Health Care News *is sent to every national and state elected official and thousands of opinion leaders.*

THE HEARTLAND INSTITUTE
IS ONE OF THE WORLD'S LEADING FREE-MARKET THINK TANKS. IT IS A NATIONAL NONPROFIT RESEARCH AND EDUCATION ORGANIZATION.

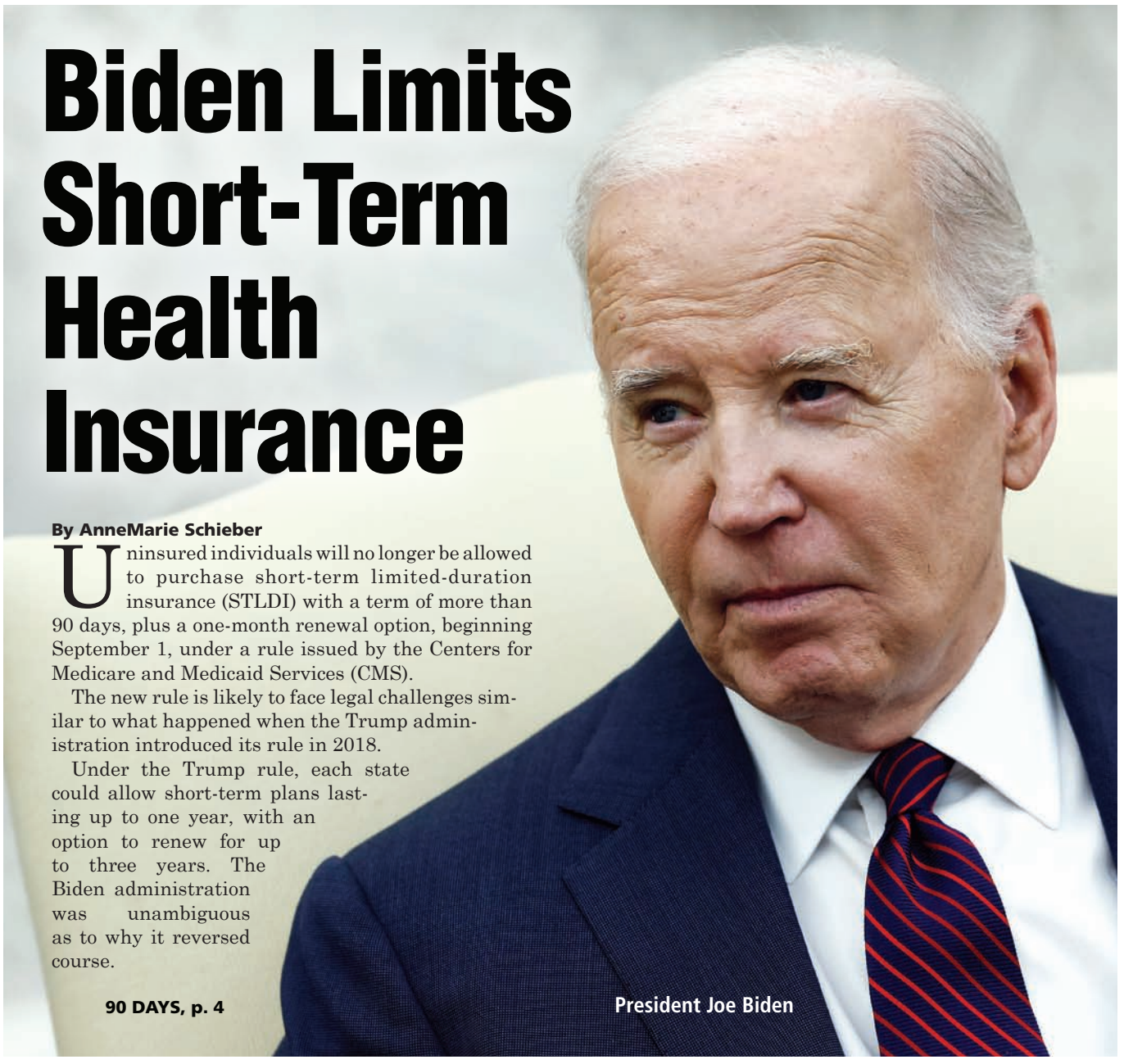
THE GOODMAN INSTITUTE
WORKS WITH THE BEST SCHOLARS FROM AROUND THE COUNTRY ON THE NATION'S MOST DIFFICULT PUBLIC POLICY PROBLEMS.

HEALTH CARE NEWS

©2024 The Heartland Institute / Goodman Institute
Vol. 25 No. 05 May 2024 HealthCareNewsOnline.com

The Pulse

Biden Limits Short-Term Health Insurance



President Joe Biden

PHOTO COURTESY ANNA MONEYMAKER/GETTY IMAGES NEWS

By AnneMarie Schieber

Uninsured individuals will no longer be allowed to purchase short-term limited-duration insurance (STLDI) with a term of more than 90 days, plus a one-month renewal option, beginning September 1, under a rule issued by the Centers for Medicare and Medicaid Services (CMS).

The new rule is likely to face legal challenges similar to what happened when the Trump administration introduced its rule in 2018.

Under the Trump rule, each state could allow short-term plans lasting up to one year, with an option to renew for up to three years. The Biden administration was unambiguous as to why it reversed course.

90 DAYS, p. 4

Justices Appear Skeptical of COVID Censorship Case, Media Reports

By Harry Painter

U.S. Supreme Court justices offered telling feedback to lawyers on both sides in oral arguments on *Murthy v. Missouri*, a landmark case testing the limits of the federal government's power to control information during a public health emergency.

The case, formerly known as *Missouri v. Biden*, was brought by the New Civil Liberties Alliance (NCLA) and deals with alleged White House and executive branch censorship of online medical opinions that did not align

COVID CENSORSHIP, p. 6

NON PROFIT
ORGANIZATION
US POSTAGE PAID
BEAVER DAM, WI
PERMIT NO. 412

The Heartland Institute
3939 North Willie Road
Arlington Heights, IL 60004

Goodman Institute
FOR PUBLIC POLICY RESEARCH

Turning Healthcare Ideas Into Public Policy

Dr. Goodman book tour stop at Cato Institute in Washington, D.C.

Dr. Goodman addressing The Economic Club of Indiana

What We Have Accomplished

Health Savings Accounts

More than 30 million people are managing some of their own health care dollars in accounts they own and control

1

Roth IRAs

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

2

Social Security

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

3

401 (k) Plans

Because of automatic enrollment in diversified portfolios, 16 million employees are enjoying higher and safer returns

4

Visit us at online at **www.GoodmanInstitute.org**

Health Care News

The Heartland Institute
3939 North Wilke Road
Arlington Heights, IL 60004
312/377-4000 voice • 312/277-4122 fax

Goodman Institute
6335 W Northwest Hwy - #2111
Dallas, TX 75225

Health Care News is available on the internet. Point your web browser to **HeartlandDailyNews.com**

PUBLISHED BY
James Taylor, The Heartland Institute
John C. Goodman, Goodman Institute

EXECUTIVE EDITOR
S.T. Karnick

MANAGING EDITOR
AnneMarie Schieber

SENIOR EDITOR
Joe Barnett

PUBLISHER
Jim Lakely

DESIGN AND PRODUCTION
Donald Kendal

ADVERTISING MANAGER
Jim Lakely

CIRCULATION MANAGER
Keely Drukala

CONTRIBUTING EDITORS
Doug Badger, Brian Blase
Dean Clancy, Twila Brase, R.N.
Matt Dean, John Goodman
Devon Herrick, Phil Kerpen
Jane Orient, M.D., Chad Savage, M.D.
Marilyn Singleton, M.D.

ADVERTISING: *Health Care News* accepts display advertising and advertising inserts. For an advertising kit with rate card, contact Associate Publisher Jim Lakely at 312/377-4000, e-mail **jlakely@heartland.org**.

Health Care News is published by The Heartland Institute and The Goodman Institute—nonprofit and nonpartisan public policy research organizations serving the nation's federal and state elected officials, journalists, and other opinion leaders. Their activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

© 2024 The Heartland Institute, The Goodman Institute. Nothing in this issue of *Health Care News* should be construed as reflecting the views of The Heartland Institute or The Goodman Institute, nor as an attempt to aid or hinder the passage of any legislation.

Small Firms Introduce More Drugs at Lower Costs, Study Finds

By Ashley Bateman

Drug price controls in the Inflation Reduction Act (IRA) will not stymie the introduction of new products, because innovative drugs are increasingly being developed and marketed by smaller companies with less capital and revenue than Big Pharma, a new study has found.

Small drug firms earning far less revenue and spending much less than bigger companies on research and development (R&D) produce more than half of the new drugs approved by the Food and Drug Administration (FDA), the report states.

"In 2020, early-stage, unprofitable companies brought nearly 62 percent of new industry-originated drugs approved by the FDA to the clinic, with no less than 54 percent of drugs brought to the clinic by emerging firms in each of the last seven years (2016–2022)," Foundation for Research on Equal Opportunity (FREOPP) health care research fellow Gregg Girvan states in the report.

FREOPP published the report, titled "No Contest: Small Pharma Innovates Better than Big Pharma," on February 28.

"Our study shows the industry is changing such that startups are increasingly bringing their discoveries to market and therefore do not need to be bought out by large firms for venture capitalists to get a return on investment."

GREGG GIRVAN
RESEARCH FELLOW
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

Reduced Revenues

The IRA requires drug companies to "negotiate" prices for the 10 top-selling drugs covered by Medicare, starting in 2023, and 20 additional drugs each year thereafter, or face a high excise tax.

Researchers have expressed concern price controls will discourage drug makers from innovating if they are unable to recoup R&D costs.

Studies have estimated pharma revenues could be reduced by $450 billion under the IRA. A paper by University of Chicago scholar Tomas Philipson and colleagues found 79 small-molecule drugs will not enter the market over the next 20 years because of the IRA's price controls.

Conflicting Research

The Congressional Budget Office (CBO) has estimated price controls will result in the introduction of 13 fewer drugs over a 30-year period, a decrease of 1 percent. Other researchers, like Philipson, estimate a much bigger loss, of 17 percent fewer drugs.

"In some ways, yes, our paper refutes studies such as the [University of Chicago paper], as well as Philipson's previous study examining the effects of a policy proposal similar to the IRA," Girvan told *Health Care News*. "Our paper does not quantify how many drugs would not be developed because of the IRA."

Philipson's estimates do not consider how many drugs developed by startups will never sell enough to be selected under the IRA rules, says Girvan.

"Our study adds valuable context that his studies ignore," said Girvan. "Critics of our work contend that reduced revenue at larger firms hurts everyone because less capital will flow to startups, but our study shows the industry is changing such that startups are increasingly bringing their discoveries to market and therefore do not need to be bought out by large firms for venture capitalists to get a return on investment."

Small-Company Challenges

Firms both large and small have a role in bringing new drugs to patients, says Joel White, president of the Council for Affordable Health Coverage.

"The idea that most new drugs originate at small firms is neither new nor controversial, but suggesting that larger firms can somehow be 'cut out' of the development process with no resulting loss in innovation demonstrates a misunderstanding of the development process," said White. "While roughly two-thirds of promising molecules begin at small firms, this is only the first step."

Following the initial discovery, a drug candidate must undergo additional lab testing, clinical trials, regulatory approval, marketing, manufacturing, and post-approval trials, says White.

"In general, startups lack the experience and financial resources to complete all of these steps themselves," said White. "This is why small firms commonly partner with established firms to bring promising drugs to market. Imposing price controls on medicines that began at startups, but were later acquired and developed by large companies, will severely impact small firms' ability to attract investment and, by extension, their ability to innovate."

Exaggerated Impact?

Girvan says the University of Chicago study employed flawed methodologies that resulted in inaccurate estimates of lost R&D spending and years of life under the IRA.

Philipson calculated a loss of one statistical life year for every $2,000 less in pharma R&D spending, using data on drug development from 1960 to 1997. An updated calculation found one life year lost for every $35,817 less R&D spending.

"These authors are therefore grossly exaggerating the negative impacts of the IRA's drug provisions," said Girvan.

FREOPP recommends reducing red tape at the FDA to allow drugs to get on the market sooner and more cheaply.

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

Biden Limits Short-Term Health Insurance

President Joe Biden

PHOTO COURTESY ANNA MONEYMAKER/GETTY IMAGES NEWS

Continued from page 1

"These regulatory amendments further the goals of the Affordable Care Act (ACA) by improving access to affordable and comprehensive coverage, strengthening health insurance markets, and promoting consumer understanding of their coverage options," states the CMS press release on the regulation.

'How Insurance Used to Work'

Short-term plans are primarily attractive to individual purchasers because the premiums are a fraction of the cost of Obamacare plans and come with a variety of deductibles.

Unlike Obamacare, the plans do not cover preexisting conditions. Consumers buy the plans as a "safety net" to cover unlikely but high-cost medical events. A typical consumer is someone with middle income and no Obamacare subsidies who is too young for Medicare and finds premiums to continue a former employer's group health coverage are too expensive, says Kansas state Sen. Beverly Gossage (R-Eudora), a licensed health insurance agent.

"I had a client who needed emergency gallbladder surgery," said Gossage. "Since it was not a preexisting condition, his short-term plan covered the entire $95,000 treatment bill, less his $2,500 deductible.

"This is how insurance used to work before Obamacare," said Gossage. "Agents were like underwriters and could shop plans best suited for their client's needs, not just the one-size-fits-all ACA plans."

Forced Out of Insurance

The final rule makes government-regulated health insurance worse, not better, says Michael Cannon, director of health policy studies at the Cato Institute.

"Under the new rule, it is possible that a consumer could face up to 12 months with no insurance," Cannon said. "In fact, the Congressional Budget Office estimates one-half million consumers would lose comprehensive insurance coverage."

"[Short-term limited-duration insurance (STLDI)] is too good, so the Departments are trying to make it bad. It is too comprehensive, so the Departments want to make it less comprehensive. The [Notice of Proposed Rulemaking] reveals the Departments' actual purpose is to boost Obamacare enrollment by punishing consumers who make what the Departments—not Congress—believe to be the 'wrong' choice."

MICHAEL CANNON
DIRECTOR OF HEALTH POLICY STUDIES, CATO INSTITUTE

Uninsured consumers are vulnerable to crushing medical bills. Cannon cites the example of Jeanne Balvin in a March 14 paper titled "Biden Short-Term Health Plans Rule Creates Gaps in Coverage."

In 2017, Balvin opted for an STLDI plan from UnitedHealthcare with a monthly premium of $274 a month and a $2,500 annual deductible. The cheapest Obamacare plan for a 61-year-old woman at that time was $744 with a $6,000 deductible.

