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

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

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

HEALTH CARE NEWS

Vol. 26 No. 04 April 2025 HealthCareNewsOnline.com

The Pulse

Medicaid Improper Payments Estimate: $1,100,000,000,000

By AnneMarie Schieber

Medicaid issued approximately $1.1 trillion in improper payments over the past decade, double the agency's stated amount, the Paragon Health Institute estimates.

"Cracking down on improper payments is a necessary first step that could provide hundreds of billions of dollars in Medicaid savings for federal taxpayers," states the organization's March 3 policy brief based on examination of eligibility checks from government audits.

Audits included state eligibility determinations in only two of the past 10 years, the document states. "In those two years that did include meaningful, complete audits of state Medicaid programs, improper

MEDICAID PAYMENTS, p. 6

CMS Appears to be All-In on Drug Price Negotiation

By Kevin Stone

The Trump administration indicated Medicare drug price negotiations under the Inflation Reduction Act (IRA) may undergo a reexamination to add greater transparency and possibly other reforms.

A 125-word news release on January 29, 2025 stated lowering drug prices is a "top priority" for President Donald Trump, who wants to "provide opportunities for stakeholders to provide specific ideas to improve the Negotiation Program, consistent with the goals of

DRUG PRICES, p. 4

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

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

Goodman Institute
FOR PUBLIC POLICY RESEARCH

Turning Healthcare Ideas Into Public Policy

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

Dr. Goodman addressing The Economic Club of Indiana

What We Have Accomplished

Health Savings Accounts

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

1

Roth IRAs

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

2

Social Security

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

3

401 (k) Plans

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

4

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

Health Care News

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

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

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

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

EXECUTIVE EDITOR
S.T. Karnick

EDITORIAL DIRECTOR
Chris Talgo

MANAGING EDITOR
AnneMarie Schieber

PUBLISHER
Jim Lakely

DESIGN AND PRODUCTION
Donald Kendal

ADVERTISING MANAGER
Jim Lakely

CIRCULATION MANAGER
Keely Drukala

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

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

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

Giving Patients Money is the Ideal Way to Reform Government Health Programs

By AnneMarie Schieber

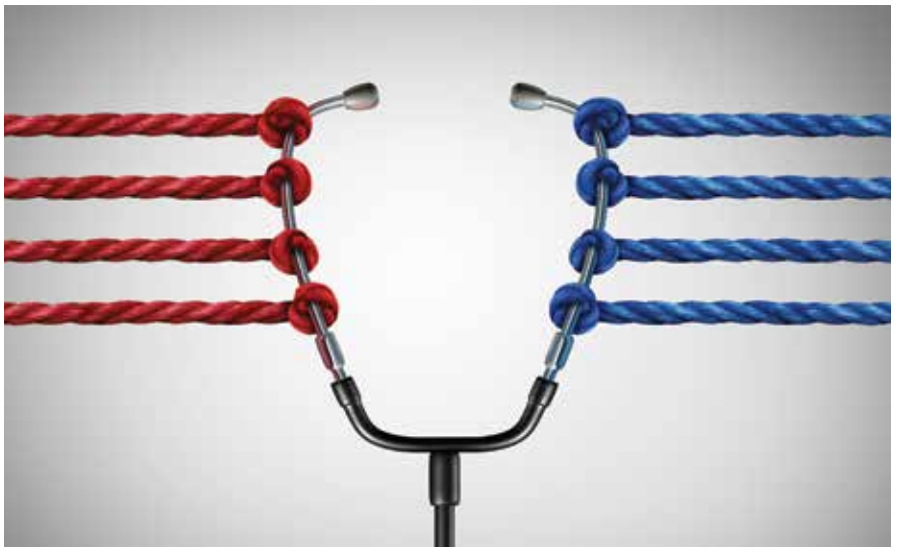
Offering people money instead of social programs and market regulations can help lawmakers get health care budgets under control without a huge political fight, said panelists during a public forum on February 12.

"Who is the best judge of value? People," said David Hyman, M.D., J.D., a Cato Institute scholar and law professor at Georgetown University Law Center, at a Cato Institute forum titled "Health Reforms That Meet the Need." (See related articles, pages 1,5.)

"If you want to disrupt the status quo, you need to figure out a way to enlist patients on your side for whatever reform it is you're proposing and the best way to do that is to give them money directly rather than funnel it through other people," said Hyman

With Congress under heavy pressure to reduce the $1.7 trillion federal deficit, the House Energy and Commerce Committee is looking at ways to reduce $900 billion of that spending over the next decade. Opponents of budget cuts claim Medicaid and Medicare will be under the knife.

Health care spending is growing faster than the overall economy, but cutting public benefits is always politically harmful, the panelists noted.



"Health care is intensely personal, and if you want to make big changes, you better be prepared for the push-back."

DAVID HYMAN, M.D., J.D.
LAW PROFESSOR, GEORGETOWN UNIVERSITY LAW CENTER

Money Talks

Opinion polls show Social Security has wider public support than Medicare, probably because it provides people with a check in hand instead of telling them what to buy, Hyman told the gathering. Medicare and Medicaid are payers and are more popular among doctors and hospitals, who are paid by the programs, than among patients, said Hyman.

The median spending on a Medicare enrollee is $15,727 a year.

Medicare is an open-ended "defined benefit plan," rather than a "defined contribution plan" which is not how most pension plans are run now, said Hyman.

"That doesn't work out so well, from a budgetary perspective and a quality-of-care perspective," said Hyman.

Funneling health care spending through a government budget makes little sense, said Hyman.

"If you look at how people make their spending decisions, they value health care, but they value all sorts of things, but we subsidize health care to a degree that we don't in other areas of the economy," said Hyman.

Employer Advantage

Another area where Congress can act if it wants to slow down increases in health care spending and put more money into people's pockets is to eliminate the employer tax exclusion, said the panel.

"It is the functional equivalent of a mandate to purchase health insurance, which by the way is lousy health insurance," said Michael Cannon, director of health policy studies at Cato.

The tax exclusion allows employers an exemption from payroll taxes on a portion of employee compensation that is spent on health insurance. Cannon said this robs workers of control over their earnings and drives up health care costs because there is no incentive to shop for the best prices.

In addition, Cannon said, the employer plans are not portable, so employees lose their insurance when they leave their jobs.

Cannon says Congress should reconsider the $1 trillion per year it spends to subsidize employer plans and direct that money into tax-advantaged universal health accounts, about $9,000 a year for individuals and $18,000 for families.

"This is the best politically feasible option Congress has before us," said Cannon. "It can be bipartisan, efficient, and equitable," and can "provide a large, immediate benefit."

Political Risk

Legislators should bear in mind what happened when Congress passed the Medicare Catastrophic Coverage Act of 1988 and then had to repeal it shortly afterward due to public backlash, said Hyman. House Ways and Means Chairman Dan Rostenkowski was chased down the street by angry senior citizens.

The plan improved Medicare, especially for those with severe disabilities or acute illnesses, and was an ideal way to design an insurance product, but lawmakers made the political mistake of frontloading "the spinach while backloading the dessert by forcing the beneficiaries to pay for the benefits they were going to receive" later, said Hyman.

"Health care is intensely personal, and if you want to make big changes, you better be prepared for the push-back," said Hyman.

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

CMS Appears to be All-In on Drug Price Negotiation

Continued from page 1

achieving greater value for beneficiaries and taxpayers and continuing to foster innovation."

Trump met privately with drug company executives on February 20. *BioSpace,* citing *Bloomberg*, reported the group discussed the IRA, tariffs, and antitrust regulations (see related article, page 5).

Drug Makers' IRA Ire

Several drug manufacturers have filed lawsuits to block the drug negotiation mandate under the IRA, which was signed in 2022 by former President Joe Biden. A February 19 filing by the Trump administration agreed with the legal arguments used by the prior administration and with rulings made by lower courts.

Health and Human Services Secretary Robert Kennedy Jr. indicated in his confirmation hearing that he will comply with the law as it stands and support Trump's position on prescription drug price negotiation.

In the final weeks of Biden's administration, the Centers for Medicare and Medicaid Services (CMS) announced 15 additional drugs subject to price negotiations. The government made 10 drugs subject to negotiation in the first round under the IRA on August 15, 2024.

The Congressional Budget Office (CBO) had estimated the program would save consumers $100 billion in the first 10 years. Biden's CMS administrator, Chiquita Brooks-LaSure, announced on January 17, 2025 a modest forecast of $1.5 billion.

The price reductions are scheduled to go into effect starting in 2026.

Bad Fits

Of the 15 drugs announced in the second round, none met the criteria for price and utilization set out in the law, says Douglas Holz-Eakin, president of the American Action Forum.

"The poster child of the 'need' for negotiation is a branded drug with no [branded] competition and an extremely high price per dose, treatment, or beneficiary," wrote Holz-Eakin in a blog post. "The first 10 drugs contained many that looked nothing like this—notably Xarelto and Eliquis, two blood thinners that are relatively cheap, compete vigorously with one another, and are simply used by a large number of seniors."

The second round of 15 drugs is not much better, says Holz-Eakin.

"I don't believe CMS should be doing this at all, but if the goal is to lower prices, the focus should be on prices, not total [Medicare parts B and D] spending," Holz-Eakin told *Health Care News*.

Regulatory Discretion

The IRA granted CMS the authority to determine a drug's "maximum fair price (MFP)" but does not specify how the agency should do that.

In 2018, the Trump administration released a global international reference pricing model called the International Pricing Index (IPI) to "preserve or enhance quality of care for beneficiaries while reducing expenditures for Medicare Part B drugs to more closely reflect international comparator countries."

In any case, "the entire 'negotiation' regime is poor policy," says Holz-Eakin. "Nevertheless, [the IRA] is sufficiently flexible, and such a black box, that CMS can use any criteria for setting the Maximum Fair Price, including a global reference price," said Holz-Eakin.

Political Horse Trading

Subsidizing other countries or U.S. drug manufacturers and their research and development teams is not the purpose behind the high drug prices under Medicare, says Michael Cannon, director of health policy studies at the Cato Institute. The real reason Medicare drug prices are higher than those of peer nations is in the unusual way American politics functions, says Cannon.

"Medicare pays significantly higher prices for medicines than government programs in other countries and even other government programs in this country," said Cannon. "In many cases, Medicare enrollees can buy their medicines with cash for a lower price than Medicare gets.

"If we can say those high prices have a purpose, it is that they create a political equilibrium where drug manufacturers, Medicare enrollees, and voters are happy enough with how Medicare is operating that they do not demand major changes," said Cannon. "That's all. And it should tell us something about government's ability to manage health care that those equilibrium prices are so outrageously high."

"Unlike many in Republican circles, President Trump takes a hard line on drug manufacturers and the high prices they charge on brand-name drugs."

GREGG GIRVAN
RESEARCH FELLOW
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

Steady State

Trump may be content to leave the IRA price negotiation regime largely untouched for now, says Gregg Girvan, a research fellow at the Foundation for Research on Equal Opportunity.

"As a general matter for how things will proceed under the new administration, not much is going to change for the second round of IRA price negotiations taking place this year," said Girvan.

"Unlike many in Republican circles, President Trump takes a hard line on drug manufacturers and the high prices they charge on brand-name drugs," said Girvan. "The CMS press release on January 29 largely reflects the administration's intent to move forward with negotiating prices for the 15 drugs selected prior to Trump's inauguration. Notably, the statement also makes clear the administration's intent to improve the process, including through greater transparency, which is a step in the right direction."

