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The Pulse

President Donald Trump

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Will Republicans Try Again to Repeal Obamacare?

By Bonner Russell Cohen

With Donald Trump having won the presidency and Republicans capturing majorities in the House and Senate, the prospect of repealing Obamacare is back on the table.

The Republicans' razor-thin majority in the House and filibuster-vulnerable 53-47 margin in the Senate will make it difficult to pass a sweeping overhaul of Obamacare. The current situation resembles the state of affairs at the beginning of Trump's first term in 2017, when Republicans controlled the House, the Senate, and the White House but failed to repeal and replace the Affordable Care Act (ACA).

OBAMACARE, p. 4

Trump Nominations Signal Major Health Care Policy Changes

By Kevin Stone

President-elect Donald Trump will press for major reforms to the trillion-dollar U.S. health care industry, a series of provocative, high-profile health care leadership nominations indicates.

Trump's nominee for Health and Human Services (HHS) secretary, Robert F. Kennedy Jr., is a staunch critic of big pharma, vaccine schedules, chemical food additives, and more. Martin Makary, M.D., nominated to head the U.S. Food and Drug Administration (FDA), is

NOMINATIONS., 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

Roth IRAs

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

2

Social Security

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

3

401 (k) Plans

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

4

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Biden's Short-Term Plan Limit Roils Insurance Markets

By AnneMarie Schieber

The "ping-ponging" of rules on short-term, limited-duration health insurance (STLDI) is wreaking havoc on underwriting in the insurance markets, said panelists in a discussion hosted by the Cato Institute on October 15, 2024.

The focus of the discussion was President Joe Biden's new rule limiting the duration and renewability of STLDI. President-elect Donald Trump or a new Congress could reverse the rule, or it could be challenged in court.

In his first administration, Trump issued an executive order allowing states to offer the plans for one year and renewable for three years beyond that, a rule that held up in court.

In July 2024, President Joe Biden reversed the rule, limiting the plans to four months with no option to renew. The change strips the plans of any value because if someone gets sick, the policyholder could wait up to one year before being able to jump onto an Obamacare plan.

Michael Cannon, Cato's director of health policy studies, led the discussion. The panelists were Natasha Murphy, director of health policy at the Center for American Progress, and Sal Nuzzo, executive director for Consumers Defense.

President Joe Biden

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"There has always been an incentive for insurers to skimp on care for the sick," said Cannon. "What Obamacare's preexisting conditions [rule] did was to take away what was once an option for insurers—to shortchange their enrollees—to now make it mandatory."

MICHAEL CANNON
DIRECTOR OF HEALTH POLICY STUDIES
CATO INSTITUTE

Different Standards Applied

STLDI represents a small slice of the insurance market, said Cannon at the discussion. An estimated three million people are enrolled in such policies.

The plans are far more affordable than non-subsidized Obamacare plans but don't cover preexisting conditions and options such as mental health. Obamacare supporters attack the plans as "junk insurance."

"If that sort of imperfection means a product is bad or dangerous, Congress should ban it or slap a warning label on it, but then we should apply that rule consistently, to Obamacare plans," said Cannon at the discussion.

Obamacare plans offer little variation in coverage and have become a "race to the bottom" with increasingly narrow networks, Cannon told the audience. The rule that Obamacare plans must cover everyone, regardless of risk, becomes in effect a price control because insurers cannot charge more money to higher-risk enrollees, said Cannon.

"There has always been an incentive for insurers to skimp on care for the sick," said Cannon. "What Obamacare's preexisting conditions [rule] did was to take away what was once an option for insurers—to shortchange their enrollees—to now make it mandatory."

Beefing up Obamacare

Murphy said Biden's restriction on short-term plans is intended to encourage people to enroll in Obamacare plans.

"When you take a look at some of the people enrolled in [STLDI], they can be younger, lower-income, who are price-sensitive, who find these lower premium amounts enticing," Murphy told the audience. "We don't want to leave people in these plans longer than they should have to [be], to protect them."

Biden's removal of renewability "does exactly what Congress has been trying to prevent for the 30-some years it has been regulating," because it exposes consumers to big gaps when it is impossible to get coverage, Cannon told the gathering. The renewal feature "is a product intended to fill gaps in coverage," said Cannon.

"I think the [Biden] rule is vulnerable to a legal challenge, particularly after the recent Supreme Court ruling in *Loper* v. *Bright*, because the agencies have no authority to regulate, much less ban [renewability]," said Cannon.

The Loper case was a landmark 2024 Supreme Court decision that limited federal agencies' latitude in interpreting Congress' intent.

Let's Make a Deal

Congress could make the Trump rule permanent as a tradeoff for Obamacare subsidy hikes, Cannon told the audience.

"There will be a debate in 2025 about enhanced Obamacare subsidies," said Cannon. "Maybe there should be a deal, a reauthorization of the subsidies for a limited time, and codify the Trump rule."

Nuzzo said he would prefer an even playing field in the insurance market. Employers get tax incentives to provide health care when the self-employed or unemployed don't.

Germany allows a market for health insurance with no price controls, "where insurers can risk-rate their premiums and then offer renewal markets," Cannon said. The same approach could work in the United States, Cannon told the audience.

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

Will Republicans Try Again to Repeal Obamacare?

President Donald Trump

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Continued from page 1

Obamacare Power

Ten years after passage of the ACA, Obamacare has a strong grip on the nation's health care system, reaching deep into Medicaid, the individual market, and employer-provided health insurance, further complicating prospects for reform.

Less than a week before the November 5, 2024 election, House Speaker Mike Johnson (R-LA) told reporters the ACA is "deeply ingrained" and would require "massive reform," while saying the GOP's Doctors Caucus has been working on reform proposals.

In May 2023, Rep. Pete Sessions (R-TX) introduced the Health Care Fairness for All Act, an extensive health care reform bill that would expand personal choice in health care.

The bill would provide a tax credit to purchase insurance on the individual market or deposit in a health savings account (HSA). The bill failed to gain traction and would have to be reintroduced in a new Congress.

High Costs

Despite the obstacles, there is a strong case for reforming Obamacare, says John C. Goodman, president of the Goodman Institute for Public Policy and co-publisher of *Health Care News*.

"I am sure Republicans will try to cut the expanded subsidies for Obamacare. It's possible Republicans will also try to cut back some of the mandates in Obamacare, such as free contraceptives and the mandate to cover every contraceptive. Before the ACA, most insurers covered some, but usually not all, contraceptives, with a small copay."

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

"Obamacare is costing roughly $240 billion a year," Goodman wrote at *Forbes* before the election. "Yet we are not getting any additional health care. … Doctor visits per capita for the country as a whole have actually gone down, and visits to the emergency room haven't changed.

"The original promise of Obamacare was to insure the uninsured with private health insurance," wrote Goodman. "In fact, almost all the increase in health insurance under Obamacare has been an increase in Medicaid."

Deductibles in the insurance plans offered on the exchanges are two or three times higher than those in most employer plans, Goodman notes.

"The typical plan sold in the [Obamacare] exchange looks like Medicaid with a high deductible," wrote Goodman. "It is not accepted by many doctors and medical facilities, and if enrollees go out of network, the plans usually pay nothing."

Market 'Thoroughly Destroyed'

Although a sweeping overhaul of Obamacare is unlikely and probably not possible, Congress could pass reforms to repair some of the damage, says Devon Herrick, Ph.D., a health economist and policy adviser to The Heartland Institute, which co-publishes *Health Care News*.

"Obamacare so thoroughly destroyed the health insurance market that it would be impossible to go back to risk-related health coverage," said Herrick. "I suspect Trump will tinker around the edges, possibly scaling back Biden's premium subsidies. The Trump administration will possibly enforce greater transparency and maybe address shortcomings in the No Surprise Act.

"One area of consensus is the need to enact site-neutral payments," Herrick said. "A real concern is that Trump's picks to run the Department of Health and Human Services, Robert F. Kennedy Jr., and Centers for Medicare and Medicaid Services, Mehmet Oz, M.D., do not have a history of advocating for market-based health reform."

Other Reforms Possible

Congress might try to move forward by increasing the allowable size of HSAs, says Merrill Matthews, Ph.D., a scholar at the Institute for Policy Innovation.

"That essentially allows employers to deposit all of the money an employer spends on an employee's health insurance into an HSA, and then the employee can buy his own health insurance from the account," said Matthews.

Congress might also loosen the restrictions the Biden administration put on association health plans, says Matthews.

"There has been a decades-long effort to allow trade associations to offer self-funded health insurance coverage as large employers offer," said Matthews. "That allows the associations to bypass some government-imposed mandates."

Association health plans would expand the availability of more affordable insurance large employers can offer because of the much bigger risk pools.

Congress could also remove restrictions on short-term plans (see related article, page 3) and "allow that market to create and offer policies people want, though still generally for shorter terms," said Matthews.

Action Expected

In any case, Congress and Trump will not ignore health care, says Matthews.

"I am sure Republicans will try to cut the expanded subsidies for Obamacare," said Matthews. "It's possible Republicans will also try to cut back some of the mandates in Obamacare, such as free contraceptives and the mandate to cover every contraceptive. Before the ACA, most insurers covered some, but usually not all, contraceptives, with a small copay."

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

Looking Back: How Obamacare Escaped Repeal

In 2017, House Republicans voted to scrap the Obamacare individual mandate and phase out the ACA's Medicaid expansion.

Using the legislative procedure known as budget reconciliation, which requires only 51 votes for passage, Senate Republicans tried to pass a bare-bones repeal of Obamacare. The effort failed when three Republicans—Lisa Murkowski (AK), Susan Collins (ME), and John McCain (AZ)—joined all 48 Democrats in voting no. The Senate repealed the individual and employer mandates but left the rest of Obamacare largely in place.

—Bonner Russell Cohen

Is Execution in Shaken Baby Syndrome Case a Certainty?

By Joe Barnett

A medical expert's testimony on Shaken Baby Syndrome (SBS) in a 2003 capital murder trial in Texas and the state's "junk science" law have played a prominent role in legal maneuvers to stop a scheduled execution.

Robert L. Roberson, age 58, received the death penalty for the capital murder of his two-year-old daughter, Nikki Curtis, and was scheduled for execution on October 17. The Texas Supreme Court temporarily halted Roberson's execution after the Texas House Criminal Jurisprudence Committee subpoenaed him to testify.

On November 15, the court rejected a petition from the committee to delay the execution until after the next Regular Session of the State Legislature begins in January.

The delay would allow the lawmakers to consider legislation that would require a new trial in such cases, the petition said. The court noted there is ample time for the committee to hear Roberson's testimony, as a new execution date will not be set for at least 90 days after the original date.

"Dr. John Caffey wrote that subdural bleeding in the absence of external evidence of trauma is an extraordinary diagnostic contradiction, and in an effort to resolve the paradox he published an idea called the whiplash shaking infant syndrome. The problem is when you examine the anatomy of the dura, there is no paradox: bleeding can occur around the brain in the dura without trauma."

