

KHN's 'What the Health?'

Episode Title: Manchin Blows Up Biden's 'Build Back Better'

Episode Number: 227

Published: December 22, 2021

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 this holiday week on Wednesday, Dec. 22, at 10 a.m. As always, news happens fast and things might have changed by the time you hear this. So here we go. Today, we are joined via video conference by Rachel Cohrs of Stat News.

Rachel Cohrs: Hi, good morning, Julie.

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

Joanne Kenen: Hey, everyone.

Rovner: And Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Hi, Julie.

Rovner: Later in this episode, we'll have an interview with Ceci Connolly. Ceci is a former journalist for CQ and The Washington Post, and now runs the Alliance of Community Health Plans, which represents nonprofit health plans. And because this is our last episode for 2021, we'll have a look back and maybe a look ahead at the most important health policy stories of the year. But first, much news.

So Congress isn't even here this week, but the biggest news of the week comes from the legislative branch, where West Virginia Sen. Joe Manchin on Sunday basically pulled the plug on negotiations to become the deciding vote on President [Joe] Biden's big social spending Build Back Better package, at least in its current form. So, to paraphrase Monty Python, how dead is this bill?

Cohrs: You know, it seems like this bill in its current form is pretty dead. I think there have been a lot of conversations over the past few months — there's been conversation in the past couple of days — and there's just been a complete breakdown in trust between the different factions of the Democratic Party that would have to come together to make this happen. So I think they still do have this reconciliation mechanism that's an incredibly important resource. And I think they will want to use that somehow coming into election year. So it's not going to look exactly like it does now. Because there was this junction where Democrats were able to choose, like, are we going to

do a bunch of programs for a shorter amount of time? Please everyone? And they did. But that's not aligned with Sen. Manchin's vision for doing a couple programs for a long time. And that paring-down process would be painful and ugly. So, if they make it through, it's not going to look like it does right now.

Rovner: I know. Well, I mean, Manchin seemed pretty clear that he doesn't believe that this is truth in budgeting to do a bunch of expensive programs for two years and then assume that you're going to come back in two years and find money or not find money to keep them going. But he certainly suggested that he might be willing to do a couple of things for a shorter time, too. Are there any health items that we expect will be in those couple of things that they're going to ... that looks like the only way the Democrats are going to get anything passed here?

Cohrs: Yes. Well, I think The Washington Post had a great scoop on the proposal that Sen. Manchin had given the White House earlier in the week before these negotiations broke down. And one of the items on that list was premium subsidies for Affordable Care Act plans, which, again, was one of [House] Speaker [Nancy] Pelosi's top priorities. It's one of the only health care coverage provisions that the Biden administration originally included back in the spring. So that is looking pretty good. And I think, we'll talk about this later but, with all the enrollment that the Biden administration has been seeing, to pull the premium assistance away from these people in about a year would be pretty painful. So I think they'd like to avoid that. There's been some talk about drug pricing, but I think it's unclear what shape that would take. Sen. Manchin has indicated he maybe doesn't think the Democrats' plan they have right now goes far enough. And that's a "pay for," too, which I think is easier to put in the bill because it doesn't cost money. But I think those are the two options that are on the table, but I think you need everybody on board. And it's unclear whether they can get everyone on board with that plan.

Rovner: Yes. Well, as long as you're bringing up the Affordable Care Act, we might as well get to that now. The Department of Health and Human Services has announced just this morning that they have the early figures for Affordable Care Act enrollment, and thanks in large part to the very generous subsidies enacted earlier this year — that, as Rachel points out, will end at the end of 2022 if they don't continue them — [a] record 13.6 million people have signed up for health coverage in the marketplaces. There's still a month to go in open enrollment. It doesn't close this year until January 15. Those are really big numbers, but they also set the Democrats up for a real problem. If these affordability extensions are allowed to expire, they're walking themselves out on a pretty big plank here, aren't they?

Cohrs: Yeah, the stakes are very high. The impact of this will be felt — again, as we've talked about — mostly in non-expansion states or at least at a higher rate. Politically, there's a lot of questions about how much that really benefits Democrats. I don't know what the answer to that is, but I think there would be significant outrage, certainly, to pull these subsidies away and for people to see these premium hikes if they did sign up for this coverage just because it was cheaper than it had been before. So it's certainly a major cliff that Democrats are staring down, and it seems like there's the political will to do something as long as it doesn't get caught up in all the other drama going on.

Rovner: Sarah, one of the things that Rachel mentioned that Democrats — the more progressive Democrats who are upset with Manchin, as well they should be, because it looked like he had promised to support this framework, which he clearly now doesn't — want the president to push ahead, particularly on drug prices using executive authority. Does he have executive authority to do much on drug prices? I mean, there was a reason this was all in legislation, right?

Karlin-Smith: Certainly to allow the government to negotiate drug prices in Medicare, you need Congress to act because the bill that initially set up Medicare Part D includes what's called the non-interference clause. And that's in legislation. That's not to say that he doesn't have authority, particularly if you look at the Center for Medicare & Medicaid Innovation, which was set up to do a lot of demonstration and pilot projects. There's a lot of flexibility there to test things out. And so that could be a way to do something smaller that could have impact. The problem that we've seen in the Obama administration, with the Trump administration as well, is that oftentimes these sorts of demonstration projects run into political problems as well, even though Congress may have a little bit less ability to stop them. Sometimes the pushback is so great that it can be hard to even get those things off the ground.

