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HEALTH CARE NEWS

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The Pulse

Government Shutdown Exposes Obamacare's True Costs

By AnneMarie Schieber

The COVID-19 pandemic-era enhanced subsidies for Obamacare are set to expire on December 31, and members of Congress are at odds over whether to extend them.

On October 1, the federal government shut down as Democrats in the Senate refused to join Republicans to pass a continuing resolution (CR) bill to fund the government unless Republicans agreed to make the enhanced subsidies permanent. Republicans hold the majority in

GOV SHUTDOWN, p. 6

Hospitals Don't Meet Charity Requirements, Ways and Means Chairman Says

By Kevin Stone

U.S. hospitals receiving nearly $40 billion annually in federal and state tax benefits through their nonprofit status are failing to meet the mandated "community benefit standard," testimony at a House Ways and Means Committee hearing revealed.

Ways and Means chairman Jason Smith (R-MO) recounted key moments from the September 16 hearing in a news release.

"The generous benefits bestowed on tax-exempt hospitals come with an obligation on their part to provide charitable benefits to their communities,"

CHARITY REQ, p. 4

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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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Costco Selling Ozempic, Wegovy at Big Discount

By Harry Painter

The company that sells Ozempic and Wegovy, drugs known for promoting easy weight loss, is now selling the products at Costco.

Novo Nordisk, which manufactures the injectable-pen semaglutide drugs for type 2 diabetes and weight loss, said in October it is making the prescription drugs available at Costco pharmacies for $499 for a four-week supply. Costco's direct-to-consumer website and CVS and Walmart also sell the drugs for around that price.

The discount price is only for Costco members paying out of pocket. Members using insurance to purchase the drugs will have a different price that may vary depending on the insurance plan.

Novo Nordisk said it is making the discounted prescriptions available at more than 600 Costco pharmacies nationwide. In addition to treating diabetes and weight loss, GLP-1 drugs such as Ozempic and Wegovy have shown signs of improving outcomes for stroke risk, heart health, and liver disease.

"I was just shocked when I read that one in eight people have tried these drugs. They're fairly new. We don't know the long-term consequences. I would be afraid to take the drugs even if I had like 20 pounds to lose, because I'd be afraid that if I went off the drug, my weight would explode."

ANNEMARIE SCHIEBER
EDITOR, *HEALTH CARE NEWS*

Direct-Pay Benefits

The announcement could have a positive effect on public attitudes toward health insurance, as insurance companies have often blamed the cost of obesity drugs for rising premium prices, says *Health Care News* editor AnneMarie Schieber.

"So, [retailers] are going to sell [the drugs] for 500 bucks, which means that perhaps insurance companies and drug plans will say, 'No, we're not going to pay for this—you can pay for it. Five hundred dollars a month is affordable if you value it,'" said Schieber on the October 15 episode of the Heartland Daily Podcast.

The FDA originally approved semaglutide for diabetes in 2017. Doctors have been prescribing the drugs off-label as a treatment for obesity. A 2024 report from KFF found up to 13 percent of U.S. adults had taken a semaglutide, and 6 percent were taking them at the time of the survey.

"I was just shocked when I read that one in eight people have tried these drugs," said Schieber on the podcast. "They're fairly new. We don't know the long-term consequences. I would be afraid to take the drugs even if I had like 20 pounds to lose, because I'd be afraid that if I went off the drug, my weight would explode."

Schieber's cohost, health economist Devon Herrick, agreed.

"It is a great development—500, or 499 [dollars] a month is definitely a discount," said Herrick. "Some of these drugs have a price of, I don't know, like 1,200, 1,300 dollars a month, so yeah, that's a great deal. It's still expensive, but it's affordable to some degree."

More Use, More Information

If Ozempic and Wegovy become popular at the lower price, the drug makers will acquire more information about their effects, like a large clinical trial.

"Dosages vary," said Herrick. "A morbidly obese individual with diabetes would be on a different dose than someone who's just needing to lose some weight. I've written about saving money on drugs by, you know, using your brain."

Herrick has written about how increased competition and reduced regulation can make drugs more affordable.

Big Potential Market

Lower prices allow many more people to try the drugs and see if they work, says Herrick.

"Regular people that are just 30 pounds overweight, let's say," are an untapped market for drugs like Ozempic and Wegovy, said Herrick on the podcast.

"They're selling it for $500 for people who are presumably obese or wealthier or vain," said Herrick. "Why don't they [price] it where ordinary people can microdose it for, say, $100 a month? There's a huge market there."

People in this group could try different dosages, says Herrick.

"I'm wondering if you could buy one auto injector that had a large quantity and just microdose it, and make it last more than a month, maybe two months, three months," said Herrick.

"Maybe that's where they're going," said Herrick on the podcast. "Maybe this is a first step."

Other Potential Competition

Costco's price cut could spur greater competition in a market where there is high consumer demand, says Herrick, such as from Mounjaro (tirzepatide), another drug for treating type 2 diabetes and obesity.

"Hopefully, this move will translate into more consumer-friendly prices and options for a wider audience," said Herrick on the podcast.

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

Hospitals Don't Meet Charity Requirements, Ways and Means Chairman Says

Continued from page 1

said Smith. "Yet, we have data showing that from 2020 to 2022, over half of such hospitals got more in tax benefits than they invested in their community. In 2020 alone, the tax-exempt benefit was worth an estimated $28 billion, while the amount spent on charity care totaled more than $10 billion less."

Hospitals Define Giving

Hospitals overstate the amount of "community benefit" they provide, because clear guidance is lacking, the Government Accountability Office (GAO) says.

The Internal Revenue Service (IRS) "does not have authority to specify activities hospitals must undertake and makes determinations based on facts and circumstances," the GAO stated. "As a result, tax-exempt hospitals have broad latitude to determine the community benefits they provide, but the lack of clarity creates challenges for IRS in administering tax law."

In 2020, the GAO recommended Congress specify what constitutes a "community benefit."

"As of April 2023, Congress had not enacted such legislation," the GAO stated.

Industry Interests

The definition of community benefit has expanded to serve the hospital industry, not the community, says Linda Gorman, director of the Health Care Policy Center at the Independence Institute.

"The Hill-Burton Act of 1946 defined the community benefit as free care for those who could not pay," said Gorman. "This grew into providing uncompensated care, which includes care provided at a discount. By 2005, the GAO found that services such as parenting education, fitness, health screening, cash donations to community organizations, coordination of unspecified community events, and hospital facility and other infrastructure improvements were included."

The expansion of qualifications allows hospitals to use the exemption to their advantage, says Gorman.

"The definitional creep has turned community benefit spending into just another slush fund used for the benefit of the well-connected," said Gorman.

Mission Creep

Witnesses at the September 16 hearing testified hospitals have been straying from their core mission and moving into unrelated activities and initiatives.

"One of the reasons that this imbalance has grown so much is that increasingly hospitals don't see themselves as just health care providers, or even as hospitals," said William Hild, executive director of Consumers' Research. "In the report we put out, one of the common themes across all of the executive C-suites of these hospitals was that they only saw health care as part of their mission—or highlighting other things that they thought were core to their mission that a reasonable person would not consider part of providing health care.

"I think the mission creep of a lot of these hospitals getting into real estate investment, getting into DEI, getting into political activism, naming stadiums, this shows a lack of discipline in making sure that they stay within the health care provision," said Hild. "I think that's part of the issue is you have a massive mission creep."

"The culprit behind increasing concentration in the health sector is the reason the health sector is experiencing a bubble: excessive government intervention. Social engineering through the tax code, government subsidies, and regulations reward scale and encourage market concentration in health care."

MICHAEL CANNON
DIRECTOR, HEALTH POLICY STUDIES
CATO INSTITUTE

Social Activism

Hospitals are using tax exemptions, a taxpayer expense, to engage in activism, testified Stanley Goldfarb, M.D., chairman of Do No Harm, a health care policy organization.

"At Massachusetts General Hospital, administrators announced in April 2024 that they would scale back child neglect and abuse reports from mothers who test positive for drugs, because they feared that mandatory reporting was perpetuating what they called 'structural racism,'" said Goldfarb.

Goldfarb cited additional examples.

"Duke University Health System, which received over $1 billion in federal funding in fiscal year 2023 alone, was the subject of a federal rights complaint in March of this year for implementing race-based preferences in hiring and medical school admissions while promoting the notion that white males are 'agents of oppression,'" said Goldfarb.

"Corewell Health in Michigan required every employee to sign a pledge in support of DEI or risk termination," said Goldfarb. "Just two years ago, the Mayo Clinic pledged $100 million for indoctrination sessions about microaggressions and eliminating systemic biases and the supposed dangers of 'color blindness' and meritocracy."

Market Manipulation

Government wrongly uses tax policy to control markets, says Michael Cannon, director of health policy studies at the Cato Institute.

"The culprit behind increasing concentration in the health sector is the reason the health sector is experiencing a bubble: excessive government intervention," said Cannon. "Social engineering through the tax code, government subsidies, and regulations reward scale and encourage market concentration in health care.

"The purpose of a tax should be to raise revenue at the lowest possible cost," says Cannon. "Tax policy should not give the government the power to engage in social engineering or to interfere in the activities of private businesses."

Write-Downs as Community Benefit

Hospitals have expanded the definition of community benefit to include even accounting and billing matters, says Devon Herrick, a health care economist at the Goodman Institute Health Blog.

"Hospitals argue that they suffer a Medicaid shortfall that is a community benefit worth $41 million," said Herrick. "Some even want to add $26 billion in [patients'] bad debts to the so-called community benefit.

"Some analysists have found for-profit hospitals who pay taxes provide about as many community benefits as the nonprofits," said Herrick.

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

States Consider Dozens of Bills to Protect 340B Drug Price Subsidy Abuse

By AnneMarie Schieber

Lawmakers in states across the country are working through a spate of bills written to shield a growing source of revenue for large hospital systems and drug chains.

Congress created the 340B drug pricing program in 1992 to help a small set of safety-net hospitals purchase discounted prescription drugs from manufacturers by subsidizing purchases for low-income patients. Over the past 10 years, the program has expanded to become the nation's second largest purchaser of drugs, behind Medicare Part D.

"Profits from 340B markups now account for $66 billion—10% of brand medicine spending—and continue to grow unchecked," states the drug industry trade group, PhRMA.

An analysis by BRG, a consulting firm, funded by PhRMA, says 340B prices average 59 percent lower than list prices, and in some instances are as low as a penny per dose. Hospital systems can distribute the drugs at huge markups and have contracted with large drug chains to sell the discounted drugs at the retail level. The federal government does not require "covered entities" to prove the drug sales are serving the needy.

"The lack of accountability has allowed providers to bend the rules to benefit their bottom lines. 340B is an important factor in the explosive growth of the hospital industry, and why small mom-and-pop drug stores are going out of business. It's another example of how a government program robs Peter to pay Paul."

S. T. KARNICK
SENIOR FELLOW
THE HEARTLAND INSTITUTE

Powerful Backers

Lawmakers offered a flurry of state bills that would expand access to 340B money this year. Bills are working their way through state legislatures in multiple states, including Illinois, Kansas, Massachusetts, Michigan, and Ohio.

"In my experience, it is not a coincidence when you have 20 or so states all introduce some form of legislation, all around the same time in a 12- to 15-month period," said Cameron Sholty, director of government relations at Heartland Impact. "If you look at all the bills, they appear to have two things in common: they prohibit manufacturers from restricting drugs they want to include in the program, and any sharing of data."

Sholty, who testified in Ohio and submitted written testimony in Kansas on the issue, says it appears hospitals are behind the legislation.

"The One Big Beautiful Bill Act clipped the wings on Medicaid spending, and hospitals saw that as cutting into their revenue," said Sholty. "The hospitals may see 340B as a way to re-juice their revenues.

