

KHN's 'What the Health?'

Episode Title: KHN's 'What the Health?': Compromise Is Coming — Maybe

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Julie 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 this week on Thursday, Nov. 4, at 10:30 a.m. As always, and particularly this week, 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: Margot Sanger-Katz of The New York Times.

Margot Sanger-Katz: Hello.

Rovner: And Mary Ellen McIntire of CQ Roll Call.

Mary Ellen McIntire: Hi, everyone.

Rovner: Later in this episode, we'll have our latest "Bill of the Month," with Rae Ellen Bichell. The patient this week got an unexpected emergency room bill for a routine baby delivery. We will tell you what happened then. But first, this week's news.

OK, as usual, we will start on Capitol Hill with the latest on the Biden administration social spending agenda or Build Back Better or budget reconciliation or whatever it is you would like to call it. When we met last, last week, President Biden had jettisoned some major priorities, including prescription drug price negotiation and guaranteed family leave, and cut the price tag of the overall bill by nearly half. And still, there was no promise of support from Senate Democratic holdouts Joe Manchin and Kyrsten Sinema, whose votes would be required to pass this given the zero support among Republicans. Now it appears that both of those items are provisionally, at least, back in. Although, while Sinema has apparently signed on to the drug deal, Manchin still says family leave is a no-go. Alice, let's start with where we are with the entire package. Until now, it looked like they wanted to quote-unquote pre-conference this. They didn't want to pass anything in the House that they didn't think could pass the Senate. Now it looks like they might pass something in the House that they know can't pass the Senate.

Ollstein: I mean, the great uncoupling has happened. You know, the great uncoupling, sort of, between the two bills — between this and the infrastructure bill — but also the uncoupling of the House track and the Senate track. A lot of folks in the House said, "Don't make us vote on something that's never going to pass the Senate anyways. Don't make us take some tough votes on things that could get stripped out by the parliamentarian or just not supported by a particular senator." And it seems like they're going to do that anyways. They're moving forward with a vote on the bill — could be today, probably not today, probably in a couple of days — a version of the bill that does include the drug pricing provision, does include paid family leave. But aspects of it could get taken out by the parliamentarian in the weeks ahead or by opposition from Manchin when it comes to paid leave or any one senator on any one other provision. It's very precarious at this point.

Rovner: Yeah. Mel, is that your feeling, too, that now we're no longer doing ... these things are only going to leave the House in the form in which they're going to pass the Senate?

McIntire: That's definitely what it seems like. I think after the elections in Virginia and New Jersey and obviously other states — but those were the big governor's races this week — the immediate question kind of was, What does this mean for Democrats' agenda? You know, it wasn't as good a night for Democrats as they would have hoped, and there were a lot of questions about ...

Rovner: That's putting it mildly!

McIntire: Sure. Yes. You know, I think there were some questions: Does this, how does this — if it does — affect the Democratic agenda in the House? And it kind of seems like the House move now is: Double down, let's pass these bills, the infrastructure bill to the White House for President Biden's signature. Let's double down and add in paid family leave, even though Sen. Manchin is saying that he doesn't want to pass that through reconciliation without knowing how these Byrd rule rulings will go, and move ahead with this and start to say, OK, we have these majorities; we're going to act with them while we can and hopefully pass something that will resonate with the American people and the voters. So that's sort of what it seems like at this point.

Rovner: Yes. Well, as an old person here at the table, I get to say that the ACA [Affordable Care Act] actually had to come back to the House because it got a couple of provisions taken out by the parliamentarian under the Byrd rule, and it had to pass the House one last time, which a lot of people don't remember. So — and that was pre-conference. That was *really* pre-conference. That was pre-conference for months. So, you know, these things do happen. ... Mel, you kind of anticipated my next question, which was, What impact did the elections in Virginia and New Jersey — Virginia, where the Republicans took back the governorship and all the top seats in, apparently, the House, and in New Jersey, where the Democratic governor survived, but just barely. That seems to have kind of lit a fire under Nancy Pelosi, yes?

McIntire: Yeah.

Ollstein: It depends who you ask. You know, some members were saying, you know, this shows the need to pass this quickly more than ever so that people can really feel the impacts, blah blah blah. But others, including Manchin, said this shows that we need to, you know, hit pause and be more careful and not add to the deficit and not potentially worsen inflation. And so I think that election results were really like a Rorschach test where everybody could read into it whatever they wanted and whatever they previously believed.

Rovner: So, even before the elections on Tuesday, prescription drugs, which had been taken out, were put back in. I think that the president had left them out to kind of, again, light a fire under negotiators, and that seemed to have worked. Who wants to tell me what's left of the prescription drug negotiation provision? It seems to be in.