Rovner: Yes, I should point out that predates even the creation of the Center for Medicare & Medicaid Innovation. That goes back to — I think, Joanne probably remembers — when they were trying to change the way they paid for medical devices, and it was just a CMS demonstration. And immediately the states that were included in the demonstration pushed back and stuck something in a bill that got it stopped. So this is nothing new, that if you feel like your ox is being gored, you're going to complain to your lawmakers, and they're going to try to get something into legislation for you.

Kenen: I still remember when the entire government — I forgot what year it was — after one of these really long, prolonged, months-long, CR CR CR and you finally had a budget deal. It was when [Dennis] Hastert was speaker, so it was awhile ago. We were sitting there at 2 in the morning. Julie, you and I were probably in the gallery. And then it was all on hold, and it turned out to be something about two oxygen cylinder manufacturers in Hastert's district. I may not recall the details, but I'm pretty close, right?

Rovner: I think it was something like that. Yeah. And that was not the only time things on a huge bill hung up over something really small that had to do with Medicare. Do not underestimate how powerful some of these forces can be.

Kenen: CMMI was designed to create some insulation, to make it easier for CMS to go ahead and experiment without having to get so much congressional approval or authorization or pushback. It's not fully insulated. They've been able to have some more autonomy than the old system, but I don't think it's as political-free or pushback-free as they had desired.

Rovner: And it's worth pointing out that CMMI is now being run by Liz Fowler, who was on the Hill when the [Affordable Care Act] was written and helped write it.

Kenen: She wrote a great deal of it. Yes. And MMA, the Medicare drug bill.

Rovner: She knows exactly what power they're supposed to have. And we'll see how much she uses it. All right, let us move on to covid. In the not-so-good news, it looks like a lot of Americans will be getting covid for Christmas. The omicron variant in just a few weeks went from unknown to representing three-quarters of all new cases, and it appears to be super-contagious. While it appears to be fairly mild for those who are vaccinated and/or boosted, I've seen suggestions from some public health experts that pretty much everyone can be expected to get this. How worried are you guys, and how much are you changing how you're living your daily lives? I'm pretty much shutting things down for now.

Cohrs: I think reporting on Capitol Hill has been an interesting gauge of people's comfort levels because there was a point back in May where a lot of us weren't wearing masks anymore because we didn't think we had to. But things have cycled in and out, and I think things are definitely more quiet. There's a lot more N95s. Certainly I am concerned traveling to see family over the holidays. There's going to be more spread as people travel too. It's just not something we can really avoid. But being young and boosted, after that risk period is over — wearing good masks and I'm hoping not to completely shut down. But I know everybody is different, and that risk profile is a tough one to navigate.

Rovner: Sarah, you've got a little one at home.

Karlin-Smith: Yeah, I have a little one at home and another one sort of on the way. So I have vulnerabilities.

Kenen: Not sort of on the way, Sarah. Very much on the way — two more months.

Karlin-Smith: So there's some extra vulnerability there. I am concerned because one thing that following this all the time for your job is that you see all these doctors and hospital workers and so forth saying, "Look, our hospitals are already overwhelmed. We can't help everybody now in the way we normally could." And that means that — people like to go skiing this time of year. Well, imagine breaking your leg skiing but not having the resources or hospital staff available. So the messaging coming from the White House and a lot of politicians has been if you're vaccinated, particularly if you're boosted, you should feel like you can live your life to a degree and don't have to hunker down. But I think we're at this really big surge right now where you really do have to be a bit more cautious and think about how much your actions are going to impact your entire community because we know even people who are boosted are getting infected and this spreads so easily. We just aren't at a point right now in our system where we can handle a big influx because as we've talked about in various weeks in this podcast, even if for many people this variant is more mild, the amount of people getting infected, and who then ultimately will have serious infections, is still going to be more than enough to overwhelm our systems.

Rovner: And one of the big concerns I'm seeing is that because people who are vaccinated and boosted are still getting it — most of them aren't getting very sick, but they're definitely getting it and testing positive. If we assume that 20% or 30% of the health care workers will then get sick and end up having to quarantine, in an already super-stressed health care system, I think that's one of the things that just has not been talked about enough. An emergency room doctor —

somebody messaged me on Twitter yesterday — who is just desperate and pulling their hair out and at their wit's end, and yet people don't seem to be taking very many precautions here.

Kenen: Well, I think the fact that we are hearing “mild,” there's two problems with that. One is we are not yet sure it's mild. We all hope it's mild. We do know it's not worst-case scenario. I wrote something a week or so ago — it's not the vaccine-evading virus from hell. It's not the worst case. What we were worried about when we woke up Friday of Thanksgiving weekend and read about 50 mutations — oh my God, right? — it's not that. Is it mild? We don't really know for sure. There's some hopeful signs, but also remember, “mild” doesn't mean asymptomatic. “Mild” means you're not in the hospital — and to the epidemiologists, the public health people, “mild” means you're not in the hospital needing oxygen. So you could still be pretty sick. You can be out of work. For people who don't get paid sick leave, for people who have ... other family members, their children and elderly people they are taking care of, if you're flat on your back for two weeks, “mild” is not mild. There's economic consequences. This has family consequences. It has economic consequences, both for individual families and there are worker shortages in a lot of fields. Biden may not be shutting down restaurants, but if the whole staff gets sick, a restaurant's going to shut — or they better because otherwise they're just going to infect more people. Also mild makes people think — well, if we're saying omicron's here, you need to get vaccinated even if you've been resisting all this time — and then people will say, “Well, it's mild, why?” So “mild” is a problematic four-letter word.

