

## **KHN's 'What the Health?'**

**Episode Title:** It's Health Costs, Stupid (2022 Edition)

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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, Feb. 17, 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 Tami Luhby of CNN.

**Tami Luhby:** Good morning.

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

**Sarah Karlin-Smith:** Hi, everyone.

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

**Rachel Cohrs:** Hi, Julie.

**Rovner:** Later in this episode, we'll have an interview with Hannah Wesolowski of the National Alliance on Mental Illness. We'll talk about how the pandemic has shone a spotlight on mental health problems in this country and what we might do to start to address them. But first, this week's news. Well, for the first time in the Biden administration, there is a Senate-confirmed FDA commissioner. The Senate approved Rob Califf to return to the job he held at the end of the Obama administration on Tuesday by a vote of 50 to 46. It was technically a bipartisan vote, with five Democrats [including independent Bernie Sanders] voting "no" and [six] Republicans voting "yes." But this vote was actually more of a squeaker than it appeared, right, Rachel?

**Cohrs:** Yes. It was pretty dramatic. Both the cloture vote — we didn't really know if he would get there. He got through with 49 votes just because of who ended up showing up, and there were two Republicans who offered their support closer to the end, which are Sens. Roy Blunt [of Missouri] and Pat Toomey [of Pennsylvania], ended up voting for him. Both of them are retiring, so I think they had more immunity to the pressure from some of these anti-abortion groups because they weren't up for reelection again. And there was a really extraordinary moment on the floor, too, where Sen. Mike Rounds [of South Dakota] changed his vote from a "no" vote — he's a Republican — to "present" to balance out the fact that Sen. [Ben Ray] Luján was not able to be there for New Mexico because he is recovering from a stroke. So it was pretty dramatic for floor votes for a nomination, but he did squeak through.

**Rovner:** The last time Rob Califf was up for confirmation to the same vote, he was easily confirmed — it was 89 to 4. So Califf hasn't changed that much in seven years, and the Senate hasn't changed that much in seven years. Is it just the FDA and its agenda has changed in seven years? Sarah, you must have been covering FDA then, too, right?

**Karlin-Smith:** Right. So we tabulated this all. I believe it was like 26 Republicans who voted “yes” for him last time changed their votes and voted “no.” And then there’s a few others that shift in different ways. But he actually got 48 Republicans to vote for him last time as well. So that’s how dramatically different it was this time. Two big things I think that hurt him. The biggest thing was, as Rachel mentioned, this controversy over the abortion pill when Califf was first at FDA. They relaxed some restrictions to make it easier for people to get access to the pill. And then, even more recently, right around the time he was getting going through the HELP [U.S. Senate Health, Education, Labor, and Pensions] committee process for his confirmation, FDA relaxed those restrictions even more. Califf in some written commentary essentially indicated he would stand by FDA’s decision there. And that really upset anti-abortion groups, and they very much pressured Republicans to not support him because of that. On the Democratic side, I think the opposition that the smaller group of Democrats had didn’t really change about how they thought Califf would handle opioids and his connections to the drug industry. The only thing there I would say that shifted is he did work much more directly in some ways for industry since leaving FDA than perhaps before.

**Rovner:** So Janet Woodcock, who’s been the acting FDA commissioner for the past year, was expected to retire or leave, but she announced that she’ll stay on as Califf’s principal deputy. Is that a vote of confidence for the incoming boss or something else?

**Karlin-Smith:** I think that her and Califf worked together before, and my understanding is they generally worked together well. I think some of it is just, like, we’re in the middle of a pandemic and there’s a need for some continuity and help getting him on board fast. People I talked to don’t necessarily think Woodcock’s going to stick around forever. Even though her title is a very high position, she doesn’t have the power she has. In the commissioner’s office, she actually in some ways without being the top person has a lot less power than when she headed the [Center for Drug Evaluation and Research] prior to becoming acting commissioner. So my guess is she helps out for some kind of transition period and then moves on and figures out what she would like to do. There’s been rumors she’s wanted to retire for years.

**Rovner:** She’s my age. It makes me feel very old. I’m not retiring any time soon, by the way. Well, so now there’s finally a boss at FDA. Does that change the agency’s immediate agenda? I saw a whole bunch of “OK, now FDA can go and do all of these things.” What are some of these things, Rachel? You guys had an agenda story.

**Cohrs:** Yes. I think my colleague Nick had a good rundown just of the different decisions facing the FDA. And it’s important to note that, especially in some of these approval decisions, the commissioner isn’t necessarily in the room driving those, but he’s certainly going to be publicly accountable for those decisions? So I think that’s just an important note to have. But I think there is an opioid decision coming up. There’s questions about tobacco. These agenda items are really important. There’s obviously the decision-making around the vaccinations for young children that have been so controversial.