Balvin developed diverticulitis, requiring several surgeries. Under the Obama administration's rule at the time, much like the Biden rule now, Bavin's plan ended mid-treatment.

"Balvin lost her coverage and was ineligible to enroll in an Obamacare plan for six months," wrote Cannon. "Requiring her insurer to cancel her plan after just three months left Balvin with $97,000 in medical bills."

'Reasonable Alternative to Obamacare'

Supporters of government health care deride STLDI as "junk insurance," but limiting coverage to four months makes things worse, says Cannon.

"Longer contract periods and renewals increase health plan quality by increasing enrollees' ability to pool their medical expenses with others and by enabling continuous coverage," wrote Cannon. "By prohibiting these features, the Departments would be requiring STLDI issuers to offer *lower*-quality coverage" (emphasis in original).

Cannon says the entire purpose of the joint rule from the U.S. Departments of Health and Human Services, Labor, and Treasury is to protect Obamacare, not patients.

"Their objection to STLDI is not that it is low-quality but that it is of sufficiently high quality that millions of consumers are choosing it as a reasonable alternative to Obamacare," wrote Cannon. "STLDI is too good, so the Departments are trying to make it bad. It is too comprehensive, so the Departments want to make it less comprehensive. The [Notice of Proposed Rulemaking] reveals the Departments' actual purpose is to boost Obamacare enrollment by punishing consumers who make what the Departments—not Congress—believe to be the 'wrong' choice."

'Federal Regulators Lack Statutory Authority'

The STLDI rule is contrary to the U.S. Supreme Court's decision in *King v. Burwell*, the 2015 case that interpreted the provisions of the ACA, wrote Cannon.

"Federal regulators lack statutory authority to implement this proposal," wrote Cannon. "They should abandon it and reaffirm their current interpretation of the statute, including their finding that current STLDI rules can improve Obamacare's performance. Furthermore, Congress should codify current STLDI rules, and states should exempt STLDI from all health insurance regulations."

It would be easy for Congress to make the Trump administration's STLDI rules permanent, says Cannon.

"Codifying the current rules, which allow short-term plans to last 12 months and allow renewal guarantees, would only require a few lines of legislative text," Cannon told *Health Care News*. "It would be a simple change and should be small enough substantively to insert in a larger piece of must-pass legislation."

That change could benefit individuals in the ACA marketplace as well as those who purchase STLDI policies, says Cannon.

"Codifying those rules would prevent future administrations from undoing them," said Cannon. "It would eliminate the regulatory uncertainty that has prevented insurers from investing in renewal guarantees that would yield numerous benefits, including reducing Obamacare premiums."

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

COMMENTARY

Short-Term Health Plans Plus Indemnity Plans Offer Huge Savings

By John C. Goodman

We would have very few public policy problems if we followed one of my rules for rational public policy: let markets handle all the problems markets can solve; turn to government only to meet needs competitive markets cannot or do not meet.

In the first four years before Obamacare went into full effect, the federal government made risk pool coverage available to any uninsured person who had been denied coverage because of a preexisting condition. Called preexisting condition insurance plans, the insurance resembled a garden-variety Blue Cross plan, and the premium was the same amount a healthy person would pay for such insurance. By the time these plans ended, roughly 135,000 people had enrolled.

On the eve of Obamacare's passage, virtually the entire argument for Obamacare—on TV, on radio, on social media, in the halls of Congress—was that people with preexisting conditions should be able to buy insurance for the same premium healthy people pay.

Not only did the federal risk pool insurance described above solve the problem without disrupting everyone else's lives, but we also came to learn less than 1 percent of the population was truly unable to buy insurance because of preexisting conditions.

Obamacare Has Hurt the Sick

Obamacare these days is a boon to the healthy. Four out of every five people in the Obamacare exchanges are paying premiums of $10 a month or less.

If you are sick, things are very different. The annual out-of-pocket maximum for a family in the exchanges this year is $18,900, and that is the exposure in a typical exchange plan. That's the amount you may have to pay in the form of deductibles and coinsurance, over and above any premium payment. Plus, if you have an above-average income and don't get a subsidy, the average family premium last year was $13,824.

One alternative has been short-term limited-duration insurance (STLDI). The basic product has been around for many years. A typical plan lasts for only 12 months and serves as a bridge for people transitioning from a family policy to school, from school to work, or from job to job.

STLDI is largely unregulated. Obamacare-mandated benefits don't apply, and most state-mandated benefits don't apply either. That means these plans don't have to cover maternity care or substance abuse. They can and do ask health questions. They exclude people with expensive chronic conditions.

Precisely because these plans avoid cost-increasing regulations and they only need to cover risks healthy people care about, they often sell for as little as one-half the price of Obamacare insurance. They also typically have lower deductibles and broader provider networks. The Trump administration allowed the plans to last 12 months with an option to renew for up to three years.

'Change of Health Status Insurance'

The Trump executive order also sanctioned a separate type of insurance, what I call "change-of-health-status insurance," to bridge the gap between three-year periods.

Health status insurance protects you against any deterioration in your health. It pays any extra cost that arises because of a change in your medical condition, leaving you free to pay the same premium a healthy person would pay.

By stringing together these two types of insurance, we had the possibility of a market that healthy people can buy into and is guaranteed to be renewable indefinitely into the future, regardless of health condition. Potentially, this could become the closest thing we have ever had to genuine free-market health insurance.

Unfortunately, the Biden administration has cancelled the Trump order (see page 1) and reimposed the Obamacare rules governing this market.

Indemnity Insurance on the Block

Another insurance option the Biden administration wants to restrict is indemnity insurance. These policies pay a fixed amount of money per medical episode. For example, a plan might pay $100 per doctor's visit for up to five visits a year. For a hospital stay, the plan might pay $6,000 per day. The plan also allows patients to pay in-network rates to the providers.

STLDI with an indemnity plan can save families bundles of money and provide financial protection. Take a family of three, with adults near age 50, living in Springhill, Florida (about an hour north of Tampa). A typical exchange plan with no subsidy would cost this family a $26,400-a-year premium. Plus, their out-of-pocket exposure (in terms of deductibles and coinsurance) is $18,900—every year!

By contrast, this family can buy a high-deductible, short-term plan and fill in the first-dollar expenses with an indemnity plan. The combined annual cost of both plans: $10,800.

There is another benefit. Suppose someone in the family gets sick (cancer, for example), and they are denied the opportunity to renew their short-term policy. They will have to turn to an Obamacare exchange plan. But since the indemnity policy is guaranteed to be renewable, it can travel with them to the exchange. Also, you can buy indemnity plans that cover the entire country—which are ideal for people who travel a lot.

"It is interesting that critics of less-regulated insurance call it 'junk insurance' and see Obamacare as the remedy. I suspect most people would be inclined to reverse that judgment. Bottom line: let people buy health insurance that meets their financial and medical needs. At the end of the day, if there are any remaining and socially important unmet needs, those should be the limited focus of government."

JOHN C. GOODMAN
PRESIDENT
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

Less-Regulated, More-Useful

The short-term and indemnity insurance markets are booming, growing by leaps and bounds. It's not hard to understand why.

It is interesting that critics of less-regulated insurance call it "junk insurance" and see Obamacare as the remedy. I suspect most people would be inclined to reverse that judgment.

Bottom line: let people buy health insurance that meets their financial and medical needs. At the end of the day, if there are any remaining and socially important unmet needs, those should be the limited focus of government.

John C. Goodman, Ph.D. (**john goodman@goodmaninstitute.org**) *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *An earlier version of this article was published in* Forbes. *Reprinted with permission.*

Justices Appear Skeptical of COVID Censorship Case, Media Reports

U.S. Supreme Court Justice Neil Gorsuch

PHOTO COURTESY LBJ LIBRARY/FLICKR.COM

Continued from page 1

with the Biden administration's narrative on COVID-19.

Coverage 'Far Too Simplistic'

Media characterized the justices' reactions during oral arguments on March 22 as favorable to the Biden administration's case. These reports, such as an article in *Politico* calling the case "doomed" and a similar blog item at *Above the Law*, have been "far too simplistic," says Jenin Younes, an attorney representing the private plaintiffs.

The justices "appeared to be grappling with determining the line between acceptable government communications with social media platforms about content moderation and First Amendment violative ones," said Younes.

Contrary to the administration's arguments, the Constitution does not mention coercion but instead bans all government involvement in censorship, says Younes.

"The First Amendment forbids the government from 'abridging' the freedom of speech," said Younes. "'Abridge' means to reduce or diminish, so any action the government takes to censor protected speech based on viewpoint constitutes a First Amendment violation.

"Thus, the government engaging in any kind of joint venture with tech companies to take down speech is unconstitutional; coercion by the government to accomplish this isn't required," said Younes.

Coercion Debated

Justice Clarence Thomas signaled agreement with Younes' view, asking Deputy Solicitor General Brian Fletcher, "Is the coercion/encouragement framework … the only way to look at this case?"

Justice Neil Gorsuch challenged Fletcher on the grounds that strong government encouragement could border on coercion, asking Fletcher whether an "accusation by a government official that unless you change your policies, you're responsible for killing people" could be coercion.

Justices Brett Kavanaugh and Elena Kagan, by contrast, indicated government efforts to encourage Big Tech censorship are analogous to public officials calling media companies to complain about their coverage.

Third Parties Ignored

Younes calls that a "misguided analogy" by "defenders of the censorship regime."

"First, when a government actor tries to persuade a journalist not to publish a story for some reason—national security, embarrassing for the administration, etc.—they're trying to convince the individual not to publicize his or her own work."

In such cases, a journalist's writings are the subject, whereas the Biden administration was trying to get people to censor other people's communications, Younes notes.

"Here, the government is coercing and persuading the tech companies to take down the speech of other individuals, who aren't part of the conversation and probably didn't even know it took place," Younes said.

"Second, the journalist can always go to another venue and get the story published, and it's only one story," said Younes.

"Here, the government was pressuring, coercing, and persuading the companies to censor entire narratives and lines of discourse and thought, resulting in the censorship of tens or hundreds of thousands of people and millions of posts," said Younes.

"The argument differed from what we expected in that the justices focused more on issues like standing than on the merits. Somewhat predictably, Justices Alito and Thomas seemed to signal their support for the plaintiffs, and Justice Gorsuch appeared to lend support on the question of standing. For the justices who were more skeptical, I think they may have underestimated the extent and constancy of the demands placed on the social media platforms."

BOB CORN-REVERE
CHIEF COUNSEL, FOUNDATION FOR INDIVIDUAL RIGHTS AND EXPRESSION

More Skeptical Than Expected

The justices showed less concern about the scope of the administration's actions than might have been expected, says Bob Corn-Revere, chief counsel at the Foundation for Individual Rights and Expression.

"The argument differed from what we expected in that the justices focused more on issues like standing than on the merits," said Corn-Revere.

"Somewhat predictably, Justices Alito and Thomas seemed to signal their support for the plaintiffs, and Justice Gorsuch appeared to lend support on the question of standing," Corn-Revere said. "For the justices who were more skeptical, I think they may have underestimated the extent and constancy of the demands placed on the social media platforms."

Searching for a Standard

Corn-Revere said the oral arguments left room for improvement.

"I am concerned that Louisiana's Solicitor General did nothing to help the Court devise a workable standard with some limiting principles," Corn-Revere said.

Louisiana is a party to the lawsuit, along with Missouri.

"That said, it is important to keep in mind the argument was paired with *NRA v. Vullo*, which presented essentially the same basic question, although it was focused more on the problem of coercion. Between those two cases, I think the Court has enough to work with to fashion a workable test."

Corn-Revere called the state attorneys general hypocritical in bringing First Amendment claims "based on jawboning when they regularly engage in such practices themselves."

"It is little wonder some of the justices were openly skeptical of their arguments," said Corn-Revere. "Nevertheless, I am optimistic that, whether in this case or in *Vullo*, the Court will try to fashion a rule to shore up the First Amendment protections against informal censorship."

Sees a Divided Court

While criticizing the media coverage of *Murthy v. Missouri*, Younes says she agrees that the justices will be divided in their opinions.

"The main questions are whether the plaintiffs have standing [whether they have suffered an injury for which the government defendants are responsible] and whether persuasion [to remove protected speech from platforms] constitutes a First Amendment violation, or coercion is required," said Younes.

If the court sets the standard at coercion, it will "be a travesty for free speech, and is not consistent with the text or spirit of the First Amendment, nor the relevant precedent," said Younes.

A decision on the case is expected in June.

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

COMMENTARY

Amicus Briefs Reveal Censorship Supporters

By Brownstone Institute

The convergence of state and corporate power has spawned unexpected bedfellows as Stanford University, the Cato Institute, and New York State Attorney General Letitia James have joined forces to support the censorship regime in *Murthy v. Missouri*.

The David and Goliath dynamic of the case, which was argued before the U.S. Supreme Court on March 18, cannot be overstated. One side carries the combined power of the intelligence community and the federal government colluding with the largest information centers in the history of the world on behalf of the country's largest lobbying forces.

Against that hegemon stands a series of independent doctors, news outlets, and state attorneys general.

Money Trail to Government

To that point, four federal judges have found that the Biden administration, the Department of Homeland Security, the FBI, and the CIA violated the First Amendment in their ongoing collaboration with Big Tech to censor disapproved narratives, including those related to COVID, crime, and mail-in voting.

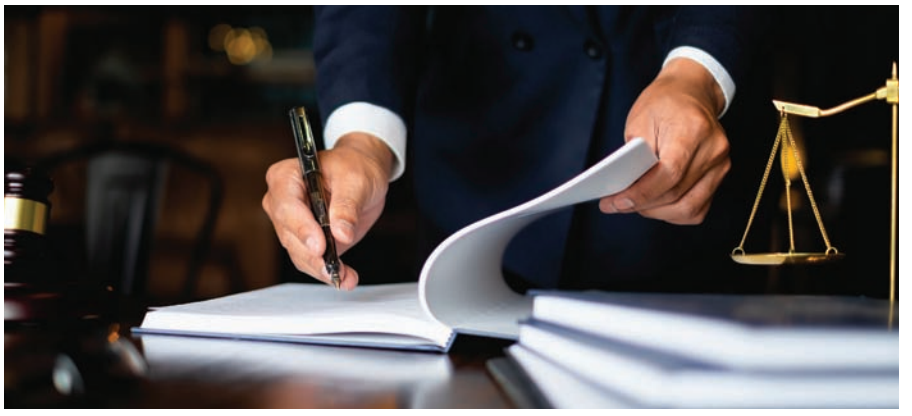
During the legal process, third parties can present briefs, called amici curiae, to the courts to explain their interests and offer support for either side of a case.

