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The Pulse

Medicaid Overhaul Falls Short, Jeopardizing Tax Cuts

By AnneMarie Schieber

Republican lawmakers are resisting efforts to overhaul Medicaid, a program that now insures one in five Americans and involves billions of dollars per year in waste, fraud, and abuse.

House Republicans dropped their "One, Big, Beautiful Bill" on May 12, a reconciliation bill that doesn't require the Senates's 60-vote threshold to pass.

Instead of per-capita cuts or a major overhaul, the

MEDICAID OVERHAUL, p. 4

Trump EO to Bring U.S. Drug Prices in Line with Other Countries'

By Kevin Stone

President Donald Trump issued an executive order (EO) aimed at drastically reducing the cost of prescription drugs for Americans by tying their prices to those in other nations.

A February 2024 Rand report found U.S. drug prices average 2.78 times higher than those in an index of 33 other nations. The disparity is even greater for brand-name drugs, with U.S. prices 4.22 times higher.

In 2023, the United States led the world in per capita drug spending, at

TRUMP RX EO, p. 6

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Turning Healthcare Ideas Into Public Policy

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

Dr. Goodman addressing The Economic Club of Indiana

What We Have Accomplished

Health Savings Accounts

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

1

Roth IRAs

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

2

Social Security

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

3

401 (k) Plans

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

4

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Health Care News

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Hospitals Say NO to Medicare Advantage

By Bonner Russell Cohen

Hospitals and medical centers across the United States are increasingly opting out of Medicare Advantage (MA), a popular program that provides coverage to millions of older Americans.

Providers are exiting MA so fast that *Becker's Hospital Review* now continuously updates its growing list of cancellations.

In 2025, Dallas-based Baylor Scott & White severed ties with Humana Medicare Advantage; Raleigh, North Carolina-based WakeMed left the network of Cigna Medicare Advantage; Nashville-based Vanderbilt Health left BCBS Tennessee; and Sioux Falls, South Dakota-based Sanford Health dropped Humana Medicare Advantage, among more than 40 cancellations in all.

Hospitals cite rising administrative burdens, delayed reimbursements, and frequent denial of insurance claims.

"[Medicare Advantage] plans have a financial incentive to scrupulously monitor emergency-room decisions and challenge them if they appear unjustified. No wonder hospitals like traditional Medicare as a payer rather than Medicare Advantage. But remember when MA plans eliminate unnecessary spending, they are ultimately saving taxpayers money."

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

Millions Stranded

Nearly 33 million Americans are enrolled in MA plans, accounting for 54 percent of those eligible for Medicare coverage, reports KFF. MA enrollment has doubled over the past 10 years. With more hospitals and medical centers exiting MA plans, more MA enrollees are left with fewer providers.

In explaining why Memorial Hermann Health System terminated its agreement with Humana's MA plan last year, Michelle Lindsley, the organization's vice president of managed care, said agreements with insurers require "mutual trust, transparency, and respect," the *Dallas Morning News* reported.

"In absence of this necessary foundation, we must make decisions we feel are best for our patients, our workforce, and ultimately the viability of our organization so we might continue serving the Greater Houston community for many years to come," Lindsley said.

Trump to the Rescue?

The Trump administration increased support for MA during Trump's first term. The new administration has increased payments, but has not expanded the program.

In early April, the Centers for Medicare and Medicaid Services (CMS) announced payments to MA and Part D Prescription Drug Plans would rise by 5.06 percent in 2026, more than double the Biden administration's proposed 2.23 percent increase. The higher rates may reflect the Trump administration's use of updated data, says Jeffrey Davis, a director at McDermott Plus.

"It's not a change in policy, but [in] how they calculate things," Davis told *Managed Healthcare Executive*.

MA proponents, led by the Better Medicare Alliance, are urging the administration to promote Medicare Advantage.

"Fully 95% of Medicare Advantage beneficiaries are satisfied with the quality of health care they receive," stated a February 20 letter to then-acting CMS administrator and chief of staff Stephanie Carlton.

The average MA beneficiary spends $200 less per month than they would in fee-for-service Medicaid, the letter stated.

Hospitals Dislike Monitoring

MA plans monitor extra charges by hospitals, known as upcoding, more closely than traditional Medicare does, says John Goodman, Ph.D., president of the Goodman Institute for Public Policy Research and co-publisher of *Health Care News*.

"MA plans have a financial incentive to scrupulously monitor emergency-room decisions and challenge them if they appear unjustified," said Goodman. "No wonder hospitals like traditional Medicare as a payer rather than Medicare Advantage. But remember, when MA plans eliminate unnecessary spending, they are ultimately saving taxpayers money."

Hospitals just want more money from MA, says Goodman.

"Under current law, MA plans are entitled to pay Medicare rates," said Goodman. "They can pay more than that, and they sometimes do. For example, if there is a shortage of a certain type of specialist in an area, an MA plan might offer to pay more than Medicare's fee schedule to meet its patients' needs. It's a good guess that this what the hospitals have in mind."

The hospitals may be engaging in a power play, says Goodman.

"Sit on the sidelines until the MA plans offer to pay more to draw them back into the market," said Goodman.

Calls for Elimination

Medicare is a failed system, says Twila Brase, R.N, PHN, president of the Citizens' Council for Health Freedom.

"Medicare Advantage is a lucrative scam," said Brase. "Medicare Advantage is all about limits: limited care, limited networks, limited doctors. For the sake of patients and fiscal sanity, Congress should repeal Medicare Advantage, restore access to affordable, real medical-indemnity insurance for all Americans, and allow seniors to voluntarily opt out of Medicare."

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

Medicaid Overhaul Falls Short, Jeopardizing Tax Cuts

Continued from page 1

section on Medicaid calls for work requirements for able-bodied enrollees, better oversight of improper eligibility, a ban on reimbursement for gender transition procedures, and penalties on states that provide benefits to noncitizens.

The bill would also limit states' ability to tax and then reimburse providers, a move supplemented by a proposed rule by the Centers for Medicare and Medicaid Services.

"It is going to be the force of tax cuts hitting the wall of those of us who believe we need to restrain government spending," said Roy. "Republicans are very good at running on tax cuts and then talking about 'a balanced budget.' I believe in cutting taxes for economic growth and stimulus from a moral standpoint, but we've been promising a whole bunch of programs for decades."

REP. CHIP ROY (R-TX)

Budget Scrutiny

The House Energy and Commerce Committee advanced the health care portion of the bill on May 14 to the House Budget Committee, which reviews all portions of the bill before it moves to the full House.

"This proposed rule stops the shell game and ensures federal Medicaid dollars go where they're needed most—to pay for health care for vulnerable Americans who rely on this program, not to plug state budget holes or bankroll benefits for noncitizens," CMS Administrator Mehmet Oz, M.D. said in a May 12 news release.

The Congressional Budget Office says the Medicaid portion of the bill would reduce the federal deficit by $625 billion over the next decade.

President Donald Trump floated the idea of raising the highest income tax rate to 39.6 percent to spare Medicaid from spending cuts. The rate would apply to single filers earning more than $2.5 million.

Political Hazards

Reforming Medicaid is a high-stakes proposition. All House members are up for reelection in 2026, and nine states have "trigger" laws requiring them to pull back Medicaid expansion if the reimbursement rates drop. Missouri, Oklahoma, and South Dakota have Medicaid coverage embedded in their constitutions, meaning any cuts to federal Medicaid expansion could mean huge state bills.

"*The New York Times* identified 25 Republican members of the House who are from districts where 30 percent or more of the population is in Medicaid," said John C. Goodman, president of the Goodman Institute for Public Policy and co-publisher of *Health Care News*. "There are MAGA members in Medicaid, so Republicans cannot afford to slash Medicaid benefits.

The best way to save Medicaid is to make it better."

Fear Factor

Rep. Chip Roy (R-TX) told *Health Care News* he is one of several Republicans frustrated by the reluctance to get Medicaid under control, and the dispute will come down to a battle over spending versus tax cuts.

"Republicans are drunk on both spending and tax cuts, and that is a dangerous combination which is yielding massive deficits," said Roy. "It's not all Republicans, but they are deathly afraid of cutting Medicaid. I get that some Republicans are in razor-thin 'D' districts, but at some point you have to lead and decide what is right."

Massive Expansion

Medicaid is no longer the safety-net health care program it was intended to be, says Roy.

"The fact that the able-bodied are getting more in federal funding than the vulnerable population for whom Medicaid was originally designed, the fact that you can get more from Medicaid than you can in Medicare, the fact that you have this money-laundering scam in which blue states like California can get $3,400 per recipient and Texas gets $1,800 per recipient, the fact that you have one trillion dollars in improper payments, that Medicaid has gone from $400 billion to $600 billion from 2019 to 2025 and it will get to over one trillion by 2030, these are things that should have people concerned, particularly if you go around calling yourself a fiscal conservative, which every Republican does but few are."

On May 9, Roy and Rep. Scott Fitzgerald (R-WI) introduced the "Ending Medicaid Discrimination Against the Most Vulnerable Act." The bill would end the higher subsidy given to able-bodied enrollees under Medicaid expansion in the Affordable Care Act.

Real Reform Plan

The Republican majorities in Congress can avoid major political damage for Medicaid cuts if they emphasize that their reforms will improve service to the truly needy, says Goodman.

"The best way to save Medicaid is to make it better," said Goodman. "If Republicans got half the Medicaid vote, they'd never lose an election for the next ten years. They must make the program better at the same time they save money."

Goodman has listed 12 ideas for that, including Roth HSAs, personal spending accounts resembling food stamps, and liberalizing licensing laws (see article, page 21).

"Give enrollees spending accounts," said Goodman. "Let them shop out primary care. Most people who are in emergency rooms do not need to be there. Waits can be six hours or more. They lose wages during those waits."

Roy says lawmakers are about to receive a rude awaking for failing to keep their promises about balancing the federal budget.

"It is going to be the force of tax cuts hitting the wall of those of us who believe we need to restrain government spending," said Roy. "Republicans are very good at running on tax cuts and then talking about 'a balanced budget.' I believe in cutting taxes for economic growth and stimulus from a moral standpoint, but we've been promising a whole bunch of programs for decades."

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

INTERVIEW

Rep. Chip Roy: U.S. Health Care Is Worse Than Single-Payer

Rep. Chip Roy (R-TX) released a 46-page report, "The Case for Healthcare Freedom," earlier this year. The paper comprehensively reviews the multiple challenges in health care today, which have driven up costs to an unprecedented level and reduced access. Discussing the report with Health Care News *Managing Editor AnneMarie Schieber, Roy explained why he believes President Donald Trump and congressional Republicans have a golden opportunity to deliver "transformational reform."*

"I believe we need an actual free market in health care, or as close as we can get, and the way to do that is to put money in people's pockets to procure the products we're currently getting through our corporate-crony, government-regulated system."

REP. CHIP ROY (R-TX)

Health Care News: "The Case for Healthcare Freedom" describes how health care should be, covering multiple subjects such as food, drugs, and crony capitalism. How does that translate to legislative action?

Roy: The purpose of the report was to lay out the philosophical case for what I call health care freedom, the ability of an American to go to a doctor of their choice, to get care, and have the financial backstop to do that. We have essentially broken that whole system.

Health Care News: It's been said our current health care system is socialized medicine run by private health insurance companies. Is that accurate?

Roy: Yes. We pat ourselves [on the back] on how we "stopped single payer care," and what we have is something that may even be worse: a combination of government so-called care and half of it is highly regulated insurance-run health management, but nowhere is care involved in any of it.

Health Care News: Americans seem to believe that government has a magic formula to fix health care. There is growing distrust toward the government, however, so why does that notion persist for health care, even among conservative-leaning politicians?

