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HEALTH CARE NEWS

Vol. 26 No. 05 May 2025 HealthCareNewsOnline.com

The Pulse

Republican Medicaid Plan: Yes to Reform, No to Benefit Cuts

By AnneMarie Schieber

Partisan rhetoric over the federal budget has intensified with Democrat politicians claiming Republicans will cut Medicaid benefits.

Illinois Gov. J. B. Pritzker, a Democrat, argued it will be impossible for Republicans to find $880 billion in spending cuts without touching Medicaid. The House budget reconciliation bill instructs the House Energy & Commerce Committee to cut $880 billion

MEDICAID PLAN, p. 6

Speaker of the House Mike Johnson

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

States Poised to Ignore the FDA on Ivermectin as Rx

By Harry Painter

Ivermectin (IVM) will now be sold over the counter (OTC) in at least one state, with other states in the process of granting that status.

Gov. Sarah Huckabee Sanders of Arkansas signed Senate Bill 189 into law on March 25, approving ivermectin for use without a prescription.

Idaho's SB 1211, a similar bill, was passed with overwhelming support, and Gov. Brad Little signed it into law on April 14.

Another similar bill, HB 278, is

IVERMECTIN, p. 4

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

Dr. Goodman addressing The Economic Club of Indiana

What We Have Accomplished

Health Savings Accounts

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

1

Roth IRAs

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

2

Social Security

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

3

401 (k) Plans

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

4

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

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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.

Congress Looks at Fast-Tracking Drugs, Devices Approved in Other Countries

By Bonner Russell Cohen

Legislation now in Congress would allow the Food and Drug Administration (FDA) to approve drugs and devices that have been approved in other industrialized countries and give Congress power to override an FDA rejection.

"Washington bureaucracy and regulations far too often interfere with health care decisions of patients and their doctors," said Sen. Ted Cruz (R-TX) in joining forces with Rep. Chip Roy (R-TX) to reintroduce the bicameral Reciprocity Ensures Streamlined Use of Lifesaving Treatments (RESULT) Act.

"The RESULT Act amends the Food, Drug, and Cosmetics Act to allow for the reciprocal approval of drugs, devices, and biologics approved in certain trusted countries, including the UK, European Union member countries, Israel, Australia, Canada, and Japan," states a press release from Cruz's office.

Senator Mike Lee (R-UT)

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Logjam Breaker

Senate cosponsor Mike Lee (R-UT) says government red tape denies Americans access to cutting-edge medical innovations.

"Americans should have access to the very best medicines and treatments in the world, without bureaucrats standing in the way," Lee said in a statement. "This legislation will strengthen medical freedom, increase healthcare options for patients, and allow the most brilliant innovations from our trusted allies from across the globe to help countless families in the United States."

Introducing reciprocity into FDA approval procedures would break the logjam that has long denied U.S. patients access to treatments readily available in other advanced countries, says Gail A. Van Norman of the Department of Anesthesiology and Pain Medicine at the University of Washington-Seattle.

"Whereas the United States has always relied on a centralized process through one agency, the Food and Drug Administration (FDA), the European Commission synchronized the regulations of 28 different countries as they combined to create the European Union," wrote Van Norman in a study posted by the National Library of Medicine.

Lost Opportunity

The FDA's lengthy approval process has profound effects on patients. A 2019 article in *Health Care News* described the case of a brain stimulation device that failed to receive expedited FDA approval.

Patient Carolyn Brodsky was diagnosed with Alzheimer's in 2011. After undergoing six weeks of treatment in Boston using the NeuroAD Therapy System developed by the Israeli company Neuronix, her memory rebounded.

After being off the treatment for several months, Brodsky's memory faded. Researchers gave her another round of Neuronix treatment, and it brought a noticeable recovery of her memory.

Brodsky's husband, a businessman, raised $15 million to help Neuronix conduct clinical trials for FDA approval. In March 2019, an FDA advisory panel rejected the company's application to market its treatment without further U.S. trials.

Carolyn Brodsky was subsequently treated with prescription drugs, which did not improve her condition. She died in December 2021.

'Corrupt, Untrustworthy' Process

The FDA process fails to provide prompt approval of useful drugs and allows the use of drugs that do harm, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"The FDA's approval process has kept many useful drugs and devices from Americans for decades while adding enormously to the cost, so that only potential blockbusters can be brought to market," said Orient. "Yet, many have had to be withdrawn for adverse effects that became apparent later, some of which had been concealed.

"Then there is the Operation Warp Speed disaster," said Orient. "The process is corrupt, untrustworthy, and errs in both directions. What is most needed is honesty and full disclosure—'transparency'—and better after-market surveillance. The suggestion for reciprocity is good. Free markets work better than regulation."

'Disruptive Force'

Passage of the RESULT Act would be a significant step toward meaningful reform at the FDA, says Craig Rucker, president of the Committee for a Constructive Tomorrow.

"The FDA has been doing the American public a grave disservice by refusing to change its ways," said Rucker. "The Trump administration prides itself on being a disruptive force. The FDA is an agency crying out for disruption, and Congress and the White House can make that happen."

Members of Congress introduced the RESULT Act four times previously, in 2015, 2019, 2021, and 2023. Republicans, who have supported the bill, now control both houses of Congress and the White House.

"The bill is primarily aimed at smaller companies, which have a harder time than larger manufacturers navigating and paying for the FDA approval process," noted a news release at the time of introduction in 2019.

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

States Push to Allow Ivermectin to Be Sold Over the Counter

Continued from page 1

making its way through the Alabama legislature but is under delay in the House Health Committee.

Other states have passed laws protecting physicians' auhority to prescribe ivermectin and other treatments off label.

Pandemic Deceit

Ivermectin became widely known for its demonization during the COVID-19 pandemic. After IVM became a well-known alternative treatment for COVID-19, the U.S. Food and Drug Administration opposed its use for that purpose.

The drug was originally used to treat parasitic worms, leading to false claims that it was intended only for animals. Researchers William C. Campbell and Satoshi Omura earned a Nobel Prize for their discoveries in treating humans with ivermectin.

'Perfect' OTC Candidate

"Ivermectin is a perfect candidate to be moved to over-the-counter status," said Charles L. Hooper, president and cofounder of Objective Insights, Inc., a health care consulting firm. "It is very safe. It has been dosed more than 4 billion times around the world, and it has been safely used in pregnant women, children, and infants."

Hooper was an employee at Merck when Campbell helped discover ivermectin.

"Those who argue against Rx-to-OTC switches for drugs claim that patients will misuse or abuse the OTC drugs," said Hooper. "But patients can misuse and abuse Rx drugs.

"With ivermectin, some are concerned that it would be used for viruses such as SARS-CoV-2, the virus that causes COVID-19, but ivermectin has been shown to work against SARS-CoV-2, so this is an unscientific, paternalistic, and patronizing position," said Hooper.

"Most pharmaceuticals are under-prescribed and underused. There are many chronic conditions for which drugs have shown tremendous benefits, but for which only a fraction of the patients who would benefit actually get the beneficial drugs. OTC makes drugs easier to acquire."

CHARLES L. HOOPER
PRESIDENT AND COFOUNDER, OBJECTIVE INSIGHTS, INC

Conflicting Priorities

The Food and Drug Administration (FDA) should review drugs for safety but not efficacy, says Hooper.

"Efficacy is much harder, and more expensive, than safety to demonstrate in clinical trials," said Hopper. "And what is the typical result? Something like: '20 percent of those who got the placebo improved while 50 percent of those who got the active drug improved.'

"Patients and doctors can already understand this," said Hooper. "Why do we need the FDA to tell us that 50 percent versus 20 percent is good enough?"

In addition, "no one can know what effect a certain patient will get," Hooper said.

Vaccine Favoritism

Public health bureaucrats pushed for development and distribution of vaccines during the pandemic, and they discouraged use of readily available treatments, says Jeffrey A. Singer, M.D., a senior fellow at the Cato Institute and author of *Your Body, Your Health Care*.

"I think many in the public health community developed an almost visceral opposition to the idea of people self-medicating with ivermectin," said Singer.

"Public health officials were biased toward a vaccine-related solution to the COVID pandemic and believed that discovering a drug can treat COVID infections would impede emergency use authorization of a newly developed vaccine," said Singer. Studies of the effectiveness of ivermectin in treating COVID-19 have been inconclusive, Singer says.

Officials "also objected to people doing their due diligence and exercising their right to self-medicate without first receiving approval from credentialed experts," said Singer. "This paternalism persists post-pandemic."

FDA Option

The public can ask the FDA to classify ivermectin as OTC nationwide, says Singer.

"The FDA commissioner has the authority to unilaterally reclassify ivermectin as OTC," said Singer. "And the commissioner can consider requests from any interested party, including pharmacists and patients, to reclassify a drug as OTC."

The agency, however, "has tended to defer to the pharmaceutical manufacturers and won't reclassify without their request," said Singer.

Current FDA Commissioner Marty Makary, M.D. "might be more receptive to requests by professional or patient advocacy groups," said Singer.

Makary discussed his views on drug policy and the dangers of medical groupthink in a September 20, 2024 Cato Institute panel cohosted by Singer.

Agency Agendas

Doctors care far more about patient choice and autonomy than government agencies do, says Singer.

"Clinicians have marinated in the ethics of informed consent and respect for autonomy," said Singer. "Unfortunately, the government doesn't respect autonomy.

"Lawmakers on the federal and state level must repeal laws that let the government control what medications we can take, what kinds of health care professionals we can consult, what kinds of treatments we can undergo, and what kinds of substances we can consume," said Singer.

More prescription drugs should be classified as OTC, says Devon Herrick, a health care economist.

"More Rx drugs should be switched to over-the-counter," said Herrick. "A way for this to happen would be to allow pharmacists to authorize more drugs directly to patients," said Herrick.

There are many such "behind the counter" drugs, such as pseudoephedrine, cough syrups, insulin, and emergency contraception.

OTC Lowers Costs

Consumers benefit with greater access and lower costs, when drugs are approved for OTC sales, says Hopper.

"OTC drugs are generally a lot cheaper than Rx drugs," said Hopper. "In one example, the OTC drugs were priced at 10 percent of the Rx equivalents.

"Most pharmaceuticals are underprescribed and underused," said Hopper. "There are many chronic conditions for which drugs have shown tremendous benefits, but for which only a fraction of the patients who would benefit actually get the beneficial drugs. OTC makes drugs easier to acquire."

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

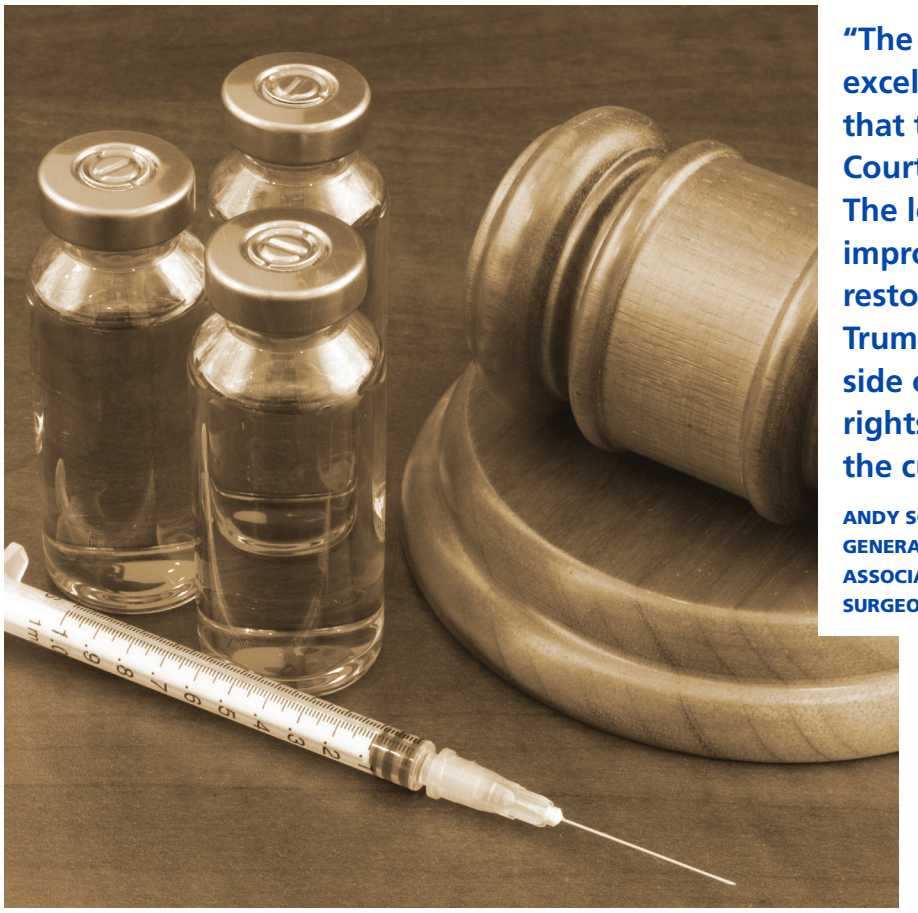
Court Affirms Parents' Right to Sue Over Forced Vaccinations

By Ashley Bateman

A recent court ruling may increase accountability of school and state employees who overruled parents' rights to make health care decisions for their children during the COVID-19 pandemic.