Rovner: It is. So President Biden weighed in on this on Tuesday. The administration is belatedly going to make rapid testing kits available by mail to Americans, although not soon enough for the holiday rush, and it's not entirely clear how. The federal government is also sending the National Guard to help overburdened hospitals and redeploying some of their pop-up vaccine clinics. Joanne, you wrote a really good [story](#) this week, though, about the difficulties Biden faces. I just want to read one line from it. “The combination of a worn-out public, mixed messaging from health officials and stiff skepticism from large swathes of the country mean the president will struggle to break through.” What more can he do at this point, or does this just have to play out the way it seems to be in Europe too?

Kenen: There are two things he can do. One is the steps he's taking in a lot of the testing, the things Julie just listed, which a lot of public health people don't think enough or they're good ideas that aren't going to happen. They reversed themselves; they're going to have free rapid tests available, but they're not going to be available tomorrow or next week. At best, it's sometime in January. So there's the: “Is he going far enough” and “Is it happening fast enough?” You know, you think, “Oh, he's putting a thousand military medical personnel to help hospitals.” Well, a thousand spread over 50 states, it's really not that much, right? If this really goes national fast, which it might, in warm and cold climates, as people travel. So there's the public health “what he can do and is it enough?” Because he's ruling out a shutdown. And there's the communicating. And the people who have listened to him are the people who are already largely taking appropriate or reasonably appropriate ... the people listening to him are not all boosted because there's been so much confusion about who needs to get boosted and when. It was one of the weakest moments in health care communication. The whole booster thing confused people, and there's data on that

from Kaiser Family Foundation, in fact, that [came out yesterday](#). So his audience, the ones who are tuning in, are pretty much on board, although, yeah, he wants to get the booster shots up. I mean, they're wearing masks. They may be traveling, but they're going to travel safely. Some of them are canceling their travel, some of them are moderating their travel. The people who are resistant, who are not wearing masks or who are not getting vaccinated, who are saying that this is exaggerated nonsense and it can't hurt me — because there's still data on that too. Something like 40% of the unvaccinated don't believe they can get really sick. So the people he needs to reach are the people who aren't paying attention or who are, you know, just ... we all see, we write about this! We all see the obscenities and stuff that we get on Twitter and the attacks. They don't they don't think he's their president, and then they don't believe science. ... I think another section that's true which I talked about: We all understand that science is incremental. We also understand, and public health people will admit it, they made mistakes in the last two years. Everybody's made mistakes. All of us have written something that, looking back, we would have done differently or said differently or portrayed differently. It's new, it's confusing, and it keeps changing. We understand that. But there are some people when they hear science changing and they think they're all liars, or when scientists say “get ready for something really bad” and it doesn't turn out to be as bad as they predicted. We all hear, “Oh, thank our lucky stars!” And other people say, “See, they're lying.” So that's the bottom line: Biden didn't create this problem. It's years in the making. But he's living with it. And it's not that he isn't trying to communicate. But we are such a divided country. I mean, I call this a “Humpty Dumpty of a nation consumed by disease, division and distrust.” I wasn't sure that would get through the editors, but they liked it. You know, we're broken in so many ways. We're broken over disease, we're broken over politics, and it's hard.

Rovner: And I think maybe the most frustrating covid story of the week has been the delay in vaccines for kids under age 5. I've seen so many angst-ridden parents.

Kenen: There's one on this podcast.

Rovner: Yeah, exactly!

Kenen: And also the failure of the monoclonal antibodies.

Rovner: Yes. And the fact that two of the three monoclonal antibody treatments don't seem to work on omicron. We may get lucky. You know, omicron won't be that serious, but there's a lot of things that don't look great right now, right?

Karlin-Smith: Yeah. The one thing to look forward to, potentially, in the therapeutics space is that we are hearing reports that FDA [Food and Drug Administration] is finally going to authorize the Pfizer and Merck antiviral pills that could be very helpful. Again, if we can get people who are caught early in their disease progression and treated, before they progress, if we think they're at high risk for that. Of course, as we've talked about before, that involves having the testing infrastructure and everything else to really catch those people fast enough that you can get the drugs into people when they still work. Because if you get them later in your course of illness,

they're not seen to be helpful. And then we're also going to have, unfortunately, given the amount of spread right now, probably a shortage of these pills for a couple of months.

Rovner: Yeah, it's going to take a while to get production up. So this is ... clearly, this is the story that will follow us into 2022, even though we hoped it would not.

Kenen: The only good thing is, you know, in South Africa, it looks like, because it's so contagious, it may also peak faster. We don't know this for sure, but there are some signs that it's not a three- or four-month thing, that in any given area it might really hit hard, but not be as prolonged as we might fear. But again, we don't, we're not sure of that.

Rovner: Yeah, but it's certainly going to make it into January. Well, we have talked a fair bit about the opioid crisis here, particularly how the giant \$4.5 billion settlement with Purdue Pharma, makers of OxyContin, which they falsely advertise is not addictive, spared the wealth of its owners, the Sackler family. Well, last week, a judge in New York tossed that settlement out, ruling that the bankruptcy judge who initially approved it didn't have the authority to shield the Sacklers from other lawsuits. The Sacklers, not surprisingly, said they would appeal. Do we expect this to end up at the Supreme Court at some point?

Karlin-Smith: You know, I think that's a reasonable possibility. It's certainly an interesting case, and I think that the Supreme Court and other justices will see it as having ramifications beyond just this one case. And so that's something that the Supreme Court often likes to weigh in on — the appropriate use of bankruptcy law in a wider way. When I was reading about the Sackler situation, I was thinking about what Johnson & Johnson is trying to do to handle their liabilities with the baby powder contamination fallout, also in splitting into two companies. So the more, again, you seize potential questions about “Is there abuse of bankruptcy to get out of corporate responsibility?” the more likely that the higher courts or even legislatures start to want to weigh in.