Roy: The easiest path is to say, "I'm going to solve your problem." Then you get the program in place. Everyone becomes dependent on the program. Then you can't fix the program because you're criticized for taking away benefits, so what is left is to add more money.

Well, where is the money coming from? You'll hear, "We'll grow the economy." Republicans have been campaigning for decades on limited government, the Constitution, and a balanced budget. Name for me how many Republicans stood up in defense of those things.

I'm a free-market guy. I get all kinds of bills thrown in front of me that say, "You must fund cancer research," or "You must fund ALS research," or "Burn pits for veterans"—who are hurt because government warmongers put us in war for 20 years and now we have to have an expanded burn pit program that will probably fold in people who shouldn't necessarily be in the program, and now it's spiraling out of control. Those who vote against it are deemed "anti-veteran," and now here we are.

Health Care News: In your report, you propose increasing contribution limits for health savings accounts (HSAs) to $12,000 for individuals and $25,000 for families. How did you arrive at those figures? How would that improve the market, and how soon would that happen?

Roy: I believe we need an actual free market in health care, or as close as we can get, and the way to do that is to put money in people's pockets to procure the products we're currently getting through our corporate-crony, government-regulated system. The average family of four is spending either out-of-pocket or [with an] employer contribution roughly $24,000 a year for "insurance." For that, they get a handful of doctors in a network with high deductibles, copays, and constraints on when and how you can use it.

Our theory is we should equalize the tax treatment so an employer can put that into an HSA and get the same tax break they currently do and give that same benefit to those who are self-employed, and free up how you can use those dollars. You should be able to buy health insurance, true health insurance, a deregulated policy, and go to direct primary care.

There are lots of parts, like breaking some of the monopolies, but on HSAs you're not going to get competition unless you put cash into people's pockets and let them go out and shop.

There is a reason why there are 50 oil-change places not far from my house. But if I'm looking for health care, where do I shop?

Health Care News: Do price transparency mandates help solve these problems?

Roy: I don't want to see mandatory transparency, because right now, prices are fake. What are hospitals going to post? The Medicare prices? The private sector prices?

Health Care News: Some analysts argue the employer tax exemption for workers' health insurance is the root of all evil in the system because it pushes people into highly regulated health plans and incentivizes wasteful spending. Should we put this money back in American workers' hands? If so, what would it take for Congress to move in that direction?

Roy: I think it is a huge part of the evil. What will get movement on it? It would take go-out-on- a-limb leadership from a popular president, speaker of the House, and majority leader to lean into it and say we're going to transform health care because we're supposed to be a free country. It requires a leader who could stand up to corporations and insurance companies.

To break it loose, we need to get people comfortable with transformative change. We must get out of the trap of talking about Obamacare, talking about Medicaid, talking about coverage—because when you're talking about that, you're not talking about care.

Trump EO to Bring U.S. Drug Prices in Line with Other Countries'

President Donald Trump

PHOTO COURTESY WHITE HOUSE

Continued from page 1

$1,564 per person. Germany ranked second, at $1,159, and number ten, Italy, was at $820, or just over half what Americans pay for the same products. Mexico and Costa Rica pay $294 and $162, respectively.

On a Truth Social post, the day before the May 12 EO, Trump stated the plan would reduce prescription drug and pharmaceutical prices "almost immediately, by 30% to 80%."

Under a "most favored nations policy," the United States would pay the same price as the nation that pays the lowest price.

"An executive order is often little more than a wish list. To a significant degree, the president is telling his staff to see if they can make something happen. A president can do little to force drug makers to lower prices. To equalize prices domestically and abroad, federal law would have to change to allow drug reimportation. Without the ability to prevent arbitrage, drug makers would be unable to charge higher prices in one country compared to the next."

DEVON HERRICK
HEALTH ECONOMIST

Contrasting Views

Rep. Dan Meuser (R-PA) took to *X* to express his support for the decision.

"This action will help increase competition and lower costs across the board for essential prescription drugs," Meuser wrote in part. "It's exactly the kind of bold, America-First reform we need to fix our healthcare markets—and I applaud President Trump for taking action to deliver this historic change."

Douglas Holtz-Eakin, president of the American Action Forum and former director of the Congressional Budget Office under George W. Bush, disagrees with the plan.

"I don't know which is worse: the process or the policy," Holtz-Eakin told *Health Care News*. "I don't see how the president can run over Congress and the operation of federal programs or break open private contracts. And the idea of importing price controls at the expense of advancing medical science is horrific. It is a complete overreach.

"In the aftermath of *Loper v. Bright*, there is no court that can uphold it, and Congress has more sense than to legislate this," Holtz-Eakin said, citing a 2024 U.S. Supreme Court decision limiting executive agencies' latitude in interpreting congressional intent in federal laws.

Government Distortions

Government spending on prescription drugs inevitably creates problems, says Michael Cannon, director of health policy studies at The Cato Institute.

"Government should not purchase medicines for civilians, period," said Cannon. "The U.S. Medicare and Medicaid programs illustrate why. Medicare pays significantly higher prices for medicines than other government programs. Medicaid likewise overpays for prescription drugs and has spillover effects that increase drug prices for private purchasers."

Any movement toward the ideal price is good, says Cannon.

"Government should get out of the business of purchasing or subsidizing medicines for civilians," said Cannon. "In other words, the price that Medicare and Medicaid should be paying for drugs is $0.00. To the extent Trump's executive order moves the prices Medicare pays for medicines closer to the ideal price of $0.00, it is a step in the right direction."

Trump has another option, says Cannon.

"Price controls are never an answer, but Trump could unilaterally expand Executive Order 13938 [from July 2020] by directing the secretary to finalize a regulation that waives the prohibition on reimportation for all classes of drugs and devices from all Organisation for Economic Co-operation and Development member nations," said Cannon.

Effects on Innovation

Drug price negotiation, a form of price control under the Inflation Reduction Act, has already hurt new drug development, says Holtz-Eakin.

"We have already seen the IRA dry up venture capital for small-molecule [drug] R&D," Holtz-Eakin said. "This is even more sweeping and is a death sentence for innovation. This will not raise prices abroad in any way. It will simply dry up revenues from the United States, curtail R&D, and stifle innovation."

Patent Reform Option

Congress can address concerns about lost revenue through its constitutional power to protect returns on research and development, says Cannon.

"If Congress fears that lower Medicare prices would lead to insufficient pharmaceutical research, development, and innovation, the way to correct that market failure is to adjust the patent system," said Cannon. "Medicare is not a drug-innovation program."

From 2010 to 2019, NIH research contributed to the development of all but two of the 356 drugs approved for use in the United States, a public investment of $187 billion, roughly the same amount as was spent by private drug companies, a study released in April 2023 found.

Whether this entitles Americans to lower-cost drugs is a complex issue, say Cato Institute scholars David Hyman, M.D., J.D. and Charles Silver, J.D.

"Some publicly funded research is basic research that qualifies as a true public good, Hyman and Silver wrote in a 2020 paper. "Other publicly funded research does not involve public goods, but even here the relative contribution of all parties (including the risks that each one bears) must be considered."

Presidential 'Wish List' Item

The public should exercise caution in evaluating EOs, says Devon Herrick, a health economist who writes for the Goodman Institute Health Care Blog.

"An executive order is often little more than a wish list," said Herrick. "To a significant degree, the president is telling his staff to see if they can make something happen.

"A president can do little to force drug makers to lower prices," said Herrick. "To equalize prices domestically and abroad, federal law would have to change to allow drug reimportation. Without the ability to prevent arbitrage, drug makers would be unable to charge higher prices in one country compared to the next."

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

Why Are Lower-Cost Biosimiliars So Hard for Patients to Get?

By Kevin Stone

The House Ways and Means Committee heard testimony on hindrances to expanded use of biosimilar drugs, medications close in structure and function to patented biologic medicines.

Witnesses at the April 8 hearing told legislators biosimilars save patients and taxpayers money, that pharmacy benefit manager (PBM) middlemen often raise prices or limit availability for biosimilars, and provisions of the Inflation Reduction Act (IRA) introduce pricing unpredictability that inhibits biosimilar development.

Testimony indicated biosimilars provide a 53 percent reduction in the average price for both the name brand and the biosimilar medications they replace, and have added 344 million more patient days of therapeutic care than would have otherwise been provided. In addition, with proper incentives to increase biosimilar accessibility, expanded use could result in savings of $7 billion to Medicare over 10 years, witnesses testified.

PBM Pricing Gimmicks

Witnesses described how pharmacy benefit managers (PBMs) frequently offer large rebates for more-expensive brand-name drugs, establishing an artificially low price compared to biosimilars. This creates a perverse incentive where physicians can profit from the rebate on prescribing the higher-cost drug while biosimilars are "underwater" because the physician's reimbursement is less than their cost.

South Carolina rheumatologist Colin Edgerton, M.D. testified about his experience with PBMs.

"Currently, for one of the medications we use for rheumatoid arthritis, most commercial insurance plans that are served by a PBM are requiring one of two biosimilars as the first-line agent for treating that condition," Edgerton told the committee.

"Unfortunately, both of those biosimilars are underwater, so we wind up with this kind of perverse situation where the preferred medication, which should also be the lowest-cost medication, cannot be obtained because of this situation where the acquisition cost of the drug is higher than the reimbursement," said Edgerton. "It's not helpful that those medications are required by the PBM, so to speak, in that setting, because the acquisition has been undermined."

Reform Necessity

PBM reform is essential, says Gregg Girvan, a resident fellow at the Foundation for Research on Equal Opportunity.

"We need PBM reform, especially reforms that increase transparency into how PBMs operate and the ways they profit," Girvan told *Health Care News*. "Many bills proposed in Congress would also prohibit certain PBM practices, such as spread pricing or direct and indirect remuneration fees. While addressing these types of fees is a step in the right direction, my fear is that PBMs will find ways around these prohibitions and will use other pricing techniques that do not serve the best interests of patients."

IRA Impediments

Rep. Carol Miller (R-WV) expressed concern a potential pause in price-setting for certain biosimilars in the Inflation Reduction Act (IRA) complicated the process and disrupted the predictability needed for biosimilar development. Miller asked Craig Burton, senior vice president of policy and strategic alliances for the Association for Accessible Medicines and executive director of the Biosimilars Council, about that.

"For a biosimilar manufacturer, if you're thinking about investing $300 million in a new, lower-cost product, you need predictability," Burton testified. "You need to know that that market is going to be there 10 years from now when you actually get to the end of that race. That means you need to be able to guess what the market size is going to look like.

"It also means you need to know you're going to get adoption," said Burton. "Not only do biosimilars face all the issues we've discussed today, but the IRA puts in place what I think was a well-intended approach that will harm biosimilar adoption."

Executive Action

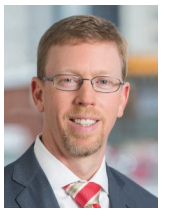
The president can help remove obstacles to greater acceptance and use of biosimilars, says Girvan.

"President Trump has expressed a willingness to take on high drug prices, including enhancing the IRA's drug price negotiation program and by once again proposing a most favored nation model—this time applied to drugs sold in Medicaid—that would tie prices of drugs to those of other nations," said Girvan (see article on opposite page).

"Trump should also work with Congress to pass meaningful reforms, including allowing generic and biosimilar companies to more easily challenge drug patents, reducing the [Food and Drug Administration's] exclusivity timeline for biologics, and designating all biosimilars as interchangeable with reference biologics to facilitate automatic substitution at the pharmacy level."

Trump can supplement that with other actions, said Girvan.

"With Trump's backing, a reform package could include measures to reduce the cost and time of drug approvals, which has the potential to achieve drug affordability on a scale similar to Hatch-Waxman," said Girvan. "The Fair Care Act of 2024, introduced by Rep. Bruce Westerman (R-AR), includes these and many other provisions that would make America's health care system more affordable."