Sanger-Katz: I actually think that what happened on prescription drugs is pretty interesting. So, just to back up a little bit, the House in 2019 passed a big prescription drug price reform bill that was very ambitious and it was very aggressive. It would have made very large changes in the way that the U.S. buys and prices drugs. Some estimates said that it would have reduced the revenues to the pharmaceutical industry by, like, 40%. So, these were very substantial reforms. And basically what would have happened is that Medicare would have had the ability to regulate the prices of a pretty large subset of prescription drugs, and they would lower them to a benchmark price that's based on what other countries pay. And we know the U.S. pays about 2 1/2 times what other OECD [Organization for Economic Cooperation and Development] countries pay on average for prescription drugs. So, we're talking about pulling it down towards that benchmark. That's a big reduction. There were some other things in that package as well, but I think from the beginning it was clear that that was not going to fly in the Senate, that it was just a little bit too big and too aggressive. And then it sort of fell apart, was not in the president's framework last week. And then there were discussions last week among key negotiators where it seemed like, really, what was on the table was something that would have almost no effect on the prices of prescription drugs at all. And then they sort of, like, pulled the rabbit out of the hat this weekend and came up with a compromise that I

think is sort of a rare Washington compromise where it feels like not just half a loaf, but actually something different and interesting. And I think that really balances a lot of the competing concerns about this legislative idea, which is the pharmaceutical industry — and I think a lot of smart people who are not making money in this industry — think that if you pull 40% of the revenues out of this industry by substantially lowering the prices of drugs as soon as they come onto the market, even if they are quite innovative and have major health care implications, that it will interfere with the pipeline for new research that people ...

Rovner: And the incentive.

Sanger-Katz: Yeah, I mean, why would people put their venture capital dollars into an early-stage biotech startup that has, like, an interesting drug for cancer? If that drug works, they can't make any money at the end. You know, they'd rather put their money somewhere else. That's sort of the theory, and I think the pharmaceutical industry hypes that up to ridiculous extremes, where they say, "Any dollar that comes out of our pocket will break the whole system." But, basically, what Congress, what the various negotiators in both the House and Senate came up with is drugs that come into the market are basically going to get a bunch of years where their price cannot be negotiated by Medicare. So, in the case of normal prescription drugs — they call them small-molecule drugs — I think it's nine years. And in the case of biologic drugs — these are drugs that are based on, like, proteins or other kind of more complicated manufacturing processes — it's 12 years, so you get onto the market and you basically get nine or 12 years with the current system. And then, after that, Medicare gets to bring down the hammer. And it is not this international price index. So we're not talking about really, really slicing down the prices, but there's kind of a clear schedule where the price ratchets down over time to be sort of similar to what happens when there is generic competition. [unintelligible] kind of normal, ideal version of our system: You introduce a new drug, you have a patent, the patent expires, someone makes a copy, a bunch of competitors come in, and the price quickly collapses. And this is sort of mechanically causing the same thing to happen, even in the case of drugs where there might be additional patents or other reasons why there isn't a generic entry that causes that price collapse. So, it's smaller. We're talking about smaller reductions in the prices of drugs. There's this delay, so it's not going to have the same impact right away. And they did agree that it would be a smaller number of drugs. So not every drug, even when it hits this deadline, is going to be subject to these negotiations. Nevertheless, I think it will hit a lot of very expensive drugs. It will prevent the pharmaceutical industry from being able to charge high prices indefinitely if they can come up with new patents or do other sorts of shenanigans that we've seen in the market. And then — sorry, I'm talking for a very long time — but the bill also ...

Rovner: I mean, it looks like this might actually be the deal, finally. There's also an out-of-pocket cap, right?

Sanger-Katz: Right. ... There's two more things. One is that it does restrict the amount that pharmaceutical companies can raise the prices of drugs in each year. So right now they can, they often raise the price twice a year by amounts that are larger than inflation in the general economy. So this says, basically, "You get to raise the price of your drugs only by the rate of inflation. And if you raise the prices by more, you get a big penalty." ... I think that this is sort of a sleeper issue, actually. It completely redesigns the Medicare Part D drug benefit. So, seniors who are in Medicare, they buy a separate insurance plan that covers their drugs, and it's actually a terrible insurance product and has been for many years. It has no limitation on how much people can be asked to pay out of their own pocket. And, indeed, I wrote a story last week about — you know, cancer patients were paying \$15,000, \$16,000 a year ...

Rovner: Right. When they passed it, the idea was there is a catastrophic benefit, but you have to continue to pay 5%, and when they passed this in 2003, nobody anticipated that that 5% could turn into tens of thousands of dollars, which is what has happened.

Sanger-Katz: So, what Congress is doing in this bill is, first of all, they're just putting on a hard cap. They're saying no one's going to have to pay more than \$2,000 a year for their drugs out of their own pocket. That's

still a lot for a lot of seniors in Medicare. You know, the median income for someone in Medicare is, like, less than \$30,000, I think.

Rovner: I think it's \$27,000.

Sanger-Katz: Yeah, you know, so \$2,000 a year, that's a lot, but it's a lot less than \$16,000. And they also are doing some things — and this is sort of complicated — but they're trying to encourage the plans to negotiate harder on the prices of expensive drugs. In the current system, the government basically pays for almost all of the cost of drugs once the plans get over a certain dollar — this kind of catastrophic part of the benefit. And so they're trying to put more of that onto the backs of the insurance companies so that the insurance companies don't just let these very high prices go unaddressed. So, anyway. So, again, three things: More limited negotiation for the price of drugs directly, a limited set of drugs, a kind of slightly less aggressive metric, and they get this delay before it goes into effect. Then, no increases on the price of drugs higher than the rate of inflation. And then this changes to the insurance for drugs that really reduce the amount of out-of-pocket spending that seniors are going to have to make for their drugs, regardless of what their underlying price is.