Rovner: Yeah, though, I think in this case that the Sacklers are the poster children for rich people personally getting away with bad behavior. And I think there was a lot of reaction to that. So we'll watch that one too. Well, speaking of drugmakers, Biogen, maker of the controversial Alzheimer's drug Aduhelm, this week announced it would cut the drug's cost in half after it has received not much business following its approval back in June. Now, mind you, cutting the cost in half will only reduce it from about \$56,000 a year to about \$28,000 per year, so it's still pretty pricey. Is this enough to boost insurance coverage, Sarah, or is part of the problem that we really don't know if it works?

Karlin-Smith: Yeah, I'm a little bit skeptical that this is going to make a huge difference. Again, because we have a drug that we both don't have a great sense of how much benefit it may offer people, if any, And that has a lot of really serious safety concerns. And some of the safety concerns actually have become even more public and concerning as this treatment's been rolled out a little bit. So you're still seeing a pretty high price tag for a pretty big trade-off in terms of benefit risk. I think some people are speculating that Biogen timed this price cut to coincide with CMS [the Centers for Medicare & Medicaid Services] trying to issue a national coverage decision for the

drug. Do they have some indication from conversations with the agency or something else that maybe this will at least get them to some more ideal level of coverage? One thing I think they're concerned about is sometimes CMS can require coverage with evidence development, so you have to do more work to prove your drug works. And some people are thinking this might push it to a price where they'll get them out of those requirements. I'm not sure. Again, you know, we know CMS had to raise Medicare Part B premiums an enormous amount.

Rovner: This was my next question.

Karlin-Smith: When they did this, they said they weren't hiding the fact that a lot of this has to do with this drug, but they were also sort of anticipating other similar products. So I'm not sure if there's any way for them to reverse that move or not, or, again, if they just feel like there's going to be some other stuff coming down the line. But yeah, that's a tricky calculus for the federal government now at this point.

Rovner: Yeah. I mean, because of Aduhelm alone, Part B premiums are going up \$20 — an *extra* \$20 a month, starting in January, and that's going to prompt a pretty big backlash. I am surprised, actually, that Congress didn't try to do something to address that, and now they're going to complain: "Well, this was based on this \$56,000 price that doesn't exist anymore." Medicare doesn't cover it. And yet you're still going to see this \$20-a-month increase. So I think that is also going to drift into the following year as a big thing that Congress is going to have to deal with in some way, shape or form.

Kenen: Julie, is there any mechanism for Congress to authorize a rebate or something?

Rovner: I don't think so. I mean, I think they might be able to ...

Kenen: ... to come up with something.

Rovner: That's what I'll be interested to find out. I don't think they can lower it now.

Kenen: But they might be able to give some kind of rebate, right before the election!

Rovner: Yes. Yeah, I will be curious. Rachel, have you looked into this at all?

Cohrs: I have.

Kenen: And before we move on, we should just point out, too, that you don't take this drug for six weeks and you're done. This is, like, multiple ... I don't think we know if people have to take it forever, but it's multiple years and it might be the rest of their lives, so ...

Cohrs: Yeah, just two quick points here on the coverage. Medicare isn't supposed to take cost effectiveness into account when it's making its coverage determinations. So I think a lot of experts are saying, sure, you know, maybe in the private insurance market it might have an impact. And I think there's a gray area as to how much CMS really looks at cost when it's making its decisions, but technically it's too late. This decision, they've been drafting it for a long time and it's supposed to come out in a couple of weeks. I think it's unclear.

Rovner: The coverage decision, but it's the actuaries who determine the premium.

Cohrs: Right, so the coverage decision, but then there's the premium, too. I would not expect Congress to fix this. It's possible, but I think you see Sen. Ron Wyden really pushing the administration to do it because it costs money when Congress has to do it, and they're just having problems getting anything through. So I think the administration could make a revision, from the experts that I've been talking to. It's unprecedented for them to do that, but I think this is kind of an unprecedented situation. And if the price is cut in half, in theory, the contingency fund they would need for this specific drug would be cut in half. So I think there is a possibility, but I think people aren't really expecting that until after at least January, where there's a draft coverage decision to figure out where this might go.

Rovner: OK, more stories that will follow us into 2022. Well, that is the week's news, or at least a chunk of it. Since this is our last podcast of 2021, I thought we'd do a goodbye and maybe good riddance round for each of these. We will go around our virtual table. Let us start with the biggest health policy story of the year. Obviously, for me, it's covid. Anybody have something different? ... We're all laughing. No? Yes? 2021 is going to be the year of covid?

Kenen: It's going to change our world in ways we still don't understand.

Rovner: All right. Well, that was obviously a story that we have all covered. What about the most under-covered story? Joanne, what have we not paid enough attention to?

Kenen: I guess one of the things that simmers and doesn't burst out is, you know, we talk a lot about gun violence and we can't do anything about it, legislatively. But I think we're not paying enough attention to the public health consequences and talking about that and addressing that, not just — it doesn't just kill people, it also disables people for life. Many, you know, there's a lot of young people in walkers. And then there's also the mental trauma, not just for the people who've been involved in shootings, but for the people who have relatives or who've witnessed or who've heard the gunfire, you know, next to their apartments or a tremendous amount of both disability and mental trauma that I don't think we've gotten our arms around that. So that's an under-told story.

