

KHN's 'What the Health?'

Episode Title: Much Ado About Drug Prices

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Julie Rovner: Hello, and welcome back to "What the Health?" I'm Julie Rovner, chief Washington correspondent for Kaiser Health News. I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, Sept. 16, at 10 a.m. As always, news happens fast and things might have changed by the time you hear this. So, here we go. Today, we are joined via videoconference by Alice Miranda Ollstein of Politico ...

Alice Miranda Ollstein: Good morning.

Rovner: ... Rachel Cohrs of Stat News ...

Rachel Cohrs: Hi, Julie.

Rovner: ... and Shefali Luthra of The 19th.

Shefali Luthra: Hello.

Rovner: Later in this episode, we'll have the latest KHN-NPR Bill of the Month with Phil Galewitz, about a two-part jaw surgery with the same doctor, hospital and insurer, but two very different price tags. But first, this week's news.

OK, we've been away for a couple of weeks and a lot has happened — particularly on Capitol Hill, where Democrats have been rushing to meet a very tight deadline to put together that 3½ trillion-dollar spending bill. And before we get to what they have done, let's talk about the process, because I know that's still really confusing. What has been happening this week? Alice and Rachel, you guys have been covering it.

Ollstein: Yeah. So all of the different committees have been going through their pieces of the bill. And there's some overlap, you know, particularly in the health care space. Multiple committees have jurisdiction. And so they all had these marathon, late-night, early-morning, all-day, all-night markups this week. And the idea is that they had to finish and send everything to be all cobbled together into one big monster bill that the Budget and Rules committees can now look at. And that did happen, although there was some drama that we can get to in a minute.

Rovner: Well, we'll get to that. Yes.

Cohrs: And on the Senate side, there was also a deadline this week. And I think there definitely isn't, you know, complete legislative text from every committee on the Senate side. But they did have conversations this week. You know, they're continuing to put policy together. They had a lunch meeting on Tuesday where they did kind of run over kind of the broad contours of the package. So, the formal committee hearings, all that happened in the House. The Senate is working on that, too, but just kind of more behind closed doors still.

Rovner: I should remind people that sort of the normal procedure with a budget reconciliation bill, which is what this is, is that both houses pass the budget resolution, which they have done, which orders and creates the outlines for the reconciliation bill. The committees go ahead and basically write, mark up, their portions of the bill in the House. The Rules Committee and the Budget Committee put those together, put them on the floor for a vote. Normally in the Senate, they would do the same thing and there would be two different bills and then they would go to conference to conference the bills. But I get the impression that they're on a tighter schedule this time so that maybe, I guess they don't want the House to have to vote on something that can't pass the Senate. So maybe a lot of stuff that happens at the back end is going to happen at the front end here.

Ollstein: Yes, especially moderate Democrats in the House have been really hammering [House Speaker Nancy] Pelosi and leadership on the idea of pre-conferencing. So, basically, having the House and Senate work out their differences beforehand to avoid the House and Senate passing really different bills and having to hash that out, and like you said, forcing some vulnerable House members to take tough votes on things that maybe can't become law because they can't pass the Senate or there's a narrower margin. And that flared up a lot this week in the markups we were watching. We had a lot of people say "Why are we doing this? This has no chance of passing the Senate" about various pieces.

Rovner: Yes. So, let us get to that. This is not just a spending bill. It's also a savings and taxing bill. And the lion's share of the savings, at least for health, are supposed to come from reining in the cost of prescription drugs. That effort — not going so great in the House. Right?

Cohrs: Right. I mean, I think this certainly was dramatic. I mean, this sort of kind of rebellion against House leadership doesn't happen all that often. However, this bill was dead in the water, you know, the day it was introduced two years ago. You know, it was dead in the Senate. Now it's dead in the Senate again. You know, we've had Senate Finance Chair Ron Wyden come out and say more explicitly this week than he has before that that measure does not have the votes to pass.

Rovner: That measure, meaning the measure that was before the House Energy and Commerce Committee.

Cohrs: Right. And it's pretty controversial.

Rovner: And dramatically failed on a tie vote.

Cohrs: Yes, it did. And I think it's also notable, certainly it was, you know, a dramatic vote, and it's a controversial bill. But in that committee the lawmakers did have an opportunity to just vote on one portion of the bill, which they're not going to have that privilege when it's on the floor. They have to, you know, up or down vote the entire package together. So, I think that's important to remember. And they were kind of hedging their bets, too, in terms of leadership by marking up the same bill in two different panels. So, definitely, that legislation that ties Medicare negotiations on drug prices to the prices offered in other countries could still show up in the final House bill. Like, we don't know quite what that will look like yet, but they do still have that procedural option to proceed anyway.

Rovner: Well, it made it through the Ways and Means, right?