**Rovner:** Which we will get to.

**Cohrs:** Yes, we'll get there in a minute. The Novavax application for their vaccine as well. So there's just some really controversial immediate decisions coming up but also bigger questions about accelerated approval and how that will be handled going forward, that Sen. Ron Wyden [of Oregon] pushed Dr. Califf on during the confirmation process. So there are some big, immediate decisions. But, again, these are just important to keep in mind, that the commissioner is an important leadership figure in the agency, but he won't necessarily be in there making the decisions himself.

**Rovner:** Sarah, is it going to help to have an actual spokesman from FDA out there leading some of these things? I assume that's been the holdup with Woodcock. There's this stigma to being an acting anything.

**Karlin-Smith:** Right. I think people do feel like having a permanent commissioner may give the FDA more legitimacy in handling of the crises. I think it'll be interesting to see if the Biden administration uses Califf in different ways than they used Woodcock. One thing, if you watch the White House's covid response briefings, you see Anthony Fauci representing [the National Institutes of Health] and [the Centers for Disease Control and Prevention] Director [Rochelle] Walensky representing her agency. And you never see anybody from FDA. Will they sort of elevate FDA because of that? On the other hand, if there was ever going to be an acting commissioner of FDA in a crisis where you really hoped you had a permanent one, it's hard to say there's anybody more permanent-like than Janet Woodcock who would be comfortable acting in that way. So I'm a little bit skeptical it makes as big a difference as some of the people who've been screaming at Biden for not getting this done sooner have been, but perhaps symbolically, it'll be important.

**Rovner:** Well, we shall continue to watch the FDA. And so with the notable exception of drug prices, we haven't really talked about the elephant in the room of health care costs lately. And, coincidentally, we have a bunch of different threads that I want to pull on this. I want to start with a really undercovered story out of Massachusetts, where the state's Health [Policy] Commission, which was created in 2012, has for the very first time ordered a hospital system, in this case the venerable Mass General Brigham, to implement a performance improvement plan to rein in its spending growth. The commission, headed by the venerable Massachusetts health economist Stuart Altman, has also said that a proposed expansion of outpatient facilities into the suburbs would actually boost health costs for everyone, and it's recommending that it not be approved. Now, to me, this kind of feels like two bull elephants going at it, and you definitely don't want to get caught underfoot. But there's a lot more going on here. The hospital system says it's expanding capacity that is badly needed, which is something we have been talking about. While the commission says that driving up prices will mean that people won't be able to afford that capacity even if it gets added. Is somebody right here, or is this the entire health cost debate pushed into one argument?

**Cohrs:** And the most important part of this debate to me is that there's been so much conversation about how to control prescription drug costs at the federal level, at the state level. And it's been very, very rare that a state will lift a finger against hospitals. And I think Massachusetts is just kind of the perfect lab for this sort of thing, just because there are so many organizations, there's been so much consolidation. And I think there ...

**Rovner:** And hospitals are so powerful in Massachusetts.

**Cohrs:** They really are. We saw the surprise billing debate play out, with [U.S. Rep.] Richard Neal [of Massachusetts] very much listening to his hospital interests and ...

**Rovner:** He's the chairman of the House Ways and Means Committee.

**Cohrs:** Adding some context there. But, yes, it was very representing the hospital industry's concerns in that debate, and it really shaped the outcome. So I think this just could potentially be a model going forward. There has been model legislation on cost commissions like this in Massachusetts and other states. And I think there's just big questions about how much authority they would have, whether it's like a rate-setting committee. This is just a really fascinating test case of how ... I think the drug industry always likes to point to hospitals too and say they are a much bigger proportion of national health spending.

**Rovner:** True.

**Cohrs:** True. But I think because there's physicians that people see hospitals — it's human-based, it's something you experience much differently than prescription drugs. So I think it'll be really interesting to watch this play out.

**Luhby:** Hospitals employ a lot of people in their neighborhoods, so when you're talking about expanding, you're talking about more jobs, too.

