nurse Practitioner.

I was at the height of my career with no medical issues prior to receiving Dose 1 of the Pfizer Covid vaccine on December 29, 2020.

Within hours, I developed paresthesia along my right injected arm which radiated up my back and progressed to my face.

I was seen by a neurologist at my hospital who advised that I proceed with a second dose due to mandates. Against my own medical judgment, I acquiesced and got a dose 2 on January 19, 202l.

Within 4 days, the paresthesia in my right side returned with intensity and I developed severe ringing in my right ear.

Over the next 14 days, I developed cardiac arrhythmias, positional tachycardia, wildly fluctuating blood pressures, severe right-sided headache, worsening tinnitus, stinging sensations all over my body, muscle twitches and vibrations in my legs.

Frequent testing showed I did not have Covid and the temporal association of my symptoms with the vaccine was clear. This is well documented in my medical records and in an attached case study.

In my desperate search for care, I was confronted by an ill-informed, ill-equipped medical system that simply did not know how to help. Distressingly, I was often censored in my attempts to seek answers and advocate for help online.

At the height of the pandemic, I was considered a nurse hero, a mainstream medical provider working on covid interventions including, ironically, vaccine research.

Now, I am disabled, with 24/7 constant torture by burning neuropathies, screeching ear ringing and autonomic nervous system dysfunction.

I have lost income and have mounting medical costs. I am frightened for my future and my medical career is in ruins.

I understand this bill is about helping those medical professionals who were harmed by long Covid, but I urge you, do not neglect and abandon those harmed by the Covid vaccines.

We are faced with a broken compensation system, no research, and no help.

Please amend the bill to include compensation and help for those disabled by Covid vaccines.

Thank you.

Shaun Barcavage

ADDENDUM:

I now know from personal experience what happens to someone harmed by a Covid vaccine in the United States. I didn't have time verbally to list the ways that those like me with Covid vaccine injuries are abandoned and left to struggle medically, financially, socially, and emotionally, but it is in my written testimony below.

1. You are caught in the crosshairs of extremist politics. Your voice is often censored, silenced, or labeled. You have an affliction where no one is running a marathon or wearing a ribbon for you.
2. There is no research for you, and you are minimized in vaccine studies as “rare” events – as if our being harmed is irrelevant, as if we are an unacceptable, statistical human casualty. It may be rare in numbers, but the cost to many of us is catastrophic.
3. You have no legal recourse. In essence, many of us were mandated to accept 100% of the risk, while under emergency use authorization, our government and the manufacturers have zero risk or obligation to research or help you. We researchers knew with any new drug like this there would be adverse events, but the government failed to put in place robust policies to protect those who would be harmed.
4. I have little to no chance for any compensation. Covid vaccines were placed into a special compensation program that is broken, underfunded, lacks transparency and to date has paid out less than 30,000 dollars to ALL applicants in total.

This is not about being pro-vaccine or anti-vaccine, this is about getting those medical professionals who were harmed the recognition they deserve, the help they desperately need and fixing faults in the system. I urge and beg you to include those disabled by the Covid vaccines in your bill.

You can read and understand more about Shaun's injury here:

Twitter
@ResearcherNP

Instagram
the.solivagants

Facebook Profile
https://www.facebook.com/shaun.barcavage

Facebook Tinnitus Post-V Support Group
https://www.facebook.com/groups/265035901879921

Links to speeches and important content:

Washington D.C. Roundtable

Shaun R. Barcavage, FNP-BC
Speech

https://www.bitchute.com/video/mRgoY8ozE5ek/

Appearance in Anecdotals Movie
https://www.anecdotalsmovie.com/

German NGO Article
"The Vacuum"
https://www.human-perspective.org/single-post/the-vacuum

Shaun Barcavage Dr. Been First Interview
https://www.youtube.com/watch?v=SobqUw7gqhs

Shaun Barcavage Dr. Been Second Interview
https://www.youtube.com/watch?v=-Bmg758Cgdo

Shaun Barcavage Dr. Been Third Interview
https://www.youtube.com/watch?v=TCkqz3kzf4s

