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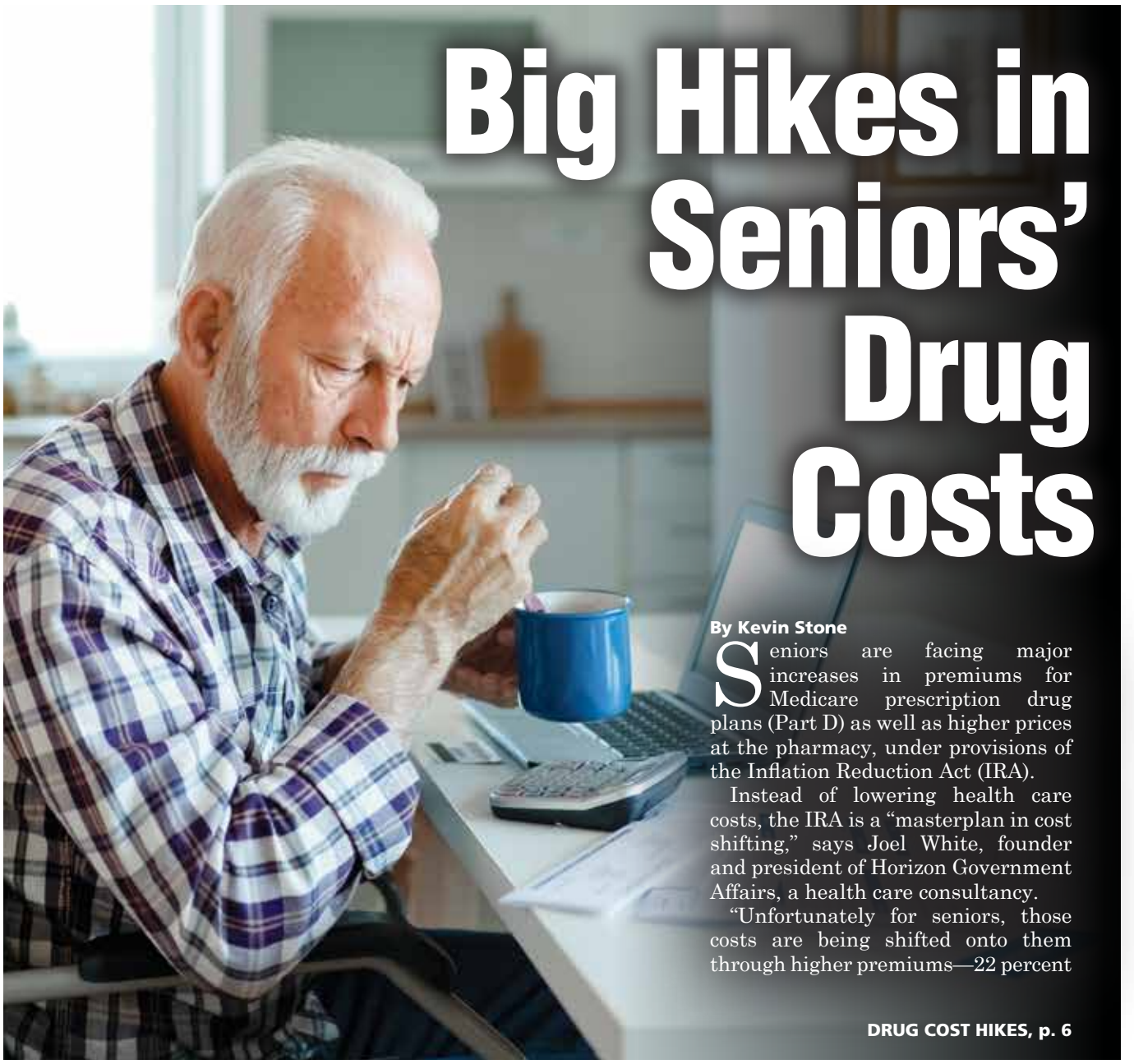
The Pulse



Big Hikes in Seniors' Drug Costs

By Kevin Stone

Seniors are facing major increases in premiums for Medicare prescription drug plans (Part D) as well as higher prices at the pharmacy, under provisions of the Inflation Reduction Act (IRA).

Instead of lowering health care costs, the IRA is a "masterplan in cost shifting," says Joel White, founder and president of Horizon Government Affairs, a health care consultancy.

"Unfortunately for seniors, those costs are being shifted onto them through higher premiums—22 percent

DRUG COST HIKES, p. 6

FBI Targets Child Trans Treatment Whistleblowers

By Harry Painter

Two employees of Texas Children's Hospital are facing the wrath of the U.S. Department of Justice (DOJ) after blowing the whistle on the hospital's alleged illegal secretive treatment of sex-confused children.

In June, the DOJ indicted Eithan Haim, M.D., on four felony charges for exposing child transgender surgeries

WHISTLEBLOWERS, p. 4

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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

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U.S. Supreme Court Reins in Regulatory State

By Bonner Russell Cohen

The U.S. Supreme Court overturned a 40-year-old legal precedent that forced judges to defer to federal agencies in interpreting ambiguously written federal statutes.

The landmark decision in *Loper Bright Enterprise v. Raimondo* on June 28 limited the authority of federal agencies that set rules governing almost every aspect of Americans' lives.

In a six-to-three ruling, the high court did away with a practice known as Chevron deference, rooted in its 1984 opinion in *Chevron v. Natural Resources Defense Council*.

Writing for the majority, Chief Justice John Roberts said a doctrine that defers to agency employees' interpretations of federal laws "is misguided because agencies have no special competence in resolving statutory ambiguities. Courts do."

The Court's decision strips the government bureaucracy of its ability to make such far-reaching decisions, returning that power to federal judges and, by extension, to Congress, which can avoid disputes over ambiguities by writing clearer legislation.

'Agencies Will Be Less Aggressive'

Competitive Enterprise Institute (CEI) Senior Fellow Joel Zinberg, M.D., says the decision will have an enormous impact on health care because of the trillions of dollars spent annually by the Centers for Medicare and Medicaid Services, the Food and Drug Administration, and the Department of Veterans Affairs. Those departments and agencies impose a multitude of highly detailed regulations managing what health care entities must do to receive payments.

"Agencies will be less aggressive in advancing dubious statutory interpretations in their regulations, which could improve regulations by making them more faithful to congressional intent," said Zinberg.

Zinberg has argued it is essential that Congress legislate "good guidance practices."

"Guidance allows agencies to bind the regulated public without adequate notice and public input, without an opportunity for regulated entities to know the full range of rules relevant to their actions," wrote Zinberg in a policy paper CEI published on June 12, 2024.

"Agencies will be less aggressive in advancing dubious statutory interpretations in their regulations, which could improve regulations by making them more faithful to congressional intent."

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

"Agencies have even used guidance to avoid enforcing existing laws," wrote Zinberg. "Should the Supreme Court overturn or substantially limit its longstanding Chevron doctrine, as many expect it will, agencies will likely increasingly rely on guidance to evade notice and comment rulemaking."

'A Landmark Victory'

The Court's decision is a "landmark victory for the Constitution's Separation of Powers and the rule of law," said Julie Marie Blake, senior counsel with the Alliance Defending Freedom, which has represented clients who have run up against Chevron deference.

"Chevron deference was a very dangerous idea that said judges should not read the law themselves and instead must defer to agencies to determine what the law says," said Blake. "This led to all sorts of damaging incentives for agencies to be judge, jury, and executioner in their cases. Adjudicating disputes over a contested understanding of a law's language is the job of the courts."

The decision protects individual rights and the role of Congress, says Blake.

"Under *Chevron*, the Biden administration has been greatly endangering individual liberties, including, for example, trying to twist the law to end women's sports under Title IX," said Blake. "This is also a resounding win for Congress because it respects Congress's role in writing laws. Administrative agencies have been trying to take those powers away from Congress."

'Judicial Hubris'

Justice Elena Kagan left little doubt she understood the practical implications of the legal blow the court's decision dealt to the administrative state. The majority replaced a "rule of judicial humility" with one of "judicial hubris," Kagan argued in her dissenting opinion.

"The court has substituted its own judgment on workplace health for that of the Occupational Health and Safety Administration; its own judgment on climate change for that of the Environmental Protection Agency; and its own judgment on student loans for that of the Department of Education."

Pacific Legal Foundation (PLF) attorney Adi Dynar says *Chevron* gave federal bureaucrats vast, unjustified power over ordinary Americans.

"It allowed bureaucrats to claim power Congress never gave them," said Dynar. "It distorted our system of government, putting a thumb on the scales of justice at the expense of American citizens facing federal agencies in court."

'The Judiciary Should Interpret'

The *Loper* decision represents a commonsense return to the Constitution's Separation of Powers, says PLF Senior Attorney Anastasia Boden.

"Congress should pass laws, the Executive should enforce them, and the Judiciary should interpret them," said Boden. "This scheme of checks and balances is our best shot at a free and just society."

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

FBI Targets Child Trans Treatment Whistleblowers

Continued from page 1

and transgender hormone treatment of minors at Houston-based Texas Children's Hospital (TCH), the nation's largest children's hospital.

Whistle Blown

Haim, currently a general surgeon in the Dallas area, in May 2023 anonymously leaked to *City Journal*'s Christopher Rufo documents showing TCH secretly continued its child transgender treatment program after announcing in 2022 it was halting the services.

"The hospital had said unequivocally they were going to shut down their transgender program because of potential criminal legal liability," Haim told *Health Care News*. "Because I worked there, I knew that this was a lie. Categorically, it was untrue. They not only continued the program but expanded it."

The documents showed TCH performed "gender-affirming care" just days after the announcement, which came as a result of Texas Attorney General Ken Paxton issuing an opinion that such treatment is a form of child abuse. One such procedure done shortly after the announcement was performed on an 11-year-old girl.

"So, you had the biggest children's hospital in the world lying about a program they acknowledged was potentially criminal," said Haim. "And in actuality, it was manipulating, mutilating, and sterilizing young children. And they talked about this openly. It was my responsibility to do something about it."

Alleged Privacy Violations

The DOJ alleges Haim violated HIPAA, the federal law protecting patients' medical information, when he exposed TCH's secret program. Haim faces up to 10 years in prison.

Rep. Chip Roy (R-TX) revealed a January letter from Haim's legal team pointing out even a "quick glance" at the documents makes it obvious all patient information was redacted.

The letter further argues a "basic HIPAA violation" is a misdemeanor and normally not prosecuted "absent some additional, more significant crime."

Intimidation Tactics

One day after Rufo's report, Texas passed a law banning gender interventions in children. Haim argues the interventions were already illegal when he blew the whistle, with SB 14 merely reaffirming existing law.

"So, you had the biggest children's hospital in the world lying about a program they acknowledged was potentially criminal. And in actuality, it was manipulating, mutilating, and sterilizing young children. And they talked about this openly. It was my responsibility to do something about it."

