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The Pulse

AGs Question Pediatricians Pushing Trans Treatment

PHOTO COURTESY ANDREW HARNIK/STAFF/GETTY IMAGES

Idaho Attorney General Raul Labrador

By Ashley Bateman

Attorney generals from 20 states and legislators from Arizona signed an interrogatory letter to the president of the American Academy of Pediatrics (AAP) about the group's support of puberty blockers, cross-sex hormones, and surgery for children and adolescents who have been diagnosed with gender dysphoria.

"Often the AAP has exercised its influence responsibly," states the letter. "… But when it comes to treating children diagnosed with gender dysphoria, the AAP has abandoned its commitment to sound medical judgment."

The AG letter demanded responses to multiple questions about the organization's

PEDIATRICIANS, p. 4

RFK Jr. Reveals Health Care Agenda

By Bonner Russell Cohen

After dropping out of the race for president in August, Robert F. Kennedy Jr has turned up the volume on national health care and drug policy and attracted attention over a possible future role in the White House depending on the outcome of the November election.

Kennedy has endorsed former President Donald Trump, and Trump has hinted Kennedy could have a role in a second Trump administration.

Kennedy, who founded the safety advocacy group Children's Health Defense, recently revealed the scope of his health care recommendations through his "Make America Healthy

RFK JR., p. 6

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

Dr. Goodman addressing The Economic Club of Indiana

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1

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2

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4

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Speech: 'Silicon Curtain' Is Protecting Government Censorship

By AnneMarie Schieber

Citing Winston Churchill's "Iron Curtain" metaphor describing the Cold War division of Europe, health care policy expert Dr. Jay Bhattacharya told an audience, "We are now in the middle of a Silicon Curtain of censorship descending across the previously free West."

In a keynote address at The Heartland Institute's Benefit Dinner in Chicago on September 13, Bhattacharya said public health is the new "fig leaf" for justifying government censorship.

"Free speech is in dire danger in the U.S.," said Bhattacharya. "The government will use its power to suppress criticism [of] its own misinformation."

Bhattacharya is a plaintiff in *Murthy v. Missouri*, in which the Supreme Court lifted a preliminary injunction directing the Biden administration not to "coerce or significantly encourage social-media companies to suppress protected speech" and remanded the case to a lower court.

"This gives a way to the government to censor at will," said Bhattacharya. "All they have to do is send emails and algorithms to social media companies without naming a single person—just name ideas not allowed to be said online.

"The First Amendment, in effect, is an unenforceable dead letter," said Bhattacharya.


Dr. Jay Bhattacharya

Under Fire for Opinions

Bhattacharya, a medical doctor and professor of medicine, economics, and health care policy at Stanford University, rose to prominence when he published The Great Barrington Declaration (GBD) on October 4, 2020, with epidemiologists Martin Kulldorff and Sunetra Gupta. The declaration criticized COVID-19 lockdowns and urged authorities to focus on keeping children in school and protecting the elderly instead of imposing broad-based restrictions.

Although the writers were highly recognized for their work and associated with Stanford, Harvard, and Oxford Universities, respectively, powerful government figures denounced them. Francis Collins, then-director of the National Institutes of Health, and Anthony Fauci, then-director of the National Institute of Allergy and Infectious Diseases, called the trio "fringe epidemiologists" in emails that were made public later.

Ostracized and Blacklisted

Bhattacharya was ostracized by other professors at Stanford and was blacklisted on Twitter. When Elon Musk purchased the social media giant, he discovered the list and shared it with Bhattacharya.

Google "de-boosted" the GBD, which was posted online and signed by more than 940,000 doctors, researchers, and concerned citizens. Facebook banned posting of it altogether.

Citing internal government emails, the plaintiffs showed the Biden administration was controlling social media companies by threatening to regulate them out of business if they disobeyed White House censorship demands.

The Biden administration also used universities to help with the censorship work, which the government is prohibited from doing directly. Bhattacharya brought up the case of the Stanford Internet Observatory, which received government grants to develop algorithms to target a particular idea. The government shared that information with social media platforms.

Rising Worldwide

Europe, Canada, the U.K., and Australia have led the way on legislation to control speech, Bhattacharya told the audience. The bills and laws ostensibly outlaw violence, pornography, and hate on the internet, carry Orwellian names, and establish authorities to do the enforcement.

These include the Digital Services Act in the E.U., the Online Harms Act in Canada, the Online Safety Act of 2023 in the U.K., and the Security and Regulation of the Digital Space law in France.

"It is dangerous to let governments have control over the definition of hate," said Bhattacharya. "It's even more dangerous to allow government to determine what is misinformation, because science and medicine depend on free speech to operate properly."

'Rights Are Under Attack'

Bhattacharya brought up the case of Scott Jensen, a medical doctor and Minnesota state senator who ran against Tim Walz for governor in 2022. Jensen was a prominent critic of COVID-19 policies, and Facebook censored his election page. Jensen lost the race, and Walz went on to implement some of the most draconian COVID-19 restrictions and is Vice President Kamala Harris's running mate in this year's presidential election. Jensen says his respect for Bhattacharya is immense.

"Dr. Bhattacharya's willingness to present and stand by a contrarian narrative—which ultimately proved to be profoundly wise—will go down in history as an act of immense courage in the face of smothering government censorship fueled by behemoth, profit-driven technological companies," said Jensen.

"Americans' First Amendment rights are under attack by a political elite, but Dr. Jay Bhattacharya continues to stand in the breach and do whatever is necessary to protect and defend free speech," said Jensen.

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

AGs Question Pediatricians Pushing Trans Treatment

Idaho Attorney General Raul Labrador

PHOTO COURTESY ANDREW HARNIK/STAFF/GETTY IMAGES

Continued from page 1

child gender policies by October 8, and it stated AAP's conduct is being reviewed further.

Sounding an Alarm

The American College of Pediatricians (ACPeds), an alternative medical professional organization, has spent years sounding the alarm on AAP-approved transgender treatments.

ACPeds organized a coalition of health care professionals to create the Doctors Protecting Children Declaration, a document urging organizations to stop promoting what ACPeds calls unethical, harmful practices in treating children with gender dysphoria. Some 82,500 professionals and concerned citizens have signed the declaration.

"We have personally reached out to the AAP leadership and leaders of the other named organizations, asking them to put a stop to this, and have not received a response," said ACPeds Executive Director Jill Simons, M.D.

"Unfortunately, the leadership of the AAP and other organizations have silenced their very members from engaging in medical discourse when they have put in question these harmful protocols, and they continue to double down on them even as they stand without evidence-based research to support their current positions," said Simons.

Questioning What's 'Reversible'

In encouraging the use of puberty blockers, cross-sex hormones, and surgical interventions, the AAP claims the treatments are reversible. The AG letter says that is "misleading and deceptive."

"It is beyond medical debate that puberty blockers are not fully reversible, but instead come with serious long-term consequences," the letter states.

The letter cites the widely recognized Cass Review commissioned by Britain's National Health Service and published in April. The review showed "the current protocols of social affirmation, puberty blockers, and cross-sex hormones do not improve the health outcomes of children with gender dysphoria and in fact there is evidence of causing harm," said Simons.

"Dr. Hilary Cass's recommendation has shut down the practice of transitioning kids in England," said Simons. "Many other European countries are also reversing course and returning to proven medical care, which is supportive mental health and addressing underlying diagnoses."

Leaked files from the World Professional Association of Transgender Health and a recent statement from the American Society of Plastic Surgeons have bolstered the case against surgical and hormonal trans treatments, says Simons.

APA, AMA Uninterested

Major medical organizations ignore the science on this issue, says Dr. Tim Millea, chair of the Health Care Policy Committee and Conscience Rights Protection Task Force of the Catholic Medical Association (CMA).

"Physician organizations such as AAP and [American Medical Association] appear to be uninterested in those studies, at the expense of ongoing harm to Americans that they encourage to enter the 'gender-industrial' medical system," said Millea. "It seems to be true that the leadership of these groups prioritize ideology over science, which is a dereliction of duty in the vocation of medicine."

"I speak to countless pediatricians who are members of the AAP who disagree with the AAP's policies and fully support our efforts to put a stop to these unethical protocols, but they are truly fearful of losing their jobs and the harms that will come to them if they speak out. I unfortunately speak to pediatricians who have been reprimanded and even fired for speaking out."

JILL SIMONS, M.D.
EXECUTIVE DIRECTOR
THE AMERICAN COLLEGE OF PEDIATRICIANS

Afraid to Speak Out

Most U.S. pediatricians are members of the AAP. The AAP is too radical for most pediatricians, though they are reluctant to say so, says Simons.

"I speak to countless pediatricians who are members of the AAP who disagree with the AAP's policies and fully support our efforts to put a stop to these unethical protocols, but they are truly fearful of losing their jobs and the harms that will come to them if they speak out," said Simons. "I unfortunately speak to pediatricians who have been reprimanded and even fired for speaking out.

"We remain hopeful that doctors will push back against these protocols and follow their oath to do no harm," said Simons. "There will be a tipping point when doctors are no longer fearful and will speak out."

Going to Court

The AAP has been named in multiple lawsuits against doctors and hospitals. Members of ACPeds have served as expert witnesses and submitted amicus briefs on the other side.

ACPeds also filed a lawsuit against the Biden-Harris administration for its rule requiring doctors to perform gender transition procedures on minors against their medical judgment.

"The American College of Pediatricians is filing this lawsuit against HHS because doctors should never be forced to violate their sound medical judgment and perform life-altering and sterilizing interventions on their patients," an ACPeds news release stated. "Our doctors take an oath to do no harm, but the Biden administration's rule forces them to violate this oath and perform procedures that are harmful and dangerous to our patients—vulnerable children. What the Biden Administration is calling for is wrong and unlawful."

Changing the Culture

The CMA has likewise been involved in gender intervention cases and hosted a two-hour panel discussion on September 8, 2024, in which several detransitioners recounted the harms they suffered from gender transition procedures as minors. The organization wants to make sex-change procedures among non-adults unthinkable, a goal that is primarily cultural and "of greatest importance," says Millea.

"The public needs to learn and understand the negative and lifelong risks and complications of gender transition," said Millea.

AGs from Alabama, Arkansas, Florida, Georgia, Idaho, Iowa, Kansas, Louisiana, Mississippi, Missouri, Montana, Nebraska, North Dakota, Ohio, South Carolina, South Dakota, Texas, Utah, Virginia, and West Virginia signed the interrogatory letter to the AAP, as did the president of the Arizona State Senate and the speaker of the Arizona House.

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

Biden-Harris Offer 'Bribe' to Medicare Drug Insurers

By AnneMarie Schieber

The Congressional Budget Office (CBO) says it will cost taxpayers more than $25 billion to "paper over" a Medicare drug premium price jump created when the Inflation Reduction Act (IRA) shifted the burden of drug price cuts to Part D insurers.

The result has been a 22 percent increase in 2025 Medicare Part D premiums expected to hit just before the election.

To soften the blow, the Biden-Harris administration launched a three-year "premium stabilization demonstration" program that will subsidize those affected by the price hike by up to $35 per enrollee in 2024 and $142.70 in 2025. The program will cost $7 billion in 2025, including $2 billion in interest.

