



“We can’t talk about it around here” *Why Social Security issues are so sensitive*

By Merle Herr

If you care about mutual aid and economic issues, then you hold a vital conviction about how the church should care for members’ medical and alms needs. Let’s cut to the chase and clarify the issues. Historically, Anabaptists have always held mutual aid as a central expression of their faith. When hardship hits, our faith is expressed by humbly being our brother’s keeper. Even Christian Protestants and Catholics know that Anabaptists help each other in radical ways. The picture of an Amish barn raising is iconic. My own family felt this powerful expression of aid with a fire in 1984 which destroyed four barns. For two months, work crews came from multiple states; hundreds of people offered voluntary labor to rebuild all four barns. This made a vivid impression on my young heart, and mutual aid became riveted in my soul.

Anabaptist Brotherhood does not cover fire, storm, or theft; other Anabaptist mutual aid organizations do. Instead, Brotherhood’s mission is bodily mutual aid—medical and alms assistance. Similarly, the government has its own version of aid—Social Security. It covers the same four needs: medical, widows, disabilities, and low-income. Medicare handles the medical, and Medicaid handles the rest.

So why are Social Security issues so sensitive? And why can’t we talk about them? The title of this article is a quote from a minister responding to his church’s Social Security problems, especially the exemption. It was an honest admittance; he shrugged his shoulders with resignation. As with any deep problem, if it seems unsolvable, we lose hope and stop talking about it.

An Issue of Acceptable Diversity

To be clear, Anabaptist Brotherhood seeks to help churches find peace amid this diversity. We are not promoting being on Social Security or being exempt. Most Anabaptist groups encourage members to be exempt, while a few groups prefer members to be on Social Security. Many churches have a mix of people on both sides of the issue. Not surprisingly, some churches live on the cliff of concern because long-standing problems are unaddressed with the option of exemption. While Brotherhood publishes educational materials to help churches with the exemption, in doing so, it may appear that we are pro-exemption and anti-Social Security. That’s not the case. Instead, we are committed to helping churches navigate this diversity peacefully by facing and solving the financial problems that plague the exempt side of the issue. In addition, Brotherhood serves people on Social Security and exempt with its Medical Aid and Alms plan, treating everyone the same—without government intervention—until age 65.

Why is the Issue so Sensitive?

Unless we forsake our long-held convictions, these issues must remain sensitive. I propose that Social Security issues are sensitive for three reasons.

First, the nerve lies along the bone of our theology. It matters. Bodily mutual aid is part of the infrastructure of the house of God—not a surface issue. **If we lose our convictions for bodily mutual aid, we’re no longer Anabaptist!** Being our brother’s keeper is rooted in our

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understanding of Scripture. If practical love ignores those with financial hardship, we are liberal wolves masquerading in conservative sheep's clothing.

Second, the issue is sensitive because mutual aid is not socialism; no one gets a free ride. Biblically, everyone must “bear their own burden” (Galatians 6:5). Bluntly, if we don't provide for our own, we're “worse than an infidel.” (1 Timothy 5:8) We can't talk about the exemption because those on Social Security are understandably concerned that the exempt are not bearing their own burden! Some wonder if the exemption option weakens our work ethic and is chosen by the financially less responsible.

Third, the issue is sensitive because **strong evidence suggests the exemption option doesn't work**. Convictions without viable practice are wells without water. Some of the outcomes look troublesome:

- Families with disabled children revoke their exemption due to lack of aid, applying for Medicaid.
- Exempt widows suffer without enough income, secretly wishing they could apply for Medicaid.
- Individuals revoke their exemption before age 55 to **milk the system**—pay into Social Security for a minimum of ten years and still receive full benefits after 65. Yes, this is happening!
- Elderly couples run out of money without structured alms aid.
- Young people forego exemption because church leaders lack vision for it.
- Too many medical aid sharing plans exclude alms aid from their mission.

It shouldn't surprise us that we can't talk about it. The proverbial elephant in the room is so large that we've lost the freedom to discuss it. At best, it's extremely uncomfortable.

Why Have These Problems Remained Unsolved for Decades?