Brownstone has reviewed the amici curiae in *Murthy v. Missouri* and found that a coalition of libertarians, academics, and blue states all stand together to support society's most powerful groups.

Stanford's Government Benefactor

Stanford University, home of the Stanford Internet Observatory and the Virality Project, is host to some of the chief censorship organizations in the United States. Journalists such as Andrew Lowenthal have documented how these groups worked with Big Tech to censor "stories of true vaccine side-effects" and resisted subpoenas from the U.S. House of Representatives.

After Judge Terry Doughty issued an injunction barring the federal government from working with social media companies to censor "constitutionally protected speech," Stanford urged the Fifth Circuit to overturn it. The injunction "has cast a chill across academia as an example of political targeting of disfavored speech by state government and the federal judiciary," the university wrote.



"The federal government is far and away Stanford's largest and most consistent benefactor, as it siphons taxpayer funding toward the state-sponsored censorship industry. ... Each year, the ostensibly private university receives more than $1.35 billion in government grants, nearly 20 percent more than the university earns from student tuition."

BROWNSTONE INSTITUTE

Of course, Judge Doughty's order did not affect Stanford's First Amendment rights at all. Instead, it prevented the university and its subsidiaries from working with the federal government to abridge "constitutionally protected speech," such as political dissent.

So why would the university side with the White House? The federal government is far and away Stanford's largest and most consistent benefactor, as it siphons taxpayer funding toward the state-sponsored censorship industry. Stanford has over $60 billion in assets, including an endowment of $40 billion. Each year, the ostensibly private university receives more than $1.35 billion in government grants, nearly 20 percent more than the university earns from student tuition.

Blue States' Concern: Politics

New York Attorney General Letitia James led a coalition of 20 Democrat-controlled states, including Arizona, California, Pennsylvania, and Michigan, in opposing the injunction.

The AGs claimed the absence of censorship would amplify the "dangers of social media in promoting extremist violence." As support for the Biden administration, they invoked a mass shooting in Buffalo, discussed incidents of "cyberbullying," and favorably cited Connecticut's use of taxpayer funds to hire "specialists" to "combat election misinformation."

Notably, however, the amicus brief does not make a single reference to the text of the injunction or the opinions from the district court and the Fifth Circuit Court of Appeals. The states that signed onto James' amicus brief carry a combined 260 electoral votes. If Biden wins those states, he will only need to win Maryland, which he won by 30 points in 2020, to secure a second term.

Letitia James's brand of "lawfare" is untethered from constitutional concerns. It is blunt-force politics, and its proponents' primary objective is to control the citizenry. We are now at a crossroads where a group constituting an effective political majority seeks to codify mass censorship into law.

Libertarians' Dithering

The Cato Institute, D.C.'s leading libertarian think tank, submitted a tepid brief "in support of neither party." Like a mother asked to choose sides in a fight between her children, Cato could not bring itself to stand against the parties partnered with the world's largest monopolies. Conveniently, those monopolies happen to be Cato donors.

According to Cato, the Court should "make clear" that First Amendment violations occur only when "interactions between the government and digital services regarding displayed content rise to the level of coercion."

Coercion, however, is not the standard for unconstitutional government action. The Supreme Court has previously held that the government "may not induce, encourage, or promote private persons to accomplish what it is constitutionally forbidden to accomplish."

ACLU's Conspicuous Silence

Not long ago, the American Civil Liberties Union (ACLU) would have championed the plaintiffs in *Murthy v. Missouri*. The ACLU famously defended neo-Nazis' right to march through a Jewish suburb, but the organization later became an arm of the Democratic Party, shedding its former principles in the process.

The group has no shortage of amici briefs and opinions on its website; it has petitioned courts to support gun control, abortion, COVID vaccine mandates, and race-based university admissions and to oppose bans on men in women's sports and efforts to curb illegal immigration. Despite this flurry of opinions and news releases, the ACLU has not made a single mention of *Murthy v. Missouri* (or *Missouri v. Biden*) on its website.

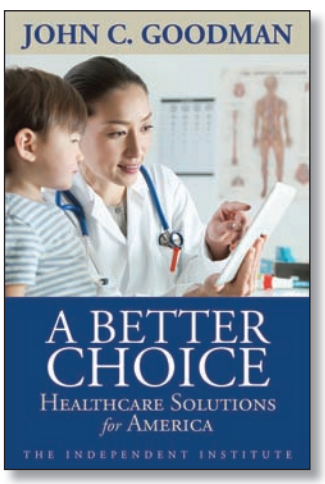
Rebel Alliance

There is, however, a coalition resisting the march toward tyranny. The New Civil Liberties Alliance, a nonpartisan, nonprofit civil rights group representing the plaintiffs in the case, is among those leading the fight for constitutional freedoms.

Other defenders committed to the foundation of our legal system, precedent, facts, and the rule of law include the Foundation for Individual Rights and Expression, the Foundation for Freedom Online, the Thomas More Society, Children's Health Defense, The Heritage Foundation, and the State of Ohio.

Brownstone Institute for Social and Economic Research (**tucker@brownstone.org**) *is a nonprofit organization founded in 2021. An earlier version of this article was published at brownstone.org. Reprinted with permission.*

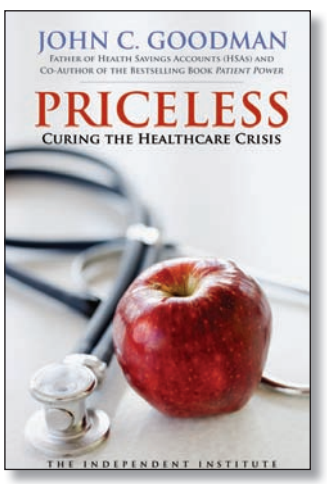
Prescription for Better Healthcare Choices



A Better Choice
Healthcare Solutions for America
John C. Goodman

"John Goodman understands the real life effects of the Affordable Care Act and the proposed alternatives. John also writes extremely well, making complicated concepts clear. All this makes ***A Better Choice*** a highly recommended read for those who wish to understand the current health policy debate."
—**Bill Cassidy**, M.D., U.S. Senator

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



Priceless
Curing the Healthcare Crisis
John C. Goodman

"There's no question that today's healthcare system is littered with distorted incentives and what John Goodman calls dysfunctionality. ***Priceless*** is a call to arms to do something about it. . . . You should read this book if you want to be an informed participant in the debate over the future of healthcare in this country."
—**Peter R. Orszag**, former Director, Congressional Budget Office

Americans are trapped in a dysfunctional healthcare system fraught with perverse incentives that raise costs, reduce quality, and make care less accessible. Now ***Priceless*** cuts through the politics and proposes dozens of bold reforms to free patients and caregivers to be empowered to chart their own lives with low-cost, high-quality healthcare.

TOLL FREE: 800-927-8733
ONLINE: independent.org

INDEPENDENT INSTITUTE

100 Swan Way
Oakland, CA 94621-1428

Health Care News wants to hear from you ...

Give us feedback.

1. Do you want our newspaper to continue?

2. Does HCN inform you?

3. What topics do you want to see covered?

Text Your Responses to (312) 638-8423

FDA Authority Under Scrutiny in Abortion Pill Case

By Ashley Bateman

The U.S. Supreme Court is considering legal arguments over the Food and Drug Administration's (FDA) regulation of mifepristone, the first pill pregnant women take in inducing chemical abortions.

The case, *Food and Drug Administration v. Alliance for Hippocratic Medicine,* questions the legality of the FDA's removal of basic patient safeguards for mifepristone since it was first approved for market use in 2000.

The Biden administration is appealing an August 16, 2023, decision by the Fifth Circuit that the FDA must restore safety protections. The three-judge panel disagreed with the lower court's decision that the FDA was incorrect when it approved mifepristone in 2000, which the Biden administration does not dispute. Also being considered are conscience protections for doctors.

Oral arguments before the Supreme Court took place on March 26.

"The case before the Supreme Court exposes the impact of bad politics, money, and ideology. The Biden administration has pushed the FDA way beyond the limits of its authority. The FDA has been weaponized to make abortion a norm, as easy as a telehealth visit, and a prescription for death. Over the last 20 years, the FDA has shredded its authority and reputation. Commonsense protections from mifepristone must be restored, and Americans [must be] protected from a drug with a single, deadly purpose."

JOHN MIZE, CEO, AMERICANS UNITED FOR LIFE

High-Risk Drug

The abortion pill has taken on a new significance since June 2022 when the Supreme Court affirmed the authority of individual states to regulate abortion in *Dobbs. v. Jackson Women's Health Organization*.

Just before opening arguments in the current case, the Guttmacher Institute released new data showing 63 percent of all abortions are now done chemically, a 10 percent increase since 2020.

Initially, the FDA required patients to have three in-person doctor visits and be screened for conditions and potential complications. Doctors were also required to advise on the time and place of use. Time is critical because there is a narrow window for pregnant women to use the pills safely.

In 2016, the Obama administration began stripping away those safeguards. The Biden administration doubled down during the COVID-19 pandemic. Physicians have argued chemical abortions are more dangerous than surgical ones.

In an extensive breakdown of the arguments made before the Court, Americans United for Life (AUL), a group representing 145 pro-life members of Congress from 36 states, says the case will decide "important issues about standing, administrative law, conscience rights, and health and safety safeguards for chemical abortion drugs."

'FDA Has Been Weaponized'

A key issue in the case is whether the FDA failed in its regulatory duties regarding the abortion pills.

"The lower court's decision merely restored longstanding and crucial protections under which millions of women used abortion drugs," Alliance lawyers argued before the Supreme Court justices. On April 7, 2023, U.S. District Judge Matthew Kacsmaryk of the Northern District of Texas suspended the FDA's initial approval of mifepristone in 2000, but his ruling was stayed by the Fifth Circuit Court of Appeals.

AUL filed an amicus brief in the Supreme Court case, calling the FDA's deregulation of the pill a subversion of statutory authority. AUL says the FDA rules promote access to chemical abortion drugs, creating a significant danger to women's and girls' health and safety.

"The case before the Supreme Court exposes the impact of bad politics, money, and ideology," AUL CEO John Mize told *Health Care News*. "The Biden administration has pushed the FDA way beyond the limits of its authority. The FDA has been weaponized to make abortion a norm, as easy as a telehealth visit, and a prescription for death.

"Over the last 20 years, the FDA has shredded its authority and reputation," Mize said. "Commonsense protections from mifepristone must be restored, and Americans [must be] protected from a drug with a single, deadly purpose."

'Too Bad, Nobody Can Sue?'

The issue of standing came up, over whether the plaintiffs can legally hold the FDA accountable.

Chief Justice John Roberts asked lawyers from the Biden administration and abortion drug manufacturer Danco what percentage of hurt and hospitalized women would be considered significant enough to warrant a lawsuit against the drug. Defense counsel said there was no ceiling to the amount of harm that should be allowed.

Justice Clarence Thomas asked who would have legal standing to challenge the agency if the court found the Alliance is ineligible to sue. Justice Alito followed a similar line of questioning, saying, "It doesn't matter if FDA flagrantly violated the law, it didn't do what it should have done, endangered the health of women, it's just too bad, nobody can sue in court?"

In response to those justices' questions, Biden administration counsel argued the FDA is untouchable.

"It is clear that the FDA's removal of basic safety standards was reckless, leaving [emergency room] doctors to handle the fallout," Alliance Defending Freedom senior counsel Julie Marie Blake told *Health Care News*. "It is appalling that the FDA now says no one has the right to question that decision in court."

Claims 'Broad' Conscience Coverage

Justice Brett M. Kavanaugh asked the FDA to confirm whether federal law protects the conscience right of doctors to refuse to perform or assist in abortions.

Biden administration counsel said "federal conscience protections provide broad coverage here," adding, "The Church Amendments have the most comprehensive protection here, and we think that those amendments guard against the kind of injury that Respondents are asserting."

The Church Amendments were enacted about 50 years ago to protect the conscience rights of anyone asked to perform an abortion or sterilization.

Mize says this could be the lynchpin in the decision.

"At the very least, even if the Alliance is unable to convince the Court to set aside the FDA's chemical abortion rules at this time, it may still issue for the first time a resounding affirmation of their right not to participate in abortions."

Justice Ketanji Brown Jackson asked Alliance where in the declarations "a declarant states that they attempted to object but were unable to." Jackson said the remedy sought by Alliance has a "plainly overbroad scope" if exemptions to using and prescribing the drugs are already in place.

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

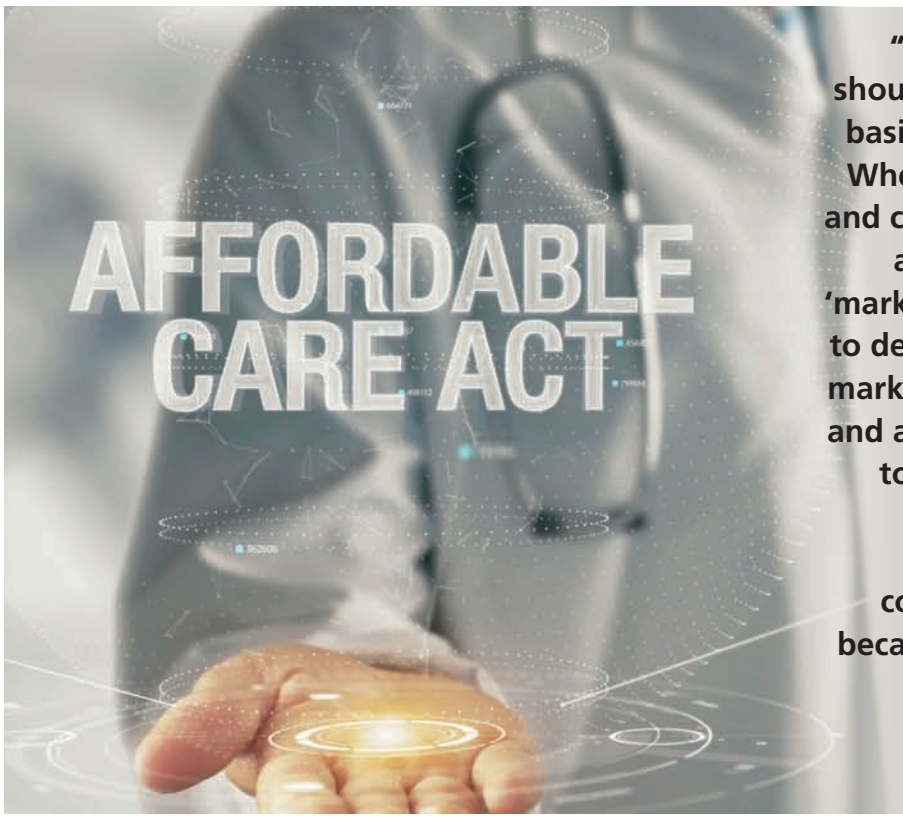
Obamacare Success Stories Still Scarce After 14 Years

By Bonner Russell Cohen

Former President Barack Obama is celebrating the 14-year anniversary of his signing into law the Affordable Care Act (ACA), or Obamacare, the most sweeping overhaul of the health insurance market in U.S. history, on March 23, 2010.