President Joe Biden and Vice President Kamala Harris

PHOTO COURTESY ADAM SCHULTZ/FLICKR.COM

"To avert that unpleasant reality, they concocted a 'demonstration project,' which is another name for 'bribery,' under which insurers would receive billions of dollars if they promised not to raise their premiums."

JOHN C. GOODMAN
FOUNDER, THE GOODMAN INSTITUTE FOR PUBLIC POLICY

IRA Backfire

The CBO analysis of the subsidy plan came at the request of the House Ways and Means Committee.

"The so-called Inflation Reduction Act—which is law as a result of Vice President Harris' tie-breaking vote in the Senate—has led to a predictable spike in the cost of prescription drug coverage for America's seniors," said House Ways and Means Committee Chairman Jason Smith (R-MO) in an October 3 news release.

"Rather than change course, the Biden-Harris Administration is cutting taxpayer-funded blank checks to large health insurers to sweep the mess under the rug," said Smith. "It is a shameful attempt to delay the inevitable fallout of a failed policy that leaves taxpayers footing the bill today and seniors paying the price tomorrow."

Election-Year Cost-Shifting

The IRA, signed into law on August 16, 2022, capped insulin costs under Medicare Part B at $35 a month, eliminated cost sharing for vaccines, and capped out-of-pocket drug costs at $2,000 under Part D. The law also forces drug companies to negotiate with Medicare on the prices of top-selling drugs or face stiff penalties.

To offset other costs, the IRA reduced federal subsidies on catastrophic prescription drug insurance from 80 percent to 20 percent, thus driving up Part D premiums.

"When Democrats unilaterally enacted major changes to Medicare two years ago, they set seniors up for new expenses and fewer options," said Senate Budget Committee Ranking Member Chuck Grassley (R-IA). "This nonpartisan CBO analysis confirms CMS's cost-shifting plan is a dishonest election-year gimmick to cover up those consequences."

Trump EO Scuttled

Open enrollment for Medicare plans begins in mid-October. Some 13.3 million people are enrolled in Medicare Part D, says the health care research organization KFF, and have been paying $43 a month on average for 2024.

"Medicare Part D premiums increased by over 11 percent from 2021 to 2023, costing seniors on average $52 more per year for their prescription drug coverages," states the October 3 Ways and Means news release.

Seniors might have saved money if the IRA had not delayed a Trump executive order requiring pharmacists to pass on undisclosed rebates drug companies give to drug plans. The IRA delayed that action until 2032. Coinsurance payments are based on nominal prices, not discounted ones.

Flawed Changes, Cost Estimates

The IRA provision and the Biden-Harris patch will end up wasting billions of dollars, says Joel White, founder and president of Horizon Government Affairs, a health care consultancy.

"CBO has confirmed taxpayers and seniors will pay more because of the flawed IRA changes to Medicare drug coverage," said White. "In fact, it will now cost more to paper over the law's problems than the Biden-Harris administration claimed they saved in 'negotiating' drug prices."

White House estimates of costs have been way off, says White.

"To date, the Biden-Harris administration has spent $7 billion to stabilize premiums, which is more than the $6 billion 'saved' from price controls," said White. "In addition, CBO confirmed they undershot the estimate of costs in the IRA. After assessing plan bids—what plans say it will cost to deliver drug benefits to seniors—CBO says the law will cost $10 [billion] to $20 billion more than they originally estimated. I guess this is Bidenomics."

Broken Promise

"Despite Joe Biden's promise to never cut Medicare, that is exactly what was done in the IRA bill," said John C. Goodman, founder of The Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"That is the bill that Biden and the congressional Democrats brag about passing," said Goodman. "It removed more than $300 billion from Medicare, mainly from the Medicare Part D program. Because of that withdrawal, the private sector has to make up the difference, and that mainly means Part D premiums were destined to rise.

"To avert that unpleasant reality, they concocted a 'demonstration project,' which is another name for 'bribery,' under which insurers would receive billions of dollars if they promised not to raise their premiums," said Goodman.

With Part D premiums about to skyrocket just before an election, Biden and Harris juggled the books to buy off insurers and voters, Goodman says.

"Although the administration claimed the funds for the demonstration project were coming from the Medicare Trust Fund, the trust fund does not hold cash or any other marketable asset," said Goodman. "It is nothing more than an accounting device that keeps track of revenues and payments related to Medicare.

"The trust fund doesn't even have a bank account," said Goodman. "So, where's all the money coming from that the administration is giving to the insurance companies? The administration is running up debt that will have to be paid by the taxpayers."

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

RFK Jr. Reveals Health Care Agenda

Robert F. Kennedy Jr.

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

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Again" agenda.

Trump has named Kennedy to his transition team and pledged to establish a panel of experts to work with Kennedy to investigate the increase of chronic health problems and childhood diseases in the United States (see related articles, pages 8, 9).

In a September 5 op-ed in *The Wall Street Journal,* Kennedy laid out his 12-point Make America Healthy Again plan. His ideas include reducing conflicts of interest at federal health agencies, implementing drug price caps, setting chemical and pesticide standards, requiring nutrition classes in medical school, redirecting money toward preventative care, re-releasing a presidential fitness standard, and expanding health savings accounts.

"Kennedy, by virtue of his family name, is an insider, but his unorthodox views make him a provocative outsider. The public-health establishment, against which he has railed for years, failed miserably during the coronavirus pandemic. The ties between HHS and Big Pharma are far too cozy, and we have good reason to believe public health suffers as a consequence. A free spirit like his could be just what the doctor ordered."

CRAIG RUCKER
PRESIDENT
COMMITTEE FOR A CONSTRUCTIVE TOMORROW

Boundary Crossing

Over the years, Kennedy has challenged long-held positions of the public-health establishment on issues from vaccines and childhood obesity to the role of big pharmaceutical companies.

Kennedy's stances cross ideological boundaries. His support of a single-payer national health care system conflicts with free-market opinions on the right, and his criticism of big-government bullying alienates the left. The nation's painful experience with COVID-19 attracted attention to Kennedy's health care opinions through his forceful criticisms of lockdowns and vaccine policies.

In an interview with *Preferred Health* magazine in June, Kennedy lambasted the lockdowns and the people he says profited from them.

"The people who came into the pandemic with a billion dollars, the Bill Gates, the Mark Zuckerbergs, the Bloombergs, the Jeffrey Bezos, increased their wealth on average by 30 percent," Kennedy told the publication.

"The lockdowns were a gift to them, the super-rich," said Kennedy. "Jeffrey Bezos, the richest or second-richest man in the world, was able to close down all of his competitors, 3.3 million businesses, and then give us a two-year training course about how to never use a retail outlet again in our lives. Forty-one percent of the black-owned businesses will never reopen. And he was instrumental because he was censoring the books that were critical of the lockdowns, including one that I wrote."

Insider Advantage

Kennedy's criticisms appeal to Craig Rucker, president of the Committee for a Constructive Tomorrow.

"Kennedy, by virtue of his family name, is an insider, but his unorthodox views make him a provocative outsider," said Rucker. "The public-health establishment, against which he has railed for years, failed miserably during the coronavirus pandemic. The ties between HHS and Big Pharma are far too cozy, and we have good reason to believe public health suffers as a consequence. A free spirit like his could be just what the doctor ordered."

NIH Reform Call

Echoing his criticisms of the pandemic response, Kennedy says he wants to overhaul federal health care agencies, beginning with the National Institutes of Health (NIH).

The NIH suppressed the use of ivermectin and hydroxychloroquine during the early stages of the pandemic, in favor of remdesivir and later the COVID-19 vaccines, Kennedy argues. Saying the NIH "has been transformed into an incubator for the pharmaceutical industry," Kennedy recommends removing much of the institute's funding for virology.

"It has stepped away from rigorous, evidence-based science, evidence-based medicine, into kind of a magical world," Kennedy told *Preferred Health*. "It needs to have scientific discipline reimposed on the entire field of virology. We ought to be funding the study of the etiology of chronic diseases in our universities."

Focus Shift

Kennedy has also spoken widely on chronic childhood diseases, some of which he has attributed to vaccines. Kennedy has called for public health authorities to shift their focus from infectious diseases such as COVID-19 and influenza to devote more attention to diabetes, obesity, environmental toxins, and other longer-term concerns.

Kennedy has also cited large-scale factory farming and processed food as contributing to the nation's health problems.

Peter Pitts, president and cofounder of the Center for Medicine in the Public Interest, says Kennedy brings a fresh perspective to public-health debates.

"RFK Jr.'s penchant for not taking things at face value could go a long way toward forcing government public-health agencies to argue on behalf of their beliefs rather than simply relying on a 'because I said so' defense," said Pitts.

Surprising Endorsements

Texas Agriculture Commissioner Sid Miller, a Republican, praised Kennedy's efforts in a September 26 op-ed for *Fox News*.

"The role of Big Food, much like Big Pharma, is to prioritize their profits over our health," wrote Miller. "I enthusiastically support RFK Jr.'s campaign to hold these industries accountable by reforming our food and medicine approval and patenting systems. In this he is uniquely qualified: the $1.7 trillion pharmaceutical industry has unfairly maligned him for decades, and he's still standing strong."

In a move that raised eyebrows, Robert Redfield, who headed the Centers for Disease Control and Prevention (CDC) from 2018 to 2021, endorsed Kennedy's reform efforts in a *Newsweek* op-ed in September.

"If the next president prioritizes the National Institutes of Health (NIH) to identify which exposures are contributing to the spike in chronic disease in children, we will finally find out and end what is slowly destroying our children," wrote Redfield.

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

Use of Weight Loss Drug Widespread, and Costly

By Kevin Stone

As obesity rates in the United States soar, insurance companies, including Medicaid and Medicare, are facing financial headwinds to pay for prescription drugs for weight loss.

Semaglutide, the generic name for Mounjaro, Wegovy, and Ozempic, is an injectable medication using GLP-1 agonists (incretin mimetic drugs) to trigger the pancreas to release the right amount of insulin when blood sugar levels are high.

The Food and Drug Administration (FDA) approved semaglutide for treatment of type 2 diabetes in 2017. Since then, off-label use to treat obesity has garnered widespread attention.

Although three of the drugs contain semaglutide as the primary active ingredient, Ozempic is targeted specifically at type 2 diabetes patients, whereas Wegovy is marketed as a treatment for obesity, and semaglutide is the generic, available primarily from compounding pharmacies—those that can make specialized medications for individual customers.

Mounjaro, like Ozempic, is targeted at diabetes, and it uses a related drug called tirzepatide. A tirzepatide-based obesity drug is marketed under the brand name Zepbound.

Driving Shortages, Cost Hikes

Medicare, Medicaid, and most private insurance cover these drugs for treatment of diabetes. Many employer plans and some Medicaid programs extend coverage for obesity. Medicare, by law, does not. Many have identified these drugs as a major driver of higher insurance costs and premiums in annual filings with state regulators.

The widespread use of these drugs for off-label weight loss is also driving concerns that they will become unavailable to patients with diabetes. The American Society of Health-System Pharmacists (ASHP) issued an August advisory warning of shortages of the Novo Nordisk products Ozempic and Wegovy.