**Rovner:** That's right. And there's a hospital in pretty much every congressional district. I know I have told this story before, but when I was covering the Clinton health plan in 1994, it finally went to the Senate floor after long delays. And the very first amendment from the then-chairman of the Senate Finance Committee, Daniel Patrick Moynihan, was basically to protect the New York teaching hospitals. Not that much has changed since then. That's still one of the things that seared into my brain. It was literally the first thing that Moynihan was going to do was make sure that the New York teaching hospitals were protected in all of this. And I think that is — how many? — 30, almost 30 years ago. And it is still the same. So, well, let's stay with hospitals for a minute. We are seeing a spate of antitrust lawsuits around the country charging that monopoly power and these all or nothing contracts — meaning if you contract with one hospital that belongs to a hospital chain, you're going to have to contract with all of them — those are driving up prices for everyone, according to these lawsuits. Sutter Health in California, which already settled one big lawsuit, is now facing another one. Suits have also recently been filed in North Carolina and Connecticut, challenging the same sort of behavior. Now this is something that's been tried before without a whole lot of success. I'm wondering if we're in a new place with antitrust, with so many giant providers and such huge amounts of money involved.

**Cohrs:** I think that's an excellent question, and I think certainly federally that the landscape on antitrust has changed with the new administration. I think they are very much interested as part of President Biden's platform to address consolidation and just antitrust issues in the health care system. I think the [Federal Trade Commission] is also looking at pharmacy benefit managers, too — there certainly is an appetite for this in D.C. And I think it's worth noting, too, that Sutter was Xavier Becerra's case when he was attorney general in California. That was a really important case,

and I think was the tip of the iceberg in terms of exposing some of the contracting practices that health systems use to maintain their power. So I think each of these — I think the Sutter one may settle — trials are really expensive and high-profile. A lot of systems don't want to engage with that. So, again, I think these will be really great test cases to see, and I think each of them has somewhat of a different model for who the plaintiffs are and how that will play out in different venues too. So more attention to hospitals, consolidation, power, and pricing going forward. And I think each of these will be worth watching.

**Rovner:** Is this going to be the only way we're ever going to get control over hospital ... and I hesitate to say spending here. I want to say prices. I mean, this is one of those cases where it really is the prices, stupid. Legislatures, as we just discussed, don't have a lot of incentive to go after hospitals. So we're going to have to basically count on the courts to do it?

**Luhby:** Well, one thing that we did see is that even though I think it still has yet to manifest — now hospitals do have to publish their prices. So they're kicking and screaming doing that. The Biden administration actually kept that Trump rule and increased the penalties for it. So we may see some results with that. And then, of course, you also have the surprise billing legislation that was passed under the Trump administration, enacted by the Biden administration. Now, insurers are mad. Oh, I'm sorry. Hospitals are mad because they feel that they were shortchanged in the way that the Biden administration created the rules, and they think that it tips the scales toward insurers. So if you can't have these out-of-network providers now charging giant rates unexpectedly to people and insurers know more about — presumably insurers know more about the hospital billing practices, then we may over time see some change.

**Rovner:** Well, let me add another element to it. I'm so glad you brought up surprise bills. This is courtesy of Rachel this week. Those of you who closely followed the saga of the effort to curb surprise bills will remember that private equity firms were quite involved. Mostly, they were buying up hospital-based physician practices like pathologists and emergency room doctors and then keeping them out of insurance networks and charging — I believe the right word here is exorbitant — amounts of money, often to patients. Well, that spigot has been, if not shut off, at least turned down for the moment. But, Rachel, now you say private equity is getting involved in the traveling nurse business, which is the latest source of lots and lots of money. Tell us what you found.

**Cohrs:** Sure. So I think it's important to make the distinction here that nurses aren't billing people. So it's unlikely we're going to see a similar model. But I think these private equity firms see all the money flowing into this sector, and I think they've been interested for a long time because there are general trends like the population's getting older and there's a wave of retirements that are expected for nurses in the coming years. So I think they've been interested in this for a long time, but investors could never have imagined the workforce disruption that we would see with the pandemic. And it's very possible that could accelerate all of these dynamics going forward for hospitals and for nursing homes as well. I think there's just going to be a staffing crunch. There already is one, and it's certainly ... the disruption is not going to magically go away after the pandemic. I think it's just altered the workforce.

**Rovner:** Yeah, and we've talked about this before, the whole traveling nurse phenomenon. If they pick up and move, they can get paid two or three times what they're getting paid now. But that disrupts the continuity of care. And for a lot of them, they're discovering it's disrupting their lives, too. They're living out of hotel rooms or RVs, and, yeah, they're banking a lot of money for the moment, but it's not necessarily how they want to live their lives.