Rovner: And we should point out that even though this is sort of, you know, a tiny bit of what they started with, the drug industry still hates it. This is, this is a compromise between Democrats on various sides of this issue, and the drug industry still hates it. You know, and it seems, as I mentioned [at the] top. family leave, whose elimination infuriated a lot of progressive Democrats, is back in, at least in the House version, but not Medicare dental and vision benefits. That was supposed to be the one thing for the “Medicare for All” wing of the party, given that there's — remember — no public option and no lowering of Medicare's eligibility age. They were just sort of banking on these extra benefits. And other than some coverage of hearing aids, there really doesn't seem to be any. And that's really OK with the progressives? They're just going to let this go by for getting everything else?

Ollstein: They were ready to endorse the bill without any drug pricing included either. I mean, they really have given a lot of ground, but I think, you know, they're accurately reading the situation and seeing that this is what they're going to get with the narrowly divided margins in the House and Senate. And so, they are looking at what they consider a lot of the wins in the bill, including on child care, on climate, on a bunch of other things they care about, and they're ready to support it. Look, from their perspective, they thought the entire bill was not going to happen at all. They were worried that Congress would just pass the bipartisan infrastructure bill and completely abandon this entire social spending bill, and so they consider this a win in that sense. I think there was a push this week from some advocacy groups to say, “Hey, now that drug pricing is back in, let's use that money to get some dental back in.” I asked around; that is not happening. That money is just going to go back into the general pool, and you know, it could go to paid leave, but it's not like a one to one. And so it's really too late in the game to add some of this stuff back. Dental, of course, is the most expensive benefit of the three and the most logistically challenging to set up, and it had a lot of resistance from the dental industry, as well as private insurers who have private Medicare plans because there was, you know — they don't want seniors to drop their private Medicare plans and go towards traditional Medicare now that they can get these benefits. And so there was a lot of industry resistance as well as, you know, just logistics and cost concerns that prevented that. But, you know, progressives are not thrilled. They're not thrilled with how much weaker the drug pricing provision is than where they started, and they're not thrilled on the Medicare benefits front, considering that was one of their top priorities and because Democrats might not have a chance to pass anything like this for many years to come. This is really leaving it on the table.

Rovner: And they're not thrilled with the home care coverage — right? — which got, has been cut again. And with the Medicaid gap coverage. What is left of the people in the Medicaid gap, the people who have no ability to get coverage in the 12 states that haven't expanded Medicaid?

Sanger-Katz: [unintelligible] But it's only for four years. Instead of, like, standing up a brand-new government program that copies Medicaid, which was part of the original plan, instead, people in the

Medicaid gap — so, in these 12 states that did not expand Medicaid — they're going to get access to effectively free plans in the Obamacare exchanges that have additional wraparound benefits. So they're going to have cost sharing that's similar to Medicaid, which is to say almost no copays, copayments, for doctor's visits and medical treatments. They are going to have additional benefits that are not part of the normal Obamacare plans, things like transportation to their medical visits. And, you know, they're going to get to piggyback off of this existing health insurance system that has already been set up and which — flipping the switch of giving them subsidies is actually a relatively trivial matter, as opposed to building up a whole new infrastructure just for them. So, there are people that really think that Medicaid is the perfect program for low-income people in this country, and they make a lot of good points about how the benefits really are designed for this population. There's a lot of thought that has gone into the way the Medicaid program is built, and this solution does not capture all of that. This is a program that is meant for higher-income people, and they're trying to kind of backfill it with these additional subsidies and benefits. But on the other hand, this is a population that is extremely vulnerable. They are poor, and they have had no access to affordable health insurance, and this is going to give them access to affordable health insurance almost immediately. And they're going to have it for several years and then we get to have a fight about whether it will be extended or there'll be some other solution down the road.

Rovner: All right. Well, we should, we do need to move on. But I will say that there's still a long way for this bill to go, but I do feel like it's starting to take shape of what might actually pass at some point, maybe before Thanksgiving. Oh, well, I'm fairly confident it will not be in its final form by the time we meet again next week. And because there's not enough health news right now, it's open enrollment for both the Affordable Care Act and for Medicare. That's the time of year when people can sign up for health plans or change their plans. I think it's fair to say that both programs suffer from one big problem that's the same: that there are lots of people who could save money by switching, but they don't bother to even look because it's so complicated. Is there any way to fix this? I mean, Medicare at least tried. Medicare has standardized Medigap plans. But now there's, you know, dozens in some cases of Medicare Advantage plans and various permutations of drug plans. We all know that the Affordable Care Act has way, way more plans than anybody can possibly make sense of. I mean, this is sort of the paradox of choice, right?

McIntire: Yeah. I mean, I think, you know, the thing to look at this year — and I'm a little bit more up to date on what's happening with the Affordable Care Act open enrollment than I am Medicare open enrollment — but you know, a big thing for that is, you know, obviously we've spent much of the past year generally in a special enrollment period. So, we did have a sizable number of people after Democrats passed the American Rescue Plan earlier this year that included the enhanced subsidies available on the exchanges. I forget exactly what the numbers were, but you know, a sizable number of people who did go back in and shop tried to take advantage of the fact that they may have become eligible for a subsidy for the first time or have a larger subsidy.

