

KHN's 'What the Health?'

Episode Title: Funding for the Next Pandemic

Episode Number: 240

Published: March 31, 2022

Mary Agnes Carey: Hello, and welcome back to KHN's "What the Health?" I'm Mary Agnes Carey, partnerships editor for Kaiser Health News, and I'm filling in for Julie Rovner, your regular host, this week. As usual, I'm joined by some of the best and smartest health reporters in Washington. We're taping this week on Thursday, March 31, 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're joined via video conference by Amy Goldstein of The Washington Post.

Amy Goldstein: Hi, good to be with you.

Carey: Jennifer Haberkorn of the Los Angeles Times.

Jennifer Haberkorn: Hi, MAC, thanks for having me.

Carey: And my KHN colleague Rachana Pradhan.

Rachana Pradhan: Thanks, MAC.

Carey: Later in this episode, Julie Rovner will talk to Julie Appleby, who reported and wrote the latest NPR-KHN "Bill of the Month" about an air ambulance bill that might be one of our largest Bills of the Month ever. But first, this week's news. Let's talk about the Biden budget. President [Joe] Biden's fiscal 2023 budget plan would give the Department of Health and Human Services a nearly 27% spending boost. A top priority is \$28 billion to bolster pandemic preparedness. And that's money that's separate from the current stalemate on Capitol Hill over coronavirus aid. What's the significance of this new pandemic preparedness spending? What would it go towards and is that where the money is most needed?

Goldstein: Well, there's been a lot of criticism during this pandemic that, for years, public health and research to cope with pandemics just wasn't flowing in advance of the coronavirus pandemic. So this administration is saying, "Look, we're going to be better prepared next time." They've got criticism on Capitol Hill, and they've gotten criticism around the country for being a little slow on the uptake — not to develop vaccines, which obviously happened at a record pace, but for some of the other rudiments of fighting a public health crisis. So that's what this money is about, is saying we'll be ready in the future.

Haberkorn: I think it's also important, too, for lawmakers to capitalize on this moment. I mean, for decades, pandemic funding and anything that was viewed as looking out too far in the distance was ignored by Congress. Congress is very good at dealing with what's exactly right in front of them, what's on fire in front of them. And so now a pandemic is still fresh in the mind. Obviously, there's still a lot of political controversy around whether we need funding to continue to fight the covid pandemic. But a future pandemic has some sense of urgency, and it's pretty smart for the

administration to capitalize on that moment and try to get Congress to boost these pots of money while they can.

Carey: Is it going to work?

Haberkorn: Well, it might be a good strategy. That doesn't mean necessarily that it will work. But you know, I think it's better to have this conversation now than in 10 years when we're many years away from the covid pandemic. Hopefully, hopefully, we're many years away from a future pandemic. But it's good to be having the conversation now.

Pradhan: I'm going to be the budget Debbie Downer overall, which is that it's very rare these days that Congress actually passes a spending plan that's signed by the president. So, more often than not, of course, the budget, the White House's budget proposal is a statement of priorities and what they *would* like to see. But I could probably count how many times that has Congress actually passed an actual budget for an entire fiscal year, probably fewer than the times I can count on one hand in recent years, so. But like Jen said, it's smart to at least use this moment to show that we do care about pandemic preparedness and making sure that we have more resources the next time around.

Goldstein: And MAC, you made an important distinction, which is this is about the future. This is not what the administration thinks it needs to continue fighting covid. And the White House made a very interesting strategic calculation, which was to leave out of this budget, in terms of dollar amounts, at least, any of the things it's still pushing Capitol Hill for to lower drug prices, to provide more money for testing and treatment for covid. There had been a \$22 billion package that the White House had been advocating be included in the last big spending bill that Congress did pass. And, if you recall, that money was left out because the parties couldn't agree on what should be in it or how much should be in it. And what the White House decided in presenting this budget was to, rhetorically — I mean, they have some language that reminds people, “Oh, and we really want to do these things too,” but they didn't put those dollar amounts right in that budget.