**Cohrs:** True. Yeah, there are definitely advantages, but disadvantages, too. I think really — they're usually going in hot spots, places where they're understaffed. But I think the big question here with private equity's involvement with these staffing firms — there has been a spate of purchases over the past year — is how much money are they making off of each nurse that they're placing. I think the industry argument is that they're taking a relatively consistent ... or at least the big publicly traded firms are saying, "We're taking a consistent percentage of the pay. The pay is just higher and there's more nurses, so that means more money for us." But I think there's not a whole lot of transparency into these private equity-owned firms. So I think lawmakers, hospitals, nursing homes really want more information about how much of the fees that hospitals and nursing homes are paying are actually going to the nurses versus these firms and how those dynamics have changed over time.

**Rovner:** And this, of course, all feeds into the hospitals wanting to charge insurance more because now their staffing costs have gone up so much more. And in the end, it's all trickling back to private investors, even from nonprofits. It is all still a mess.

**Luhby:** And, actually, just before we move on, I just want to note that Avalere recently looked at some [Bureau of Labor Statistics] figures and found that year over year compensation for nursing homes and other residential care facilities increased 5.7%, more than any other industry category. It was up 4.5% for all health care workers, and that compares to 4% for all workers. So, yeah, we're going to see more price increases because hospitals are saying we have to pay so much for traveling nurses and others. And then just a little scary note to end this on: Even though we've all been talking about the rising cost of gas and food and housing and everything else, inflation hasn't actually hit the health care sector that much yet. Axios' Bob Herman took a look and found that health care inflation is up only 2% to 3% since the pandemic began, which is far lower than overall inflation. So price hikes and more spending is on the way.

**Rovner:** Something to look forward to! All right. One more thing before we leave our health costs discussion: Another source of increased health costs, or maybe not, is telehealth. I'm pretty confident that everybody at this table has had at least one telehealth visit during the pandemic. Yes? Everybody's nodding. How many of you had had telehealth visits before the pandemic?

**Luhby:** I did. I actually participate in One Medical, and I've used it and really enjoyed it.

**Rovner:** I had not. Rachel?

**Cohrs:** I think I had used the chat function with One Medical as well, but I don't think I had had a video visit before the pandemic.

**Rovner:** Yeah, that's how I was too. Sarah?

**Karlin-Smith:** I could be wrong, but I don't think so.

**Rovner:** So it seems that entering year 3 of covid, we still don't know if telehealth actually saves money by being presumably cheaper than in-office visits or costs money by presumably stimulating more visits because it's easier and more convenient. And it all obviously depends on how much providers charge for telehealth and how much payers are willing to pay. Is it even possible at this point to put the telehealth genie back in the bottle? Or is this going to be yet something else that we're going to fight over when it comes to cost and providers versus insurers versus patients?

**Luhby:** We're looking at it as people who have the option to go to a doctor. But remember a lot of telehealth is also in rural areas where they don't have specialists. And this may open up the opportunity. And, yes, it may increase prices and increase spending. But this is care that is desperately needed in many parts of the country that is not available in any other way other than telehealth. So it may be driven in part by providing more care to the rural areas and other areas.

**Rovner:** Well, that's always sort of the question: Are you providing care that's been underprovided and needed, or are you providing excess care where it's just a convenience factor?

**Cohrs:** Right. And I think there's a [Department of Health and Human Services] report, too — I don't know, roughly a month or two ago — that I think called into question how much telehealth services during — I think 2020 was the frame they were looking at — actually helped health equity concerns just because, yes, certainly people in rural communities have less access to specialists, but they also have less access to broadband. And so it's chicken-and-the-egg kind of concern too. Like how much do you have to invest to make this more accessible to certain communities who really need it? So I think there'll be really interesting data as we look at the 2021 calendar year, and I'm looking at some of those trends as everything's evening out and it's not quite as much of an emergency where everything is so dramatically shifted and in-person is an option for some people too.

**Karlin-Smith:** The other thing I think about a lot is so much of health care can be very physical in terms of your actual interaction with a doctor. So, well, a lot of mental health care can maybe be done over telehealth, and it can be like a one for one trade-off. Sometimes I've heard of company doctors or insurance companies even sending people devices at home to take some of the measurements and so forth that a doctor would. It can be hard to replicate everything you really need to do in a physician's office with a telehealth visit. So that's where you get into this issue of "can it really replace it, or what does it replace?" And in my experience during the pandemic, one of the things that frustrated me was our pediatrician's office, before we would ... if we needed a covid test, we would have to do a telehealth visit first. And sometimes it just didn't seem really logical and just seemed like another, again, like an added hurdle and an added step because we knew at the end of the day we were going to need to get that test.