FDA Delays

Semaglutides bring up a broader policy issue as well, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"Off-label prescribing is very common, with surveys suggesting some one-in-five drugs being prescribed off-label," said Matthews. "It used to be that cancer drugs were the most prescribed off-label, but that may have changed, with several psychiatric and other drugs being prescribed off-label.

"One important reason for off-label prescribing is the FDA approval process is long, complicated, and expensive—and patients are not inclined to wait for years, or even months, for a drug that might help them," said Matthews. "If patients cannot get Novo Nordisk's Wegovy, which is approved for weight loss, a doctor may prescribe Ozempic, which has the same active ingredient, semaglutide, just less of it."

Premium Cost Driver

With these drugs already allegedly driving up insurance costs, there is a risk of large additional increases. The FDA says approximately 90 million privately insured Americans may be eligible to use the drugs.

Although some compounding pharmacies can provide generic semaglutide for under $200 a month, pharmacy and online prices—those most likely to be paid by insurers—range from about $950 to $1,080 a month. The cost of covering these drugs would average approximately $1 billion per million eligible people insured.

"Semaglutide is unique in that it's a brand-name drug that could help a very large population, and therefore put a strain on government finances and drive up private insurance premiums like no other drug we have seen before," said Gregg Girvan, a resident fellow at the Foundation for Research on Equal Opportunity.

Cost Mitigators

Some factors might mitigate the cost, such as that semaglutide is classified as a small-molecule drug, not a biologic, says Girvan.

"That means the drug's FDA exclusivity will run out sooner, and several of the drug's patents are set to expire within the next couple of years," said Girvan. "The drug will also be eligible for the IRA's Medicare drug price negotiations as soon as 2027, though again, this could be impacted by the availability of generics. These factors should in theory limit the financial exposure of taxpayers and patients alike."

Semaglutide could help make the case for reforming exclusivities granted to biologic drugs, often the priciest drugs on the market, says Girvan.

"Given that semaglutide was first granted FDA marketing authorization in 2017, we would expect semaglutide to remain exclusive until at least 2029 if it were a biologic, and likely longer given possible extensions to that exclusivity," said Girvan.

What About Diet, Exercise?

The money spent on these drugs would probably produce better results if used for therapies other than appetite suppression, says Chad Savage, founder of YourChoice Direct Care and a policy advisor to The Heartland Institute, co-publisher of *Health Care News*.

"For the roughly $1,400 per month that Wegovy costs, a patient could hire a personal trainer, train at the gym, include the gym membership, and have healthy meals specially prepared for them for an entire month and still have money left over," said Savage. "That would have markedly more benefit than appetite suppression alone."

Semaglutides pose important and potentially costly dangers to those who use them, says Girvan.

"People have to understand that this drug is unnatural in the way it achieves weight loss— it essentially starves the body by shutting off a person's appetite," said Girvan. "Patients on this drug must be mindful that they must remain on the drug for their entire lives to maintain its effect and must take extra care to eat enough and in the right variety that the body needs to function properly.

"There really is no substitute for proper eating and living an active lifestyle, which comes with a slew of other positive health effects beyond weight loss," said Girvan.

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

"People have to understand that this drug is unnatural in the way it achieves weight loss—it essentially starves the body by shutting off a person's appetite. Patients on this drug must be mindful that they must remain on the drug for their entire lives to maintain its effect and must take extra care to eat enough and in the right variety that the body needs to function properly."

GREGG GIRVAN
RESIDENT FELLOW
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

‘Skyrocketing’ Chronic Illness Rates Prompt Concerns in Congress

By AnneMarie Schieber

With health care expenditures soon to reach 19 percent of U.S. Gross Domestic Product (GDP), the House Ways and Means Health Subcommittee announced the formation of a bipartisan caucus to investigate the escalating incidence of chronic disease and how best to stop it.

Rates of cancer, cardiovascular disease, and Alzheimer’s disease “are skyrocketing,” said Health Subcommittee Chair Vern Buchanan (R-FL) in his opening statement on September 18.

“According to the American Cancer Society, in the coming year we’re expecting to hit a bleak milestone: the first time new cases of cancer in the U.S. are expected to cross the two million mark,” said Buchanan. “This daunting number tells me that we need to invest in technologies that will be able to catch these chronic diseases early and often.”

High Costs

Buchanan also expressed alarm over obesity rates, now comprising 45 percent of adults and 20 percent of children. Doctors are increasingly treating obesity with semaglutides, which cost $1,029 to $1,430 per month. Waiting until people get sick wastes lives and money, Buchanan told the committee.

“In Israel, for instance, they live five years longer than the average American and spend less than 8 percent of their GDP on health care,” said Buchanan. “We need to learn from other nations that are prioritizing prevention and healthy living and lifestyles, to ensure our country and people can live longer, healthier, and happier lives.”

Obesity is even undermining national security, says Buchanan.

“Shockingly, according to the CDC, just over one in three young adults aged 17 to 24 are overweight and unable to serve in our military,” said Buchanan.

Nutrition Literacy

The newly formed Congressional Preventive Health and Wellness Caucus will focus on educating Americans on nutrition and better lifestyle choices, Buchanan told the committee.

The issue requires new ways of thinking, says Katy Talento, president of KFT Consulting and a former top health care advisor for President Donald Trump’s Domestic Policy Council.

“I was floored to see the recent four-hour roundtable held by Sen. Ron Johnson that brought together leading experts in these issues. It’s a miracle that the truth is finally going mainstream about the unholy alliance between Big Food, Big Chemical, Big Ag, and Big Health Care, and about the capture and corruption of our regulatory agencies by these same interests.”

KATY TALENTO
PRESIDENT, KFT CONSULTING

“The most encouraging step in decades with respect to addressing our extinction-level chronic disease epidemic is the ‘Make America Healthy Again’ initiative now being spearheaded by the partnership between two glass-breakers: Robert F. Kennedy Jr and President Trump,” said Talento.

“I was floored to see the recent four-hour roundtable held by Sen. Ron Johnson that brought together leading experts in these issues,” said Talento. “It’s a miracle that the truth is finally going mainstream about the unholy alliance between Big Food, Big Chemical, Big Ag, and Big Health Care, and about the capture and corruption of our regulatory agencies by these same interests.

“Expect the corporate profiteers off our suffering to unite with the Deep State to try to stop the MAHA agenda in its tracks,” said Talento. “It will take a whole-of-government fight, led by the White House with steely-eyed resolve, to win this war, but it can be done,” said Talento.

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

Medical Groupthink Makes People Sicker, Analysts Argue

By AnneMarie Schieber

Medicine has a huge "blind spot" that has led to an explosion of childhood obesity, diabetes, autism, peanut allergies, and autoimmune diseases in the United States, says Martin Makary, M.D., author of the bestselling book *Blind Spots*.

"We have the sickest population in the history of the world … right here in the United States, despite spending double what other wealthy countries spend on health care," said Makary during a September 20 presentation at the Cato Institute, titled "Blind Spots: When Medicine Gets It Wrong, and What It Means for Our Health." Also on the panel were Cato scholars Jeffrey A. Singer, M.D., and David A. Hyman, M.D., J.D.

Makary became well-known during the COVID-19 lockdowns as one of a small group of prominent physicians who publicly questioned the government's response to the virus. Makary is a professor of surgery at Johns Hopkins Medicine, where he researches the underlying causes of disease and has written numerous scientific articles and two other bestselling books.

Chronic-Disease Epidemics

Makary said the rates of some diseases have reached epidemic proportions. Half of all children in the United States are obese or overweight, with 20 percent now diabetic or prediabetic. The proportion of children being diagnosed with autism has risen by an average of 14 percent per year for the past 23 years, one-in-five U.S. women have been diagnosed with an autoimmune disease, and gastrointestinal cancers have doubled over the past two decades.

"We have got to ask the big questions," Makary said in his remarks. "We have developed blind spots not because we're bad people but because the system has a groupthink, a herd mentality."

Health care has become assembly-line medicine, with health professionals pressured to focus more on productivity and billing output than on improving overall health, says Makary.

"We need to look at gut health, the microbiome, our poisoned food supply; maybe we need to look at environmental exposures that cause cancer, not just the chemo to treat it; maybe treat diabetes with cooking classes instead of throwing meds at people; maybe we need to treat high blood pressure by talking about sleep quality," said Makary.

"Agencies make decisions in the shadows of how [they think] Congress will react. Congress can make your life really miserable if you're a federal regulator. They can cut your budget, call you in, and yell at you because you haven't taken aggressive steps to protect the American public."

DAVID A. HYMAN, M.D.

Sticky Theories

Hyman says cognitive dissonance can cause blind spots, highlighting an example of a surgeon initially resistant to trying less-invasive antibiotics before surgically removing an appendix, as recounted in Makary's book.

"Easy problems are already fixed, so how do we fix this hard problem?" asked Hyman at the presentation, pointing out unjustified medical opinions can persist for decades.

Such opinions include the ideas that "opioids are not addictive, or antibiotics won't hurt you, or hormone therapy causes breast cancer even though the data never supported it, the dogma of the food pyramid," said Makary.

"We love to hold on to old ideas not because they're better or more logical or [more] scientifically supported than new information, but just because we heard it first," said Makary. "And it gets comfortable. It will nest in the brain, and subconsciously we will defend it."

Peanut Allergy Mix-Up

Singer asked Makary about the peanut allergy dogma the American Academy of Pediatrics pushed in 2000, recommending children not eat peanuts before three-years-old. It turned out to be wrong, said Singer.

"We have peanut allergies in the U.S. at epidemic proportions, [yet] they don't have them in Africa and parts of Europe and Asia," said Makary. The United States "got it perfectly backward," said Makary. "Peanut abstinence results in a sensitization at the immune-system level."

An early introduction of peanuts reduces the incidence of people being identified with peanut allergies by 86 percent, Makary told the audience.

Makary said he confronted those who argued for peanut abstinence, noting there were no studies to back up the recommendation. They replied that they felt compelled to weigh in because the public wanted something done, said Makary.

'Demonized' HRT

The recommendation against hormone replacement therapy (HRT) for older women because of breast cancer risk is another example of misguided groupthink, Makary told the audience.

"It is probably the biggest screw-up in modern medicine," said Makary.

"HRT replaces estrogen when the body stops producing it," said Makary. "Women who start it within 10 years after the onset of menopause live on average three-and-a-half-years longer, have healthier blood vessels, they will have 50 to 60 percent less cognitive decline, the risk of Alzheimer's goes down by 35 percent. Women feel better and live longer. The rate of heart attacks goes down by half. And their bones are stronger. There is probably no medication that has a greater impact on health outcomes in populations than hormone therapy."

A demonization campaign against HRT began 22 years ago when a single scientist at the National Institutes of Health held a press conference saying HRT was linked to breast cancer, Makary told the audience.

"The incredible back story is that no data were released at that announcement," said Makary. "And today there is no statistically significant increase [of breast cancer]."

Political Challenges

The panelists said medical groupthink leads to bad government policies.

"Agencies make decisions in the shadows of how [they think] Congress will react," said Hyman. "Congress can make your life really miserable if you're a federal regulator. They can cut your budget, call you in, and yell at you because you haven't taken aggressive steps to protect the American public."