The Obama Foundation now features 26 interviews on its website that "bring to life so many moments of triumph, impact, and compromise" in getting the law passed. "[M]ore than 21 million Americans now have access to quality, affordable health care," Obama states on the website.

The ACA was sold to the public as a solution for individuals and families who lacked access to employer-sponsored health plans and could not afford the high premiums of individually purchased insurance. It has evolved into a highly complex, heavily subsidized, and increasingly expensive government enterprise that derives most of its growth from the dramatic expansion of Medicaid.



"Unfortunately, this outcome shouldn't surprise anyone with a basic understanding of markets. When the government comes in and creates, in painstaking detail, a 'marketplace' for anything, 'market' is never an accurate way to describe it. A true, functioning marketplace must be competitive and allow for insurers to respond to consumers. That was never designed to happen under the Obamacare system, so consumers' needs are ignored because insurers must answer to regulators."

JEFF STIER
SENIOR FELLOW, CONSUMER CHOICE CENTER

Medicaid on Steroids

In 2010, the uninsured were told they would be able to choose from a host of ACA-compliant private insurance plans on marketplace exchanges that would be both affordable and comprehensive in coverage, and those with preexisting conditions were assured they could not be denied coverage and would pay the same premiums as healthy people.

The Congressional Budget Office (CBO) projected at the time that 25 million Americans would sign up for plans, four million short of the number claimed by Obama in 2024. The CBO also projected that coverage would be evenly split between private insurance and Medicaid expansion.

An assessment of Obamacare's real-world impact by the Paragon Health Institute found that, as of 2021, "while 19 million additional people got health insurance coverage, only about 2 million got private insurance. The remaining 17 million were covered under the act's Medicaid expansion provisions."

John C. Goodman, president of the Goodman Institute for Public Policy and co-publisher of *Health Care News*, noted in *Forbes* on March 19 the private insurance sold in the Obamacare exchanges has "increasingly come to resemble Medicaid with a high deductible."

Planned or Accidental?

Many of the ACA's original provisions, such as the individual mandate and its fines for noncompliance, were overturned by the courts, Congress, or presidential executive orders. The system's structure was further undermined by consumers, who have avoided the exchanges.

The promised affordability of the plans did not materialize, except for people who qualified for premium subsidies. To attract new enrollees, Congress has increased the premium subsidies through 2025.

"Under the ACA, Medicaid was significantly expanded to non-disabled, working-age adults earning up to 138% of the federal poverty level," wrote Adam Millsap in *Forbes* on March 22. "To entice states to expand Medicaid, the ACA also increased the federal match given to states to offset the program's cost, known as the federal assistance percentage (FMAP)."

The ACA-driven Medicaid expansion has had wide-ranging effects. In another Paragon study, Brian Blase and Drew Gonshorowski note Medicaid is now the largest program in state budgets, exceeding spending on K-12 education.

Rising Cost of Health Insurance

Americans with private group coverage are paying more than ever because of the ACA's costly regulations on health plans, wrote Sally Pipes, president and CEO of the Pacific Research Institute, in *Newsweek* on March 25.

"In 2019, just five years after Obamacare's cost-inflating regulations took effect, average premiums had more than doubled, compared with what they were pre-ACA," wrote Pipes. "Premiums have since continued to climb. The average family in 2023 paid 22 percent more for employer-sponsored coverage than they did in 2018."

"These cost increases are no accident," wrote Pipes. "They were baked in from the start. Obamacare's mandates are designed to increase costs for the general population as a means of subsidizing coverage for favored groups."

Insurance companies, through their heavily subsidized ACA marketplace plans, could be considered one of those "favored groups." The premium subsidies are "a very efficient mechanism for the Treasury to transfer money to health insurance companies," Brian Blase, president of the Paragon Health Institute, told *The Washington Post* on March 30.

Boon to Health Insurers

The ACA's Medical Loss Ratio (MLR) regulation was designed to limit insurers' profits, but the premium subsidies reduced the insurers' incentive to control costs, says Jonathan Wolfson, chief legal officer and policy director at the Cicero Institute.

"Everyone knew the ACA would send the insurance companies millions of new customers, as Obamacare 'capped' their profits with the MLR," said Wolfson. "But the MLR actually gave the insurance companies a profit incentive to let prices rise because 15 percent of $100 million is a lot more profit than 15 percent of $50 million. As my colleague Josh Archambault and I explained, the MLR may be the least-discussed problem with the ACA, but patients feel its effects every time they pay higher premiums or visit the doctor."

No Competition, No Market

Jeff Stier, a senior fellow at the Consumer Choice Center, says the government-driven approach to health care was bound to fail.

"Unfortunately, this outcome shouldn't surprise anyone with a basic understanding of markets," said Stier. "When the government comes in and creates, in painstaking detail, a 'marketplace' for anything, 'market' is never an accurate way to describe it.

"A true, functioning marketplace must be competitive and allow for insurers to respond to consumers," said Stier. "That was never designed to happen under the Obamacare system, so consumers' needs are ignored because insurers must answer to regulators."

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

Everything We Were Told About COVID-19 Was Wrong—Report

By Bonner Russell Cohen

"Lockdowns, school closures, and other mandates were catastrophic errors, pushed with remarkable fervor by public health authorities at all levels," concludes a report on the government's response to the COVID-19 pandemic.

The report, titled "COVID Lessons Learned: Retrospective After Four Years," by Scott W. Atlas, M.D., Steve H. Hanke, Ph.D., Philip G. Kerpen, and Casey B. Mulligan, Ph.D., was published by the Committee to Unleash Prosperity (CTUP) in March.

The authors examined pandemic policies from health, economic, education, and civil liberty perspectives.

'Stoked and Amplified Fear'

Government officials ignored experience with previous epidemics, says the CTUP report.

"[C]ommunities respond best to pandemics when the normal social functioning of the community is least disrupted," states the report. "During COVID, the public health establishment followed the opposite principle: they intentionally stoked and amplified fear, which overlaid enormous economic, social, educational, and health harms of the virus itself."

Among the disruptions, lockdowns put "over 49 million Americans out of work, according to Bureau of Labor Statistics (BLS) survey data, and over two million remaining out of work due to COVID closures as recently as July 2022."

'Excess Deaths from Lockdowns'

Social isolation and the inability to access care for other conditions led to deaths from causes other than the SARS-CoV2 virus, say the authors.

"Non-COVID excess deaths from lockdowns and societal panic are estimated at about 100,000 per year in the United States and zero in non-lockdown Sweden," states the report.

The lockdowns "were realized around the time when hospitalization peaked, which due to the time-lag between infection and serious disease, necessarily occurs well after the infective peak," the report states. "They were timed to take credit for declining waves, but rarely had any discernable causal impact."

'Caused Serious Harm'

Even though it was known by spring and summer 2020 that COVID primarily threatened the elderly and people with preexisting conditions, teachers unions insisted schools remain closed, the report notes.

"The harms to children of closing in-person schooling are dramatic and irrefutable," the authors state. "The shutdowns caused serious harm to children, including poor learning, school drop-outs, social isolation, mental illness, drug abuse, suicidal ideation, and 300,000 cases of child abuse unreported in spring 2020."

Health authorities ignored differences in severity and fatality risk between young and old, state the authors.

"One of the most striking features of the earliest COVID morbidity and mortality data was a profound differential in risk between the old and the young," write the authors. "When specific populations are known to have a high risk of death or serious illness, a strategic use of resources to heighten their protection and awareness should be employed."

Mask Mania

Mask mandates ignored the science on masking, say the authors of the CTUP study.

"There was no high-quality evidence in support of community masking for respiratory illnesses in spring 2020; in fact, the randomized clinical trials regarding masking for influenza found it to be ineffective for protecting the wearer and for preventing spread," the report states. "Unfortunately, rather than commission randomized controlled trials to produce high-quality evidence on masking with respect to SARS-CoV2, global and U.S. public health authorities overstated the benefits of masking and persisted even as evidence to the contrary accumulated."

The Centers for Disease Control and Prevention (CDC) has yet to revise its position on masking. "The CDC continues to recommend, contrary to evidence, masking for respiratory viruses, undermining its credibility," states the report.

Were Lockdowns a Test?

The authors note dissenting views were suppressed during the pandemic.

"Scientists used the media to bully others, and the media gave them the imprimatur of 'the experts' to disparage the opposing views," states the report.

The CTUP study confirms what many experts and clinicians already knew, says California-based physician and health care analyst Marilyn M. Singleton, M.D.

"Pursuant to a recent lawsuit settlement, the [Food and Drug Administration] rescinded their 'you are not a horse' campaign against ivermectin, a Nobel Prize-winning medication approved for veterinary and human use, as part of an alternative COVID treatment program," said Singleton. "For the government to ignore the social and medical meltdowns unfolding before their eyes leads me to believe the public health response was a test of the limits of government control, not measures instituted for the benefit of the public."

Public Not Informed

The mandates went against science, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"For all the posturing about evidence-based medicine, public health diktats went against evidence that harms greatly exceeded benefits, if any," said Orient. "People must be allowed to decide on the precautions they want to take, and they should be able to rely on health authorities for accurate information instead of fearmongering."

"Businesses were often subjected to costly but useless regulations, like the six-foot distancing, while engineering solutions that would also be effective against other risks were neglected—for example, better ventilation, consideration of UV lighting, and use of ozone disinfection in public transportation," said Orient.

"People were not informed of the need for adequate vitamin D and zinc levels, the effectiveness of Betadine or peroxide gargles or nasal swabs, or the value of prophylactic or early use of hydroxychloroquine or ivermectin," said Orient. "Hundreds of thousands of lives may have been lost for lack of early treatment of COVID and neglect of treatment of other conditions, as well as from lockdowns."

"People were not informed of the need for adequate vitamin D and zinc levels, the effectiveness of Betadine or peroxide gargles or nasal swabs, or the value of prophylactic or early use of hydroxychloroquine or ivermectin. Hundreds of thousands of lives may have been lost for lack of early treatment of COVID and neglect of treatment of other conditions, as well as from lockdowns."

JANE ORIENT, M.D.
EXECUTIVE DIRECTOR
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

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

INTERNET INFO

Scott W. Atlas, M.D.; Steve H. Hanke, Ph.D.; Philip G. Kerpen; and Casey B. Mulligan, Ph.D., "COVID Lessons Learned: Retrospective After Four Years," Committee to Unleash Prosperity, March 2024: **https://committeetounleashprosperity.com/wp-content/uploads/2024/03/240313_CTUP_COVIDCommitteeReport_Doc.pdf**

UK Bans Puberty Blockers for Children, France Could Be Next

By Kenneth Artz

Massive changes are occurring across Europe in the matter of "gender affirming" care for children.

Britain's National Health Service announced in March it will no longer cover puberty blockers for teens. There are indications France could be next. A landmark Dutch study that concluded most kids outgrow gender confusion was released in April.

The U.S. medical establishment and the Biden administration have taken the opposite course, doubling down on what a growing number of health professionals characterize as deceptive and deadly "cargo cult" science.

Several states, most recently Kentucky and Tennessee, have enacted laws blocking "gender-affirming" care for children under age 18. In January, the Biden administration petitioned the U.S. Supreme Court to roll back those laws. The administration is using *Bostock v. Clayton County,* where the Court ruled an employer can't discriminate against transgender employees, in its arguments.

Moving Farther Apart

The divide between the governments and medical establishments of Europe and America on the issue has never been greater. Europe has reviewed and rejected the claims of pro-transition advocates regarding the treatment of gender dysphoria in minors.

Several nations in Europe have done high-level, independent, systematic reviews of the evidence-based research and determined it to be of "low" to "very low" quality, says Lauren Schwartz, M.D., a board-certified practicing psychiatrist.

"Those aren't arbitrary terms—those are robust research categories—and they said, 'My gosh, the evidence that has been pushed out there is not there; we're not seeing it,' and so they're rolling it back, which is a very difficult thing to do," said Schwartz.

The U.S. medical establishment has embraced the World Professional Association for Transgender Health (WPATH) as the authority on the issue, despite the huge release of leaked documents and videos of WPATH experts admitting "its members know they are creating victims and not getting 'informed consent,'" as investigative journalist Michael Shellenberger tweeted.

"[T]hey know that many children and their parents don't understand the effects that puberty blockers, hormones, and surgeries will have on their bodies. And yet, they continue to perform and advocate for gender medicine," Shellenberger wrote.

"It will go down as one of the worst medical scandals in history," Shellenberger wrote.

NGOs vs. Parents

WPATH has an outsized influence in the United States, says Schwartz.

"[The WPATH experts] know they're not able to get sworn consent from a 12-year-old, and then talk to them about the risk of sterility, or possible risk of having adult challenges in life, or of being permanently dependent on hormones," said Schwartz. "Then you look at all our American medical and psychiatric associations. For example, the textbook the American Psychiatric Association put out, they reference the WPATH 'standards of care' 14 times at least.

"If we start to question the certainty of it, there is a fear of, or an effort to avoid getting sucked into, a different direction politically," Schwartz said. "Politics and medicine just don't play well together."

Parents and families know more about their children than the countless experts that weigh in on these matters, says Schwartz.

"No one is a greater expert on their children than a parent," said Schwartz. "So, when you're getting pushback from a school or a policymaker, or a lawmaker, … a hospital, or a physician, a psychiatrist, or a therapist, and they tell you, 'We're the experts. You don't know,' just as a parent you know that's not right.

"Listen to that intuition and sit down and talk with your kids about it and have open conversations about it, and frequently," said Schwartz. "I think this is the best way we can protect kids."

Guilt Factor

The differing histories of Europe and America could be driving the divide over transgender treatments for children, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

Contrition over the United States' history in addressing racial injustice is one reason progressives and the medical community strongly embrace and promote "gender-affirming care," says Matthews. Progressives equate "transgender inequality" with denying blacks the right to vote, go to public schools with whites, or take a desired seat on a bus, says Matthews.

"Think of Germany's efforts, given its past, to ensure it isn't doing anything to discriminate against Jews," said Matthews. "Most of Europe doesn't have that past, and so is more willing to accept the science and [acknowledge] the ridiculousness of allowing young children to have life-altering medical treatment.

"While many of us may disapprove of it, adults are free to take gender-transition steps if they choose," said Matthews. "But we don't let children buy tobacco products, alcoholic beverages, or guns, vote, or even get tattoos. We put limits on what children can do. So, the notion that children can make such life-altering decisions, even if their parents or doctors approve, is just wrong."