"Policymakers must solve for these issues through legislation, as well as by reforming the ill-thought-out drug price negotiation provisions in the IRA that ultimately harm biosimilar competition and increase costs for patients and the health care industry in the long term. Biosimilars are the best tools we have to ensure more Americans receive access to lifesaving medicines. We must start treating them as such."

CRAIG BURTON
ASSOCIATION FOR ACCESSIBLE MEDICINES

Legislative Initiatives

Legislation is necessary to bolster the biosimilars market, Burton told *Health Care News*.

"The U.S. biosimilars market is languishing due to outdated and costly regulatory requirements, anticompetitive tactics used by brand manufacturers, and the fact that insurers and PBMs continue to pick higher-cost reference products due to the financial incentives associated with them," Burton said.

"Policymakers must solve for these issues through legislation, as well as by reforming the ill-thought-out drug price negotiation provisions in the IRA that ultimately harm biosimilar competition and increase costs for patients and the health care industry in the long term," said Burton. "Biosimilars are the best tools we have to ensure more Americans receive access to lifesaving medicines. We must start treating them as such."

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

Kennedy Orders Top-Down Review of Abortion Pill after Alarming Study

By Harry Painter

A new study has led Health and Human Services Secretary Robert F. Kennedy Jr. to order a "complete review" of the abortion pill mifepristone, amid queries from Congress.

Sen. Josh Hawley (R-MO) and Sen. Steve Daines (R-MO) asked the Food and Drug Administration (FDA) to reinstate safety protocols for the drug in response to a study by the Ethics and Public Policy Center (EPPC).

At a hearing before the Senate Health, Education, Labor and Pensions Committee on May 14, Kennedy called the study alarming and said "clearly it indicates at the very least the [FDA] label should be changed."

Kennedy did not provide a timeline for action but affirmed it would be a top priority. Any changes to safety protocols on the drug that were removed by the Biden administration would ultimately be made by President Donald Trump, Kennedy said.

Congressional Action

Hawley introduced the Restoring Safeguards for Dangerous Abortion Drugs Act, which would require reinstatement of the protections and allow women who have suffered complications the legal right to sue telehealth providers and pharmacies for damages. The bill would also ban foreign companies from mailing or importing mifepristone into the United States.

In 2024, the U.S. Supreme Court rejected a lawsuit calling for the court to rule the FDA's approval of mifepristone in September 2000 was illegal. The procedural decision did not consider the merits of the case.

Serious Complications

The EPPC study, "The Abortion Pill Harms Women," found close to 11 percent of women experience severe or life-threatening complications after using the drug to end pregnancies. The observed rate is 22 times higher than the less-than-0.5 percent complication rate listed on the drug's label.

Study authors Jamie Bryan Hall and Ryan T. Anderson wrote that it is the "largest-known study of the abortion pill" and is "based on analysis of data from an all-payer insurance claims database that includes 865,727 prescribed mifepristone abortions from 2017 to 2023."

The database is 28 times larger than the total included in all FDA-cited clinical trials and is more recent than the data used to justify approval of mifepristone, the study states.

Obliterated Objectivity

"Fierce debates about abortion in our society often prevent objective analysis of data on the topic; however, given that chemical abortions now account for two-thirds of all abortions, these findings deserve close scrutiny and attention," wrote EPPC fellow Aaron Kheriarty in a Substack post about the study.

The findings of clinical trials may not coincide with what happens when a drug or procedure goes into widespread use, says Kheriarty.

"Real world data can sometimes differ from the findings of highly controlled and selective clinical trials, for example, if the patient selection criteria in clinical practice is less stringent than the controlled experimental conditions of a clinical trial," writes Kheriarty.

"Furthermore, during the previous two administrations, the FDA relaxed the safety protocols for mifepristone, which may also contribute to these findings," writes Kheriarty.

Kheriarty provides a chart showing the weakening of safeguards for the abortion pill during those presidential administrations (see graphic).

Outdated Data

The evidence supporting the approved "less than 0.5 percent" figure is "based on old studies conducted under extremely controlled conditions," says Donna Harrison, M.D., a board-certified OB-GYN and director of research for the American Association of Pro-Life Obstetricians and Gynecologists.

"We've seen a lot of evidence pointing to the possibility that this drug's real-world rate of complications is actually much higher, especially given the proliferation of mail-order abortion," said Harrison.

The EPPC report and other studies highlight "the urgent need for the FDA to conduct further research into the safety of mifepristone and immediately reinstate the original safeguards on this drug that were in place when it was first approved," says Harrison.

Risky Mail-Order Abortions

"Real-world data proves common sense: these drugs are dangerous," said Marjorie Dannenfelser, president of Susan B. Anthony Pro-Life America. "A growing body of evidence shows the serious harm these drugs pose to women as well as their babies."

"At a minimum, the Trump administration should reverse the Biden FDA's reckless nationwide mail-order abortion drug policy," said Dannenfelser. "We urge the Trump administration to reinstate basic measures that require real medical oversight."

The FDA announced in 2023 it would allow pharmacies to mail mifepristone to customers, leading to pushback from 20 state attorneys general at the time.

Returning to the Clinton administration's regulations on mifepristone would protect women from unsupervised abortions through mail-order drugs, says Harrison.

"Restoring the drug's original regulations would, most importantly, end the reckless practice of mail-order abortion, through which women have been abandoned to undergo a risky and potentially traumatic or even life-threatening process with minimal medical supervision," said Harrison.

Trump's Take

Harrison says the Trump administration is improving the balance between access and safety.

"Luckily, the current administration has shown interest in investigating the safety of abortion drugs and potentially taking action to protect the safety of the women who take them," said Harrison. "Our patients deserve better than the appalling quality of care that has been sold to them in the name of abortion access."

The current policy on mifepristone is unfair to women, says Dannenfelser.

"Women and girls deserve better than high-risk drugs with no in-person doctor, no follow-up, and no accountability," said Dannenfelser. "This isn't health care; it's harm."

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

Weakening FDA Safeguards for Mifepristone	2000 Clinton Initial Approval	2016 Obama REMS Changes	2023 Biden REMS Changes
Required number of in-person visits	3	1	0
Maximum gestational age (LMP)	7 weeks	10 weeks	10 weeks
Drugs prescribed only by physician	✓	✗	✗
Drugs dispensed only in office	✓	✓	✗
Drugs taken only in office	✓	✗	✗
Required in-office follow-up	✓	✗	✗
Required reporting of adverse events	✓	✗	✗

Source: "*Human Flourishing*" Substack, April 28, 2025. Used with permission.

INTERNET INFO

Jaimie Bryan Hall and Ryan T. Anderson, "The Abortion Pill Harms Women: Insurance Data Reveals One in Ten Patients Experiences a Serious Adverse Event," Ethics and Public Policy Center, April 28, 2025: **https://eppc.org/wp-content/uploads/2025/04/25-04-The-Abortion-Pill-Harms-Women.pdf**

Medically Assisted Suicide Bills Are Sweeping the Nation

By AnneMarie Schieber

Forgoing the long, expensive, and unpredictable ballot proposal process, an increasing number of states are pushing legalized assisted suicide through their legislatures.

The bills are having mixed success. Maryland defeated an eighth attempt to pass assisted-suicide legislation when a bill failed to gain traction before the Maryland General Assembly ended its session for the year on April 7. The Delaware legislature and state assemblies in Nevada and New York (April 17, May 2) passed assisted-suicide bills, but the measures have an uncertain future in their state senates and with their governors.

The bills, often termed "medical aid in dying" or MAID, allow terminally ill and mentally competent adults with six months or less to live to request medication to end their life.

The New York bill prompted a strong rebuke from U.S. Rep. Elise Stefanik (R-NY).

"Instead of investing in palliative care, mental health support, and life-affirming resources for those facing terminal illness, this legislation offers an immoral shortcut that devalues human life," said Stefanik in a news release on May 1. "It sends a chilling message to our seniors and disabled communities that their lives are expendable."

"The medical profession exists to help people live until they die, not to push them over the edge. Resources other than death are available for people who are suffering through palliative care and proper hospice techniques. We need to let people know that they are valuable and cherished even when they are very sick and disabled at the end of life."

HEIDI KLESSIG, M.D.

MAID Stampede

Today, nine states and the District of Columbia have MAID laws through legislation or ballot initiative, and assisted suicide is legal in Montana as the result of a lawsuit. The other states are California, Colorado, Hawaii, Maine, New Jersey, New Mexico, Oregon, Vermont, and Washington.

In addition, Vermont allows nonresidents to enter the state for assisted suicide.

There have been 10 ballot initiatives to legalize or ban assisted suicide since 1991. Four proposals were successful. After failed attempts in Washington and California to legalize assisted suicide, Oregon became the first state to approve an assisted-suicide ballot proposal in 1994, followed by Washington in 2008, and Colorado in 2016.

In addition to New York and Nevada, Delaware and Illinois are currently considering legislation for assisted suicide. The Oregon and Vermont bills would expand legalization to allow nonphysicians to prescribe the lethal drugs, and activists in Washington are trying to reduce the waiting period for terminal patients.

"Proponents usually work through the legislature but decide which states should propose a ballot measure, and that is usually a political calculation depending on the demographics of the state," said Jason Negri, an attorney for the Patients' Rights Action Fund.

Bipartisan Opposition

Both Republicans and Democrats have opposed the legalization of assisted suicide for a variety of reasons, says Negri.

"[These include] issues like concern for the vulnerable, health care cost control, and elder abuse," said Negri. "For example, last month in New York, after over a decade of pushing legislators—including such tactics as disrupting Assembly sessions and cornering legislators in elevators—assisted-suicide proponents received a floor vote in the Assembly. Over 20 progressive Democrats voted against it, citing racial and health-care disparities that make this policy so dangerous for marginalized communities."

Though proponents pitch safeguards, that can be misleading, says Negri.

"Such 'safeguards' include waiting periods, residency and witness requirements, and conscience protection for doctors who don't want to help their patients die," said Negri. "The safeguards are a calculated move to garner support from people who are uncertain about assisted suicide."

The safeguards are often removed within a few years, says Negri.

"Proponents characterize them as 'barriers to care,'" said Negri. "Their goal is death on demand, and the 'safeguards' they put in are only temporary and for show."

Ranking Lives

The push to pass assisted-suicide bills coincided with the expansion of Medicaid to cover able- bodied people, which sent costs soaring. MAID laws target the disabled, says Norm DeLisle, a policy consultant with the Michigan Disability Coalition.

"Every time I hear someone support laws enabling assisted suicide, what I really hear is that my disabled life isn't worth living," said DeLisle. "Trust me, we in the disability community feel this kind of judgment daily. Our lives are seen as less valuable, less meaningful, less worth protecting than yours. The message is, 'Better Off Dead.'"

People are more inclined to end their lives when they are in the hospital, DeLisle says.

"If you have a permanent disability, there is no place that drains your personal worth faster than a hospital," said DeLisle. "Even medical staff have written books about this loss of self when they become patients. Each day chips away at your sense of self as you lose more control over even tiny decisions in your life. You are an object, and you never feel more powerless than when others decide what your life is worth without asking you. No experience can make you more vulnerable to pressure you to die."

Death a Poor Option

Opposing MAID does not imply disregard for pain and suffering near the end of life, says Heidi Klessig, M.D., author of *The Brain Death Fallacy*.

"The medical profession exists to help people live until they die, not to push them over the edge," said Klessig. "Resources other than death are available for people who are suffering through palliative care and proper hospice techniques. We need to let people know that they are valuable and cherished even when they are very sick and disabled at the end of life."

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

Pfizer's COVID-19 Shot Linked to More Deaths Than Moderna's, Study Finds

By Kenneth Artz

Recipients of the Pfizer mRNA vaccine experienced more all-cause deaths within the first 100 days post-vaccination than those who received the Moderna shot, a new study of 1.47 million people found.