Makary said doctors must avoid making recommendations based on "gut feelings."

"We spend a staggering amount of money on delivering health care, and very little money on what actually works," said Hyman.

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

Michigan Becomes Sixth State to Axe Abortion Data Collection

By AnneMarie Schieber

Despite the American College of Obstetricians and Gynecologists calling abortion an "essential component of women's health care," Michigan has become the latest state to stop requiring collection of statistics on the procedure.

The Reproductive Health Act, signed by Gov. Gretchen Whitmer on November 21, 2023, amended the state's Public Health Code to remove the requirement that clinics report the age, race, general residence, and physical complications that may result from abortions. The Act also repealed the requirement that abortion facilities be licensed as freestanding surgical outpatient facilities, in addition to other provisions.

Michigan had been collecting abortion data for 45 years until 2023.

"For years, women and their doctors faced burdensome requirements when seeking abortion care that had no basis in medicine and were designed to dissuade women from accessing the care they needed," Michigan Department of Health and Human Services spokesperson Lynn Sutfin told *Bridge* magazine on June 11.

"Abortion reporting in the United States is, overall, of poor quality and resembles a patchwork of quality, requirements, and laws."

MIA STEUPERT
RESEARCH ASSISTANT, CHARLOTTE LOZIER INSTITUTE

Patchy Data

Five other states in addition to Michigan no longer collect abortion data to submit to the Centers for Disease Control and Prevention (CDC), says Mia Steupert, a research assistant at the Charlotte Lozier Institute. Those states are California, Maryland, New Hampshire, New Jersey, and North Dakota.

In addition, said Steupert, "Several other states only report abortion data to the CDC for its annual abortion surveillance reports that are published two years behind schedule. These states [and D.C.] include Hawaii, Rhode Island, Tennessee, Virginia, and Washington. To make matters worse, the states that report data solely to the CDC often do not report all data points that the CDC publishes in their annual summary."

The Charlotte Lozier Institute and Guttmacher are two nongovernmental organizations that track abortion data. Steupert says the data is often "delayed, sporadic, and poor-quality."

"Abortion reporting in the United States is, overall, of poor quality and resembles a patchwork of quality, requirements, and laws," said Steupert.

Zero Abortions?

The fact that several states have banned abortion has made data reporting even more sporadic and inaccurate. Steupert cites Oklahoma and South Dakota.

"The states reported zero abortions occurred," said Steupert. "However, the states failed to report any of the exceptions data and did tell me in an email that the zero figures did not take into account the abortions which they could not track: abortion drugs being shipped into the state from pro-abortion states with [privacy] shield laws."

In its last report, released this summer, Michigan tallied 31,000 abortions, an increase of 3.7 percent from the previous year.

The Michigan report included information on the type of facility where the abortion was performed, age of gestation, type of procedure, ultrasound verification, complications, and whether the abortion failed. The report also included information on the patient's marital status, age, residing state, history of abortion, origin of referral, and the payer.

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

Abortion Pill Complications Hike Medicaid Costs

By Harry Painter

A new study that found abortion pills lead to more ER visits than birth or surgery raises questions about who is responsible for paying for the care, a coauthor of the study states.

"Approximately one-in-20 women sought emergency room care for abortion-related complications within 30 days of taking abortion drugs in 2015," Ingrid Skop, M.D., coauthor of the study and vice president of medical affairs at the Charlotte Lozier Institute (CLI), told *Health Care News*. (See related article on opposite page.)

Although not everyone who reports to the ER requires the attention of a doctor, the costs can be significant, says Skop.

"Even if this were merely observational care and did not include treatment, it would be a strain on emergency resources, and the emergency follow-up care would impact Medicaid budgets even if Medicaid did not pay for the original abortion," said Skop.

"Notably, 60 percent of these visits were miscoded as being a complication of miscarriage, demonstrating the hesitancy of women to report their abortions to medical providers," said Skop.

"I think that as more women suffer from their chemical abortions, we may see a coalition of post-abortive female patients bring lawsuits against past abortion providers similar to what we see happening with over a dozen de-transitioners who have sued their physicians."

DR. MICHELLE CRETELLA
CHAIR, ADOLESCENT SEXUALITY COMMITTEE
AMERICAN COLLEGE OF PEDIATRICIANS

Publisher Withdrew Papers

The study's findings were based on Medicaid data in the 17 states where the government program pays for elective abortions and follow-up care.

Skop says CLI's two peer-reviewed studies documenting these findings were published by Sage but were later retracted for no legitimate reason. The findings "were targeted by pro-abortion researchers," said Skop.

CLI has published the works on its assaultonscience.org/#papers website, along with two related papers that were also retracted.

Calls Requirement Justified

The CLI study shows abortion pills "warranted the in-person physician requirement that the FDA struck down," says Dr. Michelle Cretella, chair of the Adolescent Sexuality Committee of the American College of Pediatricians. The Food and Drug Administration (FDA) under the Biden administration removed the in-person physician requirement in April 2021.

"Now that women can use these toxic medications with little to no medical supervision, they are ending up in emergency rooms with significant issues," said Cretella. "The only way to rule out a life-threatening ectopic pregnancy is to be aware of its symptoms and then obtain an ultrasound before it is too late," said Cretella.

The harm done to women who have undergone chemical abortions could lead to lawsuits, Cretella says.

"I think that as more women suffer from their chemical abortions, we may see a coalition of post-abortive female patients bring lawsuits against past abortion providers similar to what we see happening with over a dozen de-transitioners who have sued their physicians," said Cretella. "And when that happens, I know thousands of pro-life physicians who will continue to stand by their side."

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

STUDY

Abortion Pills Lead to More ER Trips than Surgery, Birth

By Harry Painter

Chemical abortions are more likely to cause serious emergency room visits than surgical abortions or giving birth, a new study has found.

The Charlotte Lozier Institute study found emergency department (ED) visits from 2004 to 2015 caused by the abortion pill were "significantly more likely to have a severe or critical acuity rating than a visit following surgical abortion, live birth, or an ED visit at any time by a woman who was never pregnant."

The study, published in the *International Journal of Epidemiology and Public Health Research* in August, measured the acuity, or severity, of emergency department (ED) visits. American Medical Association procedures code acuity at five levels: nonurgent, urgent, moderate, severe, or critical.

An ED visit after the use of abortion drugs was twice as likely to have a severe or critical rating (affecting nearly seven out of 10 women) as one following live birth or unrelated to pregnancy, and 50 percent more likely to have a severe or critical acuity rating compared to a woman who had a surgical abortion, the study found.

"These findings demonstrate conclusively that most women are having severe complications in need of complex care when they present to an emergency room following abortion drug use," Ingrid Skop, M.D., vice president of medical affairs at the institute and coauthor of the study, told *Health Care News*.

Dangers of Abortion Drugs

"It is crucial that we combat the false narrative that abortion drugs are 'safe and effective' if we truly care for the health and wellbeing of women in crisis," said Skop.

Mifepristone, the first of a two-part series of drugs used to induce a chemical abortion, was authorized in 2000 under the Food and Drug Administration's (FDA) protocol for inherently dangerous drugs.

"The abortion drugs, mifepristone and misoprostol, cause complications frequently," said Skop. "High-quality international studies document approximately 15 percent of women will experience hemorrhage when used at less than nine weeks' gestation."

Sometimes "infection can progress rapidly to a life-threatening sepsis," a possibility for which the FDA maintains a black box warning to physicians, said Skop.

"Abortion drugs send approximately one in 25 women to the ER, according to the FDA's own label," said Skop. "Unfortunately, no data about abortion is mandatorily collected by the U.S. federal government, so the FDA has relied upon abortion industry studies, with many women lost to follow-up, undoubtedly undercounting complications, in order to promote a false narrative of safety." (See related article, opposite page.)

FDA Removes Safeguards

Skop says the FDA has consistently removed safeguards on the use of mifepristone and misoprostol, including the requirement for an in-person visit with a medical professional.

"This allows the drugs to be ordered by telemedicine or online, and delivered in the mail, without any pre-abortion testing or post-abortion evaluation," said Skop. "Women are forced to self-manage their own abortions and seek emergency room care for complications when the abortionist is unavailable, possibly out of state or even out of the country."

Skop said such actions will result in even more complications, because "failure to perform ultrasound cannot rule out a potentially deadly ectopic pregnancy or accurately determine gestational age."

Furthermore, the failure to perform pre-abortion lab tests "will not screen for women more likely to have complications from the drugs or in future pregnancies, and failure to obtain in-person informed consent may lead to coerced or unwanted abortions," said Skop.

Mail-Order Abortions

"The Biden-Harris administration's 2023 FDA altered its regulations on abortion drugs to allow them to be mailed nationwide by nonphysicians using telehealth unless there is a superseding state law," Lozier Institute State Policy Director Katie Glenn Daniel told *Health Care News*.

"Most states require a licensed physician's involvement, and many prohibit telehealth abortion by maintaining laws to ensure in-person screening, counseling, and/or dispensing," said Daniel.

Multiple states have "shield laws" that protect blue-state abortion providers who break laws in relatively pro-life states, says Daniel.

"Not surprisingly, it is pro-life states with gestational limits that also ensure that abortion drugs cannot be sold to minors without parental consent and that women are given in-person screening and access to follow-up care," said Daniel. "Blue states like Massachusetts and California have enacted 'shield laws' that shield the abortion industry from legal liability if they break other states' laws and even if the products they sell, or their lack of meaningful informed consent, leads to a woman getting hurt, or worse."

Cheaper Pills

Obtaining abortion pills online can be cheap but dangerous, says Daniel.

"The cost of abortion drugs varies widely, especially if they are purchased online," said Daniel. "Websites like Plan C list sellers [charging] from just a few dollars, or even free, up to several hundred dollars.

"Some of these cheaper options are coming from overseas manufacturers that the FDA does not inspect and has warned Americans from using," said Daniel. "The pricier options may come with a video or phone visit, although that is becoming increasingly less common since it slows down providers from filling drug shipments as quickly as possible."

Use Up by 53 Percent

Chemical abortion pills have become the dominant method for abortion, rising from 53 percent of all abortions in 2020 to 63 percent in 2023, according to a March 2024 policy analysis by Guttmacher. American women had 642,700 medication abortions in 2023.

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

INTERNET INFO

James Studnicki, Ingrid Skop, M.D., *et al*., "Comparative Acuity of Emergency Department Visits Following Pregnancy Outcomes Among Medicaid Eligible Women, 2004-2015," *International Journal of Epidemiology and Public Health Research*, August 20, 2024: **https://lozierinstitute.org/comparative-acuity-of-emergency-department-visits-following-pregnancy-outcomes-among-medicaid-eligible-women-2004-2015/**

STUDY

ACA Quality of Coverage Is Getting Worse

By Bonner Russell Cohen

Enrollees in Affordable Care Act (ACA) insurance plans are being burdened not just by higher premiums but also a marked decline in the quality of coverage available to them compared to what is offered in employer-sponsored insurance, a new study states.

The study found the percentage of consumers "enrolled in plans with broad provider networks declined from 36 percent to 11 percent from 2014 to 2023." An increasing proportion of enrollees are in plans that resemble Medicaid managed care, the study found.