"Hospitals have more or less turned into arbitrage machines, buying up 340B-qualifying covered entities so they can purchase even more discounted drugs," said Sholty.

Surface Nobility

In legislative hearings, state lawmakers have raised concerns about rural hospitals' financial stability. According to the Cecil G. Sheps Center for Health Services Research, 195 rural hospitals have closed since 2005 in the United States.

"The legislators who support the 340B bills are bipartisan and appear to have the noblest of intentions regarding the bills," said Sholty. "They want to protect struggling rural hospitals, especially.

"However, the backers of the bills, the special-interest lobbyists, are likely driven by the massive profits the program generates for them," said Sholty.

The 340B program is fundamentally flawed and indefensible, says Sholty.

"In essence, it is a drug price control program which ultimately hurts all patients," said Sholty. "And its massive reach into so much of the drug market now raises antitrust questions.

"Let's face it: if the kind of collusion we're seeing between the hospitals and drug chains were happening in the oil and gas business, there would be congressional hearings," said Sholty.

Smoke and Mirrors

Two other special-interest groups that can profit big from 340B are the abortion and transgender medicine industries, says Sholty.

"Hospitals can use 340B to get around federal restrictions on that spending," said Sholty. "Money is fungible, and what they save in one area can be used to support something else."

The lack of transparency in the program has made it difficult for drug makers to figure out the real demand for their drugs.

"They're piloting a plane in cloud cover," said Sholty. "They don't have any data on how their drugs are being used and in what way. If the drugs are being used off-label, they have no way of knowing that, and for a drug company trying to determine efficacy, that would be helpful information. Data could also be useful if the drug company faced a lawsuit."

Federal Response Needed

States and hospitals are taking advantage of the federal government's inadequate disclosure requirements for 340B drug sales, says Sholty.

"Some of these state bills impose prohibitions on pharmacies and hospitals providing any sort of data on how the money is being spent," said Sholty. "States should stay away from this and let the federal government respond."

In August, the federal Health Resources & Services Administration announced a model pilot program that could provide more transparency. Drug makers whose products are listed in the CMS Medicare Drug Price Negotiation Selected Drug List would be eligible for the program, which would provide rebates to covered entities instead of off-the-top drug discounts. Rebates could enable the federal government to keep better track of where the drugs are being distributed.

"The lack of accountability has allowed providers to bend the rules to benefit their bottom lines," said S. T. Karnick, a senior fellow at The Heartland Institute, which co-publishes *Health Care News*, and author of the *Life, Liberty, Property* weekly e-newsletter. "340B is an important factor in the explosive growth of the hospital industry, and why small mom-and-pop drug stores are going out of business.

"It's another example of how a government program robs Peter to pay Paul," said Karnick.

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

Government Shutdown Exposes Obamacare's True Costs

Continued from page 1

the Senate but need seven Democrats to avoid a filibuster and pass bills.

Republicans say they want to negotiate Affordable Care Act (ACA) changes in separate legislation.

Open enrollment for plans on the health care exchanges began on November 1, and insurance companies indicated premiums for 2026 would increase by at least 15 percent.

The Congressional Budget Office estimates permanently extending the enhanced subsidies would raise the budget deficit by $350 billion over 10 years, not including billions of dollars in interest costs on the additional debt.

"With Covid-era subsidies, taxpayers are paying for 90 percent of the premiums charged in the [Obamacare] marketplace exchanges. If the subsidies are allowed to expire, the taxpayer share drops to 80 percent. That means the government is still paying the lion's share of the costs."

JOHN C. GOODMAN
PRESIDENT
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

Hidden Costs

Obamacare subsidies have long been a point of contention between Republicans and Democrats. During the pandemic, Congress, under Democrat control, extended the subsidies to allow households earning as much as $600,000 a year to qualify. The extension ends in 2025.

With subsidies, enrollees have limited exposure to the true costs of Obamacare plans. The government pays the subsidies directly to the insurance companies, and the insurance companies lower the monthly premiums and other out-of-pocket costs before they bill the policyholder.

"With Covid-era subsidies, taxpayers are paying for 90 percent of the premiums charged in the [Obamacare] marketplace exchanges," wrote John C. Goodman, president of the Goodman Institute and co-publisher of *Health Care News*, in *Forbes*. "If the subsidies are allowed to expire, the taxpayer share drops to 80 percent. That means the government is still paying the lion's share of the costs."

Obamacare Cliff

Since Congress enhanced the Obamacare subsidies in 2021, Obamacare enrollment has doubled from 12 million in 2021 to 24.32 million today, and the number of enrollees with incomes exceeding 400 percent of the federal poverty level has quadrupled to more than 1.5 million households, according to an analysis by the KFF research group.

Premiums for Obamacare plans vary widely, based on where an enrollee lives and the coverage level chosen (Bronze, Silver, Gold, Platinum, Copper). (For more on Copper plans, see story on page 19). Premiums can range from $1 to more than $1,000 a month, on top of co-pays and deductibles, reports *Nerdwallet*.

Insurers depend on lower-cost, younger, and healthier enrollees to balance out their risk pools. Such enrollees are likely to drop out of Obamacare if the premiums cost more than they would spend directly for health care. (See related article on indemnity insurance, pages 20 and 21).

Reform Opportunity

Health care reformers have advanced several proposals to address what they say are the fundamental problems with Obamacare.

In an October 1 op-ed in the *Washington Post*, Avik Roy of the Foundation for Research on Equal Opportunity suggested a bipartisan compromise that would reduce premiums for young people and directly fund premiums for people with preexisting conditions.

Michael Cannon of the Cato Institute wrote in *National Review* that the only "defensible" deal on Obamacare would be for Congress to make permanent "President Trump's biggest first-term health victory": a rule allowing consumers to buy short-term, limited duration insurance plans that last a full year and are renewable for three years beyond that. The Biden administration reversed that policy after Trump left office.

Political Timidity

Republicans backed themselves into a corner when they punted on the One Big Beautiful Bill Act (OBBBA), says Charles Silver, a professor at the University of Texas School of Law and coauthor of *Overcharged: Why Americans Pay Too Much for Health Care*.

"Personally, I believe that we would have seen more serious reforms in the OBBBA if they were going to happen at all," said Silver. "There was a golden opportunity for the GOP to really dig in and fix problems, but the party chickened out and made mostly adjustments around the edges."

Republicans avoid serious reforms because they fear losing power over the government, Silver says.

"The Democrats think that government can solve all problems if it just spends more money; Republicans claim to disagree but won't make any serious cuts because their main objective is to hold onto power, which they fear they will lose if they cut back on entitlements," said Silver.

"The best predictor of the future is the past," said Silver. "I don't see much changing until there is a financial crisis, at which point our elected representatives will likely enact 'reforms' that make things even worse."

Base Concerns

Both parties have dug in their heels on the enhanced subsidies, says HSA Coalition President Daniel Perrin.

"I think each party's base would have a great deal of difficulty, bordering on impossible, to compromise on the COVID-era ACA enhanced subsidies, for reasons other than the subsidies themselves," said Perrin.

"Republicans are resistant to rejecting the subsidies, [even while] knowing that ACA plans pay for abortion and transgender transition surgeries," says Herrin. "Those are not issues the GOP will be able to ignore, especially since the Charlie Kirk assassination and the mass shootings by transgender individuals."

Perrin says he believes the Democrats will vote to pass a clean CR bill and "use the COVID-era credits as a political issue in the midterms."

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

White House Announces Policies to Expand IVF, Fertility Treatment

By Bonner Russell Cohen

The Trump administration announced two initiatives it says will aggressively lower the costs of in vitro fertilization (IVF).

On October 16, President Donald Trump announced drugmaker EMD Serono would offer its fertility drug GONAL-F at a 73 percent discount or more, in line with the lowest price paid by other developed nations, known as most-favored-nation pricing. The drug will be offered directly to women through TrumpRx.gov.

The drugs represent about 20 percent of the total cost of a fertility treatment cycle, states the White House fact sheet.

Trump also announced a "New Benefit Option" in which employers will have a "new legal pathway," resembling supplemental plans for vision and dental coverage, to offer employees fertility treatments. Forty-two percent of employers provide coverage of fertility services, the announcement states. Employer-paid premiums for health insurance are exempt from federal income taxes.

The drug decision and benefit option were announced after the White House Policy Council delayed for months a list of policy recommendations to protect access to IVF.

President Donald Trump

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

Political Pushback

After Trump issued a February 18 executive order (EO), "Expanding Access to In Vitro Fertilization," Trump's political base, medical ethicists, and free market insurance advocates pushed back, saying the EO does not address the root causes of infertility, favors one remedy over others, and ignores the ethical and practical problems IVF can present.

In early August, *The Washington Post* reported the White House had no plans to require health insurers to cover the cost of IVF or to mandate coverage for people who acquire their health insurance on the Obamacare exchanges, citing anonymous sources.

The source told the *Post*, "while expanding IVF access remains a 'huge priority' for Trump, the president can't legally make IVF an essential health benefit without Congress first approving legislation to do so. It is unclear whether the administration plans to ask lawmakers to take up a bill, but the two people said that forcing insurance companies to cover IVF is not currently on the table."

Insurance Factor

Requiring health insurers to include expensive IVF treatments in their coverage could help offset the cost of the procedure, says Trump.

"Americans need reliable access to IVF and more affordable treatment options, as the cost per cycle can range from $12,000 to $25,000," the EO states.

IVF would have to be designated as an "essential health benefit" to be covered under the Affordable Care Act. Currently, individuals and couples write off some of the costs as a deductible medical expense on their taxes.

Ethical Cost

The procedure involves the fertilization of mature eggs in a lab, creating human embryos that may be destroyed in the process. Medical ethicists such as Mark Blocher, author of *Missional Medicine: Restoring the Soul of Medicine,* say the technology could open a floodgate of individuals who want to raise children outside the family.

The controversy over IVF puts the administration in a tough spot, says Jeff Stier, a senior fellow at the Consumer Choice Center.

"While there are understandable concerns by some in the 'pro-life' camp, IVF is, at its essence, a pro-family move," said Stier. "The administration should consider how broad-based guardrails could mitigate ethical concerns and have a net ethical benefit while still promoting American families."

Having insurance cover IVF forces people to subsidize the procedure for others, says Stier.

"It's hard to conceive a way out of the economic reality that if you squeeze the proverbial balloon in one place by requiring insurers to cover the expensive treatment, the costs will emerge through higher premiums," said Stier.

Conscience Disregard

The question of whether insurance companies, enrollees, or taxpayers should pay for IVF is a critical one, says Jane Orient, M.D., executive director of the Association of American Physicians and Surgeons.

"There is that moral question," said Orient. "Leaving that aside, there is also a dark side to IVF. Some embryos are chosen; others are deselected. They may be discarded, frozen indefinitely, or selectively aborted in the event of a multiple pregnancy.

"Of course, countless embryos perish naturally," said Orient. "Does it make a difference whether a human plays God and denies a chance at life to a being that is the 'wrong' sex or perceived to be defective? Is a designer baby industry a good thing?"

Health Dangers

IVF may endanger a mother's long-term health, says Orient.

"There are risks to egg harvesting," said Orient. "Dr. Jennifer Schneider has publicly raised questions because she lost her daughter, a three-time egg donor, to colon cancer at age 31. There has been no systematic study of long-term risk from the intense hormone stimulation."

To resolve the ethical concerns, aspiring parents can consider adoption or unused frozen eggs for which the donor gives up their property rights. In addition, prospective parents should consider prevention and cures, says Orient.

"Restorative reproduction health should be explored," said Orient. "Possibly scarred Fallopian tubes can be restored. Young women also need to think about prevention. Untreated asymptomatic chlamydia infection is the 'thief of fertility' and is very common in today's promiscuous culture.