Big Money

Gender-affirming care has become a huge profit opportunity for the medical centers and doctors who provide it, says Matthews.

"Some of them have been open about that economic incentive," said Matthews. "However, there are law firms representing individuals who initiated their care as children that are beginning to file suits against the medical centers and doctors. If those plaintiffs prevail and win major settlements—and I suspect many will—then that will force the medical providers to rethink their support."

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

"Some of them have been open about that economic incentive. However, there are law firms representing individuals who initiated their care as children that are beginning to file suits against the medical centers and doctors. If those plaintiffs prevail and win major settlements—and I suspect many will—then that will force the medical providers to rethink their support."

MERRILL MATTHEWS, PH.D.
RESIDENT SCHOLAR
INSTITUTE FOR POLICY INNOVATION

EPA: Chemical Used to Sterilize Medical Equipment is Unsafe

By Kevin Stone

The Environmental Protection Agency (EPA) is tightening limits on a gas widely used to sterilize medical devices.

The agency first proposed new restrictions on ethylene oxide (EO), as a suspected carcinogen, in 2023, recommending an 80 percent reduction in the use of the chemical. The new standards, announced on March 14, call for a reduction of close to 90 percent.

The rule will impose new costs on manufacturers for monitoring and providing proof of reduction of emissions.

EO is used 20 billion times per year to sterilize medical devices ranging from pacemakers to catheters to ventilation equipment. It is generally used for devices that cannot be sterilized with steam. The United States is the world's leading producer of EO, manufacturing more than four million tons per year.

"There is no evidence using ethylene oxide ever has or will induce cancer, outside of EPA's computer models. Pulling this long-existing, safe product from the market will increase already soaring health care costs, and in the process increase the likelihood of infection from medical devices while making treatment unaffordable for the poor and middle class. No lives will be saved by the EPA's harmful intervention in common medical practice. In fact, it will likely cost lives."

H. STERLING BURNETT, PH.D.
DIRECTOR, ARTHUR B. ROBINSON CENTER ON CLIMATE AND ENVIRONMENTAL POLICY
THE HEARTLAND INSTITUTE

Government Hair-Splitting

The new rule stems from a 2020 revision of the Integrated Risk Information System (IRIS) toxicity value for the inhalation unit risk estimate (URE) for EO, which was used in developing an updated National Emission Standards for Hazardous Air Pollutants rule for miscellaneous organic chemicals.

The EPA drew fire from the industry when it revised the URE from 0.000088 µg per cubic meter to 0.005 µg per cubic meter, more than a fifty-fold increase of estimated risk.

An industry group, including Huntsman Petrochemical, petitioned the EPA to accept a much lower, peer-reviewed risk assessment developed by the Texas Commission on Environmental Quality. The EPA rejected the request, triggering a petition to review on February 21, 2023, by the American Chemistry Council, Louisiana Chemical Association, and Huntsman Petrochemical.

Burden of Compliance

The EPA estimates the cost of compliance to medical equipment sterilization companies alone will be $220 million in one-time amortized costs, in addition to an ongoing annual burden of some $86 million.

It is unclear how the industry will shoulder the financial burden imposed by the rule change. Many smaller companies may be forced to exit the market, significantly reducing capacity in this medically essential sector.

The rule will impose similar burdens on other industries that use the chemical.

'Likely to Cost Lives'

The financial burden imposed by the rule is not justified by the estimated cancer risk, which remains speculative, says H. Sterling Burnett, Ph.D., director of the Arthur B. Robinson Center on Climate and Environmental Policy at The Heartland Institute, which publishes *Health Care News*. In addition, the cost of compliance will likely cause shortages of lifesaving equipment and cost lives rather than save them, while imposing yet another burden on the U.S. economy, Burnett says.

"Ethylene oxide has been in use for decades and is the most widely used chemical to sterilize medical instruments and materials," said Burnett. "It has saved millions, possibly billions of lives by preventing infections. Yet now, after years of safe use, the EPA wants to pull it based on the agency's unjustified chemophobia.

"There is no evidence using ethylene oxide ever has or will induce cancer, outside of EPA's computer models," said Burnett. "Pulling this long-existing, safe product from the market will increase already soaring health care costs, and in the process increase the likelihood of infection from medical devices while making treatment unaffordable for the poor and middle class. No lives will be saved by the EPA's harmful intervention in common medical practice. In fact, it will likely cost lives."

'No Scientific Basis'

Supporters of the new rule claim the carcinogenicity of EO justifies the onerous burden the rule will place on critical industries. The Toxicological Profile for Ethylene Oxide published by the U.S. Centers for Disease Control and Prevention (CDC) in August 2022 provided no proof of a link between EO exposure and cancer in humans.

"The carcinogenicity of ethylene oxide has been evaluated in a number of cohorts involved in ethylene oxide production and/or uses in sterilization," the CDC report states. "Results from some cohort studies suggest that exposure to ethylene oxide may increase the risk of selected cancer types (e.g., lymphohematopoietic cancer, leukemia, breast cancer)."

The meaning of the data regarding the amended rule can be summed up in one concise statement, says Steve Milloy, publisher of JunkScience.com and a member of The Heartland Institute's board of directors.

"Per the CDC assessment of the human data on EO, there is no scientific basis for changing any standards," said Milloy.

Lawsuit Status

The U.S. Court of Appeals for the District of Columbia heard oral arguments in *Huntsman Petrochemical LLC v. EPA* on February 16. The U.S. Chamber of Commerce filed an amicus brief on behalf of the plaintiff urging the court to enforce core administrative-law principles and invalidate the EPA decision regulating EO emissions.

In its brief, the Chamber argues IRIS analysis and its resulting value are not regulations, no statute governs their preparation, the rules are not being adopted through notice-and-comment rulemaking, and the relevant IRIS findings were not subjected to peer review.

The rule will affect 90 production plants across the country, including facilities in Florida, Georgia, and Texas, according to *The New York Times*.

EPA administrator Michael S. Regan affirmed the agency's position on the proposed rule.

"We have followed the science and listened to communities to fulfill our responsibility to safeguard public health from this pollution, including the health of children who are particularly vulnerable to carcinogens early in life," said Regan in a public statement.

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

Becerra Grilled on Putting Politics Before Health Policy

Health and Human Services Secretary Xavier Becerra

PHOTO US DEPARTMENT OF LABOR/FLICKR.COM

By Bonner Russell Cohen

Health and Human Services Secretary Xavier Becerra defended a wide range of White House health policies during a hearing of the House Ways and Means Committee on March 21.

Members repeatedly confronted Becerra with allegations the Biden administration puts politics ahead of patients. Issues addressed included what GOP committee members said was the administration's flawed implementation of a bipartisan law to end surprise billing by hospitals and the White House's proposed nursing home staffing mandate.

Nursing Home Staffing Rule

Under a September 2023 proposed rule, nursing homes participating in Medicare or Medicaid would be required to meet specific nurse staffing levels, including providing each resident a daily minimum of 0.55 hours of care from a registered nurse and 2.45 hours from a nurse aide, exceeding existing standards in most states.

An exchange between committee chairman Jason Smith (R-MO) and Becerra over the administration's proposed staffing rule typified the proceedings, according to a partial transcript.

"Earlier in the month, the Committee passed legislation introduced by Representative Fishbach to block implementation of the unworkable, one-size-fits-all nursing home staffing mandate," said Smith. "Estimates show that this rule will impose a $40.6 billion cost on nursing homes, 94 percent of which currently wouldn't be in compliance, jeopardizing access to care for 1.2 million Americans.

"Can you commit to the Medicare beneficiaries watching this hearing that no nursing home will close and patients won't lose access to care as a result of this rule?" Smith asked Becerra.

"I can commit to you, and I commit to each and every one of the Medicare beneficiaries that is out there, that if they need a nursing home, they will find one that offers them quality care," said Becerra.

Nursing Home Staff Shortage

Because of the government mandate, "280,000 seniors could lose their spot in a nursing home," the committee's website notes.

Rep. Greg Murphy (R-NC), a practicing physician, pressed Becerra on the proposed rule.

"We don't have the nurses," said Murphy. "We have closed beds at my institution, at my medical center, because—guess what—we don't have the nurses. I'm fine if we can work on some program to get nursing homes up to par. I believe it's absolutely necessary, but you can't make them out of thin air. … I would urge you to postpone this until we can reasonably do this."

Becerra asked, "Congressman, are you saying we don't need nurses in a nursing home?"

"No, I'm not saying that at all," said Murphy. "Please don't try to change my words. I'm saying there are not enough nurses in this country."

Donna Jackson, director of membership development for the Project 21 black leadership network, says the nursing home staffing rule will disproportionately affect lower-income people.

"Sadly, the Biden administration's new requirements for nursing homes seem to be created purely for the sake of government agency growth and political grandstanding, but the costs of these mandates fall squarely on vulnerable low-income and minority communities," said Jackson. "Nursing home costs are already sky-high, and these mandates will make things worse."

Medical Device Inaction

Shortly after Biden took office, he repealed the Medicare Coverage Innovative Technology Rule, a Trump-era policy designed to give seniors immediate access to new devices approved by the Food and Drug Administration.

Despite promising a swift replacement, no final rule from the Biden administration has been forthcoming. Asked whether he could give a timeline for a replacement, Becerra said, "I wish I could give you a specific timeline," saying the administration's proposal is still under review by several agencies.

Fentanyl Crisis and Border Policy

Fireworks also erupted over the subject of fentanyl and how the administration's open border policies are creating an overdose crisis.

"The word 'fentanyl' is mentioned in President Biden's FY 2025 HHS budget a whopping one time—one time—even though this is clearly a public health emergency," said Rep. Kevin Hern (R-OK). "Can you tell us how you expect to curb the fentanyl deaths and help [those] struggling [with] addiction when the southern border continues to stay wide open, allowing the free flow of fentanyl into our country?"

Becerra replied, "We are moving forward to try to make Naloxone and other treatments that can counteract the effects of a fentanyl overdose to keep a person alive, more available. … We are continuing to make the types of services that work to keep people from dying available."

"Wouldn't it be better if we just stopped the flow across the southern border?" Hern said.

Strain on Foster Care

Becerra clashed with Rep. Beth Van Duyne (R-TX) over another border-related problem, the surge of unaccompanied minors, which is putting severe strains on her state's foster-care system and is exacerbated by the Office of Refugee Resettlement not properly vetting prospective homes.

Van Duyne "inaccurately depicted the work that we do," Becerra said. "So, it's hard to answer."

"It is sadly ironic that the Biden administration HHS is dragging its feet on implementing approaches to solve today's most urgent problems, such as the inflow of fentanyl across our porous borders, while at the same time defending fatally flawed fixes such as the nursing home regulations," Jeff Stier, a senior fellow at the Consumer Choice Center, told *Health Care News*. "Ideologically progressive policy wins out even when the outcomes are obvious failures."

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

"It is sadly ironic that the Biden administration HHS is dragging its feet on implementing approaches to solve today's most urgent problems, such as the inflow of fentanyl across our porous borders, while at the same time defending fatally flawed fixes such as the nursing home regulations."

JEFF STIER
SENIOR FELLOW
CONSUMER CHOICE CENTER

Medigap Increases Medical Consumption and Drives Up Costs, Study Finds

By Kevin Stone

Medicare enrollees who purchase Medigap insurance spend an average of $2,300 more per year on health care than those who don't, a Michigan Retirement and Disability Research Center (MRDRC) study reports.

In an MRDRC working paper titled "Insurance Purchases of Older Americans," funded by the U.S. Social Security Administration (SSA), University of Michigan researchers examined why older Americans purchase Medigap insurance to pay for medical costs not covered by Medicare. The study found no evidence the higher spending is caused by adverse selection of the less-healthy in the insurance market and only modest evidence that crowd-out and behavioral factors are significant.

On the contrary, the study found Medigap purchasers tend to be healthier than those who do not carry the additional coverage, which indicates higher spending is not related to greater need due to poorer health.

The results are consistent with the view higher spending is caused by a moral hazard driven by the lower out-of-pocket costs for additional care among those with Medigap, state the authors.

"What is likely to happen here is premiums for Medigap will continue to rise but those with Medigap will likely have better choices for services. A good solution here is to look into high-deductible Medigap plans—have some more skin in the game with a deductible but offset it with low premiums."

ROBERT KLEIN
INDEPENDENT CONSULTANT

Medigap Premium Costs

Medigap premiums range from $50 to more than $300 per month, depending on such factors as tobacco use, health problems, gender, location, and age. Most Medicare Part B users pay a monthly premium of $174.40.

For Medicare recipients on a fixed income, the additional cost of Medigap results in Medicare users often either moving to Medicaid or defaulting on outstanding medical expenses in the event of costly or catastrophic medical conditions, the study found.

Although some financial advisors cast the purchase of Medigap as the fiscally responsible option, that may not be true, according to the study data.

'People Tend to Overconsume'

Medigap can make enrollees oblivious to the cost of care, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"Most health economists have never had a good word to say about Medigap insurance," said Goodman. "By law, it has to cover the deductibles and coinsurance in regular Medicare. This means medical care is essentially free to Medicare enrollees who also have a Medigap plan."

Providing goods and services for free tends to create waste, says Goodman.

"When you remove the financial incentives to be economical in the consumption of medical care, people tend to overconsume it," said Goodman. "They obtain medical services they would not have obtained if they had to pay full price.

"There is a great deal of waste in the health care system," said Goodman. "Some observers think one of every three dollars is wasteful. Medigap insurance contributes to that waste."

'More Providers Will Drop Out'

The tendency to take greater risks, known as "moral hazard" because the primary agent suffers no penalty for making a bad choice, is complicated when it comes to Medigap, says Robert Klein, an independent consultant on Medicare and long-term care who is a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"I will argue that the moral hazard with Medicare is based on two key issues," said Klein. "First, Medicare B is grossly underfunded. The premiums one pays when enrolled cover about 25 percent of the actual cost. Second, in the case of Medicare Advantage (MA), too many policies have too low of a premium or are premium-free. They also reimburse providers much less than Medigap."

As a result, MA provider networks are becoming narrower and there are fewer choices of plans, says Klein.

"Older, sicker people cannot switch," said Klein. "More providers will drop out of accepting Advantage.

"The simple answer is that government involvement often distorts markets and encourages bad behavior," said Klein. "Medicaid was supposed to be a safety net for the poor and disabled, not a planning tool when you screw up."

'More Skin in the Game'

Klein says the overreliance on government-sponsored health insurance must be remedied.

"Insured persons should be in the position of being better consumers by understanding that insurance is not supposed to cover you from the first dollar of a loss," said Klein. "Insurance exists to cover risks you cannot absorb."

