from obtaining subsidized coverage in the ACA marketplaces, and refugees, asylees, and some other groups will no longer be eligible for Medicare, Medicaid, or subsidized marketplace coverage — which makes their coverage options extremely limited. Some states are also including provisions in their H.R.1-implementation bills for referring Medicaid applicants or beneficiaries to the Department of Homeland Security, which may stoke fear and increase care avoidance among immigrant families. But under the Immigrant Children's Health Improvement Act, which most states have adopted, lawfully present children and pregnant women can retain access to Medicaid and CHIP without the usual 5-year waiting period.

H.R.1 resurrects the notion of the "deserving poor" and incites fear that people will cheat to get benefits (malinger). These beliefs operate to the detriment of millions of people who are legally eligible for Medicaid but may be unable to document their compliance with the new requirements. Evidence shows that work requirements neither cause more people to work nor shift them into commercial health insurance; people simply become uninsured.[5] These effects cannot be limited to the expansion population; such surgical exclusion is impossible, since many prospective enrollees will be confused about the new rules and timelines. Much of the resulting chaos will not be apparent until after the November midterm elections.

Congress's desire to increase employment and self-sufficiency may result in the opposite, removing the only source of health insurance coverage for low-income people and, paradoxically, making it harder for them to maintain employment. Neither legislators nor CMS appear to have considered the predictable effects on health care providers, but H.R.1 will soon once again demonstrate that law is a determinant of health for patients and physicians alike. And as the new regulations place doctors and patients in direct conflict, patient care will certainly suffer.

Disclosure forms provided by the authors are available at NEJM.org.

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What I See before Anyone Speaks

Robert B. Shpiner, M.D.[1]

There is a moment, before the conversation begins, when I know what I'm facing. It's in the eyes — a quality of withdrawal that arrives before the first question, before I've opened my mouth. The absence of a thing that used to be there: a provisional, fragile willingness to cross the distance between what a family knows and what I know.

Physicians rarely recognize trust as a clinical instrument, but that's what it is: the precondition for informed consent, for shared decision making, for the moment when a family allows a physician to do what needs to be done. I have spent more than 40 years in intensive care units at the University of California, Los Angeles (UCLA), and I've watched that instrument degrade. The degradation is not theoretical. I see it manifesting with increasing frequency, in my neurocritical care unit at Ronald Reagan UCLA Medical Center.

Earlier this year, a daughter said to our team and me, as we kept her mother alive, "We don't trust you." Not "I" — "we." The word carried the weight of something decided before she arrived, a conclusion imported into the room from somewhere I could not reach. No one filed an incident report about the remark. No camera recorded it. But such moments are becoming a common pattern in hospitals throughout the United States, as surveys of public trust in medicine suggest.

The data confirm what I see at the bedside. In a 2025 study of

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more than 5 million births, researchers at the Children's Hospital of Philadelphia found that the proportion of newborns not receiving vitamin K prophylaxis — not a vaccine, a naturally occurring vitamin that has been used since 1961 to prevent hemorrhagic disease of the newborn — increased from 2.9 to 5.2% between 2017 and 2024.[1] Preliminary data suggest that parents who decline vitamin K are substantially more likely to also decline hepatitis B vaccination and neonatal eye prophylaxis — the refusals generalize.[2] In Idaho, pediatricians have reported multiple infant deaths from vitamin K deficiency bleeding in the past year alone.[3] Between January and early April 2026, measles — declared eliminated in the United States in 2000 — had infected more than 1500 Americans, nearly all of them unvaccinated.[4] I read the news the way I read a chest x-ray, looking for the pattern underneath the individual finding, and this pattern's repetition is accelerating.

I was an intern at UCLA in 1981 when the first patients with what would become AIDS appeared on our wards. We had no treatment. The only thing we had was the ability to stand in a room, say we didn't know, and be believed. That trust was not incidental to our clinical response. It *was* the clinical response — the bridge between what we could offer, which was almost nothing, and what a patient could accept. It carried us through the worst epidemic of our professional lives.

I am watching that bridge erode. Not from the inside — not from the accumulated failures of medicine, though those are real and must not be minimized — but from the outside, by a continual undermining of the credibility on which clinical relationships depend. And yet the forces driving that erosion will not be standing in the room when a parent refuses the injection that would have prevented her infant from bleeding into his brain.

I know how to treat what comes through my door. I have done it for 40 years. What I do not know how to treat is the erosion of the condition that makes treatment possible. Trust, once lost at this scale, is not recoverable within a single policy cycle. It is barely recoverable within a generation. And the people who will pay for its loss are not the ones who set it in motion, but the ones in the beds.

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Perspective Roundtable: Examining the Use of Race in Clinical Algorithms



Many clinical algorithms and guidelines have long incorporated race, perpetuating the notion that race is a biologic variable and leading to harm for patients from marginalized groups. In this Perspective Roundtable, supported by the Doris Duke Foundation, Helen Burstin talks with Felicity Enders, Sean Levy, Shazia Siddique, and Joseph Wright about efforts to revise these tools to make care more equitable and about persistent barriers to change and opportunities for continued learning in this area.

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