"Should medicine draw a red line prohibiting intentional destruction of life, whether by 'assisted dying,' abortion, or deselecting embryos?" said Orient. "Government should not be funding such activities, the gateway to a brave new world."

"Restorative reproduction health should be explored. Possibly scarred Fallopian tubes can be restored. Young women also need to think about prevention. Untreated asymptomatic chlamydia infection is the 'thief of fertility' and is very common in today's promiscuous culture. Should medicine draw a red line prohibiting intentional destruction of life, whether by 'assisted dying,' abortion, or deselecting embryos? Government should not be funding such activities, the gateway to a brave new world."

JANE ORIENT, M.D.
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Bonner Russell Cohen, Ph.D., (**bonnercohen@comcast.net**) *is a senior policy analyst with the Committee for a Constructive Tomorrow.*

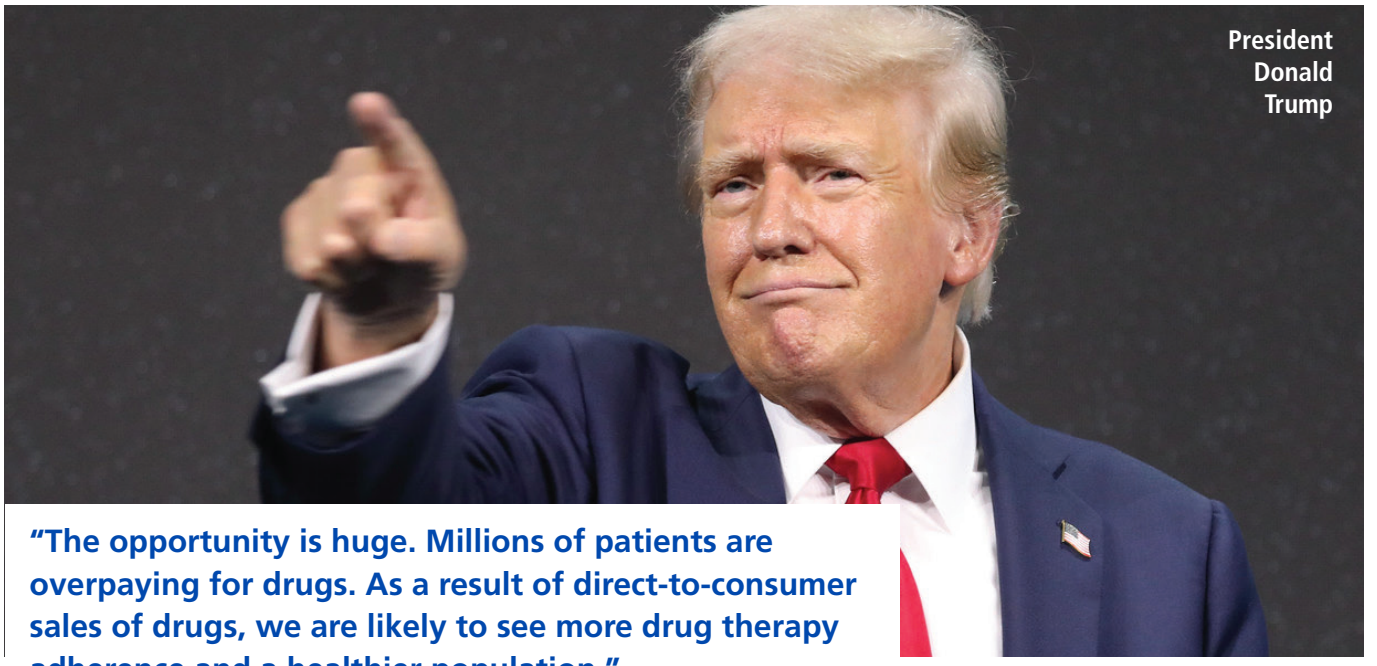
COMMENTARY

What Trump Gets Right About TrumpRX

By John C. Goodman

Donald Trump is the first American president to take an active interest in what is happening to patients when they buy drugs at a local pharmacy. Without any new legislation, private companies are responding.

Cigna Scripts, the nation's largest pharmacy benefit manager (PBM), just announced that for many of its clients it will end its rebate system and pass along negotiated drug price discounts to patients at the pharmacy. And a slew of private companies are offering to help employees get drugs for the cash price directly from pharmaceutical companies.



President Donald Trump

PHOTO COURTESY GAGE SKIDMORE/FLICKR.COM

"The opportunity is huge. Millions of patients are overpaying for drugs. As a result of direct-to-consumer sales of drugs, we are likely to see more drug therapy adherence and a healthier population."

JOHN C. GOODMAN
PRESIDENT
GOODMAN INSTITUTE FOR PUBLIC POLICY RESEARCH

Pharmacy List Prices

In Trump's first administration, a proposed regulation would have required the pharmacist to pass along any secret discount to the patient at the point of sale.

Unfortunately, Democrats in Congress delayed the effective date of that rule for 10 more years under the Inflation Reduction Act. The problem Trump was addressing was the little-known practice of basing the patient's out-of-pocket expense at the pharmacy on the drug's list price, which is generally much higher than the amount the insurer pays the pharmacy.

In his second administration, President Trump is advocating an even more radical idea: encourage patients to buy drugs directly from Pfizer, Eli Lilly, and other manufacturers. Right now, the price the drug manufacturer receives is often less than half the price patients and their health plans are paying.

Direct Sales

It appears a lot of money could be saved if drug companies advertised and sold directly to consumers (DTC) and if patients were encouraged to buy from the companies directly.

Under the rubric of TrumpRX, the president sounds as though he envisions the White House setting up its own pharmacy. That is not the plan. Instead, patients will be directed to discount pharmacies such as Mark Cuban's Cost Plus Drugs.

Cuban's business plan is simple. He acquires drugs at the manufacturer's cost, adds a 15 percent administration fee, and sells to patients.

But here is the problem: Cuban doesn't accept payment from insurance companies or from employers. He sells directly to patients. And that makes sense. The whole idea behind the direct-to-consumer arrangement is to bypass the insurers and pharmacy benefit managers who are pocketing big discounts they negotiate and not passing them on to patients.

Medicaid, PBM Incentives

Most people who have health insurance have insurance for drugs—either in an integrated plan or as a supplemental plan. Yet if pharmaceutical companies sell drugs to insurance companies or to self-insured employers, two problems arise.

The first problem is Medicaid. By law, drug companies must charge Medicaid the lowest price they sell to any other health plan. So, if an aggressive insurance company pressures a drug company to sell at a lower price, that reduces the price not only for the enrollees in that health plan, but it also affects 50 state Medicaid programs.

This restriction does not apply to sales to individuals, however. Unlike insurance companies or employers, drug companies can sell to an individual for any price without affecting their Medicaid revenues. That is why individual patients may be able to get better prices than a PBM like Cigna.

The second problem is incentives. PBMs have perverse incentives to discriminate against the sick in favor of the healthy. The "profit" they make when patients are overcharged at the pharmacy tends to get competed away in the form of lower premiums for drug insurance. Since most people are healthy and don't need expensive drugs, they prefer plans with low premiums without realizing that those premiums are made possible by the higher prices paid by the sick.

Solution: Private Accounts

A solution should overcome both problems.

There are three types of commonly used accounts where individuals have control over their own health care spending: health savings accounts (HSAs), flexible spending accounts (FSAs), and health reimbursement arrangements (HRAs).

In the first two, employees have a property right in the funds. Money not spent is theirs. When combined with high-deductible health insurance, these plans are ideal vehicles for purchasing generics and moderately priced drugs directly.

The accounts are not as useful for really expensive drugs, however. The annual limit on deposits is $4,300 for an HSA or $3,330 for an FSA. Employers can contribute to these accounts. But if an employer puts a dollar in the account of an employee who needs a drug, the employer must also put a dollar into the accounts of all the employees who don't need the drug.

Credit Card Workaround

HRAs are more promising. But since HRA funds belong to the employer rather than the employees, this appears to violate the conditions for a DTC sale.

Paydhealth is a Dallas firm that has found a way around that problem. Without going into a lot of technical details, the company satisfies all the legal requirements if the employee uses a special kind of credit card to pay the bill. Another company with a similar approach is RxSaveCard.

The opportunity is huge. Millions of patients are overpaying for drugs. As a result of direct-to-consumer sales of drugs, we are likely to see more drug therapy adherence and a healthier population.

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

Trump, Drug Companies Make Deal on Discounted Drugs Through TrumpRX

By Kevin Stone

American consumers will be able to buy discounted brand-name drugs through a government direct sales exchange called TrumpRX starting in early 2026.

The Trump team on October 16 announced an agreement with a drug maker to sell fertility drugs directly at a deep discount to lower the cost of in vitro fertilization treatments (see page 9). On October 10, the administration reached a deal with AstraZeneca, and on September 30 the Trump administration announced a deal with drug maker Pfizer to provide most-favored-nation (MFN) pricing for its drugs through TrumpRX to sell directly to consumers and state Medicaid programs.

Pfizer and AstraZeneca also pledged to spend at least $50 billion each in the United States for new manufacturing and research and development operations.

The agreements build on a May 12 executive order from President Trump directing the Secretary of Health and Human Services to propose a rulemaking plan to achieve MFN pricing on drugs sold in the United States.

Pfizer agreed to provide some of its most popular drugs on the platform at discounts of 50 to 100 percent.

Policy analysts writing at *Reason* magazine said drug makers have been overcharging U.S. consumers to subsidize drug discounts elsewhere in the world.

"An important step would be to reform patent law to prevent gaming the system such as by pharmaceutical companies creating patent thickets that artificially extend exclusivity. Trump should also make it a priority to streamline the approval process at the FDA to further boost competition."

DEVON HERRICK
HEALTH CARE ECONOMIST

Consumer Tradeoffs

The TrumpRX discount deals may involve a tradeoff for consumers, says Sally Pipes, president and chief executive officer of the Pacific Research Institute

"MFN pricing sacrifices access to cutting-edge drugs for lower prices," said Pipes. "That's not a tradeoff most Americans would accept. MFN imports the same price controls that have failed patients overseas.

"American patients gain access to revolutionary new therapies much sooner than European patients do," said Pipes. "In some cases, European patients never gain access to those therapies. Fewer than one in four new medicines between 2012 and 2021 debuted in Europe. By contrast, nearly 60 percent of medicines that hit the market during that decade launched in the United States."

Taxpayer Savings

It's not clear that consumers will get massive price reductions through MFN pricing, says Pipes.

"The administration's deals with Pfizer and AstraZeneca promise MFN pricing for state Medicaid programs," said Pipes. "By law, Medicaid already pays the lowest price available in the United States. Any savings here will flow to the government, not beneficiaries.

"Further, for many people with insurance, the cash price available through the administration's planned TrumpRx direct-to-consumer drug sales portal is unlikely to be lower than what they currently pay," said Pipes.

The deals are a "step in the right direction" but may not have much of an impact on most Americans," says Gregg Girvan, a health care research fellow at The Foundation for Research on Equal Opportunity.

"The two main components of the deals—MFN prices for Medicaid, and MFN prices for drugs purchased directly from the drug companies with TrumpRx as a conduit, without insurance—will change nothing for the half of the country on private insurance or the more than 69 million on Medicare. It won't make a difference for those on Medicaid either, since Medicaid recipients receive prescription drugs and pay nothing at the pharmacy counter."

Political Turnover

The drug discount deals may end up being only temporary, says Devon Herrick, a health care economist who posts on the Goodman Institute Health Blog.

"The problem is the possibility that Trump's drug deals won't long survive his presidency," said Herrick. "Agreements he negotiates through sheer force of personality may disintegrate when he's no longer around to enforce them."

Trade Deal Leverage

Although MFN pricing could lower drug prices for some consumers, policymakers can find better solutions that would last longer, says Pipes.