Karlin-Smith: I think what concerns me — this is sort of an aspect of the covid story — and what concerns me is the stories that haven't gotten enough attention. Or at least these stories haven't changed much over the past two-plus years, it seems like, of this crisis. So the focus being very heavily in the U.S. on vaccines in the vaccine effort, but not as much on some of the strategies and methods other countries have used in terms of public health to really contain the virus and that there just hasn't been a lot of talk and, in some cases, there's been congressional pushback of funding future investments in our public health systems and infrastructure to ensure that when, unfortunately, we likely will be hit by some other big health crisis and infectious disease like this, we're prepared. So I think that's really the under-covered thing is we're still acting like we're in that immediate, beginning fog of war two years into this and not really thinking about ...

Rovner: ... the next pandemic.

Karlin-Smith: Right. We keep making the same mistakes, and that's what I think really makes me very nervous, nerve-wracked.

Rovner: Rachel, what have we not covered enough?

Cohrs: Yeah, I think mine is sort of similar to Sarah's, but just thinking about the vaccine effort in other countries and just how what we are doing here won't necessarily translate very well. I think there's been some great reporting by The New York Times about vaccine manufacturing facilities like, what? What places could actually manufacture these vaccines? I think there's been a lot of talk about, like, WHO [the World Health Organization] and not intellectual property, that kind of thing. But I think, just as we all, you know, have faced these logistical challenges, I think we just haven't gotten these on-the-ground stories from around the world that I think we so desperately, as a U.S. audience, need to be reading and thinking about. So I think that is something that I'm hoping ... the vaccines won't fix everything, but I think there needs to be an honest conversation about the vaccines we have. And now, with the new variants, some vaccines may not be effective. So I think there's so much work to be done in this area, so much examination of how this happened. That's certainly been covered in chunks, but I think there's definitely more to be done.

Rovner: Well, my under-covered story is mental health in general and the opioid crisis. I feel like this sort of brings together everything you guys have been talking about. Gun violence, obviously, has a mental health component. Opioid addiction often, although not always, has a mental health component. The fallout just from being isolated for almost two years has a huge mental health component, and I just ... I feel like there's more mental anguish than we've ever seen and not really the capacity to deal with it. I mean, you can't find therapists in most big cities right now. It's simply, you know, the need for mental health services does not match the availability of mental health services. All right now, I want to ask you guys what you think is the sleeper story of the year. Not so much one that did or didn't get a lot of attention, but the one that we're actually going to look back to 2021 and remember in 10 or 50 or 100 years, assuming the planet is still here. Sarah, why don't you go first? You're laughing.

Karlin-Smith: I mean, I think that abortion rights is going to be a huge one, no matter how some of the upcoming Supreme Court decisions go. I mean, this has been probably — the last year or so — has seen the biggest changes in abortion restrictions and so forth for women that have been upheld in probably decades. And I think, personally, if you had told me even five years ago or a couple of years ago, this was possible, I wouldn't have believed you.

Rovner: Yeah, the idea that in the second-largest state in the union, abortion is basically unavailable after six weeks, even though the court has yet to officially overturn *Roe [v. Wade]* is kind of mind-boggling. Rachel, what's your sleeper story?

Cohrs: I think my sleeper story is one that I think my colleague Lev Facher has written about a bit, but just the conversation about how there is going to be this disparity in state requirements for vaccines at all to go to schools and how, I think, with kids in the future, they just may not be required to get shots. The exceptions may be just so much broader. I think vaccine skepticism has reached a whole new audience than it had even before. I mean, this has been a problem for so

long. But I think just thinking about how it's going to shape our world and the future of public health, I think it's possible if these kids aren't getting vaccinated that we could see these crazy outbreaks of diseases that there's really no reason that we should be dealing with. I think that's definitely one to watch.

Rovner: Joanne.

Kenen: Well, apropos of how Julie introduced this segment, you know, I think climate, I mean, the stories right now that are saying — which is a health story! I mean, it's more than smoke and wildfires. It's a health story and in many, many ways that we are going to be covering more and more of. But I think this year the planet is screaming at us and we aren't listening.

Rovner: Mine sort of goes with everything that everybody has said. I feel 2021 is going to be remembered as the year that the world stopped believing in science — that we've rejected vaccines, we've rejected climate. We've rejected the existence of covid in some cases. You know, it used to be, when I was growing up, scientists were revered and you learn science and, yes, science changed, as Joanne said earlier, but you believed in the scientific process and every elementary school student started out, you know, you had your hypothesis and you went through your testing and you got to your conclusions. And we learned actually how science worked. And I think that science is now seen as just another arm of politics. And not to compromise our reportorial objectivity here, but is there someone who stands out to you as the health policy hero of 2021? The person that you listen to the most? Rachel, why don't you start this one?

Cohrs: I don't know if “hero” is quite the word I would choose, but I think just ...

Rovner: You can make it the Health Policy Person of the Year. OK.

Cohrs: Two people, yes. Well, I'll say People of the Year. Somebody that I listen to when they talk, I think are the two FDA scientists who stepped down earlier this year in protest over the way the FDA is moving on vaccines and on boosters: Marion Gruber and Phil Krause. They have been continually outspoken about their perspectives on different moves by the Biden administration. And I just find their perspective really interesting. And I think it was a striking example of scientists really standing up for what they believe in. So I think when they speak or when they write an op-ed it definitely catches my attention.

Rovner: Sarah.