EITHAN HAIM, M.D.

The day Haim graduated from his medical residency at Baylor College of Medicine, which is associated with TCH, federal agents showed up at Haim's house and informed him about the investigation.

"The feds come to my apartment a month later, on the day of my graduation, one of the most important days of my life, to inform me I'm a potential target of a criminal investigation," Haim said. "That day, we decided to fight back."

Haim had tried to remain anonymous, he said, "because I live in a very small town. I work in an even smaller town. I wanted to live a quiet life and raise a family, but the corruption was so bad that I had no choice."

Wife, Nurse Targeted

After Haim blew the whistle, the DOJ threatened his wife's career—she had just been hired as an assistant U.S. attorney for the Northern District of Texas—and began to pursue a trial as a form of lawfare, Haim says.

"They had said explicitly that they were going to bring me to a jury trial, even if they were going to lose," said Haim.

In June, Rufo revealed federal agents visited the home of another TCH whistleblower, Vanessa Sivadge, a nurse who accuses TCH of illegally billing Medicaid for transgender procedures, some of which she says she participated in, even telling a child how to inject a sex-change hormone, before realizing these were what she called "deeds of evil and darkness."

Culture War Microcosm

Haim says he is pleading not guilty to the four felonies he faces.

"I will say this: there is a major disparity between the charges that they're alleging and the story they're telling to promote it and the reality of the truth," said Haim. "Never in American history has something like this been charged before.

"Not only am I not guilty of anything they're alleging, but the extent they're willing to come after someone like me is horrifying, absolutely horrifying," said Haim.

Haim's case is at the center of a hot culture-war debate, with Haim being interviewed by conservative commentators Jordan Peterson and Tucker Carlson.

Million-Dollar Legal Costs

Haim says he and his wife spent everything they had on legal fees before going public with the story. Haim's GiveSendGo page sets a goal of $1,000,000 to cover his ongoing fees. Haim had raised more than $959,000 at press time.

Haim, who is expecting to be a first-time father in October, says he sees his fight as a necessary battle to protect the next generation.

"For generations, mothers and fathers took care of their children, right? Like they had sacrificed everything they had, right? They left home to fight something, even if it meant they weren't going to come back," Haim said.

Haim says the experience has been frightening, but "the more terrifying thing is if my daughter grew up knowing that her father was not willing to fight for her future."

Physicians at Risk

Haim's story shows the power of ideology over health care today, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"Dr. Haim's story is that what THC was doing is irreversible, life-changing procedures on minors and lying about it," said Orient. "Major medical organizations—their staff and leadership—favor the transgender ideology and receive funding from interests that will make billions from creating lifelong patients."

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

Obamacare Discrimination Rule Sparks Pushback from States

By AnneMarie Schieber

Health care entities in the United States are now barred from discriminating against patients on the basis of their sexual orientation and gender identity as well as race, color, national origin, age, sex, or disability.

The U.S. Department of Health and Human Services' (HHS) final rule revising Section 1557 of the Affordable Care Act (ACA) took effect on July 5. The 181-page rule covers any health care service or practice that receives direct or indirect federal financing from HHS. Since most health care entities deal with Medicare, Medicaid, the Children's Health Insurance Program, subsidized Obamacare, or veteran care, the rule will apply to most health care professionals.

In section 92.207, the rule describes "nondiscrimination in health insurance coverage." Insurers receiving direct or indirect federal financing cannot deny or limit coverage or claims, or impose additional costs based on gender identity, nor exclude or limit "health services related to gender transition or other gender-affirming care."

The changes are an "important step" to "health equity," states an HHS news release. "The rule will restore protections gutted by the prior administration and help increase meaningful access to health care for communities across the country," HHS stated. "The 1557 final rule draws on extensive stakeholder engagement, review of over 85,000 comments from the public, the Department's enforcement experience, and developments."

"A physician's use of their training and ability should not depend on their acquiescing to an ideology which they do not believe in. It may be a violation of their freedom of speech and their basic economic rights for them to have to use specific terms in addressing their patient for them to get paid for their services or practice their profession."

ROBERT KOSHNICK, M.D.
AUTHOR
EMPOWER-PATIENT ACCOUNTS EMPOWER PATIENTS!

Hysterectomies for All

Section 1557 protections were part of the ACA when it was enacted in 2010. Various administrations have defined its scope differently, using their rulemaking authority. The new rule redefines sex to include "sexual orientation" and "gender identity." In addition, health care professionals must recognize a patient's choice of pronouns, regardless of their biological sex.

Specifically, the rule prohibits a "categorical position" against trans procedures. If a doctor performs a hysterectomy on a woman for cancer, the physicians must be open to performing the same procedure for transition purposes. "A gynecological surgeon may be in violation of the rule if they accept a referral for a hysterectomy but later refuse to perform the surgery upon learning the patient is transgender," states Section 92.206 of the rule, as originally proposed.

Rapid Growth from Niche

When the Obama administration recognized sexual orientation and gender identity in its version of the rule in 2016, "gender affirming care" was a niche market, generally for adult patients who paid for such procedures out of pocket.

There has been an explosion in marketing "gender transition" since 2016, including for children. Admiral Rachel Levine, M.D., Assistant Secretary for Health at HHS and a biological male who identifies as a woman, said earlier this year the procedures have the "highest support" of the Biden administration.

An article in the Manhattan Institute's *City Journal* backs up Levine's claim, describing emerging evidence the White House is taking "marching orders" from transgender interest groups.

"This rule is going to transform the medical system for the worst because a categorical policy against gender-transition interventions is not 'individualized,' and would therefore be prohibited discrimination," said Julie Marie Blake, a senior counsel at the Alliance Defending Freedom (ADF).

Due to the short- and long-term effects of puberty blockers, cross-sex hormones, and surgeries, many European countries have restricted their use, particularly for minors. Today, more than 23 U.S. states have outlawed such procedures on children.

Immediate Lawsuit

Florida state Attorney General Ashley Moody and the Catholic Medical Association, represented by ADF, immediately filed a federal lawsuit against HHS to stop the new rule.

"Florida passed a law to protect our children from dangerous, irreversible gender-transition drugs and surgeries," said Moody, in a press release. "Now, Biden and his federal bureaucrats are trying to go around our child-protection law to force the state to pay for puberty blockers and gender-transition surgery for children."

The lawsuit asks the court to set aside the new rule immediately and to declare it capricious and arbitrary.

'Gross Abuse of Power'

Doctors and hospitals could lose the federal funds on which many are financially dependent if they do not revise their anti-discrimination policies to conform to the HHS rule, says Blake.

"That would prevent them from practicing medicine in most settings, and certainly take them away from the low-income patients who need them the most," said Blake. "They're really trying to compel physicians to transform health care in this way, which is a gross abuse of power."

The rewrite of Section 1557 should be a wake-up call to Congress, says Robert Koshnick, M.D., author of *Empower-Patient Accounts Empower Patients!*

"A physician's use of their training and ability should not depend on their acquiescing to an ideology which they do not believe in," said Koshnick. "It may be a violation of their freedom of speech and their basic economic rights for them to have to use specific terms in addressing their patient for them to get paid for their services or practice their profession."

End-Run Around State Bans

Unrelated to the rule change but potentially pivotal is the U.S. Supreme Court's decision on June 24 to hear the Biden administration's challenge to Tennessee's "gender transition care" ban, with a decision expected in 2026. The U.S. Department of Justice contends such bans violate the Constitution's equal protection clause.

"[The legality of state bans] is at the heart of this mandate," said Blake. "The rule was designed to displace or set aside all of these state laws trying to protect children."

"Even if you look at the ACA and say Congress has spending authority, those spending power conditions don't give the federal government power to displace and preempt state laws," said Blake. "You can't pay people to violate state laws."

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

Big Hikes in Seniors' Drug Costs

Continued from page 1

on average this year, and possibly more than doubling next year," said White.

"Democrats know it is coming, but instead of being honest and preparing the more than 65 million Medicare beneficiaries for a cost spike, many of whom are on fixed incomes, they are pulling every magic trick possible to have seniors look anywhere but at the truth," said White.

Political Fallout

Medicare premiums for the following year are announced in October. This year, the expected price spike will occur before a general election in which voters will be choosing a president, representatives in Congress, and one-third of the U.S. Senate.

Premium increases could be embarrassing to the Biden administration and Democrats who promised the IRA would make health care more affordable. The IRA capped insulin costs under Part B at $35 a month, eliminated cost-sharing for recommended adult vaccines under Part D, and limited out-of-pocket drug costs under Part D to $2,000 a year. The law also forces drug makers to negotiate with Medicare on the price of 10 common drugs in the first year.

"So, while Democrats are shouting from the campaign trail about their win over health care costs, seniors will be scrambling to figure out how to pay for that win," said White.

Shell Game

Though the IRA included a premium stabilization provision capping annual growth in the Part D base beneficiary premium at 6 percent, the law did not apply this 6 percent cap to the individual plan premiums of the non-standard plans that cover most beneficiaries.

The estimated average enrollment-weighted monthly premium for Medicare Part D standalone drug plans is projected to be $48 in 2024, based on current enrollment, up 21 percent from $40 in 2023.

"President Biden has promised older voters that he is lowering prescription drug prices and will stop any attempt to cut Medicare spending. Yet Medicare beneficiaries are paying 22 percent more in Part D premiums for prescription drug coverage than last year. This October, when the 2025 rates are announced, industry experts believe premiums will double."

JOHN GOODMAN
PRESIDENT AND CEO
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

President Joe Biden promised to cut prescription drug costs and hold the line against Medicare spending cuts, but the IRA extensively reallocated Medicare funding and shifted the burden of cost cuts to Part D insurers, who can pass them along to seniors through higher premiums.

Overcharged at the Drug Counter

The IRA also penalizes seniors at the drug counter. Their coinsurance payment is based on the nominal price, while the drug plan gets undisclosed rebates from the drug manufacturer. A Trump administration executive order would have required pharmacists to pass these discounts to along to the patients.

"According to the consulting firm Milliman, the net savings for Part D members were expected to be almost $15 billion over the next 10 years. The IRA, however, delayed Trump's regulation until 2032. As a result, Medicare beneficiaries continue to be overcharged at the pharmacy for just about every drug they purchase," said John Goodman, president and CEO of the Goodman Institute for Public Policy Research and co-publisher of Health Care News.

Medicare Advantage Shortchanged

Medicare Advantage (MA) provides a model where seniors could see drug cost savings. "Enrollees buy one plan, not several plans, which they must do in traditional Medicare, and the plan has an economic incentive to keep enrollees healthy," said Goodman.

Goodman says some MA plans already give enrollees free insulin because they consider insulin "maintenance." However, scheduled government payments to MA plans have not kept up with inflation, and plans have had to cut back or drop out of the market altogether.