There are ways to lower drug prices other than forcing companies to cut their prices, says Girvan.

"There are different approaches than the IRA to accomplish this, including patent and FDA reform that brings generics and biosimilars to market quicker," said Girvan. "Lower prices in the United States may cause prices to rise outside the United States as well, reducing American subsidization of prescription drugs across the world."

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

Big Pharma Meets with President, Questions Remain

By Bonner Russell Cohen

A much-anticipated February 20 meeting between President Donald Trump and representatives of the pharmaceutical industry ended without the companies getting a firm commitment from the new administration that it will scale back provisions of the 2022 Inflation Reduction Act (IRA) that force manufacturers to negotiate lower prices for certain widely used prescription drugs.

The president did not tell the CEOs what his administration plans to do about the IRA drug-pricing provisions, instead informing them their companies would be subjected to tariffs if they did not reshore their manufacturing plants to the United States, Bloomberg reported.

The president has vowed to eliminate the climate-related provisions of the IRA, reported Bloomberg, though he did not commit to addressing other industry concerns.

Possible Irrelevance

The fact that there was no major announcement after the meeting may suggest Trump thinks the price negotiations are a sham, says Jeff Stier, a senior fellow at the Center for Public Choice.

"President Trump sees himself as a dealmaker," said Stier. "Trump knows what negotiations all are about: the government sets the prices, and if the company does not agree, it faces confiscatory and likely unconstitutional fines and penalties."

Patent Wildcard

Much of the controversy over drug pricing is rooted in the Biden administration's changes to the 1980 Patent and Trademark Amendments, also known as the Bayh-Dole Act. In December 2023, the Biden administration issued a final rule limiting patents, or "march-in rights," as a way to control prescription drug prices.

"The announcement advises federal agencies to control the relicensing of high-priced drugs when 'reasonable terms,' as defined by the administration, are not met," reported *Health Care News* on January 18, 2024.

The Trump administration's aggressive budget-cutting may flip the script on Biden's plan to pull patents to limit drug prices, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"The Biden administration's effort to reinterpret the Bayh-Dole law by allowing the government to essentially seize the patent of any federally funded drug if the feds didn't like the price may become a nonissue," said Matthews. "If Washington drastically cuts back federal funding for basic drug research, in the future there won't be any federally funded patents to seize."

President Donald Trump

"President Trump sees himself as a dealmaker. Trump knows what negotiations all are about: the government sets the prices, and if the company does not agree, it faces confiscatory and likely unconstitutional fines and penalties."

JEFF STIER
SENIOR FELLOW, CENTER FOR PUBLIC CHOICE

Vaccine Concession

In addition to wanting Trump to lift Biden's de facto price controls on drugs, vaccine policy has been on Big Pharma executives' minds.

Top Trump health officials, such as HHS Secretary Robert F. Kennedy, Jr. and Trump's nominees to head the FDA, Marty Makary, and the CDC, Dave Walden, have expressed varying degrees of skepticism about the safety and efficacy of vaccines, a subject that continues to roil public opinion in the aftermath of the nation's experience with mRNA vaccines during the pandemic.

At a PhRMA Forum two days before the White House meeting, Pfizer CEO Albert Bourla said he thinks Kennedy will stand in the way of any big vaccine rollouts.

"Do I think we can convince them to do something bold on vaccines with Kennedy in HHS? Probably not," *Science* quoted Bourla as saying. "Do I think we can convince them to do something very bold for cancer or cardiovascular diseases with Kennedy in the HHS? Absolutely yes."

Kennedy published a favorable March 2 op-ed for *Fox News* on vaccines. Responding to widespread reports of a measles outbreak in Texas, Kennedy, a prominent critic of the mumps, measles, and rubella (MMR) vaccine, wrote, "Vaccines not only protect individual children from measles, but also contribute to community immunity, protecting those who are unable to be vaccinated due to medical reasons."

Trust Issues

Kennedy pointed out that 79 of the 146 cases at the time of writing were individuals who did not receive the MMR shot.

"Parents play a pivotal role in safeguarding their children's health," wrote Kennedy. "All parents should consult with their health care providers to understand their options to get the MMR vaccine. The decision to vaccinate is a personal one."

Kennedy's op-ed did not convince Matthews that he has changed his mind.

"The anti-vax Secretary Kennedy was likely pushed to say something positive about the measles vaccine – just as then-President George W. Bush pushed some of his free-market trade economists to support steel tariffs," said Matthews. "But Kennedy has several behind-the-scenes ways of limiting or roadblocking vaccine development and promotion, like his decision to cancel two vaccine advisory committee meetings just as they are gearing up to consider the fall flu vaccine."

Drug Equality

The drug industry has criticized other Biden policies that Trump could address.

One is the so-called pill penalty, a provision of the IRA that sets a shorter time for chemically derived, small-molecule drugs to be protected from price negotiations than is the case for biologics, drugs that are developed from living organisms and more complex to produce. The industry wants the same treatment for both, Bloomberg reports.

A new administration might also consider giving pharmaceutical companies a break from the strict antitrust policies of the previous administration, including improper patent listings in the FDA's "Orange Book," merger enforcement, and actions related to pharmacy benefit managers, according to a forthcoming Rutgers Law School paper.

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

Medicaid Improper Payments Estimate: $1.1 Trillion

Continued from page 1

payment rates exceeded 25 percent," the paper states. "Applying a 25 percent improper payment rate across the $4.3 trillion of federal Medicaid spending from 2015 to 2024 yields roughly $1.1 trillion in federal Medicaid improper payments over the past decade."

Obamacare, which vastly expanded Medicaid eligibility, went into effect in 2014. In the early years of expansion, the Obama administration stopped including state eligibility determinations, "likely because such audits may have conflicted with [President Barack Obama's] attempts to build public support for the law," the paper states.

"In those two years that did include meaningful, complete audits of state Medicaid programs, improper payment rates exceeded 25 percent. Applying a 25 percent improper payment rate across the $4.3 trillion of federal Medicaid spending between 2015 and 2024 yields roughly $1.1 trillion in federal Medicaid improper payments over the past decade."

POLICY BRIEF
PARAGON HEALTH INSTITUTE

'Essentially Money Laundering'

During a February 12 panel discussion hosted by the Cato Institute, Paragon President Brian Blase said the federal government pays for at least half of states' Medicaid spending, and for many recipients it can reach 100 percent.

"States don't actually need to come up with their share of the [Medicaid] spending," said Blase. "They have been incentivized to create financial gimmicks that give the appearance of an actual expenditure, … so the federal government is reimbursing states for what is essentially money laundering."

Additionally, there is no cap on how much states can spend on their programs.

"If you are going to have an open-ended reimbursement program, you have to make sure the expenditures are legitimate," said Blase.

Congress is considering giving states block grants to rein in Medicaid spending, which now exceeds $880 billion a year.

'Provider Tax' Scam

In addition to failing to review eligibility determinations, states use other schemes to maximize federal reimbursements.

One scheme that got its start before Obamacare went into effect is the so-called "provider tax" that states impose on health care providers, who then submit the tax to the state as a Medicaid expense. After the federal government reimburses the state for the expense, the state often gives the money back to the provider.

"It is not a 'tax' if the recipient develops the tax and lobbies the government to assess it on them," said Blase.

The scheme has been no secret, but Congress and presidents have failed to end it, said Blase. The practice has gotten so out of hand that states are now ordering Medicaid managed care plans to reimburse hospitals at commercial rates for their services—two to three times what Medicare pays.

These "direct payments" should be capped at what Medicare pays or lower, said Blase.

"Health care providers should not be making windfall profits through a welfare program," said Blase.

Ninety Percent Match

The 90 percent "match rate" the federal government pays to cover able-bodied enrollees with incomes above the federal poverty level is another problem, Blase told the audience. The government pays a 50 to 75 percent "match rate" for Medicaid's traditional population.

"This makes no sense," said Blase.

Paragon proposes transitioning the able-bodied population who earn 100 to 138 percent of the federal poverty level in to the Obamacare exchanges over the next 10 years and giving the group a premium tax credit. Health coverage would remain the same, but because all Medicaid enrollees would be reimbursed at the same level, there would be no incentive to favor one group over another.

"We think this reform will save over half a trillion dollars over the next decade," said Blase.

Incentives to Overspend

Congress should also address the Medicaid funding formula known as the Federal Medical Assistance Percentage (FMAP), which was designed to help poorer states cover mandatory benefits, says Blase. FMAP considers average per capita income and applies a multiplier to even out federal reimbursement. Blase says the formula is doing the opposite of what was promised.

"We are transferring far more money to wealthier states that have grown more profligate Medicaid programs, than poorer states," said Blase.

Under the formula, Medicaid is prohibited from reimbursing less than 50 percent. Blase said to get back to the original intent of FMAP, the 50 percent floor should be lowered for wealthier states.

Obamacare Enrollment Fraud

Wasteful government health care spending is also occurring in Obamacare plans, as increased federal subsidies have pushed them close to the no-cost care that Medicaid provides, says Blase.

The American Rescue Plan Act and the Inflation Reduction Act changed the formula for Obamacare insurance plans to allow more people to qualify.

"If you think of the value proposition here, you're expanding coverage to people who don't need to get any financial value from the product," said Blase.

In addition, enrollees must predict their household income for the following year to qualify for the subsidies, which has incentivized signups, said Blase. Signups in the states far exceed the number of people who meet the income guidelines for the nearly free health care, says Blase.

"Government programs should not be operating like this," said Blase.

'Just Let Them Expire'

The enhanced subsidies are set to expire at the end of 2025.

"Congress should do no harm here, and they should just let them expire," said Blase.

Another good reform would be to allow low-income Americans to use a portion of their Obamacare subsidy as a contribution to a health savings account, Blase said.

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

ID Verification for Entitlements Can Save $1 Trillion a Year, CEO Tells Congress

By Harry Painter

Simply verifying recipients' identification could save $1 trillion in entitlement spending per year, LexisNexis Special Services CEO Haywood Talcove told a congressional committee.

"Between federal, state, and local government, you can save one trillion dollars a year by simply putting in front-end identity verification, eliminating self-certification, and monitoring the back end of the programs that are providing the benefits," Talcove said before the Delivering on Government Efficiency (DOGE) Subcommittee of the House Committee on Oversight and Government Reform.

"Since 2003, federal agencies have reported approximately $2.7 trillion in cumulative improper payments, a staggering figure that underscores the persistent vulnerabilities across government programs," Talcove told the lawmakers.

U.S. welfare programs, in particular, are fraught with "fraud, mismanagement, and outdated verification systems," said Talcove. "In fiscal year 2023 alone, improper payments totaled $236 billion, spanning over 71 federal programs," as just part of the total amount of fraud.

'Giant Piñatas for Thieves'

"There is no reason to believe Mr. Talcove is incorrect," said Linda Gorman, director of the Health Care Policy Center at the Independence Institute. "For decades, it has been widely acknowledged that federal programs are giant piñatas for thieves of all sorts. The GAO and various Inspectors General issue reports detailing rampant fraud in entitlement programs."

Fraud is a consequence of bureaucracy and politics, says Gorman.

"The people running the federal government have measured program success by budget growth, not by whether the funding was properly targeted," said Gorman. "The politicians supposedly overseeing programs run on how much money they have given to how many people."

Wrong Numbers

The income calculation for welfare program eligibility is very inaccurate and should be changed, says Gorman.