Karlin-Smith: I was going to say Céline Gounder, and I hope I pronounced her name correctly. She's an infectious disease doctor and epidemiologist who's often in the media, and I just ... one of the reasons I find her so helpful and kind of my hero is she can always take complicated topics and make them understandable. And that is not a characteristic ... it seems easy when someone does it well, but it is very hard. And I think another thing that's admirable about her that has come out in recent weeks is while she has served some sort of official-unofficial role as advising the Biden administration, it's been clear she's been willing to push back on leaders when she feels like they're not making the best decisions based on health and science. And, you know, we have seen

in this crisis that sometimes some very high-level scientists have felt like they had to cave to political pressure. So I think that's admirable that she's been able to keep pushing back as well.

Rovner: Joanne.

Kenen: I really couldn't think of like one person. I think that there's a host of doctors, an epidemiologist and state health commissioners who have made time, who are exhausted, but who have made time to both communicate through us or communicate to the public. And when I say "thank you for your time" to one of these sources, I mean it.

Rovner: Yeah.

Kenen: In a way that's not pro forma that I would have said in another context. I think that, you know, we have the license to ask dumb questions, and that's part of our job. You know, if we don't understand something, we can't explain it. And there's a lot of this that's new to us. So I would say that every expert who took the time to communicate to the public as honestly as they could is a public health hero.

Rovner: I absolutely agree with Joanne. I've singled out two more, not necessarily as better than the rest, but two that have really helped me get through this year. And that's Michael Osterholm at the University of Minnesota and Scott Gottlieb, the former FDA commissioner who's been super available. I think both of them have been ... Michael Osterholm calls himself the Cassandra ...

Kenen: With reason!

Rovner: Yeah, with good reason. He usually predicts the worst possible outcome. But he's been right a whole lot more than he's been wrong. And I think Scott Gottlieb has been another one of those who has that ability to take really complicated things and make them pretty understandable. And, as you know, someone who was in a Republican administration, he can speak to people that perhaps some of these other public health officials can't reach. So I think it's been a really useful voice. All right. Finally, how about the unsung health policy hero of the year? Somebody whom we haven't seen on TV that much, but who's really contributed to this year's work. Sarah, why don't you go first?

Karlin-Smith: I still think she doesn't get much credit and notoriety, as she said, although in the pharma world she does. But Kizzy [Kizzmekia Corbett] — I always think of her as @KizzyPhD because that's her Twitter handle. But she was one of the lead scientists who helped develop an mRNA vaccine at the NIH [National Institutes of Health], and I think a lot of people think of it as "the Fauci vaccine." As a really inspiring woman of color and female scientist, she doesn't always get the credit she deserves, and she's also done a ton of work, really reaching out to communities where there's been vaccine hesitancy and so forth and really helping reduce that in a very targeted way. So I think that's important. And her last name is Corbett!

Rovner: [laughing] It's OK. We'll hear from her more next year. Joanne?

Kenen: Yeah, she's pretty terrific. I think the unsung heroes are all the quote-unquote "lower level" — I don't want to use that disparagingly, but we as a society don't give them credit: the

respiratory therapists, the people who keep the hospitals open, the dietary and the cleaning [staff] and the lab technicians who are running these hundreds of thousands of tests 24/7 and not able to keep up, the people filling out your vaccine cards. And they had [to deal with] weather during these outsourced mass vaccination centers who are disproportionately people of color as well. They're not as well-educated, they're not on TV, and they're saving lives.

Rovner: Rachel.

Cohrs: I think I've spent most of this year on Capitol Hill, and I think I've just learned to appreciate the staff that are working on these really, really difficult problems. And, you know, none of these bills get passed without people actually having to sit down and write the legislative text and think about potential lawsuits. And I think this year has been so chaotic. There has been so much back and forth and such tight, I mean, timelines to get things done, get things together. But there has just been such diligent work by, I think, so many staff. It's unclear, I think, how much we'll see of it, how much will actually go into effect. But I've just been struck by their diligence. These people are also tired. I mean, in 2020, they were pushing out billions and billions of dollars every couple of weeks. They've just stayed in the trenches and just done work to try and work through these really tough challenges and figure out what can get done.

Rovner: Well, mine is similar to Joanne's, and I think it's everybody working on the front lines in health care, in hospitals and clinics, in just regular doctor's offices. This has been a time of such incredibly high stress and people taking a lot of abuse — not fair. And I think we just don't think of them. I think when the president mentioned that it's your patriotic duty to get vaccinated so that we don't swamp our health care system. I just ... I say thank you to every single health care worker I meet and, as Joanne says, it's not just the doctors and the nurses, although they've been doing heroic work too, but everybody who helps keep our health system running. And boy, there's a lot of them. All right. That is our year in review.

Now it is time for my interview with Ceci Connolly. Then we will come back and do our extra credits for the week. We are pleased to welcome to the podcast Ceci Connolly. Ceci is president and CEO of the Alliance of Community Health Plans, which represents the nation's top nonprofit health plans. Before that, Ceci was a journalist at The Washington Post and at CQ [Roll Call], where she was my colleague. Ceci, thank you so much for joining us.

Connolly: It is always a treat to be back with you, Julie.

Rovner: So first, for our more novice audience, tell us what community health plans are and what they do and how they're different from what we think of as the big health insurers.

Connolly: Absolutely. A couple of little unique traits of our membership, which is why I just enjoy them so much. The first is they are all closely aligned with provider entities. So, many of them are the large delivery system, integrated systems that you know and love around the country. They also are locally based, so the markets that they serve are where they live and work, and they see their members in the grocery store and at church every weekend. They're not dropping in and out of markets, they're there on the ground.

