

KHN's 'What the Health?'

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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, Jan. 13, at 10:30 a.m. As always, news happens fast, and things might have changed by the time you hear this. So here we go. Today, we are joined via video conference by Joanne Kenen of Politico and the Johns Hopkins [Bloomberg] School of Public Health.

Joanne Kenen: Hi, everyone.

Rovner: Sarah Karlin-Smith of the Pink Sheet.

Sarah Karlin-Smith: Morning, Julie.

Rovner: And Rachel Cohrs of Stat News.

Cohrs: Hi, everybody.

Rovner: We had a guest lined up for this week, but she came down with covid, which I guess is very on brand for this January. So we shall go straight to the news. My covid theme for this week is: It's all kind of a mess. We really don't know how many people have covid in most parts of the country. Home-test positives are likely being underreported if they're being reported at all. And even hospitalizations don't tell us that much, since there's still a lot of delta circulating along with the omicron. And since we don't know who has which strain, it's hard to know whether or how to treat them. But the breaking news of the morning comes from the Supreme Court, where the justices decided not to decide the vaccine mandate cases they heard on an emergency basis last Friday. This actually seems weird because the employer mandate, the rule from the Occupational Safety and Health Administration requiring employers with more than 100 workers to either require vaccines or require masks and weekly testing, actually went into effect in part on Monday, and everybody expected the court to act to stop it, at least temporarily. Do we have any feel for what this lengthy silence suggests — that they disagree or that they don't care that employers are waiting to hear whether they're going to have to obey this mandate?

Kenen: Well, I mean, it's chaos, but everything is chaos. So chaos is now normal. They didn't do it this morning, and they can do it whenever — the court can do [it] whenever they want. We do not think this will drag on for weeks, but it may be a few more days. And remember that businesses can still voluntarily impose mandates, and many have, such as the major airlines and so forth. This is whether the government can require businesses — I believe it was 100 and over employees — to do it, so it doesn't mean that all mandates would be voided. It means that OSHA doesn't have, in the view of the court if they block it — OSHA doesn't have the power to mandate a mandate.

Rovner: And to be clear, I listened to the four hours of arguments on Friday. The question is not whether you can have vaccine mandates. The Supreme Court established back in the early 1900s that vaccine mandates are allowable. The question is who gets to order them. States have what's called police power, where they can actually do things like this for the public health. The question here is whether OSHA, whether the federal government, has the power to do something as "drastic," as it was referred to, as a vaccine mandate nationwide. And that's the real question. And obviously we've seen cities with vaccine mandates and obviously lots of companies with vaccine mandates.

Kenen: Also, there are two issues before the court, and this is about the private-sector mandates being mandated by the government. This is not about the health care workers, which the court seemed more sympathetic to, although we don't know for sure until they tell us what they actually do think.

Rovner: And, of course, the irony here is that, because of what happened at all the lower courts, the health care worker mandate, the requirement from [the Centers for Medicare & Medicaid Services] that facilities that participate in Medicare and Medicaid have their workers vaccinated — not vaccinated or masked and tested, but vaccinated — that one is actually on hold in half the states. So what we're really, based on the arguments, expecting is for the court to lift that stay and let that mandate go into effect but block the OSHA one for non-health employers. But as of our taping, they haven't done either. So watch that space. [Editor's note: The ruling did come down later in the day. Read [KHN's coverage here](#).]

Well, speaking of testing, which is still hard to find, both in-home and lab-based, the Biden administration this week put some meat on the bones of its testing reimbursement program [and] said that starting Jan. 15, people with health insurance will be eligible for reimbursement for up to eight tests per month per person. But there are still lots of unanswered questions. One of the big ones is why Medicare beneficiaries who aren't in private Medicare Advantage plans aren't included, given that they are among the most at highest risk. Was this just an oversight?

Cohrs: That is a good question. I think the jurisdictional issues are complicated. I don't know if there had to be a separate process potentially when you're regulating employer plans versus Medicare benefits, but other people can jump in too.