"If President Biden were truly concerned about the cost of drugs, you would think he would be a big fan of companies like these," said Goodman.

False Promises

The higher drug plan premiums and cuts in subsidies will disproportionally burden older and lower-income Americans, says Goodman.

"President Biden has promised older voters that he is lowering prescription drug prices and will stop any attempt to cut Medicare spending," said Goodman. "Yet Medicare beneficiaries are paying 22 percent more in Part D premiums for prescription drug coverage than last year. This October, when the 2025 rates are announced, industry experts believe premiums will double."

Meanwhile, Medicare spending is being cut, says Goodman.

"The second promise appears to ignore that the Inflation Reduction Act cut more than $300 billion in subsidies for Part D insurance over the next 10 years," said Goodman. "Furthermore, the federal government has been paying 80 percent of the cost of catastrophic prescription drug insurance. Under the IRA, that drops to 20 percent next year, and the bulk of that reduction is shifted to private insurance plans. Since the market for Part D insurance is very competitive, those costs are being passed on to customers as higher premiums."

'Reverse Robin Hood'

Goodman says the cost savings Biden promoted will be spent to fund Obamacare and other administration priorities.

"A large chunk of it is being used to subsidize insurance under the Affordable Care Act that higher-income individuals buy in the marketplace exchanges, with individuals earning more than $600,000 sometimes receiving a partial subsidy," said Goodman.

"Another large chunk is spent on green-energy companies and subsidies for buyers of electric vehicles," said Goodman. "All told, the IRA is a 'reverse Robin Hood' bill. It takes from the poor and the middle class and gives to the rich. Despite repeated attempts by President Biden to spin the Inflation Reduction Act as a cost-saver, it is a piggy bank for the government to finance non-health-related projects that often benefit the wealthy."

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

U.S. Supreme Court Ignores Precedents in Abortion Pill Case

By Harry Painter

A U.S. Supreme Court ruling will keep the abortion pill available, with the justices declining to decide the merits of the case.

In *FDA v. Alliance for Hippocratic Medicine*, the high court ruled unanimously the plaintiffs lacked standing, meaning they did not show an injury to themselves, on June 13.

The court did not rule on whether the U.S. Food and Drug Administration (FDA) acted improperly in its 2000 approval of mifepristone, the first of a two-pill series pregnant women take to induce chemical abortions, or by expanding access to the drug, most recently during the pandemic.

The plaintiffs included the Alliance for Hippocratic Medicine, a group of pro-life medical associations, and four individual physicians. The plaintiffs were represented by the Alliance Defending Freedom (ADF), a legal group.

Justice Elena Kagan

Procedural Decision

Erik Baptist, a senior counsel at ADF who worked on the case, called the court's opinion a procedural decision.

"What the Supreme Court decided was that our clients didn't show sufficient injuries where we were not allowed to bring such a case against the FDA," said Baptist.

"The court did not rule on the merits of our case or whether what the FDA did was reckless and unlawful," said Baptist. "That's an issue and a question that's going to be answered later."

Conscience Injury

Baptist and his team had alleged multiple injuries, including a "conscience injury" to the doctors.

"FDA's own label for the drugs says one in 25 women will end up in the emergency room," said Baptist. "When the FDA was pushed to require those prescribers to treat women for those complications, the FDA's response was to direct women to America's emergency rooms and hospitals, where our doctors, obstetrician-gynecologists, work and care for and treat women."

Baptist says his team cited examples of how the FDA's actions have put women into dangerous situations "where they may require surgical intervention which would lead to the end of the life of their baby or make our doctors feel complicit in elective chemical abortions in general."

Additionally, the plaintiffs argued the FDA "expressly conscripted" the pro-life doctors away from helping deliver babies and required them to "help the women who are suffering from the complications from these elective chemical abortions," said Baptist.

"What the Supreme Court decided was that our clients didn't show sufficient injuries where we were not allowed to bring such a case against the FDA. The court did not rule on the merits of our case or whether what the FDA did was reckless and unlawful. That's an issue and a question that's going to be answered later."

ERIK BAPTIST
SENIOR COUNSEL
ALLIANCE DEFENDING FREEDOM

Environmental Precedents

The ADF team relied on Supreme Court precedents on environmental law to argue the plaintiffs had standing. Baptist says decades-long Supreme Court precedents recognize emotional and psychological harm as sufficient injury to meet standing requirements, citing cases related to the Endangered Species Act and the Keystone Pipeline.

"We cited the equivalent argument, saying that our doctors, again, are heartbroken and hurt emotionally when they see women harmed by chemical abortion drugs and have to experience the heartbreak of watching unborn life being taken away," Baptist said.

"Someone's heartache over an endangered species, such as a beetle or a whale—we value human life over all those," said Baptist. "That to me gives us equal, if not more reason, for standing."

Standing Double Standard

The Supreme Court did not respond to the ADF's argument for precedents on injuries to conscience, says Baptist.

"It was in our brief," said Baptist. "It was there. I can't explain why the court did not address it."

In a blog post at The Federalist Society website before the decision was released, Baptist said the Supreme Court had only three options: overrule precedent, uphold precedent, or create a double standard.

"The fourth option, which I did not write about, was just to ignore this argument," said Baptist. "And so, it didn't affect the precedent in any capacity whatsoever."

Baptist says the ADF is discussing next steps with its clients.

"I think the court took pains to make this decision about only this particular case and these particular plaintiffs and nobody else," said Baptist.

'Inherently Dangerous Drugs'

In a 2023 interview with *Health Care News*, Katie Daniel, an attorney and state policy director at Susan B. Anthony Pro-Life America, said the FDA required protocols designed for dangerous drugs in approving mifepristone and misoprostol, the second drug used in chemical abortions.

"The FDA originally approved the abortion pill combo in 2000 under rules that are applied to inherently dangerous drugs," said Daniel. "FDA knew it could not get them through the normal protocols, and so it had to push them through a protocol called Subpart H, which was originally created for AIDS medications and cancer drugs—drugs that have inherent, severe side effects, drugs that treat life-threatening illnesses."

The FDA initially required certification of prescribing physicians, time limits on when the drug could be dispensed, complication reporting, and in-person visits, but subsequently liberalized or eliminated those restrictions.

"Additionally, it reclassified pregnancy—a normal pregnancy, not a high-risk pregnancy—as a life-threatening illness, just to get it through the process," said Daniel.

A March 2021 report by The Heritage Foundation documented the safety concerns of abortion pills; as of 2018, there were 24 deaths associated with the pill and more than 4,000 adverse incidents.

State Action

Several states restricted abortion after the Supreme Court overturned *Roe v. Wade*, which in 1973 legalized abortion in every state, in the case of *Dobbs v. Jackson Women's Health* in 2022.

A separate lawsuit by Kansas, Idaho, and Missouri is challenging the 2016 and 2021 FDA decisions to remove requirements for in-person doctor visits and to allow mail-order abortions.

Several blue states are thwarting other states' abortion bans by allowing their licensed doctors to prescribe abortion pills via telemedicine and shielding the doctors from prosecution.

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

COMMENTARY

FDA Blocks Better Sunblocks

By Devon Herrick

The United States is in the full throes of summer. After a rainy spring, summer arrived in my home state of Texas a couple of months ago. The sun has burned off the cloud cover, and my grass has begun to fry. Hello, big water bills!

The grass is not the only thing the sun fries in Texas (and elsewhere). It also fries Americans' skin.

Skin cancer is the most common form of cancer in the United States. One in five Americans will develop skin cancer within their lifetimes. In the past few decades, Americans have become increasingly aware of the danger of skin cancer and the need to wear sunscreen.

Improvements Stalled

American sunscreens suck. The newer sunscreens sold in Asia and Europe are far better. By "better," I mean they work better, they feel better, they go on smoother, and they are less greasy. The sunscreens sold in other countries are superior in all the attributes that make slathering on American sunscreens unpleasant.

Thanks in part to the U.S. Food and Drug Administration (FDA), Americans do not have access to these sunscreens. The only ingredients allowed in over-the-counter personal care products in the United States are those that are "generally recognized as safe and effective (GRASE)."

The GRASE List may sound benign, but it is not. If an ingredient is not on the GRASE List, it's not allowed in products sold over the counter. The FDA currently allows 17 UV filters in American sunscreens. Of those, only eight are typically used, because the others have undesirable side effects, have textures that don't lend themselves to skin care products, or are difficult to manufacture.

The FDA has not approved a new sunscreen ingredient since 1999, which means the sunscreens Americans have access to have not changed in decades. A 2014 law, called the Sunscreen Innovation Act, was an attempt to force the FDA to fast-track approvals of more advanced sunscreen ingredients. It did not work. Congress tried again in 2020, and the jury is still out on whether that will work.

Clinical Testing Roadblock

Here is the problem: the FDA considers the evidence for the newer UV-blocking ingredients, safely used by hundreds of millions of people for more than a decade, as anecdotal.

It is true that anecdotes are not data. The Europeans and Asians who have safely used newer sunblock were not part of any clinical study. In Europe, for example, sunblock is categorized as a cosmetic and thus does not require clinical testing to obtain the government's permission to manufacture.

In the United States, by contrast, sunblock is regulated by the FDA. The FDA invited manufacturers to submit costly clinical studies on safety and efficacy. That is a tough sell because (1) clinical trials are expensive, and (2) the data proving the ingredients for the GRASE List are safe would allow competitors to produce a competing sunscreen.

In other words, no company has an incentive to be the first to apply for approval and bear the cost of clinical trials, because it would not recoup the cost.

It is not that the FDA believes newer sunscreen ingredients are unsafe. The blockage happens because bureaucrats want the process to comply with how they believe the process should work. They want a costly paperwork exercise so they can file it away as evidence that newer UV blockers are safe enough to be added to the GRASE List.

Unnecessary Bother

As a result, when millions of Americans head outdoors this summer and hit the beach, visit local lakes, or do other outdoor activities such as hiking, biking, baseball, picnics, cookouts, and pool parties with friends, they will have less protection from the sun than their European counterparts.

Many Americans will slather on a greasy sunblock before heading outdoors for activities in the sun, and others will skip it. Many will forget to reapply sunscreen after a few hours, and they will get burned. More people would probably use sunscreen if better, more-pleasant products were available at the local drugstore.

They would be available if the federal government would get out of the way.

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.*

It is not that the FDA believes newer sunscreen ingredients are unsafe. The blockage happens because bureaucrats want the process to comply with how they believe the process should work. They want a costly paperwork exercise so they can file it away as evidence that newer UV blockers are safe enough to be added to the [Generally Recognized As Safe and Effective] List.