Although all-cause mortality for either shot should have been the same, 230 more people per 100,000 who got the Pfizer jab died within the first 12 months after injection, and 83 out of 100,000 more died from cardiovascular causes, than with the Moderna shot.

Florida Surgeon General Joseph Ladapo, M.D., and statistician Retsef Levi conducted the study using Florida's public health databases to identify adults who received at least two doses of COVID-19 mRNA vaccines within a six-week interval. The database also provided demographic information about vaccine recipients and where they received their shots.

Ladapo wrote a letter to the Food and Drug Administration in January 2024 calling for a halt in the use of COVID-19 mRNA shots for safety reasons.

Outcomes, Not Odds

"This study is important because it's a comparative analysis—not measuring the overall risk of death from each vaccine, but directly comparing the death outcomes between the two," said John Dale Dunn, M.D., a Texas physician, attorney, and policy advisor for The Heartland Institute, which co-publishes *Health Care News*.

"What the study found is that there is a difference," said Dunn. "It's not a huge difference, but it is noticeable."

The study did a good job of controlling for confounding variables such as socioeconomic status, age, and other factors to avoid adverse selection bias, and it eliminated people in institutions or who died from violent causes, said Dunn.

"The reported numbers showed a clear difference between the two vaccines, but the disparity wasn't large enough to definitively conclude that the Pfizer vaccine poses an unacceptable risk," said Dunn.

Sample Strength

The study's large, diverse sample size gives it unusual credibility, says Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation and a columnist for *The Hill*.

"Importantly, the number of deaths potentially attributable to the vaccines is actually quite low," said Matthews. "That matters because there have been numerous claims suggesting far higher vaccine-related death rates."

Although Phase III clinical trials typically have thousands of participants, they don't match the scale of post-market use, so some side effects may not become evident until a drug is widely administered, says Matthews.

"For example, myocarditis began showing up in younger men after receiving the COVID-19 vaccine, a pattern not seen during clinical trials," said Matthews. "But that's not unusual; it happened with some Cox-2 inhibitor NSAIDs like Celebrex and Vioxx when they hit the market in the 1990s."

Unanswered Questions

Although the study suggests higher all-cause mortality for one formulation of the vaccine over another, it lacks critical information, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"What we really need to know is how those vaccinated compare with a matched unvaccinated population," said Orient. "And what about the causes of death? How many of the deceased underwent autopsies? Was there any investigation into a possible link between the vaccine and death?"

The public might see both shots as risky, says Orient.

"One might conclude that the Pfizer vaccine is more dangerous than Moderna's, and it's possible Pfizer could pressure the media not to report on that," said Orient. "But the broader takeaway some people might have is that both vaccines carry risks. Also of note is that vaccinated people were still dying of COVID, though much less often than from other causes."

"One might conclude that the Pfizer vaccine is more dangerous than Moderna's, and it's possible Pfizer could pressure the media not to report on that. But the broader takeaway some people might have is that both vaccines carry risks. Also of note is that vaccinated people were still dying of COVID, though much less often than from other causes."

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

Media Silence

There could be a particular reason why the study hasn't gotten more attention, says Matthews.

"I think the public and the media are over the pandemic," said Matthews. "There's just not as much interest anymore. Booster shots are down, many doctors aren't recommending the newest versions, and the media has moved on to other stories."

The silence could also be a case of the media disliking the messenger, says Matthews.

"Dr. Joseph Ladapo is viewed by many as a vocal vaccine skeptic, especially regarding the COVID vaccines," said Matthews. "That reputation, along with his strong support for former President Trump, may cause the media to dismiss the study or avoid amplifying it altogether."

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

HHS to Require Placebo-Controlled Trials for New Vaccines

By Kevin Stone

The Department of Health and Human Services (HHS) announced it will enact a new policy requiring placebo-controlled trials for all novel vaccines.

The Washington Post reported on May 1 HHS sent the outlet a statement that said, in part, "All new vaccines will undergo safety testing in placebo-controlled trials prior to licensure—a radical departure from past practices."

Placebo testing has long been the gold standard for safety evaluation of pharmaceutical products. Vaccines in current use have generally been tested against another vaccine that includes some of the ingredients used in the manufacture of the vaccine being tested, often including additives known as adjuvants to increase the drug's potency.

"Instead of being compared to a neutral substance, they were often tested against another vaccine or an active ingredient, such as an aluminum adjuvant—making it nearly impossible to isolate genuine safety signals."

MARYANNE DEMASI, PH.D.
AUSTRALIAN INVESTIGATIVE JOURNALIST

Placebo Substitutes

"Until now, many vaccines—particularly those on the Centers for Disease Control and Prevention childhood immunization schedule—were licensed without being tested against an inert placebo," said Maryanne Demasi, Ph.D., an Australian investigative journalist.

"Instead of being compared to a neutral substance, they were often tested against another vaccine or an active ingredient, such as an aluminum adjuvant—making it nearly impossible to isolate genuine safety signals," said Demasi.

"This approach defies basic scientific principles," said Demasi. "An inert placebo group is essential to determine whether an adverse event is caused by the vaccine or would have occurred regardless. These vaccines are administered to perfectly healthy children, which means the safety threshold must be exceptionally high. Yet regulators have routinely accepted comparisons that obscure potential harms rather than clarify them."

Implicit Admission of Failure

Demasi says criticism of the HHS statement, as reported by *The Washington Post*, reveals a "deep resistance to scientific transparency" and shows "deeply entrenched assumptions" that have allowed vaccines to evade the safety scrutiny required of other drugs.

"Paul Offit, coinventor of a rotavirus vaccine and frequent media spokesperson on vaccine safety, warned, 'You are watching the gradual dissolution of the vaccine infrastructure in this country. The goal is to make vaccines less available and less affordable,'" said Demasi.

That admission by Offit is a red flag, says Demasi.

"Let me be blunt: if your 'infrastructure' depends on avoiding gold-standard safety trials, then perhaps it deserves what's coming," said Demasi. "Offit's statement isn't a defense of science or public health; it's an admission that the system cannot withstand scrutiny. He's effectively arguing that vaccines must remain exempt from proper testing to stay commercially viable."

Ethical Concerns

Driving the new policy is the idea that many adverse effects of new vaccines may not be observed if they are tested only against existing vaccines or adjuvants, as is generally the case with the vaccines in the childhood vaccine schedule. Using a different vaccine as a control in a study group fails to provide a true control, nor does it protect the test subject against the disease for which it is being tested, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"They claim it is 'unethical' to deprive a subject in a study of a vaccine, but I don't see how giving a different vaccine responds to that," said Orient. "It is interesting to compare adverse effects of the new vaccine vs. the supposedly safe control. They may be about the same and very high compared with what saline would give."

Using an adjuvant as a substitute for a placebo does not reveal the safety of a product if the adjuvant itself carries potential side effects, says Orient.

"Gardasil was supposedly tested against saline, but one subject got a very serious reaction: the placebo turned out not to be saline but rather the new adjuvant, which deliberately inflames the immune system," said Orient. "Adjuvants, usually aluminum, are not well-tested and are much more reactogenic than the antigens, which don't work well or are needed in much larger—and expensive—quantities without the adjuvant."

Risk-Benefit Neglect

Given all these problems, rushing a vaccine into production using such shortcuts may cause more problems than it solves, says Orient

"Risks from a future pandemic are hypothetical, and vaccines are not very good in pandemics anyway," said Orient. "Some say you should never vaccinate into an active pandemic. Risks to healthy experimental subjects are real, and there may be no benefit."

Watching the Watchmen

With the press touting objections against the new HHS policy from individuals such as former FDA advisory board member Offit and Michael Osterholm, a University of Minnesota infectious-disease expert who served on President Joe Biden's transition team, Orient and others who support full testing to ensure safety say the complaints are a sign of the revolving door between regulators and the industries they oversee, a practice that can put the public at risk.

"Regulatory capture is a real issue," said Orient. "Paul Offit is heavily conflicted, in my opinion. Most vaccines in the schedule are for currently rare diseases. Some are not readily transmissible and/or are treatable and/or preventable with post-exposure antibiotic prophylaxis.

"We need to work much harder on finding treatments," said Orient. "Investigating repurposed drugs is the most efficient method. It is better to treat people who are sick than to inject the whole population, who might never get sick but could suffer harm from a vaccine."

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

FDA to Phase Out Synthetic Food Dyes

By Ashley Bateman

The U.S. Department of Health and Human Services (HHS) and the Food and Drug Administration (FDA) plan to phase out all petroleum-based synthetic dyes from food and drugs in the United States by the end of 2026.

The agencies plan to create a national standard and timeline to transition from synthetic to natural alternatives. That includes revoking authorization for two synthetic dyes, Citrus Red No. 2 and Orange B, within months, and eliminating the six remaining dyes on the market by the end of next year.

Those include Red Dye No. 40, Yellow Dye No. 5, Yellow Dye No. 6, Blue Dye No. 1, Blue Dye No. 2, and Green Dye No. 3.

An April 22 FDA news release states the plan is designed to standardize a patchwork of dye allowances throughout the states that make it difficult for companies to comply. Approximately 30 states have banned or are considering banning certain synthetic food dyes.

"We've had wonderful meetings with the food industry," FDA Commissioner Marty Makary said at a news conference. "I've been amazed, and they are eager to do this. They are good people. … They have kids too, and I think we all want the same thing."

"I'm not holding my breath that all these companies will get these toxins out of the foods in a timely, comprehensive, or appropriate way. I suspect the FDA will have to use its enforcement and regulatory powers, and when that happens, I have no doubt that some of these companies will not hesitate to use lawfare to continue poisoning Americans."

KATY TALENTO, EPIDEMIOLOGIST

Concerns About Chronic Disease

In the release, Makary elaborated on the push to remove food dyes.

"We have a new epidemic of childhood diabetes, obesity, depression, and ADHD," said Makary. "Given the growing concerns of doctors and parents about the potential role of petroleum-based food dyes, we should not be taking risks and do everything possible to safeguard the health of our children."

Food companies in Europe and Canada use natural dyes instead of the petrochemical compounds used in U.S. food.

"These poisonous compounds offer no nutritional benefit and pose real, measurable dangers to our children's health and development," HHS Secretary Robert F. Kennedy Jr. stated in the release. "That era is coming to an end. We're restoring gold-standard science, applying common sense, and beginning to earn back the public's trust."

Connection to Illnesses

Kennedy mentioned food dyes as a major concern when he was appointed to head the HHS in November. A *Lancet* study published in 2007 found increased hyperactivity in children in the general population who consumed products with synthetic food dyes.

Years later, most of those dyes are still being used in many American packaged foods. In some cases, use has increased. A 2016 study published by the National Institutes of Health found 350 out of 810 grocery store products sampled contained artificial dyes.

An NIH study by Laura J. Stevens et. al., published in 2013, found a fivefold increase in artificial food dyes inspected by the FDA from 1950 to 2012. A recent *Wall Street Journal* report found 13 percent of American food products contain at least one petrochemical dye.

The vast majority of these are Red Dye No. 40 and Yellow Dyes No. 5 and 6, says Peter McCullough, M.D., a cardiologist and chief scientific officer of The Wellness Company.

"Clinical studies show consuming these dyes is clearly associated with worsening of ADHD, which the [Centers for Disease Control and Prevention] says is evident in 11 percent of our children," said McCullough. "It disrupts their social interactions and learning."

Parents have managed their children's ADHD symptoms by changing the children's diets, says Michelle Cretella, M.D., a pediatrician and member of the American Association of Physicians and Surgeons.

"It is possible for individuals to see improvements relatively quickly," said Cretella.

Doubts About Compliance

The FDA's news release does not state what will happen if companies do not cooperate with the six stated actions. Recent history has not been promising, says Katy Talento, an epidemiologist and longtime health policy advisor. In 2015, Kellogg's announced it would no longer use synthetic food dyes in its products, but the company never followed through, says Talento.