While acknowledging many factors go into the selection of an individual health insurance plan, the study released in August by the Paragon Health Institute identified three characteristics that define value and motivate participation in insurance products: "the availability of provider networks with generous benefits, the cost-sharing structure that divides financial responsibility between insurance companies and enrollees, and the cost of premiums."

Over time, structural weaknesses in the ACA have manifested themselves across these three characteristics and led to lower-quality plans being offered in the Obamacare exchanges, the study states.

"Legislative or regulatory tweaks to fix the scheme's distortions is a fool's errand. Like a game of whack-a-mole, in the absence of a truly market-based system, distortions will continue to appear far faster than they can be addressed … and will continue to wreak havoc on quality health care."

JEFF STIER
SENIOR FELLOW
CONSUMER CHOICE CENTER

Networks, Cost-Sharing, Premiums

The study, titled "It's Not Just the Prices," examines the value of individual-market health insurance products in the Obamacare exchange from 2014 to 2023 and compares the quality of these products to those in the employer-sponsored insurance group market.

Cost-sharing can be a great burden for enrollees. As overall premiums have risen, "middle-income exchange enrollees with incomes above 200 percent of the federal poverty level were much more likely to choose a bronze plan than they were a decade ago (33 percent)," the study states.

The quality of insurance Obamacare consumers feel they can afford is decreasing as "premiums in Obamacare plans have increased more rapidly—50 percent more—than employer plan premiums over the past decade," the study states.

Quality Race to the Bottom

The study attributes the declining quality of Obamacare plans to structural elements of the ACA market framework.

"In particular, the ACA insurance rules caused premiums to increase and led insurers to offer narrower and more restrictive networks over time," the study states. "The design of the ACA premium tax credits has also incentivized enrollees to select lower-quality plans. In addition, the ACA risk-adjustment program is overcompensating insurers for lower-income enrollees who enroll in silver plans, causing significant price competition for these plans and a race to the bottom in plan quality. Lastly, a variance in state enforcement of ACA rating rules further distorts and complicates plan offerings and consumer selections."

Unacknowledged Mistakes

Recognizing the poor and declining quality of Obamacare plans is a necessary step in improving them, the study states.

Paragon recommends updating the ACA risk adjustment program to include "income-based" risk factors. Cost-share reduction subsidies should be based on actuarial values for all tier plans, the study states. The third recommendation is to expand employers' ability to offer individual coverage health reimbursement arrangements—accounts funded by employers that employees own to purchase health care.

Market Damage

Although the ACA has resulted in lower-quality product offerings to date, this should not be considered an inherent feature of a federally regulated health insurance framework, Paragon says. Instead, it is caused by the ACA regulatory environment.

"In all health insurance markets, there is some incentive to buy less expensive coverage and save on premiums while absorbing higher cost-sharing exposure, but this incentive is uniquely strong in the individual ACA market with premiums proportionally inflated for all plans with flat-dollar subsidies," the study states. "The proposed opportunities for reform will create a better-functioning individual market with stronger offerings to consumers and more efficient government subsidies."

Systemic Distortions

Cushioning the blow of the declining value of ACA plans has been the large government subsidies that have been distributed to attract enrollees. Nearly half of ACA enrollees qualify for zero out-of-pocket premiums and little cost-sharing.

Instead of reducing the number of people without private health insurance, the ACA distorts financial incentives and has changed "the characteristics of the U.S. population that was insured," the study states. Far from living up to its original promise, the ACA wound up roiling health insurance markets in many unforeseen ways, the study suggests.

Jeff Stier, a senior fellow at the Consumer Choice Center, says he admires the Paragon report but believes the ACA cannot be fixed.

"Legislative or regulatory tweaks to fix the scheme's distortions is a fool's errand," said Stier. "Like a game of whack-a-mole, in the absence of a truly market-based system, distortions will continue to appear far faster than they can be addressed … and will continue to wreak havoc on quality health care."

Compounded Problems

Merrill Matthews, a resident scholar at the Institute for Policy Innovation, says the ACA is behind much of what is wrong with health care in the United States.

"Prior to passage of the ACA, Democrats complained that too many people had high-deductible policies, generally in the range of $2,500 per family, and millions of Americans didn't have access to quality health care," said Matthews "Today, the ACA's bronze plans have a deductible in the range of $7,250, and double that for a couple. And many doctors and high-level health care providers, such as M. D. Anderson, won't take Obamacare insurance.

"In other words, after a decade and hundreds of billions of taxpayer dollars, millions of Americans with Obamacare struggle with unbelievably high deductibles and still can't see many doctors," said Matthews.

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

Man Dies After Mental Health Care Denied on Obamacare Plan

By Harry Painter

A man struggling with alcoholism died after trying unsuccessfully for months to find a mental health therapist covered by his Obamacare plan.

An NPR/ProPublica report describes in depth the events preceding Ravi Coutinho's May 2023 death, apparently from an accident involving a relapse into alcohol abuse while alone in his Phoenix apartment.

Coutinho's Ambetter plan, purchased for $379 a month from the HealthInsurance.gov federal marketplace, appeared at first glance to have plenty of providers in the Phoenix area—but every lead Coutinho followed went cold.

Coutinho's search for a therapist was a key part of his treatment plan, as recommended by his previous therapist from his time living in Austin, Texas.

Even the help of his friends and family—his mother worked as the head of a New Mexico health care access advocacy group and had a connection who worked for Ambetter parent company Centene—could not get him the care he needed, according to the report.

Tragically Perverse Incentives

The tragic tale laid out in the NPR/ProPublica report mirrors a problem with the Affordable Care Act identified by John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*, a decade ago in a 2015 *Forbes* article.

"Health plans are keeping premiums down by choosing narrow networks that leave out many mental health providers," wrote Goodman. The "networks themselves are frequently deceptive," Goodman wrote, citing a report that just 14 percent of psychiatrists listed in qualified health plans in the Maryland marketplace were available and taking new patients within 45 days.

Goodman calls the problem a "race to the bottom," caused by government rules giving insurers distorted incentives to provide worse coverage.

"In the [Obamacare] exchanges, health plans get the same premium regardless of the health status of the person who joins the plan," Goodman told *Health Care News*. "That gives them an incentive to attract the healthy and avoid the sick.

"Patients who do not have mental health problems are more profitable than patients who do," said Goodman. "This is true for all chronic conditions, but it is especially true for mental health."

Massive Moral Hazard

Twila Brase, founder and president of the Citizens' Council for Health Freedom and a registered public health nurse, says Obamacare encourages insurers to limit access to care.

"Obamacare opened wide the door to subsidized coverage and coverage for people with preexisting conditions," said Brase. "It introduced massive moral hazard because taxpayers are paying the bill."

Every health plan, Brase said, "rations care through prior authorization, network limitations, hiring fewer practitioners than needed, long waits for appointments, drug formulary lists, and corporate treatment protocols which directly control medical decision-making."

Advantages of Traditional Plans

Tragedies like Coutinho's are far less likely under traditional indemnity-based insurance plans that keep costs down by covering only large health care expenses and have more freedom to accept or reject people with preexisting conditions or at least price them more in line with the cost-risk they present, says Brase.

"In a world of indemnity insurance, prices would be known, prices would be competitive, and charity would be more available because doctors would set their prices according to what most people would be willing to pay and the doctor could afford."

In addition, "Indemnity insurance does not have networks" that limit the range of providers, said Brase.

Fewer people might take up appointment slots, reducing wait lines for all patients, says Brase. There is also the prospect of out-of-pocket payment. Therapists can be found for less than $150 an hour, but "whether that therapist is near you is another question," said Brase.

Telehealth and charity or church ministries are other ways to lower costs and make it easier to get mental health treatment.

Unnecessary Expenses

Obamacare also expanded Medicaid to cover more people, making it even harder to find a therapist.

"Today, Medicaid consumes the time of practitioners unnecessarily through boatloads of paperwork," said Brase. "They'd have more time and energy if all payments were direct, not third-party funded. That also means prices could be lowered, since they wouldn't have to do all the requisite government and health plan paperwork."

Insurance Addiction

Third-party payers' domination of health care is behind most of the flaws in the system, says Brase.

"The biggest problem is networks, third-party controls, bureaucracy, and the fact that the American mind is not used to thinking of health care as a cash-based item," said Brase. "That needs to change, or care and coverage will remain unaffordable and less accessible, and every patient and enrollee will continue to be exploited for the profit it provides the health plans and the political agendas driven by government subsidy programs."

Insurance is not designed for everyday primary care, Brase says.

"Primary care is not an insurable event," said Brase. "Insurance should only be to insure you against a financial disaster—in this case, unaffordable, high-cost medical expenses related to catastrophic or insurable events, like coma, car crash, cancer, and expensive chronic conditions.

"And there should always be skin in the game until costs reach the level of reinsurance," where the insurance company has purchased its own insurance to cover the most expensive situations, said Brase.

The way we think about insurance under the Obamacare regime inevitably leads to these problems, says Brase.

"Insurance is not for primary care, but since it's being used for that, it's more expensive and less accessible to patients," said Brase.

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

"The biggest problem is networks, third-party controls, bureaucracy, and the fact that the American mind is not used to thinking of health care as a cash-based item. That needs to change, or care and coverage will remain unaffordable and less accessible, and every patient and enrollee will continue to be exploited for the profit it provides the health plans and the political agendas driven by government subsidy programs."

TWILA BRASE
FOUNDER AND PRESIDENT
CITIZENS' COUNCIL FOR HEALTH FREEDOM

Courts Order Controversial Program for Estranged Parents

"This is a classic example of the therapeutic state at work. Traditionally, the family, unless flagrant child abuse is apparent, had had the final say in issues that affect their kids."

LARRY SAND
EDUCATOR AND FAMILY RIGHTS EXPERT

By Ashley Bateman

A judge in a child custody matter allowed the forced and unannounced removal of children from their custodial mother so they could enter a "reunification" program with the estranged father, an increasingly common occurrence.

The Wall Street Journal on August 24 reported on the case of Tori Nielsen, aged 16, and her brother, aged 12. An unnamed judge in Ventura County, California authorized four strangers to whisk the siblings into a van and bring them to an offsite, four-day "reunification" program with their father. The children were then barricaded in a room to await the meeting.

The children were unable to contact their mother after they were taken away, and the mother was unable to contact them. The mother was not allowed to reconnect with her children until two years later, when the daughter turned 18. The father had argued in court the mother was poisoning the children's minds against him.

Broken-Family Industry

Reunification therapy has become a growing business as divorce rates rise and parents tangle over physical and legal custody of their children. Family courts may assign such programs when parents cannot work together, and family court guidelines promote the idea that children deserve a chance to bond with both mother and father, usually by establishing a visitation schedule.

Building Family Bridges, the program used in the Nielsen case, was one of the first companies to get into the reunification business, in 1991. The company receives referrals from courts, child custody evaluators, therapists, counselors, attorneys, and "child representatives," the company's website states.

The four-day program, which the company calls an "educational and experiential workshop," is aimed at "children who reject a parent after divorce, who refuse or resist contact with a parent, or treat a parent with contempt," states the website.