**Rovner:** All right. Well, let us talk about covid. We passed a milestone you might not have noticed this week, the announcement that the pandemic has resulted in more than a million excess deaths in the U.S., meaning not just deaths from covid specifically, but deaths from other causes that wouldn't have happened but for covid. People who didn't go to the hospital emergency room

when they had a heart attack or a stroke. One of those things that I don't think anybody would have predicted: There's been a big increase in auto fatalities. David Leonhardt at The New York Times dug into this trend and found that while at the beginning it was people driving faster on mostly empty roads — that kind of makes sense — now it's also people who are angry and tired and frustrated still driving faster on more crowded roads. Is there a point where we all get to stop feeling so grouchy? I'm dead serious. This is a serious public health issue. I think everybody is on their last nerve, and it is affecting people's health. I mean, we're seeing obviously increases in violence also as the pandemic drags on. And it's not just in the U.S. Every time I think, "We Americans, we're just impossible." I look around the world and I see angry Canadians. I never thought I would see angry Canadians.

**Luhby:** Well, I guess as mask mandates start to drop, there are going to be less confrontations because you won't hear as many of those horrible stories of security guards or salespeople at stores getting shot or stabbed because they tell somebody to put on a mask. So, I suppose then the people who do still want those mask mandates will either wear the masks themselves, or not go to the stores, or go at calmer hours. But, yeah, I think that you can see that a lot of governments are slowly starting to drop — well, actually, not even that slowly — they're starting to drop the mandates pretty quickly.

**Rovner:** This is my next question: Is the dropping happening too fast?

**Luhby:** Well, yes. States will say no, as we can see, because now there's so few of them that still have the mandates. But the federal government is pushing back, saying, "Don't do this quite so quickly."

**Rovner:** As these mandates are lifted and in some cases really rapidly, people with compromised immune systems and people with kids under 5 are feeling increasingly left behind. Tami, some of your colleagues this week talked about yet another source of inequity, which is in testing. What's going on with that?

**Luhby:** Well, it was interesting. I was going to do a story because I had written about the free federal tests that were being sent out, and we received almost 8,000 reader responses to it back in January. But there're still flowing in, and we're still getting a lot of people who said that they haven't gotten their tests. So I was looking into this, but, actually, then yesterday we heard both on CNN and at the daily press conference that more than 50 million households have already received their tests, and that's about out of 60 million that have been ordered. I'll say that I ordered mine on Jan. 18. I haven't seen mine. I don't know if you guys have received either ...

**Rovner:** I got mine.

**Luhby:** You did get yours. When? Recently?

**Rovner:** No, I got mine pretty quick. It was like the first week of February.

**Luhby:** Right. So it's interesting that it does seem to be very varied. And so I spoke to a couple of people. And they were even more annoyed. This one woman I spoke to in Connecticut who hasn't received hers and wants them before she goes to travel for a family reunion in Las Vegas. She's



mad because she said other people that she knows in the state, not necessarily in her community, but other people, her friends in the state, have received theirs. I spoke to a man in North Carolina who said that his family in Detroit has received theirs but he hasn't. So even though 80% of Americans have received the tests, which is great, you still have roughly 10 million people who haven't. And they're annoyed. And it comes at a time when the urgency has somewhat passed because you had ... when the government opened up this program on Jan. 18, there were nearly 750,000 average cases reported a day in the U.S., and now that's down to 136,000. And also, at the same time, you can go now and get a test, an at-home test, at your pharmacy; they're much easier to find. I went out in December, late December or early January, to multiple stores in my neighborhood ...

**Rovner:** And there were none to be had.

**Luhby:** There were none around. And I went this weekend, and there were just boxes and boxes behind the counter. So that's not as much of a problem. And of course, people on private insurance can have those reimbursed generally, although that's another issue.

**Rovner:** Yeah, that's another story!

**Luhby:** And interestingly, actually, just pivoting to that, WBUR called some insurers in Massachusetts to see what was happening there. And Blue Cross Blue Shield of Massachusetts said that only 0.5% of its eligible members have filed for reimbursements between Jan. 15 and the end of the month. And Tufts Health Plan and Harvard Pilgrim Health Care said that the number was fewer than 0.05%. So ...

**Rovner:** Well, gee, it's been so easy, as we've seen, you only have to fill out like, you know, five pages and cut out the little code on the box, but other than that ...

**Luhby:** And maybe use the fax machine. But, yeah, so obviously a lot of people don't know they can be reimbursed. And if they do, they don't know how to do it. It's a cumbersome, old-fashioned process. That was a great story — that the fax machine is being kept alive by the insurance industry. I actually have one and have used it for insurance, sadly. But that's the situation with the testing.