Rovner: So I originally wanted to talk about what's going to happen when the public health emergency ends, and we will do that. But clearly that isn't going to be anytime soon. Now we're entering yet another phase of the pandemic. How stressed is the health care system right now? I imagine your members are pretty close to what's going on since they are providers as well as insurers.

Connolly: In many, many parts of the country they are exceedingly stressed and on the verge of, dare I say, some sort of breakdown or collapse. And it really is that perfect storm of horrors, if you will. So, of course, you have the rising number of cases, and I just got off the phone with a CEO who told me that in his hospitals, 99% of those hospitalizations are unvaccinated, and they're going on ventilators, by the way, and they're running out of ventilators. But the other challenging things are workforce. So you have health care workers that have been on the front lines for two full years, they keep thinking there's going to be light at the end of the tunnel; there isn't. And it's disheartening for them to be caring for people that have not taken the practical steps and the proven scientific moves to protect themselves and their families. And as a result, and you know this, Julie, the hospitals are also now not able to care for other patients and cases because they're so overwhelmed. And it's just so demoralizing for people that have been trying so hard for so long.

Rovner: Yeah, I mean, people think, "Well, I'm vaccinated, and I'm safe. I can go out and do anything I want." But if you then fall off your bike and break your ankle and end up in an emergency room, you're going to be in serious trouble at that point.

Connolly: Absolutely. Or if you had your hip surgery planned or you have a heart condition that needs some careful monitoring. Just so many of those cases — now those folks are being turned away.

Rovner: We've never seen our health system actually melt down. I mean, what could it look like?

Connolly: You know, Julie, I hate to say this, but it reminds me going back to my Washington Post reporting days when I went to New Orleans, 48 hours after Katrina hit, and you saw just a complete debilitation of that health care system. You know, one of the only bright spots in that health story in Katrina was that the VA [Department of Veterans Affairs], because it had electronic medical records and because it knew how to use technology, including telehealth, way back before anybody else ...

Rovner: Yeah, that was, what, 2005?

Connolly: ... those veterans, they spread out to 48 states in the United States, but they all could access their medical records. But otherwise, you know, I walked through a charity hospital that had 2 feet of water. You know, they had the tents set up. I mean, it was MASH [Mobile Army Surgical Hospitals] units and, heaven forbid, if we are going in that direction.

Rovner: So what does the health system need most right now?

Connolly: It needs everybody to get their bloody shots. [laughing] I'm sorry. I don't mean to sound cavalier, Julie, and clearly, you understand that and your audience probably does as well. But we've got to go back to the basics of: Who are the trusted messengers in the communities?

Because, honestly, this isn't about me lecturing somebody on getting a shot. These are the people on the ground in the communities that have those relationships. They may be running soup kitchens, they may be in churches. Maybe they're the local day care group or at the schools. I mean, you've got to meet people where they are, and you need to communicate to them in a way that builds trust and confidence.

Rovner: So I know that the health system writ large was counting on a lot of the things in the Build Back Better bill that is now on ice, to put it mildly. I mean, what happens to the health care system if that bill doesn't pass?

Connolly: Well, we're extremely worried about a rise in the number of uninsured. It won't be instantaneous, but there are a couple of specific reasons why all of the modeling, all of the things that we look at suggest a real danger zone for a group of Americans, lower-income working Americans who either went onto Medicaid during this pandemic, or they were able to access those higher ACA subsidies. In both instances, we are looking at, first of all, the ACA subsidies, a cliff at the end of 2022. Very, very troubling if Congress does not extend those beyond. The other, with Medicaid, is that we expect when the public health emergency ends, states will be given the authority to disenroll again. Now, this doesn't have to be a terrible thing. This could be good news if those individuals now have higher income. That's great. They're working, they're making some more money, terrific.

Rovner: And maybe they're getting health insurance.

Connolly: Exactly. But the thing is, when you disenroll them from Medicaid, you want to be able to show them, for instance, an option with their job or that individual exchange product so that it can be smooth and they don't fall through the cracks. One of the things that we've been discussing with the Biden administration is: Please give everyone enough time. Maybe a 90-days heads up at least, so that everyone can develop good messaging and communications that's going to go out to these folks and say, here are some other options for you and we can help you enroll. But if not, you are going to see a rise in the number of uninsured. No doubt.

Rovner: And that's not the only piece of the Build Back Better bill that went to health care. I mean, you guys have been working hard on drug prices too, right?

Connolly: Oh, my goodness. Yes. And that's another one that ... it's just disheartening, Julie. And you know, you and I have probably been at it and watching this game in Washington for too long. But gosh, it seemed as if Congress actually was going to do something that consumers care about, which was bring down the price of prescription drugs in a very reasonable way. There's nothing radical in those proposals. I'm thrilled that, last April, our board of directors — it's the first and only payer organization to get behind a package of those drug pricing reforms. And I'll just point out to anyone who's worried about the cost of your health insurance, CMS, in its announcement of the next Medicare premiums, the largest increase in history — and what was the No. 1 reason for that? A single drug, Aduhelm. It was supposed to be an Alzheimer's treatment. We could do a whole show on that speculative science.

Rovner: And we have! [laughing]

Connolly: But you want to understand why that's not health insurers saying that. That's CMS actuaries doing the math on one unproven drug. So that's what we're in store for. If we don't start to do something sensible about drug approvals and coverage decisions and pricing.

Rovner: So I don't want to leave this on such a grim note. Is there is there something in 2022 that you think maybe is looking up for health care?