When Anabaptist Brotherhood was engineering its exemption solution, I sought the counsel of retired bishop Ivan Weaver. His answer shocked me: “**It's twenty years too late,**” he lamented. “**Theologically, it makes sense, but it hasn't proved practical!**” His sorrowful remarks are insightful. Ordained leaders have felt conflicted. Principles must produce sustainable practice; conviction must result in action.

First, the problem is not a lack of local conviction, but a practical **infrastructure problem** requiring widespread collaboration. One individual cannot solve this knotty issue. Heavy burdens like medical and alms aid cannot be carried by a single family or church. A network of churches or a structured plan like Brotherhood is necessary. A single deacon cannot cope with the current complexity, lack of transparency, and overpricing of medical services. It requires organizational horsepower. Ohio Medical Aid Services (Amish) manages \$60 million annually, a testament to grounding theology in historical tenets with strong, practical solutions that work—without government intervention.

Second, a long-standing problem is the **separation of medical aid from alms aid**. While some segments of Anabaptists never separated medical and alms (e.g., Weaverland Conference and others), some medical aid organizations focus exclusively on medical aid and exclude alms aid from their program—leaving local churches alone with the responsibility of alms aid. Alms aid may seem small compared to the “800-pound gorilla” of

medical aid, but the evidence proves local churches cannot carry the burden of alms aid alone. Why are more and more parents of disabled children going to Medicaid for support instead of utilizing alms aid? These are real stories. Personally, I know of two families in my local area that have revoked their exemption and tapped into Medicaid because sharing plans offered insufficient aid for their disabled children. Why is this happening? Is Anabaptism an impoverished people group? Where is the wealth going if not to the most vulnerable and needy among us? We send millions of extra wealth around the world in relief aid. Why then are our own widows, disabled, and low-income silently slipping away into Medicaid's arms?

When a church accepts exempt members, it accepts responsibility for all four bodily needs—medical, widows, disabilities, and low-income. Churches with exempt members shouldn't assume that they can shoulder this burden alone. However, alms aid should not be exclusively outsourced to a third party. The reins of alms aid must stay in the hands of local church leadership. They are the shepherds that know the situation within their household of faith; especially the widow, disabled, and low-income. Nonetheless, local churches can align with a secondary aid plan that shares both medical and alms needs across thousands of shoulders. If alms aid is silently replaced with Mother Medicaid, deep erosion of faith occurs for all. For Anabaptists, alms aid has always been a supreme privilege of the church. It's one of the cords that binds our hearts together in love. Regardless of whether a person is on Social Security or exempt, there is no need to send our most vulnerable to depend on Medicaid. Galatians 6:1-10 sums up the vision for caring for each other. The vision is to bear one another's burdens, (v. 2) and yet bear your own burden (v. 5) and don't become weary in burden bearing. (v. 9) Lastly, as we have opportunity, do it especially within the household of faith. (v. 10)

Third, a long-standing problem is the **lack of accountability for life-long savings for the elderly years**. People on Social Security pay in 15% of their income because the government requires it. The government does not regulate or structure long-term savings for the exempt. They assume we are self-governing and accountable on this front. But there are real situations where exempt people spend their entire annual income without saving for the elderly years. This knotty problem requires organizational structure and accountability. Brotherhood solves this with its **Long-term Medical Reserves requirement**. (See article in this newsletter.)

Summary

Anabaptist convictions regarding mutual aid are a historically non-negotiable theological tenet. In some segments of the constituency, medical and alms aid have not been supported by sustainable, practical financial infrastructure. This has led to a loss of vision by leaders caught on the horns of Social Security issues with a seemingly unsolvable dilemma. Meanwhile, the conviction for the exemption option is weakening, and uneasy tensions exist between church members on Social Security and those that are exempt. The solution requires local churches to collaborate with other churches in bodily mutual aid, insisting that sharing plans integrate both medical and alms aid into their mission and establishing structured accountability for long-term savings for exempt members. This multifaceted approach ensures that our historical theological mutual aid principles produce viable practice and result in deep-seated peace among members. 

Updates & Reports

Membership Update

The Medical Aid and Alms Plan is designed to serve a broad range of Conservative Anabaptist groups—including Amish, Mennonite, German Baptist, and Brethren churches—that align with the constituency parameters outlined in the *Complete Guidelines*.