Seniors in traditional Medicare who purchase supplemental insurance will face higher premium payments, but they have a greater choice of providers than MA enrollees, says Klein.

"What is likely to happen here is premiums for Medigap will continue to rise but those with Medigap will likely have better choices for services," said Klein. "A good solution here is to look into high-deductible Medigap plans—have some more skin in the game with a deductible but offset it with low premiums."

Government Data Sources Used

The primary data source for the study was Health and Retirement Study (HRS) survey data linked to restricted administrative Medicare and Medicaid records, which provide information on health care spending and out-of-pocket medical payments.

A secondary data source was the Medical Expenditure Panel Survey (MEPS), which was used to impute medical payments from other sources, including those made by Medicare Part C, private insurers, and other smaller payors such as the Veterans Administration and state or local health departments.

The HRS is a nationally representative biennial survey of the over-50 U.S. population and their spouses. The MEPS is a nationally representative survey of non-institutionalized households.

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

INTERNET INFO

Karolos Arapakis, Eric French, John Bailey Jones, and Jeremy McCauley, "Insurance Purchases of Older Americans," Working Paper 2023-463, Michigan Retirement and Disability Research Center of the University of Michigan: **https://mrdrc.isr.umich.edu/publications/papers/pdf/wp463.pdf**

States Expand Pharmacists' Prescribing Authority

By Ashley Bateman

Colorado, Idaho, and Montana have broadly expanded the prescribing authority of pharmacists to make health care more accessible and to lower costs, a new report states.

Expanding pharmacists' scope of practice can decrease the burden on emergency departments and help cover physician shortages for basic care, especially in rural areas, because pharmacists are more numerous and accessible than primary care physicians, say Marc Joffe, a federalism and state policy analyst, and Jeffrey A. Singer, M.D., a senior fellow, both of the Cato Institute, in "Let Pharmacists Prescribe," a study published by the institute on March 21.

In several countries, pharmacists have broader prescribing authority than in the United States, the authors note.

"States should allow patients to access pharmacists for a wide array of routine medical problems, which would save them time and money and improve access to primary health care."

JEFFREY SINGER, M.D.
CATO INSTITUTE

Scope Expansion

While many states expanded pharmacists' scope of independent practice to include vaccinations, Idaho enacted broader prescribing reforms in 2019, Colorado in 2021, and Montana in 2023.

Idaho law (H.B. 182) allows pharmacists to prescribe drugs if a new diagnosis is not required, the condition is minor and generally self-limiting, laboratory tests are not required for diagnosis, or immediate care is required to avoid an emergency. The law limits the amount of a drug prescribed in emergencies to the quantity needed until a patient can see another provider.

"There is already evidence that pharmacists and patients are willing to use the new independent prescribing at scale," Joffe and Singer write. "This new class of legislation appears to be having a greater impact than previous reforms."

Pharmacies in many states have expanded into clinics, and in four states, Safeway pharmacies are already prescribing treatment for strep throat, say Joffe and Singer.

"Safeway pharmacies have expanded their practices to include prescribing in several states," Joffe and Singer write. "But only in Idaho and Colorado does the chain advertise prescriptions for medications to treat cold sores, men's hair loss, migraines, motion sickness, topical acne, and UTIs [urinary tract infections]."

Routine Emergencies

Many health conditions—such as UTIs, strep throat, middle ear infections, vaginal yeast infections, and influenza—are short-lived and simple to treat, Singer told *Health Care News*.

"States should allow patients to access pharmacists for a wide array of routine medical problems, which would save them time and money and improve access to primary health care," said Singer. "State lawmakers should expand pharmacists' scope of practice to allow them to independently treat a wide range of medical conditions."

Patients are using expensive emergency room treatment because wait times for an appointment with a physician are growing, says Singer.

"It's getting more and more difficult to get in to see a doctor," said Singer. "The average wait time in the U.S. for a first-time visit is 26 days. Many people with these simple problems might resort to hospital emergency rooms or urgent care centers, which cost more than a doctor's office and may have even greater wait times."

"Pharmacists are well-positioned to prescribe in other situations as well, such as extending previous prescriptions or addressing emergencies," Joffe told *Health Care News*.

Physician Opposition

The American Medical Association (AMA) has repeatedly opposed federal legislation that would expand the allowed scope of practice for pharmacists, saying they lack the "extensive education and training" of physicians.

In 2022, the American Academy of Pediatrics and the American College of Physicians cosigned a letter to legislators arguing expanding pharmacists' freedom to treat could "undermine the physician-led, team-based care models that have proven to be most effective in improving quality, efficiency and, most important, patient health."

Though physicians have legitimate concerns about pharmacists' training, pharmacy education covers many of the same subjects as medical school, says Chad Savage, M.D., president of DPC Action and a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"While physicians can certainly critique the adequacy of the training of physician extenders, they are at least trained in the same areas of history, examination, diagnosis, and treatment, even if not as robustly," said Savage.

Room for Judgment

Pharmacists' lack of diagnostic training could lead to major health repercussions for patients, so they would have incentives not to overstep their abilities.

"Pharmacist training is dramatically different despite some areas of overlap," said Savage. "Pharmacists are not trained in physical examination."

Singer says in his own surgical experience complex problems outside of his purview require referrals, which is ethical and avoids liability.

"There is no reason to think a pharmacist will not act the same way," said Singer. "They would not test and treat for a routine condition without taking a history. And if they are concerned that the condition may be complex, they can refuse to test or treat and tell [a patient] they must see a doctor."

Potential Savings

Helping patients avoid emergency room visits could reduce insurance premiums, says Joffe.

"Insurance premiums are heavily influenced by the cost of care," said Joffe. "If patients can avoid physician visits and especially emergency room visits while getting relief for their conditions, costs of claims will be lower, which should bring down insurance rates."

Insurers are less effective in ensuring quality of care than in containing costs, says Savage.

"Premium increases are reactionary to poor care and not proactive," said Savage. "Basically, many patients could be harmed before any adjustment is made. If reliant on malpractice lawsuits, those cases do not always correlate with the quality of care provided but are more highly correlated with subjective qualities of the care experience.

"For pharmacists to assume the provider role, they would truly need to massively change their training, expanding into history, examination, diagnosis, care management, and care coordination of patients," said Savage. "Essentially, they would have to go to medical school."

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

States Change Medical Licensing Rules to Ease Doctor Shortage

By AnneMarie Schieber

Several states are extending medical licenses to foreign and assistant doctors to fill shortages of physicians that are projected to reach 86,000 nationwide by 2036.

Tennessee will give provisional licenses to physicians with clinical experience who migrate to the United States, in 2025.

Governors Ron DeSantis of Florida and Glenn Youngkin of Virginia signed similar bills into law. The Florida bill will go into effect January 1, and the Virginia measure becomes effective on July 1.

A bill removing the requirement for a medical residency is moving through the Idaho legislature, and a similar bill in Wisconsin was signed into law on March 23.

The state reforms are focused on extending provisional licenses to experienced foreign doctors and issuing licenses to assistant or associate physicians (APs)—medical school graduates who have been unable to find places in overcrowded U.S. medical residency training programs.

Adding Foreign Doctors

Removing license restrictions on foreign-trained doctors would expand access to physicians, says Jeffery Singer, M.D., a senior fellow at the Cato Institute.

"Unlike Canada, Australia, the European Union countries, and many other developed countries, states require such doctors to repeat their entire residency training in an accredited residency program in the U.S.—even if they have been practicing for years in their home countries—and pass the standardized U.S. Medical Licensing Exam," Singer wrote in a March 14 blog post.

Americans Studying Abroad

Under the Tennessee law, foreign doctors and international medical graduates (IMGs), which includes Americans who studied abroad, can forgo the clinical residency requirement but must be licensed in their native countries, pass U.S. medical exams, and be supervised for two years by a licensed physician before receiving an unrestricted license.

The bills grow the ranks of physicians more quickly and are helpful to U.S. medical school graduates who do not have residency places, says Singer.

"By requiring experienced and practicing foreign doctors who migrate to the U.S. to repeat a residency program, you are adding them to the pool of med school graduates competing for an already scarce number of residency slots [that isn't] enough to accommodate current U.S. med school grads," Singer told *Health Care News*.

Crowding Into Residencies

In 2023, 40,375 medical residency slots were filled via the National Resident Matching Program (NRMP), which pairs medical school graduates with federally funded clinical training programs, says Matt Dean, a senior fellow in health care policy outreach for The Heartland Institute, which publishes *Health Care News*.

"But the real number is much lower as those who withdrew, delayed, or did not rank multiple programs were uncounted in this figure," wrote Dean in a March 26 research and commentary document. NRMP data show 2,590 U.S. IMGs and 5,118 non-U.S. IMGs were not matched to residencies in 2023.

Limiting Assistant Physicians

In 2014, Missouri became the first state to create a path for APs and now has 348 active licenses, says Dean. Graduates train under licensed physicians, and their medical practices are limited in scope and confined to underserved areas.

Similar programs now exist in Arizona, Kansas, Maryland, Utah, and Washington. Alabama, Minnesota, and Oklahoma are considering similar legislation. Some states have a time limit on practicing APs, with the expectation they will eventually be placed in conventional residency programs.

Vetting Foreign Doctors

One concern about extending licenses to medical school graduates who have not followed the conventional training route is safety, as residency programs serve as a "vetting" process.

Graduates of fly-by-night or easy-entry offshore medical schools could start medical practices that harm patients, as in the case of an assistant physician in Minnesota who owned multiple clinics, supplied drugs illegally to patients, and was convicted of fraudulently receiving $300,000 in federal funds.

Dean says he favors expanding the ranks of licensed physicians through the AP track for non-ranked U.S. graduates, instead of bringing in more foreign doctors.

"The medical training programs developed in the United States over the past century have set the global gold standard for clinical training," Dean told *Health Care News*. "Clearly, the accreditation of non-U.S. training programs for U.S. licenses needs to be uniform and have as its goal the best interests of the patients who will be in their care."

Distorting the Price System

Easing up on medical licensing won't solve the physician access problem by itself, says David Teuscher, M.D.

"Rural and urban access issues are not primarily the result of an insufficient workforce," Teuscher wrote in an email discussion moderated by the Galen Institute. "The problem doesn't exist in communities with a greater percentage of privately insured patients with stable and acceptable contracted rates for in-network services.

"If the IMGs fill the shortage, I'd anticipate declining government reimbursement to continue, a downward death march without any inflation factored in, essentially a race to the bottom," said Teuscher. "The vast majority of IMGs that I have worked with locate to affluent communities for the very reason that American-trained physicians do: compensation is higher. It's Economics 101."

Shortchanging U.S. Graduates

The federal government's freeze on the expansion of graduate medical education (GME) residencies leaves some medical school graduates without a route to licensing, says Teuscher.

"Medical school expansion without GME for every graduate is a disservice to the taxpayers, the physician graduates, and the patients who can't access a physician," Teuscher told *Health Care News*. "If policymakers want to ease immigration for foreign fully trained, experienced, and equivalent physicians, and require additional GME in the U.S., that GME funding will be essential."

"Medical school expansion without [graduate medical education (GME)] for every graduate is a disservice to the taxpayers, the physician graduates, and the patients who can't access a physician. If policymakers want to ease immigration for foreign fully trained, experienced, and equivalent physicians, and require additional GME in the U.S., that GME funding will be essential."

DAVID TEUSCHER, M.D.

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

COMMENTARY

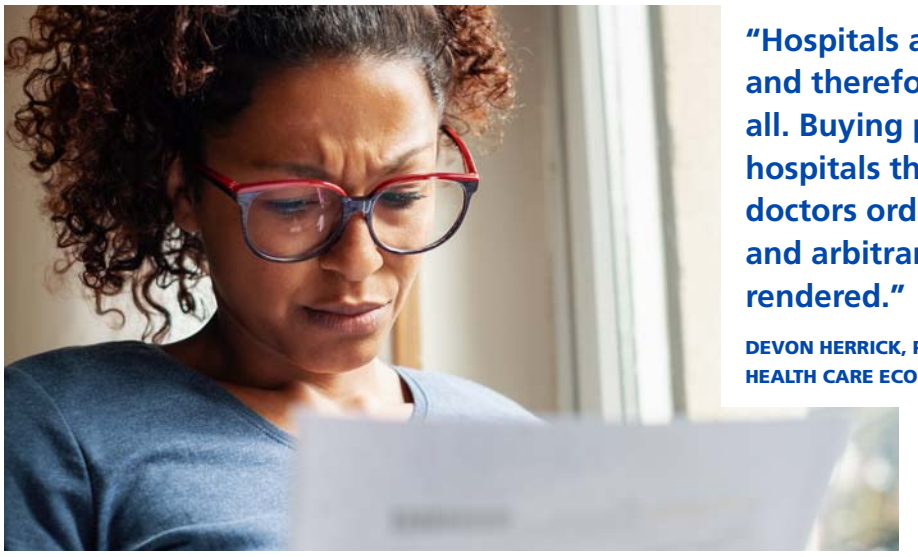
‘Facility Fees’ Are the New Surprise Medical Bills

By Devon Herrick

Facility fees are becoming increasingly prevalent in the U.S. health care system, *The Wall Street Journal* reports. In some cases, a facility fee for using a physician employed by a hospital nearly triples the cost of those services.

The WSJ article describes how Tim Ebel’s visit to an Ohio ear, nose, and throat clinic in a local hospital system resulted in a $645 facility fee on top of the $348 treatment bill.

This is yet another example of why hospitals should not be allowed to buy physician practices and employ physicians. Hospitals are not competing on price, and therefore they don’t compete at all. Buying physician practices gives hospitals the ability to control what doctors order on behalf of patients and arbitrarily bill for services not rendered.



“Hospitals are not competing on price, and therefore they don’t compete at all. Buying physician practices gives hospitals the ability to control what doctors order on behalf of patients and arbitrarily bill for services not rendered.”

DEVON HERRICK, PH.D.
HEALTH CARE ECONOMIST

Hospitals are charging billions of dollars in “facility fees” for work done in the outpatient clinics they own, the WSJ reports. The fees might apply to standard imaging services such as mammograms, and they have become more pervasive as hospitals own an increasing number of outpatient clinics within their markets.

Hospitals Expanding Power

Meet the new surprise medical bill, where hospitals tack on arbitrary fees because they have bought your physician’s practice and now technically employ him or her.

When small medical equipment firms bill Medicaid for services not rendered, they often get indicted for fraud. Their executives and co-conspirators get sent to prison. When hospitals do it on a wider scale, officials wring their hands and lament how unfair it is but do nothing about it.

The Journal article cites an estimate that more than half of all physicians in the United States now work for a hospital. It says hospitals are on an “acquisition tear” to gobble up independent practices.