Carey: Oh, that's an interesting calculation. They did add some other things, like more money for safety inspections at nursing homes, a vaccine-for-adults program to target uninsured individuals, some money for new investments in maternal and mental health and addiction services. Is there any way that these might bridge the partisan divide that is so strong on Capitol Hill, these particular areas, or, as Rachana notes, it's sort of, like ... it's out there. But this is the budget, and the old adage of “The president proposes and Congress disposes” that maybe this stuff just isn't going anywhere.

Goldstein: Well, I think that's the aspiration — that the White House has found a set of things that are, in the very fractious world of health care policy, perceived to be neutral enough that maybe they could get it through both parties. It's one of those giant “time will tell” things.

Carey: Absolutely. Well, we'll keep our eye on that one. So speaking of spending, the Centers for Medicare & Medicaid Services, which is also known as CMS, released new estimates this week that showed national health spending growth had slowed, after a rise due to covid-19. National health spending is projected to have grown 4.2% to \$4.3 trillion in 2021, and that's compared with a

growth surge of 9.7% in 2020, according to the report, which is compiled by the CMS actuaries. The slowdown was due in part to a decline in the use of health care services and that federal financial stimulus money for covid, as you know, declining as covid-19 cases [were] declining. So this was interesting, but they also had some interesting trends for the future. One that [stuck] out to me is that health care is expected to account for nearly a fifth of the U.S. economy in 2030, but that's roughly the same as in 2020. What do you make of that? And are there other takeaways in this report that you thought were interesting?

Pradhan: One of the things that I thought was interesting about this report that just came out this week — MAC, per your point — it highlighted that projected spending on Medicaid, the federal-state health insurance program for low-income people, it rose to 10.4%, up from 9.2% in 2020, because enrollment has been growing in Medicaid extremely rapidly over the last few years. That program now — I think our latest estimates are that 79 million people are on Medicaid because there is a pandemic-era protection, basically, that was put in place in 2020 that prevented states from disenrolling people during the pandemic. Now that will end sometime, you know, probably maybe in the not-so-distant future. We don't know when exactly. But I think once enrollment starts to ... when states can start disenrolling people again, enrollment is going to drop, probably by millions of people, I think is likely. But how many we don't know for sure. So I think that that's part of it. Actually, we might see some, at least in the next few years, we'll see Medicaid spending growth maybe slow down a little bit because there just won't be as many people on the program as there are now.

Carey: Sure. And to your point, you're going to see people ... some people are going to lose their Medicaid coverage, as this additional federal funding dwindles.

Pradhan: Yeah, I think there's a question — the big question is there almost certainly are people on Medicaid right now that are no longer eligible based on their income, but have not been disenrolled in the last two years because of this continuous-coverage requirement. But just because of bureaucracy and administrative burdens for people trying to justify their renewals and try to stay on the program, there will likely be people that fall off the program who are still eligible. And so ... but the question is how many of those?

Goldstein: There have been estimates by the Urban Institute that perhaps 16 million people will drop off the rolls. And the question is how many of them will slide over to other coverage? The administration, including CMS, has been working really, really hard to try to get states to plan for this, including by helping people who are no longer ... legitimately no longer eligible for Medicaid move over to ACA marketplace health plans. But how well that's going to work around the country is a really open question.

Carey: So as has been noted here, Medicaid spending is expected to grow over the next decade, as is Medicare spending, private health insurance spending, increases for spending on drugs, hospital, and physician services. And our colleagues here at the Kaiser Family Foundation just released some very interesting polling that the public says these items should be a top priority for Congress: limiting price increases for medicines to the rate of inflation, capping out-of-pocket costs for insulin at \$35 a month, placing a limit on seniors' out-of-pocket health costs, and allowing

Medicare to negotiate the price of prescription drugs. So you have this tension, right? You've got these spending increases. Yet voters expect Congress to take care of the spending increases. Are these two natural tensions that simply exist and are these rises in all these areas of spending, are they simply inevitable? Have we grown so accustomed to them that they're almost expected every year?

Haberkorn: Perhaps so. And, I mean, as Democrats try to build this case for everything that you listed are things that Democrats want to do on Capitol Hill right now and don't have the support to do. So take, for instance, the \$35 cap on insulin. It's extremely popular. Democrats would love to get that done for political reasons. Everyone agrees that it's terrible that people have to pay a ton of money for their insulin. But putting a cap on that insulin comes at a broader cost. You know, it's not free. And so where is that cost going to get absorbed into the system? And no one yet has a good answer for how to do that.