Rovner: I think it was, like, a couple of million people. It was a big number.

McIntire: It was a sizable group of people, so it'll be interesting to see — you know, those enhanced subsidies are still in play for this year. They are further extending them as part of the reconciliation package that we were just talking about. So, it'll kind of be interesting to see how that continues to grow this year. But I think, you know, one of the things that's sort of interesting is coming off of a year of so much of it was spent in a special enrollment period that people were just doing that. Does that have any effect on this? How does it affect how people are thinking about open enrollment this year, I think is somewhat interesting.

Rovner: And also, this year's open enrollment period is still longer than it has been in the last year or two because the Biden administration went back to the original. So I guess it's open until Jan. 15? Medicare open enrollment closes in December because Medicare open enrollment's always only six weeks long, but the Affordable Care Act open enrollment is going to go on a little longer. Yes, Margot.

Sanger-Katz: Well, just so much of our system is built on this idea that people benefit from choice and that they want to shop, and that the process of shopping and choosing will make insurance better, will create incentives for insurance companies to offer us better products, to negotiate harder with medical providers and lower the cost of health care. I mean, we see this now kind of throughout our health care system. Our employers often give us multiple choices of plans. The Obamacare exchanges are built on this idea — right? — where you're going to have lots of choices. And indeed, politicians often brag about how many plans there are. When there were not enough plans, that was seen as bad. Now there's more plans; that's seen as good. And you know, Medicare increasingly is a privatized program in which people are also shopping among various Medicare Advantage options in these kind of regulated private marketplaces. So this is our system. Lots of people have to choose a plan. Almost all of them have to choose a plan at this time of year. And, so, I just want to say that economists who study this have found that everyone is terrible at this. So, if you find it hard and stressful to pick a plan and you don't know if you're picking the right one or you're scared and you end up just renewing the thing you have because you can't deal with it, you're not alone. Everyone is bad at this. I wrote about a study last year that found that insurance brokers — so, these are people whose job it is to pick plans — were worse at picking plans than a computer program. So, this is a really, really hard task that our system asks of people, and we're kind of stuck in this system where people have to make really, really difficult choices about extremely complicated financial products. Picking the best insurance plan for you means identifying: What is going to happen to me? What is it going to cost, and how do these plans match up with all of these possible scenarios? That's really, really hard math for most people to do. It's much harder than most financial shopping decisions that we make. That said, health insurance is so valuable; it is so important. We have growing evidence that the difference between having insurance and not having insurance could be the difference between life and death. It is, can be the difference between ensuring good health and bad health. It can be the difference between financial stability and financial ruin. And in this environment, where there are these really enhanced subsidies for people across the income spectrum, I just would — my advice would be that if you know someone who is frustrated by this system and who is wanting to throw up their hands, I would just would encourage them to pick something. I think it really does behoove you to buy some insurance and to just take some comfort in the fact that it is not only hard for you.

Rovner: No pressure or anything. All right. Well, let's talk about abortion, which may or may not have been an issue in the Virginia gubernatorial race, although it very much was in the advertising for it. The Supreme Court on Monday heard nearly three hours of extremely complex arguments about two cases challenging that Texas law that bans abortions at about six weeks and incentivizes members of the public to enforce the law by providing bounties of at least \$10,000 for those who successfully sue people providing or aiding abortions. One of the cases was brought by abortion providers and the other by the Biden Justice Department. Interestingly, it seemed from the arguments that the court, despite twice refusing to put the Texas law on hold — it is in effect — might have enough votes to allow that law to be challenged by the abortion providers — probably didn't seem that way, maybe by the Biden administration. But by the time they get around to challenging this law, it might all be moot because of Mississippi. Right, Alice?

Ollstein: Well, because the Supreme Court scheduled this case faster than they've scheduled any case in decades, there is the expectation that some kind of ruling could come down in the next couple weeks, you know, potentially allowing the earlier, the lower court's block on the law to go back into effect. So, there could be news on that front — maybe not. In less than a month, the Supreme Court is going to hear this bigger case on the fate of *Roe v. Wade*, but a decision in that case isn't expected until next summer. And so it is likely there will be some changes on the Texas front before then. But a lot of the arguments in this case — even though, of course, it's about abortion — were not really about abortion at all. They were about whether judges can be sued. They were about whether the federal government can get involved in a case like this. And there was a lot of talk from the abortion clinic side that if Texas' law is allowed to stand, states will be able to pass all kinds of crazy laws allowing private citizens to bring lawsuits about any federal right or law that they disagree with. And so there was sort of this imagining this world in which states will be able to pick and choose which federal laws they want to follow if this is allowed to go forward. And so it was really fascinating, really convoluted. And yeah, there was a very surprising breakdown among the justices of who seemed to be on what side. Of course, you can't always tell from the questions they ask, but

it was really notable that Justices [Amy Coney] Barrett and [Brett] Kavanaugh seemed very skeptical of what Texas was doing, and even Clarence Thomas — and no one is more vocally anti-abortion on the court than Clarence Thomas — even he said some things along the lines of: Texas, you're going a little too far on your arguments here.