**Rovner:** Yes. So Sarah, what's going on with the under-5s? This is also a continuing saga.

**Karlin-Smith:** I think you're referring to the vaccines?

**Rovner:** Yes, the vaccine.

**Karlin-Smith:** So late last week, we had surprising end-of-Friday news. We were expecting FDA Friday last week to issue preview documents ahead of an advisory committee meeting this week that would have reviewed Pfizer-BioNTech's vaccine in children under 5. There was a really last-minute shift where basically Pfizer and FDA have decided that it's not ready for FDA review, and they're going to wait until the company gets data on three doses of the vaccine in this population. This whole process has gone in a circle because, in December, Pfizer said our study didn't really meet the criteria it needed for the vaccine to be successful, particularly in the 2- to 4-year-old age range. And they said, "We're going to have to wait for three-dose data. We'll get back to you in the

spring.” And then a few weeks later, FDA and the companies did a bit of a pivot and said, “Well, actually, we think there may have been some benefit to the two-dose shot, and we want to see if we can get that two-dose version authorized faster. And it raised a lot of expectations, though there was not a lot of data to understand what had shifted. And then, pretty fast, FDA said. “Well, actually just kidding. We don't really think the data is there,” and pulled the rug out from under parents again.

**Rovner:** So where we are is we're still waiting for the three-shot data that we will see in the spring, right?

**Karlin-Smith:** Correct. Nothing else changing. And I think it's just been a strange public relations communications issue for the FDA, in part because there's so little data publicly available. We have, like, a couple of lines from Pfizer press releases and a couple of comments from FDA to get a sense of what's going on here. I think what's important to think about here is people are saying, like, it's a good thing for FDA to pull back if they said, if they thought, OK, we see something that maybe we'll let us move faster here, but now we realize we really can't. It's good that FDA made that decision. It's also good that they were trying to think about, like, could they be flexible in an emergency? The problem, I think, is more about how they communicated. And again, there's a segment of people that are really, really looking forward to these vaccines. They raised a lot of people's expectations. I think people just had this assumption that because FDA made those announcements, these vaccines were ready for their kids, and now they feel like they're being asked to wait unfairly.

**Rovner:** With the frustration that continues to mount. Hopefully, we're getting towards the end of it. Well, we have gotten towards the end of the news for this week. Now we will play my interview with Hannah Wesolowski of the National Alliance on Mental Illness. Then we will be back with our extra credits.

We are pleased to welcome to the podcast Hannah Wesolowski of the National Alliance on Mental Illness. Welcome to “What the Health?”

**Wesolowski:** Hi, Julie. Thanks so much for having me.

**Rovner:** I feel like the pandemic has obviously exacerbated what was already a pretty big mental health crisis in this country. How serious were things before and how much more serious are they now, Two years into the pandemic?

**Wesolowski:** We are really concerned about the state of mental health in this country. One in 5 people in the U.S. had a mental health condition prior to the pandemic. But now we are seeing exploding rates of symptoms of anxiety and depression, and we're seeing a special impact on youth and children's mental health. And one of our big concerns is that when people need help, there isn't help available. In 2016, and so this is a number of years ago, the Health Resources and Services Administration said that by 2025, we would be 250,000 workers short of projected demand in mental health and behavioral health. And 122 million Americans live in the federally designated mental health professional shortage areas. And now we're seeing burnout in the profession at rates that we can't anticipate, plus higher demand. So while people are experiencing

more symptoms of a mental health condition, where can they go? There's very limited help available.

**Rovner:** And it's not like truck drivers. You can't go take a course for three months and then put yourself out on the road as a counselor.

**Wesolowski:** Absolutely, yes. It's not just psychiatrists and psychologists. There are lots of types of mental health professionals out there, but all of them need training. They need to know how to de-escalate. They need to know symptoms of mental health conditions. They need to know where to direct people for additional care. So it is extensive training, no matter what type of mental health professional you are.

**Rovner:** So one thing Congress did manage to do for mental health during the pandemic was to pass a law creating a three-digit number people can call with mental health emergencies. Starting this July, 988 rolls out nationwide. How is this going to work? Who answers when you call 988 and what services will they be able to provide?