In August 2021, Tanner Smith was sent to his high school's clinic in Guilford County, North Carolina, for COVID-19 testing. Clinic employees allegedly forced Smith to get a vaccine shot even though his mother had not signed the required consent form and Smith had not agreed to the injection.

In March 2023, Smith's mother, Emily Happel, filed a lawsuit against the Guilford County Board of Education and the school clinic's operating partner, Old North State Medical Society, for battery and violations of state constitutional rights.



"The mother and son have an excellent chance of winning now that the North Carolina Supreme Court has ruled in their favor. The legal situation on this is improving, and this ruling helps restore the full rights of parents. Trump and RFK Jr. are on the side of parents, so parents' rights will be respected under the current administration."

ANDY SCHLAFLY
GENERAL COUNSEL
ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS

Rejected, then Accepted

The Superior Court of Guilford County and the Court of Appeals dismissed Happel's right to sue and rejected all claims, ruling the defendants were immune from any legal claims under the federal Public Readiness and Emergency Preparedness (PREP) Act. Happel was seeking declarative and injunctive relief, reimbursement for attorney fees and costs, and whatever else the court deemed proper.

Chief Justice Paul Newby of the North Carolina Supreme Court overturned the lower courts' decisions in March.

The PREP Act appears to provide immunity only for torts, or civil injuries, not constitutional violations, Newby wrote in his decision.

"It is similarly unconvincing to insist that the PREP Act merely displaces the remedy for a constitutional violation, as opposed to destroying the underlying right," wrote Newby.

Newby dismissed Happel's battery claim and remanded the case for further proceedings on the issue of constitutional rights violations.

Parents' Rights Upheld

Newby's ruling was right, says Andy Schlafly, general counsel for the Association of American Physicians and Surgeons.

"Parents have traditionally been the sole decision makers concerning pediatric medical care for their children," said Schlafly. "Only courts have the right to override parents' decisions to allow or decline medical care for their children younger than 18-years-old."

Emergency exceptions must be very narrow to fall within legal limits, such as performing CPR or some other urgently necessary action to save someone's life, says Schlafly.

"Having a COVID shot is not an emergency," said Schlafly.

Even during emergency situations, the burden should be very high for the state to override fundamental freedoms, confining such action to the least restrictive means possible, says Victoria Cobb, president of the Family Foundation's Founding Freedoms Law Center.

"We always believe that unless a parent has forfeited their parental rights by truly abusing their child in the eyes of the law, they must retain the right to do as they see best fit for their child," said Cobb. "They know best. It is never ideal for the state to make decisions about what constitutes an emergency and step in over the parent."

Forced Vaccines Upheld

Some state courts continue to rule in favor of COVID-19-era controls.

In March 2025, the Maine Supreme Judicial Court ruled the PREP Act granted immunity to vaccine administrators in a case similar to Happel's.

In Vermont, a family is petitioning a court to review a 2024 lower court ruling in their lawsuit claiming a school district staff member administered COVID-19 shots to their child in 2021 without parental consent. In February, the U.S. Supreme Court rejected a fast-track petition to review the case.

Fears Exploited

In 2021, Gov. Gavin Newsom of California announced a COVID-19 vaccine requirement for all middle- and high-school children, pending Food and Drug Administration approval of COVID shots for minors.

"California probably led the country in COVID craziness," said Larry Sand, president of the California Teachers Empowerment Network.

Sand says the state and federal governments pushed their way into people's lives.

"If you didn't get the vaccines, you were selfish," said Sand. "Masks were omnipresent. Clearly, science took a back seat to fearmongering and groupthink."

Some states treated schools like prisons, said Jeanne Ann Noble, M.D., an emergency room physician at the University of California, in *FrontPageMag* in March 2022.

"Schools have been lumped in with high-risk settings including health care sites, homeless shelters and prisons, despite young people having a very low risk of serious illness," said Noble.

COVID-19 policies were the result of "fear-based policy and teachers' union politics," Noble told the magazine.

Floodgates Opened

Vaccines are not the only area where institutions have taken control from parents with government permission. Hospitals have been allowing patients as young as 12 to receive treatment on their own, with no parent present and no written authority from them.

This trending "minor in charge" approach has come under scrutiny in recent months with revelations of radical gender treatments that schools and health care groups have encouraged children to undergo while conspiring to hide that knowledge from parents.

Rights Protected

Happel's case adds to the legal scrutiny over institutional control of minors and could set a precedent for other lawsuits and a return to government protection of parents' rights to manage their children's health care, says Schlafly.

"The mother and son have an excellent chance of winning now that the North Carolina Supreme Court has ruled in their favor," said Schlafly. "The legal situation on this is improving, and this ruling helps restore the full rights of parents. Trump and RFK Jr. are on the side of parents, so parents' rights will be respected under the current administration."

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

Republican Medicaid Plan: Yes to Reform, No to Benefit Cuts

Speaker of the House Mike Johnson

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

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over the next 10 years. The bill does not mention Medicaid cuts. The House and Senate are currently reconciling the two chambers' versions.

"Medicaid is where most of us think they will go after because Republicans have been attacking Medicaid for years and years," said Pritzker on *Fox News Sunday* on April 13. "Where will you find $880 billion? That's the big question, and the rest of us can see through it."

"I'm not for cuts in Medicaid," said Rep. Vern Buchanan (R-FL), chair of the House Ways and Means Health Subcommittee, in a public forum on April 2. "There are a lot of inefficiencies [in the federal government]. We've got to find a way to be able to ... do things better for less."

"Tightening eligibility to focus on the truly needy, reducing administrative bloat, and strengthening oversight can generate savings without harming essential services."

GARY ALEXANDER
PARAGON HEALTH INSTITUTE

Kickback Scheme

A source of contention is so-called "provider taxes," where a state will impose a tax on Medicaid hospitals and clinics to boost federal reimbursements and then give the "tax" back to the hospitals as a rebate. This gives those states more federal tax money without providing more or better services for recipients. Republicans say disallowing these taxes could save $600 billion over a decade.

Hospitals are pushing back, calling the idea "devastating."

"It would certainly create a financial strain on the ability to continue to provide [Medicaid] services," American Hospital Association Executive Vice President Stacy Hughes told *The Wall Street Journal*.

Reform Call

The only way to save Medicaid and stop the political blowback is to reform the program in a big way, says John C. Goodman, president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"The rhetoric is getting stronger," said Goodman. "You have conservatives saying they won't vote for any bill that cuts benefits. It is puzzling why Republicans are resistant to reform the program altogether."

Health Care 'Stamps'

Goodman says three reforms would give Medicaid enrollees access to the same kind of care middle-income patients receive, while saving several hundred billion dollars.

To start, lawmakers should allow needy people to buy health care the way they use food stamps to buy food, Goodman says.

"If they go to a community health center or an ER, they pay Medicaid rates," said Goodman. "But if they go to a MinuteClinic, or a freestanding ER, or any private practice doctor, they can add to the Medicaid rate with cash and pay the market price. This gives them access to the same type of care that is now only available to other patients. This practice is currently illegal."

Roth-Style HSA

Congress should also allow Medicaid enrollees access to a Roth-style health savings account (HSA), says Goodman.

"Medicaid managed care insurers should be able to make deposits to these accounts, which can be designated for numerous purposes, including purchasing all primary care," said Goodman. "Any money not spent can be withdrawn for other purposes without taxes or penalties.

"This arrangement would be voluntary," said Goodman. "It would be an opportunity, not a requirement."

DPC Access

In addition, Medicaid enrollees should have access to direct primary care, membership-style care that works outside the insurance reimbursement system for an affordable monthly flat fee, says Goodman.

"This is 24/7 access along with a doctor's phone number," said Goodman. "Medicaid could supply the funds, or let enrollees make monthly payments from their Roth HSA. In all cases, they should be able to pay the market price, so that doctors will compete for their business. The cost in Wichita is $50 a month for a mother and $10 for a child."

Abundant Waste

Republicans can help taxpayers and the needy alike by "prioritizing efficiency, accountability, and smarter resource allocation," says Gary Alexander, who leads the Medicaid and Health Safety Net Initiative at the Paragon Health Institute.

"Medicaid's annual cost exceeds $900 billion, and inefficiencies—like the $1.1 trillion in improper payments over a decade—highlight clear opportunities for reform," said Alexander. "Tightening eligibility to focus on the truly needy, reducing administrative bloat, and strengthening oversight can generate savings without harming essential services. Also, implementing Paragon Institute's recommendation on the federal match rate for able-bodied working age adults would be highly effective" (see related commentary, page 20).

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

House Hearing: Can Medicare Deliver Better, Cheaper Post-Acute Care?

By Kevin Stone

The House Ways and Means Health Subcommittee held a hearing on ways to improve access to quality post-acute care.

Millions of Medicare enrollees require care after a hospital stay, such as rehabilitation, hospice, and home health care, and quality and access have suffered over the years, the expert witnesses said.

Consolidation, mergers, and acquisitions by national chains have reduced competition in the $60 billion post-acute care industry, witnesses told the subcommittee. Medicare reimbursement models that do not reflect the actual cost of advanced long-term care, and models focused on rehabilitation, do not adequately reduce hospital readmittance, witnesses stated.

Complicated cases that require costly and extended care can cause facilities to operate at a loss, which discourages caretakers from admitting patients most in need of specialized care, Paul Congilli, a Nebraska hospital leader, told the subcommittee.

"From a provider and patient perspective…when [the high-cost outlier threshold was lower], we were able to allow more patients who would enter into the facility who we knew would become high-cost outliers, because that fixed loss amount was such that we could manage that and still make a relatively small margin within our long-term care hospital," said Congilli.

The panel at the March 14 hearing discussed possible remedies, such as expansion of telehealth services, implementation of a unified payment system, and establishment of a pay-for-performance system modeled on private-sector programs.

High-Cost Outliers

Patients with complex or difficult-to-treat conditions who need post-acute care can impose an outsized financial burden on facilities and staffing, says Linda Gorman, director of health care policy at The Independence Institute.

"There are well-known reasons for staffing problems," said Gorman. "The first is that the payers—primarily Medicare and Medicaid—pay at below cost. If one is operating a facility with high fixed costs, staffing is where one cuts back, with hours, numbers of hires, or quality of hires.

"This is just basic economics," said Gorman. "Given that, perhaps the most significant moment in the subcommittee hearing was the discussion of the increase in the high-cost outlier threshold and its effect on margins."

The dwindling margins have caused many long-term acute care (LTAC) and skilled nursing facilities (SNFs) to limit services required by high-cost outlier patients.