Connolly: Yes, yes, yes, Julie. A lot of people say telehealth or virtual care. I'm going to expand it even just a touch here. We like the phrase "care anywhere," because the exciting future, which is now happening in many places, is this combination. You get the care when and where and how you want it. A big piece of it is that telehealth, with the technology — we're glad that broadband money is heading out the door because we need that piece of it. But it can also be hospital at home, for instance. It can be in community locations. It can be that combination of providers, not always an M.D. You know, there are people that are doing their physical therapy virtually, speech therapy virtually. Of course, mental health care services. But, you know, out in Marshfield, Wisconsin, they built a hospital-at-home program for hundreds of diagnoses. You can tell them if you want to go into the hospital or you want the care in your home. And it's remote monitoring, it's a nurse stopping by occasionally, it's that full package. It is here to stay, and I'm super-jazzed about it.

Rovner: Well, something at least to look forward to. Ceci Connolly, thank you so much for joining us.

Connolly: It's my pleasure, as always.

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 links on the podcast page at khn.org and in our show notes on your phone or other mobile device. Rachel, why don't you go first this week?

Cohrs: My extra credit is headlined "['Get That Money!' Dermatologist Says Patient Care Suffered After Private Equity-Backed Firm Bought Her Practice.](#)" It's with NBC News by Gretchen Morgenson. And I think this story just made the trade-offs with private equity ownership of health care practices so tangible. Because I think scholars that I talked to, you know, I can speculate about the incentives, when they don't seem to align, the profit-seeking entity, the quick three- to five-year timeline turnarounds with great patient care. But I think Gretchen did a great job of finding someone who saw it play out in her own practice. Dermatology has been this specialty of interest for the private equity industry, and we really see it expanding into all these other specialties, too. So I think this is only going to increase, and I think this is a great, just real-world grounding example that you don't see all the time because a lot of these private equity firms don't really like their portfolio companies talking to the media. So I think it's difficult to report and a good job.

Rovner: I like the phrase "specialty of interest." Sarah.

Karlin-Smith: I picked a piece by Ed Yong in The Atlantic called "[I Canceled My Birthday Party Because of Omicron](#): Here's How I Thought Through the Decision." And I just think it's a really helpful piece for people who are trying to think about what is safe for them individually and what is safe for all of us as a society to do right now. And he really emphasizes that a pandemic is a collective problem that needs to be solved by everybody. People, individuals and the government not acting in self-interest and thinking just about what our individual risk and our individual risk tolerance is, but how our own decisions might impact everybody's risks, not just even the people you know, but the people you have never met who may be more vulnerable. And we're in one of those moments in this pandemic crisis where that kind of attitude and way of thinking is going to be more important than ever as this surge overwhelms us. And I know, as he goes through, it's hard, it's frustrating. He thought in writing about this a year ago, he would certainly be able to have this milestone birthday party safely. But he also ends with some optimism that he knows eventually we will be able to come out of this and do these things.

Rovner: Yes. Happy 40th Birthday, Ed Yong. Joanne.

Kenen: He could have a 41st birthday. I mean, you know, that's the whole point, we'll be here next year. OK, mine is from ProPublica by Lydia DePillis. It has a rather long headline: "[This Scientist Created a Rapid Test Just Weeks Into the Pandemic. Here's Why You Still Can't Get It.](#)" It was a rapid test that was not perfect, but it was cheap and useful, or it could have been useful. The FDA was slow to get these at-home tests approved. They had high standards. They made it difficult to do. The amount of science these companies had to do to get approval — it was sort of a mirror image. The FDA was like: Pretty good isn't good enough, so we won't have anything. It was the same sort of thing as the CDC did with the PCR test. You know, CDC wouldn't use the global health ... the WHO-approved ones, the German ones, the South Korean ones in the first few months. They were going to do a better one. And again, we had nothing. The analogy that Lydia uses is — or one of those people she quoted is — if you're in a war and your machine guns are on order and they haven't arrived yet and all you have is a pistol, you're going to use the pistol! And we need a lot of tools. Public health calls it having layers, and we did not use this layer when we should have.

Rovner: Good. Well, my story is from my KHN colleague Fred Schulte, and it's called "[Crash Course: Injured Patients Who Sign 'Letters of Protection' May Face Huge Medical Bills and Risks.](#)" And while that sounds like a mouthful, the story is pretty basic. A lot of people who are injured due to someone else's negligence can't afford the medical treatment that they need, and so they sign a promise to use a future insurance or court settlement to pay their bills. But if something goes wrong and they die, or if the settlement or judgment is less than the often-inflated cost of that medical care, patients can be left on the hook for thousands of dollars in medical debt. It is just one more way that our health care system is stacked against the people who aren't wealthy.

OK! That is our show for this week and for this year. Thank you to all of the panelists, not just this week's, and to you, our listeners. As always, if you enjoy the podcast, you can subscribe wherever you get your podcasts. We'd appreciate it if you left us a review — that helps other people find us, too. Special thanks, as always, to our ace producer, Francis Ying, who got us through this year. Everybody could hear! Also, as always, you can email us your comments or questions. Get those

questions in for our “Ask Us Anything” episode, which we’ll do early in the new year. We are at whatthehealth — all one word — @kff.org. Or you can tweet me: I’m @jrovner. Joanne?

Kenen: @JoanneKenen

Rovner: Sarah.

Karlin-Smith: @SarahKarlin

Rovner: Rachel.

Cohrs: @rachelcohrs

Rovner: We will be back in your feed in January. Have a safe and happy holiday season and now, more than ever, be healthy.