Carey: All right. I guess I want to ask a broader question, too, from your perspective as health reporters who've watched the system for a long time. Are we getting what we pay for? You know, is the health care system better, is it more efficient? Is it serving patients better than before? Or are we simply paying more, but getting less. I know we can have a whole podcast on this, but quick takes would be appreciated. Rachana, what do you think?

Pradhan: No, I don't think we get what we pay for. I think that's one of the biggest flaws of our health care system. We pay among the highest prices in the world for things. And while there are many marvels about our medical system and health insurance system, what we pay in premiums and out-of-pocket costs for coverage, I think, research has shown over and over again that we should have much better outcomes given what we pay in the United States.

Goldstein: Two thoughts. One, we have very bad health outcomes as a country compared to our expenditure on health care, and we also have a very socioeconomically diverse population in this country, and the vast number of underserved people and people without health insurance drags down those outcomes, even though we're spending a lot of money on people who do have coverage. That's point No. 1 one. Point No. 2 is if you think back to the creation of the Affordable Care Act in 2010, one strand of it — I mean, it's obviously a very broad law — and one strand of it was to try to come up with some innovations that would make health spending more efficient. So there's been a decade of an agency within HHS has been trying to do that, and it's a little bit debatable what it's achieved.

Haberkorn: To your point, Amy, you know, you think about the things that were in the ACA that were supposed to help reduce costs. You know, I'm thinking about the “Cadillac tax” that was supposed to be one of the drivers to get people to not get addicted to their first-dollar coverage. And that, you know, Democrats didn't have the political will to keep that in place and angered the unions. So this is hard. I mean, what you're asking, MAC, is really difficult, and policymakers don't have any good answers for how to do this.

Pradhan: Do you guys remember before the unicorn term, or the term of the day, was “value-based care” and “accountable care organizations”? I mean, that was maybe 2010, 2011. I want to

say, when I arrived in Washington to do health reporting, that was the, ooh, ACOs were the big, hot thing that were supposed to cut down on costs, and value-based care was the big expression that was thrown around at every health care conference that I went to. Now we talk about different things because we're in the middle of a pandemic, but just goes to show, I think, some of those things have not borne out.

Goldstein: But, Rachana, those two things, value-based care and ACO, are still kind of the guiding principles of the innovation center that the law created within CMS. So it hasn't gone out of style among health policy nerds who were trying to do something about it, just as not a lot of evidence that it's achieved what its aspirations have been.

Pradhan: You're totally right.

Carey: All right. So that is the elusive quest to control health care spending — it continues. So let's move on to covid. Of course, we can't have a "What the Health?" without talking about covid. In covid news this week, the [Centers for Disease Control and Prevention] and the FDA have given the go-ahead for another covid vaccine booster for people age 50 and older and certain people who are immunocompromised. What's the rationale behind this decision? Does everyone 50 and older need to get a second booster?

Pradhan: This is a land mine of debate, I think what you just asked, MAC. So I think we can try to maybe first and foremost step back and appreciate the balance that the Biden administration is trying to have, which is they don't want to be accused of going too slowly and being caught flat-footed if we do have another variant of concern that really causes another surge in cases in the U.S. But at the same time, in trying to move a bit quickly, it means that we do not have all the data and evidence that perhaps a lot of public experts and scientists would like to see about whether do we really need a second booster dose, which for a lot of people would mean their fourth vaccine dose overall. There is a [Wall Street Journal op-ed](#) — written earlier this week by the former, I believe, either deputy director or head of the FDA's vaccine review office and a former National Security Council adviser, or, I'm sorry, employee who coauthored — that you likely don't need a second booster shot. So I think that's their perspective. But, of course, the Biden administration is trying to push their feelings as to why this is a responsible thing to do now, especially for these age groups and immunocompromised individuals you mentioned, who are at higher risk of hospitalization or death from the virus.