Ollstein: Right. So, I mean, it's kind of a mess right now. But, you know, how the House leadership is projecting confidence and saying, "This will be part of the final package, whether we use the Ways and

Means pathway or we just put it back in when it gets the Rules Committee. We have options. Don't worry." But, obviously, when you have people willing to vote against it, they could also vote against it on the floor. Democrats have such narrow margins that they can only lose three votes. You have five people sponsoring this alternative drug bill that is much narrower, and also using different committees isn't necessarily, you know, the golden ticket because different committees have been allocated different pots of money. And so it's really a mess right now. And they're really scrambling to see a way forward on this in the House.

Rovner: Although I will say, in the olden days when they would do a reconciliation bill every year, Energy and Commerce and Ways and Means shared jurisdiction over part of Medicare, and they would traditionally do different things and it would pass the House because of the way the budget rules work. They just stitched that bill together. They don't change anything. It would pass the House with conflicting provisions and they would hash it all out in conference with the Senate. So you would go into the Senate with three different possibilities on some of these provisions. Obviously, the House leadership, because of what you were saying before, Alice, does not want that to happen. But right now, technically, the drug stuff would be in the Ways and Means version of the bill, it wouldn't be in the Energy and Commerce version of the bill, and they would sort it all out later. I think in this case they want to sort it out in advance.

Ollstein: And I just want to highlight, like, how big a deal this is. I mean, not only has this been a huge promise that Democrats made on the campaign trail to lower drug prices — and this, they believe, is the best way to do that — but also this is set to generate hundreds of billions of dollars that they're counting on to pay for all of the other stuff: expanding Medicaid in the red holdout states; expanding Medicare benefits to include dental, vision and hearing; making the Obamacare subsidies permanent. Without the drug piece, a lot of that could be in jeopardy. And so there's just a ton of pressure here. And I think that's why you saw the very unusual drama in committee this week. You had the chair, Frank Pallone, making these public last-minute appeals, saying, "Please, please vote for this. This is just to continue the conversation. This isn't the final thing. We can work out your concerns and differences down the road." And it didn't work. The three Democrats on the committee voted it down, and that's where we are today.

Rovner: Rachel, it seems that those three Democrats who voted it down were also recipients of a lot of campaign contributions from the drug industry. I mean, we can pretty much see the drug industry's opposition to this in big flashing neon signs, right?

Cohrs: Yes. And I think it's important to note that each of these members is a little different in terms of what might be motivating them. But certainly with Congressman Scott Peters, he represents a district in San Diego that has a lot of biotech. And I think we reported over the summer that pharma executives, lobbyists funneled him so much money after, you know, he kind of co-led a group of moderates back in May who signaled that they might have problems with this drug-pricing provision. You know, it was a very straight line, pretty much as good as you get in campaign finance filings. And I think he hasn't been bashful about his support for the industry, especially kind of the small biotech drug companies that, you know, are kind of in his district. You know, Kurt Schrader, who's been a longtime moderate, he opposed the entire package, not just the drug-pricing portion. So I don't know that that was terribly surprising. And Kathleen Rice, her campaign contributions weren't, you know, to the level that either Schrader or Peters were seeing. But I think there are larger political considerations, too, to think about. And she did

sign onto the letter back in May. So, I think she had kind of telegraphed her potential opposition, even though she hadn't seen the same, you know, flood of campaign money that we saw to Scott Peters earlier. But pharma knows who their allies are and they are not afraid to spend to make sure that their policy priorities are represented.

Rovner: And we should point out that pharma gives to pretty much everybody on all of the committees that oversee pharma, because that's how it works. You know, everybody say[s], "Oh, the people who voted against this are, you know, in the pocket of the pharmaceutical industry." If you go back and look at all the campaign contributions, they're spread pretty widely there. So, as Alice was saying, it's not just drugs. There seems to be some real heartburn happening among Democrats about whether to scale back some of their items. In other words, do a little for a lot of pet issues — talked about Medicaid and Medicare and the Affordable Care Act — or do a few issues in a big way and save the rest for another day. Do we have any feel for which way things are leaning at this point?

Ollstein: Right now, it's leaning towards the former camp, doing a little bit for everybody. You know, you have the Medicare dental-vision-hearing benefits, but they're not as robust as progressives wanted. They require Medicare enrollees to pay more for those things and then especially the dental provision wouldn't kick in for several years. So, you know, that's scaled back a bit. The Medicaid expansion piece really got full funding. It's set to be permanent, at least in the House version, and the Obamacare subsidies as well. And so there was sort of a tussle between the Democratic leadership in the House that wanted more put towards shoring up Obamacare and making it less vulnerable in the future to a potential Republican majority seeking to let things expire. And progressives are upset because they wanted more to go towards the Medicare benefits piece. But, yes, instead of, you know, dropping any one of these big priorities, they just decided to scale some of them back. What really got scaled back a lot in the House version is the home health investment. That's half of what folks wanted, including what [President Joe] Biden has asked for. The new ARPA-H cancer research institute that would work on a lot of chronic diseases also got a lot less than requested. And so, yeah, they are trying to do everything in not as fulsome a way as they originally wanted. And, you know, if the drugs piece falls through or if, you know, [Joe] Manchin in the Senate gets his way and shrinks the overall bill, that could change and we can see entire provisions getting nixed.