"Income is a fluid concept and should not be used for large-scale program enrollment," said Gorman. "Using federal poverty levels for Medicaid eligibility may be convenient, but it comes with serious problems. For example, federal poverty levels include only reported money income. They ignore the value of any in-kind state and federal benefits a household may be receiving."

Enrollees can misstate their income and get away with it, says Gorman.

"Evidence from Medicaid suggests that a lot of people misstate their income and become eligible because government does not check like the private sector does," said Gorman.

Multiple Dippers

The government also fails to check whether a person has enrolled multiple times, says Gorman.

A 2024 Massachusetts audit found the state made "more than $3.8 million in improper capitated payments to managed care organizations on behalf of members with more than one ID," said Gorman.

In the state of Washington, double enrolling led to $300 million in waste, an audit reported in October 2024. An audit in Colorado found the state paid $7 million to known dead people from 2018 to 2020.

"From 2015 to 2024, Medicaid alone paid about $1.1 trillion for the care of individuals who were probably not eligible," said Gorman, citing a study by Brian Blase of the Paragon Health Institute. "This is double the rate reported by CMS." (See related article, page 5).

"Estimates of total fraudulent payments are mindboggling," said Gorman. "Agencies face zero consequences for not addressing fraud and have no incentive to try to retrieve their funds."

Obsolete Processes

Congress has failed to require government bureaucrats to spend taxpayer money only on its stated purposes, says Gorman.

"The private sector has embraced computers in management and used software to replace hordes of middle managers and clerks who tracked sales, inventories, and costs," said Gorman. "It is long past time for the federal government to do the same."

Evidence of the need for better oversight is piling up, says Christopher Talgo, editorial director and a research fellow at The Heartland Institute, which co-publishes *Health Care News*.

"I.D. verification is more than necessary to prevent at least some of the rampant waste, fraud, and abuse that has become so entrenched in the Big Three entitlement programs over the past several decades," said Talgo, referring to Medicaid, Medicare, and Social Security.

"For instance, we know that illegal immigrants are getting Medicaid even though they are not eligible for the program," said Talgo.

System Failure

Talgo is coauthor of a September 2024 report for The Heartland Institute calling for further verification of Medicaid eligibility in addition to other measures for cutting fraud and waste.

"As Talcove's report shows, Social Security, Medicaid, and Medicare are rife with improper payments," said Talgo. "From outright fraud to people receiving checks who are no longer living, these programs must be properly vetted to ensure that taxpayer dollars are not being wasted."

"To really reform our out-of-control entitlement spending, we must reform these programs to ensure they are serving only the most vulnerable people. These programs are on the brink of insolvency because they have been thoroughly abused by fraudsters and con artists."

CHRISTOPHER TALGO
EDITORIAL DIRECTOR
THE HEARTLAND INSTITUTE

Cheating Incentives

The Centers for Medicare and Medicaid Services (CMS) has failed to provide proper oversight of states' claims about enrollees, says Gorman.

"Given the size of the federal match for the expansion population and the fact that states get matching funds for the taxes they levy on health care, they have little incentive to make sure that only people who are eligible are enrolled," said Gorman.

Fraud and abuse in entitlement programs divert help from those who need it, says Talgo.

"To really reform our out-of-control entitlement spending, we must reform these programs to ensure they are serving only the most vulnerable people," said Talgo. "These programs are on the brink of insolvency because they have been thoroughly abused by fraudsters and con artists.

"Reinserting commonsense policies like work requirements and asset verification would make a huge dent in the blatant waste, fraud, and abuse that has put these programs in jeopardy," said Talgo.

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

INTERNET INFO

S. T. Karnick, Matt Dean, Christopher Talgo, "American Health Care Plan: State Solutions," The Heartland Institute, September 3, 2024: **https://heartland.org/opinion/new-heartland-institute-report-the-2024-american-health-care-plan-state-solutions/**

Federal Court Blocks NIH Research Grant Administrative Fee Rate

By Kevin Stone

A federal judge in Massachusetts issued a nationwide preliminary injunction to stop the National Institutes of Health (NIH) from setting "indirect costs" for grants at a flat rate of 15 percent.

"Indirect costs" are paid to universities and research institutions to cover administrative expenses attributed to research projects. Indirect costs can run as high as 69 percent of direct grant monies. The move would save taxpayers billions of dollars each year, $9 billion dollars in 2023 alone, according to *Forbes*.

In her 76-page opinion on March 6, U.S. District Court Judge Angel Kelly, a Biden appointee, ruled the cap violated federal statutes because it would apply to grants already approved, is "arbitrary and capricious," and causes "irreparable harm."

The federal government can appeal the ruling.

Quick to Court

On February 7, NIH announced the cap on "indirects." Within days, 11 universities and two related academic associations filed a lawsuit opposing the rule, and 22 mostly blue states filed another.

The stakes are high. Last year, Harvard received $135M in NIH funding for indirect costs, which would have been limited to $31M under the new cap.

The 15 percent indirect rate is in line with what many of the nation's largest private sector funders of research grants, including the Bill and Melinda Gates Foundation, pay out to cover administrative costs. The limit is often 10 percent for institutions of higher education.

In addition to Harvard's 69 percent rate, NIH has paid Yale University at 67.5 percent, and Johns Hopkins University at 63.7 percent. All those schools have large endowments in the tens of billions of dollars.

Bureaucracy Over Research

These well-funded institutions neither need nor deserve such large payments, says Phil Kerpen, president of American Commitment and the Committee to Unleash Prosperity.

"Taxpayers are being ripped off to fund the administrators and bureaucracy of institutions like Harvard and Johns Hopkins that are more than capable of funding themselves," said Kerpen. "All else equal, every dollar of indirects is a dollar that could go to another scientific grant.

"These numbers are unheard of for any funder in the world besides the NIH," said Kerpen. "It is de facto federal funding of university and medical center bureaucracies."

Gregg Girvan, a resident fellow at the Foundation for Research on Equal Opportunity, says major research universities are anything but financially strapped.

"Consider that there are about 150 universities in the United States that have endowment funds of $1 billion or more," said Girvan. "It is hard to square this fact with universities demanding they be able to pull in whatever indirect percentage they want.

"This also needs to be viewed in the broader political context around universities themselves," said Girvan. "According to Gallup, public opinion of higher education is at an all-time low. The poor image of universities is reinforced when campus administrators complain that lower indirect spending will result in research programs closing while they sit on endowment funds as high as $52 billion."

More for Researchers

Though universities are calling the cap "an existential threat" to research, the cuts likely have a silver lining, says Girvan.

"It makes no sense how a cap on indirect costs will kill scientific discovery and innovation," said Girvan. "First, indirects make up about a quarter of NIH grant awards, which in turn is a small percentage of total spending in medical R&D. Drug companies themselves are spending multiples of the total grants NIH awards every year.

"In addition, reducing indirect spending means those funds are freed up to award grants directly to researchers," said Girvan. "It is perplexing to me why the scientists themselves are so upset that indirects will be cut, since they have the most to gain from the policy."

Said Kerpen, "Legitimate research projects will benefit because more will be funded when less money is diverted to overhead."

Legislating the Ratio

The most important reform would be to lower NIH grant spending overall, says Michael Cannon of the Cato Institute.

"The indirect-cost percentage is not as important as the total grant amount," said Cannon. "If you push the indirect-cost percentage down, grantmakers and recipients might independently or collusively increase the grant amounts to compensate.

"That's why a good rule is 'never legislate a ratio,'" said Cannon. "Even if you can control the numerator—which isn't always the case—you have less control over the denominator."

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

"Taxpayers are being ripped off to fund the administrators and bureaucracy of institutions like Harvard and Johns Hopkins that are more than capable of funding themselves. All else equal, every dollar of indirects is a dollar that could go to another scientific grant."

PHIL KERPEN
PRESIDENT
COMMITTEE TO UNLEASH PROSPERITY

Economists: No Link Between Health Care Spending and Better Outcomes

By AnneMarie Schieber

As Congress grapples with how to get the $1.83 trillion a year budget deficit under control, a group of panelists suggest health care spending can be cut by as much as 30 percent with no effect on overall health.

Health care spending consumes approximately 18 percent of U.S. gross national product, the largest percentage among developed countries.

"The reason we spend so much on health care is because the government compels us to," said Michael Cannon, director of health policy studies at the Cato Institute, during a three-hour February 12 panel discussion titled "Think Bigger: Meaningful Health Reform."

Also on the panel were Robin Hanson, an associate economics professor at George Mason University, and Mark Miller, executive vice president of health care at Arnold Ventures.

Eighty-five percent of all U.S. health care spending is compulsory, a few notches behind Cuba, Cannon told the group, meaning health care spending "reflects government's preferences rather than consumers'."

If lawmakers were to cut $2.5 trillion from that spending, about 9 percent of the total, it would make little difference in a key measure of health, Hanson said.

"A typical estimate, if there is a benefit, is usually 1 percent of mortality, roughly two months of life," said Hanson. Some studies have shown overtreatment can be harmful, Hanson noted.

"If 9 percent of GDP is at stake here, we have the potential for huge savings if we could believe that in fact half of medical [spending] just isn't that useful."

ROBIN HANSON
ASSOCIATE ECONOMICS PROFESSOR
GEORGE MASON UNIVERSITY

Can't Buy Health

Hanson says four randomized controlled trials make a strong case that spending more on health care does not improve overall health outcomes.

The Rand Health Insurance Experiment looked at 7,700 people, half of whom got unlimited care and the other half of whom did not. The group that received unlimited care spent 30 to 40 percent more on health care with no significant improvement in health.

The Oregon Medicaid experiment was a two-year trial of about 8,000 people in which some were selected through a lottery to receive Medicaid coverage. The group that received Medicaid showed no significant improvement in health. Notably, the group reported feeling better before the trial began.

A third study looked at 52,000 people in rural India who had access to cheap hospital insurance. Those people spent more on health care, accessed health care more often, and showed no significant improvement in health.

The fourth study, often referred to as the "U.S. Taxpayer" experiment (2019), looked at the impact of a letter warning people they would receive a penalty if they did not purchase insurance. Researchers compared this group (4.5 million people) to an equal-sized group that did not receive the letter. The people who received the letter bought 0.23 months more insurance (about one week) than the control group and showed a 0.06 lower mortality rate.

That sounds impressive only until you read the appendix, said Hanson.

"They picked a certain age range," said Hanson. "They tried other age ranges but didn't get significant results."

Waste or Value

Hanson said there are better ways to determine the value of health care spending.

Among those are Cochrane reviews and individualized mining of the margins in medical studies. When a treatment is not offered in a small hospital or low-spending geographic region, that is often an indicator that it is of low value. Another gauge is how strongly doctors recommend a treatment and how much patients say they would be willing to pay for it, Hanson told the gathering.

"If 9 percent of GDP is at stake here, we have the potential for huge savings if we could believe that in fact half of medical [spending] just isn't that useful," said Hanson.

"Congress could cut back on health care spending by a substantial amount without reducing overall health outcomes," said Cannon.

Health Care, Not Pet Care

Medicare and Medicaid especially deserve scrutiny, said Cannon.

Cannon shared several charts demonstrating inefficiencies and overpayments for procedures. A study found when Medicare enrollees switch from traditional fee-for-service to Medicare Advantage, Medicare pays 22 percent more, Cannon said.

The increase is caused by "selection and upcoding," and it is notable more insurance companies are entering the MA market, said Cannon.