Goldstein: Well, if you think about how the FDA and the CDC have treated previous vaccine recommendations, they're treating this one very differently because they're not saying, "We think you should do this." They're saying, "If you want to do this, we think it's OK." And that really reflects the data ambiguity or the lack of sufficient data on what's warranted. There are some bases for concerns. One big one is that people who got a first booster, it looks as if that boost doesn't protect people forever. It begins to wane after several months, and some people who had those boosters in the fall are reaching the point where that protection is dwindling. On the other hand, there's particularly little U.S. data — a lot of the data comes from other countries such as Israel — and it's just, as you were saying, Rachana, it's not super clear. So the administration's been getting a little bit of criticism from people saying, "Well, you left us kind of in a confused

muddle. Why don't you tell us what you think?" On the other hand, I think the administration wanted to straddle things between saying, "Well, there's some basis for this, but we're not entirely sure, so you make up your own mind. But we're OK with it."

Carey: So what's the average person to do? How do you make up your own mind in an informed way if you fall into one of these categories?

Goldstein: Well, I can tell you that my colleagues who directly covered the CDC and the FDA on that decision have been getting inundated with reader questions this week from people saying, "Well, you cover this. What should I do?" And they're feeling kind of awkward because they're saying, "Well, we're not doctors. Talk to your doctor." Which is really the right answer, but there's just not a lot of clarity.

Pradhan: Yeah, I've gotten multiple questions this week from relatives who are 50 or older saying, "What do you think? Should I do that?" And I even sent that op-ed that I just referenced to one of them and said, "You should read this, because these are credible experts, and see what they think," but it's a very weird thing to have to make any sort of recommendation on.

Haberkorn: And, really, in the last six months of this pandemic, it feels like people are making their own decisions. You know, President Biden could be out there giving away free cars to get boosters, and there's going to be some people who are not going to get that booster. And vice versa. And so people are making their own decisions at this point. I mean, it doesn't help that the administration doesn't make it easy on them and does not give them clear guidance. But it does feel like we're at the point where people are making their own calculation for themselves — unfortunately not consulting their doctor all the time. And that really is the best advice, to see what your doctor thinks.

Carey: So it seems like funding is also an issue here because the Biden administration lacks the funds to purchase a potential fourth coronavirus vaccine dose for everyone, even as other countries are placing orders, right? Federal officials have secured enough doses to offer a fourth shot for Americans ages 65 and older, as well as the initial shots for kids under 5 if regulators determine those are necessary. But they can't expand this to other age groups, right, unless Congress passes this stalled \$15 billion funding package? There seems to have been possibly some movement overnight, possibly in the Senate, between Republicans and Democrats. Can someone bring us up to date there?

Haberkorn: Yeah, there's a bipartisan group of senators who are trying to get this deal done. If you recall, a couple of weeks ago, the House tried to pass a \$25 billion covid package as part of a larger bill, and it was scuttled at the last minute because some of the funding mechanism would take funds that were already promised but not spent by states. It would usurp it, essentially — claw it back and put it in this package. And so senators are trying to come up with a deal. The big point of contention is that Republicans feel like some of this covid money in the last couple of rounds has been a little too reckless, and they want to make sure there's a good accounting of how the money is being spent. So a bipartisan group of senators, including Republicans Mitt Romney, Richard Burr, Roy Blunt — folks who have a long history working on health care — worked with some

Democrats, tried to come up with this agreement. Some people left the meeting saying that we're close to a deal. Some left is saying a deal is far off. So in typical Washington fashion, it's somewhere in between those two. And it does feel like, particularly if this money is going to go toward therapeutics, which seems to be the focus right now, that something might be in the offing in the next coming weeks.

Carey: And we're coming up to a spring recess deadline, right? Which might help. I believe it's April 9. Congress loves deadlines.

Haberkorn: Yes, that's the only way they get anything done. Yes, they're leaving town at the end of next week, April 8, for two weeks for their spring break. So, yeah, they're under the gun, and they have a couple of things they need to get done as well. But this seems to be a priority. We might be watching them work on this, I should say, until Friday at midnight, but that's when things get done.

Carey: How else would you want to start your weekend, right? There you go.

Haberkorn: Exactly.

Carey: All right. So let's go to another aspect of money drying up. Amy, you've written about this. Some federal money will soon be drying up to pay providers, health providers nationwide who provided covid care to the uninsured. Can you take us through what's happening there?

