

KHN's 'What the Health?'

Episode Title: The Big Biden Budget Bill Passes the House

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Julie Rovner: Hey, "What the Health?" listeners, this is Julie Rovner. If you like our show, then you should check out "Sick," a podcast from WFYI and PRX. This season, the team at "Sick" is investigating prisons. Incarcerated people are entitled to health care under the Constitution, but a lot can go wrong in a place that's supposed to keep people healthy yet designed to punish them. What happens inside a prison affects all of us. Visit sickpodcast.org and listen to "Sick" wherever you get your podcasts.

Rovner: Hello! And welcome back to KHN's "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 early this holiday week, on Tuesday, Nov. 23, at 10:30 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 video conference by Margot Sanger-Katz, The New York Times.

Margot Sanger-Katz: Good morning.

Rovner: Joanne Kenen of Politico and the Johns Hopkins School of Public Health.

Joanne Kenen: Hi, everybody.

Rovner: And my colleague Mary Agnes Carey of Kaiser Health News.

Mary Agnes Carey: It's great to be here.

Rovner: Later in this episode, we'll have an interview with Mary Ziegler. She's a law professor at Florida State University and author of several books on the abortion controversy. She'll help me preview the big Mississippi Supreme Court case that will be argued on Dec. 1, which is next week, and could lead the Supreme Court to overturn *Roe v. Wade*. But first, this week's news.

So, the House passed the big Biden Build Back Better social spending bill last Friday (that's what I intend to call it from here on) — following an all-night speech, delaying things, from House Minority Leader Kevin McCarthy. Fun fact: There is no filibuster in the House, but the Democratic and Republican leaders have something called, quote, "leader time." That's effectively unlimited, as McCarthy showed by hosting his one-person pajama party. Anyway, the bill eventually passed, and now it is on to the Senate, where it's very likely to change and then come back to the House. But before we talk about the Senate, let's review what finally made it into the House bill when it comes to health. Margot, this is basically your extra credit this week, so why don't you start?

Sanger-Katz: Yeah, I wanted to recommend this amazing herculean effort from my colleague Alicia Parlapiano called "Everything in the House Democrats' Budget Bill," where she went through the entire legislative text and pulled out each of the different programs that are created under it, or

extended or changed — tells you how long they're meant to last and also what the cost is, according to the [Congressional Budget Office], or the savings, depending on the program. And it's just beautifully designed and, I think, incredibly helpful. This is a bill that is so large and expansive in terms of the various things that it's trying to do that I think it can be really hard to get your arms around it. I mean, even just the health care parts, which I know we'll talk about, there are a lot of them, and some of them are small and some of them are big. So just being able to go through and actually understand what's in the bill, I think, is just really a great resource.

Rovner: So, health care — why don't you start?

Sanger-Katz: So, I sort of think of these things in a couple of big categories. So there are some changes to Medicare. So people who get Medicare are going to get a hearing benefit for the first time. They are going to get a change to their drug benefits. So there will be a cap on the amount they can be asked to pay for their drugs out-of-pocket and also a cap on their insulin out-of-pocket costs at \$35 a month. There are some changes to Medicaid and CHIP. People in the Medicaid gap in states that did not expand their Medicaid programs are going to get access to subsidized federal health insurance — a little bit like an Obamacare-plus plan, with basically no premium, very little cost sharing and some extra wraparound stuff, but it is private coverage. The CHIP program, which is the Children's Health Insurance Program, is going to be made permanent. So that program already exists, but it has to get authorized every once in a while, and that [reauthorization requirement is] going to go away if this bill becomes law.

Rovner: I should point out that I'm cheering not because I'm for or against CHIP, but because it's ... every health reporter who has had to cover the reauthorization of CHIP, however many times, and it's always a gigantic headache.

Kenen: Even though they all agree on it, it's still a gigantic headache.

Rovner: Yes.

Kenen: It's Congress at its best.

Rovner: Right! So, yay for things we don't have to worry about as reporters.

Sanger-Katz: Also in Medicaid, there's going to be a provision that will allow women after they give birth to keep their Medicaid coverage for an entire year for postpartum care. And there are going to be some technical changes that will require that once children get signed up for Medicaid, they can't get kicked out for a year, even if their family's income changes or there's some other weird paperwork irregularity. It's just a way to keep kids covered in a more continuous way. So that's kind of the main Medicaid stuff. There is some ACA [Affordable Care Act] stuff. So, the subsidies that were expanded as part of the stimulus bill this year that really gave people a lot more financial help buying insurance — those would be extended for a few more years through the end of 2025. There also would be more money for outreach and advertising. Some of these other things that are supposed to pull people into ACA. And then there is [the topic of] drugs. ... We talked about this a couple of weeks ago, but there's sort of been a negotiated, whittled-down approach to Medicare price negotiations, where the Medicare program would have the ability to

regulate the prices of about 20 drugs a year after they've been on the market for a few years. And then there would also be limits, not just in Medicare but across the marketplace, for drugs, in how much the prices can increase from one year to the next. So they would be limited to [the] inflation [rate] for those price increases. So those are the big things, and all that drug stuff, I think, is sort of the most in flux of the things that I just mentioned, and I'm sure there are lots of other small things that I've forgotten.