JULIE MACK, M.D.
PEDIATRIC RADIOLOGIST

Diagnostic Controversy

Roberson's 2003 trial included testimony by a medical expert who diagnosed Curtis's death as a case of SBS, based on medical imaging at the hospital where she died.

SBS is a diagnosis proposed by the pediatric radiologist John Caffey, M.D., in the early 1970s to account for specific symptoms in the absence of external evidence of injury in infants. The diagnostic protocol identifies three symptoms: subdural bleeding, brain swelling, and retinal hemorrhages.

By the 1990s, law enforcement and medical professionals were taught to look for signs of SBS in cases of injured infants, which could trigger police investigations leading to criminal prosecution.

Dueling Explanations

There is scant scientific evidence for SBS, says pediatric radiologist Julie Mack, M.D., who discussed the Roberson case in a Cato Institute webinar on October 2.

"Dr. John Caffey wrote that subdural bleeding in the absence of external evidence of trauma is an extraordinary diagnostic contradiction, and in an effort to resolve the paradox he published an idea called the whiplash shaking infant syndrome," Mack told the audience.

"The problem is when you examine the anatomy of the dura, there is no paradox: bleeding can occur around the brain in the dura without trauma," said Mack.

SBS due to child abuse is an accepted medical diagnosis, and physicians should look for symptoms, according to the National Institute of Neurological Disorders and Stroke.

Junk Science Accusation

Over the past three decades, thousands of convictions for child abuse and murder have been based on SBS diagnoses, according to the Innocence Project (IP), a legal advocacy group. The convictions of several individuals were overturned after appeals showed the alleged injuries could have other causes, such as chronic or acute illness or previous, undiagnosed traumatic injuries.

Roberson's attorneys contend Curtis died of complications of severe pneumonia and there was no physical abuse.

On October 10, 2024, the Texas Court of Criminal Appeals (TCCA), which is coequal with the state Supreme Court, rejected Roberson's petition for a new trial based on Texas' 2013 "junk science" law, which allows prisoners to appeal convictions by showing new scientific evidence or changes in forensic science would have led to a different outcome.

ME Testimony Support

Evidentiary hearings in the Roberson case in 2018 and 2021 produced "mountains of evidence" the TCCA has ignored, the IP says.

"But even if we set to one side—for the moment—the evidence of shaking, the evidence also showed multiple impacts to Nikki's head," wrote Criminal Appeals Court Judge Kevin Yeary in a concurring opinion. "At trial, Dr. Jill Urban [the medical examiner] testified that she was confident, given the separate areas of dense hemorrhage in different areas of the head, that there were 'multiple blows to different points on the head.' Urban concluded the victim died as a result of 'blunt force head injuries.'"

A 2006 murder conviction in another SBS case was overturned by the Michigan Supreme Court in July. In a Texas conviction for nonlethal injury of a child that was based solely on an SBS diagnosis, the TCCA granted a new trial to Robert Roark on October 9. Dallas County District Attorney John Creuzot announced on November 18 he would not retry the case.

Law Requires Second Opinions

Texas state Rep. Stephanie Klick (R-District 91), a registered nurse, told *Health Care News* expert testimony on SBS played a prominent role in the Roberson case and other child-abuse convictions.

"A lot of these convictions are based on the testimony of certified child abuse pediatricians, of which there are about 25 in Texas," said Klick.

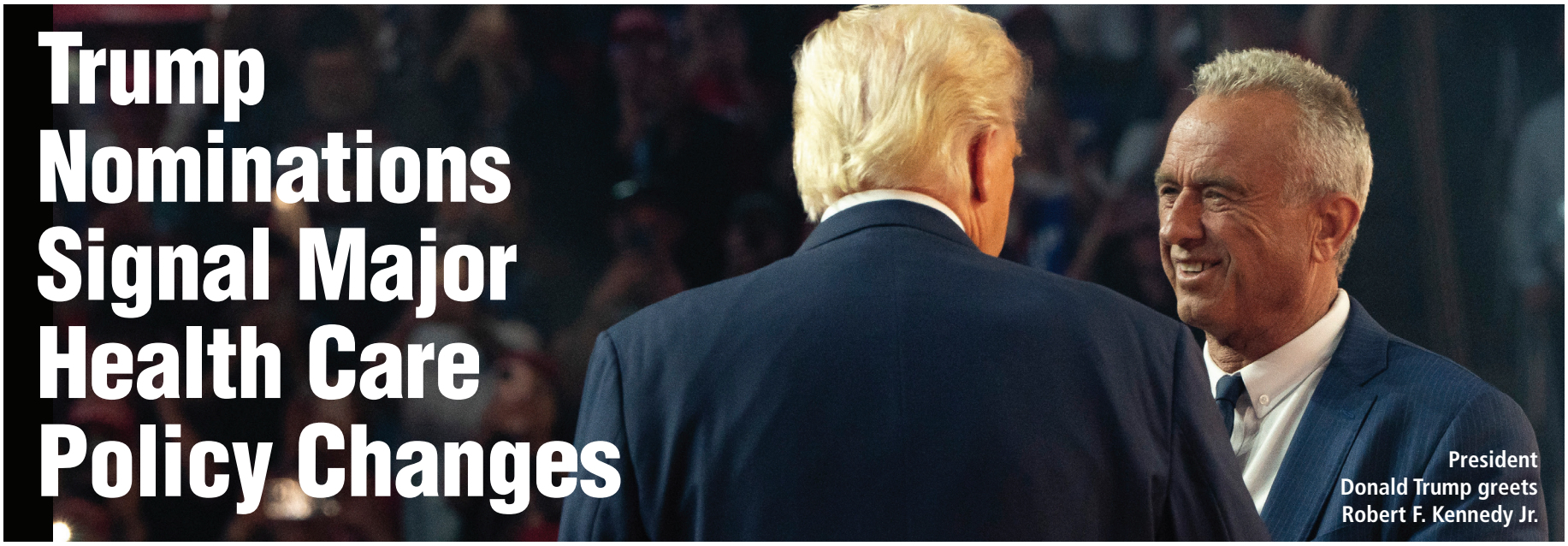
Numerous parents have lost custody of their children because of physicians' incorrect diagnoses of SBS or other child abuse, says Klick.

"In one case in which I was involved, a couple lost custody of their child based on a shaken baby diagnosis when they took their child to an emergency room five days after a traumatic birth with neurological problems," said Klick. "It took them a year to get her back."

Klick cosponsored a bill, enacted in 2023, that requires a second medical opinion before the state can remove children from parents suspected of child abuse.

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

Trump Nominations Signal Major Health Care Policy Changes



President Donald Trump greets Robert F. Kennedy Jr.

PHOTO COURTESY REBECCA NOBLE/STRINGER/GETTYIMAGES

Continued from page 1

noted for his contrarian views on pandemic lockdown policies, especially while he held a prominent position at Johns Hopkins Medical School. Makary recently wrote the book *Blind Spots*, in which he criticized "groupthink" in health care.

Trump nominated Jay Bhattacharya, M.D., Ph.D., to head the National Institutes of Health. Bhattacharya, a physician and epidemiologist at Stanford University Medical School and author of the Great Barrington Declaration, was a leading voice against lockdown policies and government-led censorship during the pandemic and after. Bhattacharya was a keynote speaker, discussing the "Silicon Curtain," at the September 2024 Benefit Dinner of The Heartland Institute, which co-publishes *Health Care News*.

Former Congressman Dave Weldon, M.D. (R-FL), nominated to head the Centers for Disease Control and Prevention (CDC), has been a physician for 40 years and is an Army veteran. Weldon served in leading roles on the Government Oversight and Reform Committee, dealing with HHS and the CDC. Weldon sponsored the Weldon Patent Ban, which in 2011 permanently banned patents developed from human embryos.

Big Differences

Heading into Senate confirmation hearings, Kennedy is facing stiff opposition from big pharma and the likes of billionaire Michael Bloomberg and Scott Gottlieb, Trump's former FDA commissioner. If confirmed, Kennedy would be leading a massive, well-entrenched bureaucracy that administers policy in a sector, health care, that accounts for 17.3 percent of the nation's gross domestic product.

"It is not a matter of ability; it's a matter of will. If Kennedy does the right thing, the greatest resistance will come from the biggest players who are profiting at the expense of patients, taxpayers, and medical ethics: hospitals, health plans, big pharma, and big data—and likely a boatload of government bureaucrats under him. Their jobs, power, pensions, and purpose will be threatened."

TWILA BRASE, RN, PHN
COFOUNDER AND PRESIDENT
CITIZENS' COUNCIL FOR HEALTH FREEDOM

Kennedy has spoken out against much conventional thinking on vaccines, drugs, and foods over the years, and he would have the ability to reverse policies implemented under outgoing HHS Secretary Xavier Becerra. Becerra rankled conservatives on many fronts, championing "gender-affirming care," broad abortion access including subsidization under Title X, and the use of untested mRNA vaccines on children under an emergency authorization.

"I believe RFK will require HHS leaders and staff to take a look in the mirror and conduct a long-overdue and critical self-examination involving the performance of the CDC, FDA, NIH, and all other agencies reporting to HHS," said Scott Jensen, M.D, a former member of the Minnesota State Senate and gubernatorial candidate.

"Millions of Americans have been astonished, distressed, and frightened by how our public-health leaders stumbled during the Covid pandemic," said Jensen. "RFK will demand that a ruthless [strengths, weaknesses, opportunities, threats] analysis be carried out and short-, mid-, and long-range strategies be devised to carry out the mission of the HHS."

Entrenched Resistance

It will probably prove difficult for the new administration to make major changes in health care policy, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"Immediate changes to policy will not likely be as radical as Kennedy and Trump would like," said Matthews. "HHS is huge, with 60,000 permanent and 23,000 temporary employees, with 13 agencies administering 100 programs. As an outsider with no experience at HHS, just getting up to speed on what they all do will be a monumental task. Plus, [Kennedy] will likely face resistance to many of his recommendations.

"There also may be several court fights," said Matthews. "So, while there is a lot of merging or eliminating that can be done, it's likely to take a while."

'Full-Blown Roadblock'

In a trillion-dollar sector of the economy, pushback against disruptive regulatory changes is likely, however necessary or beneficial they would be, says Matthews.

"The biggest areas of resistance are likely to be the ACA, Medicaid, and the NIH and its affiliates," said Matthews. "Congress will almost certainly end the expanded subsidies going to ACA premiums, and CMS will look favorably on states imposing work requirements if Congress doesn't impose them, so I expect progress there. As for the NIH, CDC, etc., I expect a full-blown roadblock."

FDA Gap

The FDA will put up strong resistance to any reforms Kennedy is likely to propose, says Matthews.

"Kennedy is a huge critic of pharmaceutical companies and a big proponent of therapies that are generally seen as unproven and even fringe, such as legalizing and expanding psychedelics," said Matthews. "This gap between the Kennedy vision of health care and the traditionalists at the FDA is likely to create a great deal of tension. Of course, a lot of people in the various HHS agencies will likely quit, perhaps reducing internal opposition."