For example, patients in Texas, home to two of the five largest metropolitan areas in the United States, can only find one SNF actively accepting patients who need both hemodialysis and invasive ventilation. Having one such facility in a state as large as Texas could cause patients and their families a great deal of inconvenience, as this writer has experienced.

Telehealth Debate

With telehealth having gained a great deal of interest during the COVID-19 pandemic, subcommittee witness Dana Madison, a Texas home health administrator, said the practice could be helpful now in easing LTAC staffing shortages.

"In Lubbock, Texas, six years ago we did a study, and at that point, we were a city of 260,000," Madison testified. "We were 1,000 [registered nurses] short and 1,000 [licensed vocational nurses] short, and that's a hole that you can never backfill enough. We are dealing with it right now.

"Telehealth would help with that tremendously," said Madison. "If we could do telehealth visits, one particular nurse could make 20 visits a day instead of the normal eight that they make. For those patients that don't need to actually have hands-on care that day, I think telehealth would be a great way to take care of those patients."

Telehealth and home care will not solve the staffing problems, says Gorman.

"There are cases that can best be handled in nursing homes because of severity, scale, organizational, and continuity problems," said Gorman. "That is why the nursing home industry developed."

Pay-for-Performance Support

Jonathan Fleece, a Florida home-based care provider, testified that tying Medicare reimbursement to the quality of care provided, a practice already embraced by the private sector, could push health providers to improve performance.

"If you look at the current star rating system that is prevalent in Medicare today, it is one that does not adequately pay for performance for the providers," said Fleece. "We would certainly advocate that for those organizations that have higher star ratings, that they get paid more under the reimbursement system. That would be one model of a pay for performance."

Star ratings have limited value, says health care economist Devon Herrick.

"The metrics for what constitutes quality performance are hard to measure," said Herrick. "Yet, Medicare should claw back reimbursements when costs are driven up by poor-quality care."

"Since there is a limit to the amount of money that is available for health care, it is important to ensure the public programs put paying for the care of people who have serious medical problems at the top of their list. This may mean cutting other nice but nonessential things. Paying for medical care for the seriously ill, for example, is more important than paying for coverage for able-bodied, mostly healthy people that is seldom used."

LINDA GORMAN
DIRECTOR OF HEALTH CARE POLICY
THE INDEPENDENCE INSTITUTE

Priority Call

Post-acute care in public health programs should actively engage patients in health care choices and prioritize care for those most in need, says Gorman.

"The people who know about quality are the patients and those supervising their care," said Gorman. "But as Medicare and Medicaid are currently constructed, patients or their agents have little say in how government health money is spent, particularly if they are in managed care.

"Since there is a limit to the amount of money that is available for health care, it is important to ensure the public programs put paying for the care of people who have serious medical problems at the top of their list," said Gorman. "This may mean cutting other nice but nonessential things. Paying for medical care for the seriously ill, for example, is more important than paying for coverage for able-bodied, mostly healthy people that is seldom used."

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

Trump Taps Microbiologist Monarez to Head CDC

By Bonner Russell Cohen

President Donald Trump has nominated microbiologist Susan Monarez to be the new director of the Centers for Disease Control and Prevention (CDC).

With a Ph.D. in microbiology and immunology, Monarez will be the first non-M.D. to head the Atlanta-based agency in more than 70 years. Monarez was serving as acting CDC director when Trump announced her nomination.

Monarez replaces former U.S. congressman Dave Weldon, M.D., an army veteran and vaccine skeptic, whose nomination was withdrawn in March after it became clear the Senate would not confirm him.

"Dr. Monarez's expertise in microbiology is certainly needed, but her cited accomplishments seem more related to 'social justice' concerns such as maternal outcomes disparities and access to mental health care. The CDC is not supposed to be involved in chronic, noninfectious disease, but if it is, the CDC's focus should be on figuring out why we have so much chronic disease rather than on wearables to monitor certain health parameters."

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

Low Profile

Monarez has a reputation as a low-key scientist who has avoided the spotlight and has not been associated with outspoken critics of the public-health establishment.

One of her most recent positions before becoming acting CDC Director was director of the Advanced Research Projects Agency for Health (ARPH-H).

"Prior to joining ARPA-H, Dr. Monarez led high-impact initiatives focusing on the ethical use of artificial intelligence and machine learning to improve health incomes, novel approaches to addressing affordability and accessibility in healthcare, expanding access to behavioral and mental health interventions, ending the opioid epidemic, addressing health disparities in maternal morbidity and mortality, and improving the country's organ donation and transplantation programs," Monarez's CDC bio states.

Monarez has also served in the White House Office of Science and Technology Policy and on the National Security Council.

"During that time, Monarez led efforts to improve the nation's biomedical innovation capabilities, including combating antimicrobial resistance, expanding the use of wearables to promote patient health, ensuring personal health data privacy, and improving pandemic preparedness," her CDC bio states.

Ongoing Reorganization

If confirmed by the Senate, Monarez will take over an agency whose performance during the COVID-19 pandemic garnered heavy criticism. The week Monarez was nominated, the Associated Press reported at least five senior-level CDC officials had departed the agency.

In addition to that reduction in senior management, the CDC is expected to undergo a staff cut of some 2,400 employees, or 18 percent of the agency's workforce, the news publication *STAT* reported.

At the beginning of 2025, the CDC had more than 13,000 employees and nearly 13,000 contract workers. The center's entire Freedom of Information Act (FOIA) office was fired as part of a broader HHS reorganization.

Economic, Social Life Influence

Restoring public trust in the CDC and other health agencies in the pandemic's wake will be a top priority for new leadership.

"Americans learned the hard way the CDC is not just a public-health agency, it is part of the administrative state, embedded in a powerful federal bureaucracy with considerable influence over economic and social life," wrote the American Enterprise Institute's Brian J. Miller and M. Anthony Mills in 2023.

"Yet the CDC's policy guidance is peculiar, neither strictly regulatory nor simply advisory," wrote Miller and Mills. "And the processes and evidence the CDC uses to make such consequential decisions are, compared with those of other administrative agencies, unusually opaque."

Monarez is a "serious scientist" and a "team player," said McCullough Foundation President Peter A. McCullough, M.D., MPH, on *Fox News*.

McCullough says he met Monarez and told Fox News he believes she will focus on "bio-pharmaceutical safety, outbreak analysis, and data transparency." Monarez will "bring the agency back to where it was 10 or 15 years ago," McCullough said.

Calls for Reform

The CDC is a troubled agency that has gotten far out of control and needs a determined leader, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"I think a 'team player' is not what the CDC needs at this point, since the current team was responsible for the disastrous response to COVID-19 and has a long history of concealing data," said Orient. "The CDC has been engaged in mission creep for decades, departing from its task of investigating and advising on infectious disease outbreaks."

Monarez will have to work hard at keeping the CDC on mission, says Orient.

"Dr. Monarez's expertise in microbiology is certainly needed, but her cited accomplishments seem more related to 'social justice' concerns such as maternal outcomes disparities and access to mental health care," said Orient. "The CDC is not supposed to be involved in chronic, noninfectious disease, but if it is, the CDC's focus should be on figuring out why we have so much chronic disease rather than on wearables to monitor certain health parameters."

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

Trump Administration Downsizes Federal Health Agencies

By AnneMarie Schieber

Ten thousand staffers at federal health agencies received pink slips on April 1 in a major overhaul to shrink the Department of Health and Human Service's (HHS) headcount from 82,000 to 62,000.

"Our hearts go out to those who have lost their jobs," posted HHS Secretary Robert F. Kennedy on X. "But the reality is clear: what we've been doing isn't working. Despite spending $1.9 trillion in annual costs, Americans are getting sicker every year. In the past four years alone, the agency's budget has grown by 38%—yet outcomes continue to decline. HHS needs to be recalibrated to emphasize prevention, not just sick care."

The changes will not affect Medicare, Medicaid, or other essential health services, Kennedy wrote.

HHS is the seventh-largest department in the federal government, about one-tenth the size of the U.S. military. It includes the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the National Institutes of Health (NIH).

President Donald Trump shaking hands with Robert F. Kennedy Jr

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"HHS defends and funds ineffective programs like Head Start, nurse home visiting programs, and Medicaid doulas. Its programs on the social determinants of health seek to expand its meddling into the food, housing, and labor markets even as many of its quality measures and guidelines have been shown to be of questionable value."

LINDA GORMAN
DIRECTOR, HEALTH CARE POLICY CENTER
INDEPENDENCE INSTITUTE

'Consolidating the Agency'

There is plenty of room for cuts despite much fearmongering, says Kennedy.

"We're not cutting front-line workers, we're cutting administrators, and we're consolidating the agency to make it more efficient," Kennedy told NewsNation on March 27. "We have over 100 comms departments. You have 40 procurement departments. We have dozens of IT departments, dozens of HR departments. None of them talk to each other."

The April 1 cuts arrived after voluntary resignations earlier in the year and included high-profile individuals such as Jeanne Marrazzo, who replaced Anthony Fauci as director of the National Institute of Allergy and Infectious Diseases on August 3, 2023.

April 1 was the first day on the job for FDA Commissioner Marty Makary and NIH Director Jay Bhattacharya, *Reuters* reported.

Former FDA Commissioner Robert Califf, who stepped down in January, criticized the cuts.

"The FDA as we've known it is finished, with most of the leaders with institutional knowledge and a deep understanding of product development and safety no longer employed," wrote Califf on LinkedIn. "I believe that history will see this a huge mistake. I will be glad if I'm proven wrong, but even then, there is no good reason to treat people this way."

'Wasteful Spending'

The federal government has plenty of bloat, fraud, and abuse in its health care programs, says Sally Pipes, president of the Pacific Research Institute.

"Recent federal statistics reveal an astounding level of wasteful spending in Medicare and Medicaid, but it's important to be strategic about eliminating waste," said Pipes. "Indiscriminate cuts are unwise."

Wasteful spending is not necessarily the biggest reason for concern about the FDA, says Devon Herrick, a health care economist who posts on the *Goodman Institute Health Care Blog*.

"Most of [the FDA's] budget is paid for by industry fees," said Herrick on the *Heartland Daily Podcast* on March 26. "The trouble with the FDA is not what it is costing taxpayers; it is the bureaucracy. Nobody knows the bureaucracy quite like the people who worked there, and they are in high demand as consultants in the private sector."

Maze of Regulations

The agency's regulations and guidance documents conflict with one another and cause confusion, says Herrick.

"What could probably improve quality is if the FDA could do a wholesale review of these regulations so that industry can understand what is required of them," said Herrick.

Pipes says drug and device approvals are already too slow, and the administration should be careful to avoid making the situation worse.

"Patients depend on the FDA, for instance, to rapidly review and approve promising new therapies," said Pipes. "But there's concerning evidence that cuts at FDA are slowing review and approval of new drug applications even further. That's the opposite of what this country needs. Instead, Trump officials should be modernizing the FDA and expediting the approval process."

'Deserve to Lose Their Jobs'

The COVID-19 pandemic was enough of an alarm bell to warrant a massive purge, even if it means letting supposedly good people go, wrote Jeff Childers at his *Coffee and Covid* Substack on April 2.

"All these 'good' CDC and NIH employees kept their mouths shut during covid," wrote Childers. "They *could have* spoken up and mitigated the harm. But the 'good ones' stayed silent, kept their heads down, to save their jobs. … *Silence in the face of institutional corruption is complicity*."

Michael Cannon, director of health care policy studies at the Cato Institute, says downsizing HHS is the right thing to do.

"Let's be honest. Many HHS employees deserve to lose their jobs," wrote Cannon in a blog post on Cato.org.

'Misused Public Health Law'

The health agencies must undergo a major cultural shift if they are to become more responsive to the American public, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

"For decades, HHS has devoted itself to remodeling U.S. health care to make it more like the dysfunctional British, Canadian, and European systems," said Gorman. "It oversaw the corruption of health data during COVID. It misused public health law to impose an eviction moratorium during the COVID epidemic."