BMJ Rapid Response on the CICP
https://www.bmj.com/content/377/bmj.o919/rr-0

Muscle & Nerve Case Report – Completed in 4/2022 – with severe deterioration in symptoms in 5/2022
https://onlinelibrary.wiley.com/doi/10.1002/mus.27696

Dearly Discarded
NIH Study Interview
https://podcasts.apple.com/us/podcast/episode-9-shaun-barcavage-first-ever-nih-study-on-neuro/id1618595974?i=1000563916266

General Articles:
https://kmph.com/we-do-exist-some-americans-suffer-life-changing-covid-vaccine-injuries

https://www.newsweek.com/2022/05/13/doctors-shrug-off-patients-rare-vaccine-disorders-delaying-treatment-1703110.html

https://worldcouncilforhealth.org/multimedia/react19/

NIH Study Link
Neuropathic symptoms with SARS-CoV-2 vaccination
https://www.medrxiv.org/content/10.1101/2022.05.16.22274439v1

SB0431.pdf
Uploaded by: Suzanne Price
Position: FWA

SB0431 I support this bill with amendments. Those amendments should be to include eligible employees who have been damaged, been harmed or injured by the covid vaccinations.

Thank you for this added amendment that could help so many in need and suffering.
Check VAERS for deaths and adverse side effects from C19 shots.

https://www.cdc.gov/vaccinesafety/ensuringsafety/monitoring/vaers/index.html

VAERS AE reports	***N* (%)**
Number of AE reports of COVID-19 vaccines	604,157
Pfizer-BioNTech COVID-19 vaccine	262,883 (43.51)
Moderna COVID-19 vaccine	284,765 (47.13)
Janssen COVID-19 vaccine	55,111 (19.73)
Reports with missing manufacturer	1,308 (0.22)
Mean age (range), years	49.43 (0.08–119)
0–18	26,454 (4.38)
19–44	200,776 (33.23)
45–64	186,073 (30.80)
65–84	119,189 (19.73)
85 +	12,776 (2.11)
Missing	58,889 (9.75)
Female sex	412,610 (68.30)
AE outcomes	
ER visits after being vaccinated	75,911 (12.56)
Hospitalization	36,030 (5.96)
Life-threatening events	9,193 (1.52)
Disability	8,890 (1.47)
Death	7,674 (1.27)
Birth defect	343 (0.06)
Prolongation of existing hospitalization	305 (0.05)

VAERS Vaccine Adverse Event Reporting System
www.vaers.hhs.gov

Of course you know by now that the CDC is stating to treat C19 like the flu. The CDC and Fauci have reversed any and all original recommendations. Fauci is now telling the world (live/video) that the shots are causing myocarditis, especially in young males and athletes.

Please include these people in this bill, thank you.

Suzanne Price
AACo, MD

Tricia Teichler-SB0431 Testimony.pdf
Uploaded by: Tricia Teichler
Position: FWA

March 4, 2024

To Whom It May Concern,

My name is Tricia Teichler. My husband, Derek Teichler, is a veteran police officer of 27 years and I have been with him throughout his entire career and before. He has always been active and invested in the community. We served together in the Fire Department as volunteers before he became a police officer. He enjoyed doing things outside and in the yard. March of 2020 changed all of that!

Everyone was sent home and told to remain home under a shut-down around March 13th due to COVID-19. However, there remained critical staffing needs such as First Responders who still needed to report. At that time all we knew was that COVID-19 was extremely contagious, little known about it or how to treat it, and the scariest was people were dying from it! But in light of that, many still had to put their lives on the line to serve the community for essential needs.

My husband, along with many others, answered the calls! Unfortunately for him, it nearly cost him his life!!!

He started to develop symptoms around March 19th-20th and from there the symptoms continued to get worse. He contacted his primary doctor, but at that time you needed a doctor's order to get tested and you had to meet specific criteria to test. On March 25th my husband's doctor had him go to Holy Cross Hospital in Germantown due to the decline in his condition and his symptoms getting worse. They admitted him to meet the criteria for testing and discharged him the next evening. On Friday, March 26th he was contacted to inform him he was COVID +. With his breathing issues, chest discomfort and other symptoms, his doctor told him to return to Holy Cross. The ER doctor discharged him to return home with no real testing or treatment and a diagnosis of asthma!