We opened our doors on May 1, 2025 with 22 households from 8 churches. As of January 1, 2026, we have grown to 331 households from 88 churches. Of those churches, 14 have chosen to reach the 70% participation threshold, gaining the added benefits available to congregations that commit to one primary sharing plan.

Operational Report

This report is a snapshot of mutual aid in action, showing how our shared commitment translates into tangible care and meaningful medical savings for our members.

Report Period: May 1, 2025 - December 31, 2025

Gross Charge of Eligible Bills: \$838,623

Total Savings: \$719,564

This reflects the reductions achieved through our Reference Based Pricing model and provider negotiations, resulting in 85.8% savings on medical bills.

Amount Eligible for Sharing: \$119,059

This is the portion of eligible medical expenses shared among members and the Annual Unshared Amount which members pay out of pocket.

Administrative Account Report

To provide the most transparent and accountable financial picture, we keep administrative income and expenses separate from the Medical Aid and Alms account.

For 2025, the donor contributions equaled \$376,500 and administrative fees equaled \$61,469 for a total income of **\$437,969**.

For 2025, administrative expenses were \$294,882, plus a software development cost of \$167,642 for a total of **\$462,524**. Together, these startup costs are directed toward building a robust software and operational platform—tools that will make your experience as a member smoother and our processes more efficient. This strategic spending resulted in a net negative of \$24,555, covered by loans.

Medical Aid and Alms Account Report

Your quarterly contributions demonstrate the strength of a collective mutual aid plan. From May 1—when we began actively serving members—till December 31, your total contributions produced an income of \$682,994.

During this period, Medical and Alms expenses totaled \$183,528 including the 9% administrative fee. Through God’s providence, this humble beginning has resulted in a net cash reserve of **\$499,466**. Each quarter, we are building the reserves that will prepare us to meet the inevitable, larger medical needs our community will face in the future.

Below is an abbreviated Income and Expense Statement.

Administrative Account Report

Income	
Admin 9%	\$61,469
Donations	\$376,500
Total Income	\$437,969
Expenses	
Office	\$211,311
Payroll	\$83,571
Software	\$167,642
Total Expenses	\$462,524
Net	\$(24,555)

Medical Aid and Alms Account Report

Income	
Contributions	\$682,994
Total Income	\$682,994
Expenses	
Medical	\$119,059
Alms	\$3,000
Admin 9%	\$61,469
Total Expenses	\$183,528
Net	\$499,466

Income Tiers: The Financial Engine of the Alms Plan

The **Income Tiers** is the essential structure that powers the financial engine of Brotherhood's Alms Plan. It is a modern expression of the historical Anabaptist principle of mutual aid.

This plan provides a way to fulfill the call in **James 1:27: "Pure religion and undefiled before God and the Father is this, To visit the fatherless and widows in their affliction, and to keep himself unspotted from the world."** It establishes a structured and compassionate system for deacons and church leaders to care for their most vulnerable members: widows, people with disabilities, and low-income families.

The Financial Engine: Income Tiered Contributions

The Alms Plan's financial engine is a **tiered contribution system** based on annual household income, in which every member participates. This system is designed with two key features:

- 1. Capacity-Based Responsibility:** It aligns with the principle that those with greater financial capacity have the responsibility—and privilege—to financially support the needy. This is accomplished by using seven Income Tiers with most of the financial support coming from those with annual incomes over \$100,000.
- 2. Universal Connection:** It connects all members of Brotherhood to each other for the purpose of alms support. Every member or church has access to Alms support because everyone participates with a quarterly alms contribution.

Determining the Quarterly Contribution

The amount of the quarterly contribution is determined by the previous year's Adjusted Gross Income (AGI), which is reported from federal tax Form 1040, line 11.

- This annual income amount is correlated to an income-tiered range.
- The tier then determines the members' quarterly alms contribution for the following year.

Quarterly contributions range from a modest amount for low-income households to higher rates for those with greater financial means (See Table).

The Submission Process

The Income Tiers Form is an annual requirement to capture necessary income information:

- Sent to Members: By October 1st each year.
- Submission Deadline: Must be submitted to Brotherhood by November 1st each year.