Rovner: Yeah, I think the argument was not about abortion; it was about, can you can you limit a constitutional right and not allow people to sue in federal court over it? That's basically what this argument was about, right? And I think Justice Kavanaugh seemed to be swayed, if you will, by a brief filed by a gun rights group in California that said, you know, if Texas can do this, then California could make it impossible to, you know, to sue over gun laws, over gun restrictions, and that seemed to kind of turn some heads. Meanwhile, as I mentioned at the top, Democrat Terry McAuliffe, the Democratic candidate and former governor of Virginia, ran ad after ad here in the Washington media market that covers much of Democratic Northern Virginia, warning that now-Gov.-elect Glenn Youngkin would try to make abortion illegal in Virginia if the court overturns *Roe* next year, as it seems that they very well might. Likely that the court will overturn *Roe*, not necessarily that Youngkin would try to make it illegal, although he might well try that, too. Can we read anything from Virginia about voters and abortion, or is it too early? I feel like we constantly see ads that say, you know, "The Supreme Court might overturn *Roe v. Wade* and then bad things would happen, if you support abortion rights." But the Supreme Court has not overturned *Roe v. Wade* in 50 years, even though we know that it's more likely that they will than any time they have since the 1990s. I mean, do we think this can become a voting issue?

Ollstein: I think every state is so different. I mean, we saw abortion rights be a big motivator for Democrats in the California recall race that kept the current Democratic governor in power and that turned out to be a successful strategy there. But Virginia is not California. A lot of voters are more conservative on that issue, and so it didn't prove as much of a motivator as the issues the right was trying to highlight in terms of critical race theory and education and all of that. And so I think you can't make one big national takeaway assumption about abortion right now. I think it really depends state by state.

Sanger-Katz: I do think that we're in this interesting period in which in Texas we are effectively running a test case for what it's like to not have *Roe v. Wade*. I mean, *Roe v. Wade* still exists, but because of these weird procedural issues, Texas has effectively banned abortions after six weeks of pregnancy, which is clearly in conflict with *Roe v. Wade*. At the same time, we have this Mississippi case that was specifically taken by the court to address the core questions of the *Roe v. Wade* finding. And indeed, you know, Mississippi, like in their briefing, has come straight ahead and basically said, "Yeah, we want to overturn *Roe v. Wade*. That's what we're doing here." They're not trying to give the justices a little middle wiggly path to, like, weaken abortion rights but still hold on to *Roe*. So I have not really talked to anyone in the legal community and I haven't talked to everyone, obviously, but people think that the court is going to take a whack at *Roe* in this term. And, again, we are seeing on the ground what that might look like in a state that is, where politicians are opposed to abortion. And I just don't see this groundswell of liberal voter energy around this issue. You know, for decades abortion has been extremely mobilizing for conservative voters, for evangelical voters. I think it's been a very helpful issue for Republicans. And, you know, we hear this conventional wisdom like "Oh, well, like, liberals aren't as exercised about this because they have the constitutional right on their side. They don't have to worry about it as much." I think we are in a moment where, if you were going to be worried about it, like, we're there now, and I don't see this kind of, as Alice said, sort of nationwide activism around this issue. Maybe it will be different when the Mississippi case comes down and starts to feel a little bit more real to people. And I think it will be interesting to see what happens in Texas politics in the coming months, because Texas is kind of living through this now. But I don't know what my prior was because I'm always bad at predicting politics, but I do think that I have noticed how muted the response has been on the left to this very large current and looming change to the legal status of abortion in this country.

Rovner: No, I agree with you, Margot. I think, you know, this is all just completely up for grabs. We're in very new territory here. We will see how it goes. Well, let us talk about covid, at least briefly. The good news: Kids as young as 5 are now eligible for vaccines. The not-so-good news: Also this week, the world

passed the 5 million mark in covid deaths, and that's almost certainly an underestimate. Meanwhile, we are still here fighting about vaccine mandates. The Supreme Court, which has been pretty solicitous toward religion in the religion versus public health argument, ruled for public health, at least in Maine last week, refusing to block a vaccine mandate for health workers that doesn't include a religious exemption. And today we are getting that long-delayed rule from the Biden administration requiring that health care workers and facilities that accept Medicare and Medicaid be vaccinated and that employers of more than 100 workers require either vaccines or weekly testing, and there's now a new single deadline of Jan. 4. Is this going to touch off a whole nother round of debate? Or have so many employers basically done this already that what's left is just kind of *de minimis*?

McIntire: I think this is going to touch off another round of debate, and you're already seeing this. You know, there's a large number of Republican senators, 30-something, who are pushing back on this. They're definitely trying to make this an issue. I think it'll be interesting what the court does. You know, surely we can expect additional lawsuits on this. The main case from last week is telling, that they let the mandate go forward, but you know, it's only so much. I think that it'll be interesting to see, you know, is there a difference between employers and health care workers? You know, you do have the testing option, obviously, for employees who do not want to get vaccinated; they can do testing. And this rule sort of fleshes out some questions around that. For example, employers can put the cost of testing on employees rather than having to cover it themselves. So, you know, I think these rules are interesting, but I think this is going to continue to be, you know, a big political issue. Even if we are seeing that a lot of employers who have put forward these mandates are getting [an] overwhelmingly large number of their employees to comply with it, I still think this is going to at least be a political issue in the months to come.