Karlin-Smith: I don't want to overstep what I know, but I saw somebody on Twitter who has worked at CMS before talk about how this is actually something embedded in the Medicare law in terms of the type of testing and things Medicare can cover. So this may not have been something easily fixable, essentially, by the Biden administration. Like I said, I haven't done a lot of research into this because, again, it does on its face seem odd that one of the populations most at risk of severe covid even when they are fully vaccinated might not have this access. But it seems like it was maybe not so much an oversight or trying to disadvantage Medicare patients but a problem that can't easily be fixed by the administration.

Rovner: To go back to the Supreme Court case for a minute, there was a lot of talk during the arguments about "workarounds" and things that the administration does and doesn't have authority to do. And even though it would seem that they would have a lot more authority over Medicare than they do over private insurance, I think you're right that sometimes even the administration can't figure out how to do some things that really maybe Congress ought to be doing. Well, speaking of administration authority, there's also talk that the administration might send better masks to all Americans. This is something lots of other countries have done. Local governments are starting to do this in some places, but the federal government has not. Do we have a feel for why? I think this was talked about as long ago as the Trump administration, that we should send good masks to everybody. Obviously, there used to be a shortage, but now there really isn't. Is this something that we feel like it's going to happen, or are we just going to argue about it some more?

Karlin-Smith: There's become more political pressure from Congress. A lot of the Democratic senators are signing on to legislation pushing for those higher-quality N95 or KN95 masks to be pushed. And there certainly has been more public pressure, certainly pressure from the media and experts, on [the Centers for Disease Control and Prevention] to update and change its masking guidance to more explicitly recommend and touch on the benefits of these masks. But so far, even yesterday, the CDC director, Rochelle Walensky, indicated they probably will update their guidance and maybe provide more details about the different types of masks and what their benefits [are] and so forth. But she seems to be sticking with this idea that

she says the best-fitting mask is the one you will wear, the one that's just best fitting. And there's this implication there that goes along with their past guidance and so forth that they feel like people either won't wear these higher-quality masks properly or they just won't wear them for the period of time they need to, so maybe they're better off wearing masks that maybe don't work quite as well but they might be more willing to wear. I guess my question is where is the data or research that shows people feel more comfortable or will wear a cloth mask or a surgical mask for a longer period of time compared to some of these higher-quality masks, which it seems like absent government guidance but [with] a lot of academic and other scientific expertise recommendations, lots of people have made the transition, and I haven't heard of a lot of people saying, "Oh, this is actually too hard for me to do."

Rovner: I personally get frustrated between — I know there is some data on how well cloth masks do not work, although there are different kinds of cloth masks. I personally have the ones that are just one-ply that I've basically given up on, but I have some two- and three-ply cloth masks that come with filters. And I also have some KF94s, KN95s — I can't even remember what they are. But I find sometimes the cloth mask is more comfortable, and I'll wear it if I'm in a less crowded place. I wear the really heavy-duty ones to go to the grocery store and stuff. And I'm an educated person, and I don't know what to do. I guess that's my point here. I can only imagine how confused everybody else is.

Kenen: Well, I mean, one thing is that the KN95s — or the N95, whichever variant, 94 [or] 95 — they stay on better. So like these people ... you go into a setting where there are a lot of people and half of them are (a) wearing cloth masks that are not as effective and (b) they're not wearing them right — they're wearing them around their chin. So the higher-quality masks also stay on and also they tend to fog your glasses less, and once people try them, they may like them better for that reason.

Rovner: Yes, if you wear glasses, that's a very good point. Well, meanwhile, and obviously we've already gotten into this — we are still having lots of messaging problems here. People don't understand when and how to get tested or even how to use the tests, what kind of mask to wear if they're even willing to wear a mask. We're seeing federal officials still giving conflicting advice in some cases. And the fact that needed information is not getting out was a major theme from senators on the Senate HELP [Health, Education, Labor and Pensions] Committee, who this week had the top federal health officials in for a hearing. Why is this still so hard? We're about to start our third year of this.