The Income Tiers Form operates on the honor system, trusting each head of household to accurately report their Annual Income Tier. Members are not required to submit or disclose their tax return.

Summary

The Income Tiers is only **one aspect** of the Alms Plan—the financial engine. The Alms Plan requires individuals to first bear their own burden, then the local church to do its part with their local alms funds, then Brotherhood's Alms Plan does its part.

The purpose remains clear. As the Apostle James reminds us, **"Pure religion visits the fatherless and widows in their afflictions."** If the church fails to fulfill this duty, the needy among us must depend on the world's system for support, and in doing so, James warns, we become **"spotted by the world."** Our responsibility is sacred, clear, and non-transferable.

Quarterly Alms Contribution

Income Tiers	Quarterly Rate
\$1-\$25,000	\$55
\$25,001-\$50,000	\$115
\$50,001-\$75,000	\$170
\$75,001-\$100,000	\$255
\$100,001-\$150,000	\$560
\$150,001-\$200,000	\$790
\$200,001 and above	\$1,015

Hiring a Chief Financial Officer

Brotherhood is seeking a person at management level to serve as the Financial Officer. The organization is rapidly scaling up and looking for an experienced person to oversee the financial aspects of the organization. This role requires experience in accounting, IT, and office software. In addition, it requires in-person presence at the organization's headquarters in Guys Mills, PA. For a complete job description, contact our office.

Long-Term Medical Reserves

This article provides essential information regarding the **Long-Term Medical Reserves** requirement for Brotherhood members who are **Social Security Exempt (SSX)** under Form 4029.

Note: If you currently receive or contribute to Social Security (SS), this specific requirement **does not** apply to you.

The Long-Term Medical Reserves requirement is a foundational part of the structure that ensures the Brotherhood's Alms Plan works. "The Income Tiers" (see article in this newsletter) is the counterpart which provides funding for the Alms Plan. No mutual aid plan can succeed if individuals neglect the personal responsibility to save throughout life in preparation for their elderly years.

As an SSX member, it is your **personal responsibility** to save to cover potential medical and living expenses in your later years. This aligns directly with the Scripture in **Galatians 6:5**, "**For every man shall bear his own burden.**" The Long-Term Medical Reserves policy provides a much-needed structure to guide responsible, life-long savings for those exempt from the government's Social Security system.

Purpose of Long-Term Medical Reserves

Medical reserves accumulated throughout life are specifically intended to cover **medical and alms-related expenses** from age 65 to 85 years of age.

Per the CDC, the average life expectancy in the United States is approximately 78.4 years. For an extra margin of safety, we use an assumed lifespan of 85 years. For medical reserve calculations, this results in a **twenty-year span** from age 65 to 85.

These reserves are *not* intended for basic needs such as food, shelter, and clothing.

Items intended to be funded by the medical reserves include:

- Quarterly Medical Contributions
- Annual Alms Contributions
- Annual Unshared Amounts
- Ineligible Medical Expenses

Annual Saving and Reporting Requirement

Each year, **SSX members must save and report at least 8%** of their prior year's **Adjusted Gross Income (AGI)**.

1. Locate your AGI on **federal tax Form 1040, Line 11**.
 2. Multiply that amount by **8%** to determine the minimum annual amount to be saved for the following year.
 3. This amount is reported on the **Long-Term Medical Reserves Form**, along with the total accumulated amount.
- **Reporting is Mandatory:** Must be submitted annually.
 - **Honor System:** Reporting is based on the honor system; tax returns are not required to be submitted.
 - **Deadline:** Annually, a reminder is sent to members on October 1st. The Long-Term Medical Reserves Form must be submitted annually by **November 1st**.

Acceptable Types of Medical Reserves

You may hold your long-term medical reserves in either cash accounts or appreciating assets, provided they are readily accessible for use in elderly years.

Acceptable Types	Description
Savings Accounts and Investments	Held at any credible financial institution, including self-directed IRAs or general long-term savings/investment accounts.
Appreciating Assets	Funds can be saved by making extra loan payments (accelerating equity) on assets like your home, secondary property, or business property.

(Note: Anabaptist Brotherhood does not offer investment services or financial advice.)