Hospitals are becoming aggressive in pursuit of more market power. *Health Care News* described how Alliance Cancer Centers, an independent cancer care practice, lost privileges in a local health care system when it rebuffed a buyout offer. The doctors are not even allowed to write notes in their own patients’ hospital charts.

Not a New Practice

I first read about facility fees in 2009 in *The Wall Street Journal*. A full 15 years later, the problem has only gotten worse. In contrast, Site-neutral payments would save Medicare billions of dollars, notes *The Washington Post*.

“Site-neutral payments” means paying the same fees regardless of whether a service is performed inside a hospital or in a freestanding clinic far from the hospital campus. Hospitals claim they need to charge higher fees for hospital-owned clinics, to cover overhead. Yet, it makes no sense to pay more when the same service can be performed more cheaply elsewhere.

Meanwhile, Medicare site-neutral payment legislation would do nothing for younger Americans with employee health insurance or those with high-deductible Obamacare plans.

The Wall Street Journal says it is all but impossible for patients to know in advance whether a clinic is associated with a hospital that will charge facility fees. Perhaps if hospitals were required to provide price quotes in advance for services to be legally collectible, there would be more transparency.

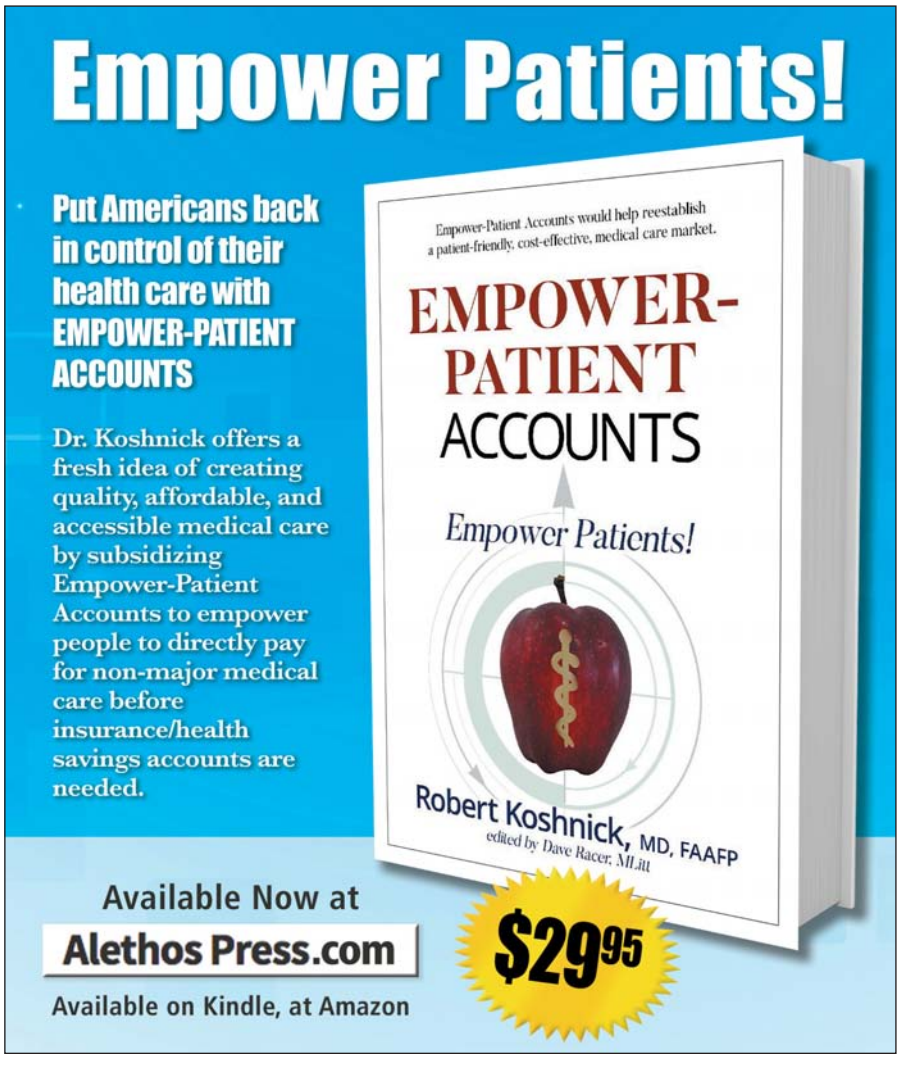
States Are Fighting Back

This also illustrates why laws against corporate practice of medicine should be enforced. Physicians given the sole legal right to practice medicine should not be bought and used by hospitals to ambush patients.

Fortunately for patients, government payors are starting to clamp down on this form of surprise billing. Medicare now refuses to pay facility fees for drug infusions at hospital-owned off-campus sites. The Journal reports that beginning in July, Colorado will require hospitals to disclose the fees before billing, and Indiana has banned the state’s largest nonprofit health systems from charging facility fees, starting next year.

Other jurisdictions, and the private sector, should follow suit.

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



Private Equity Skirts Malpractice Laws in Texas

By Kenneth Artz

A medical malpractice lawsuit claims the University of Texas at Tyler Health Science Center (UT Tyler) fraudulently identifies physicians as medical school professors to protect them from malpractice litigation.

The lawsuit claims Ruben Garcia, M.D., failed to share a cancer diagnosis with patient Michael Simington, aged 67, for a year and a half, costing Simington eight to 10 years of his life, *The Texas Tribune* reported on February 23. Under Texas law, Garcia is immune from malpractice lawsuits because he is employed by a public university, though he works in a clinic owned and operated by private equity investors.

UT Health East Texas is a for-profit health practice formed as a partnership with UT Tyler in a deal funded by Ardent Health Services, the fourth-largest private hospital operator in the United States, according to Becker's Hospital Review.

Simington is deceased. His children could sue the physician's employer, but for a significantly smaller amount than a typical medical malpractice lawsuit, under state statutes.

'What Happens Is Mind-Boggling'

Quentin Brogdon, a personal injury trial attorney at Crain Brogdon, LLP in Dallas, Texas and a former president of the Texas Trial Lawyers Association, says he is seeing more and more of these arrangements in medical malpractice cases.

"Most of my clients don't think about who employs their doctor until something goes off the rails," Brogdon said. "Then it really matters. It certainly seems these arrangements are being set up for the express purpose of inoculating doctors from being held accountable for malpractice."

Though the intent of the statute was to protect government agencies and their employees, there is often a for-profit company in the mix, enabling doctors to obtain protections not intended by the statute, says Brogdon.

"The sheer arbitrariness of what happens is mind-boggling," said Brogdon.

"If two doctors commit the same malpractice and one is employed by a private health care provider, that doctor can be held liable for the malpractice," said Brogdon. "But if the other doctor is the beneficiary of one of these arrangements with a governmental entity, that doctor can't be held liable for the malpractice.

"Of course, the patient invariably has no understanding of this arbitrary distinction when the patient seeks out medical care from a doctor," said Brogdon.

'Little to No Accountability'

Obviously, there is no equality under the law in this policy, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Huge entities with deep pockets, with vast control over how medicine is practiced, have little to no accountability, while individual physicians can be ruined by a single lawsuit," said Orient.

Patients need to understand that their doctor is not working for them and is responsible to the entity writing his paycheck, says Orient.

"Private entities and universities do not care about patients—who are just cost or profit centers," said Orient. "Evidently, the doctor in the lawsuit didn't care either, making no effort to follow up with the patient.

"Patients and their families need to find an independent doctor if they can, and they need to be vigilant," said Orient. "The corporate practice of medicine used to be recognized as unethical—and it still is."

'They Sold Their Immunity'

The issue is not whether the arrangement is an artifice to avoid malpractice insurance and litigation costs for physicians who are claiming immunity, but whether the government policy itself should be struck down, says John Dale Dunn, M.D., J.D., a physician and policy advisor to The Heartland Institute, which publishes *Health Care News*.

"You can call the arrangement a fraud, but it is nothing more than an arrangement to create a Texas Tort Claims Act immunity for an entity that is privately owned but a partner with a state entity," said Dunn.

"The cost and attractiveness of the for-profit private/nonprofit state cooperation is not hard to assess: it involves millions of dollars, short- and long-term," said Dunn. "The state sold a valuable thing to the buyer, Ardent: they sold their immunity. ...The question is, does the arrangement violate public policy if it impairs injured-party malpractice lawsuits?"

'Judges Work for the State'

As to whether a private entity should be able to benefit from an acquired immunity via association with a state entity, the important consideration is why state entities are given immunity in the first place. Immunity can reduce operating costs for state institutions, but it should not be extended to private entities for a price, says Dunn.

Regardless of the rights and wrongs, political dynamics will decide the issue, says Dunn.

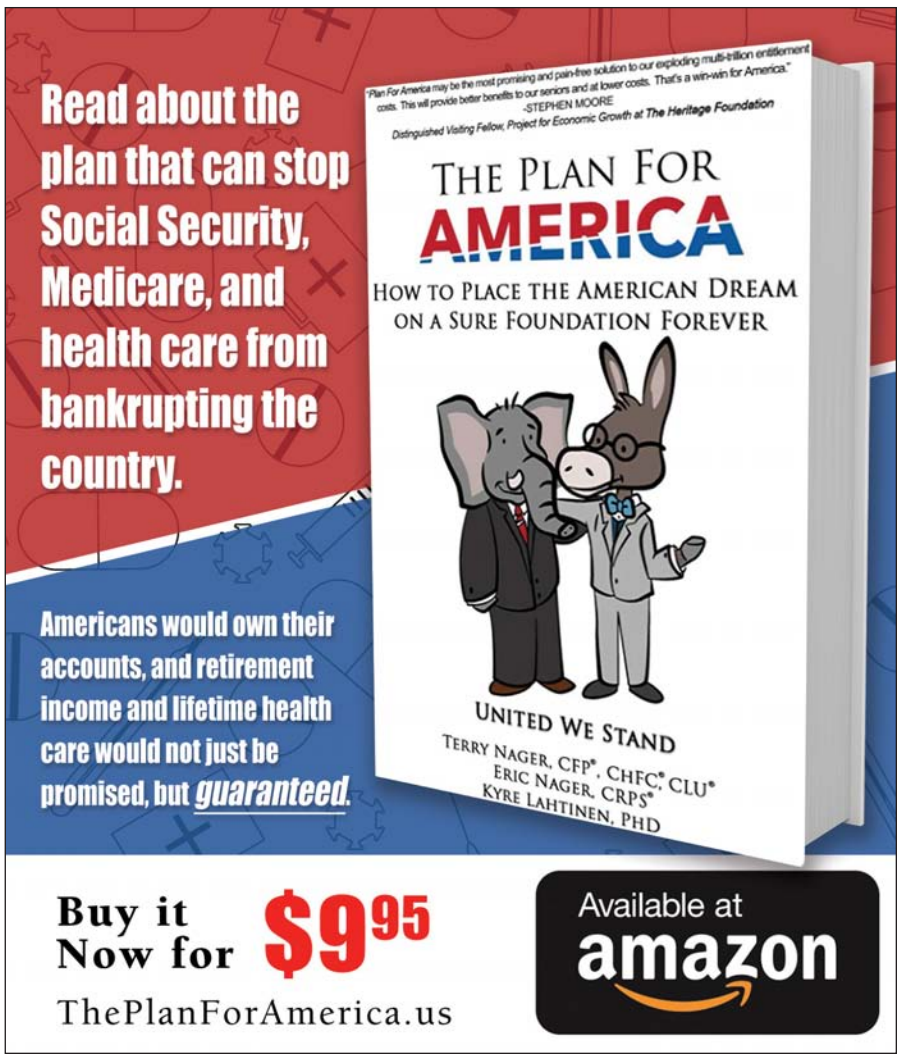
"I bet the court will allow the state to sell its immunity or put up its immunity as a valuable interest to be considered in the financial arrangements of the sale," said Dunn. "One reason I believe this is that judges work for the state. They have state interests as a real factor in such situations.

"My conclusion is that the immunity creates a saleable, valuable commodity for the private entity, state affiliation, but the state has sold its immunity value knowing that was a value added to encourage the private investment," said Dunn. "All things and real politics considered, I bet the state court judge comes down on the side of immunity."

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

"The cost and attractiveness of the for-profit private/non-profit state cooperation is not hard to assess: it involves millions of dollars, short- and long-term. The state sold a valuable thing to the buyer, Ardent: they sold their immunity. ...The question is, does the arrangement violate public policy if it impairs injured-party malpractice lawsuits?"

JOHN DALE DUNN, M.D., J.D.
POLICY ADVISOR, THE HEARTLAND INSTITUTE



FILM REVIEW

Big Medicine, Anti-Depressants, and Suicide Examined in New Documentary

Review of *SICK: Unmasking Big Medicine* (Daily Caller News Foundation), 52 minutes, 2024

By Bonner Russell Cohen and AnneMarie Schieber

The public health establishment's response to COVID-19—prolonged lockdowns and school closures, vaccines that provided no immunity and didn't stop transmission, mask mandates that served no public health function—came as a rude awakening to many people.

How could so many physicians and once-revered institutions get so many things wrong? For those who have experienced the heavy hand of Big Medicine in recent years, the pandemic only confirmed their worst fears. *SICK*, a documentary by *The Daily Caller*, sheds new light on the corruption and dishonesty that pervade a health care system dominated by Big Medicine.

"Any film or article that opens eyes to the dismal realities of the current health care system is welcome, and for that *Daily Caller* should be commended."

Cure Worse Than the Illness

SICK adroitly depicts the human wreckage left behind by a medical system that has actively promoted chemical dependency for decades.

The 52-minute film lets people caught up in the madness tell their own stories. One woman's dependence began when she was an 18-year-old student trying to cope with the typical stresses of college life. A physician in Nashville, who had routinely prescribed painkillers to his patients, began experimenting with them himself and wound up addicted.

A woman describes the tragedy of her husband, who was given the prescription drug Zoloft to deal with work-related stress. Over time, the man spiraled out of control and was found hanging from a rope in his garage. Medications sold as antidepressants frequently prolong and deepen depression.

Pressured and paid by Big Pharma to prescribe their latest offerings, doctors frequently downplay drugs' side effects. They may not even be fully aware of what the drugs are doing to their patients. A health care professional shown in the film recommends patients seek advice from pharmacists because they are generally better informed about what a pill can do.

Money Trail

Lack of transparency and conflicts of interest abound in a system where money talks. Pointing to the influence of Big Pharma, a health and life coach says in the film, "They fought harder against ivermectin than they did against fentanyl." There was no money to be made from ivermectin, regardless of its effectiveness in combatting COVID-19.