Rovner: This bill, we should point out, this bill has a very long way to go. And I'm sure we will talk about it every week for the next two or three months. So. All right. Next topic: By far, the biggest thing that happened while we were gone is that abortion became effectively unavailable in Texas as of Sept. 1 after the Supreme Court declined to step in to stop that state's new law, even though its six-week ban is in direct contravention of existing court precedents in both *Roe v. Wade* and *Planned Parenthood v. Casey*. Regular listeners already knew about this law because we've been talking about it since it passed last spring. But, Shefali, remind us one more time how this works and tell us about your extra credit, which is about how it's all actually playing out on the ground in Texas.

Luthra: This law is just so different from any other six-week ban, right? And the reason that it was able to stand up is because it doesn't turn abortions after six weeks into sort of a criminal act, per se, but it empowers private citizens to sue anyone, not who got an abortion after six weeks, but if you believe they may have aided or abetted someone in doing it. And this is deliberately quite vague. So it's if you were a doctor, if you were the receptionist, maybe if you drove them knowingly to the facility, maybe if you helped them get money. And the incentives for suing are substantial, right? It's a minimum \$10,000

if you get a guilty verdict; plus, your legal fees are reimbursed. There is no such reimbursement for the defendants in these cases. And what's happened is we haven't actually seen any lawsuits take effect. But there is this really intense chilling effect because providers are quite terrified of being found in violation of the law. We are seeing them across the board stopping abortions after six weeks, but many are going much further. Some in San Antonio have stopped providing abortions altogether. We're seeing folks travel out of state. And then this extra credit that I really thought was just so important and helped highlight the impact is by my colleague Jen Gerson. And it's from The 19th. The headline is "No One Wants to Get Sued': Some Abortion Providers Have Stopped Working in Texas." And this, I think, gets at a really important dynamic, which is that in states hostile to abortion rights, there's been a long history of doctors flying in from out of state to provide abortions, and they are scared. They don't feel safe doing that anymore. And so, large numbers of doctors at Whole Woman's Health in particular, which is the biggest abortion provider in Texas, are just no longer performing the service at all, even before six weeks. And this is going to have implications, at least for the next month, until we see if there is an injunction granted, but potentially for much longer, right? Because it's really hard to rebuild those services once they have been decimated.

Rovner: Yes. And we saw that. I mean, when Texas passed its previous law that the Supreme Court struck down in 2016, a number of clinics had already closed and were just, it took them a while to ... and I think, I believe that even before this took effect, there was still less access to abortion in 2021 than there was before that law was struck down in 2016. We've long been expecting that the Supreme Court, which nominally has a 6-3 majority against abortion rights, would use the 15-week ban in Mississippi to roll back abortion protections as a case that they agreed to take in the spring. We were waiting for them to set an oral argument date, and we were expecting that that decision would come down sometime next June or July. I think a lot of people were caught kind of flat-footed that abortion could essentially be banned in the second-largest state in the union on what's called the Supreme Court shadow docket, where it really, you know, there were no, there were no oral arguments. There were only the most cursory briefs. It literally happened in the middle of the night. What happens now, both for people in Texas and politically?

Luthra: Well, in Texas, the implications are quite clear: Abortion is effectively unavailable. And we are seeing copycat legislation being talked about in many other states, although most state legislatures aren't in session. So, we could probably see more laws like this appear next year. Politically, it's really like there's a spooky precedent almost, because in the Supreme Court, the decision when they said they wouldn't intervene to block the law, they spoke about standing. And they said that they wouldn't intervene because the plaintiffs hadn't shown that they actually were necessarily going to be sued by the defendants. And I was just talking to a law professor earlier this morning and she made the point, if the Supreme Court ultimately decides that this is a perfectly fine model of essentially passing laws that don't appear to comply with our constitutional understanding, then that opens the door to many other things. You could see a world, her argument was, where there is a \$10,000 sector, essentially bounty. If you sue someone you believe broke voting laws or something to that effect, it's just like a really big new world of ways to effectively pass laws that should not be constitutional, if this is upheld. Although, as you mentioned, we have so many complicating factors between this and the *Dobbs* [Mississippi abortion] case that we really don't know what the next couple of months, let alone year, on abortion law is going to look like.