Cohrs: Something I've been thinking about is that when we started off, generally, people were in similar situations. But now the CDC is trying to message to people who haven't gotten vaccinated at all, who are partway through their vaccine regimen, who are operating under these vastly different state guidance and rules. Many places outside the Beltway, there's no mask mandate. People don't wear them indoors [or] outdoors. You rarely see people wearing masks anymore. So I think there's just massive complexity and the need to balance the science, to communicate the science that everything's changing so quickly with the variants, that so much of the data that we had doesn't seem very relevant or useful moving forward. And people [are] like, "It's changing and the virus is changing," which is ... it's just a hard thing to do. Rochelle Walensky isn't a communicator. She certainly was very media-savvy when she was at [Massachusetts General Hospital]. But she has had a learning curve. She's clearly working on it. But there are serious problems. And as someone, I use TikTok, and the CDC has become a meme among the young people, among everyone. And I've just seen that ...

Rovner: I assume not in a good way.

Cohrs: No, not in a good way. But as people poking fun at what the CDC is recommending, just like these random things. So I think there is a serious trust issue, that it's been long-running through the whole pandemic, but it's certainly possibly getting worse.

Rovner: Yeah ... obviously, part of the problem is that omicron is different from delta, which was different from alpha, who is different from the original. So everything that we think we were internalizing, knowing about this disease and what its symptoms are and how it spreads is not necessarily the same. And people ... you've got the anti-science thread going through saying, "See, they were wrong." And it's like, "No, they weren't wrong. This is different." But it's been really, it's been amazingly, difficult to communicate that, OK, this spreads more easily, so you need different masks. Cloth masks were probably OK for the original covid, but they're not OK now. For some reason, it seems really hard for people to be able to say that.

Karlin-Smith: In some of the areas where they've gotten criticized recently, like the tests to leave isolation or quarantine guidance, they want to convey this idea that every decision they're making is very scientific when oftentimes a decision like that is balanced by science and real-world political economic needs. So in my mind, perhaps they do have to make a calculus that a hospital worker who no longer seems symptomatic and who likely will wear a high-quality mask and do everything they can to protect their patients might be better off going back to work than a person not having any health care workers right now to care for them. But then when they're applying that to the whole broader society and letting people sort of go out and about, there's different calculus there, and they haven't really been consistent in saying, "Maybe this should just be for health workers or really essential places where there's that trade-off of 'Well, it actually may be safer for people to have a health care worker than not,'" versus them saying, "Well, you can leave, but don't go around your grandma or don't take a plane." And then Rolling Stone did a good piece the other day saying, "Well, there's lots of people out and about in the world that are immunocompromised and just as at risk as your grandmother, and all these people may be unknowingly exposing them." And I think they haven't done a good job figuring out how to weave those complex kinds of narratives that aren't just about science.

Rovner: I was just going to say ... Everybody says, Oh, well, they're making these decisions for politics or for business. I think they're making these decisions ... that's what Walensky was saying: The best mask is the one that you will wear, which is undoubtedly true, that having a crappy cloth mask is better than having an N95 if you won't wear the N95. That's part of what public health communications is, is sort of figuring out that sweet spot between what advice people will actually take, but I don't know why they're unable to say that.

Kenen: Well, I think that there's like three or four strains of why they're having problems. One is [what] all of you said, there's trust issues in this society about medical expertise and expertise in general that predated this pandemic and have obviously gotten way worse. There is [that] the virus keeps changing and the science is new, so that scientifically keeping up with a changing virus is very difficult. And three is self-inflicted wounds, that all this stuff is really, really hard and really, really rapidly changing. And, yes, public health is figuring out the science in how to apply it in the real world, and they're doing a really ... job. I mean, a lot of this is self-inflicted. I think we've all been quite shocked at how it's confusing, it's contradictory, it's mushy. It's just not been good. And they're not always even on the same page, that even the government experts sometimes contradict one another. So it's really disturbing because we need clarity and we need trust, and we have neither.