The newest frontier in the ever-expanding world of Big Medicine is the lucrative opportunities presented by transgender ideology. There is serious money to be made in puberty blockers and other gender-altering treatments, and Big Pharma doesn't want to miss out. Confused adolescents undergoing the transition from childhood to their teen years can wind up irreversibly mutilated for life, but that seems to be of little concern when big bucks are at stake.

No New Ground

Although *SICK* gives some interesting examples of earnest people harmed by pharmaceuticals, the documentary comes up short on several fronts.

Many of the cases of overprescribing are years old. The medical doctor in the film went into recovery in 2004, according to his online description, and the wife who lost her husband to suicide while on Zoloft has been a drug safety advocate for two decades. There have been more recent examples of overprescribing harm, such as the Massachusetts mother accused of killing her three children while taking a cocktail of psychotropic drugs.

Also, it is not clear how much overprescribing of opioids is taking place today. Legislators came down heavy on prescribing practices when the opioid crisis picked up steam a decade ago, and people who use these drugs can describe full well the hoops they must jump through to get the drugs they need and take responsibly.

The documentary needed more voices of authority instead of mere critics of Big Pharma. Of the five or six voices in the film, only one is a medical doctor. The documentary is dominated by the voice of Charlie Fagenholz, who is presented as "Dr. Charlie Fagenholz," a "holistic physician." According to his online description, Fagenholz is a chiropractor, a profession well-known for its animosity to pharmaceuticals.

Symptoms of a Broken System

The film doesn't spend much time exploring what makes medical professionals so quick to pull out the prescription pad. It is easy to point the finger at aggressive marketing by Big Pharma, but you can't sell something to an unwilling buyer. Patients today often demand "quick fixes," as when trying to lose weight or deal with stress.

How many patients want to do the heavy lift of serious lifestyle changes? How many doctors have the time or freedom to follow through on lifestyle recommendations? Health care professionals increasingly work for big hospital corporations that demand allegiance to them and not just the patient. Fifteen-minute visits with a physician a few times a year will do little to advance effective alternatives to prescription drugs.

Meanwhile, third-party payers encourage the pursuit of easy fixes. Patients are quicker to demand any treatment at any risk when someone else is picking up the tab.

Although *SICK* is stronger on anecdotes than analysis, it does effectively illustrate how a system that is supposed to help people is harming them. Any film or article that opens eyes to the dismal realities of the current health care system is welcome, and for that *Daily Caller* should be commended.

Bonner Russell Cohen, Ph.D. (**bcohen@nationalcenter.org**) *is a senior fellow at the National Center for Public Policy Research. AnneMarie Schieber* (**amschieber@heartland.org**) *is the managing editor of* Health Care News.

COMMENTARY

Trump and Biden Differ Widely on Health Care Reform

By John C. Goodman

Although he rarely talks about it, the most significant gift President Donald Trump bequeathed to economic prosperity was deregulation. And the one sector that was deregulated more than any other was health care.

Since Joe Biden has been re-regulating the economy, it's hard to think of a starker contrast between the two leading presidential candidates this year—and it affects all aspects of health care.

Trump might have won the 2020 election if he had campaigned on his health care accomplishments. Below are some of them.

"Since Joe Biden has been re-regulating the economy, it's hard to think of a starker contrast between the two leading presidential candidates this year—and it affects all aspects of health care. Trump might have won the 2020 election if he had campaigned on his health care accomplishments."

JOHN C. GOODMAN
PRESIDENT
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

Insurance Tailored to Individuals, Families

Imagine combining the average premium with the average deductible for health insurance purchased by a family of four in the Obamacare exchanges. In 2020, that totaled more than $25,000. In other words, a family not getting a subsidy had to spend more than $25,000 before getting any benefit from their health insurance plan! And they had to do that every year!

Not surprisingly, the unsubsidized part of the market was in a freefall. Democrats in Congress responded by creating "enhanced subsidies"—even for people who are wealthy. The government is now virtually giving away free health insurance to average-income families.

If you are sick, things are far less rosy, however. The annual out-of-pocket maximum exposure for a family this year is $18,900. That's the amount you may have to pay in the form of deductibles and coinsurance—over and above any premium payment. Families with ongoing, chronic conditions have to pay as much as that amount—every year!

Self-Management of Chronic Illnesses

There is mounting evidence patients suffering from diabetes, heart disease, and other chronic illnesses can (with training and the right support) manage a lot of their own care as well as—or better than—traditional doctor therapy can. They can do an even better job if they are also managing the money that pays for that care.

Health Savings Accounts (HSAs) are a natural vehicle. However, current law requires an across-the-board deductible, making HSAs incompatible with smart insurance design for chronic care. For example, a wise employer might want to make insulin available for free to diabetic employees to encourage its use. The same employer might ask noncompliant employees who show up in emergency rooms to pay for that care out of their own account.

Under guidance issued by the Trump administration, employers and insurers can now provide first-dollar coverage for the purchase of maintenance drugs for 13 chronic conditions without running afoul of HSA regulations.

More needs to be done. HSAs ought to be completely divorced from the high-deductible requirement. Let the market, rather than government, make decisions about the optimum role of cost-sharing.

Personal, Portable Insurance

Before Obamacare, some employers gave their employees pre-tax dollars to purchase individually owned insurance. This was insurance the employees could take with them from job to job and in and out of the labor market.

President Obama completely shut down this practice with a threat to fine any employer caught doing it as much as $100 per employee per day. This was countermanded by a Trump rule that has allowed (and even encouraged) employers to fund employee-owned health insurance since January 2020.

It is striking to observe how many significant health policy changes have been effected by presidential action alone—without any act of Congress. Yet congressional action is needed to take full advantage of the opportunities.

Under the Trump executive order, employees can only use their employer's funds to buy "Obamacare compliant" insurance, which mainly means insurance sold in the exchanges. Moreover, they cannot get the subsidies other buyers get in the exchanges. Since the exchange plans are otherwise very unattractive, the take-up rate for this opportunity has been well below initial expectations. What is needed is congressional action to allow the employees to buy any kind of insurance.

Round-the-Clock Primary Care

Concierge doctors used to be available only to the rich. Today "direct primary care" (DPC) is much more affordable. Atlas MD in Wichita, Kansas, for example, provides all primary care along with 24/7 phone and email access. They offer discounts on lab tests and generic drugs for less than what Medicaid pays. The cost: $50 a month for a middle-aged adult; $10 a month for a child.

An unfulfilled goal of the first Trump administration was to allow employers to put money into individual accounts from which the employees could make monthly payments to DPC doctors of their choosing.

This should be a high priority in a second Trump term.

Focused Factories in Medicare

Another important development in the first Trump administration was encouraging "focused factories" in Medicare. In contrast to the rest of the healthcare system, Medicare Advantage "special needs" plans can specialize in 15 chronic conditions.

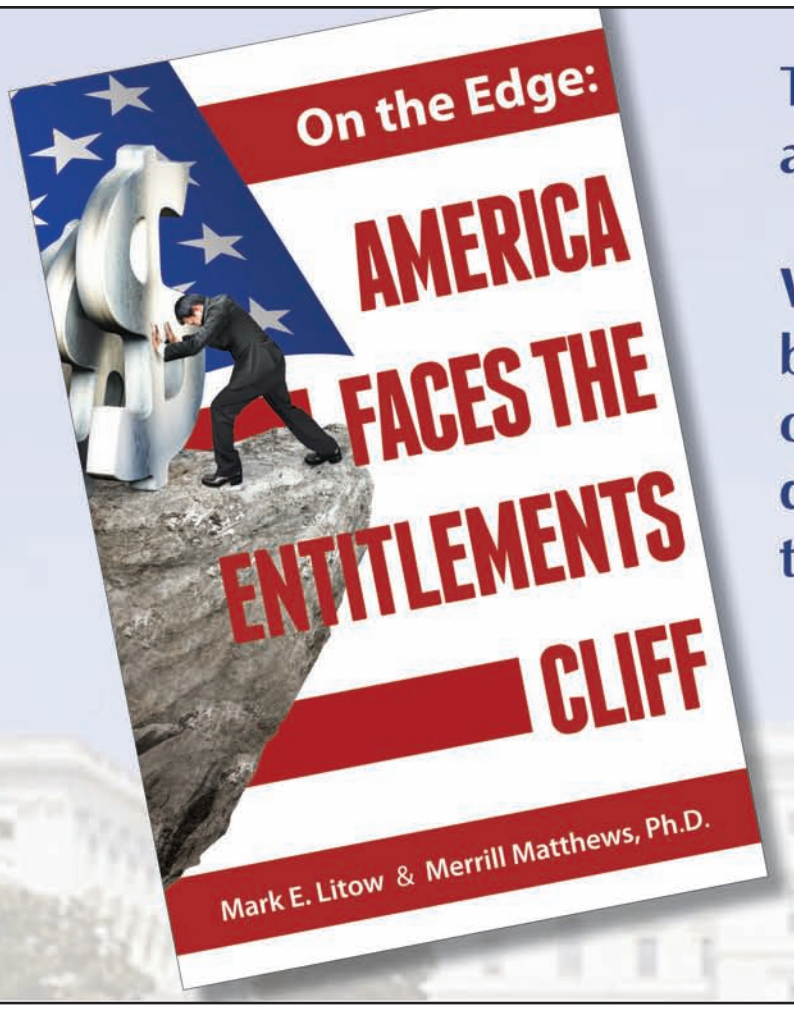
The Obamacare exchanges would be enormously improved if they allowed the same sort of specialization and the same type of risk adjustment that we now find only in the Medicare Advantage program.

Back to the Future Agenda

Space does not permit a discussion of other reforms, including liberation of Association Health Plans, renewable short-term plans (see articles on pages 1 and 5 of this issue), requiring hospital price transparency, and expanding options under Medicare Advantage.

But I hope I have made clear that Donald Trump does not need a new health policy agenda. He merely needs to complete the agenda of the first Trump administration.

John C. Goodman, Ph.D. (**johngoodman@goodmaninstitute.org**) *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *An earlier version of this article was published at goodmaninstitute.org. Reprinted with permission.*



The United States is approaching an entitlements cliff.

Will we meander over the edge, be dragged down to the bottom—or will we recognize the imminent dangers and take a step back to fiscal security?

New from the Institute for Policy Innovation

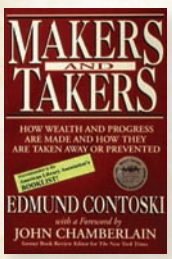
IPI

Available at amazon

THE BOOKS OF
EDMUND CONTOSKI

Available online at **store.heartland.org.**

MAKERS AND TAKERS: How Wealth and Progress Are Made and How They Are Taken Away or Prevented
$24.95



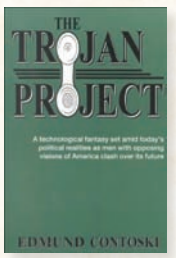
"If you buy only one book this year, if you read only one book this year, this is the one. It is meticulously researched. It is beautifully written. It is fantastic!" –Ed Flynn, host of *Talk of the Town* radio program.

"In spite of the huge amount of information, it is exceptionally well organized and fun to read with 'Ahaas' on every page. I couldn't put it down." –Reader in Thousand Oaks, CA.

"His economic research is awesome, and his analysis is sharp...Makers and Takers will become a classic of erudition in the struggle for true individual freedom. –The Book Reader

Recommended by the American Library Association's *BOOKLIST* for library purchase.

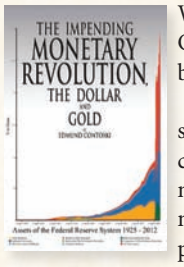
The Trojan Project
$17.95



"*The Trojan Project* is a timely, thrilling romp through the possibilities of a technological nightmare....Within this fictional journey, the author examines existing laws and real Constitutional conditions to ponder today's political problems and probabilities… Contoski pricks political balloons without preaching and spins a great yarn in the process. A terrific conclusion." –*The Book Reader*

"An intriguing and absorbing novel, *The Trojan Project* is a technological thriller/fantasy set squarely in the middle of today's political climate. The work is both fiction and non-fiction. Taking current realities in our political infrastructure, Contoski has woven a masterful tale of technological horror...a novel that will keep you in uncertain anticipation until the very last period—and beyond."—A Writer's Choice Literary Journal.

The Impending Monetary Revolution, the Dollar and Gold, 2nd Edition, 283 pages
$28.95



Won a non-fiction award from Feathered Quill, one of the preeminent internet book review sites.

"Strikingly perceptive financial straight talk. A solid overview of the current financial crisis and impending monetary revolution...incorporates a new dynamic to the current monetary policy discussion." –*Penn Book Review*

"A striking vision of the future of the greenback as America's fiscal time bomb clicks." –*Kirkus Review*

"Due to his writing skill and tremendous knowledge of the topic, Mr. Contoski has taken the complex subject of finance and economics and left me with an unbelievable sense of understanding it. His thoroughness in opening the camera lens beyond the economic restraints within the U.S. to incorporate a global perspective is fascinating and well documented. I say bravo for writing this book, Mr. Contoski! The end result is extremely compelling and informative."–Diane Lunsford

Buy all 3 and get 50% off the bundle!

Legislators:

Make Us Your New Legislative Aide!

Join Heartland's Legislative Forum today and stay on top of the latest research and policy solutions.

Why Join?

Simply, The Heartland Institute delivers what elected officials need. Busy elected officials have little or no staff and need a reliable source of research and commentary on the most important public policy issues of the day. For decades Heartland has been that resource.

Benefits of membership include:

- Travel scholarships to Heartland's Emerging Issues Forum
- Priority access to your very own free-market think tank
- Bringing experts to your state
- Invitations to Legislative Forum members-only events
- Complimentary copies of *Heartland Policy Studies* and books

Membership is limited to current elected officials and costs just $99 for a lifetime membership. As a lifetime member, you will enjoy the great benefits the Legislative Forum offers for your entire time in office, as well as alumni benefits thereafter.

Visit **heartland.org/sign-forum** to sign up.

For more information, please call 312/377-4000 and ask for a member of the government relations team.

"Heartland's research and advocacy for science-based policies that improve people's lives have been very helpful to me and my colleagues."

REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA

THE HEARTLAND INSTITUTE

The Heartland Institute is a national nonprofit organization based in Arlington Heights, Illinois. Its mission is to discover, develop, and promote free-market solutions to social and economic problems. For more information, visit our Web site at heartland.org or call 312/377-4000.

THE EPOCH TIMES

TRUTH *and* TRADITION

COVERING IMPORTANT NEWS OTHER MEDIA IGNORE

The very fabric of America is under attack— our freedoms, our republic, and our constitutional rights have become contested terrain. The Epoch Times, a media committed to truthful and responsible journalism, is a rare bastion of hope and stability in these testing times.

SUBSCRIBE TODAY

ReadEpoch.com