HHS is a classic case of government overreach and mission creep, says Gorman.

"HHS defends and funds ineffective programs like Head Start, nurse home visiting programs, and Medicaid doulas," said Gorman. "Its programs on the social determinants of health seek to expand its meddling into the food, housing, and labor markets even as many of its quality measures and guidelines have been shown to be of questionable value."

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

Baby Formula Will Get First Federal Review Since 1998

By Ashley Bateman

Government health agencies have launched an effort to ensure the "quality, safety, nutritional adequacy, and resilience" of infant formula in the United States.

Under Operation Stork Speed, the Food and Drug Administration (FDA) will review the nutrients in infant formula and increase testing for heavy-metal contamination. Companies will have to provide transparent and clear labeling on their products and communicate those changes to the public.

Operation Stork Speed is the federal government's first comprehensive review of infant formula since 1998.

The initiative also directs the FDA to collaborate with the National Institutes of Health and other scientific bodies "to address priority scientific research gaps regarding short- and long-term health outcomes associated with formula feeding in infancy and childhood across the lifespan," states the news release.

"The FDA will use all resources and authorities at its disposal to make sure infant formula products are safe and

wholesome for the families and children who rely on them," said Health and Human Services Secretary Robert F. Kennedy in the directive. "Helping each family and child get off to the right start from birth is critical to our pursuit to Make America Healthy Again."

Metals in Formula

The announcement of Operation Stork Speed came a day after *Consumer Reports* published an investigation that found contaminants in half of the 41 formulas its researchers tested.

Data on formula and nutritional directives from the medical community are long overdue, says Kathleen Berchelmann, M.D., a pediatrician and founder and president of MyCatholicDoctor.

"There are certain populations, especially the immunosuppressed population and sick babies, that this [particularly] impacts," said Berchelmann. "It's been known for a very long time that there's a certain acceptable level for safety."

Babies in neonatal intensive care are especially susceptible to contaminants and illnesses given their immature immune system, and contaminated formula can have detrimental, even deadly effects.

"Families are already stressed and traumatized with their baby's illness; they should not have increased stress regarding formula safety," said Anna Camacho, a board-certified family and neonatal nurse practitioner. "I have had parents ask me if the formula is safe, so this is certainly a concern on their minds. As far as the outpatient community, it has also affected parents' stress levels [over] access to formula with shortages after recalls."

Bureaucratic Delays

The FDA has organizational problems that create a time gap between collection of evidence and data and implementation, which can cause safety concerns for the neonatal population, says Camacho.

"In addition, there are also ethical concerns in completing rigorous research in such a vulnerable population," said Camacho. "That barrier is not likely to change anytime soon, but advocacy may influence the administration to correct these issues."

Supply Disruptions

Although more highly regulated than most products on the market, there have been recent cases of infant formula contaminated during the manufacturing process.

In 2022, suspected contamination at a manufacturing facility led to widespread shortages of baby formula, causing panic.

"I think the American people need an explanation regarding what happened with the critical formula shortage and to prevent contamination, the cause of that closure and contingency," said Berchelmann.

Other countries did not experience shortages in 2022 and 2023, Kim Corba, D.O., told *Health Care News* in May 2022.

Consumers should be asking why there are no supply safeguards in place, says Berchelmann. "We wouldn't do this for other critical resources," said Berchelmann. "There is and should always be contingency planning."

Limited Competition

The federal government's supplemental nutrition program for Women, Infants, and Children funds two companies, Similac and Enfamil, which might be causing market distortions, says Berchelmann.

"The American people need an answer as to why a small number of organizations have limited competition," said Berchelmann. "More locations of production would allow for less contamination when it comes to safety and access. I think the shortage opened eyes to this ridiculous situation of this limited number of factories making formula. When we run into contamination, we run into a critical shortage in our country."

Nutrition Deficiencies, Overdependence

Though the gold standard for infant nutrition is breastmilk, parents in the United States depend heavily on formula for their infant children. Nearly 20 percent of American newborns are fed formula exclusively early in life, according to the Centers for Disease Control and Prevention. At six months of age, the number of infants on formula as part of their diet has increased to 75 percent.

"Breastfeeding is the optimal source of nutrition, so [it] should always be encouraged, regardless of a formula crisis," said Camacho. "No formula can replicate all the benefits of breastfeeding. However, not every mother is able to breastfeed, for various reasons."

To encourage breastfeeding, Camacho says education and support services for breastfeeding should begin before a woman is pregnant, to help normalize it and dispel myths, and if a woman cannot breastfeed, she should be able to rely on formula as a safe alternative.

"First and foremost, breastfeeding is supported almost universally by pediatricians as the best choice, but we recognize that there are many people, for many good reasons, who cannot breastfeed," said Berchelmann. "Formula is a necessary essential for our babies, and the future of America needs good nutrition for babies."

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

Food Companies May Lose Option to Affirm Ingredient Safety

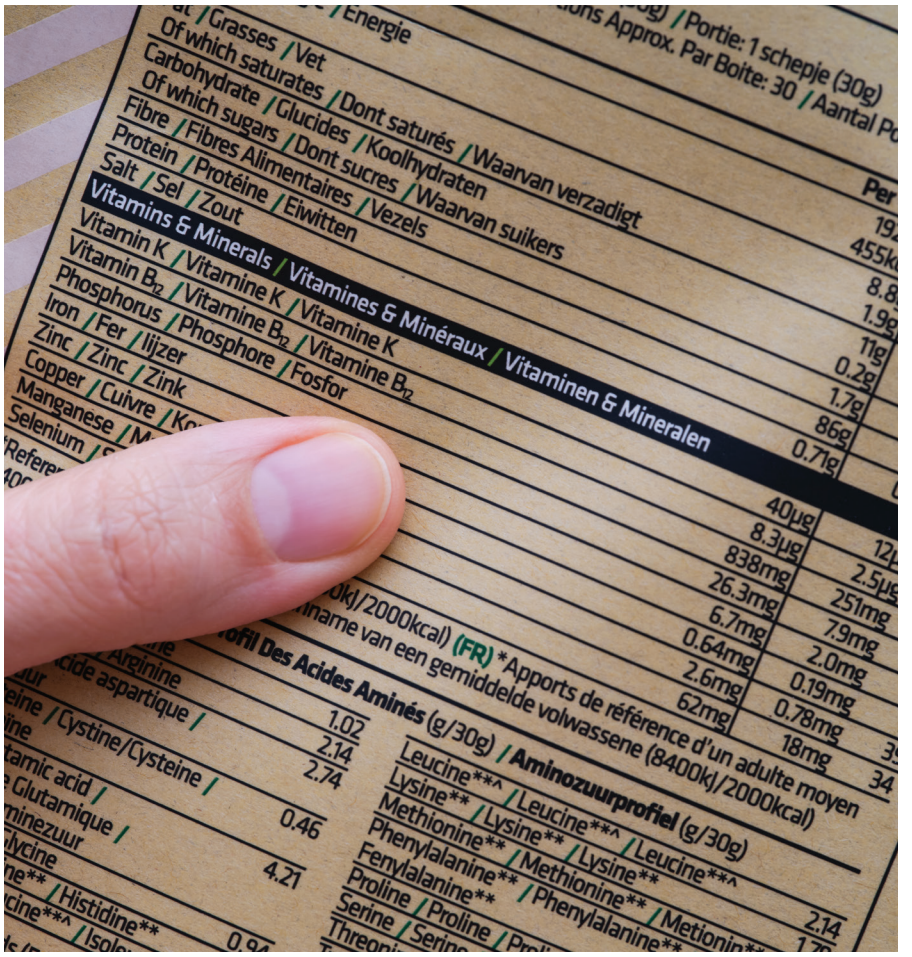
By Ashley Bateman

Food companies across the country may lose their authorization to self-affirm food ingredients, dyes, additives, and stabilizers are safe.

Department of Health and Human Services Secretary (HHS) Robert F. Kennedy Jr. has directed the Food and Drug Administration (FDA) commissioner to explore revisions to the Substances Generally Recognized as Safe (GRAS) pathway that gives food manufacturers authority to "self-affirm" the safety of new ingredients.

"For far too long, ingredient manufacturers and sponsors have exploited a loophole that has allowed new ingredients and chemicals, often with unknown safety data, to be introduced into the U.S. food supply without notification to the FDA or the public," said Kennedy in a March 10 news release. "Eliminating this loophole will provide transparency to consumers, help get our nation's food supply back on track by ensuring that ingredients being introduced into foods are safe, and ultimately Make America Healthy Again."

The directive will be overseen by Martin Makary, M.D., who was sworn in as FDA Commissioner on April 1.



Safety Assumption

The public was probably unaware of companies' ability to self-declare ingredient safety, says Peter McCullough, M.D., MPH, a cardiologist and president of the McCullough Foundation.

"I think Americans were alarmed to find out about this GRAS loophole where the companies would present a new ingredient as being generally recognized as safe based on their own assertion," said McCullough. "Companies are motivated to have a new entry logged with the FDA with the lowest amount of scrutiny possible. We think this is how these ingredients get on the market."

Eliminating the loophole would require congressional legislation or an administrative change through the rulemaking process. Kennedy should not rely on Congress for that, says McCullough.

"I have little or no confidence that our U.S. Congress has the best interest of America's health in mind," said McCullough. "During the Health and Human Services confirmation hearings, senators had the opportunity to show whether they care about American health, and one after the other they shut down any inquiry. It's clear the senators were compromised by Big Food and Big Pharma. Americans saw that on full display."

Chemical-Laden Food

In 1958, an amendment to the federal Food, Drug, and Cosmetic Act required food companies to get premarket approval of substances added to food unless the product was on the GRAS list. In 1997, the FDA streamlined the process to "eliminate the resource-intensive rulemaking procedures" and "replace the GRAS affirmation petition process with a notification procedure," states a 2018 document on the FDA's website.

Today, more than 10,000 chemicals are allowed in American food, most of which have not undergone rigorous third-party testing, according to the EWG watchdog group.

A report by Rep. Chip Roy (R-TX) released in January states, "the U.S. actively subsidizes foods that are making us sick, to the tune of $30 billion per year," and "the U.S. science and regulatory structure is littered with conflicts of interest that promote certain foods and guidelines that are influenced by industry ready to profit."

"Read any package label and one has to have a degree in organic chemistry to try to understand what they're eating," said McCullough. "My general understanding is the reason companies use complex, often petroleum-based, chemical products in food is either they are usually less expensive or more efficient in the manufacturing process, particularly adhesives that hold foods together and may extend the shelf life of products."

Hungry for More

Removing the loophole would be a way to get unsafe additives out of the American food supply, says McCullough.

"An expert review [of a new ingredient] would probably be a sufficient deterrent for companies," said McCullough. "With this new normal, companies would have to consider using natural products."

> **""An expert review [of a new ingredient] would probably be a sufficient deterrent for companies. With this new normal, companies would have to consider using natural products."**
>
> **PETER MCCULLOUGH, M.D., MPH**
> **CARDIOLOGIST**
> **PRESIDENT, MCCULLOUGH FOUNDATION**

Ensuring ingredient safety is a federal responsibility, says McCullough.

"I think the states just simply couldn't effect change with the food supply because of the complexities of food distribution, shipping, inspections; all of those processes have to be at a central level," said McCullough.

States do control some food programs. In Texas, a bill to increase healthy options in the Supplemental Nutrition Assistance Program is making its way through the legislature.

Katy Talento, an epidemiologist, naturopath, and former Trump administration policy advisor, welcomes Kennedy's directive to remove the GRAS loophole.

"Congress seems wholly beholden to industry interests and the inertia they demand in ways that states do not," said Talento. "The good news is … the Secretary can fix this through his own authority."

Out on the Table

"It's refreshing to see the absolute corruption of the revolving door in the food industry called out so openly," said Talento. "The regulatory capture must end. These agencies are supposed to be protecting us against the regulated entities. Instead, they protect the companies against us—against public scrutiny and accountability."