"I'm not holding my breath that all these companies will get these toxins out of the foods in a timely, comprehensive, or appropriate way," said Talento. "I suspect the FDA will have to use its enforcement and regulatory powers, and when that happens, I have no doubt that some of these companies will not hesitate to use lawfare to continue poisoning Americans."

Food companies may be slow to change, says Cretella.

"The number one reason this ban has taken so long is the same reason the vast majority of physicians have no idea that petroleum-derived products are harmful to human health; namely, there are widespread financial conflicts of interest in American medicine and education," said Cretella.

The dyes are also used in pharmaceuticals, says McCullough.

"We should get these artificial dyes out of prescription medication and supplements," said McCullough. "Some daily drugs are taken for decades."

Confounding Factors

It will take time to determine the precise effect of dye removal on people's health, says Talento.

"These toxins are just one of many types of toxins causing chronic illness," said Talento. "We know their rates of disease causation in controlled studies, when isolated from a bunch of other exposures. Without comprehensive science about the independent impact of the toxins over certain durations, quantities, age of exposure, and impact of the combination of other toxic exposures, we can't predict exactly when we'll see health impacts."

It is important to document these effects, says Talento.

"We must start somewhere, and then move on to the next set of toxins, and the next set after that, if we hope to truly conquer the chronic illness epidemic," said Talento.

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

Florida Becomes Second State to Ban Water Fluoridation

By Kenneth Artz

Florida Gov. Ron DeSantis signed a bill on May 15 removing fluoride from the state's list of approved additives in public water systems.

The law goes into effect on July 1. Florida follows Utah, which became the first state in the nation to prohibit state and local governments from adding fluoride to public water systems.

Gov. Spencer Cox signed Utah House Bill 81 into law on March 27, and it went into effect on May 7. The legislation also bans political subdivisions from enacting or enforcing laws to override the law.

The American Dental Association, the nation's largest dental organization, had urged Cox to veto the bill, emphasizing fluoridation's cost-effectiveness in reducing tooth decay and its widespread support across the health care sector, in a February 25 letter.

Eighty-Year History

Fluoride, a naturally occurring compound present in groundwater, was found to help prevent tooth decay and cavities in the early 1900s. Grand Rapids, Michigan became the first U.S. city to fluoridate its municipal water system, in 1945.

Fluoridation of water systems expanded throughout the United States, and by 2022 the Centers for Disease Control and Prevention estimated 72.3 percent of Americans connected to community water systems—or about 62.8 percent of the total U.S. population—were receiving fluoridated water.

Despite continued endorsement by the Centers for Disease Control and Prevention (CDC), debates over fluoride's safety persist today.

In November 2024, Robert F. Kennedy Jr., now Health and Human Services Secretary, suggested removing fluoride from U.S. water systems, calling it a "dangerous neurotoxin." On April 7, Kennedy announced a task force to study the issue and said he plans to tell the CDC to stop recommending fluoride in drinking water.

Other states are considering legislation similar to Utah's ban. Ohio and South Carolina are exploring fluoride bans, and lawmakers in New Hampshire, North Dakota, and Tennessee have rejected such measures. A Kentucky bill to make fluoridation optional stalled in the state Senate.

'Scaremongering Through Bad Science'

Anti-fluoride arguments are "scaremongering through bad science," says John Dale Dunn, M.D., J.D., a Texas physician and policy advisor to The Heartland Institute. Dunn criticizes the use of the "linear no-threshold" model, which assumes that even minimal exposure to a substance could be harmful, regardless of real-world exposure levels.

"They produce research that shows toxic effects at levels far higher than those found in fluoridated water," said Dunn. "It's nothing more than generating fear based on bad science."

The benefits of fluoridation, particularly in reducing cavities, far outweigh any hypothetical risks at recommended levels, which have been shown to be safe, says Dunn.

"There's a reason fluoride is in the water," said Dunn. "Yes, people can use fluoride toothpaste, but are we going to outlaw that too? The idea that fluoride is harmful at the levels used in water systems is simply not supported by credible evidence."

Dunn attributes the suspicions about fluoride to the "precautionary principle," which he says creates exaggerated public fears of substances such as fluoride and mercury.

"What you have to do is look at risk versus benefit," said Dunn. "At recommended levels, there's no risk—and fluoride has dramatically improved dental health in the United States."

Issue of Local Control

Fluoridation decisions should be made at the community level, says Merrill Matthews, Ph.D., a columnist for *The Hill*.

"Voters and their elected representatives should decide," said Matthews. "The closer the decision is to the people, the better, and if problems arise, communities can always reverse course."

Transparency is critical, says Matthews.

"Cities that fluoridate should make water fluoridation levels publicly available online, including how those levels compare to CDC recommendations and the rationale for any differences," said Matthews.

'Toxicity Is Highly Unlikely'

Most dental professionals support water fluoridation because of its effectiveness in reducing tooth decay, particularly in children. While some people get fluoride from toothpaste or direct treatments, water fluoridation provides broad, consistent protection, says Matthews.

"Fluoride toxicity is highly unlikely at recommended levels," said Matthews. "Nearly all studies that found problems were examining excessive levels far above what's used in public systems."

Fluoride is important for children's dental health, with a study in Israel having found increased dental cavity rates after the country stopped water fluoridation, says Matthews.

The debate also represents a political divide over environmental health concerns.

"There's a reason fluoride is in the water. Yes, people can use fluoride toothpaste, but are we going to outlaw that too? The idea that fluoride is harmful at the levels used in water systems is simply not supported by credible evidence. What you have to do is look at risk versus benefit. At recommended levels, there's no risk—and fluoride has dramatically improved dental health in the United States."

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

"Liberals tend to be more concerned about toxins in food and the environment, while conservatives often argue that these fears are based on unrealistic exposure levels," said Matthews.

Continuing Debate

Although high fluoride intake can be toxic, public health authorities say the levels used in U.S. water systems are both safe and beneficial. The CDC continues to list water fluoridation as one of the top-10 public health achievements of the twentieth century.

Similar debates over public exposure to metallic and nonmetallic elements such as fluoride have occurred regarding mercury and lead, says Dunn.

"If you're loaded up with mercury, lead, or fluoride, it will cause nerve damage, but to get to that level of toxicity, you've got to be eating lead or getting some kind of wild exposure to a heavy metal that doesn't exist in the normal environment," said Dunn.

As Utah and Florida move forward with their bans, the debate over fluoridation remains active at both the state and national levels. Supporters argue fluoridated water has helped reduce health disparities, while opponents call for more individual choice and greater scrutiny of government health mandates.

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

‘Designer Babies’ Raise Ethical Concerns

By Harry Painter

Genetic screening technology now allows parents employing in vitro fertilization (IVF) to select for certain traits, allowing them to avoid passing on diseases or undesirable traits to their children.

Orchid, a genetic screening company that bills itself as “the world’s most advanced whole genome screening for embryos during IVF,” allows parents essentially to customize children, selecting not just against deadly diseases but also for particular heights and eye colors.

A technology cited in an April 1, 2025, *New York Times* article is known as polygenic risk scoring, and its use with IVF has raised questions.

“The usefulness of polygenic risk scoring in adults is still an open question; its application to embryos is even less straightforward,” wrote Anna Louie Sussman.

Orchid customers get an extensive risk analysis of their embryos’ susceptibility to any number of health conditions, including autism, obesity, diabetes, inflammatory bowel disease, schizophrenia, Alzheimer’s, and breast cancer.

The company advertises its ability to screen for intellectual disability, raising questions about “the mass ranking of embryos by dubious risk scores,” the *Times* story reports.

“As far as ethics, if you ‘select’ some embryos as ‘high quality,’ you are also judging other human embryos to be low-quality, lower-grade beings, even unworthy of life. That embryonic attitude toward other humans is inhumane.”

DAVID A. PRENTICE, PH.D.
STEM CELL RESEARCHER AND BIOETHICIST

‘Questionable Science’

President Donald Trump has said he plans to release his IVF policy recommendations in May, which could place even more attention on the topic.

Stem cell researcher and bioethicist David A. Prentice, Ph.D. calls preimplantation genetic testing (PGT) “eugenics at the earliest days of life.” Orchid and similar companies are “using questionable science that is actually not nearly as accurate as advertised,” said Prentice.

“Despite the hype, the evidence on PGT and polygenic screening shows that it doesn’t improve efficiencies and may actually decrease chances of a healthy, full-term pregnancy,” said Prentice.

Prentice’s December 2024 paper titled “The Facts of Life: A Review of the Science and Ethics of IVF,” cites studies indicating PGT “does not improve pregnancy, implantation, or live birth rates and should not be used except perhaps for research studies.”

“As far as ethics, if you ‘select’ some embryos as ‘high quality,’ you are also judging other human embryos to be low-quality, lower-grade beings, even unworthy of life,” Prentice told *Health Care News*. “That embryonic attitude toward other humans is inhumane.”

Moral, Legal Differences

There are legal and moral distinctions between different kinds of gene editing and genetic tests, says Prentice.

“Currently, use of such eugenic tests to select embryos is legal in the United States,” said Prentice. “But the next step, gene editing of embryos for heritable genomic alterations, is illegal based on the Aderholt Amendment, first signed into law in 2015.”

The Aderholt Amendment was a bipartisan amendment signed into law by President Barack Obama in 2015 to “preclude the FDA from reviewing any investigational new drug application related to intentional germline editing,” according to *GEN News*.

“Somatic gene editing, i.e. gene editing that is not heritable but used to treat born individuals for specific diseases, is ethical and should be encouraged,” such as new gene therapies approved by the FDA for sickle cell disease, said Prentice. “But there should be a global moratorium on heritable genomic editing.”

Eugenic Editing

Governments should ban the practice of designing babies, says Michelle Cretella, M.D., president of the American College of Pediatricians.

“Gene editing for designer babies is eugenics—the death of countless innocent human lives at the embryonic stage is required,” said Cretella. “Like all eugenics, it must be banned.”

Such gene editing is a violation of children’s rights, says Cretella.

“Children have the God-given and natural right to be loved and raised by their mother and father,” said Cretella. “Mothers and fathers have the right and responsibility to love, nurture, educate, and protect their children.”

Designing babies makes a huge presumption that parenthood by any means is justified, says Cretella.

“Parents who fail through abuse may lose custody of their children,” said Cretella. “Adults do not have the right to [have] children. Children are gifts from God, not made-to-order luxury items or trophies.”

People As Products

The ability to pick and choose traits brings up larger questions about IVF, says Jane Orient, M.D., executive director of the American Association of Physicians and Surgeons.

“‘Designer babies’ are also human, and in creating one acceptable to the buyers, many of its brothers and sisters are destroyed,” said Orient.

It is possible to cherish IVF babies while criticizing the methods used to conceive them, says Orient.

“What does this say about respect for human life?” said Orient. “It becomes a commodity, not a priceless gift. What if the chosen one turns out to be defective?

“Human gene editing is promoted as a way to cure certain diseases with a known genetic defect—sickle cell anemia, cystic fibrosis, some errors of metabolism,” said Orient. “So far, [it has achieved] no great success. Most other things are far more complex, and we really don’t know the consequences of making a change here and there. Disasters are certain to occur.”

Doctors and researchers should concentrate on finding more ethical solutions to infertility, says Orient.

“Infertility is very sad, and we should be working on ways to help—without playing God,” said Orient. “Our culture is creating a lot of infertility: STDs, delayed childbearing, possibly some contraceptives and abortions. We’re trying to fix it with science, but the end still doesn’t justify the means.”