Rovner: And, well, before we leave covid, I want to touch on something that we've covered ...

Kenen: We're never going to leave covid, Julie.

Rovner: I meant for today, before we leave, go in for today, I want to touch on something that Sarah brought up, which is this growing group of people who feel overlooked right now, particularly parents of kids under 5 — we have one sitting here on the panel — and people with disabilities, for whom getting and doing even at-home tests is a challenge. I saw a story this week about how there are no Braille instructions

for any of these at-home tests, so if you're blind, you can't do one. Are we just giving up on big swaths of the population? I'm seeing increasingly frantic messages from people with little kids, so, Sarah, you're the little-kid mom here. You get to start.

Karlin-Smith: I think that certainly a lot of parents of young kids or people in the disabled community feel like, and particularly with some of the communication and messaging that has come out of top leaders' mouths this week ... But leaders are basically saying, "Well, there's a very, very, very small fraction of people that might get seriously ill or die from this." And they seem to have acted like maybe we're just accepting that and we're not creating a society that's thinking about how to protect everybody right now in the best way possible. And I think that's where a lot of the anger and fuel come from. Obviously, the situation with young children is a bit different than people that have comorbidities that may put them highly at risk for covid because the expectation is that most young children will likely do OK. But the policies that are keeping our economy and so forth broadly open now still put a lot of burden on parents with school-aged children because even when schools are open now, what we're seeing is there's not enough teachers to teach them. The kids [are] constantly being exposed and quarantined, and parents are expected to work. So I think you're seeing a lot of pushback [on] how we just kind of decided it seems like at this point to not quite go with that "let 'er rip" mentality that some people have been saying we should just get it over with. But it also doesn't seem like we're really doing a lot to try and slow the spread in the way we tried in March 2020. And even though this is a more ... this likely for many people isn't as dangerous a variant, we still see by the hospitalization and case numbers that as a society, it is just as dangerous because our health systems are overwhelmed. We don't have people to drive buses to get kids to school, and so we are just as crippled really as we were with other variants.

Rovner: Yes. I don't know why it's so hard for people to understand the concept that even if omicron is only half as severe, if twice as many people get it, that's the same number of people who end up in the hospital.

Kenen: There's also an economic issue that's not being talked about. There's a lot of the conversation among people who are relatively privileged. And even if you don't get really seriously ill, if you're out for a week or 10 days and you're a working-class person who is paycheck to paycheck, barely making it already, being out for a week or 10 days, or maybe more if you then have your kids get it and you're then the caregiver, that's not like, "Well, OK, I've got to cut back for a week." That's like, are you going to get evicted? Really being sick for 10 days can be an economically devastating thing for I don't know how many Americans, but like a lot more than one or two.

It's a significant slice of the population. And, you know, sneezing and having a sore throat for a day, that's not going to be economically ruinous. But if ... you're out there, people who still get mild and flat-on-your-back mild.

Karlin-Smith: I was going to say that's another communication failure that we didn't bring up.

Rovner: Yes, it is.

Karlin-Smith: A lot of people have been pointing out lately [that] mild covid is actually ... for many people a really, really bad version of the flu and they are knocked out for 10 days, like Joanne said.

Rovner: Yeah. Just because you don't end up in the hospital doesn't mean that you're not really sick.

Kenen: Like I said last time, mild is a four-letter word.

Rovner: Yeah. All right. Well, covid is not the only big health story this week even though it feels like it sometimes. Medicare officials announced how they plan to handle reimbursement for Aduhelm, the

controversial drug approved by the FDA last summer that may or may not help the millions of Americans with Alzheimer's disease. Rachel, you correctly predicted what Medicare would do, so tell us what they did.

Cohrs: Sure. So it's an extraordinary step for them to make an individual decision for a class of drugs. This isn't normal. And they chose the most restrictive option they had under this very rare option to cover this drug. Basically, it's a draft decision, by the way — nothing is final yet. I think they're aiming for April for a final decision.