Over the next several days he continued to worsen. He was at a point that he could not even talk because he could not really breathe and talk at the same time. This was while on a nebulizer and prednisone. His doctor sent him to the hospital again and we decided to go to Shady Grove Hospital.

Immediately upon being seen in the ER at SGAH, they did a CT scan and sent him directly to the Intensive Care Unit! He was at the threshold for being placed on a ventilator and I could not even be there with him. Thankfully I had a good friend that was a nurse there that could check in on him, as many others going through this did not have. She called me to prepare me for the possibility of him being placed on a vent. When she was concerned, I knew it was bad! He could not communicate with me as he could not talk, and he struggled with every breath. Then I had to sit our 2 sons, my mother-in-law that lives with us, and my sister-in-law, down to break the news to them. At this time all you heard in the news was the death toll. What does

this mean for my husband, father of my children, and my best friend? It was an extremely scary time!

Thankfully his life was spared! We are so thankful to have him here with us today! However, it did come at a cost! It has been a long road and he will never be the same as he was before COVID-19.

So initially we thought he would eventually recover and be able to return to life as it was before. When he came home, he was still very much in recovery and still got short of breath just walking in the house. He had doctors to continually follow up with from a pulmonologist, infectious disease doctor, a cardiologist, hematologist, and his primary. He had trouble breathing, congestion, high blood pressure, enlarged heart, joint pain, chest pain with exertion, diminished oxygen levels, malaise, lethargy, coughing fits, light headedness, migraines and headaches, loss of appetite, etc. Many of these lasted for months to a year after, but many he still has to this day. The concern is the ongoing health issues he will experience for the rest of his life.

When he came home, he was frustrated and angry at everything. He was so active before and was unable to do any of the things he could do before. He was the bread winner and worked as much as he could to provide for his family. He no longer was able to do that, which greatly affected us financially. He was home and unable to work for about 10 months. He pushed to return to work on a light duty status. Although he eventually was given the clearance to return, he still struggled to do so. He was angry about not being able to be on the road and doing the job he did before. He struggled because working a 10-hour day, even in an “in office” role, was exhausting. He struggled not being able to support and back up his fellow officers. He struggled with the limitations he was having to come to terms with!

It will be 4 years ago this month that COVID-19 changed our lives forever. At the time Derek contracted COVID-19 he was working. If he had been injured in any other way, it would be workers comp. If he contracted another disease from someone on a call, he would be covered. So why when you have someone who sacrificed themselves to continue to answer the call during a global pandemic, would they not be covered when they have lifelong affects and consequences from their selfless service?

That is why I am here to support and fight for SB0431 Long COVID Home of the Brave Act 2024! We need to support the people and their families that will be suffering the consequences for a lifetime!

Thank you,

Tricia Teichler

MML-SB 431 - OPP.pdf
Uploaded by: Angelica Bailey Thupari
Position: UNF

Maryland Municipal League
The Association of Maryland's Cities and Towns

TESTIMONY

March 5, 2024

Committee: Senate Finance

Bill: SB 431 – Workers' Compensation - Occupational Disease Presumption - Long COVID (Home of the Brave Act of 2024)

Position: Unfavorable

Reason for Position:

The Maryland Municipal League opposes Senate Bill 431, which creates a presumption for essential government workers that a long COVID diagnosis qualifies as a compensable workers' compensation claim.

This measure would expose local governments to a new type of claim with a variety of viability, requiring local governments to spend significant time and resources on their defense. Several variants of COVID-19 were highly contagious, resulting in literally hundreds of thousands of infections. The likelihood that an essential local government employee contracted COVID-19 is high because the likelihood that most Maryland citizens contracted COVID-19 is high. An influx of claims, whether meritorious or not, are inevitable.