Rovner: Yeah. Well, there's also, I mean, then there's what I call the health-adjacent things, the home care ...

Sanger-Katz: Oh, of course, home care!

Rovner: ... and child care and universal pre-K, things that we like to categorize under the "social determinants of health."

Sanger-Katz: ...and maybe paid family medical leave, right?

Rovner: And four weeks of paid family leave that may, yeah, that may or may not stay in as we get there. You know, I feel like ... we've sort of fallen into the Democrats' messaging trap, which is that this thing started out so big and it has ended up much smaller than it started out. But even [if it's] much smaller than it started out, this is an enormous bill that would make some enormous changes to social programs, right?

Carey: Oh, it absolutely would. And one could make the argument that it's completely warranted. You know, if you look at, for example, covering the coverage gap in Medicaid in some of those states or permanently funding CHIP. ... I think, a lot of people would agree with [that]. They like CHIP. They like the program. Let's get rid of this annual funding fight. There's more money in there for public health infrastructure. These are all things that people like and enjoy. But when you put them all together, to your point, Julie, it is quite big.

Rovner: So that's basically what made it into the House-passed package. Now it goes to the Senate, where there are three big obstacles: Democratic Sens. Joe Manchin and Kyrsten Sinema and parliamentarian Elizabeth MacDonough. What's most likely not to make it in because of one of these three people?

Carey: Well, it's the "Byrd bath," right? For all you people outside Washington who don't know what we're talking about, it's this rigorous scrubbing of every provision to make sure they have a direct budgetary effect. And it happens in the Senate, and it's known as the "Byrd bath" after Bobby Byrd, the Democratic senator of West Virginia. And so it happened with everything that wants to go through reconciliation, right, which is the 51-vote margin. So, they'll go through and they're going to start presentations, I think, within the next week or so to the parliamentarian. And this is going to be a whole thing to see what stays and what goes.

Rovner: Yeah, there's actually two parts to this. There's the "scrub," where the parliamentarian goes through and makes sure that the bill can go to the floor, that everything in it currently generally falls within the rubric of being allowed under reconciliation. And then there are individual challenges to individual provisions that legislators can raise. And they basically get

litigated in front of the parliamentarian. They go and sit in the parliamentarian's office and they argue. And then the parliamentarian hears both sides and renders a decision about whether, you know, this is allowed. And I guess one of the big ones that a lot of people think we'll hit the cutting-room floor is there are immigration provisions in this bill that are going to have trouble getting through the parliamentarian because lawmakers have tried to put immigration provisions in reconciliation bills before, and parliamentarians have said, "Yeah, no, that's not directly enough connected to the federal budget for us to allow that to go through in reconciliation." Is there anything else that we're thinking, any of the health provisions we think might not make it?

Sanger-Katz: I know there's been some discussion of this provision that I mentioned that would limit the price increases for drugs, not just in the Medicare program, but for everyone. So, there's some question about whether or not that could get through. And the test — this is a very technical test. There's multiple parts to it, but the key phrase that I always think of is "merely incidental." So, there are lots of policy changes you can make that have some effect on the budget. The CBO says there's a score: It will cost or save a certain amount of money. But the question that the parliamentarian has to make, and it's a very subjective judgment, is: Is the point of the policy to save or spend the money? Or is the point of the policy something else, and the saving or spending is "merely incidental"? And so I think people feel that trying to regulate the prices of drugs paid by Medicare, which is a federal program that is spending the money on the programs, that those are going to pass the budgetary test because that's really the goal: to save Medicare money. But that potentially trying to lower the price of drugs outside of Medicare — even though it would have a budgetary effect because the federal government subsidizes all other kinds of health insurance — might fail this, might be considered to be "merely incidental." So that's the decision that she's going to have to make. And just one more thing about all of this, I think it's so important to remember that we are going through this insane process for a reason. Normal legislation does not require a "Byrd bath," does not require us to adhere to all of these strange budgetary tests, does not require one person to have the final say on what kind of provisions can become law or not. And the reason why we're in this world is because the filibuster exists in the Senate. And that means that normal legislation that doesn't have to follow these rules needs assent, effectively 60 senators to sign on. And the Democrats could do away with the legislative filibuster, but some of their members don't want to do that, and they have not done that. And so, they're trying to pass this giant bill that's trying to do all of these things as a budget bill. And so they are now bound by these budget rules.

Rovner: Which is a perfect segue into my next question, which is that two of the senators who say they don't want to do away with the filibuster are Joe Manchin and Kyrsten Sinema. And they're also the two senators who have not officially signed on to this yet. I know Manchin does not ... has said pretty clearly he does not like the family leave provisions, even though they were very popular in the House. I know that Kirsten Gillibrand of New York is working on him very hard to accept them. I mean, how confident are we that they will eventually come along? And do we know what kind of changes they might force before they do? Because, obviously, this doesn't pass without them, because they need all 50 Democrats plus Vice President [Kamala] Harris to break the tie and make that 51st vote.