Rovner: And there's a public comment period.

Cohrs: Yes, there is, but they already had one. But, yes, there's another one. And they said Medicare patients have to be enrolled in CMS-approved clinical trials to have this drug covered. And I think there's still a lot of questions about how these trials would operate. We don't have answers to that right now, but it does look like this will significantly restrict access for Medicare beneficiaries. It is an FDA-approved drug. But because of geographic issues, we don't know which centers might be even interested in running these trials because many hospitals and major medical centers have chosen not to administer it so far. I think there are major questions about how many patients would be able to access it if they even want to.

Kenen: And equity issues because clinical trials are not always representative of the population. We've made progress with the coronavirus vaccines, we were better than in some trials. But by and large, clinical trial still is an equity issue.

Cohrs: I think that is something that they talked about significantly, that in order to even get approved, the design, everything would have to meet certain standards of representativeness of who gets Alzheimer's and is taken seriously. That's a disproportionately underrepresented population in these clinical trials, so it's certainly something they're aware of. But it's going to be difficult to operationalize.

Rovner: Sarah, I think some people were really surprised. They assumed that if the FDA approves a drug, that Medicare has to cover it. And that's not the case, right? I mean, we need to back up a little bit here.

Karlin-Smith: Technically, Medicare operates under its own three-part standard that was recently updated, maybe a year or so ago. It's what's called reasonable and necessary for the Medicare population. The reason why I think most people were surprised is because usually some of the components of that are: Is it safe and effective? And those components, they generally just say, "Well, if FDA has said that," which is what an FDA approval is supposed to mean, "that checks the box." And really what Medicare sometimes tends to do is look at, "OK, is the product appropriate for our population?" Well, we're talking about Alzheimer's, so you would think that's inherently a Medicare population. Sometimes, we often do get drugs approved that weren't really studied in anybody in the Medicare population. Then you have to think about, again, do people in that situation ... So I think this is surprising in that sense because for the most part, Medicare has deferred to CMS on that element.

Rovner: To FDA.

Karlin-Smith: I'm sorry, yes, Medicare has deferred to FDA on that element of safe and effectiveness, and here they had a pretty scathing rebuke of FDA's decision. It wasn't just that they didn't agree with them. They clearly expressed their feelings very strongly that they felt like FDA did not approve a drug that was safe or effective.

Rovner: They basically said we still want to know if this drug is safe and effective and so we're going to make you find out before we're going to pay for it broadly. That's effectively what this does, right?

Karlin-Smith: Right. And it's fairly unusual to have national coverage decisions to begin with and to have coverage decisions with this evidence development and clinical trial requirement. And it's even more unusual. Oftentimes, they do try and restrict the population to the group of Medicare beneficiaries they think are most likely to benefit based on the data. Right. So here, basically, to a certain extent, the FDA approval no longer matters for the Medicare population, right? Because if you have to be in a trial, that's more of the ... to get the drug — that's basically more of a pre-FDA approval environment.

Rovner: And we should mention that it's not just this drug they did this for, it's drugs that may come along that purport to do the same thing that, again, we still don't know if that makes a clinical difference to people with Alzheimer's.

Cohrs: Right. And I think that with these other treatments, if there is really great evidence of clinical benefit, Medicare could reconsider this. They would have to go through the regulatory process to change their decision if there's some new circumstance that warrants that. But right now, I think these other drugmakers definitely are really concerned about what this could mean for them in terms of coming to market and just the gap that Sarah was talking about, too, especially with accelerated approval, too, because normally you have to show clinical benefit to patients — like you have to help their symptoms. But with accelerated approval, that isn't necessarily the standard. But as we're seeing again, there's this gap where that is the standard for CMS.

Rovner: The drug industry is unhappy, but I haven't seen — and the Alzheimer's Association is unhappy. But some of the Alzheimer's groups are funded by the drug industry. But most of the public health comment I've seen about this decision suggests that people agree with it.