Additionally, supporting evidence that actual workplace exposure caused the illness is not required, further lowering the bar for plaintiff employees. Instead, the bill creates a rebuttable presumption requiring an employer to provide "substantial" evidence that the employee contracted COVID-19 outside of the workplace. Employers cannot be expected to have access to this information, so the proposed presumption will be nearly impossible to rebut.

Opening the door to significant difficult-to-prove but difficult-to-rebut litigation will be unfairly and overly burdensome for local governments. For these reasons, the League respectfully requests an unfavorable report on Senate Bill 431.

FOR MORE INFORMATION CONTACT:

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Bill Jorch — Director, Public Policy & Research
Justin Fiore — Deputy Director, Advocacy & Public Affairs

Memo - SB 431 - Long COVID.pdf
Uploaded by: Ashlee Smith
Position: UNF

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Senate Finance Committee

Testimony of the Maryland Defense Counsel, Inc. ("MDC") in Opposition to Senate Bill 431 – Workers' Compensation – Occupational Disease Presumption – Long COVID (Home of the Brave Act of 2024)

Senate Bill 431 creates a rebuttable presumption that a Long COVID-19 diagnosis is an occupational disease arising out of and in the course of employment for government employees. SB 431 will allow an injured worker to establish a *prima facie* case for Long COVID as an occupational disease by submitting (1) proof of COVID-19 diagnosis by a medical profession, (2) proof that the worker was diagnosed within 14 days after the employee worked for the employer in an assigned location other than the employee's home, and (3) proof that the employee was diagnosed with Long COVID as defined by the statute. Once this threshold evidence is submitted, the burden would then shift to the employer/insurer to submit "substantial evidence" showing that the injured worker's infection is not related to the employment. Notably, SB 431 applies to all diagnoses that occur between March 5, 2020 and July 5, 2021. This renders the statute retroactive as it explicitly applies to diagnoses that occurred *prior to* the effective date of the statute.

It is the MDC's position that the retroactive aspect of this presumption bill is unconstitutional. Retrospective statutes that abrogate vested property rights, including contractual rights, violate the Maryland Constitution; specifically, Articles 19[1] and 24[2] of the Maryland Declaration of Rights and Article III, § 40, of the Maryland Constitution.[3] *See Dua v. Comcast Cable of Maryland, Inc.*, 370 Md. 604, 629-30, 805 A.2d 1061, 1076 (2002).

In *Dua v. Comcast Cable,* the Court of Appeals of Maryland ruled two different statutes passed by the General Assembly were unconstitutional. The first was a statute enacted in 2000 that

[1] Article 19 of the Declaration states "[t]hat every man, for any injury done to him in his person **or property**, ought to have remedy by the course of the Law of the Land, and ought to have justice and right, freely without sale, fully without any denial, and speedily without delay, according to the Law of the Land." Md. Const. Declaration of Rights, art. 19 (emphasis added).

[2] Article 24 of the Declaration states "[t]hat no man ought to be taken or imprisoned or disseized of his freehold, liberties or privileges, or outlawed, or exiled, or, in any manner, destroyed, or deprived of his life, liberty **or property**, but by the judgment of his peers, or by the Law of the land." Md. Const. Declaration of Rights, art. 24 (emphasis added).

[3] Article III of the Constitution states "[t]he General Assembly shall enact no Law authorizing private property, to be taken for public use, without just compensation, as agreed upon between the parties, or awarded by a Jury, being first paid or tendered to the party entitled to such compensation." Md. Const. art 3, § 40.

increased the allowable recovery for late fees in consumer contracts that were "entered into, or in effect, on or after November 5, 1995." *Id*. at 610-11, 805 A.2d. at 1065. The second statute provided that contracts between a health maintenance organization ("HMO") and its customer were permitted to contain subrogation provisions allowing the HMO to be subrogated to a cause of action that a customer had against another person. *Id*. at 611, 805 A.2d. at 1065. The HMO statute was also enacted in 2000 and it applied to "all subrogation recoveries by an [HMO] recovered on or after January 1, 1976." *Id*.

In finding both of the statutes unconstitutional, the Court emphasized that "[n]o matter how "rational" under particular circumstances, the State is constitutionally precluded from abolishing a vested property right or taking one person's property and giving it to someone else."[4] *Id.* at 623, 805 A.2d at 1076. It held that **there is normally a vested property right in a cause of action which has accrued prior to the legislative action**. *See id*. at 633, 805 A.2d at 1078.