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

INTERNET INFO

David A. Prentice, “The Facts of Life: A Review of the Science and Ethics of IVF,” DPrentice.org, Dec 11, 2024: **https://dprentice.org/wp-content/uploads/2024/12/The-Facts-of-Life-A-Review-of-the-Science-and-Ethics-of-IVF-Prentice-Dec24.pdf**

Innovators Call for More Access to Cutting-Edge Treatments

By Bonner Russell Cohen

The Department of Health and Human Services (HHS) should not overlook new applications of existing therapies to improve patients' lives in pursuing the goal of making Americans healthier, a panel discussion hosted by The Heritage Foundation concluded.

The panel focused on photobiomodulation (PBM) and hyperbaric oxygen therapy (HBOT) as proven treatments that stimulate cell growth in patients suffering from a vast array of conditions. Managing pain, promoting wound healing, and treating brain injuries are just a few of the applications the panelists discussed during the May 1 conference.

Cutting-Edge Therapies

PBM "is a non-invasive photogenic-based therapy, capable of dealing with immune-inflammatory, neurological, and musculoskeletal disorders, as well as healing oral and chronic skin wounds," according to *Science Direct*.

HBOT, *Johns Hopkins Medicine* explains, "is a type of treatment used to speed up healing of carbon monoxide poisoning, gangrene, and wounds that won't heal. It is also used for infections in which tissues are starved for oxygen. For this therapy, you enter a special chamber to breathe in pure oxygen at air pressure levels 1.5 to 3 times higher than average."

Panelists addressing the potential of these therapies were Paolo Cassano, M.D, Ph.D., director of the Brain Photomodulation Clinic at Massachusetts General Hospital; Mohammed Elamir, M.D., lead physician at Aviv Clinics in Central Florida; and Ann Liebert, Ph.D., coordinator of photomolecular research in the Sydney (Australia) Adventist Hospital.

Heritage Foundation Senior Research Fellow Robert E. Moffit, Ph.D., chaired the panel.

'Alternative to Opioids'

Moffit described PBM as "an alternative to opioids" that has "served over 100 million patients around the world and has been researched in thousands of studies."

Liebert said the use of light for healing began in 1903, with modern applications dating to 1967.

"Light has a great effect on our lives, from the time we get up in the morning until we go to bed at night," said Liebert. PBM therapy reduces inflammation and "is nonpharmaceutical," Liebert said.

Though some patients with high sensitivity to light may have minor negative reactions to the therapy, "there are no adverse effects" from PBM, Leibert said.

Cassano said PBM boosts brainwave activity and provided an example of the role the therapy plays in healing traumatic brain injuries: a man who suffered from severe headaches for years after his car was struck by a crane while he was driving in New York City received PBM therapy at Massachusetts General for six weeks; the headaches went away, and the man, now 80, is living a normal life.

Oxygen for Cells

Discussing HBOT, Elamir said as people age, getting oxygen to all parts of the body becomes more difficult. Elamir treats many older patients at his clinic.

Properly administered, HBOT "enables oxygen to get to the cells that need it and helps the body to create new cells," Elamir told the audience.

All therapies have side effects, and in HBOT, the key is the right level of oxygen, said Elamir.

"We ask our patients undergoing treatment if they can pop their ears," said Elamir. "If they say yes, we know they are fine." As with PBM, Elamir favors HBOT as an option to improve surgery outcomes.

Slow Acceptance

When Moffit asked the panelists whether medical professionals are ready to accept expanded use of the therapies, all three said no. Cassano said most physicians have not been trained in PBM, and Elamir said doctors generally "wait until conventional treatments have failed" before turning to HBOT.

Discussing the costs of the therapies, Cassano said a PBM device costs $1,000 to $3,000, and the purchase is not covered by insurance.

Extended treatment can cost $70,000, but it could potentially be covered by Medicare as an alternative to opioids. PBM is also available at VA hospitals, where it is used to treat patients suffering from military-related brain injuries.

Elamir said HBOT costs $300 per session, with some patients needing many sessions.

All panelists said the two therapies could play a role in treating autism, a growing problem in the United States.

Limited Progress

"There is more evidence behind HBOT than there is supporting PBM," Dallas-based cardiologist Peter McCullough, M.D., told *Health Care News*. "Both are attractive because they are not prescribed medications or nutraceuticals." Nutraceuticals are naturally based substances such as vitamins and food supplements.

Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons, says she is happy that alternative treatments are getting more attention.

"I am delighted to see promotion of PBM and HBOT, although the latter, at least, has been known for over a hundred years but has been brutally suppressed," said Orient. "There are 14 indications that are covered by insurance, but many amputations still occur because treatment is long-delayed. Meanwhile, treatment is denied or not even considered for healing brain and spinal cord injuries."

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

Access Problems

Access to cutting-edge treatments is too limited, says Orient.

"Star athletes may get prompt treatment for a concussion, but soldiers with traumatic brain injuries from blast exposure get backpacks full of dangerous and ineffective drugs from the VA, and many commit suicide," said Orient.

"Thousands of veterans have been healed at private treatment centers while the VA claims there's no proof that it works," said Orient. "Some places charge $150 per session, while hospitals may demand $1,000 or more. Stroke patients, drowning victims, and children with cerebral palsy or autism have experienced miraculous-appearing recovery."

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

Medical Journals Under Fire for Lack of Neutrality

By Bonner Russell Cohen

The Justice Department has sent letters to leading medical journals, requesting information on how the publications chose and present their content.

Although the letters do not constitute a formal DOJ investigation into the journals' practices, the wording leaves little doubt the publications are under scrutiny in the latest escalation of the conflict between the Trump administration and the nation's health care establishment. A letter dated April 14 from then-interim U.S. Attorney for the District of Columbia Edward R. Martin to Peter Mazzone, M.D., editor-in-chief of *CHEST Journal*, published by the American College of Chest Physicians, cites frequent requests for "information and clarification" from the public.

"It has been brought to my attention that more and more journals and publications like CHEST Journal are conceding that they are partisans in various scientific debates—that is, that they have a position for which they are advocating either due to advertisement (under postal code) or sponsorship (under relevant fraud regulations), wrote Martin. "The public has certain expectations, and you have certain responsibilities."

Influence through pressure from sponsors or advertisers falls under federal fraud regulations and the U.S. Postal Code, Martin wrote.

'Assess Your Responsibilities'

Martin requested answers to several questions.

"How do you assess your responsibilities to protect the public from misinformation? wrote Martin.

Other questions included, "How do you clearly articulate to the public when you have certain viewpoints that are influenced by your ongoing relations with supporters, funders, advertisers, and others? Do you accept articles or essays from competing viewpoints? How do you assess the role played by government officials and funding organizations like the National Institutes of Health in the development of submitted articles?" and "How do you handle allegations that authors of works in your journal may have misled their readers?"

Martin asks whether publishers, journals, and organizations Mazzone works with are adjusting the "method of acceptance of competing viewpoints," and whether "new norms" are being set.

Healthcare Innovation reported *The New England Journal of Medicine* and *Obstetrics and Gynecology* also received DOJ letters questioning their editorial practices.

Martin was replaced as interim U.S. attorney for the District of Columbia in early May by Jeanine Pirro, a former judge in Westchester County, New York. The move was unrelated to the DOJ's medical journal inquiry.

'Vaccine Promotional Vehicles'

Jeff Stier, a senior fellow at the Center for Consumer Choice, says the DOJ inquiry reflects a crisis in the medical literature.

"Studies published in peer-reviewed journals become the basis for everything from the advice your doctor gives you to the very laws that govern us," said Stier. "A journal's ability to tell good science from bad is critical. But some journals have used poor judgment, and even rejected judgment with a bias of their own. The Trump administration is right to try to shed some light on this process."

Nicolas Hulscher, an epidemiologist, says he believes the DOJ letters "raised legitimate concerns about bias, lack of transparency, and whether these journals fairly presented competing scientific viewpoints—especially on topics like COVID-19 policies and treatments," in a post on the *Focal Points* substack.

"The consistent direction of bias was to suppress any new studies of combination early therapeutics and reports on poor efficacy and side effects of COVID-19 vaccines," wrote Hulsher. "Essentially, the journals became vaccine promotional vehicles. None of the major journals published manuscripts that concluded the risks outweigh the benefits of vaccination, despite more comprehensive papers published elsewhere arriving at the truth."

'Not an Editorial Inquiry'

Editors, former editors, and associates of the medical journals quickly protested the inquiry.

"What are they doing?" Michael Eisen, former editor of the biomedical journal *eLife*, said to NBC News. "I've just never been in this position of providing information to the Department of Justice about something. This is not an editorial query. This is from an organization that prosecutes crimes. That makes it different."

In his response to the DOJ, dated April 25, Eric Rubin, M.D., Ph.D., editor-in-chief of the *New England Journal of Medicine*, defended his publication's editorial practices.

"As practicing physicians, we recognize our responsibility to doctors and patients," wrote Rubin. "We use rigorous peer review and editorial processes to ensure the objectivity and reliability of the research we publish. We support the independence of medical journals and their First Amendment rights to free expression. The Journal actively fosters scholarly scientific dialogue and remains steadfast in its commitment to supporting authors, readers, and patients."

'Like-Minded Reviewers'

Science journals engage in too much groupthink, says Stier.

"All science deserves the utmost scrutiny," said Stier. "But today, scientific journals lean so heavily on finding potential 'conflicts of interest' that they've lost sight of the peer-review process. Instead of doing the hard work of bringing together diverse experts to critically analyze a paper, they go into an echo chamber of like-minded reviewers. The journals tout their conflict-of-interest policy, but at the expense of true scrutiny.

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JEFF STIER
SENIOR FELLOW
CENTER FOR CONSUMER CHOICE

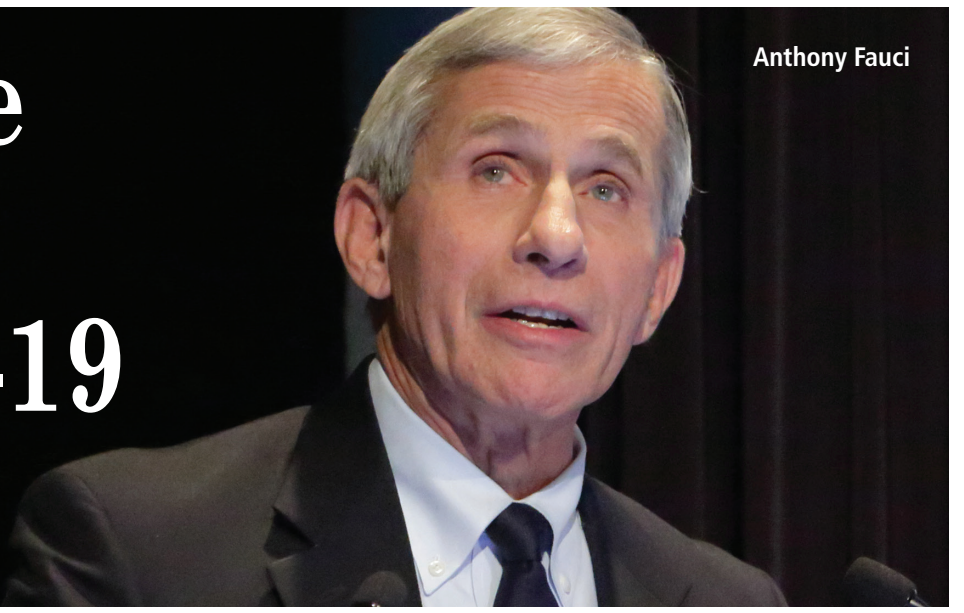
"Because of their track record, it's about time the gatekeepers were subjected to more oversight," said Stier.

Merrill Matthews, Ph.D., a resident fellow at the Institute for Policy Innovation, says he is "skeptical of the DOJ leaning on medical journals, just as I was skeptical of the government leaning on social media outlets trying to get them to support the government's position.