Karlin-Smith: Right. I think that there's been general frustration that FDA made the wrong call to begin with. They went against their own advisory committee in approving the drug. They even went against really their own history of guidance around Alzheimer's drug development, which basically had said that this, looking at amyloid plaque reduction in the brain from a drug, was going to ... There had been no evidence that that was going to improve the course of Alzheimer's disease in patients. And they sort of flipped that on its head for this drug and decided maybe it was a good surrogate. So I think there's again a very strong ethical, bioethical case that the best way to help Alzheimer's patients right now is if they would like access to a drug like this and they feel comfortable taking the risks of this type of treatment — which we don't know what benefit it provides and we do know it has some serious safety concerns that could potentially even be fatal — that it should be done in the context of a clinical trial because that's the only way we will ever find out if the product is beneficial and helps. And, again, that is with that bit of the caveat of which Joanne mentioned very early on that, unfortunately, oftentimes people with less means have less access to clinical trials. Medicare is trying to push Biogen to ensure that's not the case here. And also, of course, if you want to go all the way back, you also have to fault Biogen because they also didn't try very hard to get diverse patients in their initial trial. So a lot of this really goes back to what the company was unwilling to do to begin with, some of the inequities.

Rovner: So to add another layer of complication to this already complicated story — just the possibility that Medicare would cover this drug contributed to the largest ever Part B premium increase for 2022, more than \$22 per month. [It] went from just under \$150 a month to over \$170 a month. Now Health and Human Services Secretary [Xavier] Becerra is calling on CMS to lower the premium in light of Aduhelm's price cut, which happened in December. They cut the proposed price in half, from \$56,000 to \$28,000 a year. Might the premium actually be lowered? I should point out that it never has before once it's taken effect, but we've also never seen this kind of increase caused by a single drug either.

Cohrs: I think the data has changed somewhat. Because actuaries, when they're setting these premiums, they have variables that they're working with, trying to account for uncertainty, and at least where we are right now — where we'll get to in April may be different — but where we sit right now, Biogen cut the price of the drug in half, as you mentioned. So I think that's one variable that looks very different than it did before. And then this coverage decision is, if it's finalized, it's extremely restrictive. We don't know how many patients — Medicare officials wouldn't say — but it's not very many. Not very many people are getting the drug right now. So I think that number looks much smaller than it did. And I think there's also been political pressure as well from Congress. Looking toward the midterms, they don't want a big premium increase right now. And if they could look like they're doing something about that, then that could be advantageous, too. So it's certainly been a matter of discourse giving ... I think one expert I spoke with said that there's really no downside to giving seniors their money back. So I think usually they calculate it in next year. But with the increase being so high this year, I think there's just this extra heightened sensitivity around it.

Rovner: Yeah. I've been sort of surprised at how little a backlash there has been to this enormous premium increase. I think maybe there was just so much other news that people hadn't noticed because ... Joanne and I have been covering this long enough to remember that an increase of \$3 or \$4 a month was enough to create a gigantic fount of complaints to Congress. I've seen a few things on this, but less than I would have expected.

All right. Well, since I have my two drug experts here this week, I need to ask about another new rule from [the Department of Health and Human Services] that purports to save money at the pharmacy counter for Medicare beneficiaries by limiting payments from pharmacies to PBMs, the pharmacy benefit managers. Could this make a real difference in patient premiums? Obviously, lowering the Part B premium would be a big deal, but is this a big deal too?

Karlin-Smith: So this is actually sort of the opposite of lowering premiums. It's something that would help people with their actual drug costs when they go to the pharmacy counter and pay for a product. The flip side of it is that it could actually potentially raise Part D premiums is my understanding of how Medicare has factored this all in. I tend to think of these pharmacy — what's called direct and indirect remuneration a little bit like rebates, which most people are familiar with, which go from drug manufacturers to the PBMs — but as rebates from the pharmacies to the PBMs. And it's just like a much smaller pool of the pie. And that's why most people aren't aware of it. And basically what they're saying is ...