McCullough told *Health Care News* the Trump administration should drop the last letter of MAHA (Make America Healthy Again) to make it accurate.

"We have never previously had a healthy food culture that I know of," said McCullough. "In the 1970s, for example, 50 percent of the adult population smoked. Of my patients who are in their 80s or 90s, 50 years ago none were making choices to enhance their health. They got to be 80 or 90 with no personal investment in diet and fitness."

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

Violent Attacks in Hospitals, Clinics on Rise

By Kevin Stone

A violent attack in a Pennsylvania hospital that resulted in the death of a police officer prompted the American Nurses Association (ANA) to ask Congress to pass legislation for a workplace violence prevention standard.

"Workplace violence is a longstanding and unresolved issue in healthcare," said ANA President Jennifer S. Mensik in a February 23 news release. "It is a growing public health crisis that demands urgent attention. It worsened during the COVID-19 pandemic, overburdening an already strained healthcare system."

Planned Attack

On February 22, 49-year-old Diogenes Archangel-Ortiz entered UPMC Memorial Hospital in Pennsylvania with a firearm and shot a doctor, a nurse, a custodian, and three police officers. The previous evening, hospital staff had removed Archangel-Ortiz from the premises after he became highly agitated upon learning there was no further treatment available for his terminally ill wife.

Archangel-Ortiz returned the next morning with a backpack containing a firearm, zip ties, and duct tape. He took staff members hostage before being killed in a shootout with police. One of the police officers died from his gunshot wounds.

Weeks after the Pennsylvania attack in March, an employee of Corewell Health Beaumont Troy Hospital in Troy, Michigan was arrested after shooting a coworker in the hospital garage, striking the person twice in the arm.

Dozens of Killings

In a review of large medical databases, an analysis in eClinical Medicine in June 2024 found about 3,197 citations by searching "workplace violence" and "health care." A deeper look into the papers revealed 156 health care workers were killed at their workplaces between 2011 and 2018 in the United States, about 20 deaths a year.

A 2023 study found the frequency of workplace violence against health care workers from January 2020 to March 2022 was 1.2 percent. About 72 percent of the incidents reported were verbal, and 28.1 percent were physical. In terms of workplace violence exposure, doctors accounted for 62.3 percent of the incidents, nurses 20 percent, and administrative workers 7.4 percent.

The analysis found most incidents occurred in outpatient clinics (34.8 percent), followed by emergency departments (25.9 percent). Among the main reasons identified for workplace violence against health care workers were health care workers not following expected procedures (49.6 percent), problematic communication (27.4 percent), and dissatisfaction (23.1 percent).

Soft Targets

The increase in health-care-related violence mirrors previous times of societal stress, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation

"Hospital shootings appear to increase during times of economic stress: the dot.com crash, the 2007-09 [economic contraction] and for a few years after, and the COVID recession all saw increases in hospital shootings," said Matthews.

"It's likely that hospital shootings are taking the place of school shootings, since schools have increasingly stepped up security, taken steps to harden the facilities, and have security guards or armed employees available," said Matthews.

"Hospitals became the next soft target," said Matthews. "They are often large buildings filled with vulnerable people, most of the employees are women, and there have been few efforts to monitor those who enter. Plus, with the rise of violent gangs, hospitals make it easy to retaliate against a gang-member patient or to take out some other form of retribution."

System Strains

Stress in the health care system could also be partly to blame, says health care economist Devon Herrick, Ph.D.

"Violence in hospitals has increased markedly since COVID-19," said Herrick. "Hospital emergency departments are the most vulnerable. There are various theories about why violence and verbal abuse have risen, but long waits for physician appointments, understaffed emergency rooms, and dissatisfaction with the health care system are the most likely reasons."

Another factor is the shortage of primary care physicians, says Herrick.

"It forces some Americans to seek care in an emergency room," said Herrick. "Staffing of emergency departments has been taken over by private equity investors, who reduce staff to save money. It is easy to understand how long waits in the ER lead to dissatisfied customers."

Relationship Problems

The growing resentment could also stem from the third-party payment system, says Chad Savage, M.D., founder of YourChoice Direct Care and a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"This issue can, at least in part, be traced back to the payment system," said Savage. "In the past, doctors worked directly for their patients. That model rewarded physicians who delivered the kind of care that patients valued. Doctors who took time, built trust, and formed strong therapeutic relationships tended to thrive."

That changed when the payment model shifted to third-party payers, says Savage.

"Doctors began to adapt their practice styles to align with what was most financially rewarding under that system: high volume, rushed visits," said Savage. "Unfortunately, that environment isn't conducive to fostering meaningful doctor-patient relationships."

Contentious lawsuits show the hostility the payment disconnect can lead to.

"Research has shown that patients who have strong relationships with their physicians are less likely to sue, even when mistakes occur," said Savage. "Conversely, patients who lack that connection are more likely to pursue legal action. It stands to reason that if a patient is willing to cause financial harm to a physician they don't trust, they might also be more likely to consider physical harm."

Unhealthy Attitudes

Problems outside the doctor-patient relationship can also cause conflict within care facilities, says Savage.

"I've seen countless instances over the years where patients direct anger at medical staff for issues unrelated to the actual care—confusion over deductibles or frustration with insurance coverage decisions," said Savage.

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

Feds Allocate Another $1 Billion to Stop Bird Flu, Reduce Egg Prices

By Joe Barnett

The federal government is allocating an additional $1 billion to combat the avian flu, an outbreak of which led to the killing of millions of healthy chickens and soaring egg prices over the past 12 months.

Agriculture Secretary Brooke L. Rollins unveiled a "comprehensive strategy to curb highly pathogenic avian influenza (HPAI), protect the U.S. poultry industry, and lower egg prices," in an article in *The Wall Street Journal* on February 26.

The U.S. Department of Agriculture (USDA) will spend $1 billion on the plan, said Rollins, with up to $500 million allocated to improve "biosecurity" measures and $400 million going to farmers who lost their flocks.

The USDA announced the availability of $100 million in funding to "identify and foster innovative solutions to fight highly pathogenic avian influenza (HPAI) and directly support America's farmers and ranchers," in a March 20 press release.

The avian flu "has resulted in about 166 million laying hens being culled since 2022," wrote Rollins.

The killing of so many birds caused the price of eggs to soar temporarily. State regulations contributed to the price spike, said Rollins, with mandatory minimum space requirements for fowl in California "increasing production costs and contributing to the Golden State's average price of $9.68 a dozen."

"The public health people prematurely declared a bird flu pandemic about 15 years ago, and everybody went nuts. People who lived with chickens in their pathetic dwellings got the bird flu, and all of a sudden everybody is going nuts. Mass culling for bird flu is not justified, in addition to which the test [for the virus] is unreliable, just like the COVID tests. A [chicken] population can develop herd immunity, and natural immunity is important in stopping the virus now and in the future."

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

Pandemic Panic Redux?

Bird flu does not pose a danger to humans, says John Dale Dunn, M.D., J.D., a policy advisor to The Heartland Institute, which co-publishes *Health Care News*.

"The public health people prematurely declared a bird flu pandemic about 15 years ago, and everybody went nuts," said Dunn. "People who lived with chickens in their pathetic dwellings got the bird flu, and all of a sudden everybody is going nuts."

Killing birds that are not sick will not stop the spread of bird flu, says Dunn.

"Mass culling for bird flu is not justified, in addition to which the test [for the virus] is unreliable, just like the COVID tests," said Dunn. "A [chicken] population can develop herd immunity, and natural immunity is important in stopping the virus now and in the future."

Public Health 'Overkill'

The virus that causes bird flu is spread principally by wild ducks and geese, says Dunn.

"The virus is being transmitted by feral birds," said Dunn. "Culling doesn't stop it; it just destroys production of domestic eating chickens and egg layers.

"Public health people are just being too damn anxious to be powerful and save the planet," said Dunn. "That situation often ends with what is commonly called overkill."

Though the virus has reportedly spread to cows, humans, and cats fed raw chicken meat, it poses little danger to the public health, says Dunn.

"Transmission to humans or other birds or mammals is not as serious as is being claimed and can easily be reduced by isolation of suspect bird populations," said Dunn. "They are not free-range chickens—it's chickens in gigantic henhouses they are killing."

Food Supply Safety

The bird flu outbreak poses little danger to consumers, and the only reported human fatality was to a chicken-farm worker, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"As far as I know, the eggs and meat from exposed chickens that are not sick will not transmit the disease to humans," said Orient. "I think it likely that overvaccination may be creating more problems than it solves."

Chicken-Killing Government Money

Most of the hens killed by farmers were not sick, and many millions were in coops that had no cases of bird flu, press reports stated.

Some farms that culled their chickens have experienced repeated outbreaks and received multiple indemnity payments, wrote epidemiologist Nicolas Hulsher, M.P.H., in an article at the *Focal Points* Substack in February.

In 2024, the USDA spent more than $1.25 billion on indemnity payments for chicken farmers who culled their coops, wrote Hulsher.

"The strikingly large sum of indemnity payments not only incentivizes farmers to comply with state-run mass killing of their animals but also represents a serious misuse of taxpayer money, as mass culling triggers a cascade of severe downstream consequences," wrote Hulsher.

Big Pharma Bird Vaccines

Like human flu viruses, HPAI viruses mutate, so there were no specific vaccines for chickens when the current variant, or clade, was identified in the spring of 2024. Drug developer Zoetis received "a conditional license for its Avian Influenza Vaccine, H5N2 Subtype, Killed Virus," from the USDA on February 14, 2025, states a company press release.

There is no U.S. mandate to vaccinate poultry for bird flu, says Zoetis.

"The decision to vaccinate commercial poultry flocks against HPAI rests solely with national regulatory authorities in partnership with the poultry industry," said Zoetis in a news release.

The virus has affected poultry in other countries. France conducted mass vaccination campaigns for ducks and chickens, which have been so successful that fowl will be allowed outdoors, *Reuters* reported on March 26.

The drug maker Moderna received a $590 million contract from the U.S. Department of Health and Human Services to develop an mRNA bird flu vaccine for humans, using the same technology as its COVID-19 vaccine, in the final days of the Biden administration. The Trump administration is reviewing the contract, *Bloomberg* reported on February 26.