"If DOJ can demand answers from *JAMA*, could a future Democratic administration demand answers from *Christianity Today* or the *Journal of Church and State*, or the publication of the Christian Medical and Dental Association to explain how they decide on which articles to accept?" said Matthews.

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

Fauci's Fortune Doubled While He Led COVID-19 Policy



Anthony Fauci

PHOTO COURTESY NIAID/FLICKR.COM

By Kevin Stone

Anthony Fauci, the retired director of the National Institute of Allergy and Infectious Diseases (NIAID), doubled his fortune from $7.6 million to more than $15 million from January 2019 to December 2023, the watchdog group Open the Books reports.

Fauci earned $3.5 million in his first year of retirement in 2023 alone. In March, he reportedly sold his memoirs to a subsidiary of Penguin Random House for $5 million.

In addition to those windfalls, taxpayers were paying $15 million for Fauci's personal security detail provided by the U.S. Marshals Service. President Donald Trump terminated that arrangement three days after taking office this year.

"Distrust in public health officials is at an all-time high. One way to restore trust is to make sure that public policy isn't influenced by personal gain. The Royalty Transparency Act will allow more information to be seen by the public to ensure federal decision makers, and the policies they write, aren't being influenced by the royalty payments they receive."

SEN. RAND PAUL, M.D. (R-KY)

NIH Royalties

Fauci is among a group of National Institutes of Health (NIH) employees who earned undisclosed amounts in royalties for the mRNA vaccines.

Moderna admitted to making what it described as a "catch-up royalty payment of $400 million to the National Institute of Allergy and Infectious Diseases" in 2022. As part of the licensing agreement, Moderna said NIAID also would receive ongoing royalties on net sales of Moderna's vaccines, which brought in over $36 billion in revenue from 2020 to 2022.

Although NIH provided the names of royalty recipients from its various agencies, it did not specify the amounts paid to those individuals.

Civil Servant Fortunes

The notion of government regulators earning royalties from products they are charged with regulating raises ethical concerns regarding the objectivity of that regulation, a concept known as regulatory capture says John Dale Dunn, M.D., a physician, attorney, and policy advisor to The Heartland Institute, which co-publishes *Health Care News*. Fauci's career is a classic case of regulatory capture, says Dunn.

"What we appear to be witnessing in the mutual profit of these vaccine manufacturers and the regulators in charge of their oversight is the reciprocity end of the regulatory capture of the institutions meant to protect Americans from predatory pharmaceutical interests," said Dunn. "This is a classic case of the problem of corruption that comes when regulated industries buy influence with their regulators.

"It's just as bad in America as it is in the tinpot banana-republic dictatorship oligarchies of lesser nations," said Dunn.

Congressional Concerns

Congressional legislators have expressed concerns about the potential conflicts of interest. Sen. Rick Scott (R-FL) and Sen. Rand Paul, M.D. (R-KY) in March reintroduced a bill to improve transparency of royalty payments to government employees. In a press release announcing the bill, the lawmakers stated a lack of transparency prevents taxpayers from holding federal government personnel accountable for conflicts of interest and other abuses.

"Distrust in public health officials is at an all-time high," stated Paul. "One way to restore trust is to make sure that public policy isn't influenced by personal gain. The Royalty Transparency Act will allow more information to be seen by the public to ensure federal decision makers, and the policies they write, aren't being influenced by the royalty payments they receive."

Other potential conflicts of interest arise from the fact that one of the NIH watchdogs tasked with investigating agency employees like Fauci is Christine Grady—Fauci's wife.

Ethical Leeway

A doubling of the wealth of a public servant during a crisis that arises in his bailiwick is not necessarily proof of ethical violations, says medical ethicist Merrill Matthews, Ph.D., a resident scholar with the Institute for Policy Innovation.

"Fauci was considered by some to be the top infectious disease expert in the world, though COVID-19 destroyed that belief," said Matthews. "Most of the Open the Books criticisms are over how much money Fauci and his wife made. And while it may be unseemly, I don't know that it's unethical.

"I certainly think Fauci did a deplorable job handling COVID, and especially his involvement in gain of function," said Matthews. "But did he make unethical decisions or just bad decisions? I just don't think I know enough to publicly criticize him."

Gain of Function Prohibitions

After his contentious exchanges with Fauci, Paul introduced the Royalty Transparency Act in March 2024.

Fauci flatly denied involvement in the funding or facilitating of gain-of-function research, though his agency provided a grant as recently as 2022 to the EcoHealth Alliance to conduct research in conjunction with the Wuhan Institute of Virology, even though NIH found the organization out of compliance with the terms of earlier grants.

On October 13, 2022, Select Subcommittee on the Coronavirus Crisis Ranking Member Steve Scalise (R-LA), House Committee on Oversight and Reform Ranking Member James Comer (R-KY), and House Committee on the Judiciary Ranking Member Jim Jordan (R-OH) issued a scathing news release demanding answers regarding the grant.

"We have grave concerns that one of your last acts at NIAID is to send even more taxpayer dollars to an organization whose prior involvement in the very same subject may have contributed to a global pandemic," the lawmakers wrote in their 2022 letter. "We write seeking information about your decision, including whether anyone at NIH has a financial or other non-official interest in EcoHealth continuing to receive taxpayer funds."

In April, White Coat Waste Project, a public-health watchdog group, revealed the U.S. government had given EcoHealth a total of $60 million in funding since the pandemic.

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

Handout Helps Patients Determine Doctors' Independence

By AnneMarie Schieber

Patients often trust they are getting personalized advice from their health care providers, yet that is not always the case, a new consumer guidance sheet warns.

"Hospitals and health systems are quietly swallowing up private medical practices," states a handout published on April 3 by the Citizens' Council for Health Freedom (CCHF). "Once independent physicians are now controlled by corporate profit models, government programs, and insurance mandates."

The document, "Is Your Doctor Independent?" offers 12 questions patients can ask health care providers to help identify where their allegiances lie.

"[D]octors are told what treatments to offer, what words they can use, and which patients they can see," the handout states.

Doctors may have to follow certain protocols and may not be working in a patient's best interest, the document says.

"The tone and demeanor of the patient may determine the staff's willingness to answer. We always encourage [patients to be] kind but firm. As the handout indicates, current and prospective patients can ask one or more questions before they use the clinic or during their visit."

TWILA BRASE
COFOUNDER AND PRESIDENT
CITIZENS' COUNCIL FOR HEALTH FREEDOM

Patient Protection

The idea for the guidance sheet arose from a reader's inquiry.

"We received an email from a woman asking us how she would know if a clinic was independent," CCHF cofounder and president Twila Brase told *Health Care News*. "We saw her question as an opportunity to create a helpful handout for her and others. We believe it is the first of its kind. I have not seen another like it."

Brase says her organization offers several "Helpful Handouts," which are downloadable and free of charge. Patients can find them by going to CCHF's website, cchfreedom.org, and clicking on "Helpful Handouts."

The handout on doctors' independence suggests questions patients might not otherwise think to ask, such as, "Is my doctor required to use 'step therapy'?" a practice that directs providers to try the cheapest treatment before using one judged to be more effective.

Other questions concern treatment rationing; use of ivermectin and other drugs "off label"; whether the clinic accepts Medicare, Medicaid, or Obamacare payment; financial incentives to push one treatment over another; and privacy of medical records.

Confrontation Concerns

Patients may be reluctant to confront their health care providers, given how personal health care can be. Brase offers some advice on that.

"The tone and demeanor of the patient may determine the staff's willingness to answer," says Brase. "We always encourage [patients to be] kind but firm. As the handout indicates, current and prospective patients can ask one or more questions before they use the clinic or during their visit."

Defensiveness among caregivers can be a red flag, says Brase.

"The staff's willingness to answer one or more of these questions will be a testimony to their belief in full transparency," said Brase. "Every patient has a right to know whether the clinic or the doctor may have conflicts of interest with the patient due to third-party influence. Asking the questions may also put the doctor and clinic on notice in ways they've not been on notice before."

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

COMMENTARY

Best Way to End Medicaid Waste: Give Enrollees Cash

By Robert Koshnick, M.D.

In their paper titled "Leveraging the Medicaid Expansion," David Hyman and Charles Silver write, "We propose that rather than adhering to Medicaid's traditional structure, where states pay providers at unreasonably low rates for treating beneficiaries, expansion projects should be modeled on Social Security and the Earned Income Tax Credit, both of which distribute money that recipients can spend as they wish."

"This simple but fundamental design change would ameliorate or eliminate many of the major problems that existing third-party payment arrangements foster," Hyman and Silver write.

As of this publication, 10 states have opted out of Medicaid expansion because they foresaw how uncontrolled Medicaid spending could turn into a state budget nightmare. Giving people cash accounts in Medicaid could end the waste, fraud, and poor outcomes we witness in Medicaid today.

People who receive coverage through government plans have no reason to economize or seek the best value. The same can be said for people with private health plans. In fact, high premiums encourage more health care spending, which leads to a cat-and-mouse game between insurance providers and the policyholders, in the form of pre-authorization rules and benefit denials.

Defined Benefits, Not Costs

State legislatures should have the option to periodically deposit set amounts into recipients' health savings accounts (HSAs) to be accessed by debit cards. This would change the current "defined benefit plan" structure, with its unpredictable costs, to a defined contribution plan with set costs.

The federal government would match the contributions states put in the accounts, using the reimbursement formula used currently for Medicaid expansion states. Beneficiaries could use the funds to purchase catastrophic health insurance, join comprehensive care organizations, or pay directly for their medical care. Catastrophic coverage plus direct primary care "might be especially attractive to many consumers," the authors write.

Open-ended defined-benefit coverage that pays for not only catastrophic but almost all medical care services invites people to overuse services because they are disconnected from the costs. This is true of private insurance, Medicaid, and Medicare. Third-party payers increase the cost of care through burdensome regulations, pre-authorization rules, benefit denials, and price-setting, which skews the price of medical care services.

Cash accounts that people own, by contrast, incentivize people to purchase high-quality health care at market-driven prices. Health care spending and inflation would both decline.

Cash accounts are also an anti-poverty measure. Joseph V. Kennedy put it this way in his book *Ending Poverty*: "Ownership of resources is the path to a decent life free of poverty and dependency: a goal for all Americans." Cash accounts would give people ownership of their medical care resources.

Positive Incentives

Milton Friedman famously observed, "nobody spends somebody else's money as carefully as they spend their own."

People who receive coverage through government plans have no reason to economize or seek the best value. The same can be said for people with private health plans. In fact, high premiums encourage more health care spending, which leads to a cat-and-mouse game between insurance providers and the policyholders, in the form of pre-authorization rules and benefit denials.

Cash accounts incentivize people to economize and seek out the highest value. There would no longer be a need for finicky rules and oversight: people could serve as their own spending regulators. Naturally, health care spending would decline.

Hospitals and providers would no longer have to "cost shift" to cover bottom lines, because a free market would force them to provide services at the best possible price and focus on procedures that provide value.

Price Power

For cash accounts to be truly game-changing, there must be a system of price transparency. Markets cannot function without consumers knowing what a price is and determining whether it is worth it to them.

Several states and President Donald Trump, through his price transparency executive order, are making progress in this regard. Hospitals and other health care entities have been slow to provide this data in a machine-compatible way so app developers can use it to create consumer pricing tools.

People will economize and seek high value only when they are spending their own money. Today, nearly 90 percent of health care spending is done through a third party. If costs rise, third parties will increase premiums or, in the case of the government, borrow more money, take the money from another government service, increase taxes, or all the above.

Corporatization of Medicine

Another requirement for cash accounts to work their magic is the enforcement of corporate practice of medicine laws (CPOM). The HMO Act of 1973 allows corporations to make medical decisions and insure people without proper training and licenses.