Rovner: I don't think I was aware of it until this rule came out.

Karlin-Smith: Right. Basically what they're saying is it's similar if you think about the concept of the rebate rule the Trump administration was trying to implement to some degree that, basically, if you're going to get these payments back from the pharmacies, the PBMs and the health plans have to apply it directly to the patient's cost sharing of the drug. You can't use it to lower premiums. Ironically, because of how this would all shake out, drug companies might actually benefit from this. Medicare might actually lose some money because, again, historically what the money is used for is to lower premiums for everybody, and this will be more of a direct benefit to patients. The interesting thing, again, I think is thinking about this in the context of the rebate rule. The justification is kind of similar of why to do this, it's just kind of interesting that we're moving forward with squashing that idea on the federal level. Of course, for, again, it's complicated because it's baked into getting some savings for bigger, other legislation, but that this smaller part of the drug-pricing sector, where they're seen as being unfair — harm to patients in terms of them not benefiting from discounts on their drugs.

Cohrs: Yes. One important point, I think, was that not all beneficiaries would pay less under this proposal. I think that the phrase that Medicare officials used is that “more than half” of Medicare beneficiaries would see a net benefit to their pocketbook, which is not terribly encouraging. I mean, usually if they have really good numbers, they'll say it. So what they're saying is that the premium will go up [and] more than half of beneficiaries would be expected to pay less at the pharmacy counter. That will even it out. But there's also potentially a significant chunk of people that would just pay higher premiums and wouldn't see the benefit, which is, I think, where similar policies have run into issues before. So we'll see.

Rovner: This is an issue in health insurance all the time, you know, they call it the “sick tax.” The question is, how much should you pay when you're using services as opposed to how much you should pay in premiums if you *might* use services. And it's always a balance and it's always complicated. Well, while we've been spending all this time talking about the FDA, today the Senate HELP Committee is scheduled to vote on the nomination of former Obama-era FDA commissioner Rob Califf to be the next FDA commissioner. Also, I say “scheduled” because this vote was supposed to be Wednesday and it got put off. We've already seen at least one Democrat, New Hampshire's Maggie Hassan, declare her opposition to the nomination because she says that Califf, when he was in charge of the FDA, didn't do enough to stem the opioid epidemic. Now, a bunch of anti-abortion groups are urging all Republicans to vote against the nomination, too, on the grounds that Califf does not oppose the abortion pill mifepristone, which, I add, was not approved under his leadership. It was approved under the Clinton administration. But my bigger question is, do we think this nomination is in trouble or is he still going to get through? There's obviously some Democrats who have some issues, and now we may see some Republicans who will have some issues.

Karlin-Smith: I'd be surprised if he doesn't make it through, but he definitely is going to need some Republicans. So if there could potentially be an issue where maybe it gets placed on hold or something over the abortion pill issue and maybe that's dragged out — but I'm not sure that they are, at this point, going to sink it because of this. I did note, you know, senators can send written requests, written questions that we don't hear about. And I know Sen. Mike Braun, who's on the HELP committee, asked Califf about the abortion pill question, and he definitely did not get the response he wanted. So he's one person I'm interested to see how he votes today. The HELP Committee vote today may be telling us what's the obstacles he would face moving forward on the floor, because we do know he's probably going to lose more than just Maggie Hassan on the Democratic side.

Rovner: If you'd asked me a year ago which major HHS position would still be unfilled 51 weeks into the administration, I don't think the head of FDA would have been on my list. And yet here we are. So we will see how that goes. All right. That is the news for the week. Now it is 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 piece is a collaboration between Fortune and Kaiser Health News. The headline is “[The ‘TurboTax of Bankruptcy’ Aims to Help People in Medical Debt Rebuild Their Financial Lives](#),” and that's by Blake Farmer. I just thought this piece was really interesting and nuanced and kind of explored the pros and cons and accessibility of declaring bankruptcy at all. We know medical debt is a huge issue, a huge contributor to bankruptcy, because, as was pointed out in the piece, it's unpredictable. People don't necessarily know when they're going to have a massive medical bill to deal with, and I think just the equity concerns addressed here were really important about the cost of filing for bankruptcy and how that's inaccessible to some people, but how increasing access too much could still be bad. And you know, people's credit, and you can only declare bankruptcy so often, every few years. So I definitely learned a lot.