DEVON HERRICK, PH.D.
HEALTH CARE ECONOMIST

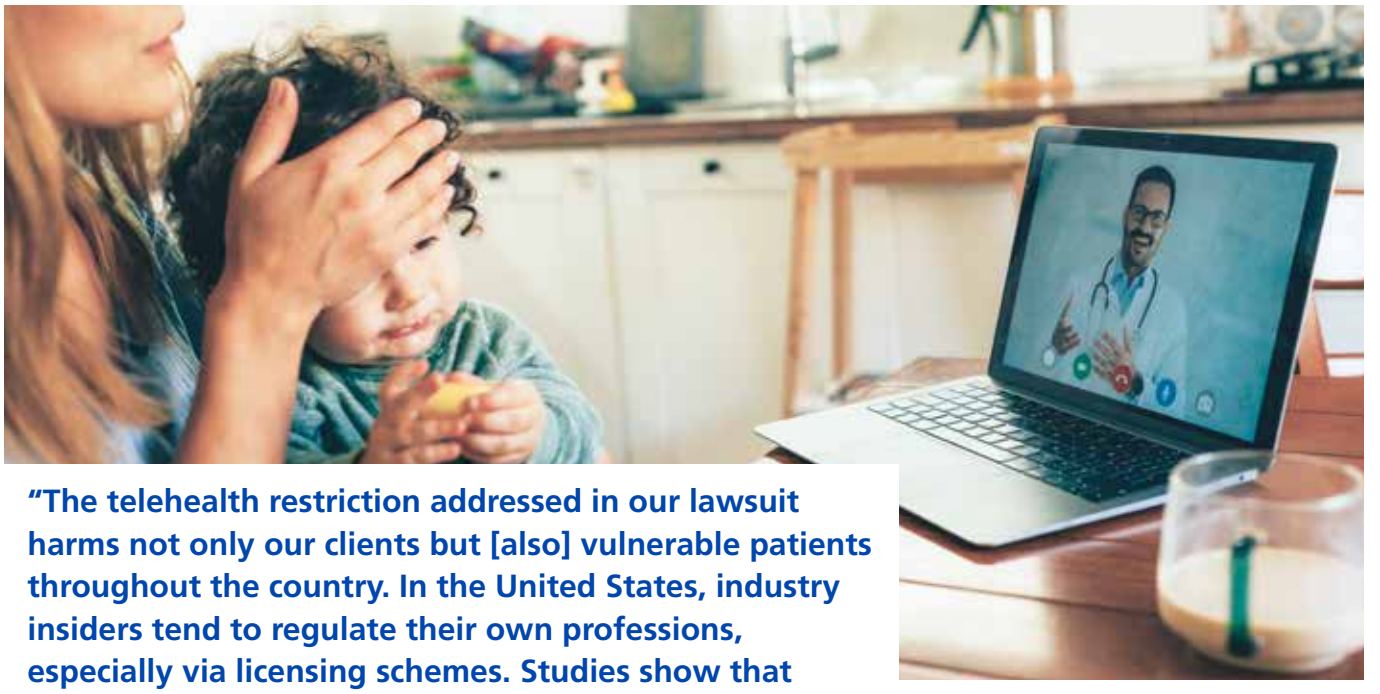
California Blocks Life-Sustaining Telehealth Treatment

By Bonner Russell Cohen

California licensing laws are blocking a patient's access to care from a medical specialist in another state, leaving her to go without help or make a 14-hour car trip for treatment in person.

Shellye Horowitz of Trinidad, California, suffers from hemophilia A, a rare bleeding disease affecting women and girls. There are no physicians in or near her coastal town trained to treat the condition. After undergoing unsuccessful surgery at a San Francisco Bay Area hospital, Horowitz sought care via telehealth from specialists at a hemophilia treatment center in Portland, Oregon.

California is one of 30 states that require physicians who engage in telehealth to be licensed in the patient's state of residence. Doctors who violate this mandate by consulting with out-of-state patients in need of care face criminal charges and stiff fines that can jeopardize their medical careers. During the pandemic, some of these restrictions were lifted, but they have since been reimposed, with devastating consequences for people suffering from serious or rare illnesses.



"The telehealth restriction addressed in our lawsuit harms not only our clients but [also] vulnerable patients throughout the country. In the United States, industry insiders tend to regulate their own professions, especially via licensing schemes. Studies show that these licensure boards act in their own self-interest, rather than in the best interest of the public. In the context of telemedicine, these duplicative and needless licensure requirements can keep patients from accessing lifesaving health care."

HALEY DUTCH, ATTORNEY, PACIFIC LEGAL FOUNDATION

Court to Decide

Horowitz is suing the state in a federal court, represented pro bono by the Pacific Legal Foundation (PLF), which says California's limits on telehealth are unconstitutional.

"Limiting access to medical specialists benefits no one," said Caleb Trotter, an attorney with PLF, in a press release. "There is no excuse for Californians—or anyone—to suffer simply because a member of their care team is in another state."

Joining Horowitz in the PLF suit is Sean McBride, M.D., a radiation oncologist at Memorial Sloan Kettering Cancer Center in New York. McBride uses telehealth to consult with out-of-state patients and to discuss whether they should travel to New York for advanced in-person treatments.

McBride is licensed and board-certified in New York, but not in California, and thus is barred from practicing telehealth with patients in the Golden State. California patients seeking his care must fly cross-country for in-person office visits and cannot do follow-up consultations with him over the phone.

Constitutional Questions

"California's telehealth restrictions are not just wrong, they're also unconstitutional," PLF says in an article on its website. "Placing undue burdens on both out-of-state physicians and California patients—that far outweigh any benefits—violates the Constitution's Dormant Commerce Clause and Privileges and Immunities Clause."

The Sacramento-based foundation says "just as physicians have a First Amendment right to speak with potential and existing patients via telehealth, physicians and their patients have the right to receive information from each other. The government cannot use licensing requirements to impede the exchange of information between patients and their doctors."

The case, *Sean McBride et al. v. Hawkins*, was filed on May 16 in the U.S. District Court for the Eastern District of California.

NJ Case

California is not the only state where telehealth restrictions are undergoing legal challenges. After the New Jersey State Board of Medical Examiners last year reinstated restrictions on out-of-state telehealth consultations, which had been suspended during the COVID-19 lockdowns, a Boston-based physician found herself barred from consulting with cancer patients in the Garden State over the phone or via Zoom.

Shannon MacDonald, M.D., a pediatric oncologist and proton therapist at Massachusetts General Hospital, is licensed in several states, but not in New Jersey. PLF is representing MacDonald in a lawsuit against New Jersey officials that alleges the same unconstitutional violations of her rights as those raised in the California case. The case, *Shannon MacDonald et al. v. Otto Sabando*, was filed in the U.S. District Court for New Jersey on December 13, 2023.

Regulatory Protectionism

Haley Dutch, an attorney with PLF, says onerous licensing restrictions such as those in California put high-quality health care out of reach for those who need it the most.

"The telehealth restriction addressed in our lawsuit harms not only our clients but [also] vulnerable patients throughout the country," Dutch told *Health Care News*. "In the United States, industry insiders tend to regulate their own professions, especially via licensing schemes. Studies show that these licensure boards act in their own self-interest, rather than in the best interest of the public.

"In the context of telemedicine, these duplicative and needless licensure requirements can keep patients from accessing lifesaving health care," said Dutch. "California should look out for the interests and well-being of all its citizens, not just the powerful insiders of the medical industry. It should update its rules to allow licensed physician-specialists to consult and follow up with patients wherever they may be. Such reforms increase access to care for all Americans."

Pandemic Lessons Unlearned

The coronavirus lockdowns led to a beneficial expansion of telehealth, which is now being rolled back in many states, says Jeff Stier, a senior fellow at the Consumer Choice Center.

"The liberalization of restrictions on telemedicine became a large-scale natural experiment on what would happen if patients could see the doctor of their choice using the same technology we use every day, but with enhanced privacy," said Stier.

"The outcome solidified both patient and provider comfort with telemedicine," said Stier. "The myriad benefits were pronounced and tangible, and any feared risks never materialized. Ironically, the courts, which are still widely using Zoom for their business, will have the final say on whether doctors and patients will have the same freedom."

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

OBITUARY

HSA Pioneer David Boaz, R.I.P.

By AnneMarie Schieber

David Boaz, a leading libertarian thinker and the driving force behind the Cato Institute for more than four decades, lost his battle with cancer on June 7 at the age of 70.

Boaz was a pioneer of the health savings account concept, says John Goodman, co-publisher of *Health Care News* and founder of the Goodman Institute for Public Policy Research.

"David commissioned *Patient Power* with a $5,000 grant to the National Center for Policy Analysis in the late 1980s," wrote Goodman on the Goodman Institute Health Blog. "After I didn't deliver, he persisted—even upping the offer to $50,000. I got Gerry Musgrave to be the coauthor and we finally produced it."

The book makes the case for a competitive market in which consumers control their health care spending, rather than a government bureaucracy.

"*Patient Power* introduced the concept of Health Savings Accounts to the public policy community," wrote Goodman. "It shaped the way Newt Gingrich, Paul Ryan, Sean Hannity, and many others thought about health care."

PHOTO COURTESY CATO INSTITUTE

'Sharp Intellect'

Boaz gravitated to politics and public policy in high school, his obituary states. He was known for his "sharp intellect," as a spelling bee champ, class valedictorian, and National Merit Scholar. Boaz was drawn to libertarian ideas after reading Henry Hazlitt's *Economics in One Lesson*.

Goodman singled out a particular insight. Boaz wrote, "You learn the essence of libertarianism in kindergarten. Don't hit other people, don't take their stuff, and keep your promises."

Boaz published a condensed version of *Patient Power* around the time "HillaryCare" was being debated. Some 300,000 copies were distributed.

"Without David's persistence, Health Savings Accounts might never have become a reality. Ditto for the whole notion of consumer-driven health care," wrote Goodman. "He will be missed."

Cato Legacy

Boaz joined the Libertarian Party almost immediately after graduating from Vanderbilt University in 1975. Boaz co-managed the gubernatorial campaign of Ed Clark in California and later became his research director when Clark became the Libertarian nominee for president in 1980.

In 1981, Boaz joined Ed Crane to get Cato off the ground as a leading policy organization advancing libertarian ideas. Boaz became a national commentator, frequently quoted in leading news outlets.

Health Care Wisdom

In 2009, Boaz discussed the Obamacare bill on KDKA's *The Fred Honsberger Show*. Boaz was struck by the provision imposing a fine for refusing to buy health insurance.

"Eventually, all criminal penalties can land you in jail," Boaz told the host. In the bill, "there are all kinds of things like that. It is the first time we ever told people [you] must buy a consumer product simply because you live in the United States."

The entire law violated the Constitution, Boaz told the listeners.

"Look in Article One, Section 8, and it lists the things we set up the government to do," said Boaz. "It doesn't say education, retirement, or health care."