Rovner: Well, actually, I learned this week that this, that the Texas law is actually based on a Mississippi law — not the Mississippi abortion law, [but] a Mississippi law that basically lets individual citizens sue over LGBTQ discrimination, or that basically lets people discriminate. So, this is kind of the second one that we've seen along these lines. That basically that law, if the state, if they had written it in the way that the state were to enforce it, you would have been able to sue the state and say, no, this violates, you know, what the Supreme Court has said. But because of the way they wrote it, they're still ... I mean, they're, they're working on in court. So, we're working on sort of both of these in court. I do feel like there are people who are concerned for things well beyond abortion with the way this law was written that basically, you know, it creates bounty hunters. I mean, that's what the president called it, and that's essentially what it is.

Ollstein: I think it's also playing into a lot of angst and debate about the Supreme Court itself. And I think the reason a lot of folks, myself included, were surprised by what happened is that many justices on the Supreme Court are already well-known to be anxious about the public perception of the court, perception that they are partisan and political actors. And so the thinking was, why would they essentially gut the protections of *Roe v. Wade* in the middle of the night on the shadow docket in a process that could be seen as, you know, illegitimate when they could just do it through the more formal channels in a few months when they take up the Mississippi case? But enough of them just went for it. And so now we have the Biden administration suing Texas. That case is set to be heard on Oct. 1. The hearing date was announced last night. And you also have other pending legal challenges. And so it's not yet known if that will make it back to the Supreme Court before the Mississippi case. It's really all swirling around right now. But I think it just highlights ... so, what's true now is that, you know, *Roe v. Wade* is still the law of the land, but it is functionally not there for the people of Texas. But I think that, you know, I'm hearing a lot of advocacy groups argue that that has just really been the case for a long time. *Roe v. Wade* has been the law of the land for decades and decades. But if you are poor or live in a rural area or you're in a state with only one clinic left, like Mississippi, having that law on paper doesn't really mean anything to you if you are not able to access an abortion. And so there's a lot of talk about, yes, there's a lot of anxiety around the fate of *Roe v. Wade* in the courts, but there's also growing attention on what else needs to be done besides that from [an] abortion rights perspective.

Rovner: And we should point out that Chief Justice [John] Roberts was actually in the minority on having this law take effect, that he actually voted with the liberals. And I think it was, you know, one thing we know about the chief justice, he's no fan of abortion rights, but he also is really, really, really worried about the court's credibility, and I think he would much prefer to write a reasoned opinion in the Mississippi case than have this happen in the middle of the night, as you said, you know, when there was a hurricane bearing down. I mean, it was just, like, impossibly bad timing. Is this going to change the politics here in Washington? Are you seeing any evidence of that, Alice? I mean, one would think that actually having abortion unavailable for a large number of women might actually shake some things up.

Ollstein: So, I think you're seeing it more in the states as a political driver so far and not really a ton of change in D.C. In D.C. the politics of abortion is pretty baked. I think that the major change I saw in D.C. was the Biden administration is getting more vocal and more active on the issue. This is something they have really tried to keep a distance from. Biden was opposed to abortion for a long time as a devout Catholic, was not supportive of getting rid of the Hyde Amendment, was not supportive even of *Roe v. Wade* in the past. But that has changed as the party has moved to the left on this. And he has come

under criticism in the early months of his administration for sort of talking around the abortion issue, but not talking about it directly. I've heard a lot of complaints ...

Rovner: He never said a word until this happened.

Ollstein: Exactly. And so he would say, you know, "women's reproductive health" or some sort of euphemism. And groups are saying, look, if you're not even willing to say the word "abortion," what are you going to do to protect it? And so, finally, when this all came to a head with the Texas law, you know, he was more upfront and vocal about this and directed the Justice Department to get involved, which they now have. And so I think that's the biggest change in Congress. They are planning to take this vote that would codify *Roe v. Wade* so that even if the court did its thing and got rid of it, it would still be in federal law. That probably does not have the votes to pass the Senate. So that has not changed that we've seen yet. But I think that it's also a major driver at the state level. You know, we saw in the California recall election just now, it was something that the [Gov. Gavin] Newsom campaign really hammered a lot. And that's rare. You don't often see state-level Democrats making abortion rights a big argument. They really leaned on that to turn out disengaged voters. And it seems to have worked because it was not close; it was a decisive victory for the Democrats. It's also now playing up into the Virginia governor's race. The Democrats are really hammering that. And so I think it will continue to be something on the state level that plays a big political role.

Rovner: And we will also be watching this space closely. All right, covid. I want to start with a serious question I never thought I would have to ask: Is our health care system actually melting down? We have multiple states with not just full ICUs and emergency rooms, but completely full hospitals, to the extent that people with non-covid emergencies are dying because they can't get care for things that normally medicine can cure. I feel like this is not being taken as seriously as perhaps it should be. Shefali, I saw you nodding.