**Wesolowski:** We have a lot of hope around 988. 988 will route through the existing National Suicide Prevention Lifeline. But when Congress created 988, they also expanded the scope of the lifeline to include mental health crises. So we're able to leverage an existing network of about 200 local call centers across the country that are part of the Lifeline Network already, and it's trained crisis counselors who are answering those calls. So it's estimated about 80% of callers can be de-escalated over the phone and connected to additional resources and information. And this is a range of crisis situations. It's suicidal ideation. It's an acute mental health crisis, somebody experiencing psychosis or hallucinations. It's a family member who's concerned about their loved one who can call, and also substance-use crises. So there's a lot of ways that this number has the potential to help. It's just a question of are we providing the services that are needed on the other end of that phone?

**Rovner:** So the 988 number provides one element of an effective mental health crisis response effort — somebody to talk to. What are the other elements and what's being done to address them?

**Wesolowski:** So after someone to talk to, that about 20% that need more help, that can be provided over the phone, we need someone to respond. And right now, it is much more likely that someone in crisis is going to come in contact with law enforcement than a mental health professional. So our vision, the vision of the mental health community of SAMHSA [Substance Abuse and Mental Health Services Administration] and so many others is that mobile crisis teams are available to respond when that help is needed. And these are teams that are staffed by behavioral health professionals. It really takes law enforcement out of the equation and makes sure that we're providing a mental health response to mental health crises. And then beyond that, sometimes they need a place to go. And, you know, overcrowded emergency departments are not the solution. We see people with mental health conditions boarded in emergency rooms far too often and for egregious amounts of time. So crisis stabilization facilities and services are really critical, and these are typically short-term facilities, less than a day, 23 hours. And they're often a living-room-like environment, and it's really to assess an individual and try to figure out what's

going on. If substance use is at play, you don't know that right away. So really trying to talk to the individual, engaging them, finding out what's going on with them, what they're feeling, and determining what the next steps for care are.

**Rovner:** Leaders in Congress just in the last couple of weeks have talked about making mental health a priority for 2022, even in the limited time left before the midterm elections. What are the possibilities of things that Congress could do to help, and what are your top priorities at NAMI?

**Wesolowski:** Yeah, there's a lot of demand and a lot of needs. So there's a lot of ways Congress can help here. First is really around 988. There's just not enough resources out there. Local call centers that are answering these 988 calls are funded at the local level, and they're funded by a hodgepodge of different funding sources: state funding, local funding, grants, universities. And that means the services and capacity really vary state to state. And, ultimately, we want all of those calls answered in-state and not going to a national backup center. Because only those local call centers can really provide the resources that are needed and connect people to different tools and supports in their community. And, plus, the other components that I talked about — mobile crisis teams and crisis stabilization facilities — are very rare and not available in most communities. So the response people are going to get, once 988 goes live, really depends on where you live. And we think everyone deserves an equitable and robust response if they're in crisis. So our top priority is really making sure we leverage this opportunity with 988 coming and really provide the help that we know people need. We don't want to lose people's trust. And if they call 988 just once and don't get the help they need, they're never going to call again. And so we got to do this right and we really only have one chance to do that.

**Rovner:** I feel like I've been covering health care since the 1980s, and I feel like mental health is always sort of the forgotten child of health care. Has the pandemic, perhaps in its own strange way, helped put mental health a little bit more front and center on the health agenda?

**Wesolowski:** It really has. We were seeing that momentum before the pandemic, that there was a lot more conversation about mental health and really broad bipartisan support. But I think the pandemic has accelerated it because more policymakers than ever realize this can happen to anyone. Anyone is susceptible to symptoms of a mental health condition, and it makes it a lot more real, and they're seeing the impact on their constituents. So it definitely has accelerated conversations about what to do. And I think, as we also see a youth mental health crisis, policymakers are especially concerned. I mean, our kids are struggling. The last two years have been hard on all of us, but in those key developmental phases of youth, it's been a real struggle. And so we're really concerned. We know that the mental health impact of this pandemic is going to have a long wave of repercussions. And we're seeing Congress talk a lot about how they can help kids in particular, which is really important, in the top priority for NAMI.

**Rovner:** Well, we'll see if they follow through and we will stay in touch. Hannah Wesolowski, thank you so much for joining us.

**Wesolowski:** Thank you so much. It was a pleasure being here.

**Rovner:** OK, we are 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](http://khn.org) and in our show notes on your phone or other mobile device. Tami, why don't you go first this week?