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

Boaz gravitated to politics and public policy in high school, his obituary states. He was known for his "sharp intellect," as a spelling bee champ, class valedictorian, and National Merit Scholar. Boaz was drawn to libertarian ideas after reading Henry Hazlitt's *Economics in One Lesson*.

OBITUARY

Bold Advocate for Health Care Integrity and Honesty: Marilyn Singleton, M.D., J.D.

By Bonner Russell Cohen

Never afraid to swim upstream—even at the risk of professional retaliation from entrenched interests with good reasons to fear her—Marilyn M. Singleton, M.D., J.D., never forgot that the calling of a physician is to treat patients in need of care.

Singleton, aged 77, died unexpectedly on June 18, according to the Association of American Physicians and Surgeons (AAPS), where she had served as president and board member.

Friends and colleagues say her remarkable life models a path future physicians should follow. After graduating from Stanford University, Singleton earned her medical degree from the University of California-San Francisco. A board-certified anesthesiologist, Singleton had practiced medicine in Oakland, California since 1973.

Singleton used her legal training to challenge government policies detrimental to the practice of medicine and the well-being of patients everywhere. In 2012, she ran for Congress in California's 13th Congressional District as an independent.

Marilyn Singleton, M.D., J.D., stands beside former AAPS president Al Fisher, M.D.

No Identity Politics

Over the years, Singleton provided *Health Care News* with numerous commentaries and quotes sharing her prodigious knowledge of the medical world and her understanding of the forces undermining the doctor-patient relationship and, by extension, public health.

"We were so grateful to have Dr. Singleton as a contributing editor," said AnneMarie Schieber, managing editor of *Health Care News*. "A gifted writer and speaker, she was generous with her time, insights, and wit.

"She really did blaze a trail as a daughter of a flight surgeon who applied to Stanford after being told 'they don't accept Negroes,'" Schieber said. "Identity politics deeply offended her."

Singleton Gems

Here's a small sampling of Singleton's wisdom. On California joining Colorado, Oregon, Vermont, and Washington in allowing the composting of human corpses, as an alternative to cremation or burial, to protect the planet from climate change, Singleton said, "The religion of Mother Earth now supersedes all human decency. … Human composting is yet another way to devalue life—we are the same as kitchen scraps that don't fit in the garbage disposal."

On the World Health Organization (WHO) planning to confront "Disease X" in a global pandemic treaty: "In what universe does adding more top-down bureaucracy [increase] efficiency, transparency, and accountability? WHO continues to tout itself as a public health leader but kowtowed to China by failing to challenge it on the origins of the new coronavirus, now known as SARS-CoV-2."

Criticized Pandemic Policies

Throughout her career, Singleton called out the health care establishment on many fronts, most pointedly on policies surrounding the COVID-19 pandemic.

Singleton was particularly critical of mandated COVID-19 shots and how the government shielded the drug companies with immunity from the effects of their products.

"When it was clear the injections had serious side effects and did not stop transmission of COVID, the government should have suspended the injections program as in 1976 with the H1N1 vaccine," Singleton told *Health Care News*. "Importantly, mandates to take a drug that was not effective as a vaccine should have been prohibited. … There was no informed consent. These cases deserve to be in a medical malpractice civil court."

The Centers for Disease Control and Prevention (CDC) particularly raised Singleton's ire for being more beholden to special interests than protecting the public. The agency's poor performance during the pandemic indicated it needs a complete overhaul.

"First, it needs an independent, external review to see how the public health agency should actually work," said Singleton. "When you look at the CDC's history, when it started in 1946 it was a center for communicable diseases, and that might be the first step. Walk it back to communicable diseases—period, end of story."

Corporate Health Care

Singleton frequently observed corporations were taking over health care with collusion by government.

"Over the last couple of years, we've been living in a frenzied political atmosphere of inflation worries, unaddressed crime, Covid, monkeypox, and a variety of social issues," Singleton wrote in an op-ed in *Tulsa Today*. "These are distractions from thinking about the big picture: the march toward government and corporate control over our lives, including absorbing medical practice into the statist-corporate complex."

Singleton published many policy briefs and commentaries, which are posted on her page, "Marilyn Singleton, MD, JD—American. Black. Doctor: Uncensored," at the journalism website Muck Rack.

One Last Battle

In the months before her death, Singleton and the Pacific Legal Foundation (PLF) pursued a lawsuit on behalf of patients challenging California's mandate for implicit bias discussions in all continuing medical education (CME) courses.

"'Implicit bias' is the idea that medical professionals unconsciously treat patients differently based on their race or other immutable characteristics," the PLF states on its website. "In practice, this means that CME courses on advanced cardiac life support, minimally invasive surgery, or diabetes management, for example, must reserve time in each session to remind everyone that they should be conscious of a patient's race, ethnicity, gender, or sexual orientation."

Singleton wrote in *The Washington Post* that the implicit-bias requirement spreads "the malignant false assumption that White people are inherently racist."

PLF announced that the case Singleton helped bring, *Azadeh Khatibi et al. v. Hawkins et al.*, will continue in her absence.

Proving Others Wrong

Singleton's death is a "terrible loss," said AAPS Executive Director Jane Orient, M.D.

"She was a third-generation physician who proved everybody wrong who said a black doctor wouldn't make it in the top-tier institutions where she trained, including Stanford, the University of California-San Francisco, and Harvard," said Orient.

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

Congress Considers Bill to Protect Raw Milk Producers

By Kevin Stone

A bill that would give consumers more choice in the kind of milk they buy is making its way through Congress.

The Interstate Milk Freedom Act (H.R. 8374), introduced by Rep. Thomas Massie (R-KY), would prohibit the federal government from interfering with the interstate traffic of unpasteurized milk and milk products packaged for direct human consumption.

The bill is being offered in response to federal regulations that have targeted small producers of raw, unpasteurized milk products who sell their product across state lines.

Congress has passed no law banning the sale of raw milk. The Food and Drug Administration (FDA) issued a regulation blocking interstate sale of raw milk in response to a consent decree arising from a 1986 lawsuit.

Rep. Thomas Massie (R-KY)

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"The U.S. Constitution vests the power to regulate interstate commerce firmly and solely within the purview of Congress, not regulatory agencies. This type of regulatory overreach and mission creep has unfortunately become all too common as the regulatory state and rule by alphabet agencies with little oversight or accountability has grown."

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

'Reversing the Criminalization'

In a May 14, 2024 press release, Massie explained why he introduced the bill.

"Executive branch agencies, such as the Food and Drug Administration, do not and should not have the power to shut down trade between peaceful farmers and willing consumers," said Massie. "It is Congress's job to legislate. The Interstate Milk Freedom Act would make it easier for families to buy the milk of their choice by reversing the criminalization of specific dairy farmers."

Targeting Small Producers

A January raid by state regulators on a small farm in Bird-in-Hand, Pennsylvania has drawn attention to the issue. The case has involved both state and federal regulators. Miller's Organic Farm is owned by Amish farmer Amos Miller.

Miller's run-ins with regulators began in 2016 and led to legal battles with the FDA and the Food Safety and Inspection Service (FSIS) under the U.S. Department of Agriculture, as well as regulators in Pennsylvania.

The farm operates as a "private membership association," with some 2,000 members purchasing its products, which are delivered to their doors both in-state and out-of-state. Miller's products are nutrient-dense in comparison with processed milk and are chemical- and cruelty-free. Many of the farm's members use them medicinally, the farmer says.

A case brought against Miller in 2023 was dismissed. Miller and his defenders say the immediate follow-up with yet another raid appears to be intimidation and an infringement of his Fourth Amendment rights under the guise of consumer protection.

Public-Safety Disputes

A growing number of pro-market policy professionals are questioning the public health mission of the FDA and other regulatory agencies in promoting highly modified and processed milk products over raw, unpasteurized milk.

Raw milk provides tremendous health benefits in comparison with pasteurized products, says Katy Talento, president of KFT Consulting and a former top health advisor to President Donald Trump's Domestic Policy Council.

"The notion that small and family farmers offering natural milk are somehow endangering the public health is awfully rich for the regulatory state and giant corporate dairy industry to assert," said Talento. "The chemically-altered-milk industry is riddled with tortured, stressed animals living in conditions that induce an unnatural hormonal brew in their milk; pesticide-drenched, nutrient-deficient feed; toxic vaccines; and microbiome-destroying antibiotics.

"And of course, that's before the pasteurization process, which destroys or dramatically reduces the nutrients in milk, especially the rich proteins always affected by heat, and critically, the heat-sensitive, fat-soluble vitamins like A, D, E, and K, for which deficiencies are epidemic in the U.S. and behind many acute and chronic illnesses," said Talento.

Constitutional Issue

Federal intrusion into the relationship between consumers and food producers is unconstitutional, says H. Sterling Burnett, director of the Robinson Center on Climate and Environmental Policy at The Heartland Institute, which publishes *Health Care News*.

"The U.S. Constitution vests the power to regulate interstate commerce firmly and solely within the purview of Congress, not regulatory agencies," said Burnett. "This type of regulatory overreach and mission creep has unfortunately become all too common as the regulatory state and rule by alphabet agencies with little oversight or accountability has grown.

"I have read the U.S. Constitution, which was designed to limit the power of the federal government, and I can nowhere find authority granted to the federal government to limit or regulate the food people eat," Burnett said. "In addition, the Ninth and Tenth Amendments to the Constitution specify respectively that rights not enumerated in the Constitution are retained by the people, and that the federal government only has the powers specifically delegated to it in the Constitution, with the remaining authorities and powers reserved to the states or the people therein. Clearly, the decision on whether to allow the exchange and consumption of raw milk is an authority retained by individual states or their peoples."

Ending these rules is fully justified, Burnett says.

"It is sad that this bill is necessary, but if that's what it takes for the people to get their sovereign powers back, then so be it, and good luck," Burnett said.

Back to Nature

Talento says increasing public-health problems have led her to become a naturopathic doctor in addition to her consulting work.

"I would recommend placing every family's health and safety in the hands of a regenerative-dairy farmer raising 100 percent grassfed cows over the dangerous potion mislabeled as 'milk' on offer in our grocery stores any day of the week," Talento said.

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

Massachusetts Hospitals Refuse to Report Newborns' Drug-Dependency

By Kenneth Artz

Major Massachusetts hospitals no longer regularly perform toxicology tests on newborns or report prenatal exposure to addictive substances to state welfare agencies unless there is other evidence of infant abuse or neglect.

Mass General Brigham (MGB) changed the hospital policy to address the "racial and ethnic inequities" present in health care, arguing substance abuse disorder in the context of pregnancy "disproportionately affects Black individuals," according to an MGB website statement.

MGB is the largest hospital-based research enterprise in the United States, with annual funding of more than $2 billion and total revenue of nearly $18 billion in 2022.

MGB joins Boston Medical Center, which revised its reporting of suspected abuse and neglect in 2021.