Kennedy's proposals will face a broad range of resistance, says Twila Brase, R.N., cofounder and president of the Citizens' Council for Health Care Freedom.

"It is not a matter of ability; it's a matter of will," said Brase. "If Kennedy does the right thing, the greatest resistance will come from the biggest players who are profiting at the expense of patients, taxpayers, and medical ethics: hospitals, health plans, big pharma, and big data—and likely a boatload of government bureaucrats under him. Their jobs, power, pensions, and purpose will be threatened."

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

CBO: Illegal Aliens Are Costing Medicaid Billions

By Kevin Stone

Federal and state spending for medical services for illegal aliens topped $16 billion under "border czar" Kamala Harris, an increase of 124 percent compared to the same period under the Trump administration.

The Congressional Budget Office (CBO) reported those figures in an analysis requested by House Budget Committee Chairman Jodey Arrington (R-TX).

"The Congressional Budget Office's analysis confirms that the mass migration of illegal immigrants is costing billions of dollars to Medicaid—a program created to serve the health care needs of the most vulnerable Americans," said Arrington in a statement addressing the findings. "This is on top of the executive action taken to provide $9 billion in Obamacare to illegal immigrants."

In addition to disincentivizing people from pursuing legal avenues for migration, this illegal use of taxpayer-funded health care is draining federal resources, says Arrington.

"With over $16.2 billion flowing from federal and state governments' coffers to pay for emergency services for illegal aliens, it is clear that Open Border Czar Vice President Harris's failed border policies remain the greatest threat to both the United States' national security and our economic standing," Arrington said.

"The projected spend of $16 billion by the House Budget Committee is very likely only a fraction of the actual cost of care to pay for the health care of illegal aliens crowding hospitals and clinics," said Dean. "We all pay for this shift in the cost of care, which disproportionately and unfairly falls on the backs of middle-class Americans who pay higher rates for private health insurance and obtain less care for their families as it is rationed to stretch scarce out-of-pocket dollars."

MATT DEAN
SENIOR FELLOW, THE HEARTLAND INSTITUTE

'Likely Only a Fraction'

As shocking as the numbers provided in the analysis are, the taxpayer cost may be much higher, says Matt Dean, a senior fellow for health care policy outreach at The Heartland Institute, which co-publishes *Health Care News*.

"The projected spending of $16 billion by the House Budget Committee is very likely only a fraction of the actual cost of care to pay for the health care of illegal aliens crowding hospitals and clinics," said Dean. "We all pay for this shift in the cost of care, which disproportionately and unfairly falls on the backs of middle-class Americans who pay higher rates for private health insurance and obtain less care for their families as it is rationed to stretch scarce out-of-pocket dollars."

'No Good Numbers'

Gauging the real number of illegal aliens siphoning benefits meant for taxpayers is tricky because of everchanging rules for reporting and estimating the population of undocumented border-crossers and overstays, says Dean. Estimates of the number of illegal aliens in the United States and of those receiving health care vary widely, with highly implausible numbers being reported by the Department of Homeland Security (DHS) under President Joe Biden, says Dean.

"The real problem is that we have no good numbers to show how many illegal aliens are in the U.S., how they are receiving health care, or how that care is being paid for," said Dean. "The DHS contends that there were around 11 million illegal aliens in 2022, with little change over the past 10 years.

"Sen. Marco Rubio claims that the number could be as high as 30 million," said Dean. "The fact that encounters at the southern border by the DHS skyrocketed from 2.37 million during the years 2017-2021 to 8.72 million since, would indicate that a static population of inadmissible aliens during those years is unbelievable. If we don't know whether the number is 11 million or 30 million, it makes no sense to budget their cost of care."

Cost analysis can become a guessing game, says Dean.

"It is hard to determine exactly how much care is being received by unauthorized aliens in our care system, because we don't have good numbers on how much care is delivered, how much is uncompensated, and which patients are in the country legally," said Dean.

'The Endpoint Is California'

In addition to direct payouts for medical care for illegals by Medicaid and other taxpayer services, lax oversight of health care expenditures for illegal aliens imposes other financial burdens on citizen taxpayers, such as higher copays and premiums caused by the increased demand for services.

Poor or nonexistent vetting of aliens seeking health care is an intentional policy, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute

"Federal policy is all about reducing the number of uninsured," said Gorman. "It doesn't matter whether the uninsured get medical care or the insured don't get medical care or whether the uninsured person is here illegally and goes home for medical care: all policies supporting the expansion of government control of health care are defended by saying it reduces the number of uninsured."

"Admitting illegals increases the number of uninsured, which bolsters the case for bigger and bigger roles for government in medical care, increasing the tax burden on American citizens," said Gorman. "The endpoint is California, which has recently decided to cover all residents who qualify for Medicaid on an income basis regardless of citizenship. The fig leaf is that California is supposed to use state funds to pay for those people."

'Activists Began Whining'

States habitually enroll people who are ineligible for Medicaid, says Gorman.

"Eligibility checks on Medicaid enrollment have not been taken seriously for a long, long time," Gorman said. "In 2006, when people were required to provide real ID for enrollment, Medicaid enrollment fell for the first time in 40 years."

Harvard physician and health economist Benjamin Sommers estimates 390,000 adult noncitizens in Medicaid (one in four) and 81,999 child noncitizens (one in eight) were screened out by the requirement, says Gorman.

"Because coverage is all that matters, the left immediately began beating the drum about people losing coverage, and activists began whining about the loss of coverage and set about weakening the ID requirements," said Gorman. "By and large, they have been successful."

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

Washington State Voters Keep Long-Term Care Tax

By AnneMarie Schieber

Voters in the state of Washington rejected a proposal that would have made a payroll tax to fund long-term care optional.

The proposal, known as Initiative 2124, failed by an 11-point margin in November.

Each Washington worker will continue to have 0.58 percent of his or her wages taken from every paycheck to fund WA Cares, a program that promises to provide each resident a lifetime benefit of $36,500, indexed for inflation, to pay for long-term care when needed.

Most workers must participate in the program, even those who purchase long-term care insurance privately.

> **"The long-term care tax in Washington State is likely to become a costly entitlement that will quickly become insolvent. "**
>
> **DEVON HERRICK**
> **HEALTH CARE ECONOMIST**

Big Shortfall

Washington is the first state to impose a tax to pay for long-term care, and it could be the last, says Devon Herrick, a health care economist and policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"The long-term care tax in Washington State is likely to become a costly entitlement that will quickly become insolvent," said Herrick. "The benefits are too small to provide much in value, and the cost will likely rise faster than wages or premiums."

Herrick says a simple calculation shows revenues will fall far short of what is required.

"To break even on one resident claiming benefits, the state would need to collect taxes on nearly $6.3 million in lifetime earnings: $6,300,000 times 0.058 equals $36,540," said Herrick. "Over time, there will be pressure to raise premiums above 0.58 and raise benefits above $36,500."

No Escape

An analysis by the actuarial firm Milliman for the Washington Office of the State Actuary showed mandatory participation for all workers was the only way the program could survive.

"Under a voluntary structure, individuals with lower claims risk or higher wages may choose to not participate" in the program, the analysis states. "If this 'selection' occurs, the remaining covered individuals in the program would have higher claims risk and/or lower wages, therefore, requiring a higher premium assessment for the program."

If the program were made optional, lower-risk participants or those with higher wages would reconsider their participation, and if they calculated it did not provide value above their expected payments, they would probably drop out, causing a downward revenue-versus-costs spiral, the report concluded.

Medicaid Effect

Washington voters are responding to a crisis in long-term care that all Americans are facing, says Stephen Moses, president of the Center for Long-Term Care Reform.

"Few people plan or save for long-term care, because they can easily qualify for Medicaid to pay for it," said Moses. "The government deducts private medical and long-term care expenses from income before applying a low-income standard, and most large assets such as home equity are exempt, meaning income and assets can be very high and still qualify for Medicaid coverage. Government-paid long-term care discourages private coverage, creating a provider shortage and rising costs."

In a report published by the Paragon Health Institute in 2023, Moses recommended closing eligibility loopholes to create a more robust market for long-term care.

With Washington's median family income at $89,067 in 2021, the state's residents are getting a bad deal from the system, says Herrick.

"That adds up to more than $500 in annual premiums [for the tax] per household," said Herrick. "Not accounting for income growth or compound interest, the tax would amount to about $20,000 over a 40-year career, which would be better deposited in a family's health savings account."

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

Popular R&B Artist Spotlights Murky Health Care Pricing

By Jesse Hathaway

Before voters reelected Donald Trump, a music artist had been promoting a Trump health care reform from his first administration: transparency in hospital pricing.

Starting in 2022, R&B artist Fat Joe has been pitching "Power to the Patients." The public-interest campaign calls for the enforcement of Trump's rule requiring hospitals to post prices for all their services. The federally mandated rule took effect in 2021 and was supported by the Biden administration.

Fat Joe, who gained notoriety for his 2000s-era hit songs such as "What's Luv" and "Lean Back," has released videos, billboards, and ads informing the public about murky hospital pricing.


Fat Joe

PHOTO COURTESY NRK P3/FLICKR.COM

'We Just Need the Prices'

Instead of making a public policy argument, Fat Joe addresses the issue from a consumer perspective.

"Our health care system is robbing all of us," Fat Joe states in one of his videos. "To every elected official and politician in America, the people stand united, desperate for you to listen. If you're not advocating for prices and transparency in health care, you're compromising every single American across this country, because when we can't see prices, hospitals, insurers, and their middlemen charge us whatever they want.

"Our very own health care system is robbing all of us," the rapper states. "We just need the prices. That's how our economy works!"

Not a Typical Market

The current health insurance system hides prices from patients and complicates decision-making, says Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"When you walk in to a pharmacy, you see prices and sales on lots of drugs," said Matthews. "But when you walk up to the counter to buy a prescription drug, there are no prices. Have you ever wondered why all over-the-counter drugs have prices that you as a consumer can see and compare, but not the behind-the-counter drugs? The difference is health insurance."

Hiding prices behind insurance prevents patients from judging treatments based on their value.

"If you're paying for those over-the-counter drugs out of your own pocket, you care about the price and you want the best value, so the drug makers compete on price and quality to attract your dollar," said Matthews. "If insurance is paying for that prescription drug behind the counter, you have much less reason to be a value-conscious consumer."

Insulated from Cost

Unlike other sectors of the economy, health care's reliance on a third-party payer system protects companies that engage in overpricing, says Matthews.

"Health insurance insulates people from the cost of their health care," said Matthews. "Generally speaking, what consumers really care about is not the actual cost but how much they have to pay out of their own pocket. Because most consumers don't care about how much the insurance company has to pay, they don't demand transparent prices like they do in every other sector of the economy."