"That's an indication the insurers are getting pretty lavish subsidies," said Cannon.

MA insurers attract enrollees by offering things not traditionally covered by Medicare, such as pet care, hair care, transportation, and structural home modifications, said Cannon.

If Congress cuts Medicaid, "every state in the union has the power to levy taxes to keep its Medicaid program exactly as it is," Cannon said.

If states keep the lower Medicaid coverage in line with reduced federal subsidies, it will be because the states don't value the programs, Cannon told the audience.

200 Percent Payment Boost

Another reform would be to pay the same amount for each service, regardless of who provides it. Medicare pays more for services conducted by hospitals, which pushes private practices to join hospital groups.

"Overnight, you can increase your revenues 50, 100, 200 percent" by aligning with a hospital, said Miller.

The practice also increases costs for beneficiaries in the form of higher copays, said Miller. Miller recommends keeping off-campus offices off the hospital fee schedule and eliminating the practice of paying hospitals more Medicare money for treatments.

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

Trump Orders Hospitals to Disclose Prices, 'Not Estimates'

By AnneMarie Schieber

President Donald Trump ordered the Departments of Treasury, Labor, and Health and Human Services to develop a framework to enforce hospital price transparency within 90 days.

Trump originally established the rule during his first term in office, but compliance and enforcement under the Biden administration were weak.

Trump signed the new "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" executive order (EO) on February 25. The order directs the administrative departments to develop an enforcement plan to ensure hospitals disclose "actual prices, not estimates" and make "prices comparable across hospitals and insurers, including prescription drug prices."

"Our goal was to give patients the knowledge they need about the real price of healthcare services," the White House Fact Sheet on the EO quotes Trump as saying. "They'll be able to check them, compare them, go to different locations, so they can shop for the highest-quality care at the lowest cost. And this is about high-quality care. You're also looking at that. You're looking at comparisons between talents, which is very important. And then, you're also looking at cost. And, in some cases, you get the best doctor for the lowest cost. That's a good thing."

Price transparency is one of the nine reforms listed in "The 2024 American Health Care Plan: State Solutions" report published by The Heartland Institute, which co-publishes *Health Care News*.

"Our goal was to give patients the knowledge they need about the real price of healthcare services. They'll be able to check them, compare them, go to different locations, so they can shop for the highest-quality care at the lowest cost. And this is about high-quality care. You're also looking at that."

PRESIDENT DONALD TRUMP

State Initiatives

Frustrated by the lack of enforcement by the Biden administration, Colorado and Ohio took hospital price transparency into their own hands, preventing hospitals from collecting on unpaid bills if their prices are not disclosed in a "comprehensive machine-readable file."

Cynthia Fisher, founder and chairman of PatientRightsAdvocate.org, says the EO is a welcome measure.

"Real prices will forever transform the American health care system," said Fisher. "Price transparency unleashes competition and shifts the power to the true purchasers of care—patients, employers, and taxpayers—allowing them to lower their costs and be protected from overcharges."

Patient Rights Advocate (PRA) studied hospitals across the country last year and found a little more than 21 percent were in full compliance with the rules, well below the 34 percent compliance rate in 2023.

"Real, true price transparency by posting actual prices and not estimates is going to force hospitals to compete on prices and quality," Ilaria Santangelo, director of research at PRA, told *Health Care News*.

$3,000 or $300

An independent economic analysis found full implementation of the regulations in the EO could save consumers, insurers, and employers $80 billion this year alone.

"Why would anyone pay $3,000 for an MRI when they could get the same quality for $300?" said Fisher. "Likewise, no patient would agree to pay a $12,000 colonoscopy bill when the fair market price is around $1,000."

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

INTERVIEW

Truly Voluntary Medicare Would Bring Down Health Costs for All

As Congress grapples with how to cut health care spending by $880 billion in the next budget, one move that could permanently bring down costs in both the public and private sectors is to decouple Medicare from Social Security, says Twila Brase, president and cofounder of the Citizens Council for Health Freedom. Brase spoke with Health Care News *contributor Ashley Bateman about how that can happen and why it should, now more than ever.*

Health Care News: People can opt out of Medicare, but if they do, they lose their Social Security benefits. How did these two programs become attached?

Brase: The Social Security Administration's (SSA) Program Operations Manual System says people were asking to exit Medicare because they preferred their private insurance. In 1993, the Clinton administration responded by tying Medicare Part A, the part that covers hospitalization, to access to Social Security benefits. If a person refuses to enroll in Medicare Part A, they are not allowed to receive Social Security benefits.

Health Care News: What law put this in place?

Brase: No law authorized the directive, and it's not clear who gave the order. As one Medicare official once told me, it was an "executive instruction," written in. There was no debate, no public notice. It just appeared in the manual and has been followed ever since.

Despite discovery conducted for a lawsuit filed in 2008, the source of the order was never uncovered.

Health Care News: Who filed the lawsuit, and what was the result?

Brase: The lawsuit was filed by Americans who preferred their private insurance and didn't want to [have to] exhaust all Medicare options for treatment before accessing private benefits. It went all the way to the U.S. Supreme Court, which refused to hear it.

Judge Brett Kavanaugh, at the D.C. Court of Appeals, wrote a very bad majority opinion on which SCOTUS likely relied. He ruled that Americans cannot choose to opt out of their eligibility for Medicare; they cannot "unentitle" themselves. But that was never the question, as Judge Karen Henderson pointed out in her brilliant dissent. The plaintiffs were asking for the right to "disenroll" from Medicare, not "unentitle" themselves, in a similar way to how people can choose to opt out of Medicaid.

Health Care News: How are people discouraged from disenrolling?

Brase: If a person enrolls and later chooses to disenroll from Medicare, the Clinton administration's directive requires them to pay back all Medicare and Social Security benefits ever received.

Health Care News: Has tying these two programs together caused Medicare spending to increase?

Brase: Yes. Medicare has facilitated the theft of Social Security benefits. The government automatically deducts the Part B fees from the monthly Social Security payment. Citizens have no choice. The higher Medicare Part B fees go, the lower the monthly Social Security payment.

Many older seniors have little left over each month after dollars for the Part B payment are taken from their account. Government may feel free to raise the fees because the money is there for the taking. It doesn't have to ask for permission.

Health Care News: How do these government programs affect health care costs overall?

Brase: There are many other reasons for the rise in Medicare costs. Most practitioners and institutions are essentially forced to game the system. Since Medicare cuts their charges by about 60 percent, they overcharge to try to cover actual costs and not get shorted.

Also, Obamacare regulations and the mandated government-approved version of the electronic health record have forced massive consolidation of the market, all but ending the lower prices caused by competitive forces. Health plans have little incentive to push for lower premium prices due to Obamacare's "minimum loss ratio," which requires them to spend 80-85 percent of premiums or pay back part of the premium.

Another result of Obamacare regulations and funding formulas is excessive funding to Medicare Advantage organizations. For health plans, Medicare Advantage is a cash cow, a profit center.

Health Care News: Are there enough choices on the market to make decoupling a viable solution, as Congress has dragged its feet on increasing limits on HSAs, for example?

Brase: Currently, because there is no real insurance market in the United States, there are not enough choices if people are allowed to leave Medicare and keep their Social Security benefits.

We are pushing for a repeal of the Obamacare prohibition on catastrophic health insurance. Most people don't realize that the Affordable Care Act unconstitutionally prohibits the sale of catastrophic coverage to anyone over the age of 29-years-old. ACA proponents want every American enrolled in a health plan, which we consider the corporate version of socialized medicine which controls the dollars, the data, the decisions, and the doctors.

We are working on a "Make Health Insurance REAL Again" bill in Congress, to not only bring back catastrophic coverage but to bring back real insurance, the kind of policy that pays the patient, who then uses [that money] to pay the doctor and the hospital. This will end third-party payments, third-party interference, third-party delays and denials, and the multitude of third-party fingers in health care that make medical care and coverage so unaffordable.

Health Care News: Is decoupling more attainable with the current administration?

Brase: On October 3, 2019, we secured an executive order from President Trump requiring HHS and SSA to work together to decouple Medicare and Social Security. However, COVID-19 intervened, and President Trump was not reelected. Now, we're asking Congress to pass a bill to do the same thing by passing the Retirement Freedom Act.

We would like it on President Trump's desk and signed within the next 18 months. Medicare needs an escape hatch, and Americans need this path back to health freedom.

"Medicare has facilitated the theft of Social Security benefits. The government automatically deducts the Part B fees from the monthly Social Security payment. Citizens have no choice. The higher Medicare Part B fees go, the lower the monthly Social Security payment."

TWILA BRASE
PRESIDENT AND COFOUNDER
CITIZENS COUNCIL FOR HEALTH FREEDOM

HHS Secretary Pledges to End Conflicts of Interest at Health Agencies

HHS Secretary Robert F. Kennedy Jr.

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

By Bonner Russell Cohen

In his welcoming remarks at the Department of Health and Human Services (HHS), Secretary Robert F. Kennedy Jr. told the agency's employees it is time for a new era of "radical transparency" in dealing with the public.

Newly confirmed by a 52-48 Senate vote, Kennedy embraced the spirit of Elon Musk's Department of Government Efficiency (DOGE) by telling his audience via video link on February 18 that those unwilling to adopt transparency and openness "can retire."

HHS, a $1.6 trillion agency, includes the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). Kennedy's tenure at HHS arrives as the nation grapples with the legacy of public-health agencies' response to COVID-19.

"Kennedy is correct to propose balancing committees with other stakeholders. A diversity of well-argued approaches, even when those scientists previously provided their expertise for an interested party, is the best way to achieve the radical transparency Secretary Kennedy has promised."

JEFF STIER
SENIOR FELLOW, CENTER FOR CONSUMER CHOICE

Clearing the Air

Given his well-known views on hot topics such as vaccines, Kennedy made an effort to establish common ground among those entrusted with protecting public health.

"I'm not going to come in here and impose my belief on any of yours," said Kennedy. "My goal as secretary here at HHS will be to create a culture of competency, of ethics, of openness, of transparency, of caring, and of pride, so that individuals who share these ideals can flourish and thrive," said Kennedy, according to an HHS transcript of his remarks.

Kennedy left little doubt changes are on the way.

"We will remove conflicts of interest on committees and research partners wherever possible, or balance them with other stakeholders," said Kennedy. "We will make our data and policy process so transparent that people won't even have to file a FOIA [Freedom of Information Act] request."

New Targets

Kennedy also spoke of specific areas of concern not mentioned in President Donald Trump's executive order titled "Make American Healthy Again" (see article on opposite page).

"Some of the possible factors we will investigate were formerly taboo or insufficiently scrutinized," said Kennedy. "The childhood vaccine schedule, electromagnetic radiation, glyphosate, other pesticides, ultra-processed foods, artificial food additives, SSRI and other psychiatric drugs, PFAs, PFOAs, microplastics."

Kennedy suggested those substances are behind some disturbing public health trends.

"It is not difficult to understand why in the U.S. six out of every 10 adults have at least one chronic disease and four in 10 have two or more," said Kennedy. "The U.S. has the highest age-standardized cancer incident rate among 204 countries in the world, nearly double the next highest rate. Asthma and autoimmune diseases are far more common in the U.S. than in any other part of the world."

Vaccines are a possible factor in U.S. disease rates, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"In considering potential causes for U.S. rates of cancer and autoimmune disease, vaccines should be at the top of the list, not an afterthought, based on biological plausibility," said Orient. "Microplastics are everywhere, and air pollution in the U.S. is currently much improved and likely better than in many other nations," making them unlikely to be responsible for higher cancer rates.