Sanger-Katz: I do think that this family leave provision is the one that seems the most obviously to be a problem because Sen. Manchin has said very clearly and repeatedly: “No, no, no, no, no. I do not want this to be in the bill.” So it is going to take changing his mind for it to stay in there. I think there is also some discussion about the state and local tax deduction. So, there is this effort to try to basically give a big tax deduction back to everyone, but predominantly to higher-income people who live in high-tax blue states. That was done to bring aboard the votes of several moderate Democrats in the House, who come from those high-tax states, like New Jersey and New York.

Rovner: And Connecticut.

Sanger-Katz: So that's like I feel like less of a Manchin-Sinema issue. But there are other senators who are kind of grumbling about that. Whether it will cause them to not vote for the whole package seems maybe more unlikely. And Sen. Sinema was at the table directly negotiating with House leadership over these prescription drug provisions. So I think she has pretty strong preferences on that and certainly made it clear to everyone involved that if they did not adhere to her preferences that she might be a veto on the entire bill. But my sense is that they reached an agreement that she is comfortable with. So I think that on the health care stuff, aside from family medical leave, things are looking good and then whether other issues are going to pop up is to be seen.

Rovner: Yes. All right. So we're starting to see some of the debate on some of the smaller items that made it into the bill, but not into the major summaries. For example, there's apparently a new tax on vaping products. Supporters say it will deter young people from starting to vape. But opponents say it could deter existing tobacco users from switching to safer vape products. This is kind of the entire vaping debate in a microcosm, right?

Carey: No, absolutely. And vaping has been viewed as, and rightfully so, as a very bad thing, especially for teens and for younger folks. But if I'm remembering correctly, there's some evidence that people who try to go off cigarettes and they go to vaping are more successful than those who don't do that. So it's an interesting thing that they're doing, but it's, as often happens in health care, it's complicated, right? It sparks a whole 'nother debate, that people are ...

Rovner: It's the harm reduction debate.

Carey: Exactly, exactly.

Kenen: We know that tobacco taxes over the years have been one factor, along with a lot of public health messaging that have reduced the use of cigarettes. I'm not sure if we know people switch from cigarettes, from traditional, what they call, combustible tobacco, what we think of as a cigarette, to e-cigs for other reasons, including the hope that it is less harmful and there is some evidence that it is. I don't think the public health world is completely certain long term that this is the answer, but there are people who switch because they believe it's less harmful to them. So, will the tax deter that? It's not the same thing as smoking-not smoking, a teenager being able to afford a pack of cigarettes. Now I don't know that we know yet; we don't have enough history yet on how different kinds of tobacco-related taxes affect smoking behavior. So does this make adult smokers keep smoking? I don't know that. We know that's the argument, but you know, there's so

much politics and money in this as well. I just don't know that we have an actual behavioral answer to what this kind of tax does.

Rovner: Yeah. Well, I think another secondary issue that's likely to get heavily lobbied is staffing requirements for nursing homes. The bill also has something that would seem to be, but is not an obvious requirement, for a registered nurse to be on the premises of a nursing home 24/7/365. Currently, a registered nurse must only be on hand eight hours a day. But there's a major shortage of labor in nursing homes already, which the covid pandemic has worsened substantially. Nursing home industry officials say if the requirement is made, that many facilities would be forced to close. So, is this another case where while we're looking at the big stuff, other stuff is going to happen here below the surface?

Sanger-Katz: I think if you are a senator who has preferences about these smaller items, you have been wise to keep your powder dry until now. Like now, the bill has passed the House. They need your vote. It's do-or-die. And if you are not a Joe Manchin or Kyrsten Sinema who is committed to killing the whole package if you don't get everything you want, I think now is the time to say, "Hey, I love this package. I'd love to help you out, but I have a problem with this little thing right here. What can you do for me?" And so I think we're starting to see some of that kind of stuff come out of the woodwork now, where people who have maybe not been particularly specific or vocal about their preferences are making them known to leadership. And so, I think there will be a lot of these kind of smaller changes. And, of course, this is also the kind of last hurrah for industry and other kinds of lobbies to make their points and preferences. Man, I mean, they, of course, have been working diligently throughout this year to try to influence lawmakers and staffers on the details big and small. But you know, this is sort of do-or-die for them. And I think the pharmaceutical industry is, of course, the one that I think all of us have been watching the most closely because they have a lot at stake, and they are apoplectic, and they are just spending huge bucks. And there's been really great reporting in Politico over the last few days about all of these very small details that they are continuing to fight and push on and hope that they can have modified in this kind of last round of negotiations.

Kenen: I would point out it's never really the last round. There's never really the last hurrah on K Street, because if you lose legislatively, and I do think this package will be changed, I agree with everybody. But if you lose legislatively, then you get to try to influence the regs. And if you fail to influence the regs, then you try to repeal things or put things on hold. Because if you can't repeal it, you can say, "Well, instead of 2024, the industry really needs to do this in 2026. We saw that with the ACA, a lot of provisions did get delayed. Some of the taxes eventually did get repealed. They got delayed for years before they got repealed. So yes, every interest is going to push as hard as they can for the next couple of days, weeks, months, whatever. Probably, you know, I think Biden really would like to have this done in December, but we don't know because there's a debt ceiling and other funding. The government also has the defense bill, there's all sorts of other stuff. But no. Washington has never seen the last hurrah on anything.