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

Teen Death Puts Spotlight on Abortion Dangers

By Harry Painter

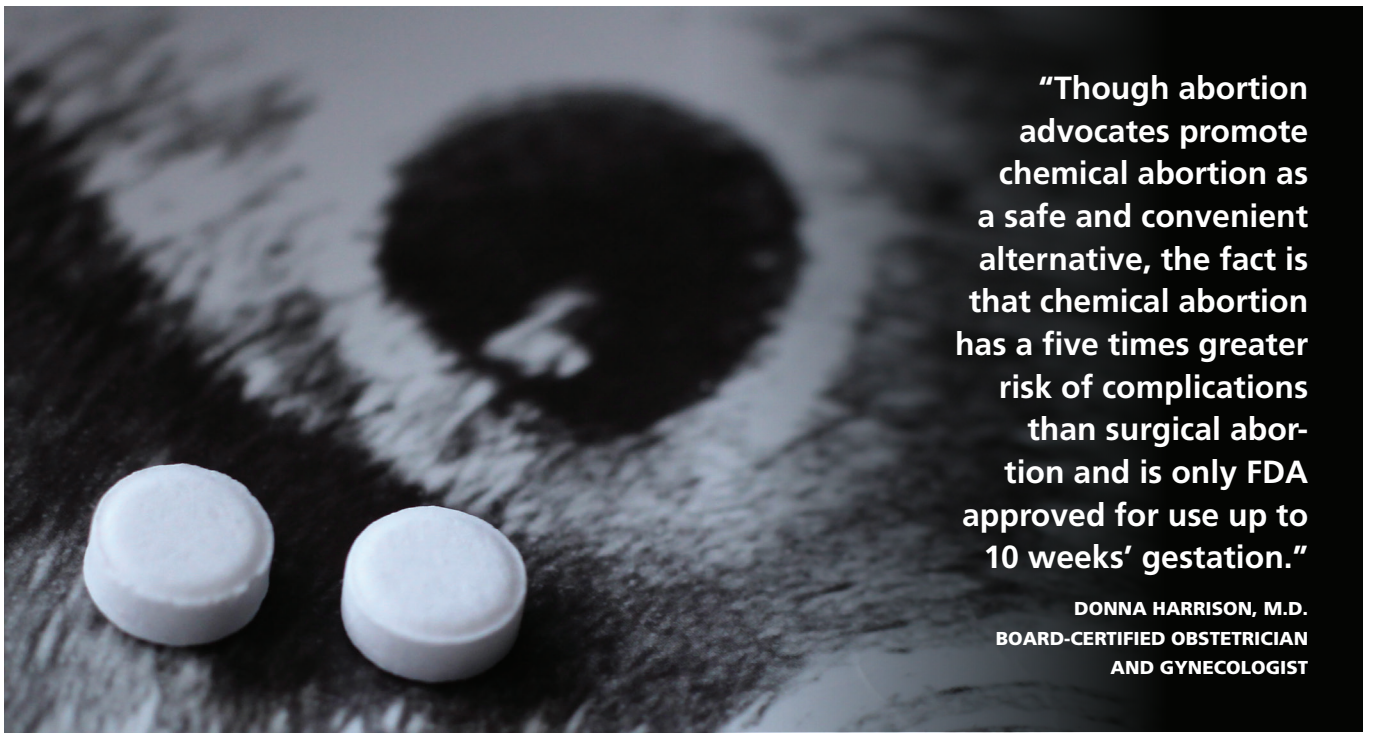
A nonprofit organization is investigating the death of an 18-year-old woman who died after a late-term abortion at a Colorado-based Planned Parenthood clinic.

Keri Kasun, PharmD, told Colorado's House Health and Human Services Committee the family of Alexis "Lexi" Arguello reached out to her for answers about the medical complication Arguello experienced after having her 22-week-old unborn child aborted in February at a Planned Parenthood clinic in Fort Collins, Colorado.

Arguello's grandfather, who was then unaware his granddaughter was pregnant, was summoned to the hospital on February 6, and she died that day. Kasun says Arguello suffered an amniotic fluid embolism (AFE), which led to her developing disseminated intravascular coagulation, a serious blood-clotting condition.

Operation Rescue, a pro-life organization, says it has spent weeks gathering information on Arguello's death, in a March 13 news release.

Arguello is not the only recent victim of a late-term abortion gone wrong. In Illinois, an abortionist is being sued over failing to remove body parts of a 22-week-old aborted baby in 2023, which was discovered after the mother underwent emergency surgery weeks later.



Under Pressure

Recent abortion deaths are bringing out more scrutiny of the industry.

"Patients report failed abortions, misplaced IUDs and inadequately trained staff," states the subhead of a February 15, 2025 *New York Times* article titled "Botched Care and Tired Staff: Planned Parenthood in Crisis."

Planned Parenthood announced on March 19 it was selling the New York City building that houses its only clinic, blaming "inflation and stagnant reimbursement."

At about the same time, President Donald Trump announced he would freeze tens of millions of dollars in Title X grants going to the nationwide organization while his administration reviews its operating policies.

Safety Last

After the Supreme Court's 2022 decision in *Dobbs v. Jackson Women's Health Organization* reversing the *Roe v. Wade* decision that had legalized abortion nationwide, the industry underwent a transformation. States varied widely in their responses, restricting or banning abortion or removing regulations seen as impeding abortion access.

Deregulating abortion clinics harms women, says Genevieve Marnon, legislative director of Right to Life of Michigan.

"There is no question that health and safety regulations for abortion clinics are a public good," said Marnon. "The idea that removing them somehow serves the interest of women's health is a fallacy. It doesn't pass the straight-face test.

"In 2022 in Michigan, the proabortion-majority legislature, along with their ally the governor, repealed the abortion clinic health and safety standards," said Marnon.

In 2024, Michigan became the sixth state to exempt abortion providers from reporting physical complications from abortions.

Protections Removed

Michigan's safety law previously "required standardized information be given to women prior to an abortion, a 24-hour waiting period, and a provision that only doctors could perform abortions," said Marnon.

The safety law also included regulations requiring abortion clinics to attain the standard of outpatient surgical facilities, "including standardized hallway widths to accommodate emergency providers and stretchers, infection control protocols, and emergency medical equipment, etc."

The removal of these protections puts patients at risk, says Marnon.

"The law required periodic inspections by the department to make sure the clinics were sanitary, that medications were not outdated, and that instruments were in good working order, etc.," said Marnon. "In the year following the repeal of the clinic licensing and inspecting law, serious abortion complications rose 38 percent! This is directly from the annual reports provided by the Michigan Department of Health and Human Services."

Legislation Halted

The Colorado legislature responded to the Lexi Arguello incident with House Bill 25-1252, which would apply to abortion providers the same regulations and reporting requirements as all other medical establishments. In an 8-4 vote, the House Committee on Health and Human Services postponed the bill indefinitely.

"This heartbreaking case out of Colorado is yet another reminder of the fact that induced abortion after 20 weeks' gestation presents a greater immediate risk of maternal death than live birth," said Donna Harrison, M.D., a board-certified obstetrician and gynecologist (OB-GYN) and director of research at the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG).

AAPLOG released a statement in 2019 outlining the dangers of allowing abortions after 20 weeks. Harrison says the abortion pill mifepristone would not have been a safer choice for a mid-term pregnancy and in fact would have been riskier.

"Though abortion advocates promote chemical abortion as a safe and convenient alternative, the fact is that chemical abortion has a five times greater risk of complications than surgical abortion and is only FDA approved for use up to 10 weeks' gestation," Harrison told *Health Care News*.

Sending Help

Pregnant mothers need more financial and moral support from the public, says Marnon.

"Current efforts underway in Michigan include increased support for pregnant women so that they aren't left with abortion as their only choice," said Marnon.

"Michigan passed a Constitutional amendment in 2022 which allows abortion up to birth for any reason or no reason at all," said Marnon. "So, we are working to support bills to reduce the financial burdens on pregnant women and to make it easier to have children in our state. For choice to truly exist, women must be given every opportunity to make a choice for life."

Harrison says AAPLOG is part of a growing community of OB-GYNs who prioritize life.

"As the community of pro-life OB-GYNs grows, we will be sure to grow more outspoken in our defense of our pregnant and preborn patients," said Harrison.

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

Supreme Court Considers State's Selection of Medicaid Providers

By AnneMarie Schieber

The U.S. Supreme Court heard arguments on April 2 over whether federal law allows states to select which medical providers they want to fund in their Medicaid programs.

In *Medina v. Planned Parenthood South Atlantic*, South Carolina defended its right to reject Medicaid vendors who provide abortions elsewhere in the nation, which the state bans after six weeks.

The Alliance Defending Freedom (ADF), representing South Carolina, argued the state should be free to direct Medicaid tax dollars to vendors that most benefit low-income women.

"Much of it went instead to pro-abortion politicking and legal support. Planned Parenthood's own leaders say they have repeatedly prioritized the political fight for abortion over supporting their affiliates that are supposed to be providing care for women. In sum, Planned Parenthood's leadership has openly prioritized abortion activism over maintaining its facilities and offering essential health care for low-income patients."

JOHN BURSCH
SENIOR COUNSEL, ALLIANCE DEFENDING FREEDOM

Abortion Emphasis

In a news conference after oral arguments before the Court, ADF Senior Counsel John Bursch said Planned Parenthood is not a typical Medicaid provider.

"Planned Parenthood is a multibillion-dollar organization dedicated to providing abortions and dangerous gender-transition drugs, not comprehensive health care," said Bursch.

"According to its own reporting, Planned Parenthood performs between one-third and two-thirds of all abortions in the United States annually, while its provision of other medical services declined," said Bursch. "Between 2022 and 2023, preventative care visits fell 31 percent, and the number of patients seen annually has fallen by 60 percent since the 1990s. Meanwhile, cancer screening and prevention services have dropped by 71 percent since 2010."

Planned Parenthood has argued the Medicaid Act gives patients a "privately enforceable right of action," a right to sue, to get care from the qualified provider of their choice.

Language Debate

The arguments, lasting about 90 minutes, focused mainly on the "privately enforceable right" issue.

"The fact that the 12 of us can have such a robust conversation about whether this statute is mandatory or not, whether it's rights-creating or not, demonstrates that the rights-creating language is ambiguous, not clear and explicit," said Bursch in his arguments.

"The Justices seemed to get the point that we were making, which is that Congress creates rights enforceable in federal court only when it uses clear, explicit language in the statute, and that the provision that we're talking about today simply doesn't have that," said Bursch in the news conference.

It appeared Justices Amy Coney Barrett and John Roberts shared that view, Bursch told the press. Those two Justices often serve as swing votes in the Court's decisions.

A decision is expected by June.

Political Pressure Funding

Arguing South Carolina's decision is justified, Bursch cited for the press a *New York Times* article that described Planned Parenthood as being under fire for botched care (see opposite page) and distributing more than $899 million to local affiliates for activities other than medical services.

"Much of it went instead to pro-abortion politicking and legal support," said Busch. "Planned Parenthood's own leaders say they have repeatedly prioritized the political fight for abortion over supporting their affiliates that are supposed to be providing care for women. In sum, Planned Parenthood's leadership has openly prioritized abortion activism over maintaining its facilities and offering essential health care for low-income patients."

Hiding from Hyde

Medicaid has been a way for Planned Parenthood to avoid the Hyde Amendment, which prohibits the use of federal money to fund abortion, says Genevieve Marnon, legislative director for Right to Life of Michigan.

"Tax dollars that Planned Parenthood receives for Medicaid-eligible services such as [sexually transmitted infections] testing and treatment and contraceptive prescriptions are used to shore up their abortion business," said Marnon.

"Medicaid patients and abortion patients use the same building, the same equipment, and are seen by the same staff," said Marnon. "While Medicaid money can't be used for abortions due to the Hyde Amendment, it can be used to pay for rent, salaries, utilities, and equipment, which allows Planned Parenthood to profit from their abortion activities."

Questionable Definition

Although arguments avoided the abortion issue, it raises the question of whether abortion is really health care, says Marnon.

"The Merriam-Webster definition of 'healthcare' is 'efforts made to maintain, restore, or promote someone's physical, mental, or emotional well-being especially when performed by trained and licensed professionals,'" said Marnon. "Abortion neither restores nor promotes physical, emotional, or mental health of women. On the contrary, abortion often hurts women both physically and mentally, and it always kills an unborn child.

"In Michigan, abortion complications spiked 38 percent in the year after the removal of abortion clinic health and safety standards, and a recent study showed women were twice as likely to attempt suicide following an abortion," said Marnon. "Pregnancy is not an illness, and terminating the life of an unborn baby is not health care."

Choice Decision

States have a right to choose not to fund Planned Parenthood through Medicaid, says Rep. Chris Smith (R-NJ), co-chair of the House Pro-Life Caucus. Smith has filed three amicus briefs as the case has worked its way through the courts.

Once South Carolina chose not to provide Medicaid funding to Planned Parenthood in 2018, the organization "immediately took to the courts to try to block South Carolina's right to administer the Medicaid program and not subsidize organizations that pay for elective abortion," said Smith in a press release on April 2.

Smith says Medicaid is Planned Parenthood's largest federal funding source, providing $1.5 billion in reimbursements nationwide over the past three years.

"The multibillion-dollar abortion industry cleverly markets the sophistry of choice while going to extraordinary lengths to ignore, trivialize and cover-up the battered baby-victim," Smith stated. "However, the truth is that the child decapitation, dismemberment and starvation that occur at Planned Parenthood is not health care."