**Luhby:** OK, my extra credit hits home to me. It's by Sarah Gantz of The Philadelphia Inquirer. It's titled "[COVID-19 Has Even Ruined Our Feet.](#)" So, we know of a lot of surprising issues with covid-19. This isn't actually anything due to the illness itself. This is due to our lifestyle changes that have happened during the pandemic, and it's two separate issues. One is that people have all of a sudden decided to become more athletic because they may have gained weight or they have more time on their hands. So they've decided they're going to become runners. And oftentimes they don't know that you really need to have the right shoes, as I've learned somewhat the hard way sometimes, to become a runner. You don't just go out and run in your tennis shoes or basketball shoes and go out and do 5 miles. So that's one problem. And then the other problem, on the flip side, is that people are at home all day, so they're not walking around in heels, which is a good thing, but they're also not walking around in shoes at all. So they're usually, you know, a lot of people are barefoot or they're walking around in slippers or flip-flops and they don't have any support. And that can actually cause a lot of foot problems. So we're finding our podiatrists, orthopedic surgeons, and physical therapists told Sarah that they are seeing more painful conditions of plantar fasciitis and Achilles tendinitis than they ever have before. It actually was eye-opening to me because I don't wear the best footwear at home either, even though I do have the right running shoes. So I hope that a lot of people read the story, will either know what to do to avoid these painful conditions, or will actually at least know how to treat them if they do crop up.

**Rovner:** Or at least will know that misery loves company.

**Luhby:** Yes. They're not alone.

**Rovner:** Sarah.

**Karlin-Smith:** So I looked at an opinion piece in Scientific American by Steven W. Thrasher called "[There Is Nothing Normal About One Million People Dead From COVID.](#)" And he critically picks apart a narrative he's seen in some of the media and from politicians lately, basically trying to push us back towards so-called normal, and as we slowly see this omicron wave die down, and he basically argues we are nowhere near normal with this crisis, given how many people have died so far. The continued risk to use swaths of the population and so forth and, again, basically seems to be suggesting, you know, we are trying to ... by pushing this conversation around "normal," now we're essentially trying to rationalize incredible amounts of death and suffering instead of thinking through more carefully now what we can continue to do to protect people and ensure we don't continue on this cycle of mass casualty, which, no, I don't think people in this country really appreciate how alone we are, particularly compared to other wealthy nations, similar nations, and how much death and devastation we have. The other big thing he doesn't really get into this here, but I think there is so much talk now about returning to normal, and even in a city like D.C., which probably has more restrictions than many parts of the country, to me, there's not a lot that isn't normal right now. If you choose to take a little bit of a risk and you're willing to wear masks and so

forth, you can pretty much do everything you could have done in your life pre-pandemic. So I find this whole “return to normal” narrative a bit perplexing sometimes, because part of what seems to be our problem right now is we've continued on operating as normal at times rather than trying to contain the virus.

**Rovner:** Indeed. Rachel.

**Cohrs:** Yes. Mine is a piece in Bloomberg Businessweek, and the headline is “[Nurses Who Faced Fines, Lawsuits for Quitting Are Fighting Back](#),” by Josh Eidelson. And as I was doing research and reporting for the [travel nursing story that I worked on](#) this week, I just thought this piece was excellent. And it focuses on one travel nurse staffing firm not owned by private equity, but it's called Health Carousel. And I think the whole story is about a lawsuit where the nurses are claiming that they were exploited. A lot of it's travel contract workers who are traveling from the Philippines, they're facing really big fines if they choose to leave their jobs. And it's just a really eye-opening conversation about the predatory practices of this one agency. And I think one interesting point that came up in my reporting relating to this agency that just I didn't get to was that they are offering to buy smaller staffing agencies, too, and posing themselves as like a private equity alternative. And clearly, there are some big questions here about consolidations industry. So I just think this story did a really great job of making this issue personal and putting the spotlight on another element of this, which is immigration and visas and that aspect of the health care workforce crisis.

**Rovner:** Yes. There's always so many things to talk about. Well, my story is from my KHN colleague Markian Hawryluk and it's from the category of quote “Stories I Wish I'd Written.” It's called “[Demand for Service Dogs Unleashes a 'Wild West' Market](#).” And it's another supply-chain story, really. The demand for trained service dogs is much higher than the supply, which has led to people charging outrageous prices for questionably trained canines. As an amateur dog trainer myself, I know what it takes to train a service dog, and I know how many of them wash out during training for no other reason than that they're not actually suited to that kind of work. And frankly, I wouldn't be surprised to see private equity get into this line of business, too. That part is a joke. Maybe.

Anyway, 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 it, 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 — at kff.org. Or you can tweet me. I'm @jrovner. Rachel?

**Cohrs:** @rachelcohrs.

**Rovner:** Sarah.

**Karlin-Smith:** I'm @SarahKarlin

**Rovner:** Tami.

**Luhby:** @Luhby. L-U-H-B-Y.

**Rovner:** We will be back in your feed next week. Until then, be healthy.