The hidden-cost system in health care causes extensive overutilization and overpricing, says Matthews.

"The biggest challenge to creating transparent health care prices is consumer apathy due to insurance coverage," Matthews said. "Since the patient only pays a small portion of the price, that increases utilization and overall health care spending. Once a patient has met his copay or out-of-pocket deductible, he no longer cares how much the system spends," said Matthews.

"Think of it this way: What would happen to spending for automobiles if car buyers could choose a small Buick or the top-of-the-line Lexus for the same $50 copay?" said Matthews.

Pricey Secrets

The system cheats consumers of critical price information, says Katy Talento, executive director of the Alliance of Health Care Sharing Ministries and a former White House advisor on health care price transparency in Trump's first administration.

"Imagine going in to a restaurant and getting a menu with no prices," said Talento. "When you ask the price, you're instead told that the price varies based on which credit card you use and that you can only find out several months after your meal," said Talento.

"We wouldn't accept that at a restaurant, at Amazon, or anywhere else," said Talento. "Even in the service industry, such as for lawyers or real estate agents, hourly rates or commission levels must be disclosed in advance."

Hidden Contracts

The current system forces patients to accept the terms of contracts to which they never agreed, says Talento.

"Prices are generally set by secret contracts between insurance companies and hospitals or doctors," said Talento. "Patients, employers, and taxpayers are not parties to these contracts but are somehow expected to be bound by the terms therein, even though they have no access to such terms in advance. What ends up happening is that people need care, they seek and are provided that care, and then they're shocked by an outrageous bill showing up in the mail a few months later."

"Our health care system is robbing all of us. To every elected official and politician in America, the people stand united, desperate for you to listen. If you're not advocating for prices and transparency in health care, you're compromising every single American across this country, because when we can't see prices, hospitals, insurers, and their middlemen charge us whatever they want. Our very own health care system is robbing all of us. We just need the prices. That's how our economy works!"

FAT JOE

Broad Appeal

"Power to the Patients" targets a broad range of demographic groups. Other hip-hop artists and a NASCAR motorsports team have joined the campaign.

The broad appeal of the campaign is no surprise, says Matthews.

"Health care transparency is important to everyday people only in the sense that it sounds like something that should happen because it is standard in every other sector of the economy," said Matthews.

Politicians will have a hard time ignoring the message, says Talento.

"The good news is that ending secret health care prices is bipartisan, polling at 95 percent support among the American people, and it is next to impossible for the industry to openly fight against it," said Talento. "They're forced into the shadows, and that makes it easier to get good policies passed, because it's difficult for any elected official to argue that health care prices should be secret."

Jesse Hathaway (**think@heartland.org**) *writes from Columbus, Ohio.*

Biden Admin Spurred Higher Medicare Drug Premiums, Fewer Choices

By Bonner Russell Cohen

Seniors perusing the offerings during the most recent Medicare enrollment period found higher prescription drug plan premiums and fewer choices of plans.

Data compiled by Ed Haislmaier, a health care policy analyst at The Heritage Foundation, and Joel White, president of the Council for Affordable Health Coverage, show the Inflation Reduction Act's changes to Medicare have sent "premiums sky-high" and eliminated plans for at least three million seniors.

IRA Shifted Costs

The diminished options are rooted in the Biden administration's signature legislative achievement: the 2022 Inflation Reduction Act (IRA). Known primarily for its provisions supporting a slew of green energy climate initiatives, the IRA also made far-reaching changes to Medicare.

The centerpiece of the IRA's Medicare provisions was the plan by the White House and congressional Democrats to rein in the cost of prescription drugs, covered under Medicare Part D, by mandating caps on out-of-pocket spending. In addition, the IRA reduced most of Medicare's funding for high-cost drug reinsurance, shifting that burden to Part D insurers. Insurers responded by passing those costs on to consumers in the form of higher premiums.

Pitched as Financial Relief

While congressional Democrats and the Biden administration presented a favorable view of the IRA's Medicare provisions, the potential for higher drug premiums did not go unnoticed. The health care policy organization KFF, for example, identified the implications in an analysis of the bill in January 2023.

"With the new hard cap on out-of-pocket spending, it is possible that enrollees could face higher Part D premiums resulting from higher plan liability for drug costs above the spending cap, though these premium increases could be mitigated by the provisions to stabilize premiums between 2024 and 2030," the KFF study stated.

Plans might try to hold down costs through efforts such as "more utilization management or increased generic drug utilization," KFF noted.

Another way plans could "exercise greater control of costs" would be to stop participating in Medicare Part D altogether, which is exactly what Haislmaier and White discovered in their 2024 analysis.

Premiums Up 57 Percent

The promised relief in prescription drug costs has not materialized, Haislmaier and White found.

"The data shows that under four years of Biden-Harris administration policies (plan years 2022 through 2025), the national average monthly premium paid by Medicare beneficiaries for stand-alone Part B prescription drug plans has increased by 57%," Haislmaier and White write in *The Daily Signal*.

"At the same time, the average number of plans offered in each state has dropped by more than one-half, from 29 in 2021 to 14 in 2025," the authors write. "Seniors in some states face even bigger hits in their wallets. Under the Biden-Harris administration, Medicare drug plan premiums jumped by more than 90% in 10 states. Premiums more than doubled in three of those states (California, 122%; New York, 116%; and Nevada, 104%.)"

When premium prices were released in October 2024 for the 2025 year in the run-up to the November 5 election, the Biden administration unveiled a demonstration project that will pay insurers not to raise Part D premiums by more than $35 a month in 2025. According to the Congressional Budget Office (CBO), the demonstration project will cost taxpayers $7 billion in 2025, with the program set to run for two more years.

Higher Scrutiny on the Way?

The demonstration project was carried out without congressional authorization. That and the program's high cost could put it in the crosshairs of President-elect Donald Trump's planned Department of Government Efficiency (DOGE).

The DOGE is an outside-of-government advisory commission headed by entrepreneurs Elon Musk and Vivek Ramaswamy, which Trump has directed to identify wasteful spending across the federal government. The commission has no statutory authority to defund the demonstration project but will make recommendations to Trump and government departments.

"Seniors have been repeatedly assured that Medicare will be there for them throughout their retirement years, but it's not the same Medicare," said Craig Rucker, president of the Committee for a Constructive Tomorrow (CFACT). "Costs rise, quality declines, and choices disappear. Between the social engineers of the Biden administration and the inertia of career bureaucrats at HHS, Medicare has degenerated into an empty promise."

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

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CRAIG RUCKER
PRESIDENT
COMMITTEE FOR A CONSTRUCTIVE TOMORROW

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New Guidebook Helps Seniors Avoid Costly Medicare Mistakes

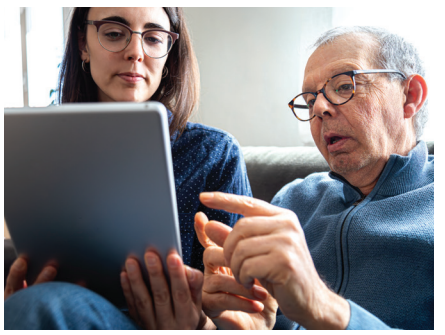
By AnneMarie Schieber

Medicare's annual enrollment period has begun, and a nonprofit policy organization has released a first-ever guidebook to help seniors make decisions they will not regret.

The *Medicare How-To Guide*, a 120-page PDF publication from the nonprofit Citizens' Council for Health Freedom (CCHF), helps seniors cut through the confusion and fine print of the numerous options, which require many tradeoffs and cannot be easily changed.

"When individuals enroll in Medicare, they often surrender key freedoms, including the ability to make private, independent health care decisions," said CCHF Cofounder and President Twila Brase, RN, PHN, in a press release. "This guide was created to help Americans understand the restrictions and limitations of the Medicare system, from penalties to narrow provider networks to the often-overlooked painful realities of Medicare Advantage plans."

There are various enrollment periods for Medicare, with coverage generally beginning at age 65. Medicare's webpage shows enrollment is no simple task. Mistakes can be costly, as choices can limit coverage or provide more coverage than necessary, and there are penalties for failure to meet enrollment deadlines. The guidebook explains the enrollment periods in detail.



Important Concerns

Seniors must keep in mind several key areas of concern and focus on the long term when they make their Medicare choices, the guidebook states.

The guidebook says it is important to remember Medicare is a defined-benefit program with coverage limits. Most of all, Medicare is not "free" health care; it offers various plans with separate premiums.

"Medicare Advantage plans, while initially appealing, can severely restrict access to care," states the guidebook. "It can be difficult to change from Medicare Advantage to Original Medicare."

The guidebook details 12 key points, 10 "Medicare traps," a checklist, and a list of questions enrollees should ask brokers, such as what commissions they earn when they sell you a plan. The questions are based on actual statements from brokers.

The guidebook also answers frequently asked questions, such as whether a person with an employer plan must enroll in Medicare at age 65, and a glossary of Medicare terminology.

Needed Clarity

One reason the CCHF released the guidebook is because nothing like it exists, Brase told *Health Care News*.

"We've heard from people who are surprised by what they learn," said Brase. "Some are preparing to change their coverage from Medicare Advantage to Original Medicare. One woman gave me a hug because she was so happy to have the *Guide*. She's halfway through reading it. A physician emailed, saying she likes the 10 Medicare Traps section the best."

Interest in the guide has been robust, says Brase.

"We expect the CCHF *Medicare How-To Guide* to grow and grow in readership, especially through word of mouth," said Brase. "There are 10,000 baby boomers becoming eligible for Medicare every day. Free copies are being downloaded from our website from across the country. Although the costs [of Medicare] will change every year, in many ways it's evergreen."

CCHF is adding the latest cost updates, released this fall, to the guide.

"We've heard from people who are surprised by what they learn. Some are preparing to change their coverage from Medicare Advantage to Original Medicare. One woman gave me a hug because she was so happy to have the Guide. She's halfway through reading it. A physician emailed, saying she likes the 10 Medicare Traps section the best."

TWILA BRASE, RN, PHN
COFOUNDER AND PRESIDENT
CITIZENS' COUNCIL FOR HEALTH FREEDOM

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

Drug Plan Sticker Shock

In 2025, Medicare enrollees are seeing for the first time a significant jump in premiums for Part D drug plans.

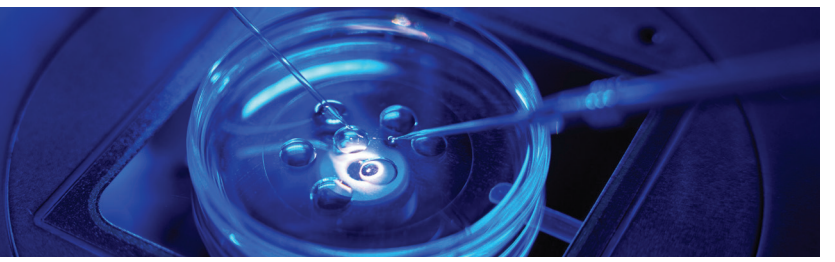
The increase is the result of changes made to Medicare under the Inflation Reduction Act (IRA) (see related article, opposite page). The costs of drug-price cuts were shifted to Part D insurers, who passed on those costs in the form of higher premiums or dropped out of the market altogether.