Enforceable CPOM laws would restore the primacy of the physician-patient relationship and restore professional medical ethics rules that place patient interests before corporate profits. CPOM laws could be nationalized to prevent corporate entities from practicing medicine or employing physicians, with a professional medical corporation exception.

Unfortunately, the political power of the present medical rent seekers in the United States makes effective CPOM laws a pipedream.

HSA Freedom

The best hope for restoring a cost-effective medical market in the United States is for Congress to decouple HSAs from high-deductible health plans and allow everyone to have them. Congress should also increase contribution limits and remove some of the spending penalties.

As Friedrich Hayek wrote in his seminal book *The Road to Serfdom*, "By allowing millions of decision-makers to respond individually to freely determined prices, it allocates resources—labor, capital, and human ingenuity—in a manner that can't be mimicked by a central plan, however brilliant the central planner."

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

COMMENTARY

Medicaid Is Not a Test Lab for Foreign Price Controls

By Sally Pipes

In a desperate bid to claim fiscal discipline without touching entitlements, President Donald Trump is pushing congressional Republicans to adopt a "most favored nation" (MFN) drug pricing model for Medicaid.

This policy would tie Medicaid reimbursements to the lowest prices paid in other developed countries—countries where government officials dictate drug prices under threat of coercion, patent confiscation, or market exclusion.

Let's be clear: MFN is price fixing. It is not market reform. It is not a tough negotiating tactic. Republicans who fall for this scheme are abandoning any pretense of free-market principles.

The [most favored nation] proposal isn't tough on foreign freeloaders. It's soft on math, hostile to innovation, and blind to the realities of drug development. It would make Medicaid more expensive, less effective, and more dangerous, not just to patients but to the future of American medicine. The real solution isn't to copy the failures of other countries. It's to lead with principle—and reform.

Price Fixing Already Exists

Medicaid doesn't need price controls from other countries; it already imposes them here. Under the program's existing "Best Price" rule, manufacturers must offer Medicaid the lowest price they give to any other buyer, plus pay steep, mandatory rebates. The result? Medicaid receives average discounts exceeding 50 percent.

For many drugs, manufacturers are already forced to sell at a loss—what's euphemistically called a "negative price." That means the government not only takes the medicine, it also demands a cash payment for doing so. MFN would make this problem exponentially worse by anchoring Medicaid's drug pricing to markets where prices are dictated by bureaucratic fiat.

In practice, this could force companies to stop offering their drugs in Medicaid entirely. And thanks to federal law, exiting Medicaid also means forfeiting Medicare Part B coverage. One act of economic illiteracy would therefore sabotage both Medicaid and Medicare simultaneously.

Bad Example to Follow

MFN proponents like to frame the policy as a way to stop "foreign freeloading." But there's nothing tough or strategic about adopting the failed price-fixing systems of Europe or Canada.

International reference pricing is not a neutral benchmark. Countries like France and the UK don't "negotiate" prices—they dictate them. When manufacturers refuse, they are locked out of the market entirely and risk patent theft through compulsory licensing.

In Germany, a drug's price is set after one year based on whether a government board deems it "more effective" than existing options—a bureaucratic exercise so flawed that it regularly rejects FDA drugs that physicians consider groundbreaking.

Importing foreign price controls is not a clever budget tactic. It's surrendering to extortion.

Lost Innovation

Proponents of MFN like to gloss over its long-term effects. But we don't have to speculate about this: decades of data show what price controls do to innovation.

It costs over $2.6 billion to develop a new drug, largely because the failure rate is staggering; fewer than eight in 100 drugs that enter clinical trials ever reach patients. Yet more than two in three new medicines are developed in the United States because our system still allows innovators to earn a return on successful products. That incentive structure is precisely what MFN would destroy.

Another Twist: 340B

MFN would also deepen the dysfunction of the 340B program, a cronyist distortion of the drug market that has ballooned beyond its original mission and inflates costs for employers and taxpayers.

The 340B prices are pegged to Medicaid rebate formulas. Cut Medicaid prices through MFN, and 340B discounts expand automatically. That means hospitals and clinics participating in the program—most of which resell those discounted drugs to private insurers at massive markups—reap even larger windfalls.

Instead of doubling down on price controls, Republicans should get serious about structural Medicaid reform.

Better Cost-Cutting Options

Rep. Chip Roy (R-TX) and 19 of his House colleagues have outlined exactly the right approach: restore fiscal responsibility to Medicaid through block grants or per-capita caps, tighten eligibility verification, and align incentives with outcomes. Without serious reform, Medicaid's current trajectory will necessitate massive tax hikes and benefit cuts across the board.

That's the choice. It's either real reform now, or fiscal collapse and rationing later.

The MFN proposal isn't tough on foreign freeloaders. It's soft on math, hostile to innovation, and blind to the realities of drug development. It would make Medicaid more expensive, less effective, and more dangerous, not just to patients but to the future of American medicine.

The real solution isn't to copy the failures of other countries. It's to lead with principle—and reform.

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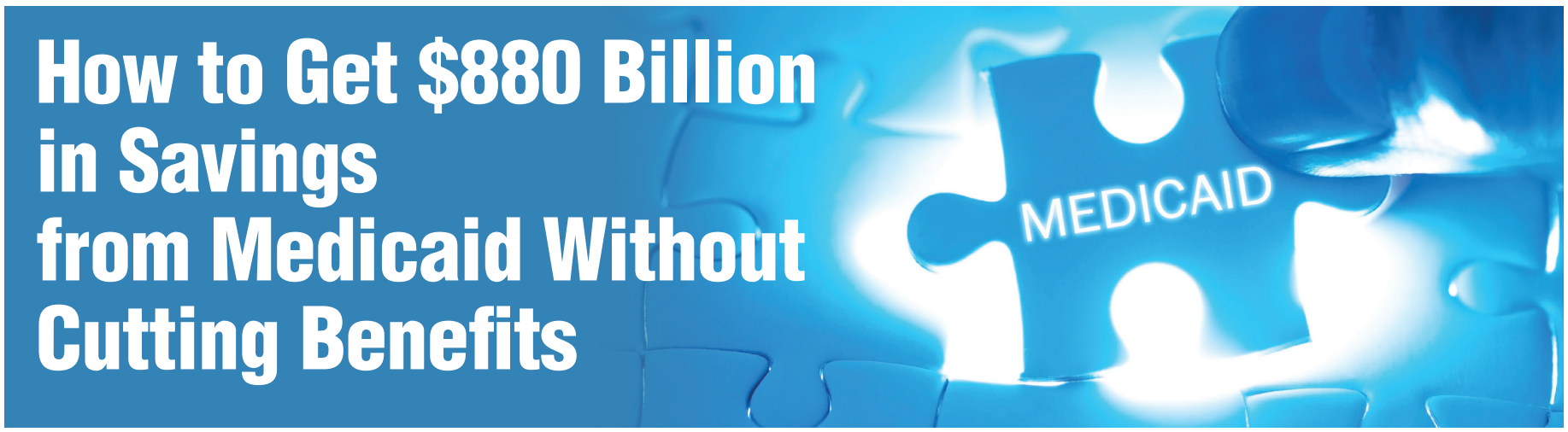
COMMENTARY

How to Get $880 Billion in Savings from Medicaid Without Cutting Benefits



By John C. Goodman

Of the following potential reforms, the first three would give Medicaid enrollees access to the same kind of care middle-income patients receive and save several hundred billion dollars in the process. Below are 12 reforms to supplement what I wrote in my *Forbes* column in March, "What Should Americans Do About Medicaid?"

Because the payment rates are so low, many doctors refuse to treat Medicaid patients. Among those who do, the Medicaid patient is the last they want to see. This is one reason why newly enrolled Medicaid patients increase their visits to the emergency room by 40 percent.

Parkland Hospital in Dallas (the city's safety-net hospital) tells the public online the average in-and-out time in their ER is almost six hours. And since Medicaid patients tend to be hourly employees, they lose a day's pay.

Of the following potential reforms, the first three would give Medicaid enrollees access to the same kind of care middle-income patients receive, and save several hundred billion dollars in the process. Below are 12 reforms to supplement what I wrote in my *Forbes* column in March, "What Should Americans Do About Medicaid?"

'Health Stamps'

Let people buy health care the way they buy food with food stamps.

If they go to a community health center or an ER, they pay Medicaid rates. 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 type of care that is now available only to other patients. This practice is currently illegal.

Roth HSA

Let enrollees have a Roth-style health savings account.

Medicaid-managed care insurers should be able to make deposits to HSAs, which can be designated for numerous purposes, including purchasing all primary care. Any money not spent can be withdrawn by the consumer for other purposes without taxes or penalties. This arrangement would be voluntary. It would be an opportunity, not a requirement.

Direct Primary Care

Let enrollees have access to direct primary care. This is 24/7 access along with a doctor's phone number. Medicaid could supply the funds, or let enrollees make monthly payments from their Roth HSAs. In all cases, they should be able to pay the market price so doctors will compete for their business. (DPC Cost in Wichita: $50 a month for a mother and $10 for a child.)

End Fraud

States must follow recommendations from the General Accounting Office (GAO) on eliminating fraud.

Over the past decade, CMS has made more than $1 trillion in improper payments: to the wrong person or entity, or for the wrong amount or the wrong reason. Many GAO recommendations have still not been implemented. One reform would be to conduct eligibility determinations more frequently.

Ban Insurer Taxes

California taxes insurers, gets a 60 percent match from the federal government for the tax, and then spends the money on government expansion, including medical care for illegal aliens.

Ban Provider Taxes

This provider tax is when states charge providers a tax and then pay it back to them after the federal government reimburses the state for the spending. As *The Wall Street Journal* explains, this is mainly money laundering. If the practice were ended, ten-year savings would be more than $600 billion, the Congressional Budget Office predicts.

Equalize Reimbursement

In expansion states, the federal government is paying 90 percent of the cost of able-bodied adults, versus an average of 60 percent for everyone else. Children appear to be the victims of these distorted incentives. Especially disabled children.

Reps. Chip Roy (R-TX) and Scott Fitzgerald (R-WI) introduced the "Ending Medicaid Discrimination Against the Most Vulnerable Act" on May 9, which would end this imbalance (see page 4).

End LTC Subsidies for the Wealthy

California has abolished the asset test for Medicaid long-term care. As a result, federal taxpayers are subsidizing care for wealthy Californians. Many states allow these loopholes, and because it is so easy for anyone to get subsidized nursing care, few people save for it.

End Double Dipping

Medicaid has a poor record of tracking enrollees who move to another state. Medicaid spent $4.3 billion over three years paying insurers for the same patient more than once.

Work Requirements

If people value Medicaid coverage, they will work to keep it. People tend to put less value on goods and services that are free.

Fewer than half of Medicaid recipients work enough to comply with a work requirement today. When people work, they earn incomes that make them eligible for other insurance and reduce their need for Medicaid.

Liberalize Practice Rules

Congress should require states to liberalize their medical practice statutes as a condition for participation in Medicaid. If nurses could practice to the top of their training, they would provide more care at lower cost. The same is true for foreign-trained physicians.

Offer Block Grants

State governments should have the option of receiving 90 percent of their federal Medicaid dollars in the form of a block grant, saving federal taxpayers the other 10 percent. With their share, the states could do some of the things discussed above.

For example, states could allow Roth HSAs outside the federal tax system. States could make deposits to these accounts and let enrollees pay market prices for their care.

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

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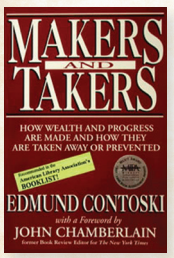

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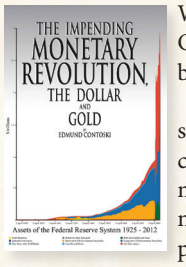

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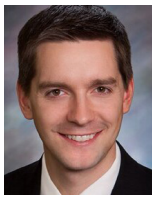

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