Goldstein: Yes. Well, if you recall, the first couple of covid relief laws that were passed in the spring of 2020 had provided relief money in it, and it was up to HHS how to divide up that money among different kinds of health care providers. And one of the — HHS kept using the word tranche, if you recall — one of the tranches of money was an uninsured fund that was going to be administered within HHS at the Health Resources and Services Administration, which is not a part of HHS that usually handles reimbursement for care, but it was given responsibility for this uninsured fund. I remember covering that and unlike the other tranches of money, which were things like rural providers or other niche groups, there was no specific dollar amount that was publicly released for this uninsured fund. And the administration kept saying, "We'll have enough money for it." Well, it turns out, almost two years later, that money for a lot of parts of that provider relief fund [is] running short. And, in particular, this uninsured fund out of HRSA has hit its end early because it's the only fund for which, whether it's a clinic or a hospital or a pharmacy, have to actually submit claims for care that they provided. And what happened is that HRSA announced a week ago that the deadline had come for submitting claims for testing and treatment of the uninsured, and April 5 will be the deadline for submitting claims for vaccinating the uninsured. And that pertains to all kinds of people in the health care system who are treating uninsured patients. But it hits particularly hard for safety net providers, things like community health clinics or safety net hospitals, which have been very dependent on that money. And I spoke with some of them around the country, and they're really concerned about what this is going to do to their bottom line.

In terms of vaccination, the FDA basically has a rule that nobody can charge anybody for a covid vaccine, so patients on the receiving end of those shots are protected, but there's no such rule for

testing. And, already, we've started to see a few places, including Quest, a big medical testing and diagnostics company, say, "If you're uninsured and you want to get a covid test, we'll do it, but we're going to charge you a \$125 for it."

Carey: Wow. So would this package [that's being] negotiated on the Hill bring more money back to treat the uninsured? Do we know that?

Goldstein: Well, that's an interesting question. We don't know exactly how that money would be allotted. I mean, one figure I saw ... It's a little unclear whether it's going to happen. If this happens, it's a little unclear how much money it's going to be. But one set of figures I saw this morning was perhaps a \$10 billion package. Well, [the] HRSA uninsured program has recently been spending about \$2 billion a month. So you can see the math that even if all of that money went to that program, which of course would never happen, it's not going to last very long.

Carey: That's the news for this week. Now we'll play the Bill of the Month interview Julie Rovner taped with KHN's Julie Appleby, and then we'll come back and do our extra credits.

Julie Rovner: We are pleased to welcome to the podcast my KHN colleague Julie Appleby, who reported and wrote the latest KHN-NPR "Bill of the Month." Julie, welcome back.

Julie Appleby: Thanks for having me.

Rovner: So, this month's patient was diagnosed with a very serious ailment and ended up with an even more serious bill. Tell us who he is, where he's from, and what happened to him.

Appleby: Yeah, thanks. This was a really big bill. Sean Deines and his wife, Rebekah, were out road-tripping. They were out in Wyoming. He'd lost his job as a bartender when the pandemic hit. So he was out there and visiting his grandfather and doing some other things, and he started to feel pretty sick. Ended up going to an urgent care center, and they called him back and said, "Wow, your white blood count is through the roof. You need to get to an ER right now." So they drove initially to a hospital in Casper, but the hospital really couldn't take care of him there because they figured he had this aggressive cancer. So they transferred him to Denver. And that's where our story really starts. Because in Denver, the specialist confirmed that he had acute lymphoblastic leukemia, which is a fast-growing, aggressive blood cancer. And then he had to figure out what to do.

Rovner: Right. So ... they decided to try to go home, right?

Appleby: Their families were all in North Carolina, so they wanted to get back there, where they could get help from his mother and his mother-in-law and some other things. So they selected Duke University in Durham and decided to go there. And Sean was being treated at this time in the hospital. He was getting some antibiotics and some other treatment. And he was a little bit in and out of it. But his family was helping him, and they arranged a flight with something called Angel MedFlight, which is part of Aviation West Charters of Scottsdale [in Arizona]. And the flight was going to take them from Denver to Duke University.

Rovner: So an air ambulance, basically.