Cumulative Savings Requirements

This is the required reserve amount to be accumulated by age 65:

Member Status	Minimum Cumulative Reserve
Individual	\$300,000
Couple	\$600,000

While reserves may be saved initially in an appreciating asset like your home, the minimum cumulative medical reserve amount must be **in addition to the equity of your primary residence** to ensure liquid access to the funds in elderly years.

Practical Outcomes

A cumulative medical reserve of **\$600,000** at age 65, with a modest 5% return on investment, yields an annual payout of approximately **\$47,628** over 20 years (using a declining balance calculation). Given that the maximum annual cost of medical and alms expenses is about **\$20,000 per year**, this provides a **margin** to cover additional, non-shareable medical costs such as extended Hospice Care (over 60 days), pharmacy costs (over 90 days), or long-term assisted living costs.

Compliance and Hardship Protocol

Scenario	Protocol
Noncompliance	Members under age 65 who miss the November 1st reporting deadline will receive a 30-day reminder. If the issue remains unresolved after 60 days, their membership will be canceled.
Financial Hardship	Withdrawals from Long-Term Medical Reserves prior to age 65 are not permitted under any financial hardship circumstances.

If a member experiences financial hardship, their church leaders or representative may request support on behalf of the member through Brotherhood's Alms Plan. 

Considering Causes: Can We Know Which Treatments are Truly Effective?

by Michael Sauder

How do we know which health treatments truly work? How do we ever conclude that one thing has caused another? Consider these fictional letters:

“Dear Editor: My neighbor has a cousin whose dad was cured of cancer after drinking hydrogen peroxide for two years. I’m trying it now, and I feel good.” –Sam

“Dear Editor: I now take a cold shower every morning, and suddenly all my warts disappeared!” –Cold in WA

“Dear Editor: Many people have difficulty losing weight. I started taking a new pill called Six O’clock that is effective, however. It seems strange because you need to swallow it at exactly 6:00 PM and then not eat anything before breakfast the next day. It’s also a bit expensive. However, I want others to be helped, so I’m writing this letter to the editor.” –Bob

“Dear Editor: I’ve long suffered from low energy, digestion issues, strange rashes, and Lyme disease. Over the past month, taking selenium supplements with ice-cold water every evening has given me energy and cured my digestion. Also, my Lyme and rashes have disappeared. And all from selenium! Please share this with all your readers so they can be benefited!” –Sally from PA

What is an editor to do? I am not an editor, but as a physician, I do answer health questions for a monthly periodical. Sometimes a reader requests that the magazine publish a testimonial about improvement. Should we publish what happened to that person?

How do any of us respond when friends share testimonies? What if the story seems fantastic or bizarre? It is one thing to hear and refrain from disapproving. Generally only when far-fetched attempts at cure are very expensive or known to be harmful do I express concern. But before I actively recommend a therapy, a different kind of thinking is required. Before recommending a therapy, I need to have substantial confidence that it will benefit. So here is what I would share with an editor about the fictional patient testimonials above.

Doctor to Editor

Dear Editor: Physicians and other medical practitioners are besieged by friends, family, and perfect strangers who want to relate stories of healing. Most of the stories are routine, some surprising, and a few fantastic. People outside of the medical field hear such stories also.

For each of the people who improve, I am thankful. Doctors do not know everything about what can help our bodies. People say “this caused that,” and they may be right. But, although none of us knows everything, we all know something. We know we cannot believe everything about all testimonials. If all the claims people make about how to be cured were true, we would have few sick people. But why must we be cautious with testimonials? I suggest that caution is required not so much with the details of the happenings in the story, but the teller’s *interpretation of cause and effect* within that story.

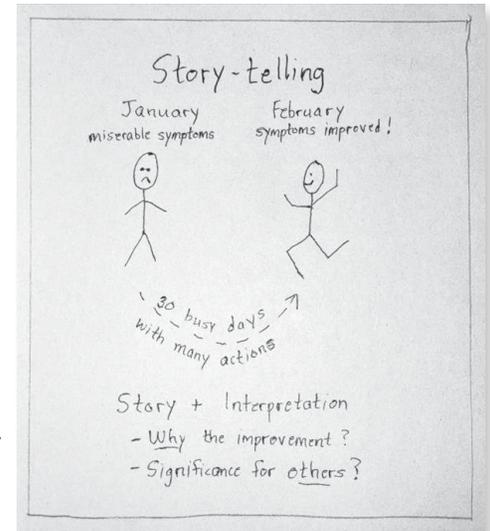
We hear that someone had a health problem with particular symptoms. A month later the problem is gone. In between, the person accomplished various actions. Of course, in every 30-day period, we do many different things. Some of those actions might be attempts at therapy, intended to cure a medical problem. How could we know whether an attempt at therapy was really the cause of symptoms disappearing?