Accordingly, the legislature is barred "from retroactively creating a cause of action, or reviving a barred cause of action, thereby violating the vested right of the defendant." *Id*. *See also Smith v. Westinghouse Electric*, 266 Md. 52, 57, 291 A.2d 452, 455 (1972). It is further precluded from "abrogating accrued causes of action." *Dua*, 370 Md. at 645, 805 A.2d at 1085 (citing *Gibson v. Commonwealth of Pennsylvania*, 490 Pa. 156, 160–162, 415 A.2d 80, 83–84 (1980), which held that a constitutional provision similar to Maryland's Article 19 providing that persons are entitled to justice "'by the law of the land,'" means "'that the law relating to the transaction in controversy, at the time when it is complete, shall be an inherent element of the case, and shall guide the decision; and that the case shall not be altered, in substance, by any subsequent law.'").

The Court further clarified that even a remedial or procedural statute may not be applied retroactively if it will interfere with vested or substantive rights. *Id*. at 625, 805 A.2d at 1073. This principle applies to both common law and statutory causes of action. *Id*. at 632, 805 A.2d at 1077.

These principles were previously applied by the Court of Appeals with respect to retroactive modifications of the Workers' Compensation Act in *Cooper v. Wicomico County Department of Public Works.* In *Cooper* I and *Cooper* II the Court issued decisions analyzing the constitutionality of a retroactive increase in the amount of benefits payable to a claimant who was found to be entitled to permanent total disability ("PTD") benefits. *See Cooper* I, 278 Md. 596, 366 A.2d 55 (1976), and *Cooper* II, 284 Md. 576, 398 A.2d 1237 (1979). In the *Cooper* cases the subject statute increasing the compensation rate was enacted in 1973 and it retroactively applied to all injuries suffered after July 1, 1965 and prior to July 1, 1973. *See Cooper* I, 278 Md. at 598, 805 A.2d at 57. Given that Mr. Cooper was injured in 1969 and awarded PTD benefits in 1971, the statute increased the maximum compensation payable for his PTD award from $30,000 to $38,397 and it applied a supplemental allowance to his weekly benefit increasing it from $45.33 to $57.96.

[4] Maryland does not apply the "rational basis" test applied by the Federal Courts when analyzing whether a retroactive civil statute violates the U.S. Constitution. *See* i*d. at* 623, 805 A.2d at 1072.

The Court held that the statute unconstitutionally disturbed the vested rights of the employer and insurer because the operational effect of the statute required them to pay more than they were required to pay under the law in effect at the time of the injury.[5] *See id.* The Court held as such because "the basis for a compensation award is contractual and the amount payable thereunder cannot be increased retrospectively." *Id*. at 598-99, 366 A.2d at 57. In doing so, the court noted that:

> An award under the Workmen's Compensation Law is not made on the theory that a tort has been committed; on the contrary, it is upon the theory that **the statute giving the commission power to make an award is read into and becomes a part of the contract**…. The contract of employment, by virtue of the statute, contains an implied provision that the employer, if the employee be injured, will pay to him a certain sum to compensate for the injuries sustained, or if death results, a certain sum to dependents.

Id. (quoting *State Industrial Commission v. Nordenholt Corp.*, 259 U.S. 263, 271 (1992)) (emphasis added). As indicated above, the Court's holdings in *Dua*, *Cooper* I and *Cooper* II, make it clear that it is unconstitutional for the General Assembly to enact retroactive legislation that impairs or adversely impacts a defendant's vested rights in a cause of action that has already accrued in the workers' compensation context.