Again, a very important issue that so many people are dealing with. I think the statistic was that 20% of households have some sort of unpaid medical debt. So definitely an interesting area to watch. And I thought this piece is very well done.

Rovner: And yet we're the only industrialized country where you would have to write a piece like this about people going broke from medical debt. Sarah.

Karlin-Smith: I am looking at a piece by Stat News' Lev Facher, [“I'm Going to Prove You Wrong': How a D.C. Power Couple Used an ALS Diagnosis to Create a Political Juggernaut.”](#) And it's a story of a couple — the husband was diagnosed with ALS, I guess almost about five years ago now, and his wife, they're both sort of high-level Democratic officials in the Obama administration and so forth, and how they ended up using those connections and knowledge of government and policy and lobbying to really make some pretty big impacts rather fast in terms of government policy to help ALS patients, which is pretty interesting. You know, speeding up disability benefits, just getting a lot more government money for research and so forth. But it's just a really good piece, where you see both the human side of ALS and what it means to live with and also help care for somebody with the disease and have a family, and think about the politics and policy implications of how things get done in Washington.

Rovner: Yes. Effective advocacy is not to be underrated.

Karlin-Smith: Right. And I think ALS has been, you know, for a number of years, something that, I've noticed in my coverage, it's one of those diseases that really gets a lot of support from some lawmakers and from politicians. I think it is just because of the incredibly devastating nature of the disease and how it really robs people of their lives at such a young age. And there's just been some interesting coverage of that because there are so many diseases like this that I think sometimes don't get that push and don't get that coverage or have those voices. And so there sometimes has been this tension of: How do we fairly spread out all of that money and resources and time? But it's a really fascinating piece.

Rovner: It's a really good story. Joanne.

Kenen: There was a piece in [The New York] Times by Davey Alba called [“Covid Test Misinformation Spikes Along With Spread of Omicron.”](#) So we've had mask misinformation, we have had vaccine misinformation, and now we get to have test misinformation saying they don't work, that you can put them in your kiwi juice — I didn't know there was such a thing as kiwi juice. I would argue that misinformation and disinformation are two different things, but I'm not sure. In some cases, there's misinformation [but] some of what's been circulating, about the tests, months into this, probably, is verging into disinformation. The tests are not perfect. Like all tests, there is such a thing as a false negative. There is such a thing as a false positive — not a perfect test, but that this new mythology is incorrect.

Rovner: Yeah, that was quite a story. Well, my story comes courtesy of Joanne. So, thank you, Joanne. It's from the AP by Collin Binkley and Ryan J. Foley, and it's called [“Flush With COVID-19 Aid, Schools Steer Funding to Sports,”](#) and that's exactly what this story is about. It seems that Congress sent \$123 billion to public schools around the country to help students catch up from their lost year of academics, thinking ventilation improvements and tutoring, for example. But it seems some school districts are using the money to build new football fields, outdoor tracks and indoor weight rooms and ... capitalism! It seems that sports companies are now going around to school districts to urge them to use that money on athletic improvements. Now, I suppose you can make a case that students lost a full year of athletics, too, and that's not unimportant. But that's apparently not what this money was intended for and good job, AP, for tracking where all this money is actually going. It's really a well-researched and -written story.

Kenen: It reminds me of one of the Dakotas spent their tobacco settlement on a morgue.

Rovner: Yeah. That's at least linked! OK, 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 — all one word — @kff.org. Or you can tweet me. I'm @jrovner. Joanne?

Kenen: @JoanneKenen

Rovner: Sarah?

Karlin-Smith: I'm @SarahKarlin

Rovner: Rachel.

Cohrs: @rachelcohrs

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