An analysis by Edmund Haislmaier of The Heritage Foundation and Joel White of the Council for Affordable Health Coverage reports the IRA has eliminated plans for three million seniors and caused premiums to jump by more than 90 percent in 10 states for 2025.

"Now you know what 'we finally beat Medicare' really means," write the authors, referring to President Joe Biden's misspoken words during last June's debate with Donald Trump.

—*Staff reports*

Trump Promises to Mandate IVF Coverage



By Harry Painter

Since the November election, President-elect Trump has repeated his promises to require coverage of in-vitro fertilization (IVF) treatments.

Trump's base voters had raised concerns about the ethics of IVF in recent years. Trump told NBC News in August 2024 he would not only defend IVF but mandate the government and private insurance companies cover it.

In February 2024, several IVF clinics paused treatments after the Alabama Supreme Court ruled frozen embryos should be legally considered children. Three couples filed wrongful death lawsuits after a clinic destroyed their frozen embryos. Gov. Kay Ivey signed a law protecting doctors from lawsuits and criminal prosecution over IVF the following month.

In June 2024, President Joe Biden expanded IVF coverage under the Department of Veterans Affairs to unmarried service members and those in same-sex relationships who are unable to conceive because of service-related injuries or health conditions.

Trump's planned move would be a more significant and widespread expansion of federal IVF promotion and subsidies.

"Insurance is appropriate for unpredictable, unlucky events that people have no direct control over," said Goodman. "IVF is not a risky event. It is a procedure people choose, and since it typically requires multiple tries, it is very expensive. People should be free to buy insurance that does not force them to cover other people's lifestyle choices."

JOHN C. GOODMAN
PRESIDENT
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

Knowledge Gap

In many cases, doctors and patients are confused about what IVF entails, says medical ethicist Mark Blocher, founder of Christian Healthcare Centers, the largest nonprofit direct primary care organization in the United States.

In an unpublished paper detailing guidelines for Christian health care professionals, Blocher writes, "IVF is one of several so-called medically assisted reproduction technologies widely used in the U.S. Over 8 million babies have been born using IVF since the first successful IVF live birth in 1978."

IVF involves stimulation of the woman's ovaries with medication, writes Blocher, "which is intended to produce multiple ova (eggs) for insemination."

Doctors then retrieve four or more ova for insemination in a petri dish. Embryos undergo genetic testing, and any that are "found to have genetic anomalies are typically destroyed."

Next, doctors transfer an "appropriate" number of healthy embryos to maximize the chances of a successful pregnancy. They can store unused embryos for future use.

"If several embryos successfully implant on the uterus, doctors may recommend aborting selected embryos to maximize the survival of the remaining embryo(s) and better manage the mother's wellbeing," writes Blocher.

Ethical Debate

Many Christians rejected IVF in its early years as an attempt to "play God," Blocher notes.

Clinicians "create conditions that would never occur naturally," writes Blocher. "For example, over-stimulating a woman's ovaries with hormones to release as many as eight, 10, or 12 ova in a single menstrual cycle. Normally, women produce one ova per menstrual cycle."

The Catholic Church and Southern Baptists, two of the largest religious denominations in the United States, explicitly condemn IVF on moral grounds.

"The initial goal of IVF was to assist married heterosexual couples experiencing medical difficulties with childbearing," writes Blocher. "However, America's permissive views on human sexuality and the cultural redefinition of marriage/family was seized upon by the fertility industry to offer its services to wealthy celebrities, same-sex couples, unmarried single women, and gay men paying surrogates to bear their children."

Fertility clinics have become a $5.4 billion industry, with most women requiring three to four cycles to achieve one live birth, according to Blocher.

Cost Debate

A *Forbes* analysis reports a single IVF cycle costs up to $30,000 and sometimes more. If the incoming Trump administration requires insurers and government programs to cover IVF, taxpayers, insurance companies, or some combination will be on the hook for as much as $90,000 to $120,000 per IVF cycle per patient.

The price would be paid by inflation and debt, says Vincent Cook of the University of California, Berkeley.

"To the extent that health insurers are forced to cover the costs of IVF treatments in the policies they offer, the price of health insurance policies would have to go up," wrote Cook at *Mises Wire*. "Employers who pay for most health insurance policies, in turn, would have to shift costs onto workers by reducing their wages (and onto owners of natural resources, etc.)."

Insurance was not designed for elective procedures, says John C. Goodman, co-publisher of *Health Care News* and president of the Goodman Institute for Public Policy Research.

"Insurance is appropriate for unpredictable, unlucky events that people have no direct control over," said Goodman. "IVF is not a risky event. It is a procedure people choose, and since it typically requires multiple tries, it is very expensive. People should be free to buy insurance that does not force them to cover other people's lifestyle choices."

Creating New Demand

Total current expenditures on IVF in the United States are about $8 billion per year, and at the moment it is a niche market, says Cook.

"There are estimates that only a quarter of those who desire IVF treatments can actually afford them at current prices, so artificially reducing the price paid by patients to zero might mean at least a four-fold increase in the number of IVF cycles administered," wrote Cook. "It might even mean more if clinics (which would also have no incentive to control costs) encourage a greater number of cycles per patient to increase the chances of achieving a successful pregnancy."

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

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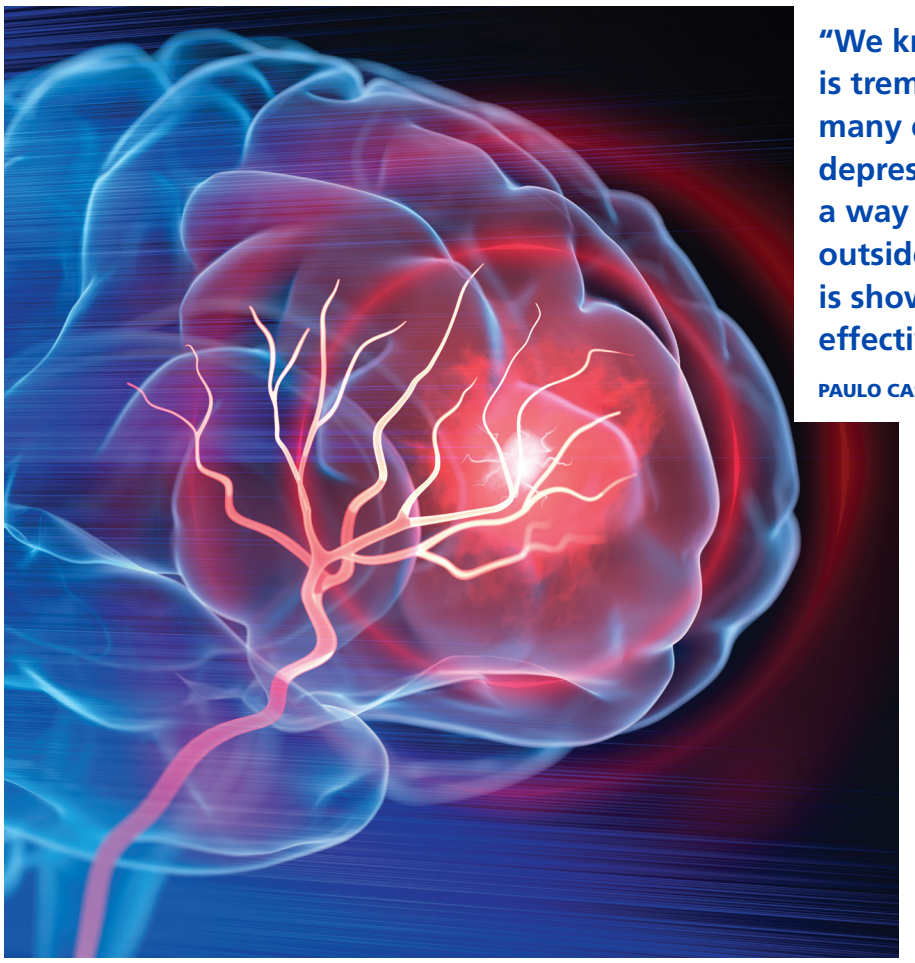
Military Explores Light Therapy for Brain Injuries

By AnneMarie Schieber

The U.S. Department of Defense (DOD) is taking steps to explore how noninvasive, nondrug light therapy can help military members and veterans recover from traumatic brain injuries (TBI).

Transcranial photobiomodulation (PBM) uses red- and near-infrared light rays to stimulate mitochondria to restore cell function. The technology is rapidly showing promise in treating a variety of medical conditions such as drug addiction, pain, and mental health disorders.



"We know that neurostimulation is tremendously effective for many conditions, including depression. We need to find a way to bring this treatment outside the office and the data is showing these treatments are effective."

PAULO CASSANO, M.D., PH.D.

Proposed Clinical Trial

At the invitation of the DOD's Congressionally Directed Medical Research Program, Paulo Cassano, M.D., Ph.D., and his PBM team in the Neuropsychiatry and Neuromodulation Division at Massachusetts General Hospital in Boston are applying for a grant to perform a randomized, double-blind, sham-controlled clinical trial on 96 subjects who have suffered from TBI effects for at least one year.

The study will look at how office and at-home PBM treatments can improve executive function and memory and control anxiety and sleep disturbances commonly experienced by individuals who received violent or repeated blows to the head or suffered from weapon reverberation during combat and training.

A bipartisan panel of U.S. legislators has been pushing the military to do more to treat TBI.

Accelerating Interest

PBM emerged as a possible treatment modality in 1967, but only in the past 15 years have researchers been studying it as a therapy for brain injuries.

"In Canada, children injured to the point of disorientation showed spectacular recovery in less than one week after being treated with PBM," Cassano told *Health Care News*. "So, there is growing evidence that it works. The missing piece is showing whether there is a clinical benefit in a sufficient sample size."

PBM has been used on more than 100 million patients without documented side effects, the PBM Foundation states. There have been more than 1,000 randomized clinical trials and 9,000 research studies on PBM, many published in leading medical journals and registered with the National Institutes of Health.

Portable, Immediate Treatment

The *Journal of the American Medical Association* lists PBM as one of the first options for treating pain. The VA recommends PBM for treating neurological conditions in vets. The DOD uses PBM in its warfighter effectiveness program.

Leading cancer centers use PBM to treat pain, and there is an ongoing study to see if PBM can reduce cravings and depression from opioid addiction.

"Mass General has over 600 professionals interested in PBM," said Cassano. "We aspire to have neurostimulation play a role at the scene in an ambulance or the periphery of the football field so that treatment can be beneficial right away.

"We know some lesions are related to the immediate hit, but some injury is related to the brain's response to the hit, the inflammation, and we want to prevent those secondary lesions," said Cassano.