As a listener, I am not really in the place to judge the symptoms. The storyteller is the one to judge how his or her own body feels at any time. But the causal connections drawn by the person telling the story is something different. Stories will contain not just descriptions of events, but also interpretations of events. Interpretation involves meaning-making. The meaning conveyed by a story might carry a

lesson for the listener. But happenings are something different than interpretation of cause and effect between those happenings. These are difficult to separate. We have experiences, but at the same time we interpret those same experiences, making meaning for ourselves. And we generally think our interpretation is correct. But might improvement have happened even without that attempt at therapy? Might Sally have had more energy and better digestion even without taking the selenium? Here is my main point: **people generally underestimate their body’s own healing ability over time, and they overestimate the power of whatever attempt at therapy they were trying over that same time period.**

How Big is the Benefit?

How accurately most Americans estimate benefit or harms of treatments, screenings, and medical tests has been systematically investigated. One study summarized dozens of such studies. The authors concluded that most people overestimate the benefits of treatments, and underestimate the potential harms of a treatment or medical test.¹ Patients often assume that more tests and treatments indicate superior care. The authors noted “the appetite that people have for medical interventions. Many want to have more and resist having less.” One hundred years ago the Baltimore physician William Osler commented that what distinguishes humans from animals is that humans want to take medicines.²



1 Hoffmann, TC et al. JAMA Internal Medicine 2015; 175(2): 274-86.

2 Physicians also sometimes overestimate the benefit of therapies. Maybe a treatment has been proven effective for a certain condition, but we prescribe it for a different condition. This is usually unwise. Since doctors and patients together strongly desire that therapies work, sometimes we allow ourselves to get pulled into trying treatments that probably will not work.

I've heard people say that physicians are too skeptical about alternative therapies, that is, attempts at cure that have not been systematically investigated for efficacy. But my impression is that physicians hold this skepticism not so much because of a bias that alternative therapies or "anything that is not expensive" cannot work or should not be attempted, but more because they realize how powerful the body's own healing capacities are. Medical school teaches not just how the body works, but also how little we know about how the body works. Is the reluctance of physicians to recommend a therapy that has not been systematically investigated just an exercise of power, an attempt to exclude homegrown cures? Or is it due to an acute awareness that the body very often puts itself to rights, *no matter what we do*?

People can make their own choices about how they spend their money for their health. But refraining from judgment of others' choices is one thing, and recommending a therapy is another. It is quite a responsibility to recommend that a patient spend hard-earned money on a particular type of cure. Before I can do that in good conscience, I need a substantial reason to think it will work. I need reliable information about the risks and benefits of that therapy. Price and effectiveness are both important. But considering effectiveness comes first. As a doctor, I propose and discuss treatments shown to be effective, even if expensive. But being cheap does not make it effective. And some inexpensive things (like hydrogen peroxide) are both inexpensive and dangerous, if used unsafely.

Of course, there are many things that are fine to try, even if there is no clear idea that they might work. You might avoid certain foods that seem to bother your stomach. Buy supplements if you want. Take cold showers whenever you want. This article is not about what you might decide to try. Instead, it is about judging whether what works for you will necessarily work for others.

I am sure there are many effective, inexpensive treatments that we have not yet found. Many of our drugs are derived from plants. But I suspect that many more uses of herbal compounds are beneficial, even if the studies have not been done. Often inexpensive attempts at therapy have not been studied systematically, and thus have not been demonstrated to work. Why are they not studied? It takes intense, organized investigation to establish whether a therapy actually works. It usually requires studying many people in a controlled, systematic way over time. That is complicated and expensive. Many simple attempts at therapy might work, but are not studied, precisely *because* they are simple. They would not yield enough profit for a private company to justify investigating them. As it turns out in our all-too-human world, treatments physicians propose are often expensive.