Currently, in Maryland if a workers' compensation claim is controverted by the employer/insurer, then the injured worker generally bears the burden of proof to establish that his or her condition is an occupational disease that arises out of and in the course of employment.[6] *See Hathcock v. Loftin*, 179 Md. 676, 678-79, 22 A.2d 479, 480 (1941). If enacted, SB 431 will shift the burden of proof in Long COVID claims from the injured worker onto the employer and insurer

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[5] In *Cooper* I the court held that the retroactive increase in the amount of benefits awarded was unconstitutional, but the case was remanded to obtain evidence as to whether the reimbursement provision in the statute removed the adverse financial impact to the employer/insurer. In *Cooper* II the court reviewed the evidence obtained and concluded that the reimbursement provision in the statute did not render it constitutional because there was still a financial injury to the employer and insurer. *See Coope*r II, 284 Md. at 584, 398 A.2d at 1241.

[6] There are exceptions to this general rule due to some statutory presumptions set forth in the Act, but none of the presumptions currently set forth in the Act apply to a COVID-19 diagnosis. *See* Md. Code Ann., Lab. & Emp. §9-202(a) (2024) (presuming that a worker is a covered employee while he or she is in the service of an employer under an express or implied contract for hire); Md. Code Ann., Lab. & Emp. §9-503 (2024) (creating statutory presumptions that certain diseases (heart disease, hypertension, lung disease, Lyme disease, and specific cancers) constitute occupational diseases arising out of and in the course of employment for certain types of employees in public safety related positions); Md. Code Ann., Lab. & Emp. § 9-506(f)(1) (2024) (presuming that injuries are not the result of an employee's deliberate act and placing the burden upon the employer to prove an employee's intent to inflict injury); Md. Code Ann., Lab. & Emp. § 9-506(f)(2)-(3) & (g) (2024) (presuming that injuries were not caused solely or primarily by intoxication of the employee); Md. Code Ann., Lab. & Emp. § 9-702 (2024) (presuming that the claim "comes within the Act," that the injured worker provided sufficient notice of the injury to the employer, and that the employer was not prejudiced by a claim filed more than 60 days after the injury).

in claims where the cause of action has already accrued (*i.e.*, the diagnosis has already occurred). Doing so adversely impacts the rights of employers and insurers by prejudicing their defenses and substantially reducing the amount of proof required in order for an injured worker to successfully pursue a claim. This will make it remarkably easier for an employee to obtain workers' compensation benefits related to Long COVID, which would have an adverse financial impact on employers and insurers by requiring it to pay claims that would normally have been defensible under the existing burden of proof. Such a shift in the burden of proof is unconstitutional when applied to the employer and insurer's vested property rights in the accrued cause of action related to a Long COVID diagnosis.[7]

For all these reasons, the MDC respectfully requests that the Committee provide an unfavorable report on SB 431.

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[7] *See e.g., San Carlos Apache Tribe v. Superior Court*, 972 P.2d 179 (Ariz. 1999) (finding a statute that retroactively changed standards pertaining to water rights violated the state's constitutional due process clause because it impaired or altered vested property rights and noting that legislation "may not disturb vested substantive rights by retroactively changing the law that applies to completed events."); *DeWoody v. Superior Ct.*, 8 Cal. App. 3d 52, 56-57, 87 Cal. Rptr. 210, 212-13 (1970) (finding a change in the rules of evidence by creating a presumption of intoxication based on blood alcohol levels was unconstitutional when applied retroactively because it deprived the defendant of substantial protection and permitted the defendant's conviction upon "less proof, in amount or degree," than was required at the time of the offense).

SB0431-FIN_MACo_OPP.pdf
Uploaded by: Brianna January
Position: UNF

Senate Bill 431

Workers' Compensation - Occupational Disease Presumption - Long COVID
(Home of the Brave Act of 2024)

MACo Position: **OPPOSE**

To: Finance Committee

Date: March 5, 2024

From: Brianna January

The Maryland Association of Counties (MACo) **OPPOSES** SB 431. This bill designates long COVID as a new statutory presumption under workers' compensation for a very wide swath of public sector employees, making any related care or work loss fully borne by the employer. County opposition revolves around compensability, especially with the impossibility of ascertaining whether COVID was contracted on the job or from any number of other sources or exposure situations.

The bill applies to employees who, because of the nature of their roles, were unable to work from home during the height of the COVID-19 pandemic, were diagnosed with COVID, and then later diagnosed with symptoms consistent with long COVID. Under Maryland's statutes and case law, this presumption would be effectively irrebuttable for a lengthy list of public sector employees.