The program is not therapy or counseling but "an educational experience based on scientifically established concepts and procedures," states the website.

The parent who requests the program pays the fee. The website does not state the costs.

'Vulnerable Participants'

Tori Nielsen told the *Journal* she and her brother resisted meeting with their father because of his temper. Nielsen described the time away from her mother, and tactics by Building Family Bridges staff members, as something she had to survive.

"I tried to numb myself to what was happening," Nielsen told the *Journal*. "But that only worked for so long because it all absolutely destroyed me."

The Foundation for Child Victims of the Family Courts (FCVFC) published an analysis of treatment intervention ordered by courts earlier this year.

Reviewing the history of court involvement and forced reunification therapy, the FCVFC noted the courts "preside over a captive audience of vulnerable participants where assets of wealth and property, as well as children, are subject to court authority," and found "family court, unrestrained … has been allowed to excise unlawful detention, sloppy legal processes, and the manipulation of so-called experts approved by the courts."

Courts have used their power to "extort a financial advantage over subjects … [through] unlawful practices which have combined and conspired to deprive innocent subjects of lawful defenses and the ability to protect children," the analysis states.

New Protections

Testifying before Arizona lawmakers earlier this year, Tori Nielsen helped convince them to ban reunification programs that prevent contact with the favored parent unless both parents agree. Gov. Katie Hobbs (D) signed the bill into law in April.

New Hampshire, Tennessee, and Utah also enacted legislation to limit court-ordered reunification therapy, requiring added scrutiny of such programs. California and Colorado halted the use of such programs in 2023.

The federal government, under the Keeping Children Safe from Family Violence Act, now provides federal funds to states to improve child custody laws to protect children, including limits on court-ordered reunification programs.

Government Overreach

The controversy over family reunification treatment programs is an example of increasing government control of family life, says educator and family rights expert Larry Sand.

"This is a classic example of the therapeutic state at work," said Sand. "Traditionally, the family, unless flagrant child abuse is apparent, has had the final say in issues that affect their kids."

In California, government intrusion into family life became obvious earlier this year with the passage of AB 1955, signed into law by Gov. Gavin Newsom on July 15, says Sand.

"This deplorable legislation bars school districts from requiring staff to notify parents if their child decides to change their gender," said Sand. "But even California now has passed a law restricting unification treatment."

As a Minnesota licensed marriage and family therapist, Ben Baker has provided therapy for a family that previously participated in reunification therapy.

"In general, if a parent proves, over an extended period, to be a safe adult and responsive to the physical, emotional, and relational needs of a child, then a parent-child relationship can be repaired," said Baker. "For a child to regain trust that a caregiver is safe and responsive can be a time-intensive and delicate process."

Rough Justice

Nielsen told the *Journal* her experience with the system was anything but delicate. The separation from her mother was abrupt, and the court failed to consider her wishes.

"Though situations vary widely, the developmental needs of a child, level of environmental support, mental health status, trauma history, and the willingness of both the parent and child contribute to the effectiveness of family therapy," said Baker. "A competent and ethical therapist would keep these factors in mind."

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

Psychiatric Hospitals Hold Patients Involuntarily—for Money

By Joe Barnett

In-patient mental health and drug abuse facilities across the country are holding patients involuntarily, now aided by a new Biden administration rule requiring insurers to cover the treatment equally with other hospital care.

An investigation by the U.S. Department of Justice alleges some in-patient facilities for psychological or drug abuse problems fraudulently kept people hospitalized to maximize reimbursements from government health programs, according to *The New York Times*.

"Acadia Healthcare, a nationwide chain of psychiatric hospitals, faces new federal charges after it just agreed to a nearly $20 million settlement over accusations it defrauded government health insurers by holding patients longer than necessary," states a *Times* article published on September 27.

ER Patients 'Locked In'

Some of Acadia's patients were held involuntarily in the first place, the *Times* reports.

"In at least 12 of the 19 states where Acadia operates psychiatric hospitals, dozens of patients, employees and police officers have alerted the authorities that the company was detaining people in ways that violated the law, according to records reviewed by The Times," states the article. "In some cases, judges have intervened to force Acadia to release patients."

This included individuals who did not consent to treatment, the *Times* reports.

"Some patients arrived at emergency rooms seeking routine mental health care, only to find themselves sent to Acadia facilities and locked in," the *Times* reported.

Second Opinion Needed

The providers who determine whether a patient should be hospitalized or treated on an outpatient basis have a financial stake in those treatment decisions, says Linda Gorman, director of the Healthcare Policy Center at the Independence Institute in Colorado.

"The problem with mental health [care] is that conditions generating payment are defined by a majority vote of the self-interested," said Gorman. "And so much of 'treatment' is ineffective and even may make things worse. Dropout rates for drug treatment are so high that many of the formal studies are uninformative."

Obamacare Parity Rule

Private insurers and health plans are required to provide equal coverage, or parity, for psychological and physical problems, under a series of increasingly exacting federal regulations covering annual and lifetime limits on benefits, narrow provider networks, and prior authorization requirements for treatment.

The U.S. Departments of Labor, Justice, and Health and Human Services published on September 9 a final rule implementing provisions of the Mental Health Parity and Addiction Equity Act of 2008, which were expanded by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010.

According to the Biden administration, the final rule bars health plans from using more restrictive prior authorization rules for mental health care than other care.

"[H]ealth plans need to evaluate their provider networks, how much they pay out-of-network providers, and how often they require—and deny—prior authorizations," states a White House factsheet published on September 9.

'Costly Compliance Hurdles'

Though mental health advocates applauded the parity rule, insurers are more cautious, says Pamela Greenberg, president and CEO of the Association for Behavioral Health and Wellness. The association includes mental health care plans such as Aetna, Optum, and Centene.

"We are concerned that provisions in the final rule, such as the material difference standard and meaningful benefits provisions, go beyond the law's intent and will create costly compliance hurdles that may negatively impact affordability and access to mental health and substance use disorder care," Greenberg said, according to *MedPage Today* on September 12.

Mental Health Is Different

Underlying parity is the costly and mistaken idea that psychological problems are always equivalent to medical conditions, says Gorman.

"We need to stop pretending that mental health and physical health are the same, stop funding self-interested research, and take a hard look at redefining what types of mental health conditions are serious enough to deserve taxpayer funding," said Gorman.

Mental health care is more vulnerable to overuse than other treatments tend to be, says Gorman.

"Most people do not like treatments for physical ailments and so have an incentive not to overuse it," said Gorman. "Mental health has different incentives because many people, especially adolescent girls, like the individualized attention that goes with diagnosis and talk therapy treatment. Schizophrenics, on the other hand, typically do have an identifiable physical illness, and often try to avoid treatment."

Joe Barnett **(joepaulbarnett@att.net)** *writes from Arlington, Texas.*

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LINDA GORMAN
DIRECTOR, HEALTHCARE POLICY CENTER
INDEPENDENCE INSTITUTE

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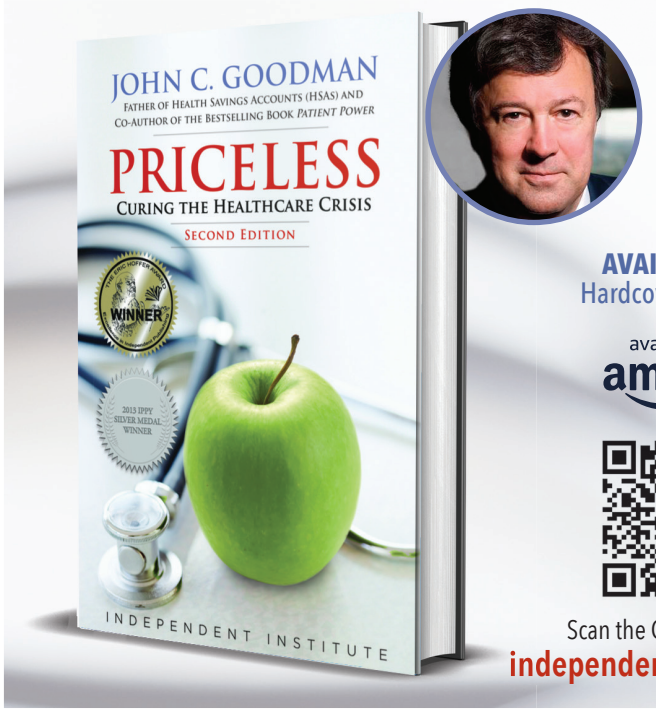

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PRICELESS

CURING THE HEALTHCARE CRISIS

SECOND EDITION

In this long-awaited **updated edition** of his groundbreaking work ***Priceless: Curing the Healthcare Crisis***, renowned healthcare economist **John C. Goodman** ("father" of Health Savings Accounts) analyzes America's ongoing healthcare fiasco—including, for this edition, the extra damage Obamacare has inflicted on America's healthcare system.

Goodman then provides what many critics of our healthcare system neglect: *solutions*.

If you read even one book about healthcare policy in America, this—once again—is the one to read.

Election Outcome Might Mean Big Changes in Medicaid

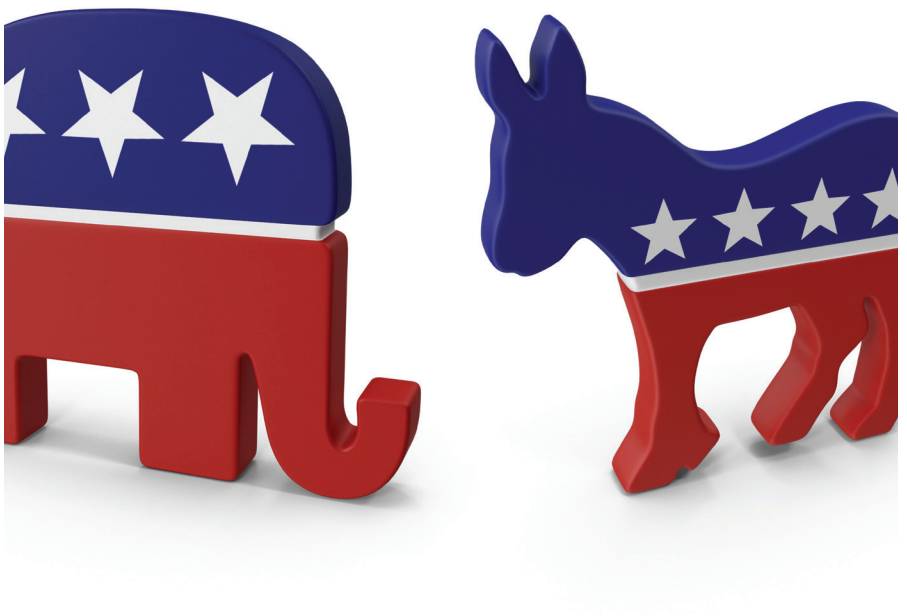
By Bonner Russell Cohen

Though it has received scant attention in this year's presidential campaign, Medicaid, the $600 billion federal program for lower-income people, could be in for big changes, depending on who is in charge at the White House and in Congress come January.

Some 81 million Americans are currently enrolled in Medicaid, a number that has expanded greatly since the 2010 enactment of the Affordable Care Act (ACA), which encouraged states to expand Medicaid.