And I agree with what Margot said, a lot of really smart stuff — but I take issue with "the last hurrah." I've never seen one yet. Maybe the ACA repeal. Maybe finally seeing the ACA repealed.

Carey: No, no, no, no. Watch it.

Rovner: I take this moment to remind everyone who wasn't there that the ACA, which was in a similar position to this — it passed the House in November, the Senate worked on it for all of December, and it finally passed the Senate on Christmas Eve morning in a snowstorm.

Carey: That's right.

Rovner: So, beat that, President [Joe] Biden.

Carey: They just might.

Rovner: Yeah, it's true. Let us turn to covid. As we predicted last week, boosters are now available to all adults — six months out from their last dose of the two-shot mRNA regimen, or two months out from the single-dose J&J vaccine. That should alleviate at least some of the confusion. But is it too late to prevent the current surge from getting worse as people travel and gather for the holidays?

Kenen: Well, boosters won't change Thanksgiving. Boosters could change late-December travel, winter break for kids and Christmas and all that, boosters could help there. You know, in terms of a booster is it going to help ... turkey? No. I mean ... will they, because some people already got ... I mean, those of us who have elderly relatives who are going to join, I mean, my mom is 87. She is coming for Thanksgiving. My son is driving her, she's not doing public transportation. You know, people are going to rapid-test before we see her. But yeah, she's boosted. I don't know that an 87-year-old should travel. I mean, in my family and her own health status, I feel a lot safer, I mean, having her drive, yeah, my having my son drive her, she would have been safe anyway. But generally, would I feel so good about an 87-year-old who wasn't boosted as I feel about an 87-year-old who's boosted? Yeah, I'm glad my mom is boosted.

Carey: But it might help also curtail further surges in the wintertime. I mean, it's getting colder. We're all getting indoors. You know, the messaging around this is going to be really critical. People can get it, should they get it, if they're debating it? I mean, the public health message, I think, has to be pretty consistent. I was thinking this morning, maybe bring back that Nike ad: Just do it, you know, just get out there and get the shot. Don't parse it between 65 and older and 65 and younger, and you may ... you're eligible, but we really recommend it for ... no. Like, just do it, just get out there and do it.

Sanger-Katz: Well, it really seems like the public health messaging has changed around that, like even just in the last week. Like, I do feel like the messaging was really nuanced. Like, I personally have not gotten a booster because it just felt like it wasn't really recommended for me before. And then I feel like very recently we've started to see federal public health officials and also just, you know, public health experts who all of us talk to and hear from and read their tweets saying, no. Basically, every adult who's been six months out from their vaccine should get a booster. And I do think that that is a change. It was not really recommended in that blanket way before, it was not approved in that blanket way before, and a lot of municipalities and states weren't providing it to people who didn't fit into one of these more narrow categories. So I think it's a much easier

public health message to communicate to people than what it was before. But it seems like there has just now been this decision that that is, in fact, what they want to recommend.

Rovner: Yes, there was this: “You can get it, but should you get it?” I will point out that Ashish Jha, the dean of the School of Public Health at Brown University, who has been on this podcast, tweeted yesterday, and he's been sort of worried about the confusion with the public health messaging. [His tweet] said, ‘You know what?’ he said. “If you're an adult and you're more than six months out from your vaccine, get a booster.” See that's the tweet, that part of it has gotten easier. But if this is too late for lots of people, we have yet to find out. As you know, we are starting to see surges in more states. And obviously, Europe is in the midst of a full fourth wave and lockdowns, which we'll get to in a minute. But, in the meantime, here's an unsettling factoid: More people have died of covid in the United States in 2021, a year in which we've had vaccines, than in 2020, the year in which we did not. Now there are a lot of obvious reasons for that, including the spread of the much more contagious and potentially more deadly delta variant. The fact that covid was not geographically widespread in the U.S. for most of 2020, and maybe, most important, the fact that there was almost certainly a giant undercount of deaths in 2020 as we were unable to test for covid in a lot of hard-hit places. But I have a more existential question: Why does everybody act like we're getting to the end of this crisis when clearly we are not?

Kenen: Well, I think, you know, you hear someone like Tony Fauci talking about, you know, next spring, next summer. I mean, the expectations game is already being changed. The death toll did hit around 2,000 a day for a few days during the peak of delta. It was higher than I thought it would get if you asked me six months ago. It did not get to the 4,000 a day that was the worst that we had last January. Right now, you know, we're in that situation where cases are rising again. Deaths actually have been stable at around 1,000 a day. We'll probably see an uptick because cases are rising, but these new drugs are probably going to get approved pretty quickly. It's not going away, but it might not be quite as brutal. And we may be in this transitional period where it's here to stay, right? It's not going away completely. But when does it become something we can actually live with? When can we have some confidence we might be at the beginning of that transition, that people will still get sick, but they won't die because we're going to have medication we need. The medication requires testing, it requires rapid diagnosis, it requires people understanding that they have a breakthrough [case]. The other thing with the rising caseloads right now is states have been uneven about tracking breakthroughs. If some of these cases are breakthroughs, you know, as people travel and get exposed, but they were vaccinated and they don't have a severe case, then that death rate, we hope, won't be anything like what we saw last year.