'Scalable' Mental Health Care

Cassano plans to study whether patients can get the same results from a wearable device as from office devices, which are generally heavier and bulkier and require a technician.

"We want interventions that are scalable, that could potentially be applied to a location, the warzone for example, and scalable in terms of number of people that can be treated," said Cassano.

"If the office device is a winner, we can work and understand what it takes to deploy those devices," said Cassano.

'Future of Psychiatry'

The low cost, ease of use, and portability of PBM can help with the growing shortage of psychiatrists and greater demand for mental health. The mainstays of mental health treatment today are medication, which can cause major side effects, and psychotherapy, which is labor-intensive and takes a long time.

"Psychotherapy can be very effective, but it is difficult to scale," said Cassano. "It is difficult to find providers who have the level of training on evidence-based psychotherapy, to deal with things like [post-traumatic stress disorder], depression, or emotional dysregulation, and even if they have that care, they still may not achieve total recovery."

Like PBM, electroconvulsive therapy and transcranial magnetic stimulation work on the cellular level. Those treatments involve anesthesia.

"We know that neurostimulation is tremendously effective for many conditions, including depression," said Cassano. "We need to find a way to bring this treatment outside the office, and the data is showing these treatments are effective.

"You want to accumulate sufficient data if you're going to scale it to the public," said Cassano. "This is the future of psychiatry. Psychiatrists will be trained to prescribe this treatment, and because these treatments are safe and have nonsignificant risk" according to the U.S. Food and Drug Administration (FDA), "some of these low-dose devices will be available for wellness, as they are already."

Regulatory Hurdles

Although the FDA has approved PBM for a variety of medical conditions, there is still room for wider application, says Scot Faulkner, an advisor to the PBM Foundation.

"The FDA still talks about photobiomodulation as a non-heating heating lamp," said Faulkner. "In terms of formal indication for use, it is still only there for general wellness, not specific indications. It is not being fully reimbursed [by insurers]. We are hoping to work through that with Medicare and perhaps a national coverage determination."

It is also important to develop a certification process for devices, many of which are sold by the thousands on the internet, says Faulkner.

"Studies have shown consistency is all over the map," said Faulkner. "Many devices coming out of China have no quality control. It does everyone a disservice, because if someone is presenting it as red-light therapy and it doesn't work, then they are going to be a skeptic and believe PBM doesn't work."

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

Trump Looks to Build on First-Term Health Policy Reforms

By Kevin Stone

President-elect Donald Trump has chosen Robert F. Kennedy Jr. to head the Department of Health and Human Services (HHS) with the goal of restoring and building on reforms from Trump's first term, many of which the Biden administration reversed or stalled.

> **"I seriously doubt Obamacare will be repealed, so Republicans will look for ways to allow consumers to purchase health insurance they actually want.."**
>
> **MERRILL MATTHEWS, PH.D.**
> **RESIDENT SCHOLAR, INSTITUTE FOR POLICY INNOVATION**

Traditional Reform Approach

First-term Trump HHS Secretary Alex Azar was an establishment and big pharma pick who led the administration through some policy successes, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"Azar was not just an establishment Republican," said Matthews, "He was a traditionalist. He certainly had a much deeper knowledge of the health care system and of HHS [than Kennedy], but Azar wanted to improve the health care system, not remake it."

Trump and Azar cut through some of the excesses of Obamacare, says Matthews.

"The Tax Cuts and Jobs Act zeroed out the penalty for individuals not having government-approved health insurance," said Matthews. "That was his biggest win. And he gave HHS more freedom to reduce regulations and let states experiment, like with Medicaid work requirements."

New Agenda

Matthews says he expects Trump to be both ambitious and practical in his second term.

"I seriously doubt Obamacare will be repealed, so Republicans will look for ways to allow consumers to purchase health insurance they actually want," said Matthews. "Plus, I think HHS will shut down many of its Biden-era efforts, like changing Bayh-Dole to include prices."

The Bayh-Dole Act was enacted in 1980 to promote the "commercialization of inventions arising from federally supported research or development," according to the law firm Ropes & Gray. On March 24, 2023, the Biden administration issued a final rule limiting patents, or "march in rights," to control drug prices.

Agencies such as the Federal Trade Commission supported the move. The policy went into effect on December 7, 2023.

Multiple Successes

There were some notable reforms in Trump's first term, says Sally Pipes, the president, CEO, and Thomas W. Smith Fellow in health care policy at the Pacific Research Institute.

"Trump implemented a rule requiring hospitals to publish their prices in machine-readable files," said Pipes. "Price transparency allows people to compare providers' rates and shop around for health care services, as for any other commodity, and thus motivates health care providers to compete for patients' business" (see related article, page 9).

"The first Trump administration also created more health insurance options for individuals and small businesses, expanded access to short-term health plans, made it easier for employers to band together and buy insurance through association health plans, and boosted individual coverage health reimbursement arrangements, which enable companies to give employees lump sums to spend on health coverage rather than purchasing a traditional plan [for them]."

The Biden administration reversed Trump's reforms and concentrated on steering more people into Obamacare plans, such as by limiting the use of short-term, limited-duration health insurance (see related article, page 1).

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

INTERVIEW

Genetic Data of 15 Million People May Be Up for Grabs

The popular ancestry-tracing company 23andMe may be up for sale, CEO Anne Wojcicki says, putting 15 million customers' genetic data up for grabs. The acquisition could include the legal rights for the purchaser to do virtually anything with the data. The company recently paid out $30 million in a settlement over a data breach. Keith Hanson, a seasoned law enforcement agent and security specialist, talked to Ashley Bateman of Health Care News *about the dangers of the sale and what people should know about the potential exposure of their DNA data.*

Health Care News: 23andMe has been highly popular since it launched in 2006. Why did the company catch your attention in recent months?

Hanson: One of the founders of Google was married to one of the founders of 23andMe. That set off a red flag for me. Google is a search engine company that is seeking power, government power, and now wants access to people's genetic information. That's really concerning. Genetic information is not protected under [the Health Insurance Portability and Accountability Act].

23and Me first came on my radar when people were talking about it. I like to know the backstory of a service. People are sending in a lot of genetic information because it's a novelty.

Health Care News: Will there be any protections of this private data if the company is sold?

Hanson: I would imagine there is some degree of due diligence before a buyer would be allowed to have access to the database. Will it be based on ethical or legal standards? Internally, the company, the seller, may have a separate way to access information.

Health Care News: Would the company's customers be notified about a sale?

Hanson: Based on the terms of a deal, the purchaser may want to know what the seller will tell its customers. A buyer is not acquiring the company because of the trademark and website, but [for] the data the company has aggregated. That's what they'd monetize.

I imagine it would be a difficult, arduous process for customers to have their information removed.

Health Care News: How do these companies monetize this data?

Hanson: Insurance companies or underwriters, for example, pay them a fee that gives them a license and security key to access the database. The underwriters then take the genetic profile and [use] predictive modeling to determine whether you have a higher risk of certain cancers, for example.

People think determining risk profiles cannot be done in health care because of privacy protections, but we do this already for car loans and car insurance. So, the information contained within 23andMe and Ancestry.com can be used to create a risk model for each individual based upon this very private information, an individual's DNA.

Health Care News: Is this why online services such as social media are offered to customers for free?

Hanson: With every platform that is free or sold at discounted rates, the users are the commodity. The information the user is putting in is aggregated and sold. It's more cost-effective to keep it free, to have more users.

Health Care News: Can genetic data, or data in general, be manipulated and weaponized against consumers?

Hanson: You're giving a company that monetizes people's data the most intimate data about you. That can be used with AI-based predictive modeling programs to determine which diseases you could get.

Conservatives were being accused of scaremongering, but with access to that information you have medical providers who could determine whether you are or are not a good candidate for the cost of a surgery, and this could be the basis for denial of insurance coverage. Part of the risk modeling in the underwriting process would be to conduct a [genetic] screening.

Most people have a normalcy bias where [they believe] everything is fine. However, the company could be using the information illegally, for nefarious, immoral purposes, and it is legal because people sign user agreements and sign their rights away.

Health Care News: Wouldn't the company have to comply with state and federal laws?

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KEITH HANSON
SECURITY SPECIALIST

Hanson: On the surface, this is a voluntary transaction. The company isn't obtaining the information immorally, illegally, or unethically. They are providing a legitimate service. The company is honoring the terms of the agreement.

But there is a lot of fine print in that agreement that customers don't typically read. And unless you are an attorney, you would have a hard time understanding the terms in the fine print.

Health Care News: Why do people overlook data privacy concerns?

Hanson: I don't think people understand that data and information are the single most valuable resource we have. I think people may have a basic understanding, but it's too inconvenient to think through because it's intangible. Data security and privacy are largely intangible in an online environment.

Not a day goes by without another data breach, but it's largely intangible. That's where the biases start coming in. Your data allows me to pretend that I'm you, steal things from you, and have a better understanding of what you do, so I can control you.

Consumer habits, lifestyle, whatever it might be, can be used in AI-based programs capable of manipulating human psychology. Data is being sold to analytics firms that utilize and rely upon artificial intelligence.

Gates Faces Dutch Lawsuit over COVID-19 Shots

By Bonner Russell Cohen

Billionaire Bill Gates is facing charges in the Netherlands brought by seven people who allege they were harmed by the COVID-19 injections the Bill and Melinda Gates Foundation promoted.

A judge ruled on October 16 the Dutch court had jurisdiction to hear the lawsuit against Gates, an American citizen. Other defendants include Albert Bourla, CEO of Pfizer and a U.S. citizen, and several Dutch officials.

Of the seven Dutch citizens who originally filed the lawsuit in 2023, one has died. A date for the trial has yet to be determined.

Bill Gates

PHOTO COURTESY KUHLMANN/MSC

Globalism on Trial?

The court's ruling specifically addressed Gates' international role in supporting mandatory vaccinations to slow the spread of COVID-19, reported *The Defender*, the publication of Children's Health Defense (CHD). CHD is a patient advocacy organization founded by Robert Kennedy Jr., President-elect Donald Trump's nominee for the position of Secretary of Health and Human Services.

"The Bill & Melinda Gates Foundation is also affiliated with the World Economic Forum, … an international organization whose statutory objective is to unite 'business, governments, academia, and society at large into a global community committed to improving the state of the world,'" states the ruling.

"This is a project aimed at the total reorganization of societies in all countries that are members of the United Nations … as described by [World Economic Forum] founder and executive chairman Klaus Schwab in his book *COVID-19: The Great Reset*," the Dutch judge's ruling states in its description of the dispute in the main case.

"Characteristic of this political ideology is that this forced and planned change is presented as justified by pretending that the world is suffering from major crises that can only be solved by centralized, hard global intervention," the ruling states. "One of these pretended major crises concerns the COVID-19 pandemic."

Gates' Motive?

The ruling sums up what Gates' motivation might be, says Jane Orient, M.D., executive director of the American Association of Physicians and Surgeons and an advisor to The Heartland Institute, which co-publishes *Health Care News*.