"Instead of importing foreign price controls, the Trump administration should leverage the power of trade policy and market forces to bring about lower drug prices in the United States," said Pipes. "University of Chicago economist Tomas Philipson has argued that the United States should press other wealthy nations to take on responsibility for a greater share of the global pharmaceutical research, and [Trump] could do something similar in the pharmaceutical market."

Costly Middlemen

Another solution to high drug prices is to eliminate middlemen along the drug distribution chain, says Pipes.

"Pharmacy benefit managers—who work with insurers to decide which drugs are covered and how much patients pay—take a huge cut of every dollar spent on drugs and distort the market," said Pipes. "PBMs' compensation is often calculated based on the 'discount' they can secure from a drug's list price. So, they have an incentive to favor high drug prices.

"Lawmakers should insist that PBMs be transparent about their business practices and pass along any discounts they secure to beneficiaries at the pharmacy counter," said Pipes.

MAHA Leverage

Focusing on MFN status to address health care costs may be misguided, says Girvan.

"The MAHA movement is squandering an incredible opportunity to make progress on the extremely high chronic disease burden in the United States, the vast majority of which existed before COVID, but instead is focusing on issues that animate the base with little impact," said Girvan.

Competition Measures

A better way to lower drug prices is to open the door for more competition, says Herrick.

"An important step would be to reform patent law to prevent gaming the system such as by pharmaceutical companies creating patent thickets that artificially extend exclusivity," said Herrick. "Trump should also make it a priority to streamline the approval process at the FDA to further boost competition."

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

Merck Leaves UK Over Fears of Drug Price Controls

By Bonner Russell Cohen

American pharmaceutical giant Merck announced the cancellation of a planned $1.3 billion research center in London and the termination of all research and development activities in the United Kingdom (UK).

The company said on September 10 its decision "reflects the challenges of the UK not making meaningful progress addressing the lack of investment in the life-science industry and the overall undervaluation of innovative medicines and vaccines by successive UK governments."

UK Out, U.S. In

Drug manufacturers have repeatedly warned UK policies, "including the process through which the [National Health Service] buys medicines, could compel them to devote their resources elsewhere, and even not launch their medicines in the country," *StatNews* reported.

Merck opened a $1 billion facility in North Carolina in March and is one of several major U.S. and foreign drug makers to announce multibillion-dollar investments in the United States in recent months. Others include Eli Lilly, GlaxoSmithKline, Johnson & Johnson, Novartis, Pfizer, Roche, and Sanofi.

Weeks after Merck said it would abandon its London operations, British drug maker AstraZeneca announced it would open a $4.5 billion manufacturing facility in Albermarle County, Virginia as part of a planned $50 billion investment in the United States the company unveiled in July.

"Today's groundbreaking demonstrates the Trump administration's commitment to onshoring drug manufacturing and strengthening supply chains to improve Americans' access to medications," said Dr. Mehmet Oz, administrator of the Centers for Medicare & Medicaid Services, in a statement. "I congratulate AstraZeneca for their investment and invite other manufacturers to follow suit."

Tariff Avoidance

In the past few months, drug makers have committed to spending more than $500 billion on new facilities in the United States, expected to generate "roughly $1.2 trillion in economic output and more than 100,000 new jobs, including 25,000 biopharmaceutical jobs," according to the industry trade group PhRMA, *The Washington Times* reported.

Alongside U.S. drug companies trying to make deals with the Trump administration, "Global drug makers are rushing to boost U.S. manufacturing and inventory as the Trump administration weighs a 100% tariff on imported branded and patented drugs," reports Reuters.

"Because building a factory takes years and most U.S. drugs are imported, the Trump administration has granted tariff exemptions to companies that commit to building drug-making facilities in America," reported Sara Eisen in *The Washington Post*.

Biden Price Controls

Though U.S. consumers benefit from hostile regulation in the UK and elsewhere in Europe, the U.S. pharmaceutical industry and American patients struggle under Washington's own heavy hand, says Sally Pipes, president and CEO of the Pacific Research Institute.

"Take the price-control scheme signed into law by former president Joe Biden as part of the 2022 Inflation Reduction Act (IRA)," Pipes wrote in *Newsmax*. "That policy allows the federal government to name its own price for a growing number of medicines paid for through Medicare. The first 10 drugs dispensed through the Part D prescription drug benefit will be hit with price caps in January 2026. Fifteen more will be subject to price controls beginning in 2027."

In 2029, the IRA drug policy will impose government price negotiation on 20 drugs, writes Pipes.

"As this price-control program unfolds, the U.S. drug market will come to resemble the UK's," Pipes wrote.

Trump Pricing Deals

Trump administration drug policies, notably most-favored nation (MFN) pricing deals (see article, page 9), also give government control over drug prices, writes Pipes.

"This proposal would force drug companies to sell their medicines to Americans at the lowest price available in any other nation," wrote Pipes. "The United Kingdom shows exactly what will happen under such price controls."

In addition, the 340B drug pricing program, which Congress created in 1992, compels drug makers to sell their prescription drugs at a discount, often to large hospital systems that receive excess profits on the lower prices (see article, page 5).

Homegrown Obstacles

Although Trump administration policies for "shoring up U.S.-based production, which is properly seen as a matter of public health and national security in a perilous world," are a welcome development, the president's team "must proceed with caution," says Jeff Stier, a senior fellow at the Consumer Choice Center.

"The Trump administration, which elsewhere stands up for free-market principles, must reverse course [on U.S. drug policies] and reject price controls for pharmaceuticals," said Stier.

"By advancing policies, including the Biden administration's Inflation Reduction Act price controls, the administration risks destroying the lifesaving innovation that only comes about when investors have reason to believe that a very risky investment could offer commercial returns. There's no use in bringing back the golden goose from overseas only to sacrifice it on socialist policies dressed up as populism."

Imported Side Effects

Letting the market determine prices has benefited the United States, says Jeremy Nighohossian, Ph.D., an economist and senior fellow at the Competitive Enterprise Institute.

"Pharmaceutical companies are investing and researching in the United States because this nation provides the freedom to innovate and reap the rewards of innovation," said Nighohossian. "The Trump administration's Most Favored Nation pricing policy, however, will replace that incentive with other countries' restrictive policies and import all the harmful side effects that Americans don't yet worry about."

"Pharmaceutical companies are investing and researching in the United States because this nation provides the freedom to innovate and reap the rewards of innovation. The Trump administration's Most Favored Nation pricing policy, however, will replace that incentive with other countries' restrictive policies and import all the harmful side effects that Americans don't yet worry about."

JEREMY NIGHOHOSSIAN, PH.D.
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FDA Approves New Generic Abortion Pills

By Harry Painter

The Food and Drug Administration (FDA) approved a generic version of the abortion pill mifepristone in October, making chemical abortions more affordable and accessible to pregnant women who wish to terminate the lives of their unborn children.

Mifepristone is used in two-thirds of American abortions, according to the pro-abortion Guttmacher Institute.

Republicans such as Sen. Josh Hawley and former Vice President Mike Pence criticized the HHS approval, arguing it undermines President Donald Trump's pro-life position and Health and Human Services Secretary Robert F. Kennedy Jr.'s previously stated intention to review the FDA's original approval of the name-brand version of the drug.

White House Press Secretary Karoline Leavitt said the government's approval of generics is "not an endorsement by any means."

Democrats and abortion advocates praised the HHS decision.

"Mifepristone has been associated with 36 deaths, thousands of serious adverse events, and hundreds of known, life-threatening complications based on post-marketing safety reports."

MICHELLE CRETELLA, M.D., AMERICAN COLLEGE OF PEDIATRICIANS

Prior Approval

The approval, made effective immediately, allows Evita Solutions, LLC to offer its drug on the basis that it is equivalent to the name brand Mifeprex, which is manufactured by Danco Laboratories, LLC.

Evita Solutions expects its version to reach the market in January 2026.

Trump approved the first generic version of mifepristone, manufactured by GenBioPro, in 2019. His administration had earlier rejected the drug, in 2018. The company had sent in its approval application in 2009, during President Barack Obama's first term.

Expected Expansion

"Chemical abortions with mifepristone account for over 63 percent of induced abortions in the United States," said Michelle Cretella, M.D., chair of the Adolescent Sexuality Council at the American College of Pediatricians. "We can expect that percentage to increase dramatically once cheaper generics become available, and more still should [Affordable Care Act] subsidies be renewed, making the abortion pill 'free' for some groups of patients."

The Affordable Care Act (ACA) subsidies, set to expire at the end of 2025, have been a point of contention in the abortion debate.

"Two of the three concerns of the GOP on the ACA enhanced subsidies—all ACA plans paying for abortion and for transgender transition surgeries and drug regimens—are not issues the GOP will be able to ignore, especially since the Charlie Kirk assassination and the mass shootings by transgender individuals," Daniel Perrin, president of the HSA Coalition, said on an email forum of health reform analysts.

Lowering costs, whether through generic mifepristone or by subsidizing the abortion pill, will harm women who choose abortion, says Cretella.

"This is bad news not only for the preborn children who will lose their lives, but also for the pregnant women who will take the pills and suffer associated adverse events up to and including death," said Cretella.

Adverse Reactions

Cretella cites an Ethics and Public Policy Center study released in May that prompted Kennedy to order a review of mifepristone that month.

"It has been reported that 11 percent of women suffer serious adverse reactions within 45 days of using the drug to induce an abortion," said Cretella. "Harms from mifepristone obtained without physician examination, ultrasound, and follow-up visit include nausea, vomiting, severe abdominal pain [and/or] cramping, incomplete abortion of preborn baby and placenta requiring surgery, infection, hemorrhage, and death."

Eight percent of women who use mifepristone experience serious hemorrhaging, bleeding for more than 30 days after mifepristone use, the study found.

"Death may be caused by overwhelming infection, hemorrhaging, or an undiagnosed ectopic pregnancy," said Cretella.

Ectopic pregnancies can go undiagnosed because the law does not require a doctor's visit and ultrasound before obtaining the abortion pill, says Cretella.

"Mifepristone has been associated with 36 deaths, thousands of serious adverse events, and hundreds of known, life-threatening complications based on post-marketing safety reports," said Cretella, citing FDA figures. "That's not accounting for weak state and federal reporting requirements, which means the numbers are drastically undercounted."

'All Is Not Lost'

The decision to approve another generic version of mifepristone is a setback for the protection of women and children, says Cretella.

"All is not lost, but I believe that we need to make our voices heard even louder," said Cretella. "Pro-life organizations must partner with 'Make America Healthy Again' to keep the pressure on Kennedy's HHS so that they follow through on their promised independent analysis of the abortion pill and evidence-based action."

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

Preexisting Conditions Strongly Affect Maternal Mortality: Report

By AnneMarie Schieber

Maternal mortality rates are on the rise for all races in the United States and are strongly affected by the health of a woman before she conceives, a Texas advisory committee to the U.S Commission on Civil Rights reports.

"The United States has one of the highest maternal mortality rates in the developed world, and Texas has one of the highest rates among the states," wrote Texas Advisory Committee Chair Merrill Matthews in the report's Executive Summary.

Maternal mortality rates are now at 17.6 deaths per 100,000, nationally, the report says.

Pregnancy-related mortality rates in Texas are highest for black women and Native American women. The rates are lowest among white and Hispanic women.

The Texas committee of liberal- and conservative-leaning volunteers gathered testimony from October 2024 to February 2025 and released the report on August 6.

"It is true that maternal mortality rates are too high in the United States, but it's always important to remember that overall statistics can paint a misleading picture. The U.S. counts maternal mortality in different ways than most other countries, so we should never take the claim that it is more dangerous to give birth than in other developed nations at face value.

PATRICK T. BROWN
ETHICS AND PUBLIC POLICY CENTER

Rise in White Mortality

Black women in Texas are three times more likely than their white counterparts to die during pregnancy or immediately after birth, but white mortality rates are closing the gap, states the report.