Rovner: Margot.

Sanger-Katz: But I also think we're seeing sort of the predictable results of a country where vaccination is widespread but is not as widespread as perhaps public health officials had hoped. You know, especially children are just starting to get vaccinated because it took a while for the clinical trials to demonstrate that the vaccine was safe and effective for children. And we do have this variant of the virus that is more contagious than what was spreading in 2020. And I think that combination of things where you have kind of a large population of people who are very

susceptible to catching covid and then you also have a covid virus that spreads very easily — that just means that there are more opportunities for people to get sick. As Joanne said, it seems like people who were vaccinated are less likely to have really serious illness or to die, and that's good. But they can get these breakthrough cases and the more unvaccinated people who have very serious cases where they're spreading a lot of virus around, the more likely it is that people who are vaccinated are going to be exposed to enough virus, that they will get one of those breakthrough cases. And so I think that's why we're seeing so much.

Kenen: Right. If people get boosters, if we see a lot of booster uptake in the next couple of weeks before the winter holidays, which is, you know, a lot of traveling and celebrating indoors and people being together, kids bringing things home from college, which is like a whole flu issue, which we're not getting into.

Rovner: My alma mater is leading the flu outbreak!

Kenen: Julie! Right, your alma mater is really doing it! You know, if people are ... or people get boosters, that's another tool we have in terms of, you know, this ratio of cases to really serious hospitalization, ICU and death cases. The percentage of breakthrough cases are from waning immunity for people who got their shot almost a year ago, and they need their booster. We could see a drop in the breakthrough rates. I mean, our data on breakthrough. is not great. It's a lot of guesswork on that.

Rovner: I'm curious about sort of the covid fatigue behavior issue, though, I mean ...

Kenen: Well, raise your hand if you're not tired of it!

Rovner: Well, yeah, but I went to my first football game this weekend (Michigan clobbered Maryland), and I wore a mask and almost nobody else did. And then I went to an indoor agility trial at a place where people had been wearing masks. And again, I wore a mask and almost nobody else did. And I'm boosted. I'm seeing sort of this very much, you know, we're just going to pretend it's not happening, even in places where people had been very careful at a time when cases are going up. And I just, I worry about sort of what the combination of those two things could mean.

Kenen: But even look at the patchwork, right? Look at the four of us. Two of us live in Montgomery County, two of us live in D.C., all of us live within a couple of minutes' drive from one another. I mean, from Margot's house to Julie's, it's more than a couple of minutes, but it's still close, you know.

Rovner: Not that much, like 20 minutes.

Kenen: Right. And yet Julie and I live in Montgomery County, which had a mask mandate, lifted the mask mandate, and put it back on. And now D.C., which I can actually walk to from my house, had a mask mandate when Montgomery County didn't have a mask mandate, and now D.C. is taking off its mandate. But Montgomery County just put its back on. I mean, it's cra-, you know, dealing with this.

Carey: The fatigue is real.

Sanger-Katz: I think it's not just that, though. There's been like a, I think there's been a change in the way that people think about this. I think early on there was this expectation that we all had to hang in together until we got to herd immunity and then we could all just go all the way back to normal and everything would be fine and the virus wouldn't spread. And I think there's been a realization with delta that we are not going to achieve herd immunity with the virus as contagious as the delta variant. And I do feel like people just feel it's a little bit more "every man for themselves." If you are someone who is vaccinated and you're not worried about getting covid, then go out and do what you want. And if you were a person who was vaccinated and is worried about getting covid, then you're still wearing your mask at your agility trial and you're working from home. And if you're someone who is unvaccinated and unconcerned, you're just kind of going about your life as though nothing is different. And I think it just has become much harder, both because of the fatigue, but also because there's sort of no obvious light at the end of the tunnel. There's no goal for people. I think it's much harder for public health officials and other government officials to really ask people to make these major sacrifices to change their lives in this extended way, because it's not: Do this until there's a vaccine. There's not: Do this until there's herd immunity. It's not: Do this until there's a vaccine for kids. I think we've kind of hit a lot of those milestones and there's so much political backlash and economic pain associated with these big public health restrictions that I think that many people have started to just think much more kind of individually about their own risk preferences and much less about this kind of community public health "stop the spread" kind of thinking that dominated the early months of the pandemic.

Kenen: But I think half the states didn't buy into that from the very beginning. We might have had a hope of national unity, but we did not experience national unity. I mean, there was resistance even in March of 2020. I mean, President [Donald] Trump did the 15-day stay-at-home order and then it was extended another couple of weeks. And, you know, they had to sort of basically, you know, pile on him to not lift it early. You know, and then some states didn't respect the full length of it, of the initial stay-at-home, and then the gateways that we were supposed to have to figure out this gradual reopening, it got all blown up in a matter of minutes. So I don't think we ever had a realistic we're-all-in-this-together experience. From the very beginning, it was politicized. It was related to the Trump reelection campaign. You know, we may have had 10 minutes of national unity.