"Bill Gates, acting through his 'philanthropies,' with the apparent intention of imposing global governance while drastically reducing global population, has immense harm to answer for," said Orient. "What can a Dutch court do? Perhaps [it can] force Gates to pay damages to persons who were likely harmed because of false statements he made to government authorities. That would make an amazing precedent."

U.S Implications?

While the Dutch lawsuit against Gates has received little attention in the U.S. media, it could have implications for potential litigation in the United States, says Jeff Stier, a senior fellow at the Center for Consumer Choice.

"The case against Mr. Gates is in its early stages, and experts predict it is unlikely to prevail on its merits," said Stier. "Nonetheless, the court's jurisdictional ruling suggests that although Gates is not a Dutch citizen, his substantial efforts to impose vaccine mandates in the Netherlands suffice to expose him to litigation.

"Mr. Gates and his organization expended significant resources to impose vaccine mandates on the Dutch citizenry; and therefore, the legal theory goes, they should be held to account for their actions in the courts of the country where the affected citizens reside," said Stier.

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JEFF STIER
SENIOR FELLOW
CENTER FOR CONSUMER CHOICE

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

FDA Resists COVID-19 Vaccine Document Request

By Bonner Russell Cohen

The U.S. Food and Drug Administration (FDA) asked a federal judge in Texas to throw out a public information request by a group of scientists and medical experts seeking licensing information the agency relied on in approving the Pfizer-BioNTech COVID-19 vaccine in 2020.

As concerns grew over the efficacy and safety of COVID-19 vaccines, Public Health and Medical Professionals for Transparency (PHMPT) in late 2021 sued the Biden FDA to release records relating to the vaccine approval process.

A 55-Year Wait

The FDA responded that it could take at least 55 years to process and release the information after receiving PHMPT's original request under the Freedom of Information Act in 2021, *Reuters* reported.

PHMPT's lawsuit alleges "the medical and scientific community and the public have a substantial interest in reviewing the data and information underlying the FDA's approval of Pfizer's Vaccine."

The FDA now says it has produced more than a million documents in the case. The scientists and medical professionals are suing to force the FDA to release the rest of the records.

"Despite years of litigation and the Court's order to produce all clinical trial documents, the FDA continues to withhold over a million pages of trial documents," Aaron Siri, PHMPT's attorney, said in a statement after the judge's October 17 ruling.

New FDA Sheriff

It is not clear what direction the lawsuit could take under a new administration. President-elect Donald Trump, who takes office on January 20, nominated Marty Makary, M.D. to head the FDA. Makary, a Johns Hopkins University surgeon, has been an outspoken critic of heavy-handed pandemic policies.

If anything, the lawsuit calls attention to the great need for reform at the FDA, says Jeff Stier, a senior fellow at the Center for Consumer Choice.

"The Biden administration's rush to impose vaccine mandates and demand vaccination of younger, healthier Americans was misguided," said Stier. "Further examination of what led to the decisions is not only warranted but essential in order to learn from mistakes made."

"The FDA has a greater responsibility than under standard procedure if it's going to allow the use of a dangerous experimental product while suppressing safe repurposed drugs, as do the other government agencies that pushed or even mandated this use," said Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

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

Texas Doctors Could Lose Licenses for Child Trans Treatments

By Ashley Bateman

Texas Attorney General Ken Paxton is taking legal action against transgender activist physicians who prescribed gender transition medications to minors after state law forbade the practice.

Paxton filed lawsuits, the first of their kind, against three doctors from October 17 to November 4, for allegedly treating children with gender transition drugs after the practice was banned under state law. The civil suits request an immediate injunction against the doctors to stop their unlawful practices and misleading of pharmacies and insurance payers in records and billing descriptions. The suit asks the court to impose a $10,000 fine per violation.

The doctors are May Lau, M.D., a pediatrician and professor at the University of Texas Southwestern Medical Center; Hector Granados, M.D., a pediatric endocrinologist; and M. Brett Cooper, M.D., a physician at UT Southwestern.

The lawsuits allege Lau, Granados, and Cooper also falsified medical records, prescriptions, and billing records to "intentionally conceal the unlawful conduct" to avoid responsibility under state law and collect fees from insurance companies on treatments that are illegal.

Court Approval

Signed into law in June 2023 by Gov. Greg Abbott, Texas Senate Bill 14 bars procedures and treatments of minors for gender transitioning, reassignment, or dysphoria.

Upheld by the U.S. Supreme Court in June 2024, the law explicitly outlaws surgeries, puberty blockers, and cross-sex hormones for "transition treatment," with few exceptions.

The law cites a growing body of data indicating these treatments are largely ineffective and in fact damaging over time. Texas doctors who disobey the law face license revocation and lose authority to practice medicine in the state, in addition to civil fines.

Medical Board Discretion

SB14 gives the Texas Medical Board the authority to revoke the license of any physician who engages in "prohibited acts regarding gender transitioning or gender reassignment procedures and treatments on certain children." Currently, the three physicians named in Paxton's suits still retain authority to practice in the state.

"Many of the medical boards as well as medical schools have been largely taken over by progressive doctors who see providing gender-affirming care as a civil-rights issue," said Merrill Matthews, a resident scholar with the Institute for Policy Innovation who serves on the Texas Advisory Committee of the U.S. Commission on Civil Rights.

"What steps medical boards will take, if they don't really want to do anything, is assign a committee to investigate and then subtly encourage the committee to slow-walk its investigation so that nothing gets done quickly, and perhaps the issue will go away," said Matthews.

Activist Medical Boards

The bias of professional medical boards, which can revoke board certification and influence state boards, is no secret, says said Jill Simons, M.D., executive director of the American College of Pediatricians, a group that serves as an alternative to the American Academy of Pediatrics (AAP), which supports gender transition treatments on children.

"I talk to pediatricians all the time, and I know that the majority of the pediatricians in the AAP do not go along with this," said Simons. "It is really the leaders, some of them not even physicians, who are following these political agendas."

State licensing board authority varies by state, says Simons.

"Some medical boards have jurisdiction to revoke someone's medical license, but in other cases medical providers are subject to malpractice lawsuits," said Simons.

Insurance Enforcers

If the suits continue, it is possible malpractice insurance companies would refuse to cover these doctors, especially if juries award large amounts to plaintiffs hurt by transition treatment, says Matthews.

"I believe that civil lawsuits, filed by people who were minors at the time of the gender-affirming care, will be the most effective way to stop these practices," said Matthews. "When individuals who underwent the care as minors explain to juries the lifelong medical challenges they now face and how they believe they and their parents were snookered into transitioning, those juries will be delivering hefty awards.

"For transgender care centers and physicians, those penalties could amount to millions of dollars," said Matthews. "Malpractice insurance would then stop covering the centers and the practices. And with the profit factor removed and jury awards piling up, health care providers will have to stop."

Planned Parenthood Vulnerability

This process could extend to powerful transition propagator Planned Parenthood, named in a lawsuit by de-transitioner Cristina Hineman earlier this year. After a single visit lasting approximately 30 minutes, Planned Parenthood providers prescribed Hineman cross-sex hormones and continued to do so for well over a year, despite Hineman's documented history of mental health problems, the lawsuit alleges.

In her complaint, Hineman claims the transition treatments caused permanent physical scars.

Trump Turnaround

In a recent announcement, President-elect Donald Trump laid out a plan to ban federal support, including Medicare and Medicaid participation, to providers who engage in so-called gender-affirming care and gender transitions. Trump says he will also encourage Congress to pass a law prohibiting child sex-change treatments in all 50 states, provide an avenue of legal recourse for victims, and direct the Department of Justice to investigate pharmaceutical companies and health care providers involved in these treatments.

The court of public opinion will ultimately decide how public policy handles the issue, says Simons.

"I'm always optimistic this is going to end, and how it ends is that people will hear what is actually happening," said Simons. "It doesn't take a medical degree just to hear what is happening and see that this isn't right."

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

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

COMMENTARY

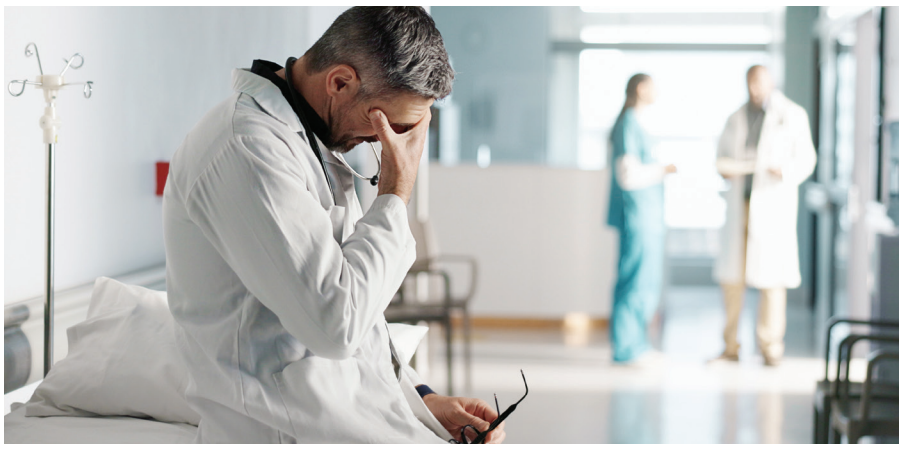
Are Medicare Doctors Paid Too Little?

By Mario H. Lopez

Today, it can take weeks to see a doctor, and when patients do get in, appointments last about 15 minutes. The reason is simple: America has a shortage of doctors.

Nearly 19 percent of the U.S. population is covered by Medicare. Declining reimbursement rates under Medicare are forcing many doctors to retire early or not accept Medicare. The problem will only get worse. Seniors are living longer than was anticipated in 1965 when Medicare was signed into law. Sixty-seven million people are enrolled in Medicare today.

Long-term, free-market solutions can fix the doctor shortage, but change will not happen overnight. The most immediate way to keep an adequate supply of doctors is to adjust Medicare reimbursement rates to be more in line with the private market. Failure to do so invites more government control over health care.



Inflation Tax

Adjusting for inflation, Medicare reimbursement rates for doctors have fallen by 29 percent over the past 23 years, while payments for other health care providers (skilled nursing facilities, hospices, inpatient and outpatient hospitals) have kept pace with rising prices. In 2023, physicians were the only provider group that did not receive an inflation adjustment.

The Centers for Medicare and Medicaid Services (CMS) sets reimbursement rates based on bureaucratic formulas that fail to adjust for inflation. The American Medical Association (AMA), among others, has called for reform.

A recent analysis by the Pacific Research Institute shows low Medicare payments exacerbate the physician shortage and can reduce health care access for vulnerable patients. This should surprise no one. Doctors in private, independent practices operate as small businesses. Assuming Medicare covers about 19 percent of their patients, when payments fail to keep up with their cost of doing business, doctors have no choice but to stop seeing Medicare patients, scale back staff, cut down on service, accept buyouts from larger providers, or close.