Appleby: An air ambulance. And this was an airplane. It's not a helicopter, obviously, because that's a long flight. It was like 1,400 miles. But they took this flight, and they took the flight on Dec. 1, 2020, and they took a ground ambulance back and forth from the hospitals to the airport and back, right? So that was his trip, and he *did* get to Durham. He did get treatment. He spent 28 days in the hospital in Durham getting treatment. And then he went home.

Rovner: So medically there was a good outcome. But, as we say, then the bill came. How big was the bill? And this is just for the air ambulance, right? He was treated in an in-network hospital.

Appleby: Right. He was in-network in Durham. Yes, this is one of the largest bills I've seen. It came to \$489,000 from the air ambulance company,

Rovner: Which is just crazy. I mean, even by air ambulance standards, that's really crazy.

Appleby: That's a lot of money. And in the reporting, what we found out was that approximately \$70,000 of that \$489,000 was the portion that they billed for the ground ambulance service to and from the airports.

Rovner: So from Denver to the Denver airport, which is far, but not that far.

Appleby: Exactly.

Appleby: And then in North Carolina, from the Durham airport to Duke, right?

Appleby: Right. And that's where this gets interesting because this was a very large bill. And his family was told that by the air ambulance company that they would accept the payment from the insurer and that they would not come after them for additional payments, which is sometimes known as a balance bill. And that happens in air ambulance cases. And, remember, this was before the law changed to cover air ambulances under the No Surprises Act.

But what happened with Sean was that the insurer and the air ambulance company disagreed over whether the flight was medically necessary. So that's what this came down to. The air ambulance company requested ahead of time prior approval to fly him. But the insurer says the fax arrived in the predawn hours on the day of the flight, so there was no prior ...

Rovner: Fax, f-a-x, not f-a-c-t-s.

Appleby: Right, f-a-x. They faxed the information seeking this prior authorization, but they flew him anyway. He got to Durham, and then later the dispute came out that the insurer said the flight wasn't medically necessary, that he could have gotten treated in Denver and the flight wasn't needed. So that's what this particular case turned on.

Rovner: Close listeners to the podcast and close readers of our Bill of the Month will say, "Aha, if this had happened after the surprise bill legislation had gone into effect, then this wouldn't have happened." But it actually might have still happened, right? That's not what the fight was about.

Appleby: It might have still happened. I think there'd be a couple of different things if it happened today. For one, the family might have gotten an upfront estimate of the costs. They might have

learned ahead of time that it was going to cost \$489,000 because the No Surprises Act does require that providers of out-of-network care give that information to people upon request. So they might have found that out. But, no, it probably would not have touched on the medical necessity issue because the No Surprises Act doesn't get in between those decisions. That's a decision made by the insurer generally on what is covered and what is not.

Rovner: So what eventually happened to the bill?

Appleby: Well, the insurer sent Sean Deines a check for \$72,000, which he immediately turned over to the air ambulance company because they requested it. So he thought the matter was settled. But later he got a request from the insurer to give the money back, and he didn't have \$72,000 lying around. He never really even put this money in his bank account. He just signed the check over to the air ambulance company. So that's when the bill got sent to collections. Mr. Deines was very concerned about this, and it wasn't until KHN and NPR started calling and asking about this bill that he suddenly started getting a lot of calls back. And he did talk with the insurer and the air ambulance company. And I can say that at the end of the day, Sean Deines is not going to have to pay that \$72,000 back. Both companies have said they are not going to pursue him for that money, and they're going to work it out between themselves in terms of who owes money for what.

Rovner: And, of course, that's what the No Surprises Act is supposed to do, right? There's a disagreement. Get the patient out of the middle.

Appleby: Exactly. So even though this didn't fall under the No Surprises Act, and it might not even if it was today. That's essentially what happened. Sean was taken out of the middle of this thing. He doesn't owe any money, and the air ambulance company and insurer are going to have to duke it out.

Rovner: What's the takeaway here if you're diagnosed with a life-threatening disease away from home?