Sanger-Katz: I agree with everything you've said, Joanne, but I also think I did a project where we did very, very large surveys. So we kind of surveyed people at the county level about whether they were wearing masks. And I think this was like maybe July or August of 2020. And I was just really floored by it. There was regional variation and there were places where people were wearing masks more and people were wearing masks less. But basically, like large majorities, you know, like 70%-80% of people almost everywhere said that they were wearing masks when they were around other people, and that was similar to the national polls from lots of polling outfits. I think that there was politicization and I think there was variance in compliance and there was certainly variance in public health rules. But I do think that for the early portion of the pandemic, for much of 2020, I think there really was a lot of shared sacrifice. I mean, people stayed home and gave up

their livelihoods. They endured, you know, enormous inconvenience, economic pain. They home-schooled their children. They did wear masks, which you know, are kind of a pain, you know, I think that they're worth it, but it is an inconvenience, and it is uncomfortable. And it was a little bit expensive at the beginning, too. I think a lot of that has fallen away over time. But I just want to give the American people credit for, I think, it actually really having, by and large, a sense of community and shared enterprise early in this experience.

Kenen: But they didn't have a choice. School was closed. It wasn't like, I'm going to keep my kids home voluntarily. For a lot of people, it wasn't a choice if you stayed home, your business was closed. And I think that there was so much resentment because they didn't buy into it and that fed the toxicity that with a lot of other things that are toxic in this country. It's more than who wore a mask and how long, and whether you told someone you were wearing a mask versus how consistently did you really wear it. Plus the fact that — how many Americans actually know where their nose is? Which just ... don't even get me started, right? That's not necessarily a compliance issue. It's a paying-attention issue, or figuring out how to tie your straps better issue. But I don't really feel like we've had a deep ... and it's not just our country, we've seen it around the world too. I mean, there have been, these things have been divided and protest and angry. And, you know, sort of, it's been a horrible experience. There's nobody who's had a good pandemic, and some people have said, this is what we need to do for solidarity and [for] other people it is just fueled grievances. And you know, the four of us have jobs that we could stay at home, and we may not like the isolation, but we didn't lose ... none of us got lost our jobs and none of us lost our incomes. It was hard and it's still hard. People both in the masks and the vaccines and the larger discussion, people are treating this as a personal risk rather than an infectious disease. And it's not just, you know, I'm going to do some extreme sport, and maybe I'll get hurt. If you take that risk, you're also putting other people around you at risk. And that has never been really absorbed on a societal basis.

Rovner: Although I will say, having read the history now of some of these outbreaks, this is not unique to the United States in 2020 and 2021. And if you look across the pond in Europe, where they're having a bigger wave and they're having more strict lockdowns, there is a huge backlash. So I mean, as much as we like to sort of beat up on ourselves for not having better sense of the rest of the community, this seems to be a worldwide thing. That's why I mentioned the sort of, you know, covid fatigue, that sort of every time a government tries to crack down, there's a larger portion of the population ... and to do what Margot and Joanne were saying, I think it's a large minority, so I think you're both absolutely right. But that large minority gets a little bit louder every time because everybody is so exhausted by all of this. I think that's ... am I seeing any disagreement here?

Sanger-Katz: I also think the other thing is that there's not a clear endpoint. And I think an earlier phase of the pandemic there was like something that we were moving towards. And now we're basically seeing an environment where the adult vaccination rate is probably about as high as it's ever going to get. And we're still looking at a thousand deaths and, you know, something like 70-some thousand cases.

Kenen: We're up to 90-something [thousand] cases.

Sanger-Katz: Yeah, I mean, it's just I think it is hard to imagine just an indefinite period of these large life restrictions for most Americans. And so again, I think that's contributing to the rise in cases because people have sort of given up.

Rovner: I'm getting better-fitting masks. All right. Well, I think we've exhausted this for this week. That is the news. Now we will play my interview with Florida State law professor Mary Ziegler, and then we will come back with our extra credits.

We are pleased to welcome to the podcast Mary Ziegler. She's a professor at the Florida State University College of Law and the author of several books on abortion. I've called her to help us preview the big abortion case the Supreme Court will hear next week that could lead to the overturn of *Roe v. Wade*. Professor Ziegler, thank you so much for joining us.

Mary Ziegler: Thanks for having me.

Rovner: So let's start at the beginning. The case has called *Dobbs v. Jackson Women's Health Organization*. Who is Dobbs and what is Jackson Women's Health Organization?

Ziegler: Jackson Women's Health Organization is the only remaining abortion clinic in the state of Mississippi, 'cause even though *Roe v. Wade* is still the law and abortion is theoretically a constitutional right, there are very few clinics that are still in operation. Thomas Dobbs is a state health officer for the Mississippi Department of Health. So really, this is a case between an abortion provider representing the interests of the clinic, the doctors and patients suing the state of Mississippi.

Rovner: And what does the Mississippi law do?