Luthra: I was just thinking about that wrenching ProPublica story — right? — where it was like it was a child who died because he couldn't get the hospital care he needed. And I wish I had a better answer to why it is that it's so hard to get people's attention to this. I mean, all I can come to is that people don't have the attention span anymore to focus on this because it's been almost two years of it. But we're also seeing this splintering where where you live really is shaping in such dramatic terms what covid looks like to you. Because I live in D.C. We have a high vaccination rate, right? Things are pretty good. They're not pre-covid, but they're much better. And if you think about somewhere in Texas or if you think about Jacksonville, Florida, it looks really, really different. And what I worry about is that, because it is so geographically divided, it's difficult for many, including the press, which is concentrated in these very blue, vaccinated, safer cities, to give it the attention and emphasis that it deserves. I don't know what we do about that.

Rovner: Yeah, I don't know what we do about it either, but I think you're absolutely right. I think, you know, I also live in sort of a little bubble where things are OK and people are wearing masks. And I traveled last week to a place where people — to New Jersey. I mean, you know, I didn't go to Texas. But people weren't wearing masks, and it looked really very different. And I realized that I've been sort of existing in this little bubble. Well, meanwhile, President Biden has ordered the Occupational Health and Safety Administration to effectively require large employers to mandate vaccines, which has a lot of Republicans seeing red for real, but it's not fair to call this an actual vaccine mandate, right?

Cohrs: I think the measure ensured employers would, you know, either require proof of vaccination or weekly testing. So, I think there is an option, you know, if employees don't want to, you know, get a vaccine to have some weekly testing. I think Sarah Kliff at The New York Times did a great deep dive just into this issue of who pays for the tests. We've been talking about this for months. So, I think, yeah, "vaccine mandate" may not be the preferred word, but I think that's definitely how it kind of came across, that it's just another, more, if you're thinking about a carrot-and-stick approach, it's definitely on the stick side of the approach in terms of helping ensure those vaccination rates just continue to climb across the country in a way that we've seen in some of these more hard-hit areas.

Rovner: And I wonder, you know, there are those who say that maybe sort of making the vaccine requirements more strict might actually push some employers to not do it. I mean, that it either is going to give employers cover, saying, "Oh, the federal government is making us do it, so we're going to do it," or they're going to now wait to see. It's going to take a while for OSHA to come out with their guidelines. It's like, well, maybe they should wait so they don't get in trouble. So they do it exactly the way the federal government says it. I mean, could it backfire?

Cohrs: I think it would be extremely difficult to enforce, just like all the public health guidance we've had for the entire pandemic. You know, it's really hard to police this stuff, but agreed that the federal government is just doing what they can in terms of policy. And the implementation is going to have to happen, you know, at other levels. And they realize that enforcement is going to be a challenge here.

Rovner: Yeah, so Biden covid plan 2.0 also requires hospitals that get Medicare or Medicaid — in other words, almost all of them — to require vaccines for their workers. But we're starting to see kind of a scary backlash from this: health workers who are quitting rather than getting vaccinated. In fact, we've seen a lot of health facility administrators say they've resisted vaccine mandates because they fear they won't be able to hire or keep workers. How do we resolve this?

Ollstein: It's really scary. And I think it's, you know, compounding the staffing crisis we're already in. You know, people are burned out and, you know, traumatized from dealing with the pandemic in the health care setting and in nursing homes, just seeing all this death and suffering. And so, you know, a lot of people have left the field because of that. Also, you know, people say, I don't want to keep putting my family at risk by going to work in these settings and then coming home to my kids or my parents or whatever. And so coming on top of that, the mandates are leading some to quit rather than get vaccinated. And so it's just a staffing crisis all around. And I don't know what to do about that. You know, I talked to some, you know, nursing unions who say that, you know, they're offering these huge signing bonuses for new hires, but the retention bonuses they're offering are very small. And those should be bigger because they need to keep the trained and experienced people they have. So that's one idea. Also just heard that employers just need to do more to protect their employees in terms of, apparently, PPE is still an issue. Even though it's more widely available from the manufacturing side, some employers are still skimping and making workers, you know, reuse a single mask for a long period of time. And so I think there's a feeling like: Our employers are not looking out for us, so why should we put ourselves at risk?

Rovner: You know, one of the things — going back to what Shefali was saying about how the pandemic looked different depending on where you live — is I think people are underestimating the toll that this has taken. You know, and now I think there's so many health workers who feel like ... you know, last year it was nobody's fault when you got sick. But this year there's this sort of undercurrent of "Really? You

couldn't bother to get vaccinated and now you're sick?" And I think that the toll this is taking on the health care workforce is something that we have sort of underestimated. And I'm afraid it's going to be one of those sort of long tails on this pandemic that we're going to have to deal with. I also want to talk about testing or the lack thereof. With delta spreading in schools, rapid tests are in increasingly short supply. And when you can find them, they're expensive. Other countries have them in grocery stores for less than a dollar apiece or even for free. How did we fail on this so badly? We've had public health experts talking about expanded testing for a year and a half.