"Fatal overdoses during and shortly after a pregnancy more than tripled nationwide between 2018 and 2021," reports Boston radio station WBUR-FM.

"(W)hen you turn the medical professions into a social justice profession, you end up with all kinds of crazy medical policies. If you just accept the fact that doctors ought to be focused on the welfare of the patient that's in front of them, then the conduct of the physician, the professional, would be in accordance with that concern."

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

Showing Only Selective Concern

Doctors who support traditional medical ethics view the policy change at MGB as ill-advised and dangerous. To consider standard care and treatment as racist requires twisting the meaning of words, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"'Racist' in Newspeak means disproportionate to percentage in population," says Orient. "To me, it would seem racist to neglect diagnosis of substance abuse because failure to treat it would disproportionately harm black babies."

Ignoring 'Preventable Damage'

MGB's policy is not just an exercise in sophistry but is a burden on patients, says Orient.

"Preventable damage from being born addicted is very costly, and what about the cost in human suffering?" said Orient.

Although there are racial disparities in health care, ignoring maternal drug use or children born with dangerous drugs in their system will lead to worse outcomes for minorities, says Orient.

"Black babies are disproportionately killed by abortion," said Orient. "So why isn't this disparity a concern? And what about sending them home with a drug-abusing mother? And shouldn't she be treated?

"It is hard to answer this, because I can't see how failure to diagnose and treat sick babies can be justified," said Orient.

Normalizing Illicit Drug Use

Though newborn drug testing has focused primarily on opioids, the use of marijuana during pregnancy should also be a concern, says Orient. Recreational marijuana is legal in many states, and the Biden administration has reclassified the drug to reduce restrictions on its use.

These policy changes may lead hospitals to eliminate testing for cannabis, says Orient.

"There is a lot of denial about its harmful effects," said Orient.

Babies can be harmed if their mothers get high while pregnant, Orient notes.

"So, how come we warn them about having a glass of wine but not an addicting drug?" said Orient.

One motivation behind these changes could be to normalize illicit drug use, says Orient.

"And maybe that is part of our effort to eradicate morality and traditional standards," said Orient.

Turning Their Backs

MGB's policy is typical of a syndrome that has overtaken the health care industry and turns every health care provider into a social justice warrior, says Texas physician John Dale Dunn, M.D., J.D., a policy advisor to The Heartland Institute, which publishes *Health Care News*.

"Here's the way it works," said Dunn. "The medical community has decided they're not going to get involved with any kind of effort to deal with the illegal criminal conduct of members of any segment of the population that is identified as an oppressed minority."

MGB's policy ignores the purpose of infant drug screening, which is to identify those mothers who are drug abusers, who are, by definition, abusing their babies, and are likely to do so in the future, says Dunn.

"In effect, what you're dealing with is medical personnel are not going to find out what their patient's drug status is because they don't want them to be subject to any kind of law enforcement or social services actions," said Dunn.

Politicizing Medicine

Policymaking by medical organizations is all about politics, says Dunn.

"(W)hen you turn the medical professions into a social justice profession, you end up with all kinds of crazy medical policies," said Dunn. "If you just accept the fact that doctors ought to be focused on the welfare of the patient that's in front of them, then the conduct of the physician, the professional, would be in accordance with that concern."

The social justice movement views the issue as protecting the oppressed minorities who just happen to have a problem with drug abuse, says Dunn.

"The consequences of well-meaning bull*** social justice programs and policies are the obvious reason why we shouldn't accept this kind of stupidity," said Dunn. "What drives them is their concern about social justice. It's the kind of thing Marxists and socialists talk people into because their approach to societal conditions is to identify the oppressors and the oppressed and do everything that you can to protect the oppressed because the oppressors are the bad guys."

Heading for Other States

This trend of subjecting treatment standards to political tests is likely to spread, says Dunn.

"I don't trust the medical professions at this point under any circumstances, because they have become a tool of the socialists," said Dunn. "They have adopted the ideological positions of the socialists, and that's the reason why this medical community problem in Boston is something you will probably see in other parts of the country."

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

REPORT

Hospitals Are Responsible for Rising Health Care Prices

By Ashley Bateman

Hospitals are responsible for escalating health care prices, empowered by a lack of market incentives to curb costs, new data shows.

A growing number of Americans are having difficulty paying their medical bills, due to rising health care prices. In response, some states are using tax dollars to help consumers pay off big medical bills, and others are reviving laws that hold relatives responsible for unpaid bills. Recently, the Biden administration proposed erasing medical debt from credit reports.

Rising hospital charges are the main cost driver, accounting for 30 percent of all spending in the health care sector, states a May 17 Buckeye Institute policy memo, "How Higher Hospital Costs Lead to Higher Prices," by Rea Hederman Jr.

"When companies are competing, they are trying to deliver products that people want to use and want to pay for. With massive consolidations and physician buyouts, that competition is sorely lacking in the hospital industry."

REA HEDERMAN JR., THE BUCKEYE INSTITUTE

Industry Consolidation

Factors contributing to hospital cost increases include corporate consolidation, pricing power achieved by keeping out lower-cost competitors, and the acquisition of private physician groups by health care systems.

Hospitals continue to expand their facilities even though hospital bed occupancy has plummeted by 30 percent, the publication states.

Hederman cites a $2 billion expansion of Wexner Medical Center at Ohio State University despite declining hospital bed occupancy and increasing telemedicine and outpatient care. The cost of debt to fund such projects has risen dramatically in the last four years—costs ultimately passed down to patients, insurers, and taxpayers, says Hederman.

Privately Insured Pay Costs

A RAND study found hospitals bill commercial insurers nearly 277 percent of what they charge Medicare, Hederman says. Insurers pass that cost on to consumers in the form of higher premiums and deductibles and narrow networks, says Hederman. These higher costs have not resulted in higher quality care for Americans, says Hederman.

"When companies are competing, they are trying to deliver products that people want to use and want to pay for," Hederman told *Health Care News*. "With massive consolidations and physician buyouts, that competition is sorely lacking in the hospital industry."

Hospitals take full advantage of "misguided government mandates" giving them outsized pricing power, Hederman says.

No 'Real Market'

Legislators from both sides of the aisle are conducting reviews of escalating hospital prices. Wisconsin state Rep. Jimmy Anderson (D-Fitchburg), who is disabled, introduced legislation in the current session of the State Assembly to eliminate medical jargon in hospital bills. The bill got no traction.

In 2019, the Trump administration issued price transparency requirements to "increase competition among hospitals, group health plans and health insurance issuers … [and] require that pricing information be made publicly available."

The results of price transparency laws have been mixed. The Centers for Medicare and Medicaid Services (CMS) found 30 percent of hospitals violated price transparency requirements in 2022.

"For a market to be free, you need a price signal; you need information," said Hederman "If you're trying to figure out hospital pricing for an optional surgery, a lot of the time you simply don't get the full picture. That means we don't have a real market in health care. We need to enforce price transparency."

Billion-Doller Nonprofits

Many hospitals are nonprofits and pay no property taxes, with large hospital complexes becoming billion-dollar enterprises that can outcompete private practices that have to pay taxes. Additionally, municipalities lose out on property tax revenues when these hospitals use large chunks of land. These nonprofit hospitals should be subject to legislative oversight, says Hederman.

"That's not interfering in the market," said Hederman. "If you're getting major tax benefits from the government, there should be oversight."

With the massive role hospitals play in medical spending, policymakers must address expansion and exorbitant spending while enacting cost-benefit practices, the report concludes.

"It's important that we use transparent pricing and good policies to give power to consumers, and we need to inject new competition," said Hederman. "Competition is how we get better prices and better products."

What States Can Do

Escalating health care costs are the reason The Heartland Institute, which publishes *Health Care News*, is updating its American Health Care Plan, introduced in 2021.

"The best place to fix escalating health care prices is at the state and local level," said Heartland Senior Fellow Matt Dean.

"There are many things that can increase competition, empower consumers, and make health care entities like hospitals more responsive to the people they are supposed to serve," said Dean. "Health care should not be driven by how much money you can extract from the public with the government's help."

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

POLL

Out-of-Pocket Medical Costs Will Affect Presidential Election

By Kenneth Artz

Health care affordability may be a big issue in the 2024 presidential election, says Drew Altman, president of KFF.

In a recent article, Altman says the most important issue in health care for consumers is out-of-pocket costs. Between a quarter and a half of all Americans report real problems paying their medical bills, depending on how sick they are, says Altman.

Everything else, including Medicare solvency, value, state Medicaid spending, employer premiums, and national health spending, is far down the list, and polls confirm this, says Altman.

KFF (formerly the Kaiser Family Foundation) reported on May 28 that health care spending reached $4.5 trillion in 2022, up from $74.1 billion in 1970. Much of the increase has occurred relatively recently, with health spending rising 10.6 percent in 2020.

Obamacare Harm

People are not filling prescriptions, and they are skipping doctor visits and other forms of care to decrease their out-of-pocket costs, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"Obamacare is making things worse because the out-of-pocket exposure is higher than we've seen before in the health insurance market," said Goodman. "If you go into a hospital or require serious medical attention, your out-of-pocket expense can be as high as $9,400. If two people in a family experience this, then just double that and it's almost $19,000.

"If a family member has continuing chronic conditions—like a child with a disability from birth requiring many years of care—that family could be hit with year-round medical bills year after year," said Goodman.

The government's rules favor those who need the least health care, says Goodman.

"What's happening in the individual market is they're giving away the health insurance for free," said Goodman. "If you have an average income, your premium is probably $0, so this is great for the healthy because they only need preventive care and that's supposed to be free as well. But if you get sick, the examples of coinsurance are quite high, and out-of-pocket exposure is higher than we've ever seen. This includes maintenance drugs—some people are not taking insulin because of the high cost."

Short-Term Limitation

The Biden administration has undercut short-term insurance, an alternative with lower premiums and deductibles. Such plans were common before Obamacare went into full effect in 2014.

Like the Obama administration, Biden limited the plans to three months with no ability to renew. If an enrollee gets sick and needs continuing care, the only option will be Obamacare.

Under Trump, people could get a plan for a year and renew it for two more years, even if they got sick.

"So, the best opportunity to lower all health care costs is being outlawed by the Democrats," said Goodman. "If we have a change of administration, I would say that Trump will open up the short-term market [again]. Short-term health care has been around for many years; it's called 'gap insurance,' and it covers situations like moving from home to college or from college to a job, or if you're between jobs."

One reason short-term plans cost less is that they are not regulated like Obamacare plans, and state mandates don't apply either, Goodman says.

"It's the closest thing we have to a free market in health insurance," said Goodman. "A free market for health insurance ensures having an incentive to give people what they want to buy."

Political Focus

During this election cycle, Democrats are focusing on at least three aspects of health care affordability, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

Democrats are raising questions about pharmacy benefits managers (PBMs), especially "current economic incentives that may prod PBMs to promote more-expensive brand-name drugs as opposed to lower-cost generics," said Matthews.