Foxes in Henhouse?

In pledging to remove conflicts of interest on HHS advisory committees, Kennedy addressed the longstanding practice of experts serving on government advisory panels on drug and vaccine safety while receiving consulting fees and research funding from pharmaceutical companies.

Bloomberg Law raised the notion that Kennedy, as an agency head, may make panel selections more in line with his own views, including those on vaccines.

Sen. Bill Cassidy, M.D., (R-LA) chairman of the Senate Health, Education, Labor, and Pensions Committee, said Kennedy assured him prior to his confirmation that he would not do so at CDC's Advisory Committee on Immunization Practices (ACIP).

'Perhaps Trillions at Stake'

Big Pharma and other huge corporations stand to gain much from their relationships with regulators, says Orient.

"There are unquestionably conflicts of interest in the agencies concerned with drug and vaccine safety, and billions of dollars at risk if ACIP were to recommend against a vaccine— perhaps trillions at stake if failure to add a vaccine to the childhood immunization schedule meant the company would lose its protection against product liability," said Orient.

Transparency is another area that needs attention, says Orient.

"Aside from removing conflicts, the government needs to make research data available for public scrutiny," said Orient. "The need for informed consent should be sacred for all products, including vaccines, and consent cannot be fully informed without access to data.

Avoiding Cudgels

Removing conflicts of interest should not be used as a political tool, says Jeff Stier, a senior fellow at the Center for Consumer Choice.

"He should exercise caution to address actual current conflicts, and not use it as a cudgel to remove legitimate scientists with prior conflicts who don't support his agenda," said Stier. "It's important to recognize that conflicts can arise from a wide range of sources, not simply prior employment history. An expert who served as a witness for plaintiffs in glyphosate litigation or who sat on the board of an environmental group is equally as conflicted as an expert who served as a witness for the defense, or who consulted for industry."

Balance is key, says Stier.

"Kennedy is correct to propose balancing committees with other stakeholders," said Stier. "A diversity of well-argued approaches, even when those scientists previously provided their expertise for an interested party, is the best way to achieve the radical transparency Secretary Kennedy has promised."

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

President Creates Commission to 'Make America Healthy Again'

By Ashley Bateman

President Donald Trump issued an executive order (EO) establishing a commission to "Make America Healthy Again."

The February 13 order identifies multiple areas for reform and calls for the creation of a panel of agencies to enact research and policy plans.

The order directs the government to "aggressively combat the critical health challenges facing our citizens, including the rising rates of mental health disorders, obesity, diabetes, and other chronic diseases."

The order was announced after Robert F. Kennedy Jr. was sworn in as Secretary of Health and Human Services. Kennedy will chair the commission, which will include other Cabinet members and heads of government agencies such as the Environmental Protection Agency, Office of Management and Budget, and National Economic Council.

HHS Secretary Robert F. Kennedy Jr. and President Donald Trump

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"'Healthy life expectancy' is the most nuanced comparative statistic because it is based on the total longevity, corrected for the decrease in quality of life due to chronic disease. Despite the incredible progress in medical science over the past 20 years and our rapid adoption of new medical technology, Americans' healthy life expectancy has fallen from 38th in the world in 2000 to 67th in the world in 2021."

JOHN ABRAMSON, M.D., RETIRED LECTURER HARVARD UNIVERSITY

Shorter Lives, More Spending

Recent decreases in average life expectancy are concerning, says John Abramson, M.D., a retired lecturer at Harvard University.

"One of the most important measures of the function and well-being of a country, if not the most important, is the number of years its citizens will live in good health," said Abramson.

"'Healthy life expectancy' is the most nuanced comparative statistic because it is based on the total longevity, corrected for the decrease in quality of life due to chronic disease," said Abramson. "Despite the incredible progress in medical science over the past 20 years and our rapid adoption of new medical technology, Americans' healthy life expectancy has fallen from 38th in the world in 2000 to 67th in the world in 2021."

As Americans' life expectancy has decreased, health care spending has reached record highs, according to the Peterson-KFF Health System Tracker.

Misplaced Priorities

The federal government has done a poor job of improving health outcomes, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

"Interactions between genetics, individual behavior, and medical care determine health," said Gorman. "Government needs to focus on health programs that significantly improve individual health. We know that better health is correlated with higher incomes, so it is possible that unnecessary spending may even harm health."

The government places too much emphasis on health care delivery, and a thorough review of Medicaid, the Supplemental Nutrition Assistance Program, and the National School Lunch Program would be a good place to start reforming priorities, says Gorman.

"Ever since [President Barack] Obama expanded Medicaid in pursuit of coverage for all, billions of dollars have been wasted paying managed care companies to cover the largely healthy expansion population at the expense of the truly ill and disabled. The current Medicaid program is a national scandal," said Gorman.

It is important to remember different maladies can rise while others fall, says Gorman.

"A rise in cancer cases is not, in and of itself, an indicator of poorer [population] health," said Gorman.

Pediatric Dietary Setbacks

"Fighting Childhood Chronic Disease" is a top priority in the EO. The president ordered the commission to provide an initial assessment of the problem within 100 days and develop an improvement strategy within 180 days.

The order calls for comparing U.S. childhood rates of chronic disease to other countries; analysis of possible overutilization of medication; and investigation of the effects of food ingredients, chemical exposure, use of psychotropic drugs such as selective serotonin reuptake inhibitors, antipsychotics, mood stabilizers, and stimulants, and the use of weight-loss drugs.

The commission must also evaluate "best practices" for preventing childhood health problems such as inadequate physical activity, declining mental health, and poor nutrition.

Government has exacerbated the nation's eating problems instead of solving them, says Gorman.

"Government dietary advice has been a mess for decades," said Gorman. "There is no particular reason to expect that government health advice will improve with a whole-of-government approach."

Science Integrity

The order calls for restoration of the "integrity" of science, including elimination of "undue industry influence." Policy actions should include "open-source data" and transparent research that will "empower" Americans while eliminating conflicts of interest, the order states.

"In the United States, the knowledge upon which our citizens and their doctors must rely is now largely controlled by financial goals of industry, and that is undermining not only our health but also our freedom," said Abramson.

With 96 percent of medical research addressing new drugs and devices, only 4 percent is allocated to efficient and effective health care delivery, says Abramson.

"Our medical research agenda has been relegated to the market," said Abramson. "The currency of the market is dollars. The currency of health care ought to be improving Americans' health most effectively and efficiently. Allocation of research investment cannot be driven by corporate financial goals."

Other commission directives include expansion of treatment options and greater flexibility in health insurance.

Vaccine Punt

Vaccine safety is a notable omission from the president's order, says Jane Orient, executive director of the Association of American Physicians and Surgeons.

"Chronic illnesses, especially in children, are a grave concern," said Orient. "However, we will not make much progress if we refuse to consider the potential role of 70-plus doses of vaccines. These are deliberately intended to permanently alter the immune system.

"We must know the health status of vaccinated [children] versus the small but essential control group of unvaccinated [children]," said Orient.

Orient says it is important to evaluate the long-term efficacy and safety of vaccines versus other methods of preventing disease transmission, "such as whether early treatments using repurposed medicines might be an adequate or even better approach."

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

Measles Outbreak Sparks National Concern

By AnneMarie Schieber

A limited outbreak of measles in Texas has received nearly daily media attention, with 200 cases confirmed as of March 10 and one child and one adult having died with the disease.

Alarm grew after a case not associated with the Texas outbreak was confirmed in Maryland. The patient had recently traveled internationally through Washington Dulles International Airport on March 5 and went to a pediatric emergency department later for treatment. The Maryland Department of Health issued an alert, warning residents that symptoms can appear seven to 21 days after exposure.

Vaccine, Vitamin A Recommended

Measles is extremely contagious and can cause brain damage, prompting newly confirmed Health and Human Services Secretary Robert F. Kennedy Jr. to make the outbreak a top priority (see related article, page 16). Kennedy supplied Texas with 2,000 doses of the mumps, measles, rubella (MMR) vaccine, stating the decision to get the

shot is a "personal one."

Kennedy suggested another treatment as well.

"[The Centers for Disease Control and Prevention] has recently updated their recommendation supporting administration of vitamin A under the supervision of a physician for those with mild, moderate, and severe infection," Kennedy wrote in an op-ed on Fox News on March 2. "Studies have found that vitamin A can dramatically reduce measles mortality."

Media Push Political View

Media speculated vaccine hesitation was behind the outbreak. The MMR vaccine has long been under attack for a possible link to autism.

It is important to keep the recent outbreak in perspective, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"The first measles vaccine was licensed in 1963," Orient wrote in an email newsletter. "Vaccine coverage rates were around 50-60 percent in the 1970s. But despite more than 90 percent coverage now, measles has not been eradicated, nor can it be.

"The vaccine is not perfect," Orient wrote. "Children can still get infected and transmit disease, especially if they get 'atypical measles,' which is not recognized. Vaccinated persons may be carrying infectious virus in their secretions even if they don't get sick. Persons who recently received MMR, a live virus vaccine, may be contagious.

Cases, Deaths 'Have Plummeted'

In addition, "immunity, whether from vaccine or natural, wanes with time," said Orient.

The age distribution of measles has creeped upwards, with more infections occurring in older children and adults, who are more seriously affected than children, says Orient, citing a Fall 2019 article in the *Journal of American Physicians and Surgeons*.

"Both the case rate and death rate have plummeted since 1960, and death rates have been sharply decreasing since 1920," wrote Orient. "Improvements in sanitation and nutrition eliminated about 98 percent of measles deaths before 1960."

People can reduce their susceptibility to infectious diseases by keeping their immune systems in top shape with "good food, exercise, sunlight, and adequate levels of vitamins A, C, and D," Orient writes.

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

Seasonal Influenza Levels Remain Elevated, CDC Reports

By Bonner Russell Cohen

The Centers for Disease Control and Prevention (CDC) says the just-concluded winter presented unusually high flu risk.

The winter was "classified as a high severity season overall and for all age groups (children, adults, older adults) and is the first high severity season since 2017-2018," the agency of the Department of Health and Human Services (HHS) stated in its latest update on the 2024-2025 flu season.

The CDC's assessment arrived amid widespread media coverage of the seasonal flu and the unrelated bird flu (avian) epidemic that killed millions of chickens and caused egg prices to soar above $8.50 per dozen.

Key findings by the CDC for the seventh week of the flu season ending on February 15 included 2,486 viruses reported by public health labs, two new cases of avian influenza with no reports of human-to-human transmission, 44 geographical areas reporting high or very high flu activity, a total of 33 million people infected, 430,000 hospitalizations, and 19,000 deaths from flu so far, including 86 in the pediatric population.

While hospitalizations for flu and cases of outpatient respiratory illnesses declined for Week 7, ending on February 15, deaths attributed to influenza were up by 3 percent for the same period.

"'Influenza-like illnesses' occur every year, and we are unable to pinpoint the exact virus in the majority of cases even if testing is done. Since it makes no difference in the treatment, the main reason for testing is epidemiological. The CDC advocates annual shots for almost everyone. The main reason is to make it economically feasible to maintain production capacity in case of another 1918-style pandemic. Does this practice make a patient less likely to catch some respiratory illness? It may actually increase influenza-related deaths."

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

Fear of 'Co-Infection'

Whereas influenza infection rates have remained high this season, the incidence of COVID-19 remains low. The CDC reports cases of COVID-19 for the week ending on March 1 were at the same level as at the same time last year.