Ollstein: I've heard a lot of complaints that, you know, we've basically put all of our eggs into the vaccine basket and really ignored the testing side of it, which is really crucial because that helps catch outbreaks, that helps catch breakthrough cases. And, you know, especially for the biggest chunk of people who can't get vaccinated, which are kids — although that might change soon, which we can talk about — testing has really gotten ignored. And there are very few, like, big school districts, for example, that are having any sort of systemic regular testing regime, and would you rather have to shut down a whole school and make everyone go virtual, or would you rather be able to pinpoint a small outbreak and isolate the kids and keep everybody else in school? It seems like a very easy choice to me, but either the resources or the planning or whatever is not there.

Rovner: All right. Last covid topic is about the boosters and kids' vaccines. And actually, my colleagues Sarah Jane Tribble and Arthur Allen have a really good story out this morning talking about how, apparently, one of the reasons that the NIH is, and Dr. [Anthony] Fauci, have been talking about boosters and getting a little bit ahead of the CDC and the FDA is that they've been collecting their own data. You know, I worry about how this looks to the public, with the bickering and disagreement among the scientific experts on "Do we need boosters, and when do we need boosters, and who should be boosted, and how fast are we going to approve this for younger kids?" Obviously, this is someplace where the science changes a lot. And I think public health officials have said that. But this looks particularly messy. And I would think that it would kind of hurt people's confidence in what they should do at this point.

Cohrs: You know, it has been extremely chaotic. And I think we've seen this week and there was this, you know, paper that where former — they're still at the FDA, but they've announced plans to leave the FDA ...

Rovner: Retiring members.

Cohrs: Retiring senior staff. Yes. Who work on vaccines. And I think there just has been this enormous frustration between the White House and the FDA and CDC and leadership and, you know, career staff — like, it's just been absolute chaos. And I think they're, you know, "What does 'follow the science' mean?" You know, I think we have, you know, maybe the science leads towards boosters, maybe it doesn't. But maybe there's this whole global aspect that it's hard to represent in numbers and, like, predict how variants will emerge. Like, it's just a very complex issue. And there's moral aspects to it. There's global and, you know, national interest might not be the same. So I think we've just seen all of those play out in a very public way. And it definitely could be problematic going forward in terms of building trust in this push to get people to go back to the pharmacy again or go back to their doctor's office, you know, whenever that time, you know, may come. And that communication for that will be very important. And it hasn't been very clear so far.

Ollstein: Oh, this is already something Republicans on Capitol Hill have jumped on. And they're saying, look, you guys during the Trump administration constantly accused the Trump White House of stepping on the scientists, preempting the scientists — which all happened, I should note. But, you know, now we have potentially an example of the Biden administration doing the same. And you have, you know, these career scientists at the FDA raising these alarms that the messaging and the guidance is not waiting for the science. It's moving forward before the evidence is necessarily there about who might need boosters and when. So I think that, you know, it's something that, you know, if we were hitting the Trump administration for this, we should be equally critical when we look at this as well.

Rovner: Yeah, well, we'll definitely know more about this next week because the FDA advisory committee is about to meet. All right. Well, it is September, and that means we had our health policy report cards of sorts. First, the Medicare trustees report. This normally comes out in late spring or early summer, and there was some consternation that it was so late this year. But, in fact, it found that in spite of all the lost jobs last year, the Medicare Hospital Insurance Trust Fund, which is funded by the payroll tax, isn't expected to become insolvent until 2026. That's the same date as projected last year. Now, on the one hand, there was some concern that the trust fund could start to run out of money as soon as the year after next. But five years is still pretty soon. Does Congress really, shouldn't Congress be addressing this sooner rather than later?

Ollstein: It's the classic, you know, Rorschach test, where people are citing it to argue for the things they already believe. So you have Republicans say, "Democrats want to expand Medicare at a time it's about to run out of money? That's crazy." And they're using it to argue against adding the benefits and such, even though that comes from a different pot of money. And then you have Democrats saying, you know, this shows the need to, you know, tax the rich more and shore this up. And so it's basically just feeding into everybody's priors.

Cohrs: It's true. And I think the mood on the Hill right now is that Democrats very much realize that their, you know, dominance may be short-lived. So I don't think anyone's thinking about how to cut back.

Rovner: Yeah, let somebody else worry about that. All right. Well, this week we also got the official uninsured numbers from the Census Bureau. And like the Medicare report, things were pretty much unchanged with the number of uninsured, basically the same as it's been since 2018 — although there was a fairly significant shift from private insurance to public, which suggests that the safety net, Medicaid and the Affordable Care Act in particular, is doing what the safety net is supposed to do. But I think this is the first time there's been a real recession without the number of the uninsured going up precipitously. That's something we should take note of, right?