They are also claiming they have lowered prescription drug prices, mostly citing insulin but also "claiming that the Inflation Reduction Act (IRA) is lowering prices, even though the law's drug price 'negotiations' are only in the beginning stages," said Matthews (see related article, page 1).

Democrats are also pushing a largely new topic led by Federal Trade Commission Chair Lina Kahn's antitrust war on hospital mergers. Hospitals are merging so they can reduce competition and charge higher prices to get around government price controls on Medicare, says Matthews.

"Ironically, while hospital systems were merging and buying up physician practices before the passage of the Affordable Care Act, Obamacare supercharged the trend," said Matthews.

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

"What's happening in the individual market is they're giving away the health insurance for free. If you have an average income, your premium is probably $0, so this is great for the healthy because they only need preventive care and that's supposed to be free as well. But if you get sick, the examples of coinsurance are quite high, and out-of-pocket exposure is higher than we've ever seen. "

JOHN GOODMAN
PRESIDENT AND CEO
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

North Carolina Medicaid Expansion Tops 450,000 Enrollees

By Ashley Bateman

North Carolina has picked up 450,000 new Medicaid enrollees in the first six months since becoming the 41st state to expand Medicaid.

The state's Department of Health and Human Services reports nearly 6 percent more of the state's population has enrolled in Medicaid since December 1, 2023, when the legislature approved Gov. Roy Cooper's budget, which included expansion. Cooper had made several earlier attempts to expand Medicaid eligibility but was up against a resistant legislature. Cooper said expansion could open Medicaid to more than 600,000 new enrollees.

Adults with earnings 38 percent above the federal poverty level are now eligible for coverage in the state.

New enrollees have claimed coverage for more than 1,000,000 prescriptions since December 2023, according to Cooper's office, with North Carolina health care providers receiving more than $347.5 million in health care reimbursements.

Federal Carrots

Cooper had pushed to increase enrollment in the program since 2017, even after a Republican-led lawsuit to halt expansion was brought against him in federal court.

"States are under significant pressure to take the federal money to expand Medicaid," said Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which publishes *Health Care News*. "It's hard to blame legislators and governors who are under significant pressure to take billions in 'free money' to pay for the health care of people who cannot afford health insurance. But a look at states that have adopted expansion of Medicaid shows that there is no free lunch."

Minnesota exemplifies the effects of expansion, says Dean. Boasting one of the lowest numbers of uninsured in the country, Minnesota was one of the first states to sign on for expansion in 2011, completing coverage goals in 2014. The result was disastrous, says Dean.

"As folks dumped private health insurance, the costs of individual health insurance skyrocketed," said Dean. "In some counties, there were no plans to buy. This precipitated a private insurance bailout from the state, which continues to this day."

Rural Hospital Fallout

In 2023, Cooper singled out rural residents as a population in particular need, saying in a news release the state's "rural residents are 40 percent more likely to be uninsured and eligible for Medicaid expansion" and citing the closing of several rural hospitals since 2005.

Rural residents comprise more than 30 percent of the new Medicaid enrollees.

With mounting pressure on the state's budget, rural hospitals will have to deal with Medicaid's low payment reimbursements, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"I think Medicaid is a huge portion of most state budgets," said Orient. "It generally underpays for care, so hospitals are stressed, and that can increase costs to non-Medicaid providers, including commercial insurers and those who pay out of pocket."

Medicaid expansion increases problems for rural hospitals, says Dean.

"While states see some lowering of that important uninsured number, you also see migration from private insurance to taxpayer-funded entitlement health care," said Dean. "This hits rural hospitals with a double whammy of lower reimbursement and increased utilization of emergency care."

Ineligible Recipients

The suspension of Medicaid eligibility rules during the COVID lockdowns increased states' problems in moving ineligible people off the program.

"Medicaid is a cash cow for managed care. Most Medicaid recipients are in a 'plan.' A plan such as UnitedHealth gets the money and doles it out to people who provide care, keeping a hefty share of it and doing everything possible to deny or obstruct care, creating a huge uncompensated burden for physicians. The plans and the state need a forensic audit."

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

"The Medicaid rolls continue to be populated with folks who do not qualify because they make too much money, live in another state, are on another public plan, or are dead," said Dean. "As Medicaid numbers swelled during the emergency-powers Medicaid expansion, many states failed to disenroll enrollees who did not qualify or are drastically behind in doing so."

Health care companies can benefit from Medicaid expansion, says Orient.

"Medicaid is a cash cow for managed care," said Orient. "Most Medicaid recipients are in a 'plan.' A plan such as UnitedHealth gets the money and doles it out to people who provide care, keeping a hefty share of it and doing everything possible to deny or obstruct care, creating a huge uncompensated burden for physicians. The plans and the state need a forensic audit."

ER Bunk

Reducing the use of emergency rooms (ERs) for routine care has been another empty promise of expansion proponents, says Dean.

"ER utilization has increased, not decreased," said Dean. "There is little incentive to not just show up at the ER for routine care if patients have no premium, deductible, or copay."

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

Many People on Medicaid During Pandemic Thought They Were Uninsured

By Bonner Russell Cohen

The suspension of Medicaid eligibility requirements during the COVID-19 pandemic created confusion among Medicaid recipients and government officials over who was enrolled in the program, a new report by *Health Affairs* states.

The confusion remains to this day, the study found.

"Continuous coverage" was the term coined by Congress in allowing low-income individuals who enrolled in Medicaid, beginning in March 2020, to remain in the program throughout the government-declared public health emergency, even if their incomes no longer qualified them as beneficiaries.

With the expiration of the continuous coverage provision on March 31, 2023, states were required to begin disenrolling beneficiaries who no longer qualified for the program.

"At first blush, it appears the Biden administration is playing a shell game between Medicaid and Obamacare enrollment. But upon further analysis, it is just playing a different game of deception. While our eyes are focused on these two inefficient government-run systems, we lose focus on the ball representing more efficiency, more patient choice, and a pathway to more affordable health care. That ball is the category we are being distracted from: the ball of market-based health care."

JEFF STIER, SENIOR FELLOW, CENTER FOR CONSUMER CHOICE

Medicaid Undercount

Addressing the effect of pandemic-related changes in Medicaid enrollment policies, the *Health Affairs* report highlights the difference between Medicaid participation self-reported in government surveys and the administrative records of Medicaid enrollment.

"The difference between the two is known as the 'Medicaid Undercount,'" states the report. "We estimated that nearly half of the 5.9 million people who we projected were likely to become 'unwound,' already reported that they were uninsured in the 2022 Current Population Survey. This finding suggests that the impact of ending the continuous coverage provision on the estimated uninsurance rate, based on self-reported survey data, may have been smaller than anticipated," *Health Affairs* explains.

"It also means that efforts to address Medicaid unwinding should include people who likely remain eligible for Medicaid but believe they are already uninsured," the report concludes.

Similarly, a study published April 5 in the online *JAMA Health Forum* found unrecognized Medicaid coverage. The authors compared self-reported Medicaid coverage in the American Community Survey to actual Medicaid enrollment and found self-reported Medicaid coverage was far lower than actual enrollment.

Disenrollment Worries

Confusion over the number of people enrolled in Medicaid, together with the expiration of continuous coverage, sparked fears that the U.S. health system would be flooded with uninsured former beneficiaries.

For example, KFF (formerly, the Kaiser Family Foundation) reported in April 2024 that more than 20 million people have been disenrolled during the "unwinding" process.

"Three-fourths of those who were disenrolled from Medicaid say they were worried about their physical health while six in ten say they were worried about their mental health," reported KFF. "Additionally, a majority (56%) say they skipped or delayed getting health care services or prescriptions while attempting to renew their coverage (13% of total enrollees)."

Many of those disenrolled from Medicaid wound up obtaining coverage in heavily subsidized Obamacare plans. This boosted Obamacare signups by the end of the 2024 open enrollment period to 21.3 million, a 30 percent rise from the 2023 level.

President Joe Biden was quick to take credit for the development, saying in a January 24 statement, "My actions to protect the Affordable Care Act and lower premiums continue to make a difference."

Obamacare Fraud

A study released in June by the Paragon Health Institute uncovered widespread fraud in Obamacare signups during the 2024 enrollment period. The study, "The Great Obamacare Enrollment Fraud," found nearly half the people signing up "reported income between 100 percent and 150 percent FPL [federal poverty level], qualifying for fully subsidized, 94 percent actuarial value plans."

The percentage of people signing up who reported income in this range increased substantially after the enhanced pandemic subsidies took effect and, in some states, exceeded the eligible population in such households, states the study.

"Overall, fraudulent exchange enrollment appears to be a significant problem in nearly half the states," the Paragon study states. "We estimate that fraudulent enrollment at 100 percent to 150 percent FPL is likely upwards of four to five million people in 2024."

Game of Deception

Enrollment in Medicaid or Obamacare is not the same as having access to quality health care. Many Americans, especially those with limited means, choose alternatives such as short-term plans, indemnity plans, and no-insurance direct care.

Jeff Stier, a senior fellow at the Center for Consumer Choice, suggests the confusion over Medicaid enrollment may be a political ploy to mislead the public.

"At first blush, it appears the Biden administration is playing a shell game between Medicaid and Obamacare enrollment," Stier said. "But upon further analysis, it is just playing a different game of deception. While our eyes are focused on these two inefficient government-run systems, we lose focus on the ball representing more efficiency, more patient choice, and a pathway to more affordable health care. That ball is the category we are being distracted from: the ball of market-based health care."

Enrolling Phantoms

In addition to people not realizing they are qualified for Medicaid or recognizing that the program is insurance, the system has incentives for phony signups by outsiders, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"The problem is when no premium is required, agents—and maybe providers—have incentives to enroll people on paper, even without their knowledge," said Goodman.

There are enrollees in plans on the Obamacare exchanges who are paying no premium, Goodman says.

"An agent can sign them up without their knowledge and collect a commission for doing so," said Goodman. "The Paragon Health Institute has recently reported on this."

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

REVIEW

‘South Park’ Mocks Massive Health Care Dysfunction

Review of South Park: The End of Obesity *(Paramount+), 50 minutes, 2024*

By AnneMarie Schieber

The nation’s health care system has become so blatantly dysfunctional that the producers of the satirical television series *South Park* devoted an entire 50-minute episode to a serious matter—obesity—which manages to keep you laughing every single second.

Granted, it’s *South Park*, where obscenities and raunch proliferate like lobbyists on Capitol Hill, but “The End of Obesity” on Paramount+ is both funny and meaningful.

The episode takes on Big Pharma, Big Insurance, Big Hospitals, vanity, sloth, greed, and even wokeness, in one hilarious swoop.