The active flu season is drawing the attention of public health officials for another reason: possible co-infection with bird flu.

"This is certainly a huge concern," Aubree Gordon, an epidemiologist at the University of Michigan School of Public Health, told *NPR*. "The danger with flu activity is that we have so many people who are infected with these seasonal viruses that it could increase the chance that you get a co-infection in a person with one of these seasonal viruses and H5N1, which gives the opportunity to generate a new virus that transmits really well from human to human. And that is one way you get a pandemic."

The CDC recommends everyone over six-months-old get a seasonal flu shot although a preliminary report released in October by the CDC suggested flu shots' effectiveness in keeping children 5-years-old and younger out of hospital was 39 percent.

Vaccine Safety on the Hot Seat

How vigorously the current administration will promote vaccines against viral infections may be up for question. On March 13, President Donald Trump withdrew the nomination of former Florida congressman Dave Weldon, M.D., to head the CDC. Like HHS Secretary Robert F. Kennedy Jr., Weldon is a longtime skeptic of vaccine safety.

In 2007, Weldon cosponsored a bill that would have removed most vaccine safety research from the CDC and given responsibility for vaccine safety to an independent agency within HHS.

"There's an enormous inherent conflict of interest within the CDC, and if we fail to move vaccine safety to an independent office, safety issues will remain a low priority and public confidence in vaccines will continue to erode," said Weldon.

This season, 147 million flu shots have been distributed; 157 million were distributed by the same time last season.

Efficacy Questions

McCullough Foundation President Peter A. McCullough, M.D., MPH, says this year's flu vaccines do not provide adequate protection. McCullough recommends patients consider other treatments to reduce symptoms.

"My clinical impression is that this has been a particularly severe influenza with only modest protection from the vaccine," said McCullough. "I help my patients reduce their risk with twice-daily viricidal nasal sprays and gargles every day, and I strongly advise high-risk individuals to have oseltamivir or baloxavir available on day one of the illness.

"I have found that we can get to near zero cases of flu using these strategies," said McCullough. "It is clear that vaccination alone is not sufficient."

The flu vaccine does not have a good track record for efficacy, says Jane Orient, M.D., executive director of the American Association of Physicians and Surgeons.

"'Influenza-like illnesses' occur every year, and we are unable to pinpoint the exact virus in the majority of cases even if testing is done," said Orient. "Since it makes no difference in the treatment, the main reason for testing is epidemiological.

"The CDC advocates annual shots for almost everyone," said Orient. "The main reason is to make it economically feasible to maintain production capacity in case of another 1918-style pandemic. Does this practice make a patient less likely to catch some respiratory illness? It may actually increase influenza-related deaths."

Data Shortage

The hypothesis that vaccines can increase illness warrants investigation, says Orient.

"What is the effect of repeated annual doses, with the load of adjuvants that stimulate the immune system?" said Orient. "This has not been studied. Patients need to weigh the risks and benefits before getting the annual flu shot, though this is difficult because of inadequate data."

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

COMMENTARY

Government Policies Have Made Americans Anti-Vaxx

By John Droz Jr.

Health and Human Services Secretary Robert F. Kennedy Jr. issued a "call to action" on March 2 after the death of a child with measles in Texas.

Kennedy urged parents to consult with their physicians about the MMR vaccine, which covers mumps, measles, and rubella, and directed the Centers for Disease Control and Prevention (CDC) and the Administration for Strategic Preparedness and Response to provide support to Texas.

As these actions take place, it is important to understand the nation's history of vaccine development and how this has led to the vaccine skepticism we see today.

Slow, Costly Process

When vaccines became available in the United States nearly 90 years ago, they underwent rigid scientific testing and protocols, such as randomized control trials, before being approved for distribution. These studies typically took 10 or more years to assess safety (especially long-term) and effectiveness.

The CDC defined vaccines correctly as "a product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease." As time went on, pharmaceutical companies tried to reduce the cost of developing these vaccines and the time needed to gain approval. Lawsuits became more frequent.

In 1986, President Ronald Reagan signed the National Childhood Vaccine Injury Act, which largely indemnified the drug makers. Vaccine development took off on a rapid trajectory, which has raised questions about safety and effectiveness.

Vaccine Explosion

In 1995, the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, and the American Association of Family Physicians "harmonized" the childhood immunization schedule. Today, they recommend nearly 20 different vaccines, resulting in some 40 injections by the time a child turns 2-years-old.

Ramping up the vaccine schedule made vaccine development more profitable for drug makers. If parents were willing to take their children in for a handful of traditional shots, why not add more to the list?

Since then, reports of vaccine side effects have increased. Cases of autism and other childhood diseases have escalated. Not surprisingly, the ramped-up vaccine schedule came under suspicion.

Although there was scientific testing regarding the safety and effectiveness of individual vaccines, there has been little to no investigation of effects of vaccines when given in combination. Such an inquiry is warranted because it is well-established contraindications can occur when medications are taken together.

Getting to the bottom of vaccine safety is paramount, and government policy needs examination in light of that knowledge gap.

Pandemic Expansion

Vaccination having become the norm, it was easy for Big Pharma to convince politicians and government agencies that injections for the COVID-19 "global medical crisis" were the best way to control transmission.

However, there was a huge obstacle to that plan: scientific safety and efficacy testing for traditional vaccines takes about 10 years to do properly. To get around this roadblock, Big Pharma introduced a new type of injection, the mRNA, which government agencies, now far removed from their original mission statements, readily approved.

Faux Vaccines

The mRNA shots are genetic engineering that "codes" for the antigen of a particular virus. "It relies on carefully removing this particular nucleic acid from the virus and then purifying and using it to form a vaccine; this vaccine is then delivered to the person in a fluid containing lipids," states differencebetween.net.

Traditional vaccines are made from virus proteins that are injected into biological material such as an egg to produce an antigen response, which is then used to create the vaccine.

As recently as 2023, the mid- to long-range safety record of mRNA shots was in question.

"There are no published studies on the bio-distribution, cellular uptake, endosomal escape, translation rates, functional half-life and inactivation kinetics of synthetic mRNA, rates and duration of vaccine-induced antigen expression in different cell types," K. Acevedo-Whitehouse and R. Bruno state in a paper published by the National Institutes of Health.

Convenient Redefinition

The mRNA shots did not fit the CDC's definition of what a vaccine is. During the COVID-19 pandemic, the CDC simply changed the definition.

Instead of a "product that stimulates a person's immune system to produce immunity to a specific disease, protecting the person from that disease," the CDC now states vaccines are a "preparation that is used to stimulate the body's immune response against diseases."

It is wrong to call mRNA shots "vaccines." They are biochemical injections that can be developed more quickly than traditional vaccines.

Crowd-Out Effect

One of the most unfortunate developments in the history of vaccines is the "crowding out" of other approaches to addressing disease. The focus is on "prevention" instead of "treatment," but prevention is not always better or safer.

During COVID-19, health care agencies went out of their way to denigrate drugs with proven safety records, such as ivermectin and hydroxychloroquine, as early treatments for infection. This was stunning given ivermectin's safety and effectiveness track record as an antiparasitic, antibacterial, and antiviral. Researchers are now testing the drug as a cancer treatment.

Mission Drift

The FDA's mission statement says the agency is responsible "for advancing the public health by helping to speed innovations that make medical products more effective, safer, and more affordable and by helping the public get the accurate, science-based information they need to use medical products to maintain and improve their health."

The new administration would do well to review that statement and determine how vaccine policies may have gone off the rails.

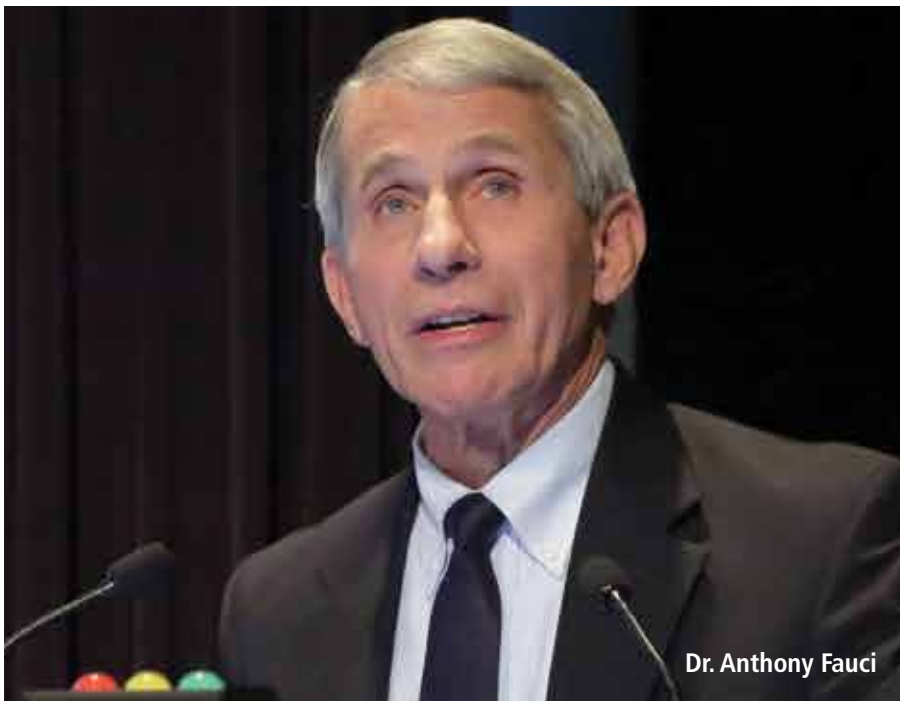
John Droz Jr. (**aaprjohn@northnet.org**) *is a physicist and the founder of the* Media Balance Newsletter. *A version of this article appeared on the* Critically Thinking *blog.*

State AGs Take Legal Action Against Fauci in Wake of Pardon

By Bonner Russell Cohen

Attorneys general from 17 states are preparing to take legal action against Dr. Anthony Fauci for his conduct during the COVID-19 pandemic.

In a February 5 letter to House Speaker Mike Johnson (R-LA) and Senate Majority Leader John Thune (R-SD), the state AGs offered their cooperation in further investigations of the nation's response to COVID-19 and reminded them former president Joe Biden's pardon of Fauci "does not preclude state-level investigations or legal proceedings"



Dr. Anthony Fauci

PHOTO COURTESY NIH

"As we all know, and as the report found, the weight of the evidence increasingly supports the lab leak hypothesis, and Dr. Fauci's potential involvement in attempting to discredit that hypothesis is troubling. Any deliberate manipulation or suppression of alternative hypotheses could have delayed understanding of and responses to the pandemic, with dire consequences for global health."

LETTER FROM 17 ATTORNEYS GENERAL TO HOUSE SPEAKER MIKE JOHNSON

Scathing House Report

The AGs' letter followed a December 24, 2024 House select subcommittee report on the federal government's response to the coronavirus pandemic. That report strongly criticized Fauci, the director of the National Institute of Allergy and Infectious Diseases during the pandemic, a member of the White House Coronavirus Task Force, and Chief Medical Advisor to the President, along with other federal officials and agencies.

"As part of your continuing efforts in holding malign actors accountable for their actions arising out of the Pandemic, if you believe that further findings or direct evidence that [sic] suggest there may have been any violation of state laws, please include us in any actions taken so that we may be able to evaluate state-level courses of action," the AGs wrote. "Although former President Biden attempted to shield potential bad actors—like Dr. Anthony Fauci—from accountability via preemptive pardons, we are confident that state laws may provide a means to hold all actors accountable for their misconduct."