"The gap between Black and White maternal mortality rates has narrowed in recent years, but troublingly, this is due to increased maternal mortality rates among White mothers, not improvements in maternal mortality for Black mothers," the report notes.

Big Role of Chronic Illness

Health conditions before conception are a significant factor in the mortality rates, accounting for nearly 80 percent of the gap between black and white mothers, the report says.

"In Texas, one in three pregnant women suffers from chronic conditions such as diabetes, hypertension, nicotine addiction, and/or obesity," states the report. "When pregnancy occurs alongside these chronic illnesses, the likelihood of complications such as maternal morbidity or mortality significantly rises.

Obesity, hypertension, and diabetes are the most dangerous conditions for pregnant women, and they are more common among black women, the report states.

Violence, Mental Health Effects

Domestic violence and poor mental health are major causes of maternal mortality, the report states.

"Twenty-one percent of pregnancy-related deaths are from mental disorders, and 28 percent are due to violence, including suicide and homicide, often occurring in the postpartum period," the report states.

It is important for health care providers to screen mothers for depression and domestic violence through all stages of pregnancy and beyond, the report states.

Socioeconomic Factors

Other factors that may contribute to high maternal mortality include lack of transportation, child care, and healthcare access, the report states.

Texas has a large rural population, with 4.6 percent of pregnant women lacking access to a birthing facility within 30 minutes of home, the report states.

Postpartum care is an "essential part of addressing maternal mortality," the report states. The Texas legislature extended postpartum Medicaid coverage to 12 months after birth, starting in March 2024, though many mothers lack reliable transportation to take advantage of the care, the study states.

History of Mistrust

Lack of connection with the health care system is a strong driver of the nation's high maternal mortality rate, Matthews told *Health Care News*.

"Part of it has to do with U.S. racial history that has led some black women to mistrust the health care system," said Matthews. "And black mothers tend to have higher uninsured rates, which discourages accessing prenatal care. As a result, maternal mortality among black and native Americans can be three times that of white and Hispanic women, negatively affecting the U.S. average."

MAHA Limits

President Trump's Make America Healthy Again program is unlikely to lower maternal mortality rates without additional efforts, says Matthews.

"Concerns about food dyes and fluoride in the water are things higher-income people worry about," said Matthews." Low-income, pregnant women's primary challenge is access to affordable care, and I don't see [Health and Human Services] Secretary [Robert F.] Kennedy [Jr.] doing anything about that."

The most effective solutions may come from experimentation at the state level, "much as [Wisconsin and Oregon] experimented with welfare reform in the late 1980s and 90s," said Matthews. "Those efforts produced real results that the federal government later tried to imitate."

Focus on Root Causes

It is important to view the issue with a critical eye, says Patrick T. Brown, a scholar at the Ethics and Public Policy Center.

"It is true that maternal mortality rates are too high in the United States, but it's always important to remember that overall statistics can paint a misleading picture," said Brown. "The United States counts maternal mortality in different ways than most other countries, so we should never take the claim that it is more dangerous to give birth than in other developed nations at face value.

"That said, we know there are certain preconditions that make it riskier to have a baby: diabetes, obesity, high blood pressure, and other underlying conditions can raise the risk of pregnancy [complications] and have little to do with the process of giving birth," said Brown. "A concerted effort to address those, such as through better prenatal care and more focus on the root causes of poor health, will both improve outcomes for moms and babies and put the lie to the push that would use a 'crisis' in maternal mortality to advocate for legalized abortion."

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

INTERNET INFO

Merrill Matthews et al., "Racial Outcomes in Maternal Mortality," Texas Advisory Committee to the U.S. Commission on Civil Rights, September 2025: **https://www.usccr.gov/files/2025-09/tx-sac-report-on-maternal-mortality.pdf**

Florida Becomes First State to End Vaccine Mandates

By Ashley Bateman

Florida Surgeon General Joseph Ladapo, M.D., and Gov. Ron DeSantis are working with the legislature to end all vaccine mandates for schoolchildren in the state.

"The Florida Dept. of Health, in partnership with the governor, is going to be working to end all vaccine mandates in Florida law—all of them," Ladapo said to applause at a news conference on September 3. "Every last one of them is wrong and drips with disdain and slavery."

State lawmakers do not have the right to mandate vaccines and are "going to have to make decisions," said Ladapo. "People are going to have to choose a side. … People have a right to make their own decisions, informed decisions."

"The department initiated the rule change on September 3, 2025 and anticipates the rule change will not be effective for approximately 90 days," the state health department told the Associated Press (AP) in an email. Vaccine requirements "remain in place, unless updated through legislation," the department told AP.

Florida is not eliminating vaccine access but only mandates that force compliance.

Florida Gov. Ron DeSantis

Florida MAHA

DeSantis announced on September 3 a state-level Make American Healthy Again (MAHA) commission. Part of the commission's early actions will be to shape a "medical freedom package" for legislative approval. The proposal will address vaccine regulations.

In an *X* post, DeSantis lauded Florida as "the national model for medical freedom."

The commission will "recommend state-level integrations of MAHA principles and expanded protections for parental choice regarding childhood vaccines," wrote DeSantis.

States' Power

"This is a huge step forward in medical freedom," said Chris Downey, founder of VaxCalc, a website that evaluates and publicizes vaccine efficacy and safety.

"The states have the power to compel vaccination and to protect their citizens from that compulsion," said Downey. "The federal government only has that power when it declares a national emergency, and this power needs to be removed.

"We need more states to show by example that to live free requires courage," said Downey. "Forcing everybody to vaccinate according to a national schedule, or even statewide school mandates, shows a distinct lack of courage and a misunderstanding of health."

Disease Doom Predictions

Although the announcement called only for an end to vaccine mandates and no loss of access to vaccines, professional medical associations and politicians warned of disease outbreaks.

"This unprecedented rollback would undermine decades of public health progress and place children and communities at increased risk for diseases," said American Medical Association Trustee Sandra Adamson Fyhofer, M.D., in a September 3 statement. "While there is still time, we urge Florida to reconsider this change to help prevent a rise of infectious disease outbreaks that put health and lives at risk."

The American Academy of Pediatrics (AAP), which recently broke from tradition by opposing updated vaccination guidance by the new federal advisory panel on vaccines, said eliminating school vaccine mandates would endanger children's health.

"When everyone in a school is vaccinated, it's harder for diseases to spread, and easier for everyone to keep the fun and learning going," said AAP President Susan J. Kressly, M.D., FAAP, in a September 3 news release.

Idaho, Louisiana Reforms

Earlier this year, Idaho and Louisiana took steps to give families more vaccine freedom.

In July, Idaho enacted the "Idaho Medical Freedom Act," which prohibits vaccine mandates in some instances. Louisiana's surgeon general announced in February an end to the state's promotion of mass vaccination.

Lost Trust

Since the COVID-19 pandemic, parents have increasingly questioned vaccine mandates. Driving the skepticism is reduced confidence in vaccines' safety and effectiveness, says Downey.

"Most emails I receive from parents today equate 'pressure to vaccinate' with 'there is something wrong with these vaccines and this doctor wants us to do it too much,' [which is] not trustworthy," said Downey. "That's what they did with the experimental COVID shot. So now all pressure to vaccinate is highly suspect, unethical, unprofessional behavior.

"If you want to be trusted, you must first be trustworthy," Downey added. "During Covid, the [Centers for Disease Control and Prevention, CDC], public health officials, and doctors lost our trust by lying again and again and again. The CDC has lost all credibility. This has made vaccine mandates a soft target in red states."

Although most parents will continue to vaccinate their children, Downey predicts a significant decline in vaccine mandates within five years.

"There is an emerging public consensus that there are too many vaccines, given too soon, and that this is driven by profit, not by health," said Downey. "One of VaxCalc's most popular pages is an article that compares the CDC childhood schedule to Denmark's vaccine schedule and our very different health outcomes."

"I think we have an amazing opportunity here. If Florida can be the emboldened one to remove these mandates, then we can show the world. This legislative session, we should show up and show [legislators] that this is what the people want. In Florida right now, families who use a religious exemption still pay for everyone else's vaccines. The real issue is choice. Being bound to take a medical intervention to attend school is not freedom; it's coercion."

SUSAN SWEETIN
VACCINE FREEDOM ACTIVIST

Choice Example

Florida's openness to removing vaccine mandates shows why the state is attracting people, says vaccine freedom activist Susan Sweetin.

"I think we have an amazing opportunity here," said Sweetin. "If Florida can be the emboldened one to remove these mandates, then we can show the world. This legislative session, we should show up and show [legislators] that this is what the people want."

Giving people a choice is a matter of fairness, says Sweetin.

"In Florida right now, families who use a religious exemption still pay for everyone else's vaccines," said Sweetin. "The real issue is choice. Being bound to take a medical intervention to attend school is not freedom; it's coercion."

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

Trump Administration Gives Mixed Signals on Marijuana Market

By AnneMarie Schieber

The Trump administration has stalled in its effort to determine whether to reclassify marijuana from a Schedule I to a Schedule III drug, a new filing by the Drug Enforcement Administration (DEA) in an administrative law hearing acknowledges.

"This doesn't constitute a new delay of rescheduling's consideration, which has been stalled out for months after legal challenges to the administrative process were raised during prior proceedings," wrote reporter Kyle Jaeger for the online publication *Marijuana Moment* on October 7. "But it does signal that there hasn't been substantive movement between the parties with respect to the interlocutory appeal."

A hearing on reclassifying marijuana was scheduled to begin on January 21, 2025, but the administrative law judge for the hearing postponed it pending resolution of an appeal by an involved party.

'A Very Complicated Subject'

In an August 6 news conference, Trump said reclassification is "a very complicated subject" and that he had "heard great things" about medical marijuana but "bad things" about other uses.

In a November news conference, Trump said he supported Florida's medical marijuana ballot proposal and he would "continue to focus on research to unlock medical uses of marijuana to a schedule III drug, and work with Congress to pass commonsense laws."

As a Schedule I drug, marijuana is in the same category as heroin and LSD. If marijuana were designated as a Schedule III drug, cannabis businesses would no longer face certain tax penalties and would have better access to banking and investment capital.

High Abuse Potential Cited

On August 28, nine members of Congress wrote a letter to Attorney General Pam Bondi, copied to Trump, urging her not to reschedule marijuana to a Schedule III drug.

"Rescheduling marijuana would send a message to kids that marijuana is not harmful and allow Big Marijuana and foreign drug cartels to get billions per year in federal tax breaks," the nine Republican representatives wrote.

The drug schedule is not a "harm index" but a measure of potential abuse, the legislators wrote.

The effort to reclassify marijuana began under the Biden administration in 2024. A proposed rule generated 40,000 comments, and 11 state attorneys general spoke out against the change in a 40-page letter.

"Marijuana's potential for abuse is high; the addiction rate is a staggering 30%," states the attorney generals' letter. "One study suggests that as many as 30% of schizophrenia cases in young men might have been prevented if they had not abused marijuana. Another study found a clear association between marijuana use and psychosis, anxiety, cognitive failures, respiratory adverse events, cancer, cardiovascular outcomes and gastrointestinal disorders. Other research on the effects of marijuana found that marijuana use elevates the risk of heart attack and stroke by 25% and 42%, respectively."

Growing Use Identified

Marijuana use has skyrocketed, the Republican legislators say.

"In 1992, fewer than one million Americans used marijuana daily," states the letter. "In 2022, close to 18 million were daily users, outpacing daily alcohol use rates."

"Before changing the schedule classification, there should be a nonpartisan review of states that have legalized marijuana, to learn how outcomes and usage rates have changed," said Chad Savage, M.D., founder of YourChoice Direct Care and president of DPC Action.

Reading the tea leaves on Trump's marijuana position has been difficult, says John Dale Dunn, M.D., J.D., an emergency medicine physician in Texas.