Luthra: I think it was Larry Levitt [of KFF] who said that the pandemic would show us if the ACA worked. And it seems like, at least in this regard, it did.

Rovner: Yeah. And, of course, Congress did a lot of things both last year and this year to make sure that people who lost their job-based insurance were able to get insurance. So, I think to some extent — and, of course, a lot of this was before all of that happened, so it's hard because the numbers lag. But it certainly would seem that things were working. And then finally — and this won't be reflected until the uninsured statistics next year — the Biden administration this week announced that 2.8 million people signed up for Affordable Care Act coverage during the open enrollment that ran from February through

August. That's a much bigger number than I think a lot of us were expecting. Now the exchange covers an all-time high of more than 12 million people. Does that make it more or less likely that Congress is going to make those temporary extra subsidies that enabled so many people to sign up permanent? Alice, is that sort of a push towards it?

Ollstein: Yes, absolutely. And for those who were already arguing about the need to invest more in Obamacare, this is their prime example, saying, look, we went into this pandemic, there was a possibility that millions and millions of people would become uninsured when they lost their job-based coverage, but instead they were able to enroll in the market. And that came from investments in subsidies to make the plans cheaper. It came from investment and outreach to help people enroll, to even let them know about their options. And so, you know, you have some progressives who really want to move away from just the government continuing to subsidize private insurance and really push more towards public insurance on the long road to "Medicare for All," but really where we're more going down the doubling-down-on-private-insurance role, although this is also doing what a lot of folks want, which is decoupling someone's insurance status from their employment status, given the precarity of our times.

Rovner: Yes, it's all one big issue. All right. That is the news for this week. Now we will play my Bill of the Month interview with Phil Galewitz. Then we will come back and do our extra credits.

We are pleased to welcome back to the podcast my colleague Phil Galewitz, who wrote and reported the latest KHN-NPR Bill of the Month. Thanks for joining us, Phil.

Phil Galewitz: Nice to be here.

Rovner: So, this month's patient had a jaw problem, treatment for which involved two surgeries, I guess a couple of years apart. Tell us about him and his ailment.

Galewitz: Yes. Ely Bair, who lives in Seattle, for years had issues with migraines, high blood pressure, and wasn't sure what was causing it. And finally, he had a dentist who had diagnosed him who said a lot of this was related to his jaw being misaligned. So, back in 2018, Ely had surgery on his jaw, sort of a two-part surgery. First, he did the upper jaw. Then, a couple of years later, he would get the lower jaw fixed. When he had the first surgery done, he had surgery, no problems, at Swedish Medical Center. He had his insurance cover it. He paid about \$3,000 out of pocket. Surgery went well. He wore braces for a couple of years after. And then in 2019, he went back to have his lower jaw done to finish the surgery. And again, surgery went well. He spent all of one night in the hospital. But then he got the bill and he was shocked. Instead of a three or four thousand dollars that he might be responsible for, the hospital and his insurer said he's responsible for \$27,000. And Ely was shocked because he obviously is the same person, he went to the same hospital and he was also using the same insurance carrier, Premera. And so that's how he ended up contacting us to let us know what happened.

Rovner: But the important thing is that even though he had the same insurance carrier, he didn't have the same insurance, right?

Galewitz: Correct. What happened in the in between this first surgery and the second surgery was that Ely had changed jobs. And even though the same carrier he had, the actual health insurance itself — which when you work for a large company, most large companies are determining your benefits and how much you pay. The insurer is just paying the claims and setting a provider network. And the second company, unbeknownst to Ely, didn't consider his type of surgery an essential benefit and had a cap on

how much it would pay out for this type of jaw surgery. And he didn't realize that he would have a \$5,000 cap. And now Ely thought he had asked his doctor ahead of time, before the second surgery, "Hey, I just want to make sure I'm covered." His doctor said he looked at the information online that he had been provided and it looked like that he didn't see any reason why he wouldn't be covered. It was only until after the surgery that Ely found out, and his doctor found out, that there was a \$5,000 cap on the surgery.

Rovner: And this is a really important point, right? Because we've been led to believe that we don't have these caps anymore, that they were made illegal by the Affordable Care Act. You can't say that you're only covered for X amount and you have to pay everything above that. But dental surgery is not always medical care, right?

Galewitz: Right. The ACA did do away with annual and lifetime caps, but only in areas where things are considered, quote-unquote, essential health service. And that varies around the country, and that varies based on where you live and across a very ... what your insurance provides. And so in this case, in Washington jaw surgery like this is not considered an essential health benefit. So his insurer did not have to provide an unlimited amount of benefit. They could cap it. And that's what they did here. Thankfully to Ely, he tried to resolve his bill several ways. First, he appealed the decision from Premiera to not cover a larger share of the cost. He tried three times, but they rejected him all three times, saying he should have known. Ely then went to the attorney general's office in the state of Washington and tried to get their help. After that occurred, Swedish, the hospital system, did decide to reduce his bill from over \$27,000 to approximately \$7,100. Ely decided that was acceptable to him and he went and paid that amount.