Collateral Damage

The AMA predicts a shortage of up to 86,000 physicians by 2036. Doximity, which describes itself as "the largest professional medical network for U.S. healthcare professionals," states, "88% [of physicians surveyed] said that their clinical practice has been impacted by the physician shortage," with 30 percent describing the shortage as "severe." Worse, "half of all physicians surveyed are having thoughts about leaving clinical practice altogether."

While skyrocketing costs, burnout, and increasing retirements all play a part, Medicare's inadequate reimbursements directly drive the cost factor. Naturally, the systemic strains affect all patients.

Doximity states 70 percent to 87 percent of U.S. physicians report longer wait times, diminished access, worsened disparities, and treatment delays.

"Many physicians also believe the shortage has contributed to worse or preventable outcomes (42%) and later-stage diagnosis (36%) in some patients," Doximity reports. When a disease or illness is identified in later stages, it becomes more expensive to treat and outcomes are often worse.

Underserved Patients

Government data show about 75 million Americans live in Health Professional Shortage Areas for Primary Care. Unsurprisingly, the populations of these areas tend to "include low-income populations," according to the Health Resources and Services Administration.

Nearly one quarter (24 percent) of Hispanic adults say they have no usual source of health care other than the hospital emergency department, and 21 percent of Hispanic adults say it is somewhat or very difficult to get to a location for health care.

The Association of American Medical Colleges reports more than 200,000 additional doctors would have to be trained and installed in the workforce to ensure underserved communities have access to care at the same rate as everyone else.

Parity for Doctors

A bipartisan coalition of physician members of Congress has introduced the Strengthening Medicare for Patients and Providers Act (H.R. 2474) to address the inflation factor in Medicare reimbursement. A report from the Senate Finance Committee on Medicare physician reimbursement is gaining praise.

The Medicare reimbursement model is essentially a type of price control, which reduces the supply of the affected good or service. While the health care system needs plenty of reforms, one cornerstone is inescapable: without enough doctors, policy changes—no matter how well drafted and implemented—will always fall short. In the end, patients will bear the heaviest burden.

Mario H. Lopez **(MHL@HispanicLeadershipFund.org)** *is president of the Hispanic Leadership Fund, a public policy advocacy organization that promotes liberty, opportunity, and prosperity for all.*

Trump Must Use His Victory to Fix Health Care

By Chad Savage, M.D.

With the reelection of Donald Trump and the potential involvement of transformative figures such as Elon Musk and Robert Kennedy Jr., the United States may have a unique opportunity to reform health care in ways not seen in generations.

It's widely recognized that our current health care system is severely flawed. Health care comprises nearly one-fifth of the U.S. economy and is bogged down by layers of administrative and bureaucratic inefficiencies that inflate costs, distort incentives, and hinder both quality and accessibility of care.

Nearly half of health care jobs are nonclinical, meaning they are held by people who do not meaningfully interact with patients, such as billers, coders, administrators, and bureaucrats. These jobs often add little to no value while bureaucratizing care at a massive financial and health cost.

Many of today's health care problems can be traced to the fact that control has been relinquished to governmental and private-sector insurance third parties that relegate the patient to a secondary role, as financial transactions occur between providers and third parties rather than directly involving patients.

Opposing true reform are powerful but parasitic entities that have enriched themselves at the expense of patients, their health, and society. Effective change will not come from top-down tweaks that merely paint over the cracks in the current broken system; it will require transformative incentives that cause the system to reform itself.

President Donald Trump

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Power of Self-Pay

The foundation of this change is to restore the patient as the primary payer in health care, and thus the center of the system's focus. Doing so would eliminate waste, price distortions, and the inherent conflicts of interest in the current system.

A simple shift from third-party control to patient control would trigger a domino effect of meaningful change, introducing incentives for providers to reform or go out of business. Now beholden to patients instead of third parties, health care entities would compete to provide the highest-quality and most cost-effective care, as judged by the end consumer: the patient.

Central to this approach is the understanding that patients already pay for their care at inflated rates. The full extent of this expense is hidden under layers of taxes, premiums, wage deferrals, copayments, and other charges.

Patient Control

Mechanisms already exist that, with minor modifications, could prevent this diversion to third parties and instead allow greater investment in patient-controlled Health Savings Accounts (HSAs) for younger patients and Medical Savings Accounts (MSAs) for Medicare recipients. These accounts should be separated from traditional insurance and be made available for paying premiums for insurance, health-sharing plans, short-term policies, or other options deemed best by the patient to meet individual needs.

With control over these tax-preferred accounts, patients would access the care they want—not just what a third party allows. Restrictive networks, obstructive authorizations, and referrals would no longer stand between patients and their care.

Guided by a trusted physician, the only authorization a patient would need is his or her own. Patients would demand high-quality, cost-effective, accessible care from their providers—and if unsatisfied, they could take their dollars elsewhere.

Domino Effect

This patient-centered payment method would be flexible enough to allow for rapid innovation. That would put legacy health care establishments under positive stress to provide value or risk being outcompeted by providers better at meeting patients' demands. Insurance, while still necessary, would return to its intended role as a financial tool to prevent catastrophic financial loss, not the overriding manager of all medical care.

For those truly unable to afford even this more affordable model, a means-tested approach could support their accounts, with contributions from family, friends, charities, or the government. These patients would still control their funds and retain incentives to help rein in excesses in the health care system.

This simple approach could transform our health care system, potentially halving our $4.8 trillion price tag. Such savings—on par with the GDP of entire nations—could reduce the national budget deficit, alleviate the leading cause of bankruptcies, and lower employment costs, enhancing American companies' competitiveness in the global market.

With Trump's solid victory and and Republican majorities in the U.S. Senate and House, we are at an unprecedented crossroad. Will we seize this opportunity?

Chad Savage, M.D. (**chad.savage@yourchoicedirectcare.com**) *is a Heartland Institute policy advisor, Docs 4 Patient Care Foundation policy fellow, and the president of DPC Action. A version of this article was published by* RedState. *Reprinted with permission.*

COMMENTARY

A Little-Known Cost Driver: Seniors Love Going to the Doctor

By Devon Herrick

Visiting the doctor is often an exercise in inconvenience.

I once read that when you include travel, sitting in the waiting room, filling out paperwork, waiting in the exam room, and talking with the office nurse, that 15 minutes of face time with your doctor takes about three hours out of your day. That sounds a little high, but the average time varies by the physician's specialty and whether the clinic is urban, suburban, or rural.

Then there is the lead time required to schedule a visit. The average time to see a family physician is three weeks (20.6 days), according to a recent survey by *AMN Healthcare*. That is an improvement from 2017, when the average wait time was 29.3 days. However, wait times for specialized care like cardiology appointments have increased from 21 days in 2017 to 26.6 in 2022.

"YouTube would be a great way to provide interactive group therapy. Any of the thousands of physicians on YouTube could create interactive group practices and monetize them with a small fee, maybe $20, spread over 100 people. Patients could log on at various times to participate in video chats or live events on different health topics."

DEVON HERRICK
HEALTH CARE ECONOMIST

Specialist Proliferation

The New York Times wrote on November 24, 2024, about the time taken up by physician visits, especially by seniors, who generally are covered by Medicare and may be retired.

The *Times* quoted a senior who explained every body part has its own doctor—one for primary care, another for the heart, a lung surgeon, a pulmonologist (for a family history of lung cancer), an ophthalmologist, a gynecologist, a urologist, a podiatrist, a gastroenterologist, and a dentist.

The senior estimated she sees a doctor or gets medical services about 24 times a year. She is not alone in that. Medicare data shows people 65 and older average about 17 contacts with the health care system per year (excluding the dentist).

For seniors with a myriad of chronic conditions (14 percent of seniors), contact days with the health care system rise to 30. Eleven percent of seniors see a doctor or some other ambulatory medical service 50 times a year.

Some seniors experience treatment cascades: the more they go, the more a doctor finds wrong, leading to more treatments that can cause more harm than good.

Low-Value Care

The *Times* article says one way to reduce these time burdens is to eliminate "low-value care." This category includes services of "dubious worth" such as screening for prostate cancer in men older than age 70, and "unneeded testing before surgery."

The *Times* suggests health care centers reduce treatment burdens by moving specialists to one building and removing incentives for scheduling multiple tests and visits.

That sounds like happy talk by public health advocates and makes little sense to an economist. Our health care system is not competing on price, quality, or other amenities. Doctors' schedules are typically fully booked. The only incentive they have to reduce low-value care is if they can instead fill their time with more-lucrative patient treatments.

Considering some of the care they provide is performed by others (blood tests, CT scans, physical therapy, etc.), turning away a low-value-care patient is unlikely to boost their income but would reduce their hospital employer's income.

Socialization Factor

There may be another, more disturbing mechanism at work. Many seniors like going to the doctor. A while back I read an article about seniors in Florida, a state with a large senior population. The article claimed visits to the doctor function as social occasions for many seniors.

Seniors go to the doctor and talk to other seniors in the waiting room, compare notes, and recommend new doctors to each other. Strangers they did not know prior to their visit now want to see the doctor another senior raved about. Indeed, it is well-known that seniors living in retirement destinations see their doctors more than their contemporaries who live in places with a lower concentration of people in their age group.

I have even talked to some pharmacists and policy analysts who said seniors often refuse to switch to mail-order prescriptions because their trek to the pharmacy is part of a monthly ritual that gives purpose to their life.

Interactive Group Therapy

If seniors want a heath care village (you know, it takes a village) with interaction with other seniors and tons of care at low cost, my idea of social-media-based interactive group therapy would work well. Recent data found about half of Generation Z turns to health influencers on TikTok because it's both convenient and cheap—free, actually.

Seniors may not gravitate to TikTok, but most know how to search the internet for information. Surveys going back 20 years have consistently found that more than 100 million Americans search online for health information each year. Google reports there are roughly 70,000 health-related searches every minute. One article even claimed doctors use Google and YouTube to learn about diseases and conditions they treat.

YouTube would be a great way to provide interactive group therapy. Any of the thousands of physicians on YouTube could create interactive group practices and monetize them with a small fee, maybe $20, spread However, wait times for specialized care like cardiology appointments have increased from 21 days in 2017 to 26.6 in 2022. 100 people. Patients could log on at various times to participate in video chats or live events on different health topics.

Apart from that, it may not be easy to make physician visits less of a pain or discourage unnecessary trips to the doctor.

Devon Herrick (**devonherrick@sbcglobal.net**) *is a health care economist and policy advisor to The Heartland Institute. A version of this article appeared on the* Goodman Institute Health Blog. *Reprinted with permission.*

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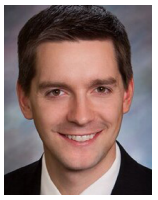

"Heartland's research and advocacy for science-based policies that improve people's lives have been very helpful to me and my colleagues."

REPRESENTATIVE ISAAC LATTERELL
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