MACo is grateful for the important service of these critical employees during the most significant public health crisis in recent memory. County opposition is to the bill's presumption of compensability, which would place an undue burden on counties as the major employers of these professions, with potentially staggering fiscal impact on local government.

Maryland's workers' compensation law already creates a nearly "perfect storm," where a series of statutory presumptions prompt consideration of workplace exposures leading to compensability. Maryland's courts have effectively ruled that these presumptions are irrebuttable in compensability proceedings, so the outcome of presumption-related cases is virtually assured. Adding even more tenuous categories to this already biased structure would overburden public employers, causing them to shoulder the burden of an even longer list of employee claims − even those that are hard to diagnose and link to professional exposure, like long COVID.

Furthermore, counties are concerned with the uncertain and varied diagnoses of long COVID. A December 31, 2023, *Washington Post* article reported that "long COVID" has as many as 200 symptoms that "continue to confound doctors and patients alike."

Counties caution against the legislating of medical diagnoses that remain largely unagreed upon. Doing so would result in a patchwork of workers' compensation claims and benefits based on widely varying medical opinions. Ultimately, some claimants' situations would be deemed compensable, and others would be denied, despite experiencing the same symptoms. This would create volatility for workers and employers alike. For these reasons, MACo **OPPOSES** SB 431 and urges an **UNFAVORABLE** report.

SB 431 Chesapeake-IWIF Testimony.pdf
Uploaded by: Lyndsey Meninger
Position: UNF

Senate Finance Committee
March 5, 2024

Testimony of Chesapeake Employers' Insurance Company and Injured Workers' Insurance Fund in Opposition to Senate Bill 431

Senate Bill 431 proposes to add an occupational disease presumption for "Long COVID" for governmental essential workers that were employed by a governmental entity during the declared state of emergency that performed labor or services at a work site that could not be performed remotely or they were required to be at the work site. The bill is retroactive to March 5, 2020 and applies to any individuals listed above that worked within 14 days of their positive test or diagnosis by a health care practitioner and subsequently diagnosed with Long COVID from March 5, 2020 to before July 15, 2021. Additionally, the bill includes a rebuttable presumption with "substantial evidence".

The chart below details the COVID claims for Chesapeake Employers' Insurance Company and the Injured Workers Insurance Fund related to First Reports of Injury (FROIs) and Employee Claim Forms (ECFs) filed with the Workers' Compensation Commission as of January 2024. A large amount of the State of Maryland and Local Government claims are from governmental essential workers as listed above. It is unknown how many of these claims would be considered "Long COVID", although we do have several injured workers who have been diagnosed and treated for same.

	State:	**Local Government:**	**Private:**
Total First Reports of Injury (FROIs) for COVID Related Claims (1,379)	368	851	160
Total Number of Employee Claim Forms filed with the WCC (234)	148	47	39

Breakdown of Employee Claim Forms Filed			
	State:	**Local Government:**	**Private:**
Claims Accepted (150):	92	35	23
Claims Contested/Pending (25):	11	6	8
Claims Settled (44):	35	3	6
Claims Disallowed by WCC (15):	10	3	2

Given the above data, COVID-19 claims have largely been accepted by the State of Maryland and Chesapeake Employers' Insurance (or the Commission following a hearing). With that said, as with other presumptions, we can expect an increase of claims due to this addition to the statute, despite the above data's demonstration of fairly providing benefits to employees that contracted work related COVID-19. Additionally, the retroactivity of the bill will create constitutional questions regarding validity of the bill.

Finally, of note, the bill creates an occupational disease presumption; however, COVID-19 is categorized as an accidental injury. COVID-19 does not fall within the definition of an occupational disease and has been found compensable as an accidental injury by the Commission in most claims.

Given that injured workers already have compensable COVID-19 claims, including Long COVID, often filed as an accidental injury, without constitutional challenges to retroactivity, Chesapeake Employers' Insurance Company and the Injured Workers' Insurance Fund must respectfully oppose Senate Bill 431.