Rovner: But still a lot of money.

Galewitz: Right. It sure is. But Ely, who had been through this and it's causing him a lot of headaches, decided that he would pay this. And this was not the only bill that Ely would have to pay. He also had some other anesthesia costs. He still had his doctor bill as well.

Rovner: The surgeon bill.

Galewitz: The surgeon bill, and the surgeon decided to reduce how much he would have to pay, which helped him out as well.

Rovner: So, after all that, the surgery worked, right? I mean, that part of his headaches is better?

Galewitz: Yeah. The good news in that is that Ely feels a lot better. His blood pressure is down. He doesn't have the migraines he had before. So he was very happy with the surgical outcome. He was not happy with the headaches that the insurance companies put him through.

Rovner: So what's the takeaway here for people who ... obviously, it was not an emergency situation. These were planned well in advance. How do you avoid having this happen to you?

Galewitz: As with everything else, get it in writing. Ely sort of learned the hard way that before you're going to have any procedure or surgery where it's not an emergency and you have time, make sure you go to your insurance company and say, Am I covered, and how much will I have to pay out? Not just call, but you should be getting that in writing from your insurance company and also getting that in writing from the hospital. So you know ahead of time, What am I on the hook for? You don't want to wait until

afterwards. And people can say you should have known. You always want to find out ahead of time. So you need to contact both your hospital and your insurer. And even though a lot of people might assume, hey, if my doctor says I'm OK, you should be OK, make the extra call. Get it from your insurance company ahead of time.

Rovner: Phil Galewitz, thank you very much.

Galewitz: You're welcome.

Rovner: OK, we're back. And it's time for our Extra Credit segment, where we each recommend a story we read this week we think you should read, too. Don't worry if you miss it; we will post the list on the podcast page at khn.org. Shefali, you've already done yours. Rachel, why don't you go next?

Cohrs: So, my extra credit this week is from Kaiser Health News, and the headline is "Over Half of States Have Rolled Back Public Health Powers in the Pandemic" by Lauren Weber and Anna Maria Barry-Jester. I think this story was just a great kind of summary and quantification of the trend that we've seen where states, you know, have taken action to kind of roll back public health authorities for state and local governments. I think, you know, we have clearly seen that this pandemic isn't over. I think as we were chatting about earlier, there are certain pockets, you know, across the country which, you know, may correlate with these places that have real bad public health protections that are still very much struggling with the pandemic. So, I think this is just a great project, very public service, to show kind of how things have changed. And, you know, there are great graphics, very accessible. I'm going to highly recommend.

Rovner: Alice.

Ollstein: So, I picked a devastating story from The New York Times that's called "Phony Diagnoses Hide High Rates of Drugging at Nursing Homes." And it's just this incredible investigation into how frequent it is that nursing homes are giving residents antipsychotics and giving them diagnoses of schizophrenia when there's no evidence that they have schizophrenia, because that lets them give them these drugs without having to report it to the federal government. The federal government put these protections in place requiring nursing homes to report how much they're drugging their residents because that plays into how they're rated for safety, etc. And so they are skirting those reporting requirements by just slapping these schizophrenia diagnoses on way more people than have them. And it's primarily driven by the fact that these are understaffed. We talked about understaffing earlier. They're understaffed and this sort of helps them control their patients because they need fewer people to monitor them at all times. But it's really dangerous for the patients giving them these drugs when they already have a bunch of health problems. It makes them sleepy. It makes them sleep through meals and lose weight. It makes them more unsteady on their feet so they're more likely to fall — which, as we know, an older person falling can be fatal or extremely dangerous. So, gosh, yes, I hope this article shines a light on this and brings some needed enforcement and regulation, because it's just a very painful thing to read about.

Rovner: Well, mine is also a troubling story, also from The New York Times. And it's called "A Medical Career, at a Cost: Infertility" by Jacqueline Mroz. And it's another troubling story about how women in medicine face extra challenges. It seems that infertility is a problem that many women physicians share, in part because so many wait until they're finished with their very long training to try to get pregnant,

but also because that training can be so physically rigorous that it makes infertility more likely. More women going into medicine should make it more of a priority, but it hasn't happened yet.

So, that is our show for this week. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review; that helps other people find us, too. Special thanks as always to our ace producer, Francis Ying, who still manages to make us all sound good. Also, as always, you can email us your comments or questions. We're at [whatthehealth](http://whatthehealth.com), all one word, [@kff.org](https://twitter.com/kfforg), or you can tweet me; I'm [@jrovner](https://twitter.com/jrovner). Rachel.

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Rovner: We will be back in your feed next week. In the meantime, be healthy.