"Trump is an alpha male and has all the characteristics, including an excess of ego and aggressive control characteristics that are sometimes balanced by his tendency to listen," said Dunn.

"I would say he needs to be concerned about the law-and-order implications of creating a segment of the population that is intoxicated a good share of the time," said Dunn. "Look at the turn for the worse in places that loosened up marijuana access, like Colorado: intoxicated drivers, street thugs juiced up and violent. Congress needs to get up and get noisy—he's listening too much to the stoner intellectuals."

Violence, Persistence Noted

Trump should be mindful of what is happening on American streets today, says Dunn.

"Lots of evidence shows that modern THC [the psychoactive compound in marijuana] is much more potent and intoxicating than the Jefferson Airplane/Grateful Dead days of the 60s, and it has a role in violent conduct that is becoming more apparent," said Dunn. "THC amplifies the intoxication for multi-drug abusers. Also, THC is a long-acting thing. It sticks around because it goes into [the user's] fat, so the potency effects are around for more than a few hours; they linger."

Recent reports show marijuana is becoming more popular than wine, beer, and spirits, says Dunn.

"There is nothing mysterious about it, as there is a lot of history in a culture that has multigenerational THC use, and they will, of course, always claim that THC is a preferred intoxicant to alcohol," said Dunn.

"This new stuff has a greater psych effect and is an invitation to more crime, violence, and use of stronger drugs of abuse, [which are] psych triggers like schizoaffective and schizophrenia," said Dunn. "The worst part is the half-life problem of THC. Use it tonight and you'll still feel it tomorrow."

"Lots of evidence shows that modern THC [the psychoactive compound in marijuana] is much more potent and intoxicating than the Jefferson Airplane/ Grateful Dead days of the '60s, and it has a role in violent conduct that is becoming more apparent. THC amplifies the intoxication for multi-drug abusers. Also, THC is a long-acting thing. It sticks around because it goes into [the user's] fat, so the potency effects are around for more than a few hours; they linger. There is nothing mysterious about it, as there is a lot of history in a culture that has multigenerational THC use, and they will, of course, always claim that THC is a preferred intoxicant to alcohol."

JOHN DALE DUNN, M.D., J.D.
EMERGENCY MEDICINE PHYSICIAN

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

MAHA Report Outlines Health Care Policy Changes

By Ashley Bateman

President Donald Trump's Make American Healthy Again (MAHA) Commission released its "strategy plan" to combat an epidemic of chronic disease among the nation's children.

The "Make Our Children Healthy Again Strategy" follows a less condensed draft version that was leaked to the media on August 18. The official version, released on September 9, includes 120 initiatives. The strategy outlines "targeted executive actions to advance gold-standard science, realign incentives, increase public awareness, and strengthen private-sector collaboration," a press release from the Department of Health and Human Services (HHS) states.

Trump called for the creation of a MAHA commission in a February 13 executive order, plus an assessment of the nation's health crisis with a focus on childhood chronic diseases. The commission released its assessment report on May 22.

"The MAHA Report provides a blueprint for the entire government to focus on solving the chronic disease crisis facing American children," said National Institutes of Health Director Jay Bhattacharya, M.D., in a news release on September 9. "We must make America healthy again so our children live longer and healthier lives than we will."

"The government should not create a 'unified set of data on all Americans.' Claims that it will maintain rigorous privacy and consent protections … cannot possibly be true. Medical information is widely shared every day because the so-called HIPAA privacy rule allows companies that hold our confidential data to share it without patient consent. So, either the administration doesn't know this, or the administration is trying to deceive the American people."

TWILA BRASE
PRESIDENT
CITIZENS' COUNCIL FOR HEALTH FREEDOM

Root Causes

The strategy report identifies four "potential drivers" of the increase in childhood disease that present actionable options for improvement: poor diet, chemical exposure, chronic stress and lack of physical activity, and overmedicalization.

The 19-page plan calls for increased research on nutrition, cumulative exposure to chemicals, autism, water quality, and commonly prescribed mental health drugs. Policy directives are to update dietary guidelines, advance policies to "limit or prohibit" petroleum-based food dyes, implement GRAS (Generally Recognized As Safe) reform, and enforce laws on direct-to-consumer drug advertising.

The commission plans to identify evidence gaps and evaluate peer review and publishing quality to improve scientific research standards.

New Focus

The commission's initial report in May focused much attention on ultra-processed foods. The summer draft and official version from September place more emphasis on the prescribing of pharmaceuticals to children.

The strategy plan calls for the development of a special working group to "evaluate prescription patterns for SSRIs, antipsychotics, stimulants, and other relevant drugs for children and evaluate the therapeutic harms and benefits of current diagnostic thresholds, overmedication trends, and evidence-based solutions that can be scaled-up to improve mental health."

Executive Force

Of the nearly 120 initiatives the report recommends, maybe 10 to 15 percent will get pushed through, says Ray March, a research fellow at the Independent Institute.

"The most actionable ones will have to pass through [executive order]," said March. Those would likely include nutritional labeling reform, food dye bans, and federally funded autism research, says March.

"I think in a lot of cases that's also where you'll see the pushback," said March. "The American Medical Association has entrenched interests in some regard, and they're pushing back against Trump and his executive orders."

HHS Restructuring

It will be interesting to see how the "compilation of facts, opinions, and priorities spanning across the nation, industry, and ages" and the "broad array of initiatives" will emerge as policies, says Twila Brase, president of the Citizens' Council for Health Freedom.

"The report will likely jumpstart discussions and action only if someone at the executive or legislative levels uses it as leverage to make changes," said Brase. "I expect certain items in the report—such as the chronic disease task force, the new Administration for a Healthy America [in HHS], and new research accountability and food guidelines—to appear soon."

Transparency Boost

The report calls for increased federal efforts by various public health agencies to improve transparency, including public reporting of research grants, tighter guardrails on HHS advisory committee member conflicts of interest, and establishing a public database disclosing financial relationships with industries they are entrusted to regulate.

Data Tangle

The strategy plan also calls for the development of a Real-World Data Platform by the NIH, linking multifaceted datasets "for researchers studying the causes of, and developing treatments for, the chronic disease crisis." The platform will "dramatically reduce administrative overhead, while maintaining privacy and consent protections," the plan states.

The plan also mentions the importance of data from electronic medical records, insurance claims, and wearable devices. This raises Fourth Amendment concerns, says Brase.

"The government should not create a 'unified set of data on all Americans,'" said Brase. "Claims that it will maintain rigorous privacy and consent protections … cannot possibly be true. Medical information is widely shared every day because the so-called HIPAA privacy rule allows companies that hold our confidential data to share it without patient consent. So, either the administration doesn't know this, or the administration is trying to deceive the American people."

Notable Absences

Several groups criticized Kennedy's removal and replacement of the Advisory Committee on Immunization Practices (ACIP) this spring, and his cancellation of nearly $500 million in mRNA research funding. The first meeting of the new ACIP panel on June 25 voted on three uncontroversial recommendations. mRNA was not mentioned in the report.

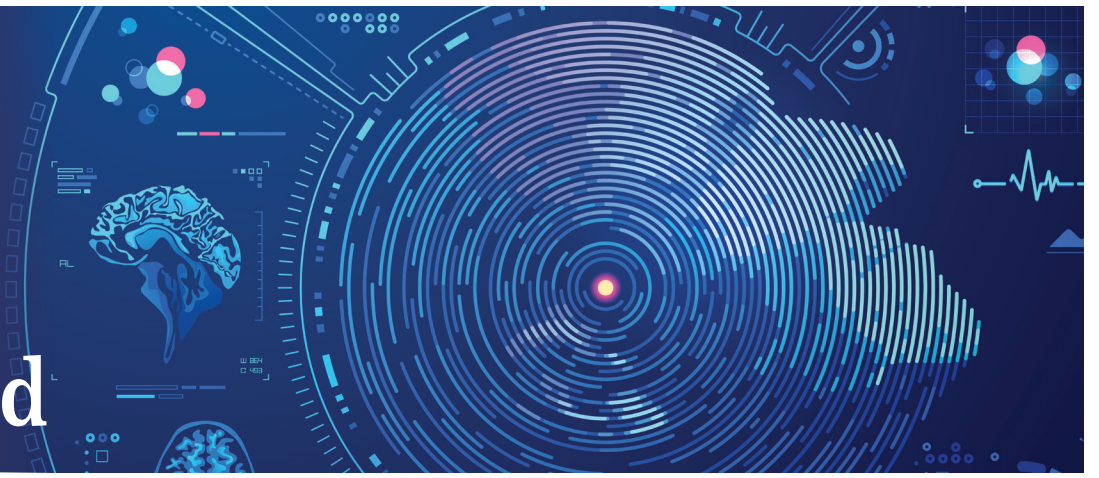
"The absence of any mention of mRNA and COVID vaccination in a report that claims to be about improving the health of children leads one to believe that political realities continue to trump real-world data," said Brase. "That said, the report's new vaccine injury research program may be an easier way for NIH Director Bhattacharya to attack the COVID shots without attacking President Trump's Operation Warp Speed."

The report has another gaping hole, says Brase.

"Nothing deals with the insurance industry's control of care and coverage, including the monopoly pricing enabled by the Affordable Care Act that confiscates family dollars that could otherwise be used for everything that makes you healthy, from food to exercise to time spent with loved ones," said Brase.

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

Federal Agencies Are Using Data Analytics to Stop Health Care Fraud



By Kenneth Artz

Health care fraud enforcement remains a top priority of the Trump administration, says a law firm specializing in False Claims Act and Whistleblower/Qui Tam Defense.

"All individuals and businesses working in any aspect of the health care field should pay close attention to the government's planned use of data analytics to spot anomalous billing," wrote Jonathan S. Ross on the website of law firm Maynard Nexsen on August 25.

The warning came after the Department of Justice, the U.S. Department of Health and Human Services Office of Inspector General (HHS-OIG), and other law enforcement agencies announced on June 30 criminal charges against 324 individuals who attempted to bilk the U.S. health care system of $14.6 billion in total, discovered through a joint investigation.

The previous record for a "National Health Care Fraud Takedown" was $6 billion, HHS-OIG stated. "Takedowns" are government-wide enforcement actions that have been done annually in recent years, writes Ross.

HHS-OIG, DOJ, the FBI, and other federal agencies will be setting up a "Health Fraud Data Fusion Center" to expand the use of data analytics to detect fraud more quickly, DOJ said in its news release about the criminal charges.

"Every administration claims it will crack down on Medicare and Medicaid fraud, but they barely scratch the surface. So, kudos to the Trump administration for going after the scammers. An aggressive, sustained effort could save taxpayers billions and eliminate one more reason for criminal gangs to infiltrate the country. An HHS inspector general's attorney told CBS at the time, 'Building a Medicare fraud scam is far safer than dealing in crack or stolen cars, and it's far more lucrative."

MERRILL MATTHEWS, PH.D., HEALTH CARE POLICY ANALYST

Patients Harmed

The indictments included 96 doctors, nurses, pharmacists, and other licensed professionals. The fraud cases spanned 50 federal districts and 12 state attorneys general offices, making it the largest coordinated health-care fraud action in U.S. history.

"The Criminal Division is intensely committed to rooting out health care fraud schemes and prosecuting the criminals who perpetrate them because these schemes: (1) often result in physical patient harm through medically unnecessary treatments or failure to provide the correct treatments; (2) contribute to our nationwide opioid epidemic and exacerbate controlled substance addiction; and (3) do all of that while stealing money hardworking Americans contribute to pay for the care of their elders and other vulnerable citizens," said Matthew R. Galeotti, head of the Justice Department's Criminal Division, in the June 30 news release.

Authorities seized more than $245 million in cash, fancy cars, cryptocurrency, and other assets on June 30. The U.S. Centers for Medicare and Medicaid Services (CMS) said it blocked more than $4 billion in fraudulent claims before they were paid.