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MD 2024 NAMIC letter SB 431 WC Presumption Long CO

Uploaded by: Matt Overturf

Position: UNF

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Senate Judicial Proceedings Committee

SB 431: Workers' Compensation – Occupational Diseases Presumption – Long COVID

UNFAVORABLE | March 5, 2024

Chair Beidle and Members of the Senate Finance Committee,

The National Association of Mutual Insurance Companies (NAMIC) appreciates the opportunity to provide this letter in opposition to Senate Bill 431. While well-intended, we believe SB 431 is unnecessary and will likely create upward pressure on workers' compensation premiums in the state.

NAMIC is the largest property and casualty insurance trade association in the country, with nearly 1,500 member companies. NAMIC supports regional and local mutual insurance companies aswell as some of the country's largest national insurers.

NAMIC very much appreciates the desire to ensure that first responders and frontline medical personnel are protected. Workers' compensation coverage is a critical part of this protection, as it has been for decades. A key principle of workers' compensation coverage for occupational disease is that the disease must bework-related and arise in the course and scope of employment.

The existing statute provides the necessary structure to determine whether COVID-19 claims likely were caused by employment or not. COVID-19 does present challenges because it is also a disease that is spread in the community at large. But this fact only illustrates the caution called for when presumptions of work-relatedness are established. An overly broad presumption of the work- relatedness of COVID-19 claims combined with rampant community spread could easily overwhelmany workers' compensation system.

Presumptions in general remain a concern because of the lack of ability to rebut something that did not need to be proven. Employers and insurers want to compensate injured employees for theircontractually compensable claims and assist workers in getting back to work if possible. However, when clear standards are eliminated and overbroad presumptions are placed upon the system, it adds significant and potentially unwarranted costs.

Workers' compensation systems have existed for more than a century, and claimants have always been able to submit proof to prove the legitimacy of a claim. Employers and insurers willingly pay workers' compensation claims that aremeritorious and have been underwritten and priced according to the known risk at the time of contractual promise. However, when conditions that have traditionally been absorbed by health insurance and other accident and sickness policies are shifted to the workers' compensation system, a significant disruption occurs that has a significant impact.

Finally, SB 431 is applied retroactively to claims filed on or after March 5, 2020. This particular provision is problematic because adequate premium has not been obtained to cover these losses which may cause solvency concerns for smaller insurers in particular.

For the many reasons outlined above, NAMIC respectfully requests an unfavorable report on SB 431.

Thank you,

Matthew Overturf

Matt Overturf
Regional Vice President
Ohio Valley /Mid-Atlantic Region

SB 431 Long Covid Presumption APCIA Unf 03052024 F

Uploaded by: Nancy Egan

Position: UNF

Testimony of

American Property Casualty Insurance Association (APCIA)

Senate Finance Committee

Senate Bill 431 -Workers' Compensation - Occupational Disease Presumption - Long COVID

(Home of the Brave Act of 2024)

March 5, 2024

Unfavorable

The American Property Casualty Insurance Association (APCIA) is a national trade organization whose members write approximately 67% of the U.S. property and casualty insurance market, including 89% percent of Maryland's workers' compensation market. APCIA appreciates the opportunity to provide written comments in opposition to Senate Bill 431.

APCIA opposes Senate Bill 431, which would establish that that governmental essential workers are presumed to have an occupational disease that is compensable under workers' compensation law after being diagnosed with long COVID. The period of initial covid diagnosis must have occurred during the period of March 5, 2020, to July 15, 2021.

Presumptions of compensability are drastic measures that are rarely enacted because they dispense with the fundamental and reasonable requirement that a worker prove that an injury or illness is work-related. Creating a presumption for long COVID for this class of workers would be particularly incongruous here because the Legislature appropriately did not create a presumption for *underlying* COVID for these workers. A worker with long COVID can already file a claim and prove that it arose out of the course and scope of employment, and the playing field should be kept level instead of unfairly stacking it against employers.

For these reasons, APCIA urges the Committee to provide an unfavorable report on Senate Bill 431.

Nancy J. Egan,

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