How could we fund expensive studies of inexpensive therapies? When knowledge would be in the public interest, everyone does have an interest in acquiring that knowledge. This is what the National Institutes of Health (NIH) and some philanthropies work to accomplish. The National Center for Complementary and Integrative Health, part of the NIH, funds some research on alternative therapies.

Examining Testimonials

In the last part of this essay, let us return to thinking about testimonials, sometimes routine, sometimes fantastic. There is more to say about how to consider causality. It is one thing to have events (cold showers; warts gone), it is another thing to interpret, to assign meaning, to say that "this thing that happened to me *means* such and so for you. If you have warts, include in your future a particular act

(a cold shower)." Such an interpretation might not be correct. The correctness depends not just on the factual input (an assessment of whether the shower was indeed cold or whether it was indeed in the morning), but also on whether the speaker has correctly concluded that the cold shower was *actually the cause of* the warts disappearing. Thinking in the right way about causation is challenging, and often we cannot be completely sure.

Think of it another way: acknowledging what happened in one person's experience (person X) is one thing. Being aware of what happened is very different than understanding why it happened. On what basis could you truly recommend that someone else (person Y) act in a particular way based on the experience of person X? If you recommend that person Y follow what person X did, you are professing that you understand the causal relationships, the *connections between the events* in the life of person X. Furthermore, you are confident that the same causal relationships will hold in the different circumstances that necessarily exist in the life of person Y.

Very frequently we do not understand the world. In fact, I would say that we don't understand the world more frequently than we *do* truly understand it. As a physician, my reservation to recommend interventions that have not been studied is based on my seeing many therapies recommended and then later demonstrated to be ineffective. We encountered this often in medical school lectures. Even treatments that seemed to have good evidence are sometimes later understood to cause more harm than good.

Meanwhile, as days pass, natural improvement might happen. We call it spontaneous regression. Often, digestion issues can improve on their own. We often do not understand what causes warts to disappear when they do. Sally completed many actions over a 30-day period. She was focused on selenium as a possible cause. How does she know that the cause of her improvement was not a different one of her many actions or improvement due to an unknown cause beyond her knowledge or control? To answer this question requires studying many people in a systematic way.

Regarding the testimonials, I would not dispute any of the reported diagnoses or symptoms. But I am skeptical about the causal relationships the writers have shared and thus would question the meaning the writers are assigning to their story. Editor, what would we communicate if we published these testimonials? What kind of confidence can we have that Sally's improvement was related to the selenium? Publishing Sally's story would seem a recommendation for others to try selenium with cold water for Lyme disease. In Sam's case, is publishing his story endorsing hydrogen peroxide as a cure for cancer? I understand that we never have complete confidence or knowledge. Even therapies that have been investigated and are known to work for many people still might not work for everyone. But what level of confidence or evidence is required before we recommend a therapy? For sure, more evidence is needed than that supplied by a single use. Cause and effect are not easily understood. Rigorously evaluating the effectiveness of a treatment requires studying multiple cases across time. 

Michael earned his medical degree from Johns Hopkins University and practices at Lancaster General Hospital. He has a master's degree in Public Health, another in Philosophy of Medicine, and is pursuing a PhD in Health Care Ethics. He serves on Brotherhood's Therapeutic Evaluation Committee.

Anabaptist Brotherhood

caring for our own



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Newsletter

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Newsletter Editor Merle Herr
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Anabaptist Brotherhood

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By this shall all men know that ye are my
disciples, if ye have love one to another.
John 13:35

Appreciation for Donors

We launched in 2025 and invested heavily by building organizational infrastructure that will last for years to come. Various donors made this possible with their combined generous gifts totaling **\$376,500**. While much of the infrastructure is complete, throughout 2026, we plan to continue building out our software—the engine that enables us to process medical bills using the Reference-Based Pricing approach. The budgeted cost for the software development this year is **\$200,000**. If you have financial capacity to help with these costs, please consider giving to this cause. The organization is a 501(c)(3) non-profit entity, and donations will receive a tax-deductible receipt.

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