Ziegler: So, Mississippi's law bans abortion at 15 weeks, and the theory underlying the law is that fetal pain is possible at 15 weeks, and there are a few — it's worth saying there's a few limited exceptions to the law as well. There's a medical emergency exemption. There's one for certain severe fetal abnormalities, but those are very narrow exceptions. So for the most part, it bans all abortions at 15 weeks. You won't hear most people talking about the fetal pain piece of it. There's not a lot of support for the idea that fetal pain occurs at 15 weeks. Even most abortion restrictions that take that position usually start around 20 weeks. Instead, you'll hear talk about words like viability or even just about the ultimate fate of *Roe*, and I'm sure we'll talk about why those are implicated by this case.

Rovner: Yes, I've been covering reproductive health since the late 1980s. More than once I have covered a Supreme Court case that was described as likely to result in the overturn of *Roe v. Wade*, but this case is really the real deal, right?

Ziegler: It is, yeah. And I think it's worth kind of unpacking why people say that, because I think there's probably a feeling some people have of the Chicken Little, the sky is falling. You hear this all the time. Why should we feel differently this time? So, one thing to remember is that the Supreme Court gets to pick the cases it takes, so it doesn't have to take abortion cases with explosive questions if it wants to proceed slowly. And yet it chose to take this case. And the reason that's a big deal is because at the moment, under the law, the right to choose abortion applies

until viability, and there's some fluidity as to exactly when viability, which is what survival is possible outside the womb, when that occurs. But somewhere between 21 and 24 weeks, depending on the hospital, the technology available, even the particular pregnancy. It definitely isn't possible at 15 weeks. So for the Supreme Court to take this case and presumably uphold the law, which is what most people assume will happen given that the court has a conservative super majority, the justices will either have to say Mississippi is within its rights to do this because there's no right to choose abortion at all or because viability as a dividing line doesn't make sense. So that means, in essence, the court is either going to have to overrule *Roe* entirely or transform what *Roe* means in order to side with Mississippi. And either of those things would be a huge deal.

Rovner: Yeah, and that's what I mean. We've talked about the Texas case quite a lot with its sort of unique enforcement mechanism. But the court made pretty clear in its deliberations on the Texas case. It is not looking at the threshold issue of whether or not Texas can ban abortion. It's really looking at whether Texas can have the law enforced by sort of getting out of the way of all of state officials. But in this case, the court actually is taking up the question of can a state ban abortion before viability? Right? That is the threshold question here.

Ziegler: Yeah. And it's worth saying again that the court didn't have to deal with that question. I mean, even if it wanted to address Mississippi's law, which would be weird anyway, because there's only two laws like this. Usually when the Supreme Court gets involved, you know, for example, there's what's called a circuit split when the lower courts disagree about what the law is. There's nothing like that going on here. So it seems as if the court was interested in this law and in this particular question, because Mississippi, when it initially asked the Supreme Court to hear this case, wasn't even really talking much about overturning *Roe*, because that just seemed like too long of a shot. So the fact that the justices want to deal with this question of bans before viability seems pretty obvious and should definitely get our attention.

Rovner: Could the court uphold the Mississippi law without overturning *Roe* or *Casey*?

Ziegler: So this is one of the questions that I think you'll see disputed, in part because we don't agree. We don't agree on what *Roe* is, right? So some abortion rights supporters have taken the position that you can't get rid of viability without overruling *Roe*. And on some level, that's correct because you certainly can't keep *Roe* and its successor case *Planned Parenthood vs. Casey* intact and uphold Mississippi's law. But the Supreme Court has a track record of changing what *Roe* means, including in *Casey*, where it dispensed with what was then the rule that applied to all abortion regulations, but still said there was a right to choose abortion until viability. So it's conceivable that the court could sort of do a similar magic trick and say, you know, what really matters is that there's a right to choose abortion, that you can't unduly burden it and this viability thing, it's not really that important. We can get rid of it and keep the rest. The tricky thing, of course, is if this is a court that's invested in overturning *Roe* down the road, the court would have to do that without inadvertently shoring up abortion rights and giving itself more to overrule *Roe* in a year or two years' time — if that's what the justices are interested in doing.

Rovner: Because that's what *Casey* did, right?

Ziegler: Yeah.

Rovner: It weakened *Roe*, but it said, Yeah, there's a right to abortion.

Ziegler: Yeah, exactly. And the court has played these games, as you mentioned with what counts as the essential holding. So in *Roe*, the rule was called "the trimester framework," and that made it very hard to regulate abortions in the first trimester of pregnancy. And *Casey* said the trimester framework is unessential. Now that would have come as a big surprise to anyone paying attention at the time, because that was quite literally the rule that every court ... you should determine whether a law was constitutional or not. But *Casey* dispensed with it and said that isn't really what's important. And you could easily imagine the Supreme Court doing something just as credible, for better or worse, when it comes to viability.

Rovner: So if the court actually does overturn *Roe* or does say that the Mississippi law can be upheld, it could affect things well beyond abortion, right? Like birth control?

Ziegler: Yeah, absolutely. And one of the reasons for that, so there are two different ways of thinking about that. One would be the court's reasoning. If the court, for example, says that there's no right to an abortion because of the original public meaning of the 14th Amendment. It's quite hard to explain how, as a matter of original public meaning, there's a right to birth control, either, because in the 19th century, of course, abortion was illegal, but so too was contraception and, frankly, sex education and lots of other things. The other, I think, more practical thing is that people don't agree on what abortion means. So if states are allowed to ban abortion, we're going to have to have serious conversations about when abortion begins and birth control ends. Those conversations will be particularly pressing when we're thinking about things like emergency contraception or ...