Transnational Crime Operation

A key scheme known as "Operation Gold Rush" involved a transnational criminal network that acquired U.S. medical-supply companies using foreign straw owners. Once in place, the criminals used stolen identities and filed massive false claims for urinary catheters and other durable equipment.

Investigators used data analytics to detect billing anomalies.

Another scheme, in Arizona and Nevada, targeted elderly patients in hospice care. Medical companies applied "medically unnecessary" amniotic allografts to patients' wounds.

Some operations involved opioids and illegal clinics. In one case, five defendants associated with a Texas drug store illegally distributed more than three million opioid pills, which were later sold by street-level drug dealers.

Fake Test, Treatment Claims

Investigators also discovered fraudulent health claims for genetic testing and substance abuse treatment that were never given. In one scheme, a clinic with owners in Pakistan and the United Arab Emirates paid kickbacks to get patient referrals recruited from homeless populations and Native American reservations.

The indictments could lead to seizure of property and civil lawsuits brought by individuals. Authorities have filed civil claims against some of the defendants, reaching $34.3 million in settlements so far.

'Alien Thug-Parasites'

With more than $1 trillion in federal taxpayer money propping up health, disability, and welfare programs, it should be no surprise that thieves rush in, says John Dale Dunn, M.D., a Texas physician, attorney, and policy advisor to The Heartland Institute.

"These alien thug-parasites are smart enough to know how to rip off America," said Dunn. "They target housing, food, mental health, disability, and health care programs. Billions are billed as fake. The Department of Government Efficiency found it, and that's invaluable work."

Dunn says bureaucratic indifference is responsible for the thefts.

"The bureaucracies of the health care/welfare state are populated by incompetent and lazy people," said Dunn. "DOGE auditors found fraud by actually looking: auditing billing patterns, verifying identities, and matching claims to real services. Computers can do this easily."

The indifference of huge bureaucracies invites cheating, says Dunn.

"Bureaucrats are careless with taxpayer money because it isn't theirs, or they think it isn't," said Dunn. "That carelessness fuels the health care fraud crisis."

Theft Invitation

U.S. crime families recognized years ago that Medicare and Medicaid were easy fraud targets, and it was only a matter of time before foreign cartels moved in as well, says Merrill Matthews, Ph.D., a health care policy analyst and columnist for *The Hill*.

"Every administration claims it will crack down on Medicare and Medicaid fraud, but they barely scratch the surface," said Matthews. "So, kudos to the Trump administration for going after the scammers. An aggressive, sustained effort could save taxpayers billions and eliminate one more reason for criminal gangs to infiltrate the country."

Years ago, Medicare and Medicaid fraud schemes linked to the Mafia were a staple of investigations by CBS's *60 Minutes* news and commentary show, Matthews says.

"An HHS inspector general's attorney told CBS at the time, 'Building a Medicare fraud scam is far safer than dealing in crack or stolen cars, and it's far more lucrative,'" said Matthews.

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

COMMENTARY

Why Obamacare Led to a Government Shutdown

By John C. Goodman

People with Obamacare insurance aren't getting any more health care today than they did a decade ago, before the program was started. Yet the costs of the program keep soaring.

Democrats want more taxpayer dollars to pay for those costs. Republicans are resisting. Both parties should do the public a favor and consider sensible reforms instead of forcing taxpayers to continue throwing good money after bad.

Basic Design Flaw

The problem with Obamacare is not difficult to understand. The program was designed to force people to buy a product that few people would buy on their own if they had to pay the full price.

Originally, there was an individual mandate to buy the insurance, backed by fines for those who refused. Congress dropped the fines, but the government at various times has taken steps to try to prevent alternatives to Obamacare from being sold on the market or offered by employers.

Initially, Obamacare subsidies were available only for people with incomes up to 400 percent of the poverty level. But as costs kept rising, people not getting a subsidy (especially those who were healthy) began to abandon the market.

From 2016 to 2019, the unsubsidized part of the market was cut almost in half—exhibiting the characteristics of a "death spiral" in which soaring costs drive the healthy away and the remaining pool becomes sicker and more costly. Ever-higher premiums are needed to keep the program solvent, and as premiums rise, the healthiest of those remaining in the pool begin to leave, contributing to a never-ending cycle.

COVID Smokescreen

Democrats passed a second round of subsidies to keep the system afloat. Although these are often called "COVID era" subsidies, they had little to do with COVID. They were enacted to prevent the death spiral from destroying Obamacare completely.

Take a 50-year-old with an income of twice the federal poverty level (roughly the age and income of the average enrollee). From 2014 to 2020, the annual premium for this enrollee increased from about $4,500 to $8,000. With the COVID-era subsidies, government stepped in to pay almost all the increase in cost. This year, 93 percent of the premium is being paid by federal taxpayers.

Private Sector Superiority

So, what's the alternative? We should begin by recognizing that the way we treat health care is completely different from how we approach other essential goods and services, such as food, clothing, and shelter.

For these other necessities of life, we let the private sector meet all the needs it can, on the theory the market is generally superior to government in doing so. We establish a government-funded safety net for those needs that are socially important but unmet by the market.

Health care should be no different.

John C. Goodman, Ph.D., (**johngoodman@goodmaninstitute.org**) *is co-publisher of* Health Care News *and president and founder of the Goodman Institute for Public Policy Research.* *A version of this article was published in* Forbes *on October 14, 2025. Reprinted with permission.*

COMMENTARY

Democrats Fight to Extend Obamacare's Costly Middle-Class Subsidies

By Devon Herrick

Democrats in Congress have been desperately trying to keep Obamacare on life support. A recent scare tactic came from the Kaiser Family Foundation (KFF), which estimates Obamacare premiums will rise 114 percent if Congress and President Trump do not extend the so-called enhanced subsidies.

"In 2021, the American Rescue Plan Act, a pandemic relief law, temporarily increased the amount of the premium tax credit and expanded eligibility to households with an annual income of more than 400% of the federal poverty limit. (This includes a family of four with income of more than $128,600 in 2025, for example.)," CNBC stated on October 17.

One would have to dig deeper into the fine print to see what scenario KFF is referring to. Averages mean almost nothing: the subsidies and premiums vary with age, income, region, and the type of plan purchased.

Before the enhanced subsides went into effect, only the poor (who got generous subsidies) and the sick found Obamacare to be a fair value. The middle-class and upper-middle-class largely opted out of Obamacare because of the prohibitive cost and low value.

An Intentionally Bad Deal

Obamacare is a bad deal regardless of who pays the tab. And having taxpayers subsidize a bad deal to make it supposedly affordable distorts the market further and delays needed reform. The reality is that ACA marketplace plans are beneficial for less than 10 percent of those who have them.

The left-leaning Commonwealth Fund calculated about 90 percent of those with Obamacare plans do not surpass their deductibles. That suggests they would be no worse off financially if they were uninsured rather than enrolled in Obamacare.

In 2019, before COVID-19, 23 percent of enrollees did not file a claim during the plan year. After enhanced subsidies went into effect, that proportion increased to more than one-third (35 percent).

Obamacare was purposely designed to be a bad deal for most people. By most, I mean a bad deal for more than eight in 10 customers. In health care, there is what is known as the 80/20 rule. That is, 80 percent of costs are accrued by the sickest 20 percent of enrollees.

People purchase insurance in case they land among the unlucky 20 percent. Actuaries claim the sickest 20 percent are not the same every year, but sometimes they are. That is the whole point of Obamacare: to force healthy people to overpay every year by $5,000 to $7,000 so the sickest 5 percent of people can get coverage for the same price.

My (Bad) Experience

I had Obamacare for more than two years: 2022, 2023, and part of 2024. The combined premiums totaled nearly $20,000, of which Uncle Sam paid roughly $5,500. My out-of-pocket premiums were about $14,000.

During this 28-month period, I did not file a single claim. My first year, the insurance company's provider network was so bad the state of Texas asked the company not to participate in the Texas Marketplace the following year. I consulted with physicians a time or two, but none were in my network. I received some health care—a prescription and comprehensive blood tests each of those years—but I paid for it all out of pocket.

I know what you're thinking: insurance is best when you do not have to use it. That is true, and I do not worry that I am not getting my money's worth out of my auto, motorcycle, umbrella, and homeowner's insurance if I do not suffer a loss. The difference between my other insurance products and Obamacare is that all the other policies' combined cost is about half what an ACA plan will cost me next year.

"When 90 percent of customers are no worse off without your overpriced product, it is time to go back to the drawing board and design a better product. Let the enhanced subsidies expire. Without any subsidies, Obamacare would collapse under its own weight."

DEVON HERRICK
HEALTH-CARE ECONOMIST

Double the Cost

It is hard to estimate, but a low-quality health plan with 40 percent cost-sharing and deductibles of $8,000 to $9,000 for 28 months would probably cost no more than $4,000 if not for Obamacare regulations.

In round numbers, I threw $10,000 down an Obamacare rathole (and the government flushed an additional $5,500 on my behalf). That amounted to a $10,000 tax on my health that would have been better spent being added to my health savings account for future medical care.

Where did that $10,000 go?

Undoubtedly, it went to pad the health insurance company's profit margin. Health insurers would argue it was used to pay for someone else's medical care. Perhaps it went to pay for another patient's $2 million drug. However, the reason $2 million drugs exist is because Obamacare banned annual and lifetime caps on benefits.

When 90 percent of customers are no worse off without overpriced product, it is time to go back to the drawing board and design a better product. Let the enhanced subsidies expire. Without any subsidies, Obamacare would collapse under its own weight.

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

COMMENTARY

In Health Care, Copper Is the New Gold

By Chad Savage, M.D.

Since the Affordable Care Act (ACA) was enacted, Americans have faced soaring health insurance premiums, which have more than doubled since 2013.

Rising deductibles have compounded the problem, creating a double blow to affordability. Government subsidies, often touted as relief, merely mask this price inflation rather than addressing it, obscuring from consumers the true cost of care.

A lesser-known ACA option, Copper plans, could change this.

These bare-bones plans feature high deductibles but significantly lower premiums—20 percent to 30 percent less than Bronze plans and up to 60 percent less than Platinum plans. The premium savings are so profound that patients may more easily afford the high deductibles required by most ACA plans.

While Copper plans were previously little-used because of restrictions (such as for those aged 30-years or younger), the Trump administration's recent "hardship exemptions" now allow many Americans to purchase them during open enrollment for 2026.

High-Deductible Workaround

Like all ACA plans, Copper plans cover the 10 essential health benefits (e.g., preventive care, hospitalization, prescription drugs, maternity care) with no cost for preventive services and no denials for preexisting conditions.

Critics argue high deductibles may lead patients to delay care, potentially worsening health outcomes. However, pairing Copper plans with health savings accounts (HSAs) and direct primary care (DPC) mitigates this concern.

DPC practices operate on an insurance-free, subscription-based model, offering same- or next-day appointments, extended visits, and after-hours access without copays. Since DPC physicians are prepaid through memberships, patients can access care without worrying about deductible costs.

DPC providers handle about 80 percent of medical issues in-house, addressing most needs at no additional cost. For more complex issues requiring specialists, a DPC physician functions as a trusted advisor, reassuring the patient they have a situation justifying seeking care within the insurance context.

HSAs are tax-free investment accounts that can be used for medical expenses. The One Big Beautiful Bill Act (OBBB) clarified that HSAs can be used to cover DPC memberships. By doing so, the OBBB augmented the synergy between Copper plans and DPC by allowing tax-free HSA funds to be used for the already low-cost DPC memberships, which average $80 per month, making them even more affordable.

Fortunate Timing

The timing of these changes could not be better, as an HSA-linked Copper plan with DPC could function as a cost-effective, self-funded option for those affected by Medicaid reductions or in unsubsidized Obamacare plans. By making coverage more affordable, Copper plans can help patients avoid fickle government largesse and gain the confidence of self-sufficiency.