Rovner: All right. Well, one more topic this week that you might have missed, even if you're a health nerd: The Texas Medical Association is suing the Biden administration over the regulations the administration issued to implement last year's surprise-bill ban passed by Congress. The Texas Medical Association says the rules, unlike the original legislation, are too tilted towards insurers to the detriment of providers, meaning that providers will be paid less than they anticipated. Margot, you've covered this, I think, the most closely of anybody here. Do these rules put a thumb on the scale for the insurers?

Sanger-Katz: I mean, certainly the providers have been making that argument early and often. I, if you read the legislative text, I really do not think that these regulations are very far off of what Congress intended. You know, the surprise-billing legislation was also the result of a compromise in Congress. There were competing bills and they were merged and various parties were brought together to come up with some kind of consensus. And we have seen letters from some of these members of Congress who wanted a more provider-friendly version of the law, saying, "We did not intend for this law to be interpreted in the way that the regulations have interpreted it. We want it to do something completely different." But I think if you look closely at the law, I think that they voted for a bill that does not do what they think it does. So it will be interesting to see. I mean, in general, the courts do grant quite a lot of deference to regulatory agencies to make reasonable, good-faith interpretations of what laws say. I am not a ...

Rovner: Go Google "Chevron."

Sanger-Katz: I'm not an administrative lawyer, but I really think that this regulation seems, like, squarely in that non-arbitrary, non-capricious reading of the surprise-billing law. But, you know, it just is a reminder that, you know, this is a solution that is going to be borne somewhat on the backs of providers. The CBO [Congressional Budget Office] always said it was going to reduce their pay a little bit, and, you know, they're angry about it.

Rovner: And also, I mean, this is not the first time that a Congress has passed a compromise bill and then that compromise has been reopened during the regulatory process of implementing it.

Sanger-Katz: Well, it's funny to me because I spent a lot of yesterday reading the legislative text of the Build Back Better law. And it's just a reminder that these members of Congress, even though they are

engaged in very detailed negotiations, they really did spend all weekend, you know, sitting around trying to figure out what they were going to do on the prescription drug bill. You know, at the end of the day, they're coming up with a couple of bullet points. Maybe they have, like, a one-page summary of what they want and then they're handing it over to people whose job it is to write the sort of fine-print legislative text. And that stuff is, I don't know, it's like a whole other language. You know, I try to read it and I try to interpret it. But I just was reading Build Back Better yesterday and thinking to myself, Wow, this is really hard. Like, it's hard for me — even knowing what the summary is — it's hard for me to understand what this law is saying. These regulators are going to have to interpret it; that's a really hard job. And I think this whole fight about the surprise billing is like a reminder of that, too, where, you know, people were in a room and they basically agreed to a set of concepts. But then that had to be written down. And I think the way that it was written down maybe was a little different than some of those people hoped it would be.

Rovner: Or they painted it a little bit differently from what they possibly agreed to in that room. Sausage making is complex.

Sanger-Katz: Can I just — sorry, this should have been my extra credit. Perhaps I will now make it my extra credit prematurely, but ...

Rovner: Go ahead.

Sanger-Katz: I really was reminded of the sausage-making metaphor recently, that my late colleague Robert Pear wrote an amazing article during the Obamacare legislative debate in which he went to a sausage factory and discussed the metaphor of sausage making with a sausage-maker who was deeply offended that his work was being compared to the process of writing legislation, that he said, “We have set recipes. We have procedures” — you know. Anyway, it's just sort of a hilarious look at all of the things that are weird about the legislative process. But also I learned a lot about the sausage-making process, too.

Rovner: I do remember that and I will go back and find it. I promise. All right. Well, that is the news for this week. Now we will play my “Bill of the Month” interview with Rae Ellen Bichell. Then we will come back and do our extra credits.

We are pleased to welcome back to the podcast my KHN colleague Rae Ellen Bichell, who wrote and reported the latest KHN-NPR “Bill of the Month.” Rae, thanks for joining us.

Rae Ellen Bichell: Hey, Julie. Thanks.

Rovner: So, tell us about this month's patient — who she is, where she's from and how she ended up at the hospital.

Bichell: Yeah, her name is Caitlin Wells Salerno. She's a conservation biologist, so she spends lots of time way up in the Rocky Mountains, like trapping very rare squirrels and studying how much they invest in their young and how that's changing with climate change. But this story has nothing to do with that. It has to do with how much *she* invested in *her* young. So, what happened is she was having her second child. It was the day before her due date. She went into labor. She goes into the hospital — Poudre Valley Hospital in Fort Collins, where she lives — and has a great birth and comes out with a healthy big kiddo named Gus, and they're doing great; they go home. The only problem was this was during early covid lockdowns. So everything was a little empty and weird in some ways. But they were really, the couple was really happy with the experience, and the kid.

Rovner: And then the bill came.