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

Trump Administration to Submit Plan to Address Infertility

By AnneMarie Schieber

President Donald Trump's Domestic Policy Council is scheduled to submit a list of policy recommendations to improve access to in vitro fertilization (IVF) and reduce the cost, on May 19.

"My Administration recognizes the importance of family formation, and as a Nation, our public policy must make it easier for loving and longing mothers and fathers to have children," states President Donald Trump's executive order (EO) of February 18. "In vitro fertilization (IVF) offers hope to men and women experiencing fertility challenges."

The EO states that to improve access to IVF treatment and make it more affordable, the government should ease "unnecessary statutory or regulatory burdens." On the campaign trail, Trump mentioned mandating insurance coverage of IVF, though the EO does not address that.

The Domestic Policy Council has a tall order on its hands, says medical ethicist Mark Blocher, CEO of Christian Healthcare Centers and author of *Missional Medicine—Restoring the Soul of Medicine*.

"Since IVF is largely unregulated, it is an industry that is ripe for abuses: economic exploitation, troublesome experimentation with human embryos, and the moral confluence of the virtue of childbearing with the evil of eugenics and abortion," said Blocher.

'Health and Safety Red Flags'

Trump's executive order skirts ethical questions about IVF, says Blocher.

"Like too much of government involvement in health care, it focuses too much on cost and not enough on outcomes, quality," said Blocher. "Making IVF more affordable doesn't make it more ethical."

IVF is an area of medicine unlike any other, wrote Carter Snead and Yuval Levin in *The Hill* on February 24

"This is the only medical context in which the treatment consists in the creation of a new human being," wrote Snead and Levin. "In vitro fertilization allows procreation to be fractured into its component parts, creating an array of multiple potentially vulnerable people—genetic parents, gestational parents, rearing parents, and, of course, the children conceived and born with its aid."

IVF poses risks to mothers and babies alike, the authors write.

"The CDC itself has identified an association with the use of in vitro and birth defects and other maladies," wrote Snead and Levin. "In vitro fertilization has a well-known heightened incidence of preterm births with attendant serious risks for mothers and children. Yet there are still no federally funded longitudinal studies on the health and well-being of in-vitro mothers and babies."

Multiple Ethical Issues

Blocher says the bioethical side of IVF involves many nuances the administration should consider, such as "personhood of human embryos, substantial embryo loss common in IVF, cryopreservation of embryos, selective pregnancy reduction, preimplantation genetic diagnosing, sex selection, and surrogacy."

> **"Since IVF is largely unregulated, it is an industry that is ripe for abuses: economic exploitation, troublesome experimentation with human embryos, and the moral confluence of the virtue of childbearing with the evil of eugenics and abortion."**
>
> **MARK BLOCHER**
> **CEO, CHRISTIAN HEALTHCARE CENTERS**

The EO avoids another important question, says Blocher.

"It doesn't address why fertility rates have declined for several decades," said Blocher.

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

COMMENTARY

Trump's Plan to Address Infertility Could Give Birth to New Problems

By AnneMarie Schieber

Although President Donald Trump's executive order (EO) on "Expanding Access to In Vitro Fertilization" (IVF) is surely well-intentioned, it opens the door to numerous ethical and practical problems.

Technological Fertility Fix

Policymakers should note that IVF is not the only way to address declining fertility. The obvious approach to solving a problem is to identify the causes and deal with them directly.

There is a fertility technology that does just that: NaProTechnology.

"The NaPro infertility approach is disease-based," Sister Renee Mirkes, director of the Center for NaProEthics, told *Catholic Vote* in March. "It views infertility or subfertility as a symptom of underlying organic hormonal, or ovulatory dysfunctions. And because NaPro treats these underlying diseases/conditions by comprehensively evaluating, diagnosing, and effectively treating them, NaProTechnology, both nationally and internationally, has been extremely successful in helping infertile couples to conceive, gestate, and give birth to a healthy newborn."

Mirkes told the publication the success rate of NaProTechnology is 50 to 90 percent, depending on the cause of the infertility.

Ethics Charges

After Trump issued his executive order, Mirkes wrote an open letter to Vice President J. D. Vance urging the administration to promote effective fertility technology that avoids the ethical and governance pitfalls of IVF.

Mirkes outlined IVF ethical problems in her *Catholic Vote* interview: "any reproductive technology—like IVF—that replaces the act of intercourse with a laboratory technique that simulates the mere procreative structure of the marital act is immoral; it is a grave injustice or a tyranny that fails to lead the couple to greater happiness, greater fulfillment.

"Additionally, any reproductive technology, such as IVF, that fails to respect the dignity of the baby being conceived—by threatening the child's right to life, cryopreserving the child, or exposing the embryonic human being to further objectification via research—tyrannically deprives the newly conceived human being of his or her just right to be conceived, gestated, born into, and raised within the marital love of his or her parents."

Family Problems

Policymakers should consider how an IVF explosion could redefine the family in damaging ways, says Mark Blocher, a medical ethicist and author of *Missional Medicine—Restoring the Soul of Medicine*. The technology could open a floodgate of individuals wanting to raise children outside traditional marriage, eroding "the morally special nature of human procreation as a feature of an intact nuclear family with both a mother and father to nurture their children," said Blocher.

Raising children without marriage causes numerous problems, says Blocher.

"The cultural breakdown of heterosexual marriage has brought about significant social pathologies that affect mental and physical health, so why should taxpayers fund via tax credits a further erosion of cohesiveness and belonging in American families?" said Blocher.

Sympathy for childless couples does not mean every possible response is ethical, says Blocher.

"IVF is not a morally neutral technology," said Blocher. "Expressing concern over the moral hazards IVF entails does not indicate a lack of empathy for infertile couples. The EO misconstrues compassion for infertile couples as a justification for encouraging unethical solutions. Just because IVF works doesn't make it ethical."

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

COMMENTARY

Murky Health Care Pricing Is Making Money for Hospitals

By Devon Herrick

Even though President Donald Trump has issued directives to make hospital prices more transparent twice, there are no tools to make it easy for patients to compare prices of an MRI, for example.

This is more than a casual observation, as noted in a March 19 article in *Health Affairs*.

"Although hospitals and health plans have posted a massive amount of health care price data, actionable information on prices is still not readily and widely available, partly due to ongoing issues with the usability and quality of the data," wrote Stacy Pogue, a senior research fellow and faculty member at the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy.

Hospitals were supposed to post prices by January 2021, with health plans doing so 18 months later. Hospitals sued to block the transparency rules but were unsuccessful. Four years out, you have to wonder whether the data problems are intentional.

"Once patients begin to realize they can save money by comparison shopping, providers will have an incentive to compete for their business. Merely mandating price transparency will not get us to competition without the additional steps required to allow competition to flourish."

DEVON HERRICK
HEALTH CARE ECONOMIST

Transparency Spelled Out

During his first term, Trump created rules that required hospitals and health plans to post prices in both a user-friendly format for consumers and a "machine-readable format (MRF)" for researchers and content creators to create apps and tools for patients and others trying to make price decisions.

On February 25, Trump introduced the "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information" executive order (EO), which does primarily three things.

The EO requires the disclosure of "actual prices of items and services, not estimates"; the issue of "updated guidance or proposed regulatory action" to make sure prices are "standardized and easily comparable across hospitals and health plans," and updating of enforcement policies to ensure hospitals are compliant in "transparent reporting of complete, accurate, and meaningful data."

Biden Administration Punted

Enforcement of the transparency rules during the Biden administration got off to a slow start, making real transparency a significant problem. The price data posted by hospitals are still not usable. The February 25 EO was written to address those lapses, notes *Health Affairs*.

"A 2024 Government Accountability report found that hospital data quality issues have prevented large-scale, systematic use of the data, though analysts anticipated some improvements in light of new CMS requirements for more standardized reporting formats and additional data elements phased in on July 1, 2024, and January 1, 2025," wrote Pogue.

"Furthermore, based on a data audit of a sample of hospitals, the Department of Health and Human Services Office of Inspector General estimated that 46 percent of hospitals were not fully compliant with requirements for MRFs, consumer-friendly shoppable service displays, or both," wrote Pogue.

Insurers Floundered

Health plan compliance has also been slow. Problems with data have made it almost impossible to use. It is reasonable to think that my health plan could help me find the cheapest vendors they reimburse. However, it does not.

The *Health Affairs* article reports MRFs are full of duplication and irrelevant data, such as "ghost rates," services provided by atypical providers.

"A range of other well-documented data issues make it challenging to analyze the data, make comparisons, and draw meaningful conclusions," *Health Affairs* reports.

Private Equity Intruded

Missing from the analysis of price transparency failure is the corporate takeover of independent doctor practices. More than 75 percent of physicians now work for a hospital or large group practice, and many of those providers are owned by private equity investors.

An independent doctor may recommend an MRI and not care where the patient gets it done. A patient may be able to get a recommendation where there is a good price with good quality. However, if the doctor is employed by a hospital, it is likely the patient will be directed to the employer's facility.

What good is information on prices if a doctor is under orders to steer a patient to a specific provider's facilities where prices are high?

Furthermore, if a physician's order requires multiple tests and follow-up care, should those physicians be allowed to steer patients to services that are unusually costly?

Competition Thwarted

Price transparency is a necessary condition for competition to thrive. However, it is not the only requirement. Price transparency is the natural response when firms compete for consumers on price, quality, and other amenities.

Firms competing for consumers do not have to be required to disclose prices. Firms do it because when they fail to reveal how much something costs, they lose business. The U.S. health care system, however, is not competitive. Two things could be at play. Either health care firms believe price transparency is of no use to them, or they realize revealing prices actively reduces their profits.

Once patients begin to realize they can save money by comparison shopping, providers will have an incentive to compete for their business. Merely mandating price transparency will not inject competition into the health care sector without the additional steps required to allow competition to flourish.

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

INTERNET INFO

Stacy Pogue, "New Executive Order Outlines Next Steps for Health Care Price Transparency," *Health Affairs*, March 19, 2025: **https://www.healthaffairs.org/content/forefront/new-executive-order-outlines-next-steps-health-care-price-transparency**

New York Backs Off Ban on 'Consent to Pay' Patient Forms

By Bonner Russell Cohen

The state of New York is revising a law that would have prohibited hospitals and health care practices from requiring patients to sign "consent to pay" forms before receiving treatment.

NY Public Health Law (PHL) 18 was set to take effect in late 2024. It is in limbo after the New York State Department of Health indicated it does not intend to enforce the statute until it better understands the legislature's intent.

As it stands, the law "currently requires that patients provide consent for payment separate from consent to receive healthcare services," a legal analysis by the law firm McDermott, Will & Emery states. "That consent for payment cannot be given before the provider discusses treatment costs with the patient and the patient receives services. The statute has significant ambiguity and no formal guidance or regulations have been issued to date for [the law]."

"I suspect the reason they cannot discuss prices ahead of time is because too many patients would walk out the door. Yet, that is how competition works: customers decline a service and start to leave, forcing service providers to negotiate or lose business."

DEVON HERRICK, PH.D.
HEALTH ECONOMIST

Murky Prices

PHL 18 was the state's attempt to push health care practices to be more transparent about the prices they charge.

At the federal level, the first Trump administration issued a final price transparency rule that went into effect on January 1, 2021. The rule required each hospital operating in the United States to provide price information online as a "comprehensive machine-readable file" and "in a display of shoppable services in a consumer-friendly format."

Few hospitals complied under loosened enforcement during the Biden administration.

In addition, the No Surprises Act went into effect on January 1, 2022. The law was designed to protect patients from unexpected out-of-network medical bills for emergency services, certain nonemergency services at in-network facilities, and air ambulance services. It, too, had limited impact.

In January 2025, Ohio became the first state to codify the federal price-transparency rule. In 2022, Colorado approved legislation barring hospitals from debt collection if they are not complying with the federal rule.

Other states have enacted "right to shop" provisions to increase incentives for patients and insurers to shop for the lowest cost for services. (See related article, page 19.)