Policymakers could take these plans even further. Since ACA plans must include 10 essential health benefits—and direct primary care practices already provide many of them—ACA guidelines should be revised to allow Copper plans to integrate with DPC. This reform would let insurers exclude from premiums the benefits already covered by DPC, sparing consumers from paying twice for the same care. That would make coverage truly affordable.

Incentive Reform

Finally, the incentive structure for selling health insurance should change to minimize the incentive for insurance agents to oversell high-cost ACA plans and instead induce them to act more in a fiduciary role, ensuring the patient is truly getting the coverage best suited to his or her situation.

With these changes, a true transformation could occur within health care: fewer people dependent on the fractious governmental system while gaining the confidence that comes with quality, affordable health care and self-sufficiency.

Chad Savage, M.D., **(think@heartland.org)** *is a Heartland Institute policy advisor, founder of YourChoice Direct Care, Docs 4 Patient Care Foundation policy fellow, and the president of DPC Action. A version of this article appeared in* Red State. *Reprinted with permission.*

More Hospitals Drop Medicare Advantage

Thirty-three hospital systems are dropping their Medicare Advantage (MA) contracts at the end of the year, reports *Becker's Hospital Review*.

Citing contracts ending in 2025, Becker's listed 33 hospitals as becoming "out of network" for Medicare Advantage contracts.

The publication has been monitoring participation rates for several years. In 2024, 32 hospitals ended MA participation, the publication reported. In 2023, 13 hospitals ended their contracts.

The latest list includes the Rochester, Minnesota-based Mayo Clinic; Vanderbilt Health in Nashville, Tennessee; and Mass General Brigham in Somerville, Massachusetts.

"Among the most commonly cited reasons are excessive prior authorization denial rates and slow payments from insurers," wrote Jakob Emerson and Elizabeth Casolo for *Beckers*. The publication says its list is not exhaustive and researchers will continue to update it.

Saving Money

MA enrollees pay about $200 less per month in out-of-pocket costs than under fee-for-service Medicare, the Better Medicare Alliance stated in a letter to the Centers for Medicare and Medicaid Services in February 2025.

MA plans must scrupulously monitor hospital charges, says *Health Care News* co-publisher John C. Goodman.

"Because MA plans are managed by private companies, they have more incentive than the government to be more efficient in spending, something that hospitals may not like," said Goodman. "Ultimately, this saves taxpayers money."

Congress should give Medicare enrollees a more affordable option, says Citizens' Council for Health Freedom President Twila Brase, R.N., PHN.

"Allow enrollees to buy real, affordable, medical indemnity insurance, and allow seniors to drop out of Medicare if they wish to do so, without penalty," said Brase.

—Staff reports

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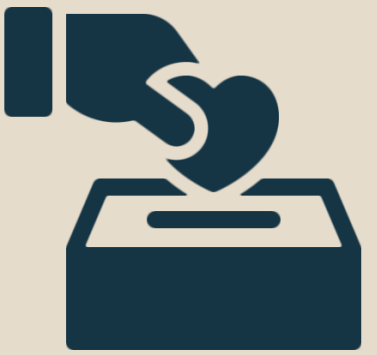

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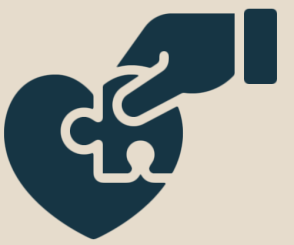
- Rewards over-treatment
- Forces subsidization of morally objectionable procedures



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COMMENTARY

Longing for the Days of Indemnity-Style Health Insurance

By AnneMarie Schieber

Obamacare plans have reached the edge of a cliff. The U.S. government has shut down because Democrats and Republicans disagree on how much taxpayers should subsidize premiums.

Health care is a service, not an entitlement, so why should taxpayers have to support any of it, except for the neediest? Does the government help Americans pay for other costly items, such as a home purchase, rent, or tuition? Does it subsidize auto, life, or homeowner's insurance?

"Insurance" is a contract between an individual or business to protect a person from financial loss due to an unexpected event such as an accident, illness, or natural disaster. Taking care of one's health throughout life is not "unexpected." The idea that we need insurance to pay for routine health care is not because health events are unexpected but because health care today is cost-prohibitive to many people. We can thank government meddling for that.

Heavy Government Control

The U.S. government controls 84 percent of the nation's health care spending, just behind the level of Cuba, writes Cato Institute health policy director Michael Cannon in *National Affairs*.

"In fact, government controls a larger share of health spending in the United States than in 27 out of 38 OECD-member nations, including the United Kingdom (83%) and Canada (73%), each of which has an explicitly socialized health-care system."

Payment Plan Distortions

The Affordable Care Act (Obamacare) redefined insurance. In the Obamacare era, health insurance isn't necessarily "risk mitigation" but a "payment plan" designed to pay for services most people in past years could afford to pay out of pocket.

In a direct-pay system, consumers continually determine the value of products or services. When a "payment plan" or other third party pays the bill, the consumer is unaware of the cost. With costly health plans such as Obamacare, consumers say "yes" for reasons other than the value of the service, such as whether they are getting their money's worth from the health insurance premium they pay each month.

When consumers utilize health insurance for services of questionable value to them, it drives up costs for everyone. Suddenly, there are not enough health professionals to service that artificial demand. The prices of diagnostics, imaging, pharmaceuticals, and other services all rise.

Indemnity Advantages

A graph on the Association of American Physicians and Surgeons (AAPS) website shows health insurance premiums increased by 297 percent from 2000 to 2024.

"True health insurance, which reimburses the subscriber—not the provider—according to the terms of the contract (as through an indemnity table), has practically vanished," writes AAPS. "Such insurance covers only unpredictable catastrophic costs, not routine or known costs. It does not "manage" care, but just pays bills, like other casualty insurance. Premiums are based on risks, as calculated by actuaries."

This is known as indemnity-style insurance. With indemnity insurance, consumers choose the coverage amount and length of term, similar to term life insurance policies, which are quite affordable when people buy them when they are young and relatively healthy.

Indemnity policies can address many of the health care complaints heard universally today, says Twila Brase, R.N., president and cofounder of the Citizens' Council for Health Freedom.

"When there were indemnity plans, there was no quibbling, no prior authorization, no post-treatment denials of payment, no corporate protocols controlling physicians and medical decisions," said Brase. "Many people forget what real health insurance is and how inexpensive it used to be."

Limited Options

With Obamacare having upended the health insurance market, it is nearly impossible to find an indemnity-style health insurance plan today. Many of those you might find are only "supplemental," meaning you are required to have a health insurance plan to cover most of your health care bills.

Consumers can couple true indemnity plans and pay directly for primary care through the direct primary care (DPC), model, a low-cost, non-insurance membership service that provides unlimited primary care.

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This arrangement may not work for the small percentage of people with significant disabilities. In that case, states could go back to the systems they had in place for that population before Obamacare went into effect, known as "insurers of last resort," or "reinsurance," which states funded in a variety ways, like a catastrophic claims program for auto insurance.

"Many of us get sick, old, or unlucky. Over a lifetime, such events happen infrequently. Insurance companies have to be solvent to keep offering coverage. It is almost impossible to provide affordable coverage when people can jump on plans when they need them and not have to pay premiums otherwise, which is what Obamacare allows. I believe consumers would love to have lifelong coverage and buy it over a lifetime if the plan is affordable. Indemnity plans do that."

ANNEMARIE SCHIEBER
MANAGING EDITOR
HEALTH CARE NEWS

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Many of us get sick, or unlucky. Over a lifetime, such events happen infrequently. Insurance companies have to be solvent to keep offering coverage. It is almost impossible to provide affordable coverage when people can jump on plans when they need them and not have to pay premiums otherwise, which is what Obamacare allows.

I believe consumers would love to have lifelong coverage and buy it over a lifetime if the plan is affordable. Indemnity plans do that.

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

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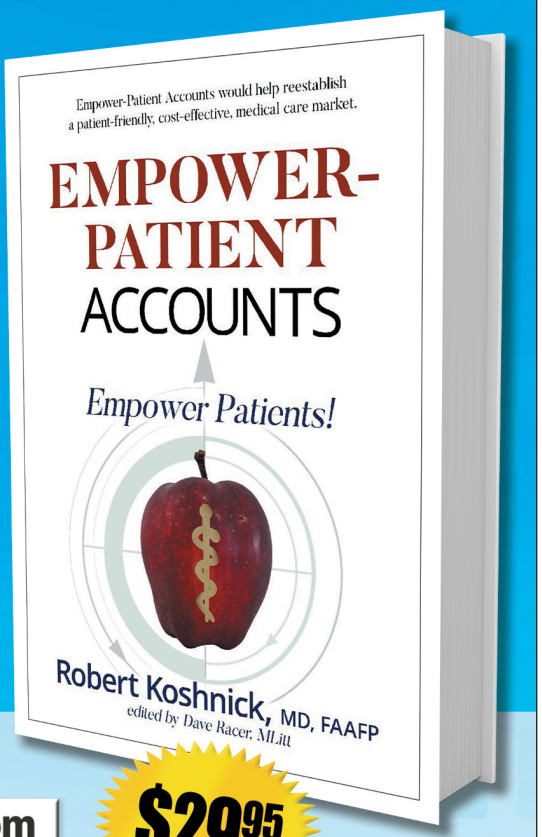

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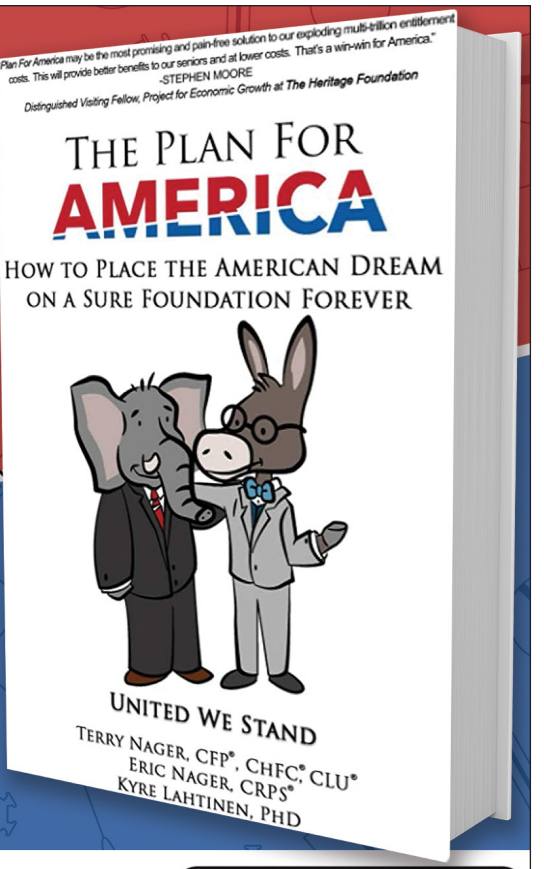

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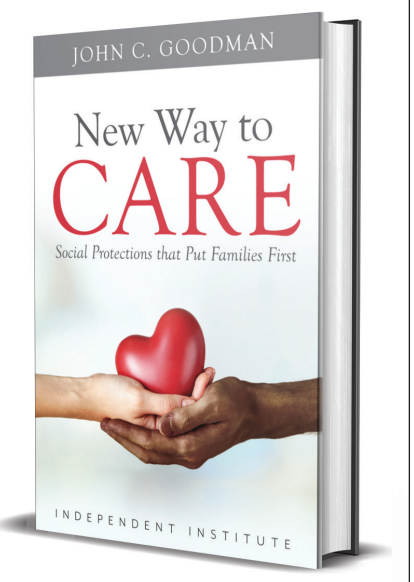

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