Biden signed a preemptive federal pardon for Fauci moments before Donald Trump was sworn into office as president on January 20.

Allegations of Misinformation

The AGs' letter notes the House report found Fauci promoted a theory on the origin of COVID-19 that discredited the "lab leak" explanation for how the virus emerged in Wuhan, China.

"As we all know, and as the report found, the weight of the evidence increasingly supports the lab leak hypothesis, and Dr. Fauci's potential involvement in attempting to discredit that hypothesis is troubling," the AGs wrote. "Any deliberate manipulation or suppression of alternative hypotheses could have delayed understanding of and responses to the pandemic, with dire consequences for global health."

Citing the subcommittee's report, the AGs pointed out that during a Senate hearing, Fauci denied three times that U.S. tax dollars went to the Wuhan Institute of Virology for gain-of-function research. Evidence later emerged that this was not true and that National Institutes of Health (NIH) payments were, in fact, made through EcoHealth Alliance.

"This discrepancy not only raises questions about the integrity of his testimony but also about the broader implications for scientific integrity and public trust," wrote the AGs. "The possibility of perjury or at least a significant lack of transparency demands attention."

Dereliction of Duty?

Fauci had a duty to provide oversight of the NIH payments and to make sure policies were transparent and trustworthy, the AGs state.

"This subsequently siloed crucial information from the public that may have led to more public awareness concerning the risks of myocarditis and pericarditis among young adult males; the verified increased risk of blood clots in women; and the long-term effects the vaccines had on fertility," wrote the AGs. "The notion of 'trusting the science' was not only grotesquely false, but was the very definition of propaganda that contributed to serious vaccine injuries—and in some cases, death."

Claim of Authority

Noting Biden's preemptive pardon for offenses committed from January 1, 2014 to January 17, 2024, the AGs argue one tool at their disposal is Fauci's obligation to present "pertinent findings" to state officials.

Biden's pardon does not apply to breaches of state laws, the AGs note.

"As state Attorneys General, we possess the authority to address violations of state law or breaches of public trust," the letter states.

The AGs asked Johnson and Thune to provide them with any and all necessary details from the subcommittee's report that could provide an outline for potential state legal action if warranted.

'Crimes Against Humanity'

A strong case can be made that Fauci and others in the government committed crimes, says Peter A. McCullough, M.D., MPH, author of *Courage to Face COVID-19: Preventing Hospitalization and Death While Battling the Bio-Pharmaceutical Complex*.

"Two papers, each with V.D. Menachery as the lead author, describing the creation of primordial SARS-CoV-2 by a joint U.S.-Chinese team in the Wuhan Institute of Virology, tie together the key perpetrators of crimes against humanity," McCullough told *Health Care News*. "Dr. Ralph Baric, Dr. Peter Daszak, and Dr. Anthony Fauci all played critical roles in the research that led both to the design of the virus and the code for the spike protein used by Moderna and Pfizer for the development of mRNA COVID-19 vaccines."

The code for the virus is a key to the group's motives, says McCullough.

"Baric, Daszak, and Fauci all refuse to publicly release the code for their 'SARS-like WIV1 Poised for Human Emergence' designated virus [developed] using taxpayer dollars," said McCullough. "Likely it closely matches the original wild type SARS-CoV-2 that emanated from [the Wuhan Institute of Virology] in late 2019. Let's hope that the code is released and there is a proper investigation of both the conspiracy to create the global threat as well as its coverup."

Uphill Battle

Although "Fauci contradicted himself repeatedly," state AGs contemplating action against him face a difficult task, says Merrill Mathews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"Fauci was, in my opinion, clearly guilty of hubris and doling out misinformation," said Matthews. "And while I'm not a lawyer, given the lack of clear cause-and-effect and the divergent opinions of so many 'experts' at the time, I think it would be hard to prove intentional or criminal intent in court."

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

Judge Blocks President's Ban on Child Trans Treatments

By Harry Painter

A federal judge blocked President Donald Trump's executive order defunding institutions that perform transgender treatments on children.

U.S. District Judge Brendan Hurson in the District of Maryland issued a preliminary injunction on March 4 preventing the order, titled "Protecting Children from Chemical and Surgical Mutilation," from going into effect.

The judge ordered the injunction in response to a February lawsuit filed by the American Civil Liberties Union and Lambda Legal, among other groups, alleging Trump's order disrupted "essential care" for transgender individuals.

Hurson, appointed by former President Joe Biden, called the alleged disruptions "potentially catastrophic."

The preliminary injunction will stay in effect until the court makes a final decision on the merits of the case.

Days earlier, a federal judge in Seattle had also blocked Trump's order, with that decision applying only to Colorado, Minnesota, Oregon, and Washington.

"Gender-dysphoric children who present to transition clinics are commonly 'fast-tracked' to puberty blockers and cross-sex hormones, rather than referred for counseling. At least 85 percent of children with gender dysphoria will revert to their correct sex identity if they are simply allowed to receive counseling."

TIM MILLEA, M.D.
CATHOLIC MEDICAL ASSOCIATION

Mixed Reaction from Hospitals

Hospitals have varied in their response to the order and subsequent court rulings. Michigan-based Corewell Health briefly paused child hormone therapy and other treatments before resuming them after Hurson paused the president's order in February.

Michigan's attorney general had sent out a warning to health care providers on February 7 that denying treatment due to gender identity "may constitute discrimination under Michigan law."

The University of Virginia (UVA) announced on January 31 it would stop transgender treatments on new patients. The hospital system is continuing care for existing patients.

Money Talks

The executive order to stop transgender treatments on children comes with a big stick: loss of federal money.

"If there was no financial gain to be realized by providing transgender interventions on minors, hospitals would not be interested in such programs," said Tim Millea, M.D., chair of the Catholic Medical Association's (CMA) Health Care Policy Committee.

If the executive order is reinstated on appeal, "hospitals that continue to provide such interventions on children and adolescents risk significant repercussions, including loss of Medicare and Medicaid funds, loss of research and educational grants, and investigation by the Department of Justice," said Millea.

In announcing it would cease transgender treatments on minors, UVA stated "loss of such federal funding would jeopardize the financial viability" of the university.

Child protection should come before profit, says Millea.

"Ending such programs may decrease a hospital's income, but it will protect young people from needless and harmful procedures with lifelong ramifications," said Millea.

Ongoing Biden Roadblocks

Trump's order was bold and much-needed, says Matt Bowman, a senior counsel at the Alliance Defending Freedom (ADF).

"President Trump has taken strong executive action to protect children from the dangers of so-called 'gender transition' efforts by asking federal agencies to consider defunding hospitals that inflict such harm on children," said Bowman.

The EO would not necessarily block all transgender treatments on children, says Bowman.

"These specific funding decisions only occur after agencies evaluate and make specific determinations about particular hospitals," said Bowman. "Agencies are also constrained by certain regulations passed during the Biden administration that push experimental 'gender transition' efforts upon children. This is why ADF is still litigating several cases against the Biden administration's radical gender mandates."

The Trump administration should persevere to protect the EO, says Bowman.

"We hope that federal agencies like HHS will agree that the court should eliminate these unlawful mandates, to safeguard children from the promotion of gender ideology as soon as possible," said Bowman.

Publicity War

The practice of gender transitioning on children is a triumph of ideology over science, says Millea.

"Over the past several years, secular medical organizations and government agencies that oversee medicine have frequently foregone scientific inquiry and allowed ideology to direct their positions on many issues," said Millea.

"Regardless of the outcome with the executive order, it is critically important that the Trump administration and Congress continue to shed light on the dangers of transgender interventions in minors," said Millea. "The most important factor in protecting children from these harms is the public's growing awareness of this problem."

Millea says there is "abundant evidence from European countries and elsewhere" that gender transitions lack benefits while causing "obvious damages."

These children are being denied appropriate mental health treatment and rushed into unnecessary and destructive hormone treatments and surgery, says Millea.

"Gender-dysphoric children who present to transition clinics are commonly 'fast-tracked' to puberty blockers and cross-sex hormones, rather than referred for counseling," said Millea. "At least 85 percent of children with gender dysphoria will revert to their correct sex identity if they are simply allowed to receive counseling. The majority of these children have other mental health difficulties that are best managed by counseling rather than medications and surgery that produce permanent, lifelong changes."

Lawsuit Counterattack

"It is imperative that American medical organizations such as the CMA continue to speak out and bring attention to these misguided and unethical programs," said Millea. "The AMA [American Medical Association] and the American Academy of Pediatrics (AAP) continue to pronounce support for transgender interventions in children, which is very difficult to understand given the overwhelming contrary evidence."

Millea says litigation for damages can be an effective way to solve the problem, "charging hospitals, physicians, and groups like AMA and AAP with negligence and malpractice."

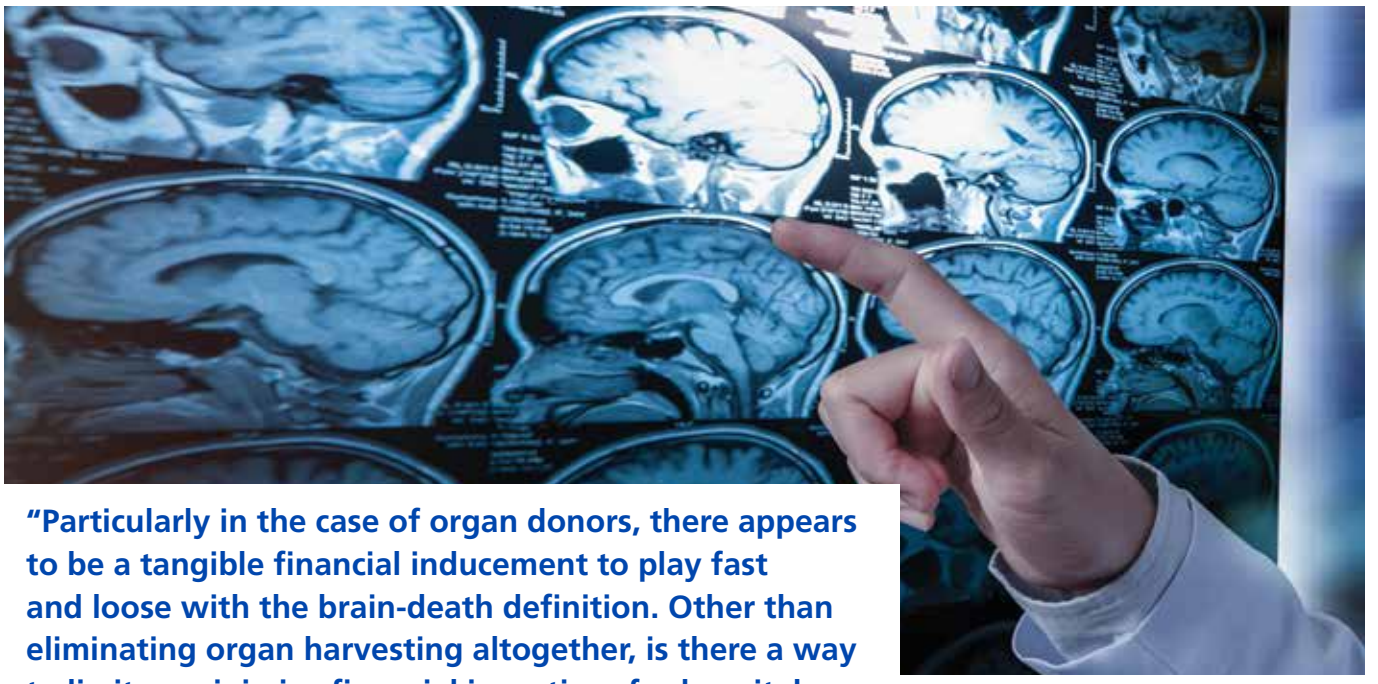
Such cases are increasingly common and "may end this 'transgender industrial complex' more quickly," said Millea.