Stiff Resistance

New York's law encountered stiff resistance from hospitals and physicians. The health care research group KFF said patients and providers continued their tug of war over prices.

"Patient advocates don't want them to get stuck signing blank-check forms that put them in financial jeopardy," stated *KFF Health News*. "Doctors, hospitals, and other providers don't want to disrupt their practices' workflow and payment logistics with cost discussions and paperwork, especially after services have been provided."

Another problem could be providers' desire to avoid competition that would push prices down, says Dallas-based health economist Devon Herrick, Ph.D.

"I suspect the reason they cannot discuss prices ahead of time is because too many patients would walk out the door," wrote Herrick on The Goodman Institute Health Care Blog. "Yet, that is how competition works: customers decline a service and start to leave, forcing service providers to negotiate or lose business."

Herrick says Trump's executive order on price transparency in his second administration provides hope because it requires providers to specify actual prices, not estimates. (See related article, page 17.)

Transparency 'Hack'

"It is unfortunate that New York state officials and the Biden administration didn't have the gumption to enforce the respective law and regulation," said Jeff Stier, a senior fellow at the Center for Consumer Choice.

Stier says it is not hard to see how the forms play out.

"It is not uncommon for a patient to go in for a procedure, say a colonoscopy, and even after receiving a prior authorization for the in-network provider to perform the service, an anesthesiologist calls in sick and an out-of-network provider steps in," said Stier. "The anxious patient, who is told he or she must sign a tiny electronic agreement on a signature pad, consenting to pay whatever their insurance doesn't, at 6:45 a.m., rarely foresees and considers that the colonoscopy was only the second-most vulnerable position they had put themselves in that day."

Without enforced transparency rules, Stier says he recommends patients take an assertive approach.

"Patients should exercise their right to demand a printed agreement with a pen and modify it to agree to only pay for preauthorized services and agreed-upon fees," said Stier.

Third-Party Payer Cover

Patients have to speak up to defend their interests, says Merrill Matthews, Ph.D., a resident scholar at the Institute for Policy Innovation.

"The issue of how to get hospitals and doctors to post real prices will not be resolved until patients demand to know those prices," said Matthews. "And patients won't demand that information until they, not their insurance company, bear most or all of the cost.

"Health insurance insulates patients from the cost, which also insulates them from the curiosity of knowing the price," said Matthews. "What difference does the price of surgery make to the patient if his insurer is charging him a $350 copay [regardless]?"

The struggle over posting real prices isn't all the fault of the hospitals and physicians, says Matthews.

"The insurers have negotiated different prices with different providers," said Matthews. "Hospitals could post a standard price, but that's misleading if the negotiated price is only 25 percent or 20 percent of the list price.

"The only solution to this problem is to have insurers indemnify the patient with a set amount of money for major medical procedures, much like auto insurance writes a check to the insured, and then the patient pays the medical provider," said Mathews.

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

INTERVIEW

No Better Time Than Now for Real Medicaid Reform

Republicans are taking much political heat for trying to cut $880 billion in federal spending, with Democrats saying the GOP will cut Medicaid benefits. Gary Alexander, director of the Medicaid and Health Safety Net Initiative at the Paragon Health Institute, talked to Health Care News *about how Republicans can turn this challenge into a huge win from both the political and policy standpoints.*

Health Care News: The Democrats claim there is no credibility to the charge that Medicaid benefits will not be cut. Are they wrong?

Alexander: Yes, there is strong credibility to the claim that Medicaid benefits can remain intact while achieving significant savings. During my tenure as Secretary of Health and Human Services in Pennsylvania, we implemented the Enterprise-wide Program Integrity Initiative, which saved nearly $2 billion by enforcing eligibility rules, conducting audits, and enhancing recoveries, etc.

"Proposing to save $880 billion over ten years through tighter eligibility reviews, better oversight, and more rational financing is anything but radical."

GARY ALEXANDER
PARAGON HEALTH INSTITUTE

This initiative not only delivered substantial savings but also allowed us to return a surplus to the general fund, proving that fiscal improvements are possible without cutting benefits or eligibility.

The House Republicans' proposal to cut $880 billion over 10 years aligns with this approach, focusing on eliminating fraud, waste, and abuse. Given that improper payments in Medicaid could be as high as $1.1 trillion over the past decade, this target is not only credible but also essential for the program's sustainability while preserving care for recipients.

Health Care News: In addition to "prioritizing efficiency, accountability, and smarter resource allocation" (see article on page 3), are there other ways Republicans can respond to taxpayers as well as to those who truly need Medicaid?

Alexander: Paragon commissioned a poll in early March that showed Americans support specific Medicaid reforms, like work requirements, eliminating the current financing discrimination that favors able-bodied working-age adults over low-income children, the elderly, and the disabled, and capping Medicaid payment rates at Medicare levels.

Health Care News: Should we create a "cash-based" program, similar to food stamps, where the needy can shop for the best health care service available and seek out options such as direct primary care?

Alexander: Direct primary care (DPC) is a promising model worth exploring as another care management system to deliver medical services. Costing around $100 monthly, DPC provides recipients with subscription-based access to primary care and some medications, fostering direct patient-provider relationships that often lead to better health outcomes and reduced unnecessary care.

It's an effective and lower-cost system that could give recipients more control over their health care while keeping expenses down.

DPC could be deployed in different ways: recipients could be provided cash to select a DPC provider, or they could simply be given the choice to enroll in a DPC plan without a cash transfer. Either approach positions DPC as a structured care model that emphasizes efficiency and personal responsibility. Testing this through state pilots could demonstrate its value as a conservative, cost-saving solution within Medicaid.

Health Care News: Why are lawmakers hesitant to do something disruptive in Medicaid?

Alexander: The reluctance to pursue disruptive Medicaid reforms stems from practical and political challenges. The barrier to real Medicaid reform is powerful special interests guarding the status quo.

Hospitals, advocacy groups, and state bureaucracies benefit from a system that rewards spending over outcomes. Hospital systems, advocacy organizations, and state bureaucracies have built entire operations around maximizing federal reimbursements.

Many states, particularly wealthier ones, have developed financing schemes that divert funds toward politically favored entities while deprioritizing the most vulnerable enrollees. These stakeholders resist shifts that threaten their interests by fearmongering and threatening lost coverage, angry voters, or headlines about reduced access to care.

Proponents of the status quo intentionally ignore that projected federal Medicaid spending increased by $1.2 trillion under the last administration. Proposing to save $880 billion over ten years through tighter eligibility reviews, better oversight, and more rational financing is anything but radical. It is a technocratic, targeted response to a bloated program which saw explosive growth over the last four years.

Pennsylvania's $2 billion savings through the Enterprise-wide Program Integrity Initiative demonstrates it's achievable with stricter adherence to current rules, greater accountability, and more prudent management. Conservatives could embrace this as a responsible, non-radical path to strengthen Medicaid's fiscal health.

COMMENTARY

Let's Reward Patients for Shopping the Best Prices

By Edmund F. Haislmaier

Rules exist to be followed, not ignored. Or at least that's what most people think.

But in many cases, hospitals and insurers haven't been following the rules, and the government has been letting them get away with it.

During President Trump's first term, his administration pursued health care price transparency regulations. Under Joe Biden, the administration didn't do much to implement or enforce those rules.

Those price transparency regulations implement provisions enacted by Congress in 2010. There continues to be substantial bipartisan support in Congress for requiring public disclosure of the costs of medical services. In December 2023, the House of Representatives voted 320-71 to pass legislation that included additional price transparency provisions (though the Senate never acted on that bill).

"Congress should reinforce the president's initiative to make health care price information available to consumers. But it should also take the next step and give health plans and patients additional incentives to use that information to shop for better-value care."

EDMUND F. HAISLMAIER
PRESTON A. WELLS JR. SENIOR RESEARCH FELLOW
THE HERITAGE FOUNDATION

Ramping Up Enforcement

Now, President Trump is putting health care price transparency back on the agenda. Recently, he ordered executive agencies to step up implementation and enforcement of the transparency regulations. This means noncompliant hospitals and insurers may actually be forced to follow the existing rules requiring public disclosure of medical services' costs.

This is a positive change, one that Congress should reinforce legislatively. But Congress should also build on this change by creating incentives to ensure that price transparency ultimately leads to patient savings. In theory, by requiring medical providers and insurers to make prices public, the government will enable patients to shop for care, creating competition that will put downward pressure on prices.

Motivating Patients

However, making this pricing information publicly available is one thing; patients using that information when making decisions is another thing entirely.

Not only that, but price transparency directly challenges entrenched health care business models, which center on opaque financial arrangements and hidden cross-subsidies. Because of this, any further legislation requiring health care price disclosure should also incentivize patients to use that information in decision making, as well as incentivizing health plans to help their enrollees find better-value care. The latter is key.

Ending Secret Deals

Health plans are the entities best positioned to translate the "actionable information" of price data into "informed action" by patients shopping for care. But doing that requires health plans to rethink some of their current business practices.

Today, health plans typically negotiate payment rates with doctors and hospitals and—based on the (undisclosed) results of those negotiations—create "networks" of favored providers. Plans then steer (or limit) their enrollees to those providers.

That whole process is a "black box" for patients, who receive no explanation for why specific providers are in or out of their plan's network. Nor are patients given the information they need to compare the cost and quality of competing providers.

Rewarding Smart Shoppers

Rather than limiting patients' choices, health plans should leverage the data generated by price transparency to inform enrollees, empower them with easy-to-use shopping applications, and offer them tangible rewards for making better-value purchases.

Software developers have already built applications that can help patients use price data to shop for nonemergency tests and procedures. But health plans should be giving their enrollees those tools and the financial incentives to use them.

For instance, plans should encourage patients to shop for care by sharing with them the savings that result when they choose a less costly provider. Currently, if a patient chooses a less expensive provider, the plan typically pockets all the savings—giving patients no financial incentive to shop for care.

That could change dramatically if health plans instead rewarded patients with cash (out of some of the money saved) when they opted to get care from a lower-cost provider.

Adjusting Tax/Obamacare Laws

Congress can encourage that kind of positive change with some modest adjustments to current law.

First, Congress can clarify in the tax code that when a health plan gives a patient a cash reward for choosing to get care from a better-value provider, that payment is tax-free to the patient (just like other insurance reimbursements or refunds).

Second, Congress can modify the tax code so that patients can deposit health plan rewards into their health savings accounts without those rewards counting against the maximum annual contribution limit.

Third, Congress can amend the Obamacare provision requiring health plans to give enrollees refunds if the plan spends less than 80 percent of premium revenue on medical care or "activities that improve health care quality." Specifically, Congress should expand this to include any money plans spend on incentivizing enrollees to shop for care.

That way, insurer investments in shopping apps and providing cash rewards to patients for obtaining better-value care would count as spending that benefits enrollees, rather than as higher administrative costs, for which plans are penalized.

Informing Action

According to the White House press office, Trump's executive order is meant to "empower patients with clear, accurate, and actionable healthcare pricing information." But the point of actionable information is to be acted on—and that only happens when people have incentives to do so.

Congress should reinforce the president's initiative to make health care price information available to consumers. But it should also take the next step and give health plans and patients additional incentives to use that information to shop for better-value care.

Edmund F. Haislmaier (**HeritagePress@heritage.org**) *is the Preston A. Wells Jr. Senior Research Fellow in The Heritage Foundation's Center for Health and Welfare Policy.* *A version of this article was published in* RealClearHealth. *Reprinted with permission.*

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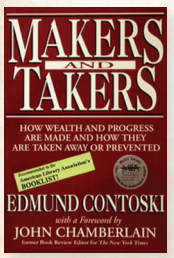

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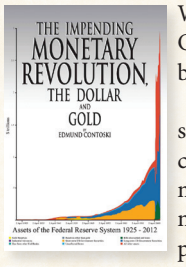

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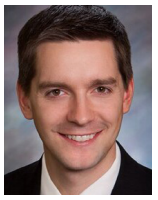

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