Rovner: ... even some hormonal birth control.

Ziegler: Absolutely. Yes, especially IUDs. It's worth saying even the regular pill, although that hasn't been in the crosshairs as much, I would say, as emergency contraceptives and IUDs.

Rovner: So how do you, I mean, you've looked not just at the law of this, but you've looked at the abortion debate over your career. How would this ... how is this likely to change the abortion debate if the court, as we assume, does something dramatic to *Roe* or to the right to abortion?

Ziegler: Well, I think it depends on how clear and how dramatic. If the court is going to sort of bide its time and dismantle *Roe* in pieces, you know, maybe take a couple of years and a couple of decisions to do that, the political fallout will depend on how the court does this when it does it. The more complicated the court's decision-making, the harder it is to understand, often the less of a political reaction there is simply because people don't really know what's going on. And I think to some degree you see that in the fights about SB 8, which on the one hand, you know, people were riveted by what was going on in Texas. On the other hand, people were really confused about what exactly legally was happening. So the more of the Supreme Court obfuscates, the more it can mute political response. I think if there is a clear overruling, we would expect to see a backlash, given that there's polling suggesting that most people support *Roe v. Wade* ... support at least the

idea of keeping abortion legal, if restricted. And so, really, the only questions would be, you know, the extent of that backlash, whether that backlash translates into voting patterns, given that there's so many things going on between, you know, the economy and covid, voting restrictions and so on. And also, I think, given our political polarization, whether that backlash translates into concrete change in both either the state or the federal level that we would expect to see serious political consequences, we just don't know exactly what kind.

Rovner: Well, first, we will expect to see the oral arguments. So. Mary Ziegler, thank you so much for the excellent preview.

Ziegler: My pleasure. Thanks for having me.

Rovner: OK, we're back. 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 and in our show notes on your phone and other mobile devices. Margot, you've already gone this week. Joanne, why don't you go next?

Kenen: My colleagues and I, Darius Tahir and Allan Vestal, we did a big project, a multi-month project last summer about what was going on in the state veterans' homes, which are specific long-term care facilities for aging vets, sometimes their spouses. And we had been working for the last few months on filling in the data gaps we had been calling in, reaching out to every home that didn't report their data. There was no government agency that was reporting the data. We just did not know what the hell was going on in some of these homes. That story was being edited and was about to be published when the VA, the VA scooped us and changed their policy, annoyingly for us, but good for the public. They began publishing the data. There are still holes in the data. We do still do not know about some of the states that also were not responding to our calls and emails. But the story is the VA stats show devastating covid toll at vets' nursing homes and the VA does say they will be updating and we will be watching to see if the VA actually does update it and whether we actually get prior data out of these states that have not told us what is going on.

Rovner: Thank you for persevering. MAC.

Carey: So my extra credit is written by my KHN colleague Rae Ellen Bichell. It's called "A Covid Head-Scratcher: Why Lice Lurk Despite Physical Distancing." Lice are back shouldn't really surprise anybody. They've been around "for tens of thousands of years," Rae Ellen writes. "A little lockdown wasn't going to end the romance." And, oddly, the idea of lice coming back to regular numbers is kind of a sign that things are back to normal. We do have social distancing in schools, but it's things like, as people get more comfortable with sleepovers and play dates and summer camps and family gatherings. Preschoolers are kind of cuddly, so that's a nice conduit for those lice to get to know each other, and teens like to do those selfie pictures. So it's a great story to read. You get a little window into the life of the professional delouser, Linda Holmes. And as somebody who has endured this in her own household when our kids were younger, I just thought it was a fabulous story.

Rovner: I know, I love that story, too.

Kenen: It's a great headline. Yeah, really great headline.

Rovner: My extra credit this week is from our fellow podcaster Stephanie Armour and her colleague Robbie Whelan in The Wall Street Journal. It's called "Telehealth Rollbacks Leave Patients Stranded, Some Doctors Say." And it's kind of a follow on to our telehealth conversation from a couple of weeks ago. It seems that one of the huge advances for patients when telehealth rules were expanded came for patients who needed to see specialists in other states or who were too sick to travel regularly to the doctors or, in some cases, both. It seems that now the telehealth policies are reverting, in many cases to the pre-pandemic rules. It's cutting off people with chronic illness from their practitioners. Just one more example of how changing health care policies always produces unintended consequences, no matter how hard you try for it not to. It's a really good story.

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. Also, as always, you can email us your comments or questions. We'll do an "Ask Us Anything" episode in December, so start getting those questions in. We're at [whatthehealth](http://whatthehealth.org) — all one word — @kff.org. Or you can tweet me. I'm [@jrovner](https://twitter.com/jrovner). Joanne?

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Rovner: MAC?

Carey: [@maryagnescarey](https://twitter.com/maryagnescarey).

Rovner: Margot.

Sanger Katz: [@sangerkatz](https://twitter.com/sangerkatz).

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