Medicaid enrollment received a further boost during the COVID-19 pandemic as Congress incentivized states to keep lower-income people covered in exchange for increased federal funding.

"Since March 2024, states have been 'unwinding' the continuous enrollment provision, leading to more than 21 million people losing Medicaid coverage as of August 2024," the Commonwealth Foundation recently noted.



"J. D. Vance outlined a shift to the provider side of the equation. Vance proposed that states 'experiment a little bit on how to cover both the chronically ill [and] the non-chronically ill,' highlighting Trump's first-term success with waivers. Vance concluded, 'It's not just a plan. He actually implemented some of these regulations when he was president of the United States.'"

MATT DEAN
SENIOR FELLOW, HEALTH CARE POLICY
THE HEARTLAND INSTITUTE

Differences Over Eligibility

About three-quarters of Medicaid recipients are Democrats, the KFF research organization estimates. This gives Republicans and Democrats vastly different perspectives on the program. In addition, Medicaid is the single biggest federal source of revenue to the states.

The two parties' contrasting approaches to Medicaid eligibility are likely to drive change.

A Harris administration, with a substantial number of Medicaid recipients among its constituents, can be expected to try to expand Medicaid coverage and services. If this cannot be done legislatively (if, say, Republicans win control of the Senate), the White House could try to do this through the administrative rulemaking process. For example, Harris could loosen eligibility requirements for Medicaid enrollment.

Recent rulings by the U.S. Supreme Court, however, have curtailed the power of the administrative regulatory state, so any moves to expand the program beyond the language of the law could face a court challenge.

Federalism Alternative

A Trump administration would likely allow states to put stricter controls on eligibility and disenroll free riders who use programs they don't qualify for, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"Trump's first term emphasized fraud deterrence and private health care plans," said Dean. "A second Trump term could embrace federalism in a much bigger way."

The vice-presidential debate provided clues about Trump's likely approach, says Dean.

"J. D. Vance outlined a shift to the provider side of the equation," said Dean. "Vance proposed that states 'experiment a little bit on how to cover both the chronically ill [and] the non-chronically ill,' highlighting Trump's first-term success with waivers. Vance concluded, 'It's not just a plan. He actually implemented some of these regulations when he was president of the United States.'"

Allowing states to have a larger say in how they manage their Medicaid programs could be a centerpiece of a second Trump term. Those efforts could also face court challenges, as they did in Trump's first term.

Possible Waiver Battle

In a September 12 blog post for KFF, Drew Altman, the CEO and president of the organization, said states may press for freedom from federal rules on Medicaid eligibility and other major elements of the program's structure.

"The most likely result is a big debate and retreat to 'Waiver-land,'" wrote Altman.

Medicaid Section 115 gives the Centers for Medicare and Medicaid Services authority to allow states to change certain rules upon request. Waivers offer numerous possibilities through somewhat convoluted ways to restrict Medicaid eligibility, Altman says.

"Watch for waivers for time limits and work requirements (currently in place only in Georgia)," wrote Altman. "[Watch] for premiums for beneficiaries. And for time limits on Medicaid eligibility. Even potentially to block grant the program in a state. There would be legal challenges to these waivers, opening up a new battleground in the arcane, inside baseball world of waivers that can have huge implications for people and for policy precedent."

State Innovation Advantages

Innovative use of Medicaid waivers could do much good, says Gary Alexander, director of the Medicaid and Health Safety Net Reform Initiative at the Paragon Health Institute.

"For a new president, reforming Medicaid is essential to ensure sustainability for those most in need," said Alexander. "Waivers like the 2009 Rhode Island Global Medicaid waiver proved that when states are given flexibility to manage their own programs, they can reduce costs while improving care.

"By capping federal spending and allowing the state to innovate, Rhode Island was able to streamline services, cut waste, and better meet the needs of Medicaid recipients," said Alexander. "This model demonstrates that flexibility coupled with an aggressive cap can be a powerful tool for Medicaid to become more efficient and sustainable."

Minnesota Model?

Minnesota provides a picture of what might be in store with a Harris administration, says Dean.

"Gov. Walz, now Harris' running mate, reinstated a 'sick tax' on health care providers in Minnesota—his Democratic predecessor Mark Dayton had killed the tax—to expand eligibility for public programs," said Dean. "Walz also supported efforts for a 'public option' that would allow anyone to buy into taxpayer-supported health care plans and expanded access to public plans to some illegal immigrants, while slow-walking eligibility redetermination.

"Generally, Walz followed the traditional path of more people on public plans with fewer options and less accountability for fraud," said Dean.

The election could also determine the separate but related issue of what to do about the enhanced Obamacare premium subsidies, which are set to expire at the end of 2025. Democrats favor extending the subsidies; Republicans generally do not.

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

INTERVIEW

Assembly Line Medicine Weakens Doctor-Patient Relationships, Patients' Health

Editor's Note: On July 31, JAMA Network published the results of a survey that found patients' trust in doctors and hospitals dropped 31 percentage points from April 2020 to January 2024. The findings came as no surprise to Chad Savage, M.D., founder of a direct primary care (DPC) practice, president of DPC Action, and a policy advisor to The Heartland Institute, which co-publishes Health Care News*. We talked with Dr. Savage about why trust in doctors is declining and what effects it is having.*

Health Care News: A recent study showed that doctor trust has plummeted, especially during the pandemic years. Do you believe the pandemic is largely to blame for patients' loss of trust, or could something else be happening?

Savage: This is a complex issue with clear financial conflicts of interest in medicine, where a doctor's self-interest can sometimes clash with the patient's best interests, eroding trust. The third-party payer system, meaning insurance companies and the government, has become deeply intertwined with the actual provision of care.

These entities often dictate the pace at which doctors see patients, the tests they can order, and the treatments they can prescribe. This loss of autonomy diminishes the doctor's role and accelerates the pace of visits, hindering the development of a trusting doctor-patient relationship.

Health Care News: One could argue health care resources are limited and efficiency in a practice is a good thing. What problems does the loss of trust create?

Savage: Loss of trust is highly detrimental because a patient's adherence to treatment protocols is closely linked to the trust they have in their physician. Furthermore, when patients don't understand the reasons behind their treatment plans, they are less likely to follow them. If given sufficient time, doctors can more thoroughly explain their reasoning, thereby improving patient compliance.

The abbreviated visits incentivized by the third-party system have also led to greater pharmaceutical prescribing. Time-constrained physicians may see prescribing medication as the quickest route to the next exam room, rather than focusing on the more time-consuming task of lifestyle modification.

This excessive prescribing feeds into the perception that physicians are in collusion with pharmaceutical companies, when in reality they may simply be rushed and overwhelmed by the demands of a bureaucratized health care system.

Health Care News: What role do health insurance plans play in influencing practice behavior?

Savage: As mentioned earlier, direct financial conflicts of interest do exist between doctors and patients. The seemingly appealing "pay-for-performance" insurance payment programs can incentivize physicians to avoid the sickest patients, who might negatively impact their scores and thus reduce their reimbursements. Additionally, "performance" as defined by insurance companies may not be what patients consider performance.

Doctors may be rated by insurance companies based on their ability to defend insurance companies' coffers, whereas patients may consider a doctor high-performing based on their advocacy for the patient's best interest. For instance, doctors may receive higher compensation by denying expensive tests like MRIs, potentially putting their self-interest in conflict with the patient's best interest.

Such conflicts of interest should have no place in the medical system. Even if a doctor is altruistic and strives to remain unbiased, the mere existence of these incentives can erode patient trust. Patients now must question the doctor's motivation behind their recommendations.

This is just the beginning. I could write a textbook on this topic, without even touching on the corruption in licensing that was used to force doctors to adhere to specific narratives during COVID, or the censorship of doctors with opposing viewpoints creating the false impression of uniformity of opinion from the perceived health care monolith.

Health Care News: If patients understood these forces, would that be enough to restore trust, or do physicians have some responsibility here?

Savage: These issues have collectively eroded, in just a few short years, the hard-earned trust that physicians have built over a millennium. As mentioned, this loss of trust will lead to reduced patient participation in their treatment plans. Fewer cancers will be detected, and there will be increased illness and death.

Doctors must vigorously oppose the forces that have undermined this trust and work to reestablish the altruistic relationships upon which our patients' health depends. This starts with eliminating the trust-eroding third parties from the doctor-patient interaction.

COMMENTARY

Managerialism Is Destroying Medicine

By Aaron Kheriaty, M.D.

Americans are rapidly losing trust in the medical profession.

The percentage of U.S. adults who are confident medical scientists act in the best interests of the public declined from 40 percent in 2020 to 29 percent in 2022, according to Pew research.

A 2021 survey by the American Board of Internal Medicine found one-in-six people—including physicians—no longer trust doctors, and one-in-three do not trust the health care system. Almost half the population does not trust our public health agencies to act in their best interests.

Doctors are leaving the profession in droves. One-in-five doctors plan to leave the medical field in the next two years, and one-in-three intend to reduce their working hours over the next year, according to the American Medical Association.

Why is medicine today failing many of its brightest students and pushing large numbers of its best-seasoned practitioners into early retirement?

The answer is complex and multifaceted, but a major contributing factor is the managerial revolution in medicine.

"What primarily ails medicine today is not just technical problems or eco- nomic challenges, important as these are to address. Our deepest problems are philosophical, fueled by ideologies that distort the nature and purpose of medicine."

AARON KHERIATY, M.D.
PSYCHIATRIST

Technocratic Scientism

Since World War II, medicine, like many other institutions, has succumbed to managerialism: the unfounded belief that everything can and should be deliberately engineered and managed from the top down. Managerialism is destroying good medicine.

The managerialist ideology consists of several core tenets, according to social thinker N. S. Lyons. The first is Technocratic Scientism, the belief that everything, including society and human nature, can and should be fully understood and controlled through materialist scientific and technical means, and that those with superior scientific and technical knowledge are therefore best-suited to govern.

In medicine, this manifests in the metastatic proliferation of top-down "guidelines" imposed on physicians to dictate the management of various illnesses. These come not just from professional medical societies but also state and federal regulators and public health agencies. In 1990, the number of available guidelines was 70; by 2012 there were more than 7,500.

"Guideline" is in fact a euphemism obscuring their real function: they control physicians' behavior by dictating payments and reimbursement for achieving certain metrics.

Utopian Progressivism

The second tenet of our managerial ideology is Utopian Progressivism, the belief that a perfect society is possible through application of scientific and technical knowledge and that the arc of history bends toward utopia as more expert knowledge is acquired.

Promising to deliver miracles only sets up physicians for failure and patients for disappointment. When the promised miracles fail to materialize—an incurable cancer is every bit as incurable at Hopkins as it was at your local community hospital—patients feel betrayed.

A humble and realistic acknowledgment of the limits of medicine is a necessary starting point for any sane and sustainable health care system. Doctors are not miracle workers, much less gods. Science cannot save us.

Liberationism

The third feature of the ideology is Liberationism, the belief that people are held back by the rules, restraints, relationships, historical institutions, communities, and traditions of the past, all of which are necessarily inferior to the new, and which we must be liberated from to move forward.