No-Sweat Weight Loss

“The End of Obesity” zeros in on the craze for semaglutides—the injectable drugs Ozempic, Wegovy, and Rybelsus—which have developed a reputation for causing quick and easy weight loss.

Obesity is a serious problem in the United States, and the cure is not complicated: eat less, burn more calories. Millions of Americans struggle with their weight, almost as if food producers and the $93.8 billion weight-loss industry planned it that way.

The episode begins with a doctor telling teenager Eric Cartman and his mother that they must take drastic measures to combat Eric’s obesity.

“Exercise just doesn’t seem to work for him,” his mother complains.

Cue the angelic music. The doctor mentions semaglutides: “they are the active ingredient in Ozempic, a drug made for people with diabetes, but we now discovered they can help obese people lose vast amounts of weight.”

Big, Fat Cost

The doctor, sounding like a pharma sales rep, says, “Young man, how would you like not to be fat anymore?” Eric and his mom are enthused until they hear the price tag is $1,200 a month. The doctor says insurance won’t cover the drug for weight loss, only diabetes, and if the family can’t afford it, tough luck.

The doctor says he wants to help Eric, so he writes him a prescription for “Lizzo.”

Lizzo, the doctor explains, is “a really good singer who talks about body positivity and just being happy with the way you look.”

Eric is told to watch her videos five times a day, for life.

Seeking a Fix

The remainder of the episode shows the family’s quest for affordable semaglutides. Outraged that money should prevent help for someone with a health problem, Eric and his friends march into an insurance company and are greeted with open arms until they say they want to complain, not buy insurance.

Next, we see a group of suburban women who distinguish themselves by wearing midriff shirts exposing their six-pack abs. This group has been getting ample supplies of the semaglutides, and they even entice a suburban dad, a closet stoner, to join their “injection” parties.

Eric and his buddies figure out a solution: compound the drug themselves after watching YouTube videos and buying the raw ingredients from India.

Obesity Drug Cartels

A group of cereal industry executives get wind of the semaglutide craze and are outraged that it is cutting into their ability to get people addicted to sugar. The cereal market is behind “Lizzo,” which is not working. Later, the cereal execs stage a terrorist attack on the drug makers in India, led by a thug resembling Captain Crunch.

The terrorist attack causes a semaglutide shortage in the United States, which pushes everyone to desperation. The suburban moms become armed robbers, hitting drug stores and hijacking trucks delivering the weight-loss drugs.

Meanwhile, Eric keeps dreaming of being skinny so he can be cruel and make fun of other people.

Moral to the Story

Without spoiling the fun by telling how the story ends, it is safe to say the episode makes a point: in a distorted marketplace, special interests can compete against one another to exploit consumers and undermine progress.

Markets depend on consumers being allowed to think and choose freely. When consumers are prevented from getting full information (censorship) or competing interests use the government to gain an unfair advantage (lobbying), markets cannot function as they should.

As “The End of Obesity” shows, these activities hurt people, and we all end up paying for it.

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

COMMENTARY

Health Care Can Be Fixed with Commonsense Solutions

By John C. Goodman

Since most of the restrictions were created by Democratic legislation, it is tempting to view the liberation of health care as a Republican project. Yet there is no reason that it couldn't be bipartisan.

The reforms suggested below are not conservative or liberal, Democratic or Republican. They are commonsense solutions that will appeal to the vast majority of voters.

Give Cash, Not Medicaid

Many doctors won't take Medicaid patients because Medicaid payments are so low and because Medicaid rejects more claims than either Medicare or commercial insurance. Many of our top medical centers won't take them, either. A similar problem arises with various forms of convenient care—such as walk-in clinics and freestanding urgent-care facilities.

One consequence is that Medicaid patients frequently turn to community health centers or hospital emergency rooms (ERs) for their medical care. In fact, new enrollees in Medicaid visit emergency rooms 40 percent more frequently than others do. Wait times in ERs can be as long as six hours.

Why not let Medicaid enrollees buy medical care the way they buy food with food stamps? They could add out-of-pocket cash to pay any portion of the bill that the government subsidy doesn't cover and acquire care at market prices. Patients could add this cash to any portion of the bill Medicaid does not cover.

One possibility is to put money into a health savings account (HSA), from which people could buy medical care and private insurance. Any remaining HSA funds could be withdrawn for non-medical spending.

Let Employers Fund Direct Care

Not long ago, wealthy people paid thousands of dollars to "concierge doctors" who could talk to their patients by phone. Such arrangements were completely outside the normal third-party-payer system.

Today, this kind of service is called direct primary care (DPC), and it is increasingly affordable and popular. It is membership-based and can cost as little as $50 a month for an adult. DPC doctors can communicate with patients using phone, email, or video conferencing, 24-7, without government restrictions.

The government prohibits employers from putting money into an account from which employees can pay for DPC. This needs to change.

Let Employees Pick Health Plans

Most people with health insurance get a subsidy from the government or an employer, with lots of strings attached.

Before Obamacare, some employers funded personal and portable health insurance chosen by the employee and owned by the employee. Administrations can fine employers for doing this. Or they can order employer insurance to be Obamacare-compliant.

Employees should be allowed to choose whatever plan best suits them and be able to keep this insurance when they change jobs.

Allow More Insurance Options

Obamacare was originally sold to the public as a way of protecting people with preexisting conditions, but the plans sold on the exchanges are lousy protection for the sick.

If you are sick, the annual out-of-pocket maximum exposure for a family this year is $18,900 in deductibles and coinsurance, over and above any premium payment. The average family premium last year was $13,824. People with above-average incomes do not qualify for a government subsidy. And because network provider choices are limited, Obamacare plans resemble Medicaid but with higher deductibles.

One alternative is short-term, limited-duration insurance. These plans are largely unregulated and can exclude people with chronic conditions, but because of that, premiums are about half the price of an Obamacare plan and the coverage networks are much broader.

President Joe Biden restricted these plans to three-month terms, which limits protection in case you get sick, whereas President Donald Trump allowed the plans to last 12 months and be renewable for up to three years. When Trump did this, demand for the plans jumped to three million from 600,000.

Incentivize Insurers to Cover the Sick

Unwise government regulations give insurers every reason not to want to cover the chronically sick. One exception is Medicare Advantage, in which Medicare pays insurers more money (a risk adjustment) to cover seniors with a specific health condition, such as cancer.

This setup incentivizes insurers to be on the lookout for changes in patients' health status. It also gives plans a reason to specialize in covering certain kinds of care. This sort of specialization is not allowed in the Obamacare exchanges, where plans have to be all things to all patients.

The market for individually purchased insurance would be radically transformed overnight if we allowed it to operate under the same rules as Medicare Advantage.

Unleash Health Savings Accounts

We need to divorce HSAs from any deductible requirement and allow the market to make decisions about cost-sharing by patients. To be eligible for an HSA, patients must be enrolled in a high-deductible health care plan. Those deductibles may discourage people from taking steps to avoid high-cost medical problems, such as by taking insulin.

President Trump allowed employers to provide maintenance drugs freely to employees for 13 chronic conditions without jeopardizing the employees' HSAs.

Unwise government regulations give insurers every reason not to want to cover the chronically sick. One exception is Medicare Advantage, in which Medicare pays insurers more money (a risk adjustment) to cover seniors with a specific health condition, such as cancer. This setup incentivizes insurers to be on the lookout for changes in patients' health status. It also gives plans a reason to specialize in covering certain kinds of care. This sort of specialization is not allowed in the Obamacare exchanges, where plans have to be all things to all patients.

JOHN GOODMAN
PRESIDENT AND CEO
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Establish Tax Fairness

Currently, people at the same income level are getting radically different tax subsidies, depending on where they get their health insurance.

In the Health Care Fairness for All Act, introduced by Rep. Pete Sessions (R-TX) and his colleagues, health insurance subsidies would resemble John McCain's proposal in 2008 to ditch subsidies with a uniform, refundable tax credit. That would be another important improvement.

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 appeared in* National Review. *Reprinted with permission.*

Federal Debt Bolsters Case for 'Plan for America,' Proponents Say

By AnneMarie Schieber

The nation's $27.9 trillion federal debt, now equal to 99 percent of annual gross domestic product (GDP), is one of the strongest reasons yet why Plan for America (PFA) is the "most viable, long-term solution," say the plan's proponents.

PFA is a voluntary alternative to Social Security and Medicare that would eliminate the national government's debt and state liabilities for pensions and Medicaid.

Terry Nager, Eric Nager, and Kyre Lahtinen updated their plan with new fiscal data in June. The three authors have developed PFA over 18 years, driven by concern about the fiscal stability of the United States. Terry Nager and Eric Nager are principals in an investment advisory firm. Lahtinen is an economist.

The team released a new white paper in June, plus a list aimed at the presidential candidates on how PFA can benefit every voter constituency.

The group has also released details on how private accounts in the PFA can provide a "pathway" to homeownership by serving as collateral for a home mortgage down payment. The use of the PFA account as collateral would not be deemed a taxable distribution under state or federal law.

FAST Accounts

PFA would be a public-private partnership allowing Americans to opt out of Social Security and Medicare and direct their payroll taxes into a private account held by a trust named For America Security Trust (FAST).

The FAST accounts would be invested in a broad-based index fund of American-domiciled companies to pay for retirement and for lifetime health care, including long-term care. Upon death, the remaining proceeds of the account could be passed on to designated beneficiaries.

PFA would relieve federal and state taxpayers from the escalating liability in the nation's entitlement programs that is contributing to the escalating national debt, say the plan's designers.

"The only thing in the Social Security Trust Fund today are nonnegotiable IOUs, so the argument could be made that the system is bankrupt now," said Eric Nager during a June 14 webinar.

> **"Right now, they have no plan, and this gets worse every year. The interest costs eat up more and more of the budget, and we may reach a point where we can no longer sell the bonds."**
>
> **TERRY NAGER**
> **CO-AUTHOR, PLAN FOR AMERICA**

Government Debt Paydown

There are not enough workers in the United States to support retirees, and none of the solutions to meet the upcoming obligations will work, says Nager. These include rolling the debt over and continuing to borrow, printing more money, or repudiating the debt obligations altogether.

"The best way to handle debt is to pay it off, and our plan does that," said Nager.

"We have to demand the politicians get this under control," said Terry Nager. "Right now, they have no plan, and this gets worse every year. The interest costs eat up more and more of the budget, and we may reach a point where we can no longer sell the bonds" that cover federal government budget deficits.

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

INTERNET INFO

"How Plan for America Can Benefit a Presidential Candidate by Benefitting Virtually Every Constituency," Plan for America, June 2024: **https://heartlanddailynews.com/wp-content/uploads/2024/06/Presidential-Benefits-.pdf**

"The Mechanics of the Pathway to Homeownership," Plan for America, June 2024: **https://heartlanddailynews.com/wp-content/uploads/2024/06/Mechanics-of-the-Pathway-to-Homeownership.pdf**

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