Bichell: Then the bill came. It was very big. The grand total of all the items on the bill from the hospital was more than \$16,000. So that's what the hospital wanted from the family, the Wells Salernos, and also the insurance company. It's not what they got in the end, but it was a galling number to Caitlin and her

husband, Jon Salerno, and they were especially disturbed for two reasons. One, they were supposed to be paying \$3,600 of that, which might not sound like a ton to some people. I think we're sort of accustomed as a society to paying a lot for a healthy vaginal birth. But it was really surprising to them because their first child, they'd only had to pay \$30 for his delivery.

Rovner: She had better insurance, right?

Bichell: That was a different state, different insurance — way better insurance. But they're like, wait a minute. Gus is a great guy, but his birth was not worth 100 times more than Hank. What's the deal here? The other thing that really made their eyeballs pop was this one line embedded in there, which was for a Level 5 emergency department charge. And that left them thinking: Wait, we never went to an emergency room. What is this, even?

Rovner: Now, they did go in through the emergency entrance, right? Because it was covid, and that was the only one that was open.

Bichell: They did. They were told — this was in the early weeks of covid lockdown, so hospitals were responding in a lot of different ways to try to streamline things or make sure that there was sort of a limited access, I guess, through funneling people through certain areas. In thinking about where this charge could have come from, Caitlin and Jon were like, “Well, yeah, we did. We went through the ER doors. We checked in at the ER desk” — but that's because their doctor told them to. They said that's the only door open; go in through there. So they came to us with this bill, saying, Is this possibly why we got the charge? And they had the same questions for the hospital, too.

Rovner: And what'd they find out?

Bichell: First off, it took a really long time to get an answer. But eventually they found out that no, it was not for going through the emergency room door or checking in at the ER, that it was actually something much more surprising. It was for the thing that they did after that point. So, they walk through the ER, check in, go up the elevator to labor and delivery. Caitlin was in good enough shape, doing fabulous, that she walked herself. She said, “No, thanks” — you know, [a] nurse said, “Can I wheel you up there?” She said, “No, I'm doing fine.” Once they got to the labor and delivery floor, she went to a small triage room. And in that room, she got some pretty routine care. She got an IV placed, her dilation was checked by her regular doctor she'd seen the whole time, and they confirmed her water had broken. So they just wanted to know, Are you really in labor? There you go. And then she walked herself — and even took a selfie, smiling, so she was still in great shape; no emergency happening — walked herself to the actual delivery room and had the baby. So the ER charge was for the little triage room, which, crazy enough, is called in some hospitals an obstetrical emergency department and bills like an ER.

Rovner: So, this was in no way an emergency, but she was billed for a Level 5 emergency visit, right? How much was the bill? How much was the emergency part of the bill?

Bichell: The Level 5 emergency department charge was \$2,755. That is the single largest item on this list, other than the actual delivery, the vaginal delivery itself. Level 5 charges are something that are reserved for usually really serious stuff. I mean, that's like you come into the ER in the middle of a stroke kind of a deal, or you're, like, having a heart attack, you know — like, there's usually a life-threatening, needs serious care, and ...

Rovner: Or you fell off a mountain in Colorado.

Bichell: There you go. It's not healthy, full-term labor. That's what's supposed to happen. It would be a problem if that did not happen. Not if that did.

Rovner: So, in looking into this, you discovered that this is not unique to this hospital or even your state, right?

Bichell: Yeah. I mean, it turns out a lot of hospitals have these triage rooms that have been essentially rebranded, or relicensed at least, as obstetrical emergency departments. And in a lot of cases, you, as the patient, would have no idea. Maybe there's a sign that says "Obstetrical Emergency Department," but probably when you're in labor, you're not going to be taking in all the details around you. So there were, I spoke to a lot of people before and also since the story is published across the country who've gotten this charge, been confused, tried to dispute it with the hospital and with insurance, and some of them have never gotten a satisfying answer. And some of them have been told this is "Oh, yeah, you did have emergency services. You went to that special triage room, and this is therefore justified." So, this is happening all over. I haven't been able to track down a sense of how common it is, but it is something that is relatively new in some hospitals. One mom that I spoke to who went to the same hospital as Caitlin Wells Salerno did, found out that it started in July 2019 at that hospital. And the reason she was able to find that out is because she did a ton of phone calls saying, "Why do I have this charge on the birth for my second kid in 2021, when I didn't have it for my first kid in 2018?" And they said, "Well, yeah, we changed the room in 2019."

Rovner: So, what happened with this particular bill?

Bichell: So, in this particular bill, the family did end up paying what they were supposed to. So \$3,609 ...

Rovner: What they were charged, basically, or at least what their insurance had negotiated.

Bichell: So, this case is a little bit funky. There's two ways that insurance plans will reimburse a hospital for a birth, or for many things. One is a fee for service. So line by line, they will reimburse the hospital for specific lines in that itemized bill. The other one is they'll reimburse in sort of a preset lump sum. ... A DRG [diagnosis-related group] is what it's called. In this case, that Level 5 charge — the hospital didn't actually get anything from that, and the family did not actually have to pay specifically because of the Level 5 charge because their insurance plan reimbursed the hospital for the DRG that's called, you know, uncomplicated vaginal delivery.

Rovner: Right. Of which this was clearly a part.