At its foundation, medicine relies on a particular kind of relationship, one based on trust between a patient made vulnerable by illness and a doctor who uses his knowledge and skills always and only for health and healing.

Liberationism seeks to "free" medicine from these constraints. Why should physicians pursue only health and healing? In addition to making the sick well, we can make the healthy "better than well." Through hormones, gene editing, or psychopharmacology, we can make short people tall, weak people strong, and average people more intelligent. These projects of "human enhancement" will explode the boundaries of medicine and liberate man from the constraints of human nature, the story goes.

To take a contemporary example, "gender affirming care" is quickly crumbling under the weight of evidence showing puberty-blocking hormones, cross-sex hormones, and surgeries that destroy healthy reproductive organs have not improved the mental health outcomes of gender dysphoric youth.

Homogenizing Universalism

Homogenizing Universalism, the fourth tenet, is the belief that all human beings are fundamentally interchangeable units of a single universal group and that systemic "best practices" discovered by scientific management are universally applicable in all places and for everyone.

As with the "clinical guidelines" discussed above, medicine has had a recent explosion of so-called quality metrics. These measures, also numbering in the thousands, cost each physician at least $40,000 a year to manage—costs that get passed on to patients.

None of this improves medical outcomes. In fact, the metrics often worsen outcomes by mandating a one-size-fits-all approach to clinical care.

Homogenizing universalism has led to preventative overprescribing. In the United States, 25 percent of people in their 60s are on five or more long-term medications, rising to 46 percent of people in their 70s, and 91 percent of nursing home residents.

Medicine's Biggest Challenge

What primarily ails medicine today is not just technical problems or economic challenges, important as these are to address. Our deepest problems are philosophical, fueled by ideologies that distort the nature and purpose of medicine.

Will we recognize that the managerialist ideology undermines medicine's goals of health, and summon the will necessary to cut away the excrescences that undermine the ability of physicians to heal?

Aaron Kheriaty, M.D., (**akheriaty@icloud.com**) *is a psychiatrist and a former professor of psychiatry and director of medical ethics at the University of California-Irvine.* *A version of this article was published by the Brownstone Institute. Reprinted with permission.*

Pharma Giant Pfizer Launches Health Care Hub

By Ashley Bateman

Pfizer is getting into the health care delivery business.

The company announced the launch of PfizerforAll, an initiative to combine health care services, medication, and vaccinations through an online platform. Pfizer leads the world in pharmaceutical sales.

PfizerforAll will work within the existing health care system to make "managing everyday health quicker and more convenient for millions of Americans," a Pfizer press release stated on August 27.

Pfizer is marketing the program to patients seeking vaccines and treatment for migraines, discounts on Pfizer medications, and an "easier" way to connect with a health care provider.

PfizerforAll promises same-day appointments with independent health care professionals and home delivery of prescription medicines, over-the-counter treatments, and diagnostic tests. Patients can also access vaccines by appointment locally through the site.

PHOTO COURTESY JANOS KOROM/FLICKR.COM

"It's more marketing, but Pfizer is also finding a niche they can exploit because people are dissatisfied with the timeliness of care. This is a pilot program for them, and if they are successful, they will [expand]."

TWILA BRASE
FOUNDER AND PRESIDENT, CITIZENS' COUNCIL FOR HEALTH FREEDOM

"As one might expect, the emphasis is on selling vaccines and Pfizer meds," said Dr. Jane Orient, executive director of the Association of American Physicians and Surgeons. "It promises an 'independent doctor,' but for whom is the doctor working?"

Public Dissatisfaction

Pfizer cites a recent poll by the American Academy of Physician Associates in which most respondents said U.S. health care is too complicated and time-consuming and does not meet their needs. Most of those surveyed also expressed interest in increased digital management of their care.

"People often experience information overload and encounter roadblocks when making decisions for themselves or their family in our complex and often overwhelming U.S. healthcare system," said Aamir Malik, a Pfizer executive vice president and chief U.S. commercial officer, in a news release. "This can be extremely time-consuming and lead to indecision or inaction—and as a result, poor health outcomes."

Revenue Pressure

Pfizer's revenue from pharmaceuticals declined by 42 percent in 2024, while other top-10 drug companies had minor dips or increases in sales. Similarly, vaccine-focused Moderna has suffered stock drops.

Drug makers have been struggling to justify massive investments in new treatments for common diseases. In 2009, Pfizer paid $2.3 billion to settle civil and criminal charges related to the misbranding of several drugs and giving kickbacks to providers.

"Since then, the company has discovered that the most profitable substances are not pharmaceutical products, but vaccines for which the company bears no product liability and for which it can easily persuade the governments of the world to foot the bill," wrote blogger John Leake in a September 11, 2024 post with Peter McCullough, M.D. at *Courageous Discourse*.

Funneling patients toward Pfizer purchases and matching patients with providers on the PfizerforAll platform is a way to broaden the company's reach, says Twila Brase, cofounder and president of the Citizens' Council for Health Freedom.

"This is just a different angle on the corporatization of care, a marketing strategy," said Brase. "This is Pfizer trying to snatch part of the health care delivery market."

Capitalizing on Dysfunction

Many Americans are looking for nontraditional access to health care as the health care market remains plagued by provider shortages, limited access, and rising costs.

"Because of the corporatization of health care—so many doctors are corporatized, on quotas, and scheduled—and Obamacare has consolidated health care, there are just fewer slots for patients to fit into in a doctor's office," said Brase. "So, people are looking for a quick fix for certain conditions and certain situations."

The Pfizer initiative will not help make health care more personal, says Brase.

"This is an entire movement to an impersonal Pfizer from a personal relationship with a doctor who knows you," said Brase. "It's more marketing, but Pfizer is also finding a niche they can exploit because people are dissatisfied with the timeliness of care. This is a pilot program for them, and if they are successful, they will [expand]."

New Avenues for Profits

Other big companies have tried to gain a slice of the health care market through online platforms in recent years.

In 2023, Whole Foods founder John Mackey launched Love.Life, a "health and wellness company" providing access to online practitioners licensed across the states through a "cash-only" service. That same year, Amazon acquired One Medical, a large, membership-based primary care company offering same-day virtual care.

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

COMMENTARY

Empowerment Accounts Can Fix Restrictive HSAs

By Robert Koshnick, M.D.

In the early 1970s, Paul Ellwood, M.D., the "father of the HMO," convinced President Richard Nixon that physicians who owned their clinics were greedy entrepreneurs.

Ellwood's solution, to have corporations manage people's health care expenditures, led to the HMO Act of 1973. Health maintenance organizations (HMOs) were given the right to practice medicine and provide insurance without a license to do either.

What emerged was the profit-driven corporatization of medicine, one of the main reasons health care costs are at the staggering $4.5 trillion we see today (as of 2022).

People are incredulous when I tell them I made a good living in 1974 charging $6.50 for an office call. I delivered a lot of babies and did various surgeries in my single physician office in Perham, Minnesota, a town of about 2,000 people. I did not have to charge much to make a living because my overhead was very low—office rent, a receptionist, malpractice insurance, and a licensed practical nurse—and documentation requirements were minimal.

Robert Kocher, M.D., one of the architects of the Affordable Care Act, published an article in 2013 in the *Harvard Business Review*, titled "The Downside of Medical Care Job Growth." Kocher showed that 95 percent of the growth in health care system workers in the United States from 1990 to 2012 were non-provider workers, and the median cost of non-doctor expenses averaged $823,000 per physician in 2013. The 906 pages of the ACA added considerably more to medical care operational costs.

Third-Party Payer Mayhem

Under the current system, 90 percent of health care is paid by the government or a private insurance company. The government aims to control costs by outsourcing management to third parties such as health maintenance organizations, accountable care organizations, and other corporate management entities such as Medicare Advantage Plans.

Anytime the government tries to control a market, the controlled parties will find workarounds. Health care is no exception. These organizations find ways to manipulate reimbursements, which drives up costs without producing better health outcomes.

There is a limit to what the government can pay out. The solution at that point is to ration care. That is happening right now: shrinking provider networks, longer wait times for appointments, and delays for "prior authorizations" (approvals providers must get from payers before a claim can be paid).

Over time, this financial pressure makes it difficult for practices to update their technology and maintain facilities.

Private insurance companies, such as those on the Obamacare exchanges, have an incentive to increase costs. Obamacare restricts administrative fees on plans to 15 percent but allows higher government subsidies when premiums increase.

HSAs to the Rescue, Maybe

One way Congress has tried to fix the third-party payer mess is by authorizing health savings accounts (HSAs). The idea is to reward consumers by allowing them to keep money not spent on unnecessary health care. These accounts can grow over a lifetime and be used for bigger health care expenses in the future or upon retirement.

An HSA, however, must be paired with a high-deductible, employer-sponsored insurance plan, making it incompatible with non-employer plans such as those on the Obamacare exchanges. HSAs are also not available for people on Medicaid or Medicare, and account holders face a 20 percent penalty for non-medical withdrawals.

A Better HSA?

In 2023, the Hoover Institution proposed Individual Health Accounts (IHAs), an enhanced HSA-type account that would be available to most individuals. Out-of-pocket individual contributions to the accounts would be tax-deductible, reducing the tax filer's adjusted gross income. Hoover suggests contribution limits could be increased to the average cost of an employer-sponsored insurance plan, which according to KFF was $23,968 in 2023. That is much more than what is allowed for HSAs.

Money withdrawn from the accounts would be taxable, but there would be no penalty for early withdrawal as with HSAs. The only requirement would be that people buy some form of catastrophic health care coverage.

Employers would have several options. They could continue to manage their employees' insurance coverage, contribute money to employees' IHAs, or increase their employees' pay in lieu of paying directly or indirectly for their health insurance. Employee contribution limits would be reduced by the amount of employer contributions.

The payroll tax exclusion for employer-sponsored insurance (ESI) costs taxpayers $299 billion per year (2022 figures) and incentivizes employers to purchase high-premium health insurance. Under IHAs, this tax break would shift to individuals when they make contributions to their accounts.

Integration with Government Plans

The Hoover Institution suggests states should be allowed to reform the ACA marketplace plans and related regulations within Medicaid and Medicare to allow integration with IHAs.

Medicaid expenditures per person vary by state, ranging from $7,522 (Utah) to $14,007 (New York), according to the Centers for Medicaid and Medicare Services. The 2023 Medicare Trustee report states the average per person expenditure for that program is $15,727. The government could allow people to opt out of these programs and put that money in IHAs.

Exploding health care spending is pushing the nation into deeper debt and driving state taxes higher. IHAs are a solution, but they deserve a more powerful and accurate name: Empowerment Accounts.

Robert Koshnick, M.D. **(bob.koshnick@gmail.com)** *is a retired family medicine physician from Detroit Lakes, Minnesota, program director for the MN Physician-Patient Alliance (physician-patient.org), and author of the 2022 book* Empower-Patient Accounts Empower Patients!

INTERNET INFO

Lanhee Chen, Tom Church, and Daniel Heil, "Choices for All," Hoover Institution, July 2023: **https://www.hoover.org/sites/default/files/2023-07/Choices%20for%20All.pdf**

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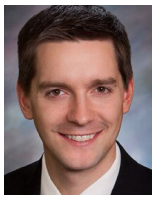

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