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

Controversial Brain Death Diagnoses Under Fire

By Kevin Stone

Recent dubious brain death diagnoses have brought out calls for an end to the controversial protocol.



"Particularly in the case of organ donors, there appears to be a tangible financial inducement to play fast and loose with the brain-death definition. Other than eliminating organ harvesting altogether, is there a way to limit or minimize financial incentives for hospitals such that the existing conflicts of interest do not exist?"

TWILA BRASE, R.N.
PRESIDENT AND COFOUNDER, CITIZENS' COUNCIL FOR HEALTH FREEDOM

Brain-Death Declaration

A prominent recent case involved a 23-year-old Jamaican woman who admitted herself to Montefiore Hospital in the Bronx, New York for elective surgery on July 30, 2024.

In February, Amber Ebanks, a business student attending school in New York, had been found to have a ruptured arteriovenous malformation (AVM), which involves an abnormal formation of blood vessels in her brain. Although she quickly recovered, doctors recommended an embolization procedure to prevent further ruptures and potential brain damage.

The procedure did not go as planned. Ebanks suffered occlusion of a major artery, accompanied by a subarachnoid hemorrhage, and was transferred to the intensive care unit. On August 9, doctors declared her brain-dead even though she did not meet the conditions of the New York Determination of Death statute or of the Uniform Determination of Death Act (UDDA), both of which require either irreversible cessation of circulatory and respiratory function or irreversible cessation of all functions of the entire brain, including the brain stem.

Hospital Pulls the Plug

Amber met neither of those criteria. Her circulatory and respiratory functions were intact, and she was normally regulating body temperature and liver and kidney function.

Even so, the hospital ceased feeding and basic care.

Two doctors, acting at the behest of Amber Ebanks' family, submitted sworn affidavits that Ebanks was alive when the hospital pulled the plug on September 6, ending her life despite doctors' ongoing efforts to keep her alive.

Physicians Paul Byrne, M.D., a board-certified pediatrician and neonatologist and brain-death expert, and Thomas M. Zabiega, M.D., a board-certified psychiatrist and neurologist signed affidavits stating Ebanks had a "quiet brain," a temporary condition known as global ischemic penumbra (GIP). With proper treatment, patients have recovered from GIP.

Woke Up During 'Harvesting'

Another case involved Anthony Thomas Hoover, a Kentucky man who doctors determined to be brain-dead following a drug overdose in 2021. Hoover was a registered organ donor. Despite complaints by some medical staff that eye movement and other signs of life indicated he was not brain-dead, doctors proceeded with organ harvesting.

One hour into the harvesting procedure, the patient woke up, physically thrashing and shedding tears. The hospital released Hoover to his family. More than three years later, he is alive and recovering.

UDDA Validity Questioned

Numerous patients' rights advocacy groups argue the Uniform Determination of Death Act (UDDA) is a flawed standard that causes unnecessary deaths.

"There seem to be an alarming number of such cases of 'brain dead' patients regaining function," said Twila Brase, R.N., president and cofounder of the Citizens' Council for Health Freedom. "The only way to make sure a patient is actually dead is to return to [the standard of] circulatory death. If the heart stops beating and doesn't start again, there can be no doubt the patient is dead.

"State legislatures also need to reconsider the Uniform Anatomical Gifts Act, which allows extraction of organs if the patient doesn't have a form on hand refusing donation or if the patient's family cannot be reached in time to say no to the taking of organs," said Brase. "Most Americans unwittingly believe that simply not putting 'organ donor' on their driver's license will protect them. It will not."

Dubious Origin

Retired anesthesiologist Heidi Klessig, M.D. says the UDDA standard is not in the interest of gravely ill patients who can recover.

"Brain death is not biological death, so it's not surprising that people with this diagnosis can recover,' said Klessig. "In 1968, thirteen men at Harvard Medical School proposed redefining certain comatose people as being dead. They did this on utilitarian grounds, saying that the lives of these neurologically injured people were a burden to themselves and others. They thought that redefining them as being dead would serve the social purposes of freeing up ICU beds and increasing the number of organs available for transplantation."

Donor cards and "gift of life" narratives are misleading, says Klessig.

"The public has been given propaganda and slogans about brain death rather than facts and science," said Klessig. "They are being denied fully informed consent when they sign a donor card. They are not being told that the newest American Academy of Neurology brain-death diagnosis guideline expressly allows people to be declared brain-dead who still have ongoing partial brain function. We need to tell people the truth."

Big Money in Organ Trade

An infographic by the Millman consulting group on billed charges for various organs shows a heart for transplant generates an average of $1,664,800 in billable charges, $1,240,700 for an intestine, $878,400 for a liver, and double lung at $1,295,900.

"Particularly in the case of organ donors, there appears to be a tangible financial inducement to play fast and loose with the brain-death definition," said Brase. "Other than eliminating organ harvesting altogether, is there a way to limit or minimize financial incentives for hospitals such that the existing conflicts of interest do not exist?"

Government health programs encourage organ harvesting and hence declarations of brain death, says Klessig.

"Hospitals are required to have relationships with organ, eye, and tissue banks, and to alert organ procurement organizations (OPOs) as soon as someone might potentially become brain-dead," said Klessig. "If they don't do these things, they risk losing Medicare funding. So there's financial pressure to comply with the desires of OPOs, which seems to have been a big part of what happened in the T. J. Hoover case."

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

COMMENTARY

What Should Republicans Do About Medicaid?

By John C. Goodman

Republicans are in a bind.

To give substance to their new budget bill, they need to cut Medicaid spending by billions of dollars. Yet the White House and many congressional Republicans insist that they do not want to cut Medicaid benefits.

Here is where the Department of Government Efficiency can come to the rescue. In mainstream economics there is a technical definition of "waste." A system is wasteful if it is possible to make a change that can in principle make everyone better off.

Fortunately, Medicaid is so inefficient that it provides us with a rich bundle of opportunities. We can make changes that vastly improve services for the beneficiaries and free up billions in savings for the tax bill—at the same time.

"A number of the ideas discussed here are already in legislation coauthored by Rep. Pete Sessions (R-TX) and his colleagues. So, a good part of the reforms described here could be achieved by little more than cut and paste."

JOHN C. GOODMAN, PH.D.
PRESIDENT AND FOUNDER, GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

Freedom to Shop

When people are newly enrolled in Medicaid, their visits to the ER increase by 40 percent! A likely cause is that many doctors won't see Medicaid patients, and even if they do, these are the last patients doctors want to see. Also, many of our best medical centers won't take Medicaid managed care.

Medicaid rates are often half the prices charged at walk-in clinics and urgent care centers. Even if some accept Medicaid fees, they rarely locate in areas where Medicaid enrollees live.

One answer is to let Medicaid patients buy medical care the way they buy food. In the supermarket, low-income shoppers are free to combine food stamp funds with out-of-pocket money and pay market prices. In health care we have made that option illegal.

In a reformed system, Medicaid enrollees could still get free care at the emergency room and possibly lose a day's pay. (The in-and-out time at Parkland, a safety-net hospital in Dallas, is almost six hours!) Or they could save time and taxpayer money by getting care where middle-income patients go.

If this reform (coupled with the 24/7 primary care option described below) cut Medicaid emergency room spending in half, it would save the federal and state governments as much as $135 billion over 10 years.

Roth-Style Health Savings Accounts

Private companies managing Medicaid (or the state itself) should be able to make deposits to an account that would cover, say, all of an individual's primary care. Enrollees would be restricted to using the money for health care during an insurance year.

Afterward, enrollees could withdraw any unspent funds for any purpose. If there were no penalties for nonmedical withdrawals, health care and other purchases would trade against each other on a level playing field under the tax law. People wouldn't spend a dollar on health care unless they got a dollar's worth of value.

An early study by the RAND Corporation suggests these accounts would reduce Medicaid spending by 30 percent. Aside from payments for the disabled and nursing home care, if Medicaid spending could be reduced by 30 percent, the savings would amount to almost $1 trillion over 10 years. This saving would be shared by the beneficiaries and the taxpayers who fund Medicaid.

We could probably double that number with creative programs of self-management and self-directed care for all the Medicaid population.

24/7 Primary Care

What we used to call concierge medicine is now commonly called "direct primary care" (DPC), and the prices have come way down. In a national model that originated in Wichita, Kansas, the monthly fee is $50 for a mother and $10 for a child.

In return, the family gets the doctor's phone number and 24/7 access to all primary care. This is a competitive market, and if at any time the family is unsatisfied, they can switch to another DPC doctor.

Currently, employers are not allowed to put funds in an HSA to be used for DPC. By contrast, the Roth HSAs for Medicaid described above would be a perfect vehicle to facilitate DPC.

Fraud Reduction

Fraud in Medicare and Medicaid amounts to $100 billion a year, and that's a low estimate, according to the General Accounting Office.

In principle, credit card fraud should be much easier to commit than health care fraud. (Think of how often your card goes out of sight in the possession of a waiter or other vendor.) Yet losses to credit card fraud amount to a fraction of 1 percent of spending.

If the federal government could manage Medicare and Medicaid as efficiently as the credit card industry (or maybe contract out to them), the savings would approach $1 trillion over the next decade.

Medicaid Block Grants

State governments should have the option of receiving 90 percent of their current federal Medicaid dollar allotment in the form of a block grant, saving federal taxpayers the other 10 percent.

With their share, the states could do some of the things discussed above. States could create Roth HSAs outside the federal tax system, make deposits to these accounts, and let enrollees pay market prices for their care.

They could also allow HSA money to be used to pay the fees of direct primary care doctors providing 24/7 care.

If every state accepts the deal, taxpayer savings will be about $630 billion over 10 years.

Legislation in Hand

A number of the ideas discussed here are already in legislation coauthored by Rep. Pete Sessions (R-TX) and his colleagues. So, a good part of the reforms described here could be achieved by little more than cut and paste.

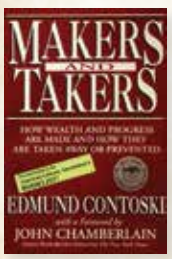
John C. Goodman, Ph.D., **(johngoodman@goodmaninstitute.org)** *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *A version of this article was published in* Forbes. *Reprinted with permission.*

THE BOOKS OF EDMUND CONTOSKI

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

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

$24.95



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

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

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

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

The Trojan Project

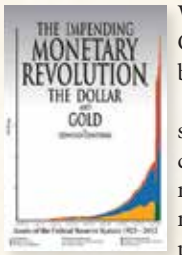
$17.95

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

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

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

$28.95



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

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

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

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

Buy all 3 and get 50% off the bundle!

Legislators:

Make Us Your New Legislative Aide!

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

Why Join?

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

Benefits of membership include:

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

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

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

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

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

REPRESENTATIVE ISAAC LATTERELL
SOUTH DAKOTA

THE HEARTLAND INSTITUTE

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