Bichell: Right. However, this family was still frustrated. They're like, "On principle, this doesn't make any sense." And I spoke to many experts who said this shows a habit of billing. And even if in this one case it didn't affect the patient's wallet, think about the people with different insurance plans. Think about the people without insurance plans. I did speak to one patient who gave birth at this hospital, received this Level 5 charge and therefore had to pay \$375 in coinsurance because that's what she has to pay when she accesses emergency services as part of her plan. I've spoken to people at other hospitals who are also on the hook for this coinsurance payment because of Level 5 charges. So, even though in this particular case it did not impact the family's finances, they identified this as confusing, weird, didn't get a satisfying explanation and could be impacting lots of other people who might not even know it.

Rovner: I would say. So, what is the takeaway here? I mean, giving birth when you're due, you know, in an uncomplicated way in a hospital is one of the most common medical procedures in the United States.

Bichell: Right.

Rovner: And it's one of the few things that you can actually try to check the price of in advance. Should people now be asking: Are you going to have a separate charge for an emergency triage when I show up with my water broken?

Bichell: I think so. I wish I had a really clear takeaway here for how to wrap your head around whether this is going to show up, and if it does show up surprisingly, how to dispute it. I don't have that, but I do think that the place to start is [to] ask your hospital: Do you have an obstetrical emergency department? Do you have an OB-ED? And if so, what are the conditions under which I would get a charge for that service? You know, in this case, the conditions are as follows: You think you're in labor. You come in to the hospital as your provider tells you and are subsequently admitted. That's pretty straightforward. And unless you go to the clinic beforehand, unless you happen to go into labor, like, during business hours during the weekday and can go see your regular provider in their regular office and they can directly admit you, then you're going to get this Level 5 charge. So, try to clarify ahead of time: Is this a thing at the hospital — if you want to give birth at a hospital — and when, under what conditions might I expect this on my bill? The second thing is to ask your insurance plan, I think. You know, how do they reimburse the hospital for birth? Because if they reimburse them on a DRG basis, that lump sum, then the line items might not matter so much. And you as an individual patient, you then have to ask, how important is this to me?

Rovner: Right. You're just going to have to pay your share of the lump sum.

Bichell: The last thing here is just, if you do give birth, look at your itemized bill and look at the individual items on there. Is there something called a Level 5 charge? Is there something called an emergency services charge? If there is, call the hospital and ask, Has this been upcoded? You know, Level 5 charge is for very specific conditions, and healthy full-term birth is not typically considered one of them.

Rovner: All right. Well, as usual, buyer beware. Rae Ellen Bichell, thank you very much.

Bichell: Thanks for having me.

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 and in our show notes on your phone or other mobile device. Alice, why don't you go first this week?

Ollstein: Sure. So, this story in ProPublica caught my eye because I did a lot of reporting over the past year on the state of sexually transmitted infections in the United States, the very bad state of it and how they've gotten even worse during the pandemic. And Carolyn Chen did such a good piece along that front about congenital syphilis, which is syphilis that is passed from a pregnant person to the child. And it's completely preventable. If it's treated while the person is pregnant, it can be eradicated and not happen. And so every instance that a baby is born with syphilis is a failure of public health, and it's just happening a lot and it's getting worse. And there's a lot of good information in the piece about how the United States as a country was focused on this and then predictably abandoned the effort, cut funding, didn't follow through when they were within sight of completely eradicating it, and that it got even worse in the pandemic as contact tracers shifted from tracking syphilis to tracking covid, etc. And so a very heartbreaking piece and hopefully a call to action.

Rovner: Mel.

McIntire: Yeah, my extra credit this week is a story that was in Stat looking at how there wasn't really a way that the U.S. came up with to overcome vaccine hesitancy with the covid-19 vaccine. You saw employers, states, local governments, private businesses trying, you know, really everything that they could think of to try to encourage people to get the vaccine.

Rovner: Free doughnuts for a year!

McIntire: Free college tuition, \$500 — whatever it was. And for the group of people that was truly vaccine hesitant, this didn't really do a whole lot to convince them. And there wasn't a clear public health strategy that was laid out as we began. ... The Biden administration came in with their plans for vaccination and to

ramp up vaccinations, and there was that. But to really target people who had genuine concerns and really were unsure, a lot of these things did not work. And sort of looking at that, I thought that was really interesting.

Rovner: It was. Margot, you've done yours. Mine is from my KHN colleague Anna Maria Barry-Jester. It's called "Labs With No One to Run Them: Why Public Health Workers Are Fleeing the Field." It's the latest in a series that KHN has been working on about the crisis in public health. As workers are being overworked, underpaid and viciously harassed on the job, sometimes their actual lives are being threatened. And now it's threatening more than the war on covid. This line from the story is particularly chilling: "Public health nurses, microbiologists, epidemiologists, health officers and other staff members who fend off infectious diseases like tuberculosis and HIV, inspect restaurants and work to keep communities healthy are abandoning the field. It's a problem that temporary boosts in funding can't fix." At some point, we as a society are going to have to decide whether we want to have a public health infrastructure or not.

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're at [whatthehealth](http://whatthehealth.org), all one word, @kff.org, or you can tweet me. I'm [@jrovner](https://twitter.com/jrovner). Mel?

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Rovner: Margot.

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

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