Appleby: Yeah, I think one of the first things to do is really talk with your insurer because they set rules on what is covered and what's not, and it's called medical necessity. They may decide that you don't qualify for an air ambulance because you could get treated where you are. Or, conversely, they might say, "Yeah, you know what? There are no specialties there. We need to get you to a place where you can go." So I would always say check first. This obviously does not apply if you're in a car wreck and you are on the side of the road and they're calling an air ambulance. That is not what we're talking about here. We're talking about nonemergency scheduled air ambulance. So I would say that's the first thing: Talk to your insurer. Second of all, get an upfront cost estimate. Get it in writing.

Rovner: Which now they are required to do, thanks to the new federal surprise bill law, right?

Appleby: That is correct. That is correct.

Rovner: OK, well, glad this story had something of a happy ending, even though I guess it was a hassle for all involved. Julie Appleby, thank you very much.

Appleby: Thanks for having me.

Carey: All right, we're back, and it's time for our extra credit segments, where we each recommend a story we read this week and think you should read, too. Don't worry if you miss it. We'll post the links on the podcast page at khn.org and in our show notes on your phone or other mobile device. So, Jen, why don't you go first this week with yours?

Haberkorn: Sure. Mine is from The New York Times. The headline is "[The FDA Rushed a Drug for Preterm Births. Did It Put Speed Over Science?](#)" The headline gives away the story. It's a very well-written story about a drug that was supposed to help forestall the threat of preterm birth, and there's a big debate over whether FDA rushed that to the market on the big, wonderful promise of what it could do.

Carey: Amy?

Goldstein: So my pick is from Stat this week, "[NIH's Identity Crisis: The Pandemic and The Search for a New Leader Leave the Agency at a Crossroads.](#)" It was written by Lev Facher. And on one level, it's really a story about the search for a successor to Francis Collins, who retired at the end of the year and then unexpectedly ended up as a science adviser in the White House. So it's about that search for who's going to succeed Collins, who had a very successful, long tenure directing the [National Institutes of Health]. But at a deeper level, the story really raises questions about what should be the role of this federally funded biomedical engine. Should it move at the pace that it has historically, with a big emphasis on basic research? Or should it be more akin to Operation Warp Speed, which was a very quick effort to develop vaccines for covid when the country really needed them? And it raises some very interesting questions about ... the NIH's identity, how diverse it is or isn't, and what its fundamental mission should be.

Carey: Rachana?

Pradhan: My story this week is from The Washington Post. The headline is "[Is This What a Good Mother Looks Like?](#)" — in quotes — "After Struggling to Get Treatment for Her Mentally Ill Son, a Mother's Act of Desperation: Giving Up Custody." This story was ... You have to be ready to read something really sad, for anyone looking to read it. But it's really beautifully told by William Wan at the Post and basically profiles one family, a mother in North Carolina, showing how — of course, personally, at a personal level — how having a son with mental health issues really caused her even to fear for her own safety and her own life, but at the same time really exposes the heartbreaking lack of access to meaningful mental health services in this country for people who struggle from those kinds of issues and really gets into what would be an unimaginable choice for many families, which is having to give up legal custody of your child in order to try to help them.

Carey: I remember reading that story. I thought it was incredibly moving. Mine is from The New Yorker, and it's called "[A Freelancer's Forty-Three Years in the American Health-Care System: Bills That Aren't Bills Arrive in the Mail, Doctors Opt Out of Treatment, and Patients Need Expert Help to Figure Out Which Diseases They Can Afford to Have.](#)" I just thought this was a fabulous story. It really looked at the central idea about some of us who have jobs with decent benefits may not realize how hard life is in the United States for people who don't have those benefits. The writer

takes you through all of his experiences, including being covered by union insurance, purchasing coverage on the individual market, purchasing coverage through the Affordable Care Act, and now navigating Medicare with all those twists and turns along the way. I think it's a terrific read.

So that's 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 a review — that helps other people find us, too. Special thanks, as always, to our ace producer Francis Ying. And also, as always, you can email us with your comments or questions. We're at whatthehealth@kff.org. Or you can tweet me. I'm @MaryAgnesCarey. Amy?

Goldstein: @goldsteinamy.

Carey: Jen?

Haberkorn: I'm @jenhab.

Carey: Rachana?

Pradhan: And I'm @rachanadixit.

Carey: We'll be back in your feed next week. Until then, be healthy.